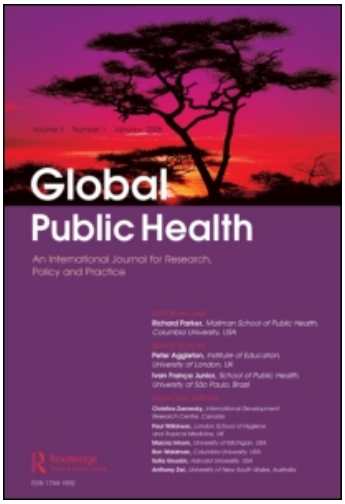

Global Public Health
Publication details, including instructions for authors and subscription information:
http://www.informaworld.com/smpp/title~content=t716100712

Understanding women's experiences with medical abortion: In-depth interviews with women in two Indian clinics

B. Ganatra [a]; S. Kalyanwala [b]; B. Elul [c]; K. Coyaji [d];S. Tewari [e]
[a] Ipas, Pune, India [b] Population Council, New Delhi, India [c] Mailman School of Public Health, Columbia University, New York, NY, USA [d] KEM Hospital, Pune, India [e] Parivar Seva Sanstha, New Delhi, India

First published on: 08 May 2009

To cite this Article Ganatra, B. , Kalyanwala, S. , Elul, B. , Coyaji, K. andTewari, S.(2010) 'Understanding women's experiences with medical abortion: In-depth interviews with women in two Indian clinics', Global Public Health, 5: 4, 335 — 347, First published on: 08 May 2009 (iFirst)
To link to this Article: DOI: 10.1080/17441690802551340
URL: http://dx.doi.org/10.1080/17441690802551340

Global Public Health
Vol. 5, No. 4, July 2010, 335–347

Routledge
Taylor & Francis Group

Understanding women's experiences with medical abortion: In-depth interviews with women in two Indian clinics

B. Ganatra[a,*], S. Kalyanwala[b], B. Elul[c], K. Coyaji[d] and S. Tewari[e]

[a]*Ipas, Pune, India;* [b]*Population Council, New Delhi, India;* [c]*Mailman School of Public Health, Columbia University, New York, NY, USA;* [d]*KEM Hospital, Pune, India;* [e]*Parivar Seva Sanstha, New Delhi, India*

(Received 9 March 2008; final version received 14 October 2008)

We explored women's perspectives on using medical abortion, including their reasons for selecting the method, their experiences with it and their thoughts regarding demedicalisation of part or all of the process. Sixty-three women from two urban clinics in India were interviewed within four weeks of abortion completion using a semi-structured in-depth interview guide. While women appreciated the non-invasiveness of medical abortion, other factors influencing method selection were family support and distance from the facility. The degree of medicalisation that women wanted or felt was necessary also depended on the way expectations were set by their providers. Confirmation of abortion completion was a source of anxiety for many women and led to unnecessary interventions in a few cases. Ultimately, experiences depended more on women's expectations about the method, and on the level of emotional and logistic support they received rather than on inherent characteristics of the method. These findings emphasise the circumstances under which women make reproductive choices and underscore the need to tailor service delivery to meet women's needs. Women-centred counselling and care that takes into consideration individual circumstances are needed.

Keywords: medical abortion; women's perspectives; India

Introduction

Mifepristone-misoprostol abortion, a safe, effective and acceptable non-invasive alternative for early pregnancy termination, holds great promise to increase access to safe abortion in countries such as India, where abortion has been legal for over 30 years, but where the majority of the estimated annual six million induced abortions are conducted in uncertified settings, and/or by uncertified providers, and abortion-related mortality and morbidity remain significant (Chhabra and Nuna 1994). In 2002, the Drugs Controller of India approved the use of mifepristone for pregnancy termination in gestations of 49 days or less, making India one of the first developing countries to introduce medical abortion. A year later, the legislation governing the provision of abortion services was modified to allow certified abortion providers to offer medical abortion at uncertified facilities, if they have access to a certified facility for back-up, further paving the way for increased access to safe abortion

*Corresponding author. Email: ganatrab@ipas.org

ISSN 1744-1692 print/ISSN 1744-1706 online

DOI: 10.1080/17441690802551340
http://www.informaworld.com

services nationwide (Government of India 2003). Within a year of approval, five Indian pharmaceutical companies were marketing mifepristone, an estimated 700,000 tablets had been sold nationwide (Zydus Cadila, personal communication, 2003), and a survey of obstetrician–gynaecologists suggested significant familiarity with and use of medical abortion (Elul *et al.* 2006).

Despite these important regulatory changes, the documented large volume of mifepristone sales in India, and reports of significant familiarity and use of medical abortion among providers, very little is known about how Indian women experience medical abortion and how well it meets their needs and expectations. While qualitative methods have been used to explore women's attitudes towards medical abortion in a range of settings, at the time of this writing only four published studies included in-depth interviews with users (Harvey 1995, Simonds *et al.* 1998, Elul *et al.* 2000, Lafaurie *et al.* 2005). Only one of these was conducted outside the USA, and looked at women's experiences with misoprostol use in legally restrictive settings in Mexico and several Latin American countries. This study showed that women chose medical abortion because they perceived it to be less painful, less risky and less expensive. The study also highlighted the need for psychosocial support during the abortion process. There were no published data on women's perspectives from India; in order to fill this gap, we completed in-depth interviews with 63 women undergoing medical abortions in two Indian clinics.

Methodology

Women were recruited from two clinics – one in Pune and one in Delhi – which have legal, well-established surgical abortion services, and, at the time of data collection, were offering mifepristone-misoprostol abortion either as part of routine services or through clinical trials. In Pune, women were recruited from the out-patient department of a large non-governmental hospital catering to middle and lower-middle class women. In Delhi, women were recruited from a free-standing abortion and family planning clinic run by a large non-governmental organisation in a middle-income suburb. At the time of the study, both clinics were using a three clinic visit medical abortion regimen for women with pregnancy durations of 56 days or less. At their first visit to the clinic, women received 200 mg mifepristone. At their second visit, two days later, they received 400 mcg oral misoprostol. At the Pune clinic, some women who were part of an ongoing trial also received an additional 400 mcg misoprostol, or placebo, three hours after the first dose. All women received the misoprostol at the clinic; there was no home use. Women at both clinics were required to return for a follow-up visit 12 days after the misoprostol dose. Completion of abortion was confirmed based on ultrasound in Pune on history and pelvic examination in Delhi. All medical abortions were free in Pune, and in Delhi women paid Rupees 480 (US$11), approximately the same cost as a vacuum aspiration.

Women were recruited during variable time periods, from August 2003 to July 2004, depending on interviewer availability. Women in both clinics were informed about the study and invited to participate at their second clinic visit (i.e., the misoprostol visit) – or, in other words, before they knew their abortion outcomes. Recruitment was not done at the first visit to avoid any perception of participation being linked to service provision. If a woman agreed to participate, an interview was

scheduled to be conducted at the clinic during the follow-up visit. At the time of the follow-up visit a female researcher, unconnected with service provision, reconfirmed that the woman was willing to be interviewed. If she was, then the interview was conducted in the local language using a uniform guide of open-ended questions based on an instrument used previously by one of the authors (Elul *et al*. 2000). Neither the service provider nor any other person was present during the interview. If women were willing to be interviewed but the follow-up visit was at an inconvenient time, or the interview remained incomplete, another interview appointment was scheduled, at the clinic or home, a few days later. If women were willing to be contacted at home, a follow-up interview, for between one and four weeks from the date of the follow-up visit, was also scheduled. This additional visit was meant to help judge changes in perceptions of the experience over time.

Interview sessions lasted 30–45 minutes each, and interviewers took detailed notes, and, if women agreed, tape-recorded the sessions. Notes and recordings were transcribed and translated into English. Each interview was coded in Atlas-Ti by two authors using pre-determined categories, and discrepancies were discussed and resolved. While we used the clinics to recruit women who had undergone medical abortions in order to study their perspectives on the process, we did not study the efficacy, side effects or any other clinical parameters. The study protocol was approved by all the participating partner organisations and clinics, and also went through the Population Council's ethical review process. All women gave oral informed consent.

Findings

In all, 63 women were interviewed. At the Pune clinic, 54 women were invited to participate, eight refused, three did not return for their follow-up visit at the scheduled time and could not be contacted; 43 were interviewed. In Delhi, 63 women were invited and 62 agreed to participate at the time of their misoprostol visit, but only 20 were interviewed and included in the study. As the researcher in the Delhi clinic was available for limited hours and only on some days of the week, some women who agreed to participate could not be interviewed when they came in for their follow-up. Additionally, many did not come to the clinic at the scheduled time of their follow-up visit (coming in earlier or later or not at all), so these women were also not interviewed. We did not attempt to contact them at home as we did not have their permission to do so. Twenty-five women (all from Pune) agreed to an additional interview at home. All initial interviews took place at the follow-up visit or a few days later, except for two women where the interview could not take place until two to four weeks after their follow-up visit to the clinic.

Participant characteristics

Table 1 shows the participants' demographic characteristics. Less than half the women reported experiencing at least one previous induced abortion, including five who had previous medical abortions. Of the 63 women interviewed, 59 had complete medical abortions. The remaining four had incomplete abortions and, thus, received surgical interventions.

Table 1. Participant characteristics.

	Delhi ($n=20$)	Pune ($n=43$)	Total ($n=63$)
Marital status			
Married	19	43	62
Unmarried	1	0	1
Age			
<20 years	1	3	4
20–29 years	13	35	48
30–35 years	5	5	10
>35 years	1	0	1
Completed schooling			
1–7 years	2	3	5
8–10 years	5	17	22
>10 years	13	23	36
Type of family			
Nuclear	11	19	30
Joint	9	24	33
Occupation			
Housewife	13	32	45
Service industry	4	7	11
Small business	2	4	6
Student	1	0	1
Previous pregnancy history			
≥1 spontaneous abortion	1	5	6
≥1 surgical abortion	12	12	24
≥1 medical abortion	2	3	5

Abortion decision-making and method selection

Almost all women ($n=55$) confirmed their pregnancies either with a neighbourhood doctor or by using a pregnancy kit from a chemist before approaching the clinic for an abortion. Fifteen women also reported using various tablets – ayurvedic preparations, oral contraceptives and emergency contraceptives – before seeking care at the clinic. In most of these cases, the tablets were procured by their husbands from local chemists.

All women reported playing a major role in the decision to have an abortion, and 52 of the 62 married women said that their husbands had also played an important role in the decision-making process. Of the other 10, nine described their husbands as not having had strong feelings, or as having agreed to their wishes or 'given consent'. One woman hid the abortion from her husband until it was over. Mothers-in-law and other extended family members did not appear to play a major role in the decision to end the pregnancy. The most common reasons for ending the pregnancy were to limit family size ($n=25$), or because the previous child was still small ($n=13$). Financial, marital and job-related difficulties were cited by 11 women, three women did not want a pregnancy so soon after marriage, four women had medical reasons and one was unmarried. No clear reason was mentioned by the other six.

Just under half the women ($n = 30$) had some knowledge of medical abortion before approaching the study sites, and six came specifically seeking the method. Five had previous experience with medical abortion. Another five learned about it from friends or relatives who had used it successfully themselves:

> My mother-in-law told me about this method. My sister-in-law had an abortion using tablets and it was okay. So my mother-in-law said we should go to the same clinic and use the tablets. (Age 27)

Two read about the clinic in the newspaper and the husband of one woman inquired about the method after seeing an advertisement outside the clinic. Eleven women learned of medical abortion from their family doctors who referred them to the study clinics. Three of these women were actively looking to avoid surgical termination after previous bad experiences. Just over half the women ($n = 36$), however, reached the clinics with no specific knowledge of, or preference for, medical abortion and selected the method after learning about it from the clinic doctors.

Irrespective of how women learned of medical abortion, when asked why they selected this method, almost all ($n = 59$) initially said it was because the method was simple or easy, and/or did not involve surgery. As women spoke in more detail, however, the nuances behind these words became clearer. One woman described strong fears and misperceptions about surgical abortion:

> I'm afraid of curetting ... basically I'm afraid of the machine. I don't know how it works, and scared that it may cause harm to my uterus. I really don't know how it works but people say that the machine affects the uterus. (Age 23)

For women in Pune, where surgical abortion entailed an overnight stay, medical abortion allowed them to continue with their household obligations and minimised the need for assistance from family members:

> There's no need to get admitted in this method. There's no need to bring relatives along with you. Problems may arise at home if you go for curetting because when you're admitted, the domestic work doesn't get done and somebody must accompany you to the hospital. (age 35)

Five women felt that avoiding a hospital admission also allowed them to keep the abortion confidential. For six women, perceptions that they would avoid a physical intervention or an internal examination by a male doctor heightened the appeal of medical abortion. Cost factors were also a consideration for six women in Pune, where medical abortion was being offered free but surgical abortion was not. Most women ($n = 54$) reported that their husbands did not actively participate in the abortion method selection, though two women said that they went ahead with medical abortion despite their husbands' not wanting them to use that method. Regardless of individual contexts and reasons for selecting medical abortion, women reported that the counselling received played a key role in making them feel comfortable with the method.

The abortion process

Over three-quarters of the women were accompanied by family members – generally their husbands – on their first visit to the clinic (see Table 2). Although all respondents said that they had been advised to bring a companion during the

Table 2. Accompaniment to clinic visits.

	First visit (mifepristone administration; $n=63$)	Second visit (misoprostol administration; $n=63$)	Third visit (assessment of abortion completion; $n=63$)
Accompaniment			
Unaccompanied	15	34	45
Accompanied	48	29	18
Person who accompanied the woman[a]			
Husband/partner	38	17	14
Mother	2	4	0
Mother-in-law	2	3	2
Sister-in-law/sister	6	5	2
Friend(s)	2	3	0

[a]May sum to more than the number of women who were accompanied as women may have been accompanied by more than one person.

misoprostol visit, just over half came alone, and by the time of the follow-up, most were unaccompanied.

All but three women reported that they had been counselled and were prepared for what to expect. Only three women spoke of expecting serious side effects, but three others talked of taking leave from work and eight talked of making precautionary arrangements for additional support, including inviting their mother or sister to stay with them for a few days, or arranging for domestic help to work additional hours.

When asked about disruptions to their daily routines during the abortion process, a majority ($n=37$) felt that these were minor, mainly the need for additional rest because of nausea or other side effects following misoprostol ingestion, or having to arrange for the repeated clinic visits. Women's acceptability of these disruptions depended to a large extent on how they perceived the support they received from their families. Twenty-two women spoke positively of the support they received from their husbands:

> He supported me. He insisted that I eat on time and suggested that we ask the doctor about weakness and for a prescription for (pain) medication. (Age 24)

> He told me to go to my mother's place for 15 days so I could take rest. He was quite understanding. (Age 29)

Eleven women noted practical ways in which their husbands helped them during the abortion process that went beyond accompanying them to the clinic and providing money for payment. This ranged from one husband who took three days leave from work to look after housework, four who assisted in childcare and one who ordered prepared meals for three to four days to spare his wife the burden of cooking. However, 10 women said it was inappropriate for the husbands to get involved in housework or childcare:

> He is traveling most of the time so he is hardly around. And how can he do housework or cook? That's my job. (Age 24)

Thirty-four women spoke of looking for support from other marital or natal family members, friends or domestic help. And for six women, the care received from an empathetic service provider supported them emotionally through the process:

> The doctor called us and gave us care and medicine. We liked this a lot. The doctor asked me whether I had a lot of pain. At any other place maybe you wouldn't get so much care but here the doctor gave really good care. (Age 25)

Some side effects were experienced by most women ($n = 47$), usually cramping and pain during the expulsion process. However, 10 of these women went on to say that the side effects were less bothersome than they had expected:

> I didn't need it (rest) so much. The abortion was normal – I had a lot of bleeding only on the first day. Then I had pain and burning in my stomach but that had to happen. The medicines were hot but by the second day I was normal and I got up. I sent the children to school also. (Age 25)

Five women reported substantial discomfort during the abortion process:

> When I took the first tablet, I had a lot of pain. The pain was quite similar to the delivery pain. It started in my back and then shifted to my lower abdomen. It was really unbearable. I couldn't sleep for several days and nights. I found it difficult to work or even walk. (Age 28)

> On the first day I felt uneasy, and began to have pain and a bad backache. After I took the tablet (misoprostol), I went back home and my condition was so bad that I couldn't get up to get a glass of water. (Age 32)

Observing the products of conception (POC)

Thirty-four women spoke of observing the products of conception and often described this in great detail emphasising the colour of the products:

> The clots were big – white on one side and black on the other. (Age 32)

> As I was getting off my scooter, I felt something coming out. I ran to the toilet and a big red thing came out. It was like delivery, but this was much smaller and came out easily. (Age 24)

Four women who lived in low-income housing with shared toilets reported significant inconvenience when trying to monitor the POC:

> There is a public toilet on the ground floor. There is a mori (a place for passing urine) in the house itself but how can I regularly check in there? Family members are around. There are no lights in the toilet. In the daytime you can see a little but at night it's completely dark in there. I brought a candle when I went to the toilet, but checking it (the expulsion) was difficult. (Age 35)

Assessing abortion completion

Fear of the abortion remaining incomplete, and judging abortion completeness was a source of anxiety for nearly half of the women ($n = 29$) as they went through the abortion process:

> I thought and hoped I'm not in those 10 percent (of failed abortion). I was just praying to God to be in the 90 percent the whole time. (Age 26)

Four women did have incomplete abortions. All four suspected this either because the expelled products were not as described by the doctor or because their bleeding continued for many days:

> I was suspicious. The doctor told me that a pink yellowish clot would come out but nothing like that happened. Only one small and white-coloured clot was discharged. I showed it to my husband's brother's wife because she had had an abortion with tablets. She said that my clot was too small. It was the size of a tamarind seed. So, I suspected that not everything had been discharged. (Age 35)

Eleven other women (who had complete abortions) also reported significant concern about the POC, and fear that their abortion was incomplete, as what was expelled did not match in size, colour or shape to what they had been told to expect:

> Initially some pieces came out and then a yellowish ground-nut shaped knot came out. At that time I thought that it (POC) had come out, but I wasn't sure. I held the clot in my hands. It was not hard like a ground nut. It was a little soft. (Age 20)

> She (the doctor) had said that a white thing would come out. But nothing like that came out. It was pink. So I wasn't sure whether I was having a complete abortion or not. (Age 27)

Six women spoke of needing a doctor or other medical person to confirm that the abortion process was complete. One woman who lived far from the clinic described it as follows:

> Madam (the doctor) told me to wait (at the clinic) until 4:30 pm for my abortion to take place and then to go home. I didn't have my abortion by 4:30 pm so I went home. The next day I had bleeding and the day after, it (POC) came out. I kept it. I kept it in a carry bag . . . on a pad inside the carry bag. It was whitish and pinkish in color. Two days later, I went back to the hospital and showed it (to the doctor). (Age 21)

Sixteen women from the Pune clinic, where ultrasound was used routinely at the follow-up visit, felt that this was an absolute necessity to confirm complete abortion; at the Delhi clinic, ultrasound was not routinely used and no women reported a need for this. Though not specifically probed in every interview, six women categorically stated that they were able to judge pregnancy completeness themselves and did not see the need for even a follow-up visit:

> Yes, I have seen the pieces. When the pieces came out, I knew that something was different. And after some time, the nausea and uneasiness that I had during pregnancy just went away. (Age 26)

Reactions after the abortion

Most women with a complete abortion expressed a sense of relief and freedom from tension once they knew their abortion was complete, but 10 women spoke of momentary feelings of discomfort and guilt after seeing the POC:

> I felt that I had done something very wrong. If you don't see it, then you don't feel like that. (Age 28)

These feelings were usually temporary and lasted only a few minutes to a few days.

Thirteen women expressed concerns regarding potential long-term effects of mifepristone and misoprostol. One woman likened them to anti-cancer medications, six expressed fears about birth defects in future pregnancies and two were concerned that the medicines were not locally made:

> I was scared. I'd never consumed foreign tablets before! (Age 27)

> With any strong medicine, there can be an effect on your skin or with your eye sight. With this medicine, I'm also afraid that it may affect my future pregnancies. The effects of these medicines must remain for a few days at least. (Age 24)

Reactions were different in the four women who were confirmed to have incomplete abortions at the follow-up visit. All of them were offered the option of waiting a few more days as the abortion process could still complete itself, but none wanted to wait any longer:

> She asked me to wait and said that the abortion would definitely occur. But my family members started shouting and saying 'nothing is happening with the tablet' and the days (gestational age) are increasing, so I decided to get admitted for a surgical abortion. (Age 35)

Three of these four women rated the method as unsatisfactory during the exit interview conducted as part of the clinical trial they were participating in, and one rated the experience as neutral. One of these women refused to continue with the in-depth interview once she knew her abortion was incomplete. We were able to do additional follow-up interviews at home with the other three; all of them were philosophical about their failed medical abortions once their pregnancies had been terminated and a few days had passed:

> Madam (the doctor) did her best so I would have a complete abortion so how can I blame her? It depends on everybody's health. The tablets will 'suit' some people and will not 'suit' others. . . .The tablets didn't 'suit' me. (Age 35)

Links to post-abortion contraception

Almost all women ($n = 60$) reported being counselled about post-abortion contraception, and most ($n = 45$) said they intended to use it. Fifteen women said their husbands would use a condom, 10 intended to use oral contraceptives, 12 were planning to have an Intra Uterine Device (IUD) inserted and four wanted a tubal ligation. One mentioned using natural methods and the other three did not specify. We did not have follow-up data to know how these intentions translated into actual use, but three of the 25 women who were re-interviewed a few days after the follow-up visit qualified their intent to use contraceptives depending on circumstances and effort required:

> I feel I'm still slightly weak from the medical abortion. This winter has gone, so next winter I will get the operation (sterilization) done. I do not want to do it in the summer. (Age 26)

> She told me to come after my period is over. The IUD can be inserted then. But let's see. If my mother comes then I'll come with her. (Age 28)

De-medicalising medical abortion

Most women accepted the three visit protocol as a given but several ($n = 14$) talked about the difficulties they faced when arranging to come to the clinic for these visits:

> There's nothing wrong in coming but I have to finish the household chores first. That can be difficult as I have to look after everything. Managing all those things and coming here can be tiring. (Age 35)

> A lot of women have problems coming for the second visit. Even I had a problem as I didn't tell my in-laws that I was coming to the hospital. I just informed them that I had some work to do. (Age 26)

When asked if the number of visits could be reduced by allowing women to take misoprostol at home, only 16 of the 63 women unequivocally supported the idea. Others were more guarded, and most felt that it depended on the level of support women receive at home and their confidence in dealing with the process.

When queried about the idea of selling mifepristone-misoprostol in pharmacies, 30 of the 43 women who were asked this question expressed concern that chemists would not provide sufficient information and support. Twelve women were also worried that wider availability would lead to an increase in pre-marital sexual activity:

> If the tablets are available in medical stores then it's very likely that use by young girls will increase. This is wrong. They'll do all sorts of things then. (Age 35)

> Tablets available in medical stores may not have proper power (efficacy). There's no guarantee! Something untoward can also happen. Suppose the abortion doesn't occur and the pregnancy continues, then it's a problem, no? Also one may not know whether the abortion is complete or not. What will the chemist tell women then? (Age 33)

Thirteen women, however, suggested that this approach might increase access and could be useful for women in need of secrecy and unable to visit doctors.

Discussion

The in-depth interviews with 63 mifepristone-misoprostol clients provide important insights into women's experiences with this method in India. First, while the non-invasive nature and simplicity of medical abortion appealed to many women, method selection was determined ultimately by the degree of family support required, the need for confidentiality, and, in some cases, cost considerations. Some women also opted for medical abortion to avoid perceived negative characteristics of surgical abortion, including an overnight hospital stay and/or general anesthesia, which are not inherent to the method but, rather, reflect provider practices.

Nearly half of the women presented to the study clinic after having heard about medical abortion from friends, relatives or others. As medical abortion had been approved in India about one year before we began our interviews, this finding confirms the role of social networks in method selection, as noted previously (Ganatra *et al*. 2005). Additionally, many women in our study relied on ayurvedic or over-the-counter oral (and often ineffective) medications as a first response when faced with unwanted pregnancy, highlighting the need for accurate information

about pregnancy termination among general practitioners, pharmacists and the community at large.

Expectations regarding medical abortion were derived mainly from providers. This seemed to work in a variety of ways, both positive and negative. On the one hand, comprehensive and empathetic counselling from providers, about possible side effects, increased tolerance for pain and bleeding and allayed fears about side effects and effect on future pregnancies. On the other hand, opinions regarding de-medicalisation of the medical abortion process were determined largely by expectations set by providers, and may explain why few women endorsed home use of misoprostol, or why many in Pune felt that ultrasound is needed to assess abortion completeness.

Expectations were invariably modified by family dynamics and the level of support received from family. In most cases, women expected only limited support from their partners but, for a few women, just having their husbands inquire about their health made them feel emotionally supported. Women had a high degree of contact and extended one-on-one interactions with their providers, which served as an additional source of emotional support, especially when it was not forthcoming from family members. This may explain why many women endorsed the three clinic visit regimen. Similarly, irrespective of the level of family support received, the lack of privacy or toilet facilities at study participants' homes (a not uncommon situation in the developing country context) made some women uncomfortable with the idea of abortion at home.

However, even women who endorsed the three visit regimen did report difficulties in making these visits. Clinical practice should be modified to offer a range of protocol options to women, including the choice of taking misoprostol at home. This approach has been shown to be safe and effective in several developing countries, and has been included in the Indian National Consortium Guidelines on Medical Abortion Use (AIIMS 2004). Similarly, use of ultrasound to determine pregnancy completion, which can increase costs considerably, is not mandated as routine practice (WHO 2003), and, as observed in our study, women who did not expect it did not feel any need for it.

Although very few women were troubled by their side effects, most felt the need for adjustments in their daily routines once bleeding started, and several expressed a feeling of weakness or the need to rest. Ultimately, however, the central issue that dominated their abortion experience was having a successful outcome. The extended time involved, from initiation of the medical abortion process to assessment of the outcome, proved to be a significant source of stress for many women, and anxiety over the process not matching exactly the expected course of events was high. Providers need to balance the counselling and instructions in order to make sure that women are aware of individual variations, and do not become over anxious about judging abortion completion, and can develop more confidence in their own instinctive ability to do this.

Post-abortion contraception has to be appropriately linked to medical abortion services. Women who expressed interest in post-abortion contraception were often deterred, as spacing methods were suggested but generally not provided to women at their follow-up visits, and an additional visit was required for women who desired an IUD or tubal ligation. Every woman needs to be given condoms prior to leaving the service delivery site, and also oral contraceptives, should she want them. While

coercion needs to be avoided, the effort required in returning to the clinics and getting an IUD or sterilisation should not be so high as to deter women. Evidence-based guidelines on appropriate contraception, and the timing at which contraception can be given following a medical abortion, need to be followed.

Several limitations of our study should be noted. First, not all women who had a medical abortion during the study period could be interviewed. Women who could not be contacted, or declined to participate, may have had more negative experiences than those who were interviewed. Additionally, as women who opted for a surgical abortion rather than a medical one after being counselled on both methods were not interviewed, we cannot compare experiences across methods. Many of the women interviewed received abortions within the context of ongoing clinical studies and, thus, the services, cost concessions and counselling they received may differ from those that are offered in routine service delivery, and these may have modified their experiences.

Several aspects of the findings merit further study through large-scale representative studies. A study comparing women's ability to judge completeness of abortion with ultrasound evidence could help provide the confirmation needed to show that reliance on women's judgment is an acceptable option. Data on post-medical abortion contraceptive use practices are virtually non-existent and much needed.

Although we cannot generalise our findings beyond the women in our study, the experiences of the interviewed women suggest that their experiences with medical abortion depend partly on their expectations and partly on their level of emotional and logistic support and the context of their environment, and less on the inherent characteristics of the method. The findings, that document for the first time in-depth women's experiences with medical abortion in a developing country context, emphasise the processes that determine women's choices and experiences, and highlight the need to tailor service delivery and clinical protocols to meet those needs.

Acknowledgements

The study was funded by a grant from the Hewlett foundation to the Population Council. Ipas received a sub-award from the Population Council to collaborate on this study. The study was carried out by Ipas and the Population Council in partnership with KEM Hospital in Pune and Parivar Seva Sanstha in Delhi. The authors are grateful for the contributions of Savita Kanade, Shubha Ambardekar, Shalini Verma, Abhijeet Anand, Tina Bhalla and Alok Banerjee. We also thank Shireen Jejeebhoy, Traci Baird and Janie Benson for reviewing earlier drafts of this paper.

References

AIIMS (All India Institute of Medical Sciences), 2004. *Use of RU 486 with misoprostol for early abortion in India. Guidelines for medical officers.* New Delhi: AIIMS.

Chhabra, R. and Nuna, C., 1994. *Abortion in India: an overview.* New Delhi, India: Ford Foundation.

Elul, B., Pearlman, E., Sorhaindo, A., Simonds, W., and Westhoff, C., 2000. In-depth interviews with medical abortion clients: thoughts on the method and home administration of misoprostol. *Journal of the American Medical Women's Association*, 55, 169–172.

Elul, B., Sheriar, N., Anand, A., and Philip, N., 2006. Are obstetrician–gynecologists in India aware of and providing medical abortion? *The Journal of Obstetrics and Gynecology of India*, 56 (4), 340–345.

Ganatra, B., Manning, V., and Palimapulla, S., 2005. Availability of medical abortion pills and the role of chemists: a study of Bihar and Jharkhand, India. *Reproductive Health Matters*, 13 (26), 65–74.

Government of India, 2003. The Medical Termination of Pregnancy Rules, vide G.S.R. 485(E), the Gazette of India, Extra, Pt. II, Sec. 3(i).

Harvey, S.M., 1995. Knowledge and perceptions of medical abortion among potential users. *Family Planning Perspectives*, 27, 203–207.

Lafaurie, M.M., Grossman, D., Troncosa, E., Billings, D.L., and Chavez, S., 2005. Women's perspectives on medical abortion in Mexico, Columbia, Ecuador and Peru: a qualitative study. *Reproductive Health Matters*, 13 (26), 75–83.

Simonds, W., Ellertson, C., Springer, K., and Winikoff, B., 1998. Abortion, revised: participants in the U.S. clinical trials evaluate mifepristone. *Social Science and Medicine*, 46, 1313–1323.

WHO, 2003. *Safe abortion: technical and policy guidance for health systems.* Geneva, Switzerland: World Health Organisation.