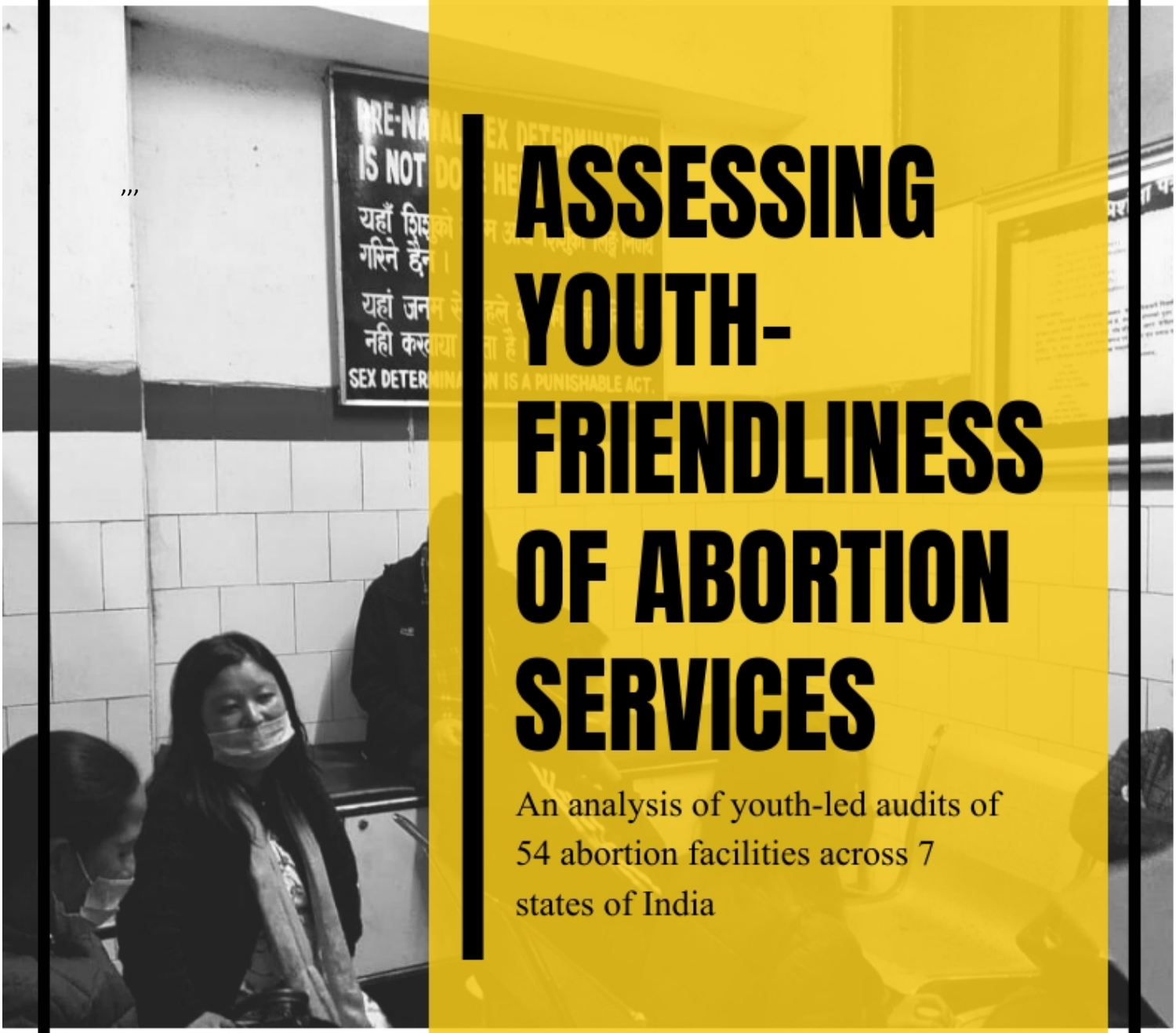

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ASSESSING YOUTH-FRIENDLINESS OF ABORTION SERVICES

An analysis of youth-led audits of 54 abortion facilities across 7 states of India

CONTENTS

INTRODUCTION

Although abortion is largely legalised in India through The Medical Termination of Pregnancy Act (MTP), 1971, it continues to be underpinned by religious, moral, ethical, and socio-cultural concerns. Negative community perceptions, lack of accurate and easily accessible information on safe sex practices and safe abortion and denial of young peoples' bodily autonomy can often deter an already vulnerable population from seeking healthcare, a situation compounded by stigma around pre-marital sex and contraceptive usage. Lack of a rights-based and pleasure-affirmative approach to young peoples' sexuality further aggravates the problem.

Fear of judgment from service providers, ambiguities of medico-legal restrictions as well as lack of privacy and confidentiality in health facilities can influence young abortion seekers to opt for unsafe methods of abortion, which often involves fatal health risks and high costs. Are existing healthcare services and facilities well-equipped to accommodate the unique needs of young people? How should interventions be designed and implemented to make abortion facilities youth-friendly?

In an attempt to answer these questions, the **Safe Abortion For Everyone (SAFE) Fellowship** led by The YP Foundation aims to equip young people with evidence-based and factually accurate information on safe abortion and engage them in generating evidence that is grounded in their lived experiences as well as identifying and assessing gaps in service delivery, providers' attitudes and accessibility of abortion services from a young person's perspective. This report aims to analyse the evidence on the status of abortion services for young people generated by 10 Fellows from seven states of India who were onboarded and trained to conduct audits of abortion facilities in their respective districts.

IMPLEMENTATION ROADMAP

3. Undertaking training workshops on evidence generation using mystery client methodology and analysis.

4. Conducting field visits to collect data in accordance with the research tool.

5. Preparation of report on youth-friendliness of abortion facilities based on assessment of various parameters.

2. Mapping abortion facilities and service providers in their vicinity.

1. Undertaking MOOC to have a rights-based and factual understanding of abortion discourse in India.

STUDY SETTING

The total of 54 audits were conducted in 10 locations across 7 states of India, i.e., Assam(Nagaon, Dibrugarh, Kamrup Metropolitan), Kerala(Kollam, Ernakullam), Punjab(Rupnagar), Maharashtra(Nagpur), Odisha(Bhubaneshwar), Darjeeling(Siliguri) and Sikkim(Gangtok).

Out of 54 facilities, 32 were private and 21 were government-owned.

METHODOLOGY

The primary objective of the research study is to map the youth-friendliness of abortion facilities and service providers by making a qualitative assessment the responsiveness, attitude, accessibility of the abortion providers and the authorities involved as well as by identifying potential barriers. To ensure the validity of quality assessments and to get insight into actual experiences of young beneficiaries, the mystery client methodology is used.

Mystery Client (MC) methodology is a form of participatory research that aims to provide a unique opportunity to monitor and evaluate the performance of health care providers or health facilities, in this case - abortion facilities, from the perspective of the service user. It has been used in several studies to assess the quality of health care delivery and evaluate areas for improvement.
Training workshops were conducted prior to the field surveys to familiarize the researchers with the process and make them comfortable with their role as undercover auditors.

Moreover, an audit tool was developed for the purposes of data collection. Indicators with the potential to evaluate the quality and responsiveness of abortion service providers were identified and incorporated into the tool. To identify provider bias, participants posed as unmarried and, in some cases, married individuals. Some participants were accompanied by male company (spouse or boyfriend), female company (sister or friend), and in some facilities went alone as well.

AUDIT TOOL

Based on a comprehensive review of peer-reviewed published studies measuring youth-friendly SRH services as well as national and international standards of youth-friendly health services, an audit tool was developed to assess and evaluate the quality, responsiveness, attitude, accessibility of the abortion providers and the authorities involved. Twelve assessment parameters were incorporated into the tool:

1. **Accessibility of service**
2. **Timing and duration of availability of services at the facility**
3. **Waiting time to avail the services**
4. **Cost of services**
5. **Overall infrastructure of the facility**
6. **Privacy and confidentiality**
7. **Insistence on knowing marital status**
8. **Insistence on guardian/parental consent**
9. **Respect and sensitivity by the service providers**
10. **Availability of abortion-specific IEC material**
11. **Provision of comprehensive information by service providers**
12. **Feedback mechanism within the facility**

ANALYSIS

1. ACCESSIBILITY OF SERVICE:

The variables considered are the location of the facilities, their proximity to public transportation services and, the availability of directional signage and disability-friendly infrastructure.

- For a young beneficiary of abortion services, the location of access points is a crucial criterion that decides the overall convenience and cost of accessing the required services. Centrality of location along with reliable public transport accessibility ensures mobility and cost-saving.

- **83.33%** of the facilities audited were centrally located and were easily accessible via public transportation services like auto-rickshaws and buses. The cost to travel to all 54 facilities didn't exceed more than **100** Rupees in all the ten districts across seven states. Among the remotely located facilities, **66.66%** facilities were private.

- The availability of clear and reliable directional signage on the road is important for easier navigation. However, directions on the road were available for only **40.74%** of the facilities out of which **54.46%** (12) were Government facilities and **45.45%**(10) were private.

- Out of 54 facilities, ramps and wheelchairs for disabled persons were available in **50** of them. 2 private and 1 Government facility in Sikkim and another 2 private facilities in Nagpur didn't have any such provision. In one private facility in Nagpur, although a ramp was available, it was too narrow and uneven to be functional. Thus, the mere availability of ramps and elevators do not indicate that the hospital infrastructure is disability-friendly until and unless they are properly maintained.

2. TIMING AND DURATION OF AVAILABILITY OF SERVICES AT THE FACILITY:

The variables considered are the operational hours and days of the facilities, and whether they open and close at convenient hours, To arrive at an objective assessment of convenience, MNREGA working hours(8 AM- 5PM) and school/college hours on weekdays(9 AM- 3PM) are taken into account.

- All facilities are open on weekdays and are mostly operational from 8 AM to 4PM. **29** facilities are operational after 5 PM, out of which **20** are private. Only **15** facilities are operational 24×7, out of which **9** are private and **7** are government facilities.

3. WAITING TIME TO AVAIL THE SERVICES

The variable considered is whether the waiting time at the facility was more or less than 30 minutes.

- On an average, Private hospitals had a waiting time of 10-15 minutes.
- Comparatively, Government facilities had a longer waiting time (30 minutes- 2 hours) due to higher patient load.
- CHCs in Assam(Nagaon and Kamrup Metro) had a longer waiting time for registration and the audits were unsuccessful as consultation service was denied.

4. COST OF SERVICES

The variables considered are the cost of registration and consulting fees. Information provided by a few service providers on total cost of undergoing an abortion is also taken into account.

- Registration and consultation was mostly free and subsidized in Government facilities with a minimal fee of Rs. 10 in some.

- The cost of registration and consultation in private facilities ranged from Rs. **200-800**.

- During consultation, cost of MTP kit and surgical abortion was discussed in Punjab, Nagpur and Bhubaneshwar. In Rupnagar district of Punjab, 2 Govt. hospitals charged INR 1,000 and INR 2,500 respectively for an MTP kit while 2 private facilities charged INR 700 for the same, which is 40% higher than the market rate. The cost of surgical abortion was cited within the range of INR 8,500 - 12,000 in private facilities.

5. OVERALL INFRASTRUCTURE OF THE FACILITY:

The variables considered are the availability of wayfinding signage systems within the facilities, adequate space and seats in the waiting area, and the quality of the toilets.

- Out of the 54 facilities, a directional map of the facility could be found only in **1** private and **1** Government hospital in Rupnagar, Punjab. **4** facilities in Rupnagar were reported to be challenging to navigate. The auditors had to face difficulty in reaching the reception and/or to the gynaecologist's department.

- While most facilities had decently spaced waiting areas with adequate seats, auditors who visited government facilities in peak visiting hours (11 AM- 1 PM) reported a crowded waiting area.(Nagaon, Assam; Kamrup Metro, Assam; Kollam, Kerala)

- While all the facilities had toilets with locks and running water, only private facilities had clean toilets and **37.03%** (20) of Government facilities were reported to be in unhygienic conditions.

6. PRIVACY AND CONFIDENTIALITY:

The variables considered are maintenance of discretion at the reception desk, presence of other patients in the consultation room, interference by staff during consultation, and whether the consultation room provided auditory and visual privacy.

"**Visiting a facility for abortion services was challenge for me because, when I was enquiring about the services in the reception, the people standing there stared at me and listened to my conversation with the receptionist the whole time**."
/In a private facility in Assam accessed by an unmarried female.

- In only **27** facilities, privacy was maintained by ensuring that door/curtain of the consultation room was closed and no second one interrupted. In 18 facilities, privacy and confidentiality protocols were not maintained. It was observed that some government facilities allowed two patients into the consultation room, making communication difficult for the abortion seeker.

7. INSISTENCE ON KNOWING MARITAL STATUS:

The variables considered are whether the service providers probed unnecessarily to know the marital status of the service seekers and if they denied services on those grounds.

"The service provider asked me not to speak loudly because they didn't want others to know that I was unmarried and seeking abortion. Moreover, they asked me to visit again so that they could refer me to a different doctor (since I was unmarried). They also mentioned that it would be done quickly and the cost might be different."
/In a Govt. facility in Assam, accessed by an unmarried male.

- Service providers in **38** facilities (16 public and 22 private) insisted on knowing marital status. **5** private facilities in Punjab and **1** tertiary-level government facility in Assam denied abortion service to unmarried persons. Infact, doctors at **3** private hospitals in Punjab said informed that ultrasound scans are illegal for unmarried abortion seekers.

8. INSISTENCE ON GUARDIAN/PARENTAL CONSENT:

The variables considered are whether the service providers insisted on getting parental consent despite the abortion seeker's age being 18 and above and if they denied services on those grounds.

"The doctor asked me about my marital status and whether I have guardian's approval. When I asked about the options I have for seeking abortion, she wrote a prescription for ultrasound. She asked me to return with the report and emphatically asked me to return only with a guardian. Otherwise, she would not provide the service."

/In a private facility in Darjeeling, accessed by an unmarried female.

- Service providers in **27** facilities, **12** public and **15** private, insisted on having parent's consent. In certain circumstances where some of the auditors posed as married individuals, their husband's consent was demanded.

9. RESPECT AND SENSITIVITY BY SERVICE PROVIDERS:

The variable considered is whether the service provider was non-judgemental, sensitive and respectful during consultation.

"The nurse questioned my reason for visiting and I vaguely answered to which she loudly asked in (Nepali) "You're not pregnant right?" and explained that pregnant women are referred to a different doctor. After answering that I needed to consult the doctor as I suspect that I may have conceived, she asked me to step on a weighing scale which had large text on it saying "PREGNANT WOMEN ONLY". I couldn't help but notice the sign and feel a little uncomfortable"

/In a private facility in Sikkim, accessed by an unmarried female.

- In **17** facilities (**7** private and **10** government), auditors observed that service providers and staff didn't show respectful and sensitive behaviour. There was a tendency to impose value judgements on pre-marital sex. In one government facility in Darjeeling, the auditor was asked to leave the consultation room when she mentioned about abortion.

10. DISPLAY OF ABORTION-RELATED IEC MATERIAL:

The variable considered is the type of IEC material displayed in the consultation area and whether it is abortion-centric.

- A lack of IEC materials with comprehensive information on safe abortion was reported across all facilities.
- While brochures and posters on pre-natal care, maternal care and breastfeeding were available in most facilities, only **2** private facilities in Punjab and Assam had IEC material on family planning.
- Tertiary facilities in Kerala, Nagpur and West Bengal had information stating that sex determination tests are illegal under the Pre-Conception and Pre-Natal Diagnostics Testing (PCPNDT) Act.
- **2** private facilities in Punjab and Nagpur had IEC material explaining the legalities of abortion.

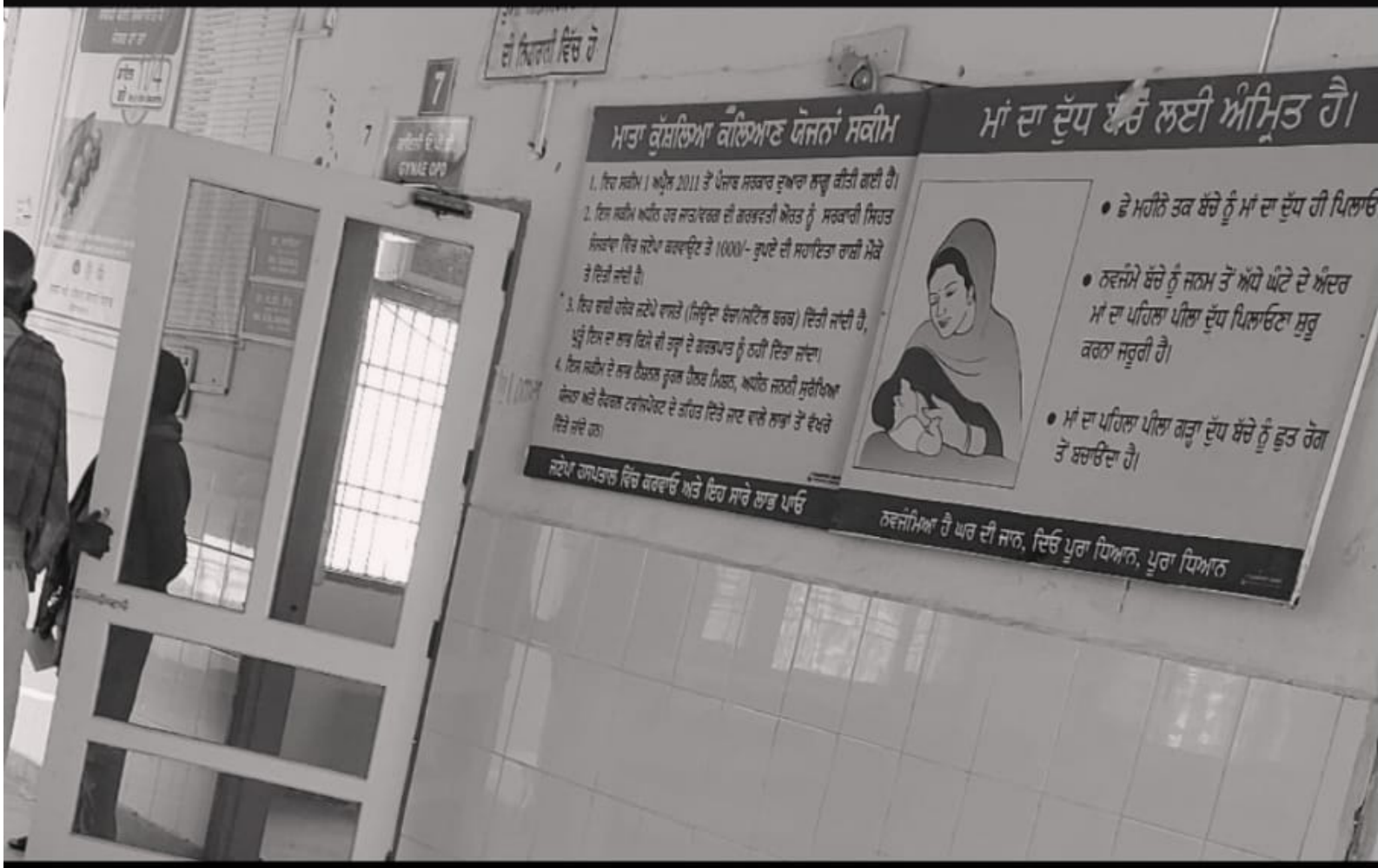
11. PROVISION OF COMPREHENSIVE INFORMATION BY SERVICE PROVIDERS:

- Service providers in private facilities were observed to provide comprehensive information on abortion and contraception more easily than service providers in government facilities.

12. FEEDBACK MECHANISM WITHIN THE FACILITY:

The variables considered are whether any verbal or written feedback was sought from the patient and whether grievance redressal was ensured.

- Patient feedback can be considered a strategic tool to improve quality of patient-centred care and increase accountability.
- In all the 54 facilities, there was no mechanism for seeking any verbal or written feedback post consultation.



KEY OBSERVATIONS

1

“When I mentioned that I am 18 years old, he explained that without parental consent, he would be in legal trouble if the parents came asking questions…The nurse then became sympathetic and asked me to wait for some time. After 5 minutes, she explained that I would need to get an ultrasound done. She then explained the same doctor would perform the medical abortion in a different nursing home (a private nursing home) for which he would charge around Rs 10,000 – 15000.”
/In a tertiary government. hospital in Darjeeling, accessed by an unmarried female.

Unregulated overpricing of abortion services was observed in private facilities. In another private facility in Rupnagar, Punjab, the service provider sold non-prescription medical abortion pills at INR 600.

2

Service providers and staff were observed engaging in unethical practices in some facilities. A private hospital referred one of the auditors to an unregistered facility which offered to perform abortion using vacuum aspiration in secrecy for INR 10,000. In another private facility, the service provider tried to conduct a two-finger test, which was banned by the Supreme Court in 2013, on an unmarried researcher. At a government facility, non-prescription medical abortion pills were sold by the receptionist for INR 1000.

3

There was a tendency among service providers to impose value judgements on pre-marital sex and have a moralistic perspective on abortion. 5 private facilities in Punjab and one tertiary-level government facility in Assam denied abortion service to unmarried persons.

“The provider went on for five minutes about the risks involved in having multiple partners and mentioned that she

saw that a lot of young people were doing these 'immoral' activities these days."
/In a private facility in Nagpur, accessed by an unmarried female.

4

A gender-based disparity was observed when a man accompanied the beneficiary as a spouse/boyfriend and a woman accompanied them as a sister/friend. Provider bias was observed based on who their companion was. In the former case, it was felt that service providers and supporting staff were cordial but faced some cases of moral policing to be "responsible adults". In the latter, it was felt that the staff were likely to be inhospitable, intimidating and unsympathetic.

5

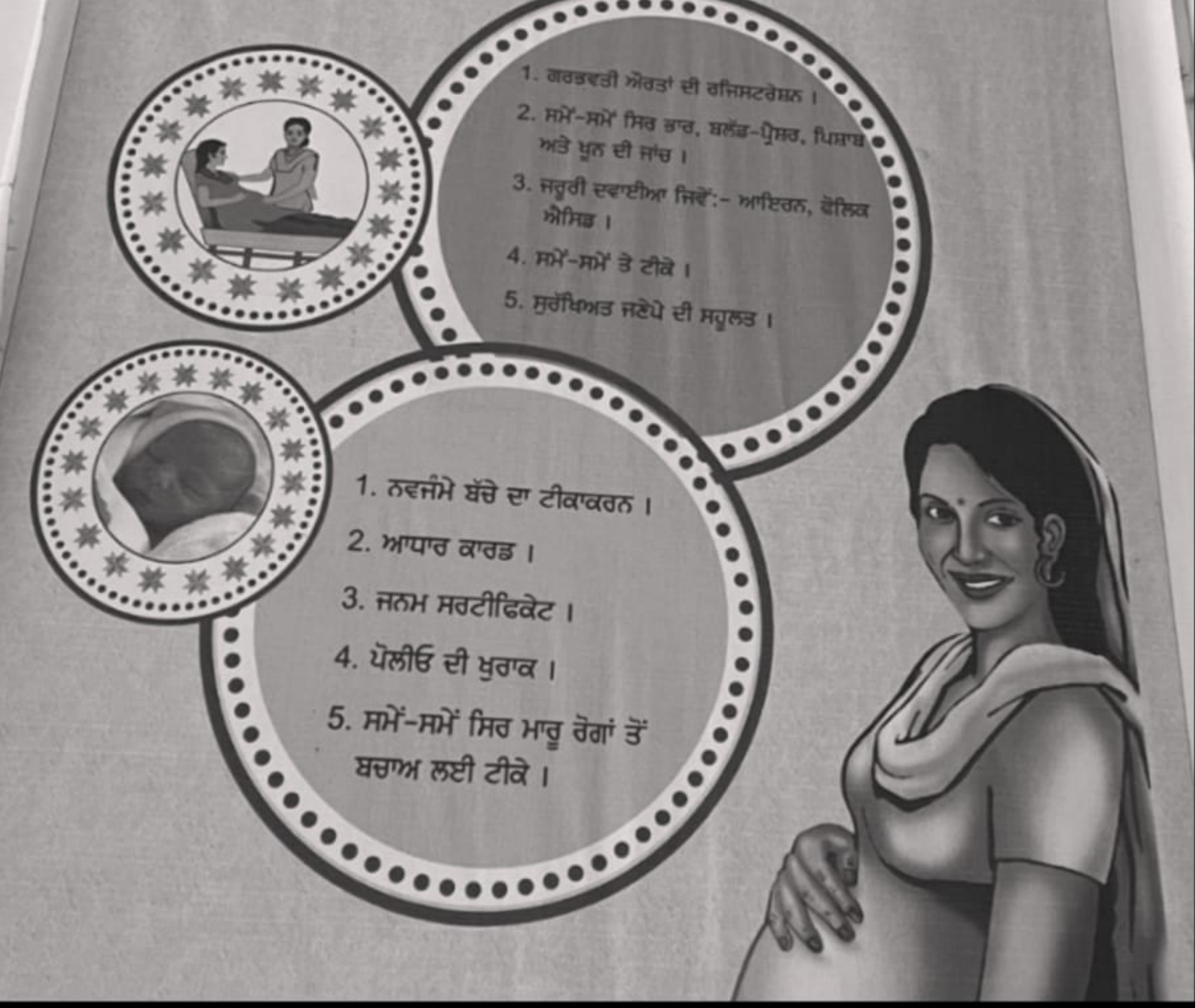
The lack of clarity on legal knowledge such as provisions of the MTP Act, 1971, its amendments, its conflations with the PC-PNDT Act, 1994 and POCSO Act, 2012 was observed among service providers. For example, instances faced by the auditors included doctors suggesting two-finger test for pregnancy verification, using unmarried status to deny abortion services, or insisting on parental consent for adults.

6

Confidentiality was breached mostly in government hospitals due to allowing two patients together in the consultation room.

7

A resident of a tea garden community of Assam was denied service by an FRU on the grounds of inability to provide a referral from the local dispensary. Such mechanisms and bureaucratic ways put the anonymity of the abortion seeker at risk and further discourage them from availing safe healthcare services.



RECOMMENDATIONS

TO IMPROVE YOUTH-FRIENDLINESS AT THE PROVIDER LEVEL:

1. COMMUNICATE IN A SENSITIVE AND NON-JUDGEMENTAL MANNER:

Young abortion seekers and service providers often experience communication barriers when involving young clients' sensitive and personal aspects of life. A lack of emotional safety can deter them from seeking services. There should be focus on making the young person feel less intimidated and improving client-provider interaction to build trust and rapport.

2. UPHOLD THE YOUNG CLIENT'S AUTONOMY:

Due to moralistic perspectives on pre-marital sex and abortion, seeking abortion service often becomes difficult for the young person. Regardless of their personal stance on abortion, service providers have the ethical responsibility to uphold the young person's autonomy by providing them unbiased and comprehensive information and ensuring that their decision is truly informed and autonomous and safe abortion services are not disrupted or blocked.

3. SEEK INFORMED CONSENT:

It is crucial to uphold the young abortion seeker's decision-making capacity and right to acquire correct information. Key elements of informed consent include explaining the client about the nature and benefits of the procedure along with the potential health risks using simple language as well as informing them about their right to take decisions about their own bodies.

4. ADOPT A RIGHTS-BASED APPROACH:

Despite their subjective opinions and perspectives, service providers must recognise access to abortion as an essential human right and uphold the reproductive autonomy and right to health of young abortion seekers. They must have a thorough understanding of the MTP Act and its conflation with the POCSO Act and PCPNDT Act to navigate medico-legal restrictions efficiently.

5. AVOID USING STIGMATISING LANGUAGE:

It is possible to unintentionally stigmatise abortion by using terms such as "aborting a baby" or "female foeticide", further perpetuating myths and misinformation. Instead, terms like "embryo/foetus", "terminating a pregnancy", and "gender-biased sex selection" should be used.

6. MAINTAIN PRIVACY AND CONFIDENTIALITY:

Young people often fear the risk of their parents and peers finding out about them engaging in pre-marital sex and seeking abortion, making them vulnerable to violence and stigmatisation. Thus, service providers must ensure that privacy is maintained during consultation and identity of clients is not revealed.

7. EQUIP YOUNG CLIENTS WITH COMPREHENSIVE INFORMATION ON ABORTION:

Denying access to accurate and comprehensive information on abortion on the grounds of age and marital status can often lead young clients to opt for unsafe abortion services and put their health at risk. It is crucial to provide them health information in easy, accessible language so that they can make informed decisions about their bodies.

8. PROVIDE COUNSELLING ON SAFE SEX PRACTICES AND CONTRACEPTIVE SERVICES:

It is crucial to provide counselling on safe sex and contraception to young abortion seekers in order to avoid unplanned pregnancies in the future and maximise their autonomy and choice.

9. CARE FOR SURVIVORS OF VIOLENCE:

Unwanted pregnancies in young people can sometimes also be a result of sexual violence and abuse. It is important that abortion providers are sensitive to these issues and are oriented on the relevant laws. Providers should facilitate redressal for victims of violence after offering them medical aid.

10. DO NOT PRESSURISE PARENTAL CONSENT:

Due to abortion stigma, revealing sensitive information to parents can compromise the safety of young abortion seekers, making them vulnerable to physical and emotional violence. Thus, providers should assess situational contexts to better negotiate dynamics between young clients and their parents. If

the abortion seeker is 18 years and above, the provider must uphold their autonomy and not deny service on the grounds of absence of parental consent. If the abortion seeker is a minor, the provider should maintain a balance between the provision of abortion services and compliance with the Protection of Children from Sexual Offences (POCSO) Act, 2012 and may ask the client to suggest a trusted adult of their preference in place of their legal guardian.

TO IMPROVE YOUTH-FRIENDLINESS AT THE FACILITY LEVEL:

1. STOCK ESSENTIAL COMMODITIES AND OTHER SUPPLIES:

Pregnancy test kits, medical abortion pills and other contraceptive devices like condoms, oral contraceptive pills, etc. should be made easily available in clinics and hospitals.

2. ENSURE EFFECTIVE WAYFINDING SIGNAGE SYSTEM WITHIN THE FACILITY:

To help young abortion seekers easily navigate the facility on their own, it is crucial to install physical/digital signages that helps them locate and identify the service providers.

3. ENSURE AVAILABILITY OF SERVICE PROVIDERS OF THE SAME GENDER:

To address communication barriers and increase comfort, the provision of service providers of the same gender must be ensured. In case of a consultation of a female client by a male provider, it is essential to have a female chaperone in the room, unless requested otherwise by the young client.

4. MAINTAIN INFRASTRUCTURE AND CLEANLINESS:

It is crucial to ensure that the facility premises, including the OPD and consultation room, are kept clean and maintained in good physical condition. Moreover, it is important to comply with WASH guidelines. It is to be noted that lack of access to clean water and sanitation can especially discourage menstruating and assigned female at birth(AFAB) clients from seeking healthcare services.

5. TRAIN SUPPORT STAFF TO BE MORE SENSITIVE:

Support staff should be trained on following protocols, upholding rights, maintaining privacy and confidentiality of young abortion seekers as well as

helping them to navigate the facility.

6. DISPLAY IEC MATERIAL ON SAFE ABORTION:

Ensuring availability of pamphlets, brochures and other IEC material that provides accurate and easily comprehensible information on safe abortion, its legalities and associated stigma can play a pivotal role in bringing awareness, eradicating myths and misinformation, and championing the cause for access to safe abortion.

7. DEVELOP MECHANISM FOR FEEDBACK AND ENGAGEMENT:

Providers should ensure that verbal feedback is sought post consultation to confirm whether all doubts were addressed and comprehensive information was provided. To increase accountability and identify gaps in service delivery, a mechanism to get feedback from young people anonymously should be organised. These inputs and grievances should be periodically assessed and addressed.

8. ENSURE AUDITORY AND VISUAL PRIVACY:

To make young abortion seekers feel safe to consult the service provider, the environment of the facility must ensure that privacy is maintained. Visual privacy should be ensured by installing separate enclosures and curtains. Moreover, auditory privacy should be maintained by keeping other people out of the room and not letting people in OPD overhear conversations with the young person.

RECOMMENDATIONS FOR GOVERNMENT STAKEHOLDERS:

1. REGULATE PRICING OF ABORTION SERVICES:

Affordability of abortion services is a crucial factor that influences a young person's decision to seek safe abortion. Higher costs at private facilities and lack of information on standard costs can lead to overpricing. The state must focus on regulating the abortion economy in India to make safe abortions accessible to all.

2. PROVIDE COMPREHENSIVE ABORTION CARE (CAC) TRAINING TO PROVIDERS:

To ensure the provision of high-quality comprehensive abortion services to young people, training should be provided to healthcare providers with relevant specializations and skills on how to obtain accurate information and understand the administrative and regulatory boundaries related to abortion in India. Moreover, they should have a thorough understanding of the social, cultural and religious norms surrounding abortion in their respective communities so that they can assist young abortion seekers to engage in health-promoting behaviours and opt for safe services.

3. ORIENTATION OF ASHA WORKERS:

Training should be provided to community workers to increase their competency in providing information, support and supervision as well as assist young people in visiting safe abortion facilities while maintaining confidentiality.

4. UNDERTAKE PUBLIC MESSAGING ON SAFE ABORTION:

To build public awareness and increase visibility of factually accurate and stigma-free information on safe abortion, the state should focus on disseminating IEC material through diverse media as well as physical posters and handouts. Existing IEC material that uses stigmatizing language and inappropriate images like pregnant women with 'baby bumps' or fully formed foetuses with a sense of sadness or trauma around abortion should be reviewed and revised.