CHAPTER VIII

SUMMARY AND CONCLUSION

SUMMARY:

The study has been carried out in Kamrup district of Assam. In all 440 women were interviewed and the questionnaire filled up by direct questioning.

As regards the Psychological and Socio-economic problems it is necessary to know the condition of women before M.T.P. and after M.T.P. Therefore, the women included in this series of studies are divided into three Groups.

**Group I** :- Consists of three hundred fifty four (354) married women who came to hospital for M.T.P.

**Group II** :- Consists of sixty eight (68) married women who reported in hospital for health check up after M.T.P.

**Group III** :- Consists of eighteen (18) unmarried girls who came to hospital for M.T.P.

Women were divided into two groups for analysing the Psychological problems of these cases.
Group IV - Consists of three hundred five (305) married women who were suffering from psychological problems and who came to hospital for M.T.P. and health check up after M.T.P.

Group V - Consists of (16) sixteen unmarried girls suffering from psychological problems who came to hospital for M.T.P.

In the matter of socio-economic problems women are grouped in one unit.

Group VI - Consists of three hundred thirty five (335) married women having poor socio-economic problems who came to hospital for M.T.P. and health check up after M.T.P.

All the eighteen (18) unmarried girls who reported at hospital for M.T.P. came from the family having poor socio-economic status which were already analysed in group III.

Important demographic characteristics of these Groups of women are briefly analysed below -

Group I - Majority of the women (85.87%) who came for M.T.P. belong to the age ranging from 19 years to 36 years; 44.92% women came from rural areas and 55.08% were from urban areas. Of them 84.18% were Hindu, 14.68% Muslim and 1.13% Christian women.
Regarding educational status of these women 39.3% stated as illiterate, 46.09% read up to primary level, 15.82% read up to secondary level, 2.26% read up to undergraduate level and 0.56% women read up to Graduation and above. 16.67% women who read up to secondary level were still reading and 37.50% who read up to undergraduate level were still studying 23.16% husbands were illiterate 47.17% studying up to Primary level, 21.78% up to secondary level, 5.09% read up to undergraduate level and 2.82% studied up to graduate level and above.

Regarding occupation of these women 90.11% were housewives, and 9.89% were working outside home while their husbands were engaged in different kinds of work such as class I govt. officers, teachers, clerks, businessmen, cultivators, labourers and Class IV grade workers like Chowkider in offices, Peon etc. 55.23% women stated their family income as between Rs. 500 to Rs. 1000 per month, 25.42% had income below Rs. 500 per month and 18.36% had above Rs. 1000 per month.

Out of 354 (Three fifty four) married women 0.56% separated from their husbands and another 0.56% women stated as widows. 218 (two hundred eighteen) 61.68% married at the age ranged from 17 years to 21 years, 18.36% between 14 years to 16 years and rest married between 22 years to 33 years of age. 35.31% women had three children and more 32.77% had two children.
20.34% women came for M.T.P. late that is, with more than 20 weeks pregnancy, 32.77% done abortion previously. 4.31% done M.T.P. more than four times. 11% done abortion criminally previously. The two main reasons for doing M.T.P. were to reduce the number of children and socio-economic reasons (spacing mainly). Reasons for present M.T.P. were as below:

88 accepted M.T.P. (24.86%) to reduce the number of children and 108 (30.51%) for socio-economic reasons. Other reasons were failure of contraceptives or irregular use of contraceptives, physical problems, mental problems to avoid the birth of a female child, illegal pregnancy etc.

Regarding the attitude of women towards M.T.P. 23.16% said legalisation of abortion was bad, 51.41% said it was good, 25.42% had no idea about M.T.P., 80.51% women said abortion should be done very secretly. 73.45% women stated to have got co-operation for M.T.P. Only from husband, 55.08% stated that disclosure of M.T.P. would degrade their social status, 74.57% women had mental problems like depression, guilty feeling and were sorry, repentant, anxious and afraid etc., 35.31% women did not want to accept contraception after M.T.P., 52.26% wanted temporary method and 12.43% wanted permanent method, though the
number of living children of each of them were more than three.

**Group II.**—Out of 60 women who came for health check up after R.T.P., 76.47% women stated their age at the time of R.T.P. as between 19 years and 36 years, 16.18% stated as between 16 years and 18 years and the rest between 37 years and 43 years. Of these 23.53% rural women and 76.47% urban women and 85.29% Hindu, 14.71% Muslim women, 16.18% illiterate, 29.41% women stated as studying up to Primary level, 39.70% up to secondary level, 8.02% up to undergraduate level and 5.88% women studied up to graduate level and above.

Regarding educational status of the husbands 5.88% were illiterate. 17.65% studied up to Primary level, 32.35% up to secondary level, 26.47% up to undergraduate level and 17.65% husbands studied up to graduation level and above. 91.18% women stated that they were housewives, 8.82% were working outside. 67.68% women stated their monthly family income as between Rs. 500 to Rs. 1000 and 32.35% stated as above Rs. 1000/-. 

Out of 60 married women 1.47% stated as separated from their husbands, 83.62% women stated their age at the time of their marriage as between 17 years to 21 years, 11.77% between 14 years to 16 years and 4.41% married at the age between 22 yrs.
to 27 years. 38 (55.88%) women had three children and more. Regarding the duration of their pregnancy at the time of M.T.P. 13.24% women stated it as between 17 weeks to 20 weeks. 38.23% between 13 weeks to 16 weeks and rest between 9 weeks to 12 weeks and below 9 weeks. 36.76% women said that they had done M.T.P. previously. 5 (20%) women stated as having done M.T.P. three times and more. 20 (25.41%) done abortion criminally.

The two main reasons for doing M.T.P. previously were to reduce the number of children and for socio economic reasons, mainly spacing. Regarding the reasons for present M.T.P. 30.88% stated as to reduce the number of children. 35.29% for socio economic reasons. 17.65% women said that legalisation of abortion was bad. 30.88% called it good. 51.47% had no idea. 88.24% women stated that M.T.P. should be done very secretly. 61.76% women said that M.T.P. would improve their economic condition by reducing the number of children. 85.29% women got co-operation for M.T.P. only from their husbands. 73.5% women said that disclosure of their M.T.P. would diminish their social status. 60.29% women had mental problems. 41.16% did not want to use any contraception after M.T.P. 30.23% wanted to use temporary method and 20.59% wants permanent method of contraception.
Group III - Out of 18 unmarried girls 53.36% stated that their age at the time of M.T.P. was between 17 years to 19 years. 33.33% stated as between 14 years to 16 years. 11.11% girls between 20 years to 22 years. 61.11% girls came from rural areas and 38.89% from urban areas, 88.89% were Hindu and 11.11% were Muslim girls.

Regarding educational status 22.22% girls were illiterate, 44.44% girls studied up to primary level, 33.33% up to secondary level. All the girls showed social fear to continue their studies after M.T.P. 77.78% girls were unoccupied 11.11% were students. 61.11% girls stated their family income as between ₹.500 to ₹.1000 per month. 38.89% girls stated it as below ₹.500 per month, 55.56% girls stated the duration of their pregnancy at the time of M.T.P. as above 20 weeks, 11.11% girls did M.T.P. previously, the reason for previous M.T.P. were to avoid illegal pregnancy, social stigma, poor economic condition etc. 22.22% did abortion criminally. Reasons for present M.T.P. as stated by these girls were also for poor economic condition, to avoid illegal pregnancy, social stigma etc. 22.22% girls said legalisation of abortion was bad, 44.44% had no idea, 33.33% said that it was good. All the girls said that abortion should be done very secretly, 55.55% girls got co-operation for M.T.P. from their parents and 44.44% girls got co-operation only from their mothers. All the
girls said that disclosure of H.T.P. would spoil their future life. 88.89% girls were found suffering mental problems like depression, guilty feeling anxiety, fear etc. These girls had no idea about contraception.

PSYCHOLOGICAL PROBLEMS (GROUP IV):

Out of 422 married women 305 (72.27%) were suffering from different psychological problems. Majority of these women were between 19 years to 36 years of age. 45.9% were rural women, 54.10% were urban, 82.30% Hindu women, 16.39% Muslim women and 1.31% Christian women.

Regarding educational status of the women 33.11% were illiterate, 54.78% studied up to primary level, 11.5% read up to secondary level, 0.66% studied up to undergraduate level, 97.05% were housewives 69.8% women stated their family income as between ₹.500 to ₹.1000 per month. 29.5% women had income below ₹.500 per month and 0.09% had income of above ₹.1000 per month. Majority of the women that is 82.30% married at the age between 17 years to 21 years. 17.70% married between 14 years to 16 years of age 51.48% women had three and more children 1.31% women had only male children and 2.23% had only female children.
57.05% women come for A.T.P. very late that is between 13 weeks to 20 weeks and more than 20 weeks, of pregnancy 46.23% women did A.T.P. previously and out of this 26.24% women did A.T.P. three times or more than three times, 13 % women stated as doing abortion criminally and 26% admitted to hospital for their physical problems, 30.2% women did A.T.P. to reduce the number of children, 36.07% did A.T.P. for socio-economic reasons.

All these women were suffering from different psychological problems, such as - depression, fear, anxiety and guiltiness etc. 28.20% women said that legalisation of abortion was good, 30.0% called it bad, 40.9% had no idea 83.61% women said that abortion should be done very secretly. 77.05% women stated that A.T.P. would improve their economic condition by reducing the number of children. 73.77% women get co-operation for A.T.P. from husbands only. 70.62% women said disclosure of A.T.P. would demean their social status, 51.48% women were eligible for permanent methods of contraception that is, these women had three and more children but only 19.02% wanted permanent method of contraception, 69.2% women wanted temporary methods of contraception.
GROUP V (UNMARRIED GIRLS):

Majority of the girls (16 or 88.89%) suffered from psychological problems. Majority of these girls were coming for M.T.P. between the ages of 14 years to 19 years, 62.50% girls came from rural areas and 39.50% from urban areas. 87.80% were Hindu and 12.5% were Muslim girls. 25.00% girls were illiterate, 50.00% studied up to primary level, 25.00% up to secondary level. 87.50% were unemployed and 12.50% were working outside as labourers and maid servants in private houses.

Regarding their family income 43.75% girls stated that it was below Rs. 500 per month, 56.25% girls stated it as between Rs. 500 to Rs. 1000 per month. 12.5% girls stated the duration of their pregnancy as between 13 weeks to 16 weeks at the time of M.T.P. 25.00% girls stated it as between 17 weeks to 20 weeks and majority that is, 62.50% stated the duration of their pregnancy as above 20 weeks. 25% girls stated as doing abortion criminally at home previously. Avoidance of social stigma, poor economic condition etc. were stated to be the main reasons for coming to hospital for M.T.P.

37.50% girls said that legalisation of abortion was good. 12.50% girls said that it was bad, 50.00% girls had no idea about the subject. All the girls stated that abortion should be done
very secretly. 50.00% girls had co-operation for M.T.P. form their parents and 50.00% got co-operation only from their mothers. All the girls said that disclosure of M.T.P. would spoil their future life. All these girls suffering from psychological problems like - guilty feeling, depression, anxiety and severe fear psychosis etc. Regarding family planning these girls had no idea.

SOCIO-ECONOMIC PROBLEMS (GROUP VI):

Of the women included in the present series of studies 56.08% women had income between ₹.500 to ₹.1000 per month and 21.3% women had income below ₹.500 per month.

Age of majority of these women were between 19 years to 36 years (90.1%). 9.3% were between 16 years to 18 years of age and 0.60% women were between 37 years to 42 years and above at the time of M.T.P. 43.3% women were coming from rural areas and 56.7% coming from urban areas; 85.97% were Hindu women, 14.03% were Muslim women, 37.6% women were illiterate 51.3% studied upto Primary level, 11.04% read upto Secondary level, 0.90% women were separated from their husbands and 0.59% women said that they were widows.
Regarding age at the time of their marriage 78.8% women stated it as between 17 years to 21 years. 21.6% women stated it as between 14 years to 16 years of age (42.35%) had three and more children. 95.5% women were housewives, 4.5% women were working outside as labourers, 42.00% women stated as doing M.T.P. Previously. 26.24% did M.T.P. three times and more previously. 12.1% did abortion criminally, Previously 21.8% women stated the duration of their present pregnancy at the time of M.T.P. as between 9 weeks to 12 weeks. 30.4% stated it as between 13 weeks to 16 weeks. 26.6% as between 17 weeks to 20 weeks and 21.5% women stated the duration as above 20 weeks at the time of M.T.P. 29.2% women came for M.T.P. to reduce the number of children 39.4% came for socio-economic reasons.

Regarding the opinion about M.T.P. 34.6% women said that legalisation of abortion was good. 28.1% called it as bad, 37.3% women had no idea. Majority that is, 89.5% women stated that abortion should be done very secretly. 70.4% women stated that present M.T.P. would improve their economic condition by reducing the number of children. 92.5% got co-operation for M.T.P. only from their husbands. 73.1% women stated that disclose about their M.T.P. would lose their social status. Majority of the women had
been suffering from some kind of mental problems, only 8.96% women had no mental problems. 59.1% women wanted contraception after M.T.P. and 40.9% did not want to use any contraception after M.T.P.

After analysis of the data in the present series of studies some important facts came to light.

Illiteracy, ignorance and poor economic condition were responsible for physical, mental, social and many other problems of women associated with the termination of pregnancy. Illiteracy and ignorance creates social problems. The study shows that women belonging to very low income group (monthly income below Rs. 500) were not coming to hospital for health check up after M.T.P.

There is a popular belief that M.T.P. is done mainly an unmarried girls to get rid of illegal pregnancy. The study shows that only 4.09% were unmarried girls. Married women avails of this method as a means of fertility control.

The present studies show that illiterate women often come for termination of pregnancy during the later period. Professional women come early, labourers tended to come late. Lower income group generally come late. Women having no children and those
women with more than three children come late. Women with previous history of induced abortion tended to report early. Social stigma, religious factors, economic condition are some of the important causes of coming late for M.T.P.

Abortion by trained hands is safe. Majority of the women are afraid of sterilization. It shows the need for health education to the people which would wipe off their misconcepts. After M.T.P. majority of the women wanted to use contraception which indirectly help to improve population problem.

Social and moral considerations attribute to feeling of shame and disgrace and concern over responsibility and financial support. Psychological condition of women is affected by their religious attitude. Inadequate sex knowledge is presumed to be common finding.

An abortion, when it is to be done, should be done as early as possible to avoid immediate and remote problems. The study shows that majority of the women are still ignorant about the M.T.P. Act.
A change in social outlook and easy availability of expert help will save the life of women from the complications of illegal abortion. The present study shows that only 16.1% women came for health check up though health check up after M.T.P. is very essential. Induced abortion does offer a unique opportunity to educate the couple in current methods of contraception. Since women are highly motivated to accept some form of contraception at the time of undergoing abortion. This opportune period should be properly utilised to promote the use of different methods of contraception.

CONCLUSION:

From the findings in the present series of studies, it can be concluded that, as the termination of pregnancy leads to adverse psychological problems the outcome, specially the feeling of guilt is significantly higher amongst women and hence it demands careful psychiatric evaluation before and after M.T.P.

Reassurance and general emotional support are often very helpful to the apprehensive woman as a routine. Before the operation, a woman must be given enough time and privacy to
express her fears, anxieties and fantasies regarding the operation. It is useful to involve the husbands and other responsible members of the family in discussion and counselling.

Several adverse effects were observed on the mother and unwanted child in cases where M.T.P. was refused due to late stage of pregnancy or other physical or mental problems. Hence, the decision should be taken carefully in individual cases and where there is history of previous psychiatric illness or underlying personality suggesting immaturity or excessive guilt proneness due precaution should be exercised.

Pregnancy termination should always be done in an well equipped centre and the operations should be performed under optimal conditions under the direct supervision of well experienced specialist who have acquired great experience and skill from the large number of such operations they have performed and it is important to motivate the women to undergo M.T.P. in early pregnancy as far as possible keeping it in mind that complications varies with the duration of pregnancy.
Therefore, the need for late abortions is unlikely to be totally eliminated, although it can be greatly reduced both by the use of adequate contraception and by a greater availability of simple procedures for early abortion. Women should be enlightened by education for which both the medical profession and social workers have responsibility to give advice early in pregnancy. They should be told that "sooner the safer".

R.T.P. cases need special care in handling communication and feedback. These cases are quite different from the cases of ordinary contraceptive users. Therefore, education, information and communication approach are very essential for such a programme. Medical communication and administrative workers should co-ordinate because the aim of R.T.P. Services is to facilitate safe performance of R.T.P. by skilled staff with the minimum of delay. Women fail to take advantage of the available services due to lack of information. There should be a proper dissemination of information to the public at large and to potential abortion seekers about the availability of services and the nature of the procedures employed.
A large number of teaching hospitals in India now have departments of psychiatry. Unfortunately in very few centres combined training programmes in psychiatry and gynaecology are organised. Adequate training in psychiatry would provide the future gynaecologist with additional skills in diagnosis, treatment and communication with his patient and would certainly make him a better gynaecologist. This kind of training is also likely to stimulate more research and improve the quality of research into the psycho-somatic aspects of obstetrics and gynaecology in our country.

Apart from the area of family planning very little research has been done in psychiatric and psycho-somatic aspects of obstetrics and gynaecology in India. Good inter disciplinary co-operation is certainly necessary in the field also.

Criminal abortion is a major socio-economic problem worsened by illiteracy in our country. It is a global problem and deaths from illegal and unskilled abortions play considerable role in the maternal mortality pattern of the country. Septic abortions, in fact reflect the social inadequacies, lack of health education and sex education as well as poor concern for asepsis and poor skill of the practising abortionists. The
delay in seeking aid due to the desire of secrecy makes management difficult and results of treatment poorly awarding.

The problem of illegal septic abortion and the problem of illiteracy, high maternal mortality reflects not only an inadequacy of health care services for the mother but also a low standard of living, religious taboos, unawareness to available medical facilities, a high pregnancy rate and also the socio-economic status of the community. With the existence of laws of termination of pregnancy, it is hoped that many of the abortions which were previously induced by untrained personnel should now be undertaken by medical personnel minimising the sequelae. Of course, more of the married cases resort to legalised abortion now a days. This is indeed a welcome change in the trend.

As septic abortion contribute to a considerable number of maternal death these should be avoided by offering pregnancy counselling and abortion services for unwanted pregnancies. The findings of the present study suggests that there has not really been a decline in the cases of criminal abortion even after the implementation of the M.T.P. Act of 1972 as a health measure. Criminal abortions still continue to take a major toll of
maternal death, since a large number of women still prefer to get the abortion done in real secrecy and only register in hospital when complications arise. It only indicates that under coverage of liberalised laws of abortion more and more untrained persons are carrying out abortions in unauthorised centres which should be restrained.

The public should be made aware of the recognised centres for N.I.P. The medical and paramedical staff should be well trained and very conscious about sepsis. Urgent steps to decrease this risk of maternal death need to be implemented.

Illiteracy and ignorance play an important role in great many of the procured abortions. Only a wide campaign on the immediate and remote dangers of such abortions can reduce interference and deaths from abortions. It is to be seen how the legislation on abortion in the form of liberalisation will reflect on the abortion mortality of our country and psychosomatic health of our women folk.

Knowledge of the availability of the abortion services and the hazards of late abortion has not pursued the depth of our villages. The medical and health services should be extended to
the rural areas. This is only possible if the health education along with improvement of socio-economic conditions is provided to all concerned. Better organisation of the maternal and child health services in the rural areas are urgently necessary.

Well equipped abortion clinics have to be established in rural areas to provide service to those who now resort to induced abortion with the help of untrained abortionists. Even after the liberalisation of abortion consequent on the introduction of the pregnancy termination Act necessary facilities for induced abortion are still lacking in most rural areas as eighty percent (80%) of our women still live in the villages.

Though a large number of M.T.P.s are done in cities and towns the rural areas are not benefited. In the rural areas the long distance needs to be covered by the people to reach primary Health centres (P.H.C.s) to undergo M.T.P. but even the Primary Health Centres are not authorised centres for undergoing M.T.P. Facilities should be made available at all P.H.C.s. Even the nurses should be trained for this service. There is an urgent need for health education screening of high risk pregnant women, provision of suitable communication (telephone), transportation (including mobile squads) and blood transfusion services besides
making available skilled personnel and operation theatre facilities in upgraded P.H.C.s and smaller hospitals. By appropriate and intensive family health education and providing safe and effective contraceptive and abortion facilities at the P.H.C.s, it may be possible to reduce the problem of the number of illegal abortions. Then only can the benefits of M.T.P. reach the villages.

Rural people have great faith in local "Dai" (traditional midwives) and in most instances she is the first person to be called upon and her advice is given due weight and technical assistance is called for as per advice. It must therefore come to terms with conditions as they exist and for the next decade or so devise means to utilise the services of persons who are already part and parcel of the rural scene and enjoy the confidence of the local people. Even the services of the traditional "Das" can be turned into advantage by just teaching them simple rules of cleanliness thereby eliminating the scourge of dreaded diseases like tetanus, which to-day take such a heavy toll. Hence, training and winning the faith of local "Das" is of paramount importance for improving services.
The finding of the studies suggest that as the number of women coming to hospital for health check-up after M.T.P. is very small though the health check-up after M.T.P. is very essential and can bring down the different physical and mental problems of these women. Therefore, prospective and meticulous long term follow up of M.T.P. acceptors are required to establish an orbit of health education leadership to guide and send others for M.T.P. and also to know the exact risk physical, social, psychological and early as well as late sequelae of induced abortion.

Each case of M.T.P. needs to be studied over a long period to see adjustment to M.T.P.'s before and after. The married women in this study wanted abortions for spacing or were not interested in any further additions to the family. They had typical difficulties as housewives due to social economic and health reasons. It is necessary to persuade these women to accept contraceptive measures or a surgical method of sterilization.

Since women are highly motivated to accept some form of contraception at the time of undergoing abortion, this opportunity should be properly utilised to promote the different methods
of contraception. With the introduction of M.T.P. Act 1972 concurrent sterilizations have become popular. Almost all gynaecologists agree to the concept of abortion with concurrent sterilization. But it seems that in the present society even the acceptance of contraceptive measures is not practicable because of illiteracy, lack of awareness of the availability and inhibition due to traditional practices and beliefs.

The findings of the study show that contraceptive acceptance amongst acceptors of induced abortions are significantly higher. Motivation during induced abortions increased acceptance. Increased motivation and awareness of people in the community are very much needed. During induced abortion also should try motivate couples as acceptance of contraception and sterilization increases appreciably. Awareness of the public about the dangers of illegal abortions and motivation for contraceptives and sterilization are needed to minimise uptake of illegal abortion. Increased acceptance and proper use of contraceptives and sterilization will help reduce avoidable and unplanned pregnancies lead to less demand for M.T.P. and illegal abortions with consequent complications as well as boost up ongoing family welfare services.

All possible method to satisfy the couple with their
existing offsprings irrespective of the sex should be considered some ways and means for achieving this idea are giving education, employment status, and raising the age of marriage. The government of India has raised the minimum age of marriage for girls as 18 years, but as the study shows early marriage still prevalent. The couple who now fix the arrival of a male child as the green signal for adopting contraception should be assured that the sex of the child is not a serious factor as an asset during the evening of their lives.

Our social system is not yet geared up to give the woman the right to take her choice. It is pointed out that the family planning programme should be based upon emancipation of the woman, her right to study and participate in personal, public and common decisions and her heightened social consciousness. Planned parenthood and marriage are factors for the promotion of a healthy society but they must be based on full equality of both the partners self respect and knowledge.

The task of propagation of contraception is shared as a collective responsibility by the Medical Officers, lecturers in Health Education, Extension Educators and Family Welfare planning Social workers. It is the work of the social workers.
to convince the woman about the usefulness and safety of the method and to remove the idea of committing sin against creation simply by preventing unwanted child birth or of going against nature, of danger of developing cancer, of injury to herself and her husband and many other silly notions common among the uneducated village women. The traditional cultural misconceptions like children as God's gift with the inherent provision of food and shelter should be eliminated. The religious stand also should be discouraged. This demands extensive health education for the people which would wipe out their misconcepts.

Regarding the problems of unmarried girls the findings of the present study suggest that some of these girls showed the need for psychiatric consultation and treatment. The girls in the present study came from different needs and there should be more pragmatic and practical approach to the girl's need for physical, psychological and social problems.

In India there are 21 million girls in 15-19 years of age group. Though the fertility at this age is said to be low, the age specific marital fertility rate is 228 per 1000. A national sample survey has revealed that there are 27 married couples belonging to this age group per 1000 population.¹

Abortion Act is a boon to our unmarried girls, but it raises a big question whether M.T.P. Act enhances immorality among the Indian girls and women by encouraging sexual promiscuity particularly in the permissive society. Since our society is family oriented illegitimacy is a major social problem and the children born out of wedlock must be the social concern. Though this is an age-old problem, public interest in it is getting intensified. The topic of sex is no more tabooed but is being discussed quite frankly and openly. Films and magazines are full of it and this is a good opportunity to channelize this interest into positive thinking rather than to allow it to lead to alarming attitudes.

The objective after every termination of pregnancy of an unmarried girl should be the non-recurrence of this situation. This can be achieved to some extent through a well-organized rehabilitation program centres conducting Medical Termination of pregnancy. Rehabilitation is an important aspect of the modern existence partly because of the economic pressures of the present times. The girls coming for M.T.P. seem to be in need of a social, economic and mental rehabilitation. This research study suggests that as these girls had never received any sex education, they were not even aware of their own biological role in the pregnancy, they had come to terminate.
Therefore, some sex knowledge should be imparted to them. This can be done through group discussions on subjects such as physiology and anatomy, choice of partners, venereal diseases, contraception etc.

A big hurdle and limitation has been the inability to provide proper economic and material aid to those girls to improve their economic condition. Job opportunities are very limited especially for this category of people with limited education and skills. Training in some sort of practical and productive work can be imparted to these girls and government as well as some social organisations can help these girls by way of financing them during their training period.

Another frustrating experience in the present series of studies has been that despite legalisation pregnant women who are out of wedlock still resort to criminal abortion. In the present study these girls come for R.T.P. very secretly. It is because the social stigma attached to unmarried motherhood. Therefore, it is felt that so long as society does not accept unmarried motherhood, illegal abortions will continue. What is needed, is that change in the attitude of the people and the social taboos associated with unmarried motherhood should soften out. In a permissive society, where conditions are created for
frequent meeting between a boy and a girl, the consequences should also be accepted by the society. If an unmarried mother is treated with respect they would be less inclined to resort to illegal abortion.

It can be assumed that with intensive health education and with changing concept of morality these problems will ultimately cease to exist. A change in social outlook and easy availability of expert help might have saved these lives. A sincere and all round effort in educating women in family planning and contraceptive procedures is necessary to avoid unwanted pregnancies during the most fertile period of life. This in turn can prevent death or decay of so many maternal lives at their early ages.

Many countries have realised the need of literacy for socio-economic development. But under privileged sections of the societies are yet to realise the very significance of the 3 R's. Education is a potential instrument for social change and now considered to be the very lever of development.

Illiteracy among girls is connected with the age of marriage and education automatically raises that age. Education in turn accords employment status necessary facilities and
sufficient incentives when provided to educate the girls, a change in their outlook of life, improvement in their understanding can be expected. This will not only reduce the number of illegal abortion rate but also provide them opportunities for jobs or wage earning confidence.

A distressing factor noticed was a large number of very young girls between the ages of 14 and 16 who came for termination of their pregnancies. Unless the A.T.P. cases of these girls are followed up with proper social and medical counselling there is no hope of avoiding repetition of the problem. It was also observed that some young girls who came to procure of abortion were often unaccompanied by their parents or guardians. The medical personnel must be made aware that nothing must be undertaken without parental consent in these minor girls breach of which will make them liable to public prosecution.

It is felt that to prevent unwanted pregnancies in unmarried girl certain measures like censorship of the film, banning of cheap literature and sex education in school should be taken. In the teachers' training courses sex education and sex information should be included in the curriculum so as to make it possible for them to give correct information in a proper way while teaching in the schools. Schooling is one
of the most earliest and the most important methods of socialization.

The present study suggests that the nuclear family is considered to be the best environment for an individual's growth and development. It has a very significant role to play as it is gradually replacing the traditional joint family. Children no longer regard grand parents or other adults as authority. On the other hand, such living may also be offering very poor interpersonal relationships, because the parents are themselves too harassed and pre-occupied. The sexual activity may thus sometimes become a means of gratifying childhood deprivations.

With good parental supervision, education including moral, religious and family health and improved socio-economic conditions this problem of pregnancy in the unmarried can be minimised. It is better to offer them health education at high school and college before their marriage than several years following it or after some of them have had premarital conceptions.

A team of professionals comprising of the gynecologist and obstetrician, the social worker and other para-medical
staff with a good insight into human behaviour, should all work closely to help the girls seeking help. Impartation of sex and health education even at the village level may help to improve matters in this regard.

Public should be made aware of M.T.P. services by various audiovisual and mass communication media, like newspapers, radio, T.V. community talks etc. and informing details as to where such facilities are available free of charge in the teaching hospitals, government and Municipal hospitals, as well as in some district hospitals. Even the facilities of M.T.P. in first trimester (early pregnancy upto twelve (12) weeks) should be available at the Primary Health Centres and M.T.P. in the second trimester (Pregnancy upto 20 weeks) at the district hospital carried on by properly qualified personnel. Such measures will dissuade women going to quacks for M.T.P. where they are risking their own lives and future ill health, as well as chances of inability to conceive at a later date.

The liberalisation of 'Abortion Law' in majority of the countries of the world has generated marked proliferation of the statistical data pertaining to M.T.P. As counselling is very important in dealing with unwanted pregnancy, the knowledge of attitudes and trends in different groups of cases would go
a long way to satisfy the women. A number of problems namely the changes occurring in fertility rates, lack of available contraceptions and the time necessary for contraceptive practice to diffuse through a society all combine to make it likely that abortion will continue to be one of the major means of fertility regulation for years to come.

As the present Act has failed to modify the pattern of illegal abortion mortality, such as type of interferences interference-admission ratios, causes of death, socio-economic status and age group of women. In view of these factors the present M.T.P. Act needs to be reappraised and adequate knowledge in family welfare to these women should be emphasised. The M.T.P. services till now are restricted to hospitals in cities mostly and the doctors in the periphery are not well trained. The task force should train more doctors in this field. Maintenance of proper assemples in family planning centres and clinics and facilities available should be improved upon. A wider publicity regarding availability of M.T.P. services amongst the under privileged group should also go a long way to reduce this maternal deaths. To achieve better results our communication service also needs to be improved. After implementation of all these methods, the efficacy and utility of the law can be assessed properly.
The present M.T.P. Act probably had a role in the reduction of population and thus partly serve the purpose of population control. Thus it can be assumed with confidence that the abortion law atleast prevented the expected national yearly rise in the number of illegal or septic abortion cases which would have taken place in the absence of such a law, besides its beneficial effects on maternal mortality due to illegal abortions and on population control.

There is really no diagnostic way of finding out the number of abortions a woman has under gone. Intensive medical, social and ecological studies are necessary to get into the depth of such cases while it is difficult to get current statistics and picture of all abortion cases, a critical analysis of abortion deaths will atleast throw some light on the background of such cases. The data will help in future to compare the achievements in post legalisation and its impact on the population dynamics of the nation.

As women are still reluctant to disclose their previous abortion because the social factor related to abortion is very high. Education has made a difference. In the circumstances a woman would seek abortion only then if she would seek it at all and need better education of M.T.P.
As Psychological problems affect the acceptability of the various family welfare programmes including R.T.P., the physician should be made well acquainted with these aspects so as to make him capable of motivating the masses in the right direction and training the paramedical personnel and social workers in that direction. Social workers must try to involve the family especially the mothers and make every effort to help these women and girls and their families in solving their socio-economic problems.

The research findings suggest that the practice of abortion has remained a taboo in the minds of most of the women coming for R.T.P. So to eradicate such beliefs from the minds of the women there should be occasional meetings, seminars, discussions etc. on the subject and the leading women social workers should participate in these forums first to motivate the women folk to be aware of their own status in the society.

Researchers doing research on R.T.P. and such other allied subjects should be supported and encouraged by the government to encourage the women-folk to accept R.T.P. and thus to do away with the now prevailing criminal abortion. This in turn will help understanding the women's problems and facilitate R.T.P.