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Postabortion Complications and their Management:

A Community Assessment Conducted in Rural Uttar Pradesh, India

Final Report

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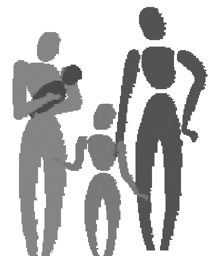

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Contents

Abstract v
Authors vii
Acknowledgements vii
Acronyms ix
Executive Summary xi
Introduction 1
Methodology 5
- Selection of partner institutions 6
- Description of study sites 7
- Research team identification and training 8
- Data collection procedures 9

Findings 13
- Characteristics of informants 13
- Characteristics of providers 14
- Abortion in rural Uttar Pradesh 16
- Postabortion complications 22
- Postabortion care in rural Uttar Pradesh villages 27

Conclusions 63
Recommendations to improve postabortion care 65
References 73
Appendices 75

Tables and Appendices

Tables

Table 1 Hindi terms related to abortion and postabortion care used in interviews ... x

Table 2 Research method by informant characteristics – Allahabad site ... 9

Table 3 Research method by informant characteristics – Kasganj site ... 10

Table 4 Providers interviewed (self-categorized): Allahabad sites ... 10

Table 5 Providers interviewed (self-categorized): Kasganj site ... 11

Table 6 Socio-demographic characteristics of key informants – Allahabad sites ... 14

Table 7 Socio-demographic characteristics of key informants – Kasganj sites ... 14

Table 8 Method of induced abortion by provider, Kasganj site (as reported by informants) ... 17

Table 9 Treatment for complications associated with induced abortion (as reported by non-provider informants) ... 35

Table 10 Aspects of postabortion care that can be offered by various levels of community provider ... 69

Appendices

Appendix 1 A review of the literature on postabortion care in Uttar Pradesh, India ... 75

Table A.1 Medical treatment seeking behavior of women with abortion complica-tions ... 89

Appendix 2 Discussion guides used in data collection ... 97

Appendix 3 Consent forms for data collection ... 137

Appendix 4 List of abortifacients collected from community-level providers from Kasgani study team ... 145

Abstract

Despite the fact that abortion has been legally available for a broad spectrum of indications since 1972, an estimated 90 percent of induced abortions are performed illegally in India. Low-income rural women and adolescents are among those most likely to have unsafe abortions and associated complications. For these women postabortion care is critical to reducing morbidity and mortality from unsafe abortion, yet is often unavailable. Uttar Pradesh has among the highest estimated abortion rates in India, coupled with inadequate abortion services at rural health centers. Unsafe abortion and associated complications are widespread.

To support the State Innovations in Family Planning Services (IFPS) Project, research teams supported by the USAID PRIME project conducted this community-level assessment to gain an understanding of how postabortion care is provided and how it can be improved at the village level in rural Uttar Pradesh, India. Research teams at Kasganj Christian Hospital and Kamala Nehru Memorial Hospital facilitated the assessment. Data collection took place August through November 1999.

Qualitative methods were used for data collection. Through preliminary community surveys, research teams identified relevant organizations, institutions, and leaders in four villages in rural Uttar Pradesh. Eighteen community mapping exercises and 24 focus group discussions were conducted with married and unmarried women and men from specific population sub-groups. Key informants (n=53) were interviewed in-depth, multiple times, and included women who had experienced spontaneous abortion or induced abortion and complications. Abortion providers were also interviewed in-depth, and were asked about their perceptions and practices regarding abortion, abortion-related morbidity, and postabortion care (n=38).

Through the assessment researchers found that women turn to a number of untrained community-level providers for abortion and postabortion care services. These include: *dais* (traditional birth attendants), Auxiliary Nurse Midwives, and medical shopkeepers, among others. In addition, women use home remedies for abortion and postabortion care.

The postabortion care provided in rural villages is insufficient. Emergency care offered at the community level can exacerbate complications and delay access to appropriate care. Postabortion contraceptive counseling and services are uncommon and inadequate. Community-level providers do not recognize the need to link women who have had abortion complications to other reproductive health services.

Despite the fact that the postabortion care provided in rural villages is inadequate, community-based providers are likely to remain the first point of contact for many rural women with abortion complications because such providers are accessible, affordable, and familiar.

The authors recommend taking advantage of existing community networks to promote contraceptive use and decrease rates of unwanted pregnancy, to increase prompt access to high-quality emergency postabortion care by linking women to qualified health providers, and to provide postabortion contraceptive counseling and services at the community level. Community-based providers are essential to recognizing complications, getting women to appropriate care promptly, and providing a steady supply of postabortion contraception and counseling.

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Acronyms

ANM	Auxiliary Nurse Midwives
BAMS	Bachelor in Ayurvedic Medical Services
CA	(USAID) Cooperating Agency
CHK	Christian Hospital Kasganj
D&C	Dilation and Curettage
DGO	Degree in Gynecology and Obstetrics
FGD	Focus Group Discussion
FGP	Focus Group Participant
IFPS	Innovations in Family Planning Services
INT	Interviewer
ISMP	Indian Systems of Medicine Practitioner
KI	Key Informant
KNMH	Kamala Nehru Memorial Hospital (Allahabad)
MBBS	Bachelor's in Medical Surgery
MTP	Medical Termination of Pregnancy, or Induce Abortion
PAC	Postabortion Care
PI	Provider Informant
RMP	Registered Medical Practitioner
RTI	Reproductive Tract Infection
SIFPSA	State Innovations in Family Planning Services Administration
USAID	United States Agency for International Development

Table 1. Hindi Terms related to abortion and postabortion care used in interviews

Term	Meaning
Aganwadi worker	Woman who meets with mothers and children in community to promote good health practices
Bacche girvana	"Child waste" - refers to induced abortion
Balaatkar	Rape
Baram	Swelling
Batti	Traditional village-level abortion technique, a mixture of abortifacients rolled into a long thin matchstick shape and inserted vaginally
Behenji	"Sister" - a respectful term of address
Bota	Blood clots
Chota pariwar, sukhi pariwar	"A small family is a happy family" – a message promoted by the government
Dactarni	Female "doctor," practitioners with varying qualifications
Dai	A traditional birth attendant
Dava (sing.) davai (pl.)	Medicine(s)
Didi	"Sister" - a respectful term of address
Garmi	Warmth
Goli, goliyan	Tablets, sometimes used to refer to oral contraceptives
Hakeem	Practitioner of traditional medicine
Harami	Abusive term
Harira	A mixture of dried fruits and tea, consumed orally as an abortifacient
Jaggery	Coarse brown cane sugar, used in teas or oral medicines as an abortifacient
Jhola chhap	"Bag brand" – an untrained provider who carries supplies door to door in a medical bag while attending to patients
Mala-D	Brand of oral contraceptives
Nasha	Anesthesia
Pindi	Fetal tissue
Pradhan	Village headman
Safai	"Clean" - Commonly used to refer to cleaning the uterus, usually with D&C instruments.
Unani	Ayurvedic medicine

Executive Summary

Despite the fact that abortion has been legally available for a broad spectrum of indications since 1972, an estimated 90 percent of induced abortions are performed illegally in India. Low-income rural women and adolescents are among those most likely to have unsafe abortions and associated complications. For these women postabortion care[1] is critical to reducing morbidity and mortality from unsafe abortion, yet is often unavailable.

At the request of the Uttar Pradesh State Innovations in Family Planning Services (IFPS) Project, the USAID PRIME project provided support for research teams based at the Kasganj Christian Hospital and the Kamala Nehru Memorial Hospital to conduct exploratory research on postabortion care provision in rural Uttar Pradesh. Initially research teams conducted preliminary community surveys to identify relevant organizations, institutions, and leaders in four villages in the Gangetic plains of rural Uttar Pradesh. Eighteen community mapping exercises and 24 focus group discussions were conducted with married and unmarried women and men from specific population sub-groups. Key informants (n=53) were interviewed in-depth, multiple times and included women who had experienced spontaneous abortion, or induced abortion and complications. Individuals identified by informants as abortion providers were also interviewed in-depth, and asked about their perceptions and practices regarding abortion, abortion-related morbidity, and postabortion care (n=38).

Through this research the teams found that women turn to a number of untrained community-level providers for abortion and postabortion care services. These include: *dais* (traditional birth attendants), Auxiliary Nurse Midwives, and medical shopkeepers. In addition, women use home-remedies for abortion and postabortion care. Both abortion and postabortion care appear to be processes along a continuum with accessibility, affordability, and familiarity at one end, and reliability at the other.

The postabortion care provided in rural villages is appealing to women because of the accessibility, and familiarity of the provider, and affordability of the service. However, village level care tends to be insufficient. Emergency care offered at the community level can exacerbate the complication and delay access to appropriate care. Postabortion contraceptive counseling and services are uncommon and inadequate. Many providers do not recognize the need to link women who have had abortion complications to other reproductive health services.

Research results showed that even though the type of postabortion care provided in rural villages can worsen a woman's situation, community-based

1 Postabortion care refers to a service delivery approach to reduce risk related to abortion. The three elements of postabortion care are: emergency treatment for abortion complications, postabortion contraception, and links between emergency treatment and comprehensive reproductive health services.

providers are likely to remain the first point of contact for many rural women with abortion complications. Women interviewed generally recognized the need for higher quality local care. Some recommended establishing a hospital with a "lady doctor" in their community to better meet the reproductive health care needs of women in the community.

Recognizing a dependency on local care providers, the authors make the cost-sensitive recommendation to enable existing community health providers to recognize complications, link women to appropriate care promptly, and provide a steady supply of postabortion contraception and counseling. The research results demonstrate that community-based providers are essential to strategies to decrease rates of unwanted pregnancy, increase prompt access to high quality emergency postabortion care, and provide postabortion contraceptive counseling and services in rural areas.

Introduction

In India millions of unsafe and illegal abortions and countless subsequent complications occur annually, despite the fact that abortion law was liberalized almost 30 years ago. The Medical Termination of Pregnancy Act of 1971 permits abortion (MTP) for a broad range of social and medical reasons, including: to save the life of the woman; to preserve physical health; to preserve mental health; to terminate a pregnancy resulting from rape or incest; and in cases of fetal impairment. Contraceptive failure is sufficient grounds for legal abortion. Abortion is legal in the first 20 weeks of pregnancy, when performed by a registered[2] physician in a government-approved facility (Chhabra and Nuna 1994; United Nations 1993).

The Government intended for the MTP Act to reduce the incidence of illegal abortion and consequent maternal morbidity and mortality. However the majority of women seeking abortion still turn to illegal abortion services because of the barriers to legal abortion. While some illegal abortion services are safe, many are unsafe and result in complications, or death. Women with access to fewer resources – for example low-income rural women and adolescents – are among those most likely to turn to unsafe abortion and to experience abortion complications (Ganatra, Coyaji, and Rao 1998; Jejeebhoy 1998). Although limited data exist on the number of maternal deaths due to legal and illegal abortion in India, abortion-related deaths are conservatively estimated at 15% of all maternal deaths (Mathai 1998).

Barriers to safe abortion services include the fact that many of the approved MTP facilities actually do not provide services, and that registered providers working at government-approved facilities are most often based in urban areas while the vast majority of Indian women live in rural areas. All Primary Health Centers, Community Health Centers, postpartum centers, and similar higher-level public facilities are supposed to provide abortion services. In Uttar Pradesh, where this study takes place, only approximately one-quarter of Primary Health Centers and 59 percent of Community Health Centers do so (Barge et al. 1997; Khan et al. 1999).

Complications of unsafe abortion are a growing public health concern and the health system's current ability to manage these complications with postabortion care has been questioned (Chhabra and Nuna 1994; Khan et al. 1999).

2 In this report and in general in India a "registered" MTP provider is one who has been trained in MTP to the level required by the government, and provides MTP in a facility approved by the government.

Previous studies suggest that many unregistered providers in India ignore postabortion care (PAC) and that PAC can be improved among registered providers. A 1989 Indian Council of Medical Research study of unregistered providers revealed that postabortion abdominal pain and prolonged bleeding among women who have just had abortions are often ignored (Indian Council of Medical Research 1989). Government, hospital, and clinic statistics show very low levels of contraceptive acceptance after MTP. Registered and unregistered MTP providers are missing a crucial opportunity to assist those women most likely to have an unmet need for contraception (Chhabra and Nuna 1994).

Uttar Pradesh has the second highest rate of unwanted fertility of any state in India – over one excess birth per woman, on average, according to the 1992-93 India National Family Health Survey (International Institute for Population Studies 1995). High rates of unwanted fertility are closely related to low rates of contraceptive use. Eighty percent of rural married women of reproductive age in Uttar Pradesh use no contraception (International Institute for Population Studies 1995). Women who have an unmet need for family planning are among those most likely to have unwanted pregnancies, and in turn, to elect to have an abortion. With an estimated 68 abortions per 1,000 married women of reproductive age per year, Uttar Pradesh has one of the highest abortion rates in India (Chhabra and Nuna 1994; Johnston forthcoming; Mishra, Ramanathan, and Rajan 1998).

In India, Uttar Pradesh is second only to Bihar in having the lowest per capita availability of legal abortion facilities – one per 369,000 people (the average in India is one per 101,000 people) (Johnston forthcoming). A large number of abortions are performed illegally by medical and non-medical practitioners (Chhabra and Nuna 1994; Kerrigan, Gaffikin, and Magarick 1995). By implication Uttar Pradesh is among the states for which the need for high-quality postabortion care is most urgent.

When PRIME coordinated site assessments of private and public sector health facilities in Uttar Pradesh, with assistance from SIFPSA (Uttar Pradesh's State Innovations in Family Planning Services Agency) and EngenderHealth, unexpectedly small numbers of women with abortion complications were found to present at registered private and public facilities. The facility assessment identified the key questions:

(1) Where do women go when they have complications of abortion? and

(2) What standard of postabortion care do these providers offer?

To explore informal community-level provision of PAC services, this subsequent assessment was designed. The objectives of this assessment were to:

- Understand and document women's and decision-makers' conceptualization of and behavior related to unsafe abortion

and its complications, and the availability of comprehensive postabortion care at the community level;

- Assess roles that community-level health care providers can play in recognizing abortion complications and in helping women with complications access appropriate care quickly; and
- Examine the extent to which community-level providers are prepared to and actually offer postabortion contraceptive counseling and services.

The expected outcomes of the assessment were to:

1. Provide results useful for guiding the development of community-level interventions aimed at preventing and treating complications of unsafe abortion; and
2. Guide the development of reproductive health education messages targeting married and unmarried women of reproductive age, household level decision-makers, and community-level PAC providers in rural Uttar Pradesh.

In order to meet the above objectives, this assessment investigated: how community members and formal and informal health care providers conceptualize reproductive health and unsafe abortion as well as the impact of abortion in their communities; community members' knowledge about the prevention and treatment of unsafe abortion; barriers related to access to safe abortion care and PAC, including gender and status dynamics, economics, distance, transport, and women's relationships with the existing health care system; the medical and cultural barriers that cause delays in recognizing danger signs and cause delays in accessing PAC; and similarities and differences regarding PAC issues in different rural contexts in Uttar Pradesh.

In addition to meeting the defined objectives, the findings and recommendations from the assessment may be able to contribute to appropriate training programs for community-level providers of PAC as part of USAID's Innovations in Family Planning Services Project. SIFPSA, USAID Cooperating Agencies, and local implementing organizations may be able to use the findings to incorporate relevant information into ongoing training modules for community-level workers, paramedics, and medical professionals and to develop further interventions.

Methodology

Qualitative data collection methods were used for this assessment as they provide an appropriate means of collecting information about sensitive topics such as abortion, and can yield data on both the range of perceptions and practices of the informants and the decision-making processes supporting these perceptions and practices. Such in-depth information is key for knowing how to best adapt or develop programs for local cultural conditions.

The study design allowed for the research teams to gradually gain entry into the communities, by first conducting very public data collection activities, and gradually asking women and health care providers in the community if they would participate in in-depth interviews. The following series of data collection activities were conducted:

- Quick descriptive surveys of formal and informal organizations, institutions, and key leaders in the four selected villages;
- Community mapping, a participatory research method in which community members are asked to create a visual representation of information (n=18);
- Focus group discussions with specific population subgroups, including married and unmarried women and men and female and male adolescents (n=24);
- In-depth interviews with married women who were particularly knowledgeable about abortion and postabortion care issues at the community level (n=53);
- In-depth interviews with providers of abortion and postabortion care services (n=38).

The use of multiple methods of data collection in this assessment helped to ensure the validity of the data collected.

Through the community mapping exercises and focus group discussions interviewers collected information on the social norms of abortion and treatment of complications[3] of unsafe abortion in the communities. In these exercises interviewers identified women who were knowledgeable about induced or spontaneous abortion and invited these women to participate in in-depth interviews at later dates. Also in the focus group discussions, interviewers asked a series

3 For the purposes of this study, the term "postabortion complication" was defined broadly. Any symptom of reproductive morbidity that women perceived as having arisen because of the abortion procedure was probed in depth. Persistence of symptoms beyond one week and symptoms that disrupted the woman's ability to carry out routine chores were identified as complications, regardless of whether or not women sought care for the symptoms.

of questions about a fictional woman who had an unwanted pregnancy, including which health providers the woman might go to in the community for abortion or postabortion care. Through this mechanism, a list of health care providers who offer abortion and/or postabortion care was generated. A sample of these providers subsequently participated in in-depth interviews.

The assessment employed purposive sampling, that is, individuals were selected based on their specific age and sex characteristics, as well as their informally demonstrated level of knowledge of abortion and postabortion care at the community level. Attempts were made to have adequate coverage of important sub-populations (age, religious, and caste groups). For the focus group discussions, relatively homogenous groups (in terms of socio-economic status and educational level) of community members were selected. The age/sex groups participating in the assessment included unmarried girls age 15-19; ever-married women age 18-24; ever-married women age 25-34; unmarried adolescent boys age 17-21; and married men age 30-39 (see Tables 2 and 3).

As the sampling was purposive and non-random, the data are not intended to measure incidence or prevalence of abortion, PAC, attitudes, or proportion of community members or providers who fall into specific categories.

Selection of partner institutions

This PAC assessment was conducted by two organizations selected because of their strong presence in rural communities in Uttar Pradesh, their experience in reproductive health service delivery, their appropriate linkages with referral centers, and their aptitude for and open-mindedness to qualitative research. The two partner institutions were Kamala Nehru Memorial Hospital in Allahabad, and Christian Hospital in Kasganj, Etah District.

Kamala Nehru Memorial Hospital, Allahabad (KNMH) was established nearly 50 years ago, originally as a tertiary care hospital, but over the last two decades has established strong community health programs about 30 kilometers from Allahabad City. KNMH has a base hospital that offers outpatient services to rural villagers. The main hospital in the city is a common referral destination for the population living in rural areas near Allahabad. The organization has a grant from USAID's Innovations in Family Planning Project (IFPS) to improve family planning and reproductive health services in rural areas surrounding Allahabad City. KNMH has a network of village-level workers who work with community groups and individuals to improve access to and quality of family planning and reproductive health services.

Christian Hospital Kasganj (CHK) has worked in rural Etah District for over 80 years, and is well known throughout the district as a center

that provides high-quality referral care. The assessment site was located about 20 kilometers from Kasganj town. CHK has been working in the area for four decades. Like KNMH, CHK is also a grantee of the IFPS project, with a network of community-level workers who have close linkages with their clients. CHK does not have a service delivery center in the rural areas, but the main hospital in Kasganj attracts people from the surrounding areas.

Description of study sites

The assessment was conducted in two villages located about 25-30 kilometers from the major city of Allahabad and in two villages 15-20 kilometers from the town of Kasganj, in Etah district. Both sites are based in rural Uttar Pradesh and benefit from the activities of the SIFPSA project, which expose residents to family planning messages via SIFPSA health team members and public messages, such as writings on village walls and slogans on buses and in newspapers. Written messages are less effective as the target audience (particularly at the Kasganj site) is largely illiterate. Because of increased access to electricity, the Allahabad sites are more exposed than are the Kasganj sites to national mass media television and radio family planning campaigns.

The Allahabad sites are more characteristic of rural areas near large cities. Proximity to a large city like Allahabad offers opportunity for higher education, high-quality health services, and increased economic opportunity. There are primary schools in almost every village and almost universal electrification. Literacy levels are higher than in typical rural areas, especially among the younger age groups, including girls. Yet the villages retain characteristics of rural areas such as poor infrastructure development, low overall literacy, limited access to health services, and agriculture as an important livelihood source.

Of the two study villages near Allahabad, one had a population of about 5,000, the other a population of about 1,850. The two villages are about four kilometers apart. The more populated village has both Muslim and Hindu residents, with a slight preponderance of upper caste households. The smaller of the villages has mostly Hindu families, with a large number of upper caste households. The main sources of livelihood are agriculture and employment in private sector industries. The majority of households have access to electricity, running water, and radio. Dirt roads connect the villages to nearby towns. Transport is available at a cost from private entrepreneurs. Health care providers in the villages included *dais* (traditional birth attendants), Auxiliary Nurse Midwives (ANM) from the public sector, untrained male and female medical practitioners, and spiritual healers. Tertiary level hospitals in Allahabad City provide care for medical emergencies.

At the Kasganj site the two villages in which the assessment took place are about three kilometers apart. The total population of the two villages studied by the Kasganj team is about 4,500. The socioeconomic status of both villages is low and an estimated 60 –70 percent of the population is non-literate. The primary occupation is agricultural but there are also laborers, businessmen, and servicemen. The larger of the villages has both private and government schools.

Etah District, where Kasganj is located and where the assessment took place, has a high rate of unemployment and associated poverty, poor infrastructure, and low literacy rates. The population is predominantly engaged in seasonal agricultural work. The majority of the population is landless or has marginal landholdings. Infrastructure development – including roads, public transport, electricity, and primary schools – is very poor throughout the region. The nearest city, Aligarh, is about 70 kilometers from Kasganj.

Health care providers are available in the larger village but not in the smaller village. Providers include *dais*, ANMs, Bachelors in Ayurvedic Medical Science (BAMS), Registered Medical Practitioners (RMP), and medical shopkeepers. The dirt roads connecting these villages to nearby towns are in very poor condition. Transport facilities include bicycles, bullock carts, tractors, one jeep, one car, a few motorcycles, and one private bus. At night, in case of emergencies, people use tractor trolleys. The smaller village has no electricity supply. The larger village has electricity for a few hours each day. There are wells and hand-pumps in both villages for water supply. In both villages few households have radios and television sets.

The Christian Hospital, Kasganj, and the government Birla Hospital provide postabortion care. Birla Hospital treats patients on an outpatient basis. The gynecologist sees 15-20 patients per month with abortion complications such as pelvic inflammation, incomplete abortion, and weakness. More severe complications are referred to the Christian Hospital. The Christian Hospital is a tertiary care facility with 110 beds. During the year in which the study took place (April 1999 – March 2000) eight to ten percent (5-8 patients per month) of patients admitted to the hospital were admitted with abortion complications. Patients with severe complications may also be referred to hospitals in the larger cities of Aligarh (70 kilometers from Kasganj) or Agra (115 kilometers from Kasganj).

Research team identification and training

Teams from both sites included three interviewers, six assistant interviewers, and two translators. The Kasganj team also included two transcribers. Each team was led by the site project manager. Important common criteria for all team members included the ability to relate to rural community members, fluency in the local dialect, and competence in taking notes in Hindi. Interviewers were women with academic training and field experience in social science research.

For both teams the training included an orientation to the study objectives, training in relevant reproductive health concepts and qualitative data collection techniques, and supervised field practice. Regular workshops were held throughout the data collection process. During the workshops study managers and team members reviewed incoming data for content and quality, refined discussion guides, and addressed issues interviewers faced during data collection.

Data collection procedures

The study was conducted in five phases. Initially cursory community appraisals were conducted in the four villages where the study took place. Research teams conducted community appraisals to gain an overall view of the community, including: community leaders, presence of community organizations, places where people congregate, presence of health care facilities, housing conditions, etc. Subsequently a total of 18 community mapping sessions were held. With the same groups that participated in the community mapping exercises, a total of 24 focus group discussions were conducted. Informants from the focus group discussions with married women were asked to participate in key-informant interviews if they appeared to have above-average knowledge of abortion in their community.[4] The majority of the 54 key informants were interviewed multiple times, yielding a total of 89 key informant interviews. Tables 2 and 3 illustrate the number of data collection exercises conducted with each group of informants.

Table 2. Research method by informant characteristics - Allahabad site

Informants	Community Mapping	Focus Group Discussion	In-depth Interviews
Older Married Women (>25)	3	3	18 (25 interviews)
Younger Married Women (<=25)	3	4	13 (20 interviews)
Adolescent Girls	3	3	-
Married Men	-	-	-
Adolescent Boys	-	2	-
Total	9	12	31 (45 interviews)

4 Additionally, one unmarried adolescent who had been treated for abortion complications at the Kasganj hospital that served as the study site agreed to be interviewed.

Table 3. Research method by informant characteristics - Kasganj site

Informants	Community Mapping	Focus Group Discussion	In-depth Interviews
Older Married Women (>25)	3	5	10 (20 interviews)
Younger Married Women (<=25)	1	2	12 (23 interviews)
Adolescent Girls	1	2	1 (1 interview)
Married Men	2	2	-
Adolescent Boys	2	1	-
Total	9	12	23 (44 interviews)

Interviews with formal and informal providers of abortion and postabortion care services composed the final phase of the study. A total of 122 such providers were identified during the previously described data collection procedures. A purposive sample of 38 providers was selected for single provider in-depth interviews (see Tables 4 and 5).[5]

Table 4. Providers interviewed (self-categorized): Allahabad sites

Type of provider	Number interviewed
Dai with training	1
Male "doctor," no formal health training	4
Auxiliary Nurse Midwife (ANM)	1
Female "doctor," no formal health training	1
Bachelor in Ayurvedic Medical Science (BAMS)	4
Ayurveda Ratna	1
Registered Medical Practitioner (RMP)	1
MBBS Gynecology	3
MBBS Orthopedics	1
MBBS Surgery	1
Total	18

5 The approach of generating lists of abortion and postabortion care providers through focus group discussions may not be appropriate in many settings. However, in the rural Uttar Pradesh context villagers who provide abortion and postabortion care services are generally not stigmatized, but rather are acknowledged as offering health services that are in demand in the community. Prior to participation in the assessment, providers were approached in a careful and sensitive way, and informed consent was obtained from them before proceeding with data collection.

Table 5. Providers interviewed (self-categorized): Kasganj sites

Type of provider	Number interviewed
Dai with no formal health training	5
Dai with training	7
Male "doctor," no formal health training	1
Bachelor in Ayurvedic Medical Science (BAMS)	3
Bachelor's of Science (B.Sc.)	1
Registered Medical Practitioner (RMP)	1
MBBS Gynecology	2
Total	20

Recognizing the sensitive nature of the information requested from assessment informants, measures were taken to maintain their confidentiality. The interviews were conducted in as private a setting as possible. Prior to a data collection exercise, whether community mapping, focus group discussion, or in-depth interview, informants were individually read a statement of informed consent explaining the objectives, risks, benefits, confidentiality, and other details of the study. Women and men who agreed to participate as informants were asked to verbally agree to the consent statement.

Prior to data collection, interviewers familiarized themselves with discussion guides developed specifically for each age/sex group. Interviewers would open the conversation using questions from the discussion guide, and would then allow the informant(s) to lead the conversation. Interviewers used intensive probing to collect more in-depth information than that initially given. Interviewers would guide the discussion back to the topics of the discussion guide when digressions occurred. Each data collection exercise typically took about 1.5 hours.

During the data collection process interviewers requested permission from the informants to take hand-written notes of the conversation and use cassette recorders to capture what was not included in their notes. The vast majority of participants permitted note taking and cassette recording of the conversation. Interviewers did notice, however, that some informants were more candid when cassette recorders were not used. After the data collection informants were given a small gift such as soap or skin cream to thank them for their participation. They were also given information about the hospital institution supporting the study and encouraged to visit the hospital if they had any questions or problems regarding their participation in the study or their health.

Handwritten notes and cassette recordings were used to transcribe the interviews. Effort was made to transcribe the interview on same day it was conducted in order to allow the interviewer maximum recall of events and conversation that took place during the interview. The handwritten Hindi transcript was translated into English as it was entered into a word processor.

The data from the in-depth interviews are thought to most accurately describe how abortion is conducted in the community. The vast majority of the data presented in this report comes from the in-depth interviews. Focus group discussions with married men and adolescent males and females are also important sources of information.

Each team participated in weekly workshops to review data collection methods and issues that arose during data collection. The discussion guides were reviewed and, if appropriate, revised during the workshops. Each team provided reports of data collection to the principal investigator. Preliminary analysis using a matrix tool occurred parallel to data collection. The project manager at each site supervised the matrix analysis.

Findings

Characteristics of informants

At the study sites near Allahabad, three community mapping exercises, three focus group discussions, and 25 in-depth interviews were held with married women over age 25; three community mapping exercises, four focus group discussions, and 20 in-depth interviews were held with married women age 25 and younger. Three community mapping exercises and three focus group discussions were held with unmarried adolescent girls; and two focus group discussions were held with unmarried adolescent boys (see Table 2).

Table 6 shows important characteristics of the 31 key informants (KI) who participated in multiple in-depth interviews at the Allahabad sites. Of the 31 key informants, 23 had undergone induced abortions and 20 had had spontaneous abortions. Nine informants had experienced both spontaneous and induced abortion. Thirteen of the key informants had experienced complications after a spontaneous or induced abortion.

At the study sites near Kasganj, three community mapping exercises, five focus group discussions, and 20 in-depth interviews were held with married women over age 25; one community mapping exercise, two focus group discussions, and 23 in-depth interviews were held with married women age 25 and younger. One community mapping exercise and two focus group discussions were held with unmarried adolescent girls; two community mapping exercises and two focus group discussions were held with married men; and two community mapping exercises and one focus group discussion were held with unmarried adolescent boys (see Table 3).

At the Kasganj study sites, of the 24 women who participated in the in-depth interviews, 15 had had at least one induced abortion, and 18 had undergone at least one spontaneous abortion. All had either had an induced or spontaneous abortion or both, and all claimed to have experienced complications after the abortion. Important characteristics of the key informants are provided in Table 7.

Table 6. Socio-demographic characteristics of key informants – Allahabad sites

Informant Characteristic	Age	Number	Percent
Age	18-24	5	16
	25-34	21	68
	35+	5	16
	Total	31	100
Religion	Hindu	29	94
	Muslim	2	6
	Other		0
	Total	31	100
Number of children	0	1	3
	1-2	6	19
	3-4	15	48
	5+	9	29
	Total	31	100
Number having had induced abortions		23*	
Number having had spontaneous abortions		20*	
Number having had postabortion complications		13	

* Nine informants had both induced and spontaneous abortions

Table 7. Socio-demographic characteristics of key informants – Kasganj sites

Informant Characteristic	Age	Number	Percent
Age	18-24	8	33
	25-34	9	34
	35+	7	29
	Total	24	100
Religion	Hindu	19	79
	Muslim	3	13
	Hanijan	2	8
	Total	24	100
Number of children	0	1	5
	1-2	6	25
	3-4	8	33
	5+	9	37
	Total	24	100
Number having had induced abortions	None	9	38
	1-2	15	62
	3+		0
	Total	24	100
Number having had spontaneous abortions	None	5	21
	1-2	18	75
	3+	1	4
	Total	24	100
Number having had postabortion complications		24	100

Characteristics of providers

For purposes of the study, providers are classified into two major categories: community-level providers and referral-level providers. Community-level providers are those located in the villages who are

accessible to the community at the time the community requires their services, and who offer services that do not rely on sophisticated medical equipment and/or in-patient treatment facilities. Referral-level providers are located in nearby towns or a city, are based in facilities with sophisticated medical equipment and/or in-patient treatment facilities, and are qualified to conduct MTP.

At the Allahabad study site, a total of 74 providers were identified from the community survey, community mappings, focus group discussions, and key informant interviews. Eighteen of these providers were interviewed (see Table 4). Of these, seven were practitioners who had no formal (academic or practical) training in any system of medicine, five had degrees in Indian Systems of Medicine (ISM), and five were trained in allopathic medicine. The untrained providers and the ISMP practitioners were based in the study villages or in nearby towns. All the allopathic doctors were based in Allahabad, but also worked in nursing homes[6] closer to the study villages. Of the 18 providers only the three gynecologists were registered to perform MTP. However, all were providing either medical or surgical abortion services. Six of the providers were women. Seven operated out of nursing homes, and had the capability to provide postabortion care, including evacuation and transfusion. The remainder had one-room clinics.

Except for the three gynecologists, all the providers identified offered a range of services for men, women, and children. All were referred to as "doctor" by the informants. The village-level providers, in addition, were referred to by name or respectfully as "elder son," indicating a relationship of trust and comfort. All the providers had been practicing for between five and 15 years, and all had been consulted for postabortion complications resulting from both spontaneous and induced abortions.

At the Kasganj study site 48 providers were identified. These included 16 *dais*, five Registered Medical Practitioners (RMPs), two BAMS doctors, three ANMs, one medical shopkeeper, and six trained doctors who did not work locally but were known by the villagers. Of the 48 providers identified, 20 were interviewed (see Table 5). Of these, twelve were *dais*. Five *dais* had some training and seven had no formal training. One provider was a male "doctor" with no formal medical training. Five were male "doctors" with different levels of formal or informal training in health service provision, but none had MBBS degrees. Two female MBBS providers from Kasganj town were interviewed. Though all providers performed abortion and/or gave treatment for postabortion complications, only the two MBBS doctors were registered to conduct MTP.

6 Nursing homes are private facilities (outpatient and sometimes inpatient) that offer medical care of varying degrees of quality.

Again, although this study was not meant to collect data on abortion prevalence, interviewers did ask providers about the number of abortions performed. Many providers were uncomfortable answering the question. However as an example of the local demand for abortion, one *dai* reported inducing 600-700 abortions annually. An MBBS doctor in Kasganj reported conducting 800-900 MTPs per year.

Abortion in rural Uttar Pradesh

Pregnancies in rural Uttar Pradesh are aborted for a number of economic, health, and social reasons. Many couples feel an abortion is preferable to the economic stress of an additional child, particularly an additional girl (resulting in sex-selective abortion). Some women feel a pregnancy followed a birth too quickly, and want to give their body a chance to recover. Extra-marital pregnancies can have dire social consequences for women, and are often aborted. Married women with older children, or whose husbands are alcoholics or have deserted them, also may have abortions when faced with an unwanted pregnancy.

Abortion: a process

Villagers tend to turn to other villagers for reproductive health services such as assistance with childbirth, irregular menstruation, and induced and spontaneous abortion. Abortion services at the village level are more familiar and accessible, less expensive, available at a low cost or on credit, and can be more discreet than abortion services at higher-level facilities. For these reasons, abortion services are often sought first at the village level even though most informants are aware that higher-level care is safer. Because village-level procedures can be ineffective or result in complications, village-level care is generally the first step in a chain of care providers.

Inducing abortion and seeking care for complications of spontaneous or induced abortion can be more of a process of visits to multiple providers than a single visit to a provider who gives the necessary and appropriate services. Resorting to less effective but more accessible methods delays women from seeking appropriate abortion care, increasing the gestational age of the fetus and the likelihood of complications.

Abortion methods

When seeking abortion many informants – from both areas – report first attempting to induce abortion using non-invasive techniques that are accessible at home or in the village. Home remedies include consuming “heat producing” solutions such as vinegar, *harira* (mixture of dried fruit), or tea made with *jaggery* (coarse brown sugar made with sugarcane). When home remedies do not work, the trend is to seek inexpensive non-invasive “medical” methods available from village

stores or invasive procedures. Such methods include: Anandkar tablets, bovine oxytocin, and others listed in Appendix 4. Invasive techniques provided at the village level include *batti* (a medicated material in the shape of a stick or wick that acts as a laminaria tent), dilation and curettage (D&C), and other techniques listed in Appendix 4. Table 8 shows the abortion methods used by various village-level providers at the Kasganj sites.

Methods found at the village level at the Allahabad site were more limited, including D&C, sticks, dyes, Foley's catheter, and intra-amniotic injections of saline and other chemical irritants. When village-level methods do not work, or lead to complications, women generally seek care from a provider outside their village. Referral-level providers at both sites used D&C, sometimes after electric vacuum aspiration, to induce abortions.

Table 8. Method of induced abortion by provider, Kasganj site (as reported by informants)

Provider	Method
Dai	Drinkable concoctions of Kadha and Harira; medicated douche; injections, including bovine oxytocin; IUD insertion; vaginal insertions; D&C
Medical shopkeeper	Tablets; provision of batti for insertion at home; oral contraceptive pills
Village RMP (male)	Injections; capsules
Nurse	D&C; medicine
BAMS (female)	Inserts fetex paste and V. Cradil (both are chemical irritants that serve as abortifacients) in uterus; medicines, injections; D&C
MBBS	D&C; electric vacuum aspiration; injections

The abortion methods used by village-level providers depend largely upon the sex of the provider. Females are much more likely than male providers to use invasive techniques. For invasive abortion procedures women prefer female providers. As a result, the untrained wives of male MBBS doctors often perform D&C at private nursing homes. Male providers tend to provide non-invasive abortifacients such as ergometrine derivatives, antimalarials, oxytocics, and ayurvedic preparations. The methods, both invasive and non-invasive, used by the village-level providers can cause complications that necessitate higher-level care.

The informants and focus group participants in general seem to be aware that abortions using "instruments" (D&C) from a doctor are safer than the care available in the village. However, the relative difficulty of accessing higher-level care encourages a first attempt to induce abortion using methods obtainable from village-level providers.

Abortion providers

Providers who serve women for abortions and abortion complications range from traditionally trained to those trained in formal and informal apprenticeships to formal training in medical schools. Providers who work at the village level include *dais* with no training; *dais* with some government training in safe delivery; registered medical practitioners (RMP); bachelors of ayurvedic medicine (BAMS); Indian systems of medicine practitioners (ISMP); medical shopkeepers, and others. MBBS doctors tend to work in towns or cities, and not in rural villages.

The services offered by the village-level providers vary, based more on the risks the provider is willing to take than on the provider's level of training. Many providers explained to interviewers that their services are in demand, and though the abortion services they offer tend to be dangerous, the pregnant woman would be better off aborting the pregnancy than keeping it. The desperation of the clients justifies, to many community-level providers, the provision of illegal and unsafe abortion services. Many unregistered providers were reluctant to divulge information about the abortion services they provide.

The broader range of non-physician providers, including *dais*, who are not formally trained to conduct the types of services they provide, voiced skepticism regarding the value of formal training and stated that they could provide good care without such training. This point of view presents challenges for encouraging referral from the village to more highly trained health care providers.

Dais working at the village level may present the greatest danger to women seeking abortion as they generally use invasive techniques and have little respect for or knowledge of women's reproductive anatomy, or infection prevention protocol. The *dais* who conduct abortions provide abortions from one and a half months gestation. Some reported conducting abortions up to seven months gestation. Regarding infection prevention protocol, one *dai* asked an interviewer why she should wash her hands prior to inducing abortion. She perceives that it is through conducting the procedure that her hands become unclean by becoming exposed to *gandagi* (dirt - the term used to refer to blood and fetal tissue that is evacuated during an abortion).

Women and decision-makers generally associate care from providers in town with safer care. Most providers who work in relatively urban areas tend to use D&C to induce abortion. Many of these providers learned the procedure in informal apprenticeships, are self-taught, and not qualified to perform abortion services. MBBS doctors who are trained and qualified, if not registered, to conduct abortion procedures have practices in the relatively urban areas of Kasganj and Allahabad City.

Legal status of abortion not an influential factor

Among community members, there is widespread lack of knowledge regarding the legal status of abortion. When discussing the acceptability of abortion, instead of using legal terms, informants used terms of social and cultural stigma. No informant said that a woman should not have an abortion because abortion is illegal, but most informants expressed the opinion that inducing abortion is "not right:"

> INT: What do you think? Is *bachche girvana* (induced abortion) socially acceptable?
>
> KI: *Bachche girvana* is wrong.
>
> INT: What effect does this have on society?
>
> KI: They consider it murder.
>
> INT: You follow the Hindu religion. How is *bachche girvana* considered in your religion?
>
> KI: It is considered wrong. Even I personally consider it wrong.
>
> INT: Why is it considered wrong?
>
> KI: Because it is considered murder.
>
> INT: Then why did you get it done?
>
> KI: I got it done because my other child was small.
>
> – *25 year-old, married Hindu woman, 9th Standard pass, six living children*

As the above quote demonstrates, there are times when abortion is considered the best option. This can be the case even when the informant knows of the potential grave complications of inducing abortion.

Making the decision to seek abortion

The decision to induce abortion is generally made in consultation with husbands and sometimes with his family, particularly the mother-in-law. In some cases, the decision is made by the woman herself, with support from a neighbor or from her natal family. In the relatively urbanized villages outside of Allahabad, women have more power as decision-makers regarding their health-seeking behavior than in the relatively rural villages outside of Kasganj. Some of these women reported making the decision to induce abortion without consulting their husband.

Factors influencing the decision of where to seek services include: cost (cost of service, cost of transport, credit availability), familiarity

with and trust of the provider, and geographical accessibility of providers. Home remedies and village-level abortion services are relatively inexpensive, and travel costs are negligible. For these reasons, women often turn to home remedies and village-level providers even when they know qualified providers in town are safer and more effective.

Again, the legality of services is not a strong consideration, but the social stigma associated with aborting a pregnancy is. As a result, keeping the abortion event undisclosed is important, but generally less so than keeping the event low cost. The exception is the case of unmarried adolescents, for whom confidentiality of services is of utmost importance.

Availability of services influences decision-making. The Allahabad population has more access to nursing homes and providers of D&C than does the Kasganj population, and seems more able and likely to access safer care in a timely manner than does the Kasganj population. Kasganj-area women seem more likely to seek care from untrained female village-level providers such as *dais* and ANMs. Women from both communities prefer female providers – particularly for invasive procedures. A preference for private over public providers was also noticed in both communities. Private providers (including informally trained) are more prevalent, thus more accessible, and are viewed as offering more caring services.

Abortion issues relevant to adolescents

The perceptions and experiences that adolescents have with regard to providers influence the type of provider they seek care from. In a focus group discussion with unmarried adolescent girls, one participant describes the power she perceives an abortion provider would wield over an unmarried abortion patient. Using the abusive term *harami* to refer to the doctor, she claims:

> FGP: He will make her life a hell. There is the possibility of his blackmailing her.

Unmarried adolescents expect providers to have a scolding attitude toward abortion seekers. This expectation most likely acts as an additional barrier to care seeking among this group.

Confidentiality is considered an important concern for adolescents seeking abortion services. Unmarried adolescents are under considerable social pressure to keep an abortion event secret. A participant in a focus group discussion of married men gave this perspective:

> FGP: Both (the boy and the girl) are blamed. Sometimes society even kills the boy as well as the girl. Sometimes

the boy quietly gets some medicines to give to the girl and if needed the boy will accompany the girl to get her uterus cleaned.

This perception suggests anticipated violence as justification for the fears adolescents associate with terminating an extramarital pregnancy, and emphasizes the need for secrecy associated with adolescent termination of pregnancy.

The village-level providers, particularly the *dais*, have a reputation for turning away unmarried adolescents – seemingly because such providers do not want to become involved in a scandal. The more controversial cases – extra-marital pregnancies in general – tend to seek services outside the village.

Key findings on abortion in rural Uttar Pradesh

- The most common reasons cited for terminating a pregnancy were that the desired family size had been reached or that the pregnancy occurred too soon after a previous birth
- A range of illegal and unqualified providers offer various unsafe techniques of inducing abortion
- Safe abortion services are not available in rural villages
- Villagers are generally unaware of the legal status of abortion
- Women turn to home remedies and village providers even when they know safer abortion services are available in town
- Inducing abortion is often a process, starting with less effective and continuing with more effective (and often more dangerous) methods
- Husbands and mothers-in-law may contribute to making the decision to abort a pregnancy
- Having to seek permission from a decision-maker can delay the abortion
- Relatively urban areas have more access to safe abortion services
- Private providers are preferred to public, as they are seen to offer more caring services
- Adolescents express fear of abortion providers and stress the need for confidentiality of services

Postabortion complications

A wide range of abortion complications was reported by informants in this study. The implications of complications varied largely based on socioeconomic status and age. Women from lower economic strata appear to suffer more from both acute and chronic postabortion complications. This appears to be a result of a number of factors, including that those women were likely to: delay seeking abortion and postabortion care; receive inappropriate care; and have less resilience as a result of chronic malnutrition, particularly chronic anemia. The complications that adolescents face are both physical and social.

Range of abortion complications

The complications of abortion reported ranged from mild to fatal. All of the Kasganj key informants and over one-third of the Allahabad key informants reported postabortion complications. Reported complications included persistent bleeding (moderate to heavy) for two to four weeks after the procedure, low backache, abdominal pain, fever, fatigue and weakness, and fainting spells. Some, but not all, informants mentioned death as a possible result. Some women tended to ascribe other symptoms of reproductive morbidity (which are not considered to be postabortion complications), such as uterine prolapse and menstrual irregularities, to the abortion procedure.

In general, informants were aware that inducing abortion at later stages of gestation is more likely to result in complications and that abortion procedures conducted in referral hospitals and nursing homes were infrequently associated with complications. Almost all women who reported complications sought treatment – either from providers located in the village or from referral-level providers.

Providers reported seeing a range of complications – from mild to life-threatening. Referral-level providers reported treating potentially life-threatening complications such as uterine perforation, intestinal gangrene, and vaginal fistula. None of the *dais* interviewed reported ever coming across any complications after inducing abortion.

Referral-level providers were more cognizant of signs and symptoms of postabortion complications than were community-level providers, suggesting that they are more able to identify and treat such complications promptly and correctly. Both referral-level providers and ISMPs reported that the severity and type of complications were associated with the training of the abortion provider and the abortion method used.

All referral-level providers interviewed narrated experiences of women presenting with postabortion complications and requiring intensive care with surgical procedures. In all such instances the abortion had been induced by an untrained provider (*dai*, "nurse," or village doctor)

through uterine penetration with a curette.

PI: I get cases of incomplete abortion, septic abortion, perforation (uterine), and peritonitis. I also get cases of infertility and pelvic inflammation.

INT: How do these patients explain their problems to you?

PI: They complain of weakness, bleeding, and abdominal pain. They also complain of distention of the abdomen and absolute constipation with a high fever. Patients are also brought to me unconscious in septicemia.

– *35 year-old, female MBBS (D.G.O) doctor, running a private nursing home*

Another MBBS interviewed reports seeing serious complications:

INT: Dr. PI, in your practice, what postabortion complications do you come across?

PI: As for immediate complications, there are cases of uterine perforation with intestines hanging out, septic abortions with septic shock and peritonitis, and others. In later stages, there are complications of infertility in 70 to 80 percent of cases. Pelvic inflammation is very common. Four years back, a lady came to me. She was one and a half months pregnant and her husband had tried to induce abortion with a knitting needle. She had perforations in her uterus as well as the fornices (vaginal vault) and her intestines were also punctured in many places. With great difficulty, I was able to save her. I just cannot forget her. Just imagine how much pain she must have gone through!

– *32 year-old, female MBBS/MS doctor, working in a private nursing home*

Severe bleeding resulting from ingestion of medicines can result from abortions from home remedies and most if not all types of abortion from village-level providers. Complications associated with perforation generally result from abortions conducted by female providers at the village level, as male providers are restricted by cultural barriers from performing invasive procedures on women.

In the Allahabad study sites, all village-level providers were aware of the life-threatening consequences of infection after an induced abortion. In Kasganj, the community-level care providers had less awareness of the severe consequences that complications of abortion could represent.

Implications of complications

Abortion complications result in lost labor, financial cost, chronic morbidity, and death. Abortion complications restrict women from doing their routine chores and participating in household or agricultural duties. In most households the inability to contribute to work causes women mental anguish. These two examples show the ways in which the burden of their work is borne by children, husbands, and other family members.

> After I had my *safai* (uterine evacuation) done, I had excessive bleeding for one and a half months. I lay in bed and could not work. My husband and children did the kitchen work. I could not get up from bed.
>
> – *25 year-old, married Hindu woman, non-literate, two living children*

> INT: So what was the effect of all this (complications and treatment) on your children and your household?
>
> KI: I had no sensation in my body and was unable to get up.
>
> INT: Then who looked after your children?
>
> KI: My mother-in-law and sister-in-law looked after the children.
>
> INT: What effect did this have on your husband's work?
>
> KI: My poor husband was also troubled and had to take leave from his work as a laborer.
>
> – *25 year-old, married Hindu woman, non-literate, six living children*

Abortion complications necessitate expenditure that most poor families were unable to meet and have deleterious consequences on the economic well-being of families as well as on women's reproductive health. An example is offered by this 30 year-old Muslim housewife, educated up to middle school with six daughters, who has had one induced abortion and one spontaneous abortion. After a second-trimester induced abortion performed by an untrained provider in a town nearby, she had persistent bleeding and fever for one and a half months. The cost of the abortion and attendant complications amounted to 4,000 rupees and necessitated travel to four towns in the vicinity for treatment.

> I spent 4,000 rupees and my body had to pay. I didn't get good treatment anywhere. I underwent various treatments for three to four months but none of them helped. I went to Rampur, Bhirpur, and Karchana, but

> didn't recover fully. Then I went to Dr. J in Allahabad and I got better. He gave me medicines worth 400 rupees.

During this period her young daughters took on the household work and care of the cattle and poultry. The family had to sell several of its possessions to pay for the treatment of postabortion complications. The informant's peers view her as useless if she cannot bear more children:

> I have suffered a lot. My family members taunted me by saying, "let her suffer for what she has done." In the village they said: "She is unable to reproduce, now she is useless." So I deliberately stopped taking family planning medicine. If a son is born, I will get an operation done. This time when I conceive, I will get an ultrasound done and know. If it is a boy, then I will give birth to it, or I will get a *safai* done if it is a girl.
>
> – *30 year-old, married Muslim woman, middle school education, six living children*

Women who were able to date the complications generally claimed that they arose within the first two days after the procedure. While most complications were resolved (with treatment) within two to four weeks, some persisted beyond four weeks. This informant had complications following an abortion induced by the untrained wife of an allopathic doctor:

> After the *safai*, I bled for 15 days. After that bleeding stopped, but started again after a week. Now I have continuous bloody discharge, little by little. I also have pain in my lower abdomen.
>
> – *40 year-old, married Hindu woman, non-literate, nine living children*

While there are clear linkages between induced abortions conducted by untrained providers and the severity of complications, postabortion complications were also experienced by some women who went to referral-level providers.

> After a *safai*, done by the doctor at the Community Health Center, I had a fever. I went back to the doctor and she said that she had made a mistake and she did the *safai* again. Four or five months have passed, but I still have lower abdominal pain. I am now taking pain killers from the medicine shop."
>
> – *36 year-old, married Hindu woman, non-literate, three living children*

Adolescent perceptions of abortion complications

The complications that adolescents perceive are often different from those married women perceive. Complications such as social stigmatization and sterility have different implications for young unmarried women than married women with children.

Abortion among unmarried adolescents is not unfamiliar to those living in rural villages. As possible complications of abortion, adolescent focus group participants mentioned sterility, difficulty finding a husband, and disapproval from a future husband in addition to stomach pain, vomiting, and dizziness, weakness, fever, and infection.

This married informant suggests that premarital pregnancy can drive unmarried girls to commit suicide.

> KI: There are many girls who commit suicide because of the fear of getting a bad reputation (from having an extramarital pregnancy). Then they get it from the shop.
>
> INT: What do they get from the shop?
>
> KI: Tablets.
>
> INT: Which tablets?
>
> KI: They get these *sulfa* (insecticide) tablets from the market, eat them, and die.
>
> – *36 year-old married, Hindu woman, non-literate, three living children*

As the adolescent girls pointed out in focus group discussions, complications are not only physical, but also social. This case illustrates the severe consequences of an unmarried adolescent having an abortion. An MBBS gives the history:

> PI: A few months back, an unmarried girl was brought to me in a tractor trolley by ten or 15 people from a nearby village. She was one and a half months pregnant, and a *dai* had induced an abortion in one of her relatives' homes. About four days after the abortion, she suffered from abdominal pain with a high fever and distention of the abdomen. On examining her and taking her history, I found out that she suffered from peritonitis due to uterine perforation. As her condition was serious and she needed an immediate operation, I spoke to her mother about it. The mother spoke to the father and the relatives who got infuriated as they had not known about the abortion. They refused any treatment and just left the girl to her fate on the streets and went away. Later

on, I found out about it and after contacting some other doctors, I sent her to the government hospital. There, the doctors started her treatment and she was operated upon and thus saved. After her recovery about 15 days later, she started doing odd jobs in the very same hospital until she was married recently to someone there.

– *32 year-old, female MBBS/MS doctor, working in a private nursing home*

Key findings on postabortion complications

- Informants (from all data collection methods) are aware of and some had experienced a range of abortion complications – from mild to severe
- Informants report seeking care from local providers
- Spontaneous abortions are reason to seek care
- Costs (direct and indirect) of caring for postabortion complications are difficult for many villagers to afford
- Referral-level providers treat particularly severe complications
- Village-level providers generally deny seeing patients with abortion complications
- Social stigmatization and sterility as repercussions of abortion were of particular concern to adolescents

Postabortion care in rural Uttar Pradesh villages

Emergency care: a process of delays

Women may delay seeking care for abortion complications for several reasons – they may not recognize the need for care, they may not communicate their need for care with a decision-maker, and a decision-maker may not realize the urgency of seeking care.

When women do seek care, they tend to first seek it at the village level. This level of care is convenient, but tends to be inappropriate – and can exacerbate the complication. In addition, the care provided at the village level delays the woman and decision-makers from seeking appropriate higher-level care. The lack of a referral system also contributes to delays in seeking appropriate care. The delays can result in the complication worsening and subsequent chronic morbidity or death.

Village-level care appears initially to have the advantages of being relatively affordable, accessible, and discreet. In the end, however, after seeking care from multiple providers and delaying appropriate care and thereby exacerbating the complication, seeking local care first can cause the entire process of managing a complication to be more expensive and less discreet.

a. Delays in seeking care for abortion complications

All informants interviewed said that postabortion complications need care. However, there is a varied degree of awareness of the need for immediate attention for specific types of complications of abortion.

Just as perceived causes of abortion range from spiritual to lifting heavy objects to eating warm foods to inducing abortion by various means, and complications range from weakness to death, the means of managing the complications vary, primarily with the perceived cause of the abortion, the perceived severity of the complication, available financial resources, and the degree of concern of the decision-maker.

Women's lack of decision-making power, lack of access to economic resources, and hesitation to discuss reproductive health issues with decision-makers causes delays in seeking care.

– Deciding to seek care

Several factors were found to contribute to delayed decisions in seeking care: the difficulty for men and women to discuss health, men's decision-making power, women's reluctance to seek assistance from men until they feel severely compromised by the complication, and finally, a lack of understanding of the differences between minor and severe complications.

Wives may delay informing their husbands about a complication and thus delay the care seeking process. Women with complications often hesitate to confront husbands about problems until the complication becomes serious:

INT: To whom will a woman speak in case of abortion complications?

KI: She will speak to her husband and he will do what needs to be done.

INT In case of these problems, when will a woman seek treatment?

KI: At the point when it becomes impossible for her to move around she'll speak about it to her husband.

– *35 year-old, married Hindu woman, non-literate, six living children*

Many barriers to seeking appropriate higher-level care were identified in the study areas, including lack of husband's or other decision-maker's support, limited financial resources, and lack of transport. Local care providers can delay or assist women in seeking higher-level care. These two informants tell of some of the barriers to appropriate care:

INT: What are barriers a woman faces in accessing good treatment?

KI: She will not get good treatment if there is a lack of money or if the husband does not take her, or if there are no provisions in the village. The reality is that the woman has no say in front of the man.

– *35 year-old, married Hindu woman, non-literate, five living children*

INT: What can cause delays in seeking treatment?

KI: When the husband is away from the house working in the fields, when transport is not available, and mainly when a woman has no money with her, treatment can be delayed.

– *25 year-old, married Hindu woman, non-literate, four living children*

In their position of decision-maker, husbands may show little concern for their wife's situation and serve as a barrier to any care, much less appropriate care:

INT: After your child fell down (your spontaneous abortion) and you bled profusely, what help did you get from your husband?

KI: (She kept wiping away tears and the interviewer tried to console her) He did nothing. Why would he be troubled? Am I not there to do all the agricultural work? When I ask for *davai* (medicine), or *goli* (tablets) he only says, "I have no money." He doesn't worry about me at all. Sometimes he spends the whole night out and doesn't come home. Sister, I am really miserable. Sometimes there is no food in the house to eat.

– *34 year-old, married Hindu woman, non-literate, seven living children*

The following example illustrates the informant's perception that chronic morbidity is not a priority with decision-makers:

> I have continuous pain in my lower back and abdomen. I am not able to do household work. Family members say: you are absolutely fine. My husband also gets irritated when I ask for money. Nobody takes me for treatment.

– *26 year-old, married Hindu woman, non-literate, two living children*

Mothers-in-law also make decisions regarding reproductive health care. The woman's natal family members may take over if they decide that care by the husband's family is inadequate.

Several factors influenced women's decisions to seek care for postabortion complications. Key decision-makers in seeking care were the husband, mother-in-law, and less often, the woman herself. The severity of symptoms appeared to influence the decision to seek care. More dramatic postabortion complications, such as excessive bleeding accompanied by fainting, often spurred families to borrow money for emergency treatment.

– **Choosing a provider**

The process of seeking care for an abortion complication shares characteristics with seeking an abortion. There is a tendency to first seek care from relatively accessible, affordable, familiar, and discreet providers. As the complication worsens, women tend to seek higher-level care. The general trend observed was for women to first turn to home remedies; second seek care from a village-level provider; and third, or when symptoms are perceived as life-threatening, seek care from a referral-level provider. Despite the tacit understanding that treatment from referral-level providers is safer and more effective than treatment from local providers, women often do not seek care beyond the nearby villages. Conditions often dictate that care is first sought at the village level. Many factors go into the decision of who to seek care from, including the perceived severity of complications and the degree of concern exhibited by the decision-maker (as discussed above). Women prefer to seek care from a female rather than a male provider. Furthermore, familiarity with provider, perceived provider courtesy, perceived cost of treatment, cost of accessing treatment, distance of the provider from the patient, and the time of day care is sought influence the decision of which provider to seek care from. Also, for complications of induced abortion there is a tendency to seek care from the same provider who caused the complication. While quality of medical care is a consideration, and most people know where high-quality allopathic care is offered, in all but the most severe cases it is a luxury perceived as not worth the cost.

The sex of the provider is an important issue to the person seeking care. Typically the husband will seek medicines from a local male provider or the wife will seek care from a local female provider. When the complication continues, the

husband and wife will go together to seek care at a higher level. Women feel strongly that they should seek care from female providers. Whereas female providers can conduct internal exams on female patients, there is a strong preference for male providers to conduct superficial examinations only.

Familiarity with the provider weighs heavily in the decision of choosing a care provider. The following is an example of a woman with a complication returning to the provider who initially conducted the abortion:

KI: They took me to the *dactarni* because everyone said since the lady doctor had spoiled the case she should take the responsibility.

– *30 year-old, married Hindu woman, non-literate, seven living children*

Women have faith in local *dais* who have taken care of family members in the past. This informant gives the example of using the services of a close provider even though the services are known to be unsafe: The informant's sister-in-law became pregnant and wanted to abort because her son and daughter were grown and of marriageable age. She had a *safai* done in her house with D&C instruments from a village-level provider (Dr. S). During the *safai*, the woman was injured and an infection developed. She took treatment from the local village shop, but did not improve. The local "doctors" advised that she be taken to Kasganj or Agra for care. In transit she died – three days after the *safai*.
After this complication and death, village women still seek care from Dr. S. because she is perceived as intelligent, and her services are provided in the village

INT: Do the village folk have full faith in her (Dr.S.)?

KI: They have a lot of faith in her. Only my sister-in-law's case got spoiled.

INT: Does anyone else provide such services in the village?

KI: Oh yes, we have a government clinic nearby.

INT: So what was the reason you went to see Dr. S. for treatment?

KI: She is intelligent.

INT: But there is a government clinic in the village.

KI: In a hurry the closest help available is called upon. If the husband has a business he does not have time to go far.

– *21 year-old, married Hindu woman, non-literate, two living children*

Other informants reported that women prefer to seek care from the provider who conducted the abortion because they perceive that that provider would have a good idea of how the complication was caused, and that provider would be less likely to scold the client for having had an abortion.

Provider courtesy is an important consideration. Local *dais* who have good reputations in the village, treat clients kindly, and make home visits are easily more popular than the government providers who are difficult to access, and reputed to scold patients for having unwanted pregnancies and unsafe abortions.

This informant reports that staff at the government hospital were disrespectful. When the informant felt pain after having an abortion, she returned to the provider who had initially conducted the abortion. This provider refused to admit the pain was evidence of a complication. The informant then sought care at the government hospital, where she was treated poorly:

KI: There is no consideration for a sense of shame over there. The nurses just lifted off my clothes and opened my sari and put it aside. I was left only in my blouse. They put a sheet on me and made me lay down on a table. They placed a bucket underneath me and made me lift up my legs and tied them.

INT: They tied your legs?

KI: Yes, they tied my legs (said sadly).

INT: Were you conscious at the time?

KI: I was in my senses. They tied my legs and gave me IV fluids. There was neither a fan nor a cooler. I was dying from the heat. I thought, "there's no question of surviving. My poor children will be on the street. Great harm has been done to me!" (The interviewer had her hand on the informant's back, comforting her). A number of ladies kept coming and getting their *safai* done before my eyes and going away.

INT: Did they do the *safai* in the same room in front of you?

KI: Yes, just in front of me, three to four women had their *safai* done, in the very same room.

INT: Did they get any *nasha* (anesthesia)?

KI: No! Some were in their second month of pregnancy. I wasn't deaf. I could hear everything but I couldn't speak.

When I called out someone shouted at me and slapped me on the cheek. But when the *safai* was done I was not fully conscious.

INT: How did they do your *safai*?

KI: They put some instruments inside.

INT: Could you feel the instruments?

KI: As they were putting in the instruments I had pain in my stomach. My hands were tied to the table. Two of them were holding my thighs tight and one was pressing down on my chest. One was doing the *safai*. And yet another gave me a slap as I had no control of my legs and they were coming together. I was not in my senses after that. The *dactarni* told my uncle to take me to Agra or Aligarh as there were no chances of my survival.

– *30 year-old, married Hindu woman, non-literate, seven living children*

The informant received emergency care from another hospital in Kasganj and recovered.

Cost is a major factor in the decision of where to seek care, particularly when substantial amounts have been already been spent on the abortion procedure. The cost of treatment not only includes the actual charges for treatment and medication but also the costs of transport, food and lodging for accompanying family members, and lost economic activity.

This informant lists financial constraints, lack of transport, and shame as reasons why women delay seeking care:

INT: What can prevent a woman from going for treatment?

KI: She may not go out of shame. Shortage of money or the unavailability of transport can prevent her from going for treatment. In a case of severe bleeding she might not go out of the house to call anyone to help her.

– *26 year-old, married Hindu woman, non-literate, four living children*

Often the anticipated cost of treatment deters women and decision-makers from seeking care for complications.

I continue to have bleeding after the *safai* (done by untrained female provider). I went to Dr. R (Untrained Provider near the informant's house) and he said that the *safai* was not done properly, so it will have to be done again. Now I don't have money. I don't understand

where my husband will get the money for another *safai*.

– *Married, non-literate Hindu woman, nine living children*

When seeking a provider, affordability of services is an important criteria:

KI: There is a lot of poverty in the village. Therefore women choose a person who is less expensive.

– *25 year-old, married Hindu woman, 12th Standard pass, one living child*

The longer a woman has a complication, the longer her corresponding absence from important household economic activities. However, avoiding lost labor does not seem to be among the initial considerations for decision-makers when choosing a provider.

Geographical proximity also influences the choice of which provider treatment is sought from. If the provider who conducted the abortion was in close proximity to the woman's residence, the woman may return to the same provider for treatment for a complication. If the provider was located in an area that was difficult to reach and had already charged a large sum for the abortion procedure, women are likely to turn to community-level providers.

Confidentiality is important to some women, particularly unmarried women, but less important to informants such as this one:

INT: You went to the village *dai* (for induced abortion). Are you sure she won't tell anyone?

KI: She will tell people – to spread her name around, and to gain popularity because she has to earn money.

– *35 year-old, married Hindu woman, non-literate, five living children*

Household-level decision-makers at the study sites were generally ignorant about: legality of services; importance of infection prevention protocol; and the potential for serious complications from an abortion provided by a *dai* or other village-level provider. As such, those factors rarely enter into the equation of provider choice.

b. Managing complications at the village level

In its current state, the management of postabortion complications at the village level generally contributes to the complications and does not provide relief. When women seek

care at the village level, they tend to receive inappropriate care – which can exacerbate the complication. In addition, the care provided at the village level delays the woman and decision-maker from seeking appropriate higher-level care. Again, these delays can result in the complication worsening and subsequent chronic morbidity or death.

– **Inappropriate village-level emergency care**
  The types of providers who offer care for postabortion complications are generally the same as those who provide abortion services. Rural providers are often not trained to accurately diagnose and provide care for abortion complications. As a result, some providers do not recognize the need for emergency care and offer inappropriate treatment that intensifies complications and delays appropriate care (See Table 9).

Table 9. Treatment for complications associated with induced abortion (as reported by non-provider informants)

Provider	Type of Treatment
Mother-in-law	Tablets; teas
Bhagat ji (holy man)	Talismans
Dai	Hot tea with jaggery; tablets; tonic; injections; cotton swab soaked in ghee for vaginal insertion; enema; IV fluids and antibiotics (Taxim); douche; manual removal of retained fetus; D&C;
"doctor" (not formally trained)	Good diet; tablets; tonics; D&C; leaves
Ayurvedic	Powder; tablets
Village RMP	Analgesics; antibiotics; ergot tablets; oxytocin injections; IV fluids; injections; tablets; tonics; powder
MBBS	Iron tablets; tablets with milk; capsules; D&C; medicine; laparotomy; tonics

Dais are among the first level of care providers that rural women turn to in the case of a complication. For this reason it is particularly important that *dais* know how to recognize complications. This *dai*, who has had a six-month government training course, recognizes symptoms of severe complications, but would benefit from training to recognize complications before they get too severe, and to make timely referrals to appropriate higher-level care:

INT: Please tell me, how do you determine if a problem which a female has is caused by the complications of an abortion?

PI: I first of all ask the patient and then put my hands on her stomach. If all of the *pindi* (fetal tissue) has not come out then there will be swelling of the abdomen. If all the placenta has not come out then there will be a lot of foul discharge. If wounds have occurred inside and pus has formed then the woman will complain of pain. She will also complain that she is having burning sensation at the mouth of the urethra. She will also have a high fever along with chills.

– *40 year-old, female dai, six months government training*

Social restrictions based on the sex of the provider limit the means available for male village-level providers to diagnose a complication. This male village-level provider is a registered medical provider with a bachelor's degree in pharmacy. He identifies postabortion complications as explained below.

INT: How do you determine whether a woman has complications arising from abortion?

PI: (Postabortion complications are indicated) if there is excessive bleeding, relentless pain like labor pain, if the pain increases after you give the woman painkillers, some women vomit heavily. These symptoms come to the forefront between the third and fourth months. Such cases cannot be controlled. In the end, only getting *safai* done is appropriate to save the life of the pregnant woman.

– *Male RMP working in the village since 1987*

Emergency treatment techniques vary by training and sex of the provider. Male providers are severely limited in the extent to which they can examine and treat female patients. Many ISMP and untrained village-level providers treated complications with antibiotics, analgesics, and styptics. Some ISMP providers initiated IV fluids. While both ISMP practitioners and untrained providers were able to discuss the signs and symptoms of postabortion complications, the former showed a better understanding of the nature of the complications and the treatment that each warranted necessary for emergency versus non-emergency situations.

While male village-level providers recognize the difficulty of diagnosing women with reproductive tract complications, many continue to provide care for symptoms that could indicate severe complications. This male provider, a BAMS who has been working in the village for 30 years, is unable to conduct an internal exam. The treatment he gives for complications delays the woman from seeking appropriate care:

PI: An abortion will easily cost a minimum of Rs. 200. If a woman is suffering from excessive bleeding, I will give her an IV solution of glucose, 10% dextrose, and haemaccel. After that a woman improves and begins to talk.

INT: What else do you do?

PI: I give other medicines as well, for instance, clauden injections. After 3 to 4 hours, I give butrophase injections or premarin injections. I also give two Cadisper C tablets and gyne C.V.P capsules once a day for five days. I always give methargin injections whenever there is excessive bleeding. This helps to stop the bleeding.

– *40 year-old. male BAMS practitioner, working in private practice*

As a result of male providers' socially proscribed inability to properly diagnose and treat patients, the treatment provided delays appropriate care and allows the complication to worsen. A patient who had severe repercussions from delaying appropriate care is described below. A referral-level provider describes the treatment provided to the patient who had been given antibiotics and painkillers for septicemia:

> A patient came to me in septicemia, which meant she had severe infection. She was running a very high temperature, and had entered a state of shock. She underwent MTP about 15 days before. She kept taking antibiotics and analgesics. Then she came to me. We gave steroids and a blood transfusion. She was here for 5 or 6 days and then she recovered.
>
> – *Female gynecologist, with private clinic (nursing home) near study site*

Among village-level providers there seems to be a belief that uterine evacuation is necessary treatment for certain obstetric complications. However, the readiness of *dais*, semi-trained nurses, wives of MBBS doctors, and other non-formally trained female providers to offer D&C or substitute care shows a lack of appreciation of the danger of abortion complications and the urgency of appropriate treatment for women with such complications.

This *dai* has had some government training as a birth attendant. She has provided care to women with complications of abortion for the past 30-35 years. Her

mother and daughter are also *dais*. Her techniques exacerbate the complications:

INT: Aunty, please tell me something about the problems that follow abortions.

PI: A woman can suffer from cold, and she can suffer from *baram*.

INT: What do you mean by *baram*?

PI: *Baram* means swelling. A woman can also get jaundice and fever. If the *safai* is done in the wrong place by the wrong people, some pieces (of fetal tissue) can be retained and as long as these pieces remain inside, the woman goes on bleeding and this can lead to anemia. In such cases, a woman needs a transfusion of glucose and if there is too much blood loss, she may even need a blood transfusion. In these circumstances a patient can get cured sometimes, or she can even die sometimes. The death wants some sort of excuse. There is no one greater than God. A woman can even die due to postabortion complications.

INT: Aunty, do you get these kinds of complicated cases?

PI: I do get them and I have attended to number of them. Women have come to me with heavy bleeding and uterine swelling. In these cases, I douche them.

INT: What do you mean by "douche"?

PI: I take some lukewarm water and mix some Dettol into it and push it inside the uterus and wash out the uterus. With this, the whole uterus is cleaned out. If some pieces are left inside, they come out with the douche. If the bleeding continues, I do the *safai* once again with the instruments."

– *55 year-old. female dai, 12th standard pass*

Another *dai* reports providing treatment to manage a complication. Again, her treatment would exacerbate the complication:

PI: If the bleeding is excessive then I send her to Kasganj. Only if I think that I can manage the case do I keep the patient. *Ander rui ke faye mein deshi ghee laga kar rakh detein hun* (I put a piece of cotton soaked in home made butter inside the vagina) and tell the woman to rest, with this relief is obtained. If there is no relief then I send the patients to Kasganj.

– *40 year-old. female dai, six months government training*

The providers at the village level are acknowledged by some to not be adequately qualified to treat abortion complications. From a focus group discussion with married men:

INT: Kindly tell me who the villagers tend to approach to get abortions done, or when they have complications of abortion?

FGP: They go mostly to private practitioners.

INT: Are these private practitioners qualified?

FGP: Most of them are not qualified, but the general population thinks they are. There is no MBBS doctor here. There's an ayurvedic practitioner. Some are BMS. Some are *jhola chhap* (literally, "bag brand," referring to an untrained practitioner who carries equipment door to door in a doctor's bag) who go door to door treating patients, and several others call themselves doctors after working with qualified doctors.

– *A married man*

The informants explained that a number of types of untrained providers offer emergency care in rural villages. The care provided can increase the severity of the abortion complication.

– **Absence of a referral system delays appropriate care-seeking**

Whereas village-level providers could be an important first point of contact in seeking appropriate postabortion care, many actually delay or prevent women from seeking appropriate care. Of those who do suggest women seek higher-level care, only a fraction refer women to specific facilities. Some referrals were appropriate – others were not. Inappropriate referrals could be to other village-level providers or to providers in towns who claim to be able to provide care for obstetric complications but who are not trained to provide such care. Many untrained *dais* and similar providers use D&C equipment and further jeopardize the health of their patient.

There is a tendency, and an incentive, for village-level providers to treat patients rather than to refer them. A referral to another provider would mean lost income for the provider and greater expense for the patient:

INT: So after the treatment what advice did the *dai* give to you?

KI: She advised me not to go to Birla Hospital Kasganj (the government hospital) because it would cost more money. She said she would treat me for only 50 rupees.

– *35 year-old, married Hindu woman, non-literate, five living children*

The following example illustrates a missed opportunity for a provider to refer the patient to higher-level care when he recognizes he cannot manage the complication. The decision-maker, the husband, does not seem to appreciate the seriousness of the complication and the urgency of seeking appropriate care, and the family does not have the resources to seek more appropriate care at a higher level.
The informant induced abortion by inserting a *batti* (mixture of perceived abortifacients rolled into a long thin matchstick shape and inserted into the vagina – purchased by her husband at the village medical store). After inserting the *batti*:

KI: Some sort of red water and a kind of foul-smelling sticky liquid like pus started oozing out. After that I had a high temperature and pain in the lower abdomen.

INT: Did you take treatment for it?

KI: My husband brought some doctor's medicine from Soron.

INT: How far is Soron from Fatehpur?

KI: About 2 kilometers.

INT: Sister, from which doctor did you take the *dava* (medicine)?

KI: Dr. S.P. These doctors provide medicines for fever and cold.

INT: How long did it take for your fever to subside?

KI: The fever used to rise sometimes and come down. My husband brought medicines for one or two days and then stopped. I didn't take any one treatment continuously. Sister, I was really in great trouble.

INT: Can you tell me how much was spent for your treatment?

KI: Maybe 100 – 150 rupees. I got medicine three or four times.

The medicine shopkeeper advised that the situation was beyond his control, and suggested that the patient see another provider. Funds limited the care the patient could seek:

KI: When the doctor provided medicines and the bleeding did not stop he told us it was beyond his control. He advised us to go and consult someone else.

INT: Where did you go after that?

KI: To N.

INT: Where does he live?

KI: He is in Soron. He is a *hakeem*. I have stopped bleeding but I still have great pain in my lower abdomen.

INT: When did you take his medicines?

KI: A month ago. Due to the shortage of money I did not get my *safai* done.

– *34 year-old, married Hindu woman, non-literate, seven living children*

Informants reported that some village-level providers would refer the patient to another care provider when the provider recognizes that the care required was beyond his or her ability. The data show that some *dais*, village doctors, and ISMPs do refer women to higher facilities.

This informant was given an appropriate referral for a spontaneous abortion. She was experiencing vaginal bleeding and went to a *dai:*

KI: The *bota* (blood clots) started coming out in small pieces. Then the *dai* told me that the baby could not remain in my stomach because all the blood in my body had been drained, and that I should go to the hospital and have D&C done to prevent further harm to myself.

– *24 year-old, married Hindu woman, Tenth Standard pass, three living children*

In this example a village "doctor" refers the woman to a higher-level facility:

INT: How did you come to know your baby was falling (you were spontaneously aborting)?

KI: I had severe pains in my back and stomach that made me cry out loud, along with bleeding. Then I went to the hospital when some would have gone to a *dai.*

INT: Did you also go to a *dai*?

KI: No, I didn't. I said that I would only take medicines from a "doctor" who had a shop. But this doctor

refused to see me, saying I should go to the Mission hospital in Bareilly, or go to Kasganj.

– *25 year-old, married Hindu woman, Ninth Standard pass, six living children*

This *dai*, who has had 6 months of government training, explains that she also refers women with severe complications to higher-level care:

INT: If *kisi aurat ka baccha gir raha ho* (If some woman's baby is aborting) then tell me about such a problem.

KI: (Thinks and answers) Sometimes *garmi se maila kattha hai* (foul vaginal discharge is due to *garmi*, warmth). *Agar jyada maila kattha hai* (if this discharge is excessive) then I send the patient to Kasganj. I don't keep such patients.

– *40 year-old, female dai, six months government hospital training*

Though the *dai* would refer a patient when she perceives complications are beyond her control, she reports that sometimes she would refer to other rural providers, and sometimes to hospitals in town. This suggests that though she knows higher-level care can be necessary, she perceives village-level care to be appropriate for some complications:

> Look *behenji* (sister), if the foul discharge is too much then I will tell them to go to either Dr. D or Dr. R., (village-level providers), Birla Hospital (the government hospital) or Mission Hospital, Kasganj. I don't keep such patients.
>
> – *40 year-old, female dai, six months government hospital training*

Appropriate care for most serious abortion complications is available in Kasganj town and Allahabad City. An MBBS who works at the government hospital and her own private clinic describes a complication she has treated recently. The patient had endangered her life by not recognizing the need for higher-level care and delaying seeking such care:

PI: Fifteen days back, a village woman came to me. She complained of abdominal pain and a fever for five days. I examined her and it appeared to me that she suffered from peritonitis. I asked her a number of times, but she did not tell me anything. When I checked her internally, the cotton swab was foul smelling. Then she told me that she had got the abortion done in the village through a *dai* six days before. She told me that she had had

abdominal pain and yellow discharge for two days. I found her toxic, she had peritonitis and hadn't passed stools for four days. Her bowel-sounds were absent. She was treated conservatively with IV fluids, high antibiotics, and two bottles of blood were transfused to her. She responded well to the treatment. She was discharged just five days ago.

– *35 year-old, female MBBS (DGO) doctor, running a private nursing home*

Referral-level providers such as this one refer women to higher-level facilities when they cannot provide the necessary care.

– **Village-level care increases total cost of care**

While village-level care may appear initially to have the advantages of being relatively affordable, accessible, and discreet, in the end, after seeking care from multiple providers and delaying appropriate care and thereby exacerbating the complication, seeking local care first can cause the entire process of managing a complication to be more expensive and less discreet.

Managing a complication at the village level often means seeking care from multiple providers. This increases the total cost of care, as this informant, who had complications following a spontaneous abortion, reports:

INT: How much did you pay your *dactarni* (from the government hospital)?

KI: She took 150 rupees for the *safai* of one and a half month's pregnancy, and gave me medicines worth 150 rupees.

INT: What? 150 rupees?

KI: I had spent a lot of money already, as I also went to Doctor M (the village doctor)

INT: Where did the money come from?

KI: I took a loan from one person, and borrowed 600 rupees from the village *pradhan* (head man). I took another loan from my mother. This is how I got my treatment done.

The woman described by this MBBS doctor had an abortion done by a *dai* who had six months training and worked in Kasganj for six years. The *dai* gave an enema to the patient and caused severe complications. The cost of care for complications was exorbitant:

PI: The woman's husband paid me the money. The woman was operated on in Delhi in Safdarjung Hospital and her uterus was taken out. Thus the woman was saved from death. The expenses over there came to about Rs. 40,000: Rs. 30,000 for the operation alone and Rs. 10,000 for other expenses. The woman's husband later told me that he had to sell some of his land and a buffalo in order to get that amount of money.

– *38 year-old, female BSc, B.Pharm, RMP, working in private practice*

c. Adolescent postabortion emergency care issues

Married women can more easily access postabortion emergency care than can adolescents. Because of very different socio-cultural situations, adolescents tend to have different priorities than married women in selecting a provider for care for complications of abortion. The stakes are much higher for unmarried adolescents, and the barriers are more difficult to surmount.

Confidentiality is a most important quality for unmarried adolescents seeking care for abortion complications. In a focus group discussion of unmarried adolescent girls, participants explain:

FGP: Deepali (a fictional unmarried adolescent girl who was raped and has an unwanted pregnancy) will do whatever she can do on her own to solve her problem. Probably she will go to a doctor, or she will speak to an ANM, or maybe she'll go to a chemist. She may even go to (the local) *dai* for help. If she has further problems she'll certainly go to a doctor out of sheer necessity.

– *An unmarried adolescent girl*

Embarrassment can result in unmarried adolescents delaying seeking care:

FGP: She might feel ashamed that her secret might become known to everyone and that the doctor might ask embarrassing questions. Thus she might not seek help.

– *An unmarried adolescent girl*

Unmarried adolescent girls feel they cannot go to village-level "doctors" because these "doctors" are all men:

FGP: There are many doctors here, but none to whom one can go because of embarrassment. There is no lady doctor here.

– *An unmarried adolescent girl*

Unmarried adolescent boys reported that they would help a girlfriend get care for an abortion complication if the situation arose. They suggested, like the married women, that if the girl suffers complications they would take her back to the initial provider rather than to another provider.

d. Summary

The most important barriers to appropriate care for abortion complications are the inavailability of appropriate care at the village level, and the lack of appreciation of the life-threatening duress that women can be under when experiencing abortion complications.

The conversations among community members about the management of abortion complications led to an understanding that many community members and village-level providers are not sufficiently aware of the signs of emergency obstetric complications. In part because the potential danger of complications are not fully recognized, the management of abortion complications is inefficient. Delays in seeking appropriate care can make complications of abortion worsen. Additional barriers that prevent women from accessing appropriate care include the availability of less expensive care at the village level and in town; cost of transport to appropriate care providers; and distance of appropriate care from a village residence.

e. Key findings on emergency postabortion care

- No formal referral system exists at the community level. However, an informal referral system does exist and can be improved upon. Village-level providers can be incorporated into a formalized chain of care providers who work to get women with obstetric complications to appropriate care efficiently
- Village-level management of abortion complications – as currently provided – can delay appropriate care, and thus contribute to the complication
- For women with abortion complications, care tends to be a process – starting at the most accessible and seeking higher levels of care as perceived as necessary
- Local care providers sometimes assist and sometimes delay women with complications to seek appropriate care
- Husbands, mothers-in-law, and neighbors may act as decision-makers in the process of seeking care

- Women hesitate to discuss women's reproductive health issues with men, which can result in care seeking delays
- Lack of knowledge on the part of women with complications and decision-makers about the urgency of seeking care when experiencing emergency obstetric complications leads to delays in seeking care
- Neither community members nor community-level providers are necessarily aware of the signs or implications of emergency abortion complications
- Issues determining which provider to seek care from include: cost of treatment, cost of accessing treatment, convenience of treatment, sex of provider, and familiarity with the provider
- Women prefer seeking care from a female provider
- When men seek care on a woman's behalf, they are more likely to seek care from a male provider
- Male providers at the village level do not give women physical exams
- Patients prefer providers who show respect to the patient
- Confidentiality of care is a particularly high priority for adolescents
- Embarrassment and fear causes adolescents to delay seeking care

Postabortion contraceptive counseling and services

Many providers (formal and informal) who induce abortion and care for postabortion complications are cognizant of the need for increased use of contraception, but do not perceive themselves as responsible for providing contraceptive services. Providers often do not have the knowledge or incentive to provide contraceptive counseling and thus do not inform the client of correct method use or potential side effects. In general, the more highly trained a provider, the better the contraceptive counseling provided. However, throughout the chain of care, postabortion contraceptive counseling and services need to be improved to reduce the risk of repeat unwanted pregnancy and unsafe induced abortion.

a. Postabortion contraceptive counseling and services: uncommon care

Postabortion contraceptive counseling, after the abortion procedure or after treatment for postabortion complications, was reported by only a few of the key informants who reported having

had an induced abortion. This is despite the fact that most of the key informants in the study had chosen to abort because the pregnancy was unwanted and the most common reasons cited for terminating the pregnancy were that the desired family size had been reached or that the pregnancy occurred too soon after a previous birth.

The women and men interviewed, even unmarried adolescents, demonstrated at least a superficial knowledge of the available modern contraceptive methods. However, with this knowledge, a host of negative myths and misperceptions coexist and need to be addressed with appropriate counseling. Married and unmarried men were able to list a number of modern contraceptive methods including oral pills, condoms, intra-uterine devices, "injectables" (reported by informants to be effective for up to three years), ayurvedic medicines, and other traditional practices.

– **Contraceptive awareness high, use low**
  The high levels of contraceptive awareness do not correspond with either intentions to use or actual use of contraceptive methods. Misperceptions of contraceptive methods are widespread, minimizing use, even among women who want no more children. Some women who had abortion complications expressed that they would rather have another abortion than use family planning. Additional barriers to contraceptive use included the low status and lack of autonomy of women of reproductive age within the household. A preference for sons dictated by family and society discourages contraceptive use. Relatively socially restricted women are less aware of contraceptive methods and less able to access contraceptive methods and services.

– **Postabortion contraceptive counseling and services inadequate**
  While some providers encourage contraceptive use, contraceptive counseling at the village level is inadequate. A provider who explains multiple methods and asks the client to choose a method is the exception rather than the rule. No provider was reported to give thorough contraceptive counseling that included issues such as counseling on a range of contraceptive options, return to fertility, contraceptive side effects, and contraceptive re-supply. The data collected emphasize that after an abortion complication, contraceptive counseling and services are particularly relevant to prevent future unwanted pregnancies and abortions.

This provider was one of the more thorough of those reported to offer postabortion contraceptive services and/or counseling. She suggested a range of contraceptive options in conjunction with advice to eat nourishing foods:

INT: What advice did the *dactarni* give to you?

KI: She asked me to either get the copper-T inserted or to go for the tubectomy. She also said I could take Mala-D (oral contraceptives).

INT: Did she give any other advice?

KI: She advised me to rest and eat nourishing foods and some fruits.

– *26 year-old, married Hindu woman, non-literate, four living children*

Informants reported that many providers reported suggesting only one contraceptive method. In doing so, providers made the decision of which method is appropriate for the client without fully understanding the needs of the client. For example, this informant reports that the provider counseled her to have a tubal ligation, and does not report that the provider discussed other available modern contraceptive methods. Abstinence was recommended, but to aid recovery, not as contraception:

INT: Did she (*dactarni* who conducted abortion) give you any advice?

KI: She said that no method other than the operation (tubal ligation) was proper for me. She also forbade me to drink cold water and eat cooling things like rice.

INT: Did she give you any other advice?

KI: She advised me not to meet (have sexual intercourse with) my husband for three months because it could cause prolapse of the uterus.

– *25 year-old, married Hindu woman, non-literate, six living children*

Similarly – this provider is reported to have suggested tubal ligation without offering a range of options:

INT: Dr. A. asked me to undergo the operation (tubal ligation) because there was no other method suitable for me.

– *25 year-old, married Hindu woman, non-literate, six living children*

In the following example, the gynecologist felt her client was not capable of using the oral pill, and so did not suggest the pill as on option:

I gave her family planning advice. Only a month has passed since I did this case, once her treatment has

settled I will give her Multiload (IUD). I didn't advise her to take pills because she is non-literate and would not be able to take them regularly, she would have to understand a lot, and she could also forget.

– *Gynecologist, nursing home in Allahabad*

Some providers claim to discuss, but not offer, contraceptive methods. This provider, incompletely trained as a nurse and running a nursing home, provides D&C for abortion. After providing the abortion, she says she gives women contraceptive advice, but not services:

INT: Do you give any advice to the woman after the *safai* … like *agla baccha kab theharna hai* (when the next pregnancy can take place)?

PI: I advise them to *copper-T lagva lo* (get copper-T inserted) for 3 years or *Multiload ya Zicoid laga lo ,yeh panch saal tak ka hota hai* (get Multiload or Zicoid inserted, this is for 5 years).

INT: Do you provide such services?

PI: No, I don't provide this.

– *35 year-old, female provider, almost 2 years of nursing training*

Some providers do not offer contraceptive counseling at all. For example this *dai* does not offer contraceptive counseling because she feels women have no control over contraceptive use, so counseling women is futile:

INT: What advice do you give in case of complications which come upon a woman *baccha girane ke baad* (after having an abortion)?

PI: I tell them *sardi mein haanth mat dena* (do not get exposed to the cold), and don't eat anything cold for at 1 or 2 months.

INT: So do you also tell them how long *pati se nahi milna hai* (they should observe sexual abstinence with their husbands)?

PI: No.

INT: Do you provide any *salah ya sadhan* (advice or material) about *pariwar niyojan* (family planning)?

PI: When I tell them then they tell me, what can they do?

– *35 year-old, female dai, untrained*

Misinformation about available contraceptive methods persists even after interaction with health care providers. This informant has had a spontaneous and an induced abortion and doesn't want any more children:

INT: Did you make any arrangements so you wouldn't have any more children?

KI: How do you do it? I have heard that there is an injection that lasts for five years. I have asked some people about where to get it. I have heard that it can be dangerous and when it is used *khoon khat nikalta hai* (there can be vaginal bleeding). So I didn't do it.

INT: So you don't know of any other method?

KI: No. I wouldn't have had so many problems if I knew more. (Later, she reported knowing about an operation, Mala-D, and condoms, but said that none worked for her).

– *21 year-old, married Hindu woman, non-literate, five living children*

The postabortion contraceptive counseling this informant reported receiving was about methods she could use, but not about the advantages and disadvantages of each method. The informant was dissatisfied with oral contraceptive pills, and has had an unwanted pregnancy despite condom use. Even after having had an unwanted pregnancy while using condoms, condoms remain her chosen contraceptive method:

INT: Sister, after getting the *safai* done, what methods did you make use of in order to prevent further pregnancies?

KI: I started taking Mala-D tablets but they did not help me. On the contrary, I suffered from heat in the body, giddiness, and lethargy. I did not feel like doing any work, so I gave them up.

INT: What method did you make use of after stopping the Mala-D tablets?

KI: I made use of *nirodh* (condoms) on both the occasions after having the abortions, and even until today I am making use of them.

Some women narrated experiences of using a variety of methods and being dissatisfied with each method. Such dissatisfaction is prone to be circulated, and, in the absence of any counseling to counter such information, discourage other users or potential users.

KI: People say use *nirodh* or Mala-D, but I don't believe all those things. We used *nirodh* and it burst. Then my daughter was born. When I used Mala-D, the doctor said I would have bleeding for 15 days, but I bled for about 2-3 months. I used copper-T also but had excessive bleeding. Now I have had two *safais*.

– *25 year-old, married Hindu woman, 12th standard pass, five living children*

Some providers spread contraceptive misinformation. For example, this *dai*, who should dispel myths about family planning, propagates negative misinformation about the copper-T:

PI: They (clients) can make use of copper-T. Earlier, there were the loops that were dangerous. They used to get inside the uterus. Patients could die due to this. I used to get a number of this kind of patient and I used to refer them elsewhere. I tell my patients to make use of *nirodh* and the Mala-D tablets.

– *55 year-old, female dai, 12th standard pass,working in private practice*

The data on postabortion contraceptive counseling show that providers rarely counsel couples to use contraception after an abortion. None of the women reported that they had received systematic counseling informing them of available methods, side effects, source of services, and support in selecting the right method or the immediate return to fertility after an abortion.

At the village level IUDs, oral pills, and condoms were recommended for women who had had an abortion or abortion complication. Male village-level providers see their role as curative agents and not as contraceptive service providers. Thus while several male providers reported giving women advice on one or more methods, only a few stocked contraceptives. Some referred women to the public sector services for contraception. Female providers at the village level, such as ANM or *dais*, tended to advise women to use IUDs. These providers supply IUDs and charge for insertion. Referral-level providers provide sterilization and IUDs, and only rarely suggest pills or condoms. For temporary methods, women obtain supplies from an ANM or from a village shop. While most referral-level and village providers provided some contraceptive counseling, none offered comprehensive contraceptive counseling. Follow-up of clients is not common.

Several providers advised abstinence and use of the rhythm method, and acknowledged at the same time the limited efficacy of these methods, given the women's minimal decision-making

powers. In the Kasganj site, many providers suggested traditional healing practices, such as eating hot foods, along with suggesting one or more modern contraceptive practices.

– **Inadequate contraceptive counseling and services can lead to more abortions**

Abortion providers and providers who offer care to women with abortion complications have a key opportunity to provide correct contraceptive counseling and services to women or men who are in need and may not be exposed otherwise. The textual data presented in this section show the importance of good postabortion contraceptive counseling for decreasing the likelihood of repeat unwanted pregnancies and induced abortion.

This informant has six children – four girls and two boys. She induced abortion because she and her husband feel they cannot afford another child. Though they do not want more children, they use abstinence as their contraceptive method. She claims to be unaware of other contraceptive methods. The abortion provider missed a valuable opportunity to educate the informant about modern contraceptive options:

KI: I did not take any precautions (after the induced abortion). My husband said "we will not produce any more children. We will not meet (have sexual intercourse) in the future." My friends and neighbors tell me I should have one more son. (Firmly) We don't want to have any more children.

INT: Sister, the relationship between husband and wife will definitely continue, won't it?

KI: But what else can I do? I'm very weak and cannot produce any more children.

INT: Are you aware of the methods people make use of in order to avoid pregnancy?

KI: I know nothing because I do not go anywhere but the four houses where I work. My husband doesn't like for me to go out.

The interview continues:

INT: You are not using any method, so what if you get pregnant again?

KI: I will again have an abortion.

– *25 year-old, married Hindu woman, non-literate, six living children*

This informant had an abortion and no postabortion contraceptive counseling. She wants no more children by her abusive husband but refuses to admit a need for family planning:

KI: No sister, I won't go back there (to my husband's house) again. If I do I'm sure to die. It won't happen. If I do get pregnant I'll get the *safai* done.

– *25 year-old, married Hindu woman, 12th standard pass, one living child*

Women who cannot afford safe abortion care and who rarely leave their compound for cultural reasons are difficult targets for public health messages, making their rare interaction with the formal health care system a particularly critical opportunity for the provider to discuss contraceptive options.

– **Men need postabortion contraceptive counseling**

Some informants induce abortion using medicines from a village medical store, purchased by husbands. The example of the husband obtaining the medicine for abortion and being responsible for contraception emphasizes the need for men to receive contraceptive counseling from village-level male providers when purchasing abortifacients for their wives. This example of a woman who rarely leaves her house and is not exposed to information about contraception further emphasizes the need and shows the opportunity to target men in contraceptive campaigns:

INT: So did you use any contraception (after your abortion)?

KI: No.

INT: Then you may conceive again.

KI: Yes.

INT: What do you know about government programs like *chota pariwar, sukhi pariwar* (a small family is a happy family?)

KI: I don't know anything. Look, I just don't go anywhere!

INT: Do you go to the doctor on your own?

KI: My husband goes there.

– *25 year-old, married Hindu woman, non-literate, six living children*

Husbands may act as a barrier to contraceptive use. This informant had an induced abortion and wants no more children but is not allowed to use contraception:

INT: Did you make any arrangements so that such a thing (unwanted pregnancy) would not happen again in the future?

KI: They gave me tablets but my husband does not use any method, nor does he let me use anything.

– *21 year-old, married Hindu woman, non-literate, two living children*

Sometimes providers postpone postabortion contraceptive counseling until a return visit. In such cases, providers must be prepared to lose the client altogether or counsel the husband who might return to see the provider in his wife's place.

– **Counseling during the emergency postabortion care visit**
Even when women come from long distances referral-level providers do not view the time immediately after an abortion as appropriate for contraceptive counseling. Given below is an excerpt from an interview with a provider, who knew that the women needed contraceptive counseling, but expected her to come back for a follow up visit. The patient was 28 years old and had been treated for sepsis after an abortion:

> She just had two children. I could not tell her about any terminal methods. She wanted more children. After that she did not come to me for follow-up. I thought that when she came to me after one or two months I would tell her about contraceptives. At that stage (during the treatment for complications) nothing could have been told to her. She did not come to me after that.
>
> – *Gynecologist, nursing-home near Allahabad study site*

In the following text the MBBS doctor claims that if women do make a return visit, it is usually because they are again pregnant:

INT: What do you usually tell patients after MTP?

PI: At the next menstrual period after the MTP, I insert the copper-T. During the period in between, I advise the woman or the girl to practice abstinence and if the couple wishes, they can also make use of the condoms. If I do laparotomy for postabortion complications I ligate the tubes if the lady has completed her family.

INT: After the MTP, how many women usually come back to you for family planning advice?

PI: Not all come back and if they come back, they come pregnant.

INT: In cases when you perform laparotomy for complications, do all patients agree to undergo tubectomy?

PI: Most of them agree to it, and I tell those who do not agree about the complications of another pregnancy. After some time, a few of them come back for the insertion of a copper-T.

– *32 year-old female MBBS, MS (Ob/Gynae) doctor, working in private nursing home*

– **Key findings on postabortion contraceptive counseling and services**

- Community-level providers could improve the quality of contraceptive counseling and supply
- Few informants reported receiving postabortion contraceptive counseling
- Most informants had some knowledge of available contraceptive methods
- Contraceptive misperceptions prevent contraceptive use
- No provider was reported to give thorough contraceptive counseling that included issues such as a rapid return to fertility after an abortion, contraceptive side effects, dispelling contraceptive misperceptions, and contraceptive re-supply
- Many couples resist contraceptive use, even after abortion complications
- Women who do not get postabortion contraceptive counseling are key candidates for subsequent unwanted pregnancy and abortion
- The interface between socially restricted women and the formal health system can be a rare occurrence. The existence of social restriction of women in rural Uttar Pradesh emphasizes the need for providing *complete* postabortion care when women present with complications
- Providers who provide men with abortifacients or postabortion treatments for their wives must also provide those men with postabortion contraceptive counseling
- Providers should offer postabortion contraceptive counseling when care is given; patients rarely return for follow-up visits

- Referral-level providers are not practical as contraceptive re-supply points
- Many providers recognize the need for postabortion contraceptive services, but do not see providing it as their role
- Barriers providers faced in getting villagers to accept contraception included son preference, religious superstitions, and fear of elders in the family who disapprove of contraceptive methods

Linkages with other reproductive health services

The third aspect of postabortion care, linkages with other reproductive health services, is often neglected in discussions of postabortion care. It is based on the same assumptions as postabortion contraception – that for many women, seeking care for postabortion complications represents a rare interface with the formal health care system. Just as this rare interface should be tapped to provide women with appropriate contraceptive counseling and services, the interface also should be utilized to identify and serve women's other reproductive health needs.

The results show a need for linkages with other reproductive health services, and other health services in general. The need seems generally unrecognized in the community judging from conversations with community members and providers.

a. Violence against women

The concept of identifying and meeting the broad range of women's reproductive health needs is not widely recognized among providers in rural Uttar Pradesh. To collect information operationalized questions were asked. For example, if a woman had had an abortion after a rape incident, the interviewer asked what actions an abortion provider would take. Likewise, we asked if the husband were abusive what actions an abortion provider would take.

Some male and female providers suggest taking the case to the government for legal assistance. For example, this *dai*, with six months of government-sponsored training, says that when women come to her to abort a pregnancy caused by rape, she would link the woman with the law via the government hospital:

INT: What advice do you give a woman, who has had a *safai* due to *balaatkar* (rape)?

PI: I will tell them that they should go to a *sarkari hospital* (Government hospital) and tell everything clearly so that the government comes to know.

– *50 year-old, female dai, six months government training, working in private practice*

In general, however, questions about rape or an abusive husband resulted in the provider stating the woman should take precautions against pregnancy. The providers did not seem prepared to help the woman to address the abusive situation in any way. This provider gives a typical response:

INT: If a woman has had an abortion because her husband is a drunkard, then what advice will you give her?

PI: I will tell her to get a copper-T inserted, because she will be saved from a lot of trouble in the future.

– *35 year-old, female provider, two years nursing training, working in private service*

This informant needs options for managing her relationship with her abusive husband:

KI: No, sister, my child did not fall out by itself. I had *bache girvana* (induced abortion). My husband is a drunkard. He keeps on beating me. Therefore I spend most of my time in my mother's house. About three months ago I went to my husband's place and got pregnant. My husband beat me up and sent me out of the house. When I came back to my mother I was two months pregnant. My mother said I couldn't afford to keep the child.

INT: Do you mean to say that you wanted to have that child? (The interviewer asked this question by holding the informant's hand lovingly)

KI: No. I was not anxious to keep the child because I have a son and my husband does not care about him. Both my child and myself are suffering from want of food and clothing. He drinks from morning till evening and he is also addicted to other intoxicants like opium and smack (heroin). I am not aware of the rest.

– *25 year-old, married Hindu woman, 12th Standard education, one living child*

Not only did the provider not offer counseling about where to seek help with an abusive husband, she also gave no postabortion contraceptive counseling.

For rape cases providers tend to blame the victim, and advise her to keep the situation secret rather than seek legal counsel, STD screening, or psychological counseling. This quote from a partially trained nurse working in Kasganj town shows an absence of

recognition of the need to link women who experience abusive situations with appropriate legal or social services:

INT: What advice will you give a female who has had an abortion due to rape?

PI: I would tell her not to make such a mistake again, and forget all about what has happened. I would prescribe medicines for her and tell her to take them regularly. I would also tell her that she may have heavy bleeding and stomach aches and that she should report to me regularly.

– *35 year-old, female provider, two years nursing training, working in private service*

Referral-level providers claimed to frequently see unmarried girls for abortion. They blame the girl for rape, and counseling includes the advice to not be raped again, and to marry soon. This doctor is a gynecologist at the government hospital in town:

INT: In a case in which a woman who was pregnant due to a rape came to you for MTP, what advice would you give to her or to her family members?

PI: I would do her MTP and tell her not to do that again. What more could I tell her? These days, everybody knows about everything.

– *35 year-old, female MBBS (D.G.O) doctor, running a private nursing home*

One unmarried, 17 year-old Hindu girl was interviewed. She had been raped by her brother-in-law several times and twice had to induce abortion. Her mother helped her choose a provider. The provider gave no rape or violence counseling. Clearly awareness of women's psychological needs after sexual violence are not recognized, and furthermore, facilities for appropriate care are not available.

b. Key findings: linkages with other reproductive health services

- Examples of domestic abuse and rape were identified in the villages
- Providers are unprepared to offer women appropriate care after incidences of rape and domestic violence
- Modern techniques of addressing subfertility are not available in villages

Community and provider recommendations to improve postabortion care

Many informants, when asked about how women's reproductive health care could be better provided in the future, suggested that a hospital with a lady doctor be set up in their village. These female providers would need to be available to provide services 24 hours per day. Such recommendations are unlikely to be realized. More realistic recommendations from informants include: improve transport facilities and provide affordable and effective medication at the village level. Informants in the Allahabad assessment site felt that medication should be available free of cost at the village level.

As shown by the following two examples, some suggest that high-quality care can start at the village level, provided as appropriate by village doctors, educated *dais*, and Auxiliary Nurse Midwives. The perception of what type of care can be provided by various levels of providers varies.

> INT: *Behenji*, do you have any suggestions for arranging medical facilities in the village for women suffering from postabortion complications or similar women's problems?
>
> KI: In case of abortion, one should go to a good doctor or a well-educated *dai*.
>
> – *26 year-old, married Hindu woman, non-literate, four living children*
>
> KI: Let the *polio wali behenji* (ANM) speak to the women and let the village women speak to her about their problems. Let the ANM educate the village women not to resort to unsafe methods of *bachche girvana*, and also tell them how to have safe deliveries done in the village.
>
> – *30 year-old, married Hindu woman, non-literate, seven living children*

Advice from referral-level providers on how to improve care seems to be to educate patients and community members on the importance of family planning, and the need to seek care from "appropriate" doctors. Most referral providers said that women should promptly access tertiary referral facilities in case of abortion complications. In Kasganj, referral-level providers emphasized the need to prevent village-level providers, particularly *dais* and ANMs, from providing abortion and treatment for complications that they are neither trained to do nor capable of doing. The following quote is from a referral-level MBBS doctor:

INT: Dr. PI, could you kindly tell me about your suggestions for improving care for women's reproductive health problems?

PI: A woman should consult a doctor for each and every such problem. There are good doctors to whom everybody can go. The *dais*, ANMs, and the health workers should be stopped from performing abortion under any circumstances. A *dai* is trained to conduct safe deliveries whereas the ANMs and the health workers are meant to look after the contraceptive work and to immunize children and pregnant ladies. But, neglecting their main duty, these people get themselves involved in doing abortions. There should be stern action taken against these *dais* and the ANMs and health workers who conduct abortions (she suggested that the social workers should work in the villages in order to motivate the villagers to make use of contraceptive methods and to avoid unwanted pregnancies since they will change the thinking of the people without interfering in the medical field).

– *35 year-old, female MBBS (DGO) doctor, running a private nursing home*

Recommendations to bar village-level providers from conducting unsafe abortion and unsafe treatment for abortion complications are sensible, but difficult to implement. The underlying issue is the motivation of the *dais* and ANM to restrict their activities to those they are trained in and can safely provide, but are not well rewarded, and to turn away from conducting abortion procedures, which are more lucrative and in demand.

Encouraging villagers to seek appropriate care initially, rather than first seeking care at the village level, may be the best tactic to get women to seek appropriate care. This partially trained nurse explains the economic benefits of seeking care at a higher level initially instead of seeking care first at the local level, then at higher levels:

INT: *Didi*, where should a woman go for good treatment?

PI: She should go to a good doctor. There are some women who, in order to save money, spend 100 Rs on a *dai* and then have to spend 10,000 Rs. on treatment. If you get treatment from a doctor then you get good treatment as well as good advice.

– *35 year-old, female provider, two years nursing training, working in private service*

The recommendations from community members and providers indicate a demand for increased access to improved care – through providing better care at the village level, and / or making care at referral levels more accessible.

Key findings: community and provider recommendations

- Villagers stated a need for increased access to appropriate care
- MBBS doctors stated that *dais* and ANMs should be prevented from inducing abortion

Conclusions

For the forseeable future, complications of abortion will continue to occur in rural Uttar Pradesh. These complications occur at the village level, and that is where women seek care. As such, there is a need for a strong decentralized postabortion care program.

This assessment report provides a description of the range of practices of abortion and postabortion care at the community level in rural Uttar Pradesh. In doing so it depicts an informal system that has the potential to much more effectively serve the local population in terms of preventing abortion complications and linking patients with complications to appropriate care facilities promptly. The assessment finds that community-level providers need to be more aware of the potential dangers of abortion and other obstetric complications and more able to facilitate care for women with complications. Furthermore these community-level providers need to be able to provide the elements of safe and appropriate PAC for which they are qualified. Furthermore, women and household-level decision-makers need to be able to recognize the signs of abortion complications and be encouraged to seek appropriate care promptly when these symptoms occur.

The assessment identified the need to improve practices on many fronts. In terms of preventing unwanted pregnancies through contraceptive use: Most of the men and women interviewed were aware of multiple methods of contraception. However, couples listed a number of reasons for not using effective contraception. To reduce the number of unsafe abortions, contraceptive use needs to be addressed. In terms of preventing abortion complications by seeking services from trained providers: Many women interviewed knew of dangers of abortion from untrained providers. Despite knowledge of those risks, they turn to untrained local providers for abortion services for various reasons. Such women deserve improved knowledge of where to seek safe services.

Typically when complications of abortion occur, the woman or decision-maker will delay seeking care. When care is sought it tends to be sought at the community level, where the provider, often untrained or inadequately skilled, will attempt to treat the complication. The woman, decision-maker, and provider tend to be unaware of the urgency of seeking care from a primary level or higher care facility staffed by appropriately trained providers.

Perhaps the most discouraging example of the current system not serving women properly are the cases of couples who have had an unwanted pregnancy, an abortion, and a complication, and who still

reject contraception. Female informants in this situation reported a lack of complete information about available contraceptive methods, a fear of side effects, and the unwillingness of decision-makers to allow contraceptive use. This mistrust of contraception may reflect the prevalence of social conditions, developed prior to and during the decades of implementation of India's family planning program, within which over-ambitious family planning campaigns have turned many against modern contraceptive methods.

Recommendations to improve postabortion care

Recommendations are made based on analysis of the data collected for this assessment and intensive discussions among the data collectors, study managers, principal investigators, and members of the Postabortion Care Consortium based in New Delhi, India. Recommendations are presented in three areas: knowledge and behavioral change; advancing service provision; and policy. While not all recommendations will be possible for all communities or providers, the recommendations can serve as goals to strive toward.

1. Knowledge and behavioral change

Critical to improving postabortion care at the community level are behavioral change programs engaging rural community members and health care providers. Messages could be developed around the broad areas of preventing unwanted pregnancies, preventing unsafe abortion, and accessing appropriate postabortion care. At the community level a range of groups could be addressed specifically. Additional mass media messages could be developed to address all groups simultaneously.

Messages of similar content could be disseminated to providers and community members. The delivery of the message will vary according to the level of training of the provider, and the age, sex, and marital status of the community member. The community members to focus on include couples and married and unmarried women of reproductive age who are at risk of having unwanted pregnancies, and male and female decision-makers who determine when and where a woman goes for care. It is particularly important to engage men to alert them to the fact that (in the current social structure) they are critical to the effort of getting women to appropriate care promptly. Providers to focus on at the village level include: *dais*, ANMs, ISMPs, and village-level medical shopkeepers. Additionally, it is crucial to obtain the support of the village leaders, or village *Pradhan*, to effectively disseminate these messages.

Strategies to improve knowledge and encourage behavior change at the community level can be designed, implemented, and evaluated in an operations research context prior to being implemented on a large scale.

a. Messages for community members might include:

- The value of women in a health context: "A woman with a health problem deserves appropriate care";

- Seeking appropriate care initially from trained providers, as opposed to after a long chain of inadequate care, is better for the woman and saves time and money in the long run;
- Obstetric complications of unsafe abortion can be life-threatening;
- Signs that indicate a woman needs emergency obstetrical care;
- Appropriate care must be sought immediately when a woman experiences obstetrical complications;
- Actions to take when a woman has signs of emergency obstetrical complications;
- Means of recognizing nearby facilities where care for complications is affordable and high quality;
- Appropriate use of contraception prevents unwanted pregnancies and unsafe abortions;
- Fertility can return immediately after an abortion;
- Address misperceptions about available contraceptive methods;
- Advertisements for service-delivery points where contraceptive services and counseling are offered to married and unmarried women;
- Advise about where appropriate contraceptive counseling and supplies are available to various members of rural communities, including adolescents;
- Positive testimonials on contraceptive use.

b. Messages for providers might include:

- A caring, non-judgmental approach is most effective
- Treating women with abortion complications according to protocol is legal and a medical responsibility;
- Appropriate care starts at the village level and includes recognizing the complication and linking the patient to a primary or higher-level health care facility;
- A non-judgmental attitude is most effective when treating women with complications of abortion;
- Counsel women who have had abortions about contraceptive options;
- Fertility can return immediately after an abortion;
- Maintain an adequate supply of contraceptive methods;

- Postabortion contraception should be offered before a woman is discharged from a service center;
- Counsel partners about contraceptive methods.

2. *Advancing service provision at the rural village level*

To save women's lives and reduce maternal morbidity, appropriate postabortion care can be made as widely available and as accessible as possible. To improve the availability of safe postabortion care at the village level, a range of rural-based health care providers could be trained in aspects of postabortion care, as appropriate to their professional qualifications. To improve access to safe postabortion care, rural-based health care providers and community leaders can be included in a referral chain that facilitates women's access to the appropriate level of care for their situation. Table 10 suggests aspects of postabortion care that could be offered by various levels of community provider.

A system of advancing service provision at the community level based on these recommendations would need to be designed, implemented, and evaluated and modified in a pilot project prior to being implemented on a large scale.

The following recommendations have been developed by the authors based on the findings described in the report. These recommendations should be further developed with input from community members and formal and informal health care providers at all levels.

The recommendations presented here identify some of the most immediate solutions available to address unsafe abortion through postabortion care. The researchers recognize that in the communities studied, other more fundamental changes are needed in the range and quality of health care services available to women in order allow them to fulfill their reproductive health and rights.

a. Increase access to postabortion emergency care:

- Train women, decision-makers, and community-level providers in the signs that indicate a need for emergency care, and the importance of seeking prompt and appropriate care for abortion complications.
- Train community-level providers to appropriately manage patients with abortion complications before referring patients to appropriate care facilities; this training should include background on sanitary techniques and women's reproductive systems.
- Formalize a referral chain in which community-level providers facilitate access to the formal health care system for women with obstetric complications.

- Increase the number of rural facilities (PHCs, CHCs, and private sector) that offer emergency PAC services.
- Formalize a system of transport to facilities that provide emergency care.
- Alert rural community-level providers of nearby facilities where care for complications is affordable and of high quality.
- Encourage registered providers of postabortion care to charge prices affordable to rural poor clients and to offer non-judgmental care.
- Emphasize the importance of offering non-judgmental care when treating women presenting with complications of unsafe abortions.

b. Improve postabortion contraceptive counseling and services:

- Provide training and continuing education to community-level providers in postabortion contraceptive counseling and service provision. A crucial aspect of the training is empowering providers to reassure clients experiencing contraceptive side effects.
- Train providers at all levels (referral-level and community-level) to offer a range of appropriate contraceptive methods for men and women, and explain benefits, side effects, and resupply issues.
- Ensure that male and female providers are aware of the importance of postabortion family planning counseling and services.
- Encourage and as possible enable community-level providers to provide a stable contraceptive supply to married and unmarried women and men.
- Encourage two-way referral: community-level providers refer patients up to the primary care level for contraceptive services such as IUD insertion or sterilization; primary level care providers can refer women to contraceptive providers in their communities for contraceptive resupply and continuing counseling.
- Educate communities to expect a level of quality in contraceptive supply.
- Empower women to both request and refuse contraceptive methods.
- Continue campaigns that educate men, women, and adolescents about the benefits of modern contraceptive use.

c. Link women with other necessary reproductive health services:

- Identify or develop reproductive health resources for women or couples with postabortion reproductive health issues, such as subfertility, exposure to sexual violence, and risk of RTIs and HIV/AIDS.
- Educate community-level providers about and encourage them to refer patients to these reproductive health resources.

Table 10. Aspects of postabortion care that can be offered by various levels of community provider

Community-level provider	Activity to reduce abortion related morbidity/mortality
Aganwadi workers	• Provide appropriate referral to women in need of pregnancy-related or contraceptive counseling and services
Dais	• Explain healthcare options available to women in the community and at referral levels • Provide health education on the dangers of unsafe abortion and the benefits (and side effects) of various contraceptive methods • Counsel women in family planning and the importance of its use immediately after an abortion • Provide FP counseling and services as appropriate • Refer women to FP providers as appropriate • Recognize symptoms of abortion complications • Recognize symptoms of spontaneous abortion • Provide basic first aid to patients with complications (such as: keep patients warm and horizontal, do not administer oral fluids) • Provide link to formal health care network • Counsel women to seek care for abortion complications from trained providers • Counsel unmarried girls in contraceptive services • Counsel unmarried girls to seek care for abortion complications from trained providers • Recognize signs of reproductive tract infections (RTIs) and refer women to appropriate care • Regular communication with ANM and primary health care facility
ANMs	All activities of *dais*, plus: • Regularly discuss contraceptive and postabortion care issues with *dais* • Recognize *dais* as assistants who have the advantage of constant contact with and trust of community women • Ensure *dais* have adequate supply of the contraceptive methods they are able to provide • Counsel unmarried boys to seek care for abortion complications from trained providers • Recognize signs of RTIs and refer men to appropriate care • Regular communication with primary health care facility
Male teachers	• Provide health education to boys on dangers of unsafe abortion and on recognizing symptoms of unsafe abortion • Provide health education to boys on the benefits (and side effects) of family planning

Table 10 (continued)

Community-level provider	Activity to reduce abortion related morbidity/mortality
Female teachers	• Provide health education to girls on dangers of unsafe abortion and on recognizing symptoms of unsafe abortion • Provide health education to girls on the benefits (and side effects) of family planning
Village *Pradhan*	• Support community health program (including PAC program and referral system) • Understand and help facilitate referral system by helping to arrange transport for emergency care patients
Referral-level provider	• Training in emergency postabortion care • Training in postabortion counseling and services • Training in two-way referral network • Recognize community-level providers as assistants who have the advantage of constant contact with and the trust of villagers • Training in empathetic service delivery • Training in identifying patients with reproductive health problems and linking them to appropriate providers

3. *Policy recommendations*

Local, state and national governments might consider adopting and publicizing a national reproductive health policy that includes information on postabortion care. National, state, and local policy-makers and providers need to know that providing postabortion care is a legal activity and need to be convinced of the value of postabortion care in saving women's lives. In this vein, the following activities could be considered:

- Distribute to policy makers and health care providers at all levels (national to community) materials that demonstrate the importance of PAC in saving women's lives;
- Determine the capacity of various levels of health care providers to provide PAC;
- Ensure that each block has at least one clinic that provides postabortion care and can arrange transport to a higher-level facility when necessary;
- Train various levels of providers to provide safe PAC to the limit that their professional qualifications allow;
- Engage private and NGO providers in the provision of postabortion care;
- Pilot demonstration projects to evaluate approaches to postabortion care that are likely to succeed in different contexts (district hospitals to village *dais*);

- Increase the variety of contraceptive options available;
- Offer choice in contraceptive options, provide information on potential side effects, and dispel myths surrounding contraceptive method use;
- Encourage regional, statewide, and national workshops to review progress in providing PAC.

Community-level health care providers could be included in such policy discussions as they have an understanding of the needs of women and their families and can be vital sources of information for policy makers.

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