

Where Do Rural Women Obtain Postabortion Care? The Case of Uttar Pradesh, India

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CONTEXT: Although Indian law permits abortion for a broad range of social and medical indications, millions of unsafe and illegal abortions and countless subsequent complications occur annually. Nonetheless, in the central Indian state of Uttar Pradesh, few women with abortion complications are reported to seek care at registered private and public health facilities. Information is needed about where rural women seek care for abortion complications and about the quality of care they receive.

METHODS: Qualitative data were collected in 1999 in four villages in rural Uttar Pradesh. The study team conducted community mapping exercises, focus group discussions with female and male community members, and in-depth interviews with women of reproductive age and with postabortion care providers.

RESULTS: Postabortion care is widely available in the villages studied, largely from untrained or inappropriately trained providers. Because village-level providers are the front line of care for many women, abortion complications may be exacerbated rather than alleviated, appropriate care delayed and the cost of treatment increased. Village-level postabortion care does not include family planning and contraceptive counseling services or links to reproductive and other health services.

CONCLUSIONS: Existing village-level postabortion care services are inadequate. There is an urgent need to increase women's access to higher-quality postabortion care. This can be done by simultaneously engaging village-level providers in the formal system of postabortion care service delivery, as appropriate, and addressing the prevailing social and cultural mores that discourage women with abortion complications from seeking higher-level care.

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Although Indian law permits abortion for a broad range of social and medical indications,¹ only about 538,000 of the estimated 6.7 million pregnancy terminations occurring annually are performed by registered providers in licensed facilities.² Women with access to few resources—for example, low-income, rural women and adolescents—are among those most likely to receive unsafe services and experience complications of abortion.³ Although data are limited, about 20,000 deaths—or approximately 18% of all maternal deaths in India—are believed to be related to unsafe abortion.⁴ The total number of abortion-related complications is thought to be much higher. With an estimated 68 induced abortions per 1,000 married women of reproductive age per year, Uttar Pradesh has one of the country's highest incidences of abortion,⁵ reflecting the fact that only 18% of rural, married women of reproductive age in that state use a modern contraceptive method.⁶

A 1998 report on the quality of postabortion care services in Uttar Pradesh revealed that surprisingly few women with abortion complications presented at secondary- or tertiary-level private or public facilities.⁷ These results raised several questions: If women with abortion complications do not seek care at these facilities, where do they receive care, and what is the level of quality of the care they receive?

The objectives of this study were to document the avail-

ability and quality of postabortion care available to the women of four selected rural villages in India. Study results have immediate relevance for the design of reproductive health interventions in Uttar Pradesh, and also should be pertinent elsewhere, as information on access to postabortion care in rural areas is largely absent from the literature. The need for such information is great, as three-quarters of India's population live in rural areas, reflecting the situation in many developing countries. Our findings are presented according to three areas of postabortion care: treatment for complications, postabortion contraceptive counseling and services, and links to other reproductive health services.

METHODS

Data were collected from August to November 1999 by research teams based at Kamala Nehru Memorial Hospital, in Allahabad, and Christian Hospital, in Kasganj, in the Etah District. These two institutions were selected because of their strong presence in rural communities in Uttar Pradesh, their experience in reproductive health service delivery, their linkages with referral centers and their capacity for qualitative research. Research teams comprised women and men experienced in social science field research and fluent in Hindi and English. They were trained in reproductive health

TABLE 1. Types of providers sought by rural Indian women with abortion complications, according to type of training and treatments offered, Uttar Pradesh, 1999

Provider	Training	Treatments offered for abortion complications
Mother-in-law	No formal training	Tablets, teas
Bhagat ji (holy man)	No formal training	Talismans (magical charms)
Jhola chhap (literal translation: "bag brand," because such providers carry equipment door-to-door in a doctor's bag)	No formal training	Powder, tablets, capsules
Dactar/dactarni (male/female village "doctor"), rural medical practitioner	No formal training	Dilation and curettage, analgesics, antibiotics, ergot tablets, oxytocin injections, intravenous fluids, injections, tablets, tonics, powder, good diet, leaves
Dai (traditional birth attendant)	Some have six months of government training	Dilation and curettage, cotton swab soaked in ghee (semifluid butter) for vaginal insertion, manual removal of retained fetus, enema, intravenous fluids and antibiotics, injections, douche, tablets, tonic, hot tea with jaggery
Ayurvedic provider	Some are trained informally; others hold a bachelor of Ayurvedic medicine and surgery (BAMS) degree	Powder, tablets
Medical doctor	Formally trained—e.g., may hold a bachelor of medicine and bachelor of surgery (MBBS) degree	Iron tablets, tablets with milk, capsules, dilation and curettage, "medicines," laparotomy, tonics

Note: Based on information reported by key informants (married female community members of reproductive age) in the four villages studied.

concepts and qualitative data collection techniques.

We designed the study to allow the research teams to gradually gain entry into the communities by first conducting public data collection activities, and later asking women and health care providers in the community to participate in private, in-depth interviews. The data collection activities included quick descriptive surveys of formal and informal organizations, institutions and key leaders in four selected villages; community mapping exercises, in which participants mapped the health care services in their village; 24 focus group discussions with informants from specific population subgroups, including married women and men, and single female and male young adults; and 88 in-depth interviews with 53 "key informants"—married women whom interviewers identified as being particularly knowledgeable about abortion and postabortion care issues in their village. These data collection exercises yielded an exhaustive list of health care providers in the four villages, as well as a list of providers from whom village women sought postabortion care outside of the villages. Of the 122 postabortion care providers identified, a purposive sample of 38, representing every type of provider listed, was selected to participate in in-depth interviews. All interviews were conducted and transcribed in Hindi and then translated into English.

Interviews were conducted in as private a setting as possible, with interviewers changing the topic of discussion whenever noninformants came within hearing range. All study participants orally agreed to the informed consent statement.

Throughout the data collection process, interviewers worked with supervisors to conduct preliminary data analy-

sis by using a matrix tool. Subsequently, the principal investigators coded the translated data, identified thematic areas and reduced the information to its essential points.

RESULTS

Complications of unsafe abortion* reported by informants and providers ranged from mild to fatal. Some complications resulted from the use of inappropriate substances, such as bovine oxytocin, or of invasive techniques performed by unqualified providers. The majority of key informants (35 of 53) reported having had an induced or spontaneous abortion and a resulting complication. Reported symptoms of complications included septic shock, septicemia, two to eight weeks of moderate to heavy vaginal bleeding, lower-back ache, abdominal pain, vomiting, fever, fatigue and weakness, dizziness and fainting spells. Almost all women who reported having had abortion complications had sought treatment—from providers in the village, and in some cases, from referral-level providers.

Treatment for Abortion Complications

Informants reported that every health care provider identified at the village level provided some aspect of postabortion care (Table 1). No physicians worked in the villages studied, and some participants acknowledged that the providers available in the villages are not qualified to treat abortion complications. A man in a focus group discussion noted that

*For this study, postabortion complication was defined broadly as any symptom of reproductive tract-related illness that lasted for more than one week and interfered with routine daily activities, and that the woman perceived as having arisen from a recent induced abortion; the woman need not have sought care for the symptom.

when women seek care for abortion complications, “they go mostly to private practitioners....Most of them are not qualified, but the general population thinks they are.” Although physicians work in the nearby town of Kasganj and the city of Allahabad, a woman with an abortion complication will seek their care only if she can garner the necessary financial resources and is willing to risk exposure.

Reported treatments for abortion complications varied according to the severity of the complications, and by the training and sex of the provider. Male village-level providers reported that societal taboos prohibit them from conducting physical examinations or invasive diagnostic and therapeutic procedures in women; instead, they offer a range of injections and pills to treat abortion complications. Because of the restrictions placed on male village-level providers, their diagnoses are unlikely to be precise. As a result, the treatments they provide can burden women with unnecessary costs, delay access to appropriate care and cause complications to worsen.

Female providers are socially permitted to provide invasive care, even if they lack the proper training. A 55-year-old *dai*—a traditional home birth attendant—provided treatment for abortion complications although she lacked formal training: “Women have come to me with heavy bleeding and uterine swelling. In these cases, I douche them—I take some lukewarm water and mix some Dettol* into it and push it inside the uterus and wash out the uterus....If some pieces are left inside, they come out with the douche. If the bleeding continues, I [perform dilation and curettage].”

Another *dai*, a 40-year-old woman with six months of government training, reported providing invasive treatment in postabortion patients with excessive bleeding: “Only if I think that I can manage the case do I keep the patient. I put a piece of cotton soaked in ghee (semifluid 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.”

Village-level providers tend to treat patients rather than refer them to a more appropriate provider, as such referrals could mean lost potential income and represent greater initial expense for the patient. A key informant, a married, illiterate Hindu woman, aged 35 with five children, reported that a village *dai* “advised me not to go to the government hospital because it would cost more money. She said she would treat me for only 50 rupees.”[†]

Some village-level providers referred patients to higher-level care. Some referrals were appropriate; others, however—such as those to village “doctors” who lacked appropriate training—were not. The 40-year-old *dai* with six months of government training reported that if a patient with foul-smelling discharge came to her seeking postabortion care,

she would refer the patient to one of two village “doctors,” or to a government hospital or the mission hospital in Kasganj. “I don’t keep such patients,” she explained. Moreover, according to providers and key informants, only a fraction of the providers who advised patients to seek a higher level of care referred the patients to specific facilities. In some cases, inappropriate referrals, combined with dangerous or ineffective treatments for unsafe abortion, can prolong resolution of the injury, risk exacerbation of the complication and result in increased cost to the patient by necessitating multiple visits to ineffectual providers.

Postabortion Care Contraceptive Counseling and Services

Providers of postabortion care have a key opportunity to offer appropriate contraceptive counseling and services and to decrease the likelihood of repeat unwanted pregnancies and unsafe abortions. Thorough postabortion contraceptive counseling and services include counseling on the timing of the return to fertility; a range of available contraceptive options, their use and side effects; contraceptive provision; and, if applicable, information about resupply. In the villages in this study, few providers of postabortion care offered patients multiple options for contraceptive methods, and other aspects of contraceptive counseling and services were absent.

Some providers, however, such as the *dactarni*—female village “doctor”—described by a woman she had treated, provided more comprehensive contraceptive services or options counseling:

“[She] asked me to either get [an IUD] inserted or go for [a] tubectomy. She also said I could take [a low-dose combined oral contraceptive]. She advised me to rest, and eat nourishing foods and some fruits.”—*illiterate, married Hindu mother of four, 26 years of age*

Informants reported that many providers suggested only one contraceptive method, thereby denying the patient a role in choosing a method. Presumably, they did so without fully understanding the patients’ individual needs. For example, a gynecologist from a clinic in Allahabad believed that her patient was incapable of using oral contraceptives:

“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 [an IUD]. I didn’t advise her to take pills because she is not literate and would not be able to take them regularly. She would have to understand a lot, and she could also forget.”

Some providers said that they regularly discuss contraception with patients but do not offer specific contraceptive services. Others do not offer contraceptive counseling at all. One untrained, 35-year-old *dai* said that she does not offer contraceptive counseling because she believes her patients do not have the authority within their household to make decisions about contraceptive use; she said that she does not tell her patients for how long they should observe sexual abstinence with their husbands. When asked whether she provides any advice or materials about family planning, the *dai* replied, “When I tell them, then they

*Dettol is a liquid antiseptic containing chloroxylenol.

[†]In 1998–1999, the per-capita income of Uttar Pradesh was Re 8,633, approximately equivalent to US\$199 (source: Ministry of Finance, Government of India, Economic Survey 1999–2000, Per capita net state domestic product at current prices, <<http://indiabudget.nic.in/es2002-03/chapt2003/tab18.pdf>>, accessed Oct. 28, 2003).

respond, "What can I do?"

No informant reported receiving systematic counseling about available methods and their side effects, being informed of providers or facilities offering contraceptive services, receiving advice on selecting a method or being told that they could become pregnant again soon after their abortion.

An illiterate mother of four girls and two boys said that she underwent an abortion because she and her husband could not afford to have more children. To avoid future pregnancy, she and her husband practice sexual abstinence, the only contraceptive method of which she is aware:

"[After I had an abortion,] I did not take any precautions. 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, [but] we don't want to have any more children."
—25-year-old Hindu woman

This woman, acknowledging that she and her husband would probably have sexual relations again in the future, reported that she would have another abortion if she were to become pregnant. She commented, "But what else can I do? I'm very weak and cannot produce any more children." Speaking about her lack of knowledge regarding contraceptives, she noted, "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." In this case, the provider missed a valuable opportunity to counsel about modern contraceptive options.

According to interviews with several providers and women informants, some husbands accompany their wives to postabortion care visits. In families in which the wife rarely leaves her housing compound, the husband may visit a health care provider without his wife if she experiences abortion complications. For example, a married, illiterate Hindu mother, aged 25 years with six living children, said that her husband seeks health care on her behalf. She noted that she had used no contraceptives since her abortion and acknowledged that she could therefore become pregnant again. When asked about her knowledge of government-sponsored media campaigns promoting contraceptive awareness and use, she replied, "I don't know anything. Look, I just don't go anywhere!" Although circumstances such as these deny women the opportunity to be counseled about contraceptives, they do provide opportunities for the counseling of men.

Links with Reproductive and Other Health Services

Providers of postabortion care often neglect to refer women to reproductive and other health services. For many women with abortion complications, their postabortion care may be a rare interaction with the formal health care system. Just as this rare interaction should be tapped to provide appropriate contraceptive counseling and services, it also should be used to identify and address other health needs—such as education about, screening for and treatment of sexually transmitted infections, including HIV, and screening, counseling and referral for gender-based violence.

Several informants had aborted pregnancies resulting from rape, indicating that gender-based violence is a reality that providers need to be prepared to address. When asked how they would assist rape victims who had had an abortion, some providers suggested taking the case to the government for legal assistance. A 50-year-old dai with six months of government training who worked in private practice said that if such women came to her, she would link them with the legal system via the government hospital: "I will tell them that they should go to a government hospital and tell everything clearly, so that the government comes to know." In general, however, questions about rape or an abusive husband during the provider interviews resulted in the provider's stating that the woman should take precautions against future pregnancy. The providers seemed unprepared to help women address their abusive situations.

A 35-year-old female private practitioner with two years of nursing training was asked what advice she would give to a patient seeking postabortion care whose husband is abusive and consumes excessive quantities of alcohol. Her response was typical of the providers interviewed: "I [would] tell her to get [an IUD] inserted, because she will be saved from a lot of trouble in the future."

In discussing cases of rape, providers tended to blame the victims and to report that they typically advise such women to keep their situation to themselves rather than seek legal counsel, undergo testing for sexually transmitted infections or obtain other care. A 35-year-old female gynecologist at a government hospital in Kasganj reported that if a woman pregnant as a result of rape came to her for an abortion, she would perform the abortion and "tell her not to do that again." She added, "What more could I tell her?"

DISCUSSION

The qualitative data from this study in four villages in rural Uttar Pradesh demonstrate that women who experienced abortion complications generally first sought care from untrained or inadequately trained providers in their village. When their medical condition worsened, some women sought the services of providers who were more qualified but less affordable or less conveniently located. Treatment for abortion complications was widely available in the villages studied, but as this treatment was largely inappropriate, it tended to exacerbate rather than alleviate complications, cause delays in patients' seeking appropriate care and increase the total expense associated with treatment by necessitating multiple visits to providers.

In the villages in this study, postabortion contraceptive counseling and services were inadequate. Many providers who cared for patients with abortion complications seemed aware of their patients' contraceptive needs but did not perceive themselves as being responsible for providing contraceptive services. Because providers often lacked the knowledge or incentive to provide contraceptive counseling, they did not inform postabortion patients of the range of available methods, correct method use or potential side effects. Moreover, providers did not recognize the need to

link women presenting with abortion complications to additional reproductive and other health services.

Village-level providers, who are the front line of care for many village women, have an opportunity to engage their patients in a formal network of care. The providers identified in the villages studied, all of whom already provide postabortion care in some form, could contribute to decreasing maternal morbidity and mortality from unsafe abortion by appropriately referring women to higher-level care for abortion and postabortion care services; providing contraceptive counseling and methods, or referral; and linking postabortion care patients to reproductive health and other services as necessary.

The results of this study emphasize the need to strengthen links between rural, village-based providers and the formal health care system; to help women avoid unsafe abortion (by using contraceptives and accessing safe abortion care) and receive appropriate and timely treatment for complications of unsafe abortion; and to ensure that health care services reflect and meet the priorities and needs of women and those who seek care on their behalf. To facilitate women's access to higher-quality medical care and counseling, several types of complex questions need to be examined through further exploratory data collection and analysis, review of existing safe motherhood programs and operations research. First, which individuals make decisions about selecting providers of postabortion care, and what priorities do they use to do so? Can (or should) secondary- and tertiary-level providers strive to meet these priorities to attract rural patients? Second, how can the skills of village-level providers be upgraded and maintained so that higher-quality care is available to rural women who have abortion complications and other reproductive health needs? Finally, what are appropriate incentives to encourage village-level providers to develop and participate in effective referral networks that can help rural women obtain timely, high-quality care?

Answers to such questions are critical to the conceptualization and implementation of programs linking rural populations to appropriate reproductive health care in Uttar Pradesh and elsewhere in the developing world.

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RESUMEN

Contexto: Aunque en la India la ley permite el aborto inducido para una amplia gama de condiciones sociales y médicas, anualmente se realizan millones de abortos ilegales y se registran innumerables complicaciones. Sin embargo, un informe de 1998 revela que en el estado central de la India, Uttar Pradesh, pocas mujeres con complicaciones causadas por abortos procuran atención en las instalaciones de salud privadas y públicas. Se carecen de datos sobre dónde acuden las mujeres rurales para el tratamiento de complicaciones de abortos y sobre la calidad de la atención recibida.

Métodos: En 1999 se recopilaron datos cualitativos en cuatro poblaciones de la zona rural de Uttar Pradesh. El equipo del estudio realizó ejercicios de mapeo comunitario, llevó a cabo grupos focales con mujeres y hombres de la comunidad, y realizó entrevistas a fondo con mujeres en edad reproductiva y con proveedores de servicios de atención postaborto.

Resultados: La atención postaborto es una práctica ampliamente difundida en las poblaciones estudiadas y por lo general la realizan proveedores no capacitados o pobremente adiestrados. Dado que dichos proveedores son la principal fuente a la que recurren muchas mujeres, las complicaciones de abortos pueden ser agravadas en vez de ser aliviadas, y la atención adecuada puede ser demorada y el costo del tratamiento aumentado. La atención postaborto por proveedores no capacitados a nivel comunitario no incluye los servicios de planificación familiar y de consejería en materia de anticoncepción, ni nexos con otros servicios reproductivos y de salud.

Conclusiones: Los servicios actuales de atención postaborto a nivel comunitario son inadecuados. Hay una necesidad urgente de incrementar el acceso de la mujer a una atención postaborto de mayor calidad. Esto se puede realizar haciendo participar en forma simultánea a los proveedores comunitarios en el sistema formal de servicios de atención postaborto, según corresponda, y abordando las costumbres establecidas sociales y culturales que desalientan a la mujer que tiene complicaciones a recurrir a servicios de atención de mayor calidad.

RÉSUMÉ

Contexte: En Inde, bien que la loi admette l'avortement dans de nombreuses circonstances sociales et médicales, des millions de procédures illégales non médicalisées se pratiquent chaque année, avec les innombrables complications qui s'ensuivent. Dans l'état central d'Uttar Pradesh, cependant, peu de femmes souffrant de complications d'un avortement cherchent à se faire soigner dans les établissements de santé privés agréés ou de l'État. Le lieu où les femmes des milieux ruraux s'adressent en cas de complications d'un avortement et la qualité des soins qu'elles reçoivent doivent être documentés.

Méthodes: Des données qualitatives ont été recueillies, en 1999, dans quatre villages ruraux d'Uttar Pradesh. L'équipe chargée de l'étude a procédé à des exercices de cartographie commu-

nautaire, à des groupes de discussion avec les membres féminins et masculins de la collectivité, et à des entretiens en profondeur avec des femmes en âge de procréer et des prestataires de soins après avortement.

Résultats: Les soins post-avortement sont largement disponibles dans les villages soumis à l'étude, auprès de prestataires non formés ou inadéquatement formés surtout. Comme les prestataires de village représentent les services de première ligne pour de nombreuses femmes, les complications de l'avortement peuvent être exacerbées plutôt que soulagées, tandis que les soins appropriés sont différés et que le coût du traitement augmente. Les soins post-avortement au niveau du village ne comprennent ni services de conseil sur le planning familial et la contraception, ni renvoi ou lien à des services de nature génésique ou autres prestations de santé.

Conclusions: Les services de soins post-avortement existants

au niveau du village sont inadéquats. Il existe un besoin pressant d'accroître l'accès des femmes à des soins de meilleure qualité. Une solution consisterait à introduire les prestataires de village dans le système formel des prestations de soins post-avortement, tout en cherchant à résoudre simultanément le problème des mœurs socioculturelles prédominantes qui découragent les femmes atteintes de complications d'un avortement de chercher à obtenir des soins de plus haut niveau.

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CALL FOR PAPERS

The reproductive health of women around the world is compromised by violence, often perpetrated by intimate partners or used as a strategy of social control or a tactic of intimidation during war. Still, relatively little is known about its frequency and effects, and how it varies geographically and culturally. To address this lack of information, the December 2004 issue of *International Family Planning Perspectives* will focus on gender-based violence. We are seeking papers on levels of violence and the effects of actual and threatened violence on contraceptive use, protection against HIV and other sexually transmitted infections, fertility and other aspects of reproductive health. We are also interested in gender-based violence occurring during war and in refugee camps. We will consider commentaries as well as qualitative and quantitative research.

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