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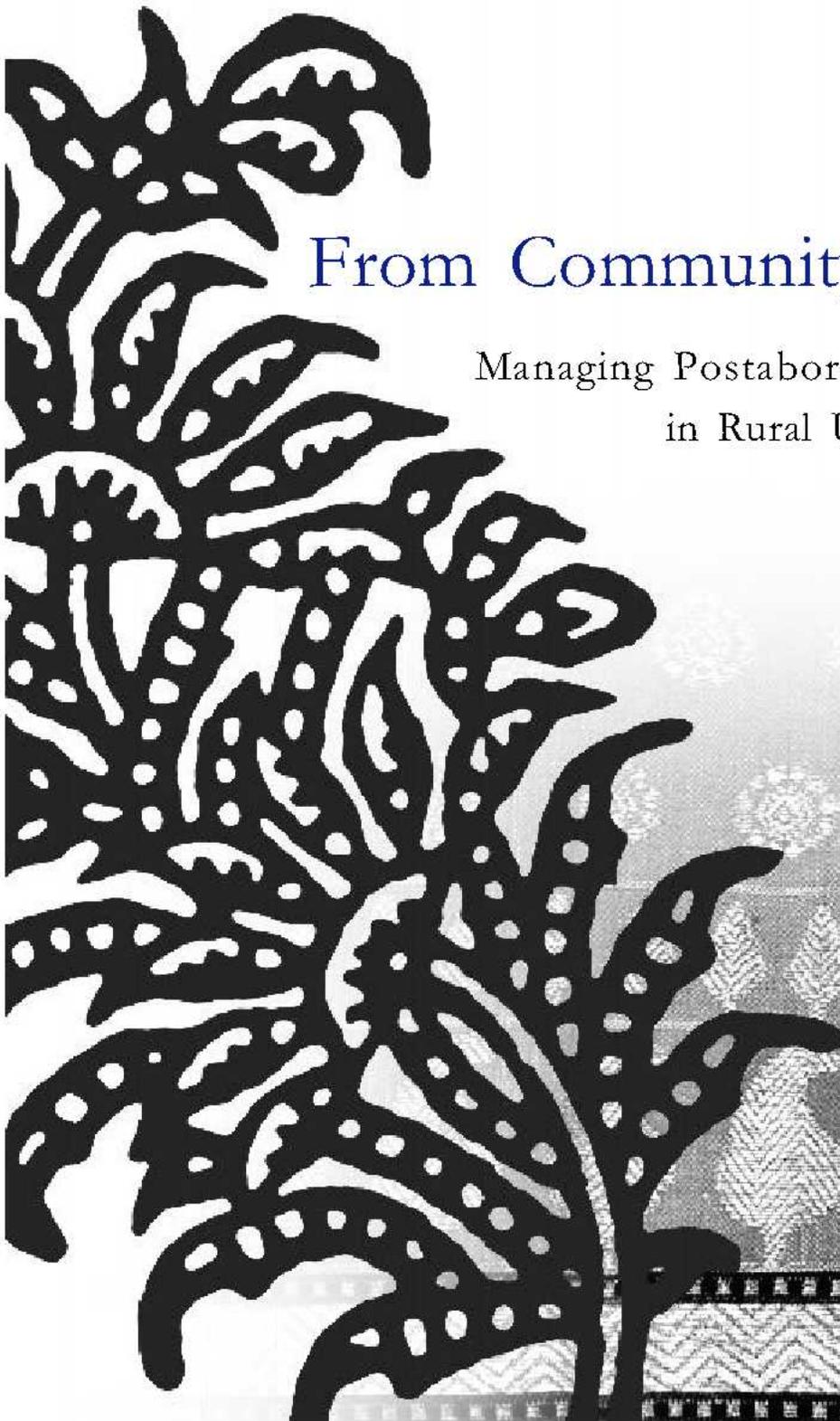


## From Community to Action

Managing Postabortion Complications  
in Rural Uttar Pradesh, India

*A Qualitative Study*

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# The Situation in Uttar Pradesh

Countless women suffer from postabortion complications each year in India. Women with access to the fewest resources—low-income rural women and adolescents, for example—are most likely to develop complications from spontaneous abortions or from unsafe abortions performed by untrained or unskilled providers.<sup>1</sup> These complications constitute a growing public health concern in the state of Uttar Pradesh in northern India.

With the plains of the sacred Ganges River dominating much of its landscape, Uttar Pradesh is a place of rich history and daunting modern challenges. Uttar Pradesh is home to more than 15% of India's population, but ranks near or at the bottom among Indian states in per capita income, literacy rates (only 42.7% for females over six years old), life expectancy, electrification, and teacher/pupil ratios.<sup>2</sup> Uttar Pradesh has one of India's highest fertility rates (3.99 TFR) and among the nation's highest rates of infant mortality and malnourished children.<sup>3</sup> Postabortion complications

are considered widespread in Uttar Pradesh, which has a tremendous unmet need for family planning. Only 18.3% of married women of reproductive age in rural Uttar Pradesh use a modern method of contraception, and Uttar Pradesh has the second highest rate of unwanted fertility in India: one unplanned birth per woman, on average.<sup>4</sup>

The USAID-funded PRIME II Project has been active in Uttar Pradesh supporting family planning and reproductive health care provision at the primary level. Site assessments of public- and private-sector health care facilities in Uttar Pradesh coordinated in 1998 found that an unexpectedly small number of women with postabortion complications were represented in the patient records. Two key questions emerged:

- Where do women in Uttar Pradesh seek medical attention for postabortion complications?
- What standard of care do they receive from the providers they visit outside the formal health care system?



*Postabortion complications cause women mental anguish by restricting them from doing their routine chores and participating in household or agricultural duties.*

*“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 woman; non-literate; two living children.



# Engaging the Community

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Through an in-depth exploration of the community-level dynamics of postabortion care services and their management in four rural villages in Uttar Pradesh, the PRIME study endeavored to meet five objectives:

- To document and understand the decision-making processes and behavior patterns related to postabortion complications for women in Uttar Pradesh
- To determine the availability of comprehensive postabortion care at the community level
- To assess the roles that community-level health care providers can play in recognizing postabortion complications and helping women with complications access appropriate care quickly
- To examine the extent to which community-level providers are prepared to offer and actually do

offer family planning counseling and services to their postabortion care patients

- To explore medical, cultural, and logistical barriers to safe postabortion care, including gender and status dynamics, economics, distance and transportation issues, and women's relationships with the existing health care system.

In supplying information on postabortion care at the community level, this assessment lays the groundwork for the development of interventions to prevent and treat postabortion complications. The study also creates a framework for the future design of community education materials that aim to reach women and unregistered providers, encouraging rapid responses and referral to facilities where appropriate care is available.

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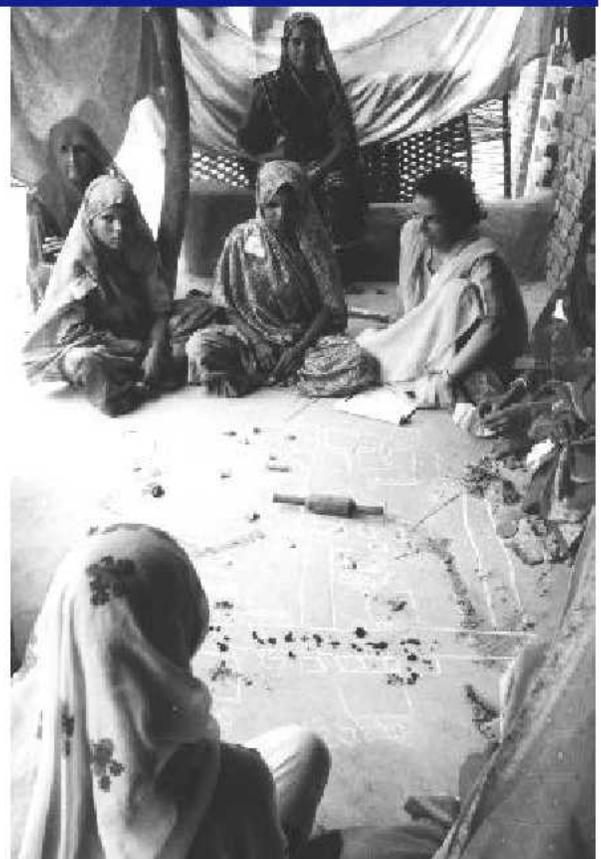
## The Four Components of Postabortion Care

Postabortion care (PAC) refers to a service delivery approach to reduce maternal mortality and morbidity.

The four elements of postabortion care are:

- Emergency treatment for postabortion complications
- Postabortion family planning counseling and services
- Linkages with other reproductive health services
- Community participation to prevent unplanned pregnancies and to support postabortion care.

*Groups of six to eight women constructed maps of their community using locally available materials. This photograph was taken during a pre-test exercise in Etah District.*





*“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.”*

—30-year-old married woman; middle-school education; six living children.

## Our Partner Institutions

Two hospitals with strong ties to communities in rural Uttar Pradesh—Kamala Nehru Memorial Hospital in Allahabad District and Christian Hospital Kasganj in Etah District—conducted the study. Both had already been working to improve family planning and reproductive health services in rural areas through grants from USAID’s Innovations in Family Planning Services Project.

In the relatively prosperous Allahabad District, the majority of households in the two villages that were studied have access to electricity, running water and radio, and literacy levels are above average for the state. Agriculture and private-sector industries are the main sources of employment. Dirt roads connect the villages to nearby towns, and transportation is available from private entrepreneurs.

Representative of less developed rural areas of Uttar Pradesh, the two villages examined by the Etah team are populated mostly by seasonal agricultural workers and consequently suffer from high rates of unemployment and poverty. An estimated 60 to 70 percent of the population is illiterate, electricity is intermittent

or nonexistent, and the dirt roads connecting the villages to nearby towns are in very poor condition, with transportation options including bicycles, bullock carts, tractor trolleys, and a few automobiles. Wells and hand pumps supply water, and few households have radios or television sets.

During the period of data collection, health care providers in the villages included *dais* (traditional birth attendants), Auxiliary Nurse Midwives (ANMs), Bachelors in Ayurvedic Medical Science (BAMS), Rural Medical Practitioners (RMPs), medical shopkeepers, untrained or informally trained practitioners both male and female, and spiritual healers. At the time of the study, none of them had been trained to provide postabortion care. Women in Allahabad District have a wider range of options for health care and are more likely to be aware of the potential hazards associated with seeking care from untrained practitioners than women in Etah District, where access to trained providers is more limited. In both areas, however, the low skill and knowledge levels of providers often present barriers to safe care.



# Collecting Information

The research teams from the two hospitals consisted of women and men with academic backgrounds, field experience in social science research, and fluency in the local dialect. Specifically for this project they received training in relevant reproductive health concepts and qualitative data collection techniques, including supervised field practice. Study participants were asked to take part in interviews only after reading or listening to an explanation of the purpose of the study, and verbally agreeing to a statement of informed consent. Interviews were conducted in settings

women and men and female and male adolescents (n = 24)

- Seeking out married women who are particularly knowledgeable about postabortion care issues at the community level and interviewing them in-depth, multiple times, as key informants (n = 53)
- Identifying providers of postabortion care services and interviewing a selection of them to purposively sample an understanding of their perspective on postabortion care services at the community level (n = 38).<sup>5</sup>

## Timeline of Delays

Women delay recognizing the complications



Decision-makers postpone the decision of whether or not to seek care

Women put off discussing the problem with husbands and other decision-makers (such as mothers-in-law)



Women try home remedies and wait to see if they will work



When a decision is made to seek care—or her care-givers—the process of access transportation and medical costs leads

that were as private as possible and the data collected were kept under lock and key at the project hospitals.

The teams embarked on a series of qualitative data collection activities:

- Compiling descriptive surveys of formal and informal organizations, institutions, and key leaders in the four selected communities
- Stimulating discussion through exercises in community mapping, a participatory research method in which community members are asked to create a visual representation of information (n = 18)
- Holding focus group discussions with specific population subgroups, including married and unmarried

These qualitative data collection methods provided a means of collecting information about the sensitive topic of postabortion care, and yielded data on both the range of perceptions and practices of the informants and the decision-making processes supporting those perceptions and practices. Attempts were made to ensure adequate coverage of specific age, religious, and caste groups. As the sampling was purposive and non-random, the data are not intended to measure incidence or prevalence of postabortion complications, attitudes about postabortion complications, or the proportion of community members in specific categories.

# Delay and More Delay

The study found that the postabortion care currently offered in the villages tends to exacerbate rather than alleviate postabortion complications. For reasons of familiarity, accessibility, discretion, and affordability, women in the communities under study turn to untrained or poorly trained village-level providers for postabortion care, even when they are aware that they would likely receive safer and more effective care at a higher-level facility. Often, these are the very same providers who performed the unsafe abortion using such methods as boiled carrot seeds, tea made with

pain) to chronic (infertility) to life threatening (referral-level providers in the Allahabad and Kasganj hospitals reported cases of intestinal gangrene and vaginal or uterine perforation). Paradoxically, the improper diagnosis, treatment, and management of postabortion complications by “affordable” village-level providers often winds up increasing the cost of treatment by necessitating multiple visits or by prolonging complications.

Making matters worse, there is often a limited understanding among both community members and village-level

Frequently, a woman, her husband, or another decision-maker, will seek care from the original abortion provider, who will, often for a profit, suggest medications

to seek care—either by the woman or her husband. The lack of access to funds to cover the costs leads to further delays



Women wait to see if the medications will be effective

An inappropriate referral to another provider, at the village or a higher level, may result in additional delays, costs, and the prolonging of complications.



or boiled carrot seeds, tea made with *jaggery* (a coarse brown sugar), and ayurvedic medicines. Occasionally more alarming techniques are employed, including the insertion of *batti* (sticks of chemicals prepared by *dais*) into the uterus or the use of dilation and curettage instruments without formal training or sterile procedures.

The majority of women (37 out of 53) interviewed in-depth had experienced postabortion complications, which

ranged from mild (prolonged bleeding, back and abdominal

providers of the urgency of appropriate treatment for postabortion complications. Some non-physician providers interviewed in the study voiced skepticism about the value of formal medical training, further decreasing the likelihood of referrals in cases where treatment of the complications is beyond the scope of the village-level provider. Informants also confirmed that social and cultural stigma adds to the reluctance of women to seek immediate care. Thus, emergency care for postabortion complications usually becomes a process of delays.



# Culture, Society, and Communication between Husband and Wife



Cultural factors—especially the inability of men and women to comfortably discuss women’s health concerns—contribute to delays in the care-seeking process. Too often, women hide obstetric problems from their husbands until they become extremely serious: “At the point when it becomes impossible for her to move around she’ll speak about it to her husband,” related a 35-year-old informant with six children. And in their position as decision-makers, husbands may serve as a barrier to appropriate care—or any care at all—for financial or other reasons: “The reality is that the woman has no say in front of the man,” said a 35-year-old mother of five children.

The sex of the provider also presents cultural issues for care-seekers and care-givers. In some instances of postabortion complications, a husband will seek medicines from a local male provider on his wife’s behalf. A woman will seek care from a local female provider. If a complication continues or becomes more serious, the husband and wife may go together to seek care at a higher level. While female providers can conduct internal examinations on female patients, male providers at the village level feel socially proscribed to perform only superficial examinations when dealing with female patients. Women display a strong preference for female providers, but this too forms an obstacle to appropriate care in situations where a qualified female provider is not available.

Not surprisingly, unmarried adolescent informants often perceived postabortion complications differently

from married women. Social stigmatization concerning abortion and the fear of sterility hold serious ramifications for young, unmarried girls, to whom the confidentiality of health care services becomes of paramount concern. As one participant in a focus group discussion with unmarried adolescent girls noted, an abortion provider has the power to “make her life a hell. There is the possibility of his blackmailing her.” The threat of community-sanctioned violence adds to the pressure felt by unmarried adolescents to keep postabortion complications a secret, consequently affecting decisions over the choice of a provider or how soon to seek care.

Perpetuating the incidence of postabortion complications in the communities under study is the fact that family planning and contraceptive counseling and services are inadequate at both the village and referral levels. Providers who do dispense contraceptives seldom appear to offer a choice of methods, and even referral-level providers seem to miss opportunities for family planning counseling, which when offered tends to be judgmental rather than supportive. Although awareness of contraceptive methods is high in the villages, usage is low and misperceptions and myths are prevalent. Women who live in purdah or other restrictive environments are especially difficult targets for public health messages, making an interaction with the formal health care system in the case of postabortion complications a particularly important opportunity for the provider to discuss contraceptive options.



*Postabortion complications have deleterious consequences on the economic well-being of families as well as on women's reproductive health.*

*“I spent 4,000 rupees and my body had to pay... I underwent various treatments for three to four months but none of them helped.”*

—30-year-old married woman; middle-school education; six living children.



## Conclusions

**F**or the foreseeable future, postabortion complications will likely continue to occur in rural Uttar Pradesh, and women will persist in seeking care at the village level for such reasons as familiarity with the provider, accessibility, and affordability. Thus, there is a need for a strong decentralized postabortion care program and referral network.

In documenting the range of postabortion care practitioners and practices at the community level in rural Uttar Pradesh, this assessment describes an informal system that has the potential to serve the local population much more effectively in terms of preventing postabortion complications and linking patients with appropriate care facilities promptly. To realize this potential, community-based providers would need to be trained to offer safe postabortion care at the level for which they are professionally qualified, to be aware of the potential dangers of postabortion complications, and to improve their referral systems in order to help facilitate higher-level care when necessary. Women and household decision-makers would need to be educated to recognize the signs of postabortion complications and to

identify situations that require treatment through the formal health care system.

Perhaps the most discouraging examples revealed by the study are the cases of couples who have had an unwanted pregnancy, an unsafe abortion and subsequent complications, but who still reject contraception. The reasons for this gap include a lack of accurate information about available methods, a fear of side effects, and the unwillingness of household decision-makers to allow contraceptive use. For the system to serve women more effectively, community-level providers would have to play a much stronger role in providing family planning counseling and services.

Another aspect of more comprehensive postabortion care—linkages with other reproductive health services—is likewise often neglected at the community level. The goal of identifying and meeting the broad range of women's reproductive health needs—including counseling for rape and domestic violence as well as infertility and subfertility issues—should be more widely recognized among community-level providers.

# Recommendations

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## Promote safe reproductive health care for women

Informational and educational messages about preventing unwanted pregnancies and increasing access to appropriate reproductive health care may encourage positive behavior change. At the community level a range of target groups could be addressed, including decision-makers, such as husbands and mothers-in-law; married women of reproductive age; adolescent males and females; providers such as *daïs*, Auxiliary Nurse Midwives, medical shopkeepers, and Indigenous Systems of Medicine Practitioners; and village leaders. Specific messages for community dissemination might include the following:

- Women with health problems deserve appropriate care
- Postabortion complications can be life-threatening
- Postabortion complications require urgent care

- Seeking safe care first is best for the woman and saves time and money in the long run
- Unwanted pregnancies and postabortion complications can be avoided when contraception is available and used properly
- After a spontaneous or induced abortion, fertility can return immediately.

Supplementary messages aimed at providers could emphasize that:

- Treating women with postabortion complications according to protocol is legal and is a medical responsibility
- Appropriate care starts at the community level and includes recognizing the complication and linking the patient to a higher-level health care facility when necessary
- A non-judgmental attitude is most effective when treating women with postabortion complications
- Women who have had postabortion complications should be counseled



*Postabortion complications can drive unmarried women—especially adolescents—to suicide.*

*“There are many girls who commit suicide because of the fear of getting a bad reputation... They get these sulfa (insecticide) tablets from the market, eat them and die.”*

*—36-year-old married woman; non-literate; three living children.*



in family planning and contraceptive methods

- Women who have had postabortion complications need to know that fertility can return immediately
- Men who accompany their wives in seeking postabortion care deserve appropriate family planning and reproductive health counseling.

### **Adopt and support a postabortion care policy at local, state, and national levels**

Policy-makers and providers at all levels need to know that postabortion care is legal and valuable in saving women's lives. Where postabortion care is not specifically addressed in local, state, and national reproductive-health service policies, guidelines could be adopted, supported, and disseminated. These guidelines would specify the types of postabortion care and family planning services that should be made available at various levels of facilities by different cadres of providers. Mechanisms could be explored to involve community members, providers, and policy-makers in pinpointing service delivery gaps

and developing intervention strategies and priorities for improving access to safe postabortion care services and referrals at the primary level.

### **Advance postabortion care service provision**

The experiences of women interviewed for this assessment indicate that to improve the quality of postabortion care in rural Uttar Pradesh, health care providers at the community level require training to offer selected reproductive health services, including postabortion care, as their professional qualifications allow. This would include training to recognize serious postabortion complications and deliver emergency care, making referrals when necessary. Access to a community-based referral network that facilitates prompt access to the appropriate level of care when emergency situations arise is critical. Similarly, rural couples would greatly benefit from community-level providers offering women and men postabortion family planning and other reproductive health counseling and services.

### **Notes**

1 Under the Medical Termination of Pregnancy Act of 1971, abortion is available legally in India during the first 20 weeks of pregnancy on a number of grounds when performed by a registered physician in a government-approved facility. However, an estimated 90 percent of abortions in India are illegally induced.

2 International Institute for Population Sciences. *National Family Health Survey Key Findings, 1998-99*. Mumbai, India, Measure DHS; 1999.

3 Ibid.

4 Ibid.

5 For a detailed examination of the study methodology and the data collected, see: Johnston HB, Ved R, Lyall N, Agarwal K. *Postabortion complications and their management: a community assessment conducted in rural Uttar Pradesh, India*. PRIME Project Technical Report No. 23. Chapel Hill, NC: Intrah (forthcoming).

### **Photo Credits**

Noah Evens (pages 6, 7, 8, 9)

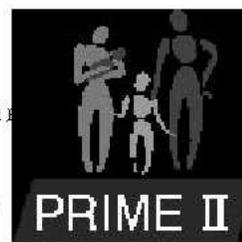
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