

ABORTION OPTIONS FOR RURAL WOMEN : CASE STUDIES FROM THE VILLAGES OF BOKARO DISTRICT, JHARKHAND

Lindsay Barnes

Abortion Assessment Project - India



Centre for Enquiry into Health and Allied Themes, Research Centre of Anusandhan Trust,
Survey No. 2804 & 2805, Aaram Society Road, Vakola, Santacruz East, Mumbai - 400055,
Maharashtra, India; Ph:(+91-22) 26673154, 26673571; Fax : 26673156; Email
:cehat@vsnl.com; www.cehat.org

First Published in September 2003

By

Centre for Enquiry into Health and Allied Themes

Survey No. 2804 & 2805

Aaram Society Road

Vakola, Santacruz (East)

Mumbai - 400 055

Tel. : 91-22-26147727 / 26132027

Fax : 22-26132039

E-mail : cehat@vsnl.com

Website : www.cehat.org

© CEHAT/HEALTHWATCH

The views and opinions expressed in this publication are those of the author alone and do not necessarily reflect the views of the collaborating organizations.

**Printed at
Chintanakshar Grafics
Mumbai 400 031**

ABORTION ASSESSEMENT PROJECT - INDIA COORDINATION

TECHNICAL ADVISORY COMMITTEE (TAC)

- q Dr. R.N. Gupta, Social Scientist and Researcher, Indian Council of Medical Research, New Delhi
- q Dr. Leela Visaria, Coordinator of Healthwatch and Researcher, New Delhi
- q Dr. Saramma Thomas Mathai, Consultant in Maternal & Child Health, New Delhi
- q Dr. Thelma Narayan, Epidemiologist - Community Health Cell, Bangalore
- q Dr. Padmini Swaminathan, Senior Economist and Researcher, Madras Institute of Development Studies, Chennai
- q Ms. Manisha Gupte, Health and Women's Activist, Mahila Sarvangeen Utkarsha Mandal (MASUM), Pune
- q Dr. Sudarshan Iyengar, Researcher and Academician, Director of Gujarat Institute of Development Research, Ahmedabad
- q Ms. Sudha Tewari, Provider of Abortion Services, Parivar Seva Sanstha, New Delhi
- q Dr. Kamini Rao, Professional, President Federation of Obstetrician and Gynaecological Societies of India (FOGSI), Bangalore
- q Dr. Narika Namshum, Asst. Commissioner (Maternal Health), Dept. of Family Welfare, Government of India, New Delhi
- q Ms. Ena Singh, Assistant Representative in UNFPA India Country Office, a member in her personal capacity as an experienced Research Administrator, New Delhi

ETHICS CONSULTATIVE GROUP (ECG)

- q Dr. Sudarshan Iyengar, Representing the TAC, Gujarat Institute of Development Research, Ahmedabad
- q Dr. S.V. Joga Rao, National Law School of India University, Bangalore
- q Dr. Sanjay Gupte, Chairperson, Ethics and Medico-Legal Committee, Federation of Obstetrician and Gynaecological Societies of India (FOGSI), Pune
- q Dr. Vasantha Muthuswami, Expert on Bio-Medical Ethics DDG (SG), Indian Council of Medical Research, New Delhi
- q Dr. Ritu Priya, Researcher and Academician Jawaharlal Nehru University, New Delhi
- q Ms. Padma Prakash, Associate Editor, Economic and Political Weekly, Mumbai
- q Dr. V.R. Muraleedharan, Researcher and Academician, Department of Humanities and Social Sciences Indian Institute of Technology, Chennai
- q Dr. Amar Jesani, Trustee, Anusandhan Trust, Founder Member of Forum for Medical Ethics, Presently Visiting Faculty, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Thiruvananthapuram, Kerala

PROJECT CO-ORDINATORS

Ravi Duggal

Coordinator, CEHAT, Mumbai.

Vimala Ramachandran

Managing Trustee, HEALTHWATCH TRUST, New Delhi

SECRETARIAT

Centre for Enquiry into Health and Allied Themes (CEHAT)

Research Centre of Anusandhan Trust

Survey No.2804 and 2805, Aaram Society Road, Vakola, Santacruz (East), Mumbai 400055

Tel. : 91-22-2614 7727/26132027 Email: cehat@vsnl.com

TABLE OF CONTENTS

PREFACE.....	v
ABSTRACT.....	vii
GLOSSARY OF TERMS AND ACRONYMS.....	viii
I. BACKGROUND.....	1
II. METHODOLOGY.....	2
III. SELECTION METHOD.....	2
IV. PROFILE OF THE WOMEN.....	4
V. PREVENTING UNWANTED PREGNANCIES: WOMEN'S EXPERIENCE OF CONTRACEPTION.....	5
A. CONTRACEPTION USE PRIOR TO ABORTION.....	
B. CONTRACEPTION USE FOLLOWING ABORTION.....	
VI. THE ABORTION OPTIONS AVAILABLE: SERVICE PROVIDERS AND TECHNIQUES.....	7
A. QUALIFIED MEDICAL PRACTITIONERS (PRIVATE/GOVERNMENT).....	
B. UNQUALIFIED MEDICAL PRACTITIONERS.....	
C. FEMALE HERBAL PRACTITIONERS.....	
VII. DEALING WITH UNWANTED PREGNANCIES : RURAL WOMEN'S EXPERIENCES OF ABORTION.....	10
A. DECISION-MAKING AND ABORTION.....	
B. THE ABORTION EXPERIENCE.....	
C. COST AND ABORTION CARE.....	
D. ACCESSIBILITY AND ABORTION.....	
E. IMPACT ON WOMEN'S HEALTH.....	
VIII. CASES OF ABORTION-RELATED DEATHS..... NOT INCLUDED IN THIS STUDY.....	14
IX. DISCUSSION.....	15
X. APPENDIX.....	
1. APPENDIX I ABORTION ASSESSMENT SCHEDULE.....	17

PREFACE

Abortions have been around forever. But at different points of time in history it has received attention for differing reasons, some in support of it, but often against it. Abortion is primarily a health concern of women but it is increasingly being governed by patriarchal interests which more often than not curb the freedom of women to seek abortion as a right.

In present times with the entire focus of women's health being on her reproduction, infact preventing or terminating it, abortion practice becomes a critical issue. Given the official perspective of understanding abortion within the context of contraception, it is important to review abortion and abortion practice in India.

The Abortion Assessment Project India (AAP-I) has evolved precisely with this concern and a wide range of studies are being undertaken by a number of institutions and researchers across the length and breadth of the country. The project has five components:

- I. Overview paper on policy related issues, series of working papers based on existing data / research and workshops to pool existing knowledge and information in order to feed into this project.
- II. Multicentric facility survey in six states focusing on the numerous dimensions of provision of abortion services in the public and private sectors
- III. Eight qualitative studies on specific issues to compliment the multicentric studies. These would attempt to under-

stand the abortion and related issues from the women's perspective.

- IV. Household studies to estimate incidence of abortion in two states in India.
- V. Dissemination of information and literature widely and development of an advocacy strategy

This five pronged approach will, hopefully, capture the complex situation as it is obtained on the ground and also give policy makers, administrators and medical professionals' valuable insights into abortion care and what are the areas for public policy interventions and advocacy.

The present publication is the second in the AAP-I series of working papers. Lindsay Barnes has conducted a survey in Bokaro district in newly created Jharkhand state and presented first hand information on safe and legal abortion services scenario in the area.

We thanks Sunanda Bhattacharjea for assisting in the language editing of this publication and Mr. Ravindra Thipse, Ms. Muriel Carvalho and Margaret Rodrigues for timely publication of this entire series.

This working paper series has been supported from project grants from Rockefeller Foundation, USA and The Ford Foundation, New Delhi. We acknowledge this support gratefully.

We look forward to comments and feedback which may be sent to cehat@vsnl.com Information on this project can be obtained by writing to us or accessing it from the website www.cehat.org

22nd September 2003

Ravi Duggal
Coordinator, **CEHAT**

ABSTRACT

This study aimed to document poor, rural women's experience of abortion in a backward part of the Bokaro district in Jharkhand. Twenty five women who had experienced abortions during the previous two years were selected, and interviewed utilizing a semi-structured questionnaire. A small number of service providers were also interviewed.

All the women were married, and most had accessed abortions after reaching their optimum family size. The average age of the women was 31.2 years. Only two women in the study were literate, and were mostly tribal, Muslim, backward and scheduled caste.

The study highlighted the total lack of accessible, affordable and safe abortion services. Only three

women experienced a complication-free, safe abortion from a single, qualified service provider. Fifteen women had to access care from more than one provider, since the complications that arose could not, normally, be managed by the same provider. Women of-

ten accessed different methods of abortion, which added to cost and risk.

The crucial role of the unqualified rural medical practitioners was noted: as providers of abortion services, and as agents for service providers. These private, unqualified practitioners were found to have a negative impact on women's health, and gain financially from the promotion of abortion. None had provided contraceptive counseling, warned women of the dangers of repeated abortion or the risks of infection.

None of the women in the study had availed government services for abortion care, or for the management of abortion-related complications. Apart from the four women who accessed abortions from the hospital of Bokaro Steel Plant (since they agreed to undergo the compulsory sterilization) all women had accessed illegal abortion services. The study shows that in a system dominated by private practitioners, abortion care becomes a lucrative source of profit, and women's overall health and well-being is a low priority.

GLOSSARY OF TERMS AND ACRONYMS

BGH	Bokaro General Hospital
D&C	Dilation and Curettage
D&E	Dilation and Evacuation
DGO	Diploma in Gynaecology & Obstetrics
FHP	Female Herbal Practitioner
IUD	Intrauterine Device
MMS	<i>Mahila Mandal Samiti</i>
MMWSHG	<i>Mahila Mandal Women's Self Help Groups</i>
MTP	Medical termination of Pregnancy
OCPs	Oral Contraceptive Pills
RCH	Reproductive & Child Health
RMP	Rural Medical Practitioner

ABORTION OPTIONS FOR RURAL WOMEN : CASE STUDIES FROM VILLAGES OF BOKARO DISTRICT, JHARKHAND

The aim of this study is to document poor, rural women's experience of abortion in a backward part of the Bokaro district in Jharkhand. We hope to explore what women do when faced with an unwanted pregnancy, and what obstacles they face in accessing safe and accessible abortion.

I. BACKGROUND

Although the medical termination of pregnancy (MTP) has been legalised for almost 30 years and abortion care is supposedly provided for in the Government's 'Reproductive and Child Health' (RCH) program, safe and legal abortion remains inaccessible for the vast majority of rural women in Jharkhand. Poor, village women continue to risk their lives and health in seeking termination of an unwanted pregnancy. The collapse of the government's health system, the non-availability of birth spacing methods in spite of the priority given to the promotion of family planning, has further exacerbated this problem.

Bokaro district, in the newly created Jharkhand State, is typical of the sort of development that is taking place. Although the state has a well-equipped hospital, it is available only for the employees of the steel plant. Safe and legal abortion services are available in the hospital, but the service charges prohibit the vast majority of poor women from accessing the service.

If women agree to undergo tubectomies, abortion services at the Bokaro General

Hospital (BGH) are provided free of cost. However, the bureaucratic obstacles to get admission, the number of visits needed, the amount of time involved, have all served to deter many women from accessing this facility. Besides, during the busy 'family planning campaign season', from November to March, this service is in practice withdrawn. Women with unwanted pregnancies are refused admission.

The government health centres in the district do not provide regular birth spacing services, delivery care, let alone abortion services. The government's referral hospital does not have the facilities to perform a major surgery that may be needed during obstetric emergencies or as a result of abortion complications (such as perforation of the uterus, which may necessitate a hysterectomy). The Civil Surgeon informed us that no government doctor in the district is qualified to provide abortion services.

Faced with an unwanted pregnancy, poor village women have the following 'options':

- 1 To continue with the pregnancy
- 1 Agree to undergo a tubectomy and try to get admission into Bokaro General Hospital
- 1 Access (illegal) abortion from a qualified, private (MBBS/ MBBS & Diploma in Gynaecology & Obstetrics[DGO]) doctor in Bokaro
- 1 Access (illegal and unsafe) abortion care from an unqualified allopathic medical

practitioner (RMP/ unqualified 'nurse')) in the city or at village level

- 1 Access (illegal and unsafe) abortion care from a female herbal practitioner (FHP)

A cloud of illegality surrounds abortion care, with almost all medical practitioners in the district involved in providing illegal services. Most village women are ignorant of the fact that the termination of pregnancy is not illegal. This has all resulted in the detriment of their health, and added to cost.

There are few studies of women's actual experience of illegal abortion, which is the most common form of service available to the vast majority of women in India. In the villages of Bokaro district, there is no sharp dividing line between the varieties of abortion services accessed by poor women. The popular perception of the 'modern', clean and safe medical abortion techniques practiced by qualified doctors on the one hand and the 'traditional' unsafe practices of village midwives on the other, is much more complicated in reality. This study aims to unearth the sort of abortion service women are actually availing, and what the obstacles they face actually are in accessing quality care.

II. METHODOLOGY

The author is currently involved in organising women's reproductive health services through a federation of over 200 self help groups, with a membership of around 5000 women, in the Chas and Chandankiari blocks of Bokaro district. This federation, the 'Mahila Mandal Samiti' (MMS), has helped set up a women's health centre, in which a weekly reproductive health clinic is organised, attended by a qualified gynaecologist. Many members of the groups access health services from this centre, and often come for advice regarding unwanted pregnancies, for help in accessing abortion and tubal ligation operations from Bokaro General Hospital, and with complications from unsafe abortions. The health centre does not provide abortion services, and can only refer

women. Few women, however, access the safe abortion care as advised, and most resort to unsafe practitioners or continue with the pregnancy.

At the time of the interview, December 2002, the need for safe abortion services was very much on the agenda of the 'Mahila Mandal Samiti'. During the previous year three members of the women's groups had died due to unsafe abortions. Two of these women had approached the women's health centre for help in terminating their early, unwanted pregnancies. They were referred to Bokaro General Hospital (if they were ready to accept sterilisation) or to a private, qualified medical practitioner. Neither followed these routes. Their deaths were widely discussed in the women's groups, leading to a questioning of referral practices and the demand for easier, safer, accessible abortion services. The women's health centre hopes to be able to provide safe and early abortion in the near future.

This study coincided with this increased concern amongst members for abortion services, and most women were willing to participate in the interviews. The author also felt that documentation of rural women's experience of unsafe and illegal abortion ought to be highlighted for local advocacy at district and state level.

Through the network of women's groups and the health centre, 25 village women were identified who had experienced abortion in the last 2 years. All the women were members of the 'mahila mandals' (self help groups), and the author knew them. The 25 women are 'representative' of the members of these groups, (most members of the groups are mainly lower caste, tribal or Muslim; poor marginal farmers or involved in petty trading) although no 'sampling' was undertaken.

III. SELECTION METHOD

This method of selection was undertaken for several ethical and practical reasons:

1. Almost all abortions in the private sector are 'illegal', and most women are vaguely aware of this. It was anticipated that women unfamiliar to the group would be reluctant to discuss their experience of abortion. Even amongst group members, who were personally known to the author, some were unwilling to discuss their experience, and interviews could not be undertaken. It was only through the women's groups and the health centre that women could be contacted, and sufficient trust established for meaningful interviews to be undertaken.
2. It was felt that women would feel reluctant to discuss their experience of abortion with strangers - since abortion was an unpleasant experience in their life, best forgotten about. Since the women's health centre could not provide free health care for post-abortion complications, the question might arise as to the usefulness of divulging such personal information. If the woman was experiencing no current health problem, she would probably be unwilling to spend time on the interview.
3. The women selected for this study were married and middle-aged and were accessing abortions after completion of their families. The author has helped several young, unmarried girls and older widows to access safe abortion care over the last few years. However, these girls and women were unwilling to participate in this study. Few rural women seek abortion services as a birth spacing method, and usually continue with unwanted pregnancies rather than opt for termination, if their family size has not been reached. (This may not be the case in the urban centres, as reported by private practitioners, but their experience was beyond the scope of this study)
4. All these interviews were undertaken during the month of December 2002. Each woman contacted for this study was approached firstly by women health workers, and then interviewed by the author. Most of the interviews took place in the health centre, except those of women who lived more than 15 kilometres away. Their interviews took place at home. Since each interview took more than three hours to complete, restrictions of time also influenced the selection of women.
5. The focus of this study was to collect qualitative data, documenting women's experiences. Therefore the 'sample' size needed to be kept small.

A semi-structured interview schedule was utilised to collect information regarding their experience of abortion. A copy of this schedule is provided in Appendix 1. Excerpts from these interviews have been included in this paper to better portray rural women's experiences in dealing with unwanted pregnancies.

Apart from the case studies, interviews with a small number of service providers were also undertaken. Questionnaires were not used, but they were asked about their methods, costs, and the problems that they face.

Only three qualified gynaecologists agreed to discuss their methods of terminating an unwanted pregnancy. All were private practitioners, and were known to the author earlier. Two were based in Bokaro and one in Dhanbad. Several doctors were approached, but few agreed. There are no registered private MTP centres in the whole district. No private practitioner records the patients' pregnancy status and duration, whether an earlier abortion has been performed, or the medicines used. Only BGH legally provides abortion care, but the doctors there were not interviewed for this study.

Five RMPs were interviewed during the course of the study. All of them were husbands of the group's members. They were all village-based, educated (up to matriculation level), lower caste Hindus, and were part-time medical practitioners. The full-time, richer, higher caste RMPs, not known to the author, were not willing to divulge any information regarding their methods.

The two female herbal practitioners were also group members. One was a lower caste Hindu, and the other a tribal. Both were poor, marginal farmers.

Contrary to expectations, these unqualified 'doctors' (RMPs) and female herbal practitioners were much more forthcoming than the qualified medical practitioners were, but that was perhaps because the author knew them. They were, possibly, ignorant of the illegality of the service they provide. Full-time RMPs, nurses and private medical practitioners (MBBS, but not gynaecologists) were not willing to participate in this study.

IV. PROFILE OF THE WOMEN

A profile of the women selected for this study has been provided in Table 1. As can be seen, all the women are from families of scheduled castes and tribes, Muslims or other backward castes. The experiences of higher caste women in abortion care could not be highlighted in this study since the women's groups, and the health centre which helped identify the women that had undergone abortion, work closely and are involved with these communities. However the lower caste, tribals and Muslims do dominate the rural parts of the Chas and Chandankiari blocks, where this study was located.

22 out of the 25 women who were interviewed for this study had undergone abortion in the past 2 years and lived in villages more than 16 kilometres away from any urban centre. The nearest town for most of these women was Chas, which lies adjacent

to Bokaro Steel City. Two women from one village lived closer to Jharia, which is in Dhanbad district.

Only one of their husbands was employed in government service, one was employed in the coal mines, and one more had a small business. The rest of the women were from poor families of marginal farmers and daily wage earners. The educational level of the women was low, 20 were non-literate, one was a 'matric-fail', one was educated up to 7th standard, and three more were only able to sign their names. The men folk were marginally better, eighteen were non-literate, two were graduates, two were matriculates, one was 'matric-fail' and two were educated up to Class 7.

The number of children that the women who sought abortion had birthed ranged from 2 to 7, with the average being 4.1. All of them had at least one male child before undergoing an induced abortion. Only one of the women accessed abortion as a means to space births; the rest had already reached their optimum family size when they decided to terminate their unwanted pregnancy. Most villagers here are still unaware about sex determination tests, and none of these women aborted a foetus after determining its Sex.

Neonatal and infant mortality is high amongst these women. 16 women had lost one or more children. 11 women had experienced one or more neonatal death (1 woman had lost 2 babies, and one had lost 3). 5 women had lost one or more children (1 woman lost 2 children). Ten women had experienced more than one spontaneous abortion (1 had 2 spontaneous abortions).

Most of the women, since they were accessing abortion after completing their families, were in their early and mid 'thirties. The oldest was 38, and the youngest was 23. The average age was 31.2 years.

Table 1. Profile of 25 Women

A.	Age Group	Number of Women
	30 years and below	12
	31 to 35 years	9
	Above 36 years	4
B.	Social Group	
	Scheduled tribe	8
	Backward/scheduled castes	9
	Muslim	6
	Other Hindu castes	2
C.	Educational level	
	Literate	2
	Non/barely literate	23
D.	Number of Children	
	2	1
	3	8
	4	8
	5	4
	6	3
	7	1
E.	Number of Spontaneous Abortions	
	0	15
	1	9
	2	1
F.	Number of Neonatal deaths	
	0	14
	1	9
	2	1
	3	1
G.	Number of Infant Deaths	
	0	20
	1	4
	2	1

V. PREVENTING UNWANTED PREGNANCIES : WOMEN'S EXPERIENCE OF CONTRACEPTION

Women resort to abortion with an unwanted pregnancy. It was therefore useful to understand what women in this area had tried to do to prevent such pregnancies.

A. CONTRACEPTION USE PRIOR TO ABORTION

Use of modern, temporary methods of contraception for spacing births was low (see Table 2). 14 of the women had never accessed any sort of method before undergoing abortion. Five women had earlier used oral contraceptive pills (OCPs), and one had had an intrauterine device (IUD) inserted (and removed after 1 year), 2 had used condoms and 3 women had tried herbal medicines. Two of the women who had taken OCPs had stopped taking them due to nausea and dizziness, another two stopped for fear of long-term side effects and one stopped because she thought she was too old to conceive again. The woman who removed the IUD complained of lower abdominal pain, which she attributed to the device.

Most women, however, are aware of at least one method of contraception. All of them knew about tubal ligation operations (female sterilisation), 10 knew that men could also undergo vasectomy, 18 knew about OCPs and 17 knew about condoms. Only 7 had heard of IUDs. Knowledge of accessibility of all these different methods however was low. Although all knew that sterilisation operations were available in Bokaro General Hospital, they remained ignorant about how to actually go and get admission on their own. The women were not in favour of vasectomy, and usually laughed at the idea! Most women prefer to access contraception or sterilisation themselves, rather than leave it to the men.

15 of the 18 women, who had heard of OCPs, knew where to access them, but did not wish to take pills every day, or were anxious about their side effects. 14 women expressed the idea that women needed to be healthy in order to take OCPs. 'How could I take pills every day, do I have enough blood in my body?' was stated frequently. The idea that OCP causes anaemia and weakness is common.

'I was taking pills for five or six months, but people told me that my blood would dry up if I carried on taking them. So I stopped taking them. Then I became pregnant again...' (N Devi of S village)

Two women stopped taking OCPs because they thought their blood would dry up, even though they were not experiencing any unpleasant side effects.

Most women felt that men would not use condoms regularly. One woman told us that her husband refused to use them claiming that his blood would dry up.

Of the 7 women who had heard of IUDs, 5 had heard that there are serious side effects.

'I knew about "copper-T", but villagers told me that it would lead to cancer. So then I got it removed. One year later I had to go to get it "washed" again...' (S Devi of C village)

Four women in this study assumed that IUDs lead to cancer.

Although there was considerable awareness of contraceptive methods, there was a great deal of misunderstanding regarding the side effects, particularly over long term use. Much of the misinformation stems from the RMPs, who are found in every village. Since most women are weak and anaemic, and birth spacing methods yield low profits, RMPs often counsel women to consume tonics and vitamin capsules to 'compensate' for the adverse effects of OCPs or IUDs. Poor women, who cannot afford tonics and vitamin injections, conclude that it is better to avoid contraception.

On the whole women had little access to accurate information regarding the risks and possible side effects of modern methods of birth spacing. Few 'doctors' - qualified or unqualified - provide rural women with sufficient or accurate information to enable them to make an informed choice. The government health workers, on the other hand, underplay any possible side effect, in

order to fulfil their targets. Consequently many women have heard of contraceptive methods, but are apprehensive about the side effects. They no longer want more than 3 or 4 children (unless they have only daughters) which leaves them vulnerable to unwanted pregnancies. RMPs warn women of the risks of contraception, but not of repeated abortions. Few of the women in this study were aware of the risks of abortion at the time they had undergone it.

Table 2. Contraception Prior to Abortion

Contraceptive method used	Number of women
Oral contraceptive pills	5
IUD (Copper-T)	1
Condoms	2
Herbal	3
Nothing	14

B. CONTRACEPTION USE FOLLOWING ABORTION

Since undergoing termination of pregnancy, 18 women have already opted for tubal ligation (four had undergone both sterilisation and MTP at the same time in Bokaro General Hospital) Two women are now taking OCPs, and one is using condoms. Only four out of twenty-five women are currently using no method at all to prevent further conception. (See Table 3)

All the women in the sample who had undergone ligation, and those who had undergone MTP at the same time, at BGH, were helped to get admission by the women's health centre.

The high number of women who opted for tubal ligation following abortion is probably due to the help provided by the women's health centre of the 'Mahila Mandal Samiti' in taking women to BGH. It also indicates that the women in this sample were not, on the whole, using abortion as a method of spacing births. Regardless of caste or com-

munity women's preference for terminal methods of limiting family size is also brought out. The health centre provides all modern methods of temporary birth spacing that are available in the government health centres - IUDs, OCPs and condoms - but most women still preferred permanent sterilisation. Women are also counselled against repeated abortions, and advised to access some method of contraception.

Most women felt that tubal ligation operations were more risky than abortion, and needed more rest and better nutrition than they could usually avail. This was the main reason why four of the women in the sample had opted for abortion but were not using any sort of contraception following abortion.

A severely anaemic woman made the following comments, after undergoing three abortions in four years, she was of the opinion that tubal ligation operations led to anaemia, but she had no such reservations about abortions. Two abortions were performed on women who stated that they are 'alone' when no other working female hands are in the household and therefore preferred it to an operation.

'When will I manage to go for "operation"? I am alone in this household. If I go for operation I'll need to rest for at least a month. Who will do all the housework? And look at me! Am I strong enough? I don't have enough blood in my body. You have to be healthy to go for operation.' (D Devi, of S1 village)

Table 3. Contraceptive Use Following Abortion

Contraception Used	Number of Women
Oral contraceptive pills	2
IUDs (Copper-T)	0
Condoms	1
Herbal	0
Sterilisation (Tubal ligation)	18
Nothing	4

VI. THE ABORTION OPTIONS AVAILABLE: SERVICE PROVIDERS AND TECHNIQUES

In order to terminate an unwanted pregnancy, village women can 'choose' from one of the following service providers:

1. Qualified gynaecologists (Either in Bokaro General Hospital or private practitioners) (MBBS/[Diploma in Gynaecology and Obstetrics] DGO) and qualified medical practitioners (MBBS) (not gynaecologists),
 2. Unqualified medical practitioners (male RMPs - 'Rural' rather than 'Registered' Medical Practitioner, since few are actually 'registered') and unqualified 'nurses',
 3. Female herbal practitioners (FHPs)
- A. QUALIFIED MEDICAL PRACTITIONERS (PRIVATE/GOVERNMENT)

Qualified gynaecologists are available for providing abortion services in Bokaro Steel City, (either in the Bokaro General Hospital or in private nursing homes), Jharia (Dhanbad district) and Purulia (in the state of West Bengal). Village women do not access abortion facilities at BGH unless they are willing to undergo tubal ligation, and even then only if it is not the busy winter months. However, they do use these services if they have experienced a serious abortion-related complication, which no other private nursing home is prepared to handle. Most village women do not usually access abortion services provided by qualified gynaecologists, unless complications have already arisen as a result of interventions by other practitioners. Qualified gynaecologists are more expensive than other medical practitioners, and usually cater to the needs of richer villagers and the urban middle class. In this study only 3 women accessed abortion from a private qualified gynaecologist directly, in two cases only after referral by the women's community centre.

I prefer to only terminate pregnancies up to 12 weeks pregnancy, as it is relatively easy and safe. Still there are risks, many of the women who come to me are lactating mothers and their uterus is very soft. This makes it more difficult and risky. I use 'Prostodin' to make the uterus hard in such cases, but this increases the cost. I know other doctors are much cheaper, but I refuse to take such risks. Many women from villages come with unwanted pregnancies after taking ayurvedic drugs that are freely available in the shops. They are often brought by the same RMP that has given the medicine to them. In the beginning they used to tell me, "I'll take two hundred and you take a hundred". Depending upon the relationship with the doctor, they dictate in this way. I refuse to oblige them, even if this means they go elsewhere....' (Private gynaecologist, Bokaro)

More village women access the services of private medical practitioners, MBBS-qualified doctors, since they are cheaper than gynaecologists. Most of them are based in Chas, which is adjacent to Bokaro Steel City. They have developed strong linkages with village-based RMPs. Many RMPs have learnt their 'skills' in the nursing homes of these doctors.

The qualified gynaecologists and medical practitioners normally conduct abortions by D&E (dilation and evacuation) method. There is no record on the prescriptions of any of the qualified private medical practitioners that medical termination of pregnancy has been undertaken. The sort of procedure that a woman has undergone whilst going through an abortion can only be guessed at from her narrative. The medicines that have been given, the number of weeks of pregnancy, are never found in written form.

B. UNQUALIFIED MEDICAL PRACTITIONERS

Having learnt their 'skills' in the nursing homes of the private medical practitio-

ners, the RMPs receive commissions from the doctor when they bring them abortion cases. The unqualified 'nurses' that work in these nursing homes have also learnt their 'skills' on the job, and sometimes assist RMPs in conducting abortions in the villages of Chas and Chandankiari. These 'nurses' are sometimes called by RMPs to conduct abortions in village homes where, once again, the latter get around 50 per cent of the service charges as their commission. RMPs alone are also conducting abortions, using the D&E method, in their own 'nursing homes', and sometimes in the home of the woman.

Most RMPs, however, do not themselves perform abortions. They administer a variety of medicines, combinations of ayurvedic and allopathic drugs to induce abortion. The ayurvedic preparations they use are administered in the same way as allopathic drugs. These ayurvedic drugs are in tablet/capsule form, freely available in chemist shops, and some MBBS doctors even prescribe them.

'See, if a woman has only missed two months, then only these medicines will work. I use "Gynomic Forte" (an ayurvedic capsule). On the packet it's written once a day, but all of us doctors, including MBBS doctors, give this medicine twice or even thrice a day. Along with this I give "Lariago" (chloroquin) for three days. I give antibiotic coverage, like "Tetracycline" for three days, and vitamin injections of course. I suppose around 50 per cent are successful using these drugs. If this doesn't work, then I advise them to go for a D & C. I don't take them anywhere, it's up to them. It's not worth my while to spend the whole day to take them, and how much will they pay? Fifty or a hundred rupees, it's not worth it. If they want to continue with the pregnancy, then I give B Complex capsules, this compensates for the earlier drugs and all the babies I've seen have come out well.' (A. M, RMP, Chandankiari)

'Getting abortions done is no problem at all. If it's early enough, say less than two months, then I give EPForTE. This is the main medicine for causing abortion. It has to be taken with hot tea, otherwise it won't work. Of course I give an injection or two, otherwise how can I earn? RPForte doesn't cost much. Other doctors give "Lariago", which is a malaria medicine really, but I don't. I give "chloramphenicol" by injection. If this doesn't work, or if the woman is more than two months pregnant, then I take her for a dilation and curettage (D&C) to one medicine shop at the roadside. One doctor from Jharia comes every week for doing D&Cs. I round up 3 or 4 cases every week for him. The doctor gets three hundred and I get two hundred rupees. With medicines the total cost is about seven hundred.' (S R, RMP, Chandankiari)

RMPs are also called upon to give injections if heavy bleeding occurs as a result of methods used by other practitioners. They 'partner' with both MBBS doctors in Chas as well as female herbal practitioners in the village.

C. FEMALE HERBAL PRACTITIONERS

The female herbal practitioners are not, as is commonly assumed, traditional birth attendants or 'dais'. None of the 'dais' in this area was found to be conducting abortions. There are, however, several women who have learnt how to induce abortion. These women do not normally provide any other health service to women apart from inducing abortions.

The female herbal practitioners have a variety of methods. Some administer herbal concoctions orally, and some insert them into the cervix of the woman with a stick. Some remove the stick immediately, and some leave it until it is expelled along with

'I learnt how to do abortions around ten years ago, when I was working in Jharia. One nurse there taught me. I use a small neem stick, and I put medicines on the tip, which are inserted into the mouth of the uterus. I bring this medicine from Katras, it's not available near here. There are more problems when the woman is only two or three months only, the baby isn't fully formed, and bits get stuck inside. The best month is the fourth. After the fifth month then sometimes heavy bleeding take place, so I call a doctor to be on hand, so that he can give injections. I don't go beyond the sixth month. I give the medicine in the home of the woman, or I send her home after giving it to her here. I don't want her aborting here in my house. Sometimes the baby is born alive, now what would I do then? I tell them all that if anything goes wrong, it's their problem. They'll have to make arrangements to go to some hospital. Most of the women who come to me are tribals, especially unmarried girls. I charge one hundred rupees for every month of pregnancy....' (FD, herbal practitioner, Chandankiari)

the foetus. Although these women discussed the methods they use, they were not prepared to divulge the drug composition. The popular belief here is that if the composition is known the medicine becomes ineffective.

'I learnt from my mother-in-law how to cause abortions. I have to buy some of the medicines, and grind it up with some herbs from the jungle. I only give medicines orally. With every month of pregnancy, I simply increase the amount of medicine given. I charge one hundred rupees per month...' (B Devi, herbal practitioner, Chandankiari)

VII. DEALING WITH UNWANTED PREGNANCIES: RURAL WOMEN'S EXPERIENCES OF ABORTION

A. DECISION-MAKING AND ABORTION

The decision to undergo an abortion was in all cases made by the woman, or the woman along with her husband. In no case was the woman forced to undergo abortion against her wishes. In 3 cases the women induced abortion without the prior knowledge of their husbands.

'First of all I went to the doctor who sits in our village. I didn't tell my husband at that time. He would have said, "Let the child be born, I'll take care of it." But I'd had enough. I have six children - and two who are no more. So that doctor called one nurse from Chandankiari. He gave me an injection and she gave me some pills. I had only missed two months then. I started bleeding soon after, but the main thing was stuck inside. I carried on bleeding for a month. Then he called another doctor. He said the placenta was stuck inside. Then I went to Chas to a nursing home. The doctor said I was more than three months at the time.' (R Bibi, village, Chandankiari)

'I went alone to the woman for abortion. I only told my husband later. What was the need of him knowing? He's not that bothered.' (S Devi, S2 village, Chandankiari)

The men folk, however, often influenced the sort of service accessed. Knowledge of the different methods of aborting unwanted pregnancies is widespread. Thirteen women who consulted the doctor at the 'Mahila Mandal Samiti's health centre prior to the abortion were informed about the options available to them, and the risks involved. Five women who did not consult the health centre were guided by other village women, four by their husbands and three by local medical practitioners.

'I came here when I had only missed one moon, and you told me to go for abortion in Bokaro, and to discuss what to do with my

husband. Well he talked to a "doctor" in Babudi who said he'd get it done. So he brought one "doctor", who brought along a "nurse" from Chas. She came and inserted some pipe into me. God knows what she did. I started having severe cramps, and bleeding, but nothing came out. The "doctor" brought the "nurse" back again in the afternoon, and she put these big spoons inside me. I don't know what came out, but I carried on bleeding for a month. After that I had to go for another "wash" in Bokaro....' (J Bibi, A village)

'I had gone along to the "doctor's" house with another woman from our village. The village "doctor" had told my husband that he could get a "wash" done for three hundred rupees only. He wasn't a real "doctor", or it wouldn't have been so cheap, would it? When the other woman started screaming inside I ran away. I thought, "I'm not going to have that doctor sticking instruments into me." But my husband came after me. He had to almost drag me back. ...After one month I started bleeding heavily, it just didn't stop. I had to get another "wash" done. But the second time I went to a proper doctor, and my father paid.' (S Bibi, B village, Chas)

'I didn't want to go to that place (nursing home of RMP in Chandankiari). When I saw him with these big scissors, don't you think I was scared! I thought I was going to die. But what to do? Where could I have gone? He (her husband) took me there because it was cheaper than the doctors in Bokaro. Only us poor people have to take such risks.' (S2 Devi, village, Chandankiari)

Women admitted that they did not wish to be burdened with unwanted pregnancies, and they often take the decision to abort, but they are not able to access quality abortion services independently. Safe abortion services cost money and necessitates travelling to nearby towns, and this is where men influence the sort of provider accessed. Safe abortion is less of a priority for men than their wives.

B. THE ABORTION EXPERIENCE

Only 5 women accessed early first trimester abortion, within less than 10 weeks of pregnancy. 17 were between 11 and 14 weeks pregnant at the time of abortion, and 3 were more than 15 weeks pregnant. Accessing abortion from a qualified medical practitioner usually took place in the second trimester, after women had tried other, more accessible methods. This obviously adds to both risk and expense.

The women revealed that all methods of abortion, by all types of providers, result in complications. Infections were common following abortions. Few women were given any advice regarding means to prevent infection. Women who accessed abortion services from a RMP or FHP were rarely given any antibiotics. RMPs usually gave inadequate doses and incomplete courses of antibiotics. All women, however, were given injections of vitamins and sometimes 'Methergin' to prevent bleeding together with a bottle of tonic. Five women complained of serious infection following the abortion.

'The doctor told me nothing about keeping clean or about not staying with my husband. I took a bath in the pond the next day...' (A Devi, village J)

Heavy bleeding following abortion was common. Eight women said they experienced such heavy bleeding that they needed further treatment. In 6 of these cases RMPs were involved in conducting the abortion. This, however, is probably under reported since many women expect heavy bleeding and even worry if they bleed very little. One woman had an MTP by a qualified gynaecologist, after having experienced one earlier in the village, induced by an RMP.

'The first time I had an abortion I bled for a whole month. For the first week I lost a huge amount of blood. This time I hardly bled at all, only a small amount for one day. I thought the

doctor must have left the thing inside!' (C Devi, C village)

5 women had to undergo D&Cs twice due to retained foetal parts, which had caused continuous bleeding.

Many women had to use the services of a variety of providers and techniques to terminate an unwanted pregnancy. 15 out of the 25 women in the survey used the services of more than one provider. Only three women had a 'safe' abortion from a single, qualified, service provider. What was striking was the use of a combination of service providers when complications occurred, due to the ineptitude of the practitioner. Only in one case was the complication, which arose from the MTP, managed by the same practitioner, a qualified gynaecologist.

Table 4 gives an idea of the number of service providers women are accessing in order to terminate an unwanted pregnancy. The role of the RMPs in providing abortion services was found in 14 cases. In 2 cases the RMP performed the abortion himself, without assistance from another practitioner. Although RMPs conduct medical abortions, in most cases they act in combination with other practitioners, often as touts or agents.

In 4 cases MBBS (including one DGO) doctors performed D&Cs after the RMP had failed with ayurvedic/allopathic combinations. In 3 cases the 'nurses' and RMPs performed the abortion together, with 2 of these cases resulting in serious complications (heavy bleeding due to incomplete abortion) needing further treatment and D&C from a qualified doctor. In 5 cases RMPs were called to stop bleeding after the ministrations of the female herbal practitioner. In one of these cases the woman had to undergo another D&C from a qualified medical practitioner.

Table 4. Abortion Service Providers Accessed by Women

Service providers	Number of women
MBBS/DGO only	3
MBBS only	2
RMPs only	2
FHPs only	3
RMPs + MBBS	3
'Nurse' + RMPs (together)	1
RMP + MBBS/DGO	1
RMP + 'nurse' (together) + MBBS	2
FHP + RMP	3
FHP + RMP + MBBS	2
MBBS/DGO	
(2 different providers)	2
MBBS + MBBS/DGO	1

Although Bokaro General Hospital is the only 'safe' and 'legal' abortion service provider in the district, it is also the least woman-friendly. None of the women in the study could have accessed abortion care independently, even though they accepted sterilisation as a pre-condition.

Women who accessed 'safe' abortion services from BGH also encountered complications. Four women in this study had abortions along with tubal ligation operations, yet two of them had to use the services of another, private, gynaecologist, following complications.

'The day after coming home from the hospital I had severe cramps in my belly, then I squatted and pieces of flesh and bones came out. Then the pain reduced a bit, but I kept on bleeding for a month. I took medicines, but you know what happened. I had to have another abortion...' (M Devi of village C)

The woman above aborted another foetus at home, after MTP had supposedly been completed. It was probably a twin pregnancy.

After one month of bleeding due to retention of foetal parts a private gynaecologist did another D&C. Yet other woman accessed the services of another private gynaecologist following severe infection after having an abortion at BGH. Treatment of any complications resulting from MTP and tubal ligation operations at BGH are not provided free of cost, so women normally do not return there.

One woman in the sample who had gone to BGH for MTP and tubal ligation continued to remain pregnant.

'After two months I still didn't see any menstruation. I felt sick and realised I was still pregnant. But after leaving the hospital I never wanted to return! When they were doing the operations I could see everything. I was lying there and this doctor with big scissors and blood all over her hands was standing over the next woman...I wanted to run away, but it was too late. Never, never will I return to that place. My husband called the "doctor" from the next village. He came and gave some injections and medicines, but nothing happened. Then he called another "doctor". He gave some more injections...but still nothing came out. Then my husband, he knows a bit about herbal medicines, you know, he brought me some medicine from the jungle. After that I started to bleed. I carried on bleeding for a month, but the main thing was stuck inside. We called the first doctor back again; he gave me some more injections. But they didn't do any good. I was so weak by then I could hardly walk. My aunt here was giving me an oil massage; we were wondering what to do. She knows a thing or two about these things; she helps us all during childbirth... Anyway she called for some coconut oil, and the help of a couple of other women. They held me down whilst she inserted her hands into me and pulled the thing out. I thought I was going to die....' (H Devi, B village)

H Devi was clearly more terrified of the doctors, with their scalpels and forceps, than her aunt's bare hands.

(Whilst the above interview was taking place in B village another woman came to show me her small baby. She had also been pregnant at the time of tubal ligation, but decided to continue with the pregnancy. Childbirth following ligation operations are not uncommon)

C. COST AND ABORTION CARE

Cost is one of the main obstacles the women faced in looking out for safe abortion care. The women who access FHPs and RMPs are initially fully aware of the risks involved, expecting costs of the abortion to be less than that charged by qualified doctors in towns, and they can only hope complications do not arise.

The cost of terminating unwanted pregnancies for village women is heavy, financially as well as physically. The cheapest was Rs.200 for terminating a 2-month pregnancy by a FHP. The most costly was Rs.2, 200 which was the total cost of an incomplete abortion by a RMP and 'nurse' in the village, followed by another D&C by a qualified doctor. The average cost of abortion in this study was Rs. 1, 066.

Private medical practitioners' charges often exceeds the total cost of qualified gynaecologists, but they allow the woman's family to pay by instalments. RMPs vary their charges according to the capacity of the woman to pay, or play on their ignorance. One woman, a non-literate, tribal woman was gullible enough to pay Rs.800 to an RMP for a D&C, whereas his normal charge is around Rs. 500.

'I knew the risks involved. But we are poor people. She (the herbal practitioner) only takes one or two hundred, and we can pay by instalments. If we go to a big doctor in town, just going and coming will cost more than that. And we have to pay the doctor beforehand. But with her, we pay her off whenever we can.' (S3

Devi of S2 village of her induced abortion by a FHP)

Not only does the cost consideration determine 'choice' of provider, but it often delays accessing an abortion.

'I was around four months pregnant when I finally got it out of me. I knew I was pregnant after the first moon, but what to do? I went to the doctor, and she told me it'd cost four hundred. So we came home and saved up four hundred. This took two weeks. Then she told us it would be six hundred. We saved up some more. In the end we paid almost a thousand.' (M Devi, S1 village, Chandankiari)

Table 5. Cost of Abortion

Cost of Abortion and complications	Number of Women
Less than Rs.500	9
Rs. 501 to Rs.1000	10
Rs.1001 to Rs.2000	4
Above Rs.2001	2

D. ACCESSIBILITY AND ABORTION

Accessibility is another reason why women did not utilise safer abortion services. Women can access RMPs and FHPs easily and independently, which is not the case when it comes to a qualified practitioner.

Many of the women were more at ease using the services of known practitioners, either the village 'doctor' or the female herbal practitioner. Women often turn to these providers first because this is within their capacity. They can go to them without the presence of men, it does not need large amounts of money, and the practitioners are nearby. To access abortion services of a qualified doctor necessitates the support of their husband, both financially and physically, since most medical practitioners in Chas and Bokaro insist on the husband's presence. And to use the services of BGH, accepting sterilisation along with abortion, necessitates the support of the husband (to

sign the admission papers) and staff from the women's health centre. It may also necessitate several visits spread over many days, before the operation is performed.

E. IMPACT ON WOMEN'S HEALTH

- 1 The impact of repeated D&Cs and induced abortions on women's health can be well imagined. All the women in the survey were found to be anaemic. Nine women were mildly anaemic, eleven were found to be moderately anaemic, and five were found to be suffering from severe anaemia.
- 1 16 women were found to be suffering from vitamin deficiencies, whilst almost all (23) complained of weakness following the abortion.
- 1 Currently, six women were found to be suffering from severe pain in the lower abdomen, due to reproductive tract infections.

VIII. CASES OF ABORTION-RELATED DEATHS NOT INCLUDED IN THIS STUDY

During the course of this study 4 abortion-related deaths were discovered in nearby villages. The villagers who narrated the details of these deaths were all of the opinion that abortions were the cause of death.

1. S DEVI, J VILLAGE

According to the women of the village, Saraswati's death was the result of repeated abortions. She had undergone three abortions over the last four years. Two abortions were undertaken by an RMP who has a 'nursing home' in Chandankiari and another by a qualified medical practitioner in Chas. During her last unwanted pregnancy she had approached the women's health centre, and she was advised to access abortion care in a qualified doctor's nursing home in Bokaro. Instead she was taken by her husband, and another man from her village - who has become an agent for that RMP - for a cheaper abortion, in the 'nursing home'

that he set up. Another D&C was performed. She already had four children. Her husband remarried one year later.

'She refused to go for sterilisation, she was scared. The "doctors" never told her about the risks of having abortions. Why should they? They are only interested in money, aren't they? Every year she got weaker, but still she went for abortions. Ultimately, her uterus got infected and nothing could be done....' (J Devi, S's neighbour, J Village)

2. F DEVI (S VILLAGE)

In F's case, her husband called an RMP from another village. He, in turn, brought a 'nurse' to help perform an abortion in the home of the woman. She had four children and her husband has since remarried.

'The husband called me in the night, I saw a huge pool of blood, and the woman was barely conscious. I told them there was nothing I could do; it looked like her uterus had been ruptured to me. I told them to get her to a hospital immediately, but next day he took her to her father's house instead. She never reached a hospital, but died there in her father's house...' (S M, RMP, Simulia)

3. J BIBI (K VILLAGE)

J's abortion-related death was caused by the combined services of a RMP and FHP. In this case the woman concerned had come to the women's health centre for help in terminating an unwanted pregnancy. It was during the busy winter months at BGH, when MTP along with ligations are not admitted. She was advised to get an abortion privately, at the nursing home of a qualified gynaecologist. Since she already had six children and was then in her second trimester, it was risky. She was asked to discuss it with her husband first. Instead her husband called an RMP and FHP. Her husband remarried one year later.

'After you'd told her that her abortion might cost around Rs.800, her husband called the "doctor" from the shop on the roadside. The "doctor" told him not to waste so much money,

he'd give some medicines instead. He gave some medicines and injections, who knows what he did, but the main thing didn't come out. She bled and bled. Then he called the old woman, (a FHP). She inserted a stick inside her and left. Then she really bled. Next morning we took her to Chas, but the nursing home wouldn't admit her. The doctor there took one look inside her, saw the stick, and told us to get to BGH fast. Somehow we got the Rs.5000 needed to get her admitted. Then they operated on her, removed her uterus, and gave her blood. But still she died by evening. The doctor told us that the stick had gone right through to her stomach....' (J1 Bibi, J's neighbour, K Village,)

4. A DEVI (B VILLAGE)

The last, most recent case took place in a nursing home of a gynaecologist in Bokaro.

'We had gone to that nursing home because they had advertised all over Chandankiari that abortion only cost Rs.299. They also said they could perform sterilisation as well...When she went into the operation theatre she was fine. The doctor told me to come back in the afternoon... When I reached I saw the doctor along with some of her staff bundle my wife into an ambulance, with a bottle of saline attached to her. They told me she was having trouble, and needed to get to BGH fast. On reaching BGH the doctors told me she must have died around two hours earlier... ' (A P, husband of deceased, B Village, Chandankiari)

The first three deaths outlined above involve RMPs, and the role of husbands in calling them in for abortions. In two of these cases, S and F, they were subjected to D&C operations at village level. Unqualified medical practitioners performed the D&Cs without taking basic precautions. The complications were serious, and poverty, ignorance and callousness led to their death.

In the last case, however, the doctor was qualified, but death still occurred. The nursing home's abortion services have been widely advertised throughout Bokaro, in both the city and villages. The doctor could not

manage the complications, nor did she refer the patient fast enough to BGH. The cost of admission to BGH, which was to be born by the patient, was not immediately available. The husband was rightly angry that the doctor referred a dead body to BGH, so that a death certificate could not be arranged. This death reminds us that abortion always carries a risk, and unless timely referral is available, the consequences can be fatal.

IX. DISCUSSION

Due to the small sample size, and the wide spectrum of experiences, it has been difficult to make generalisations. It is clear, however, that good quality, accessible and affordable abortion services for village women are not available.

Women are aware of the risks involved in accessing abortions. They juggle accessibility, affordability and quality, since all three are not available. A qualified gynaecologist may be 'safe', but is inaccessible and too expensive for most village women. At the other end of the spectrum, a female herbal practitioner is the most accessible and affordable, but less safe. In-between these two, there is a huge number of combinations of abortion providers. Fifteen women in our study accessed services from a combination of providers, indicating the inadequacy of the method used. It also shows that care providers cannot, on the whole, deal with complications arising from the method they are using.

By having to combine methods and access services from several providers women pay heavily in terms of cost and health. The delays due to method failure and incomplete abortion, the complications that arose added to cost and risk. Few women could access early first trimester abortion care, with most women (17) terminating their pregnancies between 11 and 14 weeks. Women already weak and anaemic had to put themselves at considerable risk to terminate an unwanted pregnancy.

There were a large number of women in the sample who had availed of the services of herbal practitioners, but the rate of complications reported by these women was less than those that had accessed abortions from RMPs. The use of the D&C method by RMPs and unqualified 'nurses' resulted in the most serious complications - ruptured uterus - which cannot be treated in any government hospital in the Bokaro district. RMPs were crucial in providing abortion services, and gained financially from its promotion. None of the women in this study, who went to private medical practitioners (MBBS or RMPs) for abortions were given advice regarding birth spacing or means to prevent infection. RMPs often act as agents for private medical practitioners, which substantially increases the cost to the woman. In some cases this 'commission' is almost as much as the service providers' fees.

The use of ayurvedic medicines that are easily available is also a matter of concern. Many 'doctors' (qualified and unqualified) tell women to 'try these drugs first'. This delays accessing abortion services and adds to both the cost and risk. Many women, however, continue with pregnancies after these medicines have failed. The impact of these drugs on the foetus is not known.

Women who accessed abortion through private practitioners were rarely counselled regarding contraception, nor did they warn women of the risks of repeated abortions. The 'profits' to be made from providing abortion by private practitioners are considerable, and the incentive is for repeated abortions rather than contraception.

Women who succeeded in effecting abortion along with sterilisation from Bokaro General Hospital, were all helped to get admission, counselled regarding the procedure, provided pre- and post-operative care from the Mahila Mandal Samiti's health centre. Bureaucratic procedures coupled

with the hospital staff's behaviour and repeated visits that it entails, are all factors that deter women from approaching BGH.

In spite of abortion services not being made available, many women in this study initially approached the MMS's health centre for terminating an unwanted pregnancy. However, the women's health centre cannot really refer women for safe, affordable and accessible abortion care, since this service does not exist. Women with unwanted pregnancies are often advised to continue with the pregnancy rather than utilise unsafe abortion services if their optimum family size has not been reached. Women who suffer health problems (heart disease or tuberculosis for example) are similarly advised due to the lack of emergency care within the district for emergencies. The abortion-related deaths as well as the high number of complications, also points to the dire need for government hospitals to provide emergency care within the district.

Neither government nor private health sectors place women's health on their agendas. Either they are a source of profit, or targeted for population control. It is therefore unrealistic to expect women-friendly abortion services, which provide counselling, accurate information, and quality care from either sector.

The sensitivity of the abortion issue, both from a legal as well as a women's rights perspective, leads us to argue in favour of providing safe and accessible abortion in women-centred health care facilities. Only when women's overall well being is the principle concern of the health care provider, can safe abortion care be made accessible and available. Until such a service is made available, poor women do not have any real 'choice', nor do they have a decision making role in their own fertility. This study clearly shows that women's control over their own bodies and their fertility is at variance with existing options for abortion care.

APPENDIX

Appendix 1 : Abortion Assessment Schedule

1. Name:
2. Husband's name:
3. Distance from urban centre:
4. Age:
5. Family Income:
6. Educational status:
 - a) *Wife*
 - b) *Husband*
7. Number of live children:
 - a) *Boys:*
 - b) *Girls:*
8. Number of:
 - a) *Spontaneous abortions:*
 - b) *Neonatal deaths:*
 - c) *Child deaths:*
 - d) *Induced abortions:*
9. Total number of pregnancies:
10. How long ago did the abortion take place?
11. When was the pregnancy confirmed?
 - a) *4-6 weeks*
 - b) *7-10 weeks*
 - c) *11-14 weeks*
 - d) *15 plus weeks*
12. When was the decision to abort pregnancy taken?
 - a) *4-6 weeks*
 - b) *7-10 weeks*
 - c) *11-14 weeks*
 - d) *15 plus weeks*
13. Who decided to abort pregnancy?

14. Had any birth spacing method ever been used?
 - a) *Which method?*
 - b) *Was any contraception being used at the time of conception?*
 - c) *Why did they stop using birth spacing method?*
15. If no method of birth spacing was used, did you know about —?
 - a) *Ligation (tubectomy)*
 - b) *Vasectomy*
 - c) *Oral contraceptive pills*
 - d) *Copper-T*
 - e) *Natural family planning*
16. Why was no method of birth spacing accessed?
17. Did you know where to access these different methods?
18. Who provided information about abortion services?
19. Were you aware of the risks involved?
20. Did anyone inform you of the risks beforehand?
21. Were you aware of the different methods of abortion and their risks?
22. What method of abortion was accessed?
23. Where was it undertaken?
24. What were the qualifications of the practitioner?
25. Did any complications arise?
26. Who managed the complications, if any?
27. Did the practitioner provide any advice regarding:
 - a) *Possible risks/side effects/need for follow-up?*
 - b) *Possible infection and need for prevention?*
 - c) *Birth spacing?*
28. What was the total cost of the abortion (and complications, if any)?
 - a) *Medicines*
 - b) *Service charges*
 - c) *Other costs*
29. Were you suffering from any other illness at the time?
30. Are you presently suffering from?
 - a) *Anaemia*
 - b) *PID/STD/RTI*
 - c) *Weakness/Vitamin deficiencies*
31. Has any birth spacing method been subsequently accessed?
32. Would you undergo the experience again if pregnant again?

ABOUT THE AUTHOR

Lindsay Barnes

Lindsay Barnes is a social activist, living and working in a backward part of the Bokaro district for the last fifteen years. She has lived there since completing her doctoral thesis from Jawarharlal Nehru University on the struggles of the women colliery workers in the nearby Jharia coalfield, in 1989.

She has been involved with issues facing village women, and has helped set up a federation of self help groups, the 'Mahila Mandal Samiti', which is a grass roots women's organization with around 5000 members. Women's health activities have been prioritized since the beginning. The federation has its own women's health centre, and Lindsay has encouraged and trained village women to become 'barefoot gynaecologists'. She has attempted to promote 'self help' in the sphere of women's health and micro credit.

Alongside these activities Lindsay also contributes articles for various newspapers, writing on development and women's health issues. She lives in the village with her husband and two children.

CEHAT

(Centre For Enquiry Into Health And Allied Themes)
Research Centre Of Anusandhan Trust

CEHAT, in Hindi means "Health". CEHAT, the research centre of Anusandhan Trust, stands for research, action, service and advocacy in health and allied themes. Socially relevant and rigorous academic health research and action at CEHAT is for the well being of the disadvantaged masses, for strengthening people's health movements and for realising right to health care. Its institutional structure acts as an interface between progressive people's movements and academia.

CEHAT's objectives are to undertake socially relevant research and advocacy projects on various socio-political aspects of health; establish direct services and programmes to demonstrate how health services can be made accessible equitably

and ethically; disseminate information through databases and relevant publications, supported by a well-stocked and specialised library and a documentation centre.

We are a multi disciplinary team with training and experience in Medicine, Life Sciences, Economics, Social Sciences, Social Work, Journalism and Law. CEHAT's projects are based on its ideological commitments and priorities, and are focused on four broad themes, (1) Health Services and Financing (2) Health Legislation, Ethics and Patients' Rights, (3) Women's Health, (4) Investigation and Treatment of Psycho-Social Trauma. An increasing part of this work is being done collaboratively and in partnership with other organisations and institutions.

HEALTHWATCH TRUST

Health Watch Trust is a network of field based or national organisations, researchers, women's health advocates and social activists who are concerned about women's well being. The group was informally formed prior to the International Conference on Population and Development (ICPD), held in Cairo in 1994 and has since expanded to include those who are committed to promoting a holistic approach to health, population and development.

The objectives are to translate the national and international commitments made in Cairo (1994) to concrete programmes in India, to engage in constructive yet critical dialogue with the government at multiple levels and to lobby for a shift in the family welfare programme for provider-driven to people-centred programme; to strengthen public and primary

health care and related aspects of development, especially education and women's economic, social and political empowerment; in particular to advocate restructuring government programmes based on vibrant NGO experiences in this area and link these interventions to reproductive health and rights; to provide a forum for effective networking among like minded NGOs; to provide a forum for continuous exchange of information and sharing of ideas and experiences among NGOs themselves.

The network has made concerted efforts to sustain the free and frank dialogue initiated before and after ICPD with the government and donor agencies.

Health Watch brings out UPDATE an occasional newsletter to share information and experiences of NGOs, researchers and activists, government officials, donor agencies, media personnel, etc.