

WOMEN'S PERSPECTIVES ON THE QUALITY OF GENERAL AND REPRODUCTIVE HEALTH CARE:EVIDENCE FROM RURAL MAHARASHTRA

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There is a need to document women's perceptions regarding the quality of their health care, including abortion services, since most studies to date have approached this issue from the viewpoint of service providers, policymakers, or the state (Jesani and Iyer 1995). Basic maternal and child health (MCH) care, from both public and private sources, has been grossly neglected in India. MCH services, which are practically the only special program for women, receive a mere 2 percent of the national health budget. In fact, with less than 1 percent of the gross domestic product currently allocated for health services, there is a large gap between health needs in India and the public infrastructure intended to serve them. The number of health workers and the infrastructure available for even the existing limited services are inadequate and of poor quality. Added to this deficiency is a bias favoring urban areas in health care delivery (Duggal 1995).

Whereas most government–run primary health centers (PHCs) lack functional equipment and trained personnel to carry out medical terminations of pregnancy (MTPs), the private sector, which is often characterized by inadequate equipment and insufficient facilities for such procedures, engages in profit-making through unstandardized treatment and charging practices (Nandraj 1994). In fact, the use of unnecessary and even hazardous procedures and drugs has been found to be far more common in private clinics than in government clinics (Phadke 1994).

Implementation of the statutes of the MTP Act¹ has been geographically uneven. Women not only find the services inaccessible, but are also reluctant to use them because of the lack of confidentiality and anonymity (UN, Population Division 1993). The ratio of illegal to legal abortions is estimated to be anywhere between 3:1 (Karkal 1991) and 8:1 (Jesani and Iyer 1993). Numerous recommendations have been made in the recent past for improving women's access to safe abortions; they include upgrading the health infrastructure, training providers, and increasing public awareness and information dissemination (Parivar Seva Sanstha 1994).

Women's access to all health services is extremely limited in the region of Pune District, Maharashtra, the area of our study. Women have been found to suffer more than men from chronic ailments, on which their households have been reluctant to spend money for treatment. Neither landowners nor the state has been willing to compensate women for health problems related to employment in the landowners' fields or on government sites for drought relief. Vaginal white discharge, prolapsed uterus, backache, and problems resulting from the Copper-T intrauterine device (IUD) and sterilization have generally gone unheeded (Gupte and Borkar 1987). Women use PHCs mainly during their reproductive years; the health care needs of girls are largely neglected. PHCs' hours of

operation frequently conflict with women's work schedules, and the inconvenient location of PHCs have made them inaccessible to many villages in rural areas (Awasthi et al. 1993).

The concept of quality of health care (QHC) has been developed as a tool for identifying health needs and assessing health services. In the late 1980s Donabedian advanced the QHC concept (Donabedian 1988), and Simmons, Koblinsky, and Philips (1986) and Bruce (1990) applied it to the assessment of how clients are treated in family planning programs. Protocols have been developed to assess whether quality has been considered – along with quantity, accessibility, and the distribution of health care delivery – in evaluations of health services (Roemer and Montoya-Aguilar 1988). In the study reported here, we have used the QHC concept to understand women's needs in a variety of situations in which they seek health services, including abortion services. The study documents their choice of providers in those situations and women's feelings about both public and private health services. The study took place in a rural area of Pune District, Maharashtra, between April 1994 and March 1996.

METHODOLOGY AND SAMPLE

As part of a larger qualitative study on rural women's perceptions and experiences related to abortion, participants in our focus groups were interviewed about their desired QHC, choice of providers, and their views about public versus private abortion services. We used rank-ordering and a semistructured questionnaire to collect this information. We selected six villages on the basis of their access to health services, their size (ranging from 1,500 to 3,500 inhabitants), and access by transport to nearby towns. The intention was not to do a comparative analysis, but rather to record the qualitative nuances in the narration of women in differing situations when asked to consider their specific health needs. Collecting information about a sensitive issue such as abortion was not difficult because we had established rapport with women in the region over a period of eight years. We identified as contact persons women with whom we had long-standing relationships; they helped to authenticate the collected data and served as a voice of conscience to us we went about collecting information.

During monthly meetings with the focus groups, which took place over eight months, we documented women's needs for health care delivery. On the basis of those discussions, we drew up a list of 21 QHC indicators based on the women's expressed concerns. The list was field-tested with the women and subsequently refined. As we spoke with the women, we realized that the QHC they desired was not a fixed entity, but instead depended on their social circumstances and specific health needs. Our respondents wanted situation specific services for general health care, for delivers, and for abortions. Among women seeking abortions, the needs of those who were married differed somewhat from those who were not.

We believed that the QHC for abortion, if considered in a vacuum, would give an inaccurate picture of women's needs. When women choose a few indicators as a priority for abortion services, they may do so at the cost of omitting other indicators that they also feel are important. To correct any artifacts in our data that rank-ordering might create, and to understand women's needs related to abortion in real-life situations, we decided to ask them not just about their needs related to abortion services but also about their needs for general health care and

obstetrical care, both of which are considered socially acceptable needs. Our assumption was that in the latter two areas they were freer, at least theoretically, to choose good QHC. By introducing the topic of abortion within this broader context, we hypothesized that women would feel more comfortable expressing their underlying feelings when they talked about abortion services.

From the focus-group discussions, we learned that when seeking any kind of health service, all women had concerns about cost and affordability. Some of them spoke of the distance and time involved in seeking health care, mentioning the amount of money they would have to pay for transport or how much they would lose in wages if they spent too much time on medical treatment. We therefore decided to treat opportunity costs and affordability as separate and important concerns, rather than as merely one indicator of QHC.

In the survey that followed the focus-group discussions, we asked our respondents several sorts of questions: To understand women's preferred choice of providers when seeking health care for various needs, we asked which services they used, or preferred to use, for minor illnesses, chronic ailments, health emergencies, antenatal and postnatal care, delivery, sex-determination during pregnancy, gynecological problems, intramarital abortion, and extramarital abortion (defined as abortion by a nonmarried woman, whether deserted widowed, or never married). To understand the linkage between the accessibility of services and choice of provider, we asked them about public and private services that were available in their villages, at the taluka (subdistrict) level or in the neighboring towns, and in the district headquarters. We also recorded the women's reasons for choosing public or private health services. Cost and affordability were better understood in this context.

For the survey portion of the study, 61 of the 67 ever-married women who had regularly been part of our focus-group meetings were interviewed about QHC, 49 were interviewed about their choice of providers, and all 67 women were interviewed about their choice between public and private abortion services. The interview processes are described in detail in the findings section.

Care was taken to include both cohabiting and noncohabiting women from various caste, class, and age groups. About half (49 percent) of the respondents were Maratha women, the dominant caste (numerically, economically, politically, and culturally) in the region; but the sample also included significant numbers of women from scheduled castes and resettled nomadic tribes. Muslims and Jains were also included in the sample. The majority of women were between 20 and 40 years of age. The youngest respondent was 17 years old, the oldest 60 years.

Because the first two instruments involved the use of cards for rank-ordering preferences, we had to select literate women from among our focus groups. The respondents were selected from all six villages of the research project. The 49 women who were interviewed about their choice of providers participated in all three sections. Because the three interviews were lengthy, it proved impossible to interview all 67 women for all three sets of data. In all three sections, the respondents freely expressed their feelings and opinions. Their narratives have been classified

by content, and representative narratives are presented in the following sections at appropriate places. In recording and translating their comments, we have taken care to preserve the idiom of their language.

PERCEPTIONS OF QHC

The 61 ever-married women whom we interviewed about QHC were each given a set of 21 cards in random order, each of which spelled out one indicator of service quality. The respondents were asked to identify and rank-order the three most important indicators of service quality for each of four types of health care need: general health care, obstetric care, medical abortions within marriage, and medical abortions outside of marriage. Respondents were asked to consider each type of health care need, regardless of whether they had ever used this service themselves. The three highest-ranked indicators were recorded for all four situations for each respondent. After the woman had chosen the three indicators, she was asked to place them in order of priority. To confirm her selection and to understand the logic of her choice, the respondent was then asked to explain why she had chosen those indicators.

Because abortion is a sensitive subject and extramarital abortions are difficult to obtain in India, we did not ask respondents whether they had ever had an extramarital abortion. For the sake of simplification, we classified all conceptions of single women – whether unmarried, widowed, or deserted-as extramarital and all conceptions of currently married, cohabiting women as intramarital. Our reason for doing so was that women who cohabit with their husbands have easier access to abortion than single women. Cohabiting married women who become pregnant as the result of an extramarital relationship can, in all probability, pass off the pregnancy as resulting from intramarital intercourse.

Table 7.1 presents the results of the rankings, cross-tabulated by the four situations. For each situation, the first column gives the added score (ranks 1+2+3) for each indicator. The “ranked first” column shows the number of women who ranked each indicator as the most important factor in QHC for that particular situation. Together the two columns reveal which indicators the respondents considered to be most important in a particular situation, as well as the placement of other indicators in the rankings. The highest score in each column is in bold type.

The rankings indicate that the women's priorities for QHC varied according to the situation in which they might seek health care. Two indicators, presence of a women doctor and empathy or concern of doctor, received high cumulative scores in three situations, whereas many others (e.g., easy access, safety and reliability, round-the-clock service, and equipment and machinery) received high cumulative scores in two situations each. Another interesting pattern revealed by Table 7.1 is that in three of the four situations (general health care, delivery care, and abortion outside marriage), the first ranked indicator received that ranking from substantial numbers of women, whereas in the case of intramarital abortion the first – ranked indicator was so ranked by only seven women. The contrast between some of the QHC indicators for abortion and nonabortion services helps one to understand the complex social milieu in which women's sexuality and their decision making (or lack of it) about abortion take place.

GENERAL HEALTH CARE

Among women seeking general care, the indicators receiving the highest cumulative scores were, in descending order, the attention and concentration of a doctor when examining and treating a patient, round-the-clock service to deal with emergencies, easy access and conveniently located service, and - receiving equal scores - the doctor's respect for the patient and readiness to listen to her description of symptoms, the doctor's empathy for the patient, and the cleanliness of the facility.

TABLE 7.1

Importance of indicators of quality of care in four health-care-seeking situations: Six villages of Pune District, Maharashtra, 1994-96.

Indicator	Ranking of quality of care indicators in specified situations*							
	General health care		Obstetric care		Abortion within marriage		Abortion outside marriage	
	Top3	First	Top3	First	Top3	First	Top3	First
Easy access, nearby services	15	s7	18	11	4	1	1	0
Short waiting period	6	2	4	0	5	1	12	2
Quick service, quick return	2	0	5	1	17	4	8	0
One visit, no repeated visits	3	1	4	2	11	4	11	2
Doctor's attention, concentration	29	16	6	1	5	3	2	1
Presence of woman doctor	9	2	11	5	5	1	11	7
Sex of doctor immaterial	3	1	3	1	3	1	3	1
Respect for client/listens	13	7	5	1	7	1	3	0
Safety, reliability	8	1	11	6	17	5	9	4
Effective treatment, quick relief	10	2	2	1	7	3	1	0
concern, counseling	13	3	5	0	10	6	12	6
Boarding facilities	11	0	11	1	4	0	3	1
Cleanliness	13	8	10	4	0	0	1	0
Courteous behavior from staff	4	0	11	2	13	5	5	2
Adequate staff to clean up	1	0	27	7	1	0	0	0
Round-the-clock service	18	6	18	7	7	3	6	4
Drugs available	6	0	6	1	7	2	10	3
Equipment and machinery	8	2	11	3	15	5	3	0
Confidentiality	4	0	1	1	2	1	35	13
Discreet location	0	0	1	0	7	3	27	8
Husband's signature not required	5	3	6	4	21	7	14	5
No response	2	0	7	2	15	5	6	2
Total No. of responses	183	61	183	61	183	61	183	61

a For the "ranked in top 3" columns, numbers represent the number of respondents who considered each specified indicator to be one of the three most important QHC indicators. for "ranked first" scores, numbers represent the number of respondents who ranked each specified indicator as the single most important. Numbers in bold type represents the choice of the largest number of women in each column.

Other indicators receiving somewhat lower but still high cumulative scores were the availability of boarding facilities, effective treatment and quick relief, and the presence of a woman doctor. The quality indicator for general health care that was ranked first in importance by the largest number of women was the attention and concentration of the doctor. Much smaller numbers of women ranked cleanliness, easy access, respect for the client, and round-the-clock service as the single most important indicator.

The following comments are representative of those made by respondents when they were asked to describe their concerns about general health care:

How will the doctor know about our illness if he isn't paying attention? Nothing will get into his head. He won't even know which injection he's giving. In case we don't get better, we'll keep thinking that it was because he wasn't concentrating. We'll feel that maybe he cheated us out of our money.

A doctor may have his timings [schedule], but does an illness come that way? It's their duty to attend to us at all times. An urban patient can go to another doctor, but a villager doesn't have transport. Doctors don't pay attention to poor patients. They're not social workers any more; they've become businessmen.

If the doctor doesn't listen to our complaints, we feel all tensed up. It further adds to our illness. We're already so tired waiting in the queue. If he listens, it soothes us.

At least the patient should get food in the hospital. Attendants can stay hungry. What if the patient's anesthesia wears off in the middle of the night and she asks for food? Sometimes there's no food available within a mile of the hospital.

OBSTETRIC CARE

The indicator for obstetric care that received by far the highest cumulative score was adequate staff to clean up the labor room. Other indicators given high cumulative rankings for this health situation were easy access and convenient location, round-the-clock service, presence of a woman doctor, safety and reliability of treatment, boarding facilities, courteous behavior from staff, adequate equipment and machinery, and cleanliness. The indicator considered to be most important by the largest number of respondents was easy access and convenient location of the delivery service. Ranked first in importance by smaller numbers of women were adequate staff to clean up, round-the-clock service, safety and reliability, and the presence of a woman doctor.

Respondents made the following comments:

Heart attacks and childbirth can happen at any time. We must have a clinic close by. Someone can die just because of this.

They make us clean up the labor room after our daughters deliver. What do they charge us for? What's the use of the nurses and ayahs [helpers]?

The first childbirth hurts, doesn't it? If we scream, they shout and slap us. They say, "You didn't feel any shame when you got the thing in there. Why are you shouting when it's coming out now?" They don't give us any information. If they don't pay any attention, we're forced to keep quite and stop asking.

ABORTION WITHIN MARRIAGE

When women seek abortions within marriage, they have legal access to the service. Nevertheless, they may experience feelings of guilt and be bothered by the fact that staff at public services ask for the husband's approval and exert pressure on the woman to use contraception after the abortion. The quality-of-care indicators that our respondents chose in this situation were quite telling. The indicator receiving the highest cumulative score was that a husband's permission not be required. Other indicators receiving high cumulative scores were quick service enabling a quick return to the home; safety and reliability; adequate equipment and machinery; courteous behavior from staff; only one visit required; and empathy, concern, and counseling from the doctor. Not requiring the husband's signature received the highest individual score.

Characteristic comments on this situation were:

If a husband refuses to sign, what is the woman to do? Your husband may turn back and say, "Whose bundle of sin were you carrying? You dropped [aborted] it because it wasn't mine." Or he may say, "Why are you dropping my child? I want it to stay." Who knows what he will say! Often husbands don't use a contraceptive and don't let the wife use it either. He says, "You will sleep with others if you are free." Sometimes you don't tell your husband that you're emptying it out. The doctors shouldn't hold us back for his [the husband's] signature.

We should be able to go back [home] immediately. The family won't send us if the travel and stay takes many days. The housework has to be done, and they won't like to spend much on my needs. Besides, if I haven't told my mother-in-law, she will begin to suspect.

The staff abuses us. They insult us for not using a Copper-T. If we get pregnant soon after delivery, they say dirty things [about us].

The doctor should explain to the woman that repeated episodes of dropping [abortion] are not good. Sometimes young girls get pregnant because they are ignorant or rebellious. Sometimes there is force. Someone may have done it [had sex] for money, because of her poverty. She can become weak. A doctor knows these things. He should explain [them] to her.

ABORTION OUTSIDE OF MARRIAGE

Given the social circumstances under which an unmarried, widowed, or deserted woman seeks an abortion, it is not surprising that respondents to our survey gave secrecy precedence over all other considerations when asked which indicators were important for women seeking extramarital abortion care. Confidentiality on the part of the doctor received the highest cumulative score and was the first-ranked score among the indicators of quality. Also receiving high cumulative scores were a discreet and distant location for the abortion service, not having to obtain a husband's permission, a short waiting period, empathy and concern from the doctor, only one visit being necessary, the presence of a woman doctor, and the availability of drugs.

Characteristic of comments about this situation were the following:

The woman is already so harassed. If the doctor talks about her problem to others, she won't get a husband later on. She may even be driven to suicide. The whole family, [including] her brothers, will lose face. If the doctor keeps the confidence, she may have the courage to come back to him for other illnesses. Sometimes a woman gets weak and ill after the emptying out. She may have to stay indoors for a while. In such a case, the doctor should find excuses on her behalf.

Why should a doctor betray the woman? Hasn't he earned his food and drink from her? It's his need too. He frees her from her problem only after she has paid his fees.

No one should know that we went to the doctor. Then there won't be any gossip about the woman. Our relatives mustn't get to know anything [about this]. The hospital should be at a place where we won't meet them. Everything must be done in the utmost secrecy.

A male doctor deliberately asks embarrassing questions. We feel shy with a male in such a situation. If there's a lady doctor, we can talk freely and find an early solution. It's so necessary in this case.

If she [a single woman seeking an abortion] has to wait for long, she may meet people she knows. Then the news will be all over the place. People will say, "She was perfectly all right. Then why has she been taken to the hospital? Why hasn't the family taken anyone else along?" The story will sprout too many branches. If the woman returns [home] quickly, nobody will get suspicious.

If we go to the chemist for the drugs, he will know what they are used for. He may talk around. There are barely one or two medical stores, even in the taluka place, and everyone knows everyone. If we move around for medicines, we're bound to run into our relatives and villagers. Then the news will be out. So all the drugs must be available with the doctor.

If she doesn't have a husband, from where can she get one to sign [the permission form]? Doctors shouldn't ask these questions.

CHOICE OF PROVIDER

For the section of the survey on women's preferences with regard to a provider, we gave the 49 respondents a set of 10 cards in random order. Each card mentioned one kind of provider, either a person or an institution. At one end of the spectrum were a traditional healer and self-or folk-remedies; at the other end, public and private hospitals. The respondents were asked to select their first choice of provider for nine situations in which women typically seek health care. Because the category of general health care was too broad to be useful, we divided it into three subcategories: minor health problems, chronic health problems, and emergencies. Likewise, we divided reproductive health concerns into six subcategories: antenatal and postnatal care, delivery care, gynecologic

village doctors	9 0	4	3	2	0	0	0	0
Qualified private doctors(towns)	5 30	5	17	7	9	20	7	23
PHC(own)	4 3	2	5	14	18	6	0	5
PHC staff (ANM/nurse)	8 0	0	3	14	8	5	0	3
PHC,taluka	0 8	3	2	5	7	3	0	8
Govt. hosp., pune	0 3	32	2	0	1	4	2	4
Private hosp., Pune/Bombay	0 1	3	16	1	2	3	33	3
Do not know/ not sure	0 1	0	0	3	1	0	5	0
Would not seek service	0 0	0	0	1	0	0	0	1
No response	0 3	0	1	2	0	0	2	0
Total number of women	49 49	49	49	49	49	49	49	49

Note: Numbers in bold type represent the choice of the largest number of respondents in each situation. ANC/PNC=antenatal care or postnatal care; ANM = auxiliary nurse-midwife; PHC=primary health center.

CHRONIC ILLNESSES

Respondents regarded tuberculosis, arthritis, and asthma, among other illnesses, as chronic. When asked about their preferred choice of provider for chronic illnesses, 65 percent selected the government hospitals in Pune. Much smaller proportions chose other providers ranging from qualified private doctors in nearby towns to private hospitals in Pune and Bombay.

Typical comments were the following:

We'll go to Sasoon [the district civil hospital]. You don't have to spend there, except for the case paper [an official document]. There aren't enough facilities in the PHC. But in the big government hospitals, there's everything you need.

When you see symptoms of TB [tuberculosis], you shouldn't waste time on home remedies. You must go to Sasoon or to the Chest Hospital in Pune. Why go to private doctors and waste money when we'll surely get cured here?

EMERGENCIES

In response to a question about their provider preferences in case of emergencies, two-thirds of the respondents selected qualified private doctors in nearby towns or private hospitals in Pune or Bombay as their first choice. One-fifth chose local public health services, including their own PHC and its staff.

The following comment was characteristic:

When there's a heart attack, we should find whoever is available first. After that, one shouldn't hesitate to go to a good private doctor who has all the facilities. If we go close by [to a nearby facility], they will anyway ask us to take the patient to a bigger place. Better not to waste any time.

ANTENATAL AND POSTNATAL CARE

Fifty-seven percent of the respondents preferred public health services, either their own PHC or PHC nurses or auxiliary nurse-midwives (ANMs), for antenatal and postnatal care. Fourteen percent chose qualified doctors in nearby towns, and 10 percent preferred the taluka PHC.

One woman stated:

The PHC staff come to the village every month and check us up. Then they give tablets and TT [tetanus toxoid] injections. We don't have to go anywhere else.

Others suggested that the government facilities were fine for normal pregnancies and postnatal care, but if there were complications they would want to have a private doctor:

If one has no problems in pregnancy, we can go to the PHC. But if there's pain or any other problem, then we have to go to the private doctor.

DELIVERIES

Sixty-nine percent of our sample preferred the public health services for their deliveries, most of them choosing their own PHC. Twenty-two percent preferred to have their deliveries attended by a qualified doctor in a nearby town or to deliver at a private hospital in Pune or Bombay.

After trying to deliver her with a local dai [traditional midwife], we go to the rural hospital. Time is very important in this case. It's an unnecessary waste of money going to a private hospital. If you can get a good service in the PHC, why go around?

The PHC doesn't have equipment for cesarians. We then go to a private hospital without wasting time.

GYNECOLOGICAL DISORDERS

For gynecological disorders, 47 percent of the women said they would prefer going to a private doctor in a nearby town or in Pune or Bombay, whereas 37 percent would go to public health services ranging from their own PHC

and its staff to the government hospital in Pune. Sixteen percent said that they would use folk or traditional remedies or treat themselves.

We'll go to a gynecologist in the town or in Pune. They don't pay any attention to you in the PHC.

There are good remedies with leaves and herbs for these problems. A woman from a nearby village can also treat a prolapsed uterus.

SEX-DETERMINATION TESTS

Prediagnostic tests for the purpose of determining the sex of a fetus are banned in India. When a doctor passes an information about the sex of a fetus to a pregnant woman or her family, he or she is engaging in an illegal act. Nevertheless, sex-determination tests are available to people through private, illegal channels at high cost. Son preference is deeply rooted in India's patriarchal social structure, and it is so strong that couples are willing to incur heavy debt to pay for sex-determination tests, followed by a second-trimester abortion in the event the fetus is female. Four-fifths of the respondents in our sample said they would go to a private hospital in Pune or Bombay or to a qualified private doctor in a nearby town to obtain a sex-determination test during a pregnancy. Equipment required for prenatal diagnostics might be available in government hospitals, but sex-determination test would not be conducted there. None of our respondents had availed herself of sex-determination facilities in the public sector. Five respondents did not know whether sex-determination tests were available, and one woman said that such tests were banned.

My sister went to Kolhapur. In Lonand, Pune, and Bombay also you can get these tests. The results are 99 percent right in Kolhapur, where they use a TV [sonar-scanning device]. They don't perform these tests in government hospitals.

ABORTION WITHIN MARRIAGE

For nearly one-half of the sample (47 percent), the first choice of provider for an abortion within marriage was a qualified private doctor in a nearby town. One-third would prefer their PHC, PHC staff (ANM or nurse), or the taluka PHC. Eight percent said they would go to the government hospital in Pune, and 6 percent would choose a private hospital in Pune or Bombay. Two women (4 percent) preferred a local abortionist. One woman said that she would never have an abortion, and so the question of choosing a provider was not relevant to her.

We'll go to a private doctor. There you can get what you want. In the government hospitals they ask too many questions. In a private hospital, you get the service immediately.

If you eat Anacin or malaria tablets, the pains start and you can drop it [abort the fetus] at home.

She [an abortionist using a folk method] uses a root which is still wet with its sap, which she puts inside you. After a few hours, the bleeding starts and the root come out with the whole thing.

ABORTION OUTSIDE OF MARRIAGE

When asked what kind of provider they would choose if they were seeking an abortion outside marriage, a sizable majority (61 percent) said they would prefer a qualified private doctor in a town, whereas 22 percent would prefer going to a PHC, especially one at some distance. Few (only 8 percent) would go to a government or private hospital in Pune or Bombay.

They ask for the husband's signature in the government hospital. That's why it's difficult to go there.

It's the question of the girl's future. Who will answer all those questions? In the government hospital, they take down your name and address. Even if we have to sell our fields, we'll go to the private doctor and then get her married off.

VIEWS ABOUT PUBLIC VERSUS PRIVATE ABORTION SERVICES

Using questions from a knowledge, attitude, and practice (KAP) survey questionnaire on the MTP Act, we asked 67 women who had been part of the focus groups about their preferences regarding public or private services for abortion care and problems of obtaining abortions from both types of service. Forty-nine of the women who took part in this section of the study had also participated in the quality of care and choice-of-provider rank-ordering.

Forty-four women (66 percent) wanted abortions to be available from the public sector, 6 (9 percent) preferred the private sector, and 17 (25 percent) wanted the service to be available in both sectors.

It [abortion] should be available in government services. How much money they ask for in the private hospitals! The PHCs must become more friendly to women. Private doctors will build tall houses with our money. Do they care if the poor die? Medicines for the PHC also go to the doctor's house for private practice. Just look at our doctor – he didn't own a bicycle when he came. Now he has two motorbikes and he's built a house in a taluka place.

Let it [an abortion] be available in both places. In the PHC, they keep sending us back all the time. The pregnancy keeps advancing. If you can pay, you'll get quick service in the private hospital. The rich can go there. The poor will go to the government. Nobody cares if they live or die.

As the following attests, public-sector providers also frequently make access to abortion conditional upon a woman's accepting a long-term contraceptive method.

The doctor insisted that I should use a Copper-T, but my husband was adamant that I shouldn't. I finally agreed to use pills, but the doctor wouldn't trust me to take them regularly. The junior doctors asked their boss, and she said that I had to use the Copper-T after all. Since I wanted to drop the thing [abort the pregnancy], I then accepted the Copper-T, hoping that my husband would never find out.

Asked whether the husband's signature was demanded when a woman sought an abortion, 37 women (55 percent) replied in the affirmative. Twenty-eight women (42 percent) said that private as well as public services demanded the husband's signature. In fact, some women reported that private doctors were more demanding because they feared a legal threat from women's husbands. The demand for the husband's signature was a source of great discontent among the respondents.

Twenty-seven women said that only married women would use abortion facilities if they were made available at the village level. Another 27 said that all women, irrespective of their marital status, would use village-level facilities.

Married women will use the benefit in the village because it will save time and money. Even the others will go there secretly. They'll pretend that their stomach is aching or something.

Once women trust the village-level service they will start going there. Women from this village may go outside, but others can come here. Sometimes a woman doesn't tell the mother-in-law. So she will have to go somewhere outside.

DISCUSSION

The findings indicate that women's major concerns about the quality of general health care services reflect the needs of any rural population: the services must be nearby and easily accessible, and a doctor should be available for handling emergencies at any time. The distance and time involved in seeking services often determine how much cost a household will incur. Most poor households cannot afford to spend money for women's medical services, and a woman's access to health care is further reduced if the treatment is going to be very costly—either in direct expenses or in lost wages or housework lost due to her absence from the household.

Women expect a doctor to pay attention when he examines and treats them. Many of the women we interviewed told us that their doctor did not listen to their complaints, that instead he would interrupt them and try to get rid of them, especially if they were poor. Women want doctors to treat them with more respect. Treatment by a female physician was a consistently mentioned quality indicator, irrespective of the type of treatment a woman was seeking. Respondents felt that they could discuss their symptoms more easily with a woman doctor, and that they felt more secure in her presence than with a male, especially when discussing sexual matters.

Most women consider empathy, concern, and counseling from the doctor to be very important, especially in abortion care. Because women are rarely attended by physicians during labor, however, those attributes are not considered so important for delivery care. In normal deliveries, women are supervised by other hospital or PHC staff, about whom our respondents voiced many grievances. Women thus consider courteous and respectful behavior from clinic or hospital staff to be an important aspect of health care during deliveries and medically terminated pregnancies.

Cleanliness is an important criterion for general health care and deliveries. Some respondents complained that they had been made to clean up the labor room when they accompanied a woman admitted for a delivery. They thought that hospitals and PHCs should be adequately staffed with support staff to perform that function.

Women consider 24-hour service to be important for general health care and during labor, but not for induced abortions, which can be scheduled during normal hours. When they have to stay at a hospital overnight or for a few days, as in cases of serious illness or during childbirth, they wish to have food facilities in the hospital premises. Because women who seek abortions generally return home the same day, food and lodging facilities are not an important issue for them.

In fact, women seeking induced abortions do not want to stay overnight, mainly for social reasons and to maintain secrecy. In contrast with their desire to have an easily accessible health service for other types of health care, women in need of abortion services want those services to be located at a discreet distance from their communities - even though in the focus-group meetings respondents said they wanted abortion services to be available in every PHC and as nearby as possible. For most women in the six villages we surveyed, abortion services were not available within a radius of 10 kilometers.

While the desire exists to have such services as close to home as possible, social attitudes towards abortion make it extremely difficult for a rural woman, especially if she is not married or living with her husband, to obtain an abortion in her neighborhood clinic. The desire for secrecy and confidentiality overwhelms all other concerns when single women seek abortions. Effective treatment, the availability of equipment and machinery, safety and reliability, the doctor's attention and respect for the client - none of these criteria for quality care has as high a priority in such situations. Women want a short waiting period so that they are not seen sitting outside the doctor's office. They want the procedure to require a single visit so that they can terminate an unwanted pregnancy quickly and not have to return to the same doctor. They want the physician who performs the procedure to dispense any drugs they may require for follow-up-care, not as a convenience, but because they do not want to be seen acquiring medicine in the town or to arouse the pharmacist's suspicions. Thus women who seek an abortion may overlook many of the considerations of good health care that they would normally regard as important. For single women, the problem is magnified. Although their first concern is confidentiality, women who undergo extramarital abortions want to receive empathy, concern and counseling from the doctor. Perhaps for that reason, having a female doctor is particularly important to single women in such situations.

Among married and cohabiting women, the major impediment to obtaining an abortion is the doctor's insistence that the husband approve the procedure by signing a permission form. This requirement is more common at public health services than at private facilities, but many private doctors also resort to this defensive practice to avoid having the husband create a scene or threaten to file a lawsuit after an abortion has taken place. Being able to obtain an abortion without the approval of their husbands has the highest priority for married women who wish to terminate a pregnancy.

Single women who request an abortion also face impediments from the health system. If they claim to be married, they may be required to produce a husband's signature. If they admit that the pregnancy was conceived outside marriage, they have to say that they were raped or that they are under physical or mental stress, the only other conditions for induced abortion permitted by the MTP Act. For a single woman to acknowledge her sexuality openly and, if pregnant, obtain an abortion is to incur social censure. Single women who are sexually active therefore are made to feel as though they are engaging in an illegal activity, as well as ashamed and immoral. Their situation is made worse by their limited access to good reproductive health care.

As we move from a consideration of how rural women in Maharashtra perceive general health care to how they perceive the provision of abortion services to women outside marriage, we find that their perceived bargaining power is gradually reduced. Women trade safety and good health care for confidentiality. Noticeable in the women's narrations is that the word "abortion" does not appear at all – it is taboo. One can thus begin to understand the plight of a single woman seeking an abortion. Such a woman is a victim of society's double standard of morality, and it is unfair that she must risk her health to terminate an unwanted pregnancy.

Women choose providers pragmatically, using self-medication and unqualified doctors for minor illnesses. In one of the narrations quoted, the traveling practitioner is referred to as "Red Helmet," obviously because he wears a red helmet when he comes to a village on his motorbike. Women are aware that he is not a doctor, but his services suffice because their health problems are not severe. In contrast, women will turn to government services for chronic - that is, more serious-ailments, believing they will get reliable cures. For women with long-term diseases such as tuberculosis, itself an indicator of poverty and malnutrition, private services are unaffordable. In emergencies, women will go to any provider who is immediately available; but after receiving first aid they will go to someone more competent, usually a private doctor, who is available day or night. They will do so even if it means travelling to the city, which may be as far as 60 kilometers away.

For care during pregnancy, which usually involves simply taking iron and folic acid tablets and receiving TT shots, women prefer public health services. Most pregnant women in the area do not "register" with a doctor, and so the only services that are easily accessible to them and free of charge are those of the PHC. Public health services are also the first choice of women if they have to choose an institutional delivery, in spite of the fact that they do not regard themselves as being well treated by the staff. Their logic is that unless their labor is difficult, there is no need to spend money on a private doctor.

Because sex-determination tests are available only in the private sector, women choose to go there as the first choice. Sonography is the more popular method, and it is often followed by second-trimester abortions. For gynecological ailments, women's first choice is a private doctor, followed by the public health service. This preference reflects poorly on the latter, which does not address women's health needs beyond their needs for maternity care and family planning.

The first choice of married women seeking abortions is the private sector, favored by slightly more than half of our respondents. Because the government program asks for the husband's signature and puts pressure on women to use contraception after obtaining an abortion, some women consider the services hostile. For women seeking extramarital abortions, the clear-cut first choice is the private sector because it is less rigorous in observing the provisions of the MTP Act. Single women are made uneasy by being asked many questions, having to tell lies, and knowing that their name are kept on record. It is easier for them to go to a private doctor and have an abortion quickly, without much fuss. Their primary concern is to guard the family honor or, in the case of a mother with an unmarried pregnant daughter, to ensure that the girl remains marriageable at any cost.

In conclusion, our finding suggest that women are critical of the existing health services, including abortion services. They are upset that doctors demand their husbands' approval before performing an abortion and that government services pressure them to accept an IUD after an abortion. They are also upset that private doctors take advantage of their situation and charge them unreasonably high fees. They resent having to pay for health services in the private sector because a PHC's staff is callous or its facilities are inadequate. Nevertheless, the women feel neither defeated nor cynical. They would like their choices of care to be increased by having abortion services located nearby, and even within their villages, thereby enhancing their physical and economic access to safe abortion.

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NOTE

1 The Medical Termination of Pregnancy (MTP) Act came into effect in April 1972. According to the Act, a pregnancy may be terminated by a registered medical practitioner at a government-recognized venue: (1) as a health measure when there is danger to the life or risk to the physical or mental health of the woman (such as when a pregnancy results from the sex crime of rape); (2) if pregnancy occurs as a result of failure of any device used by a married woman or her husband; (3) on eugenic ground where there is substantial risk that the child, if born, would suffer from abnormalities and disease.

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