Research
Brief Series

MARIE STOPES INTERNATIONAL

# What obstacles do rural Indian women face when attempting to end an unwanted pregnancy?

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## Summary

While termination of an unwanted pregnancy is legal in India, women living in the state of Madhya Pradesh (MP), where fertility and maternal mortality are higher than the Indian average,[1] often encounter numerous challenges when trying to access safe abortion services. Through participatory ethnographic research, 15 men and women living in a rural district in Bhopal in MP offered their perspectives and those of their friends on barriers to accessing safe abortion services. A number of women recounted undergoing a prolonged process involving up to four abortion attempts before successfully terminating an unwanted pregnancy.

The process starts at the woman's home in the village and often escalates to a hospital visit in town. It starts with homemade concoctions and extends to medical – and later to surgical – methods. It begins with trying an affordable option by using traditional remedies and ends with more expensive procedures. Because women cannot afford to access high-quality services, they endure this process in an attempt to keep their unwanted pregnancy private and to keep the price paid to a minimum. However, the process leads to delays in women seeking services and results in high physical and financial costs. Private providers of sexual and reproductive health (SRH) services were perceived as offering the best quality of care and privacy. If they could offer effective and client-centred services at an affordable price, private providers have the potential to dramatically reduce the physical and financial burden on rural families seeking to end unwanted pregnancies.



## Findings at a glance

- Women in Madhya Pradesh often discussed unwanted pregnancies with their husband or close family members. They lacked access to safe abortion counselling, because Anganwagi workers (AWW) – the only formal source of SRH advice – are not trusted to discuss abortion.
- Stories about failed abortions are common; up to four attempts with different methods can be undertaken to end an unwanted pregnancy.
- Private providers were expensive, but considered leaders in quality of care. An accessible private provider whose service is effective can be seen as a way to reduce costs.

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## Background

The promotion and uptake of modern family planning methods in rural MP, where Marie Stopes India is setting up its first social franchising network of private providers in India, continues to be a challenge. Female sterilisation – the most common form of contraception in India, used by 38% of modern method users[2] – is sought when the family is considered complete. But few couples are aware of the benefits of long-acting reversible contraceptives for spacing births. As a consequence, women and men living in MP rely on condoms and the oral contraceptive pill (OCP) and struggle with using these short-term methods effectively.

Marie Stopes India learned from previous work that even though men name condoms as their preferred form of contraception, women are not always able to negotiate the use of this method. We also know, anecdotally, that a lack of female social mobility means that if a woman uses the OCP, it will often be her husband who buys it from the local pharmacy and he won't always convey the correct dosage. Awareness of other family planning methods is limited: misconceptions about the intrauterine device (IUD) and ignorance about injectables are reflected in a low modern contraceptive prevalence rate of 52.8% across the state.[2] As a consequence, unwanted pregnancies are common. In India, 'a large proportion of women already have more children than they now consider ideal'.[2]

Because abortion has been legal in India since 1971, various methods of termination are available in the market. However, most Indians are unaware that abortion is legal[3] and our study showed that advice on how to deal with unwanted pregnancies was sought primarily within the family and a small social network. For women, we found the only formal source of information about SRH was the Anganwagi worker (AWW), a lower level government health cadre that primarily offers child immunisation. Women consulted AWWs for discreet and factual information about family planning. However, they did not feel comfortable discussing unwanted pregnancies for fear of gossip and social stigma. Instead, women often resorted to discussing these matters with their husband or their sister in law.

In order to ensure that Marie Stopes India meets the needs of women living in MP, we explored factors affecting women's decision-making when seeking to terminate a pregnancy. This paper outlines the manner in which women access termination methods in a rural district of Bhopal in the state of MP.

Because women in MP do not openly discuss issues around abortion, we employed an innovative research method called PEER (Participatory Ethnographic Evaluation and Research), a qualitative research method pioneered by Options Consultancy Services,[4] in which we trained illiterate community members to become researchers themselves. Having obtained consent, these trained community members interviewed their friends during informal, everyday encounters and reported back their findings in private debriefing sessions. Over a period of three weeks, PEER was used to obtain an insider's perspective of social relationships, health-related behaviours and beliefs about abortion seeking behaviours in MP.

# Findings

## Steps to terminating an unwanted pregnancy

When seeking to terminate a pregnancy, women living in this rural district of Bhopal underwent a prolonged process of abortion that involved up to four stages of escalation.

1. Women who experienced delays in their menses used homemade concoctions including boiled jaggery (an unrefined sugar), black pepper, saunth (a sweet chutney), cloves and carom seeds in water. Women who drank this concoction believed that it would generate heat inside their body, resulting in bleeding the next day.

2. Medical abortion is widely known and discussed in the district as a discreet strategy for dealing with unwanted pregnancies. It is available through pharmacies and private doctors within the vicinity of the village. It is offered at limited cost and is often purchased by the husband for his wife to use in the privacy of the home. However, most women, and some men, were unaware of the correct regimen. As a result, the community shared stories of unwanted pregnancies continuing after a medical abortion attempt: 'Private providers will give medical abortion pills for a cost of 500 to 800 Rupees [£6 to £9] depending on the quality of the pills. One tablet is given at the doctor's office, one after lunch, and one at dinner. If this dosage does not work, then the woman is instructed to come back to the office'.

3. Some community members described an injection of Oxytocin, which must be undertaken in a hospital and administered by a doctor. Others mentioned an unspecified injection, also administered by a doctor (which may also have been Oxytocin). Limited awareness of this method served to heighten concerns about its legality. There were stories about failure of this 'third stage' method.

4. Women attempted a surgical abortion, initially at a government hospital. Women from this rural district of Bhopal explained that D&C (Dilation and Curettage) costs 350 Rupees [£4] at a public facility. The journey to visit a public hospital requires travelling from the village to town and incurs transport costs. Community members also described long waiting times for services and long home-based recoveries after the termination procedure, which impacted on women's ability to fulfil household duties. Furthermore, some procedures were described as being incomplete: 'Afterwards there is no check-up. If (…) they go for a follow-up visit because the D&C was not successful, the doctor will say: "It's your fault, we did a perfect D&C" and they will charge her another 300 Rupees [£3.50] to complete the procedure.'

If the surgical abortion from the public provider was unsuccessful and the pregnancy had not progressed beyond the legal limit of 20 weeks, the process continued as the woman sought a surgical termination from a private provider. The services of private providers were considered expensive, but more effective. 'For this visit [after an unsuccessful D&C] the women prefer going to a private provider because, if it is going to cost so much money, they might as well get it done properly. They do not go the first time, because the government facility is less expensive. The private providers cost 600 Rupees [£7].'

The successful surgical termination constituted the final of four abortion methods attempted, in a prolonged process which put physical and financial strain on women and their families.

## Abortion cost and willingness to pay

Because not every woman undergoes all four stages to achieve a successful termination, couples hope that by trying cheaper methods they will limit costs. While the intention is to keep the price paid to a minimum, the result is often the opposite. Table 1 displays prices paid for abortion services, as reported by couples from this rural district of Bhopal, who say families earn on average 150 Rupees [£1.70] per day. The cumulative price paid for four abortion attempts, plus transport and opportunity costs of lost labour, can quickly exceed the price of one high-quality surgical termination.

Community members said that if providers offered high quality of care and counselling for a range of family planning methods, women would be willing to pay higher fees: 'If a provider was offering good care during and post-abortion, women would be willing to spend around 1,000 to 1,500 Rupees [£11 to £17]. But doctors do not provide counselling in relation to using post-abortion family planning as it's not in their interest for women to use contraception. Doctors who are concerned about the health of the woman, may suggest a sterilisation after an abortion.'

## Community perspectives on public versus private providers

Private providers were perceived as leading in terms of quality of care and privacy of SRH services, compared to providers working in public hospitals. However, accessing private services was also challenging for rural women. There were reports that women were treated badly by both private and public health providers. Women were reportedly left uncared for and naked on hospital beds. Furthermore, doctors were judgemental and critical of clients' choice to end a pregnancy. Some private providers did not disclose information on medical abortion to prevent women from accessing the drugs from pharmacies at a lower price. Lastly, private services were perceived as being too costly for low-income families: 'Most women would not spend more than 800 to 900 Rupees on a surgical abortion and related costs such as medicines, doctor's fees and transport. If women see that they have to spend closer to 2,000 to 2,500 Rupees [£23–28.50], they will prefer to have the child.' The large price discrepancy between public and private providers is shown in Table 1.


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**TABLE 1:** Prices of abortion services as reported by women in a rural district in Bhopal, Madhya Pradesh, India

| Type of service | Private provision | Public provision |
|---|---|---|
| **Medical abortion** | • 50–100Rs [50p– £1] (from traditional healer)<br>• 60–70Rs [80p] (direct from pharmacy)<br>• 600Rs [£7] ('strong' drugs via doctor)<br>• 1,000–2,000Rs [£11–22] (for unmarried women) | • 20Rs [20p]<br>• 120Rs [£1.40]<br>• 300Rs [£3.50] ('weak' drugs) |
| **Surgical abortion (D&C)** | • 500–6,000Rs [£6–68] | • 350–600Rs [£4–7] |

## Conclusion

Couples in this rural district in Bhopal have limited knowledge of and access to effective family planning options, which in turn results in unwanted pregnancies. While abortion is legal, unsafe abortion methods are used to terminate pregnancies and experiences of failed abortions are common, due to a lack of high-quality services. Our study showed that, as a consequence, women endure a prolonged process of multiple abortion attempts to end unwanted pregnancies. Through this approach, women hope to keep their unwanted pregnancy private, as well as keeping the cost to a minimum. However, the result was often the opposite, and a sequence of up to four abortion attempts led to delays in seeking services as well as high physical and financial costs.

Private providers have the potential to cut short this escalation process and serve women's needs locally, at a comparatively lower cost and earlier on in the pregnancy.

In order for couples in this rural district of Bhopal to make use of private services, community members recommended the following:

- The cost of a termination should not exceed 1,500 Rupees [£17].
- The location must be accessible to women and in close proximity to public transport routes. An inconspicuous, low-profile exterior is valued.
- Privacy and a client-centred clinic environment are important to rural women who are unaccustomed to and frightened of visiting formal facilities.
- Transparent counselling should provide correct information on the drug name and dosage to enhance clients' understanding of medical abortion and should clarify the benefits of paying for an efficient and effective service.
- Post-abortion family planning is currently unavailable and should be offered.


## Evidence to action

Marie Stopes India is setting up its first social franchising network of private providers in India, offering a wide range of family planning options and safe abortion methods, and targeting the state of MP.

Based on this study, we built archetypes of potential Marie Stopes clients. These archetypes helped us to design services with couples such as those interviewed in mind and will help us to reduce the physical and financial burden on families.

The community's expectations of an ideal service have informed our service delivery offering at franchised providers. For instance, the price information gained from this study informed pricing guidelines for the private provider network. Similarly, client expectations around privacy, counselling and post-abortion family planning services informed the package of services provided by MSI franchisees. Findings related to medical abortion have guided our training programme with pharmacists, emphasising the need to impart the regimen to clients correctly.

Using the findings from this study, Marie Stopes India will ensure that its services in MP are client-centred and are serving those in need.

References

1. Government of India, Ministry of Home Affairs. Maternal & Child Mortality and Total Fertility Rates, Sample Registration System. 2007. http://www.censusindia.gov.in/vital_statistics/SRS_Bulletins/MMR_release_070711.pdf
2. International Institute for Population Sciences (IIPS) and Macro International. National Family Health Survey (NFHS-3), 2005–06, Volume I. Mumbai, India: IIPS, 2007.
3. Malhotra A, Nyblade L, Parasuraman S, MacQuarrie K, Kashyap N, and Walia S. Realizing Reproductive Choice and Rights: Abortion and Contraception in India. International Centre for Research on Women, 2003. http://www.icrw.org/files/publications/Realizing-Reproductive-Rights-and-Choice-Abortion-and-Contraception-India.pdf
4. Price N and Hawkins K. Researching sexual and reproductive behaviour: a peer ethnographic approach. Social Science & Medicine 55 2002; 1325–1336.

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### Further Reading

Thoai D. Ngo et al. Risk factors for repeat abortion: implications for addressing unintended pregnancy in Vietnam. FIGO, 2012 & FIAPAC, 2012.

Azmat SK et al. Delivering post-abortion care through a community-based reproductive health volunteer programme in Pakistan. Journal Biosoc Sci. 2012 Nov;44(6): 719-31.