Workshop on

SAFE ABORTION: A COMPREHENSIVE UPDATE

A Report

GUWAHATI, ASSAM

17-18 JUNE 2010

Organized by

Asia Safe Abortion Partnership (ASAP)

in collaboration with

Common Health (CH), Federation of Obstetrics and Gynaecologists' Society of India (FOGSI) and

State Institute of Health & Family Welfare, Assam

SAFE ABORTION: A COMPREHENSIVE UPDATE

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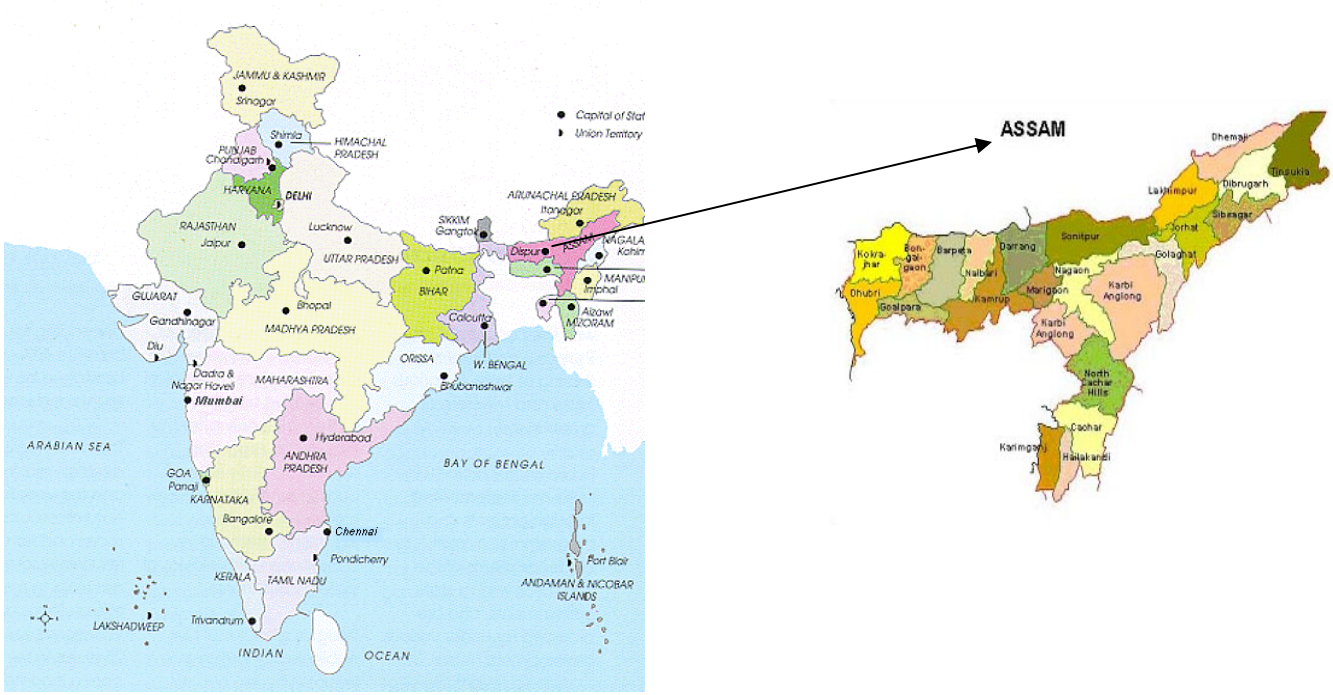
Assam State



Assam State

Assam is situated in the North East of India surrounded by Bhutan and Arunachal Pradesh in North, Bangladesh, Mizoram and Manipur on South, Nagaland on East and West Bengal and Meghalaya on West. Its geographical area is 78438 sq km. with a population density of 340(2001) per sq. km. The total population of Assam stood at 26655528 as per the provisional results of the Census of India 2001. The capital of Assam is Dispur, a suburb of Guwahati.

Some riverine areas created by the mighty Brahamaputra River are inhabited by a large number of populations comprising of mainly ethnic people in upper reaches and immigrants from Bangladesh in lower reaches.

There are some difficult areas viz riverine areas popularly called as char areas, tribal areas, tea garden areas, hill areas and forest village bordering neighbouring states and countries.

Health Indicators of Assam

The Total Fertility Rate of the State is 2.6. The Infant Mortality Rate is 64 and Maternal Mortality Ratio is 480 (SRS 2004 - 2006) which are higher than the National average. Comparative figures of major health and demographic indicators are as follows:

Table I: Demographic, Socio-economic and Health profile of Assam State as compared to India figures

S. No.	Item	Assam	India
1	Total population (Census 2001) (in million)	26.66	1028.61
2	Decadal Growth (Census 2001) (%)	18.92	21.54
3	Crude Birth Rate (SRS 2008)	23.9	22.8
4	Crude Death Rate (SRS 2008)	8.6	7.4
5	Total Fertility Rate (SRS 2008)	2.6	2.6
6	Infant Mortality Rate (SRS 2008)	64	53
7	Maternal Mortality Ratio (SRS 2004 - 2006)	480	254

Rationale for workshop

According to the Sample Registration Services (SRS) 2004-2006, the maternal mortality ratio (MMR) for Assam was 480 per 100,000[1] live births - the highest in the country[2]. India's MMR was 254.

Reasons for Assam having the **highest maternal mortality** include -Insurgency in the state as one of the main reasons because it affects access to basic healthcare services. There is a gamut of social issues, insurgency, poor development, lack of infrastructure, lack of manpower in healthcare system and other such barriers. Eighty seven percent of the population is rural which combined with the geographical surrounding is likely to make the access to healthcare services limited. As it has been recognised in various studies conducted earlier, unsafe abortions contribute to the causes of high maternal mortality.

Worldwide, 210 million women become pregnant every year, of which about 42 million women faced with an unplanned or unwanted pregnancy terminate their pregnancies voluntarily. Nearly half of all induced abortions (20 million) are unsafe[3]. Ninety five percent of unsafe abortions occur in developing countries. Five million women – or 1 in 4 who have an unsafe abortion --are likely to suffer severe complications. Almost 70,000 women die from these complications every year[4].

[1] Sample Registration Services (SRS) 2004-2006

[2] http://beta.thehindu.com/health/policy-and-issues/article183147.ece

[3] The World Health Organization defines ***unsafe abortion*** as a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.

[4] World Health Organization. *Unsafe abortion: global and regional estimates of incidence of unsafe abortion and associated mortality in 2003*. Geneva , Department of Reproductive Health and Research, WHO, 2007.

Many reasons underlie **women's unmet need** for safe abortion. Women's limited access and control over information and financial resources and lack of decision-making power erect formidable barriers to accessing safe abortion services. Unmarried women, widows and single women face additional barriers due to the social stigma attached to pregnancies outside marriage. Abortion services may be unavailable or inaccessible because of lack of public health facilities and high costs in private health facilities[5].

The role of **public health delivery systems** is very vital in making safe abortion services available and accessible to women especially keeping in mind the difficult geographical terrain and remote difficult to access areas. Government has taken the initiative to improve access to the health care service through strengthening Primary Health centres (PHCs), providing Mobile services in order to take the services as near to the community as possible, apart from training Accredited Social Health Activists (Asha's) and setting up Village level health and sanitation committees.

In order to further strengthen and improve the availability and accessibility of quality safe abortion services which are acceptable to the women by involving the stakeholders in the public health service delivery sector, Asia Safe Abortion Partnership (ASAP) organised a workshop on **Safe Abortion: A Comprehensive Update** along with CommonHealth (CH), FOGSI and Ministry of Health and Family Welfare, Assam.

The workshop concentrated on the issue of improving the scope of comprehensive safe abortion services including post abortion family planning services which are vital to improve the maternal health. Newer methods for providing safe abortion services like MVA and MA were also discussed, in order to provide wider choice to women even in resource constrained settings especially where provision of basic facilities like electricity supply is also difficult. Discussions were undertaken on the social issues, barriers to access services and how to overcome such constraints in order to make these services accessible to women. The importance of providing services through rights based and gender sensitive approach were discussed.

Methodology

Training workshop with PowerPoint presentations, Group work based on case studies, Quiz, Classroom as well as hands on training.

[5] SAFE ABORTION: WOMEN'S HEALTH AND RIGHTS ISSUE – CommonHealth fact sheet, 2009

DAY 1: 17 June 2010

The Superintendents and Gynaecologists –a total of **43 from 26 districts of Assam** arrived and registered for the workshop at about 9.30am. **Dr Hazarika**, **Director, State Institute of Health & Family Welfare** welcomed all the participants, the resource persons and the Health Officials. Followed by this there was an inauguration ceremony attended by Officials from the Ministry of Health of Assam and from NRHM. Dr P N Bora **State Programme Manager (SPM), NRHM, Assam** and **Dr Ekka**, **Mission Director, NRHM, Assam**, where among the state official who visited and met the participants.

During the inaugural talk emphasis was laid on the occurrence of teenage pregnancy which was said to be 66% in one of the districts. The prevalence of high MMR and the possible reasons for the same in the state of Assam was also discussed. The importance of Quality assurance in the service delivery was also emphasised by one of the officials. Dr. Hazarika then announced the official start of the workshop. (Annex 1)

Sessions

We started the day with the introductory session: **Introduction of Safe Abortion as an Issue- *Dr. Shilpa Shroff*, ASAP**. This session explored the issues related to safe abortion and why unsafe abortion is still prevalent in the community. The audience then discussed reasons of high MMR such as late referrals, delayed prolonged labour, obstructed labour, PPH and eclampsia. It was said that the incidence of septic abortions are reducing at district level hospitals and it may be because they are being treated at private clinics. There is an increase in cases of incomplete abortion due to inappropriate MA dosage by quacks and chemists. It is noticed that along with Mifepristone and Misoprostol some local drugs are used for medical abortions whose names are unknown.

It was pointed out that morbidity related to unsafe abortion is greater than mortality. It was found that Medical Abortion (MA) is easily available OTC even though not prescribed by a Gynaecologist. It was also felt that surgical abortion is safer than MA, and some of them even added that they used combination of MA and Surgical Abortion. On being asked about the details it was seen that they use Misoprostol for Cervical dilation prior to surgical evacuation (EVA). D & C is also still practiced.

Criteria of Safe Legal Abortion - Dr. Sukhbir Kaur, *Programme Officer*, CommonHealth - Session started with a quiz based on MTP Act. After the participants answered the quiz, it was discussed in the audience.

Some of the points elaborated during the session were

- Training of MTP providers - some participants felt that the Ayurvedic practitioners were eligible for providing MTP services
- Rape case - role of Doctors in informing the authorities
- Age – if the client is obviously minor but states that her age is 18 years, what should be the role of a provider?
- Who is a legal guardian of a minor?
- Consent issue

In response to reasons why women seek abortion from untrained providers:

- Easy accessibility
- Confidentiality issues
- Fear of surgical intervention
- Lack of awareness of services available, legality of MTP
- Cost
- Lack of availability of trained personnel

Some of the observations from the session were

- Most of people were not aware that MTP reports from licensed institutions were to be sent to Family district office by form II.
- Most of the participants were not aware of the requirements of the health care facility and approval for the 1st TM and 2nd TM abortion under the amendments
- Participants were very clear about the PCPNDT act.

The quiz was followed by a power point presentation based on the MTP Act which further clarified the doubts.

Post abortion care - ***Dr Sukhbir Kaur-*** The presentation started with discussions on different types of abortions cases that needed the post abortion care, with focus on unsafe abortions leading to septic abortions and provided an insight into the highest amount of care required. The implications at various levels such as personal, social, economical, healthcare were discussed. The Post abortion care dealt with a holistic approach required in order to provide the whole range of abortion care services. Stress was laid on the importance of establishing the linkages for integrating emergency services, post abortion contraceptive services and other reproductive health services inclusive of the focus on adolescent health care needs. The immediate necessity of providing the post abortion contraceptive options and services to the women undergoing MTP was emphasized since fertility can return as early as 11 days after the abortion. Various contraceptive options including the male methods and when they can be started were discussed. The importance of counseling and male involvement was shared. Care of the client during emergency services, use of newer technologies like MVA and Misoprostol for management of incomplete abortion was

Some of the observations were

- Hardly any gynaecologist uses MA in their practice. On being asked about the reasons we found that they were comfortable practicing the surgical evacuation, non availability of MA at district level and MA was mostly available OTC , so patients did not come to them for MA
- One of the doctors discussed a case of septic abortion which led to intestinal perforation and the woman had to undergo 3 major reconstruction surgeries to be saved.
- Non availability of the MTP inform consent forms and , Form 1 and Form II at district hospitals and the situation is varying in different districts

shared during the session. Finally, the things a client should know before she leaves the clinic were reiterated.

Gender and Rights - ***Dr Shilpa Shroff and Dr. Sukhbir Kaur.*** Participants were divided into three groups and were given three case studies. They were asked to identify gender issues, violation of rights and the health outcomes in these cases. (Annex 2)

They were then asked to present their finding on each case. The discussion that followed brought out the fact that participants were **unaware of gender as a concept and the issues related to gender and health**. But they could identify the rights being violated and the health outcomes of each case.

The linkages between the three issues were discussed, barriers were taken into account during discussion and the critical role of health care system in the whole scenario was identified.

Manual Vacuum Aspiration and **Allied issues: Availability of USG facility and other services; Informed Consent; Discharge of the patient; Post abortion contraception; role of nurses** - ***Dr. Milind Shah*****, ASAP and FOGSI.**

Importance and steps of pre and post abortion counselling with a focus on women centred counselling in order to assist women to choose was discussed in detail. Examples of day to day experience where discussed. Informed consent which is also **necessary while providing MA** was shared. Role and usage of allied techniques while providing the abortions services, client assessment, elements of comprehensive abortion care were discussed in detail. He then showed the video clips

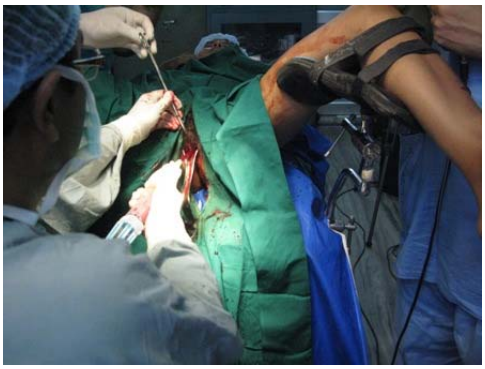
on MVA syringe - its parts, handling of MVA syringes, dismantling, and arranging the tray prior to procedure. The Video clips also demonstrated the technique of MVA, examination of products of conception, and also the procedure for disinfecting the instruments following the procedure.

The day ended with questions on MVA techniques from the floor. The group was assured that this will be taken up in more details on the next day with the hands-on training.

DAY 2: 18th June 2010

The participants and the resource persons attended the Hands on Training at the Government Medical College in the first half of the second day of the workshop.

Hands-on training on MVA at the Government Medical college Hospital-



The arrangements for the hands-on training were made at the Government Medical College, Assam in the OBGYN operation theatre. Five cases were arranged for MVA. The clients were assessed for eligibility and later on posted for surgery. Four women were for MTP and one was for evacuation for incomplete abortion. CCTV arrangements were made in the auditorium and Dr. Saswati Choudhury from FOGSI facilitated the discussions from the auditorium. Dr. Milind Shah (FOGSI), Dr. D. J. Gharpholiya (Government Medical College, Assam) and Dr. Gokuldas (FOGSI) demonstrated the MVA technique in the OT which was followed by the hands-on training of few of the participants. All of the participants could not have the hands- on experience due to shortage of cases.

The pertinent questions/ discussion were:

- Regarding sterilization of MVA Set.
    - The sterilisation using HLD and autoclave was discussed.
- Advantages of MVA over EVA :
    - Done in resource limited setting without dependence on electricity
    - Use of plastic canulae is much safer
    - Pressure is equivalent to that created under EVA
    - Products of conception can be easily visualised while being removed
    - Asepsis is better maintained in MVA if protocols are properly followed

- Usage of Misoprost and Primiprost prior to the procedure were discussed
- Screening, eligibility criteria and use of allied techniques were discussed
- It was shared by the resource persons that the technique can be safely used till 8 weeks of MTP in PHC settings while it can be used till 12 weeks in the settings having better back up facilities.

Use of General Anaesthesia wherever necessary especially in post caesarean MTP cases was also discussed. Management of the fainting attacks before taking up the procedure, importance of monitoring of hemodynamic stability in such cases and further management was discussed.

Participants had queries on the volume of syringe in case of evacuation of large vesicular mole at greater gestation age. It was advised to use two or more syringes for the procedure and again the safety of using MVA was emphasised.

MVA use by MBBS doctors for treatment of incomplete abortion was also discussed.

Following the demonstrations there was **session** on **Medical methods of abortion by Dr. Saswati Choudhury and Dr. Gokul Chandra Das**. The entire development over the years of the methods of Medical abortion, dosage, gestation age for use and various developments were shared. Post abortion contraception following MA was emphasised with a basket of choice. Second trimester abortion using MA with emphasis on use in clinical settings and role of allied techniques in such cases was discussed.

Post Lunch Session

Panel Discussion- **Dr. Milind Shah, Dr. Gokul Chandra Das, Dr. Saswati Choudhury, Dr. Shilpa Shroff and Dr. Sukhbir Kaur** had interactions with the participants during this session.

The concerns expressed by the participants which were answered during the session were

- Use of MMA in second trimester abortion and complications
- Low lying placenta and MA use
- Multigravida with 20 weeks pregnancy and MA use
- Non response to the MA use if used as per protocol, the maximum waiting time and repeat of dosages
- Maintaining the records and documents as per MTP Act

Valedictory session

The facilitators, participants and organisers shared their thoughts on the workshop. Dr. Hazarika, Director of State Institute of MOHFW proposed the formal vote of thanks.

The feedback on the use on MVA techniques at the district level after about 3-4 months was also discussed with the Director MoHFW and ASAP was reassured that this feedback will be collected from all the districts officials.

The workshop came to an end with the distribution of Certificates and the distribution of MVA kits for each District Hospital.

Analysis of the Feedback forms

The feedback forms were gathered on both days from the participants (39 out of 44 gave the feedback). The feedback of five participants was missing. On first day the forms were collected from all the superintendents. The second day was for only Doctors which had initial sessions arranged at the medical college hospital, while lunch and valedictory was arranged back at the institute. As we had collected the forms after valedictory function in the institute, it is possible that these five Doctors had left early.

The feedback forms received from 39 participants were further analysed.

The questions asked and responses on the workshop topics and discussions were

- Whether the subjects were well chosen - 23 out of 39 (59 %) participants agreed and 16 out of 39 (41 %) strongly agreed
- Whether the Presenters were knowledgeable – 21(54%) agreed and 18(46%) strongly agreed
- Whether the design of the presentations was appropriate – 28 (72%) agreed and 11(28%) strongly agreed on it.
- Whether the supporting material was useful - 29 (74%) agreed, 9(23%) strongly agreed while one was Neutral on it.

Questions asked in the context of the personal value in relation to the workshop and the responses on the same were –

- Whether gained new knowledge and insights-while 27(69 %) agreed and 11(28 %) strongly agreed but one (3%) was neutral
- Whether the quality of work will be enhanced as a result of participating in the workshop – 26 (67%) agreed, 12(31%) strongly agreed while one was neutral
- Whether participants were satisfied with the opportunity to participate in the workshop – 29 (74%) agreed and 10(26 %) strongly agreed
- Whether the interactions between participants and presenters were ideal - 27(69%) agreed and 12 (31%) strongly agreed
- Whether the conversations with other participants were beneficial - 29(74%) agreed and 9(23%) strongly agreed and one was neutral

The topics that were found most valuable to the participants were:

Majority of the participants felt that almost all the sessions were relevant and useful while few of them specified about the following sessions

- Six participants felt that the session on the **MTP Act** was very useful as it provided the in depth information on the MTP Act, rules and amendments. Further discussions during the

session brought out the clarity on doubts related to consent, records, etc and which will also help in hospital administration

- Five participants felt that the **hands on training for Manual Vacuum Aspiration** was useful as it was also supported by closed circuit camera and interactive communication and provided opportunity for the participants to put forth their queries directly to resource persons

- Six participants felt that the session on **Manual Vacuum Aspiration** was very useful as it provided an understanding of on the MVA technique as a safe procedure and effective procedure with fewer complications. One participant also shared that the In depth information on the MVA syringe, it maintenance and functioning was also useful as he/ she was ignorant about it in the past

- Couple of participants felt that the session on **Gender and Rights** was useful as the knowledge till know was limited on these issues. This session provided clarity on the rights of women as an individual

- One participant shared that the **Presentations of case studies was useful** as these facilitated interesting discussions and interactions

- One participant shared that information **Medical methods of abortion** was useful and it also provided information on the importance of obtaining the consent for same, as till now he/she were not keeping the record of the same.

The topics that were found least valuable to the participants:

- While most of the participants felt that all the topics were relevant and useful, two of them felt that Gender and Rights was least valuable. One did not specify any reason while the second one felt that the session was lengthy. These responses were from the forms collected on day one which were from superintendents.

In the future sessions of this workshop, they would like to have these areas covered:

- Medico legal aspect of MTP; Medico legal updating of doctors
- Legal and practical issues related to MTP in teenagers
- Involvement of Media persons should be there in such workshops.
- Septic abortions
- Hands on training for all the participants
- Management of complications
- Community acceptance of MVA

- Requirements for abortion procedures
- Disinfection and sterilisation
- How many times a woman can undergo MTP
- Soft copy of the topics to be provided to the participants
- Abortion in HIV positive women

Suggestions made to improve the future workshop were:

- Audio visual sessions to be improved by providing soft copies of session presentations
- Smaller groups and interactive sessions
- More detailed description, taking more time for discussions
- Training of rural doctors; Include PHC and CHC level Doctors
- MBBS doctors to be included in this workshop
- Increased duration of workshop for elaborate information.
- Presentation of more case studies
- Separate sessions for superintendents and Gynaecologists
- Such types of workshops to be organised more frequently
- Sonologist may be included as resource person

Additional Comments by participants

- Many of them found that the workshop was short comprehensive and more beneficial with the techniques discussed in the workshop
- Many of them agreed to pass the techniques of MVA to colleagues and try to promote it at district level
- Some felt that there should be better information sharing between the district office and rural hospitals
- Few mentioned that there is a need of District officials to keep check on the practices by quacks
- One participant felt that there is need to share the information with health workers under him
- Awareness to be created on issues related to Safe Abortions in view of social stigma women's disempowerment
- Few mentioned that there is a need of District officials to keep check on the practices by quacks

Annexure I

AGENDA

Asia Safe Abortion Partnership

Workshop On

Safe Abortion: A Comprehensive Update

June 17-18, 2010

Venue: State institute of Health and Family Welfare

Asia Safe Abortion Partnership (ASAP) in collaboration with **Common Health (CH)** , **Federation of Obstetrics and Gynaecologists' Society of India (FOGSI) and State Institute of Health & Family Welfare, Assam**

Day 1		
Time	**Session**	**Speaker**
9.00 am – 10.00am	Registration and Tea	
10.00 am - 10.30am	Inauguration	
10. 30 am – 11. 00 am	Introduction of Safe Abortion as an issue	Dr. Shilpa Shroff , ASAP
11.00am – 11.30 pm	Criteria of Safe Legal Abortion	Dr. Sukhbir Kaur, CH
11.30am – 12.30 pm	Post abortion care	Dr Sukhbir Kaur, CH
12.30 – 12.45 pm	Gender and rights	Dr Shilpa Shroff and Dr. Sukhbir Kaur
12.45 pm – 1.30pm	Lunch	
1.30pm – 2.00pm	Presentation of the case studies	Dr Shilpa Shroff and Dr. Sukhbir Kaur
2.00pm - 2.30pm	Training to provide abortion services	Dr. Milind Shah, ASAP, FOGSI
2. 30pm – 3.15pm	Requirements for abortion procedure (disinfection/ sterilization/ disposal of biomedical waste)	Dr. Milind Shah,ASAP, FOGSI
3. 15pm – 3.30 pm	Tea	
3.30pm – 4.30 pm	Allied issues: Availability of USG facility and other services; Informed Consent; Discharge of the patient; Post abortion contraception; role of nurses.	Dr. Milind Shah,ASAP, FOGSI
4.30pm – 5.30pm	Manual Vacuum Aspiration	Dr. Milind Shah, ASAP,FOGSI
5.30 pm	End of day 1	
Day 2		
Time	**Session**	**Speaker**
10.00am – 12.30pm	Hands-on training on MVA at the Government Hospital	Dr. Gokul Chrandra Das and Dr Saswati Choudhuri , FOGSI
12.30 – 1pm	Travel back to the Venue	
1.pm – 1.45pm	Lunch	
1.45 pm – 2.45pm	Medical Methods of abortion (1st and 2nd Trimester)	Dr. Gokul Chrandra Das and Dr Saswati Choudhuri , FOGSI
2.45 pm- 3.15pm	Tea	
3.15pm – 4.15pm	Panel discussion : practical issues of safe abortion	ASAP, CH, FOGSI
4. 15 pm	End of the WS	

Annex 2

Case study: Anjana

Anjana came to the clinic with her 78-yearold grandmother, who was not able to provide any support other than waiting outside the clinic. She would wait outside the clinic till her granddaughter got things cleared at different stages in the health care system.

The young woman was working as a housemaid for the past year at a place far from her house. She had been recruited through a broker. She said, “I lost my father 10 years ago. Mother, grandmother and my younger brother were at home. I have an elder sister who is married and lives away from home. My mother was not able to go for work for the last few years because she suffers from weakness of hands and limbs. My brother rarely gets some work. Since I have to support the family I opted for the job.”

Three months after starting work as a housemaid, the unmarried boy in the house, who was 28, (he and his mother stayed in the house), asked Anjana to have sex. She refused. He approached her again with reassurances. She consented and they had regular sexual contact for nine months. He used condoms for about two weeks initially but then discontinued, saying using them was painful. He bought three packets of oral contraceptive pills and asked Anjana to use them. She refused because she did not know how to use the pills. She also thought that the pills might harm her uterus. She knew about pills, condoms, as well as IUDs and injectables from the radio, television and books.

Anjana developed itching and vaginal discharge after a month of sexual contact. She was not able to approach any health care provider and took no treatment. She suspected pregnancy at about six weeks of amenorrhoea and told her sexual partner. He said he would not marry her because nobody would agree to such a match. He gave her Rs. 800 and asked her to go home and go to a hospital.

Anjana informed her mother and grandmother but not her brother. Her mother advised her to go to a local hospital. The pregnancy was confirmed and the local hospital referred her to the tertiary care centre. Because her mother was sick, Anjana came to the clinic with her old grandmother.

She came late to the hospital and could not get registered that day. She went back and could return only after three weeks because of financial problems. She had a vaginal infection that was treated symptomatically. Her pregnancy was terminated without any immediate morbidity. Anjana said that abortion was bad in general and it was specifically bad for the uterus because there was a chance that in future she may not be able to have another child.

Case study: Anita

She came with her 36-year-old mother to the clinic to terminate her pregnancy. The mother had been working in a far away place for the last two years. The girl was staying with her father and younger brother. The mother would come home once in two months, but she used to talk on the telephone every week with her daughter. The girl attained menarche at the age of 12, and since then had irregular cycles.

She reported frequent (at least twice a week) sexual contact with her father over the past one year. Initially, the father would beat her for refusing to have sex with him. Later, seeing no way out, she continued the relationship. She had no idea that this could lead to pregnancy. “Only now I have started learning about reproduction in school. We have a chapter about this,” she said.

The girl missed her periods but never thought of pregnancy. The amenorrhoea was regarded as part of her irregular cycles. She never talked about the amenorrhoea with anyone. She said she was afraid to tell her mother because she was afraid that her mother would scold her. She did not tell her father or any other family members or close friends. "How could I say bad things about my father to others?" she asked.

When her mother came home from her contract work, the girl was taken to a nearby hospital because of pain in the leg. The pregnancy was not diagnosed and she was put on some medication for pain. She was then moved to a hostel for further studies. When she began to feel uneasy, she told the warden about the amenorrhoea. The warden informed the mother. Since then the father has been absconding. There were no further delays in the health system and the girl did not develop any morbidity.

The hospital authorities wanted to register a case against the father, but the mother did not agree. The mother blamed her daughter, saying that the girl should have informed her early about the entire situation. About the abortion, the girl said, "It is good to terminate for my future."

Case study: Muneja Bibi

Muneja Bibi was a Muslim woman, living in a large extended family with 9 brothers and their families. They are not poor, and have many small scale business ventures. They have a two-storied 'pukka' house in an otherwise poor village. She was pregnant for the 4th time. She had 3 daughters but she desperately wanted a son. She went with her husband to a big doctor in the city, where an ultra sound was done and they told her that the baby was another female. It was the 4th month of the pregnancy. She and husband returned to the doctor (an MBBS & DGO) the next day for an abortion. The abortion was done. The doctor told her to come back for check up after 8 days.

When she returned home her in-laws all came to know what they had done, and she faced much abuse from them. They said whatever be the case, she should not have had an abortion. She did not return to the doctor after 8 days for the check up. However the bleeding didn't stop. She bled for 18 days. One day she went to the pond for a bath, and she collapsed. The family took her to a private hospital in the city, where the doctor told them that she had no blood left in her body. Before they could give any blood or start the treatment she died.

This story was told by an old woman of the village. The family of the woman gave a different story. They say that she was bleeding before the abortion was done (missed abortion), and went for a D & C. They do not mention anything about the ultrasound. Her husband, however, remarried after 6 months.

Annexure III

List of Participants of Workshop on Safe Abortion from 17.06.2010 to 18.06.2010

SL NO.	DISTRICT	NAME OF PARTICIPANTS	DESIGNATION	SPECIALIZATIO	ADDRESS	PHONE NO.
1	Barpeta	Dr.(Mrs). BinitaGoswami	Dy. Supdtt.	MD(Path)	Civil Hospital	9435042452
2	Barpeta	Dr. Sanjib Kr.Sarkar	Sr. M & HO	DGO	Civil Hospital	9435025268
3	Baska	Dr. Subhash Sarma	Sr. M & HO	MD(O&G)	Civil Hospital	9435305163
4	Bongaigaon	Dr. Mahendra Nath Saikia	Supdtt. I/C SDM & HO	MS(GS)	Civil Hospital	9435021354
5	Bongaigaon	Dr. (Mrs) Shalibi B Bora	M & HO-1	MD(O&G)	Civil Hospital	9435022594
6	Cachar	Dr.(Mrs). Tapati De	Supdtt.		Civil Hospital	9435503463
7	Cachar	Dr. Arun Dev Nath	M & HO-1	DGO	Civil Hospital	9435071808
8	Chirang	Dr. Ujjal Kr.Sarma	Supdtt. I/C		Civil Hospital	9435340059
9	Darrang	Dr. Samsul Hoque	M & HO-1	MD(O&G)	Civil Hospital	9435191725
10	Dhemaji	Dr. P.K. Sarma	Supdtt.	DMRD	Civil Hospital	9435085790
11	Dhemaji	Dr. Trikendrajit Taid	M & HO-1	DGO	Civil Hospital	9435089531
12	Dhubri	Dr. K.M.Das	Supdtt.	MD	Civil Hospital	9435561305
13	Dhubri	Dr. Sashi Dhar Deka	SDM & HO		Civil Hospital	9435029641
14	Dibrugarh	Dr. Apurba Rajkonwer	Sr. M & HO		O/O the Jt DHS	9435390170
15	Dibrugarh	Dr. Debajit Sahu	Consultant (O &G)	O & G	Naharani FRU	9957643255
16	Goalpara	Dr. Bipin Rabha	Supdtt.		Civil Hospital	9957479424
17	Goalpara	Dr. Juri Sarma	SDM & HO	DGO	Civil Hospital	9435024039
18	Golaghat	Dr. Apurba Kr.Hazarika	Supdtt.	MD(O&G)	Civil Hospital	9435053718
19	Golaghat	Dr. Kabita Uzir	M & HO-1	DGO	Bokakhat FRU	9435526710
20	Hailakandi	Dr. Mritunjoy Das	Dy. Supdtt.	MS(Surg)	Civil Hospital	9577366637
21	Hailakandi	Dr.S. Chakraborty	Sr. M & HO	MD(O&G)	Civil Hospital	9864527567
22	Jorhat	Dr. Dwipul Kr. Bora	Supdtt.	MD(Anas)	Titabor SDCH	9435090244
23	Jorhat	Dr. Achyut Kr. Das	M & HO-1	MD(O&G)	Titabor SDCH	9435168618
24	Kamrup(M)	Dr. Pritti Devi Kakoty	SDM & HO	MD(O&G)	MMC Hospital	9706011983
25	Karbi Along	Dr.(Mrs). K. Rangpipi	Supdtt.	MBBS	Civil Hospital	9435166273
26	Karbi Along	Dr. R.C. Rongpher	Consultant (O &G)	MD(O&G)	Civil Hospital	9854431611
27	Karimganj	Dr. S.Das	M & HO-1	DGO	Civil Hospital	9435075389
28	Kokrajhar	Dr. Abdul Moid	Supdtt.	MS(GS)	Civil Hospital	9435026113
29	Kokrajhar	Dr.Jitendra Kr. Nath	Sr. M & HO	O & G	Civil Hospital	9435027246
30	Lakhimpur	Dr. Ananda Dihingia	Supdtt.	MD(Medicine)	Civil Hospital	9435084549
31	Lakhimpur	Dr. Gobin Saikia	M & HO-1	MD(O&G)	Civil Hospital	9435085246
32	Morigaon	Dr. Krishna Kanta Bora	Supdtt.	MD(Medicine)	Civil Hospital	9435161863
33	Morigaon	Dr. Dhiren Ch Nath	Sr. M & HO	MD(Gynae)	Civil Hospital	9435060425
34	N.C.Hills	Dr.(Mrs). Krishna Kemprai	Supdtt. I/C		Civil Hospital	9435712794
35	Nagaon	Dr. Pulin Bhattacharjee	Supdtt.	Anaes.	Civil Hospital	9435060419
36	Nagaon	Dr. Lakshan Pd. Sarma	M & HO-1	DGO	Civil Hospital	9435062958
37	Nalbari	Dr. Nripendra N. Dutta	Supdtt.	MD(GS)	Civil Hospital	9435028666
38	Nalbari	Dr. Harkumar Sarma	Sr. M & HO	DGO	Civil Hospital	9859421754
39	Sivasagar	Dr.(Mrs) Reena Changmai	Supdtt.	MD(O&G)	Civil Hospital	9435057764
40	Sivasagar	Dr. Hemanta Kr. Baruah	Sr. M & HO	DGO	Civil Hospital	9435055488
41	Sonitpur	Dr. Anjali Goswami	Supdtt.	MD(Medicine)	Civil Hospital	9864180353
42	Sonitpur	Dr. Ranjan Kr. Das	M & HO-1	MD(O&G)	Civil Hospital	9435081722
43	Udalguri	Dr. Subhash Ch.Das	Supdtt.	MS(Gynae)	Civil Hospital	9435081116
44	Udalguri	Dr. Chandan Saha	M & HO-1		Civil Hospital	9435185382