The Gender and Reproductive Health Research Initiative
Mapping a Decade of Reproductive Health Research in India

Gender Gaps in Research on Abortion in India

A Critical Review of Selected Studies (1990-2000)

TK Sundari Ravindran

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The Gender and Reproductive Health Research Initiative has been supported by The Ford Foundation. Support for printing, publishing and dissemination has been provided by The Rockefeller Foundation.

Suggested Citation:
Ravindran, T.K.S. Gender Gaps in Research on Abortion in India: A Critical Review of Selected Studies. The Gender and Reproductive Health Research Initiative. CREA. New Delhi.2002.

Project co-ordinators:
Geetanjali Misra (CREA) and T.K. Sundari Ravindran (RUWSEC)

Published and disseminated by:
Creating Resources for Empowerment in Action (CREA)
2/14, Shantiniketan, Second Floor, New Delhi 110021
Phone: 91-11-24107983, 91-11-26874733 Telefax: 91-11-26883209,
Email: crea@vsnl.net Website: www.creaworld.org

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CONTENTS

I. CONTEXT

In a global context where induced abortion is restricted by law and even criminalised in several countries, India enjoys the dubious distinction of being a country where abortion is legal but largely unsafe and unavailable. In 1972, with the implementation of the Medical Termination of Pregnancy (MTP) Act of 1971, India joined 25 other countries, which had enacted a legislation decriminalising abortion and making it legally available.

The MTP Act of 1971 permitted abortions to be performed not only on therapeutic and eugenic grounds, but also for humanitarian reasons such as pregnancy resulting from rape, for pregnancy resulting from contraceptive failure, and for 'social' reasons: 'where actual or reasonably foreseeable environment (social/economic) would lead to risk of injury to the health of the mother.

Assessments of India's abortion scenario in the 1990s raised an alarm bell. The legalisation of abortion had not solved the problem of morbidity and mortality related to septic abortion. A larger number of women were found to be seeking abortion services outside the approved facilities in the 1990s than was the case in the 1960s when concern on this score brought about the MTP legislation *(3)*. Mortality from septic abortions was estimated to range from 11% to 20% of all maternal deaths in the late 1990s *(53)*.

India's MTP Act was championed by medical practitioners who were concerned with the high toll that septic abortions took on women's lives, as well as those who saw induced abortions as a response to India's growing population.

A 1965 article suggests that legalising induced abortions would 'rapidly bring down the rate of population growth in India', and could be used 'till the population is educated in modern contraceptive methods'.[1] Articles published after the enactment of the MTP law also saw the move 'as one of the most recent steps taken by the government towards checking population growth.' [2, 3]

However, there were others who conceived of the MTP Act as a health measure. An editorial appearing in the Indian Journal of Public Health in 1972 emphatically states that 'one important point to note is that this measure (the Act) is not a birth control measure but a measure for preventing mortality and morbidity amongst the mothers.' [4]

Unlike in many countries of the world where liberalisation of abortion was and is a central demand of the women's movement, in India abortion was never framed as a women's reproductive rights issue, affecting women's ability to control their sexuality and fertility. Writings by medical practitioners in the years following the legalisation of abortion make this amply clear. Many medical practitioners saw abortion as a necessary evil subject to misuse by irresponsible 'lay people', and the role of the physician was to ensure that it was not misused.[5] It was feared that women's 'abortion-proneness' had increased because of the publicity following the legalisation.[6] A study on the 'problem of unmarried mothers' condemns the legislation for contributing to an increase in 'pre-marital sexual excursions, as this (the MTP Act) has removed from the minds of unmarried girls the fear of social ostracism by removal of the unwanted foetus'. The study holds the 'unmarried mothers' responsible for 'entering into incestuous relationships' motivated by 'sexual urge' and trying to cover up this naked truth with 'many excuses'.[7]

1. Sengupta B. Liberalisation of abortion as a population control measure. Indian Journal of Public Health Vol ix no.2, April 1965, pp 69-73
2. Goraya R, Mohan D, Agarwal N, Takkar D, Hingorani V. A pilot study of demographic and psychosocial factors in Medical Termination of Pregnancy. Journal of Indian Medical Association Vol 61 No.11, 1975. pp 309-315
3. Roy M, Ghosh BN, Lahiri BC. Indian Journal of Public Health Vol. XXI no.2, 1977, pp.83-88
4. Editorial, Indian Journal of Public Health, Vol. XVI no.2, 1972, pp37-38.
5. Ghosh N. Misuse of Medical Termination of Pregnancy. Editorial, Journal of the Indian Medical Association, Vol 80 No.1, 1983, pp 32-33.
6. Lahiri D, Konar M. Abortion hazards. Journal of the Indian Medical Association, Vol 66 no.11, 1976, pp.288-94
7. Mandal KT. Problem of unmarried mothers. Journal of the Indian Medical Association Vol.79 No. 5&6, 1982.

Subsequent research on abortion concerned itself largely with estimating abortion rates and ratios, morbidity and mortality associated with induced abortion, impact on fertility, and characteristics of abortion users. It is not until the 1990s that research was initiated on social aspects and service delivery issues pertaining to abortion, when concern was raised about the persistence of high morbidity and mortality from illegal and septic abortions.

Research on abortion in India during the 1990s (1990-99) may be grouped under one or more of the following categories.

- Studies on levels of induced abortion and profile of abortion users.
- Studies on perceptions of abortion, reasons for seeking abortion and decision-making processes
- Studies on health seeking behaviour
- Studies on health outcomes of an induced abortion
- Studies on service delivery and policy issues

Of the above, more studies exist on abortion rates and ratios, demographic profiles of women, contraceptive behaviour and morbidity and mortality. Much less is known about the socio-economic and gender-power context underlying a woman's exposure to the risk of an unwanted pregnancy, the process of decision-making and seeking abortion services, and having a safe abortion.

In this paper we examine studies carried out on abortion in India during 1990-99 through a gender lens. Our intention is to synthesise from the body of research available, the ways in which gender in conjunction with caste and class influence women's abortion experiences and to identify 'gender gaps' in abortion research in India, and outline the range of gender issues related to abortion which have not yet been adequately researched.

II. VIEWING ABORTION IN INDIA THROUGH A GENDER LENS

Induced abortion is perhaps the most contentious of all reproductive health needs of women, the subject of acrimonious and emotional debates in international and national policy arena. The reasons are not hard to understand. Denial of access to abortion has been an effective mechanism of patriarchal control over women's sexuality. Women's access to induced abortion de-links sexuality and reproduction. It does away with fear of the consequences of an unwanted pregnancy and childbirth as a deterrent to women's sexual activity outside socially sanctioned relationships.

It is for this reason that abortion is more than a medical issue, and is the 'fulcrum of a much broader ideological struggle in which the meanings of the family, the state, motherhood, and young women's sexuality are contested.[8] The conflict over who should have legitimate control over abortion - women, whose bodies are the sites in which pregnancies occur, or others - husbands, medical professionals, religious leaders, the state - is an ongoing one.

The threat of a potential pregnancy outside wedlock has been at the core of women's patriarchal subordination, limiting girls' and women's access to education, employment, free movement and independent existence. Access to safe and legal abortion is thus an issue central to the rights and status of women.

Unwanted or mistimed pregnancy is in itself to a large extent a reflection either of unwanted or coercive sex within or outside marriage; to women's lack of control over contraceptive use, and men's lack of responsibility to prevent a pregnancy. It is in the context of abortion decisions that one becomes acutely aware of the power differentials between women and men in matters related to sexuality - while both are responsible for the pregnancy, it is the woman who has to face the consequences of the pregnancy, either in going through an induced abortion and all the difficulties it may entail, or carrying through the pregnancy and taking responsibility for bearing, nurturing and raising a child (or yet another child). Accessing induced abortion services is a path strewn with obstacles at many levels - from decision making to raising the money needed and finding a service provider who will carry out a safe abortion. The woman may be suspected of infidelity, treated badly at the health services, and risk morbidity and mortality as a consequence of the abortion, especially those carried out in unsafe conditions.

Despite the centrality of gender roles and norms, and gender power relations to the issue of induced abortion, research on the gender dimensions of induced abortion in India is limited. This paper is motivated by the need to consolidate what is known about gender dimensions of abortion within the body of abortion research in India, and to identify research gaps. In order to do this, the paper reviews literature produced during the 1990s from a gender perspective, or 'through a gender lens'.

By 'gender' we mean the socially constructed differences between women and men in roles and responsibilities; in access to and control over resources; in decision-making power; and norms and values related to masculinity and femininity.

Wearing a gender lens would mean examining, for example, how gender and social status influence

- women's exposure to an unwanted or mistimed pregnancy;
- their ability to make decisions to continue with or terminate the pregnancy:
- their access to appropriate, affordable, safe and quality abortion services;
- health outcomes following an induced abortion.

8. Petchesky RP. The state, sexuality and reproductive freedom. North eastern University Press, 1990.p.xi

And further,

- whether and how gender and social stereotypes inform the way abortion service providers understand factors underlying the need for abortion, and consequently, the way in which they treat women seeking abortion services; and
- whether and to what extent is conceived by health policies and programmes as an issue of women's reproductive rights and autonomy rather than exclusively as a public health or a family planning issue

The analysis is based on an annotated bibliography of 79 studies conducted in India during 1990-1999 on various aspects of abortion. The annotated bibliography included select published studies and unpublished reports, which contain any data or information disaggregated by sex and/or social groups, or gender differentials.

This review paper is part of an informal initiative started in 1998 to consolidate the learning from research done over the previous decade on women's health and reproductive health in India. The specific focus of this initiative was to examine the gaps in research from a 'gender and social dimensions' perspective.

The paper consists of three sections: The first section, of which this commentary is a part, contains the background section stating the context and defining the scope of this paper. The second section synthesises research on abortion under each of the five categories stated above: studies on levels of induced abortion and profile of abortion users; on perceptions of abortion, reasons for seeking abortion and decision-making processes; on health seeking behaviour; on health outcomes of an induced abortion; and on service delivery and policy issues. For each of these categories of research on abortion, we examine the extent to which gender and social issues have been addressed by the studies. The third section identifies priority issues that need to be addressed in research on the gender and social dimensions of abortion in India.

III. WHAT DO WE KNOW?

Levels of induced abortion and profile of abortion users[9]

Abortion ratios and rates

Estimates of the incidence of abortion at the national and state levels and inter-state comparisons are available from studies analyzing the National Family Health Survey data of 1992-93 *(1,6,32)*. In 1992-93, the induced abortion ratio for India was 13 per 1000 pregnancies *(1)*. The ratio was highest in Delhi (46 per 1000 pregnancies), followed by Tamil Nadu (43 per 1000 pregnancies), and lowest in Bihar (3 per 1000 pregnancies). The proportion of ever married women reporting an induced abortion in 1992-93 was higher in urban than in rural areas *(6)*.In Kerala, which has among the lowest fertility levels in India, induced abortion has played a role in fertility transition. Revised estimates of abortions for 1972-73 to 1988-89 for Kerala based on the ratio emerging from NFHS-I data *(32)* showed that induced abortion might have contributed to a reduction in birth rate of between 1 and 2 per 1000 population.

It is believed that NFHS data on induced abortion are underestimates, and that several induced abortions may have been reported as spontaneous abortions. Besides the NFHS data, there have been a few community-based surveys that provide estimates of abortion ratios and rates. A 1995 rapid household survey in rural Maharashtra documented 3.9 abortions per 1000 women in the age group 15-44 years, and 29.4 abortions per 1000 live births *(9)*. In Haryana, a study covering 6 rural blocks and 600 women reported an induced abortion ratio of 18.5 per 1000 pregnancies *(14)*. These again appear to be underestimates, when viewed against the backdrop of a study covering three rural districts of Maharashtra, using innovative 'case-finding' methods to identify abortion users *(10)*. This latter study found a rate of induced abortion that was six -fold higher than previous estimates, and abortion ratio that was ten-times higher than national estimates: 19.1 induced abortions per 1000 women and 141 induced abortions per 1000 live births.

Profile of abortion seekers

NFHS-I data on the profile of abortion seekers shows that at the national level and at the level of individual states, urban, literate women aged 21-30 years with a higher standard of living and fewer living children were more likely to have an induced abortion *(1,6)*. Other smaller scale studies *(9,70,72,36,40)* report a greater proportion of women in the 21-30 or 35 year age group. In terms of education status, some studies *(9,72,36,65)* report that a majority of abortion seekers were literate; while others *(70)* report that a majority was illiterate or had very low literacy levels. The distribution of women undergoing induced abortions by gravidity and number of living children, varied across different sites. The majority had two or fewer living children *(9,36,40,70,72,65)*. 12-18% of women seeking abortion were 'repeat' abortion seekers *(10,70,72,65)*. Some degree of son preference is indicated by some studies *(66,70,72)*, reflected in a greater proportion of women seeking abortion when they have more living sons than daughters, than the other way around.

However, these studies do not have denominator data, and it is therefore not possible to state whether or not the profile of abortion seekers varies from that of the general population of ever-married women in the reproductive age group. Longitudinal data on the changes in profile of abortion users is available from Calicut Medical College Hospital in Kerala for the period 1976-1995 *(32)*. This shows a shift towards younger ages over the years, with an increasing proportion under the age of 24 years (24% in 1975 to 37% in 1994-95) and a decreasing proportion of abortion users over the age of 35 years (19% in 1975 to 10% in 1994-95). Eighty seven per cent (87%) of the women in 1994-95 had 2 or fewer children, as compared to 65% in 1975.

9. The following studies fall under this section: Reference numbers 1,3,6, 23,26,30,32,55,63,65, 70.

Another interesting trend was the shift in the profile of abortion users from less to more educated categories during the two decades, from 27% with high school education or more, to 60% in 1994-95 - probably a reflection of changing educational profile of women in the state. All the above information pertains to ever-married or currently married women. Only a small number of studies provide information on the profile of single women who are abortion users.

In a community based study in Maharashtra *(10)*, about 7% of all abortions identified (136 of 1853) were to single women. Of these, 77 women agreed to participate in the study. A third of the women were unmarried adolescents, about 47% were separated women and 20% were widows. In another study from Sevagram, Maharashtra of users of abortions services at the Mahatma Gandhi Institute of Medical Sciences *(66)* during a ten-year period (1976-87), 30% were unmarried women. A case-control study comparing married and unmarried abortion users in a Chandigarh hospital *(27)* found that 83% of unmarried users were below 21 years of age, while 79% of the married users were above 24 years of age. Further, there were a greater proportion of illiterate women (33%) among unmarried abortion users than among married abortion users (19%).

Research gaps:

There is a need for more community-based studies that use innovative case-finding methods to be able to get reliable information on the levels of induced abortion. Such studies should include all sexually active women as their sample population. Currently, the NFHS and most studies measuring abortion rates and ratios or documenting the profile of abortion users are based on a reference population of currently married or ever-married women in the 15-44 age group.

The non-inclusion of never married and/or single women in the measurement of levels of induced abortion not only results in under-estimation of abortion rates and ratios, but also renders this group of women invisible from the discussion on avoidable morbidity and mortality following unsafe abortion.

A serious methodological limitation of many small-scale studies providing information on the profile of abortion users is the absence of denominator data on the population from which the women are drawn. This is because most are hospital-based studies. As already pointed out, it is therefore not always clear whether or not the profile of abortion users is any different from that of the population group to which they belong.

This is however, not the case with NFHS data, which show that induced abortion is more common is urban women with higher levels of education and higher standard of living. What we do not know are the reasons why. Is it because there is better availability of services in urban areas? Or is this because educated and urban women have a relatively equal position vis-à-vis their husbands? Another possibility is under-reporting of induced abortions in rural areas because of a higher use of informal providers and to some extent to stigma attached to abortions.

The association of variables such as women's autonomy and intimate-partner violence with induced abortion has not been explored by studies.

We do not have any studies examining the profile of the male partners of women having induced abortions, or looking into how couples' characteristics (e.g. differences in age, educational attainment, occupation) may be associated with the incidence of an induced abortion. Both these are indirect indicators of the relative power of women vs. men within married relationships.

Not all women have a mistimed or unwanted pregnancy, and not all women with such pregnancies

succeed in terminating it. In what ways, if any, do women who are able to avoid an unwanted pregnancy differ from those who are not able to do so? What are the differences between women who are able to terminate an unwanted pregnancy as compared to those who carry an unwanted pregnancy to term? These are issues that we know very little about.

Perceptions of abortion, reasons for seeking abortion and decision-making processes[10]

Women's perceptions

In its reference to abortion, the compromise wording in paragraph 8.25 of the ICPD Programme of Action states *'In no case should abortion be promoted as a method of family planning'*.

But what do women themselves think? Among women undergoing abortion in two hospitals in Chandigarh *(70)* over a five month period (August- December 1987), about 50% perceived abortion as a method of birth control, 27% thought that it should not be used as a method of birth control because it had adverse consequences for women's health, and 23% were uncertain about the use of abortion as a routine method of birth control. They believed that women ought to be allowed to have an abortion when they did not want another child or when the previous child was too small, and also for economic reasons. Only 5% of the women thought that abortion should only be allowed on medical grounds. About two-thirds of the women stated that should it be necessary, they would have a repeat abortion *(70)*.

The perceptions of women who have not had an abortion differed from that of abortion users in many ways. For example in a study conducted in Assam *(72)* from June to November 1999, 78% of never users of abortion said that it would affect their health, 5% feared death and about 11% thought it was a sin. Non-use of abortion was not on moral grounds for a majority. Sixty eight per cent (68%) of never users of abortion did not think it was a sin, and an even larger proportion (72%) did not believe that abortion was against religion. A majority of the respondents (87%) were from rural areas and were Hindu (73%).

In a qualitative study of women's perceptions on abortion in Maharashtra that included both users and non-users of abortion, women were ambivalent about abortion, since pregnancy and motherhood were cherished goals *(12)*. They were also uneasy about the selective abortion of the female foetus. At the same time, they saw the necessity for women to have access to abortion services without having to seek permission from husbands and family members. They articulated this in terms of women's 'right' to terminate an unwanted pregnancy.

When 'community' perceptions on abortion were sought through key informant interviews in a study carried out in two villages of Uttar Pradesh, there appeared to be more frequent mentions of abortion as a sin *(17)*.

Provider perceptions

Perceptions of abortion providers have been documented in two studies, one from a community based study in rural Uttar Pradesh *(17)* and another, a situational analysis covering four states: Gujarat, Maharashtra, Tamil Nadu and Uttar Pradesh *(37)*. It is disturbing to note from the Uttar Pradesh study that medical officers performing abortions and also staff of health facilities often believed that abortion was not a 'right' thing. The nurse midwives helped women get an abortion, in their words, 'only because the women would also undergo sterilisation, helping the nurse midwives fulfil their 'targets' for sterilisation.

In the study of four states *(37)*, less than 25% of the doctors and health workers in abortion service

10. The following studies fall under this section: Reference numbers 9, 10, 12, 13, 15, 17, 20, 21, 23, 37, 38, 50, 55, 57, 59, 70, 71, 72.

facilities approved of abortion unconditionally. Between 7 and 25 per cent of the doctors and 22-52 per cent of health workers totally disapproved of abortions. The others approved of abortions under certain conditions but not in others - in other words, they believed that abortion should only be provided under certain circumstances and not under others.

These negative perceptions are likely to influence health providers' decision on whether or not a woman 'deserves' to get an abortion, especially in government health facilities where services are free, and the provider has no financial incentive to perform an abortion. Hostile and unkind treatment of abortion seekers may also result from such attitudes and perceptions. Unfortunately, we do not have comparable data for private and public sector abortion facilities to verify this hypothesis.

Reasons for seeking abortion

Three major reasons for terminating a pregnancy appear in almost all studies. These are: To avoid an additional birth after desired family size had been reached; to ensure a reasonable birth interval after the previous birth, and to prevent the birth of a female child *(9,10,17,38,70,72,59)*. Other reasons included economic compulsions, a pregnancy soon after marriage, poor health status of the woman during the index pregnancy, negative experiences with previous pregnancies, lack of social support, and suspected or diagnosed foetal anomalies *(9,10,13,17,70)*. Although not often mentioned, pregnancy in older women who have adult children is almost always terminated *(13)*.

In Maharashtra *(9,10)*, 7-10% of the women had undergone abortions because they were unmarried. Another study in 14 abortion facilities in Rohtak city in Haryana examined the profile of 83 adolescent abortion seekers *(50)*. Ninety per cent of the girls were unmarried, and 16% of the pregnancies were the result of incest. This is the only study that indicates coercive sex as an underlying factor for abortions.

Prevention of another female birth is a reason for abortion by 12% of women in the India Council of Medical Research (ICMR) study covering 23 districts *(59)*. The paper compares maternal and child health services based on two studies conducted in 1989 and 1997. Between 13% and 18% of women in three different studies from rural Maharashtra *(38,9,10)* also stated prevention of female births as a reason for abortion. In another study of sex preferences and reproductive behaviour among 2000 couples in Mumbai *(21)*, it was found that a much larger proportion of educated women whose first born was not a male terminated the second pregnancy, as compared to those with no education. They also had fewer children ever born. This suggested that women wanted to have at least one male child but also a family size of no more than two, and therefore relied on sex-detection tests and selective abortion of female foetuses. A qualitative study from Maharashtra *(13)* documenting women's stories of abortion seeking notes that sex-determination test preceded the abortion of a female foetus. In focus group discussions in villages of Punjab and Haryana *(15)* - states with a very low female sex ratio in childhood - women and men spoke about the widespread use of sex-determination tests and abortion if the foetus was female. Sex selective abortions female foetuses have also been reported from other states of India such as Tamil Nadu *(20)*. These studies indicate that sex-selective abortions constitute an important segment of abortions in India.

Decision-making

Abortion seekers represent a fraction of all women who experience an unplanned or unwanted pregnancy. For many, the decision to have an abortion is not theirs, and they have to continue with an unwanted pregnancy. In Aligarh, UP, a state with a very low abortion rate, a study of women delivering in a hospital found that more than half (52%) of the pregnancies had been unplanned or unwanted *(23)*. They included women who were nulliparous and conceived soon after marriage; women whose previous

birth had occurred less than two years ago; and women who wanted no more children. Most of them had either been persuaded by their families to continue with the pregnancy, while a few had been afraid of an induced abortion. Of these, 41% had reconciled to the pregnancy but 11% had not. Another study of two UP villages *(17)* also found that only 47% per cent of 487 pregnancies were planned and wanted, and 35% were not. A majority of those with unplanned or unwanted pregnancies had reconciled to the pregnancy and carried it to term, about a quarter had attempted an abortion and 11% of the women who wanted to terminate their pregnancy were not allowed to do so.

Women may also be persuaded to terminate a pregnancy, which they would have preferred to continue with. In Maharashtra *(10)*, 97% of women who had undergone an abortion said that their husbands knew about the procedure, although 24% of women had not informed their mothers-in-law. However, during in-depth interviews with a sub-sample of the respondents, the women disclosed that their husbands and significant elders in the household had insisted that they terminate the index pregnancy. An ICMR study covering 23 districts in 14 Indian states found that although abortion decision was reported to have been taken by women and their husbands, 30% of the women who had undergone an abortion expressed regret *(59)*. It is possible that this is a consequence of having been persuaded to have an abortion, as in the in the Maharashtra study above.

Abortion of a female foetus may be one situation when a woman may be persuaded by family members to terminate a pregnancy. Another situation may be when the husband suspects that he is not the father of the child, as for example when pregnancy occurs when he is using condom to prevent a pregnancy *(17)*.

One study indicates that changing social values about the acceptability of restricting family size may help younger women act more decisively when faced with an unplanned or unwanted pregnancy as compared to older women *(71)*.

Where women want to terminate a pregnancy and proceed to have an abortion, the decision to terminate a pregnancy is almost always taken by the women and their husbands, although other members of the household may not be informed about this. The Assam study *(72)* reported that less than 1% of the women who had undergone abortions had not sought anyone's permission, and 97% had their husband's permission.Similar results were reported in health-facility based as well as community-based studies of women seeking abortions across different parts of the country *(17,55,70,71)*. In these studies about half or more of the women reported that the decision was primarily theirs and they then talked to their husbands about it and obtained their consent, while in the remaining cases, the women were unsure and their husbands advised them to have an abortion.

In the Chandigarh study *(70)*, husbands had a decision-making role among a smaller proportion of educated women as compared to women who were illiterate. Interestingly, husbands had been the decision-makers in a larger proportion of younger women (20-29 years). In the older age groups, a smaller proportion of husbands had been involved as decision-makers. This is also observed by a qualitative study of abortion users in two Uttar Pradesh villages *(17)*. This may indicate either a shift towards greater participation of husbands in their wives' reproductive decisions as compared to earlier times, when these matters were considered 'women's affairs' and were decided by the senior female members of the household. Alternately, it may be that women are in a better position to take crucial reproductive decisions as they grow older and have had several living children *(70)*.

Besides playing a pivotal role in the abortion decision-making process, husbands or male partners may also play a role in procuring abortifacients from medical stores of providers for the women, according to one study of male involvement in rural Gujarat *(57)*. Many of the other studies above also report some male involvement in accompanying women to the abortion facility, paying for services as well as

obtaining abortifacients *(70,17)*.

Research gaps

Overall, only a very small number of studies provide information on how abortion is perceived, and most of these are about women's perceptions. Only one study discusses these perceptions in all it complexities - women's ambivalent attitude to abortion, variations in perceptions and attitudes depending on the context of abortion. None of the studies ask about men's perceptions on abortions.

One important question to explore is how the social construction of femininity shape women's and men's perceptions on abortions, and especially on who is responsible for the unwanted pregnancy in the first place, and who ought to have the right to decide on whether or not to continue with a pregnancy and under what circumstances.

Generational differences in perceptions on abortion and differences across social groups- between the better-off and low-income groups, better and less educated women and so on are also areas of information gaps.

Provider perspective on abortion is again a relatively little researched topic. Do perspectives on abortion vary across male and female providers? By socio-economic and religious backgrounds? Across different categories of providers: specialists, other trained allopathic providers as compared to untrained providers? Even more important to know would be how provider perspectives influence whom they are willing to provide abortion services to and whom they refuse; and further, the relationship between provider perspectives on abortion and the quality of care they provide. Another dimension that remains a research gap is the differences if any between public and private sector abortion facilities in terms of provider attitudes and quality of services.

The reasons for women's use of induced abortions include the need to space or limit births. The many unexplored gender-related questions related to this are discussed in a later section on abortion and contraceptive use.

The gap in our knowledge related to unwanted pregnancy in single women is very large. One reason for this is that including single women in an abortion study is a very sensitive matter. However, the few studies that do include single women (with some rare exceptions) have tended to assume that sexual activity in unmarried girls and single women is misguided and wrong. These studies have not even considered the possibility of non-consensual and coercive sex, and other sources of powerlessness that underlie unwanted pregnancy in single women.

We know that avoidance of the birth of a female child is a not so uncommon reason for abortion. Given the intense debate on the increase in sex selective abortions leading to an alarming decline in the sex ratio at birth in some parts of the country, the absence of good studies documenting the magnitude of the problem and the circumstances surrounding sex selective abortions is cause for concern.

Studies included in this review provide no insights into the risk and protective factors at the individual, household and community level for the incidence of a sex-selective abortion. Instead, there is a tendency to attribute all sex-selective abortions to the low status of women, although the relationship is not this simple or direct. There are also communities and households where women enjoy a relatively better status where sex-selective abortion is common. The designing of interventions to prevent sex-selective abortion would best be served by an understanding of the risk and protective factors.

This review includes qualitative studies that provide rich details on the abortion decision-making

process within the many-layered context of women's lives - their social, economic, and gender-power situation vis-à-vis their husband and marital families. These studies give rise to many interesting issues for further exploration and analysis. What are the contextual and gender-related factors that affect abortion decision-making? Under what circumstances is the decision mutual and consensual among couples? When is there discordance? What happens when there is disagreement between couples? What factors enable women to successfully negotiate with their husbands? Which women proceed to terminate their pregnancy despite objection from their husbands, and why? What are the circumstances that make it possible for women to do so? What may be the consequences, (e.g. violence, refusal to support in case of health problems)?

In order to address these questions, studies are needed that talk to a large enough number of both women users of abortion as well as their husbands/partners to be able to arrive at a conceptual framework on factors influencing the abortion decision pathway.

Health seeking behaviour [11]

Delay in seeking abortion services

How far into the pregnancy do women seek abortion services and undergo the procedure? What are the reasons for delay?

Several studies give information on the gestational period at which abortion was finally carried out. The vast majority of abortions took place during the first trimester *(9,10,36, 65,70,72)*, but there were also a significant number of second trimester abortions in some studies. In the rural Maharashtra study, 26% of abortions took place in the second trimester and about 3% beyond the legally acceptable limit of 20 weeks *(10)*.

Those who wanted to space or limit births decided fairly early, by 8 weeks, although there was a delay in actually availing of the services. In contrast, those seeking to abort a female child had an abortion at a mean gestational period of 16.6 weeks because of the wait to have a sex-detection test which is done in the second trimester *(10)*.

Another reason for delay in availing of abortion appears to be marital status. Unmarried women have several barriers to accessing abortion, such as the stigma attached to a pregnancy out-of-wedlock, as well as public sector providers' reluctance to perform abortions in unmarried women. This can cause considerable delay in getting an abortion. In Sevagram hospital in rural Maharashtra, 72.2% of induced abortions in unmarried women took place in the second trimester as compared to 42.6% among married women *(66)*. A similar observation is made also by the Chandigarh case-control study comparing married and unmarried abortion users *(27)*. In this latter study, 60% of unmarried women were second trimester abortion seekers, as compared to only 7% of married women.

Delay may also be caused at an earlier stage - in recognition of the pregnancy by the woman. This is likely to be the case when pregnancy follows sterilisation failure or occurs during lactational amenorrhoea, when women may believe they could not possibly be pregnant. Women for whom poor nutrition and irregular periods may be the norm may also have difficulty identifying a delayed period as a potential pregnancy till symptoms such as morning sickness begin to appear. However, only one study *(71)* mentions that women were into denial of their pregnancy, and none of the others have examined the contribution of this 'first delay' to the delay in the overall process of seeking abortion services.

Choice of service providers

11.The following studies fall under this section: Reference numbers 9, 10, 13, 17, 27, 30, 36, 50, 55, 59, 65, 66, 70, 71, 72, 76.

Where do women go, when they decide to have an abortion?
There is not a clear documentation of the sequence of care seeking for terminating a pregnancy except in a Baroda-based study of 32 women who had undergone an unsafe abortion *(30)*. About a third of the women had consulted only one provider who carried out the abortion, 45% had had 2-3 consultations, and 6 of the 32 women had consulted between 4 and 7 providers before an abortion was performed.

Case studies from rural Maharashtra *(13)* of individual women also provide a glimpse of the pathway traversed by many women. Women who could afford it went to private clinics or practitioners as soon as the abortion decision was made. 'Affording' private care implies that the husband is supportive of the abortion as well as willing to pay for it. Women who do not have the money, or the support of their husbands, or both, have to travel a tortuous road through several providers ranging from a traditional provider to the 'free' but unavailable government health services which keeps one waiting and insists on concurrent contraceptive acceptance, and the private provider who charges heavily.

The distribution of abortion between the public and private sectors is reported differently by different studies, reflecting perhaps the geographical differences in the availability of abortion services in these sectors. According to the ICMR study covering 14 states, private clinics accounted for 44% of abortions among the women interviewed *(59)*, and about 36% of abortions took place in government hospitals. These figures represent a more general situation across various states of the country, in many of which health services infrastructure may be limited. In states where there is a very large private sector, such as Maharashtra, women may prefer to use private clinics and hospitals. The community surveys from Maharashtra show that more than three-quarters of the married women sought services from private sector providers *(9,10)*. Nearly half those using the private sector went to licensed or unlicensed gynaecologists, and the rest went to non-allopathic or allopathic physicians who were not necessarily trained or licensed for performing abortions *(10)*. Only about 10% of the women went to government hospitals. Use of traditional providers was however, marginal, at only 2% *(10)*.

Unmarried women may have a completely different pattern of seeking abortion services, as revealed by the study above *(10)*. Among this group, use of traditional abortionists was 23%, or 10 times that among married women. In-depth interviews with the women showed the moralistic attitude taken by physicians towards unmarried abortion seekers, which would be a major deterrent to their use of safe abortion services *(10)*. In another study of adolescent abortion seekers in Haryana *(50)*, 56% of the abortions were carried out by unqualified personnel in unapproved centres, corroborating the finding from the Maharashtra study.

Women who go ahead and attempt to terminate a pregnancy even if their husbands object to it, or sometimes, without their knowledge may be compelled to use unsafe methods and untrained providers. Case studies of women in such circumstances have been documented graphically by the study of two UP villages *(17)*. Women do not have the financial resources to seek abortions services from a medical facility, and have to use unsafe providers who assure their anonymity as well as cost less. This study is among the few that lays bare the gender power inequalities that may underlie an unsafe abortion, rather than assuming that women did so because of ignorance and illiteracy.

Women were willing to travel long distances in order to preserve their anonymity when seeking abortion. This was found in in-depth interviews with 32 women admitted to a Baroda hospital with complications following an unsafe abortion *(30)*. Only 4 of the 32 women had undergone abortion in a hospital. In nine women, a traditional dai had induced abortion; eight women had sought abortion from an auxiliary nurse

midwife, and six from non-allopathic doctors.
Concern for secrecy may override that for safety. Women in rural West Bengal who had suffered complications following an unsafe abortion stated that they had gone to untrained providers in order to maintain the secrecy and anonymity *(76)*.

What are women's reasons for choice of a particular abortion provider? In Maharashtra *(10)*, the main reasons were that the provider was a specialist, stated by 81% of the women, followed by 61% who chose a provider because s/he was *'good-natured, listens and explains'*. Similar reasons were cited by abortion users in Varanasi *(55)*, but cost was the most important consideration above all else. Those who could afford went to a private clinic such as the Parivar Seva Sanstha, and those who did not have the money went to the traditional *dai* who used unsafe methods and charged a low fee. In Chandigarh *(70)*, the choice was based on recommendations by a physician or the local auxiliary nurse midwife (ANM) in about a third of the women, and the quality of care and cost were each stated as a reason only by 12.5%. Among adolescents seeking abortion in Haryana, 86% identified cost and confidentiality as the most important factors governing choice of abortion provider *(50)*.

Research gaps

Drawing on the 'three delays' model in seeking obstetric care, there appear to be four major delays in terminating an unwanted pregnancy successfully. The first delay occurs in recognising the symptoms of pregnancy; the second, in deciding to terminate the pregnancy; the third, in making contact with an abortion provider; and the fourth, in having the pregnancy terminated successfully. As seen above, information on one or the other delay is available from many studies. However, there is no single study that traces the pathway to induced abortion in a large enough group of women of varying characteristics.

We also do not know how each delay is influenced by gender-factors such as lack of awareness of one 's body, shame and embarrassment related to an unwanted pregnancy, lack of decision-making power, the need to find an escort or the money to go to an abortion facility, fear or being reprimanded by the provider, and being passed on from one provider to another because of provider-perceptions on appropriate female sexual and reproductive behaviour. The combination of poverty and gender factors may exacerbate each delay for low-income women. Cost of abortion services as a reason for delay in seeking induced abortion has not been explored adequately in studies examining delay in care-seeking.

Studies show that women prefer to use private rather than public sector health facilities for having an induced abortion. The attitude of personnel in public sector health facilities is mentioned as a reason in some of the studies. A prospective comparison of women's abortion experiences in public and private sector health facilities may yield better insights into the range of reasons for preferring one over the other, and also the differences in profile of the women who use abortion services in the public and private sector, and those who use the services of traditional providers.

Abortion and contraceptive use[12]

Data on knowledge of reversible and permanent methods of contraception in India show high levels of knowledge of both, although sterilisation is by far the best-known method to all groups of women. Also, use of sterilisation has risen consistently over the past few decades and fertility levels have declined in all states of India, more rapidly in some than in others. Despite the clear motivation to regulate fertility, Indian women often do not use contraception, especially for

12. The following studies fall under this section: Reference numbers 3, 10, 63, 70, 71, 72

spacing births.

Pre-abortion contraceptive use

While the overwhelming majority of women have an abortion to space or limit births, only a very small proportion of women: between four and 8% had used contraception immediately before the index pregnancy. Others had become pregnant usually because of irregular use of reversible methods and method failure - including failure of sterilisation.

For example, only 4% of 1853 women in rural Maharashtra were using contraception at the time of getting pregnant, including 2% who had undergone sterilisation. In a study of 5574 women users of the Family Planning Association of India's clinics in Lucknow, Calcutta and Indore *(63)* during 1986-88 for terminating a pregnancy, only 7.5% were using contraception at the time of getting pregnant, the majority of them users of condom. In Assam *(72)*, 18% of the women reported being irregular users of contraception - mostly oral pills, while in 6% the pregnancy resulted from sterilisation failure. And in a Mumbai government teaching hospital *(71)*, 47 of 100 women seeking abortion had been using a method of contraception, more than half of whom were condom users.

However, a significant proportion of abortion users had used a method of contraception sometime in the past ('ever users') and had discontinued their use. The proportion of ever users of contraception among abortion seekers ranged from 21% in Maharashtra *(10)* to 60% in Mumbai *(71)*, 67% in Chandigarh *(70)* and 77% in Assam *(72)*. Reasons for discontinuation included side effects, dislike of the method and non-availability of regular supplies of condoms and oral pills *(70,72,63)*. This is an important finding to take on board - women undergoing abortions may be those who are highly motivated to regulate their fertility and have tried numerous methods against various odds, and not women 'ignorant' of contraceptive methods.

Although only one study has examined this aspect, husbands may play a decisive role in women's non-use of contraception despite not intending to get pregnant. The study from Mumbai teaching hospital *(71)* observes that husbands had many misconceptions about reversible methods of contraception and were not in favour of its use.

Post-abortion contraception

Acceptance of contraception post-abortion has been a concern of several studies. For example, an overview of abortion studies in India from the mid-1990s *(3)* observes, based on Family Welfare Year Book data that 54% of abortion users nationally did not want to use any method of contraception. Similar figures are quoted by the Maharashtra community study of three districts *(10)*. Sterilisation was the most preferred method of contraception following an abortion *(10,63)*.

The proportion of those 'accepting' contraception following an abortion appears to be related to the effort made by a health facility to ensure post-abortion contraception acceptance. There may be a subtle undertone of coercion in operation in several settings, although health facility-based studies do not usually discuss this. In Sevagram hospital in Maharashtra *(66)*, 88% of women accepted contraception after the abortion. But acceptance was low in those undergoing second trimester abortion, especially for IUDs because women 'often changed their minds'. For first trimester abortions, the women 'did not have the opportunity' to change their minds because IUD was inserted concurrently with the abortion procedure.

Induced abortions are often viewed as an indication of unmet need for contraception. However, the fact that a significant proportion of women choose not to adopt contraception following an abortion suggests

that the reasons may not be so simple.

Research gaps

Why do women opt not to use contraception and rely on abortions instead? This is a question that continues to baffle those attempting to understand the reproductive behaviour and choices of women in India.

The context within which women make choices related to fertility regulation may be the key to this puzzle. The fact that many women undergoing abortions had used contraceptives at some point in their reproductive lives suggests that women may be using both contraception and abortion as strategies for fertility regulation, using one or the other depending on the situation at hand. As seen from one study, women's non-use of contraception is likely in many situations to be dictated by their husbands' preferences and attitudes to contraception. Women may be forced to discontinue contraception because of this, and when they get pregnant, have an induced abortion if possible, or continue with the pregnancy and then have sterilisation. The role of intimate partner violence in women's ability to use contraception and avoid an unwanted pregnancy is also an area that has not received any attention in the studies reviewed.

To be able to understand the underlying factors and compulsions that result in women's reliance on induced abortion to space or limit births requires in-depth qualitative studies that document women's reproductive histories within the context of their social situation and of the gender-power dynamics in their marital relationship. It is important to include husbands as study participants and document their role in decisions pertaining to fertility regulation.

Pre and post abortion contraceptive behaviour of single women seeking abortion, and barriers to their use of contraception is another area that needs to be better understood.

Health outcomes of an induced abortion[13]

Despite the legalisation of abortion in 1971, mortality and morbidity related to abortion remained high even into the late 1990s. Most of these resulted from unsafe abortions performed by unlicensed physicians and other untrained practitioners.

According to model registration data on causes of death in rural India, abortion accounted for about 11-12% of all maternal deaths during 1978-1990, a period when abortions were legal and available in government health facilities free of cost *(3)*. During 1991-94, age-specific mortality related to abortion was highest among women in the 20-24 year age group in rural India *(5)*.

An institution-based ICMR study in the 1980s noted that abortion as a proportion of maternal deaths in institutions had remained at around 20% during the 1970s and 1980s *(5)*.

Information from studies on morbidity following an abortion procedure is often based on recall and their reliability may vary depending on the sample. Where the sample includes only women who have had a recent abortion experience, recall may be better than in studies where the sample includes all women who have ever had an abortion. Health facility based studies that document immediate post-abortion morbidity may not have recall errors but are based on a self-selected sample. Abortion morbidity data have to be interpreted keeping these limitations in mind.

In rural Maharashtra *(10)*, there were 1396 episodes of morbidity in 1492 women who had undergone

13. The following studies fall under this section: Reference numbers 3, 5, 10, 24, 28, 29, 30, 33, 34, 35, 36, 72, 76.

abortions, even when morbidity was defined to include only major episodes, which either caused the women to be bed-ridden, or seriously hampered their daily routine. More than two-thirds of the women reported morbidity, with bleeding and weakness being the most important problems reported. Symptoms of fever with foul-smelling discharge, indicative of an RTI were reported by less than 5% of the women.

In Assam *(72)*, only one-third of abortion users reported morbidity, and the conditions reported included bleeding, abdominal pain, weakness and swelling of the feet.

About 25% of women from two villages in rural West Bengal *(76)* developed post-abortion complications. The likelihood of complications depended on the type of provider: in abortions performed by specialists and physicians trained to perform abortions, complications developed in 12% of abortions performed. In abortions performed by general medical practitioners the complication rate was 46%, and in those performed by paramedical workers and providers with no professional training at all, the complication rate was100%.

Incidence of complications reported from studies of users of a health facility may be much lower. Incidence of complications of about 5% is reported among abortion users in the Parivar Seva Sanstha clinic in Calcutta *(36)*, where the quality of services was relatively good. About half of the instances were of retained products of abortion requiring repeat procedure. A quarter of the complications were cases of mild pelvic inflammation. There were also a few instances of genital tract injury and of total failure of the procedure. Fortunately, all these complications were identified in a first follow-up visit and treated successfully.

In a teaching hospital in New Delhi *(24)*, nearly two-fifths of the women undergoing abortion reported post-abortal bleeding (PAB). Post-abortal bleeding was defined to include bleeding lasting more than seven days post-abortion, more profuse than normal period, or starting 7-15 days post abortion. Post abortal bleeding was significantly associated with age and parity but not with gestational period.

Many studies on abortion morbidity and mortality are based on admissions to hospitals with post-abortion complications. These studies do not give us information on the incidence of complications among all abortion users, but on the nature of complications and recovery and case fatality rates in women with complications.

According to reports from various studies, between 10 and 20 per cent of all women admitted to hospitals with septic abortion died *(30,33,35,28,34)*, several had serious health consequences and almost all had reproductive tract infections.

An ICMR Task Force Study covering abortion admissions in 31 teaching hospitals from all over India recorded a death rate of 16.8 per 100 cases of septic abortions admitted *(28)*. Abortion services in these cases had been provided by a registered medical practitioner (RMP) or a doctor in 40% of the women, by untrained *dai* in 27% and trained *dais* in 15% of the women. A greater proportion of women whose abortions were carried out by untrained *dais* died as compared to those who had abortions performed by the other categories of providers. This result must be interpreted with caution, because women seeking abortion from untrained *dais* may not have a high risk profile - they may be poorer and unable to seek abortion services from other types of providers; they may not have the information or the permission to seek abortion from other sources, and so on.

Retrospective analysis of 358 patients admitted to hospital with septic abortion in Pondicherry, South India *(33)* over a period of eight years showed that 34 women, or about 10% had died. The vast majority if these women (26/34) had grade III sepsis, and 24 died of septicaemia. In 74% of the patients,

untrained practitioners had induced abortion, but general practitioners had induced 25%.
A death rate of 13% among patients admitted with septic abortion was reported also from a Delhi study of 53 patients *(35)*. One third had grade III sepsis, and all cases had pelvic inflammatory disease. Some had serious complications such as uterine perforation, bowel injury, acute renal failure and septic shock.

In a Baroda hospital, of 35 women admitted for complications of unsafe abortion, 12 had septic peritonitis, 9 had acute PID, 4 had perforations and bleeding and 3 died *(30)*. In a rural hospital in North Bengal, 10 of 50 septic abortion patients or 20% died, 70% recovered fully and 10% still had PID three months after they had been discharged *(34)*.

Despite these depressing figures, the current situation may be much better than the past. A North Bengal hospital study *(29)* shows that the proportion of septic abortions among all admissions for abortion in the hospital had declined from about 10% in 1976 to 6% in 1990. In the recent series, more than 75% of the septic abortions were induced by physicians, and not by traditional practitioners. Serious damage had been caused in 25% of the cases, with the gut hanging outside the uterus, and the bowel injured. Timely surgical management helped save most lives, and the mortality from septic abortion was only 6% in 1990 as compared to 25% in 1976.

Research gaps

Relatively little is known on risk factors for abortion morbidity and mortality. One of the most commonly identified risk factors is the type of provider. We have seen that women who need to preserve the secrecy of the abortion are less able to use trained providers. We need to better understand how women's autonomy or lack of it is associated with factors that elevate the risk of mortality and morbidity. It is important to probe the gender factors underlying a risk factor identified through multivariate analysis.

Women's perceptions and experiences of abortion morbidity, and their care seeking behaviour and ability to access appropriate health care is an important area for further investigation, given its implications for avoidable mortality and long-term reproductive morbidity. Cost of treatment of abortion-related morbidity is another major area where research is needed.

Special attention is needed to groups especially at risk - such as those seeking sex-selective abortions in the second trimester; single women and other women who seek abortion in secrecy for a variety of reasons. Their situation may put them in double jeopardy - compelling them to seek unsafe abortion in the first place, and compromising the possibility of seeking health care for a complication that may arise as a consequence.

Service delivery and policy issues[14]

Abortion services

Studies examining the availability, accessibility, cost and quality of abortion services are very few. Some of these are overviews, presenting secondary data and collating information from other studies *(53,60)*. There are two studies documenting the abortion service delivery scenario in Indian states *(37,68)* and one study examining women's perceptions on the quality of abortion care *(11)*.

In 1995, nearly 'twenty-five years' after the Medical Termination of Pregnancy Act in 1971, the number of licensed abortion facilities in India was far from adequate to meet women's needs. At the national level, there were only 10 licensed abortion facilities authorised under the Act per million population, with 17,600 couples having to depend on one facility. In some states of India such as Bihar, UP and Madhya Pradesh, the ratio of centres per million population was much lower, with only 1 centre per million population in

14. The following studies fall under this section: Reference numbers 11, 19, 37, 41, 43, 45, 46, 49, 51, 52, 53, 54, 56, 60, 68.

Bihar *(60,53)*. What is more, many of these centres may not actually be providing abortion services.
A situational analysis of four states - Gujarat, Maharashtra, Tamil Nadu and Uttar Pradesh undertaken during 1995-96 gives a detailed understanding of problems related to abortion services in India *(37,68)*. The study included 510 government institutions and 241 private practitioners licensed to provide abortion services. It found that between 20 and 60 per cent of the licensed facilities did not actually provide abortion services. Licensed PHCs were much less likely to provide abortion services than higher-level facilities. Overall, abortion services were available in less than 20% of primary care facilities in Gujarat, Maharashtra and UP, and in 40% of primary care facilities in Tamil Nadu.

The most important reason why a licensed primary care facility was unable to provide abortion services was because it did not have a medical officer who was trained to provide abortions. Lack of equipment to perform abortions and non-functional equipment were other common reasons. In Tamil Nadu, non-availability of an anaesthetist was an important reason why a licensed facility could not provide abortion services *(37,68)*.

There was a mismatch between trained doctors and licensed facilities. Not all doctors who performed abortions were trained to do so, and many doctors trained to perform abortions were posted in health facilities that were not equipped to carry out the procedure. The quality of training was questionable in Maharashtra and Tamil Nadu, where the training period was of 6-8 days and trainees were able to perform at best 6-8 MTP procedures as a part of the training *(37,68)*. As a consequence, even those doctors who were 'trained' did not feel confident about performing an abortion, and were likely to refuse to do so. The facilities providing abortion services often did not even have basic amenities. Only about half or a third of the PHCs had a toilet with adequate water supply, auditory and visual privacy was neglected, and the operation theatre was not well maintained. The worst situation was found in Tamil Nadu, followed by UP. Essential anti-haemorrhage drugs were available in only one-third of the facilities, but antibiotics were generally available in most PHCs providing abortion services *(37)*.

Costs of abortion services varied across states and between public and private providers. Women had to pay between Rs 136 and 534 (US $ 4.5-13.5) in government facilities, and between Rs 425 and Rs 649 (US$ 12.2 - 16.5) in private facilities. Costs were highest in UP both in the public and private sectors. Cost of abortion services depended on the gestation period at which abortion was performed, and increased substantially for second trimester pregnancies *(37)*. These are cost estimates from women attending specific health facilities. Community-based information available from a qualitative study in rural Rajasthan *(19)* indicates that costs incurred overall may be up to ten times higher than the above: up to Rs 1500 including costs of transportation and drugs.

The quality of services, as seen from the four-state situation analysis *(37)*, clearly leaves a lot to be desired in terms of basic amenities and facilities, privacy and drugs and supplies. However, when women were asked about their satisfaction with the services, they generally responded positively.

Another article criticises the callous treatment of women seeking abortion, especially those who are single, in government health facilities. This forces women to seek services from unsafe practitioners, at considerable risk to their health and lives *(43)*. The discrimination of unmarried women in provision of abortion services; linking abortion services to contraceptive acceptance and other dimensions of poor quality which drives women towards unsafe abortion constitutes a violation of women's reproductive rights *(49)*.

Women's perspectives on quality of care issues in abortion services are documented in detail by a study

in rural Maharashtra *(11)*. It emerged clearly that women were willing to trade safety and good health for confidentiality, and seek private sector services, licensed or unlicensed, under less than competent providers if that was all they could get. Many also preferred a 'lady doctor'. Another 'quality' issue of concern to women included the insistence of facilities for husbands' signature in the consent form for abortion, which was more prevalent in the public than in the private sector. Another issue was the persuasion by public sector providers that women accept contraception concurrently with abortion. Both these factors often led to women's seeking a less than adequate facility which did not require the husband's permission or acceptance of contraception. Women voiced their anger about the exploitation by private facilities of their lack of bargaining power to charge high fees.

The availability of medical abortions has the potential of making abortion services more widely available, accessible and affordable. Two introductory studies of medical abortion in India *(51,52)* found the method to be feasible, safe and acceptable among women.

Policy issues

There exist a small number of commentaries on the limitations and problems related to the content of the current abortion legislation in India *(45,46,54,56,41)*.

These commentaries observe that the abortion legislation in India has not been framed in terms of women's right to regulate their fertility, but as a public health issue. The law does not entitle women to abortion on demand. Indications for an abortion that have been mentioned in the legislation include serious physical and mental health consequences to the mother if she continues with the pregnancy, serious foetal anomalies, contraceptive failure and pregnancy following rape. Marital rape is however not included in this category. The law enjoins doctors to take into account the woman's environment when making the decision on her eligibility for abortion. However, the final decision on whether or not a pregnancy is eligible to be terminated rests with medical professionals.

The conditions set forth in the abortion legislation create a number of barriers to the widespread availability of abortion services. For example, only medical practitioners who have been trained to provide medical termination of pregnancy, or specialist obstetrician/gynaecologists are permitted by law to perform abortions. Further, abortion can only be performed in facilities that have been specifically approved by the department of health on the basis of their meeting certain standards outlined in the legislation. These categories of service providers and facilities are concentrated in urban areas, making it almost impossible for rural women to have a 'legal' abortion.

Licensing procedures are cumbersome, and inspection of a facility before approving it as an abortion facility provides ample scope for corruption. Further, the legislation does not set out standards for other dimensions of quality of abortion care, such as pre and post-abortion counselling.

There is nothing in the law that provides women with the option of challenging the medical professionals' decision, or any recourse when she is unfairly denied services. The legislation could easily be interpreted in narrow, conservative terms to deny abortions to the majority of women, should there be an ideological swing towards an anti-abortion stance. Thus, there is no room for complacence about the legality of abortion in India.

There have been gaps between the content of the legislation and its implementation. For example, the law does not say anything about the need for husband's permission or signature for performing an abortion. Providers, however, insist on obtaining the husband's signature in order to pre-empt any

problems should the procedure go wrong *(54)*.

Research Gaps

The situation analysis studies above are an excellent contribution to our understanding of the dismal scenario in India in making abortion services available and accessible to women. Such studies are needed for all Indian states, and an attempt made to analyse differential availability of services within a state. Inclusion of private sector abortion services would make these analyses more comprehensive and useful in informing advocacy and action to expand access to abortion services. It would also be important to 'engender' the situation analyses by including in the assessment many of the facility and provider-based barriers identified by women. For example, are facilities able to provide abortion services soon after a woman makes first contact? If not, what are the procedural and organisational factors causing delay? Do facilities insist on signature from the husband? Do they refuse abortion services to single women? Is there an implicit policy to ensure that all induced abortion seekers 'accept' contraception concurrently? What are the total costs of services to women, from the point of making contact with an abortion facility to returning home after an abortion? What proportion of women who approach an abortion facility do not manage to get an abortion from that facility, and for what reasons? What is the profile of women who drop out?

There is anecdotal as well as user-reported evidence on the harsh and prejudiced attitudes of providers towards poor women seeking abortion. We need to better understand how providers' social biases interact with notions related to appropriate sexual behaviour for women, and their attitudes to abortion. And further, how these attitudes and biases impact on whether and to whom they provide abortion services. Studies need to look also at dais, ANMs and rural practitioners and not only doctors and specialists, and at private sector as well, and not only the public sector. Facility-based studies that document experiences as they happen or soon after would give a more representative picture than retrospective reports which may be influenced by women's sense of relief at having successfully terminated a pregnancy.

More studies with a women-centred approach to quality of abortion services are needed of the genre of the Maharashtra study above by Gupte et al *(11)*. What are women's criteria for a good abortion service facility, and how do these vary across women from different social classes? How do women's criteria for quality of care vary across circumstances surrounding abortion, as for example in a sex-selective abortion as compared to an abortion for spacing births? What is the bottom-line, when women would avoid a facility for reasons of quality of services?

In terms of writing and commentaries on abortion policy, more conceptual work would be timely. What would be the main elements of an abortion legislation that is centred on women's reproductive rights and gender equality? How would this translate into programme and service delivery components? If we were to design a gender and rights based abortion intervention or an abortion service facility what would these look like? Comparative studies of progressive abortion legislations and programmes from other countries would help make a start. A major research undertaking needs to follow, that consults diverse groups of women from different sectors and geographic regions.

IV. OUTSTANDING RESEARCH NEEDS

Research on abortion in India has traditionally been concerned with rates and ratios, socio-demographic profile, contraceptive use and mortality. Writings on abortion from the 1970s and 1980s betray moralistic views condemning women's sexual 'indulgence' as a cause for unwanted pregnancy. They also express concern that the availability of legal abortion services may encourage irresponsible sexual and contraceptive behaviour by women.

The foregoing review suggests that barring a few exceptions, women's voices and a gender perspective are largely absent even from the body of abortion research carried out during the 1990s. Abortion research in India rarely features abortion as a right of women, and women as persons with agency who make reasonable and rational choices within the constraints of their reality.

Gaps in our knowledge are substantial on the role of gender in women's need for abortion and in their ability to access safe abortion. The following is a summary, by no means comprehensive, of key areas of research warranting further attention.

1. In most studies, there is little discussion on the ethical issues related to researching a sensitive topic such as abortion, and on measures taken to preserve women's privacy and ascertain confidentiality of the information collected. Some promising work has been initiated in this area *(10)*, and more is needed.

2. The gender-related antecedents of an induced abortion, the gender and other factors that render women at risk of an unwanted and mistimed pregnancy in the first place, and make it possible or impossible for them to terminate it - is an area in which there is very limited information.

3. The abortion experiences of specific groups of women, especially single women and women seeking sex-selective abortion, are very difficult to study and yet, renders this group of women invisible from the discussion on avoidable morbidity and mortality following unsafe abortion. Innovative methods that can ethically research this group are an urgent need.

4. The association of variables such as women's autonomy and intimate-partner violence with induced abortion has not been explored by studies.

5. The profile of male partners of women seeking abortion, and of their role in the unwanted pregnancy as well as in the decision to terminate it is important to understand, so that programmes and interventions may encourage men to take responsibility for pregnancy prevention.

6. Qualitative studies that trace the pathway from the recognition of an unwanted pregnancy to its termination in an abortion or in an unwanted birth would fill an important gap in our understanding of the care-seeking process.

7. The continued use of induced abortion to space births even in low fertility states where the motivation for fertility control is high poses challenges the standard interpretation of abortion as resulting from unmet need for contraception. Women's use of contraception and induced abortion during their reproductive span, and the contextual factors that influence the use of one or the other at a particular point in their lives is a black box waiting to be opened.

8. Provider and user perspective studies on quality of abortion services are needed, across different groups of providers and users. In particular, provider and facility- related barriers to women's access to abortion services have to be understood from the perspective of providers as well women who have used and women who have been denied or unable to use abortions as a consequence of the barriers. This is the first step towards making concrete changes within facility settings so that abortion services become more accessible. Intervention research to assess the effectiveness and user satisfaction of these changes would be the logical next step.

9. The need of the hour is research that would help construct an advocacy and action agenda based on a gender and rights perspective, for changes in policy and programmes and in service delivery settings. This should be based on participatory research conducted in many different settings across the country, and able to truly represent the voices of Indian women. This should go hand-in-hand with comparative research of experiences from other countries on the pathways to effecting changes in abortion policy.

The first step in the long-term endeavour to make abortion services safe and available to women and provided in a manner that respects their rights and autonomy is to carry out meaningful research that is informed by a gender and social perspective. We hope that this review has contributed to this first step by identifying the long list of unexplored issues in this regard.

In conclusion, it is our hope that this review contributes to initiating research that would catalyse advocacy and activism around abortion in India as a women's reproductive rights issue, and succeed in making social, policy and programmatic changes that enable women to exercise this right.

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Author's Contact details:

Dr. T.K. Sundari Ravindran
'Sruti', Ananta Co-op Housing Society
Thuruvikkal Post
Trivandrum- 695031, Kerala
Phone: 91-471-244 7974
Email: ravindrans@usa.net

Creating Resources for Empowerment in Action (CREA)
2/14, Shantiniketan, Second Floor, New Delhi 110021
Phone: 91-11-24107983, 91-11-26874733 Telefax: 91-11-26883209,
Email: crea@vsnl.net Website: www.creaworld.org