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ABORTION ASSESSMENT PROJECT - INDIA

Preface

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

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

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

I. Overview paper on policy related issues, series of working papers based on existing data / research and workshops to pool existing knowledge and information in order to feed into this project.

II. Multicentric facility survey in six states focusing on the numerous dimensions of provision of abortion services in the public and private sectors

III. Eight qualitative studies on specific issues to compliment the multicentric studies. These would attempt to understand the abortion and related issues from the women's perspective.

IV. Household studies to estimate incidence of abortion in two states in India.

V. Dissemination of information and literature widely and development of an advocacy strategy

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

The present publication contains summaries of all research studies and papers done under the aegis of the AAP-India project. This summary report also includes a CD, which contains full reports, and papers, which were produced under this project. The CD also includes press clippings related to AAP-India project. Further a film on Abortion produced by CEHAT is also included.

This publication has been supported from project grants from Rockefeller Foundation U.S.A. and The Ford Foundation, New Delhi. We acknowledge this support gratefully.

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

Ravi Duggal **Vimala Ramachandran**
Co-Coordinators AAP-India

2nd December 2004

I. Abortion Assessment Project - India (AAPI)
A Brief Profile

Background and Justification

Abortion has been a sensitive issue in most countries of the world, and has recently received international attention as a public health issue. In India Medical Termination of Pregnancy (MTP) is permitted under specific conditions. The MTP Act of 1971 and the MTP Rules and Regulations of 1975 lay down the legal and medical framework for abortion services. Despite the legal status of abortion it is "estimated that 6.7 million abortions per year are performed in other than registered and government recognised institutions, often by untrained persons in unhygienic conditions". Public discussion in India on abortion related morbidity and mortality is practically absent. Despite an intensive national campaign for safe motherhood, the issue of abortion has not captured public attention. The ICPD at Cairo provided an opportunity to change this.

Government of India's decision in the post Cairo period (1996) to introduce a more comprehensive Reproductive and Child Health (RCH) program in place of vertical safe motherhood, child survival and family planning programs gave women's health advocates an opportunity to re-establish the importance of a holistic approach. Donors supporting the Government's efforts (UNFPA, World Bank, European Community, Swedish International Development Co-operation Agency, DANIDA and DFID) highlight the importance of looking at abortion-related mortality and morbidity as a part of the RCH package. This has created a favourable climate in the country to examine the issue from different dimensions and work towards making abortion safe. In the last three years donors have been working with the Government of India and various State Governments to develop district-specific plans for Reproductive and Child Health Programs. These efforts have been noteworthy and administrators are trying to grapple with hitherto unexplored public policy issues. It will be many years before this will bear fruit, but given the present public policy climate in the country, the trend is positive.

The Process Leading up to this Proposal

Given this favourable climate afew researchers and policy advocates got together to look at the possibility of developing a research and advocacy initiative on abortion at the national level. The Indian Institute of Health Management Research, Jaipur (IIHMR) was given a planning grant by Ford Foundation to prepare a detailed proposal after consulting important stakeholders in India. This grant was made in June 1998. The first consultation was organised in Jaipur on 27-29 August 1998. This brainstorming meeting reviewed the current status of abortion care in India and listed information gaps. It became quite obvious that no single study could do justice to the range of issues that were flagged in the meeting. Starting from assessment of abortion care facilities in the public and private sector to a changing societal norms and values that push women into making decisions to terminate pregnancy (unwanted, wanted and sex selective) – the multifaceted nature of issues surrounding abortion were highlighted. One of the concerns flagged by some participants was the feasibility of accommodating the agenda of different stakeholders – the Government, women's health advocates, medical establishment, donors and international research bodies. It was acknowledged that the agenda of different stakeholders are not contradictory, but competing. Assuming the financial kitty available for the abortion assessment study is limited, the priorities of different stakeholders cannot be reconciled easily. Some of those involved in the planning phase of this project were of the view that a community based survey to study issues surrounding women's access to safe abortion and the range of societal issues that influence decision making need not be included in the study at this stage. There were others who felt that a survey that is limited to assessment of facilities, technology and related logistical and administrative issues will be one-sided. Weaving in a user's perspective cannot be limited to exit interviews in abortion care facilities and the latter is also ethically not a sound proposition. While it is important to

acknowledge that community based qualitative and quantitative studies are not easy to do on a large scale, the latter group of participants were felt that this dimension should not be left out. There were others who said that a comprehensive abortion assessment study should be followed by a time-bound advocacy programme to bring about policy changes and also change the attitude of the medical establishment. They felt that abortion is fast becoming a public health issue, especially in the light of fast changing social values. Sex selective abortion, desire for small families, low male involvement, inadequate information about spacing methods coupled with poor service have contributed to the growing demand for abortion care. Abortion care providers report that it has almost become a family planning method – especially in the more developed / accessible parts of the country. As a result the number and range of providers has increased, and we do not have authentic information about abortion care providers in the private / informal sector (including traditional abortionists and unregistered / unqualified practitioners).

The August 1998 brainstorming meeting was informative, unfortunately we could not arrive at a consensus on the scope of the study. It helped us flag important issues and also survey available literature. However, given that we could not arrive at a consensus on the scope of the study, we initiated a one to one dialogue with Government, Ford Foundation and select institutions / individuals who have done pioneering work in this area in India. As a result of these informal consultations we decided to constitute a Technical Advisory Committee to review the rich outcome of the August brainstorming meeting and take a decision on the scope. The TAC was constituted for the preparatory planning phase of the National Abortion Assessment Project (NAAP), as it was called then. The final proposal and strategy is the outcome of the decisions taken in the TAC meeting held in New Delhi on 15 January 1999, in Jaipur on 29 April 1999 and in Delhi again on 17-18 Jan. 2000.

Between May and December 1999 the coordination mechanism necessary for the project were reviewed by the potential donors and also the TAC members. It was felt that CEHAT should house the project secretariat and coordinate the project. Draft proposals were also invited from potential collaborating agencies for the multicentric studies in order to get a clearer picture of the financial requirements and also the capacity of agencies to undertake the study. Further the qualitative studies component would be coordinated by Health Watch.

The third and last meeting of the TAC, along with potential partners for the multicentric study, researchers who have recently done exhaustive work in this area and representatives of the three donors (Ford Foundation, Rockefeller Foundation and Mac Arthur Foundation) was held in New Delhi on 17 and 18 January 2000. The draft proposal was reviewed and finalised. The coordination mechanisms were also reviewed and finalized.

Overall Objective of the National Abortion Assessment Study

- Review Government policy towards abortion care, availability of funds, its flow and policy / programme environment in the country - –including Family Planning and abortion care
- Assess and analyse abortion services, including organisation, management, facilities, technology, registration, training, certification and utilisation in the public and private sector.
- Study user perspective with special focus on women's perceptions of quality, availability, accessibility (including barriers to utilisation of safe abortion facilities), confidentiality, consent, post-abortion contraception and attitude of service providers.
- Study social, economic and cultural factors that influence decision-making: impact of changing social values, male responsibility, family dynamics and decision making.
- Document costing and finance issues related to the above.
- Estimate rate of abortion, resultant morbidity and mortality; causes of spontaneous and reasons for induced abortion.
- Disseminate information on abortion issues widely and do advocacy on issues of concern in the context of reproductive rights of women.

Anticipated Constraints

At the outset, it is important to recognise that abortion is not only a sensitive issue, but that the vast numbers of service providers are not registered. Therefore, gaining their confidence will be very important. Given the prevalent political and administrative climate in the country, certification / registration is a contentious issue. Unregistered providers may not be willing to talk unless the researchers ensure complete confidentiality. This implies that the study adhere to strict ethical norms and ensure confidentiality. This will be necessary to not only gain the confidence of service providers but also create a non-threatening environment for inquiry.

Researchers and social activists point out that given the secrecy and often "shame" associated with abortion, women do not speak freely. However, if a local woman's group or a heath worker has gained the confidence of the community, women are more willing to talk about abortion experience. Therefore, any study on abortion and related issues must factor in under-reporting. It would also be necessary to design questionnaires in such a way that important information is gathered in a gentle and non-judgemental manner. Therefore, any researcher with a track record of good quality research cannot do community based qualitative studies and surveys on abortion without factoring in these facets. The support of a local group / organisation with credibility is important. Even so, this constraint would have to inform overall project design.

Ethical Guidelines

The technical Advisory Committee discussed the above constraints at length and was of the unanimous view that the AAPI should adhere to strict ethical guidelines. While medical research in India is normally undertaken within the framework of Indian Council of Medical Research's ethical guidelines; this practice is not prevalent in social science research. The TAC was of the view that this project should mark a departure and adopt a code of ethics for research on abortion and related issues. To this end, the TAC recommended the following:

- On commencement of the project, all the collaborating institutions will come together and mutually agree on a code of ethics to be followed during the course of the study and in dissemination of study findings.
- Taking informed consent of the respondent by communicating (verbally or in writing as the case may be) the objective of the study, how the information collected will be used and commitment to protect the identity of respondents.
- Protect the identity of the provider / respondent by using code numbers instead of name of the facility surveyed, name of the service provider and identify of the respondent.
- Data generated in this project will be presented only in a tabulated form. Individual case studies / information will not be made public and will be stored carefully and also protected.
- Data collected through this study will be available for use of researchers, women's health advocates, the Government and any other stakeholder. To this end, efforts will be made to ensure the tabulated data and the reports are available with all the collaborating institutions, donors, the Government and if possible, on the Internet Website.
- The AAPI will constitute one ethics committee for the national study and separate ethics committee in each collaborating institution (qualitative and qualitative studies). The composition of this committee will be made public alongside mechanisms of appeal. The committees will ensure guidelines are followed. To this end they will also conduct surprise visits and spot checks.

Study Design – A Five Pronged Approach

Given the prevailing situation of abortion services and the changing perception and values of the community, a national assessment study would not only cover a wide geographic area but also try to capture the various dimensions of the problem. There are five dimensions of this study.

I. Overview paper on policy related issues, series of working papers based on existing data / research and workshops to pool existing knowledge and information in order to feed into this project. (**Component I**);
II. Multicentric facility survey in six States (**Component II**).
III. Eight qualitative studies on specific issues to compliment the multicentric studies. These could be done by researchers, grassroots groups and medical establishments and will not be confined to the six states. (**Component III**);
IV. Community based studies to estimate abortion rate, utilization patterns and costs in two States in India (**Component IV**).
V. Dissemination and advocacy programme: While a larger advocacy initiative will constitute an independent phase to be worked out towards the end of the proposed phase, some significant initiatives in disseminating information and carrying out advocacy work through workshops, meetings and analytic literature both via academia and through popular media have been planned in the current phase. (**Component V – the dissemination and advocacy component in the present phase will be part of Component I**).

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

Project Management

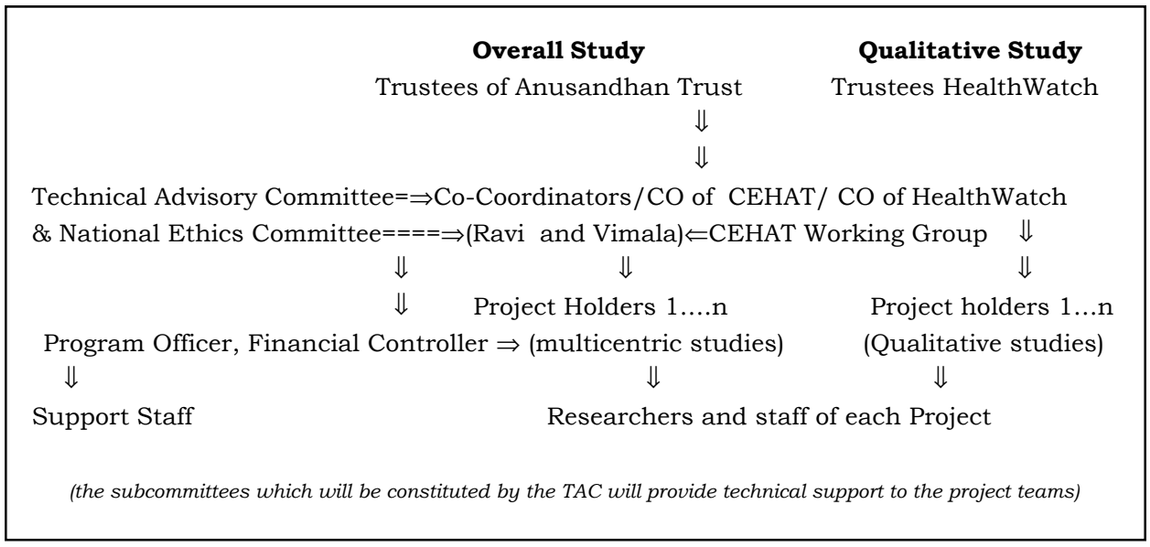
The overall coordination and management of the project will be done by CEHAT, Mumbai and the two Coordinators are Ravi Duggal of CEHAT and Vimala Ramachandran of HealthWatch Trust, Jaipur. The Management structure is outline in the box below :

Role of Co-coordinators

While the TAC will define the terms of reference for the Coordinators of AAPI some broad responsibilities have been worked out in discussions between the Coordinators.

Joint Responsibilities

- Providing leadership and vision
- Planning activities, processes etc..
- Reviewing proposals, reports etc..
- Recommending decisions to TAC
- Keeping TAC and donors informed about progress.



(the subcommittees which will be constituted by the TAC will provide technical support to the project teams)

Vimala's Prime Responsibilities and Sphere of Decision-making

- Liaison with the TAC, coordinating their meetings and activities
- Coordinating the Qualitative Studies and all matters related to it, including administrative and financial through Health Watch
- Overseeing Haryana, MP and Rajasthan multicentric studies
- Coordinating all aspects of the Working Papers, including the Policy Review paper

Ravi's Prime Responsibilities and Sphere of Decision-making

- Liaison with the NEC, coordinating their meetings and activities
- Overseeing multicentric studies in Kerala, West Bengal and Mizoram
- Overseeing community-based studies
- Overseeing the planning of various workshops and meetings
- Coordinating financial flows
- Management systems development
- Developing and coordinating reporting systems
- Financial monitoring and control of projects supported through CEHAT
- Facilitating information flows across all involved in this process
- Coordinating dissemination of outcomes

Technical Advisory Committee (TAC)

At the apex will be a Technical Advisory Committee consisting of select experts, representative of MOHFW, GOI, ICMR, CEHAT (Secretariat) and HealthWatch (Nodal organisation for qualitative studies). The TAC will be the apex committee that will take all decisions for the project. Therefore, collaborating agencies who are potential recipients of studies will not be members of the TAC. They will be part of other project committees, including one each for the multicentric studies, qualitative studies, workshops, working papers etc. The Secretariat will facilitate the work of the TAC.

Secretariat of the National Abortion Assessment Project

The Secretariat of AAPI will shoulder coordination responsibilities and provide administrative and logistical backup to the TAC and the National Ethics Committee (NEC), (later changed to Ethics Consultative group or ECG) which will be set up to support AAPI. It will also coordinate and liaison with all collaborating institutions and facilitate linkages with the TAC and the ECG.

The Secretariat will function as a clearinghouse for AAPI and all associated with it. It will organise meetings of the TAC and ECG, and workshops to review the various research projects as and when necessary.

The Secretariat will keep the TAC informed regularly of progress and developments in AAPI. The Secretariat staff will accompany and monitor progress of all projects on a regular basis and document this to keep TAC updated.

The Secretariat will receive reports from all projects, compile them and distribute/ disseminate as decided by TAC.

The Role of TAC

Once proposals are sanctioned the reconstituted TAC will hold consultation/s with the research teams to finalise protocols and plans of actions. The TAC will define the work of the Secretariat and how it will relate to the various institutions conducting the research. The TAC will be kept updated and informed by the Secretariat team and it will meet once in six months to review progress and make suggestions for mid-term corrections and help with any trouble-shooting.

The TAC's budget is included in the Secretariat budget. The Secretariat will facilitate the organising of its meetings, and members attending and providing any services to the projects will be paid per diems (consultant fees) as commonly agreed to.

The Role of the ECG

The ECG will be constituted on the advise of the TAC. Its terms of reference will also be developed by TAC. At present it has been agreed that as there is no guideline for ethical standards in social science research in India the participating institutions will adopt a mutually agreed to framework. Some work already done by CEHAT on evolving ethical guidelines for social science research in health and medicine will be shared with the TAC and ECG to facilitate the formulation of the framework.

Phasing and Time Frame

Phase One*:* The first phase will cover the above four components. At the outset, a Technical Advisory Committee will be constituted to oversee the studies. The project commenced in June 2001.

ACTIVITY	**MONTH**
Establish the Secretariat, setting up systems, planning	1 – 4
Constitute the TAC	2 – 3
Constitute Ethics Committee and other sub-committees	
(Working papers, Workshops, Qualitative Studies, Multicentric Studies)	3 – 5
TAC	
Six-monthly meetings to review, approve and plan	3 onwards
Monitoring and support activities of TAC members	As planned by TAC
Ethics Committee:	
Six-monthly meetings to review, approve and plan	5 onwards
Monitoring and support activities of members	As planned by EC
Multicentric Studies	
Approval of proposals for Multicentric Studies / Community Based Rate.	4 – 5
Methodology Development Workshop for Multicentric Studies	5 – 6
Mutlicentric Studies – ongoing support and monitoring	7 – 18
Review of data / results /quality	19 – 24
Draft reports presentation	25 – 28
Qualitative Studies	
Qualitative studies project begins – establish HW Secretariat etc	7 – 9
Workshop to develop methodology and finalise themes for qualitative studies	9
Qualitative Studies approvals	9 – 10
Qualitative studies begin – ongoing monitoring and support	12 – 24
Workshop	28 – 30
Working Papers – including policy overview	
Planning for working papers – meeting of sub-committee	10 – 12
Commission working papers	12 – 14
Workshops – thematic and sharing findings	
Methodology Development Workshop	5 – 6
Pooling existing knowledge / data	12 – 14
Multicentric studies related (2)	20, 26
Qualitative studies (1)	28 – 30
Advocacy strategies (1)	28 – 30
Advocacy and Dissemination	
Planning	24
Workshop	28 – 30
Preparing proposal and action plan for Phase Two	24 – 30
Dissemination of draft report	30
National Workshop to share findings	32
Final report preparation	33 – 34
Wrapping up and end of Phase I	**36**
Strategy and Plan for Phase II	34-40

***Phase Two**:* This phase will commence in the last quarter of the first phase. A detailed proposal and budget for this phase will be prepared in the last quarter of Phase One. A consultative process will be initiated whereby information from the above studies will be shared with a select group of stakeholders and a draft strategy will be drafted. The consultative process in Phase Two involves bringing together like-minded groups with objective of facilitating dialogue between groups who hold different points of view on reproductive health / abortion as a women's health issue.

Who are the Stakeholders at the State Level?

- Policymakers and administrators who are involved in the decision-making process related to medical standards for abortion care;
- Medical community – including private and government providers of reproductive health (especially abortion) services, national / local units of FOGSI, pharmacists etc.
- Family planning service providers (private and public sector).
- People who influence decisions about abortion care;
- Community-based organisations;
- Women's health advocates;
- Paramedical providers associated with maternal and child healthcare;
- Citizen (consumer) protection groups;
- Social science and medical researchers;
- Demographers and family-planning advocates (members of the population lobby)

As part of Phase Two the TAC will begin to identify key issues and leaders in the area of abortion care and reproductive health through a consultative process. State level teams will be constituted and they will begin meeting with local groups and individuals to disseminate findings of the literature review and modify and build consensus about and strategies for improving abortion care in India. They will interview a wide range of stakeholders including, but not limited to, key researchers, providers, policymakers, women's health advocates, and representatives of community-based NGOs. The State Teams will work with the Government and interested NGOs to share information and conduct small group and individual interviews with their constituents to see what women want and need regarding improvements in abortion services. This phase is expected to take twelve months. The TAC was of the view that networks like HealthWatch Trust, Medico Friends Circle, VHAI and WAH Network could be asked to take responsibility for Phase Two.

Estimated Budget for National Abortion Assessment Project-India

This budget is based on the decisions taken at the joint meeting with the donor agencies. The budget gives overall allocations for the activities planned and approved at the meeting held in Delhi on 17-18 Jan 2000.

To Anusandhan Trust (CEHAT)	**Total In Rupees**	**Ford Foundation US $**	**Rockefeller Foundation US $**
AAPI Secretariat, Technical Advisory	90,00,000	158,000	57,000
Committee and National Ethics			
Committee			
Multicentric studies (six)	74,58,000	-	177,000
Workshops (six)	30,00,000	35,500	35,500
Working Papers and Policy	15,00,000	35,500	-
Review paper			
Community based studies (two states)	71,58,800	50,000	120,000
Dissemination and advocacy	15,00,000	-	35,500
TOTAL	**296,16,800**	**279,000**	**425,000**
		US $ 704,000	
To HealthWatch Trust Rupees	**Indian Foundation**	**MacArthur US $**	
Qualitative Studies	**77,64,500**	**185,000**	
GRAND TOTAL in Indian Rupees	**Rs.373,81,300**		
In US $ @ Rs. 42 per $	**US $ 890,000**		

II. Summary and Key Findings

Ravi Duggal and Vimala Ramachandran

For many decades now maternal health has been recognised as a crucial area of concern. In this context, incidence, access, safety, legality, cost, social and cultural dimensions, and women's control over decision and choice and other related issues regarding abortion and abortion services in India have assumed serious concern in the context of women's reproductive health needs. The Abortion Assessment Project-India (AAP-I), an all-India research study that commenced in August 2000, was initiated with the objective of assessing ground realities through rigorous research. The overall objectives of the project were:

- Review Government policy towards abortion care, and policy/programme environment in the country[1]
- Assess and analyse abortion services, including organisation, management, facilities, technology, registration, training,certification and utilisation in the public and private sector[2].
- Study user perspective with special focus on women's perceptions of quality, availability, accessibility (including barriers to utilisation of safe abortion facilities), confidentiality, consent, post-abortion contraception and attitude of service providers[3].
- Study social, economic and cultural factors that influence decision-making: impact of changing social values, male responsibility, family dynamics and decision-making[4].
- Estimate rate of abortion, resultant morbidity and mortality; causes of spontaneous and reasons for induced abortion[5].
- Document cost and finance issues related to the above[6].
- Disseminate information on abortion issues widely and develop an advocacy strategy on issues of concern in the context of reproductive rights of women.

To achieve the above objectives a wide range of studies with differing methodologies were undertaken. Given the prevailing situation of abortion services and the changing perception and values of the community, a national assessment study should not only cover a wide geographic area but also try to capture the various dimensions of the problem. There were five dimensions of this study:

I. Overview paper on policy related issues, series of working papers based on existing data / research and workshops to pool existing knowledge and information in order to feed into this project. (*Component I*);
II. Multicentric facility survey in six States – Kerala, Rajasthan, Haryana, Madhya Pradesh, Orissa and Mizoram(*Component II*)
III. Eight qualitative studies on specific issuesto complement the multi-centric studies. These have been done by researchers, grassroots groups and medical establishments in six states – Tamilnadu, Karnataka, Andhra Pradesh, Maharashtra, Gujarat, and Haryana. Also a multicentric qualitative study of informal providers was undertaken in Rajasthan, Maharashtra, Madhya Pradesh, Karnataka, Uttar Pradesh, Haryana and Delhi (*Component III*);
IV. Community based studies to estimate abortion rate and out-of-pocket expenditures in Maharashtra and Tamil Nadu (*Component IV*).

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[1] *See Siddhivinayak Hirve (2004), Abortion Policy in India – Lacunae and Future Challenges, Abortion Assessment Project India, CEHAT and Healthwatch, Mumbai*
[2] *See facility survey reports of 6 states and the national synthesis report – under publication, CEHAT and Healthwatch, Mumbai*
[3] *See Qualitative Studies – A Report (2004), Healthwatch and CEHAT, Delhi; and Household study reports from Maharashtra and Tamil Nadu - under publication, CEHAT and Healthwatch, Mumbai*
[4] *Ibid*
[5] *See houshold study reports from Maharashtra and Tamil Nadu – under publication, CEHAT and Healthwatch, Mumbai*
[6] *Ibid*

v. Dissemination and advocacy programme through workshops, consultations and meetings with various stakeholders and analytic literature/publication dissemination both via academia and NGOs and through popular media (*Component V*).

Over the last decade abortion has indeed become a major global issue in the context of reproductive rights of women. Worldwide of the 210 million pregnancy outcomes each year 46 million or 21.9% are estimated to be induced abortions. These are very large numbers and given the context of wide-ranging restriction on free use of abortions in a number of countries and also an outright ban in many countries, the risks faced by women who are often forced to use unsafe alternatives is tremendous and this is reflected in 13% of maternal mortality worldwide being due to unsafe abortions[7]. Given this scenario the women's movement and health groups have taken up proactively various concerns related to abortion.

In the last decade women's health advocates have tried to draw the attention of policy makers and administrators to a range of issues related to abortion in order to improve the availability, safety and use of services, including:

- Abortion perceived as an extension of the Government's population stabilisation programme;
- Tendency to use abortion as yet another means of family planning;
- Growing trend in some parts of the country towards sex selective abortion;
- Inadequate safe abortion facilities within reach of the majority of poor women in rural and urban areas;
- Dearth of medically approved abortion providers and registered facilities;
- Inadequacy of post-abortion family planning counselling and services; and
- Abortion not perceived as a women's health issue among policy makers and service providers;

Government of India's decision in the post Cairo period (1996) to introduce a more comprehensive Reproductive and Child Health (RCH) program in place of the vertical safe motherhood, child survival and family planning programs gave women's health advocates an opportunity to re-establish the importance of a holistic approach. Donors supporting the Government's efforts (UNFPA, WHO, European Community, SIDA, DANIDA and DFID) highlight the importance of looking at abortion-related mortality and morbidity as a part of the RCH package. This has created a favourable climate in the country to examine the issue from different dimensions and work towards making abortion safe. In the last six years donors have been working with the Government of India and various State Governments to develop district-specific plans for Reproductive and Child Health Programs. The first phase of the RCH program is now coming to an end and plans for the next phase are being finalized. While the first phase of the RCH program may have limited achievements, greater participation of larger number of stakeholder in its review and the next phase planning shows willingness on the policy front to move ahead. These efforts have been noteworthy and administrators are trying to grapple with hitherto unexplored public policy issues. With regard to abortion, despite the US gag-rule, during the first phase of the RCH program some important changes in the MTP Act and Rules related to certification, penal provisions and medical abortion have been made. Also the struggle by activists with regard to sex-selective abortions has moved up this issue in the state agenda and implementation within the states of the PNDT has improved substantially. Also the Government of India has recently passed the completely amended PNDT Act, which now also covers pre-conception techniques.

While the climate seems to be favourable to initiate debate on safe abortion among key stakeholders, lack of reliable information, wide regional variations, rural-urban differences and a thin research base, make it difficult for policy makers, administrators and women's health advocates to develop strategic interventions. There is little dialogue between different

[7] *WHO: Safe Abortion – Technical and Policy Guidance for Health Systems, World Health Organisation, 2003, Geneva*

stakeholders and it is not uncommon to see registered service providers, unregistered / untrained practitioners, women's health advocates, population control lobby, public health advocates and others working at cross purposes. While the moderate spectrum in all the above constituencies are open to dialogue and change, it is indeed a big challenge to bring them together in a non-confrontational forum.

The policy review, working papers and various studies undertaken in this project highlight the inadequate attention given to abortion within the health and population policy of the country and reiterates the often voiced concern that even the recent Reproductive and Child Health programme, initiated by GOI in 1997, has failed to address issues related to abortion.

Key Findings

1. The study of 380 abortion facilities across six states (Kerala, Madhya Pradesh, Orissa, Rajasthan, Haryana and Mizoram) tells us that on an average there are 4 formal (medically qualified though not necessarily certified for abortions) abortion facilities per 100,000 population in India. At the country level this adds up to 40,000 facilities or 48,000 providers (each facility averages 1.2 providers). Of all the formal abortion providers 55% are gynaecologists and 64% of the facilities have at least one female provider. Each of these facilities average 120 abortions per year and this adds up to 4.8 million (one third in public facilities) abortions being handled in formal abortion facilities annually. In addition to this there are more or less similar number of informal (traditional and/or medically non-qualified) abortion providers but they undertake on an average about one-third of the cases handled by formal providers. This gives us an estimate of about 6.4 million abortions annually in India.

2. The Medical Termination of Pregnancy Act (MTP Act), which legalised abortion, has been around for 33 years. Though amended in 2003 to facilitate better implementation the proportion of certified and legal abortion facilities accounts for only 24% of all private abortion facilities in the country. The 380 facilities (285 private) across six states (Kerala, Madhya Pradesh, Orissa, Rajasthan, Haryana and Mizoram) covered in the study provide evidence that those who were certified had obtained certification on an average within a month and of those who were not certified, 68% had never tried to obtain certification. Thus the problem lies largely in the domain of the medical professionals who are not keen to register and become accountable to the authorities. Lack of ethics in medical practice and absence of self-regulation amongst the profession is largely responsible for the present state of affairs. On the positive side it is observed that two-thirds of the providers in the non-certified facilities had the requisite training or qualification as per MTP Act to conduct abortions; thus a majority of uncertified facilities were perhaps providing safe abortions. The latter is confirmed with by the fact that with regard to technical aspects and infrastructure facilities the difference between the certified and non-certified facilities was small.

3. On the method of abortion, our research found that 73% of abortions are conducted for pregnancies with less than 12 weeks gestation. However, dilatation and curettage (D&C) seems to be the preferred method for nearly 89% of induced abortions; even amongst those who use vacuum aspiration the practice of check curettage is very common. This obsession with curettage both adds to the cost of the procedure as also contributes substantially to post-abortion complications and infections thus affecting quality of care. Physical infrastructure was overall better in private facilities as also availability of equipment and instruments. But information provision to clients and counselling are better in public facilities.

4. As regards referrals about two-thirds of the facilities said that they referred cases to higher facilities and as many as one–fifth were referring more than 50% of the cases. It is interesting to note that 78 percent of the providers have mentioned that it is the second trimester cases that are most commonly referred. Medical risk and incomplete abortion conducted elsewhere constitutes 58 percent and 25 percent

respectively of the referrals. The data thus suggests that the providers, especially in the unregistered private facilities, really do not take any chance in handling a case with which they are not comfortable. The place where the referrals are sent are mainly government hospitals which include district hospital (44 percent), medical college (25 percent), post-partum centers (15 percent), sub-district hospital (11 percent) and CHC (7 percent).

5. While physical access seems to be reasonably good, social access remains restricted since providers, especially in formal and certified facilities, do not provide services to women if they come alone and/or if the spouse or some close relative does not give consent. In the household and qualitative studies women said that the decision for undergoing an abortion is rarely their own; more often than not their spouse or some relative decides for them. This affects the woman's freedom to access such services and hence to protect her confidentiality and privacy she may often resort to providers who may not be very safe. As regards reasons for seeking induced abortions, only 25% of them fall into what is permitted under the MTP Act (failure of contraceptives, threat to the woman's life, biological reasons), the rest were unwanted pregnancy, economic reasons and even unwanted sex of the foetus. The community-based household surveys, qualitative studies and working papers all indicate the prevalence of the practice of sex-determination and female-selective abortions.

6. Public investment in abortion services is grossly inadequate. Only 25% of abortion facilities in the formal sector are public facilities, 87% of the abortion market is controlled by the private sector; the average (median) cost of seeking abortion in the private sector in the facilities studied is Rs.1294, 7.5 times more than the cost in public facilities. This constitutes a major handicap for women who come from poorer classes or other disadvantaged groups like dalits and adivasis. The household studies under this project reveal that women from poorer classes and from dalit and adivasis communities have significantly lower rates of induced abortion because they often do not have the purchasing power to access abortion services from the private sector or travel long distances to access public services. This makes a strong case for both strengthening as well as expanding public abortion facilities across the country. The RCH-2 phase currently under preparation needs to factor this in if reproductive health and healthcare of women have to improve.

7. The incidence of abortion recorded in Maharashtra and Tamil Nadu as per the household studies is higher than hitherto known studies for both states. In Maharashtra induced abortion during the reference period (1996-2000) was 4.54% of pregnancy outcomes in contrast to nearly twice that in Tamil Nadu (7%). The difference of abortion rate across rural and urban areas as well across classes and social groups in both states was significantly different – in urban areas abortion rates were nearly twice than that in rural areas (more so in Maharashtra) and amongst classes and social groups too there was a clear gradient indicating that those better off had much higher rates than those economically and socially disadvantaged. Such association clearly indicates that access both physical and financial is a critical factor in determining abortion rates and use of abortion services.

8. As regards utilisation of services the poor access of the public health sector in providing abortion services comes out very sharply with the share of public health facilities being less than one-fifth of the abortions reported in the studies in both states. The access of public services in urban areas was twice better than in rural areas in both states. But with regard to socio-economic class it was clear that the poorer sections were much larger users of public facilities for abortion services wherever they are available. This read along with the pattern of abortion incidence across classes increases the strength of the evidence that physical and financial access is the most crucial determinant in access to abortion care and services and this makes a very strong case for the public sector to strengthen its participation in abortion

care. Interestingly the out-of-pocket burden (median of Rs. 1220 in Maharashtra and Rs.950 in Tamil Nadu) for accessing abortion services as revealed in the household studies is very similar to the costs recorded in the facility surveys. Extrapolating this cost per abortion to the total number of estimated abortions of 6.4 million we find that the abortion economy is worth Rs.800 crores. This is a mere 0.64% of the total health sector expenditures out-of-pocket.

9. The eight qualitative studies revealed that the overwhelming reason for seeking abortion among married women was to limit the family size. When women were asked to indicate the situations in which they would seek abortion or had actually sought abortion, the majority of the women in studies conducted in Maharasthra, Gujarat, Andhra Pradesh and Tamil Nadu reported limiting the family size as the main reason for abortion. Equally disturbing was the finding that non-use of contraception rather than contraceptive failure was reported to be the chief reason why the unwanted pregnancy situations described above tended to occur. Actual contraceptive failure was reported in very few cases. Though all respondents across studies reported knowledge of sterilisation as a method of limiting family size and a majority of the women knew about the reversible methods of contraception such as condoms, oral pills and IUD for spacing births – yet this knowledge did not translate into practice for a range of reasons – fear about its effect on health, pain and discomfort, irregular supply and problems with obtaining permission from husband. Use of condoms for contraception was rare! Paradoxically, there was a perception that abortion was safe and did not have any long-term adverse health consequences. For some respondents it was seen as a 'safer' option than the use of IUDs and other spacing methods!

10. Also, almost all women were aware that sex selective abortion was illegal, and admitted that women approach different facilities for ascertaining the sex of the foetus and for abortion. Awareness of the new PNDT Act was far greater among women and service providers in comparison to the details of the MTP Act. Group discussions invariably turned spirited when sex selection was discussed. While most respondents admitted that sex selective abortion is indeed illegal, they expressed helplessness as their status in the family and sometimes the very survival of their marriage depended on their ability to produce sons. Women openly and without any hesitation talked about it in almost all the areas. The studies also revealed that when couples have more than two female children, then female selective abortion was approved by the family and condoned by the community. There was no social stigma associated with sex selective abortion – especially for mothers with many daughters. Women from Gujarat and Haryana also reported that while they were not comfortable with abortion per se, when it was done for the sake of the family, then they accepted it.

11. There was an overwhelming perception that private facilities were better. The reason for preferring private providers was quite wide, suggesting that the women and their families do weigh the alternatives before deciding where to go. Reasons cited by women were:
    a. Abortion in private facility takes much less time – everything is done in one visit, meaning that they do not waste time waiting and going through formalities (as most government hospitals are not client friendly) and that everything could be wrapped up in one visit.
    b. Private doctors have better facilities and equipment and that they are not in a hurry to discharge women soon after the procedure if they need rest for an hour or so before going home. In public hospitals, on the other hand, given a shortage of beds women are asked to leave as soon as possible.
    c. Private doctors treat women better and ensure confidentiality.

12. It was accepted that while the services of private providers cost money, visits to the government hospitals were also not cost-free because women had to pay for medicines separately. They were sometimes required to make repeat visits before the abortion

was performed. The long waiting period implied that the time of the service seeker and of the accompanying person (generally women do not go alone to impersonal large facilities) was wasted, leading particularly in poor families foregoing wages for that time. The cost varied according to the type of provider and the gestation period.

13. In the multicentric study of informal providers using qualitative methodologies across seven states it came out quite clearly that such providers are largely used by women to handle delayed periods and very early abortion. A majority of informal providers are using oral methods like herbs, *kadha's,* tablets etc.. However there is considerable variation across states wherein it emerges very clearly that in states like Rajasthan and Uttar Pradesh where access to formal providers is very limited the informal providers continue to use invasive methods in contrast to other states like Maharashtra, Karnataka, Haryana and Delhi where access to formal providers is reasonably good. Findings also reveal that the informal providers cater in a very large way to unmarried women. Also in many areas the informal providers are a link between formal abortion providers and abortion seekers, especially in rural areas. Infact, the latter is viewed as a future trend for the role of informal providers to work in collaboration with formal providers as referral links between communities and abortion services.

14. As part of the AAP India project a policy review was undertaken that focused on the dynamics of the MTP legislation and involved consultation with a wide range of stakeholders to identify lacunae and concerns on abortion policy. The review paper also brings out the future challenges and issues for advocacy on the abortion policy front, which are crucial to take abortion into the rights domain. Apart from the policy review a number of working papers were commissioned which reviewed a wide range of abortion issues and concerns based on existing literature[8]. Similarly a special issue of Seminar (Issue No 532, December 2003) was commissioned which published 13 original articles largely based on the various studies under the AAP India project.

Emerging Advocacy Issues

Based on the findings of the study and discussions and consultations with various stakeholders during the various stages of the studies a number of key issues and concerns vis-à-vis abortion and abortion services have emerged. In a national consultation held in New Delhi in Nov. 2003 all these findings and issues of concern were brought together in the presence of a wide array of stakeholders who are active on the abortion and women's health issues. On the basis of the discussion, debate and suggestions which emerged during this consultation the following advocacy issues were short listed to be taken forward during the dissemination phase of the AAP India project to be advocated with policy makers, medical profession, NGOs, donor community etc. and for future actions beyond the phase of this project. We hope the dissemination meetings in different states will add their experiences and take forward these issues and others, which may emerge in the state level meetings that will take place between July and Sept 2004 bringing to an end this phase of the AAP India project. The following issues do not constitute a complete list but only an indicative list of the

[8] *The papers published so far include: Abortion Policy in India – lacunae and Future Challenges (Siddhivinayak Hirve), Abortion Practice in India – a review of literature (Heidi Johnston), Negative Choice – sex determination and sex selective abortion in India (Rupsa Mallik), Abortion Options for Rural Women – case studies from the villages of Jharkhand (Lindsay Barnes), Abortion Training – a long way to go (Sangeeta Btra and Sunanda Rabindranath), Professional Abortion Seekers – the sex workers of Kolkatta (Swati Ghosh), Assessing Potential for Induced Abortion among Indian Women (US Mishra and TR Dilip), Methodological Issues in Abortion Estimation (Shelley Saha), Abortion Costs and Financing – a review (Ramamani Sundar), Sexuality Abortion and the Media – a review odf adolescent concerns (Anita Anand). These papers are available with cehat@vsnl.com*

major key issues which were identified for future action and advocacy:

- Changing mindset of providers through their professional associations to accept certification on a universal basis
- Integrating abortion services under Primary Health Centres and Community Health Centres through a strengthened RCH programme – which would automatically enhance women's access to abortion care services.
- Substantial increase in investments in public facilities to strengthen abortion services
- Promoting safer technologies by changing the mindset of providers away from unnecessary use of curettage
- Strengthening regulation of abortion facilities to evolve minimum standards for quality care and accreditation
- Promoting safe spacing methods of contraception to reduce the need to resort to abortion as a spacing method
- Broadening the base of providers by training paramedics for early trimester abortions as is done in many countries like South Africa, Bangladesh etc.
- The need to widely display certification status of abortion facilities so that women can recognise a safe abortion facility
- The need to educate providers on ethics of sex-determination tests and respecting the provisions of the PNDT Act
- The need for medical associations to get active in training abortion providers, especially those in the private sector
- Promoting apprenticeship as a method of training
- Reskilling of traditional providers to play alternative roles in supporting abortion services

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The studies referred to above were carried out by various research institutions and individual researchers in the different states and coordinated by Ravi Duggal from CEHAT, Mumbai and Vimala Ramachandran from Healthwatch, Delhi. The AAP-India project was supported by the Ford Foundation, Delhi, MacArthur Foundation, Chicago and Rockefeller Foundation, New York. Copies of papers and reports in printed and electronic versions are available at the addresses below.

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III. Abortion Policy In India : Lacunae and Future Challenges

Siddhivinayak Hirve

Executive Summary

In India, legalising abortion, which was done in 1971, has not yielded the expected outcomes. Despite the existence of liberal policies, the majority of women still resort to unsafe abortion, contributing substantially to the burden of maternal morbidity and mortality. This is partly due to the low awareness of the legality of abortion amongst women, and a large number of misconceptions about the law amongst providers. Liberal abortion policies and legislation by themselves are thus not adequate to ensure access to safe abortion services. This paper critically reviews current abortion policy (in terms of content, context and conformity with international policy, as well as how it is practised), identifies policy gaps in the context of reproductive rights and emerging reproductive technologies, examines programme barriers to policy implementation and advocates evidence-based policy change for policy-makers and all stakeholders to review and reinforce their commitment to safe abortion care.

Abortion policy in India is consistent with safeguarding reproductive rights as envisaged by International Conference on Population and Development (ICPD) and other international agreements. It does not advocate abortion as a family planning measure. Rather, it encourages the promotion of family planning services to prevent unwanted pregnancies and at the same time recognises the importance of providing safe, affordable, accessible and acceptable abortion services to women who need to terminate an unwanted pregnancy. The MTP Act aims to regulate and ensure access to safe abortion care and defines 'when' 'where' and under 'what' conditions abortion is permissible. The recent amendment to decentralise regulation of abortion care to the district level serves to encourage registration of abortion facilities by minimising administrative delays. While defining punitive measures to deter abortion facilities that provide unsafe abortion care, the Act offers full protection to registered providers from any legal proceedings for any injury caused to a woman seeking abortion.

A major critique of the MTP Act is its apparent 'over-medicalisation' and 'physicians only' policy that reflect a strong medical bias and ignore the socio–political aspects of abortion. The need for two doctors to certify opinion for a second trimester MTP is an unnecessary restriction imposed by law. Abortion policy within the 'rights framework' emphasises not only the woman's 'right' to seek safe abortion, but also her 'right' to access safe abortion services as well as information about the availability of such services and the consequent responsibility of the state to provide these services. Though abortion law allows for termination of pregnancy for a wide range of reasons construed to affect the mental and physical health of the woman, it remains with the doctor (and not the woman) to opine in good faith, the need for such a termination. Such a provider-dependent policy might result in denial of abortion care to women in need, especially the more vulnerable amongst them, for various reasons, including 'conscientious objection'. It is also argued that it may compel a woman to lie about the situation surrounding her unwanted pregnancy. Further, the same provider-depended law, however liberal it may be, can become restrictive under different socio–politico–religious compulsions without the alteration of even a single word. Moreover, while the MTP Act permits women seek legal termination of an unwanted pregnancy for a wide range of reasons, the clause about contraceptive failure applies only to married woman. This discrepancy needs to be corrected.

While the abortion policy allows for monitoring of quality of abortion care in the private sector, its recognition of all public health institutions as abortion facilities by default exempts the public sector from certification. This raises a potential 'moral hazard' in that public sector abortion facilities are not constrained to adhere to the physical standards and quality of abortion care expected of the private sector.

The default recognition of all public health institutions as abortion facilities also implies the responsibility of the government to make each public health institution capable of providing abortion care and hence makes the state accountable for it.

The MTP Rules specify certification procedures, and regulatory and redress mechanisms to ensure compliance with safe abortion care. For registration of abortion facilities, the amended MTP Rules stipulate a time frame of two months for inspection after receipt of application and another two months for approval after full compliance with requirements. By making the government accountable, this mandate serves to encourage abortion facilities to obtain registration. However, it does not specify measures or redress mechanisms if certification procedures are not completed within the stipulated time frame. More substantively, the amended MTP Rules differentiate between and rationalise the training/experience criteria required of the doctor and the physical standards required of the facility for first and second trimester abortions. This amendment has the potential to increase the availability of first trimester abortion without compromising on safety. The amended MTP Rules also allow registered medical practitioners to provide medical abortion within the scope of the law. Such providers need to have access to (and not necessarily have on-site capability) surgical abortion services. This amendment potentially serves to expand the availability of medical abortion.

Another major critique of the abortion policy is its lack of a link with good clinical practice and research. The MTP Rules define 'person' and 'place' requirements, but do not refer to any national or international technical guidelines for safe abortion care. In the absence of such linkages with guidelines for 'good clinical practice', providers continue to use unsafe abortion practices like sharp curettage, check curettage following a vacuum aspiration, general anaesthesia, different drug dosage schedules and protocols for medical abortion, etc. The scope of an abortion policy needs to be broad enough to internalise emerging advances in reproductive technology and newer practices within the legal framework.

The MTP Regulations define procedures to ensure confidentiality and anonymity in provision of safe abortion services. However, there are no guidelines for ensuring the privacy and dignity of the woman. States are yet to respond to the recent (June 2003) amendments to the MTP Rules and Regulation and some of them continue to add layers of bureaucratic procedures not required by policy, leading to unnecessary administrative barriers. For instance, regulatory procedures like the need for a blood bank within a 5 km distance of the abortion facility are illogical and not required by abortion policy. The irrational nature of such overzealous regulations by states becomes apparent when we realise that these requirements are applied *only* to abortion facilities in the private sector. The time and effort required to procure registration for an abortion facility reflects the states' attitude and approach towards facilitating abortion services. Low awareness and misconceptions about abortion laws and policies amongst providers adds to the overall lack of availability of safe abortion services. The general 'spirit' of the State Regulations thus appears to be that of 'controlling' rather than of 'facilitating' abortion services. Mifepristone has been recently licensed for use in medical abortion. A major critique of the Drug Controller General's Policy is its over-medicalisation and restricted access. By permitting the use of mifepristone only up to seven weeks and making it contingent on a gynaecologist's prescription, the drug licensing policy conflicts with the abortion policy and technical guidelines. Further, with no national consensus on medical abortion protocols regarding dosage and schedules, the current MTP policy offers no technical guidelines for the practice of medical abortion. The government has not yet adopted either the international technical guidelines or those recommended by the Expert Consortium on Medical Abortion in India, which advocates home administration of mifepristone/misoprostol under medical supervision.

Para 63(iii) of ICPD+5 mandates the health system to adequately train and equip health service providers and to take measures to ensure that safe abortion care is available and

accessible. A large unmet need for MTP training exists in both the public and private sectors. Selection norms for training centres should ensure an adequate caseload to allow 'hands-on' training. Further, the few training centres that do exist are inequitably distributed between states, and function below par. The private and non-governmental sectors' potential for training has not been tapped. And while the goal of training policy is to provide MTP training to medical officers at all Public Health Centres (PHCs), poor coordination, low priority and lack of clarity about training needs have resulted in very few trained doctors at PHCs. An important gap in training policy is the lack of training opportunity for private medical practitioners desirous of providing abortion care. Training policy needs to address the training needs of the private sector and allow MTP training centres to charge private medical practitioners for training services.

Comprehensive abortion care is integral to abortion services. This includes providing pre- and post-counselling services for contraception, STI and HIV counselling and voluntary testing, extended care up to six weeks after abortion and management of abortion complications. Covert and overt coercion for post-abortion contraceptive use in public institutions often compels women to seek unsafe abortion elsewhere. Abortion policy also needs to explicitly link up with national and international technical guidelines for management of post-abortion complications.

Access to safe abortion care goes beyond an enabling policy environment. Rules and regulations may themselves create barriers to policy implementation. Many administrative barriers not dictated by law evolve simply as through practice and get misinterpreted as 'required by law'. Spousal consent, informal fees, lack of awareness about the legality of abortion, judgmental attitudes, conscientious objection to abortion by providers, the traditional neglect of underserved women — such as adolescents and single women — by the health services, and other barriers need to be identified and measures taken to end such misguided practices.

Policies need to clearly demarcate the purposes and domains of the PNDT Act and the MTP Act. Recent media campaigns to enforce the PNDT Act to prevent sex selective abortions have blurred this demarcation and often denied access to safe abortion care to women seeking to terminate a pregnancy within the legal framework. The PNDT Act and the MTP Act do not conflict or contradict but coexist. The belief that a restrictive abortion policy will prevent sex selective abortion is unfounded. Policies need to ensure that measures for preventing sex selective abortion do not affect access to safe abortion care for the genuine abortion seeker.

Despite its ability to influence and shape policy, the private sector has traditionally distanced itself from all matters relating to it. It is only recently that non-governmental professional bodies like FOGSI have interacted with the government to reshape abortion policy. Though being the largest provider of abortion services, the private sector has until recently played a minimal role in educating and training its fraternity in safe abortion care. While not shy of critiquing public policy, the general phobia for record keeping and reporting and the consequent fear of 'accountability' to the state, has restrained private doctors from taking part in public policy dialogue. The general lack of concern in the private sector about ethical violations and the lack of adherence to minimal quality standards on the one hand, and the blind eye it turns towards the uncertified and unqualified providers of illegal and unsafe abortion among its fraternity on the other, raises concerns about self-regulation within the sector. It is only recently that some private actors have begun to play a more proactive advocacy role for improving access to safe abortion care, though there have been/are many opportunities for public–private partnerships in the areas of policy formulation, research, training and practice, and the strengthening of safe abortion care.

Several national-level consultative efforts involving policy-makers, professionals groups, NGOs and health activists, have made major policy recommendations to improve access to safe and legal abortion services in India. Many of these policy recommendations are in line with the objectives and Action Plan of India's National Population Policy, 2000. Increasing availability, creating qualified providers and facilities, simplifying the registration process, de-linking place and provider, linking policy

with technology and research and good clinical practice, and providing comprehensive and quality abortion care are some of the immediate policy measures needed to bring about a change in the current abortion scenario in India.

A concerted and sustained advocacy effort 'to make abortion safe' directed towards national and state policy-makers as well as programme managers, coupled with a sustained campaign to increase the overall awareness about abortion laws and policies amongst women and dispel myths about abortion amongst policy-makers and programme managers, are needed to ensure the political and administrative commitment to provide safe abortion care to a woman seeking termination of an unwanted pregnancy within an enabling legal and policy framework.

IV Abortion Services In India
Report Of A Multicentric Enquiry

Ravi Duggal and Sandhya Barge

Executive Summary

In India the recommendation of the Shah Committee to propose a legalisation for abortion was a historic step in addressing the health rights of women. As abortion was anyway available to women widely despite it being criminalized under the IPC, the state took up the cause proactively under its family planning program and by 1972 abortion had been made legal under the Medical Termination of Pregnancy Act 1971 (34 of 1971). Apart from making abortion legal, the MTP Act created a monopoly for provision of abortion services within the allopathic medical profession, and that too for Obstetricians and Gynaecologists and other medical doctors who received special training as mandated in the Act and its Rules. This rendered all traditional providers and other abortion providers, whether medically qualified or not, illegal. Historically the *dais* and related local practitioners who acquired knowledge and skills traditionally were the main providers of abortion services in India.

Under the Abortion Assessment Project - India an attempt was made to understand the situational analysis of abortion care facilities in order to comprehend issues and concerns from the provider's perspective, and how the situation could be improved for the abortion seekers so that they get access to good quality abortion services. Some of the key issues addressed in this study includes registration, training and certification, availability, technical competence, training needs and current training facilities / programmes for abortion care providers in the public and private sectors; technologies used in the public and private sectors, management and organisation of abortion services (including management of complications and life threatening situations), and utilisation of facilities and costs of abortion services.

A modest attempt at the above objective was done through a multi-centric study done across six States in India covering facilities in the public and private sector. The study covered providers in the formal sector, defined as healthcare facilities where medically qualified practitioners, in any recognised system of medicine, were providing abortion services. The study takes a comparative look at public and private providers across better-developed and less developed regions of the country. The states selected for the purpose ware based on women's health indicators and also representing different regions of India. The states included in the study are Haryana in north, Kerala in south, Orissa in east, Rajasthan in west, Madhya Pradesh in central India and Mizoram from the north east. The development of the methodology and the protocols for the study was a collective exercise between the researchers, TAC members and selected experts.

As per the study design two districts were selected in each state on identified indicators, and within each district the blocks were selected on the basis of level of urbanisation. In the process three blocks, the average block in terms of urbanisation, one above average and one below average were selected. In each selected Block the researchers enumerated all formal and institutional providers of abortion services, registered or unregistered, and public and private (definition: formal provider is one who has been trained in a formal institution which awards a degree or diploma, like MBBS, BAMS, BUMS, DHMS etc.; an institution is one which provides nursing care, including day-care, by formal providers, like dispensaries, clinics, nursing homes, hospitals (often these may be in the residence of the provider)). This listing was done with a standard protocol, which recorded a few basic characteristics of the facility, including willingness to participate in the study. This process helped define the universe. Local lists and key informants

(medical reps, pharmacy shops, hospitals etc..) were the main source of generating this list.

In each block all public providers like PHCs, CHCs, PPCs, municipal and government hospitals and dispensaries were covered. While for private practitioners around 40 private providers per district (excluding Mizoram, which in the entire state had only three private providers) were identified. In four states (excluding Mizoram and Kerala), where informal providers were available they more than made up for the paucity of formal private providers. All the states used the standardized and common methodology and protocols for data collection, which was collaboratively developed by the researchers and the TAC.

Findings discussed here is a synthesis from the findings of the six states. This overview report is a result of an independent analysis of pooled data from the six states, which was reorganised to place the selected districts in the national context rather then as representative of the state. That is, the designation of districts as better or less developed in this synthesis report is based on the national average rather than the state average, as was the case with the state level studies. This obviously changed the designation of a couple of the districts.

Of the total abortion facilities in the sample, public sector accounts for only one-fourth of the facilities. This low level of investment by the state in the context of large scale poverty limits access of women to abortion services. This is exacerbated by the fact that PHCs which are mandated by policy to provide abortion services are not doing it in any significant numbers, as most public facilities in our study were either district, sub-divisional or rural hospitals. The availability of abortion facilities in both better and less developed regions is reasonably good at 4 facilities per 100,000 population with public facilities accounting for one-fourth of this. If all the PHCs and CHCs were providing abortion services the average for public facilities would alone have gone up to 5 per 100,000 population. This is an important concern emerging from this study and needs immediate attention for the sake of improving access of women to abortion services, especially the poor and those in rural areas.

Among the private facilities only 18 percent of the facilities were certified. Often the provider community blames the implementers of the MTP Act for being barriers to obtain certification but this does not come out in the present study. It is seen that those who tried to get registration and were successful obtained certification in less than a month; infact in better developed districts it was about two weeks only. Among those who are not certified, two-thirds never tried for registration indicating a callous attitude amongst the providers. This is a serious lapse in the system and both the state and the provider community need to become more responsible on this front.

Reporting of abortions to the authorities is not complete as expected but even registered facilities do not file complete returns. Hence the data published by the authorities about registered abortions is in itself under-estimated, let alone the large number of unregistered abortions. The authorities do not demand accountability on this front and the providers don't show much enthusiasm to report resulting in a deficient database on abortions in the country.

Interestingly a large proportion of the providers are gynaecologists and a majority of them are female providers. This, coupled with the fact that even the uncertified facilities have a large proportion of certified providers, thereby indicates that access to safe abortion in formal/institutional facilities may not be as bad as anecdotal evidence has been suggesting.

While physical access to abortion services from the facility perspective does not seem to be a problem, information access is a major gap. Insignificant numbers of facilities, even amongst the certified facilities, display the availability of abortion services or their MTP certification. This is a major setback for the abortion seekers who in the absence of knowledge about the legality of the facility or provider is unable to distinguish the genuine and safe abortion facilities. Social access is somewhat of a concern because providers may not provide abortions services if women come alone, if spouse or other relatives are not there, as they feel that it is risky to do that as well as it is illegal in their understanding. This

certainly affects the woman's freedom to access, and hence to protect her confidentiality and privacy she may turn to providers who may not be very safe.

Financial access is definitely a concern because cost of access to abortion is quite high in the private sector. Given the fact that a much larger proportion of private sector is involved in providing abortion services and the very low proportion in the public domain, the access of poor women to safe abortion services becomes a major issue needing immediate attention.

In terms of physical amenities the facilities do have the required infrastructure with the situation being better in the private certified facilities than the private uncertified facilities and the public facilities. Private certified facilities are also better equipped in terms of complete sets of equipments, anaesthesia and sterilization related equipment. This could be a deterrent factor for the clients to seek services from the public sector.

Among the total providers almost seven out of ten providers are formally trained for conducting MTP, majority among them are gynaecologists. The percentage of untrained providers is more in uncertified private facilities. The study further demonstrates that certification of a clinic for MTP as per the Act, does not necessarily ensure that the abortion services would be provided by a trained provider.

The abortion method that the providers receive training in is still predominantly Dilatation and Curettage, a method which is normally not recommended except in extreme circumstances. Training for methods like Manual Vacuum Aspiration, which is a simple method for early gestational week is not taught. The providers do not get trained in all the methods. Training in other supportive areas like counselling and interpersonal communication is almost non-existent. This further indicates that the training institutes need to take a re-look at their MTP training programme both for methods and other supportive areas.

A little more than seven out of ten facilities provide only first trimester services. To some extent it is mainly the public facilities and the private certified facilities that are conducting second trimester terminations. Data indicates that the availability of the skilled provider in the facility determines the gestation week upto which the services are provided. Caseload of the MTP clients is more in the public domain with around 40 clients during the reference period of three months per facility, while this was only 27 in the private clinics. Utilization of the public facilities is similar irrespective of its location in a better or less developed district. But in case of private clinics the demand for services is more in the less developed districts, indicating thereby that the couples even in less developed districts are becoming conscious of their family size and terminating the unwanted pregnancy.

Clients do prefer seeking services from a DGO rather than a MBBS or a provider with other qualification. A little more than one-third of the DGOs conduct second trimester termination, which declines with the decrease in provider's qualification. All the facilities cannot cope up with all the cases; they do need to refer cases. For private facilities too, the referral point is the public sector to a large extent. Post-abortion complication cases are received by all the facilities. The number of cases received by the facilities located in the less developed districts is more than those in better developed districts. Measures will have to be taken to strengthen the service providers in the less developed districts. The study also indicates that the public sector domain will continue to be the referral point for the difficult and complicated cases even by the private sector.

V. Provider Studies

Situational Analysis of MTP Services in Kerala
Provider Perspectives

Executive Summary

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Introduction

As a public health issue unsafe abortion invites attention of the researchers working in the health sector. To reduce the adverse effect of the unsafe abortion it is also necessary to understand the issues related service provisions. There have been very few studies on abortion in Kerala and even less from a providers' perspective. The study formed part of a multi-centric initiative to study provider perspectives in abortion in six states of India under the aegis of the Abortion Assessment Project of India, coordinated by Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai.

Objectives

This study is an attempt to fulfill this gap in abortion research in Kerala by attempting to assess and analyse abortion services in Kerala from a providers' perspective, including organization, management, facilities, technology, registration, training certification and utilization in the public and private sector.

Methodology

This cross sectional survey was carried out in two districts of the State during 2001-2002. These two districts represent one of the relatively higher and relatively lower reproductive status within all the 14 districts of Kerala.

The survey collected information from 85-health institutions both the public and the private sector in terms of the infrastructure availability using a structured checklist and their management mechanisms using a structured interview schedule for the 85 administrators. This study also explores the practices and experiences of 21 providers from the public and 86 from the private sector. In addition some case studies were conducted to understand the quality of services and to identify problems related to abortion services.

Salient Findings

The mechanisms for monitoring MTP services in the State are inadequate. Several private health institutions provide abortion without the site certification especially in the northern part of Kerala. The State officials do not have an updated record of the number of institutions providing abortion nor do they have an idea of the number of abortions conducted in these institutions. Negligence regarding the submission of monthly reports does not lead to detail enquiry of the reasons or the cancellation of the site registration.

Some of the administrators were not aware of the requirements of site registration for the provision of MTP. Registration of MTP centers is not an issue of serious concern for the District Medical Officer who has been entrusted with the authority to register or de-register institutions within the district. The private facilities do not experience any urgency to obtain registration from the government. This could be because of the non-implementation of State regulatory mechanisms that seem to follow a laissez faire policy in this regard as long as there are no serious public health threats that result.

However, a majority of the providers working in both public and the private sector were well qualified irrespective of the site certification. Religious beliefs restrict some providers and administrators from applying registration. This is more visible in the northern parts of Kerala. However, services are being provided in these institutions with appropriately trained providers as it is remunerative.

Consent from both the woman and her husband or any other close relative is necessary for most providers as this provides them with legal and social protection. Most institutions obtain written consent before performing the procedure.

Private sector institutions provide for auditory and visual privacy compared to public sector. As a result most of the women in the community prefer the private sector even if government facilities are available free of charge. Clean toilets with running water and well furnished waiting area result in the clients perceiving the quality of services to be better in the private sector. But in the government hospitals these facilities are not available in many places and even if it is available proper maintenance is lacking.

The necessary equipments are available in the health institutions irrespective of the site registration. Private sector gives prompt maintenance for the damage of instruments compared to the public institution. Most of the private institutions keep the necessary drugs in their institutions. Hover, contraceptive commodities were more likely to be available in the public sector institutions. The providers working in public sector were also more likely to be trained in reproductive health and rights and universal precautions.

The informal providers were invisible and the researchers could not identify any who were willing to participate in the study. All the providers who participated in the study had basic medical qualification and majority of them had postgraduate qualifications. Such providers were more likely to be found in the public sector. The public sector also had better qualified nursing staff.

There exist no adequate disposal mechanism in both the public and private institutions. Many institutions using open pit garbage disposal and burying mechanism for waste disposal. Only very few institutions has access to incinerators. Half of the private health institutions and one-third of the public health institutions mentioned that they burn syringes and gloves.

Accessibility of services is very good in all the institutions and most of the hospitals were within a kilometer distance from public transport. The cost of abortion services varies by institution and duration of gestation in the private sector, but in public it is said to be completely free of charge. The highest number of abortions provided per month was in tertiary care public health institutions. All the providers in the study were able to communicate in the local language and a majority were women.

The private health institutions benefit from the lucrative practice of selective first trimester abortions but do not take on the burden and the associated insurance and legal costs of more difficult second trimester abortions allowed by the law. The high-risk cases are often handled by the public sector causing them a doubld burden as they have the mandate to take on the provision of services that are legally mandated and also that which are more difficult.

A summary composite index was constructed to understand the overall quality of services in the selected institutions. On the whole the quality of services were found to be better in the private sector. In Kollam district there was a sense of openness whereas in Malappuram district, a sense of secrecy surrounding the provision of abortion.

A few case studies were also conducted to understand the dynamics of quality of service provisions in both public and private health institutions.

Conclusions

The process of site registration needs to be streamlined in Kerala making it more transparent. The quality of infrastructure and equipments were better in the private sector and so was the maintenance. However the training and skills of staff in the public sector were better. There is a need to improve the services in the public sector by staggering the work at the tertiary care through mechanisms of referral from lower level public sector institutions and equipping these with the infrastructure and staff to deal with first trimester abortions. Such initiatives could be funded through the RCH programme or managed by the local self-governments that can decide on the mechanisms of subsidizing these necessary reproductive health services.

An Enquiry Into Provision of Abortion Services In Madhya Pradesh

Executive Summary

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Rationale

Though the MTP Act 1971 has legalised abortions with the consent of only the woman, the necessary facilities for conducting abortions are not adequately available in the public or the private sector. While in the public sector several facilities, which are supposed to provide the service, are not providing it, the availability of providers with the necessary training and institutions with the required registration under the Act is very limited. The training facilities for imparting training in MTP are also limited in number. This has given rise to a lack adequate facilities and providers for conducting safe abortions and to the mushrooming of unregistered facilities and untrained providers who conduct abortions, causing concerns of quality and safety. In addition to unregistered providers with formal qualification in one or other stream of medicine who are conducting abortions, the informal providers who do not have any formal qualifications are also conducting abortions. The study intends to look into the provision of abortion services in detail and to come up with findings which would facilitate making necessary changes in the registration, training, quality of abortion service and to improve the provision of the service in such a way that it benefits the end user: the woman seeking abortion. With this end, the study has the following objectives, which are listed below, as a sub section.

The state of MP was selected for the study based on an analysis of the women's health and related indicators of states of India and MP's score in it. The indicators selected for this ranking included institutional deliveries, maternal mortality ratio, neonatal mortality rate, female infant mortality rate, couple protection rate, total fertility rate and female literacy rate. The indicators of the pre-divided state of MP before the passage of the Chattisgarh formation Bill was taken into consideration. The scores of different states were aggregated under four clusters. The combined state of MP was ranked along with UP and Rajasthan as Fourth category state i.e. in the lowest category.

Objectives

The study intends to understand and analyse issues related to the provision of abortion services in public and private sectors with the following objectives:

- Management of abortion services including management of complications.
- Technologies used
- Registration, training and certification
- Availability, technical competence, training needs and current training facilities/ programmes for abortion care providers
- Utilisation of facilities
- Adequacy/ appropriateness of the MTP Act from the providers perspective
- Costing and Finance related issues

Sampling: Selection of Districts

The values of six variables- sex ratio, percentage of institutional deliveries, female IMR, female literacy, total fertility rate (TFR) and couple protection rate (CPR) were ranked for each district. The ranks were added up to arrive at a composite score for each district, and the district with the lowest rank scored the rank one and so on. From the ranked districts, one district each from the top and the bottom quartiles were selected, excluding the top and the bottom ranked districts as outliers. District of Ujjain as second most developed and district of Sidhi as second least developed were selected from the highest and the lowest quartiles. Some new districts and blocks were created in M P in the last few years and hence the selection of districts were restricted to the old districts.

Selection of Blocks

The blocks were first ranked according to their percentage of urban population, which was taken as an indicator of development. The ranked blocks were then divided into three groups, one group that was closest to the average urbanisation percentage of the district, another group, which had blocks above the district urbanisation percentage and the

third group below the average level of urbanisation. In the district of Ujjain with an urbanisation percentage of 38.74, Ujjain block with 76.40% urbanisation, was selected as the block with above average urbanisation, Kachrod block with 39.35% urbanisation as the block with average urbanisation and the Tarana block with 9.87% urbanisation was selected as the block with below average urbanisation. Similarly in the district of Sidhi with an urbanisation percentage of 14.28, Baidhan with 44.32% was selected as the above average block, Gopanbandhas block with 19.72% as the block closest to average urbanisation and Rampur Naikin with 8.57% urbanisation was selected as the below average block.

Sample Size, Sample Selection and Mapping

In each selected block all the formal public providers/institutions like Primary Health Centres (PHC), Community Health Centres (CHCs), civil hospitals, District hospitals and hospitals of Public Sector Undertakings and private formal providers; both registered and unregistered were mapped using a listing form. The listing form recorded a few basic characteristics of the facility and the willingness to participate in the study. For the purpose of this study formal providers are defined as one who has been trained in a formal institution, which awards a degree or diploma like MBBS, BAMS, BUMS, BHMS, etc, and conduct abortions. Informal Providers are defined as those persons, who do not have recognised qualifications in any of the above mentioned streams, but conduct abortions.

For listing the providers, help from the CMOs of both districts, superintendents of district hospitals, nurses, medical representatives, chemists, hospitals, local journalists, and other concerned people were utilised. A detailed map of each district and of selected blocks, which were collected from the concerned Block Development Officers, were also utilised for the purpose.

Out of the 33 identified public facilities, which were supposed to provide abortion service only 11 were providing the service. They participated with the study and have got included in the sample. Out of the 68 identified private formal facilities in both the districts together, only 51 co –operated with the study, and got included in the sample. Non participation of private providers was the highest in Ujjain District, which had a concentration of organised providers in the city who refrained to participate. Of the 42 private providers in Ujjain only 25 participated in the study. In Sidhi district, the total number of private formal providers was small. Since they were probably less organised also, all the 26 formal private providers/institutions participated.

Number of Mapped Facilities and Those who Agreed to Participate by Facility Type and District

State	Abortion Service Facility					
	Public		Private		Informal	
Madhya Pradesh Identified	Total	Number who were providing the services and agreed to participate	Total Identified	Number who agreed to participate	Total Identified	Number who agreed to participate
Ujjain	11	6	42	25	75	75
Sidhi	22	5	26	26	95	95
Total	33	11	68	51	170	170

Since it was found during the mapping that informal providers constituted the major chunk of abortion providers in rural areas and even in some urban areas of both districts, we included 75 informal providers from Ujjain District and 95 from Sidhi District in the sample. Each nook and corner of the selected blocks in two districts was explored to list the informal/traditional providers using details maps to assist the logistics.

Tools Used and Data Collection

The Administration Schedule and Provider Schedule addressed the formal facilities and providers respectively. Except in the case of five facilities, the facility assessment data was collected through direct observation by the investigators, in the case of the 46 facilities, which agreed to provide this information. The schedule for informal providers addressed the issues of informal provision and was administered to such providers. The information for all schedules was collected by investigators through direct interviews. The researchers were on the field to supervise the investigators. They also made sure that the investigators had interviewed the concerned administrators/ providers and conducted more than random checking on the field. All the forms were checked in the evening of every fieldwork day and gaps or inadequacies in them were corrected with further visits to the facilities/ providers.

Selection and Training of Investigators

Out of the six investigators in the team, three were postgraduates in Social Work from Nagpur University, with some field experience. They were helpful in dealing with the doctors and collecting data, which had more social and economic bearing. Two female investigators were nurses with Diploma in General Nursing from Sulthania Ladies hospital, Bhopal. The nurses assisted in collecting data on medico-technical aspects of abortion services, particularly in observing the equipment and instruments for facility assessment. For local support in the sample districts, two social activists from Bharat Gyan Vigyan Samiti (BGVS), Bhopal were selected. They were also trained as part of the investigators team.

Three day residential training was given to the investigators, prior to the fieldwork in each district using common guidelines and instruction manual. A detailed explanation of social, economic, medical, legal and ethical aspects of all the questions was provided during the training. The Project Co-ordinator for MP, explained the social, legal and ethical aspects of abortion, which were also implied in the schedules used for data collection. A Gynaecologist explained the medical and surgical processes and terminologies mentioned in the protocols. The gynaecologist also demonstrated and explained the functioning of various abortion related equipment and instruments to the investigators at Government hospital in Bhopal.

Findings

Provision of Abortion

The provision of abortion services in the public sector is mainly concentrated in the urban areas. The PHCs, which are expected to provide the service to the rural women, are not offering it. No PHCs in the two sample districts of Ujjain and Sidhi were conducting abortion. Lack of an operation theatre or absence of a trained provider was cited as the reasons. Only 2 of the 4 CHCs in Sidhi were providing the service. In the developed district of Ujjain only a little over half of the public facilities which were supposed to provide abortion were doing so and in the less developed district of Sidhi only less than a quarter of them.

Formal private sector – registered and unregistered, as well as the informal sector provides the major chunk of abortion in the sample districts. Their participation in the study is dealt with in the introduction.

Certification

It was found that certification of facilities for conducting MTP was a cumbersome procedure. The mean time gap between application and registration was as long as 7.18 months and the mean number of times application was refused was 2.73. All this would have prevented even well equipped facilities with trained medical personnel also from applying for certification. This partly explains why as many as 71 % of facilities did not apply at all

for certification. True, many of them may not have met the required criteria specified in the MTP Act 1971 and its Rules. But there could have been at least some facilities, which met the criteria, but did not want to go through the bureaucratic formalities of certification.

There is also a serious lack of adequate institutions to train doctors in abortion procedures. Training facilities are restricted only to the five Medical Colleges in Madhya Pradesh and just 8 district hospitals in the state, which has as many as 45 districts according to the Census 2001.

Reporting and Consent

All the public facilities and only 55% of the certified private facilities reported the MTP cases to the Government. All public facilities and an almost equally high 92% of private facilities took the consent of the women. Except in a little over one third of private institutions the consent was written in all other institutions. Abortion procedure was mentioned in the consent forms of only 28% of private hospitals and higher 64% of public hospitals.

Although as per the MTP Act only the woman's consent was necessary for conducting abortions, no public institution would do it so. Among private institutions only 2 % would do abortions only with the woman's consent. Thus, in spite of legal sanction, the woman's right to abort is not culturally approved by the society. This social refusal of the woman's right to abort is getting reflected in the behaviour of the providers who seek the consent of the woman's husband and relatives in conducting abortions.

Physical Facilities Available in Institutions

Eighty nine percent of district, civil and other public facilities had visual and auditory privacy in the consulting room, while it was 100% among certified private facilities. In the case of uncertified private facilities the percentage for the two variables was relatively less than the other two categories of hospitals mentioned i.e. 67% and 50% respectively.

Place in Hospitals where MTP was done

Among the District hospital, civil hospital and other public institutions, which are supposed to have relatively better facilities, 11% conducted abortions in the out patient department. Twenty three percent of uncertified private facilities also conducted abortions in their consulting room. Eleven percent of District, civil and other public hospitals conducted abortion in the procedure room. Among the private facilities also 18% of certified and 27% of uncertified facilities conducted abortion in the procedure room. How the requirements of equipment, instruments and that of privacy could be met when abortions were conducted in OPDs and consulting rooms causes concern.

Equipment / Instruments

It was possible to observe the abortion related equipment & instruments in all the public institutions. But a comparatively low 82% and 88% of certified and un certified private institutions only allowed us to do so. Yet, this rate in the private sector is high, compared to some other states where the study is being conducted simultaneously. Our strategy of keeping the researchers rather inconspicuous and projecting the apparently young and unthreatening but trained investigators seems to have paid off.

Fifty percent of CHCs had shadow less OT lamp while none of them had adjustable focus lamp. Shadow less OT lamp was available in 67% of Dist/ Civil and other public hospitals and 73% of certified private facilities while only 21% of uncertified private facilities were having it. Eighty nine percent of other public facilities and 91% of certified private facilities had adjustable focus lamp, while 50% of the uncertified private facilities also had it.

Sixty seven percent of District/Civil/other public hospitals and certified private facilities had electric suction machine (ESM), whereas only 33% of not certified private facilities had ESM. Eighty nine percent of district, civil and other public hospitals and 67% of certified private hospitals had MVA syringe. Only 78% of district, civil and other public hospitals and 67% of certified private facilities had at least 3 different sizes of MVA cannulae. The availability of MVA syringe, cannulae and adapters among the uncertified private facilities were 67%, 67% and 56% respectively.

Among the CHCs only 50% had the above-mentioned instrument.

Hundred percent of certified private facilities and CHCs had Sim's/ Cusco's speculum, Tenaculum/ Volsellum, Ovum forceps, Uterine curette. The availability of these instruments among the District/Civil/ and other public facilities and certified as well as uncertified private hospitals were on the higher side: above 85%. Dilator set was available for 50% of CHCs and 78% of district, civil other public hospitals, while 67% of certified private facilities had the set. Compared to other categories 91% of uncertified private facilities had complete set of Dilators.

A higher percentage of public and certified private hospitals had most of the anaesthetic equipment. Among the district and other public hospitals, 89% had Oxygen cylinders, 78% had Boyles apparatus as well as laryngoscope. The first two of these equipment were not available in both the CHCs, which in fact would be the main contact point for the rural people, as PHCs were not providing abortions. Not even half of the non-certified providers were having, either Oxygen cylinders, Boyles apparatus or laryngoscope.

The public and certified private hospitals showed a higher percentage of availability of various sterilization equipment such as Steam sterilizers, formalin chambers & autoclaves. The corresponding percentages were low for the non certified facilities.

Availability of Drugs

Among the drugs used for inducing abortion or cervical priming, Ethcrydine was available in only up to or less than 50% hospitals in the four categories of hospitals. Prostaglandin injection was not available at 100% of CHCs (2). It was available at 78% of the Dist/ Civil and other public hospitals, and an equal percentage of certified private institutions. Its availability dropped to only 43% in non-certified private institutions. In the case of Oxytocin injection, except among the CHCs, where only 50% had it, the other three categories Viz. Dist/Civil and other public hospitals and the private institutions had a higher availability ranging from 89% to 100%.

Family Planning Devices

Tubectomy and IUD were the methods insisted by 71% and 74% of formally trained providers. Tubectomy scored the highest among the most preferred method of the providers. It appeared that commercial considerations and the primacy given to tubectomy in the Govt. health sector were influencing the providers in the private sector also.

Temporary devices of FP such as Oral Pills and Condom were also available in both the CHCs in the sample, while IUD was available only in one of them. Condoms were available at 100% of district & other public hospitals, while 89% of them had Oral Pills & IUDs. The pattern found in the district & other public hospitals was also seen in the certified private facilities. But non-certified institutions showed a low availability of all these devices. Since female sterilisation seem to be the preferred method of providers, the mere availability of spacing methods does not amount to their high utilisation.

Maintenance of Equipment

Only 10% of the institutions had taken annual maintenance contracts. It was highest among the District, Civil & public hospitals with 33% and lowest at 5% among the non-certified providers. Twentynine percent of institutions had to depend on other cities for getting their equipment repaired. The low level of AMC contracts coupled with the fact that a large percentage of institutions do not have the facility to repair their equipment in the cities where they are located raises concerns about the timely delivery of abortion services.

Availability of Service Providers

There was at least one or more full time gynaecologist with MD/ MS/ DNB in Gynaecology & Obstetrics or DGO in 73% of public facilities and 45% certified private institutions. Only 15% of non-certified facilities had full time gynaecologists. A small 9% & 13% of certified and non-certified private facilities had them visiting on specific days**.** Only 18% of uncertified facilities had full time MBBS doctors.

Provider Characteristics

There were 27% (19) public providers and 73% (52) private providers. Among them only 34%

were MD/MS/ DNB in Gynaecology & Obstetrics or were DGOs. Trained providers with MBBS or MD/ MS in other branches were also only 16%. On an average the mean number of years of abortion practice of the providers was 13 years. The Mean age of the providers was 41.5 years, with a range of 24 – 65 years.

Training

Training in abortion was provided only at the 5 medical colleges in the state and eight district hospitals. The paucity of adequate training institutions also could be one of the reasons for the large number of untrained abortion providers in MP, who are catering to a market need, though improperly. In terms of qualifications, as many as 77% of the public providers were either MD / MS/DNB in Obstetrics & Gynaecology or DGOs. Among the private formally trained providers, only 44% had such qualifications. The presence of large percentage of highly qualified providers in the public sector could be one of the reasons for more referrals from the private to the public sector in the case of complications. At the same time it should not be lost sight of that in terms of numbers the private providers who amount to 73% of the providers could be having a wider reach than the public providers, who come to only 27%.

Gestations for which Abortion Done

On the whole most of the abortions were conducted within first 12 weeks of pregnancy. Sixty nine percent of the abortions conducted in CHCs were up to 12 weeks. Twenty percent of them were from 12-20 weeks and the rest 10% were for above 20 weeks. Only 19.67 abortions were conducted in a month in the two CHCs. On the contrary, in the District / civil and the other public hospitals 231.33 abortions were conducted in a month. Of them 69% were in the up to 12 weeks category and 31% were in the 12-20 weeks category. There were no abortions conducted in this group of hospitals for the above 20 week pregnancies. Among the certified private institutions, 79% of abortions conducted were in the up to 12 weeks category, 21% belonged to 12-20 weeks, while no abortions were conducted in the above 20-week category. In the non-certified institutions 95% of the abortions conducted were in the up to 12 weeks category. Four percent and 1% of abortions respectively were conducted in the 12-20 weeks category and the above 20 weeks category.

Postponement / Refusal

In 46% of the public institutions, abortion was postponed at least once in the three months preceding the fieldwork. Such instances occurred in 31% of private institutions also. High Patient load was mentioned as one of the reasons by as high as 60% of public institutions. Non availability of the provider (40%), instrument related reasons (40%) and equipment disorder (20%) were the other reasons given by public institutions. In 50% of private institutions, equipment disorder was cited as the reason for postponement / refusal. Mean days of time lag due to repairs was as high as 11-37 days in different categories of public hospitals and 4 to 5 days in certified & non certified institutions.

Functioning at Nights

Eighty two percent of public facilities were open at night, while only 55% of private facilities did so. Doctors were available at night only in 46% of public facilities and a still less 41% of private facilities.

Managing Complications

The percentage of institutions, which handled in-house, the complications of abortion such as Excessive Bleeding, Perforation due to Peritonitis, Septicaemia, shock and infection was relatively higher in public than among private facilities. Immediate referrals after developing complications and referrals after stabilisation from private institutions ranged from 47% for shock to 59% for septicaemia. As regards management of post abortion complications, 82% of public institutions received cases of incomplete abortions, while only 59% of private institutions did so. Cases of Haemorrhage were taken in 73% of public institutions, while only 55% of private institutions treated them.

Referral Patterns

Majority (55%) of public institutions treated abortion patients in house, even when they developed complications, where as only 22% of private institutions did so. The four public facilities, which referred cases, did so for 2nd trimester abortions and medical risk cases. In the private sector also 87% and 79%

facilities respectively referred cases of these two categories. Not surprisingly, a large 41% of private facilities referred abortion cases to the District / Civil or other public hospitals.

Other Reproductive Health Services
Several Reproductive Health Services were provided by around 90% of both public and private facilities. Other Gynaecological problems were attended to in only 33% of private institutions, while 82% of public institutions were attending to them. Vaginal procedures were conducted in 51% of private institutions while 73% of public institutions did so. In the case of Laparotomy and Lapraroscopy the variation between public and private institutions is very wide. Laparotomy: public – 55% and private 22%. Lapraroscopy: Public – 73% and private – 12%.

Techniques Used & Pain Control
For abortions up to 8 weeks many of the formally trained providers used D&C (38%) and Manual Vacuum Aspiration (MVA). Several of the not formally trained providers used D&C (50%). In the case of abortions between 9-12 weeks, large number of formally trained providers used D&C (45%) while 58% of not formally trained providers also used the same method.

Only 36% of formally trained providers and 15% of not formally providers were conducting second trimester abortions. Majority of formally trained providers i.e. 53% used D&C for second trimester abortions. Intra Amniotic 7.1% and Extra Amniotic 5% methods were also used by a small number of formal providers**.**

Pain Control Methods
To control the pain of abortions up to 8 weeks 93% of formally trained providers used analgesics and sedatives, while local anaesthesia was also used by 67% of them. The pattern was the same with reduced percentage for the not formally trained providers also: 58% and 42% respectively.

In the case of 9-12 weeks abortions 79% of formal providers used analgesics and sedatives, while 67% also used local anaesthesia. General anaesthesia was used by 14% of formally trained providers. Half of the not formally trained providers used analgesics and sedatives for 9-12 weeks abortions, while local anaesthesia was used by 42 % of them.

Analgesia & sedatives and General Anaesthesia were used for pain control for second trimester abortion by majority of formally trained providers. The respective percentages for formally trained providers were Analgesics & Sedatives 73% and General Anaesthesia 53%. While 75% of not formally trained providers also used analgesics, sedatives and local anaesthesia, all of them used general anaesthesia .

It appeared that only few providers were doing abortions above 20 weeks, which is not legally sanctioned. Among the two formally trained providers who were doing abortions for above 20 weeks, one was using local anaesthesia, while both used analgesics and sedatives. One not formally trained provider was using only local anaesthesia.

Pre discharge Examination
General physical examination was conducted by large majority of the formally trained i.e, 98% and not formally trained providers i.e, 81%. Pelvic examination was done by 60% of formally trained providers, while only 23% of not formally trained providers conducted it. Abdominal examination was conducted by 45% of formally trained, while only 31% of not formally trained providers conducted it.

Pre & Post Abortion Counselling & Follow Up Advice
As per the responses received from the providers, all formally trained providers and 96% of not formally trained providers were providing pre and post abortion counselling. Excessive bleeding, abdominal pain and vomiting were the conditions for which follow up was advised by 95%, 91% & 71% respectively of formal providers. Ninety six percent of not formally trained providers advised follow up for excessive bleeding, while 81% of them advised for abdominal pain. It is true that the above responses of providers for pre and post abortion counselling amount to very high claims by the providers. Such a high positive response regarding counselling could be doubted. But since the survey method is based on the stated responses of the research participants, this is a limitation of the study.

Contraceptive Counselling
All the 42 formally trained providers (100%), offered contraceptive counselling, while this percentage was slightly less at 89% with the not formally trained providers. Majority i.e. 60% of formally trained providers offered contraceptive counselling before the procedure, while 46% of not formally trained also did so. Fourteen percent of formally trained and 27% of not formally trained providers gave counselling on contraception after the procedure.

Insistence of the providers that the women adopt certain Family Planning methods amounts to coercing the women, when they are in a vulnerable situation, seeking the providers help in getting an abortion done. As high as 95% of formally trained providers insisted on the FP method, while a slightly less 77% of not formally trained providers also did insist on it. Tubectomy and IUD were the methods insisted by as high as 71% and 74% respectively of formally trained providers. On the contrary, probably due to the lack of technical knowledge of conducting tubectomy, only 50% of not formally trained providers insisted on Tubectomy. IUDs, Pills and Condoms were the methods insisted on by 62%, 65% and 58% of not formally trained providers.

Access to Abortion Services
Eighty two percent of public and 91% private facilities were situated on the roadside or close to it. Bus service was available to reach 91% of public and 69% of private facilities.

Cost of Service
Seven of the 11 public facilities charged an average maximum amount of Rs. 286 for abortions of 12 week old pregnancies and 2 facilities charged an average maximum amount of Rs.775 for abortions up to 20 weeks. We doubt on the basis of information from the field that in the case of many public institutions, these are partly or fully private payments to the concerned providers in the public sector and are not fully user charges. The cost of abortion in private facilities for different gestational periods was considerably higher. The average maximum cost of MTP service in private sector for up to12 weeks gestation and up to 20 weeks were Rs.559 and Rs.1321 respectively.

Out of 51 private facilities only 3 were providing MTP service for above 20 weeks. The mean maximum cost of MTP for above 20 weeks in private facilities was Rs. 1583. The range of maximum cost in private sector varied from Rs.1000 to Rs. 2250.

Facilities with Female Providers
Seventy three percent of public facilities were having at least one female abortion provider, while 55% of private facilities were not having even one woman provider.

Circumstances under which Facilities Provide Abortion
According to the MTP Act 1971, certified facilities are expected to provide abortion even if a woman came alone. Out of 11 public facilities, 27% said that they would provide abortion service even if a woman came alone. In the private sector also 36% of certified facilities said that they provided the service if women came alone. The percentage of uncertified private facilities offering MTP service, even when a woman came alone was reasonably higher than for the other two categories i.e. 42%. But it could be that this was more of a market driven decision in order to attract clientele. In case a woman came with a friend but not with any family member, 82% of public facilities and 55% of certified private facilities would provide abortion, while 70% of uncertified private facilities also would offer the service. Even though a section of the providers in the public and private sectors are saying that they provided abortions to women who came alone this does not seem to reflect their actual practice, which is reflected in their response on consent taken presented under Reporting and Consent.

From what appears from the responses of our research participants, the unmarried women would find it more difficult to get abortion done, compared to widowed or separated women. Hundred percent of public facilities and 73% of certified private facilities would offer MTP service if the woman was a widow/separated or nullipara. Seventy three to eighty percent of uncertified private facilities would also offer the service in that case. But in the case of the woman who were unmarried only 36% and

50% of certified and uncertified facilities respectively would offer the service, while a higher 73% of public facilities claimed that they would offer the service in that case also.

Provision of Abortion by Informal Providers

Profile of the Informal Providers Interviewed

There was a conspicuous presence of males among the informal providers, with 59 male providers as against 16 females in Ujjain district and 72 males as against 23 females in Sidhi district. Altogether there were 77.5% males and 22.95% females in the overall sample of 170. RMPs or Village Practitioners formed the major chunk of informal providers in both districts. Out of the 170 informal providers 113 i.e. 67.47% were RMPs / Village Practitioners. As the number of female abortion providers was very low, there were only 17 ANMs and 2 Nurses amounting to just 11%. RMP-hood, to which the males could upgrade themselves more easily, given the general perception of the doctor as a male in rural areas, seems to have emboldened many men to take to provision of abortion.

Treatment of Delayed Periods by Informal Providers

All informal providers (100%) interviewed were treating delayed periods. Nearly two-thirds of female informal providers i.e. 64%, used instruments to induce abortion while only 41% of males mentioned that they used instruments. We felt that the male informal providers were generally reluctant to admit the use of instruments. Fiftyeight percent of male informal providers and 46 % of female informal providers also claimed that injections were successful in more than fifty percent of cases.

Instrumental Intervention to Bring on an Abortion

Out of 54 male informal providers who used instruments, 46% of them used sharp metallic instruments, while 72% of female informal providers who used instruments were using Curette / D&C for inducing abortion. Thirtynine and 34% of male informal providers used Curette/D&C and Syringes respectively. Around 26% to 28% of male and female informal providers used catheter for inducing abortion.

Among the male informal providers, the mean gestation period for which uterus evacuation was done using instruments was 8.3 weeks, with a range of 1-20 weeks. Correspondingly the mean gestation period for which the female informal providers used instruments was 9.3 weeks with a range of 1-23 weeks.

The male informal providers treated an average of 2.2 cases per month with instruments, while a slightly higher average of 3.7 cases per month were treated using instruments by female providers. Both the categories got cases within a range of two to thirty per month.

Other services provided by informal providers

The range of other services provided by informal providers was vast. Ninetytwo percent of informal providers gave injections for various other illnesses. A good number of providers treated sprains/ fractures and did sutures also. Sixty seven percent of providers attended deliveries. Among them 62% claimed that they conducted even complicated deliveries with breach presentation and excessive bleeding! More than ninety percent of informal providers claimed that they handled cases of incomplete abortions as well! Menstrual problems were attended to by almost all ie, 99% of them.

A Multicentric Study on Provider Related Issues In The State Of Orissa

Executive Summary

Child In Need Institute (CINI)
Pailan, Joka, Kolkata- 700104,

2003

One of the major causes of maternal mortality is "Unsafe Abortion", which account for nearly 20% of all maternal deaths in India; around 40,000 each year. It has also been observed that about 6 million abortions take place every year of which 4 million are induced and 2 million are spontaneous abortion. These deaths occur not only for unskilled and unqualified abortion service providers at the community level but also inadequate facilities both at public and private levels.

Keeping all of this in mind, Ford Foundation through CEHAT, sponsored a Multicentric Study in six states of this country to prepare a detail account on facilities, available to abortion service seekers at the community level. These states are Haryana, Rajasthan, Mizoram, Kerala, Madhya Pradesh and Orissa. The Child In Need Institute (CINI), Kolkata is the coordinating agency, responsible for the study entitled "A Multicentric Study on Provider Related Issues in the State of Orissa". Before the start of this study, CINI has constituted an Institutional Ethical Committee consisting of 5 members from different backgrounds that ratified the final proposal as well as the draft protocols, used in this study.

To get a picture of propensity towards abortion in the State of Orissa, the districts of Sambalpur and Mayurbhanj were chosen for the study depending on the five variables viz. Sex Ratio, Female Literacy Rate, Infant Mortality Rate (IMR), Institutional Delivery and Total Fertility Rate (TFR). The idea was to see the difference of abortion services between the better performing (Sambalpur) and the poor performing (Mayurbhanj) districts of the state, since socio-economic factors do affect to the educational status and general awareness of the community that in turn regulate the health seeking behavior. So, the need for abortion, not a very woman friendly method, is expected to be in a lesser frequency, if the factors above are favorable. For this study, three Community Development Blocks from each district were selected as sample blocks on the basis of urbanization. All available public facilities, private facilities and community providers who provide clinic services were enumerated and then the enumerated providers were asked for their willingness to participate in the study. Only those who agreed to participate in the study were interviewed. Participants were interviewed individually in a closed-door setting and they were assured that the information and comments, they have provided would never be disclosed. The names of the participants were not entered at the time of analysis and the cumulative data does not reflect the personal revelations at any stage. Few case studies of both providers as well as abortion-seekers were incorporated in the study to get a comprehensive picture of unsafe abortions in the study area.

Out of a total study population of 36,70,692, 86.62% are rural with female literacy of 34.8% only. Percentage of contraceptive prevalence and institutional births are as low as 41.64 and 19.07 respectively. But the number of abortions performed annually is as high as 25,320 in those areas. The number of abortion facilities identified in the public and private sector are 22 and 87 out of whom 20 and 77 facilities respectively agreed to participate in the study. But the alarming aspect is the existence of 49 (may be more) informal providers out of whom 41 agreed to participate in this study; and they neither have any formal training nor have any certificate to do medical practice. The majority of facilities who are not certified but doing abortion in a regular basis have offered the following justifications:

- They were not told about the need for any certification,
- Application forms were not given to them when they have asked for it.
- Applications were lost by the certifying authorities,
- Too many objections were raised and they were harassed; and
- Certification was refused after a much-elaborated process.

As a result, the private facilities (though a few are certified) do not report the abortion cases regularly to the concerned authorities. The record keeping of the public facilities also is not too encouraging in this matter. In the public sector, however, consents from the clients or at least from their family members are taken in all cases. But the record of the private facilities in this regard is poor at 38% of cases only. Details about the abortion process, anesthesia, analgesics, etc. are given

in the consent form for the client's knowledge prior to the risk she is taking but they seldom get time to read it completely.

Physical facilities, like waiting area, beds, toilet, water, electricity, etc., are adequate to almost 100% satisfaction in all public and private certified facilities. Availability of basic equipments, anesthesia related equipments and sterilization/infection prevention instruments are more or less satisfactory in these hospitals. But the availability of drugs and other consumables is at a pathetic level (varying from 17-32%). There is an absence of work culture in the public sector and therefore, service gets delayed– more alarmingly at the PHC level – because the equipments most of the time are out of order or the instruments are not properly sterilized.

An overwhelming majority of the providers in the public sector are full time staff, whereas in the private sector majority of them are on call. The later does not have any specific staff for MTP purposes and Anesthetists are also only on call. A majority of the nurses in both the sectors is only diploma trained and the percentage of degree-qualified nurses is slightly higher in the certified private facilities. Half the non- certified ones do not have nurses at all. The public sector has not only a higher number of formally trained providers, but also a higher number of those, who are trained in counseling and IEC, universal precautions and other reproductive health and rights were available.

All types of facilities provide MTP services for pregnancies up to 12 weeks. They become selective after that. As far as records show no abortion takes place beyond 20 weeks. Emergency services, like facilities open for 24 hours, providers available any time, management of excessive bleeding, perforation peritonitis and other complications are better in the public sector.

The performance of this sector is also better with regard to reproductive health services like antenatal and post-natal care contraception, infertility management, treatment of STD/HIV, etc. There are referral arrangements with other specified or better-equipped hospitals. A thoroughly disappointing fact is that no private facility has MTP Guidelines with them and only 13% of the public facilities have. This is a reflection of the poor awareness and poor sensitivity of the providers and how casually they treat their clients in those facilities.

Different techniques are used for abortions in different time periods. But EVA, D&C and D&E are the most popular ones. Analgesics or sedition is the most commonly used pain control method, followed by local anesthesia. But in case of abortion between13 and 20 weeks, the latter is practiced more. Pre-discharge examination is not satisfactory since it is only general in majority of the cases. The necessary drugs like iron and vitamins, are rarely prescribed, the most common being the antibiotics. The providers seem to be concerned with the immediate cure only. They often tend to forget that reproductive health is a lifetime process and abortion can affect the health of a woman later also. This attitude is further obvious in the fact that post-abortion counseling puts least importance to the diet and workload of the woman and most to contraception and post-abortion medication.

Insensitivity to female psyche during post-abortion counseling comes out glaringly in Table –46, where we find that tubectomy as well as oral pills irrespective of their side effects are ranked as the most popular of all methods and simpler methods of condom and vasectomy are very rarely advised. One plus point is that 81-86% of facilities are within the easy reach of the clients, i.e. on the road and within a kilometer of walking distance. Arrangements for commuting are also good. Buses and jeeps are the popular modes of transport.

The cost of MTP varies from sector to sector and according to its time period. Higher the number of weeks of pregnancy, higher is the risk involved in MTP and therefore, the rate of MTP also go up. And, it is everybody's knowledge that the cost is much lower in the public sector facilities. It can be as low as Rs. 57 (in the public sector) and as high as Rs. 1250 (in the private ones). Besides, the charges by the public facilities are generally inclusive of the cost of the ancillary services. But both formal and informal providers in the private facilities do majority of abortions.

The worst problem faced by the clients is their discomfort and inhibition due to the fact that there is hardly any female provider. Notwithstanding the fact that the providers are conversant in the local language, the women patients find it difficult to communicate with the male doctors. Almost 100% of clients to the private facilities are women with a social stigma, viz. unmarried, widowed, separated and deserted. Public facilities too, get 80-87% of such clients. So, one can understand how important is counseling about reproductive rights and gender equity. Then only women can get a better chance of fighting such demeaning situations in near future. The absence of gender awareness is visible in the fact that there are plenty of untrained providers of abortion services throughout the state and some of them are even illiterate. Women seeking abortions due to several reasons are often victimized by them and a good proportion of those women are still in their early adolescence.

Situation Analysis of MTP Facilities in Haryana

Executive Summary

Centre for Research in Development and Change
(A Division Of Society for Operations Research and Training)
Baroda

2004

The present study of MTP facilities carried out in two districts of Haryana ranked as the third best (Yamunanagar) and the second worst (Jind) in the state, in terms of various indicators of women's status has highlighted some interesting facts regarding the situation of MTP facilities available in the state. In each district, three blocks were covered. The study covered only those facilities in the formal and informal sectors which currently provided abortion services. Both public and private facilities from the formal sector were included in the study. Among the 30 government facilities in the study area, which are by default recognised for providing MTP services, only 27 percent currently provided abortion services. Among the 282 private health clinics listed, around 31 percent (87 facilities) reported that they currently provided abortion services. However, only 48 facilities agreed to participate in the study.

In addition to the study of the MTP facilities, discussions were also held with a few selected key informants (a government health official, a medical officer, and three registered abortion providers) on the MTP Act, its rules and regulations. From the discussions with the key informants, it emerged that the MTP Act was understood differently, depending on the postion and place that each key informant held. Their individual opinion and knowledge influenced their services and attitudes towards the MTP client. From the discussion it was evident that though the MTP Act was formulated with the women's health in view it was generally misinterpreted either intentionally or due to lack of complete knowledge. The study team noticed a wide gap between the implementers, the providers and the users of the MTP services and this generated confusion.

The study found that fewer facilities in the private sector had certification of both the site and the provider, which is a requirement under the MTP Act, 1971. It was also found from certified facilities that there was no problem in getting certification, contrary to the general belief that the process was very tedious. The certification was given to them on an average within a period of one and a half months. The remaining private facilities that had neither site nor provider certification also included ayurvedic practitioners. Under the MTP Act they cannot terminate pregnancies. Among the reasons mentioned by the private providers for not getting their facilities certified were: the presence of qualified obstetrician or gynaecologists, no particular reason, so far it had never occurred to them to get their facilities registered, and a few claimed that they were ignorant about the need for certification of the clinic as a prerequisite to provide MTP services. Even providers who were qualified gynaecologists had the notion that they were not required to register their facilities, as they had the necessary qualification and training to provide abortion services. Thus, largely it is ignorance about the need for site certification which is the reason for non-certification of the facilities providing MTP. Discussions with key informants who were private abortion providers also revealed that they did not have to face any problems in getting their facilities registered. The Government of Haryana on its part has delegated to the Chief Medical Officers the powers to certify facilities other than government institutions for conducting MTP in order to expedite the action on the applications received for certification. Cumbersome bureaucratic procedures are apparently not the reason why private sector facilities do not apply for certification.

Most of the facilities provided abortion services for pregnancies of either less than 8 weeks or upto 12 weeks of gestation. Termination of pregnancies up to 20 weeks gestation was performed by only three public and three non-certified private facilties. At these three non-certified private clinics, obstetrician/ gynaecologists were reported to be conducting the second trimester abortion procedures.

Almost all facilities received post abortion complication cases like incomplete abortion, pelvic inflammatory disease, haemorrhage, septicaemia, perforation, and shock, which indicated of unsafe abortions still taking place. Management of such post abortion complications depended on the type of complications. In the public facilities all types of post abortion complications were either managed in-house or were referred to government facilities only after the condition of the patient was stablised. Private facilities

usually referred the cases immediately, mostly to public facilities (district hospital), and a comparatively lesser proportion of private facilities managed such cases in-house. Fewer private facilities attempted stabilisation of the clients' condition and subsequent referral.

The monthly caseload for MTP, mostly for pregnancies up to 12 weeks, was the highest in the certified private facilities, followed by the public facilities, and it was lowest in private non-certified private clinics. Further, the monthly caseload was higher in Jind, more than two times that in Yamunanagar. This could be attributed to the availability of a lesser number of certified facilities in Yamunanagar in comparison to Jind.

The quality of abortion services provided by the facilities in terms of physical amenities, infrastructure, equipment and supplies was good in majority of the facilties. It was better in the private certified facilities than in the public facilities and the non-certified private clinics. The non-certified clinics were on par with the public clinics with regard to the availability of these facilities.

The study also identified the status of the facilities in terms of the logistics available. To a certain extent the private certified facilites were relatively better than the government and the non certified facilities. However, the facilities in all the three categories public (hospital), certified private and non-certified private clinics, need to improve their amenities and infra-structure in the following areas: additional sources of light in the procedure room, provision of recovery room, proper cleanliness of toilets and procedure room, privacy in the recovery room, client's privacy and comfort in the waiting area and availability of proper beds for recovery of the abortion client. Further, availability of anaesthesia related equipment, particularly Boyles' apparatus, needs to be ensured in the facilities.

Regarding the availability of basic equipments to carry out various abortion procedures, most of the facilities had these readily available. It was also found that the facilities were better equipped for D&C procedures and had the complete set of instruments for D&C procedures than for other procedures, like MVA and EVA. Here it needs to be mentioned that the information collected on the availability of equipment is based mainly on what the doctors who were interviewed reported, and in only three facilities it was possible to verify the availability of the equipment through on-the-spot observations.

Though D&C is a procedure that involves greater risk of complications and duration of recovery, it continues to be the most commonly used method. It is, therefore, not surprising to find that D&C equipment is available in almost all the facilties as compared to equipment for other procedures like MVA and EVA for the later procedures, doctors are to be trained in suction evacuation methods to enable them to change from D&C to less risky invasive methods.

It is clear that in the private sector, certification ensures that the necessary medical standards in terms of equipment and basic infrastructure be maintained by the facilities and providers. Many of the government facilities urgently need to make improvements in the availability of basic infrastructure, equipment, and support facilities.

With regard to infection prevention, though majority of the facilities adhered to standard procedures while sterilising instruments, only some followed the universal precautions and carried out decontamination. Waste disposal is another area, which requires improvement, particularly in the private sector. Presently, burial and burning are the main methods of waste disposal in the facilities. Use of incinerator for waste disposal is very little, and some of the facilities, mostly in the private sector, dispose of their waste (products of conception, gloves, needles and syringes) as garbage, in open pits a potentially harmful and even dangerous practice, given the fact that not only animals, but also humans - ragpickers, who are often children - scavenge these garbage dumps. Moreover, burying of non-biodegradeable waste like gloves, needles and syringes, also contributes to soil contamination. Availability of effective waste disposable methods needs to be ensured in all facilities.

Almost all certified facilities, both public and private fulfilled the 'reporting requirements' under the MTP Act, by reporting the number of MTPs conducted by them. One of the clinics did not report the number of MTPs to the authorities because the authorities had not demanded it. Though an exception, this shows that private facilities may be more likely to ignore or circumvent the reporting procedures. Reporting procedures have been found to be simple, albeit lengthy, and some of the key informants have suggested changes in the proforma to exclude items like religion, and instead include "multiparity or too many children", which according to them is the real reason, why women undergo abortion.

During key informant discussions, the government health official and the public sector abortion provider (medical officer) opined that spousal consent was necessary for providing MTP services to the woman, whereas private sector abortion providers who were key informants opined that spousal consent was not necessary. Interestingly, however, public and private sector facilities seem to practice just the opposite of what the key informants from their respective sectors stated. Public clinics either require the written consent of the woman alone, or consent of the woman and any other accompanying person. A few private certified clinics (2) also asked for the consent of both, the woman and her husband. Private clinics tend to insist on the consent of the husband or an accompanying person along with that of the woman, and some ask for the consent of the husband or other family members, but not the woman. This clearly indicates that private certified facilities insist on the written consent of persons other than the woman, and facilities that are not certified insist more on the husband's consent, perhaps because they are taking a greater risk by providing the services without certification. The providers of these facilties said that they handled only the cases of miscarriage and did not provide MTP. Moreover, women who come to them are in such a condition (have postabortion complications) that it requires immediate medical attention. Therefore, consent is not something that is foremost on their minds. Interestingly, most clinics, regardless of whether private or public, did not have any consent form available, and maintained a register to keep a record of the consent. Fewer kept a record of all the abortion specifications (abortion procedure, analgesia used/anaesthesia used) and the consent - women's accompanying persons' or witness signature.

Overall, record keeping was a weak point in majority of the clinics, particularly among the non-certified private clinics, which is hardly surprising, considering that they are under no legal obligation to maintain records of the abortions that they conducted.

It is also evident that the MTP training received by the trained providers did not emphasise on supportive areas like pre and post abortion counselling and interpersonal communication. A similar observation has been made in a study by CORT on the situation of training institutions in three states of India. The study found that counselling was the least important aspect of the training in all the institutions (CORT, 1997). In the present study, the training that doctors had received was mostly on reproductive and health rights, and universal precautions to be taken during the procedure. Pre and post abortion counselling and interpersonal communication are the supportive areas where providers do require training. Despite the lack of training in counselling and interpersonal communication, majority of the providers, particularly those with formal training in MTP, do discuss issues like possible complications associated with the MTP procedures, contraception, medication, diet, work, pain, etc. Most of the providers, especially those with formal training in MTP, also insist on the adoption of a temporary method of contraception. Insistence of the providers on the acceptance of contraception after abortion has been cited as a reason why women may choose potentially unsafe providers.

The study showed the existence of a large number of informal providers in the study areas. Many of these informal providers stated that they only treated delayed menstruation using non-invasive methods like herbs or concoctions, pills and tablets. They also stated that cases which they could not handle were referred to formal providers or facilities located in cities and towns. Data indicates that more

than half of the providers believed that they were successful in resuming the menstruation. In case of failure with the method, they resorted to other course of action. The order of treatment that the providers generally follow is herbs/concotions, followed by tablets, injections and finally referral to the city/town clinic/hospital. Most of the informal providers believed that abortion was illegal. Abortion, commonly referred to as "safai", is understood as an invasive, surgical procedure by the community as well as by providers (CRDC, 2002). This, combined with the belief that abortion is illegal, may be the reason why the providers avoid referring to the services provided by them as abortion and instead refer to them as treatment for delayed periods. Informal providers have to be very careful in handling these cases because, being local, they cannot jeopardise their goodwill and prospects.

It is evident from the study that the demand for abortion services is there in the community and they avail of the same from sources that they are aware of, irrespective of the legality issue. The proportion of public sector hospitals providing abortion services is small. Similarly existing certified private facilities are few. However, trained personnel are also involved in providing abortion services at uncertified private clinics. Quality of service in general, is poor than the desired standard. Hence a strong advocacy is required at all levels to strengthen MTP services and to achieve the reproductive health goals.

Situation Analysis of Abortion Services in Rajasthan

Executive Summary

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2004

Elective abortion was legalised in India under the Medical Termination of Pregnancy (MTP) Act, 1971 and MTP Rules, 1975. However the availability of abortion services, particularly in rural areas of states like Rajasthan, remains limited. SRS data shows that abortion complications are responsible for 15% to 35% of maternal deaths in Rajasthan[1]. The state has 32 district hospitals, 263 community health centres and 1662 primary health centres in the government sector[2], all of which are meant to provide abortion services. However, most lack trained doctors and/or equipment. A facility survey[3] sponsored by the Ministry of Health & Family Welfare in 1999 showed that only 16% of CHCs had posted an obstetrician, while only 2% PHCs had a doctor trained to perform abortions (MTPs). The survey revealed that only 4% of PHCs in fact provided MTP services.

Legal, Policy and Regulatory Environment

All government facilities (of level PHC and above) are by default considered as certified to provide MTP services, as long as they have a trained provider and the necessary equipment[4]. However, very few of these do have a trained provider, and hence not all government facilities are functional. Data from the State Directorate of Family Welfare reveals that 338 private facilities had been certified to provide MTP services in Rajasthan as of 2003[5]. This amounts to an average of 0.6 certified private facilities per 100,000 population in the state as a whole. However, the distribution of these facilities is highly skewed, with most facilities being concentrated in a few districts. Nine districts with 38% of state population have 83% of all certified facilities, while the remaining 22 districts have 17% of the facilities. Five districts (Jaisalmer, Jalore, Barmer, Dungarpur, Dholpur) do not have a single certified private facility, while 6 districts have only one each (figure 1).

Government of Rajasthan has been largely following the standard GOI guidelines for certification of private facilities, except that it also demands an architectural blueprint of the facility. However, there being no time limit on the procedure, the time taken is very long. Even after an amendment in June 2003 decentralized approval to a district committee, district level officials have remained unaware of the details and have not liberalized the certification procedure. However, it must be acknowledged that the number of new facilities receiving certification has been increasing over the years. While 11 facilities were certified in year 1998-99, 44 were certified in year 2002-3.

There were 44,265 reported pregnancy terminations during 1997-98. Estimates suggest that two to ten unreported procedures take place for each reported one[6,7]. While a proportion of unreported procedures appear to be carried out by formal providers working in government and private facilities, informal providers are known to carry out the bulk of abortion procedures, as judged from indirect estimates. Formal providers appear to under-

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[1] *SRS 1998*

[2] *Government of India, Bulletin of Rural Health Statistics in India. New Delhi: Rural Health Division, Directorate General of health services, Department of Family Welfare, Ministry of Heath AND family Welfare, 2000.*

[3] *International Instituite of Population sciences. Facility Survey (Under Reproductive and Child Health Project) Phase –I, 1999. Mumbai 2001*

[4] *Unlike private facilities, a government facility does not have to specify that it fulfils these requirements*

[5] *This data was collected from a scrutiny DFW records in 2003. However, the FW Year Book of Govt of India 1998-99 mentions 483 certified facilities*

[6] *Indian Council of Medical Research. "Illegal Abortion in Rural Areas: a Task Force Study". New Delhi. 1989.*

[7] *Chhabra R, Nuna SC. Aboriton in India: An overview. New Delhi: Veerendra Printers; 1994.*

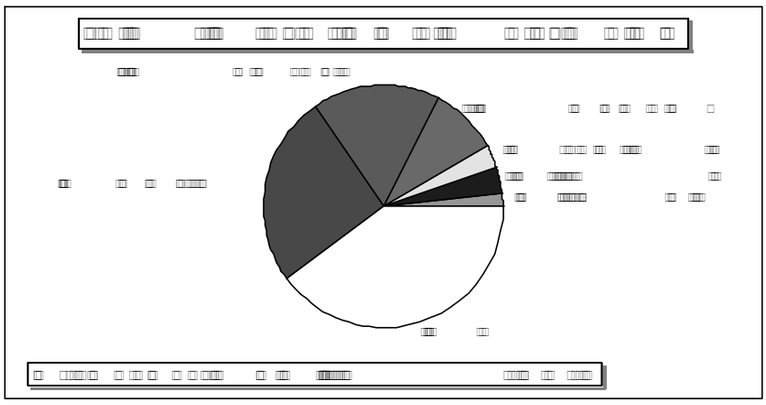

Table 1: Abortion providers in Rajasthan (ICMR 1989)			
	Number	%	
Doctors (allopathic)			
Government:	326	14.9%	Males 60.7%
Private	389	17.8%	Females 37.6%
Informal and ISM providers			67.3%
Doctors from other systems of medicine (Ayurvedic/ homeopathic/ Unani)	70	3.2%	Males 100%
Government Paramedics (ANMs and LHVs)	282	12.9%	
Chemists & other unqualified practitioners	321	14.6%	
Dais, magicians, ozha and other indigenous providers	801	36.6%	

report because of concerns related to paying income tax, fear of the Consumer Protection Act which applies to all paid services, and because several doctors are not "MTP-trained" and hence cannot legally perform abortions. Lastly, some government doctors conduct MTPs at their residence or private clinics and are not in a position to report them.

Informal Providers

A large pool of informal providers meets the huge gap between demand for abortion services and the low availability in the formal sector. Informal providers include paramedics and unqualified persons, while practitioners of Indian systems of medicine (ISM) include homeopaths and ayurvedic physicians, largely located in villages and small towns. A study carried out by ICMR in 1989 showed that informal or ISM providers carried out 67% of abortions, while doctors provided only one third of abortions in rural Rajasthan (table 1).

ARTH has recently carried out a study of abortion providers and facilities in two districts (Jalore and Kota) of Rajasthan[8]. A comprehensive listing of providers showed that there were a total of 1439 informal or ISM providers in the district, of which 738 were likely to be providing abortion services[9]. Interview of 618 informal providers revealed that 355 (57%)admitted to treating delayed periods. The providers who treated delayed periods included female paramedics (40%), male paramedics (17%), male unqualified practitioners (34%), and female untrained practitioners (8%).

[8] *ARTH, Situation analysis of abortion services in Rajasthan. 2003 (unpublished)*
[9] *the study used "treating missed periods" as a definition for providing abortion services*

The most common method used for treating delayed periods was tablets (89%), followed by injections (58%). The kinds of tablets include various Ayurvedic preparations such as "EP Forte", while the most popular injection is Carboprost tromethamine, a drug which has been licensed for treating incomplete abortion and postpartum hemorrhage. Most of these informal providers had learnt to use these drugs either on their own, by looking at prescription, or by working with a colleague.

Invasive or surgical methods are tried out by a minority (7%) of informal providers, commonly female paramedics and male unqualified practitioners. The commonest instrument used is the curette, and occasionally a syringe, catheter or copper-T. Instruments are used up to 8 months of pregnancy, while the average number of women treated each month in this manner is 2.6. However, the cost of such procedures is high, ranging from Rs 315 to 567 per procedure.

Informal providers provided a range of services. Of 618 interviewed informal providers, 90% give injections for common ailments, 84% provide IV fluids, 61% apply stitches for injuries, 52% conduct deliveries, 61% treat incomplete abortions and 64% treat menstrual problems. The strength of informal providers appears to be their reach in interior villages, and access 7 days a week for an average of 15 hours each day.

Providers of Indian Systems of Medicine

ARTH study also enumerated 63 providers of Indian Systems of Medicine in 2 districts, most of who were males, and were based in rural areas. Their degrees included BAMS (46), BHMS (6), BUMS or DHMS (11). They reported the duration of the training at between 18 months and 7 years, leading us to suspect that some were claiming but did not possess valid degrees. Their practices, and methods used to treat delayed periods were similar to those of informal providers – most of them treated delayed periods using tablets, injections and occasionally instruments. Like informal providers, majority of them provided a range of services including injections and IV fluids, while less than one third conducted deliveries. Eighteen of them worked in government service, while the rest worked through their private clinics.

Formal Facilities and Providers

In the 13.9 lakhs population covered in 2 districts, there were 42 government health centres, all meant to provide abortion services. However, only 22 government facilities were actually providing abortion services. These included 15 PHCs/ CHCs[10], and all sub-divisional and district level facilities. In the private sector in the same two districts, there were 40 facilities providing abortion services. About half of them were certified to do so. However, all private facilities were located in urban areas, while 15 of the 22 functional government facilities were located in rural areas. This suggests a severe rural-urban mismatch in the availability of abortion services. Our data revealed that rural PHCs/ CHCs have extremely low abortion caseloads of 5.9 procedures per month (average), while district or sub-divisional level government hospitals have a caseload of 60.5 procedures per month, and private hospitals have a caseload of 48.8 procedures per month.

The certification process for private facilities in Rajasthan is difficult, as evidenced by the fact that certified facilities reported an average of 14 months in becoming certified, with applications being returned an average of 2.4 times for re-submission. Eight out of 19 non-certified facilities reported that they had applied, but had not received any response from the authorities.

Not all abortion procedures get reported, while 19 uncertified private facilities do not report any abortions, 30% certified private facilities, and 23% of government facilities did not report all MTPs.

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[10] Some government and private facilities only admitted to be treating cases of incomplete abortion, and not providing elective abortion services, but for the purpose of the study, even these facilities were assumed to be providing abortion services.

Physical facilities usually allow for services to be provided, especially in the private sector. However, electric connections were not in working condition in 10 government facilities, and cleanliness of operation rooms was not maintained in several of them.

Even at facilities where abortion services are available, there were several restrictions in terms of gestation and cost of abortion. Less than half the facilities provided second trimester abortion.

At government facilities, the average minimum and maximum cost of abortion are Rs 195 and Rs 457 for a first trimester abortion, and Rs 317 to 575 for second trimester abortion, as reported by the administrators. At private facilities, the average minimum and maximum costs are Rs 540 and Rs 724 for first trimester abortion and Rs 1144 and 1681 for second trimester abortion. These costs are equivalent to 3 -28 times the daily wages of a rural woman. The above costs do not represent the total cost of an abortion. In as many as 62% facilities, all or some medicines, investigations or anesthesia are charged extra, and these costs varied widely.

Although MTP Act does not require the consent of spouse or family members for providing abortion services, nearly 86% facilities insisted on the consent of a family member and/or husband for abortion, and only 10% of facilities would provide services to women who came alone. Similarly, several facilities placed restrictions related to marital status of women or the number of children she had — only about half the administrators agreed that they would allow abortion services for unmarried women or those out of wedlock.

In general, the availability of abortion equipment was better in private facilities as compared to government facilities. Complete sets of D&C were available in 75% of public facilities, while they were available in all private facilities. Sets for EVA were available in 54% government and 93% private facilities, while sets for MVA were available in 14% public and 55% private facilities. Anesthesia equipment (Boyle's apparatus) although not necessary for providing abortion services, is a mandatory requirement for certification of private facilities. It was present in only 20% public facilities as compared to nearly 90% of private facilities. Contraceptive services are an integral part of abortion service delivery, but private facilities were deficient in supplies of oral pills or condoms, while only 15% had a contraceptive injection, and 60% offered IUDs. Government facilities fared better in this respect.

Techniques for abortion and pain control appear to be over-medicalised. For first trimester abortions, dilatation and curettage and/or evacuation[11] are the most commonly used methods (60%), followed by EVA, which is used by one third of providers (34%). MVA is used by one sixth of all providers (9-16%). For second trimester abortions, nearly half the providers use extra amniotic instillation of Ethacrydine Lactate (47%), followed by D&C or D&E (34%) and medical methods (34%). For pain control, general anesthesia continues to be used for 39% of procedures below 8 weeks and for 46% of procedures between 9 and 12 weeks.

MTP Training

The MTP Act stipulates that only doctors with a postgraduate degree (MD/MS/ DGO) or six months residency in obstetrics-gynecology can perform abortion procedures. Other doctors would have to undergo "MTP training" in a designated training center. The criteria laid out by NIHFW for approving MTP training centres include a minimum caseload of 600 procedures per year and all necessary equipment. The recommended duration of training is 2 weeks, and a curriculum has been defined[12]. It has been specified that acquisition of the above skills require that the trainee assists at least 10 MTPs, performs at least five

[11] *Use of ovum forceps*

[12] *The curriculum includes pre and post abortion counselling, selection of cases with dating of pregnancy, clinical procedure, recognition and management of complications, and management / maintenance of MTP equipments.*

under supervision and another five independently.

There are 8 MTP training centres in Rajasthan – they include 6 medical colleges (Jaipur, Ajmer, Bikaner, Kota, Udaipur, Jodhpur), and two district hospitals (Alwar, Bharatpur). An assessment of training performance, capacity and quality has been carried out by ARTH through interviews and secondary data collected from the Directorate of FW and a qualitative assessment of five training institutions. The total number of doctors trained since 1971 till April 2002 is 1056, of which 786 have been trained since 1980. This works out to an average of 35.7 doctors per year, a rather low figure, given the number of training institutions. With one training centre (Kota Medical College) having been in operation only for the last 6-7 years, this translates into 5 trainees per institution per year. This number is over and above the doctors who have been trained as MS/MD /DGO in Obstetrics and Gynecology, or have done a 6-month house job. Among the training institutions, there are wide variations with Jaipur having the highest number of trainees.

The procedure for receiving MTP training appears to be complex, especially for private doctors and is mirrored by the skewed proportion of government and private doctors trained till date. Among doctors who received training over the last 22 years, 86% were in government service. A private doctor is eligible to receive MTP training only if s/he is currently working in an MTP certified institution. However, an institution can be certified for MTP only if there already is an MTP-trained doctor in position. Hence a private doctor cannot be trained if her/his institution is not certified and the institution cannot be certified in the absence of a trained doctor, leading to a Catch-22 situation. Further, a doctors' application for MTP training needs to follow the channel of chief medical and health officer, and additional/ zonal director before it is recommended that the doctor is placed as a trainee in an MTP training institution of that zone. The procedure for private doctors is very difficult.

Interviews with faculty of MTP training institutes suggest that no defined training curriculum is used, that trainees are posted in operation theatres every day so that they may learn of the (surgical aspect of) the procedure. Thus there are few opportunities for trainees to aquaint themselves of issues such as the public health relevance of abortion services, pre and post abortion counselling for allowing women a measure of reproductive choice, and the clarification of providers' values regarding abortion.

In most training institutes, MTP is a highly medicalised procedure, carried out in operation theatres under general anesthesia and often requiring admission a day earlier. The methods in vogue are electric suction followed by check curettage, or more recently and hesitantly, medical abortion using mifepristone. In one institute, MVAs are carried out in an outpatient room, but trainee doctors are not posted there. Either oral or vaginal misoprostol or injectable carboprost is used for cervical priming. Second trimester abortions are usually carried out using ethacridine lactate, or (since the last two years) medical abortion. We gathered the impression that there are several apprehensions on part of some senior faculty that the increasing use of medical abortions would make it difficult to regulate. The greater use of MVA has recently been initiated as part of a FOGSI implemented 7-state project that includes Rajasthan – two training centers have been covered by this initiative.

Women coming to training institutions are "strongly motivated" to adopt sterilization or IUD. Women who only want to have MTP are not preferred, although there is a measure of access for women in difficult social situations. Even in MTP training institutions, the established protocol is to take consent of husband or another family member – women coming alone by and large cannot access the service.

Conclusions

- A wide range of providers in the state includes those that provide clandestine, but safe abortion services. These include government doctors.
- The boundaries between public and private abortion service provision are blurred, both

for formal and informal providers. Clandestine abortions are carried out even within public facilities.

- Highly qualified providers cannot survive the rural interiors of India. By contrast, less qualified or unqualified informal providers that successfully combine access, skills, courteous behaviour and affordable costs, are able to thrive.
- By themselves, abortion practitioners have veered towards less invasive & safer methods, even if some of the regimes are irrational or ineffective. Medical abortion is likely to accelerate this trend away from invasive procedures. Even illegal abortion is expected to become safer, as a result.
- Informal providers practice discretely but openly –everyone including the regulatory authorities appear to be aware of their existence and role. Their large-scale availability is a pointer to poor governance of the health system, rather than to an ineffective legal framework.
- The MTP Act has failed to restrict clandestine providers. With some effort, it however stands a better chance of facilitating access to safe providers.
- The availability of equipment and supplies does not limit abortion services in most of India, including Rajasthan
- With poor access to formal training especially for private sector doctors, mentorship-apprenticeship might prove to be a valuable way for aspiring providers to acquire practical skills.

Abortion in Mizoram: A Multicentric Study

Executive Summary

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2004

This study is sponsored by the Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai, and is a part of the larger project called 'Abortion Assessment Project India (AAPI)', being carried out in six states of the country. This multicentric study is one of the five components designed for making a comprehensive assessment of abortion as a public health issue. The chief purpose of the study is to make an objective assessment of the abortion situation in the country. The analysis basically deal with issues, such as, the abortion incidence, fulfillment or non fulfillment of the safety questions, quality of the health care facilities providing the abortion services, quality of the service delivery, quality of the providers and so on.

The state of Mizoram has been selected by the project formulators along with five other states of the country, on the basis of eight health indicators of women, viz., sex ratio, percentage of institutional delivery, maternal mortality ratio, neo natal mortality rate, female infant mortality rate, couple protection rate and female literacy rate. Considering all these indicators Mizoram is placed in category one.

Standardised and common methodology has been followed in the study. The survey method using structured protocols along with observation checklists, as designed by the central body, have been used. Since Mizoram is a small state, all the districts have been covered in the study.

The Salient Findings of the Study are as Follows:

Health care in Mizoram is predominantly a public domain, with only three private facilities in the state. All the public health care facilities in Mizoram above sub centre level are premitted to deliver abortion services provided a trained medical practitioner is posted there. Registration and certification are not required as such.

Mizoram appear to be well provided in terms of facility infrastructure, although PHCs lack beds in recovery room for the women undergoing MTPs. However, availability of equipment is poor , as only around 10 percent of the facilities have complete sets of MVA or EVA and only 79 percent have complete set for D&C. Ultrasound facility is available only in Aizawl Civil Hospital. Sonography is not used for abortion purpose.

While equipment like oxygen cylinder, autoclave drum, steam sterilizers are present in most of the health facilities, absence of Boyles apparatus constrain the use of anaesthesia. Provision for sterilization related consumables are inadequate. Similarly, except for contraceptives, other drugs related to abortion are not widely available.

Concentration of doctors with higher qualification is observed in Aizawl district. Lack of anaesthetists is conspicuous, especially in Lunglei and Chhimtuipui. All the MBBS doctors are MTP trained.

On an average 75 abortions are conducted per month in Mizoram. In most of the facilities reasons for postponing services did not occur in last three months prior to the survey. Despite that all the facilities remain open at night, only in 37.5 percent of the facilities doctors are actually available for the women seeking services at night.

While majority of the facilities could deal with excessive bleeding in house, very few could deal with the other complications. Post abortion complication is quite high in Mizoram, around 7 percent of all abortions that took place in Mizoram during 3 months prior to the survey had post abortion complications.

Only 25 percent of the facilities provide all the services considered part of the RH.

The only guidelines for conduct of MTP, are there provided in the MTP Act. These are available in only 29% of the facilities.

Maximum numbers of abortions, as reported by the providers have been conducted up to 8 weeks of gestation. D&C is the most predominant method both in 1st and 2nd trimester abortions.

More than 20 percent of the providers do not carry out any examination before discharging a woman from the facility after carrying out an abortion.

The study revealed that all the doctors do routinely provide both pre and post abortion counseling. Around 14 percent providers do not routinely discuss contraception with the women seeking abortion.

So far as aseptic condition is concerned although the metallic instruments are sterilized as per standards, rubber gloves and cannulae are not sterilized following the standard methods for the same. Again only 31 percent of the facilities adhered to the universal precautions necessary for processing instruments for re use.

All the facilities in Mizoram are found to be located at a distance of less than 1 k.m. from the road accessible by public transport and in majority of the cases (79.3 percent) the approach road to the facility is metalled. However, only 31 percent of the ACFs are connected by the bus service, which is the cheapest mode of transport.

It was revealed that a quarter of the facilities would offer MTP services if a woman comes alone for terminating her pregnancy.

As per the quality of care index (QCI), in Mizoram the majority of the facilities fall in the score range of 31-36, meaning the quality of care is around half-maximum attainable standard.

VI. Qualitative Studies

Abortion in India: Emerging Issues from the Qualitative Studies

Leela Visaria, Vimala Ramachandran, Bela Ganatra, Shveta Kalyanwala[1]

Abortion Scenario in India

India pioneered in legalizing induced abortion (Medical Termination of Pregnancy (MTP) Act of 1971) under which a woman can legally avail abortion if the pregnancy carries the risk of grave physical injury, endangers her mental health, when pregnancy results from a contraceptive failure in a married woman or from rape or is likely to result in the birth of a child with physical or mental abnormalities. Abortion is permitted up to 20 weeks of pregnancy duration and no spousal consent is required. According to the Ministry of Health and Family Welfare, in 1996-97 about 4.6 lakh MTPs were performed in the country (MOHFW, 1997). Against that, an estimated "6.7 million abortions per year are performed in other than registered and government recognised institutions, often by untrained persons in unhygienic conditions" (Khan et al 1998).

Despite an intensive national campaign for safe motherhood and after the initial attention on unsafe abortion in the 1960s and early 1970s that led to legalization of abortion, morbidity and mortality from unsafe abortion have remained "a serious problem for Indian women 28 years after abortion was legalised in India" (Johnston, 1999). In the last decade, women's health advocates have tried to draw the attention of policy makers and administrators to a range of issues and concerns related to abortion in order to improve the availability, safety and use of services. In the post Cairo period, the comprehensive Reproductive and Child Health (RCH) programme initiated in India, has included abortion in the RCH package and work towards making it safe.

While the climate seems to be favourable to initiate debate on safe abortion among key stakeholders, lack of reliable information, wide regional and rural-urban differences, inability to bring various constituencies on a common platform and a thin research base, make it difficult for policy makers, administrators and women's health advocates to develop strategic interventions. The Abortion Assessment Project – India (AAP-I), ventured to fill in the gap by creating evidence-based body of knowledge on all facets of induced abortion. This multi-centric research project commenced in August 2000 and was managed jointly by CEHAT (Mumbai) and HealthWatch (New Delhi). This article highlights the issues that have emerged from eight qualitative research studies coordinated by HealthWatch.[2]

Issues Emerging from the Qualitative Studies

The studies employed various qualitative research methods with some also supplementing with quantitative data. In some studies both the providers and the clients were interviewed, in some just women (without ascertaining whether they had experienced or undergone abortion) were interviewed. The range of issues covered by the studies was also quite diverse and explored, reasons for seeking abortion, decision making pathways, intergenerational differences in abortion seeking, selection and, perspectives of abortion providers and quality of care. [3]

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[1] The overview is a synthesis of the findings from the eight qualitative studies undertaken by partners whose names, affiliated organisations, and titles of their studies are shown in tabular form in Appendix 1. Without their seminal contribution to the issues and discussion this overview would not have been possible. We thank each and every one of them for the hard work and commitment to the cause of abortion as women's right. We also extend thanks to Manisha Chaudhry for her excellent editorial input

[2] MacArthur Foundation funded the qualitative studies and we are grateful for their support.

[3] Please note that each of the eight studies explored some or all of these issues to varying degrees based on the focus of the study.

Further, these studies were conducted in small geographic areas of a few relatively more developed states and therefore, their generalizabilty beyond the immediate study area is unwarranted. The synthesis of findings does not apply to the entire country or even to the entire state in which the studies were carried out and the analysis needs to be interpreted with caution and within context of the area studied.

Given the sensitivity of abortion and ethical principles adhered to in AAP-I – informed consent of respondents was obtained In all the studies only married women were interviewed with the exception of a Tamil Nadu study (where sexuality issues were explored in focus group discussions (FGDs) with women regardless of their marital status). Most of the findings on unmarried women reflect the views of the married women and represent community attitudes or the interpretation of the researchers rather than actual behaviours or practices.

In three of the seven studies social mobilisers / service providers of the partner NGO worked as field investigators, while this may have proved to be valuable in establishing rapport with women and building a relationship of trust, familiarity can lead investigators to assume certain things and preclude probing.

Reasons for Seeking Abortion

The reasons for seeking abortion reported in the various studies ranged from proximate causes such as a desire to limit family size or space pregnancies, preference for a son, seeking abortion for medical reasons or availing it on medical advice to distal determinants such as poverty, violence and belief system.

Abortion for Limiting Family Size and Spacing

There were really no surprises; the overwhelming reason for seeking abortion among married women was to limit the family size. When women in studies conducted in Maharashtra, Gujarat, Andhra Pradesh and Tamil Nadu were asked to indicate the situations in which they would seek abortion or had actually sought abortion, the majority reported this as the main reason.

Similarly, a very short inter-birth interval between conceptions was also cited as a reason for abortion. During postpartum amenorrhoea and while breastfeeding the child, some women become pregnant without realizing it. In order to avoid having another child in quick succession, women opt for abortion as a viable option. In a Tamil Nadu study the younger women viewed frequent childbirth as shameful and resorted to abortion as a spacing method to increase inter-birth interval.

Another contraceptive related reason for abortion that emerged in the studies from Tamil Nadu, Andhra Pradesh, Gujarat and Maharashtra was conception soon after marriage. Although a premium is generally placed on a proof of fertility and elders would like the young bride to bear a child within a reasonable time after marriage, conception almost immediately after marriage was reported as a reason for abortion by a few women in all the four states. Interestingly enough, as reported in a Gujarat study, if the girls married to Non Resident Indians (NRIs) became pregnant soon after marriage, they opted for abortion. The underlying reasons stated were fear that an immigration visa would not be granted to pregnant women, which would prevent them from joining their husbands abroad within reasonable time after marriage.

Links Between Contraception and Abortion

Non-use of contraception rather than contraceptive failure was reported to be the chief reason why the unwanted pregnancy situations described above tended to occur. Actual contraceptive failure was reported only in one study in Andhra Pradesh where one respondent reported tubectomy failure leading to conception and subsequent abortion.

Gap Between Knowledge and Use of Contraception

Incomplete information about contraception was a factor seen in several studies. All respondents across studies reported knowledge of sterilization as a method of limiting family size but knowledge of reversible methods such as condoms, oral pills and IUD for spacing

births was lower. Thus for example, in the RUWSEC study in Tamil Nadu, 29 of the 66 women who were interviewed knew about reversible methods. However knowledge was usually based on information received through the health outreach activities of the programme but not on the basis of actual lived experiences of people; the knowledge did not translate into actual practice. Ever use of reversible contraception was not low but many discontinued use or were irregular in their use.

The reasons cited for not using contraceptives by women ranged from fear of some methods, irregular supply, family objection to use, and health concerns. Some women in the study conducted by RUWSEC in Tamil Nadu reported that they could not use oral pills or IUD because of their side effects. Women believed that oral pills "*dry up the blood in our body*", thereby preventing them from doing hard physical labour. An opinion was also expressed that use of oral pills "*is okay for urban women, but we rural women have to do a lot of physical labour*". On the other hand, irregular supply of oral pills was reported as a reason for not using them in the Andhra Pradesh study, with some women becoming pregnant.

In some studies women admitted that while condoms were the safest method of contraception, husbands did not always cooperate in using them. In the RUWSEC study, for example, it was reported that men tended to be inconsistent and irregular in use of condoms or complained that condoms interfered with sexual pleasure.[4] As far as IUD was concerned, there was a perception among some women that it leads to pain and discomfort. This may be an outcome of poor quality of care – especially if the IUD is inserted without proper pelvic examination or in settings where basic hygienic conditions are compromised and lead to infection.

Female Sterilization as First and Final Method of Contraception

In some of the studies women reported that they find the spacing methods of contraception inconvenient or unacceptable and prefer sterilisation after giving birth to desired number of children. However, since the desired family size is measured in terms of surviving children, typically couples wait for a few years to ensure the survival of their children before accepting a permanent method. During this intervening period, some women who become pregnant opt for abortion. Curiously, women who opted for abortion in such situations reported that it is a better option as compared to relying on IUD or oral pills. Women in one of the Maharashtra studies also indicated that after abortion they did not require much rest but were able to resume daily routine work almost immediately.

Low Risk Perception for Becoming Pregnant

Further, some women who have infrequent sexual contact either because their children are grown up or married or because their husbands are often away for long periods, felt that occasional sexual contact would not lead to pregnancy. However, if pregnancy does occur, some women opt for abortion.

Perception That Abortion is Safe

All the qualitative studies were conducted in the states where availability of safe abortion services is reasonably good, especially for married women. Perhaps due to this, many study women perceived that abortion did not have any long-term adverse health consequences and perceived it as a 'safer' option compared to IUDs and other spacing methods.

Abortion for Desired Sex Composition of Children

While direct questions on sex selective abortion were not asked in most of the studies, some studies pointed out that couples and

[4] *The RUSEC study was carried out in an area where the organizational activities have focused on increasing the awareness and use of spacing methods. Condoms are promoted in the community and also among men. The methods are also available in the clinic free of cost. In spite of this, as the study findings on contraception show that it is difficult to increase the acceptance of reversible spacing methods.*

their extended family chose abortion not only to limit family size but also for achieving desired sex composition of children. The internalization of son preference was so widespread that studies conducted by Barua, Radkar, Anadhi and Visaria all reported that couples resorted to female selective abortions after undergoing a sex determination test. The reasons for why sons were preferred were expressed in terms of support in old age, continuing family line (as expressed in a Maharashtra study: 'giving heir is a prime duty of women') and performing death rites.

Women talked about availability of ultra sound facilities in almost all the areas. Also, they were aware that sex selective abortion was illegal and admitted that they would go to different facilities for ascertaining the sex of the foetus and for abortion. Awareness of the new PNDT Act was far greater among women and service providers, than about the details of the MTP Act. Group discussions invariably turned quite spirited when sex selection was discussed. In spite of being aware that sex selective abortion is illegal, women expressed helplessness as their status in the family and sometimes the very survival of their marriage depended on the ability to produce sons. Although the discussion in most of the studies was in terms of perceptions, Radkar's study in Maharashtra indicated that 8 out of 70 reported abortions or 11 percent were reported as being sex selective. She further reported that *"women who go for sex determination follow it up with the abortion of the female foetus. Everyone seemed to know at least some women who had done this"*. According to Barua's study in Gujarat, 10 out of 62 or 16 percent of abortions were performed after sex determination test and confirmation of female foetus.[5]

It was further revealed in a Maharashtra study of Morankar that when only female children were born or conceived, family approved and community condoned the need for abortion. Thus for a mother of several daughters there was no social stigma associated with sex selective abortion. Women from Gujarat and Haryana also reported that while they were not comfortable with abortion per se, when it was done for the sake of the family honour (not a son-less family), they accepted it.

In the RUWSEC study in Tamil Nadu only in two instances abortion was resorted to avoid a female birth; in one case to avoid giving birth to one more daughter and in the other case, to avoid violence for delivering a female child. Anandhi, on the other hand, also doing a study in a similar area in the same state however reported that the preference for male child and therefore for the sex selective abortion has been quite common. At the same time, instead of using the new technology for detecting the sex of the foetus, women seemed to rely on the prevailing myths for sex determination. For instance, if a girl were born with two circle marks on her bottom, it was believed that the next child born to that woman would also be a girl. Even though women agreed that the predictive power of such beliefs was questionable, nonetheless many tended to rely on this for having an abortion. Also, women preferred to undergo sterilization only after a male child was born. Further, if the male child was still young and the woman conceived again, she would not hesitate aborting the second child, in order to provide special care and attention to the male child already born.[6]

On "medical advice": While the studies by Barua, Radkar and Prakasamma indicated that abortions were resorted to for medical reasons such as when woman's life is threatened or when there is a fear of the foetus being abnormal, a divergence in the reasons cited by women and by abortion service providers was noted in a study by Barua. The providers indicated that they conduct abortions for medical reasons such as the poor health of mother; an ill-formed foetus was rarely the reason for an abortion. Whereas some of the respondent women indicated that they resorted to abortion on "medical advice". It is a moot

[5] Radkar's sample consisted of all women 15-49 who reported an induced abortion in the two study villages where the study was conducted. Barua's s sample of 62 women who had an induced abortion was purposively selected. The two figures therefore do not indicate the extent of sex selective abortion in the states and should not be compared.

[6] This is not unique to Tamil Nadu or to the study villages. There are studies, which refer to this phenomenon for seeking of abortion. For instance, see, Bela Ganatra, (2000).

point whether the terminology used by women is euphemism for sex selective abortion. This could also be a way of rationalizing the decision made about abortion and shifting the onus on to the provider.

Economic Situation, Work and Poverty as Reasons for Abortion

Poverty was cited as a reason for seeking abortion by the two Tamil Nadu studies and the Karnataka study. Anandi's study among pharmaceutical industry workers in Tamil Nadu revealed that almost all the units employing young women insisted on a contract which clearly stipulated that, if unmarried at the time of employment girls could not get married and if married, could not get pregnant during their contract period.

What is significant about the rise in abortion among unmarried young women is that on the one hand, it coincides with their increasing employment in the industrial sector and on the other it appears as a conscious reproductive choice emerging from their role as providers in the family. Unfortunately, it is only a means for negotiating the disempowering conditions of their work and production relations. For some married women the pressures of childcare and responsibility of supporting family were the primary reasons for resorting to abortion.

As observed by the author: "One would assume that *… women's work in the informal sector, such as in the pharmaceutical industry, might have enhanced their status within the family as main income earners or as providers, but it has not empowered them as decision-makers in the domain of reproduction and sexuality. In these circumstances, women's decision to abort does not signify their autonomy or the free choice…. but is an act of 'strategic accommodation'* [7] or a combination of both complicity and resistance.

Although the Karnataka study interviewed women who were engaged either in Beedi rolling work or in agricultural work and belonged to lower socio-economic segment of the population, the authors found that within this group, the younger and more literate respondents underwent induced abortions to a greater extent compared to the illiterate or older women. It is likely that the younger and more literate are more exposed to the mass media and urban influences, which in turn influence their behaviour.

In the RUWSEC study, on the other hand, poverty and need to earn to make both ends meet compelled some younger women to resort to abortion. A concomitant reason given by some women was that they generally did not have any social support during and after the pregnancy. As reported by a respondent *"I aborted two pregnancies, my third and fifth one. My family's economic situation was very bad at that time, and I was also not keeping well."* Or as reported by another respondent whose husband decided that they should terminate the pregnancy. "…b*ecause I would not be able to stand all day in the shop during my pregnancy and that would affect the sales and our income."*

Violence – Physical and Psychological

Women in several studies talked of being pressurized into having an abortion by their husbands or conjugal family members. Pregnancy may accentuate both physical and verbal violence if husband does not want the child (for e.g. later order birth or a girl child), or suspects that pregnancy is due to the wife being unfaithful to him. Violence is a way of demonstrating his power over her. In Anadhi's study, some women reported that abortion was the only recourse in order to negotiate the cycle of domestic violence that another pregnancy would bring on. As one 38 year old woman narrated *"After three girl children, when I conceived again I was afraid that this might also be a girl. Even that did not bother me as much as my husband's obscene remarks about my sexuality. For this reason, every time I got*

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[7] *This term has been borrowed from an Egyptian study of women's reproductive lives. It is a useful analytical tool to understand how unmarried girls who work in the companies comply with the discriminatory and sexually exploitative work culture against their own wishes for the sake of deriving some strategic benefits like income and some freedom and mobility. At the same time, they constantly complain and regret the situation they are in. Here, we can see 'accommodation' interacting with 'resistance'. For a detailed discussion on 'strategic accommodation' see:Dawala et al.2001.*

pregnant I tried to commit suicide. But this time I decided to abort the foetus. But the doctor advised me against an abortion, as it was too late to have it. So, I threatened the doctor saying that I would commit suicide right inside the hospital, if she did not perform the abortion. Only then she agreed and aborted the foetus. But it turned out to be a male child. Still there was a pleasure in the abortion, as this time my husband could not suspect the child and me."

Women also sometimes reported using abortion as a way to settle a family dispute or to get back at their husbands or conjugal families. As one respondent in Barua's study mentioned *"My mother-in-law and husband have been harassing and beating me since my marriage. Once when I was about 4 months pregnant, my husband, who was drunk at that time, beat me up. There and then I decided to abort the baby. The doctor did sonography on his own and said that it was a male foetus and may be I would like to continue with the pregnancy. But I was very clear in my mind. I got the abortion done without letting anybody know except my close friend"*.

Violence in the form of non-consensual sex also plays a role in women becoming pregnant in the first place. Threats of violence, accusations of infidelity and loose sexual morals as well as actual physical abuse are often used to ensure marital sexual relations even if they are against the women's wishes and in most such sexual relations contraceptive use is not likely. Some women in the RUWSEC study reported that their husbands compelled them to have sex saying that if there were a pregnancy, they would pay for the abortion.

Myths About Conceiving During Inauspicious Months

Another interesting finding of some of the studies – especially in Tamil Nadu – is that women cited conception during certain inauspicious months as a reason for abortion. The RUWSEC study also reported that there was a myth that the child born from a third pregnancy would not survive (three being an unlucky number) and therefore women becoming pregnant for the third time were forced to terminate the pregnancy. Sometimes if the pregnancy coincided with some accident to the breadwinner or the head of the family, it was perceived as an ill omen and the woman would be compelled to terminate that pregnancy. In one such case the woman was asked: "Is your unborn baby's life worth more than that of your husband'?"

Such myths may be more widely prevalent in Indian society, however, no studies from areas other than Tamil Nadu made specific references to them. It would also be interesting to explore whether there are any intergenerational differences and changing sexual practices among the younger women, who may be more exposed to education and scientific basis of conception.

Abortion Among Single, Divorced or Separated Women

None of the studies directly inquired about why or when women outside marriage resort to abortion or whether having a child outside of wedlock is an option. At the same time, in the studies conducted in Maharashtra, Tamil Nadu and Andhra Pradesh women reported that pregnancy outside of marriage must be aborted in order to preserve family honour. In the Maharashtra study, during group discussions, some of the women further opined that since such a pregnancy was a result of immoral behaviour of the woman or was an act of sin, it has to be aborted. However, some respondents were sympathetic towards such women and conceded that pregnancy can result due to rape or violence or caused by someone known to the women. Overall, abortions outside the framework of marriage were characterized by secrecy, shame and stigma.

Decision Making Pathways

While the studies generally attempted to identify the various socio-cultural factors that influence the decision to abort the pregnancy, a few also collected information on the process involved before arriving at the decision for abortion or exploring the pathways to decision making. In his effort to unravel the socio-cultural meaning of abortion in varying settings (such as need for abortion by a married woman as distinct from that by a widowed or a single

woman), Morankar used the vignette methodology to obtain data.

Radkar delineated the stages of decision making once a woman discovers that she is pregnant and wants to abort the foetus. Women first try out home remedies that are part of folklore, such as eating fruits and foods that are considered 'hot' like papaya, jackfruit and various concoctions, including headache tablets. If the menstruation does not resume after trying these methods, women may attempt invasive methods themselves like inserting a sharp instrument in their vagina and wait for bleeding to start. The study does not throw light on the extent to which the invasive methods are practiced in real life. Often hearsay and actual facts get intermingled when women discuss the pathways to decision-making process leading to abortion. Interestingly enough, a few women in the urban Gujarat study by Barua reported that they directly approached the chemist for drugs for abortion. The issue of availability of abortificient drugs with chemists needs to be probed further.

The decision making process involved in seeking abortion was relatively easy for married women but not for women who conceived outside wedlock. The widowed, separated, divorced or never married women would have to first inform their parents or partners about pregnancy who would take the decision whether and how to go about seeking abortion. If an unmarried young girl becomes pregnant, efforts are made by the parents of the girl to get her married to the boy who is responsible for her pregnancy. Morankar in his study explored in some detail how this is negotiated between the two families. When marriage is not a possible outcome, the girl is generally taken to an informal provider because there is a general perception that s/he would maintain secrecy and confidentiality much better. If either the procedure fails or if the parents cannot afford the cost, the girl is sent off for a few days to a far away place and abortion is sought in a formal facility.

The situation of widowed or divorced women is somewhat different. If pregnancy occurs while the woman is residing with her in-laws, they would know about it. Even if the person responsible for the pregnancy is known or is a member of the family, the woman is blamed for it. Abortion is sought in order to preserve the 'honour of the village'. Responding to a hypothetical vignette, some respondents in Morankar's study even indicated that such women should commit suicide or leave the village.

Making decisions about abortion is both a dynamic and a complex process. Therefore, it is important to understand with whom women discuss their pregnancy, whom they consult or whose permission is sought or who compels them to undergo abortion. Apart from the factors such as caste, education, land holding or economic status that determine the process, reasons for seeking abortion also play a role in who takes the decision. Several studies have addressed this issue. Radkar's study suggested that women themselves or jointly with their husbands made the decision about abortion in nearly half the cases and husbands took the decision in the other half of the cases. At the same time, the extended family was very much involved in the decision process. As pointed out by one woman: *"…If they (family members, especially mother-in-law and sister-in-law) don't approve of abortion, how I can get the required rest? Who will look after my children when I am away in the hospital…?"*

In the study conducted in Gujarat and Haryana, when women were asked about the decision-making process if they conceived a female child, their overwhelming response was that the pressure to abort was enormous from the extended conjugal family after one or two daughters. Women in both the states indicated that the decision to abort a female foetus was almost entirely that of their husbands and/or mothers-in-law and women had no say in the matter. However, some differences in the decision making process were observed between women of higher social groups and of scheduled caste and other backward communities with regard to the influence of the in-laws. The high caste women had to inform and consult their in-laws but the low caste women reported that they had to obtain the consent of only their husbands for abortion.

The role of natal family was reported to be minimal in matters related to abortion or sex determination test or sex selective abortion among all. However, the Tamil Nadu study by RUWSEC reported that even when the decision to abort was taken by the women's husbands and the parents-in-law, women were asked to approach their natal family for money or pawn their personal assets such as jewellery to take care of the expenses, especially when the foetus was that of a girl.

Inter-generational Differences

In the two Tamil Nadu studies focus group discussions were conducted with both younger and older women to ascertain whether there were any inter-generational differences in abortion experience or reasons for seeking it. Anandhi, in her study indicated that abortion by older women was considered shameful and dishonouring women. It was perceived that older women sought abortion not to limit family size, (because large families were accepted as a norm and not as a burden or impediment to the standard of living) but because the women desired to free themselves from childcare responsibilities; also it was indicative of women's sexuality and pregnancy perceived as a result of 'too much of sexual desire'.

In contrast, the younger women use abortion as a spacing method not merely because it is permitted by law but also because of the change in the notions of shame and honour. "With the younger generation, it is not frequent pregnancy per se, that was once perceived as an expression of excessive female desire, but the frequent childbirth, especially at the later stage of a woman's life, that is associated with the notion of shame". Honour is in having fewer children and women are not ashamed of their sexuality.

The study undertaken by RUWSEC in the same geographical area, on the other hand examined separately the abortion experience and perceptions of women (and the husbands of some of them) below 35 years and above 35 years of age. The study observed that the instances of women going for abortion without their husbands' explicit consent were far more common among the older women (11/27 abortions) than among younger women (4/25 abortions).

At first glance, the findings from the RUWSEC study are opposite of that of the study conducted by Anadhi with regard to reasons for abortion among older and younger women. Unlike in Anandhi's study, older women in the RUWSEC study mentioned that they opted for abortion 'to limit family size'. A concomitant reason was that their children were teenagers or adults and that they felt embarrassed to continue with the pregnancy or because they could not afford any additional children. Looking deeper, it is however, quite likely that the embarrassment of becoming pregnant beyond a certain age could be due to this being seen as an expression of women's sexuality. However, instead of articulating it in those terms, RUWSEC women perhaps chose to express in terms of limiting family size.

Selection of Provider

It is quite likely that since the studies were carried out in relatively more developed states of the country (and several were located in peri urban areas), most women reported that they went or would go to qualified private doctors / institutions or government facilities for abortion. However, the married respondents pointed out that the unmarried, separated and widowed women preferred or were taken by family members to informal providers because of the desire for confidentiality and secrecy .[8]

Women generally come to know of the provider through word of mouth from friends and relatives, paramedical workers or from other knowledgeable community members. Advertisements in public places like buses or in the newspapers seem to play a role in urban areas. Morankar's study in Maharashtra found that the *" information [on abortion] is usually sought under the pretext that someone else*

[8] *Although in the research reported here informal providers of abortion were rarely mentioned by the study participants, HealthWatch in association with Ipas, India, conducted a multicentric study of informal providers in six parts of the country where excepting for one centre, women did seek the services of informal providers in certain situations*

needs it. Women gather this information from other women when walking to the river to wash clothes, while working in the fields, or while fetching water. Men get such information during gossip sessions with friends."

Preference for Private Providers

The major determinants of choosing the provider by married women were his/her reputation, vicinity, familiarity and cost. Various alternatives are weighed before taking the decision There was an overwhelming perception that private facilities were better where one could obtain services in much less time, all procedures are attended in one visit, and the providers do not insist on prolonged hospital stay. According to Barua, women in Gujarat reported that in public hospitals *"a lot of time is wasted in waiting and going through formalities, these hospitals are not client friendly and the quality of services is suspect*". Radkar also reported that the quality of care and the duration of time needed to be spent at the provider's facility were major considerations in the selection of the provider.

Second group of reasons mentioned were that private doctors have better facilities and equipment, they treat women better than government doctors, ensure confidentiality especially when unmarried women seek their services. Also, the private doctors are not in a hurry to discharge women after the procedure if they need rest for an hour or so before going home; in public hospitals, on the other hand, there is a shortage of beds and so women are asked to leave as soon as possible. The exception reported was when women wanted to undergo sterilization along with the abortion. In such instances, women chose a government hospital where the acceptance of sterilization would mean that the abortion did not cost them anything. Also, when the family was poor and could not pay for abortion, government facility was the option.

Those women who wanted the sex of the foetus to be known and abort the female foetus also preferred private providers. In the Gujarat and Haryana study, majority of the women knew the towns where the private doctors with nursing or maternity homes were providing these services and also indicated that they would use them if the need arose.

Cost Considerations

It was accepted that while the services of private providers cost money, visits to the government hospitals were also not cost-free because women often had to pay for medicines, and required to make repeat visits before abortion was performed. The long waiting period implied that time of the service seeker and of the accompanying person (generally women do not go alone to impersonal large facilities) was wasted and in poor families it meant foregoing wages for that time.

In the Andhra Pradesh study, majority of the women who were interviewed selected the government hospital for abortion because of their poor economic status and also because they thought government services were free. However, after coming to the hospital they realized that the services were not free and that the doctors charged a fee for performing abortions; the average fee was a little over Rs.600. Barua reported that in urban Gujarat, the Government run tertiary hospital, though not free, was the cheapest and the private gynaecologists were the most expensive and charged according to the duration of the pregnancy. According to her, the cost of the procedure in private facilities varied between Rs. 400-600, not much different from what women in urban Andhra Pradesh paid. Interestingly enough, the local NGO in Gujarat charged nearly 15 times the fees it advertised.

It was evident during the focus group discussions that a certain group of women and their families calculate cost of abortion in a somewhat different way especially the abortion of a female foetus. The immediate cost of abortion (and also including that of sex determination test) is compared with the expenditure that would have to be incurred in future on dowry payment to the girl, if allowed to be born, at the time of marriage and on several occasions after marriage.

Quality of Care

Information collected on the place and the provider of abortion, client-provider interactions, clients' expectations and experiences have provided some assessment of the quality of abortion care. Urban women in Gujarat indicated that no preliminary tests

were done before the procedure, other than sonography for foetal sex determination. The latter was done only on the request of the client. The providers also reported that they do not carry out any physical or internal check-up of the clients but rely on the date of missed period as reported by the clients. Some provider do a urine pregnancy test prior to pregnancy termination but clients on their own often get this done prior to coming for abortion. The government tertiary hospital was an exception where several laboratory investigations including blood grouping were routinely carried out.

Further, the providers continued to use older techniques such as D&C for a variety of reasons. The Andhra study reported that three out of the four doctors at the government hospital used D&C even for first trimester abortions. Key informants in Tamil Nadu too reported that most abortions were done by D&C. The choice was governed by factors such as convenience and experience of the provider with the method. While factors like erratic electric supply made use of electric vacuum aspiration method difficult, use of manual vacuum aspiration was not perceived as safe by the providers in pregnancy beyond eight weeks of gestation. Apparently, some providers who used manual vacuum aspiration, also in addition used the D&C to ensure that abortion was complete.

Providers in Ahmedabad were aware of medical abortion and several mentioned that they had used RU 486 (mifepristone) or had treated patients who had taken the drug elsewhere and then came to them. The use of this method was not specifically mentioned in the other studies.

Counselling

Pre or post procedure counselling appeared to be limited in scope and content. Women in Ahmedabad reported that they were rarely explained any details about the procedure. Also, women themselves were not interested in knowing the details. Their main concern was to get the procedure over with and leave as soon as possible. The perception among the providers was that the clients were not interested in counseling. Also, the providers reported that they do not have "*dedicated staff or incentive to do contraceptive or consequence-related [of abortion] counselling. Further, there is no audit system for counselling in hospitals."* The providers in government hospital do not have much time to spend with the clients, and the limited counselling is done to warn the frequent users of abortion about the harmful consequences of repeat abortions.

Coercive contraception was not found in the public hospitals; either in the tertiary hospital in the Ahmedabad study or in the public hospital in Andhra Pradesh. The providers reported that they did not insist on the clients accepting family planning methods. Clients also reported that they were not coerced into accepting contraceptives.

Women in Andhra Pradesh who used the abortion services form the government hospital expressed satisfaction with the procedure, medicines, bed and the availability of toilet facility. They were not happy with diet and water because food is not provided in the hospital and the family has to arrange it from outside. Availability of water was a major problem compromising the cleanliness in the hospital. Similarly women in Tamil Nadu (RUWSEC) also generally did not express any negative views about services unless they had experienced post abortion complications.

At the same time, there was some evidence that women's sense of dignity was compromised during their hospital stay. On initial questioning, majority of the women in the Andhra study indicated that they were treated with dignity and respect. But on probing more than half (15 out of 27) said that the hospital staff scolded the poor women who did not have money but came to the government hospital because they could not afford to go anywhere else.

The length of the hospital stay for the client depended on the procedure used to perform abortion and the period of gestation; typically the longer the gestation period, the longer was the stay in the clinic. Advice about the need for a follow up visits, danger signals and the need for rest was also generally given. Women, however, were unable to take rest after abortion due to poverty

and domestic responsibilities. Some women even indicated that abortion is not a major procedure [the way sterilization is] requiring rest.

Overall, very few women in all the studies reported serious post abortion morbidity. It is quite likely that in most studies women tried to recall morbidity episodes during the lifetime and the immediate post-abortion illnesses tended to be forgotten because they were not life threatening. However, in the Andhra Pradesh study, which focused prospectively on this issue (and interviewed women immediately, two weeks, two months and six months after the abortion), 21 of the 27 women reported morbidity such as excessive bleeding, weakness / nausea, abdominal pain or discomfort after abortion. Also, 18 of the 21 women sought medical care (which could have been due to repeated contacts with the auxiliary nurse midwives). While it is difficult to correlate this with medically significant morbidity, it does mean that women need care and support following an abortion. Morbidity was reported by 21 of 34 women in the RUWSEC study, with the younger and older age groups almost equally represented. Excessive bleeding was the most commonly mentioned problem. The other problems were lower abdominal pain and back pain.

Provider Perspectives

Awareness About Abortion Laws

The provider studies indicated that the formally trained providers were generally aware about the MTP Act, but not all para-functionaries such as the ANMs were aware. At the same time, not all providers knew in detail the various situations in which the Act was applicable. Even when the providers were aware that the consent of the family members was not required, majority of them insisted on it in order to protect themselves. In Andhra Pradesh the providers said that they insisted on obtaining husbands' authorization to conduct abortion so that at a later stage the husbands do not blame them for abortion. In urban Gujarat the consent was justified in terms of abortion being a surgical procedure done under anesthesia.

The Gujarat sex selective study indicated that the service providers who were interviewed were aware about the PNDT Act, its ramifications and the consequences of aborting female fetuses. The ambivalence among them was that while they believed that the PNDT Act should be implemented with an iron rod and the violators should be punished, they nonetheless conducted sex determination tests in violation of the Act, because they sympathized with the families that wanted to decide not only the family size but also the sex composition of their children.

Registration, Certification and Reporting

Registration is perceived as a long cumbersome procedure and the resultant formal reporting mechanisms are seen as a source of harassment as was revealed by Barua's study. Qualified doctors who perform abortion tend to shy away from registering as abortion providers because of their apprehension about the procedure and resultant legal formalities. Providers also admitted that they do not record or report all the abortions conducted by them. While the registered providers report a few cases, the unregistered providers do not maintain any records.

Perception of Providers About Abortion Seekers

According to the providers, women who want to limit their family size in urban areas generally come to seek abortion in the first trimester within 8 weeks of pregnancy. Those who want to terminate the pregnancy for spacing seek abortion after 8 weeks but between 8 and12 weeks. Providers also felt that some of the clients came to them after sex determination. But since the sex determination test and abortion can be obtained from different facilities, it was difficult for the providers to find out whether the woman coming for abortion of 'unwanted' pregnancy had undergone sex determination test elsewhere. Since they were essentially services providers, according to Barua, many of them in urban Gujarat preferred to maintain silence or presume that abortion is sought for termination of unwanted pregnancy and they have limited responsibility.

In Tamil Nadu, several providers mentioned that the stigma related to unmarried women

seeking abortions is decreasing and many such women have started accessing abortion services early.

Emerging Challenges and Advocacy

As highlighted earlier, findings and leads from small and disparate micro studies cannot be generalized to represent the situation in the country as a whole but need to be interpreted with caution and in context. Nevertheless, these qualitative studies undertaken to look into abortion issues, though small in scope and size, have thrown up some common patterns and themes, some of which are listed below:

The Links Between Unmet Need for Contraception and Abortion

While across studies women wanted to limit family size or space births, abortion often seemed to be a preferred alternative to the perceived side effects and the difficulties of obtaining and using temporary spacing methods. This was especially so in the two Tamil Nadu studies but similar reasons for not wanting to use spacing methods emerged across all studies.

Son Preference

Averting the birth of a female child or ensuring the birth of a male one, often under pressure from the conjugal and extended families, was reported as one of the reasons for abortion in most settings. While the use of 'modern' sex determination tests was more common in the western and northern parts of the country, the studies from the southern part of the country highlighted that women rely on more traditional methods of predicting sex of the foetus but with the same objective of averting the female birth.

Preference for the Private Provides

Wherever private providers were available and women could afford abortion services from them, they seemed to be the preferred choice because they were perceived to be more qualified, providing quick services, less waiting time and better at maintaining confidentiality.

The Needs of Single, Widowed or Separated Women

Although none of the studies were able to directly interview the unmarried adolescents, widowed or separated women, there were sufficient indications that stigma is associated with pregnancies among these group of women, the decision making pattern is different and family and community support is not always very forthcoming.

Several studies also highlighted emerging areas of relevance for policy or programmatic action. They are outlined below.

Addressing Contraceptive Needs

Since majority of women reported relying on abortion for limiting or spacing children, the unmet need for contraception among them needs to be addressed in family welfare programmes. There is a need not only for expanding the contraceptive choice but also for ensuring the availability and informing women and men about merit and limitations of various reversible methods of contraception. While it is heartening to note from the various studies that neither the public hospitals nor private providers any longer insist on or coerce clients into accepting family planning after abortion, the providers cannot absolve themselves from promoting responsible family planning through appropriate counselling and informing the clients about various methods of contraception.

The Links Between the PNDT Act and the MTP Act

Although the two legislations are independent of each other, the qualitative studies suggest that this distinction is hard to maintain in actual practice. The widespread campaign around the PNDT act has led to high awareness about it among the community, however knowledge of the legality of abortion services and the MTP Act still remains low. While abortion is a right of a woman in India who can access it on economic or social grounds, there seems to be some evidence that abortion is equated with a ban on sex detection tests and with 'killing of girls'. Further, the PNDT Act is interpreted to mean that all abortions (whether sex selective or not) have now become illegal. Providers too often link the provisions of the two acts. As the studies show, the most common reason for women to have an abortion is still linked to limiting and spacing their children (irrespective of sex composition), and unless a clear distinction can be maintained between these two issues and the reasons for the enactment of PNDT

Act be made very clear, effort to expand access to safe abortions will receive a setback in the coming years. Concerted efforts and sending out correct messages are very essential to clear the confusion.

Increasing Awareness of the Provisions of the MTP Act

There is a need to expand awareness about when, where and under what circumstances legal abortion can be availed not only among women but also among the gatekeepers of the decision making process in the family as well. Women also need to know their rights, what are safe quality services, in order to ask for information or question poor quality care. Providers of services too need to know what the legal provisions are so that their own moral stands or their misperceptions about legal requirements (e.g. taking signature of husband) do not get in the way of providing services that are legal.

The Role of Medical Technology

The qualitative studies highlight that D&C continue to be used for performing abortion for reasons of familiarity, convenience, lack of training or misperceptions about safer options like vacuum aspiration. The recent legalization of mifepristone in the country provides yet another option for a safe and effective technology that can increase access and expand choice. Since the legalization of this technology happened after theses studies were designed, none of them explored its implications in a systematic way. The little information that did emerge does point to the fact that it is used by some practitioners and is preferred by some clients. The Ahmedabad study suggested that in some settings it might also be available directly to women over the counter (as indeed are most drugs in the country). All these issues require further exploration. The technology is known to be safe and effective and we need to understand how best to exploit its full potential in promoting safe abortions, while at the same time guarding against misuse that can stem from misinformation.

Quality of Care

While life threatening morbidity from abortions did not emerge as a major issue of concern, women's experiences at health facilities as well as the assessment of the providers themselves show that quality of care, especially of counseling, is a neglected area. Public sector facilities appear to have high case load and not adequate time to devote to pre or post procedure counseling, private sector providers appear not to see the necessity of counseling. In public facilities women often experience judgmental attitudes and rude behaviour from the providers. All types of providers could benefit from gender sensitivity training, inculcation of non-judgmental attitude and value clarification and all programmes should focus on putting the women and their individual needs as the focal point around which services must revolve.

The entire process of the qualitative studies also showed that partnerships between diverse groups of people drawn from different disciplines and with differing ideologies and positions are possible and productive. The collective process of integrating diverse viewpoints enhances a common understanding of the issue of unsafe abortions and in the long run is an essential step in progressing towards the common goal of making abortion an infrequently used but safe alternative for women faced with an unwanted pregnancy.

Appendix 1: Geographical Coverage and Objectives of the Eight Quantities Studies

Researcher, Organisation and Title of the Study	Geographical Area	Study Population/ Respondents	Main Focus of the Study
S. Anandhi, Madras Institute of Development Studies, *Women, Work and Abortion Practices in Chengalpattu District, Tamil Nadu*	Four villages in Kancheepuram District of Tamil Nadu	Dalit women (married and unmarried) working in pharmaceutical companies; village functionaries and opinion leaders; abortion service providers	Abortion decision making and practices in the context of increasing employment of rural women in industrial sector in peri urban area
Alka Barua, Foundation for Research in Health Systems, Ahmedabad, *Study on Availability of Abortion Care, Gujarat*	Two urban slums in Ahmedabad	Married women with an induced abortion experience; Abortion service providers	Provider choice; women's perspectives on quality of abortion care; provider perspectives on accessibility and quality of abortion care
S.N. Morankar, Maharashtra Association for Anthropological Sciences, Pune, *Ethnographic Exploration of Abortion and Abortion Care Related to Community Needs in Velhe Block of Pune, Maharashtra*	Fourteen villages in Pune district, Maharashtra	Married women and men from the community; opinion leaders; service providers	Ethnographic exploration of community attitudes around abortion
M. Prakashamma, Academy for Nursing Studies, Hyderabad, *Post Abortion Care through the Public Health System, Andhra Pradesh*	Three villages and selected public health facilities in Medam district, Andhra Pradesh	Women with a spontaneous or induced abortion; service providers both doctors and mid-level providers (ANMs); facility assessment	Role of public health system in care for women during and after abortion (both spontaneous and induced)
Anjali Radkar, Independent Researcher, Pune, *Abortion in Rural Community neat Urban Areas, Maharashtra*	Two peri-urban villages near Pune, Maharashtra	All currently married women in the 15-49 age group	Decision-making and provider choice
T.K. Sundari Ravindran, RUWSEC, Chengalpattu, Tamil Nadu, *Process and Factors Underlying Choice of Induced Abortions: A Qualitative Investigation in Rural Tamil Nadu*	98 hamlets from The RUWSEC project area in Kancheepuram district of Tamil Nadu	Low income, socially marginalized couples (both wives and husbands)	Gender dynamics and abortion decision-making; inter-generational differences in abortion-seeking behaviour
K. Susheela and K. Nagaraj, Madras Institute of Development Studies, Chennai, *Abortions in Dekshina Kannada: Socio-Cultural and Medical Underpinnings and Consequences*	One village in the Udipi district, Karnataka	Women – Beedi workers and agricultural workers	Estimate the extent of pregnancy wastage (including spontaneous and induced abortions) and socio-economic, cultural and medical factors associated with it.
Leela Visaria, Gujarat Institute of Development Research, Ahmedabad, *Sex-Selective Abortion in Mehsana and Kurukshetra Districts of Gujarat and Haryana*	Six villages in Mehsana district in Gujarat; Six villages in Kurukshetra district in Haryana	All currently married women in the age group 15-49; abortion service providers in Gujarat	Decision-making process and role of son preference in sex-selective abortions

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Informal Providers of Abortion Services
Some Exploratory Case Studies

Bela Ganatra
Leela Visaria

In view of the widespread belief that bulk of abortions in India are performed by informal providers, who meet certain felt needs of their clients and yet little evidence-based research having been carried out on this category of providers, an exploratory multi centric study was undertaken jointly by HealthWatch Trust and Ipas. Issues such as whom does the community recognize as informal providers, when and under what circumstances their services are preferred over those of formal providers, what services do they provide and how do they secure their practice in the community were probed by the seven partners using qualitative research tools.

Generally speaking, community members perceived informal providers as those providers who were readily available in the village or nearby and who did not function from a formal hospital/clinic set up but ordinarily functioned from their residence. It was an amorphous group that included herbalists, faith healers, traditional birth attendants, and even nurses or auxiliary nurse midwives. In rural remote and tribal areas, where services of formal providers are not readily available, women depend on them. At the same time, in rural areas the informal providers are preferred for inducing abortion among women who conceive out of wedlock because of the confidence in them for maintaining secrecy and protecting the family honour. Also, the mode of payment to them for the services is flexible – in cash or in kind – and on successful outcome.

Contrary to popular belief, the studies noted that most of the providers treated delayed menstrual period or induced abortion by giving oral herbal preparations, many of which are part of the folklore and some specifically prepared based on their knowledge of plants, etc. However, some traditional birth attendants and nurses with exposure to formally trained providers tended to go beyond traditional oral methods and used allopathic drugs, and even prostodine injections to induce abortion and used dilation and curettage technique to perform abortion. Use of invasive interventions was mentioned in three of the seven studies, although even in these sites there were few practioners who inserted medicated roots to induce abortion.

Most informal providers who gave oral concoctions, tablets or injections did so for missed period or pregnancy of 6-8 weeks only because of the belief that many of the preparations are not effective beyond that gestation period and equally importantly to avoid complications that may ensue on taking 'heat' inducing concoctions. Although almost all providers indicated that they might not have been successful in inducing abortion; they rarely reported any case of complication. However, it was not possible to match the perceptions of the providers with that of the clients in this exploratory study, but in some focus group discussions women did report having heard of instances of post-abortion complications occurring at the hands of the informal providers.

It was also observed that since the informal providers practice outside the purview of legality, the community itself becomes their protector. While they are generally well known within the community, secrecy and confidentiality are maintained with respect to outsiders. Also, it was reported that in some areas some of them have cultivated and maintain congenial relationship with the formal health system. The informal network that is established works to the advantage of all. In the event of any client experiencing excessive bleeding, fever or incomplete abortion, the informal providers can refer her to the formal provider where the service can be procured quickly and without asking inconvenient questions.

Table 1: Study Locations				
Study Partner	**State**	**District**	**Type of Area**	**Access to formal abortion service providers**
ARTH	Rajasthan	Udaipur	Rural 7 villages	CHC[1] provides irregular services. Public and Private facilities in nearby towns (30-50 km) & Udaipur (110 km)
BVS	Maharashtra	Nashik	Rural – Tribal 5 villages	CHCs in the area. Several legal private providers.
CHSSS	Madhya Pradesh	Ujjain	Siddhi 2 blocks	RuralDistrict Hospital; CHC & 1-2 legal private facilities. 2 Public Sector hospitals
KARUNA TRUST	Karnataka	Chamraj-nagar	Rural 30 sub centers 16 of which are tribal	No formal providers within easy access
SHRAMIK BHARTI	Uttar Pradesh	Kanpur	Peri Urban	A few legal private providers Public and private facilities in Kanpur (35 km)
SORT	Haryana	Jind	Rura l2 villages	Public and private hospitals in nearby town(10 km) and in the district headquarters (20-30 km)
Swaasthya	New Delhi	—	UrbanColony resettlement colony	2 large private hospitals situated within 2-3 km of the colony

[1] *Community Health Centre*

VII. Household Studies

Pregnancy Outcome in Tamilnadu
A Survey With Special Reference to Abortion Complications, Cost and Care

Executive Summary

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This survey, conducted in 2002-03, was designed to provide information on incidence of live births, stillbirths, spontaneous abortions and induced abortions in Tamil Nadu. It also aimed at providing information on service provider, post-abortion complications, cost and care associated with spontaneous and induced abortions.

Field staff collected the data from a self-weighing systematic, multi-stage stratified sample of households. They covered 5487 households and interviewed 4814 ever-married women in the age range 15-49 between October 26, 2002 and March 31, 2003.

Background Characteristics of the Sample

About two-thirds (65 percent) of the sample households live in rural areas as per the classification of urban and rural areas existing at the time of 1991 Census. Highest proportion of the population is in the quinquennial age group 15-19. Below this age group the proportion of population declines with age reflecting typical age structure of a population with fast fertility decline in the recent past. The percent of population below 15 years of age is 26.5 and that aged 65 and above is 6.1. There are 1008 males per 1000 females. There seems to have been a substantial improvement in age at marriage in the recent past. The percent of ever-married women in the age group 15-19 is 15.0 and this is 0.4 percent among men. The singulate mean age at marriage is 21.9 for women and 27.4 for men.

In the state 87 percent of households are Hindus, 7 percent Muslims and 6 percent Christians. The concentration of Muslims and Christians is more in urban area. In urban area they constitute 24 percent of households. Twenty-two percent of the households belong to Scheduled castes and one percent of households belong to Scheduled tribes. Seventy-three percent of the families are nuclear and the difference in this percent is marginal between rural and urban areas.

Eighty-seven percent of the households have electricity, 82 percent have piped water supply, and 34 percent have flush toilets. Thirty-nine percent of the households own radio or transistor, 31 percent have black & white TV and 24 percent have colour TV.

Eighty-four percent of males and 69 percent of females age six and above are literates. Both among males and females in the age 10-14 ninety-seven percent are literates. The gender gap in literacy has been bridged in the younger cohorts. In fact in the urban area the literacy rate for the age group 10-14 is 97 for males while it is 99 for females.

Medical Consultation for Illness among Family Members

If someone in the family falls ill about 53 percent of rural families seek government sources whereas 55 percent of urban families seek private service. Among those seeking government sources 59 percent prefer it for their free service. During one month preceding the date of survey around 32 percent of rural as well as urban households reported that some one in the family was sick. Fever, cold, cough and headache are the frequently reported illnesses. Pain in the body or limbs is the next in the order of frequency followed by problems of the digestive system (stomach pain, dysentery and vomiting). Type of medical consultation for these specific illnesses also reveals the pattern reported above.

Fertility and Infant Mortality

The crude birth rate in Tamil Nadu is 18.2 for the period 2000-2002. The total fertility rate is 1.94 and this is below replacement level of about 2.1. Even though the fertility is very low and is below replacement level, the age pattern of fertility shows early peak. In the age group 20-24, where the fertility peaks, 45 percent of the total reproduction takes place.

The infant mortality rate is 39.1 per 1000 live births. The neonatal mortality rate is 26.7 per 1000 live births and the post-neonatal mortality rate is 12.4.

Pregnancy Outcome

Current rates of age-specific birth, stillbirth, spontaneous abortion and induced abortion are computed based on the enumerated pregnancy

outcomes. These rates imply that a woman at the end of her reproductive period would have 2.35 pregnancy outcomes, out of which 1.92 are live births. 0.04 are stillbirths, 0.21 are spontaneous abortions and 0.18 are induced abortions. In terms of percentage, the live births are 82.2, stillbirths are 1.7, spontaneous abortions are 8.9 and induced abortions are 7.1.

The percent of induced abortions increases with rising order of outcome. Induced abortion out of all pregnancies reaches the level of about 18 percent among women with fifth pregnancy or above. Urban women start inducing pregnancies at lower order of pregnancies than the rural women. As induced abortion is a competing risk, the proportion of spontaneous abortions moderately declines by order of pregnancy. About eight percent of first order pregnancies end in spontaneous abortions as against about six percent among fifth and higher order pregnancies. This finding once again supports the observation made also by others that induced abortions are being used as a method of contraception or as a back up to temporary methods of contraception.

Underreporting of spontaneous abortions that took place within 12 weeks of gestation is observed. All induced abortions had a gestation period of first or second trimester. Induced abortions during the first trimester constitute about 60 percent. Among rural women 75 percent of induced abortions are of gestation period 8-15 weeks, and this percent is 84 among urban women. If we consider a gestation period of 16 weeks or more is late for inducing, the proportion of late inducing is 12 percent in rural and 6 percent in urban areas.

The percent of induced abortions of all outcomes increases from 3.1 percent among illiterates to 6.7 percent among those completed high school. Percentage of spontaneous abortions declines with increasing asset level while the percentage of induced abortions increase with increasing asset level.

Association between Successive Outcomes

There is association between successive outcomes. If the first pregnancy is a live birth, the chances for the second pregnancy is also a live birth is 89 percent and the chances of ending in a stillbirth or spontaneous abortion is 7.5 percent. About 22 percent of the second pregnancies end in stillbirth or spontaneous abortion if the first outcome is a stillbirth. About 30 percent of the second outcomes are spontaneous abortions if the first outcomes are spontaneous abortions. A similar association is found between second and third pregnancy outcomes, between third and fourth outcomes and so on. These findings suggest that some women are prone to spontaneous abortions and/or stillbirths.

As regards induced abortion, the chance of successive pregnancies ending in induced abortion increases with increasing order of birth. While 11 percent of all fourth pregnancies are aborted, among those who aborted their third pregnancies this percent is 31. This is indicative of women using induced abortion as a terminal method of contraception. This is also supported by the fact that the higher proportion of higher order pregnancies ending in induced abortion if the previous one is a live birth.

It is found that the chances of repeated abortions increase with increasing number of living children. The proportion of women with repeat abortions is higher among better educated than among illiterates.

Estimates of Pregnancy Outcomes Adjusted for Underreporting of Events

Estimates indicate an underreporting of approximately 27 percent in spontaneous abortions among the recognizable pregnancies (pregnancies with at least 8 weeks of gestation). In a few pockets of Tamil Nadu female selective abortions are reported to be prevalent. However, check for underreporting of sex selective abortions indicate that the incidence of sex selective abortion is too less to be ascertained for the whole of Tamil Nadu even by as large a sample as in this survey. Hence it is concluded that the incidence of sex selective abortion is insignificant and hence underreporting of induced abortion due to sex selection is treated to be close to zero.

After adjustment for under-enumeration of spontaneous abortions the percent distribution of outcomes is computed. The adjusted percentages are: 79.4 live births, 1.7 stillbirths, 12.2 spontaneous abortions and 6.7 induced abortions. After adjustment for underreporting of spontaneous abortions the expected number of outcomes per woman at the end of reproduction is 2.54, out of which 1.92 are live births, 0.04 are stillbirths, 0.39 are spontaneous abortions and 0.18 are induced abortions.

For the projected population of 64 millions in the year 2004, assuming the crude birth rate of 18.2 observed in our survey, the estimates of the pregnancy outcomes are 1,170,000 live births, 25,000 stillbirths, 181,000 spontaneous abortions and 99,000 induced abortions per year.

Estimate of Unregistered Induced Abortions

Assuming the average crude birth rate of 19.1 for the years 1997 and 1998 from the Sample Registration System, the estimate of live births during the financial year1997-98 is 1,144,000. Applying the ratio of 8.487 induced abortions per 100 live births obtained from the survey, we get 97,000 induced abortions during 1997-98. The registered induced abortions are 47,620 (Family Welfare Programme in India Year Book). This suggests that 51 percent of the induced abortions are not registered in the year 1997-98.

Place of Delivery

The percent of home deliveries during 1998-2003 is 15, which varies by residence: 20 percent in rural area and 5 percent in urban area. About 45 percent of deliveries take place in government hospitals both in rural and urban areas. Percent of home deliveries is high for higher order births both in rural and urban areas.

Spontaneous Abortions

Perceived Reason

More than two-fifths of women are not able to ascribe any reason for the incident of spontaneous abortion to them. Strain of work is reported as the cause for thirteen percent of spontaneous abortions. Frequent travel and falling down are the causes for another 7 percent of the cases. Nine percent of women report that no reason can be attributed as it occurs frequently. In eight percent of the cases women report that weak uterus as the possible cause for the event and for another six percent the cause is general weakness.

Post-abortion Medical Care

Twenty four percent of the cases did not take any treatment after spontaneous abortion. More than three-fifths of the women approached private health care providers and 11 percent went to the government health care providers after spontaneous abortions. Only 3 percent of them relied on self. About 47 percent of women underwent Dilatation and Curettage and another 21 percent were given injection and tablets/drips. Private health care providers (68 percent) had done D& C after spontaneous abortion for more cases than the government health care providers (47 percent).

Cost

Twenty seven percent of women either did not seek any treatment or resorted to self-treatment after spontaneous abortion. Majority of women traveled by bus to go to and return from the service provider. Only 14 percent of the cases used auto-rickshaws in both directions. Cross-classification reveals that, by and large, the same mode of transportation is used for onward and return travels. The average distance traveled by those who resorted service is 13 kilometers (Median = 8 km).

The average time taken to reach the service provider for post-abortion treatment by those who sought treatment is 36 minutes (Median = 30 minutes). Short distances are managed by motored two-wheelers, bicycles and walk or by hiring three wheelers. If the distance is long, bus, car or van is used. About five percent of the women had to walk an average distance of 1.3 km.

The average time of stay at service provider's place for post-abortion treatment is 23 hours, nearly a day. The median duration of stay is

12.0 hours. Twenty one percent of the cases stayed less than three hours, 19 percent of the cases stayed 3-5 hours and 16 percent of the cases stayed nearly one day for post abortion-treatment. And 17 percent of the cases stayed between 2 and 9 days.

The average expenditure (including service cost, travel, food outside home, accommodation and medication) was Rs.1134 and the median expenditure was Rs. 600. Thirty-five percent of women managed the expenses from their routine household expenditure. For 13 percent of women the entire expenditure was borne by their parents. Eleven percent of women borrowed from their parents or other relatives. Over all, 21 percent of women had to borrow. The sources for raising loan are parents, relatives, moneylenders and employers.

The mean family wage loss is Rs. 287. Average cost, both direct and indirect, per spontaneous abortion is Rs.1421, out of which 80 percent is direct cost. The median cost is Rs. 900.

Family Support

Sixty percent of women were completely and 17 percent were partly freed from household chores after spontaneous abortion. One-fourths (24 percent) had no freedom from household chores. Twenty-nine percent of women received help from women from husband's side and another 29 percent from mother's side. Among those who had a child less than 10 years of age at the time of the event, 43 percent did not get help in child care from any one. Women from husband's side extended help in childcare in 25 percent of the cases and women from mother's side in another 26 percent of the cases.

Induced Abortions

Motive

For a substantial proportion of women (42 percent) the reason to go for induced abortion was to stop having more children. Another 42 percent of women resorted to it to space childbirth. Nine percent of abortions were carried on medical advice - 5 percent for reasons of poor development of embryo or possible birth defect and 4 percent for reasons of potential risk to mother's life. Members in the family did not want the baby in 2.5 percent of the cases.

Decision-making

In 95 percent of the situations husband knew about his wife resorting to induced abortion. Only about half of the women take decision either by themselves or along with their husbands. In another half of the cases, husband decides either alone or along with woman's parents or along with his parents.

Service Provider

Eighty percent of the women approached private health care providers. Government health care institutions provided the service to 16 percent of induced abortions and 3.5 percent of abortions were carried out by quacks. Both among government and private providers 90 percent use D&C to induce.

Cost

While for onward journey to the provider's place women prefer cheaper mode of travel, they prefer safe mode of travel for returning home. This is because D&C is performed to many women and hence they need to travel by a comfortable mode on their return. On the average a woman has to travel 36 minutes (Median = 30 minutes) to cover an average distance of 12.8 km (Median = 6.0 km) to reach the place of provider. Thirty-seven percent of women stayed at the provider's place for more than a day. The average duration of stay is 26 hours (Median = 12 hours).

Overall the average expenditure for an abortion is Rs.1335 and the median expenditure is Rs. 950. This includes provider's fee, medicine, and travel, food and accommodation outside home for the individual and the accompanying persons. For D&C alone the average cost is Rs.1337 for service in private institutions, which is almost double as that in public institutions (Rs. 759). When D&C is followed by sterilization the cost in private institutions escalates to an average of Rs. 3561.

Fifty-six percent of women managed the expenses on induced abortion out of household routine budget. Thirteen percent of women borrowed from their parents and 9 percent borrowed money from moneylenders.

The average wage loss for the woman undergoing induced abortion and her family members on account of induced abortion was Rs. 287. Average of both direct and indirect costs per abortion add up to Rs. 1622 and the median is Rs. 1000.

Family Care

While 60 percent of women are freed from household chores completely, 18 percent are freed to some extent. About 22 percent of women have to bear the burden by themselves. Women from mother's side and husband's side generally extend help in household chores. Support in taking care of young children comes from women from mother's side to one-third of the cases. The second major source for help in caring for young children is women from husband's side.

Provider's Advice and Care

In both public and private institutions consent from husbands of women for induced abortion is obtained before performing abortion from little more than four-fifths of the cases as reported by women.

Refraining from arduous tasks, abstaining from sex and use of some contraception are the only suggestions given to respondents by the provider as reported by the respondents. While all women who underwent abortion in public institutions were given some advice, 4 percent of women who had abortion in private institutions did not receive any advice from doctors. About 69 percent of women who had abortion in public institutions and 63 percent who had abortion in private institutions are asked by doctors to return to them for follow up.

Among those who had abortion in public institutions, 78 percent are either sterilized soon after abortion (22 percent) or advised to use one or other method of contraception (56 percent) by doctors. The corresponding percentages are 70, 4 and 65 among women who had abortion in private institutions.

Complications

Post-spontaneous Abortion Complications and Differentials

Over three-fourths (78 percent) of women experienced one or other complications after two hours but within a day following spontaneous abortion. Sixty-two percent of the cases experienced some complication after 24 hours but within a week.

The percent of women experiencing complications in the period after a day but within a week among urban women is 66.0 and among rural women is 59.8. During second and third weeks after spontaneous abortion 17.8 of rural women and 14.9 percent of urban women experience complications. Higher the age at the time of spontaneous abortion or pregnancy order, the higher is the chance that a woman will experience post- abortion complication. Clearly there is association between gestational age and chance of post-abortion complications. The incidence of post-abortion complications increases with increase in gestational age at the time of spontaneous abortion. There is no difference in the incidence of complications following spontaneous abortion between public or private health care providers who provide check up service.

Excessive bleeding is the largest single symptom reported by women in any period following spontaneous abortion. Thirteen percent of women experience excessive bleeding even after a week since occurrence of the event. After 24 hours of the event but within a week 23 percent of women experience abdominal pain and 5 percent experience it even after a week. Another 11 percent of women report their experience of stomach pain. It is possible that many of these women do not distinguish lower abdominal pain from stomach pain. Again another 11 percent of women report body/hand/leg pain. Tiredness, fainting and dizziness, back/hip pain and general weakness are the other symptoms reported by about 3-5 percent of women.

Post-induced Abortion Complications and Differentials

The percent of women experiencing one or other complication is high (80 percent) in the period after two hours but within a day following induced abortion. Sixty-three percent of women experience some complication after 24 hours but within a week. The percent experiencing complication reduces to 2.6 after 6 weeks since induced abortions. Two percent of women experience one or the other complication permanently.

During the period after 24 hours but within a week since induced abortion the proportion experiencing complications among urban women is marginally less (62 percent) than rural women (64 percent). The proportion experiencing complication is more among women under age 25. Induced abortion done in the first trimester has less chance of leading to some complication than do those done in the second trimester. Incidence of post-abortion complication is found to be less among those done by private providers than among those done in public institutions or by others.

Bleeding and pains (abdominal pain, body/ hand/leg pain and stomach pain) are the most common complications reported by many women after induced abortions. Twelve percent of women experienced excessive bleeding even after a week since induced abortions. Eleven percent of the women experienced abdominal pain even during 2nd and 3rd week following induced abortions. Another 3.5 percent reported stomach pain. Back/hip pain has become a permanent problem for 2 percent of women and white discharge has become a permanent problem to another 2 percent.

Abortion in Maharashtra Incidence, Care and Cost

Executive Summary

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Objectives and Methodology

This community-based survey on abortion incidence, care and cost was part of the Abortion Assessment Project – India (AAP-I) studies conducted on various aspects of abortion in 18 states of the country. The main objective of the survey was to study pregnancy outcome analytically with a focus on abortions in Maharashtra. The survey collected background information on a variety of socio-economic characteristics of the population in Maharashtra. It collected data in details on service provider used for pregnancy loss, post-abortion problems, care and cost associated with pregnancy loss from 1996 to 2000.

A state representative sample of 5712 ever-married women aged 15-54 from 5405 households from all districts of the state was interviewed. The sample was selected using a self-weighing systematic, multi-stage stratified sampling procedure. The data was collected between September 2001 and March 2002. The findings of the survey have been disaggregated for rural, urban and Mumbai region and also for the state as a whole. Two separate protocols were used to collect household level information and individual information from eligible women.

Profile of Sample

Nearly 37 per cent of the population covered in the survey resided in urban areas. Around 32 per cent of the population in the state was less than 15 years of age and 10 per cent of the population over 60 years of age. This type of age distribution is typical of a population, which has experienced recent fertility decline. The sex ratio of the state was 976 females per 1000 males with the ratio being higher in rural areas (979) than in urban areas (970). At age 15-19, the proportions ever married were only 1 per cent for males and 30 per cent for females. By age 25-29, ninety-five per cent of women were married in contrast to 68 per cent of males in this age group. Overall, the data show that women in Maharashtra marry at much younger age than men, and that both men and women marry at younger ages in rural areas than in urban areas. The gender and rural-urban inequities in educational attainment continue to be sharp despite a much higher school attendance rate among the younger age groups. Overall "no schooling" is twice higher in rural areas and amongst women, and in both categories the gap got wider for higher levels of educational attainment.

A relatively larger proportion of the heads of the households was between 30 and 59 years. A large majority of heads of households was married. Eighty four per cent of the household heads are Hindu, 8 per cent Muslim, 5 per cent Buddhist and the rest 3 per cent are from other religions. The mean household size was 5.02 persons, 5.12 in rural areas and 4.85 in urban areas. Eighty eight per cent of households in the state lived in houses with three or more persons per room. About half (49.5%) of the households did not own land, joint or otherwise. About half (47.4%) of the total sampled households fall into 'medium' category as regards the SLI (Standard of Living), scores. Of the rest, about one-quarter each falls into 'low' and 'high' SLI categories. In case of urban population, a little more than two-fifths each belong to 'medium' and 'high' SLI categories; while in case of rural areas comparatively a much higher proportion of households (35.9%) were in the 'low' SLI.

Rates of Pregnancy Loss

The mean number of pregnancy outcomes was higher among rural women (3.4) than among urban women (3.0). There was a negative relationship between the level of education of mother and the number of pregnancy outcomes. Women who never attended school on an average had 3.75 pregnancy outcomes, in women with less than seven years of schooling it decreased to 3.31 and among women with more than 12 years of schooling it further decreased to 2.99. The incidence of induced abortion was more than three times higher in urban areas than rural areas and is much higher in Mumbai. The mean number of induced abortions is 16 times higher among women from the high SLI group than women from the low SLI group.

In rural areas, 4 per cent women had experienced at least one stillbirth as compared to 2.7 per cent in urban areas. In case of spontaneous abortion, 9.5 per cent of women from rural areas experienced spontaneous

abortion as compared to 11.7 per cent of women from urban areas. The corresponding figure for induced abortion was 3.72 per cent for rural women and 11.14 per cent for urban women.

The rate of induced abortion for the period 1976-1995 was 20.0 per 1000 reported pregnancy outcomes and the ratio per 1000 live birth was 21.7. For 1996-2000, the rate of induced abortion was more than double the earlier period at 45.4 per 1000 reported pregnancy outcomes and the ratio per 1000 live births was 50.7. Both the ratio and the rate of spontaneous abortion was found higher in urban areas as compared to rural areas for both the time periods.

The per cent of pregnancies ending in induced abortion increased with the rising order of pregnancy. In rural areas the rise in percentage of induced abortion from first pregnancy to second was 1.3 from 0.4 whereas in urban areas the rise was 4.9 from 1.0. More than 14 per cent of spontaneous abortion from rural areas occurred after 20 weeks whereas in urban areas, it was around 8 per cent. The rate of spontaneous abortion was higher when the interval from previous termination to next conception is short. In the case of induced abortion, 78 per cent of the pregnancies were terminated within 12 weeks.

For the period 1976-2000 about 25 per cent of the abortions that were terminated were within the framework of the MTP Act. Pregnancies terminated due to economic reasons were more than eight times higher in urban areas than rural areas during 1996-2000. While reported sex-selective abortion was only four per cent of the total pregnancies terminated between 1976 and 1995, it more than tripled to about 12 per cent for the period 1996-2000. The rate of reported sex determination test per 100 live births increased from 0.2 in 1976-1980 to 2.4 in 1996-2000 period.

Problems Associated with Pregnancy Loss

Post-abortion complications were higher for spontaneous abortions because such abortions being perceived as natural events are less likely to get medical attention and this is reflected in our data with very high proportion of 'treatment not taken'. Induced abortions have lower complications because they are voluntary acts where consciousness about medical care is higher. Post abortion reported morbidity is 2.6 times higher in case of rural areas as compared to urban areas and more than 5 times higher when compared with Mumbai.

Many abortions, both induced and spontaneous, in rural areas resulted in excessive bleeding. Problems due to vaginal discharge and pains and aches were almost twice higher among induced abortions from rural areas than urban areas. In case of spontaneous abortion, problems due to vaginal discharge were four times higher in rural areas than urban areas. As for infections, there was little difference between rural and urban areas in the case of induced abortion, but for spontaneous abortions, abortions from rural areas were associated with three times more infections than urban areas. Women using private health care providers had reported higher symptoms of abortion morbidity than government health care providers. The prevalence of problems due to abortions were reported more by women from the low SLI group than others.

Issues of Access and Care

The mean distance traveled by women for seeking care for spontaneous abortion was 9.09 km as against 11.80 km for induced abortion. Both the mean and median distances of the private facilities accessed were lower than those for public facilities in rural as well as urban settings. The services of the private sector were sought for 62.3 per cent of the spontaneous abortions and 79.3 per cent of induced abortions. The public sector services were used for 15.58 and 17.9 per cent respectively for spontaneous and induced abortions. A higher percentage of women from the low SLI access the public sector than do women belonging to the other two SLI groups. Among the host of reasons cited for choosing private health care facilities, the absence of a public health care facility nearby and the lack of attention received at public health care facilities were the prime ones. The reasons most often cited for choosing a public health

care facility for induced abortion related services, were free treatment offered and inability to pay for services elsewhere.

Consent was taken from spouse or relative in an overwhelming 87 per cent of induced abortions. Both public and private providers largely seek such consent before undertaking the abortion. About 50 per cent of the cases of induced abortion were asked to come for follow up visits. About half the women were not offered contraceptive advice following abortion.

Data reveal that overall, more than 35 per cent of women for induced abortion and 40 per cent for spontaneous abortion had not got any rest after the event. In both types of abortion, women who were from the lower SLI received much less rest than women from middle and higher category. Generally, due to non-availability of help (in 79% and 69% of cases of induced and spontaneous abortions, respectively) women had not been able to take any rest after an abortion.

The husband was usually involved in taking the final decision of terminating a pregnancy. In 48 per cent of induced abortions relatives from in-laws and in 29 per cent of the cases relatives from the natal family took part in the decision of terminating the pregnancy. In 5 per cent of abortions, the woman herself had not participated in the decision making process.

Cost of Abortion Services

The average out-of-pocket cost per abortion was Rs. 1415.4, being Rs. 1746.5 for induced abortions and Rs. 1113.7 for spontaneous abortions. The average cost per abortion to Mumbai women is much higher at Rs. 2760 per abortion than other areas. Otherwise there were only marginal rural urban differentials in out-of-pocket expenditures on abortion. For induced abortion, between public and private sector the overall cost variation was over eleven times, but for medical care costs like hospital cost it was much higher in the private sector by as much as 20 times. Medicine costs were higher in the private sector by over nine times. In the public sector main cost component for induced abortions was travel.

VIII. Working Papers

Abortion Practice in India: A Review of Literature

Heidi Bart Johnston

The Medical Termination of Pregnancy Act of 1971 greatly liberalised the indications for which abortion is legal in India. The Government intended for this Act to reduce the incidence of illegal abortion and consequent maternal morbidity and mortality. However, 30 years after the groundbreaking legislation, the majority of women seeking abortion still turn to uncertified providers for abortion services because of the barriers to legal abortion. While some uncertified providers offer safe services, many provide unsafe abortions that result in complications or death. Women with access to fewer resources, for example low-income rural women and adolescents, are among those most likely to turn to unsafe abortion and have complications. Studies suggest that the choice of specific provider is most often not made by the woman inducing abortion but with or by her husband or other family members.

While the incidence of abortion in India is unknown, the most widely cited figure suggests that around 6.7 million abortions take place annually. According to government data, only about one million of these are performed legally. The remaining abortions are performed by medical and non-medical practitioners. Levels of unsafe abortion are very high in India, especially given that abortion is legal for a broad range of indications, and available in the public and private health sector.

In the current situation abortion services are not adequately decentralized, and regulatory reform will have to take place before decentralization of legal services will happen in a meaningful way. To reduce morbidity and mortality from unsafe abortion in this context, several broad activities require strengthening: decreasing unwanted pregnancies; increasing access to safe abortion services; and increasing the quality of abortion care, including postabortion care.

Results of the studies reviewed suggest that reducing recourse to unsafe abortion will be a complex multi-step process that includes increasing women's access through improvements in service delivery and addresses the more complicated issues of rights and gender power inequities. Strategies to make safe and legal abortion services more attractive to women and decision makers include: increasing geographic accessibility; increasing affordability; providing high quality abortion care and prioritising confidentiality of services. Addressing the system of barriers limiting women's access to safe abortion services may require review and revision of the MTP Act, 1971 and associated rules and regulations.

This review suggests a need for expanded community-based education to address specific issues of women's reproductive health and the broader issues of women's right to high quality health care services. Household decision-makers, men and women, would benefit from awareness raising about the dangers of unsafe abortion and the availability of safe abortion services. Women with reduced access to reproductive health resources, such as adolescents and rural poor, should be a priority focus in com-munity-based education.

This review of the current literature of abortion in India suggests that abortion and associated morbidity and mortality from unsafe abortion are common and need to be a top priority safe motherhood issue in India. Areas for exploration to improve abortion care include, but are not limited to: motivating qualified practitioners to attend MTP training courses; reviewing MTP Act and associated rules and regulations to determine how the law can be revised to decentralize abortion services and otherwise better meet the needs of women; upgrading facilities that currently offer MTP services; orienting MTP services to meet the needs of women most at risk of accessing unsafe abortion; increasing awareness among women and men of reproductive age of the availability of safe abortion services and the dangers of unsafe abortion; involving communities and providers at all levels to

improve reproductive health care; and improving adolescent reproductive health services in general. Innovative interventions need to be developed, implemented, monitored and scaled up as appropriate.

Clearly a great deal is known about provision of and access to safe and unsafe abortion services in India and the need to improve safe abortion and contraceptive choices to more adequately meet the needs of women experiencing unwanted pregnan-cies. Still, a great deal more needs to be known before programs are implemented to ensure low-resource Indian women can readily access safe abortion services. The cost in terms of women's health and lives emphasizes the need to efficiently and effectively pursue efforts to make abortion safer and more accessible for Indian women.

Sexuality, Abortion and the Media A Review of Adolescent Concerns

Anita Anand

Is addescent sexuality on the rise? If so, are adolescents practicing safe sex? What percentage of girls and young women are experiencing unwanted pregnancies?

The numbers of adolescent girls and young women experiencing pregnancies, births and abortions is high. Older women are more likely than younger women to have married early: 39 percent of women currently age 45-49 married before age 15, compared with 14 percent of women currently age 15-19.

Young people are interested in sex because of biological reasons - hormones. The change is that they are experimenting and exploring more than before, and this information is more public.

Reproductive health needs, especially adolescent reproductive health needs, are poorly understood and under served in India. Studies addressing issues of sexual behaviour in general and adolescent sexual behaviour in particular are few and exploratory. Fewer studies discuss female sexual behaviour than male.

Adolescent marriage and adolescent fertility are disturbingly high. Double standards exist whereby unmarried adolescent boys are more likely than adolescent girls to be sexually active.

Studies of abortion in India, particularly among adolescent abortion seekers are limited.

Adolescents are not learning about sex in schools. Studies suggest that at least 60 percent people in India have probably not learned about sex in school.

A healthy exposure to sex information seems to empower adolescents to distinguish between normal sexual experiences and unwanted sexual attention. Yet, while some discussion and debate on issues such as when adolescents should learn about sex, how the curriculum should be designed, by whom and the role of parents, schools and media has begun, there is as yet no consensus. A start has been made by speaking publicly about sex, and in the context of adolescents, premarital sex.

Till recently, most outreach services were catering to girls and young women. Now there is attention to boys and young men as well. NGOs, government agencies and other civil society groups are making more outreach possible.

The media's coverage of adolescent sexuality is confused and erratic. It tends to be sensational and superficial. It will be a while before media and society are comfortable with the notion of adolescent sexuality. HIV/AIDS has forced some of these issues on all connected and concerned about adolescents and their maturation process.

Abortion Options For Rural Women: Case Studies From The Villages Of Bokaro District, Jharkhand

Lindsay Barnes

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

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

The study highlighted the total lack of accessible, affordable and safe abortion services. Only three women experienced a complication-free, safe abortion from a single, qualified service provider. Fifteen women had to access care from more than one provider, since the complications that arose could not, normally, be managed by the same provider. Women often accessed different methods of abortion, which added to cost and risk.

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

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

Assessing Potential For Induced Abortion Among Indian Women

U. S. Mishra And T. R. Dilip

This analysis based on National Family Health Survey - II (1998-99) data, is intended to provide an indirect assessment of the magnitude of induced abortion practice within marriage in India in order to attain their desired sex composition of children and to avoid unplanned pregnancies. Estimates of total induced abortion potential and its characterization in terms of sex selective and contraceptive intentions is based on births reported in the survey, which is more reliable than commonly used estimates based on pregnancies reported in the survey.

Here Induced abortion due to sex selection is assessed based on deviation of observed births from a theoretical binomial distribution, after accounting for sex selective stopping. The difference between age specific natural force of fertility and the observed one provides us the extent to which contraception suppresses fertility, which is taken as a measure of potential rate of use of induced abortion as a method of contraception.

Estimates show that in India induced abortion due to sex selection is 74 per 1000 live births and that due to contraception is 115 per thousand live births. In total there are 189 induced abortions per 1000 live births. The observation that out of the total amount of induced abortions that occur within marriage, 39 per cent of abortions are for sex selection while remaining 61 percent are for avoiding unwanted pregnancies, indicates high level of use of abortion as a contraceptive method in the country, and this has serious implications for health policy in general and women's well being in particular. The use of induced abortion as a contraceptive method as well as for sex selection is higher in urban areas than in rural area, higher amongst the highly educated than among lower educated women and in high SLI category as compared to low SLI categories.

Abortion Costs And Financing : A Review

Ramamani Sundar

The growing literature on abortions in the developing countries tend to focus on the health consequences of unsafe abortions and the limited access to abortion services, but does not look at the real and often crippling economic cost of abortion. A woman undergoing an abortion has to incur expenditure in various forms, both direct and indirect.

So far no all India household survey on abortion related expenditure has been conducted. However there are micro level surveys, which had been carried out in a specific state or a district, specially focussing on abortion. These surveys do throw some light on the expenditure incurred by women on abortion, although the sample size of abortion seekers covered by some of these studies is fairly small.

These studies show that women have to incur some expenditure to get MTP services even from public clinics, which are expected to provide free services. However, by and large the government providers seem somewhat cheaper and are probably safer than the others, especially the illegal providers.

Unfortunately, none of these studies have tried to look into the sources of financing the abortion expenses by the women. Also, the surveys included only women who had undergone an abortion from the approved MTP centres ; none of the surveys made an attempt to include the abortion seekers from illegal providers. Another limitation of these survey data on abortion cost is that it does include the cost of follow up care and this cost can be very high in case there is a complication after the MTP.

A visit to different types of MTP providers in Delhi reveals that there are a wide range of services available across the city. The type of providers include government hospitals, family welfare centres, clinics run by NGOs like the Family Planning Association of India and Marie Stopes, government approved as well as not approved qualified private doctors and illegal providers like dais and quacks. These providers cater to different segments of the city's population and the quality of services offered and the charges for abortion services also vary accordingly.

The safety and the cost of abortion, to a large extent would depend upon the method of abortion used. The dilation and curettage (D&C), is still the most commonly used method of abortion in India. The alternative method for early abortion, manual vacuum aspiration (MVA) is not widely available in the country even in the government run MTP clinics. As a result the average cost of abortions becomes very high.

Finally as far as abortion services are concerned, the option of insurance schemes is almost non- existent in the country. In fact in India health insurance is yet to pick up in a big way. Of the various schemes meant for the employees of the organized sector the ESIS, CGHS and the Railway Health Scheme provide MTP services for the women covered under their schemes in the hospitals run by them. Other insurance schemes as yet do not cover abortions .

A review of the available literature indicates that there is very limited data on the cost of abortion care in the country and hence the first step is to increase the research in this critical area of financing for abortion care. We need to know not only about the abortion charges at the various types of MTP centres, but also the household dynamics like the source of financing the abortion etc. It is evident that even in the government facilities, the abortion seekers had incurred substantial expenditure. The state has to really look into this. In the case of private certified approved MTP centres, there do not seem to be any control over the quality of services as well as on the charges for the abortion services. We need much better regulation of private medical practitioners as well as dissemination of information to them so that women seeking an abortion are not exploited financially.

‘Negative Choice’ Sex Determination And Sex Selective Abortion In India

Rupsa Mallik

Any engagement with abortion in India cannot be undertaken without engaging with the issue of sex determination (SD) and sex selective abortion (SSA). SSA adds to and underscores the profound complexities that surround the abortion debate in India. The Abortion Assessment Project - India (AAP-I) has created space for reengagement and exploration of some of these complexities. This paper is part of that initiative.

Today, more than ever, there is wide-ranging consensus in India that sex determination and sex selective abortion is morally and ethically unacceptable and the urgency to address it has gained tremendous momentum. However, the intersecting ‘spaces’ inhabited by sex selective abortion and women’s right and access to safe abortion often creates a number of thorny overlaps that makes the consensus urging a ban on sex determination *appear* laden with ambivalence and contradictions. The activism to ban sex determination and prevent SSA is an illuminating ‘case study’ that provides a roadmap for discourse as well as action in our dual efforts to secure an effective ban on sex determination while continuing to raise demands for women’s right and access to safe abortion.

In this paper a three-part analysis of SD and SSA is undertaken. In the first section, the factors that can be said to fuel this practice – son preference, growth in the political economy of diagnostic technologies and enforcement of a small family norm - have been discussed. In the second section the campaign(s) undertaken to advocate for laws that regulate diagnostic technologies and ban sex determination – Forum Against Sex Determination and Sex Pre-Selection (FASDSP) and PIL filed in the Supreme Court - has been examined with a focus on the legislative provisions that have been a key demand of both these campaign(s). In the third section key debates between activists who spearheaded the campaign and the medical community have been examined along thematic lines. Discourse analysis, is used both as a methodology as well as an interpretive framework to undertake what in essence is a political enquiry of a problem.

To write a paper on this subject has been a challenging process. Especially, as during the course of writing the paper efforts to address SD and SSA gained fresh momentum and added volatility to a discussion that is already complex. I hope I have been successful in illustrating the richness of the existing literature on the subject as well as able to provide an insightful analysis of past and current developments surrounding the issue through my discussions. Any shortcomings are my own.

Abortion Training In India: A Long Way To Go

Sangeeta Batra Sunanda Rabindranathan

Abortion has been a neglected area in reproductive health research. Partly because of the sensitivity of the subject and partly because of lack of funds for conducting abortion studies, this subject has been a particularly difficult area for researchers often due to moral and political constraints. Studies so far have revolved around provision of abortion services, profile of abortion seekers, reasons for terminating pregnancy, post abortion care, decision making in abortion and other aspects of abortion. However, are there enough providers to provide safe and early abortion services and at locations accessible to rural women? This area has not received adequate attention by researchers.

This paper looks at the current state of abortion training in India, tracing its evolution from the earlier system to what is followed under the Reproductive and Child Health (RCH) Program today. There is an unmet need for medical termination of pregnancy (MTP) training in our country, as many of the training centres that have been identified for training are still not functional due to a variety of reasons.

To understand the functioning of MTP training and its content, including the selection criteria for trainees, training curriculum and the experiences of trainees and trainers, ongoing training programs of two states have been observed. By and large, it is a clinical training and the whole emphasis is on the procedures. Other important aspects connected with abortion management like counselling are not given much importance.

At present, the number of training sites is inadequate to meet training needs. There are gaps in the training system that need to be covered to make the program a success. Changes are required at both the policy and implementation level and this forms a part of our recommendations.

Methodological Issues In Abortion Estimation

Shelley Saha

Interest in abortion research is emerging as a public health issue, as there is increasing evidence of the contribution of induced abortion in maternal morbidity and mortality. While there is no reliable estimate of the magnitude of abortions that take place, a few sporadic studies tend to suggest that the proportion of women resorting to abortion could be high. Due to inconclusive nature of most of the incidence studies on abortion, it became important to come up with reliable estimates on incidence of abortion in India. The paper reviews the methodological issues that are peculiar to abortion estimation using community based surveys.

The main sources of information are examined, and their relevance in assessing rates of induced abortion is addressed. In India one can get information on abortion from the Family Welfare Programme Year book. This contains information on a yearly basis on reported Medical Termination of Pregnancies, conducted at registered centers. Abortions based on reporting often are an under-estimate because even in countries which have legalized abortion the mechanisms for regulation and reporting are poor. Thus various other methods like indirect estimation techniques are used in calculating abortion rates. Besides the above two methods, official records and indirect estimation techniques, abortion rates are also estimated through surveys, both prospective and retrospective.

This paper mainly deals with methodological issues related to community based abortion estimation surveys. Review of literature shows that there are various factors which affect estimation of abortion. One of the important factors that affect abortion estimates is accuracy in identification of pregnancy. But in retrospective community based surveys, identification of all pregnancies is not possible and therefore most of the time the estimates are based on reported pregnancies.

Many of the abortion estimation surveys suffer from reporting errors, both non-intentional and intentional. Intentional mis-reporting may be improved to some extent by improving methodologies like ensuring privacy and confidentiality. Number of abortion estimation surveys suffer from under reporting due to recall error, though the extent of under reporting is not known. Some studies have tried to minimize under reporting by having filter questions between two pregnancy outcomes. One of the most challenging parts of abortion rate estimation surveys is to determine the required sample size, which would enable generalization of the findings. Moreover, studies should take into account factors like design effects, under reporting and non-response rates. Determining population estimate for induced abortion is a more difficult task than that based on spontaneous loss, as the determinants of the induced loss vary greatly across populations and across regions within a country. In the Indian context, in the absence of any other estimate, the formula adopted by the Shah Committee in 1966 has been widely used for population estimate of pregnancy wastage. Though both probability and non-probability sample design has been used by surveys estimating pregnancy wastage, it is better to use a probability sample design as it leads to better generalisation. This review suggests that there is a need that surveys undertaken to estimate abortion rate should be sensitive to elicit better information. Besides survey questionnaire, other data collection methods like use of randomised response technique or self-administered questionnaire have also been reviewed. The paper concludes with information on further strategies that might be adopted for future research on this sensitive and stigmatised issue.

"Professional" Abortion Seekers: The Sex-Workers Of Kolkata

Swati Ghosh

This is a paper on the practice of abortion and prevention of pregnancy among the sex-workers. In recent times sex-workers are emerging as a category of professionals claiming workers' rights. Identified as a high-risk group for AIDS, the use of contraceptives has become a very important issue within the profession. This paper explores the impact of the workers' rights movement on termination of pregnancy and contraception in the last few years in Kolkata. Secondary data being scarce, the study is based on in-depth personal interviews of brothel-based sex-workers. Information regarding abortion services, contraceptive devices and childbirth are collected from traditional red light areas of Sonagachhi, Kalighat and Khidirpur in Kolkata. Aspects such as access to abortion services, prevailing patterns of contraceptive use and family structure of the sex workers have been examined. Apart from data, practices, experiences and linkages within the trade were also enquired upon through the interviews.

It is observed that the incidence of abortion is high among the sex-workers. With legalization of abortion, dependence on unregistered private clinics has been largely replaced by state hospitals. The nature of power structure within the trade and the income differential among women were two important determinants regarding choice of the service. Sex-workers bonded within power relation were forced to avail unregistered, clandestine health clinics for termination of pregnancy that did not guarantee safety and care. Areas, which were not strongholds of the sex-worker's forum, could not attempt to break through the power nexus of the trade yet. Legalization of MTP had enhanced autonomy and mobility for sex-workers but only for the ones with greater relative autonomy. The differential nature of the trade persisting at different locations shaped the economic standing of each woman and hence influenced her choice.

Sex-workers depended on traditional mode of prevention although use of modern devices was initiated. Rather, termination and prevention of pregnancy existed simultaneously. The shift from abortion to a specific preventive mode of condom use was yet to be established although it was projected as the most effective preventive against infection from STD/ HIV. The sexual trade market was demand driven and the only route to universal use of the condom in sex-work would be possible through the education of the male client to be responsible in the relationship at one level and strengthening the regulations at the supply end for compulsory condom use.

IX. Seminar Vol. 532 December 2003
(Special Issue On Abortion)

Seminar has brought out a special issue on Abortion, which is largely based on studies undertaken under AAP-India project. These papers are listed below:

- Policy and Practice by Siddhi Hirve
- Coercion, Control Or Choice? by Bela Ganatra
- The Missing Girls by Leela Visaria
- Negative Choice by Rupsa Mallik
- Accessibility and Utilization by Sandhya Barge, Wajahat Ullah Khan, Seema Narvekar and Yamini Venkatachalam
- Safe and Accessible: Strategizing the Future by Heidi Bart Johnston
- Abortion Economics by Ravi Duggal
- From Decoctions to Instruments by Alex George
- Family Matters by Anjali Radkar
- A Provider's Perspective by Sudha Tewari
- Ensuring Ethics by Sudarshan Iyengar
- Managing Abortion Research by Vimala Ramachandran

The above papers can be downloaded from the Seminar website

www.india-seminar.com/2003/532. They are also included in the accompanying CD.

X. Selected Data On Reproductive Health

Compiled by Rajeswari Ramani

State-Level Data on Number of Registered Abortions and MTP Centre

Number of Registered Abortion

States	1975-76	1976-77	1977-78	1978-79	1979-80	1980-81	1981-82	1982-83	1983-84	1984-85	1984-85	1985-86	1986-87
Andhra.Pradesh	5,909	11,441	7,812	13,232	9,963	11,968	15,126	14,379	13,086	13,028	317	14,023	10,301
Assam	4,076	7,900	8,383	9,505	9,895	12,439	9,426	11,225	12,250	11,871	31	10,588	9,354
Bihar	4,416	6,083	2,916	6,414	7,403	5,287	9,955	13,801	13,379	13,073	104	11,146	10,859
Gujarat	10,995	15,863	16,780	23,033	21,316	21,349	21,990	21,540	20,987	19,992	532	18,396	16,630
Harayana	3,221	4,314	3,828	3,761	4,631	5,287	6,596	9,357	11,477	12,350	135	14,457	14,117
Himachal Pradesh	706	1,513	1,283	1,925	2,514	3,081	4,258	5,939	5,534	6,206	111	6,614	6,242
Jammu & Kashmir				1,570	96	NA	NA	NA	NA	NA	NA	NA	NA
Karnataka	7,807	11,025	12,053	12,730	14,718	16,895	16,726	17,775	18,395	18,300	278	17,516	16,223
Kerala	19,969	25,392	28,752	23,789	32,597	36,212	35,033	38,936	40,047	43,957	206	32,222	29,264
Madhya Pradesh	8,510	14,094	11,784	13,942	15,422	16,482	19,628	22,825	22,972	24,761	239	26,277	26,282
Maharashtra	28,525	29,260	22,112	30,600	37,751	41,061	29,455	68,608	76,425	95,836	882	119,350	122,744
Manipur	26	30	165	161	874	1,066	1,406	2,077	1,852	2,494	3	1,905	1,701
Meghalaya	324	633	766	748	290	3					1	46	NA
Nagaland	268	416	545	586	587	324	706	933	470	522	5	805	689
Orrisa	2,490	6,582	8,561	10,986	11,018	12,390	19,599	19,648	22,581	22,060	134	22,824	20,613
Punjab	4,754	7,584	7,443	8,991	9,616	12,434	22,823	25,485	25,538	24,953	230	21,656	21,488
Rajasthan	5,748	7,806	6,660	7,958	10,338	11,241	11,706	11,422	14,538	14,711	257	16,743	17,364
Sikkim							35	47,663	68,756				
Tamil Nadu	19,213	37,945	24,456	34,418	32,699	36,494	42,364	785	976	65,754	201	63,279	61,825
Tripura	290	383	354	551	920	281	233	98,938	97,136	982	3	960	2,418
Uttar Pradesh	48,086	49,985	44,017	66,462	84,393	85,804	92,606	33,904	10,360	103,285	463	98,087	101,212
West Bengal	18,655	19,436	13,778	18,906	25,472	20,293	31,225	341	415	34,458	452	38,567	43,699
A & N Islands	165	251	179	211	283	331	365	519	533	346	1	416	388
Arunachal Pradesh			34	133	336	491	424	2,189	2,014	484	8	563	923
Chandigarh	2,389	2,102	1,769	1,973	2,019	2,112	2,268	37	85	2,102	2	1,906	2,023
D & N Haveli	11	57	16	14	18	19	13	27,524	27,970	101	1	87	106
Delhi	12,122	11,428	11,821	13,977	15,027	19,453	23,421	27,542	825	31,213	118	32,850	36,680
GoaDaman& Diu	679	825	788	846	958	1,105	1,357	1,857		1,662	32	1,429	1,427
Lakshadweep													
Mizoram				62	180	216	357	359	517	538	10	703	644
Pondicherry	784	926	1,030	1,328	1,404	1,548	1,227	1,343	1,499	1,509	4	1,405	1,505
M/O Defence	1,015	1,553	1,426	1,574	2,935	3,392	3,424	3,424	3,326	3,232	83	3,739	3,957
M/O Railways	2,854	3,086	2,213	2,368	2,329	2,450	2,799	3,497	3,665	3,349	75	3,810	3,540
All India	**214,007**	**278,013**	**241,724**	**312,754**	**358,002**	**385,749**	**426,551**	**506,230**	**518,608**	**573,129**	**4,918**	**582,369**	**584,218**

Number of Registered Abortions

States	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98
Andhra Pradesh	12,593	13,662	12630	12611	10753	9830	13719	13360	15177	14067	12495
Assam	9,972	12,434	15923	17421	16406	21956	21372	22211	18386	13565	9632
Bihar	12,205	14,855	13261	11776	10383	12162	11060	9684	9148	4869	8466
Gujarat	19,285	18,922	17217	15978	15846	12560	10263	13969	13757	14999	14458
Haryana	15,485	17,426	18055	19742	20073	18469	22438	23700	23024	22751	22086
Karnataka	13,559	10,909	13397	11052	12889	12900	9077	10207	12715	15484	15448
Kerala	29,794	22,666	24353	22197	36727	35372	34433	39337	33926	34028	33361
Madhay Pradesh	28,534	28,481	32292	28431	3 0936	31147	33086	32522	32798	32846	32543
Maharashtra	109,879	115,201	119051	122337	126983	121711	97079	122388	124965	56528	NA
Orissa	24,654	25,998	24581	21977	21583	19908	19510	21586	21269	23908	24624
Punjab	20,793	15,831	18173	15965	15436	18537	19436	19849	17510	16895	15781
Rajasthan	19,933	19,923	22971	24267	26778	26584	29023	31297	35985	37880	44265
Tamil Nadu	58,654	54,452	54195	51263	49859	45861	42364	41122	42314	43066	47620
Uttar Pradesh	99,839	106,135	103327	103482	120995	118256	121035	115925	109938	102943	113277
West Bengal	41,112	37,930	50564	41054	55673	36803	64273	50687	NA	48635	41229
Himachal Pradesh	7,257	7,892	5781	6828	6567	5703	4340	4783	4905	5938	5304
Jammu & Kashmir	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Manipur	3,802	3,788	3680	4670	4182	8323	5604	6256	7509	7130	6966
Meghalaya	NA	NA	13	4	1			32	4	4	NIL
Nagaland	567	577	671	NA	492	976	271	121	479	186	245
Sikkim											
Tripura	2,150	1,774	2001	2752	2997	3957	4726	5338	4488	6614	7475
A & N Islands	398	395	334	228	298	247	259	286	270	311	307
Arunachal Pradesh	851	915	1153	1173	996	1048	864	981	1108	5938	1511
Chandigarh	1,795	2,052	1762	1649	1815	1993	2255	2233	2293	2295	2264
D & N Haveli	79	66	39	61	67	57	42	69	46	28	53
Delhi	39,178	37,710	28343	32022	32369	29351	31866	27027	24634	23659	42322
Goa	1,088	1,840	1482	1407	1559	1456	1637	1504	1385	696	1164
Daman & Diu	40	24	15	23	5	13	29	27	11	15	28
Lakshadweep				28	10	11	5	6	7	1	2
Mizoram	854	839	804	668	609	524	911	1203	756	210	459
Pondicherry	1,586	1,891	2086	2107	2181	2037	1826	1980	1744	1689	1574
M/O Defence	4,186	3768	3964	3628	3411	3808	3530	3144	3304	3422	3304
M/O Railways	3,738	3,800	3851	3943	3647	3556	3582	3097	2596	2231	2226
All India	**583,857**	**582,156**	**595969**	**580744**	**632526**	**605116**	**609915**	**625931**	**566451**	**538075**	**510489**

Source: Family Planning Year Book 1975-76 to 1997-98

Number of Registered MTP Centres

States	1975-76	1976-77	1977-78	1978-79	1979-80	1980-81	1981-82	1982-83	1983-84	1984-85	1985-86	1986-87
Andhra.Pradesh	36	37	165	22	22	198	98	198	309	317	358	370
Assam	30	30	31	31	31	31	31	31	31	31	33	33
Bihar	64	71	65	63	104	104	104	104	104	104	104	104
Gujarat	226	226	358	419	431	448	457	484	504	532	546	592
Harayana	60	73	92	92	92	92	130	135	135	135	174	174
Himachal Pradesh	35	36	37	37	37	37	37	111	111	111	111	111
Jammu & Kashmir				NA	NA	NA	NA	NA	NA	NA	NA	NA
Karnataka	47	66	227	245	245	250	265	266	269	278	448	448
Kerala	76	76	97	90	116	116	159	161	179	206	205	206
Madhya Pradesh	54	119	123	119	110	110	182	193	193	239	249	259
Maharashtra	386	419	437	514	568	593	635	639	782	882	1,151	1,308
Manipur	1	2	2	2	2	3	3	3	3	3	3	4
Meghalaya	2	1	1	1	1	1	1	1	1	1	1	1
Nagaland	3	3	4	4	4	4	4	4	4	5	8	13
Orrisa	20	18	64	105	108	108	108	108	112	134	134	135
Punjab	40	79	86	96	107	114	183	209	229	230	230	231
Rajasthan	194	194	200	194	205	215	223	228	228	257	285	311
Sikkim							NA					
Tamil Nadu	80	83	90	99	99	148	194	194	201	201	209	219
Tripura	1	1	3	3	3	3	3	3	3	3	3	3
Uttar Pradesh	169	210	231	230	243	274	351	351	382	463	463	463
West Bengal	121	137	150	156	166	173	452	452	452	452	452	452
A & N Islands	1	1	1	1	1	1	1	1	1	1	1	1
Arunachal Pradesh			2	3	6	6	7	7	7	8	9	10
Chandigarh	2	2	2	2	2	2	2	2	2	2	8	8
D & N Haveli	1	1	1	1	1	1	1	1	1	1	1	1
Delhi	36	72	73	79	79	81	91	94	110	118	128	139
GoaDaman& Diu	6	6	18	18	18	18	21	25	28	32	42	44
Lakshadweep												
Mizoram				NA	2	10	10	10	10	10	10	10
Pondicherry	4	4	4	4	4	4	4	4	4	4	4	5
M/O Defence	107	107	107	60	60	74	76	76	83	83	83	90
M/O Railways	75	75	75	75	75	75	75	75	75	75	75	75
All India	**1,877**	**2,149**	**2,746**	**2,765**	**2,942**	**3,294**	**3,908**	**4,170**	**4,553**	**4,918**	**5,528**	**5,820**

Number of Registered MTP Centers

States	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98
Andra Pradesh	370	371	371	371	371	371	373	378	378	378	378
Assam	33	33	33	33	33	34	100	100	100	100	100
Bihar	104	104	116	116	116	2209	2209	116	116	116	116
Gujarat	644	670	670	670	683	700	700	857	883	929	929
Haryana	174	208	208	208	228	228	228	228	228	228	228
Karnataka	448	448	448	470	471	471	471	471	471	471	474
Kerala	229	238	359	359	532	549	559	564	564	565	565
Madhay Pradesh	271	273	283	286	286	286	295	297	297	300	300
Maharashtra	1,387	1459	1510	1561	1618	1732	1775	1808	1985	2016	2016
Orissa	161	161	161	169	169	167	169	170	170	170	397
Punjab	274	274	274	242	242	242	242	242	242	242	242
Rajasthan	316	316	316	391	316	316	316	432	470	482	482
Tamil Nadu	225	261	454	456	519	531	623	645	660	718	741
Uttar Pradesh	463	425	425	425	425	425	425	576	576	576	576
West Bengal	452	452	452	452	452	452	452	716	716	716	716
Himachal Pradesh	117	126	126	156	156	156	156	156	95	95	87
Jammu & Kashmir	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Manipur	36	36	36	36	36	108	108	108	78	78	38
Meghalaya	1	1	1	1	1	1	1	1	1	3	3
Nagaland	13	13	13	13	13	13	13	13	8	8	25
Sikkim											
Tripura	3	3	3	3	3	3	3	46	44	44	46
A & N Islands	1	1	1	1	1	1	1	1	1	1	1
Arunachal Pradesh	10	10	11	11	11	11	12	15	15	15	17
Chandigarh	10	2	2	2	2	2	4	19	32	32	32
D & N Haveli	1	1	1	1	1	1	1	1	1	1	1
Delhi	146	165	165	182	188	210	233	259	299	311	311
Goa	44	47	49	49	52	52	56	56	56	60	60
Daman & Diu	2	2	2	2	2	1	1	5	5	5	7
Lakshadweep				2	2	2	2	2	2	2	2
Mizoram	20	20	20	20	20	21	21	57	57	57	57
Pondicherry	6	6	6	6	7	7	7	7	7	7	7
M/O Defence	90	90	90	90	90	90	90	90	90	90	90
M/O Railways	75	75	75	75	75	75	75	75	75	75	75
All India	**6,126**	**6291**	**6681**	**6859**	**7121**	**9467**	**9721**	**8511**	**8722**	**8891**	**9119**

Source: Family Planning year book: 1975-76 to 1997-98

District Level Data On Selected Variables : Sexratio, Institutional Deliveries, Female IMR, Female Literacy, TFR and CPR for Selected States

(They are ranked for each variable (highest value is 1st rank for sexratio, institutional deliveries, literacy and CPR, and lowest value is 1st rank for IMR and TFR). The ranks are then added up to arrive at a composite score for each district, and the district with the lowest score gets rank one and so on. This process has led to the selection of districts for the AAP-I study.)

Haryana: Indicators with Ranks

Districts	Sex Ratio 1	Inst. deliv. 2	Fem. IMR 3	CPR4 4	TFR5 5	Fem. Liter. 6	Rank SR 7	Rank ID 8	Rank IMR 9	Rank CPR 10	Rank TFR 11	Rank FL 12	Comp. Score 13	Rank 14	IDI 15	Rank IDI 16	13/15* 100 17	Rank of 17 18
Haryana	865	25.5	54	56.6	4.31	40.5									133.12			
Ambala	885	40.2	61	60.9	3.51	56.6	3	1	10	6	1	1	22	2	129.1	10	17.03	2
Bhiwani	880	16.8	50	61.9	4.24	35.1	6	15	6	5	7	11	50	8	102.20	15	48.92	12
Faridabad	828	28.7	66	47.6	4.78	42.1	16	5	13	15	16	8	73	14	132.81	7	54.97	14
Gurgoan	871	16.7	83	39.8	5.74	34.9	8	16	16	16	15	12	83	16	113.49	14	73.13	16
Hisar	861	24.7	53	59.6	4.42	32.1	10	9	7	9	11	14	60	12	140.75	2	42.63	9
Jind	838	17.7	48	56.7	4.45	30.1	15	14	4	14	13	15	75	15	122.24	11	61.35	15
Kaithal	852	19.9	74	57.1	4.15	28.4	12	13	15	12	5	16	73	14	134.87	6	54.13	13
Karnal	865	25.9	45	67.7	4.44	43.5	9	8	3	1	12	7	40	6	141.32	1	28.30	5
Kurukshetra	879	39.1	36	65.8	3.82	46.9	7	2	1	2	2	4	18	1	138.79	5	12.97	1
Mahendragarh	910	26	50	60.8	4.42	36.8	2	7	5	7	10	10	41	7	101.54	16	40.38	7
Panipat	854	28.1	55	57.2	4.57	41.2	11	6	8	11	14	9	59	11	131.62	9	44.83	11
Rewari	927	23.7	59	60.4	4.05	46.2	1	10	9	8	4	5	37	4	121.64	12	30.42	4
Rohtak	851	22.8	40	56.7	4.35	45.7	13	12	2	13	9	6	55	9	115.33	13	47.69	9
Sirsa	885	30.9	65	65.5	3.93	34	4	3	12	4	3	13	39	5	140.14	3	27.83	5
Sonipat	841	23.1	71	58.5	4.15	48.3	14	11	14	10	6	3	58	10	139.73	4	41.51	10
Yamuna Nagar	883	30.3	62	65.7	4.32	50.1	5	4	11	3	8	2	33	3	131.77	8	25.04	3

Source: ***1,3,5,6:*** *Census of India 1997 " Fertility And Mortality Indicators At The District Level"*
2,4 : *RCH-RHS District Level Data : http://mohfw.nic.in/break2file2.htm, http://mohfw.nic.in/break2file3.htm, http://mohfw.nic.in/breakfile3.htm, http://mohfw.nic.in/breakfile3.htm#top*

1: Female Sex Ratio , **2**: Institutional Deliveries, **3**: : Infant Mortality Rate (female), **4:** Couple Protection Rate, **5** Total Fertility Rate, **6**: Female Literacy rate, **7**:Rank of Sex Ratio, **8**: Rank of Institutional Deliveries, **9**: Rank of Female Infant Mortality Rate , **10**: Rank of Couple Protection Rate (IDI), **11**: Rank of Total Fertility Rate,**12**: Rank of Female Literacy Rate, **13**: Comprehensive Score of all the indicator,**14:** The overall Ranking of the districts, **15:** CMIE Infrastructural Development Index, **16:** Rank of IDI, **17:** 13/15*100, **18:** Rank of 17

Kerala : Indicators with Ranks

Districts	Sex Ratio 1	Inst. deliv. 2	Fem. IMR 3	CPR4 4	TFR5 5	Fem. Liter. 6	Rank SR 7	Rank ID 8	Rank IMR 9	Rank CPR 10	Rank TFR 11	Rank FL 12	Comp. Score 13	Rank 14	IDI 15	Rank IDI 16	13/15* 100 17	Rank of 17 18
Kerala	1036	86.2	2.60	41	72.2	98.18									162.42			
Kasaragod	1026	76.3	3.25	36	59.6	96.7	10	13	11	10	11	13	57	13	163.47	5	34.56	9
Kannur	1049	87.7	2.52	30	47.2	98.4	6	5	6	13	9	8	46	8	106.68	13	43.12	11
Wayanad	966	77.7	2.61	36	63.4	97.7	14	12	11	8	10	9	61	14	107.84	12	56.10	13
Kozhikode	1027	86.8	3.1	35	70.8	98.9	9	8	9	4	8	12	41	5	126.26	9	32.47	8
Malappuram	1053	84.1	4.21	37	46	88	4	10	12	14	14	14	55	11	111.06	11	49.52	12
Palakkad	1061	75.7	2.65	29	61.6	93.4	3	14	5	9	12	10	48	9	115.73	10	41.48	10
Thrissur	1085	86.9	2.1	27	69.5	99.2	1	7	4	5	6	4	34	3	169.39	2	20.07	3
Ernakulam	1000	89.3	2.1	31	59.5	99.4	12	4	7	11	4	4	50	10	167.19	4	29.61	6
Idukki	975	83	2.77	60	81.8	93.3	13	11	14	1	13	11	56	12	88.23	14	63.47	14
Kottayam	1003	94	2.22	34	57.4	99.4	11	1	8	12	4	6	45	6	153.98	6	29.22	5
Allapuzha	1051	91.1	1.99	22	74.2	100	5	3	2	2	1	2	26	1	143.52	7	17.77	2
Pathanamthitta	1062	93.3	1.85	27	73.1	99.4	2	2	4	3	4	1	29	2	169.17	3	16.85	1
Kollam	1035	87	2.14	22	67.5	99	8	6	2	6	7	5	39	4	127.64	8	30.16	7
Thiruvananth-apuram	1036	85.8	2.33	40	66.8	99.5	7	9	13	7	2	7	46	8	175.38	1	26.23	4

Source: **1- 4** : Census of India 1997 " Fertility And Mortality Indicators At The District Level",
5- 6: RCH-RHS District Level Data : http://mohfw.nic.in/break2file2.htm, http://mohfw.nic.in/break2file3.htm
http://mohfw.nic.in/breakfile3.htm, http://mohfw.nic.in/breakfile3.htm#top

1: Female Sex Ratio, **2**: Female Literacy rate, **3**: Total Fertility Rate, **4**: Infant Mortality Rate(female), **5**: Couple Protection Rate, **6**: Institutional Deliveries, **7**:Rank of Sex Ratio, **8**: Rank of Female Literacy Rate, **9**: Rank of Female Infant Mortality Rate, **10**: Rank of Couple Protection Rate, **11**: Rank of Institutional Deleveries, **12**: Rank of Total Fertility Rate,**13:** Comprehensive Score of all the Indicator,**14:** The overall Ranking of the districts, **15:** CMIE Infrastructural Development Index(IDI), **16:** Rank of IDI, **17:** 13/15*100, **18:** Rank of 17

Madhya Pradesh : Indicators with Ranks

Districts	Sex Ratio 1	Inst. deliv. 2	Fem. IMR 3	CPR4 4	TFR5 5	Fem. Liter. 6	Rank SR 7	Rank ID 8	Rank IMR 9	Rank CPR 10	Rank TFR 11	Rank FL 12	Comp. Score 13	Rank 14	IDI 15	Rank IDI 16	13/15* 100 17	Rank of 17 18
Madhya Pradesh	931	28.8	4.92	136											86.66			
Morena	826	20.8	6.63	116	29.6	26.4	44	11	41	33	45	21	194	38	91.23	4	213.20	30
Bhind	816	28.2	5.55	113	43.7	14.1	45	30	24	19	36	19	173	32	85.79	9	210.66	27
Gwalior	833	41.7	4.85	103	51.7	48.2	43	3	11	5	19	13	94	8	96.01	2	97.39	6
Datia	847	23.7	5.07	141	40.2	23.7	42	15	29	28	24	37	176	33	107.78	1	162.83	23
Shivpuri	849	15.6	5.39	139	33.8	22	41	17	36	42	32	35	202	42	79.16	25	255.81	41
Guna	875	18	5.85	144	36.7	29	37	10	32	39	41	40	198	40	75.03	33	263.89	42
Tikamgarh	871	20	6.24	153	45.5	21.5	39	19	19	36	44	44	201	41	92.00	3	218.48	32
Chhatarpur	856	21.3	5.55	149	31.9	19.1	40	22	40	32	36	43	213	44	84.80	11	251.18	39
Panna	897	19.4	5.68	129	25.6	10.1	33	42	44	38	39	31	227	45	80.26	22	282.83	44
Sagar	881	37.8	5.51	132	43.3	24.4	35	14	25	8	33	33	148	27	70.52	39	209.87	28
Damoh	905	30.5	5.13	139	41.1	8.7	30	43	27	16	26	35	177	35	76.36	31	231.80	35
Satna	918	27.8	5.54	147	35.1	13.3	26	33	35	21	34	42	189	37	79.70	23	237.77	37
Rewa	932	26.9	5.59	127	38.8	12.9	20	34	30	24	38	30	176	34	81.99	20	214.66	31
Shahdol	940	20.1	5.04	111	37.8	11.7	18	39	31	35	23	17	162	30	68.77	43	236.29	36
Sidhi	922	13.6	6.02	106	29.5	7.3	24	44	42	44	42	15	211	43	73.04	37	288.88	45
Mandsaur	945	28.3	4.1	112	48.7	25.6	17	12	16	18	6	18	87	6	83.74	14	103.89	7
Ratlam	948	29.1	4.68	32	52.6	31	16	8	7	17	16	1	65	4	88.19	7	73.70	4
Ujjain	929	32.6	4.17	74	57.5	41	21	4	5	11	7	3	51	2	81.60	21	62.50	2
Shajapur	918	19.8	5	118	44.1	29	26	10	22	37	22	25	140	25	83.17	15	168.93	24
Dewas	924	25.6	4.91	102	58	36	22	5	4	26	20	11	88	7	79.57	24	110.59	8
Jhabua	977	11.5	5.69	96	26.8	18	8	26	43	45	40	8	170	31	77.53	29	219.27	33
Dhar	951	20.7	4.97	102	45.8	17.5	14	28	18	34	21	11	126	23	84.65	12	148.85	17
Indore	906	53.3	3.81	69	67.4	62.3	29	1	1	2	1	2	36	1	86.93	8	41.41	1
West Nimar	950	23.2	5.09	124	NA	NA	15	NA	NA	29	25	28	98	11	77.79	28	125.34	14
East Minar	938	31.5	5.18	131	51.5	21.9	19	18	12	13	28	32	122	21	76.00	32	160.53	21
Rajgarh	923	15.6	5.22	144	33.3	18.9	23	24	38	42	29	40	194	38	70.99	38	273.98	43
Vidisha	874	27.8	5.55	102	40.9	19.6	38	21	28	21	36	11	155	29	73.55	36	210.74	29
Bhopal	889	54.2	4.79	98	60.8	52.5	34	2	3	1	18	9	67	5	82.22	19	81.49	5
Sehore	898	22	5.23	117	45.2	23	32	16	20	31	30	22	152	28	83.07	26	182.38	28
Raisen	879	25.5	6.14	159	52.5	15.9	36	29	8	27	43	45	188	36	78.89	27	238.31	38
Betul	966	33.9	5.32	141	61.2	25.5	11	13	2	10	31	37	105	14	74.12	34	140.99	16
Hoshangabad	899	37.6	4.67	139	48.5	32.6	31	6	17	9	15	35	113	18	90.39	5	125.01	13
Jabalpur	915	45	4.57	117	44	31.6	27	7	23	3	14	22	96	10	83.05	17	116.20	10
Narsimhapur	913	41	3.95	121	54.1	17.8	28	27	6	6	3	26	96	9	84.48	13	113.64	9
Mandla	988	22.2	4.09	104	50.7	10.7	6	40	14	30	5	14	109	16	70.15	40	154.59	18
Chhindwara	953	32.5	5.15	116	51.7	18.9	13	24	11	12	27	21	107	15	77.18	30	138.64	15
Seoni	974	31.1	4.27	118	50.8	13.9	9	31	13	14	10	25	102	12	84.97	10	119.45	12

Madhya Pradesh : Indicators with Ranks

Districts	Sex Ratio 1	Inst. deliv. 2	Fem. IMR 3	CPR4 4	TFR5 5	Fem. Liter. 6	Rank SR 7	Rank ID 8	Rank IMR 9	Rank CPR 10	Rank TFR 11	Rank FL 12	Comp. Score 13	Rank 14	IDI 15	Rank IDI 16	13/15* 100 17	Rank of 17 18
Balaghat	1002	38.9	3.92	147	49.5	12.3	3	35	15	7	2	42	103	13	88.31	6	116.63	11
Surguja	956	17.4	4.28	95	32.6	11.8	12	37	39	40	11	7	145	26	57.41	45	253.44	40
Bilaspur	978	27.3	4.71	91	35.1	13.4	7	32	35	23	17	6	119	19	73.59	35	162.39	22
Raigarh	1000	26.5	4.03	107	33.3	18.9	4	24	38	25	4	16	111	17	69.71	41	158.51	20
Rajnandgoan	1012	27.8	4.2	124	45	10.5	1	41	21	21	8	28	120	20	69.55	42	173.26	25
Durg	967	42.8	4.22	84	51.9	21.1	10	20	9	4	9	4	56	3	83.03	18	67.45	3
Raipur	993	31	4.33	122	42.5	11.7	5	39	26	15	12	27	123	22	79.03	26	156.27	19
Bastar	1002	15.3	4.49	86	36.3	11.8	3	37	33	43	13	5	133	24	58.06	44	226.34	4

Source: **1- 4** : Census of India 1997 " Fertility And Mortality Indicators At The District Level"

5- 6: RCH-RHS District Level Data : http://mohfw.nic.in/break2file2.htm, http://mohfw.nic.in/break2file3.htm
http://mohfw.nic.in/breakfile3.htm, http://mohfw.nic.in/breakfile3.htm#top

1: Female Sex Ratio, **2**: Female Literacy rate, **3**: Total Fertility Rate, **4**: Infant Mortality Rate (female), **5**: Couple Protection Rate, **6**: Institutional Deliveries, **7**:Rank of Sex Ratio, **8**: Rank of Institutional Deliveries, **9:** Rank of Couple Protection Rate, **11**: Rank of Total Fertility Rate, **12**: Rank of Infant Mortality Rate,**13**: Comprehensive Score of all the Indicator, **14:** The overall Ranking of the districts, **15:** CMIE Infrastructural Development Index(IDI), **16:** Rank of IDI, **17:** 13/15*100, **18:** Rank of 17

Maharashtra : Indicators with Ranks

Districts	Sex Ratio 1	Inst. deliv. 2	Fem. IMR 3	CPR4 4	TFR5 5	Fem. Liter. 6	Rank SR 7	Rank ID 8	Rank IMR 9	Rank CPR 10	Rank TFR 11	Rank FL 12	Comp. Score 13	Rank 14	IDI 15	Rank IDI 16	13/15*100 17	Rank of 17 18
Maharashtra	934	52.3	3.72	76	NA	NA	25.5	11	12	21	.	.	.	.	106.77	9	.	.
Kolhapur	961	53.1	2.94	47	65.4	73	7	10	1	6	5	4	33	1	110.01	6	30	1
Satara	1029	53.3	3.3	49	69.1	60	3	9	6	8	2	9.5	37	2	110.02	5	33.63	3
Sangli	958	49.9	2.95	31	63.3	69	9	17	2	1	8	6	42.5	3	110	7	38.64	4
Mumbai	818	75.9	3	35	63.2	93.1	31	1	3	2	9	1	47	4	142.17	2	33.06	2
Pune	933	59.8	3.21	44	65.7	75	27	7	4	5	3	3	49	5	106.08	10	46.19	6
Sindhudurg	1137	66.9	3.28	61	47.1	76	2	2	5	15	30	2	56	6	113.95	4	49.14	7
Ahmadnagar	949	46	3.81	42	64.6	60	14	20	15.5	4	6	9.5	69	7	97.69	13	70.63	8
Wardha	939	61	3.49	86	69.7	62.8	21.5	5	9	26	1	8	70.5	8	90.56	19	77.85	10
Ratnagiri	1205	51.6	3.66	62	58.3	51.7	1	13	11	16	16.5	15	72.5	9	88.28	22	82.13	12
Raigarh	1010	52.2	3.75	56	55.5	55	4	12	13	12	23.5	12	76.5	10	94.18	17	81.23	11
Thane	879	60.3	3.39	41	52.5	71	30	6	7	3	26	5	77	11	90.29	20	85.28	13
Nagpur	922	64.7	3.51	78	62.5	66	28.5	3	10	23.5	11	7	83	12	96.58	16	85.94	14
Solapur	934	41.7	3.48	60	63.1	57	25.5	22	8	14	10	11	90.5	13	216.49	1	41.8	5
Amravati	936	61.1	3.95	88	63.8	52.9	24	4	20	27	7	14	96	14	85.33	26	112.5	18
Bhandara	988	50.4	3.77	76	59.6	24.6	5	14	14	21	14	29	97	15	126.33	3	76.78	9
Nashik	940	49.9	4.14	55	56.5	54.5	19.5	17	22	11	20.5	13	102.5	17	101.54	12	100.95	16
Chandrapur	948	46.8	3.81	101	65.5	41	15	18	15.5	29	4	21	102.5	17	107.95	8	94.95	15
Jalgaon	940	50.3	3.89	70	62.1	42	19.5	15	19	19	12	19.5	104	18	102.83	11	101.14	17
Latur	942	39.7	4.32	50	60	40.7	18	23	24	9	13	22	109	19	87.78	24	124.17	19
Buldhana	953	46.1	4.47	68	55.3	43.9	11.5	19	26.5	18	25	18	118	20	75.61	30	156.06	26
Yavatmal	951	44.8	3.86	116	59.2	36	13	21	17	30	15	24	120	21	77.22	29	155.4	25
Bid	944	32.3	4.37	52	55.9	42	17	27	25	10	22	19.5	120.5	22	96.64	15	124.69	20
Dhule	958	39.1	4.22	78	58.3	31	9	26	23	23.5	16.5	26	124	24	89.64	21	138.33	21
Parbhani	953	29.4	4.54	48	55.5	32	11.5	29	28	7	23.5	25	124	24	77.33	28	160.35	27
Akola	939	53.3	4.59	96	56.5	49	21.5	9	30	28	20.5	16.5	125	25	86.54	25	144.44	23
Osmanabad	937	39.2	3.87	83	58.2	36.4	23	25	18	25	18	23	132	26	77.42	27	170.5	29
Gadchiroli	976	28.9	3.96	117	57.9	17	6	30	21	31	19	30	137	27	97.47	14	140.56	22
Aurangabad	922	39.6	4.62	58	49.9	49	28.5	24	31	13	29	16.5	142	28	73.86	31	192.26	30
Jalna	958	27.3	4.47	76	51.7	27.9	9	31	26.5	21	27	28	142.5	29	93.24	18	152.83	24
Nanded	945	31	4.58	66	51.4	30	16	28	29	17	28	27	145	30	88.06	23	164.66	28

Source: **1- 4** : Census of India 1997 " Fertility And Mortality Indicators At The District Level"

5- 6: RCH-RHS District Level Data : http://mohfw.nic.in/break2file2.htm, http://mohfw.nic.in/break2file3.htm, http://mohfw.nic.in/breakfile3.htm, http://mohfw.nic.in/break2file3.htm , http://mohfw.nic.in/break2file3.htm, http://mohfw.nic.in/breakfile3.htm#top

1: Female Sex Ratio, **2**: Female Literacy Rate, **3**: Total Fertility Rate, **4**: Infant Mortality Rate, **5**: Couple Protection Rate , **6**: Institutional Deliveries, **7**:Rank of Sex Ratio, **8**: Rank of Female Literacy Rate, **9**: Rank of Total Fertility Rate, **10**: Rank of Infant Mortality Rate, **11**: Rank of Couple Protection Rate, **12**: Rank of Institutional Deliveries, **13**: Comprehensive Score of all the Indicator, **14:** The overall Ranking of the districts, **15:** CMIE Infrastructural Development Index(IDI), **16:** Rank of IDI , **17:** 13/15*100, **18:** Rank of 17,**NA:** Not Available

Mizoram : Indicators with Ranks

Districts	Sex Ratio 1	Inst. deliv. 2	Fem. IMR 3	CPR4 4	TFR5 5	Fem. Liter. 6	Rank SR 7	Rank ID 8	Rank IMR 9	Rank CPR 10	Rank TFR 11	Rank FL 12	Comp. Score 13	Rank 14
Aizawl	927	85.5	5.04	58	42	69.3	1	1	2	1	2	2	9	1
Lunglie	910	72.6	4.76	54	50.2	50.7	3	2	1	2	1	1	10	2
Chhimtuipui	910	51.2	5.88	76	18.7	16.3	3	3	3	3	3	3	18	3

Source: **1- 4** : Census of India 1997 " Fertility And Mortality Indicators At The District Level"
5- 6: RCH-RHS District Level Data : http://mohfw.nic.in/break2file2.htm, http://mohfw.nic.in/break2file3.htm, http://mohfw.nic.in/breakfile3.htm, http://mohfw.nic.in/breakfile3.htm#top,

1: Female Sex Ratio, **2**: Female Literacy rate, **3**: Total Fertility Rate, **4**: Infant Mortality Rate (female), **5**: Couple Protection Rate, **6**: Institutional Deliveries, **7**:Rank of Sex Ratio, **8**: Rank of Institutional Deliveries, **9**: Rank of Female Infant Mortality Rate, **10**: Rank of Couple Protection Rate, **11**: Rank of Total Fertility Rate, **12**: Rank of Female Literacy Rate , **13**: Comprehensive Score of all the Indicator, **14:** The overall Ranking of the districts

Orissa : Indicators with Ranks

Districts	Sex Ratio 1	Inst. deliv. 2	Fem. IMR 3	CPR4 4	TFR5 5	Fem. Liter. 6	Rank SR 7	Rank ID 8	Rank IMR 9	Rank CPR 10	Rank TFR 11	Rank FL 12	Comp. Score 13	Rank 14	IDI 15	Rank IDI 16	13/15* 100 17	Rank of 17 18
Orissa	971	34.7	4.27	111	.	.	8	6	9	10	.	.	.	.	101.45	8	.	.
Sambalpur	966	33.6	4.21	101	40.2	29.2	10	7	5	8	9	5	43.5	7	115.39	2	37.7	6
Sundargarh	936	39.6	3.91	100	41.1	33.6	14	4	4	3	6	3	34	4	102.24	6	33.26	4
Kendujhar	974	30	4.15	78	44.6	19.1	7	8	1	6	4	7	33	3	93.51	12	35.29	5
Mayurbhanj	979	23.7	4.05	87	40.2	14.9	6	10	2	5	9	8	39.5	6	101.62	7	38.87	7
Baleshwar	967	44.6	4.96	112	39.9	14.7	9	3	10	13	10	9	54	12	95.22	10	56.71	11
Cuttack	962	50.4	4.27	109	63.7	40.6	11	1	8	10	1	1	31	1	108.79	3	28.5	1
Dhenkanal	948	37.3	4.35	113	44.3	31.3	12	5	11	12	5	4	49	9	105.37	5	46.5	8
Phulbani	995	20.3	5	114	25.2	12.3	3	12	12	14	13	11	65	13	82.39	13	78.89	13
Balangir	980	21.9	4.3	99	38.5	13.3	5	11	3	11	11	10	51	10	100.13	9	50.93	10
Kalahandi	1000	14.6	3.82	105	37.3	11.1	2	13	6	2	12	13	47.5	8	95	11	50	9
Koraput	994	13.1	4.18	109	40.4	11.1	4	14	8	7	7	13	52	11	71.86	14	72.36	12
Ganjam	1009	28.1	3.12	128	46.1	22.8	1	9	13	1	3	6	33	3	107.03	4	30.83	3
Puri	939	49.9	3.96	130	53.2	38.6	13	2	14	4	2	2	37	5	129.38	1	28.6	2

Source: **1- 4** : Census of India 1997 " Fertility And Mortality Indicators At The District Level"

5- 6 : RCH-RHS District Level Data :http://mohfw.nic.in/break2file2.htm, http://mohfw.nic.in/break2file3.htm, http://mohfw.nic.in/breakfile3.htm, http://mohfw.nic.in/breakfile3.htm#top

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Rajasthan : Indicators with Ranks

Districts	Sex Ratio 1	Inst. deliv. 2	Fem. IMR 3	CPR4 4	TFR5 5	Fem. Liter. 6	Rank SR 7	Rank ID 8	Rank IMR 9	Rank CPR 10	Rank TFR 11	Rank FL 12	Comp. Score 13	Rank 14	IDI 15	Rank IDI 16	13/15* 100 17	Rank of 17 18
Rajasthan	910	79	4.9	20.4	33.2	19.8									87.27			
Jhunjhunu	931	66	4.4	25.54	53.2	30	11	4	4	8	3	5	35	1	82.73	21	42.31	1
Jaipur	891	69	5.2	28.69	49	36.9	15	5	12	5	4	1	42	2	94.45	8	44.47	2
Sikar	946	51	4.9	19.88	41.5	27.4	7	2	9	12	7	7	44	3	84.47	20	52.09	5
Ganganagar	865	50	4.1	26.39	61.5	21.3	22	1	2	7	1	15	48	4	95.29	6	50.37	3
Kota	881	91	5	37.56	42.4	32.5	19	11	10	1	5	4	50	6	98.23	5	50.90	4
Hanumangarh	891	50	4.1	26.39	60.4	13.4	15	1	2	7	2	23	50	6	NA	NA	NA	NA
Ajmer	918	111	3.9	34.5	40	29.8	13	19	1	3	10	6	52	7	90.89	14	57.21	6
Bikaner	885	59	5.3	27.03	40.6	25	17	3	13	6	8	10	57	8	92.11	11	61.88	7
Baran	896	91	4.9	17.22	42.4	32.5	14	11	9	15	5	4	58	9	NA	NA	NA	NA
Banswara	969	80	4.7	13.42	32.5	32.9	3	7	7	27	21	3	68	10	84.86	19	80.13	11
Jodhpur	891	69	5.3	22.58	34.3	24.8	15	5	13	9	16	11	69	11	79.56	22	86.73	15
Jhalawar	918	88	4.5	16.18	41.8	21	13	10	5	20	6	16	70	12	87.99	16	79.55	10
Rajsamand	991	109	4.6	33.09	31.6	17	2	18	6	4	23	19	72	14	NA	NA	NA	NA
Bundi	889	96	4.8	16.13	38.2	34	16	13	8	21	12	2	72	14	107.96	1	66.69	8
Dungarpur	995	99	4.6	15.4	36.8	18.7	1	14	6	22	13	17	73	15	85.35	18	85.53	14
Udaipur	956	109	4.6	20.41	32.4	21.7	4	18	6	11	22	14	75	17	90.63	15	82.75	12
Chittorgarh	950	83	4.3	17.15	32.7	13.3	5	8	3	16	19	24	75	17	99.93	4	75.05	9
Churu	937	69	5.1	17.32	39.2	7	10	5	11	14	11	28	79	18	71.13	27	111.06	20
Alwar	880	103	4.9	22.54	40.4	15.9	20	16	9	10	9	21	85	19	92.50	10	91.89	16
Nagaur	942	71	4.8	13.29	35.1	16.6	9	6	8	28	15	20	86	20	78.74	23	109.22	19
Bhilwara	945	119	4.4	16.5	32.9	17.9	8	2121	4	19	18	18	2188	32	100.11	3	2185.60	27
Siroli	949	117	4.8	16.99	28.9	23.5	6	20	8	17	25	13	89	21	105.55	2	84.32	13
Pali	956	127	4.8	16.97	34.2	14.5	4	22	8	18	17	22	91	22	94.74	7	96.05	17
Dausa	884	69	5.1	14.15	32.4	24.7	18	5	11	26	22	12	94	NA	NA	NA	NA	NA
Dholpur	795	105	6.1	35.09	19.7	25.7	26	17	17	2	28	9	99	24	93.58	9	105.79	18
Bharatpur	832	95	5.7	19.6	30.3	21.7	24	12	16	13	24	14	103	25	91.63	13	112.41	21
Jonk	923	129	5.2	15.24	36	13.4	12	23	12	23	14	23	107	27	86.59	17	123.57	23
Jalore	942	96	5	7.75	32.6	11	9	13	10	30	20	25	107	27	91.83	12	116.52	22
S.Madhopur	869	102	5.6	14.64	25.6	26.5	21	15	15	25	26	8	110	28	77.14	24	142.60	24
Karoli	840	102	5.6	14.64	25.6	26.5	23	15	15	24	26	8	111	29	NA	NA	NA	NA
Jaisalmer	807	86	4.7	11.28	21.3	8.8	25	9	7	29	27	26	123	30	73.80	26	166.67	25
Barmer	891	102	5.5	7.68	17.7	7.9	15	15	14	31	29	27	131	31	75.47	25	173.58	26

Source: **1- 4** : Census of India 1997 " Fertility And Mortality Indicators At The District Level"
5- 6 : RCH-RHS District Level Data : http://mohfw.nic.in/break2file2.htm, http://mohfw.nic.in/break2file3.htm, http://mohfw.nic.in/breakfile3.htm, http://mohfw.nic.in/breakfile3.htm#top

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