

**ABORTION SERVICES IN INDIA
REPORT OF A MULTICENTRIC ENQUIRY**

**RAVI DUGGAL
SANDHYA BARGE**



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ABORTION ASSESSMENT PROJECT - INDIA

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ABORTION SERVICES IN INDIA A SITUATIONAL ANALYSIS

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 were 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 than 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.

CHAPTER 1

INTRODUCTION

The history of abortion worldwide is replete with challenges arising from the unpredictability of social and political regimes. In the west the influence of the Christian Church has largely determined the fate of abortion at different points of time. In non-Christian societies there is not much evidence to show that either the state or religious institutions played an active role in determining the fate of abortion. In Hindu society there is no ban on abortion, yet some stigma is attached. But the state or religious denominations in India, even under Islamic rule, left abortion to civil society and regarded it as a personal matter. It was only under British colonial rule and the influence of the medical fraternity that abortion was criminalised in India. Although there is no actual approval of abortion in the world of Islam, there is no strict, unanimous ban on it, either. The Hanafi school (predominant in Turkey, the Middle East and Central Asia) and the Shafi school (Southeast Asia, southern Arabia, parts of East Africa) allow abortions to take place principally until day 120; in aborting up to day 120, the woman commits a mere moral transgression, not a crime. For the Maliki school (prevalent in North Africa) and the Hanbali school (predominant in Saudi Arabia and United Arab Emirates) an abortion is permissible up to day 40. Some Shiite groups, such as the Ismailites, do not permit abortions to take place at all. In case of infringements of this law, abortions before day 40 are penalized with a monetary fee. Other Shiite groups such as the Zaydites allow abortions to be performed up to day 120, equating an abortion up to this point with contraception.¹

In the more recent past, with the emergence of modern medicine the legacy of Hippocrates (*I will not give to a woman a pessary to produce abortion*)² influenced the legal and professional position on abortion. And hence in most countries where modern medicine had made its inroads abortion was criminalized. The Christian Church, especially the Roman Catholic, was invariably a willing partner in maintaining a ban on abortion. When modern medicine was established in India this western understanding of abortion came with it. The setting up of the Indian Medical Service in 1763, which institutionalized modern medicine in India, used the Hippocratic oath to keep abortion out of medical practice and later in 1860 it was included in the Indian Penal Code (45 of 1860), which banned abortion, except to save the life of the woman. The latter was more or less a global phenomenon during the 19th and 20th centuries.

In India there is no historical evidence of abortion being illegal or criminalized until the 19th century under colonial rule. Some indirect references to Vedas indicate that it was allowed up to five months after which the foetus was considered viable. The code of Charaka does not mention anything on abortion, nor did religion or the state at any historical juncture take any position on abortion, notwithstanding Kautilya's *Arthashastra*, which specified severe punishment for aborting a slave woman.³ After Independence the Indian Medical Council's code of ethics of 1956 continued the colonial tradition (*I will maintain the utmost respect for human life from the time of conception*) and maintained a ban on abortion. However, the Indian state in its dogged pursuit of population control, saw an opportunity in legalizing abortion as a means to achieve its demographic goals. Of course, the committee set up to review abortion in India, the Shah Committee, used the logic of large scale unsafe abortions being done in unhygienic conditions by unqualified and untrained persons to recommend legalization of abortion. Historically that was also the time when women in many countries were

¹Christine Schirmachar: Abortion, Institute of Islamic Studies, www.islaminstitut.de/english/publications/abortion.htm

² OP Jaggi, Western Medicine in India – Social Impact, Atma Ram and Sons, 1980, Delhi

³ OP Jaggi, Indian System of Medicine, Atma ram and Sons, 1981, Delhi

demanding the right to abortion services as part of their health rights. In India 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 programme 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 among allopathic medical practitioners and that too obstetricians and gynecologists and others 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 service in India. The same *dais* who conducted childbirth were also invariably dealing with abortions, though in many places there were special local abortionists. The MTP Act dislodged them atleast legally from their profession, similar to what the putting out system and industrial revolution had done to the artisan/*jajmani* economy.

However, despite legal restrictions on performance of abortions, the overall political economy of abortion remained undisturbed because the state was uninterested in regulating abortions as per the MTP Act – their only objective was to provide a legal framework so that the abortion market would be governed by some guidelines. Surprisingly, the medical profession which was given a monopoly over abortion through the MTP Act did not show any interest or keenness to follow the rules because even in general medical practice the medical professionals had become quite used to operating without any regulations or minimum standards in their practice. Thus legalization of abortion and the lack of regulation sent out a signal that abortion was legal and anyone could enter the fray. It is contradictorily in the post 1972 period that the variety of abortion providers we see, especially the one we generally term as quacks, has increased substantially replacing the traditional providers like *dais* and other traditional providers. And post 1985 we see another boom of abortion providers because of the sex-determination and the associated sex-selective abortions. However, data and information on all this is not easily available and is mostly anecdotal or based on small-scale studies. Thus, the present study is a first step to comprehensively look at abortion and abortion services in India and hopes to fill this gap in information on abortion to some extent.

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 22 percent 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 percent of maternal mortality worldwide being due to unsafe abortions.⁴ Given this scenario the women's movement and health groups have taken up proactively various concerns related to abortion.

The global women's movement since the mid eighties has forced a debate on the abortion issue worldwide. The growing pressures from the Roman Catholic Church and pro-life groups as well as the US Government culminated in the infamous gag-rule abortion has become an international issue with a growing number of supporters for right to abortion. The first consolidation towards the right to abortion took place at the ICPD, Cairo, where women and health activists waged bitter battles with the Vatican and the US government. This process continued to the Beijing Women's Conference and many other related international consultations and conferences on reproductive rights, sexuality and women's health issues. While broadly, reproductive rights have received near universal acknowledgement, global multi-lateral forums have shown resistance on the specific issue of abortion due to a relatively strong

⁴ WHO: Safe Abortion – Technical and Policy Guidance for Health Systems, World Health Organization, 2003, Geneva

anti-abortion axis operating in these consultations. However, some minimal achievements have been secured, especially for countries where abortion is legal, with pressures on governments to assure access to safe abortions on one hand and improving access to family planning services on the other.⁵ Women's and health groups in India are since then increasingly involved in the reproductive rights and abortion issue.

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 stabilization 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 counseling and services; and
- The non-perception of abortion as a women's health issue among policy makers and service providers;

The government of India's decision in the post Cairo period (1996) to introduce a more comprehensive Reproductive and Child Health (RCH) programme in place of the vertical safe motherhood, child survival and family planning programme 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) highlighted 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 in 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 Programme. The first phase of the RCH programme is now coming to an end and plans for the next phase are being finalized. While the first phase of the RCH programme may have had part of limited achievements, the deeper and wider participation of stakeholder in its review and the next phase of planning shows a willingness on the policy makers 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 RCH programme 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 Act 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 for initiating debate on safe abortion among key stakeholders the 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 among different 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

⁵ UN: Report of ICPD – Cairo, United Nations, 1995, New York; UN: Report of the Fourth World Conference on Women – Beijing, United Nations, 1996, New York

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.

In the period preceding the Cairo conference an informal initiative led by individuals representing different stakeholders initiated a dialogue on target-free family planning programme. As a result, dialogue between a diverse group improved during and after the Cairo conference. The government's decision to go target-free and introduce an integrated RCH programme was partly a result of this dialogue. The pre-Cairo consultations not only provided a forum for dialogue but it also enabled women's health advocates create a non-confrontational forum for debate with the government. This initiative has made concerted efforts to sustain this dialogue, albeit on a low key. During this period there was a realization that creating and sustaining free and frank dialogue with the government and with donor agencies is a painstaking process where hard facts and reliable data is necessary. Small research studies highlighting qualitative issues pertaining to the implementation of the RCH programme have been extremely useful in bringing sensitive issues to the fore. Similarly, making abortion safe in India is going to be an uphill task. A time-bound programme starting from the collection of reliable information leading to dialogue between various stakeholders is needed to make policy makers acknowledge abortion as a public health issue. In this context the present study was planned in consultation with the government, donors and other civil society partners concerned with abortion as a women's rights issue.

Abortion Scenario In India

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 the 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 over six million abortions are performed each year by providers or in institutions that are not registered. And often these are untrained persons conducting abortions in unhygienic conditions.⁶ 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. Over three decades have elapsed since the MTP Act legalized abortion, but 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.⁷

Recent studies on abortion and related themes conducted in Maharashtra, Gujarat, Uttar Pradesh, Tamil Nadu, Rajasthan and West Bengal by various research organisations, highlighting different facets of the abortion issue suggest that the estimates of abortions that take place and the morbidity that follows needs to be looked into in much greater detail.

During a recent study undertaken by CEHAT, all health facilities in two districts of Maharashtra were systematically listed to define the universe from which the study sample was to be selected. It was

⁶Khan, M. E., Rajagopal, S., Barge S., and Kumar, N. (1998) "Situation analysis of Medical Termination of Pregnancy (MTP) services in Gujarat, Maharashtra, Tamil Nadu and Uttar Pradesh." Paper presented at International workshop on Abortion Facilities, Postabortion Care and Operations Research. 19-21 Jan. 1998.

⁷ Johnston, Heidi (2002) Abortion Practice In India – A Review of Literature, CEHAT – Healthwatch, Mumbai

found that there exist about four non-registered abortion care centres/providers for each registered one.⁸ This excludes indigenous and non-qualified abortion practitioners. Information on non-certified providers and quacks is not easily available in the country except a few references from small scale community based studies or facility surveys. The extent of involvement of these practitioners may vary from region to region. It is perhaps related to the development status of the region as it implies outreach of health care services, people's attitude towards modern health care services, their capacity to buy such services and their openness to the outside world. The BIMARU states, for instance, are different with regard to their health status profiles from the rest of the nation.⁹

Community based studies on reproductive health care utilisation patterns have indicated that women's health issues have often been of low priority within the household. Besides, abortion still remains a stigmatised act. Women have identified confidentiality as one of the major quality indicators with regard to abortion care services. A quick return to home after the abortion procedure, availability of abortion care which will not require more than one visit have been other priority indicators of quality of abortion care from women's perspective.¹⁰ Women's lack of access to or less control over family resources and her secondary status in the family add to the severity of the problem of women's access to health care services in general and abortion care in particular.

For improving women's access to safe and legal abortion efforts at two levels are required. One, to develop a mechanism to improve the implementation of the MTP Act for the benefit of women along with efforts to generate discussion to bring changes in the MTP Act so as to make it more friendly to women.¹¹ Second to work towards changing the socio-cultural fabric in such a way that more and more women are empowered to exercise not only their civil rights but also social rights. In that sense, legislative measures are a means to an end and not an end itself. The Abortion Assessment Project – India is thus a multi-dimensional effort at addressing this wide spectrum of issues related to abortion with a hope that the studies undertaken will leverage discussion, debate and a better understanding of the abortion scenario in the country and provide pointers for progress on this issue within the framework of reproductive rights.

Process Leading to Study

The present study has a very different trajectory in planning of research and hence in itself is a landmark in social science health research and specifically in abortion research in India. The process began in June 1998. The Indian Institute of Health Management Research, Jaipur (IIHMR) was given a planning grant by the Ford Foundation to prepare a detailed proposal in consultation with important stakeholders in India for undertaking research studies in abortion and preparing an advocacy strategy based on that.

The first consultation was organised in Jaipur in 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 changing societal norms and values that push women into making decisions to terminate pregnancy (unwanted, wanted and sex

⁸ S Bandewar and M Sumant, *Quality of Abortion Care - A Reality*, CEHAT, 2002, Pune

⁹ Preliminary data from the Abortion Assessment Project-India shows that for the country as a whole from amongst facilities having formally qualified providers 43% were registered, ranging from 96% in Mizoram to 46% in Kerala and a low of 20% in Orissa - AAP-India preliminary report, CEHAT- Healthwatch, 2003

¹⁰ Gupte, M., Bandewar, S., Pisal, H. (1999) "Women's perspectives on the quality of general and reproductive health care: Evidence from rural Maharashtra" in *Improving quality of care in India's Family Welfare programme: The challenge ahead*, ed. Michael Koenig and M E Khan. New York: The Population Council.

¹¹ The MTP Act was recently amended in Dec 2002 (64 of 2002) wherein implementation has been decentralised at the district level, punishment to the woman resorting to services of unregistered provider has been dropped and punishment restricted to the provider and owner of the facility, and medical abortion has been included.

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 facility; technology and related logistical and administrative issues would be one-sided. Weaving in a user’s perspective cannot be limited to exit interviews in abortion care facilities. 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 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). A number of meetings over a two year period consolidated the research agenda for this national initiative as under:

Overall Objectives of Abortion Assessment Project-India

- Review government policy towards abortion care, and policy / programme environment in the country —including family planning
- 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.
- Estimate rate of abortion, resultant morbidity and mortality; causes of spontaneous and reasons for induced abortion.
- Document cost and finance issues related to the above.
- Disseminate information on abortion issues widely and develop an advocacy strategy on issues of concern in the context of reproductive rights of women.

Study Components : A Five-pronged Approach

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, the national assessment study covered not only a wide geographic area but also captured 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 **(Component II)** – the contents of the present report.

- III. Eight qualitative studies on specific issues to compliment the multi-centric studies. These were done by researchers, grassroots groups and medical establishments and were not necessarily confined to the six states. **(Component III)**;
- IV. Community-based studies to estimate abortion rate and out-of-pocket expenditures 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 current phase, some significant initiatives in disseminating information and carrying out advocacy work through workshops, meetings and analytic literature both via academia and the popular media have been done during the current phase. **(Component V – the dissemination and advocacy component in the present phase is part of Component I)**.

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

The present study report is a compilation of the six multi-centric situational analyses of abortion facilities. It consists of eight chapters. The second chapter gives the detail methodology and study design used in the study. Policy and legislation related to the MTP Act is discussed in the third chapter. Details regarding the infrastructure available in the study abortion facilities are analyzed in Chapter IV. This is followed by the discussion of the available manpower and their training status related to abortion provision. The extent of utilization and accessibility of these abortion facilities is presented in Chapter VI. Technical skills of formal providers are discussed in Chapter VII. Findings from the informal providers are analysed in Chapter VIII.

CHAPTER 2

METHODOLOGY AND STUDY DESIGN

The overall aim of this study is to undertake a situational analysis of abortion care facilities in order to understand issues and concerns from the provider's perspective and how the situation can be improved for the abortion seekers so that they get access to good quality abortion services. The specific **objectives** of this study are as under.

To map, understand and analyse the following provider-related issues:

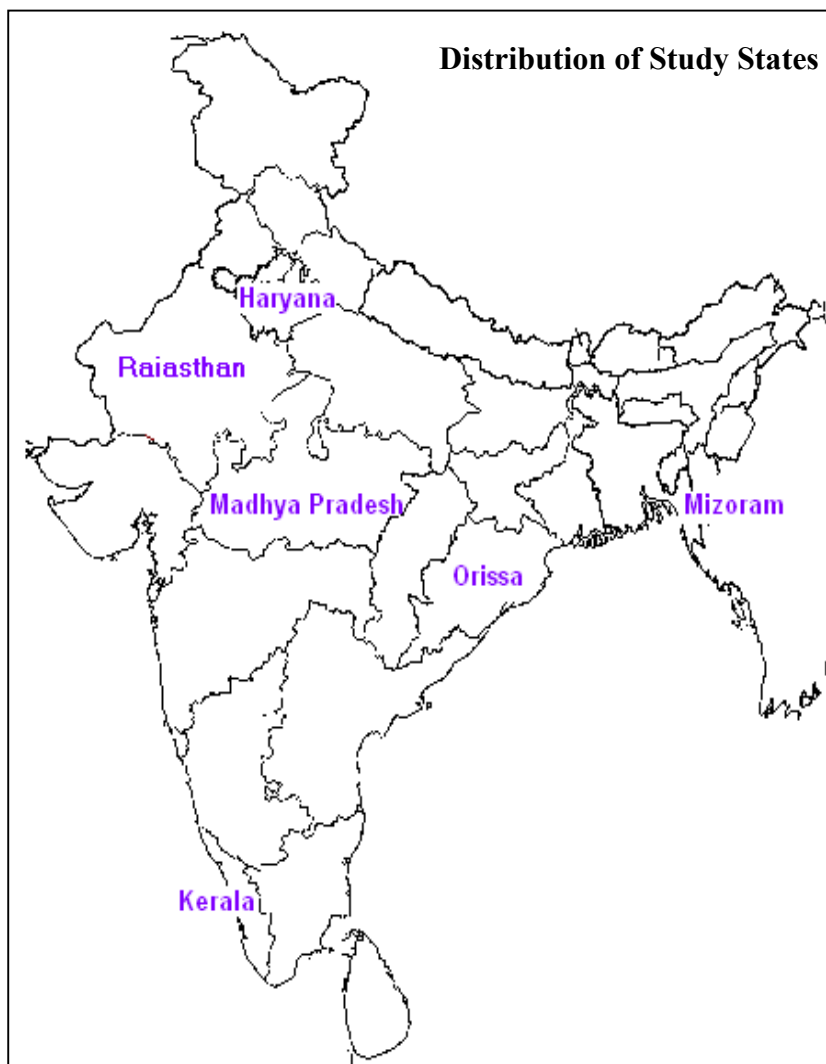
- management and organisation of abortion services (including management of complications and life threatening situations) in the public and private sectors;
- technologies used in the public and private sectors;
- registration, training and certification;
- availability, technical competence, training needs and current training facilities / programmes for abortion care providers in the public and private sectors;
- utilisation of facilities and factors responsible for poor utilisation of public sector services.
- adequacy / appropriateness of MTP Act in India from the providers' perspective;
- costing and finance related issues

This is a multi-centric study across six states in India covering facilities in the public and private sectors (providers in the formal sector¹²). The study has assessed physical standards and recorded information regarding service environment, quality, pre and post- abortion counselling. The study also looks at management of complications arising from abortions, methods used, gestation periods handled by providers, issues relating to registration, training, and costing. In the original proposal the study had also envisaged looking at client satisfaction through exit interviews and observation of client-provider interface but this was dropped due to ethical considerations, especially as a concern for the vulnerability of abortion seekers at that point of time. Provider interviews have been done to record the perceptions of service providers on avenues for continuing education / training, the constraints faced by them, barriers to registration / certification and the medical records maintained. The study takes a comparative look at public and private providers across better-developed and less developed regions of the country.

¹² Formal sector is defined as healthcare facilities where medically qualified practitioners, in any recognised system of medicine, provide abortion services. It excludes a large proportion of abortion providers but the latter are covered as a separate component of this study.

Selection of States

The states were ranked in ascending and descending order (as the case may be) on the basis of eight women's health indicators : sex ratio, percentage of institutional deliveries, maternal mortality ratio, neo-natal mortality rate, female infant mortality rate, couple protection rate, total fertility rate and female literacy rate. They were then clustered in four groups on the basis of their performance with regard to above indicators. They were next re-grouped region-wise (North, South, West, Central, East, North-east) so that each region is represented. The erstwhile Technical Advisory Committee made the selection of the states during the process of developing the proposal for this study. Since category four, representing the worst performing states, was the largest group it was decided



to select two states from this category. Also, since most of north-eastern states were in category one it was decided to select two states from this category also, and one state each from category two and three. With this in mind and giving representation to each of the six regions, as well as setting aside states that were already studied in recent years,¹³ the following selection was made:

Kerala – representing category one and south India, a good performing and reasonably well developed state, as well as a model for the rest of the country to emulate

Madhya Pradesh – representing category four and central India, a poorly performing state but with ongoing efforts at catching up quickly through innovative strategies

Haryana – representing category three and north India, economically developed but with lower than average performance on women and maternal and child health indicators

Mizoram – representing category one and north-east India, economically backward but good performance on maternal and child health indicators, quickly catching up with Kerala

¹³ COURT, CEHAT and KEM, Pune have done situational analysis studies of abortion facilities during the late nineties in Gujarat, Maharashtra, Tamil Nadu and Uttar Pradesh and hence these states were kept out of the selection process.

Rajasthan – representing category four and western India, poor performing state across the board despite innovative programs in the development sector

West Bengal – representing category two and east India, middle level development but a state where public services are collapsing rapidly (however this is replaced by **Orissa** (see below), a category four state from east India which is poor performing)

After the proposal was finalised in a discussion with officials of the Ministry of Health and Family Welfare it was decided to replace West Bengal with Orissa because the Ministry had already supported a study in West Bengal that was under completion. The eastern states did not have any category two states and hence between Bihar and Orissa the latter was preferred since Bihar was in the process of bifurcation.

Methodology and Tools

The development of the methodology and the protocols for the study was a collective exercise among the researchers, TAC members and a few experts invited to the methodology development workshops. Two workshops were organised to finalise the study methodology, design and sampling. This included an ethical review of the methodology. The major change in the methodology from the originally proposed one was the dropping of the exit interviews in the facilities. In the ethical review it was felt that women who have undergone abortion are extremely vulnerable and not in a frame of mind to respond to a questionnaire. Also the section on observation of doctor-client interaction was dropped because it violated the rights of both client and provider. The suggestion of a follow-up interview at a later date, with the women who underwent abortion was also not considered feasible because it would add to the cost and time of the study. In any case many of these issues were to be covered by other qualitative and household studies under this project.

Once the methodological framework was clear, research questions evolved and researchers were given the task of developing the draft protocols. The tools included an administrator schedule which would record the profile of the facility, abortion services provided, access factors, registration and reporting status, maintenance systems and views on the MTP Act; a provider schedule to record profile of the provider, training and skills, services provided, methods used, pre and post abortion services, referral and backup services, handling complications and other technical issues; a checklist to record physical access, physical standards, facilities, equipment, etc listing, supplies availability, universal precautions and waste disposal. These were discussed in another workshop of researchers and finalised and sent to the TAC and experts for a feedback. After receiving their comments and incorporating suggestions the protocols were sent to the ECG, which reviewed them and sent in its feedback. Subsequently two researchers were assigned the task of developing the final protocol and dummy tables and the instructional manual for investigators. These final protocols and instructional manual were to be adhered to strictly by all researchers and care was to be taken on translations and an independent review undertaken to assure that the translation was accurate.

Sample Design

1. **Selection of Districts:** As per the comprehensive proposal **two districts** in each of the selected states were selected. As per the discussions in August and December 2000 meetings of the Technical Advisory Committee and the researchers it was agreed that the districts would be selected as follows:
 - For each district the values of six variables – sex ratio, proportion of institutional deliveries, female IMR, female literacy, TFR and CPR - were identified and the districts ranked for each variable (highest value is 1st rank for sex ratio, institutional deliveries, literacy and CPR, and lowest value is 1st rank for IMR and TFR). The ranks were added up to arrive at a composite score for each district, and the district with the lowest score was ranked one and so on.
 - Once the districts were ranked, they were divided into four quartiles and one district each from the top and the bottom quartile was selected, excluding the top and the bottom ranked district. The district closest to the median rank of that quartile was selected.
 - In Orissa and MP many new districts and blocks have been created in the last few years and hence here the selection of districts was done on the basis of the old districts (as per 1991 census) as many of the newer districts did not have separate data as well as comparable health infrastructure in both the public and private domain.
 - Mizoram being a small state, all districts were included in the study.
2. **Selection of block/tehsil:** Since there is variation across states we define this unit (block or tehsil) as one with about 200,000 population. The blocks were selected on the basis of level of urbanisation. All the blocks in the district were divided into three groups, one group which is closest to the average urbanisation percentage of the district (perhaps one Block only), another group which is of blocks above the district urbanisation average and the third group of blocks below the average level of urbanisation. **Three blocks**, that is the average, one above the average and one below the average were selected. From the 'above average' *blocks* the district headquarter block was selected since the district hospital had to be included in the study and also because this partially resolved the problem of not having enough private providers in the sample in backward districts.
3. **Selection of study units:** The study units are providers of abortion services. Given the unregulated character of the private health sector and the existence of traditional and informal systems of providing care on one hand, and the role of the market forces in determining the location of abortion care facilities on the other hand, there is wide variation in location of these services across states, districts and blocks. It is clear that formal facilities concentrate in economically (read, market) developed areas and there is greater predominance of informal facilities in the economically backward areas.

Given the fact that our selection of states, districts and blocks covers this wide variation, there is every possibility that in some districts and blocks we may not have an adequate sample of private providers to study. Thus there was a strong suggestion that we make provision for study of informal providers also.

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 that 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.

Public Providers: In each block **all public providers** like PHCs, CHCs, PPCs, municipal and government hospitals and dispensaries were covered. In case the district headquarters block was not part of the sample, then the district hospital (civil hospital) was covered additionally. Also in each state one large hospital in a metropolitan city (teaching hospital) was to be covered since such hospitals account for a very large proportion of abortion cases.

Private Providers: Selection of private providers was a major area of debate, and given the wide variation of its character and lack of information on this sector, the decision about sample selection was not an easy one. While there was general consensus that in each selected block we would **select all the formal providers/institutions** which we are able to identify through the enumeration, there was apprehension that in some districts (the highly developed ones) we may end up with more than 100 private providers and in the less developed districts we may not get even 20. There was consensus that a minimum of 60 formal providers/institutions per district should be covered. Thus on an average 60 private providers/institutions would be covered in each district (we kept a range of 40-80). As per discussions amongst the researchers and the Secretariat in the April 2001 workshop it was anticipated that in many districts it may be difficult to reach the figure of 60 and hence it was decided to include atleast 5 informal/ traditional providers per block. For these providers a separate protocol was designed. (definition: informal/traditional provider means either informally trained providers like dais, traditional abortionists, herbalists, unqualified (in any system of formal medicine) medical practitioners, etc., or formally trained paramedics (not having training in abortion) like ANMs, MPWs, etc.) The reality is that we barely averaged 40 private providers per district (that too excluding Mizoram, which in the entire state had only three private providers) and hence in four states (excluding Mizoram and Kerala), where informal providers were available they more than made up for the paucity of formal private providers.

Sample Covered

Data collection in the study area was done in 2001-2002. A total of 380 facilities providing abortion services were surveyed. It comprised of 94 public facilities and 286 private facilities. The distribution of these facilities varied across the states (table 2.1).

Study Methodology and Protocols

All the states used the **standardized and common methodology and protocols** for data collection, which was collaboratively developed by the researchers and the TAC. Also the training of investigators was done using a common guideline and **instruction manual**.

The survey method using structured protocols along with observation checklists was used to collect the data as per the objectives of this multi-centric study. Three sets of protocols were designed with the help of researchers, consultants and TAC members of the project. One protocol was addressed to the **head of the institution** being studied (the head need not be a provider). It sought information on the facility, the services provided, the management of the institution, its registration and certification and

utilisation profile. The second protocol was canvassed with all **providers** of abortion services in that institution (there were more than one provider per institution). This addressed questions related to skills, qualifications, training, competence, technologies and techniques used, clinical and counselling practices etc. The third protocol was the **observation checklist** that recorded the physical infrastructure, equipment, facilities and amenities, environmental conditions etc. (Annexure I).

In addition to the above standardized methodology and tools individual researchers were free to add a small additional component that they felt would add strength to their study in the local context. This additional component would not be part of the multi-centric analysis and would be restricted to the local state analysis. However, the researchers were to take care that this additional component would not adversely affect the conduct of the multi-centric study.

Process of Conduct of Study

Once the common protocols were finalised all researchers were brought together (except those from Mizoram where the research institution was identified much later) in an orientation workshop where the protocols and their use were thoroughly discussed. Special attention was devoted to addressing ethical concerns, especially informed consent. For informed consent too a common format was prepared. The researchers were also exposed to ethical guidelines which a national committee coordinated by CEHAT had prepared.

Except one institution (Achutha Menon Centre for Health Sciences Kerala, for bio-medical research), no other institution had ever had an ethics committee. So the institutions had to be given guidance to form either institutional or project ethics committees so that ethical reviews could take place. A few TAC and ECG members and other resource persons supported by the project secretariat and provided technical and ethical review support to individual research teams through training and consultation inputs. The secretariat staff along with some TAC members helped monitor progress of individual research teams.

While data collection was on, the TAC constituted a sub-committee of experts to guide in the finalisation of the tabulation and analysis plan. This sub-committee along with some of the researchers finalised this in a workshop. Once most teams had finished their data collection a workshop was organised to review the progress and get a feel of what findings were emerging.

Data collection was over a six to nine month period. While four teams completed data collection in 2002 itself, two teams could do so only by early and mid 2003 because of unavoidable delays. In July 2002 a mid-term review of the projects, where interim findings were discussed as well as an ethical review undertaken, was done. This was also used as an opportunity for researchers to share their experiences with each other and discuss the finalisation of their analysis and draft reports. After the remaining two states completed their data collection and were ready with interim findings we organised a national consultation where the draft reports were presented by the researchers. This was a peer review workshop where experts had been invited to form panels for each state study. Apart from this an independent peer review exercise was undertaken by sending out each state report to two to three experts to review them and give their feed back, comments and suggestions. Subsequently researchers were asked to finalise their reports.

While state reports were under finalisation the secretariat took up the task of putting together the data of all the states to prepare the national overview report (the present report). This was done with the assistance of one of the research teams.

This overview report is a result of an independent analysis of the data from the six states. It is based on pooled data from the six states, which was reorganised to place the selected districts in the national context rather than as representative of the state. That is, the designation of districts as better or less developed was based on the national average rather than the state average, as was the case with the state level studies. For this purpose the total score of six indicators used was arranged in a descending order. All the districts falling above the median value were considered as the better developed districts, while those falling below the less developed district. This obviously changed the designation of a couple of the districts as used in the respective states. Thus the less developed district

of Kerala became better developed and the better-developed district of Rajasthan became less developed. The analysis in this report was done by pooling the data for all the districts together as a national sample and not state-wise. Separate state reports are available. However, in the annexure certain key variables, state-wise, have been appended to this report (Annexure II).

Table 2.1: Distribution of public and private facilities covered in the study area

State/District	Block	Facilities				All
		Public	Private		Total	
			Certified	Not certified		
Haryana¹		8	9	39	48	56
Jind	Jind	1	4	8	12	13
	Safidon	1	2	1	3	4
	Uchana	-	-	1	1	1
Yamunanagar	Jagadhari	6	3	24	27	33
	Chhachhrauli	-	-	4	4	4
	Sadaura	-	-	1	1	1
Kerala²		15	24	46	70	85
Kollam	Kollam	6	10	8	18	24
	Pathanapuram	1	10	3	13	14
	Karunagpally	5	3	3	6	11
Malappuram	Ponnani	1	-	6	6	7
	Perinthalmanna	1	1	5	6	7
	Tirur	1	-	21	21	22
Madhya Pradesh³		11	11	39	50	61
Ujjain	Ujjain	2	7	8	15	17
	Kacharod	3	2	6	8	11
	Tarana	1	-	2	2	3
Sidhi	Sidhi	1	1	6	7	8
	Rampur Neikin	1	-	4	4	5
	Waldhan	3	1	13	14	17
Mizoram⁴		23	1	1	2	25
Aizwal	Aizwal	5	1	1	2	7
	Champhai	4	-	-	-	4
	Serchip	3	-	-	-	3
	Kolasib	2	-	-	-	2
	Mamit	3	-	-	-	3
Lunglei	Lunglei	4	-	-	-	4
Chhimituipui	Saitha	1	-	-	-	1
	Lawngtai	1	-	-	-	1
Orissa⁵		15	3	74	77	92
Mayurbhanj	Baripada	3	1	18	19	22
	Udala	2	-	3	3	5
	Sirsa	1	-	1	1	2
Sambalpur	Dhankauda	4	2	39	41	45
	Jujomara	2	-	4	4	6
	Kuchinda	3	-	9	9	12
Rajasthan⁶		22	20	19	39	61
Jalore	Jalore	3	-	3	3	6
	Raniwara	3	-	1	1	4
	Sanchore	8	-	2	2	10
Kota	Ramganj Mandi	2	-	2	2	4
	Ittiwa	1	-	-	-	1
	Kota	5	20	11	31	36
Total		94	68	218	286	380

Study undertaken by:

1. **Society for Operations Research and Training (SORT), Vadodara .**
2. **Achutha Menon Centre for Health Sciences Studies (ACHMSS), Trivandrum.**
3. **Centre for Health and Social Sector Studies (CHSSS), Secundrabad.**
4. **Omeo Kumar Das Institute of Social Change and Development, Guwahati.**
5. **Child in Need Institute (CINI), Calcutta.**
6. **Action and Research for Training in Health (ARTH), Udaipur.**

CHAPTER 3

POLICY AND LEGAL ISSUES

Abortion has been a contentious issue worldwide and continues to be so even in the present times despite many countries having fairly liberal policies governing abortion and abortion care services.

As we have seen earlier while the MTP Act, 1971 came as a boon for women's health and healthcare, the state has failed to implement effectively the provisions of the act. At one level the state has not invested adequately to make available to women safe abortion services in adequate numbers, and at another level its bureaucracy has made things difficult for the private sector to come forward and register under the act to provide legal and safe abortion services.

But for this one cannot hold only the state and its agencies responsible. The medical profession and its associations too have failed miserably on this front. Lack of ethics in medical practice and absence of any standards for quality care is a prominent feature of private health services in India. The profession has done very little to set it right. Thus the unconcern of the medical profession and a policy of neglect by the state have together created a situation wherein an adverse political economy of abortion has got established. This political economy of abortion is characterised by a wild growth of abortion providers who often may not be qualified and/or trained, and who operate unregulated and thus are often a hazard to women's health and well being. The latter is reflected in the fact that 15% to 20% of maternal deaths over the last couple of decades have been due to unsafe abortions in India.

This policy of neglect and poor legal enforcement and regulation has created a scenario where abortion services of various kinds are being provided by all and sundry. From the traditional *dais* (who are losing out in the same way as in the case of childbirth) to outright unqualified and untrained people, paramedics (untrained for abortion), untrained (for abortion) medical professionals, and the certified abortion providers and gynecologists, is a wide range of practitioners who provide abortion services to women. Not all of them provide safe abortions and only a few of them are certified. Thus the MTP Act, which decriminalized abortion and opened up legal avenues for obtaining abortion services, did not change the abortion situation substantially as was expected. True, abortion became legal for a variety of reasons; but the ground reality remained the same continuum from the pre-1971 era.

In this chapter we will discuss three important concerns related to policy and legal issues impinging abortion services— certification or registration, reporting requirements and consent related issues – based on the findings of the present study of abortion facilities.

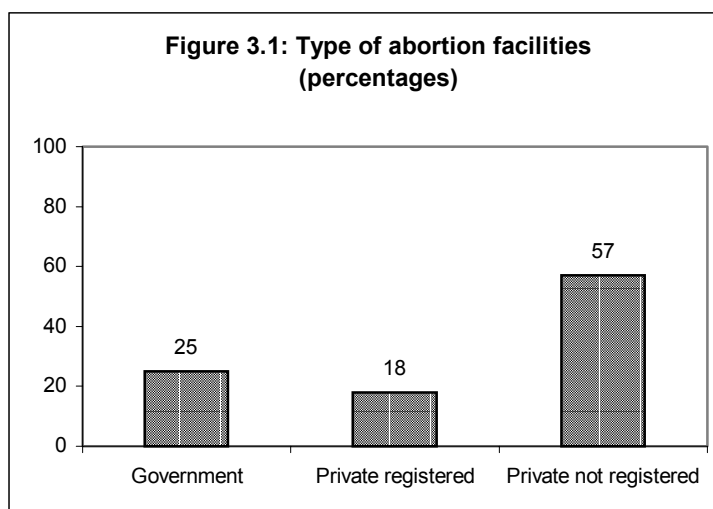
Certification/Registration

As per the MTP Act (34 of 1971) only registered medical practitioners as defined in clause (h) of section 2 of the Indian Medical Council Act (102 of 1956) are eligible to be certified under this Act as defined by Rule 3 of the MTP Rules 1975. Further, as per section 4 of the MTP Act the place where pregnancy may be terminated also needs to be certified. Section 4 of the Act states that the place should be either:

- (1) A hospital established or maintained by the government ; or
- (2) A place for the time being approved for the purpose of this Act by the government

Rule 4 of the MTP Rules 1975 defines the process of approval of the place, Rule 5 about the inspection of the approved place and Rule 6 how the certificate of approval may be cancelled or suspended.

In the present study across the six states 380 formal abortion facilities were studied. Of these 75 percent were in the private sector (including 7 percent charitable institutions) and 25 percent were government facilities (Table 3.1). As per the MTP Act government facilities are automatically certified but the private facilities have to seek registration as laid down in the Act and its Rules (Figure 3.1).



Of the private facilities, covered in the present study, only 24 percent were registered under the MTP Act. Of these 57 percent were located in the better-developed districts. In better-developed districts 21 percent of facilities were registered in contrast to 28 percent in less developed districts. One would have expected the better developed districts to have a larger proportion of certified clinics but one does not see this perhaps due to the character of the abortion economy. In fact, a study in Maharashtra¹⁴ also found that the better-developed regions had a smaller proportion of certified facilities in comparison with less-developed regions. Even among the unregistered private abortion facilities as many as 66 percent were in better-developed districts and 34 percent in less developed districts (Table 3.1). From the data it can be said that on an average there are four abortion facilities per 100,000 population in India, thus at the country level this adds up to 40,000 facilities.

The unregistered facilities are also those where the uncertified and/or unqualified practitioners are likely to be providing abortion services. Thus only 62 percent and 40 percent of providers working in unregistered facilities in better and less developed districts, respectively, were certified in contrast to 98 percent and 94 percent, respectively, for registered facilities. In the case of public facilities in the better-developed districts 97 percent providers were certified but in the less developed districts only 71 percent providers were certified. Across all facilities there were 322 certified providers (71 percent) from amongst 452 total providers in the study¹⁵. Within the public facilities there were 128 providers of which 110 or 86 percent were certified abortion providers. In contrast in the private facilities out of the 324 providers only 212 or 65 percent were certified, but only 39 percent of them being located in the registered facilities (table 3.1).

¹⁴S Bandewar and M Sumant, Quality of Abortion Care - A Reality, CEHAT, 2002, Pune

¹⁵ The total abortion providers identified in the study were 577 of which 162 were in public facilities and 415 in private facilities but only 452 of the total were available for interview.

Table 3.1: Public and Private Abortion Facilities and Abortion Providers by Registration Status across Better and Less Developed Districts

Better Developed Districts				Less Developed Districts				Better Developed	Less Developed
Total Public	Private		Total Pvt.	Total Public	Private		Total Pvt.	Public + Private	Public + private
	Regd	Not Regd			Regd	Not Regd			
All Abortion Facilities*									
57	39	144	183	37	29	74	103	240	140
Abortion Providers in above Facilities – percent certified in parentheses									
73 (97)	50 (98)	159 (62)	209 (70)	55 (71)	35 (94)	80 (40)	115 (57)	282 (77)	170 (61)

*All public facilities considered registered under the MTP Act.

The data on certification of abortion facilities and providers clearly indicates that while 75 percent of abortion facilities are in the private sector less than one-fourth of them are registered under the MTP Act. In contrast nearly two-thirds of private abortion providers¹⁶ both in registered and unregistered facilities have the requisite training and are certified to provide abortion services. This then means that in many unregistered facilities a large proportion of abortions are undertaken by certified providers; perhaps indicative of the fact that at least in the formal sector most abortions are likely to be safe. This conclusion is supported with evidence from a subsequent chapter, which shows that even in unregistered facilities the infrastructure and equipment availability is reasonably good.

Then what are the reasons why private facilities do not seek certification? Table 3.2a and 3.2b present the problems cited by respondents regarding the registration process. In Table 3.2a we see that from amongst those who have registered facilities 73 percent said that they did not encounter any problems, though there was significant variation between the better and less developed districts indicating that the MTP authorities in the better developed districts are more efficient as the mean days needed for registration was only 16 days (range 1 – 30 days). In the less developed districts the abortion facilities encountered substantive problems, mostly bureaucratic delays, and hence the average days for completing registration formalities was nearly three times that of better developed districts with the range going up to two years. Part of the delay is explained by revisions needed in the application, which was also about three times more in less developed districts. Overall the response of the authorities seems to be reasonable, with perhaps some exceptions in the less developed districts of the country, which is expected because of the underdeveloped communication and infrastructure in such districts.

¹⁶ Abortion providers included in this study are those formally qualified in any system of medicine recognized by respective medical councils. Thus paramedics, unqualified persons, dais and other traditional providers whose numbers are quite large have been excluded here. The latter providers are covered in a separate section of this study.

Table 3.2a: Problems encountered in the Registration Process across Better and Less Developed Districts(Percentage)

Types of Problems*	Better Developed	Less Developed	All Districts
No problem	92	48	73
Bureaucratic procedures	3	49	25
Information gap	3	7	5
Incomplete paper work	0	7	3
Bribes demanded	5	3	4
Mean days for registration	16	46	29
Range in days	1 - 30	1 - 730	1 - 730
Mean times application revised	0.6	1.7	1.1
Range number of times	0 - 2	0 - 7	0 - 7

*Multiple responses possible hence percentages will not add up to 100

From amongst those who did not register (218 facilities) 68 percent of the facilities said that they had never tried to do so, the remaining having tried, are either in process of obtaining registration or have given up. This proportion was surprisingly higher in the better-developed districts despite the above observation that authorities in the better-developed districts have been reasonably efficient in handling MTP certification applications. Table 3.2b explores the reasons for failure to register both for those who never tried to obtain a registration as well as those who tried and have failed to secure registration as yet.

Table 3.2b: Reasons for not Registering Private Facilities across Better and Less Developed Districts (Percentages)

Reasons for Not Registering	Better Developed	Less Developed	All Districts
Never tried for Registration*	73	58	68
Lack of knowledge	11	5	7
Lack facilities	17	12	15
Not necessary to register	16	21	18
Bureaucratic procedures	1	12	4
Not trained	12	0	9
Against religion	1	12	9
Other & not mentioned	42	38	38
Tried but Failed*	18	22	19
Under process	31	13	24
No response as yet	27	56	38
Bureaucratic procedures	15	19	17
Lack of facilities	8	6	7
Other & not mentioned	19	6	14

*The figures do not add up to 100 because 9% and 20%, respectively, in better and less developed districts did not respond to this question

The positive dimension of the data in Table 3.2b is that for those who tried to secure registration most applications are in process and the actual rejections are very few. But as mentioned earlier this category is the smaller number. The large number of those who never tried to seek registration is worrisome because the reasons mentioned appear to be frivolous, based more on myths floating around amongst the medical profession than on real experiences. The real reason perhaps is avoiding the responsibility of being accountable in any way!

We also asked respondents for their suggestions for improvement in the registration process. Unexpectedly 79 percent in better-developed districts and 45 percent in less developed districts said they had no suggestions to offer. Amongst the few who gave suggestions they mainly pertained to decentralization of process at district level and simplification of the process, reduction of delays by

making the process time bound, in addition to unrelated suggestions like training programme should be conducted, the untrained MTP providers should be punished, etc. It must be noted here that recent amendments to the MTP Act have indeed decentralised the registration process and made it time-bound.

The above analysis leads us to conclude that the registration environment is not as bad as the anecdotal evidence that the medical profession, including FOGSI, projects. Given the constraints under which the government departments functions the outcomes do not seem to be bad at all. If the medical profession shows some concern and liaisons with the authorities on a regular basis at one level, but more importantly educates its own fraternity about the importance of registration and regulation for the sake of quality of care the situation would improve substantially.

Reporting Requirements

The MTP Act requires that all abortions undertaken have to be reported as per the rules in a specified format (Form II under Regulation 4(5)). The reporting has to be done on a monthly basis to the chief medical officer of the state. The information to be reported includes duration of pregnancy in two categories, up to 12 weeks and 12-20 weeks, religion of the woman, whether IUD or sterilization was done with the MTP, and reasons for termination under six heads, namely, danger to life of pregnant woman, grave injury to the physical health of the pregnant woman, grave injury to the mental health of the pregnant woman, pregnancy caused by rape, substantial risk that if the child was born it would suffer from such physical or mental abnormalities as to be seriously handicapped and failure of any contraceptive device or method. Apart from this the consent form signed by the woman and any certified medical opinion (for pregnancies over 12 weeks) has also to be sent to the CMO periodically. Apart from this the facility has to maintain an admission register, which is a confidential document and these records have to be maintained for a minimum of 5 years.

In the present study 91 percent of public facilities in better-developed districts and 81 percent in less developed districts said that they reported all cases. In case of the private sector the figures were 59 percent and 76 percent, respectively, from amongst the registered facilities – the unregistered facilities naturally did not do any reporting. Most of the rest did not report. A majority of the facilities did the reporting on a monthly basis (Table 3.3).

Table 3.3: Patterns of Reporting of MTP cases across Better and Less Developed Districts

Reporting Patterns	(Percentage)				
	Better Developed Districts		Less Developed Districts		All Districts
	Public	Private*	Public	Private*	All
Report all cases	91	59	81	76	78
Report some cases	4	3	3	7	4
Do not report	5	38	16	17	18
Periodicity					
Monthly reporting	84	59	62	45	66
Annual reporting	4	0	8	17	6
Other	7	3	14	21	10
Do not report	5	38	16	17	18

* Only registered facilities

Overall the registered facilities not reporting any abortions were 18 percent; in the private sector 28 percent and public sector 9 percent. Of all facilities not reporting 68 percent were from the private sector. From those who did not report, 50 percent did not mention any reason. The only substantive reason was “authorities never asked”. This reason was given by one-third of those who did not report.

The above analysis reveals that reporting patterns are inadequate, especially in the private sector and hence the data reported by Department of Family Welfare in its Yearbook as registered MTPs is in itself a gross undercount given the fact only 78 percent of registered facilities report all cases.

Hence reporting of data is a serious concern that needs to be addressed by both the health authorities as well as the professional community. An improvement in reporting patterns will be beneficial towards the cause of advocating right to abortion and demanding better access for abortion services.

CONSENT

Taking consent of the woman alone or a guardian in case of minor or mentally ill person is mandatory and must be recorded in Form C as provided under Rule 9 of the MTP Rules. This form records the name, age, address of the abortion seeker and the identity of the facility where the abortion is done along with the signature and date. Almost all registered facilities were recording consent either written or verbal. Amongst non-registered facilities more than one-fifth were not taking consent for undertaking abortion. The private registered facilities used only written consent, whereas 12 percent of the public facilities and 14 percent of unregistered facilities also used verbal consent. There was no significant variation across better and less developed districts in patterns of recording consent.

Further, 79 percent of all facilities were recording consent of the woman herself but more than half also insisted on the husband's consent or consent of some other relative. The usual consent was a combination of the woman and some relative.

Table 3.4: Consent Pattern across Better and Less Developed Districts

(Percentages)

Consent Pattern	Better Developed Districts		Less Developed Districts		Public	Private Reg.	Private Not Reg.	All Districts
	Public	Private*	Public	Private*				
Type of consent								
Written	79	95 (62)	92	97 (54)	84	96	59	72
Oral	18	0 (15)	3	0 (11)	12	-	14	11
No consent/not mentioned	3	5 (23)	5	3 (35)	4	4	27	17
Person from whom consent taken#								
Woman herself	93	92(71)	97	97 (61)	95	94	67	79
Her husband	58	72 (61)	32	66 (38)	48	69	53	55
Relatives/accompanying persons	23	62 (37)	62	68 (59)	38	65	45	47
No consent	3	5 (23)	5	3 (22)	4	3	22	14

* Percent unregistered facilities in parentheses; # Multiple responses possible hence percentages will not add up to 100

While the law demands only the consent of the woman, there is adequate evidence above that facilities are insisting on consent of another family member. Part of the latter would be for the use of anesthesia like in any other surgery. However, this aspect was not probed in this study, but many other studies have shown that the reasons doctors insist on husband or relative's signature, especially in rural and semi-urban settings, is the fear that the husband or relative might come later and create trouble. Such practice apart from contravening provisions of the MTP Act (section 3 (4) (b)), which states that "Save as otherwise provided in clause (a) (that is consent of guardian for minor or mentally ill person), no pregnancy shall be terminated except with the consent of the pregnant woman", also violates the woman's privacy and confidentiality. It is hence also unethical. Policy makers and professional associations need to address this issue to protect the rights and dignity of women.

CHAPTER IV

INFRASTRUCTURE FOR ABORTION SERVICES

To ensure the provision of safe abortion services, it is imperative to have the requisite infrastructure and equipment in place. The presence or absence of these could be an impediment to quality of services rendered to the clients. This chapter discusses the findings of the survey on the availability of infrastructure facilities and the basic equipments required to perform MTPs in the clinic. Information from 380 surveyed facilities was collected using a standard checklist. The checklist contained items related to space availability in the facility, type and condition of the recovery facility, condition of the procedure room, situation of equipments and drugs related to MTP, and sterilization procedures available in the clinic. However, this checklist could be administered in only 338 facilities, hence discussion will be restricted to these facilities. In addition to this tool certain issues related to the facility was explored through a structured questionnaire that was administered to the head of administration. Some of the data presented here are also from this questionnaire.

Physical Infrastructure

Analysis of the data on physical comfort available to the client and the condition of the procedure room is presented in Table 4.1. Almost 90 percent of the facilities have a waiting area with seating arrangement for the clients; almost all of these are sheltered and protected from rain/sun. The majority of facilities have basic amenities, like toilet with water supply (89 percent), which mostly appeared to be clean (81 percent). Visual and auditory privacy to the clients during their consultation with the provider to some extent determines the clients' choice of the clinic. More than three-fourths of the facilities had visual privacy (78 percent) as well as auditory privacy (81 percent). In 76 percent of the facilities care is taken to maintain the clients privacy in the recovery room. Eighty-nine percent of the facilities have bed facility for clients in the recovery room. Indoor ward served as the recovery room in around two-thirds of all facilities. Analysis of the availability of these physical facilities by type of facility shows that these were available in almost all private registered facilities. Even private unregistered facilities fared better in terms of availability of the said physical facilities than those in the public sector. Analysis of the same data by the location of the facility in better or less developed districts indicates that there is no significant difference in the availability of these physical amenities in the two types of districts. While the private registered facilities are relatively better off in availability of all amenities, the condition of the public facilities is same irrespective of its location, however to some extent the condition of the private unregistered facilities is poorer in the less developed districts than their counterparts located in the developed districts.

The operation theatre (OT) (45 percent), followed by the labour room (32 percent) is the room predominantly used for conducting the MTP procedure. A separate Gynaec/MTP OT is used in 17 percent of the facilities. The pattern of usage of the different rooms for conducting MTP procedure is almost similar in the registered and unregistered private facilities, whereas in the public facilities, the operation theatre and labour room are utilised almost equally. Further, the condition of these rooms in terms of cleanliness - being dust free with a clean floor - is observed in all the private registered facilities and 92 -94 percent of the unregistered private facilities. Compared with this, only 69 percent and 74 percent public facilities respectively have a room which is dust free and with a clean floor. Source of light in the procedure room is predominantly tube light/ bulb (86 percent) in all types of facilities. Alternative source of light in the procedure room is available more in private facilities as 61 percent and 46 percent of them have adjustable focus lamp and shadow less OT lamp. In almost eight

out of 10 facilities running water is available in the procedure room, while in the remaining facilities water is stored. Electricity connection is found to be in working condition in almost all the facilities. Telephone facility is found to be in working condition in 85 percent of the facilities, but only 70 percent of the public facilities compared with 99 percent private registered and 87 percent private unregistered facilities had telephone in working condition. It is not surprising to note that communication materials are available more in the government facilities (49 percent) than in private facilities (20 percent).

Table 4.1: Number of facilities with available physical facilities (Percentage)

Amenities in the facility	Type of facility				Type of district		All
	Public	Private			Better develop -ped	Less develop -ped	
		Registered	Not Registered	Total			
Client privacy and comfort							
Waiting area with seating arrangement present	79	100	92	94	91	90	90
Waiting area is sheltered/protected from rain or sun	79	100	88	92	90	85	88
Toilets have water facility	82	100	88	92	92	83	89
Toilets appear clean	58	100	85	89	85	73	81
Visual privacy in consulting room	68	96	77	82	78	79	78
Auditory privacy in consulting room	72	96	79	84	83	77	81
Arrangement for privacy in recovery room	64	91	77	81	83	65	76
Beds available in recovery room for MTP client	84	100	87	91	86	93	89
Clinical/ Technical							
Room used for MTPs*							
Operation theatre	46	58	41	45	44	46	45
Gynaec/MTP OT	19	28	12	16	18	13	17
Labour room	54	28	24	25	34	28	32
Procedure room	4	5	13	11	4	19	10
OPD	1	5	2	3	3	2	2
Not mentioned	-	3	14	11	9	8	8
Number of provider (one for each facility)	91	67	210	277	234	134	368
Condition of procedure room							
Room dust free	69	100	92	94	91	81	87
Floor is clean	74	100	94	96	94	82	90
Operation table in good condition	90	100	93	95	96	90	94
Recovery room							
Indoor ward	63	67	62	63	60	69	63
Other room	30	33	34	34	34	31	33
Not mentioned	7	-	4	3	6	1	4
Additional sources of light in procedure room*							
Bulb/ tube light	87	88	86	86	83	92	86
Adjustable focus lamp	37	70	58	61	55	54	55
Shadow less OT lamp	35	63	40	46	38	52	43
Torch	23	33	29	30	20	42	28
Water supply in procedure room*							
Running water available	72	90	84	86	79	88	82
Stored water available	30	10	15	14	21	11	18
Electricity and Telephone							
Electric connections in working condition	95	99	98	98	98	96	97
Telephone facility present	70	99	87	90	89	77	85
Communication material	49	30	16	20	27	28	28
Number of facilities	92	67	179	246	214	124	338

* Multiple responses possible

Instruments and Equipment

A check list of the basic instruments required for conducting abortion procedures using different techniques was administered in the facilities. Analysis of the same indicates that Sim's/Cusco's speculum, Tenaculum/ Volsellum, vaginal wall retractor, ovum forceps, uterine curette and dilator sets are available in more than 90 percent of the facilities, while, the MVA cannulae (of at least 3 different sizes) and electric suction machine are found in 80 percent and 76 percent of the facilities respectively. MVA syringe and adapters for the syringe are available in lesser number of facilities (around 58 percent). Only 48 percent of the facilities located in less developed districts have these instruments as against 65 percent of the facilities in better developed districts. On the basis of the information on the availability of instruments collected using the checklist, a minimum set of instruments required to conduct different abortion procedures, like MVA/ EVA and D&C was identified and analysed. The analysis shows that the percentage of facilities having a complete set of D&C instruments is highest (85 percent), followed by EVA (69 percent) and MVA (45 percent). It is obvious that D&C is the most commonly used abortion technique. It is well known that use of D&C, also known as 'sharp curettage' has two or three times higher rate of major complications than vacuum aspiration methods (EVA and MVA). The WHO strongly recommends against the use of D&C and that it should be replaced by the vacuum aspiration methods to ensure the safety and quality of care.

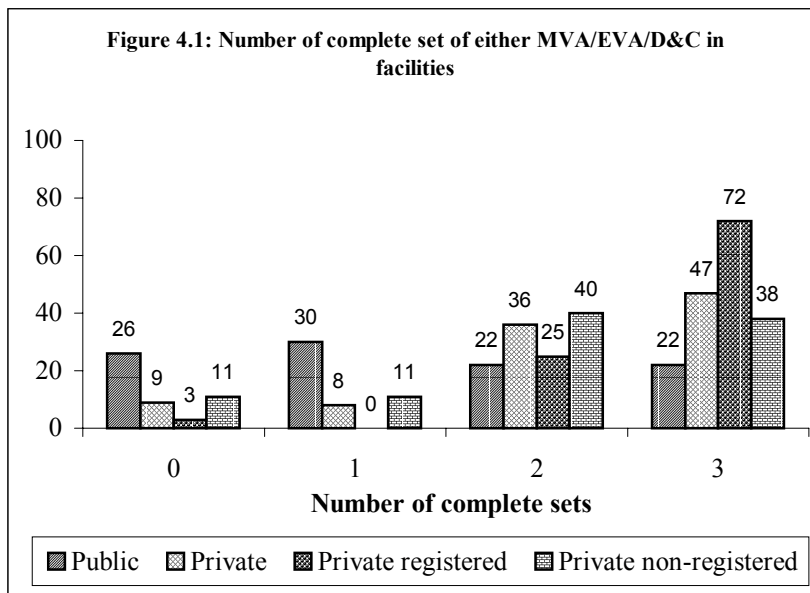
¹⁷ To some extent the private registered facilities are relatively better equipped (72 percent) with complete set of MVA instruments as against private non registered facilities (45 percent).

Table 4.2: Availability of basic equipment for abortion procedure by type of facility and district (Percentage)

Basic equipment	Type of facility				Type of district		All
	Public	Private			Better Developed	Less Developed	
		Registered	Not Registered	Total			
Electric suction machine	65	99	74	81	78	73	76
MVA syringe	44	78	59	64	65	48	58
MVA cannulae (at least 3 different sizes)	59	99	84	88	78	85	80
Adapters for MVA syringe	41	79	60	65	65	48	59
Sim's/Cusco's speculum	90	100	98	99	96	97	96
Tenaculum/Volsellum	94	97	94	95	95	94	94
Vaginal wall retractor	85	97	91	92	92	88	90
Ovum forceps	88	99	93	94	94	90	93
Uterine curette	90	100	96	97	97	93	95
Dilator set (at least 12 different sizes)	83	100	92	94	91	91	91
Complete set for MVA	26	72	45	52	50	36	45
Complete set for EVA	41	97	73	80	69	69	69
Complete set for D&C	72	97	87	89	85	84	85
Ultrasound available in house	19	69	36	45	42	32	38
Number of facilities	92	67	179	246	214	124	338
Complete set for MVA (MVA syringe+Sponge holding forceps+Sim's/Cusco's speculum+ Tenaculum/ Volsellum+Adaptor for MVA syringe+At least 3 sizes of suction cannula)							
Complete set for EVA (Suction machine+Sponge holding forceps+Sim's/Cusco's sculum+Tenaculum/ Volsellum+Dilator set (at least 12 different sizes)+At least one sizes of suction cannula)							
Complete set for D&C(Sponge holding forceps+Sim's/Cusco's sculum+Tenaculum/Volsellum+Ovum forceps+ Uterine curette+Dilator set (at least 12 different sizes)							

¹⁷ WHO : Safe Abortion – Technical and Policy Guidance for Health Systems, World Health Organization, 2003 , Geneva

An attempt has also been made to understand among the surveyed facilities, the number of facilities that have a complete set of instruments to perform abortion procedure either using MVA, EVA or D&C instruments. As can be observed from figure 4.1, private facilities are better equipped than public facilities. For instance, 26 percent of the public facilities compared with only 9 percent of the private facilities, do not have a complete set of instruments for either of the three said methods. The percentage of facilities having complete set for all the three methods is 22 and 47 percent in the public and private sector respectively. Among the private facilities, the registered clinics are better equipped than those not registered, as 72 percent of registered facilities have all the three methods, while 38 percent of the unregistered facilities reported the same. This indicates that the private facilities are ready with alternative methods to deal with emergencies.



A little more than one-third (38 percent) of the facilities have in-house ultrasound equipment. The private registered facilities are relatively better placed with almost two-thirds (69 percent) of them having ultrasound equipment. Even among the unregistered private facilities 36 percent have ultrasound facilities. This large availability of ultrasound equipment could be a pointer towards an increased use of sex-selection but we did not ask a specific question on this. An attempt is further made to understand the availability of these ultrasound machine per lakh population. Interestingly that almost a similar number of ultrasound machines (1.68 machine in better developed districts and 1.67 machine in less developed districts) exists per lakh population. This clearly demonstrate that the availability of this technology has nothing to do with the development of the district. However, there is a difference in its distribution across the states, as it is evident from the analysis for the six study states. Availability of these machines is also seen with respect to the sex ratio in 0 to 6 age groups in the study districts as per 2001 census. Survey data indicates that there are 2.04 ultrasound machines per lakh population in Haryana which has a sex ratio of 813. As the availability of these machines decreases the sex ratio is better and holds true for Rajasthan (1.95 machines per lakh population and the sex ratio is 914), Madhya Pradesh (1.07 machines per lakh population and the sex ratio is 943) and Mizoram (0.11 machines per lakh population and the sex ratio is 971). However the patterns in Kerala and Orissa is different. Kerala has 1.66 ultrasound machines per lakh population but apparently this does not seem to impact child sex ratios as it has a sex ratio of 972. In Orissa though the sex ratio is 956, it has the highest density of machines with 5.95 ultrasound machine per lakh population. It is plausible that the availability of this technology could be a recent phenomena in the study districts and maybe in the coming years impact the sex ratio.

It is encouraging to note that about four-fifths of the facilities had oxygen cylinder, an essential equipment which the facility might require at any time. Private registered facilities are much better placed (97 percent) in this respect than all public (83 percent) and unregistered private facilities (72 percent). The presence of Boyle's apparatus and laryngoscope in all the facilities is lesser still at 60 percent and 68 percent respectively. In this case too, private registered facilities are much better placed than their unregistered counterparts as well as the public facilities. Facilities in better developed districts are also to some extent, better placed than those located in the less developed districts. Anaesthesia - related equipments are required mainly for second trimester abortion methods and a smaller percentage of facilities provide second trimester abortion services. This explains why many of the facilities do not have these equipment.

Table 4.3: Availability of anaesthesia related equipment by type of facility and district
(Percentage)

	Type of facility				Type of district		All
	Public	Private			Better Develo -ped	Less Develo -ped	
		Registered	Not Registered	Total			
Oxygen cylinder	83	97	72	79	81	77	80
Boyle's apparatus	38	90	60	68	62	57	60
Laryngoscope	59	97	62	71	71	62	68
Number of facilities	92	67	179	246	214	124	338

To prevent infection, facilities should be equipped with the necessary sterilization equipment. Data indicates (table 4.4) that steam sterilizers (89 percent) followed by autoclave drum (86 percent) are commonly utilized across all types of facilities. The use of formalin chamber is reported by only 58 percent of the facilities. Facilities having formalin chambers will have ready to use dilators and cannulas, while in facilities without the formalin chamber they will have to ensure that the instruments are sterilized every day irrespective of their usage. The private registered facilities are better equipped with all these three infection prevention equipment than public and private unregistered facilities. The availability of the consumables related to sterilisation like Savlon, providone iodine and bleaching powder is available in more than four-fifths of the facilities. Only three-fourths of the facilities reported having long rubber gloves. The stock of sterilization related consumables are relatively larger in registered private facilities than in the unregistered private and public facilities. It is interesting to note that the availability of these materials in the facility does not depend on the fact that whether it is located in the better developed or less developed districts.

Table 4.4: Availability of sterilization/infection prevention equipment and consumables by type of facility and district

(Percentage)

	Type of facility			Type of district		All	
	Public	Private		Better Develo-ped	Less Develo-ped		
		Registered	Not Registered				Total
Infection prevention equipment							
Autoclave drum	87	100	80	86	86	87	86
Steam sterilizer	91	96	86	89	90	88	89
Formalin chamber	38	84	59	66	60	56	58
Sterilization related consumables							
Savlon	77	99	97	98	90	95	92
Providone iodine	78	99	88	91	86	91	88
Glutaraldehyde	48	82	67	71	65	63	65
Bleaching powder	80	85	81	82	82	82	82
Long rubber gloves	60	69	88	83	82	66	76
Number of facilities	92	67	179	246	214	124	338

Drugs

The status of availability of certain drugs required for inducing abortion or cervical priming and supportive drugs was also noted (Table 4.5). Oxytocin injection which is usually used for both the trimesters is available in four-fifths of the facilities, while the availability of other drugs in the facilities is relatively less (ethacridine – 36 percent; prostaglandin (inj) – 54 percent; and prostaglandin gel – 44 percent). It is possible that these drugs are not stocked at the facilities because these are mainly used for second trimester methods and as mentioned earlier, a lesser number of facilities provide second trimester abortion services and hence do not require to stock these drugs. Provision of IV fluids and analgesics is available in 83 percent and 87 percent of the facilities respectively. In this case too there is no difference in the stocking of these drugs among the facilities irrespective of their location in better or less developed districts.

Table 4.5: Supply of drugs and other consumables by type of facilities and districts
(Percentage)

Supplies	Type of facility				Type of district		All
	Public	Private			Better Develo -ped	Less Develo -ped	
		Registered	Not Registered	Total			
Drugs used for induced abortion or cervical priming							
Ethacridine	15	60	39	44	37	36	36
Oxytocin Injection	64	96	83	86	80	81	80
Prosataglandin (Carboprost Inj.)	16	84	62	68	55	51	54
Prosataglandin Gel	14	64	53	56	46	41	44
Supportive drugs							
IV fluids	75	93	84	87	83	85	83
Analgesics	78	97	88	91	87	88	87
Contraceptives							
Condoms	95	51	43	45	58	60	58
Oral pills	95	64	59	60	71	68	70
IUDs	96	87	61	68	75	76	75
Injectables	11	22	18	20	17	18	17
Number of facilities	92	67	179	246	214	124	338

Contraceptives

Contraceptive counselling and provision of contraception is an integral part of abortion services. Providers should ensure that women receive information and counselling on post-abortion contraception before they leave the health facility. Further, to make contraceptives easily accessible to women who want to use them post abortion, it is important that contraceptive methods are available at the facilities. Therefore, the present study looked into the availability of spacing methods in each of the facilities. All methods of contraception can be considered for use after abortion, as long as attention is given to woman's health profile and the limitations associated with it. It is interesting to note that in the public sector, almost 95 percent of the facilities have stock of condoms, oral pills and IUDs, as compared to only 45 percent, 60 percent, and 68 percent respectively in the private sector. Predominance of these supplies in the public sector could be because they form a part of the broader family welfare programme. To some extent, registered private facilities are better stocked than the unregistered private facilities. Interestingly 17 percent of the facilities offered injectable contraceptives, 11 percent in public facilities and 20 percent in private facilities.

Maintenance

To assess the impact of equipment breakdown on abortion services, information was gathered on arrangements made by the facilities for repairing equipment and the time lag between breakdown of equipment and its repair. The system for repairing the out of order equipment is to send it to the dealer located in the same town (38 percent), or to send it to the dealer based in another city (17 percent). Some facilities (9 percent) had a maintenance contract for their equipment. Some of the other answers reported mainly by public facilities included: equipment is replaced by government, inform the district health office, and themselves manage to repair. Facilities located in lesser developed districts do encounter problems in availing maintenance and support locally, hence they have to send the equipment for repair to another city (27 percent) as against 12 percent of the facilities belonging to the better developed districts. Only 4 percent of the facilities were covered by maintenance contract in the lesser developed districts. The time lag between breakdown of the equipment and repair varies from receiving the repaired equipments on the same day (26 percent) to receiving it within a week (37 percent). Seven percent of the facilities reported receiving the equipments after a gap of more than 15

days. In 3 percent of the facilities, the equipment has not been repaired. Probing was done to understand whether the facility had ever had to postpone providing abortion services for maintenance related reasons, like out-of-order equipment lack of sterilized instruments, electricity or water. The percentage of facilities acknowledging these to be the reasons is 9, 5, 13 and 3 respectively. Comparatively more public facilities have reported postponement of their services due to the above mentioned reasons than the private facilities.

Table 4.6 : Maintenance of equipment by type of facilities and districts

(Percentage)

	Type of facility			Type of district		All	
	Public	Private		Better Develo-ped	Less Develo-ped		
		Regis-tered	Not Regis-tered				Total
Arrangements for equipment repair*							
Sent to dealer in same town	22	65	36	43	41	32	38
Sent to another city	18	12	19	17	12	27	17
Covered by maintenance contract	11	9	9	9	12	4	9
Others	48	15	24	22	28	29	28
Not mentioned	1	-	13	10	8	8	8
Time lag between breakdown and repair							
Same day							
Within a week/few days	14	49	24	30	27	25	26
Within 15 days	32	37	39	39	38	34	37
More than 15 days	7	4	7	6	3	13	7
Not fixed	19	3	3	3	7	7	7
Never gone out of order	3	3	3	3	2	4	3
Others	-	4	10	8	6	7	6
	25	-	15	11	18	9	15
Facilities that have had to postpone service for maintenance reasons							
Equipment out of order	17	2	8	6	7	13	9
Instruments not sterilized	11	4	2	3	3	9	5
No electricity	19	4	12	11	8	21	13
No water	7	2	2	2	3	4	3
Number of facilities	94	68	218	286	214	124	380

* Percentage adds to more than 100 due to multiple response

The above discussion illustrates that the private registered facilities are relatively better placed in terms of the physical amenities, abortion related equipments and supply of drugs than the public facilities and private unregistered facilities. Equipments related to simple technique of abortion like MVA is less, presently it is found more among the private registered facilities, there is thus a need to advocate about the method to other providers as they continue using D&C and EVA.

CHAPTER V

PROVIDER CHARACTERISTICS AND TRAINING

In addition to the assessment of the facilities for the availability of abortion related infrastructure, the study also attempted to understand the type of the providers available in these clinics who are providing abortion services. The Medical Termination of Pregnancy Act 1971 lays down the criteria for a provider to be eligible to conduct MTP. Basically, a medical practitioner who is registered in the State Medical Register and has training in gynaecology and obstetrics either through six months of house surgery or holds a post-graduate degree or diploma in OB&Gy can terminate pregnancy up to twenty weeks of gestation. Whereas other registered medical practitioners have to undergo a special training program in an institute approved for this purpose. This training enables them to do only first trimester termination. The abortion service providers available in the study facilities were interviewed using a structured questionnaire. In addition, information on the availability of related manpower in the facilities was also collected through the interviews conducted with the head administrator. Findings from both these set of questionnaires are discussed below.

In the 380 facilities surveyed, the reported number of abortion providers were 577 or an average of 1.5 per facility. Fifty-five percent of these providers are gynaecologists by training. Of these gynaecologists 42 percent are working in the facility as either regular employees or are the owner's themselves, and the rest are available in the facility on call or on specific days. More (59 percent) gynaecologists are located in the better developed districts as against the facilities in less developed districts (48 percent). Thirty percent of the providers have a degree (MBBS/MD/MS) in other branches of medicine. Thirty six percent of these doctors are distributed in the less developed districts as against 27 percent in better developed districts. Fifteen percent of the providers belong to the 'others' category like BAMS, BUMS. These latter providers are mainly working in the unregistered private facilities (table 5.1).

Table 5.1: Availability of abortion service providers by qualification, type of facilities and districts

(Percentage)

Service Providers	Type of Facility			Type of District		All	
	Public	Private		Better Developed	Less Developed		
		Registered	Not Registered				Total
Gynaecologist (MD/MS/DGO) One or more regular employee/owner							
Available on call/visit on specific days	52	62	29	38	47	33	42
MBBS/MD/MS in other branch							
One or more regular employee/owner	1	13	19	18	12	15	13
Available on call/visit on specific days	44	22	20	20	24	32	27
Others							
One or more regular employee/owner	1	3	4	4	3	4	3
Available on call/visit on specific days	2	-	27	19	14	15	14
	-	-	1	1	-	1	1
Reported number of abortion providers in the facilities	162	111	304	415	367	210	577

Further, when we look at availability of providers (either as regular employees or on call/specific days) in the facilities in terms of specialist skills we find that 56 percent of the facilities had at least one gynaecologist, this percentage being highest (81 percent) in the registered private facilities, followed by 59 percent and 48 percent in the public and unregistered private facilities respectively (table 5.2). This is again high at 60 percent for facilities located in the better developed districts as against 50 percent in less developed districts. The percentage of facilities having at least one MBBS provider was 25 percent, and in 19 percent of the facilities there were only providers with training in one of the branches of Indian System of Medicine (ISM) (BAMS/BUMS). Facilities with such ISM providers are found only in the unregistered private facilities, wherein one-third of facilities had only such providers. The data obviously indicates that gynaecologists prefer to be located in areas which are developed, and if practicing in private facilities are more likely to get it registered.

The presence of an anaesthetist was also noted. The availability could be either on a regular employment basis or on call. Overall, only 47 percent of the facilities had at least one anaesthetist. This was highest (81 percent) in the registered private facilities, followed by 43 percent in unregistered private facilities and 31 percent in public facilities.

**Table 5.2: Availability of qualified providers at different type of facilities
(Percentage)**

Facilities having at least one	Type of Facility				All
	Public	Private			
		Registered	Not Registered	Total	
DGO/ Gynaecologist	59	81	48	56	56
MD/MS,MBBS,	41	19	19	19	25
Others	-	-	33	25	19
Anaesthetist	31	81	43	53	47
Total number of facilities	94	68	218	286	380

Characteristics of the providers: A total of 452 providers out of the 577 providers who are currently involved in providing MTP services were interviewed in 368 facilities¹⁸. Among these, 128 are public providers and 324 are private providers.

Analysis of the providers by their sex indicates that 55 percent of the providers are females, while the remaining 45 percent are males. In registered private facilities abortion providers are predominantly female (79 percent), while in the unregistered private facilities and public facilities it is almost similar with the proportion being distributed almost half for each sex. Age wise, the providers at the private facilities on an average are older by three years (around 44 years) than those working in the public facilities (41 years). Again those working in the registered private facilities are older at 47 years, than those in unregistered private facilities (42 years) (table 5.3).

Regarding other characteristics of providers, in terms of the average number of years for which these providers have been providing the service, the data indicates that it is nearly eleven years. Providers placed in registered private facilities have been providing MTP services for more (nearly 15 years) number of years than their counterparts in unregistered private facilities (10.2 years) and public clinics (10.8 years) (table 5.3). The above characteristics (namely age and years of providing abortion services) of the providers does not vary much by their location of the facility, that is either in a better or less developed district, except for the sex of the providers. As 69 percent of the female providers are based in better developed districts, while only 55 percent of them are found in less developed districts.

**Table 5.3: Profile of interviewed abortion providers in different type of facilities
(Percentage)**

	Public	Private			All
		Registered	Not Registered	Total	

¹⁸ In 12 facilities providers were not available for interview

No. of years providing abortion services					
≤ 5 years	30	14	32	27	28
6 – 10 years	25	22	30	28	27
11 – 15 years	19	24	19	20	20
16 – 20 years	12	14	7	9	10
> 20 years	11	24	12	15	14
Not mentioned	2	2	-	1	1
Mean (in years)	10.8	14.8	10.2	11.4	11.2
Age of the provider					
Mean (in years)	40.5	46.6	42.4	43.5	42.6
Range	(26-59)	(27-75)	(23-70)	(23-75)	(23-75)
Sex of the provider					
Female	48	79	50	57	55
Male	52	21	50	43	45
Total number of providers	128	85	239	324	452

Training status of providers: On analysing the training status of these providers as per the provisions of the MTP Act, it is interesting to note that around seven out of ten providers (71 percent) are formally trained for conducting MTP (table 5.4). Among the trained providers 53 percent have a degree in gynaecology and obstetrics, while the remaining 18 percent have received the MTP training following their MBBS/MD degree. The proportion of untrained providers is 14 percent in the public facilities, but in private facilities it is 2.5 times more than the public facilities. The percentage of untrained providers is relatively higher (46 percent) in private unregistered facilities. Strangely enough, even in registered private facilities 3 percent of the providers had no formal training in MTP. This clearly indicates that certification of a facility for MTP services as per the Act, does not necessarily ensure that a trained provider would provide the services always. Similarly, MTP services rendered from unregistered facilities does not mean that only an untrained provider is involved in providing the services, as 43 percent of the providers in private unregistered facilities are gynaecologist/obstetrician and 11 percent have received formal training in MTP. This is an important finding indicating that a large proportion of abortions in unregistered facilities are likely to be safe. However, 28 percent of the providers currently involved in providing MTP services do so without a formal training in the same.

Table 5.4: Training status and qualification of the abortion providers by type of facilities and districts

	Type of Facility			Type of district		All
	Public	Private		Better developed	Less developed	
		Registered	Not Registered			

Formally trained							
MD/DGO/MS/DNB in obst & gynaec.	52	82	43	53	58	45	53
Other with formal training in MTP procedures							
MBBS	29	14	6	8	16	11	14
MS/MD in other branch	4	-	2	1	1	4	2
Trained in ISM	-	-	3	2	2	*	2
Other	1	1	-	*	*	*	*
Without formal training in MTP procedures							
MBBS	12	2	14	11	8	17	11
MS/MD in other branch	2	1	3	2	*	5	2
Trained in ISM	-	-	28	21	13	18	15
Other	-	-	1	1	1	-	*
Total number of providers	128	85	239	324	282	170	452

* Percentages are less than 0.5 percent

Place of MTP Training: As per the Rules and Regulation of the MTP Act, all providers other than those who have experience or training in gynaecology and obstetrics should undergo a training in MTP in order to be eligible to provide MTP services. In our sample we have 212 providers who were non-gynaecologists. Among these 212 providers, 39 percent had attended formal training in MTP. The place where they had undertaken formal training included the training/medical college (16 percent) and district hospital (12 percent). Around 4 percent mentioned being trained in MTP at a private hospital. The remaining sixty-one percent of the providers reported that they had not undergone any formal MTP training but had acquired skills informally. Table 5.5 shows, that about 27 percent of all providers had informally acquired the requisite training from the teaching/medical college. Another 11 percent of the providers claim of having undergone the training informally from other hospitals (district hospital, post partum centre, private hospital/NGO), while 13 percent had received the training from a colleague of theirs. The process through which such informal training has been acquired needs to be looked into, as it would not necessarily be complete, meeting the standards and norms set for the same. Such informal training might be strengthening the providers in some aspects of MTP services, but whether this is sufficient or needs to be strengthened further to provide quality service needs to be understood.

Analysis of the place of training by type of facility indicates that in registered private facilities four-fifths of the providers (81 percent) have had formal training, either from teaching/medical college, district hospital or private hospitals/NGO. Among the un-registered private clinics, the situation is reverse, as only 19 percent of the providers have formal training either from teaching/medical college, district hospital or private hospital. Among the 81 percent of the providers who had no formal training, 20 percent have gained the experience through working with a colleague or other sources. Fourteen percent of the providers did not divulge the information from where they have learned about MTP (table 5.5). This type of informal training might equip the providers with skills which they might be satisfied with in providing service to the clients, but this would be limited and definitely not complete. Hence, this raises the issue of quality of service that these providers provide and their capacity to deal with complications and emergency.

Table 5.5: Providers training status and place of training by type of facilities and districts (Percentage)

	Type of Facility		Type of district	All
	Public	Private		

		Registered	Not Registered	Total	Better developed	Less developed	
% of providers attended formal training	71	81	19	26	46	29	39
Place of formal training							
Teaching/ Medical college	21	31	12	14	13	19	16
District hospital	26	25	4	7	19	4	12
Post partum centre	2	-	-	-	-	1	1
Private hospital/NGO	2	25	3	5	4	4	4
Others	15	-	-	-	8	-	4
Not mentioned	5	-	4	4	3	7	4
% of providers learnt informally	30	19	81	74	54	71	61
Place where informally learnt							
Teaching/ Medical college	20	13	33	31	19	39	27
District hospital	2	-	6	5	5	3	4
Post partum centre	3	-	1	1	1	2	1
Private hospital/NGO	2	6	7	7	8	3	6
By working with a colleague	-	-	7	7	4	5	5
Others	2	-	13	11	9	8	9
Not mentioned	2	-	14	13	8	11	9
Number of providers other than the gynaecologists	61	16	135	151	119	93	212

* Percentages are less than 0.5 percent

Method in which training received: The methods of abortion that are most appropriate and accepted for the different stages of pregnancy based on the established protocols world wide include vacuum aspiration, dilatation and curettage (D&C) and manual vacuum aspiration (MVA) as the surgical methods of abortion upto 12 weeks of gestation. While, Dilatation and Evacuation (D&E), intra and extra amniotic methods are generally used above 12 completed weeks of pregnancy. In the present study, all the 82 formally trained providers (other than the gynaecologists/obstetricians) were asked about the abortion methods they were trained in. As table 5.6 shows, 90 percent of the providers received training for dilatation and curettage, 83 percent in dilatation and evacuation (D&E), 56 percent in MVA and 50 percent in electric vacuum aspiration (EVA). About one-third of providers received training for intra amniotic and extra amniotic method. Analysis of the same data by type of facility reveals that relatively more private providers are trained in MVA and EVA (69 percent and 62 percent respectively) than those working in the public facility (MVA 44 percent and EVA 40 percent). More public providers are trained in second trimester method as compared to private providers.

Table 5.6: MTP procedures providers formally trained in by type of facilities

(Percentage)

Type of procedure	Type of Facility				All
	Public	Private			
		Registered	Not Registered	Total	
MVA	44	92	58	69	56
EVA	40	77	54	62	50
D&C	88	100	89	92	90
D&E	86	92	73	80	83
Extra amniotic method	44	62	12	28	37
Intra amniotic method	35	54	8	23	29
Number of formally trained providers	43	13	26	39	82

Training in supportive areas: In addition to the actual technical training in the use of the various methods, the providers were also asked, if at any point they received training in the area of counselling and interpersonal communication (IPC), universal precautions and reproductive health and rights. Data indicates (Table 5.7) that 44 percent of them received training in reproductive health and rights, 37 percent in universal precaution and 32 percent in counselling/inter-personal communication. To some extent, the percentage of providers with training in these supportive areas is slightly higher among the registered private facilities than among the unregistered private facilities. But overall more public sector providers are trained in these areas than the private providers. This is probably due to the continued in-service training programmes within the public sector. Again, more providers of better developed districts are trained than those located in less developed districts. This could be due to better opportunity for training in developed districts. Irrespective of the specific issue for training in supportive area, from the data we tried to understand the percentage of providers who had received training in at least one supportive area. Fifty percent of the providers have undertaken the training, with 63 percent in the public facilities and 45 percent among the private providers. Providers who received training in all the above three components constituted 27 percent. There is not much variation in this percentage between the public and private providers, though providers from the private registered facilities had the highest proportion.

Table 5.7: Providers who have received training in supportive areas by type of facilities and districts

Training in supportive areas	(Percentage)						All
	Public	Type of facilities			Type of district		
		Registered	Not Registered	Total	Better developed	Less developed	
Counselling and IPC	37	44	25	30	40	17	32
Universal precautions	46	57	25	33	47	20	37
Reproductive health and rights	55	62	31	40	50	34	44
% of providers had received training in atleast one of the areas	63	72	36	45	56	41	50
% of providers had received training in all the areas	27	40	21	26	37	10	27

Method¹⁹ currently provided: The facilities were further looked into for the abortion methods that the providers of these facilities were commonly providing. Hence, providers were asked about the abortion methods that they were currently using. Data indicates that the methods most commonly being used included dilatation and curettage (82 percent) and dilatation and evacuation (71 percent). MVA is used by only half of the providers (table 5.8). Though this method is simple, it is obviously not utilized by all. The use of MVA and EVA is relatively higher in private registered facilities (85 and 87 percent

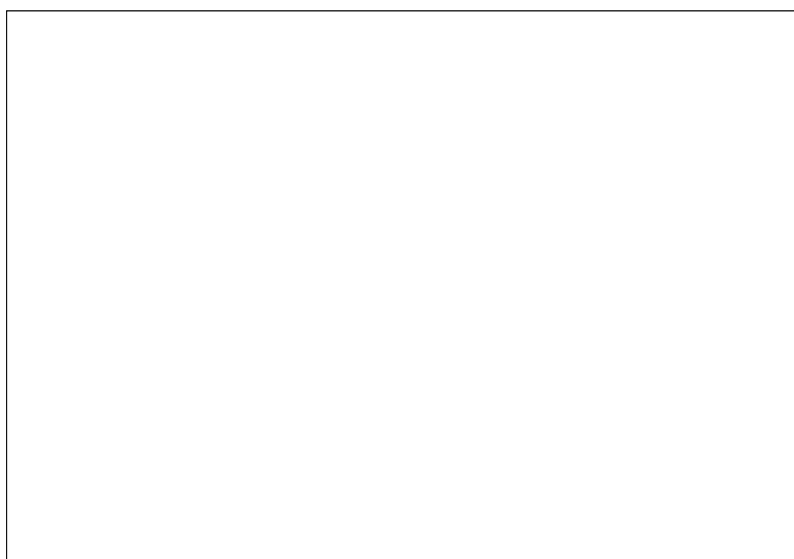
¹⁹ Dilatation and Curettage (D&C)- It involves dilating the cervix with mechanical dilators or pharmacological agents and using sharp metal curettes to scrape the walls of the uterus. Electric Vacuum Aspiration (EVA)- Vacuum aspiration involves the evacuation of the contents of the uterus through a plastic or metal cannula, attached to a vacuum source. In EVA, an electric vacuum pump is employed. With manual vacuum aspiration (MVA) the vacuum is created using a hand held, hand –activated, plastic 60ml aspirator (also called a syringe). Available aspirators accommodate different sizes of plastic cannulae. Depending on the duration of pregnancy, abortion with vacuum aspiration can be performed on an outpatient basis, using analgesics and /or local anaesthesia. Dilatation and evacuation (D&E) is a safe and most effective surgical technique for termination above 12 weeks of pregnancy. It requires preparing the cervix, dilating the cervix, and evacuating the uterus using electric vacuum aspiration with cannulae and forceps. Other medical agents used to stimulate uterine contractions and induce abortion from 12 completed weeks includes intra or extra amniotic administration of ethacridine; parenteral, intra-amniotic or extra-amniotic administration of prostaglandin analogues; and intravenous or intramuscular administration of oxytocin.

respectively) as against both public and non registered private facilities. Use of the second trimester methods namely extra amniotic and intra-amniotic methods, is less at 36 percent and 20 percent respectively. This could be due to the relatively less demand for these methods or because these procedures are more complex and hence used less.

Table 5.8 Abortion procedures currently used by providers by type of facilities

Type of procedure	Public	Private			All
		Registered	Not Registered	Total	
MVA	48	85	45	56	54
EVA	56	87	55	64	61
D&C	91	94	73	79	82
D&E	82	93	57	67	71
Extra amniotic method	41	51	30	35	36
Intra amniotic method	29	18	15	16	20
Total number of providers	128	85	239	324	452

In addition to looking at the data individually for the methods used by providers, analysis of the data was also done to understand how many methods were the providers using in practice (table 5.9). As each method has its own limitation and advantage, it also provides an opportunity to understand whether the doctor uses only one method for abortion as per their comfort or do they keep other alternative methods as stand by. Data indicates (Table 5.9) that there is a variation in the number of methods provided, by the providers. In fact there are 8 percent providers who are not using any surgical method of abortion but use only medicines. These providers all are functioning from private unregistered facilities. Nine percent of the providers are using only one method, while around half are providing either four or more methods. Analysis of the data by registration status of the facility indicates a definite difference in the availability and use of number of methods by the providers. In registered facilities, around 80 percent of the providers are providing four or more methods, but in case of unregistered facilities this is low at 39 percent. The public facilities in almost half providers are offering four or more methods. As expected, the number of methods used by providers increases with their training skill.



As Figure 5.1 indicates a higher percentage of un-trained providers is equipped to provide only one or two types of methods, while trained providers are equipped in a combination of methods. Hence, the readiness to deal with different types of abortion cases is more in registered facilities followed by public facilities rather than in unregistered facilities. It is plausible that indirectly the registration status of the facility ensures the availability of methods and training status of the provider, and therefore the readiness of the facilities are better.

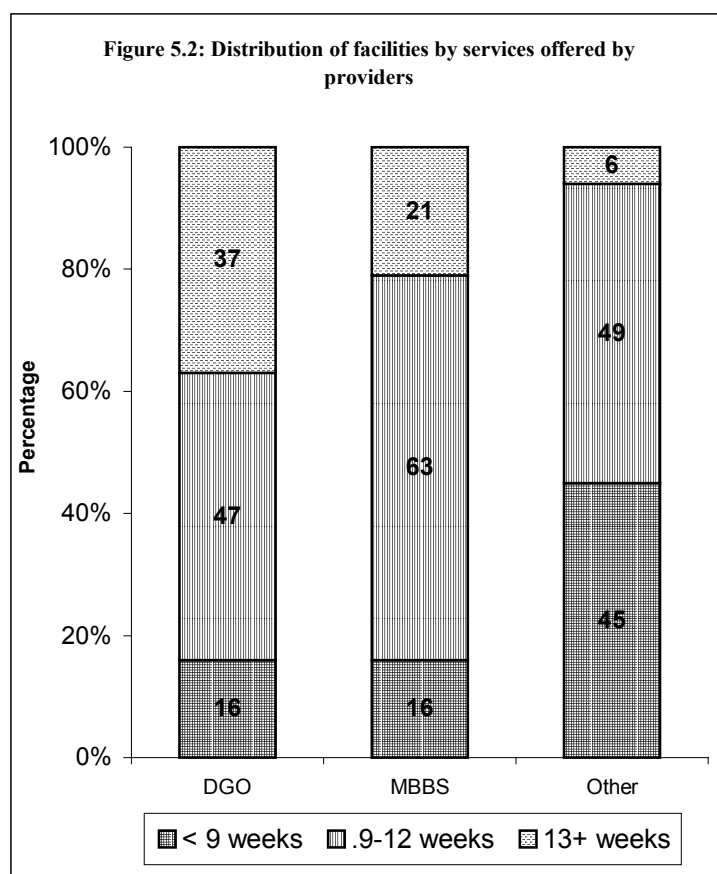
Table 5.9: Number of methods providers currently provide by type of facility

(Percentage)

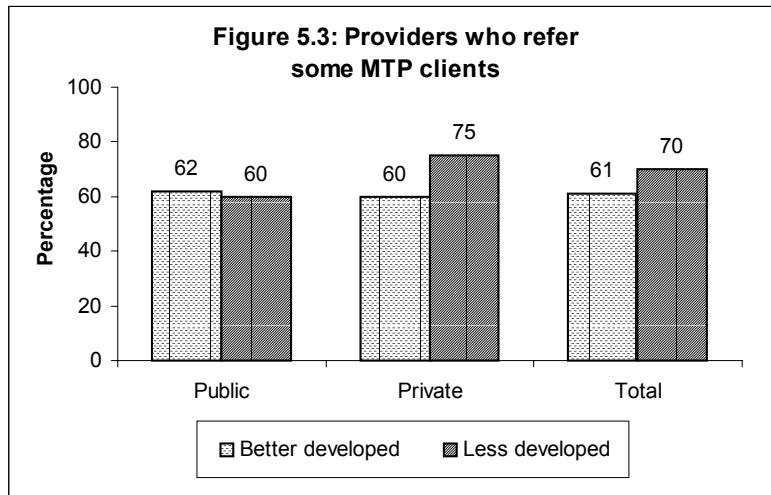
Number of methods	Public	Private			All
		Registered	Not Registered	Total	
0	-	-	16	11	8
1	9	1	11	9	9
2	20	8	16	14	16
3	22	11	18	16	18
4	21	37	24	27	25
5 and 6	28	43	15	23	24
Total number of providers	128	85	239	324	452

Further, the formally trained providers (other than the gynaecologists), who are based in the less developed districts, have, relatively, taken more training in the various types of MTPs than their counterparts in the better developed districts. Data, thus, suggests that to some extent the providers in less developed districts have equipped themselves in more methods of MTP, for example 93 percent and 57 percent of the providers in less developed districts have received training in dilatation and evacuation (D&E) and extra amniotic method respectively, while the corresponding figures are 78 percent and 27 percent among the providers of better developed districts. The method currently provided again is predominantly D&C followed by D&E in all the districts.

What is the technical skill of the providers providing these services? Analysis of the same data by qualification status of providers available in the facility (figure 5.2) indicates that facilities having at least one gynecologist perform abortions more of higher weeks of gestation (47 percent in 9 to 12 weeks and 37 percent above 13 weeks), than facilities having only MBBS providers as 63 percent of the facilities are conducting abortion of 9 to 12 weeks and only 21 percent provide services for more than 13 weeks of gestation. Facilities having 'other' providers are mainly (94 percent) involved in conducting abortions upto 12 weeks gestation. In other words the availability of technical skill and know how among the providers in the facility also determines the gestation week upto which the services are provided indicating the fact that even the providers provide the required services invidiously, as their credibility is also at stake.



In spite of the skills available, providers mentioned that they came across abortion cases in their facilities that they could not handle and had to refer cases. The percentage of such referral cases is similar in public facilities at 60 percent in both the better and less developed districts (figure 5.3), but in private facilities it is 59 percent in better developed districts and 70 percent in less developed districts. This could be because of slightly higher percentage of providers, other than gynecologists being involved in providing services in less developed district and they refer cases that they cannot handle.



Gestational week upto which services provided: Data was gathered on the weeks of gestation upto which services are offered in the surveyed facilities. As table 5.10 indicates, that almost three-fourth (73 percent) of the facilities offer services only upto 12 weeks of gestation. In fact, 22 percent of the facilities offer the services only upto 8 weeks of gestation. Percentage of facilities offering second trimester services is only 27 percent. Analysis of the same data by type of facility indicates a clear difference in the pattern of services offered by the public and private facilities. Amongst public facilities 60 percent offer only first trimester services while this is higher at 77 percent in the private facilities. This could be because the private practitioners do not want to be involved in the provision of services for higher gestation abortion services as it relatively involves more skill as well as logistic support in place with referral backup. As per the recent amendment of 2003 in the MTP Act, facilities can get certification upto 12 weeks if they meet the requisite criteria. Available data indicate that there is scope for most unregistered facilities to register themselves and become legal. Amongst the private facilities, second trimester services are offered more (38 percent) by the registered facilities as compared to the non-registered facilities (18 percent), indicating that the private registered facilities have closer similarity with public facilities in handling different gestation cases. It is also interesting to learn that more facilities (34 percent) in less developed districts are involved in conducting second trimester abortion than those located in better developed districts (23 percent). This delay in less developed districts could be due to many reasons like delay in decision making process by the abortion seekers, termination of pregnancy after going in for sex determination test to determine the sex of the foetus or poor development of other supportive health services.

Table 5.10: Gestation of pregnancy for which services are offered by type of facilities and districts

(Percentage)

Week of pregnancy	Type of facility			Type of districts		All	
	Public	Private		Better developed	Less Developed		
		Registered	Not Registered				Total
≤ 8 weeks	12	9	30	25	16	22	
9 - 12 weeks	48	53	52	52	50	51	
13 - 20 weeks	31	35	12	17	26	21	
> 20 weeks	10	3	6	5	8	6	
Total number of facilities	94	68	218	286	240	140	380

From the above analysis, it is evident that a little more than half of the providers providing abortion services are female providers. Though seven out of ten providers have undergone a formal training to provide abortion services it is not necessary that they are providing their services from a registered facility, which categorizes them as illegal provider. Even among those who have been formally trained, there is no uniform rationale on the training received by them. The content and method taught by these training centres seems to be their independent decision.

Training should include methods that are safe and involves less risk to the woman. It is very important that the training centre should also add on the issues of counselling in their training rather than just addressing to the providers technical skill. Appropriate strategies should also be developed to ensure that the providers are updated on the recent technological skills in providing abortion services. Providers having technical skills are better equipped to provide alternate methods. Further, facilities providing second trimester methods are a smaller proportion.

CHAPTER VI

UTILIZATION AND ACCESSIBILITY TO ABORTION SERVICES

In the preceding chapters we have discussed the available infrastructure and human power including their technical skills in rendering abortion services in the surveyed facilities. This chapter discusses the general profile of these facilities along with the type of services offered, extent and type of utilization. Referral patterns have also been looked into. Attempt has also been made to understand how accessible the facilities are, physically, socially and financially.

ABORTION FACILITIES AND SERVICES

Table 6.1 outlines the profile of abortion facilities from our study sample. Private facilities are mostly of the for-profit kind and mostly headed by men, except in case of private registered facilities located in less developed districts, where majority of head and/or owner of the facility are women. Almost all public and registered private facilities have amenities for overnight stay. Amongst the unregistered private facilities only about three-fifths had such provisions. The average number of beds available in the facilities was 2 to 3 times higher in the better-developed districts in case of private facilities and the average size of the facility in the less developed district was much smaller. But despite this private facilities in the less developed districts were doing twice the number of abortions and on an average per facility were also having nearly twice the proportion of facilities managing abortions of higher gestation (more than 12 weeks). In terms of facilities available and the outcomes (number of abortions), the doctors, including Ob.& Gy., and nurses available seem to be more than adequate.

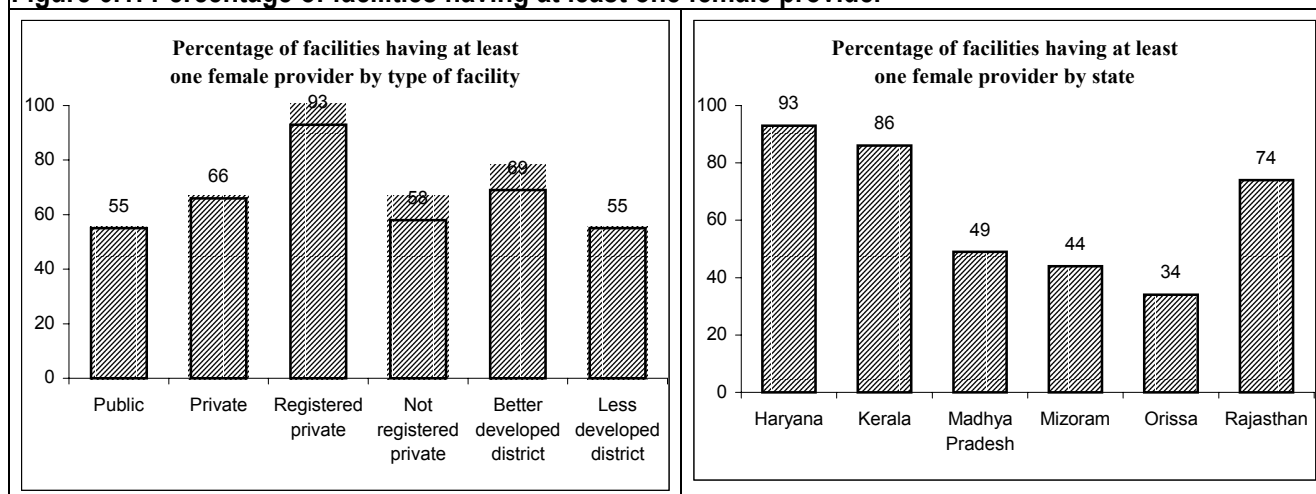
Table 6.1: Profile of Abortion Facilities across better and less developed districts (percentages, unless otherwise specified)

Selected characteristics of abortion facilities	Better Developed			Less Developed			All
	Public	Pvt. Reg.	Pvt. Unreg.	Public	Pvt. Reg.	Pvt. Unreg.	
Ownership*							
For profit facility	-	85	94	-	90	86	90
Not for profit facility	-	15	6	-	10	14	10
Female headed facility	25	39	25	14	55	27	28
Overnight facility	95	90	64	89	97	55	75
Mean number of beds	56	55	40	39	18	18	39
Percent < 16 beds per facility	35	20	46	42	79	66	46
Mean number of abortion providers per facility	1.8	1.6	1.4	1.7	1.6	1.4	1.5
Percent atleast one Ob.Gy. provider	56	82	56	60	79	32	56
Percent at least one female provider	63	92	65	43	93	46	64
Mean number of beds per nurse	3.7	2.8	2.9	3.3	2.9	4.7	3.2
Mean years of existence of facility	20	13	10	13	13	8	11
Number of Facilities	57	39	144	37	29	74	380

* Percentages are based on private facilities.

It is encouraging to note that the proportion of female providers overall is more than half. Analysis of the same data across the type of facilities and the states shows interesting findings. Overall, 64 percent of the facilities have at least one female abortion service provider. In the registered private facilities this is as high as 93 percent, where as in the unregistered private clinics and public facilities it is lower at 58 percent and 55 percent respectively (figure 6.1). Interestingly, in Haryana, Kerala and Rajasthan it is the female provider who is mainly involved in providing these services. The percentage of facilities where at least one female provider is available ranges between 93 percent in Haryana, 86 percent in Kerala and 74 percent in Rajasthan (figure 6.1). The presence of a higher percentage of female providers in these states could be attributed to greater demand for female providers which has been created due to the inhibition among the females to be examined by a male provider. In Madhya Pradesh, Mizoram and Orissa the percentage of facilities having at least one female provider is lower at 49 percent, 44 percent and 34 percent respectively.

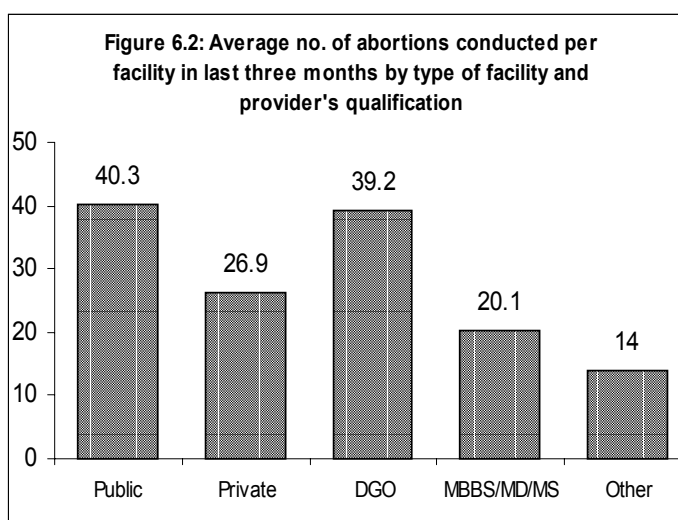
Figure 6.1: Percentage of facilities having at least one female provider



Public facilities on an average much older, though in the less developed districts on an average they had been operating for much less (13 years) than in the better developed districts (20 years). With regard to the average years since private facilities have been in existence there was no major difference across districts, suggesting that private sector expansion of abortion services took place in more or less the same period in districts irrespective of their type.

Number of clients seeking abortion services: The extent to which these services are utilized can be gauged by the extent of the caseload of the MTP clients received by the facilities. Data was collected on the number of MTPs conducted in the three months preceding the survey. The average number of abortions reported per facility in the reference period was 40 in the case of public facilities whereas in private facilities it was 26 (Figure 6.2). Among private facilities a significant difference is observed among the registered and un-registered facilities. The average turn over reported by the registered facilities is around 42 while in the latter it is 22 (table 6.2). This indicates that the pattern of utilization of services from public facilities and private registered facilities is almost similar. As expected the turn over of clients is more (around 40) among facilities located in less developed districts than those located in the better developed districts (25).

Further analysis of the same data by the professional skill of the providers in these facilities, it is evident that facilities having gynecologists have a higher caseload (39 clients). The reported number of clients seeking services from facilities with only MBBS providers is 20 and facilities having 'other' providers is 14 (Figure 6.2). This shows that if women have the choice they do prefer seeking services from skilled personnel, preferably a gynecologist.



Caseload according to period of gestation shows that the average number of cases reported is highest at 28.9 for upto 12 weeks gestation which decreases to 13.6 and 6.3 between 13 to 20 weeks and above 20 weeks of gestation (Table 6.2). It may be also pointed out that public facilities are approached more for terminating pregnancies in 13 to 20 weeks of gestation than all other private facilities. This could be because fewer private facilities provide second trimester abortions.

The data further indicates that demand for abortion services is all pervading irrespective of the type of district. To some extent there is the higher load per facility in less developed regions in the private sector (38 abortions per facility in last three months) which is probably indicative of the fact that the better availability of other reproductive health services, and the better health outcomes, including contraceptive acceptance, of the better developed districts perhaps contributes to the lower demand of abortion in the better developed districts (20 abortions per facility in last three months).

Table 6.2: Average number of abortions conducted in the three months prior to survey for different gestational weeks by type of facilities and district

	Type of facilities				Type of districts		All
	Public	Private		Better developed	Less developed		
		Registered	Not Registered			Total	
Mean no. of abortion during the last 3 months	40.3	42.0	22.3	26.9	25.0	39.5	30.3
Range	0-600	0-180	0-280	0-280	0-600	0-280	0-600
Number of facilities reported providing abortion services*	94	66	212	278	236	136	372
Mean ≤ 12 weeks							
Mean	40.4	39.1	20.8	25.4	23.8	38.4	28.9
Range	0-540	0-150	0-280	0-280	0-540	0-280	0-540
Number of facilities providing abortion services upto 12 weeks of gestation **	78	65	192	157	217	118	335
13 - 20 weeks							
Mean	18.3	10.1	11.5	10.9	13.3	13.9	13.6
Range	0-130	0-28	0-54	0-54	0-130	0-85	0-130
Number of facilities providing abortion services between 13 to 20 weeks of gestation	33	25	33	58	50	41	91
> 20 weeks							
Mean	5.0	7.5	6.9	7.0	6.8	5.5	6.3

Range	0-10	5-10	0-20	0-20	0-20	1-10	0-20
Number of facilities providing abortion services above 20 weeks of gestation	7	2	11	13	12	8	20

Note: * Eight facilities did not report the number of abortions conducted in their facilities in last three months
 ** Thirty seven facilities did not report the number of abortions conducted by gestational week

Of the total number of abortions reported by the study facilities, 88 percent of the reported abortions were of upto 12 weeks of gestation, 11 percent were between 13 to 20 weeks and one percent was above 20 weeks of gestation. This pattern is similar across the better and less developed districts. In other words this is the demand for services from the abortion seekers from formal providers regardless of whether they stay in developed or less developed districts. But it differs slightly by the professional skill of the providers. The percentage of abortions conducted upto 12 weeks increases from a gynaecologist (86 percent) to MBBS doctors (92 percent) to 'other' providers (96 percent), while as expected the reverse is true for second trimester abortions (gynaecologist-13 percent, MBBS-7 percent and others-4percent). This corroborates with the earlier findings, regarding the choice of providers, as abortion seekers do prefer skilled personnel for termination of pregnancy.

Again based on the above findings, we made an attempt to understand how the reported abortions numbers relate to the available published service statistics. As per the Family Planning Year Book, the number of terminations reported in the six study states was 1,57,338 from 2029 institutions in the year 1997-98. If the survey findings of 14 abortions per month per registered facility is to be taken for the same number of MTP centres, the number of terminations works out to be 3,40,872. In-spite of the time lag in the available reported statistics, the increase in service statistics will not be set to this level. Thus, only less than half of the terminations are being reported. If the proportion of unregistered facilities in this study is taken and added to the above said number, then number of abortions in these states would be as high as 5,59,112, which shows that only less than 30 percent of the total terminations in formal settings are being reported.

Providers were also asked if they had to postpone or refuse MTP services to clients due to logistic problems in the facility in the three months preceding the data collection. Twenty one percent of the providers in the facilities acknowledged that they had to refuse the services at least once during the reference period (table 6.3). Postponement of services was reported more in public facilities (31 percent) than in private ones (18 percent). This is as expected as private facilities will make all attempts to fulfill the needs of the clients visiting them. Percentage of providers reporting postponement of service was less in the registered private facility (13 percent). Facilities located in the less developed districts had to relatively postpone their services more (31 percent) than those located in the better developed districts (16 percent). The main reason for postponing the services was non-availability of the provider (25 percent). This was high at 37 percent among the facilities based in less developed districts as against 17 percent among the facilities of better developed districts. Equipment related reasons were reported by relatively lesser facilities. In public facilities, around 14 percent also reported 'too many patients' as one of the reason for postponing the abortion services on the day it was sought by the women.

Table 6.3: Number of facilities that postponed/refused services provision due of logistic reasons by type of facilities and districts

(Percentage)

	Type of facilities				Type of districts		All
	Public	Private			Better developed	Less developed	
		Registered	Not Registered	Total			
Facilities where service was postponed at least once in the last three months*	31	13	20	18	16	31	21
Reasons for postponing services*							
Provider not there							
Equipment out of order	34	18	23	21	17	37	25
Instruments related	10	3	7	6	6	8	7
Consumables related	11	5	6	5	5	10	7
Too many patients	7	2	3	3	4	4	4
	14	8	12	11	9	17	12
Total number of providers (one for each facility)	91	67	210	277	234	134	368

* Percentage are based on total number of facilities

The study also made an attempt to understand whether the facilities had the provision to handle emergency cases, especially if the case is received in the night. Around seven out of ten facilities mentioned that their facility was open in the night (Table 6.4). The situation is almost similar in public and private registered facilities as 88 percent and 91 percent respectively reported that their facility is open in the night. In 75 percent of the cases, doctor is available to attend to the woman at night, while in 36 percent of the cases a trained nurse is available. Overnight staying facility is available in 93 percent of the public and private registered facilities, while in the non-registered facilities this was only so in 61 percent of the facilities. Analysis of this data by type of district does not show any variation in the facilities located in the better and less developed districts.

Table 6.4: Ability of facility to function for emergency cases/in non routine hours by type of facility

(Percentage)

	Public	Private			All
		Registered	Not Registered	Total	
Facility open at night	88	91	60	67	72
Person available to see woman at night*					
Doctor	63	89	77	81	75
Trained nurse	54	20	32	28	36
Others	5	-	6	4	5
Overnight staying facility available	93	93	61	69	75
Blood transfusion facility available in house	30	28	16	18	21

* Percentage are based on those facilities that are open at night and these percentage may exceed 100 due to multiple responses

To handle abortion complications, it is essential to have facilities/arrangements for blood transfusion, as the need may arise anytime. In-house blood transfusion facility was available in 21 percent of the facilities. In this case too an almost equal percentage of public facilities and private registered facilities had this facility.

Post abortion complications: When abortion is performed by appropriately trained personnel complications are rare. Nevertheless, it is known that proportion of abortions by untrained personnel is

high and hence probability of complications would also be high, but the magnitude of this is not known. Carelessness by a qualified/unqualified professional may also lead to complications. To some extent the incidence of such complications can be gauged from the responses of the providers who acknowledge that their facilities receive post abortion complication cases. As table 6.5 shows more (86 percent) private providers have reported receiving women with post abortion complications than the public providers (75 percent), but the average number of cases seen by private providers is 6 in the last three months, while public providers have reported seeing 7 such cases.

The commonly seen complications reported include incomplete abortion (76 percent), haemorrhage (43 percent) and pelvic inflammatory disease (PID) (34 percent). This raises questions about the technical skill of the providers who are providing abortion services. These complications further lead to problems like septicaemia (33 percent), haemorrhage (43 percent) and shock (13 percent).

It is interesting to note that the pattern of response on the type of complications commonly seen and reported by the provider is almost similar across the various types of facilities. This is indicative of the prevalence and type of post abortion complications that exist among the abortion seekers. Strategies need to be worked out on how this could be addressed and minimized.

Table 6.5: Post abortion complication cases-type and number, by type of facility

	Public	Private			All
		Registered	Not Registered	Total	
Facilities which receive women with post abortion complications	75	96	82	86	83
Total number of provider (one for each facility)	91	67	210	277	368
Average number of post abortion complications in last three months	7	5	6	6	6
Commonly seen complications*					
Incomplete abortion	88	75	72	73	76
Septicaemia	37	23	35	32	33
Haemorrhage	56	41	39	39	43
Shock	18	5	14	11	13
Perforation	34	19	21	21	24
PID	41	33	32	33	34
Number of providers who receive post abortion complication cases	68	64	173	237	305

* Percentage may exceed 100 due to multiple responses

Analysis of the data (Table 6.6) on post-abortion complications indicates that the percentage of providers who reported that they receive post-abortion complication cases is 84 percent and 87 percent in better and less developed districts respectively. The average number of such cases received in the three months preceding the data collection was around four in better-developed districts and 10 in less developed districts. In these districts the average cases received by the public facilities are 13 while in private facilities it is around 9 cases. This indicates that a larger proportion of abortions lead to complications in less developed districts (one out of four) in contrast to better developed districts (one out of six).

Table 6.6: Status of post abortion complication cases

	Better Developed			Less Developed		
	Public	Private	Total	Public	Private	Total
Percent who receive post abortion	78	86	84	87	87	87

complication cases						
Average number received in last three months	4.7	3.7	3.9	13.1	8.6	10.1

Regarding the type of post abortion complications the percentage of providers reporting incomplete abortions and septicemia was 89 percent and 45 percent respectively in less developed districts while it was only 68 percent and 29 percent respectively in better developed districts (figure 6.3). Relatively more reporting of the complications from the poor developed districts indicates that the type of abortion services available in these areas coupled with the technical skill of the providers needs to be looked into. It further demonstrates that there is a demand for abortion services in the community and they seek the services from whatever source is available to them.

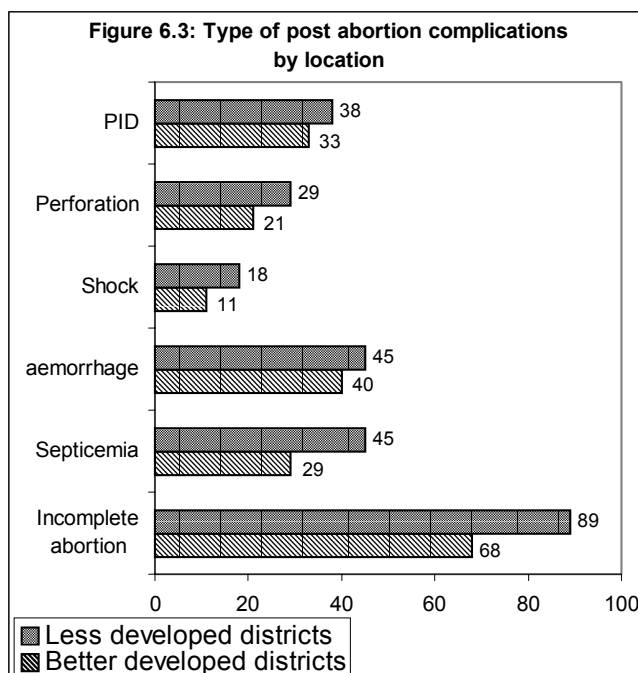


Table 6.7: Management of abortion complication

(Percentage)

Type of complication	Public	Private			All
		Registered	Not Registered	Total	
Excessive bleeding					
Referred out	13	8	29	24	20
Stabilised and referred	22	12	21	19	20
Managed in house	61	8	46	54	56
Others	3	2	1	1	2
Not mentioned	2	-	3	2	2
Perforation peritonitis					
Referred out	30	22	42	37	35
Stabilised and referred	22	9	17	15	17
Managed in house	41	68	36	45	44
Others	2	-	1	1	1
Not mentioned	6	-	4	3	4
Total number of providers	128	85	239	324	452

Constellation of services: The facilities covered in this survey are not exclusively providing MTP services, it is only one component of the reproductive health services that they provide. Almost all the facilities are involved in providing antenatal (96 percent) and postnatal care (91 percent) (table 6.8). Services related to contraception, and management of post abortion complications are also provided. Delivery is conducted relatively more by the private registered facilities (91 percent) than by public (89 percent) and unregistered private facilities (71 percent). This is probably because, as seen in the earlier discussion, more gynaecologists are based in registered private facilities. Some of the other services offered include treatment of STD/HIV, infertility management, treatment of other gynaecological

problems etc. By offering a range of services to women the providers have the opportunity to offer non-directive counselling and contraceptive information and services. Provision of complete information while providing abortion services could help in preventing future unwanted pregnancies and reduce the need for unnecessary abortions. The data further indicates that the facilities located in less developed districts are relatively involved more in providing services for management of post abortion complications treatment of STD/HIV, infertility and contraceptive than facilities located in the better developed districts.

Table 6.8: Facilities offering other types of RH services by type of facilities and districts (Percentage)

Type of RH services*	Type of facilities				Type of districts		All
	Public	Private			Better developed	Less developed	
		Registered	Not Registered	Total			
Antenatal care	98	94	95	95	97	93	96
Delivery	89	91	71	76	81	77	79
Postnatal care	95	99	88	90	92	90	91
Contraception	98	96	84	87	88	92	89
Management of post abortion complications	84	97	80	84	81	88	84
Treatment of STD/HIV	64	67	61	62	55	76	63
Infertility management	39	45	34	37	33	43	37
Other gynaecological problems	56	76	53	59	59	58	58
Vaginal procedures	79	90	70	74	75	76	76
Laparotomy	40	72	41	49	52	37	47
Laparoscopy	48	37	20	24	30	31	30
Total number of providers (one for each facility)	91	67	210	277	234	134	368

* Percentage may exceed 100 due to multiple responses

Referral Mechanisms: In the provision of safe abortion services it is extremely important that a well-functioning referral system is in place. Providers at the facility should be able to guide women to approach appropriate services if they are not available in their facility. Such referral pattern would ensure that a woman who desires services can obtain them in a timely manner. It is in this context that the study made an attempt to understand from the providers their referral mechanism in dealing with abortion cases. Data in Table 6.9 clearly indicates that around two-thirds of the facilities are referring at least some of the cases, as they are incapable of handling all types of cases. Further, analysis by type of facility indicates that facilities referring selective abortion cases are highest amongst the unregistered private facilities (71 percent), followed by the public facilities (67 percent). In the case of registered private facilities only 46 percent of them need to refer their cases. Further probing of the providers on the approximate proportion of women who seek abortion services and are to be referred elsewhere, showed that almost one-fifth of the facilities refer more than 50 percent of their cases. The proportion of referral is highest (27 percent) in the unregistered private facilities, while in registered private facilities it is only 3 percent. Relatively low percentage of referrals from registered private facilities could be due to the availability of skilled manpower and the required equipments within the facility. The types of cases that get referred to higher referral centres were also explored. It is interesting to note that 78 percent of the providers mentioned that it is the second trimester cases that are most commonly referred. As discussed earlier, the skill and instruments required for conducting second trimester abortions are relatively more complex than the first trimester abortions. Medical risk and incomplete abortions 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. Nature of facilities used as the referrals

are mainly other government hospitals which includes district hospitals (44 percent), medical colleges (25 percent), post-partum centres (15 percent), sub-district hospital (11 percent) and PHC/CHC (7 percent). Around 28 percent of the cases get referred to other private hospitals. Most of the private providers are referring the clients to public facilities, namely to district hospital, thus public facilities are viewed as institutions where all the facilities are available to the clients and hence taken as the referral facility even by the private facilities.

Table 6.9: Referral Patterns (Percentage)

	Public	Private			All
		Registered	Not Registered	Total	
Facilities referring out at least some selective abortion cases	67	46	71	65	66
Number of provider (one for each facility)	91	67	210	277	368
Facilities referring out >50 % of cases	15	3	27	23	21
Types of cases commonly referred*					
2 nd trimester abortion	77	61	81	78	78
Incomplete abortion from elsewhere	23	13	28	26	25
Medical risk	67	45	57	55	58
Place where referral is made*					
PHC/CHC	16	3	5	4	8
Sub-district hospital	8	7	13	12	11
Post partum centre	13	3	19	16	15
District hospital	43	36	47	45	44
Medical college	13	52	24	28	25
Private hospital	2	23	40	37	28
Others	7	3	6	6	6
Number of providers who are referring some cases	61	31	149	180	241

* Percentage may exceed 100 due to multiple responses

In order to understand the referral linkages of these facilities with the referral centers, the providers were probed on whether they had entered into any formal or informal arrangements/agreement with these referral centres. About 19 percent of the private facilities acknowledged that they had such kind of arrangement. This low percentage could be due to the fact that most of the private facilities refer their cases to public facilities. In public facilities, only 8 percent of them reported having referral linkage. The type of arrangement in two-thirds of the cases was the assurance by the facility that the referred patient would be treated on a priority basis.

Table 6.10: Referral Linkages (Percentage)

	Public	Private			All
		Registered	Not Registered	Total	
Formal/ informal referral arrangement with another hospital exits	8	19	19	19	16
Number of provider (one for each facility)	91	67	210	277	368
Type of arrangement*					
Patients get priority treatment	60	83	68	71	69
Patients reverted back after getting care	20	33	21	24	23
I get a nominal payment for referred cases	-	-	7	6	5
Others	20	-	4	3	5
Number of providers who had a referral arrangement	5	6	28	34	39

* Percentage may exceed 100 due to multiple responses

Physical and Social Accessibility

In Table 6.11 we have listed factors affecting physical and social access to abortion services. As regards physical access it must be noted that this is from the facility point of view and not the client, hence when we see that almost all facilities are located within easy access of motorable roads or close to public transport routes it is not a surprise because that is how facilities ought to be located. Physical access from the standpoint of the client has relevance as it indicates the status of physical accessibility of abortion care facilities with respect to abortion-seekers. The present study does not record the client perspective though this will come out in other studies under the AAP-India set of studies. What we however see here is that information about the facility having abortion services is not adequately displayed in both public and private facilities and this could become a barrier to physical access. Most facilities (95 percent) do not display their certification status, this would make it difficult for the clients to differentiate between legal and non-legal providers. With regard to clinic timings most private facilities do display them, with a larger proportion in registered facilities doing so. In public facilities, especially in the better-developed districts, less than half of the facilities (46 percent) display their timings for the benefit of the clients. Access to telephone at the facilities is reasonably good (85 percent), except in public facilities in less developed districts.

Table 6.11: Physical and Social Access for Abortion Services across better and less developed districts

(percentages)

Access Factors	Better Developed			Less Developed			All
	Public	Pvt. Reg.	Pvt. Unreg.	Public	Pvt. Reg.	Pvt. Unreg.	Total
Physical Access							
On road or < 1 km	91	92	95	95	100	93	94
More than 1 km	9	8	5	5	0	7	6
Metalled road	86	97	91	93	89	82	73
Public transport (bus/train)	64	82	87	81	72	74	78
Autorickshaw/jeep	98	82	96	92	93	97	94
Signboard display for MTP	9	21	9	16	45	14	15
Display of MTP registration	2	11	NA	11	10	NA	5
Display of clinic timings	46	79	69	68	90	64	67
Phone at facility	80	97	90	54	100	81	85
Number of Facilities	55	38	121	37	29	58	380
Social Access							
Comfortable with local language	100	100	94	100	100	94	97
Don't provide abortion on same day	55	68	42	64	37	44	49
Main reasons for above:							
1. Investigations needed	35	49	26	53	33	17	29
2. Patients not prepared	23	22	13	19	33	26	21
3. Technical reasons	2	16	6	14	0	2	8
Provide abortion under following conditions:							
1. woman comes alone	23	15	27	11	3	31	23
2. woman's friend but no family member	58	59	57	65	48	66	59
3. woman is unmarried	61	69	65	46	55	60	61
4. widowed/separated woman	74	87	74	68	59	72	73
5. nullipara married woman	46	64	47	73	66	68	56
Reasons for seeking abortions							
Rape	16	3	3	33	11	6	7
Incest	7	5	10	27	11	26	13
Failure of contraception	74	80	57	100	100	89	72
As a spacing method	67	69	68	80	78	76	70

Access Factors	Better Developed			Less Developed			All
	Public	Pvt. Reg.	Pvt. Unreg.	Public	Pvt. Reg.	Pvt. Unreg.	Total
Risk to mothers life	39	44	43	67	67	40	44
After sex-determination	4	5	7	7	-	33	10
Pregnancy outside marriage	51	36	41	60	44	56	46
For eugenic purpose	18	13	8	7	-	7	10

In addition to physical accessibility, it is equally important to ascertain the social accessibility. As the information gathered is from the facilities, certain variables were identified which could reflect social accessibility/inaccessibility. Analysis of this data indicates that the providers were comfortable in the use of local language. Almost all providers said that they had no problems on this front and language does not hinder interaction between provider and client. Providers were also asked if they provided abortion services for certain conditions like a woman coming alone to the facility for abortion. Very few providers said that they would provide abortions to such women. As we have seen earlier the law is very clear on this. Only the woman's consent is necessary, but most doctors do not want to take the risk of providing abortions without the husband's or some relative's consent. The main reasons cited were that abortions involve risk therefore some family member should be present in the facility, in other words the provider is being cautious and safe guarding himself/herself in case of any unforeseen situation. Further, around six to seven doctors out of every 10 doctors opined that they would provide abortion services to women even if they are unmarried or widowed/divorced, though the proportion is a little lower in less developed districts. Here too, those who would not provide abortion services to such women, gave risks involved and illegality as the main reasons. Reasons were also sought from the providers as to why women sought abortions most providers talked about contraceptive failure (72 percent) or use of abortion as a spacing method (70 percent). Some other reasons mentioned for availing abortion services involved risk to mother's life (42 percent), it was a pregnancy conceived outside of marriage (46 percent). A significant number also acknowledged sex-determination, rape and incest as a reason of why women seek abortions.

Financial Access and Charges

Table 6.12 looks at financial access. That is, what the facilities and providers were charging for abortion services at different gestation periods. There is a clear gradient of increasing charges for higher gestation abortions. In the public sector, especially in better-developed districts the charges are very small – in fact the median is zero, indicating that only in a few cases patients have been charged. In the less developed districts the public facilities seem to be charging significant sums but it is upto ten times less than the private sector. Since these are charges reported by the providers the fees charged in public facilities is only in cases where doctors are allowed private practice because MTPs are done free of cost in all public facilities. Within the private sector the reported charges for abortions in the registered facilities are much higher than the unregistered ones. One reason for this difference could be the larger proportion of gynaecologists in the registered facilities. The charges reported by the private facilities seem to be reasonably authentic as households studies too indicate expenditures in similar ranges.

Table 6.12: Reported charges for provision of abortion services across better and less developed districts – in Mean minimum and maximum Rupees per abortion

	Better Developed			Less Developed			All
	Public	Pvt. Reg.	Pvt. Unreg.	Public	Pvt. Reg.	Pvt. Unreg.	Total
Upto 12 weeks Minimum	26.2	967.2	609.7	156.4	460.4	369.2	451.2
Maximum	68.5	1296.9	868.4	337.9	816.1	540.0	664.2
13 – 20 weeks Minimum	76.5	1583.3	883.3	135.7	1258.3	598.6	631.7
Maximum	173.0	2166.7	1376.2	246.4	1816.7	869.3	951.5
Above 20 weeks Minimum	50.0	NA	1374.7	166.7	NA	1050.0	712.5
Maximum	180.0	NA	1642.9	500.0	NA	1450.0	1057.5

Further in Table 6.13 the charges for abortion are seen across qualification of the providers. As expected, the higher the qualification, higher are the charges levied. However in the public sector the gynaecologists charges are less than the other doctors. Again across sectors the private sector charges are 7 times that of the public sector and in case of specialists more than 12 times.

Table 6.13: Reported charges for provision of abortion services by Qualification of providers – in Mean minimum and maximum Rupees per abortion

Qualification	Public	Private	All Facilities
<i>Minimum Charge</i>			
Gyn. MD/MS/DGO	67	837	606
MBBS/ MD, MS	111	620	516
Other	--	206	206
<i>Maximum Charge</i>			
Gyn. MD/MS/DGO	110	1212	880
MBBS/ MD, MS	322	903	668
Other	--	298	298
<i>Average Charges</i>	115	801	615

Thus the above analysis indicates that there is a demand for services from both public and private facilities. Further, while physical and social accessibility is not as much a constraint, financial accessibility could be a limitation for certain sections of women.

CHAPTER VII

TECHNICAL QUALITY: PERFORMANCE STANDARDS OF FACILITIES AND PROVIDERS

The maintenance of technical quality is an essential component of abortion services. Performance standards should be maintained and followed by the abortion providers. The study has made an attempt to understand this by looking into the techniques and the pain control methods used by the providers, drugs prescribed, information/counselling given and management of waste disposal at the facility. Analysis of most of the data has been done by the training status of the providers, to assess whether this makes any difference in their services.

Table 7.1 shows the MTP techniques used by the providers in the three months preceding the survey, by their gestational week and the training status of the providers. The table indicates that 40 and 48 percent of the formally trained providers are using manual vacuum aspiration (MVA) and electric vacuum aspiration (EVA) techniques, respectively to terminate pregnancies below eight weeks of gestation, as against 14 and 18 percent among those not formally trained. Dilatation and curettage (D&C) is the most commonly used method among those not formally trained providers. Use of medical methods is more (27 percent) among those not formally trained as against 7 percent among the formally trained providers. Fifteen percent of all providers are also using the dilatation and evacuation (D&E) method. The methods commonly used between 9 to 12 weeks of gestation are dilatation and curettage (56 percent) and electric vacuum aspiration (34 percent), 30 percent are using dilatation and evacuation. MVA is used relatively less at 13 percent, while the use of medical methods is 10 percent. As per the established protocols the preferred methods up to 12 completed weeks are manual or electric vacuum aspiration or medical methods. The regimen of medical methods between 9 to 12 weeks is under investigation and this could be the reason for the relatively less use of this method for this gestation period. Dilatation and curettage, however, continues to be used most commonly despite the WHO recommendation that efforts should be made to replace the sharp curettage with vacuum aspiration. Data thus indicates that even for early gestational weeks, surgical methods are being used, instead of simple available methods. Apparently difference also exists in the methods used by the formal and non-formal trained providers. Formally trained providers depend more on the use of surgical methods while the non-formally trained providers depend more on dilatation and curettage and medical methods. MVA which is considered to be an OPD method and involves less risk is used less.

The second trimester methods used are mainly extra amniotic method (50 percent), dilatation and curettage (33 percent), dilatation and evacuation (20 percent) and intra amniotic method (10 percent).

For the termination of second trimester pregnancies dilatation and evacuation is considered to be the safest and most effective surgical technique. Analysis of the same data by better and less developed districts indicates that providers of less developed districts are using dilatation and curettage method more than other methods. This could be either due to lack of necessary equipments and logistics and/or lack of skilled providers to use other methods. Thus it may be inferred that the providers are utilizing the abortion methods which they feel most comfortable with and/or convenient to use, either due to the availability of the requisite equipments or the providers training and experience in the use of the methods which has given them the confidence to use the method.

Table 7.1: Abortion techniques used by the providers by their training status and type of districts for 1st and IInd trimester abortions

(Percentage)

Methods of abortion*	Training status of provider		Type of District		Total
	Formally Trained	Not Formally Trained	Better Developed	Less Developed	
≤ 8 weeks					
MVA	40	14	40	20	33
EVA	48	18	41	36	40
D&C	38	55	36	56	43
D&E	17	10	16	13	15
Medical Methods	7	27	11	15	12
Number of provider	285	109	198	148	394
9-12 weeks					
MVA	16	3	16	8	13
EVA	38	22	33	35	34
D&C	54	62	52	61	56
D&E	32	23	42	14	30
Medical Methods	7	16	8	12	10
Number of provider	230	73	171	132	303
13 - 20 weeks					
D&C	30	46	27	39	33
D&E	19	23	22	18	20
Extra amniotic	52	46	58	42	50
Intra amniotic	13	-	18	2	10
Medical Methods	15	5	5	21	13
Number of provider	95	22	60	57	117

* Percentage may exceed 100 due to multiple responses

Pain Management: Pain management is critical in taking care of the women's anxiety and discomfort. Medication for this should always be offered. Three types of drugs, either singly or in combination are used to manage pain during abortion: analgesics, which alleviate the sensation of pain; tranquilizers, which reduce anxiety; and anaesthetics, which numb physical sensation. In most cases, analgesics, local anaesthesia and/or mild sedation supplemented by verbal support, are sufficient.²⁰ Data collected on this has been analysed by the gestational weeks (table 7.2). For the first trimester abortions analgesia and/or sedation are reported to be used by almost 72 to 75 percent of the providers. Local anaesthesia was used by almost 34 to 45 percent of the providers. Use of pain control methods is adhered to more by the trained providers as compared to the not trained providers. A surgical method recommended to be used in the first trimester does not entail the administration of general anaesthesia as pain control. But data indicates that 21 to 30 percent of the providers are using general anaesthesia. This could be because the providers are using dilatation and evacuation method in the first trimester and general anaesthesia is usually used with this technique. The percentage of providers using analgesia is relatively more in the less developed districts as compared to better-developed districts. The advantages of using local, rather than general anaesthesia include a faster recovery time. Also, the woman remains conscious during the procedure and hence is able to alert the provider to problems that might arise²¹.

²⁰ WHO : Safe Abortion – Technical and Policy Guidance for Health Systems, World Health Organization, 2003, Geneva.

²¹ ibid

Table 7.2: Pain control methods used by training status of providers and type of districts for 1st and IInd trimester abortions

(Percentage)

Pain control methods*	Training status of provider		Type of District		Total
	Formally Trained	Not Formally Trained	Better Developed	Less Developed	
≤ 8 weeks					
Analgesia/sedation	77	61	66	82	72
Local anaesthesia	39	22	33	35	34
General anaesthesia	24	12	21	19	21
Number of provider	322	130	282	170	452
9-12 weeks					
Analgesia/sedation	76	71	68	85	75
Local anaesthesia	48	34	47	43	45
General anaesthesia	33	17	29	30	30
Number of provider	267	79	198	148	346
13-20 weeks					
Analgesia/sedation	58	54	47	67	57
Local anaesthesia	32	42	26	41	34
General anaesthesia	26	35	21	35	28
Number of provider	125	26	75	76	151

* Percentage may exceed 100 due to multiple responses

The study also attempted to look into some of the pre/post abortion services offered by the providers. Providers were asked what examination they conduct before an abortion client is discharged. As Table 7.3, indicates a little more than half (57 percent) of the providers reported conducting general physical examination, while 35 and 38 percent of them reported conducting pelvic and abdominal examination respectively. An analysis of the same data by training status of the provider indicates that a higher percentage of formally trained providers conduct these examinations. Similarly providers of better developed districts conduct these examinations to some extent more than those from less developed districts.

The low levels of such a check up prior to discharge is a serious concern and there is hence a need to develop a strategy to ensure that there become norms in practice.

Table 7.3: Type of pre discharge examination conducted by training status of providers and type of districts

(Percentage)

Examination*	Training status of provider		Type of District		Total
	Formally Trained	Not Formally Trained	Better Developed	Less Developed	
General physical	62	46	64	47	57
Pelvic	39	24	40	25	35
Abdominal	42	28	40	34	38
Total number of providers	322	130	282	170	452

* Percentage may exceed 100 due to multiple responses

Drugs prescribed: Providers were also asked to list the names of the drugs that they routinely prescribe after conducting an abortion. The providers reported prescribing combination of drugs. More than four-fifths of the providers prescribed antibiotics, this is 99 percent in better developed districts. This is followed by analgesics (19 percent), uterotonics (11 percent), etc. Antibiotics are prescribed relatively more by the formally trained providers (96 percent) than the not-formally trained providers (69

percent). To a large extent, the pattern of drug prescription is almost similar among the providers irrespective of their training status. Some of the providers prescribe iron (7 percent), vitamins (9 percent), tonic (9 percent), etc possibly because they perceive that the client requires them (Table 7.4).

Table 7.4: Drugs routinely prescribed after an abortion by training status of provider and type of district

Drugs*	Training status of provider		Type of District		Total
	Formally Trained	Not Formally Trained	Better Developed	Less Developed	
Antibiotics	96	69	99	81	88
Uterotonics	11	10	11	9	11
Analgesics	17	21	15	30	19
Pain killer	6	8	8	3	7
Iron	9	2	8	3	7
Vitamins	9	9	10	8	9
Antispasmodics	11	3	9	6	8
R.B. Tonic	7	14	5	21	9
Others	13	11	13	12	13
Total number of provider	246	108	256	98	354

* Percentage may exceed 100 due to multiple responses

Information/Counselling: The provision of information is an essential component of quality service. Information must be complete, accurate, and easy to understand, and be given in a way that respects the women's privacy and confidentiality.²² Counselling thus forms an integral part of any service delivery, more so in abortion service, as it involves pre and post abortion counselling. The broad components that fall under this are: decision-making counselling; information on abortion procedures and contraceptive information and services. The study made an attempt to understand this from the providers. They were asked about the issues/matters that they discussed with the client before carrying out an abortion procedure. About four-fifths of the providers mentioned that they talked about the possible complications in the pre-abortion counselling, while around three-fifths of the providers mentioned talking about the pain/discomfort that may arise during the procedure and how it will be minimized; return of fertility and post-abortion contraception. Analysis of this data by the training status of the providers has also been done with the assumption that formally trained providers would be providing more information than the not-formally trained providers. This is confirmed to some extent by the analysis presented in Table 7.5. As it is evident from the Table, more formally trained providers share this information than those not-formally trained.

In addition to the above, the providers were also asked about the instructions that they usually give to the client at the time of discharge. Around three-fifths of the providers mentioned when the woman should return for routine follow up. A little more than half of the providers mentioned that they talked to the clients about the danger signs that they should look for and what they should do under the circumstances; how to take the prescribed medication and the contraceptive method they should use. Information regarding the use of contraceptive following abortion is important to prevent another unwanted pregnancy. Instructions regarding diet and work was given by 33 percent and 27 percent of the providers respectively. Twenty-nine percent of the providers also reported that they tell the client when she will be able to resume sexual intercourse (Table 7.5). Analysis of this data by training status indicates that except for information regarding danger signs, follow up visits and contraception, there is really not much of a difference between the formally trained and not-formally trained providers. Analysis of the same data by type of district indicates that to some extent the issue of counselling is almost

²² Ibid

similar in both type of districts in case of pre-abortion counselling, but in post abortion counselling is relatively less in less developed districts as compared to better developed district.

The above data clearly indicates that not all providers are giving their clients complete information. A comparison of the issues discussed by the providers with their clients with the defined framework for the minimum information that should be given to a women as per the standardised protocol.²³ indicates that the details regarding the abortion procedure is not discussed by the providers.

Table 7.5: Information given during pre and post abortion counselling by training status of providers and type of district

Issues discussed in	Training status of provider		Type of District		Total
	Formally Trained	Not Formally Trained	Better Developed	Less Developed	
Pre abortion counselling*					
Pain	73	46	63	74	66
Complication	88	62	83	75	81
Return of fertility	64	46	61	55	59
Post abortion contraception	75	54	67	77	69
Post abortion counselling*					
Danger signs	61	39	67	34	54
Post abortion medication	57	51	60	47	55
Diet	33	32	29	38	33
Work	25	32	28	25	27
Sexual intercourse	30	29	33	24	29
Contraception	57	40	59	41	52
Follow up visit	68	51	73	48	63
Total number of providers	322	130	282	170	452

* Percentage may exceed 100 due to multiple responses

Follow-up visit: Ideally, women undergoing surgical abortion should have a follow-up visit with a trained provider seven to 10 days after the procedure, to assess the general health.²⁴ The study also attempted to look into this from the providers. Almost all (94 percent) the providers mentioned that they advised women to return for a follow-up. The average number of days after which the visit was recommended was around 10 days. This ranged between eight days (in the case of not-formally trained providers) to 11 days in case of the formally trained providers (Table 7.6). Providers were also probed on the circumstances when they advised a woman undergoing abortion to return immediately. As the data illustrates about nine out of 10 providers mentioned asking the client to return in case of excessive bleeding, while around two-thirds asked them to return if there was abdominal pain. Around half the providers asked the woman to return for follow-up if they had fever.

²³ I bid

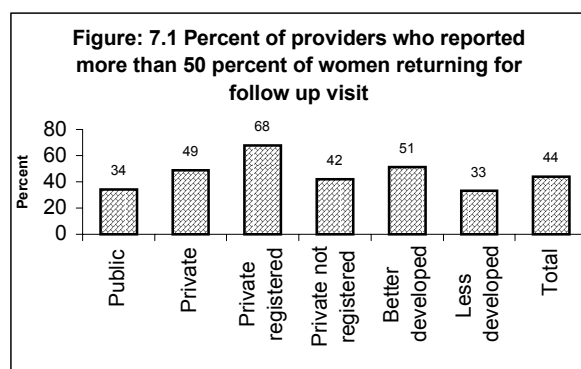
²⁴ I bid

Table 7.6: Advise given about follow-up visits by training status of provider and type of district

(Percentage)

	Training status of provider		Type of District		Total
	Formally Trained	Not Formally Trained	Better Developed	Less Developed	
Providers who advise routine follow up visit	95	91	93	95	94
Average number of days when post abortion visit is recommended	11.4	8.1	10.5	10.4	10.3
Circumstances when emergency follow up advised*					
Excessive bleeding	93	88	96	84	91
Abdominal pain	72	61	71	65	69
Vomiting	38	28	45	18	35
Fever	52	49	61	36	51
Foul smelling discharge	42	35	43	35	40
Total number of provider	322	130	282	170	452

* Percentage may exceed 100 due to multiple responses



In addition to collecting information on the instructions given to the clients for follow-up, providers were further probed to understand the approximate proportion of women who really came back for follow up. As Figure 7.1 indicates only 44 percent of the providers reported that more than 50 percent of women returned for follow up visit. Follow-up visits are reported more in the private facilities (49 percent) than in the public facilities (34 percent).

In the private facilities too, follow-up visits are reported more by the certified facilities (68 percent) than by the uncertified facilities (42 percent). This could be due to the relatively better counselling and confidence that the clients have in the certified private facilities. Revisits are done by around 51 percent of the women in better developed district as against 33 percent of the women in less developed district.

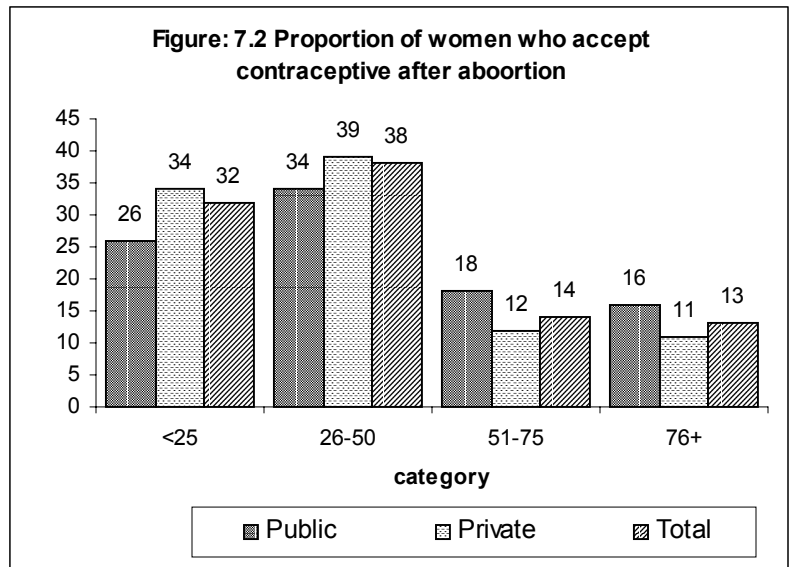
Contraceptive counselling: As discussed earlier, providing information to clients regarding contraceptive use following abortion is important to prevent another unwanted pregnancy. Women who undergo abortion have to be informed that ovulation can return as early as about two weeks after abortion thus putting them at risk of pregnancy, unless an effective contraceptive is used. In view of this, the providers were again probed in detail about contraceptive and whether they routinely discuss contraception with women seeking abortion at their facility. Almost all the formally trained (98 percent) and majority of the not-formally trained (89 percent) providers mentioned discussing this with the client (table 7.7). The high response of the providers here as compared to the response for contraceptive in the issues discussed in pre/post abortion counselling could be because here the question on contraceptive counselling was put forth directly, whereas in the earlier case it was an open ended question and the providers gave the answer that was top most on their minds. The stage at which they discussed contraception in the abortion services varied from 68 percent of the providers mentioning that they counselled before abortion, while 22 percent mentioned that they did so after the abortion procedure. Around 77 percent of the providers mentioned that they insisted their clients undergoing abortion to adopt certain contraceptive methods. Those providers who reported that they insisted on the contraceptive method were further probed on the contraceptive methods that they insisted on. In spacing methods, IUD was mentioned by 74 percent, oral pills by 68 percent and condoms by 46 percent. More formally trained providers insisted on permanent methods (vasectomy 15 percent, tubectomy 64 percent) as compared to the not-formally trained providers (vasectomy 11 percent, tubectomy 47 percent). From the data it is evident that to some extent it is the individual providers bias in deciding the contraceptive method that the woman should accept or it could depend on the type of case or availability of the methods in the facility. But clearly promotion of the male methods is not so evident.

Table 7.7: Contraceptive counselling, its timing and family method insisted by training status of provider and type of district (Percentage)

	Training status of provider		Type of District		Total
	Formally Trained	Not Formally Trained	Better Developed	Less Developed	
Providers who offer contraceptive counselling	98	89	96	95	95
Timing of contraception counselling*					
Before abortion procedure	73	52	66	70	68
During abortion procedure	3	1	3	3	3
After abortion procedure	18	31	20	26	22
Any time	10	16	15	7	12
Insistence on method	79	72	75	81	77
Total number of provider	322	130	452	282	170
Methods insisted on*					
Vasectomy	15	11	11	17	14
Tubectomy	71	47	64	65	64
IUD	79	60	81	62	74
Pills	67	72	71	65	68
Condoms	47	46	46	46	46
Injectables	21	16	9	37	20
Number of providers who insist the client to adopt FP method	322	130	210	138	452

* Percentage may exceed 100 due to multiple responses

Providers were further probed on the proportion of women who actually accepted contraception post abortion. Only 27 percent of the providers mentioned that more than 51 percent of the abortion seekers adopt a contraceptive post abortion (Figure 7.2). To some extent, the acceptability of contraceptive was reported more by the public providers (34 percent) as compared to the private providers (23 percent).



Disposal of waste: In addition to the quality to be maintained in the MTP techniques used and the type of counselling that is given, it is equally important for a facility to maintain proper standards for the disposal of waste. As Table 7.8 indicates the use of proper waste disposal by incineration for products of conception, gloves or syringes/needles is only 7 to 8 percent. Disposal of these products through burning was reported by 11 to 28 percent of the facilities. The remaining facilities disposed of the waste by either throwing the products in open pit/garbage or burying it. This pattern of disposal is almost similar across the facilities, irrespective of their location in better or less developed district. This needs to be looked into further.

Table 7.8: Process used for waste disposal by type of facilities and district

(Percentage)

	Public	Private			Type of District		All
		Certified	Not Certified	Total	Better Developed	Less Developed	
Products of conception							
Incinerator	7	9	7	8	8	6	7
Burning	9	12	11	11	10	11	11
Open pit/garbage	32	28	30	29	28	34	30
Bury and cover	47	46	38	40	42	44	42
Others	5	5	14	11	12	6	10
Gloves							
Incinerator	3	15	8	10	9	6	8
Burning	34	25	27	26	27	31	28
Open pit/garbage	47	40	37	38	35	50	40
Bury and cover	11	18	17	17	17	12	15
Others	5	2	12	9	12	2	8
Syringes/ Needles							
Incinerator	3	9	10	9	10	4	8
Burning	38	33	22	25	25	35	28
Open pit/garbage	40	40	41	41	39	44	41
Bury and cover	13	13	17	16	17	11	15
Others	5	5	11	9	9	6	8
Number of facilities	92	67	179	246	214	124	338

To conclude management of abortion services overall was relatively better by the formally trained providers. However, norms related to providing counselling and pre discharge examination need to be streamlined and adhered to.

Chapter VIII

INFORMAL PROVIDERS

We have already seen in the preceding sections that even with formally qualified medical professionals, despite legalisation of abortion, a very large proportion of abortions continue to take place outside the formal legal framework and these are considered as illegal abortions under the MTP Act. Apart from these formal providers there also exist a wide array of abortion providers who are not medically qualified and hence as per our definition do not qualify as formal providers. Such providers we have labeled as informal providers and as per the MTP Act abortions done by them are also considered illegal. As this has been hitherto an unexplored area, there are a lot more questions than answers like the 'terminology to be used to describe these persons', 'their distribution and identification' and 'lack of information regarding their numbers' etc. As explained in the chapter on methodology the large scale existence of such providers prompted us to include them in the study in a limited way. Since there is wide variation across states about the nature of such providers there is some variation in the protocols which were used. However, certain core questions were similar, and these have been analysed and presented below.²⁵ The strategy to identify these providers and their distribution was not uniform across the states. Hence, the following findings should be viewed cautiously.

In this chapter, persons have been considered as 'Informal Providers' basically because they have not undertaken a 'formal medical doctor's training' and neither do they provide their services from a 'formal clinic type of set up'. Thus, the data includes a wide range of persons from traditional practitioners to birth attendants, village doctors called RMPs or Rural Medical Practitioners, paramedical workers, chemist/pharmacist etc. Among the six study states, informal providers were identified in four states namely Haryana, Madhya Pradesh, Orissa and Rajasthan. In Kerala and Mizoram, this category of providers were not identified and hence not included in the study. The informal providers were identified in the same study area where the data collection for the formal facilities was done. Out of the total informal providers identified, 1270 who agreed to participate in the study were interviewed. Distribution of these providers state wise is 379 in Haryana, 170 in Madhya Pradesh, 40 in Orissa and 681 in Rajasthan.

Profile of Informal providers: As mentioned earlier a wide range of informal providers were interviewed in this study. This predominantly includes rural medical practitioner (51 percent), followed by health workers (18 percent), dai (11 percent), lab technician /pharmacist (10 percent) and non-degree practitioners of Indian System of Medicine (10 percent). The category of health workers include the auxiliary nurse midwife (ANM), lady health visitor (LHV), nurse and male health worker. As the training and experience of each of these providers is very varied, analysis of the subsequent data is done by controlling for their type.

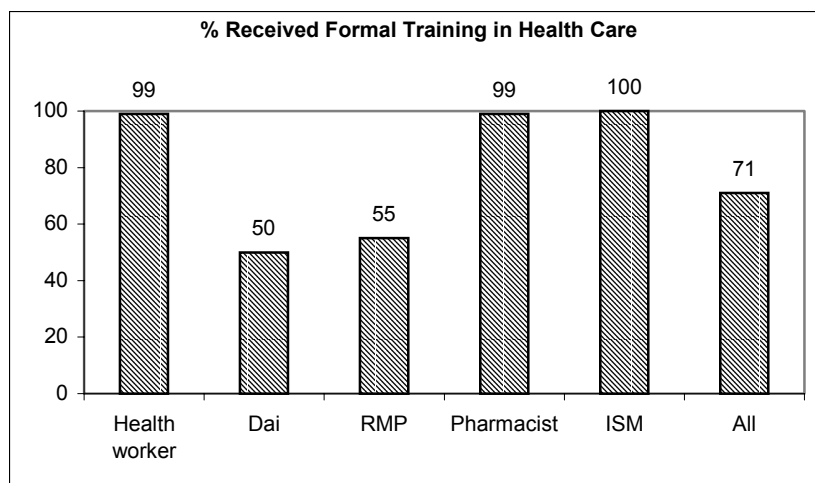
²⁵ Apart from the limited exploration in the six states reported in the present study a separate qualitative multicentric study of informal providers was also commissioned across six states, not necessarily the same states. Abortion Services In India Report Of a Multicentric Enquiry, *Ravi Duggal and Sandhya Barge* Centre For Enquiry Into Health And Allied Themes (CEHAT) and Healthwatch

**Table 8.1: Background Characteristics of Informal Providers
(Percentage)**

Characteristics	Health Worker	Dai	RMP	Pharmacist	ISM	All
Age Group (in years)						
<30	31	17	28	14	39	33
31-40	41	12	20	55	39	32
41-50	20	24	10	20	23	21
51 and more	7	46	37	11	20	14
Mean Age	37	50	37	39	41	39
Sex						
Male	3	29	99	100	97	74
Female	97	71	2	-	3	27
Education Level						
Illiterate	1	64	1	2	2	8
Primary	3	9	2	1	-	3
Mid/high school	88	15	66	39	62	62
Graduate and above	8	12	31	58	37	28
Total number of informal providers	230	139	652	127	122	1270

Data on age wise break up of the informal providers indicates that the average age of the informal provider is around 39 years. Dais are the oldest with an average age of 50 years, while the health workers and rural medical practitioners are youngest at 37 years. The majority of the informal providers are male (74 percent). Among the health workers almost all are female while it is reverse in the case of RMP, pharmacist and ISM categories where more than 97 percent are males. Further, analysis of data by education shows that more than 90 percent of the informal providers are literate and 28% were graduates and above. However, higher level of education varies from 8 percent (health worker) to 58 percent (pharmacist). As expected, educational level is very low among the dais, nearly two-thirds of them are illiterate (See Table 8.1).

Formal training is necessary even to provide basic health care services. To assess the status of formal training in health care all the informal providers were asked probing questions. Figure 8.1 indicates that except the dai and RMP categories rest of them have received some formal training in health care. Dais are mainly involved in conducting deliveries so they might not be feeling the necessity of formal training. But it is surprising to note that nearly half of the RMPs are providing health services without any formal training.



Treatment for delayed menstruation: Knowing the sensitivity and constraints of discussing about termination of pregnancy with informal providers which is illegal, the issue was approached very cautiously starting from the type of services they generally provide to women and what do they do in case women approach them for delayed/missed periods. It is assumed that any treatment given for this is actually indirectly a termination of pregnancy. As there are many assumptions, the discussion should be taken cautiously.

All the informal providers were asked about the type of treatment they provided for delayed menstruation, and their perception on the success of the treatment and action taken in case of failure of the treatment. Table 8.2 indicates that all categories of informal providers receive clients with delayed menstruation. This percentage ranges from 64 to 67 percent among the pharmacist and RMP to as high as 87 percent among the health workers. Probing on the type of treatment shows that four-fifths of the informal providers give tablets for the treatment of delayed menstruation followed by injection (51 percent) and herbs/decoction (26 percent). About 13 percent of them mentioned the use of instruments to handle such cases. It is interesting to note that the pattern of use of these techniques varied across the categories, and obviously each of them had their own preferences. For instance applying massage or pressure to women and use of herbs/decoction for delayed menstruation was practiced mostly by dais only.

Table 8.2: Treatment of women with delayed periods

Characteristics	(Percentage)					
	Health Worker	Dai	RMP	Pharmacist	ISM	All
% who receive women with delayed menstruation	87	79	67	64	71	72
Type of treatment given in such cases						
Apply massage or pressure	3	26	2	-	-	5
Give herbs/decoction	2	67	30	3	33	26
Give tablets	88	36	87	85	81	80
Give injections	60	22	57	57	34	51
Use instrument	18	17	11	11	4	13
Others	11	6	5	15	7	7
Number of informal providers providing treatment	201	110	435	81	86	913
Proportion believe successful treatment from herbs for more than 50 percent of the cases	33	42	62	100	57	55

Action taken if Herbs not successful						
Provide tablet/injections	-	7	53	50	46	37
Refer	100	73	45	-	54	55
Other	-	1	1	-	7	2
Number of informal providers providing treatment by herbs	3	74	130	2	28	237
Proportion believe successful treatment from tablets for more than 50 percent of the cases	10	39	37	14	47	29
Action taken if Tablets not successful						
Provide injections	68	46	62	57	57	62
Use instrument	2	3	1	4	1	2
Refer	32	26	36	35	40	35
Never happened	-	-	1	-	-	-
Number of informal providers providing treatment by tablets	177	39	378	69	70	733
Proportion believe successful treatment from injection for more than 50 percent of the cases	27	58	62	41	69	52
Action taken if Injection not successful						
Use instrument	24	25	18	13	7	19
Refer	76	67	78	83	86	78
Advice for abortion	-	-	1	-	-	-
Number of informal providers providing treatment by injection	121	24	248	46	29	468

Each of the provider was further probed on what proportion of their clients did they believe were successfully treated and what did they do in case of failure. The analysis of this data in Table 8.2 reveals that 55 percent of the providers believed that they are successful in resuming the menstruation in more than 50 percent of the clients by treating with herbs. In case of failure, more than half of the providers refer the clients, whereas nearly half of the RMPs, pharmacists and ISM providers treat the clients with tablets or injection.

Similarly about 29 percent of the providers believe that they are successful in resuming the cycle in more than 50 percent of the clients by treating the women with tablets. However this proportion is 52 percent in case of treatment with injection. If treatment with tablets fails the majority of providers (62 percent) administer injections while 35 percent of them refer their clients. In case of injections failing, 78 percent providers refer the women. The treatment pattern followed by the informal provider with tablets and/or injection is more or less similar among the various categories of the providers.

A close look at Table 8.2 also indicates that 19 percent of the informal providers also practice using instruments when injection fails. Surprisingly this proportion is high (around one-fourths) among the health workers and dais.

The above analysis of data indicates that informal providers use multiple ways and have varying preferences to deal with cases of delayed menstruation. The community does approach them for treatment. This dynamic needs to be understood and explored further to ensure that women receive safe reproductive health services. The individual state reports and the qualitative studies have more details on the practices of informal providers.