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AVAILABILITY AND ACCESS TO ABORTION SERVICES IN INDIA: MYTH AND REALITIES

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Women facing unwanted pregnancy have practiced induced abortion since ages in all cultures to varying degrees. Abortion is a very safe procedure when properly performed by trained health personnel. In spite of this abortion is legally restricted in many countries leading women to resort to unsafe abortion, a major cause of maternal deaths, injuries and illnesses worldwide. An estimated 20 million unsafe abortions take place each year, accounting for between 50,000 and 100,000 deaths annually. In India, according to the Office of Registrar General of India (RGI), abortion is a major cause of maternal death and contributes about 12 per cent of maternal deaths every year (RGI, 1990). Another study attributes about 20 per cent of the maternal deaths in India to septic abortions due to unsafe abortions (Coyaji, 1994).

ICPD AND ABORTION

In the International Conference on Population and Development (ICPD) held in Cairo, September 1994, abortion was perhaps the most contentious issue that was discussed and debated at length. At the end however, by consensus, unsafe abortion was recognized as a major public health problem and the right to abort unwanted pregnancy as woman's basic right. In its much-debated paragraph, 8.25, the document on the Conferences' Programme of Action states:

> *"In no case should abortion be promoted as a method of family planning. All governments and relevant intergovernmental and non-governmental organizations are urged to strengthen the commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislation process. In circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion. Post abortion counselling, education and family planning services should be offered promptly which will also help to avoid repeat abortions (264)"*

India too is a signatory to ICPD Plan of Action and recognizes women's right to seek and avail abortion services. Ministry of Health and Family Welfare (MOH&FW), under its recently announced Reproductive and Child Health (RCH) approach has reiterated its commitment to strengthening abortion services in rural areas to ensure that all women desiring abortion of unwanted pregnancies should have easy access to safe and hygienic abortion facility. The Act was implemented all over the country except Jammu & Kashmir from April 1972.

ABORTION IN INDIA: LEGAL STATUS AND HISTORICAL PERSPECTIVES

In India, it was as early as in the sixties when the need of liberalization of abortion was felt and a national debate took place. The Shantilal Shah Committee, which was formed on this occasion, deliberated for more than 2 years before submitting its report to the Government in 1966. Following further review and debate, seven years later, the Medical Termination of Pregnancy (MTP) Act was placed in the Parliament in 1971 and was approved without asking any question. The Act was implemented all over the country except Jammu and Kashmir from April 1972.

MTP Act permits the termination of pregnancy on the following grounds:

(a) Where the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or

(b) Where substantial risk exists of the child being born with serious physical or mental abnormality.

In the explanation of the Act, the note also indicated that pregnancy due to failure of contraceptive methods could also be aborted as the *"anguish caused by such unwanted pregnancy may be presumed to contribute a grave injury to the medical health of the pregnant woman"* (MTP Act, 1971).

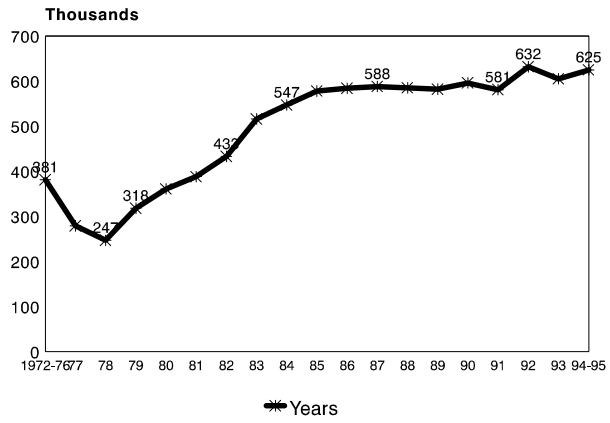
When the MTP (abortion) Act was passed in India, only three other countries in the world had liberal abortion policy. The initiative taken by Government of India in liberalizing abortion was path breaking as the law was passed with complete consensus and it also recognized that unwanted pregnancy could cause serious mental anguish to the women and hence she should have the right to abort it.

The Act, however, put several restrictions that in a way are now proving to be counter productive in making abortion services widely and easily accessible. According to MTP Act, only only those doctors who have received training in conducting abortion must perform abortion procedure. Further, while up to 12 weeks of pregnancy, opinion of one qualified doctor is sufficient, for pregnancy of more than 12 weeks but less than twenty weeks, certification from two registered medical practitioners is essential for conducting MTP. Furthermore, the procedure shall not be performed in any place other than a hospital established or maintained by the government or a clinic approved by government for this purpose. These restrictions, as we will see in subsequent sections have become a major bottleneck in making abortion services easily accessible.

After the introduction of MTP Act in 1971 legalizing abortion, reported abortion cases have been on increase. According to available statistics, the number of approved institutions providing abortion facilities has increased from 1,877 in 1976 to 8,511 in 1994-95. Similarly, the number of abortion cases from a mere 25 reported in the year 1972-73 has gone up to 625,931 in 1994-95. The graph however, also shows that since 1985 number of reported abortions has remained stationary

around 0.6 million which is only a fraction of the actual abortions which are being performed in India (See Figure 1). It is estimated that in India, every year approximately, an additional 5-6 million abortions are conducted by private practitioners (Chhabra, *et al.*, ND). Majority of these cases are performed in rural areas having inadequate facilities and hence done in an unhygienic and unscientific way. All such abortions conducted in unrecognized clinics are considered as illegal and hence not reported in any statistics. These illegal abortions, carried out by untrained village practitioners are a major determinant of continued high levels of maternal morbidity and mortality in India. In India, around 15,000 to 20,000 abortion related deaths are reported in a year.

Figure 1
Trend of Reported MTP in India



It is surprising that even after twenty-seven years of legalization of abortion its availability particularly in rural area is very limited. Recently, particularly after Cairo Conference, there is a growing realization towards an urgent need to increase abortion facilities both in rural and urban areas, so that a woman could have access to safe and hygienic abortion facilities, if she desires to terminate her pregnancy. Necessity for such facilities is crucial not only from family planning perspective, but more importantly also as a measure to ensure safe motherhood.

The present paper based on several studies tries to address to two main issues. First, what is the demand of abortion services in India? Second, are the public facilities equipped to meet these demands and if no, what are the bottlenecks?

The paper is largely based on available government statistics, published articles and a rich data base maintained at Centre for Operations Research and Training (CORT) on abortion services from its various abortion studies in Gujarat, Maharashtra, Tamil Nadu, Uttar Pradesh and Bihar (CORT, 1995, 1996, 1997a, 1997b). The data is based on a representative sample of different health facilities, which were covered under statistical procedure of situation analysis. In all 61 districts from the four states were covered. The total number of health facilities covered included 214 Primary health Centers, 117 Community Health Centers /Rural Hospitals and 49 sub –district Hospitals. Besides these government health facilities, different private clinics, and heath providers conducting abortion were also visited. The number of private clinics covered was 22 percent of the total health facilities studied in the present study. Details of the methodology used for these studies has been described elsewhere (CORT, 1995, 1997a; Khan, *et al.*, 1998).

DEMAND OF ABORTION SERVICES

In ideal situation, demand of abortion services will be equivalent to the number of induced abortion which takes place every a year. The same facilities will be also required to provide post abortion care, particularly in the case of incomplete abortion.

Officially, there is no precise estimation on annual incidence of induced abortion or number of post abortion complications demanding abortion facilities for curative services. The statistics which government publishes pertains only to the reported abortion cases conducted in government's recognized clinics. However, there are several unofficial estimates of induced abortion in India and which varies lot (Table 1).

Table 1: Estimates of Abortion (in million)

Source	Estimate of induced abortion
Shah Committee, 1966	3.9
IPPF, 1970	6.5
Goyal, 1976	4 to 6
Chhabra, et al, 1994	6.7

Source: Cited from sources in Chhabra, et al, ND.

For estimating these figures, various assumptions have been used. For instance, Shah Committee assumed that for every 73 live births, there are 2 stillbirths and 25 abortions -- 15 induced and 10 spontaneous. Chhabra estimate of 11.2 million abortions -- 6.7 million induced and 4.5 million spontaneous -- is also based on similar assumptions. IPPF estimation of 6.5 million illegal abortions in India is based on an abortion ratio of about 200:1000 known pregnancies and an abortion rate of about 55:1000 women aged 15-44 years. Others who have attempted to estimate extent of illegal abortions include Malini Karkal (1991) who estimated three illegal abortions for every one legal abortion in rural area and 4-5 illegal abortions for every abortion in urban area. Gupte gave a yet higher estimate of illegal abortions - 8 for every one legal abortion.

While it is difficult to come to a conclusive figure, perhaps the truth lies somewhere in between. If one goes by Shah Committee assumptions, the number of induced abortions will be somewhere 6 to 7 million. The statewise estimation of abortion, as given by Chhabra, *et al.*, (1994) based on Shah Committee assumptions with modified birth rate reveals large variation across the states. In absolute terms among the 16 major states, the largest number of abortion is performed in Maharashtra (122,388) as of 1994-95 followed by Uttar Pradesh (115,925). However, in terms of induced abortion per 1000 couples, it varied between 54.6 for Assam, Kerala and Punjab to 43.8 for Bihar (1991). The average for the country was estimated to be 46.8 induced abortion per thousand couples.

If we compare the estimated number of induced abortions (6.5 million) with the number of abortions reported in the services statistics (0.62 million), it will become obvious that only around 10 per cent of the induced abortions are being performed by the government's approved clinics. Even if we assume that another 10-20 per cent of the abortions are though performed illegally but under safe and hygienic condition in various private clinics and nursing homes, then untrained providers conduct 70-80 per cent abortions in India. All those women are exposed to the risk death and serious

other post abortion complications. This also indicates the magnitude of unmet need of abortion services.

AVAILABILITY OF ABORTION SERVICES:

According to the latest published service statistics in 1995, there are 8,511 hospitals and clinics in India, which have been approved by government to conduct abortions. Overtime, number of such other institutions has increased, from 3,908 in 1981-82 to 9,467 in 1997. However, considering the estimated incidence of abortions in the country, the pace of increase in the abortion facility is considerably slow. Further, distribution of even these limited facilities is quite skewed. Majority of these facilities are located in urban areas. Further, the less developed but more populous states have fewer abortion facilities than smaller but more developed states. For instance, in 1995 in Maharashtra there were 1,808 abortion centres constituting 21.2 per cent of the total registered abortion facilities in India. It compares very well when one considers the fact that Maharashtra contributes only 9.4 per cent of the total population. In contrast to that, Bihar and Uttar Pradesh, which contribute 10.3 and 16.6 per cent of the national population, have only 1.2 and 6.8 per cent of the approved abortion centres respectively. The four large less developed states namely Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh which taken together contributes 40 per cent of the country's population have only 16.7 per cent of the total abortion centres in India (Table 2).

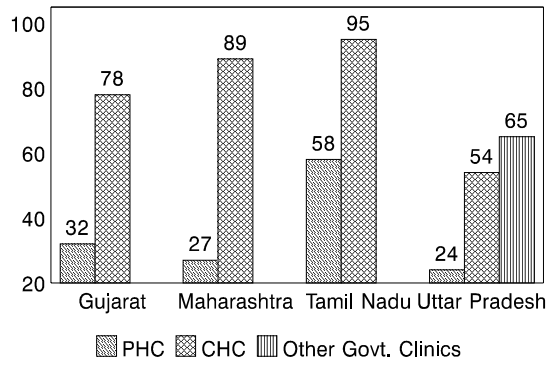
Table 2: Differential in Distribution of Approved abortion Centres

	Number of approved abortion centres (1995)	Percent of total India's population	Percent of registered abortion centres in India	Number of abortion centres per million population	Number of couples per abortion Center
Gujarat	557	4.9	10.0	21	8,400
Maharashtra	1808	9.4	21.2	23	7,650
Tamil Nadu	645	6.7	7.6	11	1,600
Uttar Pradesh	576	16.6	6.8	4	44,000
Bihar	116	10.3	1.2	1	1,76,000
Madhya Pradesh	297	7.9	3.5	5	35,200
Rajasthan	432	5.2	5.1	10	17,600
India	8511	100.0	100.0	10	17,600

How Functional Are the Facilities? Available records at the state or even at district level do not provide a correct answer to this question. However, the situation analysis of abortion facilities carried out by CORT in Gujarat, Maharashtra, Uttar Pradesh and Tamil Nadu provide detailed information on the functioning of abortion centres in these states. The four studies taken together, covered 61 districts, 510 institutions approved for providing abortion services and interviewed 241 private health practitioners. The selected districts and the public clinics were statistical representative samples of the state. Out of the 510 clinics covered, 217 were Primary Health Centres (PHCs), 116 Community Health Centres (CHCs) or Rural Hospitals (RHs), 50 Post Partum Centres (PPCs)/Sub-district Hospitals (SDHs) while the remaining 130 were private clinics.

The study revealed that all the clinics registered for providing abortion services were not functional. Only about one-fourth of the PHCs in Maharashtra (27 per cent) and Uttar Pradesh (24 per cent), one-third in Gujarat (32 per cent) and about one-half (58 per cent) in Tamil Nadu were currently providing the services (Figure 2).

Figure 2
Current Availability of MTP Services at the Clinics *



* In case of Uttar Pradesh & Tamil Nadu, PHC refer to Block PHCs

A substantially high proportion of PHCs (ranging between 24 and 40 per cent) had provided abortion services in the past but not currently, whereas 16-52 per cent of PHCs even after being approved as abortion clinic had never offered the services (Table 3).

Table 3: Availability of abortion Services at the Clinics Registered for Providing Abortion Services (Percentage)

Status of clinics with reference to provision of abortion services	Gujarat		Maharashtra			Tamil Nadu		Uttar Pradesh	
	PHC	CHC	PHC	RH	BL PHC	SDH	BL PHC	CHC	OGH
Currently providing	32	78	27	89	58	95	24	54	65
Provided in the past	40	18	41	8	26	5	24	35	28
Never provided	28	4	32	3	16	-	52	11	7
Total number of clinics	54	27	60	37	41	21	62	52	29

SDH = Sub district hospital BL PHC = Block PHC OGH = Other Government Hospital

The situation is, however, relatively better in the case of CHCs/RHs/sub-district hospitals. Majority of these facilities are equipped to conduct abortion. At the time of the survey 78, 89 and 95 per cent of the CHCs/sub-district hospitals in Gujarat, Maharashtra and Tamil Nadu respectively were providing the services. However, in Uttar Pradesh, only a little more than half of the CHCs and about two-thirds of the other government hospitals (women's hospitals and post partum centres) were currently providing the services. According to the national norm, all CHCs, post partum centres and similar higher level of health facilities are expected to provide abortion services.

In Tamil Nadu, even though the proportion of PHCs providing abortion services was relatively better (24 out of 41; 58 per cent), it was offered mainly on sterilization days to family planning (sterilization) acceptors. For instance, out of the 24 PHCs offering abortion services, 17 (70 per cent) offered it only on sterilization clinic day and the authorities (doctors) insisted on sterilization after abortion in almost all the cases except in case of unmarried girls. The study further

revealed that pressure to accept sterilization is much more in Tamil Nadu than in Uttar Pradesh or Maharashtra.

Estimated Number of PHCs and CHCs Providing Abortion Services: Based on the findings from the sample PHCs and CHCs registered for providing abortion services, number of public clinics currently providing abortion services in the rural areas of the four states was estimated. While in Tamil Nadu, 72 per cent of all the registered clinics (PHC plus CHCs registered for providing abortion services) were actually offering the services, in Uttar Pradesh, Gujarat and Maharashtra, only 41, 53, and 62 per cent respectively were providing the services at the time of the survey (Table 4). If Government commitment that all PHCs and CHCs will be equipped to provide abortion services is considered, then except in Tamil Nadu, in the remaining three states less than one-fifth (14 to 19 per cent) of the facilities are currently offering the services. In the case of Tamil Nadu, the corresponding figure was relatively better (41 per cent). It is however, important to note that in the case of Tamil Nadu and Uttar Pradesh, only Block PHC has been considered for the estimation. If all PHCs in Tamil Nadu and additional PHCs in Uttar Pradesh are considered, these figures will be still more discouraging.

Because of such low availability of abortion facilities, it is not surprising that majority of the women seeking abortion services has to either go to the district hospital or resort to private clinics, rural untrained practitioners or other traditional methods.

Table 4: Estimated Number of Public Clinics Currently Providing abortion Services in Rural Area

States	Total no. of PHCs in the state*	Total no. of PHCs* registered for abortion	Estimated no. of registered PHCs & actually providing abortion	Total no. of CHC in the state	Estimated number providing abortion services	Percent of approved institutions providing abortion	Percent of all PHC*/ CHC providing abortion
Gujarat	949	207	65 (31.4)	174	135 (77.6)	52.5	17.8
Maharashtra	1695	210	56 (26.7)	295	256 (86.7)	61.8	15.7
Tamil Nadu	431	192	112 (58.3)	136	123 (90.4)	71.6	41.4
Uttar Pradesh	907	171	43 (25.1)	213	115 (54.0)	41.1	14.1

* In Gujarat & Maharashtra it refers to PHC while in Tamil Nadu and UP it refers to Block PHC.

Reasons for Not providing abortion Services: In all the four states covered under CORT's studies, the main reason for not providing abortion services was lack of trained doctor to conduct the procedure. 70 to 92 per cent of those clinics, which despite of being approved for performing abortion were not providing the services because of the lack of trained doctor (Table 5). In few clinics (14 to 31 per cent), non-availability of required equipment was the main reason. In a substantial proportion of the clinics, both trained doctor and equipments were not available.

Table 5: Availability of abortion Services in the Clinics Covered **(Percentage)**

	Gujarat		Maharashtra		Tamil Nadu		Uttar Pradesh		
	PHC	CHC	PHC	RH	BL PHC	SC	BL PHC	CHC	Sub-dist
Percent of clinics providing abortion	31.5	77.8	26.7	89.5	68.4	94.7	27.4	53.8	65.5
In past	42.7	18.5	41.6	2.6	15.8	5.3	21.0	30.8	27.6
Never	27.8	3.7	31.7	7.9	15.8	-	51.6	15.4	6.9
Total number of clinics	54	27	60	38	38	19	62	52	29
Reasons									
Lack of the trained doctor	47.4	83.3	47.7	100.0	33.3	100.0	75.5	45.8	60.0
Lack of equipment	7.9		18.2	25.0	41.7		4.4	-	-
Lack of both	26.3		29.5		66.7		11.1	-	10.0
Equipments not working	7.9		11.4		8.3		11.1	4.2	-
Lack of water supply	-				16.7		2.2	-	10.0
No beds	-				8.3		-	-	-
No OT facility	-				91.7		6.7	-	10.0
Others	7.9	16.7	-	-	-	-	-	37.5	70.0
Total number of clinics not providing abortion currently	38	6	44	4	12	1	45	24	10

As lack of trained doctor and non-availability of working equipments were identified as the two main reasons for the non-provision of abortion services by the Government approved clinics, the studies tried to analyze both of these problems in more detail. The studies indicate that contrary to the expectation, after liberalization of abortion the government has made no serious and systematic effort to train adequate number of doctors who could be posted at the clinics approved for providing abortion. According to available statistics, altogether there are 162 institutions, mostly `A' type post partum centres, which have been designated for training doctors in abortion procedure. Similar like abortion service facilities, allocation of these abortion-training centres in different states is also very disproportionate to their size.

Each of these training centres could train upto 20 doctors in a year. However, CORT's appraisal of the training institutions in the four state shows that because of various reasons including government's procedural delay in getting leave for training, non-provision of fund in the state health budget to meet doctor's travel and living allowance during training, lack of accommodation facilities at the training institutions and lack of abortion case load to give adequate practical training, in majority of the designated training institutions only 6-10 doctors are trained in a year (CORT, 1994;1997; Khan, *et al.*, 1998).

There is no detailed documentary evidence regarding actual supply or stock of trained physicians and their distribution according to their residence (i.e. rural and urban) in the country. However, according to one estimate (Chhabra, *et al.*, 1994) only around 3000 doctors trained in abortion were

available in 1992 as against requirements of about 21,000 in the rural area itself (for PHCs)[1]. Further, it could be safely assumed that majority of these trained doctors are located in urban area.

This vast gap of demand and supply of trained manpower is largely because of lack of proper planning and allocation of resources. For instance, all the 230 A type Post Partum centres which have adequate case load could have been designated abortion training centres, but the fact that only 162 have actually been made training centres shows that no serious thinking have been given to these spects. It may not be out of place to mention that to designate an `A' type PP Centre as abortion training centre a maximum of Rs 2000 (US$47 at the current exchange rate) per year is required.

A similar probing for the reasons of non-availability of equipments at the clinics approved for abortion revealed an apathetic attitude of the government towards expansion of the abortion facility (Khan, *et al.*, 1996). It was observed that until recently in the MOH&FW, increasing accessibility of abortion services was not an important issue and hence at the time of allocation of resources it always received the least priority. For instance, since 1991-92 only an amount of Rs 150 lakhs (Approx. US$ 353,000 at current exchange rate) was allocated for the abortion programme. In 1995-96, influenced by ICPD recommendations, a serious effort was made to strengthen the services and increase the number of abortion centres. Accordingly, an amount of Rs 980 lakhs (Approx. US $ 2.3 million) was requested. However, MOH&FW considering the finance constraint again allocated only Rs 150 lakhs to the abortion programme. According to the national abortion programme officer, from such a meager amount, after paying to institutions conducting training of doctors in abortion procedure, and allocating cost of drugs for each abortion conducted at the approved public institutions, hardly any money is left for the purchase of new equipments or replace the non-working one.

The irony is that even the small fund, which is finally allocated to state government for the purchase of new equipments, remains unspent except in case of Karnataka and Maharashtra. An enquiry on why fund for purchase of abortion machine remain unutilized revealed that MOH&FW insist that the equipments must be purchased with ISI mark. There is only one company in the country `Anand Medicates' which has ISI mark and cannot meet demand of all states. For the other manufacturers, market of these equipments is not big enough to take the troubles of obtaining ISI mark for their product from the appropriate authorities.

QUALITY OF ABORTION SERVICES

Research on the quality of services provided by public clinics has remained a neglected area in India. Quality of abortion service is still more neglected area and hardly any systematic study has been taken on this subject. CORT's studies, however, provide some useful information and have been analysed in this section.

Readiness of the Clinics providing abortion services: The studies revealed a general inadequacy of the equipments in most of the PHCs/Block PHCs providing abortion services. For instance, taken

[1] The Seventh Five Year Plan (1985-90) envisaged that by the end of Seventh Plan each PHC in the country and all maternity homes would be equipped to provide abortion services.

all the states together out of 187 functional PHCs, only 55 per cent had all 5 sizes of dilators. 85 per cent of the PHCs had at least 4 sizes of dilators. It is difficult to understand how the remaining 15 per cent of PHCs were performing abortion without the availability of a minimum number of common sizes of dilators. Similarly, taken all the states together, only 21 per cent of the functional PHCs had a set of nine different sizes of cannulas. The percentage of PHCs with at least a set of 6 common sizes i.e., frequently used cannulas was only 56 per cent. Surprisingly, 7 per cent of the functional PHCs did not have even speculum. Among all the four states, the situation was poorest in Uttar Pradesh.

Table 5: Availability of Support Facilities at PHC/Block PHC Clinics (Percentage)

Other support facilities	Gujarat	Maharashtra	Tamil Nadu	Uttar Pradesh
Physical facility				
Toilet facility with adequate water supply	37	52	34	29
Operation Theatre with				
Clean room	50	88	58	40
Operation table with clean rubber sheet	43	77	32	45
Washbasin	39	15	84	76
Adequate source of light	48	88	50	77
Maintaining privacy				
Auditory	61	68	11	42
Visual	54	60	13	40
Medicine				
Antibiotics	70	95	95	90
Analgesics	67	95	92	89
Sedatives	63	82	66	74
Anti haemorrhage drugs	33	38	40	76
Number of clinics (PHC/Block PHC)	54	60	38	62

The studies also revealed several limitations in other support facilities at the clinics. For instance, only around one-third of the clinics had toilet facility with adequate supply of water. The operation theatres in general lacked cleanliness and adequate source of light. Audio and visual privacy was far from satisfactory. As abortion in Tamil Nadu is generally done on sterilization clinic day, audio and visual privacy was almost non-existing. In case of medicine, while antibiotics and analgesic were generally available in stock, supply position of sedatives and anti-haemorrhage drugs, particularly, the latter one was far from satisfactory. Over all, the analysis indicates considerable scope of improvement in the logistic and management of the clinics to improve quality of services.

Competence of the doctors: As the investigators did not have any opportunity to observe the doctors performing abortion, it is difficult to comment on the competence of the providers. However, the studies provide some detailed information on the training status of doctors conducting abortion and the quality of the training, which they had received. According to the study out of the 205 doctors providing abortion services 31 doctors (15 per cent) did not have any training in the procedure. Further, out of 32 doctors who despite of being trained in abortion were not conducting abortions, 8 other doctors expressed lack of confidence for performing the procedure. As one of the doctors said:

"Although after 4 weeks of training I was given a certificate as the trainer was confident that I could do the abortion performance, but still I do not feel confident about my capability to perform abortion. I need to do several more abortions under strict supervision of my senior before I could conduct abortion independently".

Yet, another doctor said

"We could not do a single case in the whole of the training period. From where do I get the confidence"?

CORT studies on quality of abortion training clearly revealed that the doctors are not getting adequate practical training. For instance in Maharashtra, on average duration of training was only 8 days and the trainees had conducted only 13 abortion cases against the prescribed norm of 30 days training (now modified to 15 working days) and practical experience of conducting at least 25 abortion cases. In the case of Tamil Nadu, doctors on an average had conducted only 6 cases. All these information pose a big question mark about the competence of the doctors providing abortion services.

Attitude of Providers: Abortion being a sensitive issue, many still do not approve it. Provider's negative attitude towards such matter could make major difference in the quality of counselling, provision of services and overall client-provider interaction.

The studies revealed that majority of the doctors as well as other health functionaries approved abortion conditionally. In all the states, proportion of doctors/workers approving abortion unconditionally was less than 20 per cent. However, most of the remaining approved abortion conditionally. Those who totally disapproved abortion ranged between 4 to 24 per cent among the doctors and 23 to 52 per cent among the workers (Table 6).

Table 6: Attitude of providers towards abortion: Percentage approving abortion

Providers	Gujarat		Maharashtra		Tamil Nadu		Uttar Pradesh	
	UC	C	UC	C	UC	C	UC	C
Doctor	25	51	13	83	17	58	14	65
Other health functionaries	13	53	3	45	14	50	19	59

UC - Unconditional, C - Conditional

It was observed that generally, doctor's interaction with women seeking abortion was not sympathetic and often they insisted with them to accept sterilization. Such pressure was strongest in Tamil Nadu where it is almost an unwritten rule that abortion must be followed with sterilization. This is perhaps one of the reasons that in Tamil Nadu abortion service is provided only on the sterilization day.

From other states also similar pressure to accept sterilization or at least IUD, though of lesser intensity was reported. Often doctors were reported to discourage women from abortion, as one of the women from Uttar Pradesh said (Khan, *et al., 1998*).

> *"When I conceived unwontedly (3rd pregnancy), I wanted to get it aborted. When I contacted lady doctor at PHC, she discouraged me and persuaded to continue with pregnancy. She suggested that after delivery I could get sterilized. When I again requested her, she agreed and said, OK I will do it but you have to undergo sterilization also. As I did not want to undergo sterilization, I came back".*

In fact some of the doctors and other providers confessed that they do not like conducting abortion, and try to discourage women from doing so. However, if they insist they perform it. As one of the lady doctors said

> *"As human being I will also say that it is not good but I am doing it because it is my profession".*

Interestingly, some of the providers/health workers despite of disliking abortion were supporting it because it helps in getting them sterilization case. As one of the health worker puts it.

> *"Nobody will be in favour of abortion within. We are doing it because it is our duty. We have to bring cases for sterilization, so if a women is ready to accept sterilization after abortion, we can not leave the case".*

Quality of Counselling: The analysis clearly indicates scope for substantial improvement in the counselling particularly the quality of information provided to the women about the procedure such as safety, risk involved or possibility of infection. While about 70 per cent of the cases, women were informed about the procedure and its safety, very few (21 per cent) were mentioned about possible risks and possibility of infection (49 per cent) if proper care is not taken. Similarly, only about half were given instruction when to come back for check up and even fewer women were informed what to do in case of any complication. On all these aspects, performance of Tamil Nadu was poorest.

Human aspects such as protection of modesty (80 per cent) or an effort to make the women comfortable (81 per cent) were generally reported to be good. Expect Tamil Nadu, in all the states more than 90 per cent of the women were satisfied with the services they received.

Concluding Comments

The paper thus shows that there is a huge gap between demand of abortion services and facilities available. Women, who do not have access to safe abortion services, resort to unsafe abortion methods, risking their lives and getting exposed to serious reproductive morbidities. However, available studies also indicate that whatever limited facilities are available, are not fully utilized. A time series analysis of service statistics shows that over period number of abortions per approved institutions has not only remained low (89 - 124 per institution) but has also declined over time --- from 124 in 1982-83 to 73 in 1994-95. In other words, each approved institution does one abortion in

4 working days. This is an extremely low caseload considering the large number of abortions, which are taking place every year. This clearly indicates that merely increasing the number of approved abortion facilities may not be sufficient to ensure physical and social accessibility of abortion services to women who need them.

In Indian cultural context sexuality, reproduction, abortion, sexual health, etc. are sensitive issues and are not discussed openly. Abortion is all the more sensitive subject, as still it is widely believed that abortion is a sin and even today only a small proportion of the community members are aware that the government legally approves abortion. According to a multi-centric ICMR study (1989), 31 per cent women in Tamil Nadu and 75 per cent in Uttar Pradesh and Haryana believed that abortion is illegal. A similar observation was made in Bihar where only 28 per cent of people were aware that abortion is legal (CORT, 1996).

Therefore, to increase accessibility to abortion services and to make the services socially acceptable, it is critical to understand the dynamics of decision-making process related with unwanted pregnancy and abortion, within the framework of conjugal relationship. To enhance the utility of available services it is equally important to understand women's perspectives in seeking abortion services: What they expect from these services; and how they want these services to be delivered.

GOVERNMENT'S INITIATIVES AND FUTURE CHALLENGES

The Ministry of Health and Family Welfare is making all out efforts to address to the problem of growing number of illegal abortions. Under the RCH program, it also proposes to provide abortion equipments to well run and competent medical clinics in the non-government sectors which have essential facilities including Operation Theater and trained staff.

The initiatives taken by MOH & FW are certainly in the right direction and will be helpful in taking the ICPD agenda forward. However, the scenario, which emerges out of this paper, demands a much bigger effort and investment to make the abortion services both physically and socially accessible. At the medical and clinical front the situations seems to be quite difficult and complex. Given the number of abortion training institutions and the number of doctors actually been trained every year, it would take more than a decade to train the required number of doctors. Hence, unless a serious effort is made to address to this issue and adequate resources are allocated for abortion programme, availability of trained doctors will remain a problem. Yet, there is no assurance that after the training they will be available to serve in the remote rural areas.

One way to address this issue is to train paramedical staff like Lady Health Visitors (LHV) and public health nurses to conduct menstrual regulation (MR) and early (first trimester) abortion using MR kits and manual vacuum aspirator respectively. In many countries such as Bangladesh, Vietnam, etc. paramedical staffs are providing safe abortion services. Such a move can make the MR and abortion services easily accessible and indeed also reduce the social distance between providers and the women. It may also make the services socially more acceptable. However, the present abortion

Act does not allow such possibility. The abortion Act passed in 1971 has strong medical bias and unless it is modified and demedicalized any initiative to involve paramedical staff for providing abortion services is not possible. It is high time to initiate discussion on the need of modifying the existing abortion Act and redrafts its clauses from women's perspective. Any such move is expected to receive big resistance from medical lobby. Hence one of the challenges for the MOH&FW will be how to induce such changes with abortion Act without making abortion a controversial issue.

At societal level, the community members, both men and women must be informed that abortion is legal and the sources from where safe abortion services could be obtained. They also need to be educated about the dangers women are getting exposed by approaching untrained providers for abortion services. Local institutions like Panchayat, ICDS, schoolteachers; National Service Scheme (NSS), Mahila Samakhya and other NGOs could be effectively used for such educational campaign. Any such undertaking will require strategic planning and a sustained effort at all levels - MOH&FW, state's Health and Family Welfare Departments and other local stakeholders.

Recommendation of the National Consultation on Safe Abortion Service, MOH & FW March 1998

- Functioning of abortion program should be reviewed every year at national level
- Establish abortion cells in every state
- List of all recognized abortion clinics should be updated annually
- Low performing abortion clinics should be reviewed for it's functioning
- Existing abortion training system should be reviewed to improve quality of training
- Duration of the training should be at least of one month
- Each trainee must assist 10 abortion cases; perform 10 cases under supervision and 5 independently
- Pre and Post abortion counselling should be a part of the training
- To encourage private institutions income tax rebate should be provided for abortion and sterilization
- All institutions recognized for abortion should be reviewed every three-year for recertification
- Procedure for recognizing Institutions for abortion should be simplified and expedited
- Focused IEC campaign to inform all section of community about legal status of abortion and available sources for its services should be organized

The poor status of women and gender inequality within the conjugal equation is major cause of unwanted pregnancy as well as inability to use available abortion services. Therefore, any serious effort to make contraceptive and abortion services easily accessible should be strategically planned in the gender frame work, an aspect which has been neglected in the past and continued to be neglected. Strategic planning and a sustained efforts are needed at all levels to operationalise these concepts

REFERENCES

Barge, S. M. E. Khan, Rajagopal. S, Kumar, N. Kumber, S. 1998. Availability and Quality of abortion services in Gujarat, Maharashtra, Tamil Nadu and Uttar Pradesh - An In-depth Study. Paper presented at the International Workshop on Abortion Facilities and Post Abortion Care in the Context of RCH Programme organized by Centre for Operations Research and Training, held at New Delhi, March 23-24, 1998

Centre for Operations Research and Training (1995) *Situational Analysis of Medical Termination of Pregnancy (MTP) Services in Gujarat*, Monograph CORT, Baroda

Centre for Operations Research and Training (1997) *Situational Analysis of Medical Termination of Pregnancy (MTP) Services in Uttar Pradesh*, Monograph CORT, Baroda

Centre for Operations Research and Training (1997) *Situational Analysis of Medical Termination of Pregnancy (MTP) Services in Tamil Nadu*, Monograph CORT, Baroda

Centre for Operations Research and Training (1996) *Situational Analysis of Medical Termination of Pregnancy (MTP) Services in Bihar*, Family Welfare Programme in Bihar - A Baseline Survey. Monograph CORT, Baroda

Centre for Operations Research and Training (1996) *Situational Analysis of Medical Termination of Pregnancy (MTP) Services in Maharashtra*, Monograph CORT, Baroda

Chhabra Rami and Sheel C. Nuna (N.D) *Abortion in India - An Overview*, Delhi

Gupte, M. Bandewar, S. Pisal, H. 1997 Abortion Needs of Women in India: A case study of Rural Maharashtra, *Reproductive Health Matters*, 9: 77-86

ICMR (1989) **Illegal** *Abortion in Rural Areas: A Task Force Study*, Monograph Indian Council of Medical Research, Delhi.

Jalnawala, S.F. 1975 Medical Termination of Pregnancy ACL: A Preliminary Report of the First Twenty-Month of Implementation *Journal of Obstetrics and Gynaecology of India* October 25(5)

Karkal, Malini (1991) Abortion Laws and the Abortion Situation in India *Issues in Reproductive and Genetic Engineering*, Vol.4 No.3

Khan, M.E., Bella C. Patel and R. Chandrasekhar Abortion Acceptors in India: Observation in India: Observations from a Prospective *Study Preceding of IUSSP International Population Conference Montrea*l, 1993, Vol.3

Khan M.E., S. Rajagopal, Sandhya Barge and Nayan Kumar (1998) Situation Analysis of Medical Termination of Pregnancy Services in Gujarat, Maharashtra, Tamil Nadu and Uttar Pradesh. Paper presented at Global Meeting on Post Abortion Care and Operations Research organized by Population Council, held at New York, January 19-21, 1998. Also published as Working Paper 13, CORT, Baroda.

Khan, M.E., Sandhya Barge and George Philip 1996 Abortion in India - An Overview *Social Change* Vol.26 No. 3 & 4.

Khan, M.E., Ranjana Sinha, Bella C. Patel, Seema Lakhanpal and Payal Khanna (1998) Decision Making in acceptance and Seeking Abortion of Unwanted pregnancies paper presented in the International Workshop on Abortion Facilities and Post Abortion Care in the Context of RCH Program organized by Centre for Operations Research and Training, held at New Delhi, March 23-24, 1998.

Mathai, S.T. 1997. Making Abortion Safer *Journal of Family Welfare*, 43: 71-80

Ministry of Health and Family Welfare (1998) *Report of the National Consultation on Safe Abortion Services*, New Delhi, March 11, 1998

Mukhopadhyay, P. and A. Das (1975) Termination of Pregnancy by Vacuum Aspiration with and without Sterilization *Journal of Obstetrics and Gynaecology of India 25(5)*

RGI (1990) *Survey of Census of Death, (Rural) Annual Report, 1990*. Office of the Registrar General, New Delhi

Barge, S., Khan, M.E., Rajagopal, S., Kumar, S., and Kumber, S. 1998. Availability and Quality of MTP services in Gujarat, Maharashtra, Tamil Nadu and Uttar Pradesh - An in-depth study. Paper presented at the International Workshop on Abortion Facilities and Post Abortion Care in the Context of RCH Program. March 23-24, 1998

Centre for Operations Research and Training, 1995. Situational Analysis of Medical Termination of Pregnancy (MTP) services in Gujarat. CORT, Baroda

Centre for Operations Research and Training, 1996. Situational Analysis of Medical Termination of Pregnancy (MTP) services in Maharashtra. CORT, Baroda

Centre for Operations Research and Training, 1997a. Situational Analysis of Medical Termination of Pregnancy (MTP) services in Tamil Nadu. CORT, Baroda

Centre for Operations Research and Training, 1997b. Situational Analysis of Medical Termination of Pregnancy (MTP) services in Uttar Pradesh. CORT, Baroda

Chhabra, Rami and Sheela, C. Nuna (N.D) *Abortion in India - An Overview*, Delhi

Gupte, M. Bandewar, S. Pisal, H. 1997 Abortion Needs of Women in India: A case study of Rural Maharashtra, *Reproductive Health Matters*, 9: 77-86

Indian Council of Medical Research, 1989. *Illegal Abortion in Rural Areas: A Task Force Study*, Monograph Indian Council of Medical Research, Delhi.

Jalnawala, S.F. 1975 Medical Termination of Pregnancy ACL: A Preliminary Report of the First Twenty-Month of Implementation *Journal of Obstetrics and Gynaecology of India* October 25(5)

Khan, M.E., Barge, Sand George Philip Abortion in India - An Overview *Social Change* Vol.26 No. 3 & 4.

Khan M.E., Rajagopal, S., Barge, S and Kumar, Nayan. 1998. Situation Analysis of Medical Termination of Pregnancy Services in Gujarat Maharashtra, Tamil Nadu and Uttar Pradesh. Paper presented at Global Meeting on Post Abortion Care and Operations Research organized by Population Council, held at New York, January 19-21, 1998. Also published as Working Paper 13, CORT, Baroda.

Khan, M.E., Sinha, R., Patel, B.C., Lakhanpal, S and Khanna, Payal. 1998. Decision Making in acceptance and Seeking Abortion of Unwanted Pregnancies. Paper presented at the International Workshop on Abortion Facilities and Post Abortion Care in the Context of RCH Program organized by Centre for Operations Research and Training, held at New Delhi, March 23-24, 1998.

Khan, M.E., Patel, B.C and Chandrasekhar, R, 1993. Abortion Acceptors in India: Observations from a Prospective Study. Paper presented at IUSSP International Population Conference, Montreal 1993.

Mathai, S.T. 1997. Making Abortion Safe. Journal of Family Welfare, 43: 71-80

Ministry of Health and Family Welfare (1998) Report of the National Consultation on Safe

Abortion Services, New Delhi, March 11, 1998

Mukhopadhyay, P. and Das, A. 1975.Termination of Pregnancy by Vacuum Aspiration with and without sterilization *Journal of Obstetrics and Gynaecology of India* 25(5)