

### **Abortion in India: An Overview**

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*The estimates of abortions, state-wise, trend of MTP in India and causes of illegal abortions, including pragmatic and societal, have been discussed. The enormous gap between estimated abortions and reported MTP cases suggests that only less than ten percent of the abortions are carried out in government recognized institutions. Safe abortion is not available to desiring women, particularly in rural areas, after twenty-four years of legislation of MTP. The paper points to a number of problems, why abortion service is not available to women who want to undergo MTP and suggests certain remedial measures.*

#### **Introduction**

In India, after the introduction of Medical Termination of Pregnancy (MTP) Act in 1972 legalizing abortion, reported MTP cases have been on increase. According to available statistics, the number of approved institutions providing MTP facilities has increased from 1.877 in 1976 to 7.121 in 1991. Similarly, the number of 'YITP' cases from a mere 25 reported in the year 1972-73, has gone up to 632.526 in 1991-92. However, these figures are only the tip of an iceberg as it is estimated that in India, every year approximately, an additional 5-6 million abortions are conducted by private practitioners. Majority of these cases are done 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 15000-20000 abortions related deaths are reported in year. The ICMR study (1989) attributed 12 per cent of the maternal deaths septic abortions due to unsafe abortions. While another study puts this figure around 20 per cent (Coyaji 1994).

It is surprising that even after twenty-four years of legalization of MTP, its availability, particularly in rural area, is very limited. Recently, however, there is a growing realization towards an urge need to increase safe MTP 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 as a measure to ensure safe motherhood.

The first step towards this initiative to perhaps to understand what and where the lacuna are? Why even after two and half decades of liberalized law, it has not been possible to provide a safe abortion service to a woman who desires it? The present paper makes an attempt to answer some of these questions.

The study is largely based on published government statistics published papers and a rich data base maintained at Center for Operations Research & Training (CORT) on abortion services from its various MTP studies in Gujarat, Maharashtra, Tamil Nadu, Uttar Pradesh and Bihar.

## **Current Status**

### **Estimates of abortions in India**

Officially there is no precise estimation on annual incidence of induced abortion. The statistics which Government publishes pertains only to the reported MTP cases conducted in government's recognized clinics. However, there are several unofficial estimates of induced abortions in India which vary a lot (Table 1).

**Table 1:** Estimates of abortions (in million)

<b>Source</b>	<b>Estimate of Induced Abortion</b>
<b>Shah Committee 1966</b>	3.9
<b>IPPF 1970</b>	6.5
<b>Goyal 1976</b>	4.6
<b>Chhabra et al. 1994</b>	6.7

For estimating these figures, various assumptions have been used. For instance, Shah Committee assumed that for every 73 live births, there are 2 still births 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 made some attempts to estimate extent of illegal abortions include Malini Karkal (1991) who estimated 3 illegal abortions for every one legal abortion in rural area and 4-5 illegal abortions for every MTP in urban area. Gupta gave a higher estimates of illegal abortions 8 for every one legal MTP.

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 abortions will be somewhere 6 to 7 million. The state-wise estimation of abortion, as given by chhabra et al., (1994) based on Shah Committee assumptions with modified birth rate is given in Table 2.

The reported figure of induced abortion by GOI is only 0.63 million in 1991-92. A study of MTP trends also shows that since 1982-83, the increase is almost stationary or at best very marginal (Figure 1). In other words, the gap between estimated abortion (6.5 million) and reported MTP cases is enormous, reflecting a fact that less than 10 per cent of the abortions which take place in India, are carried out in government's recognized institutions. Among the remaining cases, perhaps a small proportion is conducted by trained and qualified doctors, who do not report the cases to the government, while the remaining majority of women go to unauthorized and untrained abortionists.

### **Causes of Illegal Abortions**

There could be several reasons for such a state of affairs and one could broadly divide them into programmatic and societal reasons. At programmatic level, the important one could be lack of infrastructural facility/equipment, lack of trained manpower, inadequate resource allocation and medical base.

While at societal level, sensitivity about abortion and lack of awareness about legal status of MTP and insistence of the providers to accept sterilization or at least IUD along with MTP could be some of the main reasons for not utilizing recognized MTP services. In the following, paragraphs both of these aspects have been briefly discussed.

Availability of MTP facility: Table 3 presents the increase in the number of government approved institutions providing MTP facilities. It increased from 1877 in 1972-76 to 7121 in 1991-92 (Figure 2). However, the pace of increase is quite slow as compared to the demand. This could be judged by the fact that in rural area still large number of CHCs and majority of PHCs do not have MTP facilities. Situation analysis of MTP facilities carried out by CORT in Gujarat, Maharashtra, Uttar Pradesh and Tamil Nadu shows that in these States less than 20 per cent of the total PHCs had MTP facilities. In case of Uttar Pradesh, the corresponding figure is less than 5 per cent.

A probing with the authorities of these States revealed that it has been decided that at present only CHCs and Block PHCs which have OT facilities would be equipped with MTP facilities. Even with this qualification, still majority of block PHCs in Uttar Pradesh and a substantial number of PHCs in Gujarat do not have MTP facilities. For instance, in Uttar Pradesh, out of 907 block PHCs CHCs, only 175 (19.3 per cent) have been registered for MTP. In case of Tamil Nadu, however, the situation is relatively better as out of 384 block PHCs, 298 (78 per cent) have been registered for providing MTP services.

It is, however, important to note that registration for MTP does not mean actual provision of MTP services. ICMR national survey on quality of services (1991) revealed that out of the 200 Block PHCs, 91 PHCs (45.5 per cent) were registered for MTP but only 25 per cent had adequate equipments to conduct abortion. Further, in only 88 cases, the PHCs has a trained doctor for conducting MTP. The number of PHCs where both equipments and trained manpower were available was still low. Similarly, in Gujarat study, CORT observed that out of 53 registered PHCs visited, only 15 (28 per cent) were actually providing the services. The rest either were not providing services because of unavailability of equipments and trained manpower.

In the absence of public clinics, majority of the rural women desiring to abort unwanted pregnancy are left with no option either to accept the pregnancy or to go to private sources: majority of which are untrained and often conduct abortions in a way which could cause serious health hazard.

Distribution of MTP facilities by State: Distribution of approved MTP facilities in the major states of India is presented in Table 4. The Table shows large variation across the States. A comparison of these percentages with the proportion of total country population contributed by those States shows that often the MTP centers are disproportionately concentrated in few better performing and progressive States. For instance, Maharashtra has about 23 per cent of total MTP approved clinics in the country while it contributes only 9.4 per cent country's population. Similarly, while about 10 per cent of the MTP centers are located in Gujarat, the State contributes only 4.9 per cent of the total population. In contrast, Uttar Pradesh which contributes 16.6 per cent of the country's population has only about 6 per cent of the MTP centers. Situation of Bihar is still worse which has 10.3 per cent of country's population and has a share of only 1.6 per cent of the MTP facilities in the country (Figure 4). This shows wide disparity in allocation of MTP facilities across the country. Thus, the problem is not only lack of inadequate availability of MTP facilities, but also wide disparity across the States.

### **Trained Manpower and Training Facilities**

Liberalization of MTP was expected to follow with establishment of adequate number of MTP centers to provide the services and training of manpower to conduct the process. As we saw in the above section, even after more than two decades of introduction of MTP Act, the facilities for MTP services, particularly in rural area is extremely limited. The same pattern is observed in establishing training institutions for generating adequate number of trained manpower. According to the available information, at national level there are altogether 162 designated MTP training centers providing training in MTP to doctors. These

institutions are classified as A type Post Partum (PP) centers generally attached with some medical college or district hospital. In India, altogether there are 554 post partum centers, out of which 230 are in A type category.

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 MTP were available in 1992 as against requirements of about 21.000 in the rural area itself (for PHCs). Further, it could be 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 centers which have adequate case could have been designated MTP training centers, but the fact that only 162 have actually been made training centers shows that on serious thinking have been given to these aspects. It may not be out of place to mention that to designate a A type PP Center as MTP training center not much resources are required. A MTP training center gets a maximum of Rs.2,000/- per year (@ Rs.100 - per trainee) for training a maximum of 20 doctors. Similarly like MTP service facilities, allocation of these training centers in different States are also very disproportionate to their size.

During situation analysis of MTP facilities in Gujarat, Tamil Nadu and Uttar Pradesh, CORT also conducted a quick assessment of the training facilities in these three States and quality of training provided.

The curriculum development Government of India (GOI) for MTP training is fairly comprehensive and covers both theoretical and practical aspects. There are two different training courses, one for the general practitioners having no specialized training or less than 3 years of work experience in Ob/Gyn. The second for those who have received post graduate diploma or degree in Ob/Gyn or doctor with at least 3 years experience of Working in Ob/Gyn (Ministry of Health and Family Welfare, 1986). The duration of course is one month. During this period, apart from the theoretical course, performing 25 MTP cases independently is an essential requirement. Recently, however, duration of training has been reduced to 15 working days provided the doctor has conducted 25 MTP cases and the trainers are satisfied that they are sufficiently trained to carry out MTP.

In Gujarat there are eight MTP training centers, in Tamil Nadu 15 and Uttar Pradesh 17 centers. Some of these training centers are attached to teaching medical colleges, while others are attached to non-teaching hospitals. During the present study, all these MTP training centers were visited and either the incharge

of the training center or some other senior faculty member was contacted and interviewed. Subsequently, 6 to 8 doctors in each State who were recently trained were also contacted to assess their views on the training they received.

Data on number of doctors trained in MTP for all the institutions during the last five years revealed the following result:

**Table 5:** Average number of doctors trained per training center per year

States	Average number of doctors trained per institution	
	Training institutions	Non-training institutions
<b>Uttar Pradesh</b>		
1994	3	5
1990-95	5.5	7.3
<b>Tamil Nadu</b>		
1994	23	17
1990-95	20	12
<b>Gujarat</b>		
1993	6	6

Table 5 shows that performance of MTP training centers Uttar Pradesh and Gujarat is quite poor and they could not train even half of the expected number in a year. In contrast, the performance of training centers in Tamil Nadu is much better. A discussion with a senior official of the Tamil Nadu revealed that the performance has improved a lot during the last two years as the Govt. of Tamil Nadu has made it compulsory for each government doctor to go through MTP training and hence there is a pressure on each training centre for taking maximum load. In fact some of the Catholic Christian doctors are quite unhappy with this decision as they approve MTP and are not interested in training.

**Table 6:** MTP workload at selected MTP training centers, number of doctors trained and number of MTP performed by the trainee doctors

	Type of training institutions					
	Teaching			Non-teaching		
Sr. No. of the training institution	1	2	3	4	5	6
Total no. of MTP, performed during 1993	2055	460	305	798	534	800
Monthly average turnover of MTP cases	171	38	25	66	44	66
No. of doctors trained during 1993	7	7	4	6	4	7
No. of doctors trained during	Nil	Nil	1	3	1	1

Dec 92 - Mar 93						
No. of MTP cases generally a trainee performs	2-3	2-3	4-5	25*	25	25

\* This is not a true picture. The doctor who was interviewed said that "If you ask the honestly, the number of MTP cases they perform are very few but as your are taking an official interview and writing my answers. I will say they conduct 25 cases". Subsequently, by interviewing some of the trainees we came to know that it was 3-4 cases.

Table 6 presents an overview of the performance of 6 MTP training institutions in Gujarat. Similar detailed analysis of Tamil Nadu and Uttar Pradesh was also done. The results revealed the following points.

- Generally, the turnover of MTP cases is quite low to train enough doctors at a time.
- Accordingly, only 4 - 7 doctors in Gujarat, 1-7 in Uttar Pradesh and, 6-25 are trained per year per institution. In case of Tamil Nadu however, there are two institutions which on an average train 30-54 doctors per year.
- During January-March (to be precise December-March) doctors are not sent for training due to Family Planning (FP) workload at PHCs.
- The trainee doctors do not get enough practical experience in conducting MTP in medical colleges. In non-teaching institutions generally the doctor gets a chance to perform about 25 cases.

Further discussion shows that in the teaching medical colleges, generally most of the cases are attended by Resident Doctors, hence the Medical Officers (MOs) deputed for MTP training hardly get any chance to perform MTP. As Resident Doctors are internal trainees, they get preference and most of the MTP cases are done by them, particularly when the inflow of MTP cases is limited.

The following verbatim statement of the Officer Incharge/Senior Faculty member of the MTP training centers are good illustrations of the problems faced in giving proper training to the doctors:

"Everyday we get 4 MTP cases. 4 Resident Doctors are also to be trained here. We do not allow trainee doctors to do the cases independently as it is risky and could cause complication".

"We get very few cases for MTP. Some of them are in the 1<sup>st</sup> trimester. Hence they are not able to see much".

" If you ask me honestly, the number of MTP cases they perform are very few but as you are taking an official interview and writing my answers, I will say they conduct 25 cases".

"Generally we give him chance to check cureyttage and feel the uterus. Then he starts assisting the doctors who perform the MTP. At the end before the doctor completes the training and is about to leave, we give him chance to perform 2-3 cases independently" (Teaching institution).

Some of the trainees who were contacted to assess quality of training also reported that they had more opportunities to watch the performance but very less chances to do actual performance. As one of the trainee from Tamil Nadu said:

"While during pelvic examination I could touch and feel the gritting sensation of the uterus. But I could not do a single case of MTP in the OT".

Yet another doctor from Tamil Nadu said:

"At the time of training, more doctors were posted and there was a heavy pressure. The case load was equally less. Hence we could not perform".

Two more doctors stated

"We could not do a single case in the whole of the training period".

Training in UP was no different. As one of the trainee said:

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

Further informal interviews with government officials and few trainees who had recently received training show that because of various procedural problems and lack of facilities both at training centers and subsequently at PHCs (for MTP), there is not much demand or enthusiasm for receiving MTP training. Generally there is no waiting list of Medical Officers (MOs) for training (for details see CORT, 1994). Similarly, the DHOs also do not take any initiative to encourage doctors for MTP training. He has to arrange a doctor who could release him for the period of training. At least 2 of the 6 doctors in Gujarat who were recently trained in Gujarat and were interviewed by the CORTs executive informed that they got the permission after more than 2 years since they applied for it. It was further observed that out of these 6 doctors, 3 Mos, even after training, were not providing MTP at PHCs/ CHCs, because of lack of equipments.

One MO reported that he had 'borrowed' the equipments from neighboring PHC where equipments were available but the doctor was not trained. Yet another two doctors mentioned that they are now trying to seek transfer to PHCs where equipments are available and they could provide MTP services.

Discussion with government officials at central level as well as doctors at PHCs on why they do not take interest in getting MTP training revealed that apart from procedural problems, the fact that TA/DA for sending doctors for 15 days training is not built in the state budget, it is difficult for sending many doctors for training.

Lack of interest on the part of trainee is also because they have to leave their home for at least 3 weeks (earlier 4 weeks), pay TA/DA from their own pocket



with no assurance that when they will get back. On top of that they lose money from their private practice. Describing this a senior Central Ministry official narrated the following conversation which he had with one doctor in Uttar Pradesh.

I Why you do not get training in MTP?

Dr What advantage I have? I have to go for 15 days out of my home leaving my family behind, I have to spend TA/DA first to be recovered afterwards. Who knows after how many months? On top of that I lose my earning from private practice.

I But after training you could earn still more as you will start doing MTP. Is not MTP a good business?

Dr Yes, but I am already doing it.

I Presently it is illegal. After training you will get a Certificate to do MTP.

Dr Who (patient/authority) who ask for that ?

### **Resource Allocation for MTP Services**

Given the fact that to enhance MTP centers in public clinics, considerable amount of planning and additional resources are required, an attempt was made to assess how the MTP program is coordinated at Central and State levels. Discussion with program managers at different levels revealed interesting findings.

First thing which emerged from the discussion is that till recently strengthening of MTP was not an important issue in the MOHFW and hence at the time of allocation of resources it received the least priority. For instance since 1991-92 an amount of Rs. 150 lakhs is being allocated for the MTP program. In 1995-96 a serious effort was made to strengthen the services and increase the number of MTP centres. For this a demand of Rs. 980 lakhs was made resource constrain did not allow any additional resource to MTP and again Rs. 150 lakhs was allocated for 1995-96. There is no rational for such allocation. Further probing revealed that generally last year MTP performance of each State is taken into account and allocation of fund is done as follows:

No. of MTP training institutions X Rs. 2000

No. of MTP done X Rs. 15 for drug

No. of MTP done X Rs. 1 for State MTP Cell

After allocating all the money, if any amount is left then it is allocated for purchase of equipments and adding new MTP centers. It was pointed out that Rs. 15 for drug per MTP cast is totally inadequate but at the time of budgeting as MTP gets very low priority, nobody wants to discuss it.

Money from Center to State is released on monthly basis. Starting the 1<sup>st</sup> installment, somewhere in April end or May. States are expected to send

monthly expenditure statements regularly. However, release of money continue till December despite of the non-receipt of expenditure report. After December, center holds back the monthly installments and ask for submitting the expenditure statement. Discussion at Central level reveals that Uttar Pradesh and Bihar are permanently defaulters and do not submit money utilization report.

Generally all money allocated for MTP, particularly for purchase of new MTP machine remain unutilized except, in case of Karnataka and Maharashtra. Probing on why fund for purchase of MTP machine remain unutilized revealed that GOI insist that the equipment must be purchased with ISI mark. There is only one company in the country "Anand Medicates" which has ISI mark. But the States have their own procedure of purchasing equipments. They generally call for tender in which "Anand Medicates" do not have the lowest bidding and others do not have the ISI mark. Other manufacturers of MTP machine say that because of procedural problems and restrictions imposed by ISI they do not want to apply for ISI mark. For them the market of these equipments is not big enough to get into all these troubles.

It is surprising that for so long GOI was aware of this problem but had not taken any measure to ensure utilization of these funds. However, this year (1995-96) GOI instead of forwarding the funds to States, directly purchasing from the company 854 MTP machines under various WHO programs. These machines will be allocated to different States depending on their previous performance, size of the State and availability of MTP center.

### **Licensing of MTP Centers**

In the public sector lack of resources and times proper utilization of funds is a major cause for slow increase of registered MTP centers. In case of private clinics, the licensing procedure is at times difficult and discourage the doctors clinics from applying recognize the clinic for MTP services.

According to the MTP Act, no pregnancy termination shall be made in any place other than:

- A hospital established or maintained by government, or,
- A place for the time being approved for the purpose of this Act by government (MOH and FW, 1971).

The Act also ensures: a. Safe and hygienic conditions: b. Provision of 1) an operation table and instruments for carrying out abdominal and gynecological surgery; 2) anesthetic, resuscitation and sterilization equipments. 3) drugs and parental fluids for emergence use.

In general, there is a well-defined protocol for the submission of application for the approval of registration of an institution. This is to be made on Form A to the Chief Medical Officer of the district. After due verification by the district health authorities about the availability of all required instruments and facilities they

make a recommendation and forward the same to the State health authorities (usually to MTP cell of Directorate of Family Welfare). The State health authorities, in turn, after scrutinizing forward the name of the clinic to the State administration for approval. After approval is granted, certificate is issued by the Director General of Health and Family Welfare authorizing, the clinic to conduct MTP. This procedure in the three States are quite similar. However, the time taken for completing these procedure in the three States are quite different. Similarly, the experience of getting the application approved and efforts required to complete the formalities also vary vastly. For instance, in the State of Uttar Pradesh the process of licensing usually takes several months to over a year, consequently a widespread dissatisfaction could be observed at all levels due to this cumbersome process. This is also cited as one of the major reasons for a lagging interest among institutions and clinics to get registered for provision of MTP services.

A State level official, in a discussion on the reasons for such delay, said:

"In either of the case (private or public) once the request for approval with CMO's recommendation is forwarded to us (MTP cell of Directorate of Family Welfare), within a month we try to scrutinize the case and forward the names of the clinic to the State administration".

He continues,

"The actual problem starts at the higher level. The application before it is finally approved, get virtually lost in the jungle of files".

It was also observed that several follow up and reminders by the medical professional and contact by private parties (clinics) involved before the final approval is granted. Usually it takes 5-6 months to get approval from the government. However, it was also reported that some applications that were seeking approval for MTP were still lying in the Directorate of Health and Family Welfare of Uttar Pradesh way back in 1992-93. Senior officials at Secretariat were contacted to understand the specified reasons for delay in approval. As one of them explained,

"The first reason is the inefficiency of the system coupled with the low status MTP program is assigned with within the overall Health and Family Welfare Program. Moreover, it is ranked under 'routine paper', so obviously it is treated and moved as routine paper only".

Nonetheless in order to assess the actual situation, some of the recently (during 1993-95) approved clinics were visited by the CORTs research team. High level of grouse, dissatisfaction and mistrust towards the system was vocal amongst these doctors.

One doctor who was, as he himself puts,

"Fortunate to get my clinic registered (approved for MTP) within 6 months as I had some good approach above, while other one (not so fortunate) had to run around over one year for the same, its absolute nightmarish".

Quite contrary to this, in Tamil Nadu, it was given to understand from different government officials as well as private practitioners that registration procedure was very simple. It was neither time consuming nor cumbersome. It was also reported that no follow-up nor any paper work was to get a clinic registered. The time that was taken to register a clinic was maximum 30 days. In fact some of the officials felt that licenses are being issued in an indiscreet manner to the private clinics and nursing homes.

Their argument is that the government doctors are expected to motivate all the clients who seek abortion to accept either sterilization or one of the spacing methods. Elaborate probing is done with the abortion seekers. The clients are subjected to series of questions which are also documented. But the clients who go to private nursing homes may not be subjected to all these queries nor they are motivated for any methods. There could be repeat abortion cases which may endanger the life of the women. One doctor reported.

"Just because abortion is legalized, does not mean that doctors should be so liberal in doing this".

There was also the grievance that private nursing homes and clinics with abortion facilities were mushrooming in the city of Madras.

#### **Utilization of Available Public MTP Centers**

While the number of MTP centers in rural India is very limited and in general women do not have easy access to MTP services, it is also true that majority of these centers underutilized. The data indicates that at present on an average each institution does one MTP in 3 working days ( Chhabra and Nuna 1994). Earlier expert projections had calculated an average workload of 3-4 MTPs per trained physician. In other words only one-tenth of the actual optimal potential in terms of trained manpower and approved centers are being utilized.

One of the important reasons of under utilization of public clinics for MTP services could be lack of awareness among the women whether or not abortion is legal. For instance, in a ICMR multi-centre study in five States showed that a large number of women either had no information about legal status of MTP or believed that it was illegal (ICMR 1989). Percentage of such woman varied from 31 in Tamil Nadu to 75 in Uttar Pradesh and Haryana. Taken all the 5 States together, about 36 per cent were aware that MTP was legal, another about 38 per cent women expressed their unawareness while about 26 per cent said that abortion was illegal.

A similar study carried by CORT (1995) in Bihar revealed that only about 28 per cent of women were aware that abortion was legal, 35 per cent said that it was illegal while remaining 37 per cent were not sure about its legal status. It was also noted that among those who were aware that MTP is legal, 37 per cent

approved MTP. While those who considered it illegal, only 10 per cent approved abortion. Those who were not sure 17 per cent had no objection to abortion. Thus, awareness of the legal status of MTP appears to have positive impact on approval of abortion.

This clearly indicates that abortion is a sensitive issue and a large number of women are not aware of its being legal and also do not approve of it. In such circumstances, most of these women if they had to go for abortion, they would prefer sources which are not public (like PHC or CHC) and go to private clinics where privacy and confidentiality is better maintained (CORT 1994).

**Table 7:** Awareness about legal status of abortion and proportion of women approving abortion in case of unintended pregnancy

% approving abortion in case of unintended pregnancy	Percent aware that abortion is			
	Legal	Illegal	Not aware	All
Approve abortion	26.5	4.8	8.8	12.3
Approve under certain circumstances	3.5	6.2	8.0	6.1
Not approve	69.3	89.0	78.0	79.5
Uncertain	0.7	-	5.2	2.1
Total number of eligible women	599 (27.6)	765 (35.1)	811 (37.3)	2175

**Source:** CORT (1995)

In Gujarat study (CORT 1994) it was observed that public clinics more strictly followed the procedure of various examinations prior to MTP and asked women to stay for longer period in the recovery room for observation after the procedure. This also work as a hindrance to those women who come for abortion without, asking their husbands and other family members. A longer time at clinic may create problem for them. In private these restrictions were not strictly followed and the clients were discharge fairly quickly after MTP.

The study also revealed that often in public clinics, the modesty and privacy of the women was not well maintained. Invariably, the patients were asked to purchase drugs and in some cases, even fees were charged. A comparison of total cost spent on obtaining MTP from the public clinic was estimated to be Rs. 173/- in case the doctor of the clinic had not charged any fee otherwise it was estimated to about Rs. 311/-. The corresponding figure for obtaining the MTP form a private clinic was estimated to be Rs. 480/-. As the difference between the two is not much and overall perception of the services provided by the private clinic is better, many people may favor private clinic to public clinic.

Yet another factor which is a strong discouraging factor for women to seek, MTP services from public clinics is the insistence by providers for accepting either sterilization or IUD. In case the women are not interested in adopting the

method, often they are denied the services. In an ongoing village level study of CORT in Uttar Pradesh on decision making process in acceptance of abortion and preference for services, it was observed that many women went to PHCs for accepting MTP but when they were asked to accept sterilization, they came back without undergoing abortion. Out of the five such cases, 2 continued with pregnancy, one tried drugs but failed in inducing abortion while the remaining two went to some private clinics and got aborted. The verbatim from these cases reflect their feelings:

"When I became pregnant for the sixth time I decided to go for abortion. I with a neighbor went to Sarsa PHC. The lady doctor agreed for abortion but said that you must accept sterilization also. I became very much nervous. I did not want to go through operation and hence came back" - The women delivered her sixth child".

"I went to - PHC for abortion. This was my fifth pregnancy. There I was told that only those women will be accepted for MTP who will adopt sterilization IUD. I had heard so much side effects of these methods that I could not agree with them. The lady doctor then became very angry and said go and deliver this child also. Why are you wasting my time? After this my husband gave me some tablets for abortion but it did not work. Finally I accepted the pregnancy".

### **Conclusion**

The present paper thus clearly brings out that despite the fact that MTP has been legally approved in India for more than two decade, its services are not easily accessible to majority of the women, particularly in the rural areas. As a result 90 percent of the 6.7 million estimated abortions performed in India, are conducted by untrained village practitioners using unsafe methods under unhygienic condition. According to the available studies 12-20 percent of the maternal deaths in India's are contributed by septic abortions due to unsafe due to unsafe abortion practices.

The study shows not only a slow growth of MTP facilities but also a disproportionate distribution of the facilities across the country. Better managed States like Maharashtra and Tamil Nadu have a significantly larger proportion of MTP clinics than poor States like Uttar Pradesh or Bihar. The same pattern is observed in allocating MTP training institutions. Difficult Government formalities to recognize a clinic as MTP center also contribute to the slow expansions of the MTP facilities in India.

Situation analysis of MTP facilities carried out by CORT in selected States shows that majority of the PHCs (75-80 percent) do not have MTP facilities. Even those 20-25 PHCs who are officially recognized for carrying out MTP are often not fictional because of lack of trained manpower, non-availability of required equipments or both.

On the part of government no serious effort has been made to train enough doctors to conduct MTP. Hence even if equipments are made available to all the

block PHCs, and CHCs, with the existing, level of training facilities 15 to 20 years will be needed to train required number of manpower. According to an estimate, in 1992 only 3000 doctors, trained in MTP, were available as against a requirement of about 21,000 in the rural area itself.

According to CORT studies, whatever limited number of MTP training institutions are available, are poorly utilized. For instance the number of doctors yearly trained are often less than half of the approved training capacity. Lack of interest among doctors for undergoing MTP training and difficult formal procedure for getting duty leave sanctioned to attend training contribute significantly to the present state of affairs.

Quality of training itself is far from satisfactory and do not provide enough practical experience. Often the doctors, even after training do not have the confidence in conducting MTP independently.

At the departmental level, MTP has remained a neglected area. At the time of allocation of resources it receives the lowest priority. Since 1991-92 it is fixed at 150 lakh (US\$ 435,000 approx.) annually which is totally inadequate for all purposes. The donor agencies who have contributed significantly in expending health and family welfare facilities in the country have also not shown any interest in supporting MTP program.

On the demand side, while all estimates show a large unmet requirement, available studies also indicate that most of the public clinics providing MTP services remain under utilized. The reasons mentioned for such state of affairs include sensitivity attached with abortion as still majority of the people do not approve of it on moral and religious ground, lack of awareness that abortion is legal and fear of women that at all public clinics acceptance of sterilization/IUD is precondition for availing MTP services.

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