

## **Situation Analysis of MTP Facilities in Maharashtra**

*Sandhya Barge*  
*S. Rajagopal*

*Ever since its legalisation in India in 1972, MTP cases including illegal abortion have increased steadily. To strengthen MTP facilities in rural areas, a good database is essential which could provide information on its adequacy and utilisation. With the support of Ford Foundation, Centre for Operations Research and Training, Baroda conducted a situation analysis of MTP facility covering 97 registered clinics falling in 17 districts of Maharashtra. Only 33 rural hospitals and 16 PHCs providing MTP services at the time of survey. Services could not be provided because of lack of required equipment's or trained doctors or both (Rural hospitals were better equipped with essential working equipment's for MTP than the PHCs). Two-thirds of the 139 medical doctors interviewed reported; the incidence of MTP is increasing. On an average, more than one-fourth of all doctors see a MTP seeker daily. Prevalence of illegal abortions can also be gauged by the number of post-abortion complication cases received at the clinic. The status of the doctors shows that a major gap existed in training and their posting at the clinics. The average cost for obtaining MTP services from public clinics varied between Rs.218 to Rs.258. The paper highlights the need to improve the MTP facilities in rural areas and provide alternate strategies to train doctors.*

### **Introduction**

In India, after the introduction of Medical Termination of Pregnancy (MTP) Act in 1972 legalizing abortion reported MTP cases have been on a steady increase. According to available statistics, the number of approved institutions providing MTP facilities have increased from 1,877 in 1976 to 7,121 in 1991. Similarly, the number of reported MTP cases from a mere 25 in the year 1972-73 have 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, 5-6 million abortions are conducted by trained or untrained private medical 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 are not reported in any statistics. These illegal abortions mostly carried out by untrained village practitioners have contributed to the continued high levels of maternal morbidity and mortality in India. According to an estimate, 12 percent of the maternal deaths are due to septic abortions.

Recently there has been a growing realization towards an urgent need to increase safe MTP facilities both in rural and urban areas, so that women could have access to safe and hygienic abortion facilities, if there is a need to terminate the pregnancy. Necessity for such facilities is crucial for ensuring women's health. It is surprising that even after twenty years of legalization of MTP, its availability in rural areas is very limited and even in the Rural Hospitals (RHs) and Primary Health Centres (PHCs) registered for providing MTP services, no information is available on its utilization and its efficient functioning. To strengthen MTP facilities, perhaps, the starting point is to develop a good database, which could provide information on availability of the facilities, its adequacy and utilization. In case the utilization is not optimum, it is necessary to understand the reasons why the utilization is low and how the utilization of the facilities available could be improved so as to reduce the number of illegal abortions. Realizing the importance of MTP and lack of information on its availability, adequacy etc. The Ford Foundation commissioned Centre for Operations Research and Training, Baroda to do a Situational Analysis of MTP, particularly in rural areas of Maharashtra a relatively more advanced State.

### **Historical Background of MTP Act**

India was one among the few developing countries that legalized Medical Termination of Pregnancy (MTP) Act as early as April 1972. The MTP Act however created two major legal restrictions to the accessibility of abortion services in terms of designating the place where it could be provided. Abortion could be legally done in a hospital established or maintained by the government or in a place for the time being approved for the purpose of this Act by the government; secondly the termination is to be done by medical practitioners specifically registered as competent to perform MTP. Such registered MTP competent practitioners can terminate the pregnancy, but they must have a second opinion from at least one other practitioner if the duration of pregnancy is between 12 to 20 weeks. In such cases, they must also certify that the continuance of pregnancy would involve a risk to the life of the pregnant woman.

### **Objectives of the Study**

More specifically the study makes an attempt to look into the following:

- To what extent MTP facilities are available in rural and semi-urban areas of Maharashtra?

- To what extent MTP facilities are actually available in the rural hospitals (RH) and PHCs, which are registered for providing MTP? If these clinics are currently not providing the services, why?
- to what extent are these clinics properly equipped, with trained personnel and support facilities to provide the services effectively
- what is the quality of MTP services provided by the public clinics as compared with private clinics

### **Sampling Design**

The number of PHCs within a district varies considerably. Thus, the starting point of the study was to prepare a district-wise list of total PHCs and PHCs registered for providing MTP services. This information was not readily available at one place or even at the State level. Different departments and district offices had to be visited for this.

From this information, the percentage of PHCs registered for providing MTP facility in each district was calculated. To give adequate representation, a stratification was adopted. Based on the proportion of PHCs registered for providing MTP facility out of all PHCs in the district, the districts were stratified as 'low' and 'high' While stratifying the districts, care was also taken to see that all the five administrative zones were represented. Hence, finally 17 districts were selected out of a total of 30 districts, 9 representing the 'high' category and 8 representing the 'low' category of available services. In districts which fell in 'low' category, 3 to 4 PHCs and in 'high' category district 8 PHCs were selected for study.

This way, 97 public clinics (60 PHCs and 37 RHs) were covered in the survey. In each district, if the number of registered MTP centre was more than the required sample size; the clinics were selected randomly from the list of names of PHCs and rural hospitals (RH) that were availed from the Government of Maharashtra. However, it may be noted that in many PHCs the administrators were not even aware that the clinics have been registered as MTP clinics. It also happened in some districts that though the list showed the name of a clinic with the status of PHC, in actual field visit it was observed that the PHC has been upgraded to Rural Hospital. In case an alternative registered PHC was available, it was substituted; otherwise information was collected from the upgraded PHC having the new status of rural hospital. Besides the PHCs in each district, public clinics in 2 towns with less than 100,000 population were also contacted.

In the study design it was also proposed that women who had undergone MTP on the day of field visit to the clinic would be interviewed. The actual fieldwork revealed that the number of clinics providing MTP facility was low. And wherever the MTP service was being provided, the field visit did not coincide with actual MTP being conducted on that day. Hence, registers were used to get the names and addresses of the MTP acceptors within a period of days. This way 32 acceptors were followed, of whom four were from private clinic.

### Number of MTP Centers in Maharashtra

Out of the total 1808 MTP centers, 515 (28.5 percent) were public clinics and the rest 1,293 (71.5 per cent) were non-government institutions. The total number of approved MTP centers in Maharashtra have increased from 1,151 in 1985-86 to 1,808 in 1994-95 (Table 1), which is an increase of 57 per cent over nine years.

During the same period the increase in the Government approved MTP centres has been 76 per cent, while the growth of the non-government institutes had been 51 per cent. This does show that the government is making efforts to increase the accessibility of its services and it also ensures that the non-government institutes that are getting approved fulfills all the criteria laid down by the government norms. However, at present there are almost three private institutions for even one Government institution providing MTP services.

**Table 1:** MTP approved institutions in Maharashtra

MTP approved institutions			
	Government	Non-government	Total
1985-86	293	858	1151
1986-87	376	930	1308
1987-88	416	971	1387
1988-89	419	1040	1459
1989-90	430	1080	1510
1990-91	448	1113	1516
1991-92	450	1168	1618
1992-93	515	1217	1732
1993-94	515	1260	1775
1994-95 (upto Dec'94)	515	1293	1808

Source : Directorate of Health Services, Maharashtra State, Bombay, May 1995.

### As a Private Gynecologist in the Jat town in Maharashtra mentioned,

"I have all the available facilities and qualification to do MTP, but my centre is not recognized because there is no blood bank facility available within a radius of 20 kms, which is essential."

**Observations showed that this clinic was clean and well equipped.**

Among the government institutions, two-fifth (40.7 per cent) of the institutions are primary health centres followed by rural hospital (27 per cent).

A comparison of the number of approved MTP centres in Maharashtra with those given in the national statistics shows that though Maharashtra constitutes only 9.4 per cent of the country's population, 22.7 per cent of the total approved MTP centers are located in the State (as of 1991-92). In fact, Maharashtra has the highest number of MTP centres in the country. This is followed by Kerala which is though the second State in the list has quite low number of approved MTP centres (7.5 per cent).

**Extent to which RHs/PHCs are registered for providing MTP facilities are functional**

The distribution of RHs and PHCs in the study areas as well as their registration status for providing MTP are given in (Appendix 1). There are a total of 175 rural hospitals and 1,003 PHCs in the 17 districts selected for the study out of 30 districts in Maharashtra state. All rural hospitals and only 136 out of 1,003 PHCs (13.6 per cent) are registered for MTP. For the present study, 37 rural hospitals and out of 136 registered PHCs, 60 (44.1 per cent) PHCs were visited and detailed information was collected on MTP services. The study shows that out of the 97 registered public clinics (37 RH and 60 PHCs) covered in the study only 49 (50.5 per cent) were currently providing MTP services, 33 (89.5 per cent) rural hospitals and only 16 PHCs (24.4 per cent). The data thus reveal that the observations from the field situation do not present the same picture as the service statistics of approved facilities.

**Appendix 1** : District-wise number of RHs and PHCs that provide MTP services

Region	Name of district	Number of RHs				Number of PHCs					Total public clinics providing MTP services in rural area (per lakh population)
		Total RHs	Visited	Providing MTP services	Estimated no. of RHs provide MTP service	Total PHCs	Regd. To provide MTP	Visited Regd. PHCs	Actually providing MTP	Estimated no. of PHCs provide MTP services	
KONKAN	Ratnagiri	10	2	2	10	67	10	6	2	3	0.9
	Shidhaldurg	7	2	2	7	38	10	6	4	7	1.8
NORT	Nasik	18	5	5	18	97	11	3	2	7	1.0

HERN	Jalagao	15	2	2	15	77	8	3	1	3	0.8
MAHA	n	12	2	2	12	88	--	--	--	--	0.4
RASH	Ahmed										
TRA	nagar										
WEST	Pune	14	3	2	9	83	21	7	5	15	0.9
ERB	Sangli	9	2	2	9	57	6	2	--	--	0.5
MAHA	Solapur	10	2	2	10	66	16	6	--	--	0.4
RASH	Kolhap	13	2	1	7	67	4	2	--	--	0.3
TRA	ur										
MARA	Aurang	7	2	2	7	43	13	6	1	2	0.6
THWA	abad	9	2	2	9	51	--	--	--	--	0.5
DA	Parbha	8	1	1	8	45	3	2	--	--	0.5
	ni	8	1	1	8	44	7	3	1	2	0.8
	Bidh										
	Latur										
WIDH	Buldha	7	2	--	--	47	11	6	1	2	0.1
ARBH	na	13	2	2	13	61	16	8	--	--	0.8
A	Yeoth	8	3	2	5	45	--	--	--	--	0.4
	mal	7	2	2	7	27	--	--	--	--	0.9
	Nagpur										
	Wardha										
Total		175	37	32	151	1003	136	60	17	39	0.7

\* All rural hospitals are registered to provide MTP services.

The data also shows that among the five zones, Konkan and North Maharashtra zone have better availability of MTP services than the other three regions. It also reflects a fact that even in a State like Maharashtra which is a better developed State functioning of the clinics is far different from their registration status. Hence, the figures of registered clinics do not provide a realistic picture of the existing facility for MTP service delivery which needs to be seriously considered by policy makers.

Services were not been provided currently in 11 percent of the RHs and 75 percent of the PHCs due to various reasons, mainly because of lack of required equipments and trained manpower, while in RH it was mainly lack of trained doctors (11 per cent). In more than half of the PHCs (54 percent) a trained doctor was not available to conduct MTP. Some of the other reasons mentioned, were lack of OT facility (2 percent), doctor lacks the confidence for conducting MTP (5 percent) (Table 3).

**Table 3** : Availability of the services in the clinics covered

Availability of Services	RH	PHC
% of clinics providing MTP	89.5	24.4
Currently providing	10.5	74.6
Currently not providing	7.8	42.4
In past	2.7	32.2
Never		

<b>Reasons for not providing MTP (Percentage) *</b>	2.6	28.8
Required equipments are not available	10.5	47.5
Lack of trained doctors	--	8.5
Official formalities are incomplete	--	6.8
Neither trained doctor nor equipment are available	--	1.7
Lack of OT facility	--	5.1
Trained but lack of confidence/interest and other		
<b>No. of clinics covered in the study</b>	37	60

\* Multiple answers

The RHs were relatively better equipped for providing the MTP services. It was interesting to note that 19 PHCs and 1 RH had never provided the MTP facility though they had been registered on an average for more than 2.6 years. Non-availability of trained manpower in the clinics was the major reason for why clinics were not providing MTP services. As a RH doctor in Jalgaon district mentioned,

*"In Jalgaon district there are 77 PHCs, of which only 24 PHCs have a MBBS doctor posted in them while in the rest it is manned by a BAMS doctor and out of these only 17 doctors are involved in surgical work"*

### **Equipments and Support Facilities at the Clinics**

A probing into the availability of essential equipments for MTP that were in working condition shows that the RH and private clinics were somewhat better equipped than the PHC. At least one set of dialators and canulas were available in all the RH and in private clinics except for one private clinic. Again only one clinic in each of the category had all the five sets. RH was relatively better equipped than the private clinics too. It was more or less equipped to meet any emergency while conducting the MTP. Yet anaesthesia facility was available only in 35 percent of the clinic. This shows that care was taken in the government clinics to see that all the necessary equipments were in position to meet any eventuality ([Table 4](#)).

Information on the available support facilities at the clinic shows that overall the facilities available at the RH was better than even the private clinic. It shows that the required norm was followed more in government clinic than the private clinic. In terms of physical infrastructure the RH had waiting room facility (92 percent) and toilet facility (100 percent) with adequate water supply (81 percent) ([Table 5](#)). This was about half the number in PHC. Even the auditory (71 percent) and visual privacy (58 percent) was not available in all the private clinics though the turnover of clients was more in these clinics. From the above analysis it is evident that RH had better facilities to provide quality service.

## **Perception of the Doctors Regarding Incidence of MTP**

An interview with a total of 139 doctors from PHCs, RHs and private clinics on their opinion revealed the trend of MTP cases in Maharashtra was assessed. More than two-third of the government doctors believed that the incidence of MTP was increasing. Less than 10 percent perceived that it was decreasing. About one-third of the private practitioners believed that the trend had remained the same (Table 6).

## **Extent of MTP Services given by the Doctors**

A study in 121 clinics regarding the frequency of the women seeking advice for MTP shows that, on an average more than one-fourth of all doctors see an MTP seeker daily. This was almost double (55 percent) in private clinics where more than half of the doctors saw an MTP client duly. This was 23 percent in RHs and still less frequently (14 percent) in the case of PHCs. In 49 percent of the RHs a MTP advise is sought once or twice in a week. This shows that the use of private clinic by women seeking MTP services was more. Utilization of the PHC was least as 48 percent of the doctors reported that they gave advise only in one to three months (Table 7).

Similarly, the case load of the MTP acceptors was highest in the private clinics. On an average a private doctor performs 18 MTP in a month, while in the government clinics it was less than half of this. In RH which were usually located in small towns, doctor performs on an average 6 MTPs in a month, while at PHC only 2 MTPs were done. From the above data, it is evident that the MTP services are being provided more in the private clinics.

The prevalence of extent of illegal abortions in Maharashtra state is reflected by the proportion of the doctors reporting about the post abortion complication cases received by them and the frequency of such cases. Even in government clinic more than three-fifth of the doctors (RHs - 61 percent, PHC - 65 percent) reported that they receive cases of post abortion complications from outside their clinics. In a month on an average they receive one to two cases. In private clinics this was still higher. As 88 percent of the doctors reported receiving of such cases, and in a month they see at least 4 cases (Table 8).

Further probing with the doctors on whether they had heard about any death due to abortion or other pregnancy related complications during the last two years (Table 9). Again the doctors of private clinics were much more informal about it. As 9 and 21 percent of the private doctors reported of death during the last 6 months and 2 years respectively. The corresponding figures in the public clinic was low at 2 per cent in RH and 3 per cent in PHC for deaths in last two



years. While the public sector doctor reported of one death in last two years. Private doctor reported on an average of two such deaths. In absence of proper denominator it is difficult to estimate mortality rate due to abortion complication. However, it is a serious issue for women's health and morbidity. The figures of deaths due to abortion complications however, were much higher (8 and 33 respectively) in Gujarat State (CORT, 1994).

### **Training Status of Doctors Conducting MTP**

Around 106 medical officers from the government clinics and 33 doctors from the private clinics were contacted and interviewed. As expected, all the doctors in the private clinics were conducting MTP. But in RH, only 4 out of 5 doctors were giving this service, while in the PHC the situation was still worse as only 2 out of 5 doctors were conducting the service. It should be recalled that these are the doctors who are posted at clinics registered for providing MTP services. It is further interesting to note that not all the doctors who are conducting MTP are trained or have received any formal training in MTP services. While in RH 72 per cent have received the formal training, in private clinics the situation was worse as only 67 percent of the doctors were formally trained. 18 percent of the private doctors were Obs Gynec, but there were 15 percent of the doctors who were providing MTP services but had not received any kind of training (Table 10).

The data also shows that there were 11 doctors out of the total 26 in PHC who were conducting MTP but are placed in clinics that do not provide these services. This shows that a large gap exists first in the training of the doctors and secondly in their posting in clinics where there were no equipments to provide the services.

As a doctor who was trained, some years back mentioned,

*"when I had taken training, extra-ovular method and electrical suction method was not used But currently these methods are used. I am not trained in these methods and hence I do not have the confidence in conducting MTP"*

Another PHC doctor who was trained to perform MTP said,

*"the centre here does not have the necessary. equipment to conduct MTP. I have my own clinic and I do MTP there"*

Yet another doctor who reported,

*"officially I am not trained to do MTP, but I do conduct MTP"*

This shows that the doctors were conducting MTP either privately in their own clinics even if they are officially not trained to do so.

The doctors were further probed on the number of MTP cases seen and actually performed during the training period. As seen from (Table 11), 60 doctors from the government clinic and 22 doctors from the private clinics had undergone formal training, the average number of MTP cases actually seen during the training period was only 5 to 6 cases.

A few of the public doctors did not even have the opportunity to perform MTP during the training period. Even those who did have the opportunity have actually conducted only 4 to 6 MTP per doctor. This shows that in reality the doctors were not getting the opportunity to see and perform 25 cases as set in the norm of MTP training programme. In spite of this, some of the doctors do conduct MTP, while there were some doctors who do not receive enough confidence to perform MTP with this training programme, and hence do not give the services. This shows that at least the norm laid under the training programme should be properly implemented.

### **Type of Methods used for MTP**

An attempt was made to understand from the doctors conducting MTP about the type of MTP methods that they were utilizing (Table 12). Dilatation and curettage using the ovum forceps was the most commonly used method. More than three-fourths of the doctors in RH and private clinics were using this method. This was followed by electric vacuum aspiration method. The second trimester method extra ovular method and intra amniotic method was conducted by about half of the RH and private clinic doctors. In PHC usually the second trimester method was not provided, but in this case a small percentage was seen this could be because there were 7 PHCs that were upgraded to RH. As in our study list they were listed as PHC and also it had not started functioning completely as a RH, these clinics had been considered for analysts purpose in PHC.

On analyzing the data by the number of methods provided by the doctor, the percentage of doctors providing at least one method was highest in private clinics (97 per cent), followed by RH (86 percent) and PHC (44 percent). The average number of methods used by doctors was around 2 in RH and private clinic, while it was little less than one in PHC (Table 13). The percentage of doctors providing the first trimester service was more in both RH and private clinics. This is the duration in which risk of complication is less and usually the MTP acceptors are more. The risk of complication specially in late second trimester is three to four times greater than those in the first trimester. Abortion

in second trimester was attempted by only about half of the doctors in both RH and private clinics.

### **Quality of Service Delivery**

The opinion of MTP acceptors about the quality of service provided to them were gathered from a total of 32 exit interviews of MTP acceptors; 28 from public clinics and 4 from private clinics (Table 14). It was found that more than 88 percent of all doctors counsel that the procedure would be safe. Around two-fifth of the doctors also informed the client that the procedure could be infectious. 88 to 94 percent of all doctors do take preliminary information from the clients like menstrual history, Family Planning practice, family size reasons for MTP, etc., to the MTP seekers.

Probing into the perception of MTP acceptors about the MTP service received by them shows that 81-91 percent of acceptors reported positively that the waiting time was reasonable and effort was made by the clinic to protect their modesty and make them comfortable. All acceptors perceived that the services that they received was satisfactory. About 3 out of every five acceptors were counselled on what to do if they face problems and 3 out of every 4 acceptors were advised to come back for check up after MTP. 66 percent of all MTP acceptors had accepted family planning methods. In the private clinics it was not possible to contact more clients. Among the clients surveyed there was no significant difference between the response of the MTP acceptor from public and private clinics.

### **Cost of MTP Service**

For estimating the total cost of MTP service provision, the information was collected from service provider and MTP acceptors in case of public clinics and private clinics (Table 15). In both types of clinics the acceptors reported more expenditure than that reported by providers.

The service providers in public clinics reported that Rs 302 are spent towards fees and medicines but the acceptors reported that they had to spend Rs 218/- when fee was not charged and Rs 258/- when fee was charmed. The qualified private doctors report an average expenditure Rs 645/- and this was reported to be Rs 447/- by the acceptors. In Gujarat, a woman had to pay Rs 480/- in private clinics and Rs 170/- in public clinics for obtaining MTP service (CORT, 1994).

However, the higher expenditure in private clinics than the public clinics may be due to provision of service without any questioning and assurance of secrecy and non-compulsion of Family Planning method acceptance. This of course, needs further probing.

## Summary and Conclusion

Considering the felt need of the people the Medical Termination of Pregnancy (MTP) Act was legalized from 1972 which certainly led to a steady increase in the proportion of abortion in different states of India, so in Maharashtra. The statistics of the Maharashtra State shows that the MTP cases reported is much lesser than the actual. This happens due to the under estimation as still a number of MTPs are performed illegally. This underlines the urgent need to increase the accessibility of the safe and hygienic MTP facilities to all the women, whenever they need to terminate their pregnancy. This is crucial not only from Family Planning perspective, but also more important to ensure safe motherhood and sound Reproductive Health of women.

To strengthen MTP facility and to provide information on availability of the facilities, its adequacy and utilization a good data base is required. To fill up this information gap, a situation analysis of MTP services in various parts of the country is perhaps the logical starting point. The present report briefly makes an attempt to highlight the current situation of MTP facility in Maharashtra. To be specific, it looks at the availability of MTP facility, extent of its utilization, adequacy of available equipments and other support facilities. An attempt has also been made to look into the quality of services provided to the acceptors both in the public and private clinics.

The information for the present paper have been collected from 17 districts out of the total 30 districts of Maharashtra. Altogether 97 public clinics (Rural hospitals and Primary Health Centres) and 32 private clinics functioning in these areas were covered. 32 MTP acceptors were also informally interviewed to assess the quality of the service in terms of the later's satisfaction.

In the State of Maharashtra, available service statistics of the last one decade shows that in spite of the substantial increase in the number of approved MTP centres, there is a continuous decline in MTP during the same period. This indicates that the reported declining trend may be due to an under-reporting of MTP cases. It is known that the private clinics conduct a large number of MTP cases - but they do not inform it to the government to avoid income tax problem. The present investigation shows that out of the 60 registered PHCs only 24 percent were currently providing MTP services. Of the remaining, 32 percent had never provided MTP facility or were not providing it presently (75 percent) because of non-availability of trained manpower as well as lack of the required equipments. In RHs also out of the 37 registered RHs, 90 percent were currently providing MTP services. Of the remaining, 3 percent had never provided MTP facility or were not providing it presently (11 percent) mainly because of non-availability of trained manpower.

Information on the availability of other support facilities like waiting room facility, clean toilet, privacy during counselling etc. shows that overall the facilities at the RHs were the better private clinics than also. In contrast the facilities were poorest at PHC level. D and C method and electric vacuum aspiration were the most commonly used methods both at public and private clinics.

In the present study, out of the 139 doctors interviewed, 58-67 percent believed that the incidence of induced abortion was increasing. The average monthly turnover of MTP cases is higher in the private clinics (18 in number) than in the public clinics (6 in the RHs and 2 in the PHCs). The fact that illegal abortion exists is reflected from the high percentage (61-88 percent) of doctors reporting post abortion complication cases received in their clinics.

Further all the doctors interviewed for the study (139) were not conducting MTP. A substantial proportion of those who were conducting MTP were not trained for it. As the data reveals, only 74 and 48 percent of RH and PHC doctors respectively, and 85 percent in private clinics were trained in MTP (this includes the Obstetrician/Gynecologist). The doctors posted at RH and Private clinics had conducting around 6 MTPs during their training period. It is important to point out that as per the norm a minimum of 25 cases are necessary to be performed during training period which is evidently lacking. Some of the PHC doctors, even after training were not performing MTP as they lacked confidence.

To assess the quality of care received by, the women from the clinics, the exit interviews of acceptors of MTP were made. Data shows that more than 88 percent of the acceptors were counselled about the safety of the procedure. But less than half of the acceptors only were told about the possibility of procedure being dangerous. Regarding the other part of the quality of care, viz. Satisfaction, pre and post-MTP counselling a considerable proportion of the acceptors reported in positive.

The average cost for obtaining MTP services from a public clinic varied between RS 218 when no fee was charged to the women to Rs 258 when the women had to pay for services. In case of private clinics the cost for obtaining MTP services varied between Rs 645 to Rs 447 as stated by the providers and acceptors respectively.

The study provides an awareness for an urgent need to undertake serious efforts to improve the situation of MTP facilities, provide alternative strategies to train doctors in MTP provide necessary, equipments and of course to improve the accessibility of the needy so as to develop safe abortion environments

## References

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