QUALITY OF ABORTION CARE: A REALITY

From Medical, Legal And Women's Perspective

A study in two districts of Maharashtra

Sunita Bandewar
(assisted by Madhuri Sumant)

Research Centre of Anusandhan Trust

Centre for Enquiry into Health and Allied Themes (CEHAT)

AUGUST 2000

Draft not to be Qouted

Thelma Narayan
AAP-I

QUALITY OF ABORTION CARE: A REALITY

From Medical, Legal And Women's Perspective

A study in two districts of Maharashtra

Sunita Bandewar
(assisted by Madhuri Sumant)

Research Centre of Anusandhan Trust

Centre for Enquiry into Health and Allied Themes (CEHAT)

PUNE OFFICE
2/10, Swanand, Aapli Sahakari Society, 481, Parvatidarshan,
Pune - 411 009. Tel.(91) (020) 444 3225, 444 7866
E-mail: cehatpun@vsnl.com

MUMBAI OFFICE
2nd Floor, C/o BMC Maternity Home, 135 A-E, Military Road,
Next to Lok Darshan, Marol, Andheri (E), Mumbai: 400 059.
Tel.:(91) (022) 851 9420; Fax.: (022) 850 5255
E-mail: cehat@vsnl.com

August 2000

Acknowledgements

We would like to thank individually all the doctors and women who agreed to give interviews and provided us with the required information without hesitation, which gave useful insight to our study. We are grateful to them for the hospitality they bestowed upon us. The study would not have been possible without their active participation and co-operation.

Our sincere thanks to the Government officials, who gave their valuable time and information, which was of great importance to our study. In that, Dr.Mandakini Megh, Deputy Director of Health Services needs a special mention.

We would like to acknowledge & specially thank our consultants Dr Anant Phadke, Dr Madhuri Talwalkar, Ravi Duggal, Padma Prakash, Dr A M Deshpande for their constant support and invaluable inputs. We owe special thanks to Anant for his tenacious and warm support all through the study and to Ravi for giving us valuable feedback during the last & critical phase.

We are extremely grateful to participants of the State level consultation meeting on Access to 'Safe and Legal Abortion': Issues and concerns', and 'MTP registration procedure: Issues and concerns' for enriching our understanding of the issue at hand.

We are also grateful to our team members Dr. Hemlata Pisal and Ms. Mugdha Lele for their valuable support, especially during the phase of data collection. We are also thankful to Ms. Anjali Ganpule and Ms. Rohini Lele for their short but meaningful and lively association with the study. Over and above the diverse academic inputs of theirs to the project, each one's unique qualities gave a unique character to the team and maintained its spirit.

We offer our very special thanks to Ms. Shelley Saha for her enthusiastic support and cheerful help during the critical last phase of the report completion.

We also are thankful to Mr. Kiran Mandekar and Ms Sneha Fulambrikar for their secretarial assistance. Our erratic work schedules could be maintained only because of Kiran's diligent and tolerant secretarial support.

We are also grateful to all our colleagues at CEHAT to support us in various capacities towards completing this study.

We would be remiss without expressing our deep gratitude to Dr Amar Jesani and Ms Manisha Gupte for being the source of our inspiration to take up and pursue abortion research. Special thanks to Amar for being with us through ups and down during the tenure of the project in addition to being the sounding board.

Finally, we would like to the Ford Foundation for its generous grant, which allowed us to conduct this study.

We must add that although we greatly benefited from the advice, help and suggestions received from all those mentioned above, the errors and omissions in this report are our own.

CONTENT

List of Abbreviations

ACF: Abortion care facility

AN: Anaesthetist

AP: Abortion care provider

CH: Cottage hospital

FT: First trimester abortion (length of gestation upto 12 weeks)

FWC: Family welfare centres

GA: General anaesthesia

HCF: Health care facility/institution. Institution and Facility are used synonymously

HI: head of an health care institution

LA: Local anaesthesia

LT: Laboratory technician

LR: Labour room

NBM: Nil by mouth

NR-ACF: Non-registered abortion care facility

OT: Operation theatre

PHC: Primary Health Center

PPC: Post partum centres

R-ACF: Registered abortion care facility

ST: Second trimester abortion (length of gestation upto between 13 -20 weeks)

RH: Rural hospital

WB: Ward boy

UPT: Urine pregnancy test

CHAPTER I

QUALITY OF ABORTION CARE: PERSPECTIVE AND CONTEXT

1. INTRODUCTION

Literature, empirical research, people's experiences as regards abortion practices all over the world, especially in the latter half of the present century indicate that access to abortion services depends much on state's political agenda. In that case the State will do so irrespective of whether there existed such a legislation or not. For example, in Bangladesh, a very restrictive abortion law is softened by improving access to abortion services through government funded Menstrual Regulation (MR) services. The law prohibits abortion except to save the life of the mother. But to enhance the family planning programme to meet state's goal to limit population growth it began to support MR services. By leaving MR practices outside the purview of definition of abortion, women are allowed to manage unwanted pregnancies in a rather 'open secret' fashion. The State could meet its ends without getting into controversy by liberalising the existing abortion law. In Hungary, 'social justifications' are interpreted to accommodate virtually all women wanting to have abortions. On the other hand in Bermuda, Kuwait and Quatar the more liberal laws compared to earlier ones make little sense for women who face insurmountable administrative obstacles in getting

abortion services. We also find intra-country variation as regards this. Many more examples could be quoted. The state's encouragement for abortion or reluctance to offer abortion services is primarily to meet its own ends, viz. to control population growth (in Bangladesh) or to pacify fundamentalists (in Bermuda, Kuwait, Quatar). The racist motivation of some governments (viz.: pronatalists policies towards whites and antinatalist towards blacks in the US) is more than obvious. This, therefore, indicates that abortion legislation (or lack of it) is less to do with actual availability of abortion services[1]. This is not to deny the significance of legislative measures as one of the essentials in moving towards making possible women's access to safe and legal abortion care services. In this light legislative measures are essential but not sufficient.

Policies and legislative measures, either liberal or restrictive in nature, decriminalising abortion started taking shape the world over since middle of the 19th century. The context of decrimilalising abortion differed from nation to nation. More often than not liberalisation of abortion policies had links, as explained above, with state's agenda and its pro or anti-natalist population policies. This influenced not only the content and nature of legislation but also quality and nature of abortion care service delivery.

In India it is more than a quarter century since the Medical Termination of Pregnancy (MTP) Act is passed in 1971 and implemented in 1972. It decriminalised abortion. However, there are reasons to believe that the manner in which the Act is being implemented is less adequate and the quality of care that is available to women seeking abortion care either at institutions or otherwise are gruesome. Among others, the wide gap between the estimates of incidence of abortion and the reported MTPs as per the official records testifies this. **Primarily the objective of this study was to assess quality of facility based abortion care services holistically.**

The present chapter presents the content of the MTP Act in brief. **It offers a critique of the legislation which has provided the analytical framework for this study. Further it provides a scenario analysis as regards abortion care services, incidence of MTPs and estimates of incidence of induced abortions, mortality and morbidity situating the need to study quality of abortion care services.** Thereafter it details aims and objectives of the study and presents the quality of abortion care model that has been evolved to assess the quality of abortion care during this study.

2. THE MTP ACT

2.1 The content and the critique

Liberalisation of abortion through implementation of the MTP Act took place without it ever being on the agenda of women's movement. The Act is often described as one of those revolutionary efforts for two reasons. One, it was for the first time in the world that abortion was made legally permissible in case of failure of contraception. And two, it did not require husband's consent for a woman to undergo abortion.

[1] The agrument placed here is drawn from Jodi L Jocobson's article titled Global Politics of Abortion, a Wordwatch paper. Please see the Reference list

Despite these strengths of the Act, it provides space to be critiqued for its over-medicalisation and for allowing its liberal or restrictive interpretations depending upon the broader socio-political context.

The Act stipulates that pregnancies could be terminated legally only under certain circumstances and for certain reasons by only a registered Medical Practitioner with the necessary qualifications and training and at a place where the facilities available are in keeping with the standards prescribed in the Rules and Regulations of the Act. In the following it details specifics of the Act and our critique.

Legally permissible indications for terminating pregnancy and length of gestation: It is stated in the Act that *a pregnancy may be terminated*

(a) where the length of the pregnacy does not exceed twelve weeks if medical practitioner is, or
(b) where the length of pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practioners are, of opinion, formed in good faith, that –

(i) the continuation of the pregnancy would involve risk to the life of the pregnant woman or of grave injury to her physical or mental health; or
(ii) there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.

Explanation 1: Where any pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman.

Explanation 2: Where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the angusih caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman.

The critique:

Medical practitioners as 'gatekeepers'

The Act enjoins the medical practitioner as an ultimate authority to assess any possible consequences to women's mental and physical health of continuing the pregnancy to full terms while deciding upon whether to provide or deny abortion care services to a woman. In that sense a medical practitioner plays a role of **'gatekeeper'** in the process allowing **over-medicalisation** of abortion care services.

Patriarchal and gender biases in assessment of women's abortion needs

An assessment of women's abortion needs reflected in the 'explanations' rendered in the Act inherit patriarchal and gender biases. It exhibits moralistic positions about women's sexuality. It links woman's sexuality and use of contraception with her

marital status. Simultaneously, this then precludes all other situations and circumstances in which a woman may express her sexuality leading to a pregnancy, may be an unwanted or unintended one.

With such formulation of the clauses and/or explanations in the Act, the pregnant woman seeking abortion is compelled to furnish explanations that fit into the conditions listed in the Act. It also, keeps the Act open to differing interpretations, especially on part of the medical providers engaged in abortion care services. Following the government's preoccupation with population control and the somewhat dubious motivations of the medical profession the present interpretation of the law, ironically, has been a liberal one. However, the grave possibility of the Act assuming a restrictive meaning without even one word of the text being altered, remains. (Jesani and Iyer, 1993).

Implications for quality of abortion care

The current socio-political context, which permits a liberal interpretation of the Act may allow all women to undergo an abortion when sought at the health care institution. However, it remains to see as to how the patriarchal biases, unwritten proscriptions about woman's sexuality, moralistic views about the act of abortion reflected in the formulation of the Act impact at the pragmatic level the quality of abortion care services that a woman receives. It also remains to examine as to how the dubious motivations of the medical professionals intersect with their efforts to fit a particular case into the legally permissible abortion indications and what implications – either positive or negative - it would have for a woman, especially in terms of quality of abortion care she receives.

For example, research in the past has documented that husband's consent is demanded despite it being illegal. (Gupte et. al. 1999; Khan et. al., 1998). It, therefore, needs to be studied as to what pushes the medical fraternity to do so and what it means to a woman and quality of abortion care she receives.

The minimum physical standards set by the MTP Act: The Act has laid down the minimum physical standards to be maintained at a medical setup to be in position to offer MTP services. The Act states that *no place shall be approved under clause (b) of section 4, -- Approval of the Place.*

i. unless the Government is satisfied that termination of pregnancies may be done therein under safe and hygienic conditions; and
ii. unless the following facilities are provided therein, namely:

a) an operation table and instruments for performing abdominal or gynaecological surgery;
b) anaesthetic equipment, resuscitation equipment and sterilisation equipment;
c) drugs and parenteral fluids for emergency use.

The critique:

Lack of clarity

There is lack of clarity which leaves a lot of scope for subjective interpretations. For example, the terms `safe' and `hygienic' used in clause '(i)' are neither defined nor there are any guidelines to that effect in the Act. As a result, individual inspectors may apply their own interpretations while inspecting a particular place for provision of MTP facility. Besides, taking an advantage of this obscure formulation, the ill-functioning bureaucracy and poor implementation of any legislation in general may allow mal-practices in the process of approval of the place.

Lack of specificity

The clause about the requirement of instruments for abdominal/ gynaecological surgery doesn't take into account the need to have range of various sizes of different instruments that constitute this set. It also does not state the minimum number of sets that must be maintained at the institution depending upon the number of clients that may be admitted/attended at a time (size of the set up in terms of abortion admission capacity) etc.

Assumptions about the other minimum physical standards

In general, the abortion care facilities are rarely 'stand-alone' type of services. They are situated either in the general health care service facilities or in the maternity care centres. The MTP Act lays down standards, which are primarily about instruments and equipment required for abortion procedure and for administering anaesthesia; about the maintenance of the hygienic and sterile conditions in the operation theatre, about essential drugs and parenteral fluids. These are very specific to abortion care services and do not cover the entire range of specifications as regards minimum physical standards at the health care facilities at which abortion care services are situated. Neither does it specify the minimum physical standards in a comprehensive manner for a health care facility engaged in providing abortion care alone, though 'stand-alone' abortion care facility is not a norm.

It appears that the MTP Act assumes that the other minimum physical standards at a particular HCF are maintained at which abortion care services are situated. However, the situation is not so. The only medical legislation which deal with these aspects are Bombay Nursing Home Act, 1949 which covers only urban area of the state of Maharashtra (?); some other legislations which are applicable provincially, such as Tamil Nadu Private Clinical Establishments Regulation Act, 1997. In absence of any monitoring system and any vigilance mechanism in place these legislations in reality mean little as reported by the research studies. Besides, these legislations are applicable only regionally and not nationally. If so, the basic assumptions that seems to have been made in the MTP Act about health care facilities meeting the entire range of minimum physical standards appears to be grossly unfounded.

Thus, lack of any nationwide medical legislation to have such a regulatory mechanism in place leaves much at the hands of those running the health care facilities. As a result, practically speaking a health care facility engaged in abortion services may meet the minimum physical standards laid down in the MTP act but may violate some others impacting negatively on quality of abortion care.

Against this backdrop, it is essential to lay down a comprehensive model of quality of abortion care against which an assessment to be made.

Experience or training/qualification of the abortion service providers: The Act states that *a medical practitioner registered in the State Medical Registered*

(i) *if has completed six months of house surgency in gynaecology and obstertics; or*

(ii) *if he had expereince at any hospital for a period of not less one year in the practice of obstetrics and gynaecology; or*

(iii) *if he has assisted a registered medical practitioner in the performance of twenty five cases of medical termination of pregnancy in a hospital established or maintained, or a training institute approved for this purpose, by the Government; or*

(iv) *if holds a post-graduate degree or diploma in gynaecology and obstetrics, the experience or training gained during the course of such degree or diploma.*

The critique:

Non-comparability among the stipulated alternatives as regards experience/training of the aboriton service providers

The clause '(iii)' suffers from lack of clarity. The term 'assisted' is ambiguious. It could be interpreted as no hands-on practice is required but only 'assistance' experience is sufficient. If so, the wide gap can be observed, between '(iii)' and the rest of the clauses and thus these aforesaid experience/training requirements are not comparable or at par with each other. .

While it mentions the need of experience of assisting 25 cases, it fails to make any reference to the need of experience to handle a range of variations that exist with regard to abortion situation. One, while acknowledges the problems of feasibility of having such stricter rules, feels the need to incorporate, at least, a theoretical component in the training module.

Exclusive emphasis on medical skills ignoring non-medical ones

The stipulated 'experience and training' requirements to be met by the abortion service providers component exclusively focuses on the medical skills. The non-medical aspects, such as, provider-client interactions, staff-client interactions, quality of information exchange including counselling that is required during the delivery of abortion care services, do not feature here at all. These soft facets of service delivery have a special significance in abortion care services. Given the complexities around

abortion having such skills is essential for any abortion service provider to be in position to interact with her/his clients more sensitively and humanely. It plays an important role in meeting some of the immediate reproductive health care needs of women. These, then would have positive implications for her health in the long term. For example, it is essential to understand her fertility history and intentions so as to guide her appropriately about the contraception methods. This would help her to avoid situations of repeat abortions, which certainly has negative consequences for her health.

MTP training facilities

The Act also does not lay down any mechanism for those who aspire to learn MTP procedures. The role of the private registered abortion care facilities remains unclear.

2.2 Implementation of the Act

Any legislation without having an arm of a clearly laid down implementation mechanism makes it a little sense to those for whom it is meant. The MTP Act lays down in details the reporting mechanism for heads of the abortion care facilities to be followed. But it does not delineate the responsibility to be shouldered by the concerned offices/government authority as regards periodic inspection of those institutions which are registered or about having a vigilance committee to keep a track of indulgence, if any, of institutions in illegal abortion care service provision.

Lack of such an arm would automatically lead to growth of illegal abortion service care provision through health care institutions exposing women to unregulated and possibly unsafe abortion care services.

With these critical comments on various aspects of the Act, we don't intend to suggest stricter formulation of the Act, which may negatively affect women's access to safe, legal and affordable abortion care services. But we certainly are concerned about the patriarchal bias, the lack of clarity in the formulation, space for its liberal or restrictive interpretation, its over-medicalisation etc. This is because it mostly would work against women's interests seeking abortion care services. In such a situation, women may rarely be denied an abortion care but perhaps will have no control over the quality of abortion care that she receives.

One cannot dispute the need to make available properly trained medical personnel and well - equipped centers. Unfortunately, the ground realities are quite different in India where basic health care services – leave alone abortion services – are inaccessible and unavailable for many. Legal restrictions to abortions must, therefore, be coupled with the necessary provision of services. The MTP Act fails to make the right to have access to abortion services a justiciable right. In any case, no law can automatically create easy access and utilisation of the abortion services, nor can it automatically improve the quality of services. A brief analysis that follows of the current situation as regards abortion care services, abortion related mortality & morbidity would help us understand better the ground realities and limitations of the MTP Act at the

operational level as regards its role in enhancing women's access to safe, legal and affordable abortion care services.

3. INDUCED ABORTION IN INDIA: A SCENARIO

3.1 Abortion care services and providers

The data on abortion services and providers need to be examined from the point of view of its adequacy, accessibility, equitable distribution, and contribution of the public and private health care service sector. These facets of abortion care services have implications for women's access to safe, affordable and legal abortion care services. Difficulties in getting accurate data on health care services, even from the government sources, are well documented (Nandraj, ----). In case of data on abortion services the additional difficulties are those arising from unavailability of data on illegal institutional and non-institutional abortion care services. The government sources provide data only about legal abortion care services and only on certain limited aspects, such as, number of registered MTP facilities, number of MTPs conducted, length of gestation, reasons for abortion and method of contraception adopted post MTP, if any. The little data that are available on illegal institutional and non-institutional abortion services come mostly from community based or facility based empirical research.

The available data on these various aspects obtained from various sources are presented below to highlight the fact that the present MTP services are inadequate and, unequally distributed. The data on illegal abortion services provides us an idea of the magnitude of the problem.

MTP services and providers

The trends in growth of the MTP facilities and their performance pattern over the years must tell us adequately about availability of MTP services. Table 1.1 presents that increase in number of MTP institutions is about five fold since 1972 to 1997, but the increase in number of MTPs at these institutions is not even even two fold. It is only about 1.4 fold. The average number of MTPs per institutions reduced to less than half since 1972 to 1997. The average annual percentage increase in MTP institutions between 1972-1980-1981 is 9.4, over 1981-82 to 1985-86 is 10.98; over 1986-87 to 1990-91 is 4.4 and in the last next six years till 1996-97 is 4.5. The corresponding numbers for average annual percentage increase in MTPs is 7.8, 8.66, -0.08 and –1.2. This indicates the regressive trends in registration of health care facilities for MTP services and their performance. Additionally, the regressive trends in the latter reflect on the poor performance of the institutions and the authority in informing and influencing population about such legal abortion care facilities that women can seek MTP services from. It perhaps is even suggestive of poor reporting and/or poor implementation of the legislation. Moreover, there are certain spurts both, in average annual percentage increase in number of registered institutions and number of MTPs, which are without any correspondence between them in those respective years. This provides us further space to doubt the 'reporting' and the possibiliry of other aforesaid problems.

The available data also suggest that the MTP services to date are inadequate. There were over 22,010 PHCs; 2,662 Community Health Centres (CHCs); 13, 692 hospitals in India in 1997 (MOH&FW, Annual Report, 1997) all of which are eligible under the MTP Act to offer MTP facilities. Of these, only 8,891, that is 23.2 per cent, were approved MTP institutions in the entire country in 1996-97. These institutions conduct, on an average, 61 legal induced abortions every year. If these institutions were to conduct all the estimated induced abortions, that is 4.7 million, in the country, they would be required to do on an average 529 abortions every year, resulting into nine fold increase in their work. Since these are averages, the increase in the workload would be unevenly distributed. Needless to add, such a nine fold increase in work would seriously compromise the quality of care unless something is done to increase the number of registered institutions.

These scanty services are distributed unequally within the states; over private and public health service sector; and over rural and urban areas. This would further aggravate the problem of not having access to safe, legal and affordable abortion care services. Table 1.2 reveals the unequal distribution over the states. According to unpublished data for the state of Maharashtra, 1992-93, about 70.3 per cent of the approved centres are in the private sector (Jesani and Iyer, 1995). The following analysis of public health care facilities should give us adequate idea about the unequal rural/urban distribution of MTP services given the fact that there prevails a trend of the growing concentration of private health care facilities in urban areas over the decades
In general, the contribution of the public health care facilities in MTP services is poor. The Indian Council of Medical Research (ICMR, 1991) study evaluating the quality of family welfare services at the PHC level in 1987-89 reveals an abysmal state of affair of rural health care services. The study covered 398 PHCs from 199 districts in 18 states and one union territory. One of the major findings was that the majority of PHCs was lacking in functional equipment and/or trained humanpower to carry out pregnacy termination even after two decades of the MTP Act. Also, about 40 per cent PHCs did not have any stock of oxygen readily available and there was a total absence of records in one-third of PHCs. In 1994, only 8% (1800 of 21,563) of the public health facilities both, CHCs and PHCs, qualified as 'approved' (Chhabra & Nuna, 1994). Often the public health care facilities are ill-equipped as regards qualified professionals and infrastructural facilities. For instance, all community health centres are expected to have a surgeon, physician, an obstetrician & gynaecologist and a paediatrician. In 1995, of 2401 CHCs, only 710 (29.6%) were equipped with surgeon, 574 (24%) with physician, 548 (22.8%) with obstetrician & gynaecologist and 498 (20.7%) with paediatrician. At 7,607 (34.9%) PHCs of the total 21,802 there was no doctor.

In another multi-state study conducted by Centre for Operations Research and Training (CORT, 1998), it was revealed that around one-quarter of PHCs in Uttar Pradesh (UP) and Maharashtra provide abortion services. In Gujrat and and Tamil Nadu (TN) it is one-thrid and two-thirds respectively. And among CHCs, about 59 per cent in UP, 78 per cent in Gujrat, 89 per cent in Maharashtra and 95 per cent (CHCs and sub-district hospitals together) in TN provide abortion care services.

It is to be noted that according to the Seventh Five Year Plan (1985-90) the Government of India stated the intention to equip all PHCs to conduct abortion

services. The data discussed above though exhibit a trend of improvement, there remains much to be achieved.

Illegal abortion services and providers

Illegal abortion services could be both, non-institutional and institutional. The non-institutional illegal abortion services mostly mean paramedics involved in abortion care services and local abortionist. Institutions if provide abortion services without acquiring legal registration be treated as illegal abortion services. Non-qualified aboriton service providers at registered MTP centre also mean illegal institutional abortion services. There is not much data available on this aspect. However, the study conducted by CORT (1998) of the public health care facilities to assess quality of abortion care services notes that all the doctors who were conducting MTP services were not necessarily trained in the procedure. On the other hand, there were some doctors who were trained for conducting MTP but were unable to provide the services because the clinic did not have the required facilities. Of the total 319 Medical Officers interviewed from four states, 205 (64%) were conducting MTPs. Of these 31 (15 %) were not trained to conduct MTPs. The ICMR (1989) study on illegal abortion in rural areas in two states, Rajasthan and Tamil Nadu records 422 abortions done by paramedics, 1470 by indigenous providers, such as dais and magicians/witch/ojha and others, and 132 by practitioners of Indian Systems of Medicine (ISM).

Survey data from 1984 showed that only about 1,000 out of total of 15,000 physicians (that is only 6.7 per cent) trained to perform abortions were living in rural areas, although 78 percent of the country's population falls in this category (Jacobson, 1990).

These are glimpses of practice of illegal abortion care services. However, the wide gap between the number of MTPs (aboriton conducted at registered MTP centres) and the estimated number of abortions helps us to appreciate the extent of the ubiquity of such illegal services (Table 1.4).

Inadequate financial outlays

The government funds allocated for abortions are grossly inadequate. In 1986-87, the Ministry of Health and Family Welfare (MOHFW) formulated a central scheme for the expansion of MTP facilities by providing Government of India funds on a year-to-year basis. This has allotted RS 1/- per MTP performed and total expenditure of Rs. 100/- per trainee doctor to a maximum of 20 trainees per training centre a year. In 1993, Rs 15/- were given towards drugs and dressing per MTP case (Chhabra & Nuna, 1994).

There is not much systematic empirical research available to know the resource constraints and the problems being faced by the concerned authority and the abortion service providers even in public health care services in providing quality abortion care services. (Policy analysis and programmatic evaluation of the health financing?). A study conducted in Uttar Pradesh documents difficulties in the programme as regards provision of funds for instruments and maintenance and repair of the apparatus (Mukharji, undated). The resource constraint could be imagined based on low health

budget in general and status of affairs with regard to many other government programmes.

Abortion services: A cause of concern

The statistics about various aspects of MTP services in India, such as, number of MTP centres available; their distribution over public/private sector and over rural/ urban areas; MTP training facilities and quantum of public funds allocated for the purpose, are quite alarming. In general inadequate, difficult to access, inequitably distributed public & private health care service over rural & urban areas, are the issues of concerns as regards abortion care services.

The questions those need to be explored at the level of service provision are many. What are the reasons for inadequate growth and a shift towards a regressive trend in its growth to date of the MTP care facilities? Why is the performance of these existing facilities poor? Is the Act being implemented effectively? If not, what is causing an ineffective implementation? What kind of resource constraints – financial, human power, information dissemination, redressal etc. – the process of implementation is facing? What are the specific problems being faced by the concerned authority/offices at various level in the process of implementation and by the medical fraternity in getting their centres registered? Are there any mechanisms in place which ensures that the registered centres comply with the MTP Act and have a vigilance over the indulgence of the non-registered centres in abortion care provision? An exploration along these lines would help us understand the issue partially. *Most of these issues must have a bearing on the quality of abortion care services that are offered to women.*

Needless to mention that service providers' are the important players in providing quality of abortion care services. The kind of perspective they hold has implications for the quality of care that women receive. There is not much research available on providers' knowledge about the legislation and their views about the various aspects of the legislative provisions that are available today and providers' perspective on and attitude towards women's abortion care needs. *In brief, research on providers' perspective on abortion service provision is lacking.*

3.2 Incidence of induced abortion, mortality and morbidity

Data on abortion incidence are difficult to come by because, as mentioned earlier, of the unavailability of data on incidence of non-institutional abortions. Needless to mention that underreporting of the institutional abortions adds to the problem. We even today have to rely on estimates, when required.

Induced abortion incidence

The Shah Committee, which was appointed to study the abortion situation in India way back in 1966. (GOI, 1966), assumed that for every 73 live births 25 abortions take place of which 15, that is three fifths are induced. Table 1.3 presents estimated abortions and other related statistics. With extrapolated figures about population and birth rate, in 1997, the estimated number of induced abortions were 4.8 million. The

total abortion (spontaneous and induced together) rate per 1000 live births is 341 (205 induced and 136 spontaneous). Of 4.8 million induced abortions, if 0.54 were legal as per the government data (Table 1.1), then for every single legal induced abortion there must be 8 illegal abortions taking place. Table 1.4 shows that over the years the ratio of legal to illegal continues to remain the same. Only about 9 per cent of the total induced abortions seem to be legal. The rest are illegal, institutional or non-institutional.

The community based research to study abortion incidence pattern alone are almost absent. However, studies with focus on maternal mortality, pregnancy and related issues may record abortion incidence and mortality etc. World Health Organisation (1994) compiled about 17 community based studies, which made reference to abortion incidence and mortality of unsafe abortion. These studies were conducted between 1969 to 1992 either in urban slums, rural areas or cities. Except one all were prospective. Women constituted the study units. The abortions recorded were induced and presumed to be non-legal or "back-street" abortions. These studies recorded abortion incidence ranging from 0.5 to 19.6 per cent of live births. National Family Health Survey (1992-93) records 1 per cent abortions of recent pregnancies for India and is said to be a gross under-reporting of abortion incidence (Jeejibhoy, 1999). A community based study conducted in 1998 in Marathwada region of Maharashtra, records 33.4 abortions per 1000 live births. (IHMP, unpublished). The only abortion rate study that we came across recorded induced abortion rate of 148 per one thousand live births which is much less than 255 that could be calculated for the same period as per Shah Committee formula (Ganatra et. al., unpublished).

The determinants/parameters for arriving at abortion incidence at a given point of time are population and birth rate. Based on the data available then, that is about 35 years ago, the Shah Committee assumed that there prevails about one third of wastage of pregnancies. The major constraint, to date, seems to be not being able to adjust the estimates in the light of the changing scenario, such as, changing trends in indications/ reasons for abortion. According to one estimate, about 10 per cent of the induced abortions are followed after the sex selection tests (VHAI, 1999). In another rural community based study conducted during 1994-96 in Maharasthra, it is estimated that one in every six pregnancy terminations among married women were sex-seletive (Ganatra et al; 1998). The same study records that women not currently married constitute a special group of abortion seekers who have different needs and behave differently from married women. Studies have demonstrated the large scale unmet needs of contraception which may lead to increase in abortion for reasons of limiting family size. A multicentric hospital based study shows that 67 per cent of abortions were sought for limiting the family size and 44 per cent mentioned failure of contraception as a reason to undergo abortion (Khan et. al. 1990). In this changing context of abortion it is very likely that the figures arrived at using Shah Committee assumption are the under estimates.

The wide gap prevails the abortion incidence based on estimates and the community based research experiences. (Table 1.5). The wide variation even within the community based research indicate that there must be multiple factors responsible, such as, methodologies, socio-cultural characteristics of the communities. Abortion not being

the focus of these studies must partially explain the gross under reporting. It also marks the difficulties in capturing anything close-to-actual incidence of abortion through such community-based research. Despite these gaps and variation, the fact that comes in forefront is that the magnitude of women's abortion needs is substantial enough to be ignored.

Abortion related mortality and morbidity

Globally, it is estimated that there are about 100, 000 deaths resulting from complications. It is estimated that abortion related mortality explains about 20 per cent of total maternal mortality. It is said that for every death due to abortion, there are 240-330 women who suffer from ill-health associated with complications of abortion. This amounts to a disease burden of of 17-23 million morbidities worldwide (Finger, 1994). In Indian context, there exists limited data on abortion mortality and morbidity. The share of abortion related mortality in the maternal mortality for rural India over the period starting from 1978 to 1995 as per the official records. It shows a mixed trend. (Table 1.6). The current pattern is characterised by a substantial rise in it compared to that in 1978. Some other data on abortion mortality is presented in Table 1.7. The records at DHS, Mumbai at the MTP cell for three consecutive years (1996-97, 1997-98, 1998-99) to one's surprise show 'nil' abortion related deaths and has been the case even in the past. The 'under (no)-reporting' is more than obvious.

The fact that about 90 per cent of the induced abortions are estimated to be taking place at other than registered institutions does give us the idea of the enormity of the problem at hand of abortion related mortality and morbidity. Besides, its magnitude could be appreciated based on the prevailing status of abortion care services in particular and general health care services in general and the other related factors. These include limited number of abortions that take place at institutions which are not necessarily safe, limited number of qualified abortion service providers, its skewed distribution over urban and rural areas, and an indulgence of untrained persons in providing abortion care. In a PHC based study wherein 372 abortion among 300 females were studied who had undergone abortions one or more time, all the abortion performed by quacks and paramedical had led to post-abortion complications (Mondal, 1991). And in the same study, out of the total cases aborted by MBBS private practitioners 45.8 per cent had led to complications. Reasons for these were improper aseptic techniques, lack of training, overconfidence and popularity in the area ignoring meticulous care.

It is to be noted that legal abortion centres may not necessarily be providing 'safe' abortion care and vice-a-versa. The high percentage of abortion morbidity and mortality must largely be attributed to lack of adequate and well placed registered abortion care service centres. At the same, large proportion of private sector in abortion practice contributes to abortion morbidity and mortality necessarily because it is highly unregulated in general. In a rural community based study in Maharashtra, it was found that abortions mostly take place within the private sector; about two-thirds of the women complaining of a problem that was severe enough to disrupt their routine work; and post abortion care was lacking (Ganatra, et. al., 1998).

These data about abortion service facilities, public funds for MTP services and high incidence rate of illegal abortions are more than telling. The serious difficulties that arise and get compounded further are then on account of economic, socio-cultural and socio-political factors those surround the issue of abortion.

Reasons for women resorting to illegal abortion care

The key question that arises is why do women resort to illegal abortion care services. The nature of legal abortion care services on the one hand and the socio-cultural context of woman's abortion need on the other hand, are the two key domains that influence women's choice of provider. The data presented in the earlier part of this chapter adequately reflect the possible reasons those could be attributed to the nature of abortion care services for women seeking illegal abortion care services.

The socio-cultural factors in shaping 'abortion seeking behaviour' of women and non-medical indicators of quality of care.

Researches have demonstrated that the socio-economic variables do impact women's health seeking behaviour (ref....). If so, these socio-economic and additionally the cultural correlates of health seeking behaviour must play a much stricter role when it comes to women's abortion seeking behaviour. There is some evidence available to this effect through the empirical research conducted in the second half of the 90s.

Women's concerns and priorities while seeking abortion care were found to be different than those in other health seeking situations (Gupte et al 1999). This study demonstrated that among others, women's expectations from the health care services/providers as regards quality of care are important determinants of choice of abortion care services/providers. Women had something to say very clearly and precisely about 'quality of abortion care'. It was, to an extent, different from what they perceived to be the 'quality of general health care or maternal health care'. While overwhelming importance was given to 'confidentiality', 'quick service and return' and 'not wanting to make husband's signature compulsory' as part of abortion care. In general, women appear willing to trade safety and quality of care considerations for assured confidentiality, which helps explain why the private sector is preferred source for this service. Some other researchers too have documented similar indicators of 'quality of abortion care'. (Ganatra et al, 1998;). Reasons for approaching quacks were documented to be secrecy, availability, affordability and accessibility of the abortion services (Mondal, 1991). In addition to demonstrating the role the socio-cultural factors play in shaping women's abortion seeking behaviour, it also reflects women's concerns for the 'non-medical' aspects of quality of abortion services. Some of these social analyses to understand 'pathways of abortion seeking' suggest that the prevalent services lack users' perspective forcing them to approach unsafe abortion care services. A need to look beyond the physical standards of care and to incorporate factors related to patient satisfaction in the legal provision is obvious.

Researches have also documented unawareness of women about the availability of legal provisions for abortion services and its details (Gupte et. al., 1999; Ganatra et. al., 1998). The complexities surrounding abortion on the one hand and lack of

awareness of legal provision on the other appears to underlie the higher incidents of illegal abortions which may, therefore, be exploitative, unsafe and life threatening. Efforts towards provision of safe a*bortion care services, therefore, can be one of the important health care intervention to reduce mortality and morbidity in women during abortion. The need for safe abortion care is as important as prenatal or maternal care given its contribution to the maternal mortality and morbidity.*

Where does this scenario analysis take us? What does it tell us about the status of induced abortion in India today? The scenario analysis provides adequate space to critically examine the current state of affair at two levels. One is at the level of service provision. Two is at the level of women as users of these services. The overarching issue that emerges from the above discussion is that the magnitude of the unsafe abortion even today continues to be worrisome to the extent that it requires to be treated as a 'public health concern'. If so, the situation demands an assessment of quality of abortion care so as to delineate user sensitive health care interventions. This is the broader context in which the present study has been undertaken.

4. AIMS AND OBJECTIVES OF THE STUDY

The overall aim of the research was to study quality of abortion care services at the health care facilities. The specific objectives were as follows:

1. To define indicators of and prepare criteria for medical and non-medical aspects of quality of abortion care services.
2. To assess quality of abortion services at the registered and non-registered; government and private institutions providing induced abortion services in rural and urban Maharashtra using the conceptual framework with three components, that is, structure, process, outcome.
3. To study as to how limitations of the MTP Act are manifested in abortion services by understanding
    (a) providers' need and rationale for demanding husband's signature,
    (b) various coping mechanisms adopted by providers in an attempt to fit an abortion case within the framework of the MTP Act and the institution of the marriage and family,
    (c) compromises made about quality of abortion services by both providers and clients in case of perceived socially 'non-sanctioned' pregnancies.
4. To study views/reasons of providers for not adhering to the minimum 'quality of abortion care services'.
5. To formulate detailed and specific guidelines for improving quality of abortion care services.

At this juncture it would be worth taking a look at the progression of the concerns in the past for quality of health care services. The model that has been evolved for assessing quality of abortion care in the present is evolved from these core ideas that are discussed in the following.

5. CONCERNS FOR QUALITY OF CARE

5.1 An historical background

Those engaged in research on quality of care are well acquainted with the trajectory it has followed. The core ideas are believed to be borrowed from management and industrial sectors of Japan in the 1950s and were subsequently adapted to the private sector in the United States, including health care (Brown et al, 1995). However, one finds that the core idea of quality of care was articulated by Ernest Codman way back in 1910, specifically in the context of health care (Donabedian, 1989). Though the terms 'structure', 'process' and 'outcome' were not used by Codman, he certainly had conceptualised and used them in his life time practice. Various soft facets of quality of care, now constituting 'process' component, were taken note of by him. For him, the idea of 'end result' was the vital link between the science of medicine and the science of management. He, all through his career, pursued the idea of 'end result' which he believed was 'the satisfied and relieved patient'. It was Avedis Donabdian who put forward the structure-process-outcome model of quality of care (Donabedian, 1988). Donabedian's contribution to the assessment of health care is his emphasis not only on the technical domain, but also the interpersonal. He noted that the relationship between patient and provider should be characterised by "privacy, confidentiality, informed choice, concern, empathy, honest, tact and sensitivity," and argued that the "interpersonal process is the vehicle by which technical care is implemented and on which its success depends" (Donabedian, 1988). Importance of client-provider interface was emphasised by some others in their pioneering work, especially in areas of family planning (Simmons et al. 1986; Simmons and Phillips 1990; Simmons 1994). Eventually, Donabedian's concepts formed the foundation for Bruce-Jain's model (Bruce, 1990;), generally referred to as 'population council model'. It was evolved in an attempt to evaluate 'family planning programmes', one of the major ventures of the Council towards population control. The long awaited shift in family planning programmes' focus from fulfilling larger community's reproductive goals to individual woman's own needs took place, at least hypothetically, because of this model. Feminist health movement's concerns that health care providers should hear to women's voices and perspectives on services experience were partially addressed to by incorporating 'process' component in the assessment model of quality of care. Most of the elements of the Bruce family planning framework are transferable to a woman's health care framework (Mensch, 1994)

By adding the 'process' component as part of the 'quality of care' model, a space was given to the users' perceptions and expectations of quality of care. Empowering clients by providing them adequate, relevant information during provider-client interaction in a legible manner has been considered as an important indicator of quality of care. Population Council's model is considered as a gender sensitive one but it doesn't enable researchers to identify or to measure the influence of gender in the interaction between services and the population (Pittman, undated). It doesn't really address the issue of influence and impact of socio-cultural factors on attitudes of both - clients and providers in a particular health care seeking situation. In that, the power relationships arising from class (professional and social), gender etc. can't easily be translated in measurable indicators. This is to appreciate that the interactions between the users and providers of health care services do not take place in vacuum but they always have

socio-cultural context. The most significant aspect, therefore, would be not only to ensure that there is space created for such an interaction but further to ensure that such a space will be made free of inequities between client and provider arising from above mentioned factors.

5.2 Different context of family planning sevices and abortion care services

One finds hordes of literature based on the research on quality of family planning program from all over the world. Researchers, by and large, used the concepts and ideas put forth by Donabedian in 80s. Studies evaluating family planning programme using the Jain-Bruce model are abundant in India, too (Gangopadhyay and Das, 1997; Reddy, 1997; Foo, 1995; Levin et. al., 1992; ICMR, 1991). As a consequence, in India and even elsewhere, mostly public health care facilities have been covered. The private health care sector, which contributes to 70 per cent of the total health care services, therefore, is less studied from quality of care perspective. We have earlier seen that the share of the private health care sector in abortion care service provision is also of this magnitude. In addition to these, family planning services and abortion care services are different on various dimensions as shown in below.

The contexts of family planning services and abortion care services

Different aspects of services	Abortion care services	Family planning services
State's perspective and role		
1. Programmatic nature	No government programme for MTP services alone. But constitutes one of the elements of the other programme, such as, RCH	Constitutes one of the major programmes
2. Period of Implementation of programmes, if any	Made legal since 1971, but does not constitute state's programmes/package	National programmes implemented since 1951
3. Involvement of the private sector	Large share	Comparatively less
4. State's funding	Expected to be available free of charge at public health care facilities	Fully funded at the public health care facilities
5. State's financial support to private health care sector	Marginally (Pearl centre, Mumbai and Pariwar Sewa Sanstha)	Yes
6. State's interest	Population control	Population control
7. Place in state's population control drive	Indirect and moderate	Direct and very prime
8. State's concern for woman's health	Very low	Very low

Socio-cultural perspective		
1. Socio-cultural acceptance	Very low	Fairly well
2. Stigma	High degree	Almost nil
3. Moralistic values attached	Very high	No
Women's perspective:		
1. Nature of need	Almost desperate	Almost optional or imposed by the program managers
2. Attitude towards	Not very positive	Not very specific
3. Awareness about its legislative nature	Very low	Not applicable
4. Prevalence of misconceptions about its medical consequences	Immaterial (does not affect woman's abortion seeking behaviour)	High
5. Decision making	Very complex and dynamic	Less complex
Providers' perspective		
1. Market interest of private practitioners	High	Very low
2. Cost of services	Very high At private health care facilities available only at cost. Public health care facilities too indulge in charging abortion care	Free at the public health care. Available at cost at private health care facilities
3. Attitude towards	Not very positive	Positive

This comparative picture of abortion care and family planning services tells us that their socio-cultural and political contexts are different. This, therefore, required us to lay down a specific model for making an assessment of quality of abortion care. As stated earlier, private practitioners are important players in abortion services. Though abortion situations are not emergencies in medical sense, they are so for women in need of abortion. These complexities around abortion required indicators of quality of care to be defined differently than that of family planning services. However, the commonalties are in terms of state's and providers' interests involved in provision of these services. State is providing these services with an intention to control population while medical fraternity by and large makes business out of it. Women's needs and health concerns feature only marginally despite much hue and cry about it.

6. QUALITY OF ABORTION CARE : A MODEL

The structure-process-outcome model that is widely used to study quality of care formed the basic premise for making an assessment of quality of abortion care (QAC) services in this study. It also accommodates the six elements, which constitute the much known and most frequently used Bruce-Jain model. The content of each of the components and sub-components specific to abortion care services was defined based

on (a) the scientific literature review of abortion procedures; (b) the MTP Act; (c) women's expectations about quality of abortion care that were captured in community based empirical research with women; and (d) literature review of the women's group experiences while providing reproductive health care and abortion care services. The first two mostly helped us to draw the medical indicators whereas the last two to draw the non-medical indicators.

While conceptualising the indicators of QAC, it would be erroneous to ignore the fact that *abortion care services by and large are situated in the health care service facilities. The present health care delivery system on the one hand and socio-cultural fabric of abortion & its legal status on the other hand form the context in which abortion care service delivery takes place*. The QAC model is presented below keeping this in mind. It offers the perspective and context for each of its indicators. It explains in brief the significance of and contribution of these indicators to QAC. The contents of these indicators and criteria for their assessment are presented in Table A.

6.1 Structure

The three aspects, access to ACFs, physical standards at ACFs and human power (service providers) at ACFs constitute 'structure'.

6.1.1. Accessibility

Access to health care services impacts utilisation of health care services. Empirical research centred around utilisation of health care services has dealt with physical access to health care. Not much empirical research one comes across which may have mapped the health care facilities to study these two aspects at micro level. But there are insightful analytical research work on these issues mainly based on national or state level secondary data. The critical role that the health policies, resource allocations, and priorities of the government play in shaping profile of health services have been the common thrust of these works. Secondary data were used to critically examine distribution of health care facilities (Nanda and Baru, 1994; Baru, 1993) highlighting the fact that inequitable distribution leads to poor access for some and/or in certain areas. Ashish Bose (1988) who studied the issue of physical accessibility in a few North Indian states pointed out that little attention was paid to variation in size of settlement patterns in the health policy. This resulted in a blanket approach to the location of PHC facilities irrespective of population density or size of settlements. Implications of side-tracking these differences become even sharper when one takes physical accessibility in terms of connectivity, i.e. how many villages are linked with roads and availability of transport facilities.

These problems as regards availability of and approachability to health care services must have far reaching ramifications for their utilisation. This is because of the complex relationship between these factors and the range of socio-economic status of users of these services. This has been demonstrated by empirical research. For example, the household survey of medical care documented that people from rural area had to travel more than 10 km for taking treatment for illness, which increased the average cost of treatment of illness. (NCAER, 1992). The complex and significant

relationship among social-geography of health care facilities; the rural and urban based users of health care services; the extent of remotely located users; their economic class & purchasing power; and prevalence of illnesses was unveiled in an empirical research on household expenditure in Jalgaon district, Maharashtra (Duggal & Amin 1989). The study showed that despite higher prevalence of illnesses in remote rural areas, there was underutilisation of health care services for the reasons of poor accessibility to health care services and low or no purchasing power of the people there.

Many of the perspective and analytical literature critiqued the existing health care delivery system from a point of view of women as users of these services. They highlighted the need to understand prevalence of women's illnesses and access to care in the context of women's time and work, the demands made on her by the family, children and society, her status in the family the patterns of work related illnesses, women's low incomes and poor purchasing power in the unorgansied sector etc. (Prakash, 1984; Sathyamala, 1984, Shatrugna, et. al. 1987). Many of the community based research on prevalence of women's illnesses, their utilisation patterns and household health expenditure have demonstrated that there exists a complex inter-relationship between women's status seen from the above mentioned perspective and their access to health care services (Madhiwalla, 1999; Duggal & Amin, 1989). In addition to this, empirical studies have demonstrated that women would use public health care services provided they are available, approachable and would provide quality services. (Gupte, et.al., 1999). Difficult physical access to health care services and poor quality of health care provided were found to be correlates of poor or no utilisation of health care services.

The far reaching ramifications that are being referred to will have an added edge on account of *indirect costs* woman bears. Difficult access in terms of long distance, inconvenient modes of travel implies longer time that she is away from the family. This may result in loss of wages and leaving children and family unattended. The stress that these women bear to manage to meet all ends is less talked of and less articulated both by women themselves and by researchers in most of the empirical studies. But it would not be difficult to imagine the extent of its burden on women.

Against this backdrop and given the social-cultural context of abortion, access to abortion care has a special significance for women seeking abortion care. We, for the present research defined access in terms of **availability, approachability** and **affordability.** The content of these indicators and criteria for assessment are presented in Table A.

6.1.2 Physical standards

Improved access to health care services may not necessarily result in its improved utilisation. For instance, state's efforts to improve access of the rural population to the health care services by setting up primary health centres (PHCs) has not had the expected impact of making primary health care universally and freely available. PHCs are grossly underutilised primarily because they are inadequately provided with staff, medicine, equipment, transport etc (Gupta J P et al., 1992; Ghosh B, 1991; ICMR, 1991). This indicates that mere expansion of the health care services in the haste of

meeting targets of covering maximum population did not really improve people's access to quality health care services.

In India it is since late 80s that aspects such as physical standards and availability of appropriately qualified human power at medical health care facilities were paid attention to by the health researchers and were viewed as one of the major determinants of quality of health care services. The recognition to these aspects was in the context of failure of people's access to health care services despite its expansion as mentioned above. The research on these aspects remained focused on an assessment of quality of state's family planning programme because state's obsession with population control. This relied mostly on the international model for various indicators and its content. However, for assessment of quality of other types of services it is required to lay down the framework; to define the specific indicators; and to determine measures & means to assess them. The major constraint that has been eventually voiced by health researchers was about not having any minimum physical standards laid down against which assessment could be made. Some efforts were made in mid 90s to lay down such minimum physical standards for making an assessment of the private health care facilities. This initiated the process of enabling a rational assessment of the minimum physical standards. It sharply brought out the need to have (a) such standards laid down and (b) medical legislation/s to monitor institutions' compliance with these minimum physical standards.

For instance, in Indian context, the earlier research on physical standards at general health care facilities had to develop the minimum physical standards, an exercise in itself, against which an assessment could be made. (Nandraj & Duggal, 1997). While doing so, a range of factors had to be taken into account, such as, type of health care provision, number of beds. These therefore have made significant contribution to both, understanding this aspect of quality of care and to methodologies of quality of care studies.

Against this backdrop, abortion care services appear to stand out. This is because the MTP Act has laid down specific guidelines about the minimum physical standards to be maintained and training and experience for abortion service provider and anaesthetist. There is not much research available on quality of abortion care, which has looked into its various aspects. In a multi-state study on abortion care, Centre for Operations Research and Training (CORT), Baroda, Gujrat, India has used the well-known approach of situation analysis to study quality of abortion care. (Khan et al., 1998). However, against the critique that we have posed on this particular aspect of the MTP Act earlier in the present chapter, we included some additional complementary and peripheral services and facilities as indicators of quality of abortion care model.

Equipment, instruments, drugs, quality of space etc. constitute physical standards. *We, for the present study, classified them in categories such as* ***'essentials', 'complementary' and 'peripheral'*** *depending upon the extent to which fatality and/or risk to women could be caused because of their absence or unavailability.* Also, in general, 'essentials' are of critical importance from medical point of view whereas 'complementaries' are of much significance to women as users abortion care services.

Essentials: Lack of essentials subjects women to unsafe and even fatal abortion care services.

Essential equipment, instruments and life saving/emergency drugs: We considered the items listed in the clause (b) of Section 4 - Approval of Place, of the MTP Act as essentials.

Essential facilities: In addition to the above, we included, availability of a generator set, at least at the operation theatre, in 'essentials'. All the women are equally at risk at the ACFs, if are not fully equipped with essentials. The risks at those with no generator set at OT are no less except that not every woman necessarily would be subjected to it.

Complementary facilities: Complementary services are those without which having in-house, abortion care could be provided. However, it is implied that they are available in the vicinity. It is desirable to have them in-house.

Availability of these essentials and complementaries at ACFs is the criterion for an assessment of these indicators.

6.1.3 Human power:

Adequate and qualified staff contributes to safe health care delivery. In case of abortion care, heads of institutions (HI), abortion care providers (AP), consultants, anaesthetists (AN), laboratory technicians (LT), nurses/paramedics, aayas, ward boys, enquiry attendants and social workers constitute human power at abortion care service facilities. *While qualified abortion care service providers and anaesthetists are essential services from medical point of view, the other services are important from women's point of view.*

Essential service providers:

AP and ANQ: The MTP Act has laid down minimum qualifications for abortion care service provider and for anaesthetist.

Complementary service providers:

LT: Service provision by in-house laboratory technician (LT) are not essential at ACF either legally or medically. However, it is essential that providers prescribe/conduct some minimum diagnostics, such as, urine test, blood group and Hb count, for abortion seeking women keeping her safety at the centre. In-house technician and the related services save woman trouble of getting tests done from outside.

Lack of in-house laboratory facilities implies that women have to get the tests done from outside of a ACF when they are prescribed. It may mean that she has to forgo her concern for confidentiality. Also, in this age of rampant

practice, this will have additional potential for women to get exploited monetarily.

Nurses: The central MTP Act does not include nursing care as part of the essential abortion service package. However, the Maharashtra state level 'Rules and Regulations' complementary to the central MTP Act make the nursing care essential. It states that the nurses assisting through abortion procedure should either be degree holders or certificate holders. However, we did not include them in 'essentials'.

Aayas and ward boys: These constitute the complementary staff at any health care facility. Their significance is necessarily because they contribute greatly to maintenance of and cleanliness at ACFs in various ways. They attend to non-medical needs of clients adding to latter's comfort and conveniece.

Social worker: Abortion care services in the West have demonstrated that women centred counselling services do help women in these critical situations of abortion seeking. This facilitates helping them release the stress and guilt feeling caused by undergoing an abortion. Counselling also has a potential to educating women about contraception and help women avoid repeated abortions thereby reducing at least to some extent their burden of reproductive labour. It has long lasting positive implications for women's health.

In Indian context it perhaps is an over expectation given the poor status of health care delivery system in general. However, counselling services need to be offered to women. It can be done either by of the staff members, such as, nurses and/or providers themselves. Assessment of this indicator, therefore, has been done accordingly.

Availability of various service providers at ACFs; the type and the extent of their professional training and experiences were the criterion for assessment of these indicators.

6.2 Process

The process component has both, medical and non-medical aspects. The focus is on 'how health care is delivered to its clients' in the given structure of a health care facility. Though existence of quality structure is a prerequisite, it may not necessarily mean quality 'process' of health care delivery. For instance, an appropriately qualified AP in an appropriately equipped health care facility unless seeks sufficient information from woman and provides her adequate relevant information; screens and monitors the woman appropriately; conducts all the minimum required post-operative examinations; communicates her dos and don'ts; and counsels her to avoid unwanted pregnancy in the future, can't be treated as quality care.

Research has demonstrated that utilisation of health care and choice of provider are determined also by factors such as the extent of waiting period, attention paid to user's perception of their own illness, the extent of information exchange and counselling,

the extent to which providers' are inclined to seek active involvement of users of services; careful examination and checking, quick admission, the extent of respectful treatment etc. (Gupte et. al., 1999; Reddy, 1997; Iyer et.al., 1996; Gangopadhay & Das, 1993; Levin, et. al., 1992; Visaria & Visaria, 1990;). This implies that the gap between users' expectations from health care delivery system and their perceptions of quality of care must assume importance in delivery of health care for its optimum utilisation.

In India, it is five decades since the family planning programme is being implemented intensively and supported by large resources. And yet it did not help meet either people's contraception needs or state's population control goals. Reasons for failure of family planning programme are now being located in the way the services are being delivered. Ramasundaram (1994) attributes poor quality of family planning programme to attitudes of health workers, who showed little respect for clients, especially if they were poor, illiterate, or from lower social strata. Among many others, the factors that can affect service quality are the failure to provide adequate information to acceptors of family planning methods; the failure to check clients for contraindications before inserting intrauterine devices etc. (Word Bank, 1995). Synthesis of 28 research studies from all over India on quality of family planning programme demonstrated that interpersonal dimension of quality of care is quite poor. (Foo, 1995). The power relationship between providers and clients, cultural gap and the vast knowledge differentials between them were the various factors those affected/influenced these interactions.

The quality of care model defines 'process' in terms of four sub-components. They are provider-user information exchange; provider competence; interpersonal client-provider relations and continuity. Their content for assessment of family planning programme is well defined. However, their objective assessment still remains difficult. As far as the interpersonal interactions and information exchange is concerned, it remains difficult to influence 'how' aspect of communication delivery for improving its quality as there exists a range of intervening factors. The difficulties are also on account of the fact that the intervening factors are of 'behavioural' nature, such as, providers' attitudes towards, for instance, women and abortion; providers' perceptions of women's abortion needs; their convictions and beliefs about power of communication with and counseling to clients. In addition to this, the difficulties that arise while assessing 'providers' competence' are of different nature. Case to case variation – client's needs and circumstances and provider's response to it - makes it arduous to standardise the indicators which would measure quality of 'process'. These studies have also indicated that it is difficult to quantify this indicator. The efforts always have been to demonstrate the quality of 'process', that is how appropriately and adequately health care services are delivered meeting specific needs of a particular client of health care – family planning – services with the help of narratives/case description drawn from data collected through observations.

In the context of abortion care, neither the MTP Act nor any other medical legislation has laid down any specific criteria or guidelines for providers while interacting with abortion seeking women. However, one finds elaborate guidelines in the medical text books for medical providers while conducting abortion procedures. The thrust of these

has been on medically significant checks and tests to be done pre and post abortion as well as precautions to be taken during the procedure. We, therefore, operationalised the concept using these as foundation. In addition, documentation available of experiences of women's groups as regards women's health care were used, especially while operatonalising the soft-facets of process, such as, client-providers interpersonal interactions.

Provider-user/clients information exchange: This refers to listening to and understanding a woman. It involves **(a) Obtaining information on & (b) Conveying/informing the client about**

Provider competence: This refers to technical competence and proficiency of abortion service provider. It includes **screening, management and monitoring**

Interpersonal relations (Client – provider relations): This refers to the sensitive treatment of women.

Continuity: This involves giving information a) about when to return and, other locations where services and medications can be obtained, and b) specific follow-up procedure.

As stated earlier, assessment of 'process' component has remained difficult. However, they are assesses by observing client – provider interactions for their texture, content, appropriateness and adequacy.

6.3 Outcome

It was the poor 'end result' which initiated the thought processes to look into how the services are delivered. Outcome of health care delivery is one of the major indicators of quality of care. Indicators of outcome are (a) biomedical and (b) sociobehavioural. In the present context of abortion services, they are conceptualised as follows:

Researchers found it difficult to get hard data on biomedical indicators, both in retrospective and prospective study designs, especially in developing countries. The former approach may be impractical because of lack of accuracy and the latter because of limited resources available.

Sociobehavioural indicators of quality of care are sensitive and are to be used very cautiously. Sensitivity of these indicators is on account of the fact that they are more participatory and accommodative of user's perception and evaluation. Responses about 'users' satisfaction' are often guided by socio-cultural values. They can neither be considered as perfect indicators of 'quality of abortion care' nor can their socio-cultural context be under estimated. One may get entrapped in the prevalent cultural and structural value system by treating "users' satisfaction" as the sole indicator of 'abortion care'. It is the researcher's responsibility to strike the balance between objectivity and subjectivity.

Biomedical indicators

These refer to absence of post-abortion complications, sepsis, infections, deteriorating health or menstrual problems on account of contraceptive, any kind of uterine problems which could be associated with the abortion procedure, incomplete abortions, mortality and morbidity resulting out of these and any difficulties in conceiving which could be associated with the abortion procedure.

Socio-behavioural indicators: Refer to women's/users satisfaction with the abortion care services. They are mostly related to their perceptions of the delivered services.

Table A

QAC: INDICATOR AND THEIR CONTENT	CRITERIA/METHOD FOR ASSESSMENT
STRUCTURE	
Accessibility	
▪ Availability (non-medical) ▪ Existence ▪ Adequacy	▪ Share of HCFs in abortion care service provision, ▪ Adequacy in terms of meeting women's abortion care needs
▪ Approachability(non-medical) ▪ Distance to ACFs, ▪ Approach roads, ▪ Transport facilities	▪ Spatial distribution, ▪ Availability and type of road ▪ Transport facilities used ▪ Time taken to reach ACFs
▪ Affordability (medical & non-medical) ▪ Travel cost, ▪ Fees for abortion care, cost of medicines, diagnostics tests conducted ▪ Other costs (stay, food,	▪ Cost incurred by women ▪ for travel ▪ for abortion procedure, drugs, diagnostics ▪ others
Physical standards	
▪ Spaces and their condition	
▪ Operation theatre* *(medical)*	▪ Availability and hygienic condition
▪ Others *(non-medical)* (waiting room, consulting room, wards, special rooms, sanitory block)	▪ Availability and cleanliness
▪ Essentials	
▪ Equipment and related infrastructure* *(medical)* ▪ Anaesthetic equipment ▪ Resuscitation equipment ▪ Sterilisation equipment ▪ Operation table	▪ Availability
▪ Instruments *(medical)* ▪ Required for abdominal/gynaecological surgery* ▪ Required for laparotomy**	▪ Availability

▪ Essential drugs *(medical)* ▪ Required for the abortion procedure* ▪ Required for administering anaesthesia* ▪ Parenteral fluids*	▪ Availability
▪ Facilities *(non-medical)* ▪ Power back up such as generator set ▪ Fire extinguisher	▪ Availability
▪ Complementary facilities *(non-medical)* ▪ Telephone, ▪ Ambulance, ▪ Food	▪ Availability
Human power	
▪ Essentials *(medical)*	
▪ Abortion service providers*	▪ Availability of qualified allopaths
▪ Anaesthetists*	▪ Availability of qualified anaesthetist
▪ Complementary	
▪ Laboratory technician *(medical)*	▪ Availability of in-house LT
▪ Paramedics (Nurses) *(medical)* ▪ Paramedics (aayas, wardboys etc.) *(non-medical)*	▪ Availability of trained nurse and others
▪ Social worker *(non-medical)*	▪ Availability
▪ Peripherals (enquiry attendant) *(non-medical)*	▪ Availability

PROCESS	
Provider-user/clients information exchange *(non-medical)*	
▪ **Obtaining information on:** ▪ background including details about her last menstrual cycle, ▪ reasons to undergo abortion, ▪ contraceptive history, ▪ reproductive intentions and ▪ overall current health status and history (any major illnesses in the past she has suffered from); and ▪ **Conveying/informing the client about:** ▪ length of gestation, ▪ methods to be used, ▪ risks involved, ▪ legal requirements, and ▪ precautions to be taken before coming for abortion, if she decides to undergo, and after operation safety measures.	Woman - provider interactions were observed for their content, texture, appropriateness and adequacy.

Provider competence: *(medical)*	
▪ **Screening** ▪ Accurate diagnosis of the gestation period ▪ decision about appropriate abortion method to be used ▪ ability to foresee probable complications during the procedure ▪ **Management** ▪ Technical proficiency in providing safe and appropriate clinical abortion method depending upon gestation period and her health status ▪ **Monitoring** ▪ Involves detecting blood group, checking blood pressure, hemoglobin percentage, weight, urinary tract infection etc.	**Screening:** Observation of cases **Management:** We did not assess this facet **Monitoring:** Oservation of cases an assessment on these indicators
Interpersonal client-provider relations (non-medical) ▪ Maintaining privacy ▪ Respectful and responsive provider behaviour ▪ Encouragement of women's participation in decision making ▪ Avoiding moral judgement ▪ Maintaining confidentiality ▪ Limited waiting time and quick appointment for the actual procedure	Observation of cases
Continuity ***(non-medical):*** This involves giving information ▪ About when to return and other locations where services and medications can be obtained ▪ Specific follow-up procedure	Observation of interactions to examine whether it takes place.

OUTCOME	
Biomedical ***(medical)*** ▪ Absence of post-abortion complications, sepsis, infections, ▪ deteriorating health or menstrual problems on account of contraception ▪ any kind of uterine problems which could be associated with abortion ▪ incomplete abortion, mortality and morbidity resulting out of these ▪ any difficultires in conceiving which could be associated with abortion procedure	Recording morbidities occuring immediately after abortion either by observing, interviewing or examining the case papers.
Sociobehavioural ***(non-medical)*** ▪ Women's satisfaction with abortion care services	Collecting women's perceptions and satisfaction about abortion care services received by them.

* These are stipulated in the MTP Act. ** These are stipulated in the State's Rules and Regulations

7. Salient features of the study

The present research has an advantage of continued and consistent involvement of CEHAT in abortion issue. The two of the stakeholders in abortion care are women and the service providers. We gathered women's perspective on abortion from our earlier community based work with women. This provided the context to conceive this research. With this grounding in the issue, studying quality of care made a difference. This research though exploratory in nature, could bring out some complex analysis of the abortion care situation.

- It defined 'safe and legal abortion care' from not only the perspectives of medical sciences but also from women's perspective and assessed quality of abortion care that prevails today. Such an assessment of quality of abortion care would provide us with not only facts and figures but also to tap the gap between the minimum and prevailing so as to enable design remedial measures to improve the conditions.

- It took into account the entire health and abortion care service sector by enumerating the health and abortion care facilities in the study area.

- The study units are public & private; registered & non-registered; and urban & rural. It for the first time private non-registered abortion care facilities are studied in details and in-depth.

- It assessed quality of abortion care against the model evolved taking into consideration both, the medical and non-medical aspects of quality of care. This, therefore, has provided space for women's perspective on quality of care. The non-medical indicators were evolved from a woman centred community based abortion research.

- It studies all the three components of quality of abortion care thus providing insights into the issue in a comprehensive manner.

- The composite analysis of medical indicators (essential physical standards and qualified human power) at the level of individual abortion care facility made it possible to assess an individual unit for quality of abortion care comprehensively beyond the level of individual indicators. This clearly brought out the enormity of the problem of institution based unsafe abortion care services.

- It is for the first time the role of abortion service providers as 'gatekeepers' in the context of abortion care service delivery is studied demonstrating the over medicalisation of abortion services.

- While it made an assessment of the abortion care services, it also studied providers perspectives and views about the women's abortion needs and MTP legislation.

Table 1.1: Legal Abortions

Year	No of Approved Institutions	Increase in no. of Institutions over previous Year.(%)	No. of MTPs performed	Increase in No. of MTPs over previous year (%)	Average No. of MTPs per Institutions
1972-76	1877	-	381,111	-	130
1976-77	2149	-	278,870	-	90
1977-78	2746	27.8	247,049	-11.4	115
1978-79	2765	0.7	317,732	28.6	123
1979-80	2942	6.4	360,838	13.6	118
1980-81	3294	12.0	388,405	7.6	111
1981-82	3908	18.6	433,527	11.6	124
1982-83	4170	6.7	516,142	19.1	120
1983-84	4553	9.2	547,323	6.0	117
1984-85	4921	8.1	577,931	5.6	106
1985-86	5528	12.3	583,704	1.0	101
1986-87	5820	5.3	588,406	0.8	96
1987-88	6126	5.3	584,870	-0.6	93
1988-89	6291	2.7	582,161	-0.5	89
1989-90	6681	6.19	596,357	2.4	85
1990-91	6859	2.66	581,215	-2.5	89
1991-92	7121	3.82	636,456	8.8	89
1992-93	7374	3.55	606,015	-4.78	82
1993-94	7628	3.44	612,291	1.04	80
1994-95	8511	11.58	627,748	2.52	74
1995-96	8722	2.48	570,914	-9.05	66
1996-97	8891	1.94	538,075	-5.75	61

Source : Family Welfare Year Books, 1988-89 and 1996-97, Government of India. .

rate / pop.

Magnitude of issue - MTP 5 lakhs

illegal abor 6-7 million (informal providers)

Table 1.2 : Statewise MTPs and Government Approved Institutions 1993-94

State	No of MTPs	No of Institutions	MTP Inst. Ratio	State population 1996 ('000)	Percentage share of population (1996)	Population Institution ratio
Andhra Pradesh	13719 (2.3)*	373 (4.0)*	36.8	72,155	7.7	193,445
Assam	21372 (3.5)	100 (1.1)	213.7	24,726	2.7	247,260
Bihar	11060 (1.8)	209 (2.3)	52.9	93,005	10.0	445,000
Gujarat	10263 (1.7)	700 (7.6)	14.7	45,548	4.9	65,069
Haryana	22438 (3.8)	228 (2.5)	98.4	18,553	2.0	81,373
Karnataka	9077 (1.5)	471 (5.1)	19.3	49,344	5.3	104,764
Kerala	34433 (5.7)	559 (6.3)	61.6	30,965	3.3	55,394
Madhya Pradesh	33086 (5.4)	295 (3.2)	112.2	74185	7.9	251,475
Maharashtra	97079 (15.9)	1775 (19.2)	54.7	86,587	9.3	48,781
Orisa	19510 (3.2)	169 (1.8)	115.4	34,440	3.7	203,787
Punjab	19436 (3.2)	242 (2.6)	80.1	22,367	2.4	92,426
Rajasthan	29023 (4.8)	316 (3.4)	91.8	49,724	5.3	157.354
Tamil Nadu	42364 (6.9)	623 (6.7)	68.0	59,452	6.4	95,429
Uttar Pradesh	12103 (2.0)	425 (4.6)	28.5	156,692	16.8	368,687
West Bangal	64273 (10.5)	452 (4.9)	142.2	74,601	8.0	165,047
Other states	170679(28.0)	2334 (25.2)	73.1	41,874	4.5	17,941
India	609915 (100.0)	9271 (100.)	62.7	934,218	100.0	100,768

Data are taken from Government of India. Ministry of Health and Family Welfare. Family Welfare Program in India. Year Book (1993-94). Nirman Bhavan, New Delhi: Ministry of Health and Family Welfare, (n.d.) [4]

* Figures in paranthesis are column percentages

Table 1.3 Estimated number of abortions

Year	Population (inmillion)	No of live births (in million)	CBR	Total abortions in the year (in million)	Induced abortion (in million)	Spontaneous abortions (in million)	Abortion rate (per 1000 popn)	Abortion rate (per 1000 live births)
1991	843.9	24.9	29.5	8.5	5.1	3.4	10.1	341
1992	861.7	25.2	29.2	8.6	5.2	3.4	10.0	341
1993	877.0	25.2	28.7	8.4	5.0	3.4	9.8	333
1994	892.5	25.6	28.7	8.8	5.3	3.5	9.6	344
1995	907.8	25.0	27.5*	8.6	5.2	3.4	9.5	342
1996	923.1	23.0	24.9*	7.9	4.7	3.2	8.6	343
1997	938.2	23.4	24.9*	8.0	4.8	3.2	8.5	341

*** Source :** Government of India, Planning Commission , Eighth Five Year Plan: 19992-1997, vol I, New Delhi, 1992 (the figures are extrapolated)
Source for data on population and CBR otherwise : Data Base, CEHAT, Mumbai-Pune, India. The data used in this data base is drawn from various government sources.

How have we arrived at the statistics on 'total number of abortions'?

The Shah Committee (1966) assumed that for every 73 live births there are 25 abortions. It also assumed that of the three-fifths of these are induced and two-fifths are spontaneous.

Accordingly then, Number of estimated abortions = No of live births x 25/73 **or**

$$= \frac{\text{Crude Birth Rate} \times \text{Population}}{1,000} \times \frac{25}{73}$$

Table 1.4 Proportion of legal (MTPs) to illegal abortions: An estimation

Year	Total number of Induced abortion (in million)	Total Number of MTPs (in million)*	Total number of illegal abortions	Proportion of legal to illegal
1991	5.1	.58	4.5	1:7.8
1992	5.2	.64	4.6	1:7.2
1993	5.0	.60	4.4	1:7.3
1994	5.3	.61	4.7	1:7.7
1995	5.2	.63	4.6	1:7.3
1996	4.7	.57	4.1	1:7.3
1997	4.8	.54	4.3	1:7.9

***Source:** Family Welfare Programme in India, Year Book, 1996-97

Table 1.5 Estimates of Number of induced abortions nationwide annually

Source	Number of Induced Abortions Nationwide (Millions)
Shah, 1966	3.9
IPPF, 1970	6.5
Goyal et al, 1976	4.6
Unicef, 1991	5.0
GOI, 1991-92	0.6
Chhabra and Nuna, 1994	6.7
CEHAT, 1997	4.8*

* Using Shah Committee formula , extrapolated population and birth rates for 1997, Government of India, Planning Commission, 8th FYP, 1992-97, Vol I, New Delhi, 1992

Table 1.6 Percentage of abortion deaths to child birth and pregnancy (maternal). All India (Rural)

Year	78	79	80	81	82	83	84	85	86	87	88	89	90	93	94	95
Abortion	11.0	11.7	12.5	13.7	10.1	10.7	10.8	11.5	8.0	7.6	5.0	10.9	11.8	11.7	12.6	17.6

Sources : Model Registrar Scheme, Survey of Causes of Death(Rural) 1984-1996- A Report, Series 3 No. 17-19, Statement No. XIX, Registrar. Gen. Of India, New Delhi.
Government of India Survey of Causes of Death (Rural), Annual Report, 1990 Office of the Registrar. Gen. of India, New Delhi.

Table 1.7 Abortion related causes of Maternal deaths*

Location	Percent of Maternal Mortality Attributable to Abortions
Selected Hospitals 1978-81	15.1
Anantapur District, Rural and Urban, 1984-85	11.9
India, Urban, 1985	16.9
Karnataka, Rural, 1989	4.5
India, Rural, 1989	10.8
India, Rural, 1993	11.7
India, 1991-95	18.0

Sources: World Bank, 1996, for Anantapur (Bhatia, 1988) ; for Karnataka (Reddy, 1992); for India rural 1989, (Ofifce of the Reg Gen, GO, 1991); 1993 (Ofifce of the Reg Gen, GO, 1993); for India Urban (Ofifce of the Reg Gen, GO, 1998) ; for selected hospitals (Rao, 1988); for India 1991-95 (GOI, 1991-95) as cited in (Matha 1998)

*Source: Heidi Bart Johnston (1999). Abortion and postabortion care in India a review of the literature.

CHAPTER II

STUDY DESIGN AND METHODOLOGY

1. Selection of the study area
2. Sampling
3. Collection of data
   3.1. Quantitative survey
   3.2. Qualitative case studies
4. Data analysis and presentation
5. Problems encountered
6. Methodological and ethical issues

Various methodologies have been tried out to study the three fundamental components - structure, process and outcome. The most used is a situation analysis (SA) methodology, a research tool that was developed by the Population Council to describe what a family planning program looks like at the grass-roots level. (Mensch et al., 1994). It is one of the approaches to translate the quality of care model to be useful at the field level. (Miller et al, 1992). It primarily involves studying the service delivery points/ centres. It mostly uses a combination of quantitative and qualitative methods/ tools of data collection. It provides a comprehensive package of methodological tools to assess quality of care. Some standard instruments are used in all SA studies. They include, an inventory for facilities available and services provided at the service delivery point; an observation guide for interaction between the consenting family planning client and the service provider; an exit questionnaire for family planning clients attending the service delivery point; and an interview schedule for staff providing family planning services at the service delivery point; and an interview schedule for staff providing family planning services at the service delivery point. Over the years research in this area have brought refinements in the methodologies, especially to study 'process'. Ethical issues involved are discussed and articulated, though not resolved completely. A range of methodologies and issues involved therein while studying client-provider interactions are discussed at length by Simmons (Simmons and Elias, 1994).

In the present research, the QAC model that we laid down guided the methodology entirely, including selection of the appropriate method of data collection, designing the tools of data collection and their content. We conducted the study in two subsequent phases. In that a quantitative survey was followed by an in-depth qualitative study of the sub-sample. The former was designed primarily to assess 'structure' component of QAC whereas the latter was to assess 'process' and 'outcome'. In addition, we undertook an enumeration of health care facilities (HCFs) in the study area to define universe for the study. Such an enumeration was essential in absence of availability of any data on abortion care facilities (ACFs).

1. SELECTION OF THE STUDY AREA

Selection of Districts

The study was restricted to two districts, Pune and Ratnagiri of the state of Maharashtra, India. They were selected using relative development status of the districts, as a primary criterion and relative status of urbanisation as a secondary criterion. Development status of a particular area has a significant bearing on the physical standards of health care facilities. (Nandraj & Duggal, 1997). Also, with urbanisation, a change is expected in people's lifestyle. We anticipated links between people's enhanced economic status and accentuated expectations about the quality of health care facilities that they access, on the one hand, and quality of care on the other. If so, the developed areas may score better on indicators of quality of care.

Pune and Ratnagiri occupying opposite ends on the continuum of these two indicators were selected to ensure that a reasonable range of variation is captured. With regard to Relative Index of Development (RID), Pune (157 points) topped the list after Mumbai. Ratnagiri and Latur occupied the lowest positions having the same RID values (51 points) (Table 2.1). As regards their relative status of urbanisation, Pune (50.74) and Ratnagiri (8.94) though did not follow exactly the same order as above, did fall into one among the highest and lowest percentage of urbanisation respectively. Latur (20.39) occupied one of the middle range positions and much above Ratnagiri with regard to its urbanisation status. Latur, therefore, was dropped. High rate of out-migration was an additional consideration in case of Ratnagiri. Inverse relationship between migration and fertility are fairly well established (Bhatia & Sabagh 1980; Srutikar, 1980; Singh, Yadava & Yadava 1981).

Selection of talukas

In absence of any systematic and adequate data either on health care or abortion care facilities or number of reported MTPs, we selected talukas based primarily on the proportion urbanisation. (Table 2.2(a) & (b)). The added consideration was sex ratio. (Table 2.2(a) and (b)). Generally, it appears that talukas with low proportion urbanisation show comparatively more favourable sex ratios. The data on registered abortion care facilities (R-ACFs) show that some of the talukas did not have a single private R-ACF. (Baramati, Indapur, Mulshi, Shirur and Velhe from Pune district and Rajapur and Guhagar from Ratnagiri district). (Table 2.3). Lack of R-ACFs would imply high incidence of illegal abortions and/or women travelling long distances for getting MTP services. It has direct consequences for quality of abortion care that women receive. Inclusion of these areas in the study was also intended to capture the range of problems, if any, as regards the MTP registration procedure.

More than one talukas from higher and lower proportion urbanisation were picked up when the required sample could not be drawn from one single taluka.

The study area is shown in Fig 1.

2. SAMPLING

Sample size

The size of the sample was fixed at 100 ACFs for a quantitative survey and size of the sub-sample at 20 ACFs for in-depth case studies. This number seemed sufficiently large to capture variations across the three analytical categories of the ACFs based on their location, MTP registration status and public/private sector, if any. In absence of any data on ACFs, we arbitrarily decided to cover 40 ACFs each from private registered and non-registered categories and 20 from the public sector. (Table 2.4). However, the sample emerged differently from the proposed one basically for two reasons. One, the large number of NR-ACF constituting the universe could actually be identified, unexpectedly. Two, we tried to adjust the sample size at taluka level not to loose on having an adequate representation from the selected talukas. **Finally, 115 ACFs were included in the quantitative survey of which 23 were studied in-depth qualitatively. And we could study woman-client interactions for 40 women who sought abortion care from these 23 ACFs.** The increased sample size than proposed one is because of our anxiety of large drop out and/or no response, which in reality did not happen at all.

Selection of the study units

The only data available on ACFs were those at Directorate of Health Services (DHS), Mumbai and at the Zilla Parishad and or Civil Hospitals. The former contained district wise information about private R-ACFs while the latter provided information about the public health care facilities (HCFs) engaged in abortion care services. This would leave a large number of NR-ACFs out of purview of the study, if study units were limited only to this domain. In absence of well defined universe from which this sample could be drawn, we relied upon our own enumeration of the health care facilities in each of the selected taluka. The data on all the public HCFs, and of those engagaed in abortion care service provision in the study area were obtained, from the government sources as stated above. For enumerating private health care facilities, we used snow ball method using various sources. These included lists available with the local medical associations, pharmacists' shops, health care providers themselves, and lists of the health care institutions/providers obtained from the pharmaceutical company. The specialised health care facilities, for instance, an ENT center, were excluded from this enumeration, assuming that they possibly would not engage themselves in obstetrics and gynaecological and abortion care services.

Enumeration of HCFs in the rural areas may have been less than perfect as we relied mostly on the various sources mentioned above but did not practically visit each and every village in the study area, unlike what we did in the urban and semi-urban areas.

During enumeration we obtained data from each of the HCF, on structure and type of the institutions, whether it provides abortion care, qualification of head of institution (HI), abortion care service providers (AP), if it provided abortion care services, and its MTP registration status. (Annexure 1).

Based on this enumeration and keeping in line with the proposed sampling framework, we selected the study units purposively. This inclusion turns out to be about 72 per cent of the total ACFs (universe) in the study area. (Table 2.4(b)). In case of Pune district, NR-ACFs constitute about 57 per cent of the sample and the same for Ratnagiri constitutes 85.3 per cent. The number of public ACFs and the private R-ACFs in the enumerated HCFs was so meagre that to have an adequate number of units in the sample from selected talukas and districts, we had to include almost all of them. Consequently, to have an adequate representation from each of the taluka, we compensated the deficit in these categories, especially R-ACF, by including more number of NR-ACF. The better strategy would have been to undertake enumeration of the entire study area at a stretch before arriving at a sample frame. Nonetheless, inclusion of a large number of ACFs from various categories in the sample would be able to provide adequate representation despite the sample emerging differently from the proposed one. Also the fact that the proportionate percentage of the sampled units over various categories is comparable to that of the universe suggests that selection bias, if any, of the researchers has been equally distributed over these categories. (Table 2.4(c)).

Thus, such an exhuastive enumeration of HCFs in the study area helped us in more than one ways. ***(a)*** *It defined the entire health care service sector, both public as well as private, in the selected area.* ***(b)*** *It delineated the universe for this specific study by identifying all the abortion care facilities, a sub-set of the health care service sector. (c) It helped us interact with the medical fraternity on a one-to-one basis, which contributed a great deal in the* subsequent phases. **(d)** It helped prepare ground for the subsequent phase of the quantitative survey as we used this opportunity to communicate them adequately about our study, especially about significance of their participation and co-operation in the later phases of the data collection.

3. COLLECTION OF DATA

The data were collected in two phases. The first was a quantitative survey of the 115 ACFs followed by an in-depth qualitative study of the sub-sampled 23 ACFs.

3.1 Quantitative survey

The quantitative survey was *primarily designed to collect data for an assessment of 'structure'.* The QAC model provided the framework for designing the tools of data collection. Besides, *perceptions of both providers and heads of the institutions on some key issues were gathered through this survey.* These were obtained mostly through open ended questions.

Tools of data collection

Separate interview schedules were designed for HIs and for APs (Annexure 2(a), 2(b)). Acquiring information on human power and profile of abortion care services offered were the thrust areas of these tools. These were **complemented by an observation guide,** which was **primarily designed to collect data on physical standards** as defined in the QAC model. (Annex 2(c)).

Other important heads of data collection were as follows:

Providers' perceptions about the MTP Act: This was included primarily to assess knowledge of the medical fraternity about MTP legislation. It was also to know their opinions about the stipulated qualifications for doctors, assistant providers and nurses; opinions about the quality of the existing MTP training facilities and other related matters. This, we assumed, have a bearing on women's access legal abortion care service. This was also intended to unravel the range of issues involved in MTP registration procedures. This would directly feed into advocacy for safe and legal abortion care.

In this, the HI schedule contained questions related to MTP registration and stipulated physical standards, whereas the AP's were asked about the stipulated qualifications of the providers, assistant providers, nureses, MTP training facilities etc.

Providers's perceptions about women's abortion needs: A set of questions were included to understand perceptions of HIs and APs about women's abortion needs and its socio-cultural context. These are the potential/latent determinants of quality of abortion-care, especially of the client-provider interactions. Without understanding these socio-cultural constructs around abortion, we would loose on an holistic understanding of quality of abortion care and dynamics involved therein.

Abortion providers as gatekeepers: A set of hypothetical questions were designed to capture as to which situations and circumstances of women would they accept women's request for abortion care services. Questions were articulated to assess as to how woman's marital status, husband's consent and her willingness to accept post-abortion contraception impact providers' decision about offering women abortion care services.

Pilot testing

All the tools of data collection were pilot tested in the Pune city and sub-urban areas. Tools were revised based on the feed-back and experiences of the pilot test. Some of the questions required restructuring and we also reorganised the sequence of questions to bring about a smoother flow in the interview schedules.

Conduct of the quantitative survey

We conducted our quantitative survey, including enumeration during the last quarter of 1997 for about 2 and a half months with a longish break in between because of Diwali vacation. The quantitative survey followed immediately after enumeration in a particular area. A team of four field researchers was engaged in data collection. Of them, two were working on the project almost from the beginning and were part of the processes involved to reach the stage of conducting the field work. The other two joined a month before actual field work started. Both had background of working in health. One each from the former and the latter formed the two functional teams for the fieldwork. However, it was flexible for them to either work in teams or independently as per the situation.

We conducted rigorous training before getting into the field. This had a special significance since the subject matter demanded not only an understanding of the issue at

hand but a good grasp of medical aspects of abortion and medical vocabulary in general. Following were the thrust areas of training.

a) Getting well oriented with the content of the project (medical, socio-cultural and legal aspects of abortion) and its theme. This was achieved through discussions and overall orientation about abortion as an issue of women's health and women's rights and unsafe abortion as a public health issue.
b) Getting well versed with the medical and legal vocabulary. This was achieved by preparing a detailed glossary of various medical terms related to abortion, instruments and equipment. The field researchers could use this glossary during their field work as and when required (Annexure 4). Besides, the entire team visited a gynaecological health care center to learn in detail about the drugs, equipment and instruments and understand the set-up at health care facilities. We also had a session with the gynaecologists to understand the abortion procedures from medical point of view. Senior researchers had studied the medical text books concerning the abortion procedures and women groups' experiments in providing abortion care and other gynaecological services while preparing the tools of data collection.
c) Administering the various tools of data collection. Understanding the questions and its relevance was fundamental to scientifically sound administering of the tools. We also role-played this among ourselves simulating various field situations. This exercise was found to be very educative for both, senior and junior researchers. An elaborate protocol (Annexure 5) to be followed while administering was also prepared.

We could establish rapport with the members of the medical fraternity during the enumeration phase. Once we would finish the enumeration in particular taluka, we selected the sample units after discussing among ourselves the entire set of abortion care facilities to know their profiles vis-à-vis various characteristics.

Locally, members of the medical fraternity became aware of our research within no time. At times, the providers who exhibited scepticism in the first visit or contact on telephone showed faith in us during the subsequent interactions. This happened as they would confirm with their friends about the study and consequences of their own participation in the study. At two places, the local associations of medical professionals were quite active. We were invited to share our views with them on abortion issue. We even presented a paper in one of seminars organsied by one of them for doctors. This helped us establish rapport and strengthen our ties with the community. In fact, we hardly experienced any antagonism during the field work. In fact, cooperation and response of even NR-ACF was quite overwhelming.

The team of the field researchers lived in the closest township. They then would fix up appointments with the concerned HI and/or APs. At times respondents were anxious to know as to why were they selected and not the others from the same village/place. However, our explanation about the concerns for variation in the sample made them feel comfortable. We did not come across any denials from HIs to participate in the quantitative survey. A detailed letter of introduction to the organisation and the research was given to the respondents. It also explained the thrust of the research, significance of their participation in the study. It assured them of the confidentiality of the information obtained from them and of their identities. (Annex 6). We during our introductory

communication with them emphasised the fact that they had right to withdraw their participation at any point of time.

In case of the public ACFs included in the sample, we upon the request from the concerned officials at respective centres, had to seek a written permission from the district health officer allowing participation of former in the study.

The appointments with HIs/APs for interviewes were generally during their off hours, like afternoons. Researchers either went alone or in pairs for interviews. It mostly depended upon the logistics, the need for time optimisation, and need for the researchers themselves. If in pairs, one person while engaged the respondent by interviewing, the other one recorded physical standards using observation guide with the help of other staff at the health care facility. On average, it took about an hour and a half. Privacy during the interview with HI/AP by and large was not a problem. However, we found it difficult at times to maintain it with women respondents when their husbands, too were in the medical profession and were running the set up together. The sensitive areas for them, as we perceived, were questions about MTP registration status. And there was also a sort of anxiety the husbands felt that their wives would disclose something to us which was not supposed to be. But in general, the respondents were at ease while going through these lengthy interviews.

The institutions where HI was also an AP, we interviewed the respondent for both the roles. For additional providers other than HI at ACF, we interviewed them separately. There were multiple providers providing their services at a particular ACF. Often HI were also providers and engaged themselves in providing service support to ACFs other than his/her own. We interviewed an individual provider only once regardless of number of ACFs he/she is providing his/her services for.

The schedules for HI and AP contained some common sections, such as, perception about women's abortion needs. In case, a respondent was both, HI and AP, these common sections were administered only once. As regards the section on role of providers' as gatekeepers, we assumed that such a role could be played by either of them or by both. This section therefore was administered accordingly.

Some *ground work for the qualitative phase, the second phase of data collection was also done in terms of introducing them with the idea of the this subsequent phase. .*

As a token of our gratitude for their cooperation, participation and sharing their views with us on this socially relevant research, the institutions were presented with a set of our educational material in local language (Marathi) on abortion for the benefits of the clients availing these facilities.

3.2 Qualitative case studies

Survey methodologies are inadequate to assess 'process' and 'outcome' components of QAC, given the complexities involved in. We, therefore, decided to undertake in-depth qualitative study of a sub-sample of 23 ACFs . 'Process' was assessed primarily by

observing pre-abortion and post-abortion woman-provider interactions, both from medical and non-medical point of view.

Selection of the ACFs

The selection was once again purposive. We ensured that ACFs from the three analytical categories are adequately represented. In addition, qualification of the providers was considered as one of important variables for inclusion of a particular ACF. (Table 2..7 (a), (b)). Whether the head of the institution would be willing to participate in in-depth study was one of the major considerations for obvious reasons. Of the 24 selected for this phase, there was one drop out. He withdrew because he perceived that our intervention of such a nature would affect his practice, which they were trying to establish newly.

We, detailed this phase of study to the heads of the institutions during the quantitative survey. Field researchers used their own discretion and were selective while doing so. This formed the domain of the units from which we could select the units to be included in the qualitative phase We allowed this strategy to be used. This is because over and above the willingness of the HI to participate in the study, it was necessary for us to get to see at least some women seeking abortion care and that HI allowed us to sit through their centres and consulting and move around freely. Any restrictions on these would affect the quality of data collected.

There was a mixed response to this request of ours seeking their participation. This was anticipated given the intrusive nature of the proposed methodology. We explained to them its relevance as transparently as possible. Those who were exposed to such kind of work appreciated fully well the significance of their contribution to the study and agreed almost immediately to participate in the qualitative case studies. It was an encouraging experience. However, some others looked at us more as 'investigators', investigating into their "rights & wrongs" rather than as researchers. This, in certain other cases was combined with a feeling of insecurity, which they themselves attributed either to 'their dwindling practice' or to 'the phase of establishing their own practice'. They perceived that our presence at the institution for three days and communication with women clients on such issue might put the latter off affecting their practice negatively in the future. However, once again, as was experienced during the quantitative survey, the registration status of the institution did not matter for those who consented to participate in the qualitative case studies.

Women clients

We aimed at interviewing minimum one abortion client at each centre. Woman's willingness to participate in such a research was the prerequisite. The team of the two field researchers spent minimum three days at each of the selected ACFs. During our stay at 23 study units, we could interact with 40 women who came seeking abortion care services. Of these 10 did not undergo abortion and therefore could only be studied for pre-abortion care. The rest 30 were observed for various aspects both, pre and post abortion care services.

Tools of data collection

A combination of tools was used in this phase of data collection. We designed an observation guide, which was complemented by in-depth interview guide for women who utilised abortion care services. (Annexure 3(a) & (b)). A record sheet for analysing case papers to study the biomedical aspects of 'outcome' was also designed. (Annexure 3 (c) & (d)). Content of these tools of data collection were largely guided by (a) content of the 'process' and 'outcome' indicators of QAC as laid down the model and (b) by our field experiences and trends observed in the data obtained during the quantitative survey.

Observation Guide for observing pre and post operative interactions between **provider and client** and between the **other staff and the client**. Consulting room, wards/rooms where the clients were admitted were the sites for these observations. We documented the interactions mostly on the spot, as extensively as possible.

Interview Guide for women clients to respond to who have undergone abortions and those who have come for post abortion complications.

Conduct of the qualitative phase

We conducted qualitative case studies two months after the quantitative survey was over. These were used mainly used to get some data trends before we launched the second phase. We sent out detailed letters to the respondents and scheduled the field visits in consulation with them. They were responsive and co-operative. We communicated them the need to seek woman's informed consent before we included her in the study. This was appreciated and respected. However, it was difficult to operationalise. This was the most significant and difficult part of the qualitative study. The process remained rather unstructured. Many a times, HI or AP had done this on our behalf. While we acknowledged the implications of HI or AP seeking a consent of women, we had less choice and less control over the situation. Women, too felt more comfortable with the staff of the institution, at least, for initial interactions. The researchers were introduced to women at appropriate time by the medical staff. From that point onwards, we built communication with women. We preferred to communicate the study to women verbally and therefore did not have anything in writing about the study. This obviously implied variation in the style and the flow of communication as researchers used their own discretion to decide upon these aspects keeping woman's comfort at the centre. Women's right, and for that matter even of the heads of the institutions, to withdraw from the study at any point of time, was regarded of the utmost importance. Generally, women talked to us. However, we would hesitate to consider them as enthusiastic responses. The physical and mental strain and stress that they were bearing was more than obvious. The setting of medical care institutions provided us less scope for better means of rapport establishment. Interviewing women in this setting had both advantages and disadvantages. It was advantageous for there were less chances of we missing out on some information. However, the presence of the staff around them, which was beyond our control, seemed to have constrained their openness while responding.

In the entire phase of data collection, the most vulnerable situations the researchers found themselves in were those of collecting information from women as we could empathise

with their mental state of mind. We did find ourselves 'investigative' and 'interrogative' then and almost did not want to interview women.

We could not complete interviews with two women. In case of one of them, the field researcher felt that she was scared of her husband for letting such views out about the health care facility in general or the medical staff in particular. Our communication with her was perceived by her husband to be affecting their relationship with the institutions. It was more of our decision not to continue with her than her withdrawal. The other woman did not want to interact with us at all or for that matter with anyone around her. The field researcher came to know that she has had two consecutive abortions of 4-5 months of gestation in the near past and was kind of feeling helpless for not being able to tackle it. She perhaps had developed some inferiority complex. It was not very difficult for us to understand and empathise with her state of mind. The field researcher neither wanted to encroach on her privacy nor wanted to hurt her feelings. We did not go ahead with it, respecting her decision of not participating in the study.

The data were either documented on the spot or the short-notes were expanded later on the same day depending upon the situation.

4. DATA ANALYSIS AND PRESENTATION

Registration status, location (rural/urban) and type of the sector (private/public) of the health care facilities are the three basic analytical categories used in the report. Quantitative data were analysed using SPSS (Windows version).

The data obtained from the quantitative survey are mainly used to understand physical standards. We relied mostly upon simple frequency tables and contingency tables. At times composite analysis is used, especially while dealing with the data on 'structure'. The explanatory notes will be found in the report when required.

Data obtained on perception of HIs and APs about women's abortion needs etc. in the quantitative survey were used in the form of narratives to construct the arguments followed by discussion. The responses to open ended questions were structured and quantified to be used.

The data obtained through qualitative case studies, are mostly used to present the various live situations that we witnessed with the least possible of contamination arising from intermingling the data and their interpretations. We presented situations, which are followed by our commentary and/or discussion. However, the subjectivity that arises because of researcher's point of view and overall ideology/position on a particular issue while presenting such situations is implied and inevitable. The presentation of the data follows themes picked up from the QAC model. Not all cases could provide us data on all aspects of quality of care that were being studied during the qualitative phase of the study. Selecting a particular situation (a case or part of the case) for a particular theme was mainly guided by the quality of the data. We also tried to quantify some of the information obtained through qualitative case studies, such as, diagnostics conducted, information given and obtained.

5. PROBLEMS ENCOUNTERED

A number of problems were encountered during the conduct of the entire project, specially during the phase of designing the methodology and conducting the field work on account of poorly maintained data in the government offices. A few are listed here. (a) The government records about registered MTP centres were poorly maintained, and there was under reporting and/or non-existence of records of MTPs done at these centres. (b) There were discrepancies in official records kept by different offices about the public HCFs engaged in abortion care services. (e) They were no data available on health care facilities, which could be used to draw our sample for the study. Researchers, in the past, often faced problems of defining the universe in any such study because of high percentage of unregistered nursing homes and poorly maintained records of health care facilities and providers by both, the government and Medical Associations. We were no exception.

We found difficulties in obtaining data on case papers, records, consent form, doctors' approval form etc. They generally were not systematically maintained. Besides, one particular document was used for more than one purpose. For instance, often there was no separate consent form maintained for woman undergoing abortion. Often case paper was additionally used either as woman's consent form and/or as doctor's approval form. Similarly, we found that heads of the institution found it difficult to respond to a querry on number of beds for O/G etc.

6. METHODOLOGICAL AND ETHICAL ISSUES

Primarily we faced problems as regards operationalisation of the indicators of QAC, measurement of the indicators and choosing the appropriate methodology/tool of data collection. Not able to quantify or measure the indicators in a tangible manner, not able to completely control subjectivity (observational tools of data collection), not able to control the impact of confounding factors, not able to completely address the ethical issues involved etc. were the areas of concern.

Some of the problems could be taken care of by refining the tools of data collection. However, at times, tools of data collection and methodologies themselves have inherent limitations, which can hardly be helped. We chose them despite these limitations because they are less intrusive and are more sound ethically and otherwise, than the others. For instance, direct observation of client-provider interactions was preferred over the other methods such as simulated or mystery-client approach. In certain regards, optimisation of the available resources was the concern in choosing one method over the other. For example, some data would have come by on bio-medical indicators measuring 'outcome', if women were followed up post abortion for some specific period. Below are the various issues and concerns that we feel are important to be recorded, shared with and discussed among the peers.

Measurement of indicators and choice of methodology

Assessment of 'structure'

Most of the data on 'structure' aspect were collected in the quantitative facility survey using observation guide containing exhaustive checklists. And yet, we were not able to talk in terms of sufficiency of instruments and range/sizes of a particular instrument. For instance, not all institutions had the entire range of cannulae or speculum of different sizes. Also the aspects such as sufficient sunlight, cleanliness, hygienic conditions at the operation theatre, crowdedness etc. could not be made totally free of individual researchers' bias. e of the aspects, such as, availability of filled oxygen cylinders all the time was difficult to judge.

Assessment of 'process'

We used observation guide to assess provider-client relationship. It helped to assess the content of communication and the extent of coverage of type of information exchange. However, aspects such as, assessment of an impact of power relationship between clients and providers remains intangible. These aspects of communication are more to feel and sense rather than measure and quantify. As far as methods of data collection are concerned, there is less scope to improve upon it. However, the methods of data presentation and analysis can take care of inadequacies of these methods of data collection to certain extent. For example, narratives and case presentations drawn from observation data can help understand the impact of these factors and to gather nuanced insights into situations.

We also decided against an assessment of the technical competence of the abortion care providers (medical professionals). None of the researchers or field investigators belonged to medical fraternity. We, therefore, did not feel it ethically justified to assess this particular aspect. Two, we on ethical grounds decided not to observe the provider-client interaction during actual examination and abortion procedure regardless of whether the provider and woman had allowed us to do so. However, the extent of encroachment that we had to impose both on women and providers was perhaps inevitable in this kind of research which we have indulged ourselves in.

Aggregating data

Aggregating the results of such observation based data are not possible and thus is the inherent constraint of this approach. This is necessarily because they are the data drawn froma sub-sample. Besides, at one particular institution, more than one women were observed who naturally differed as regards their profile in every sense. These differences introduced confounding factors. At one particular institution, there were multiple providers which added another set of confounding factors. In this situation, presenting the detailed narratives describing the context of a particular client-provider interaction is more insightful despite its constraints as regards aggregating and quantification of data.

Waiting period was difficult to assess objectively. It generally is a function of the qunatum of the clients at a particular HCF and of the time the provider spends with his/her clients. More waiting period for a woman may mean more time a provider spends with an individual client. It was therefore difficult to assess it objectively.

The extent of hawthorne effect

The presence of researcher that would change the behaviour of those being studied in positive direction is known as hawthorne effect. In the present we found that the respondents were quite 'their own souls' despite our presence. At times, the respondents perceived that we were there to gauge the immorality that exists out there in the society and to which they were the witness. In that, we were considered as their allies rather than researchers assessing the quality of care that they were providing. This is because the quality of care that the women seeking abortion care received, as the data reveal in the report, is found to be unacceptably poor. Thus, even if we assume that our presence affected the behaviour of providers positively, one can only imagine as to how worse off the situation must otherwise be.

Assessment of 'outcome'

Data on biomedical outcome were difficult to come by in the present study as we did not follow-up women post abortion to know if they had any post abortion complications. The other option was to identify and interview women who have undergone abortion at these health care facilities in last three/six months to trace the post abortion complications, if any. This is generally referred to as case finding method. We consciously avoided this as we did want to get into the communities where women live as 'confidentiality' of abortion would be their prime concern.

We used post-operative interviews, quite similar to the technique of exit interviews for eliciting women's responses about their (dis)satisfaction vis-à-vis abortion care responses. This method has an edge over the conventional exit interviews in the present context as the researchers and the women respondents had by then interacted enough at least to break barriers arising of being strangers to each others. However, the known limitations of exit interviews, such as courtesy bias, unwillingness to speak after an operative procedure couldn't be completely eliminated. In fact, courtesy bias in abortion care may be more compared to other health care seeking situations for obvious reasons. Measuring magnitude of these biases is difficult.

The record sheet as a tool for analysisng the case papers and related documents to study post abortion complications did not fetch us any meaningful data for record maintenance at ACFs was poor.

Table 2.1 : District-wise relative index of development and percentage of urbanisation

DISTRICTS	RELATIVE INDEX OF DEVELOPMENT*	DISTRICTS	URBANISATION (%)**
Mumbai	704	Mumbai	100.00
Pune	**157**	Thane	64.64
Thane	128	Nagpur	61.78
Nagpur	109	**Pune**	**50.74**
Kolhapur	104	Nashik	35.55
Wardha	99	Aurangabad	32.76
Raigarh	88	Amravati	32.60
Sangli	87	Solapur	28.77
Solapur	85	Akola	28.65
Aurangabad	85	Chandrapur	28.04
Jalgaon	85	Jalgaon	27.44
Satara	83	Wardha	26.56
Nashik	81	Kolhapur	26.33
Ahmadnagar	79	Sangli	22.74
Amravati	74	Parbahani	22.51
Bhandara	73	Nanded	21.72
Dhule	72	Buldhana	20.59
Chandrapur	72	Dhule	20.50
Sindhudurg	68	Latur	20.39
Parbahani	67	Raigarh	18.01
Akola	65	Beed	17.94
Jalna	65	Jalna	16.91
Gadchiroli	64	Ahmadnagar	15.82
Osmanabad	62	Osmanabad	15.19
Buldhana	59	Bhandara	13.09
Beed	55	Satara	12.88
Nanded	53	**Ratnagiri**	**8.94**
Latur	51	Gadchiroli	8.71
Ratnagiri	**51**	Sindhudurg	7.59
Maharashtra state		**Maharashtra state**	

***Source** - 'Economic Intelligence Service', Published by Centre for Monitoring Indian Economy Pvt. Ltd., November 1993

The weightage pattern adopted to develop Relative Index of Development is as follows :

1. Agricultural sector --- 35% (per capita value of output of crops - 25% + per capita bank credit to agriculture - 10%)
2. Mining & manufacturing sector --- 25%
(Mining , manufacturing non-household & household workers per lakh of population-15%
Per capita bank credit to industry --- 10%)
3. Service sector --- 40% (Per capita bank deposit - 15% + per capita bank credit to services - 15% + literacy - 4% + urbanisation - 6%)

** **Source** - 'Economic Intelligence Service', Published by Centre for Monitoring Indian Economy Pvt. Ltd., November 1993.

Table 2.2 : MTP facilities in the private and public sector

Sr No	Talukas in Pune district	Number of institutions providing abortion care facilities		Sr No	Talukas in Ratnagiri district	Number of institutions providing abortion care facilities	
		Private	Public (PHC + RH+ Civil/ district)			Private	Public (PHC + RH+ Civil/ district)
1	**Ambegaon**	**3**	**1 of 6 + 1**	1	**Chiplun**	**3**	**2/-+ 2 + 0**
2	**Baramati**	**Nil**	**1 of 8 + 1 + 1**	2	Dapoli	1	- + 1 +0
3	Bhor	1	3 of 5 + 1	3	**Guhaghar**	**Nil**	**0+0+0**
4	Daund	1	1 of 5 + 1	4	**Khed**	**3**	**0+0+0**
5	Haveli	18	1 of 10 + 0	5	Lanja	Nil	1/-+1+0
6	Indapur	Nil	4 of 8 + 2	6	**Mandangad**	**1**	**0/-+1+0**
7	**Junnar**	**1**	**2 of 10+ 1**	7	**Rajapur**	**Nil**	**1/- + 2 +0**
8	Khed	3	4 of 10 + 1	8	**Ratnagiri**	**8**	**2/- + 0+1**
9	Mawal	4	1 of 7 + 1	9	Sangameshwar	2	
10	Mulshi	Nil	1 of 5 + 0				
11	Purandar	1	1 of 5 + 1				
12	Shirur	Nil	1 of 7 + 1				
13	Welhe	Nil	1 of 2 + 1				
	Total	**32**	**22 of 88+12+1**			**18**	

Source : MTP cell, DHS, Mumbai, Maharashtra; Zilla Parishad, Pune; Civil Hospital, Ratnagiri.

Table 2.3(a) Ranking of teshsils in Pune district on sex ratio and proportion urbanisation

Sr no	Tahsil	Sex ratio	Rank	Sr no	Tahsil	Proportion Urban	Rank
1	Bhor	1038	1	1	Pune city	99.54	1
2	Velhe	1044	2	2	Haveli	66.45	2
3	**Ambegaon**	**1002**	**3**	3	Mawal	38.78	3
4	**Junnar**	**1002**	**4**	4	Purandar	18.91	4
5	Purandar	989	5	5	**Baramati**	**14.34**	**5**
6	Mulshi	972	6	6	Indapur	13.74	6
7	Shirur	969	7	7	Daund	12.63	7
8	Khed	960	8	8	Bhor	9.73	8
9	**Baramati**	**940**	**9**	9	Shirur	7.69	9
10	Daund	933	10	10	**Junnar**	**7.05**	**10**
11	Indapur	931	11	11	Khed	3.62	11
12	Mawal	926	12	12	Velhe	--	-
13	Pune city	919	13	13	Mulshi	--	-
14	Haveli	882	14	14	**Ambegaon**	--	-

Table 2.3(b) Ranking of teshsils in Ratnagiri district on sex ratio and proportion urbanisation

Sr no	Tahsil	Sex ratio	Rank	Sr no	Tahsil	Proportion Urban	Rank
1	**Guhaghar**	**1,355**	**1**	1	**Ratnagiri**	**22.47**	**1**
2	**Mandangad**	**1,280**	**2**	2	**Chiplun**	**15.39**	**2**
3	**Rajapur**	**1,277**	**3**	3	Dapoli	12.34	3
4	Dapoli	1,264	4	4	**Khed**	**6.20**	**4**
5	Sangameshwar	1,231	5	5	**Rajapur**	**5.47**	**5**
6	Lanja	1,227	6	6	**Mandangad**	--	-
7	**Khed**	**1,175**	**7**	7	**Guhaghar**	--	-
8	**Chiplun**	**1,125**	**8**	8	Lanja	--	-
9	**Ratnagiri**	**1,107**	**9**	9	Sangameshwar	--	--

Table 2.4(a) Universe and sample

District	Tahsil	Characteristics of the HCF								
		Public			Private					
					Registered			Non-registered		
		Proposed sample	Universe	Sample	Proposed sample	Universe	Sample	Proposed sample	Universe	Sample
Pune	Baramati	10	5	5	10	0	0	10	33	28
	Ambegaon/ Junnar	5	6	4	10	8	6	10	50	19
Sub-total		15	11	9	20	7	6	20	83	47
Ratnagiri	Ratnagiri/ Chiplun	3	3	3	10	13	13	10	21	16
	Manadangad Rajapur/Khed/ Guhaghar	2	4	4	10	4	4	10	13	13
Sub-total		5	7	7	20	17	17	20	34	29
	Total	20	18	16	40	24	23	40	117	76

Table 2.4 (b) Percentage coverage in the sample

Characteristics of HCF	Sample & % coverage	Universe
Urban	71 (71.0)	100 (100)
Rural	44 (74.6)	59 (100)
Public	16 (88.9)	18 (100)
Private		
Registered	23 (95.8)	24 100.0)
Non-registered	76 (65.0)	117 (100.0)
Total	115 (72.3)	159 (100.0)

Table 2.4(c) Comparison of Proportionate Representation of various categories in the universe and sample

Characteristics of HCF	Sample & % coverage	Universe
Urban	71 (61.7)	100 (62.9)
Rural	44 (38.3)	59 (37.1)
Public	16 (13.9)	18 (11.3)
Private		
Registered	23 (20.0)	24 (15.1)
Non-registered	76 (66.1)	117 (73.6)
Total	115 (100.0)	159 (100.)

Table 2.5: Profile of the HCF and ACFs surveyed during enumeration

Characteristics of the health care facilities surveyed	No of HCFs	Total No of ACFs (universe)	No of ACFs In the sample
Districts			
Pune	301	102	62
Ratnagiri	223	57	53
Tahsil			
Baramati	174	38	33
Ambegaon	43	24	11
Junnar	84	40	18
Ratnagiri	71	21	19
Chiplun	56	15	13
Mandangad	19	4	4
Rajapur	40	3	3
Guhagar	17	5	5
Khed	20	9	9
Rural/Urban			
Urban	299	100	71
Rural	225	59	44
Public/private			
Public	38	18	16
Private	486	141	99
Institutions providing abortion care			
No	365	-	
Yes	159	159	115
MTP Registration status			
Registered	42	42	39
Non-Registered	117	117	76
Don't provide abn care	365	-	-
Total	**524**	**159**	**115**

Table 2.6(a) Gaps between government information sources and the preparatory survey as regards MTP care facilities

Selected tehsils in the selected Districts	Number of MTP facilties in					
	Public			Private		
	According to Government sources	According to Preparatory survey	Included in the sample	According to Government sources	According to Preparatory survey	Included in the sample
Pune	6	11	9	4	8*	6***
Ratnagiri	11	7	7	15	16**	17****

* Of these, 4 were found to be claiming MTP registration status. However, during the second phase, during our interactions with them at length, it was found that they were not registered

**

*** Two got their MTP registration cleared during our field work period

**** One got its MTP registration cleared during our field work period

Table 2.6(b) MTP facilities at the public health centres - infn from govt records, first hand infn and the inclusion in the sample

Sr No	Taluka	Number of public health care facilities providing MTP care facilities		
		According to govt sources PHC + RH + Civil/Distirct/ municipal	According field sources (preparatory phase)	Included in the sample
1.	Ambegaon	0 + 1 + 0 Ghodegaon	1 + 1 + 0 Dhamani Ghodegaon	0+1+0
2.	Junnar	1 + 1 + 0 Otur Narayangaon	2 + 2(RH Narayangaon Belhe & cottage at Junnar) Otur	1+ 2 (RH+cottage) Otur
3.	Baramati	1 + 1 + 1 Pandere Supa Baramati	1(PHS) + 2 +1+ 1 Jalgaon Pandere Supa Bara Pathare Lonibhapkar	1(PHS)+2+1+1
4.	Ratnagiri	2 + 0 + 1 Pawas Ratnagiri Kotawade	1 +0 +1 Kotwade Ratnagiri town	1+0+1
5.	Chiplun	2 + 2 + 0 Rampur Chiplun (cott) Dadara Kamthe (RH)	0+1(RH Kamthe)+0	0+1(Cottage) +0
6.	Mandangad	0 + 1 + 0 Mandangad	0+1(Manddangad) +0	0+1+0
7.	Rajapur	1 + 2 + 0 Jaitpur Rajapur Raipatan	0+1(Rajapur) +0	0+1+0
8.	Guhaghar	0 + 0 + 0	0+1 (Guhaghar) +0	0+1+0
9.	Khed	0 + 0 + 0	0+0+1 (Khed)	0+0+1(Municipal)

Note : Except two, we included all the public health care facilities providing MTP services that we visited in the preparatory survey. One (Dhamani PHC) from Ambegaon and one (Yenere PHC) from Junnar are the ones not included. At the former, the MO had not yet started providing abortion care and at the latter, we could not meet the MO and thus interviews could not be conducted.

Table 2.7(a) Profile of the health care institutions included for case studies

Characteristics of the health care facilities surveyed	No of health care facilities
Districts	
Pune	9
Ratnagiri	14
Tahsil	
Baramati	4
Ambegaon	2
Junnar	3
Ratnagiri	6
Chiplun	4
Mandangad	1
Rajapur	--
Guhagar	1
Khed	2
Rural/Urban	
Urban	16
Rural	7
Type of institution	
Public	4
Private	19
Structure of the institution	
Maternity Hospital	8
General Hospital	15
Registration status	
Registered	11
Non-registered	12
Qualification (HI)	
Gyneac (DGOs & MDs)	11
Allopath + MTP trg	5
Other non-gyneac allopaths	3
Non-allopaths	4

N=23

Table 2.7(b) Distribution of the private ACFs over rural and urban in the study area according to their registration status

Districts	Urban	Rural	Total
Public	3 (75.0)	1 (25.0)	4 (17.4)
Private			
Regtrd	6 (85.7)	1 (14.3)	7 (30.4)
Non-regrd	7 (58.3)	5 (41.6)	12 (52.2)
Total	**16 (69.6)**	**7 (30.4)**	**23 (100.0)**

FIGURE 2

MAP OF THE STUDY AREA

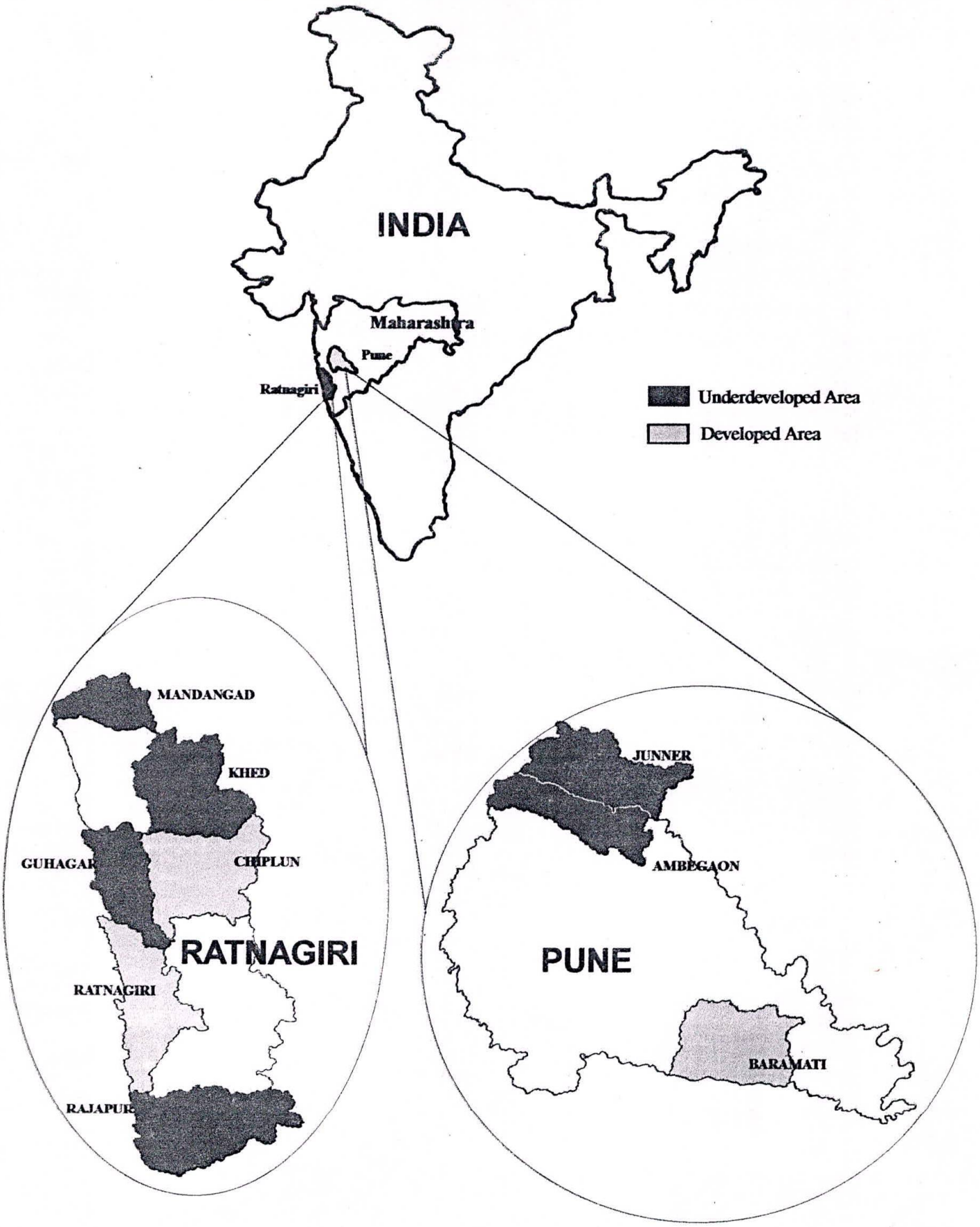
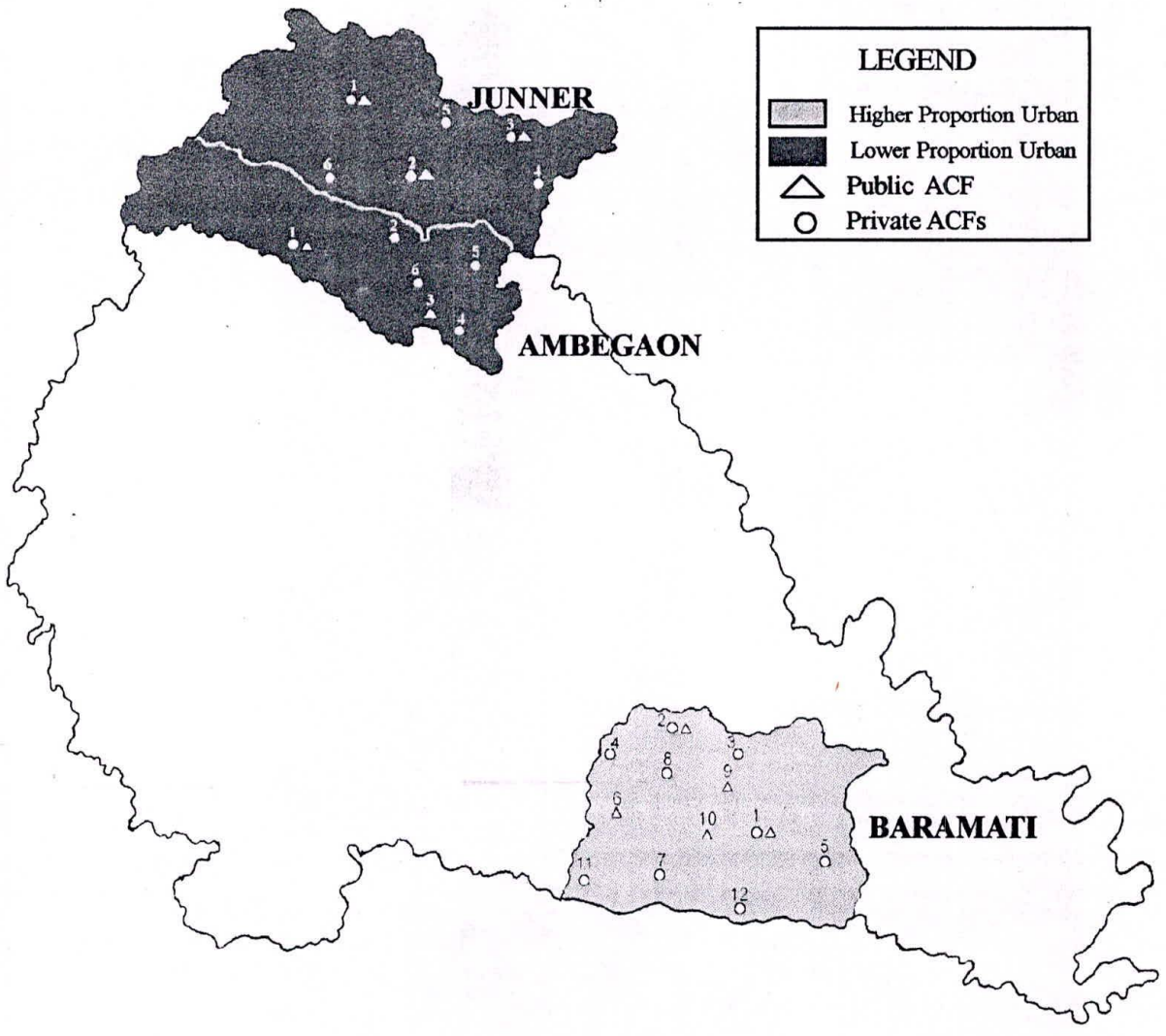


FIGURE 2(a)

SPATIAL DISTRIBUTION OF ABORTION CARE FACILITIES (ACFs) IN SELECTED TEHSILS OF PUNE DISTRICT

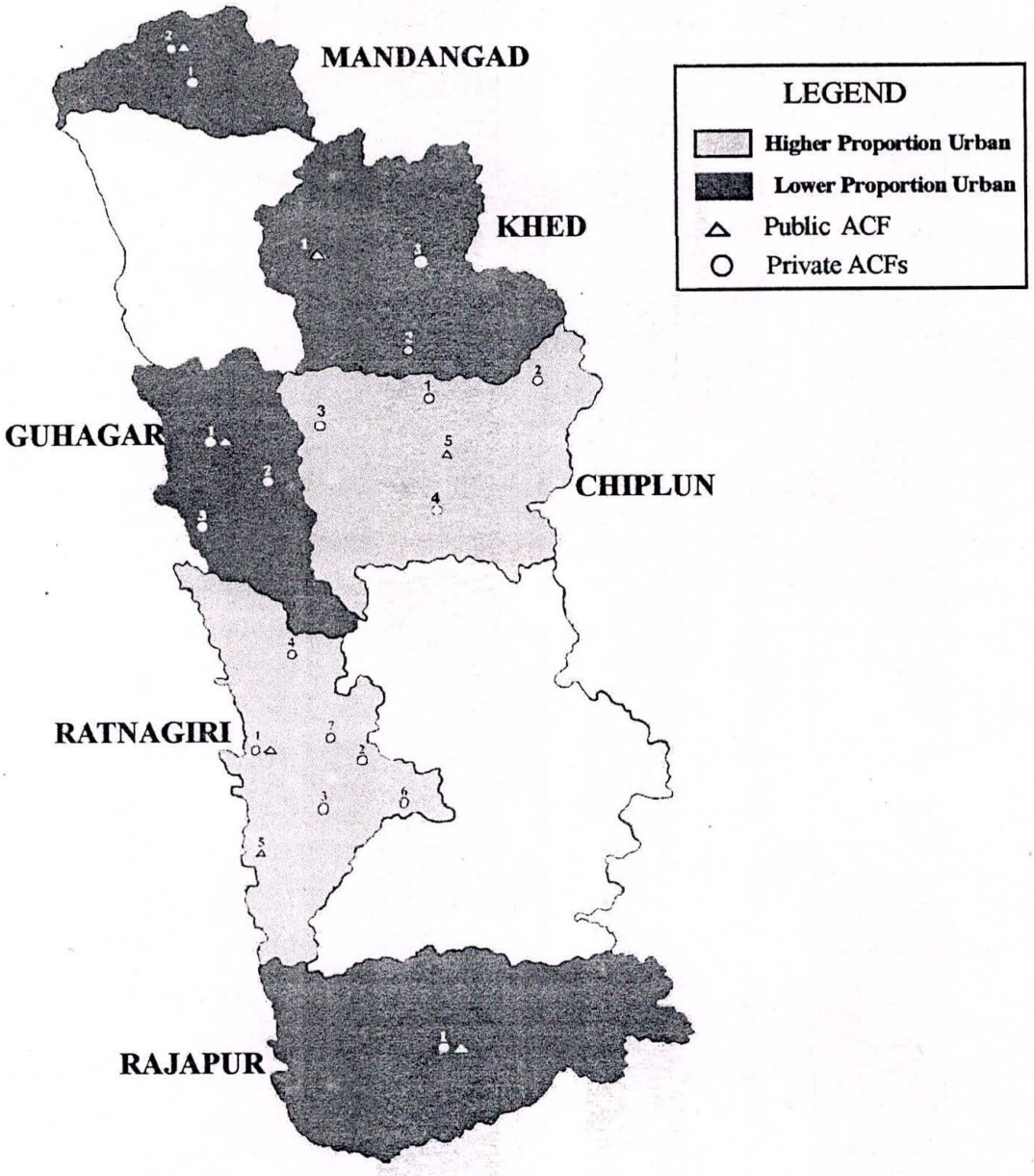


BARAMATI			AMBEGAON			JUNNAR		
Code	Village	ACF Pvt. - Public	Code	Village	ACF Pvt. - Public.	Code	Village	ACF Pvt.- Public
1.	Baramati (TP)	- 22 + 1	1.	Ambegaon(TP)	- 6 + 1	1.	Junnar(TP)	8 + 1
2.	Supe	- 1 + 1	2.	Manchar	- 10 + 0	2.	Narayangaon	14 + 1
3.	Moregaon	- 3 + 0	3.	Dhamani	- 0 + 1	3.	Otur	4 + 1
4.	Katewadi	- 1 + 0	4.	Loni	- 4 + 0	4.	Belhe	4 + 0
5.	Sangavi	- 1 + 0	5.	Awasari (K)	- 1 + 0	5.	Alephata	5 + 0
6.	Jalgaon K.P.	- 0 + 1	6.	Awasari (B)	- 1 + 0	6.	Pimpalwandi	2 + 0
7.	V. Nimbalkar	- 2 + 0						
8.	Malegaon B	- 1 + 0						
9.	Pandare	- 0 + 1						
10.	Loni-Bhapkar	- 0 + 1						
11.	Sortewadi	- 2 + 0						
		38			24			40

△ **Denotes One Public Centre**

FIGURE 2(b)

SPATIAL DISTRIBUTION OF ABORTION CARE FACILITIES (ACFs) IN SELECTED TEHSILS OF RATNAGIRI DISTRICT



RATNAGIRI			CHIPLUN			GUHAGAR		
CODE	VILLAGE	ACF	CODE	VILLAGE	ACF	CODE	VILLAGE	ACF
		Pvt.+Public			Pvt.+ Public			Pvt. + Public
1.	T. P.	14 + 1	1.	T. P.	10 + 0	1.	T. P.	2 + 1
2.	Pali	1 + 0	2.	Akhale	1 + 0	2.	Naravan	1 + 0
3.	Nivali	1 + 0	3.	M. Tamhane	2 + 0	3.	Welamb	1 + 0
4.	Jakadevi (Khalgaon)	1 + 0	4.	Dervan	1 + 0			
5.	Pawas	0 + 1	5.	Kamthe	0 + 1			
6.	Khandala (Watad)	1 + 0						
7.	Nachane	1 + 0						
		21			15			5

MANDANGAD			KHED			RAJAPUR		
CODE	VILLAGE	ACF	CODE	VILLAGE	ACF	CODE	VILLAGE	ACF
		Pvt.+ Public			Pvt. + Public			Pvt. + Public
1.	T.P.	2 + 1	1.	T. P.	6 + 1	1.	T. P.	2 + 1
2.	Panderi	1 + 0	2.	Lavel (D)	1 + 0			
			3.	Lote	1 + 0			
		4			9			3

△ Denotes One Public Centre

Chapter III

ACCESS TO ABORTION CARE SERVICES: AVAILABILITY, APPROACHABILITY & AFFORDABILITY

1. Availability of abortion care services
   - 1.1 Share of abortion care facilities
   - 1.2 Contribution of the public health care facilities
   - 1.3 Contribution of the private health care facilities
   - 1.4 Distribution pattern of abortion care facilities
   - 1.5 Adequacy of abortion care facilities

2. Approachability to abortion care services
   - 2.1 Spatial spread of the abortion care facilities
   - 2.2 Approach road, mode of transport and time taken

3. Affordability/cost of abortion care
   - 3.1 Cost of travel
   - 3.2 Cost of medical care

4. Summary & Conclusions

The data presented in this chapter are organised under three sections. They are **(1) Availability of abortion care services. (2) Approachability to abortion care services. (3) Affordability /cost of abortion care.** Analysis is carried across districts to explore if development status of a district has any association with access to abortion care services. Availability of abortion care facilities has been assessed by analysing the data obtained from **524 HCF that constituted the entire health care service sector** except the specialised ones and **159 ACFs from among these, which constituted the entire abortion care services** in the study area. These data have been contextualised by using secondary data on availability of MTP services at national and Maharashtra state level, when required and possible. An asessment of approachability to and affordability of abortion care cost is made using the data obtained from 40 women who came to our sub-sample of abortion care facilities.

1. AVAILABILITY OF ABORTION CARE SERVICES

Availability of abortion care services is studied by examining the proportion of HCFs that was engaged in provision of abortion care services in the study area; the extent of contribution of the public and private HCFs to abortion care services. The distribution of ACFs over urban/rural; public/private is examined. Further, adequacy of abortion care facilities to meet women's abortion needs is also estimated.

1.1 Share of abortion care facilities[1]

The extent of share of HCFs in abortion care service provision, in general, would suggest the scope for expansion of abortion care facilities at the available HCFs. Only about 30.3 per cent (159 of 524) of the health care facilities were engaged in abortion care services suggesting a wide scope for expansion of abortion care services (Table 3.1). This is better than the national level figures which is 23.2 per cent according to 1997 data. Better share of abortion care services in the total health care facilities available in Pune district compared to Ratnagiri (about one third and one fourth respectively) indicates *that development status may have association with the extent of availability of abortion care services.*

Similarly urban areas seemed to be better placed as proportion of the urban based HCFs enganged in abortion services is more than that of rural based ones.

Table 3.1 Proportion of ACFs to the total HCFs in the study area

District	Characteristics of HCFs	Whether provides abortion care services		Total
		Yes	No	
Pune	Urban	65 (36.5)	113 (63.5)	178 (100.0)
	Rural	37 (30.1)	86 (69.9)	123 (100.0)
	Sub total	**102 (33.9)**	**199 (66.1)**	**301 (100.0)**
Ratnagiri	Urban	35 (28.9)	86 (71.0)	121 (100.0)
	Rural	22 (21.6)	80 (78.4)	102 (100.0)
	Sub total	**57 (25.6)**	**166 (74.4)**	**223 (100.0)**
	Grand total	**159 (30.30)**	**365 (69.7)**	**524 (100.0)**

1.1.1 Contribution of the public health care facilities

All PHCs, RHs, CHs, distirct hospitals and civil hospitals along with all the post partum and family welfare centres are eligible for providing abortion care provided they meet the minimum physical standards stipulated in the MTP Act and are equipped with qualified abortion care service provider as stated in the Act. Information was collected on all the public HCFs eligible for providing abortion care and on which of them are providing abortion care services in the nine tehsils under study to better understand the proportionate share of public HCFs in abortion service provision.

Only about 24.7 per cent of the total eligible public HCFs in the study area are engaged in abortion care services. (Table 3.2). This is about three times more than the national level statistics which shows that it was only about 8 per cent according to the data available for year 1994. This wide gap between macro and micro level data *must reflect the skewed*

[1] The share of health care facilities in abortion care service provision could be studied as all the health care facilities (except specialised health care services) were surveyed in the study area

distribution of public ACFs across the regions and states. The percentage proportion of the public ACFs in case of Pune district is about three times larger than that of Ratnagiri district. Across tehsils, the percentage proportion of the eligible public HCFs engaged in abortion care service provision ranges between 9.1 per cent to 55.6 per cent. Within districts, there is variation across tehsils, too. In Pune district it is at least about one third whereas in Ratnagiri it is at the most is about one third. *This reflects on the fact that the skewed contribution pattern prevails even over smaller geographical areas.*

The differentials in contribution of public HCFs in abortion care service provision across Pune and Ratnagiri districts is also a pointer towards a *probable positive association between development status of the areas/districts and the contribution of public health care facilities to abortion care services.* However, it can't be generalised for obvious reasons.

With regard to general health care (or overall health care sector), private sector's contribution is about 70 per cent (Duggal, 1996; Jesani, 1994). In the study area, contribution of the private sector shoots up to the level of 87 per cent of the total health care service provision leaving only 13 per cent to be served by the public health care services[2]. Against this reality, the contribution of the public HCFs in abortion care service provision of the magnitude of about less than a quarter alarmingly magnifies its poor contribution. *It, therefore, also is a pointer to the fact that a very large number of public HCFs are not equipped to meet women specific health care needs in general.*

The low contribution of public HCFs to abortion care services suggests that there is a considerable scope for expansion of MTP services within the public sector. Based on our field experiences and some of the earlier research one of the immediate measures to achieve this is to optimise the existing resources. In that, efforts to coincide appointment of skilled personnels/ doctors in MTP care with infrastructurally equipped HCF for MTP would certainly enhance physical availability to quite some extent without really increasing budgetary allocations per se for MTP services, an often stated constraints by the government.

Table 3.2 Abortion care services: Contribution of the public health care facilities in the study area*

District	Tahsil	Public HCFs engaged in abortion care services	Total public HCFs**	Proportionate share of public HCFs engaged in abortion care services (%)
Pune	Baramati	5	9	55.6
	Ambegaon	2	6	33.3
	Junnar	4	10	40.0
	Sub-total	**11**	**25**	**44.0**

[2] In the study area, in an exhaustive enumeration of health care facilities, 486 private HCFs were identified. In addition, 73 public HCFs existed according to the various government sources totalling the size of the entire health care service provision to 524 HCFs.

Ratnagiri	Ratnagiri	2	9	22.2
	Chiplun	1	11	9.1
	Guhaghar	1	5	20.0
	Khed	1	10	10.0
	Mandangad	1	3	33.33
	Rajapur	1	10	10.0
	Sub-total	**7**	**48**	**14.6**
Total		**18**	**73**	**24.7**

* Includes urban (district and municipal hospitals) and rural (RHs and PHCs) public health care facilities.
** Data are obtained from various government offices.

1.1.2 Contribution of the private health care facilities

Only about 29 per cent of the total private HCFs in the study area were engaged in abortion care service provision (Table 3.3). There is no national level or other data available on this aspect for comparison to make. The percentage proportion of the private ACFs across districts does not show much difference, though it is slightly more in Pune compared to Ratnagiri district. This trend differs from that observed in case of proportionate contribution of public ACFs across disctricts. The percentage proportion of the private ACFs varies to a great extent across tehsils ranging from 10.5 per cent to 56.5 per cent and is similar to that found in case of public ACFs. But, it does not show any specific pattern indicating association with the level of urbanisation of a particular tehsil. In fact Baramati tehsil, a more urbanised tehsil compared to other two, exhibits comparatively a much smaller share of private HCFs in abortion care service provision. This suggests chances of under reporting of provision of abortion care facilities by heads of the HCFs. In case of tehsils in Ratnagiri, two of the less urbanised tehsils, Guhaghar and Khed show comparable percentage proportion of private ACFs to that of the most urbanised tehsils – Ratnagiri and Chiplun.

Lack of substantial differential in contribution of private HCFs in abortion care service provision across Pune and Ratnagiri districts could perhaps be explained by underreporting in Baramati. This provides space to draw a similar inference as was drawn in case of the public ACFs. *That is, the development status of the region or district would have positive relationship with contribution of the private HCFs in abortion care service provision.*

The fact that only less than one third of the private HCFs are engaged in abortion care service provision leaves much for its increased role by expanding the scope similar to that found in case of public health care services. And also indicates alike public health care service sector, that even the private health service sector is largely ill-equipped to meet women specific health care needs or at least unwilling to render such services. And this is an area for exploration.

Table 3.3 Abortion care services: Contribution of the private health care facilities in the study area

District	Tahsil	Private HCFs engaged in abortion care services	Total private HCFs	Proportionate share of private HCFs engaged in abortion care services (%)
Pune	Baramati	33	161	20.5
	Ambegaon	22	39	56.4
	Junnar	36	77	46.8
	Sub-total	**91**	**277**	**32.9**
Ratnagiri	Ratnagiri	19	67	28.4
	Chiplun	14	54	25.9
	Guhaghar	4	16	25.0
	Khed	8	37	21.6
	Mandangad	3	16	18.8
	Rajapur	2	19	10.5
	Sub-total	**50**	**209**	**23.9**
	Grand-total	**141**	**486***	**29.0**

* Of the 524 HCFs surveyed, 486 were private and 38 were public.

1.2 Distribution pattern of abortion care facilities

Skewed distribution of health care facilities in favour of urban areas and developed regions has been a persistent problem. Such a skewed distribution in case of MTP services was also observed in the analysis of the data from the government sources presented in the introductory chapter. This has consequences for people's physical access to health care services in general.

Urban/rural distribution: Little less than 2/3 of the abortion care facilities are urban based. (Table 3.4(a)). This serves about 9.8 per cent of the total population under the study area, which lives in urban areas. Consequently, about 1/3 of the abortion care facilities serve the rest 90.2 per cent population, which is rural based. In general, Pune and Ratnagiri districts seem to be similar as regards proportion of urban based and rural based abortion care service facilities to the total abortion care facilities. Within districts, there is a variation in the proportionate share of urban based and rural based abortion care facilities. In five of the nine tehsils, proportion of urban based ACFs is about twice or more than that of rural based ones. *This distribution pattern proves an accentuated skewed distribution of abortion care facilities in favour of urban areas.*

Public/private distribution: Public ACFs have a meagre share (11.3%) in the total provision of abortion care services. (Table 3.4(a)). In general, the two districts are similar as regards proportionate share of public and private ACFs in the total abortion care service provision. Public HCFs in the four tehsils (Guhaghar, Mandangad, Khed, Rajapur) from Ratnagiri district which were selected on the basis of their comparatively less urbanised status seem to have better share in abortion service delivery compared to such a share in case of other tehsils with higher level of urbanisation. It is to be noted that in general these are smaller tehsils in terms of population. They have comparatively less number of health care facilities and yet smaller number of abortion care facilities. It indicates that less number of private practitioners prefer to establish their practice in less urbanised tahsils.

Earlier we have seen that only less than a quarter of the total eligible public HCFs in the study area are engaged in abortion care service provision. This together with a meagre share of the public HCFs in total provision of abortion care service suggests *that currently a large proportion of abortion care needs are being met with only at a price in private ACFs forgoing their right to free abortion care services.* Women compelled to access abortion care services at private HCFs also imply that they are subjecting themselves to unregulated and unaccountable abortion care facilities *leading to increased chances of abortion related morbidity and mortality.*

MTP Registration status of abortion care service facilities: Availability of registered MTP care facilities implies that women can access legal abortion care services provided they live in conditions, which would enable them to do so. There is no data available on the existing non-registered ACFs though one can have some estimates about proportion of legal to illegal abortions.

Overall, the proportion of non-registered (including both public and private) to registered abortion care facilities is about 2.8: 1. (Table 3.4(a)). In general, two districts differ to a great extent as regards proportionate share of registered abortion care facilities. It is 4.4:1 in case of Pune district and 1.5:1 in case of Ratnagiri district. The range of variation across the tehsils also varies to a great extent. Within districts, the degree of skewed distribution varies to a great extent. For instance, it is as high as 6.6:1 in case of Baramati, one of the more urbanised tehsils of Pune district and as low as 2:1 in case of Rajapur, comparatively less urbanised tehsil of Ratnagiri district. In general, the proportionate shares of registered centres in teshsils of Ratnagiri are better compared to those in Pune district. Though *generalisation* ***must not be drawn*** *from such a study, the above pattern suggests to the least that the 'developed' or 'urbanised' status of a particular area ensures better legislative compliance and implementation of the Act.*

MTP registration status of the private ACFs: Our data show that for every registered private ACF there exist about 5 non-registered private abortion care facilities (NR-ACFs) (Table 3.4(b)). *This proves unequivocally that abortion care services in private health care service sector by and large are illegal.* In case of Pune, the developed district it is much more accentuated (about 1:10) and is comparatively less in Ratnagiri district (about 1:2). Absence of a single registered private ACF in Baramati tehsil of Pune district may explain the extraordinarily alarming ratio of registered to non-registered private ACFs. Similarly, in rural areas, for every 1 registered private ACF there are about 11 non-

registered private ACFs. In case of urban areas this proportion is about 1:4 (Table 3.4(c)). *Urban areas seem to be better placed on this count compared to rural areas.*

An overwhelming large share of NR-ACFs in the total abortion care service provision indicates that women are exposed to illegal abortion care services which may be unsafe. In addition, it is evident that the monitoring system is almost non-existent and non-functional. And it also implies that medical fraternity is either less concerned about complying with legal measures or is ignorant of such matters. Additionally, this also suggests that prevailing estimates of unsafe and illegal abortions may be far below the actuals having adverse implications for policy planning and resource allocations.

Table 3.4(a) ACFs by characteristics

District	Tahsil	Number and % of ACFs in								
		Urban	Rural	Total	Public	Private	Total	Registered	Non-registered	Total
Pune	Baramati	24 63.2	14 36.8	**38** **100.0**	5 13.2	33 86.8	**38** **100.0**	5 13.2	33 86.8	**38 100.0**
	Ambegaon	10 41.7	14 58.3	**24** **100.0**	2 8.3	22 91.7	**24** **100.0**	6 25.0	18 75.0	**24 100.0**
	Junnar	31 77.5	9 22.5	**40** **100.0**	4 10.0	36 90.0	**40** **100.0**	8 20.0	32 80.0	**40 100.0**
	Sub-total	**65** **63.7**	**37** **36.3**	**102** **100.0**	**11** **10.8**	**91** **89.2**	**102** **100.0**	**19** **18.6**	**83** **81.4**	**102** **100.0**
Ratnagiri	Ratnagiri	15 71.4	6 28.6	**21** **100.0**	2 9.5	19 90.5	**21** **100.0**	10 47.6	11 52.4	**21 100.0**
	Chiplun	10 66.7	5 33.3	**15** **100.0**	1 6.7	14 93.3	**15** **100.0**	5 33.3	10 66.7	**15 100.0**
	Guhaghar	--	5 100.0	**5** **100.0**	1 20.0	4 80.0	**5** **100.0**	1 20.0	4 80.0	**5** **100.0**
	Khed	7 77.8	2 22.2	**9** **100.0**	1 11.1	8 88.9	**9** **100.0**	5 55.6	4 44.4	**9** **100.0**
	Mandangad	--	4 100.0	**4** **100.0**	1 25.0	3 75.0	**4** **100.0**	1 25.0	3 75.0	**4** **100.0**
	Rajapur	3 100.0	--	**3** **100.0**	1 33.3	2 66.7	**3** **100.0**	1 33.3	2 66.7	**3** **100.0**
	Sub-total	**35** **61.4**	**22** **38.6**	**57** **100.0**	**7** **12.3**	**50** **87.7**	**57** **100.0**	**23** **40.4**	**34** **59.6**	**57** **100.0**
Total	**Grand-total**	**100** **62.9**	**59** **37.1**	**159** **100.0**	**18** **11.3**	**141** **88.7**	**159** **100.0**	**42** **26.40**	**117** **73.6**	**159** **100.0**

Table 3.4(b) Districtwise registration status of private ACFs in the study area

Districts	Private ACFs		Total
	Registered	Non-registered	
Pune	8 (8.8)	83 (91.2)	91 (100.0)
Ratnagiri	16 (32.0)	34 (68.0)	50 (100.0)
Total	**24 (17.0)**	**117 (82.9)**	**141 (100.0)**

Table 3.4(c) Distribution of the private ACFs over rural and urban in the study area according to their registration status

Districts	Private ACFs		Total
	Registered	Non-registered	
Urban	20 (21.5)	73 (78.5)	93 (100.0)
Rural	4 (8.3)	44 (91.7)	48 (100.0)
Total	**24 (17.0)**	**117 (82.9)**	**141 (100.0)**

1.3 Adequacy of abortion health care facilities

Adequacy of the available abortion care facilities is assessed by studying proportion of the women of reproductive age that abortion health care facilities may have to attend to for their abortion care needs. Alternatively, number of abortions per abortion care facility, that is the case load of abortion would also provide such an assessment.

Data show that the number of women per ACF to varied between 172 to 21553. (Table 3.5(a)). Consequently the case load ranged between 54 to 480 abortion procedure per ACF per annum. This is much higher than the national level statistics which was 66 MTP procedures per MTP centre. (Family Welfare Programme in India, Year book, 1993-94).

The extent of the case load would have implications for other aspects of quality of abortion care, too. For example, skewed distribution of ACFs would lead to corresponding skewed case load at ACFs. This means at HCFs with heavier case load, the limited resources, such as, the entire range of infrastructural facilities and human power, at a particular facility, get shared among the larger number of clients than what it should serve. Contrary to this, with low caseload at HCFs, the resources may remain underutilised. If so, service providers' economics is likely to work against the interests of users of services. This is because providers would tend to charge more to users to compensate for underutilisation of their facility. It, therefore, seems that the implications of either heavier or lighter case load would be far reaching for users of services as regards quality of care.

As regards adequacy of abortion care services, women in urban areas are better placed compared to those in rural areas. (Table 3.5(a)). In general, ACFs in Pune district have to attend to comparatively much lesser number of women than those in Ratnagiri district. In general, Pune district exhibits a much better situation to that of Ratnagiri districts as regards abortion case load per abortion care facility. (Table 3.5(b)). The trend does not necessarily continue across the tehsils within the districts. For instance, Baramati, a comparatively more urbanised tehsil shows higher case load than that of other comparatively less urbanised tehsils. However, in case of Ratnagiri district, more urbanised tehsils (Ratnagiri and Chiplun) exhibit lower abortion case load compared to less urbanised tehsils. If we assume that Baramati is a deviation, then this trend, *in general is in line with earlier trends and supports the overall hypothesis that better developed areas would be better placed as regards adequacy of abortion care services.*

Table 3.5(a) Adequacy of abortion health care facilities

District	Tahsil	Abortion care facilities		Female Population*		Female population of reproductive age**		Number of women of reproductive age per abortion care facility	
		Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
Pune	Baramati	24	14	21367	129036	11260	60001	469	4285
	Ambegaon	10	14	--	94068	--	43741	--	3124
	Junnar	31	9	10164	141958	5356	66011	172	7334
Ratnagiri	Ratnagiri	15	6	27577	104626	14533	48651	968	8108
	Chiplun	10	5	19103	112547	10067	52334	1007	10466
	Guhaghar	--	5	--	70264	--	32672	--	6534
	Khed	7	2	5590	92703	2945	43107	420	21553
	Mandangad	--	4	---	38289	--	17804	--	4451
	Rajapur	3	--	5050	95568	2661	44439	887	--

*** Source :**

- Census of India, 1991, Series 14, Maharashtra, Part XII - A & B District Census Handbook : Village & Town directory, Village & Townwise Primary Census Abstract for Pune, table 1, pp. 25.
- Census of India, 1991, Series 14, Maharashtra, Part XII - A & B District Census Handbook : Village & Town directory, Village & Townwise Primary Census Abstract for Ratnagiri, table 1, pp. 20.

** Percentage of female population of reproductive age for urban Maharashtra is 52.7 and 46.5 for rural Maharshtra according National Family Helath Survey 1992-93 is to arrive at these figures.

Table 3.5(b) Adequacy of abortion health care facilities

District	Tahsil	Abortion care facilities	Estimated number of induced abortions*	Number of abortions per abortion care facility
Pune	Baramati	34	2484	73
	Ambegaon	28	1498	54
	Junnar	40	2436	61
Ratnagiri	Ratnagiri	21	2017	96
	Chiplun	15	1998	133
	Guhaghar	5	979	194
	Khed	9	1461	162
	Mandangad	4	544	136
	Rajapur	3	1442	480

*Formulae used are as follows:
1) Birth rate = (No. of live births × 1000)/ Population
2)Estimated no of abortion = No of live births x 25/73
3) Adjusted estimated no. of abortions = Estimated no. of abortions × 39/birth rate
4) Induced abortions = Adjusted estimated no. of abortions × 3/5

2. APPROACHABILITY TO ABORTION CARE SERVICES

Approachability to ACFs is assessed by studying the pattern of their geographical spread; availability and nature of approach roads to them; mode of transport facilities and time taken to reach them. Approachability also implies certain direct and indirect costs that women bear to approach the facilities. Survey data on 159 ACFs are used for the purpose. Further insights are gained from the data drawn from the abortion seeking women from the sub-sample of ACFs studied in-depth for in the qualitative phase of the present research.

2.1 Spatial spread of abortion care facilities

The 159 ACFs identified in the survey are plotted on the map by marking the boundaries of the villages and/or townships which situated these ACFs to understand the pattern of spatial distribution and distance to abortion care facilities (Fig. 2) that women have to travel to access abortion care.

The skewed distribution of ACFs observed in the earlier section is an adequate indication of the possible uneven distribution of ACFs. In general, both the districts exhibit an uneven distribution pattern of the ACFs. But Pune district seems to have a better spatial spread compared to that prevails in Ratnagiri district. Within the districts, Junnar in Pune district seems to have a better spread compared to Ambegaon and Baramati. In case of Ratnagiri district, tehsils do not differ much as regards this. All of them are characterised by sparse and uneven distribution of abortion care facilities. The difficult terrain in Ratnagiri would further worsen the situation for women as regards approachability to abortion care facility.

Even in rural areas, the ACFs are found to be concentrated in the villages with more than 5000 population. For instance, Manchar in Ambegaon teshil of Pune district; Narayangaon and Otur in Junnar tehsil of Pune district which are more densely populated villages compared to others have more number of ACFs. These data suggest positive association between development status of the region and better spread of the ACFs.

Public ACFs, when present, always co-existed with the private ACFs. This, generally, would lead to underutilisation of public ACFs as users perceive that private HCFs are better compared to public HCFs. Our earlier study has shown that women prefer private ACFs over the public. This is because they perceive that their abortion specific concerns vis-à-vis quality of care are better served by the former ones. (Gupte, et.al., 1999).

2.2 Approach road, mode of transport and time taken

The sparse and uneven distribution of ACFs requires better availability of approach roads and transport facilities for women to have access to these facilities. We, therefore examined the extent to which these sparsely and unevenly distributed ACFs are approachable in this sense. Availability of state transport facilities was considered as a crude indicator of connectivity of villages to outside world. This is because (a) it does not tell us about their plying frequency, (b) it leaves out availability of other transport facilities, and (c) absence of the state transport facilities does not necessarily and strictly means non-availability of approach road.

As demonstrated earlier, the number of locations/villages/townships with ACFs situated therein are much less (Fig 2). The census data on availability of state transport facilities show that a large number of villages are without such facilities. (Table 3.6(a)). As a result, it could be expected that women's access to ACFs is obstructed. To one's surprise, the average connectivity, at least in terms of availability of state transport facilities in Pune district is poorer compared to Ratnagiri. There does not seem to be any plausible explanation one can offer for this pattern. But, in both the districts more urbanised tehsils exhibit much better connectivity compared to less urbanised ones. Poor connectivity together with lesser number of locations with ACFs, such as, Junnar and Mandangad, will have compounding adverse impact on approachability to ACFs.

Table 3.6(a) Availability of transport facilities

District	Tahsil	Total number of villages/ townships *	Total number of villages/ Townships with a bus stop* (connectedness)	Number of villages/ townships with HCFs**	Number of villages/ townships with ACFs **
Pune	Baramati	112	105 (93.8)	26	11 (9.8)
	Ambegaon	136	72 (52.9)	8	6 (4.4)
	Junnar	167	35 (21.0)	12	6 (3.6)
	Sub-total	**415**	**212 (51.0)**	**46**	**23 (5.5)**
Ratnagiri	Ratnagiri	199	198 (99.5)	10	7 (3.5)
	Chiplun	164	161 (98.2)	7	5 (3.1)
	Guhaghar	122	53 (43.4)	7	3 (2.5)
	Khed	215	192 (89.3)	5	3 (1.4)
	Mandangad	109	17 (15.6)	10	2 (1.8)
	Rajapur	218	162 (74.3)	13	1 (0.5)
	Sub-total	**1027**	**783 (76.2)**	**52**	**21 (2.0)**

*Census ** Our survey.

**Figures in parenthesis are percentages with the total number of villages/townships.

Further, these aspects of approachability are also assessed with the help of the data on 39 women who sought abortion care services from a sub sample of 23 abortion care facilities which were studied in-depth. The constraint of restricting analysis only to women reaching ACFs is that those who do not use these services, perhaps for reasons of difficult access, remain out of our purview.

Of the 40 women who sought abortion care at ACFs, 9 had to travel on unmetalled road, 25 on metalled road. In general, more women (8 of 28) in Ratnagiri travelled unmetalled road compared to Pune (1 of 12). State transport facilities and private vehicles, such as, rikshaws, two wheelers; jeeps were the various modes of transport used by women to reach the abortion care facilities. In all, 18 women utilised public transport facilities, 14 used private transport such as, motorcycles, auto rickshaws or jeeps. Seven women approached ACFs by walking generally ranging between 5 to 15 minutes, except one woman walked for an hour to reach the ACF. One woman had use three modes of transport to reach the ACF. Majority of women in Ratnagiri had used state transport facilities whereas in case of Pune women used private transport facilities. Time taken to reach abortion care facility ranged between five hours to a few minutes. On average women took about 30 minutes to reach to ACFs. It differed across districts. In Pune average time taken to reach ACFs was about 20 minutes whereas in Ratnagiri district it was about 42 minutes. In case of Ratnagiri, the range of time taken to reach abortion care facility is much larger compared to that in Pune. This could be attributed to the terrain difference between the two districts. It is also likely that the ST buses ply less frequently from interior villages to nodal points. *The two districts are different on the three aspects of approachability - type of road, mode of transport and time taken.*

These data are not adequate enough, both size and methodology wise, to draw any concrete inferences about association between approachability and women's choice of a particular ACF. However it gives glimpses of difficulties that women face on these fronts.

3. Affordability/cost of abortion care services

It is examined with the help of costs incurred both on travel and for medical care by these women. Indirect costs incurred by women could not be dealt with because it was the facility based study. Information on cost of care was gathered from women themselves. Women generally told us the costs incurred though a few did fumble.

3.1 Tavel cost

On average women incurred about Rs 64/- towards the travel to reach the facility. In Ratnagiri it was Rs 72/- while in Pune it was Rs 55/-. Women, logically should be incurring double of this towards the travel cost if one considers that about the same sum would be spent on the way back home. Most of these women were accompanied by one or more persons to ACFs. This travel cost includes the expenditure incurred for their travel, too.

3.2 Medical care fees

Cost of abortion care in terms of medical expenses incurred is determined practically by many factors regardless of whether they are rational determinant or not. These include, length of gestation, type of procedure used, type of pre-diagnostics conducted, drugs used and prescribed during and after the procedure, stay at the ACFs, its nature and its quality and qualification of service providers. Lack of any regulatory mechanisms in place allows these factors to be indiscriminate determinants of cost of abortion care.

We found a wide variation in the medical care cost of abortion that women told us. We found it difficult to get the break up of the cost over different heads and thus hampered any systematic analysis. However, we could observe some salient features.

In private ACFs, on average Rs 927/- were charged towards the medical procedure, diagnostics used (such as, sonography, blood tests, urine pregnancy test, VDRL) and drugs. Consistency in abortion fees was absent. However, the stay or in-admission and sonography played a decisive role in hiking the abortion fees. But, abortion as an 'office procedure' not requiring in-admission did not necessarily mean less fees to women. There were trends indicating that qualification of the abortion service provider determines fees if a particular abortion care situation is controlled for other variables such as 'type of procedure used', 'length of gestation', 'diagnostics conducted' and 'in-admission'.

Some of the examples of determining the fees indiscrimanately are presented below.

A woman who required a blood transfusion was charged Rs 1,000/- for a bottle.

An EP Forte injection to induce menstruation was charged for Rs 60/-

Sonography to confirm pregnancy costs women between Rs 175/- 350/-. The woman who was charged Rs 350/- for sonography was in her second trimester.

In the public ACFs, women though did not have to pay fees for the procedure, they had to spent on drugs.

This analytical description of medical cost of abortion care confirms that it is beyond women's control like in any other health care utilisation situation. The fees charged were indiscriminate and average fee was exorbitantly high.

The total direct cost inclusive of both travel and medical care totals up close to monthly minimum wages of India. The average per capita income for India is Rs 45/-. This shows that for an average earning woman, it is almost either impossible to seek institutional abortion care or if in case she does so, it would not be without getting indebted.

Against this backdrop, it needs to be noted that women's abortion care needs are different than their other illnesses including reproductive ones. Unaffordable cost of care may prohibit women from seeking them. And unattended health care needs of women in general would have adverse implications for her health. However, abortion care needs in most of the situations can't remain unattended. Unaffordable cost of abortion care simply means forcing women to face unsafe abortion leading to increased burden of mortality and morbidity. The 'essential' nature of abortion care would have multiplying adverse impact on her health. This is because women at a given point of time, are likely to render priority to abortion care needs ignoring their other health care needs, if any. The prohibitive cost of abortion care in such situation makes them to face ill consequences of unsafe abortion and ill health resulting from leaving other health care needs unattended. *This contextual analysis adequately suggests that prohibitive cost of abortion care would have far reaching and multiplying ill effects for women's health.*

3.4 SUMMARY & CONCLUSIONS

By and large, the problems as regards access that plague general health care services, stands true with abortion care facilities, too but in much more accentuated manner. They translate for the latter causing problems of much severity because of the specific socio-cultural context of abortion.

Availability of abortion care services

- In general, there is a **wide scope for expansion of abortion care services** both in public and private health care service sectors as only about less than a quarter and less than one third of respective sectors are engaged in abortion care service provision.

- The scenario at the micro level compared to the national or the state level is comparatively better as regards share of the health care services in abortion care service provision **indicating skewed contribution pattern.**

- The skewed distribution of the available ACFs in favour of urban areas leaves a large number of rural population to be served by a much smaller proportion of the rural based ACFs. **This would have implications for quality of abortion care that rural women may receive.**

- A meagre proportion of the public ACFs in the total abortion care service provision implies that women **have to seek abortion care services at private ACFs at cost forgoing their right to free abortion care at public ACFs.**

- This further implies that **women with no or poor purchasing power would be forced to trade of quality of care** either by choosing inferior institution based abortion care or non-institutional unsafe abortion providers.

- Existence of a large number of non-registered abortion care facilities of the magnitude of 5 NR-ACFs for every ACF in the private sector, insinuates that **women are exposed to illegal abortion care service provision which may also be unsafe.**

- Further, it also **demonstrates poor implementation of the MTP legislation and non-compliance** on part of the heads of these institutions.
- Except a meagre number, the **majority of the rural based private ACFs are non-registered**.

- **Urban areas are better placed as regards adequacy of ACFs meaning lesser case load.** This suggests better chances of receiving quality abortion care services compared to rural areas.

- In general, **development status of regions would exhibit positive correlation with various aspects of 'availability' of abortion care services.** There were some exceptions to this, such as, extremely low compliance with legislative measures in the developed district.
- Consequently, the **same is true with urban status of the region.**

Approachability to abortion care services

- In general, the smaller share of HCFs in abortion care service provision observed in the study area consequently lead to their sparse and uneven spread.
- There prevails positive association between the development status of the region and better spread of ACFs conforming with the trends observed in case of other aspects of access to abortion care services.

Affordability /cost of abortion care.

- Women incur considerable cost towards travel to reach ACFs amounting to about 6.5 per cent of the total direct cost of abortion care.
- Average medical care fees of abortion care were prohibitively high. They were wide ranging indicating unregulated charges at private ACFs.
- The prohibitive cost of abortion care may force women to approach unsafe abortion care services, which would have far reaching ramifications for her health.
- From women's perspective, their own abortion care needs have the status of 'essential' and are of prime 'priority'. If abortion care services are available mostly at unaffordable cost, it would have multiplying ill-effect for her health as she faces consequences of unsafe abortion care as well as that arising of ignoring other health care needs.

CHAPTER IV

PHYSICAL STANDARDS: INFRASTRUCTURE, EQUIPMENT & INSTRUMENT; AND DRUGS

1. Type of abortion care

2. Physical standards
   2.1. Types of various spaces available at the HCFs
   2.2. Physical condition of spaces
   2.3. Essentials
   2.4. Complementary

3. Assessment of minimum physical standards: A composite analysis

4. Summary and conclusions

The present chapter uses the data drawn from the quantitative survey of the 115 study units. It deals with data on physical standards as operationalised in the QAC model. It carries analysis along the three basic analytical categories, urban/rural; public/private; and registered/non-registered status of HCFs when required.

1. Type of abortion care (FT and/or ST) across characteristics of ACFs

All ACFs, except one, provided first trimester abortion care. (Table 4.1). Of the total 115 ACFs, 70 (60.9%) provided abortion care up to 20 weeks. About one fifth (20.9%) of the ACFs were engaged in providing abortion care even beyond 20 weeks, which, according to the MTP Act is not permitted. They prevailed in both, urban and rural areas. The public ACFs as well as private registered ACFs were no exception to this.

Table 4.1 Type of abortion care by characteristics of ACFs

Characteristics of HCF	Length of gestation*			
	Up to 12 weeks (FT)	Up to 20 weeks (ST)	All trimester (FT,ST &TT)	Others**
Urban	71	46	13	2
Rural	43	24	11	2

Public	16	8	2	1
Private				
Registered	23	15	6	-
Non-registered	75	47	16	3
Total	**114**	**70**	**24**	**4**

N=115

*The categories are not mutually exclusive.

** Others constitutes institutions providing abortion care (a) only between 13-20 weeks, (b) up to 12 weeks and beyond 20 weeks (FT+TT but not ST))

2. PHYSICAL STANDARDS

2.1 Types of various spaces available at the ACFs

Not all institutions had enquiry counters and special rooms. (Table 4.2). A large number of institutions (35.7%) were not well placed with regard to having separate spaces for operation theatre and labour room, a requirement from the point of view of maintaining the minimum hygienic and sterile conditions at operation theatre. (Table 4.3).

The data show that urban/rural, public/private and registered/ non-registered status of ACFs has association with availability of separate spaces for OT and LR. (Table 4.2). A larger proportion of the urban ACFs and the majority (77.5%) are with separate OT and LR compared to rural based ones. A substantial number (22.7%) of rural based ACFs are without OT. The majority of the public ACFs are with separate spaces for OT and LR. The majority of the private registered ACFs had separate OT and LR. Only about half of the private non-registered ACFs were characterised of separate spaces for OT and LR. A very clear trend shows across the size (in terms of number of beds) of the ACFs. Smaller the ACFs, less likely they are to have separate OT and LR.

In substantial number of ACFs the *same space was shared for labour room and operation theatre*. This should be the cause of concern as it means that the users, especially *of surgical care including abortion care service are subjected to less than sterile conditions and would be more likely to suffer post operative morbidity post operatively.*

Table 4.2 Types of spaces available at ACFs

Type of spaces	Number & % of ACFs with such spaces
Enquiry counter	64 (55.7)
Waiting room	113(98.3)
Wards*	111(96.5)
Special rooms	53 (46.1)
Consulting room	111 (96.5)
Labour room(LR) and/or Operation theatre (OT) **	114 (99.1)

N=115

*Partitioned and/or open space has not been counted as wards. However, it was difficult to distinguish between shared rooms (more than two beds) and/or general rooms and wards. Thus, all these three categories were considered as wards.

** LR and OT were found to be the same at certain institutions. Refer Table 4.6(a)

Table 4.3 Separate spaces for operation theatre and labour room by characteristics of ACFs

Characteristics of the ACFs	Separate spaces for operation theatre and labour room				
	Separate OT & LR	Same OT & LR	Only LR	None	Total
Urban	55 (77.5)	14 (19.7.)	1 (1.4)	1 (1.4)	71 (100.0)
Rural	19 (43.2)	15 (34.1)	10 (22.7)	-	44 (100.0)
Public	14 (87.5)	1 (6.3)	1 (6.3)	-	16 (100.0)
Private					
Regtrd	21 (91.3)	2 (8.7)	-	-	23 (100.0)
Non-Regtrd	39 (51.3)	26 (34.2)	10 (13.2)	1 (1.3)	76 (100.0)
Total	**74 (43.2)**	**29 (25.2)**	**11 (9.6)**	**1 (0.9)**	**115 (100.0)**

2.2 Physical condition of spaces

Waiting rooms (Table 4.4 (a)): At the majority of the ACFs, the waiting rooms were found to be with adequate ventilation, sufficient light and were clean. Waiting rooms at about 9.6 per cent ACFs were with seepage. Little more than half of the ACFs had no drinking water facilities at waiting rooms. Waiting room at about 37.4% of the ACFs were overcrowded.

Consulting room (Table 4.4(a)): Even the consulting rooms were not free of various inadequacies in terms of the above mentioned characteristics. About a quarter (23.5%) of the institutions had their consulting rooms overcrowded, as was true with waiting rooms. More than one client at a time inside the consulting caused this problem (37.5%) as per our observation. The consulting rooms at about 42.6% of the ACFs lacked aural privacy as the conversation between the service provider and the user was heard outside.

Table 4.4(a) Condition of waiting rooms, wards, special rooms and consulting room

Features	Number & % of ACFs			
	Waiting Room	Wards	Special rooms	Consulting rooms
Ventilation (adequate)	113 (98.3)	99 (89.0)	52 (98.1)	107 (93.0)
Light (sufficient)	112 (97.4)	104 (93.7)	53 (100.0)	109 (94.8)
Cleanliness (present)	112 (97.4)	91 (82.0)	52 (98.1)	105 (91.3)
Seepage (absent)	104 (90.4)	86 (77.5)	45 (85.0)	95 (82.6)
Sink (present)	NA	NA	NA	64 (55.7)
Water facility at the sink (present)	NA	NA	NA	63 (54.80
Drinking water (present)	56 (48.7)	87 (78.4)	41 (77.4)	29 (25.2)
Overcrowding (absent)	72 (62.6)	90 (81.1)	48 (41.7)	88 (76.5)
Bathrooms	NA	37 (33.33) (separate)	35 (66.0) (attatched)	NA
Toilets	NA	37 (33.33) (separate)	35 (66.0) (attached)	NA

Provides Privacy				
Aural/audio (yes)	NA	NA	NA	66 (57.4)
More than one client inside (not found)	NA	NA	NA	72 (62.6)
Total	**115 (100.0)**	**111 (100.0)***	**53 (100.0)***	**115 (100.0)**

* Only those institutions having these spaces are considered while calculating the percentages.

Special rooms and wards (Table 4.4 (a) & 4.4 (b)): The so called special rooms at all institutions were not necessarily with attached bathrooms and toilets, perhaps a major deviation from the concept of 'special room' itself. Besides, special rooms being overcrowded also suggests that the concept is conceived differently than that in the cities and comparatively developed areas. Not all spaces were free of seepage etc., for instance like waiting rooms. Analysis across the characteristics of the ACFs (Table 4.4(b)) indicates that at majority of the ACFs, there were no separate sanitary blocks for the wards. Majority of the rural based ACFs were without special rooms. Except one, no public ACFs had special rooms. About half of the private ACFs had special rooms.

Table 4.4 (b): Special rooms by Characteristics of the ACFs

Characteristics of the ACFs	Whether special rooms exist		
	Yes	No	Total
Urban	44 (62.0)	27 (38.0)	71 (100.0)
Rural	9 (20.5)	35 (79.5)	44 (100.0)
Public	1 (6.3)	15 (93.8)	16 (100.0)
Private			
Regtrd	19 (82.6)	4 (17.4)	23 (100.0)
Non-Regtrd	33 (43.4)	43 (56.6)	76 (100.0)
Total	**53 (46.1)**	**62 (53.9)**	**115 (100.0)**

Operation theatre and Labour room (Table 4.5): OTs at a substantial number of institutions (17.5%) were with seepage, affecting very obviously the necessary hygienic conditions at the operation theatre. The basic facilities, such as sink (regardless of what form they are) and water at sink were lacking at operation theatre at more than half of the institutions with OTs. Only about less than 40 per cent of the institutions having LRs were with attached toilets and bathrooms.

Table 4.5 Condition of Operation theatre and Labour room

Features	Number & percentages of Institutions	
	OT (N= 103)	LR (N=85)
Exhaust fan /AC (present)	87 (84.5)	15 (17.7)
Light (sufficient)	99 (96.1)	82 (96.5)
Cleanliness (present)	93 (90.3)	72 (84.7)
Seepage (no)	85 (82.5)	72 (84.7)
Sink (present)	60 (58.3)	69 (81.2)
Water facility (running)	55 (53.3)	61 (71.8)
Drinking water (present)	NA	33 (38.8)
Bathrooms (available)	NA	32 (37.6) (attached)
Toilets (available)	NA	35 (41.2) (attached)

Toilets and bathrooms at the institutions (Table 4.6(a) & 4.6(b)): Of 115 institutions, 3 did not have toilets and one was under construction. All three were private ACFs; 1 was urban based; all three were non-registered. Substantial number of institutions lacked the basic hygienic conditions at the sanitary block. In that, lack of cleanliness at sanitary block at as large as about 43.5 per cent of the institutions is certainly a cause of concern. However, comparatively a large number (94 of 111 with toilets) of institutions with running water at sanitary block/s, was consoling, especially against the fact that 38.23 per cent of the institutions in the sample are rural based. At some ACFs, we were told that the entire set up did not have running water but the toilets and bathrooms were provided with running water. Of the 17 which did not have running water, were mostly from rural areas and were private ACFs.

Toilet facilities at ACFs in general and at those which are engaged in women specific health care services assume significance for obvious reasons. Lack of clean toilet facilities with ample water for use certainly exposes women to infections who often are required to use them, especially when required to undergo PV examination. We observed that even at the large private health care facilities and the public health care facilities, these facilities were either absent or when present were extremely unclean, almost in non-usable condition. Women had no choice but to use them.

Lack of basic hygienic condition at sanitary blocks at about 43.5 per cent ACFs was quite puzzling. This is because substantial number of ACFs (94 of 111 ACFs) had running water in the sanitory blocks. The answer perhaps could be found in the fact that in general our health care facilities are characterised by lack of maintenance. Inadequate staff should cause such ill-maintained situation. Heads of the institutions and other concerned authorities often tend to attribute this to their inability to support such staff for lack of finances. And above all there prevails a tendency to blame and hold responsible the "uneducated and in-hygienic" lot of clients to cause such a situation. By many, any extra effort to maintain hygienic condition is excused by the institutions as they hold a view that 'they do not deserve any better services'. *However, more than anything else it certainly is a result of low priority of owners of the health care facilities for clients' right to clean and hygienic health care services.*

Table 4.6(a) Conditions of toilets and bathrooms at the ACFs

Characteristics	Number & percentage of the ACFs
Cleanliness (yes)	65 (56.5)
Airy (yes)	74 (64.3)
Light (adequate)	87 (75.7)
Running water (present)	94 (81.7)

N=115

Table 4.6(b) Toilets and/or bathrooms without running water by characteristics of ACFs

Characteristics of the ACFs	Number and %
Urban	5 (29.4)
Rural	12 (70.6)
Public	7 (43.8)
Private	10 (10.1)
Regtrd	8 (47.1)
Non-Regtrd	9 (52.9)
Total	**17 (100.0)**

3. Essentials: equipment, instruments, drugs and facilities

3.1.a Essential equipment (Table 4.7(a)): A substantial number of institutes engaged in abortion care were not equipped with the essential equipment as stated in the MTP Act. Oxygen cylinders and Boyles' apparatus were available in-house, when they were. In case of other equipment, anaesthetist/s supported the ACFs with their own set of equipment. Percentage of such ACFs varied from about 6.9 to 10.4. Percentage of ACFs having these equipment in-house varied from about 60.9 to 68.7. Boyle's apparatus was available only at about 29.6 per cent of the institutions. The majority of the institutions were equipped with oxygen cylinders. There was no operation table at 7 ACFs.

Table 4.7(a) Essential equipment/instrument required either for anaesthesia and/or resuscitation; sterilisation and availability operation table

Sr No	Description of the equipment	Number & % of the ACFs			
		In-house	Brought by service providers	Not available	No Data
	Equipment required for anaesthesia and/or resuscitation				
1	Oxygen cylinder	96 (83.5)	--	16 (13.9)	3 (2.6)
2	Breathing hoses	76 (66.1)	11 (09.6)	25 (21.7)	3 (2.6)
3	Self inflating bags	70 (60.9)	12 (10.4)	30 (26.1)	3 (2.6)
4	Airways	74 (64.4)	10 (08.6)	28(24.3)	3 (2.6)
5	Endotracheal tubes	79 (68.7)	8 (06.9)	25 (21.7)	3 (2.6)
6	Boyle's apparatus*	34 (29.6)	--	78 (67.8)	3 (2.6)

	Sterilisation Equipment				
1	Autoclave	104 (90.4)	--	10 (08.7)	1 (0.9)
2	Pressure cooker	8 (07.0)	--	106 (92.2)	1(0.9)
	Furniture				
1	Operation table	105 (91.3)	--	7 (06.1)	3 (2.6)

N=115

* This is exclusively required for administering anaesthesia. The rest are essential for both anaesthesia and resuscitation.

3.1.b Essential equipment for anaesthesia and resuscitation: A composite analysis (Table 4.7(b)): A composite analysis was done to understand whether a particular ACF was equipped with all the essential equipment required for administering anaesthesia and/or resuscitation when needed,[1].

Analysis of this composite variable/index across characteristics of the ACFs indicates that only little more than quarter (27 %) of the ACFs are equipped fully and completely with essential anaesthetic and resuscitation equipment. Of all a majority (about 60 %) was only partially equipped. This pattern persisted within all the categories, such as urban, rural and public and private NR-ACFs. For instance, a majority of the urban based ACFs and little more than half of the rural based are only partially equipped. And about more than a quarter of the rural based were not at all equipped. Only about one fourth of the public ACFs are fully and completely equipped and a majority was only partially equipped. The private registered ACFs exhibit a better pattern compared to the other categories as about more than half of them were fully equipped leaving about little less than half being partially equipped. Of the total private NR-ACFs, only about one fifth were fully equipped. A substantial number of them was not equipped at all.

It is to be noted that, public ACFs are no exceptions to 'not being equipped' with as essential equipment as anaesthetic and resuscitation. And the registered status of ACFs does not ensure being fully equipped. At the same non-registered status does not necessarily mean being ill-equipped.

[1] HCFs if had all the essential equipment for anaesthesia and resuscitation were considered as HCFs with 'all equipment available'; if had even one of them less, were treated as 'partially equipped'; and those with none of the equipment were considered as 'none' in the composite analysis.

Table 4.7(b) Availability of essential equipment (anaesthesia & resuscitation) by characteristics of ACFs

Characteristics of the ACF	Availability of essential equipment (anaesthesia & resuscitation)*				
	Completely ** Equipped	Partially equipped	None at all	No infn	Total
Urban	24 (33.8)	45 (63.4)	1 (1.4)	1 (1.4)	71 (100.0)
Rural	7 (15.9)	23 (52.3)	12 (27.3)	2 (4.5)	44 (100.0)
Public	4 (25.0)	10 (62.5)	1 (6.3)	1 (6.3)	16 (100.0)
Private					
Regtrd	12 (52.2)	11 (47.8)	--	--	23 (100.0)
Non-Regtrd	15 (19.7)	47 (61.8)	12 (15.8)	2 (2.6)	76 (100.0)
Total	**31 (27.0)**	**68 (59.1)**	**13 (11.3)**	**3 (2.6)**	**115(100.0)**

*Six instruments/equipment were listed as minimum physical standards requirement for administering anaesthesia and/or to meet resuscitation needs.

**Completely equipped: ACFs with all six instruments/equipment

Partially equipped : ACFs with less than six instruments/equipment

Lack of equipment : ACFs with none of the six instruments/equipment

3.3.a Essential instruments for MTP procedure (Table 4.8(a)): The majority of the institutions seem to be meeting the needs of the instruments and/or equipment required for the first trimester MTPs. A large number of institutions (45.2%) are not equipped with laparotomy equipment and the majority (74.8%) lack laparoscope. These institutions therefore are short of meeting the requirements for conducting second trimester MTP procedures. A small percentage of institutions are supported by the service providers with regard to these equipment by bringing their own sets of the material. It is to be noted that 114 of the 115 institutions provide first trimester abortion care and 70 institutions provide second trimester abortion.

Table 4.8(a) Essential equipment/instruments for MTP procedure

Sr No	Description of abortion specific instrument and equipment	Number & percentage of the institutions			
		In-house	Brought by service providers	Not available	No Data
	Required for both first and second trimester abortion care				
1	Set of dilators (different sizes)	92 (80.0)	5(4.3)	9 (7.8)	9 (7.8)
2	Vulsellum forceps	93 (80.9)	5(4.3)	15 (13.0)	2 (1.7)
3	Ovum forceps				
4	Long ovum forceps (with narrow top end, transverse serrations and a rachet in the handle for locking)	94 (81.7)	5 (4.3)	14 (12.2)	2 (1.7)
5	Curette	94 (81.7)	5 (4.3)	14 (12.2)	2 (1.7)
6	Suction machine (electric/hand/foot pump)*	98 (85.2)*	3 (2.6)	13 (11.3)	1 (0.9)
7	Sim's speculum	97 (84.3)	5 (4.3)	11(9.6)	2 (1.7)
8	Suction cannula	84 (73.0)	5 (4.3)	24 (20.9)	2 (1.7)

	Required for second trimester, in addition to the above ones				
1	Catheter (Folly's / Simple rubber)	88 (76.5)**	5 (4.3)	17 (14.8)	5 (4.3)
2	Laparotomy equipment	56 (48.7)	3 (2.6)	52 (45.2)	4 (3.5)
3	Laparoscope	22 (19.1)	4 (3.5)	86 (74.8)	3 (2.6)

N=115

* This includes three types of suction machines - electric, hand operated and foot operated. 82 institutions have electric suction machines, either by itself or in combination with hand or foot operated.

** Of these, at 5 institution, it is prescribed and at other two, it is not used for MTP procedure.

3.3.b Essential instruments for MTP procedure: A composite analysis(Table 4.8(b))

A similar type of composite variable as was done for anaesthetic and resuscitation equipment was constructed to get a comprehensive idea about the proportion of fully equipped ACFs as regards MTP procedures. This shows that about 62.6 per cent of the ACFs are fully equipped.

Proportion of fully equipped urban ACFs is better than that of proportion rural ACFs; and of the private registered ACFs is better than that of private NR-ACFs. The proportion of 'partially equipped' was substantial across all the three characteristics of the institution. As large as 43.8 per cent of the public ACFs are equipped only partially. And a little more than a quarter of the private registered ACFs were only partially equipped.

Table 4.8(b) Availability of essential equipment for FT by characteristics of ACFs

Characteristics of the HCF	Availability of essential equipment for FT*			
	Fully equipped	Partially eqipped	Lack of equippment	Total
Urban	48 (67.6)	21 (29.6)	2 (2.8)	71 (100.0)
Rural	24 (54.5)	16 (36.4)	4 (9.1)	44 (100.0)
Public	9 (56.3)	7 (43.8)	-	16 (100.0)
Private				
Regtrd	17 (73.9)	6 (26.1)	-	23 (100.0)
Non-Regtrd	46 (60.5)	24 (31.6)	6 (7.9)	76 (100.0)
Total	**72 (62.6)**	**37 (32.2)**	**6 (5.2)**	**115(100.0)**

* Fully equipped: ACFs with all the 7 equippment/instruments required for abortion procedure,
Partially equipped: ACFs with less than 7 instruments required for abortion procedure,
Lack of equippment; ACFs with none of these instruments

3.4.a Life saving/emergency drugs (Table 4.9(a)): Data show that even the 'emergency drugs' are not stocked by all the institutions

Table 4.9(a) Availability of life saving/emergency drugs

Sr No	Life saving/emergency drugs	Number & percentage of the institutions where drugs are available
1.	Adrenaline	107 (93.0)
2.	Glucose I.V.	111 (96.5)
3.	Ringer lactate	110 (95.7)
4.	Hydrocortisone inj. (Efeorline) / Dexamethasone	103 (89.6)
5.	Mephensine inj.	99 (86.1)
6.	Avil inj.	110 (95.7)
7.	Dopamine	81 (70.4)
8.	Soda bicarb.	107 (93.0)
9.	Frusemide	100 (87.0)

N=115

3.4.b Life saving/emergency drugs: A composite analysis (Table 4.9(b)

A similar type of composite variable as was done for anaesthetic and resuscitation equipment was constructed to get a comprehensive idea about the proportion of fully equipped ACFs as regards life saving drugs. This shows that only about 60 per cent of the ACFs seem to stock all the life saving drugs.

Proportion of urban ACFs with all the life saving/emergency drugs is much better than proportion rural ACFs. Proportion of private ACFs with all the life saving/emergency drugs is more than double the proportion public ACFs. Poor drug supply to PHCs has been documented by an earlier study. (Phadke, A., 1998). The majority (60% or more) of the private ACFs, both registered and non-registered were found to have stocked all essential drugs though the R-ACF were further better placed. However, neither the urban based, or public or R-ACFs were exception to being 'not fully equipped ACFs' as regards life saving/emergency drugs. And such proportion was substantial across all these three characteristics of the institution.

Table 4.9(b) Availability of life saving/emergency drugs by characteristics of ACFs

Characteristics of the HCF	Availability of life saving/emergency drugs*			
	Completely** stocked	Partially stocked	None	Total
Urban	51 (71.8)	20 (28.2)	-	71 (100.0)
Rural	18 (40.9)	23 (52.3)	3 (6.8)	44 (100.0)
Public	5 (31.3)	10 (62.5)	1 (6.3)	16 (100.0)
Private				
Regtrd	19 (82.6)	4 (17.4)	--	23 (100.0)
Non-Regtrd	45 (59.2)	29 (38.2)	2 (2.6)	76 (100.0)
Total	**69 (60.0)**	**43 (37.4)**	**3 (2.6)**	**115(100.0)**

* Nine drugs were listed as life saving/emergency drugs.

** ACFs with all 9 of them are coded as 'Completely stocked'; with less than 9 of them are coded as 'partially stocked' & with no drugs are coded as 'lack of life saving drugs'.

3.5 Essential facilities (Table 4.10) : About 27 per cent (31 of 115) institutions did not have any back up in terms of generator set in case of failure of electricity supply, not even for operation theatre. Ambulance and fire fighting arrangements seemed a low priority for most of the institutions

Table 4.10 Essential facilities

Sr No	Item	Number & percentage of the ACFs where they are available
1	**Generator set for :**	
1.a	Operation theatre alone	22 (19.1)
1.b	OT & Emergency wards/rooms only	7 (6.1)
1.c	OT and LR only	2 (1.7)
1.d	Entire setup	53 (46.1)
2	**Ambulance**	30 (26.1)
3	**Fire fighting arrangements available:**	
3.a	Fire extinguisher	9 (7.8)
3.b	Easily accessible water supply	27 (23.5)
3.c	Fire extinguisher and easily accessible water	4 (3.5)

N=115

2.4 Complementary services and facilities

4.1.a Complementary services (Table 4.11): Only about one third of the ACFs had in-house pathology laboratories. The various tests that are listed above, ideally speaking, are expected to be conducted. However, in case the providers at these institutions prescribe these tests for their abortion clients, women had to get these tests done from outside the HCF.

Table 4.11 Complementary services

Sr No	Type of services	Number & percentage of the institutions where they are available
1	**In-house Pathology laboratory (yes)**	38 (33.0)
	Urine tests conducted	
1.a	Urine sugar	38 (33.0)
1.b	Albumin	37 (32.2)
1.c	Urine microscope	33 (28.7)
1.d	Pregnancy	33 (28.7)
2	**Blood tests**	
2.a	Blood group (including Rh)	34 (29.60
2.b	Hb percentage (Hb)	37 (32.2)
2.c	Blood sugar	32 (27.8)

N=115

4.1.b Access to Blood bank: We have earlier seen in chapter III that 114 of the 115 of our sample ACFs were engaged in providing abortion care up to 12 weeks of gestation, and only 70 of 115 were providing abortion care up to 20 weeks.

As anticipated, none of the rural based ACF providing abortion care up to 20 weeks had access to blood bank. (Table 4.12). Even in case of urban institutions only a little more than half (56.5%) met the legal requirement of access to blood bank.

Surprisingly, even the public ACFs were found to be violating the law as regards access to blood bank. Of the 8 public institutions providing abortion care up to 20 weeks of gestation, only 2 had access to blood bank as stipulated in the MTP Act.

Only about 9 (39.1%) of 23 registered MTP centres providing abortion care up to 20 weeks of gestation had blood bank within 5 km.

We conclude that urban institutions stand a better chance of access to blood bank at a distance of 5 km or less. Either 'registered' or 'public' status of the abortion care centre did not ensure compliance with legal specification regarding access to blood bank.

Table 4.12: ACFs engaged in abortion care up to 20 weeks and their access to blood banks

Characteristics of ACFs	Distance at which blood bank was situated			Total
	5 km or less	More than 5 km	No access at all	
Urban	26 (56.5)	10 (21.7)	10 (21.7)	46 (100.0)
Rural	--	19 (76.0)	6 (24.0)	25 (100.0)
Public	2 (25.0)	4 (50.0)	2 (25.0)	8 (100.0)
Private				
Registered	7 (46.6)	5 (33.3)	3 (20.0)	15 (100.0)
Non-registered	17 (35.0)	20 (41.7)	11 (22.9)	48 (100.0)
Total	**26 (36.6)**	**29 (40.8)**	**16 (22.5)**	**71 (100.0)**

2.4.2 Complementary facilities (Table 4.13): The majority of the ACFs had telephone facility, though not all. Proportion urban (69.0) was slightly higher than proportion rural (65.9) with telephone facility. Proportion private (72.7%) was much higher compared to proportion public (37.5) ACFs equipped with telephone facility. Food facility at the institutions even for clients seemed a rare facility.

Table 4.13 Complementary facilities

Sr No	Type of facilities	Number & percentage of the ACFs where they are available
1	**Telephone facility (available)**	78 (67.8)
2	**Food facility available for :**	
2.a	Users of health care (clients)	4 (03.5)
2.b	Users and relatives	1 (00.9)
2.c	Room/gas for cooking	9 (07.8)

N=115

3. ASSESSMENT OF MINIMUM PHYSICAL STANDARDS: A COMPOSITE ANALYSIS

Complete set of equipment/instrument for conducting abortion procedure; for administering anaesthesia and/or to meet resuscitation needs; complete set of life saving /emergency drugs and an operation table are considered to constitute the minimum physical standards for providing abortion services at a particular HCF. Health care institutions, therefore, were assessed to examine the extent to which they were equipped with these minimum physical standards.

Composite analysis **(Table 4.14)** brings down the number of ACFs which meet the minimum physical standards requirements in totality to as low as 18, constituting a mere 15.7 per cent of the total 115 ACFs studied. Majority of the ACFs are equipped with either three or two of the four sets of physical standards requirement. Proportion of the completely equipped ACFs as regards minimum physical standards is better in case of the urban based compared to rural based, in private ACFs compared to public, and in registered ACFs compared to non-registered ones.

Table 4.14 Availability of minimum physical standards for abortion care by characteristics of ACFs

Characteristics of the institutions	Availability of essential equipment and life saving drugs*					Total
	All** essentials	Three essential	Two	One	None	
Urban	14 (19.7)	32 (45.1)	16 (22.5)	7 (9.9)	2 (2.8)	71 (100)
Rural	4 (9.1)	9 (20.5)	17 (38.6)	9 (20.5)	5 (11.4)	44 (100)
Public	2 (12.5)	3 (18.8)	6 (37.5)	4 (25.0)	1 (6.3)	16 (100)
Private						
Registered	8 (34.8)	10 (43.5)	4 (17.4)	1 (4.3)	-	23 (100)
Non-registered	8 (10.5)	28 (36.8)	23 (30.3)	11 (14.5)	6 (7.9)	76 (100)
Total	**18 (15.7)**	**41 (35.7)**	**33 (28.7)**	**16 (13.9)**	**7 (6.1)**	**115 (100)**

* These include (1) complete set of equipment/instrument for conducting abortion procedure; (2) complete set of instruments and equipment for administering anaesthesia and/or to meet resuscitation needs; (3) complete set of life saving /emergency drugs and (4) an operation table.

**All essential: ACFs with all the above mentioned sets

Three essentials: ACFs with three of the four essentials instruments/equipment and drugs

Two essentials: ACFs with any two of the four essential instruments/equipment and drugs

One essential: ACFs with any one of the four essentials instruments/equipment and drugs

None : ACFs with none of the four essentials instruments/equipment and drugs

4. SUMMARY & CONCLUSIONS

Availability of spaces and their physical condition

- **By and large the spaces or zones**, such as, waiting rooms, wards, consulting rooms **were available at almost all health care facilities**.

- **At substantial number of ACFs the same space was shared for labour room and operation theatre.** This consequently would subject the users of health care services, especially of surgical care including abortion care, to less than sterile conditions. Users **as a result, would be more likely to suffer morbidity post operatively.**

- **There was lack of basic hygienic condition at sanitary blocks at about 43.5 per cent ACFs** despite availability of running water. These are potential situations to cause infections to the users. It also suggests **a low priority of owners of the health care facilities for clients' right to clean and hygienic health care services.**

Availability of essential equipment, instruments and drugs

- **Only little more than a quarter (27 %) of the ACFs was equipped fully and completely with *essential anaesthetic and resuscitation equipment.*** Only a quarter of the public ACFs were completely equipped . Only about half of the private R-ACFs were completely equipped with these essentials.

- **About 62.6 per cent of the ACFs were fully equipped as regards the *surgical instruments required for MTP procedures.*** Only a little more than a half of the public ACFs was equipped fully. About little less than three quarters of the private R-ACFs were fully equipped.

- **About 60 per cent of the ACFs stocked *all the life saving drugs.*** Only about a little less than one third of the public ACFs were completely stocked with essential drugs. A large majority of the magnitude of a little more than four fifths of the private R-ACFs was completely stocked with essential drugs.

- About **73 per cent ACFs were *equipped with generator sets* at OTs to manage the situations of failure of electricity supply.** This as a consequence leaves a substantial number of users at risk who avail services from the rest of the facilities.

- **Composite analysis of essentials (equipment, instruments and drugs) has brought down the number of fully equipped ACFs for safe abortion care services to as meagre as 18 ACFs of 115**. Of these, 2 were public and 8 each were private R-ACFs and NR-ACFs.

- This clearly indicates that **women have weak chances of receiving abortion care in an infrastructurally sound and equipped set up**. This, as a consequence, exposes women to fatal risks.

- It once again proves that **neither the public ACFs nor the private registered ACFs comply with the MTP Act as regards stipulated minimum physical standards.**

- At the same, it again proves that **not all non-registered ACFs are unsafe as regards abortion service provision.**

- It also reflects on the fact that the **MTP Act is being poorly implemented.**

Availability of complementary services and facilities

- **Only about one third or less ACFs had in-house facilities to provide services, such as, pathological diagnostics.** Lack of these complementary services in-house causes not only physical inconvenience in terms of time, energy and money but women also have to desist their concerns and priority for 'confidentiality'.

- There were **no complementary facilities, such as, boarding arrangements, telephone facilities at about 93 to 97 per cent of the ACFs.** Absence of these would cause inconvenience, for obvious reasons, to women seeking abortion care and to those who accompany her.

- Thus, the majority of the ACFs are neither sound in terms of medically prescribed minimum physical standards nor do they meet women's expectations of quality of care.

Chapter V

HUMAN POWER: AVAILABILITY, STRENGTH & PROFESSIONAL COMPETENCE

1. Heads of institutions
2. Abortion care service providers
3. Anaesthetists
4. Consultants
5. Laboratory Technicians
6. Nurses
7. Aayas and ward boys
8. Professionally competent service provider and essential services: a composite analysis
9. Summary and conclusions

The chapter presents **data on human power at sample 115 ACFs in the study area**. As explained in the quality of abortion care model, the heads of the institutions (HI) as administrative heads, abortion care service providers (APs), anaesthetists (ANs), laboratory technicians (LTs), nurses, aayas, ward boys and enquiry attendants constitute human power at ACFs. **Of these APs and ANs form essential service providers while the rest form complementary ones.**

An assessment of human power in made in terms of **(1) availability of professionally competent service providers and (2) their numerical strength[1].** Data obtained from 115 sampled ACFs on these aspects are used for the purpose. Differential across urban/rural; public/private and registered/non-registered are examined. For each of the service provider categories, the data are organised along the two aforesaid aspects.

We found, as often is the case in health care delivery system, that individuals played more than one role vis-à-vis one particular ACF. For instance, an HI was also an AP for a particular ACF and was the dominant trend that we observed in the study area. Besides, a particular service provider from some of the above mentioned categories, rendered her/his services to more than one ACF. As result, we observed that in a given restricted geographical area, a group of service providers formed the network of service provision by catering to more than one service delivery points. This was observed especially in case of APs and ANs. This we treated as a service link/contract. *Thus, an individual service provider had more than one type of relationship with a particular ACF and one particular ACF had multiple service providers.* This has implications, either positive or negative, to users of services depending upon the extent to which qualified professionals are engaged in attending multiple service delivery points.

---

[1] Staff strength in terms of adequacy vis-à-vis case/client load is a useful concept for assessment of quality of care. However, we did not study it for lack of systematic data on client load.

An individual institution remains the unit of analysis as was the case for data presented in the earlier chapters. In addition, *it was required to analyse services links established through service provision by an individual to a one or more ACFs.*

1. HEADS OF INSTITUTIONS (HIs)

Heads of the institutions are the administrative heads of the health care facilities. Though they need not necessarily be medicos, in Indian context they often are. They, therefore, are termed as owner-doctors. Regardless of their medical background, they certainly are the decision-makers and managers of the set-up. The managerial decisions and policy vis-à-vis the set-up are decided by them. Quality of care that is available depends much upon their decisions. As far as abortion care is concerned, they would also play an important role in deciding as which women could avail of abortion care services.

1.1 Profile: Males though dominated (65.2%) the position of head of an institution, substantial number (34.8%) of institutions were headed by females. *All HIs were medicos.* About a *little more than two fifths of the HIs were qualified for abortion service provision as they were either gynaecologists-* either post graduates or diploma holders or were trained in conducting MTPs. *Non-allopaths headed about a little less than one third of ACFs.*

1.2 Qualification of heads of institutions by characteristics of ACFs (Table 5.1)

Except about one fifth (21.1%), the rest of the urban based ACFs were headed by allopaths. About half of the urban ACFs were headed by gynaecologists. The pattern was almost exactly reverse in case of rural based ACFs. About 45 per cent of them was headed by the non-allopaths. This also confirms the earlier researched trends as regards general health care services that allopaths are less attracted to rural areas to establish their practice leaving larger rural population at hands of non-allopaths who often engage themselves in cross practice.

A much larger number of the private ACFs was headed by gynaecologists compared to the public ACFs. Of the total ACFs headed by gynaecologists, except two, the rest all were private ACFs. Two of the public ACFs were headed by non-allopaths. *This suggests that the public ACFs are mostly supported by non-specialised practioners.* Lack of availability of health care services of gynaecologists has been articulated even by rural women and thus their choice for private practitioners, almost out of 'no choice' situations'.

Of the total private R-ACFs a large majority (87%) was headed either by gynaecolgists or MTP trained allopaths. In case of the private NR-ACFs, such a proportion was only less than one third. However, inferences about safety of abortion care services would not be drawn based on this as ACFs are expected to acquire MTP registration against qualification of AP/s and not of HI. At the same, given the low compliance with any of the medical legislations on part of the medical fraternity in general, it would not be surprising to find if unqualified HIs are enaged in providing abortion care services.

Table 5.1 Qualifications of HIs by characteristics of ACFs

Characteristics of the Institution	Qualification of heads of institutions				
	Gynaecs (DGOs & MDs)	Allopaths + MTP trng	Other non-gynaec allopaths	Non-allopaths	Total
Urban	35 (49.3)	3 (4.2)	18 (25.4)	15 (21.1)	71 (100.0)
Rural	6 (13.6)	6 (13.6)	12 (27.3)	20 (45.5)	44 (100.0)
Public	2 (12.5)	5 (31.3)	7 (43.8)	2 (12.5)	16 (100.0)
Private					
Regtrd	18 (78.3)	2 (8.7)	1 (4.3)	2 (8.7)	23 (100.0)
Non-Regtrd	21 (27.6)	2 (2.6)	22 (28.9)	31 (40.8)	76 (100.0)
Total	**41 (35.7)**	**9 (7.8)**	**30 (43.3)**	**35 (30.4)**	**115 (100)**

2. ABORTION CARE SERVICE PROVIDERS (APs)

All those individuals mentioned by the HIs as abortion service providers at their ACFs were considered for analysis of APs. These include HIs themselves if they were engaged in abortion service provision. In all 121 APs were identified by HIs of 115 ACFs. We interviewed 116 of them, as the rest could not be contacted.

2.1 Profile (Table 5.2): A larger number of the APs were males. More than half were doing abortion practice for more than 11 years. *Of the total APs, only a little more than half were qualified as per the MTP Act for conducting MTP procedures.* About more than a quarter of the APs were non-allopaths. *This shows that a large number of untrained APs are engaged in providing abortion care services in the study area.*

Table 5.2 Profile of abortion care providers

Characteristics of AP	Freq	%
Sex		
Male	72	62.9
Female	44	37.1
Age (in yr)		
35 years or less	38	32.8
36-45 years	47	40.5
46 years and above	31	26.7
Years of abortion practice		
Upto 5 years	27	23.3
6-10 years	21	18.1
11-20 years	54	46.6
More than 20 years	14	12.1
Qualification		
Gyneac (DGOs & MDs)	50	43.1
Allopath + MTP trg	11	9.5
Other allopaths	23	19.8
Non-allopaths	32	27.6

N = 116

2.2 Service contracts (Table 5.3): As explained initially in the chapter, we could identify 158 service contracts formed by 116 APs. An individual service provider forming a service link also means her/his services are sought by others.

The majority (60.1%) of the providers forming the service contracts is owner-doctors. In general, not too many were regular employees at ACFs. A little more than quarter were providing services either on call or were attached to ACFs. *Employment status of the abortion service providers, therefore, indicates that the trend is 'not to be dependent' on other providers unless required in case of emergency.*

It was also examined as to who (which characteristics of the APs) are better sought than the others. The data show that (Table 5.4) more of the male providers compared to females serve more than one ACF. *The gynaecologists were the most sought (58 %) abortion service providers compared to other providers.* Suprisingly, even the services of non-allopaths were sought, though a meagre percentage.

Table 5.3 Profile of APs constituting the service contracts

Characteristics of AP constituting service contracts	Freq	%	% formation of the service contracts*
Sex			
Male	105	66.5	45.8
Female	53	33.5	20.5
Qualification			
Gyneac (DGOs & MDs)	79	50.0	58.0
Allopath + MTP trg	13	8.2	18.2
Other allopaths	32	20.3	28.1
Non-allopaths	34	21.5	6.3
Employment status			
HI as AP	95	60.1	NA
Regular employee	7	4.4	NA
Attached	11	7.0	NA
On call	31	19.7	NA
Spouse/son/dr-in-law	14	8.8	NA

N = 158 service contracts

*Calculated using percentage of difference between number of service contracts and APs in respective categories

2.3 Service contracts by characteristics of ACFs (Table 5.4): *In general, the patterns across these three analytical categories are consistent with the earlier ones.* In that, larger proportion of the urban based ACFs; larger proportion of the private ACFs; and larger proportion of the private R-ACFs than their respective counter categories are supported by appropriately qualified APs. For instance, three quarters of the service contracts with the private R-ACFs were constituted by gynaecologists. Of the total service contracts with private NR-ACFs, about fifty per cent was constituted by non-qualified abortion service providers. The majority of non-qualifieds (non-gynaecologist allopaths and non-allopaths) APs are with NR-ACFs. *Neither the public ACFs engaged in abortion care service provision nor the registered ACFs are free from service provision by non-qualified abortion service providers.*

Table 5.4 Qualification of APs forming service links by characteristics of ACFs

Characteristics of the ACFs	Qualification of APs constituting service contracts				
	Gynaecs (DGOs & MDs)	Allopaths + MTP trng	Other non-gynaec allopaths	Non-allopaths	Total
Urban	54 (58.1)	4 (4.3)	17 (18.3)	18 (19.4)	93(100.)
Rural	25 (38.5)	9 (13.8)	15 (23.1)	16 (24.6)	65 (100)
Public	6 (27.3)	8 (36.4)	6 (27.3)	2 (9.1)	22(100)
Private					
Regtrd	22 (75.9)	3 (10.34)	1 (3.5)	3 (10.3)	29 (100)
Non-Regtrd	51 (47.7)	2 (1.9)	25 (23.4)	29 (27.1)	107(100)
Total	**79 (50.0)**	**13 (8.2)**	**32 (20.3)**	**34 (21.5)**	**158(100)**

2.4 Abortion service support by other than HIs (Table 5.5): *About 82.6 per cent (95/115) of the total ACFs were self supported as regards abortion care services.* This clearly indicates indulgence of untrained APs, either allopaths and/or non-allopaths, in abortion care service provision. This is because as seen earlier only 43.5 per cent of the HIs were qualified to provide abortion care services. (Table 5.1). Of those self supported, about three quarters did not seek abortion services from anybody and about a quarter did seek abortion services from others in addition. At the rest, where HI did not provide abortion care, 70 per cent of the ACFs sought abortion service from at least one AP. *Of the 72 institutions which were not supported by any additional APs other than HI, 28 (38.9 %) did not have either consultants or referral system to fall back upon;* in case of another 28, consultants were invited and the rest 16 institutions (22.2%) reported to have referral system to fall back upon.

Table 5.5 APs other than HIs

Whether HI provides abortion services at his own ACF	Number of APs other than HIs				Total number of ACF
	One	Two	Three	No Additional AP	
Yes	13 (13.7)	6 (6.3)	4 (4.2)	72 (75.8)	**95 (100.0)**
No	14 (70.0)	6 (30.0)	--	--	**20 (100.0)**
Total	**27 (23.5)**	**12 (10.4)**	**4 (3.5)**	**72 (62.6)**	**115 (100.0)**

2.5 Abortion service support sought by characteristic of ACFs (Table 5.6)

The analysis of service contracts/links enhances understanding of the entire range of professional competence as regards abortion care service providers that was available through these ACFs. *But it does not tell us availability of qualified abortion providers at a particular ACF. For this, the unit of analysis was shifted from 'service contract' to*

'ACF'. From among the multiple service providers at a particular ACF, the one with highest qualification was considered for this analysis[2].

As seen earlier (Table 5.5), not all ACFs were supported by APs by other than HIs. Analysis of qualifications of such APs across that of HIs would help us understand as to who seeks such support and what level of professional competence is sought by them.

Data show that higher the qualification of HIs, less is the need for them to depend on such contractual services. (Table 5.6). The majority of the ACFs headed by gynaecologists, thus is self-reliant and appears to be logical. However, tendency of being self reliant of HIs who are not qualifide for providing abortion services, at least in legal sense is worrisome. This, therefore, requires further exploration. The ACFs whose heads are not engaged in abortion service provision seem to be depending upon outsiders/contractual services but not necessarily upon qualified APs in a stricter sense. This also needs a further exploration.

Table 5.6 Availability of qualified abortion service support: Abortion service support from outside

Qualification of Heads of institutions	Qualification of an abortion provider*					Total
	Gynaecs (DGOs & MDs) APs	Allopaths + MTP trng	Other allopaths	Non-allopaths	No outside	
Gynaecs (DGOs & MDs)	7 (17.1)	--	--	--	34 (82.9)	41 (35.7)
Allopaths + MTP trng	1 (11.1)	1 (11.1)	--	--	7 (77.8)	9 (7.8)
Other allopaths	3 (15.0)	--	1 (5.0)	1 (5.0)	15 (75.0)	20 (17.4)
Non-allopaths	3 (12.0)	--	3 (12.0)	3 (12.0)	16 (64.0)	25 (21.7)
Heads (HI) are not abortion providers (AP)	13 (65.0)	2 (10.0)	3 (15.0)	2 (10.0)	--	20 (17.4)
Total	**27 (23.5)**	**3 (2.6)**	**7 (6.1)**	**6 (5.2)**	**72 (62.6)**	**115(100)**

*From among the multiple service providers with a particular ACF, the one with highest qualification is considered here. Heads of the institutions who were providing abortion care were excluded from 'multiple service providers' (Q_aaptop)

2.6 Availability of qualified APs by characteristics of ACFs (Table 5.7):

To understand as to how many ACFs were equipped with qualified APs regardless of their status as HI, analysis at the level of ACFs was done. From among the multiple APs at a particular ACF, the one with highest qualification was considered for this analysis[3].

Though the majority (61.7%) of the ACFs has at least one qualified AP, a substantial number (38.3%) was supported only by non-qualifides (non-gynaec allopaths and non-allopaths) APs. More of the urban based ACFs seem to be better supported than that of rural based. Of the private registered ACFs, a large majority is supported by qualified APs.

[2] This is a little liberal way of analysing the institutions as regards professional competence that they are equipped with. This is because the underlying assumption is that all the clients of a particular institutions are attended to by the one with the highest qualification from among the multiple service providers, which may or may not be true. 'Multiple service providers' do not include heads of institutions who were providing abortion care.

[3] 'Multiple service providers' also include heads of institutions who were providing abortion care.

Abundance of non-qualifide providers in the private non-registered ACFs is more than clear. A substantial number of the public ACFs is not supported by qualified APs.

These trends raise a lot of questions regarding the MTP registration procedure and also about the quality of post MTP registration monitoring mechanism that exists today. It also *reflects on poor compliance on part of HIs.* A large number of non-registered ACFs are supported by qualifide APs (gynaecs and MTP trained allopaths). This requires us to understand the reasons behind they running the risk of not registering their institutions despite meeting at least one of the major legal requirements in terms of qualifications of abortion providers. This certainly requires, in addition to the need to look into implementation of the MTP Act, an analysis of attitudes of heads of institutions towards medical legislation, social accountability and also an overall awareness level. Besides, the economics of individual health care institutions also needs to be looked into to explore the relationship between non-registered status of a particular ACF and enhanced profit margins, if exists any.

Table 5.7 Availability of qualified APs by characteristics of ACFs

Characteristics of ACFs	Qualifications of AP*				
	Gynaecs (DGOs & MDs)	Allopaths + MTP trng	Other allopaths	Non-allopaths	Total
Urban	45 (63.4)	3 (4.2)	14 (19.7)	9 (12.7)	71 (100.0)
Rural	16 (36.4)	7 (15.9)	9 (20.5)	12 (27.3)	44 (100.0)
Public	3 (18.8)	6 (37.5)	6 (37.5)	1 (6.3)	16 (100.0)
Private					
Regtrd	19 (82.6)	2 (8.7)	--	2 (8.7)	23 (100.0)
Non-Regtrd	39 (51.3)	2 (2.6)	17 (22.4)	18 (23.7)	76 (100.0)
Total	**61 (53.0)**	**10 (8.7)**	**23 (20.0)**	**21 (18.3)**	**115 (100)**

*From among various service contracts with a particular institution including heads of institution providing abortion care (Q-aphtop), the one with the highest qualification is considered for this analysis.

3. CONSULTANTS AND REFERRAL: BACK-UP IN ABORTION CARE EMERGENCIES

Generally, seeking consultants' services and relying on referral are the ways to deal with emergencies. The situations arise because a particular health care facility may not be in position at times to attend to the health care needs with the help of given resources, both in terms of professional competence of the service providers and various infrastructural facilities. For any health care facility it is advisable to have consultants and referral system in place to fall back upon in case of emergencies.

In abortion care, the significance is also because a large number of ACFs are found to be ill-equipped as regards minimum physical standards and professional competence of abortion service providers thereby potentially increasing the chances of situations requiring such a support structure or back-up system.

Our data show that about 40 per cent of the ACFs invited consultants and about 20 per cent had some referral system in place. About 40 per cent of ACFs did not invite either

consultants or had any referral system in place. (Table 5.8). Almost about half (52.1%) of the urban based ACFs invited consultants rather than depend on the referral system. The trend is reverse in case of rural based ACFs. This is logical because rural based ACFs will have less scope to depend upon consultants. Proportion of public ACFs inviting consultants and having referral system was higher than the respective proportion of private ACFs. As we are aware the referral system in public health care sector is set and is much better compared to that prevail in the private health care sector. However, there existed, though a comparatively smaller number, public ACFs without either of these back-up services. Compared to private R-ACFs, a larger proportion of private NR-ACFs relied upon consultants' services in case of emergencies and had referral system in place. The explanation could be in terms of better supported R-ACF by adequately and appropriately trained APs that we discussed earlier in this chapter.

The trends in general are reverse over urban/rural; private/public and registered/non-registered than that were exhibited till now on other aspects of quality of abortion care.

Table 5.8 Type of back-up in abortion emergencies by characteristics of ACFs

Characteristics of the ACF	Type of back-up available in case of emergencies in abortion care			
	Consultants	Referral	None	Total
Urban	37 (52.1)	5 (7.0)	29 (40.8)	71 (100.0)
Rural	9 (20.5)	18 (40.9)	17 (38.6)	44 (100.0)
Public	7 (43.8)	5 (31.3)	4 (25.0)	16 (100.0)
Private				
Regtrd	6 (26.1)	1 (4.3)	16 (69.6)	23 (33.9)
Non-Regtrd	33 (43.4)	17 (22.4)	26 (34.2)	76 (66.1)
Total	**46 (40.0)**	**23 (20.0)**	**46 (40.0)**	**115 (100.0)**

4. ANAESTHETISTS

Services of a technically competent anaesthetist during the first trimester abortion care are critical to the safety of women undergoing abortion. It is also a legal requirement as per the MTP Act. Second trimester abortion care does not require anaesthesia to be administered. Clinical studies on adequacy and safety of local anesthesia (LA) and general anaesthesia (GA) for abortion procedures have shown that the former is adequate and safe for the first trimester abortion procedures. (ref...). With some exceptions, it is advised that general anaesthesia should not be administered as it involves much higher risks compared to LA. These studies concluded that LA in combination with sedatives is sufficient during the first trimester abortion care. In Indian context, the hospital based studies have shown that providers prefer GA over the LA. (ref..). The often quoted reasons by the providers is that it is easier for them to deal with the woman and the procedure. Further, according to them it cause less or no trouble to women. However, it means more business to them as woman has to pay more for anaesthetic services and also in most of the cases she may have to stay overnight at the institution. The recent studies indicate declining use of GA (ref..). It is, therefore, clear that unnecessary use of GA during the first trimester abortion care is irrational and unethical practice, too. Women are unnecessarily exposed to higher

risks and also are forced to bear unnecessary expenses towards abortion care that she receives.

Anaesthetists are available either in-house constituting the regular staff or may provide services 'on call' basis depending upon the load of surgical procedures requiring such services. Anaesthetists' services are involves substantial fees the reasons of the expertise required and risks involved.

4.1 Profile (Table 5.9): Only 30 anaesthetists were identified during the survey. Males clearly dominated anaesthetic services. Though the majority was qualified, non-qualifieds were not absent. And the latter were from Indian Systems of Medicines.

Table 5.9 Profile of anaesthetists

Characteristics	Frequency
Sex	
Male	21 (70.0)
Female	9 (30.0)
Qualifications	
MD Anaesthesia	13 (43.3)
MBBS, Dipl in anaesthesia	13 (43.3)
BAMS + Anaesthesia course	1 (3.3)
DASF	1(3.3)
BAM&S	2(6.6)

N = 30

4.2 Service contracts (SCs) (Table 5.10): Anaesthetists also formed multiple service contracts. *The thirty anesthetist formed 172 service contracts with 71 ACFs giving an average of 2.4 anaesthetists per ACF.* Thirteen allopaths with diplomas in anaesthesia constituted the majority of (60 %) of SCs. Thirteen of post graduate anaesthetists constituted another substantial number (36.6%) of SCs. The four unqualified indulging into anaesthesia services did not seem to be in demand as they exhibited no additional service contracts.

The average number of service support links show that it is clearly skewed in favour of urban based ACFs; of private based ACFs. Thus, the differentials are more sharp on account of location and type of ACFs. It is slightly more for NR-ACFs compared to R-ACFs.

Table 5.10 Qualification of anaesthetists constituting service contracts by characteristics of ACF

Characteristics of the Institution	Qualification of anaesthetists constituting service contracts					
	Anaesthetists (MDs)	Anaesthetists (MBBS+ diploma)	Non-allopath+ course in anaesthesia	Non-allopaths (DASF/BAMS/ BAM&S)	Total	Average*
Urban	51 (35.2)	91 (62.8)	-	3 (2.1)	145 (100.0)	2.6
Rural	12 (44.4)	13 (48.1)	1 (3.7)	1 (3.7)	27 (100.0)	1.6
Public	4 (33.3)	7 (58.3)	--	1 (8.3)	12 (100.0)	1.7
Private						
Regtrd	20 (42.6)	27 (57.5)	--	--	47 (100.0)	2.2
Non-Regtrd	39 (34.5)	70 (61.9)	1 (0.9)	3 (2.7)	113 (100.0)	2.5
Total	**63 (36.6)**	**104 (60.5)**	**1 (0.6)**	**4 (2.4)**	**172 (100)**	**2.4**

*Average SC constituted by anaesthetists. These exclude 44 ACFs which were not supported by any anaesthetist. Eg. Of the 71 total urban based ACFs, only 55 which were supported were counted while arriving at averages.

4.3.a Service support by anaesthetists (Table 5.11): The 30 anaesthetists were meeting needs regarding anaesthetics services of 71 of 115 institutions from the study area. The rest 44 (38.3%) ACFs did not have these services. It is to be noted that except one, all the ACFs from the sample offered first trimester abortion services which require ACFs to be equipped with these services. The risks involved on account of non-qualified in these services are life threatening and fatal. Against this backdrop then, about 12.12 per cent of non-qualifieds engaged in these services is a distressing situation.

A considerable number of institutions had more than one anaesthetists which is mostly because of the very specific nature of these services (Table 5.11). The advantage of multiple anaesthetists being linked to a particular ACF are obvious given the nature of their 'on-call' nature of services. Multiplicity enhances their availability when required. Thus, it reduces chances either of women being denied abortion care services or of women having to take the trouble of making another visit. Or else they are exposed to unsafe abortion care in absence of qualified anaesthetist in situations of such requirement.

Table 5.11 Service support by anaesthetists

Number of Anaesthetists	Freq & %
Self	1 (0.8)
One	25 (21.7)
Two	19 (16.5)
Three	11 (9.6)
4 & more	15 (13.4)
No anaesthetist	44 (38.3)

N= 115

4.3.b Availability of technically competent anaesthetists by characteristics of ACFs (Table 5.12): To understand as to how many ACFs were equipped with qualified anaesthetist/s, analysis at the level of ACFs was done. From among the multiple anaesthetists providing services at a particular health care facility, the one with highest qualification was considered for this analysis.

Of total urban based ACFs, the majority (74.6%) was supported by qualified anaesthetists' services. Of the total rural based ACFs, only 36.4 per cent were equipped with these services. Of the total ACFs without anaesthetists' services, the rural based ACFs constitute the majority (63.6%, 28 of 44). Except a small number (8.7%), *a large majority of the private R-ACFs were supported by qualified anaesthetists.* The private NR-ACFs had a major share (75%, that is 33 of 44) among those not having these services. However, a little more than half of them were supported by qualified anaesthetists. Of the total public ACFs, only 37.5 per cent were supported by qualified anaesthetists while 62.6 per cent (62/99) of the private ACFs were supported by these services.

The differentials across the analytical categories exhibit similar trends as observed earlier. The urban based ACFs are better placed. Not all public ACFs were supported by these essential services. Not all NR-ACFs were ill-equipped as regards anaesthetists.

Table 5.12 Availability of qualified anaesthetists by characteristics of ACFs

Characteristics of the ACFs	Qualifications of anaesthetists*			Total
	Anaesthetist with MDs &/or Diploma	Not qualified (DASF & BAM&S)	No anaesthetist	
Urban	53 (74.6)	2 (2.8)	16 (22.5)	71 (100.0)
Rural	15 (34.1)	1 (2.3)	28 (63.6)	44 (100.0)
Public	6 (37.5)	1 (6.3)	9 (56.3)	16 (100.0)
Private				
Regtrd	21 (91.3)	--	2 (8.7)	23 (100.0)
Non-Regtrd	41 (53.9)	2 (2.6)	33 (43.4)	76 (100.0)
Total	**68 (59.1)**	**3 (2.6)**	**44 (38.3)**	**115 (100.0)**

*From among various service contracts with a particular institution of anaesthetists, the one with the highest qualification is considered for this analysis.

5. LABORATORY TECHNICIANS (in-house)

Service provision by in-house laboratory technician (LT) are not essential at ACF either legally or medically. However, from women's pespective, these services being in-house is of significance.

5.1 Profile (Table 5.13): There were 47 laboratory technicians who provided pathology services to 41 of the 115 ACFs. The majority of them were males. A large majority (72.3%) of the LTs were diploma holders. Non-qualified constituted a considerable number.

Table 5.13 Profile of Laboratory technicians

Characteristics	Freq	%
Sex		
Male	29	61.7
Female	18	38.3
Qualifications		
Degree in lab tech	1	2.1
Diploma in lab tech	34	72.3
Certificate in lab tech	1	2.1
In-house training/expereince	3	6.4
Non-qualified	7	14.9
No information	1	2.1

N = 47

5.2 Availability of qualified LTs by characteristics of ACFs (Table 5.13): Not all ACFs were supported by services of laboratory technician. A large number (64.4%) of the ACFs did not have LTs as part of their regular staff.

The pattern of availability of these services across urban/rural differs from the earlier trends. In that, a larger proportion of the rural based ACFs are equipped with these facilities compared to urban based ones. Availability of full-fledged patholgy laboratories in urban areas could be one of the plausible explanations for this pattern. The pattern across private R-ACFs and NR-ACFs is in line with the earlier ones. An overwhelming majority of the R-ACFs was equipped with these facilities. Also, a larger number of the public ACFs have these facilities in-house. However, not all public ACFs were in position to have them in-house. The direct implications of these are, either women undergo abortion procedure without providers conducting these tests or if prescribed, women have to get them done from outside which mostly means approaching the private facilities and paying for these tests.

Table 5.13 Availability of laboratory technicians

Characteristics of the Institution	Whether LT is available In-house		Total
	Yes	No	
Urban	23 (32.4)	48 (67.6)	71 (100.0)
Rural	18 (40.9)	26 (59.0)	44 (100.0)
Public	9 (56.3)	7 (43.7)	16 (100.0)
Private			
Regtrd	14 (60.9)	9 (39.1)	23 (100.0)
Non-Regtrd	18 (23.7)	58 (76.3)	76 (100.0)
Total	**41 (35.7)**	**74 (64.3)**	**115 (100.0)**

N = 115, figures in braces are the column percentages.

Of the ACFs supported by in-house services of a laboratory technician, the majority (33 of 44) had one such technician.

6. NURSES

Nursing care constitutes one of the essential services in case of abortion service provision as stated in the Maharashtra State level Rules and Regulations. Availability of nursing care from women's point of view is significant.

6.1 Profile and availability: As generally is the pattern, *women shouldered the responsibility of nursing care.* About 79.1 per cent of the ACFs (91 of 115) did have nurses to attend to their clients' nursing care needs. (Table 5.14). However, of those who did not have nurses, the share of rural based, private ones and the private NR-ACFs were more compared to their counterparts in urban areas, public ones and R-ACFs. *All the public ACFs were supported by nurses. Not all private R-ACFs were supported by nursing care.*

Table 5.14 Availability of nurses

Characteristics of the ACFs	Availabililty of nurses		Total
	Yes	No	
Urban	62 (87.3)	9 (12.7)	71 (100.0)
Rural	29 (66.0)	15 (34.0)	44 (100.0)
Public	16 (100.0)	--	16 (100.0)
Private			
Regtrd	21 (91.3)	2 (8.7)	23 (100.0)
Non-Regtrd	54 (71.1)	22 (28.9)	76 (100.0)
Total	**91 (79.1)**	**24 (20.9)**	**115 (100.0)**

N = 115, figures in braces are the column percentages.

Ninety one of the 115 ACFs (as 24 ACFs did not have any nurses) were supported by 367 nurses. (Table 5.15(a)). *That gives an average of 4 nurses per ACFs.*

6.2. Qualifications/training: *As anticipated about half (52.9%) of the total nursing staff has acquired training in-house. Such in-house trained nurses were employed at about more than half of the ACFs.* (Table 5.15(a)). The rest of the professionally trained nursing staff from each category supported comparatively small number of ACFs, for instance, 49 qualified nurses supported only 15 ACFs.

The listed certificate courses were mostly private run. Most of the ACFs in Baramati tehsil had nurses who completed 'certificate courses' in nursing. This atypical trend could attribute to the nursing training institution that exists in Baramati.

Table 5.15(a) Type of training of nurses

Type of training of nursing staff	Number & % of	
	Nurses	ACFs at which nurses were employed*
Degree holders	49 (13.4)	15 (13.0)
Diploma holders	41 (11.2)	12 (10.4)
Certificate holders	83 (22.6)	28 (24.4)
In-house trained	194 (52.9)	61 (53.0)
Total	**367 (100.0)**	**115**

*** Not mutually exclusive.**

Of the 15 ACFs having degree holder nursing staff, two third were urban based; and one third private R-ACFs was supported by degree holder nurse (Table 5.15(b)). These also tend to be large (in terms of number of beds) set ups. Diploma holders do not seem to exhibit any striking pattern as regards characteristics of ACFs at which they are employed. Certificate holders are more at urban based ACFs and are in private sector.

Table 5.15(b) Formally qualified nurses by characteristics of ACFs

Characteristics of the institutions	Number of ACFs with		
	degree holders	diploma holders	certificate holders
Rural/Urban			
Urban	10	6	21
Rural	5	6	7
Public/private			
Public	10	5	7
Private			
Registered	1	2	5
Non-Registered	4	5	16
Size (Number of beds)			
5 or less beds	-	2	2
6-15 beds	2	4	19
16-25 beds	7	3	5
26 or more beds	6	3	2
Total	**15**	**12**	**28**

6.3 Availability of professionally trained nursing care by characteristics of ACFs: We further analysed as to the extent to which the ACFs were supported by formally qualified nursing care service providers. (Table 5.15(c)). As anticipated, as large as 60 per cent of ACFs had no single formally trained (degree/ diploma/ certificate) nurse. Proportions of ACFs with at least one qualified nursing staff shows an ascending trend along the increasing number of beds at ACFs, indicating a positive association with size of the ACFs. Larger set ups seem more likely to have qualified nursing staff. In general, *the*

pattern is consistent with the earlier ones in that urban based, and private R-ACFs are better placed than their counterparts. The distinct feature is that *all the public ACFs were supported by at least one qualified nurse.*

Table 5.15(c) Availability of qualified nurses by characteristics of ACFs

Characteristics of the ACF	Number of ACFs with		
	At least one qualified nurse	No qualified Nurse	Total
Urban	32 (45.1)	39 (54.9)	71 (100.0)
Rural	14 (31.8)	30 (68.2)	44 (100.0)
Public	16 (100.0)	-	16 (100.0)
Private			
Regtrd	8 (34.8)	15 (68.5)	23 (100.0)
Non-Regtrd	22 (28.9)	54 (71.1)	76 (100.0)
Total	**46 (40.0)**	**69 (60.0)**	**115 (100.00**

7. AAYAS AND WARD BOYS

These constitute the complementary services at ACFs and are important from woman's point of view. Our data show that not all ACFs were supported by these services. (Table 5.16).

7.1 Aayas: The majority (75.7%) of the ACFs were supported by services of aayas. About 236 aayas supported 87 ACFs *giving an average of 2.7 aayas per ACF.* Among those ACFs which did not have, like in other cases, the rural based were more in number compared to the urban based. Not all the public ACFs were supported by these services. This perhaps could be explained with the fact that all the public ACFs were equipped with nurses unlike private ACFs. All the private R-ACFs had aayas to serve the users. The majority (69.7%) of the NR-ACFs too had aayas. *It appears that in the private ACFs, lack of availability of trained nursing care is compensated by services of aayas.*

7.2 Ward-boys: A large number of ACFs (41.7 %) did not have ward-boys. Of the total, 67 ACFs had 169 wardboys giving *an average of 2.5 per ACF.* Proportion of urban ACFs without ward boys was much higher than proportion of the rural based ACFs. The majority of the public ACFs (81.3%) had ward boys. The private NR-ACFs were slightly better place compared to R-ACFs.

7.3 Enquiry attendant: More than half (56.8%) of even the rural based ACFs had a person to attend to the enquiries of the clients. All public ACFs were not equipped with an enquiry attendant. Proportion of the private R-ACFs was more than NR-ACFs as regards these services. We, however, would like to record here that *enquiry attendants were with multiple job responsibilities and were not with the sole task of attending to clients' enquiries.*

Table 5.16 Availability of aayas, ward boys and attendant

Characteristics of the ACFs	Availablility of						Total
	Aayas		Wardboys		Enquiry attendant		
	Yes	No	Yes	No	Yes	No	
Urban	59 (83.1)	12 (16.9)	36 (50.7)	35 (49.3)	47 (66.2)	24 (33.8)	71 (100.0)
Rural	28 (63.4)	16 (36.4)	31 (70.5)	13 (29.5)	25 (56.8)	19 (43.2)	44 (100.0)
Public	11 (68.8)	5 (31.3)	13 (81.3)	3 (18.8)	8 (50.0)	8 (50.0)	16 (100.0)
Private							
Regtrd	23 (100.)	--	11 (47.8)	12 (52.2)	18 (78.3)	5 (21.7)	23 (100.0)
Non-Regtrd	53 (69.7)	23 (30.3)	43 (56.6)	33 (43.4)	46 (60.5)	30 (39.5)	76 (100.0)
Total	**87(75.7)**	**28 (24.3)**	**67(58.3)**	**48 (41.7)**	**72 (62.6)**	**43 (37.4)**	**115 (100.)**

5.7.4 The extent to which ACFs are equipped with all the three services providers, nurses, aayas and ward boys (Table 5.17): Not all ACFs were supported by these services. There were at least 4 ACFs, which did not have either of these staff employed. All of them were private NR-ACFs. And 3 of the 4 were rural based. Also they were with less number of beds. Further, analysis across the three basic analytical categories shows that the trends are in favour of ACFs which are urban based, public ones and the registered.

Table 5.17 Support services of nurses, aayas and ward boys by characteristics of health care institution

Characteristics of the Institution	Service support of nurses, aayas and ward boys				
	None	No nurses*	Nurse/s alone or with wb or aaya**	Nurse/s & aaya/s & wb/s	Total
Urban	1 (1.4)	8 (11.3)	35 (49.3)	27 (38.0)	71 (100.0)
Rural	3 (6.8)	12 (27.3)	14 (31.8)	15 (34.1)	44 (100.0)
Public	-	-	7 (43.8)	9 (56.3)	16 (100.0)
Private					
Regtrd	-	2 (8.7)	11 (47.8)	10 (43.5)	23 (100.0)
Non-Regtrd	4 (5.3)	18 (23.7)	31 (40.8)	23 (30.3)	76 (100.0)
Total	**4 (3.5)**	**20 (17.4)**	**49 (42.6)**	**15 (34.1)**	**115 (100.0)**

* These either were with only ward boys or only aayas or both together but no nurses

** These either were with only nurse, or nurse & aaya, or nurse & ward boy.

Social workers: No single ACFs offered such services.

8. PROFESSIONALLY COMPETENT SERVICE PROVIDER OF ESSENTIAL SERVICES: A COMPOSITE ANALYSIS

For a health care facility to be able to provide safe and legal abortion services to women, it is essential that it is supported by a qualified abortion service providers. Till now, ACFs as regards availability of qualified human power, were assessed independently for each type of service providers. This does not tell us the extent to which a particular ACF, at a time, is equipped with all essential service providers with required and legally stipulated professional competence. ACFs, therefore, are assessed for simultaneous availability of qualified abortion service providers and anaesthetist.

The data show that only 53 institutions are supported by both, the qualified abortion provider/s and qualifed anaesthetist/s. (Table 5.18(a)). Of the total, 29 ACFs do not have either a qualified abortion service provider or a qualified anaesthetist.

Table 5.18(a) Availability of qualified abortion service providers and anaesthetists

Qualification of abortion provider*	Qualification of anaethetist**			Total
	Anaesthetist (MDs &Diploma)	Not qualified anaesthetist (DASF & BAM&S)	No	
Gynaecs (DGOs & MDs)	49 42.6*	1 0.9	11 9.6	61 53.0
Allopaths + MTP trng	4 3.5	1 0.9	5 4.3	10 8.7
Non-gynaec allopaths	11 9.6	–	12 10.4	23 20.0
Non-allopaths	4 3.5	1 0.9	16 13.9	21 18.3
Total	68 59.1	3 2.6	44 38.3	115 100.0

N = 115

* From among multiple abortion service providers, including heads of institution providing aboriton care, the one with the highest qualification (Q_aphtop) is considered for this analysis.

** anaethetists, the one with the highest qualification (Q_antop) is considered for this analysis.

Only about 57.7 per cent of the urban based ACFs are equipped both with a qualified abortion service providers and a qualified anaesthetist. (Table 5.18(b)). Three quarters of the public ACFs are not equipped with these two essential services simultaneously. A large majority (82.6%) of the private R-ACFs are equipped with these two essential services at a time. Of the total private NR-ACFs, two fifths are equipped with these services. Larger ACFs tend to be better equipped with these two essential services.

In general, the trends across urban/rural; public/private and registered/non-registered are in line with those seen in case of various other structural aspects of quality of care.

Ill-supported public ACFs and private R-ACFs and reinforces the two arguments, among others, those emerged from the data trends. One, the registered status of a particular ACF does not ensure safe abortion and not all public health care facilities engaged in abortion care necessarily meet all the legal requirements. Two, not all non-registered ACFs are unsafe as regards abortion care services. Consequently, it also confirms the issues that were discussed from time to time in earlier part of the report about medical fraternity's low compliance and poor monitoring of the legislative measure by the state administrators, in general.

Table 5.18(b) Characteristics of ACFs equipped with Qualified abortion service providers and anaesthetists

Characteristics of the ACFs	Number of ACFs with		
	Qualified APs & AN	Non-qualified AP & AN or no services	Total
Urban	41 (57.7)	30 (42.3)	71 (100.0)
Rural	12 (27.3)	32 (72.7)	44 (100.0)
Public	4 (25.0)	12 (75.0)	16 (100.0)
Private			
Registered	19 (82.6)	4 (17.4)	23 (100.0)
Non-Registered	30 (39.5)	46 (60.5)	76 (100.0)
Total	**53 (46.1)**	**62 (53.9)**	**115 (100.0)**

9. SUMMARY & CONCLUSIONS

Providers of essential services

- **Only a little more than a half of the APs were qualified. More than a quarter were untrained (for abortion procedures) non-allopaths and about one fifth were untrained allopaths.**

- About **two fifths (38.3%) of the ACFs did not have a single qualified AP** About one fifth of the ACFs were served only by untrained non-allopaths. A little more than two fifth of the public ACFs did not have a single qualified AP. Except a small percentage (8.7) all the private R-ACFs were served by qualified AP. About a half of the NR-ACFs were served by a qualified AP.

- **In all, 30 anaesthetists supported 71 ACFs.** Four of the 30 were non-qualified anaesthetists.

- **About two fifth (38.3%) of the ACFs were not at all supported by anaesthetists.** A little more than a half of the public ACFs were not supported by any anaesthetist's services. A large majority of about four fifth of the private R-ACFs were equipped with anaesthetist's services. About more than a half of the private NR-ACFs were supported with anaesthetist/s.

- **Only 53 per cent of the ACFs were equipped simultaneously with the essential qualified service providers, both APs and ANs.** About three quarters of the public ACFs were not equipped with these essential service providers comprehensively. An overwhelming majority of about more than four fifth of the private R-ACFs were supported by essential service providers. About two fifth fo NR-ACFs were also supported simultaneously by these essential service providers.

- It once again proves that **neither the public ACFs nor the private R-ACFs comply with the MTP Act as regards stipulated qualifications of essential services such as abortion provider and anaesthetist.**

- At the same, it again proves that **not all NR-ACFs are unsafe as regards abortion service provision.**

Providers of complementary services

- **In all 47 LTs supported 41 ACFs. Of these the majority (70.3%) were diploma holders.**

- **The majority (64.3%) of the ACFs did not have in-house services by laboratory technicians.** About two fifth (43.7%) of the public ACFs were lacking such in-house services. About three fifth of the private R-ACFs were equipped with these services in-house.

- **About half (52.9%) of the nursing staff was trained only in-house. About 13.4 per cent were degree holders; 11.2 per cent were diploma holders and 22.6 per cent were certificate holders.**

- **About three fifth of the ACFs did not have a single formally trained nurse. And About one fifth (20.9%) of the ACFs were without any nursing care services.** All the public ACFs were equipped with at least one trained nurse. Only about one third of the R-ACFs had nursing care available by professionally trained one. About one third of the NR-ACFs were equipped with such nursing care.

- **About** a quarter of the ACFs did not have any aayas. Only about three fifth ACFs had wardboys.

- **Thus, a substantial number of ACFs are poorly equipped as regards essential service providers as well as complementary service providers.**

Table 6.2 Availability of qualified abortion service providers and all the minimum required life saving drugs

Qualification of abortion provider *	Availability of life saving /emergency drugs**			Total
	Completely*** stocked	Partially stocked	Lack of life saving drugs	
Gynaecologists (MDs & DGOs)	44 (72.1)	17 (27.9)	--	61 (100.0)
Allopaths + MTP trng	4 (40.0)	6 (60.0)	--	10 (100.0)
Non-gynaec allopaths	13 (56.5)	9 (39.1)	1 (4.3)	23 (100.0)
Non-allopaths	8 (38.1)	11 (52.4)	2 (9.5)	21 (100.0)
Total	**69 (60.0)**	**43 (37.4)**	**3 (2.6)**	**115 (100)**

*From among various service contracts with a particular institution including heads of institution providing abortion care (Q-aphtop), the one with the highest qualification is considered for this analysis.
** Nine drugs were listed as life saving/emergency drugs.
***ACFs with all 9 of them are coded as 'Completely stocked';
with less than 9 of them are coded as 'partially stocked' &
with no drugs are coded as 'lack of life saving drugs'.

2. PHYSICAL STANDARDS AND HUMAN POWER: ANAESTHETISTS' SERVICES

Availability of qualified anaesthetist and complete set of the instruments/equipment required for anaesthesist services (Table 6.3): Such a comprehensive assessment shows that 26 of 115 ACFs meet these requirements and thus are comprehensively equipped for anaesthetist services.

Table 6.3 Availability of qualified anaesthetist and complete set of instruments/equipment for administering anaesthesia

Qualification of anaesthetist	Availability of essential equipment for anaesthesia and resuscitation*				Total
	Completely** equipped	Partially equipped	Lack of equipment	No Infn	
Qualified (MDs & Diploma)	26 (38.2)	42 (61.8)	--	--	68 (100.0)
Not qualified (DASF & BAM&S)	--	3 (100.0)	--	--	3 (100.0)
No anaesthetist	5 (11.4)	23 (52.3)	13 (29.5)	3 (6.8)	44 (100.0)
Total	**31 (27.0)**	**68 (59.1)**	**13 (11.3)**	**3 (2.6)**	**115 (100.0)**

*From among various service contracts with a particular institution (Q-antop) of anaesthetists, the one with the highest qualification is considered for this analysis.
**Six instruments/equipment were listed as minimum physical standards requirement for administering anaesthesia and/or to meet resuscitation needs.
***Completely equipped: ACFs with all six instruments/equipment
Partially equipped : ACFs with less than six instruments/equipment
Lack of equipment : ACFs with none of the six instruments/equipment

3. PHYSICAL STANDARDS AND HUMAN POWER: A COMPREHENSIVE ASSESSMENT OF ABORTION CARE SERVICES

A particular ACF could be considered as structurally sound as regards quality of abortion care services if it is supported simultaneously by at least one qualified AP, a qualified anaesthetist and is equipped with complete sets of instruments/equipment for abortion procedure, for administering anaesthesia and all the minimum required life saving drugs.

Such a comprehensive assessment (Table 6.4 (a) and alternatively 6.4(b)) shows only a meagre number of 13 of 115, (11.3 %) are equipped for providing abortion care services. In a stricter sense, only these many are in position to offer safe abortion care services.

The trend of urban based ACFs being better than rural ones and R-ACFs than NR-ACFs continues. Of the public ACFs only one is equipped to provide safe abortion care. (Table 6.5).

Table 6.4(a) Physical standards and human power: A comprehensive assessment

Qualification of abortion provider	Qualification of anaesthetist	Availability of essential equipment & life saving/emergency drugs***					Total
		All essentials	Three essential	Two essential	One essential	None	
Gynaecs (DGOs.& MDs)	Qualified*	12 (24.5)	25 (51.0)	8 (16.3)	4 (8.2)	-	49 (100.0)
	Not qualified**	-	1 (100.0)	-	-	-	1 (100.0)
	No anaesthetist		5 (45.5)	4 (36.4)	1 (9.1)	1 (9.1)	11 (100.0)
Sub-Total		**12 (19.7)**	**31 (50.8)**	**12 (19.7)**	**5 (8.2)**	**1 (1.6)**	**61 (100.0)**
Allopaths + MTP trng	Qualified	1 (25.0)	1 (25.0)	2 (50.0)	-	-	4 (100.0)
	Not qualified	-	-	-	1 (100.0)	-	1 (100.0)
	No anaesthetist	-	-	3 (60.0)	2 (40.0)	-	5 (100.0)
Sub-Total		**1 (10.0)**	**1 (10.0)**	**5 (50.0)**	**3 (30.0)**	-	**10 (100.0)**
Non-gynaec allopaths	Qualified	3 (27.3)	4 (36.4)	3 (27.3)	1 (9.1)	-	11 (100.0)
	Not qualified	-	-	-	-	-	-
	No anaesthetist	1 (8.3)	1 (8.3)	8 (66.7)	2 (16.7)	-	12 (100.0)
Sub-Total		**4 (17.4)**	**5 (21.7)**	**11 (47.8)**	**3 (13.0)**	-	**23 (100.0)**
Non-allopaths	Qualified	1 (25.0)	3 (75.0)	-	-	-	4 (100.0)
	Not qualified	-	-	1 (100.0)	-	-	1 (100.0)
	No anaesthetist	-	1 (6.3)	4 (25.0)	5 (31.3)	6(37.5)	16 (100.0)
Sub-total		**1 (4.8)**	**4 (19.0)**	**5 (23.8)**	**5 (23.8)**	**6(28.6)**	**21 (100.0)**
Grand Total		**18 (15.7)**	**41 (35.7)**	**33 (28.7)**	**16 (13.9)**	**7 (6.1)**	**115 (100.0)**

* (MDs & Diploma) ** (DASF & BAM&S)

Table 6.4 (b) Physical standards and human power: A comprehensive assessment

Qualification of abortion provider *	Qualification of anaesthetist **	Availability of essential equipment & life saving/emergency drugs***		Total
		all essential	Not all/none	
Qualified Gynaecs (DGOs & MDs)/ Allopaths + MTP trng	Qualified (MDs & Diploma)	13	40	53
	Not qualified/not available	- --	18	18
Sub-Total		**13**	**58**	**71**
Not qualified (Non-gynaec allopaths or non-allopaths)	Qualified (MDs & Diploma)	4	11	15
	Not qualified /not available	1	28	29
Sub-Total		**5**	**39**	**44**
Grand Total		**18**	**97**	**115**

Table 6.5 Characteristics of ACFs with qualified service providers and completely equipped with minimum physical standards

Characteristics of the institutions	Number of ACFs
Rural/Urban	
Urban	10 (76.9)
Rural	3 (23.1)
Public/private	
Public	1 (7.7)
Private	
Registered	7 (53.9)
Non-Registered	5 (38.5)
Size (Number of beds)	
5 or less beds	-
6-15 beds	4 (30.8)
16-25 beds	5 (38.5)
26 or more beds	4 (30.1)

N = 13

Chapter VII

THE MTP ACT: KNOWLEDGE AND PERCEPTIONS OF THE HEADS OF INSTITUTIONS AND THE PROVIDERS

1. The MTP Registration Procedure
   - 1.1 Efforts made and problems encountered during MTP registration
   - 1.2 Why MTP registration was not tried for?
   - 1.3 Suggestions and improvement
   - 1.4 Compliance with the MTP Act

2. Content of the MTP Act
   - 2.1. Physical standards
   - 2.2. Qualification of abortion providers
   - 2.3. Comparability of qualifications of provider as stipulated in the MTP Act
   - 2.4. Minimum qualifications for the assistant doctors
   - 2.5. Minimum qualifications for the assistant nurses

3. The MTP training facilities
   - 3.1 Avenues to learn MTP skills
   - 3.2 Training facilities offered by the government
   - 3.3 The training in counselling
   - 3.4 Prevailing MTP training facilities

4. The legal requirement of blood bank: How scientific and feasible
   - 4.1. Availability of blood banks in the study area
   - 4.2. The need for blood transfusion during MTP

5. Summary and conclusions

Chapter VII

THE MTP ACT: KNOWLEDGE AND PERCEPTIONS OF THE HEADS OF INSTITUTIONS AND THE PROVIDERS

There prevails a large number of private non-registered abortion care facilities everywhere. The findings, especially on 'physical standards' and 'human power', the structural aspects of quality of abortion care, presented earlier in the report clearly bring out the fact that compliance on part of the medical fraternity is extremely poor. It is therefore logical to explore with the HIs and APs as to what views they hold about the legislation and what problems do they face as regards complying with the legislative measures. Non-compliance on their part, obviously, would have impact on women's access to safe and legal abortion care. Perspectives of heads of the institution and providers, therefore, assume a significance in provision of quality abortion care services to women.

This chapter focuses on the knowledge and perceptions of the heads of the institutions and the providers. The data, however, needs to be viewed in the larger socio-political context. As we know, the MTP Act, in addition to specifying 'the situations under which women could seek abortion care', deals with two major aspects of health care institutions: one, it talks about the minimum physical standards in health care institutions providing MTP care; two, it stipulates minimum qualifications for abortion providers. Besides, the complementary *'Rules and Regulations', Maharashtra State* specifies the minimum qualifications that the assistant providers and assistant nurses must have. We, therefore, designed a set of questions (semi-structured) to administer to the **HIs** (115 respondents) about physical standards of institutions, and, another set of questions for providers (116 respondents) about qualifications of providers, assistant providers and assistant nurses.

The chapter presents the data on knowledge and perceptions of **a) the heads of the institutions (HIs)** and **b) the abortion service providers (APs)**, about different issues related to the MTP Act. **HIs** were asked about their: awareness about the MTP Act, experiences of the registration procedure, suggestions for improving the registration procedure, and opinions about the minimum physical standards that are laid down in the MTP Act. Views of **APs** were sought on: the minimum qualifications for abortion providers (doctors and assistant doctors), minimum qualification for the assistant nurses, MTP training facilities with related issues, and their experiences of the same. However, these data in isolation, without having been complemented by facts about ground realities would not have provided the required insights. Therefore, interviews were conducted with **c) representatives of the bureaucracy and the faculty of teaching hospitals**. They have given information mainly about the MTP training facilities and related matters. They have also talked about availability and spatial distribution pattern of the blood banks and related matters.

Based on the analysis of data[1], we arrived at some concrete recommendations for improving women's access to safe and legal abortion. Towards the end of the chapter, we have raised a few issues which lie outside the limited scope of abortion care and MTP Act.

---

[1] Descriptive responses were quantified to arrive at the figures.

1. THE MTP REGISTRATION PROCEDURE

Heads of the institutions are involved in MTP registration procedures. We, therefore, elicited the data on these issues from them and not from abortion service providers.

The public health care institutions engaged in abortion care services do not have to undergo the registration process like the private ones do. Therefore, the 16 public health care institutions in our sample of 115 institutions were not asked about registration. Of the remaining 99 private institutions, 23 were registered. Of the 76 non-registered institutions, **HIs** of 28 had tried for registration, while those of 48 had never tried for it.

1.1 Efforts made and problems encountered during MTP registration: We could elicit data on the problems encountered during the registration process from only 51 (23 registered, and 28 that tried but could not get registration) of the total respondents.

Ten of the 23 **HIs**, who had registered, said that they **did not encounter any problems**. **Four** mentioned that problems encountered were for the reasons of **mismanagement at the government offices** and **two** others attributed them to **corruption** there. **Seven** of them said that the procedure was very **tedious and time consuming**.

Heads of 28 institutions **could not register despite efforts**. They mentioned various reasons for it. (See Table 1).

Table 1: Why the institution did not get MTP registration?

Reasons	N (%)
• No response from the government/concerned authority	16 (57.1)
• Did not meet the criteria stipulated in the MTP Act	4 (14.3)
• Other (not pursued/in process/applications were not available)	8 (28.6)

N=28 (responses of 28 of 76 non-registered who had tried for MTP registration)

According to 16 **HIs**, the government authority was responsible for this. The concerned authority either never responded to their applications, or the inspecting authorities never turned up or, the application form was not available. Some also added that the concerned authorities/offices were ill-informed and misguided them. Often, multiple reasons were given. Some of the reasons given are quoted here:

1. "Have applied (for registration) but haven't yet got it. Even DHS office does not know about it. Application forms are not available when one wants to have one. We then requested to one of the officers there. He told us,

"if you register your centre for MTP, you have to offer abortion services at very low fee. Instead, registration for FP (family planning operation) is more profitable because of the government grants.".

2. If you ask (them) for MTP registration, they keep looking at each other. Not only that, they further told us,

"since you both are qualified, (you) need not seek registration. You are qualified to conduct MTPs"."

Heads of four institutions reasoned that the legal criteria for registering a centre are too stringent and it is not practically possible to meet the conditions. These are some more responses:

3. "No (access to the) blood bank and therefore refused the registration".

4. "A sister (nurse) is required. Here, (we) don't get the trained staff. Therefore refused (the registration)".

5. "Overall it is a serious problem... Blood bank is required. Qualified nurse is required. These (criteria) are very problematic (to meet with). Otherwise, I do meet the physical standards (as per the MTP Act). ..."

1.2 Why MTP registration was not tried for: Forty-eight HIs had never tried for registration either because of lack of information about the registration procedure or because they knew that their institutions did not meet the legal specifications or because they were ill-informed about the MTP Act and related matters. (See Table 2)

Table 2: Why MTP registration was not tried for?

Reasons	N (%)
• Lack of information about the registration process	6 (12.5)
• Know that the conditions stipulated in the Act would not have been met	11 (22.9)
• Misconceptions about what is stipulated in the Act	9 (18.8)
• Other	9 (18.8)
• No specific reason mentioned	13 (27.1)

N=48 (responses 48 of 76 non-registered who never had tried for MTP registration and did not get it)

Those who feared that their applications would not be considered were either not qualified or were in the government service or generally felt that they did meet the criteria stipulated in the MTP Act. Their responses tell us that they were conscious of their illegal MTP practice:

1. "I have done a course in Homeopathy. How could I get (an MTP) registration?".

2. "(I am a) government employee. (My) wife is a BAMS. Registration, therefore, can't be (done) on my name. Now that I am gradually settling in my practice, once (I have) settled (I) would leave government job. I, then, would seek a registration".

The ill-information was of a wide range:
'small clinics do not require registration', 'gynaecologists do not require to seek separate registration', 'recognition as family planning centre implies recognition for MTP practice', 'private practitioners are not allowed to conduct MTPs', 'such a registration is not required for MTP practice', 'registration is not required for conducting MTPs for married women', 'registered with the Medical Council and therefore does not require MTP registration'. One respondent says:

3. "... There is no problem in case of (abortions of) marrieds. After all, it is only a minor surgery. However, if (abortion cases are of) unmarrieds, one definitely needs to seek permission (registration) for..."

Of the 48 **HIs** who never tried for registration, 41 were either 'non-gynaec allopaths' or 'non-allopaths'- the non-qualified as per the MTP Act for conducting abortions.

1.3 Suggestions for improvement: Suggestions made by the **HIs**, regarding the registration procedure, were based on their own experiences or on those of their colleagues. An open-ended questionnaire was used for this purpose. (See Table 3).

Table 3: Suggestions for improving MTP registration procedure

Suggestion	N(%)
1. Registration should come through within a short time span which should be stipulated in the Act explicitly	31 (27.0)
2. The registration procedure should be simplified	23 (20.0)
3. Government/concerned authority/offices should be responsive to the applications made	8 (7.0)
4. Access to information should be improved	5 (4.3)
5. Some flexibility should be exercised while inspecting the physical standards	8 (7.0)
6. Authority to sanction MTP registration should be decentralised	13 (11.3)
7. Blood bank requirement is impractical to meet and therefore should be removed	5 (4.3)
8. Training module for non-allopaths should be designed to enable them to practice MTP	7 (6.1)
9. Quality MTP training module should be made available and accessible to those who desire to learn MTP technique	3 (2.6)
10. The level of stipulated qualifications/experience either of providers or assistant providers or nurses should be brought down	14 (12.2)
11. The qualified medical practitioners should not be asked to seek MTP registration separately	10 (8.7)
12. Others	14 (12.2)

Note: These data are elicited from responses to an open ended question. A respondent has offered more than one suggestions. Responses, therefore, do not add up to 115, the total number of heads of the institutions. However, the percentages are calculated with N=115.

1.3.1 The registration procedure[2]: The suggestions were not so much to overhaul the registration procedure. Instead, the concern seemed to be more about poor implementation of the MTP Act on part of bureaucrats and the concerned offices. In the table above, the suggestions from (1) to (6) are mainly about improving the 'how' of the registration procedure. Major concern behind the suggestions seems to be the urge to enhance substantially the operational effectiveness. **HIs** feel that once made, the application should either be passed or rejected as quickly as possible. In case of rejection, the applicant should be given an explanation. **HIs** perceived that this situation could be improved by 'decentralization of the sanctioning authority'.

[2] Medical Termination of Pregnancy Rules, 1975, Section 4 (Annexure 2.9)

The delay in sanctioning MTP centres was attributed to the centralized sanctioning system at *MTP cell, DHS, Mumbai*.

1. "The (registration) procedure is lengthy. Too many documents are required. Criteria to be met are very stringent. Government should take initiative and sanction MTP centres in proportion of population. (Government) should provide the centres with required resources and should disseminate the required information."

2. "... We have to struggle hard for these things (registration). (It) should not take so much time. How could we find time to visit (the concerned offices) so frequently?"

3. "... Here there is a big Civil Hospital (government hospital). An authority to sanction should be given to them. And for that matter even to PHCs. They know everything. DDHS also should be authorised. An hospital can't be run without basic facilities. The entire bureaucratic procedure, therefore, should be simplified".

4. "... Red tapeism (bureaucratic functioning) should be stopped.... Upon receipt of an application, 'yes' or 'no' should immediately be communicated to (the applicant) after an (required/prescribed inspection. Doctors don't want to run the risk because of CPA[3] If so, the needy don't have access to (abortion) services."

1.3.2 Physical standards[4], and qualifications of doctors[5] and nurses: Suggestions (8) to (12), (41.8% of the total), in Table 3 fall in this category. Fourteen respondents felt that the stipulated qualifications for providers and/or assistant providers and/or nurses were over-prescribed. Three mentioned the inadequacies in the MTP training facilities. Seven explicitly mentioned the need of designing the MTP training module. This, according to them, would allow non-allopaths to practice MTP within the legal framework. As one would have anticipated, such responses came from non-allopaths. As against this, the suggestion that the 'qualified (gynaecologists) should not be expected to seek MTP registration separately' came mostly from the gynaecologists. Some of them explicitly mentioned that the non-qualified should not be given MTP registration.

Though these conflicting views, and, the attitude of medical fraternity to safeguard their own interests are not revealingly new, they certainly raise a wider issue of whether to allow non-allopaths to practice MTP. The issue is complex because it has direct implications for women's access to safe and legal abortion and also because a large number of non-allopaths are involved in abortion care. Empirical data from our survey as well as other similar surveys indicate that the qualified providers and/or MTP registration status of the institution do not necessarily ensure 'access to safe abortion care'. If so, the issue of involvement of the non-allopaths or even those allopaths not trained in MTP procedures calls for a wider debate.

The suggestion that 'the expected level of qualifications of providers/assistant providers/nurses should be brought down' was elaborated upon on two points. Firstly, unavailability of such skilled staff, especially the assistant doctors and trained/degree holder nurses in rural as well as

---

[3] The Consumer Protection Act.
[4] Medical Termination of Pregnancy Rules, 1975, Section 4, sub-section 1(ii) (Annexure 2.9)
[5] Medical Termination of Pregnancy Rules, 1975, Section 3 (Annexure 2.9)

in urban areas and in private as well as in public health care institutions was argued. Secondly, it was felt that such trained assistance was not required for MTP procedure. The providers expressed the same views on this issue. They will be discussed elsewhere in this chapter.

1.4 Compliance with the MTP Act: By and large **HIs** were found to be either ignorant or ill-informed about the following two post-registration legal requirements:

1.4.1 Informing the concerned office about the change in MTP provider: Only 6 of the 39 heads of the registered institutions (**HRIs**) knew that it was necessary to inform the concerned office when MTP provider was changed. Except one, the rest five were aware of the underlying legal rationale: the minimum qualification for the provider laid down by the MTP Act. Four of the **HRIs** did not know about it. Thirteen said that they did not or would not inform such a change to the concerned offices. The explanations offered by them were, 'since the providers are trained/qualified, they did not/would not feel the need to inform', 'the Act did not mention so', 'such a communication was required in case the head of the institution changed'.

1.4.2 Reporting of the MTP cases and the periodicity of reporting[6]: As per the MTP Act, registered centres are expected to send a weekly statement of MTP cases to the Chief Medical Officer of the State. The majority (32 of 43) of **HRIs** stated that they had been reporting MTP cases. The reporting offices mentioned include Civil Hospitals, Zilla Parishad, DHS-Mumbai, DDHs, Circle, and, Primary Health Care Centre. Except one, the rest said that they reported every month. However, the information that we have from the respective offices does not match with these data, both in terms of number of institutions claimed to have reported and the number of the MTP cases. It seems that though they were aware of the legal requirement of reporting, they were ill-informed about its periodicity and the reporting office.

Whether heads of institutions are complying with the legal requirement of reporting, is an important question. Weekly reporting of MTP cases to the concerned offices is impractical. Besides, validity of such data in absence of a monitoring mechanism is also questionable. Such unsystematically recorded data are of little use. Thus, firstly, there is a need to activate the monitoring mechanism to ensure validity of the data. Secondly, the periodicity of reporting also needs to be changed.

At the end of this section we can say that in general, heads of the institution were found to be poorly informed or ill informed about various aspects of the Act. A wide range of misconceptions prevailed among them, especially regarding the legal specifications of physical standards. This appears to have affected the extent of their efforts towards seeking an MTP registration. Once registered, the compliance on their part with legal specifications was rather poor. This reflects their ignorance as well as apathy towards meeting the legal requirements. **The data clearly makes a case for systematic dissemination of information amongst prospective applicants about the MTP Act and the process of registration.**

---

[6] Medical Termination of Pregnancy Regulations, 1975, Section 4, sub-section 5 (Annexure 2.9)

2. CONTENT OF THE MTP ACT

2.1 Physical standards: As stated earlier, **heads of the institutions** were asked to opine on appropriateness of the stipulated physical standards at the institution. An overwhelming agreement (111 of the total 115 respondents) with the stipulated standards indicates that medical fraternity accepts them as essential. Only 4 of 115 **HIs** felt that the stipulated standards laid down in the MTP Act were more than required. According to them, the instruments for abdominal surgery were unnecessary for the MTP procedure.

Against this backdrop, as discussed in the chapter on physical standards, it is disappointing that in reality the physical standards at their institutions were nowhere close to those stipulated in the MTP Act.

2.2 Qualification of abortion providers: The minimum qualifications laid down for an MTP provider are part of the Central Act. The MTP Act states that a medical doctor is eligible to provide abortion services if he meets one of the three conditions. **Abortion providers** were asked to opine on appropriateness of qualification stipulated for them. According to the MTP Act, the MTP provider must have one of the three qualifications (Annex 2.9). Their responses about appropriateness of these three qualifications vary to a great extent (See Table 4). It, therefore, suggests that these three conditions are not comparable according to the providers. This is discussed later in the chapter.

Table 4: Whether the stipulated qualifications in the MTP Act are overprescribed, appropriate or underprescribed?

Qualification	Overprescribed	Appropriate	Underprescribed	Total
For MTP providers				
1. Six months of surgery in gynaecology	15 (12.9)	69 (59.5)	32 (27.6)	116 (100.0)
2. Experience at any hospital for not less than a year in practice of OBGY	15 (12.9)	77 (66.4)	24 (20.7)	116 (100.0)
3. Experience of assisting a registered practitioner in performance of 25 MTP cases in an established hospital	2 (1.7)	52 (44.8)	62 (53.4)	116 (100.0)
For Assisting doctors				
Certificate indicating experience as assistant doctor during abortion procedure and for minimum 2 years at the institution	87 (75.0)	26 (22.4)	3 (2.6)	116 (100.0)
For Nurses				
Qualification certificate, registration with the Maharashtra Nursing Medical Council, and certificate indicating experience as assistant nurse during abortion procedure at the government recognised institution	50 (43.1)	66 (56.9)	-	116 (100.0)

In general, opinions about appropriateness of the first two conditions were less divided. However, they were clearly divided in case of third condition.

In general, providers who felt that the conditions were 'over-prescribed', were concerned with their practical possibility, while those who found the conditions 'under-prescribed' were concerned with the quality of training, experience, and, the grasp of the trainee. The providers who said that either of these conditions was '**over-prescribed**' felt that it was not practical to expect availability of trained doctors anytime & everywhere. Those who said that either of these conditions was '**under-prescribed**' explained that the duration of experience was not very important. Instead, providers' experience gain in terms of hands-on practice covering wide ranging cases and probable complications was important. Some mentioned that the providers should be able to judge the position of uterus and should be confident about it. Many emphasized that assisting MTP procedures was of limited use as far as gaining expertise was concerned. Instead, conducting the procedures on one's own responsibility was very crucial to feel confident about it. Before switching from 'assisting' to 'doing independently', one should perform the MTP procedure under the 'supervision of trainers' as an intermediate stage. Some mentioned that MTPs should be conducted only by gynaecologists. The various other concerns expressed were 'the type of hospital where the trainees are placed', 'the quality of training', 'expertise of the supervisor' and 'grasping level of a trainee'.

Table 5 cross-tabulates opinions of providers about the stipulated qualifications of doctors against their own qualifications.

Table 5. Whether the stipulated qualifications are over-prescribed, appropriate or under-prescribed?

Qualification of the respondent providers	Six months housesurgency in gynaecology & obstetrics				Experience at any hospital in the practice of obstetrics and gynaecology for a period of not less than a year				Experience of assisting a registered medical practitioner in 25 MTP cases at govt. approved centre			
	O. P.	Apr.	U.P.	**Total**	O. P.	Apr.	U.P.	**Total**	O. P.	Apr.	U.P.	**Total**
Gynaecologists (MDs+ DGOs)	2 (4.0)	32 (64.0)	16 (32.0)	**50 (100.0)**	2 (4.0)	37 (74.0)	11 (22.0)	**50 (100.0)**	--	17 (34.0)	33 (66.0)	**50 (100.0)**
Allopaths with MTP training	--	9 (81.8)	2 18.2	**11 (100.0)**	2 (18.2)	7 (63.6)	2 (18.2)	**11 (100.0)**	--	4 (36.4)	7 (63.6)	**11 (100.0)**
Non-gynaec allopaths	6 (26.1)	9 (39.1)	8 (34.8)	**23 (100.0)**	6 (26.1)	12 (52.2)	5 (21.7)	**23 (100.0)**	--	13 (56.5)	10 (43.5)	**23 (100.0)**
Non-allopaths	7 (21.9)	19 (59.4)	6 (18.8)	**32 (100.0)**	5 (15.6)	21 (65.6)	6 (18.8)	**32 (100.0)**	2 (6.3)	18 (56.3)	12 (37.5)	**32 (100.0)**
Total	**15 (12.9)**	**69 (59.5)**	**32 (27.6)**	**116 (100.0)**	**15 (12.9)**	**77 (66.4)**	**24 (20.7)**	**116 (100.0)**	**2 (1.7)**	**52 (44.8)**	**62 (53.4)**	**116 (100.0)**

O. P. = Over-prescribed, Apr. = Appropriate, U. P. = Under-prescribed.

As regards first two conditions there was not much difference across 'qualification of respondent providers'. However, as regards the third condition, non-allopaths, and allopaths other than gynaecologists exhibited a reverse trend than that of gynaecologists, and allopaths with MTP training. More than fifty per cent of non-allopaths and non-gynaec allopaths said that the third condition was appropriate whereas only about little more than one third of the gynaecologists, and the allopaths with MTP training (34.0 % & 36.4% respectively) agreed that it was appropriate.

Doctors' opinions about availability of trained doctors hold true to a great extent. Does this mean that women should be exposed to unsafe abortion care in the absence of trained doctors? Or

should we address the issue by taking some measure to improve the situation? Doctors' emphasis on the importance of hands-on training is also rational. The question is how could this concern be translated into a reality? Rationality of these responses get rather tainted when we observe that qualifications of respondent doctors are affecting their responses (See Table 5). It actually alerts us about the vested interests of doctors of various systems of medicines who are engaged in abortion care. We will take this argument ahead in the discussion towards the end of the chapter.

2.3 Comparability of qualifications of provider as stipulated in the MTP Act: We, earlier had made reference to the fact that opinions of the providers about appropriateness of qualifications (medical education and/or training experience vis-à-vis the MTP Act) of doctors as stipulated in the MTP Act did not follow quite the same pattern. This, we considered as a pointer to providers' perception/ understanding that these were not comparable. Providers did not feel that fulfilling one of these stipulated conditions would fetch equal level of expertise (See Tables 6 & 7). If this is the case, this needs to be debated between medical fraternity on one hand, and policy makers on the other.

Table 6: Comparison among stipulated qualifications of the abortion providers: Providers' perceptions

Opinions of providers	Number & %
All 'a', 'b' & 'c' are appropriate	36 (31.0)
Only 'a' and 'b' are appropriate	26 (22.4)
Only ('a' and 'b') or ('a' and 'c') are appropriate	6 (5.1)
All 'a', 'b' and 'c' are underprescribed	20 (17.2)
Others	28 (24.1)

N = 116

a: Six months of surgency in gynaecology & obstetrics
b: Experience at any hospital for not less than a year in practice of OBGY
c: Experience of assistance to a registered practitioner in performing 25 MTP cases in an government approved hospital for such practice

Table 7: Opinions about comparison by respondent providers among stipulated qualifications of providers by qualification of respondent providers

Qualification of respondent providers	All Appropriate	'a' & 'b' appropriate	'a' & 'c' or 'b' & 'c' appropriate	All Under-prescribed	Others*	Total
Gynaecologists (MDs + DGOs)	15 (30.0)	15 (30.0)	2 (4.0)	10 (20.0)	8 (16.0)	**50 (100.0)**
Allopaths with MTP trng	3 (27.3)	4 (36.4)	1 (9.1)	2 (18.2)	1 (9.1)	**11 (100.0)**
Non-gynaec allopaths	6 (26.1)	2 (8.7)	1 (4.4)	4 (17.4)	10 (43.5)	**23 (100.0)**
Non-allopaths	12 (37.5)	5 (15.6)	2 (6.3)	4 (12.5)	9(28.1)	**32 (100.0)**

Total	**36 (31.0)**	**26 (22.4)**	**6 (5.2)**	**20 (17.2)**	**28 (24.1)**	**116 (100.0)**

* 'Others' constituted various other combinations and clubbed together as they were not of significance to the issue at hand.

2.4 Minimum qualifications for the assistant doctors: Abortion providers were asked to opine on appropriateness of minimum qualification stipulated for assistant providers. Three quarters of the providers stated that the stipulated qualifications were 'more than required' (See Table 8).

Table 8: Opinions about appropriateness of stipulated qualifications of assistant doctors by qualification of respondent providers

Qualification of the respondent providers	Over prescribed	Appropriate	Under prescribed	Total
Gynaecologists (MDs+DGOs)	40 (80.0)	9 (18.0)	1 (2.0)	50 (100.0)
Allopaths + MTP trng	8 (72.7)	2 (18.2)	1 (9.1)	11 (100.0)
Non-gynaec allopaths	18 (78.3)	5 (21.7)	--	23 (100.8)
Non-allopaths	21 (65.6)	10 (31.3)	1 (3.1)	32 (100.6)
Total	**87 (75.0)**	**26 (22.4)**	**3 (2.6)**	**116 (100.0)**

Most of the providers felt that such an assistant is not required. Some of them informed that such an assistant was not available. Some of the opinions stated by the providers are:

1. "Assistant doctor is not required. He does not do the actual procedure. It is a very minor procedure. Assistance is not needed."

2. "(Why is) an assistant doctor required? Not even a sister (nurse) is required. I conduct even tubectomy (procedure) on my own. I have trained myself. Assistance is not required even for suction as I do it with (suction machines with) foot pump."

Providers also aired their frustrations with the existing MTP training facilities:

3. "The one who actually performs the surgery has the job to do. The other one (is) there only to assist. With such great difficulty that we underwent training. Where the assistant (providers) will have opportunities for such training? Sassoon (the state run hospital in Pune) has closed down such a training."

Those 22.4 per cent providers who felt that the stipulated minimum qualifications were appropriate, offered various explanations. A few felt that this was how an experience could be gained. The other explanations were: 'if the MTP provider is a medical doctor with only MTP training, such an assistance is essential', 'it was better to have such an assistance in case of complications', 'it is preferable if there are a number of MTP cases to be attended to at a time', 'in case of second trimester MTP cases'.

4. "(Qualified) assistant doctor is essential. In case an artery ruptures, assistance of skilled hands proves to be of great help."

Opinions do not vary across 'qualification of respondent providers'. That is to say majority of the providers regardless of their own qualification, felt that the stipulated qualifications for the

assistant provider were 'more than required'. However, percentages did show variation. In that, about 80 per cent of the gynaecologists treated these qualification as over-prescription and comparatively less number of non-allopaths felt the same way. It perhaps is a pointer to the fact that, generally, non-allopaths rather than gynaecologists would prefer to have an assistant provider (See Table 8).

The fact that there is no consensus among the respondent providers about the requirement of an assistant provider, indicates that the issue needs to be discussed. It generally hints at bringing some appropriate amendments in the concerned state level 'Rules and Regulations'. The discussion among the medical professionals and the other stakeholders (bureaucrats, women activists etc.) would help attending to this need. Therefore, the perceived 'over-prescribed' and/or 'unnecessary' legal requirements must certainly be obstructing registration of institutions.

2.5 Minimum qualifications for assistant nurses: Abortion providers were asked to opine on the appropriateness of stipulated qualification for the assistant nurses. There appeared a clear divide among the providers on this issue. A little more than half of them felt that assistance of such a qualified nurse was 'more than required' and the rest felt that it was appropriate. No one felt that this was 'under-prescribed' (See Table 9).

Table 9: Opinions about appropriateness of stipulated qualifications of assistant nurses by characteristics of providers

Characteristics of providers	Over prescribed	Appropriate	Total
Qualification of the respondent Providers			
Gynaecologists (MDs +DGOs)	19 (38.0)	31 (62.0)	50 (100.0)
Allopaths + MTP trng	2 (18.2)	9 (81.8)	11 (100.0)
Non-gynaec allopaths	11 (47.8)	12 (52.2)	23 (100.0)
Non-allopaths	18 (56.3)	14 (43.8)	32 (100.0)
Total	**50 (43.1)**	**66 (56.9)**	**116 (100.0)**
Public/private based			
Public	4 (22.2)	14 (77.8)	18 (100.0)
Private	46 (46.9)	52 (53.1)	98 (100.0)
Total	**50 (43.1)**	**66 (56.9)**	116 (100.0)

The explanations offered for 'over-prescribed' show that nursing assistance is not required for abortion procedure (See Table 10).

Table 10: Whether the stipulated qualification of Assistant nurse is appropriate?

Over-prescribed, because	Freq & %	Appropriate, because	Freq & %
1. In-house trng/experience of assisting operative is sufficient	25 (50.0)	1. because such a trained assistance is required	20 (30.2)
2. Such a trained nursing assistance is not required during MTP procedure	20 (40.0)	2. but practically not possible to have such a trained assistance	29 (44.0)
3. No explanation offered	5 (10.0)	3. No explanations offered	17 (25.8)
Total	50 (100.0)	Total	66 (100.0)

Some of them referred to the economics involved in it. Over-prescription was also perceived in terms of 'impracticability' of such a demand.

1. "She (nurse) has minimum role to play (in abortion surgery/procedure) and therefore need not be a registered one."

2. "In rural areas, it is rare to get qualified nurses. (Besides,) the provider is responsible (for the procedure). He does train them (in-house). Hardly, Rs 600/ - (for a MTP procedure) are earned. Where would trained nurses' heavy salaries be paid from?"

Some poured out their agitation and sour feelings for the policy makers, who, according to them, were far away from understanding the ground realities.

3. *"It is not practical! All these Acts are made (/drafted) in Delhi sitting in Air-conditioned rooms. They don't know what India is!"*

Those who said that such a trained assistance was required re-emphasised the same fact while explaining it (See Table 10). Some suggested ways as to how it could be done:

4. "Number of nursing colleges should be increased. There should be two years' course in Maharashtra. They should undergo an internship of an year in a big hospital. Any hospital should have at least one such (qualified) nurse. Hospitals should not be recognised, otherwise (without such a qualified nurse)."

However, a large number of them also expressed a view that though such a trained assistance was appropriate, it was close to impossible (See Table 10).

5. "Trained nurses should be there. (However), such trained nurses are not available in rural areas even after paying luxuriously (fat salaries). They don't like to be here at small places, (instead) prefer to be in big cities like Pune and Bombay".

The data on 'human power' at these health care institutions have been discussed in the earlier chapters. The majority of the institutions were found to be equipped only with in-house trained 'nurses'. This fact does not match with the claim by some providers that such an assistance was appropriate. This raises wider issues about 'quality of nursing care' that health care institutions offer to users of health care services.

The data presented in this section indicate that there exist colossal gaps between the prevailing situations as regards physical standards as well as qualifications of abortion care providers and the positions taken by the **HIs** and providers on those aspects. Thus it appears that the compliance with the conditions stipulated by the MTP Act on part of the **HIs** and the providers was low. This reflects very clearly on three facts. 1) The MTP Act monitoring mechanisms and systems are almost non-functional. 2) The medical fraternity is trying to give an impression that it wants the situation to 'ideal' as far as physical standards are concerned and that it is beyond their control and they are not responsible if the situation is not ideal. 3) Views as regards 'unavailability of stipulated expertise' or 'impracticability' have persisted throughout the data in this section. The disagreement among the respondent providers on the required qualifications for a MTP provider, itself indicates that the three stipulated qualifications do not fetch the same level of experience and competence. These views, therefore highlight a need for a review of the MTP Act afresh.

3. THE MTP TRAINING FACILITIES

3.1 Avenues to learn MTP skills: Providers without formal training in gynaecology (n=66) were asked where they learned to conduct the MTP procedure (See Table 11).

Table 11: Place of learning and employment status of providers while learning MTP skills

Place of learning MTP skills	Employment status				Total
	Formal* (Student)	MTP** training	In-service***	Informal****	
Public hospitals	8(25.8)	12 (38.7)	11 (35.5)	--	31 (100.0)
Private health care institutions	--	--	17 (54.8)	14 (45.2) --	31 (100.0)
Both (pvt & public)	--	--	3 (75.0)	1 (25.0) --	4 (100.0)
Total	**8 (12.12)**	**12 (16.7)**	**31(48.5)**	**15 (22.7)**	**66 (100.0)**

Of the 116 respondent providers, 50 were gyneacologists who are not expected to undergo MTP training over and above their formal diploma or postgraduate courses in gynaecology.
*Formal- during medical education; ** MTP trng : Through MTP training facilities provided under the MTP Act; ***In-service: While employed ; ****Informal: own set-up, relatives, friends.

The data indicate that both, public and private health care institutions had almost equally provided the learning opportunities to providers. However, the formal training, either during medical education or during the MTP training course, had little role to play. It is interesting to note that a very small number of providers had acquired their skills during their formal medical education. A large number of MTP providers had learnt MTP procedures during their service tenures either at private or at public health care institutions.

A substantial number of providers had picked up MTP skills informally, at private health care institution, either at their own setups or at institutions of their friends or relatives.

These data underscore the dire need of setting up MTP training facilities, easily accessible to those interested doctors. It again reflects on poor monitoring system on part of the concerned government authorities and the need to improve it.

3.2 Training facilities offered by the Government: Eleven of the 115 providers, had undergone MTP training. They were asked to opine on (a) infrastructural facilities available for training, (b) the content of training and (c) the skills of trainer. All of them were satisfied with the infrastructural facilities at the training hospitals. This is not surprising because they underwent training at the government teaching medical hospitals. Most of them said that they were satisfied with training as regards content as well as skills of the trainers. It was either because of the situations were better there than those of their working ones, or sometimes it was attributed to 'experienced and higher education of the trainers', or because trainee were friends with the trainers'. A few also mentioned that a lot depended upon how much initiative was taken by trainee. Two of them were dissatisfied because hands-on practice was not up to their expectations. It was said that the trainers were not interested in trainees. Trainees were hardly trusted in, to conduct the MTP procedure.

3.3 The training in counselling: Currently, formal training in none of the systems of medicines up to bachelor's level includes training in counselling. MTP training modules too do not find any place for training in counselling skills. Against this backdrop, providers were asked if they found such a training necessary. A large number of the providers felt the need for 'training in counselling' to better deal with abortion seeking women (See Table 12 & 13).

Table 12: Should MTP training include training in counselling?

Yes/No	Freq & %
Yes, it should	76 (65.5)
No, not required	40 (34.50)

N = 116

Table 13: Whether training in counselling should be included in the MTP training modules?

Yes, why?	Freq & %	No, why?	Freq & %
1. For the benefits of patients	45 (59.2)	1. It is part of the medical training and practice	29 (72.5)
2. For providers' benefits	20 (26.3)	2. Instead, nurses should be trained for counselling	4 (10.0)
3. For mutual benefits of patients and providers	5 (6.6)	3. Counselling does not help	7 (17.5)
4. It is the responsibility of providers	5 (6.6)		
No explanations offered	1 (1.3)		
Total	76 (100.0)	Total	40(100.0)

The providers who believed that training was essential, felt that counselling might help providers: to persuade women in good faith to continue with the pregnancy, to make women aware of the situation, to deal in a better way with women's psychological pressures, to elicit

required information from women smoothly, to convince women about contraception, to have better dialogue with family members of women etc. Some felt that counselling would reduce the number of MTPs in future.

About 26% of the providers felt that it would be for their own benefit to have a training in counselling (See Table 13). They felt that it would help them to develop better understanding of woman's situation, to form positive attitude about women's abortion needs, to generate healthy dialogue with the women clients in such situation etc.

A large number of those who disapproved of the idea of training in counselling felt that it was very much apart of their medical training and/or providers did practice such counselling for their clients (See Table 13). Four of them felt that such a counselling was more a duty of nurses than that of providers. Seven of them were skeptical about the usefulness of such a counselling to women.

3.4 Prevailing MTP training facilities: We made an attempt to understand the situation at an MTP training centre and interviewed a trainer so as to get a comprehensive picture of the current status of MTP training facilities.

The MTP Act does not detail any of the aspects of the MTP training. We had to interact with concerned office holders[7], in order to find out about the process involved in the enrollment for training. We tried to get information about eligibility conditions for training, the application process, the process of screening of applications, the finance for the training, the institutions authorized for training and the structure of training modules.

3.4.1 Who can apply for the MTP training? We could get relevant information only after interviewing several office bearers. Applications are processed by the Additional Director, Health Services. This responsibility has been transferred from the Directorate of Health Services, Mumbai (State level) to the regional offices. Applications of doctors working in the public health sector with MBBS degree alone are processed through this office. There is no specific application form, per se. A doctor either puts up a request for training himself/herself or his/her superior recommends a candidate for such a training. Either way the application as a part of the procedure has to be forwarded by the superior of the applicant. One of the sources told us that it has been the policy of the government to train as many doctors as possible who are posted at PHCs.

However, according to the information received from those at the government recognised training institution, names of trainees are sent to the concerned training centers (teaching medical hospitals) by Directorate of Health Services (DHS). These may include those serving in public health care sector as well as those who have their private practice. They were not aware of the details of the process and the channel, though. The training institutions do not have any authority to admit trainees for MTP training on their own. But, they seemed to have a say in deciding as to how many trainees from the recommended ones could be admitted at their institution. Information from various sources did match on this aspect.

[7] These include, a bureaucrat at the DDHS, Pune; the Office of Additional Director of Health Services situated at the State Dept of Family Welfare; and an office holder and trainer at the medical teaching hospital.

One of the sources told us that there were no trainees recommended since 1995.

The trainees have degrees like MBBS, MS or even MD (gynaecology). The trainer opined that a degree in gynaecology did not necessarily ensure required skills. It depends, according to him, on the quality of medical education that s/he had undergone.

3.4.2 Financial support: The number of recommended trainees is determined by availability of funds in the given budget. The training institutions then are provided with contingency to support these trainees. However, as mentioned above, it remains a prerogative of the training institutions as to how many of them to be accommodated at a time.

3.4.3 MTP training centres: Hypothetically speaking, all the Civil Hospitals and Rural Hospitals are authorized to offer MTP training. However, our field experience indicates that it is not a practice. There were no trainees at either Rural Hospitals or at Civil Hospitals that we had visited. Earlier some of the Corporation Hospitals used to provide MTP training. At the moment only the state run hospital (teaching hospital) and other two hospitals which are partially supported by the government have recognition for MTP training

Most of the information that we obtained about the actual training refers to medical college hospitals. In these hospitals the trainees are accommodated in the regular practical courses that are conducted for postgraduate medical students. Only about two trainees can be accommodated at a time. The training is not conducted round the year. The trainer elaborated upon the constraints in accommodating more than two trainees at a time. Postgraduate students are given priority over the trainees. Hence, if sufficient MTP cases are not available, trainees are left with less scope to get hands-on practice of the procedure. The trainer also expressed his resentment about spending time for these trainees -

1. "In any case, they (trainees) don't necessarily use these skills at PHCs (or at the government set-ups where they are employed). They perform MTPs at their private clinics".

Bureaucrats too, expressed resentment about training doctors who are in the government service. According to them -

"The employees won't disclose about their MTP training. Some don't because they are not interested in offering MTP services. Some others won't disclose that they perform MTPs because it means that they have to report (to the concerned authorities). If so, they can't charge (their clients)."

The bureaucrats were aware of the fact that MTP services are being offered at PHCs up to any length of gestation, at a price, regardless of whether the set-up meets minimum physical standards and other legal requirements.

3.4.4 Syllabus for the MTP Training: There are no specific guidelines, leave alone the syllabus, either for theoretical or practical training. The trainer said that no theory was taught during such training. However, the certificates were issued only after the trainers were satisfied with the skills acquired by trainees. He emphasised the importance of acquiring the ability to judge exact length of gestation. This, according to him, requires an experience of about 200 per vaginal examinations (PVs).

The trainer highlighted that (a) the trainees are given equal opportunities as those given to the postgraduate students for hands-on practice, (b) the trainees observe the trainer performing the procedure. In that, the 'feel' of the uterus at various stages is demonstrated, (c) all the abortion procedures are not taught, (d) they are allowed to conduct MTPs independently only after trainers feel confident about trainees' skills.

He emphasised that trainees need not have an expertise to deal with complications. It was sufficient to be able to recognise indications of complications at appropriate time so that the case could be referred.

In sum, the concerned offices should critically look at inadequate MTP training facilities. Improvements are required at various levels. These include streamlining the procedure, disseminating information about this procedure to the medical fraternity as well as the concerned bureaucrats, increasing the MTP training budget, inviting a discussion so as to recognize some of the private health care institutions as MTP training institutions. The data also indicate that there is need to improve the monitoring of registered institutions.

4. THE LEGAL REQUIREMENT OF BLOOD BANK : HOW SCIENTIFIC AND FEASIBLE?

The State level 'Rules and Regulations, MTP Act' stipulates that a health care centre providing MTPs up to 20 weeks of gestation must have a blood bank at a distance less than 5 km. The applicant is required to produce a guarantee/assurance letter from the proprietor of the blood bank.

We earlier have seen that the majority of the ACFs in the study area did not have access to blood bank as stipulated in the legislation. Below is a brief situation analysis of the availability of blood banks in the selected districts followed by an analysis of the blood requirement during abortion care.

4.1 Availability of blood banks in the study area: Currently a total of 19 public and private blood banks provide services in the Pune district[8]. Out of the total of 19 blood banks, 11 are situated in the heart of the city. These blood banks do not fall within 5 km of some of the peripheral areas of city itself, leave aside the hospitals at the *taluka* places. Six of them provide blood exclusively to the hospitals they are located in. The remaining five provide blood against any demand from outside. Five blood banks are operating in the periphery of Pune city. There are only three blood banks in the district which cater to people residing outside the city. They are: one each in the towns of Talegaon and Lonavala, and one at a taluka place, i.e. Baramati.

The Ratnagiri district has only one blood bank run by the district civil hospital, in the Ratangiri city. Hence, hospitals outside this city are not eligible to provide MTP services for pregnancies between 13-20 weeks. However, the data collected during our field study suggests otherwise.

At present, none of the *taluka* places in Maharashtra, has a government-run blood bank.

At this juncture, as regards the issue of access to blood bank, two questions of immediate importance are (a) What is the frequency of blood requirements during MTP procedures? Is it more in second trimester than the first trimester MTPs? (b) Are there any feasible alternatives to the blood bank, in case of emergencies? We will discuss these issues here.

4.2 The need for blood transfusion during MTP: Gynaecologists say that second trimester MTPs can be managed without an access to blood banks. They say that blood requirement is not so much for the induced abortions but for either the post-operative complications or in cases of spontaneous abortion. In case of the latter, sometimes, the degree of blood loss is tremendous by the time the woman reaches an appropriate health care centre. It is argued that in such cases the surgery/operative can be postponed if the haemoglobin level is too low. However, in the case of induced abortion care, postponing the operative till the Hb status improves may not suit the women as they have different considerations and prefer to return home the same day.

Data on blood requirement: Despite our hard and persistent efforts to acquire hard data on blood requirement during abortion care, we managed to get only a few general figures. With some exceptions, heads of the institutions and/or providers were not willing to share the relevant

[8] Dr. Wani, Director, Janakalyan Blood Bank, Pune who is also the Chairperson, Pune Chapter, Blood Bank Association of Maharashtra State (on July, '99)

records with us. Sassoon Hospital, a state run hospital in Pune city records two cases of blood transfusion for the year 1998 of the total 360 abortion cases which mainly included second trimester abortion procedures. Other private abortion centre (Dr. Bhavsar) in the city which provides only abortion care records no single case of blood transfusion in his entire career. Dr. Sanjay Gupte, a leading gynaecologist based in Pune city told us that in last 5 years, there was not a single case of blood trasnfusion at his hospital. FPAI, Pune told us that there were no cases of blood requirement.

To be able to handle the emergencies during MTP requiring blood transfusion is part of quality care. In this light there is a need to consider the well thought out alternative of unbanked directed blood transfusion (UDBT) proposed by some experts.

5. SUMMARY AND CONCLUSIONS

- In general, the heads of the institutions, the abortion providers and the concerned government officials were **poorly informed about the MTP Act**. Most of the **HIs** and **APs** who were comparatively better informed do not comply with the legal requirements. This reflects apathy on part of the medical fraternity to comply and poor implementation on part of the government authority.

- The need for **simplifying the MTP registration procedure** has come out sharply. Operational efficiency was demanded for.

- The **stipulated physical standards in the MTP Act** seem to be a rather less controversial issue as overwhelming number of respondents felt that they were appropriate. However, the reality vis-à-vis physical standards is distressing.

- As regards stipulated **minimum qualification for doctors, non-comparability among the three alternatives stipulated in the MTP Act comes out sharply.**

- The MTP training facilities are inadequate and inaccessible, especially to those from the private health care service sector. Given the fact that a large number of unqualified providers are engaged in abortion care service provision it is necessary to consider improving or almost revamping MTP training facilities.

- Providers opined against the need to have a qualified assistant doctor and a nurse as a mandatory ones for MTP service provision. It was articulated that they are not feasible.

References

1. Baru R.V.(1993): 'Inter-Regional Variations in Health Services in Andhra Pradesh',*Economic and Political Weekly,* May, pp.963-967.
2. Bhatia J.C. & Sabagh, Georges (1980): 'Migration and fertility in India', *Demography India*, Vol. 9, (1&2), Jan-Dec, pp. 54-74.
3. Bhatia J.C. (1988): 'A study of Maternal Moratality in Anantpur District, Andhra Pradesh, India', Indian Institute of Management, Banglore .
4. Bose A. (1988): 'Logistic support and facilities for primary health care', *Medico Friend Circle Bulletin*, (137), Feb.
5. Bruce J. (1990): 'Fundamental elements of the quality of care: A simple framework', *Studies in Family Planning*, Vol 21(2), March-April, pp. 61-91.
6. Chhabra, R. & Nuna, S. C. (1994): 'Abortion in India : An Overview', New Delhi : Veerendra Printers.
7. Donabedian A.(1988): 'The quality of care: How can it be assessed?', *Journal of the American Medical Association* 260 (12), pp. 1743-1748.
8. Donabedian A.(1989): 'The end results of health care: Ernest Codman's contribution to quality assessment and beyond', *The Milbank Quarterly*, Vol. 67(2), pp. 233- 267.
9. Duggal R. and Amin S. (1989): 'Cost of health care : A household survey in an Indian district', FRCH, Bombay.
10. Duggal R., Nandraj S. and Vadair A.(1995):'Special Statistics on Health expenditure across states - Part I', *Economic and Political Weekly*, Vol. XXX(15), April 15.
11. Finger, William R. (1994): 'Maternal morbidities affects tens of millions' *Network,* Vol 14(3), Feb.pp.8-11.
12. Foo G. H.C. (1995): 'A Synthesis Of Research Findings On Quality Of Services In The Indian Family Welfare Programme', Proceedings From The National Workshop On Operations Research For Improving Quality Of Services, The Ford Foundation, USAID, The Population Council., Vol. 44.
13. Ganatra B.R., Hirve S.S., Walawalkar S. et al.(19--): 'Induced abortion in a rural community in Western Maharashtra: Prevalence and Patterns'.
14. Gangopadhyay B. and Das D. N. (1997): 'Quality of Family Planning Services in India : The User's Perspective'. *The Journal of Family Welfare,* Vol. 43(3), Sept., pp.5 -12.
15. Gupte M., Bandewar S., Pisal H.(1999): 'Women perspectives on the quality of general and reproductive health care: Evidence from rural Mahrashtra', M Koenig and M E Khan (eds)., *Improving quality of care in India's Family Welfare Programme: The Challenge Ahead,* New York, Population Council, 1999, pp. 117-139.
16. Gupte M.,Bandewar S., Pisal H. (1997): 'Abortion needs of women in India: A case study of rural Maharashtra', *Reprodutive Health Matters*, Vol. 9, May , pp. 77-86.
17. Health Committee, Lok-Vidyan Sanghatana, Pune, Maharashtra, 1998. 'Draft Rules for Blood Banks: A prescription to take blood away from the common person', *Bodhi,* 23, July-Aug
18. Indian Council for Medical Research (1991):'Evaluation of quality of Family Welfare Services at primary Health Centre level', New Delhi.
19. Iyer A., Jesani A., Karmarkar S.(1996): 'Patient Satisfaction in the context of Socio-economic Background and Basic Hospital Facilities', CEHAT, Oct., pp. 56.
20. Jacobson, Jodi L, (1990): ' The Global Politics of Abortion', Worldwatch Institute Washington D C, USA.
21. Jesani A. and Annatharam S. (1993): 'Private sector and privatisation in the health care services', FRCH, Bombay.

22. Jesani A. and Iyer A. (1995): 'Abortion - Who is Responsible for our Rights?' Karkal (Ed), *Our Lives, Our Health*, Coordination Unit, New Delhi.
23. Khan M.E., Patel B. and Chandrashekar R. (1990): 'A study of MTP acceptors and their subsequent contraceptive use', *The Journal of Family Welfare*, 848(25), pp. 70-85.
24. Khan M.E., Rajagopal S., Barge S., et al (1998): 'Situation Analysis of Medical Termination of Pregnancy (MTP) services in Gujrat, Maharahstra, Tamil Nadu and Uttar Pradesh', CORT, Baroda. Paper presented at Global Meeting on Post-abortion Care and Operations Research organised by Population Council held at New York, USA, Jan 19-21.
25. Levine R.E., Cross H.E, Chhabra S., et al (1992): 'Quality of health and family planning services in rural Uttar Pradesh: The Client's view', *Demography India,* Vol. 21(2), pp.247-265.
26. Mathai S.T. (1998): 'Review of incomplete and septic abortions in India with particular reference to West Bengal' Department for International Development, pp.50.
27. Mensch B, Fisher A., Ian A., et al (1994): 'Using situation analysis data to assess the functioning of family planning clinics in Nigeria, Tanzania,and Zimbabwe', *Studies in Family Planning*, 25(1), Jan-Feb, pp. 18-31.
28. Mensch B. (19--): 'Quality of care: A neglected dimension' Koblinsky, Marge, Judith Timyan and Jill Gay (eds.) *The Health of Women: A Global Perspective*, place ?
29. Miller R.A., Lewis N., Gachara M. M., et al (1992): 'Situation analysis study of Kenya's Family Planing Program' Jain Anrudh (ed.), *Managing Quality of Care in Population Programs*, Kumarian Press, Inc, USA.
30. Ministry of Health & Family Welfare (1997). Annual Report.
31. Mondal A., (1998): 'Induced Abortions in Rural Society and Need for People's Awareness', *Journal of Obstetrics and Gynaecology of India,* Vol.113, pp. 450 - 451.
32. Mukharji, R. (1998): 'MTP Programme in Uttar Pradesh', pp.762.
33. Nanda P., Baru R. (1994): 'Private Nursing Homes and their Utilisation - A case study of Delhi', *Health for the Millions,* Vol. 2(1), Feb., pp.6-9.
34. Nandraj S., Duggal R. (1997): 'Physical Standards of Health Care Available in the Private Health Sector : A Case study of rural Maharashtra", CEHAT, Bombay.
35. Nandraj, S., Khot, A., Menon, S. (1999): 'Accreditation of Hospitals: Breaking Boundaries in Health Care. Centre for Enquiry into Health and Allied Themes, Mumbai.
36. National Council of Applied Economic Research. (1992): 'Household Survey of Medical Care', New Delhi.
37. Office of the Registrar General of India, n.d.(1995): 'Survey of the Causes of Death (Rural) India, 1991-1995'. New Delhi: Vital Statistics Division..
38. Office of the Registrar General (1993): 'Survey of the Causes of Death (Rural): India, Annual Report, 1993', New Delhi RGI.
39. Office of the Registrar General (1991): ' Survey of the Causes of Death (Rural), Annual Report, 1989', New Delhi RGI, Vital Statistics Division.
40. Office of the Registrar General Government of India (1990): 'Survey of Causes of Death (Rural)', Annual Report, New Delhi, (as cited in Chhabra and Nuna, 1994).
41. Office of the Registrar General (1988): 'Mortality Statistics of Causes of Death 1985", New Delhi RGI.
42. Phadke A. (1998): 'Drug supply and use: Towards a rational policy in India', Sage Publications. New Delhi.
43. Pittman P. (undated): 'Assessing quality from a gender perspective (draft copy)'.
44. Prakash P. (1984): 'Editorial Perspectives', *Socialist Health Review*, Vol.1(2), pp.53-57.

45. Ramasundaram S. (1994): 'Quality of care in health and family welfare programme: A service provider's perspective', paper presented at the Seminar on Quality of care, Gujrat Institute of Development Research, Ahmadabad, 28-29 April.
46. Reddy P. H. (1992): ' Maternal Mortality in Karnataka', Population Centre, Banglore.
47. Reddy P.H.(1997): 'Quality of Client-Provider Interaction and Family Welfare Service In Rural Karnataka', Centre for Technology Development, Bangalore, Vol. 17.
48. Rural Health Division, Directorate General of Health Services (1995). Bulletin on Rural Health Statistics in India, Dec , Ministry of Health and Family Welfare, pp. 24 (cf: Independent Commission on Health in India, VHAI)
49. Sathyamala C. (1984): 'Is medicine inherently sexist?' *Socialist Health Review* Vol.1 (2), pp.53-57.
50. Shatrugna, V., Maheswari U., Sujatha T. (1987): 'Women and the Health care system in Zaheerabad - towards a New Paradigm of Health', A report submitted to the Task Force on Health, National Commission on self employed Women, Ministry of Human resources and Development, Dec.
51. Shatrugna V., Vidyasagar P., Sujatha T., (1993): 'Women's work and reproductive health', *Medico Friend Circle Bulletin, (*197-201), Aug-Dec, pp. 1-4.
52. Simmons R., Christopher E. (1994): 'The study of client-provider interactions: A review of methodological issues', *Studies in Family Planning*, Vol.25(1), Jan-March, pp. 1-17.
53. Simmons R., Marjorie A., Koblinsky et al (1986): 'Client Relations in South Asia: Programmatic and societal determinants', *Studies in Family Planning*, Vol.17(6), pp. 257-268.
54. Singh S N, Yadava R.C., Yadava K.N.S., (1981): 'A study of fertility of migrants', *Health and Population Perspectives and Issues*, Vol. 4(1), Jan-Mar, pp. 59-65.
55. Srutikar P. (1980): 'Extent and type of migration streams in north-east of India during 1961-71', IIPS, Mumbai.
56. The Gazette of India, Extraordinary (1997), published by Dept. of Health, Ministry of Health and Family Welfare. Dec. 15.
57. Tongaonkar R. (1998): 'Unbanked Directed Blood Transfusion (UDBT): A safe and life saving procedure & need of the day. Why ban it? Why make it illegal?', Annasaheb Tongaonkar Memorial Trust, Dhule, Maharashtra, India.
58. Visaria Leela and Visaria Pravin (1990): ' Quality of services and family planning in Gujrat State', working paper No. 34, Gujrat Institute of Development Research, Ahmadabad.
59. Voluntary Health Association of India (1999): 'The independent commission on health of India'.
60. World Bank (1995): 'India's Family Welfare Program: Towards a Reproductive and Child Health Approach. Population and Human Resources Operations Division Report

ANNEXURE 1

Rec No	Govt(PHC/CHC/RH/ or Private	Name of the institution, address, landmark	Name of the Head of the institution	Qualification of Head of the institution	Type of Health care services you provide (General/ Maternity/ Daycare/ Clinic	Do you provide abortion care? (Yes/No)	Do you provide D&C care? (Yes/No)	Do you yourself provide abortion care? (Yes/No)

(Contd...)

ANNEXURE 2-3

(... Contd)

(...cont d) Rec No	Are there additional abortion providers? (Yes/No). If yes, how many?	If yes, name and qualification of Abortion Provider (AP)- 1	Name and qualification of Abortion Provider (AP)- 2	Name and qualification of Abortion Provider (AP)- 3	Name and qualification of Abortion Provider (AP)- 4	Registration status of the institution (Registered/non-registered)	(Observation) Is the Abortion Board displayed? (Yes/No)	(Observation) Is the MTP certificate displayed? (Yes/No)

Phase II: Quantitative Facility Survey

Annexure 2(a)

INTERVIEW SCHEDULE TO BE ADMINISTERED WITH THE HEAD OF THE INSTITUTION

1. Schedule no :
2. ~~Name of the interviewer:~~ _____
3. Date :

Section I : Profile of the institution

4. Name of institution :
5. Address and landmark :

   Pin code :
   Tel :

6. Institution type :
   1. PHS 2. PHC 3. RH
   3. Cottage Hospital 4.Corporation/Muncipalty 5. District hospital
   6. Private

7. Structure of the institution :
   1. Maternity hospital 2. General hospital 3. Only abortion centre
   4. Anyother specify _____

8. Name of the head of the institution :

9. Sex : 1. Female 2. Male

10. Age -------- yrs

11. Qualification *(pl. record actual degree)*:
    1.Post graduate 2. PG Diploma
    3. PG Certificate 4.Graduate
    5. Other, pl. specify ----------

12. System of medicine : 1. Allopathic 2. Ayurvedic
    3. Homeopathic 4. Others, pl. specify --------

13. (*In case of non-government institution*) Owership of the institution :
    1. Individual ownership 2. Partnership 3. Trust
    4. Society 5. Corporate 6. Cooperative
    7. Any other, pl specify ----------

14. Total no. of beds - ----------
    If there are separate O/G beds, number --------
    If there are separate abortion beds, number -------

15. What is the proportion of the abortion clients of the total women clients?

16. **Personnel :** *(in case of doctors pl. ✓ for those performing abortion)*

No	Category	Sex	Age	Qualifications including specialisation	Training (in case of non-gynaec abortion providers)	Attached/on call/regular employee
1.	**Doctors** 1. 2. 3. 4. 5.					
2.	**Anaesthetist** 1. 2.				NA	
3.	**Laboratory Technician**				NA	NA
4.	**Social worker**				NA	NA

17. What are the job responsibilities of the social worker *(if applicable)* ?

18. In case of emergencies in abortion what is the back up you have in terms of expertise/ consultants?

Section II: Abortion services

19. Up to what length of gestation do you provide abortion services?
1. upto 12 weeks 2. 13-20 weeks 3. 21 to 24 weeks and above

20. *(if only 1 is selected or only 1 and 2 are selected in the above)* Why don't you provide abortion services for 13-20 weeks and/or 21 to 24 weeks of gestation length?
1. don't have equipment 2. don't have space 3. don't have skills
4. not remunerative 5. don't get enough cases 6. no referral nearby
7. more risk involved 8. legally not allowed 9. don't approve of
10. any other, pl. Specify ----------

21. How much do you charge for an abortion in case of **(only when applicable)**-

Duration of pregnancy	Charge in Rs.	What does it include?
Upto 12 weeks		
13-20 weeks		
21-24 weeks		

22. How are drugs supplied to the client for abortion?
1. In-house facilities 2. Replacement of essential drugs 3. No drugs are supplied

23. **Card exercise** : We have listed five factors which may determine cost of abortion. Will you please rank them in descending order that is followed at your centre as determinants of the abortion cost .

Ranks	Sr nos of determinants
1	
2	
3	
4	
5	

(Administer this section only if HI is the person who decides regarding taking up abortion cases)

Section III : Access to abortion services

24. We have made a list of reasons for which women seek abortion. Please rank them in descending order with reference to this centre?

Ranks	Sr. nos. of reasons

25. Do women come alone to get an abortion done?
    1. Yes, under what situations?

    2. No

26. Do / will you provide her abortion services if a woman comes alone?
    1. Yes 2. No, why ?

27. Do/will you conduct abortion if woman's friend/s accompany her?
    1. Yes 2. No

28. Do you provide abortions services to singles, such as, unmarried widows, deserted/separated?
    1. Yes 2. No, why?

29. Do you provide abortion service to a married primie?
    1. Yes, why? 2. No

30. Do you make it compulsory for a woman to accept IUCD/sterilisation after abortion?
    1. Yes, why? 2. No

31. Do/will you provide services to HIV positive women?
    1. Yes 2. No, why?

32. *(If yes)* Do/will you charge more for such cases if you provide services to them ?
    1. Yes 2. No 9. NA

33. Whose consent do you take before conducting abortion?
    1. Only woman herself

    2. Only her husband, why?

    3. Both, woman and her husband, why?

    4. Parents/in-laws/close, responsible and elder relatives, why?

34. *(If 1/3/4 to above Q)* Do you insist for husband's signature?
    1. Yes, why? 2. No, why?

35. Do you take second opinion for abortions between 13-20 weeks?
1. Yes 2. No 9. NA

36. The MTP Act provides abortion in case of :
a). Failure of any contraceptive device or method b). Danger to life of the pregnant woman
c). Grave injury to physical health of woman d). Grave injury to mental health of woman
e). Pregnancy caused by rape f). Substantial risk that if the child was born, it would suffer from such mental and physical abnormalities so as to be seriously handicapped.

Do you think that the Act thus defined provides abortion to all women, irrespective of their marital status ?
1. Yes, how? 2. No, how?

37. *(If no)* Do you think all women should have legal access to abortion?
1. Yes, why? 2. No, why?

38. Do you think the MTP Act has helped women in some concrete way?
1. Yes, how? 2. No, how?

Section IV : MTP Act :

Registration status :

39. Is the centre registered under the MTP Act ? : 1. Yes 2. No

40. (If not registered) did you ever try to get your centre registered?
9. NA
1. Yes, what happened?

2. No, why ?

41. (If registered) year of first registration : 1. 19-- 9. NA

42. (If registered) is the registration for - 1. Up to 12 weeks 2. 13 to 20 weeks 9. NA

43. (If registered) do you have to renew registration? 1. Yes 2. No 9. NA

44. If yes, what is the period for renewal? -------- yrs 9. NA

45. When did you renew your registration last? 19-- 9. NA

46. (If registered) did you encounter any problems while getting the centre registered?
1. Yes, what problems? 2. No 9. NA

47. (To all, registered and non-registered) What are your suggestions for improving the method of registration?

48. (If registered) In case, the MTP provider at your centre changes do/will you inform to the authority?
1.Yes, why? 2. No, why? 9. NA

Opinion about the Act :

49. As per the MTP Act, a registered centre need to have
    a *.safe and hygienic conditions for conducting an abortion,,*
    b. *operation table and instruments for performing abdominal or gynaecological surgery,*
    c. *drugs and parenteral fluids for emergency use.*

    Do you think that these requirement standards are
    1. Too high, How?

    2. Just appropriate, how?

    3. Too low, How?

Maintenance of the records :

50.

Type of records	Do you have? ---------- Yes / No	How long are they maintained ?	*(If the records are not shown)* What information does it contain?
Operation theatre registre (OTR)			
Case sheets			
Consent form for any operative procedure in general			
Separate admission register for abortion clients			
Woman's consent form for abortion			
Doctor's approval form in case of abortion clients			

51. Are the abortion cases enterd in the OT register ?
    1. Yes 2. No

52. Are these entries different than the other entries in OT register?
    1. Yes, how? 2. No

Reporting of the MTP cases :

53. *(only for registered centre)* Do you report the MTP cases?
    1. Yes,
    To whom?

    1. Zilla Parishad 2. Civil hospital 3. Any other, pl. Specify

    How frequently ?

    1. Monthly 2. Bimonthly 3. Quarterly 4. Six monthly 5. Annually

    2. No, why ?

3. Not all cases, why?

9. NA

(Administer this section only if HI is the person who decides regarding taking up abortion cases)

Section V - Perception :

54. Why do you think women have to face the situations of second trimester abortions?

55. Who do you think is responsible for abortion situations that a woman faces? How?

56. What is your opinion about abortion as spacing method ?

57. What is your opinion about abortion after sex determination?

58. What is your opinion about abortion as a woman's right ?

59. (*In case of registered*)Could we have look at your MTP registration certificate ?

60. Could we have specimen documents of ----- ?:

Type of the document	Obtained/not obtained/NA
1.Consent form for any operative procedure	
2. Woman's consent form for abortion	
3. Doctor's approval form for abortion	

Phase II : Quantitative Facility Survey.

Annexure 2(b)

INTERVIEW SCHEDULE FOR PROVIDER

1. Schedule no :
2. Name of the interviewer :
3. Date :
4. Name of institution :

Section I - Identificatory data :

5. Name of the provider :
6. Sex : 1. Female 2. Male
7. Age : -------- yrs
8. Qualification *(pl. record actual degree)*:
   1.Post graduate 2. PG Diploma
   3. PG Certificate 4.Graduate 5. Other, pl. specify --------
9. System of medicine : 1. Allopathic 2. Ayurvedic
   3. Homeopathic 4. Others, pl. specify --------
10. How long you have been doing abortion practice? ---- yrs

Section II - Abortion services :

11. *(Skip in case HI and provider are the same)* Up to what length of gestation do you conduct abortions?
    1. upto 12 weeks 2. 13-20 weeks 3. 21 to 24 weeks and above

How many abortions do you conduct at this centre per month ----? *(ask whichever is applicable)*

Length of gestation	Cases per month
Upto 12 weeks	
Between 13-20 weeks	
Between 21 - 24 weeks	

13. How many visits woman has to make before you conduct abortion----?
    - Up to 12 weeks -------- visits
    - Between 13 -20 weeks --------- visits
    - Between 21-24 weeks --------- visits

14. Which are the most important informations you ask woman before taking her up for abortion?

15. Which procedure do you use for abortion ------? (ask when applicable. Pl. -- under the procedure mentioned)

Length of gestation	**Procedure used**					**Why do you prefer this Particular method?**
	VA/ SC	**D&C**	**D&E**	**Intra-amniotic induction**	**Extra-amniotic induction**	
Up to 12 weeks						
Between 13-20 weeks						
Between 21-24 weeks						

16. *(If induction is used)* Do you use check curettage after induction?
1. Yes, Always. Why? 2. No 3. Sometimes, if required. In which situations 9. NA

17. Which anaesthesia do you mostly use for abortion ------?

Duration of pregnancy	Type of anaesthesia used
Upto 12 weeks	
13-20 weeks	
21-24 weeks	

18. Which pathological tests do you conduct before taking up a case for abortion, as a routine?
1. Hb 2 . Rh 3. Urine 4. VDRL 5. HIV
6. Any other, pl. specify --------

19. Which examinations do you conduct for an abortion client just before discharge?

20. Do you prescribe any drugs after abortion is conducted ?
1. Yes, which? Why? 2. No

21. Generally, what post-abortion precautions do you ask women to take?

22. What is the percentage of abortion clients who come for follow up? (If not 100%) Why is it not 100%?

23. Generally, for which post-abortion complications have you treated women?

24. What according to you are the reasons for post-abortion complications?

25. *(If conducts abortion between 13-20 weeks)* Do you conduct abortion during 13th to 15th week?
1. Yes, why?

2. No, why?

26. Do you insert IUCD immediately after abortion?
1. Yes, why? 2. No, why?

27. Do/will you provide services to HIV positive women?
1. Yes 2. No, why?

(Administer only if provider decides regarding taking up an abortion case)

Section III : Access to abortion services

28. We have made a list of reasons for which women seek abortion. Please rank them in descending order with reference to this centre?

Ranks	Sr. nos. of reasons
1	
2	
3	
4	
5	
6	
7	

29. Do women come alone to get an abortion done?
    1. Yes, under what situations?

    2. No

30. Do / will you provide her abortion services if a woman comes alone?
    1. Yes 2. No, why ?

31. Do/will you conduct abortion if woman's friend/s accompany her?
    1. Yes 2. No

32. Do you provide abortions services to singles, such as, unmarried widows, deserted/separated?
    1. Yes 2. No, why?

33. Do you provide abortion service to a married primie?
    1. Yes, why? 2. No

34. Do you make it compulsory for a woman to accept IUCD/sterilisation after abortion?
    1. Yes, why? 2. No

35. Whose consent do you take before conducting abortion?

    1. Only woman herself

    2. Only her husband, why?

    3. Both, woman and her husband, why?

    4. Parents/in-laws/close, responsible and elder relatives, why?

36. *(If 1/3/4 to above Q)* Do you insist for husband's signature?
    1. Yes, why?

    2. No, why?

37. Do you take second opinion for abortions in case of 13-20 weeks? 1. Yes 2. No 9. NA

38. The MTP Act provides abortion in case of :
    a). ***Failure of any contraceptive device or method*** ***b).*** ***Danger to life of the pregnant woman***
    c). Grave injury to physical health of woman ***d).*** ***Grave injury to mental health of woman***
    e). Pregnancy caused by rape ***f). Substantial risk that if the child was born, it would suffer from such mental and physical abnormalities so as to be seriousely handicapped.***

    Do you think that the Act thus defined provides abortion to all women, irrespective of their marital status ?

    1. Yes, how? 2. No, how?

39. *(If no)* Do you think all women should have legal access to abortion?
1. Yes, why? 2. No, why?

40. Do you think the MTP Act has helped women in some concrete way?
1. Yes, how? 2. No, how?

Section IV - MTP Act :

41. As per the MTP Act, an abortion provider needs to meet one of the following training requirements ---- ----. Do you think they are -------?

Training requirements	Over prescribed	Just appropriate	Under prescribed
six months of surgery in gynaecology			
experience at any hospital (more than one year) in practice of OBGY			
assistance of 25 MTP cases in a Govt. approved centre)			

42. Do you think the MTP training should include training regarding counselling skills?
1. Yes, why? 2. No, why?

43. *(Skip in case of gynaecs.)* From where did you learn the technique of abortion?

44. *(If trained at the government recognised setup or at hospitals as per the Act)* Were you satisfied during your training about the following :

Training in terms of	Satisfied, why?	Not satisfied, why/
Infrastructure at the training centre • Instruments • Equipment		
Content of training • Theory • Hand on training of various abortion methods		
Trainer • Imparting knowledge • Imparting skills		

45. The act prescribes that the assistant doctor should have
- certificate indicating experience as assistant doctor during abortion procedure and for minimum 2 years at the institution

Do you think this is ----?
1. over prescribed, how? 2. just appropriate 3. Underprescribed, how?

46. The act prescribes that the assistant nurse should have
- qualification certificate (1/2/3 yrs nursing course)
- registration with the Maharashtra Nursing Medical Council, and
- certificate indicating experience as assistant nurse during abortion procedure at the government recognised institution

Do you think this is ----?
1. over prescribed, how? 2. just appropriate 3. Underprescribed, how?

Section V - Perception :

47. Why do you think women have to face the situations of second trimester abortions?

48. Who do you think is responsible for abortion situations that a woman faces? How?

49. What is your opinion about abortion as spacing method ?

50. What is your opinion about abortion after sex determination?

51. What is your opinion about abortion as a woman's right ?

Section VI : Views about abortion practice by non-allopaths, paramedical and local abortionists

52. What do you think about non-allopathic medical professionals practicing abortion?

53. Do you think paramedicals such as ANMs, trained birth attendants (TBAs), Nurses, dais could be trained for Menstrual Regulation (MR) for conducting abortion?
    1. Yes 2. No, why?

54. Do you think local abortionists could be trained for MR for conducting abortion ?
    1. Yes 2. No, why?

55. Do you think training paramedicals and/or local abortionists will affect the practice of the abortion provider?
    1. Yes 2. No

Phase II : Quantitative Fascility Survey.

Annexure 2(c)

INFORMATION TO BE GATHERED AT THE CENTRE

- Schedule no :
- Name of institution :
- Name of the observer :
- Date :

---

*1 *(Only for registered centre)* **Display of MTP board and certificate :** (Pl. ✓if yes and × if no)

No	Item	Yes/No
1.	Board displaying availability of MTP facilities	
2.	MTP registration certificate displayed	

*2. **Enquiry counter (Peripheral facilities) :** - (Pl. ✓if yes and × if no)

No.	Item	Yes/No
1.	Enquiry counter	
2.	Person attending enquiry counter	

*3. **Consulting room (Privacy) :** (Pl. ✓if yes and × if no)

No.	Item	Yes/No
1.	Separate consulting room	
2.	Conversation is heard outside the consulting room	
3.	More than one patient enters the consulting room	

*4. **Waiting room and consulting room :** (Pl. ✓if yes and × if no)

Observations about	Waiting room	Consulting room
Ventilation		
Light		
Cleanliness (garbage, smell)		
Seepage		
Sink		
Water facility at the sink (running/stored in buckets etc)		
Drinking water		
Whether overcrowded		

*5. **Wards and special rooms** (Pl. ✓if yes and × if no)

Sr no	Observations about	at Wards	at Special rooms
1	Ventilation		
2	Light		
3	Cleanliness (garbage, smell)		
4	Seepage		
5	Drinking water		
6	Toilets		
7	Bathrooms		
8	Whether overcrowded		

*6. **Wards and special rooms :** (Pl. ✓if yes and × if no)

No	Item	Comfortable/Clean (Yes/No)
1.	Condition of cots	
2.	Condition of mattresses	
3.	Condition of bedsheets	

*7. **Sanitary conditions :** (Pl. ✓if yes and × if no)

No.	Condition of toilets and bathrooms in the institution	Yes/No
1.	Cleanliness	
2.	Airy	
3.	Light	
5.	Running water	

*8. **Furniture :**

	Furniture	Total no.
1.	Examination tables	
2.	Stretchers	
3.	Trolley	

*9. **Operation theatre :** (Pl. ✓if yes and × if no)
Whether operation theatre and labour room are separate - 1 Yes 2. No

Observations about	at OT	at Labour room
Exhaust fan		
Light		
Cleanliness (garbage, smell)		
Seepage		
Sink		
Water facility (running/stored in buckets etc)		
Drinking water	NA	
Toilets	NA	
Bathrooms	NA	

10. **Information to be gathered at the operation theatre :**

	OPERATION THEATRE	Total no.
1.	Operation table (head low)	
2.	Oxygen cylinder	
3.	Breathing hoses	
4.	Self inflating bags	
5.	Airways	
6.	Endotracheal tubes	
7.	Boyle's apparatus	

11. **Information to be gathered about the contents of the emergency tray:** (Pl. ✓if yes and × if no)

	EMERGENCY TRAY	Yes/No
1.	Adrenaline	
2.	Glucose I.V.	
3.	Ringer lactate	
4.	Hydrocortisone inj. (Efcorline) / Dexamethasone	
5.	Mephentine inj.	
6.	Avil inj.	
7.	Dopamine	
8.	Soda bicarb.	
9.	Furosemide	

12. **Information to be gathered about abortion specific instruments and equipment :**
(Pl. ✓if yes and × if no)

ABORTION SPECIFIC EQUIPMENT	Total No
MTP sets Required for both first and second trimester : 1. Set of dilators (different sizes)	
2. Vulsellum	
3. Ovum forceps 4. - long ovum forceps (with narrow top end, transverse serrations and a rachet in the handle for locking)	
5. Curette	
6. Suction machine (electric/hand/foot pump)	
7. Sim's speculum	
8. Suction cannula (ideally its size has to match with the size of dilators that are used for dialatation)	
In addition to above following are the intruments required for second trimester abortion : 1. Catheter (Folly's / Simple rubber)	
2. Currette	
3. Ovum forceps (both curved and straight varieties)	
4. Laparotomy equipment	
5. Laparoscope	

13. **Information to be gathered about Sterilization equipment (essential facility) :**
(Pl. ✓if yes and × if no)

Sterilisation equipment	Yes/No
1. Autoclave	
2. Pressure cooker	

14. **Information to be gathered about access to Blood bank** : (Pl. ✓if yes and × if no)

Item	Yes/No
Access to Blood bank If yes, mention distance ------ (km)	

15. **Information to be obtained about complementary services** : (Pl. ✓if yes and × if no)

Whether there is pathology laboratory - 1. Yes 2. 3. No

Item	Yes/No
If yes, tests performed - Urine test . urine sugar . albumin . urine microscopic . pregnancy	
Blood test . blood group (inluding Rh) . Hb percentage (Hb) . blood sugar	

16. **Information to be obtained about Essential Emergency facilites :** (Pl. ✓if yes and × if no)

No.	Items	Yes/No
1.	Generator/battery set If yes, . For operation theatre . For emergency wards/rooms . For whole setup	
2	Ambulance	
3.	Fire fighting arrangements . fire extinguisher (mention no. - -----) . easily accessible water supply	

17. **Information to be obtained about Complementary facilities :** (Pl. ✓if yes and × if no)

No.	Items	Yes/No
1.	Telephone facility	
2.	Food facilities - . patients . relatives	

18. **Infomation to be obtained about Disposal of waste** (Pl. ✓if yes and × if no)

	Incinerated/Burnt	Common garbage	Any other (specify)
Aborted foetuses			
Used gloves			
Syringes			
Needles			
Packs & Menstrual Pad			

Main Water supply to the institution :

19. Source of water supply - 1. Well 2. Tap

20. Covered water storage - 1. Yes 2. No

21. Frequency of cleaning water storage ----- times per ---------

22. Method used for purifying drinking water -

Paramedical and other staff :

23. How many nurses do you have?

24. Of these how many have formal training and how many are registered?

Type of training	Number of nurses	Registration status	Number of nurses
Formal training . Degree . Diploma . Certificate		Registered	
In-house training		Non-registered	

25. How many *ayahs* are working ? ----------

How many ward boys do you have? ----------

Annexure - 2(d) (Card Exercise)

Q 23. We have listed five factors which may determine cost of abortion. Will you please rank them in descending order that is followed at your centre as determinants of the abortion.

- Health status of women
- Length of gestation (even within the particular trimester)
- If the women is unmarried, divorced, separated or widow
- Economic status of Women
- Procedure used for Abortion

Q24. We have made a list of reasons for which women seek abortion. Please rank them in descending order with refernce to this centre. (Q 28 in the Interview schedule for provider)

- Rape or incest
- Failure of contraception
- Spacing method
- Risk to mother's life
- After sex determination
- Pregnancy outside marriage
- Eugenic purposes

g:\shelley\reap\Rinpopp off

Annexure 3(a)

III

Phase 3: Qualitative Case Studies

INTEGRATED OBSERVATION AND INTERVIEW GUIDE

1. Name of the institution :
2. Name of the HI :
3. District : Tahsil : Village :
4. Name of the interviewer :
5. Date/s : / /
6. Name of the provider :

Common observations about the centre :

7. Waiting period :
   Average waiting time for the clients
   Average time spent with clients by the provider

8. Privacy :
   Separate consulting room
   Conversation is heard outside the consulting room
   People other than provider and client sitting in the consulting room (list people present)

   (Note : O - Observation, I - Interview. Once observed will not be asked to the woman. There are certain things which will be only be observed or only be asked to the woman while interviewing her.)

I. General :

(Here it will be either observed by the researcher about these aspects or the woman will be asked about it.)

9. *{I}* Name of the woman :

10. *{I}*Address :

11. *{I}* Village : ---------, Taluka : ----------, District : ----------

12. *{I}* Socio-economic status :
    Age : ------- yrs Caste - Education : Occupation : Income (if working) : Marital status : Age at marriage :

13. *{I}* Husband's identificatory data : (in case of married woman)
    Name :
    Age : ------yrs Education : Occupation :
    Income : Place of job :

14. Family income :

15. *{I}* Land ownership :
    Quantity of land owned : Irrigated : ---------- acres Rainfed : -------- acres.
    Who cultivates the land : 1. Family members 2. Employed labourers

16. *{I}* No. of family members :

II. Pre-operative interactions : Reproductive history

*(Here it will be **either observed** whether the provider seeks information on various aspects from the woman **or the woman will be asked** if such information was obtained from her by the provider).*

17. *{O/I}* Fertility history : Total Pregnancies
Abortions(Induced/Natural)
Death(Male/Female)
Living(Male/Female)

18. *{O/I}*Any reproductive illness :

19. *{O/I}* Experiences of earlier MTPs, if any (Reason, post-abortive complications such as bleeding, fever, pain in abdomen, D&C, continued pregnancy, perforation)-

20. *{O/I}* Use of contraception : (past, source of information, experiences, future plans of family planning, mention of mandatory contraception in this episode)

21. *{O/I}*Overall current health status & history (any major illnesses such as BP, diabetes, heart, convulsions etc, weight, Hb)

III. Pre-operative interactions (obtaining information) : Abortion related

*(Here it will be **either observed** whether the provider **seeks information** on various aspects from the woman **or the woman will be asked** if such information was **obtained from her** by the provider).*

22. *{O/I}*Menstrual history (LMP, dysmenorrhoea, menstrual cycles regular/irregular)

23. *{O/I}* Reason for abortion.

24. *{O/I}* Decision-making regarding doing abortion (who all from the family or outside participated in the decision making process)

25. *{O/I}* If husband/partner was asked, by the provider to be there? Why?

26. *{O}* Contraindications : (Contraindications for abortion by induction method using hypertonic saline solution : anaemia/sickle cell anaemia cardio-vascular disorders / illness, such as high BP, heart failure, liver or kidney problems. Contraindications for abortion by induction method using prostaglandin : convulsions, epilepsy, asthma)

27. *{O/I}* in case of immediate admission obtaining information about the NBM (Nil by mouth)status.

IV Pre-operative medical examination

*(Here it will be **either observed** by the researcher whether these examinations are conducted or **or the woman will be asked** by the researcher about it).*

28. *{O/I}* Physical examinations conducted (Gynaec examination such as PV/internal examination -to know the length of gestation and to examine if there is any local infection)

29. *{O/I}* General examinations conducted (Observation of nails, eyes and tongue, BP, pulse, temperature)

30. *{O}* Pathology tests (Hb, Rh, HIV)

31. *{O/I}* Any other doctor has examined (in case of second trimester abortion)
(Check doctor's approval form and second opinion response from quantitative format)

V Pre-operative interactions : Giving information to the client about the procedure

*(Here it will be **either observed** whether the provider gives information to the client on various aspects **or the woman will be asked** if such information was given to her by the provider).*

32. *{O}* Length of gestation

33. *{O}* Methods to be used for abortion /MTP (describing these procedures in a way that woman understands them, seeking clients' participation in decision-making)

34. *{O}* Risks /complications involved (these are procedure specific)

35. *{O}* Legal requirements, if applicable (if consent is required from any one other than the client, filling up the forms)

36. *{O/I}* Consent while undergoing the procedure (Check consent form and related data)

37. *{O/I}* Instructing about being NBM and its reasons in case she is not admitted on the same day.

38. *{O}* Time required for the procedure, how many days of in-admission at the centre, whether she can return on the same day, expenses that she has to incur, removal of ornaments before coming for the procedure (if she is not admitted on the same day) etc.

39. *{O}* If there is written material for the client about abortion and related issues.

VI. Woman's choice of abortion provider : considerations

40. *{I}* Time taken to reach the centre :

41. *{I}* Mode of Transport :

42. *{I}* Date of admission in hospital :
{O/I} Date of procedure :

43. *{O/I}* Number of visits made including that for the procedure and reasons.

44. *{O/I}* Companions while visiting the centre (at each visit)

45. */I}* Source of information about the provider

46. *{I}* Considerations while choosing this provider
    - competence,
    - reputation,
    - cost,
    - distance,
    - facilities,
    - time required between the admission and discharge
    - distance to maintain confidentiality vs cost
    - any other

47. *{I}* Consulted any other provider/doctor before coming here? Why?

VII. Woman's evaluation of abortion/MTP care centre :

48. *{I}* Woman's evaluation of the the abortion care centre. :
    - Privacy (no. and composition of people inside the cabin, sound proofness, privacy during consultancy, surgery and stay)
    - Equipment and pathology/sonography

49. *{I}* Woman's satisfaction about other facilities at the centre :
    - Food facilities
    - Ambulance (only if she has required it)
    - Water facility
    - Telephone facility

50. *{I}* The cost incurred for this abortion procedure (travel cost per person, food, medicines, total cost incurred in the hospital)
    Desirable cost according to you :

51. *{I}* Satisfaction about the services of the follwoing and their behaviour with her
    - Doctors, (eg tension about abortion, if doctor assured you)
    - Nurses,
    - Aaya,
    - Wardboy,
    - Administrative staff

52. *{I}* Would you give reference of this centre to anyone? Why?

53. *{I}* Card exercise (regarding woman's evaluation of the centre. Women have to either select or deselect the cards)

54. *{I}* Whether MTP leave was taken (Record).

VIII. Post-operative interactions :

*(Here it will be **observed** whether the provider **gives information** to the client on various aspects and conducts necessary medical examinations for the woman).*

55. *{O}* Mandatory Medical check-ups and medication, if any is required before the discharge
    - Bimanual to confirm if the uterus is hard and smaller than that was prior to the procedure
    - The extent of bleeding to check if the abortion procedure has been successful
    - Prescribing antibiotics in case of local infection or to prevent it in near future
    - BP, temperature, bleeding, general condition

56. *{O}* Mandatory revisits for check-ups and indications of post-operative complications
    - Advised to revisit the provider for routine checkup after 2 weeks
    - Advised to revisit earlier if the woman notices acute pain in lower abdomen, rise of temperature, persistent pain for more than 7 days, heavy or persistent fresh bleeding or persistent pregnancy symptoms
    - Referrals

57. *{O}* Post-operative Precautions (Do's and don'ts)
    (NBM for 2 hours after the procedure and reasons, intaking water, tea and light food could be possible etc; about giddiness, weakness, pain in the limbs after the procedure for a day or so, how much bleeding and pain will be there and for how long; when can she start her normal activities, she should not have intercourse for 10-14 days after abortion, use of post-abortive birth control methods).

58. *{O}* Reassurance to the woman and her companions (relatives/friends) that the procedure was successful etc.

59. *{O}*Responds to doubts and querries of the client.

IX. Provider - client interactions (Pre-operative) :

(For the reference of the peer group and committee only : observations will be made by the researcher about the quality of provider's interaction with the client. This particular section will be on the separate sheet. While documenting, care will be taken that it remains out of site of anyone other than the research team)

60. *{O}* Provider behaviour towards the client (presence of value loaded statements during conversation, nasty remarks about client's sexual life, any comment which directly or indirectly conveys client that her abortion, need is a result of her/couple's irresponsible behaviour)

61. *{O}* Provider's responsiveness (does the s/he responds to what client is narrating by raising more questions or by adding/ complementing/ supplementing to what the client is saying)

62. *{O}* Provider's lack of attentiveness (attending to more than one thing, such as, talking to his staff, attending to other patient, doing something else other than listening to her)

Annexure 3(b)

PHASE III: QUALITATIVE CASE STUDIES

OBSERVATION GUIDE

(interactions between the client, her companions and paramedics, administrative staff, aayas)

Name of the interviewer :
Date/s and time of the session/s :

Name of the institution :
Name of the provider
Tel :

Interactions with the administrative staff, if any :

- Women and her companions are provided with the required information
- Helped her/relatives/friends in completing the paper work at the time of admission and at the time discharge
- Behaviour pattern

Interactions with paramedics :

- Drugs are given on time
- Supervision of IVs etc
- Preparing the woman for the procedure
- Maintaining the case papers at her bed side
- Reporting to the provider other responsible medico as and when required
- Behaviour pattern

Interaction with aayas and wardboys

- If the woman is provided with care, such as, giving her bed-pans, sanitory pads etc as and when required
- Reporting to the paramedics or to the provider as and when required
- Behaviour pattern

This is only a guideline. However, additional case specific information will be documented.

Annexure : 3(c)

PHASE III: QUALITATIVE CASE STUDIES

INTERVIEW/OBSERVATION GUIDE FOR WOMAN WITH POST-ABORTIVE COMPLICATIONS (to study 'outcome' component of QAC)

1. Name of the institution :
2. Name of the HI :
3. Name of the provider :

4. District : ---------- Tahsil : ---------- Village : ----------

5. Name of the interviewer :
6. Date/s : / /

Post-operative complications :

7. *{O/I}* Name of the woman
8. *{O/I}* What complications
9. *{O/I}* Length of gestation in that episode.
10. *{O/I}* Procedure used.
11. *{O/I}* When was the abortion/MTP conducted?
12. *{O/I}* Where was it conducted (name of doctor, place)
13. *{I}* Qualifications of that provider?
14. *{I}* Registration status of the centre ?
15. *{O/I}* Why the same rpovider was not approached?

Annexure 2. (d)

RECORD SHEET FOR SCREENING CASE PAPER
(to study 'outcome' component of QAC)

1. Name of the institution :
2. Name of the HI :
3. Name of the provider :
4. District : ---------- Tahsil : ---------- Village : ----------
5. Name of the interviewer :
6. Date/s : / /

Information to be noted down from the case paper

sr no	Date on the case paper	Complaints by the clients as recorded on the case paper (Fever, bleeding, duration of bleeding, pain in abdomen)	Diagnosis by the provider (Perforation, septicaemia, haemorrhage, incomplete abortion)	Treatment

- Pl. note if spontaneous / incomplete to complete, if any
- Pl note D & C, if any

Annexure - 4

GLOSSARY & NOTES

(For researchers' reference)

Glossary

1. **Abortion** : Abortion is the prevention of pregnancy that has already begun from going to term, from eventuating in childbirth; and abortion may be accomplished through a variety of methods - chemical, herbal, mechanical, surgical. (R Petchsky, pp 29).

   . Induced abortion - Willful termination of pregnancy.
   . Spontaneous abortion - Expulsion from the uterus of the products that is occurring naturally (Dorland's Medical Dictionary)

2. **Abortion procedures** :
   . Surgical procedures - Abortion procedure which involves use of surgical tools to clean the uterus of products of conception.
   . Medical procedures - Abortion procedures where drugs are used for expulsion of conception products.
3. **Amenorrhoea** - Absence or abnormal stoppage of the menses (Dorland's Medical Dictionary)
4. **Amniotic sac** - Sac of fluid surrounding the foetus. (OBOS)
5. **Aspiration** - The act of inhaling, removal by suction. (Dorland's Medical Dictionary)
6. **Cervical laceration (Tear)** - (Post operative complication - POC) - The cervix may get injured during a second - trimester abortion. A small tear heals without any treatment. However, a more serious tear may require stitches, and there may be some bleeding from the tear. (OBOS, pp 359)
7. **Clinic** - A special place or time at which specialized medical treatment or advice is given to visiting patients. (Oxford dictionary)
   - An establishment where patients are admitted for study and treatment by a group of physicians practising medicine together. (Dorland's Medical Dictionary)
8. **Counselling** - Professional advice about a problem (Oxford dictionary)
9. **Curettage** - Scrapping the inside of the uterus with a metal loop, called a *curette*, to loosen and remove tissue. (OBOS)
10. **Dysmenorrhoea** - Painful menstruation. (Dorland's Medical Dictionary)
11. **Endometriosis** - The aberrant occurrence of tissue containing typical endometrial granular and stromal elements in various locations in the pelvic cavity or other areas of the body. (Dorland's Medical dictionary)
12. **Endometritis** - Inflammation of the endometrium. (Dorland's Medical Dictionary)
13. **Ecbolics** - An agent that promotes rapid labour by stimulating contractions of the myometrium (Dorland's Medical Dictionary)
14. **Dilation** - Enlarging the cervical opening by stretching it with tapered instruments called *dilators*, or with laminaria. Many medical technicians use the word "dilatation" to mean the same thing. (OBOS)
15. **Forceps** - Grasping instruments used to remove tissue. (OBOS)
16. **Hospital** - An institution providing medical treatment and care for ill or injured people (Oxford dictionary)
17. Incinerator : a furnace or enclosed container for burning rubbish (Oxford Dictionary). It is said that the gases produced during incineration are harmful and are feared to cause cancer among the inhalers.
18. **Infection** (POC) - Inspite of using sterile instruments and antiseptics, bacteria sometimes travel into the uterus. Signs of infection are fever of 100.5^0F or higher, bad cramping, vaginal discharge with foul odour. Tetracycline or ampicillin is the treatment for this. (OBOS, pp 359).
19. **I.V.F.** - Intravenous fluids
20. **Laminaria tent** - It is a sterilised sea weed that absorbs moisture and expands, gradually stretching the cervix. Helps softening and further dilatation of the cervix and reduces the chance of cervical injury and make the operation much easier.
21. **LMP** - Last normal menstrual period. (OBOS, pp 356)
22. **Length of gestation / pregnancy** - It is usually counted from the first day of the LMP and not from the day of conception (fertilization). (OBOS, pp 356)

23. **Maternity hospital** - An institute for the care of obstetric patients. (Dorland's Medical Dictionary)
24. **Menorrahhagia** - Both, heavy bleeding and long periods (bleeding for more number of days) together.
25. **Missed abortion - Continued pregnancy** (POC)- This is probable in early pregnancy, less than four weeks after conception, six weeks LMP. The tissue removed from the uterus immediately after abortion should be inspected to ensure that all pregnancy tissue has been removed. The abortion has to be repeated in a week or so. (OBOS, pp 359)
26. **MTP Act** - Medical Termination of Pregnancy Act.
27. **Parenteral fluids** - Fluids injected through some other route, other than alimentary canal, as subcutaneous, intramuscular, etc. (Dorland's Medical Dictionary)
28. **Perforation** (POC) - It occurs if an instrument pierces through the uterus wall. The pulse, blood pressure, cramping and bleeding are closely monitored. The uterus generally heals quickly on its own. However, if a large blood vessel or another organ is damaged, hospitalization and probably surgery is needed. If abortion has been left incomplete due to perforation, it is finished in a hospital.
29. **Polyclinic** - A hospital and school where diseases and injuries of all kinds are studied and treated. (Dorland's Medical Dictionary)
30. **Postabortal Syndrome (Blood in the Uterus)** (POC) - If the uterus does not contract properly or if a blood lot blocks the cervical opening and prevents blood from leaving the uterus, blood collects within it resulting in pain, cramping and sometimes nausea increase. The clots can be removed either by deep massage directly over the uterus or if this failsb by reaspirating the uterus. (OBOS. pp 359)
31. **Primie** - First pregnancy
32. **Primie amenorrhoea** - Not getting the menses at appropritate age. this could be either congential (which mostly are difficult to attend to) or could be on account of anaemia and weak health status.
33. **Prostaglandin** - Non-hormonal substance, formed widely in body tissues of both males and females, from unsaturated fatty acids by the action of enzymes called prostaglandin synthetases. Natural prostaglandin of medical use are PGE_2 and $PGF_{2\alpha}$
34. **Quality** -
35. **Retained tissue** (POC) - Sometimes some tissue may be left behind after the abortion. Signs include heavy bleeding, passage of large blood clots, strong cramps, bleeding for longer 3 weeks, signs of pregnancy for more than one week. This tissue may get infected. To remove the tissue either methergine or ergotrate are given to stimulate the uterus to contract and push the retained tissue out or aspiration procedure is carried out. (OBOS, pp 359)
36. **Saline** - Salt water (OBOS)
37. **Suction** - Drawing out the contents of the uterus through a narrow tube attached to a gentle vacuum source. (OBOS)
38. **Trimester :**
    . First trimester - It is the first thirteen weeks
    . Second trimester - It is the fourteenth through twenty-fourth weeks
    . Third trimester - It is twenty-five weeks LMP and later (OBOS) .
39. **Uterine haemorrahge** (POC) - It may occur in second trimester abortions due to retained tissue, perforation or failure of uterus to contract. Drugs may be given to stimulate the uterine contractions, or aspiration may be done to slow done the bleeding. (OBOS, pp 359)
40. **Instruments used for abortion** - (Diagrams will be added).

NOTES

1. **Abortion procedures** - (OBOS)

a). Abortion by early uterine evacuation (EUE) -

- Pelvic exam confirms pregnancy
- Same technique as pre-emptive abortion except cannula size (5-6 mm) - flexible.
- Population control projects used this technique in Third World countries because it is easy to train lay persons to do it and doesn't require a motorised suction pump or much equipment.

b). Pre-emptive abortion (endometrial aspiration) - This is an aspiration procedure.

- 5-6 weeks
- Can be done without pregnancy test
- Smaller size cannulas (4-5 mm) - flexible
- No dilatation required, thus reducing the risk of perforating the uterus because of flexible cannulas.
- Only a few minutes procedure

- No anaesthesia required since no dilatation
- No motorised pump required for suction. Only a syringe is used to create a vacuum
- Test of Rh blood type are not part of pre-emptive abortions and Rh negative women are not usually offered Rhogam.

c). Abdominal hysterotomy - It is a minor caesarean section. It is performed in some centres when sterilization is wanted along with termination of mid-trimester pregnancy or in some cases of failure in the induction of abortion (Chaudhari, 1996, pp 230)

In a hysterotomy, the surgeon removes the foetus and placenta through an incision into the abdomen and uterus, like a small caesarean section. The incidence of serious complication for this kind of major surgery is considerably higher than for other methods of abortion. It may be required when induction methods have been repeatedly unsuccessful or can't be used for medical reasons. (OBOS, pp 358-359).

d). Dilatation and curettage - It is a standard gynaecological procedure used to treat conditions such as excessively heavy bleeding and to diagnose various uterine problems. It is usually done in a hospital under general anaesthesia. Most commonly used for the first trimester abortion. Now it has virtually been replaced by the quicker, easier and safer aspiration techniques which are usually done in clinics with local or no anaesthesia. Some doctors will do a D & C for abortions from 12 to 16 weeks. (OBOS, pp 358).

e). Dilation & Evacuation - It is newer method that combines D & C and VA techniques for abortions later than 12 weeks LMP. (OBOS, pp 358)

f). Induction abortion - The doctor injects (instills) an abortion causing solution through the abdomen into the amniotic sac, which surrounds the foetus. Before sixteen weeks LMP this sac is not large enough to be located accurately, so the induction procedure cannot be used until this time. Hours later, contractions cause the cervix to dilate and the foetus and placenta to be expelled.

g). Vacuum aspiration - removal of the uterine contents by application of a vacuum through a hollow curet or a cannula introduced into the uterus. (Dorland's Medical Dictionary)

In this, cervical opening is stretched (dilated) so that a larger cannula can be used. An electrically powered aspirator is the source of infection. (OBOS, pp 357)

h). Hysterectomy - There are certain situations where hysterectomy is preferable, e.g., in elderly patients with fibroid and often pelvic pathology; where ligation is not permitted by the church even after repeated caesarean sections; where there are previous histories of menorrhagia. (Chaudhari, pp 231).

Hysterectomy can't be supported as a routine method of terminating second trimester pregnancy where sterilization is required.

i). <u>Opposite views</u> - Use of D & E in ST :
OBOS - They are in favour
Chaudhari - He is not in favour

Woman should be given a choice if the provider can provide D & E (i.e., he has the required competence) and environment and the facilities.

j). Second trimester procedures - Advantages of D & E over induction :
- D & E is safer
- It is physically easier for a woman than an induction abortion, where she goes through labour and delivery of a foetus, often in a hospital room all by herself.
- D & E is much quicker (10-15 mins., compared to many hours with an overnight stay in a hospital for induction abortion).

D & C can be done in a properly equipped doctor's office or clinic with local anaesthetic and perhaps also with a tranquiliser.

Abortion procedures	First Trimester	Second Trimester
Surgical	Vacuum Aspiration D & C D & E	D & E Hysterotomy Hysterectomy
Medical	Induction method using prostaglandin as a - . smooth muscle stimulant / priming agent (to alter and soften the structure of cervix) . luteolytic agent inhibiting progesteron secretion of corpus luteum (not yet being used in human beings)	Induction by using either - - Drugs (Hypertonic saline, urea, emeredil, rivanol, ethacridine lactates.) either . Intra-amniotically or . Extra-amniotically or . Trans-cervically or . Trans-vaginally - Devices - Combined procedures using different combinations of drugs and devices.

2. Abortion equipment -

a). <u>Opposite views</u> : Use of flexible / non-flexible cannulas

Abortion procedure - Vacuum Aspiration (VA)

Source OBOS - Women's group feel the need to develop the safest, least physically traumatic VA techniques. Prefer minimal dilatation and small flexible cannulas reducing the chance of tearing or perforating the uterus or cervix. Experience at these clinics show that this approach is more comfortable for women than that of most conventionally trained abortionists, who use larger, rigid plastic or metal cannulas (which require more dilatation and curette after the suction).

Source Dr Chaudhari S.K., Practice of fertility control - For VA non-flexible plastic cannulas are preferable to the flexible Karman type of cannula because the latter stick to the uterine wall, the smaller holes are often choked with uterine contents and sometimes the tips are snipped off. Chaudhari prefers the metal cannulas because they can be sterilized by boiling for half an hour and can be used repeatedly, involves less cost.

Rigid plastic cannulas can be used repeatedly for 25 operations. Plastic cannulas can be sterilized by immersing them in a weak aqueous solution of povidine-iodine (1:2500) [Betadine solution of a definite orange colour, not yellow or brown] or other antiseptic solution (2% cetrimide in water) for about 20 minutes.

b). Electric suction machines - (Berclay is the best one) - locally made machines are also available.

- Suction machine used by the anaesthesists in the operation theatre also could be used.
- Hand pump / foot pump sets may be used where electricity is not available or power fails.
- Suction apparatus must produce atleast 25 inches or 625 mm Hg negative pressure during operation.
- Set should be checked pre-operatively and must be leak proof.

Reporting of the MTP cases : PHCs are expected to report the MTPs to the ZP whereas the private sector (from the whole district) reports to the DHS, Pune Circle in case of Pune. In case of Ratnagiri district both, private and public are supposed to report to ZP.

<u>Sterilisation</u> : There are two methods of sterilisation. They are autoclaving and boiling. Both are equally good. Except the fact that certain things, such as, plastic material, cloth, gloves etc can't be boiled for obvious reasons. Either autoclave machines or pressure vessels/cookers are used for autoclaving.

References:

1. Petchesky Rosalind Pollack, 1990, *Abortion and Woman's Choice: The State, Sexuality and Reproductive Freedom*, (Revised edition), Northeastern University Press, Boston.
2. Chaudhari S.K., 1996, *Practice of Fertility Control : A Comprehensive Textbook*, (Fourth Edition), B.I.Churchill Livingstone Pvt. Ltd.
3. *The New Our Bodies, Ourselves : A book by and for women*, 1992, Simon & Schuster Inc. New York, London, Toronto, Sydney, Tokyo, Singapore.

Annexure 5

PROTOCOL AND GUIDELINES FOR THE RESEARCH TEAM MEMBERS/INVESTIGATORS.

The guidelines laid down for the researchers/investigators were basically to maintain consistency and uniformity during data collection. The efforts were to made to minimise individual biases. They couldn't be eliminated completely yet by strictly following the guidelines, we tried to minimise them. It had special significance in the present case since a large portion of the data collection were through observation.

Following were the guidelines laid for field researchers while administering various interview schedules

General

- The name of the interviewer/observer, number of visits and the date of interview must be entered clearly.
- There is a set of interview/observation schedules to be administered at one single unit of the study. n case HI and the provider are the same persons.
- Even otherwise we have obtained these information from HI in 'personnel (Q No --)'.
- In case of gnarl hospital/polyclinic/cooperative/corporate/civil hospital (any setup which has more than one doctor/medical providers) the interview schedule designed for the provider should be administered with the one who provides abortion services. Please cover all the abortion providers in case there are more than at a particular centre.
- Please pose the question the way it has been framed.
- Try to maintain structured nature of the questions to reduce 'after efforts' required for data cleaning and stream-lining.
- . Avoid explaining a question since it may introduce investigators' biases while posing the question
- Please don't skip or alter the sequence of the questions, unless mentioned .
- If 'any other', please specify.
- Daily protocol should be maintained.
- Ideally there should be daily discussion after the field work which may not be possible but meeting once/twice a week is essential to discuss problems and experiences during the field work

Guidelines for researchers while administering 'Interview schedule for Head of the institution (HI)':

Q No 6 : Type of the institution (Public/private) : The categories Primary health centre (PHC), Rural hospital (RH), Cottage hospitals, corporation/municipality health care centres and district hospitals are the public health care service centres. RHs are earlier known as mother PHCs or Community Health centres (CHC).

Q no 7 : Structure of the institution : Maternity hospitals are those medical care service centres which provide obstetrics and gynaecological health care services which include delivery care, antenatal care (ANC), postnatal care (PNC), gynaecological illnesses under one roof. Many a times it may have paediatric health care facilities, too.

General hospitals are those which provide more than one specialised health care services including obstetrics and gynaecological health care services.

Q No 11 : Qualifications : Pl record the actual degree told by the provider and then tick the relevant category. Pl clarify, in case of any doubts about the system of medicine of his qualifications and level of his training in medical care. Specialisation should get recorded.

Q No 13 : Ownership of the institution :

5. *Corporate hospitals* are those which are sponsored/looked after by the companies. These hospitals are profit making.
6. *Cooperatives hospitals* are those which are supported by shareholders. Benefits and losses are shared among the shareholders
3. *The trust hospitals are* registered as trusts under the trust Act. There are trustees and beneficiaries and are run on no profit no loss basis.
4. *The society hospitals* are registered bodies as a society. These too are run on no profit, no loss basis and is more democratic in its style of function.

These hospitals thus are different from each other mainly in terms of rules and regulations which are guided by the respective Acts under which they are registered. This may have bearing on their policies about charges for the medical care they provide, subsidies, mode of drug supply etc.

NGOs could be either trusts or societies.

Q No 16 : Personnel : *1. Doctors :* Pl. record all the doctors, get information on sex, age and qualifications and their mode of associations with the centre (attached/on call/employee/uses this set up to attend his cases, especially those requiring operatives and admissions). Then get information on who all from among these conduct abortion at the centre and tick against them. Ask **'training' in abortion** only for abortion providers who are non-gynaecologists. Here we have to be specific about **abortion training.**

Q no 19 : Up to what length of gestation abortion services are provided
If the respondent mentions only up to 12 weeks, pl enquire if the centre ever attends abortion cases of more than 12 weeks.

Q No22 : Mode of drug supply : In case of '3' pl confirm if there is no replacement system of either all or essential drugs. If response is 'prescription', it should be categoried as '3 - no drugs are supplied in-house' only after confirming about replacement.

Ranking exercises : For example Q No 23 about the cost determinants
Hand over the set of cards to the respondents. Once s/he ranks them in descending order record the serial nos of the determinants written at the back of the card in the table here against the respective pre-typed ranks in the table.

Q No 39 : Registration status : If the centre appears in the DHS list, pl pre-record the registration status.

Which centres could be categorised as Non-registered abortion service centres ?

The **centre is registered**, but the **providers are not qualified in formal sense** (they are non-gynaecologists and do not have any training as per the Act) but do have skills to conduct abortion since they are conducting abortion for long or they have acquired such training in informal setup but in equally good setup, that is, **they are qualified in practical sense**).
The **centre is registered**, but the **providers are not qualified**, that is, they are non-gynaecologists and do not have any training as per the Act either formally or informally. **Thus are not qualified either in formal or practical sense.**

The centre is not registered, the **providers are qualified** (gynaecologists - MD, Gyneacologist, MBBS, DGOs etc.) or trained as per the need of the MTP Act (.....)

The centre is not registered, the **providers are not qualified in formal sense** (they are non-gynaecologists and do not have any training as per the Act) but do have skills to conduct abortion since they are conducting abortion for long or they have acquired such training in informal setup but in equally good setup **(that is they are qualified in practical sense).**

The **centre is not registered**, and the **providers are not qualified**, that is, they are non-gynaecologists and do not have any training as per the Act either formally or informally. **Thus are not qualified either in formal or practical sense.** (This includes ANMs, PHC doctors providing abortions at their own place, private practitioners and also local abortionists in conventional sense)

Guidelines for researchers while administering
Interview schedule for provider

Q No 8 : Qualifications

PI record the actual degree told by the provider and then tick the relevant category. PI clarify, in case of any doubts about the system of medicine of his qualifications and level of his training in medical care. Specialisation should get recorded.

Q No 15 : Preference to a particular method :

If the respondent does not respond with reference to the other methods of abortion, the probe could include names of these methods that are mentioned in the table here to get more focused response. For example : Respondent has said VA/SC is used. The probe could be 'The methods such as D & C and D & E are also used for abortion up to 12 weeks. Why do you prefer VA/SC particularly?'

Also if respondent says that s/he prefers a particular method because it is 'well accepted method', probe to understand as to why is it 'accepted' .

Q No 34 : IUCD/sterilisation compulsory or mandatory :

In case the respondent says that s/he does insert IUCD immediately after abortion (Q 26) then restrict the Q No 34 only to whether sterilisation is mandatory and don't ask whether IUCD is mandatory.

Annexure 6

THE MEDICAL TERMINATION OF PREGNANCY ACT, 1971

[No.34 OF 1971]

[10th August, 1971]

An Act to provide for the termination of certain pregnancies by registered medical practitioners and for matters connected therewith or incidental thereto.

Statement of Objects and Reasons – (1) *The provisions regarding the termination of pregnancy in the Indian Penal Code which were enacted about a contury age were drawn up in keeping with the British Law on the subject. Abortion was made a crime for which the mother as well as the abortionist could be punished except where it had to be induced in order to save the life of the mother. It has been stated that this very strict law has been observed in the breach in a very large number of cases all over the country. Furthermore, most of these mothers are married women, and are under no particular necessity to conceal their pregnancy.*

(2) *In recent years, when health services have expanded and hospitals are availed of to the fullest extent by all classes of society, doctors have often been confronted with gravely ill or dying pregnant women whose pregnant uterus has been tampered with a view to causing an abortion and consequently suffered very severely.*

(3) *There is thus avoidable wastage of the mother's health, strength and, sometimes, life. The proposed measure which seeks to liberalise certain existing provisions relating to termination of pregnancy has been received (1) as a health measure – when there is danger to the life or risk to physical or mental health of the woman, (2) on humanitarian grounds – such as when pregnancy arises from a sex crime like rape or intercourse with a lunatic woman, etc., and (3) eugenic grounds – where there is substantial risk that the child, if born, would suffer from deformities and diseases.* – Gazette *of India, Pt. II, Section 2, Extra, dated November 17, 1969, p.880.*

Be it enacted by Parliament in the Twenty-second Year of the Republic of India as follows :-

1. **Short title, extent and commencement** – (1) This Act may be called the Medical Termination of Pregnancy Act 1971.
   (2) It extends to the whole of India except the State of Jammu and Kashmir.
   (3) It shall come into force on such date as the Central Government may, by notification in the Official *Gazette*, appoint.

2. **Definitions** – In this Act, unless the context otherwise requires, –
   (a) "guardian" means a person having the care of the person of a minor or a lunatic;
   (b) "lunatic" has the meaning assigned to it in Section 3 of the Indian Lunacy Act, 1912 (4 of 1912);
   (c) "minor" means a person who, under the provisions of the Indian Majority Act, 1875 (9 of 1875), is to be deemed not to have attained his majority;
   (d) "registered medical practitioner" means a medical practitioner who possesses any recognised medical qualification as defined in clause (h) of Section 2 of the Indian Medical Council Act, 1956 (102 of 1956), whose name has been entered in a State Medical Register and who has such experience or training in gynaecology and obstetrics as may be prescribed by rules made under this Act.

NOTES

Though the Indian Lunacy Act defines "lunatic" as an idiot or a person of unsound mind, the said words have not been defined. Both these words indicate an abnormal state of mind as distinguished from weakness of mind senility following old age. A man of weak mental strength cannot be called an idiot or a man of unsound mind. The definition does not include dull-witted people but only those who suffer from a mental disorder or derangement of the mind. Ganga Bhavanamma v. Somaraju, AIR 1957 AP 938.

"Unsoundness of mind" implies some unusal feature of the mind as has tended to make it different from the normal and has in effect impaired the man's capacity to look after his affairs in a manner in which another person without such mental irregularity would be able to do in the matter of his own. The idea suggests some derangement of the mind and it is not to be confused with or taken as analogous to a mere mental weakness or lack of intelligence. Sarjug Singh v. Gulabo Kuer, AIR 1969 Pat 33.

No person can have direct experience of the mind of another and the proper test of insanity is conduct. A person might conceivably have all kinds of delusions, but if his conduct remains normal there would be no justification for holding him to be lunatic. Abdul Razak v. Commissioner of Income Tax, AIR 1935 pat 425.

If a man is able to understand and answer questions on various matters except those relating to arithmetical calculations, he cannot be regarded as mentally unsound although he would be held as having a weak or undeveloped mind. Joshi Ram Krishan v. Rukmini Bai, AIR 1949 All 449.

Under Indian Majority Act, 1875, a person in respect of whose person or property a guardian has been appointed by a court of justice or a person who is under the jurisdiction of Court of Wards attains majority on the completion of twenty first-year and in all other cases a person is deemed to attain the age of majority on the completion of eighteenth year.

3. When pregnancies may be terminated by registered medical practitioners – (1) Notwithstanding anything contained in the Indian Penal Code (45 of 1860), a registered medical practitioner shall not be guilty of any offence under that Code or under any other law for the time being in force, if any pregnancy is terminated by him in accordance with the provisions of this Act.

(2) Subject to the provisions of sub-section (4), a pregnancy may be terminated by a registered medical practitioner, –

(a) where the length of the pregnancy does not exceed twelve weeks, if such medical practitioner is, or

(b) where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioners are,

of opinion, formed in good faith, that –

(i) 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

(ii) there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.

Explanation I.– Where any pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman.

Explanation II. – Where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman.

(3) In determining whether the continuance of a pregnancy would involve such risk or injury to the health as is mentioned in sub-section (2), account may be taken of the pregnant woman's actual or reasonably foreseeable environment.

(4) (*a*) No pregnancy of a woman, who has not attained the age of eighteen years, or, who, having attained the age of eighteen years, is a lunatic, shall be terminated except with the consent in writing of her guardian.

(b) Save as otherwise provided in clause (*a*), no pregnancy shall be terminated except with the consent of the pregnant woman.

4. Place where pregnancy may be terminated. – No termination of pregnancy shall be made in accordance with this Act at any place other than –

(a) a hospital established or maintained by Government, or

(b) a place for the time being approved for the purpose of this Act by Government.

5. Section 3 and 4 when not to apply. –(1) The provision of Section 4, and so much of the provisions of sub-section (2) of Section 3 as relate to the length of the pregnancy and the opinion of not less than two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman.

(2) Notwithstanding anything contained in the Indian Penal Code (45 of 1860), the termination of a pregnancy by a person who is not a registered medical practitioner shall be an offence punishable under that code, and that code shall, to this extent, stand modified.

Explanation. – For the purpose of this section, so much of the provisions of clause (*d*) of Section 2 as relate to the possession by a registered medical practitioner, of experience or training in gynaecology and obstetrics shall not apply.

NOTES

Good Faith : Meaning – Good faith is defined by Section 52 of the Indian Penal Code. Nothing is said to be done or believed in good faith which is done or believed without due care and attention. Under the General Clauses Act. "A thing shall be deemed to be done in good faith where it is in fact done honestly whether it is done negligently or not". The element of honesty which is introduced by the definition prescribed by the General Clauses Act is not introduced by the definition prescribed by Section 52 of the Penal Code.

Absence of personal malice may be a relevant fact in dealing with the plea of good faith but its significance or importance cannot be exaggerated. Even in the absence of personal malice it will have to be shown that the act was done with due care and attention. Harbhajan Singh v. State of Punjab, AIR 1966 SC 97 : 1966 Cri LJ 82.

Due care and attention implies a genuine effort to reach the truth and not the ready acceptance on ill-natured belief. The question of good faith is a question of fact and must be gathered from the surrounding circumstances. Mere actual belief without any reasonable grounds for believing is not

Good faith precludes pretence or deceit and also negligence and recklessness. A lack of deligence which an honest man or ordinary prudence's accustomed to exercise, is, in law, a want of good faith. Once this is shown, good faith does not require a sound judgement. Harbhajan Singh v. State of Punjab. AIR 1961 Punj 215.

Good faith requires due care and caution, but there can be no general standard of care and attention applicable to all persons and under all circumstances. The standard of care and caution must be judged according to the capacity and intelligence of the person whose conduct is in question. State of Orissa v. Ram Bahadur Thapa, AIR 1960 Ori 161.

It is not necessary for the surgeon to wait until the patient is in peril of immediate death if he ahs reasonable grounds to believe that the probable consequence of the continuance of the pregnancy would be to make the patient a physical and mental wreck. (1938) 3 All ER 615.

It the doctor is of opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck the court is entitled to take the view that the doctor who, under those circumstances and in that honest belief, operates, is operating for the purpose of preserving the life of the mother. (1939) 1 KB 687.

A patient who puts himself under the treatment of a medical practitioner qualified or otherwise gives an implied consent to suffer the harm and to take the risk. But where the medical practitioner is not qualified or begins to apply a medicine which no man in his senses would dare to apply, the consent is not a consent obtained in good faith. Tuggankhan Tamshan Khan v. State, AIR 1963 MP 102.

6. Power to make rules. – (1) The Central Government may, by notification in the Official *Gazette*, make rules to carry out the provisions of this Act.

(2) In particular, and without prejudice to the generality of the foregoing power, such rules may provide for all or any of the following matters, namely –

a) the experience or training, or both, which a registered medical practitioner shall have if he intends to terminate any pregnancy under this Act; and
b) such other matters as are required to be or may be, provided by rules made under this Act.

(3) Every rule made by the Central Government under this Act shall be laid, as soon as may be after it is made, before each House of Parliament while it is in session for a total period of thirty days, which may be comprised in one session or in two successive sessions, and if, before the expiry of the session in which it is so laid or the session immediately following, both Houses agree in making any modification in the rule or both Houses agree that the rule should not be made, the rule shall thereafter have effect only in such modified form or be of no effect, as the case may be; so, however, that any such modification or annulment shall be without prejudice to the validity of anything previously done under that rule.

7. Power to make regulations. – (1) The State Government may, by regulations, –

(a) require any such opinion as is referred to in sub-section (2) of Section 3 to be certified by a registered medical practitioner or practitioners concerned, in such form and at such time as may be specified in such regulations, and the preservation or disposal of such certificates;
(b) require any registered medical practitioner, who terminates a pregnancy, to give intimation of such termination and such other information relating to the termination as may be specified in such regulations;
(c) prohibit the disclosure, except to such persons and for such purposes as may be specified in such regulations, of intimations given or information furnished in pursuance of such regulations.

(2) The intimation given and the information furnished in pursuance of regulations made by virtue of clause (*b*) of sub-section (1) shall be given or furnished, as the case may be, to the Chief Medical Officer of the state.

(3) Any person who willfully contravenes or willfully fails to comply with the requirements of any regulation made under sub-section (1) shall be liable to be punished with the fine which may extend to one thousand rupees.

8. Protection of action taken in good faith. – No suit or other legal proceeding shall lie against any registered medical practitioner for any damage caused or likely to be caused by anything which is in good faith done or intended to be done under this Act.

****

MEDICAL TERMINATION OF PREGNANCY RULES, 1975

In exercise of the powers conferred by Section 6 of the **Medical Termination of Pregnancy Act, 1971** (34 of 1971), the Central Government hereby makes the following rules, namely:

1. **Short title and commencement.** – (1) These rules may be called the Medical Termination of Pregnancy Rules, 1975.

(2) They shall come into force on the date of their publication in the Official *Gazette*.

2. **Definitions.** – In these rules, unless the context otherwise requires,
   (a) "Act" means the Medical Termination of Pregnancy Act, 1971 (34 of 1971);
   (b) "Chief Medical Officer of the District" means the Chief Medical officer of a District, by whatever name called;
   (c) "Form" means a form appended these rules;
   (d) "Owner" in relation to a place, means any person who is the administrative head or otherwise responsible for the working or maintenance of such hospital or clinic, by whatever name called;
   (e) "Place" means such building, tent, vehicle or vessel, or part thereof, as is used for the establishment or maintenance therein of a hospital or clinic which is used, or intended to be used for the termination of any pregnancy;
   (f) "Section" means a section of the Act.

3. **Experience or training etc.** –For the purpose of clause (*d*) of Section 2, a registered medical practitioner shall have one or more of the following experience or training in gynaecology and obstetrics, namely –
   (a) in the case of a medical practitioner who was registered in a State Medical Register immediately before the commencement of the Act, experience in the practice of gynaecology and obstetrics for a period of not less than three years;
   (b) in the case of medical practitioner who was registered in a State Medicial Register on or after the date of the commencement :
      (*i*) if he has completed six months of house surgency in gynaecology and obstetrics ; or
      (*ii*) where he has not done any such house surgency, if he had experience at any hospital for a period of not less that one year in the practice of obstetrics and gynaecology ; or
      (*iii*) if he has assisted a registered medical practitioner in the performance of twenty five cases of medical termination of pregnancy in a hospital established or maintained, or a training institute approved for this purpose, by the Government.

(*c*) in the case of a medical practitioner who has been registered in a State Medical Register and who holds a post-graduate degree or diploma in gynaecology and obstetrics, the experience or training gained during the course of such degree or diploma.

4. **Approval of a place.** – (1) No place shall be approved under clause (*b*) of Section 4, –
   (*i*) unless the Government is satisfied that termination of pregnancies may be done therein under safe and hygienic conditions; and
   (*ii*) unless the following facilities are provided therein, namely:
      (a) an operation table and instruments for performing abdominal or gynaecological surgery;
      (b) anaesthetic equipment,resuscitation equipment and sterilisation equipment ;
      (c) drugs and parenteral fluids for emergency use.

(2) Every application for the approval of a place shall be in a Form A and shall be addressed to the Chief Medical Officer of the District.

(3) On receipt of an application referred to in sub-rule (2), the Chief Medical Officer of the District shall verify or enquire any information contained in any such application or inspect any such place with a view to satisfy himself that the facilities referred to in sub-rule (1) are provided therein, and that termination of pregnancies may be made therein under safe and hygienic conditions.

(4) Every owner of the place which is inspected by the Chief Medical Officer of the District shall afford all reasonable facilities for the inspection of the place.

(5) The Chief Medical Officer of the District may, if he is satisfied after such verification, enquiry or inspection, as may be considered necessary, that termination of pregnancies may be done under safe and hygienic conditions, at the place, recommend the approval of such place to the Government.

(6) The Government may after considering the application and the recommendations of the Chief Medical Officer of the District approve such place and issue a certificate of approval in Form B.

(7) The certificate of approval issued by the Government shall be conspicuously displayed at the place to be easily visible to persons visiting the place.

5. **Inspection of a place.** – (1) A place approved under Rule 4 may be inspected by the Chief Medical Officer of the District, as often as may be necessary with a view to verify whether termination of pregnancies is being done therein under safe and hygienic conditions.

(2) If the Chief Medical Officer has reason to believe that there has been death of, or injury to, a pregnant woman at the place or that termination of pregnancies is not being done at the place under safe and hygienic conditions, he may call for any information or may seize any article. medicine, ampule, admission register or other document, maintained, kept or found at the place.

(3) The provisions of the Code of Criminal Procedure, 1973 (2 of 1974), relating to seizure shall, so far as may be, apply to seizures made under sub-rule (2).

6. **Cancellation or suspension of certificate of approval.** – (1) If, after inspection of any place approved under Rule 4, the Chief Medical Officer of the District is satisfied that the facilities specified in Rule 4 are not being properly maintained therein and the termination of pregnancy at such place cannot be made under safe and hygienic conditions, he shall make a report of the fact to the Government giving the detail of the deficiencies or defects found at the place. On receipt of such report the Government may, after giving the owner of the place a reasonable opportunity of being heard, either cancel the certificate of approval or suspend the same for such period as it may think fit.

(2) Where a certificate issued under Rule 4 is cancelled or suspended, the owner of the place may make such additions or improvements in the place as he may think fit and thereafter, he may make an application to the Government for the issue to him of a fresh certificate of approval under Rule 4 or, as the case may be, for the revival of the certificate which was suspended under sub-rule (1).

(3) The provisions of Rule 4 shall, as far as may, apply to an application for the issue of a fresh certificate of approval in relation to a place, or as the case may be, for the revival of a suspended certificate as they apply to an application for the issue of a certificate of approval under that rule.

(4) In the event of suspension of a certificate of approval, the place shall not be deemed to be an approved place for the purposes of termination of pregnancy from the date of communication of the order of such suspension.

7. Review. – (1) The owner of a place who is aggrieved by an order made under Rule 6, may make an application for review of the order to the Government within a period of sixty days from the date of such order.

(2) The Government may, after giving the owner an opportunity of being heard, confirm, modify or reverse the order.

8. Form of consent. – The consent referred to in sub-section (4) of section 3 shall be given in Form C.

9. Repeal and saving. – The Medical Termination of Pregnancy Rules, 1972, are hereby repealed except as respects things done or omitted to be done before such repeal.

FORM A

[*See* sub-rule (2) of Rule 4]

Form of application for the approval of a place under clause (*b*) of Section 4.

1. Name of the place (in capital letters)
2. Address in full
3. Non-Governmental/Private/Nursing home/Other Institutions*.
4. State, if the following facilities are available at the place:
   - (*i*) An operation table and instruments for performing abdominal or gynaecological surgery.
   - (*ii*) Drugs and parenteral fluid in sufficient supply for emergency cases.
   - (*iii*) Anaesthetic equipment, resuscitation equipment and sterilisation equipment.

Place: *Signature of the owner of the place*

Date:

*Strike out whichever is not applicable.

FORM B

[*See* sub-rule (6) of Rule 4]

Certificate of approval.

The place described below is hereby approved for the purpose of the Medical Termination of Pregnancy Act, 1971 (34 of 1971).

Name of the Place _____ Address and other descriptions _____ Name of the owner _____

to the Government of the _____

Place:
Date:

FORM C

[*See* Rule 8]

I _____ daughter/wife of _____ aged about _____ years of _____

_____

(here state the permanent address)

at present residing at _____ do hereby give my consent to the termination of my pregnancy at _____

_____.

(State the name of place where the pregnancy is to be terminated)

Place:
Date:

Signature

(To be filled in by guardian where the woman is a lunatic or minor)

I _____ son/daughter/wife of _____ aged about _____ years of _____ at present residing at _____

_____

(Permanent address)

do hereby give my consent to the termination of the pregnancy of my ward _____ who is a minor/lunatic at _____

(place of termination of pregnancy)

Place:
Date:

Signature

*****

MEDICAL TERMINATION OF PREGNANCY REGULATIONS, 1975

In exercise of the powers conferred by Section 7 of the **Medical Termination of Pregnancy Act, 1971** (34 of 1971), the Central Government hereby makes the following regulations, namely : –

1. Short title and commencement. – (1) These regulations may be called the Medical Termination of Pregnancy Regulations, 1975.

(2) They extend to all the Union territories.

(3) They shall come into force on the date of their publication in the Official *Gazette*.

2. Definitions. – In these regulations, unless the context otherwise requires –

(a) "Act" means the Medical Termination of Pregnancy Act, 1971 (34 of 1971);

(b) "Admission Register" means the register maintained under regulation 5;

(c) "Approved place" means a place approved under Rule 4 of the Medical Termination of Pregnancy Rules, 1975;

(d) "Chief Medical Officer of the State" means the Chief Medical Officer of the State, by whatever name called;

(e) "Form" means a form appended to these regulations;

(f) "hospital" means a hospital established or maintained by the Central Government or the Government of the Union territory;

(g) "section" means a section of the Act.

3. Form of certifying opinion or opinions. – (1) Where one registered medical practitioner forms or not less than two registered medical practitioners form such opinion as is referred to in sub-section (2) of Section 3 or Section 5, he or they shall certify such opinion in Form I.

(2) Every registered medical practitioner who terminates any pregnancy shall, within three hours from the termination of the pregnancy certify such termination in Form I.

4. Custody of forms. – (1) The consent given by a pregnant woman for the termination of her pregnancy, together with the certified opinion recorded under Section 3 or Section5, as the case may be and the intimation of termination of pregnancy shall be placed in an envelope which shall be sealed by the registered medical practitioner or practitioners by whom such termination of pregnancy was performed and until that envelope is sent to the head of the hospital or owner of the approved place or the Chief Medical Officer of the State, it shall be kept in the safe custody of the concerned registered medical practitioner or practitioners, as the case may be.

(2) On every envelope referred to in sub-regulation (1), pertaining to the termination of pregnancy under Section 3, there shall be noted the serial number assigned to the pregnant woman in the Admission Register and the name of the registered medical practitioner or practitioners by whom the pregnancy was terminated and such envelope shall be marked "SECRET".

(3) Every envelope referred to in sub-regulation (2) shall be sent immediately after the termination of the pregnancy to the head of the hospital or owner of the approved place where the pregnancy was terminated.

(4) On receipt of the envelope referred to in sub-regulation (3), the head of the hospital or owner of the approved place shall arrange to keep the same in safe custody.

(5) Every head of the hospital or owner of the approved place shall send to the Chief Medical Officer of the State, a weekly statement of cases where medical termination of pregnancy has been done in Form II.

(6) On every envelope referred to in sub-regulation (1), pertaining to a termination of pregnancy under Section 5, shall be noted the name and as address of the registered medical practitioner by whom the pregnancy was terminated and the date on which the pregnancy was terminated and such envelopes shall be marked "SECRET".

Explanation. – The columns pertaining to the hospital or approved place and the serial number assigned to the pregnant woman in the Admission Register shall be left blank in Form I in the case of termination performed under Section 5.

(7) Where the Pregnancy is not terminated in an approved place or hospital, every envelope referred to in sub-regulation (6) shall be sent by registered post to the Chief Medical Officer of the State on the same day on which the pregnancy was terminated or on the working day next following the day on which the pregnancy was terminated:

Provided that where the pregnancy is terminated in an approved place or hospital, the procedure provided in sub-regulations (1) to (6) shall be followed.

5. Maintenance of Admission Register – (1) Every head of the hospital or owner of the approved place shall maintain a register in Form III for recording therein the admissions of women for the termination of their pregnancies

(2) The entries in the Admission Register shall be made serially and a fresh serial shall be started at the commencement of each calendar year and the serial number of the particular year shall be distinguished from the serial number of other years by mentioning the year against the serial number, for example, serial number 5 of 1972 and serial number 5 of 1973 shall be mentioned as 5/1972 and 5/1973.

(3) The Admission Register shall be a secret document and the information contained therein as to the name and other particulars of the pregnant woman shall not be disclosed to any person.

6. Admission Register not to be open to inspection. – The Admission Register shall be kept in the safe custody of the head of the hospital or owner of the approved place, or by any person authorised by such head or owner and save as otherwise provided in sub-regulation (5) of Regulation 4 shall not to be open to inspection by any person except under the authority of : –

(*i*) in the case of a departmental or other enquiry, the Chief Secretary to the Government of a Union territory;

(*ii*) in the case of an investigation into an offence, a Magistrate of the First Class within the local limits or whose jurisdiction the hospital or approved place is situated.

(*iii*) in the case of suit or other action for damages, the District Judge, within the local limits of whose jurisdiction the hospital or approved place is situated;

Provided that the registered medical practitioner shall, on the application of an employed woman whose pregnancy has been terminated, grant a certificate for the purpose of enabling her to obtain leave from her employer:

Provided further that any such employer shall not disclose this information to any other person.

7. Entries in registers maintained in hospital or approved place – No entry shall be made in any case-sheet operation theatre register, follow-up card or any other document or register (except the Admission Register) maintained at any hospital or approved place indicating therein the name of the pregnant woman and reference to the pregnant woman shall be made therein by the serial number assigned to such woman in the Admission Register.

8. Destruction of Admission Register and other Papers. – Save as otherwise directed by the Chief Secretary to the Union territory Administration or for in relation to any proceeding pending before him, as directed by a District Judge or a Magistrate of the First Class, every Admission Register shall be destroyed on the expiry of a period of five years from the date of the last entry in that Register and other papers on the expiry of a period of three years from the date of the termination of the pregnancy concerned.

FORM I

(*See* Regulation 3)

_____

(Name and qualification of the Registered Medical Practitioner in block letters)

_____

(Full address of the Registered Medical Practitioner)

I _____

(Name and qualification of the Registered Medical Practitioner in block letters)

_____

(Full address of the Registered Medical Practitioner) hereby certify that * I/we/am/are of opinion, formed in good faith, that it is necessary to terminate the pregnancy of _____

_____

(Full name of pregnant women in block letters)

resident of _____

(Full address of women in block letters)

for the reasons given below**.

*I/we hereby give intimation that *I/we terminated the pregnancy of the woman referred to above who bears the serial No _____ in the Admission Register of the Hospital/approved place.

Place:

Signature of the Registered Medical Practitioner

Date

Signature of the Registered Medical Practitioner

* Strike out whichever is not applicable.

** of the reasons specified items (*i*) to (*v*) write the one which is appropriate: –

(*i*) In order to save the life of the pregnant woman.

(*ii*) In order to prevent grave injury to the physical or mental health of the pregnant woman.

(*iii*) In view of the substantial risk that if the child was born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

(*iv*) As the pregnancy is alleged by pregnant woman to have been caused by rape.

(*v*) As thee pregnancy has occurred as a result of failure of any contraceptive device or method used by the married woman or her husband for the purpose of limiting the no. of children.

Note :– Account may be taken of the pregnant women's actual or reasonably foreseeable environment in determining whether the continuance of a pregnancy would involve a grave injury to her physical or mental health.

FORM II

[*See* Regulation 4 (5)]

1. Name of the State.

2. Name of Hospital/approved place.

3. Duration of pregnancy (give total No. only)
   a) Upto 12 weeks
   b) Between 12-20 weeks.

4. Religion of woman.
   a) Hindu
   b) Muslim
   c) Christian
   d) Others
   e) Total

5. Termination with acceptance of contraception.
   a) Sterilisation
   b) I.U.D.

6. Reasons for termination : (give total number under each sub-head).
   a) Danger to life of the pregnant woman.
   b) Grave injury to the physical health of the pregnant woman.
   c) Grave injury to the mental health of the pregnant woman.
   d) Pregnancy caused by rape.
   e) Substantial risk that if the child was born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.
   f) Failure of any contraceptive device or method.

Signature of the Officer Incharge with date.

SECRET

FORM III

[*See* Regulation 5]

ADMISSION REGISTER

(To be destroyed on the expiry of five years from the date of the last entry in the Register)

S. No.	Date of Admission	Name of Patient	Wife/Daughter of	Age	Religion
1	2	3	4	5	6

Address	Duration of Pregnancy	Reasons on which pregnancy is terminated	Date of termination of pregnancy
7	8	9	10

Date of discharge of patient	Result and Remarks	Name of Registered Medical Practitioner(s)by whom the opinion is formed	Name of Registered Medical Practitioner by whom pregnancy is terminated
11	12	13	14

*****

ANNEXURE 7
Letter of Introduction to the Respondents

Dear Dr

Greetings! We are a research centre of Anusandhan Trust, a non-profit educational trust. The research centre CEHAT (which in Hindi means health) is working in health and related areas. The various areas in health research that are flourishing in our institution are women's health; health economics; health legislation, ethics and patients' rights, and law; health and human rights; medical ethics. On each of these themes CEHAT is committed to do Research, Action, Service and Advocacy.

We have been working on abortion issue from rural women's perspective for last three years. One of the major areas, which came into focus very sharply, was about women's perceptions, which are based on their experiences about abortion facilities. This required us to take up a research programme with abortion providers to understand their views about this sensitive issue, especially focusing on existing abortion services vis-à-vis areas and scope of improvement so as to facilitate woman's access to abortion. We have appreciation for abortion providers who face odd situations on number of account, be it counselling services to woman or dealing with government authorities and bureaucrats. Providers' initiative in offering abortion services is valuable for obvious reasons. When we tried to understand one side of the coin - women's perspective - it is equally important to get back to providers to understand and feel the problems they are facing while providing abortion services at various level, such as, lack of resources, especially in rural areas, legal restrictions and cumbersome procedures involved in registration formalities and lack of co-operation from government inspecting authorities. Lack of safe abortion facilities has direct bearing on increased mortality and morbidity in abortion we all together have to work towards providing and assisting to provide safe abortion services.

This meeting with you constitutes part of survey being conducted to locate abortion service centres. We are here to seek your cooperation in locating abortion providers and if you provide such services we will get back to you soon for an interview. Your participation in the study is much appreciated and welcome. It is valuable not only for data collection but for each one of us who is associated to the issue of abortion, though in different capacities and roles but are equally concerned about women getting safe abortion facilities. **Your identities, unless wanted by you, will not be revealed ever at any point during or after the research.**

We have come up with some research material based on the earlier study. We would be most happy to make it available for you. Please feel free to get more information from us about our institution and our work. Ms. Anjali Ganpule, Ms. Madhuri Sumant, Ms. Mugdha Lele, Ms Hemlata Pisal and myself form the research team on this project. One of us will be there for conducting interview. I am sure you will have lot many queries to be answered by us. We will be happy to do it.

Thanking you for sparing your precious time for us. With regards,

Sincerely

(Dr Sunita Bandewar)
Project-in-charge, REAP, CEHAT.