

Abortion Assessment Project - India

Situation Analysis of Abortion Services in Rajasthan

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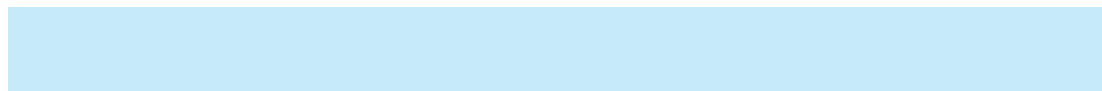
List of Abbreviations

BAMS	Bachelor of Ayurvedic Medicine & Surgery
BHMS	Bachelor of Homeopathic Medicine & Surgery
BUMS	Bachelor of Unani Medicine & Surgery
CHC	Community Health Centre
CMHO	Chief medical & Health Officer
DHMS	Diploma of Homeopathic Medicine & Surgery
DGO	Diploma of Gynecology & Obstetrics
D&C	Dilatation & Curettage
D&E	Dilatation & Evacuation
EVA	Electric Vacuum Aspiration
ESI	Employees State Insurance
FW	Family Welfare
FOGSI	Federation of Obstetricians and Gynecologists of India
GOR	Government of Rajasthan
HIV	Human Immunodeficiency Virus
ISH	Indian Systems of Medicine
IUD	Intra Uterine Device
IEC	Information Education & Communication
MD	Doctorate of Medicine
MS	Master of Surgery
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
MSW	Master of Social Works
MBBS	Bachelor of Medicine & Bachelor of Surgery
MOHFW	Ministry of Health & Family Welfare
NIHFW	National Institute of Health & Family Welfare
OT	Operation Theatre
OPD	Outpatient Door
PHC	Primary Health Centre
POC	Products of Conception
RTIs	Reproductive Tract Infections
RMP	Registered Medical Practitioner
RCH	Reproductive & Child Health
STDs	Sexually Transmitted Diseases
SC	Subcentre
TT	Tetanus Toxoid
UTI	Urinary Tract Infection
VDRL	Venereal Disease Research Laboratory
WHO	World Health Organization

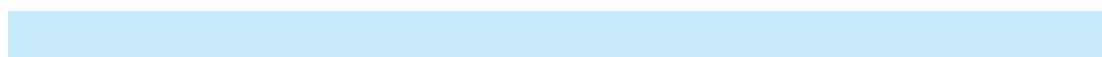
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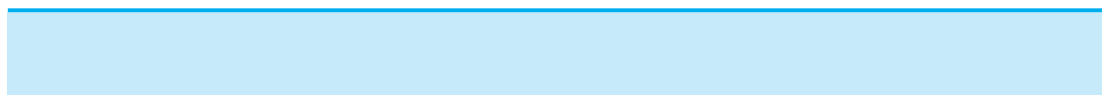
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Introduction

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7.2 MTP Training

7.2.1 Guidelines for MTP training

Introduction

Despite legalization of elective abortion through the Medical Termination of Pregnancy (MTP) Act in 1971, the availability of abortion services, particularly in rural areas of states like Rajasthan, remains limited. Data from the sample registration scheme (SRS) shows that abortion complications are responsible for 15% to 35% of maternal deaths in Rajasthan⁶. The state has 32 government district hospitals, 263 community health centres and 1662 primary health centres⁷, all of which are mandated to provide elective abortion services. However, most rural health centres and several hospitals lack trained doctors and/or equipment. A facility survey⁸ sponsored by the Ministry of Health & Family Welfare in 1999 showed that only 16% of CHCs had posted an obstetrician, while only 2% PHCs had a doctor trained to perform abortions (MTPs). The survey further revealed that only 4% of PHCs provided MTP services.

The “Abortion Assessment Project” was initiated to understand the situation regarding abortion services in India. Two civil society entities — Center for Enquiry into Health & Allied Themes (CEHAT), Mumbai and HealthWatch coordinated the project, which included a review of abortion related policies, a multi-centric study of abortion facilities in 6 states, a community based study of abortion rates in two states, and several qualitative studies on specific issues to explore provider, user perspectives and the social and economic context of abortion. A major part of the project resources were devoted to a multi-centric study of 6 states, initiated in 2001.

6 SRS 1998

7 Government of India, Bulletin of Rural Health Statistics in India. New Delhi: Rural Health Division, Directorate General of health services, Department of Family Welfare, Ministry of Health AND family Welfare, 2000.

8 International Institute of Population sciences. Facility Survey (Under Reproductive and Child Health Project) Phase-I, 1999. Mumbai 2001

In Rajasthan, the general objectives of the study were:

1. To assess availability and adequacy of abortion services in districts of the state
2. To assess institutional readiness for delivery of quality MTP services in the state.

Covering the public, private and informal health sectors in the state, the specific objectives were to carry out the following:

1. Map the availability of abortion providers
2. Outline the organization of abortion services and their linkage to other reproductive health services
3. Study the techniques used for abortion
4. Review processes for training of personnel; and certification of institutions
5. Assess institutional readiness for delivery of quality MTP services in terms of:
 - त Physical facilities and service environment
 - त Equipment and supplies
 - त Professional standards and service guidelines
 - त Privacy and confidentiality
 - त Training systems
 - त Technical competence of providers and managers
6. To assess the utilization of available capacity for abortion care, and estimate the cost of service.

Methodology

2.1 Sample selection

Based on defined criteria, two districts, Jalore and Kota were selected for this project. Jalore represented one of five most backward districts of Rajasthan (the others were Jaisalmer, Barmer, Sawai Madhopur and Karauli), while Kota represented one of the five most progressive districts (the others were Jaipur, Sikar, Churu and Jhunjhunu), and it also included a large urban area. For each district, we listed all blocks along with census 1991 information on population (projected to 2002), sex ratio, urbanization, population belonging to scheduled castes and tribes and female literacy ratio.

Table 2.1: Profile of Selected Districts

	<i>Dist 1 (Jalore)</i>	<i>Dist 2 (Kota)</i>	<i>State</i>	<i>Source of information and year</i>
Area (square kilometers)	1,0640	1,2436	34,2239	Census of India, 1991
Total population	750,613	1,952,597	2,703,210	Census, 2001
% Rural population	90.6%	52.3%	62.9%	Census, 2001
Total fertility rate	5	5	4.9	
Contraceptive prevalence rate	32.6	42.5	19.8	
Percentage of institutional births	11	32.5	19.8	
Male/female IMR	96	91	79	
Female literacy	81667	459142	540809	Census, 2001
Male literacy	199957	739613	939570	Census, 2001
Sex ratio	942	881	910	

Demographic data on the blocks of the sampled districts has been depicted in table below

2.2 Listing of providers

Table 2.2: Demographic profile of sampled districts

Block	Population 1991	Estimated Population 2002	Proportion urban	SC+ST	Total literacy	Female literacy
Jalore District						
Ahore	150,191	187,739	0%	31%	28%	11%
Raniwara	123,125	153,906	0%	33%	20%	5%
Sayla	165,270	206,588	0%	27%	20%	6%
Jaswantpura	106,325	132,906	0%	17%	21%	5%
Jalore	107,936	134,920	24%	29%	26%	9%
Sanchore	260,312	325,390	7%	22%	19%	3%
Bhinmal	146,196	182,745	17%	23%	18%	3%
Jalore District	1,142,563	1,428,204	7%	26%	21%	6%
Kota District						
Itawa	127,120	158,900	0%	48%	28%	19%
Sultanpur	123,824	154,780	0%	42%	33%	21%
Ladpura (Including kota city)	663,013	828,766	83%	22%	55%	37%
Ramganj Mandi	168,360	210,450	28%	37%	34%	25%
Sangod	138,188	172,735	11%	31%	34%	22%
Kota city	537,371	671,714	100%	20%	60%	38%
Ladpura rural	125,642	157,053	13%	31%	31%	22%
Kota District	2,030,831	2,538,539	36%	34%	38%	29%

From each district, we short-listed one block that was more urban than the district average. As expected, these turned out to be the blocks containing the district headquarters. In the case of Kota district, we treated Kota city as one large (urban) block. We next sampled one block whose proportion of urbanization was closest to the district average. Lastly we sampled blocks that were less urban than the district average. In both districts, more than one “less urban”, i.e. highly rural block was eligible. We narrowed further by selecting blocks with the highest proportion of scheduled castes and scheduled tribes, and the lowest female literacy rate. These were taken as proxies for lower socio-economic status, and resulted in the selection of one block in each district. Hence our sample covered Jalore, Sanchore and Raniwara blocks of Jalore district and Itawa and Ramganj Mandi blocks and Kota City in Kota district.

Since the population of Kota City was too large (671,714) as compared to the average rural block, we decided to cover about one-third, or 250,000 population residing in low-income wards. For this we procured the list of wards (60 in all) from the municipal council. We then listed each ward along with its population and geographic location. The Corporation Health Officer of Kota scrutinized data on each ward and based on his 16 years experience in the post, allocated each ward to low or high-income groups. To do this, he considered the presence of slums, migrant colonies or tenements to signify low-income groups. This resulted in a list of 34 low-income wards. We then listed these wards in serial order and then used a random number list to select wards in random sequence, until the total population of sampled wards exceeded 250,000. This resulted in 21 randomly selected low-income group wards.

2.2 Listing of providers

We decided that the process of listing must be comprehensive and should be able to identify all potential abortion providers in the area, so that even if many respondents did not subsequently acknowledge that they provided abortion services (during the interview), the listing process would have identified them as probable providers. We carried out a pilot listing exercise in one entire block and half of another block of Udaipur district. We learnt that:

1. The number of providers, especially informal providers is much greater than what we had anticipated
2. Many informal providers actually are government parmedics practicing on the side. Hence the listing process should be carried out without involving government officials (i.e. there should be “nothing official about it”)
3. Listing should be carried out rapidly, before providers get to learn of it from their colleagues and put up their guard. For similar reasons, listing should be carried out in a discrete, unobtrusive manner
4. Information from key informants should be triangulated with that from typical rural women
5. Different categories of providers could be expected to give information about each other, even if they did not acknowledge their own roles.
6. The team must use local terms and contexts in referring to abortion, or missed periods.

After collecting a list of panchayats from the panchayat samiti office, two pairs of research investigators travelled to all panchayat HQ villages and all major villages within each panchayat, making inquiries from key informants (govt officials, private providers and shopkeepers, etc) and from 2 separate groups of women⁹ per village. To minimise drawing attention to themselves while ensuring a high degree of mobility, they used motorcycles (a jeep/ car would have attracted too much attention in remote villages). Inquiries from key informants or community members included questions like who provided health services, whether they treated children, men or women, did they conduct deliveries, did they treat women having problems with their periods and if so, then did they treat women “whose period had not come on time”. If they did so, then what did they use – herbs, tablets, injections, instruments or other methods? Each team visited 4-6 panchayats per day, covered all major villages therein and met key informants. The listing process was designed to achieve the objective of complete enumeration of all potential abortion providers while observing ethical considerations. On the basis of a “yes” response to the question, “Does he/she (the provider) provide treatment to women for missed or delayed periods?”, each provider was categorized through listing, into one of the following four categories.

⁹ They restricted this to women from households that did not have any government employee or health provider

Table 2.3 : Respondent category

<i>Respondent category that answered "yes"</i>	<i>Category</i>	<i>Category code</i>	<i>Number of providers</i>
None	Not an abortion provider	1	825
Key informants: chemists, shopkeepers, teachers, government employees, panchayat members, other health providers, etc	Possible abortion provider	2	557
Any one key informant + at least two local village women (from families that had no health provider or govt official)	Probable abortion provider	3	354
Health provider himself/herself	Definite abortion provider	4	27
Total			1763

Thus there were 938 providers who were mentioned through listing as possible, probable or definite abortion providers. For inclusion in this study, the eligibility of facilities (excluding those that were MTP registered) was determined on the basis of providers working there. In case of MTP certified facilities, all were selected. This has been explained below.

Table 2.4 : Eligibility criteria

<i>Provider category</i>	<i>Eligibility criteria</i>
Unqualified village practitioners	All, irrespective of status (informal)
Gynecologists General surgeons (MS, General Surgery)	All, irrespective of status (formal)
All other categories	Only those that were categorized as possible, probable or definite abortion providers on listing (formal or informal)

2.3 Data collection tools

- i. Listing form (informal and formal providers)
- ii. Administrator's schedule for formal facilities and providers
- iii. Providers' schedule for formal providers
- iv. Checklist for formal facilities
- v. Informal providers' schedule

For informal providers, the form was pre tested by the team by carrying out listing and interviews in one block of Udaipur district. Based on this experience, the method of study of informal and ISM providers was modified on several fronts:

- i. On pre testing, we found that most practitioners of ISM did not acknowledge that they provided (surgical) abortion services. Hence it was not possible to administer checklist and administrator's and providers' schedule designed for formal providers. Many ISM practitioners however agreed that they treated delayed periods by giving tablets or injections, and hence we used the questionnaire designed for informal providers for them.

- ii. Several informal providers were not willing to give information on issues regarding conduct of abortion when the investigator filled the information in front of them. Therefore, one part of the form was separated, and was filled only after coming out of his clinic/ house. This has been discussed in the section on ethical considerations (section 2.8)
- iii. We found that if the team visited formal providers first (which revealed that the team was studying abortion services), the informal providers of the area soon came to know of the team's intentions. They then either refused to participate in the study, or, if they agreed to participate, claimed that they did not treat women or provide abortion services. Hence the team covered the interviews of all informal providers of a district, before starting the interviews of formal providers.

2.4 The Study team

A team of 4 persons: one Research Associate (Masters in Social Work), 2 field investigators (a post-graduate statistician and sociologist), and a clinical investigator (qualified diploma nurse) carried out listing and collected data from informal providers. In addition, two more field investigators were assigned to this project for shorter periods of time. Four physicians (two gynecologists, one public health professional, one physician who had retired from government health services) directly collected data from all private doctors and many government doctors (formal providers), while the Research Associate covered most PHC medical officers.

Two data entry operators were assigned the task of dual data entry, an assistant data manager handled data validation and consistency checks, while two Research Assistants (Sociology & MSW) assisted the Research Associate with data coding, cleaning and checking. The Co-Investigator carried out protocol development, service related training and analysis, while the Principal Investigator carried out field training, training on ethical issues oversight of data collection and analysis.

Data on the MTP certification process and training systems from the Directorate of Medical, Health & FW services in Jaipur and on MTP training institutions was collected by a Medical Research Consultant and the Co-investigator .

2.5 Training

The Principal and Co-Investigators trained the team over 22 days, combining classroom orientation on issues surrounding abortion, a visit to ARTH's clinic to see study facility requirements, visits to 2 PHCs and 2 private nursing homes, mock sessions with different instruments and field training on listing and interviews of abortion providers in one block of Udaipur district. The PI and a member of the IEC (AK Pendse) carried out training on ethical issues. A member of the ECG (Mr. Sudarshan Iyengar) attended and participated in the training on ethical issues.

2.6 Data collection

The data collection was carried out in 3 phases:

- i. Listing of providers
- ii. Interview of informal providers and further listing of formal providers
- iii. Study of formal facilities

Data collection was carried out first in Jalore district and then in Kota district between August 2002 and January 2003.

The process of data collection was completely separated from the listing process. The team visited all panchayats / facility locations in two rounds in Jalore district. In the second round in Jalore, all village practitioners and peripheral informal providers were covered first, and then the government paramedics and doctors of govt PHCs or hospitals. However, the team discovered that once they requested the CMHO to issue a letter to PHCs advising them to cooperate with the study, and the CMHO complied, all PHC staff (including the informal govt providers therein) became aware of study objectives. Besides, interviewing formal and informal govt providers in one round meant (for example) that practicing paramedics came to know of study objectives when doctors in the same PHC were contacted as administrators or formal providers. Hence the team changed strategy in the second (Kota) district — listing was carried out in the first round, informal providers were covered in the second round, and then, after meeting the CMHO and getting a letter from him, formal providers were contacted in the third round.

Most interviews of formal providers and administrators (particularly of private facilities) were carried out by doctors. Study of informal providers was carried out by a team of 4 investigators (including 1 supervisor).

2.7 Data cleaning, coding, entry and analysis

Forms were checked by the supervisor everyday and coded. Further coding of open-ended questionnaires and of formal facilities was carried out in the office. The coding of formal providers' questionnaires was carried out by 2 doctors, while coding of open ended questions of informal providers' questionnaires was carried out by supervisor or a coder (MSW). Double data entry was carried out for the questionnaires, on Epi-Info 6.02 package. All inconsistencies of entry could therefore be corrected. Further cleaning was carried out during analysis by the Principal Investigator & Co - investigator.

2.8 Ethical issues

During the process of study, the following ethical issues were encountered and resolved.

a. During the process of listing

We had decided to make the listing process comprehensive. We made enquiries from key informants (govt officials, private providers and shopkeepers, etc) and from 2 separate groups of women¹⁰ per village. Confidentiality during listing was preserved in the following manner:

- ☐ Informants were assured about confidentiality. Consent was however not taken during the process of listing – this was considered to be un-indicated by the IEC.
- ☐ Informants were not informed what other informants had said about a particular provider
- ☐ Some of the informants were providers themselves. Some of them asked what the team had found out about other providers, especially their “competitors” – the team politely declined to share such information.

10 Women from households that did not have any government employee or health provider

- Govt authorities have not been given any information on names, identities or locations of informal health providers from listing. As a matter of fact, the provider lists have not been shared outside the study team.
- To prevent information from reaching government health employees that an abortion study had commenced in the district, the listing team carried out its work without any prior official contact and stayed only in private hotels.
- Listing of formal providers was from a variety of secondary sources (directories, membership lists of professional associations) as well as from the primary listing process. Information on individual formal providers was not shared with other providers or office bearers of professional attractions.

b. Two or three stages of data collection

As described above, the process of data collection was completely separated from the listing process - listing was carried out in the first round, informal providers were covered in the second round, and then, after meeting the CMHO and getting a letter from him, formal providers were contacted in the third round. The IEC agreed that no harm would come to the interests of research participants in this manner, and that the three stage process, while being more time and energy intensive, was required for getting valid information.

c. Disclosure of study objectives

Investigators did not discuss findings of interviews / the survey with any person outside the research team. Other staff members of ARTH (except a few concerned with logistics support) remained completely unaware of the objectives of the study throughout the data collection process – they remained under the impression that this was a study of women’s health services. Team members always used the term “services” and “providers” while referring to abortion services and abortion providers, when in the ARTH office, while making long distance phone calls to report progress and while traveling.

d. Custody of forms

Even though a few providers asked to see them, data entry forms of one provider were not shown to other providers or administrators. As a matter of fact the team did not carry any completed forms from the previous day / session, while collecting data. After data collection, all forms were kept in safe, restricted custody of a research associate in the ARTH office.

e. Privacy and confidentiality – informal providers

Several government health employees turned out to be informal providers. Wherever feasible, the team interviewed them either in subcentres (where there is a single provider anyway) or at home, but not at PHCs or hospitals. This was done for the sake of confidentiality. Investigators tried to collect all data in private. However, in some instances, the spouse of the informal provider would come and sit down in the middle of an interview at home. The investigator continued only after it became evident that the provider did not mind the information being shared.

f. Privacy and confidentiality - formal facilities

In many private facilities and a few govt facilities, the administrator and provider were husband and wife, and insisted on being interviewed together (often the administrator/ husband insisted and the wife demurred). There was one instance in which the administrator (husband)

contradicted the provider (wife) over certain responses – he wished to reveal less than she did. The personal as well as professional power-relationship in such cases, was blurred. In a few cases, an evidently uneasy relationship between husband and wife affected the responses.

In formal facilities, providers were not interviewed in front of their administrator. However, in 6 cases a senior colleague or administrator did not leave the provider's room, despite a polite request. As a result, the provider had to respond in front of them. The nature of responses is likely to have changed as a result.

g. Consent related issues – informal providers

The IEC has reviewed that the study team has practised consent procedures as approved. One ethical dilemma was brought to the notice of the IEC midway through the study – during several informal provider interviews, the respondent gave consent and then at some point insisted on looking at the responses the investigator was filling in the questionnaire. At certain points they would dictate what the investigator should write, which was often at variance with what they had just said. For example, they would say that they restored missed periods or performed abortions, and then insist that the investigator write a different response in the negative. This happened during the training period itself, in Udaipur district. The investigator's immediate response during the training period was to write what the respondent insisted on, and then after leaving the provider, change it as per the actual, spoken response. For the actual study, the team identified one section of the informal provider questionnaire containing the "sensitive" questions, memorised all questions, verbally canvassed that section last during the interview and completed the questionnaire only after leaving the informal provider's premises.

The IEC reviewed this measure. It felt that as part of informed consent and respondent's free choice, he/she could give any response, but could not dictate or insist as to what was being written in the questionnaire. The respondent's rights did not extend to scrutinizing and checking the interview schedule while it was being filled. Hence a non-confrontationist solution by way of filling a finite number of responses after the interview could be allowed, provided it was ensured through training and supervision, that there was no loss of accuracy as a result.

Another consent related problem reviewed by the IEC was the one related to spouses of informal providers, who would start questioning the investigator in the beginning or in the midst of an interview. The investigator then informed the spouse all about the study and if required, took an additional verbal consent from the spouse. However, in no case was separate consent from the actual provider avoided.

h. Consent related issues – formal facilities and providers

Trained doctors, including the principal investigator and co-investigator, carried out sixty seven per cent of administrator/ formal provider interviews. These included all private facilities in Kota district and all barring two, in Jalore district. They invested time and energy and utilised their credibility as doctors who themselves were providing abortion services, to persuade private administrators and providers that no harm would come from disclosure about abortion services being provided, even if the facility was not certified. At the same time, the process of taking consent remained voluntary. The consent process often involved detailed inquiries by the potential respondent, about ARTH and its work. In some cases, when administrators and providers saw the name of the IEC member on the consent form,

they readily opened up because they had trained under him at the medical college in Udaipur. To summarise, ARTH's credibility as an organisation that has doctors (in effect, private abortion providers) on its staff and medical college (ex) faculty on its Board / IEC, helped respondents to open up, especially in Kota¹¹

Facility checklist: A trained nurse, trained social worker or doctor on the ARTH team filled this form. In some small private facilities, the administrator/ provider (often one and the same) wanted to be personally present when the facility checklist was being filled. It was clear that in such cases, they either considered their own (often untrained) nurse to be either not suited or incompetent to answer queries. For form's sake, the doctor-investigator had to therefore accompany the doctor-administrator to the OT and wards to fill the checklist. In three cases, the administrator/ provider denied providing abortion services¹², but the theatre nurse quietly informed ARTH's nurse in private, that elective abortions were indeed being carried out. This posed a dilemma in terms of what was correct – the team relied on the administrator/ provider's responses.

i. Refusal rates:

The IEC noted that 93% formal providers, 95% informal providers and 98% ISM provider had given consent – the rest had refused to participate. These included two cases in which a formal provider refused consent even though the administrator had given consent.

j. Respondent's time and compensation:

The formal interviews required a total of 1 to 1.5 hours of individual respondent's time, and informal provider interviews required 45 minutes to one hour. A few (about 10-12) encounters took much longer – up to 3 hours (!) either because the respondent unilaterally started a long discussion on health service related issues, or insisted on serving refreshments (which then took time to arrive), and/or just wanted to have a chat. These generally took place after the interview was completed. In no case did the team report an expectation of monetary compensation. Hence no compensation was contemplated or offered.

11 Only recently has Kota got its own medical college. Most of the older practicing doctors of Kota have trained at Udaipur and retain an affinity for the town, their alma mater and teachers.

12 In such cases they claimed that only incomplete abortions were (occasionally) managed or that non-abortion D&Cs were being carried out.

Chapter 3

Coverage

3.1 Coverage results

The study covered a total population of 1,389,277 in the five blocks and one urban area (table 3.1).

Table 3.1: Study area and population

<i>Block/urban cluster</i>	<i>Population 2001(from census)</i>	<i>Percentage rural</i>
<i>District 1: Jalore</i>		
व Raniwara	163,322	100%
व Jalore	219,296	80%
व Sanchore	367,995	93%
<i>District 2: Kota</i>		
व Itawa	155,565	100%
व Ramganj Mandi	228,452	59%
व Kota City (21 wards)	254,647	0%
Total	1,389,277	70%

As a result of the listing process, a total of 1763 providers of health care were listed in the study area. They comprised categories as shown in table 3.2. It is clear that while there was an average of one provider per 790 population, people's greatest access (assuming equitable distribution) was to trained paramedics, unqualified and traditional practitioners. As a single category, the local, rural unqualified medical practitioner was the most available, in terms of numbers.

As a result of listing, 557 (32%) providers were classified as being "possible abortion providers", 354 (20%) as being "probable" and 27 (2%) as 'definite'. The rest (46%) were reported as not providing abortion services, on listing. A disproportionately larger number of male / female providers were listed as providing abortion services, as shown in the table (3.2) below.

Thus 938 providers (738 informal or ISM and 200 formal) were recorded as being possible, probable or definite abortion providers as a result of the listing process. Based on our inclusion criteria, we attempted to contact 837 informal and ISM providers, of whom we were able to contact and interview 681 (81%). Table 3.2 below, shows that we were able to contact a similar proportion of all major categories of providers.

Table 3.2: Provider listing exercise

<i>Provider category</i>	<i>Listed</i>	<i>Eligible</i>	<i>Inter-viewed</i>	<i>% eligible providers interviewed</i>	<i>Population per provider</i>
<i>Doctors (sub-total)</i>	293	225	133	59%	4,482
व MBBS	141	103	62	60%	9,516
व MD Other	60	31	11	35%	22,408
व MS Other	44	43	24	56%	27,786
व Gynecologist	48	48	36	75%	26,717
<i>Paramedics (sub-total)</i>	534	357	309	87%	2,508
व ANM	230	173	156	90%	5,837
व Ayurvedic Compounder	26	11	8	73%	57,887
व Compounder	43	17	15	88%	28,353
व GNM (Diploma nurse)	23	16	8	50%	63,149
व LHV	30	27	25	93%	40,861
व Lab Technician	18	3	3	100%	77,182
व Male nurse/ supervisor	164	110	94	85%	8,221
<i>ISM/ other qualified (sub-total)</i>	100	61	56	92%	13,620
व Ayurvedic practitioner/ BAMS	72	47	44	94%	19,031
व BDS	7	2	0	0%	173,660
व BHMS	13	6	6	100%	106,867
व BUMS	8	6	6	100%	173,660
<i>Unqualified practitioners (sub-total)</i>	369	354	272	77%	3,316
व Unqualified practitioner	349	349	269	77%	3,609
व Anganwadi worker	8	0	0		173,660
व Other Nurse	12	5	3	60%	81,722
व Peon/ ward boy	0	0	0		277,855
<i>Traditional (sub-total)</i>	371	58	44	76%	3,695
व Bhopa (Faith / tribal healer)	50	1	1	100%	27,786
व TBA	321	57	43	75%	4,262
Total	1667	1055	814	77%	790

3.2 Sample coverage

Informal and ISM providers :

There were 1439 informal and ISM providers listed for the study. Of these 738 were either probable or possible providers of delayed periods. Of these seven hundred and thirty eight, 613 were contacted. The rest could not be contacted for a variety of reasons. In addition, 99 unqualified practitioners were also interviewed, although on listing they were not mentioned to be treating delayed periods. Thus out of 712 informal/ ISM providers who were contacted, 681 agreed and 31 refused to participate (table 3.3).

Table 3.3: Total no. of informal and ISM providers and number that agreed to participate

<i>Informal and ISM providers</i>	<i>Number</i>
Total Identified	1439
Eligible for study	837 (58% of total identified)
Contacted eligible providers	712 (85% of those eligible)
Agreed to participate and be interviewed	681 (96% of those contacted)

Formal facilities covered

A total of 114 formal facilities were contacted. Of these, 47 were government facilities and 67 were in the private sector. All government facilities being mandated to provide MTP services, were included, while private facilities were administered a simple list of 4 screening questions inquiring whether they provided delivery services, services for incomplete abortion, or elective abortion. Several non-certified facilities providing abortion services agree only about providing incomplete abortion services – these were included in the study. Out of 67 listed private facilities, 27 denied that they provided either MTP or services for incomplete abortion, hence they were ineligible for the study. The remaining 40, that agreed that they provided either services for incomplete abortion (16) or induced abortion (24), were included in the study. Providers' schedule was administered for 39 private providers belonging to 35 facilities (providers of 5 facilities could not be interviewed).

There were 46 public facilities in the districts, that could potentially have provided MTP services (district hospitals, PHCs, CHCs, medical college, railway, military and ESI hospital) and all of them were contacted. The administrators' schedule could be administered in 42 public facilities, while the checklist could be administered in all 46. Since only 22 public facilities were functional and had abortion providers, the providers' schedule was administered for 30 public providers from 21 of these 22 facilities (the provider of one facility could not be contacted) (table 3.4).

Table 3.4: Total no. of facilities and no. who agreed to participate (n), by facility type and district

Formal facilities >>	Public facilities			Private facilities			
	Total Identified	Contacted	Agreed to participate	Total Identified	Contacted	Eligible for study	Agreed to participate
District 1	26	26	26	14	14	7	7
District 2	21	21	20	68	53	33	33
Total	47	47	46	82	67	40	40

The total number of formal and informal facilities listed and then covered by the study has been given in the table 3.5 below.

Table 3.5: Data collection tools and coverage

Instrument	Requirements	No. of forms actually filled	Breakup of public and private
Administrator Schedule	1 per participating facility	82	42 public 40 private
Provider Schedule	All providers at each facility which actually provides services ¹³	69	30 public 39 private
Facility Assessment (checklist)	1 per facility	86	46 public 40 private
Informal Provider Schedule	1 per provider	618 informal providers & 63 ISM	283 government informal 335 private informal 18 govt ISM, 45 private ISM

13 At the Kota Medical College hospital, 5 of the 18 providers were interviewed

Formal Abortion Services

This chapter outlines the situation with respect to readiness and quality of abortion care within formal abortion facilities, and on part of formal providers. The functional status of government facilities that can potentially provide abortion services has been assessed. On the other hand, in case of private facilities, the process related to certification has been studied. The availability of trained providers and processes related to MTP training has been assessed for both government and private facilities. Where services are available, we explored the quality of services in relation to equipment, supplies, methods used for abortion and pain control, information and counseling, providers' attitudes, cost of services and the range of other services available.

4.1 Legal or regulatory requirements

4.1.1 Number of certified facilities

Certification requirements for Rajasthan are along the lines of the MTP Act, except that a blueprint of the facility is additionally required. As per the central Act, public facilities do not require any certification. We found a discrepancy between the number of private facilities that claimed to have been certified on interview, and the list of certified facilities provided by CMHO's office and information on certified facilities provided by directorate. As per the list from the directorate, there were 19 certified facilities in Kota, and none in Jalore. As per the list provided by CMHO in Kota, there were 16 certified facilities in the district. All private facilities were located in urban areas, while 15 of the 22 functional government facilities were located in rural areas (table 4.1).

Going by administrators' interview, of the 40 private formal facilities, 21 claimed that they were MTP certified, while 19 reported they were not. These 21 certified facilities included one in District 1 (Jalore) and 20 in District 2 (Kota).

A comparison of status of MTP certified providers and sites indicates that seven facilities in Kota district had a MTP trained provider, but the facility was not certified. Ironically, of the 22 functional government facilities (all of which are considered eligible to provide MTP services), only 14 had an MTP trained provider. This reflects differential criteria for eligibility of private and public facilities in providing MTP services (table 4.2).

Table 4.1: MTP Certification status of private facilities

	<i>Dist 1 (n=07)</i>	<i>Dist 2 (n=33)</i>	<i>Total (n= 40)</i>
Registration status of enumerated institutions as reported by administrators			
☐ MTP Registered	1	20	21
☐ Not Registered	6	13	19
Registration status as per the list at the CHMO office / directorate			
☐ MTP Registered	0	16	16
☐ Not Registered	7	17	2

Table 4.2 : Training status of MTP providers by facility

MTP certification status of private facilities	Dist 1 (n=07)	Dist 2 (n=33)	Total (n= 40)
Facilities with certified provider + site certification	0	20	20
Facilities with certified facility, but no trained provider	1	0	1
Facilities with trained provider but facility not certified	0	7	7
Facilities with neither trained provider nor certified facility	6	6	12

4.1.2 Certified facilities: process of certification

Twelve out of 21 facilities reported difficulties in certification — the most common difficulties were long, tedious process and repeated demands for information. It took an average of 14.3 months for a facility to get certified, ranging from 0 to 60 months. On average, application papers were returned twice or more for modifications (Table 4.3).

Table 4.3: Difficulties faced in the Registration process: Evidence from certified facilities

Private, certified facilities	Dist 1 (n=1)	Dist 2 (n= 20)	Total (n= 21)
Average time between application and certification (mean no. of months and range)	6.0 (6-6)	14.8 (1-60)	14.3 (1-60)
Average number of times registration papers were returned for modifications			
☐ Mean (range)	2.0 (2-2)	2.4 (0-7)	2.39 (0-7)
☐ Median 2.0	2.0	2.0	
Number that reported having any difficulty	0	12	12
Problems faced in certification			
☐ Long, tedious process	0	12	12
☐ Excessive complicated paperwork	0	1	1
☐ Repeated demands for information	0	5	5

4.1.3 Non certified facilities: reasons for not being certified

Of 19 facilities that reported that they were not certified, 11 stated that they had not attempted to be certified, while the remaining 8 reported that they had tried, but the application had not been cleared (table 4.4).

Table 4.4: Status of application for non certified facilities

	<i>Dist 1 (n=6)</i>	<i>Dist 2 (n=13)</i>	<i>Total (n= 19)</i>
Not applied for certification	5	6	11
Applied but application still not cleared / was rejected	1	7	8

Most of those who had applied, but had not got certified, reported that they had not received any response from the authority.

Of the eleven facilities that had not even tried to get certified, 4 were not aware of the need for certification, while 2 had apparently been intimidated by the prospects of a long tedious process, and hence decided not to try. Difficulty on part of private doctors in receiving MTP training also prevented some providers from getting certified (table 4.5).

Table 4.5 : Difficulties faced in the registration process: Evidence from uncertified facilities

<i>Uncertified Facilities</i>	<i>Dist 1</i>	<i>Dist 2</i>	<i>Total</i>
<i>Reasons why the facility did not try to get certified (multiple responses possible)</i>	<i>(n= 5)</i>	<i>(n= 7)</i>	<i>(n= 12)</i>
☐ Did not feel the need	0	1	1
☐ Long tedious process	2	0	2
☐ Not aware of need for certification	2	2	4
☐ Training facility only for govt. doctors	1	0	1
☐ Religious/ ideological objections	1	7	8
<i>Reasons why facilities that had applied had not been certified (multiple responses possible)</i>	<i>(n= 1)</i>	<i>(n= 7)</i>	<i>(n= 8)</i>
☐ Did not pursue	1	1	2
☐ No response from authority	1	3	4
☐ Application pending with authority	0	5	5

That the process of registration should be quick, time bound or on the spot were the most common recommendations made by most hospital administrators. A decentralized process whereby the need to pursue the matter at the state level would not be required, was also suggested by many. Many administrators also felt that facility registration should not be required for facilities operated by gynecologists (table 4.6).

Table 4.6 : Key recommendations by administrators for improving the registration process

Suggestions	Dist 1 (n=7)	Dist 2 (n=33)	Total (n=40)
व Registration should be quick	3	15	18
व It should be time bound (the facility should be considered as registered by default after a certain period)	2	5	7
व On the spot registration or after inspection	2	1	3
व Registration process should be decentralized to local / district level	0	10	10
व Facilities with gynaecologist should not require certification / should be considered registered automatically	1	5	6
व Private doctor also should be given MTP training	1	0	1
व Strict action should be taken if abortions are carried out by unqualified, untrained persons (other than doctors)	1	2	3
व Strict action should be taken against uncertified persons	0	1	1
व No Suggestions	1	11	12

4.14 Reporting of MTPs

The MTP Act stipulates strict reporting requirements for all facilities conducting MTP procedures. However, only about three fourths of all facilities (both government and private) reported all the MTPs being conducted. About one fourth did not report any MTPs or only some MTPs. Even government facilities did not report all MTPs. Common reasons for not reporting all MTPs include nobody having asked them to report or that they did not record detailed information about the patient and hence could not report. Interestingly, 4 administrators who had claimed to be certified at the beginning of the interview, later cited reasons such as “we are not entitled to report”, or “not yet fully certified”(table 4.7).

Table 4.7: Facilities and their reporting of MTPs

Whether facilities report MTPS	Public (n=22)	Certified private facilities (n= 20)	Total (n= 42)
Report all MTPs	17	14	31
Report some MTPs	0	02	02
Do not report any MTPs	5	4	9
Reasons for not reporting (n= 11 who do not report all MTPs)	(n=5)	(n=4)	(n=9)
Not fully certified yet	0	1	1
Very low case load, hence no need to report	1	0	1
Patient’s detailed information not entered in the register, hence unable to report	1	1	2
“We are not entitled to report”	1	1	2
Nobody asked for a report	1	2	3
Not registered or certified at all	1	0	1

(n= 82 based on questionnaire completed by administrators)

4.1.5 Consent

The MTP Act requires written consent of the woman wishing to terminate her pregnancy. The Act does not require spousal or parental authorization, except in case of a minor or a mentally ill person. The study showed that 57 out of 61 facilities took the written consent of a woman. However, providers and administrators put unnecessary restrictions in terms of spousal and family authorization — less than one sixth of facilities took the consent of woman alone for MTP. Most facilities required the consent of family members or accompanying persons or husbands before conducting MTPs (table 4.8)

Table 4.8 : Consent Requirements at Public and Private Sector facilities

	Public (n=22) %	Private (n=39) %	Total (n=61) %
Consent taken	20	38	58
□ Written	19	38	57
□ Oral	01	0	01
No consent taken at all	2	1	3
Person whose consent is taken before abortion (multiple responses possible)			
□ Woman alone	8	2	10
□ Woman + any family member/accompanying person	16	28	44
□ Woman +husband	4	15	19
□ Husband or other family members but NOT the woman herself	0	1	1

Observation of consent forms revealed that 31 out of 39 consent forms had provision for signatures of other persons. This implies that women must find it difficult to access MTP services if they go alone. Several circumstances might make it difficult for women to take approval from other family members, especially when husbands are migrants and work in another city or village, or do not support woman's decision to have an abortion. For women out of wedlock, such practices severely restrict access, leading them to risk going to unsafe abortion providers.

Of the 57 facilities using written consent, 39 used a printed written consent form, which we scrutinized. Most forms did not specify the technique or kind of anesthesia to be used for abortion. Provision for a witness's signature was there in 22 forms. In situations where literacy levels are low and women might be able to affix only a thumb impression, provision for a witness's signature might safeguard women's interests (table 4.9), although as mentioned earlier, family or witness authorization is not necessary for pregnancy termination.

Table 4.9 : Observation of Consent Form

Consent Form contains following (multiple responses possible)	Public (n=6)	Private (n=33)	Total (n=39*)
r Abortion procedure specified	2	12	14
r Analgesia /anesthesia mentioned	5	28	33
r Provision for woman's consent	5	32	37
r Provision for others' consent	5	26	31
r Provision for witness's signature	2	20	22

**(Out of 57 facilities who take written consent, a printed consent form is being used by 39)*

4.2 Facility infrastructure and equipment

Eighty-six facilities were assessed in terms of infrastructure, amenities for client convenience, equipment and supplies. All 46 government facilities (of PHCs level and above) were covered to assess their readiness to provide abortion services, whether or not they were functional. In addition, all functional private facilities were covered. One certified facility, although non-functional was also covered.

4.2.1 Infrastructure

The infrastructure of a facility was assessed in terms of:

- Its ability to provide privacy in consulting room and recovery room,
 - Convenience to clients like waiting area, basic amenities like toilets, cleanliness
 - Availability of wards with beds to allow observation of women after procedure
 - Availability of electric connections and sources of light in procedure room to allow adequate light at the time of procedure
 - Availability of running water in procedure room to allow for proper hand-washing to maintain asepsis
 - Availability of telephones to allow for referral in case of emergencies
- i. *Convenience to clients like waiting area, basic amenities like toilets, cleanliness:* Waiting area with seating arrangement, and shelter and toilets were present in almost all private facilities, while some government facilities did not have these facilities. While 39 out of 46 government facilities had toilets, only about half had water facilities, and were clean.
 - ii. *Privacy in consulting and recovery rooms:* An arrangement to maintain privacy in consulting room was present in 46% of government facilities as compared to nearly 95% of private facilities. Lack of privacy can be a major deterrent for women to seek services from government facilities.
 - iii. *Availability of wards with beds to allow observation of women after procedure:* Most public and private facilities were equipped with either an indoor ward or another room to allow patients to recover. Seventy six per cent public and 95% private facilities had a bed available in the recovery area for MTP clients (table 4.10) .

Table 4.10 : Proportion of facilities with listed physical facilities

	Public (n=46)	Private (n=40)	Total (n=86)
Client privacy and comfort			
▫ Waiting area with seating arrangement present	37	39	76
▫ Waiting area is sheltered /protected from rain or sun	36	39	75
▫ Toilet(s) present	39	40	79
▫ Existing toilets have water facility	21	40	61
▫ Existing toilets appear clean	19	39	58
Arrangement for privacy			
▫ Arrangement of visual privacy in consulting room	26	38	64
▫ Arrangement for auditory privacy in consulting room	29	35	64
▫ Arrangement for privacy in recovery room (n=60 where recovery room is present)	22	28	50

	<i>Public</i> (n=46)	<i>Private</i> (n=40)	<i>Total</i> (n=86)
Recovery room			
☐ Indoor ward	33	27	60
☐ Other room	4	12	16
☐ Not applicable	9	1	10
☐ Beds available in recovery area for MTP clients	35	38	73
Electricity and telephones			
☐ Electric connections in working condition	36	40	76
☐ Telephone facility present	11	39	50
☐ Communication material on contraception	37	7	44

iv. *Availability of electric connections and telephones* : In order to allow adequate light at the time of procedure, and to sterilize the instruments, it is helpful to have electric connections in working condition. However, functioning electric connections were not present in nearly one fourth of government facilities. All private facilities had functioning electric connections. Telephone facilities, while not essential, are useful to keep in contact with other facilities. Telephones were present in only 11 government facilities, but nearly all private facilities. Thirty-five out of 42 government facilities were located in rural areas, while only 6 out of 40 private facilities were located in rural areas. This could explain the discrepancy.

v. *Communication materials on contraception* : Fewer private facilities had communication material on contraception, as compared to government facilities.

Observation of operation/ procedure room: This was possible only in 60 out of 86 facilities. In 13 of government and private facilities each, observation was not possible. Reasons for the team's inability to observe the OT were that it was locked or the storekeeper was not available. In certain cases, the OT / or room was open, but many instruments or anaesthesia equipment were locked in a storeroom, and hence could not be observed. In certain cases, sterilization equipment was available outside the procedure room and could be observed, even though OT / procedure room was locked. In a certain number of private facilities, the administrator did not allow the team to visit the OT / procedure room or equipment, and insisted on filling the checklist on his/her own (table 4.11).

Table 4.11: Facilities where actual observation of OT, Equipment and Supplies was possible

<i>Whether actual observatin of OT or equipment was possible</i>	<i>Public</i> (n=46)	<i>Private</i> (n=40)	<i>Total</i> (n=86)
Observation of OT possible	33	27	60
Observation of Anesthesia equipment possible	30	27	57
Observation of Sterilization equipment possible	35	27	62
Observation of Instruments/ MTP equipment possible	28	27	55

vi. *Condition of procedure room and operation table* : Even where the observation was possible, it was found that a dust-free procedure room was present only in about half the government facilities, while all private facilities had dust free rooms. Similarly, in two thirds of government facilities as compared to all private facilities, the operation table was in good condition.

- vii. *Availability of water in procedure room* : Water is required to allow for proper hand washing, which is crucial to maintain asepsis during MTP procedure. Although running water is better, in rural areas it may not be feasible, and facilities can maintain asepsis even with stored water, provided it is available in adequate quantity. In 42% of government facilities, arrangements for adequate water were not available. Running water was available in majority of private facilities.
- viii. *Source of light* : Performance of MTP procedure requires a source of focused light, and in its absence can be performed using a large torch. Adjustable focus lamp was present only in 5 of 33 government facilities and 18 out of 33 private facilities. Since greater number of government facilities did not have regular electricity supply, it is important that they have backup arrangements in form of torch, etc. Torch was available only in 36% public facilities, and 59% of private facilities.

While a shadow-less OT lamp is not essential to provide MTP services, it is a mandatory requirement for MTP certification of all private facilities as per the MTP Act before the 2003 amendments. However, it was available in less than one third of public facilities, and more than two thirds of private facilities (table 4.12).

Table 4.12 : Condition of procedure room

Condition of procedure room (n=60 in which OT/procedure room observed)	Public (n=33)	Private (n=27)	Total (n=60)
Cleanliness of procedure room			
☐ Room dust free	15	27	42
☐ Floor is clean	16	27	43
Operation table in good condition	23	26	49
Sources of light in procedure room			
☐ Bulb/ tube light	27	25	52
☐ Adjustable focus lamp	5	17	22
☐ Torch	12	16	28
☐ Shadow less OT lamp	10	19	29
Water Supply			
☐ Running water available	17	26	43
☐ Stored water available	16	1	17
☐ Inadequate water supply	14	1	15

4.2.2 Equipment and supplies

MTP instruments

As mentioned above in table 4.11, observation of equipment was possible in only 55 facilities. Among various methods of first trimester termination, sets of D&C were available in highest number of facilities (87%), followed by electric vacuum aspiration (73%), and MVA (35%). In general, the availability of equipment was better in private facilities as compared to government facilities. Complete sets of D&C were available only in 75% of public facilities, while it was available in all private facilities. Sets of EVA were available in 54% of government and 93% of private facilities, while sets of MVA were available in 14% of public and 55% of private facilities. Public facilities were less equipped to perform EVA and MVA compared to private facilities (table 4.13).

Table 4.13: Availability of basic equipment for abortion procedure¹⁴

Observation of instruments & equipment (n=55)	Public (n= 28)	Private (n= 27)	Total (n=55)
Electric suction machine	20	25	45
MVA syringe	5	17	22
MVA cannulae (at least 3 different sizes)	6	25	31
Adapters for MVA syringe	5	14	19
Sim's /Cusco's speculum	25	27	52
Tenaculum/ volsellum	26	27	53
Vaginal wall retractor	20	26	46
Ovum forceps	17	27	44
Uterine curette	21	27	48
Dilator set (at least 12 different sizes)	22	26	48
Ultrasound available in house	1	17	18
Complete set for MVA	4	15	19
Complete set for EVA	15	25	40
Complete set for D&C	21	27	48

Anesthesia equipment

While pain control for MTP procedure is important, in most cases analgesics, local anesthesia (para-cervical block) and/ or mild sedation supplemented by verbal support is sufficient¹⁵. General anesthesia increases the risk of complications and cost of procedure, and is not recommended. However, equipment for general anesthesia and resuscitation are a mandatory requirement for MTP certification of private facilities, and hence all facilities were assessed for availability of these equipment items. It was found that Boyle's apparatus was present in only 20% public facilities as compared to nearly 90% private facilities. Laryngoscope was present in 30% of public facilities as compared to 96% of private facilities. Since public facilities are considered eligible to provide MTP services, this reflects a discriminatory provision of MTP Act. Private clinic settings that do not intend to perform major surgeries, or do not wish to invest in high cost anesthesia equipment are unable to get themselves certified (table 4.14).

Table 4.14: Availability of Anesthesia Related Equipment (only facilities where actual observation was possible)

	Public(n=30)	Private(n=27)	Total(n=57)
Oxygen Cylinder	23	25	48
Boyle's Apparatus	6	24	30
Laryngoscope	10	26	36

Sterilisation related equipment and supplies

An abortion service should be able to follow infection prevention and control practices. Facilities were assessed for their readiness to provide universal precautions, by assessing their

14 Data has been presented only for those facilities where actual observation was possible.

15 World health organization. "Safe Abortion" Technical and Policy Guidance for Health Systems". 2003.p 31

equipment and supplies. Equipment was observed, while information related to supplies was recorded on the basis of interview of respondents.

Most public and private facilities had an autoclave or steam sterilizer. Two thirds of facilities also had formalin chambers. However, sterilization related consumables were not adequate in both public and private facilities. Savlon and Betadine, required for cleaning of perineal area and cervix, were present in most facilities. Glutaraldehyde, required for high-level disinfection and sterilisation of plastic and rubber equipment was present only in two thirds of private and three fourths of public facilities. Bleaching powder, required for HIV decontamination of equipment, was not available in one-fourth private facilities, while it was present in most public facilities. However, it appears that bleaching powder is used for purification of drinking water, and not for decontamination of equipment in public facilities. Long rubber gloves, which are useful to clean floor and equipment soiled with blood or blood products, thereby reducing risk of HIV infection to health care staff, were present in less than half of the facilities (table 4.15).

Table 4.15 : Availability of sterilization /infection prevention equipment and consumables

Equipment (only facilities where actual observation was possible)	Public (n=35)	Private (n=27)	Total (n=62)
Autoclave drum	33	26	59
Steam sterilizer	34	26	60
Formalin chamber	18	22	40
Sterilization related consumables (as reported by respondents)	Public (n=46)	Private (n=40)	Total (n=86)
Savlon	41	39	80
Povidone Iodine	46	38	84
Glutaraldehyde	31	26	57
Bleaching powder	43	31	74
Long rubber gloves	19	18	37

Drugs used for inducing abortion or priming cervix :

Availability of following drugs was assessed: Ethacridine lactate (used for inducing second trimester abortions), prostaglandin injection (commonly used for priming cervix or for controlling haemorrhage), analgesics (for pain control), IV fluids (for stabilising if excessive haemorrhage), and oxytocin injection (sometimes used for inducing second trimester abortion, in combination with other drugs). These drugs were available in a greater proportion of private facilities than government facilities. This could be because these drugs are not part of government supply. However, IV fluids and analgesics were found in most government and private facilities.

Contraceptives

Contraceptive services are an integral part of abortion service delivery, and facilities should be able to provide most contraceptive methods, if the woman chooses a method. However, less than half the private facilities had oral pills or condoms, while only 15% had a contraceptive injection. IUDs can be safely inserted after a first trimester abortion procedure, but were available only in 60% of private facilities. On the other hand, contraceptives were available in all government facilities. Although private facilities claimed that they prescribed the contraceptives, physical availability of contraceptives would allow more women to adopt a contraceptive along with the abortion procedure (table 4.16).

Table 4.16: Drugs, contraceptives and other consumables (as reported by respondents)

	<i>Public (n=46)</i>	<i>Private (n=40)</i>	<i>Total(n=86)</i>
<i>Drugs used for inducing abortion or cervical priming</i>			
Ethacridine lactate	2	21	23
Prostaglandin (Carboprost injection)	4	31	35
Prostaglandin gel	2	21	23
Oxytocin injection	40	37	77
<i>Supporting Drugs</i>			
IV fluids	46	37	83
Analgesics	45	40	85
<i>Contraceptives</i>			
Oral pills	46	17	63
Condoms	46	13	59
Injectables	2	6	8
IUDs	46	24	70

4.3 Human Resources

Facilities were assessed for the availability of a doctor carrying out abortions, for anaesthetists, and nurses.

4.3.1 Abortion providers

Out of 42 public facilities (PHCs, CHCs, and district hospitals) where the administrator's schedule was administered, only 22 had a doctor carrying out abortions. Of 40 private facilities, 39 had a doctor carrying out abortions. Results are biased by the fact that only those private facilities were included that were functional (providing abortion services) or certified.

Of 61 facilities carrying out abortions, 38 had at least one gynaecologist, most of who were in private facilities. Overall, a gynaecologist was working with 70% of private facilities and less than one fourth of public facilities. Some of them had other doctors (MBBS or with specialization in other branches) also. All doctors in government facilities were full time, while 44% of all providers in private facilities were part time, or attended on call (table 4.17).

Table 4.17: Availability of abortion service providers at different facilities

	<i>Public (n=42)</i>	<i>Private (n= 40)</i>		<i>Total (n= 82)</i>
		<i>Certified (n=21)</i>	<i>Not Certified (n=19)</i>	
Facilities which have any (at least one) doctor carrying out abortions	22	20	19	61
☐ Total number of doctors carrying out abortions	30	33	34	97
At least one Gynecologist (MD / DGO)	10	17	11	38
☐ One or more Full time (on staff)	10	15	4	29
☐ One or more available on call or attend on specific days	0	2	7	9
At least one MBBS	14	6	12	32
☐ One or more Full time (on staff)	14	4	10	28
☐ One or more available on call or attend on specific days	0	2	2	4

	Public (n=42)	Private (n= 40)		Total (n= 82)
		Certified (n=21)	Not Certified (n=19)	
At least one other doctor	4	3	6	13
☐ One or more Full time (on staff)	4	3	4	11
☐ One or more available on call or attend on specific days	0	1	3	4

4.3.2 Anaesthetist

The availability of an anaesthetist is a mandatory requirement for MTP certification as per the un-amended Act. However, it is known that most abortions can be carried out with the use of local anaesthesia or with sedation, without the need for an anaesthetist. However, 21% of public sector facilities and 17% of private facilities had a full time anaesthetist employed with them. In addition, 70% of private sector facilities had a part time anaesthetist or one available on call (table 4.18).

Table 4.18: Availability of anesthetic (MD or diploma) at different facilities

	Public (n= 42)	Private (N=40)		Total (n= 82)
		Certified (n=21)	Non certified (n=19)	
Any anaesthetist attached to facility	9	21	14	44
☐ Full time (on staff)	9	4	3	16
☐ Available on call	0	16	11	27
☐ Attends on some days	0	1	0	1
No Anaesthetist	33	0	5	38

4.3.3 Support staff

Although only doctors are allowed to perform abortion procedures, a nurse has an important role to play in provision of abortion services. A nurse can confirm pregnancy, counsel women before procedure, sterilize and store MTP equipment, assist a MTP procedure and perform post abortion follow-up. For certification of private facilities also, it is a necessity to have a registered nurse. All the government facilities had at least one qualified and registered nurse. Seven private facilities had untrained nurses, while 4 others had a nurse who was trained but not registered. Thus a total of 11 facilities did not have a nurse registered with the nursing council. A social worker or counsellor was available only with 6 facilities (table 4.19).

Table 4.19 Availability of nursing and support staff at different facilities

Availability of nursing staff (multiple responses possible)	Public (n= 42)	Private		Total (n=82)
		Certified (n= 21)	Non certified (n= 19)	
☐ At least one degree qualified nurse	12	3	1	16
☐ At least one diploma trained nurse	18	5	3	26
☐ One or more ANMs	34	16	7	57
☐ Only In house trained nurses	0	3	4	7

Availability of nursing staff (multiple responses possible)	Public (n= 42)	Private		Total (n=82)
		Certified (n= 21)	Non certified (n= 19)	
Registration status of nursing staff				
☐ No registered nurse	0	4	7	11
☐ At least one nurse registered with nursing council	42	17	12	71
Social Worker / Counselor				
	2	3	1	6

4.4 Provider Characteristics and MTP training

A total of 97 doctors were providing abortion services in 61 functional facilities, as reported by administrators. Of these, 30 were MBBS doctors, 53 were MS/ MD / DGO in obstetrics and gynecology, and 14 were MS/MD in other branches. Of these it was possible to interview 69 providers.

4.4.1 Profile of providers

A profile of abortion providers interviewed has been given in table 4.20. The mean age of providers was 42 years, about two thirds of all providers were females. Thirty of the providers were from public sector, while 39 were from private sector. Of 69 interviewed providers, about half (35) were gynecologists (degree or diploma in gynecology), about a third were MBBS doctors, while 11 were MS/MD in other branches. About one third of non – gynecologist providers were MTP trained.

Out of a total of 47 MTP trained providers, greater numbers were present in private facilities, probably because most private facilities were in urban areas, while most public facilities were in rural areas. A comparison of public and private sector providers shows that about 40% of public sector providers and 59% of private sector providers were gynecologists. The proportion of MTP trained providers was 63% and 72% in public and private sectors respectively. Fifty seven percent providers in the public sector were male as compared to 13% in the private sector (table 4.20) (table 4.21)

Table 4.20 : Profile of providers according to sector in which they were working

MTP training status	Public (n=30)	Private (n=39)	Total (n=69)
MTP trained	19	28	47
Not formally trained in MTP	11	11	22
Qualification			
☐ MD/MS/DGO obstetrics and gynecology	12	23	35
☐ MBBS	13	10	23
☐ MS other branch	3	6	9
☐ MD other branch	2	0	2
Sex			
☐ Female	13	34	47
☐ Male	17	5	22
AGE (Mean Age in years. range)			
	38.9 (27-54)	44.6 (27-74)	42.1 (27-74)

Table 4.21 Qualification of MTP Trained & Untrained providers in public and private sectors

MTP trained		Public (n= 19)	Private (n= 28)	Total (n= 47)
व	MD/MS/DGO obstetrics and gynecology	12	23	35
व	MBBS	3	4	7
व	MS other branch	3	1	4
व	MD other branch	1	0	1
Not MTP trained		(n= 11)	(n= 11)	(n= 22)
व	MBBS	10	6	16
व	MS other branch	0	5	5
व	MD other branch	1	0	1

On looking at the district wise profile of abortion providers (Table 4.22), it is apparent that in Jalore district, only 41% providers were MTP trained, majority were in the public sector and were male. In contrast, nearly 81% providers in Kota district were MTP trained, were in private practice, and nearly 90% were female.

Table 4.22 : Profile of interviewed abortion providers (district wise)

	Dist 1(n=22)	Dist 2(n= 47)	Total (n= 69)
Sector in which practicing			
व Private	6	33	39
व Public	16	14	30
Training			
MTP Trained	(n=9)	(n=38)	(n=47)
व MD/DGO /MS/DNB IN Obgyn & Gynec.	4	31	35
व MBBS	2	5	7
व MS in other branch	2	2	4
व MD in other branch	1	0	1
Without formal training in MTP procedures	(n=13)	(n=9)	(n=22)
व MBBS	10	6	16
व MS in other branch	2	3	5
व MD in other branch	1	0	1
Years of providing abortion services (mean in years. Range)	7.95 (1-25)	14.9 (0-50)	12.6
Sex			
व Female	5	42	47
व Male	17	5	22
Mean Age in years (range)	38.5 (27-67)	43.8 (27-74)	42.1 (27-67)

4.4.2 MTP training

Providers were asked questions related to the place of training in abortion procedures, the methods of abortion in which they received training.

Place of training

Those with MS/MD/DGO in Gynaecology received MTP training during their postgraduate studies in obstetrics and gynaecology in medical colleges, and were not asked about their place of training. Twelve providers without specialisation in gynaecology reported receiving formal training in MTP, while 22 had learnt it informally (Table 4.22). On reviewing the place of training, it is clear that 75% of formally trained providers had learnt it from medical colleges. Private hospitals and postpartum centres also played a small role in MTP training. It was interesting to note that more than half of those who had learnt to perform MTP procedures informally, had also learnt it from medical colleges. The rest had learnt it from private hospitals, government postpartum centres, or by working with a colleague. What emerges from this analysis is that the MTP training capability is largely limited to medical colleges, with district and private hospitals playing a very small role (table 4.23).

Table 4.23 : Place of training for doctors excluding gynecologists (includes both formally MTP trained and untrained)

Place of training	Public (n=18)		Private (n=16)		Total (n= 34)
	Formal training (n=7) %	Informally learnt (n=11)%	Formal training (n=5) %	Informally learnt (n=11) %	
Teaching/ medical college	6	7	3	5	21
District hospital	0	0	0	1	1
Postpartum center	1	2	0	0	3
Private hospital / NGO	0	1	2	2	5
By working with a colleague	0	0	0	2	2
Other	0	1	0	1	2

Methods of abortion in which trained

Those who received formal MTP training had not received training in all methods of MTP. Providers were most likely to receive training in D&C, D&E, and extra amniotic methods. Only about two thirds received training in EVA, while just above half had received training in manual vacuum aspiration. Ten of the 47 providers had not received training in any vacuum aspiration method (table 4.24).

Table 4.24 : Procedures in which provider received training

Techniques in which trained	(n=47 formally trained providers)
MVA	27
EVA	34
D&C	42
D&E	40
Extra amniotic method	35
Intra amniotic method	21

This training was also reflected in the methods used by providers to conduct MTPs. Vacuum aspiration methods were more likely to be used by formally trained providers¹⁶. Even so, formally trained providers continue to use D&C and D&E in preference to vacuum aspiration methods. This suggests that training in medical colleges needs to improve and that safer and more up-to-date techniques need to be used far more, in medical colleges. Those who had learnt to carry out abortions informally, were largely relying on D&C or D&E and were using vacuum aspiration methods in fewer cases (table 4.25).

Table 4.25 : Type of procedure currently using by formally trained and untrained providers

	<i>Formally trained (n=47)</i>	<i>Informally learnt (n= 22)</i>	<i>Total (n=69)</i>
MVA	28(60%)	8 (36%)	36 (52%)
EVA	29(62%)	8 (36%)	37 (54%)
D&C	44(94%)	19 (86%)	63 (91%)
D&E	40(85%)	11 (50%)	51 (74%)
Extra amniotic method	21(45%)	4 (18%)	25 (36%)
No vacuum aspiration method used	11(23%)	11 (50%)	22 (32%)

Non clinical aspects of training

In order to provide good quality abortion services, providers need to be oriented not only in clinical skills including techniques of abortion, but also in public health aspects of abortion, counseling and provider- patient interaction, quality of care and administrative / managerial aspects¹⁷. Attention to these aspects would help ensuring that providers respect reproductive rights, and provide women informed choice in matters of decision to abort, abortion procedure, contraception, care after abortion etc. However, less than one fifth had received training in counseling and less than half of all providers had received training in reproductive rights. These aspects need to become part of pre service and in service MTP training (table 4.26).

Table 4.26 Providers who have received training in support areas

	<i>Public (n =30) %</i>	<i>Private (n=39) %</i>	<i>All (n=69) %</i>
Counseling and IPC	7	5	12
Universal precautions	14	8	22
Reproductive health and rights	17	15	32

16 The term formally *trained* providers refers to MD/MS/DGO in obstetrics and Gynecology and those with MTP training.

17 World health Organization. "Safe Abortion: Technical and Policy Guidance for health systems". Essential content for curricula on abortion services. P 71.

4.5 Actual functioning of facilities, service provision and range of services provided

4.5.1. Proportion of facilities providing abortion services

Of 42 public facilities that could potentially provide abortion services (PHCs, CHCs, sub divisional hospitals, district hospitals, other hospitals such as railways, army etc.), only 22 were actually providing abortion services.

Only 43 % of PHCs/ CHCs were providing abortion services, while all government hospitals were functional. Out of private facilities that claimed¹⁸ to be certified to perform MTPs, all except one were providing MTP services. *Further analysis in this section refers only to functional facilities (table 4.27).*

Table 4.27 Facilities that are functional

Type of facility	Dist 1		Dist 2		Total	
	No. of facilities	Number providing abortion services	No. of facilities	Number providing abortion services	No. of facilities	Number providing abortion services
Public	(n=25)	(n=14)	(n=17)	(n=8)	(n=42)	(n=22)
☐ PHC/CHC	23	12	12	3	35	15
☐ SDH/PPC	1	1	0	0	1	1
☐ District hospital/ medical college	1	1	1	1	2	2
☐ Other	0	0	4	4	4	4
Certified Private	1	0	20	20	21	20

4.5.2 Gestation up to which facilities provide abortion services

Although the MTP Act allows facilities to provide MTP services up to 20 weeks, all functional facilities were not providing services up to 20 weeks (table 4.26). While more than 80% facilities in both public and private sectors provided services up to 12 weeks, only 41% of private and 36% of functional public facilities provided second trimester abortion services. Five percent of facilities also admitted to providing MTP services beyond 20 weeks. Of those 24 facilities providing second trimester services, two thirds were private (mostly certified) and one third were public facilities (table 4.28) (table 4.29).

18 Based on the data collected from state directorate, there is not a single certified MTP facility in district 1.

Table 4.28 : Gestation of Pregnancy for which services are offered by facilities (functional facilities only)

	Public		Private		All (n = 61)%
	PHC (n=15)%	Dist /SD Hospital (n = 7)%	Certified (n=20)%	Not Certified (n = 19)%	
<=8 weeks	3	1	1	4	9
<=12 weeks	7	3	5	13	28
<=20 weeks	3	3	14	1	21
> 20 weeks	2	0	0	1	3

Table 4.29 : Gestation up to which pregnancy termination services are offered in facilities

Gestation up to which pregnancy is terminated	Public (n=22)	Private (n=39)	Total (n=61)
Up to 8 weeks	22	39	61
9 to 12 weeks	18	34	52
13 to 20 weeks	8	16	24
Beyond 20 weeks	2	1	3

Gestation up to which providers terminate pregnancies : Nearly 54% of providers terminate pregnancies of only first trimester, while 48% providers terminate second trimester pregnancies too. Almost all providers who reported terminating second trimester pregnancies are formally trained (table 4.30).

Table 4.30 : Gestation of Pregnancy up to which providers terminate pregnancy

	Public (n=30)	Private (n=39)	Formally trained (n=47)	Not formally trained (n=22)	Total (n=69)
Up to 8 weeks	3	3	3	3	6
Up to 12 weeks	16	15	19	12	31
Up to 20 weeks	9	18	23	4	27
> 20 weeks	2	3	2	3	5

4.5.3 The number of MTPs conducted per month

The average number of MTPs conducted by all levels of facilities is close to 40 per month (shown in table 4.31). Private institutes are conducting nearly double the number of MTPs, (averaging 49) done by public facilities (averaging 23). The highest number of MTPs is conducted by certified private facilities (averaging 63.5 every month) and district level or sub-divisional public hospitals (average 60 MTPs every month). Rural peripheral facilities (PHCs/CHCs) conduct the lowest number of MTPs, averaging 5.9 per month. The data therefore suggests that access in rural areas continues to be poor.

Table 4.31 : Mean number of MTPs conducted per month (3 month recall, with range) by functional facilities

	Public (n=22)			Private (n= 39)			All (n=61)
	PHC/ CHC (n = 15)	Dist /SD Hosp (n = 7)	Total Public (n=22)	Certified (n=20)	Not Certified (n=18)	Total Private (n= 39)	
Up to 12 weeks	5.1 (0-30)	52.6 (29-180)	20.9 (0-180)	57.2 (3-150)	28.7 (1-129)	44.1 (1-150)	35.7 (0-180)
13-20 weeks	0.7 (0-5)	7.9 (0- 45)	3.1 (0-45)	5.5 (0-20)	2.8 (0-35)	04.3 (0-35)	3.9 (0-45)
> 20 weeks	0.07 (0-1)	0	0.05 (0-1)	0.75 (0-10)	0	0.4 (0-10)	0.3 (0-10)
Total	5.87	60.5	23.05	63.5	31.5	48.8	39.9

4.5.4 Number of visits required to get an abortion

Women are known to face several restrictions in visiting a health facility, such as lack of family approval, pre-occupation with care of children, lack of money etc. In such circumstances, the need for repeated visits becomes a barrier to access particularly for women living in rural areas since they have to visit distant facilities in the city or other towns to seek an abortion. However, more than a third of all providers said they'd had to postpone services at least once over the past 3 months. The common reasons were that the consumables were in short supply, or that there was lack of electric supply, or that instruments had not been sterilized in time (table 4.32).

Table 4.32 Need to postpone / refuse service provision because of logistic reasons* - functional facilities only

	Public (n=22)%	Private (n=35)%	All ¹⁹ (n=57)%
Facilities that reported that abortion services had to be postponed / refused at least once in the last three months	7	13	20
Reasons for postponing Services –only those cases where postponement occurred			
☐ Consumables related	2	12	14
☐ Instruments not sterilized	4	0	4
☐ Electricity supply	3	0	3
☐ Equipment out of order	1	0	1
☐ Too high a patient load	0	1	1
☐ Others	1	3	4

19 Only one provider interview per facility was used in calculating this information, since this information is about the facility. The providers reporting highest number of MTPs were selected.

4.5.5 Overnight facility

To be able to deal with complications of abortion, health facilities need to be able to provide access during the night hours too. Also, for second trimester abortion services, where the time between induction and expulsion is often long, facilities need to provide overnight services. It was encouraging to find that out of fifty-seven providers, all except 4 said their facilities were open at night. Although abortion services can be provided even as day - outpatient services, these findings indicate that most providers offer overnight facilities.

In more than half the cases, a doctor was available to attend to women at night, while in about one fourth cases, a nurse attended during the night hours. Nurses can play a very useful role in attending to women after abortion. This is particularly relevant in rural PHCs and CHCs where doctors may not be available at night, or may commute from a city (table 4.33).

Table 4.33 Ability of facility to function for Emergency cases /non routine hours – functional facilities only

	Public (n =22)	Private (n =35)	AIP⁰ (n =57)
Facility open at night *	21	32	53
Person available to see woman at night¹			
☐ Doctor	11	25	36
☐ ANM	2	0	2
☐ Trained nurse	6	7	13
☐ Other	2	0	2

4.5.6 Ability to treat complications

It is important that facilities are equipped to identify and manage common complications of abortion (like incomplete abortion) and refer to higher-level facilities in case of serious complications (e.g. perforation, the most dreadful complication of induced abortion). Information was collected from providers about the management of 2 specific complications (excessive bleeding and perforation). Two thirds of government facilities could manage a woman with excessive bleeding in house, while about one third had to refer. In case of perforation, one third were able to manage in house, while the rest referred. On the other hand, majority of private facilities reported being able to manage excessive bleeding, and more than half said their facilities could manage a woman with perforation in house. This discrepancy is related to the fact that most private facilities were urban, where they could easily call for anesthetic and other kind of help (table 4.34).

Table 4.34 Management of Abortion Complications by functional facilities

Complication / action	Public (n= 22)	Private (n=35)	AIP¹ (n=57)
Excessive Bleeding			
☐ Referred out	5	2	7
☐ Stabilized and referred	2	0	2
☐ Managed in house	15	32	47
☐ Other	0	1	1

20&21 Only one provider interview per facility was used in calculating this information, since this information is about the facility. The providers reporting highest number of MTPs were selected.

Complication / action Excessive Bleeding	Public (n=22)	Private (n=35)	All(n=57)
Perforation / Peritonitis			
☐ Referred out	13	15	28
☐ Stabilized and referred	2	0	2
☐ Managed in house	7	20	27

The average number of post abortion complications seen in last 3 months was 7.4, most of which were incomplete abortion or hemorrhage. Nearly one third providers reported having encountered pelvic infection, septicaemia or perforation. Providers reported that these represented complications of unsafe abortions performed by unlicensed providers. This data indicates that the actual number of complications encountered by providers is small, but referral arrangements need to be worked out (table 4.35).

Table 4.35: Emergency cases seen by functional facilities²²

	Public (n=22)	Private (n=35)	All²² (n=57)
Facilities that receive women with post abortion complications	18	35	53
Average no of post abortion complications in last three months (mean and range) – only those facilities that receive cases	4.8 (1-10)	9.3 (0-80)	7.4 (0-80)
Commonly seen complications			
☐ Incomplete Abortion	18	34	52
☐ Haemorrhage	10	9	19
☐ Septicaemia	8	8	16
☐ Shock	2	5	7
☐ Perforation	10	7	17
☐ PID	5	11	16

4.5.7 Provision of other RH services by abortion facilities

It is desirable that abortion facilities provide a wide variety of other related services, as this would allow for confidentiality to be maintained and thereby reduce the stigma attached to seeking the service. Provision of other services also enables greater continuity of care, e.g. women who undergo abortion may require treatment for RTIs and contraceptive services.

Nearly all providers reported providing maternal care services (antenatal, delivery and postnatal care) and contraceptive services at the same venue. About two thirds of facilities also treat infertility and other gynecological problems, as well as provide treatment of STDs. However, diagnosis and management of HIV is provided by less than half the facilities. Facilities for major abdominal surgery (laparotomy) were available in about half the facilities. However, facilities for laparoscopy were available in more than half the government facilities, and less than one third of private facilities (table 4.36).

22 Only one provider interview per facility was used in calculating this information, since this information is about the facility. The providers reporting highest number of MTPs were selected.

Table 4.36: Range of RH services offered by abortion facilities*

	Public (n= 22)	Private (n= 35)	AI²³ (n= 57)
Antenatal care	22	31	53
Delivery	22	33	55
Postnatal care	22	33	55
Contraception	22	34	56
Management of Post abortion complications	21	35	56
Treatment of STDs	21	31	52
Management of HIV	6	19	25
Infertility management	12	32	44
Treatment of other gynecological problems	17	23	40
Vaginal procedures	22	33	55
Laparotomy	8	22	30
Laparoscopy	12	11	23

4.5.8 Referral for elective abortion

Sometimes facilities that have the capability to provide elective abortion may need to refer certain cases — 61 percent of providers said that they'd had to refer certain cases of abortion elsewhere. Five facilities had to refer more than half of all cases seeking induced abortion—most of these were government facilities. The most common reasons for referral were medical risk factors, second trimester abortion, and incomplete abortion induced elsewhere. Most of the referrals for these reasons were made to the medical college hospital, indicating poor capacity of other facilities to handle high-risk cases. Some government facilities also referred to other PHC/ CHCs, while private facilities tended to refer to other private facilities (table 4.37).

Table 4.37 Referral patterns*

	Public (n= 22) %	Private (n=35) %	AI²⁴ (n=57)%
Facilities referring at least some elective abortion cases	14	21	35
Facilities referring out > 50% of cases	4	1	5
Types of cases commonly referred (only those who refer cases)			
☐ Medical risk	11	14	25
☐ 2 nd trimester abortion	8	9	17
☐ Incomplete abortion from elsewhere	4	4	8
Places where referral is made (only for those who refer)			
☐ Medical College Hospital	1	16	17
☐ PHC / CHC	7	1	8
☐ District Hospital	4	3	7
☐ Post Partam Centre	1	2	3
☐ Private Hospital/ NGO hospital	0	4	4

23 & 24 Only one provider interview per facility was used in calculating this information, since this information is about the facility. The providers reporting highest number of MTPs were selected.

In most cases, referrals are carried out without any formal referral linkage. Only one out of 35 facilities reported that they had a formal referral linkage. The facility provided through this formal linkage was that patients got priority treatment.

4.6 Medical Standards

The quality of clinical care for abortion was assessed on the basis of the technique used for abortion, the techniques used for pain control, pre abortion care, contraceptive counseling and follow-up care provided.

4.6.1 Availability of service guidelines

Guidelines on abortion services were available with two thirds of providers. Greater proportions of private providers reported having guidelines, more commonly scientific journals or copies of the MTP Act. Yet even when guidelines were available, they did not include relevant guidelines such as those by Government of India or by World Health Organization (table 4.38).

Table 4.38 : Availability of Service Guidelines

	<i>Public (n= 30)</i>	<i>Private (n= 39)</i>	<i>Total (n= 69)</i>
Guidelines Available	12	33	45
<i>Types of Guidelines available</i>			
MTP Act old or new	1	12	13
Scientific journals/ FOGSI newsletter	9	18	27
Gynec/ obstetrics books	1	2	3
Other	1	1	2

4.6.2 Techniques used for abortion

Recommended methods for first trimester abortion are manual or electric vacuum aspiration (for up to 12 weeks pregnancy) and medical abortion (for up to 9 weeks pregnancy)²⁵. Dilatation and curettage (D&C) is less safe and should be used only when other methods are not available. For second trimester abortions, dilatation and evacuation and medical methods are recommended.

In this study, providers were asked about the methods they commonly used for pregnancies up to 8 weeks, for pregnancies 9-12 weeks and for pregnancies in second trimester. The findings show that for abortions up to 8 weeks, D&C or D&E are the most commonly used methods (59%), followed by EVA which is used by less than one third of all providers (32%). MVA is used by one sixth of all providers (16%). A similar pattern is observed for abortions between 9 and 12 weeks, with D&C or D&E being the commonest methods (60%), followed by EVA (34%). Manual vacuum aspiration is used by even lower proportions of providers after 8 weeks (9%). Five providers mentioned also using medical methods. At the time of data collection for this study, the drug controller had just approved medical methods (mifepristone and misoprostol).

25 World health Organization Safe Abortion: Technical and policy guidance for health systems. 2003.

On comparing formally trained and other providers, it was noticed that formal providers used vacuum aspiration (60%) more often as compared to other providers (22%) for abortions under 8 weeks. This indicates that training of providers in MTP correlates with their use of safer techniques, but a lot of trained providers continue to use less safe techniques, and training institutions (including medical colleges) need to bring about changes in their practice (table 4.39).

Table 4.39 : Techniques used by providers for first trimester abortions

<i>Methods (multiple responses possible)</i>	Training /Qualifications		Total (n =69)
	<i>Formally trained provider (n =47)</i>	<i>Other providers (n =22)</i>	
<u>Up to 8 weeks (n= 69)</u>			
☐ MVA	8	1	9
☐ EVA	16	4	20
☐ D&C	20	16	36
☐ D&E	3	2	5
☐ Medical Methods	7	1	8
<u>9-12 weeks (n= 63)</u>			
	(n= 44)	(n= 19)	(n= 63)
☐ MVA only	5	0	5
☐ EVA only	14	4	18
☐ D&C	19	15	34
☐ D&E	3	1	4
☐ Medical Methods	5	0	5

Of 32 providers who acknowledged providing second trimester abortions, nearly half were using extra amniotic instillation of ethacridine lactate dye (47%), followed by D&C or D&E (34%) and medical methods (34%). The use of D&C and D&E was more common with providers who were not formally trained in MTP as compared to those who were formally trained (table 4.40).

Table 4.40 : Techniques used by providers for 2nd trimester abortions

<i>Methods (multiple responses possible)</i>	Training /Qualifications		Total (n =32)
	<i>Formally trained provider (n =24)</i>	<i>Other providers (n =8)</i>	
Extra amniotic	13	2	15
D & C	1	7	8
D & E	3	0	3
Medical Methods	11	0	11
Other	0	1	1

The private sector appeared to be using safer techniques for first trimester as compared to public sector. Among public providers, 17% preferred using EVA or MVA and 70% preferred using D&C. On the other hand, among the private providers, 46% preferred using EVA and 38% preferred using D&C. Medical methods were being used by 3% of public providers and 18% of private providers. Part of the reason for this difference could be due to the fact that there were a greater number of gynecologists among private providers, while public providers more often featured MBBS doctors posted in CHC/PHCs (table 4.41).

Table 4.41 : Use of different methods for first trimester abortion by type of sector

Method up to 8 weeks	Public (n= 30)	Private (n= 39)	Total (n= 69)
☐ MVA (1,2)	4	5	9
☐ EVA (3,4)	5	15	20
☐ D&C (5)	21	15	36
☐ D&E (0)	2	3	5
☐ Medical Method (9)	1	7	8
Method 9-12 weeks	Public (n=27)	Private (n=36)	Total (n= 63)
☐ MVA	2	3	5
☐ EVA	5	13	18
☐ D&C	19	15	34
☐ D&E	2	2	4
☐ Medical	0	5	5

4.6.3 Use of medical abortion

In response to the question on whether the providers used medical methods for abortions, nearly 60% admitted that they did use medical methods for abortion. The use of medical methods was equal among public and private sector providers (16 out of 30 in public sector and 20 out of 39 in private sector), and higher among formally trained providers as compared to untrained providers (28 out of 47 and 8 out of 22). The commonly used methods included misoprostol alone or in combination with mifepristone, followed by carboprost (an injectable prostaglandin, not recommended to be used for inducing abortion), and other preparations (estrogen, progesterone, methergin, oxytocin etc.) (table 4.42).

Table 4.42 : Use of medical methods

	Number of facilities(n=61)
Use of medical methods	36
Medicines used	
☐ Prostodin or Carboprost	6
☐ Misoprostol	28
☐ Mifepristone (RU486)	25
☐ Hypertonic Saline	1
☐ Preparations of oestrogen and / or progesterone	1
☐ Methergine / oxytocin	2

4.6.4 Pain control methods

Most women feel some degree of pain during abortion procedure, and it is important to provide adequate pain management in order to reduce her anxiety and discomfort. The degree of pain experienced by women varies widely depending on various factors. Recommended approaches to reduce the pain include analgesics, tranquillizers, and local anesthesia, either singly or in combination, along with counseling and sympathetic reassuring treatment. General anesthesia is not recommended since it is less safe and increases the recovery time.

The study showed that general anaesthesia continues to be used for 39% of procedures below 8 weeks and 46% of procedures between 9 to 12 weeks. Sedation was used by 69% and 67% of procedures below 8 weeks and between 9-12 weeks respectively (table 4.43). Lesser pain control is used for second trimester abortions, probably because most are carried out using extra amniotic or medical methods, which doesn't cause much pain (table 4.43).

Formally trained providers used general anaesthesia more frequently as compared to informally trained providers. This appears to be related to the finding that medical colleges use general anaesthesia for abortion procedures, and the same is learnt by the trainees who in turn are more likely to be based in cities where availability of anaesthetists is better. On comparison of public and private providers for 9-12 week period, it appears that private providers use general anaesthesia more often than public providers. (Table 4.44)

Table 4.43 : Pain control methods (according to training status of providers)

< 8 weeks (multiple responses possible)	Formally trained providers (n = 47)	Other providers (n = 22)	Total (n = 69)
Sedation	34	14	48
Analgesia	27	17	44
Local anaesthesia	2	0	2
General Anaesthesia	23	4	27
No need	1	0	1
9-12 weeks	(n = 44)	(n = 19)	(n = 63)
Sedation	29	13	42
Analgesia	25	13	38
Local anaesthesia	2	0	2
General Anaesthesia	24	5	29
13-20 weeks (multiple responses possible)	Formally trained providers (n = 24)	Other providers (n = 8)	Total Providing second trimester services (n = 32)
Sedation	3	3	6
Analgesia	11	3	14
General Anaesthesia	1	1	1
No need	12	3	15

Table 4.44 : Pain control methods in public and private sectors

< 8 weeks (multiple responses possible)	Public (n=30)	Private (n=39)	Total (n = 69)
Sedation	18	30	48
Analgesia	21	23	44
Local anaesthesia	1	1	2
General Anaesthesia	12	15	27
No need	1	0	1

9-12 weeks (multiple responses possible)	Public (n=27)	Private (n=36)	Total (n= 63)
Sedation	17	25	42
Analgesia	19	19	38
Local anaesthesia	1	1	2
General Anaesthesia	10	19	29

These findings indicate that pain control for abortion is over-medicalised within formal facilities. This not only makes the procedure less safe, but also makes it less feasible to provide in smaller level rural settings. Also, after general anesthesia or heavy sedation, women need an escort to go home, cannot resume the work immediately, they get noticed if they are groggy, or have side effects such as vomiting, and all these problems need care and attention and thereby reduce the confidentiality.

4.6.5 Pre abortion care

Before abortion is carried out, history and physical examination are required to confirm pregnancy, its duration, and to rule out any medical conditions. Laboratory tests are not necessary, but may be carried out if a medical condition is suspected. Haemoglobin can be done in areas where anemia is prevalent, while blood group and Rh typing should be provided where feasible. Since there is no conclusive evidence about the need to give Rh immunoglobulin for all Rh-negative women after first trimester induced abortion.

The questions on pre abortion counselling were dropped after pre test, because it was found that providers saw them as intended to test their medical knowledge and felt intimidated or offended by them. Questions on routine laboratory tests were asked – the response to this question showed that most providers reported having carrying out haemoglobin, blood group and urine tests. Some also reported carrying out VDRL and HIV tests (table 4.45).

Table 4.45: Routine laboratory tests done before abortion

Routine laboratory tests done	Public (n=30)	Private (n=39)	Total (n=69)
Hemoglobin	29	39	68
Blood group	18	38	56
Urine	26	34	60
VDRL	2	2	4
HIV	1	3	4
Other	1	1	2

4.6.6 Information and counseling after abortion

At the time of discharge, providers need to give instructions to women about how to care for themselves after leaving the health facility, and how to recognize complications that require medical attention.

Instructions at time of discharge :

Nearly all providers reported that they routinely advised women to come for follow-up visits after abortion. Follow-up visits are advised anytime between 2 and 42 days, with an average of 10.8 days. Those who were not formally trained, tended to advise women to come for follow-up visits earlier than those who were formally trained. This suggested that formally trained providers were more confident about the procedure.

Information on danger signs

Symptoms that warrant clinical attention include excessive bleeding, fever lasting for more than one day, and pelvic pain. Forty-nine providers were asked about the information they give regarding circumstances when women should immediately return. The responses show that information on danger signs is incomplete — information on fever and foul smelling discharge is not routinely given by providers, while only three fourths reported giving information about abdominal pain. However, some providers said they informed women to return in case of complications or “wrong D&C”. This indicates that medical terms, and not lay-symptoms were used to convey messages to women (table 4.46).

Table 4.46: Information given after abortion regarding follow up visits

	<i>Training/Qualifications</i>		<i>Total (n=69)</i>
	<i>Formally trained (n=47)</i>	<i>Not formally trained (n=22)</i>	
% who advise routine follow up visit	46	22	68
Average no. of days post abortion when visit is recommended (range).	11.6 (3-42)	8.8 (3-30)	10.7 (2-42)
<i>Circumstances when emergency follow up is advised (multiple responses allowed)</i>	<i>Formally trained (n = 34)</i>	<i>Not formally trained (n = 15)</i>	<i>Total²⁶ (n = 49)</i>
☐ Excessive bleeding	31	15	46
☐ Abdominal pain	23	14	37
☐ Fever	9	8	17
☐ Foul smelling discharge, infection	2	6	8
☐ “Complications”, “ Perforation”, “ Wrong D & C” , doubt regarding retained POC”, “missed periods”, “UTI”	6	0	6
☐ Not asked ²⁷	13	7	20

Follow up : It appears that the proportion of women returning for follow up is low. More than one third of providers said that not even 25% of all women return for follow-up visits. Only 36% of providers said that more than three fourths of women return for follow-up, while as many as 45% said that less than half the women return for a follow up visit (table 4.47)

Table 4.47 : Proportion of women returning for follow-up

<i>Proportion of women returning for FU</i>	<i>Training/Qualifications</i>		<i>Total (n=68)%</i>
	<i>Formally trained (n=46)%</i>	<i>Not formally trained (n=22)%</i>	
<25%	18	6	24
26-50%	5	2	7
51-75%	4	8	12
76-100%	19	6	25

26 Information on danger signs was collected only from 49 providers.

27 At some places, where it appeared that the provider resented his/her knowledge being assessed, this question was dropped.

4.6.7 Contraceptive provision and counseling

Nearly all providers reported providing contraceptive counseling to women - most of them do it before the abortion procedure. Greater proportion of formally trained providers (77%) counsel women on contraception before the procedure as compared to those who are not formally trained (60%). Not much difference was found between public and private providers (table 4.48).

Table 4.48 : Contraceptive counseling

<i>Formally trained</i>	<i>Training /Qualifications</i>		<i>Total</i>
	<i>Not formally trained</i>	<i>Total</i>	
	<i>(n=47)%</i>	<i>(n=22)%</i>	<i>(n=69)%</i>
% who offer contraceptive counselling	47	20	67
<i>Timing of contraception counselling</i>			
Before abortion procedure	36	12	48
During abortion procedure	4	0	4
After abortion procedure	17	8	25
Any time	1	0	1

It is known that in some cases pressure to adopt certain contraceptives can become a barrier for women to seek abortion services, questions were therefore asked as to whether providers insisted on use of contraceptives, and if yes, then which contraceptives. As many as 80% of the providers insist that women adopt some contraceptive method after abortion. A greater proportion of public sector providers insist on agreement to use contraception as compared to private sector providers. There is also a difference in the methods on which they insist — public providers seem to insist more often on tubectomy, while private providers more often insist on reversible methods (table 4.49).

Table 4.49: Insistence on contraceptive methods

	<i>Public (n=30)</i>	<i>Private (n=39)</i>	<i>Total (n=69%)</i>
Insistence on contraceptive methods	26 (87%)	29 (74%)	55 (80%)
<i>Methods insisted on –(only those who insist on a method. Multiple responses possible)</i>			
Vasectomy	4	8	12
Tubectomy	21	20	41
IUD	5	13	18
Pills	14	28	42
Condoms	11	20	31
Injectables	21	24	45

Women coming for repeat abortions are refused the procedure by 22% of providers, while another 22 % do the abortion only if she agrees to undergo sterilisation. Nearly one fifth do the procedure without any conditions, while 6% have never faced such a situation. Public providers seem to insist on sterilisation more than private providers (table 4.50).

Table 4.50. How providers deal with women seeking repeat abortion

	<i>Public (n=30)</i>	<i>Private (n=39)</i>	<i>Total (n=69)</i>
Refuse to do procedure (MTP)	7	8	15
Perform MTP	3	11	14
If she agrees for sterilization then do MTP	10	5	15
If she agrees to have some contraception then do MTP	6	10	16
Perform the procedure but make her do more than one visit.	0	2	2
Not faced such situation	4	3	7

The most commonly available methods were IUD, pills, and tubectomy. Vasectomy was least frequently provided by MTP providers. The availability of contraceptives in general was better by public sector providers as compared to private sector providers, except for injectables, which were available through private sector more often (table 4.51).

Table 4.51 : Contraceptives provided by providers

<i>Contraceptives</i>	<i>Public (N=30)</i>	<i>Private (N= 39)</i>	<i>Total (n=69)</i>
Vasectomy	13 (34%)	8 (20.5%)	21 (30%)
Tubectomy	27 (90%)	31 (79%)	58 (84%)
IUD	30 (100%)	36 (92%)	66 (96%)
Pills	27 (90%)	34 (87%)	61 (88%)
Condoms	25 (83%)	23 (59%)	48 (70%)
Injectables	3 (10%)	19 (49%)	22 (32%)

However, on physical verification based on checklist, all public sector facilities were found to have IUDs, pills and condoms, while private sector facilities did not have all contraceptives available with them. It appears that the latter prescribed the contraceptives to women after MTP. It is expected that physical availability of contraceptives e.g. IUDs would make it more likely that women accept them on the same visit as the procedure, since women are expected to be most motivated to adopt a contraceptive on the day of the MTP, and it would improve access (table 4.52).

Table 4.52 : Contraceptives physically available

<i>Contraceptives</i>	<i>Public (n=45)</i>	<i>Private (n=41)</i>	<i>Total (n= 86)</i>
IUD	45 (100%)	25 (61%)	70 (81%)
Pills	45 (100%)	18 (44%)	63 (73%)
Condoms	45 (100%)	14 (34%)	59 (69%)
Injectables	2 (4%)	6 (15%)	8 (9%)

By providers admission, the most popular contraceptives method are pills and IUD among women who undergoing abortion services. The least popular method is vasectomy) (table 4.53).

Table 4.53: Methods ranked by providers as being most popular

Method	1st rank (n= 69)	2nd rank (n= 74)
Pills	38	18
IUD	19	20
Condoms	4	23
Tubectomy	5	5
Injectables	2	6
Vasectomy	1	2
Others/ Centchroman	1	2

4.6.8 Technical standards related to sterilisation and waste disposal

Instruments and rubber gloves are sterilized as per standards in 87% and 85% of facilities. The standards related to technical standards are followed more frequently in private sector facilities as compared to public sector facilities (table 4.54).

Table 4.54 : Sterilization /Infection Prevention

	Public (n= 46)	Private (n= 40)	Total (n= 86)
Instruments sterilised as per standards (N= 86)	35	40	75
Rubber gloves sterilised as per standards (N= 86)	38	35	73
Cannulae sterilised as per standards (n=33)	7	13	20
Universal precautions - decontamination followed (N= 86)	18 (39%)	13 (32%)	31 (36%)

However, the step of decontamination²⁸, a key marker of universal precautions is followed only in about one third of facilities. This indicates that facilities are not taking adequate steps to prevent transmission of HIV.

The most common methods of disposing product of conception and blood are throwing in open pit garbage followed by burying. Gloves are most commonly disposed by throwing in open pit garbage followed by burning, while syringe and needles are most commonly burnt. Less than 4% facilities use incineration to dispose the waste (table 4.55)

Table 4.55 : Waste disposal methods

For products of conception and blood	Public (n= 46)	Private (n= 40)	Total (n= 86)
☐ Incineration	2	1	3
☐ Burning	3	6	9
☐ Bury	3	12	15
☐ Open pit. Garbage	15	16	31
☐ Not applicable	23	0	23

28 Dipping the instruments and gloves in a chlorine solution after use

<i>For products of conception and blood</i>	<i>Public (n= 46)</i>	<i>Private (n= 40)</i>	<i>Total (n= 86)</i>
Gloves			
व Incineration	2	3	5
व Burning	14	15	29
व Bury	11	2	13
व Open pit. Garbage	18	21	39
Syringes/needles			
व Incineration	0	1	1
व Burning	20	21	41
व Bury	15	2	17
व Open pit. garbage	10	17	27

4.7 Accessibility of Services

4.7.1 Physical Access

In terms of physical access, nearly all facilities were located either on road, or within one kilometer of a road. However, only 61 had public transport available close by – this is related to the poor network of public transport in Rajasthan in general.

To improve access, it is important that a board outside the facilities announces what services are available, whether MTP services are available, what are the clinic timings, etc. However, only 14 functional facilities (22%) out of 66 had displayed information that they were providing abortion services, while information on other services was displayed by as many as 62% facilities. Timings were displayed in more than three fourths of facilities (table 4.56).

Table 4.56 : Physical access to health facilities

	<i>Public (n= 46) %</i>	<i>Private (n=40) %</i>	<i>All (n= 86) %</i>
Distance from road			
On road or less than 1 km	45	40	85
Greater than 1 km	1	0	1
Type of public transportation available nearest to facility			
Bus	38	23	61
Train	3	0	3
Jeep and similar	42	38	80
Publicity of abortion services (only for functional facilities)			
	<i>(n= 26)</i>	<i>(n= 40)</i>	<i>(n= 66)</i>
Signboard announcing MTP displayed	2	12	14
Signboard announcing other services displayed	14	27	41
MTP certification displayed	0	1	1
Timing of clinic displayed	19	31	50

4.7.2 Financial access

Information on costs was obtained by asking administrators to state the maximum and minimum cost incurred by the average woman towards fees, drugs and medications, hospitalization, etc for obtaining the service at their facility. Table 4.50 reveals that abortion services do cost a substantial amount, even in public facilities. Considering the fact that abortion is meant to be a free service in public facilities, these costs are quite high. The cost is quite high even in private facilities, and might act as a deterrent for women seeking services (table 4.57).

Table 4.57 : Cost of Services by sector and trimester of pregnancy

	<i>Minimum cost Mean (range) Rs</i>	<i>Maximum Cost Mean (range)Rs</i>
Public Facilities (n= 22)		
< 12 weeks (n= 18)	195.4(0-500)	456.8(0-2500)
13-20 weeks (n= 6)	316.6(0-500)	575.0(0-1200)
>20 weeks (n= 1)	500.0	1500.0
Private Facilities (n= 39)		
< 12 weeks (n= 38)	540.5(100-1500)	723.7(200-2000)
13-20 weeks (n= 16)	1143.7(300-3000)	1681.2(500-3500)
> 20 weeks (n=2)	1750.0(1500-2000)	2250.0(2000-2500)
All facilities (n= 61)		
< 12 weeks (n= 60)	414.0 (0-1500)	752.5 (0-2500)
13-20 weeks (n= 21)	918.2 (0-3000)	1379.5 (0-3500)
> 20 weeks (n=3)	1333.3 (500-2000)	2000 (1500-2500)

The above costs are not the total cost charged by the hospitals for abortion. In as many as 62% facilities, all or some medicines and investigations are charged extra, over and above the costs of the procedure. These costs can vary depending on the extra fee charged for anesthesia, nature of laboratory tests used, and types of medicines prescribed. In places where contraceptives are purchased from outside, they can further increase the costs, e.g. the IUDs prescribed by most private providers (such as Multiload, Copper-T 380A) cost around Rs 250-300 to women (table 4.58).

Table 4.58 : Inclusion of ancillary services in cost of service

	<i>Private (n= 39)</i>	<i>Public (n=22)</i>	<i>Overall (n=61)</i>
All drugs/ lab tests etc included in abortion fee	11	12	23
Some medicines /investigations included in the fee	15	8	23
All medicines /investigations are charged extra	13	2	15

4.7.3 Social / Cultural /Woman's Perspective

Women and their families in most societies, including those in Rajasthan, prefer a female provider. Although more than 90% of private facilities had a female service provider, only 41% of functional public facilities had one (table 4.59).

Table 4.59 : Facilities with female abortion service provider

	<i>Private (n=39)</i>	<i>Functional Public facilities (n= 22)</i>	<i>Total (n=61)</i>
At least on female abortion service provider available	36	9	45
No female provider	3	13	16

Women, particularly rural women, do not have much autonomy and mobility to go repeatedly out of their house to a health facility located in another town or city. Therefore those who do manage to visit an abortion facility are often unable to come for a repeat visit if the abortion is not provided on the first visit. However, as many as 42% providers reported that they call women for a second or repeat visit before the procedure is carried out (table 4.60).

The most common reasons for which providers reported that they had to postpone the abortion procedure included lack of drugs and supplies, lack of electricity and instruments not being sterilized.

Table 4.60 : Providers providing abortion services on the same day as woman's visit

	<i>Public (n= 30)</i>	<i>Private (n= 39)</i>	<i>Total (n= 69)</i>
Abortion on first visit	14	26	40
Multiple visit required	16	13	29
<i>Reasons for having to postpone abortion services in the last 3 months (providers' responses)</i>			
Lacks of drugs and supplies			14
Lack of electricity			4
Instruments not sterilized			4
Too much crowd			1
Equipment not functional			1
Others			4

The MTP Act restricts the provision of services only to married women or women with children. It does not require that another person be present with a woman before providing her abortion services. However, our study revealed that administrators and/or providers had added their own restrictions. For example, only 10% of facilities would provide services to women who come alone. Only 43% provided abortion services to women who come unaccompanied by a family member. Just about half the administrators provided services to unmarried women or to those out of wedlock (Table 4.61).

Table 4.61 : Circumstances under which facilities provide abortion

Facilities that provide services under following conditions	Public (N= 22)	Private (n = 39)		All (n= 61)
		Certified (n=21)	Not Certified (n= 18)	
Woman comes alone	2	1	3	6
Woman comes with friend, but without a family member	10	8	8	26
Unmarried woman	7	14	9	30
Widow / separated / deserted	11	13	10	34
Married but has no children	14	15	6	35

However, the common reasons why abortion services were not provided to women who came alone were that the doctor was concerned about an unexpected complication, or they felt that consent of the husband or a relative was necessary, or that he/she perceived a medico-legal risk. Common reasons for not providing services to unmarried women or women out of wedlock included the belief that the pregnancy and therefore the abortion was illegal, or the fear that family and community members would turn against them. This suggests that doctors were not clear about the legal requirements of abortion, and even if they were, they tend to give more importance to husbands' or community's willingness than to the woman's need. As a result they landed dealing in somewhat insensitive manner to personal situations under which unwanted pregnancies occurred (table 4.62).

Table 4.62 : Reasons why services are not provided in specific circumstances

Reasons for not providing services to a woman who comes alone (n= 52 providers)	Number
☐ An attendant should be present in case there is a complication	29
☐ Medico-legal risk	13
☐ For consent	5
☐ Husband should accompany	5
Reasons for not providing services to a woman who comes with a friend but not family member (n= 31)	
☐ Family member must be present	20
☐ Husband should concur with the decision	9
☐ Apprehension about woman's motives/ other reasons	3
Reasons for not providing services to an unmarried woman (n=28)	
☐ Fear of medico-legal problems	20
☐ Belief that it is illegal	5
☐ Religious / ideological reasons	1
☐ Fear of adverse reactions on part of family and community	2
Reasons for not providing services to a widow (n=23)	
☐ Fear of medico-legal problems	14
☐ Belief that it is illegal	6
☐ Religious or ideological objections	1
☐ Fear of adverse reactions on part of family and community	1
Reasons for not providing services to a woman without children (n= 22)	
☐ Prefer to convince her to continue because of medical risk	12
☐ Prefer to convince her to continue because of other risks	6
☐ Refer her to another provider	8

Chapter 5

Practitioners of Indian Systems of Medicine

Practitioners of Indian system of medicines were administered the questionnaire designed for informal providers, since on pre testing in another district, most ISM practitioners did not acknowledge that they provided abortion services. It was consequently not possible to administer questionnaires designed for formal providers (checklist, administrator's and providers' schedule) to these practitioners. When interviewed without revealing study objectives, most ISM providers however agreed that they treated delayed periods by giving tablets or injections, and hence we used the questionnaire designed for informal providers for them.

It was often difficult to identify the ISM providers as being separate from informal providers, since several informal providers claimed to have degrees with doubtful names, such as HMDS or BEHMS. All those who said that their training was BAMS, or BHMS, or BUMS or DHMS were included in the analysis of ISM providers, after confirming that they correctly knew the extended form of these abbreviations. However, the duration of training mentioned by some of them varied from 18 months to 90 months.

5.1 Background of ISM practitioners

A total of 63 ISM providers were covered. All except one were males, and their median age was 40 years. Most had a BAMS degree (table 5.1). Those who reported a BUMS degree said that their training was for 3 or 3 and half years, while 2 with a BAMS degree said their training lasted 18 and 24 months.

Nearly three fourths belonged to Rajasthan, while the rest belonged to other states. Nearly eighteen had a government job while the rest had a private job. Four reported that they had both government job and private practice, but it is possible that a greater number of government doctors also provided services privately since private practice is allowed for government doctors in Rajasthan (table 5.1).

Table 5.1: Profile of ISM Providers Interviewed (n=63)

Parameter	Providers
व Female	1
व Male	62
व Average age in years (mean & range)	41.5 (27-65)
व Median age	40.0
Educational Background	
व High school / middle school	30
व Graduate and above	31
व Post graduate	2
Duration of training	
व 18- 24 months	2
व 36-42 months	6
व 48-54 months	6
व 60-66 months	36
व 72-78 months	5
व 78- 90 months	8
State of origin	
व Rajasthan	48
व West Bengal	5
व Other states	10
Government/ private	
व Government	18
व Private only	45

5.2 Range of Services

Nearly three fourths of these providers agreed that they treated women with delayed periods. However nearly three admitted that they used surgical methods – the rest treated women using tablets or injections. Most of them had learnt the treatment of delayed periods on their own or during pre service training (table 5.2) .

Table 5.2: Treatment for delayed periods by ISM providers

Treatment for delayed periods by ISM providers	Total ISM (n=63)
व Admitted to treating women with delayed periods	46
Types of Treatment (Multiple methods possible)	
व Herbs /concoctions	1
व Tablets	38
व Injections	18
व Use instruments	3
व Refer	7
Place from where the provider learned to treat delayed periods	
	(n=46)
व During pre –service training	18
व Working with a doctor	3
व From a colleague/ From a nurse/ compounder	2
व Self	15
व Other	1
व No Response	7

Only about 20% of providers who used tablets thought that it was successful in at least half the cases, while more than half of those who used injections thought it was successful. It is evident that most ISM providers used these treatments without an expectation of their effectiveness– it appeared to be a way to allay the anxiety of women with an unwanted pregnancy (table 5.3).

Table 5.3: Perception of success of methods used by ISM providers

<i>Providers who felt that method successful in >50% of cases</i>	<i>Total ISM (n=63)</i>
☐ Herbs /concoctions (n=1)	0
☐ Tablets (n= 38)	8
☐ Injections (n= 18)	10

Providers of Indian system of medicines did not restrict their services to ayurvedic medicines. Eighty six percent of them also gave injections, while more than three fourths used IV fluids. A large proportion of them applied sutures to wounds, but very few were able to treat fracture, sprain, or treat snakebite. Considering the poor availability of doctors in rural areas of Rajasthan, ayurvedic practitioners are often the most qualified persons available and they are required to treat a whole variety of problems for which ayurvedic treatment may not suffice. Therefore it is desirable that they provide a wide range of services, but considering the fact that they are not trained in allopathic methods of treatment, there is likelihood that some of this treatment is irrational (table 5.4).

Table 5.4: Range of services provided by ISM providers

<i>Type of Service</i>	<i>Number of ISM Providers (n=63)</i>
Deliveries	19
Complicated deliveries	25
Incomplete abortions	47
Menstrual problems	48
Injections	54
Stitches	45
Sprains /fractures	6
Snake bites	1
IV fluids	48
TT injections	46

Most practitioners of ISM treat menstrual problems, and even incomplete abortions. However less than one third conduct deliveries. Interestingly, when they were asked whether they are called to attend to complications of deliveries, eight ISM providers who did not conduct deliveries, said they were called to attend to complications of deliveries. Most common problems for which these providers were called were prolonged labour, fever after delivery, breast problem, and sometimes premature labour or breech delivery. They treated prolonged labour by giving oxytocin injections, and other problems by other injections or tablets. Thus they came across as visiting consultants called in to handle delivery complications.

Only 3 providers admitted that they used instruments to treat delayed periods. All 3 used D&C for abortion. Mean gestation till which the evacuation was done is 4.3 months, ranging from 2-8 months. Their case load was 4.5 women per month. The cost of abortion was quite low for surgical ISM providers compared to formal providers, ranging from Rs 300 to Rs 600. However, since the curriculum for BAMS or BUMS or BHMS courses does not include skills that would allow them to perform abortions, it is likely that these procedures are risky. Two of them had learnt the uterine evacuation from a private hospital, while one did not respond (table 5.5).

Table 5.5: Instrumental Intervention by ISM providers

<i>Instrumental intervention</i>	<i>Total ISM Providers (n=63)</i>
व Admitted to using instruments to evacuate the uterus	3
Types of instruments used Curette /D &C	3
व Maximum gestation till which evacuation is done (Mean in no. of months and range)	4.3 (2-8)
व Average number of cases per month (mean in no. of weeks and range)	4.5 (0-88)
व Minimum amount charged per case (average Rs)	300 (100-500)
व Maximum amount charged per case (average Rs)	600 (300-1000)
Place from where the provider learned uterine evacuation	
व Private hospital or Clinic of City	2
व No response, not told	1

5.3 Workload and most common problems treated

Most ISM providers worked 7 days a week. Although one third of them provided services for less than six hours, most provided services for longer hours, averaging 11 hours every day. The average daily caseload of these providers was 15 patients every day, ranging from 3 to 40 (table 5.6).

Table 5.6 : Workload of ISM providers

<i>Workload</i>	<i>Total ISM Providers (n=63)</i>
Daily Caseload	14.8 (3-40)
Number of days in week when patients are seen	
व 1-5	0
व 6	13
व 7	50
Mean number of working days	6.8
Average working hours	11.2
व Up to 6	24
व 7-12	23
व 13-18	1
व 24 hours	15

The most common problems seen by ISM providers among children were respiratory symptoms (cough, pneumonia, asthma), followed by abdominal complaints and fever. The most common problems seen among men were also fever, respiratory problems and abdominal problems. Among women, however, the problems were different- they included "gupt rog" (sexual problems), menstrual problems, and weakness or anemia (table 5.7).

Table 5.7: Most common problems

<i>Common problems treated</i>	<i>Total ISM Providers (n=63)</i>
<i>Children's problems (5 most common problems)</i>	
1. Pneumonia, cold, asthma	49
2. Vomiting, diarrhea, abdominal pain	45
3. Fever	27
4. Malnutrition, child drying up	9
5. Skin infections and other skin problems	6
<i>Men's problems (5 most common problems)</i>	
1. Pneumonia, cold, asthma	33
2. Fever	26
3. Vomiting, diarrhea	21
4. Malaria	16
5. TB	15
<i>Women's problems seen (5 most common problems)</i>	
1. Sexual problems or "Gupt Rog"	50
2. Menstrual problems	31
3. Weakness, Anemia	27
4. Fever	22
5. Vomiting diarrhea	15

5.4 Type of facility, its location and equipment etc available in it

Fifty ISM practitioners were interviewed at their private clinics or clinic cum house, while 14 were interviewed at government clinics (table 5.8).

Table 5.8: Place of interview

<i>Place of interview</i>	<i>Total ISM Providers (n=63)</i>
Govt hospital/ CHC/ PHC / Subcentre/ Ayurvedic dispensary	14
Private clinic or Clinic cum house	48
Provider's Home /Bus stand / outside	1

Information on certain aspects was recorded when ISM providers were interviewed at their private clinics. Private clinics were observed for the type of facility, its location, type of furniture, equipment, condition of facility, etc. Thirty-six of these providers had a separate clinic, while the rest had a home-cum-clinic. About half the clinics were located in a market area, while the rest were in a residential locality. Surprisingly, a signboard outside was present only in case of 32 facilities. It is possible that some of those who had not put up a board were actually not qualified as BAMS (table 5.9).

Table 5.9: Type of facility

<i>Type of facility</i>	<i>ISM Providers who were interviewed in private clinics or home cum clinic (n=48)</i>
व Separate clinic	36
व Clinic + house together	12
Location of facility	
व Market area	27
व Residential	21
Sign board outside	31

Among the furniture items, a table, chair, and bench were available in most facilities, but a bed was available only in 21 facilities. However, for recording this information, the investigator did not actively ask the provider, but recorded this information based on what she or he saw in the course of his interview. Observation of the general condition of clinic indicated that generally it was in good condition and clean, while in a few cases, it was dirty and in a poor condition. There was sufficient light in 39 places, while in 11 cases the light was insufficient.

At the time of the visit of the investigator, providers were looking after patients or doing some other work (table 5.10).

Table 5.10: What was provider doing at the time of visit

<i>Providers activity at the time of visit</i>	<i>ISM providers who were interviewed in their private clinics (n= 48)</i>
व Was talking to or treating a patient (giving tablets, injection or IV fluids)	20
व Was at clinic but was not doing work related to patient	5
व Was doing personal work at home (e.g. eating, bathing, resting, watching TV, sitting, sleeping, playing, was going out or returning from somewhere)	15
व Not at home/ clinic (was in a meeting, bus stand)	7
व Other	1

Twenty-nine of the providers had at least one patient present at the time of visit, but as many as 21 providers did not have any patient present in their clinics at the time of visit (table 5.11).

Table 5.11: Number of patients at the time of visit

<i>Number of patients at the time of visit</i>	<i>(n= 48)</i>
Nil	21
1-2	13
3-5	10
6-10	4

Chapter 6

Services by informal providers

6.1 Categories and background of informal providers

A total of 618 informal providers were interviewed in this study. Of these two hundred and fifty six providers were listed in district 1, and 362 in district 2. The largest single category of providers was unqualified practitioners (commonly known as “Bengali doctors” in Rajasthan), followed by female paramedics - nurses and nurse-midwives (auxiliary nurse-midwives or ANMs, lady health visitors or LHVs, trained and untrained nurses), and male nurses. Traditional Birth Attendants were another significant category. In a few cases, lab technicians, pharmacists, and peons of hospitals were providing treatment to women and children. Sixty two per cent of these providers were male, and majority had passed high school.

About 46% of all informal providers held a government job, most of these were female or male paramedics and three peons. Two-thirds of those in government jobs were women. Untrained providers included unqualified village practitioners, untrained nurses, dais, peons, and pharmacists. Except dais and untrained nurses, all of these were male (table 6.1).

Table 6.1: Profile of Informal Providers Interviewed

<i>Category of Provider</i>	<i>Holding govt job (n=280)</i>	<i>Only private service (n=338)</i>	<i>Total (n=618)</i>
<i>Paramedics</i>			
व ANM	15	6	157
व LHV	22	3	25
व Trained Nurse	16	2	18
व Untrained Nurse	0	2	2
व Compounder / Male Nurse / (male) ayurvedic compounder	77	15	92
व Male health worker	11	3	14
व Lab /x ray technician	0	2	2
व Pharmacist	0	2	2

Category of Provider		Holding govt job (n=280)	Only private service (n=338)	Total (n=618)
Village locality based Paractitioners				
व	RMP / "Bengali doctor" /community worker	0	259	259
व	Dai / TBA	0	44	44
व	Peon	3	0	3

Distribution by districts reveals that there were more women in district 1 (Jalore) and vice versa in district 2 (Kota). This was because in Jalore, most women paramedics were locally resident and (male) private practitioners were few. By contrast, in Kota, male practitioners predominated while government paramedics tended to commute and hence played a lesser role in delivering services (table 6.2).

Table 6.2 : Distribution of informal providers by district

	District 1 (n= 256)	District 2 (n= 362)	Total informal providers (n=618)
Sex			
व Female	149	88	237
व Male	107	274	381
Holding government job	181	99	280
Only private	75	263	338

Nearly three fourths of these providers were from Rajasthan, about 12% belonged to Kerala, 9% from West Bengal, and 5% from other states. The families of two thirds of them stayed in the same village as their place of work, families of 21% stayed in a village or town in the vicinity, while families of fourteen percent of providers stayed in a distant town or village (table 6.3).

Table 6.3 : Background of practitioners

Parameter	Govt. (n=280)	Pvt. (n=338)	Total (n=618)
Educational background			
व Illiterate	0	45	45
व Can read /write	0	3	3
व Primary school	1	5	6
व High school / middle school	205	174	379
व Graduate and above	64	98	162
व Post graduate	11	12	23
Age and sex			
व Mean age (range)	36.27 (21-90)	39.09 (20-70)	37.81 (20-90)
व Median age	35.0	37.0	36.0

<i>Parameter</i>	<i>Govt. (n=280)</i>	<i>Pvt. (n=338)</i>	<i>Total (n=618)</i>
Age and Sex			
व Female	178	59	237
व Male	102	279	381
State to which the provider belongs			
व Rajasthan	213	248	461
व Kerala	66	6	72
व West Bengal	0	55	55
व Other states	1	29	30
Where the provider's family stays			
व Same village/ town/ city	146	257	403
व Village/ town/ city nearby	80	50	130
व Distant town or village	54	31	85

6.2 Treatment of delayed periods

Although 409 (66%) providers admitted that women with missed periods visited them, only 356 (57%) admitted to treating them in some way, the rest said they referred them to another facility. About 67% of government providers and 49% of private providers admitted to treating delayed periods (table 6.4). On comparing different categories of providers by sex and training status, it is clear that trained female providers as a group most commonly (76%) treated delayed periods, followed by untrained female providers and trained male providers (table 6.5).

Table 6.4: Treatment for delayed periods by informal providers (by sector)

<i>Treatment for delayed periods by informal providers</i>	<i>Govt. (n=280)</i>	<i>Pvt. (n=338)</i>	<i>Total (n=618)</i>
Admitted to seeing women with delayed periods	217	192	409
Admitted to treating women with delayed periods	190	166	356
Type of treatment (Multiple reasons possible)			
व Massage/pressure	1	7	8
व Herbs/concoctions	0	26	25
व Tablets	188	139	327
व Injections	123	96	219
व Use instruments	16	10	26

Table 6.5 : Treatment for delayed periods by informal providers (by training status & sex)

	Male (n= 381)%		Female (n=237)%		Total (n=618)%
	Trained (116)	Untrained (265)	Trained (188)	Untrained (49)	
Admitted to treating women with delayed periods	60 (52%)	122 (46%)	144 (77%)	30 (61%)	356 (57%)
Types of treatment (multiple methods possible)					
Massage/pressure	0	1	1	6	8 (2.2%)
Herbs/concoctions	0	3	0	22	25 (7%)
Tablets	59 (50.8%)	116 (43.8%)	143(76.1%)	9 (18.4%)	327 (89.2%)
Injections	38 (32.7%)	81 (30.6%)	96 (51.1%)	4 (8.2%)	219 (57.9%)
Instruments	6 (5.2%)	3 (1.1%)	15 (8%)	2 (4.1%)	26 (7.1%)

The most common method mentioned by providers for treating delayed periods, was tablets (53%) followed by injections (35%), herbs/ decoctions (4%) and instruments (4%). Injections and tablets were used by all categories of providers similarly, except for female untrained providers who largely used massage and herbal methods. Posing as customers in need of abortion pills for a family member, some members from our team requested a few sample chemists from the study area for “tablets to bring on a period in case of early pregnancy”. They received various ayurvedic preparations such as “EP Forte”, with the caution “not to be used in pregnancy” (table 6.6). The most popular injection was Carboprost tromethamine, a drug which has been licensed for treating incomplete abortion and postpartum hemorrhage, other injections used are various preparations of progesterone and estrogen hormones. The kinds of tablets collected, their ingredients and costs have been shown in table 6.6 below.

Table 6.6 : Tablets & injections used to “treat delayed periods”.

Name of tablet/capsule	Ingredients	Company	MRP	Comments
EPForte (3 tablets)	Ext Gajjar Beej, Ext Kapas Beej Ext Mooli Beej, Ulatkambal, Kasis Bhasma, Claviceps Purpurea	Wellchem Pharmaceuticals, Mumbai	Rs 14	Caution: Not to be used in suspected case of pregnancy
Mensolin forte (6 capsules)	Alwa, Revond Chini Satva, Kasis, Gajar Beej Satva, Kapas Mool Satva, Keshar, Excipients	PRADPharma Products, Mumbai	Rs 60	Warning: Not to be used in pregnancy. To be taken under medical supervision.
E.P. Gynon (10 capsules)	Daucas Carota, Rupanous Sativas, Aloes Indica, Carica Papaya, Ferula Foctida, Sudha Saubhagya, Trikatua, Exp	CAM India, Mumbai	Rs 50	Caution: Not to be taken in pregnancy
Pregno capsules (4 capsules)	Kapas ka mool, Amaltas ki Phali ka Chilka, Gokharu, Indrayan ka mool, Saunf ka	Suprex laboratories, Ujjain/ Mumbai	Rs 60	Warning : Not to be sued in pregnancy. To be taken under

Name of tablet/capsule	Ingredients	Company	MRP	Comments
	mool, Bans ka mool, Gajar ke beej, Mooli ke beej, Nirgundi, Chitrak mool			medical supervision
Gynacal (3 tablets)	Moringa Pterygo sprema, Raphanus sativas, Aloe Barbadenis, Gosypium herbaceum, Ponkara SY, Trikatu Ghan	Digsun Pharma, Ujjain	Rs25	Not to be use in pregnancy period to be taken under medical Supervision
Ceph-Forte-C (6 capsules)	Mooli Beej, Suhaga Sudh, Kaprdika Sudh, Kasisa sidh, Karpas mool	Digsun Pharma, Ujjain	Rs60	Not for use in pregnancy period. It may be cause of abortion.
EPR forte (injection)	Pregnedione 25 mg	Aarge Drugs Pvt. Ltd.	Rs 12.50	Do not use if pregnancy is suspected
Estogen (injection)	Oestradiol Benzoate 5 mg	Macmillon Pharmaceuticals Ltd.	Rs 23.70	
Progesteron 50 (injection)	Progesterone 50 mg	Macmillon Pharmaceuticals Ltd.	Rs 15.50	

Only 21% of providers who used tablets felt that it was successful in more than 50% cases, while as many as 66% of those using injections perceived that they were successful in more than 50% cases (table 6.7).

Table 6.7 : Informal providers' perception of success of various methods

Method	Number
व Herbs /concoctions (n= 26)	8 (30.8%)
व Tablets (n= 327)	70 (21.4%)
व Injections (n= 219)	144 (65.8%)

Those who admitted to treat delayed periods were asked as to how they had learned this treatment — the most common response was that they learnt it on their own or by looking at a prescription (42%). The second most common method was that they learnt it by working with a doctor or colleague (26%). About 11% said that they learnt it during pre-service training (table 6.8).

Table 6.8 : Place from where provider learned to treat delayed periods (n=356 who treat delayed periods)

	Govt (n=190)	Private (n=166)	Total (n=356)
During pre–service training	38	8	46
Working with a doctor	14	21	35
From a colleague, nurse or compounder	31	40	71
One his/ her own	71	78	149
By looking at prescriptions	20	4	24
Other / no response	20	15	35

6.3 Use of instruments

Twenty-six providers admitted to using instruments for treating missed periods. These included 15 trained female providers, 6 trained male providers, 3 untrained male providers and 2 untrained female providers (“trained” refers to any medical / paramedical training, not training for treating missed periods). The commonest type of instrument used was the curette (table 6.7). One ANM said she inserted Copper-Ts in women coming with missed periods. It is known that a pregnancy with Copper-T in situ has higher chances of abortion, and this appears to have been the logic for the ANM to use a Copper-T to induce an abortion (table 6.9).

Table 6.9: Instrumental intervention to bring on an abortion

	Govt. (n= 190)	Pvt. (n=166)	Total (n=356)
Admitted to using instruments to evacuate the uterus	16	10	26
Types of instruments (multiple responses possible)			
☐ Curette / D&C	15	8	23
☐ Syringe	0	1	1
☐ Catheter	0	1	1
☐ Copper-T	1	0	1
Maximum gestation up to which evacuation is done Mean months (range)	3.0 (1-8)	2.4 (2-4)	2.76 (1-8)
Average number of cases per month Mean (range)	2.93 (0-40)	2.30 (0-15)	2.63 (0-40)
Minimum amount charged per Rs case (Mean & range)	273 (100-400)	370 (150-500)	315 (100-500)
Maximum amount charged Rs per case (Mean & range)	515 (300-1000)	635 (200-1000)	567 (200-1000)

Informal providers terminated pregnancies using instruments up to 8 months, with a mean gestation of 2.7 months. On average, about 3 cases were treated using instruments every month - private providers had higher caseloads than government providers. The cost of abortion was lower than that charged by formal providers, as mentioned in the preceding section.

Those who were using instruments were far more likely to have learnt by observing or assisting a doctor in a government or private hospital (table 6.10).

Table 6.10 : Place from where the provider learned uterine evacuation

	Male trained (n=6)	Male untrained (n=3)	Female trained (n= 15)	Female untrained (n=2)	Total (n= 26)
Govt hospital or health center	1	0	3	0	4
Private hospital or clinic	2	0	7	2	11
Other (from brothers / sisters)	1	2	1	0	4
Self	0	1	1	0	2
No response, not told/ not clear	2	0	3	0	5

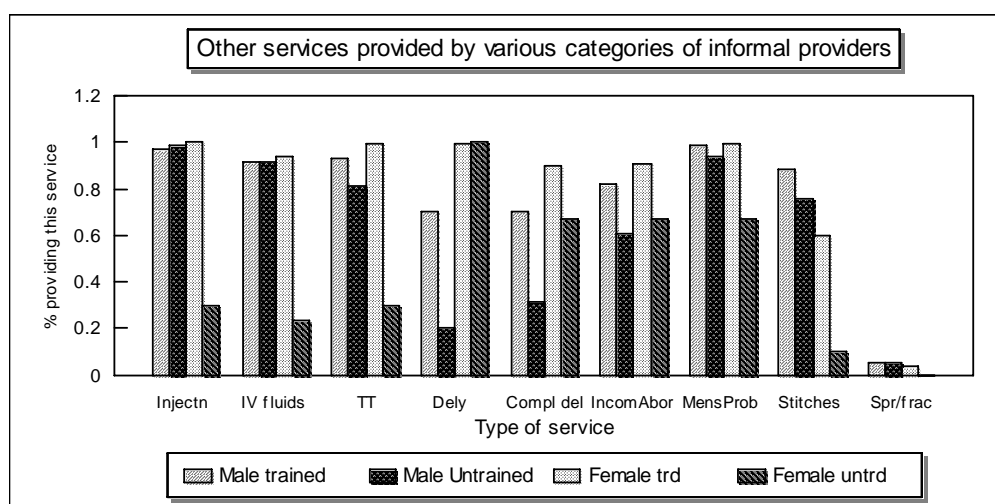
6.4 Range of services provided by informal providers

Informal providers (who treated delayed periods) provided a range of services. The most common service was giving injections for common ailments (93%), TT injections (86%) and IV fluids (87%). Sixty six percent also provided stitches for injuries, but only 4-5% claimed providing treatment for sprains and snake-bites. Regarding gynecological - obstetric services, nearly two thirds conducted deliveries, while more than three fourths said they treated incomplete abortions. Nearly all of them said they treated menstrual problems too (table 6.11).

Table 6.11 : Range of services provided by informal providers who treat delayed periods

<i>Other Services(multiple responses possible)</i>	<i>Govt.(n=190)</i>		<i>Pvt.(n=166)</i>		<i>Total(n=356)</i>	
	<i>Number</i>	<i>%</i>	<i>Number</i>	<i>%</i>	<i>Number</i>	<i>%</i>
Injections	188	99%	143	86%	331	93%
Stitches	128	67%	106	64%	234	66%
Sprains /fractures	8	4%	6	4%	14	4%
Snake bites	11	6%	6	4%	17	5%
IV fluids	175	92%	135	81.3%	310	87%
TT injections	185	97%	122	73%	307	86%
<i>Services for reproductive health needs</i>						
Deliveries	172	91%	68	41%	240	67%
Complicated deliveries	163	86%	67	40%	230	65%
Incomplete abortions	167	88%	107	64%	274	77%
Menstrual problems	188	99%	149	90%	337	95%

On comparison of services provided by various categories of providers, it is clear that injections and IV fluids are provided by all categories except female untrained providers. Tetanus injections are provided by larger proportion of trained female and male providers. Deliveries, on the other hand are conducted by most male trained and most female providers, but by very few male untrained providers. Similarly, treatment of incomplete abortions is also carried out least by male untrained providers.



6.5. Workload and common problems treated

Overall, informal providers provide services 7 days a week. They work for an average of 15 hours a day, with 48% providing 24-hour access to services. Ability to provide services for long hours and on all days appears to be their strength in comparison to formal providers in villages and towns, who usually commute from cities and are not available on holidays and beyond few hours of daytime (table 6.12).

Table 6.12 Workload of informal providers

	Govt.(n=190)	Pvt.(n=166)	Total (n=356)
Daily case load	12.82 (1-90)	9.80 (0-50)	11.42 (0-90)
Number of days in a week when patients are seen			
व 1-5	2	6	8
व 6	36	13	49
व 7	152	147	299
व Mean	6.7	6.8	6.7
व Median	7.0	7.0	7.0
Average working hours			
	13.6 hours	17.1 hours	15.2 hours
व Upto 6 hrs	100	12	112
व 7-12 hrs	9	59	68
व 13-18 hrs	0	4	4
व 24 hours	81	91	172

The most common problems treated by informal providers for children and men included respiratory infections, gastrointestinal problems (vomiting, diarrhea) and fever. However, the common woman's problems treated included sexual problems or "gupt rog", weakness and menstrual problems (table 6.13).

Table 6.13: Most common problems treated by informal providers

Five most common problems for each category	Govt.(n=190)	Pvt.(n= 166)	Total (n= 356)
Children's problems			
1 Pneumonia, cold, asthma	163	137	300
2 Vomiting, diarrhea, abdominal pain	133	98	231
3 Fever	116	86	202
4 Skin infections and other skin problems	60	13	73
5 Malnutrition, child drying up	12	7	19
Men's problems			
1 Fever	142	101	243
2 Pneumonia, cold, asthma	96	88	184
3 Vomiting, diarrhea	62	71	133
4 Malaria	19	39	58
5 TB	27	20	47

<i>Five most common problems for each category</i>		<i>Govt. (n=190)</i>	<i>Pvt. (n= 166)</i>	<i>Total (n= 36)</i>
Women's problems				
1	Sexual problems, "Gupt Rog"	168	119	287
2	Vomiting diarrhea	66	64	130
3	Weakness, Anemia	111	64	175
4	Menstrual problems	72	85	157
5	Fever	64	52	116

6.6 Facilities in informal providers' facilities

Of 283 government providers, 197 were interviewed in their government health centres or hospitals, while a few were interviewed at private clinics or homes. Most private providers were interviewed at their clinics or homes (table 6.14).

Table 6.14: Place of interview

<i>Place of interview</i>	<i>Govt. (n= 190)</i>	<i>Pvt. (n= 166)</i>	<i>Total (n= 356)</i>
Govt hospital/ CHC/ PHC / SC	128	0	128
Private clinic	38	135	173
Provider's Home /Bus stand / outside	24	31	55

We observed the condition of shop, boards etc., in case of those who were interviewed in their private clinics/ homes. These largely included unqualified male practitioners (table 6.13). Interestingly, boards were present outside 41% of male untrained providers, while fewer trained providers had put up a board outside their clinics. By comparing government and private providers, 17% of government providers, and 37% of private providers had put up a board outside their clinics (table 6.15).

Table 6.15: Board present outside facility run by informal providers

<i>Category</i>	<i>Private clinics/homes observed</i>	<i>Board outside present</i>
☐ Male trained	23	5
☐ Male untrained	119	49
☐ Female trained	28	2
☐ Female untrained	3	2

Of 318 private providers interviewed within their facilities (the rest were interviewed outside their clinics), two thirds had a separate clinic, while one third had a house-cum-clinic. The situation with government providers appeared to be different – far greater number provided treatment from within their government centres, while the rest provided treatment from home.

Nearly half the providers had their facilities located in market areas. The investigators also discretely observed the furniture and general conditions in the clinics. It is possible that they missed some items which were kept in the inner areas or rooms. Less than half the clinics had a bed (42%), while a table and chair or stool was present in 85%. A large number of facilities were dimly lit and 26% looked unclean (table 6.16 and 6.17).

Table 6.16: Observation of informal providers' facilities

Type of treatment facility		Govt. (n= 38)	Pvt. (n= 153)	Total (n= 191)
व	Separate clinic	10	99	109
व	House	15	19	34
व	Clinic + house together	13	35	48
Location of facility				
व	Market area	13	80	93
व	Residential	25	73	98
Type of furniture available				
व	Bench	11	108	119
व	Table	34	126	160
व	Chair	32	119	151
व	Stool	23	99	122
व	Bed	17	65	82
व	Shop in dirty condition	8	39	47
Light in room				
व	Dimly lit	11	52	63
व	Sufficient light	27	101	128

Table 6.17: Number of patients at the time of visit

Number of Patients	Govt. (n= 52)	Pvt. (n= 318)	Total (n= 370)
Nil	70	93	163
1-2	29	39	68
3-5	25	19	44
6-10	2	10	12
10+	1	3	4

6.4 Range of services provided by informal providers

Table 6.11 : Range of services provided by informal providers who treat delayed periods

Regulation and Training Capacity for Elective Abortion in Rajasthan

In order to assess policy and legal environment in Rajasthan, especially in relation with certification of facilities and MTP training, information was collected at state level. The methodology used was visits to the Health Directorate in Jaipur, a series of interviews with key government officials, and secondary data collection. Interviews were also carried out from trainers of 5 MTP training institutions of the state. The areas explored were:

1. What is the extent to which certified or approved MTP facilities are available in the government and private sectors in the state? How many such facilities have been certified till date?
2. What guidelines are used by the GOR to certify MTP facilities in the state? What guidelines (if any) are used for approving MTP services in government institutions (teaching hospitals, other hospitals and health centers)?
3. What is the training capacity in the state, for carrying out MTPs? What is the curriculum in use? What is the annual performance of existing institutions? How many MTPs has the average trainee observed, assisted and performed, in the course of training? What are the perceptions of directorate personnel and MTP trainers (including medical school faculty) regarding the adequacy for training? What ideas do they have for enhancing or improving this performance?
4. What are the perceptions of health officers and trainers regarding medical abortion? What role have they played in influencing access to medical abortion?

7.1 MTP certification

7.11 Procedure of approval of government facilities:

All government facilities are by default considered as certified to provide MTP services, as long as they have a trained provider and the necessary equipment²⁹. In this regard, it appears that there was some confusion regarding interpretation of MTP Act till July 1993, since there was a

29 Unlike private facilities, a government facility does not have to specify that it fulfils these requirements

letter from the Directorate of Health Services to all principal medical officers, CMHOs, and deputy CMHOs (FW) which noted that : *“government institutions of some districts of Rajasthan are not providing MTP services .. and they are interpreting that they can provide MTP services only after permission from the state government .. only private medical institutions will need to take permission of state government to be authorized to provide termination of pregnancy... In case of government medical institutions, wherever necessary facilities, and well equipped operation theatre, all necessary equipment and a doctor trained in MTP is available, then they are instructed to start providing MTP services... they need not take permission for it.”* Directorate officials maintained that although they had received this letter, they had not certified or approved any government institution even prior to that.

However, very few government facilities had a trained provider, and hence not all government facilities were functional. The state has 32 district hospitals, 263 community health centres and 1662 primary health centres in the government sector³⁰, . all of which are meant to provide abortion services. However, most lack trained doctors and/or equipment. A facility survey³¹ sponsored by the Ministry of Health & Family Welfare in 1999 showed that only 16% of CHCs had posted an obstetrician, while only 2% PHCs had a doctor trained to perform abortions (MTPs). The survey revealed that only 4% of PHCs in fact provided MTP services.

7.12 Procedure of certification of private facilities:

Government of Rajasthan has been largely following the standard Government of India guidelines for certification of private facilities, except that it also demands an architectural blueprint of the facility. If a private facility which wishes to get certified for MTP, it has to send an application to the CMHO, who in turn would visit the place and assess its readiness on the basis of a “Form A”, and then forward the application to the Directorate in Jaipur with his/her comments as to whether the place could be approved for conducting MTPs. The concerned officer in the Directorate would look into the form and assess it. A checklist to assess the completeness of an application by a private facility has been used by the directorate, which requires a blueprint of the facility, and certificates of paramedical staff, MTP certified doctors and anesthetists, along with registration in a state nursing council of all these categories of medical persons. The requirement of an anesthetist can become a barrier in rural areas³². On the basis of this assessment, the directorate gives a final approval regarding certification to the place. Both the steps (recommendation by the CMHO and approval by the directorate) are expected to take one month each.

The concerned person (RCH Consultant and Section Officer) at the Directorate made the following observations regarding the procedure:

- 3 Although the process of certification should not take longer than two months, it generally takes about 5-6 months.
- 3 Only 50% of the applications received are complete and certified. The rest have to be sent back due to objections on various fronts.

30 Government of India, Bulletin of Rural Health Statistics in India. New Delhi: Rural Health Division, Directorate General of health services, Department of Family Welfare, Ministry of Health AND family Welfare, 2000.

31 International Institute of Population sciences. Facility Survey (Under Reproductive and Child Health Project) Phase –I, 1999. Mumbai 2001

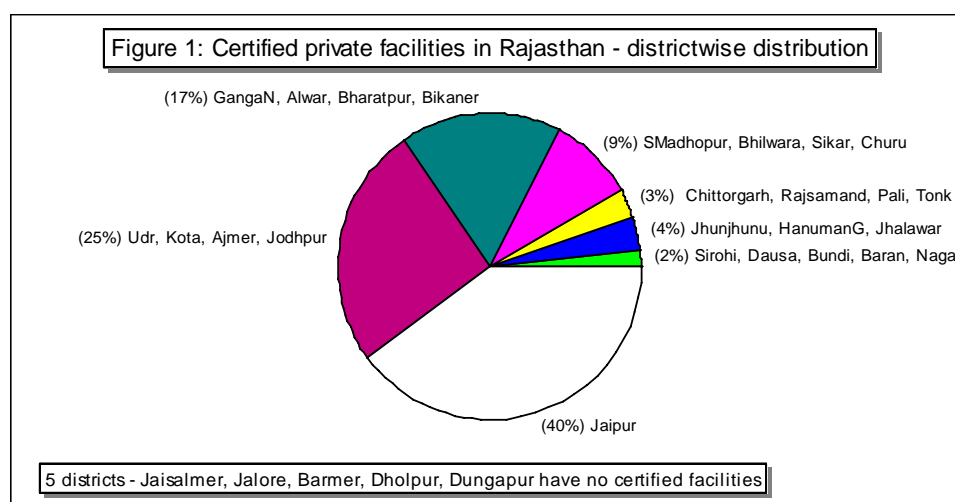
32 Iyengar K. and Iyengar SD. (2002) Elective abortion as primary health service in rural India: experience with manual vacuum aspiration. Reproductive health matters 10 (19) : 55-64

- 3 The most common reasons for raising an objection to an application are lack of blueprint of the area and lack of a trained nurse at the facility.

The officers at the Directorate felt that the government needed to be strict in certifying institutions, as there was a high liability cost to be paid. They were concerned that if they certified an institution and then subsequently there were cases of negligence or death, then the government would be held responsible.

7.13 Number and distribution of private certified facilities

Data from the State Directorate of Family Welfare reveals that 338 private facilities had been certified to provide MTP services in Rajasthan as of 2003³³. This amounts to an average of 0.6 certified private facilities per 100,000 population in the state as a whole (table 7.1). However, the distribution of these facilities was highly skewed, with most facilities being concentrated in a few districts. Nine districts with 38% of state population had 83% of all certified facilities, while the remaining 22 districts had 17% of the facilities. Six districts (Jaisalmer, Jalore, Barmer, Dungarpur, Dholpur, Karauli) did not have a single certified private facility, while 6 districts had only one each (figure 1), while Jaipur had the maximum number of 135 of the 338 registered centres. Districts with no private facilities or very few private facilities had entirely dependent on government institutions for safe abortion.



The number of private MTP facilities available per 100,000 population was less than 1 in all the districts, except Jaipur (2.85) and Ajmer (1.15). This clearly shows that more centers need to be approved for MTPs, to ensure provision of safe abortion facilities (table 7.1).

Table 7.1: District wise certified Private institutions

<i>District</i>	<i>Population (2001)</i>	<i>Number of certified private facilities</i>	<i>Certified pvt facilities per 100,000population</i>
Jaipur	4723000	135	2.9
Udaipur	2889000	28	1.0
Kota	2031000	19	0.9
Ajmer	1729000	20	1.2
Alwar	2297000	16	0.7

33 This data was collected from a scrutiny DFW records in 2003. However, the FW Year Book of Govt of India 1998-99 mentions 483 certified facilities

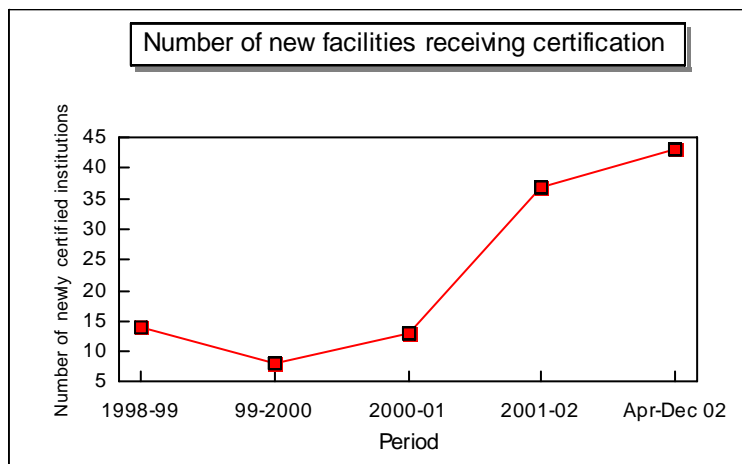
District	Population (2001)	Number of certified private facilities	Certified pvt facilities per 100,000population
Bharatpur	1652000	12	0.7
Ganganagar	2623000	18	0.7
Jodhpur	2153000	19	0.9
Bikaner	1211000	12	1.0
Bhilwara	1593000	9	0.6
Sikar	1843000	9	0.5
Churu	1543000	7	0.5
Tonk	975000	2	0.2
Jhunjhunu	1582000	4	0.3
Hanumangarh	1220000	5	0.4
Pali	1486000	3	0.2
Jhalawad	957000	3	0.3
Sawai Madhopur	1963000	6	0.3
Rajasmad	822000	3	0.4
Chittorgarh	1484000	2	0.1
Sirohi	654000	1	0.2
Dausa	834000	1	0.1
Bundi	770000	1	0.1
Baran	953561 ³⁴	1	0.1
Nagaur	2145000	1	0.0
Banswara	1156000	1	0.1
Barmer	1435000	0	0.0
Dholpur	749000	0	0.0
Dungarpur	875000	0	0.0
Jaisalmer	345000	0	0.0
Jalore	1143000	0	0.0
TOTAL	56400000	338	0.6

Higher officials in the government appear to be concerned by a shortage of certified MTP institutions in the state and the difficulties faced by private institutions for certification. In this connection, the Health Secretary of Rajasthan issued a letter to the Director (FW) in July 1999, which stated that “.. in a meeting with the representatives of private hospitals and nursing homes society..... the representatives pointed out that the CM&HOs do not process their applications for months together. The Government is very keen that private sector is actively involved in the implementation of the Family Welfare programme. It is, therefore decided that in case the CMHO does not send his recommendation within one month from the receipt of the application, the Director would be authorized to forward the application to the Government for sanction. Government would issue sanction in the absence of the report of the CMHO....”. However, this letter unfortunately does not appear to have had much impact on the process of certification and the private sector still has to wait for months together for certification.

However, it must be acknowledged that the number of new facilities receiving certification has been increasing over the years. While 11 facilities were certified in year 1998-99, 44 were

34 Populations are estimated on basis of 1991 population with 28% increase

certified in year 2002-3. The two possible reasons for this increase could be that after the directives of the Health Secretary, district offices and the Directorate has started processing applications and granting certification more actively, moreover more private institutions have started applying.



Even after an amendment in June 2003 decentralized approval to a district committee, district level officials have remained largely unaware of the details and have not liberalized the certification procedure. As per records of the Directorate, 17 institutions have been certified in 2004³⁵.

7.1.4 Reported number of MTP cases

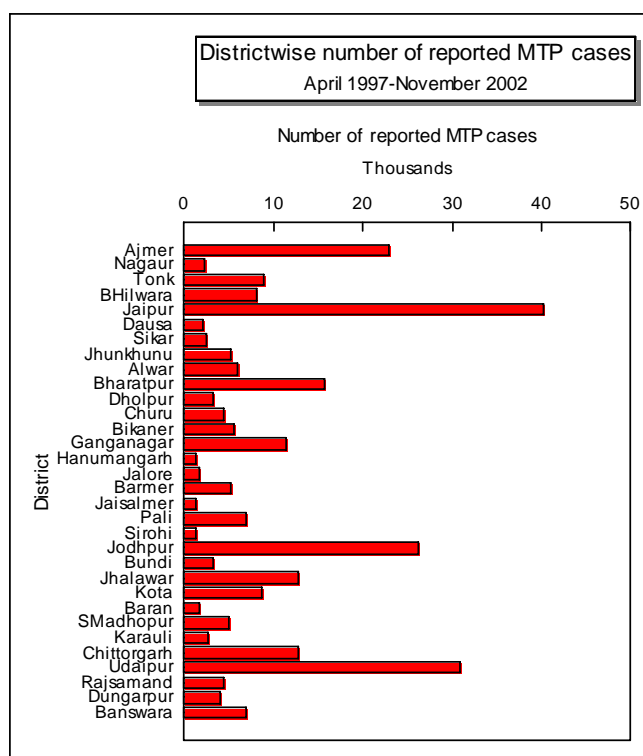
There were 44,265 reported pregnancy terminations during 1997-98, while 53762 cases were reported in 2001-02. Estimates suggest that two to ten unreported procedures take place for each reported one^{36, 37}. While a proportion of unreported procedures appear to be carried out by formal providers working in government and private facilities, informal providers are known to carry out the bulk of abortion procedures, as judged from indirect estimates. Formal providers appear to under-report because of concerns related to paying income tax, fear of the Consumer Protection Act which applies to all paid services, and because several doctors are not "MTP-trained" and hence cannot legally perform abortions. Lastly, some government doctors conduct MTPs at their residence or private clinics and are not in a position to report them.

Looking at reported MTP cases district wise for period April 1997 to November 2002 (annexure 1 & figure 2), it also reflects the highly skewed distribution ranging from an average of 19-20 MTPs per month in Sirohi, Hanumangarh and Jaisalmer to 590 MTPs per month in Jaipur district. In districts with extremely low numbers of MTP cases, it is likely that number of abortions performed by untrained persons is quite high.

35 Source DEO, Directorate of FW, Jaipur

36 Indian Council of Medical Research. "Illegal Abortion in Rural Areas: a Task Force Study". New Delhi. 1989.

37 Chhabra R, Nuna SC. Aboriton in India: An overview. New Delhi: Veerendra Printers; 1994.



7.2 MTP Training

The MTP Act stipulates that only doctors with a postgraduate degree (MD/MS/ DGO) or six months residency in obstetrics-gynecology can perform abortion procedures. Other doctors would have to undergo specific MTP training in a designated training center.

7.2.1 Guidelines for MTP training

Criteria laid out by NIHFV for selection of training centre, duration, content of training, number of procedures and number of trainees is as follows :

Selection of training centres: The criteria for approving MTP training centres include:

- ☐ a minimum caseload of 600 procedures per year,
- ☐ availability of essential facilities like operation theatre and MTP equipment.
- ☐ availability of the manual “First trimester Medical Termination of Pregnancy”

The recommended duration of training is 2 weeks or 12 working days, and a curriculum has been defined. The training program should be competency based and the trainer must ensure that the trainee has acquired necessary skills for:

- 3 Pre and post abortion counseling, including post MTP contraceptive counseling
- 3 Selection of cases with dating of pregnancy
- 3 Clinical procedure
- 3 Recognition and management of complications
- 3 Management/maintenance of MTP equipments

It has been specified that acquisition of the above skills require that the trainee assists at least 10 MTPs, performs at least five under supervision and another five independently. The number of participants per course should be two or three, depending upon the caseload of the training centre. Medical Officers of CHC/PHC should be trained where necessary equipments are already available.

Other guidelines for MTP training: Although the training in charge at the Directorate said that these guidelines are strictly being followed for training, there is a letter from the MOHFW in Delhi to all State Family Welfare officers, dated 18th Nov 1986, which varies a bit from these guidelines, in that it contains instructions to postpartum centers acting as training centres. Some of the differences noticed are:

- 3 Each post partum centre would have to train at least 20 medical officers in a year (not more than 2 to 3 trainees in one course).
- 3 The medical officers, during their 15 day training would conduct:
 - i. MTP—15-25 cases (depending upon the availability of cases)
 - ii. Minilap/Tubectomy—5 cases
 - iii. IUD insertions— 10 cases
 - iv. Follow up of cases with oral pill administration vis-à-vis eligible couple register maintained by the ANM—10 cases.

There is a format giving the details of the training program conducted during the month, which would be filled in by the trainer and sent to the MOHFW by the 15th of every month.

7.2.2 Number of training institutes and number of doctors trained in MTP

There are 8 MTP training centres in Rajasthan – they include 6 medical colleges (Jaipur, Ajmer, Bikaner, Kota, Udaipur, Jodhpur), and two district hospitals (Alwar, Bharatpur). An assessment of training performance, capacity and quality has been carried out by ARTH through interviews and secondary data collected from the Directorate of FW and a qualitative assessment of five training institutions. The total number of doctors trained since 1971 till April 2002 is 1056, of which 786 have been trained since 1980. This works out to an average of 35.7 doctors trained in MTP per year, a rather low figure, given the number of training institutions. With one training centre (Kota Medical College) having been in operation only for the last 6-7 years, this translates into 5 trainees per institution per year. This number is over and above the doctors who have been trained as MS/MD/DGO in Obstetrics and Gynecology, or have done a 6-month house job. Among the training institutions, there are wide variations with Jaipur having the highest number of trainees.

Table 7.2: MTP training trends over the years

Period	Number of doctors trained		
	Total	Govt.	Private
1971 – 79	270	NA	NA
1980 - April 2002	786	677 (86%)	109 (14%)

7.2.3 Procedure for receiving MTP training

The procedure for receiving MTP training appears to be complex, especially for private doctors and is mirrored by the skewed proportion of government and private doctors trained till date. Among doctors who received training over the last 22 years, 86% were in government service. A private doctor is eligible to receive MTP training only if s/he is currently working in an MTP certified institution. However, an institution can be certified for MTP only if there already is an MTP-trained doctor in position. Hence a private doctor cannot be trained if her/his institution is not certified and the institution cannot be certified in the absence of a trained doctor, leading to a Catch-22 situation. Further, a doctors' application for MTP training needs to follow the channel of Chief Medical and Health Officer, and additional/ zonal director before it is recommended that the doctor is placed as a trainee in an MTP training institution of that zone. For a government doctor, the procedure is simpler and the likelihood of being recommended for training is higher.

Data from the Directorate in Jaipur shows that there is an unequal distribution of trainees within training institutions, with Jaipur having the maximum load, while some other training centres like Bharatpur, Jodhpur and Ajmer having only 2-6 trainees over 7 years (table 7.2).

Table 7.3: Performance of MTP training centres

Year	Number of doctors trained	MTP training centre							
		Kota	Bikaner	Ajmer	Udaipur	Jodhpur	Bharatpur	Jaipur	Alwar
1996	20	2	4	1	1	1	3	8	
1997	21	1	4	1				10	5
1998	32	2	3			1		26	
1999	61	9	3	3	8		2	30	6
2000	36	4	2		4		1	25	
2001	21	1	1					19	
2002	20	1						19	

7.2.4 Curriculum and experience gained by trainees :

Interviews with faculty of MTP training institutes suggest that no defined training curriculum is used in any training institute, that trainees are posted in operation theatres every day so that they may learn the (surgical aspect of) the procedure. In fact, in some training centres, faculty were not even aware that a curriculum existed, in the first place. Thus there are few opportunities for trainees to acquaint themselves with issues such as the public health relevance of abortion services, pre and post abortion counselling for allowing women a measure of reproductive choice, and the clarification of providers' values regarding abortion.

Of the 8 training centres, there is an unequal distribution of trainees, with Jaipur having the maximum load. Regarding the experience gained by trainees, some faculty members were dissatisfied. They felt that the trainers were not really interested in teaching, since the caseload was heavy and there was shortage of time. Because of heavy caseload, and lack of time, the trainers sometimes try to complete all procedures on their own, instead of "wasting" time on teaching someone else. Moreover, they felt that sometimes several trainees are posted at one time, creating a crowd in the OT, making it difficult for the trainer to concentrate on the job.

Some trainers at one training institute felt that trainees too are often not interested – sometimes doctors posted in rural areas take up MTP training because it allows them to stay for 15 days in the city, with their family. At few places, the faculty was dissatisfied with the quality of

training. They perceived that trainees must be frustrated at not being allowed to carry out the procedure independently, and must be feeling that trainers were not interested in teaching them. The trainer at one centre was, however satisfied with the training being provided for MTP. He said that whoever came for this training was interested and completed the course. One trainer commented that although there is no set curriculum, the trainees are told about post abortion contraception and counseling, follow up, referrals during the training. During training, the IUD is taught as the most common method of post abortion contraception.

One trainer suggested that there should be an individual doctor in every hospital who would be responsible only for training. This person should give enough opportunity to trainee doctors for learning. The number of trainees should also be limited to 2 or 3.

7.2.5 Service protocols being followed at training institutes:

In most training institutes, MTP is a highly medicalised procedure, carried out in operation theatres under general anesthesia and often requiring admission a day earlier. Because of this over-medicalisation of the procedure, the trainees attempt to follow similar protocols, or avoid providing services in low resource settings (e.g. PHCs, CHCs) where for example, general anesthesia facility is not available. Thus, training centres appear to be blind to the reality of the working environment of the trainees, and also unaware of the recommended protocols. This ultimately reduces access. The methods in vogue are electric suction followed by check curettage, or more recently and hesitantly, medical abortion using mifepristone. In some training centres, the technique predominantly used is dilatation and curettage. Either oral or vaginal misoprostol or injectable carboprost is used for cervical priming.

Second trimester abortions are usually carried out at all training centres using the extra amniotic method (using ethacridine lactate). At some training centres, since the last two years, medical abortion has been used increasingly for second trimester abortion. Although WHO guidance endorses this protocol, it has not yet been approved for the purpose in India. We gathered the impression that there are several apprehensions on part of some senior faculty that the increasing use of medical abortions would make it difficult to regulate MTP.

The greater use of MVA has recently been initiated as part of a FOGSI implemented 7-state project that includes Rajasthan – two training centers have been covered by this initiative. Use of MVA has started in these centers, and as part of the thesis of some students, in one. In one training center, MVAs are carried out in an outpatient room, but trainee doctors are not posted there. At two training centres, the faculty said that they had received training in MVA technique, and were keen on performing it in hospital, as they found that this technique was simpler and required no anesthesia. But there were no MVA syringes provided for the purpose. The trainer at one institute recognized that trainees are rarely taught about techniques such as medical abortion, extra-amniotic instillation and MVA.

Women coming to training institutions are “strongly motivated” to adopt sterilization or IUD. Women who only want to have MTP are not preferred, although there is a measure of access for women in difficult social situations. Even in MTP training institutions, the established protocol is to take consent of husband or another family member – women coming alone by and large cannot access the service.

7.2.6 Cost of abortion

At most training centres, the faculty said that patients who undergo MTP had to bear the cost of the drugs required for cervical priming and for medicines to be taken after the procedure.

However, if she agreed to undergo sterilisation, then she didn't have to pay for anything. At one training centre, the administrator mentioned that earlier MTPs were being carried out in the minor OT, but now only the main operation theatre is used for MTPs as an administrative measure to stop staff who were charging money for conducting MTPs in the minor OT.

7.2.7 Issue of MTP certificate

Once the trainee completes his/her training at an MTP training centre, the trainer of that centre submits a report to the Directorate, and then the Directorate issues a certificate awarding MTP training. There is no particular assessment procedure for the trainees after completion of the course. The time taken for this procedure is approximately 2 months, according to the training In-charge at the Health Directorate. However, there have been cases where the certificates have not been issued to trainees for more than a year after successful completion of the course, making it difficult for the trainees to conduct MTPs at their clinics.

7.3 Medical Abortion

Medical abortion drugs were licensed for use in India since 2002. Since then their availability and use has been gradually increasing. Interviews with faculty of 5 MTP training centres has revealed that their use has gradually started for first trimester as well as for second trimester abortions. However, it was not clear as to what proportions of all abortions are being carried out using medical abortion drugs, and whether these are recorded in the MTPs carried out. As faculty of one training institute said, *"The lecturers prescribe these drugs to the patients, who in turn preserve the (prescription) papers. Next time, if they miss their periods, they don't even come to the doctors, and take the medicines by directly approaching the chemist."*

Some trainers feel that medical abortion drugs should only be given in a hospital set up that has all the facilities for surgery, trainers of some other institutes feel that medical abortion drugs could safely be given in an OPD set up. Some of these trainers had already started counseling their patients about the option of medical abortion, and had gained some experience of using these drugs in an OPD setup. However, although they claimed not receiving any complaints related to its use, no data was being collected from patients. One doctor also felt that being very expensive, they could not be prescribed to most patients, and that government needs to subsidize the drugs. Medical abortion drugs (Misoprostol or Carboprost) are commonly used in training institutes for cervical priming before surgical abortion.

The data from formal providers shows that nearly 60% of providers had started using medical abortion also, the use was almost equal between public and private providers, but was more common among formally trained providers. Interestingly, the use of these drugs, had also invaded informal providers as revealed in the study of informal providers. Fifty eight percent of informal providers who treat delayed periods, used injections, commonly of Carboprost. Personal communication with ARTH's paramedical staff has revealed that some agents or sub-agents of pharmaceutical companies or chemist shops have begun to actively market their products to paramedics and unqualified practitioners working in rural areas.

Chapter 8

Conclusions

Our study of abortion services, facilities, providers and the policy and training environment has led us to certain major conclusions as follows:

There is an extremely large number of women's health service providers in Rajasthan- this includes a wide range of providers ranging from informal unqualified practitioners, paramedics, ISM practitioners, MBBS doctors without MTP training and MTP trained doctors. Highly qualified providers cannot survive the rural interiors of India. Informal and ISM providers practice in rural areas and seem to operate a parallel primary health system. These less qualified or unqualified informal providers deliver a wide range of services, and their strength appears to be their courteous behavior, continuous presence in rural areas and long working hours. By themselves, informal abortion practitioners have veered towards less invasive & safer methods, even if some of the regimes are irrational or ineffective. Medical abortion is likely to accelerate this trend away from invasive procedures. The use of instruments by illegal abortion providers is expected to decline, as a result.

Informal providers practice discretely but openly – everyone including the regulatory authorities appear to be aware of their existence and role. Their large-scale availability is a pointer to the state of (lack of) governance of the health system, rather than to an ineffective legal framework.

Only a minority of government facilities mandated to provide MTP services were doing so. The facilities in urban areas were largely functional while those in rural areas were largely dysfunctional. Even when they did provide MTP services, case loads in PHC and CHCs were extremely low, indicating that overall availability of MTP services in rural areas continues to be low.

Overall, it appears that equipment and supplies are not a limiting factor in provision of MTP services in Rajasthan. The availability of equipment was better in private than government facilities. However, availability of MVA equipment, that are safer and more appropriate for rural areas was low in both sectors and needs to improve.

Formal providers tend to medicalise their service — general anesthesia continues to be used by a large number of providers, while some techniques used by formal providers are obsolete. Even where formal providers have begun using safer techniques such as EVA, they continue to use “check curettage” (use of a curette after completion of vacuum aspiration), thus reducing the safety of the procedure and increasing the need for pain control.

MTP training in the state needs to change and adapt to the need for increasing capacity and quality. Training institutions need to keep the situation of peripheral health centres in mind,

and demedicalize their own service. They need to use safer techniques (e.g. MVA), without general anesthesia, so that trainees posted in rural health centers can provide services. Moreover, their curriculum should include not only the clinical aspects, but also aspects related to counseling, confidentiality, women's rights, consent procedures, access, etc. The number of MTP training institutes also needs to increase. District hospitals and private hospitals with large MTP caseloads can also provide MTP training.

The large presence of informal providers indicates low access to formal MTP providers and facilities in rural areas. While punitive action against these informal providers might curtail them, it is more important that access to safe and legal providers and facilities is increased in rural areas and in those districts where certified facilities are lacking. While there are reservations among members of the medical community about ISM doctors and paramedics been allowed to be trained in MTPs, for the time being, even if greater numbers or all MBBS doctors were to be trained in MTP, the situation with regard to lack of providers would improve. The present procedure for MTP training disfavors private doctors from receiving MTP training. Given that only minority of all doctors in the state are in the government service, simpler procedure for MTP training of doctors or including MTP training in pre service curriculum would fulfill this crucial gap.

To improve access to safe abortion services, and to reduce the number and utilization of informal providers, it is also important to simplify the procedure for certification of private facilities. Although the amendment in MTP Act in 2003 have recommended decentralization of procedure, awareness of these changes at district level is low, district committees do not get formed for months together. There is a risk that even when the district committees get formed, they would include specialists from medical colleges who are often detached from reality in primary care settings, or people who are more concerned that a certified facility would make easy money rather than being concerned about women who would go to unsafe providers in absence of access to safe providers. District CMHOs would therefore need to ensure that the district committee is constituted of suitable people.

Conclusions

Executive summary

An assessment of abortion facilities and services in Rajasthan was carried out by Action Research and Training for Health (ARTH) — the study covered two districts (Jalore and Kota) of the state. In addition, an assessment of training performance, capacity and quality was carried out by ARTH through interviews and secondary data collected from the Directorate of FW and a qualitative assessment of five training institutions.

A comprehensive listing process was followed by interviews and facility assessments in two phases. It revealed that large numbers of providers exist, at the rate of one per 750 population. There were a total of 1439 informal or ISM providers in the district, of which 738 were likely to be providing abortion services¹. However, most formal providers were concentrated in urban areas, while ISM and informal providers were largely located in rural areas.

Informal providers

A large pool of informal providers meets the huge gap between demand for abortion services and their low availability in the formal sector. Informal providers include paramedics and unqualified persons, while practitioners of Indian systems of medicine (ISM) include homeopaths and ayurvedic physicians, largely operating in villages and small towns. Interviews with 618 informal providers revealed that 355 (57%) admitted to treating delayed periods. Providers who treated delayed periods included female paramedics (40%), male paramedics (17%), male unqualified practitioners (34%), and female untrained practitioners (8%).

The most common method used for treating delayed periods was tablets (89%), followed by injections (58%). The kinds of tablets included various Ayurvedic preparations such as “EP Forte”, while the most popular injection was Carboprost tromethamine, a drug that has been licensed for treating incomplete abortion and postpartum hemorrhage. Most of these informal providers had learnt to use these drugs either on their own, by looking at prescriptions, or by working with a colleague.

Invasive or surgical methods were tried out by a minority (7%) of informal providers, commonly female paramedics and male unqualified practitioners. The commonest instrument used was the curette, and occasionally a syringe, catheter or Copper-T. Instruments were used up to 8 months of pregnancy, while the average number of women treated each month in this manner

1 The study used “treating missed periods” as a definition for providing abortion services

was 2.6. However, the cost of such procedures was high, ranging from Rs 315 to 567 per procedure.

Informal providers provided a range of services. Of 618 interviewed informal providers, 90% give injections for common ailments, 84% provide IV fluids, 61% apply stitches for injuries, 52% conduct deliveries, 61% treat incomplete abortions and 64% treat menstrual problems. The strength of informal providers appears to be their reach in interior villages, and access 7 days a week for an average of 15 hours each day.

Providers of Indian Systems of Medicine

The study also enumerated 63 providers of Indian Systems of Medicine in the two districts, most of who were male, and based in rural areas. Their degrees included BAMS (46), BHMS (6), BUMS and DHMS (11). They reported the duration of their training as being between 18 months and 7 years, leading us to suspect that some were claiming but did not possess valid degrees. Their practices and methods used to treat delayed periods were similar to those of informal providers – most of them treated delayed periods using tablets, injections and occasionally instruments. Like informal providers, the majority provided a range of services including injections and IV fluids, while less than one third conducted deliveries. Eighteen of them were in government service, while the rest worked through private clinics.

Formal facilities and providers

In the 13.9 lakhs population covered in the two districts, there were 42 government health centres, all of which were mandated to provide abortion services. However, only 22 government facilities were actually providing abortion services. These included 15 PHCs/ CHCs², and all sub-divisional and district level facilities. In the private sector in there were 40 facilities providing abortion services. Only about half of these were certified to do so. However, all private facilities were located in urban areas, while 15 of the 22 functional government facilities were located in rural areas. This suggests a severe rural-urban mismatch in the availability of abortion services. Our data revealed that rural PHCs/CHCs had extremely low caseloads of 5.9 abortion procedures per month (average), while district or sub-divisional level government hospitals had a caseload of 60.5 procedures per month and private hospitals had a caseload of 48.8 procedures per month.

The certification process for private facilities in Rajasthan is difficult, as evidenced by the fact that certified facilities reported an average of 14 months in becoming certified, with applications being returned on average 2.4 times for re-submission. Eight out of 19 non-certified facilities reported that they had applied, but had not received any response from the authorities.

Not all abortion procedures were reported. While 19 uncertified private facilities did not report any abortions, 30% certified private facilities and 23% of government facilities also did not report all MTPs. Formal providers appear to under-report MTPs because of concerns related to paying income tax, fear of the Consumer Protection Act or because several doctors were not “MTP-trained” and hence could not legally perform abortions. Lastly, some government doctors conducted MTPs at their residence or private clinics and were not in a position to report them.

2 Some government and private facilities only admitted to be treating cases of incomplete abortion, and not providing elective abortion services, but for the purpose of the study, even these facilities were assumed to be providing abortion services.

Physical facilities usually allow for services to be provided, especially in the private sector. However, electric connections were not working in 10 government facilities out of 42, and cleanliness of operation rooms was not maintained in several. In general, the availability of abortion equipment was better in private facilities as compared to government facilities. Complete sets of D&C were available in 75% public facilities, while they were available in all private facilities. Sets for EVA were available in 54% government and 93% private facilities, while sets for MVA were available in 14% public and 55% private facilities. Anesthesia equipment (Boyle's apparatus) although not necessary for providing abortion services, is a mandatory requirement for certification of private facilities. It was present in only 20% public facilities as compared to nearly 90% of private facilities. Contraceptive services are an integral part of abortion service delivery, but private facilities were deficient in supplies of oral pills or condoms, while only 15% had a contraceptive injection and 60% offered IUDs. Government facilities fared better in this respect.

Techniques for abortion and pain control appear to be over-medicalized. For first trimester abortion, dilatation and curettage and/or evacuation³ were the most commonly used methods (60%), followed by EVA which was used by one third of providers (34%). MVA was used by one sixth of all providers (9-16%). For second trimester abortions, nearly half the providers used extra amniotic instillation of Ethacridine Lactate (47%), followed by D&C or D&E (34%) and medical methods (34%). For pain control, general anesthesia continued to be used for 39% of procedures below 8 weeks and for 46% of procedures between 9 and 12 weeks.

Even at facilities where services were available, there were several restrictions in terms of gestation and cost of abortion. Less than half the facilities provided second trimester abortion. At government facilities, the average minimum and maximum cost of abortion were Rs 195 and Rs 457 for a first trimester abortion, and Rs 317 to 575 for second trimester abortion. At private facilities, the average minimum and maximum costs were Rs 540 and Rs 724 for first trimester abortion and Rs 1144 and 1681 for second trimester abortion. These costs were equivalent to 3 to 28 times the daily wages of a rural woman. The above costs did not represent the total cost of getting an abortion. In as many as 62% facilities, all or some medicines, investigations or anesthesia were charged extra, and these costs varied widely.

Although MTP Act does not require the consent of spouse or family members for providing abortion services, nearly 86% facilities insisted on the consent of a family member and/or husband for abortion, and only 10% of facilities would provide services to women who came alone. Similarly, several facilities had placed restrictions related to the marital status of women or the number of children she had — only about half the administrators agreed that they would allow abortion services for unmarried women or those out of wedlock.

Legal, policy and regulatory environment

All government facilities (of level PHC and above) are by default considered as certified to provide MTP services, as long as they have a trained provider and the necessary equipment⁴. However, very few of these had a trained provider, and hence not all government facilities were functional. Data from the State Directorate of Family Welfare revealed that 338 private facilities had been certified to provide MTP services in Rajasthan as of 2003⁵. This amounted to an average of 0.6 certified private facilities per 100,000 population for the state as a whole. However, the distribution of these facilities was highly skewed, with most facilities being

3 Use of ovum forceps

4 Unlike private facilities, a government facility does not have to specify that it fulfils these requirements

5 This data was collected from a scrutiny DFW records in 2003. However, the FW Year Book of Govt of India 1998-99 mentions 483 certified facilities

concentrated in a few districts. Jaipur district alone had 40% of private certified facilities of Rajasthan. Nine districts with 38% of state population had 83% of all certified facilities, while the remaining 22 districts had 17% of the facilities. Five districts (Jaisalmer, Jalore, Barmer, Dungarpur, Dholpur) did not have a single certified private facility, while 6 districts had only one each.

Government of Rajasthan had been largely following the standard Government of India guidelines for certification of private facilities, except that it also required an architectural blueprint of the facility. However, there being no time limit on the procedure, the time taken was very long. Even after an amendment in June 2003 decentralized approval to a district committee, district level officials have remained unaware of the details and had not liberalized the certification procedure.

MTP training

The MTP Act stipulates that only doctors with a postgraduate degree (MD/MS/ DGO) or six months residency in obstetrics-gynecology can perform abortion procedures. Other doctors would have to undergo “MTP training” in a designated training center. NIHFW has laid out criteria for approving MTP training centres (a minimum caseload of 600 procedures per year and all necessary equipment), duration of training (2 weeks), number of procedures to be done and assisted by trainee, and has defined a curriculum.

There were 8 MTP training centres in Rajasthan – at the time of the study they included 6 medical colleges (Jaipur, Ajmer, Bikaner, Kota, Udaipur and Jodhpur), and two district hospitals (Alwar & Bharatpur). The total number of doctors trained from 1971 to April 2002 was 1056, of which 786 had been trained after 1980. This worked out to an average of 35.7 doctors per year, a rather low figure, given the number of training institutions. With one training centre (Kota Medical College) having been in operation only for the last 6-7 years, this translated into 5 trainees per institution per year. This number was over and above the doctors who had been trained as MS/MD /DGO in Obstetrics and Gynecology, or had done a 6-month house job. Among the training institutions, there were wide variations with Jaipur having the highest number of trainees.

The procedure for receiving MTP training appeared to be complex, especially for private doctors and was mirrored by the skewed proportion of government and private doctors trained till the date of study. Among doctors who had received training over the last 22 years, 86% were in government service. A private doctor is eligible to receive MTP training only if s/he is currently working in an MTP certified institution. However, an institution can be certified for MTP only if there already is an MTP-trained doctor in position. Hence a private doctor cannot be trained if her/his institution is not certified and the institution cannot be certified in the absence of a trained doctor, leading to a Catch-22 situation. Further, a doctors' application for MTP training needs to follow the channel of Chief Medical and Health Officer, and Additional/ Zonal director before it is recommended that the doctor is placed as a trainee in an MTP training institution of that zone.

Interviews with faculty of MTP training institutes suggested that no defined training curriculum was used, that trainees were posted in operation theatres every day so that they could learn of the (surgical aspect of) the procedure. Thus there were few opportunities for trainees to acquaint themselves to issues such as the public health relevance of abortion services, pre and post abortion counselling for allowing women a measure of reproductive choice, and the clarification of providers' values regarding abortion.

In most training institutes, MTP was a highly medicalised procedure, carried out in operation theatres under general anesthesia and often requiring admission a day earlier. The methods in vogue were electric suction followed by check curettage, or more recently and hesitantly, medical abortion using mifepristone. Either oral or vaginal misoprostol or injectable carboprost was being used for cervical priming. Second trimester abortions were usually carried out using Ethacridine Lactate, or (since the last two years) medical abortion. It appeared that there were several apprehensions on part of some senior faculty that increasing use of medical abortions would make it difficult to regulate. The greater use of MVA had just then been initiated as part of a FOGSI implemented 7-state project that included Rajasthan – two training centers had covered by this initiative.

Women coming to training institutions were “strongly motivated” to adopt sterilization or IUD. Even in MTP training institutions, the established protocol was to take consent of husband or another family member – women coming alone by and large could not access the service.

Conclusions

In conclusion, the study revealed that a large number of informal providers rendered basic health care and that over half of these treated delayed periods or performed abortions outside the scope of the law. Meanwhile, formal providers and facilities faced administrative and procedural difficulties in getting approval to provide legal MTP services. Those who did provide legal abortion services tended to over-medicalise them – this increased cost and reduced access for poorer women. Training institutions followed hospital-based complex medical protocols that were difficult to replicate in low resource primary health settings. Moreover, they had low performance levels in terms of numbers of doctors trained. Enhancing access to safe abortion in Rajasthan would therefore require measures that allowed more legal facilities to be approved in a smoother way, use of modern, simpler and safer technology and the widespread dissemination of information on provisions of the Act and technologies.

ANNEXURE

Statement Showing District-wise Progress of M.T.P. Cases

S.No.	District	1997-98	1998-99	1999-2000	2000-01	2001-02	2002-03 upto Nov.02
1	Ajmer	3682	3761	4725	4733	4152	1821
2	Nagaur	250	413	422	517	349	244
3	Tonk	1175	1285	1514	1794	2042	1124
4	Bhilwara	1433	1291	1408	1297	1587	1147
5	Jaipur	6743	6913	6319	8293	8149	3730
6	Dausa	233	673	141	378	425	149
7	Sikar	359	438	408	428	461	332
8	Jhunjhunu	1333	1056	899	562	793	499
9	Alwar	1291	1220	1572	1085	722	833
10	Bharatpur	2811	2876	2631	2435	3114	1785
11	Dholpur	590	692	669	557	492	225
12	Churu	731	704	730	763	841	733
13	Bikaner	855	783	1051	1272	1209	454
14	Ganganagar	1786	1925	1568	1912	2540	1764
15	Hanumangarh	123	145	114	253	362	265
16	Jalore	251	233	372	445	263	128
17	Barmer	1119	943	1093	823	851	426
18	Jaisalmer	228	232	335	258	191	99
19	Pali	1004	1427	1404	1283	1162	583
20	Sirohi	150	183	283	213	230	234
21	Jodhpur	4787	4862	4971	4603	4997	2040
22	Bundi	487	384	442	662	747	473
23	Jhalawar	2045	2142	2428	3348	2014	822
24	Kota	1170	751	2203	1664	2176	656
25	Baran	150	211	323	420	440	162
26	Sawai Madhopur	1468	1301	627	708	567	262
27	Karauli	-	-	732	662	725	474
28	Chittorgarh	1804	2113	2090	2611	2562	1614
29	Udaipur	3555	4894	5654	6656	7104	2995
30	Rajsamand	801	712	796	902	827	427
31	Dungarpur	711	801	864	474	579	564
32	Banswara	1140	1467	1256	1272	1089	636
	Total	44265	46831	50044	53283	53762	27700