POLICY AND PROGRAMMATIC COMMITMENT TO PROMOTING ACCESS TO SAFE ABORTION SERVICES IN SELECTED STATES OF INDIA

TK Sundari Ravindran and Bhuvaneswari Sunil

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Abbreviations

ANMs	Auxiliary Nurse Midwives
AWW	Anganwadi Workers
BCC	Behavioural Change Communication
BEmONC	Basic Emergency Obstetric and Neonatal Care
BPHC	Block Primary Health Centre
CBOs	Community Based Organisations
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CHC	Community Health Centre
CRMs	Common Review Mission
DH	District Hospitals
DLHS	District Level Household & Facility Survey
EmOC	Emergency Obstetric Care
FRUs	First Referral Units
IEC	Information, Education and Communication
MA	Medical Abortion
MMR	Maternal Mortality Ratio
MO	Medical Officer
MPWs	Multi Purpose Workers
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
NPCC	National Programme Coordination Committee
NRHM	National Rural Health Mission
PHC	Primary Health Centre
PIP	Project Implementation Plan
PPP	Public Private Partnerships
PRI	Panchayati Raj Institutions
QOC	Quality Of Care
RCH	Reproductive and Child Health (Programme)
ROP	Record of Proceedings
SDH	Sub-District Hospital
SPMU	State Programme Management Unit

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1. Introduction

Access to safe abortion services continue to elude the women of India, especially low-income women from rural and difficult to reach areas. One in five births (21%) that occurred five years prior to the third National Family Health Survey (2005-06) were unplanned - 10% were mistimed while 11% were not wanted at all [1]. Another indicator of the lack of access to safe abortion services is the fact that about 12,000 women in India die each year from complications related to unsafe abortions, accounting for about 9% of all maternal deaths [2]. It is indeed puzzling why this should be so more than three decades after the Medical Termination of Pregnancy (MTP) Act came into existence in 1971, and commitment to promoting safe abortion services has been espoused in many government policies especially since the launch of the Reproductive and Child Health (RCH) programme launched in 1998-99.

Under RCH-1 large investments were made in training doctors in MTP and Manual Vacuum Aspiration (MVA) procedures, providing equipment for performing MTPs, and producing guidelines for medical officers at the PHC level and above on MVA techniques and on medical abortion. In addition, states were also empowered to contract MTP –trained doctors to provide services at the PHC, CHC and sub-district hospital levels. This was intended to increase the availability of skilled MTP providers. The National Population Policy of 2000 noted that expanding safe abortion services was an important strategy for reducing maternal mortality ratios and recommended the expansion of MTP services to the PHC level [3]. This was followed in 2003 by the amendment of the MTP Act of 1971 aimed at simplifying the registration procedures for private facilities providing MTPs. The amendments also specified that certified MTP providers in unregistered facilities could provide medical abortion services, as long as they had access to a registered facility if back-up was needed [4].

The RCH-2 documents lay down the government's commitment to promoting safe MTP services extensively and clearly. Early and safe MTP services for the management of unwanted pregnancy are mentioned as an important component of RCH-2. The four objectives for promoting safe MTP mentioned in the RCH-2 Project Implementation Plan are to:

- Expand the network of facilities providing quality MTP services in the government and private sectors.
- Train more health professionals to conduct safe MTP.
- Provide MTP counselling at the community level.
- Increase awareness regarding safe MTP in the community [5].

A two-pronged strategy is outlined to achieve these objectives. At the community level Auxiliary Nurse Midwives (ANMs) and Anganwadi workers (AWW) were to provide counselling and information on the availability of safe MTP services and also promote post-abortion care. At the facility level, all FRUs were to provide comprehensive and high quality first and second trimester

abortions, and all CHCs and at least 50% of PHCs were to provide first trimester abortions using MVA techniques. In addition, private for-profit and not-for-profit providers were to be encouraged to establish high quality MTP services. Moreover, the use of medical abortion was to be promoted both in public and in private health facilities [5].

Despite these clearly stated policy objectives and programme goals, evidence from the various Common Review Mission (CRM) monitoring reports indicate that very little monitoring was actually done on whether these were achieved. For example the third CRM report mentions that there was poor progress on the safe abortion objective. State-level CRMs had reported on progress in MTP training for providers but there was no information on service provision [6]. The report of the fourth CRM also states that information on availability of MTP services had not been gathered from many districts, and that in general, MTP services were available in facilities with Comprehensive EmOC facilities and rarely in other facilities [7].

It is against this backdrop of limited information and a general impression that progress had been poor in promoting access to safe MTPs that this paper seeks to examine information from state-level PIPs. The objective is to understand the extent to which these have included MTP service promotion in their objectives and activities, the finances allocated for achieving this objective and the extent to which availability of MTP services has been expanded.

Section one contains, besides this introduction, sub-sections on methodology and study area. Section two presents and examines information from PIPs of six states: Assam, Gujarat, Haryana, Himachal Pradesh, Orissa and Punjab. Section three summarises the findings and highlights the inferences one may draw from available information.

1.1. Methodology

Choice of the six states for inclusion in this paper was purposive, based on the observation that there was very limited information on MTP services for these states. Two sources of information have been used for all six states. These are the State's Programme Implementation Reports (PIPs) and Record of Proceedings (ROPs).

State PIPs are generally prepared by the State Planning Team, which includes the officials from State Programme Management Unit (SPMU). They receive inputs from the District Health Action Plans which in turn incorporate village and block health plans.

Every state also prepares an annual plan detailing the objectives, strategies and expected outcomes, targets, indicators etc. for each of the health programmes under RCH along with a planned budget. These are presented for approval by the National Programme Coordination Committee (NPCC), and the document which contains the original plan as well as comments, suggestions and sanctioned/approved budget details is the Report of Proceedings (ROPs).

PIPs are the major sources of information used in this paper on objectives, activities and achievements related to MTPs while ROPs are the source for budgetary details. In addition, data from

Family Welfare Year Books of the Government of India was also used for information on approved MTP facilities and numbers of MTPs reported.

We looked for PIP and ROP documents for the period 2007-2011, but were able to obtain documents for only some of the years, and the years for which data were unavailable differed from state to state. We have also used any additional data source such as NRHM reviews that contained information on MTP activities and achievements.

Overall, only fragmentary information was available on medical terminations of pregnancy. In several instances PIPs for different years provided different figures for targets and achievements and in such cases we have considered data for the latest year available. We have made the most of what was available to arrive at an overview of investments in MTP services in the selected states.

1.2. A brief profile of the selected states

Gujarat with a population of 603.8 lakhs, holding 5% of India's population in 2011 is the most populous of the six states while Himachal Pradesh, with 68.6 lakh people has a population of a little over a tenth of Gujarat`s population. Literacy rates in the states lie in the 70-80% range except for Himachal Pradesh whose literacy rate is 83.8% (2011). Haryana, Punjab and Gujarat have low female child sex ratio of less than 900 per 1000. Assam fares worst in terms of maternal mortality ratio and Gujarat the best. Orissa has the highest under-five mortality rate of all states and Punjab has the lowest, although none of the states have achieved the MDG target of under-five mortality of less than 42 per 1000 (Table 1).

Table 1. Population and health indicators for the selected states

Indicators	Assam	Gujarat	Haryana	Himachal Pradesh	Orissa	Punjab	Sources
Population (lakhs) 2011							
• **Total**	311.7	603.8	253.5	68.6	419.5	277.0	Census
• **Male**	159.5	314.2	135.1	34.7	212.0	146.3	2011 [8]
• **Female**	152.1	289.0	118.4	33.8	207.5	130.7	
• **% share in India's population**	2.6	5.0	2.1	0.6	3.5	2.3	

Literacy rate (%) 2011							
• **Total**	73.2	79.3	76.6	83.8	73.5	76.7	Census
• **Male**	78.7	87.2	85.4	90.8	82.4	81.5	2011 [8]
• **Female**	67.3	70.7	66.8	76.6	64.4	71.3	
Child sex ratio (female /1000 male in 0-6 age group) 2011	957.11	885.67	829.99	906.41	934.4	846.26	Census 2011 [8]
MMR (per 100,000 live births) 2007-09	390	148	153	196	258	172	SRS 2010 [9]
Under five mortality rate (per 1000 live births) 2005-06	85.0	60.9	52.3	41.5	90.6	52.0	NFHS-3 [1]

Table 2 presents data on medical terminations of pregnancy carried out in approved health facilities in the six states for 2004-08. The data source is the Family Welfare Year Book for 2009. The state reporting the largest numbers of MTPs since 2005-06 is Assam, which has the least number of approved MTP centres, only 46. This means that each MTP facility would be carrying out an average of more than 100 MTPs per month. In contrast, Gujarat, where only half as many MTPs as Assam are performed each year, has 30 times as many approved MTP centres. It is not clear how reliable these figures are. Data from state PIPs may present a more accurate picture.

Table 2. Medical Terminations of Pregnancy performed in approved facilities 2004-2008

Years	Assam	Gujarat	Haryana	Himachal Pradesh	Orissa	Punjab
2004-05	21,986	29,669	37,253	5127	38,795	14,788
2005-06	64,968	28,115	39,814	4575	42,671	16,808
2006-07	58,133	29,500	32,049	3176	42,083	15,810
2007-08	58,409	27,837	31,126	2936	59,945	14,834
No. of approved MTP facilities as of 31 March 2008	46	1393	228	87	401	330

Source: Family Welfare Year Book 2009 [10]

2. Medical Termination of Pregnancy in Project Implementation Plans

2.1. Objectives and strategies related to MTPs

Of the six states, MTP is mentioned as an objective in the PIPs for four states: Assam, Haryana, Himachal Pradesh and Punjab, and as a strategy for reducing maternal mortality in two states, Gujarat and Orissa (Table 3). In Himachal Pradesh, providing early and safe abortion services is mentioned as part of a section on management of PHCs while in Punjab, 'early and safe abortion services' is mentioned as a part of operationalising EmOC facilities.

Increasing the availability of MTP services in government facilities is one of the key strategies through which safe abortion service access is to be increased in Assam, Gujarat and Haryana. In Assam and Gujarat, a complementary strategy is to increase availability of MTP in the private sector. While Assam and Haryana set themselves the ambitious task of making MTP services available at all levels from the district hospital down to PHCs, Gujarat is more modest and plans to ensure that one MTP service centre, public or private, is available in each block. In Punjab, posting a lady medical officer trained in MTP in each 24x7 PHC facility is a strategy to make PHCs 'operational'.

Table 3. Mention of MTP in objectives and/or strategies of PIPs, selected states, 2007-11

States	As an objective	Strategies
Assam	Improve safe abortion facilities and reduce unsafe abortions	**Strategy 1:** Increase access to safe abortion in government facilities **Strategy 2:** Increase access to safe abortion in private facilities
Gujarat	(as a strategy to reduce MMR)	**Strategy 1:** Improve access to safe abortion services by ensuring at least one service centre (public or private) in each block, as per MTP Act 1971. **Strategy 2:** Increase awareness in the community regarding availability of MTP and of the consequences of sex selective abortions and of PNDT
Haryana	Widen choice of MTP services	**Strategy:** Make available MTP services in all district hospitals, sub-district hospitals, CHCs and PHCs
Himachal Pradesh	In the section on management of PHCs, one of the objectives is to provide early and safe abortion services (2009-2010).	Not mentioned

Orissa	(as a strategy to reduce MMR)	Not mentioned
Punjab	One objective under maternal health component is to increase access of safe abortion services (2008-2009). Early and safe abortion services (including MVA) are also a strategy under the objective of strengthening EmOC facilities and institutional deliveries (2008-2010).	

Sources: Assam [11, 12, 13, 14]; Gujarat [15, 16, 17]; Haryana [18, 19, 20]; Himachal Pradesh [21, 22, 23]; Orissa [24, 25, 26, 27, 28, 29, 30, 31]; Punjab [32, 33, 34].

A detailed description of activities to be undertaken is found in the PIPs of a few states (Table 4).

Table 4. MTP activities to be undertaken in the selected states according to PIPs

States	Activities
Assam	**Activities under strategy 1 (government facilities) (2007-11)** • All 149 BPHCs, 93 CHCs, 3 SDH & 20 DHs will be provided with requisite Kits to provide safe MTP. • Annually between 200 and 250 Doctors to be trained in phased manner for MTP /MVA. • 5 MVA kits for each health facility mentioned above will be provided and additional Kits provided for use by newly trained MOs. **Activities under strategy 2 (private facilities) (2007-11)** • In all the districts Private Sector and Trust Hospitals are planned for PPP after signing of MOU to provide safe abortion apart from other RCH services. The private hospital under PPP will be provided with requisite logistics and funds.
Gujarat	**Activities under strategy 1 (facility-based) (2007-11)** • E-listing of MTP trained practitioners. • Train MOs /interested and qualified private practitioners for MTP. • Provide regular safe abortion services in all CHCs/block facilities. • Develop public private partnership. • Implement quality improvement program with the support of district quality assurance team by designating ADHO as a district quality assurance officer. • Medical colleges to provide MTP Training and appropriate certification to public and private practitioners.

	• The district committee will monitor the MTP services in all the recognized facilities, BCC activities; QOC and Referral services • Expanding simpler techniques like manual vacuum aspiration for providing MTP services. • 140 trained MOs in MVA/MTP services are to be panned accordingly as per the accessibility need over the state. **Activities under strategy 2 (community-based) 2007-11** • IEC on availability of safe abortion services. • Community mobilisation through CBOs, CBHVs, AWWs, Dais, PRIs, community and religious leaders, NGOs, against sex selective abortions, PNDT. • Incorporation of Dais, ASHAs and peer educator of Mamta Taruni for the mobilization of the beneficiaries for abortion to the facility and inform them on the identified and strengthened MTP institutions. • An incentive package of Rs 300 has been designed for Integrated Quality Medical Termination of Pregnancy including ECP and follow up in which the incentive of Rs. 200 will be given to Dais, ASHAs and peer educators of Mamta Taruni scheme.
Haryana	• MTP training of MOs. • IEC on dangers of abortion. • Incentives to MOs to entertain all patients of MTP. • In the absence of MTP facility or lack of trained doctors in a government health facility provision of free referral transport facility to the women to an MTP service facility.
Himachal Pradesh	The 2009-2010 PIP states performing MTPs as a strategy towards reduction of maternal mortality ratios. The 2010-2011 PIP compliance report, as against the suggestions of PIP advisory committee to address safe abortion, presented the following as planned activities: • Create awareness campaigns for safe MTPs through IEC • Enhance access to confidential counselling by MPWs and link workers • Promote post-abortion care • Encourage private sector and NGOs to provide quality MTP services Across all the years the state planned to train medical officers in MTP and MVA for two weeks.
Orissa	• Improve the quality of MTP services and its availability in health institutions. • Capacity building of MOs in MVA and suction equipment in the year 2008 -2009. • Review and assessment of accredited private institutions for MTP services.

	• Operationalise basic MTP services through district based facility assessments jointly with development partners. • Procure equipments after the MOs are trained in Basic MTP and BeMONC. • Training of MOs from the operational 24x7 BeMONC facilities in three government medical colleges, 3 private medical colleges and 8 identified District Hospitals. • ASHA will facilitate the process of safe abortion through proper information and access to safe services at institutions. • ASHA would be paid an incentive of Rs 200/-.
Punjab	• Appoint female medical officers at the operationalised PHCs and obstetrician/ gynecologist at the operationalised CHCs.

Sources: Assam [11, 12, 13, 14]; Gujarat [15, 16, 17]; Haryana [18, 19, 20]; Himachal Pradesh [21, 22, 23]; Orissa [24, 25, 26, 27, 28, 29, 30, 31]; Punjab [32, 33, 34].

The main activities for promoting access to safe abortion services proposed under the different PIPs include:

- Provision of MTP and MVA equipment to all government facilities
- Training of government medical officers in MTP and MVA techniques
- Appointing lady medical officers and obstetricians/gynaecologists in FRUs
- Enhancing community awareness on availability of safe abortion and the dangers of unsafe abortion
- Providing free referral transport to women seeking MTP in a government facility where such services are unavailable for some reason
- Providing incentives to MOs to provide safe abortion services
- Providing incentives to ASHAs and other community workers to guide users to safe abortion services in government facilities
- Promoting the private sector's role in MTP provision through training private providers in MTP and MVA techniques ; and/or entering into contracts with private providers

In addition to these, Gujarat's PIPs have outlined a few innovative activities such as E-listing of all MTP providers and implementing quality assurance measures for MTP.

If one goes by the reporting on achievements, the emphasis of the entire strategy is mainly on increasing availability of abortion services in currently existing government service delivery points at the CHC/Block level or above. The main route to this is providing the necessary drugs and equipments and by training providers. A review of budgetary allocation (see Section 2.5) reveals the same.

More than a decade ago in 2000, the Abortion Assessment Project India (AAPI) recommended making available at least first trimester abortion in PHCs, and training auxiliary nurse midwives to provide first trimester abortions including medical abortions [75]. Even 'operationalising' CHCs to provide safe abortion services and training medical personnel does not seem to have happened in an entire decade since 2000, and medical abortion, which can expand access to abortion services for those seeking first trimester abortions, is nowhere on the agenda.

Lack of information about where abortion services are available was found to be a major bottleneck to access according to AAPI [75]. The PIPs of Gujarat, Himachal Pradesh and Orissa talk of activities to increase community awareness on where safe abortions may be obtained. Unfortunately, the budget does not seem to mention community-based activities as a separate head raising questions about whether these activities were intended to be implemented at all.

Partnerships with the private sector, identified by Assam and Gujarat as complementary strategies for increasing availability do not have the scope for benefiting women who face the most serious lack of access because of being located in rural, remote and difficult areas. Private sector health facilities are typically located in areas where there is a 'market' for health services, with paying clients.

Table 5 provides data on the number of government health facilities that provided MTP services for the most recent year available and tries to compare this against the total number of health facilities at each level(T).

Table 5. Number of facilities providing MTP services at different levels of care

	Assam		Gujarat		Haryana		Himachal Pradesh		Orissa		Punjab	
	T	MTP	T	MTP	T	MTP	T	MTP	T	MTP	T	MTP
Medical college hospitals	1	1	13		1$	n.a	2	n.a	3	n.a	n.a	n.a
District hospitals	21	21	24		21	20	12	12	32	32	20	20
Sub-divisional hospitals (SDH)	13	13	26	71@	25	30	n.a	27	25	22	36	43
CHCs	108	108	273		91	n.a	73	35	231	231	126	50
FRUs (includes	39	39	148		n.a.	n.a	n.a	n.a	96	n.a	n.a	n.a.
CHCs and SDH) Block PHCs	149	149	84	41#	n.a.	n.a	n.a	n.a	117	117	n.a	n.a
24x7 PHCs	343	402	n.a		n.a	n.a	n.a	n.a	n.a	n.a	n.a	n.a
All PHCs (including block and 24x7)	844	n.a	1090		427	160	449	13	1282	117	396	62
Total govt health facilities	987	694 (70%)	1426	112 (7.9%)	565	205 (36.3%)	536	87 (16.2%)	1690	402 (23.8%)	578	175 (30.7%)

Approved private facilities	Not appli-cable	n.a		1529	n.a	n.a	n.a	n.a	n.a	n.a	n.a	n.a

T = Total facilities, MTP = Facilities reported to provide MTP, @ All hospitals providing comprehensive safe abortion services, # All facilities providing first trimester abortions, $ 1 government+2 private.

Sources: Assam total [35]; Assam MTP: 2011-2012 PIP [36]; Gujarat: 2011-12 [37]; PIP Haryana: 2009-2010 [38]; PIP Himachal Pradesh: 2009-2010 [23]; Orissa:2008-2010 [25, 29] Punjab: 2009- 2010 PIP [39].

Availability of safe abortion services in the government sector is very limited. In general, comprehensive safe abortion services including termination of second trimester pregnancy is provided only at the CHC level and above, while a few Block PHCs are also reported to be providing MTP services, likely to be first trimester terminations. Less than a third, and in some cases, less than a tenth of all government health facilities provide any MTP services, although medical abortions and MVA abortions can be provided on an out-patient basis, and therefore all PHCs can provide these services.

From the PIP for 2011-12, it would seem that Assam is an exception, with 70% of government facilities providing MTPs. In particular, 402 PHCs functioning 24x7 are stated to be providing at least first trimester abortions. However, there are many different sets of figures given, creating a rather confused picture. For example the PIP for Assam for 2011-12 also states that MTP services are provided in 22 district hospitals, 108 CHCs and 149 Block PHCs [36].

Only Gujarat's PIP provided data on numbers of MTP facilities in the private sector, and we find that less than 7% of all MTP facilities are in the government health sector.

2.2. Utilisation of MTP services during 2007-11

Data of numbers of MTPs performed was available from the PIPs only for one state, Haryana, for three successive years between 2008 and 2011 [20]. The number of MTPs performed in 2008-09 was about 32000, with 59% of these performed in government health facilities. During the next two years, total number of MTPs reported declined sharply to just about 17000, a 46% decline (Table 6). We also find that the share of MTPs performed in government health facilities declined to 43% and 41% respectively, and that there is a much greater drop in MTPs reported from government facilities (62%) than those reported from private facilities (24%).

In other words

- fewer MTPs are being reported each successive year.
- the share of MTPs reported from (performed in?) government as compared to private facilities is decreasing consistently.
- the share of MTPs reported from government facilities are declining faster each successive year.

The above trend has serious implications for access to safe abortion services for women from low-income groups who appear to be pushed to seeking safe abortion services from the private sector.

According to the PIP for 2011-12, only 3.4% and 2% of the MTPs reported from government health facilities for 2008-09 and 2009-10 were second trimester terminations. This reaffirms the argument in favour of making abortion services available in PHCs. Comparable information was not available for MTPs performed in private health facilities.

Information from the 2009-2010 PIP indicates that MTP outreach services are inadequate in urban slums and rural areas. According to this document, 10-12 percent of 6 lakh pregnancies each year in Haryana are unwanted; nearly one third of the women with an unwanted pregnancy seek trimester abortion services from unqualified providers, contributing to maternal morbidity and mortality.

Table 6. Number of MTPs performed in government and private health facilities, Haryana, 2008-2010

Years	MTPs reported from government facilities	% change from previous year	MTPs reported from private approved facilities	% decline from previous year	Total reported MTPs	% decline from previous year
2008-09	18826 (58.7%)	n.a	13232 (41.3%)	n.a.	32058 (100%)	n.a
2009-10	11546 (43.3%)	(-) 38.7%	15028 (56.5%)	(+) 13.6%	26574 (100%)	(-) 17.1%
2010-11 (upto Nov 2010)	7187 (41.6%)	(-) 37.8%	10108 (58.4%)	(-) 32.7%	17295 (100%)	(-) 34.9%

Source: 2011-12 PIP [20].

2.3. Training of medical officers for MTP/MVA

Five of six states (with the exception of Himachal Pradesh) have prioritised and budgeted for training government medical officers in performing MTPs. Assam's PIP for 2007-08 included among its MTP training target of 261, 45 private physicians in keeping with its strategy to expand MTP availability both in the public and in the private sectors.

Unfortunately, while targets are mentioned in the PIPs for each year, corresponding achievements are often not clearly mentioned (Table 7). The PIP for 2011-12 in many instances provides information on cumulative numbers of medical officers trained, and we have used this figure to get an overall picture. No medical officers seem to have been trained for MTP in Himachal Pradesh, and just about a 100 have been trained in Orissa over the entire five year period 2005-10. In Assam,

Haryana and Punjab around 200 medical officers are reported to have been trained while for Gujarat, there are two different figures given in the same PIP report: 300 and 1369. Overall, achievements in terms of capacity building of medical officers appears to be very modest, especially when considering that these states intend to make MTP services available in all government health facilities from the PHC level upwards.

Table 7. Targets and achievements in training of medical officers for MTP/MVA

Years	Assam		Gujarat			Haryana		Himachal Pradesh		Orissa		Punjab	
	T	A	T		A	T	A	T	A	T	A	T	A
			MVA - MA	OTH		MVA	MVA	n.a	n.a			MVA	MVA
2007-08	261	24	50	100	n.a	24	n.a	n.a	n.a	60	0	60	11
2008-09	52	167@	12	100	n.a	30	n.a	n.a	n.a	60	32	60	10
2009-10	205	15#	6	50	n.a	51	n.a	n.a	n.a	46	2	60	21
2010-11 (Till Dec. 2010)	205	50$	n.a	100	69	138	41	n.a	n.a	120	8	60	36
2005 April-2010 Nov/Dec	n.a	276	Two figures given: 300 and 1369		n.a	n.a	202	n.a	n.a	999	102	300	184

T = Target, A = Achievement, MVA = Manual vacuum aspiration, MA = Medical abortion, OTH = Other technique, @ Until June 2009, # Until December 2009, $ Until December 2010.

Sources: Years 2007-2008, 2008-2009 and 2009-2010: [11-13; 15-16; 18-19, 21-23, 24-33, 38-39]; Years 2010-11, 2005-2010: [14, 17, 20, 34, 36-37, 40-43]

2.4. Budgetary allocations for MTP related activities

The total budgetary allocation for all RCH-2 base flexi pool was available from the PIPs for the six states (Annex 1.1 to 1.6). From this, we were able to calculate the share of MTP-related activities for five states excluding Himachal Pradesh (Table 8). These figures are rough estimates, since for some years the RCH-2 total budgetary estimates are only proposed and not approved allocations. Also, these are based on allocations and not on actual expenditure details (which are unavailable, but could have given a more accurate picture of the states' actual investment on MTP-related activities).

Allocation for MTP-related activities constitutes a very small fraction of the total budgetary allocation for RCH-2. The proportion is less than 1% for the most part, except in some years for some

states. Allocation for MTP training as a proportion of all RCH-2 training lies between 0.5 and 3.0% for the most part. Proportional allocation for MTP equipment and drugs is the highest for Orissa, while for other states it lies between 0 and 1%. This may be because MTP equipment and drugs are not budgeted for separately but are a part of overall budget for procurement for maternal health.

Table 8. Share of MTP-related activities in budgetary allocation for Reproductive and Child Health programme-2, 2007-2011

	Assam	Gujarat	Haryana	Orissa	Punjab
Total MTP to Total RCH-2	(%)	(%)	(%)	(%)	(%)
2007-08	0.15	0.78	0.28	n.a	1.10
2008-09	0.13	0.36	0.11	0.74	0.91
2009-10	0.27	0.13	2.51	0.66	1.26
2010-11	0.41	1.78	0.0	0.60	0.66
MTP Training to RCH-2 Training					
2007-08	7.33	0.97	0.62	n.a	2.19
2008-09	1.54	2.40	1.05	4.68	1.98
2009-10	1.61	0.73	1.12	0.85	3.20
2010-11	1.99	0.66	0.0	0.83	0.71
MTP procurement of equipments and drugs to RCH-2 Procurement					
2007-08	0	1.08	0.0	n.a	0.78
2008-09	0	0	1.04	22.6	0.85
2009-10	0.22	0	0.0	13.88	0.71
2010-11	0.36	0.0	0.0	3.67	0.0

Sources: Assam [11,12, 13, 14]; Gujarat [15, 16, 17]; Haryana [18,19,20]; Himachal Pradesh [21, 22, 23, 40]; Orissa [45,46,47]; Punjab [32, 48-50]

Allocation for MTP-related activities varies widely across the six states (Table 9). Himachal Pradesh has allocated the lowest overall for the period 2007-2011, of only 6.25 lakhs while Assam has allocated more than 7700 lakhs. Gujarat's allocation is 403.33 lakhs, Orissa and Punjab in the range of 200 lakhs and Haryana, around 1.25 lakhs. These are allocated amounts and it is not clear what proportion of this was actually spent during the period under consideration.

Table 9. Budgetary allocation for MTP related activities 2007-2011 (Rupees Lakhs)

	Assam		Gujarat		Haryana		Himachal Pradesh	Orissa		Punjab
Training of MOs in MTP (MVA + other methods)	Govt.	Pvt.	MVA MA	Other meth-ods	MVA	Other meth-ods	MVA	MVA	Other meth-ods	MVA
2007-08	14.07	2.93	5.0	7.15	1.56	n.a	0.39	n.a	n.a	3.91
2008-09	17.06	3.55	12.0	18.7	2.16	2.517	1.56	20.61	9.05	3.91
2009-10	26.05	0	6.0	3.58	6.80	n.a	0	5.36	4.12	4.67
2010-11	45.47	0	7.15	0.0	n.a	n.a	0	6.52	6.52	5.83
Total	109.13		59.58		13.04		1.95	52.18		18.32
Equipments, instruments & drugs										
2007-08	0.03		6.4		0.9		0.6	n.a		0
2008-09	n.a		0.5		0		2.5	42.78		0
2009-10	4.32		0		9.15		0	45.18		0
2010-11	35.2		0		0		0	59.78		0
Total	39.55		6.9		10.05		3.1	147.74		0
Operational-isation of MTP centres/										
2007-08	0		2.5		2.88		1.2	n.a		0
2008-09	0		2.1		0		0	0		0
2009-10	0		0.0		0		0	0		0
2010-11	0		13.0		0		0	0		0
Total	0		17.6		2.88		1.2	0		0
Incentives to providers/							ASHAs			FMOs and gynae-cologists
2007-08	0		0		0		0	n.a		30
2008-09	0		0		0		0	0		38.4
2009-10	0		0		100.8		0	0		56.64

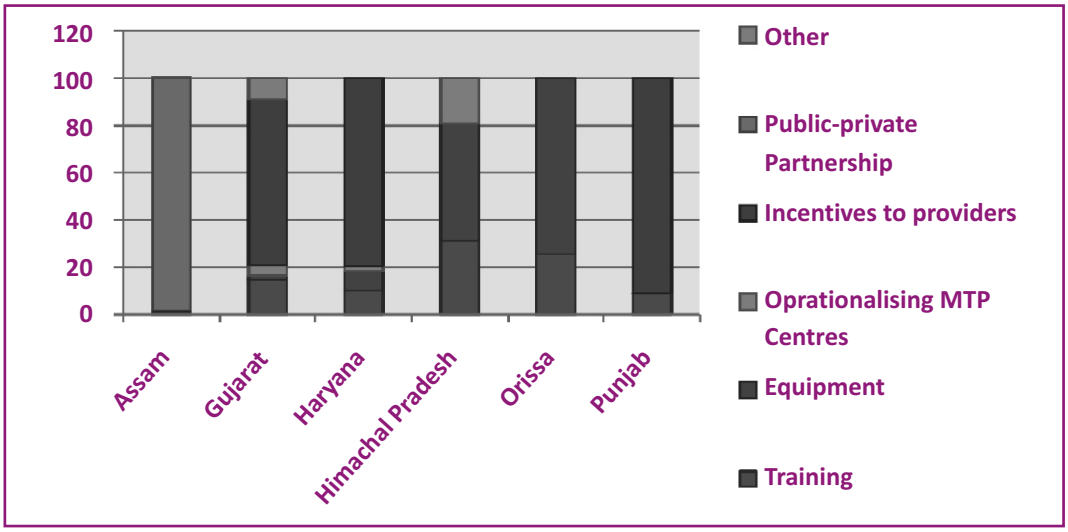
	Assam	Gujarat	Haryana	Himachal Pradesh	Orissa	Punjab
2010-11	0	283.25	0	0	0	56.64
Total	0	283.25	100.8	0	0	181.68
Public-private partnerships 2007-08	0	0	0	**0**	n.a	**0**
2008-09	2250	0	0	0	0	0
2009-10	2250	0	0	0	0	0
2010-11	3120	0	0	0	0	0
Total	7620	0	0	0	0	0
Other MTP related 2007-08	Monitoring 3 training centres 0	Upgradation of training institutions 32.0	0	0	n.a	0
2008-09	0.75	1.6	0	0	0	0
2009-10	0	2.4	0	0	0	0
2010-11	0	0.0	0	0	0	0
Total	0.75	36.0	0	0	0	
GRAND TOTAL	**7769.43**	**403.33**	**126.77**	**6.25**	**199.92**	**200**

Sources: Respective RCH budget component Assam [11,12, 13, 14]; Gujarat [15, 16, 17]; Haryana [18,19,20]; Himachal Pradesh [21, 22, 23, 40]; Orissa [45,46,47]; Punjab [32, 48-50]

Assam's budgetary allocation is hugely inflated by the amount set aside for public-private partnerships, which is Rs. 7620 lakhs for 2007-11, or 98.09% of the total amount allocated for MTP-related activities. Incentives to ASHAs and others account for 70% of the budgetary allocation in Gujarat, incentives to ASHAs account for 79.5% of the MTP-related budget for Haryana and incentives to Female Medical Officers and gynaecologists account for 90.8% of the allocation for Punjab.

For what activities have budgetary allocations been made, and how does this compare with the intended activities? In all six states, allocations have been made for training of medical officers in MVA techniques and other MTP techniques and for procurement of MVA and other equipment and MTP drugs. The proportional allocations under these budgetary heads are relatively modest as compared to the share of public-private partnerships and incentives. Gujarat, Haryana and Himachal Pradesh have allocated money for 'operationalising' MTP centres while the other states have not (figure 1). No allocations have been made for community-based activities including IEC activities.

Figure 1. Budgetary allocation for MTP related activities 2007-11



3. Main findings and recommendations

3.1. Summary of main findings

This paper attempted to get some insights into policy and programme support for the promotion of safe abortion services by the Ministry of Health and Family Welfare of the Governments of six states: Assam, Gujarat, Haryana, Himachal Pradesh, Orissa and Punjab. For this, we used information available in the government's Programme Implementation Plans (PIPs) for 2007-2012.

Information related to safe abortion and MTP services in the state PIPs is scarce, and there are no monitoring indicators for assessing progress in improving access to MTP services. MTP does not feature among objectives of Reproductive and Child Health Programme in the PIPs of some states while in PIPs for the remaining states the main MTP objectives relate to expanding availability of services. Activities corresponding to these objectives are reduced to two: training of medical officers and increasing supply of drugs and equipment. Although some activities related to informing and mobilising the community are mentioned, these remain mere intentions because no allocation whatsoever for these activities has been made in the budgets for 2007-11.

MTP services are reportedly available in all medical college, district and sub-divisional hospitals, although we do not have the data to corroborate that availability has translated into access. What is of greater concern is that a large proportion of CHCs and PHCs do not provide even first trimester abortion using medical abortion or MVA techniques.

Data available for Haryana reveals a disturbing trend of decline in the absolute number of MTPs reported and in the increasing dominance of the private sector in MTP provision. It needs to be explored whether this is also the case for the other states.

Ambitious targets have been set for training medical officers in MVA and other MTP techniques. However, over the four years 2007-11, no more than 300 medical officers have been trained in five of the six states. The reasons for poor performance have not been discussed even while fresh targets are set for the subsequent year. There may be some fundamental health system bottlenecks that need to be addressed before the desired training targets are achieved, and this calls for further probing.

Budgetary allocation for MTP-related activities is but a miniscule proportion – less than 1% - of the total RCH-2 budget for the years 2007-11. Not all of this allocation may in fact have been spent, a clear indication of the very low priority accorded to improving access to safe abortion services. Considerable amounts have also been allocated for provider incentives. The effectiveness of these strategies in increasing availability and utilisation of safe abortion services needs to be examined.

No allocation has been made for community-level awareness raising and behaviour-change communication activities, except for incentives to ASHAs. In a recent training programme for ASHAs which one of the authors of this paper facilitated, we found that none of more than 50 ASHAs who have more than 3 years of work experience knew of the MTP legislation and believed that abortion was illegal in India. Unless specific training targeting ASHAs is extensively carried out, community awareness programmes will remain a non-starter.

3.2. Conclusions and recommendations

India, through the National Rural Health Mission (NRHM), has made massive investments in promoting safe institutional deliveries in order to reduce the country's maternal mortality ratio. It is then paradoxical that unsafe abortion which contributes to at least 8% of maternal deaths in India, receives so little policy and programmatic attention and budgetary commitment. Nor is any assessment made by the government of improvements in access to safe abortion. The findings from this review suggest that safe abortion services continue to elude a significant proportion of women in India, with the private sector providing the limited services that are available, to those who can afford it. The six states examined in this paper are far from achieving the four objectives set out in RCH-2 document for expanding access to MTP, viz., expanding the numbers of government facilities, expanding the numbers of trained providers, counselling for safe abortion in the community and increasing community awareness on safe MTPs are likely to be achieved. If we are to prevent avoidable deaths of women from unsafe abortion, the following actions are needed urgently:

- Medical Termination of Pregnancy should necessarily feature as an area of action in all PIPs for Reproductive and Child Health. Clear objectives, strategies and activities need to be spelt out.

- Budgetary allocation for MTP-related activities needs to be enhanced, and the effectiveness of such investments monitored routinely. There should be budgetary allocations corresponding to each of the activities proposed, and utilisation of these allocations need to be reported as part of routine reporting.
- Availability and utilisation of MTP services and on the profile of abortion seekers need to be regularly tracked and reported in annual reports on health.
- The reasons for non-performance of MTPs in many government health facilities need to be studied, health system barriers to MTP availability identified and addressed.
- The reasons underlying the low performance in relation to training medical officers in MTP including MVA and medical abortion need to be identified and rectified.
- The role of public-private partnerships in expanding access to safe abortion services needs to be understood through a study of case examples of PPPs implemented (intended to be implemented) by some of the states.

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Annex 1.1. Budget approved in lakhs (Rs.) for major components of RCH-II, Assam 2007-2011.

	2007-2008 (approved)	2008-2009 (approved)	2009-2010 (approved)	2010-2011
Maternal health	1199.77	2119.30	259.72	607.88
Family Planning	153.41	373.25	311.51	214.74
Child Health	423.04	3544.0	0.0	6.20
Urban RCH	503.47	669.18	566.35	615.65
Tribal RCH	1238.89	0.0	0.0	0.0
Vulnerable groups	0.0	0.0	0.0	78.47
Trainings	232.06	1385.15	1621.41	2284.60
Procurement	0.0	1053.41	1897.52	9602.30
BCC/IEC	999.44	2074.88	806.44	0.0
Innovations/PPP/NGO	1272.96	2429.67	2789.14	3569.26
Infrastructure and HR	4772.04	2207.26	2376.04	2268.46
Institutional strengthening	115.11	714.92	223.97	118.88
Programme management	303.39	347.0	322.36	375.99
Others/United funds	155.04	0.0	0.0	0.0
Total RCH II Base flexi pool[@]	11418.0	16927.72	11348.59	19887.14

Source: Respective Year ROPs Assam [51 -54]

Annex 1.2. Budget approved in lakhs (Rs) for major components of RCH-II, Gujarat

	2007-2008	2008-2009	2009-2010 (approved)	2010-2011 (approved)
Maternal health	1247.03	2247.57	394.06	3634.23
Family Planning	264.55	129.59	47.75	2468.88
Child Health	37.80	662.03	1116.11	2023.72
Urban RCH	170.15	2143.01	789.97	2853.06
Tribal RCH	83.11	66.86	291.15	811.00
Vulnerable groups	0.00	2.50	2413.35	8.75
Trainings	1258.30	1276.73	1308.82	1074.53
Procurement	0.00	162.11	13.20	375.40
BCC/IEC	297.34	285.24	395.66	873.86
Innovations/PPP/NGO	2220.85	1303.30	327.95	629.80
Infrastructure and HR	520.05	475.21	828.77	771.94
Institutional strengthening	164.19	241.98	557.71	376.87

Programme management	405.58	499.03	607.11	876.15
Others/United funds	0.00	120.00	0.00	0.0
Total RCH II Base flexi pool[@]	6777.00	9732.55	9486.00	16977.39

Source: Respective ROPs [55-58]

Annex 1.3. Budget approved in lakhs (Rs.) for major components of RCH-II, Haryana

	2007-2008 (sanctioned)	2008-2009 (sanctioned)	2009-2010 (approved)	2010-2011 (approved)
Maternal health	111.76	316.42	149.0	395.23
Family Planning	0.0	132.66	200.30	2459.71
Child Health	4.62	59.92	177.36	1000.56
Urban RCH	59.35	261.34	328.94	1084.06
Tribal RCH	0.0	0.0	0.0	0.0
Vulnerable groups	0.0	0.0	0.0	0.0
Trainings	250.88	444.37	606.43	992.85
Procurement	0.0	872.6	0.0	1510.44
BCC/IEC	72.24	95.34	0.0	0.0
Innovations/PPP/NGO	0.0	503.37	135.76	327.60
Infrastructure and HR	1223.41	1110.01	2585.23	4478.68
Institutional strengthening	210.24	269.70	34.20	39.78
Programme management	126.0	243.66	392.94	617.08
Others/United funds	0.0	0.0	0.0	0.0
Total RCH II Base flexi pool[@]	1901.52	4420.54	4637.06	10060.74

Source: [59-62]

Annex 1.4. Budget approved in lakhs (Rs.) for major components of RCH-II, Himachal Pradesh

	2007-2008 (proposed)	2008-2009 (approved)	2009-2010 (approved)	2010-2011 (approved)
Maternal health	1.87	37.5	37.5	333.76
Family Planning	-	14.4	28.8	23.00
Child Health	0.25	15.6	260.54	452.35
Urban RCH	0.36	-	-	45.10
Tribal RCH	0.38	83.2	39.0	48.00
Vulnerable groups	-	-	60.0	82.50
Trainings	0.80	88.29	67.48	226.96

Procurement	-	384.25	-	678.20
BCC/IEC	0.16	110.25	50.0	164.35
Innovations/PPP/NGO	1.71	233.0	217.5	52.6
Infrastructure and HR	-	-	143.12	56.48
Institutional strengthening	0.31	143.52	43.7	114.65
Programme management	0.55	92.91	-	210.48
Others/United funds	-	-	-	0.0
Total RCH II Base flexi pool[@]	6.52	1336.14	947.64	3120.68

Source: [63-66]

Annex 1.5. Budget approved in lakhs (Rs.) for major components of RCH-II, Orissa

	2007-2008 (recommended budget)	**2008-2009 (proposed)**	**2009-2010 (approved)**	**2010-2011 (final)**
Maternal health	1023.03	2,767.57	1532.21	1881.28
Family Planning	179.08	213.53	157.52	57.38
Child Health	716.08	869.844	829.18	1083.26
Urban RCH	106.14	324.00	227.95	293.81
Tribal RCH	128.24	284.29	118.63	146.80
Vulnerable groups	Classification not found	67.10	63.35	52.93
Trainings	1364.33	632.96	1109.43	1561.66
Procurement	^^	189.26	325.35	1637.49
BCC/IEC	298.59	210.35	221.94	484.29
Innovations/PPP/NGO	504.50	730.59	729.26	739.26
Infrastructure and HR	1012.42	1679.86	2023.78	2608.70
Institutional strengthening	325.34	943.94	200.79	355.98
Programme management	Classification not found	567.13	682.07	1430.94
Others/United funds	228.06	236.86	22.0	
Total RCH II Base flexi pool[@]	6337.51	9806.18	8260.11	25837.47[#]

[@] This is exclusive of JSY, sterlisation and IUD compensation, NSV camps.

[^^] Procurement of drugs and equipments is said by NPCC as not permissible under RCH II (source: ROP, Annexure II), # inclusive of JSY (13,157.54)

Source: [67-70]

Annex 1.6. Budget approved in lakhs (Rs) for major components of RCH-II, Punjab

	2007-2008	2008-2009	2009-2010 (approved)	2010-2011 (approved)
Maternal health	176.90	280.59	120.00	210.00
Family Planning	33.13	87.6	46.5	69.55
Child Health	34.87	106.15	25.3	122.44
Urban RCH	74.00	153.00	165.60	190.44
Tribal RCH	Not applicable			
Vulnerable groups				
Trainings	503.99	461.88	654.03	813.73
Procurement	0.00	0.0	53.55	1837.25
BCC/IEC	256.97	288.11	367.82	422.00
Innovations/PPP/NGO	678.24	507.34	357.8	364.10
Infrastructure and HR	801.56	1543.35	2534.19	2632.00
Institutional strengthening	298.02	323.78	74.76	498.06
Programme management	198.71	122.5	414.22	516.35
Others/United funds	0.00	434.5	0.00	0.00
Total RCH II Base flexi pool[@]	3073.00	4662.01	4852.00	9442.89

Note: For all the years, the presented figures are those corrected after the comments of the NPCC and that resented for approval. For the year 2009-2011, it is clearly stated as approved budget. Source: [71-74]

CommonHealth Thematic Areas

Maternal Health

Make every instance of maternal morbidity and maternal death count.

Advocate for safety, quality and respect for women's rights in delivery care.

Promote health system strengthening and accountability through community mobilization.

Neonatal Health

Generate and disseminate information on neonatal health.

Encourage labour monitoring for improving perinatal and neonatal outcomes.

Advocate for right to health for newborns, through

a. Counting of stillbirths and newborn deaths.

b. Attention to newborn outcomes by promoting safety and quality in delivery.

c. Legal, policy and economic measures to support newborn care.

d. Greater participation of men, families and the community in essential newborn care.

Safe Abortion

Carry out sustained campaigns to promote access to safe and quality abortion services for all women irrespective of marital status, especially those from disadvantaged sections.

Support the prevention of sex-determination through stringent implementation of the PC-PNDT Act and campaigns against gender discrimination, without compromising on women's access to safe abortion services.

CommonHealth - a Coalition for Maternal - Neonatal Health and Safe Abortion

We are a coalition of concerned individuals and organizations from across India, who have come together to work towards changing the unacceptable situation around issues of maternal-neonatal health and safe abortion.

Vision

A society that ensures maternal-neonatal health care and safe abortion for all women, especially those from marginalised communities in India.

Mission

To raise visibility of the unacceptably high mortality, morbidity among mothers and newborns, and the lack of access to safe abortion services, especially among the disadvantaged.

To mobilise advocates from different constituencies to:

a. ensure effective implementation of relevant policies and programmes.

b. contribute to the development of new policies and changing of existing ones when needed.

c. build a rights based and gender sensitive perspective within communities, health care providers, researchers, administrators, elected representatives and the media, among others.

CommonHealth