



ACCESS TO SAFE ABORTION SERVICES IN TAMIL NADU: INTENTIONS AND ACHIEVEMENTS

An analysis based on secondary sources

TK Sundari Ravindran and Bhuvaneswari Sunil



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ACKNOWLEDGEMENT

" This study was carried out with funding support from IPAS, India. Thanks to P. Balasubramanian, Rural Women's Social Education Centre for data collection from the districts."

PUBLISHED BY:

SAHAJ ON BEHALF OF COMMONHEALTH

August - 2012

COPIES CAN BE DOWNLOADED FROM: WWW.COMMONHEALTH.IN



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Abbreviations

BEmONC	Basic Emergency Obstetric and Neonatal Care
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CHC	Community Health Centre
DLHS	District Level Household & Facility Survey
D&C	Dilatation & Curettage
EmOC	Emergency Obstetric Care
FRUs	First Referral Units
HDI	Human Development Index
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MO	Medical Officer
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
NRHM	National Rural Health Mission
PHC	Primary Health Centre
PIP	Project Implementation Plan
RCH	Reproductive and Child Health (Programme)
ROP	Report of Proceedings
RTI/STI	Reproductive Tract Infection/Sexually Transmitted Infection

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Access to Safe Abortion Services in Tamil Nadu: Intentions and Achievements

An analysis based on secondary sources

1. Introduction

1.1. Background

Tamil Nadu is the eleventh largest state of India with a population of about 72 million in 2011, 48% urban and 52% rural. The state is one of the most industrialized and urbanized states in India. It ranks 6th in human development (according to HDI) among the 16 major states in India. According to the 2011 census, the literacy rate is 80.3%, 86.8 for males and 73.8 for females [1]. Tamil Nadu's health indicators have registered dramatic improvements in the past few decades. According to SRS 2007-2009, Tamil Nadu's maternal mortality ratio was 97 maternal deaths per 100,000 live births, much lower than the average for India of 212 [2]. Thus, the state has achieved the MDG target of reducing maternal mortality ratio (MMR) to below 100 by 2015. Table 1 below presents trend in MMR figures for Tamil Nadu.

Table 1. Maternal mortality ratios for Tamil Nadu, various years

Year	MMR in Tamil Nadu (per 1,00,000 live births)
1997-1998	131
1999-2001	167
2001-2003	134
2004-2006	111
2007-2009	97

Source: 1997-2006 [5]; 2007-2009 [2].

Almost all pregnant women (98.9%) received ante-natal care services either from private, public or community health facilities during 2007-2008. The reduction in MMR in the state is attributed to the high rate (94%) of institutional deliveries and safe deliveries assisted by skilled attendants (95.5%) [3]. The state has achieved a below-replacement total fertility rate of 1.8 by 2005-06 [4]. Contraceptive prevalence rate for the state for the same period was 61.1% among currently married women aged 15-49 years [3]. With an under-five mortality rate of 36 per 1000 live births, the state has achieved the MDG goal of reducing under-five mortality to 42/1000 by 2015. However, there are differentials by place of residence and sex. The urban under-five mortality rate was 33 and 30 per 1000 live births for male and female children respectively, while the rural under-five mortality rate was 38 and 40 per 1000 live births for male and female children respectively [5].

One of the major contributors to the state's achievements in health is its health infrastructure. Tamil Nadu has an extensive network of public health facilities including at the primary care level (Table 2). There are a large number of PHCs that function round the clock and many PHCs have functioning operation theatres. Making delivery services available at the PHC level has been one of the major achievements of Tamil Nadu since the launch of the National Rural Health Mission in 2005, resulting in a shift from the private to the public sector health facilities for delivery services. While in 1999-

2000, 44% of all deliveries were in private health facilities; by 2007-08 this proportion had fallen to about 39%.

Table 2. Public health infrastructure in Tamil Nadu, 2010-2011

Nature of health facility	Number of units
Number of Hospitals attached with Medical Colleges	46
Number of District Headquarters Hospitals	27
Number of Taluka Hospitals	156
Number of Non-Taluka Hospitals	79
Number of Women and Children Hospitals	7
Number of Primary Health Centres	1539
Number of Health Sub Centres	8706
Number of CEmONC Centres	125
Number of PHCs providing 24x7 services	1537
Number of PHCs providing BEmONC services	385
Number of FRUs - At CHC, sub-district and district level	308
Number of PHCs with functioning operation theatre	320

Source: Tamil Nadu State PIP, 2010-2011 [7]

1.2. Induced abortions in Tamil Nadu

Tamil Nadu is among the Indian states with a higher proportion of induced abortion than the national average. However, it is difficult to ascertain the levels of induced abortion because of wide differences across sources. According to National Family Health Survey-2, 9.6% of all pregnancies of currently married women were reported to have ended in an induced abortion during 1998-99, highest among all Indian states. [8]¹. Data from the DLHS-3 for 2007-08 however reports a much lower percentage of induced abortions. Out of 6744 pregnancies among currently married women aged 15-49 in the three years preceding the survey, 88.6% were live births while 3.0% and 7.2% were induced and spontaneous abortions [3]. It is possible that some of the induced abortions were reported as spontaneous. In another study based on household survey carried out during 2002-03 and covering 4814 ever-married women, about 7% of all pregnancies were found to have ended in an induced abortion [9].

Data on the number of induced abortions/medical terminations of pregnancy (MTP) is also available from the Family Welfare Yearbook (FWY). These show a decline in the total number of MTPs between 2004 and 2007-08 (Table 3).

Krishnamoorthy et al estimated the number of induced abortions per year to be about 99,000 for 2002-03 [9]. It would therefore appear that about 25% of induced abortions have not been officially reported. It is also interesting to note from the study by Krishnamoorthy et al that despite the extensive public health infrastructure in the state and the predominant use of these facilities for

1) Comparable data is not available in NFHS-3 reports.

delivery services even before the NRHM, about 84% of abortion seekers sought services from private providers, including 3.5% from unqualified providers, and only 16% used government health facilities. According to the Tamil Nadu Human Development Report (2003) there was reason to believe that safe abortion services remained inaccessible to a sizeable proportion of women who need them and rural women are particularly vulnerable [10].

Table 3. Number of Medical Terminations of Pregnancy performed in registered MTP health facilities, Tamil Nadu, various years

Year	No. of Institutions Approved	No. of MTPs	% of Increase Decrease	No. of MTPs Per centre
1998-1999	907	56206	*	61.97
1999-2000	909	61282	8.28	67.42
2000-2001	994	60999	-0.46	61.37
2001-2002	1014	68659	11.16	67.71
2002-2003	1062	73335	6.38	69.05
2003-2004	1125	73372	0.05	65.22
2004-2005	1149	72710	-0.91	63.28
2005-2006	1238	71128	-2.22	57.45
2006-2007	*	67315	-5.66	*
2007-2008	*	63875	-5.39	*

Source: Government of Tamil Nadu, Ministry of Health and Family Welfare, various years

Against the backdrop of high achievements in health status overall, this paper examines the extent to which improving women's access to safe abortion services has received the attention in Tamil Nadu government's health policies, with concomitant budgetary investment and programmatic interventions especially since the start of NRHM in 2005. After the methodology section which concludes the introductory section, section two and section three describe the plan and the reality on the ground with respect to availability and utilization of MTP services in Tamil Nadu in recent years.

1.3. Methodology

Two major sources of information form the basis of the analysis in this paper. One source is the Programme Implementation Plans (PIPs) of Tamil Nadu. The second source is MTP data collected by district MTP committees for three districts viz., Erode, Kanchipuram and Virudhunagar. We did not succeed in obtaining similar data for the state from the concerned authorities, and therefore use the three-district data to examine whether plans presented in PIPs have been implemented at the district level. We do not know whether these districts are representative of the state overall, but they would nevertheless provide some indication of the congruence between plan and implementation.

PIPs are detailed annual documents describing the objectives, strategies, achievements/physical outcome for the various health programmes, along with a detailed budget plan, accompanied by physical targets. The RCH-II Project Implementation Plan (PIP) in Tamil Nadu has been developed after the problems to be addressed were identified based on the reports of the District Level Household Surveys, National Family Health Surveys and State Health Management Information

System reports. All the problems were analyzed in a systematic manner and multiple solutions were derived. The best and cost effective solutions were tailored into interventions to be implemented with special focus on underserved and vulnerable population. The progress and lessons learnt during implementation of RCH/NRHM schemes in the preceding years were used to devise these interventions and set realistic and feasible targets. All these were carried out under a State level core team under the leadership of the Mission Director. The core team constituted a state level PIP preparation team pulling together expertise from the State Programme Management Unit. Similarly, district level health teams were constituted for the preparation of District Action Plans.

We were able to obtain for 2007-2011 the report of proceedings (ROP) presenting the proposed and approved budget for each year to the National Programme Coordinating Committee (NPCC). We have used state PIPs for the years 2007-2011 and the 2011-2012 PIP has been used to understand the targeted outcomes of previous years.

District level data on MTP was collected for April 2010 - March 2011 on the number of approved MTP facilities, and the distribution of MTPs by trimester, indications, characteristics of women and type of facility.

2. Medical Termination of Pregnancy in Government's Plans

In the state of Tamil Nadu, like in other states, Reproductive and Child Health Programme includes maternal health, child health, immunization, adolescent health, RTI/STI management, and family planning. In addition to this, special focus is given to urban health, operationalising health facilities, and most importantly human resources and training. In order to provide quality care in PHCs, attention has been given to expansion of 24x7 delivery and newborn care services.

MTP services are mentioned as part of family welfare services or as part of maternal health services. In the 2010-11 PIP (and in several PIPs before then), for example, MTP was one of the maternal health objectives, alongside improvement in proportion of institutional deliveries and increasing access to EmOC, providing quality antenatal care, expanding coverage of postpartum care and availability of STI and RTI services at the PHC level. The objective, interestingly, is stated in terms of "choice": **"To widen the choice of place for MTP services"**.

The intention is to increase the choice of techniques. The vast majority of MTPs carried out in the state during 2008-10 had adopted the Dilation and Curettage (D&C) technique although many doctors had received training in using Manual Vacuum Aspiration (MVA) technique (Table 4).

Table 4. Techniques used for Medical Termination of Pregnancy, all health facilities, Tamil Nadu, 2008-09

Gestation	MVA	Other techniques	TOTAL
< 12 weeks	8741	49404	58145
12-20 weeks	0	4841	4841
Not available	0	100	100
TOTAL	8741	54345	63086

Source: [7]

The PIP for 2010-2011 also mentions and outlines a proposal to adopt a safe abortion policy for Tamil Nadu during that year (annex 1). This policy would aim to ensure public education to promote early pregnancy confirmation and use of emergency contraception; patient friendly contraception and safe abortion facilities at all levels of health care; expanding the range of abortion techniques/methods to include manual vacuum aspiration and medical abortion. This same intention is repeated in the PIP for 2011-12.

The following sub-sections will examine the strategies and activities proposed in the various PIPs and ROPs for 2007-2011 and the extent to which these have been achieved, according to these and other government reports.

2.1. Strategies and activities proposed for expanding access to safe abortion services (2007-2011)

The major strategy proposed for expanding access to safe abortion services has been widening the range and number of public health facilities providing MTP services. Thus, the PIPs of different years propose that MTP services be provided in all district head quarter hospitals, taluk and non-taluk hospitals and PHCs and CHCs with operation theatre facilities; there is also indication of a move to provide MTPs using the MVA (Manual Vacuum Aspiration) technique. The main activity proposed to achieve this is MTP training for medical officers (Table 5).

Table 5. MTPs in Project Implementation Plans of Tamil Nadu, 2007-2011

2007-2008	2008-009	2009-2010	2010-2011
All the upgraded	Component:	Component:	Component:
PHCs are envisaged	Maternal health	Family Planning	Maternal health
to provide MTP			
using MVA.	Strategy: Aims to	Activities: All	Strategy: Widen
	provide MTP	the operation	the choice and
	services in all	theatres in CHCs	place for MTP
	District Head	and PHCs providing	
	Quarters hospitals,	tubectomy services	Activities:
	Taluk, non-taluk	should provide	Provision of MTP
	hospitals and PHCs.	MVA and MTP	in all secondary
		services.	institutions and
			PHCs.
	Activities:		
	MTP training for Mos.		Provision of MTP
			training to doctors.

Sources: PIP of respective years 2007-2011 [7, 11, 12, 13]

2.2. Operationalisation of MTP centres

Outcome indicators presented in the PIPs provide conflicting numbers across years and sometimes even for the same year. We have tried to compute, based on the PIPs for 2010-11 and 2011-12, the number of government health institutions providing MTP (Table 6). For example, the number of FRUs providing MTPs has been computed from information stating that 191 district hospitals and FRUs provide MTPs and data on total number of district hospitals and FRUs, and from information that all 27 district hospitals provide MTPs. The total number of government health facilities providing MTP services has been stated as 587 in the 2011-12 PIP, and so we have included an “other government hospitals/health facilities” categories to make up to this total number.

Table 6. Number of facilities providing/approved to provide MTP services, Tamil Nadu 2010-11

Nature of health facility	Total Number of units	Units reported to be providing MTP services 2010-11
No. of Hospitals attached with Medical Colleges	46	46 (100%)
No. of District Headquarters Hospitals	27	27 (100%)
No. of FRUs - At CHC, sub-district and district level	308	164 (53.2%)
No. of PHCs providing 24x7 services	1537	51* (3.3%)
No. of PHCs with functioning operation theatre	320	73 (22.8%)
Other hospitals/health facilities		226
Total		587
Private health facilities		1328
*Provides only first trimester abortion		

Source: PIP for 2011-12 and 2010-11 [14, 7].

From the fragments of information available, it can be seen that almost half of all FRUs do not provide MTP services, and less than a quarter of PHCs which are well equipped to provide MTPs do not in fact do so. Hardly 3% of 24x7 PHCs provide even first trimester MTP services although they conduct deliveries and therefore should be having the requisite trained personnel. There is more than double the number of private sector facilities as government sector providing MTP services, and this would have consequences for affordability of safe abortion services for many women. According to one study conducted in 2002-2003 the average expenditure for an abortion in the private sector was Rs. 1375, more than 18 times the comparable cost of Rs. 75 in the public sector. Abortion followed by a sterilisation cost as high as Rs. 3561 in the private sector [9].

2.3. Coverage by MTP services

According to the PIPs, roughly 150,000 MTPs are expected to be performed each year. However, the proportion “achieved” is less than 50% of this number. This may mean that less than 50% of the expected MTPs actually get reported, either because they take place in non-approved facilities or because many approved facilities are not reporting regularly. Data from PIPs also corroborate the decline in the number of reported MTPs seen in the previous years as reported in the state government's health reports. Whether or not this means an actual decline in the number of legally performed MTPs depends on the completeness of reporting of approved MTP centres. Data from districts, to be examined in section 3, may be able to provide a better understanding of this. The PIP

for 2010-11 states that 66% of the reported MTPs are performed in private facilities and only the remaining 34% in government facilities, of which the vast majority are performed in hospitals. PHCs account for less than 3% of MTPs [7].

Table 7. Expected and actual numbers of MTPs reported

	Expected level of demand for MTP	Achieved	Percentage achievement
2006-2007	1,50,000	67,315	44.9
2007-2008			
(up to Jan')	1,50,000	63,875	42.6
2008-2009	1,50,000	59759	39.8
2009-2010	1,50,000	61,964	41.3
2010-2011			
(up to Nov 2010)	1,50,000	37,252	37.3

Source: PIPs 2008-2012 [7, 12, 13, 14].

There is also mention that the average number of MTPs performed per FRU is 12 per month/facility/provider for the period April-November 2010. Similarly, the average number of MTPs performed per 24X7 PHC is 0.7 per month/facility/provider [14].

2.4. MTP training for Medical Officers

The focus in most PIPs is on training medical officers in MVA techniques so as to expand choice for early abortions, and therefore most of the information available pertains to MVA training. However, there is some information on the total number of medical officers trained in providing MTPs. In 2007 April, there were 3113 medical officers with MTP training, constituting 92.7% of medical officers intended to be trained [11]. In November 2010, there were 3824 medical officers with MTP training [14].

Between 2007-08 and 2010, regular MVA training programmes were conducted (Table 8). As of April 2007, there were 134 medical officers with MVA training. This increased to 326 by 2009-10. The 'base-line status' figure for 2010-11 is given as 96, but this is possibly achievement in the previous year alone, so that by 2010 April, there would have been 424 medical officers trained in MVA techniques.

Table 8. Achievements and targets for MVA training of medical officers

Year	Baseline status	Target for the year
2007-2008	134	240
2008-2009	234	200
2009-2010	326	240
2010-2011	96? 424?	600

Source: PIPs of respective years [7, 11, 12, 13].

The PIP for 2009-10 talks about increasing the number of training centres for MVA from three – two in Chennai and one in Madurai - to seven - four in Chennai, and one each in the medical college hospitals of Madurai, Thanjavur and Tirunelveli [13]. The PIP of the following year contains a training plan detailing region-wise training load to be trained at Medical college hospitals in Madurai, Tiruchirappalli, Coimbatore, Government Head Quarters Hospital – Cuddalore and Government Hospital, Gudiyatham in Vellore. A set of districts were allocated under each of these hospitals for training of Medical Officers from PHCs in the respective regions (the criteria is selection of one MO per OT attached PHC in the respective districts). A 'Training of Trainers' (TOT) programme in MVA techniques was to be conducted in the Institute of Obstetrics and Gynaecology, Chennai for five women gynaecologists including the program officer from each of these five training institutions [7]. It is not clear whether these five training centres in the various districts are in addition to the existing two (or the proposed four) in Chennai.

2.5. Budgetary allocations for MTP related activities

Table 9 presents the various heads under which allocation is made for safe abortion services from the limited information on this available in the ROPs of various years. The budgetary allocation for the most recent years is in the range of about Rs. 40 lakhs per year, all of which is for training. While there is mention of allocation of funding for procuring MVA equipment for every PHC, this amount is pooled with other procurements in the overall budget for maternal health. Since personnel, drugs and equipments and other expenditure related to MTP is merged with other budgetary heads, we have compared the MTP training allocation with the total allocation for training in RCH-2, and find that it constitutes less than 5% of total budgetary allocation for training under RCH-2. Annex 2 presents the total approved budget for RCH-2 for 2007-08 to 2010-11.

Table 9. Budget allocation for MTP related activities, 2008-2011

	2008-2009	2009-2010 (Rs. in lakhs)	2010-2011 (Rs. in lakhs)
Training of MOs in MTP using MVA (FRU and 24/7 PHC MO)	NA (units)	38.47	22.40 (70 courses @ 3 MOs per course; @ Rs. 31,990 per course)
TOT for MTP using MVA	Not applicable	Not applicable	2.42 (4 training courses for 5 gynaecologists)
Safe abortion	Not applicable	Not applicable	7.95
Total	Not known	38.47	32.75
Total RCH-2 training budget	348.83	1918.06	2078.55
MTP training budget as % total training	Not applicable	2	1.6

Source: PIP of respective years [7, 12, 13].

3. Availability and utilisation of MTP services in three districts of Tamil Nadu, 2010-11

This section provides an overview of availability and utilisation of MTP services in three districts of Tamil Nadu over the past year (2010-11), and also the profile of abortion seekers. The three districts for which data were available were Erode, Kanchipuram and Virudhunagar. Erode is located to the west of Tamil Nadu, Kanchipuram to the extreme north east and Virudhunagar, to the South. According to the 2011 census Kanchipuram district has the highest population of the three, of 39.9 lakhs, followed by Erode with 22.6 lakhs and Virudhunagar with 19.4 lakhs. All districts are highly urbanised with more than 40% urban population. Erode has the lowest literacy rate of 72.9%, while Virudhunagar has 80.7% literate population and Kanchipuram, 85.3% [15].

3.1. Availability of MTP services

Table 10 presents data on the number of health facilities approved for and reporting on MTP services in the three districts. Kanchipuram and Erode have more than 75% of MTP facilities in the private sector while in Virudhunagar the proportion is 60%. In Erode, 18 approved facilities are not reporting, and further probing showed that MTP facilities in these centres were non-functional. Although information to this effect was not available, the same may be true of the one non-reporting facility in Virudhunagar. It is worth noting that only 2 of 14 approved PHCs in Erode were actually functional.

The availability of MTP facilities appear to be adequate in the three districts. Assuming women in the reproductive age group to be 47% of the total population (2001 census figures), there is roughly one MTP facility per 12,000, 17,000 and 20,000 women in the reproductive age group of 15-44 years in Erode, Kanchipuram and Virudhunagar districts respectively, which can more than adequately cater to the annual demand for abortion which is estimated to be a maximum of about 10 induced abortions per 1000 women in the reproductive age group in India [16].

Table 10. Number of health facilities approved for MTP and number reporting in 2010-11 in Erode, Kanchipuram and Virudhunagar districts

Sr. No.	Institution	Erode		Kanchipuram		Virudhunagar	
		Approved	Reporting	Approved	Reporting	Approved	Reporting
1	Government PHCs	14	2	11	11	7	7
2	Govt. hospitals	8	8	9	9	9	8
3	Medical college hospitals	0	0	1	1	0	0
4	ESI hospital/dispensary	0	0	0	0	1	1
5	Local Body	0	0	4	4	0	0
6	Voluntary organisations	2	1	1	1	2	2
7	Private nursing homes	84	79	84	84	27	27
Total		108	90	110	110	46	45

3.2. Number of MTPs carried out

Although Kanchipuram district has a much higher population than Erode and Virudhunagar districts, the total number of MTPs in all three districts is about the same, around 1300-1500 per year. The

private sector carries out 75% of the MTPs in Erode and Virudhunagar district but only 53% of MTPs in Kanchipuram. This is likely to be because the other two districts do not have a medical college hospital while Kanchipuram district does. It can be seen that government PHCs rarely perform MTPs. In Virudhunagar, two PHCs accounted for the 50 MTPs while the others did not perform any MTPs. Similarly in Erode, a single PHC performed all 9 MTPs.

Virudhunagar provides information on MVA procedures, and this accounted for only 4.5% of all MTPs, although as we shall see later, more than 70% of the MTPs were performed in the first trimester of pregnancy.

To find out the actual availability of MTP services, we tabulated the 'approved' MTP facilities by the number of MTPs performed in 2010-11 (Table 12). We found that not a single MTP was carried out during 2010-11 in 43.6% (115) of the approved facilities (public and private sectors). A further 73 facilities performed less than 10 MTPs during the entire year. It appears that the vast majority of MTPs are performed in 21 institutions each of which perform 61 or more MTPs in a year, only a third (7) of which are government health facilities. This implies that availability of MTP services is concentrated in large private hospitals in urban centres with a large enough market for MTP facilities.

Table 11. Number of MTPs performed during 2010-11 by type of facility, Erode, Kanchipuram and Virudhunagar districts

Sr. No.	Institution	Erode	Kanchipuram	Virudhunagar
1	Government PHCs	9	0	50
2	Govt. Hospitals	303	457	238
3	Medical college hospitals	0	169	0
4	ESI hospital/dispensary	0	0	0
5	Local Body	0	26	0
6	Voluntary organisations	9	35	56
7	Private nursing homes	1007 (75.8)	786 (53.4)	1042 (75.2)
	Total	1328	1473	1386

Table 12. Distribution of health facilities by number of MTPs performed during 2010-11, Erode, Kanchipuram and Virudhunagar districts

Frequency	Erode		Kanchipuram*		Virudhunagar	
	Govt.	Private	Govt.	Private	Govt.	Private
0	2	38	14	47	8	6
1-10	12	27	3	26	1	4
11-30	2	7	2	16	7	5
31-60	2	7	0	7	1	6
61-100	2	3	1	2	0	5
101-200	0	2	2	0	1	1
>200	0	0	1	0	0	1
Total facilities	20	84	23	98	18	46

*The total number of facilities for which data was available on number of MTPs performed was 121, although only 110 facilities are documented as "approved".

3.3. Profile of abortion seekers

Table 13 presents the profile of abortion seekers. More than 70% of the women who underwent an MTP during 2010-11 in Erode and Kanchipuram districts and 65% in Virudhunagar district were in the 20-29 age groups. About 19%, 23% and 29% in Kanchipuram, Erode and Virudhunagar respectively were in the 30-39 year age group and just about 1-2% was above the age of 40. Only 4-6% of MTPs were carried out in the second trimester. MTPs below 8 weeks of gestation were much higher (73%) in Erode as compared to Kanchipuram and Virudhunagar (53%). This may imply one of three things: that there are very few second trimester abortions overall; that many of the approved MTP facilities are not reporting second trimester abortions; or that the vast majority of second trimester abortions are taking place outside the approved MTP centres.

Table 13. Profile of abortion-seekers in 2010-11, Erode, Kanchipuram and Virudhunagar districts

Age group	Erode	Kanchipuram	Virudhunagar
< 15	0	0	0
15-19	25 (1.9%)	19(1.3%)	35(2.5%)
20-24	418(31.5%)	520 (35.3%)	386(27.8%)
25-29	561(42.2%)	628(42.6%)	527(38.0%)
30-34	240(18.1%)	259(17.6%)	302(21.8%)
35-39	72(5.4%)	41(2.8%)	112(8.1%)
40-44	10(0.75%)	4(0.27%)	24(1.7%)
45 and above	2(0.15%)	2(0.14%)	0
Not known	0	0	0
Total	1328	1473	1386
Duration of pregnancy			
0 to 8 weeks	968(72.9%)	775(52.6%)	737(53.2%)
8-12 weeks	295(22.2%)	608(41.3%)	588((42.4%)
13-20 weeks	65(4.9%)	90 (6.1%)	61(4.4%)
Not known	0	0	
Total	1328	1473	1386
Reasons for termination			
Danger to the life of pregnant woman	37 (2.8%)	8 (0.5%)	965 (69.6%)
Grave injury to the physical health of pregnant woman	57 (4.3%)	1465 (99.5%)	312(22.5%)
Grave injury to mental health of pregnant woman	24(1.8%)	0	44(3.2%)
Pregnancy caused by rape	0	0	0
Severe foetal abnormality	1(0.08%)	0	9(0.6%)
Failure of contraceptive device	35(2.6%)	0	1(0.07%)
Others	1174(88.4%)	0	55(4.0%)
Total	1328	1473	1386

There are wide variations in indications for termination across the three districts. In Erode the vast majority have been classified under “other” reasons for MTP, in Kanchipuram almost all women have been recorded as indicated for grave injury to the physical health of the mother, and in Virudhunagar danger to the pregnant woman's life is the indication for about 70% of the MTPs and threat to physical health of the pregnant woman for about 22%. From these results it would appear that each district has some “favoured” indications under which most MTPs are recorded, it would be difficult to explain the variations observed in any other way.

3.4. Post-abortion contraception

Sterilisation is the most common method of contraception adopted post MTP. About 44% of women undergoing MTP in Kanchipuram district underwent sterilisation alongside the MTP, and the comparable figures were 39% for Virudhunagar and 26.5% for Erode. The higher proportion of post-MTP sterilisations in Kanchipuram may be because there are more large government hospitals providing MTP services in this district. MTP availability in government hospitals being conditional on sterilisation acceptance has been reported in many studies in India published during the 1990s and 2000s. The high proportion of sterilisation acceptors suggests that these women have completed their families. Between a half and two-thirds of MTP seekers did not accept any method of contraception after the procedure. These are likely to be women who want to have more children and have terminated a mistimed pregnancy. It is worth examining whether and why reversible modern methods of contraception are not acceptable to women who intend to have more children.

Table14. Contraceptive acceptance with MTP services, 2010-11, Erode, Kanchipuram and Virudhunagar districts

Method	Erode	Kanchipuram	Virudhunagar
Sterilisation	352(26.5%)	644 (43.7%)	541 (39.0%)
IUD	38 ((2.9%)	38(2.6%)	39 (2.8%)
OP/CC	100(7.5%)	13(0.8%)	2 (0.1%)
Plain MTP	838 (63.1%)	778 (52.8%)	809 (58.4%)
Total	1328	1473	1386

4. Main findings and conclusions

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 Government of Tamil Nadu. For this, we used information available in the government's Programme Implementation Plans (PIPs) for 2007-2011; and we also examined three district data compiled by districts on MTP services provided during 2010-11.

For the state as a whole, the following observations emerge on the basis of information from official documents:

- Less than 50% of MTPs in Tamil Nadu appear to be reported.
- Two thirds of the MTPs take place in private health facilities.
- There is considerable scope for increasing MTP availability in government health facilities.
- There are 3824 MTP trained medical officers providing between them only about 21,000 MTPs (33% of 61924 MTPs reported in 2009-10), or barely 6 MTPs per head. Also, only a fifth of the

PHCs with OTs and less than 5% of 24x7 PHCs provide MTPs. Increasing these to 100% will considerably expand access to affordable and safe abortion services

- There is commitment on the part of the government to widening the range of MTP techniques used and to encourage the use of MVA techniques for first trimester abortion. Investments have been made every year for training medical officers in MVA techniques.
- There is no mention of medical abortion anywhere except in the safe abortion policy outline (Annex 1). Training and information dissemination is also needed for expanding medical abortion access.
- It is difficult to get total figures on actual investment on MTP services because these are merged under the maternal health budget head. Information of the allocation for MTP training shows that this was 1.6 -2% of the total allocation for training in the RCH programme.

Data on MTPs from the districts of Erode, Kanchipuram and Virudhunagar provide some additional insights:

- The total number of approved MTP facilities in the districts is adequate to meet the needs of women in the reproductive age group. The main problem is that almost 44% of these facilities provide no abortion at all and a further 22% provide less than one abortion a month. In effect, only a third of the facilities appear to be actually providing MTP services regularly. Most MTPs are carried out in large hospitals in the public and private sectors, implying lack of access to those in rural and interior areas.
- The vast majority of MTPs are carried out in the private sector in the two districts of Erode and Virudhunagar, while in Kanchipuram district only a little over half of the MTPs are carried out in the private sector. The main distinguishing factor is the presence of large government hospitals and a medical college hospital in Kanchipuram district. One inference to draw from this is that in the government sector, it is the teaching hospitals and large district hospitals that take the major load of MTPs.
- More than 70% of all reported MTPs take place in the first trimester, and at least 50% before 8 weeks of gestation. There is no reason why these cannot be provided in PHCs: there are 320 PHCs with OTs where abortions can be provided, and more than 1500 PHCs that are 24x7 which can provide MVA abortions and medical abortions. Unless services are expanded to PHCs, women will have problems not only of accessibility but also of affordability.
- Post-abortion contraception is focused exclusively on sterilisation, and those who have not completed family size don't seem to be covered by any other contraceptive method. The reasons for this merits further probing.
- Despite the state government's commitment to and investment in training medical officers on MVA techniques, it does not appear as if this method is being widely used. In Virudhunagar for which data is available, less than 5% of MTPs were carried out using MVA technique. Further probing showed that a single private health facility accounted for most of these procedures.

Thus, Tamil Nadu, despite its impressive performance in terms of expanding institutional deliveries in the public sector, has failed to meet the objectives it set itself for making available Medical Termination of Pregnancy facilities in CHCs and PHCs. Also, the number of MTPs performed in government hospitals is modest when compared to those performed in the private sector. One reason for this may be that MTPs are available only if women agree to undergo sterilisations, driving women to the private sector as a consequence.

Dependence on the private sector increases the burden of expenditure for women, especially those from rural areas and low income groups, and may cause some of them to seek abortions from untrained personnel. Another area of concern is that women seeking MTPs are exposed needlessly to procedures that pose relatively higher health risks and use of MVA techniques and medical abortion is rare even for first trimester abortions below 8 weeks of gestation. Urgent action is needed to alter this situation.

Based on the findings of this report, we recommend the following:

- Urgent action is needed to expand availability of MTP services free of cost in government health facilities. In particular, priority should be accorded to making available MTP services in all FRUs, PHCs with operation theatres and 24x7 PHCs.
- Investigation is needed on the reasons for low level of MTPs performed in government facilities that are well equipped to provide safe abortion services and any health system bottlenecks addressed.
- Counselling for post-abortion family planning should become an integral part of safe abortion services. At the same time, overt or subtle coercion to accept a method should be avoided. Sterilisation should in no instance be made a condition for availing MTP services in government facilities if the intention is to promote maternal health.
- The reasons why MVAs are rarely performed in the public (and private) MTP facilities also need to be investigated, and corrective action taken to ensure that MVAs are the preferred technique used in first trimester abortions.
- Training on medical abortion needs to be provided to all medical officers in PHCs on a priority basis, and complemented by public education on medical abortion.
- Action is needed to ensure better reporting of MTPs by licensed private providers, and to identify and license qualified providers who are already providing these services.
- Reporting on MTPs should become an essential component of reporting on maternal health, so that regular monitoring is possible.

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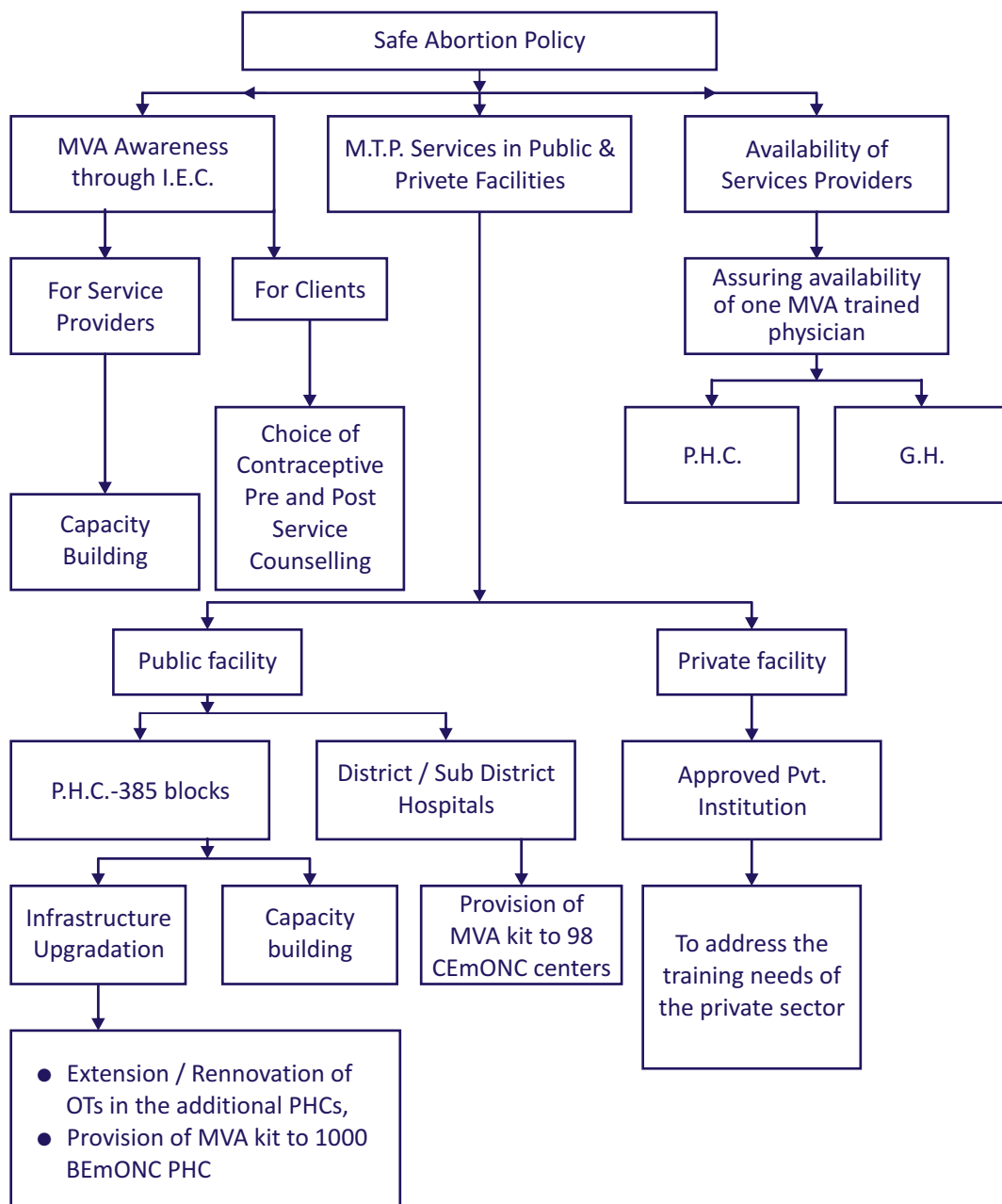
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Safe Abortion Policy

According to the State PIP, Safe Abortion policy has to be drawn up for the state with a view to protecting women's health and encouraging safe motherhood through the following strategies:

1. Promoting safe spacing methods of contraception to reduce the need to prefer abortion as a spacing method.
2. Encouraging early detection of pregnancy and appropriate use of medical method of abortion wherever possible by building awareness about the pros and cons of this method among the public and the health functionaries.
3. Making safe abortion services upto the first trimester freely available at the Primary Health Centre level itself as well as at all secondary and tertiary care centres which would automatically enhance women's access to abortion care services.
4. Enhancing the skill of the service providers and promoting simpler and safer technologies such as MVA by changing the mindset of providers away from unnecessary use of curettage.
5. Upgrading the infrastructure wherever required by provision of equipments to strengthen abortion services.
6. Providing training to the field functionaries and nursing staff of the Health department regarding the various options open to women opting for medical termination of pregnancy as well as the different institutions where services would be made available.
7. Providing Pre and Post Counselling services to the women as an especially important component of pregnancy termination care through the VHNs, Staff Nurses and Medical Officers.
8. Creating awareness among the community regarding the options available to the women and preventing them from seeking the services through unqualified personnel and organizations.
9. Roping in the private approved nursing homes in providing quality care for women seeking MTP.

The various facets of the safe abortion policy are given below in a flow chart.



Annex 2

Budget approved in lakhs for major components of RCH-II

	2007-2008	2008-2009	2009-2010	2010-2011
Maternal health	2708.47	1190.15	266.17	294.82
Family Planning	500.07	618.57	86.92	389.40
Child Health	748.22	0.0	-	0.0
Urban RCH	331.92	350.0	0.94	1.50
Tribal RCH	-	-	149.70	0.0
Vulnerable groups	-	-	0.0	0.0
Trainings	1358.0	348.83	1918.06	2078.55
Procurement	-	931.95	3117.87	3556.54
BCC/IEC	80.27	132.07	219.55	279.30
Innovations/PPP/NGO	121.07	305.88	90.67	128.52
Infrastructure and HR	855.02	5602.83	4642.29	8081.52
Institutional strengthening	850.06	516.28	1012.29	993.61
Programme management	414.23	47.5	-	0.0
Others/United funds	-	-	-	-
Total RCH II Base flexi pool	8320.0	10282.0	11532.46	3529.83

Source: Record of proceeding to NPCC for budget approval documents [17, 18, 19, 20].



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.

