Abortion Costs And Financing
A Review

Ramamani Sundar

Abortion Assessment Project - India

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First Published in September 2003

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The views and opinions expressed in this publication are those of the author alone and do not necessarily reflect the views of the collaborating organizations.

Printed at
Chintanakshar Grafics
Mumbai 400 031

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PREFACE

Abortions have been around forever. But at different points of time in history it has received attention for differing reasons, some in support of it, but often against it. Abortion is primarily a health concern of women but it is increasingly being governed by patriarchal interests which more often than not curb the freedom of women to seek abortion as a right.

In present times with the entire focus of women's health being on her reproduction, infact preventing or terminating it, abortion practice becomes a critical issue. Given the official perspective of understanding abortion within the context of contraception, it is important to review abortion and abortion practice in India.

The Abortion Assessment Project India (AAP-I) has evolved precisely with this concern and a wide range of studies are being undertaken by a number of institutions and researchers across the length and breadth of the country. The project has five components:

I. Overview paper on policy related issues, series of working papers based on existing data / research and workshops to pool existing knowledge and information in order to feed into this project.
II. Multicentric facility survey in six states focusing on the numerous dimensions of provision of abortion services in the public and private sectors
III. Eight qualitative studies on specific issues to compliment the multicentric studies. These would attempt to understand the abortion and related issues from the women's perspective.
IV. Household studies to estimate incidence of abortion in two states in India.
V. Dissemination of information and literature widely and development of an advocacy strategy

This five pronged approach will, hopefully, capture the complex situation as it is obtained on the ground and also give policy makers, administrators and medical professionals' valuable insights into abortion care and what are the areas for public policy interventions and advocacy.

The present publication is the Forth in the AAP-I series of working papers. Ramamani Sundar has reviewed research literature and emprical data on abortion costs and financing and presented significant information on public and private service providers. Author suggested state intervention is more effectively needed in the form of regulation, subsidies and social security.

We thank Sunanda Bhattacharjea for assisting in the language editing of this publication and Mr. Ravindra Thipse, Ms. Muriel Carvalho and Margaret Rodrigues for timely publication of this entire series.

This working paper series has been supported from project grants from The Rockefeller Foundation, USA and The Ford Foundation, New Delhi . We acknowledge this support gratefully.

We look forward to comments and feedback which may be sent to cehat@vsnl.com Information on this project can be obtained by writing to us or accessing it from the website www.cehat.org

Ravi Duggal
Coordinator, ***CEHAT***

22nd September 2003

ABSTRACT

The growing literature on abortions in the developing countries tend to focus on the health consequences of unsafe abortions and the limited access to abortion services, but does not look at the real and often crippling economic cost of abortion. A woman undergoing an abortion has to incur expenditure in various forms, both direct and indirect.

So far no all India household survey on abortion related expenditure has been conducted. However there are micro level surveys, which had been carried out in a specific state or a district, specially focussing on abortion. These surveys do throw some light on the expenditure incurred by women on abortion, although the sample size of abortion seekers covered by some of these studies is fairly small.

These studies show that women have to incur some expenditure to get MTP services even from public clinics, which are expected to provide free services. However, by and large the government providers seem somewhat cheaper and are probably safer than the others, especially the illegal providers.

Unfortunately, none of these studies have tried to look into the sources of financing the abortion expenses by the women. Also, the surveys included only women who had undergone an abortion from the approved MTP centres ; none of the surveys made an attempt to include the abortion seekers from illegal providers. Another limitation of these survey data on abortion cost is that it does include the cost of follow up care and this cost can be very high in case there is a complication after the MTP.

A visit to different types of MTP providers in Delhi reveals that there are a wide range of services available across the city. The type of providers include government hospitals, family welfare centres, clinics run by NGOs like the Family Planning Association of India and Marie Stopes, government approved as well as not approved qualified private doctors and illegal providers like dais and quacks. These providers cater to different segments of the city's population and the quality of services offered and the charges for abortion services also vary accordingly.

The safety and the cost of abortion, to a large extent would depend upon the method of abortion used. The dilation and curettage (D&C), is still the most commonly used method of abortion in India. The alternative method for early abortion, manual vacuum aspiration (MVA) is not widely available in the country even in the government run MTP clinics. As a result the average cost of abortions becomes very high.

Finally as far as abortion services are concerned, the option of insurance schemes is almost non- existent in the country. In fact in India health insurance is yet to pick up in a big way. Of the various schemes meant for the employees of the organized sector the ESIS, CGHS and the Railway Health Scheme provide MTP services for the women covered under their schemes in the hospitals run by them. Other insurance schemes as yet do not cover abortions .

A review of the available literature indicates that there is very limited data on the cost of abortion care in the country and hence

the first step is to increase the research in this critical area of financing for abortion care. We need to know not only about the abortion charges at the various types of MTP centres, but also the household dynamics like the source of financing the abortion etc. It is evident that even in the government facilities, the abortion seekers had incurred substantial expenditure. The state has to really look into this. In the case of private certified approved MTP centres, there do not seem to be any control over the quality of services as well as on the charges for the abortion services. We need much better regulation of private medical practitioners as well as dissemination of information to them so that women seeking an abortion are not exploited financially.

Glossary Of Terms And Acronyms

ANMs	Auxiliary Nurse Midwife
CHCs	Community Health Centres
Dai	*Untrained birth attendant*
D&C	Dilation and c urettage
FRUs	First Referral Unit
GA	General anaesthesia
IUD	Intrauterine Device
MCH	Mother & Child Health
MVA	Manual Vacuum Aspiration
OPD	Out Patient Department
OT	Operation Theatre
PHCs,	Primary Health Centres
PP	Post partum
RH	Rural Hospitals

ABORTION COSTS AND FINANCING
A REVIEW

I. INTRODUCTION

There is a growing literature on the health consequences of unsafe abortions in the developing world and the need to make safe and easy abortion available to all women who need them. However, this growing literature tends to focus on the health and psychological costs of poor or limited access to abortion. It does not look at the very real and often crippling economic costs of obtaining abortion. The access to abortion services not only includes the availability of good quality care in all geographical locations (especially at the primary level of care) and assured privacy and confidentiality, but also means that the services should be available free or at an affordable cost. The cost of an abortion can be substantial for women who turn to the private sector and even when women seek an abortion from the MTP centres run by the government, the services are not free and women do incur some expenditure (CORT, 1996, CORT 1997a, IIHMR, 2000).

In addition, the public health facilities have a tendency to put pressure on women to accept sterilisation or a long acting contraceptive like intrauterine device (IUD) after an abortion (Passano, 2002, Khan, M.E. et al 2001, Ganatra, B.R., et.al. 1996). The linking of MTP services with compulsory adoption of contraception reduces women's willingness to use the free services that are available (Ravindran, T.K.S. and R.Sen, 1994). Although after the official announcement of a 'target free approach' in 1996, the system of staff requiring to meet quotas for sterilisation acceptance is supposed to have been abolished, in practice nothing much has changed. This is not only true of public providers, but is also the case with some of the leading NGOs, who offer safe abortion services at a fairly reasonable cost. For instance, the data collected from the out patient department (OPD) registers of the clinics of the Family Planning Association of India at Delhi showed that of the sample of 811 women who underwent MTP in their clinics during the year 2001-02, 70 per cent had undergone tubectomy and another 27 per cent had gone in for IUD. While contraceptive counselling is essential to prevent the common phenomenon of repeat abortions, what is of concern is that too often this counselling is replaced by pressure to accept terminal methods of birth control.

There is very little data on the economic factors that may limit access to abortion. Several groups of women may not be able to afford the cost of an abortion. This includes not only poor women, but also women who have to obtain an abortion in secret and therefore cannot get family money for this and young unmarried women who similarly cannot turn to their families for help. Since there is lack of privacy and confidentiality in public health facilities, these women turn to private providers who exploit the situation and charge an exorbitant fee (Chakravarthy S, 1996, Passano, P .2002). A woman undergoing an abortion has to incur expenditure in various forms, both direct and indirect. While the direct cost includes

expenditure incurred on travel to the clinic, hospital and room charges, doctors fee and cost of medicine, food and follow up care, in case the abortion results in complications, the indirect cost would also include the loss of wages.

In India, where there is no system of health insurance and private expenditure on health is much greater than government expenditure, there is therefore a need to know much more about the costs of abortion and the economic barriers to abortion. The present paper reviews existing empirical data and the research literature to understand some of these costs. This information is likely to point to areas where the state can intervene more effectively in the form of additional regulation, targeting the provision of abortion clinics, provide subsidies and social security in the form of insurance.

- In Section II of this paper, the findings of some of the household surveys conducted in various parts of India are put together to get an idea of the expenditure incurred by women for seeking abortion services from different types of providers across various states.
- Section III looks at the charges for abortion services in different types of MTP clinics in Delhi and the socio-economic background of women who visit these facilities.
- Section IV covers the cost effectiveness of different methods of abortion. The discussion ranges over the debate on D&C Vs MVA and Medical abortion Vs Surgical abortion.
- Section V studies the role of the state in improving access to MTP services. It provides an appraisal of the trend in government funding for MTP services and government subsidies to institutions providing MTP facilities in the form of supply of equipment and free training of doctors, followed by an assessment of the role of the government in improving the accessibility of MTP services.
- Section VI deals with health insurance schemes and abortion, the financial burden of abortion cost on the households and the availability of insurance schemes are discussed.
- Section VII the last section, concludes with suggestions on some policy recommendations and a future empirical research agenda on abortion cost and finance.

II. Household Expenditure Abortion : Findings from Serveys

In India, nationally representative household surveys on health care utilisation and expenditures have been undertaken by the National Sample Survey Organisations (NSSO), the International Institute of Population Sciences (IIPS) and the National Council of Applied Economic Research (NCAER). The two rounds of National Family Health Surveys conducted by the IIPS and the NSS 52nd round on Maternal and Child Health Care collected detailed information on maternal and child health seeking behaviour, but it did not gather any data on household expenditure. Although the all India morbidity surveys conducted by the NSSO and the NCAER collected data on expenditures incurred by the households on morbidity, they do not have any data on abortion related expenses. However, there are smaller surveys, which had been carried out in a specific state or a district, specially focussing on abortion services. This includes studies undertaken by the Centre for Operations Research and Training (CORT) and Parivar Seva Sanstha (PSS). In addition to these studies, organisations like the Centre For Enquiry into Health Allied Themes (CEHAT), Foundation for Research in Community Health (FRCH) and the Indian Institute of Health Management Research (IIHMR) have conducted surveys either on

health status of women in general or on the reproductive health of women. Though the sample size of abortion seekers covered by some of these studies is fairly small, the studies do throw some light on the expenditure incurred by women on abortion.

The two studies conducted by the FRCH are probably the earliest attempts to understand household expenditure on health care in the country. The first FRCH study covered 1629 households over three rounds (average of 543 households per round) in the Jalgaon taluk of Maharashtra (Duggal Ravi and Suchetha Amin, 1989). In addition to collecting information on morbidity, this survey also collected data relating to utilisation and expenditure on maternity services, for a period of 18 months (Jan 1986 to June 1987). Only 7 cases of MTPs were reported during the period and all the abortions were performed in private hospitals both in the case of rural as well as urban population. The average cost of an abortion had worked out to be Rs 300.43. Considering that the mean per capita income of the sample households was as low as Rs1865.80 per annum, the abortion expenses must have upset their budget, since these women had to pay out such a large proportion of their income.

The second FRCH study was conducted in 770 households covering a population of 5202 in the two districts of Sagar and Morena in Madhya Pradesh (George, Alex et. al, 1994). The survey collected data on maternity events viz., pregnancy, abortion and delivery during the period 1 Jan 1990 to 31 January 1991, i.e. for 13 months. Only 8 abortion cases were recorded and the average cost per abortion was as high as Rs1258.13. The cost of abortion was higher in rural (Rs1497.83) than in urban (Rs539) areas, indicating the poor accessibility of free abortion services in the rural areas. Furthermore, the two events reported from the urban areas had availed of free services (not reported under paid events) and hence the cost was much lower. The study also reported that it was the household, which belonged to the lowest, and the lower middle economic status, which had spent more than a thousand rupees per abortion.

The Centre for Operations Research and Training (CORT) had carried out situation analysis of MTP services in the states of Gujarat, Maharashtra, Tamil Nadu and Madhya Pradesh. Besides examining the availability of facilities, methods used for MTP, the status of health personnel, including their training needs etc., these studies also made an attempt to contact some of the women who had availed of the MTP services from the sample clinics. The CORT study in the state of Gujarat was carried out during 1995-96 in 11 selected districts out of 19 districts in the state with a focus on rural areas (CORT, 1995). The study covered 54 PHCs, 27 CHCs and 54 private doctors\clinics performing MTP. In all 36 acceptors of MTP were interviewed and on an average, an acceptor had to spend Rs229, of which two thirds was towards doctor's fees. The remaining one-third was towards hospital room charges, medicine, transport and miscellaneous expenses. The average expenditure for private clinics was given as Rs394 and for public clinics it was lower at Rs136.

The study on the situation analysis of MTP services carried out by CORT in the 17 districts of Maharashtra in 1995-96 covered 60 PHCs, 38 Rural Hospitals (RH) and a sample of private doctors\clinics (CORT, 1996). As a part of the study 32 clients were contacted. The mean monthly family income of the acceptors was Rs1884 and on an average they had spent Rs376 for MTP services. While this was as high as Rs 447 in private clinics, in government clinics it was lower at Rs 361.

In the CORT study of situation analysis of MTP services in the state of Uttar Pradesh, the sample survey covered health facilities

registered for conducting MTP, spread over 25 districts including private rural doctors and private clinics in the semi-urban areas (CORT, 1997a). The study team contacted 126 acceptors of MTP services - 38 from block PHCs, 38 from CHCs, 24 from other government facilities and 26 from private doctors/clinics. The average monthly family income was Rs1431 for those who came to the public sector clinics, but it was higher at Rs 2360 for those who went to private clinics. The women who underwent MTP in block level PHCs spent on an average Rs 450, in CHCs it went up to Rs 484 and in other government hospitals it was as high as Rs 751. The acceptors of MTP services paid on an average Rs 649 in the private clinics. In other words, while those who sought abortion services from the public health facilities spent more than one third (37.3 per cent) of their monthly income, the acceptors who went to private clinics spent marginally more than one fourth (27.5 per cent) of their monthly family income. The acceptors of MTP services mentioned that they had paid doctors fees in all categories of hospitals, although it was supposed to be free in public facilities. This roughly accounted for 40-45 per cent of total expenses in different category of clinics except in other government clinics where it was 52 per cent. In both government and private clinics hospital room charges also contributed substantially to the total expenditure. Expenditure on medicines was more or less the same in all categories of clinics.

The study on the situation analysis of MTP services in the state of Tamil Nadu was carried out in 8 districts during 1996-97 (CORT, 1997b). In all 38 block PHCs and 19 sub-district hospitals were included in the sample. Since the private hospitals were touchy about the subject the study team could include only 6 of them. Similarly, due to difficulties in tracing the acceptors of MTP services, only 14 women who underwent abortion in public facilities were interviewed. On an average they had incurred an expenditure of Rs 450 for undergoing abortion.

All the four CORT studies showed that the costs of abortion varied considerably across the states and by type of provider, i.e. whether the services were received from the public or private clinics. The studies revealed that the women had to spend between Rs136 to Rs 534 for receiving the services from the government clinics. In case of private clinics, the cost ranged between Rs 394 to Rs 649. On further questioning the providers revealed that the expenses for MTP were directly linked with the gestation period at the time of MTP. For instance, it ranged from Rs 331 in case of pregnancy within 12 weeks, Rs 574 when pregnancy was 12-20 weeks and Rs 935 if the pregnancy was more than 20 weeks (CORT, 1998).

The study conducted by CEHAT in Mumbai on women's health care focussed mainly on the pattern of morbidity, utilisation of health care services and the expenditure incurred on treatment (CEHAT, 2001). In this study, from a sample of 466 currently married women information relating to maternity events and use of contraceptives was recorded for the reference period of one year (May 1995 to April 1996). Only 3 cases of abortion were reported and all these MTPs were performed at the private clinics. The average expenditure on abortion worked out to be Rs 989.

The IIHMR carried out a study on the financing of RCH care in Rajasthan in 1999 covering both the government financing of RCH program in the state as well as the household expenditure on maternal and child health care (IIHMR, 2000). A survey of 1100 households (726 rural and 374 urban) was conducted in the Udaipur district of Rajasthan. In these sample households all married women of reproductive age, except

those who had been sterilised, were asked whether they had used any abortion services in the past two years Out of 864 women, only 40 women had reported that they had had an abortion. Among those who responded affirmatively, 50 per cent chose government providers and another 50 per cent had opted for a private facility. The study found that 90 per cent of all women who had an abortion incurred expenditure of some kind. The average expenditure for all users (including those who did not pay anything) worked out to be Rs 925 and the average expenditure for the users of private and public facilities were Rs 977 and 873 respectively. Medicines absorbed the major proportion of expenditure (51 per cent), especially among women using government services, implying that users of public services also had to purchase medicines from outside. Users of private services had comparatively paid more for travel and lodging. Interestingly even in the case of users of government services the consultation charges accounted for 23 per cent of the expenses.

The Parivar Seva Sanstha had conducted a survey of abortion seekers in Calcutta, Lucknow and Delhi in 1999 with the help of Grasp consultants and with financial and technical support from the Population Council (PSS, 1999-2000). Three hundred women who had undergone an abortion during the past six months from the date of the survey (November 1999) were interviewed. The sample was split equally across three cities and both rural and urban areas were covered equally. The urban sample included population living in slums and resettlement colonies as well as all other population. The rural population included women who usually visit *untrained birth attendant (dai*s) who may not have received any training in conducting abortions. Thus, the sample of abortion seekers was selected from different localities, accessing different types of facilities. The survey showed that though abortion seekers considered legal centres to be more expensive than the illegal service providers, the actual cost of abortion from the latter (mean cost of abortion is Rs 802) turned out to be higher than in legal centres (where the mean cost is Rs725), particularly in Lucknow and Calcutta. In Delhi, women who had sought abortion services from legal providers had on an average spent Rs 1195, whereas those who went to 'illegal but good' (qualified doctors but without the government approval as a MTP clinic) had paid only Rs 930. However, women who sought the services of 'illegal and bad' providers (quacks, *dai*s etc) had paid on an average Rs 1000.

This only goes to prove that seeking abortion services from quacks and *dai*s need not work out to be cheaper than the service provided by qualified doctors

However, another recent study by the Parivar Seva Sanstha showed that on an average the acceptors of MTP services at government facilities incurred more expenditure as compared to women who sought abortion services from private doctors, *dai*s and ANMs (who conducted abortions privately) (PSS, 2002). Although the rapid appraisal of abortion clients undertaken in the districts of Orissa had a sample of only 23 abortion seekers, the study was qualitative in nature and case studies were conducted to understand the dynamics of unintended pregnancies. The abortion seekers who went to government facilities had incurred an average expenditure of Rs 553 as compared to Rs 400 for private, Rs 300 for *dai*s and Rs 400 for ANMs. In addition to this, the abortion seekers had spent Rs 455 towards the cost of drugs. It is interesting to note that the average cost of treating post abortion complication has worked out to be marginally lower for those who went to government facilities (mean cost Rs 217) as compared to those who went to private (mean cost Rs 250).

It is evident from all the studies that women have to incur some expenditure to

Table 1. Cost of Abortion: Findings from Household Surveys

Sl. No.	Study	Study Area	Reference Period	Sample Size of Abortion Seekers	Av. Household Expenditure Per Abortion (Rs)
1	FRCH,1989	Jalgaon Taluk,	Jan 1986- June 1987 Maharashtra	Private - 7	Private - 300.43
2	FRCH,1994	Sagar & Morena Districts, MP	Jan 1990 -91	- 8	Rural - 1497.83 Urban - 539 Total - 1259.13
3	CORT,1995	Gujarat (Mainly Rural)	1995-96	-36	Private - 393.50 Govt. - 135.80 Total - 228.90
4	CORT, 1996	Maharashtra (Mainly Rural)	1995-96	Private - 4 Govt. - 28 Total - 32	Private - 446.80 Govt. - 361.30 Total - 375.50
5	CORT, 1997a	Uttar Pradesh (Rural)	1996-97	Private - 26 Govt. - 100 Total - 126	Private -649.20 Govt. - 533.90
6	CORT,1997b	Tamil Nadu (Rural)	1996-97	-14	Govt. - 450
7	CEHAT, 2001	Mumbai	1995-96	Private - 3	Private - 989
8	IIHMR,2000	Udaipur Dist. Rajasthan	1999	Private - 20 Govt. - 20 Total - 40	Private - 977 Govt. - 873 Total - 925
9	PSS, 1999-2000	Delhi Calcutta Lucknow	1999	- 300	Legal Providers - 725 Illegal but good - 846.67 Illegal and bad - 802
10	PSS, 2002	Orissa 3 Districts	2002	- 23	Private -400 *Dais* - 300 ANMs - 400 Govt. - 553

get MTP services even from public clinics, which are expected to provide free services. These studies show that in the public health facilities the abortion seekers not only purchase the medicines from outside, but also seem to pay 'fees' in some form or the other. However, based on the findings of most of the studies one could conclude that by and large the government providers seem somewhat cheaper (although the differences in expenses were marginal in some cases) and probably safer than the others, especially the illegal providers. Only a small proportion of abortion seekers seem to know that abortion is legal and a large proportion of them are not aware that a service provider needs a special license authorising him/her to conduct an abortion (PSS, 2000-01).

These household surveys also point out the fact that the expenditure incurred by the abortion seekers varies a lot since there are a wide range of service providers. Even in the case of government approved MTP clinics there are wide variations and there is no government control either on the quality of services or on the charges to be levied. This

is confirmed by the visit to a number of MTP providers in Delhi, as the next section will indicate.

As pointed out earlier, in all the studies mentioned above, the sample size of the abortion seekers is very small and hence one cannot draw much inference based on such a small sample. It may be difficult to get hold of a large number of abortion seekers and interview them in a survey of this sort. The CORT studies also faced a lot of field problems in getting MTP acceptors on the day the team visited the sample clinics. To overcome these problems the names of acceptors who had availed the services within three weeks preceding the visit, were taken from the registers. However, some of the acceptors refused to be interviewed.

Since the various surveys are comparable neither in terms of sample size, nor in terms of their geographical coverage, one cannot draw any conclusion about the trend over the years in the household expenditure on abortion.

Unfortunately, none of these studies have tried to look into the women's sources of financing abortion expenses. This is especially important for poor women, women who seek the abortion services without the consent of their husbands, women who are not economically independent and for unmarried girls who get the MTP done in utmost secrecy. Another limitation of the survey data on abortion cost is that it does include the cost of follow up care and this cost is often very high where complications follow an MTP.

III. Cost Of Abortion At Different Types Of MTP Clinics In Delhi

A visit to different types of MTP providers in Delhi revealed that there is a wide range of services available across the city. The type of providers include government hospitals, family welfare centres, clinics run by NGOs like the Family Planning Association of India and Marie Stopes, government approved as well as non-approved qualified private doctors and illegal providers like *dai*s and quacks. These providers cater to different segments of the city's population and the quality of services offered and the charges for abortion services also vary accordingly.

A. Family Planning Association Of India

The Delhi branch of the Family Planning Association of India (FPAI) was inaugurated in 1963 and the FPAI currently has clinics at two places in Delhi, one at RK Puram and another at Pitampura and is providing area specific health and family welfare services. These two clinics, which are called Reproductive Health & Family Planning Clinic (RHFPC), provide services like immunisation of children, antenatal check-ups and family planning services including MTP. Though these clinics cater to poor and low-income households of Delhi, currently (as of 2002) women who seek abortion services have to pay Rs 405. This includes Rs10 for the OPD card, Rs 45 for the Syringe and Laboratory charges and Rs 350 as fee for MTP services. In these clinics MTP is performed only up to 10 weeks of pregnancy or in the first trimester, since they do not want to take any risks and the Manual Vacuum Aspiration (MVA) method is used in these clinics. While the charges are uniform for all the patients, if a really poor patient makes a request, a 50 per cent concession is offered on the charges. Most of the women who undergo abortion are given painkillers and other medicines like antibiotics free of cost, since they get free supplies of these medicines from the Delhi Government. The acceptors of abortion have to spend only 3 or 4 hours at the clinic.

Though there is no coercion to subject the women to either undergo sterilisation or go in for an IUD insertion along with the abortion, they are counselled to accept a

method of family planning. Even though there is growing pressure on the government to dispense with the scheme of incentives and disincentives, cash incentives are offered in these clinics for accepting sterilisation, in keeping with the policy of the Delhi government. If a woman agrees to adopt the terminal method along with the abortion, not only is the abortion service free, but she is also given a cash incentive of Rs 250 for undergoing a tubectomy or Rs 160 to her husband for accepting vasectomy.

To understand the socio-economic background of the women who seek abortion services in the FPAI clinics, a random sample of 197 women was drawn from the OPD registers out of the 811 women who underwent MTP in 2001-02. The average age of the women and their husbands was 28 and 32 respectively. Nearly half of the women and 25 per cent of their spouses were illiterate. While only 8.6 per cent of women were graduates, among the husbands the percentage of graduates was higher at 17.8. The average monthly household income worked out to be Rs 3614 and as many as 39 per cent of them had a household income of less than Rs2000 per month. Another 25 per cent belonged to the Rs 2001 to 3000 monthly income categories (Table 2). Thus, most of the abortion seekers at this FPAI Clinic belonged to poor or low- income households. The cost of an abortion for these women works out to be 11 per cent of their monthly household income and this excludes other direct expenses like transport charges and indirect costs like loss of wages.

B. Parivar Seva Sanstha (Mariestopes Clinics)

The first Marie Stopes Clinics was opened in Delhi in 1979 with the objective of providing access to safe abortion, subsequent to legalisation of abortions in India in 1972. Today there are 34 clinics spread over a number of states and by the end of 2002-03, the number of clinics is likely to go up to 40. Though originally started only as a provider of abortion services, today the services available at the Marie Stopes/Parivar Sanstha Clinics include family planning counselling, supply of contraceptives, medical termination of pregnancies, gynaecological consultations, insertion of IUDs, male and female sterilisation, treatment for RTI/STI, diagnosis and treatment of infertility, mother and child immunisation (PSS 2000-2001).

The charges for MTP services vary from clinic to clinic, depending on the location of the clinic. Each clinic has a different price structure depending on the image of the clinic i.e. whether it caters to low or middle income households. Though there are no differences in the basic health care facilities offered by different Marie Stopes clinics, there might be 'Cosmetic' differences, e.g. better furniture etc. According to the PSS, the rates are fixed keeping in mind the paying capacity of women who seek the services and the rental value of the building in which the clinic is located etc. We are told that, as a policy they ensure that fee for an abortion does not exceed one week's wages. It is not very clear as to how this is ensured, since the rates are already fixed and within the clinic the charges do not vary from individual to individual. However, if a woman is really poor a clinic may subsidise her expenses, but each clinic has a limited number of cases (quota), which they can subsidise in a year. The charges for an abortion in Marie Stopes clinics vary from Rs 250 to 600 if the abortion is performed during the first trimester and the method used is Menstrual Regulation Syringe or MVA. If the MTP is performed within 12 to 16 weeks of pregnancy, the charges vary from Rs 450 to 1500. Beyond 16 weeks, starting with Rs1200, the charges may go up to Rs3000. If the abortion is done in the second trimester, women may be asked to either stay for one more day or asked to come twice.

Table 2. Socio-Economic Profile of Abortion Seekers at FPAI* & Marie Stopes Clinics in 2001-02

	FPAI	Marie Stopes
No. of MTPs	811	74307
Income **		
<1001	0.51	6.30 %
1001-1500	5.58	0.40 %
1501-2000	32.49	24.30 %
2001-3000	25.38	22.04 %
3001-above	36.04	46.96 %
No. of Living Children **		
0	3.05	17.77 %
1	12.18	23.97 %
2	45.18	27.89 %
3	24.37	18.77%
4+	15.23	11.59%
Post Abortion Contraception		
Condom	-	25 %
Oral Pills	0.50 %	15 %
DMPA	-	3 %
IUCD	26.80 %	10 %
Sterilisation	70 %	18 %
None	2.70 %	29 %
All	100	100

Note (*) : Data refers only to the Clinics in Delhi.

*(**) : In the case of FPAI the percentage distribution is based on the sample of 197 MTP Seekers*

The abortion seekers at the Marie Stopes clinics are also counselled into accepting an appropriate method of family planning. However, unlike the FPAI clinics in Delhi, in the Marie Stopes clinics, even if a woman accepts a post abortion sterilisation, she is charged for the MTP, may be at a subsidised rate. The incentive for accepting sterilisation varies from state to state depending on the state government's policy. For instance in the states like West Bengal, UP and Delhi there is incentive money, where as in Rajasthan it is not there. It is worth noting that of the 74,307 abortions conducted at the various Marie Stopes clinics in the country during the year 2001-02, only 18% had undergone sterilisation. Another 10% had got the IUD inserted after the abortion and as many as 29% of the women did not opt for any method of family planning.

The profile of the abortion seekers at the Marie Stopes Clinic revealed that nearly 19% of them already had 3 or more living children when they came for the abortion and another 28% had two living children (Table 2). Though most of the MTP clients of Marie Stopes clinics also belonged to poor or low income households, they seemed to be better of than the clients of FPAI clinics at Delhi. As many as 47 % of the abortion seekers at the Marie Stopes clinics had a monthly household income of more than Rs3000. Another 22 per cent belonged to the Rs 2001 to 3000 monthly income categories. However, more than 30% had a monthly income of Rs.2000 or less. Of the total number of MTP clients 87.5 per cent were Hindus and another 10 per cent were Muslims.

C. *Private MTP Providers (Government Approval)*

According to the data available with the Department of Family Welfare, Ministry of Health and Family Welfare, in 2001 the city of Delhi had nearly 400 government approved MTP centres. The private nursing homes/ clinics have to get the certificate from the government to run an approved MTP Centre and once in three years it has to be renewed. There is a wide range of service providers and the charges vary according to the quality of services, location of the centre and the patients to whom they cater.

Under this category of Government approved MTP providers, gynaecologists from

four nursing homes were contacted- two from East Delhi, one from South and one from West Delhi. A visit to a full-fledged nursing home in East Delhi which caters to the middle and upper middle class population, revealed that MTP services are offered to women only up to a maximum of 10 to 12 weeks of pregnancy. The gynaecologist mentioned that she would not like to take the risk of performing an abortion beyond the first trimester. The nursing home charges Rs 3000 for an abortion and this includes charges for the operation theatre (OT) and fee for an anaesthetist (since in this nursing home MTP is done under general anaesthesia). The nursing home does not seem to be getting unmarried girls as clients for MTP services.

On the road opposite this nursing home, there is another government approved MTP centre run by a lady doctor. This centre seems to be handling mainly abortion cases (17 to 18 cases a month), though she claims to provide other services as well. The doctor who is running the centre has a MBBS degree and training to conduct MTP. She seems to be terminating only pregnancies up to 10 to 12 weeks, and her charges vary from Rs 400 to 600. Interestingly, she had no hesitation in revealing the fact that her charges are much higher for unmarried girls and the charges may go up as high as Rs1500. It has been found in other studies also that generally the costs were higher for unmarried girls when the procedure had to be conducted in utmost secrecy (Passono, P. 2002). Unfortunately it was not possible to get a profile of these girls, since the doctor was quite secretive and was not willing to reveal any details.

A gynaecologist in a nursing home in Northwest Delhi, which is registered under the Nursing Home Act of the Delhi Government catering to middle class households of the locality, was contacted. Here again the gynaecologist seems to be providing MTP services only up to 10 to 12 weeks of pregnancy. The charges for a MTP are around Rs1200. This nursing home too does not seem to attract unmarried girls wanting to abort unwanted pregnancies.

While opting for an abortion the educated upper middle class women of Delhi seem very fastidious about the nursing home. A gynaecologist in a small nursing home (run by her husband and herself) in South Delhi mentioned that even though the nursing home is located in an upper middle class locality, only women from the lower middle class background attend the clinic, since her nursing home is not posh enough. Though the nursing home not being posh enough was mentioned by the gynaecologist, as a reason for the upper middle class women not visiting her nursing home, there could well be other reasons. The women in the neighbourhood may not prefer to be patients of this nursing home, as they may be keen to undergo abortion in secrecy. The charges for MTP services in this nursing home vary from Rs 600 -1000 with local anaesthesia and Rs1600 to 2000 with General anaesthesia. The charges do not increase in the case of unmarried girls. On an average the gynaecologist does 15 abortions in a month and again she would not entertain pregnant women coming for an abortion after the first trimester. Interestingly, she also offers medical abortion (see the next section for a detailed discussion on medical abortion) to women who come for the termination of pregnancy at an early stage (within 6 weeks). Though the medicine cost has come down drastically, she continues to charge a high fee (Rs 2000). In her opinion other doctors in South Delhi are charging much higher rates- Rs 3000 - 5000 for a medical abortion.

Two interesting observations emerge from the visits to the government approved private clinics in Delhi.

- Firstly, gynaecologists generally do not want to take the risk of providing MTP services to pregnant women beyond the first trimester. One probable reason for this could be that these nursing homes

might not have the necessary back up services, in case there is some complication during the MTP procedure.

- Secondly, as far as unmarried girls are concerned, even if they do approach an approved clinic, they seem to avoid full-fledged nursing homes (since these nursing homes are generally crowded) and choose the secluded ones. The doctor in the East Delhi clinic is attracting a lot of unmarried girls, since her clinic is on the first floor with the advantage of a lot of privacy. Hence, she seems to be taking advantage of her location and charging a high price. This is similar to the findings of other studies. For instance, the CEHAT study of Rural Maharashtra also found that for abortions outside marriage, most women gave secrecy the greatest priority and opted for a discreet and distance location involving a short waiting period (Gupte, Manisha et al 1997).

D. *Private Illegal Providers Of Abortion*

The predominance of unauthorised providers like the *dai*s, female paramedics and doctors practising in other systems of medicine seem very common in many parts of the country (Chhabra, R.and S.C. Nuna, n.d., and Maitra, N, 1997). However what is surprising is that even in a city like Delhi where nearly 400 government approved clinics are available, and a number of NGOs have outreach MCH activities specially in the slums and resettlement colonies, women still opt for the illegal providers. What are the reasons for this? How important is the cost factor? A visit to the Tigri camp and the resettlement colonies (near Khampur, Sangam Vihar) and discussions with the female field workers of an NGO working with adolescent girls and women in the reproductive age spans, provided some answers to these questions. The traditional *dai*s who try various methods of abortion (herbal etc) are not particularly inexpensive. They may charge anything between Rs 800 - 1000. In the case of terminating the unwanted pregnancy of an unmarried girl, the charges could be even higher. In spite of this, women prefer to approach the *dai*s or the unqualified doctors because of ignorance of the availability of approved clinics, as has been pointed out by the PSS study (PSS, 2000-01). If a woman has to go to any of the clinics run by the NGOs or the government facilities, a whole day would be needed; distance and time constraints are a major problem. This is especially difficult for women who seek the abortion services without the knowledge of their husbands or their in-laws and for women having small children. They are more familiar with the *dai* next door and also probably have more confidence in her, since the *dai*s also take care of them through child birth. It has been found by a recent study that nearly two-thirds of women living in the slums and resettlement colonies of Delhi deliver at home with the help of untrained *dais* (Sundar, R. et al 2002). This familiarity with the local *dais* and quacks gives the acceptors of abortion an additional advantage. It offers informal arrangements for paying the abortion charges like paying in instalments, loan against some surety, deferred payment etc.

IV. Cost Effectiveness Of Different Methods Of Abortion

A. *Dilation And Curettage (D & C) Vs. Manual Vaccum Aspiration (MVA)*

The safety and the cost of abortion would depend to a large extent on the method of abortion used. Dilation and curettage (D&C) is still the most commonly used method of abortion in India. D&Cs are usually done under general anaesthesia as an in-patient procedure. The alternative method for early abortion, manual vacuum aspiration (MVA) is not widely available in the country even

Table 3 : Cost of Abortion at Different Types of Providers in Delhi

Sl. No.	Type of Provider	Type of Clients	Services Offered	Charges
1	FPAI Clinics	Poor & Low Income Households	Only up to 10 Weeks Pregnancy	• Rs 405 (Rs10 for an OPD card, Rs 45 for Syringe & Lab Charges & Rs 350 as Fees).
2.	PSS (Marie Stopes Clinics)	Poor, Low and Middle Income Households	Up to 20 weeks Pregnancy	Up to 12 weeks- • Rs 250 to Rs 600. 12 to 16 weeks- • Rs 450 to Rs 1500. Over 16 weeks- • Rs1200 to Rs 3000.
3	Full fledged Private Nursing Home in East Delhi	Middle and upper middle income households	Maximum up to 12 weeks Pregnancy	• Rs 3000 under general anaesthesia (GA).
4	Approved MTP Clinic, East Delhi	Lower middle & middle income households	Up to 10 to 12 weeks	Married women- • Rs 400 to Rs 600. Unmarried girls- • Rs 1200. Medical Abortion • Rs 2500.
5	Private Nursing Home in North West Delhi	Middle income Households	10 to 12 weeks Pregnancy	• Rs 1200.
6	Private Nursing Home in South Delhi	Lower Middle Income Households	Up to 12 weeks Pregnancy	Under local anaesthesia- • Rs 600 to Rs 1000. Under GA- • Rs1600 to Rs 2000 Medical Abortion- • Rs 2000
7	Untrained *Dais* at Tigri Camp & Resettlement Colony	Poor and Low Income Households	Up to 12 weeks Pregnancy	• Rs 800 to Rs 1000.

in the government run MTP clinics. The operational strategies spelt out in the National Population Policy, 2000 includes expansion of access to safe abortion services through the introduction of simple and safe abortion techniques such as the Manual Aspiration Technique. Till recently in government hospitals D&C and Electrical Suction methods were being used. For instance the CORT study found that for first trimester abortions, the use of manual vacuum aspiration is low and the use of D&C was much higher at 72 per cent in CHCs, and 65 per cent in PHCs. (CORT, 1995).

The MVA has been pilot tested in three major government hospitals in Delhi and in view of its efficiency, the Medical Officers are being trained in this method, especially for use in rural areas for MTP. The Government

has developed the 'Guidelines for Medical Officers for Medical Termination of Pregnancies up to eight weeks using Manual Vacuum Aspiration Technique' to help the Medical Officers to provide safe abortion services using simple and safe techniques (Government of India, 2001-02). The Federation of Obstetrics and Gynaecological Societies of India (FOGSI) has issued a statement in support of the MVA method. MVA is considered to be quicker, safer and can be performed as an out patient procedure and often there is no need for general anaesthesia, hence there is less risk for

Table 4. Cost of MVA Vs D&C

Title of Study	Study Details / Interventions considered	Country	Key Findings	Reference
The cost of treating incomplete abortion in Kenya : a cost comparison of two treatment regimes	Manual vacuum aspiration Vs sharp curettage, in two hospitals, Eldoret and Machakos	Kenya	MVA reduced equipment costs by 3 per cent , reduced total stay in hospital by 41-76 per cent and reduced patient costs by 50 and 66 per cent in the two hospitals	Bradley J. Unpublished (Popline search finding), 1990
Linkages with treatment for incomplete abortions improve family planning services in Kenya	Analysing data from six hospitals, the study aimed to compare the cost, effectiveness and quality of alternative approaches to integrating emergency treatment of abortion complications with family planning	Kenya	35 per cent of gynaecology ward admissions resulted from incomplete abortion. The introduction of MVA required no anaesthetic, & smaller operation theatres. This reduced waiting times, and in Mombasa the average length of stay fell from 60 to 21 hours	Solo J, Billings D. Taken from Population Council website. n.d.
Hospitals reduce costs by improving post-abortion care	To cost post-abortion care in six countries in Africa and Latin America. Cost data for both MVA and D&C were collected	Africa Latin America	Cost per patient for D&C = $ 78.81, cost per patient for MVA = $ 8.50. 89 per cent lower median costs for MVA patients. Average length of stay was reduced from 36 to 15 hours The bulk of costs for both interventions are salaries, and costs	King TDN, Benson J, Stein K. 1998

Title of Study	Study Details / Interventions considered	Country	Key Findings	Reference
			associated with inpatient overnight stay.	
Use of MVA in reducing cost and duration of hospital-isation due to incomplete abortion in an urban area of north-eastern Brazil	Comparison of MVA and sharp curettage interventions for post- abor tion care.	Brazil	Patients treated for incomplete abortion with MVA spent 77 per cent less time in the hospital and consumed 41 per cent fewer resources than similarly diagnosed patients treated with SC.	Fonseca W, Misago C, Fernandes L, Correia L, Silveira D. Revista De Saude Publica 1997;31(5);472-478
Treatment of incomplete abortion ; manual vacuum aspiration versus curettage in the Maternal Perinatal Institute in Lima, Peru	Comparison of MVA and sharp curettage interventions for post- abortion care	Peru	The total time (preoperative, operative, post operative) was 271 min. for MVA, 290 min. for outpatient curettage with hospitalisation. The total mean cost per patient (manpower, supplies, and administration) was US $16.30 for MVA, $16.70 for outpatient curettage and $ 84.11 for curettage with hospitalisation. Given an average of 20 incomplete abortion cases per day, the Institute would save about $50,000 a year by treating uncomplicated abortion cases on an outpatient basis.	Guzman A, Ferrando; D, Tuesta L. Unpublished - Taken from Popline database 1995.

Source : Jowett, M, 'Safe Motherhood; Interventions in Low-Income Countries: An Economic Justification and Evidence of Cost Effectiveness' Health Policy 53 (2000) pp.201-228

women (Passano, 2002). Since using the MVA method does not require sophisticated back up equipment, it has been recommended that in early abortions MVA should be preferred over D&C to increase accessibility and for ensuring safety. While in the public health facilities MVM is being used only till eight weeks of pregnancy, in the private sector this method is used up to the first trimester. Currently all the gynaecologists at the medical college hospitals are being trained in MVA and they would in turn train the doctors at the lower level.

A number of studies have shown that using MVA with local anaesthesia reduces patients' health risks, lowers hospital costs and ensures speedy recovery. The use of manual vacuum aspiration rather than D&C can reduce the costs to both the providers and the patients and the evidence regarding the cost effectiveness of MVA is available especially for the treatment of complications arising from abortion. The studies conducted in countries like Kenya, Africa, Brazil and Peru show that cost per patient works out to be lower for MVA as compared to D&C for abortion procedure and for treating complications arising from abortion, in particular incomplete abortion (Jowett, M. 2000). The findings of these studies show that as compared to D&C, in the case of MVA, the cost per patient gets reduced due to various reasons like a fall in the average length of stay in the hospital, requiring only small operation theatres, not requiring anaesthesia etc. The studies conducted in Africa and Latin America showed that the bulk of hospital costs for both D&C and MVA are salaries, and costs associated with in-patient's overnight stay. Since the average length of stay gets reduced in the case of MVA, the cost also gets reduced. (For details see Table 4). The study conducted in a Maternal Perinatal Institute in Lima, Peru also showed that as a result of reduced total time, the total mean cost per patient which included cost of manpower, supplies and administration was much lower for MVA as compared to D&C with hospitalisation.

In India too the cost of abortion would be much less if the MVA method were used since the apparatus is cheaper and it could be chemically sterilised. Moreover, since electricity is not required, it can be used even in the rural PHCs where the supply of electricity is very erratic.

B. *Medical Abortion Vs Surgical Abortion*

In recent years a considerable debate is going on about the feasibility of introducing medical abortion, using the drugs Mifepristone and Misoprostol (RU486), as an alternative to surgical abortion for the termination of early pregnancy. Since medical abortion requires less extensive infrastructure than surgical abortion, it is argued that medical abortion can improve access to abortion and safety. There has also been a debate on the side effects of Medical abortion versus surgical abortion.

An international study of Mifepristone-Misoprostol medical abortion and surgical abortion was held in China, Cuba and India from October 1991 to August 1993 in which six urban clinics participated. In this study women with a pregnancy duration of 56 days could enrol for either surgical or medical abortion. The data collected from this comparative study showed that medical abortion clients experienced more side effects than surgical abortion (Elul, Batya et al 1999). The disparity between the two groups was particularly pronounced for bleeding (except for India where there were no significant differences by method) and pain. However, the study concluded that despite more reports of side effects among women who had opted for medical abortion, assessments of well- being and reports of satisfaction at the exit interview were similar in both treatment groups.

Based on three studies conducted in India (including the already mentioned

international multicenter projects with sites in China, Cuba and India) in the 1990s, it has been concluded that medical abortions are effective, acceptable to women, feasible and safe (Coyaji, K. 2000). According to the author, since it is not possible in the near future to create adequate infrastructure for surgical abortions in India, medical abortion could provide the alternative options especially in village settings. The author views were that though the cost of Mifepristone was high, cost could be safely and effectively reduced, by reducing the dose from 600mg to 200mg. Besides which, as compared to medical abortion, under surgical abortion one has to take into account other expenses like staff training and wages, operating room time etc. Moreover, the author was of the opinion that the cost of Mifepristone would drop considerably, once India started manufacturing the drug locally and included the drug in government programmes. Free distribution or distribution at subsidised rates through existing family planning clinics would be more cost effective.

In April 2002, the Drug Controller of India approved the manufacture of Mifepristone in India and three pharmaceutical companies are already in the market. Prior to this, the tablet was being smuggled into the country mainly from China and the gynaecologists were illegally getting the supply from the agents. Obviously the tablet was very expensive (costing nearly a thousand rupees) and hence women who opted for the medical abortions were also charged heavily. Currently, three pharmaceutical companies are importing Mifepristone and packaging and marketing it in India and the price of the tablet has come down drastically - it now ranges around Rs 300 for 200mg. Including the cost of Misoprostol, which is available at 20 to 30 rupees, the total cost of the tablets comes well within 350 rupees and due to competition it is likely to fall further. Even though the cost of the tablets has reduced considerably, the private doctors who are administering medical abortions continue to charge a high fee. A visit to some of the clinics in Delhi revealed that since not many women are aware of the cost of the tablets, the gynaecologists and doctors exploit those who opt for medical abortion. Some of the gynaecologists seem to offer abortion packages to women and the charges vary from Rs 2000 to 3000, depending on the location of the clinic and the clientele. This package includes an ultra sound test to make sure the abortion is complete.

Currently, Parivar Seva Sanstha is carrying out a project, sponsored by the Ministry of Health and Family Welfare, Government of India to study the clinical and social behaviour of women accepting termination of early pregnancy up to 56 days with oral Mifepristone followed by Misoprostol. This aim of the project is to find out the efficacy of the drugs with the reduced dosage of Mifepristone (instead of 600 mg of Mifepristone, only 200 mg is given) and to understand the behaviour and attitude of women. The Indian Council of Medical Research (ICMR) has already conducted a study in medical college hospitals to find out the efficacy of a reduced dosage of Mifepristone. The results were positive, in the sense that the abortions were complete. This 18-month project commenced in April 2002 and is being carried out at the Marie Stopes clinics in Delhi, Agra and Jaipur. Though the final results of this project are not available, according to the PSS the success rate so far is fairly high. Since the government sponsors the project, women who opt for medical abortion under this project do not have to pay for the medicine. They have to pay a consultation fee of Rs 50 and incur expenses on other tests (e.g. pregnancy test) which may cost another 50 rupees. If the findings of this project are positive, instead of 600 mg of Mifepristone, 200 mg. may be sufficient and this may reduce the cost even further.

Although the abortion pill holds much promise, it has its problems. In particular, even though it can be sold only by prescription, in a country like India it is very difficult to implement this and take stringent action against the lawbreakers. A leading newspaper had recently reported the rampant illegal over the counter sale of Mifepristone. This sounded alarm bells in the state of Uttar Pradesh (Times of India, 6 August 2002). Even though the tablets may cost around Rs 350, women may find this easier and a less expensive option than going in for surgical abortion. In addition they can get this done in secrecy. The free availability and the unsupervised consumption of abortion pills can lead to severe haemorrhages and incomplete abortion resulting in life threatening emergency. Constant supervision and adequate backup facilities of trained doctors is required. Furthermore women have to be very alert and aware, which is hardly the case in India. In fact if taking abortion pills without the supervision of a gynaecologist leads to complication, medical abortion could prove to be more expensive.

V. Role Of The State In Improving The Access To MTP Services

The number of government approved institutions in the country has increased from 3294 in 1980-81 to 9759 in 2000-01, and the number of terminations done per year in these centres has gone up from 388,405 to 721,428 during the same period. The increase in the number of legal abortions could be partly due to the passing of the MTP Act, which has resulted in the increase in the number of approved MTP centres. During the last two decades, the number of women in the reproductive age group has also gone up. Unfortunately, no data\information is available which could tell us whether the number of abortions per woman has increased over the years. According to the data collected in the two rounds of the National Family Health Survey on the pregnancy outcomes of married women in the age group of 15-49, the percentage of pregnancies resulting in induced abortion has increased marginally from 1.3 in 1992-93 to 1.7 in 1998-99 (IIPS, 1995 & IIPS, 2000). (Since the cases of induced abortions are generally suppressed by women, or may be reported as spontaneous abortions, the spontaneous abortions are grossly underestimated in the surveys and hence should be interpreted with caution).

It is fairly well known that that these legal abortions form only a small proportion of the total abortions taking place in the country. It is estimated that the number of illegal abortions is 2 to 6 times more common than legal abortions. What are the reasons for this? The lack of awareness about the availability of safe abortion services and the lack of privacy and the impersonal atmosphere in government run clinics are some of the factors responsible for this phenomenon. Besides this, the availability of the government approved MTP clinics is inadequate. Firstly, the availability of abortion services varies widely across states. Almost half of the facilities for safe abortions are concentrated in four states (Maharashtra-21 per cent, Gujarat-12 per cent, Tamil Nadu-10 per cent and West Bengal-7 per cent), which accounts for only 28 per cent of the country's population. There is also a concentration of these centres in the cities, though more than 70 per cent of Indians live in the rural areas.

The non-availability of authorised clinics in the rural areas and lack of financial resources to reach the clinics in urban areas is one of the reasons for women living in the villages opting for illegal abortion. For rural women the Primary Health Centre is probably the nearest place where they can avail safe abortion services at a reasonable cost (even though in government facilities the services are free there could still be some

expenditure). However, most of the PHCs do not have the facility for conducting MTPs. According to Phase 1 of the Facility Survey conducted in 1999 in 221 districts, hardly 3 per cent of the PHCs in the country are providing MTP services (IIPS, 2001). The Facility survey shows that there are wide variations across the states in the availability of medical officers and the PHCs offering MTP services (Table 5). It is interesting to note that states like Tamil Nadu and Goa respectively have 35 per cent and 59 per cent of PHCs with at least one medical officer trained in MTP, but only 2 per cent and 8 per cent of the PHCs respectively are providing abortion services. This clearly reflects the mismatch between both the availability of skilled manpower and the infrastructure facilities. It is quite possible that in these PHCs although the Medical Officers are trained, they are not able to provide the services because the PHCs may not have proper buildings and other facilities. On the other hand, in the state of Punjab, although only 10 per cent of the PHCs have a medical officer trained in MTP, 22 per cent of the PHCs are providing MTP services. This is possible because in many states if the PHC does not have a doctor trained in MTP it is a common practice to arrange for doctors from the CHCs to visit the PHCs on a particular day (may be once every week\fortnight) and carry out abortions.

According to the studies conducted by CORT in the four states of Gujarat, Maharashtra, Tamil Nadu and Uttar Pradesh, the main reason for not providing abortion services in the PHCs and the CHCs turned out to be a lack of trained doctors to conduct the procedure and non availability of required equipment (Khan, M.E. et al 2001). Other studies have also focussed on the inadequacy of trained manpower and equipment to carry out abortion services in the rural areas through the public health care system and the lack of funding for the maintenance and expansion of abortion services (Ravindran T.K.S and R.Sen, 1994 and Jesani, A., and A.Iyer 1993). The CORT studies concluded that the vast gap between demand and supply

Table 5. Availability of MTP Services at PHCs

Sl. No.	States/Union Territories (UTs)	% of PHCs having at least one medical officer trained in MTP	% of PHCs having suction aspirator	% of PHCs giving services in MTP
1	Andhra Pradesh	14	15	2
2	Assam	14	7	8
3	Bihar	6	7	1
4	Delhi	0	20	20
5	Goa	59	35	18
6	Gujarat	14	40	1
7	Haryana	4	21	1
8	Himachal Pradesh	14	18	14
9	Karnataka	10	13	8
10	Kerala	18	8	4
11	Madhya Pradesh	3	3	2
12	Maharashtra	17	28	1
13	Orissa	9	21	1

Continued....

Sl. No.	States/Union Territories (UTs)	% of PHCs having at least one medical officer trained in MTP	% of PHCs having suction aspirator	% of PHCs giving services in MTP
14	Punjab	10	49	22
15	Rajasthan	2	18	4
16	Tamil Nadu	35	17	2
17	Uttar Pradesh	4	19	1
18	West Bengal	3	3	1
	All India (Incl. other States & UTs)	13	16	3

Source : Facility Survey, Phase-I, 1999, International Institute for Population Sciences, Mumbai

is largely due to lack of proper planning and allocation of resources. In the opinion of the authors all the 'A' type Post Partum (PP) Centres that have adequate case loads could be converted into training centres. To designate an A type PP centre as an abortion training centre a maximum of Rs 2000 per year would be required (Khan, M.E. et al 2001). Though these studies were done in the mid- 1990s, nothing much has changed since then. The first phase of the Facility Survey conducted in 1999 also revealed that only 13 per cent of the PHCs in the country had at least one medical officer trained in MTP. In Tamil Nadu the situation seemed slightly better with 35 per cent of the PHCs having medical officers trained in performing MTP (Table 5).

Similarly, only 16 per cent of the PHCs covered by the Facility Survey had MTP equipment like suction aspirators, though the situation was somewhat better in states like Gujarat (40 per cent) and Punjab (49 per cent). This reveals the apathetic attitude of the government towards expansion of abortion services and attempts at improving the accessibility of safe abortion services.

Since 1991-92, the central government has been allocating only Rs150 lakhs per year for the abortion programme. Though in 1995-96 Rs 980 lakhs was requested for increasing the abortion centres and strengthening the services, but because of the resource crunch again only Rs 150 lakh was allocated for the abortion programme (Khan,M.E. et al 2001). After the initiation of the Reproductive & Child Health (RCH) programme in 1997-98, Medical Termination of Pregnancy became one of the important components of the RCH programme. Since then, in the budget documents the allocation of funds for the MTP programme has not been shown separately and been included as a part of the RCH programme. Now under the 10th Five Year Plan, an amount of Rs 1.20 crores has been allocated as transfer to states in the year 2002-03 (Budget Estimate 2002-03) exclusively ear marked for MTP services (Ministry of Health and Family Welfare 2002-03).

In an effort to expand and strengthen safe abortion services, under the RCH programme the government has taken some initiatives. For instance, to meet the shortage of trained manpower in PHCs/CHCs and sub-district hospitals, the scheme of Safe Motherhood Consultants are being introduced. Under this scheme, the central government releases funds to states and Union Territories for engaging private doctors trained in MTP techniques, to visit

Table 6. State/UT wise Allocation of Funds for SM Consultants and Supply of MTP Equipment under RCH Program

Sl. No	States	MTP Set #		SM Consultant - Funds released - in lakhs
		No. of Kits	Estimated Value (Rs)	
1	Andhra Pradesh	10	65000	7.44
2	Arunachal Pradesh	3	19500	1.20
3	Assam	10	65000	2
4	Bihar	7	45500	0
5	Jharkhand	3	19500	0
6	Goa	1	6500	0
7	Gujarat	10	65000	10.08
8	Haryana	10	65000	15
9	Himachal Pradesh	3	19500	0.50
10	J & K	3	19500	1.80
11	Karnataka	10	65000	8
12	Kerala	10	65000	0
13*	Madhya Pradesh *	10	65000	2
14	Maharashtra	10	65000	5
15	Manipur	3	19500	2
16	Meghalaya	3	19500	0.60
17	Mizoram	1	6500	20.74
18	Nagaland	3	19500	0
19	Orissa	10	65000	7.56
20	Punjab	10	65000	0
21	Rajasthan	10	65000	0
22	Sikkim	1	6500	3.60
23	Tamil Nadu	10	65000	0
24	Tripura	1	6500	0
25	Uttar Pradesh	10	65000	184.65
26	West Bengal	10	65000	41.88
27	And. & Nic. Island	1	6500	0
28	Chandigarh	1	6500	0
29	Dadra & Nagar Haveli	1	6500	1.80
30	Daman & Diu	1	6500	0
31	Lakshadweep	1	6500	0
32	Pondicherry	1	6500	0.20
33	Delhi	1	6500	0
34	Reserves	1	6500	-
	Total	180	1,170,000	316.05

Note (*) : Includes Chattisgarh

(#): MTP Set worth Rs 6500 includes S. S. Bowl (18-20 inch diameter), Sponge Holding Forceps, IS: 7735,Sim's Speculum, IS: 6112, Anterior Vaginal Wall Retractor, IS: 5849, Uterine Sound, IS: 5829, Vulsellum, IS 6114, Curette (Double ended), Sharp / Blunt, IS: 6505, Ovum Forceps, IS: 6578, Dissecting Forceps, IS: 3643, Dilators (Hegar's pattern), I mm to 12 mm, IS: 6584, Suction Machine (Facility for negative suction upto 760 mm, with safety device), IS: 7080, Karman's Cannula (No. 6,7,8), IS: 8313 (4 Sets each)

(Source : From the records of the Ministry of Health and Family Welfare, Government of India.)

these institutions once a week or at least twice a fortnight on a fixed day for performing MTPs. These doctors were initially paid at the rate of Rs 500 per day. Now the amount has been increased to Rs 800 per day. Since 1997-98 (till Nov 2002) the government has released Rs 316.05 lakhs to the states and Union Territories (Table 6).

However, the states and Union territories have so far utilised only one third of the allotted amount and in fact very few states have reported expenditure under this account. This indicates either the non-availability of trained manpower that is willing to work in rural areas at this rate or lack of other infrastructure to implement this scheme in the PHCs. It is indeed heartening to note that the government has taken a decision to train all the medical officers of the PHCs in MTP. The Facility Survey results (Table 5) indicate that this would solve only part of the problem. In addition to training the doctors, other facilities and adequate infrastructure at the level of PHCs and CHCs should also be improved. If the facilities at the PHCs and CHCs were improved, perhaps more women would access these facilities rather than spend a lot of money at private facilities. By switching over to methods like MVA, the cost to the government would also be reduced since the apparatus required for MVA is cheaper, there is no need of electricity and it can be sterilised chemically.

In order to improve the availability of abortion services, MTP equipment is being procured centrally and provided to District hospitals, first referral units (FRUs), CHCs and PHCs through their respective medical store depots. Since the inception of the RCH programme i.e. since 1997-98, the government has supplied 180 MTP sets worth Rs11.70 lakhs (Table 6). The estimated value of each set is Rs 6500. The item description of the MTP set is presented along with the table. While most of the major states have received 10 sets, states like Himachal Pradesh, Jammu & Kashmir, Meghalaya, Manipur and Nagaland have so far received only 3 sets. All the other smaller states and Union Territories have got just one set each. Considering the current status of availability, this is hardly going to improve the situation.

In addition to the problem of non-availability of trained manpower and the availability of equipment, there is also a mismatch between the availability of trained doctors/specialists like anaesthetists and the availability of infrastructure like OT in a number of CHCs (NCAER, 2002)

VI. Health Insurance Schemes And Abortion

It has been well documented that households face enormous financial burdens in the form of out of pocket expenses to pay for health care and health spending in India goes mostly to private facilities (NSSO, 1998, Sundar, 1995, Sevaraju, 2000). This has significant adverse implications for the economic well being of the affected households, especially the poor households. The failure of the Indian public health care system to provide quality care to the people is to be blamed for this excessive financial burden on poor households. Public health care in the country suffers from under funding and accessibility problems and as a result people are forced to depend on the private health care sector, which is relatively more expensive. Keeping the financial burden on the households within a reasonable limit is a matter of policy concern. The solution for this could be found either by improving the quality and accessibility of public health services, or through the provision of health insurance schemes.

In India, given the resource crunch it is not possible to expect any drastic improvement in the public health services in the near future. In fact severe resource constraints have led the policy makers to consider alternative sources of financing the public health care system and the Health Policy 2002 'recognises the practical need

for levying reasonable user charges for certain secondary and tertiary public health services, for those who could afford to pay.'

As far as abortion services are concerned, the other option of insurance schemes is also almost non-existent in the country. In fact in India health insurance is yet to pick up in a big way. The Maternity Benefit Act, which was enacted as early as 1961, provides leave benefits for women workers during the six weeks immediately following the day of delivery, miscarriage or abortion. This maternity benefit is to be provided to all women on completion of 80 working days during the preceding twelve months. Currently, the major health insurance schemes are either state run schemes for the employees in the organised sector Employees State Insurance Scheme (ESIS) or the schemes for government employees like the Central Government Health Scheme (CGHS) and the Railway Health Insurance Scheme for railway employees. Besides these, there are public sector insurance schemes like the Mediclaim Health Insurance Plan of the General Insurance Corporation, the Senior Citizen Plan of the Unit Trust of India and schemes like Asha Deep of the Life Insurance Corporation of India. There are also community based health insurance schemes primarily for workers outside the formal sector (e.g. SEWA of Ahmedabad, Sevagram of Warda, CINI of Daulatpur in West Bengal etc.). Although most of these community based health insurance schemes provide preventive, promotive and curative health services, including Mother & Child Health (MCH) activities, they do not seem to cover MTP services.

Of the various schemes meant for the employees of the organised sector the ESIS, CGHS and the Railway Health Scheme provide MTP services for women covered under their schemes in the hospitals run by them. In the case of women employees who are insured under the ESIS scheme, both cash and medical benefits are provided for maternity related health care including MTP. The ESIS, launched in 1948 is essentially a compulsory social security benefit to workers in the industrial sector. The ESIS covers nearly 80 lakh persons (employees and their families) and this includes 14 lakh women (ESIS, 2001- 02).

In the ESIS hospitals 14,878 MTPs have been performed during the year 2001-02. Since MTP services are offered only as a family planning method (ESIS, 2001-02) the number of MTPs performed is shown as a part of the 'achievements under their Family Welfare Programme'. In fact, discussions with a gynaecologist in one of the ESIS hospitals in Delhi revealed that they offer free abortion services even to those women who are not covered under their scheme provided they are willing to undergo sterilisation. The same is true of the CGHS Maternity and Gynaecology Hospital in south Delhi. While the MTP services are available to all those covered under the scheme, for outsiders, abortion services are available only as a family planning measure i.e. with the acceptance of sterilisation, as this would enable them to full fill their 'quota' of sterilisation.

Even though a target free approach has been officially announced, in practice there are indirect pressures to meet the target.

The Mediclaim plan, which is run by the General Insurance Corporation (GIC) of India, which is meant for the general public, covers only hospital care. This scheme by and large caters to the upper middle and high-income group and as on March 2002 more than 70 lakh persons are receiving cover under the scheme (Annual Reports of the four subsidiary companies of GIC-2001-02). There has also been a tremendous increase in enrolment for the Medical Claim policy. However, under this policy only hospitalisation expenses are covered, while routine out patient care is excluded. The policy, however, not only excludes reimbursement of expenses against certain diseases, but also any ex-

penses related to pregnancy. Pregnancy and childbirth are covered only under the group insurance scheme as a benefit policy. The GIC in its effort to expand coverage introduced another policy in 1996 called the Jan Arogya Bima Policy, to cater to the health needs of people belonging to lower income groups. Since the annual premium is nominal, it has attracted a lot of people (around 3.5 lakh people as on 31st March 2002). This scheme also excludes pregnancy, childbirth and voluntary termination of pregnancy.

Several NGOs and governments worldwide have started micro- credit schemes for vulnerable groups as an effective tool for poverty reduction. To plug the erosion of income and reduce indebtedness for health care needs, some NGOs like SEWA (Self-Employed Women's Association), have introduced health insurance schemes for their members. It is rather surprising that even the health insurance scheme of SEWA which is specially designed for women, covers deliveries but does not include abortion care (Gumber Anil and Veena Kulkarni, 2000).

Given the current scenario of the availability of health facilities and the acceptors of abortion services, is it possible or even feasible to introduce schemes to include insurance cover for abortion care? In a country where illegal abortions are rampant, introduction of insurance schemes may encourage more women to opt for an approved MTP clinic even if it proves to be more expensive.

Some studies point out that a number of women seek abortion services without the knowledge of their husbands and other fam-

Table 7. Salient Features of Important Health Insurance Schemes

Sl. No.	Type of Health Insurance Scheme and year of commencement	Coverage, Age & Sum Insured	Details about the inclusions and Exclusions
1	Mediclaim,1986 General Insurance Corporation (individual\family\ group)	Individual aged 5-75 & Family 3 months to 75 years. Rs15,000 to 5,00,000	Only hospitalisation coverage with exclusion of pre-existing conditions Pregnancy & Abortion not included
2	Jan Arogya,1996, GIC (Individual\family)	Age group up to 70 years Sum assured Rs 5000	Same as above
3	Asha Deep, 1995 Life Insurance Corporation	Individual aged 18-50 years Rs 50,000 to 3,00,000	Endowment policy with coverage of four ailments- cancer, paralytic strokes, renal failure and coronary heart diseases
4	Central Government Health Scheme	Central government employees (current & retired) and families	All types of services, including MTP.

Continued....

Sl. No.	Type of Health Insurance Scheme and year of commencement	Coverage, Age & Sum Insured	Details about the inclusions and Exclusions
5	Railways Health Insurance Scheme, 1948	Railway employees and families (current and retired)	Delivery of all types of services including delivery and MTP, through hospitals and dispensaries located in Grade A stations
6	Employees State Insurance Scheme, 1948	Any employee and his/her family in an organised sector with monthly wages under Rs 6500	Medical and cash benefits through the dispensaries and hospitals. Covers maternity benefits including MTP. MTP is done free of cost in the ESIS hospitals. This extends to non insured persons also with acceptance of sterilisation
7.	SEWA, Ahmedabad, Gujarat. Union started in 1972,Health Programme in 1984	Union of self employed women Helps to organise cooperatives of various traders, provides credit facilities and health care	SEWA's health insurance scheme functions in co-ordination with LIC and New India Assurance Company. Offers comprehensive health insurance package to address women's basic needs. Covers deliveries but not abortion.

Source : Health Insurance For Informal Sector: Problems and Prospects by Anil Gumber. Paper prepared for Indian Council for Research on International Economic Relations, New Delhi, November 2002

ily members (Gupte Manisha et al 1997 and Sinha, A.K et al 1998). The socio-cultural factors like the stigma attached to abortion compels women to trade off quality of care in order to preserve confidentiality (Bandewar, Sunita 1997). Under such circumstances women would be able to take advantage of an insurance scheme, only if they have sufficient economic independence to join an insurance policy, which also takes care of abortion expenses.

The other important question is whether it is feasible for insurance companies to extend the coverage to include abortion care. This question is relevant today, since the insurance sector has been privatised and a number of private insurance companies have already started operating in the country. Any insurance scheme is based on the uncertainty of an event taking place. Given this principle of insurance, it may not be feasible for a health insurance plan like the Mediclaim to include abortion expenses, without attaching some conditions (e.g. restriction on the number of abortions per insured woman). In a country like India, where there are illegal abortions, in particular since sex selective abortions are not uncommon; the insurance companies have to be careful about the legal aspects while handling claims against abortion expenses. It may be possible to include abortion expenses along with other maternity benefits in a community based insur-

ance scheme like the SEWA plan, which basically caters to women in the informal sector.

Based on the admittedly limited information available, we may conclude by saying it is of foremost importance to provide affordable, safe and accessible MTP services to women. In addition, if at least some of the community based insurance schemes can also cover MTP it would reduce the financial burden for women seeking abortion services.

VII. Concluding Remarks

A review of the available literature indicates that there is very limited data on the cost of abortion care in the country. The first step should be to intensify research in this critical area of financing for abortion care. We need to know not only what abortion charges are at the various types of MTP centres, but also the household dynamics like the source of financing the abortion etc. In the case of most of the surveys, the sample size of the abortion seekers was too small to draw any conclusion. A well designed quantitative survey, supplemented or rather complemented with qualitative research techniques like Focus Group Discussions, with the exclusive objective of capturing the various aspects of abortion including cost and finance would serve a useful purpose for policy makers

From what little information is available, it is clear that even in the government facilities, the abortion seekers had incurred substantial expenditure. The state has to really look into this. Abortion seekers spending money on transport or medicine is understandable, but many of them seemed to have had to even pay fees in some form or the other while utilising public health facilities.

In the case of government approved MTP centres, there does not seem to be any control either over the quality of services or on the charges for the abortion services. Since the approved centres are required to renew their license periodically, the respective state government could streamline the activities of these centres.

We need much better regulation of private medical practitioners as well as dissemination of information to them so that those women seeking abortions are not exploited financially. There is too much anecdotal data, which suggests that doctors do not hesitate to unethically overcharge for example unmarried pregnant women, or women who are otherwise concerned about confidentiality. Similarly, decline in the prices of drugs (e.g. for medical abortion) often do not get translated into decline in the costs of the service for women because doctors continue to charge the old rates. It has been found that even in the government approved MTP centres, unmarried girls seeking abortion are exploited and charged an exorbitant rate. As a result those who cannot afford the expense end up with the quacks. The main reason for unmarried girls not approaching the public facilities is the lack of privacy and confidentiality. If privacy and confidentiality can be ensured, some of the cases might consider attending public clinics.

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