ABORTION ASSESSMENT PROJECT - INDIA

ABORTION TRAINING IN INDIA : A LONG WAY TO GO

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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 seventh in the AAP - I series of working papers. Authors have traced evolution of Abortion Training System in India since earlier period to present under Reproductive Child Health programme.

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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***

14th October 2003

ABSTRACT

Abortion has been a neglected area in reproductive health research. Partly because of the sensitivity of the subject and partly because of lack of funds for conducting abortion studies, this subject has been a particularly difficult area for researchers often due to moral and political constraints. Studies so far have revolved around provision of abortion services, profile of abortion seekers, reasons for terminating pregnancy, post abortion care, decision making in abortion and other aspects of abortion. However, are there enough providers to provide safe and early abortion services and at locations accessible to rural women? This area has not received adequate attention by researchers.

This paper looks at the current state of abortion training in India, tracing its evolution from the earlier system to what is followed under the Reproductive and Child Health (RCH) Program today. There is an unmet need for medical termination of pregnancy (MTP) training in our country, as many of the training centres that have been identified for training are still not functional due to a variety of reasons.

To understand the functioning of MTP training and its content, including the selection criteria for trainees, training curriculum and the experiences of trainees and trainers, ongoing training programs of two states have been observed. By and large, it is a clinical training and the whole emphasis is on the procedures. Other important aspects connected with abortion management like counselling are not given much importance.

At present, the number of training sites is inadequate to meet training needs. There are gaps in the training system that need to be covered to make the program a success. Changes are required at both the policy and implementation level and this forms a part of our recommendations.

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Glossary of Terms And Acronyms

ANC	Ante Natal Care
ANMs	Auxiliary Nurse Midwives
CHCs	Community Health Centres
CMO	Chief Medical Officer
DGHS	Director General of Health Services
IST	Integrated Skill Training
IUCD	Intra Uterine Contraceptive Device
LHVs	Lady Health Visitors
MoHFW	Ministry of Health & Family Welfare
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
NIHFW	National Institute of Health and Family Welfare
OBGYN	Obstetrics & Gynaecology
OPD	Out Patients Department
PHC	Primary Health Centre
PPC	Post Partum Centres
RCH	Reproductive and Child Health Project of the Government of India
SIFPSA	State Innovations in Family Planning Service Agency
SST	Specialised Skill Training
TOTs	Training of Trainers

ABORTION TRAINING IN INDIA : A LONG WAY TO GO

I. BACKGROUND

The lack or inadequacy of skills of the provider, hazardous techniques and unsanitary facilities characterises unsafe abortions. WHO defines an 'unsafe' abortion as one which is not provided through approved facilities and/or persons, thus equating illegal with unsafe and legal with safe abortions (WHO, 1997).

Of the 50 million abortions performed around the world every year, 20 million are unsafe. Ninety five per cent of unsafe abortions are carried out in developing countries and complications of unsafe abortions kill at least 80,000 women every year (Sexual and Reproductive Health - Briefing Cards 2000). In India, even after the introduction of the Medical Termination of Pregnancy (MTP) Act in 1972, 9 per cent of maternal deaths occur due to unsafe abortions (Sample Registration Survey 1998).

Estimates of the ratio of illegal to legal abortions are varied. The findings of the ICMR Task Force (1989) indicate that illegal abortions are 2.2 times that of legal MTP. An estimate done by Malini Karkal (1991) provides the number as 3 illegal abortions for every one legal abortion in rural areas and 4-5 illegal abortions for every MTP in urban areas. Researchers believe that the actual statistics (though a lot goes unreported) is much higher and difficult to ascertain. All studies indicate that there is a high incidence of illegal abortions in India.

There is therefore an urgent need for the provision of MTP facilities, which are safe and accessible to women living even in remote parts of the country. This can be made possible by equipping the Primary Health Centres (PHCs) with MTP equipment and availability of trained doctors at these sites. The National Population Policy 2000 also lays great emphasis on the provision of safe abortion services. A number of operational strategies have been listed in the policy and one of them is to ensure the services for termination of pregnancy at Primary Health Centres and at Community Health Centres.

An overwhelming number of abortions are being done by uncertified practitioners or by unqualified persons. This implies that a large number of doctors are still untrained to perform MTP and safe and early abortion services are still not within the abortion seekers' easy reach especially in the rural areas. Estimates in 1992 indicate that there were only 3000 trained doctors available com-

It is of crucial importance that the doctors performing the procedure are well trained. To meet the demand there should be sufficient training facilities that impart quality training to providers in the public sector as well as private practitioners who wish to be trained. There is an urgent need to look at the status of abortion training in the country focussing on assessing the adequacy of the existing number of training sites. The effort should be to look at the gaps in the training system and compare the number of doctors actually trained with the number who ought to be trained.

pared to 21,000 required to serve all rural PHCs (Chhabra & Nuna, 1994) clearly indicating that there is an unmet need for MTP Training opportunities.

Studies conducted so far have never really looked at 'Abortion training' in its entirety. 'Abortion in India: An overview' (Khan, et al., 1996) looks at the training facilities in the 3 states of Gujarat, Tamil Nadu and Uttar Pradesh besides discussing other issues related to abortion. 'Availability and Access to Abortion Services in India: Myth and Realities' (Khan et al. 2001) states that the vast gap of demand and supply of trained manpower is largely due to lack of planning and allocation of resources. Centre for Operations Research & Training (CORT) studies on quality of abortion training have revealed that the doctors are not getting adequate practical training (Khan, et al., 2001)

This paper attempts to review the various issues related to the training aspect of abortion, point out the lacunae existing in the training system and suggest improvements.

II. Objectives

The objectives of this paper are to:

Estimate the extent of unmet need of abortion training in India Gauge the adequacy of training sites

- Trace the evolution of the training system from its earlier form to its current state
- Identify the gaps existing in the health care system regarding abortion training and suggest improvements both at the policy as well as the implementation level.

The current study is a review based on the available and accessible data of the existing training system for certifying MBBS doctors to provide MTP services in India.

III. Methodology / Source of Data

To obtain the necessary information on MTP Training related to selected states, secondary data from various existing records of Ministry of Health and Family Welfare (MoHFW) and institutes of health and family welfare were used. Since the relevant information was not available in one place and with one person, interviewing concerned officials at the National Institute of Health and Family Welfare (NIHFW), MoHFW and State Institutes of Health and Family Welfare (SIHFW) were an important data collection method together with site visits. By talking to trainers and trainees and witnessing the training sessions in progress, the quality and content of training was assessed. The evolution of the training system in the country was traced by talking to senior officials in the ministry as well as NIHFW.

IV. Findings & Analysis

A. Training policy

Training requirements are covered under The Medical Termination of Pregnancy Rules, 1975 wherein Section 3 'Experience or Training' states that 'a registered medical practitioner shall have one or more of the following experience or training in Obstetrics & Gynaecology, namely:

- *In* the case of a medical practitioner who was registered in a State Medical Council immediately before the commencement of the Act, experience in the practice of Obstetrics & Gynaecology for a period of not less than three years.
- *In* the case of a medical practitioner who was registered in a State Medical Council on or after the date of the commencement -
  - i. *If* he/she has completed six months of a house job in Obstetrics & Gynaecology; or
  - ii. *If* he has not done any such house job, if he/she had experience at any hospital for a period of not less than one year in the practice of Obstetrics and Gynaecology; or

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

- *In* the case of a medical practitioner who has been registered in a State Medical Council and who holds a postgraduate degree or diploma in Obstetrics & Gynaecology, the experience or training gained during the course of such degree or diploma.'

Other than this the government has not spelt out any specification regarding MTP training.

B. MTP Training under RCH Project

Under the Reproductive and Child Health (RCH) Project of the Government of India, two types of training are conducted - Integrated Skill Training (IST) and Specialised Skill Training (SST). The training imparted to medical officers at PHCs, male supervisors, Lady Health Visitors (LHVs), male and female health workers, Auxiliary Nurse Midwives (ANMs) and staff nurses at the PHCs and CHCs is termed as Integrated Skill Training (IST) as it integrates clinical, communication and management skills. The other type of training is Specialised Skill Training (SST), which is given to medical officers (for Laproscopic Sterilisation, Mini Laprotomy Sterilisation and MTP) and to ANMs and LHVs for IUCD insertion. MTP training comes under the purview of SST. A separate management structure has been envisaged for coordination of all training activities under the RCH program. This would support the central and state Department of Family Welfare involving the Ministry of Health & Family Welfare (MoHFW) at the centre, with NIHFW as the nodal agency, 17 identified Government and Non Government institutions as Collaborating Training Institutions and a vast network of existing peripheral training centres/institutions.

NIHFW has specified certain guidelines for conducting MTP training. The training has to be conducted in conformity with the provisions of the MTP Act, 1971 as well as MTP Rules/Regulations, 1975 and any subsequent amendments. Medical officers from all CHCs are to be nominated in the first phase and in the second phase, untrained Medical Officers from all PHCs having MTP equipment/facilities. The duration of the training is for two weeks i.e. 12 working days.

As per the guidelines, the Content of Training has been stated very clearly. The training program should be competency based and the trainer must ensure that the trainee has acquired the necessary skills for:

1. Pre and post abortion counselling including post MTP contraceptive counselling
2. Selection of cases with dating of pregnancy
3. Clinical procedure
4. Recognition and management of complications
5. Management/Maintenance of MTP equipment

In order to ensure acquisition of above skills, each trainee must:

- Assist at least 10 MTPs
- Perform at least 5 MTPs under supervision
- Perform at least 10 MTP procedures independently

However, in practice it was observed that the training centres were not adhering strictly to this break up. For example, in the state of Karnataka, the trainees were made to observe 10 cases, supervise another 10 and handle 5 cases independently.

As per the Guidelines for Specialised and Integrated Skill Training brought out by

NIHFW, the trainer has to ensure that each trainee maintains a diary with details of the MTP cases they have assisted, performed under supervision and performed independently indicating a stepwise checklist of activity for each case. It has been observed that practically no checklists are maintained. The details of MTP cases as well as trainers who supervised the training should be recorded in the diary. The number of participants per course is 2-3 depending upon the MTP caseload of the training centre. The trainer must evaluate the trainees using a checklist and by inspecting the diary maintained by the trainee. At the end of the course the trainer must certify the acquisition of requisite skills by the trainee, failing which the trainee will be required to come for a second time. (National Institute of Health and Family Welfare (NIHFW). n.d.).

V. The Unmet need in Training

In India there are 22,975 functional PHCs (Rural Health Bulletin, 1999). Many of these PHCs are not equipped with instruments necessary to conduct an MTP. Even those equipped with these instruments are not functional enough to carry out MTPs due to a variety of reasons - either the infrastructure facilities are not sufficient i.e. electricity, water etc. are not readily available or the doctor at the PHC is not trained to conduct MTPs.

The Indian Council of Medical Research (ICMR) national survey on quality of services (1991) revealed that out of the 200 Block PHCs, 91 PHCs (45.5 per cent) were registered for MTP but only 25 percent had adequate equipment to conduct abortions. Further, in only 88 cases, the PHC has a trained doctor for conducting MTP. The number of PHCs where both equipment and trained manpower were available was still low (Khan, et al., 1996).

Table 1 shows that only about one-fourth of the PHCs in Maharashtra (27 per cent) and Uttar Pradesh (25 per cent), one-third in Gujarat (32 per cent) and over one-half (58 per cent) in Tamil Nadu were providing abortion services (Khan et al. 2001).

In our study we have chosen the states of Karnataka and Bihar as both of them are diverse in all aspects - location, development and culture. Though these two examples are not representative of any countrywide trends they do provide a glimpse of the current status of abortion training. In Karnataka there are 1676 PHCs and about 80 per cent of them are supplied with equipment for performing

Table 1. Estimated Number of Public Clinics Currently providing Abortion Services in Rural Areas

States	Total no. of PHCs in the states*	Total no. of PHCs* registered for abortion	Estimated no. of registered PHCs actually providing abortion	Total no. of CHC in the state	Estimated number providing abortion services	% approved institutions providing abortion	% of all PHC*/CHC providing abortion
Gujarat	949	207	65 (31.4)	174	135 (77.6)	52.5	17.8
Maharashtra	1695	210	56 (26.7)	295	256 (86.7)	61.8	15.7
Tamil Nadu	431	192	112 (58.3)	136	123 (90.4)	71.6	41.4
Uttar Pradesh	907	171	43 (25.1)	213	115 (54.0)	41.1	14.1

* *In Gujarat & Maharashtra it refers to PHC while in Tamil Nadu and UP it refers to Block PHC.*

Source: Khan et al.2001

MTP. But most of them are non-functional for MTP services due to lack of trained doctors. Our findings corroborate the fact established in the earlier studies that the number of PHCs that actually provide MTP services is a small fraction of the total number existent.

As can be seen from Table 2 above, MTP training has not started in the states of Arunachal Pradesh, Assam, Daman & Diu, Goa, Jharkand, Meghalaya, Sikkim and Uttaranchal (according to NIHFW sources the training started in Uttaranchal in November 2002). In the state of Assam, however, despite good caseloads in the training centres, training has not started because of administrative problems. Delhi's achievement seems remarkable as the number of doctors

Table 2. Status of MTP Training (RCH) as on 14.11.2002

Sl.No.	State/Union Territory	Total Training Load	Batches	No. Trained
1	Andhra Pradesh	3265	51	88
2	Andaman & Nicobar	62	3	6
3	Arunachal Pradesh	296	0	0
4	Assam	552	0	0
5	Bihar	396	21	55
6	Chandigarh	18	4	11
7	Chhatisgarh	202	3	10
8	Daman & Diu	19	0	0
9	Delhi	24	9	25
10	Goa	18	0	0
11	Gujarat		NA	760
12	Gujarat (RCH)	336	80	124
13	Haryana	650	64	174
14	Himachal Pradesh	653	15	46
15	Jharkand	193	0	0
16	J&K	346	37	110
17	Karnataka		NA	125
18	Karnataka (RCH)	2750	13	16
19	Kerala	450	22	79
20	Lakshadweep	10	1	1
21	Madhya Pradesh	604	38	78
22	Maharashtra	695	68	67
23	Manipur	204	11	32
24	Meghalaya	207	0	0

Sl.No.	State/Union Territory	Total Training Load	Batches	No. Trained
25	Mizoram	132	18	31
26	Nagaland	180	32	96
27	Orissa	2723	7	20
28	Pondicherry	6	1	2
29	Punjab	429	32	95
30	Rajasthan	3542	NA	212
31	Sikkim	8	0	0
32	Tamil Nadu	1585	9	29
33	Tripura	180	20	55
34	Uttaranchal	191	0	0
35	Uttar Pradesh	1303	9	21
36	West Bengal	905	72	174
	Total	**23134**	**640**	**2542**

Source : NIHFW (RCH unit)

trained exceeds the total training load for the state!

Table 2 also provides state-wise data of the number of doctors to be trained for MTP or the training load (this figure varies, as doctors are transferred and new doctors are recruited) and the number of doctors trained as on 14 November 2002. Under the RCH program the total number of doctors trained for MTP so far is 2542 whereas the total number who ought to be trained is 23134 i.e. approximately 11 per cent of the need for trained doctors has been met. The narrowing of this gap will eventually lead to having MTP trained doctors at the PHCs which, in turn, will result in providing safe and early abortion services accessible to women in the rural areas.

There are MBBS doctors in the private sector both in the rural and semi-urban areas who wish to undergo MTP training but no opportunity exists for them as the current MTP training in public training institutions is only for government/public sector doctors.

VI. Training Sites and Their Adequacy

In order for a site to be selected as an MTP training centre, the site should meet the following criteria:

- It should be ensured that the training centre has a sufficient caseload so that sufficient opportunity is available for hands on training. It is recommended that the selected Training Centres should be conducting at least 600 MTPs per year.
- Before sanctioning courses to training centres the availability of essential facilities like operation theatres and MTP equipment should be ascertained.
- The manual for first Trimester Medical Termination of Pregnancy must be available in all the training centres (NIHFW Guidelines. n.d). These guidelines were developed by NIHFW after consultation with many experts.

The training centres are mainly classified as 'A' type Post Partum Centres (PPC) generally attached to a medical college or district hospital. In India there are 230 'A' type PPCs but all of them have not been designated as training centres (Khan et al. 1996). There are 217 training centres identified for MTP training in India (Source: NIHFW). But all of them are not functional, moreover the process of registering training centres is still going on. In Karnataka out of the 27 identified training centres only three are currently functional and in Assam out of the 13 identified centres none are functional. Thus the number of training sites is not adequate to meet the demand for training.

VII. Training Program

A. *Evolution of the training system*

MTP Training has been going on since the 1970s. But it was not done in an organised fashion. It is only with the implementation of the RCH program that training has been given due importance and is being conducted in a more systematic manner. The RCH program is a revised and modified version of the earlier Family Welfare Program. MTP Training has been a part of RCH training since the inception of the program in 1997-98 but it is being implemented only since the end of 2001 - beginning of 2002.

In 1987 there existed an expanded program of MTP, which was funded by WHO. In the earlier program the selection of training centres was on the basis of 10,000 deliveries/abortions per year. The centre was to have 2-3 Gynaecologists and a functional operation theatre equipped with all the necessary MTP instruments. There were two different training courses catering to two different categories of medical doctors. Category I for those physicians who had a postgraduate diploma or degree in Obstetrics & Gynaecology (OBGYN) or a doctor with at least 3 years experience of working in OBGYN. Category II covered general practitioners having no specialised training or less than 3 years of work experience in OBGYN. The course duration was one month (Khan et al 1996) that was later reduced to 3 weeks. Subsequently, GOI indicated that the training period could be compressed to a fortnight. This may have been because it was difficult getting busy doctors away from their workplace for as long as a month (Chhabra et. al. 1994). Currently the training is conducted for 12 days. Earlier, those PPCs conducting more than 500 abortions a year were the ones approved for MTP training (Chhabra, 1994). Now the centres are recognised if they have a caseload of at least 600 MTP cases per year (NIHFW Guidelines).

From an informal system that existed earlier the training program has now become more methodical. Before the RCH program started, the government machinery handled training. An MBBS doctor who wished to be trained for MTP had to be attached to a gynaecologist to undergo training. Now NIHFW is the nodal agency co-ordinating with the state institutes and ensuring that the selection of trainees and the conduction of training follow a standard procedure.

The main drawback of the earlier program was that it was primarily knowledge based. With RCH, there has been a major shift in training from emphasis on knowledge to emphasis on skills. Though the training system has been streamlined, the authorities need to accelerate the pace of training. There is a wide gap between current performance and the ultimate goal. But bridging this gap is not impossible and a start has already been made.

B. *Selection of Trainees*

The selection of trainees and the conduction of the training program are entirely the state government's responsibility. The trainees are MBBS doctors selected from medical college hospitals, ESI hospitals, PHCs, CHCs and district hospitals.

The procedure of selecting trainees starts with the NIHFW informing the Director General of Health Services (DGHS) of each state about the MTP training schedule and venue. The DGHS then passes this information to Additional Directors who in turn pass it on to their respective districts. Each district has a Chief Medical Officer (CMO) who is in-charge of all the PHCs, CHCs and district hospitals of his district. The DGHS passes this advice on to the CMO's office of each district from where the particulars of the training are passed on to the PHC doctors. The 17 institutes collaborating with NIHFW for training provide information about the dates and venue of training to the CMO's office, which in turn is forwarded to the untrained doctors posted at the PHCs.

C. Training Curriculum

For both categories of medical doctors (described earlier), the training comprises of both abstract and practical theory. A training curriculum designed by GOI is available with the states and Union Territories. The curriculum is quite comprehensive in its content. It includes methods of gynaecological examination with special emphasis on:

- estimation of uterus size and position;
- selection of patients; counselling;
- different techniques of first trimester MTP, including MR, suction aspiration D & C; contraceptive cover with training in IUD insertion;
- minilap and tubectomy;
- abortion sequelae and follow up care and demonstrations of second trimester and concurrent sterilisation techniques (Chhabra et. al 1994).

But what happens practically is perhaps quite different. The Manual for First Trimester Medical Termination of Pregnancy issued by the Technical Operations Division of the MoHFW, GoI is the only document distributed to the trainees who come for training. The Manual is divided into nine main topics :

1. Equipment - suction machine and tubing, menstrual regulation syringe, suction cannulae, ancillary instruments, essential drugs
2. Patient counselling - supportive counselling, contraceptive counselling
3. Patient selection - clinical Assessment, investigations
4. Pre-operative Card & Pain Control - general Instructions, origin of pain, choice of pain control methods, sensitivity testing for local anaesthesia, technique of local anaesthesia
5. Surgical procedures - techniques of suction evacuation, technique of menstrual regulation, technical problems, dilatation & evacuation
6. Post-operative care - monitoring, instructions on discharge, follow up
7. Non-Surgical Methods - hygroscopic agents (slow dilatation of cervix), medical methods of MTP
8. Complications & Management - immediate, delayed, remote
9. Infection Control - universal precautions, sterilisation & maintenance of equipment

The trainer uses his/her discretion to impart theoretical training based on this Manual or goes directly to the practical aspects of training. Though a Program Schedule has been developed for Integrated Skill Training, there is no such schedule for Specialised Skill Training. The MTP training is thus conducted without any day-wise planning.

Counselling (both pre and post abortion) has been mentioned as an important aspect of training in the guidelines set by NIHFW, but in reality all the sites are not providing this component of MTP its due importance. Institutions like Family Planning Association of India, Surya Clinics in Bihar and MGM Hospital, Patna are some organisations out-

side the government system conducting MTP training and they claim that in their training, they emphasise the importance of counselling the abortion seeker.

D. Training Material

No training material is used for MTP training. One of the officials suggested that some dummies/pelvic models must be supplied to help the trainer in explaining the procedure to the trainees.

E. Caseloads

This is an important criterion both for a site getting registered as an MTP Training centre as well as for the trainees to qualify for a proficiency certificate. If the trainees can't meet the stipulated requirement they are not awarded a certificate.

Most of the training centres are medical colleges as they are equipped to conduct the procedures and have enough caseloads. But sometimes even after having enough caseloads these colleges are not able to conduct the training, as their priority is to give first preference to training their postgraduate students and then the medical officers coming in to be trained.

F. Post training Evaluation

Though there has to be a follow up of training whereby it is confirmed that the trainee has been adequately trained and whether he/she is confident to perform the procedure on his/ her own, so far there has been no evaluation of the training conducted. The reason cited by the concerned officials is that only when all the doctors belonging to a particular district/area are trained can an evaluation be conducted. It is to be hoped that this will be taken up in the second phase of the RCH program.

VIII. Case Study 1 : Karnataka

Currently there are 3 functional MTP training centres in Karnataka: K.C. General Hospital, Jayanagar General Hospital and H.S.I.S. Ghosha Hospital, Shivajinagar; all situated in Bangalore. We visited the first two training centres while the training sessions were in progress. Each centre had one trainee each. The reason given for not having more trainees per centre was that there were not enough caseloads to accommodate more trainees. Both the trainees came from places far away from Bangalore (Karwar and Raichur).

A. Trainees

The trainees were MBBS doctors who did not have any specialised training to conduct MTP. Both were posted at PHCs and due to the non-availability of trained doctors at their sites they have earlier had to turn down abortion seekers.

- ***Selection Process***

  A letter was dispatched from the CMOs office informing them of the MTP training and seeking their willingness to attend the course. Both the trainees sent their replies in the affirmative. They had been motivated to undergo this training, as it would equip them with yet another skill, which would enable them to handle early abortion cases and also enhance their career prospects.

- ***Views on Training***

  One trainee said that she was not sure but maybe if there was a day-wise plan she may have been able to do more cases. There were 2 days when PG students did MTP cases and on those days she was relatively free. The trainee from the other centre admitted that there were some days when there were no abortion cases. On those days she was in the out patient department (OPD). examining patients coming for an anti natal care (ANC) check up. Training here was completely dependent on caseloads; 'no cases' meant 'no training'.

- ***Confidence Level***

  One of the trainees admitted that in spite of completing the stipulated 25 cases she

was not confident enough to handle cases independently. She would go back and get some exposure to MTP cases at the CHC and later independently perform at her PHC.

B. *Trainers*

Each training centre has 4-5 gynaecologists who perform their regular duties in the Obstetrics and Gynaecological department.

- ***Experience and Competence***

  The experience of the trainer in performing MTPs ranged from 15 to 24 years. One of the centres also has a medical college attached to it.

- ***Role in Training***

  At one of the centres there is one trainer to impart theoretical training i.e. contents from the manual are explained to the trainee though there is no schedule where each day's activities are planned. The other centre doesn't impart any theoretical training; the manual is given to the trainee and everything is explained during the practical sessions. The trainers also feel that hands-on experience is more important because trainees are MBBS doctors who are already aware of the theoretical aspects.

  A trainer at one of the centres said that no extra time is devoted to trainees. When the doctors are performing the procedure, the trainees observe and assist. The trainers are careful when the trainees are handling the procedure, as the trainers are entirely responsible for the clinical procedure. One trainer said that she advises the trainees to be careful and avoid perforations. According to her, it is better to do an incomplete abortion than perform an accidental perforation. If the trainee suspects an incomplete abortion she should ask the patient to come back later. Ultimately the trainee will learn by experience and by handling the procedure herself.

C. *Training load*

Under SST, from May to September 2002, 14 doctors have been trained at 3 centres in Karnataka.

D. *Training Sessions*

Usually, the first half of training each day was spent on the examining the client or selection of client. The clinical procedure was usually done in the afternoon as the gynaecologists were busy attending OPD during the first half of the day.

- ***Selection of the Client/Counselling***

  After recording personal information from the abortion seeker, she was questioned on the reason for undergoing abortion. The reasons were usually failed tubectomies, unwanted pregnancy due to contraceptive failure or the seeker was a lactating mother. If the pregnancy was the woman's first she was discouraged from undergoing MTP. Counselling also included informing the abortion seeker about post abortion contraception. The clinical training consisted of first the physical examination and then the actual procedure. For the first 2-3 days the trainee observed the operation and then started assisting in performing it.

- ***The Clinical Procedure***

  Trainees were given a stepwise demonstration of the clinical procedure. The patient was given a mild sedative and prepared for the operation. The next step was the dilatation of the cervix and evacuation. The technology used for evacuation was Suction Evacuation. After withdrawing the contents, it was examined and a check curettage done to confirm the completeness of the procedure.

- ***Post Procedure follow-up***

  Trainees observed that instructions were given to the patient to come on the 5th day for follow up. The patient was also counselled on adopting some contraceptive measure, as repeat abortions were

injurious to her health. The importance of post procedure follow up was emphasised to the trainees.

- ***Training environment and monitoring of Trainees***

  The atmosphere in the centres was quite congenial for training and the staff and trainers were very helpful though they were very busy with their normal routine work. Trainees were required to maintain a diary of all cases they were observing, assisting and performing and prepare a report of what they had learnt during the training. Upon successful completion of training, the State Institute of Health and Family Welfare awarded them a Proficiency Certificate.

E. The Training Organisers' Viewpoint

According to one of the officials, 12 days was not enough to get an adequate number of cases; the training should be extended to 3 weeks. In the last 10 months one of the centres had an average load of 62 cases per month while the other had 135. But all the sites don't match these figures and hence are not eligible to conduct training. Since there are private agencies also doing MTPs the cases get dispersed and there are not enough government hospitals able to meet the necessary 600 cases every year. There are many potential training centres, which are equipped both with trainers and infrastructure but are not able to conduct training, as they don't get enough cases.

F. Team Observation

From Table 2 it can be seen that the total training requirement for Karnataka is 2750. Till mid November 2002 only 16 doctors have been trained i.e. only 0.58 per cent of the total training load. This clearly indicates that the training needs have not been met with and progress is slow. After talking to trainers and state officials one gets the feeling that they are willing to work but the training system needs to be in place. The guidelines for the training programs do exist but either they have not been implemented or they are working much below their capacity.

There is still a long way to go before targets are achieved but if the process of identifying training sites is accelerated then more trainees can be trained that much faster. Besides, if district hospitals can conduct training, it would be more convenient for the trainees who otherwise have to come from distant places to the city to undergo training.

IX. Case Study 2 : Bihar

In Bihar, there are currently 7 training centres - 6 are government organisations and one is run by a private nursing home. The government centres are located at two places in Patna, one each in Darbhanga, Muzaffarpur, Gaya and Bhagalpur and the private centre is located in Patna. We visited the lone private training centre in Bihar -MGM Hospital as well as the government centre in Patna at the Patna Medical College and Hospital. While the former centre has an approximate caseload of 200-250 per month, the latter has a load of 300 cases per month. At the time of our visit both the centres had 2 trainees each.

A. Trainees

- ***Their Selection***

  Selection of trainees is a random process. The prospective trainees are informed about the dates of training without checking their availability or willingness. Each training centre caters to a certain number of districts. The District authorities select the untrained doctors in their district and send their names to the training centres. Sometimes even doctors who are specialised in other fields are sent for MTP training.

- ***Their Views on Training***

  One of the trainees stated that since MBBS doctors tend to forget skills that

they are not using regularly and what was taught to them in their medical curriculum, the government should organise periodic refresher training courses for doctors.

- ***Their Level of Confidence***

  At the end of the training, the trainees were not confident that they would be in a position to conduct the clinical procedure independently. The trainees also felt that once they go back to their workplace there should be some supervision of the MTP cases they handle initially.

B. TRAINERS

There are 3 gynaecologists in one centre and 5 in the other who share the training responsibilities.

- ***Their Experience and Competence***

  The trainers are very experienced doctors who have been performing MTPs for at least 15 years.

- ***Their Role in Training***

  The trainers feel that practical training is enough and hence no theoretical training is imparted. It has been observed that the trainers don't always distribute the manual to the trainees. They believe that the trainees need to be competent in the clinical skills, which cannot be fully realised if time is allotted to teaching theory.

C. TRAINING LOAD

From September 2001 to June 2002, 18 doctors have been trained in Patna Medical College and 30 in MGM hospital.

D. TRAINING SESSIONS

- ***Selection of Client/Counselling***

  The trainees at the centres were not oriented towards any counselling or trained on these aspects of abortion. Nevertheless, counselling was taking place as part of the abortion procedure in the private centre.

- ***The Clinical Procedure***

  Clinical training was very systematic with the trainees being given a step-wise demonstration of the procedure. The technology used was Suction Evacuation and Manual Vacuum Aspiration. The trainer to trainee ratio was 1:2. For performing cases independently, there were more cases available to the trainees at the private centre than at the government centre where the cases were divided between the residents and post-graduate students on the one hand and the trainees on the other.

- ***Post procedure follow-up***

  Patients were given post-operative instructions on medication and the warning signs and symptoms to watch out for, in which case they would have to contact the provider immediately. Post abortion contraceptive advice was almost non-existent in the private centre but it was routinely emphasised in the government centre.

- ***Training environment***

  In their approach to training, trainees at the government hospital lacked the necessary commitment. That is why it is important for the state institutes to emphasise that a certificate will not be automatically awarded to the trainees at the end of the training. Only if the trainees are made to feel that their non-seriousness towards the training may even deprive them of the certificate, will their attitudes change.

E. THE TRAINING ORGANISERS' VIEWPOINT

The organisers seemed quite satisfied with the pace of the training, as about 70 doctors had been trained in 9 months in Bihar under the SST training. Though it was desirable that more trainees should be enrolled per session, it is not practically possible to do so given the caseload constraint.

F. TEAM OBSERVATION

While the trainees in Karnataka mentioned that they were asked whether they would be available for training, trainees in Bihar clearly stated that they had no choice but to attend it on the dates specified to them. Some officials say that if the doctors are given a choice to attend or not attend then it will be difficult to implement the training program and achieve the targets.

In spite of the organisers' optimistic note, figures in Table 2 indicate that as against the training load of 396 - 55 doctors had been trained by mid November 2002. This means that only 14 per cent of the target has been achieved, indicating the unmet need for training. It has also been observed that for some reason not all potential sites that have enough caseloads have been recognised as training centres. Obviously if efforts are made to recognise more training centres, more doctors will be trained and the problem of unmet needs solved.

From the two case studies researched there is no doubt that the need for MTP training has not been met. Yet the solution to the unmet need is also evident. It can be concluded that there is a lack of initiative on the part of concerned authorities to recognise more training centres, which would result in more doctors being trained

X GAPS IN THE SYSTEM

The MTP training system in India is riddled with problems. It has all the drawbacks of a Conventional Training Approach which include:

- Training systems are separate from supervisory systems;
- Follow-up is lacking;
- Knowledge and skills acquired during training are not applied to the trainee's work;
- Capacity building at local sites is limited;
- Trainees are selected inappropriately;
- Off-site, centralised training is unable to meet the growing need for training;
- Services are disrupted (Bradley et. al.1998).

The concerned authorities have not realised that tackling MTP training needs more than a conventional approach. Firstly, adequate sites should be made available, then sufficient trainees should attend the training and most important, the quality of training should be such that at the end of the sessions, trainees are able to perform procedures independently.

Looking at the system closely, some of the gaps are apparent. We observed that as most of the training centres have medical colleges attached to them, the faculty of the Obstetrics & Gynaecology department is involved in routine work along with the training schedules. They are therefore not able to devote full time to the trainees Even monitoring of the trainees becomes difficult due to the time constraint.

From the feedback received from the states, it has been seen that training is very slow but this cannot be attributed to any single reason. Identifying training institutes or sites is a difficult task. Seemingly, MTPs are taking place (as claimed by state officials) but this is not supported by recorded evidence. As of now, the centres are mainly government medical colleges. People are generally apprehensive of utilising government services and that could be one reason for the low number of cases coming to these training sites.

On the other hand, if a private practitioner wishes to be trained to do MTPs, he/she has no opportunity since the current training system is catering only to doctors employed by the government. It has also been observed that in the private sector providers are apprehensive of providing training as their patients pay them for the services and

they can't afford to have trainees handling their cases.

Another basic flaw in the training system is that the target is number based. More than the quality of training the emphasis is on quantity. Whenever there is an evaluation of a training program the first question is 'How many have been trained?' In spite of this, the actual number trained shows that there is still a long way to go.

Some inherent flaws in the training system have clearly emerged from our study:

- While selecting trainees, there is no attempt to check whether the centres where they go back to perform the procedure after training are completely equipped with supplies to conduct MTPs.
- Sometimes the medical officers selected for training cannot join the training because they are not relieved from their place of posting.
- The training centres are situated far from the trainees' residence/place of posting and this sometimes demotivates them, as they can't stay away from their homes over long periods.
- The ultimate aim is surely to make safe abortion services accessible and available to people living on the periphery and that is precisely why doctors stationed at PHCs have been targeted for training. But the truth is that even the doctors posted at the district hospitals and CHCs are not adequately trained.
- Ideally, the district hospitals with good caseloads should be providing MTP training. But that is not happening at present and the reason is unclear. For example, the district hospital in Ranchi (Jharkhand) has five gynaecologists and enough caseloads but it is not an approved training site.

As against the Integrated Skill Training, the Specialised Skill Training has received step motherly treatment. The monitoring for the IST program is higher as compared to SST. The reason cited is that the person monitoring a SST program has to be technically sound and all those monitoring are not necessarily proficient in that subject. Though SST has not been completely ignored it definitely deserves better treatment. It is hoped that maybe in the next phase of the RCH program (the first phase ended in March 2003), SST will get the importance due to it.

The state of Uttar Pradesh has a peculiar problem, which seems to have been ignored by the deciding authorities. Out of the districts in the state, about 30 are taken care of by SIFPSA (USAID project) and another 6 by Border Cluster (a private agency). Supposedly to avoid duplication, the RCH program is covering only 34 districts. The catch lies in the fact that both the SIFPSA project and the Border Cluster project do not provide abortion services (due to political reasons) and hence the training requirement of these 36 districts has not been catered to.

XI. RECOMMENDATIONS

After identifying the gaps in the system, we have come up with certain recommendations that could be incorporated to improve the current abortion training facilities in India.

1. Instead of relying entirely on the government to take on the responsibility of conducting training, private institutions and NGOs should be included in the task of imparting MTP training.
2. The training should also cater to the needs of private practitioners desirous of being trained.
3. Besides medical colleges, *Sadar (*district) hospitals should play a key role in the training as most of them have sufficient caseloads. The specified number of PHCs and CHCs can then be linked to them so that doctors from these centres go there to be trained. This should be followed up

by supportive supervision for the service delivery after the training period. This will ultimately improve the service as many trainees ask for supervision for the first few cases after completing the training.

4. Training should be competency based. Certificates should not be issued till the trainer is satisfied with the performance of the trainee.
5. Training should include all aspects of abortion care such as counselling, post abortion contraception etc.
6. A follow up system and manual should be developed to facilitate the supervision of the trainees.
7. Checklists need to be developed both for trainees and trainers. For the trainers, it is important to see that all the necessary information and training is imparted to the trainees and nothing relevant is left out. The trainees on their part need to ascertain that whatever steps are essential for the complete abortion procedure, are followed by them.
8. There is a need for orientation and motivation of trainers. There should be TOTs (Training of Trainers), which would reiterate the crucial role of trainers in training. There should be a 'Value Clarification' for trainers so that their personal biases do not come in the way of their professional role. Personal beliefs and value systems often project a bias that prevents fulfilment of professional commitments/duties. A session on `Value Clarification' would bring these thoughts upfront and may modify thinking processes, keeping the patient's priority in mind.
9. It is vital to have a training schedule which specifies the number of days to be devoted to each step of training - Counselling, Clinical procedure, Infection Prevention, Sterilisation and Follow up.
10. Pedagogical sessions on the topics related to the subject should be added to the training course to refresh the knowledge of the trainees.
11. The trainers should use Dummies/Pelvic models during the training sessions.
12. After the training, the trainees should be given some essential instruments required to perform the clinical procedure like cannula, manual vacuum aspiration (MVA) syringe, MTP set. This will ensure the immediate provision of services at their health centres because sometimes these centres are not equipped with usable instruments (some are often rusty due to non-use). The district authorities should also take the responsibility of regular monthly replenishment of disposables.
13. While selecting the trainees, care should be taken not to include doctors at the tail end of their service, as they are not motivated enough to learn new things. Besides, doctors specialised in other branches of medicine should not be asked to undergo this training.
14. The manual on first trimester MTPs and the one on MVA published by MoHFW should be given to all the trainees.
15. The manual for trainees should be revised and updated to include the ethical and confidentiality issues of abortion as well as the latest advances in this field such as the emerging technologies-manual vacuum aspiration and medical methods for abortion.

XII. LIMITATIONS

The main source of data has been the people concerned - officials of the ministry, state institutes, national institutes, staff of the training centres, trainers and trainees and information has been elicited from them through interviews. While some of these people were forthcoming with necessary details, others were not.

Facility Survey conducted by the Government of India gave some relevant information but not all that we required.

The training centres are still in the process of being identified for MTP training. In some states like Meghalaya, Sikkim, Assam etc. training has not yet begun. In Jharkhand, no MTP training has been conducted over the last couple of years. There is no separate list of training centres where training is currently going on; only a list of identified training centres is available but then again many of these are not functional.

Yet another limitation of the study is that since MTP training under the RCH program has commenced only very recently (late 2001 in some places and early 2002 in others), information from all the states is not readily available. Besides which, since this study was conducted under a time constraint, it was not possible to visit more training centres. The training at some centres is also not consistent e.g. in Delhi, MTP training was started on a regular basis at one centre but due to some financial problems it has been discontinued for the time being.

XIII. Conclusion

In the RCH program implemented in the states, abortion does not get priority. It is necessary to advocate the urgency of training doctors to conduct MTPs in a safe and hygienic environment.

Though the existing gaps need to be filled and MTP training should be a priority issue for the states, the government's attitude towards abortion and consequently abortion training has marginally changed for the better. Some officials say that the government is willing and in fact keen to involve other agencies (private hospitals and NGOs) to impart MTP training. Some NGOs have the necessary infrastructure and network across the country to impart training and take some of the load off from the government's shoulder. The Government ought to take the initiative to invite proposals from private organisations to conduct MTP training for MBBS doctors so that the speed of training is accelerated and private practitioners interested in being trained also get the opportunity to do so.

Both funding agencies and implementing organisations are keen to undertake work on other issues like HIV/AIDS, social marketing, maternal and child health, family planning etc. Unfortunately issues related to abortion, particularly the need for training to bring down the incidence of unsafe abortions and consequently maternal mortality and morbidity, are not given their due coverage.

This study has only tackled the tip of the iceberg. More states have to be covered and the status of training needs to be reviewed after a couple of months. The MTP training system needs to be streamlined and this can happen only with the concerted and combined efforts of all the stakeholders. A start has definitely been made but there is still a long way to go before targets are achieved.

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