Universal access to comprehensive abortion care in India

From historic law change to equitable programme implementation

This case study was developed by the WHO country office with support from the Country Strategy and Support (CSS) and the Prevention of Unsafe Abortion (PUA) unit at UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) Department of Sexual and Reproductive Health and Research (SRH). The work was undertaken as part of a collaborative project to address unsafe abortion through a health system strengthening approach. The project ran from 2019–2023 and included ten countries; three WHO regional offices; and five WHO HQ departments working together through a technical working group coordinated by HRP.

Background

Towards universal access to safe abortion in India

1860

- Abortion criminalized under Section 312 of the Indian Penal Code

1960s

- Deliberations on creating a legal framework for induced abortion

1966

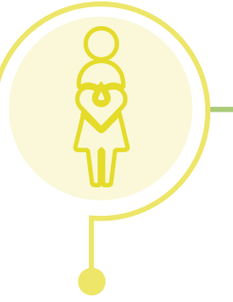
- Shah Committee Report recommends legalizing abortion

1971

The Medical Termination of Pregnancy (MTP) Act, 1971

MTP is possible:

- Up to 12 weeks gestation on opinion of 1 RMP
- Up to 20 weeks gestation on option of 2 RMPs in cases of violence or danger to life
- On contraceptive failure only for married women
- Only with written consent of the woman
- In case of minors or 'lunatics' on consent of guardian



1975

MTP Rules, 1975

- District Chief Medical Officer authorized to recommend facilities for recognition as MTP facilities

2002

MTP Amendment Act, 2002

- Lunatic replaced with 'mentally ill person'
- Decentralized approval for registration of facilities
- Stricter penalties for conducting unsafe abortions

2003

MTP Rules, 2003

- Requirements for place and personnel conducting MTPs
- MTP related data to be retained for 5 years
- Facility-wise monthly reporting to Chief Medical Officer mandatory

2021

MTP Amendment Act, 2021

- The amendment is a historic shift in laws to empower women, especially those who are vulnerable
- It expands access of women to safe and legal abortion services on therapeutic, eugenic, humanitarian or social grounds
- It ensures universal access to comprehensive abortion care for all

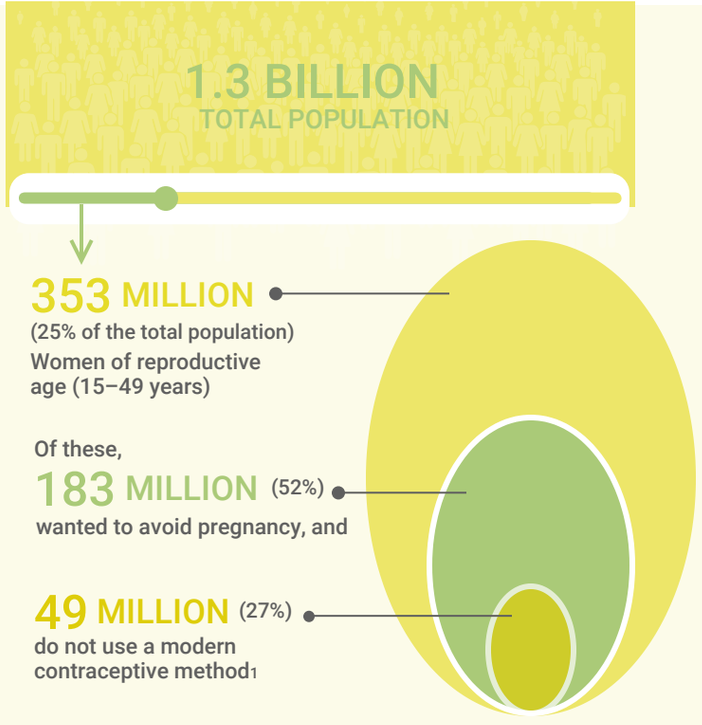
MTP: Medical Termination of Pregnancy
RMP: Registered Medical Practitioner

Introduction

Government of India has made remarkable progress on key SDG indicators particularly those on maternal and reproductive health in the last decade. Maternal mortality has declined significantly, the country has achieved replacement fertility levels, and despite the COVID-19 pandemic challenges, historic amendment was passed to safeguard and ensure universal access to safe abortion for all by law.

However, progress is not success – unintended pregnancies have increased, modern contraception usage is low, unsafe abortions still occur and inequities persist. The need for concentrated action, wider dissemination of evidence and comprehensive implementation of the new law is now more than ever.[1]

Situation of key reproductive health indicators in India



In 2015–2019, nearly
21.5 MILLION
[44% (42–48% UI)]
of all pregnancies are unintended[1]

Nearly **9 OUT OF 10**
unintended pregnancies are due to an unmet need for modern contraception

Share of unintended pregnancies that end in abortion[2]

47%
(36–57%)
1990–1994

nearly doubled

77%
(74–81%)
2015–2019

Maternal mortality ratio

97
per 100 000
live births
2018–2020[3]

Abortion remains the
3rd leading cause
of pregnancy-related death[4]

Despite progress, significant inequities and quality issues remain.

Highlights

1. Strengthening laws and policies

The Medical Termination of Pregnancy (Amendment) Act of 2021 came into force on 25 March 2021 through the Central Government notification in the Official Gazette. It was drafted by the Ministry of Health and Family Welfare, in consultation with several ministries, such as the Ministry of Law and Justice, and extensive consultation with key partners, including World Health Organization.

Salient features of the Medical Termination of Pregnancy (Amendment) Act 2021

20 weeks of gestation: Only one trained doctor (registered medical practitioner)[5] required for abortion, expanding access to remote/rural areas where provider shortages exist

20–24 weeks of gestation: Special provision made for vulnerable women (survivors of violence, minors, women affected by disasters, etc. as per Medical Termination of Pregnancy rules) with opinion of two providers

Beyond 24 weeks of gestation: Provision for cases of substantial foetal abnormalities, to be determined by a Medical Board[6]

Ensuring privacy: Name and details of woman seeking abortion to be kept confidential, when legally mandated

Provision for equity: Expanded access, irrespective of marital status, including provision for seeking abortion on grounds of contraceptive failure

2. Maintaining services during pandemic

From the very beginning, reproductive health services were declared 'essential', and specific guidelines to maintain service delivery were shared with all states. World Health Organization supported the Ministry at the national level to ensure timely issuance of guidelines and regular program support.

Two dedicated guidelines on enabling delivery of essential health services during COVID-19

Enabling Delivery of Essential Health Services during the COVID 19 Outbreak: Guidance note

Background

The COVID 19 outbreak has placed unprecedented demands on our health system. Our health facilities and workforce are currently inundated by a plethora of activities related to controlling the pandemic. In doing so, there is a risk that essential health services which communities expect from the health system, would be compromised. It is likely that health seeking may be deferred because of social/physical distancing requirements or community reluctance owing to perceptions that health facilities may be infected. *Focusing* on COVID 19 related activities, and *continuing* to provide essential services, is important not only to maintain people's trust in the health system to deliver essential health services[1], but also to minimize an increase in morbidity and mortality from other health conditions. Analyses from the 2014-2015 Ebola outbreak suggests that the increased number of deaths caused by measles, malaria, HIV/AIDS and tuberculosis attributable to health system failures exceeded deaths from Ebola[2]. Particular attention needs to be paid to the delivery of essential health care for specific population sub-groups, while ensuring the safety of health workers.

Essential services for all areas include reproductive, maternal, new-born and child health, prevention and management of communicable diseases, treatment for chronic diseases to avoid complications, and addressing emergencies. Non-Covid services such as health promotion activities, IEC campaigns, meetings of the Village Health Sanitation and Nutrition Committees/Mahila Arogya Samitis, community based screening for chronic conditions, other screening programmes, etc. could be deferred and undertaken after lockdown/restrictions are lifted. These services could be considered as **desirable**.

[1] https://www.who.int/publications-detail/covid-19-operational-guidance-for-maintaining-essential-health-services-during-an-outbreak ; 25th Mar. 2020 (World Health Organization)
[2] Elston, J. W. T., Cartwright, C., Ndumbi, P., & Wright, J. (2017). The health impact of the 2014–15 Ebola outbreak. Public Health, 143, 60-70.
Pappa, A. S., Ndeffo-Mbah, M. L., Wenzel, N. S., & Galvani, A. P. (2016). Effects of response to 2014–2015 Ebola outbreak on deaths from malaria, HIV/AIDS, and tuberculosis, West Africa. Emerging infectious diseases, 22(3), 433.

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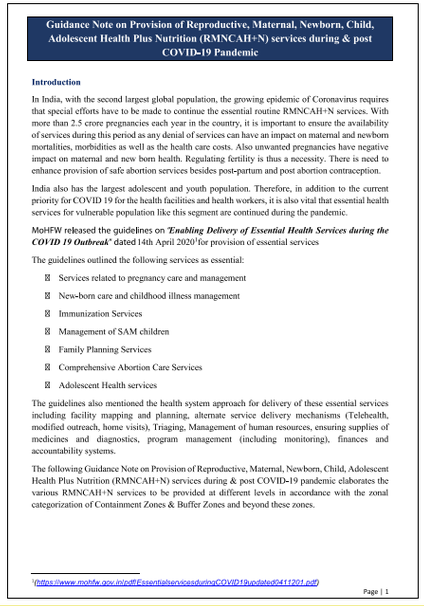
Emergency guidelines on continuity of essential health services



Guidance Note on Provision of Reproductive, Maternal, Newborn, Child, Adolescent Health Plus Nutrition (RMNCAH+N) services during & post COVID-19 Pandemic

Introduction

In India, with the second largest global population, the growing epidemic of Coronavirus requires that special efforts have to be made to continue the essential routine RMNCAH+N services. With more than 2.5 crore pregnancies each year in the country, it is important to ensure the availability of services during this period as any denial of services can have an impact on maternal and newborn mortalities, morbidities as well as the health care costs. Also unwanted pregnancies have negative impact on maternal and new born health. Regulating fertility is thus a necessity. There is need to enhance provision of safe abortion services besides post-partum and post abortion contraception.

India also has the largest adolescent and youth population. Therefore, in addition to the current priority for COVID 19 for the health facilities and health workers, it is also vital that essential health services for vulnerable population like this segment are continued during the pandemic.

MoHFW released the guidelines on ***'Enabling Delivery of Essential Health Services during the COVID 19 Outbreak'*** dated 14th April 2020[1]for provision of essential services

The guidelines outlined the following services as essential:

- Services related to pregnancy care and management
- New-born care and childhood illness management
- Immunization Services
- Management of SAM children
- Family Planning Services
- Comprehensive Abortion Care Services
- Adolescent Health services

The guidelines also mentioned the health system approach for delivery of these essential services including facility mapping and planning, alternate service delivery mechanisms (Telehealth, modified outreach, home visits), Triaging, Management of human resources, ensuring supplies of medicines and diagnostics, program management (including monitoring), finances and accountability systems.

The following Guidance Note on Provision of Reproductive, Maternal, Newborn, Child, Adolescent Health Plus Nutrition (RMNCAH+N) services during & post COVID-19 pandemic elaborates the various RMNCAH+N services to be provided at different levels in accordance with the zonal categorization of Containment Zones & Buffer Zones and beyond these zones.

[1](https://www.mohfw.gov.in/pdf/EssentialservicesduringCOVID19updated0411201.pdf)

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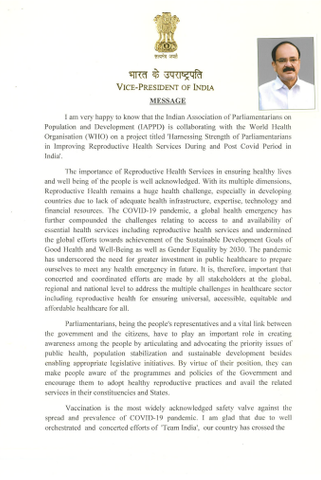
Emergency guidelines on continuity of RMNCAH+N services

Together with supporting the Ministry, World Health Organization also collaborated with the Indian Association of Parliamentarians for Population and Development to engage with Members of Parliament and sustain the momentum to prioritize comprehensive abortion care during the pandemic. For this, WHO India received a letter of recognition from the Hon'ble Vice President of India.



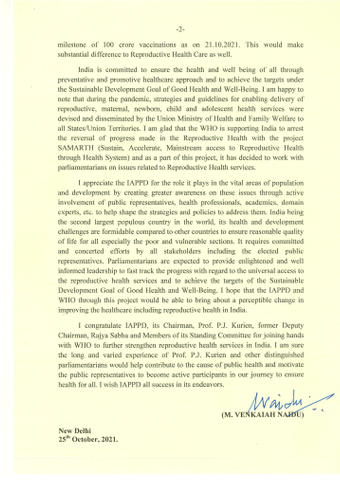
भारत के उपराष्ट्रपति
VICE-PRESIDENT OF INDIA
MESSAGE

I am very happy to know that the Indian Association of Parliamentarians on Population and Development (IAPPD) is collaborating with the World Health Organisation (WHO) on a project titled 'Harnessing Strength of Parliamentarians in Improving Reproductive Health Services During and Post Covid Period in India'.

The importance of Reproductive Health Services in ensuring healthy lives and well being of the people is well acknowledged. With its multiple dimensions, Reproductive Health remains a huge health challenge, especially in developing countries due to lack of adequate health infrastructure, expertise, technology and financial resources. The COVID-19 pandemic, a global health emergency has further compounded the challenges relating to access to and availability of essential health services including reproductive health services and undermined the global efforts towards achievement of the Sustainable Development Goals of Good Health and Well-Being as well as Gender Equality by 2030. The pandemic has underscored the need for greater investment in public healthcare to prepare ourselves to meet any health emergency in future. It is, therefore, important that concerted and coordinated efforts are made by all stakeholders at the global, regional and national level to address the multiple challenges in healthcare sector including reproductive health for ensuring universal, accessible, equitable and affordable healthcare for all.

Parliamentarians, being the people's representatives and a vital link between the government and the citizens, have to play an important role in creating awareness among the people by articulating and advocating the priority issues of public health, population stabilization and sustainable development besides enabling appropriate legislative initiatives. By virtue of their position, they can make people aware of the programmes and policies of the Government and encourage them to adopt healthy reproductive practices and avail the related services in their constituencies and States.

Vaccination is the most widely acknowledged safety valve against the spread and prevalence of COVID-19 pandemic. I am glad that due to well orchestrated and concerted efforts of 'Team India', our country has crossed the



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milestone of 100 crore vaccinations as on 21.10.2021. This would make substantial difference to Reproductive Health Care as well.

India is committed to ensure the health and well being of all through preventative and promotive healthcare approach and to achieve the targets under the Sustainable Development Goal of Good Health and Well-Being. I am happy to note that during the pandemic, strategies and guidelines for enabling delivery of reproductive, maternal, newborn, child and adolescent health services were devised and disseminated by the Union Ministry of Health and Family Welfare to all States/Union Territories. I am glad that the WHO is supporting India to arrest the reversal of progress made in the Reproductive Health with the project SAMARTH (Sustain, Accelerate, Mainstream access to Reproductive Health through Health System) and as a part of this project, it has decided to work with parliamentarians on issues related to Reproductive Health services.

I appreciate the IAPPD for the role it plays in the vital areas of population and development by creating greater awareness on these issues through active involvement of public representatives, health professionals, academics, domain experts, etc. to help shape the strategies and policies to address them. India being the second largest populous country in the world, its health and development challenges are formidable compared to other countries to ensure reasonable quality of life for all especially the poor and vulnerable sections. It requires committed and concerted efforts by all stakeholders including the elected public representatives. Parliamentarians are expected to provide enlightened and well informed leadership to fast track the progress with regard to the universal access to the reproductive health services and to achieve the targets of the Sustainable Development Goal of Good Health and Well-Being. I hope that the IAPPD and WHO through this project would be able to bring about a perceptible change in improving the healthcare including reproductive health in India.

I congratulate IAPPD, its Chairman, Prof. P.J. Kurien, former Deputy Chairman, Rajya Sabha and Members of its Standing Committee for joining hands with WHO to further strengthen reproductive health services in India. I am sure the long and varied experience of Prof. P.J. Kurien and other distinguished parliamentarians would help contribute to the cause of public health and motivate the public representatives to become active participants in our journey to ensure health for all. I wish IAPPD all success in its endeavors.

(M. VENKAIAH NAIDU)

New Delhi
25th October, 2021.

> **The bill will ensure dignity, safety, and well-being of women. It will also enhance access to comprehensive abortion care for women in need and strengthen confidentiality.**
>
> *– Tweet, Minister for Health and Family Welfare, Government of India*

3. Capacity building for 'Respectful Abortion Care'

WHO Country Office for India with the Federation Of Obstetrics & Gynecological Societies Of India (FOGSI) came together to ensure evidence-based dissemination of Medical Termination of Pregnancy Amendment despite the COVID-19 restrictions. FOSGI President launched the first-ever 'Respectful Abortion Care (RAC)' as her 'flagship initiative', adapting the World Health Organization recommendations on respectful maternity care.

Respectful Abortion Care (RAC) Training: In 2022, through two-hour virtual trainings by World Health Organization and International Federation of Gynecology and Obstetrics, 42 000+ obstetricians and gynaecologists were reached in 270+ societies across 36 States/Union Territories in India.

Safe Abortion Values, Evidence and Rights/Respect (SAVER): Innovative game-based content called 'Safe Abortion Values, Evidence and Rights or Respect (SAVER) was developed by World Health Organization experts after testing with nearly 11 000 nurses of the Trained Nursing Association of India. As an essential part of Respectful Abortion Care, it highlights gender norms, unconscious biases and personal values that surround reproductive health services like abortion.

42 000+
ob-gyn professionals trained online – first ever 'Respectful Abortion Care' – featured by International Federation of Gynecology and Obstetrics (FIGO)

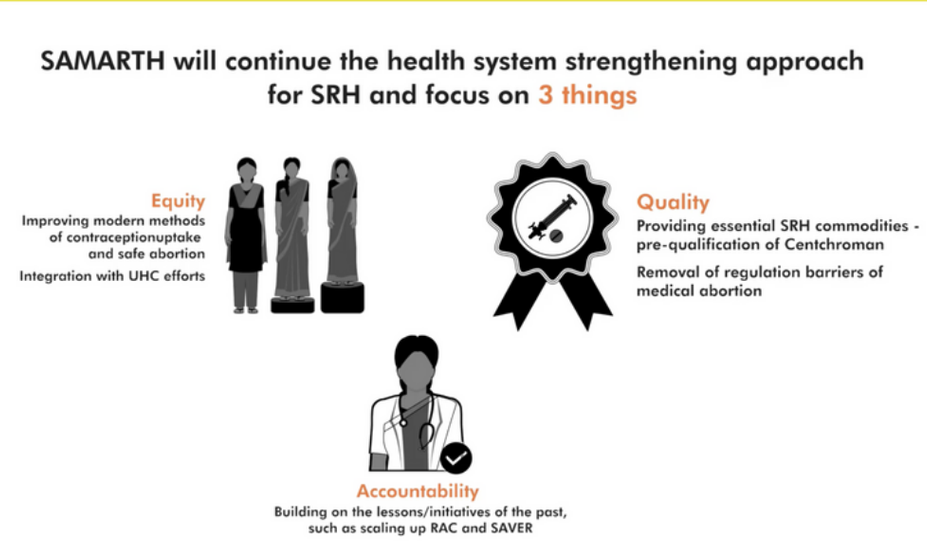
11 000+ nurses tested and
60 000+ nurses covered
the Safe Abortion Values, Evidence and Rights (SAVER) Toolkit – Innovative 'gaming' applied to sexual and reproductive health and rights – part of in-service training now

Conclusion

At a time, when globally several countries face challenges in access to comprehensive abortion care, India has taken a lead in safeguarding access to universal, safe and quality abortion care services for all women. By inculcating respect at all levels of providers, more women, specifically hitherto underserved populations, will have access to safe abortion services, eventually leading to a reduction in unsafe abortion-related and maternal mortality for the 253 million women and girls between 15–49 years of age in India.

World Health Organization has walked hand-in-hand with the Government of India to realize this vision through concrete steps that sustain-accelerate-mainstream access to reproductive health through health system or SAMARTH (which, in Hindi, means "empowered").

SAMARTH remains committed to achieving equity, quality and accountability for 350+ million people in reproductive age through universal reproductive health for all



To view the SAMARTH video, click here: http://shorturl.at/fjxLT

1 United Nations Population Fund (UNFPA)'s State of the World Population Report 2022 https://www.unfpa.org/swp2022

2 Lancet 2020 - Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019 by WHO and Guttmacher. Available at https://www.thelancet.com/journals/langlo/article/PIIS2214-109X%2820%2930315-6/fulltext#seccestitle290

3 SRS 2018-2020- Special Bulletin On Maternal Mortality In India 2018-20. Available at https://censusindia.gov.in/census.website/data/SRSMMB

4 National Family Health Survey 2019-21 (NFHS-5), Available at http://rchiips.org/nfhs/NFHS-5_FCTS/India.pdf (rchiips.org)

5 Registered medical practitioner is defined as MBBS or more with any of the following: who assisted in 25 cases of MTP, of which at least five done independently in a hospital; or who has completed 6 months of house surgency in obstetrics and gynaecology; or who holds a post-graduate degree or diploma in obstetrics and gynaecology; or who has experience of at least 1 year in the practice of obstetrics and gynaecology. Opinion of 1 RMP may be sought for cases of up to 20 weeks of gestation; 2 RMPs for 20–24 weeks of gestation; Medical Board for beyond 24 weeks of gestation: https://www.mohfw.gov.in/pdf/Telemedicine.pdf

6 For composition of Medical Boards, the following points are suggested: (i) The head of the department of Obstetrics and Gynaecology of that institution will be the chair of the Board; (ii) It should have at least one women member, and one member from the Government Hospital; (iii) Specialists from any other department may be included in the Board as per the requirement of the case; (iv) Any Board Member, if not available at the point of time of discussion on a case, may be suitably substituted by another member by the Chair: https://www.indiacode.nic.in/bitstream/123456789/1593/1/A1971-34.pdf