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

1966
- 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 opinion 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

1971
- MTP Rules, 1975
- District Chief Medical Officer authorized to recommend facilities for recognition as MTP facilities

1975
- MTP Rules, 1975
- Facility-wise monthly reporting to Chief Medical Officer mandatory

1971
- Only with written consent of the woman
- In case of minors or 'lunatics' on consent of guardian

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
- 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

1.3 BILLION
TOTAL POPULATION

353 MILLION
(25% of the total population)
Women of reproductive age (15–49 years)

Of these,
183 MILLION
(52%)
want to avoid pregnancy, and

49 MILLION
(27%)
do not use a modern contraceptive method.¹

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

Maternal mortality ratio

97
per 100 000 live births
2018–2020³

Abortion remains the
3rd leading cause
of pregnancy-related death⁴

Share of unintended pregnancies that end in abortion²

47%
(36–57%)
1990–1994

77%
(74–81%)
2015–2019

nearly doubled

Despite progress, significant inequities and quality issues remain.
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.

Highlights

20 weeks of gestation: Only one trained doctor (registered medical practitioner) 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

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

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.

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”).

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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 surgery 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

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