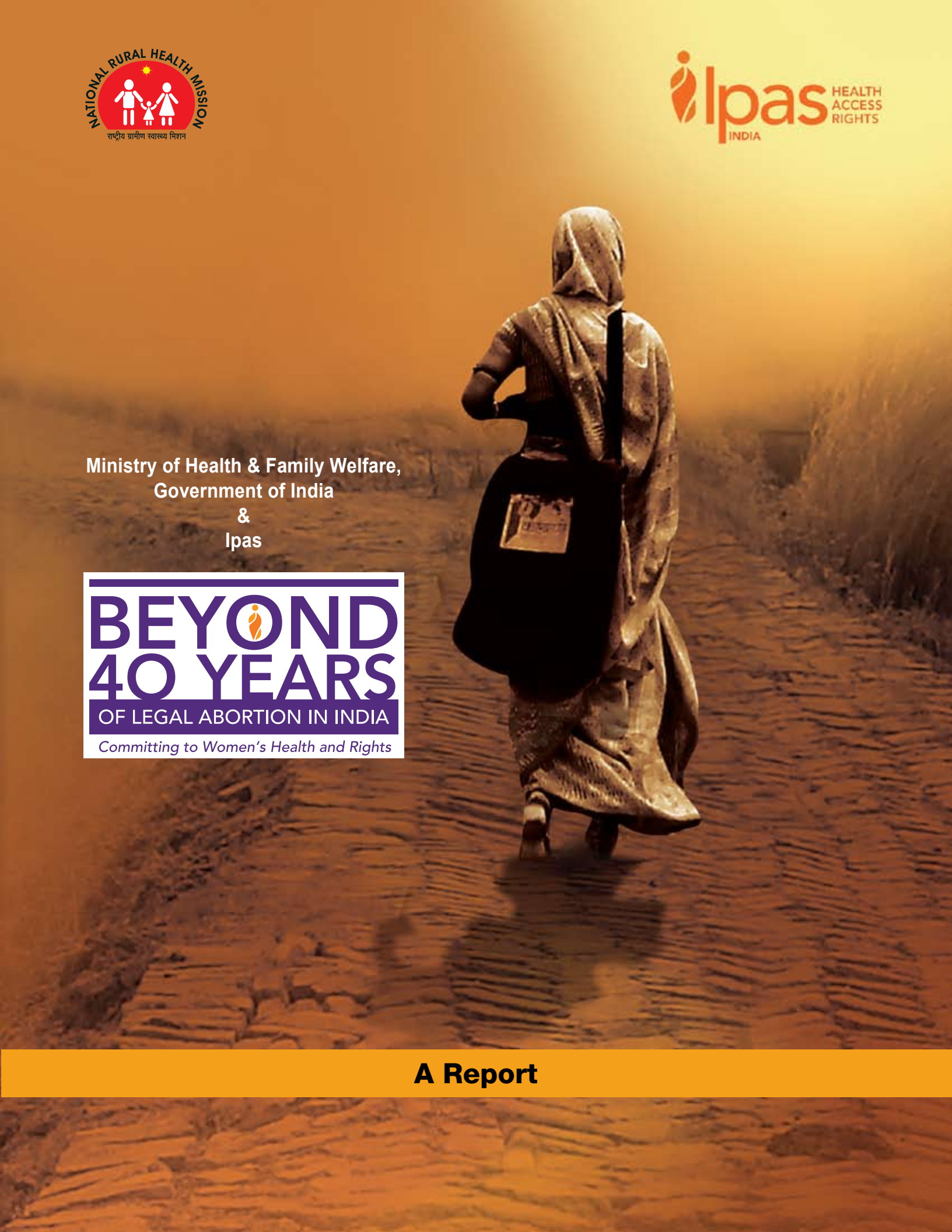

Ministry of Health & Family Welfare,
Government of India
&
Ipas

BEYOND 40 YEARS

OF LEGAL ABORTION IN INDIA

Committing to Women's Health and Rights

A Report

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12-13 September, 2013

A Report

List of Abbreviations

AEP	Adolescence Education Program
ANM	Auxiliary Nurse Midwife
ARSH	Adolescent Reproductive and Sexual Health
ARTH	Action Research and Training for Health
ASHA	Accredited Social Health Activist
BCC	Behavior Change Communication
CAC	Comprehensive Abortion Care
CEDPA	Centre for Development and Population Activities
CHC	Community Health Center
FIGO	International Federation of Gynecology and Obstetrics
FOGSI	Federation of Obstetric and Gynecological Societies of India
FPAI	Family Planning Association, India
ICPD	International Conference on Population and Development
MA	Medical Abortion
MDG	Millennium Development Goal
MoHFW	Ministry of Health and Family Welfare
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
NCW	National Commission for Women
NGO	Non-governmental Organization
NRHM	National Rural Health Mission
PAC	Postabortion Care
PCPNDT Act	Pre-Conception and Pre-Natal Diagnostic Techniques Act
PHC	Primary Health Center
PSI	Population Services International
PSS	Parivar Seva Sanstha
RMNCH+A	Reproductive, Maternal, Newborn, Child and Adolescent Health
SRH	Sexual and Reproductive Health
TARSHI	Talking about Reproductive and Sexual Health Issues
USG	Ultrasonography
WHO	World Health Organization

Contents

Message

The national consultation, 'Beyond 40 Years of Legal Abortion in India: Committing to Women's Health and Rights,' afforded a timely and valuable opportunity to review progress in advancing women's reproductive health and rights in the four decades since the Medical Termination of Pregnancy Act was enacted. Most importantly, it was also a platform for committed individuals and institutions to work together on a roadmap to address the challenges that still lie before us.

During the consultation, we heard from a diverse group of leaders and experts on current issues in access to safe abortion including expanding the provider base in India, addressing the problem of gender-biased sex selection, and addressing the needs of young women. This report captures the recommendations from participants and includes the Call to Action developed and presented at the consultation to advance the rights of women and expand access to safe abortion care.

Innovation for women's health will play a vital role in overcoming the challenges participants identified in the country. In addition, leadership from India is essential for global efforts to save and enhance women's lives. The world needs India's experience and voice in discussions that will shape future commitments for sustainable development, including in sexual and reproductive health and rights.

As we celebrate Ipas's fortieth anniversary and our successes over years, this meeting served to remind us that our work is still not done. Ipas reiterates its commitment to keep working and to keep fighting for a world where no woman will die due to unsafe abortion. It is important, now more than ever, to continue to stay the course to protect women's health and continue to stand up for women's basic human rights.

Elizabeth Maguire
President and CEO
Ipas

Foreword

Ipas India has been very fortunate for the opportunity to organize the national consultation, 'Beyond 40 Years of Legal Abortion in India: Committing to Women's Health and Rights,' in collaboration with the Ministry of Health and Family Welfare, Government of India. It has been more than 40 years since abortion was legalized in India and the time has come to revive and revitalize the efforts to ensure safe abortions for women and strengthen their reproductive rights.

The meeting brought together key stakeholders, policy makers, non-governmental organizations, and representatives of donor agencies to deliberate on expanding provider base, medical abortion, issues of gender-biased sex selection and access to safe abortion, sexual and reproductive health needs of young women, and scaling up CAC services under the National Rural Health Mission.

Speakers' presentations and panel discussions have been captured in this report. We hope that it will not only serve as reference for participants but also help take the conversation and commitment to ensuring safe abortions further.

Key recommendations made by participants have been incorporated into a Call to Action. We are confident that this guiding document, with ownership from policy makers and program managers, will pave the way for national policies and program strategies to bolster comprehensive abortion care services in India.

The occasion was also an opportunity for Ipas to celebrate 40 years of working toward saving and enhancing women's lives. We are grateful for all the support from our many partners and donors and recognize that our work is not yet finished. This meeting was an important step in reaffirming our collective commitment to women's health and rights and we are optimistic that we will take forward the recommendations made during the national consultation and continue to work together to make the lives of women better.

Vinoj Manning
Country Director
Ipas India

Executive Summary

Setting the meeting agenda in context, the opening plenary explored the abortion legislation, action and access in India and around the globe. The session focused on the point that while a lot had been accomplished in India since the MTP Act in 1971, a lot remains to be done to ensure access to safe abortion for all women in the country. The keynote address positioned safe abortion within the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) continuum of care approach and introduced the key themes of the national consultation.

Deliberating on the case for expanding the abortion provider base in India, there was consensus on the need to amend the MTP Act to allow mid-level practitioners with the appropriate educational qualifications within the legally approved abortion provider cadre. Concerns regarding the perception that an expanded abortion provider base would lead to increased numbers of sex-selective abortions were put to rest with the reminder that mid-level providers will only be permitted to offer first trimester abortions. Participants reiterated the need for setting up appropriate training programs and monitoring mechanisms to ensure effective service provision by mid-level providers.

In the session on Medical Abortion (MA) technology, participants acknowledged its contribution toward improving women's access to safe abortions thereby strengthening their reproductive rights. Increasing awareness regarding the availability and legality of MA was identified as a key element in empowering women to exercise their rights. Ensuring the availability of mifepristone and misoprostol with chemists, simplifying the long and complicated training and certification process for doctors by making provisions for an MA-only component would also go a long way toward improving and ensuring access to safe abortion.

The session, 'Addressing Issues of Gender-biased Sex Selection and Access to Safe Abortion', focused on the conflation between the Medical Termination of Pregnancy (MTP) Act and the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act. Access to safe abortion has been adversely affected by the misdirected efforts toward curbing sex selection. Deliberations at the session emphasized the importance of keeping the two legislations mutually exclusive and increasing awareness among stakeholders—particularly policy makers, enforcing authorities, and the media—of the disparate nature of the two issues so as to work toward conscientiously addressing both without negatively impacting either.

The fourth session offered the opportunity to address the sexual and reproductive health needs of young women. The imperative to target youth arises from both the fact that two-fifths of the Indian population consists of this age group as well as the fact that a significant majority of women seeking abortions are less than 25 years old. Introducing sexual and reproductive health education for adolescents through the public school system, designing age and culture-specific education models and taking advantage of the RMNCH+A approach to public health, were all identified as strategies for educating and spreading accurate information among this vulnerable group.

The session on Day Two, 'Scaling up CAC Services under NRHM—Experiences and Lessons Learnt', provided a detailed look at the various initiatives the Central and State governments have taken to ensure access to safe abortions. These initiatives include leveraging the RMNCH+A approach to re-focus attention on safe abortions, training and equipping doctors to provide MA services, and providing post-training support to providers. The need to share implementation strategies between states and collect reliable, accurate data about abortions was remarked upon.

The meeting concluded with the Closing Plenary where the Call to Action and Draft Recommendations were presented. The Secretary (Health and Family Welfare), Government of India, responded to the commitments made in the Call to Action and stated that any efforts toward improving the health of women and bolstering their rights is vital and commendable. He urged participants to broaden the abortion dialogue and keep the rights of women at the center of any action.

Opening Plenary

Speakers

Ms. Elizabeth Maguire
President and CEO, Ipas
Ensuring Access to Safe Abortions for Women: Global Perspectives

Mr. Vinoj Manning
Country Director, Ipas India
Scaling-up Comprehensive Abortion Care: A Journey of Partnerships

Dr. Nozer Sheriar
Secretary General, Federation of Obstetric and Gynecological Societies of India (FOGSI)
Abortion in India: History and Context

Keynote Speaker

Ms. Anuradha Gupta (IAS)
Additional Secretary and Mission Director, National Rural Health Mission, Ministry of Health and Family Welfare, Government of India

Ms. Elizabeth Maguire began by expressing her happiness at being in India at a time when the country is commemorating more than four decades of the Medical Termination of Pregnancy (MTP) Act. The Act, she said, was not only a turning point for India, but also an extremely important global milestone as one of the first liberal abortion laws in the developing world.

Ms. Maguire remarked that there have been advancements in improving access to safe abortions on many fronts over the last 40 years. In the policy realm, since the 1994 International Conference on Population and Development (ICPD) in Cairo, there have been a series of regional and international meetings and agreements that have reaffirmed and strengthened policy commitments to address unsafe abortion and national constitutions, laws and court decisions are further upholding women's reproductive rights and the right to safe abortion. In recent years, there has also been increased leadership from the health sector especially from the World Health Organization (WHO), Ministries of Health and professional organizations such as the International Federation of Gynecology and Obstetrics (FIGO) and the International Confederation of Midwives.

> "Since all deaths and injuries from unsafe abortion are preventable, it is intolerable that we could lose close to half a million *more* women to this cause in the next 10 years in the absence of strong sustained action."
>
> **Ms. Elizabeth Maguire**

> We need to pause to consider something here—even if each doctor serves three women a month, these three women probably are getting services from a doctor who never before provided CAC services, from a site where CAC services were never before offered. More importantly, if this doctor at this public sector site was not there, probably these three women would have opted for an unsafe abortion and been part of the grim statistics of 21 million unsafe abortions that happen globally each year.
>
> **Mr. Vinoj Manning**

She pointed out that we are at a critical juncture in global policy discussions as international leaders assess progress since ICPD and the deadline for assessing the Millennium Development Goals (MDGs) approaches. Even though it is encouraging to look at data from the WHO that shows a pronounced downward trend in maternal deaths due to unsafe abortions, Ms. Maguire urged both government and civil society representatives to renew their commitment to keep working and fighting, "despite the obstacles, despite the barriers, for the health and rights of Indian women and girls."

Ms. Maguire closed on an inspiring note by saying, "India and Ipas have come a long way in the last 40 years and with a renewed commitment to pool our knowledge, talents and resources, we can go even further in the next 40 years. I am confident that we can and will create a future where women can fully exercise their sexual and reproductive rights, a future where women will no longer suffer and die because of unwanted pregnancy and unsafe abortions."

Mr. Vinoj Manning spoke to the participants about Ipas India's journey toward making safe abortion a reality over the last 12 years—a journey that has been grounded in two basic principles: a) doing work that has the potential for rapid scale-up and b) building long-lasting, enduring partnerships.

Elaborating on these, Mr. Manning said that the Ipas scale-up model consists of three dimensions—reach, depth, and sustainability. Reach, he said, was achieving as much geographic spread as possible in order to meet India's needs, referring to Ipas's growth from a pilot project in three districts to a program that today encompasses 11 states. Mr. Manning said what Ipas is really proud of is that of the 6,600 doctors trained over the last 12 years, 4,000 are MBBS doctors who before the training were not allowed to provide services—this quiet expansion of the provider base within the existing law is a significant accomplishment.

Mr. Manning explained that depth not only means decentralization of access to services, but also deepening of the program to make it more meaningful. To this end, Ipas has developed on-site support systems to ensure provision of services by trained doctors. These include program support, clinical mentoring, and community intermediary orientation.

Defining sustainability as creating a facilitative environment where CAC training and service delivery will continue even after external support is phased out, Mr. Manning highlighted the increasing ownership of the process by state governments.

Quoting Helen Keller, "Alone we can do so little; together we can do so much," he also expanded on the very important role that Ipas India's partnerships play in making safe abortion a reality for every woman in India.

Dr. Nozer Sheriar began his talk by calling the history of abortion in India a journey of landmarks. Concerns about needless maternal deaths due to unsafe abortion led to the formation of the Shantilal Shah Committee in 1966 which recommended rationalization of abortion laws. These recommendations were passed as the MTP Act in 1971. The MTP Act protects an abortion service provider from all penal action so long as the provider adheres to its provisions. In the three decades following the Act, India had reached a point of stagnation with regard to ensuring safe abortions until October 2000 when the National Conference on Making Early Abortion Safe and Accessible took place in Agra. This conference, Dr. Sheriar said, "took MTP in India to the next level." He went on to talk about the amendments to the MTP Act in 2002 and the Rules in 2003 which formulated district level committees, established a time frame for the approval process and bifurcated requirements for first and second trimester terminations.

> Before the MTP Act was introduced, women came in hordes to teaching and public hospitals with infections from unsafe abortions and very often didn't leave those hospitals alive.
>
> **Dr. Nozer Sheriar**

Dr. Sheriar spoke about the reintroduction of manual vacuum aspiration (MVA) and MA in India in 2002 and called MA a game changer. He said that the techniques complement each other as medical abortion cannot be done confidently without the backup of surgical abortions. Dr. Sheriar further lauded the Ministry of Health and Family Welfare (MoHFW) for the national guidelines on CAC training and service delivery. He called them a blueprint for abortion services and expressed his hope that in the next 40 years abortion will no longer be a cause of maternal mortality in India.

Ms. Anuradha Gupta (IAS) began her talk by encouraging participants at the meeting, to develop a holistic strategy while considering the challenge of woman and child mortality and encompassing a wide range of interventions to improve the conditions of women and children and ensure that safe abortion is included within the continuum of care framework.

Talking about safe abortions in particular, Ms. Gupta said that access to safe abortion involves two dimensions. The first concerns reproductive rights of women—women must have control over their fertility and over their reproductive choices; the second is related to health, where it is understood that denying women access to comprehensive abortion care clearly perpetuates maternal mortality and morbidity. On the commitment to reproductive rights of women, Ms. Gupta was of the opinion that India had taken a huge step forward by putting in place a strong legislation. It is now important to ensure programmatic interventions for women to genuinely realize these rights.

One of the major challenges, in Ms. Gupta's view, is the lack of awareness among women regarding both the legality and the availability of CAC services. To this end, she recommended looking at, "The feasibility of using ASHAs effectively to increase awareness on safe abortions by telling women about the availability of services and that it is legal for them to seek safe abortion services."

Speaking passionately about the issue of inequities, Ms. Gupta emphasized the importance of identifying populations and geographic areas that are most vulnerable and marginalized—such as urban slums—and managing them by exception. This can be done, she said, by developing strategies to provide comprehensive health services for women and children in these specific areas by "reaching the unreached, un-served women and saving them."

Ms. Gupta admitted that it is a long and difficult journey from advocacy to implementation. While advocacy sets the necessary condition for action it is not a sufficient condition for results. Therefore, there is a need to develop a strategy for India's biggest challenge—implementation. State-level implementation should be strengthened with a mixture of approaches including advocacy and technical assistance.

Ms. Gupta was also in favor of expanding the abortion provider base to include mid-level service providers by tapping into the resource of nurses and non-allopathic practitioners. She pointed out that it is important to expand the number of abortion service providers, empower and authorize mid-level service providers, but at the same time put in place a system of checks and balances that ensures there is adequate monitoring to avoid complications.

Touching upon the conflation between the MTP and PCPNDT Acts, Ms. Gupta said that they are two distinct laws—one about the rights of women, one about a social problem. The answer is not to amend the MTP Act and make it harder to provide services, but to change societal attitudes and mindsets. She concluded her speech with a commitment to take forward the recommendations made by the participants at the close of the national consultation.

> "…increasing awareness among women that access to safe abortions is their right, that services are available, and that this is absolutely legal for them—there is no need for them to be diffident or hesitant or secretive—this is something we have to work diligently on."
>
> **Ms. Anuradha Gupta (IAS)**

Parallel Session 1

Expanding Provider Base: Evidence, Voices and Action

The National Population Policy 2000 identified training of mid-level providers as one of the strategies to remove barriers limiting women's access to safe abortion services. However, not much progress has been made on this. Through a special address and presentations, the session focused on the need for experiences and evidence of the safety of expanding abortion providers beyond allopathic practitioners. This was followed by a panel discussion to deliberate on the actions essential for this important strategy. Deliberations made during the panel discussion contributed to the Call to Action.

Chairperson

Mr. V.S. Chandrashekar
Country Advisor, India,
The David and Lucile
Packard Foundation

Special Speaker

Smt. Nirmala Samant Prabhavalkar
Member, National
Commission for Women

Presenters and Panelists

Dr. Shireen Jejeebhoy
Senior Associate,
Population Council
Expanding the Safe Abortion Provider Base: Evidence from India

Dr. Manju Chhugani
Principal, Jamia Hamdard
College of Nursing
Experiences of Nurses in Strengthening Maternal Health for Women: Voices from the Field

Panelists

Panel Discussion—Acting on the Need to Expand Provider Base for Abortion

Dr. Himanshu Bhushan
Deputy
Commissioner,
Maternal Health,
Ministry of Health
and Family Welfare,
Government of India

Ms. Mary Luke
Executive Vice President,
Programs, Ipas

Special Address

Smt. Nirmala Samant Prabhavalkar placed great emphasis on the need to put women at the center of all deliberations. She was of the opinion that while the downward trends in maternal mortality rates are encouraging, the loss of even one woman's life due to unsafe abortion is as great a cause for concern as the loss of many. She spoke briefly about the need for amending the MTP Act and importance of the deliberations at this national consultation especially about expanding the base of abortion providers to include mid-level providers.

Expanding the Safe Abortion Provider Base: Evidence from India

Dr. Shireen Jejeebhoy presented results from two studies conducted by the Population Council on the feasibility of expanding the abortion provider base in India. Setting the studies in context, she mentioned that countries such as Vietnam, Cambodia, Ethiopia, and Nepal allow trained non-physicians to perform abortions.

Both studies, one on MA and the other on MVA, showed that there was no significant difference in the assessment of eligibility, assessment of abortion completion and patient compliance by nurses, ayurved physicians (only in the MA study) and the comparison group of MBBS doctors. In addition, the efficacy and observed failure rates were not only similar across all three groups for the MA study but also within the bounds of internationally accepted failure rates. The failure rates for the MVA procedure were very low and did not differ between doctors and nurses. There were also very few complications with both procedures and client satisfaction levels did not differ when services were offered by non-MBBS providers.

In light of this evidence, Dr. Jejeebhoy recommended including medical practitioners with Bachelor's degrees in Unani, Ayurveda or Homeopathy, and nurses with a three and half year's degree, registered with the Nursing Council of India in the legal cadre for abortion provision. In anticipation of the amendments to the MTP Act, she also recommended involving these providers within the current legal framework for management of postabortion care (PAC).

> We *need* to amend the Act, however the civil society and government can join together to do it, that is clearly a first step.
>
> **Dr. Shireen Jejeebhoy**

Experiences of Nurses in Strengthening Maternal Health—Voices from the Field

Dr. Manju Chhugani presented the perspective of nurses with regard to an expanded abortion provider base. She said that nurses contribute greatly to reducing maternal mortality in India and therefore, there is a need to tap the potential of the increasing workforce. Nursing curricula already include aspects of abortion care like identifying and referring women for MTP, assisting providers in the procedure and postabortion care.

Dr. Chhugani pointed out that perception studies among nurses reveal that majority of them believe that they can and should be allowed to provide abortion services. She also presented international evidence from countries like Bangladesh, Nepal, Vietnam, and South Africa, where nurse-midwives are allowed greater autonomy and authority in performing safe abortions.

She recommended enhancing leadership, governance, and political commitment for expanding the provider base and bringing stakeholders together to build consensus. She further suggested inclusion of nurses in the training and certification process and building a pool of efficient trainers. If the safe abortion provider base is to be expanded, Dr. Chhugani pointed out, community mobilization and raising awareness about alternate service providers would be very important.

> “Nurses constitute the largest workforce in the healthcare delivery system and they are its essential pillars; they bind the human society with the bond of care and affection.”
>
> **Dr. Manju Chhugani**

Panel Discussion: Acting on the Need to Expand Provider Base for Abortion

As Chair of the panel, Mr. Chandrashekar first posed questions to the panelists and then opened the discussion for questions and comments from the participants. A summary of the discussions is given below under key themes:

Perceived impact of expanding abortion provider base on sex selection

Dr. Himanshu Bhushan: It is not right that expanding the abortion provider base will increase access to sex selection. If we expand the provider base for abortions, it'll be easier to reach people in difficult geographies. What the state governments must understand is that expanding the abortion provider base and curtailing sex-selection are two parallel lines that should not be allowed to intersect.

Ms. Mary Luke: We have to keep in mind that a woman's right to access safe and legal abortion in India must be preserved and will be enhanced by women having access to an expanded base of providers. I think the social issues of gender discrimination, patriarchy are all very important issues and must be tackled in a different way. Empowering women to make their decisions and exercise their rights are going to be ways of reinforcing that. We have to understand that the roots of sex selection are not in abortion but in gender discrimination and imbalance.

Smt. Nirmala Samant Prabhavalkar: The NCW believes in technical and scientific data given by medical professionals and social activists rather than in perceptions. Certain perceptions are prevalent in society but that does not mean that we should we deny a woman her genuine right to safe and legal abortions.

Dr. Shireen Jejeebhoy: Sometimes we forget that a large majority of women go for abortion not because of sex selection but because they don't have access to contraception. We studied the major reasons that distinguished those who had a second trimester abortion from those who had a first trimester abortion and found that the two main reasons are distance from a facility and poverty. This suggests that access is critical and expanding the provider base will address that.

Barriers to amending the MTP Act and steps expected from the MoHFW

Dr. Himanshu Bhushan: When working on a policy, the Government of India takes a consensus view. MTP is a sensitive issue that relates to women's rights, and keeping in mind existing societal biases, we are taking a careful and cautious path. But we assure you that we are working towards this. We also believe that nurses must be empowered, but that brings with it other concerns, such as the quality of training that must be introduced—translating proper training into a practical reality on the ground is a difficult process. We may initially begin with the government sector, in some specific areas where there is a definite lack of doctors. We can assure you that while we go slowly and cautiously we will not deprive women. Those who need these services will get them, this is our commitment.

Recommendations for India based on lessons learnt from countries where nurses and midwives provide abortion services

Ms Mary Luke: When we look at other countries, especially Nepal, all of the services provided in the rural areas are done through ANMs due to lack of doctors. First trimester abortions in many settings are done by trained midwives. In Ethiopia, where there are very few doctors, 97% of the care in health centers is provided by midwives. In South Africa as well most of the first trimester services are done by midwives. With regard to what India should be doing, once there is a supportive law there should be appropriate standards and guidelines specifying the level of providers and what they can do. There also needs to be a very clear training program, addressing the issue of how to prepare providers. Ipas has been pivotal in developing a comprehensive, hands-on training program that is practical

and gives providers a chance to practice their skills in technical aspects, counseling and treating women with respect and dignity. Certification is an important measure to reassure people of the standards that providers have to meet.

The feasibility of increasing nurses' workload given their limited numbers

Dr. Manju Chhugani: There is an acute shortage of doctors as well but we still hope that medical services continue to be provided. Shortage of providers in India is not a new thing, the number of nurses in India is less than ideal but we have seen high levels of commitment from this cadre of professionals and that is very encouraging.

Dr. Himanshu Bhushan: The shortage will always be there, but our perspectives have to change. Implementation is the most difficult aspect, we cannot deprive the society of services due a shortage of nurses, and professionals in the field must be multi-skilled.

Other comments

- There should be no concern about increasing sex-selective abortions by expanding the provider base since mid-level providers will only be permitted to offer first trimester abortions. Sex-selective abortions can be done only after 12 weeks facilitated by ultrasonography (USG).

- It is necessary to address the unmet needs of contraception and postabortion family planning within the spectrum of comprehensive abortion care.

Chairperson's comments

Mr. V.S. Chandrashekar stated that it was imperative that women be placed at the center of all discussions because irrespective of what maternal mortality numbers might be, it is important to protect the rights and choices of every woman.

He also remarked that is disheartening to see that despite the very progressive MTP Act in 1971, unfortunately India has accomplished very little in expanding the abortion provider base. Mr. Chandrashekar said that there are other countries in the South Asian region that have moved further and done more. This calls for reflection especially when there exists an objective, rational case for expanding the abortion provider base in India.

Parallel Session 2

Medical Abortion

It was expected that approval of mife-miso combination for early and safe abortions and liberalized use of medical abortion under the amendments to the MTP Rules would lead to increased choice and improved access to safe and early abortions for women in India. However, a decade after these developments, while the technology has advanced, the availability and use of medical abortion drugs within the health system in India continues to be limited. This session reiterated the potential of medical abortion especially in the public sector and its importance in the Indian context. Presentations on field-level challenges underlined the gaps and updates on the WHO-recommended protocols and approaches constructed ways to address them. The Call to Action includes recommendations from the session on effectively harnessing this technology for increasing access to safe abortion services.

Chairpersons

Ms. Gayatri Rathore, IAS
Secretary, Medical Health and Family Welfare and Mission Director, National Rural Health Mission, Government of Rajasthan

Dr. Hema Divakar
President, Federation of Obstetric and Gynecological Societies of India (FOGSI)

Presenters

Dr. Pratima Mittal
Professor and Consultant, VMMC and Safdarjung Hospital
Relevance of Medical Abortion for Indian Women

Dr. Kalpana Apte
Assistant Secretary General, Family Planning Association of India (FPAI)
Challenges of Accessing Medical Abortion

Dr. Jyoti Vajpayee
Global Clinical Advisor, Population Services International (PSI)
WHO Guidelines and Medical Abortion

Relevance of Medical Abortion for Indian Women

Dr. Pratima Mittal began her talk on the relevance of MA for Indian women with the important reminder that reproductive rights imply that women should be able to exercise complete control over childbearing and include the right to safe and legal abortion in case of an unwanted pregnancy.

Dr. Mittal stated that the introduction of MA in India caused a radical change in the abortion scenario. For women, MA increased options for choice among abortion technologies, it was a method that enhanced privacy and confidentiality and allowed women to carry on with their daily routine during the procedure. In the Indian scenario, one of the biggest challenges is that most women are still unaware of the existence of MA and lack information regarding the availability, services, and after care. Limited availability of MA drugs in the public health system further forces women to seek services from private providers at an increased cost. The fact that MA requires multiple visits to the provider is also a significant constraint.

Dr. Mittal recommended approving MA for second trimester abortions within WHO guidelines, increasing awareness on MA, particularly the distinction between emergency contraception and medical abortion, and encouraging home administration of misoprostol to reduce one of three mandatory visits to the service provider.

> “Medical abortion has great potential for improving access to safe abortion and can revolutionize the maternal health standards by reducing maternal morbidity and mortality.”
>
> **Dr. Pratima Mittal**

> As per guidelines, MA is used for first trimester abortion in India and therefore it should be evident to all of us that technically it has no links to sex-selective abortions.
>
> **Dr. Kalpana Apte**

Challenges of Accessing Medical Abortion

Dr. Kalpana Apte discussed the challenges in accessing medical abortion in India under three broad categories—information, service and referrals. With regard to information, she pointed out that there exists a significant lack of awareness and confusion among women and even providers concerning MA, emergency contraception and oral contraceptive pills. In addition, information lacunae also include legality, availability and access.

Emphasizing the importance of viewing MA within the larger MTP framework, Dr. Apte suggested that the weaknesses of the MTP framework also affect access to MA. For instance, the backlash from preventing sex-selective abortions has detrimental effects on availability of MA. However the reality is that even the introduction of MA has contributed to reducing unsafe abortions.

Dr. Apte presented evidence from an FPAI study which showed that increased vigilance on abortion service provision has negatively impacted providers who find it difficult to work in the hostile regulatory environment, especially surrounding MA. In conclusion, Dr. Apte recommended that MA be included in Government of India information-education-communication (IEC) packages, adequate MA stock be maintained at public health facilities, and strategies be put in place to ensure that the most vulnerable women have access to services.

WHO Guidelines and Medical Abortion

Dr. Jyoti Vajpayee summarized the 'Safe Abortion: Technical and Policy Guidance for Health Systems' published by the World Health Organization (WHO) in 2012, with a focus on updates in the guidelines regarding MA.

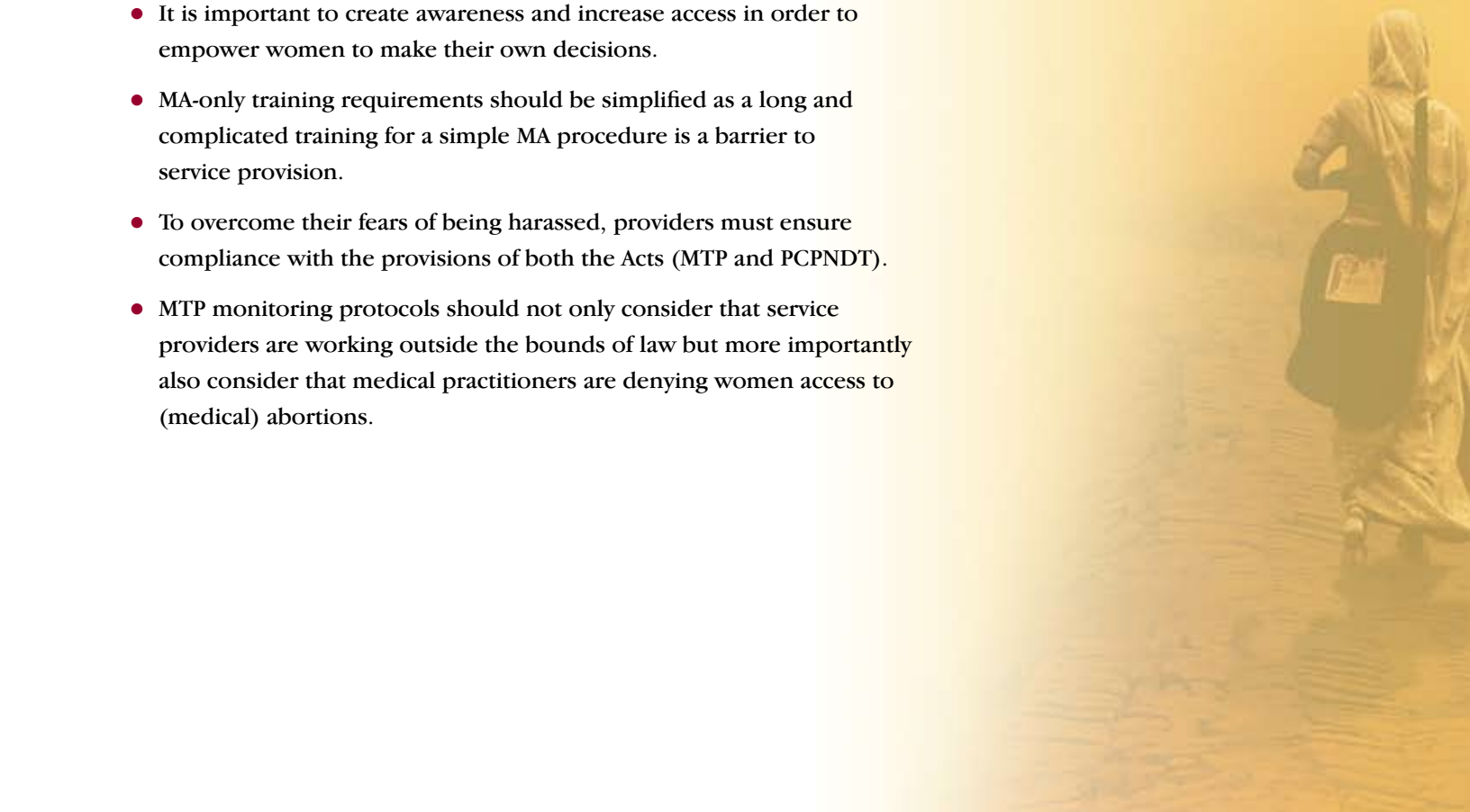
Based on current evidence, the WHO guidance extends the use of MA in the first trimester from 63 to 84 days. For termination of pregnancies over 12 weeks, a regimen of mifepristone, followed by repeated doses of misoprostol is safe and highly effective and recommended. The guidelines also say that ultrasound for the estimation of gestation, routine laboratory tests, and prophylactic antibiotics are not mandatory. Noting that the guidelines approve home use of misoprostol until nine weeks, Dr. Vajpayee stressed on the importance of effective post-procedure follow-up instruction.

She further recommended keeping up with the WHO guidelines regarding MA while being conscious of the Indian context and judiciously ensuring that levels of the public health system correspond with gestational ages. She also pointed out the need for separate guidelines for training of service providers on MA only. In addition, she recommended that MA drugs be made available at all service delivery points and the private sector be engaged with for providing quality safe abortion services.

Key Points from the Discussion

- It is important to create awareness and increase access in order to empower women to make their own decisions.
- MA-only training requirements should be simplified as a long and complicated training for a simple MA procedure is a barrier to service provision.
- To overcome their fears of being harassed, providers must ensure compliance with the provisions of both the Acts (MTP and PCPNDT).
- MTP monitoring protocols should not only consider that service providers are working outside the bounds of law but more importantly also consider that medical practitioners are denying women access to (medical) abortions.

> "I think that MA is a great technology and we should make it as easily available to women, within the guidelines, as we can... Stringent laws make it more expensive, clandestine and unsafe, and this inaccessibility does not do justice to women."
>
> **Dr. Jyoti Vajpayee**



Parallel Session 3

Addressing Issues of Gender-biased Sex Selection and Access to Safe Abortion

Two core issues in the current Indian context—gender-biased sex selection and abortions—are guided by distinct laws to enable them to be addressed effectively. However, limited understanding of these and conflation of the two issues especially in the field and the community have had adverse effects, more often on access to safe abortion. The session brought together voices of advocates for both issues, private providers, and government officials. The discussions in the session on whether a balanced approach is possible at the field level and what it entails formed recommendations on addressing issues of gender-biased sex selection and access to safe abortion for Call to Action.

Chairperson

Ms. Ena Singh

Assistant Representative, United Nations Population Fund

Presenters and Panelists

Dr. A.L. Sharada

Director, Population First

The Declining Sex Ratio: Causes and Concerns

Dr. Sharad Iyengar

Chief Executive, Action Research and Training for Health (ARTH)

How Are We Impeding Access to Safe Abortions?

Dr. Atul Ganatra

Chairperson, MTP Committee, Federation of Obstetric and Gynecological Societies of India (FOGSI)

The Voice of an Abortion Provider: Fears and Dilemma

Panelists

Panel Discussion—Is a Balanced Approach Possible?

Mr. Amitabh Behar

Executive Director, National Foundation of India

Dr. Neelam Singh

Chief Functionary, Vatsalaya

The Declining Sex Ratio—Causes and Concerns

Dr. A.L. Sharada started by saying that the desire for smaller families and societal preference for sons coupled with the blatant misuse of technological advancements in pre-conception and pre-natal diagnostic techniques have resulted in a steep fall in sex ratio. She presented evidence from the 2011 census which shows that across many Indian states the sex ratio has continued to decline.

She further suggested that the increased visibility of violence against women may reinforce the aversion to daughters. A sex ratio skewed in favor of males might result in strengthening of patriarchy and contribute to societal ills such as trafficking, polyandry, honor killings etc. She also pointed out that the same mindsets and economics which promote gender-biased sex selection also influence the implementation of the law, making it ineffective.

Dr. Sharada recommended positioning the PCPNDT Act as a move to stop gender discrimination and not as one to restrict access to safe abortions. She suggested sensitizing stakeholders at every level to gender issues and moving from an incentive-based approach to creating an enabling and nurturing environment for women. In closing, she brought up the need for creating awareness through specific sensitization and capacity building programs for key community members, medical professionals, and implementers of law.

> "In our concern for gender-biased sex selection are we undermining access to safe abortion services for women? The challenge is to address the two issues without compromising on either. Are we ready for the challenge?"
>
> **Dr. A.L. Sharada**

How are We Impeding Access to Safe Abortions?

Dr. Sharad Iyengar stated that while technological advancements made access to safe abortions easier, parallel movements such as the impetus provided by the campaign against female feticide resulted in restrictions on approval of private

> We need to evolve an alternate paradigm for dealing with sex selection in the context of gender inequality (including rape and violence), autonomy, education and health care, so that access to safe abortion and action to curb sex selection are seen as two sides of the same coin.
>
> **Dr. Sharad Iyengar**

facilities, availability of drugs, intrusive inspections of facilities, and adverse media coverage. Consequently, doctors' interest in providing abortion services has been negatively impacted.

Dr. Iyengar presented evidence from a qualitative study of MTP providers conducted in Rajasthan. Providers reported that the harsh regulation to prevent sex selection often resulted in intrusive enquiries into procedures. Doctors were of the opinion that when they reported MTP cases, they were negatively targeted. These experiences have contributed to both under-reporting of MTPs and an overall decline in procedures performed.

He said that currently in India fewer private facilities are being approved across the country, newer technologies remain on the fringes of formal provider practices, and services are not woman-friendly. Dr. Iyengar concluded his presentation with a reminder about the need for creating common ground between gender-biased sex selection and access to safe abortion—not just in civil society but in the minds of policy makers, service providers, and the media.

The Voice of an Abortion Provider: Fears and Dilemmas

Placing particular emphasis on the situation in Maharashtra, Dr. Atul Ganatra spoke of the difficulties due to increased regulation and government crackdown that have resulted in service providers not offering MTPs. He pointed out that while the last amendments to the MTP Act decentralized the approval process of private clinics, implementation of this continues to be poor. Approval of private clinics and responses to re-applications for approval are often delayed.

Taking up the issue of shortage of MA drugs in many states, including Maharashtra, Dr. Ganatra pointed out that it has become increasingly difficult for providers to prescribe these drugs as chemists do not stock them for fear of harassment from authorities. Enforcing authorities are often unaware of the MTP Act and subject service providers to unfair requirements when reporting MTP cases, including personal details of patients.

Dr. Ganatra recommended that district level committees (DLCs) be formed where required and the approval process for private clinics be streamlined. He emphasized the importance of de-linking first trimester abortions from the purview of PCPNDT authorities.

Key Points from the Panel Discussion

- Both MTP and PCPNDT Acts are powerful legislations which are designed to empower women and address the gender bias within the patriarchal Indian society.
- Deliberations and considerations regarding the right to safe abortions must be placed in the larger context of declining public health.
- There is a need to revisit the PCPNDT Act and consider more clarification of some aspects as required.
- There is need for effective communication on the distinction between the two Acts.
- There should be focus on increasing societal support for access to abortions by creating awareness that unsafe abortions are as anti-women as sex-selective abortions.

> "As a result of the harassment of providers by the authorities, women will suffer. Sex selection and providing safe abortions should not be mixed up."
>
> **Dr. Atul Ganatra**

Chairperson's Comments

Ms. Ena Singh summed up the session proceedings in her address and offered balancing views on the concerns raised during the session. Suggesting caution she stated that going back to the drawing board on the PCPNDT Act might have negative consequences for the MTP Act. She was in favor of easing access to first trimester abortions alone as long as it did not have the inadvertent consequence of tightening restrictions on second trimester abortions.

Ms. Singh remarked that there is no conflict between the two Acts on policy and conceptual levels. However, the challenge lies in making them co-exist in the Indian context—how to implement them and enable, facilitate or restrict under them. She said that there is a need to articulate and use to good effect the fact that only a small percentage of all abortions are due to sex selection. There has been more of a common understanding over the last two to three years that the language and positioning used in the communication about the two issues is very important and that in the process of communication, imbalance should not be created between the two issues. She said that it was encouraging that there is agreement now both in the government and civil society discourse that the expression female feticide will not be used; it has begun to be positioned as gender-biased sex selection.

Parallel Session 4

Addressing the Sexual and Reproductive Health Needs of Young Women

Young people constitute two-fifths of the Indian population. While it is recognized that their needs for information and services are different, little is known about gaps in their knowledge on sexual and reproductive health (SRH) and even less is done to make services available for them. This session aimed at developing recommendations for addressing the sexual and reproductive health needs of young women.

Chairperson

Ms. Dipa Nag Chowdhury
Deputy Director, India Office, MacArthur Foundation

Presenters

Ms. Sudha Tewari
President, Parivar Seva Sanstha (PSS)
Making Safe Abortion Services Available for Young Women: Experiences and Lessons Learnt

Dr. Aparajita Gogoi
Country Director, Center for Development and Population Activities (CEDPA)
Experiences and Challenges of Integrating Adolescent Sexual and Reproductive Health in the School Curriculum

Dr. S.K. Sikdar
Deputy Commissioner, Family Planning, Ministry of Health and Family Welfare, Government of India
National Commitment and Strategies to Improve Young People's Sexual and Reproductive Health (RMNCH+A)

Voices of the Young

Ms. Bhagirathi Devi
Upmukiya, Bagodar Panchayat

Ms. Paramita Aich
State Program Officer, Jharkhand, Ipas India
Working on Abortion among Other SRH Issues

Ms. Prabha Nagaraja
Executive Director, Talking About Reproductive and Sexual Health Issues (TARSHI)
Lack of Comprehensive Sexuality Education and Implications for Access to Safe Abortion

Ms. Gracy Andrew
Country Manager, CorStone
Skills that the Young in India Need to be Empowered With

Voices of the Young

The chairperson, Ms. Dipa Nag Chowdhury, introduced the first part of the session, 'Voices of the Young', by stating how important it is to understand if and how young people access information about abortion. She pointed out that one of the reasons for the high percentage of maternal deaths among young women is that they face many constraints in accessing information, especially about abortion.

Ms. Paramita Aich expanded upon her experiences from a youth-focused intervention aimed at 20,000 women in 300 villages in Jharkhand. The intervention employs a peer-to-peer approach and has developed a cadre of 32 youth leaders and 300 youth volunteers from the villages to fulfill its three key objectives: 1) To create awareness of safe abortion services from the perspective of sexual and reproductive health of women; 2) To increase young women's participation in development of communication strategies and materials to ensure they are youth-friendly and culture-specific; 3) To make clinics and service providers youth-friendly. Using unique strategies such as youth fairs, the project has been able to reach not only young women but also adolescent girls and school dropouts.

Ms. Bhagirathi Devi shared her experiences as one of Ipas's youth leaders in Jharkhand. She mentioned that her prime motivation to increase young women's awareness about SRH came from her own experience—she was married at the age of 13 years and had to give up her studies. She believes her experience is similar to that of many other young women who married at a young age. She pointed to engaging with young girls on the need to talk about SRH as her biggest challenge. She has to emphasize the importance of youth-specific information and the intrinsic value of the information itself, "I say that material gifts are temporary, but the knowledge on women's health that I give will be with you for a lifetime."

Ms. Prabha Nagaraja talked about the implications of lack of comprehensive sexuality education (CSE) on access to safe abortions. She provided examples of lack of awareness among youth regarding basic information on sex, reproduction, and abortion to demonstrate the need to establish CSE in school curricula. Lack of information does not stop young people from being sexually active and engaging in unsafe practices, leading to unwanted pregnancies and infection. And therefore Ms. Nagaraja expressed her belief that access to safe abortion begins with access to accurate sexuality information and spaces to learn decision-making and other skills.

Speaking on the importance of empowering youth with the skills to thrive, Ms. Gracy Andrew emphasized on the need to impart life-skills education to young men and women. She pointed out that the ability to make the right reproductive choices and engage in positive behaviors is determined by one's sense of self-worth and practical life skills; (self-advocacy, problem-solving, coping, communication skills) and not merely by access to information and resources. Ms. Andrew called for the development of comprehensive resilience-based communication interventions that build core skills and have lasting impact when addressing SRH for youth.

Making Safe Abortion Services Available for Young Women: Experiences and Lessons Learnt

After taking the participants through a detailed history of abortion in India, Ms. Sudha Tewari reiterated the importance of strengthening post-abortion family planning and providing access to contraception which helps reach many more women and avoid repeated pregnancies and abortions. Elaborating on the profile of women seeking abortions at PSS centers, Ms. Tewari revealed that 86% are in their first trimester; about 54% live below the poverty line with an additional 36% from low-income households; and 72% are below 25 years old.

Ms. Tewari further presented evidence from a situational analysis of pregnant women, both adolescents and youths, who sought reproductive health (RH) services from selected 25 PSS clinics. Findings show that only one third of adolescents and young people were aware that abortion is legal in India. The majority were also unaware of where to seek information and services. Acknowledging that policies around abortion are very supportive she stated that the biggest challenge lay in implementing these policies at the ground level. She also mentioned that conflation of the MTP and PCPNDT Acts is creating a hostile environment for the provision of safe abortion services in many states. Ms. Tewari recommended that these issues be addressed at the state and district levels in order to facilitate young women's access to safe abortion.

> "A major chunk of women seeking abortions—72%—are aged up to 25 years. Gaps in making safe abortion services available for young women should be addressed; particularly at the state and district levels."
>
> **Ms. Sudha Tewari**

Experiences and Challenges of Integrating Adolescent Sexual and Reproductive Health in the School Curriculum

Dr. Aparajita Gogoi spoke persuasively about her experiences of introducing the Adolescence Education Program (AEP) in Jharkhand and Bihar. She stated that while there are no barriers at the policy level, challenges emerge at the state and district levels. She pointed out the systemic and societal challenges of providing adolescents SRH education in the Indian scenario by citing example of how in mid-2000, 12 states banned AEP in schools on the basis that it was attack on the Indian culture.

Dr. Gogoi also noted that working through the school system offered many opportunities like the ability to reach a very large number of children in a short time period. However, she continued, "Until there is state ownership, these programs if only pushed by NGOs will not work." In addition, she mentioned the pressing need for convergence among all the state departments and agencies in joint program guidance, monitoring, and fund allocation.

Given the sensitivity of the subject, while developing education materials, efforts have to be made to ensure participative material development, which is needs-based and

> Arguments of morality and culture cannot justify the denial of live-saving information to adolescents and young people.
>
> **Dr. Aparajita Gogoi**

appropriate for the cultural context. One of the biggest challenges, according to Dr. Gogoi, is creating an enabling environment within the state by working with relevant state and district-level stakeholders, community leaders, media, and decision makers. She also placed great emphasis on reaching children early, as introducing them to appropriate SRH education at earlier ages leads to better results. In her concluding statements, she noted that linking information with services is a critical aspect of any education program.

National Commitment and Strategies to Improve Young People's Sexual and Reproductive Health (RMNCH+A)

Dr. S.K. Sikdar began his talk by drawing attention to the fact that India is getting younger—an increasing percentage of the population is comprised of youth. This trend, Dr. Sikdar noted, poses big challenges. Teenage fertility is a big problem. The 15-24 years age group contributes 52% of the country's fertility, which results in 12.8 million births every year and contributes to 45% of maternal mortality. In addition, only approximately seven percent women between 15-19 years use contraception. While fewer women in this age group are getting married, the percentage is still close to 30%. To combat these worrying trends, the Government of India has adopted the RMNCH+A approach—reproductive, maternal, new-born, child and adolescent health. This approach tackles health issues across life stages and between various levels of health care system by linking community and facility-based care and establishing referral mechanisms.

To address youth SRH, Dr. Sikdar said, the RMCH+A has put in place community-based promotion and delivery of contraceptives, promotion of spacing methods, prevention and management of sexually transmitted and reproductive infections and comprehensive abortion care reducing out-of-pocket expenses for the population.

> More than 25,000 young mothers are dying every year. These are stark realities. We need to have policies to change this.
>
> **Dr. S.K. Sikdar**

What is still needed, according to Dr. Sikdar, is engaging the youth and providing them with accurate information regarding SRH, increasing accessibility by addressing social barriers and developing youth-friendly policies focused on educational empowerment.

Q&A

During the Q&A the participants delved further into the various dimensions of youth SRH covered in the presentations. Following are some highlights from the discussion:

1. Barriers to educating youth on SRH

   - The biggest barrier is acceptance. There is significant opposition on multiple levels from district education officers and teachers.
   - Any sex education program requires painstaking efforts to build consensus among all stakeholders.
   - There is a need for pre-service and in-service training of trainers, general awareness-building followed by behavior change communication (BCC) in schools and communities.

2. Sustainability

   - To ensure adequate monitoring of the program once the concerned implementing agency withdraws, it is desirable that the state increases ownership and takes over the monitoring and continued implementation of the program.

3. Use of social media to reach youth

   - Experience shows that even in rural areas, it is not only easier to reach youth through technology but also more effective to deliver messages in a practical, innovative and interesting manner.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Reaching Out to Community
Technical Posters
Hospital Waste Management
Serious Adverse Event (SAE) Reporting in CAC
Putting On and
MMA Job Aid
STEPS FOR
ROUTINE HAND WASH
IPC Tool Kit Trunk
CAC Training Aid

Day Two: Session 5

Scaling-up CAC Services under NRHM: Experiences and Lessons Learnt

Having recognized increasing access to safe abortions as an important strategy for reducing maternal mortality, governments at the national and state levels have implemented programs including innovative approaches for comprehensive abortion care. Based on lessons learnt and continued commitment, this session recommended the way forward for scaling-up and replicating the CAC model in other parts of the country.

Chairpersons

Dr. Rakesh Kumar (IAS)
Joint Secretary (Reproductive and Child Health), Ministry of Health and Family Welfare, Government of India

Mr. Vinoj Manning
Country Director, Ipas India

Presenters and Panelists

Dr. Sumant Mishra
Director (Health Services), Government of Jharkhand
Scaling-up CAC Services in the Public Sector

Dr. Sanjay Goel (IAS)
Director (Public Health and Family Welfare), Government of Madhya Pradesh
The Potential of Medical Abortion in Madhya Pradesh

Dr. Sushanta Banerjee
Senior Advisor, Research and Evaluation, Ipas India
Trainee to a CAC Provider: Experiences and Lessons Learnt

Dr. Manisha Malhotra
Deputy Commissioner, Maternal Health, Ministry of Health and Family Welfare, Government of India
Government of India's Efforts for Increasing Access to CAC Services

Scaling-up CAC Services in the Public Sector

Dr. Sumant Mishra presented the strategies that the Jharkhand government has used to scale-up CAC services in the public sector over the last decade. During 2003-13, the number of CAC training centers in the state has increased from one to 13, and the number of doctors trained in CAC has gone up to 625. He said that to reduce maternal mortality due to unsafe abortions, the Jharkhand Rural Health Mission scaled-up CAC services with the objectives to increase access to safe abortion services, increase quality of abortion services, and spread correct information.

To facilitate the provision of CAC services in Jharkhand, Dr. Mishra said that the state has established an MTP cell, formed DLCs in 24 districts, shared the CAC guidelines with all facilities that have a CAC-trained provider, and conducted many IEC activities to increase community awareness. Identifying some of the biggest challenges in scaling-up, Dr. Mishra also presented replicable strategies that are used to overcome them. For instance, post-training support is given to trained doctors who are not confident about providing services and mobility support is arranged for Sahiyyas to motivate them to accompany women to public health facilities. In addition, CAC services have also been linked to the ARSH program.

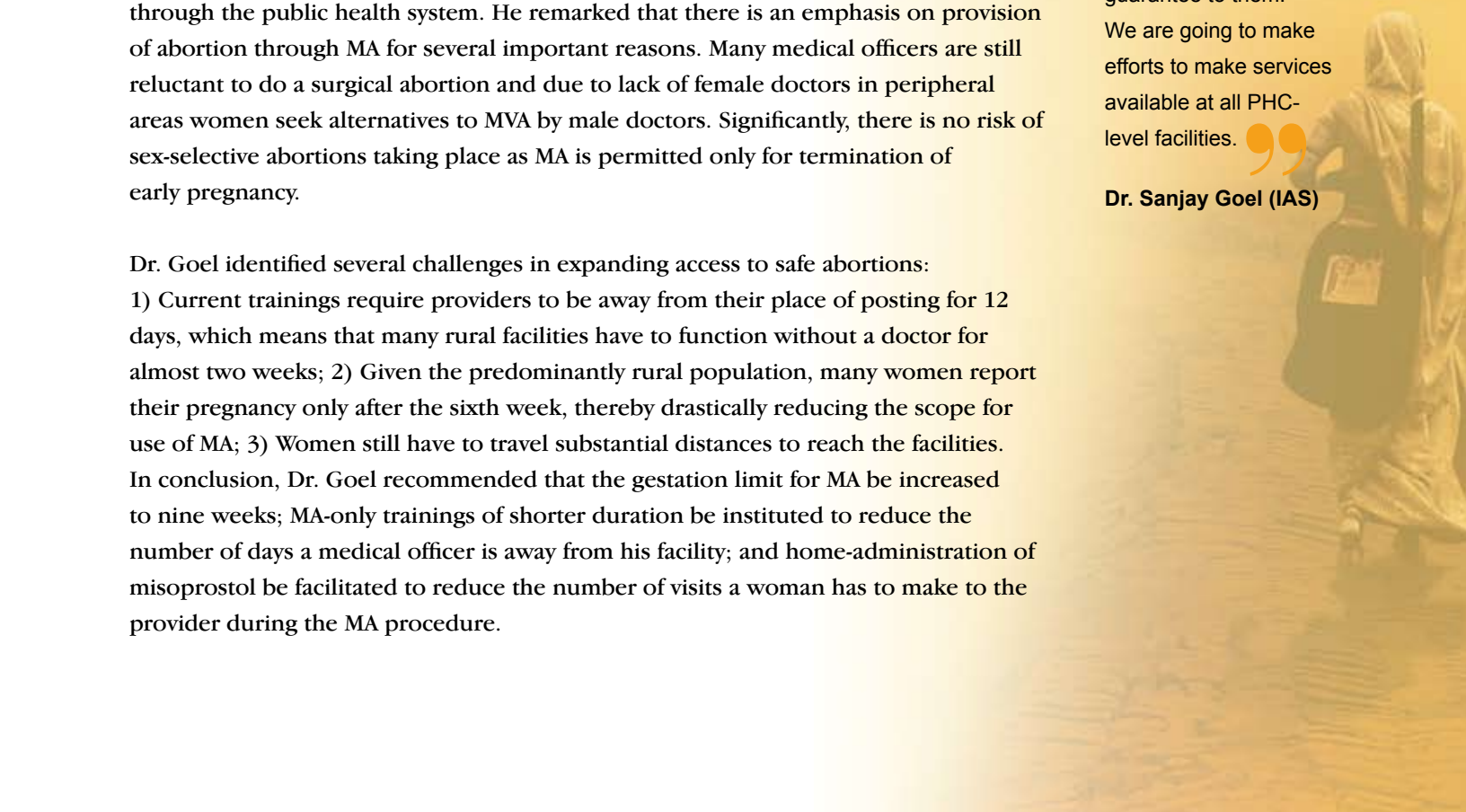
> "We have lots of challenges in our state—poor infrastructure, poorly-trained manpower, naxalism—in spite of all constraints and odds we are trying strategies for the benefit of Jharkhand."
>
> **Dr. Sumant Mishra**

Expanding Access to Medical Methods of Abortion in Madhya Pradesh

Dr. Sanjay Goel (IAS) said that the Government of Madhya Pradesh is invested in leveraging the potential of the MA technology to offer safe abortion services to women through the public health system. He remarked that there is an emphasis on provision of abortion through MA for several important reasons. Many medical officers are still reluctant to do a surgical abortion and due to lack of female doctors in peripheral areas women seek alternatives to MVA by male doctors. Significantly, there is no risk of sex-selective abortions taking place as MA is permitted only for termination of early pregnancy.

> "We should ensure early abortion as a matter of women's rights. And it is our duty at public health facilities to provide this guarantee to them. We are going to make efforts to make services available at all PHC-level facilities."
>
> **Dr. Sanjay Goel (IAS)**

Dr. Goel identified several challenges in expanding access to safe abortions:
1) Current trainings require providers to be away from their place of posting for 12 days, which means that many rural facilities have to function without a doctor for almost two weeks; 2) Given the predominantly rural population, many women report their pregnancy only after the sixth week, thereby drastically reducing the scope for use of MA; 3) Women still have to travel substantial distances to reach the facilities. In conclusion, Dr. Goel recommended that the gestation limit for MA be increased to nine weeks; MA-only trainings of shorter duration be instituted to reduce the number of days a medical officer is away from his facility; and home-administration of misoprostol be facilitated to reduce the number of visits a woman has to make to the provider during the MA procedure.



> Beyond numbers, what really improves with post-training follow-up is the quality of service provision.
>
> **Dr. Sushanta Banerjee**

Trainee to a CAC Provider: Experiences and Lessons Learnt

Dr. Sushanta Banerjee presented the scope of Ipas's training and follow-up to ensure provision of services by CAC-trained providers. Stating that successful training does not necessarily lead to service provision, Dr. Banerjee remarked that majority of the trained providers require some form of post-training support. This support, he said, must go beyond monitoring and should be need-based and provider-specific. Enumerating the reasons for non-provision of services by trained providers, he suggested that the lack of infrastructure, community awareness and personal interest and constraints due to the PCPNDT Act were major reasons, but the overarching issue was the societal stigma associated with abortions. Repeated contacts with the service provider, he said, helped improve service provision and importantly, the quality of care. Ipas India's experience shows that it takes about five months of support to transform a "trainee" into a "provider".

Closing his presentation, Dr. Banerjee recommended that careful selection of trainees, post-training support designed to fit each provider's individual needs, ensuring uninterrupted CAC services at delivery points, and building community awareness are key to ensuring quality service provision.

Government of India's Efforts for Increasing Access to CAC Services

Dr. Manisha Malhotra stated that while the declining trend in MMR in India is encouraging, there is still a long way to go, especially in providing and strengthening CAC services at the state level. She pointed out the need for comprehensive data, with adequate indicators for abortions.

The MoHFW has placed CAC within the strategic framework of the RMNCH+A and has taken up initiatives like inclusion of MMA drugs in the essential drugs list, deployment of providers at delivery points, strengthening DLCs, monitoring CAC services, and conducting state-level workshops on CAC. Acknowledging that lack of community awareness is a big challenge, Dr. Malhotra stated that the MoHFW is preparing to launch a mass media campaign to build awareness on safe abortions and will work on strengthening IPC on safe abortions through ANMs and ASHAs.

Dr. Malhotra recommended that efforts be increased for building capacity of providers for CAC services, encouraging trained providers to provide services and strengthening reporting. In addition, she called for enhancing the availability of MVA and MA across public sector sites in all states and ensuring the availability of CAC services for adolescents and young women.

> "Whether any country has a restrictive law or a less restrictive law, induced abortions will continue to happen and we will continue to grapple with providing safe services. Offering CAC is now an imperative."
>
> **Dr. Manisha Malhotra**

Chairperson's Comments

Dr. Rakesh Kumar (IAS) said that the PCPNDT Act should not prevent taking the MTP agenda forward in the country. There are many factors that result in women's inability to access CAC services, including the lack of sensitization and demand generation. These issues must be addressed.

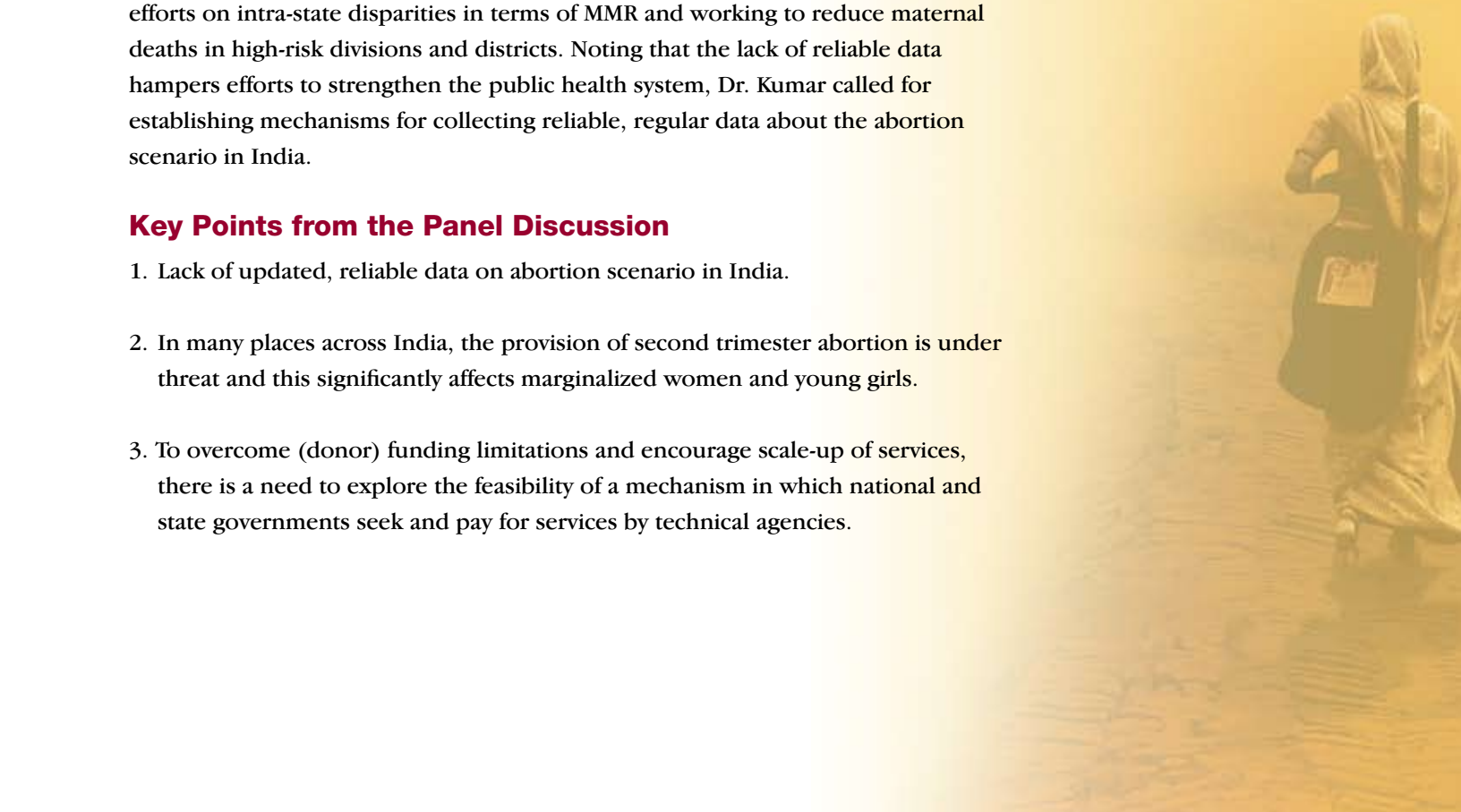
He spoke about the importance of training as a key component of strengthening health systems and congratulated Ipas India for the initiative taken to support providers post-training. Dr. Kumar placed emphasis on identifying and focusing efforts on intra-state disparities in terms of MMR and working to reduce maternal deaths in high-risk divisions and districts. Noting that the lack of reliable data hampers efforts to strengthen the public health system, Dr. Kumar called for establishing mechanisms for collecting reliable, regular data about the abortion scenario in India.

Key Points from the Panel Discussion

1. Lack of updated, reliable data on abortion scenario in India.

2. In many places across India, the provision of second trimester abortion is under threat and this significantly affects marginalized women and young girls.

3. To overcome (donor) funding limitations and encourage scale-up of services, there is a need to explore the feasibility of a mechanism in which national and state governments seek and pay for services by technical agencies.



Closing Plenary

Speakers

Dr. Rajani Ved

Advisor, Community Processes, National Health Systems Resource Center

Presentation of Draft Recommendations

Dr. Manisha Malhotra

Deputy Commissioner (Maternal Health), Ministry of Health and Family Welfare, Government of India

Presentation of Call to Action

Mr. Keshav Desiraju (IAS)

Secretary (Health and Family Welfare), Government of India

Responding to Commitments and Way Forward

Ms. Mary Luke

Executive Vice President, Programs, Ipas

Closing Remarks and Vote of Thanks

Draft Recommendations

Dr. Rajani Ved presented the draft recommendations of the national consultation. Focusing on the short-term and immediate steps that can be taken to ensure access to safe abortions within the current legal framework, Dr. Ved presented a synthesis of strategies that were deliberated on during the national consultation. These strategies are designed to enhance and bolster service delivery; update existing rules, regulations and guidelines; clarify the differences between the MTP and the PCPNDT Acts; target and address the needs of young women; effectively communicate safe abortion; and strengthen partnerships within and between the public and private sectors. *Please see Annex 1 for the complete list of draft recommendations.*

Call to Action—Committing to Women's Health

Dr. Manisha Malhotra presented the codified Call to Action to Mr. Keshav Desiraju. Based on key recommendations from each session, the Call to Action was developed by a core team consisting of representatives from the Ministry of Health and Family Welfare, the National Health Systems Resource Centre, and Ipas. It is envisioned as a roadmap for national policies and implementation of programs at various levels for increasing CAC services. While recognizing that there has been substantial progress in decreasing abortion-related maternal mortality in India, the Call to Action also noted that unsafe abortions continue to be a significant cause of maternal mortality and morbidity. Broadly, the document calls for immediate action on amending and more effectively implementing the MTP Act, empowering and leveraging nurses, community-level health workers and other agents, empowering young people and increasing awareness about legality of abortion, addressing abortion-related stigma and the conflation of sex-selection and abortion, and conducting enhanced research and evaluation of the abortion scenario in India. *Please see Annex 2 for the complete Call to Action.*

Secretary's Response

Expressing strong agreement with the Call to Action and other recommendations, Mr. Keshav Desiraju stated emphatically that guaranteeing the right to access to safe abortion services for every woman is important and necessary. Mr. Desiraju placed particular emphasis on improving service delivery and spreading awareness with special attention to ensuring privacy and upholding the dignity of women. He highlighted the necessity of expanding the abortion discourse to people who are directly affected and have differing opinions on the issue. He suggested that utilizing ASHAs who have, "shown themselves capable of sensitivity and diligence," is one way of reaching communities with the correct messages.

> Anything to do with access to health care by women is important. And I think we can move this beyond access to abortion services. In India or anywhere in the world, to be poor, sick and female is to be three times vulnerable. We must remember that.
>
> **Mr. Keshav Desiraju (IAS)**

Acknowledging the gravity of challenges arising from the conflation of the MTP and PCPNDT Acts, Mr. Desiraju noted that one way of spreading the message that access to safe abortions is a right and sex selection is a crime would be through the public health system—doctors, nurses, and other agents on the field. While admitting that this is not an easy endeavor, he noted that it is an imperative. Mr. Desiraju also brought up the need for communication among states on effective strategies and programs to ensure access and improve services across the country.

Mr. Desiraju then spoke to representatives from various states regarding their experiences with ensuring access to safe abortions and heard concerns and suggestions from the participants. These included the need for accelerating the amendments to the MTP Act, building awareness among authorities and health administrators regarding abortions and gender discrimination, setting up mechanisms to check state violations of the MTP Act, and the urgent need to ensure that adolescents' and young women's right to safe abortions are upheld.

Vote of Thanks

In her vote of thanks, Ms. Mary Luke said that it had been Ipas's great privilege and honor to work with the Ministry of Health and Family Welfare in planning and organizing the national consultation. She expressed her appreciation for the opportunity presented by the meeting to reflect on the progress made over 40 years and develop a strong action plan to move forward the safe abortion agenda in the context of women's reproductive health and rights.

Ms. Luke thanked Mr. Keshav Desiraju for his encouragement to broaden the dialogue about abortions and went on to convey thanks to Ms. Anuradha Gupta for her inspiring keynote address and commitment to the reproductive rights of women. She also acknowledged the leadership of Dr. Manisha Malhotra and Dr. Rajani Ved and their contributions to the core group that brought out the Call to Action.

Expressing her gratitude to all the plenary speakers, session chairs, and participants, Ms. Luke thanked them for sharing their experiences and challenges, and strategies about the way forward. She concluded by thanking the Ipas India team for planning and organizing the meeting and the 40th anniversary celebrations and brought the national consultation to a close by saying, "We know that it needs all of us working together in partnership to make safe abortions a reality for all women in India. Let's not take the next 40 years to do it."

Annex 1: Draft Recommendations

The "Big Picture"

- Increase awareness among women that safe abortion is a right.
- Include safe abortion services as an entitlement under the Janani Shishu Suraksha Karyakram.
- Focus on vulnerable and marginalized women, including young women, those in urban slums and difficult geographic terrains.
- Strengthen state-level implementation through a mix of approaches: advocacy, technical assistance, and supportive supervision.
- Make access to safe abortion care a "non-negotiable"; clearly distinguishing between the PCPNDT and MTP Acts.

Service Delivery

- Ensure that safe abortion is part of the continuum of care framework.
- Prioritize the provision of Comprehensive Abortion Care (CAC) at designated delivery points including those in remote, inaccessible locations.
- Enable provision of first trimester abortions as part of primary health care services (PHC/CHC); and second trimester abortions as part of secondary/tertiary care (FRU/DH/ Medical Colleges).
- Bridge the gap between trained providers and service provision by rational deployment of Human Resources.
- Strengthen District Level Committees to facilitate the process of certification and monitoring.
- Ensure inclusion of services for CAC in existing monitoring and reporting systems.
- Monitoring protocols to be designed to focus on the critical "actionables" (access, quality, availability).
- Strengthen the skills of nurses to provide post abortion care, manage incomplete abortion and treat complications of unsafe abortion.
- Sensitize pharmacists on appropriate referral of women seeking medical abortion.

Rules, Regulations, and Guidelines

- Amend MTP Rules to enable short course training and certification of providers in "Medical Methods of Abortion".
- DCG (I) approvals for MMA drugs to be in line with WHO recommendations.
- Drugs for medical abortion to be part of the Essential Drug List.
- Ensure availability of drugs and MVA kits through strengthening procurement and logistics systems.
- Develop training guidelines to manage unsafe abortion.
- Review and finalize the proposed amendments to the MTP Act.
- Expand the provider base by empowering and authorizing nurses and other appropriate cadres to provide safe abortion services.
- Ensure that the GOI guidelines are in synergy with WHO guidelines including for second trimester abortions.
- Abortion to be an integral part of medical and nursing curricula supplemented by in-service training.
- Enable competency-based training and skill certification of nurses and other cadres.

MTP and PCPNDT

- Engage with media and other stakeholders to clarify understanding of PCPNDT and MTP Acts.
- Sensitize implementing authorities on the issues surrounding sex selection and the service guarantee of safe abortion.
- Replace the terminology of "female feticide" with "gender discrimination" in legal and policy documents.

Addressing the Needs of Young Women

- Strengthen legal literacy on abortion issues, especially for adolescents.
- Include abortion as part of the package of Sexual and Reproductive Health Services for adolescents.
- Integrate adolescent sexual and reproductive health in school curricula.
- Orient teachers and school health teams to using sensitive approaches to the issue of abortion among young women.

Communicating Safe Abortion

- Design comprehensive communication strategy on abortion issues.
- Strengthen community outreach and education efforts to increase awareness, provide information on availability of services and the consequences of unsafe abortion.
- Emphasize interpersonal communication and use of culturally appropriate local media.
- Make use of existing helplines (104) to facilitate women's access to qualified providers.
- Build the capacity of the ASHA to communicate that abortion is a health right, enable pregnancy testing, and provide information on seeking early abortion at appropriate sites.

Strengthen Partnerships

- Strengthen partnerships with NGOs, professional bodies, and the private sector to expand access to services and serve as training sites to supplement public sector.
- Include safe abortion as part of the mandate of development partners and technical agencies supporting states to implement RMNCH+A.
- Build coalitions between policy makers, practitioners, civil society, media, academia and researchers to build consensus on Reproductive Health and Rights and address issues of gender discrimination.

Building and Expanding Our Knowledge Base

- Ensure inclusion of abortion-related data in large-scale surveys.
- What is the burden of morbidity on account of unsafe abortions?
- Where and under what circumstances is denial of care taking place?
- Test approaches to expand access for vulnerable groups.

Annex 2: A Call to Action

Ministry of Health & Family Welfare,
Government of India
&
Ipas

BEYOND 40 YEARS
OF LEGAL ABORTION IN INDIA
Committing to Women's Health and Rights

A Call to Action
13 September, 2013, New Delhi, India

We, the representatives of government, civil-society organizations, development partners, medical and nursing professionals, researchers and young people committed to protecting the reproductive health and rights of Indian women and safeguarding their access to affordable, woman-centered comprehensive abortion care, **recognize that**:

- India's Medical Termination of Pregnancy (MTP) Act 1971 etched a milestone in women's reproductive health and rights.
- Concerted efforts by government and civil society have led to substantial progress in decreasing abortion-related maternal mortality in India.

However, **we note** with concern that:

- Even today, about two-thirds of abortions in India are still unsafe.
- Unsafe abortion still is the third largest cause of maternal mortality and morbidity in India.
- Every two hours, a woman dies as a result of unsafe abortion.
- Young women and girls are disproportionately affected.
- Most women in India do not know that abortion is legal, nor where to obtain safe, legal abortion care.
- Ad hoc responses to sex selection have affected women's access to safe and legal abortion.

We call for action on:

- **More effective implementation of the MTP Act and related government commitments**, including:
  - Integration of comprehensive abortion care into the continuum of care for women, including young women and vulnerable and marginalized populations (for example, in urban slums).

  - Prioritizing provision of comprehensive abortion care in designated service delivery points including those in remote, inaccessible locations.
  - Updating national CAC guidelines and Drugs Controller General of India approvals to conform to World Health Organization recommendations.
  - Ensuring functional District Level Committees.
  - Strengthening monitoring and reporting of comprehensive abortion care services.
  - Strengthening decentralized procurement and logistics systems for abortion-related equipment and drugs and a full range of contraceptive methods.
  - Ensuring availability of second-trimester abortion services.
  - Partnerships with NGOs and private sector to supplement public-sector CAC services.
- **Empowering nurses** to play an active role in abortion care.
- **Strengthening pre-service and in-service training for safe abortion and certification of skills across all cadres of providers.**
- **Leveraging community health workers and other agents** to support prevention of unwanted pregnancies and to inform women about the legality of abortion and availability of services.
- **Enabling young people to exercise their reproductive rights** by integrating comprehensive sexuality education into school curricula and school-based reproductive rights programs, and reaching youth through various channels.
- **Increasing awareness of legal abortion** and where to obtain safe abortion care through a comprehensive communication strategy including mass media and interpersonal communication.
- **Addressing abortion-related stigma** among providers and communities.
- **Addressing conflation of sex selection and abortion** by:
  - Sensitizing implementing officials at all levels to distinctions between the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) and MTP Acts, so that enforcement of one does not compromise the other.
  - Engaging with media and other stakeholders to emphasize the importance of addressing issues of sex selection and gender discrimination as well as unsafe abortion.
- **Enhanced research, monitoring, and evaluation** to assess progress and improve policies and programs including in national and large-scale surveys.
- **Amendment of the MTP Act and Rules** including expanding the base of legal abortion providers and certifying providers for medical methods of abortion (MMA) only.

We **affirm**:

- That access to safe abortion is a public health and human rights imperative.
- Our commitment to eliminate gender discrimination and to promote women's empowerment.
- The essential value of broadening and strengthening partnerships in making safe abortions a reality.

There is an urgent need to collectively commit to women's reproductive health and rights and to ensure that all women have access to safe and legal abortion.

The time to act is now.

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