

Expanding the Provider Base for Abortion Care

Findings and Recommendations
from an Assessment of
Pre-service Training Needs
and Opportunities in India.

Unsafe abortions remain a major health concern in South-Central Asia.¹ The World Health Organization (WHO) estimates that more than 6.8 million unsafe abortions took place in 2008 – the highest of any region in the world.¹ Maternal deaths resulting from unsafe abortions are also high in the region, with 14,000 estimated in 2008, representing 30 percent of maternal deaths from unsafe abortions worldwide.¹ While supportive laws, policies and improved services enable some women to access care, safe abortion services remain unattainable for many. Limited awareness, lack of access to services among rural populations, costs, cultural issues, and a shortage of trained physicians, all contribute to unsafe abortion rates in the region.²

Increasing the number and types of providers authorized and able to offer safe abortion care is one strategy for improving women's access to safe abortion services. It is backed by global research^{3,4} and supported by WHO⁵, abortion can be safely provided by any appropriately trained health provider, including mid-level, non-physician providers—such as, midwives, nurse practitioners, clinical officers, physician assistants, family welfare visitors and others—who are trained to conduct basic clinical procedures related to reproductive health. WHO emphasizes that the availability of trained providers within reach of the entire population, is essential to ensuring access to safe abortion services.⁵

In 2012, Ipas undertook an assessment in Bangladesh, India, Nepal, and Pakistan to determine the specific needs and gaps in the pre-service education systems for non-physician, mid-level providers (MLP) and to identify opportunities, strategies, and recommendations for creating more equitable access to safe abortion care. **The assessment results and recommendations presented below, focus on India.**

■ The Indian Context

The Medical Termination of Pregnancy (MTP) Act was passed in 1971 legalizing abortions up to 20 weeks of pregnancy. It allows any government hospital or approved private facility, to perform abortions. In 2003, an amendment to the MTP Act expanded access to early abortion services by minimizing requirements for facilities to provide abortions only in the first trimester. The amendment also permitted obstetrician /gynecologists (OB/GYN) and other certified medical practitioners to prescribe medical abortion drugs for abortion up to seven weeks of pregnancy, even from an unapproved private facility with a referral linkage. Despite the MTP Act, unsafe abortions persist in India. Many women are unaware of the legal provisions, services are not easily accessible, and an estimated two thirds of all abortions, “take place outside the authorized health services by unauthorized, often unskilled providers”.⁶ Furthermore, implementation of the MTP Act has been slow and geographically uneven, and abortion services are not adequately decentralized. Additional regulatory reforms may be necessary to accomplish further decentralization of legal services.⁷

Additionally, strict regulations on which types of providers can provide abortion services, and under what conditions, greatly contribute to the unsafe abortion rate in India. Barring medical emergencies, the MTP Act, requires that abortions are performed by a registered

physician in a hospital established or maintained by the government or in a facility approved for the purpose by the government. For abortions taking place between 12 and 20 weeks of pregnancy, a second opinion is required. While medical abortion can and is safely being provided in many global settings under more simple requirements than surgical abortion, providing medical abortion remains cumbersome in India. Given the educational requirements of providers and shortage of training facilities in the country, these regulations place undue burden on women's access to legal abortion services in India.

Although registered physicians are in shortage, India boasts a wealth of highly trained traditional practitioners within the Indian Systems of Medicine and Homoeopathy (ISM&H)⁸ that could potentially expand the base of abortion service providers. As a department within the Ministry of Health and Family Welfare (MOHFW) and renamed in 2003 as the Department of Ayurveda, Yoga & Naturopathy, Unani, Siddha, and Homoeopathy (AYUSH), department officials made concerted efforts over the years to expand the role of traditional cadres in reproductive health care. Likewise, the National Rural Health Mission (NRHM) of the Government of India, works to overcome regulation barriers, strengthen health systems, and build the capacity of traditional health service providers across rural India. Its mission is to provide accessible, affordable, and quality health care to rural and vulnerable populations.

¹The World Health Organization reports unsafe abortion data by region. South-Central Asian countries grouped according to the United Nations Population Division include: Afghanistan, Bangladesh, Bhutan, India, Iran, Kazakhstan, Kyrgyzstan, Maldives, Nepal, Pakistan, Sri Lanka, Tajikistan, Turkmenistan, and Uzbekistan.

■ Assessment Findings

Four categories of physicians within the AYUSH system and three types of nurses were included in this assessment. All of the physician providers in the system, undergo extensive training that includes pre-service training in reproductive health. They practice in a variety of settings including government health facilities, private hospitals, and private practice. While not classified as MLPs, these categories of physicians were included in the assessment, given their potential for expanding access to comprehensive abortion care (CAC)ⁱⁱⁱ through the current structure of the health system and the desire on the part of the NRHM to mobilize these cadres. The length of training and scope of the teaching institutions is as follows:

Cadre	Length of Training	# Training Institutions	Avg # Graduates Per Year
Ayurvedic Physician	5 ½ years (includes 1 year internship)	252	12,000
Homeopathic Physician	5 ½ years (includes 1 year internship)	185	8,000
Unani Physician	5 ½ years (includes 1 year internship)	41	2,000
Siddha Physician	5 ½ years (includes 1 year internship)	9	400
B.Sc Nurse	4 years (practical training interspersed)	1,373	61,000
General Nurse Midwife	3 ½ years (includes 6 month internship)	2,178	90,000
Auxiliary Nurse Midwife	2 years (includes 6 month internship)	880	Data unavailable
Total		4,918	171,600

Ayurved

This cadre is trained in both preventive and curative medicine, includes 22 specialties (including OB/GYN), and is the largest of the assessed physician groups. Training is conducted in Sanskrit or local languages. Theoretical training includes all aspects of pregnancy, labor and delivery, emergency obstetric care, abortion, and general reproductive health care. An introduction to family planning (FP) is provided, however the emphasis is primarily on short-acting methods. Basic knowledge of laparoscopy, hysteroscopy, ultrasound, and x-ray is also included. The clinical training covers topics such as taking client history, antenatal and

gynecological examination, labor observation, addressing abscesses and mastitis, surgical observation, and instrument sterilization, among others. However, clinical training does not always include hands-on practical experience due to limited patients in hospitals affiliated with the training colleges. **Abortion is not included in practical training due to current regulations; however, this cadre's education provides many of the requisite skills for providing CAC services.** The Central Council of Indian Medicine, determines curriculum, licensing and registration of practitioners.

ⁱ ISM&H consist of Ayurveda, Siddha, Unani and Homoeopathy, and therapies such as Yoga and Naturopathy.

ⁱⁱⁱ Comprehensive abortion care (CAC) includes post-abortion care.

Homeopath

Homeopathy came to India in the early 1800s, and has been grouped with the more traditional forms of Indian medicine. Training in OB/GYN for this cadre is rigorous and extensive, especially in the second and third years. Curriculum topics include pregnancy, labor and delivery, abnormal fetal presentation, protracted gestation, multiple pregnancies, placental disease, toxemia, common obstetrical operations, and various aspects of infant care, among others. Students are required to complete a three-month clinical rotation in labor and delivery during both of those years. As with other

AYUSH physicians, training in modern FP methods was found to be limited, **and abortion is only included briefly in theoretical training due to the policy restrictions.** Community medicine is taught in this cadre's fourth year of study—via, lectures, demonstrations and field visits—and touches on maternal and child health and FP. **With up to 8,000 graduates each year, this cadre was identified as a potentially important resource for provision of abortion care.** They are regulated by the Central Council of Homeopathy.

Unani

This is a holistic system of medicine that promotes natural remedies and includes preventive, 'promotive' and curative care. Training in reproductive health and FP occurs in second and third years of study. Theoretical training in OB/GYN is relatively extensive and covers topics such as pregnancy, labor and delivery; surgical procedures such as laparotomy, laparoscopy, hysterectomy, and dilation and curettage; procedures during labor and delivery such as episiotomy, forceps delivery, and Caesarian section; and diseases related to

the vulva, vagina, uterus, fallopian tubes, and ovaries. **Students are given minimal information on abortion,** and practical pre-service training on FP is limited to observation. Students receive adequate practical training through internships in public hospitals. **This cadre would be fully capable of providing abortion services with proper training.** The Central Council of Indian Medicine, oversees the curriculum, licensing and registration of practitioners.

Siddha

One of the oldest systems of medicine in India, Siddha is practiced in Tamil-speaking areas of India and abroad. Students receive theoretical and practical training in OB/GYN and FP in their second and third years of study. Topics include, but are not limited to, stages of labor, normal delivery, ante-partum and post-partum hemorrhage, anomalies and diseases of the placenta and umbilical cord, and ectopic pregnancy. **Abortion, however, is covered only briefly.** Due to language

constraints and low caseload, clinical practice is performed on models rather than patients. Pre-service training in FP was also found to be lacking and needs to be updated to incorporate a range of modern methods, particularly long-acting methods. **This relatively small cadre, could perform abortions with training, yet training materials would need to be in Tamil.** The Central Council of Indian Medicine, oversees the curriculum, licensing and registration of practitioners.

Nurse cadres

Three different cadres of nurses were assessed: Auxiliary Nurse Midwives (ANM), General Nurse Midwives (GNM) and B.Sc Nurses. As noted in the chart above, the length of training ranges from two to four years. Training for ANMs focuses on community health nursing, including provision of immunization services, obstetric care, and family health care. GNM training covers pregnancy and pregnancy-related complications, labor and delivery and postpartum care. B.Sc Nurses are trained in pregnancy, labor and delivery—both normal and high-risk—in hospitals and community settings, as well as neonatal care. All three nurse cadres receive some training in FP, both short and long-acting, with the higher level

nurses (B.Sc) receiving more extensive training. **Abortion is covered in the curricula for both ANMs and B.Sc Nurses, but is not included in the curriculum for GNMs. No clinical training related to abortion is included.** However, given their basic knowledge and skills and their ability to oversee labor and deliveries and manage post-partum complications, **these providers have the foundation required to become CAC providers.** The Indian Nursing Council, maintains standards of quality education and monitors training institutes, as well as, updates the nursing curricula.

Allopathic Physicians

While MLPs were the focus of this assessment, the need for pre-service training for allopathic medical providers was identified as a parallel need. There are more than 42,000 seats annually in 345 pre-service institutions for the degree of Bachelor of Medicine and Bachelor of Surgery (MBBS). Under the MTP Act, a registered medical practitioner must meet one or more of the experience and training requirements detailed in G.S.R. 485(E) in order to provide first-trimester terminations, one of which states, “if he has assisted a registered medical practitioner in the performance of twenty-five cases of medical termination of pregnancy, of which at least five have been performed independently, in a hospital established or maintained or a training institute approved for this purpose by the government.” **This post-graduate legislative mandate, greatly limits the number of allopathic physicians able to provide CAC services. Inclusion of CAC in pre-service curricula and internship would save resources and expand access to care.**

Pre-service Training Methods: To contextualize the assessment findings, it is useful to clarify some terms and review the range of pre-service learning activities. Below are the various modes of pre-service education used for knowledge acquisition and skills development.

- **Theoretical or didactic training**

Health-care knowledge and skills can be acquired through manuals, textbooks and other resource materials, and through verbal transmission vis-à-vis classroom lectures, seminars, and workshops. This method may also utilize visual and audio-visual aids through various technology platforms

- **Simulated practice or skills labs**

This method of instruction serves as an extension of the clinical experience where students gain competency in designated skills, and may include observing a procedure in a clinical setting or the use of teaching aids, interactive models, and simulators to practice procedures

- **Hands-on clinical training or practical session**

Students rotate through specific clinics and learn through supervised practice, usually working with a tutor in an internship setting. Sometimes, students are not allowed to engage in practical training until they complete all the requirements for their degree, graduate, or become certified. In other settings, the practical training internship is a basic component required for graduation or certification. Some settings offer or require post-basic training to acquire specific job-related skills

Note: Once a provider begins employment, additional training is referred to as *in-service training*.

■ Recommendations

From this assessment, it is clear that mid-level and non-allopath physicians can play an important role in expanding access to comprehensive abortion services in India. However, specific gaps in pre-service training were evident for each cadre. General areas for improvement include enhancing and standardizing content on abortion as well as FP for all cadres—to include hands-on practice—and incorporating training on medical abortion. Further, significant policy barriers were identified for all cadres in the AYUSH system, including allopathic physicians. Strategies to address policy and regulation barriers, but not hamper forward movement to include CAC under existing regulations, are critical. Specific recommendations are detailed below.

1. Undertake evidence-based advocacy efforts to revise policies regulating abortion provision.

- Promote policies that would enable non-allopath physicians and nurses to provide CAC, modern contraceptive methods, including long-acting methods, and to prescribe medications, particularly emergency contraception, oral contraceptives and medical abortion
- Promote the inclusion of competency-based training in CAC as a standard part of pre-service training for allopathic physicians

2. Build capacity and improve training curricula and teaching aids for non-allopath physicians and nurses.

- Work with authorities to standardize detailed components on CAC in curricula, including pelvic examination, estimating gestational age, and treatment of abortion-related complications. Emphasize skills in pre- and post-abortion counseling, and post-abortion contraception counseling and services. Include modules on values clarification

- Prepare appropriate competency-based training protocols, manuals, and demonstration kits
- Build a pool of trainers to train these cadres of service providers

3. Expand training in medical abortion for all cadres.

- Include medical abortion in pre-service training curricula, course work, and practical training
- Comprehensively plan for changes in services, ensuring that providers have a back-up facility where they could refer complications once policies are changed

4. Equip pre-service training facilities to enable effective provision of CAC services.

- Ensure sufficient infrastructure, equipment, and regular supply of drugs and other supplies

In sum, there is a range of providers in India who, with minimal additional training, could provide safe, comprehensive abortion care. Investments in these cadres, along with updating policies and regulations to reflect global recommendations and standards of care, could significantly extend women's access to critical reproductive health services, and thereby, improve maternal health and reduce maternal mortality in India.

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■ References

¹World Health Organization. (2010). *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008*. Geneva: WHO.

²Singh, S., Wulf, D., Hussain, R., Bankole, A., & Sedgh, G. (2009). *Abortion worldwide: a decade of uneven progress*. New York: Guttmacher Institute.

³Warriner, I. K., Wang, D., Huong, N., Thapa, K., Tamang, A., Shah, I., Baird, D., Meirik, O. (2011). Can midlevel health-care providers administer early medical abortion as safely and effectively as doctors? A randomised controlled equivalence trial in Nepal. *The Lancet*, 377(9772), 1155-1161.

⁴Warriner, I. K., Meirik, O., Hoffman, M., Morroni, C., Harries, J., My Huong, N., Vy, N.D., Seuc, A. H. (2006). Rates of complication in first-trimester manual vacuum aspiration abortion done by doctors and mid-level providers in South Africa and Vietnam: a randomised controlled equivalence trial. *The Lancet*, 368(9551), 1965-1972.

⁵World Health Organization. (2012). *Safe abortion: Technical and policy guidance for health systems*. Geneva: World Health Organization.

⁶Åhman, E., & Shah, I. H. (2011). *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008*. Geneva: World Health Organization.

⁷Johnston, H. B., & Trust, H. (2004). *Abortion practice in India: A review of literature*. Mumbai: Centre for Enquiry into Health and Allied Themes.