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सत्यमेव जयते
Ministry of Health and Family Welfare
Government of India

Ipas INDIA

Prioritizing Comprehensive Abortion Care for Women within NHM

A National Consultation

May 19-20, 2014

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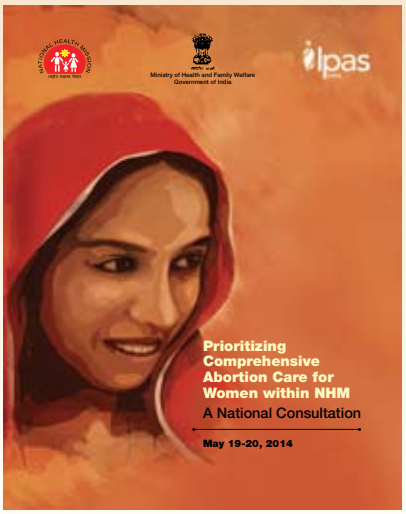
List of Abbreviations

ASHA	Accredited Social Health Activist
BCC	Behavior Change Communication
CAC	Comprehensive Abortion Care
CHC	Community Health Center
FOGSI	Federation of Obstetric and Gynaecological Societies of India
ICPD	International Conference on Population and Development
MMA	Medical Methods of Abortion
MoHFW	Ministry of Health and Family Welfare
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
NGO	Non-Governmental Organization
NHM	National Health Mission
POCSO	Protection of Children from Sexual Offences Act
PCPNDT Act	Pre-Conception and Pre-Natal Diagnostic Techniques Act
PHC	Primary Health Center
RMNCH+A	Reproductive, Maternal, Newborn, Child and Adolescent Health



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Message

The Maternal Health Division of the Ministry of Health and Family Welfare has been taking multiple steps to address one of the most easily preventable causes of maternal deaths—unsafe abortions. It is a matter of grave concern that even today one woman in India dies of an unsafe abortion every two hours.

In recent times, the Government of India has brought comprehensive abortion care (CAC) into focus in policy and practice at the national and state levels, and has made efforts to increase availability of trained providers to improve quality of services and streamline reporting. Further, the Maternal Health Division has worked closely with state officials in assisting them to implement national initiatives in CAC to ensure tangible progress.

However, significant gaps remain, particularly with regard to the availability of trained providers and awareness about safe abortion services. To ensure that these key areas get adequate attention, the MoHFW developed a national CAC training package for capacity building of providers, operational guidelines for state programme managers and a mass media campaign to raise awareness about safe abortion. These tools were released at this national consultation, which was an effective platform for sharing experiences, expectations and challenges that we all face in making CAC services available in different parts of the country. What made the consultation even more productive was the participation of all major stakeholders, including programme managers and technical officers from 30 states and Union Territories.

The Government of India is committed to reducing maternal mortality due to unsafe abortions and routinely updates policies and practices in response to changing contexts and evolving technologies. The learnings and suggestions from the consultation have been consolidated into an 'Action Plan'. The Ministry looks forward to working together with policy makers and programme managers of all states to implement and take forward this plan to improve access to CAC in the country. We hope to continue to strive towards preventing most maternal deaths from unsafe abortions as we move toward prioritizing CAC in maternal health programmes under the National Health Mission.

Dr Manisha Malhotra
Deputy Commissioner (Maternal Health),
Government of India

Preface

Ipas is honored to have partnered with the Ministry of Health and Family Welfare in conducting this two-day national consultation titled 'Prioritizing CAC under the National Heath Mission'. It is encouraging that CAC is now an integral element of the RMNCH+A strategy and that the public sector has increased its investments in ensuring and monitoring CAC services. It is further heartening that the Government of India is actively seeking civil society collaboration in advancing CAC through the country.

In the form of the MTP Act, we are fortunate to have a strong legislation in India that entitles each woman seeking an abortion to safe services. However, the unavailability of trained personnel; decline in provision of second trimester services; lack of awareness about safe abortion services; social stigma; and women's financial insecurity remain barriers to access. Working in partnerships with governments of 14 states, Ipas has been making consistent efforts to strengthen access to CAC. Our strong collaboration with the Ministry of Health and Family Welfare in recent years has provided further impetus to our work, enabling us to expand our reach.

This consultation was conceptualized as a platform for bringing together all key stakeholders for increasing access to and improving quality of CAC. It was attended by almost 200 government representatives, experts and partners, and provided an opportunity to develop an effective, practical action plan for implementing CAC at all levels of the health system.

Ipas is committed to taking forward the outcomes of this consultation and will work closely with the MoHFW, state governments and other partners. I hope this marks the beginning of a new era for CAC, as we all steadily work towards improving the health of women in India.

Mr Vinoj Manning
Country Director, Ipas India

Executive Summary

The national consultation was convened by the Ministry of Health and Family Welfare and Ipas and brought together various actors and advocates for women's health and rights. It was structured to focus on the public sector through a consultative process that benefited from the wealth of experience of the participants. The sessions through the two days were designed to focus on key aspects of comprehensive abortion care (CAC) within the National Health Mission (NHM)—training, service delivery, postabortion family planning and most importantly an enabling policy environment.

At the outset, speakers in the opening plenary articulated the need for immediate and expansive action to strengthen CAC in India. Taking a multifaceted view of safe abortion, key issues to be deliberated upon were identified as increasing awareness; improving the quality of training; establishing current and accurate estimates of abortion in the country; and focusing on the needs of young women, especially with regard to postabortion contraception. The national CAC training package and a mass media campaign on safe abortion were launched during this session.

The first session delved into various national and state-level aspects of ensuring CAC services in the public sector, and identified the successes and gaps in CAC service provision thus far. In India, there is now a clear transformation from abortion services being just a clinical procedure to woman-centric, comprehensive abortion care. Efforts have been made at the policy level to ensure that CAC is established as an integral component of the reproductive, maternal, newborn, child and adolescent health (RMNCH+A) approach; the session explored strategies to strengthen access to CAC in the public sector through improving implementation, monitoring and training at the state level.

High quality, standardized training is an imperative when expanding access to CAC services. The national training package was conceptualized to ensure effective trainings and well-functioning training centers, subsequently leading to quality CAC services in the public sector. In addition to an overview of the training package, the second session included experience sharing from states such as West Bengal, Tamil Nadu and Bihar who have substantially built CAC capacities through innovative methods for training and service delivery.

The third session addressed the substantial need to talk about positioning and prioritizing postabortion contraception as an integral part of both maternal health and family planning, along with the need to recognize that return to fertility post-abortion is much sooner than post-delivery. With the understanding that the only way to break the cycle of repeated unsafe abortion is through effective contraceptive counseling and services, this session took a closer look at the postabortion contraception scenario and focused on the needs of young women.

Session four looked at the policy environment for strengthening access to CAC and examined how CAC is positioned within the overall Maternal Health Framework and in relation to the current international abortion policies. The session further drew on experiences of states to understand how existing policies are translated into services, what the remaining gaps are, and how they can be addressed. It also explored how the private sector can contribute to an enabling environment for strengthening access to CAC.

The major points that were discussed at the meeting were consolidated and presented at the closing plenary in order to facilitate development of an action plan to strengthen access to CAC services. The action plan clearly indicates timelines and persons responsible, to enable regular monitoring. Highlighting the way forward, it was decided that first steps in prioritizing access to CAC within the National Health Mission will include improving information services; women's access to the right information; and addressing major gaps in provision of services such as lack of infrastructure, equipment/drugs through careful planning and monitoring. This report presents excerpts from speakers' presentations and discussions during each session.

Opening Plenary

Welcome and Objectives

Dr Manisha Malhotra

Deputy Commissioner (Maternal Health), Government of India

CAC in the Public Sector: The Unfinished Agenda

Mr Vinoj Manning

Country Director, Ipas India

CAC in the NHM Framework

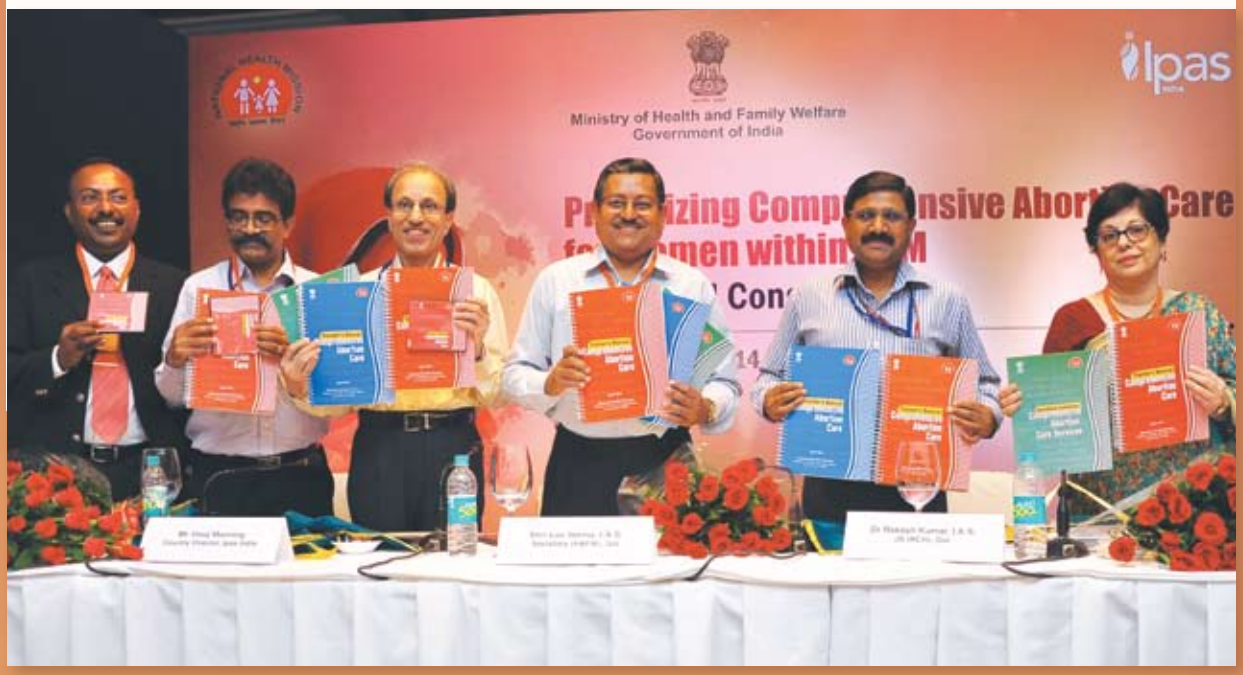
Dr Rakesh Kumar (IAS)

Joint Secretary (Reproductive and Child Health), Government of India

Inaugural Address

Shri Lov Verma (IAS)

Secretary (Health and Family Welfare), Government of India



Welcome and Objectives

Dr Manisha Malhotra

Comprehensive abortion care (CAC) is an important component of the RMNCH+A strategy under the National Health Mission. The Government of India has been making consistent efforts on the operational front to enhance access to and improve the availability and quality of CAC in the public sector. It is recognized that effective implementation of CAC can easily prevent maternal deaths and contribute to reducing the maternal mortality ratio. Further, effective implementation will prevent the considerable morbidity associated with unsafe abortions.

Two big bottlenecks in accessing CAC in the public sector are the lack of trained providers or their rational deployment, and the lack of awareness amongst women about the availability of services at public health facilities. To address these, the Maternal Health Division has produced a national CAC training package for capacity building of health care providers and a mass media campaign to raise awareness. To complement these national initiatives, there is a need to deliberate on some of the practical issues surrounding CAC services. It is imperative to explore ways to ensure accessible, affordable, confidential, high-quality CAC services for women in India.

Objectives of the national consultation:

- Discuss modalities for capacity building of service providers, including innovations in training methodology, building capacities of states for training and mentoring through partnerships;
- Deliberate on effective service delivery approaches, including public private partnership models;
- Talk about postabortion contraception including the needs of young women;
- Define the role of professional bodies and the private and NGO sectors; and
- Discuss how best to create an enabling policy environment and develop an implementation framework and roadmap for the future.

CAC in the Public Sector: The Unfinished Agenda

Mr Vinoj Manning

Abortion has been legal in India for over 42 years, yet every two hours a woman in India dies of unsafe abortion. In order to understand why so many women resort to unsafe abortions, Ipas conducted a study on the pathways to unsafe abortion in Madhya Pradesh. A woman who discovers she is pregnant and wants to terminate her pregnancy is faced by three immediate challenges—lack of awareness and information; shame and fear resulting from abortion stigma; and the financial insecurity of being unable to afford to travel and pay for the service. The study showed that more than half of these women (53 percent) first attempted to terminate their pregnancy at home, over 90 percent sought care from a sub optimal provider—with 3 percent making at least three unsuccessful visits—before reaching a district hospital or medical college for treatment of complications. What started as a decision to terminate a pregnancy resulted in multiple visits, circuitous pathways, and risk to both health and life of the woman. Given cost implications, the public sector is the only source for safe and legal abortion for such women.

Since 2002, with a pilot program in Maharashtra, Jharkhand, and Bihar, Ipas has been providing technical assistance to the public sector to increase access to CAC services. By 2011, the CAC program expanded to cover 12 states and 90 training centers where 5,000 MBBS doctors have been trained. This program is now also ISO certified.

However, training alone is not enough to ensure access to CAC services in the public sector. Studies show that in the catchment area of a Primary Health Center, approximately 12 women undergo abortion each month—Ipas data indicates that only two of these 12 women are served by a trained provider in a public facility.

To ensure that the states' investment is properly leveraged and translated to access to safe abortions, Ipas introduced an intensive, individualized, post-training support. Post training, each trained provider is offered support as needed to ensure service provision—clinical mentoring; administrative and logistical support; and orientation of community intermediaries. The result is continuous increase in service delivery along with an increase in quality and documentation—helping the state machinery to monitor provision and facilitate remedial action.

Some barriers to access continue to exist:

- Primarily when women come to a health facility, the provider is unavailable because most facilities have a single eligible provider

who has been transferred, deputed or is simply absent. Therefore, there is a huge need to amend the MTP Act and expand the provider base to include mid-level providers—more women can be reached if mid-level service providers are empowered to provide abortion services.

- Only 36 percent of all eligible sites offer second trimester services. This means that there has been a consistent, steady decline in availability of second trimester services. The most marginalized women often pose the highest demand for second trimester abortion; over a period of time the public sector has been unable to meet this demand.

Some possible suggestions:

- At the policy level
  - → Amendment of the MTP Act will have a huge impact on how the public sector can address issues of women's health and reproductive rights.
  - → Consciously ensuring that the initiatives addressing sex-selection do not adversely affect access to CAC.
- At the operational level
  - → There should be focus on quality of training and service delivery.
  - → Post-training mentorship and follow-up with providers to ensure service provision.
- Need to plan and budget beyond training
  - → There is major scope within the National Health Mission to establish innovative schemes to strengthen access. For instance there is a concerted effort in Madhya Pradesh to ensure that providers who are not providing services through surgical methods can provide medical methods of abortion (MMA).
  - → Incentives for ASHAs such as mobility support can enable the link between a woman in need and the facility.
  - → Periodic review of CAC by every Mission Director and Program Manager will ensure rational deployment of each trained provider.

CAC in the NHM Framework

Dr Rakesh Kumar (IAS)

The National Consultation on Prioritizing Comprehensive Abortion Care for Women within NHM is the first time in the history of safe abortion services that so many stakeholders have met to deliberate and identify strategies to move forward on the issue.

Looking at the global context, there are about 208 million pregnancies each year, of which 44 percent are unplanned. Fifty percent of abortions conducted worldwide are unsafe, significantly contributing to maternal mortality. Globally around 47,000 women die each year of unsafe abortion. If this is happening even after 20 years of ICPD, serious action is required.

There is an urgent need for genuine, up-to-date data about the abortion scenario in India. Currently it is estimated that there are six million induced abortions of which two-thirds are unsafe. Nearly 50 percent of the consequent deaths are of women and girls aged below 24 years. There is a great need to focus efforts on young women.

While ensuring access to safe abortion should have been a public health priority, it is one of the most neglected areas. Even though the Indian law is one of the oldest abortion laws in the world, there are huge gaps in implementation. Awareness levels in India remain very low.

Although there has been a lot of progress in reducing maternal mortality in India, there is still a long way to go. There are three 'delays' that contribute to maternal mortality and must be addressed—delay in decision to seek professional care; delay in reaching the appropriate health facility; and delay in receiving care after arriving at a hospital. CAC has been given due importance within the RMNCH+A strategy's continuum of care approach, and has become one of the important, high-impact interventions bringing focus back on safe abortions. In each life stage, there are some minimum essential commodities which must be made available including MMA drugs.

CAC can be accelerated by reaching the unreached and underserved areas; improving access and quality of CAC; creating awareness through effective information, education and communication (IEC) and behavior change communication (BCC); addressing unsafe abortions in adolescents and young women;

providing post-abortion contraception; rolling out new initiatives that address quality by improving the number of providers and quality of service provision; strategic skill building; addressing the conflation of Medical Termination of Pregnancy and Pre Conception and Pre Natal Diagnostic Techniques Acts; strengthening monitoring and supportive supervision and building public-private partnerships.

Inaugural Address

Shri Lov Verma (IAS)

The endeavor to improve women's health and empower women is one that the Government of India is firmly committed to. The last two decades have witnessed significant progress in universal quality education, skills development and healthcare which will provide a firm basis for young women to participate in and benefit from development. The social determinants of health, in particular, education, have to be stressed upon. When women are educated, the number of child brides and unsafe abortions reduce. All the stakeholders and experts in concerned fields have to work out how sexuality education can be woven into school curricula and made more effective.

The Indian context is unique, despite our large population, the birth rate has gone down and focus is being shifted to family planning methods and reducing the number of unintended pregnancies. It is a source of pride that India was the third country in the world to legalize abortion after Sweden and the United States. There were amendments to the MTP Act in 2002 and the Ministry of Health and Family Welfare is working on further amendments to make the Act more practical and practicable. It is imperative to remember that the primary aim is to prevent unintended pregnancies and deaths due to unsafe abortion.

Under the NHM more than 26,000 new infrastructural health facilities have been sanctioned, 30,000 will be renovated and upgraded and more than 70,000 beds have been added in government health institutions for the provision of essential services across the country. Nearly 1.6 lakh human resources, that include specialists, doctors, nurses, ANMs, and paramedics, and nearly nine lakh community health workers have been appointed in villages to interface between communities and the health system.

With the substantial decline in the MMR and improvement in other health indicators the focus is currently on expanding health care to meet the challenges both due to shifts in demographic profile and gradual shift of burden from communicable to non-communicable diseases as well as expanding health care for all.

The decline in MMR has been possible due to various maternal health interventions—incentivized institutional deliveries guaranteed every woman delivering in public health institutions free and cashless services that include free drugs, diagnostics, diet and transport and every child has been guaranteed free health care for the first thirty days. It is noteworthy that more than 1.66 crore women are delivering in public health facilities in a single year, which signifies that 8 out of every 10 reported child births are institutional.

A non-discriminatory adolescent-friendly program has recently been rolled out—the

Rashtriya Kishor Swasthya Karyakram—to reach the 250 million strong adolescent population. Focus has been expanded to include reproductive health, nutrition, non-communicable diseases, mental health and substance abuse. The program has vastly expanded to also include gender sensitive counselling and this is one intervention whereby adolescents can be counselled with regard to comprehensive abortion care.

Having dwelt on these achievements, the stark realities cannot be ignored. India is still contributing the largest absolute number of maternal deaths to the global total. It is also recognized that amongst others, deaths from unsafe abortion are a cause of maternal mortality. Abortion related deaths are all the more inexcusable as they are preventable. It is time to build on available infrastructure, manpower and human resources to prioritize CAC and make it accessible to even the most marginalized women living in remote and underserved areas.

Ipas's post-training follow up with providers is a very important intervention that shows the way to the future. State governments and district authorities have to follow in these footsteps. Recognizing the shortfall in human resources to deliver adequate services, we have to seriously consider tapping the potential of ANMs, staff nurses, general nurse midwives and AYUSH providers. These call for legal changes. The MoHFW is working on it, and the process will be carried forward to its logical conclusion.

The role of the NGOs and civil society is vital as they are able to reach populations that the public sector cannot. While the public sector continues to play a critical role it is also vital to recognize the importance of partnership and collaboration with technical agencies. Successes in public-private partnerships have to be built on for CAC services and at the same time regulatory standards have to be put in place to ensure quality of services. An issue of concern is affordability of services for the vast majority of the population, especially for tertiary care. In the case of CAC it is important to note that the services in most cases can be managed at the primary level in early pregnancy, however referrals for complications have to be ensured and for abortions in later gestation. The most important aspect of services is creating awareness and community level mobilization. There is a large pool of ASHAs and the strength of this workforce has to be leveraged to sensitively guide and direct women to the correct facilities and providers.

The release of the mass media campaign on such a sensitive yet critical issue and the national training package for CAC are a source of pride and joy as it is important that technical and social interventions are worked upon simultaneously for women in India. The primary objective is to save women's lives, enhance the quality of women's lives and ensure that every woman is served irrespective of her age, location, and economic status. The women of India have a right to quality services and reproductive health in an environment that is enabling and friendly.

Session 1

CAC Services in the Public Sector: What Works

Chair

Dr Rakesh Kumar (IAS)

Joint Secretary (Reproductive and Child Health), Government of India

Co-Chair

Mr Vinoj Manning

Country Director, Ipas India

Presenters

CAC Services in India

Dr Manisha Malhotra

Deputy Commissioner (Maternal Health), Government of India

Ensuring CAC Services Across Public Health System in Odisha

Ms Roopa Mishra (IAS)

Mission Director, National Health Mission, Odisha

Role of Professional Bodies in Strengthening CAC Services

Dr Nozer Sheriar

Secretary General, Federation of Obstetric and Gynaecological Societies of India (FOGSI)

Opening Remarks by the Chair

Dr Rakesh Kumar (IAS)

Every two hours one woman dies due to an unsafe abortion. The Medical Termination of Pregnancy (MTP) Act has been in place since 1971; a lot of progress has been achieved since then, but more has to be done. Data on comprehensive abortion care (CAC) service provision shows that very few facilities at the primary level (PHC) provide services and the percentage of doctors trained to provide MTP services is also very small.

Another reason for poor service provision is the attitude of providers, there is a certain amount of insensitivity that prevails in the sector, and among providers, with regard to abortion.

The primary deliverable for the consultation is to come up with an actionable plan to strengthen access to CAC.

CAC Services in India

Dr Manisha Malhotra

The Government of India has taken a number of initiatives to ensure that all states take up the agenda of ensuring access to safe abortion. However, access is impeded due to improper implementation and monitoring. Some of the biggest challenges are stigma and the lack of awareness, rational deployment of trained providers, conscientious objection of service providers, and conflation of the PCPNDT and MTP Acts.

In India, there is now a clear transformation in abortion services from being just a clinical procedure to women-centric comprehensive abortion care. In addition, the Centre has issued imperatives for states to facilitate access to safe abortion such as the inclusion of medical methods of abortion (MMA) drugs in the essential drugs list; making medical vacuum aspiration (MVA) equipment available in all facilities with emphasis on high caseload delivery points; strengthening district level committees (DLC); building the capacities of mid-level providers to provide postabortion care; and requesting genuine, comprehensive data. To address the low levels of awareness about abortion, the Ministry has released the audio-visual advertisement campaign and information, education, and communication (IEC) print material.

Apart from policy-level work on CAC, planning and programming by NHM Mission Directors and Principal Secretaries is also important to ensure services at the district level. CAC has to be built into the state Program Implementation Plans (PIP), IEC/behavior change communication material has to be optimized and utilized; training quality and consistency has to be maintained. There is a lot of variation across states in utilization of funds allocated for CAC. Some states have taken initiatives to utilize these funds by establishing innovative programs such as Yukti Yojana in Bihar, integrated training in Maharashtra, and orientation workshops in Kerala.

It is important to move towards equitable, available, and affordable services. For this, there is a need for capacity building, rational deployment, performance monitoring, strengthening the flow of information, focusing on adolescents and young women in order to provide them with CAC and postabortion contraception; and engaging with development partners for technical assistance. The proposed amendments to the MTP Act will also contribute to enhancing CAC by including midlevel providers and expanding the healthcare provider base, increasing the gestation limit from the existing 20 weeks to 24 weeks for certain categories of vulnerable women and permitting termination of pregnancy beyond 20 weeks on grounds of substantial fetal anomalies.

Ensuring CAC Services Across Public Health System in Odisha

Ms Roopa Mishra (IAS)

In order to ensure safe abortion in Odisha, consultations were held at the state level regarding CAC guidelines and the provision of CAC services as part of the RMNCH+A model. The preferable way of addressing a new health intervention is to look at it holistically, and strengthen existing health systems first. This could include ensuring availability of human resources, training and rational deployment of manpower, bolstering logistics, establishing clear and transparent procurement processes, etc.

The first step was district-wise and facility-wise situation analysis. As it is complicated to translate PIP into actionable items at each level in the state, there is a clear requirement to understand ground realities before initiating CAC services. The situation analysis revealed an alarming maternal mortality rate in Odisha with significant zonal variations and acute conditions in high-priority districts. A study of the status of MTPs in Odisha revealed that about six percent of pregnancies occurring in reproductive ages resulted in abortions and, on average, 70 percent of MTPs are done as a result of contraceptive failure. An analysis of related dimensions—adolescent population, school dropout rates among girls, age at marriage and menstrual hygiene was also done. With regard to functionality of MTP centers in the state, it was discovered that some facilities were not functional due to unavailability of trained providers or equipment.

In order to meet the unmet needs of women in Odisha, a roadmap for the operationalization of MTP facilities was drawn up and called for action on ensuring adequate manpower and equipment, provision of postabortion contraception and counseling services, expanding public-private partnerships under the Ujjwal network, mentorship of providers and performance monitoring. Odisha has planned for a three-pronged approach within the PIP to address the manpower issue—mobilizing trained providers within the system, empanelling private providers and organizing mobile teams to reach underserved areas.

In addition, the state is also looking at initiatives to address CAC-related areas such as the provision of contraceptive services, improving adolescent health, addressing the conflation of the PCPNDT and MTP Acts and intersectional coverage between health and education to ensure that the needs of young women are adequately met.

Role of Professional Bodies in Strengthening CAC Services

Dr Nozer Sheriar

Professional organizations play a large role in ensuring access to safe abortion. FOGSI, for instance, has over 29,000 members, a significant majority of whom consistently provide abortion services. In addition to service provision, professional bodies can also contribute to increasing affordability and access through advocacy and technical expertise. FOGSI played an integral role in the amendments to the MTP Act and MTP Rules which instituted the formulation of DLCs, established the time frame for registration process and the bifurcation of requirements for centers for first and second trimester terminations. Partnerships with professional organizations on safe abortions also result in the introduction and uptake of new technologies such as the MVA technique and MMA. Furthermore, FOGSI worked on the MVA pilot project in India with the World Health Organization and the Government of India.

Professional bodies also serve as direct conduits to providers with regard to knowledge dissemination and training; FOGSI conducts multiple workshops on safe abortion skill development. Safe abortion partnerships can also lead to system changes—FOGSI officially supports amending the MTP Act to allow service provision by midlevel and non-specialist providers. Another important role that professional bodies play is within the women's reproductive rights context. Issues such as women's rights to reproductive health and safe abortion, reducing abortion stigma and gender biased sex selection are areas that benefit greatly from the focus that professional bodies can provide. For instance, the recently introduced Pratigya campaign involved the partnership of several professional organizations who are working together toward gender equality and safe abortion.

The mandate for safe abortion partnerships is still unfinished: Acts clarification is required to insulate the PCPNDT and MTP Acts, DLCs have to be operationalized in order to facilitate safe abortion services through the private sector, hindrances to first trimester abortions have to be addressed, reporting systems for MMA have to be established and confidentiality of abortion seekers has to be respected and ensured.

Comments by the Chair

- Clarity is required on the abortion numbers in the country. Ensuring that the data is correct is a major challenge. Unless there is an accurate picture of the abortion scenario across the country, it will be difficult to address the associated problems. The quality of data received by the Ministry from the states is poor, the numbers often inauthentic. Mission Directors have to explore options for quality data on safe abortions.
- Safe abortion has only recently come to the fore; the situation was not monitored as it should have been. Mission Directors have to include CAC requirements in PIPs and lay greater emphasis on planning and monitoring at the state level.
- Within the RMNCH+A strategy, safe abortion is a high impact intervention. There is a need to work at the state level by talking to controlling authorities to ensure that CAC is given due importance and options of working with development partners are explored.
- 184 districts have been identified as high priority districts; gap analyses have to be conducted in these districts on safe abortion.
- To address the conflation of the PCPNDT and MTP Acts and bridge the gap between the implementation of these two Acts, a subgroup of experts has to be constituted to work on a guidance note for partners and implementing officials at the state level. Medical colleges have to be engaged with regard to safe abortion services to benefit from the experiences of senior providers' membership in professional organizations and improve the quality of medical interventions and training.

Key Points from the Discussion

- The distinction between the provisions of the MTP and PCPNDT Acts has to be recognized and each has to be insulated from the other in order to prevent detrimental consequences.
- The Protection of Children from Sexual Offences Act (POCSO), 2012 makes it mandatory for doctors providing abortion services to a woman below the age of 18 years to report her to the police as a victim of sexual offence. This requirement is in direct contrast to the confidentiality assured by the MTP Act.
- Low-dose, high frequency training and post-training support have to be linked to current training systems.
- Conscientious objection leads to discrimination against women and especially affects women seeking second trimester abortions. The specific needs and vulnerability of women who come for second trimester abortions must be clearly understood as they are often from marginalized sections of society.
- Private providers are often targeted when it comes to abortion. There is a need to create an enabling environment for private providers by establishing training mechanisms that they can access for certification.
- Clarification should be sought on termination of pregnancies by MMA—the use of the combipack is allowed to terminate pregnancies up to 63 days but separate drugs can only be used for 49 days.
- Pregnancy testing kits are available with community health intermediaries. Once a woman finds out she is pregnant and decides she does not want to continue the pregnancy, ASHAs should be empowered to take the woman to a safe abortion provider at a public health facility.

Session 2

Strengthening Training Capacities for CAC

Chair

Dr Himanshu Bhushan

Deputy Commissioner (Maternal Health), Government of India

Presenters

Overview of the Government of India CAC Training Package

Dr Sangeeta Batra

Senior Advisor – Health Systems, Ipas India

Strengthening Training Centres and Ensuring Quality in Training

Dr. C.N. Maheshvaran (IAS)

Mission Director, National Health Mission, Tamil Nadu

Innovative CAC Training Methodology

Ms Sanghamitra Ghosh (IAS)

Commissioner Family Welfare and Secretary to Government of West Bengal

Innovations in CAC – Yukti Yojana

Mr Sanjay Kumar Singh (IAS)

Secretary Health cum Executive Director, State Health Society, Bihar

Opening Remarks by the Chair

Dr Himanshu Bhushan

Training is a critical parameter of safe abortion services; unless adequate training centers are established, high quality training is imparted and trainers perform well, expecting safe abortion services is impossible. The expected number of abortions in the country is 55,95,000; the reported number of safe abortions conducted in public sector facilities is only 10 percent of this number. The abortion rate per institution per month, among abortion sites is not even four, with most abortions being done at the tertiary level. Data currently available from around 21 states shows only about 6,200 trained doctors despite approvals for higher numbers in PIPs.

Overview of the New Government of India CAC Training Package

Dr Sangeeta Batra

The national CAC training package was conceptualized to meet the need for a standardized, Government of India approved, CAC training package that could be used across the country to ensure quality trainings.

An expert group decided on the content, flow and relevant aids for the package and pilot workshops were conducted for master trainers from seven states at Safdarjung Hospital, New Delhi, in order to identify any gaps. The opinions of experts from other divisions of the Ministry of Health and Family Welfare on critical issues such as family planning were also incorporated. Other resources included the World Health Organization's (WHO) technical guidelines on safe abortion, the Government of India's CAC training and service delivery guidelines, and Ipas CAC training manuals.

All sections of the training package have been broadly designed to facilitate uniformity in the content and methodology of CAC trainings across the country and provide guidance to program managers on monitoring services post-training.

The training package consists of the following:

- The trainer's manual: It contains guidance on creating an enabling training environment to motivate providers and ensure services post-training, and includes relevant training tools with defined methodology.
- The provider's manual: It contains relevant information in an easy-to-understand manner with self-assessment tool summaries and service delivery protocols as per the latest clinical evidence.
- The training CD: It contains talking points for all sessions, a video demonstrating the MVA procedure and technical posters to assist in service delivery.
- Operational Guidelines: These are for providers and managers to establish and monitor women-centered CAC.

All state directorates, nodal training persons and CAC training centers will be sent the complete training package. States then have to ensure that the materials are budgeted for and printed; and facilitate their use in all CAC training centers. Program managers are expected to monitor provision of services by trained providers as prescribed in the operational guidelines. If required, states can seek technical assistance from relevant agencies to implement the CAC program.

Some technical updates have also been included as an addendum to the CAC training and service delivery guidelines: more options of routes for misoprostol in medical methods of abortion (MMA), option of medical management of incomplete abortion with MMA in addition to surgical management, and detailed signs and symptoms suggestive of ectopic pregnancy under contraindications for MMA.

Strengthening Training Centres and Ensuring Quality in Training

Dr. C.N. Maheshvaran (IAS)

Tamil Nadu has performed well on CAC parameters, although there is still a lot to be accomplished. The state's public works department (PWD) is dedicated to medical infrastructure; training centers have been established in most districts, training curricula is updated based on evolving social dynamics and service provision is regularly monitored.

Apart from ensuring high-quality CAC training, service provision in PHCs is reviewed at the block level. With about 25 blocks in each district, district level officials further evaluate block-wise service provision. At the state level, the family welfare department evaluates performance on a monthly basis. These training, monitoring and evaluation systems have contributed to a 5.1 percent increase in safe and legal MTPs from 2011 to 2013.

In order to ensure high-quality trainings, two important components—needs of service providers and client rights—have to be incorporated. Taking into consideration the needs of service providers, during training, trainers have to not only provide accurate, up-to-date, technical information but also make sure that providers are given adequate encouragement, feedback on their performance and the opportunity for self-expression. With regard to client rights, emphasis has to be laid on ensuring that the privacy, dignity and confidentiality are maintained, and providers impart correct information on the procedure, complications and safety.

Social and systemic barriers to safe abortion must be taken into consideration while strengthening CAC. Social barriers include cultural beliefs that limit women's access to information and services along with their consequent inability to make independent decisions on pregnancy, abortion, and child spacing. Women, in addition, take up the major burden of family planning services with limited participation from men. Systemic barriers include shortage of trained providers, narrow and incorrect interpretation of laws by health care providers, and breach of confidentiality by service providers particularly in smaller communities. To strengthen and ensure safe abortion services, the government must establish proactive policies and mechanisms for monitoring and invest resources to enhance service delivery systems.

Innovative CAC Training Methodology

Ms Sanghamitra Ghosh (IAS)

The prescribed training module for CAC is a cascading three-tier structure with training of state and district level trainers who then train medical officers. As per government guidelines, during the twelve days of CAC training for medical officers and staff nurses, the first half of each day is spent on theory and the second on hands-on practice. West Bengal faced some obstacles while replicating this model as an adequate number of MTP cases (25 cases per doctor as per the MTP Act) were not available during training days at a majority of the district hospitals. The training module was then modified to suit the ground realities of the state.

In West Bengal, CAC Master Trainers are selected from district hospitals and high caseload facilities and are then divided into batches of trainers (on rotation). The required 12-day training is further divided into three days of theory at the district hospital and nine days of hands-on practice at high caseload facilities with the master trainers. To enable continued training, medical officers (trainees) and master trainers are selected from the same facility. This method ensures that doctors are not away from their place of posting for too long and the requirement of 25 cases is consistently met, even if the duration of hands-on training has to be extended. As both master trainers and medical officers return to the facilities that they are posted at for hands-on training this modification has no budget implications.

In addition to the unique training methodology, West Bengal, with technical assistance from Ipas, provides post-training support and follow up to the CAC-trained providers. This follow up is done to make sure that trainees are rationally deployed, are consistently providing services, have adequate equipment and infrastructure, document all MTP cases accurately and provide postabortion contraception. CAC has also been included in the West Bengal PIP in order to guarantee that it is given due importance.

Innovations in CAC – Yukti Yojana

Mr Sanjay Kumar Singh (IAS)

The current abortion scenario in Bihar indicates that while there is a high demand for abortion services, the number of doctors and public sector sites providing CAC services is inadequate. In recognition of this unmet need the state government has trained almost 1,150 doctors in Bihar and, to guarantee services in rural areas, the government of Bihar is focusing on training of doctors from periphery facilities like PHCs and community health centers (CHCs). Bihar has also adopted community awareness and education strategies and provides trainees with post-training support.

Despite these efforts a significant majority of women seek abortion services from the private sector due to easy accessibility and after-hours availability. It was recognized that there is a need to involve the private sector to support services in the public sector. Yukti Yojana was conceptualized to meet this need with the primary objectives of enhancing public sector CAC services, defraying the high cost of private sector services and monitoring often unregulated (untrained/non-certified) providers. Yukti Yojana covers first trimester abortion services; treatment of incomplete abortion; treatment of abortion-related complications; and stabilization before referral of complicated cases of abortion.

This program was launched in 2011 with Ipas's technical assistance. District accreditation committees were formed in 37 districts. In addition, comprehensive guidelines were released and a toll-free helpline number was established. Under Yukti Yojana, women can avail of first trimester CAC services free of cost; transport subsidies are provided to community health intermediaries accompanying women seeking abortions. These services are reimbursed by the District Health Societies (DHS).

Yukti Yojana is now being implemented for the third successive year leading to increased access. High-intensity communication campaigns have also led to increased awareness. Since the launch of the program, 12,812 women have received CAC services and almost all of them have left the clinic with a method of contraception. Research on the efficacy of the program shows that 53 percent of women served live below the poverty line (BPL) and 66 percent live in rural areas.

Comments by the Chair

- It is important for states to incorporate timely monitoring and performance appraisal which can aid Mission Directors and program managers in mid-course correction while implementing CAC and other services.
- Social and systemic barriers to service provision can be tackled through effective and consistent use of IEC/BCC tools among stakeholders at all levels.
- Public-private partnerships such as Yukti Yojana can help in increasing access to safe abortions and reduce delays that might lead women to opt for unsafe options.

Key Points from the Discussion

- To reduce the number of days that doctors spend away from their place of posting, a blended learning training module should be developed that provides trainees with theoretical instruction followed by onsite skill-development training.
- CAC should be included in the pre-service curriculum for nurses and nurse-midwives.
- One of the focus areas of CAC training has to be to help doctors become non-judgmental as women often refrain from accessing services for fear of providers' judgmental attitudes.

Session 3

Postabortion Contraception

Chair

Dr S.K. Sikdar

Deputy Commissioner (Family Planning), Government of India

Co-Chair

Dr Shireen Jejeebhoy

Senior Associate, Population Council

Presenter

Postabortion Contraception: What do the Numbers Tell Us

Dr Sushanta Banerjee

Senior Advisor – Research & Evaluation, Ipas India

Panelists

Understanding the Needs of Young Women and Strategies for Strengthening Postabortion Contraceptive Uptake

Dr Bulbul Sood

Country Director, Jhpiego

Dr Suchitra Pandit

President, Federation of Obstetric and Gynaecological Societies of India (FOGSI)

Ms Ena Singh

Assistant Representative, United Nations Population Fund (UNFPA)

Opening Remarks by the Chair

Dr S.K. Sikdar

Around 4,000 women die of unsafe abortion in the country every year. These deaths are entirely preventable. Postabortion contraception plays a very important role in ensuring that women do not seek repeated unsafe abortions. It is also important to give careful thought to the approach through which postabortion contraception is given to women. It should be ensured that there are no elements of coercion and women are allowed to make their own choices. 53 percent of women in India do not use any modern method of contraception. In the 15-25 years age group, 28 percent have an unmet need for contraception. Consequently, it is important to focus on young women.

Opening Remarks by the Co-Chair

Dr Shireen Jejeebhoy

Postabortion contraception is an important topic that bridges maternal health and family planning. Return to fertility is much faster after an abortion than after a birth. Those women who seek an abortion are clearly those who have an unmet need for contraception and yet the services being provided to them have neglected this fact thus far. Historically, postabortion contraception has been viewed negatively as a condition used for availing abortion services and this has affected its importance as an aspect of women's rights. The unmet need for contraception among women in general is very high in the country, and this need is about twice as high for the young who are more likely to also be poorly informed about contraception and pregnancy. It is therefore of prime importance to make postabortion contraceptive services youth friendly.

Postabortion Contraception: What do the Numbers Tell Us

Dr Sushanta Banerjee

Postabortion contraception has been neglected for a long time and has come to the forefront of maternal health and family planning discourse only recently. This is important because postabortion contraception is the only factor that can help break the vicious cycle of unsafe abortion. Ovulation can occur as early as two weeks post abortion, therefore immediate provision of contraception irrespective of the method used to terminate the pregnancy is an important aspect of comprehensive abortion care (CAC).

Data from public sector sites in six states (Madhya Pradesh, Maharashtra, Bihar, Jharkhand, Uttarakhand and Rajasthan) reveals that 38 percent of abortion seekers are below the age of 24; 97 percent of recorded cases were of first trimester abortions; 65 percent had two or more children; 84 percent underwent surgical methods; 28 percent of the overall procedures were done at the PHC and CHC levels. Interestingly, 20 percent of women seeking services are from states that have low contraceptive prevalence, 52 percent from moderate prevalence states and the remainder from high prevalence states. 81 percent of women at these (Ipas-supported) facilities returned with some form of postabortion contraception and at least one third received long-acting or permanent methods. Today, 91 percent of the women receiving CAC services through providers trained by Ipas accept some form of contraception post abortion.

Data shows that the higher the level of facility the lower the postabortion contraception uptake, for instance, in these six states 92 percent of women served at PHCs went home with some form of contraception while only 76 percent did so at tertiary level facilities.

However, the data raises some concerns—postabortion contraception is probably being practiced as a component of family planning rather than maternal health. Providers uniformly take decision on contraceptive method based on parity and age rather than pregnancy intervals. Ensuring contraception after incomplete and medical abortion still remains a challenge.

Panel Discussion: Understanding the Needs of Young Women and Strategies for Strengthening Postabortion Contraceptive Uptake

Remarks from Panelists

Dr Bulbul Sood

With regard to RMNCH+A counselors, it has been seen that quite often only one counselor is available at each facility, and is more likely to be involved in the antenatal ward. To ensure that postabortion contraception is given due importance, it is important to see how best the work of counselors can be distributed between pre and post-delivery and postabortion requirements. ASHAs can play an important role in filling any gaps.

Two issues that have to be brought out in any awareness building activities are that: the return to fertility postabortion is within ten to fifteen days; there is very little awareness about this even among providers. Also, after an abortion, there should at least be a gap of six months before a woman plans her next pregnancy.

Dr Suchitra Pandit

Women should be given a basket of choices as part of their reproductive health rights. Counselling should be given priority in CAC in order to help women choose the contraceptive method that is best for them without any coercion from the provider.

FOGSI, in the private sector, sensitizes doctors to improve CAC service provision. It has been observed that in the case of adolescents, the uptake of services is much better when there is a dedicated center for adolescent issues especially in the presence of peer-group educators. FOGSI also conducts youth melas for adolescents and young adults where they are given information on reproductive health, contraception and vaccines, nutrition and prevention of physical, mental and sexual abuse. At these melas, questions often arise on the availability of contraception, indicating

that a significant percent of urban adolescents and young adults are sexually active and there is a definite unmet need for contraception and related counselling.

Ms Ena Singh

As far as young people are concerned, it has to be recognized that the demand for abortion will continue to rise—because within marriage, couples will want to delay child bearing, and the age at marriage is increasing in the country. Given this context and looking in particular at the needs of young people, there are four factors that set the issue of postabortion contraception and young people apart:

1. There must be clarity on law and policy. For instance, in the Rashtriya Kishore Swasthya Karyakram (RKSK) access to contraception for adolescents is spoken about with no distinction between married and unmarried young people. However, the MTP Act talks about contraceptive failure only amongst married women. This ambiguity has to be cleared because service providers are not going to take the risk of providing contraception to young people. The laws and policies of different elements of the national health program have to be consistent and clear.
2. Information about safety of abortion and contraception should be provided to young people, including information about where to go for these services.
3. There should be a mix of contraceptive methods made available to women. Provision should not be provider-driven, but should be a choice dictated by the preference of the individual seeking these services.
4. Role of provider's attitude in the provider-client interaction. When a young woman accesses abortion, it is an opportunity to provide her with contraception and not an opportunity to make safe abortion conditional on her acceptance of contraception. It is about the woman's health and safety rather than meeting global public health targets.

Key Points from the Discussion

- A woman who comes for an abortion is extremely vulnerable and it is very important that she makes an informed choice regarding contraception in a non-coercive environment.
- ANMs and staff nurses need to play an important role in counselling women.
- There is a need to identify methods of measuring quality of counseling rather than contraceptive methods accepted as there is no guarantee that women will continue to use the contraceptive methods they accepted post abortion. RMNCH+A counselors play a very important role and similar arrangements should be made in the private sector to ensure that women are given the right information and support.

Session 4

Policy Environment for Strengthening Access to CAC

Chair

Dr Himanshu Bhushan

Deputy Commissioner (Maternal Health), Government of India

Co-Chair

Ms Ena Singh

Assistant Representative, United Nations Population Fund (UNFPA)

Presenters

Policy Framework for Strengthening Women's Access to CAC Services

Dr Manisha Malhotra

Deputy Commissioner (Maternal Health), Government of India

CAC Services in the Private/NGO Sector

Dr Kalpana Apte

Assistant Secretary General (Programmes), Family Planning Association, India (FPAI)

Panelists

Policy Framework for Scaling-up CAC under NHM

Mr Ashish Singhmar (IAS)

Mission Director, National Health Mission, Jharkhand

Dr K.H. Govind Raj (IAS)

Mission Director, National Health Mission, Maharashtra

Opening Remarks by the Chair

Dr Himanshu Bhushan

- There are three pillars of safe abortion services that have to be focused and improved upon—information, access, and quality services being rendered with dignity and confidentiality.
- In the PIPs that states send to the Ministry, training of providers and procurement of MMA drugs are consistently being approved but ground realities show that due to poor utilization of these resources, the availability of safe abortion services is very poor.
- Regular monitoring of high caseload health facilities identified as delivery points should be a starting point to ensure that all services including CAC are being provided.
- Doctors based at delivery points should be given high priority for trainings to make certain that services are available where they are most needed.

Opening Remarks By the Co-Chair

Ms Ena Singh

- This is the twentieth year after the ICPD and a lot of advancements have been made since then, but there is agreement that more has to be done in the region to make abortion safer.
- With regard to the PCPNDT and MTP Acts, there is no confusion in the laws themselves. The confusion arises in implementation when the objectives of the two Acts are not kept separate. The PCPNDT Act comes into play in the testing space to prevent gender biased sex selection. As far as the MTP Act is concerned, whether or not a woman seeking abortions has undergone diagnostic testing should be of no concern.
- Mission Directors and program managers should take up the responsibility of curbing over-zealous implementation of the PCPNDT Act and facilitate the implementation of the MTP Act in order to enable women to make the reproductive choices that they want.

Policy Framework for Strengthening Women's Access to CAC Services

Dr Manisha Malhotra

Access to abortion as a right is embedded in global conventions and agreements including those made at the International Conference on Population and Development (ICPD) which contributed directly to India's framework for the national population policy and the reproductive and child health programs. The ICPD framework recommends that steps be taken to expand and improve family-planning services. In circumstances where abortion is not against the law, it is recommended that training is established and health-service providers are equipped for service provision. Other measures to ensure that abortion is safe and accessible, and women have access to quality services for management of abortion complications, post abortion counselling, and family planning services are also recommended.

In India the evolution of abortion policy began with the establishment of the Shantilal Shah Committee in 1966 which resulted in the MTP Act in 1971. Another landmark step was the Agra Conference in 2000 which was followed by amendments to the MTP Act 2002 and the Rules in 2003.

In taking forward CAC policy, there has been a focus on transforming abortion services from a clinical procedure to women-centered comprehensive abortion care. The following are key areas of focus:

- Capacity building through innovative models of training and mentoring;
- Meeting the needs of adolescents and young women;
- Improving the quality of CAC with the use of safe, updated technology and the provision of postabortion contraception and counselling; and
- Carrying forward legislative processes to bring about the proposed amendments to the MTP Act.

CAC Services in the Private/ NGO Sector

Dr Kalpana Apte

Although India has a liberal abortion law—the MTP Act—today, access to safe abortions is being affected by an inferred cross purpose between the PCPNDT Act and the MTP Act. The abortion scenario in India is a source of some concerns. An issue of note is the consistent, steady decline in the provision of second trimester abortions. Also, the reported numbers of MTPs has remained constant over the last few years and the number of new registered private sector facilities has not increased significantly across the country. While death due to unsafe abortions is decreasing in the country, it should also be noted that sale of MMA drugs has declined rapidly.

Access to safe abortions in the private or NGO sectors can be looked at from three points of view: access to information, services and referrals. Information on MTP is very rarely displayed openly in public spaces, therefore, there is confusion regarding the legality of abortion and the conditions under which abortions are legal not only among women and men but also grassroots level service providers across the country.

With regard to CAC services, there has been an improvement in processes due to decentralization of certification of sites; although in many places DLCs are either nonexistent or nonfunctional. Regulations vary across states especially when taking into consideration renewal periods for certification. The other issue is that quite often doctors are unwilling to put their names down on site registration for abortion services and it might be preferable to allow certification in the name of established institutions such as FPAI to facilitate service provision. Training facilities for private sector providers are scarce. There is a new, disturbing trend of stigma being attached to providers of abortion services resulting in declining interest amongst providers for fear of harassment. When it comes to access to products, availability of MMA drugs varies across the country even when prescriptions are produced. There is also limited access to the approved drug regimen for second trimester abortions. Provision of abortion in the second trimester has become very difficult. Referrals to tertiary care centers in the public sector for abortion-related complications are becoming increasingly complicated.

MTP is an essential service and refusing it is a violation of women's reproductive rights. However, as a result of the conflation of the PCPNDT and MTP Acts, this violation is now common, often affecting the most poor and most marginalized women. Urgent and immediate measures are needed to balance and insulate the two Acts and support women's choices.

Panel Discussion: Policy Framework for Scaling-up CAC under NHM

Remarks from Panelists

Mr Ashish Singhmar (IAS)

Jharkhand is focusing on operationalizing non-functional CAC training centers; where the centers face inadequate numbers of cases, the state is exploring the option of linking training centers to private sector sites to ensure that trainees receive adequate hands-on practice. 621 doctors have been trained in Jharkhand and are routinely followed-up with to ensure that they provide services. In addition, there are plans to provider refresher trainings to doctors who have already been trained but are not providing services.

The state also plans to recruit RMNCH+A counsellors to enhance CAC services.

Jharkhand's community health intermediaries—Sahiyyas—are the backbone of the ground-level health services. They are incentivized to provide services, but there is a need to ensure that they are reimbursed on time to keep them motivated. The state will also consider including incentives for Sahiyyas for MTP cases in subsequent PIPs. Efforts are also being made to ensure proper reporting and availability of documentation-related resources. Plans include bringing private providers on board to ensuring that those interested in providing CAC services are aware of proper registration processes.

Dr K.H. Govind Raj (IAS)

The Government of Maharashtra signed a memorandum of understanding with Ipas in 2008. 25 CAC training centers have been strengthened. More than 3,000 doctors have been trained. Sensitization workshops have been organized in the state for media representatives about the differences between the PCPNDT and MTP Acts.

On the procurement front, both MVA equipment and MMA drugs have been taken into account; procurement was done centrally to ensure quality and timely delivery. DLCs have been operationalized in all 35 districts; these committees make regular reports.

Capacity building of providers is given a lot of importance but rational deployment remains a barrier to service provision. The state government is trying to replicate the Karnataka model of transfer of medical officers and health personnel where posts are categorized based on various criteria, medical officers are offered counselling on their top choices of posts. The system is completely online and very transparent

Key Points from the Discussion

- Tertiary public health facilities, particularly medical colleges, should not turn away referral cases of abortion-related complication from private providers. The issue should be addressed through widespread education of medical college faculty.
- DLCs are a marker of the health of private sector service provision. States should ensure that DLCs are formed in all districts, operationalized, strengthened, and regularly monitored.
- ASHAs play a very important role in the health system. There should be no delays in payment of the incentives for their services. Central Plan Scheme Monitoring System (CPSMS) and direct benefit transfers will contribute toward transparent financial management.
- The current reporting system has to be systematically and scientifically streamlined in order to facilitate monitoring.
- Doorstep delivery of contraception means that quite often adolescents are overlooked; there is a need to explore methods to ensure that the contraceptive needs of adolescents are met.
- Over the counter sale of MMA drugs is becoming a pressing concern—there needs to be some convergence between the Public Health Department, the Food and Drug Administration, and the State Drug Controller to ensure that pharmacists are educated on the need to not provide the drugs over the counter without prescriptions.

Closing Plenary

Closing Remarks and Way Forward
Shri Lov Verma (IAS)
Secretary (Health and Family Welfare),
Government of India

Comprehensive Abortion Care Services:
Summary of Discussions and Action Plan
Dr Manisha Malhotra
Deputy Commissioner (Maternal Health),
Government of India

Key Points at the Policy and Operational Level to
Take the Agenda Forward
Dr Himanshu Bhushan
Deputy Commissioner (Maternal Health),
Government of India

Comprehensive Abortion Care Services: Summary of Discussions and Action Plan

Dr Manisha Malhotra

The major points of discussion during the national consultation have been consolidated in order to facilitate the creation of action plans by the states.

Planning and Implementation

- Gap analysis of health systems and CAC training
- Getting reliable estimates of abortion in India
- Comprehensive planning and programming for CAC in State PIPs
- Focus on Delivery Points—performance monitoring, training, etc.

Monitoring

- Improve information flow (reporting) and quality of data from states
- Focused attention to quality in CAC training and service delivery
- Utilization of existing monitoring tools

Training

- Mapping of partners for expanding partnerships in states to improve capacity building and service delivery
- Explore potential for low dose, high frequency onsite CAC training
- Establish training opportunities for private providers
- Integration of training components within RMNCH+A (e.g. Family Planning and Abortion)
- Focus on post training support
- Rational deployment policy
- Develop and implement blended learning and e-based learning platforms for CAC
- Explore induction training of MOs
- Enhance involvement of medical colleges for training and post training mentoring
- Effective dissemination and implementation of CAC Training Package

Service Delivery

- Develop mechanisms to strengthen MMA reporting (specifically from unapproved private sites)
- Disaggregated reporting of MMA in HMIS
- Explore feasibility of amending MTP rules to allow training for "MMA only" providers
- Ensuring inclusion of MMA drugs in EDL and procurement for making them available at facilities
- Explore MP model of training in "MMA only" for non-performing MTP certified doctors, for replication in other states

Postabortion Contraception

- Assessment of CPR/unmet need for contraception especially for young people
- Effective communication to change provider attitude towards post abortion contraception in young women
- Effective use of RMNCH+A counsellors keeping in mind the 3Cs approach (Care, Counselling, Contraception) for PAC in adolescents and young women

Increasing Awareness

- Increase dissemination and uptake of mid-media IEC material
- Ensure inclusion of 'Safe Abortion' mass media campaign (TV/Radio) in MoHFW's media plan for broadcasting
- Leverage ASHA workforce
  - → For safe abortion IPC
  - → For guiding women to safe abortion services through suitable incentives

Policy

- Guidance note to address conflation between PCPNDT and MTP Acts (subgroup comprising of FOGSI, Ipas, UNFPA and other partners under MoHFW oversight)
- Take forward the proposed amendments to the MTP Act
- Ensure functional DLCs for approval of private sector sites and their regulation

Key Points at the Policy and Operational Level to Take the Agenda Forward

Dr Himanshu Bhushan

Important areas that need to be addressed immediately include:

- Improving information services and women's access to the right information and addressing major gaps in provision of services like lack of infrastructure, equipment or drugs. States could incorporate innovations like providing trainees with the necessary equipment such as MVA kits to ensure initiation of services.
- Overcoming procurement barriers by empowering medical officers at primary and community health centers. This will prevent service providers from turning away women due to unavailability of drugs.

Closing Remarks and Way Forward

Shri Lov Verma (IAS)

State stakeholders should start work on action plans on the key issues that were brought out at the national consultation. These action plans should indicate timelines and persons responsible, and be regularly monitored by concerned authorities. The mass media campaign should be utilized effectively to ensure that abortion is no longer associated with shame and guilt and is liberated from the taboos with which it currently struggles. Lack of data is a very serious concern, that impacts planning and strategies on CAC—addressing this should be the starting point, followed by the information and education campaign.

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Dr Nagaraj	Government of Karnataka
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Dr Nel Druce	Department for International Development (DFID)
Dr Nidhi Pandey (IAS)	Government of Uttarakhand
Dr Nirlep Kaur	Government of Chandigarh
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Dr Obangjungla	Government of Nagaland
Dr P.K. Prabhakar	Ministry of Health and Family Welfare, Government of India
Dr P. Usha Prasad	Government of Andhra Pradesh
Dr P.K. Senapati	Government of Odisha
Dr Padmaja Allavi	Government of Telengana
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Dr Ramesh Choyal	Distrcit Hospital, Badwani
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Dr Rashmi Asif	Jhpiego
Dr Rathna Kumar	Government of Tamil Nadu
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Dr Sangeeta Batra	Ipas India
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Mr Sumit Gulati	Ipas India
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