

IMPROVING ACCESS TO COMPREHENSIVE ABORTION CARE IN INDIA WITH FOCUS ON EXPANDING PROVIDER BASE

A POLICY BRIEF

BACKGROUND

Induced abortion services were legalized in India through the Medical Termination of Pregnancy Act (MTP) in 1971. However, India still has a long way to go for universal access to comprehensive abortion care (CAC^A) services. The lack of access to CAC facilities, because of fewer numbers as well as inequitable distribution across geographies, is one of the key contributory causes of unsafe abortions^[1]. The other critical barrier is the lack of availability of trained providers^[2]. Both these barriers could be successfully addressed by expanding the provider base.

INTRODUCTION

The intent to “diversify the categories of health care providers (for provision of reproductive and child health services)”, and to “strengthen and expand safe abortion services including training mid-level providers” is clearly articulated in the National Population Policy of India, 2000^[3]. While the country has implemented task-shifting and task-sharing for many maternal health, child health and family planning interventions under the RMNCH+A framework^[4] – such as provision of life saving anesthesia and performance of C-sections by non-specialist physicians; and the insertion and removal of IUCDs by AYUSH doctors^[B], nurses and ANMs – there is a need to facilitate this process for CAC too.

WHO’s 2015 Guidelines - “Health worker roles in providing safe abortion care and post-abortion contraception”^[2] (henceforth referred to as the WHO 2015 Guidelines) – provide evidence-based recommendations on the range of health care providers who can effectively and safely perform various interventions for provision of safe abortion and post-abortion care. These technical interventions are described in WHO’s “Safe abortion: technical and policy guidance for health systems, 2012”^[5] (henceforth referred to as WHO 2012 Guidelines).

The current document lists the legal and policy changes required to expand the provider base and improve women’s access to CAC in India. The recommendations were developed following a consultative process that included mapping of the current abortion-related legal^[6] and policy (see box 1 below) landscape in India against the recommendations in the WHO 2015 Guidelines^[2] followed by a sequential expert consultation process as detailed in Table 1 on page 10.

BOX 1: List of Indian policy documents on comprehensive abortion care

CAC Training and Service Delivery Guidelines^[7]
CAC Operational Guidelines^[8]
CAC Provider’s Manual^[9]
Medical Methods of Abortion – Handbook^[10]
Post-abortion Family Planning – Technical Update^[11]
Post-abortion Family Planning – Operational Guidelines^[12]

^A Comprehensive abortion care refers to the provision of safe, high-quality, women-centric abortion services and includes abortion, post-abortion care and family planning / contraception.

^B These are doctors of complementary systems of medicine – Ayurveda, Unani, Siddha and Homeopathy.

EXPERT GROUP RECOMMENDATIONS FOR IMPROVING ACCESS TO COMPREHENSIVE ABORTION CARE

GOAL 1: EXPANDING ACCESS TO FIRST TRIMESTER ABORTIONS

A. PROVIDER-BASE FOR FIRST TRIMESTER ABORTIONS

The MTP Act permits only allopathic doctors (with specialization in Obstetrics and Gynecology or general practitioners who have undergone a pre-defined certification training) to provide abortion services. The WHO 2015 Guidelines^[2] recommend that a range of health care providers, including doctors of complementary systems of medicine, nurses and Auxiliary Nurse Midwives (ANMs), in addition to general physicians and Ob-Gyn specialists, can safely and effectively perform first trimester abortions, using either vacuum aspiration (VA)^[C] or medical methods^[D]. Studies conducted in India too have found that abortion care can safely and effectively be provided by a range of providers, including nurses and AYUSH practitioners^[13,14].

Experts recommended expanding the provider base for first trimester abortions to overcome the acute shortage of trained physicians and specialists that restricts access to CAC services. In the public sector, there is a 13% and 77% shortfall of medical officers (MBBS) and specialists (Ob-Gyn) respectively^[15]. Research studies^[13,14] have compared Manual Vacuum Aspiration (MVA) and Medical Methods of Abortion (MMA) services provided by trained nurses and ayurvedic doctors with the services provided by allopathic doctors and found the services by non-allopathic doctor cadres to be not only equally efficacious, but also equally acceptable by women. The experts felt that the simplicity and safety of current abortion technologies for the first trimester permit a wider range of health care providers to be trained to offer abortion care in the first trimester. Given the increased reliance on MMA, as well as the limited monitoring and supervision in health care provision, the experts felt that the non-physician cadres should initially be permitted to perform first trimester abortions using MMA only. This may be expanded later to include VA, or other technologies as may emerge.

RECOMMENDATIONS:

1a.i) **LEGAL:** Amend the MTP Act to permit cadres beyond MBBS doctors and Ob-Gyn specialists to perform abortions, by replacing the term “Registered Medical Practitioner” with “Registered Health Care Provider”- this includes registered AYUSH doctors (all except Yoga and Naturopathy), nurses and ANMs - as persons who are eligible to provide MTP services.

1a.ii) **POLICY:** Revise the CAC Operational^[8] and Technical Guidelines^[7,9,10] to include detailed roles for the expanded provider base.

1a.iii) **POLICY:** Specify in the CAC Technical Guidelines^[7,9,10] that the non-allopathic providers such as AYUSH doctors, nurses, and ANMs would be permitted to provide first trimester abortion services using MMA only.



^C The recommendation for doctors of complementary systems of medicine and ANMs is “conditional” to their existing participation in other RMNCH related tasks, and in BEmOC and post-abortion care respectively. While the first conditionality matches the Indian scenario, the latter one for ANMs does not.

^D The recommendation for doctors of complementary systems of medicine is “conditional” to their existing participation in RMNCH related tasks.



POTENTIAL IMPACT:

India has close to 70,000 nurses and 2,20,000 ANMs working in the public sector alone^[15]. Additionally, 40% of the primary care facilities engage AYUSH doctors as staff^[16]. Expanding the provider base for abortion provision will significantly increase the pool of trainable providers. Availability of trained cadres like nurses and ANMs will also ensure that even the most peripheral facilities are functional and services for first trimester abortion are available.

B. TRAINING OF PROVIDERS FOR FIRST TRIMESTER ABORTIONS

The MTP Rules define additional training requirements for allopathic physicians without a specialization in Ob-Gyn to be able to provide abortion services. The experts were of the opinion that while training is essential for any cadre to be able to deliver quality services, current requirements of the MTP Act, which were established more than four decades ago, are over-stringent and incongruent with the advent of simpler and safer abortion technologies. Medical technologies evolve rapidly and it is usually not feasible to amend the laws as frequently to keep up with the change. The group suggested keeping training requirements for all eligible cadres as part of policy documents/guidelines rather than as part of the law, as training guidelines are far more amenable to change.



RECOMMENDATIONS:

1b.i) **LEGAL:** Amend the MTP Rules to remove the clauses specifying additional training for MBBS doctors over and above the basic qualification to enable them to provide abortion services.

1b.ii) **POLICY:** Revise the CAC Training Guidelines^[7] to provide details of abortion technology-specific training needed to equip all abortion care providers, including the expanded provider base, with the necessary skills.



POTENTIAL IMPACT:

Shifting the training requirements from legal to policy documents will ease the process of making changes to training requirements and specifications, and ensure that they are in sync with the evolving abortion technologies and guidelines.

C. FACILITIES FOR PROVISION OF FIRST TRIMESTER ABORTIONS

The WHO 2012 Guidelines^[5] state that first trimester abortion services, whether through VA or through MMA, should be available at the primary health care level. According to the CAC Operational Guidelines^[8], for the public-sector facilities, abortion services can be provided at the primary level of care (the PHCs) till only eight weeks of gestation.

Experts opined that such gestational cut-offs for provision of services at the PHCs grossly reduce access to abortion care for pregnancies beyond eight weeks. They recommended that the infrastructure at the PHCs is adequate for provision of all first trimester abortions.



RECOMMENDATIONS:

1c.i) **POLICY:** Revise the CAC Operational Guidelines^[8] to permit all approved facilities where a skilled provider is available, including PHCs, to offer first trimester abortion services (i.e. up to 12 weeks).



POTENTIAL IMPACT:

Permitting PHCs with trained providers to offer CAC services up to 12 weeks will improve geographical access to abortions for women by bringing services closer to their doorsteps. This is especially critical in the rural context where detection of pregnancy and decision to terminate are often delayed.

GOAL 2: ENSURING TIMELY AVAILABILITY OF POST-ABORTION CARE

A. INCOMPLETE ABORTION

An incomplete abortion may result following either an induced or a spontaneous abortion. Incomplete abortions with a uterine size of less than 13 weeks' gestation can be managed either surgically using VA or medically by administering misoprostol. The WHO 2015 Guidelines^[2] recommend that a range of health care providers – including doctors of complementary systems of medicine^[E], nurses and ANMs^[F] – can safely and effectively manage incomplete abortions.

In India, the management of incomplete abortions is not governed by the MTP Act and is specified in the various CAC Technical and Operational Guidelines^[7, 9, 10]. The CAC Operational Guidelines^[8] prohibit nurses and ANMs from managing incomplete abortions, and are silent about the role of AYUSH doctors for the same. The experts were of the opinion that because incomplete abortion is a medical emergency, its management should be available in a timely manner at all referral facilities, and all health care provider cadres present in such facilities should be trained to manage the same.

The CAC Technical Guidelines^[7, 9, 10] limit the scope of incomplete abortions to only those subsequent to an induced medical abortion, leaving the management of incomplete spontaneous abortion untouched. They also restrict the management of incomplete abortions to the use of VA only and mention use of misoprostol for management of incomplete abortions in highly specific circumstances^[G], significantly restricting its use. The probable reason for this is the non-listing of management of incomplete abortions as one of the uses of misoprostol in the Drug Controller General of India's guidance.



RECOMMENDATIONS:

2a.i) **POLICY:** Revise the CAC Operational^[8] and Technical Guidelines^[7, 9, 10] to include all cadres posted at referral facilities, including AYUSH doctors (except Yoga and Naturopathy), nurses and ANMs, as eligible to provide management of incomplete abortions, and define their roles.

2a.ii) **LEGAL:** Include “management of incomplete abortions” as one of the indications for the use of misoprostol in the Drug Controller's guidance.

2a.iii) **POLICY:** Revise the CAC Technical Guidelines^[7, 9, 10] to include all evidence based methods for management of incomplete abortions, including the use of misoprostol.

2a.iv) **POLICY:** Revise the CAC Technical Guidelines^[7, 9] to expand the definition of incomplete abortions to also include those following spontaneous abortions.

E. Management of incomplete abortion by doctors of complementary systems of medicine using either vacuum aspiration or misoprostol is recommended only where health system mechanisms are established for the participation of these doctors in other tasks related to maternal and reproductive health.
F. Management of incomplete abortion by ANMs using vacuum aspiration is recommended in contexts where established health systems mechanisms involve ANMs in providing basic emergency obstetric care, and where referral and monitoring systems are strong.
G. The CAC Provider's Manual and the MMA Handbook state that an additional dose of misoprostol may be given in cases of incomplete abortion following MMA where a non-viable gestational sac is visible in the ultrasound.



POTENTIAL IMPACT:

These changes will result in timely availability of management options for incomplete abortions at referral facilities, thus preventing further complications like excessive hemorrhage and infections that may follow untreated incomplete abortions.

B. POST-ABORTION COMPLICATIONS LIKE HEMORRHAGE AND INFECTIONS

While definitive management of severe complications may require a referral level facility, life-saving management such as administering IV fluids or provision of antibiotics can be done at primary health care level as well. The WHO 2015 Guidelines^[2] state that most cadres of health care workers, including doctors of complementary systems of medicine, nurses and ANMs, can safely and effectively provide the initial management for these post-abortion complications.

While the current policy guidelines permit nurses and ANMs to provide these services, they are silent about the role of AYUSH doctors. The experts were of the opinion that since AYUSH doctors are already permitted to manage common obstetric complications like post-partum hemorrhage (PPH) and puerperal infections, both of which involve use of similar medical technologies (administration of IV fluids and parenteral antibiotics respectively), they should be permitted to administer initial care for post-abortion complications too.



RECOMMENDATIONS:

2b.i) **POLICY:** Revise the CAC Operational^[8] and Technical Guidelines^[7,9] to include AYUSH doctors (except Yoga and Naturopathy) as cadres eligible to provide initial management of post-abortion complications like hemorrhage and infections, including the administration of IV fluids and parenteral antibiotics.



POTENTIAL IMPACT:

As 40% of the PHCs currently engage AYUSH doctors as staff^[16], permitting and training them to provide these life-saving interventions will bring these emergency services closer to women and help in reducing morbidity and mortality due to these complications.

GOAL 3: INCLUSION OF MMA AS AN OPTION FOR ABORTION ACROSS GESTATIONAL AGES

A. GESTATIONAL AGE FOR MMA

The WHO 2012 Guidelines^[5] state that MMA, using a combination of mifepristone and misoprostol, is an effective, safe and acceptable (by women) method for inducing abortions, not just in the first trimester but also beyond 12 weeks of gestation.

In India, the MTP Rules limit the use of these drugs to seven weeks of gestation only. The Drug Controller General of India has approved the use of MMA combi-pack (with mifepristone and misoprostol) till nine weeks gestation only.

Experts recommended expanding MMA use beyond the current limitation of seven or nine weeks, keeping in line with WHO 2012 Guidelines^[5]. This will increase options available to practitioners. Off-label^[17] use of MMA for terminating pregnancies beyond seven or nine weeks, including second trimester pregnancies, is already a practical reality.

Experts recommended that any references to medical technologies used for abortion provision should be shifted from the law to the technical guidelines; because while technology is bound to change with time, it is not feasible to amend the relevant law(s) as frequently. From the women's perspective, the experts opined that the increasing sale of MMA combi-packs could be interpreted as an indirect indicator of women's preference for MMA for inducing abortion.

RECOMMENDATIONS:



3a.i) **LEGAL:** Amend the MTP Rules to remove references to specific abortion technologies, including the gestational age up to which MMA can be used.

3a.ii) **LEGAL:** Amend the Drug Controller's guidance to increase the allowable gestational age for which MMA can be used from the current nine weeks to cover the entire legal allowable limit for MTP.

3a.iii) **POLICY:** Revise the CAC Technical Guidelines^[7, 9] and the MMA Handbook^[10] to reflect the required changes in specifics like dosage and route of administration of drugs etc. that will emerge from the increased gestational age limits for MMA.



POTENTIAL IMPACT:

Legalizing the use of MMA for higher gestational ages will increase choice in abortion technology for women seeking abortions beyond seven or nine weeks. It will also safeguard the providers who are already using MMA for providing abortion services beyond seven or nine weeks of gestation from potential litigation.

GOAL 4: ADDRESSING WOMEN'S NEEDS THROUGH SELF-MANAGEMENT OF FIRST TRIMESTER ABORTIONS

A. VISITS TO HEALTH FACILITY FOR MMA FOR FIRST-TRIMESTER ABORTIONS

WHO's 2015 Guidelines^[2] state that for first trimester abortions using MMA, women can safely and effectively self-administer both the mifepristone and misoprostol medication without the direct supervision of a health care provider, if they have a source of accurate information as well as access to a health facility should they ever need it during the process.

The CAC Technical Guidelines^[7,9,10] require the woman to make three visits to the facility or provider for MMA – the first one when mifepristone is given, the second one for administering misoprostol, and the last one to confirm completion of the abortion process. For many women, this may be difficult because of logistical, familial and financial reasons.

The experts were of the opinion that as the first visit often entails multiple tasks beyond the administration of mifepristone, eliminating the first visit from the guidelines is not a viable option. However, in those cases where mifepristone is not administered on the day of the first visit itself, she may be advised to take the medication at home. For the second visit, the experts agreed that with technological advancements, contact may be established by means other than an in-person visit.

RECOMMENDATIONS:



4a.i) **POLICY:** Revise the CAC Technical Guidelines^[7, 9] and the MMA Handbook^[10] to explicitly state that following provision of complete information regarding MMA and its dosage schedule, the woman may take the dose of mifepristone at home, subject to the treating physician's discretion.

4a.ii) **POLICY:** Revise the CAC Technical Guidelines^[7] and the MMA Handbook^[10] to change the term "visit" to "contact" (with the health provider) for the second visit on day 3 (for administration of misoprostol) of the MMA schedule, thus allowing her to take the misoprostol dose at home.



POTENTIAL IMPACT:

Reducing the number of visits to the health facility will increase the convenience for women who opt for MMA. It will also decrease the cost of treatment by reducing the out-of-pocket indirect expenses such as travel costs and loss of wages on hospital visit days.

GOAL 5: ENSURING EASY AVAILABILITY OF ABORTION-RELATED INFORMATION FOR WOMEN

A. PROVISION OF ABORTION-RELATED INFORMATION

The WHO 2015 Guidelines^[2] make a distinction between provision of information on abortion care (its legality, which facility and/or provider to approach for care, the importance of seeking care early etc.) and counselling a woman before she undergoes an abortion. They recommend almost all cadres of health care workers as safe, effective and acceptable for provision of information on abortion care.

CAC Technical Guidelines^[7, 9, 10] use the term counselling more broadly to encompass both provision of general information and elements of counselling. Unlike for most cadres of health care workers whose jobs entail provision of abortion-related information to women who need it, the guidelines are silent about the role of pharmacists and pharmacy workers.

The expert group opined that since pharmacies are often the first point of contact for many women, pharmacists and pharmacy workers are in a unique position to offer them accurate information on the legality of abortion services and direct them to an approved provider.

RECOMMENDATIONS:



5a.i) **POLICY:** Revise the CAC Technical^[7] and Operational Guidelines^[8] to include pharmacists and pharmacy workers, as providers of information on abortion.

5a.ii) **POLICY:** Develop a new training package for pharmacists and pharmacy workers to orient them on the legality of abortion and where to refer women who approach them for MMA drugs.

POTENTIAL IMPACT:



Correct information from the first point of contact regarding legality of abortion, and eligible facility and provider for services, will increase the likelihood of women seeking abortions to reach a trained provider. Seeking services from a provider skilled in abortion care provision significantly reduces the chances of the woman developing post-abortion complications. She is also more likely to reach a trained facility/ provider in case of a complication.

B. COUNSELLING FOR WOMEN SEEKING ABORTION SERVICES

Counselling is a two-way communication that helps a woman make an informed decision about abortion and post-abortion contraception. A wide range of providers, including doctors of complementary systems of medicine, nurses and ANMs are listed as recommended providers of pre- and post-abortion counselling services in the WHO 2015 Guidelines^[2]. The CAC Operational, Technical and Training Guidelines^[7, 8, 9] in India list multiple providers as potential counsellors, but are silent about the role of AYUSH doctors for this purpose.

As counselling is an essential pre-requisite of providing abortion and is required post-abortion too, the experts were of the opinion that expanding the provider base to include AYUSH doctors for provision of abortion services will require this new cadre to be involved in counselling women.

RECOMMENDATIONS:



5b.i) **POLICY:** Revise the CAC Operational^[8], Technical^[9] and Training Guidelines^[7] to include AYUSH doctors (except Yoga and Naturopathy) as providers of pre- and post-counselling for abortion services.

POTENTIAL IMPACT:



As providers of CAC services, AYUSH doctors will be able to follow the complete procedure, including counselling women before and after an abortion. Besides, research shows that the current abortion care providers (physicians) do not have the time for counselling^[18]. Including additional cadres in counselling process will serve to fulfil the unmet need in this area.

CONCLUSION

The WHO 2015 Guidelines^[2] suggest a range of health care providers who can safely and effectively perform a particular task / sub-task in safe abortion care and post-abortion contraception. It is for a country to decide on strategies to adapt and use the guidelines based on their local context and health system. A series of consultations were held with experts to arrive at key legal and policy recommendations in the Indian context. These recommendations, when implemented, have the potential to increase women's access to comprehensive abortion care in India. It is expected that this policy brief will provide the required evidence for strengthening women's access to comprehensive abortion care in India.

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TABLE 1: Consultation process for determination of required legal and policy changes

Timeline	Activity	Outcome
January 2017	Policy environment mapping	Background note listing the “gaps” between WHO recommendations and Indian scenario; with potential recommendations.
February 2017	Expert Group* consultation to generate recommendations	Recommended list of legal and policy changes based on the gap analysis and assessment of policy and public health context of India. Background note# revised in light of the agreed recommendations, and a policy discussion note# prepared.
September 2017	Expert Group* consultation to re-evaluate and finalize recommendations	Final set of legal and policy recommendations agreed upon by the experts.
November 2017	Consolidation of the policy recommendations	Draft policy brief document summarizing the key recommendations that emerged through the consultation process.
December 2017	Expert group review of the draft policy brief	Policy brief finalized for dissemination and advocacy.

#available on IDF's website.

*The expert group included Ob-Gyns, nurses, providers of complementary systems of medicine, public health experts, researchers and representatives of civil society organizations.

LIST OF EXPERTS CONSULTED

S.No	Name	Organization
1	Ms. Amita Dhanu	Family Planning Association of India (FPAI)
2	Dr. Amrita Kansal	World Health Organization (WHO)
3	Mr. Anand Sinha	David and Lucile Packard Foundation
4	Dr. Anchita Patil	Technical Consultant
5	Ms. Anupam Shukla	Campaign Pratigya
6	Dr. Asha Sharma	Indian Nursing Council (INC)
7	Dr. B.K. Suvedi	Government of Nepal
8	Dr. Bela Ganatra	World Health Organization (WHO)
9	Dr. Dinesh Agarwal	IPE Global
10	Dr. Himanshu Bhushan	National Health Systems Resource Centre (NHSRC)
11	Dr. Jyotsna Suri	Safdarjung Hospital
12	Dr. Manju Chhugani	Jamia Hamdard University
13	Ms. Medha Gandhi	Ipas Development Foundation (IDF)
14	Ms. Merlin James	Jamia Hamdard University
15	Dr. Namita Chandhiok	Indian Council of Medical Research (ICMR)
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17	Dr. Nitin Bajpai	Population Foundation of India (PFI)
18	Dr. Nozer Sheriar	Consultant, Obstetrics and Gynecology
19	Ms. Renu Khanna	CommonHealth
20	Ms. Ritu Raj	Ipas Development Foundation (IDF)
21	Ms. Rupsa Malik	CREA
22	Dr. S.K. Sharma	Department of Ayurveda, Government of Himachal Pradesh
23	Dr. Sachin Rai	Ministry of AYUSH, Government of India
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