

# ABORTION POLICY IN INDIA

## Lacunae and Future Challenges

Siddhivinayak Hirve



ABORTION ASSESSMENT PROJECT - INDIA

# **Abortion Policy in India: Lacunae and Future Challenges**

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**Abortion Assessment Project, India**

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# Preface

Abortions have been around forever. But at different points of time in history it has received attention for differing reasons, some in support of it, but often against it. Abortion is primarily a health concern of women but it is increasingly being governed by patriarchal interests which more often than not curb the freedom of women to seek abortion as a right.

In present times with the entire focus of women's health being on her reproduction, infact preventing or terminating it, abortion practice becomes a critical issue. Given the official perspective of understanding abortion within the context of contraception, it is important to review abortion and abortion practice in India.

The Abortion Assessment Project India (AAP-I) has evolved precisely with this concern and a wide range of studies are being undertaken by a number of institutions and researchers across the length and breadth of the country. The project has five components:

- I. Overview paper on policy related issues, series of working papers based on existing data / research and workshops to pool existing knowledge and information in order to feed into this project.
- II. Multicentric facility survey in six states focusing on the numerous dimensions of provision of abortion services in the public and private sectors
- III. Eight qualitative studies on specific issues to compliment the multicentric studies. These would attempt to understand the abortion and related issues from the women's perspective.
- IV. Household studies to estimate incidence of abortion in two states in India.
- V. Dissemination of information and literature widely and development of an advocacy strategy

This five pronged approach will, hopefully, capture the complex situation as it is obtained on the ground and also give policy makers, administrators and medical professionals' valuable insights into abortion care and what are the areas for public policy interventions and advocacy.

The present publication constitutes the "Policy Review" component of the AAP-India project. The paper analytically reviews abortion legislation and related policy implications, including the recent amendments and the complexities arising due to the PNMT Act. The paper concludes with a discussion on opportunities for change and possible advocacy issues to bring abortion policy within the rights domain.

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We look forward to comments and feed-back which may be sent to [cehat@vsnl.com](mailto:cehat@vsnl.com) Information on this project can be obtained by writing to us or accessing it from the website [www.cehat.org](http://www.cehat.org)

24<sup>th</sup> May 2004

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Coordinator, CEHAT

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# Executive Summary

In India, legalising abortion, which was done in 1971, has not yielded the expected outcomes. Despite the existence of liberal policies, the majority of women still resort to unsafe abortion, contributing substantially to the burden of maternal morbidity and mortality. This is partly due to the low awareness of the legality of abortion amongst women, and a large number of misconceptions about the law amongst providers. Liberal abortion policies and legislation by themselves are thus not adequate to ensure access to safe abortion services. This paper critically reviews current abortion policy (in terms of content, context and conformity with international policy, as well as how it is practised), identifies policy gaps in the context of reproductive rights and emerging reproductive technologies, examines programme barriers to policy implementation and advocates evidence-based policy change for policy-makers and all stakeholders to review and reinforce their commitment to safe abortion care.

Abortion policy in India is consistent with safeguarding reproductive rights as envisaged by International Conference on Population and Development (ICPD) and other international agreements. It does not advocate abortion as a family planning measure. Rather, it encourages the promotion of family planning services to prevent unwanted pregnancies and at the same time recognises the importance of providing safe, affordable, accessible and acceptable abortion services to women who need to terminate an unwanted pregnancy. The MTP Act aims to regulate and ensure access to safe abortion care and defines 'when' 'where' and under 'what' conditions abortion is permissible. The recent amendment to decentralise regulation of abortion care to the district level serves to encourage registration of abortion facilities

by minimising administrative delays. While defining punitive measures to deter abortion facilities that provide unsafe abortion care, the Act offers full protection to registered providers from any legal proceedings for any injury caused to a woman seeking abortion.

A major critique of the MTP Act is its apparent 'over-medicalisation' and 'physicians only' policy that reflect a strong medical bias and ignore the socio-political aspects of abortion. The need for two doctors to certify opinion for a second trimester MTP is an unnecessary restriction imposed by law. Abortion policy within the 'rights framework' emphasises not only the woman's 'right' to seek safe abortion, but also her 'right' to access safe abortion services as well as information about the availability of such services and the consequent responsibility of the state to provide these services. Though abortion law allows for termination of pregnancy for a wide range of reasons construed to affect the mental and physical health of the woman, it remains with the doctor (and not the woman) to opine in good faith, the need for such a termination. Such a provider-dependent policy might result in denial of abortion care to women in need, especially the more vulnerable amongst them, for various reasons, including 'conscientious objection'. It is also argued that it may compel a woman to lie about the situation surrounding her unwanted pregnancy. Further, the same provider-dependent law, however liberal it may be, can become restrictive under different socio-politico-religious compulsions without the alteration of even a single word. Moreover, while the MTP Act permits women seek legal termination of an unwanted pregnancy for a wide range of reasons, the clause about contraceptive failure applies only to married woman. This discrepancy needs to be corrected.

While the abortion policy allows for monitoring of quality of abortion care in the private sector, its recognition of all public health institutions as abortion facilities by default exempts the public sector from certification. This raises a potential 'moral hazard' in that public sector abortion facilities are not constrained to adhere to the physical standards and quality of abortion care expected of the private sector. The default recognition of all public health institutions as abortion facilities also implies the responsibility of the government to make each public health institution capable of providing abortion care and hence makes the state accountable for it.

The MTP Rules specify certification procedures, and regulatory and redress mechanisms to ensure compliance with safe abortion care. For registration of abortion facilities, the amended MTP Rules stipulate a time frame of two months for inspection after receipt of application and another two months for approval after full compliance with requirements. By making the government accountable, this mandate serves to encourage abortion facilities to obtain registration. However, it does not specify measures or redress mechanisms if certification procedures are not completed within the stipulated time frame. More substantively, the amended MTP Rules differentiate between and rationalise the training/experience criteria required of the doctor and the physical standards required of the facility for first and second trimester abortions. This amendment has the potential to increase the availability of first trimester abortion without compromising on safety. The amended MTP Rules also allow registered medical practitioners to provide medical abortion within the scope of the law. Such providers need to have access to (and not necessarily have on-site capability) surgical abortion services. This amendment potentially serves to expand the availability of medical abortion.

Another major critique of the abortion policy is its lack of a link with good clinical practice and research. The MTP Rules define 'person' and 'place' requirements, but do not refer to any national or international technical guidelines for safe abortion care. In the absence of such linkages with guidelines for 'good clinical practice', providers continue to use unsafe abortion practices like sharp curettage, check curettage following a vacuum aspiration, general anaesthesia, different drug dosage schedules and protocols for medical abortion, etc. The scope of an abortion policy needs to be broad enough to internalise emerging advances in reproductive technology and newer practices within the legal framework.

The MTP Regulations define procedures to ensure confidentiality and anonymity in provision of safe abortion services. However, there are no guidelines for ensuring the privacy and dignity of the woman. States are yet to respond to the recent (June 2003) amendments to the MTP Rules and Regulation and some of them continue to add layers of bureaucratic procedures not required by policy, leading to unnecessary administrative barriers. For instance, regulatory procedures like the need for a blood bank within a 5 km distance of the abortion facility are illogical and not required by abortion policy. The irrational nature of such overzealous regulations by states becomes apparent when we realise that these requirements are applied *only* to abortion facilities in the private sector. The time and effort required to procure registration for an abortion facility reflects the states' attitude and approach towards facilitating abortion services. Low awareness and misconceptions about abortion laws and policies amongst providers adds to the overall lack of availability of safe abortion services. The general 'spirit' of the State Regulations thus appears to be that of 'controlling' rather than of 'facilitating' abortion services.

Mifepristone has been recently licensed for use in medical abortion. A major critique of the Drug Controller General's Policy is its over-medicalisation and restricted access. By permitting the use of mifepristone only up to seven weeks and making it contingent on a gynaecologist's prescription, the drug licensing policy conflicts with the abortion policy and technical guidelines. Further, with no national consensus on medical abortion protocols regarding dosage and schedules, the current MTP policy offers no technical guidelines for the practice of medical abortion. The government has not yet adopted either the international technical guidelines or those recommended by the Expert Consortium on Medical Abortion in India, which advocates home administration of mifepristone/misoprostol under medical supervision.

Para 63(iii) of ICPD+5 mandates the health system to adequately train and equip health service providers and to take measures to ensure that safe abortion care is available and accessible. A large unmet need for MTP training exists in both the public and private sectors. Selection norms for training centres should ensure an adequate caseload to allow 'hands-on' training. Further, the few training centres that do exist are inequitably distributed between states, and function below par. The private and non-governmental sectors' potential for training has not been tapped. And while the goal of training policy is to provide MTP training to medical officers at all Public Health Centres (PHCs), poor coordination, low priority and lack of clarity about training needs have resulted in very few trained doctors at PHCs. An important gap in training policy is the lack of training opportunity for private medical practitioners desirous of providing abortion care. Training policy needs to address the training needs of the private sector and allow MTP training centres to charge private medical practitioners for training services.

Comprehensive abortion care is integral to abortion services. This includes providing pre- and post-counselling services for contraception, STI and HIV counselling and voluntary testing, extended care up to six weeks after abortion and management of abortion complications. Covert and overt coercion for post-abortion contraceptive use in public institutions often compels women to seek unsafe abortion elsewhere. Abortion policy also needs to explicitly link up with national and international technical guidelines for management of post-abortion complications.

Access to safe abortion care goes beyond an enabling policy environment. Rules and regulations may themselves create barriers to policy implementation. Many administrative barriers not dictated by law evolve simply as through practice and get misinterpreted as 'required by law'. Spousal consent, informal fees, lack of awareness about the legality of abortion, judgmental attitudes, conscientious objection to abortion by providers, the traditional neglect of underserved women -- such as adolescents and single women -- by the health services, and other barriers need to be identified and measures taken to end such misguided practices.

Policies need to clearly demarcate the purposes and domains of the PNDT Act and the MTP Act. Recent media campaigns to enforce the PNDT Act to prevent sex selective abortions have blurred this demarcation and often denied access to safe abortion care to women seeking to terminate a pregnancy within the legal framework. The PNDT Act and the MTP Act do not conflict or contradict but coexist. The belief that a restrictive abortion policy will prevent sex selective abortion is unfounded. Policies need to ensure that measures for preventing sex selective abortion do not affect access to safe abortion care for the genuine abortion seeker.

Despite its ability to influence and shape policy, the private sector has traditionally distanced itself from all matters relating to it. It is only recently that non-governmental professional bodies like FOGSI have interacted with the government to reshape abortion policy. Though being the largest provider of abortion services, the private sector has until recently played a minimal role in educating and training its fraternity in safe abortion care. While not shy of critiquing public policy, the general phobia for record keeping and reporting and the consequent fear of 'accountability' to the state, has restrained private doctors from taking part in public policy dialogue. The general lack of concern in the private sector about ethical violations and the lack of adherence to minimal quality standards on the one hand, and the blind eye it turns towards the uncertified and unqualified providers of illegal and unsafe abortion among its fraternity on the other, raises concerns about self-regulation within the sector. It is only recently that some private actors have begun to play a more proactive advocacy role for improving access to safe abortion care, though there have been/are many opportunities for public-private partnerships in the areas of policy formulation, research, training and practice, and the strengthening of safe abortion care.

Several national-level consultative efforts involving policy-makers, professionals groups, NGOs and health activists, have made major policy recommendations to improve access to safe and legal abortion services in India. Many of these policy recommendations are in line with the objectives and Action Plan of India's National Population Policy, 2000. Increasing availability, creating qualified providers and facilities, simplifying the registration process, de-linking place and provider, linking policy with technology and research and good clinical practice, and providing comprehensive and quality abortion care are some of the immediate policy measures needed to bring about a change in the current abortion scenario in India.

A concerted and sustained advocacy effort 'to make abortion safe' directed towards national and state policy-makers as well as programme managers, coupled with a sustained campaign to increase the overall awareness about abortion laws and policies amongst women and dispel myths about abortion amongst policy-makers and programme managers, are needed to ensure the political and administrative commitment to provide safe abortion care to a woman seeking termination of an unwanted pregnancy within an enabling legal and policy framework.

## Abortion -- A Policy Perspective

Until 1971, abortion in India was governed by the Indian Penal Code (IPC) of 1862 and the Code of Criminal Procedure of 1898. Both these laws have their origins in a nineteenth-century British law that deemed abortion to be a crime for which both the mother and the abortionist (provider) were punishable, except when abortion was induced to save the life of the woman.

A further provision of the Indian Penal Code outlines severe penalties for infanticide and for abortions performed without the woman's consent, with the Code of Criminal Procedure laying down the procedure to try persons violating the substantive law under the Indian Penal Code.

*'Whoever voluntarily causes a woman with child to miscarry shall, if miscarriage be not carried in good faith for the purposes of saving the life of the woman, be punished with imprisonment of either description for a term which may extend to three years, or with fine or with both, and if the woman be quick with child, shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine' (Code 312 of the IPC).*

Globally, abortion laws began to be liberalised in the early part of the twentieth century as a consequence of increasing public concern over the morbidity and mortality associated with unsafe abortion. The 1960s and 1970s saw the liberalisation of abortion laws across Europe and the Americas, and in many other parts of the world through the 1980s (Berer 2000; Rahman et al. 1998). The process of liberalising the abortion law in India began in 1964, when it was realised that decriminalising abortion could lead to women availing abortion services in legal and safe

settings. Since the majority of women abortion seekers were married, they were under no socio-cultural pressure to conceal their pregnancy. However, with the increase in the availability of and access to medical and hospital care, doctors were also coming across gravely ill or dying women who had taken recourse to unsafe abortions by unskilled practitioners.

### Historical chronology of events

- 1964 : Central Family Planning Board, Ministry of Health & FP forms Shantilal Shah Committee.
- 1966 : Shah Committee report.
- 1971 : MTP Act passed.
- 1972 : MTP Act enforced in all 22 States and 9 Union Territories except J&K, Mizoram, Sikkim and Lakshwadeep.
- 1975 : MTP Rules and Regulations framed.
- 1980 : MTP act enforced in J&K and Mizoram (Sikkim and Lakshadweep, even today, have restrictive abortion laws).
- 2002 : MTP (Amendment) Act.
- 2003 : MTP Rules, Regulations amended

In 1964, on the recommendation of the Central Board for Family Planning, Government of India, the Ministry of Health and Family Planning appointed a committee under the Chairmanship of Shantilal Shah to review abortion in all its aspects -- medical, legal, social, moral and global. Based on research conducted in Gandhigram, Tamil Nadu, the Shah Committee estimated about 6.5 million abortions (3.9 million induced) annually for India's population of 500 million. After studying the opinions -- elicited through a questionnaire -- of about 570 experts from Mumbai, Calcutta and Delhi on various issues relating to abortion, the Shah

Committee recommended legalising abortion in order to prevent wastage of mothers' health and life, as well as on compassionate and medical grounds. The report it submitted became the basis for all subsequent abortion policies in India.

It is important to note here that in its report, the Shah Committee specifically denied that its recommendation was aimed at controlling population. In fact, it emphasised that legalising abortion for demographic goals might prove counterproductive for the constructive and positive practice of family planning through contraception (GOI 1966). Nevertheless, the discourse on abortion following the Shah Committee report seems to suggest that some states did look upon the proposed legislation as a potential strategy for population control and advised abortion conditional on acceptance of post-abortion sterilisation (Phadke 1998). Based on the Shah Committee's recommendations, the Medical Termination of Pregnancy (MTP) Act (the phrase 'medical termination of pregnancy' was used to reduce opposition from religious and social groups that were against liberalising the abortion law) was enacted by Parliament in 1971 as a public health measure, and applied to all states in India except Jammu & Kashmir, Mizoram, Sikkim and the Union Territory of Lakshwadeep. However, it is difficult to evaluate whether the Act was intended as an enabling measure for women, or whether it was driven by India's socio-political compulsions for population control (Chandrasekhar 1974).

### **Abortion Scenario in India**

Studies estimate that about 3.9 to 6 million abortions take place in India annually, while some media reports have projected up to 12 million abortions per year. Even if we accept the lower estimate, 3.9 abortions per year would add up to 70.2 million abortions in India during the 18 years

since the MTP Act was passed. The Indian government, however, reports this figure as 6.3 million (GOI 1990). Apart from being a gross under-representation of the estimated figures, this would suggest that the majority of abortions are either not getting reported or are taking place illegally.

Abortion estimates in India tend to vary widely. Abortion ratio estimates (defined variably as the number of induced abortions per 100 pregnancies or per 100 live births) have ranged from 1.3 in large-scale national surveys (IIPS 1995, 2000; ICMR 1989), to about 2.1 based on government statistical sources (Chhabra 1996; GOI 1996; Henshaw et al. 1999), to between 9 and 14 in micro community-based studies (Nair and Kurup 1985; Kumar et al. 1995; Ganatra 2000; Ganatra et al. 2000) and about 18–20 in studies based on estimates (Chhabra and Nuna 1994; Singh and Henshaw 1996).

Data on abortions occurring outside the legal framework (non-legal abortions) are rare and unreliable. Estimates for non-legal/unsafe abortions are largely speculative and range from 2–5 (ICMR 1989; Karkal 1991) to 10–11 illegal abortions (Chhabra and Nuna 1994) per every legal abortion. Studies are increasingly showing that women are repeatedly availing abortion services (largely illegal) for limiting family size (Khan et al. 1990) as well as for terminating unwanted pregnancies outside the marital context (Ganatra and Hirve 2002). Many abortions, though performed in safe and hygienic conditions by qualified providers, are nevertheless considered non-legal since the place of abortion has not been registered, often for non-medical/administrative reasons. There are also many abortions that are done under unsafe conditions by unskilled providers. The magnitude of both these types of abortion occurring in different settings is really not known and is often the subject of speculation.

The 14 years (1972–86) after the passage of the MTP Act saw a marginal increase of about 10 per cent in the number of approved abortion facilities and of about 8 per cent in the number of abortions reported by these facilities. The late 1980s and 1990s again showed only a marginal increase (about 4.5 per cent) in the number of approved abortion facilities, with a relative fall of about 1 per cent in the number of abortions reported by them (GOI 1998). A skewed geographical (region/state) distribution of approved abortion facilities was also apparent, with about a quarter of all approved abortion facilities concentrated in the State of Maharashtra, which accounts for about 5 per cent of India's population. The majority of approved abortion facilities are clustered in six states, which together comprise about a third of India's population. Access to safe abortion care is further compromised by urban/rural inequity (two-thirds in urban) in availability of abortion facilities (Khan et al. 1998). In addition, over the years, the overall number of legal abortions has not increased proportionate to the population, despite the marginal increases in the number of approved abortion facilities. Further, instead of decreasing, the unmet demand for abortion has risen -- notwithstanding the general increase in contraceptive use -- particularly due to the pressures of a small family norm, and a larger proportion of women today are not being able to access safe abortion services (Khan et al. 1999). However, the absence of reliable estimates of this unmet need, as also the lack of data on non-legal abortion, makes it difficult for policy-makers to understand the full magnitude of abortion as a major public health concern.

Many studies have assessed the 'quality of abortion care' available at both registered and unregistered facilities in the public and private sectors (Khan et al. 1998; IIPS 2001; ICMR 1991; Bandewar 2002; Duggal and Barge 2003). A review of public sector

abortion facilities reveals that in most states less than 20 per cent of all Public Health Centres (PHCs) are reported to be providing abortion care, and even this percentage varies widely from state to state. The situation is only slightly better for block-level PHCs/rural hospitals (ICMR 1991; Khan et al. 2001). Although a substantial proportion of PHCs, including those at the block level (30–51 per cent), are approved abortion facilities, they have never provided MTP services due to lack of either infrastructure or trained manpower or both.

Where private abortion care facilities coexist with public facilities, women tend to prefer the former. Public abortion care facilities are thus also underutilised. Currently, there are only about 3–7 per cent of PHCs that provide MTP services, pointing to a wide gap between the reported status of registered MTP centres and their functionality. Also of concern is the proportion of doctors at PHCs (5–14 per cent) who provide MTP services without having received any formal training and/or certification (Khan et al. 1998; IIPS 2001). It was found that in the public sector in Maharashtra, 27 per cent of medical doctors providing MTP had no formal training, while 9 per cent were non-allopathic medical practitioners who were providing the service in contravention of the law. So, too, in the private sector, where even in approved abortion facilities about 14 per cent of MTPs (ICMR 1989; Karkal 1991) were being performed by unqualified providers. Most PHCs are ill equipped not only to perform MTP but also to provide basic inpatient care in safe and hygienic conditions. Less than 15 per cent of abortion facilities in the public sector and about a third in the private sector meet all the minimum physical standards required by law, with compliance by the private unregistered sector being slightly better than the public sector (Bandewar 2002). In some states like Tamil Nadu, PHCs provide MTP not as a regular service but only

as part of sterilisation camps, thus limiting access to abortion care. And in some states like Gujarat and Maharashtra, there is actually a decline in the number of PHCs providing MTP services, which currently stands at less than a third.

The majority of abortions in India are early first trimester abortions that are still being induced by dilatation and curettage, with vacuum aspiration (electric or manual) being preferred by less than a quarter of providers (Khan et al. 1998; Duggal and Barge 2003). However, as a result of the rise

in adolescent pregnancies and sex selective abortions, second trimester abortions have also been increasing since the 1980s (Chhabra 1996; Mathai 1997). The quality of abortion services in terms of counselling, privacy and confidentiality is poor, especially in the public sector. The cost of MTP varies widely depending on gestation, type of facility and vulnerability of the woman, and averages at about Rs 450 in the private sector across states. Surprisingly, in some states the average cost of MTP in the public sector is almost the same as in the private sector (Khan et al. 1998; Malhotra et al. 2003).

## Abortion Care: Core Issues

Abortion has two distinct yet partly overlapping dimensions — legal vs. illegal and safe vs. unsafe. Though the WHO definition accounts for safety, it does not account for the fact that illegality is not the defining factor for unsafe abortion. The definition of safe abortion also does not consider differences in quality of MTP services or the differences in health systems that may exist across different settings (WHO 1998).

*Unsafe abortion is 'a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both' (WHO 1992).*

Recent years have not shown any significant overall increase in the number of legal abortions in India, indirectly implying an increase in illegal abortions. Legalisation has not translated into improved access to safe abortion care, which still remains inequitably distributed. The typical abortion seeker is a woman of over 25 years seeking abortion to limit family size; however, there is also a large proportion of younger women (20–24 years) who use abortion for spacing (Banerjee 2001). Unfortunately, most women and even providers are not aware that abortion is legal; misconceptions about the abortion law also abound (Ganatra et al. 2000; Gupte et al. 1997; Malhotra et al. 2003).

*The Indian abortion scenario is such that in spite of a conducive socio-political environment and liberal abortion policies, the proportion of unsafe abortion is still high....*

There are several geo-political, social and cultural factors that influence the provision of safe abortion care. Health services in some countries (e.g., Bangladesh) with restrictive

abortion policies have adapted to the more liberal socio-political climate by promoting menstrual regulation and keeping it out of the purview of abortion. On the other hand, there are countries (e.g., the USA) that have more liberal abortion policies but where the prevailing socio-political will does not allow easy access to safe abortion care. Thus, by themselves liberal abortion policies and legislation are not enough to ensure the easy availability of and access to safe abortion services; socio-political and administrative will and commitment are equally necessary.

The purpose of this paper is provide a policy analysis from both the providers' and women's perspective to understand the prevailing abortion situation in India, look at some of the policy implementation and programme issues and recommend policy and programmatic changes to improve access to safe abortion care for women in need of terminating an unwanted pregnancy.

The defining policy documents for abortion in India are the MTP Act, the Rules and Regulations enacted by Indian legislative bodies, the 2000 National Population Policy 2000, and other technical documents relating to abortion training and techniques. The MTP Act, enacted by the Indian Parliament, defines the broad framework under which termination of unwanted pregnancy is permissible by law. MTP Rules are formulated by the centre and adopted by the various states of India; they prescribe the methods and procedures required to implement the provisions of the MTP Act. MTP Regulations, though based on the guidelines provided by the MTP Act, are formulated at the state level and define the tools and instruments required to regulate the implementation of the MTP Rules within the framework of the MTP Act.

## **The MTP Act (No. 34 of 1971): Interpretation, Grey Areas and Critique**

The MTP Act (see Annexure 1) was enacted to legalise induced abortion in order to encourage women to access safer options and thereby reduce the avoidable wastage of women's health and life that is associated with unsafe abortion. The Act defines when (gestation limits, under what conditions), by whom and where an unwanted pregnancy can be legally terminated, with Section 8 offering full protection to the registered medical practitioner against any criminal or civil legal proceedings for any harm or injury caused to a woman seeking abortion, on condition that the abortion has been done in good faith, fulfilling all the legal and statutory mandates and requirements under the Act. The law is so liberal in its scope that it allows an unwanted pregnancy to be terminated under any condition which may be presumed to construe a grave risk to the physical or mental health of the woman in her actual or foreseeable environment (such as when pregnancy results from contraceptive failure), or on humanitarian grounds (such as when pregnancy results from a sex crime like rape or intercourse with a mentally-challenged woman), or on eugenic grounds, when there is reason to suspect substantial risk to the child, if born, of deformity or disease. The Act allows MTP up to 20 weeks' gestation. However, MTP between 12 and 20 weeks' gestation requires an additional and independent confirmatory opinion of a second registered medical practitioner, though its actual performance does not require the presence of such a practitioner.

Section 5 of the Act specifies the context in which Sections 3 and 4 may not be applied. In the event of an MTP to save the life of a woman, the following exceptions are made: MTP may be done irrespective of the length of pregnancy; it may be done at a centre that does not have prior certified approval to

perform MTP provided that the doctor is a qualified medical practitioner registered with the State Medical Council. Moreover, the opinion of a second doctor is not required even if the pregnancy is beyond 12 weeks' gestation. However, MTP Regulations, 1975 (see Annexure 5) do require the doctor to report such an MTP to the state authorities within one working day of its performance.

Despite its progressive nature, a major critique of the MTP Act in today's context is that it is over-medicalised. Conceived in the 1960s through a political and scientific consultative process and enacted primarily to safeguard women's lives from the high morbidity and mortality associated with unsafe abortion, the Act was undoubtedly influenced by the medical community. This is clearly apparent from the weightage it gives medical opinion in all abortion-related matters. With the intent to safeguard the interests of women and to ensure quality abortion care, the Act permits only practitioners of modern allopathic medicine with training in obstetrics and gynaecology, or as stipulated in the MTP Rules, to perform MTP, implicitly assuming that practitioners of alternative systems of medicine or mid-level paramedical workers are not capable of being trained to conduct MTP. An assistant doctor is not allowed to perform an abortion, even under the supervision of a recognised doctor. The requirement of a second opinion for a late abortion (12–20 weeks' gestation) adds yet another layer to the potential hurdles that women face in seeking abortion.

Though women may seek to legally terminate an unwanted pregnancy for a wide range of reasons, the MTP Act permits an abortion to be induced for reasons of contraceptive failure only in the context of a married woman.

The explanation put forth for Section 3 of the Act, as also in Form 1 of the MTP Regulations (doctor's opinion certificate), refers to MTP in a 'married women' context. In other words, though it does not explicitly deny provision of abortion care to women outside the marital context, the law may be misconstrued to refuse such care to the most vulnerable amongst women in need -- the unmarried adolescent, widows and separated/single women.

*Where any pregnancy occurs as a result of failure of any device or method used by any 'married' woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy ... (Section 3, MTP Act; Form 1, MTP Regulations).*

Though professional organisations and activists groups have argued for omitting the term 'married' to correct this discrepancy, their recommendation was not considered by the Ministry of Health and Family Welfare due to socio-political compulsions: omitting the word 'married' would imply the tacit recognition and socio-political sanction of such a need amongst unmarried adolescent girls, separated and single women, and widows.

The MTP Act (Section 4), by implication, recognises any and all public sector health institutions as potential abortion facilities. This means that it is the government's (and

therefore the states') responsibility to ensure that every public health institution is capable of providing abortion care. However, the Act does not require the public sector to obtain the approval/certification that it demands from the private sector, thereby exempting the former from the regulatory processes to which the private sector is expected to comply. The assumption that health institutions, by virtue of being in the public sector, have regulatory processes built into them and which therefore do not need to be spelt out in the abortion policy, is not valid as such regulatory processes often tend to be defunct and lack transparency in their implementation. The lack of an explicit policy statement in the MTP Act and failure to explicitly apply MTP Rules and Regulations to the public sector, create a potential 'moral hazard' in that public sector abortion facilities are not constrained to adhere to the criteria laid down for ensuring safe and quality abortion care. Unlike private sector facilities, public sector institutions that do not meet the requisite minimum physical standards cannot have their approval as an abortion facility suspended or revoked since they have never been subjected to any certification process. In the larger interests of an equitable and transparent policy to ensure women in need access to safe abortion services, it is necessary to explicitly apply the same exacting standards to both sectors and subject the public sector to the same audit process as is required of the private sector.

## **The MTP (Amendment) Act, (No.64 of 2002): What has been Amended**

Through a long consultative process (lasting five years) involving various governmental agencies, the National Commission on Women, NGOs, health and women activists, professional organisations and experts, the Ministry of Health and Family Welfare introduced a Bill to amend the MTP Act, which was enacted by Parliament in December 2002 as the Medical Termination of Pregnancy (Amendment) Act, 2002. Though several recommendations were made from the technical, legal and reproductive rights agendas, the final version of the Bill sought to amend the MTP Act only in three substantive areas (see Annexure 2A).

In the interests of political correctness, the amended MTP Act replaces the term 'lunatic' with 'mentally ill person'. However, a more substantive amendment seeks to decentralise the administrative and legislative process from the state to the district level. This amendment stipulates the creation of a three- to five-member District Committee comprising representatives from the government and NGOs and invests it with the authority to approve MTP facilities and

monitor their compliance with the provisos of the MTP Act, Rules and Regulations at the district level itself. By so doing, it facilitates the registration process by cutting down on administrative delays.

However, though the intent is to decentralise and simplify the process of registration and monitoring, the amendment creates the potential for abuse as well as the possibility of varying interpretations and misinterpretations of the abortion law by the district authorities. Redress mechanisms would need to be set up within the MTP Rules and Regulations framework to prevent this from happening.

Also, while the amended MTP Act defines punitive measures for violations of the Act by the provider, it de-links itself from the Criminal Code so that a woman seeking illegal abortion can no longer be punished. But the illegal abortion provider/owner of a facility not approved by the government is punishable with rigorous imprisonment of at least two years extending to seven years.

## **The MTP Rules (GSR 2543 of 1975): Interpretation, Grey Areas and Critique**

The MTP Rules, 1975 (see Annexure 3), framed by the central government in exercise of the powers conferred by Section 6 of the MTP Act 1971, provide legislative guidelines for certification of the 'person' conducting the MTP and of the 'place' where the MTP is to be conducted. The rules specify the training/experience requirements for an abortion care provider and define the physical standards (equipment, facilities, etc.) necessary at the 'place' where MTP is to be conducted. They define not only the procedures that an abortion facility must follow to obtain certification, but also regulatory and redress mechanisms to ensure that the certified facilities maintain safe and hygienic conditions for conducting MTP.

The minimum physical standards stipulated by the MTP Rules, such as the availability of an operation theatre and anaesthetic equipment, limit the provision of abortion care to very few facilities. Vacuum aspiration (electric or manual), shown to be safe in the hands of doctors and mid-level providers (Hord and Delano 1994) and successfully used in Bangladesh and Africa (Akhter 2001; Ipas 2002; Dickson-Tetteh 2000), is now accepted as a safe technique for inducing early abortion. The amended MTP Rules 2003 (Annexure 4), without compromising on quality or safety, rationalise these physical standards criteria required for a place to be approved for early abortion.

According to one critique of the MTP Rules, the various experience/training criteria that have been laid down for abortion care providers are not comparable. It is argued that there is no equivalency between the requirement for a six-month house surgency in obstetrics and gynaecology, a year's experience of obstetrics and gynaecology practice in a hospital, an MD/

DGO qualification and the experience of having assisted in 25 medical terminations of pregnancy (Bandewar 2002). In this context it must be realised that the purpose of the stipulated criteria is to define the minimal requirements for ensuring safe abortion care in different situations of MTP practice. Instead of comparability, it would be more useful for the debate to focus on how well these experience/training criteria reflect quality and safe abortion care.

A major gap in the abortion policy in India is the lack of a policy link with good clinical practice and research. Though the MTP Rules define the 'person' and 'place' requirements for safe abortion, there is no reference to safe abortion 'technique'. International technical guidelines for abortion (WHO 2003) are now well established. Vacuum aspiration (manual or electric), the preferred method for surgical abortion up to 12 weeks' gestation, is one of the safest abortion procedures. General anaesthesia is not recommended for this procedure (McKay et al. 1985; Osborn et al. 1990) since it increases the rate of haemorrhage associated with abortion. Instead, the use of an analgesic and/or mild sedation or local anaesthesia with paracervical block is recommended as sufficient for pain management. The lack of an explicit policy reference to international technical guidelines, as also the absence of a national consensus on 'good clinical practice' for abortion, results in the continued use of unsafe methods like dilation and curettage, check curettage, and general anaesthesia. Such a policy fails to ensure the adoption of improved and safer abortion practices brought about by newer abortion research and continuously evolving reproductive technology.

## **MTP Rules (GSR 485(E) of 2003): What has been Amended**

Following the MTP Act amendment to decentralise, the amended MTP Rules, 2003 provide guidelines for the composition and tenure of the district-level committee (Annexure 4) that has been empowered to ensure abortion facilities' compliance with MTP legislation for the provision of safe abortion care. The amended MTP Rules, 2003 stipulate that this committee be composed of a medical professional (by implication from the government sector – health services), members of non-governmental organisations and elected leaders of Panchayati Raj Institutions in the district, conditional that at least one member is a woman. Further, the amended rules limit the tenure of the District Committee to two calendar years and the tenure of the non-government members to two terms. They confer on the committee the authority to approve/register an abortion facility based on the recommendation of the District Health Officer, and ensure its compliance with the law. More importantly, Section 5(8) of the amended MTP Rules, 2003 now defines a time frame for the registration/approval process. It mandates the District Committee to inspect the facility seeking registration within two months of receiving an application and, in the absence of or after rectification of any noted deficiency in the facility, for the approval to be processed within the next two months. However, the amended rules do not specify measures or redress mechanisms if certification procedures are not completed in the stipulated time frame.

Though the training/experience criteria for a registered medical practitioner to practice safe abortion care remain largely the same, the criterion of having assisted a registered medical practitioner in the performance of 25 cases of MTP (of which at least five should have been done independently in a hospital maintained or a

training institute approved for this purpose by the government) now mandates that such a registered medical practitioner is qualified to do MTP only up to 12 weeks' gestation and not beyond (Section 4[c][I] of MTP Rules 2003). The experience/qualifications criteria for performing a second trimester abortion remain unchanged (Section 4[c][ii] of MTP Rules, 2003).

Unlike before, the amended rules also stipulate different registration and approval guidelines for first and second trimester abortions. This differentiation is based on international technical guidelines (WHO 2003) that separately define abortion methods, provider competency and skills levels, facilities and minimum physical standards required for first and second trimester abortions, as also the risk of complications, morbidity and mortality (see Table on page 21).

The most substantive amendment rationalises the physical standards criterion of approval for an abortion facility. While the physical standards for a facility to perform second trimester abortion remain the same as before (availability of an operation table, instruments for performing abdominal and gynaecological surgery, anaesthesia, resuscitation and sterilisation equipment, emergency drugs and parenteral fluids), the amended rules (Section 5[1] of MTP Rules, 2003) stipulate more appropriate and rational physical standards in the case of early first trimester abortion (availability of a gynaecological examination or labour table instead of an operation table, resuscitation and sterilisation equipment but not anaesthesia equipment, emergency drugs and parenteral fluids for treatment of shock, and transportation facilities in case of complications). This policy differential allows for simple and rational certification

<b>Technical guidelines recommended for early and late abortion (WHO 2003)</b>		
	<b><i>Early abortion (&lt;12 weeks)</i></b>	<b><i>Late abortion (13-20 weeks)</i></b>
<b><i>Incidence</i></b>	<i>More common</i>	<i>Less common</i>
<b><i>Risk of morbidity</i></b>	<i>Lower – safe and simple</i>	<i>Higher than for early abortion</i>
<b><i>Complications</i></b>	<i>Rare</i>	<i>Higher than for early abortion</i>
<b><i>Abortion method</i></b>	<i>Vacuum Aspiration, Medical methods (up to 9 weeks)</i>	<i>Dilatation &amp; Evacuation, Medical methods (13 to 20 weeks)</i>
<b><i>Anaesthesia</i></b>	<i>Analgesics, sedation</i>	<i>Para-cervical (local) block</i>
<b><i>Provider requirements</i></b>	<i>Fewer skills required.</i>	<i>Higher skills required.</i>
<b><i>Equipment</i></b>	<i>Basic gynaecology instruments, supplies</i>	<i>Special forceps, larger dilators &amp; large cannula, oxytocin</i>
<b><i>Operation theatre</i></b>	<i>Not required</i>	<i>Required</i>

procedures for the more common first trimester abortion, deeming periodic supervision as sufficient for ensuring continued compliance with the law. On the other hand, second trimester abortions need to be monitored more closely than early abortions as they run a greater risk of complications and morbidity. Also, late abortions are more likely to follow sex determination (Ganatra et al. 2001), except in situations where the woman has delayed seeking abortion due to socio-cultural barriers, as in the case of unmarried single women, adolescents or older women nearing menopause.

When early abortions are performed by trained personnel using the correct techniques, complications are rare, and the amended MTP Rules allow for approval of abortion facilities even if they do not have in-house capability of managing emergency complications. However, every abortion facility at all levels is required to have personnel trained to recognise complications and be equipped to provide or refer women to facilities capable of providing emergency

care for complications. The amended MTP Rules rationalise all such requirements of physical standards without compromising on quality and safety of abortion care, thereby removing unnecessary barriers in the availability of and access to abortion facilities.

Section 5 (explanation clause) further expands the scope of MTP legislation to include medical abortion using mifepristone with misopristol. The amended MTP Rules permit registered medical practitioners (as defined under Section 2[d] of the MTP Act and Section 4 of the MTP Rules) to administer mifepristone with misopristol for inducing medical abortion at their clinics, provided that such practitioners have access to an abortion facility maintained or approved by the government (as defined under Section 4 of the MTP Act and Section 5 of the MTP Rules). This amendment expands access to medical abortion by allowing a family physician with appropriate training/ experience in MTP to induce abortion by medical methods provided that s/he can certify access to an approved MTP facility.

## **MTP Regulations (GSR 2544 of 1975): Interpretation, Grey Areas and Critique**

The MTP Regulations, 1975 (Annexures 5, 7), in exercise of the powers conferred by Section 7 of the MTP Act 1971, empowers state governments to enforce regulatory procedures to ensure registration of abortion facilities (Forms A & B), certification of an induced abortion by one or two registered medical practitioners (Form 1) and the informed consent of the woman (Form C), and to establish, for district/state authorities, MTP recording (Form 3) and reporting procedures (Form 2), assuring confidentiality and anonymity to the abortion seeker and prohibiting disclosure except to such persons and for such purpose as may be specified by the MTP Regulations.

Most states have adopted these regulations without any major changes. However, some states differ in how they interpret and implement them. For instance, they have modified the approval guidelines for abortion facilities (the MTP Act and Rules) that have been defined by the central government. Although done with the intent of ensuring safety and preventing unsafe abortions, this has added layers of inessential procedures and subjected the registration process to administrative delays and unnecessary control. Some states like Maharashtra have framed MTP rules and regulations that go beyond the requirements of the law, as for example the demand for a certificate assuring blood supply from a blood bank situated within 5 km of the proposed abortion facility -- a requirement which is not only impractical but also unnecessary. The irrational nature of such overzealous rules and regulations becomes even more apparent when we see that the state applies these requirements only to abortion facilities in the private sector.

Some of the documents required at the time of registration are unnecessary,

redundant or inconsistent with policy. Maharashtra requires up to 28 documents (see Annexure 9) to be submitted -- and that too in triplicate -- by an abortion facility when applying for registration. Documents to be submitted along with Form A (application for registration) include the degree certificate, the experience certificate as well as a personal statement of willingness to attend to MTP cases from not only the main doctor who will be performing the MTP, but also the assistant doctor, the anaesthetist and sometimes even the nursing assistant. In contravention of policy, Maharashtra permits an Ayurvedic medical practitioner in public health service to perform MTPs after acquiring MTP training. In addition to the MD/DGO certificate, a gynaecologist also needs to submit three separate experience certificates attesting that s/he has performed MTPs during three residency postings. This experience certificate is neither rational nor consistent with the MTP Rules, which clearly explain that a doctor with a postgraduate degree in obstetrics and gynaecology is presumed to have acquired MTP experience as part of postgraduate training.

Some states require an experience certificate from a government-approved hospital, stating that the concerned doctor has assisted in MTP procedures for at least three years -- again a norm that is inconsistent with the abortion policy. In addition, the doctor is also required to produce the MTP registration certificate of the hospital where s/he has acquired the experience. Other states like Maharashtra and Delhi have linked the abortion law to other laws relating to nursing homes or charitable trusts. While applying for MTP registration, private or charitable hospitals are required to submit proof of adherence to physical requirements under the Nursing Homes Act. Also required is a statement from

the owner of the abortion facility seeking registration that the hospital will not perform MTP until it has received government approval.

Some states require a certificate submitting the floor area and architectural plan of the hospital, while Delhi requires the abortion facility to certify that it has parking space for cars. Yet another irrational and bureaucratic requirement for registration is a one-time certificate from the Microbiology Department of a Medical College that, based on a negative swab report, it declares the operation theatre of the proposed abortion facility to be sterile.

Overall, the time and effort required to procure registration for abortion facilities are clearly indicative of the states' attitude and approach towards facilitating abortion. The registration process usually takes more than a year and is fraught with administrative delays. A FOGSI study of 118 abortion providers found that 13 per cent obtained registration after delays ranging from one to seven years (Sheriar 2000). Reasons cited by unregistered abortion facilities which had tried to procure registration in the past but had given up, include 'no response from government', 'did not meet stipulated criteria', 'applications not available', 'did not pursue the registration process', and 'incorrect information from the government authorities' (Bandewar 2002). Abortion facilities that did manage to get registered cite mismanagement, corruption, cumbersome and tedious procedures, and no response despite follow-up as the common problems encountered. The amended MTP Rules, 2003 attempt to address at least some issues of administrative delays by specifying a time frame for the registration process.

One critique that has more to do with policy implementation than the policy itself is the low awareness of and misconceptions about MTP regulations amongst providers. A

survey of 76 unregistered abortion facilities reveals that 48 had never tried to procure registration for reasons varying from lack of awareness and the perception that the stipulations contained in the MTP Rules and Regulations could not be met, to misconceptions about the MTP law, such as the belief that small clinics and/or gynaecologists do not require to be registered, that private practitioners are not allowed to do MTP, that registration is not required for MTP in the context of married women, and that other than registration with the State Medical Council, no separate registration is required for MTP. Providers also seem unaware that there is no legal binding on abortion facilities to perform free MTPs and that registration is mandatory irrespective of the number of MTPs performed or the method (medical or surgical) used (FOGSI 2002).

Section 5(1) of the MTP Rules, 1975 empowers the Chief Medical Officer of the district to inspect a certified place, as and when necessary, to verify its continued compliance with the abortion law. However, since no mechanisms for carrying out routine or surprise inspections have been specified, in practice such inspections take place only when an abortion-related death occurs (as required under Section 5(2) of the MTP Rules, 1975).

Section 4 of the MTP Regulations detail the record keeping and reporting procedures to be followed, the prime consideration being to maintain the confidentiality of the woman seeking abortion. The MTP Rules and Regulations require the abortion facility to periodically report only summary statistics of abortions done at the facility. However, some state authorities also require the women's identity to be reported, which not only contravenes the law but is also an ethical violation of her right to confidentiality. Another critique of MTP Rules and discuss such issues as ensuring privacy in waiting rooms and the management of client flow and

other measures that could create a more private environment in which women can seek services (Jagpal 2003).

Form 2 (under Section 4(5) of the MTP Regulations) details the summary information that abortion facilities need to submit to the district authorities. Most states have adopted these reporting formats and procedures without any alteration. Some of this information has more of an epidemiological (marital status, age, educational status, etc.) than programme value. Monitoring information on post-abortion use of IUD or sterilisation has the potential of being abused by state authorities to penalise abortion providers for not meeting 'family planning targets'. It has been seen that in the public sector women are often overtly or covertly coerced into accepting IUD

by making it conditional to the provision of abortion care (Sinha et al. 1998). However, it has also been seen that these women are less likely to retain the IUD (Ganatra et al. 2000). Such coercive practices not dictated by policy serve only to deny safe abortion care, especially to underserved women in need of MTP, and drives them to seek help from the illegal sector (PSS 1998).

On the whole, the states' mindset veers more towards 'controlling' than 'facilitating' abortion services. Unless this changes, the amended MTP Act will only help to shift the 'controlling' mindset from the state to the district level. In fact, the vagaries at the district level might make matters worse by making the interpretation and implementation of abortion policy and law even more complicated.

## **MTP Regulations (GSR 486[E] of 2003): What has been Amended**

The MTP Regulations amended in 2003 are currently being reviewed by all states. A substantive amendment in the regulations (Section 4[5]) mandates the head/owner of an abortion facility to submit to the District Health Officer (Chief Medical Officer of the district) a monthly (instead of weekly, as stipulated by the MTP Regulations, 1975) summary statement (in Form 2) of the abortions provided at the facility.

Section 5(1) of the amended MTP Regulations, 2003 also stipulates the time frame for maintenance of facility records (admission register - Form 3) as five years

since the entry of the last abortion record, following which it mandates the admission register to be destroyed.

Form A (application for registration) and Form B (certificate of approval as an abortion facility) have been likewise amended as per the provisions of the amended MTP Regulations, 2003 to reflect the separate registration requirements for first trimester and second trimester abortions. Form C (consent form), Form 1 (opinion certificate), Form 2 (summary statement) and Form 3 (admission register) remain unchanged.

## Medical Abortion: Conflicting Policies

Medical methods of abortion using mifepristone plus prostaglandin regimens have been shown to be both safe and effective (Ashok et al. 1998; Winikoff et al. 1997; Elul et al. 1999), and have proved acceptable in low resource settings (Elul et al. 2001). The rationale for introducing medical abortion in India is to provide a safe, effective and less expensive non-surgical technique for MTP, ensure women anonymity and convenience and avoid invasive procedures and/or anaesthesia. Medical abortion serves to empower the woman by increasing her choices vis-à-vis safe abortion care.

Currently being prescribed in the private sector, mifepristone is not yet available in the public health sector. Most medical abortion protocols require clinical supervision and involve multiple visits to the health facility. Protocols differ in their drug and dosage schedules and in the periodicity of visits required to be made to the clinic, which depends on where the abortion actually takes place and the degree of clinical supervision needed. International technical guidelines recommend the use of mifepristone to induce abortion up to nine weeks' gestation, as well as for gestations beyond 13 weeks (WHO 2003). An Indian Expert Consortium recommends mifepristone use at PHCs for up to eight weeks' gestation (GOI 2002). The amended MTP Rules, 2003 make it legal for any registered medical practitioner who meets the training/experience criteria stipulated under the MTP Act and Rules to administer mifepristone. In this context, India's abortion policy is in direct conflict with its drug licensing policy (both in terms of who can prescribe the drug and for what period of gestation). The Drug Controller General of India has licensed the use of mifepristone for only up to seven weeks' gestation and that, too, on prescription by a gynaecologist,

thus restricting its use both in terms of gestation limits and the qualifications of those allowed to administer it. A major critique of the drug licensing policy is again its over-medicalisation. Restricting the practice of medical abortion to only gynaecologists limits its availability to cities and large towns and acts as an unnecessary barrier in accessing abortion care.

Current MTP policies do not provide any technical guidelines for the practice of medical abortion; nor is there any national consensus on medical abortion protocols regarding dosage and schedules (which may require the woman to make up to three or more visits to the clinic, thus negating the very advantages of medical abortion, i.e., convenience and anonymity). The government is yet to adopt the international technical guidelines (WHO 2003) or those recommended by the Expert Consortium on Medical Abortion in India (GOI 2002), which advocates home administration of mifepristone/misoprostol under medical supervision conditional on a mandatory follow-up visit after two weeks to ensure completeness of the abortion process.

The amended MTP Rules, 2003 have rationalised the provider criteria for medical abortion. A registered medical practitioner using medical methods for inducing abortion is not required to have on-site capability of performing surgical abortion; however, s/he does need to certify access to an approved abortion facility. The approval of a provider for medical abortion is determined by where the drug is given, i.e., where the medical abortion is initiated, and not on the basis of where the abortion actually takes place — which, in the case of medical abortion, is often at home.

## Abortion Policy: A Rights Perspective

The MTP legislation is a direction in keeping with safeguarding basic human rights as envisaged in all international treaties and covenants, including the right of every human to life, liberty, security, education and non-discrimination; the right to the highest attainable standard of health; the right to education and information; and more specifically, the basic right of all couples and individuals to decide freely and responsibly, without fear of threat or violence or discrimination, if and when to have (or not to have) children and the freedom to act on their decision. India has committed itself to upholding these rights, which have been further articulated in various international forums (UN 1995, 1996, 1999, 2000) in recent decades through the enactment of appropriate laws and policies relevant to abortion. The 1990s have seen the evolution of several consensus documents within the broader human rights framework, especially focusing on the area of sexual and reproductive rights. Indian policy encourages the promotion of family planning services to prevent unwanted pregnancies, but also recognises the importance of providing safe abortion services that are affordable, accessible and acceptable, to women needing to terminate an unwanted pregnancy.

### **Ethical Guidelines Regarding Induced Abortion for Non-medical Reasons**

*In summary, the Committee recommended that after appropriate counseling, a woman had a right to have access to medical or surgical induced abortion, and that the health services had an obligation to provide such services as safely as possible (adopted by FIGO General Assembly, 16<sup>th</sup> FIGO World Congress, Washington DC, September 2000) (FIGO 1999).*

Historically, the debate on the liberalisation of abortion policy in the 1960s took place in a context wherein the Indian Penal Code deemed abortion to be a criminal offence by both the provider and the woman.

This created an environment that led to abortions being performed by unskilled providers under unsafe conditions, resulting in high maternal mortality and morbidity. Isolated from the feminist movement in India and elsewhere, this debate was largely driven by two bodies of opinion -- medical concerns about high maternal mortality and morbidity and demographic concerns about population control. Human rights were nowhere in the picture. The human rights and reproductive rights agenda occupied centre-stage only in the years following the International Conference on Population and Development (ICPD). The post-five-year global review of the ICPD Program of Action and the Beijing Declaration Platform for Action shows that while some measures have been taken, the specific actions relevant to paras 106j and 106k of the Beijing Declaration (Annexure 10) regarding the health impact of unsafe abortion and the need for recourse to abortion have not been fully implemented. Similarly, policy measures referred to in para 63iii of the ICPD+5 Program for Action (Annexure 10) -- to equip and train health services to provide safe abortion -- though initiated, need to be implemented more intensively and actively to bring about easier and wider access to safe abortion services. Though non-governmental agencies in the country have assessed the post-Cairo and post-Beijing scenario, India has yet to formally review the five-year progress of actions taken following the Beijing Declaration.

Many women seek abortion because they cannot afford to look after the child for social and/or economic reasons. Globally, about 27 per cent of nations (UN 1999a) have policies that provide for abortion services 'on request', recognising that all women seek abortion for one or more of these reasons. However liberal our own abortion policy is in allowing for abortion under a wide range of situations, it theoretically does not permit an induced abortion 'on request' or 'on demand'.

Although the policy empowers both the doctor and the woman in terms of provision and access to safe abortion services, it does not provide women with the 'right' to abortion. The ultimate responsibility for terminating an unwanted pregnancy rests with the medical practitioner, who is required to opine, in good faith, the need for such a service. Such a provider-dependent policy may allow for denial of abortion care to women in need, especially the more vulnerable amongst them, for reasons of 'conscientious objection'. According to the Universal Code of Medical Ethics, such 'conscientious objection' applies to individuals and not to institutions and must be resolved at the individual level through value clarifications; if unresolved, the Code requires the referral of such a woman to a medical colleague who would agree to provide the abortion service without undue delay. In the event that such abortion service is not easily accessible elsewhere, the doctor, despite her/his 'conscientious objection', cannot deny the woman abortion care even if providing it conflicts with her/his value system. An abortion policy within the 'rights framework' would thus not only emphasise the woman's 'right' to seek abortion, but also her right to access affordable and safe abortion services, as well as information about the availability of such services.

Jesani and Iyer (1993, 1993a) argue that liberalising the abortion law has resulted neither in reducing the magnitude of illegal abortions nor in improving women's health. The emphasis on small family norms, coupled with the lack of a strong health education strategy, has compelled women to seek illegal abortions in the absence of access to legal abortion services (Karkal 1991). In the absence of a rights framework, the abortion law does not empower the woman to control her own reproduction. However broad and liberal the grounds for seeking abortion, the woman still has to furnish explanations and justify her reason for seeking abortion. In real life, the abortion law requires women seeking abortion to limit family size, to say that the pregnancy was wanted at the time of conception but is unwanted now, even if in

reality it was unwanted at the time of conception itself, thereby creating an environment of falsehood. This situation makes the abortion law open to differing interpretations. Though the present socio-political environment allows for a more liberal interpretation of the abortion law, there is always the potential danger that under different socio-political and demographic compulsions, the same law, without a single word of its text being altered, could become very restrictive (Jesani and Iyer 1993).

From an ethics perspective, abortion policies need to adhere to the most fundamental of obligations, i.e., show respect for the person. National norms and regulations need to protect the woman's autonomy by creating an enabling environment to facilitate free and informed decision-making, confidentiality and privacy (WHO 2000). The abortion law in India has detailed guidelines for ensuring the woman's anonymity and confidentiality, but no guidelines for ensuring privacy. Except in the case of a minor, the abortion policy does not require spousal or third party consent for termination of an unwanted pregnancy; in reality, however, abortion providers often insist on such consent, which may not only infringe on the woman's rights but also prevent her from accessing safe abortion care. Also, when pregnancy results from sexual violence, police/judicial procedural requirements or third party authorisations should not delay abortion care for women. Clear protocols for early and prompt referrals to safe abortion services need to be developed to minimise administrative or judicial delays.

Liberalising the abortion law is not enough unless backed by an enabling political will and social legitimacy for abortion in the case of both married and unmarried women. Abortion is an issue not only of political and legal right, but of social, cultural and moral conflict as well. It is therefore essential to go beyond reproductive rights and view abortion in the broader framework of gender equity, literacy and women's empowerment.

## Policy Issues in MTP Training

Section 3 of the MTP Rules, 1975 stipulates the training or experience criteria required for the medical practitioner to be legally allowed to provide abortion services. Para 63(iii) of the Key Actions for the Further Implementation of the Program of Action of ICPD (UN 1999) binds the health system to adequately train and equip health service providers and to take other measures that may be necessary for ensuring that safe abortion care is available and accessible. A review of the MTP training policy is therefore necessary to understand the lack of trained doctors, especially in rural areas.

### MTP Training Scenario

A large, unmet need for MTP training exists in both the public and private sectors (Chhabra and Nuna 1994). Of the 23,134 doctors who need to be trained in the public sector, only 2,542 (about 11 per cent) have undergone MTP training under the RCH programme (Batra and Rabindranathan 2003). Training for both public and private sectors is needed to increase and improve the reach of and access to safe abortion services. Initiated in 1997, the RCH programme seeks to empower PHCs to provide safe and legal abortion services in rural areas, with the National Institute of Health and Family Welfare (NIHFW), New Delhi, as the designated nodal agency responsible for coordinating integrated and specialised skills training. NIHFW has identified 17 collaborating institutes for conducting 'Training of Trainers' programmes. Further, about 238 centres (including medical colleges, district hospitals and NGO sector hospitals) throughout India have been identified as MTP training centres, based on a minimum MTP caseload of 600 per year and availability of essential facilities like an operation theatre and MTP equipment.

MTP training is addressed as part of the Specialised Skills Training, which includes a two-week module covering hands-on training in surgical methods of MTP. The course contents have been streamlined from four to two weeks so as to maximise available resources with minimal disruption of service delivery. The training guidelines issued by the NIHFW stipulate that during the two-week training period each trainee should, at the training centre itself, assist in 10 MTPs, perform five MTPs under the trainer's guidance, and also perform five MTPs independently (NIHFW undated). This guideline (of assisting or performing 20 MTPs) is inconsistent with the MTP Rules, which stipulate an experience criterion of 25 MTPs. The training guidelines also need to differentiate between the training requirements for first and second trimester abortions, since they require different techniques and skills.

A review of MTP training facilities in three states (Gujarat, Tamil Nadu and Uttar Pradesh) shows a wide, unmet gap between demand and supply of trained human resources that is directly attributable to lack of planning and resource allocation (Khan et al. 1996). There is also a wide disparity in state-wise training performances. Arunachal Pradesh, Assam, Goa, Jharkhand, Meghalaya, Sikkim, Uttaranchal Pradesh and the Union Territory of Daman & Diu have yet to initiate MTP training for their doctors under the RCH programme. It is only states like Gujarat, Haryana, Karnataka and Rajasthan that have pursued provider training. On the other hand, states like Maharashtra have shown a declining trend in the number of medical officers trained in MTP in recent years.

The absence of population-based norms, lack of proactive identification and the to be

selection criterion of an annual caseload of 600 MTPs have resulted in far too few training centres which often are inequitably distributed in the region, both within and between states. On the other hand, centres that meet the criterion are often not identified as training centres (e.g., the district hospital in Ranchi) (Batra and Rabindranathan 2003).

Despite the public-private partnership strategy of the RCH programme, most approved MTP training centres exist in the public sector (usually post-partum centres attached to medical colleges or district hospitals). In Maharashtra, only three of its 19 approved training centres are in the private sector. The majority of them are located in and around Pune city, leaving large regions of Maharashtra without any MTP training centres that are conveniently accessible. The three approved centres in the private sector are yet to train any medical officer.

Also, existing training centres show very low achievement in terms of medical officers trained (Khan et al. 1996). Only three of the 27 approved MTP training centres in Karnataka and none of the 13 in Assam have actually trained medical officers so far (Batra and Rabindranathan 2003). The low priority accorded to MTP training, coupled with poor coordination between the training centre and the District Health Office results in very few medical officers being deputed for MTP training. Lack of incentives for both trainee and trainer (honoraria of only Rs 200 per day) and for the training centre (15 per cent overheads for institutional capacity development based on the number of trainees trained) has not helped in making the MTP training programme attractive or prestigious enough for training institutions in either the public or private sector to give time, resources and commitment for quality training.

The goal of MTP training is itself often interpreted differently. Lack of clarity

sometimes leads the District Health Office to determine its district MTP training goals in terms of training medical officers attached to PHCs that have already been approved as MTP centres (usually a small proportion of the total number of PHCs in the district) rather than training all eligible medical officers from all PHCs. Secondly, though the policy goal is to ensure that all medical officers at PHCs receive MTP training, the actual selection of trainees needs to be based on the trainees' motivation and desire for acquiring skills in MTP.

The MTP training strategies themselves need to be critically examined. Training policies need to be flexible in their approach. The present strategy of 14 days' MTP training at one stretch restricts MTP training to centres with an annual caseload of at least 600 (a weekly caseload of 12) to meet the training requirement of 20 MTP per trainee. Instead, a strategy that spreads the 14-day training over a two- to three-month period (two days at a time) needs to be adopted. Institutions with a lower annual caseload (less than 600) can then schedule all their MTPs on two fixed days in a week, which can then be attended to by trainees. This would allow institutions with a caseload that is as low as 25 MTPs over two months to be eligible as training centres without compromising the training course requirements of 20 MTPs per trainee. While this strategy would have to restrict training to only those days when the training centres schedule their MTP cases and necessitate multiple training sessions over a longer period, it would certainly minimise extensive disruption of PHC services. The training programme also needs to be broader in scope and structured so as to allow for building competency in clinical and other skills like counselling, management skills, value clarifications and bioethics, as well as in the newer technologies of medical abortion. Post-training support and periodic appraisals need which should also specify systems to assess

the post-training confidence levels of trainees and provide for clinical support whenever required, whether at the training centre or at the PHC. Implicit in the training policy is the mandate to provide logistical/equipment and clinical support to enable the newly trained medical officer to conduct MTPs at the PHC.

A recent collaborative initiative by FOGSI, the Ministry of Health and Family Welfare and WHO, India, intends to pilot an MTP training programme in two districts of a few select states in India. Medical officers will be trained and certified by FOGSI in the technique of manual vacuum aspiration for inducing abortion up to 12 weeks' gestation at various training centres including medical colleges, and will receive from the District Health Office post-training logistics support in terms of medicines, equipment and supplies needed for the provision of safe abortion care at the PHC level. This is probably one of those rare public-private partnerships wherein a private professional body is participating in enhancing access to safe abortion services through PHCs.

However, the most important lacuna in the present training policy is that it does not provide the private sector any opportunity to acquire MTP training (except for a recent instance when the Delhi administration nominated a medical practitioner from the private sector to replace a trainee from the public sector who had dropped out at the last minute). Since the training funds are meant for public sector medical officers, District Health Offices restrict their nominations to their own officers from PHCs. Even those private practitioners who wish to acquire MTP training and are willing to pay for it, cannot do so since the RCH programme does not permit training centres to charge trainees. Consequently, there is no incentive for training private practitioners at a cost that will not be reimbursed by the RCH programme. A policy that allows trainees from the private sector to pay for their training would allow approved MTP training centres to not only address the training needs of the private sector but to also recover some of the training costs.

## Comprehensive Abortion Care

Comprehensive abortion care, which has assumed added significance with the increasing use of medical methods of abortion, involves care before and beyond the actual abortion (the post-abortion period of six weeks, similar to the puerperal period), as well as care for post-abortion complications. All abortion facilities are mandated to provide counselling services for contraception and, where possible, STI and HIV, which would include voluntary testing.

### **Barriers from the Provider's Perspective**

- *Poor understanding of abortion law*
- *Too few abortion facilities, regional/urban disparities*
- *Cumbersome abortion facility registration process*
- *Too few trained providers*
- *Mismatch between availability of trained doctor & equipment*
- *Physicians only*
- *Outdated abortion methods*
- *Conscientious objection to abortion*
- *Over-medicalisation of abortion*

Pre- and post-counselling to help the woman cope with anxiety, guilt, depression and other shared/unshared expressions of psycho-social injury is also necessary. On-site contraceptive services should be

available if the woman wishes to opt for post-abortion contraception following counselling. Compassionate pre- and post-abortion counselling is neither required nor restricted by the MTP Act and needs to be part of comprehensive abortion care (Jagpal 2003).

Another aspect of comprehensive abortion care relates to the management of post-abortion complications. Abortion-related complications are rare in the hands of trained abortion providers. Nevertheless, abortion policy guidelines need to be developed in line with international guidelines on management of post-abortion complications (WHO 2003). All health facilities at every level of the health system should have personnel trained to recognise abortion complications and to either manage the emergency themselves or to promptly refer the woman to a facility that can provide the appropriate level of care. Abortion facilities at all levels should be able to re-evacuate the uterus in case of an incomplete or failed abortion presenting early before 12 weeks' gestation, paying special attention to infection and haemorrhage. A failed or incomplete abortion presenting after 12 weeks' gestation or those presenting with complications of uterine perforations or severe haemorrhage may require referral to an appropriate-level care facility.

## Safe Abortion: Policy to Practice

Access to safe abortion care requires more than an enabling policy environment. Rules and regulations, and their varying interpretations, may themselves hamper policy implementation. Many provider-related barriers, usually administrative in nature, are not actually dictated by the policy or law, but simply evolve through practice and are then misinterpreted as being 'required by law'; over time, they become congruous with the law itself. It is therefore necessary to identify such barriers to safe abortion care and review measures to end such 'misguided and/or outdated practices'.

Apart from women's lack of complete and accurate knowledge of the abortion law, providers themselves become barriers to safe abortion care. Unaware that abortions are legal, women seek unsafe abortion services, especially when the termination sought is for pregnancies out of wedlock, or by single women or unmarried adolescents (Ravindran and Sen 1994). Providers often resort to malpractice and charge inappropriately high or informal fees (Banerjee 2001), citing reasons of high social risk to exploit women's vulnerability and ignorance.

### **Barriers from the Women's Perspective**

- *Ignorance of legality of abortion*
- *Lack of privacy, respect, confidentiality, dignity*
- *Informal fees, unaffordable*
- *Multiple authorisations*
- *Spousal consent*
- *Judgmental provider attitudes*
- *Neglect by health services of underserved women — adolescents, single women, etc.*

A very common practice amongst abortion providers is to insist on spousal consent. Ethical practice requires only the patient's consent (or that of a guardian in the case of a minor). However, based on 'common belief of the law', most doctors insist on spousal consent. Many married women seeking abortion may accept such a

conditional service — some may even prefer it as it provides proof of social legitimacy to the pregnancy and also indirectly ensures spousal responsibility for the procedure and its consequences (Ganatra and Hirve 2002). But for others, such insistence on spousal consent may serve to deny access to safe abortion care, sometimes even forcing them to lie about their marital status. The most liberal abortion policies are in South Africa, where a woman can legally seek an abortion on request without needing parental consent, even in the case of a minor.

The values and beliefs of the abortion provider can also act as an invisible barrier to provision of safe abortion services. Providers often find their religious beliefs and judgmental attitude conflicting with professional ethics and the code of medical conduct. It is not surprising, then, that they frequently end up denying women access to safe abortion care. Failure to ensure confidentiality, dignity, privacy and impersonal and uncompassionate care are often cited as the most common reasons why women prefer not to use abortion facilities in the public sector.

### **Ethical Guidelines Regarding Induced Abortion for Non-medical Reasons**

*Most people, including physicians, prefer to avoid termination of pregnancy and it is with regret that they may judge it to be the best course, given a woman's circumstances. Some doctors feel that abortion is not permissible whatever the circumstances. Respect for their autonomy means that no doctor (or other member of the medical team) should be expected to advise or perform an abortion against his or her personal conviction. Their careers should not be prejudiced as a result. Such a doctor, however, has an obligation to refer the woman to a colleague who is not in principle opposed to termination (adopted by FIGO General Assembly, 16<sup>th</sup> FIGO World Congress, Washington DC, September 2000 [FIGO 1999]).*

## The PNDT Act, 1994 and the MTP Act, 1971

The Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Act (PNDT Act), enacted by the Government of India in 1994, is meant to regulate the use of prenatal diagnostic techniques and prevent its misuse for prenatal sex determination leading to female foeticide. It bans the use of such techniques to determine the sex of the foetus and/or the advertisement of such use, requiring all facilities using such techniques to be registered and prohibiting persons conducting such techniques from revealing the sex of the foetus. The PNDT Act also prohibits family members of the pregnant woman from seeking or encouraging the woman to undergo prenatal testing for foetal sex determination and imposes penalties on providers who contravene the provisions of the Act. Its main aim is to prevent the misuse of prenatal diagnostic techniques leading to abortion of the female foetus.

Following a concerted and sustained campaign against sex determination and female foeticide and public debate in the print media exposing the large-scale social problem of female foeticide, as well as a Public Interest Litigation (Writ Petition (Civil) # 301 of 2000) filed against the Union of India & Others for failure to implement the PNDT Act, the Supreme Court directed the government to take action to ensure compliance with the law. However, since the media's expose of the female foeticide issue was not supported by public education on what the abortion law was about, female foeticide became inappropriately linked with abortion. In the absence of clarity about the MTP Act amongst

both providers and the community, a general ban on abortion was imposed in states like Haryana and Rajasthan, resulting in denial of safe abortion services even to women with a legitimate need for terminating an unwanted pregnancy. This further forced women to take recourse to illegal and unsafe abortion.

Though the aims of the MTP Act and the PNDT Act are very distinct, there have been attempts to link the two laws with the intention of preventing sex selective abortion. A policy review meeting to discuss modifying the MTP Act in the context of preventing the misuse and abuse of the PNDT Act (GOI 2002a) suggested reducing the gestation limit for abortion from 20 to 12 weeks, reporting the identity of the woman seeking abortion and recording the sex of the aborted foetus. However, experts resolved that the MTP Act and the PNDT Act did not conflict or contradict each other and there was no need to amend the MTP Act in the context of the PNDT Act. Reducing the gestation period from 20 to 12 weeks would be detrimental to the woman and, in fact, encourage her to seek unsafe abortion services. At risk would be adolescents and/or unmarried women, who often seek abortion late in the second trimester. What was required was stricter implementation of and compliance with the MTP Act. Recording the sex of the foetus would be not only unethical but also make early abortions done for legitimate reasons suspect and indirectly make access to safe abortion services more difficult. If women are to avoid stigmatisation and be ensured of their reproductive rights, confidentiality is one aspect that cannot be compromised.

## Abortion and the Private Sector

In the initial years after the legalisation of abortion, the mass media refused, for 'ethical' reasons, to carry advertisements issued by NGOs on the availability of safe abortion services or for educating the populace about safe abortion care. For several years, despite the increasing burden of maternal mortality and morbidity from unsafe abortion, the Ministry of Health, too, was reluctant to campaign for safe abortion care because of the socio-political sensitivity of the issue. While illegal abortion providers continued to exploit women by charging exorbitant fees, a few from the private/NGO sector took an early lead in sensitising the populace to the legality and safety of abortion. The Family Planning Association of India (FPAI) was one of the first non-governmental initiatives to provide safe abortion services in India (Jejeebhoy 2003). The advertisements of Pearl Abortion Centre carried by the Mumbai suburban railways in the early years following the MTP Act raised awareness about legality, availability and easy access to safe abortion services for a nominal fee (Rs70). Parivar Seva Sanstha followed suit in the 1980s, offering safe abortion services for Rs 100 through their Marie Stopes clinics in North India (Tewari 2003).

Advertising abortion services has become part of a larger and ongoing ethical debate surrounding almost every medical service. Advertising by individual abortion providers increased as more and more (mostly illegal) abortion providers tried to compete with the increasing demand for abortion services — a need unmet by the public health sector. But the purpose of mass media advertising or education campaigns is to neither increase the demand for abortions nor commercialise it, but to raise awareness and improve women's access to safer abortion services. Although a socio-politically sensitive issue,

advertising by institutions (not doctors) providing abortion services, and reinforcing it with a sustained community education campaign, is necessary to raise awareness and increase access to legal and safe abortion care.

With the advent of newer technologies like amniocentesis and sonography (which allow prenatal detection of the sex of the foetus), and as a result of conflicting social pressures of the small family norm and son preference, the private sector started offering sex selective abortion services. Though illegal since the passage of the PNDT Act in 1994, prenatal sex determination and sex selective abortion has been flourishing. Female foeticide is a complex issue and the result of two separate though related events — the act of determining the sex of the foetus and the act of selectively aborting the female foetus. Because these distinct acts are often performed at different times as well as at different places by the same or different provider, it becomes difficult to establish a link between the 'intent to abort' and the 'actual abortion' (Ganatra et al. 2001; Oomman and Ganatra 2002). Through advertisements, the private sector created a market for prenatal sex determination and sex selective abortion in blatant violation of all legal and ethical norms. A case in point is the classical advertisement which says 'spend Rs 500 now and save Rs 50,000 later', in an attempt to justify the cost-effectiveness of spending Rs 500 on a sex determination test now rather than regretting the dowry expenses later (Lingam 2001).

Following the Public Interest Litigation to stop sex determination tests in order to prevent female foeticide, the states put a ban on such tests. But though the intent of the ban was to prevent female foeticide, it had a negative effect on legal abortion services in general, particularly in states like Haryana and Rajasthan, as also on organisations like

Parivar Seva Sanstha that are dedicated to providing legitimate and safe abortion services, and thus further constrained access to safe abortion care. However, the Supreme Court's latest judgment (10 September 2003) in disposing the writ petition filed by CEHAT against the Union of India & Others, has de-linked abortion from the PNDT Act.

Despite its ability to influence and shape policy, the private sector has traditionally distanced itself from all matters relating to it. It is only recently that non-governmental professional bodies like FOGSI have interacted with the government to influence abortion policy. Although the largest provider of abortion services, the private sector has played a minimal role in educating and training its fraternity in safe abortion care. The general phobia for maintaining records and reporting, and the consequent fear of being 'accountable' to the state, has restrained private doctors from taking part in public policy dialogue, and their role has been limited to critiquing public policy and its application insofar as it is relevant to them. Their lack of concern about ethical violations and the failure to adhere to even minimal quality standards, as well as their tendency to turn a blind eye towards the uncertified and unqualified practitioners in their fraternity who provide illegal and unsafe abortions, raise concerns about the absence of self-regulation within the private sector. It is only recently that some actors in the sector have played a more proactive advocacy role for improving access to safe abortion care, though there have been/are many opportunities for public-private partnerships in the areas of policy formulation, research, training and practice, and the strengthening of safe abortion care.

## **Abortion Policy: Opportunities for Change**

Several national-level consultative efforts (CEHAT 1998; PSS 1994, 2000; FPAI 2002) involving policy-makers, professionals groups, NGOs and health activists have made major policy recommendations to improve access to safe and legal abortion services in India. Many of these policy recommendations are in line with the objectives and Action Plan of India's National Population Policy, 2000. Abortion legislation (MTP Act, Rules and Regulations) needs to be critically reviewed along national policy guidelines.

### **National Population Policy 2000 (Strategies as Relevant to Abortion)**

- *Increase awareness amongst women*
- *Expand service delivery sites*
- *Improve quality of abortion care*
- *Adopt simple safe techniques*
- *Decentralise abortion services*
- *Simplify registration process*
- *Rationalise human resource requirements*
- *Encourage training of mid-level providers (GOI 2000; Annexure 11).*

## **Increasing Availability and Reach of Abortion Service Delivery**

The National Population Policy, 2000 envisages increasing geographic spread and enhancing affordability as key strategies to increase outreach of safe abortion services. PHCs need to be strengthened to provide safe abortion care, thereby increasing availability and access to rural populations. MTP services need to be prioritised and integrated into the larger RCH Programme, which reaches out to the same woman at different stages of her life cycle. The state governments' reluctance to continue the All India Hospital Post-Partum Programme after discontinuation of central funding is one of the many 'missed opportunities' for integrating abortion with mainstream services for women's health and

thereby increasing outreach both in urban and rural settings.

**ICM Resolution: Post-abortion Care of Women (96/23/PP)**

*The International Confederation of Midwives believes that a woman who has had an abortion, whether spontaneous or induced, has the same need for care as a woman who has given birth. In keeping with this belief, the midwife should:*

- *consider such care to be within her role*
- *provide any immediate care necessary following abortion*
- *appropriately refer for any further treatment that may be required and which is beyond the limits of her practice*
- *provide education concerning the woman's future health, this education to include family planning*
- *recognize the emotional, psychological and social support which may be needed by the woman and respond appropriately* (adopted by the International Confederation of Midwives Council, May 1996, Oslo, Norway).

Another policy recommendation is to de-link the 'provider' and the 'place' in the registration process. Linking the provider with the place for approval is illogical, as a change of provider would necessitate the abortion facility to re-apply for registration and/or notify the district authorities of the change in provider along with certification of the training/experience of the new doctor. De-linking the provider from the place would allow a certified provider to perform MTP at more than one location, as well as allow a registered place to call upon more than one certified provider to perform MTP, thus making safe and legal abortion services more widely available. De-linking person from place also allows the MTP law to be relevant in the context of medical abortion, where the drugs may be administered at home under supervision and/or where the products of abortion may be actually expelled outside the provider setting at home.

Another recommendation is to encourage self-regulation within the private sector by simplifying registration and monitoring processes. Decentralisation to the district level as per the MTP (Amendment) Act, 2002 and defining a time frame for the registration process (MTP Rules 2003) are just some initial steps towards facilitating abortion care.

The MTP Act does not require abortion services to be provided free of charge. However, the National Population Policy's strategy to enhance the affordability of MTP services provides an opportunity to make safe abortion services more appealing to women who would otherwise turn to illegal and unsafe providers due to the high costs of going to registered abortion providers.

### **Creating Qualified Providers**

An abortion law that stipulates 'physicians only' and prohibits anyone who is not a medical doctor from terminating unwanted pregnancies, focuses inappropriately on medical qualifications rather than on the skills and competencies required to do an MTP. Experiences from South Africa and Bangladesh have shown that mid-level providers (nurse-midwives) trained in manual vacuum aspiration can also provide abortion services successfully (Dickson-Tetteh 2000; Akhter 2001; Ipas 2002). The National Population Policy, 2000 also recommends the training and provision of safe abortion care by mid-level providers (GOI 2000) as an operational strategy for improving its reach and availability. What is lacking, however, is political and administrative will, as well as support from the medical community, to involve mid-level health care providers in abortion care. The resistance of the medical community to widen the net of abortion providers needs to be overcome based on health systems research. In Sweden, for instance, abortion care is a team effort, and is provided by a nurse under the guidance of the doctor. But the priority

in India is to first ensure that all eligible medical doctors in the public (at PHCs) and rural private sector are trained in MTP. Training of mid-level providers would thus be the next logical step in creating a team of abortion care providers at the PHC level to further the outreach and availability of safe abortion services. Nevertheless, the process for bringing mid-level providers within the purview of the law needs to be initiated as soon as possible, as it would involve further amendment of the MTP Act.

The National Population Policy promotes collaborations and partnerships with private health sector professionals and NGOs for training, as also for increasing the availability and outreach of safe abortion services. Since this policy does not conflict with the abortion law, the issue is more of political and administrative will and commitment. Administrative and procedural barriers in involving the private and NGO sectors need to be reviewed and simplified to encourage self-regulation by shifting the onus of ensuring safe abortion care on to the provider. As a long-term strategy, training in abortion care needs to be institutionalised in medical education. Medical doctors need to build clinical as well as interpersonal communication and counselling skills, and be sensitised to issues relating to ethics, gender and reproductive health and rights. MTP training centres in both the public and private sectors need active and adequate support to build their own capacity in terms of infrastructure and human resources to address training inadequacies, and their training performance also needs to be periodically reviewed (CEHAT 1998).

### **Linking Policy with Reproductive Technology**

The lack of national consensus on technical protocols results in abortion care practices that are often inconsistent with international guidelines. In spite of technological advances, the most preferred abortion method continues to be sharp

curettage (Duggal and Barge 2003), a procedure associated with a relatively high complication rate (Cates et al. 2000; Grimes et al. 1977). Adherence to faulty protocols like performing a 'check' curettage following a vacuum aspiration is not only unnecessary but also negates the very safety of the vacuum aspiration procedure. Many abortion providers, including trainers in medical colleges (Kalpagam 2000), still prefer general anaesthesia during vacuum aspiration, which again is not only unnecessary (Iyengar and Iyengar 2002) but also increases the risk of complications during the abortion and is not recommended (WHO 2003). In accordance with government policy (GOI 2001), medical officers at PHCs are trained to terminate pregnancy by manual vacuum aspiration up to eight weeks' gestation as against the international limit of up to 12 weeks (WHO 2003). In fact, new evidence shows the efficacy and safety of manual vacuum aspiration in the hands of trained doctors up to even 14 weeks' gestation (Iyengar and Iyengar 2002). This provides an opportunity to strengthen the capability of PHCs to perform abortions consistent with international guidelines and also introduce newer techniques of medical abortion at the PHC level without transgressing the existing legal and policy framework. Policies need to be reviewed regularly by professional bodies at the national level to ensure that new and safe technologies are adapted based on scientific evidence.

### **Linking Policy with Research and Practice**

Although policy is usually guided by the capability and experiences of programmes and health systems, a systematic effort to collect information is needed to advocate evidence-based policy change (Kalpagam 2000). Evidence on quality of care, dynamics of decision-making, provider preference, abortion care utilisation patterns, etc., should feed into programme and policy. Describing best abortion practices, testing innovative strategies and documenting their

cost-effectiveness and impact on safe abortion care are essential. Abortion policies need to adapt evidence-based research findings without having to undergo the cumbersome, long-drawn out administrative and legal processes that are required to change abortion law. The adverse effect that the 'informal fees' charged by providers in the public sector have on access to safe abortion services needs to be systematically documented to create the political will to prevent such malpractices amongst abortion providers. Strategies for delivering needs-based and woman-sensitive safe abortion care by the health system need to be tested for feasibility, as also for their impact on improving access to quality abortion care. Abortion policies need to be broad and flexible enough to adapt to new and emerging research. It is also necessary to develop national norms and standards for governing the provision of quality abortion in keeping with international norms and standards, research and good abortion practice. Policy-makers at national and state levels need to link up with professional and research bodies to ensure periodic policy analysis and review.

### **Improving the Quality of Abortion Care**

Abortion is a complex and emotive issue influenced by individual, spousal, family and societal values, which in turn are influenced by political, cultural, religious and moral

belief systems. A woman seeking to terminate an unwanted pregnancy is vulnerable and it is essential that providers recognise this vulnerability and respond in an empathising and empowering manner, without allowing the prevailing cultural and socio-political value systems to colour their response. The underlying principles guiding the response of the health system should be 'respect' for the woman's autonomy and safeguarding her dignity, privacy and confidentiality. Abortion policy and law need to equitably, compassionately and without discrimination reach out to underserved women like adolescents, unmarried women, women with HIV, or women who are victims of violence. Abortion policy within the existing legal framework provides an opportunity to enhance awareness through IEC activities about both contraceptive and abortion services -- especially amongst adolescents within the larger context of sexual and reproductive health -- by integrating strategies and interventions within value systems and family and gender relations. To improve quality of abortion care, policies and programmes have to address the attitudinal shortcomings of health care providers, and develop positive role models and standards of non-judgmental and value-neutral behaviour that are based on and reinforce the principles of respect, dignity and compassion.

## Abortion Policy Advocacy: What Next?

The guiding theme for all policy advocacy efforts should be 'make abortion safe'. Such efforts would therefore need to target policy-makers and programme managers at various levels, as well as all concerned stakeholders, including women. Unsafe abortion would need to be highlighted to policy-makers as a major health concern. Abortion estimates based on service statistics alone could be misleading as such statistics grossly underestimate the magnitude of the problem of unsafe abortion. Based on relevant research evidence supported by consensus policy statements, advocacy efforts would also need to dispel common misconceptions that affect access to safe abortion care (Hord 2001).

### Common Myths about Abortion

- *Abortion is uncommon*
- *Abortion is dangerous to women*
- *Abortion would be eliminated if everyone used contraception*
- *To be safe, abortion care must be provided in hospitals by doctors*
- *Only irresponsible women have abortions*
- *Sexuality education increases adolescent pregnancy and abortion*
- *Major religions oppose abortion (adapted from Hord 2001).*

The most important policy and programme change would be one that 'facilitates' access to safe abortion care for 'all' women in need of terminating an unwanted pregnancy. The health system's commitment to do this can be easily gauged by the level of priority it accords to women's sexual and reproductive health and rights and their access to reproductive health care services, particularly safe abortion care. Advocacy needs to initiate a dialogue within the existing legal and social context to mainstream compassion, respect, care and

dignity in a value-neutral environment of abortion care. Policy-makers need to continuously review and reinforce their commitment to safe abortion care within the broader context of reproductive health and rights. Regulatory and administrative barriers in access to safe abortion services need to be highlighted and removed to create an enabling and empowering environment for the delivery of safe abortion services. Sustained information campaigns should strive to increase awareness amongst both providers and women about abortion legislation and reproductive health care and rights.

### Issues for Advocacy-a Commitment to:

- *Providing 'all' women with quality abortion care which is sensitive to their needs*
- *Increase availability, affordability and access to safe abortion services*
- *Mobilise human and material and financial resources for provision of safe abortion care*
- *Increase the number of trained providers and equipped abortion centers*
- *Authorise providers based on competency and skills rather than on titles and qualifications*
- *Simplify regulatory and administrative processes*
- *Link abortion policy with 'best clinical practices'*
- *Link abortion policy with relevant reproductive technology*
- *Link abortion policy with research*
- *The 'right to information' about safe abortion services*
- *A 'woman's right' to safe abortion care*
- *A public-private partnership in training and provision of safe abortion care*

Abortion services should be considered not in isolation but within the larger framework of other social services like protection from abuse, improvement of

women's status, sex education, reproductive and sexual health care (Jesani and Iyer 1993). Abortion care is complex issue, influenced by religion and morals, the socio-political context and sexual politics. The not-so-covert link with population policies often results in an intentional oversight of its misuse as a method for fertility control. Dilemmas and conflicts between an individual woman's right to decide freely about her reproductive and sexual health and the state's social responsibility to encourage small family norms need to be resolved, not only through policy statements but also action. To be effective, a liberalised policy

needs to be backed by political will and commitment in terms of adequate infrastructure support, as well as women-centred social inputs. Forging strategic alliances and coalitions with critical players like lawyers, mass media, policy-makers, programme managers, professional bodies, NGOs, researchers and health and women's activists to sustain political will and commitment is also necessary. Advocacy and action would be required at both central and state levels if the abortion-related strategies detailed in the National Population Policy, 2000 are to be made operational.

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## Annexure 1

# The Medical Termination of Pregnancy Act, 1971 (Act No. 34 of 1971)

An Act to provide for the termination of certain pregnancies by registered medical practitioners and for matters connected therewith or incidental thereto

Be it enacted by Parliament in the Twenty-second Year of the Republic of India as follows:

### 1. Short title, extent and commencement:

- (1) This Act may be called the Medical Termination of Pregnancy Act, 1971.
- (2) It extends to the whole of India except the State of Jammu and Kashmir.
- (3) It shall come into force on such date as the Central Government may, by notification in the Official Gazette, appoint.

### 2. Definitions:

In this Act, unless the context otherwise requires,

- (a) 'guardian' means a person having the care of the person of a minor or a lunatic;
- (b) 'lunatic' has the meaning assigned to it in Sec. 3 of the Indian Lunacy Act, 1912 (4 of 1912) ;
- (c) 'minor' means a person who, under the provisions of the Indian Majority Act, 1875 (9 of 1875), is to be deemed not to have attained his majority,
- (d) 'registered medical practitioner' means a medical practitioner who possesses any recognized medical qualification as defined in Cl.(h) of Sec. 2 of the Indian Medical Council Act, 1956 (102 of 1956), whose name has been entered in a State Medical Register and who has such experience or training in gynaecology and obstetrics as may be prescribed by rules made under this Act.

### Comments

**General, principle of construction.** There is one principle on which there is complete unanimity of all the Courts in the world and this is that where the words or the language used in a statute are clear and cloudless, plain, simple and explicit, unclouded and unobscured, intelligible and pointed so as to admit of no ambiguity, vagueness, uncertainty or equivocation, there is absolutely no room for deriving support from external aids. In such cases, the statute should be interpreted on the face of the language itself without adding, subtracting or omitting words therefrom. Where the language is plain and unambiguous Court is not entitled to go behind the language so as to add or supply omissions and thus play the role of a political reformer or of a wise counsel to the Legislature.

**Person :** The word 'person' has been used to make it clear that in order to exercise the powers of Controller under the Act, the statutory functionary has to be duly appointed by the government and that he is persona designata or designated person.

### 3. When pregnancies may be terminated by registered medical practitioners:

- (1) Notwithstanding anything contained in the Indian Penal Code (45 of 1860), a registered

medical practitioner shall not be guilty of any offence under that Code or under any other law for the time being in force, if any pregnancy is terminated by him in accordance with the provisions of this Act.

- (2) Subject to the provisions of sub-section (4), a pregnancy may be terminated by a registered medical practitioner
- (a) where the length of the pregnancy does not exceed twelve weeks if such medical practitioner is, or
  - (b) where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioners are of opinion, formed in good faith, that,
    - (i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health ; or
    - (ii) there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.

Explanation 1: Where any pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman.

Explanation 2: Where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman.

- (3) In determining whether the continuance of pregnancy would involve such risk of injury to the health as is mentioned in sub-section (2), account may be taken of the pregnant woman's actual or reasonable foreseeable environment.
- (4) (a) No pregnancy of a woman, who has not attained the age of eighteen years, or who, having attained the age of eighteen years, is a lunatic, shall be terminated except with the consent in writing of her guardian.
- (b) Save as otherwise provided in Cl.(a), no pregnancy shall be terminated except with the consent of the pregnant woman.

### Comments

**More than one registered medical practitioner not needed for actual termination of pregnancy.** The number of registered medical practitioners has relevance only with regard to the formation of the opinion. Once the opinion has been formed by the required number of registered medical practitioners, the actual termination of the pregnancy may be done by one registered medical practitioner. It is not necessary that more than one registered medical practitioner should act together to terminate a pregnancy.

**The word 'shall' - Meaning of.** It has been laid down consistently by the Supreme Court that the mere use of the word 'shall' by itself in the statute does not make the provision mandatory, but it is the duty of the Courts of justice to try to get at the real intention of the Legislature by carefully attending to the whole scope of the statute to be construed. In each case, one has to look to the subject-matter, consider the importance of the provisions and

the relations of that provision with the general object intended to be secured by the Act and upon the review of the case in that aspect decide whether the enactment is mandatory or only directory.

**'May' and 'shall'.** Where the Legislature used two words 'may' and 'shall' in two different parts of the same provision prima facie it would appear that the Legislature manifested its intention to make one part directory and another mandatory. But that by itself is not decisive. The power of the Court still to ascertain the real intention of the Legislature by carefully examining the scope of the statute to find out whether the provision is directory or mandatory remains unimpaired even where both the words are used in the same provision.

The word 'may' must be construed to mean 'shall' and it is mandatory.

**Saving provision – Effect of.** While giving effect to a saving provision when it provides that something which is done or issued under the repealed provision must be treated as having been treated or issued under the newly enacted provision, an earlier order can be saved only if such a direction or order could be effectively and validly made under the new provisions of law, which had repealed the earlier provisions.

#### **4. Place where pregnancy may be terminated:**

No termination of pregnancy shall be made in accordance with this Act at any place other than

- (a) a hospital established or maintained by Government, or
- (b) a place for the time being approved for the purpose of this Act by Government.

#### **Comment**

**Pregnancy to be terminated at a Government hospital or approved place.** This section read with Sec.5, provides that a pregnancy which is terminated on one or more of the grounds specified in Sec.3, should not be made at any place other than

- (a) a hospital established or maintained by Government, or
- (b) a place for the time being approved for the purpose of the Act by Government.

#### **5. Sections 3 and 4 -- when not to apply:**

(1) The provisions of Sec. 4 and so much of the provisions of sub-section (2 of Sec. 3) as relate to the length of the pregnancy and the opinion of not less than two registered medical practitioners, shall not apply to the termination of a pregnancy by the registered medical practitioner in case where he is of opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman.

(2) Notwithstanding anything contained in the Indian Penal Code (45 of 1860), the termination of a pregnancy by a person who is not a registered medical practitioner shall be an offence punishable under that Code, and that Code shall, to this extent, stand modified.

Explanation: For the purposes of this section, so much of the provisions of C1(d) of Sec.2 as relate to the possession, by a registered medical practitioner, of experience or training in gynaecology and obstetrics shall not apply.

## **Comments**

**Explanation.** It is now well settled that an explanation added to a statutory provision is not a substantive provision in any sense of the term but as the plain meaning of the word itself shows it is merely meant to explain or clarify certain ambiguities which may have crept in the statutory provision.

**Proviso.** A proviso is intended to limit the enacted provision so as to except something which has otherwise been within it or in some measure to modify the enacting clause. Sometimes a proviso may be embedded in the main provision and becomes an integral part of it so as to amount to a substantive provision itself.

### **6. Power to make rules:**

- (1) The Central Government may, by notification in the Official Gazette, make rules to carry out the provisions of this Act.
- (2) In particular, and without prejudice to the generality of the foregoing power, such rules may provide for all or any of the following matters, namely:
  - (a) the experience or training, or both, which a registered medical practitioner shall have if he intends to terminate any pregnancy under this Act; and
  - (b) such other matters as are required to be or may be provided by rules made under this Act.
- (3) Every rule made by the Central Government under this Act shall be laid, as soon as may be after it is made, before each House of Parliament while it is in session for a total period of thirty days which may be comprised in one session or in two successive sessions, and if, before the expiry of the session in which it is so laid or the session immediately following, both Houses agree in making any modification in the rule or both Houses agree that the rule should not be made, the rule shall thereafter have effect only in such modified form or be of no effect, as the case may be; so, however, that any such modification or annulment shall be without prejudice to the validity of anything previously done under that rule.

### **Comment**

By this section, a power has been conferred on the Central Government to make rules to carry out the provisions of the Act.

In relation to hospitals other than institutions established or maintained by the Central Government, matters in respect of which regulations can be made by the State Government under Sec.7 have been included in the rules.

### **7. Power to make regulations:**

- (1) The State Government may, by regulations,
  - (a) require any such opinion as is referred to in sub-section (2) of Sec. 3 to be certified by a registered medical practitioner or practitioners concerned in such form and at such time as be specified in such regulations, and the preservation or disposal of such certificates;
  - (b) require any registered medical practitioner who terminates a pregnancy to give intimation of such termination and such other information relating to the termination as maybe specified in such regulations;
  - (c) prohibit the disclosure, except to such persons and for such purposes as may be specified in such regulations, of intimations given or information furnished in pursuance of such regulations.

- (2) The intimation given and the information furnished in pursuance of regulations made by virtue of C1 (b) of Sub-section (1) shall be given or furnished, as the case may be, to the Chief Medical Officer of the State..
- (3) Any person who wilfully contravenes or wilfully fails to comply with the requirements of any regulation made under sub-section (1) shall be liable to be punished with fine which may extend to one thousand rupees.

### **Comments**

Under this section, the State Government has been empowered to make regulations requiring opinion referred to in sub-section (2) of Sec. 3 to be certified and the preservation or disposal of such certificate; to require the registered medical practitioner to give intimation of pregnancies terminated by them to the Chief Medical Officer of the State.

The matters in relation to which such regulations may be made have been specified in the section itself. It will be seen that the power to make regulations has been conferred on the State Government only. The regulations made by the State Governments would apply to hospitals established or maintained by it or to approved places in the State. But as regards the Central institutions and hospitals, etc. situated in a Cantonment, the State Government has no power to make such regulations. Consequently, rules have been framed by the Central Government with regard to the matters in relation to which regulations can be made by the State Government.

The Act empowers the Central Government to make regulations to provide for the maintenance of secrecy about the termination of pregnancies made under the Act. The matters in relation to which such regulations may be made have been specified in the section itself. In relation to medical institutions established or maintained by the Central Government, provisions regarding the maintenance of secrecy, etc., have been included in the rules made under Sec. 6. The said rules would apply only to hospitals established or maintained by Government or other places approved by the Government. The regulations made under this section by any State Government would apply to hospitals established or maintained by the Government and places approved by it.

### **8. Protection of action taken in good faith:**

No suit for other legal proceedings shall lie against any registered medical practitioner for any damage caused/likely to be caused by anything which is in good faith done or intended to be done under this Act.

### **Comments**

By sub-section (l) of Sec. 3, a registered medical practitioner, who terminates a pregnancy in accordance with the provisions of the Act, is protected from any prosecution for the termination of such pregnancy. By this section, he is protected from any civil action for compensation for any damage caused or likely to be caused by anything, which is in good faith done or intended to be done under this Act. In order to be able to get this protection, the registered medical practitioner must establish that his action was done in good faith. 'Act' may also include omissions. Hence, if any omission to terminate any pregnancy is made in good faith, an action for compensation for damages may not lie for such omission if such omission was done in good faith.

## Annexure 2

# The Medical Termination of Pregnancy (Amendment) Bill, 2002 A Bill to Amend the Medical Termination of Pregnancy Act, 1971.

Be it enacted by Parliament in the Fifty-third Year of the Republic of India as follows:

### 1. Short title and commencement:

- (1) This Act may be called the Medical Termination of Pregnancy (Amendment) Act, 2002.
- (2) It shall come into force on such date as the Central Government may, by notification in the Official Gazette, appoint.

### 2. Amendment of Section 2:

In Section 2 of the Medical Termination of Pregnancy Act, 1971 (34 of 1971) (hereinafter referred to as the principal Act),

- (i) in clause (a), for the word 'lunatic', the words 'mentally ill person' shall be substituted;
- (ii) for clause (b), the following clause shall be substituted, namely:

'(b) "mentally ill person" means a person who is in need for treatment by reason of any mental disorder other than mental retardation;'

**3. Amendment of section 3:** In section 3 of the principal Act, in sub-section (4), in clause (a), for the word 'lunatic', the words 'mentally ill person' shall be substituted.

**4. Substitution of new section for section 4:** For section 4 of the principal Act, the following section shall be substituted, namely:

'4. Place where pregnancy may be terminated. No termination of pregnancy shall be made in accordance with this Act at any place other than —

- (a) a hospital established or maintained by Government, or
- (b) a place for the time being approved for the purpose of this Act by Government or a District Level Committee constituted by that Government with the Chief Medical officer or District Health officer as the Chairperson of the said Committee:

Provided that the District Level Committee shall consist of not less than three and not more than five members including the Chairperson as the Government may specify from time to time.'

**5. Amendment of section 5:** In section 5 of the principal Act,

- (a) for sub-section (2) and the *Explanation* thereto, the following shall be substituted, namely:—

- (2) Notwithstanding anything contained in the Indian Penal Code (45 of 1860), the termination of pregnancy by a person who is not a registered medical practitioner shall be an offence punishable with rigorous imprisonment for a term which shall not be less than two years but which may extend to seven years under that Code, and that Code shall, to this extent, stand modified.
- (3) Whoever terminates any pregnancy in a place other than that mentioned in section 4, shall be punishable with rigorous imprisonment for a term which shall not be less than two years but which may extend to seven years.
- (4) Any person being owner of a place which is not approved under clause (b) of section 4 shall be punishable with rigorous imprisonment for a term which shall not be less than two years but which may extend to seven years.

Explanation 1. For the purposes of this section, the expression 'owner' in relation to a place means any person who is the administrative head or otherwise responsible for the working or maintenance of a hospital or place, by whatever name called, where the pregnancy may be terminated under this Act.

Explanation 2. For the purposes of this section, so much of the provisions of clause (d) of section 2 as relate to the possession, by registered medical practitioner, of experience or training in gynaecology and obstetrics shall not apply.'

### **Statement of objects and reasons**

The Medical Termination of Pregnancy Act, 1971 legalised termination of pregnancy on various socio-medical grounds. This Act is aimed at eliminating abortion by untrained persons and in unhygienic conditions, thus reducing maternal morbidity and mortality.

2. In 1997, an expert group was constituted to review the aforesaid Act with a view to making it more relevant to the present environment. The National Commission for Women also suggested certain amendments in the Act to remove provisions which were discriminatory to women. Taking into consideration the suggestions of the National Commission for Women and experience gained in the implementation of this Act, the expert group recommended certain amendments to the Act.

3. Accordingly, the Medical Termination of Pregnancy (Amendment) Bill, 2002 provides for -

- (i) Substituting the word 'lunatic' by the words 'mentally ill person';
- (ii) Amending section 4 with a view to delegating powers to the Government to approve places for medical termination of pregnancy and constituting District Level Committees to be headed by the Chief Medical Officer/District Health Officer;
- (iii) Amending section 5 so as to prescribe punishment of rigorous imprisonment of not less than two years and extending up to seven years—
  - (a) To clinics which are not authorised to conduct abortions; and
  - (b) To persons who are not registered medical practitioners with requisite experience or training for terminating pregnancy.

4. The Bill seeks to achieve the above objects.

*The 13th April 2002.*

## Annexure 2A

### Extracts from the Medical Termination of Pregnancy Act, 1971

(34 of 1971)

**2.** In this Act, unless the context otherwise requires,

- (a) 'guardian' means a person having the care of the person of a minor or a lunatic;
- (b) 'lunatic' has the meaning assigned to it in section 3 of the Indian Lunacy Act, 1912;

**3. When pregnancies may be terminated by registered medical practitioners:**

(1) Notwithstanding anything contained in the Indian Penal Code (45 of 1860), a registered medical practitioner shall not be guilty of any offence under that Code or under any other law for the time being in force, if any pregnancy is terminated by him in accordance with the provisions of this Act.

(4) (a) No pregnancy of a woman, who has not attained the age of eighteen years, or, who, having attained the age of eighteen years, is a lunatic, shall be terminated except with the consent in writing of her guardian.

**4.** No termination of pregnancy shall be made in accordance with this Act at any place other than —

- (a) a hospital established or maintained by Government, or
- (b) a place for the time being approved for the purpose of this Act by Government.

**5. Sections 3 and 4 -- when not to apply:**

(1) The provisions of Sec. 4 and so much of the provisions of sub-section (2) of Sec. 3 as relate to the length of the pregnancy and the opinion of not less than two registered medical practitioners, shall not apply to the termination of a pregnancy by the registered medical practitioner in case where he is of opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman.

(2) Notwithstanding anything contained in the Indian Penal Code, the termination of a pregnancy by a person who is not a registered medical practitioner, shall be an offence punishable under that Code, and that Code shall, to this extent, stand modified.

Explanation. For the purposes of this section, so much of the provisions of clause (d) of section 2 as relate to the possession, by a registered medical practitioner, of experience or training in gynaecology and obstetrics shall not apply.

## Annexure 3

### The Medical Termination of Pregnancy Rules, 1975

**G.S.R. 2543, dated the 10th October, 1975.** In exercise of the powers conferred by Sec. 6 of the Medical Termination of Pregnancy Act, 1971 (34 of 1971), the Government hereby makes the following rules, namely:

**1. Short title and commencement:**

- (1) These rules may be called the Medical Termination of Pregnancy Rules, 1975,
- (2) They shall come into force on the date of their publication in the Official Gazette.

**2. Definitions:** In these rules, unless the context otherwise requires,

- (a) 'Act' means the Medical Termination of Pregnancy Act, 1971 (34 of 1971);
- (b) 'Chief Medical Officer of the District' means the Chief Medical Officer of a District, by whatever name called;
- (c) 'form' means a form appended to these rules
- (d) 'owner' in relation to a place, means any person who is the administrative head or otherwise responsible for the working or maintenance of such hospital or clinic, by whatever name called;
- (e) 'place' means such building, tent, vehicle or vessel, or part thereof as used for the establishment or maintenance therein of a hospital or clinic which is used, or intended to be used, for the termination of any pregnancy;
- (f) 'section' means a section of the Act.

**Comments**

**Rule of construction.** It is well-settled canon of construction that the rules made under a statute must be treated exactly as if they were in the Act and are of the same effect as if contained in the Act. There is another principle equally fundamental to the rule of construction, namely, that the rules shall be consistent with the provisions of the Act.

Whenever the rules are plain and unambiguous and precise words have been used while framing the rules, it has always been the well-settled law that the Court is bound to construe such words in their ordinary sense and give them full effect.

If the rules are legislative in character, they must harmoniously be interpreted as a connected whole giving life and force to each word, phrase and rule and no part thereof should be rendered nugatory or a surplusage. Resort to iron out the creases could be had only when the construction of the relevant rule, phrase or word would lead to unintended absurd results.

3. **Experiences or training etc.:** For the purpose of Cl. (d) of Sec.2, a registered medical practitioner shall have one or more of the following experience or training in gynaecology and obstetrics, namely:
- (a) In the case of a medical practitioner who was registered in a State Medical Register immediately before the commencement of the Act, experience in the practice of gynaecology and obstetrics for a period of not less than three years;
  - (b) In the case of a medical practitioner who was registered in a State Medical Register on or after the date of the commencement,
    - (i) if he has completed six months of house surgency in gynaecology and obstetrics; or
    - (ii) where he has not done any such house surgency if he had experience at any hospital for a period of not less than one year in the practice of obstetrics and gynaecology; or
    - (iii) if he has assisted a registered medical practitioner in the performance of twenty-five cases of medical termination of pregnancy in a hospital established or maintained, or a training institute approved for this purpose, by the Government;
  - (c) In the case of a medical practitioner who has been registered in a State Medical Register and who holds a postgraduate degree or diploma in gynaecology and obstetrics, the experience or training gained during the course of such degree or diploma.

4. **Approval of a place:**

- (1) No place shall be approved under Cl. (b) of Sec.4,
  - (i) Unless the Government is satisfied that termination of pregnancy may be done therein under safe and hygienic conditions; and
  - (ii) Unless the following facilities are provided therein, namely:
    - (a) An operation table and instruments for performing abdominal or gynaecological surgery;
    - (b) Anaesthetic equipment, resuscitation equipment and sterilisation equipment;
    - (c) Drugs and parenteral fluids for emergency use.
- (2) Every application for the approval of a place shall be in Form A and shall be addressed to the Chief Medical Officer of the District.
- (3) On receipt of an application referred to in sub-rule (2), the Chief Medical Officer of the District shall verify or enquire any information contained in any such application or inspect any such place with a view to satisfy himself that the facilities referred to in sub-rule (1) or provided therein, and that termination of pregnancies may be made therein under safe and hygienic conditions.
- (4) Every owner of the place which is inspected by the Chief Medical Officer of the District shall afford all reasonable facilities for the inspection of the place.
- (5) The Chief Medical Officer of the District may, if he is satisfied after such verification, enquiry or inspection, as may be considered necessary, that termination of pregnancies may be done under safe and hygienic condition, at the place recommend, the approval of such place to the Government.

- (6) The Government may after considering the application and the recommendation of the Chief Medical Officer of the District approve such place and issue a certificate of approval in Form B.
- (7) The certificate of approval issued by the Government shall be conspicuously displayed at the place to be easily visible to persons visiting the place.

### **Comments**

**‘Superintendence, direction and control’- Purpose should be confined liberally.** While construing the expression ‘superintendence, direction and control’ in Art. 324 (1) one has to remember that every norm which lays down a rule of conduct cannot possibly be elevated to the position of legislation or delegated legislation. There are some authorities or persons in certain gray areas who may, be sources of rules of conduct and who at the same time be equaled to authorities or persons who can make law in the strict sense in which it is understood in jurisprudence. A direction may mean an order issued to a particular individual or a precept which may have to follow. It may be a specific or a general order. One has also to remember that the source of power in this case is the Constitution, the highest law of the land, which is the repository and source of all legal powers and any power granted by, the Constitution for a specific purpose should be construed liberally so that the object for which the power is granted is effectively achieved.

### **5. Inspection of a place:**

- (1) A place approved under rule 4 may be inspected by the Chief Medical Officer of the District, as often as may be necessary with view to verify whether termination of pregnancies is being done therein under safe hygienic conditions.
- (2) If the Chief Medical Officer has reason to believe that there has been death of or injury to a pregnant woman at the place or that termination of pregnancies is not being done at the place under safe and hygienic conditions, he may call for any information or may seize any article, medicine, ampule, admission register or other document, maintained, kept or found at the place.
- (3) The provisions of the Code of Criminal procedure, 1973 (2 of 1974) relating to seizure shall, so far as may be apply to seizures made under sub-rule (2).

### **6. Cancellation or suspension of certificate of approval:**

- (1) If, after inspection of any place approved under rule 4, the Chief Medical Officer of the District is satisfied that facilities specified in rule 4 are not being properly maintained therein and the termination of pregnancy at such place cannot be made under safe and hygienic conditions, he shall make a report of the facts to the Government giving the details of the deficiencies or defects found at the place. On receipt of such report the Government may after giving the owner of the place a reasonable opportunity of being heard, either cancel the certificate of approval or suspend the same for such period as it may think fit.
- (2) Where a certificate issued under rule 4 is cancelled or suspended the owner of the place may make such additions or improvements in the place as he may think fit and thereafter,

he may make an application to the Government for the issue to him of a fresh certificate of approval under the rule 4 or as the case may be for the revival of the certificate which was suspended under sub-rule (1).

- (3) The provisions of rule 4 shall as far as may apply to an application for the issue of a fresh certificate of approval in relation to a place or as the case may be for the revival of a suspended certificate as they apply to an application for the issue of a certificate of approval under that rule (V).
- (4) In the event of suspension of a certificate of approval the place shall not be deemed to be an approved place for the purposes of termination of pregnancy from the date of communication of the order of such suspension.

**7. Review:**

- (1) The owner of a place who is aggrieved by an order made under rule 6 may make an application for review of the order to the Government within a period of sixty days from the date of such order.
- (2) The Government may after giving the owner an opportunity of being heard, confirm, modify or reverse the order.

**8. Form of consent:**

The Consent referred to in sub-section (4) of section 3 shall be given in Form C.

**9. Repeal and saving:**

The Medical Termination of Pregnancy Rules 1972 are hereby repealed except as respects things done or omitted to be done before such repeal.

## Annexure 4

# Amended Medical Termination of Pregnancy Rules, 2003

**MINISTRY OF HEALTH AND FAMILY WELFARE**  
(Department of Family Welfare)

### **NOTIFICATION**

New Delhi, the 13<sup>th</sup> June, 2003

**G.S.R. 485(E)** - In exercise of powers conferred by section 6 of the Medical Termination of Pregnancy Act, 1971 (34 of 1971), the Central Government hereby makes the following rules, namely :-

#### **1. Short title and commencement -**

- (1) (1) These rules may be called the Medical Termination of Pregnancy Rules, 2003.
- (2) (2) They shall come into force on the date of their publication in the Official Gazette.

#### **2. Definitions -** In this rules, unless the context otherwise requires,

- (a) "Act" means the Medical Termination of Pregnancy Act, 1971 (34 of 1971)
- (b) "Chief Medical Officer of the District" means the Chief Medical Officer of a District, by whatever name called;
- (c) "Form" means a form appended to these rules;
- (d) "owner" in relation to a place means any person who is the administrative head or otherwise responsible for the working or maintenance of a hospital or place, by whatever name called, where the pregnancy may be terminated under this Act.
- (g) "Committee" means a committee constituted at the district level under the proviso to clause (b) of section 4 read Rule 3.

#### **3 Composition and tenure of District level Committee**

- (1) One member of the district level Committee shall be the Gynaecologist/ Surgeon/ Anaesthetist and other members from the local medical profession, non-governmental organization, and Panchayati Raj Institution of the District. Provided that one of the members of the Committee shall be a woman.
- (2) Tenure of the Committee shall be for two calendar years and the tenure of the non-government members shall not be more than two terms.

#### **4. Experience and training under clause (d) of Section 2:-**

For the purpose of clause (d) of section (2), a registered medical practitioner shall have one or more of the following experience or training in gynaecology and obstetrics, namely;

- (a) In the case of a medical practitioner, who was registered in a State Medical Register immediately before the commencement of the Act, experience in the practice of gynaecology and obstetrics for a period of not less than three years;
- (b) In the case of a medical practitioner, who is registered in a State Medical Register:-
  - (i) if he has completed six months of house surgency in gynaecology and obstetrics; or
  - (ii) unless the following facilities are provided therein, if he had experience at any hospital for a period of not less than one year in the practice of obstetrics and gynaecology ; or
- (b) if he has assisted a registered medical practitioner in the performance of twenty-five cases of medical termination of pregnancy of which at least five have been performed independently, in a hospital established or maintained or a training institute approved for this purpose by the government.**
  - (i) This training would enable the Registered Medical Practitioner (RMP) to do only 1<sup>st</sup> Trimester terminations (up to 12 weeks of gestation).
  - (ii) For terminations up to twenty weeks the experience or training as prescribed under sub rules (a), (b) and (d) shall apply .
- (d) In case of a medical practitioner who has been registered in a State Medical Register and who holds a post-graduate degree or diploma in gynaecology and obstetrics, the experience or training gained during the course of such degree or diploma.

**5. Approval of a place, -**

- (1) No place shall be approved under clause (b) of section 4, -
  - (i) Unless the Government is satisfied that termination of pregnancies may be done therein under safe and hygienic conditions; and
  - (ii) Unless the following facilities are provided therein, namely: -

In case of first trimester, that is, up to 12 weeks of pregnancy:-

a gynecology examination/labour table, resuscitation and sterilization equipment, drugs and parental fluid, back up facilities for treatment of shock and facilities for transportation; and

in case of second trimester, that is, up to 20 weeks of pregnancy:-

- (a) an operation table and instruments for performing abdominal or gynaecological surgery;
- (b) anaesthetic equipment, resuscitation equipment and sterilization equipment;
- (c) drugs and parental fluids for emergency use, **notified by Government of India from time to time.**

**Explanation :** In the case of termination of early pregnancy up to 7 weeks using RU-486 with Misoprostol, the same may be prescribed by a Registered Medical Practitioner (RMP) as defined under clause (d) of section 2 of the Act and Section 4 of MTP Rules, at his clinic, provided such a Registered Medical Practitioner has access to a place approved under Section 4 of the MTP Act, 1971 read with MTP Amendment Act, 2002 and Rules 5 of the MTP Rules. For the purpose of access, the RMP should display a Certificate to this effect from the owner of the approved place.

- (2) Every application for the approval of a place shall be in a Form A and shall be addressed to the Chief Medical Officer of the District.
- (3) On receipt of an application under sub-rule (2), the Chief Medical Officer of the District may verify any information contained, in any such application or inspect any such place with a view to satisfying himself that the facilities referred to in sub-rule (1) are provided, and that termination of pregnancies may be made under safe and hygienic conditions.
- (4) Every owner of the place which is inspected by the Chief Medical Officer of the District shall afford all reasonable facilities for the inspection of the place.
- (5) The Chief Medical Officer of the District may, if he is satisfied after such verification, enquiry or inspection, as may be considered necessary, that termination of pregnancies may be done under safe and hygienic conditions, at the place, recommended the approval of such place to the **Committee**.
- (6) The **Committee** may after considering the application and the recommendations of the Chief Medical Officer of the District approve such place and issue a certificate of approval in Form B.
- (7) The certificate of approval issued by the **Committee** shall be conspicuously displayed at the place to be easily visible to persons visiting the place.
- (8) (8) The place shall be inspected within 2 months of receiving the application and certificate of approval may be issued within the next 2 months, or in case any deficiency has been noted, within 2 months of the deficiency having been rectified by the applicant.
- (9) (9) On the commencement of these rules, a place approved in accordance with the Medical Termination of Pregnancy Rules, 1975 shall be deemed to have been approved under these Rules.

**6. Inspection of a place, -**

- (1) A place approved under rule 5 may be inspected by the Chief Medical Officer of the District, as often as may be necessary with a view to verify whether termination of pregnancies is being done therein under safe and hygienic conditions.
- (2) If the Chief Medical Officer has reason to believe that there has been death of, or injury to, a pregnant woman at the place or that termination of pregnancies is not being done at

the place under safe and hygienic conditions, he may call for any information or may seize any article, medicine, ampule, admission register or other document, maintained, kept or found at the place.

- (3) The provisions of the Code of Criminal Procedure, 1973 (2 of 1974), relating to seizure shall, so far as it may, apply to seizure made under sub-rule (2).

**6. Cancellation or suspension of certificate of approval, -**

- (1) If, after inspection of any place approved under rule 5, the Chief Medical Officer of the District is satisfied that the facilities specified in rule 5 are not being properly maintained therein and the termination of pregnancy at such place cannot be made under safe and hygienic conditions, he shall make a report of the fact to the **Committee** giving the detail of the deficiencies or defects found at the place and the committee may, if it is satisfied, suspend or cancel the approval provided that the committee shall give an opportunity of making representation to the owner of the place before the certificate issued under rule 5 is cancelled.
- (2) Where a certificate issued under rule 5 is cancelled the owner of the place may make such additions or improvements in the place and there after, he may make an application to the **Committee** for grant of approval under rule 5.
- (3) In the event of suspension of a certificate, of approval, the place shall not be deemed to be an approved place during the suspension for the purposes of termination of pregnancy from the date of communication of the order of such suspension.

**7. Review :-**

- (1) (1) The owner of a place, who is aggrieved by an order made under rule 7, may make an application for review of the order to the Government within a period of sixty days from the date of such order:

Provided that the Government may condone any delay in case it is satisfied that applicant was prevented by sufficient cause to make application within time.

- (2) (2) The Government may, after giving the owner an opportunity of being heard, confirm, modify or reverse the order.

**8. Form of consent, -**

The consent referred to in sub-section (4) of section 3 shall be given in Form C.

**9. Repeal and saving, -**

The Medical Termination of Pregnancy Rules, **1975**, are hereby repealed except as respects things done or omitted to be done before such repeal.

## Annexure 5

### The Medical Termination of Pregnancy Regulations, 1975

G.S.R. 2544, dated 10th October, 1975. In exercise of the powers conferred by Sec.7 of the Medical Termination of Pregnancy Act, 1971 (34 of 1971), the Central Government hereby makes the following Regulations, namely:

1. **Short title, extent and commencement:** These regulations may be called the Medical Termination of Pregnancy Regulations, 1975.
  - (2) They extend to all the Union Territories.
  - (3) They shall come into force on the date of their publication in the Official Gazette.
2. **Definitions:** In these regulations, unless the context otherwise requires,
  - (a) 'Act' means the Medical Termination of Pregnancy Act, 1971 (34 of 1971)
  - (b) 'Admission Register' means the register maintained under regulation 5;
  - (c) 'Approved place' means a place approved under rule 4 of the Medical Termination of Pregnancy Rules, 1975;
  - (d) 'Chief Medical Officer of the State' means the Chief Medical Officer of the State, by whatever name called;
  - (e) 'Form' means a form appended to these regulations;
  - (f) 'Hospital' means a hospital established or maintained by the Central Government or the Government of the Union Territory;
  - (g) 'Section' means a section of the Act.
3. **Form of certifying opinion or opinions:** (1) Where one registered medical practitioner forms or not less than two registered medical practitioners form such opinion as is referred to in sub-section (2) of Sec.3 or Sec.5, he or they shall certify such opinion in Form 1.
  - (2) Every registered medical practitioner who terminates any pregnancy shall, within three hours from the termination of the pregnancy certify such termination in Form 1.

#### Comment

Regulation 3 (2) requires the medical practitioner terminating the pregnancy to certify the termination within three hours from such termination.

#### 4. Custody of forms:

- (1) The consent given by a pregnant woman for termination of her pregnancy, together with the certified opinion recorded under Sec. 3 or Sec. 5, as the case may be and the intimation of termination of pregnancy shall be placed in an envelope which shall be sealed by the

registered medical practitioner or practitioners by whom such termination of pregnancy was performed and until that envelope is sent to the head of the hospital or owner of the approved place or the Chief Medical Officer of the State, it shall be kept in the safe custody of the concerned registered medical practitioner or practitioners, as the case may be.

- (2) On every envelope referred to in sub-regulation (1), pertaining to the termination of the pregnancy under Sec. 3, there shall be noted the serial number assigned to the pregnant women in the Admission Register the name of the registered medical practitioner or practitioners by whom the pregnancy was terminated and such envelope shall be marked 'secret'.
- (3) Every envelope referred to in sub-regulation (2) shall be sent immediately after the termination of the pregnancy to the head of the hospital or owner of the approved place where the pregnancy was terminated.
- (4) On receipt of the envelope referred to in sub-regulation (3), the head of the hospital or owner of the approved place shall arrange to keep the same in safe custody.
- 5) Every head of the hospital or owner of the approved place shall send to the Chief Medical Officer of the State, a weekly statement of cases where medical termination of pregnancy has been done in Form II.
- (6) On every envelope referred to in sub-regulation (1), pertaining to a termination of pregnancy under Sec. 5, shall be noted the name and address of the registered medical practitioner by whom the pregnancy was terminated and the date on which the pregnancy was terminated and such envelope shall be marked 'secret'.

Explanation. The columns pertaining to the hospital or approved place and the serial number assigned to the pregnant woman in the Admission Register shall be left blank in Form 1 in the case of termination performed under Sec. 5.

- (7) Where the pregnancy is not terminated in an approved place or hospital, every envelope referred to in sub-regulation (6) shall be sent by registered post to the Chief Medical Officer of the State on the same day on which the pregnancy was terminated or on the working day next following the day on which the pregnancy was terminated:

Provided that where the pregnancy is terminated in an approved place or hospital, the procedure provided in sub-regulations (1) to (6) shall be followed.

#### **5. Maintenance of Admission Register:**

- (1) Every head of the hospital or owner of the approved place shall maintain a register in Form III for recording therein the admissions of women for the termination of their pregnancies.
- (2) The entries in the Admission Register shall be made serially and a fresh serial shall be started at the commencement of each calendar year and the serial number of the particular year shall be distinguished from the serial number of other years by mentioning the year against the serial number, for example, serial number 5 of 1972 and serial number of 1973 shall be mentioned as 5/1972 and 5/1973.

- (3) The Admission Register shall be a secret document and the information contained therein as to the name and other particulars of the pregnant woman shall not be disclosed to any person.

**Comment**

Regulation 5 (3) provides for maintaining the secrecy of the information contained in the Admission Register by imposing the restriction on the disclosure of the same to any person.

6. **Admission Register not to be open to inspection:** The Admission Register shall be kept in the safe custody of the head of the hospital or owner of the approved place or by any person authorised by such head or owner and save as otherwise provided in sub regulation (5) of regulation 4 shall not be open to inspection by any person except under the authority of:

- (i) in the case of a departmental or other enquiry, the Chief Secretary to the Government of a Union Territory;
- (ii) in the case of an investigation into an offence, a Magistrate of the first class within the local limits of whose jurisdiction the hospital or approved place is situated;
- (iii) in the case of suit or other action for damages, the District Judge within the local limits of whose jurisdiction the hospital or approved place is situated.

Provided that the registered medical practitioner shall, on the application of an employed woman whose pregnancy has been terminated, grant a certificate for the purpose of enabling her to obtain leave from her employer:

Provided further that any such employer shall not disclose this information to any other person.

**Comment**

Under this regulation the employer is restricted from disclosing the information as to the termination of pregnancy of his female employee to any person.

7. **Entries in registers maintained in hospital or approved place:** No entry shall be made in any care-sheet, operation theatre register, follow-up card or any other document or register (except the Admission Register) maintained at any hospital or approved place indicating therein the name of the pregnant woman and reference of the pregnant woman shall be made therein by the serial number assigned to such woman in the Admission Register.

8. **Destruction of Admission Register and other Papers:** Save as otherwise directed by the Chief Secretary to the Union Territory Administration or for in relation to any proceeding pending before him, as directed by a District Judge or Magistrate of the first class, every Admission Register shall be destroyed on the expiry of a period of five years from the date of the last entry in that Register and other papers on the expiry of a period of three years from the date of the termination of the pregnancy concerned.

**Comment**

Normally the Admission Register should be destroyed on the expiry of a period of five years from the date of its last entry.

## Annexure 6

# Amended Medical Termination of Pregnancy Regulations, 2003

*MINISTRY OF HEALTH AND FAMILY WELFARE*  
( Department of Family Planning )

### *NOTIFICATION*

New Delhi, the 13<sup>th</sup> June April, 2003

**G.S.R. 486 (E)** - In exercise of powers conferred by section 7 of the Medical Termination of Pregnancy Act, 1971 (34 of 1971), the Central Government hereby makes the following regulations, namely ;

#### **1. Short title, extent and commencement -**

- (1) (1) These regulations may be called the Medical Termination of Pregnancy Regulations, 2003.
- (2) (2) They extend to all the Union territories.
- (1) (1) They shall come into force on the date of their publication in the Official Gazette.

#### **2. Definitions -** In these regulations, unless the context otherwise requires,

- (a) (a) "Act" means the Medical Termination of Pregnancy Act, 1971 (34 of 1971)
- (b) (b) (b) "Admission Register" means the register maintained under regulation 5;
- (c) (c) Chief Medical Officer of the **District** means the Chief Medical Officer of the **District** by whatever name called.
- (d) (d) "Form" means a form appended to these regulations;
- (e) (e) "hospital" means a hospital established or maintained by the Central Government or the Government of Union territory ;
- (f) (f) "section" means a section of the Act.

#### **3. Form of certifying opinion or opinions, -**

- (1) (1) Where one registered medical practitioner forms or not less than two registered medical practitioners form such opinion as is referred to in sub section (2) of section 3 or 5, he or she shall certify such opinion in Form I.
- (2) (2) Every registered medical practitioner who terminates any pregnancy shall, within three hours from the termination of the pregnancy certify such termination in Form I.

**4. Custody of forms, -**

- (1) (1) The consent given by a pregnant woman for the termination of her pregnancy, together with the certified opinion recorded under section 3 or section 5, as the case may be and the intimation of termination of pregnancy shall be placed in an envelope which shall be sealed by the registered medical practitioner or practitioners by whom such termination of pregnancy was performed and until that envelope is sent to the head of the hospital or owner of the approved place or the Chief Medical Officer of the State, it shall be kept in the safe custody of the concerned registered medical practitioner or practitioners, as the case may be.
- (2) (2) On every envelope referred to in sub-regulation (1), pertaining to the termination of pregnancy under section 3, there shall be noted the serial number assigned to the pregnant woman in the Admission Register and the name of the registered medical practitioner or practitioners by whom the pregnancy was terminated and such envelope shall be marked "SECRET".
- (3) (3) Every envelope referred to in sub-regulation (2) shall be sent immediately after the termination of the pregnancy to the head of the hospital or owner of the approved place where the pregnancy was terminated.
- (4) (4) On receipt of the envelope referred to in sub-regulation (3), the head of the hospital or owner of the approved place shall arrange to keep the same in safe custody.
- (5) (5) Every head of the hospital or owner of the approved place shall send to the Chief Medical Officer of the State, IN form II a monthly statement of cases where medical termination of pregnancy has been done.
- (6) (6) On every envelope referred to in sub-regulation (1), pertaining to the termination of pregnancy under section 5, there shall be noted the name and address of the registered medical practitioner by whom the pregnancy was terminated and the date on which the pregnancy was terminated and such envelope shall be marked "SECRET".

***Explanation, -***

The columns pertaining to the hospital or approved place and the serial number assigned to the pregnant woman in the Admission Register shall be left blank in Form I in the case of termination performed under section 5.

- (7) (7) Where the Pregnancy is not terminated in an approved place or hospital, every envelope referred to in sub-regulation (6) shall be sent by registered post to the Chief Medical Officer of the State on the same day on which the pregnancy was terminated or on the working day next following the day on which the pregnancy was terminated :

Provided that where the pregnancy is terminated in an approved place or hospital, the procedure provided in sub-regulations (1) to (6) shall be followed.

**5. Maintenance of Admission Register, -**

- (1) (1) every head of the hospital or owner of the approved place shall maintain a register in form III for recording there in the details of the admissions of women for the termination of their pregnancies and keep such register for a period of five years from the end of the calendar year it relates to.
- (2) (2) The entries in the Admission Register shall be made serially and a fresh serial shall be started at the commencement of each calendar year and the serial number of the particular year shall be distinguished from the serial number of other years by mentioning the year against the serial number, for example, serial number 5 of 1972 and serial number 5 of 1973 shall be mentioned as 5/1972 and 5/1973.
- (3) (3) Admission Register shall be a secret document and the information contained therein as to the name and other particulars of the pregnant woman shall not be disclosed to any person.

**6. Admission Register not to be open to inspection, -**

The Admission Register shall be kept in the safe custody of the head of the hospital or owner of the approved place, or by any person authorized by such head or owner and save as otherwise provided in sub-regulation (5) of regulation 4 shall not be open for inspection by any person except under the authority of law :-

Provided that the registered medical practitioner on the application of an employed woman whose pregnancy has been terminated, grant a certificate for the purpose of enabling her to obtain leave from her employer ;

Provided further that any such employer shall not disclose this information to any other person.

**7. Entries in registers maintained in hospital or approved place, -**

No entry shall be made in any case-sheet, operation theater register, follow-up card or any other document or register other than the admission Register maintained at any hospital or approved place indicating therein the name of the pregnant woman and reference to the pregnant woman shall be made therein by the serial number assigned to the woman in the Admission Register.

**Annexure 7**

**Forms, MTP Regulations, 1975**

**Form A**

[See Sub-rule (2) of Rule 4]

***Form of application for the approval of a place under C1. (b) of Sec.4***

- 1. Name of the place (in capital letters) .....
- 2. Address in full .....
- 3. Non-Governmental/Private Nursing Home/Other Institutions'.....
- 4. State, if the following facilities are available at the place .....

  - (i) An operation table and instruments for performing abdominal or gynaecological surgery.
  - (ii) Drugs and parenteral fluid in sufficient supply of emergency cases.
  - (iii) Anaesthetic equipment, resuscitation equipment and sterilisation equipment.

***Signature of the owner of the place.***

Place:

Date:

\*Strike out whichever is not applicable.

**Form B**

(See Sub-rule(6) of Rule 4]

***Certificate of approval***

The place described below is hereby approved for the purpose of the Medical Termination of Pregnancy Act, 1971 (34 of 1971).

Name of the owner .....

Name of the Place, Address and Other Descriptions.

.....  
.....

Place:

Secretary to the Government of .....

Date:

**Form C**  
(See Rule 8)

I ..... daughter/wife of .....  
aged about ..... years of .....  
..... (here state the permanent address)  
at present residing at .....  
do hereby give my consent of the termination of my pregnancy at .....  
.....  
(State name of a place where the pregnancy is to be terminated).

Signature:

Place:

Date:

**(To be filled by guardian where the woman is lunatic or minor)**

I ..... son/daughter/wife of .....  
aged about ..... of .....  
at present residing at .....  
(permanent address) ..... do hereby give my consent to the  
termination of the pregnancy of my ward .....  
who is a minor/lunatic at.....  
(place of termination of pregnancy).

Signature:

Place:

Date:

**FORM I**  
(See Regulation 3)

**Opinion and intimation of MTP referred to in Sub-section (2) of Section 3**

I .....  
(Name and qualification of the Registered Medical Practitioner in block letters)

.....  
(Full address of the Registered Medical Practitioner)

I .....  
(Name and qualification of the Registered Medical Practitioner in block letters)

.....  
(Full address of the Registered Medical Practitioner)

hereby certify that \*I/we/am/are of opinion, formed in good faith, that it is necessary to terminate the pregnancy of .....

(Full name of pregnant woman in block letters)  
resident of .....

for the reason given below\*\*,

\*I/we hereby give intimation that \*I/we terminated the pregnancy of the woman referred to above who bears the serial No..... in the Admission Register of the Hospital/ approved place.

***Signature of Registered Medical Practitioner***

Place:

Date:

\* Strike out whichever is not applicable.

\*\* Of the reasons specified items (i) to (v) write the one which is appropriate:

- (i) In order to save the life of the pregnant woman.
- (ii) In order to prevent grave injury to the physical or mental health of pregnant woman.
- (iii) In view of the substantial risk that if the child was born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

- (iv) As the pregnancy is alleged by pregnant woman to have been caused by rape.
- (v) As the pregnancy has occurred as a result of failure of any contraceptive device or method used by the married woman or her husband for the purpose of limiting the number of children.

NOTE: Account may be taken of the pregnant women's actual or reasonably foreseeable environment in determining whether the continuance of a pregnancy would involve a grave injury to her physical or mental health.

***Signature of the Registered Medical Practitioner***

Place:

Date:

**FORM II**

[See Regulation 4(5)]

**Secret intimation of termination of pregnancy**

1. Name of the State
2. Name of hospital/approved place.
3. Duration of pregnancy (give total number only)
  - (a) up to 12 weeks.
  - (b) Between 12--20 weeks.
4. Religion of woman:
  - (a) Hindu
  - (b) Muslim
  - (c) Christian
  - (d) Others
  - (e) Total
5. Termination with acceptance of contraception:
  - (a) Sterilisation
  - (b) I.U.D.
- (6) Reasons of termination: (give total number under each sub-head):
  - (a) Danger to life of the pregnant woman.
  - (b) Grave injury to the mental health of the pregnant woman.
  - (c) Grave injury to the physical health of the pregnant woman.
  - (d) Pregnancy caused by rape.
  - (e) Substantial risk that if the child was born it would suffer from such physical or mental abnormalities as to be seriously handicapped.
  - (f) Failure of any contraceptive device or method.

***Signature of the officer in-charge with date***

**Form III**  
(See Regulation 5)

**Admission Register**

(To be destroyed on the expiry of five years from the date of the last entry in the Register)

<b>S. No.</b> <b>(1)</b>	<b>Date of Admission</b> <b>(2)</b>	<b>Name of Patient</b> <b>(3)</b>	<b>Wife/ Daughter of</b> <b>(4)</b>	<b>Age</b> <b>(5)</b>	<b>Religion</b> <b>(6)</b>	<b>Address</b> <b>(7)</b>

<b>Duration of Pregnancy</b> <b>(8)</b>	<b>Reasons of which pregnancy is terminated</b> <b>(9)</b>	<b>Date of Termination of pregnancy</b> <b>(10)</b>	<b>Date of discharge of patient</b> <b>(11)</b>	<b>Result and remarks</b> <b>(12)</b>	<b>Name of Registered Medical Practitioner(s) by whom the opinion is formed</b> <b>(13)</b>	<b>Name of Registered Medical Practitioner(s) by whom Pregnancy is terminated</b> <b>(14)</b>

## Annexure 8

### Amended Forms, MTP Regulations, 2003

#### FORM A

( See sub-rule (2) of rule 5 )

Form of application for the approval of a place under clause (b) of section 4 Category of approved place:

A Pregnancy can be terminated upto 12 weeks

B Pregnancy can be terminated upto 20 weeks

1. 1. Name of the place ( in capital letters )
2. 2. Address in full
3. 3. Non-Government/Private/Nursing Home/Other Institutions
4. 4. State, if the following facilities are available at the place

#### Category A

- i) i) Gynecological examination / labour table.
- ii) ii) Resuscitation equipment.
- iii) iii) Sterilization equipment.
- iv) iv) Facilities for treatment of shock, including emergency drugs.
- v) v) Facilities for transportation, if required.

#### Category B

- ii) ii) An operation table and Instruments for performing abdominal or gynaecological surgery.
- iii) iii) Drugs and parental fluid in sufficient supply for emergency cases.
- iv) iv) Anaesthetic equipment, resuscitation equipment and sterilization equipment.

Place :

Date :

Signature of the owner of the place

**FORM B**  
**( See sub-rule (6) of rule 5 )**

**Certificate of approval.**

The place described below is hereby approved for the purpose of the Medical termination of Pregnancy Act, 1971 ( 34 of 1971).

AS READ WITHIN UPTO—————WEEKS

Name of the Place

Address and other descriptions

Name of the owner

Place :

Date :

to the Government of the \_\_\_\_\_

**FORM C**  
**( See rule 8 )**

I ..... daughter/wife  
of .....  
aged about ..... years of .....

.....  
( here state the permanent address)

at present residing at .....

do hereby give my consent to the termination of my pregnancy at .....

.....  
( State the name of place where the pregnancy is to be terminated)

**Place :**

Date :

Signature

**( To be filled in by guardian where the woman is a *mentally ill person* or minor )**

I ..... son/daughter/wife of  
.....  
aged about ..... years of ..... at present residing at  
(Permanent address) .....

..... **do**

**hereby give my consent to the termination of the pregnancy of my ward .....**

**who is a minor/lunatic at .....**

**( place of termination of my pregnancy)**

Place :

Date :

Signature

**FORM I**  
**[ See Regulation 3 ]**

I .....  
( Name and qualifications of the Registered Medical practitioner in block letters )

.....  
( Full address of the Registered Medical practitioner )

I .....  
( Name and qualifications of the Registered Medical practitioner in block letters )

.....  
( Full address of the Registered Medical practitioner ) hereby certify that \*I/We am/are of  
opinion, formed in good faith, that it is necessary to terminate the pregnancy of

.....  
( Full name of pregnant women in block letters ) resident of

.....  
( Full address of pregnant women in block letters )

for the reasons given below\*\*.

\* I/We hereby give intimation that \*I/We terminated the pregnancy of the woman referred to  
above who bears the serial no. .... in the Admission Register of the hospital/  
approved place.

Signature of the registered Medical Practitioner

Signature of the registered Medical Practitioners

Place :

Date :

\* Strike out whichever is not applicable,

\*\* of the reasons specified items (i) to (v) write the one which is appropriate.

- i) i) in order to save the life of the pregnant women,
- ii) ii) in order to prevent grave injury to the physical and mental health of the pregnant women,
- iii) iii) in view of the substantial risk that if the child was born it would suffer from such physical or mental abnormalities as to be seriously handicapped,
- iv) iv) as the pregnancy is alleged by pregnant women to have been caused by rape,
- v) v) as the pregnancy has occurred as result of failure of any contraceptive device or methods used by married woman or her husband for the purpose of limiting the number of children

Note : Account may be taken of the pregnant women's actual or reasonably foreseeable environment in determining whether the continuance of her pregnancy would involve a grave injury to her physical or mental health.

Place :

Date :

Signature of the Registered Medical Practitioner

Signature of the Registered Medical Practitioners

**FORM II**  
**[ See Regulation 4(5) ]**

1. 1. Name of the State
1. 2. Name of the Hospital/approved place
2. 3. Duration of pregnancy ( give total No. only )
  - (a) (a) Up to 12 weeks.
  - (b) (b) Between 12 - 20 weeks
3. 4. Religion of woman
  - (a) (a) Hindu
  - (b) (b) Muslim
  - (c) (c) Christian
  - (d) (d) Others
  - (e) (e) Total
4. 5. Termination with acceptance of contraception.
  - (a) (a) Sterilisation.
  - (b) (b) I.U.D.
5. 6. Reasons for termination :  
( give total number under each sub-head )
  - (a) (a) Danger to life of the pregnant woman.
  - (b) (b) Grave injury to the physical health of the pregnant woman.
  - (c) (c) Grave injury to the mental health of the pregnant woman.
  - (d) (d) Pregnancy caused by rape.
  - (e) (e) Substantial risk that if the child was born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.
  - (f) (f) Failure of any contraceptive device or method.

Signature of the Officer Incharge with Date

**FORM III**  
**( See Regulation 5 )**

**ADMISSION REGISTER**

( To be destroyed on the expiry of five years from the dated of the last entry in the Register )

<b>S. No.</b> <b>(1)</b>	<b>Date of Admission</b> <b>(2)</b>	<b>Name of Patient</b> <b>(3)</b>	<b>Wife/ Daughter of</b> <b>(4)</b>	<b>Age</b> <b>(5)</b>	<b>Religion</b> <b>(6)</b>	<b>Address</b> <b>(7)</b>

<b>Duration of Pregnancy</b> <b>(8)</b>	<b>Reasons of which pregnancy is terminated</b> <b>(9)</b>	<b>Date of Termination of pregnancy</b> <b>(10)</b>	<b>Date of discharge of patient</b> <b>(11)</b>	<b>Result and remarks</b> <b>(12)</b>	<b>Name of Registered Medical Practitioner(s) by whom the opinion is formed</b> <b>(13)</b>	<b>Name of Registered Medical Practitioner(s) by whom Pregnancy is terminated</b> <b>(14)</b>

## Annexure 9

### List of Documents Required for Registration

#### List of documents that need to be submitted at the time of application for registration of a centre for MTP

1. Cover letter addressed to the Deputy Director (Circle)/Civil Surgeon
2. Form A (application form).
3. Modified form — inspection of institution applying for purpose of MTP.
4. MBBS certificate of doctor performing MTP.
5. State Medical Council Registration certificate of doctor performing MTP.
6. MD/DGO certificate of doctor performing MTP.
7. Three separate experience certificates of doctor performing MTP for 3 residency posts.
8. Certificate showing experience of having done MTPs in a Government approved hospital.
9. Statement from doctor that he/she will attend all MTP cases.
10. MBBS certificate of anaesthetist.
11. State Medical Council Registration certificate of anaesthetist.
12. MD/DA certificate of anaesthetist.
13. Experience certificate of anaesthetist.
14. Statement from anaesthetist that he/she will attend all MTP cases.
15. BAMS certificate of doctor assisting MTP
16. State Medical Council Registration certificate of doctor assisting MTP
17. Diploma certificate of doctor assisting MTP.
18. Experience certificate of doctor assisting MTP.
19. Experience certificate from a Government approved hospital stating that the doctor has assisted in MTPs for at least 3 years.
20. Registration certificate of the hospital which issues the MTP experience certificate to the doctor.
21. Statement from the Centre seeking registration about the distance of the MTP centre to the nearest blood bank which supplies blood to the hospital.
22. Certificate from the Blood Bank that it will supply blood to the hospital seeking registration.
23. Statement from the Owner of the hospital seeking registration that the hospital will not perform MTPs till approval is given by the Government.
24. Registration certificate of the hospital either under the Bombay Public Charitable Trust Act or under the Bombay Nursing Home Act.
25. Certificate showing area of hospital seeking MTP registration.
26. Certificate from the Microbiology Department of a Medical College that the operation theatre is sterile based on a negative Swab report.

Total number of documents required — 28.

## International Consensus Documents

### **International consensus documents relevant to safe abortion**

#### ***1974 World Population Conference, Bucharest Plan of Action.***

'All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so' **Para 14(f).**

#### ***1984 Recommendations for the further implementation of the World Population Conference Plan of Action, Mexico City.***

'The World Population Plan of Action recognizes, as one of its principles, the basic human right of all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children. For this right to be realized, couples and individuals must have access to the necessary education, information and means to regulate their fertility, regardless of the overall demographic goals of the Government' **Para 24.**

#### ***1994 Program of Action adopted at the International Conference on Population and Development, Cairo.***

'In no case should abortion be promoted as a method of family planning. All government and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion<sup>1</sup> as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. Prevention of unwanted pregnancy must always be given the highest priority and all attempts should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process.

---

<sup>1</sup> Unsafe abortion is defined as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both (based on World Health Organization, The prevention and management of unsafe abortion, Report of a Technical Working Group, Geneva, April 1992 (WHO/MSM/92.5).

'In circumstances in which abortion is not against the law, such abortion should be safe. In all cases women should have access to quality services for the management of complications arising from abortion. Post abortion counselling, education and family planning services should be offered promptly which will also help to avoid repeat abortions' **Para 8.25.**

#### ***1995 Fourth World Conference on Women, Beijing.***

'Governments in collaboration with non-governmental organizations and employers' and workers' organizations and with the support of international institutions should:

- Recognize and deal with the health impact of unsafe abortion as a major public health concern, as agreed in para 8.25 of the Program of Action of the International Conference on Population and Development;

- In the light of para 8.25 of the Program of Action of the International Conference on Population and Development .... Consider reviewing laws containing punitive measures against women who have undergone illegal abortions' **Para 106(j)(k)**.

***1999 Key actions for the further implementation of the Program of Action of the International Conference on Population and Development.***

'Governments should take appropriate steps to help women avoid abortion, which in no case should be promoted as a method of family planning, and in all cases provide for the humane treatment and counselling of women who have had recourse to abortion' **Para 63ii**. 'In recognizing and implementing the above, and in circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortions is safe and accessible. Additional measures should be taken to safeguard women's health' **Para 63iii**.

***2000 Further actions and initiatives to implement the Beijing Declaration and the Platform for Action.***

'Design and implement programs with the full involvement of adolescents as appropriate, to provide them with education, information and specific, user-friendly and accessible services without discrimination to address effectively their reproductive and sexual health needs taking into account their right to privacy, confidentiality, respect and informed consent and the responsibilities, rights and duties of parents and legal guardians to provide in a manner consistent with the evolving capacities of the child appropriate direction and guidance in the exercise by the child of the rights recognized in the Convention on the Rights of the Child and in conformity with CEDAW and ensuring that in all actions concerning children, the best interests of the child are a primary consideration' **Para 79**.

## Annexure 11

### **National Population Policy, 2000** *(Department of Family Welfare, Ministry of Health & Family Welfare, Government of India, New Delhi)*

Section H: Promotional and motivational measures for adoption of the small family norm

(46) The following promotional and motivational measures will be undertaken:

(ix) Facilities for safe abortion will be strengthened and expanded.

#### **National Population Policy, 2000 Action Plan**

Operational strategies relevant to section H (46)(ix):

- 13) Expand the availability of safe abortion care. Abortion is legal, but there are barriers limiting the women's access to safe abortion services. Some operational strategies are:
- i) Community level education campaigns should target women, household decision makers, and adolescents about the availability of safe abortion services, and the dangers of unsafe abortion.
  - ii) Make safe and legal abortion services more attractive to women and household decision makers by (a) increasing geographic spread; (b) enhancing affordability; (c) ensuring confidentiality; and (d) providing compassionate abortion care, including post-abortion counselling.
  - iii) Adopt updated and simple technologies that are safe and easy, e.g. manual vacuum extraction not necessarily dependent upon anaesthesia, or non-surgical techniques which are non-invasive.
  - iv) Promote collaborative arrangements with private sector health professionals, NGOs and the public sector, to increase the availability and coverage of safe abortion services, including training of mid-level providers.
  - v) Eliminate the current cumbersome procedures for registration of abortion clinics. Simplify and facilitate the establishment of additional training centres for safe abortions in the public, private, and NGO sectors. Train these health care providers in provision of clinical services for safe abortion.
  - vi) Formulate and notify standards for abortion services. Strengthen enforcement mechanisms at district and sub-district levels, to ensure that these norms are followed.
  - vii) Follow norms-based registration of service provision centres, and thereby switch the onus of meticulous observation of standards onto the provider.
  - viii) Provide competent post-abortion care, including management of complications and identification of other health needs of post-abortion patients, and linking with appropriate services. As part of post-abortion care, physicians may be trained to provide family planning counselling and services such as sterilization, and reversible modern methods such as IUDs, as well as oral contraceptives and condoms.
  - ix) Modify syllabus and curricula for medical graduates, as well as for continuing education and in-house learning, to provide for practical training in the newer procedures.
  - x) Ensure services for termination of pregnancy at primary health centres and at community health centres.

# About The Author

## **Siddhivinayak Hirve, MS, MPH**

Siddhivinayak Hirve, a General Surgeon by training, also holds a Master's degree in Public Health in Epidemiology from the Harvard School of Public Health, Boston, USA. He has been involved in various biomedical and social science research while at the KEM Hospital Research Center, Pune. He has received the John D and Catherine T MacArthur Foundation Fellowship for Leadership Development (1998 - 2000) and was also awarded a post-doctoral Fellowship (2000-2001) at the Bill & Melinda Gates Institute for Population and Reproductive Health, Johns Hopkins University Bloomberg School of Public Health, Baltimore, USA.

Siddhivinayak is currently Director of the Vadu Rural Health Program, comprising the Shirdi Sai Baba Hospital, a rural hospital and community based health outreach program of the KEM Hospital, Pune which is involved in providing primary health care to a population of about 64,000 over 22 villages in rural Pune district. He pursues his research interests in reproductive health through several collaborations both nationally and internationally.

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Research Centre of Anusandhan Trust**

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# **CEHAT**

**(Centre For Enquiry Into Health And Allied Themes)**  
**Research Centre Of Anusandhan Trust**

CEHAT, in Hindi means "Health". CEHAT, the research centre of Anusandhan Trust, stands for research, action, service and advocacy in health and allied themes. Socially relevant and rigorous academic health research and action at CEHAT is for the well being of the disadvantaged masses, for strengthening people's health movements and for realising right to health care. Its institutional structure acts as an interface between progressive people's movements and academia.

CEHAT's objectives are to undertake socially relevant research and advocacy projects on various socio-political aspects of health; establish direct services and pro-programmes to demonstrate how health services can be made accessible equitably and ethically; disseminate information through databases and relevant publications, supported by a well-stocked and specialised library and a documentation centre.

We are a multi disciplinary team with training and experience in Medicine, Life Sciences, Economics, Social Sciences, Social Work, Journalism and Law. CEHAT's projects are based on its ideological commitments and priorities, and are focused on four broad themes, (1) Health Services and Financing (2) Health Legislation, Ethics and Patients' Rights, (3) Women's Health, (4) Investigation and Treatment of Psycho-Social Trauma. An increasing part of this work is being done collaboratively and in partnership with other organisations and institutions.

## ***Healthwatch Trust***

Health Watch Trust is a network of field based or national organisations, researchers, women's health advocates and social activists who are concerned about women's well being. The group was informally formed prior to the International Conference on Population and Development (ICPD), held in Cairo in 1994 and has since expanded to include those who are committed to promoting a holistic approach to health, population and development.

The objectives are to translate the national and international commitments made in Cairo (1994) to concrete programmes in India, to engage in constructive yet critical dialogue with the government at multiple levels and to lobby for a shift in the family welfare programme for provider-driven to people-centred programme; to strengthen public and primary health care and related aspects of development, especially education and women's economic, social and political empowerment; in particular to advocate restructuring government programmes based on vibrant NGO experiences in this area and link these interventions to reproductive health and rights; to provide a forum for effective networking among like minded NGOs; to provide a forum for continuous exchange of information and sharing of ideas and experiences among NGOs themselves.

The network has made concerted efforts to sustain the free and frank dialogue initiated before and after ICPD with the government and donor agencies.

Health Watch brings out UPDATE an occasional newsletter to share information and experiences of NGOs, researchers and activists, government officials, donor agencies, media personnel, etc.