

Medical Termination of Pregnancy (Amendment Bill, 2021): Is it Enough for Indian Women Regarding Comprehensive Abortion Care??

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Abstract

Medical termination of pregnancy (MTP) has been legalized in India since 1971 considering the huge burden of unsafe abortions. Even after about 50 years, Indian women continued to have unsafe abortions and face adverse and fatal consequences. At this point, only legislative amendments may not be sufficient but along with that, many other aspects need to be considered like awareness, availability, accessibility, affordability of quality MTP services, and contraceptives. People should know the adverse effects of taking unsupervised medical termination pills. Comprehensive abortion care should be provided at every level of health care to ensure the good reproductive health of the women.

Keywords: Abortion, Indian women, MT pills, medical termination of pregnancy act, unsafe abortion

INTRODUCTION

Complications arising from spontaneous and unsafe induced abortion are recognized worldwide as a major public health concern and are one of the important attributes of influencing maternal morbidity and mortality (ACOG 2009).^[1] In 1964, the Ministry of Health and Family Welfare constituted Shanti Lal Shah Committee to investigate the causes of the increasing number of abortion cases. Then, in 1970, this Committee recommended the MTP Bill, which was passed in August 1971 as the Medical Termination of Pregnancy (MTP) Act.^[2]

In all types of abortions including medical abortion also, it is always recommended to be supervised by trained health care providers with a medical prescription. Medical abortion with mifepristone and misoprostol is a very safe option for termination of pregnancy when consumed under medical supervision with a success rate of 92%–97%.^[3] Clear guidelines have been formulated by organizations like WHO and in India by FOGSI regarding the use of abortion pills.^[4]

However, safe abortion services are still inaccessible to many women especially those residing in rural and remote areas. Due to inaccessibility and lack of awareness, women

seek unsafe abortion practices.^[5-7] The amendment done in 2002 allows medication abortion up to 7 weeks' gestation. In 2003, it was further amended allowing certified providers to prescribe medication abortion drugs outside of a registered facility as long as emergency facilities were available to them.^[8] Despite such clear guidelines and recommendations, self-administration of these drugs by pregnant women has become highly prevalent due to the availability of these drugs over the counter. Many women depend on medical abortion and consider it as a method of spacing between pregnancies.^[9]

Till 2017, there was a dichotomous classification of abortion as safe and unsafe. However, with abortion technology now becoming safer, this has been replaced by a three-tier classification, which is as follows:

- Safe abortion: Provided by healthcare workers and with methods recommended by the WHO

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- Less safe abortion: Done by trained providers using non-recommended methods or using a safe method (e.g., misoprostol) but without adequate information or support from a trained individual
- Least safe abortion: Done by a trained provider using dangerous, invasive methods.^[10]

Comprehensive Abortion Care (CAC), is defined as “rooted in the belief that women must be able to access high-quality, affordable abortion care in the communities where they live and work,” was first introduced in India by IPAS in 2000. The concept of CAC encompasses care through the entire period from conception to postabortion care and includes pain management.

Even after 50 years of MTP Act (1971), the scenario of unsafe abortions is very distressing. Almost 56% of abortions in India are under the category of unsafe. It was found that 15.6 million abortions (14.1 million–17.3 million) occurred in India in 2015. There were 3.4 million abortions (22%) carried out in health facilities and 11.5 million (73%) abortions were medication abortions done outside of health facilities, and 0.8 million (5%) abortions were done outside of health facilities using methods other than medication abortion. Overall, 12.7 million (81%) abortions were medication abortions, 2.2 million (14%) abortions were surgical, and 0.8 million (5%) abortions were done through other methods that were probably unsafe.^[11]

Considering this huge burden of unsafe abortions, Rajya Sabha passed the MTP (Amendment) Bill, in 2021. The Bill was passed by the lower house in 2020.^[12] Salient features of this bill are:

1. The Bill permits abortion to be allowed up to 20 weeks on the opinion of just one medical practitioner
2. To terminate pregnancies between 20 and 24 weeks, the opinion of two doctors is required. This extension of the gestation period up to 24 weeks is given for special categories of women such as rape/incest victims, differently-abled women, and minors
3. For abortions beyond 24 weeks, a state-level Medical Board will decide if it can be permitted, in case of substantial fetal abnormalities
4. Only doctors with specialization in Gynaecology/Obstetrics can perform abortions
5. According to the Bill, the “name and other particulars of a woman whose pregnancy has been terminated shall not be revealed”, except to a person authorized by law
6. In cases where abortions are desired to terminate pregnancies arising out of rape, where the gestation period exceeds 24 weeks, the only manner would be through a writ petition.

Challenges for achieving comprehensive abortion care

Many obstacles are in the way of CAC:

1. There is still a shortage of qualified health care providers who can provide abortion. In 2017, 1.33 billion of the Indian population is being served by 1.8 million registered

medical graduates (including AYUSH Practitioners). Hence, the ratio is 1.34 doctors for 1,000 Indian citizens as of 2017. This means that India has already reached the WHO norm of 1:1000 doctor population ratio even considering the most conservative estimates including stringent attrition criteria.^[13]

However, India is a country of villages where 68.8% population^[14] live. In rural areas, few doctors want to work. As a result, the rural population suffered various complications and consequences due to a lack of professional services to abortions.

2. In remote and rural areas, there are lot of quacks, faith healers, guni-ojha, and baba. They are delivering several healthcare services through their shrewd guesswork and malpractices including abortion services. They tend to apply multiple methods to induce abortion such as herbal medicines, jadi-buti (herbs),^[15] abdominal massage, insertion of stick or, other sharp objects in genital parts.^[16] Due to the application of these methods, patients ultimately face unsafe abortion.
3. Stigma associated with abortion services are still prevalent in society. A woman cannot disclose their decision of abortion even to their husbands, in-laws, and family members.
4. Mothers used to take MT pills used to take without supervision, without reading any instruction regarding dosage, interval, and side-effects. In many cases, they report hospitals as cases of complicated abortions.
5. Lack of awareness regarding MTP Act, its conditions, and its amendments among the general population, particularly in hilly, tribal, and difficult to reach areas.^[17]
6. Lack of contraceptive awareness and non-availability of contraceptives are major roadblocks in achieving the targets of CAC, especially among unmarried and teenaged mothers.^[18]

Way forward

1. Increasing the availability of registered healthcare providers in tribal, rural, and difficult to reach areas is essential to provide CAC. In this regard, MTP Act was amended in 2014 stating about expanding the provider base. These recommendations are supported by two Indian studies^[19,20] that conclude abortion care can safely and effectively be provided by nurses and AYUSH practitioners. Furthermore, it is the need of the hour that ASHAs and AWWs should be aware about the dosage, interval, and possible side-effects of MT Pills.
2. MT Pills should always be given on the basis of prescription from the Registered Medical Practitioners (RMPs).
3. Unregistered medical practitioners including quacks, ojha-guni, and baba should be discouraged and could be replaced by registered health care providers.
4. Awareness regarding various elements of CAC is particularly important to reduce the incidences of unsafe abortions. Awareness activities should focus on the

following points:

- i. Government legislation on abortion such as MTP act 1971, amendments in 2002,203,2014)-its conditions, and services offered
- ii. Seeking abortion is not a social stigma, but it is a matter of choice. Every mother has right to choose between the continuation of pregnancy or termination^[10]
- iii. About various contraceptive devices including MT pills, its eligibility, side-effects, and contraindications should be disseminated in remote and rural areas
- iv. Importance of follow-up care after abortion should be disseminated to all women
- v. ASHA workers should be incentivized also regarding completion of CAC for any women
- vi. Adolescents (10–19 years) should be educated regarding early pregnancy testing by urine pregnancy kits and CAC including its accessibility and availability.

CONCLUSION

Along with Government legislation, several other factors need to be re-considered for achieving CAC for women. Information, education, and communication could be an effective tool regarding the generation of awareness about the MTP Act, contraceptives including detailed information of MT Pills, follow-up care after abortion, etc.

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Conflicts of interest

There are no conflicts of interest.

REFERENCES

1. ACOG. Misoprostol for Postabortion Care: ACOG Committee Opinion. The American College of Obstetricians and Gynecologists. Report No: 427 November, 2009.
2. Gaur KD. Abortion and the Law in India. Cochin Univ Law Rev 1991;15:123-43.
3. FOGSI Focus on Medial Abortion. FOGSI-ICOG-GCPR Guidelines; 2011. Available from: <http://www.issuu.com/fogsi/does/medical-abortion-2011>. [Last accessed on 2020 Aug 07].
4. World Health Organization. Safe Abortion: Technical and Policy Guidelines for Health Systems. World Health Organization; 2012. p. 1-7. Available from: www.apps.who.int/iris/bitstream/10665/709141/9789241548434_eng.pdf. [Last accessed on 2020 Aug 07].
5. Jejeebhoy S, Zavier AJ, Acharya R, Kalyanwala S. Increasing Access to Safe Abortion in Rural Maharashtra: Outcomes of a Comprehensive Abortion Care Model. New Delhi: Population Council, Government of India; 2011.
6. Powell-Jackson T, Acharya R, Filippi V, Ronsmans C. Delivering medical abortion at scale: A study of the retail market for medical abortion in Madhya Pradesh, India. *PLoS One* 2015;10:e0120637.
7. Tariq M, Chaudhury N, Kapoor A. Medical Abortion Drug Dispensing Behavior among Pharmacists in India. In: XXVII IUSSP International Population Conference; Busan, South Korea.
8. Available from: <https://main.mohfw.gov.in/acts-rules-and-standards-health-sector/acts/mtp-act-amendment-2002>. [Last accessed on 2020 Aug 07].
9. Kaur Sukhwinder B, Singh Sukhminder Jit B, Kaur Gangdeep G, Nirankar S, Anita S, Goraya SP. Medical abortion: Is it a blessing or curse for the developing nations? *Srilanka J Obstet Gynaecol* 2011;33:84-90.
10. Ganatra B, Gerdts C, Rossier C, Johnson BR Jr., Tunçalp Ö, Assifi A, *et al.* Global, regional, and subregional classification of abortions by safety, 2010-14: Estimates from a Bayesian hierarchical model. *Lancet* 2017;390:2372-81.
11. Sedgh G, Bearak J, Singh S, Bankole A, Popinchalk A, Ganatra B, *et al.* Abortion incidence between 1990 and 2014: Global, regional, and subregional levels and trends. *Lancet* 2016;388:258-67.
12. Available from: <https://pib.gov.in/PressReleasePage.aspx?PRID=170538>. [Last accessed on 2020 Aug 07].
13. Kumar R, Pal R. India achieves WHO recommended doctor population ratio: A call for paradigm shift in public health discourse! *J Family Med Prim Care* 2018;7:841-4.
14. Available from: <https://censusindia.gov.in/2011-common/censusdata2011.html>. [Last accessed on 2020 Aug 07].
15. Khan AV, Herbal abortifacients used by folk people of some districts of western Uttar Pradesh (India). *J Nat Rem* 2003;3:41-4.
16. Varkey P, Balakrishna PP, Prasad JH, Abraham S, Joseph A. The reality of unsafe abortion in a rural community in South India. *Reprod Health Matters* 2000;8:83-91.
17. Malhotra A, Nyblade L, Parasuraman S, Macquarrie K, Kashyap N, Walia S. Realizing Reproductive Choice and Rights: Abortion and Contraception in India. Washington, DC: International Center for Research on Women; 2003.
18. Kumari S, Kishore J, Pandit V. Teenage marriages and induced abortion among women of reproductive age group (15-49 years) residing in an urbanized village of Delhi. *Indian J Youth Adolesc Health* 2019;6:15-20.
19. Sukhwinder BK, Sukhminder Jit BS, Gangdeep GK. Medical abortion: Is it a blessing or curse for the developing nations? *Sri Lanka J Obstet Gynaecol* 2011;33:84-90.
20. Puwar B, Puwar T, Trivedi KN. Study of infertility indicators in slum areas of Ahmabad city in India. *Internet J Health* 2009;9:9.