

INDIA

PAC-FP COUNTRY BRIEF



Postabortion care (PAC) provides a comprehensive approach to preventing morbidity and mortality caused by abortion complications (PAC Consortium, 2014). As per the U.S. Agency for International Development (USAID) PAC model, a critical component of PAC is providing access to family planning (FP) counseling and services. Providing these services helps meet the reproductive intentions of women who most clearly demonstrate an unmet need for FP, reduces unintended pregnancies, and prevents repeat abortions, thus reducing maternal deaths (Curtis, Huber, and Moss-Knight, 2010). The information below highlights the Republic of India's investment in providing PAC and FP services to women in need.

POLICIES, LEADERSHIP, AND GOVERNANCE

The Republic of India's national policy on family planning (FP) and reproductive health (RH) is outlined in a number of documents, including the revised National Health Policy draft (2015), the National Population Policy (2000), and the National Health Mission Policy and Planning Document (2013). The latter document aims for the "attainment of universal access to equitable, affordable, and quality healthcare services, accountable and responsive to people's needs, with effective inter-sectoral convergent action to address the wider social determinants of health" (Ministry of Health and Family Welfare, 2013). Among its health system strengthening aims, India's National Health Mission prioritizes universal health coverage for reproductive, maternal, newborn, child, and adolescent health.

Specific guidelines discussing postabortion care (PAC) include the Comprehensive Abortion Care Training and Service Delivery Guidelines (2010) and the Guidance Handbook on Ensuring Access to Safe Abortion and Addressing Gender-Based Sex Selection (2015).

Legal Status on Abortion

In India, the Medical Termination of Pregnancy Act, which was passed in 1971, allows for abortions to save the life of the woman or preserve her physical or mental health; in the instances of economic or social necessity, rape, incest, or contraceptive failure; and if there is substantial risk that the child would be seriously handicapped (Stillman et al, 2014).

PAC TRAINING AND STANDARDS

The government developed comprehensive abortion care guidelines, which include PAC, in 2010. The government revised these guidelines 2014 with the aim of assisting healthcare providers in achieving or maintaining optimum standards of care, strengthening and improving PAC, and promoting women-centric care in the provision of these services (Ministry of Health and Family Welfare, 2010). These guidelines address the provision of manual vacuum aspiration, electronic vacuum aspiration, and dilatation and evacuation, as well as use of medical methods including mifepristone and misoprostol for PAC (Ministry of Health and Family Welfare, 2010). Only medical doctors and chief medical officers can provide PAC, including manual vacuum aspiration, dilatation-curettage, and misoprostol. The guidelines also cover pre- and post-procedure counseling and postabortion FP methods.

STRENGTHENING SERVICE DELIVERY

To strengthen service delivery and increase voluntary contraceptive use among postabortion and postpartum women, India increased the distribution and provision of postpartum intrauterine devices. The government launched this program in 19 states in 2012 and 2013 and is implementing it nationwide. An average of two million postpartum intrauterine devices insertions have been reported since the program launch, thanks to nurse task-sharing and an expanded role for accredited social health activists (ASHAs) in counseling women on contraceptive methods at the community level (FP2020, 2016). ASHAs have contributed to



PAC-FP THE POSTABORTION CARE
FAMILY PLANNING PROJECT
Expanding contraceptive methods and informed choice to PAC clients



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an increase in access to voluntary contraceptive methods: 0.9 million ASHAs provide contraceptives to 0.64 million villages across 670 districts (FP2020, 2016).

From an infrastructure standpoint, India has supported the creation of 6,500 new primary health facilities, 600 secondary facilities, and 41 tertiary facilities (FP2020, 2016). To strengthen service delivery, the government has upgraded and accredited the facilities for PAC service provision in accordance with national guidelines.

BARRIERS TO PAC

Women in India face multiple barriers to accessing PAC and FP services. The primary obstacle is the lack of knowledge about PAC. Women also face socioeconomic constraints; for example, they often need men or peers to accompany them to the facility to receive these life-saving services. Furthermore, facilities are often located far from home, which in turn leads to needs for childcare support and funds for transport (in addition to service costs)—all of which further constrain access (Iyengar, Iyengar, and Danielsson, 2016).

At the facility level, varying levels of care provided in rural urban areas often result in rural women receiving PAC and FP services from untrained or uncertified providers who may promote FP misconceptions (Iyengar, Iyengar, and Danielsson, 2016). In health facilities with trained personnel, a lack of accountability frequently results in poor FP service uptake (Banerjee et al., 2015).

FINANCING MECHANISMS

While the country does not have a national health insurance plan, PAC and FP services are available at public health facilities for free.

Despite national guidelines on PAC, the states are responsible for administering health programming. As a result, health expenditures vary significantly from state to state. While the government provides guidance and limited financing, states develop their own FP budgets based on individual needs.

India has the capability of manufacturing FP commodities by financing the national program with federal funds. In 2015–2016, the total budget for FP, not including the state-specific budget, was approximately \$365 million (FP2020, 2016).

| INDIA | | Year | Source | |
|---|---------------|-----------|--|--|
| Demographic/background indicators | | | | |
| Country population | 1.339 billion | 2017 | World Bank ¹ | |
| Total fertility rate | 2.2 | 2015–16 | Demographic and Health Survey/National Family Health Survey, 2015–16 | |
| Maternal mortality per 100,000 live births | 167 | 2013 | UNICEF ² | |
| Age at first birth | 21.0 | 2015–16 | Demographic and Health Survey/National Family Health Survey, 2015–16 | |
| Newborn mortality per 1,000 live births | 30 | | | |
| Infant mortality per 1,000 live births | 41 | | | |
| Under-five child mortality per 1,000 live births | 50 | | | |
| Facility-based deliveries | 79.0% | | | |
| Proportion of pregnancies in which women attended at least one antenatal visit | 79.0% | | | |
| Proportion of live births after which women receive a postnatal check within two days of delivery | 65.0% | | | |
| Abortion and FP-related indicators | | | | |
| Number of abortions | 15.6 million | 2015 | Guttmacher Institute, 2017 | |
| Abortions per 1,000 women | 47 | 2015 | Guttmacher Institute, 2017 | |
| Number of unintended pregnancies | 11,174,000 | 2017–2018 | FP2020 Core Indicator 2017–18 Summary Sheet | |
| Proportion of unintended pregnancies that end in abortion | 69% | 2015 | Guttmacher Institute, 2017 | |
| Number of unintended pregnancies averted due to use of modern contraceptive methods | 54,421,000 | 2017–2018 | FP2020 Core Indicator 2017–18 Summary Sheet | |
| Number of unsafe abortions averted due to use of modern contraceptive methods | 1,823,000 | | | |
| Number of maternal deaths averted due to use of modern contraceptive methods | 29,000 | | | |
| Modern method contraceptive prevalence rate, all women of reproductive age | 40.0% | | | |
| Knowledge of FP, currently married women | 99% | 2015–16 | Demographic and Health Survey/National Family Health Survey, 2015–16 | |
| Contraceptive use by type | | | | |
| Long-acting and permanent methods | | | | |
| Sterilization (female) | 75.3% | 2017–2018 | FP2020 Core Indicator 2017–18 Summary Sheet | |
| Sterilization (male) | 0.6% | | | |
| Intrauterine device | 3.1% | | | |
| Implant | 0.0% | | | |
| Short-acting methods | | | | |
| Injection (intramuscular and subcutaneous) | 0.4% | 2017–18 | | |
| Pill | 8.6% | | | |
| Condom (male) | 11.7% | | | |
| Condom (female) | 0.0% | | | |
| Other modern methods (e.g., cycle beads, and lactational amenorrhea method) | 0.2% | | | |
| Unmet need for FP ³ (2018) | 13.0% | 2015–16 | Demographic and Health Survey/National Family Health Survey, 2015–16 | |
| Unmet need for spacing | 6.0% | | | |
| Unmet need for limiting | 7.0% | | | |

¹ <https://data.worldbank.org/indicator/SP.DYN.TFRT.IN>

² <http://unicef.in/Whatwedo/1/Maternal-Health>

³ Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior.

REFERENCES

- Banerjee, S.K., Gulati, S., Andersen, K.L., Acre, V., Warvadekar, J., and Navin, D. 2015. "Associations between Abortion Services and Acceptance of Postabortion Contraception in Six Indian States." *Studies in Family Planning* 46(4): 387–403. <http://onlinelibrary.wiley.com/doi/10.1111/j.1728-4465.2015.00039.x/epdf>.
- Curtis C., Huber D., and Moss-Knight T. 2010. "Postabortion Family Planning: Addressing the Cycle of Repeat Unintended Pregnancy and Abortion." *International Perspectives on Sexual and Reproductive Health* 36(1): 44–48. doi: 10.1363/ipsrh.36.044.10.
- FP2020. 2016. *2016 FP2020 Annual Commitment Update Questionnaire Response: India*. http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/09/FP2020_2016_Annual_Commitment_Update_Questionnaire-India_DLC.pdf.
- FP2020. *India: FP2020 Core Indicator Summary Sheet: 2017–18 Annual Progress Report*. <https://www.familyplanning2020.org/sites/default/files/India%202018%20C1%20Handout.pdf>.
- International Institute for Population Services and ICF Macro. 2017. *National Family Health Survey (NFHS-4), 2015–16: India*. Mumbai.
- Iyengar, K., Iyengar, S.D., and Danielsson, K.G. 2016. "Can India transition from information abortion provision to safe and formal services?" *The Lancet Global Health*. [http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X\(16\)30047-X.pdf](http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(16)30047-X.pdf).
- Ministry of Health and Family Welfare, Government of India. 2010. *Comprehensive Abortion Care: Training and Service Delivery Guidelines*. http://www.nrhmhp.gov.in/sites/default/files/files/Guidelines_CAC%20Training%20%26%20Service%20Delivery%20.pdf.
- Ministry of Health and Family Welfare, Government of India. 2013. *National Health Mission Draft Operating Manual for Preparation and Monitoring of State Programme Implementation Plans*. http://palliumindia.org/cms/wp-content/uploads/2014/01/NHM_PIP_operating_manual_29.10.2013.pdf.
- Postabortion Care (PAC) Consortium. 2014. *Misoprostol for Postabortion Care: Expanding PAC Service Delivery and Access with a Highly Effective Treatment for Incomplete Abortion*. PAC Consortium.
- Singh, S. et al. 2018. "The Incidence of Abortion and Unintended Pregnancy in India, 2015." *The Lancet Global Health* 6: e111–20. [https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(17\)30453-9/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30453-9/fulltext).
- Stillman, M., Frost, J.J., Singh, S., Moore, A.M., and Kalyanwala, S. 2014. *Abortion in India: A Literature Review*. Guttmacher Institute. https://www.guttmacher.org/sites/default/files/report_pdf/abortion-india-lit-review.pdf.

