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 at 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	2017–201	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		2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Long-acting and permanent methods			
Sterilization (female)	75.3%		
Sterilization (male)	0.6%		
Intrauterine device	3.1%		
Implant	0.0%		
Short-acting methods		2017–18	
Injection (intramuscular and subcutaneous)	0.4%		
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.

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