FPA India
Family Planning Association of India

SEASON 1 : 2021 SPOTLIGHT SERIES

MTP ACT @50- A Move on the 'Right' Track?

Spotlight Series: Webinar 2

Providing MTP services after 20 weeks: The Way Forward

21st October 2021

A Brief

Background

Though legally permitted and being conducted, reliable and disaggregated data on second trimester abortions/ terminations of pregnancy in India is not easily available. Studies and estimates from government data suggest anywhere between 11 to 26 percent of abortions taking place in second trimester1. While the reported proportion of second trimester abortions/ terminations of pregnancy is small, in absence of skilled services, these are reportedly associated with a disproportionately higher rate of morbidity. Second trimester terminations of pregnancy require facilities that have skilled staff, an operation theatre equipped for emergency surgery, blood transfusion, referral and transport if necessary. In a public health system especially in the rural areas, beset with skilled staff shortage, supply chain deficiencies and access issues, terminations in the second trimester have been difficult and risk prone. It has been estimated that about 70 percent of recognised facilities in the country provide only first trimester services.

The current amendments that have come after half a century of the original Act have revised the stipulations to allow terminations beyond 20 weeks with a set of caveats. Terminations upto 24 week are permitted for defined categories of vulnerable women and beyond 24 weeks for select foetal anomalies. Realisation of the amendments at the ground level in terms of ease of relevant service provision and benefits accrued to the service seekers is critical. Obstetricians and Gynaecologists are the key to provision of these services.

The Federation of Obstetricians and Gynaecologists Society of India (FOGSI) therefore led the second Spotlight webinar **"Providing MTP services after 20 weeks: The Way Forward"** on 21st October 2021 that focused on these issues. In the webinar, the keynote speaker and panellists, all practicing clinicians while acknowledging the clarity in stipulations in the amended Act brought out anticipated challenges in implementing these and put forth relevant suggestions for advocacy.

Clarity in legal provisions

Medical abortion: The amended Act has permitted provision of medical abortion upto 9 weeks of gestation. Even a MBBS doctor who has conducted ten terminations of pregnancy using medicines under supervision of a recognized service provider/ registered medical practitioner (RMP) or has had at three month posting in Obstetric / Gynaecology department can prescribe these medications. However, prescription for the medications is mandatory.

> *"Old Act has not been repealed but new stipulations have been added", Chairperson, Ethics & Medico-legal Committee, FOGSI*

[1] Suchitra S Dalvie (2008) Second Trimester Abortions in India, Reproductive Health Matters, 16:sup31, 37-45, DOI: 10.1016/S0968-8080(08)31384-6

MTPs upto 20 weeks: One RMP can now opine about and conduct MTPs upto 20 weeks. Approval criteria for facilities remain the same as in the MTP Act of 1971 and facilities registered for second trimester abortions under the earlier Act, are automatically registered for service provision upto 24 weeks. Eligibility of service provider and indications for terminations are also same barring the one for pregnancy resulting from failure of contraception. Under the amended Act, these terminations can now be conducted even in unmarried service seekers.

MTP from 20 to 24 weeks: Two RMPs can opine about and conduct MTPs from 20 to 24 weeks. They can provide these services to service seekers who meet a defined set of criteria of vulnerability (listed in the rules) and for a fixed set of indications. An additional Form E has been added to record opinion of RMPs.

MTP beyond 24 weeks: A medical board set up at the State or Union Territory level has to provide or deny permission for abortion. Two RMPs can conduct MTPs beyond 24 weeks based on this board's approval / permission. The medical board has to give a decision within three days and the service providers have to conduct the termination within five days of that decision. The procedure has to be done with ultrasound guidance and hence the facility has to be equipped with ultrasound machine and license under the PCPNDT Act.

Other provisions: Irrespective of gestational age of pregnancy one RMP can conduct MTP to save the service seeker's life. Breach of service seeker's confidential personal information can invite one year imprisonment or Rs. 1000 fine or both.

"Amendments will open new vistas for discussion and debates. Not everything can be laid out at this stage. There will be challenges some of them unanticipated. Best interest of the service seeker should guide the process.", FOGSI representative

Ambiguities and challenges: Pandora's box

"Good legislation should bring clarity and not confusion", Bill Haslam

Issues	Challenges/Ambiguity	Suggestions to mitigate
General		
Definition of MTP: MTP has been defined as 'termination of pregnancy using medical or surgical method'. The current definition does not clarify intent of termination of pregnant status or life of the foetus.	This has the potential of creating confusion • The possibility of Caesarean section and induction of labour being considered as termination of pregnancy. • It puts foetal reduction in a multiple pregnancy in the grey zone in the legal context.	• Definition of MTP should be revised to include intent i.e. a procedure to "*cause or hasten stoppage of foetal heart*" as well as to "*cause discontinuation of pregnant state*" so that foetal reduction in case of multiple pregnancies will automatically get excluded. • The definition should also exclude "*treatment for medical condition*" so that Caesarean section and induction of

		labour get excluded. Similarly, "Humanitarian" settings should be clearly defined
Maintenance of confidentiality: The process of service provision has multiple opportunities for confidentiality of the service seeker being compromised.	Confidentiality breach would now invite one year imprisonment and may have chilling effect on service provision • The flow of cases in hospitals, from the Outpatients Department to the service provider to the laboratory to the pharmacy is such that maintaining confidentiality is difficult. • Prescription is mandatory for purchasing medical abortion pills and for surgical abortion under anaesthesia accompanying person is the signatory witness and as the person responsible in case there is emergency. Personal information gets revealed in both cases. • Form C requires recording of information such as wife of or daughter of, thus making identification of cases easy. • The Act says that a person authorized by law can ask for the recorded information. In absence of clarification, any government officer may claim to be authorized	• Protection should be provided to RMPs on procedural breach for mandated processes or processes beyond her/his control. • Identifying information from Form C does not serve any purpose and should be removed. • In case personal information is revealed by 'person authorized by law', the person concerned should be held responsible for breach in confidentiality.
Reporting: There is lack of clarity about reporting of medical abortions	This has the potential of creating confusion about reporting • Appropriate authorities do not accept reports from MBBS doctors who provide services at their clinics that are not registered under the Act, though they have documented access to a registered facility as per the Act requirement. Form I has to be filled within 3 hours of MTP and column 11 of admission register requires date of discharge. Both are not possible with medical abortion as patient may abort at home and as there is no admission in case of medical abortion.	• MBBS doctors providing medical abortion from 'unregistered' clinics should be provided protection as long as rest of the stipulations under the Act are met. • There should be separate reporting structure for medical abortions. • Timeline for reporting should be revised and column 11 in admission register should be made optional.

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Issues	Challenges/Ambiguity	Suggestions to mitigate
MTP from 20 to 24 weeks		
Criteria for termination: Ambiguities or exclusions in the vulnerability criteria and lack of clarity in addressing cases with foetal malformation	Many vulnerable service seekers maybe excluded and there maybe confusion about dealing with twin pregnancies • 'Single / unmarried' women are excluded. Also, there is no clarity about a service seeker in the process of undergoing a divorce. • Women with pregnancy in 'Humanitarian' settings finds a mention but these settings have not been defined. • Act says that women with major disabilities would be those specified in Rights of Persons with Disabilities Act of 2016, requiring familiarity of service providers.	• Advocacy should be conducted to include single or unmarried women in the criteria of 'vulnerable' women. • There should be clarity in protocol about service seeker undergoing divorce • List of disabilities under Rights of Persons with Disabilities Act of 2016 should be made available and steps should be taken to make RMPs aware of these.
MTPs beyond 24 weeks		
Medical boards Constitution of medical board and timeline for decision making are not adequately aligned to the decisions expected.	There is a possibility of uncertainty about scheduling and of delays in the termination • Medical board specifies only one gynaecologist. Other members i.e. Paediatrician, Radiologist & others who are not registered under the MTP Act would be deciding about safety of the procedure in this gestational period. • Doctors on the board are expected to be mostly those in government service. These doctors have very little time at their disposal to meet every fortnight. Time is critical in late second trimester pregnancies. The board has to give decision in three days but there is no clarity on whether these are days after application or after the board meeting.	• Only the gynaecologist member should be permitted to decide about safety of the procedure. Others should help the gynaecologist take decision based on their expertise on the foetal anomaly in question. • Constitution of board requiring government service providers should be reconsidered. • Decision of the board should be available within three days of application as earlier the abortion is done, safer it is likely to be. •

Issues	Challenges/Ambiguity	Suggestions to mitigate
Foetal anomalies Lack of clarity about dealing with cases of foetal anomalies	• No guidelines on what exactly constitutes a substantial foetal anomaly. There is potential for conflicting opinions of board	• All possible substantial anomalies listed during Nikita Mehta case should be referred to list "substantial foetal malformations" under the Act. These had been identified after extensive

	members and difficulty in arriving at an actionable decision • There in no clarity on the steps to be taken in case of twins with one foetus having anomalies. • Possibility of legal and ethical dilemma in case the foetus is born alive. The parents may refuse to accept the malformed baby and the live baby will have fundamental rights as any other living being. • A dead foetus of more than 24 weeks gestation or 500 grams in weight will not be accepted as biomedical waste. The service provider may have to report it as stillbirth.	consultations and will save time in framing an acceptable list. • Protocol should clarify steps to be taken in those advised foetal reduction. • Guidelines about method of abortion should include details about how to terminate life of the foetus while it is in the womb. Giving Potassium Chloride in foetal heart should be recommended method as it would be the most humane way of ensuring that dead foetus is expelled. • Separate category of biomedical waste should be created for disposal of products of conception expelled following MTP beyond 24 weeks.
Complexity of procedure	Late second trimester terminations are more complex and require special skills • Procedure is fraught with risk especially if the woman has scarred uterus. • It will require facilities with skilled staff and equipment for invasive procedure, which are currently very scarce in the country.	• Only gynaecologists should conduct the procedure and that too after some specialized / refresher training in late gestation termination. • These terminations should be permitted only at tertiary care hospitals.

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Webinar 2
Date: Thursday, October 21, 2021
Time: 06.00 – 07.00 PM
Providing MTP services after 20 weeks: The Way Forward
INAUGURAL ADDRESS **Dr. S. Shantha Kumari, President, FOGSI** **SETTING THE CONTEXT** **Dr. Kalpana Apte, Secretary General, FPA India** **KEYNOTE ADDRESS** **Dr. Dilip Walke, Chairperson Ethical and Medico-legal Committee, FOGSI** **EXPERT PANEL** **Dr. Bipin Pandit, Vice President, FOGSI** **Dr. Bharti Maheshwari, Chairperson MTP Committee, FOGSI** **Dr. Parikshit Tank, Treasurer, FOGSI** **HOST AND MODERATOR** **Dr. Basab Mukherjee, Vice President, FOGSI** **VOTE OF THANKS** **Dr. Aruna Suman, Joint Secretary, FOGSI**