

SUPPLEMENT ARTICLE

Respectful Abortion Care initiative: How a large-scale virtual training for providers in India increased knowledge of the new 2021 Medical Termination of Pregnancy Act

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Abstract

Background: In a historic move to ensure comprehensive abortion care, India amended the 1971 Medical Termination of Pregnancy (MTP) Act in 2021, creating an unprecedented opportunity for accelerating safe, respectful, and rights-based abortion services. The Federation of Obstetric and Gynecological Societies of India (FOGSI), together with World Health Organization (WHO) India and the Ministry of Health and Family Welfare, set up a flagship initiative “Respectful Abortion Care” (RAC) to provide training to obstetricians and gynecologists on the new Act, and also address their values and biases.

Methods: Virtual training sessions were organized during the COVID-19 pandemic to disseminate the amendments made under the MTP Act and address provider values and biases. The primary focus was on private providers as they account for more than half of all abortion services in India (52.9%). The RAC modules were systematically designed and delivered by 690 Master Trainers, trained by FOGSI and WHO.

Results: A total of 9051 FOGSI members (22%, with 50% from private clinics) completed the RAC trainings. Pretests and post-tests were conducted for impact assessment. Significant improvement was seen on knowledge of criteria for termination of pregnancy for significant birth defects (52%–83%). The post-training survey showed a high level of commitment to promote RAC: >95% were strongly motivated to perform or assist in abortion; 89% reported that the WHO value clarification exercises were helpful in facilitating open discussions on sensitive topics in a comfortable manner; 96% expressed a strong commitment to addressing the issue of respect and confidentiality in abortion care.

Conclusion: RAC was a unique initiative around the MTP Act amendment 2021 in India, which demonstrated that collaboration and leadership by professional associations can help motivate providers and lead to improved knowledge and commitment from public and private sector providers.

[French and Spanish] translations are available in the Supporting Information.

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KEYWORDS

abortion, India, legal changes, obstetricians/gynecologists, respectful care, training

1 | BACKGROUND

Nearly 73 million induced abortions occur worldwide every year.¹ Globally, 29% of all pregnancies and 61% of unintended pregnancies end in induced abortions.^{1,2} In India, the burden of unintended pregnancies and unsafe abortions remains significant. Comprehensive abortion care (CAC) refers to the provision of a range of services, including information, management, and postabortion care, for induced abortion, miscarriage, incomplete abortion, fetal death, and postabortion contraception services.¹⁻³

Recent estimates from the World Health Organization (WHO) show that 44% (95% CI, 42-48) of all pregnancies in India are unintended. The proportion of unintended pregnancies that end in abortion has increased from 47% (95% CI, 36-57) in 1990-1994 to 77% (95% CI, 74-81) in 2015-2019.^{1,2} Access to safe and CAC is crucial, especially for women with unintended pregnancies who often lack access to effective, timely, and free service due to a myriad of socio-cultural, economic, and/or legal barriers.³

While the Medical Termination of Pregnancy (MTP) Act made abortion legal in various situations in India for almost five decades, unsafe abortions remain the third leading cause of pregnancy-related deaths in the country.⁴ The private sector is the leading abortion service provider in the country, accounting for more than half of

all abortions services (53%) including management of postabortion complications (70%).⁵ Several efforts have been made to broaden the scope, remove legal barriers, and ensure access to CAC in the past decade.^{3,6-8}

In 2021, India made a historic amendment to the MTP Act, aiming for a rights-based, holistic, woman-centered approach.^{6,7} The amendment to the existing MTP Act was a result of extensive consultation led by the Ministry of Health and Family Welfare (MoHFW), Government of India with experts representing a range of stakeholders from central ministries and departments, state governments, WHO, nongovernmental organizations, academic institutions, professional bodies and associations, legal professionals, and all concerned government organizations. The amendment has significant changes, including the role of CAC service providers, confidentiality norms, and special categories (Box 1). Wider acceptance by the obstetrician/gynecologist community is imperative not only to reduce the burden of unsafe abortions,^{8,9} but also improve the overall experiences of women and girls. The law now guarantees access for younger and unmarried women; therefore, the role of CAC service providers in India is more important than ever.^{3,6,7,10}

The Federation of Obstetric and Gynecological Societies of India (FOGSI), together with WHO India and the MoHFW, set up a flagship Respectful Abortion Care (RAC) initiative. The goal was

BOX 1 Features of the MTP Amendment of 2021^{6,7}

- **Provider:** One provider for termination of pregnancy up to 20 weeks of gestation and opinion of two providers for termination between 20 and 24 weeks of gestation only. [Previously, only married women could obtain an MTP up to 20 weeks with two registered medical practitioner (RMP) opinions; today, any woman in India, married or unmarried, can safely obtain an MTP up to 20 weeks with the opinion of one RMP and between 20 and 24 weeks of gestation with the opinion of two RMPs]
- **Special case:** Increasing the upper gestation limit from 20 to 24 weeks for special categories of women including survivors of rape and other vulnerable women (like differently abled women, minors) etc. [For special/vulnerable categories, MTP is now allowed up to 24 weeks with the opinion of two RMPs. The MTP Act 2021 simplifies minor consent and prioritizes women's well-being. It makes India the only country where women can legally obtain an MTP during a humanitarian crisis]
- **Birth defect:** Upper gestation limit does not apply for substantial fetal abnormalities determined by a Medical Board defined in Rules under the Act. [Cases of substantial fetal anomalies are viewed through a humanitarian lens. Whereas, previously, the gestational limit was 20 weeks in all cases, now, there is no limit for pregnancies with substantial fetal abnormalities that are diagnosed by a Medical Board in accordance with the Rules of the MTP Act]
- **Confidentiality:** Name and other particulars of a woman whose pregnancy has been terminated is not revealed except to a person authorized by law. [The 2021 Amendment Act introduces a new privacy clause that prohibits RMPs from revealing details of a terminated pregnancy (except to authorized persons under any law), with a strict penalty for violations. Assurance of privacy will lead to an increase in demand]
- **Choice:** The grounds of failure of contraceptive extended to a woman and her partner, safeguarding access to safe abortion based on choice irrespective of marital status. [The new amendment extends the grounds of failure of contraceptive to any woman and her partner from the earlier limitation of any married woman or her husband. It also improves access to safe and legal abortion for all women, regardless of marital status or age, which is especially significant in light of the recent changes to the legal age of marriage in India]

to disseminate the details of the 2021 MTP amendment and train providers on the latest evidence and address values and biases as per recent WHO recommendations.¹¹⁻¹⁴

Drawing upon the global WHO Abortion Care Guideline (2022), we included the principles of respectful maternity care and recommendations on addressing values and biases to provide nonjudgmental abortion services. RAC was defined as: "care that maintains safety, dignity, respect, confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during and after all types of abortion and or termination of pregnancy".¹⁰ Obstetrician/gynecologists in the FOGSI network were targeted through email outreach and registration in virtual trainings through societies. The trainings also included content on promoting dignity, enhancing quality, and providing respectful services.¹¹

2 | MATERIALS AND METHODS

The initiative followed a carefully drafted plan, which involved forging partnerships with FOGSI, WHO, All India Institute of Medical Sciences (AIIMS), and MoHFW. Content creation included defining and developing the curriculum, which incorporated the WHO SAVER (Safe Abortion Values, Evidence and Rights/Respect) toolkit. The training roll-out was conducted in six phases over 15 months, utilizing virtual and hybrid sessions, with pre- and post-tests and surveys to evaluate knowledge acquisition and commitments.¹¹

FOGSI was selected for its ability to reach a large number of obstetricians/gynecologists who are currently the only cadre of health-care professionals in India authorized to provide the full range of CAC services, including both medical and surgical procedures. As one of the largest membership-based organizations of specialized professionals globally, there was an ambitious aim to reach all 42000+ members in 272 societies across 36 states and union territories.

A carefully drafted plan (Figure 1) was designed by the core team, consisting of relevant national experts to develop the curriculum, identify master trainers (MTs), and roll out the trainings in a structured manner. Special attention was given to ensuring systematic data collection. The content for the RAC workshop was based on an extensive literature review¹²⁻²⁴ and utilized relevant materials from the WHO Safe Abortion SAVER toolkit.²⁵

The curriculum was divided into four modules of 20min each, with 10min allocated for questions and answers (Box 2). These modules were meant to inform about the law, explore personal values, engage with experts, and equip participants with the tools to communicate effectively on evidence-based information and key recommendations from WHO guidance on sexual and reproductive health and rights with a focus on CAC, including contraception, safe abortion, and postabortion care. The training sessions were highly interactive with built-in spot quizzes, and question and answer sessions at the end of each topic. The training sessions were planned to be conducted virtually and lasted for a duration of 2h. Experts from the FOGSI network helped deliver the trainings.

MTs were identified to deliver the RAC content in a standardized manner across the country. A set criterion was developed for selection of MTs to include experts and leaders especially from abortion subcommittees of all societies. The requirements for MT selection were: one leader per society, more than 15 years of practice (public or private), national/state recognition, more than 10 years of teaching experience, and motivation for participation. National-level training of MTs was done to ensure that they could conduct the trainings on their own. One observer from WHO or FOGSI participated in all subsequent training to ensure quality and consistency of program implementation. The goal was to have at least 300 MTs representing all societies. However, owing to the leadership of FOGSI ultimately, RAC had 690 MTs trained by WHO experts in the RAC content delivery and standardized roll-out of trainings.

Pre- and post-test surveys were developed and tested with MTs to gather information on knowledge acquisition after training and generate commitments on carrying forward the lessons of RAC trainings in their everyday lives. A set of questions was asked to assess participant's knowledge, attitudes, and comprehension around abortion care and the recent amendments to the MTP Act 2021. The questions on the recent revisions to the MTP were:

- Who is authorized to carry out an MTP?
- Has the law been amended to expand MTP services?
- How many registered practitioners' opinions are required if MTP is to be conducted up to 20 weeks and between 20 and 24 weeks?
- Whose consent is required for an MTP in the case of a married women and in the case of an adolescent?
- Is there an upper gestation limit for an MTP in the case of birth defects?
- Is legal evidence needed for an MTP in cases of rape or incest?
- Is MTP available for married or unmarried women including failure of contraception?

In addition, participants were also asked whether they had taken part in or conducted an MTP program (which would explain their level of knowledge of the revisions) as well as whether they agreed or disagreed with the statement that legally restricting abortion leads to a reduction in abortions.

Attitude and commitments on safe abortion values, evidence, and rights/respect as a part of RAC were assessed in a post-training exit survey only. RAC training was divided into six phases conducted in a cascade approach over a period of 15 months from September 2021 to December 2022. Three months were spent on preparation including MTs, curriculum, and SAVER adaptation. The MTP amendment and its subsequent rules were finalized by the Government of India by the end of 2021.

2.1 | Phase I (September 2021)

Curriculum development, finalization and vetting, pre- and post-test questionnaire framing, development of exit survey form, design of

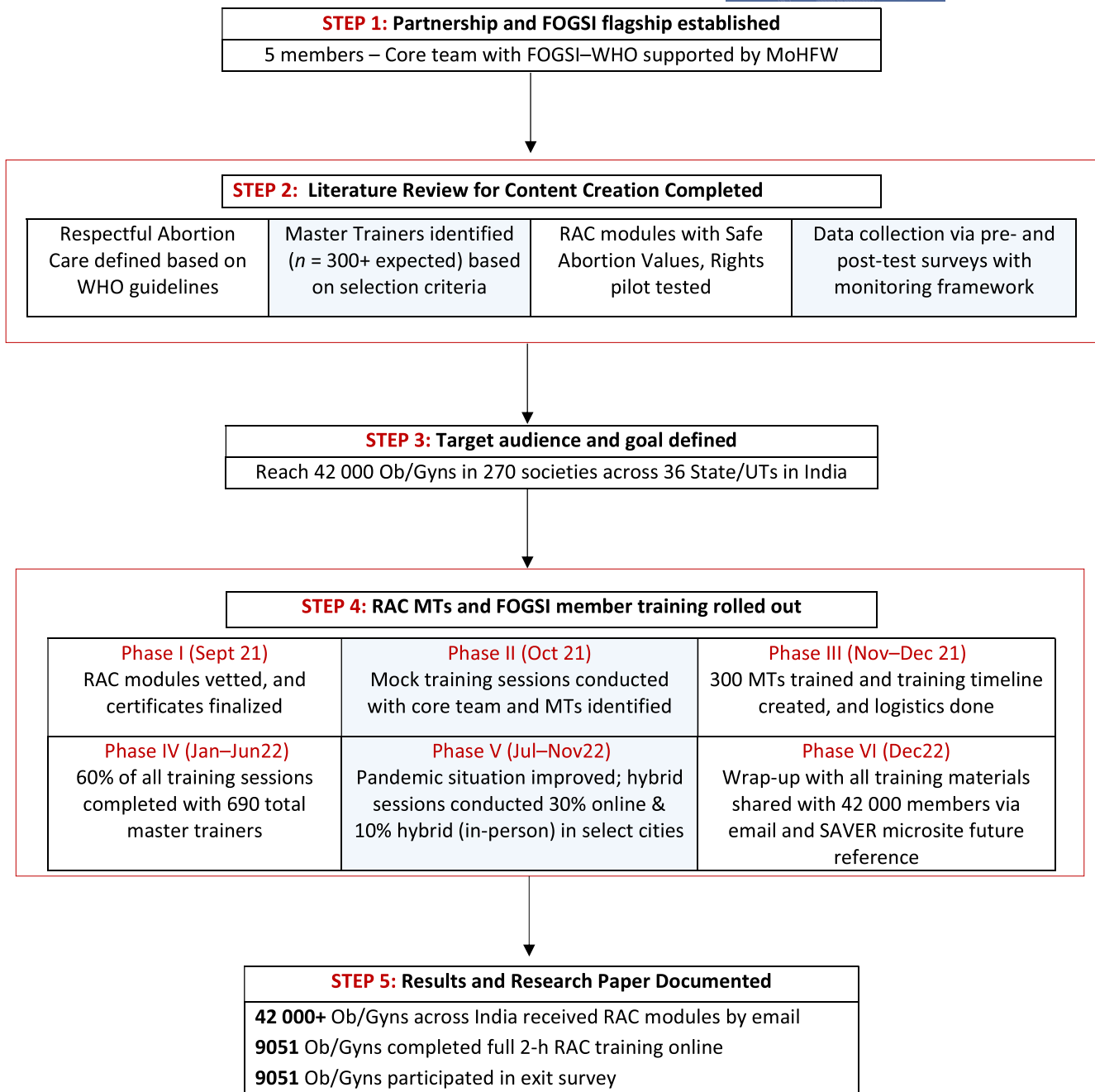


FIGURE 1 Summary of RAC initiative preparation and roll-out in India—September 2021–December 2022. FOGSI, Federation of Obstetric and Gynecological Societies of India; MoHFW, Ministry of Health and Family Welfare; MT, Master trainer; RAC, Respectful Abortion Care; UT, union territories; WHO, World Health Organization.

training certificates, and data collection template design process started.

2.2 | Phase II (October 2021)

Mock sessions with all MTs to ensure standardized delivery, address program needs, and conduct trainings with standard evidence-based responses.

2.3 | Phase III (November and December 2021)

Three hundred MTs trained and training timeline and schedule finalized. In addition, more champions from across the 272 societies were also identified and trained as additional MTs. Care was taken to ensure all training timings would take place between outpatient departments or during their break from their clinical schedules to optimize participation. Trainees were sent reminders via email and encouraged to register for RAC sessions on any day as per the MT training schedule.

BOX 2 RAC modules used in the training

- **Module 1.** Inform: MTP Amendment 2021—laws, rules, and implications for providers.
- **Module 2.** Engage: Safe abortion values and attitudes—media, social norms, and stigma.
- **Module 3.** Explore: Quality of care—need for dignity, safety, confidentiality, and respect.
- **Module 4.** Equip: Latest guidelines on abortion, contraception, and counseling.

2.4 | Phase IV (January–June 2022)

Multiple parallel online MT sessions were completed. Sessions were held 3–4 times per week during this period, resulting in 10+ MT sessions and 70+ sessions online. By this time 690 MTs across India were trained. Standardized training materials were given to all MTs at the end of each training session; 60% of sessions were completed by this time.

2.5 | Phase V (July–November 2022)

Once the pandemic situation improved, trainings were modified to enable hybrid implementation and include physical sessions. By the end of this period, 90% of trainings were completed online and 10% were completed as hybrid (in-person and virtual) sessions. Reminder emails with standardized RAC knowledge material²⁵ were shared with all FOGSI members.

2.6 | Phase VI (December 2022)

As a final step, an email with the curriculum and presentation was sent out to all member obstetrician/gynecologists (42000+) across the country. This ensured that all had easy access to standardized training materials for their ready reference and use.²⁵ A total of 9051 trained participants completed the post-training exit survey on safe abortion values, evidence, and rights/respect as part of RAC.

Data from the pre-test, post-test, and exit survey were gathered using a simple Excel tool designed for collecting responses from participants based on a standardized questionnaire. Statistical analysis was applied to pre-test and post-test knowledge scores using appropriate methods such as ANOVA, mean, standard deviation, and paired *t* test. The paired-sample *t* test compared the overall mean score of the pre-test and post-test results to determine the significance of the RAC training on participants' overall knowledge regarding the amendments introduced to the MTP Act in 2021.

However, data pertaining to safe abortion values, evidence, and rights/respect as a part of RAC were only collected in the post-training phase through a structured exit survey format. Exit survey

data were analyzed to assess the commitment and attitude of the trained obstetrician/gynecologists toward safe abortion values, evidence, and rights/respect.

3 | RESULTS

A total of 9051 (22%) FOGSI members completed the full 2-h, four-module RAC training program online. While obstetrician/gynecologists from all states and union territories participated, the majority were from Maharashtra (17%), Uttar Pradesh (16%), Andhra Pradesh (10%), and Tamil Nadu (9%). These are also some of the states with highest abortion incidence and need.⁵

The characteristics of the 9051 participants are shown in Table 1. Of the participants, 8202 (91%) were female—there is higher number of women in obstetric/gynecologic practice in India. A total of 7231 (80%) came from clinical practice, followed by 1111 (12%) academia, and 709 (8%) were students or public health professionals. The age of participants varied: 4221 (47%) aged ≥ 45 years; 2591 (29%) aged ≥ 35 –44 years; and 2239 (25%) aged 21–34 years.

Before the RAC training, as part of the pre-test, we found that 7558 (84%) participants reported that they were aware of the MTP Amendment, and 7073 (78%) knew about the latest WHO guidelines on CAC. Only 3575 (39%) participants had been part of any previous awareness program for women on safe abortion, and 3285 (36%) participants had received or completed some type of continued medical education on CAC.

Fifteen questions were included in the pre- and post-tests, out of which nine that were relevant to the 2021 MTP amendments were included in the analysis. Baseline knowledge was already high on historical abortion law: 98% were aware of the 1971 MTP law; 95%

TABLE 1 Background characteristics of 9051 participants.

Characteristics	No. (%)
Gender	
Female	8202 (91%)
Male	849 (9%)
Age, y	
21–34	2239 (25%)
≥ 35 –44	2591 (29%)
≥ 45	4221 (47%)
Area of occupation	
Clinical	7231 (80%)
Academic	1111 (12%)
Medical student and public health	709 (8%)
Place of work	
Private clinic practice	4562 (50%)
Government hospital	2244 (25%)
Other ^a	2245 (25%)

^aCharity hospital, corporate hospital, medical college, trust hospital.

were aware of recent amendments; and 94% were aware that RMPs can provide abortions.

Knowledge on details of the amendment improved significantly as measured by the post-training assessment (Figure 2). The paired-sample *t* test demonstrated that there was a significant increase in overall knowledge test score ($t=2.94$; $P<0.0186$, 95% CI) from before the RAC training (mean \pm SD 73.4 \pm 29.32) to after the RAC training (85.4 \pm 19.36).

As shown in Figure 2, 97% of participants (increase from 85%) answered that the opinion of one provider is required up to 20 weeks and two providers at 20–24 weeks of gestation. Compared to pre-test, 83% of participants (increase from 52%) now knew that in cases of significant birth defects, there is no upper gestational age limit for abortion if determined by a Medical Board. From a previous 85%, 94% of participants now correctly identified that married women do not need their husband's written consent, and in a significant improvement, 57% of participants (increase from 25%) now knew that minors do not need both parents' consent for termination. While knowledge of no longer needing legal evidence in the case of rape or incest up to 24 weeks increased significantly to 49% (from 31%), it still falls slightly below the 50% hoped for level. There was a high awareness of access for unmarried women on the grounds of contraceptive failure, with pre- and post-test results of 95% and 98%, respectively.

Post-training exit surveys on attitude and commitment as an expected outcome of the SAVER modules as part of RAC were completed by all participants as this was needed to receive the certificate of completion. The results demonstrated that 95% of participants expressed strong motivation to either perform or assist an abortion procedure in accordance with the law (Figure 3). Furthermore, 89% of participants reported experiencing value clarification through open discussions on sensitive topics,

including abortion, in a comfortable manner. Additionally, 96% of participants expressed a strong commitment to the issue of abortion, recognizing its importance.

4 | DISCUSSION

Women seeking abortion must often navigate restrictive rules, in diverse healthcare systems, if access is legal and available at all.^{14–19} Over the last decade in India, even before the amendment to the abortion law in 2021, important strides were taken to improve safety, availability, and accessibility of CAC services. However, the existing literature has serious gaps on documentation of structured training efforts for CAC providers especially in the private sector and addressing their values and biases.^{15–20}

RAC was the first-of-its-kind collaborative effort between a professional association and WHO that disseminated evidence-based information to more than 9000 service providers over a period of 12 months. We created a pool of 690 MTs across 272 societies in 36 states and union territories and provided standardized content to all 42000+ members of FOGSI. This extensive network of providers has a collective reach of over 300 million women and families throughout India. Even though training modules on CAC existed, we needed 3 months to customize the content based on the 2021 amendments and incorporate innovative ways, like videos and games, from the WHO SAVER toolkit to ensure participants remained engaged. The training was done using a digital platform (Zoom) for sessions, completing surveys, and generating completion certificates and the pre- and post-test surveys.

Having a well-organized secretariat with core team members comprising technical experts and managerial staff with clear roles

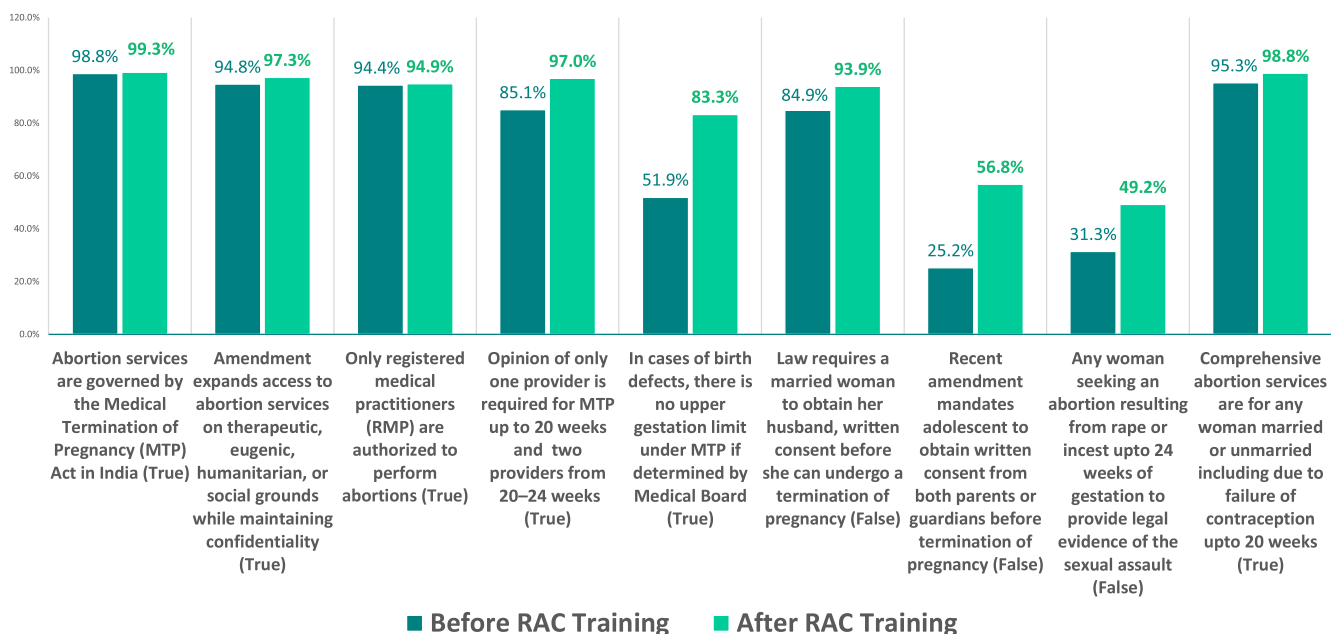


FIGURE 2 Change in knowledge of ob/gyns on salient features on the 2021 Medical Termination of Pregnancy Amendment pre- and post-Respectful Abortion Care (RAC) trainings ($n=9051$).

Exit survey (% of participants)

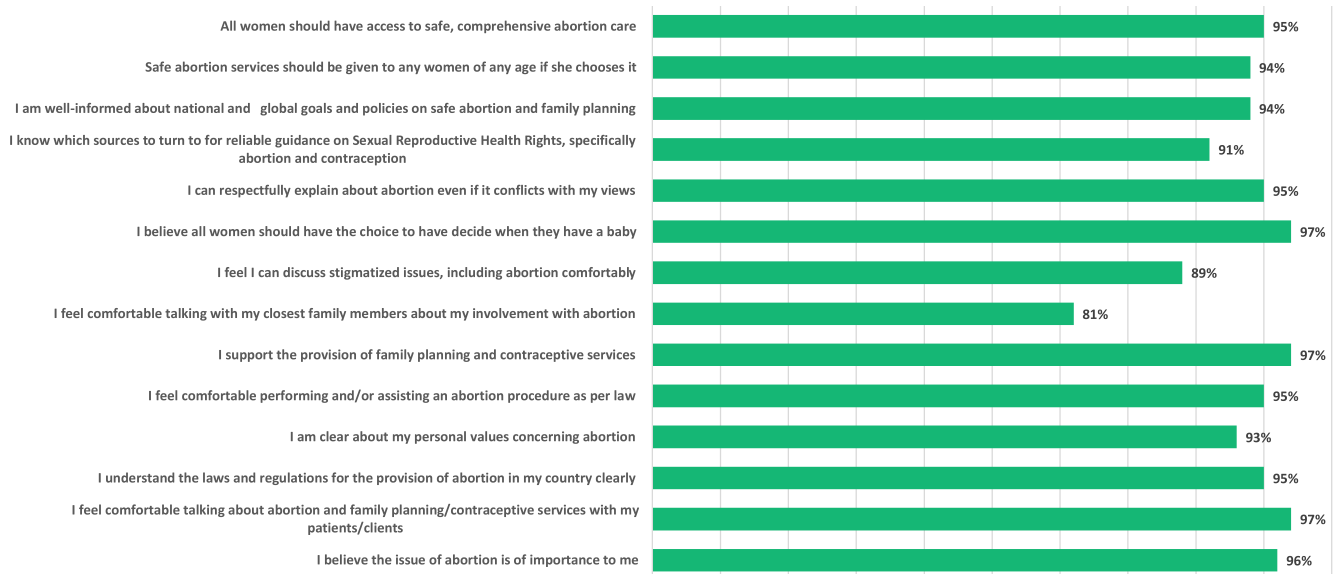


FIGURE 3 Exit survey results showing positive attitudes post value clarification, post SAVER (Safe Abortion Values, Evidence, and Rights/Respect) as part of Respectful Abortion Care ($n = 9051$).

and responsibilities and running multiple parallel sessions ensured that we were able to reach this massive cohort. We made a conscious effort to select MTs carefully, choosing obstetrician/gynecologists that were highly reputed and whom people admired and respected to drive participation. We were mindful of trainer fatigue and expanded and rotated the MTs to mitigate any impact. It was important to constantly acknowledge that MTs and participants often overcame personal and professional barriers to attend the sessions, given the COVID-19 pandemic. Thus, it was important to keep them motivated and ensure that they felt appreciated for their work. Although online trainings can be cost-effective, substantial efforts are required for meticulous planning and immaculate implementation schedules to ensure success. Even if training can be conducted in person, the online mode should also be made available to accommodate different program requirements. Providing trainees with certificates as a form of recognition further motivates their participation and learning.

Through the RAC trainings we were able to demonstrate the effectiveness of online training sessions at scale in improving knowledge and attitudes during the pandemic. Additionally, FOGSI's leadership in addressing a sensitive area like abortion in an evidence-based manner sets an example of what can be achieved by working with a strong network of committed healthcare providers, resulting in massive outreach complementing the government machinery. The trainings played a crucial role in fostering commitment among participants to acknowledge the significance of abortion and to be motivated in providing services in accordance with the law.

While values clarification and attitude transformation workshops are not new, this was the first organized, large-scale, coordinated attempt to include values and build-in respect as an integral component of CAC trainings. RAC demonstrated that professional

associations can take ownership and effectively mobilize providers, but we are far from bringing real change in attitudes toward universal respectful CAC services for all. Those that completed the sessions committed to RAC; however, despite the coordinated efforts less than 1 in 4 participants in India completed the whole course. Without benchmarking attitudes and values beforehand, we were also unable to tell the impact of this part of the training. In addition, one of the limitations of this RAC initiative is that it did not assess whether this type of training resulted in actual changes in practices or not.

Once pandemic restrictions were eased, there was a decline in the numbers of trainees, likely owing to online training fatigue, and in-person training was complex in the immediate post-pandemic period; challenges of cost, travel time, competing priorities, and clinical commitments hindered participation. However, it became evident that there was a growing demand to include practical, hands-on sessions on medical and surgical abortion in these training programs. This growing need necessitated significant redesigning of the RAC training program to better align with a physical delivery mode, enabling trainees to gain valuable hands-on experience.

5 | CONCLUSION

The RAC initiative clearly demonstrated that collaboration and leadership by professional associations can motivate professionals and lead to increased knowledge and understanding among providers in both public and private sectors. Our main aim was to demonstrate that large-scale online trainings could effectively be done during the pandemic for evidence dissemination and incorporating aspects of

RAC that address provider bias and values. While we are not there yet, our overarching goal to reach all members with evidence-based information and re-emphasize CAC service delivery without compromising on service quality, safety and incorporating respect was achieved. These trainings served as a reminder to providers about their critical role in ensuring dignity, autonomy, confidentiality, and justice for women who need an abortion. Moving ahead, as mentioned earlier, the training will be redesigned to ensure more effective dissemination through in-person sessions.

We will need sustained effort by professional associations like FOGSI, technical agencies like WHO, and government alike to bring about real and long-term change in the attitudes of healthcare providers. National and subnational authorities must continue to streamline certifying facilities for abortion provision, conduct regular refresher training, and address provider values as part of all trainings, public or private, both pre- and in-service to reduce inequality and biases in access.

Finally, we recognize the significant efforts made to increase access to safe abortion services for women in India. However, it is important to acknowledge that there is still much to be done to address the provider biases, inequities, and rudimentary sociocultural biases that continue to affect women, particularly in rural areas, and young and unmarried women. Hence, addressing the root causes of gender discrimination, while disaggregating personal values from service delivery, and clarifying provider biases remain critical. These need to be systematically included in all capacity building and training efforts on access to safe, legal, and respectful abortion services.

AUTHOR CONTRIBUTIONS

The RAC initiative was conceptualized by Shantha Kumari, Pushpa Chaudhary, Sumita Ghosh, Ajey Bhardwaj, Kandala Aparna Sharma, and Priya Karna. RAC modules and curriculum were developed by Kandala Aparna Sharma and Priya Karna. Priya Karna, Kandala Aparna Sharma, Tapas Chatterjee, Ajey Bhardwaj, and Sapna Dubey drafted the manuscript with significant contributions from Shantha Kumari, Pushpa Chaudhary, Manju Puri, and Sumita Ghosh. All authors reviewed and edited versions of the manuscript. Priya Karna, Kandala Aparna Sharma, Tapas Chatterjee, Ajey Bhardwaj, and Sapna Dubey had full access to the data and had final responsibility for the decision to submit for publication. The authors alone are responsible for the views expressed in this article, and they do not necessarily represent the views, decisions, or policies of the institutions with which they are affiliated. All authors read and approved the final manuscript.

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CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest to declare.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author, PK, upon reasonable request.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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