Increasing access to safe abortion services in Uttarakhand, India

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Background

Unsafe abortion is a neglected health issue faced by women in India and in many other developing nations. Lack of access to safe abortion services and treatment of abortion complications leads to as many as 12,000 deaths every year in India (Ipas-India, 2008). Almost all maternal morbidity and mortality related to unsafe abortion can be prevented by providing safe abortion services. Recognizing this, the Indian Parliament passed the Medical Termination of Pregnancy (MTP) Act in 1971, which enables women to seek abortion for a number of indications. In practice, however, this liberal law has not curbed unsafe abortion-related mortality and morbidity because a large number of women in India have limited access to safe services. Rural women, in particular, overwhelmingly rely on unsafe or illegal providers due to lack of access to a safer alternative. In fact, although 75% of Indian women live in rural areas, most trained and certified induced abortion providers are located only in urban areas.

Women in the hilly state of Uttarakhand (UK) have hardly any options for accessing abortion services at a primary health centre, which is almost always the first contact point between the rural population of 6.3 million and a qualified medical provider (IIPS, 2003). The primary reason seems to be that 95% of primary health centres do not have a medical doctor who has been trained to provide abortion services. Expanding access to safe abortion services is a key component of the state Reproductive and Child Health (RCH) II Project. To do so, training doctors at these primary health centres and provision of adequate facility support are required.

To address this critical gap in women's health by expanding access to safe abortion services, Ipas in collaboration with the state government of UK, embarked on a series of activities designed to implement and ensure comprehensive abortion care (CAC) service provision in public health facilities. Ipas began with a comprehensive baseline facility assessment in 2006, followed by development of CAC training sites, and ongoing training and support to providers. Endline assessment will be conducted during the first half of 2009.

Study Objectives

This paper will report results from a prospective assessment of the initiative to improve access to safe abortion care in the public health system of UK to support the broader goal of reducing maternal mortality and morbidity. The objectives of this study are to:

1. Assess baseline availability and quality of CAC services in Uttarakhand in 2006;
2. Describe comprehensive training intervention designed as a result of baseline findings; and
3. Measure impact of training intervention on availability and quality of CAC services as of 2009, paying particular attention to how these findings could be applied to other geographical areas.

Methods

The implementation period runs from July 2006 to June 2009. Before finalizing implementation plans and launching training, a baseline assessment was carried out in all 119 public facilities in the state to assess current practice and set a benchmark for assessing post-intervention practice. Baseline assessment of all 119 public health facilities spread over 13 districts in UK was conducted in 2007 during in-person visits to facilities using a structured interview with key informants (primarily doctors, some nurses).

After consideration of baseline findings, seven facilities were identified as potential CAC training sites because they fulfilled the following five criteria: (1) adequate caseload of MTPs; (2) staff availability; (3) adequate facility infrastructure; (4) training exposure; and (5) interest and motivation for providing training on MTP. After additional assessment, six of the seven facilities were approved as MTP training centres. To take advantage of the existing family planning training centres and minimize the impact on staff at the new CAC training centres, a two-fold process was developed for offering quality CAC training to doctors and support staff from public facilities in UK. First, a batch of six to eight trainee doctors and equal numbers of support staff receive theoretical training in two regional family planning training centres located at Dehradun and Haldwani. Next, trainees are sent to the six newly developed CAC training sites for skills-based clinical training.

Selected medical doctors from the six CAC training sites and two family planning training sites underwent a training of trainers program to ensure provision of uniform curriculum across facilities. As of April 2008, more than 100 doctors had gone through the CAC training. Additional training is anticipated.

Post-intervention (i.e., endline) assessment will be conducted during the first half of 2009 via in-person interviews using a structured questionnaire very similar to the baseline assessment. Appropriate statistical analysis will be used to assess the impact of training both overall and by rural/urban status.

Baseline Findings and Expected Results

Facilities assessed at baseline are presented by rural/urban and district in Table 1. Over three-quarters of facilities are located in rural areas.

Table 1. Distribution of Public Health Facilities in Uttarakhand India, 2007.

District	Rural Health Centres	Urban Hospitals	Total
Almora	12	3	15
Bageshwar	3	0	3
Champawat	3	2	4
Nainital	9	6	15
Pithgoragarh	8	2	10
Udham Singh Nagar	7	1	8
Chamoli	7	0	7
Dehradun	8	4	12
Haridwar	5	3	8
Pauri	14	5	19
Rudraprayag	3	0	3
Tehri Garhwal	10	2	12
Uttarkashi	4	0	4
Total	**92 (77%)**	**27 (23%)**	**119**

At baseline, only 18 (20%) rural health centres (RHCs) and 22 (82%) urban hospitals (UHs) were offering MTP services. Most facilities (77% of RHCs and 86% of UHs) report maintaining a case register. The mean monthly caseload for RHCs and UHs was 8.9 (sd = 9.4) and 39.5 (sd = 39.5), respectively. The percent of first trimester MTP cases performed with appropriate technology (MVA/EVA or medical abortion) was 28% for RHCs and 31% for UHs. Post-abortion contraceptives were provided in 86% of RHC cases and 76% of UH cases.

The remaining 74 rural health centres and 5 urban hospitals cited the following reasons for service discontinuation or not providing MTP services: no gynecologist or trained doctor on staff (72%), no one had initiated services/apathy (23%), lack of functioning cannulae (22%), lack of suction machine (18%), facility not authorized to provide services (10%), and low client demand (3%).

These findings suggest that lack of trained doctors is the primary self-reported concern of facilities, which supports the strategy of CAC training as the focus of the intervention. Overall, 57 (62%) of rural facilities and 4 (15%) of urban hospitals did not have any doctors on staff who were trained for MTP provision, and only half of them had received formal CAC training. Furthermore, most training had been attended two or more years previously.

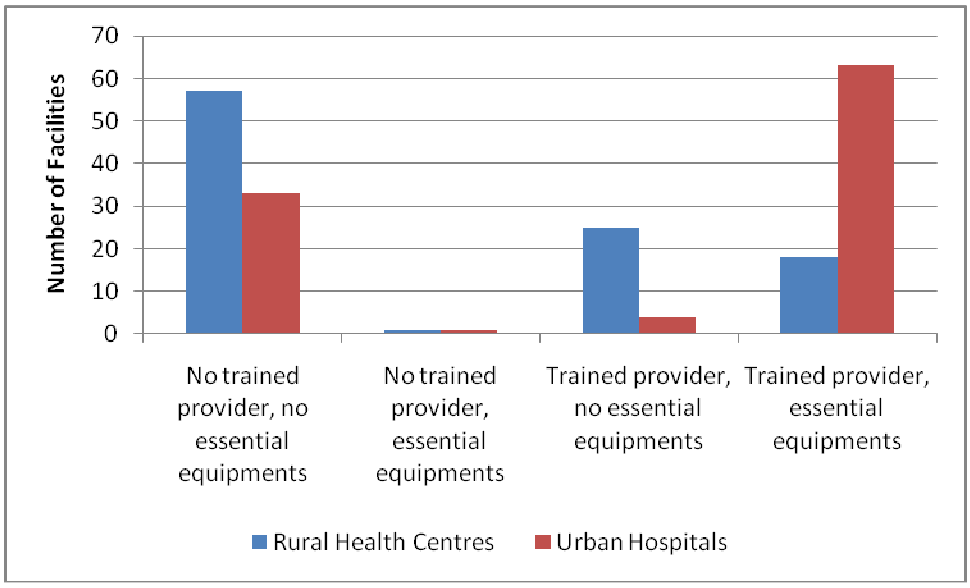
In addition, baseline facility infrastructure was assessed (Table 2). While basic infrastructure was reasonably good overall, only 14 (15%) of RHCs and 10 (37%) of UHs reported availability of all four essential equipments for MTP provision, namely, (1) suction machine, (2) MVA aspirator/MR syringe, (3) speculum, and (4) suction cannulae.

Table 2. Basic infrastructure and essential equipments for CAC provision in Uttarakhand India, 2007.

	Rural Health Center (n = 92)		**Urban Hospital (n = 27)**	
Electricity	91	(99)	27	(100)
Functional Generator	72	(78)	23	(85)
Telephone	77	(84)	27	(100)
Regular Water Supply	61	(66)		(78)
Operating Theatre/ Labor Table	87	(95)	26	(96)
Main Water Source				
Tap	77	(84)	26	(96)
Tube well/ hand well	10	(11)	1	(4)
Bore well	1	(1)	0	(---)
Other	4	(4)	0	(---)
Essential Equipment				
Suction Machine	16	(17)	15	(56)
MVA aspirator/ MR syringe	10	(11)	4	(15)
Speculum	76	(83)	25	(93)
Suction Cannulae	24	(26)	12	(44)
All 4 Essential Equipments	**14**	**(15)**	**10**	**(37)**

When considering availability of *both* trained providers and essential equipments, it is clear that training providers in isolation will not have sufficient impact on availability of CAC services unless essential equipments are also ensured (Figure 1). Over half of the rural hospitals and one-third of urban hospitals have neither a trained provider nor essential equipments. In addition, nearly one-third of rural hospitals and a handful of urban hospitals with trained providers still lack essential equipments.

Figure 1. Availability of Trained Providers and Essential Equipments for CAC provision in Uttarakhand India, 2007.



At the time of this writing, the provider training and facility support intervention is ongoing. Ipas expects to collect endline performance of facilities during the first half of 2009. Final analysis will compare pre- and post-intervention measures on service availability and quality among the 119 public health facilities in Uttarakhand, India.

References

India Facility Survey National Report (2005). Mumbai: International Institute for Population Sciences (IIPS).

Ipas-India website. http://www.ipas.org/Countries/India.aspx. Chapel Hill, NC: Ipas, 2008. Accessed 23 May 2008.