Title: A Successful government and NGO partnership in the provision of safe abortion services: a case study of Pune district, India

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OVERVIEW

The Indian government has adopted the millennium development goal of reducing maternal mortality from 400 per 100,000 women to below 100 by 2010. One pathway is the provision of safe abortion services since unsafe abortion accounts for approximately 15% of maternal deaths in South and South-East Asia (Ganatra 2006). To this end, Ipas, an international non-governmental organization in collaboration with the state government of Maharashtra launched a pilot intervention project in Pune district to provide technical guidance and infrastructural support in extending access to safe, woman-centered abortion care within the public health system. In 2003, Ipas conducted a baseline survey of all rural public health facilities in Pune district in the western Indian state of Maharashtra to assess the training and equipment needs in these facilities. In total, 26 rural health facilities were selected for the pilot intervention. The objective of the intervention package was a combination of training, technical assistance, provision of equipment and IEC and advocacy to increase community awareness and access to quality abortion services. The intervention was a joint effort between the state government of Maharashtra and Ipas. In July-August 2006, a follow-up survey was conducted in all rural health facilities to assess any changes in services and the number of women served. The preliminary findings indicate an overall reported improvement in services in terms of number of women served in the intervention centers as compared to the non-intervention sites. The encouraging results of the collaboration between the Maharashtra government and Ipas will facilitate the process of scale-up of this model to cover public health facilities both in the comparison sites in Pune district and in the remaining 34 districts in the state.

METHODS

This paper will present analyses based on the data collected in the baseline and follow-up interviews to answer the following research questions:

1. How did services at all rural health facilities compare between 2003 and 2006 (the three-year study period)?

2. How did the intervention affect availability and quality of Comprehensive Abortion Care (CAC) services between 2003 and 2006? Here comparisons are made between the intervention facilities and the comparison facilities.

3. How did the quality and availability of CAC services change between 2003 and 2006 among the intervention facilities?

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4. Was there a change in the knowledge and attitude of providers towards safe abortion services among the intervention facilities between 2003 and 2006?

The first and second analyses provide information about the scope and magnitude of the changes in intervention facilities compared with changes in nonintervention facilities during the three-year period. The third analysis provides information about the effectiveness of intervention activities to improve CAC services among the intervention facilities. The fourth analysis examines any knowledge and attitude change among providers at the intervention sites due to the training.

Study design
The study employed a pre-post comparison group design with nonrandom selection of comparison and intervention facilities. The comparison group allows for changes in intervention facilities to be compared with changes that occurred in nonintervention facilities and compensates for bias due to "naturally occurring" differences in the region not necessarily attributable to the intervention.

Sampling strategy
Considering the small size of the facility universe, all Rural Hospitals and Primary Health Centers (PHC) were selected for both the baseline as well as the follow up surveys.

Intentional assignment of selected facilities to the CAC intervention was done in consultation with the local state government of Maharashtra. These consultations resulted in the implementation of the Comprehensive Abortion Care (CAC) intervention in 26 of the surveyed facilities. The 26 intervention facilities were comprised of 11 rural hospitals and 15 PHCs. The 26 intervention sites were further divided into 9 pilot sites that received full intervention including training of providers and provision of equipment and other infrastructural needs and 17 trainee sites that received partial intervention with only training of providers.

Bivariate analysis was conducted between the intervention and comparison facilities in order to test for baseline differences using chi-square tests for categorical variables and t-tests for continuous variables. No statistically significant differences ($p<0.05$) were found between the intervention and comparison groups on any of the variables of interest related to facility characteristics and uterine evacuation status at baseline, namely serving rural patients; having a gynecologist or general practitioner on staff; being a hospital; providing uterine evacuation services; having or using MVA instruments; or mean number of staff.

Intervention description
Comprehensive abortion care encompasses providers with the skills to perform a uterine evacuation, clean environs and the proper equipment and supplies to perform the procedure (WHO, 2003). Yet in India, only physicians receive training to manage abortion complications and often only using sharp curettage. The CAC intervention

focused predominantly on gynecologists and physicians in the rural areas since these areas have a large unmet need for safe abortion services.

A pool of master trainers, primarily experienced gynecologists from the state of Maharashtra, participated in a short course on teaching techniques and methods. These master trainers in close collaboration with Ipas and the state public health system carried out a series of CAC training sessions for medical doctors and support staff drawn from the selected intervention sites in Pune district's rural hospitals, and PHCs. The training course package designed to improve health-care workers' skills, attitudes and ability to offer high-quality abortion services consisted of one-three weeks of training, an initial donation of MVA instruments, guidelines for the development of service-delivery protocols, supplies and equipment planning for logistics, forecasting commodities for infection prevention and implementation of a checklist for standardized supportive supervisory visits; During these sessions, the organization of CAC services (where they existed) was explored with trainers and participants from each facility to assess the efficiency of CAC service delivery. In addition in the 9 pilot sites (6 Primary Health Centers and 3 Rural Hospitals) provider training was combined with the supply of desired facility equipment such as logbooks for monitoring services, operating tables, disinfectant, beds, essential clinical equipment and IEC components and follow-up technical visits by Ipas staff thereby helping the creation of a favorable environment towards service provision.

Survey Instruments
A structured questionnaire was developed and pre-tested. It was translated into the local language. Trained investigators well acquainted with the local language and public health system interviewed the medical officer or ob/gyn at each selected site. The same questionnaire was used at baseline and in the follow up except for an additional section added to the post-test on attitude and knowledge of medical doctors towards safe abortion techniques and policies, perceived improvements to safe abortion care and the factors involved in these service improvements. Data obtained included information regarding the type and quality of abortion services; availability of uterine evacuation equipment and supplies; and providers' perceptions of service delivery improvements. Other collected data pertained to technical skill and training level of staff involved in CAC; availability of contraceptive services and types of contraceptive commodities present in the facility; quality of infection prevention practices; and quality of record-keeping.

Data Collection and Analysis
Pre-intervention data was collected during a six-week period from June to July 2003. Post intervention data was collected from June to July 2006. The data collectors were trained on the questionnaire content and survey methods. Collected data was entered through standard software and analysis is being carried out using SPSS and STATA.

For the first research question, comparisons between the 2003 and 2006 variables among all surveyed facilities will be calculated using McNemar's test, a nonparametric statistical test used to compare paired proportions. For the second research question, the associations between intervention status and changes in response from 2003 to 2006 will

be computed using appropriate models to predict 2006 outcomes after adjusting for intervention status (intervention/comparison) and other parameters. For the third and fourth research questions, differences between 2003 and 2006 among the 26 intervention facilities will be computed using suitable tests of significance for the different variables of interest.

RESULTS

The preliminary data analysis of the follow-up survey indicates favorable results from the intervention sites. 88% of the intervention sites are currently providing safe abortion services as against 18% of the comparison sites. Lack of trained providers and equipment in the comparison sites have uniformly been spelled out as the basic reasons for the cessation of safe abortion services. Further analysis is underway.

References:

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