Improved Access to Safe Abortion Care (IASAC)

Karnataka, India

April 2007
Pathfinder International

For nearly 50 years, Pathfinder International has been a leader in bringing reproductive health and family planning to poor and underserved communities around the world. Pathfinder believes that reproductive healthcare is a basic human right and that when women and men are given control over their reproductive lives, they are able to significantly improve the health and welfare of their families and communities.

Over the years, Pathfinder’s innovative programs have provided training and resources, improved maternal and child health care services, and expanded them to integrate the prevention and treatment of HIV/AIDS. Today, these integrated services reach millions of the most vulnerable women, men, and adolescents in the poorest communities of the world. Adolescents and youth are the focus of many projects, as their reproductive choices will influence coming generations. Pathfinder also works to ensure safe abortions where they are legal and to provide quality care for the thousands of women who have experienced unsafe abortions.

Pathfinder In India

Pathfinder International has been working in India since 1999 with programs in urban slums and rural areas of five states across India, including Delhi, Bihar, Rajasthan, Maharashtra, and Karnataka.

In a culture with long-standing traditions of early marriage and childbearing, Pathfinder promotes knowledge and understanding of the dangers of adolescent childbirth, the personal health benefits of delaying the first birth until a woman reaches age 21, and of spacing subsequent children by at least 3 years. Initiatives are currently funded by the David and Lucile Packard Foundation.

With the generous support of the Bill and Melinda Gates Foundation, Pathfinder integrates HIV/AIDS and sexually-transmitted infection (STI) prevention and treatment for vulnerable groups in high prevalence districts of Maharashtra. Interventions address sex workers and their partners, and work to prevent the transmission of HIV/AIDS and STIs through behavior change communication, STI treatment, voluntary counseling and testing, and support to adopt safe behaviors.

This report describes Pathfinder’s work to improve access to safe abortion services in selected districts of north Karnataka. The work was supported by an anonymous donor.
Improved Access to Safe Abortion Care (IASAC)

Karnataka, India

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The problem of unsafe abortion in India may be attributed both to poor medical care and to widespread ignorance and misunderstanding among women about safety and quality of care. Of central importance is the inadequate training in abortion procedures offered to Indian medical students, the majority of whom are not qualified to perform any abortions. Those who are legally qualified to perform abortions have not received training in the relatively new techniques of Manual Vacuum Aspiration (MVA) and Medical Methods of Abortion (MMA), which are far simpler, safer, and more affordable for early abortion than the widely known and used dilation and curettage. They also are inadequately prepared in infection prevention and in counseling women in postabortion contraception that could reduce the probability of future unwanted pregnancies and consequent abortions.

The IASAC project aimed to improve the quality of abortion training for present and future medical students, while, at the same time, extending that training down to a significant number of current abortion providers at the community level. The project was based in northern Karnataka, one of the poorest regions in India, and was intended to improve the access of the poorest and hardest to reach women to skilled providers.

Pathfinder joined with senior faculty from six medical colleges in Karnataka, training them in MMA and MVA and preparing them to become trainers of other physicians in their districts. Over the course of the project, 21 faculty/master trainers were trained. They, in turn, trained a total of 318 providers – two practitioners in each of 49 towns in 7 districts. Pathfinder has now trained 17 percent of the best-known abortion providers in the districts covered, who currently perform 60 percent of all abortions in these districts. The 318 community physicians trained were strategically chosen to ensure availability of a qualified provider within 20 kilometers of any village in the districts. An additional 600 general practitioners (physicians who were not legally eligible to provide abortions) participated in workshops that exposed them to the appropriate use of MVA and MMA.

The master trainers also trained fellow faculty and students in their respective colleges, and by including MVA and MMA in routine teaching, ensured the continuation of this training in the future. At the current level of training, at least 40 postgraduate physicians and 600 basic medical degree graduates (MBBS) annually will enter the profession trained in safe abortion procedures.

Improving the skills of providers was only half the challenge of addressing high maternal mortality and morbidity due to abortion in northern Karnataka. Women in poor, mostly rural areas of India are unaware that the safety of abortion depends on
seeking services early in pregnancy from a trained and certified provider. Nor are they aware of the relative safety of different methods of abortion.

Pathfinder trained seven Nongovernmental Organizations (NGOs) to provide public education and raise awareness of the importance of going to a qualified and trained provider for an abortion within the first eight weeks of gestation. Through a series of public meetings, workshops, plays, and theatre productions, as well as printed material and posters, NGO partners reached more than 40,000 women with information about pregnancy testing, the need to seek an abortion within the first seven to eight weeks of gestation to be eligible for MVA or MMA, and the need for a qualified provider to perform the procedure. Parallel educational workshops and trainings were held to expose community and religious leaders to the dimensions of the unsafe abortion problem in their midst and to the urgent need to support women’s access to quality care.

Pathfinder undertook baseline and endline surveys of providers and women to track the results of the IASAC project activities. Significant changes were documented in the proportion of women who knew that abortion is safer when sought early in pregnancy, and in the proportion of women who adopted postabortion contraception. The availability of quality MVA and MMA services increased significantly. There was also a growing demand for training from providers in adjoining districts.

This report documents the lessons learned from this pilot project and makes recommendations for the Indian Ministry of Health, medical associations, medical colleges, and other professional colleagues involved in promoting women's reproductive health and safe abortion.

With immediate changes in the law, aggressive public education efforts, and the participation of faculty of medical colleges, broad changes were achieved. Using the Pathfinder-proven approach of training private practitioners, first through preservice training of medical students, and later through inservice training of providers in their own clinics, reduction in mortality and morbidity from abortion could be achieved in a relatively short period of time. Through comprehensive and culturally sensitive community outreach, women can be informed first about the availability and advantages of contraception, as well as the important steps they must take when they need to obtain a safe abortion.
Introduction

The Improved Access to Safe Abortion Care project (IASAC) was launched in June 2003 by Pathfinder International. The project sought to promote the widest possible availability of safe abortion services in the seven relatively backward, predominantly rural, northern districts of Belgaum, Bellary, Gulbarga, Bidar, Bagalkot, Raichur, and Davangere in the state of Karnataka, India. This project sought to develop and refine a system that could effectively reduce the serious health risks taken by the thousands of women who seek abortion services throughout the country every year.

Abortion In India

More than 6.7 million abortions are estimated to occur annually in India.\(^1\) Across the country, nearly 540 out of 100,000 live births result annually in the mother’s death.\(^2\) Of the nearly 70,000 deaths due to unsafe abortion around the world every year, 20,000 of them are in India,\(^3\) representing 9 percent of maternal deaths in the country.\(^4\) Many more women suffer from complications and often permanent impairment. Pathfinder’s IASAC project baseline study indicated that 30 percent of women in project areas, who had had an abortion, reported that they had suffered from complications, including bleeding, infection, and malaise.\(^5\) Both mortality and morbidity are serious issues.

Government of India Reform Efforts

Acting to reduce mortality and morbidity arising from abortion, the Government of India passed the Medical Termination of Pregnancy (MTP) Act of 1970 to encourage women to seek services from properly qualified, rather than covert providers. The act regulates who may provide abortion services and where. Government policy stipulates that abortion must be available free of cost in all government health facilities, including rural Primary Health Centers (PHCs).

Despite government efforts, awareness of the legality of abortion remains low—particularly among uneducated rural women. Social taboos and

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2 National Family Health Survey 2 (NFHS 2) – India: International Institute for Population Sciences, ORC Macro, Maryland; October 2000 (pg. 196).
4 Ibid.
5 IASAC Project Baseline Study, Pathfinder International, July 2004, conducted in 3 of the 8 Project districts of north Karnataka
moral judgments keep abortion quiet, and poor women have no concept of trained versus untrained practitioners or different abortion methods.

Poor Provider Skills:  
Fully one-third of abortions in India are performed by untrained, informal providers. These are rural medical practitioners or traditional birth attendants (Dais) with no concept of infection prevention, who follow a variety of dangerous practices for abortion. Another 35 percent of abortions are performed by doctors with both a basic medical degree (MBBS) and a postgraduate degree in obstetrics and gynecology. The final 32 percent of abortions are performed by trained general practitioners who are medical providers with a basic MBBS degree in medicine. Although these doctors can perform surgery and deliver babies, they graduate from medical school with only theoretical exposure to abortion procedures and are not legally allowed to perform abortions unless they have performed 25 abortion procedures under supervision in a certified training facility.

The government has established MTP training centers in each state and specifies a training protocol to ensure the thorough safe abortion training of government practitioners. In spite of these measures, abortion-related maternal mortality and morbidity remain unacceptably high. Fewer than 10 percent of government doctors have received training in these centers. The training itself is not comprehensive. It focuses only on Dilation and Curettage (D&C) and Electrical Vacuum Aspiration (EVA) and excludes Manual Vacuum Aspiration (MVA) and Medical Methods of Abortion (MMA). Considering that 73 percent of abortions in India occur in the first trimester, this focus on D&C and EVA is misplaced. Providers should be encouraged to use MVA within eight weeks or MMA within the first seven weeks of gestation. Further, training in infection prevention and postabortion contraception are also ignored.

Nearly 50 percent of all abortions occur in rural India, where only 25 percent of government facilities offering abortion are located. In Karnataka, only 25 percent of PHCs have the infrastructure, equipment, and personnel to offer safe abortion services. Access to certified providers is better in urban areas, but the safety and quality of care differ little.

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Qualification of providers performing abortions

![Diagram showing the qualification of providers performing abortions.](image)

6 Abortion Assessment Project-India: Summary and Key Findings; August 2004.
7 Ibid.
8 Ibid.
Public vs Private Services

Much work is required to improve access to and utilization of safe abortion services, and that work must focus on both public and private sectors. Abortions in both sectors are performed in very rudimentary conditions. Facilities lack essential basic equipment and utilities, and basic infection prevention procedures.

Current government-sponsored inservice training opportunities are provided only to public sector practitioners, while private practitioners rarely receive continuing education.

Yet, 87 percent of all abortions in India are provided by the private sector. Government facilities are supposed to offer free abortions, but, in reality, patients pay in both monetary and personal ways. Fees are charged, and they encounter long waits, lack of privacy, and disrespectful treatment. Women fear they will be forced or strongly pressured to accept sterilization if they want to receive an abortion. As a result, most women prefer private services.

Though accurate statistics on the mortality and morbidity resulting from these abortions are not available, the methods used and the conditions in which the procedures are performed make it likely that associated complications are high.

Mechanisms for review of safety and quality of services:

Although the MTP Act requires the review of safety and quality of abortion services, systems for review are generally absent or dysfunctional. The law requires private facilities to be certified by government authorities, but certification is difficult (or nearly impossible) to obtain. Fewer than 24 percent of private facilities are certified, and 68 percent of uncertified facilities have never even tried to obtain certification. In the absence of certification, facilities do not report abortions performed, which contributes to the unreliability of data on mortality and morbidity. Fearing exposure, uncertified facilities rarely refer complications to recognized centers, thereby endangering the lives and health of their clients. Were the system of certification to work, providers could be required to display signage declaring their status, and women could then easily recognize and go only to certified facilities.

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13 Ibid.
14 Abortion Assessment Project: India: Summary and Key Findings; August 2004.,
15 Ibid.
The IASAC Project

Abortion rates in Karnataka are 1.3 times the national average.\textsuperscript{16} Sixteen percent of pregnancies in Karnataka end in abortion, compared to 13.3 percent nationally.\textsuperscript{17} And 80 percent of abortions in Karnataka are induced,\textsuperscript{18} compared to 60 percent nationally.\textsuperscript{19} Northern Karnataka was chosen for this project because of the poor reproductive health indicators of this region when compared to the rest of the state (see Table 1).

Table 1:
Reproductive Health Statistics - Northern Karnataka vs Other Parts of Karnataka

<table>
<thead>
<tr>
<th></th>
<th>Northern Karnataka</th>
<th>Other parts of Karnataka</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age of marriage</td>
<td>16.3</td>
<td>18.1</td>
</tr>
<tr>
<td>Percentage of pregnancies ending in abortion</td>
<td>18%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Total Fertility Rate</td>
<td>2.98</td>
<td>2.13</td>
</tr>
<tr>
<td>Couple Protection Rate</td>
<td>41%</td>
<td>59%</td>
</tr>
<tr>
<td>Unmet need for contraception for spacing children</td>
<td>15%</td>
<td>59%</td>
</tr>
<tr>
<td>Unmet need for permanent methods of contraception</td>
<td>16%</td>
<td>9.4%</td>
</tr>
<tr>
<td>1st trimester antenatal morbidity</td>
<td>11.6%</td>
<td>6.1%</td>
</tr>
</tbody>
</table>

Note: Virtually all first trimester morbidity is known to be abortion-related.


\textsuperscript{19} Abortion in India, An Overview, ME Khan et al, 1996.
Based on the abortion scenario in India and Karnataka, project designers decided that the greatest long-term impact could be achieved by adopting the following combined strategies:

1. Teach safe abortion techniques to faculty in district medical colleges, who would become trainers to current and future generations of providers.

Train providers to:
(a) Switch from D&C to the safer methods of MVA and MMA within seven to eight weeks of gestation. Even though 73 percent of all abortions in India are in the first trimester, providers still predominantly use D&C, which has higher postabortion complication rates. The project baseline study established that 30 percent of women complained of post-D&C complications such as bleeding, infection, fever, and malaise. The number reporting postabortion complications dropped to 14 percent with MMA and to only 2 percent with MVA;
(b) Improve infection prevention practices; and
(c) Counsel their clients in postabortion contraception to prevent repeat abortions.

2. Encourage and assist practitioners to upgrade clinics and facilities to meet the legal standards and apply for certification. Support health authorities to certify those facilities that meet prescribed standards and facilitate the process of certification.

3. Through systematic training, ensure that every district town has at least two project-trained providers, ensuring access to every woman in the catchment area.

4. Promote public education and behavior change to encourage women to seek abortion within the first eight weeks of gestation from a trained and qualified provider.

Engaging Medical Colleges and Local Doctors for Training

Six medical colleges and their affiliated teaching hospitals, and two NGOs in the seven project districts of Karnataka enthusiastically agreed to participate in the project. Forward-looking deans and leaders from the medical colleges welcomed the opportunity to learn safe methods of abortion, as well as the comprehensive package of services taught by Pathfinder, including counseling skills in postabortion family planning and method choice, condom

Project Medical Colleges and NGO Partners:

- Sri Nijalingappa Medical College (Bagalkote)
- Jawaharal Nehru Medical College (Belgaum)
- Vijayanagara Institute of Medical Sciences (Bellary)
- Indian Medical Association Bidar (Bidar)
- Jagadguru Jayadevappa Mahalinga Medical College (Davangere)
- Mahadeva Rampure Medical College (Gulbarga)
- Navodaya Medical College (Raichur)
- Agragami India (Bellary)
use, STI risk assessment, and infection prevention.
Pathfinder agreed to train leading faculty as master
trainers, who would introduce safe abortion procedures
and protocols into their own teaching hospitals and
clinics, as well as into the curriculum for their students.
The colleges and their affiliated hospitals identified
deficiencies in their infection prevention protocols,
making changes to meet essential quality standards.

Master trainers were further expected to train a
minimum number of local practitioners in their
districts. The location of colleges within each
district made a low cost, decentralized model of
training possible, allowing practitioners to be
trained in their own clinics, using their own patient
load for practicum.

Training Medical Faculty/
Master Trainers
Each college selected two to four senior specialists
in obstetrics and gynecology for training, yielding a
total of 21 master trainers. Their training included
a five-day session on theoretical and clinical
aspects of MVA and MMA. Practicum sessions
involved assisting in one MVA procedure and
independently performing at least two. A second
four-day round focused on developing skills in
participatory methods of teaching others. Master
trainers engaged in role play and experimented
with teaching techniques, while receiving support
and feedback from one another.

Master trainers were subsequently required to in-
dependently perform ten MVA procedures in their
practices before being assessed and certified. Routine
clinical screening for sexually-transmitted in-
fecations and syndromic management of infected
patients were introduced as part of integrating the
prevention and detection of HIV/AIDS into the
regular RH treatment of women.

Initially, master trainers were dismissive of
contraceptive counseling. Training in India does
not sufficiently emphasize the powerful role of

Knowing how to estimate the gestational age of the fetus, based on its size, is essential in deciding whether a client is
eligible for MMA or MVA. These master trainers are learning how to teach the technique to other doctors.
contraception in protecting the reproductive and gynecological health of women. Indian physicians often miss the opportunities provided by antenatal, labor and delivery, postnatal and postabortion contacts with clients to provide contraceptive counseling. However, these skills were critical elements in the overall approach to care being presented, and master trainers quickly grew to value the role played by postabortion contraceptive counseling in preventive care.

**Enriching the Medical College Curriculum**

Once fully trained, the master trainers began introducing the new techniques of safe abortion into the routine teaching and practice of the medical colleges and their affiliated hospitals. At the current level of training in the six medical colleges, at least 40 postgraduate physicians and 600 MBBS graduates will enter the profession annually, trained in safe abortion procedures as required by the MTP Act. This process guarantees a sustainable increase in the number of doctors qualified under current law to provide safe abortions services.

**Training Community Doctors**

The IASAC project strove for impact—to ensure that the largest possible percentage of abortions is performed safely. At least two practitioners from each of 49 towns in the 7 project districts were selected for training to ensure that, by the end of the project, women in all villages of these districts could access a project-trained practitioner within 20 kilometers (a one hour bus journey) from their villages. Practitioners chosen for training were already active abortion providers and were eligible under the MTP Act. They were required to adopt new techniques and strengthen their clinical facilities to meet the requirements of the MTP Act.

A total of 318 practitioners were trained in MVA and MMA, representing 17 percent of all the abortion providers in the project districts, and between them performing 60 percent of all abortions in the districts. Sixty-four percent of the practitioners trained were women. Seventy percent were private and 30 percent were government doctors. Twenty-eight percent had a basic degree in medicine and surgery (MBBS), and 34 percent had postgraduate qualifications in gynecology and obstetrics (MD or DGO). On average, project-trained providers were conducting 7.5 first trimester abortions a month.

In training the community doctors, not only were appropriate procedures covered, but also infection prevention, bio-safety hazard management, and facility upgrades were essential to receive certification. Trainers also addressed the chronic problem of...
poor or nonexistent patient records. Master trainers designed and provided practitioners with simple record-keeping forms, placing great emphasis on the importance of such material for competent healthcare delivery. However, based on Pathfinder’s initial post-training evaluation, 100 percent of the doctors were following infection prevention protocols, and 90 percent followed medical protocols for safe abortion correctly, but zero were maintaining records. It is clearly an area difficult to reform.

Over the 28 months of training and supervision, doctors trained in MVA conducted at least 33,000 safe abortions using the technique. Had these abortions been performed using D&C, a third of the women would have reported resultant complications and morbidity. At least 11,000 cases of postabortion complication are thus estimated to have been averted. Abortion-related mortality averted by project trained doctors during these 28 months is estimated to be 20.

Even if only the 318 providers trained in MVA continue to conduct their present average of 7.5 abortions a month, they will conduct 28,620 safe abortions and avert 19.1 maternal deaths and 9,445 complications of abortion every year.

Several practitioners trained by the project have been approached by colleagues from neighboring

Dr. Shashirekha (center) runs the Government Primary Health Center in Kerur village. She was trained by Dr. Asha Mallapur of the Sri Nijalingappa Medical College, Bagalkote. Word has spread that she conducts painless abortions without complications, expanding her already busy private practice. She does 10 to 12 abortions, 50 deliveries, and 50 tubectomies a month. Like all other physicians interviewed for this report, she has seen no infections with the MVA procedure.

Dr. Shashirekha works in a very poor area, heavily populated with transients and migrant workers, and she sees many commercial sex workers. She tests all of her clients for sexually transmitted infections and reports that 40 percent have STIs, and of those 60 percent have HIV/AIDS. She has enthusiastically adopted the new infection prevention protocols learned in her training. “It has been very effective,” she reports. “Before, many women complained of excessive bleeding and of pain from infection, but not now.”
districts and states with requests to share their skills and training. Such dissemination of know-how will result in more and more doctors adopting safe abortion techniques as a result of the project.

Training in Medical Methods of Abortion

Discussions with pharmacists, community doctors, and master trainers revealed that the medications used in MMA are widely available without prescription and are being used by a variety of providers, including general practitioners, without proper training. Improper drug regimens are leading to incomplete abortions and excessive bleeding. Pathfinder and the master trainers jointly decided that it was necessary to give the largest possible number of medical practitioners in the districts knowledge of the safe use of MMA so that those who used it would do so with safety.

Pathfinder and the medical colleges collaborated with 37 chapters of the Indian Medical Association and organized a series of 29 continuing medical education sessions at which a total of 609 MBBS doctors were educated on the safe use of MMA and counseling in postabortion contraception. Interviews conducted before training revealed that only 20 percent of these physicians knew the correct dosage or schedule of administration of the drugs involved, and only 25 percent knew when a woman returns to fertility postabortion. Particular emphasis was placed on correct drug regimen, contraindications, and estimation of gestational age to enable proper selection of cases for MMA.

Training Nurses and Paramedics

Even as the physicians were being trained in new techniques, their staff received a two-hour immersion course in infection prevention, emphasizing decontamination of instruments, equipment, and handling of bio-hazardous waste. The new curriculum teaches doctors and staff the “whys” as well as the “how” of each procedure, helping them to appreciate the importance of rigorously following protocols for their patients’ and their own safety.

As of this writing, IASAC had trained more than 1,000 nurses and paramedics in college-affiliated
hospitals. Their two-hour training session included a technical update on modern methods of contraception, as well as practice in counseling and motivating women to adopt family planning immediately after an abortion. Here again, skills in communication were emphasized.

Abortion vs. Safe Abortion – Building Awareness

At the outset of the project, Pathfinder engaged the Population Research Centre, JSS Institute of Economic Research in Dharwad, India, to carry out a qualitative study comprising focus group discussions and in-depth interviews with women and abortion providers, to collect data on existing knowledge, beliefs, and perceptions related to the legality, morality, and acceptability of abortion, as well as current practices.

The institute also surveyed practitioners and women to gather quantitative baseline data on key indicators and to establish benchmarks against which project performance could be measured. Data was gathered on local experience of complications due to past abortions and the number of women adopting postabortion contraception. The timing and costs of abortions were also assessed.

Both qualitative and quantitative studies were conducted in seven areas of the districts of Gulbarga, Bellary, and Bagalkot, including interviews with three groups: 581 married women ages 15-34; 158 married women, who had had an abortion in the last two years; and 118 medical practitioners, 48 of whom were abortion practitioners.

Morbidity has gone down to zero with the MVA method, according to all of the doctors interviewed. “It used to be 30-40 percent with infections,” says Dr. Basavaraj Reddy at his clinic in Hagaribommanahalli. “We were used to seeing women with perforations of the uterus from D&C.”

“Not a single one of my clients has ever completed a full course of antibiotics. They take them until they feel better and then sell the rest. It is difficult to practice medicine according to my best knowledge and training.” Dr. Reddy worries that medical representatives sell medicines to quacks, “who don’t know enough to be worried about how they should be used. They work blindly. I am the one who worries!”
Baseline Survey Results on Attitudes and Beliefs

The majority of women interviewed reflected the following beliefs, knowledge, and experience:

Beliefs/traditions:
• Women do not seek abortion openly or discuss it frequently;
• Women seek abortion because of health problems, wanting no more children or to space them, and because of sex preference; and
• The decision to seek an abortion is generally a joint one between the woman and her husband, and to some extent, the mother-in-law.

Knowledge and experience:
• Two-thirds of the women sought abortions by 12 weeks of pregnancy, but some waited as long as 20 weeks;
• Most women do not know that abortion is legal or that providers must be certified;
• Most women know nothing about different methods of abortion. Of those who had had abortions, three-quarters had D&C procedures, based on their descriptions;
• Few women know about the importance of hygiene or infection prevention; and
• About one-fifth of the women who had had abortions reported complications, including severe bleeding, giddiness, sweating, and fever.

Survey information on providers included:
• Of those women who had had an abortion, 93 percent had been treated by MBBS-qualified doctors, indicating that in project districts, a minimal number are performed by totally untrained providers;
• Only six percent of these women had abortions in government hospitals;
• Of the 48 physicians surveyed who were practicing abortions, only 44 percent had ever attended any training on induced abortion, and most of these were of one day only;
• Hardly any practitioners were using MVA or MMA, even though many women came early enough to qualify for these methods; and
• Two-thirds of the women received no advice from the provider about the use of postabortion contraception.

The baseline survey confirmed a widespread need for more training in safe abortion procedures for providers, particularly in the use of the newer techniques for early abortion. It also suggested the need for ongoing community education and awareness-raising about the importance of seeking abortion as early as seven to eight weeks into the pregnancy, rather than the generally understood 12 weeks or later. Results also confirmed women’s lack of awareness about the importance of seeking a certified abortion provider.

According to the project baseline study, only 15 percent of pre-project MBBS doctors in Karnataka met the MTP qualifications for certification. Unfortunately, most women seeking abortions have no information on the training and qualifications of local MBBS doctors. Too often, an unqualified practitioner seeking a fee may attempt to stimulate a delayed period or ask a woman to wait to confirm pregnancy, only to finally refer her to a certified abortion provider. The resulting delay can rule out the opportunity to use MVA or MMA, thus exposing the woman to the risks of D&C.

Few of the women surveyed had concerns about hygiene or infection control or knew that there were newer and safer methods of abortion available.

Raising Community Awareness

The original design of the IASAC project focused entirely on expanding the pool of trained and certified providers accessible to the least advantaged segments of the region and strengthening their skills in using safe early abortion techniques through intensive training and practice. Pathfinder’s training protocols required each trained doctor to independently conduct 10 cases before being certified as competent in MVA, so mobilizing a caseload for practicum became a major challenge for the program. Each medical college and affiliated hospital involved in the project launched its own public awareness and media outreach efforts to attract women from villages within a 20 kilometer radius, offering free and safe abortions over a period of three months.
Surprisingly, despite this effort, the lack of understanding at the village level remained greater than Pathfinder had anticipated, and an aggressive program to inform women at the community level was continued. Abortion is not a “water tap” topic of conversation, and knowledge travels slowly. Many women make decisions on their own without good information about how to choose a provider.

To gain access to remote villages, Pathfinder partnered with seven local NGOs already working in these communities, training their staff to educate women on the importance and availability of safe abortion.

Pathfinder developed communication content and visual aids that NGO staff could use to talk to women and health workers at the village level, and to government health and development personnel. Because abortion is such a sensitive issue, communicators were trained to introduce the topic carefully to appropriate groups.

All the NGOs incorporated Pathfinder’s safe abortion communication activities into their ongoing behavior change communication programs on immunization, antenatal and postnatal care, family planning, safe delivery, and self-help. One of the NGOs, SARDA, even trained a theater group/cultural troupe, who converted Pathfinder’s flip chart script into a drama and enacted it for women in the community. Teams of community outreach workers conducted street plays, audio-visual shows, seminars, workshops, and other trainings.

Seeking to train women between ages 15 and 34, Pathfinder’s challenge lay in gaining access to them. Members of village women’s self-help and microcredit groups were addressed. The Indian government trains village women called anganwadi workers to run village preschools and promote the nutrition and health of pregnant and lactating mothers and their children. Anganwadi centers provided an excellent point of entry to reach women of reproductive age. Interest in the topic of abortion often drew teenage girls to the meetings as well—in spite of the disapproval of their mothers. If the teens were interested and came, the organizers of the meetings did not prohibit their participation.

Pathfinder developed a flip-chart presentation detailing the pros and cons of safe and unsafe abortion choices through a simple story that deals with two women who make different decisions regarding abortion. Mallava makes the right choices and Yellamma the wrong ones, enabling listeners to evaluate the issues and learn from their experience.
The flip-chart story obtains results, because it can be used in any local language and engages audience participation and questions.

Over the course of the project, Pathfinder and its partners reached close to 40,000 women, 6,000 village health functionaries, 2,000 village leaders and office bearers, and close to 3,000 district-level functionaries in the departments of social welfare, health, and education. Women and child development workers, anganwadi workers, auxiliary nurse midwives, hospital and primary health center ward aides (ayahs), school teachers, supervisors of self-help groups, NGO outreach workers and supervisors, and small savings scheme outreach workers all learned to incorporate the messages on safe abortion into their routine communication and outreach programs. Armed with lists of trained doctors, they referred or even brought women to the trained doctors for abortion.

Midterm Survey Results
Over the course of the IASAC project, nearly 102,000 contacts were made with community leaders and women through workshops, educational and advocacy meetings, street plays, and the distribution of leaflets and posters. This degree of contact and conversation engaged a sufficient proportion of the community so that general knowledge and behavior began to shift. In 2005, a survey was carried out in the districts of Gulbarga, Bellary, Bagalkot, and Belgaum to measure change one year after project implementation. Altogether, 792 married women were interviewed, as well as 185 women who had had abortions, and 179 abortion practitioners. Significant changes in both provider behavior and abortion-seeking behavior were documented, including:

- The availability of quality MVA and MMA abortion providers increased significantly. The percent of abortion providers proficient in these methods in the project area increased from 16.7 percent to 40.2 percent;
- One hundred percent of trained providers had switched from the use of D&C to the appropriate use of MVA/MMA for first trimester abortion;
- The rate of complications in first trimester abortions, as reported by women, decreased from 33 percent using D&C to 4 percent with MVA, and 10.7 percent with MMA;
- The percent of women reporting that they accepted contraception after an abortion rose from 27.7 percent at baseline to 46 percent at endline.
- The proportion of women who were aware that abortion is safer within the first 12 weeks of gestation increased from 33.2 percent at baseline to 64.6 percent at endline.
Conclusions and Recommendations

Access to safe abortion services remains an enormous need in India. Guided by important lessons learned in the IASAC Project, Pathfinder offers a number of recommendations.

Recommendations to the Ministry of Health and Government Policy Makers:

a. Regulatory Improvements – Regulatory measures do not always succeed in India. Enforcement is uniformly weak, and considerable ingenuity is exercised to side-step regulation. The MTP Act is no exception. The government’s current approaches to ensuring safety of abortion services through the provisions of the MTP Act need reexamination:

i. The level of provider qualification and experience prescribed in the MTP Act was determined 25 years ago, when the safest available techniques included EVA and D&C, both requiring high-level providers. Today, these qualifications are not necessary. The newer techniques of MVA and MMA are simple, safe, and especially suited for early abortions. They can safely be used by properly trained general medical practitioners (MBBS) and auxiliary nurse midwives, who live and work in rural areas. If they were trained and allowed to perform first trimester abortions, access to safe services would improve significantly.

ii. The Government of India recommends that MVA be used only for gestation up to eight weeks, and MMA up to seven weeks. These recommendations are conservative and unnecessarily restrict access to safe abortion. Internationally, MVA is effectively used up to 12 weeks of gestation, and MMA up to 10 weeks, and Pathfinder recommends these parameters based on guidelines developed by WHO. All government facilities should be equipped with MVA equipment and drugs for MMA.

iii. The system of facility certification should be made effective and implemented with even-handedness, speed, and effectiveness. Once facilities are certified, they must display prominent signage at the entrance, so that women know where to go for safe abortion services.

b. If serious about improving the availability of safe abortion services, the government must ensure that safe services are available at public facilities. Once these services are well-established and generally known, government doctors will no longer be able to wean women seeking abortion away from the PHC to their private clinics for a higher fee.

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Both public and private providers must be trained. Private training facilities must be developed and certified so that private practitioners can benefit from training.

Promote public education about safe abortion through clinics and Anganwadi Centers. Women must know how to avoid unwanted pregnancies, but should they need an abortion, they must know how to track their periods, confirm pregnancy early, and seek care immediately. They need to know where to go for a safe abortion and how to evaluate the safety of services received. Education about home pregnancy testing will eliminate the role of unscrupulous providers who charge needlessly for testing and delay the actual abortion until it is no longer a safe procedure.

Recommendations to Medical Colleges:

The most effective and sustainable measure to improve abortion safety would be to ensure that medical graduates and postgraduates emerge from college with good training and practical exposure to safe abortion, including the newer techniques of MVA and MMA. Students must understand the comparative safety of these methods and of D&C and EVA. The use of D&C must be strongly discouraged as inappropriate for early abortion and the cause of avoidable morbidity. Infection prevention must be emphasized, along with public health. Medical practitioners have not realized the power of contraception in ensuring the gynecological health of women and the well being of families. Few graduates or even postgraduates in obstetrics and gynecology use a client visit to give women essential information on related issues that can keep her well and healthy or to refer her for other needed services. This can be corrected through the education and training of medical students.

Medical practitioners do not always realize the power of contraception in ensuring the gynecological health of women and the well being of families.

The wide reach of IASAC can only begin to be understood by looking at the ever-growing pool of providers who seek training. As safety has emerged as an expectation in the original project districts, it is now being sought in neighboring districts as well. This strengthening and widening of the pool of qualified providers has contributed significantly to meeting the government of India’s goals as set forth in the MTP Act. Pathfinder is currently extending the work of training practitioners in Bihar.

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Farzana Begum is 35 years old with 4 children under the age of 9. Her husband teaches the Kannada language in private schools, and they know they cannot afford more children.

Farzana decided to seek an abortion, despite the fact that it is against her Muslim faith. She and her husband agreed that it was the only thing to do. She learned from Hindu neighbors that it is now possible to obtain safe and painless abortions at the MR Medical College district hospital. (This is not a topic that she would have discussed with her Muslim friends.) “I came here because they are very well trained and can handle any complications that might arise. I came here because it is safe here!”
Acronyms and Abbreviations

D&C  Dilation and Curretage
EVA  Electrical Vacuum Aspiration
IASAC  Improved Access to Safe Abortion Care
MMA  Medical Method of Abortion
MTP Act  Medical Termination of Pregnancy Act

MVA  Manual Vacuum Aspiration
NGO  Nongovernmental Organization
PHC  Primary Health Center
STI  Sexually Transmitted Infection

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- our 21 master trainers and Dr. Vijaya Srinivasan, the IASAC Project Director, for traveling tirelessly over thousands of miles of difficult terrain and roads, to reach and meticulously train practitioners in the 49 small towns of our project districts;
- the heads of the Departments of Community Medicine of the medical colleges, who worked to educate and mobilize women in the community.
- The many practitioners who accepted training and adopted and promoted new practices, making all our efforts worthwhile.

Without you all, IASAC would not have been possible.

Photos by Jennifer Wilder, Pathfinder International