

First, our experience strengthening Government health facilities to deliver PAFP, especially PAIUD services, highlighted the importance of functional abortion services within such facilities. We designed the intervention requiring a 10% uptake of PAIUD services before we could graduate and declare a facility adequately prepared and functional for PAFP service delivery; however, many facilities were not offering abortion services and were therefore unable to attain this goal within the expected time frame. In addition to posing a challenge for our work, this also highlighted the fact that despite liberal legislation regarding abortion provision in the MTP, the public health system has not prioritized these services. This systems gap represents a window of opportunity for future programming—both to strengthen abortion service provision in eligible facilities and to concurrently continue and expand EAISI interventions to increase access to and uptake of PAFP.

Further, by design, we required intervention facilities to offer high enough abortion case loads to support the practical component of the training. Low case loads resulted in limited opportunities for this practical training and, as a result, it was primarily service providers approved to conduct abortions who were able to practice PAIUD insertions, with the trained staff nurses and ANMs often lacking opportunities to practice their skills. To ensure that our capacity building initiative aligned with demand for abortion and PAFP services, and to ensure adequate case loads for the practical trainings, we introduced a community-level awareness raising and counseling intervention through frontline workers.

Finally, legal restrictions related to PAIUD data recorded in the MTP register meant that EngenderHealth staff did not have direct access to this information, thus limiting our ability to improve PAFP data management.

CONCLUSIONS

The high rate of unintended pregnancies and consequent abortions indicates a significant unmet need for FP in India. PAIUD is a safe and effective PAFP method that can help address repeat unintended pregnancies and related abortions. EngenderHealth, through its EAISI project, demonstrated success in strengthening facilities' abilities to address abortion clients' FP needs and prevent future unintended pregnancies through the provision of quality counseling and range of contraceptive methods. We used a dynamic model that constantly evolved to meet field realities arising primarily in response to the legal context, systemic weaknesses, and community-level misperceptions and lack of awareness. As a result, EngenderHealth increased the number of facilities able to offer PAFP services and also the number of clients who adopted PAIUDs or other PAFP methods. Our experience suggests that future strategies for promoting PAFP, especially PAIUDs, need to consider the following:

- **Availability of trained staff:** Facilities certified to provide abortion services, as per the MTP Act, must have the requisite staff. This may require conducting trainings (and refresher trainings) to update staff skills in clinical and counseling services associated with abortion and PAFP services, with full understanding of abortion-related legislation.
- **Awareness creation:** Frontline workers need to be familiar with and likewise increase awareness related to the legality of abortion and the availability of services in their communities in order to generate demand to support the strengthening of facilities.

- **FP counseling:** All abortion clients should receive comprehensive FP counseling and related support to make informed, voluntary PAFP decisions.
- **Health system support:** The health system must support providers and facilities in delivering services, including through monitoring service quality, reviewing facility data, and supporting providers and facilities in addressing challenges they face in implementing the Government's mandate for abortion and PAFP services.

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ACKNOWLEDGEMENTS

EngenderHealth is grateful to the Ministry of Health and Family Welfare, the Government of India, as well as state Governments of Gujarat and Rajasthan for their leadership and collaboration in delivering this program and scaling up postabortion FP services. We would also like to thank all current and former EAISI project staff, without whom it would not have been possible to deliver quality programming and achieve these results. This document was written by Sunita Singal, Manoj Pal, Levent Cagatay, Anupama Arya, Vijay Bhaskar, Dawood Alam, Arpit Sinha, and S Kaushik. Amy Agarwal edited and designed this brief.

SUGGESTED CITATION

Singal, S., Pal, M., Arya, A., Cagatay, L., Sinha, A., Kaushik, S., Bhaskar, V., and Alam, D. 2020. *Strengthening Postabortion Contraceptive Services: Lessons Learned from the Expanding Access to Intrauterine Device Services in India (EAISI) Project*. Edited by A. Agarwal. Washington, DC: EngenderHealth.

Strengthening Postabortion Contraceptive Services

Lessons Learned from the Expanding Access to Intrauterine Device Services in India (EAISI) Project



PROJECT BACKGROUND

In Gujarat and Rajasthan, approximately 15% of currently married women of reproductive age in 2015–16 (Gujarat: 17%; Rajasthan: 12%) reported having an unmet need for Family Planning (FP) (IIPS and ICF 2017). Furthermore, studies have estimated that 53% of pregnancies in Gujarat are unintended, 64% of which end in induced abortion, suggesting a notably higher unmet need for FP (Iyengar and Iyengar 2016). Recognizing this need, EngenderHealth launched the Expanding Access to Intrauterine Device Services in India (EAISI) project in 2015 to provide technical assistance to the state and district health systems in both states to increase demand for and improve availability, quality, and sustainability of Intrauterine Device (IUD) services.

Fertility may return within 10 to 11 days of an abortion; therefore, the World Health Organization recommends delaying contraception for at least six months following an abortion, including by adopting a Postabortion Family Planning (PAFP) method (MoHFW 2016). Availability of safe and effective PAFP methods, particularly Postabortion IUDs (PAIUDs), can reduce the imminent risk of postabortion conception as well as abortion rates associated with subsequent unintended pregnancies. In India, under the Medical Termination of Pregnancy Act of 1971 (MTP Act), all Government health facilities above the primary health center level are automatically approved to offer abortion services and postabortion care, which includes medically accurate information, counseling, and a range of contraceptive methods (Iyengar and Iyengar 2016). However, barely 15% of abortions in Gujarat occurred in health facilities and only 19% of those occurred in Government health facilities (Singh et al. 2016). Further, in Rajasthan, of the 28% abortion clients who receive counseling, many have difficulty achieving their contraceptive objectives, possibly because of limited access to long-acting reversible contraceptives (Iyengar and Iyengar 2016). These studies suggest limited access to and use of Government facilities for abortion and PAFP services.

Similarly, EngenderHealth's own situation analysis of project-intervention facilities (conducted in 2014) showed that even though these facilities were authorized (under the MTP Act) to provide abortion and PAFP services, the majority did not provide such services due to a lack of obstetricians or other trained providers. We also found that provider knowledge, skills, and practices influenced service provision—



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with many providers selectively providing specific PAFP methods either based on the client's age, parity, or socioeconomic profile or in an effort to align with misinterpretations of the Government's FP priorities. Though reliable, real-time data on abortion and PAFP case loads at these facilities was not available, we found that few abortions occurred in these facilities and less than 20% of abortion clients served adopted a PAFP method. Therefore, we directed our technical assistance to strengthen postabortion services in these two states.

ENGENDERHEALTH'S PAFP INTERVENTION

EngenderHealth conceptualized a strategic approach for building the capacity of intervention facilities to offer PAFP services and strengthening data management systems to serve as the foundations for PAFP service delivery. We implemented this intervention in 359 Government facilities (129 in Gujarat and 230 in Rajasthan) between 2015 and 2019. Specific intervention activities are detailed herein.

Facility Selection

EngenderHealth collaborated with state Government officials to identify secondary and tertiary care Government facilities in Gujarat and Rajasthan that were eligible to provide abortion services and which employed providers trained in Comprehensive Abortion Care (CAC). In the process of identifying potential intervention facilities, we learned that while there were 359 facilities approved to provide abortion services, only 64 were consistently providing these services—either due to a lack of trained providers or a failure to prioritize these services and designate trained providers accordingly. While building the capacity of the facilities to provide abortion services was beyond the scope of our project, we recognized that the current situation would limit our opportunities for strengthening PAFP services. Therefore, we also nominated other providers to complete a CAC training conducted by IPAS Development Foundation in order to facilitate functionality across all of the intervention facilities.

Clinical and Counseling Skills Training

To promote efficiency and sustainability, EngenderHealth integrated PAFP training with regular FP trainings and employed a dynamic training model designed to address field realities. We provided clinical PAIUD insertion training to 658 medical officers and staff nurses and PAFP counseling training to 206 labor room nurses and FP counselors; we also oriented all participating providers on sexual and reproductive health and rights with an emphasis voluntary, informed choice for clients. Our training included a hands-on component to ensure provider competency in clinical and counseling services. We structured the training so that providers working in facilities with very few or no abortion cases could attend training in nearby district hospitals or other Government facilities with higher abortion caseloads to ensure opportunities for practicing these skills with clients. We then followed up with and provided mentoring support for the trained providers to ensure continuation of quality services. Additionally, we engaged facility obstetricians (where available) to familiarize them with this intervention strategy so that they could own and sustain it beyond the life of project.

Capacity Building for Monitoring and Supervision

We built the capacity of health facility managers to provide supportive supervision and ensure proper reporting. We used a Clinical Monitoring and Coaching (CMC) toolkit during supervisory visits to assess and identify gaps in facility readiness; service delivery; and data recording, review, and reporting. Together, EngenderHealth staff and facility managers stringently monitored PAFP coverage, quality of counseling and service provision, and method mix to ensure adherence to informed consent and voluntarism principles. We leveraged these supervisory visits to provide feedback and recommend any necessary corrective actions for integrating FP counseling and services in accordance with stipulations of the MTP Act. Further, using a collaborative strategy, the project built the capacity of district health administrations to monitor and review PAFP data and to make evidence-based decisions for course correction, as necessary.

Establishment and Enhancement of Quality Circles

EngenderHealth invested in institutionalizing training and data management inputs by leveraging existing service quality assurance mechanisms articulated in the Government service guidelines. This involved establishing, or where already established, enhancing facility-level quality circles. We then oriented supervisory staff to use the platform for assessing and maintaining service quality.

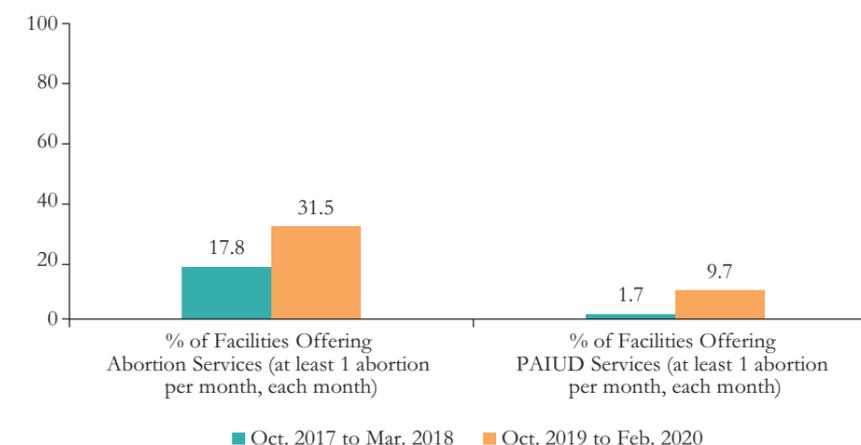
Building Capacity of Frontline Workers to Generate Awareness

EngenderHealth built the capacity of frontline workers, such as Accredited Social Health Activists (known locally as ASHAs) and sub-center Auxiliary Nurse Midwives (ANMs), to generate awareness of and demand for CAC and PAFP services. This involved enhancing these frontline workers' understanding of abortion care and PAFP—including the laws related to abortion, the availability of safe abortion and PAFP services, and the importance of informed consent and voluntarism—so that they could provide accurate information to potential clients and families within their respective.

PROJECT RESULTS

Accessing facility-based abortion and PAIUD records and data was challenging, due to privacy and confidentiality clauses included in the MTP Act; however, consolidated project data on service availability and delivery over the life of project showed an increase in number of facilities providing abortion and PAIUD services. Since training for PAIUD was not restricted to abortion service providers approved under MTP Act, but rather included staff nurses and ANMs, EngenderHealth was able to significantly increase the number providers trained and actively providing PAIUD services. This strategy of training staff nurses and ANMs also demonstrated notable success in increasing the number of PAIUD insertions at intervention facilities, as the number of PAIUD clients increased from 535 clients in 2016–17 to 1,460 in 2019–20. Similarly, the proportion of PAIUD clients within total abortion cases increased from 6.6% to 14.6% within the same period. Figure 1 illustrates overall improvements in access to abortion and PAIUD services between

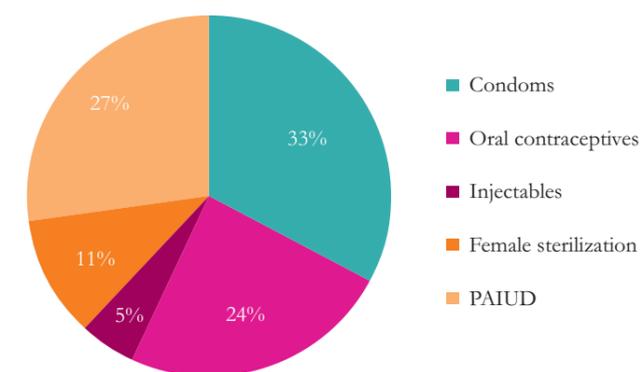
Figure 1: Improved Access to Abortion and PAIUD Services in 359 Intervention Facilities, October 2017 to February 2020



October 2017 and March 2020. The proportion of facilities consistently providing abortion services nearly doubled during this 30-month period and the facilities consistently providing PAIUD services increased six-fold. Despite these improvements, nearly 70% of the health facilities were still not consistently providing abortion services, thereby severely limiting their ability to offer PAFP services.

We were also able to analyze the PAFP method mix and use this data as a proxy indicator for voluntary, informed choice, by demonstrating an uptake of a variety of PAFP methods. Specifically, while there was an increase in PAIUD uptake, the use of other PAFP methods suggested that service providers were offering a range of choices and respecting client decisions. Figure 2 illustrates the PAFP method mix between May 2018 and February 2020.

Figure 2: PAFP Method Mix, May 2018 to February 2020



CHALLENGES AND LESSONS LEARNED

We faced several challenges in implementing the PAIUD intervention and had to continuously innovate and revise our strategies to address these challenges. Through this experience, we also learned several key lessons that may inform scale up and replication across other states in India.