

PROGRESS AND PROSPECTS OF MAPnet

A Network of
Medication Abortion
Providers in
Two Districts of
Maharashtra, India



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Ipas works globally to increase women's ability to exercise their sexual and reproductive rights and to reduce abortion-related deaths and injuries. We seek to expand the availability, quality, and sustainability of abortion and related reproductive health services, as well as to improve the enabling environment. Ipas believes that no woman should have to risk her life or health because she lacks safe reproductive health choices.

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Suggested citation: Banerjee Sushanta K., Jaydeep Tank, Mandakini Parihar, Milind Shah, Uday Thanawala, Vinoj Manning, Namita Kashyap, 2007.
Progress and Prospects of MAPnet: A Network of Medication Abortion Providers in Two Districts of Maharashtra, India. New Delhi, Ipas India.

Graphic Design: Write Media

Assisted by: Anisha Aggarwal

Produced in India



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ACKNOWLEDGEMENTS

The study was done as part of Ipas India's ongoing program intervention in the state of Maharashtra and would not have been possible without the active support of the MTP Committee of FOGSI and the ObGyn Societies of Solapur and Navi Mumbai.

We wish to thank Ms. Wendy Darby, Dr. Kathryn Andersen Clark, Dr. Debbie Billings, Mr. V. S. Chandrashekar, Dr. Rashmi Asif and Dr. Sangeeta Batra who reviewed the report and offered critical inputs.

We are grateful to the John and Catherine T. MacArthur Foundation for its financial support to implement this program. We are also thankful to the MAPnet members who agreed to be interviewed in this assessment study.

We would especially like to acknowledge Dr. Prateep Roy and Mrs. Devasri Gupta of Grasp Analytic who successfully managed the data collection activities.

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EXECUTIVE SUMMARY

The provision of safe abortion is one of the strategies for reducing maternal mortality under the RCH II. Since the majority of induced abortions in India take place in the first trimester, expanding the use of safe, simple and effective technologies such as medication abortion (MA) can play a vital role in reducing unsafe abortions. MA requires relatively limited resources and can easily be offered in small clinics.

However, as of now MA services are mostly being provided in an unorganized fashion and restricted to very few urban doctors, mainly because of a lack of method awareness and technical orientation among the medical fraternity. Ipas, in close collaboration with FOGSI (Federation of Obstetrics and Gynecology Societies of India), initiated a network of private doctors (branded as 'MAPnet') who would offer quality MA services. A total of 87 doctors enrolled for the intervention, which included a combination of technical orientation and assistance, the provision of IEC and advocacy to establish peer-to-peer support mechanism.

A follow-up assessment was conducted among all network members in December 2006 with the specific objective of assessing the postintervention progress with the provision and quality of service delivery, perceived benefits of networking and documentation of the learning experience for replicating the model with broader geographical diversity.

The follow-up assessment showed that MAPnet accounted for an overwhelming majority of doctors starting to provide medication abortion (92%) with standard guidelines on time (93%) and drug protocols (82%), contraceptive counseling (100%) and pain management (54%). Around three-fourths of the network members would like to continue their association with the network initiatives. However, the network initiative did not acquire much success in establishing interpersonal communication to facilitate knowledge flows and learning.

Given the fact that this is the first network initiative in India to promote quality abortion services through medication abortion, this follow-up assessment offers a fruitful source of information and provides interesting insight to outline a future course of action.

The overwhelming majority of network members are providing quality medication abortion services, following standard protocol and guidelines. The network members have also shown a positive inclination to continue their association with MAPnet.

These encouraging outcomes of the collaboration between FOGSI, the MTP Committee, the network of private medical doctors and Ipas have fueled efforts to extend the provision of safe and early abortion services through medication abortion methods. ■■■■■

The provision of safe abortion services is one of the strategies for reducing maternal mortality and morbidity in India under the Reproductive & Child Health, Phase-II (RCH II). Because the majority of induced abortions in India take place in the first trimester, expanding the use of safe, simple and effective early uterine evacuation (UE) technologies such as medication abortion (MA) can play a vital role in reducing unsafe abortions. MA requires relatively limited resources and can be offered at all levels of health care, particularly in low resource settings such as a small private clinic or health center.

Medication abortion has been an option for early abortion in India since April 2002 when the Drug Controller General of India approved the use of mifepristone to terminate pregnancies up to seven weeks gestation. This paved the way to use a mifepristone-misoprostol combination for terminating early pregnancies.

The MTP¹ (medical termination of pregnancy) Act was amended in 2003 to enable certified MTP providers to prescribe medication abortion drugs not only in an approved site but also in any nonapproved site, provided they have access to a site approved under the MTP Act (MoHFW 2003). Finally, in December 2006, manufacturing misoprostol in India was approved for use with gynecological conditions including early abortion (Government of India 2006).

Including MA into the larger health system can offer more choices and increase access for women who currently have limited access to safe abortion services (Banerjee 2007). It also allows providers with inadequate infrastructure for clinical procedures to provide early abortion services. However, as of now the medication abortion services are mostly provided in an unorganized fashion and restricted to a few senior gynecologists. This is mainly because of a lack of awareness and technical orientation and updates on MA among the medical fraternity. Even senior gynecologists and other providers who started practicing MA do not have the opportunity of translating their experience to other medical doctors.

¹ MTP is the local terminology of uterine evacuation.

Ipas, in close collaboration with FOGSI and the local MTP Committee, introduced a network of medication abortion providers, called 'MAPnet' to respond to this unmet need for the provision of MA services.

MAPnet promotes MA as a safe and easy option among a large number of providers and women. MAPnet was initiated in mid-2005 and piloted in selected urban pockets of two districts of Maharashtra—Navi Mumbai and Solapur. The pilot initiative (2005-2006) aimed to create a network of private sector doctors who would offer quality MA services following recommended protocols and guidelines.

Medication abortion is a nonsurgical intervention to terminate unintended, early pregnancies. It is based on a proven regimen, registered in more than 30 countries, combining two drugs—mifepristone (RU 486) and misoprostol.

Mifepristone is an antiprogesterin, which stops the pregnancy from growing and misoprostol is a prostaglandin E1 analogue, which causes the uterus to contract to expel it. The combination of these two drugs is effective in 95-99% cases.

The network included members who were committed to ensure that MA would be available to women as an option of early safe abortion.

The specific purpose of this initiative was to:

- Improve the knowledge and skills of network members about methods, protocol and guidelines through technical orientations and knowledge-sharing initiatives.
- Empower providers to counsel women to enable them to make informed choices through client communication, site signage, and other information materials.
- Lead peer-to-peer networking and mentorship towards active information-sharing.
- Document and share service delivery experience among network as well as nonnetwork providers and stakeholders.

The network currently has 87 members who received technical orientation and other information, education and communication (IEC) materials and mentoring support to practice MA and counsel women on the subject. At the end of the pilot year of this intervention, it is imperative to gain an insight into the efficacy and impact of MAPnet to facilitate mid-course corrective measures. Keeping this point in mind, Ipas, in collaboration with district-level ob-gyn societies and FOGSI, conducted a follow-up survey during December 2006-January 2007.

The specific objective of this follow-up research was to assess the postintervention progress and prospects based on the following two dimensions:

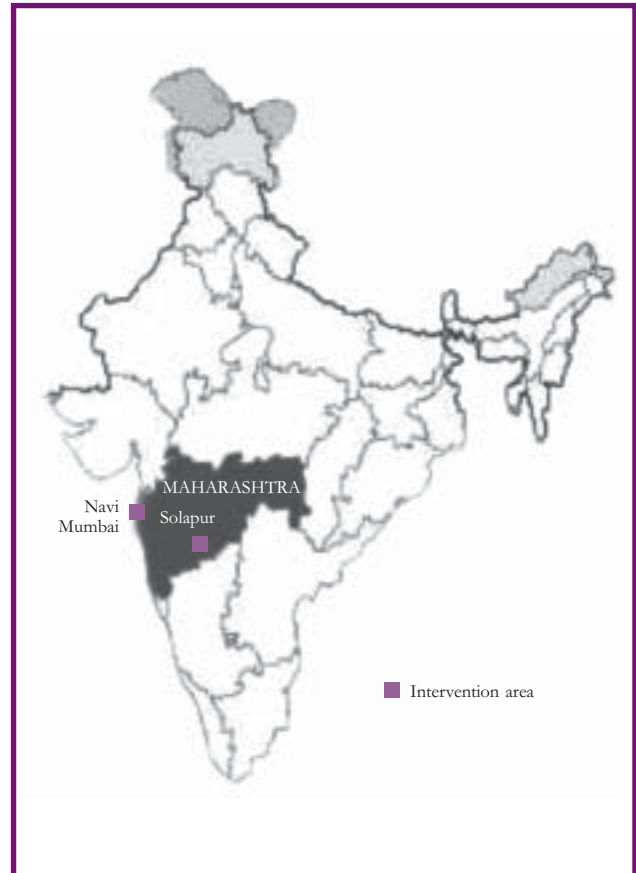
- How did service provision and quality of service delivery change during the last one year of intervention (2005-2006)?
- What were the benefits of the networking initiative perceived by the network members?

The answers to these questions will help assess the basic strengths, challenges and opportunities in extending the network model to other parts of the country. Currently, there is no evidence available on the experience and efficacy of any network of medication abortion providers.

Networking and social franchising initiatives in India are predominantly focused on family planning, sexually transmitted diseases including HIV and rural micro-financing. The objective of this report is threefold:

- To describe the findings of the evaluation research by documenting changes in service provision of

Figure 1: Geographical location of MAPnet initiatives



quality care and the experience of network members.

- To highlight opportunities.
- To evaluate the potential for extending the network with broad geographic diversity. [REDACTED]

2 | STUDY METHODOLOGY

The follow-up study was conducted among network members based in the two intervention districts of Maharashtra—Navi Mumbai and Solapur. Considering the small number of network members, all 87 network members were targeted for the follow-up survey. The study used a semistructured questionnaire for capturing the quantitative as well as qualitative dimensions of the intervention. While the questions on the key measurable indicators on service provision, quality of service delivery, postabortion care and exposure to different components of intervention were structured, indepth information was also extracted through a more natural conversational flow to supplement close-ended questions. The questionnaire had been translated and pretested before it was canvased for the original survey.

Follow-up data were collected by an independent data collection agency (Grasp Analytic) during December 2006-January 2007. A total of four interviewers and a supervisor were trained by the Ipas Research and Evaluation Unit on the technical aspects of abortion and the specific protocol for medication abortion. Interviewers were also briefed on the different levels of interventions, including technical orientation and IEC activities.

The follow-up survey was carried out in two phases. During the first phase, all network members were contacted by telephone to set up an appointment for the detailed interview and to request them to make all

clinical records (including caseload, UE technology, follow-up visits and postprocedure contraceptives) available at the time of the interview. During the second phase, the network members were met individually for face-to-face interviews.

Data were entered and checked for consistency using standard data entry software and final analyses were carried out using SPSS 13.0. The qualitative responses were coded manually and merged into the original data set. Categorical responses are presented as frequencies and percentages of nonmissing data while continuous variables (such as caseloads) are presented as means and standard deviations.

The background characteristics of the network members who could not be contacted for the follow-up survey were compared with the segment interviewed successfully to assess any significant variations in their personal characteristics. This helped examine if there was any potential influence of selection bias or sample loss. The key program indicators of the follow-up survey (December 2006) were compared with the baseline (August-September 2005) estimates for assessing the progress of the network initiatives during the last one year. As the 2006 and 2005 responses could not be linked, the 2005 response was treated as true measure and the 2006 response compared using z statistics. Statistical significance² were presented at a 1% and 5% level of significance ($p < .01$ and $< .05$).

² Variations are statistically significant, implying that estimates are truly different and it is unlikely to have happened by chance.

3 RESULTS

While efforts were made to contact all 87 network members placed in different urban pockets of these two districts, only 77 (89%) out of 87 could successfully be contacted and interviewed. The remaining 10 members (11%) could not be followed up as they were not in town (6) and had been transferred to other places (4). The background characteristics of the network members who could not be contacted for the follow-up survey were also compared with the other segment interviewed successfully and found no significant variations in their personal characteristics. This comparison infers that there is no potential influence of selection bias or sample loss.

Characteristics of network members

Table 1 exhibits the background characteristics of the network members interviewed for the follow-up survey. It is revealed that an overwhelming majority of members were specialist gynecologists (84%), followed by other specialists (9%) and medical graduates (7%). These members were predominantly

Table 1: Background characteristics of the network members successfully contacted for the follow-up survey, December 2006

Characteristics	N	%
District		
Navi Mumbai	34	44
Solapur	43	56
Sex		
Male	38	49
Female	39	51
Qualification		
Specialist ob-gyn	65	84
MBBS	5	7
Other postgraduates	7	9
Posted at		
Private clinic	68	88
Nursing home	2	3
Facility under public sector	7	9
Network members successfully contacted (N)	77	100

placed at the private sector facilities (91%), particularly private clinics (88%). Network members were almost uniformly distributed in two intervention districts. An overwhelming majority (94%) of the network members were found providing MTP services. Members who were providing MTP services were also asked to provide the details of the total cases they independently handled during the last three months preceding the survey. Seventy-two members had jointly performed 1,810 MTP procedures, implying an average of 8.4 cases per month per MAPnet member.

Table 2: Service provisions by the network members, December 2006

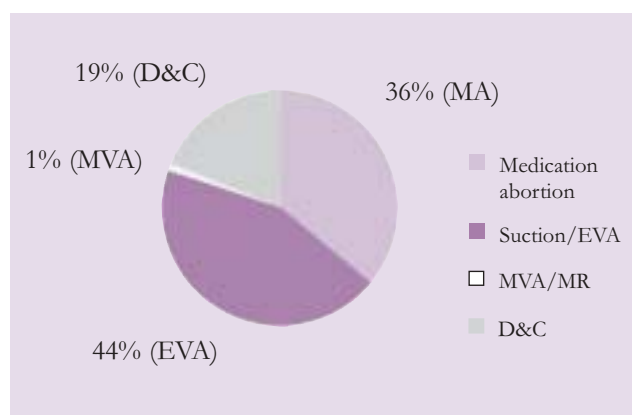
Service provision and types	N	%
Provide MTP		
Members currently providing MTP services	72	94
Members never provided MTP services	5	6
Caseload		
Procedures carried out in the last 3 months	1,810	–
Mean caseload per member per month	8.4	–
Trimester-wise distribution		
1st trimester (up to 12 weeks)	1,429	79
2nd trimester (13-20 weeks)	381	21
Total (N)	77	100

Most of these cases were of the first trimester (12 weeks of gestation). As appropriate techniques of uterine evacuation often bear an association with the postabortion complication and morbidity, it is important to know the methods used for the evacuation.

As portrayed in Figure 2, 81% of the first trimester UE cases carried out by the network members was performed by appropriate technology.³

³ Appropriate technology for the 1st trimester abortion includes MVA, EVA and MA and excludes D&C because of its low safety (Cates et al. 2000) high complication (Grimes et al. 1979).

Figure 2 : Distribution of 1st trimester procedures by MTP techniques (N= 1,429)



Provision of medication abortion by the network members

As the whole network initiative was focussed on ensuring the appropriate use of medication abortion as an option of early abortion technology, the study captured a series of quantitative as well as qualitative information for assessing the current practice and experiences of MAPnet providers in due course of the last one year of intervention. The baseline survey, which was conducted in 2005 at the initiation of this intervention, recorded that around 62% of the network members were offering medication abortion. Following the network initiatives and technical orientations, the proportion practicing medication abortion improved significantly to 92% (see Table 3).

Thus it appears that nearly 31% members started providing medication abortion for the first time after being associated with MAPnet. In contrast, only 8% members (6) either never provided (5)

or stopped (1) providing MA services. The reasons for never providing or discontinuing were recorded as:

- “Do not provide MTP (abortion services) at all” (3).
- “Perceived high rates of postprocedure complications” (2).
- “Clients are not convinced with MA” (1).

Quality of service provision

The most crucial component of the MAPnet initiative was to ensure the quality of service delivery. This can only happen if providers follow an appropriate regime of drugs in terms of recommended doses and time protocol. Along with adhering to standard drug protocol, it is also essential to ensure follow-up visits of women who received medication abortion for the confirmation of the completeness of uterine evacuation and the management of probable side effects. In India, the technical guideline on medication abortion approves a combination of mifeprestone 200 mg and misoprostol 400 mcg for the termination of early pregnancy up to 49 days (7 weeks) of gestation.

The guideline also suggests ensuring three follow-up visits of women who received medication abortion. Keeping these points in mind, MAPnet members were oriented as well as updated on the standard protocol, side-effect management, client counseling and other legal issues related with medication abortion. To assess whether the orientation was transformed into practice, all network members who were providing medication abortion were asked in detail about their practice on drug and time protocol, follow-up visits of women

Table 3: Change in provision of MA services from 2005 to 2006

	Baseline August 2005		Follow-up December 2006		P	Significance level
	n	(%)	n	(%)		
Provide MA services	60	(62)	77	(92)	0.000	**
Follow drug protocol among MA providers	37	(30)	71	(82)	0.000	**
Follow time protocol among MA providers	37	(75)	71	(93)	0.019	*

** Significant at 99% * Significant at 95% level

who had received medication abortion and the reaction of women on MA. The baseline study, which was conducted as a pre-intervention assessment of the existing practices, estimated that 30% of the members who were practicing medication abortion follow the recommended drug protocol. With one year of intervention, this proportion improved significantly to 82% ($p < 0.01$). The remaining 18% reported following different compositions of drug, which have never been recommended in the intervention. Future research needs to elucidate why a small proportion of providers prefer to practice a different composition. A same line of variation is well reflected in terms of following the standard time protocol of providing MA within 7 weeks of gestation.

Follow-up visits by women using MA and providers' actions

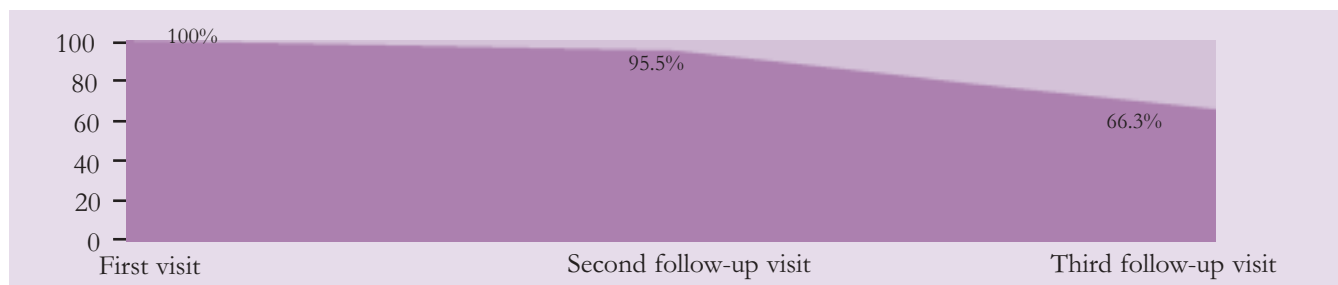
During technical orientations, MAPnet members were familiarized with the prime utility of two follow-up visits⁴ (Day 3 and Day 15) and day-specific actions of providers for service quality management. The follow-up survey tried to explore what proportion of women who received MA came for all three visits. Figure 3 exhibits that nearly 96% of women who received mifepristone (the first dose of MA administered during Day 1) also revisited for the second time (after 2 days) to get misoprostol (the second dose of MA). However, this proportion came down substantially to 66% in the case of the third visit during which women should get postabortion observations and treatment on side effects (if any) and complications (Figure 3). Thus dropout rates of 4% during the second visit further increased to 34% in the third visit. This probably would be because of the fact that women who didn't face any postabortion complication preferred not to visit the provider for the

third time. To get an insight of these issues providers were asked what they did specifically during each of the three visits. Answers to this question have been captured in a conversational flow (see Table 4). It is encouraging to note that an overwhelming proportion (94%) of providers spontaneously reported informing women on the medication abortion procedure before they dispense the same during the first visit. In contrast, a majority of providers did not spontaneously recall explaining side effects and follow-up visits as their routine actions during the first as well as the second day of dispensing medication abortion. This is an area that needs to be intervened for better service delivery. The implication of the third visit appears to be massive as providers uniformly reported counseling women on postabortion contraceptives and performing clinical examination or observation for the confirmation of the completeness of the uterine evacuation process. Thus future intervention should focus on reducing the extent of dropouts during the third visit.

Postprocedure contraception and pain management

Abortions in India are generally the result either of an unmet need for contraception (women who were not using contraception but had an unintended pregnancy) or contraceptive failure. The provision of effective modern contraception could help both of these groups of women achieve their reproductive intentions. All network members who were providing abortion services at the time of follow-up survey universally reported providing contraceptive counseling. Results portrayed in Figure 4 revealed that around 72% of women received contraceptive methods from the site while the remaining 28% of women received postabortion counseling.

Figure 3: Pattern of follow-up visits (N = 71)

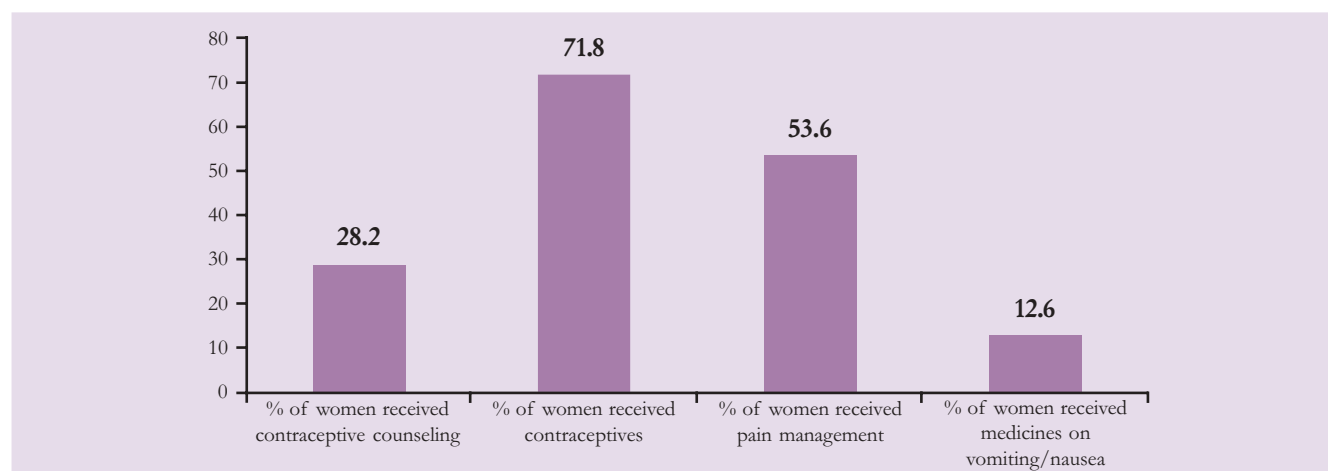


⁴ Guideline recommends a total of three visits of women who received medication during Day 1, Day 3 and Day 15, respectively.

Table 4: Network members' self-reported actions during different visits (spontaneously mentioned)

First visit	Second visit	Third visit
Explain about the procedure and provide/prescribe medication abortion (94.4%)	Dispense 2nd dose (100%)	Family planning counsel and provide contraception (91.5%)
Explain the side effects (32.4%)	Suggest painkillers (58%)	Conduct ultra-sonography (56.3%)
Specify and explain about 2nd and 3rd follow-up visits (9.9%)	Discuss side effects (22.5%)	Checkups and observations (49.3%)
	Ask for the 3rd follow-up visits (14.1%)	
	Check effects of 1st dose (5.6%)	
N=71: Members providing MA services		

Figure 4: Postprocedure management

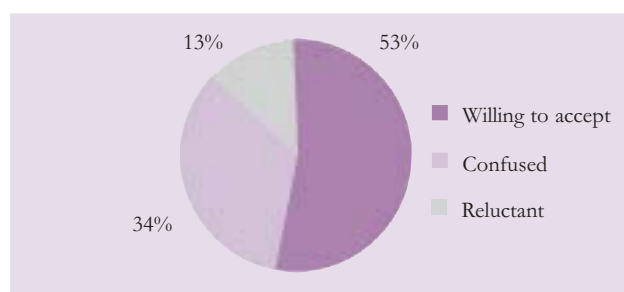


As most women report some degree of pain associated with the abortion procedure, it is recommended to provide appropriate pain management depending on the abortion methods. In case of medication abortion, it is suggested to counsel and provide analgesics well in time as a precautionary measure against expected pain. However, in reality this is not being practiced universally. As reported by the network members, around 54% of women received analgesics along with MA.

Clients' response and reaction to medication abortion as an option for abortion

Although this nonsurgical option of safe abortion was discovered long back in 1980, the actual application of this method is very new in India. There is limited evidence on the immediate reactions of women who come for induced abortion and get the first time exposure on a nonsurgical method. As MAPnet

Figure 5: Client's reaction on MA (N=71)



members have exclusively been practicing this method for at least the last one year, all current providers were asked to report on the client's reaction about medication abortion following their method counseling.

More than half of the providers (53%) were of the opinion that clients are usually willing to accept the

medication abortion method while the remaining half of the providers felt clients are either confused or reluctant to accept the same, following the method counseling.

However, it is very difficult to lead to any conclusion on the causal routes of the client’s reaction as the primacy of method counseling varies in its degree from one provider to another. As has been expressed by some MAPnet members:

“Clients who come for induced abortion often sense abortion as a surgical procedure, which ends with bleeding and pain...Sometimes, I find it quite difficult to convince them that two tablets can substitute a surgical procedure...”
(MAPnet member from Solapur)

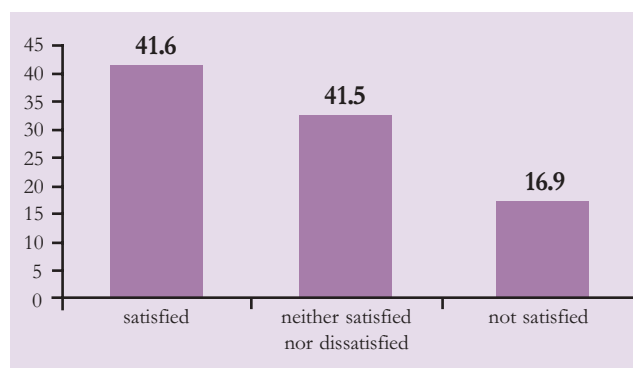
“Sometimes women get confused with our pre-procedure counseling on the rare possibility of incomplete abortion...They never want to take any risk of incomplete abortion, which unnecessarily will prolong their unintended pregnancies.”
(MAPnet member from Mumbai)

“It needs more community awareness on the efficacy of this new method...”
(MAPnet member from Solapur)

Perceived satisfaction and benefit of MAPnet initiatives

MAPnet members were asked to share their satisfaction level with the overall initiatives of the network. In response, nearly 42% of the members expressed their satisfaction with the network initiatives while a same proportion of the providers had been neutral. However, around 17% of the network members had expressed their dissatisfaction with the overall initiatives (Figure 6).

Figure 6: Perceived satisfaction levels with the network initiatives (N=77: network members interviewed)



As mentioned earlier, a spate of activities/actions had been initiated in different points in time for improving the quality of service delivery provided by the network members. To assess the comparative efficacy of these interventions, members were asked to recall those components that they perceived as benefits to their initiatives.

Results portrayed in Figure 7 are based on the respondents’ spontaneous and probed recall of benefits. An overwhelming majority of the network members perceived their association with FOGSI (83%) as the prime benefit of this networking, followed by technical orientation conducted by experts (74%) and access to technical updates on medication abortion (64%). In contrast, the majority of members did not perceive any benefit through peer-to-peer networking.

Sustained skills and knowledge building of providers and demand creation on the new methods are essential to motivate the use of medication abortion services. During the first year of intervention, a package of IEC materials and technical updates, including reference manual, posters, and pamphlets were developed and distributed among the network members.

The purpose of this initiative was not only to equip the network members with all support materials but also to learn the process of the best utilization of these components. To this end, members were requested to recall all support materials, which they had received during the last one year. Interestingly, more than half of the network members could not recall these support materials spontaneously (Figure 8).

Figure 7: Perceived benefits of the network initiatives (N=77: network members interviewed)

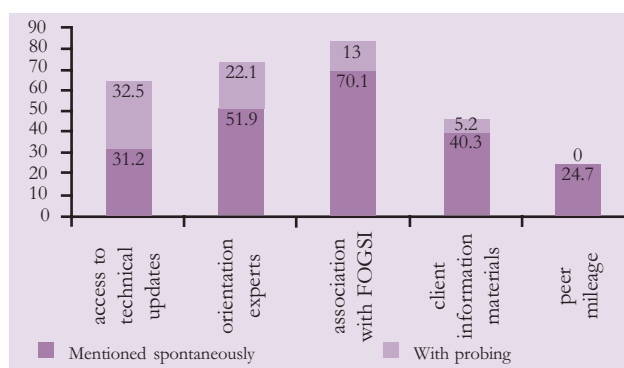
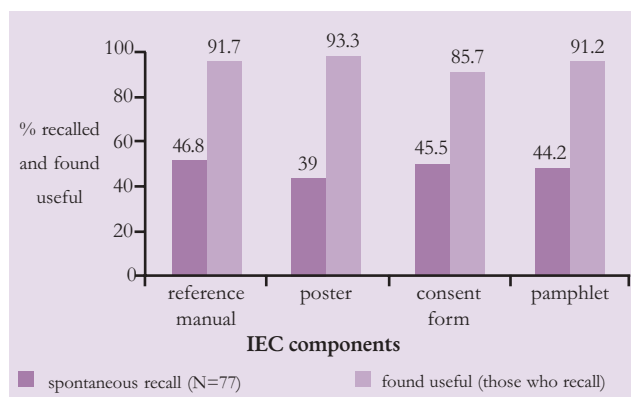


Figure 8: Spontaneous recall and usefulness of IEC materials



This ranged from 61% in case of posters to 53% for reference manuals. However, among those who recalled receiving these support materials, around 90% of them felt these materials were very useful.

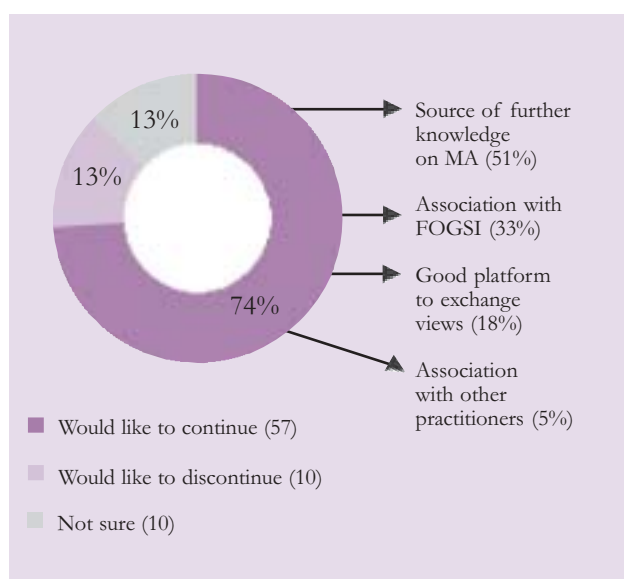
This bears an important learning for the future that providing support materials will not serve any purpose unless they are being regularly used or utilized. For example:

“I remember receiving a reference manual during the FOGSI meeting (orientation), which was made nicely (good design)...But I never felt like reviewing that document for my own practice.” (MAPnet member from Navi Mumbai)

Peer-to-peer networking and mentoring

The basic foundation of any network is that through network, small firms/clinics are able to specialize, build technological capability and interact with each other to facilitate knowledge flows and learning (Chandani et al. 2006). The follow-up study tried to capture the issue of knowledge flows and learning and asked network members about their communications with other members. Only 7 out of 71 (10%) providers who are currently providing medication abortion services mentioned communicating with other network members for discussing postprocedure complications. Further, three other members had initiated mentoring other doctors (not associated with the network) about MAPnet. Thus it appears that interpersonal communication among

Figure 9: Future intention to be associated with MAPnet (N=77)



members has not yet surfaced and needs to be linked with the future network initiatives.

Future intention

The future intention of MAPnet members to be associated with the network initiatives is the most crucial component to assess the future prospect of MAPnet. It also seems to be a proxy attribute of members’ satisfaction with the overall approach of networking. Results exhibited in Figure 9 reveal an encouraging support of the network members as 74% of them would like to continue their association in future.

A majority of these positive intenders wanted to continue their future association because of sourcing further knowledge on medication abortion and maintaining an association with FOGSI. Few providers had also projected this network as a good platform for exchanging views and making strong associations with the gynecological society. In contrast, around 26% of members either would like to discontinue (13%) or were not sure (13%) about their future intention. However, members who wanted to discontinue were mostly because they are currently not providing any MTP or medication abortion services. [REDACTED]

4 DISCUSSION

Given the fact that this is the first network initiative in India to promote quality abortion services through medication abortion, this follow-up assessment seems to be a fruitful source of information and provides interesting insight to assess the efficacy of the intervention.

The impact of network initiatives to introduce quality early abortion services through medication abortion is well reflected through improvement in key program outcomes from the pre-intervention period in terms of service provision, following standard time and drug protocols, and postprocedure client management.

After the orientation, most of the providers started following the recommended drug protocol. However, a segment of the network members (one out of five) are still following different compositions of drug, which has never been recommended in the intervention. Future research needs to elucidate why these providers prefer to practice a different composition even after the technical orientation.

The dropout of women using medication abortion particularly for the third visit posed an interesting question. This probably would be because of the fact that women who do not face any postabortion complications after the second visit prefer not to visit the provider for the third time. Future orientation on this dimension needs to take special attention and

strategy to counsel women on the utility of all three visits.

The network members have also shown a positive inclination to continue their association with the network of medication abortion providers. This seems to be the most important opportunity to scale up the pilot model with broader geographical diversity. The core components of the technical orientation have rightly been translated into action. However, the IEC and support materials, client information and technical updates are left underutilized.

The intervention has also created enthusiasm among the network members individually by encouraging them to act positively in terms of service provision. However, it failed to establish the sense of bonding among the network members to lead this process as a group initiative rather than individually. This needs special effort to promote the brand value of networking with a dual bottom line of sensitizing the ownership and integrating interpersonal communication among the network members.

Assessment of program impact must be viewed in light of limitation in study design, which lacks scope of comparing the progress over time with any control group. However, this limitation does not have much significance in the absence of any parallel intervention on medication abortion in India. ■■■■■

5

CONCLUSION AND RECOMMENDATIONS

These encouraging outcomes of the collaboration between FOGSI, the MTP Committee, the network of private medical doctors and Ipas have fueled efforts to scale up and strengthen the network base for expanding the opportunity of providing safe and early abortion services through medication abortion. The MAPnet initiatives have created a treasure trove of learning experiences with a special emphasis on the progress and prospects of networking with private providers, some of which are:

- The network has the potential to enhance the health impact by increasing the base of accessibility of medication abortion services under a small clinical setup. It offers a vital platform for including more private doctors after strengthening referral link with existing members.
- The on-clinic follow-up support might be a key factor for improving the utilization of support materials and technical updates. This will also lead to the overall improvement in method counseling and the management of side effects.

- It is necessary to balance the promotion of networks and community awareness on methods. Initial intervention was focused on establishing the service delivery, which can be motivated further by ensuring informed demand from the clients.

- Motivational components such as reward and recognition system and workshops are essential to sustain the existing effort of the network members.

- The network initiative fails to acquire much success in establishing interpersonal communication among the network members to facilitate knowledge flows and learning. This is a missed opportunity to strengthen the network of medication abortion providers.

Collaborative and strategic actions to address these issues will go a long way to add better health impact by expanding the base of the network of private providers offering an alternative option of early abortion services and serving more number of women.

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Clockwise from top left: Network members in an orientation workshop; MAPnet members meet at Solapur; Dr Jaydeep Tank, Chairperson, MTP Committee, FOGSI, addresses the members; MAPnet members' meet, Navi Mumbai.

Medical abortion is a safe and effective way to end a pregnancy. It is a choice that is yours to make. It is a choice that is yours to make. It is a choice that is yours to make.

It's your life and the choice lies with you...

It's your life and the choice lies with you...

MAPnet

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The Choice Is Yours

आपकी निवड

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