Ipas HEALTH ACCESS RIGHTS INDIA

Accreditation of Private Sector Health Facilities for Provision of Comprehensive Abortion Care Services

An initiative of the
Government of Bihar, India

An Evaluation Report

October 2013

बिहार सरकार

State Health Society, Bihar

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

युक्ति

Ipas Development Foundation is a non-profit organization that works in India to increase women's ability to exercise their sexual and reproductive rights, especially the right to safe abortion. We seek to eliminate unsafe abortion and the resulting deaths and injuries and to expand women's access to comprehensive abortion care, including contraception and related reproductive health information and care. We strive to foster a legal, policy and social environment supportive of women's rights to make their own sexual and reproductive health decisions freely and safely.

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Ipas Development Foundation (IDF)
E 63 Vasant Marg, Vasant Vihar
New Delhi 110 057, India
Phone: 91.11.4606.8888
Fax: 91.11.4166.1711
E-mail: ipasindia@ipas.org

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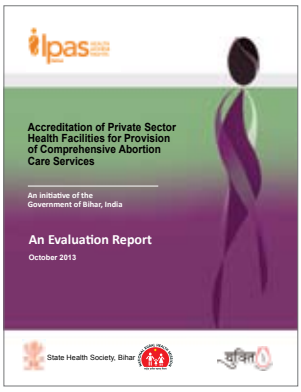
Sushanta K. Banerjee

Deepa Navin

Kathryn L. Andersen

Garima Mathias

Samshad Alam



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Executive Summary

Accreditation programs lead to increased equity across health systems and services by ensuring continuous quality improvements. It began in higher-income countries in the early 20th century. However, evidences are rare to guide developing nations, particularly in Asia and Sub-Saharan Africa, in this practice. This dearth is particularly pronounced among reproductive and child health services. A few countries—including Kenya, Zambia, Uganda, Liberia, Cambodia, and Bangladesh—developed accreditation systems in the early part of the 21st century. However, despite substantial improvements in compliance with quality standards, the programs were too resource-intensive to be sustainable in the long term. In India, the concept and practice of accrediting health care facilities is still novel. The Government of India has undertaken initiatives to accredit private health facilities for family planning services, while states like Gujarat implemented public-private partnership to provide skilled birth attendance and emergency obstetric care.

One of the most challenging states in India in terms of service provision has been Bihar, which is characterized by high maternal mortality ratio (261 deaths per 100,000 births). Unsafe abortions continue to be a major contributor to maternal mortality and morbidity in the state. Many of the public health facilities do not provide safe abortion services because of shortage of trained and certified providers. Securing abortion services in the private sector can pose a financial burden for women, especially for those requiring hospitalization for post-abortion complications or incomplete abortion as a result of receiving care from unsafe providers or from the use of inappropriate technology.

Recognizing the need to increase access to safe abortion services to reduce maternal mortality and morbidity, in 2011 the Government of Bihar developed a new mechanism of accrediting and subsidizing private health care facilities. The program, *Yukti Yojana* ("a scheme for solution"), accredits eligible health facilities and supports them in providing abortion-related services free of charge to low-income women.

To assess the progress and effectiveness of the first phase of this program, we collected both quantitative and qualitative data using three different sources: 1) Assessment of facilities accredited under the *Yukti Yojana* program; 2) Women seeking abortion services at accredited health facilities; and 3) Providers and key stakeholders responsible for providing or influencing abortion services.

Key Findings

Facility accreditation: Progress and service provision

In the past two years (July 2011 to May 2013), 49 private health facilities were accredited under the *Yukti Yojana* program in 18 districts of Bihar. Facilities had to wait for an average of five months to get an official approval. These facilities were approximately evenly distributed between nursing homes (53%) and private clinics (47%) and majority (84%) provided abortion services under the accreditation program. Facility follow-up survey conducted after six months of accreditation accounted significant improvement regarding display of MTP-related IEC material and particularly that on the *Yukti Yojana* and the availability of all essential drugs and equipment needed to provide abortion services. Significantly more number of accredited facilities were also found to be providing abortion services for all seven days in a week compared to the baseline situation (baseline=68%; follow-up 1=89%).

By May 2013, accredited facilities had provided abortion care services to 10,700 women, including 5,555 induced abortions (52%) and 5,145 postabortion (48%) care services. Almost all women (97%) presented for care within the first 12 weeks of gestation. Less than one percent women were referred to a higher-level facility either for second trimester or severe complications. Among those who received abortion care at accredited facilities, approximately 88% received uterine evacuation services with appropriate technologies including manual/electric vacuum aspirator or medical method of abortion. More than four-fifths (87%) of women received contraception immediately after the abortion procedure. More than half of these women (53%) were accompanied by a community health worker.

Beneficiaries' profile and satisfaction: Client exit interviews

To assess the profile of beneficiaries and perceived quality of abortion services provided by the accredited facilities, client exit interviews were conducted during April 14 and May 15 2013 and interviewed 569 women after they had availed the abortion service at selected 16 accredited facilities. Findings of this study reveal that one-fourth women were less than 25 years, while the mean age was around 27.4 years. Nearly all women who received abortion services were married (98%). More than one-third women (37%) had never attended

school, while another one-third had primary or middle level of schooling. Majority of them belonged to scheduled caste or scheduled tribe (19%) or other backward caste (65%). More than half of these women reported holding a BPL (below the poverty line) card, and composite standard of living index (SLI) derived through combining respondents' possession of consumer durables revealed poor economic status for the majority of the beneficiaries (71%). Most women came from nearby villages (66%) and towns (8%), traveling an average (median) distance of 11 kilometers. Around 69% of women rated the quality of services as high or moderate, while more than 90% women expressed very high or moderate levels of satisfaction. An overwhelming majority of women incurred some cost (96%), but no woman incurred any direct cost for procuring abortion services.

Operational feasibility, bottlenecks and sustainability of the program: Providers' and stakeholders' perception

Providers, owners of clinics and nursing homes and site managers uniformly expressed "response to social cause" and "opportunity of integrating safe abortion with existing RH services" as the primary sources of motivation to apply for the accreditation scheme.

Crucial to the success of any accreditation system is the willingness of private providers to be involved in the accreditation program. There has been universal acceptance of the private providers to be associated with the *Yukti Yojana* in future.

However, providers and stakeholders had raised major concerns on the complexity of the approval process and fund reimbursement. These two factors have also been perceived as important attributes of program sustainability.

Conclusions

The Government of Bihar has successfully implemented the first program of accreditation of private sector facilities in India for providing safe and quality abortion services to poor women. The experience of the *Yukti Yojana* offers a new model to other Indian states for expanding access to affordable safe abortion care services.Widespread interest on the part of facilities in becoming accredited likely reflects the crucial role that the private sector plays in addressing women's reproductive health needs as well as the recognition of the importance of subsidizing services to low-income women.

The experience in Bihar is in line with a global movement experimenting public-private partnership model of ensuring that the poorest women have access to reproductive health care. Although concerns have been raised that such private accreditation programs may not target poor women exclusively, the findings of the client exit interviews showed that the program did adequately reach poor women. This program highlighted evidence for the feasibility of involving private Ob-Gyns and general physicians to deliver safe abortion services to poor women on a large scale and a potential new direction for maternal health programming in low-income countries. Out-of-pocket costs incurred by the poor women was very limited and primarily restricted to expenses on transportation and food. Other studies in India recorded substantially high cost of securing abortion services, particularly for abortion procedure and medicines.

There are two significant areas which may affect the essential elements of accreditation. First and most important is the system of accreditation and complexity of fund disbursement. The second is the use of accreditation by governments to assure quality in health services.

Recommendations

Based on the experience of Bihar, we recommend that governments of other states where public sector services are limited explore the option of a public-private partnership to provide safe abortion services to poor women. In addition, the accreditation program should be expanded to all 38 districts of Bihar. However, along with accreditation of the private sector, the state government should continue to ensure equal emphasis on creating safe access within the public health system. This approach will not only extend the base of access, but will improve equity in access. A number of recommendations follow from the findings of this study:

1. Reduce waiting time for approval of facilities after submission of application.
2. Raise awareness among government officials about the program scope and official guideline.
3. Explore the feasibility of reducing complexity of fund disbursement.
4. Raise awareness at community level about new initiatives.
5. Revisit the reimbursement rates for provision of CAC services under the *Yukti Yojana.*
6. Make abortion services available under the PPP model in remaining districts.
7. Increase ownership of the state government.
8. Improve system of quality management.

Introduction

1.1 Background

Establishing an accreditation process for health facilities can foster sustained facility-level improvements and broader changes in the health system. Although they can assume a variety of forms, accreditation programs typically involve a formal process of assessing the degree to which health facilities meet predetermined standards pertaining to quality and availability of services [1, 2]. Accreditation programs may increase equity across health systems and services by ensuring continuous quality improvements [1, 3].

Although accreditation of health-care services began in higher-income countries in the early 20th century, few resources are available to guide developing nations, particularly in Asia and Sub-Saharan Africa, in this practice. This dearth is particularly pronounced among reproductive and child health services [4]. A few countries—including Kenya, Zambia, Uganda, Liberia, Cambodia, and Bangladesh [5, 15, 17, and 18]—developed accreditation systems in the early part of the 21st century. However, despite substantial improvements in compliance with quality standards, the programs were too resource-intensive to be sustainable in the long term [4, 5].

In India, the concept and practice of accrediting health-care facilities is still novel. To ensure the provision of quality services in sterilization, the Government of India revised the Quality Assurance Manual in 1996 and has undertaken several new initiatives, including accreditation of health facilities, empanelment of doctors for family planning services and the introduction of a family planning insurance scheme for both public and private providers [6]. While some states have implemented quality assurance programs (e.g., Gujarat's private-public partnership designed to provide skilled birth attendance and emergency obstetric care), the most impoverished areas of India lack them [7].

One of the most challenging states in India in terms of service provision has been Bihar, which is characterized by high poverty and poor reproductive and child health indicators. Bihar's maternal mortality ratio (261 deaths per 100,000 births) is considerably higher than the national figure of 212 per 100,000 births [8]. Unsafe abortions continue to be a major contributor to maternal mortality and morbidity in the state. An estimated 420,000 induced abortions take place in Bihar every year [9], yet data from the state government shows only 704 public-sector facilities that are eligible to offer abortion services [10]. Many of these do not provide safe abortion services because of a shortage of trained and certified providers, which is exacerbated by the frequent practice of transferring trained providers to facilities unequipped for the provision of abortion services.

Given the dearth of abortion services in the public sector, women frequently turn to the private sector [10] despite the legal constraints in abortion provision in private facilities. Because safe abortion services in the private sector are often inaccessible or inadequate, especially to low-income, rural populations, abortions in Bihar often occur outside of government-recognized facilities by untrained providers, possibly under unhygienic conditions. Only 15% of the reported abortions in Bihar are conducted in public facilities, whereas 85% occur at private facilities [10]. This ratio likely underestimates those occurring in the private sector as many cases taking place at unapproved sites remain uncounted.

Securing abortion services in the private sector can pose a financial burden for women, especially for those requiring hospitalization for postabortion complications or incomplete abortion as a result of receiving care from unsafe providers or from the use of inappropriate technology [11]. An estimated 25% of women admitted to hospital who are not poor become poor as a result of the cost of care [12], and many women requiring emergency obstetric care become indebted [13]. In fact, barely one-fifth of the Indian population can afford all the medicines that they require during an illness. It was also reported that 40% of those with illness or injury have to borrow money or sell some of their possessions to pay for the expenses [19].

Recognizing the need to increase access to safe abortion services to reduce maternal mortality and morbidity, in 2011 the Government of Bihar developed a new mechanism of accrediting and subsidizing private health-care facilities, including those run by nongovernmental organizations (NGOs) [14]. The program, *Yukti Yojana* ("a scheme for solution"), accredits eligible health facilities and supports them in providing abortion-related services free of charge to low-income women. We report here on implementation of the accreditation program, specify the methods used for monitoring and evaluation and report on preliminary findings from facilities accredited under the program.

1.2 Implementation of the *Yukti Yojana*

The Government of Bihar began publicizing the *Yukti Yojana* program in June 2011 with a press release, newspaper advertisement and toll-free number where people can call and ask their questions related to abortion services under the program. Communication materials highlighted the program goal of accrediting eligible, private-sector health facilities to provide

Table 1: Reimbursement rates for provision of CAC services under the *Yukti Yojana*

Service	Rate per case INR (USD)
Completed first-trimester abortion service	500 (9.6)
Treatment of first-trimester incomplete abortion	750 (14.4)
Treatment of abortion complication	750 (14.4)
Stabilization before referrals in cases of complications	300 (5.8)

Conversion: INR 52=1USD.

abortion-related services free of charge to low-income women. The state health society invited facilities in the private sector to apply for accreditation following standards and guidelines published in both English and Hindi, which detailed the eligibility requirements, application and certification procedures, compensation rates and procedures and mandatory monitoring of service statistics [14]. To be accredited, a facility had to meet three criteria: (1) availability of at least one gynecologist or other doctor trained to provide abortions; (2) availability of functioning labor and operating rooms; and (3) a system in place for making referrals to a secondary or tertiary level hospital.

A district accreditation committee (DAC) was established in each of the 38 districts of the state (Figure 1) to decentralize management of the program. DACs were responsible for promoting the program, approving qualifying facilities, signing memoranda of understanding (MoUs) with accredited facilities, compensating facilities for services provided and monitoring on-going activities. Facilities were contracted to provide comprehensive abortion care (CAC) services for women seeking care during the first 12 weeks of gestation; treatment, stabilization, or referral for complications from induced or spontaneous abortions; and treatment or referral for late abortion. Facilities were compensated to cover their costs (medications, consumables, staff salaries and overhead) on a per-case basis based on the type of treatment: induced abortion within 12 weeks of gestation (9.60 USD), abortion-related complications (14.40 USD), and stabilization before making a referral (5.80 USD). Facilities were also reimbursed for providing a transport subsidy of 3.00 USD to a community-health intermediary for accompanying a client to the accredited facility (see Table 1). In an attempt to encourage early abortion-seeking behavior, facilities were not compensated for performing induced abortions after the first 12 weeks of gestation.

Given that the initiative's success depended on community awareness of the available services, the program included an information, education, and communication (IEC) component. Signs, posters, leaflets, and newspaper advertisements were used to direct women seeking safe and legal services to either public facilities or private accredited facilities. The implementation framework is presented in Figure 1.

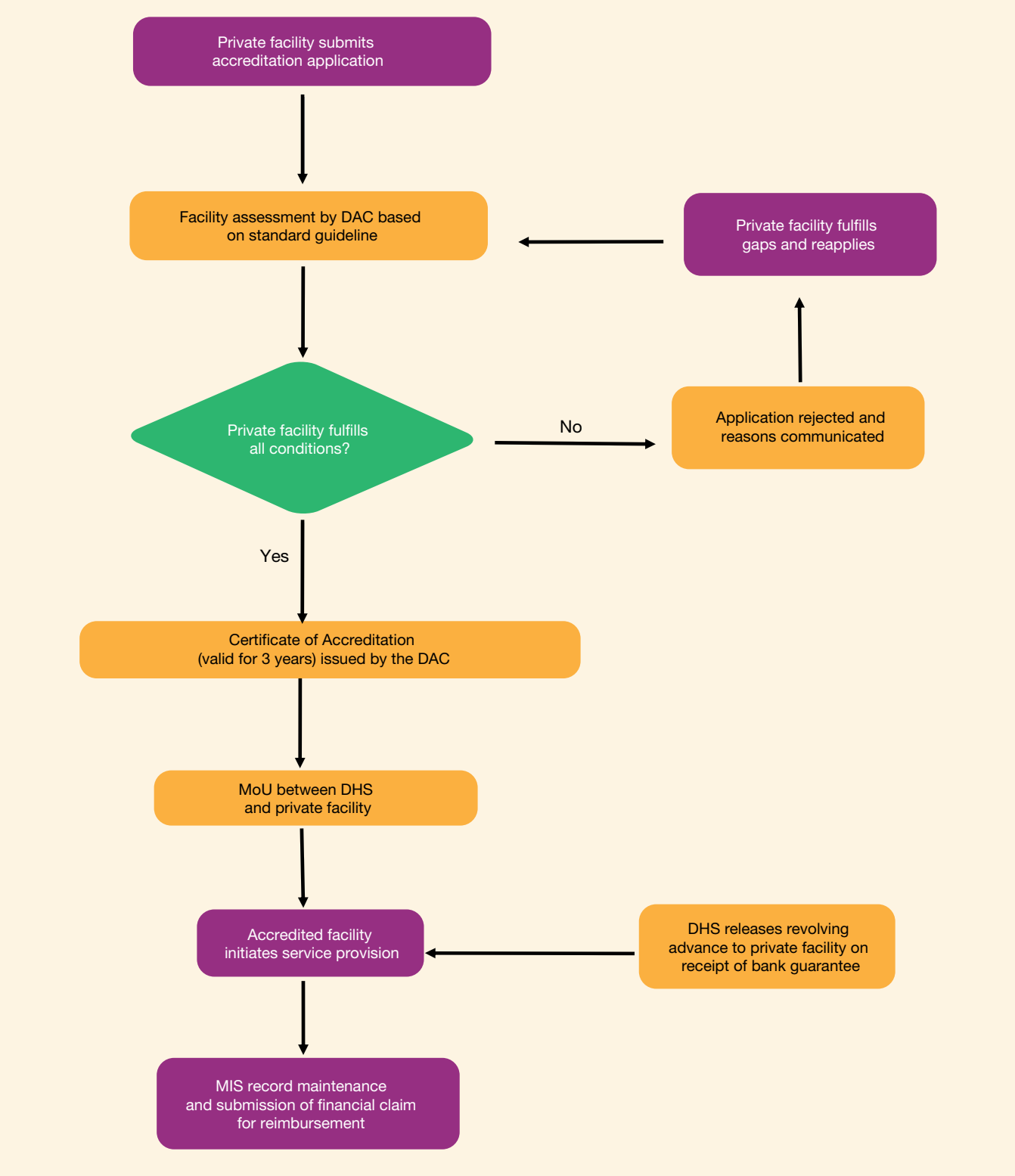
1.3 Technical support and Technical Advisory Group (TAG)

The State Health Society requested Ipas to provide technical assistance for this initiative. Ipas's role under the project, as requested by the state government, is to build local capabilities within the government to implement and sustain the program, strengthen the private sector partnership, implement the program. Ipas is also responsible to monitor progress and evaluate implementation to build evidence for innovation within the state and for replication in other states. A technical advisory group comprising eight experts (representing local research institutes, professional societies, and NGOs; international donors; and experts from national and state governments) was formed to oversee and guide the program's progress (see Annexure Table A1).

1.4 Structure of the report

The report has four main sections. Chapter 2 describes the study design while Chapter 3 exhibits profile of sites accredited by the Government of Bihar and trends and quality of service provision post accreditation. This chapter also documents the experience and perception of women who received abortion and postabortion services under this program and providers' and stakeholders' perception of the accreditation program and its operational bottlenecks. Chapter 4 summarizes the findings of this study and recommends future direction to facilitate scale-up of the program in Bihar and replication in other states.

Figure 1: Implementation framework of the *Yukti Yojana* in Bihar, India



Study Design

We collected both quantitative and qualitative data for monitoring and evaluation of services using three different sources: 1) assessment of facilities accredited under the *Yukti Yojana* program; 2) women seeking abortion services at accredited health facilities; and 3) providers and key stakeholders responsible for providing or influencing abortion services.

2.1 Methods of data collection

2.1.1 Facility assessment and monitoring of services

Each facility was assessed at baseline (immediately after accreditation) and then at periodic intervals of six, twelve and eighteen months after baseline using a structured facility assessment tool. The tool was administered to the head of the facility and providers who provided and facilitated abortion services. Data was captured on facility infrastructure, availability of trained providers, essential drugs and equipment, client flow, client characteristics, provision of abortion and postabortion complication services and quality of service provision. Measures of service provision included use of appropriate technology, provision of postabortion contraceptives, complete record keeping, availability of site signage and information, education, and communication materials, flow and frequency of reimbursement claims and payments from the district authority and providers' experience with the program.

Providers at accredited facilities were also instructed to prospectively record individual data on services for induced abortion and postabortion complications (using a separate MTP register). Abortion service data included information on client load, demographic and other characteristics of clients, types of services provided, postabortion contraception counselling and method provision and accompanying outreach workers. We collected these data every three months from each facility and compiled them to assess monthly trends. Finally, we collected data from the district authority to assess the flow of reimbursement payments to facilities.

2.1.2 Client exit interviews and client-provider interactions

We conducted exit interviews and observed client-provider interactions with women requesting abortion or postabortion care services at 16 accredited facilities. Facilities were selected using two-stage, stratified random sampling. In the first stage, all accredited facilities were stratified into two geographic regions. In the second stage, eight facilities were selected from each region through systematic random sampling. We recruited all women at least 18 years of age who sought abortion-related services at sampled accredited sites and were registered under the *Yukti Yojana* program during the study period, April 14 to May 15, 2013.

Trained female interviewers used a semi-structured questionnaire to collect data on women's experiences and perceptions of abortion care at the facility, accessibility of services, attitude and satisfaction with services at the facility and quality of services received from the facility with regard to appropriate technology, postabortion contraception counselling and service provision, privacy, confidentiality, non-judgmental attitude and respect of providers offering abortion services to women free of cost. To assess the success of the program in exclusively targeting low-income women, this study collected socio-economic data, including household durables and BPL (below the poverty line) card holding of each woman who received abortion services under the program.

Trained data collectors also observed client-provider interactions using a standard form to assess whether clients were greeted warmly, given the opportunity to discuss medical conditions and helped in decision-making, asked about their comprehension of information, encouraged to ask questions and addressed by name [11]. Data collectors were stationed in various locations within each facility, including the waiting place, consultation room, recovery room environment and location for postabortion contraceptive counselling.

2.1.3 In-depth interviews with providers and stakeholders

We conducted in-depth interviews (IDIs) with 48 providers and stakeholders to capture their experiences with and opinions on: 1) facility accreditation program (including its benefits and drawbacks); 2) socio-economic profile of beneficiaries; 3) administrative and management-level barriers experienced by the accredited facilities; 4) reimbursement process and flow; and 5) future intentions regarding the program. Participants were selected for the IDIs to ensure a range of types of providers, including general physicians (n=9), specialized Ob-Gyns (n=11), nursing staff (n=10), facility managers (n=5), district program managers and NGO workers (n=8), and community outreach workers (n=5). These providers were selected purposively from six districts: Gaya, Nalanda, Saran, Vaishali, Bhagalpur and Bhojpur. Four trained senior researchers conducted the IDIs, which were audio recorded with prior consent of the respondents.

The project was reviewed and approved by an Institutional Review Board in India and the USA. Informed consent was obtained from all clients, providers and stakeholders before their participation in interviews.

2.2 Data analysis

Facility data and service statistics are described using frequencies and percentages for categorical data or means and standard deviations for continuous data that are normally distributed. Skewed data is presented as medians and range (minimum, maximum). As part of the client exit interviews, two indices were computed: client satisfaction and quality of care. The client satisfaction index was computed based on nine parameters, including 1) overall client satisfaction; 2) client's rating compared to other facilities that provide sexual and reproductive health services; 3) future intention to come back to this facility; 4) intention to recommend this facility to others; 5) sufficient time given by the doctor; 6) behavior of staff; 7) non-judgmental attitude of the staff; 8) expression of client's individual concerns and questions; and 9) provider's attitude toward free service provision. Responses of each question were given logical weights to calculate a composite index by summing assigned weights for each individual. The composite total score ranged from 0 to 14. Further respondents were segmented into three categories—high, moderate, and low—based on composite scores 12-14, 9-11, and <9, respectively.

Similarly, a quality of care index was computed based on seven parameters, including: 1) information on all methods of abortion available at facility; 2) involvement of client or husband/relative in deciding methods of abortion; 3) audio and visual privacy reported by client; 4) observed privacy of the client-provider interaction; 5) counselling on postabortion contraception; 6) acceptance of a contraceptive method immediately following the procedure; and 7) information provided on when follow-up might be needed. A similar strategy was used to construct a composite score for quality of care, ranged from 0-7. The composite quality of care scores had further been categorized as high, moderate, and low based on composite scores 6-7, 4-5, and <4, respectively. All quantitative analysis was conducted using SPSS 13.0.

In addition, the questionnaire was designed to capture out-of-pocket costs incurred for seeking abortion care services and treatment of postabortion complications, including medical costs (consultation fees, tests, and medicine) and nonmedical and social costs (transportation, food, and lost income/time).

In-depth interviews were transcribed and coded independently by two researchers using Atlas.ti 7. Inter-coder agreement checks were conducted, with adjustments to the codebook and recoding of text as needed. Codes were cluster-analyzed, most notably to understand barriers and facilitating factors to implementation of the program.

Study Findings

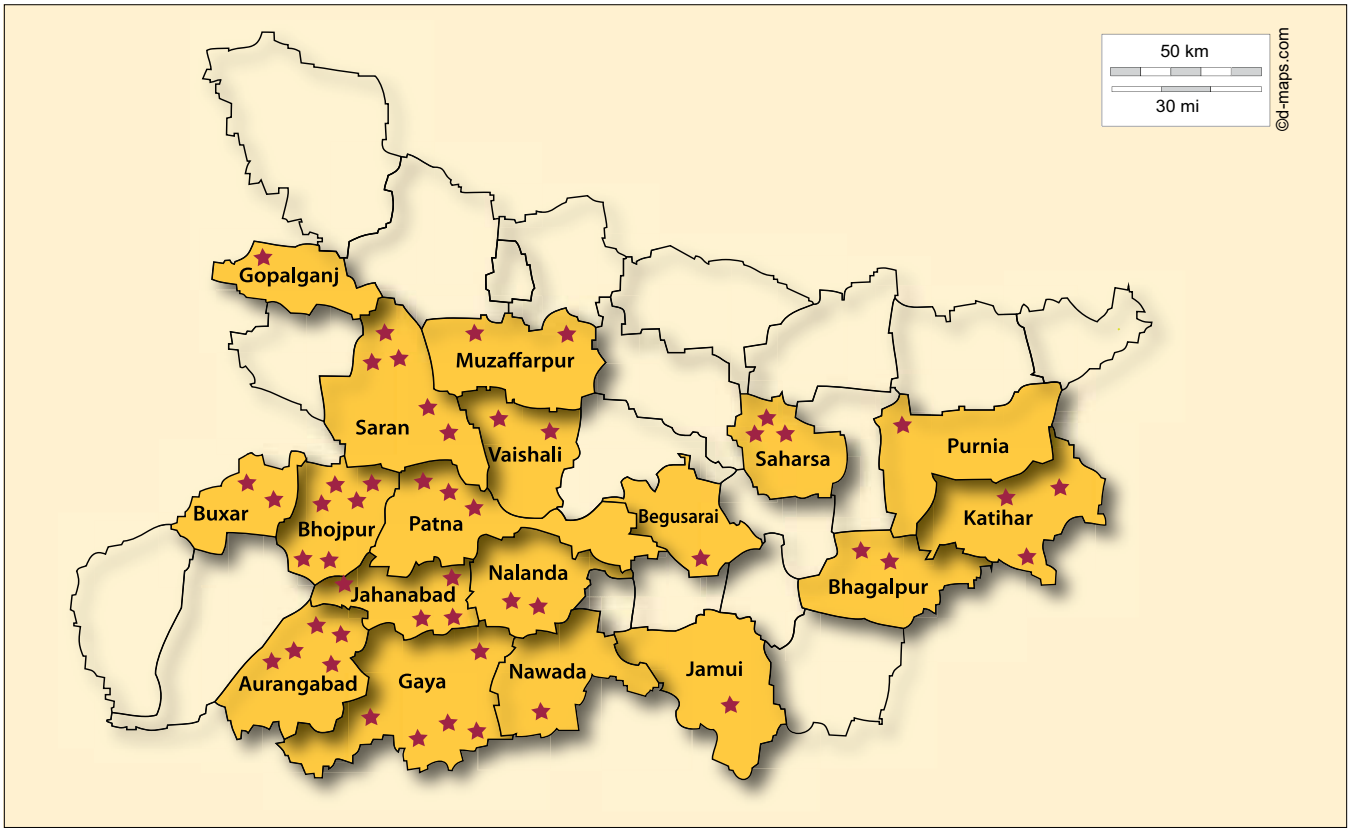
3.1 Accreditation and service provision: Routine monitoring

3.1.1 Geographic location and profile of facilities accredited under the Yukti Yojana

From July 2011 to May 2013, 49 private health facilities were accredited under the *Yukti Yojana* program in Bihar (Figure 2). These 49 accredited facilities were located in 18 different districts (see Annexure A2) and not uniformly distributed. For example, while district Bhojpur had six accredited facilities, district Nawada had one facility approved under the program. Another 20 facilities had applied for the accreditation but were found ineligible for accreditation.

Baseline facility data collected from the 49 accredited facilities immediately after state approval reveals that facilities were approximately evenly distributed between nursing homes (53%) and private clinics (47%) (Table 2). Most of the facilities (94%) obtained

Figure 2: Location of 49 private facilities accredited under the *Yukti Yojana* program as of May 2013



information about the accrediting process from the implementing NGO.[1] The mean time between submitting application and DAC's inspection was 3.7 months (standard deviation [SD] = 3.5 months); while the mean time between the inspection and securing the DAC's approval was 1.5 months (SD = 0.7 months). Almost all facilities (98%) had ≥1 MTP-trained doctor providing abortion services. Facilities had a mean of 82 adult women (SD = 20) coming per day for reproductive health-care services including abortion and postabortion complications. Almost all facilities (92%) had provided abortion care in the past three months of the baseline survey; however, only around three-fourth of them (74%) had all of the essential equipment and drugs.

Each facility was assessed at baseline (immediately after accreditation) and then at periodic intervals of

Table 2: Baseline characteristics of private facilities (N=49) accredited under the *Yukti Yojana*

	Number	%
Facility type		
Clinic	26	53
Nursing home and private hospital	23	47
Sources of information regarding accreditation program*		
Newspaper advertisement or government website	5	10
Implementing non-governmental organization	46	94
Other	1	2
Time between submitting application and DAC's inspection		
≤1 month	8	16
2-3 months	18	37
≥3 months	23	47
Mean (sd) waiting time (months)	3.7	(sd=3.5)
Time between DAC's inspection and approval		
≤2 months	33	67
3-4 months	9	18
>4 months	7	14
Mean waiting time (months)	1.5	(sd=0.7)
Mean number of adult women coming to facilities per day	82	(sd=20)
Facilities with ≥1 MTP trained doctor	48	98
Provided abortion services (in the past 3 months)	45	92
Referral linkage for 2nd trimester and serious complication	40	82
Maintains separate logbook/register	46	94
Has all essential equipment and drugs	36	74

* Percentages sum to >100 because multiple responses were possible
DAC = District Accreditation Committee.

[1]Gram Praudyogik Vikas Sansthan (GPVS), a local NGO, has been strengthened to provide on-ground assistance to the state government in implementing the program and facilitating day-to-day activities.

Table 3: Comparison between baseline and first follow-up survey for infrastructure and service provision across 37 accredited facilities, Bihar, India

Parameters	Baseline (N=37)		Follow up-1 (N=37)		Level of sig. diff
	n	%	n	%	
Facility types					
Clinic	20	54	20	54	NC
Nursing home	17	46	17	46	NC
Facility infrastructure and other facilities					
Facilities with at least one MTP-trained doctor	36	97	36	97	
Necessary instruments and supplies for infection control	36	97	37	100	
Facilities have displayed any IEC material on MTP	32	87	37	100	*
Facilities having site signage on the *Yukti Yojana* (YY)	32	87	37	100	*
Displayed any poster mentioning MTP services are free	32	87	37	100	*
Facilities maintaining separate logbook/register	35	95	37	100	
Facilities with all essential equipment and drugs	24	65	36	97	**
Service provision at accredited facilities					
Mean number of adult women coming to facilities per day	80	(SD=20.7)	81	(SD=22.0)	
Facilities provided abortion services (in the past three months)					
Yes	37	100	37	100	
No	0	0	0	0	
Facilities providing postabortion contraceptives	35	95	37	100	
Facilities provide MTP services for all seven days in a week	25	68	33	89	*
Referral linkages for 2nd trimester and serious complications	31	84	30	81	
Treatment area has both audio and visual privacy	37	100	37	100	

* Sig. at 95%; ** Sig. at 99%; NC: Not calculated.

six, twelve, and eighteen months after the baseline using a structured facility-assessment tool. The purpose of this follow-up facility survey was to monitor the preparedness of the sites to ensure high quality safe abortion services offered by them. Table 3 exhibits baseline and the first follow-up data of 37 facilities. As facilities are accredited at different points of time the follow-up data were available for 37 facilities at the time of the reporting. As reflected in Table 3, significant ($p<0.5$) improvement were recorded regarding display of MTP-related IEC material and particularly that on the *Yukti Yojana*. This includes IEC material announcing availability of free abortion services at the facility. Another significant improvement noted from the baseline was the availability of all essential drugs and equipment needed to provide abortion services (baseline=66%; follow-up 1=97%). Significantly more number of accredited facilities were also found to be providing abortion services for all seven days in a week compared to the baseline situation (baseline=68%; follow-up 1=89%).

3.1.2 Women served

To monitor routine progress and quality of service provision each site was oriented to keep individual records in separate register. By May 2013, 41 of 49 (84%) accredited facilities had provided abortion services. The remaining eight facilities had not yet started providing services due to some administrative reasons. Service delivery data available from these 41 facilities shows that they provided abortion care services to 10,700 women, including 5,555 induced abortions (52%) and 5,145 postabortion (48%) care services (Table 4). Abortion clients had a mean age of 28 years (SD=4.1 years), the majority were Hindu (91%) and almost a quarter (22%) had never attended school. Almost all women (97%) presented for care within the first 12 weeks of gestation. Less than one percent women were referred to a higher-level facility either for second trimester or severe complications. Among those who received abortion care at accredited facilities, approximately 88% received uterine evacuation services with appropriate technologies including manual/electric vacuum aspirator or medical

Figure 3: Proportion of women accompained by outreach workers by type of services (N=10,700)

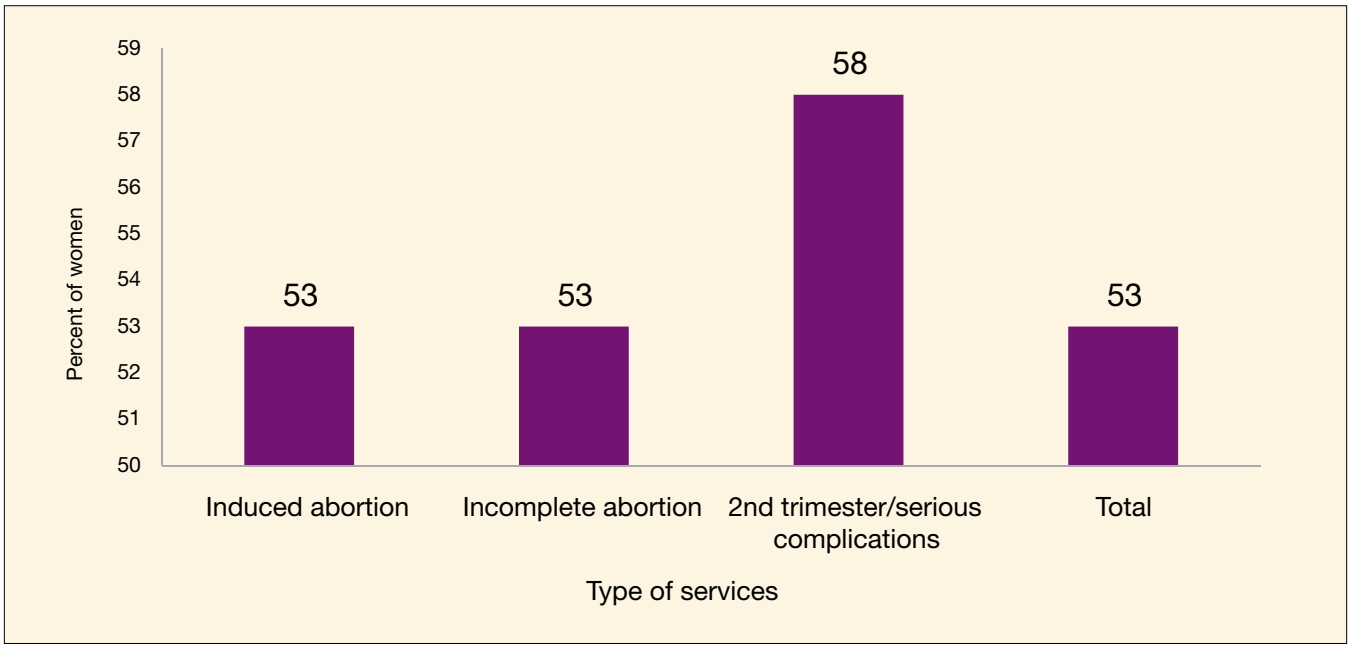


Table 4: Profile of 10,700 women received abortion services at 41 accredited facilities, Bihar, India, November 2011 to May 2013

	Number	%
Client age#		
16 - 24 years	837	15
≥25 years	4,418	80
Missing	300	5
[Mean age] (sd)	[28]	(sd=4.1)
Client religion#		
Hindu	5,058	91
Muslim	442	8
Other	3	0
Missing	52	1
Client education		
Never attended school	2,402	22
Primary or middle	4,804	45
Secondary or greater	1,875	18
Missing	1,619	15
Client caste		
SC/ST	1,670	16
OBC	5,009	47
General	3,122	29
Missing	899	8
Type of service received		
Induced abortion	5,555	52
Incomplete abortion	5,145	48
Duration of pregnancy		
≤12 weeks	10,423	97
>12 weeks	97	1
Missing	180	2
Appropriate method of evacuation* used among those not referred to higher-level facility (N=10,409)		
Yes	9,196	88.3
No	339	3.3
Missing	874	8.4
Received postabortion contraception among those not referred to higher-level facility (N=10,652)[a]		
Yes	9,222	87
No	1,430	13
Women referred to higher-level facilities	48	0.4

Individual records on age and religion were not included in Incomplete Abortion Register.
* Appropriate method includes manual or electric vacuum aspiration or medical method of abortion and calculated for the first trimester abortion; SD=Standard Deviation.
[a] excluded 48 women referred to higher-level facilities.

method of abortion. More than four-fifths (87%) of women received contraception immediately after the abortion procedure.

One of the major goals of this program was to help rural as well as poor urban women to reach these accredited facilities though outreach workers including, ANMs (Auxiliary Nurse Midwives), ASHAs (Accredited Social Health Activists) and AWWs (Anganwari Workers) to reduce the likelihood of unsafe abortion. All accredited facilities were also instructed to record information on persons who accompanied women to the facilities. As portrayed in Figure 3, around 53% women were accompanied by an outreach worker. This proportion had further increased in women who presented with serious complications or second trimester abortions.

In order to assess the trends of service provision, we analyzed the data on monthly service provision for a period of 19 months. For the first six months (November 11 to April 12) the service provision was restricted to around 200-350 women per month; while in the second (May 12 to October 12) and third (November 12 to May 13) phases the total number of women served per month had increased to 500 and 1,000, respectively (see Figure 4). This increase in absolute numbers can partly be attributable to the fact that more number of facilities approved by the state government started providing abortion services under the program. For example, for the first six months around 23 facilities started providing abortion services under the *Yukti Yojana,* while these numbers increased to 33 and 41 at the second and third phases, respectively.

The trends of average service provision per facility in any particular month are depicted in Figure 5. The trend line shows a "U" curve, starting with a high caseload of 35 women per facility per month (when few facilities were approved) and then declines to an average level of 18-19 cases per month; and then further increasing to 25 cases per facility, respectively.

Figure 4: Number of women who received abortion services from accredited facilities by month, Bihar, India, November 11 to May 13

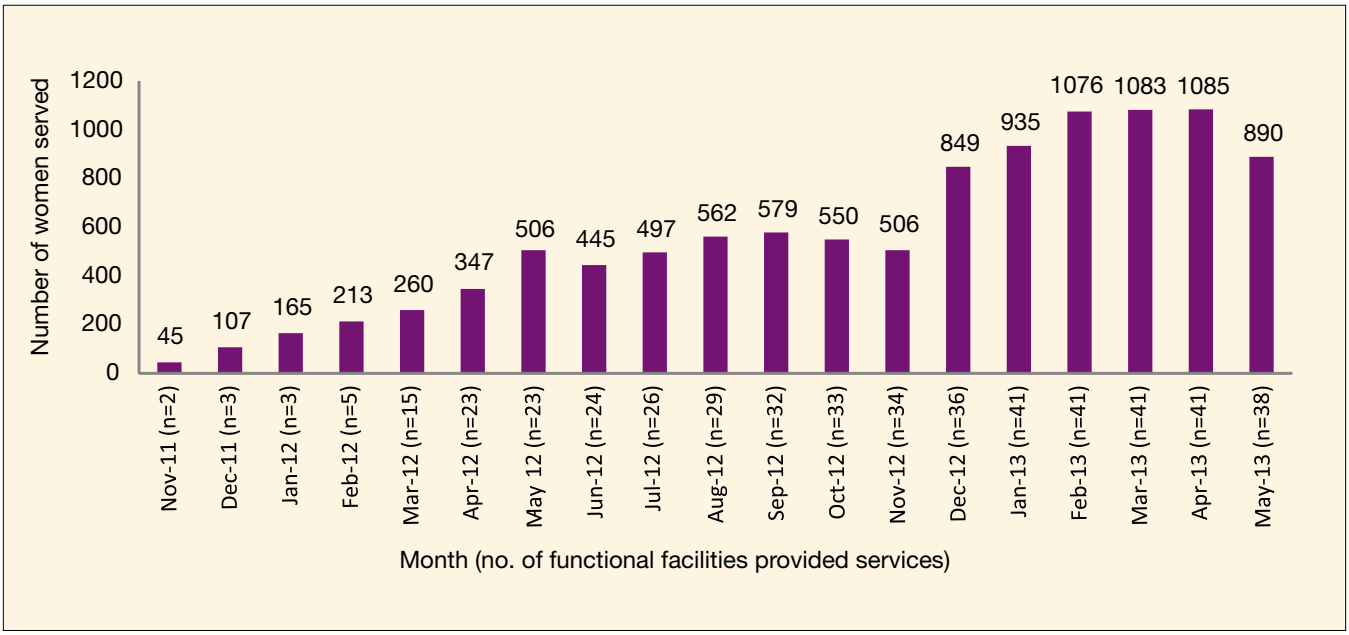
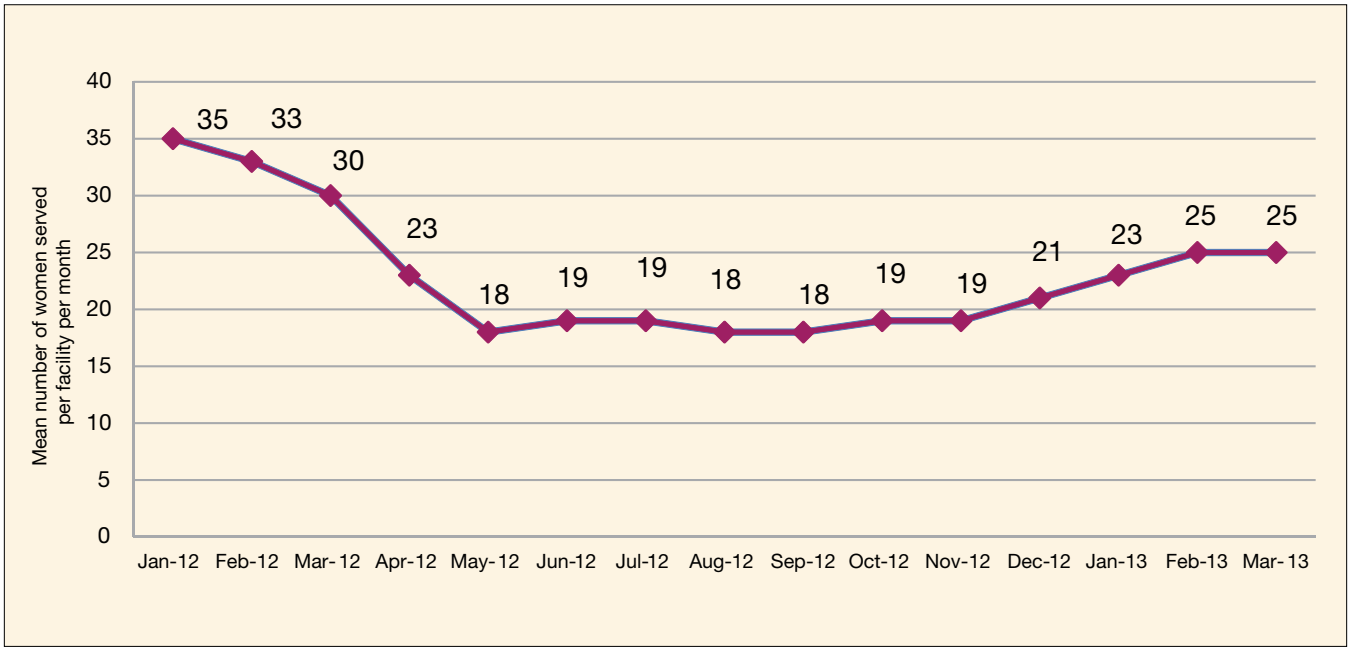


Figure 5: Mean number of women served per accredited facilities (five-point moving average)



3.2 Beneficiaries' profile and satisfaction: Client exit interviews

3.2.1 Profile of beneficiaries

Findings of the client exit interview (CEI) study elucidate the profile of the beneficiaries who received safe abortion services at 16 selected accredited health facilities. A total of 569 women were interviewed between April 14 and May 15 2013 after they had availed the abortion service at these accredited facilities. As shown in Table 5, one-fourth women were less than 25 years, while the mean age was around 27.4 years. Nearly all women who received abortion services were married (98%). More than one-third women (37%) had never attended school, while another one-third had primary or middle level of schooling. Majority of them belonged to scheduled caste or scheduled tribe (19%) or other backward caste (65%) as per Government of India's caste designations. More than half of these women reported holding a BPL (below the poverty line) card, and composite standard of living index (SLI) derived through combining respondents' possession of consumer durables revealed poor economic status for the majority of the beneficiaries (71%). Most women came from nearby villages (66%) and towns (8%), traveling an average (median) distance of 11 kilometers.

3.2.2 Reasons for visiting these accredited facilities

Women were also asked to spell out the reasons of selecting accredited sites for accessing abortion and postabortion-related services. In response to this question, an overwhelming majority of women reported to having had good reference about these accredited sites and more than half of the women (58%) decided to come to these accredited private facilities mainly because abortion services were available free of cost (see Figure 4).

Table 5: Socio-economic profile of 569 women who received abortion services at 16 selected accredited facilities during the study period April to May 2013, Bihar, India

	Number	% [average]
Age		
Up to 24 years	143	25
≥25 years	426	75
Mean age (standard deviation)	569	[27.4] (sd=5.3)
Religion		
Hindu	522	92
Muslim	47	8
Education		
Never attended school	209	37
Primary or middle	179	31
Secondary or greater	181	32
Caste		
SC/ST	109	19
OBC	372	65
General	88	16
Marital status		
Married	558	98
Not married	11	2
Living children		
None	40	7
1-2	245	43
3 and above	274	48
Missing	10	2
Holding BPL card		
Yes	303	53
No	266	47
Wealth index		
Low	404	71
Medium	160	28
High	5	1
Place of residence		
Same town	151	26
Other town	44	8
Village	374	66
Median distance traveled in km (standard deviation)	569	[11] (17.3)

3.2.3 Quality of care and client's satisfaction

Post procedure, each woman was asked a series of questions to assess the quality of services offered by the accredited facilities. These questions included informed choice of abortion methods, audio and visual privacy, counselling and acceptance of postabortion contraception, and information about follow-up visits (see Table 6). Although, around 69% clients were told about various methods available at the accredited facility, only 43% were allowed to take the final decision on the evacuation method. More than three-fourth (78%) women reported perceiving audio and visual privacy at the time of counselling and procedure, while interviewers personally observed audio and visual privacy for 87% women. More than two-third (69%) women had received postabortion counselling. However, only 44% women accepted a modern contraceptive method immediately after the procedure. Little more than half of the women reported being told about the follow-up visit in case of any postabortion complications or other issues.

A composite quality of services index was then created based on the output of these seven parameters of quality of care (Table 6a). As per this index, services were rated as high quality by 33% of women, moderate by another 36% women and low quality by a similar proportion of women—31%.

Women were also asked to express their satisfaction levels in terms of their overall satisfaction with the abortion services received, comparison of these services with similar reproductive health services received at some other private facility, providers' and other staffs' non-judgmental behavior and attitude and their intention to return to the facility in future as well as recommending it to others (see Table 7). As depicted in Table 7, clients were satisfied with the overall service provision and behavior of site staff. More than half of the women (57%) felt these accredited facilities were better than others that provide reproductive health services. In contrast, one-fourth perceived other facilities to be better than

Figure 6: Reported reasons for choosing an accredited facility (N=569 women)

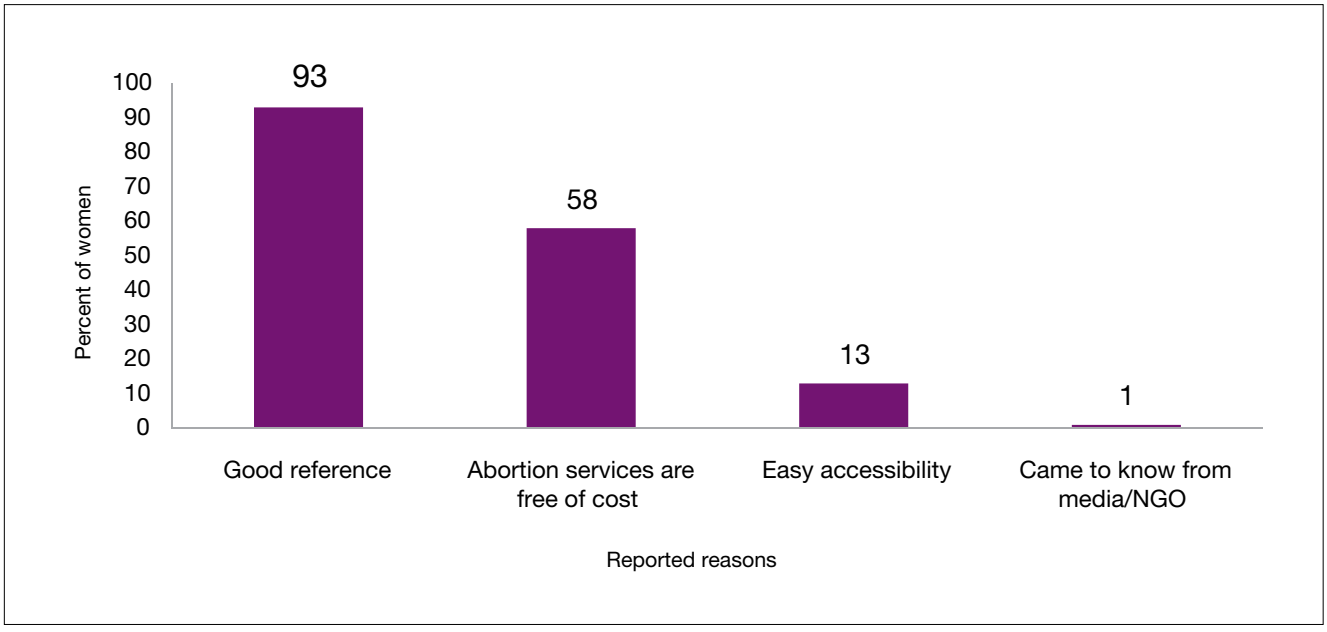


Table 6: Parameters used to construct Quality of Services (QoS) index as perceived by 569 women who received abortion services at 16 selected accredited facilities during the study period April to May 2013, Bihar, India

	Number	%
Was told about the various methods of abortion that are available	392	69
Client or husband/relatives' involvement in deciding abortion method	246	43
Both audio and visual privacy reported by client	442	78
Client-provider conversation not heard by other patients (observation)	496	87
Counselling on postabortion contraception	394	69
Acceptance of a contraceptive method immediately after the procedure	253	44
Informed when to return for follow-up in case of complication	304	53

Table 6a: Composite Index of Quality of Services (CIQoS) perceived by 569 women who received abortion services at 16 selected accredited facilities during the study period April to May 2013, Bihar, India

QoS [Index score range]	Number	%
Quality of care$ [0-7]		
High [6-7]	185	33
Moderate [4-5]	205	36
Low [<4]	179	31

$ Quality of care index is calculated based on seven quality parameters including 1) information of all methods of abortion available at site; 2) Client or husband/relatives' involvement in deciding abortion method; 3) Audio and visual privacy reported by client; 4) Client-provider conversation not heard by other patients (observation); 5) Counselling on postabortion contraception; 6) Acceptance of a contraceptive method immediately after the procedure; and 7) Informed when to return for follow-up check-ups in case of any complication.

the accredited ones. Majority of women perceived no discrimination in treatment and quality of care as they received high quality abortion services at a private clinic without bearing any service fees or procedure cost.

A client satisfaction index was constructed based on a total of these nine different satisfaction parameters. As can be seen from Table 7a, for each of these parameters individually a very high rating has been given by the women. The overall satisfaction index score shows (Table 7a) that slightly less than half the women coming for abortion services (45%) expressed very high levels of satisfaction compared to 47% and 8% who expressed moderate or low level of satisfaction, respectively.

3.2.4 Out-of-pocket cost to the client

Although abortion services were free for all beneficiaries, we asked each respondent about her out-of-pocket cost which she had incurred for accessing this abortion service. The questionnaire was designed to capture out-of-pocket costs incurred for seeking abortion care services and treatment for postabortion complications, including procedure cost, registration cost, doctor's consultation fee, clinical tests (blood test, ultrasound) and nonmedical costs (transportation and food). Table 8 shows the proportion of women who incurred any cost and the median cost of abortion services and treatment of abortion-related complications by selected clinical and nonclinical characteristics.

Table 7: Parameters reflecting clients' satisfaction with services and behavior of doctor and staff as perceived by 569 women who received abortion services at 16 selected accredited facilities during the study period April to May 2013, Bihar, India

		Number	%
Overall client satisfaction	Not at all satisfied	1	0
	Moderately satisfied	45	8
	Completely satisfied	523	92
Client's rating compared to other facilities provide SRH	Bad	146	26
	Same	100	18
	Better	323	57
Future intention to come back to this facility	Yes	536	94
	No	33	6
Intend to recommend this facility to others	Yes	566	99
	No	3	1
Sufficient time given by the doctor	Too less	47	8
	Neither less nor more	174	31
	Sufficient	348	61
Behavior and attitude of the facility staff	Agree	533	94
	Disagree	36	6
Nonjudgmental attitude of the staff	Agree	535	94
	Disagree	34	6
Allowed to express their individual concerns and question	Agree	483	85
	Disagree	86	15
Got much care, even services were free	Yes	556	98
	No	13	2

Table 7a: Composite Index of Client Satisfaction (CICS) perceived by 569 women who received abortion services at 16 selected accredited facilities during the study period April to May 2013, Bihar, India

CS [Index score range]	Number	%
Client satisfaction# [0-14]		
High [12-14]	255	45
Moderate [9-11]	266	47
Low [<9]	48	8

Client Satisfaction Index is calculated based on nine different satisfaction parameters including 1) Overall client satisfaction; 2) Client's rating compared to other facilities providing SRH services; 3) Future intention to come back to this facility; 4) Intend to recommend this facility to others; 5) Sufficient time given by the doctor; 6) Behavior and attitude of the site staff; 7) Nonjudgmental attitude of the staff; 8) Allowed to express their individual concerns and question; and 9) Providers didn't give much care to the client as services were free.

Table 8: Cost incurred by 569 women who received abortion services at accredited sites in Bihar, 2013

Components of cost	Incurred cost (N=569)		Average cost	
	Number of women	% of women	Median [Range]	Mean [Standard deviation]
Incurred any cost for availing abortion services	545	96	160 (0-2,650)	247 (282)
Average cost by components				
Registration cost	344	61	5 (0-150)	11 (21)
Doctor's consultation fee	10	2	0 (0-100)	1 (10)
Clinical test (Blood test, X-ray, urine and ultrasound)	50	9	0 (0-550)	5 (29)
Medicine	106	19	0 (0-2,500)	47 (189)
Transport and food	500	88	80 (0-1,100)	111 (123)
General anaesthesia	98	17	0 (0-1,000)	66 (164)
Copper-T/injectable	34	6	0 (0-150)	6 (27)

An overwhelming majority of women incurred some cost (96%), but no woman incurred any direct cost for procuring abortion services. On an average, a woman incurred a median cost of INR 160 (mean 247). However, very high standard deviation implies only few persons had to incur a high cost for some exceptional reasons and majority had either no or low cost.

Women almost uniformly incurred cost for transportation and food (88% and median cost INR 80; mean INR 111) followed by registration fee (61% and median cost INR 5, mean INR 11), and other medicines (19%, median 0, mean 47). Thus, barring transport and food all other reported costs were substantially low.

3.3 Provider perception study

3.3.1 Operational feasibility, bottlenecks and sustainability

Qualitative research helps in identifying the operational bottlenecks and motivational attributes of the private sector to join in this new public-private partnership (PPP). A total of 48 respondents both from public and private sectors have shared their personal and institutional experience of the *Yukti Yojana* in Bihar.

In response to a question on the sources of motivation to join with the public sector to offer safe abortion services many respondents (including providers, owners of clinics and nursing homes and site managers) uniformly expressed "response to social cause" and "opportunity of integrating safe abortion with existing RH services" as the primary factors to apply for the accreditation scheme. As expressed by few of the respondents:

"We thought of exploring new opportunity to serve poor people through this initiative beyond our routine work…where we earn money." [FM; NGO clinic]

"We are providing safe abortion services for the last few years; ...Many poor women don't opt for abortion services here mainly because of their inability to spend money and usually approach an unsafe provider; ...now with this scheme no one needs to go back..." [Ob/Gyn provider; Private clinic]

"Earlier women used to come for dual purposes, abortion and female sterilization. However, often they left my clinic without having sterilization and never came back. Now, I can integrate abortion with other RH activities; ...no one will return back without having services." [Ob/Gyn; NGO clinic]

Respondents and key stakeholders were also asked to highlight the operational issues and practices that hindered progress to this initiative. The most frequently mentioned responses included "waiting time for facility approval", "reimbursement process and delay", "reimbursement fees" and "stringent conditions of eligibility to get approval for the facility".

As expressed by few of the respondents and key stakeholders:

"...After submitting an application we followed up with the district authority twice and again after DAC inspection we did the same. It is a time-consuming and complicated procedure." [Provider; NGO/Trust hospital]

"The existing fees at private sector is substantially higher than the rate assigned under this scheme. Sometime we feel it is very difficult to manage our own internal cost."
[Ob-Gyn provider; Private clinic]

"Reimbursement process takes its own time. Government is managing 100 things at a time. …We always need to follow-up for our due payment. This is demotivating."
[Ob/Gyn provider; Private clinic]

3.3.2 Sustainability and potential for scale-up

Sustainability of any program depends on the cost-benefit analysis; as such we tried to explore perceptions of providers and other stakeholders on the relative benefits and concerns for the sustainability of this PPP initiative. Overall, respondents appeared to be optimistic about the future potential of the *Yukti Yojana.* As expressed by a senior gynecologist:

Table 9: Perceived benefits and concerns of the *Yukti Yojana* program expressed by different stakeholders

Benefits	Concerns
Improving access to safe abortion to poor women	Risk of getting branded as "abortion-providing site"
Reducing unsafe abortion and related MMR	Risk of getting branded as "site for poor women"
Improved clientele: abortion-related	Complexity of fund disbursement
Improved clientele: other SRH-related	Lack of brand promotion
Improved recognition through state government	Low service fees and profit margin
Cost less promotion of private sector site	Lack of awareness among government officials
	Too stringent process of accreditation

"…The program has just been introduced in the state; …it will take its own time to ensure (further) better quality of services. We will work together so that it reaches to more and more numbers of women." [Provider; NGO/Trust hospital]

Respondents shared multiple benefits and concerns of this PPP model, which could be used to improve the program going forward. Table 9 summarizes those benefits and concerns expressed by the different stakeholders.

These perceived benefits of this program have been instrumental in ensuring the sustainability of this public-private partnership. In contrast to these benefits, private providers and stakeholders had raised multiple concerns in term of sustainability and future scale. As mentioned by few of the key stakeholders:

"…The future of this scheme will rely on the state government's actions to reduce time of reimbursing the service charge of private clinics." [Site manager, Private nursing home]

"As of today, we are facing not much issue...but if our claims are not settled within 2-4 months, we will have no other option but to withdraw ourselves from this initiative." [Ob-Gyn, Private clinic]

"Government officials have different levels of understanding and are not clear about the guideline... It takes unnecessary time to re-orient them about the program. We should orient them at the district level." [Staff, Implementing NGO]

Discussion and Recommendations

4.1 Discussion

The Government of Bihar has successfully implemented the first program of accreditation of private sector facilities in India for providing safe abortion services to poor women free of cost. In many countries, governments provide health care directly to the poor; in India, the government ensures that the poor have access to health care via different levels of public health facilities. However, in reality a majority of Indian poor continue to approach the unorganized private health sector to access reproductive health services. The experience of the *Yukti Yojana* offers a new model to other Indian states for expanding access to affordable safe abortion care services.

In the first phase (two years) of the *Yukti Yojana* program, 49 private facilities in 18 districts of Bihar successfully completed the accreditation process. Facilities were accredited relatively slowly, with an average duration of just over five months between application and approval. Widespread interest on the part of facilities in becoming accredited likely reflects the crucial role that the private sector plays in addressing women's reproductive health needs as well as the recognition of the importance of subsidizing services to low-income women. The experience in Bihar is in line with a global movement experimenting public-private partnership models of ensuring that the poorest women have access to reproductive health care, including accreditation and subsidies (through vouchers) to private and public facilities being undertaken in Kenya and Bangladesh [15, 16].

The Government of Bihar has been effective in screening eligible facilities based on several criteria mentioned in the site accreditation protocol. Few facilities were not given approval because of their inability to satisfy all conditions. After securing accreditation, private facilities were able to provide care to a substantial number of clients within short follow-up interval. Almost all clients (97%) presenting for abortion care were seen within the first 12 weeks of gestation. This finding suggests that by removing financial and other barriers that women face when accessing induced abortion services could likely result in coming early in their gestation, which may result in fewer complications for women and lower costs for the health-care system.

Although concerns have been raised that such private accreditation programs may not target poor women exclusively, the findings of the client exit interviews showed that more than half of the beneficiaries (53%) of the *Yukti Yojana* program had the BPL card (below the poverty line identity card assigned by the local government based on their household income).

Furthermore, composite wealth index generated through access to consumer durables also had counted 71% beneficiaries holding low levels of living standard, indicating that the program did adequately reach poor women. Low levels of education and caste structure also suggest utilization of services by poor women. This program highlighted evidence for the feasibility of involving private Ob-Gyns and general physicians to deliver safe abortion services to poor women on a large scale and a potential new direction for maternal health programming in low-income countries [7].

The *Yukti Yojana* also helped poor women to access free high quality abortion services. An overwhelming majority of women (88%) received abortion services with most appropriate technology as recommended by WHO, while around 84% received a modern contraceptive method immediately after the procedure. This also resulted in high perceived satisfaction and quality of care indices.

Out-of-pocket cost incurred by the poor women was very limited and primarily restricted to expenses on transportation and food. Other studies in India recorded substantially high cost of securing abortion services, particularly for abortion procedure and medicines [11].

Crucial to the success of any accreditation system is the willingness of private providers to be involved in the accreditation program. Unlike other global experiences [20], there has been universal acceptance of the private providers to be associated with the *Yukti Yojana* in future.

However, providers and stakeholders had raised major concerns on the complexity of the approval process and fund reimbursement. These two factors have also been perceived as important attributes of program sustainability. These issues should be addressed before scaling-up this program further.

4.2 Recommendations

Based on the experience of Bihar, we recommend that governments of other states where public sector services are limited explore the option of a public-private partnership to provide safe abortion services to poor women. In addition, the accreditation program should be expanded to all 38 districts of Bihar. However, along with accreditation of the private sector the state government should continue to ensure equal emphasis on creating safe access within the public health system. This approach will not only extend the base of access, but will improve equity in access.

There are two significant areas which may affect the essential elements of accreditation. First and most important is the system of accreditation and complexity of fund disbursement. The second is the use of accreditation by governments to assure quality in health services. A number of recommendations follow from the findings of this study:

1. *Reduce waiting time for approval of facilities after submission of application*

Findings have highlighted that majority of facilities had to wait for around five months to get approval. This can easily be reduced further through administrative follow-ups and health system accountability at district level.

2. *Raise awareness among government officials about the program scope and official guideline*

A lesson to be drawn from this study is that orientation is more of a continuous than discrete process. Lack of understanding among implementing officials has not only delayed the administrative process, but is often perceived as the operational bottleneck to implement this PPP model.

3. Explore the feasibility of reducing complexity of fund disbursement

The processes of reimbursing financial incentives have uniformly been regarded as the major bottleneck of this PPP model. Majority of the stakeholders pointed out this component to be the most influencing factor of sustainability. The state government along with the district officials should work out a feasible plan of action to facilitate faster reimbursement process.

4. Raise awareness at community level about new initiatives

Public information campaign must be strengthened to educate poor and rural community about the program. They must include information on abortion services and the location of the accredited health facilities where free services are available.

5. Revisit the reimbursement rates for provision of CAC services under the Yukti Yojana

Discussion among stakeholders should start to address the right mix of incentives that need to be put in place to ensure quality of care.

6. Make abortion services available under the PPP model in remaining districts

In the first phase of intervention, the private site accreditation scheme was introduced only in 18 districts. The state should expand the base of this new initiative to the rest of the 20 districts.

7. Increase ownership of the state government

Ownership of accreditation systems can be integrated within the public health system. This will help to reduce the gaps between state and district level authorities to facilitate the program intervention in line with set guidelines.

8. *Improve system of quality management*

Evidence suggests that the systems that adopt continuous quality improvement (CQI) are proactive in preventing quality problems [21]. Findings of this study suggest that more than half of the women left an accredited site without a postabortion contraception. Keeping this point in mind, the state should explore a mechanism of continuous quality improvement (CQI) process rather than one-time inspection of facilities for screening the eligibility conditions. The quality parameters should include infection management, record keeping, postabortion contraception, and pain management.

4.3 Limitations of the study

This study has several limitations. The study was restricted to service statistics, client exit interviews, and provider perceptions among accredited facilities. These findings ideally would have been compared with non-accredited control sites through quasi-experimental design. However, we had several operational and administrative issues to include control sites. The state government had no pre-identified region and facilities where this new scheme would be piloted. Thus any site identified as non-accredited (control) sites at the beginning of the study may subsequently receive government's approval as accredited sites. This study also had limited opportunity to explore the population level impact of reducing inequalities in access to safe abortion services because of geographic diversity and limited number of accredited facilities. However, the scale of the intervention and geographic diversity of accredited facilities will add methodological complexity of finding out the universe exposed to this benefit.

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Annexure

Table A1: Members of Technical Advisory Group (TAG)

Name of TAG member	Organization
Dr. Shireen Jejeebhoy	Population Council
Ms. Rajni Ved	National Health System Resource Centre (NHSRC)
Dr. Atul Ganatra	Federation of Obstetrics & Gynecological Societies of India (FOGSI)
Dr. Kurus Coyaji	KEM Hospital Pune
Mr. V.S. Chandrashekhar	David and Lucile Packard Foundation
Mr. Vinoj Manning	Ipas Development Foundation
Mr. Ripudaman Kumar	Gram Praudyogik Vikas Sansthan (GPVS)
Mr. Shejo Bose/Don Douglas	Janani
Dr. Sushanta K. Banerjee	Ipas Development Foundation

Table A2: List of 49 sites accredited under the *Yukti Yojana* program in Bihar by district

District	Name and location of accredited sites
Gaya	Al-Zahir Navjeevan Clinic and Research
	Aayushman Nursing Home
	Vaatjatam Nursing Home
	Surgical Nursing Home Maternity Centre
	Surya Clinic
Bhojpur	Surya Clinic
	Heera Surya
	Pariwar Seva Sanstha
	Sinha Nursing Home
	Dr. Suniti Prasad Nursing Home
	Dr. Shakuntala Sinha Nursing Home
Aurangabad	Anisheela Hospital, M.G. Road, Aurangabad
	Sai Hospital, M.G. Road, Aurangabad
	Health World, New Area, M.G. Road, Aurangabad
	Pulse Women Hospital, New Area, M.G. Road, Aurangabad
	Janani Surya Clinic, Near Town Thana, Old G.T. Road, Aurangabad

District	Name and location of accredited sites
Buxar	Surya Clinic
	Dr. Usha Sinha Nursing Home
Nalanda	Bihar Clinic, Biharsharif, Nalanda
	Kisan Nursing Home, Silao, Nalanda
Jamui	Maa Jagdamba Clinic, Jamui
Saran	Surya Clinic
	Meera Hospital
	Ashis Nursing Home
	Boudh Bihar Mahila Vikas Sansatha
	Maa Nursing Home
Vaishali	Surya Clinic
	Mahavir Seva Sadan
Gopalganj	Surya Clinic (FC)
Katihar	Surya Clinic, Hirdayganj, Koshi Colony, Katihar
	Kalyani Sewa Sadan, Gerabari, Katihar
	Devesh Nursing Home, Katihar
Jehanabad	Kumar Clinics, Jehanabad
	Surya Clinics, Jehanabad
	Abhinav Clinics, Jehanabad
	Renu Singh Clinics, Jehanabad
Purnea	Surya Clinic, Purnea
Saharsa	Satyam Hospital, Saharsa
	Dr. Seema Jha Clinic, Saharsa
	Janani Surya Clinic, Saharsa
Bhagalpur	Janani Surya Clinic, Bhagalpur
	Ekta Clinic, Bhagalpur
Patna	Janani Surya Clinic, IAS Colony, Kidwaipuri, Patna
	Pariwar Seva Sanstha, Patna
	Unihealth Medical Clinic, Vishwa Bhawan Jamal Road, Patna
Begusarai	Janani Surya Clinic, Hemra Road, Begusarai
Muzaffarpur	Janani Surya Clinic, Muzaffarpur
	Pragya Seva Sadan, High School Road, Bhagwanpur Chatti, Muzaffarpur
Nawada	Janani Surya Clinic, Opp. Kanahai High School, Kadirganj Road, Mirzapur, Nawada

Abbreviations

ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwari Worker
BPL	Below Poverty Line
CAC	Comprehensive Abortion Care
CEI	Client Exit Interview
CIQoS	Composite Index of Quality of Services
CICS	Composite Index of Client Satisfaction
DAC	District Accreditation Committee
DHS	District Health Society
FM	Facility Manager
IDI	In-Depth Interview
IEC	Information, Education, and Communication
INR	Indian Rupees
MoU	Memorandum of Understanding
MTP	Medical Termination of Pregnancy
NGO	Non-Government Organization
Ob-Gyn	Obstetrician-Gynecologist
PPP	Public-Private Partnership
SC/ST	Scheduled Caste/Scheduled Tribe
SD	Standard Deviation
SLI	Standard of Living Index
USA	United States of America
USD	US Dollar
WHO	World Health Organization

Ipas Development Foundation
P.O. Box 8862, Vasant Vihar, New Delhi 110 057
E-mail: ipasindia@ipas.org

For more information, please contact:
Mr. Samshad Alam
E-mail: alams@ipas.org

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