Nepal Family Health Program
Technical Brief #9

Postabortion Care

Trained service provider counseling a couple on family planning as a component of postabortion care.

BACKGROUND

Complications arising from incomplete abortions (spontaneous and induced) are a major cause of maternal mortality and morbidity in Nepal. The Maternal Mortality and Morbidity Study (1998) reported that 5.4% of maternal deaths in Nepal were due to complications of abortion. It has been evident for some time that Nepal needs post-abortion care (PAC) services both for management of emergency situations and to help women avoid further abortions by providing family planning.

In May 1995, the Family Health Division of the Ministry of Health and Population (MOHP) established the first PAC service site at the Maternity Hospital in Kathmandu, with technical assistance from EngenderHealth, JHPIEGO and Family Health International. Nepal has continued developing PAC services over the period since then.

There are now 78 PAC service sites established in 50 districts, mainly in public sector health facilities. The Nepal Family Health Program (NFHP) was formed by USAID to assist the Government of Nepal to strengthen family planning (FP) and maternal, neonatal and child health (MNCH) services. Since 2002, NFHP has supported the Ministry of Health and Population to expand PAC services from urban referral institutions to peripheral-level public health facilities.

STRATEGIC APPROACH

The NFHP approach to providing high-quality PAC services has focused on:

- Use of manual vacuum aspiration (MVA) in place of dilatation and curettage (D&C) as the standard procedure;
- Having lower-level cadres (staff nurse and senior auxiliary nurse midwives (ANM)) as the primary service providers, to improve access;
- Expanding access by developing sites in as many districts as possible and further decentralizing to below district level to the extent feasible;
- Effectively linking PAC with FP services;
- Decentralizing PAC training centers to district level for both group-based and on-the-job-training.

Family planning counseling and provision of FP services following an MVA procedure are central to the PAC approach in Nepal. Acceptance of FP methods by PAC clients has been high. The PAC program has fostered an important link to needed FP services.

Over the life of project, NFHP has assisted in strengthening two existing training centers and existing PAC service sites and establishing two new training centers and 46 new public sector PAC service sites.

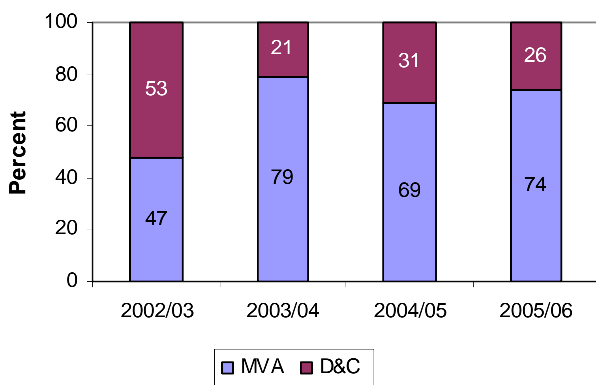
Key Achievements

- Established two new postabortion care training centers
- Established 46 new public sector PAC service sites
- Strengthened two existing training centers and existing PAC service sites
- Shifted substantial proportion of PAC services delivery from doctors to nurses
- Trained over 170 service providers in post-abortion care services.

RESULTS

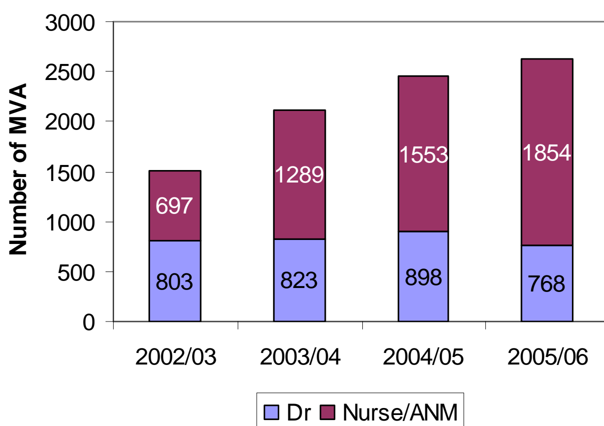
Overall, MVA now accounts for most PAC procedures. Among doctors, D&C is still often used but, even among them, a growing proportion of cases are managed using MVA. With NFHP assistance, Nepal has also been successful in shifting a substantial proportion of PAC service delivery to nurses.

Figure 1. MVA as a Percent of all Postabortion Care



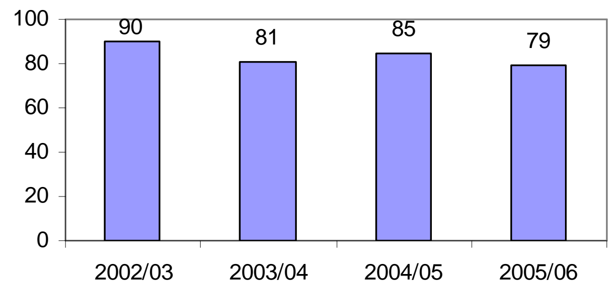
NFHP has assisted in successfully expanding the service delivery network from district to below-district level. Over the last five years, NFHP helped set up 46 PAC service sites in public health facilities. 119 service providers (43 doctors and 78 nurse/ANMs) and 96 assistants were trained using a group-based approach and 60 service providers (33 doctors and 27 nurses) were trained through on-the-job-training. We have used an OJT approach mainly to train service providers based in training centers.

Figure 2. MVA Cases by Provider Category



Although PAC services are now available in two-thirds of the districts in the country, there remains significant unmet need. The Nepal Demographic Health Survey (NDHS) 2006 reported that 5% of all pregnancies ended in spontaneous abortion. From PAC service statistics we can estimate that only about 7% of women with spontaneous abortion have ended up accessing PAC services—although there may be under-reporting of actual levels of service delivery may be somewhat under-reported. Family planning acceptance has been high among PAC clients.

Figure 3. Family Planning Acceptance after MVA



The most popular FP method among PAC clients has been the injectable Depo Provera®, followed by condoms, pills, IUCD, Norplant and VSC in declining order.

LESSONS LEARNED

- **Continuous technical support by NFHP and the MOHP Family Health Division staff to PAC service centers has been crucial in institutionalizing comprehensive PAC services,** promoting use of MVA, service provision by nurses, and establishing good links with FP services.
- **Doctors show resistance to having nurses provide PAC services.** Nurses are competent to provide comprehensive PAC services, though there continues to be some resistance from doctors and hospital management. This has been addressed through orientations (both formal and informal) to the doctors by NFHP and MOHP staff, with some positive changes in attitude.
- **It is difficult to establish a successful program when trained service providers are frequently transferred**. This remains a challenge, despite efforts by NFHP to raise awareness among MOHP officials who approve such transfers.
- **On-the-job-training is a cost-effective way to maintain skills and strengthen services**. OJT provides trainees an opportunity to become progressively more confident and competent over time, continuing to work at their own workplace, and therefore not interrupting services due to absence.
- **PAC service can be provided through peripheral public health facilities.** Primary Health Care Centers have demonstrated a capacity to consistently provide comprehensive, quality PAC services.

- **Program-specific data is difficult to collect if not included in the MOHP's regular HMIS.** Through the period of NFHP implementation PAC service data were not collected through the government's Health Management Information System (HMIS), making nationwide monitoring problematic. However, from this fiscal year the Government of Nepal has added a PAC indicator in the HMIS.

Postabortion care room in Mangalbare clinic.

CHALLENGES

- Frequent transfer of trained PAC service providers to other health facilities or units continues to disrupt services.
- If frequency of transfer of trained service providers could be reduced, continuity of PAC services could be improved.
- FP services are consistently reaching PAC clients treated with MVA, but not those undergoing D&C procedures.
- Group-based training has been difficult in certain sites due to insufficient caseload.
- Routine supply and replacement of MVA equipment remains a challenge.
- Abortion was legalized in Nepal in 2002. Comprehensive abortion care (CAC) is now being expanded up to the periphery health facility. NFHP has been successful in keeping PAC and CAC service separate. In health facilities where CAC services are not available, PAC is functioning well, but where both CAC and PAC services are available, the number of PAC clients is low.

This technical brief is one of a series seeking to capture key lessons learned from the USAID/ Nepal bilateral project, the Nepal Family Health Program (367-00-02-00017-00), 2001 - 2007. The document was produced with support from the American people through the U.S. Agency for International Development.
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