

**Facility Survey on Safe Abortion in Six Clinics of Global Comprehensive Abortion
Care Project**

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EXECUTIVE SUMMARY

The Family Planning Association of Nepal founded in 1959 has been active in implementing sexual and reproductive health programme. An affiliate of IPPF, FPAN complements and supplements the government of Nepal's efforts in providing reproductive health services. Since 2005, FPAN adopted IPPF's new strategic plan focusing on five thematic areas including adolescent RH, abortion, HIV and AIDS, advocacy and accessibility.

Since legalization of abortion in March 2002 and provision of counselling and services since 2004, safe abortion service has become one of the most important thematic areas of FPAN. To contribute to reducing unsafe abortion, FPAN started safe abortion services from 3 clinics in 2004/05 and now the number of listed FPAN safe abortion clinics is 20. Until 2007-2008, FPAN's share in national programme in safe abortion is about 10 percent.

Expansion of service sites alone is not enough to address the needs of women. Quality of care in the existing service facilities counts a lot in addressing the reproductive health needs of women. Providing high-quality abortion care requires attention to several aspects of services such as provider competency, availability of equipment, supplies and drugs. IEC, IPC, counselling and referral system are critical components of QOC. In addition, accessibility and affordability are other important aspects. This study carried out a facility survey on Safe Abortion in six clinics of FPAN under GCACP in six project districts of Nepal. The data on quality of care was collected following the IPPF GCAC guidelines and exit interviews with clients.

Study objective

The main objective of this study was to help FPAN meet quality of care standards through a facility survey on Safe Abortion in six clinics of GCAC project districts.

Methodology

The methodology of the study included review of relevant literature, some secondary data analysis and primary data collection using observation/interactive checklist on QOC and exit interviews with clients. In order to reinforce and verify the findings the existing HMIS-11 abortion register data were also analysed. The study was conducted in Ilam, Sarlahi, Palpa, Banke, Kailali and Kanchanpur.

This current study follows the quality of care framework for family planning developed by Judith Bruce. This framework can be used to examine existing services and to identify ways to make them more responsive to the needs, lifestyles and constraints of clients. Since the framework has great salience for abortion and postabortion care providers, it has been adapted by Ipas, the Population Council, the WHO and others specifically for abortion-related care- both postabortion care and induced abortion services.

Findings

The analysis of quality of care in abortion related services data collected includes data analysis based on observation and interview checklist, clinic based HMIS-11 data and client exit interview data.

Clinic set up (location, accessibility, client registration, counselling and interpersonal communication) is an important aspect of QOC. Except Kanchanpur SDP other five SDPs were

observed and the providers were interviewed. The abortion service provider (medical doctor) was not available in Kanchanpur at the time when the observation and monitoring were carried out. Except Banke all other five SDPs are readily accessible to clients. The SDP in Banke is located away from the main town. However all six SDPs are accessible by public transport.

All six SDPs have facilities for registration, waiting, counselling and physical examination. Records are maintained confidentially at the SDPs. Waiting areas have seating arrangement (tables & chairs), they are sheltered, well ventilated, have drinking water and clean toilets. Counselling and consultation/examination room ensure privacy. IPC between provider and client was found good in five SDPs.

Service provider's competency with respect to the procedure, medication, and interaction with clients was found good. Most providers maintain client records but the follow up of clients after the procedure was not up to the standards.

SDPs have suitable facilities for infection prevention services such as "a separate room for processing instruments/equipment", "clean water", "a separate room/area for examining clients", "a washing facility with immediate access to the procedure room", "a hot air oven, autoclave, or boiler" and "covered containers for storing equipment".

Surgical abortion procedure (EVA/MVA) was measured by inquiring whether the SDP has suitable facilities, supplies and equipment to perform EVA/MVAs; staffs follow IPPF QOC-infection prevention guidelines /protocols; service providers (doctors, nurses) are competent and confident to provide MVA and management of post EVA/ MVA clients (post recovery). Except Kanchanpur SDP, other five SDPs were found having adequate lighting in EVA/MVA room. However, all six SDPs were found having ventilation and necessary equipment in EVA/MVA room.

In all six SDPs resting facilities are comfortable, there is adequate lighting, there is adequate ventilation, and there is adequate privacy. Five of six SDPs have clean toilet facilities; Kanchanpur SDP does not have standard toilet facility.

In all six SDPs post-abortion counselling is given on post-abortion care including instructions on the follow up visit and on modern methods of FP and Emergency Contraception. FP methods and EC are given to clients upon departure in five SDPs; EC not given in Palpa.

In none of the six SDPs clients are followed up for two weeks although they are given instructions to come back to the clinic in case they develop complications. Mechanism for follow up is not in place.

The study found that in all six SDPs there is adequate space for storage of supplies, the stores are well maintained. Banke and Palpa SDPs, however, do not have fire extinguishers. The store room is disinfected and sprayed periodically against insects and in five SDPs it is cleaned regularly. In Palpa the store room was not found cleaned regularly.

Except in Ilam SDP, in other five SDPs supplies were found stored and labelled for easy access. "First expiry first out" (FEFO) system is practiced in four SDPs but not in Ilam and Banke. Stock register is not updated regularly in Banke. Damaged and expired supplies are separated and disposed of without delay in four SDPs but not in Ilam and Banke.

All six SDPs regularly collect client information in HMIS-11 data sheet. However, most variables have missing information. All SDPs follow the government rule of not accepting women with pregnancy over 12 weeks; some women were rejected on this ground.

For pain management drugs mostly used are Diazepam, Ibrufen, Bruflam, Flexon, Nedox and Acticet. Some women are given more than one drug at a time. The HMIS – 11 data showed that MVA was used for the procedure in all six SDPs. Overall, abortion complication rate was estimated at 1.5 percent (95% CI: ± 0.70) and it was highest in Sarlahi (5.4 percent) followed by Palpa (1.2 percent) and Kailali (0.8 percent). Of 18 complications 14 had haemorrhage and 4 were retained product of conception (RPOC).

Overall, about 85 percent of all CAC clients accepted FP methods following the CAC/PAC procedures but nothing was recorded about the acceptance of EC. Very few clients were referred out of the SDP. Data on referred in and referred out were not properly recorded.

All 20 exit interview clients from five SDPs were married and their mean age was 28.1 years. Four of them were illiterate. They belonged to various caste/ethnic groups including Muslim and Terai groups. Although 11 of 20 women said it requires over 2 hours on foot to reach the nearest clinic, most of them take public transport. For most women health worker and radio are the main source of abortion related information. Reasons for choosing clinic were that the doctor was popular followed by safe/good service, proximity, availability of female doctor and acquaintance with the doctor. Although all women knew that clinic opens at 10 am, many of them mentioned different closing times in the same area.

Quality of abortion related services was generally satisfactory to most women including post abortion counselling and EC and ten of 20 clients also accepted EC but in Banke and Palpa none accepted it. Few women suggested that a female doctor and more information would make clinics attractive to women.

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ACRONYMS

AIDS	Acquired immuno-deficiency syndrome
CAC	Comprehensive abortion care
EVA	Electric Vacuum Aspiration
FEFO	First expiry first out
FGD	Focus group discussion
FHD	Family Health Division
FP	Family Planning
FPAN	Family Planning Association of Nepal
GCAC	Global comprehensive abortion care
GON	Government of Nepal
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
IEC	Information, Education and Communication
INGO	International Non-governmental Organisation
IPC	Inter personal communication
IPPF	International Planned Parenthood Federation
IUCD	Intra-Uterine Contraceptive Device
LMP	Last Menstruation Period
MOH	Ministry of Health
MOHP	Ministry of Health and Population
MVA	Manual Vacuum Aspiration
NDHS	Nepal Demographic and Health Survey
NGO	Non-Governmental Organisation
PAC	Post Abortion Care
QOC	Quality of care
RH	Reproductive Health
SDP	Service Delivery Point
STI	Sexually Transmitted Infection
WHO	World Health Organisation

I. BACKGROUND

Founded in 1959 as a nongovernmental organization, Family Planning Association of Nepal (FPAN) is the leading NGO in the field of sexual and reproductive health (RH). FPAN is a full-fledged member of International Planned Parenthood Federation (IPPF) and works in 32 of Nepal's 75 districts. Family Planning Association complements and supplements the government of Nepal's efforts in providing reproductive health services. Since 2005, FPAN adopted IPPF's new strategic plan focusing on 5 thematic areas including adolescent RH, abortion, HIV and AIDS, advocacy and accessibility.

During the initial period of its establishment, FPAN's activities were limited to distributing contraceptive methods and insertion of intra uterine contraceptive device (IUCD) to its clients. But over the years, it changed its focus to the contemporary needs of rural and poor people. Today FPAN's activities are not confined to distributing FP contraceptives but also extended to STI (Sexually Transmitted Infection) and HIV/AIDS counselling and services, sex and RH education, and services to adolescents and youths, counselling and services on safe abortion through Comprehensive Abortion Care (CAC) and Post Abortion Care (PAC), access to RH services to marginalized and underserved populations, and advocacy in these areas. Safe abortion is one of the most important thematic areas in which FPAN is providing counselling and services since 2004. To contribute to reducing unsafe abortion, FPAN started safe abortion services from 3 clinics in 2004/05 and now the number of listed clinics is 20. Until 2007-2008, in all 8,093 abortions were performed at FPAN listed sites in the country that is equivalent to about 10 percent of the national total abortion cases performed.

The unwanted and unintended pregnancies are directly related to abortion practices. Though legal, induced abortion is still a social stigma in Nepal. Socio-cultural values, belief system, religious norms and expectations, poverty and low level of awareness among community people are hindering the access to safe abortion services in most of the rural and some of the urban areas. Social stigma and discrimination exists against those who undergo induced abortion. All these issues finally compel people to undergo unsafe abortion and conceal the case. Implications of unsafe abortion on health are major factors leading to high maternal mortality and morbidity in the country. Unsafe abortion results into adverse impact not only on health but also on socio-economic status of people.

Providing high-quality abortion care requires attention to several aspects of services in addition to the clinical or technical competence of health care providers. Also important are the use of appropriate abortion technology and the availability of equipment, supplies and medications necessary to use the technology safely. Critical components of the care that need to be provided to women include the way that staff and clients interact, the information and counselling that are available to women, and the contraceptive and other reproductive health services available on site or by referral along with community linkage. Most importantly, women's needs will not be met if care is not accessible to women because of obstacles such as distance, inconvenient service schedules, lack of

affordability or cultural norms, to name a few. The quality of care therefore calls for addressing different aspects of abortion care to provide high-quality services.

Quality of care is a core aspect of safe abortion services and plays important role for ensuring clients' Sexual and reproductive health (SRH) rights and providers' rights. This study carried out a facility survey on Safe Abortion in six clinics of FPAN under Global comprehensive Abortion Care Project (GCACP) in six project districts of Nepal. The data on quality of care was collected following the IPPF GCAC guidelines. The guideline consisted of four sections as follows:

1. Clinic set up.
2. Infection prevention.
3. Surgical abortion (aspiration).
4. Storage of contraceptives and supplies.

Data on these four aspects have been analysed with a view to gauge the QOC from the service perspective. Abortion client information recorded in clinic registers of six districts regularly has also been analysed. In addition, a short exit interview was conducted with abortion clients in five clinics¹. The exit interview was conducted with a view to measure client satisfaction of services.

I. OBJECTIVE

The main objective of this study is to help FPAN meet quality of care standards through a facility survey on safe abortion in six clinics of GCAC project districts.

2.1 Specific objectives:

- a. To assess the existing status of safe abortion facilities to ensure quality of care standards.
- b. To recommend appropriate strategies for meeting required standards and quality of care in safe abortion facilities.

II. LIMITATIONS OF THE STUDY

The study is limited to six GCAC project district sites only although ideally it would have been better to examine all 20 FPAN CAC sites. Because the main service provider (medical doctor) was not working in one of the GCAC project district sites some activities proposed in the observation checklist could not be carried out. Facility based HMIS-11 data sheet (MOHP. 2006/07 or 2063) was also limited to fewer months in that site compared to other five sites.

In order to gauge the client service satisfaction perspectives client exit interviews were conducted but the number of cases was few due to resource constraints. The study would

¹ In Kanchanpur exit interview with clients could not be conducted because of the absence of service provider at the time when data collection work was in progress.

have been better if from every site at least 30 cases could have been interviewed to represent opinions and experiences of women from different background.

III. REVIEW OF THE LITERATURE

In March 2002, Nepal's Parliament approved legislation to permit abortion on women's request during the first 12 weeks of pregnancy for any reason, up to 18 weeks of pregnancy in cases of rape or incest and up to any gestation in case of disability or risk to the woman's life or foetus deformity approved by a physician. Providing access to legal abortion has the potential to significantly reduce maternal mortality and morbidity by reducing unsafe abortion (MOH, Annual Report 2002/2003).

Prior to 2002, abortion was totally illegal. The Legal Code 1963 (*Muluki Ain*) of Nepal did not permit the termination of pregnancy even if it were the result of rape or incest or threatened the woman's life. In effect, it equated abortion with infanticide, and infanticide with other kinds of murder or homicide, and did not recognize any mitigating factors or exceptional circumstances under which abortion was not a crime of murder. Physicians and other medical practitioners were prohibited from recommending or performing abortion without exception.

In this environment, women who sought abortions and providers who provided abortion necessarily did so clandestinely. Most of the abortions that took place were unsafe; only a very small proportion of women, mostly those living in urban or semi-urban areas and able to afford the cost, had access to trained medical practitioners and safe procedures.

As a result of the illegal and criminal status of abortion in Nepal prior to 2002, the conditions under which poor women obtained abortion were often extremely unsafe. Maternal mortality ratio in Nepal was estimated at 539 deaths per 100,000 live births for 0-6 years prior to the 1996 survey (Pradhan et al 1997). In a hospital-based study of abortion in Nepal pre-legalization, deaths from abortion-related complications accounted for over half of all maternal deaths. The recognition that illegal abortion was unsafe and contributed to Nepal's high maternal mortality was instrumental in the advocacy efforts to legalize abortion.

The government of Nepal is a signatory of the Millennium Development Goals and one of the MDGs is to reduce the prevalent MMR by 66 percent by 2015. Indeed, the maternal mortality ratio has improved in recent years as it was estimated to be 281 deaths per 100,000 births for 0-6 years prior to the 2006 survey. However, maternal mortality still remains among the highest worldwide and unintended pregnancy is common. Table 1 shows that women on average have more children than their ideal number or wanted fertility. The gap between wanted fertility and actual fertility has steadily declined over the years but still the gap has remained at over one child per woman.

Table 1 Total wanted fertility rates and total fertility rates for the three years preceding the surveys, Nepal 1996, 2001 and 2006

Year	Wanted fertility rate	Total fertility rate	Gap
1996	2.9	4.6	1.7
2001	2.5	4.1	1.6
2006	2.0	3.1	1.1

Source: Pradhan et al 1997; MOH, New ERA and ORC MACRO 2002; MOHP, New ERA and MACRO International Inc, 2007

In Nepal contraceptive use has increased markedly since 1996. The contraceptive prevalence rate was 28.5 percent in 1996 which increased to 39.3 percent in 2001 and it further increased to 48 percent by 2006 (MOHP, New ERA and MACRO International Inc, 2007).

Despite steady increase in contraceptive use, it must be noted that all contraceptive methods can fail and some are more dependable than others. Research has shown that the chance of an unexpected pregnancy is almost nonexistent for couples who rely on sterilization and very low for users of IUD, injectables or implants. It is moderate for pill and condom users and very high if couples rely upon periodic abstinence, withdrawal or spermicides (vaginal methods, The Alan Guttmacher Institute, 1999).

In Nepal, along with the increase in the use of modern contraceptive methods increase in the use of traditional methods are also seen which means increasingly more couples might end up with unwanted pregnancies and thus demand abortion service.

In order to provide safe abortion services, National Safe Abortion Policy, 2002 and the Procedural Process were developed and passed in 2003. The first Comprehensive Abortion Care unit was started in 2004 at the Maternity Hospital, Kathmandu.

Nepal follows the WHO (2003) Standards in delivering comprehensive abortion care and the major elements of which are: counselling, Manual Vacuum Aspiration (MVA), post CAC contraceptive methods, and complication identification and management, including referral if needed. Comprehensive abortion care services includes examination by the trained doctor or health worker, counselling on abortion and family planning options and services, abortion service using MVA, effective pain management and other reproductive health services if needed. Increasing number of service providers have been trained and listed as abortion service providers.

This current study follows the quality of care framework for family planning developed in 1989 by Judith Bruce of the Population Council and later published (Bruce, J. 1990) outlines principles and practices that encourage responsiveness to women's and men's needs and concerns, rather than a narrow focus on how many people have been served. It can be used to examine existing services and to identify ways to make them more responsive to the needs, lifestyles and constraints of clients. Since the framework has great salience for abortion and postabortion care providers, it has been adapted by Ipas, the Population Council, the World Health Organization and others specifically for abortion-related care- both postabortion care and induced abortion services (Brazier, E.,

R. Rizzuto and M. Wolf. 1998). Aspects of high-quality abortion and postabortion care include:

- Access to the necessary services
- Appropriate abortion technology
- Equipment, supplies and medications
- Choice of contraceptive methods
- Technical competence
- Information and counselling
- Interactions between women and providers
- Linkages to family planning and reproductive health care services

In this study attempts have been made to address the above aspects of the quality of abortion care.

IV. METHODOLOGY

The current *Facility Survey on Safe Abortion in Six Clinics of Global Comprehensive Abortion Care Project* made an attempt to carry out the study from two different perspectives. They were:

- Review of relevant literature on abortion related quality of care, and
- Abortion service perspective particularly from the perspective of quality of care standards

5.1 Quality of CAC service perspective

IPPF GCAC project has developed Quality of Care CAC service standards and protocols. The current study has assessed the Quality of CAC Service Standards by employing these standards and protocols.

5.2 Sample design

All six abortion clinics in six GCACP districts were studied for this purpose.

5.3 Sample size

In order to assess the quality of CAC service all six GCACP districts FPAN CAC clinics were administered quality check questionnaire. The facilities were also observed and the main service providers were interviewed.

5.4 Study tools

The study stools included adaptation of IPPF GCAC project Quality of Care CAC service standards and protocols which was used mainly as a checklist for observation. The checklist addressed issues like registration area, counselling room or area, client assessment/ examination room, procedure room, essential equipment for CAC, essential

drugs, availability of contraceptives, POC checking equipment/ items, infection prevention, recovery room, space for instrument processing, waste management system, skilled CAC providers including FP methods, provision for complications management including referrals and mode of transport. In addition a tool was developed for exit interviews with clients utilising CAC service to examine the client perspectives.

The draft tools were discussed with the concerned officials of FPAN and they were pre-tested in Kathmandu valley. The instruments were finalised by incorporating comments and suggestions following the pre-test. The final instruments were administered in 6 study districts.

5.5 *Study area*

The current study was conducted in 6 FPAN Global Comprehensive Abortion Care Project (GCACP) district abortion clinics which are – Ilam, Sarlahi, Palpa, Banke, Kailali and Kanchanpur.

5.6 Ethical considerations

Informed consent of all facilities was obtained verbally before they are requested to participate in the study. All facilities were informed about the purpose of the research and convinced them about the confidentiality of the data. The names of study participants used during discussions and interviews are not disclosed.

5.7 *Data Analysis and interpretation*

The *data* collected through observation and semi structured interview were coded and manually edited to check consistencies in the recorded answers. Clinic based HMIS-11 data were also coded and the data were then entered into the computers using FoxPro computer software. After cleaning the data they were transferred onto the SPSS system file for detailed analysis. Quantitative and qualitative information collected through clinic counselling observations were critically reviewed and collated to generate factual qualitative data and meaningful conclusions.

Review of relevant literature and information from different methods/tools were helpful to triangulate the analysis of issues.

V. ANALYSIS

The analysis of information collected is divided into three sections viz. analysis of data based on observation and interview checklist, clinic based HMIS-11 data and client exit interview data.

6.1 **Analysis of data based on observation and interview checklist**

This section analyses clinic set up, infection prevention, surgical abortion (aspiration), and storage of contraceptives and supplies.

6.1.1 Clinic set up (location, accessibility, client registration, counselling and interpersonal communication)

As mentioned earlier, six GCAC project clinics were observed/ monitored for quality of abortion care service. They included FPAN clinics in Ilam, Sarlahi (Hariwan), Tansen, Banke, Kailali and Kanchanpur. Because of unavoidable circumstances, the abortion service provider (medical doctor) was not available in Kanchanpur at the time when the observation/ monitoring were carried out. In the observation checklist clinic set up is measured using five indicators such as clinic location and accessibility for clients; registration, waiting, counselling and physical examination facilities in the SDP; clients treated in a friendly and respectful manner by service providers (receptionist/ counsellor); service provider's skill, knowledge, attitude and empathy (counsellor) and service provider (counsellor) ensures proper recording & follow up of clients after the procedure. Each indicator is measured by asking or observing availability of facilities or performance of tasks by the clinic.

6.1.1.1 Clinic location and accessibility for clients

This indicator enquires about nine facilities or tasks performed by the clinic. The first one is “clinic is easily accessible by public transport (maximum 20 minutes walk from bus stop, etc)”. Except Banke district SDP all other five SDPs meet the IPPF standards. The field researchers reported that the SDP is located away from the main town in Banke.

All six SDPs meet the IPPF standards for two criteria such as “clinic is well sign posted (opening times & services provided clearly displayed) and “clinic entrance is clean and easily accessible to client”. One field researcher's observation supports this finding.

“In Ilam the clinic looks clean and tidy when one enters it. On the wall of the clinic and also on a signboard various types of services provided by the clinic and the amount of fees charged for abortion service are clearly and attractively displayed”.
(Field researcher)

In five SDPs, the security system is good where clients and providers are safe when they approach the clinic, while in the clinic and when they leave the clinic. Opening times were found convenient for clients in 5 clinics where the CAC service was monitored.

With regard to “accessibility of clinic for people with physical disabilities” only two SDPs, viz., Banke and Kailali met the IPPF standards while Ilam, Sarlahi, Tansen (Palpa) and Kanchanpur did not meet the standards.

Three sub-indicators namely “accurate, pro-choice Sexual and Reproductive Health (SRH) information (*leaflets, posters etc. available*)”, “similar SRH information available

in relevant formats for people with a visual impairment” and “clinic facilities (Internal & External) are well maintained” meet the IPPF standards in all six SDPs.

6.1.1.2 Registration, waiting, counselling and physical examination facilities in the SDP

This indicator enquires about eight facilities or tasks performed by the clinic. The first one is “Clinic operates appointment systems”. None of the SDPs uses appointment system to provide CAC service. Clients generally do not have facilities to make appointments with service providers in SDPs; they just come and see if the providers are there and willing they get the service. All six SDPs provide CAC service to any client who walks into the clinic.

All six SDPs meet the IPPF standards on “Registration procedure is confidentially conducted (both visual & auditory) Client is asked for preferred contact information” and “Client information is not accessible to others (without necessary permission)”.

Comfortable waiting area is measured by enquiring whether the SDP has seating arrangement (Tables & chairs), it is sheltered, well ventilated, has drinking water and has a clean toilet. Except Banke SDP all other SDPs meet this standard while all six SDPs are well sheltered. Except Kanchanpur SDP other five SDPs are well ventilated and all six SDPs have drinking water. Again except Kanchanpur SDP other five SDPs have clean toilet.

In Kanchanpur SDP it was not possible to observe whether “clients are encouraged to use the suggestion box to let staff know their opinion of the service” because service was stopped for some days but in other five SDPs this standard was met.

All six SDPs met the IPPF standards on both “counselling facility ensures privacy (both visual and auditory)” and “consultation/examination room ensures privacy (both visual and auditory)” criteria.

6.1.1.3 Clients treated in a friendly and respectful manner by service providers (Receptionist/ counsellor)

Except in Banke SDP, all other five SDPs meet the IPPF standard of “Greets the client respectfully”. Except in Kanchanpur SDP, five other SDPs “give the client the opportunity to see the provider alone”.

In Kanchanpur SDP clients were not monitored for “listens patiently to client’s needs/concerns” criterion but in other five SDPs this IPPF standard was met.

The three tasks performed by the clinic namely, “uses language the client understands”, “uses language that is supportive of the client’s decision (not judgemental)” and “assures confidentiality” meet the IPPF standards in all six SDPs.

Except in Banke SDP, in other four SDPs service provider “explains what to expect during the visit”. In four SDPs service provider “gives information to the partner or the carer (if present) on how to support the client”.

All six SDPs meet the IPPF standard because the service provider “where relevant, discusses how the client will go home”.

6.1.1.4 Service provider’s skill, knowledge, attitude and empathy (counsellor)

Except in Kanchanpur SDP where observation was not made, in other five SDPs the service providers were found explaining the CAC services available (medical & surgical) in the clinic to their clients.

In four SDPs, the service providers were observed explaining the followings:

- the procedures,
- pain medication
- benefits of the procedure
- risks of the procedures
- other tests if any are to be performed (blood, urine etc)

In Kanchanpur, no monitoring was done because of the absence of service provider.

In Ilam, Sarlahi and Kailali the service providers were found encouraging client to ask questions and they responded to clients’ questions correctly. This was not found so in Palpa (Tansen) and Banke SDPs.

In all five SDPs service providers allowed (but did not coerce) client to make her own choice of the services available. In Kanchanpur SDP this observation was not possible.

In all six SDPs the service providers use IEC materials (models, diagrams) during client counselling/education session. Although client was not observed in Kanchanpur the staff nurse mentioned that they do use IEC materials (models, diagrams) during client counselling/education session.

6.1.1.5 Service provider (counsellor) ensures proper recording & follow up of clients after the procedure

In five SDPs where service providers were providing service to clients they were found informing clients of referral and follow up protocols after the procedure (e.g. what to expect, what she can and cannot do, emergency numbers). In Kanchanpur SDP, this observation was not possible.

Service providers in all five SDPs direct clients where to go next after the procedure, record all relevant information in the client’s records (in Nepal in HMIS-11 format) and follows up with the client after the procedure in the recovery room.

Also the service providers provide information to the client about looking after herself at home, (recaps on information given at the beginning of the session) and ensure client leaves the clinic with a modern method of contraception. In most cases it was reported that clients take condom.

6.2 Infection prevention

6.2.1 *Service Delivery Point (SDP) has suitable facilities for infection prevention services*

This indicator is measured by asking or observing availability of six types of facilities or performance of tasks by the clinic.

One of such facilities is “a separate room is available for processing instruments/equipment”. Another facility inquired about is “clean water is available”. Third facility inquired about is “a separate room/area is available for examining clients”. Similarly fourth, fifth and sixth facilities inquired about are “a washing facility with immediate access to the procedure room is available”, “a hot air oven, autoclave, or boiler is available” and “covered containers for storing equipment are available” respectively. In all six GCAC project district clinics all six facilities are available and meet the IPPF standards.

6.2.2 *SDP has and adheres to QOC guidelines and standards required for the provision of adequate infection prevention measures*

In every SDP the medical doctor is in principle responsible for overseeing the implementation of infection prevention measures but he has assigned a nurse to carry out day to day administration/management of infection prevention measures.

In all six SDPs written and updated standards/ guidelines/protocols for infection control measures are available covering the following areas:

- Preparation of 0.5% chlorine solution from bleach
- Procedure for decontaminating of equipment
- Procedure for cleaning equipment
- Procedure for sterilization using an autoclave or a dry heat oven
- Use of antiseptic solutions
- Proper waste disposal
- Procedure for cleaning activity areas including clinical procedure area

In five of six SDPs these activities were observed by field researchers while in Kanchanpur the nurse at the clinic mentioned that they have written and updated standards/ guidelines/protocols for infection prevention.

In five SDPs trained staff are available at all times for Comprehensive Abortion Service while in Kanchanpur SDP the main medical doctor (service provider) has been absent from the clinic for some time.

In all six SDPs antiseptic solution, such as ethyl alcohol 70%, is available if no water is available. This was observed in five SDPs but in Kanchanpur SDP this was reported by staff nurse.

All six SDP staff use sterile surgical gloves when performing procedures. This activity was observed in five SDPs. In Kanchanpur staff nurse reported performing this activity.

Staffs in five SDPs follow hand washing protocols before & after each procedure. The nurse in Kanchanpur SDP also reported doing this but the activity was not observed.

In five SDPs staff put on HLD or sterilized gloves without contaminating them. It is done so in Kanchanpur too but field researchers could not observe it being done; the information was reported by the staff.

6.2.3 SDP provides adequate infection prevention/control in the area of decontamination and cleaning of instruments

In five SDPs chlorine solution (0.5%) is prepared daily. In Kanchanpur SDP this activity was not monitored. Except in Kanchanpur SDP where no observation was possible in all other five SDPs chlorine solution is mixed correctly.

The field researchers observed that buckets are available for chlorine solution in five SDPs but in Kanchanpur this activity was not monitored.

Five SDPs were found following the protocol “Reusable gloves are decontaminated in 0.5% chlorine for 20 minutes after use”. Nothing could be commented on Kanchanpur SDP because this activity was not monitored.

Five SDPs were following the protocol “Cleaning materials and supplies are used in the cleaning process (scrub brush, detergent/soap, water, protective rubber gloves)”. Again Kanchanpur SDP was not monitored.

In five SDPs used equipment (MVA syringes, cannula, speculum, and forceps) room are properly cleaned in soapy water and rinsed with clean water prior to disinfection/autoclaving. Kanchanpur SDP not monitored for this activity.

Except in Kanchanpur SDP, in five other SDPs cleaned instruments are dried by air or towel before further processing. This activity was not monitored in Kanchanpur.

6.2.4 SDP provides adequate infection prevention/control in the area of high-level disinfection by boiling, chemical disinfection and sterilisation

In all six SDPs equipment (containers) for storing instruments are available. This facility was observed in all six SDPs although in Kanchanpur currently there was no service provider.

Every service provider mentioned that they submerge items/instruments in water while boiling for 20 minutes. This was found true in all six SDPs.

6.3 Surgical abortion procedure (electric vacuum aspiration/manual vacuum aspiration)

Four indicators are used to measure the quality of care on surgical abortion procedure. They inquire about whether the SDP has suitable facilities, supplies and equipment to perform EVA/MVAs; staffs follow IPPF QOC-Infection prevention guidelines /protocols; service providers (doctors, nurses) are competent and confident to provide MVA and management of post EVA/ MVA clients (post recovery). Each indicator in turn is composed of several sub-indicators related to tasks performed by SDP or facility available for service there.

6.3.1 SDP has suitable facilities, supplies and equipment to perform EVA/MVAs

To measure whether SDP has suitable facilities, supplies and equipment to perform EVA/MVAs the field researchers made observation of EVA/MVA Room on twelve aspects.

All 6 SDPs were found meeting the IPPF standards of having easy access to other parts of the clinic and also maintain privacy both visual and auditory.

Five of six SDPs were found having adequate lighting in EVA/MVA room. Kancharpur SDP did not meet the standards. All six SDPs were found having ventilation and necessary equipment in EVA/MVA room.

Five SDPs were found having emergency equipment and drugs in EVA/MVA room. This was not so in Kancharpur SDP. In all 6 SDPs emergency procedures are displayed and also have water supply. Except Kancharpur SDP all other five SDPs have toilet facilities in EVA/MVA room but all six SDPs have storage facilities.

All six SDPs were found having disposal system for aspirated products of conception and clinical waste disposal system (sharps container, buckets for soiled materials, instruments).

6.3.2 Staffs follow IPPF QOC-Infection prevention guidelines /protocols

The field researchers in five SDPs were observing whether infection prevention guidelines were being followed with respect to:

- Hand washing
- Personal protection barriers
- Proper handling and disposal of sharp instruments and items
- Proper handling of instruments and materials using the aseptic technique

- Environmental cleanliness
- Proper disposal of infectious waste

They found that they were following the infection prevention guidelines. In Kanchanpur SDP observation was not possible but the nurse at the clinic said that they also follow the guidelines.

6.3.3 *Service providers (doctors, nurses) are competent and confident to provide MVA*

A. Before procedure

For comprehensive abortion procedure the following are documented before the procedure:

- Pre-procedure counselling
- Client history
- Physical examination findings

For every abortion client the nurse provider conducts counselling to the client. She takes a short history of her asking her about her age, gravida, parity, residence, LMP, etc. She counsels her about the CAC procedure and she and the doctor conduct physical examination. In five SDPs the field researchers observed all three tasks viz., pre-procedure counselling, client history, and physical examination findings. They were found satisfactory. In Kanchanpur the nurse provider told the field researcher that she also conducts all three tasks when she has a client for abortion.

In five SDPs the field researchers observed service provider asking client for informed consent and signing the form. In Kanchanpur no observation was made but the nurse provider told the researcher that she also asks client to sign the informed consent form. In all six SDPs the consent form is attached to the client record.

B. During procedure

In five SDPs the field researchers were observing that during CAC procedure the service providers (doctor and nurse) were strictly following aseptic techniques, performing the procedure steadily, carefully, gently and accurately to minimize pain/discomfort to client, time, name, volume and route of drugs were recorded, vital signs were observed and recorded and procedural notes were recorded.

The field researchers also observed medication during procedure which was found meeting the IPPF standards. Following the procedure the client is given post-operative care, information/reassurance is provided and after some rest the client is discharged which is also recorded. While resting vital signs are taken to ensure that the client is capable enough to leave the clinic.

These activities were observed by field researchers in five SDPs while in Kanchanpur SDP because of the absence of the doctor the service was on hold but the nurse told the researchers that they do all these activities.

C. Management of complications

In all six SDPs staffs are competent to manage complications. This is so because they are given CAC training before they are allowed to perform abortion procedures. This was verified in all six SDPs.

The clinic data sheet or register (HMIS-11) has provision for recording abortion complications and it was found recorded in all six SDPs.

All six SDPs record the procedures undertaken to resolve complications. The clinic register has provision for recording this activity. However, it must be noted that the current provision is not comprehensive enough to record the procedure to resolve complications and therefore the Government of Nepal is now reviewing the situation to improve it.

In all six SDPs procedural (during the procedure) and post-procedural complications are reported. The HMIS-11 data has a column to report procedural complications but in practice post-procedural complications are also reported in the last column of the form. Again this form has been found not good enough to report complications and therefore the Government is reviewing it and trying to introduce a new form which will have good provision to report procedural and post procedural complications.

In case during the procedure the client develops complications and the providers cannot handle the situation they refer the case to another centre for treatment. The referral systems are in place in all six SDPs but follow-up mechanism has to be strengthened.

In case a client has post procedural complication she is asked to contact the SDP and SDP in turn takes care of her but if even then she needs care from higher level service centre the SDP refers her to the higher level. In that case the SDP bears the costs of treatment. Therefore a follow up system is in place for clients referred to other facilities.

6.3.4 Management of Post EVA/ MVA clients (Post recovery)

A. Facilities

In all six SDPs the field researchers observed that the recovery room is a short distance from the procedure room (it is on the same level/floor- no stairs). However not all SDPs had room temperature regulation system; Palpa did not have this system.

In all six SDPs resting facilities are comfortable, there is adequate lighting, there is adequate ventilation, and there is adequate privacy (both visual and auditory).

Five of six SDPs have clean toilet facilities; Kanchanpur SDP toilet facilities are not up to the mark.

B. Service

In all six SDPs staffs provide counselling/support but it is not certain they monitor clients' welfare. This is not generally practiced.

In all six SDPs staffs provide information and guidance to the carer or partner if present, on how to support the client

In all six SDPs post-abortion counselling is given on:

- Post-abortion care including instructions on the follow up visit
- Modern methods of FP or Emergency Contraception

Information leaflets are not available. Except in Palpa SDP, emergency contraception is given with charge in other five SDPs.

In all six SDPs family planning methods are provided (pills, condoms, injectables, implants, IUCD, Tubal Ligation). Clients accept contraceptive method depending on their choice and preference. However, some clients do not take any contraceptive methods because absentee husbands.

In none of the six SDPs clients are followed up for 2 weeks although at the time of discharge they are given instructions to come back to the clinic in case they have complications. Mechanism for follow up is not in place.

In all six SDPs, other SRH information is provided if necessary (e.g. in the case of sexual violence or for STI testing).

6.4 Storage of contraceptives and supplies

6.4.1 SDP has suitable storage facilities/space for supplies and commodities

The field researchers found that in all six SDPs there is adequate space for storage of supplies, there are no signs of dampness on ceilings, walls and floors, there is no direct sunlight on supplies, and there is adequate lighting and ventilation. Also the room temperature is suitable for the drugs stored.

There is no fire extinguisher available in any of the six branches.

In all six SDPs the store room is disinfected and sprayed periodically against insects and in five SDPs it is cleaned regularly. In Palpa the store room was not found cleaned regularly.

6.4.2 Supplies and commodities are properly stored and well organised

The field researchers also observed if supplies and commodities were properly stored and well organised.

Except in Ilam SDP in other five SDPs supplies were found stored and labelled for easy access with identification labels/marks visible.

Except in Ilam and Banke SDPs in other four SDPs supplies and commodities were found stored and distributed on the basis of the "first expiry first out" (FEFO) system. Except Banke SDP all other five SDPs the stock registers are updated regularly.

Except in Ilam and Banke SDPs in other four SDPs damaged and expired supplies are separated and disposed of without delay. In all six SDPs there is a designated person in charge of the store room.

6.5 HMIS-11 Clinic Data

6.5.1 Client flow

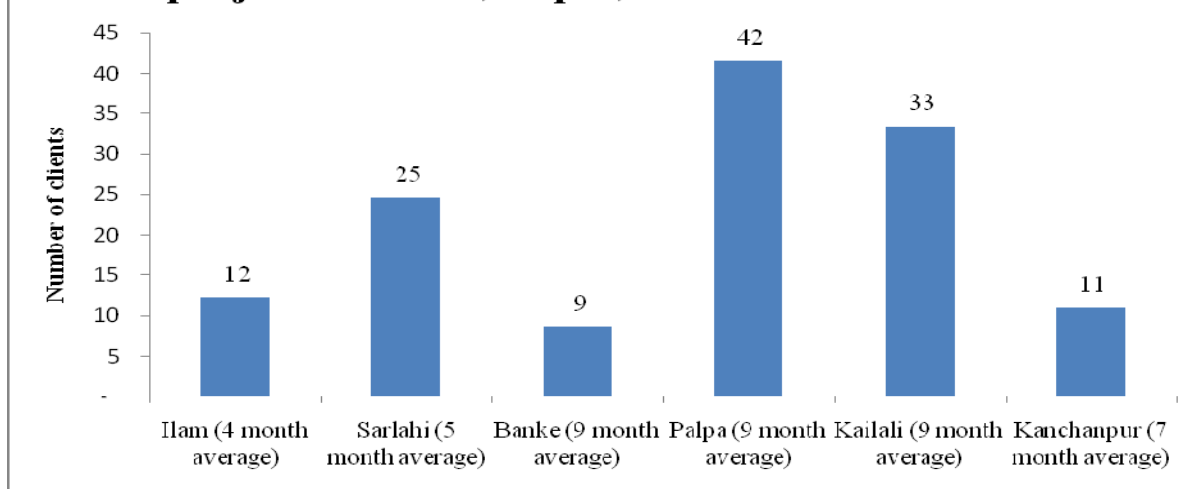
All six SDPs regularly collect client information in HMIS-11 data sheet. However, not every site began CAC service the same time. In Palpa data registration of CAC clients began on Wednesday, 12 March 2008. In Kailali data registration began on Sunday, 23 March 2008. In Banke and Kanchanpur data registration began on Tuesday, 25 March 2008. In Sarlahi data registration began on Wednesday, 2 July 2008 and In Ilam data registration began on Tuesday, 19 Aug 2008. Until the end of January 2009, in all 1,208 clients were provided with CAC service in six SDPs (Table 2).

Table 2 Distribution of number of CAC clients served by GCAC project districts according to year and month, Nepal, 2009

Year	Month	GCAC project district					Total	
		Ilam	Sarlahi	Banke	Palpa	Kailali		Kanchanpur
2008								
	March			2	19	9	24	54
	April			8	28	38	3	77
	May			10	49	36	10	105
	June			9	61	25	13	108
	July		13	9	38	30	12	102
	August	4	10	9	40	20	8	91
	September	16	26	8	23	23	5	101
	October	8	29	4	28	20		89
	November	13	27	8	51	50		149
	December	12	31	13	56	58		170
2009	January	6	48		35	73		162
Total		59	184	80	428	382	75	1208

Ideally 12-month client flow data would be appropriate to examine monthly average client flow but because different SDP began at different month and none of them has completed 12-month period it was not possible to do so. Instead only data for full working months for each SDP was used to estimate average monthly client flow in Figure 1. For instance, for Ilam SDP September to December data were used for this purpose leaving data from August because work began only on 19 August. This exercise shows highest monthly client flow in Palpa followed by Kailali, Sarlahi, Ilam, Kanchanpur and Banke (Figure 1).

Figure 1 Monthly average client flow, GCAC project districts, Nepal, 2008



6.5.2 Beneficiaries

In all, abortion clients from 25 districts (inclusive of project district) have benefitted from GCAC Project district SDPs (Table 3). Clients from 12 districts have used the CAC service of Palpa district and the corresponding number of districts using CAC services of Kailali is 6 that of Banke, Sarlahi and Ilam are respectively 5, 4 and 3. The SDP of Ilam has served clients from Ilam district alone.

Table 3 Distribution of number of CAC clients benefitted by GCAC project district SDPs according to district they belong to, Nepal, 2008 and 2009

S N	District	GCAC Project district						Total
		Ilam	Sarlahi	Banke	Palpa	Kailali	Kanchanpur	
1	Palpa				311			311
2	Syangja				44			44
3	Parbat				6			6
4	Gulmi				53			53
5	Arghakhanchi				6			6
6	Rukum			1	1			2
7	Dang			1	1			2
8	Rupandehi				1			1
9	Sarlahi		169		1			170
10	Kathmandu				1			1
11	Baglung				2			2
12	Kaski				1			1
13	Banke			73				73
14	Kanchanpur					19	72	91
15	Ilam	59						59
16	Kailali					357	1	358

17	Bardiya			4				4
18	Salyan			1				1
19	Sindhuli		9					9
20	Rautahat		5					5
21	Doti					2		2
22	Dandeldhura					2	2	4
23	Bajura					1		1
24	Bajhang					1		1
25	Mahottari		1					1
	Total	59	184	80	428	382	75	1208

6.5.3 Caste/ethnicity

Overall, largest proportion (42.3 percent) of disadvantaged Janajati has benefitted from CAC services in six GCAC project districts followed by nearly same proportion (41.8 percent) of upper caste groups, 6.0 percent of Dalit, 3.8 percent of relatively advantaged Janajati, 3.1 percent of disadvantaged non-Dalit Terai caste groups, and about one percent of religious minorities (Table 4).

Table 4 Distribution of number of CAC clients by GCAC project district SDPs according to caste/ethnicity, Nepal, 2008 and 2009

Caste/Ethnicity	GCAC Project district						Total
	Ilam	Sarlahi	Banke	Palpa	Kailali	Kanchanpur	
Dalit ¹	8.6	5.6	4.0	10.7	1.6	2.8	6.0
Disadvantaged Janajati ²	51.7	37.2	25.3	45.1	50.5	21.1	42.3
Disadvantaged non-Dalit Terai caste groups ³	1.7	11.7	12.0	1.2	0.3	1.4	3.1
Religious Minorities ⁴	0.0	2.2	4.0	0.2	0.3	1.4	0.8
Relatively advantaged Janajati ⁵	5.2	6.1	5.3	2.6	4.6	0.0	3.8
Upper caste groups ⁶	32.8	37.2	49.3	40.2	42.7	73.2	41.8
No information	1.7	2.2	6.3	0.0	3.1	5.3	2.2
Total percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total number	59	184	80	428	382	75	1208

¹ Hill: Kami, Damai, Sarki, Gaine, and Badi and Terai: Chamar, Mushahar, Dushad/Paswan, Tatma, Khatway, Bantar, Dom, Chidimar, Dhobi, Halkhor, ² Hill: Magar, Tamang, Rai, Limbu, Sherpa, Bhote, Walung, Hyolomo, Gharti/Bhujel, Kumal, Sunuwar, Baramu, Pahari, Yakkah, Chhantel, Jirel, Darai, Dura, Majhi, Danuwar, Thami, Lepcha, Chepang/(Prajya), Bote, Raji, Hayu, Raute, Kusunda and Terai: Tharu, Dhanuk, Rajbangsi, Tajpuria, Gangai, Dhimal, Meche, Kisan, Munda, Santhal/Satar, Dhangad/Jhangad, Koche, Pattharkatta/Kusbadiya, ³ Yadav, Teli, Kalwar, Sundi, Sonar, Lohar, Koiri, Kurmi, Kanu, Halwai, Hajam/Thakur, Badhe, Bahae, Rajba/Rajhbhar, Kewat, Mallah, Nuniya, Kumhar, Kahar, Lodhar, Bing/Binda, Bhediyar/(Gaderi), Mali, Kamar/Dhuniya, ⁴ Muslims, Churaute, ⁵ Newar, Thakali, Gurung, ⁶ Bahun (Hill), Bahun (Terai), Chhetri, Thakuri, Sanyasi, Kayastha, Bengali, Rajput, Baniya, (Bhumihar), (Shikh/ Punjabi), Jain, Nurang and Marwadi, (Source: MOHP. 2006/07 (2063). HMIS-11).

By district, over half (51.7 percent) of all CAC service beneficiaries were from disadvantaged Janajati in Ilam, 37.2 percent each of disadvantaged Janajati and upper caste groups in Sarlahi, nearly half (49.3 percent) of all clients in Banke being upper caste groups, largest proportion (45.1 percent) of disadvantaged Janajati in Palpa, slightly over half (50.5 percent) of all clients in Banke belong to disadvantaged Janajati and

nearly two thirds (73.2 percent) clients belonged to upper caste groups in Kanchanpur (Table 4).

6.5.4 Age, living children and education

Overall mean age for all CAC clients was estimated at 27.5 years; about one year higher in Banke and Palpa and about half a year lower in Kailali and Kanchanpur (Table 5). Age reporting/recording by every SDP was good as there were no missing cases².

Table 5 Percent distribution of CAC clients by GCAC project district SDPs according to age, Nepal, 2008 and 2009

Age	GCAC project district SDP						Total
	Ilam	Sarlahi	Banke	Palpa	Kailali	Kanchanpur	
15-19	6.9	7.6	3.8	6.8	8.4	2.7	7.0
20-24	29.3	28.3	16.3	24.3	25.1	33.3	25.4
25-29	29.3	31.5	36.3	27.3	35.6	36.0	31.8
30-34	20.7	15.2	23.8	23.1	15.4	13.3	18.8
35-39	8.6	13.0	16.3	13.6	12.0	12.0	12.8
40-44	5.2	3.3	3.8	3.7	3.4	2.7	3.6
45-49	0.0	1.1	0.0	1.2	0.0	0.0	0.6
Total percent	100.0	100.0	100.0	100.0	99.9	100.0	100.0
Total number	58	184	80	428	382	75	1207
Mean	27.7	27.1	28.5	28.2	27.0	26.9	27.5
Std. Deviation	6.23	6.29	5.52	6.21	5.87	5.10	6.02

Mean number of living children for all CAC clients was estimated at 2.3 and by district it was the highest in Sarlahi (2.6 living children), followed by Kanchanpur(2.5 living children), Banke(2.3 living children), Palpa and Kailali (2.2 living children each), and Ilam CAC clients had the lowest mean number of living children (1.4, Table 6). Recording of living children was completely covered in all six SDPs.

Table 6 Percent distribution of CAC clients by GCAC project district SDPs according to living children, Nepal, 2008 and 2009

Living children	GCAC project district SDP						Total
	Ilam	Sarlahi	Banke	Palpa	Kailali	Kanchanpur	
None	39.0	8.2	7.5	11.9	12.8	5.3	12.3
One living child	16.9	13.6	21.3	15.7	19.6	17.3	17.1

² One case in Ilam SDP did not have age recorded in HMIS-11

Two living children	22.0	31.5	37.5	33.4	29.6	33.3	31.6
Three living children	16.9	24.5	20.0	24.8	20.2	24.0	22.5
Four or more living children	5.1	22.3	13.8	14.3	17.8	20.0	16.5
Total percent	99.9	100.1	100.1	100.1	100.0	99.9	100.0
Total number	59	184	80	428	382	75	1208
Mean	1.4	2.6	2.3	2.2	2.2	2.5	2.3
Std. Deviation	1.39	1.63	1.53	1.38	1.47	1.51	1.48

HMIS-11 client register calls for recording of literacy and education level attained by CAC clients. All six SDPs have collected this information and five percent of all clients did not have this information and it was highest in Banke (27.5 percent), second highest in Sarlahi (16.3 percent), and three districts (Ilam, Palpa and Kailali) with few cases without literacy and education information. Kanchanpur SDP was the best in reporting this type of information (Table 7). At Ilam SDP this type of information was collected but the type of information was not of required standard because only clients' literacy and illiteracy levels were recorded. The HMIS-11 has given clear instructions that client completed level of education has to be recorded. It appears that literacy and education information at Kailali SDP is not of required standard either.

Table 7 Percent distribution of CAC clients by GCAC project district SDPs according to literacy and education attained, Nepal, 2008 and 2009

Literacy and education	GCAC project district SDP						Total
	Ilam	Sarlahi	Bank e	Palpa	Kailal i	Kanchanp ur	
Illiterate	10.3	29.2	8.6	14.2	12.9	25.3	16.0
Primary	0.0	0.6	10.3	23.9	0.3	14.7	10.5
Secondary	0.0	3.9	20.7	31.5	0.0	21.3	14.5
SLC	0.0	10.4	36.2	14.9	0.5	13.3	9.8
Intermediate	0.0	3.9	19.0	12.1	0.8	9.3	6.8
Bachelor and above	0.0	0.0	5.2	3.3	0.5	4.0	1.9
Literate	89.7	51.9	0.0	0.0	85.0	12.0	40.5
Total percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total number	58	154	58	422	381	75	1148
Missing (n)	1	30	22	6	1	0	60
Percent missing	1.7	16.3	27.5	1.4	0.3	0.0	5.0

6.5.5 Length of pregnancy

In all six SDPs only women with gestation by LMP up to 12 weeks were allowed for abortion procedures (Table 8). There were a few women with greater than 12 weeks of gestation by LMP but they were rejected.

The average length of gestation in weeks was 7.6 and it was slightly higher in Ilam and Banke (7.9 weeks, Table 8).

Table 8 Percent distribution of CAC clients by GCAC project district SDPs according to gestation (weeks) by LMP, Nepal, 2008 and 2009

Gestation (weeks) by LMP	GCAC project district SDP						Total
	Ilam	Sarlahi	Banke	Palpa	Kailali	Kanchanpur	
4-5	0.0	11.5	6.3	3.1	0.3	8.0	3.8
6-8	81.4	61.0	61.3	73.0	84.3	65.3	73.9
9-12	18.6	27.5	32.5	22.7	15.4	26.7	21.8
13+	0.0	0.0	0.0	1.2	0.0	0.0	0.4
Total percent	100.0	100.0	100.1	100.0	100.0	100.0	99.9
Total number	59	182	80	422	382	75	1200
Mean	7.9	7.6	7.9	7.7	7.3	7.6	7.6
Std. Deviation	1.32	1.97	2.07	1.72	1.53	1.73	1.72
Missing (n)	0	2	0	6	0	0	8

Length of pregnancy was also estimated by examination of the uterus by the service provider. Only in Palpa SDP a few women with pregnancy longer than 13 weeks were detected and they were all rejected for abortion procedures. The average length of pregnancy nearly matched using both LMP and examination methods but the results were slightly higher when examination method was used (Table 9). Most cases fell in the 7-12 weeks category.

Table 9 Percent distribution of CAC clients by GCAC project district SDPs according to uterine size (weeks) on examination, Nepal, 2008 and 2009

Uterine size (weeks) on examination	GCAC project district SDP						Total
	Ilam	Sarlahi	Banka	Palpa	Kailali	Kanchanpur	
5-6	13.6	32.5	37.5	19.5	45.8	23.0	31.0
7-12	86.4	67.5	62.5	77.1	54.2	77.0	67.8
13+	0.0	0.0	0.0	3.3	0.0	0.0	1.2
Total percent	100.0	100.0	100.0	99.9	100.0	100.0	100.0
Total number	59	166	80	420	382	74	1181
Mean	7.9	7.4	8.2	8.0	7.4	7.9	7.7
Std. Deviation	1.38	1.78	2.26	1.93	1.59	1.54	1.81
Missing	0	18	0	8	0	1	27

6.5.6 CAC/PAC

HMIS-11 data show that only 0.4 percent (5 cases, 4 in Palpa and 1 in Sarlahi³) of all clients came for PAC and the rest were CAC. In all, 23 cases were rejected, all in Palpa because of gestation/uterine size longer than 12 weeks.

6.5.7 Pain management

³ 4 cases in Palpa had induced abortion and 1 case in Sarlahi had spontaneous abortion

Pain management drugs used for the procedures included mostly Diazepam, Ibrufen, Bruflam, Flexon, Nedox, Acticet, Spospain, Niko and Doxy (Table 10). These drugs varied by SFDP. In Ilam every client was administered Flexon. In Sarlahi every client was administered Diazepam and about two-thirds were administered both Diazepam and Nedox. Some of them were administered other drugs too besides Diazepam. In Banke every client was administered Ibrufen and nothing else. In Palpa nearly every client was administered Diazepam and about two-thirds were administered both Diazepam and Bruflam; some of them were also given Flexon and Doxy. In Kailali every client was administered Ibrufen and about one in five were administered both Ibrufen and Diazepam. Surprisingly, the HMIS-11 completed in Kanchanpur does not show administration of any pain management drug. This is, however, a mandatory requirement when providing CAC service. Thirty-one clients were not found administered any pain management drug in Palpa⁴.

Table 10 Percent distribution of CAC clients by GCAC project district SDPs according to pain control drugs used, Nepal, 2008 and 2009

Pain control drugs used (multiple responses)	Percent of cases						Total
	Ilam	Sarlahi	Banke	Palpa	Kailali	Kanchanpur	
Diazepam	0.0	100.0	0.0	96.7	19.1	0.0	58.2
Ibrufen	0.0	0.0	100.0	0.0	100.0	0.0	41.9
Bruflam	0.0	0.0	0.0	78.6	0.0	0.0	28.3
Flexon	100.0	13.6	0.0	21.7	0.0	0.0	15.4
Nedox	0.0	76.1	0.0	0.0	0.0	0.0	12.7
Acticet	0.0	46.2	0.0	0.0	0.0	0.0	7.7
Spospain	0.0	30.4	0.0	0.0	0.0	0.0	5.1
Niko	0.0	9.8	0.0	0.0	0.0	0.0	1.6
Doxy	0.0	0.0	0.0	4.0	0.0	0.0	1.5
Total cases	59	184	80	397	382	0.0	1102
Missing (n)	0	0	0	31	0	75	106

6.5.8 CAC procedure

CAC procedure was MVA in all SDPs. The 5 PAC clients also had re-CAC done. Two clients in Banke when they had CAC procedure done also had Misoprostol administered.

6.5.9 Abortion complication rate

Clients experiencing complication following the procedure were used to estimate complication rates. Overall, abortion complication rate was estimated at 1.5 percent (95% CI: ± 0.70) and it was highest in Sarlahi (5.4 percent) followed by Palpa (1.2 percent) and Kailali (0.8 percent, Table 11). All 10 complication cases in Sarlahi and 3 complication cases of Kailali and 1 case from Palpa had haemorrhage while 4

⁴ Standard protocol: 400mg Brufen, 100mg Doxycyclin and 10mg Diazepam orally 30 mts before the procedure. Ibrufen, Bruct, Flexon, Brulam are same drug, but different company.

complication cases in Palpa were retained product of conception which was later evacuated.

Table 11 Induced abortion complication rates by GCAC project district SDPs, Nepal 2008 and 2009

SDP	Complication		Total clients	95% CI (of %)
	Number	Percent		
Ilam	0	0	59	na
Sarlahi	10	5.4	184	(±3.28)
Banke	0	0	80	na
Palpa	5	1.2	405	(±1.08)
Kailali	3	0.8	382	(±0.89)
Kanchanpur	0	0	75	na
Total ¹	18	1.5	1185	(±0.70)

n.a. =Not applicable

¹23 cases were rejected in Palpa after pre-procedure examination

6.5.10 Post procedure FP counselling and FP acceptance

HMIS-11 does not show whether post procedure contraceptive counselling was provided to all clients; it only shows contraceptive acceptance information. This does not necessarily mean that every client was provided contraceptive counselling. Contraceptive information shows that overall, about 85 percent of all CAC clients accepted FP methods following the CAC/PAC procedures (Table 12). By SDP FP acceptance was 100% in Ilam, 91 percent in Banke, 89 percent in Kanchanpur, 86 percent in Palpa, 82 percent in Sarlahi and 80 percent in Kailali.

Table 12 Percent distribution of CAC clients by GCAC project district SDPs according to FP method acceptors, Nepal, 2008 and 2009

FP method acceptors	GCAC project district SDP						Total
	Ilam	Sarlahi	Bank e	Palpa	Kailali	Kanchanpur	
Depo Provera	13.6	42.7	15.1	43.2	45.0	13.6	39.8
Condom	8.5	16.0	53.4	36.1	20.5	8.5	28.4
Pills	76.3	39.3	28.8	13.9	33.6	76.3	28.3
Norplant	1.7	2.0	2.7	3.0	0.3	1.7	1.9
IUCD	0.0	0.0	0.0	3.8	0.7	0.0	1.7
Total percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total acceptors	59	150	73	366	307	67	1022
Not accepting FP method	0	34	7	62	75	8	186
Total clients	59	184	80	428	382	75	1208

The FP methods that were largely accepted by clients were Depo (39.8 percent), condom (28.4 percent) and pills (28.3 percent each). Less than two percent clients accepted Norplant and IUCD (Copper T) (Table 12).

Although the observation checklist shows that clients from five SDPs were provided with emergency contraception the HMIS-11 data does not show this information. Perhaps it is the format of HMIS-11 data sheet that prevents recording EC but the provider or counsellor could have noted down EC in REMARKS column. This is not seen in the data sheet.

Upon enquiry at SDPs it was found that most CAC clients presented themselves with the desire to abort at the CAC SDP; very few cases were referred out of the SDP. Besides these information were not recorded in most SDPs and therefore detailed analysis was not possible.

6.6 Client perspectives

6.6.1 Background characteristics of exit interview respondents

In order to understand the perspectives of CAC clients a few exit interviews were conducted in 5 SDPs; because the service provider was not available at the time of field work this task was not possible in Kanchanpur SDP. In all 20 clients were conducted exit interviews (Table 13). The overall mean age of exit interview clients was 28.1 years and all of them were married.

Table 13 Distribution of CAC exit interview clients by GCAC project district SDPs according to age, Nepal, 2009

		GCAC project district SDP					Total
		Ilam	Sarlahi	Palpa	Banke	Kailali	
Age group	20-24	0	1	1	1	1	4
	25-29	4	2	1	1	0	8
	30-34	0	1	3	0	2	6
	35-39	1	0	0	0	1	2
Total		5	4	5	2	4	20

Of the 20 women interviewed 4 were illiterate – 2 each from Sarlahi and Kailali while 13 other women were educated meaning that they had been to school and completed some years of schooling (Table 14).

Table 14 Distribution of CAC exit interview clients by literacy and education according to GCAC project district SDPs, Nepal, 2009

		Literacy/Education			Total
		Illiterate	Literate	Educated	
GCAC project district SDP	Ilam	0	0	5	5
	Sarlahi	2	0	2	4
	Palpa	0	1	4	5
	Banke	0	2	0	2
	Kailali	2	0	2	4
Total		4	3	13	20

As expected, 18 of 20 women participating in exit interviews were Hindu women while 2 of them were Buddhist (Table 15). These women belonged to various caste/ethnic groups such as Bahun, Magar, Lama, Rai, Chhetri, Singh (Terai), Newar, Muslim and Tharu/Chaudhary.

Table 15 Distribution of CAC exit interview clients by religion according to caste/ethnicity, Nepal, 2009

		Hindu	Buddhist	Total
Caste/ethnicity	Bahun	4	0	4
	Magar	4	0	4
	Lama	0	2	2
	Rai	1	0	1
	Chhetri	4	0	4
	Singh (Terai)	1	0	1
	Newar	1	0	1
	Muslim	1	0	1
	Tharu/Chaudhary	2	0	2
Total cases		18	2	20

The exit interview women had on average 5.8 members in their households and the range of household size varied with a minimum of 4-member household to 11-member household.

6.6.2 Accessibility, awareness and counselling about abortion service

The exit interview women mentioned that on average they have to travel for 2 hours and 12 minutes on foot to reach the nearest CAC SDP. For 11 of 20 women travel on foot requires over 2 hours; some women need to walk for up to 6 to 8 hours. However, these days most women take a bus ride to go to a clinic. Fourteen of 20 women took a public

transport to come to the clinic for abortion while 6 women (3 women in Ilam and 1 each in other three districts) came on foot.

6.6.3 Source of abortion information

For most women participating in exit interview health worker and radio are the main source of abortion related information; 14 of 20 women mentioned health worker and 9 of 20 women mentioned radio as the source of abortion information (Table 16). Other sources of information were family member/relative, book/Newspaper, poster/pamphlet/booklet, hoarding board/wall painting, FCHV and friend.

Table 16 Distribution of CAC exit interview clients by source of abortion information, Nepal, 2009

		Number of cases
Abortion information source (multiple responses)	Health worker	14
	Radio	9
	Family member/relative	5
	Book/Newspaper	2
	Poster/Pamphlet/ booklet	2
	Hoarding board/Wall Painting	2
	FCHV	2
	Friend	2
Total cases		20

6.6.4 Reasons for clinic preference

In response to the enquiry why the clients chose to visit the clinic for abortion service most said that the doctor was popular followed by safe/good service, proximity, availability of female doctor, acquaintance with the doctor (Table 17). Only one client mentioned that it was cheap.

Table 17 Distribution of CAC exit interview clients by reason for choosing clinic, Nepal, 2009

		Number of cases
Abortion information	Popular doctor	15
	Safe/Good service	5

source (multiple responses)	Proximity	4
	Female doctor	3
	Know the doctor	3
	Cheap	1
Total cases		20

6.6.5 Clinic service times

Every exit interview client told that the clinic opens at 10 am and except one woman in Sarlahi the rest said that the opening time was convenient for them. However, clinic closing time varied from clinic to clinic. All 5 women in Ilam said that the clinic closes at 4 pm but women in other four districts gave different closing times for the same clinic (Table 18).

Table 18 Distribution of CAC exit interview clients mentioning clinic closing time, Nepal, 2009

		GCAC project district SDP closing time (hour)			Total
		3 pm	4 pm	5 pm	
GCA C projec t distric t SDP	Ilam	0	5	0	5
	Sarlahi	0	1	3	4
	Palpa	2	3	0	5
	Banke	1	1	0	2
	Kailali	0	4	0	4
Total cases		3	14	3	20

6.6.6 Appointment system

Women do not usually make appointment for service in any of the GCAC SDP; they just go there at about 10 am and if the service provider is there they wait for abortion service.

6.6.7 Quality of waiting facility

The exit interview participants in all five SDPs mentioned that the waiting area is comfortable; it has seating (tables & chairs). In every SDP there is a toilet facility and the toilet is clean and without bad smell.

Every exit interview client mentioned that the counsellor treated her respectfully; she explained to her what she was expecting and also gave her opportunity to ask questions.

Every exit interview client clearly mentioned that the counsellor got her consent for the CAC procedure. The service providers (doctor/nurse) explained about the CAC procedure to every CAC client before the procedure.

6.6.8 Post abortion FP counselling and emergency contraception

Every exit interview client mentioned that the counsellor counselled her about post-abortion care including instructions on the follow up visit and also about possible complications following the procedure. Exit interview clients mentioned about the counsellor counselling them about FP methods. However, not all clients reported accepting FP method following the post abortion FP counselling (Table 19).

Table 19 Distribution of CAC exit interview clients by FP method acceptance, according to GCAC project district, Nepal, 2009

		Accepted FP method	Did not accept FP method	Total
GCAC project district SDP	Ilam	5	0	5
	Sarlahi	4	0	4
	Palpa	4	1	5
	Banke	2	0	2
	Kailali	3	1	4
Total cases		18	2	20

Exit interview clients also mentioned about the counsellor counselling them about emergency contraception. However, not all clients reported being counselled on emergency contraception (Table 20).

Table 20 Distribution of CAC exit interview clients by emergency contraceptive counselling, according to GCAC project district, Nepal, 2009

		Yes	No	Total
GCAC project district SDP	Ilam	5	0	5
	Sarlahi	4	0	4
	Palpa	0	5	5
	Banke	0	2	2
	Kailali	4	0	4
Total cases		13	7	20

Of the 13 clients who were counselled on emergency contraception, 10 of them accepted emergency contraception (Table 21). In Sarlahi all 4 exit interview clients accepted EC while in Palpa none accepted it.

Table 21 Distribution of CAC exit interview clients by emergency contraceptive acceptance, according to GCAC project district, Nepal, 2009

		Accepted EC	Did not accept EC	Not counselled on EC	Total
GCAC project district SDP	Ilam	3	2	0	5
	Sarlahi	4	0	0	4
	Palpa	0	0	5	5
	Banke	0	0	2	2
	Kailali	3	1	0	4
Total cases		10	3	7	20

6.6.9 Overall impression of CAC service and suggestions for improvements

The exit interview clients were also inquired about their overall impression of the CAC service and 16 of 20 clients said it is very good while the rest said it is good (Table 22).

Table 22 Distribution of CAC exit interview clients by their overall impression of the CAC service, according to GCAC project district, Nepal, 2009

		Very good	Good	Total
GCAC project district SDP	Ilam	5	0	5
	Sarlahi	3	1	4
	Palpa	4	1	5
	Banke	0	2	2
	Kailali	4	0	4
Total cases		16	4	20

Of 20 exit interview clients only 2 gave suggestion that the clinic and the service need more improvements; both of them from Banke district. One exit interview participants suggested that the clinic would be better if a female doctor is there and also she said more information is needed for follow-up. Another client suggested that female doctor would be better.

VI. Conclusion and recommendations

The study of six GCAC project district facilities has revealed that overall abortion and postabortion quality of care is good. Many of the QOC framework aspects have been met. Most women in need of abortion service have fairly good access; many of them can reach the SDP by public transport. Locations, service charge, types of RH services including abortion are well displayed in most of the SDPs. However, Nepal being a mountainous country, a great deal of women in many parts needs the service.

Except in Kanchanpur SDP where detailed observation was not made, in other five SDPs the service providers were found explaining the CAC services available (medical & surgical) in the clinic to their clients. Clean and un-smelling toilet is essential for a CAC service centre. In four sites this standard was met but in Banke and Kanchanpur they lacked this standard.

Client counselling is in place in all six GCAC project districts. However, in Banke and Palpa observation has revealed that counsellors do not very much encourage clients to ask questions in case they do not understand well.

In all six SDPs MVA surgical technique is used for abortion. For first trimester surgical abortion this technique has been recommended by WHO (2003) too. Discussion with service providers in the districts reveals that this technique is easy to use for induced abortion purposes.

In all six SDPs equipment needed for abortion service have been found meeting the national government standards. In some districts some equipment such as temperature regulator, fire extinguisher, etc are not available. Except in Kanchanpur, in five sites pain management drugs are used as prescribed by the government. Supply of contraceptives including emergency contraceptives is in place. However, EC is not supplied in Palpa. Except Ilam FEFO is practiced in five districts. In Ilam labelling of items/commodities was not found either. Banke SDP was not found updating stocks of commodities regularly.

Field researchers have observed that contraceptive counselling takes place and many clients accept a contraceptive method following the procedure. This is important to avoid repeat abortion because a contraceptive method is needed to prevent pregnancy for some time following the procedure.

Emergency contraceptive counselling was found taking place in four SDPs. In Palpa and Banke this was not happening. Some clients in Ilam, Sarlahi and Kailali accepted EC before leaving the SDP. Although this is not recorded in HMIS-11, the exit interview clients reported it.

Information dissemination and sharing at SDP sites and with clients is apparently good in all six CAC sites. Leaflets, posters and wall paintings on sexual and RH including abortion, etc were seen and observed by field researchers in all six SDPs.

Of all aspects of QOC “linkages to family planning and reproductive health including abortion care services” was found relatively unimpressive. Although HMIS-11 made provision for recording of referral system, in several sites this system was hardly used. However, the field researchers when inquired with the service providers about client referral system they did mention that it is in place. When clients need higher level care following the abortion procedure they refer them there for treatment and care.

Analysis of exit interview data reveal that SDP opening time is known to all women but closing time is not universally known. They also reveal that they visited the clinic because the doctor is popular, the SDP is safe and it is near. A few women also mentioned that they visited the clinic because the doctor was a woman and some of them had personal acquaintance. Cheap service charge did not stand out as a reason for visiting the clinic.

The study identified several gaps that need to be addressed to improve GCAC project district SDP quality of care:

Clinic set up

1. No CAC SDP should be left without service provider. A human resource strategy has to be put in place to substitute a service provider in case the current one has to leave the place or takes leave for some time. CAC service should be provided as a priority service. Client should not be asked to come on some other day just because the health worker is busy with some other activities.
2. A strategy needs to be put in place to increase access of CAC service to women who come from far off places. This will encourage women to seek service on time.
3. Banke and Kanchanpur SDP need to have clean and un-smelling toilets at abortion service facility; this they should do as early as possible.
4. Service providers especially counsellors should encourage clients to ask questions in case they are uncertain or do not understand some issues. Part of quality of care is to allow clients to ask questions to counsellors and clarify confusions. This situation needs to be improved especially in Banke and Palpa.
5. Although service providers are competent to provide CAC service the clients prefer to have female doctors instead of male doctors. FPAN should as part of human resource strategy place female doctors in CAC clinics as far as possible.
6. Counsellors should be encouraged to use IEC materials (models, diagrams) during client counselling/education session. In Palpa this was lacking. Also IEC materials should disseminate clinic opening and closing times so that clients do not have to return home after a long travel without service.
7. Every SDP should have the supply of fire extinguisher, temperature regulator and updated list of commodities in stores.
8. Every SDP should keep records of all relevant information in the client's records or HMIS-11. Although overall completion of HMIS-11 form was good, there was hardly any variable without missing value. Therefore, it is highly recommended that the data recorder completes every column of HMIS-11. Also as FPAN also

distributes EC to its clients, the HMIS has to be modified by including a space to record EC information in HMIS.

Infection prevention

1. Infection prevention standards are well maintained in all six SDPs.

Surgical abortion procedure

1. Kanchanpur SDP needs to improve lighting in EVA/MVA room.
2. Kanchanpur SDP needs to have toilet facility in the EVA/MVA room.
3. All six SDPs record activities carried out for client pre-procedure, during procedure and post procedure in HMIS-11. However, it must be noted that the current provision is not comprehensive enough to record the post abortion procedure to resolve complications and therefore the Government of Nepal is now reviewing the situation to improve it. FPAN should adopt it as soon as the government introduces it.
4. Although information leaflets are available at the SDP for counselling they are not available for distribution. Therefore quantity of information materials needs to be increased for wider distribution.
5. In none of the six SDPs clients are followed up for two weeks although at the time of discharge they are given instructions to come back to the clinic in case they have complications. A client follow up strategy needs to be put in place for at least two weeks following the procedure.

Storage of contraceptives and supplies

1. All six SDPs have good stores but Palpa store room needs cleaning up regularly.
2. Ilam SDP needs to label commodities for easy access and to make them visible.
3. "First expiry first out" (FEFO) system was not in place in Ilam and Banke and therefore they need to address this issue.
4. Banke SDP needs to update stock registers regularly.
5. Ilam and Banke SDPs need to separate and discard damaged and expired supplies without delay.

Linkage with other RH services

1. Although HMIS-11 has columns to record linkages of abortion service to other RH services, this information was not well reported. Every CAC site should make efforts to complete this information. In case the client develops complications she should be transported by ambulance to other higher level service site for speedy check up and treatment.

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