

**DOCUMENTATION
OF
POST ABORTION CARE PROGRAM PROCESS
IN NEPAL**

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ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
BCC	Behaviour Change Communication
BEOC	Basic Essential Obstetric Care
CAC	Comprehensive Abortion Care
CBO	Community-based Organisation
CBS	Central Bureau of Statistics
CHW	Community Health Worker
CMR	Child Mortality Rate
CPD	Core Program District
CPR	Contraceptive Prevalence Rate
D&C	Dilatation and Curettage
DFID	Department for International Development
DHO	District Health Office(r)
DHS	Demographic and Health Survey
DoHS	Department of Health Services
DPHO	District Public Health Office(r)
EDP	External Development Partner
EHCS	Essential Health Care Services
EOC/EmOC	Emergency Obstetric Care
FCHV	Female Community Health Volunteer
FHD	Family Health Division
FHI	Family Health International
FP	Family Planning
FPAN	Family Planning Association of Nepal
GON	Government of Nepal
GTZ	German Technical Co-operation
HA	Health Assistant
HC	Health Centre
HMIS	Health Management Information System
HP	Health Post
HQ	Headquarters
HSSP	Health Sector Support Programme
ICPD	International Conference for Population and Development
IEC	Information, Education and Communication
IMR	Infant Mortality Rate
INGO	International Non-governmental Organisation
IPC/C	Interpersonal Communications and Counselling

IUD	Intra-uterine Contraceptive Device
JHPIEGO	John Hopkins Programme for International Education in Reproductive Health
HMC	Health Management Committee
LAM	Lactational Amenorrhoea Method
MCHW	Maternal and Child Health Worker
MDGs	Millennium Development Goals
MLD	Ministry of Local Development
MMR	Maternal Mortality Ratio
MNT	Maternal Neonatal Tetanus
MNTE	Maternal and Neonatal Tetanus Elimination
MO	Medical Officer
MOH	Ministry of Health
MOHP	Ministry of Health and Population
MSI	Marie Stopes International
MVA	Manual Vacuum Aspiration
NCASC	National Centre for AIDS and STD Control
NFHP	Nepal Family Health Programme
NGO	Non-Governmental Organisation
NHEICC	National Health Education, Information and Communication Centre
NHSP-IP	Nepal Health Sector Programme-Implementation Plan
NHSS	National Health Sector Strategy
NHTC	National Health Training Centre
NPC	National Planning Commission
NSMP	Nepal Safer Motherhood Project
PAC	Post Abortion Care
PHC	Primary Health Care
PHCC	Primary Health Care Centre
PHO	Public Health Officer
POC	Product of Conception
RH	Reproductive Health
SLTHP	Second Long Term Health Plan
SMP	Safe Motherhood Project
SN	Staff Nurse
SNL	Saving Newborn Lives
SOLID	Society for Local Integrated Development
SPN	Sunaulo Parivar Nepal
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infections
TBA	Traditional Birth Attendant

TFR	Total Fertility Rate
TUTH	Tribhuvan University Teaching Hospital
U-5MR	Under Five Mortality Rate
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VDC	Village Development Committee
VHW	Village Health Worker
VSC	Voluntary Surgical Contraception
WHO	World Health Organisation

Executive Summary

In Nepal, complications arising from incomplete abortions, both spontaneous and induced are a major cause of maternal morbidity and mortality. In May 1995, the Family Health Division, Ministry of Health and Population¹, established postabortion care (PAC) services with technical assistance from JHPIEGO, Engenderhealth (formerly known as AVSC) and Family Health International with financial support from USAID. Making postabortion care services available and accessible is one of the major goals of FHD as a life saving measure to reduce maternal mortality. Currently, USAID and NFHP provide financial and technical support to the PAC program of Nepal. NFHP is supporting the government of Nepal (GON) to establish PAC services in different parts of the country and is also providing support for planning, monitoring and training for the national program. A total of 78 PAC service sites have been established to date. PAC services are established in different levels of health facility e.g. zonal and district hospitals and PHCCs. Data show that PAC services provided by nurses using MVA method has increased over the years. Given the increasing demand for trained service providers, training has expanded in Maternity Hospital (Kathmandu), Bharatpur Hospital (Chitwan), Koshi Zonal Hospital (Morang) and Seti Zonal Hospital (Kanchanpur).

The aim of this assignment was to assess and document the status of the PAC program in Nepal and suggest recommendations for improvements of existing program and expansion to cover the whole country.

Methodology of assessment included interview with stakeholders, trainers and service providers and observation of service and training sites. In all, 11 PAC sites from different parts of the country were visited and 30 persons were met and their views and experience on PAC service were collected. PAC service statistics and logbook data from six PAC sites visited by the study team were also analysed.

Of the total 78 PAC sites, 57 sites are supported by USAID through several cooperative agencies and of the 57 sites 38 sites prepare service statistics while the rest need to regularise this activity. Reporting of PAC service statistics is better in NFHP supported 17 CPDs. The remaining 21 PAC sites are supported by the government and other EDPs. Increasing number of women are benefiting from PAC services. In fiscal year 2002/03, a total of 3,429 women benefited from PAC services and in the fiscal year 2005/06 this number increased to 3,877.

Over the years the proportion of MVA clients in relation to total PAC clients has increased steadily. Using data from sites reporting the number of cases, it was found that the proportion of MVA was 51.4 percent in 2002/03 which increased to 61.1 percent in 2003/04 and further increased to 70.4 percent in 2004/05 and in 2005/06 this proportion reached 76.0 percent mark. In CPD areas the corresponding proportion was even higher – 81.3%.

¹ In 1995 the Ministry of Health and Population was Ministry of Health only.

Providing family planning counseling and services to women managed for abortion complications is essential to enable women to prevent repeat unwanted pregnancies and unsafe abortions. In Nepal, family planning acceptance by women who have come for PAC service is very encouraging overall. Data from fiscal year 2002/03 to 2005/06 for 78 PAC sites show that the proportion of women receiving PAC service accepting FP after PAC service has increased from 39.7 percent in 2002/03 to 55.8 percent in 2005/06. By specific service site, FP acceptance rate was found highest (75.7%) in Koshi Zonal hospital followed by Bharatpur hospital 74.2% and Maternity Hospital 48%. Among the MVA clients alone the proportion of women accepting FP methods peaked (79.5%) in fiscal year 2004/05 and in the following year it declined to 73.4%. In CPD areas the proportion of MVA clients accepting family planning increased to 84.1%.

The major findings from the analysis of the field data from seven sites show that, about 42 percent of all women presenting before the health facility for PAC care were less than 9 weeks gestation and another 43% of cases were 9-12 weeks gestation. The vast majority of PAC clients (86.8%) were diagnosed as “incomplete abortion”. On average, one in six postabortion care clients were adolescents aged 15-19 years.

By promulgating Safe Motherhood Policy 1996, the Government of Nepal created a conducive environment to introduce PAC service in Nepal. Subsequently, training program was launched and every year new PAC service sites were established. Nepal also made a critical policy decision by including PAC in national reproductive health guideline. Despite gradual increase of PAC service sites in the last ten years, the coverage is still low; the unmet need for it is about 90%.

Records show that nurses and ANMs are the major providers (62.7% of all MVA procedures in 2005/06) of PAC services. It is also seen that nurse and assistant model is more cost-effective than physician and nurse model.

The PAC training curriculum provides the trainees with knowledge and skill on, initial assessment of client, provider attitude, initial history taking, FP/history/counseling, initial infection prevention, physical examination, client informed, MVA preparation, MVA procedure, evacuation examination, comfort ensured, post procedure care, and post procedure IP. Training manuals have been developed and used for this purpose.

Observation of various levels of health facilities reveals that the mid-level health workers are ideal for PAC service provision in Nepal. They are more committed than physicians towards client-oriented service. They are more likely to run 24-hour PAC service in remote areas of Nepal. It was also found that a group of 4 participants would be ideal for training. Small group, provided caseload is enough, might gain competency better during the training.

OJT might address the constraints of group-based training. An OJT approach focuses on training in home institute of the participants. This is the best strategy in a low income country where staffs can be trained without taking them away from their regular place of work.. However, OJT takes longer time than a regular training program.

Provider competency was measured using 27-steps and it was found that nurses did better than physicians. Applying technical performance 27 steps criteria (scores range from 8 to 24) it was found that nurses' competency ranged between 16-24 while that of physicians the corresponding range was 8-21. Most of the nurse providers were thoroughly following 27-step criteria whereas it was not so among the physicians.

Using cost items needed for various activities to set up a PAC service site, it was estimated that for 78 sites, the government of Nepal with support from USAID and other EDPs already invested some Rs. 16,001,076/-. In case the government makes a plan to expand PAC services to scale up nationally it will need, at least, Rs. 48,967,395/- to set up PAC sites in the remaining 51 district hospitals and 166 PHCCs/HCs.

Analysis of costs data and client flow suggest that it takes more than three years for a well functioning PAC centre to elevate to the break-even position. It appears that Koshi zonal hospital is at that level now. However, given that the coverage is low to date, the expansion of PAC service has a big potential.

Overall, it appears that CAC and PAC services, in the opinions of interviewees should be established and developed separately. This is so in view of the different characteristics of PAC and CAC clients.

Main recommendations for PAC service delivery include a national policy on PAC to ensure that:

- PAC is gradually expanded to all service centers;
- PAC facility is developed separately in a center with clear reasons;
- Supply of equipment is uninterrupted;
- PAC trained manpower is ever present;
- PAC service is linked to other reproductive health services;
- There is inventory control and maintenance and
- FP counseling skills are continuously improved and supply of an array of FP methods uninterrupted.

Other recommendations include strengthening of current program sites, initiation of promotional activities including community mobilization, periodic monitoring visits, analysis of data and feeding of results into programme improvement, good recording of accounts and quality improvements.

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1.0 INTRODUCTION

Making postabortion care services available and accessible is one of the major goals of FHD/MOHP as a life saving measure to reduce maternal mortality. USAID through NFHP provides financial and technical support to the PAC program. NFHP is supporting the Government of Nepal (GON) to establish PAC services in different parts of the country and is also providing support for planning, monitoring and training for the national program. A total of 78 PAC service sites have been established to date. PAC services are established in different levels of health facility e.g. Zonal and district hospitals and PHCCs. PAC report shows that PAC services provided by nurses using MVA method has increased compared to previous years (with a corresponding decline in D&C by physicians). Given the increasing demand for trained service providers, training has expanded in Maternity Hospital (Kathmandu), Bharatpur Hospital (Chitwan), Koshi Zonal Hospital (Morang) and Seti Zonal Hospital (Dhangari).

1.1 Objectives

1. Assess and document the status of the PAC program (which includes services and training) at the National level.
2. Document the PAC program process.
 - Evolution of PAC program in Nepal
 - Development and maintenance of PAC training, both group based and On-the-Job training
 - Role of nurses as PAC service providers
 - Resources and cost requirements for establishing PAC training sites and service sites at different level.
3. Document the issues raised in CAC and PAC services

1.2 Methodology

1.2.1 Interview with Stakeholders, Trainers and Service Providers

The study team members met with stakeholders, went to different hospitals and PHCCs to get first hand knowledge of PAC services sites. In all, 32 persons were met and their views and experience on PAC service were collected (**Table 1**).

the way and the consultants were also advised later in the study stage to visit Maternity Centre, Thapathali and Teaching Hospital in Kathmandu. In all, therefore, 11 PAC sites were visited (**Table 2**).

Table 2: PAC sites visited

S.N. PAC site

- 1 Maternity Hospital, Thapathali, PAC service started in 1995/96
- 2 Gandaki S. R. Hospital, PAC service started in 1996/97
- 3 Koshi Zonal Hospital, PAC service started in 2000/01
- 4 Tribhuvan University, Teaching Hospital, PAC service started in 1996/97
- 5 Myagdi District Hospital, PAC service started in 2002/03
- 6 Siraha District Hospital, PAC service started in 2003/04
- 7 Dumkauli PHCC, Nawalparasi, PAC service started in 2001/02
- 8 Mangalbare PHCC, Morang, PAC service started in 2003/04
- 9 Itahari PHCC, Sunsari, PAC service started in 2003/04
- 10 Mirchaiya PHCC, Siraha, PAC service started in 2004/05
- 11 Manohari PHCC, Makwanpur, PAC service started in 2005/06

At each facility the observers spent one day. Semi-structured interviews with various PAC stakeholders, examination of PAC records, direct observation of provider and client interactions, were under taken at each facility. Interviews with PAC service provider (medical doctor and staff nurse), counselor, coordinator, and administrator were conducted. Equal number of provider-client interaction and service delivery were observed. Qualitative and quantitative methods were used to analyze the data to understand both facility and provider perspectives on quality of care. We could not access the service quality including record in Siraha district hospital because the key of the PAC room was with the provider staff nurse, who was attending a training session out of the station. According to other staff, the only provider nurse of this center is a trainer of various safer motherhood programs, and therefore the PAC site remains closed most of the time. While assessing the quality at various levels of facilities, focus was on supplies, medicines and equipments, infection prevention, pain management and post-abortion family planning services, linkage with other reproductive health services, community involvement and referrals.

1.3 Limitations of the Study

The study team visited only 11 of 78 PAC sites and could only observe a few sites providing service. The views expressed and interpretations made here are based only on reporting from service providers, client records and observation of some service sites; no beneficiaries were met. No on site observation of training session was possible. The study team was conducting the work during conflict times which made it impossible to plan time to make field visits to observe training.

Although the study team made efforts to analyze whatever data were available, the results reported should be interpreted with caution because there were missing records too. Also as the purpose was to document PAC program, the results are in the forms of facts and figures and not much on why the results are as they are.

2.0 MATERNAL MORTALITY AND UNSAFE ABORTION

Women's health is subject to more risks than that of men because of maternity which can pose serious threat to their health and lives arising from complications from spontaneous abortions and unsafely induced abortions. Worldwide an estimated 46 million induced abortions are performed annually; roughly 20 million are unsafe, and 99 percent of these take place in the developing world. Worldwide, about 78,000 women die annually from complications related to unsafe abortion (WHO 1998).

When modern contraceptives were not widely available, abortion was one of the oldest methods of preventing unwanted births and no wonder even as early as 1979 the Population Crisis Committee suggested a figure of 40 million abortions annually (Liskin, L. S., 1982). Unsafe abortion is defined by the World Health Organization as “a procedure for terminating an unwanted pregnancy either by persons lacking necessary skills or in an environment lacking the minimal medical standards or both” (WHO 1998). The phrase “unsafe abortion” also refers to the inappropriate management of complications caused by spontaneous abortion or miscarriage.

Worldwide, about 37 percent of all pregnancies end in spontaneous or induced abortion or stillbirths; perhaps 17 percent of all pregnancies end through induced abortion (WHO 1998). The most recent global estimate of the proportion of maternal deaths due to complications of abortion is 13 percent. The risk of death from complications of abortion is global, yet varies greatly from region to region. The largest number of deaths due to unsafe abortion occurs in Asia (38,500, or 49 percent of the total), the highest rate per 100,000 live births occurs in Africa (110), and the highest proportion of maternal deaths due to unsafe abortion is in Latin America (21 percent). Within Latin America, the highest proportion of maternal deaths due to unsafe abortions is in South America (24 percent) – a proportion equal to that of Eastern Europe (24 percent - WHO 1998).

3.0 BACKGROUND

In Nepal the majority of women do not have access to full range of maternal health care services due to social, cultural, economic and political reasons. Recent data on maternal mortality revealed that in 2006 maternal mortality ratio was 281 per 100,000 live births (MOHP, New ERA and Macro International Inc, 2007). No comprehensive study of causes of maternal deaths is available but one study conducted between January 1997 and January 1998 estimated that 5.4% of maternal deaths were due to abortion complications (MOH, 1998a). In view of the fact that the proportion of maternal deaths due to complications of abortion is about 13 percent at the global level, the figure estimated for Nepal appears to be underestimated.

In order to address this serious situation, the government of Nepal, based on the National Health Policy 1991 (MOH, 1993), has launched the Safe Motherhood Programme which has two major strategies to improve maternal health. One strategy is to provide around-the-clock essential obstetric services and the other is to ensure the presence of skilled attendants at deliveries, especially at home deliveries as 81 percent of births take place at home (MOHP, New ERA and Macro International Inc, 2007). The Ministry of Health's efforts are supported by multilateral, bilateral, INGOs, NGOs and the private sector. The main thrust of the SMP is to reduce maternal and neo-natal mortality by addressing the high rates of deaths and disability caused by the complications of pregnancy and childbirth.

Experience shows that the avoidance of the three delays was imperative to achieve the goal of reducing maternal mortality. The three delays are:

1. Delay in seeking care
2. Delay in reaching care and
3. Delay in receiving care

The SMP which began in 1997 has been addressing the above issues and the MOH has also developed the National Safe Motherhood Plan (2002-2017). One of the 7 objectives of the Plan is:

- To raise public awareness about the importance of health care of maternal and neonatal particularly recognizing life threatening complication and emergency readiness;

The major components of safe motherhood and neonatal health are:

- Antenatal Care Services
- Delivery Care
- Postnatal Care
- Post Abortion Care Services and
- Birth Preparedness Package

The National Reproductive Health Strategy of 1998 included “prevention and management of complications of abortion” as one of the eight reproductive health interventions at national (central or tertiary) and district level hospitals and at Primary Health Care Center level (MOH, 1998b). At PHCC level, the activities included:

1. Initiation of essential treatments including antibiotic therapy, IV fluid replacement, and oxytocin.
2. Uterine evacuation of incomplete abortion during first trimester.
3. Referral of incomplete abortion after first trimester.
4. Basic pain control, simple analgesia and sedation.

At the District Hospital level the activities included:

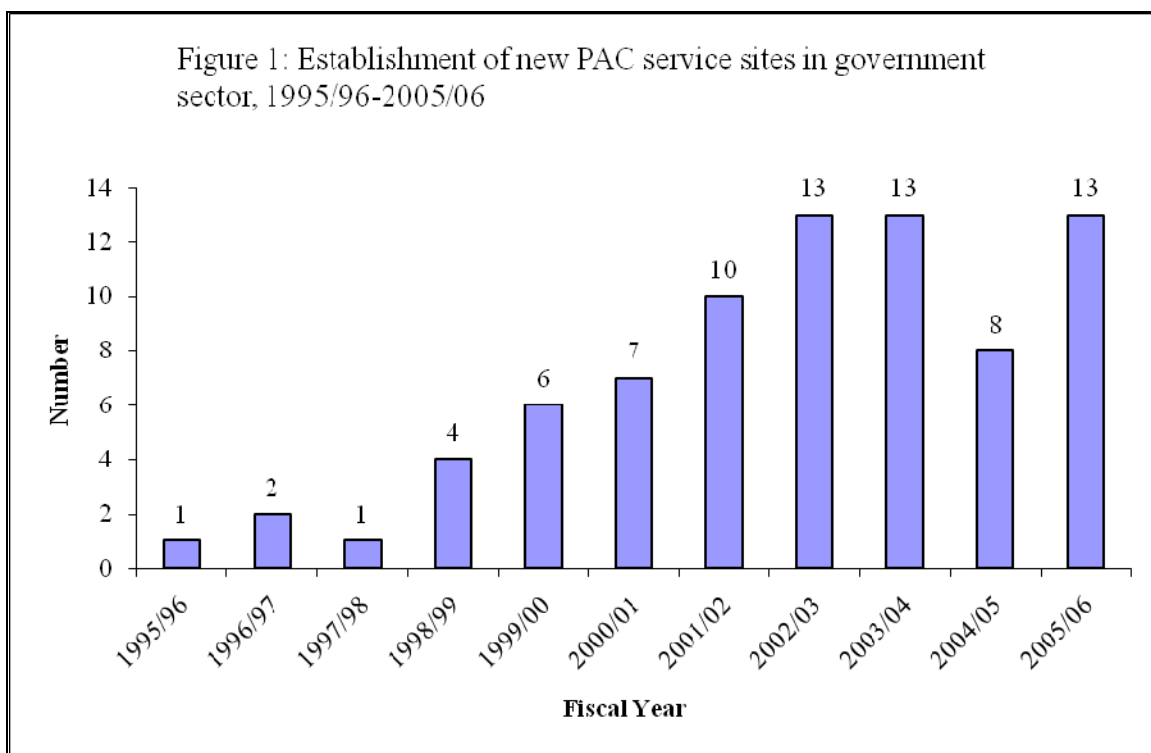
1. Emergency uterine evacuation of incomplete abortion during first trimester.
2. Treatment of post abortion complications.
3. Local and general anesthesia as indicated.
4. Diagnosis and referral for severe complication such as septicemia, peritonitis, renal failure, etc. to tertiary care level facilities.

In March 2002, Nepal's Parliament legalized abortion according to which abortion is permitted on 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 risk to woman's life and mental and physical health or fetus deformity.

4. PAC SERVICE IN NEPAL

4.1 Introduction and Growth

Nepal, being the signatory of the Plan of Action of the International Conference on Population and Development (ICPD) 1994, has committed itself to improving reproductive health in the country (UN, 1994). In view of high maternal mortality and morbidity and the commitment to ICPD, the Family Health Division, Ministry of Health, with technical assistance from JHPIEGO, Engenderhealth (earlier known as AVSC) and Family Health International (FHI) for the first time in May 1995 established post abortion care (PAC) services at Maternity Hospital, Kathmandu. The reach of PAC services continues to grow and by 2005/06 the number of PAC services sites grew to 78 in the country (**Figure 1**).



Close cooperation between FHD of MOHP, JHPIEGO, Engenderhealth, FHI, the USAID, NSMP, UNICEF and GTZ also aided in the establishment of PAC services in the country. Of the total 78 PAC sites, most (57 sites) have been supported by USAID through several cooperative agencies (**Table 3**). Of the USAID supported PAC sites, most (38 sites) prepare service statistics and report to the FHD and NFHP in Kathmandu regularly while 11 sites do not make reports (data) available, 6 sites were only recently started and 2 are not functioning because there is no provider (**Table 3**).

Although the number of PAC service sites has increased over the years, not all of them are functioning well nor are they preparing service statistics regularly. The Nepal Family

Health Program (NFHP) has been focusing in 17 core program districts (CPD)² and the performance of PAC program is found different between the CPDs and non-CPDs.

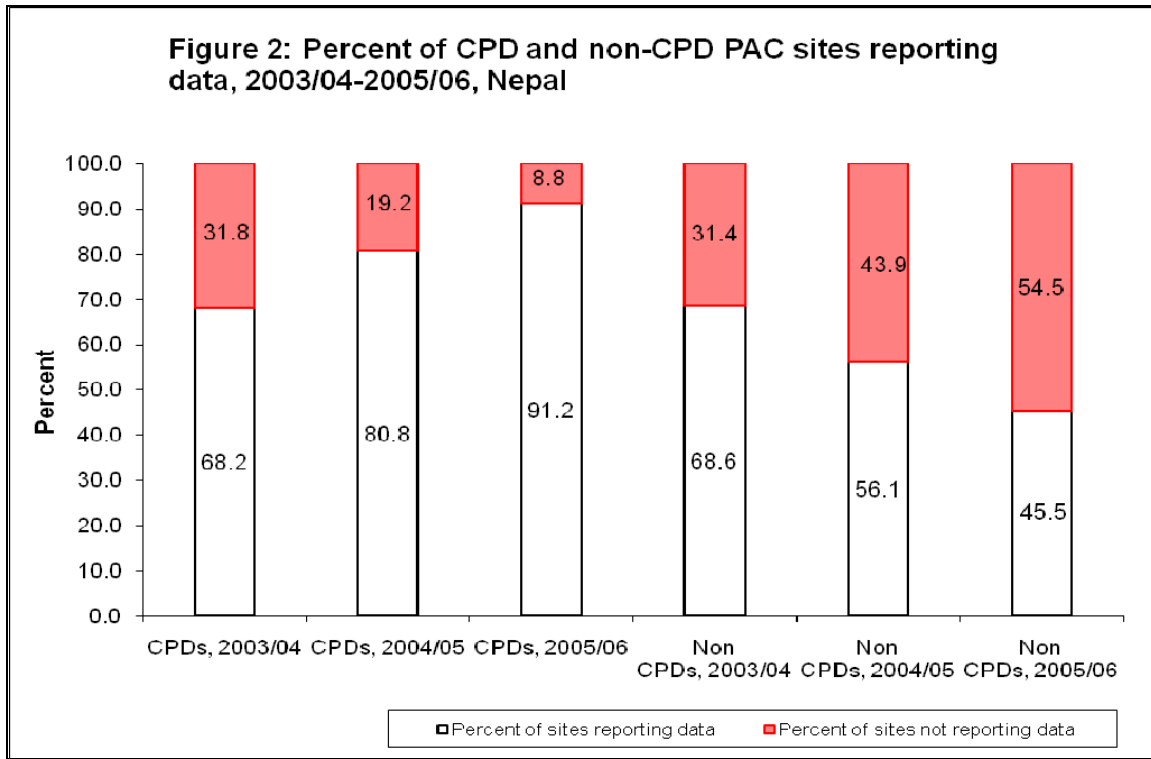
Table 3 Distribution of PAC sites by facility type by functional status and by type of donor support, 2005/06

USAID Supported	Facility Type		STATUS				Total
			Functioning	Recently started	Reports not available	Not functioning, no provider	
Special Initiative	PHCC		4	2	1		7
	Total		4	2	1		7
USAID	District Hospital		15		10	1	26
	PHCC		5	4		1	10
	Zonal Hospital		5				5
	Maternity Hospital		1				1
	Teaching Hospital		1				1
	Army Hospital		1				1
	Clinic		1				1
	Sub Regional Hospital		2				2
	Total		31	4	10	2	47
Engenderhealth	Private Hospital		3				3
	Total		3				3
Non-USAID	District Hospital		6		5		11
	PHCC		2		2	1	5
	Zonal Hospital		2		1		3
	Private Hospital		2				2
	Total		12		8	1	21
	All		50	6	19	3	78

In fiscal year 2003/04 the proportion of CPD PAC sites preparing service statistics and reporting to the centers in Kathmandu was 68.2% which increased to 91.2% by 2005/06. In contrast, the corresponding figures for non-CPD PAC sites were 68.6% and 45.5% (**Figure 2**). Although all PAC sites were started by the government and NFHP with initial inputs such as training, facility updating and supplies, follow-up in non-CPD sites was not the responsibility of NFHP while in the CPD sites NFHP made regular Technical Support Visit (TSV) and ensured the availability of necessary service items and trained manpower. For all these reasons, increasing number of clients visit CPD service sites and service statistics in CPD districts are regularly reported. Besides, the filed workers at

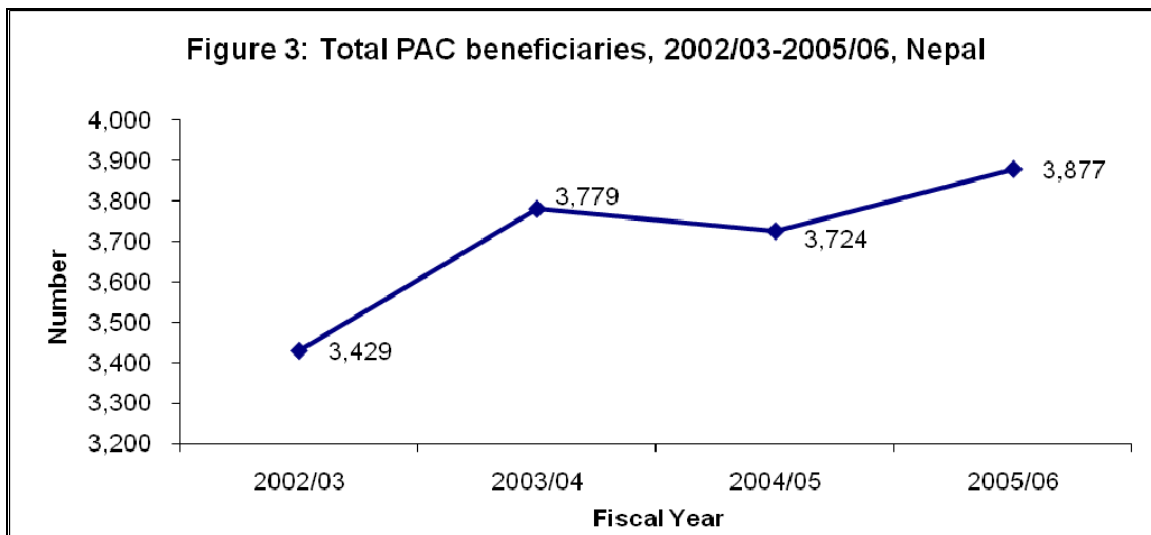
² Jhapa, Morang, Sunsari, Siraha, Dhanusha, Mahottari, Rautahat, Bara, Parsa, Chitwan, Nawalparasi, Banke, Bardiya, Kailali, Kanchanpur, Rasuwa, and Bajura

CPD sites are required to submit client service data regularly. Continuous NFHP technical assistance in PAC is showing positive results.

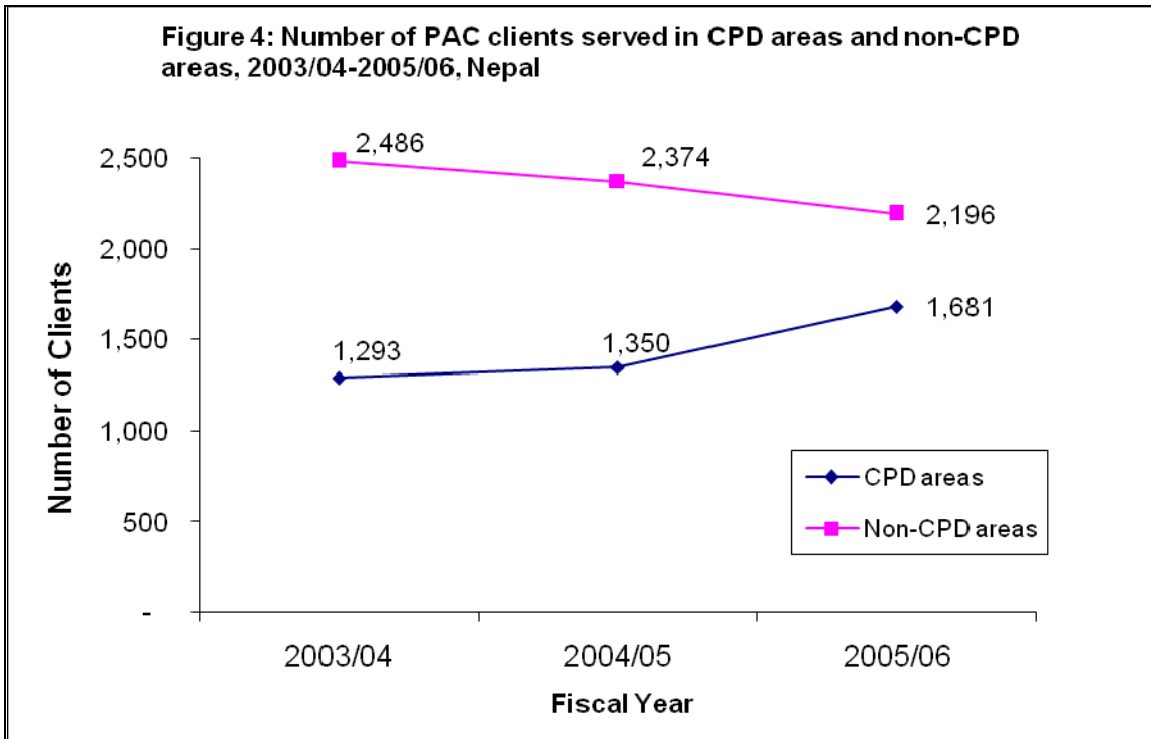


4.2 Number of Beneficiaries

The number of beneficiaries from PAC service is increasing every year; it was 3,429 in fiscal year 2002/03 which increased to 3,779 in the following year and further increased to 3,877 by the fiscal year 2005/06 (**Figure 3**). This may still be low because women seeking PAC service in the NGO and private sector are not included here.



In NFHP supported CPDs the number of PAC clients receiving services is found steadily increasing while in the non-CPD areas the opposite situation has been found. In fiscal year 2003/04 the number of PAC beneficiaries was 2,486 while in CPDs the corresponding figure was 1,293. In the following year, however, the number of beneficiaries in non-CPDs declined to 2,374 but in the CPDs it increased to 1,350. Similar trend was found in fiscal year 2005/06 (**Figure 4**).



5.0 ESSENTIAL ELEMENTS OF PAC

The PAC model includes the following three elements:

1. Emergency treatment for complications of spontaneous or induced abortion,
2. Family planning counseling and services, and
3. Linkages to other reproductive health services.

In recent years, two additional elements have also been proposed which are – community participation and counseling and client provider interaction to identify and respond to women’s emotional and physical health needs and other concerns.

5.1 Emergency Treatment for Complications of Spontaneous or Induced Abortion

Improving emergency treatment for complications of spontaneous or induced abortion has been the starting point for PAC programs. Manual vacuum aspiration (MVA) has been at the centre of this, and is being promoted as a way to improve treatment, as it is safer, less costly, and as effective as the traditionally used dilation and curettage (D&C). MVA can be performed with low levels of pain control, while D&C is typically performed under general anesthesia (Cobb, L. et al, 2001).

MVA has generally been accepted into programs, although it has also met with resistance and sometimes has taken time to become well accepted. In Nepal, at the Maternity Centre in Kathmandu (the first national training site for PAC services), from the time that PAC program began in May 1995 until December 31, 2000 (i.e. 5 years and 8 months), there were 6,763 PAC cases (average of nearly 100 clients a month) and of these, almost half (48 percent) were treated with MVA (Cobb, L. et al, 2001).

At Thapathali Maternity Hospital, of the total PAC clients served the proportion treated with MVA has steadily increased from 43.1 percent in 2002/03 to 58.2% in 2005/06 (Table 4), indicating better acceptance of MVA into the program. Overall, in 4 years the total number of clients increased to 5,931 yielding an average of nearly 124 clients a month.

Table 4 Use of MVA and D&C in Maternity Hospital, Thapathali, Kathmandu, 2002/03 to 2005/06

Year	MVA	D & C	Total PAC clients	% MVA
2002/03	610	806	1,416	43.1
2003/04	674	777	1,451	46.5
2004/05	922	701	1,623	56.8
2005/06	839	602	1,441	58.2

Source: FHD, MOHP and NFHP, Personal Communication.

Attempt has also been made to look at the numbers of clients treated with MVA and D&C for all 78 PAC sites in the country. In 2002/03, the proportion of PAC clients

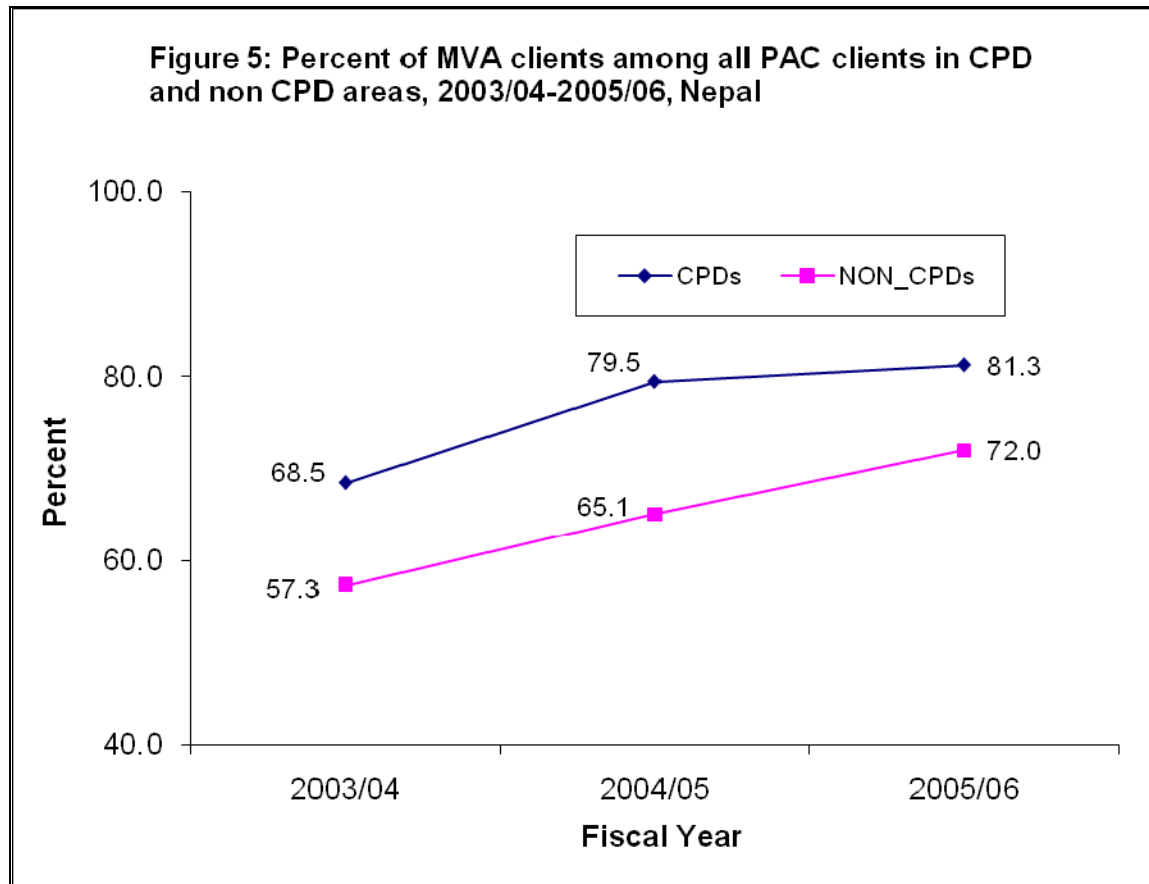
treated with MVA was a little over half (51.4 percent) in 29 sites and in the following year this proportion increased to 61.1 percent in 39 sites (**Table 5**, for details see **Appendix I**). Furthermore, in 2004/05 the MVA proportion increased to 70.4 percent in 42 sites and in 2005/06 this proportion reached 76 percent mark in 51 sites.

Table 5 Use of MVA and D&C in PAC sites in Nepal, 2002/03 to 2005/06

Year	MVA clients	D & C clients	% MVA	Number of sites	
				Reporting data	Not reporting data
2002/03	1,764	1,665	51.4	29	15
2003/04	2,310	1,469	61.1	39	18
2004/05	2,620	1,104	70.4	42	23
2005/06	2,948	929	76.0	51	27

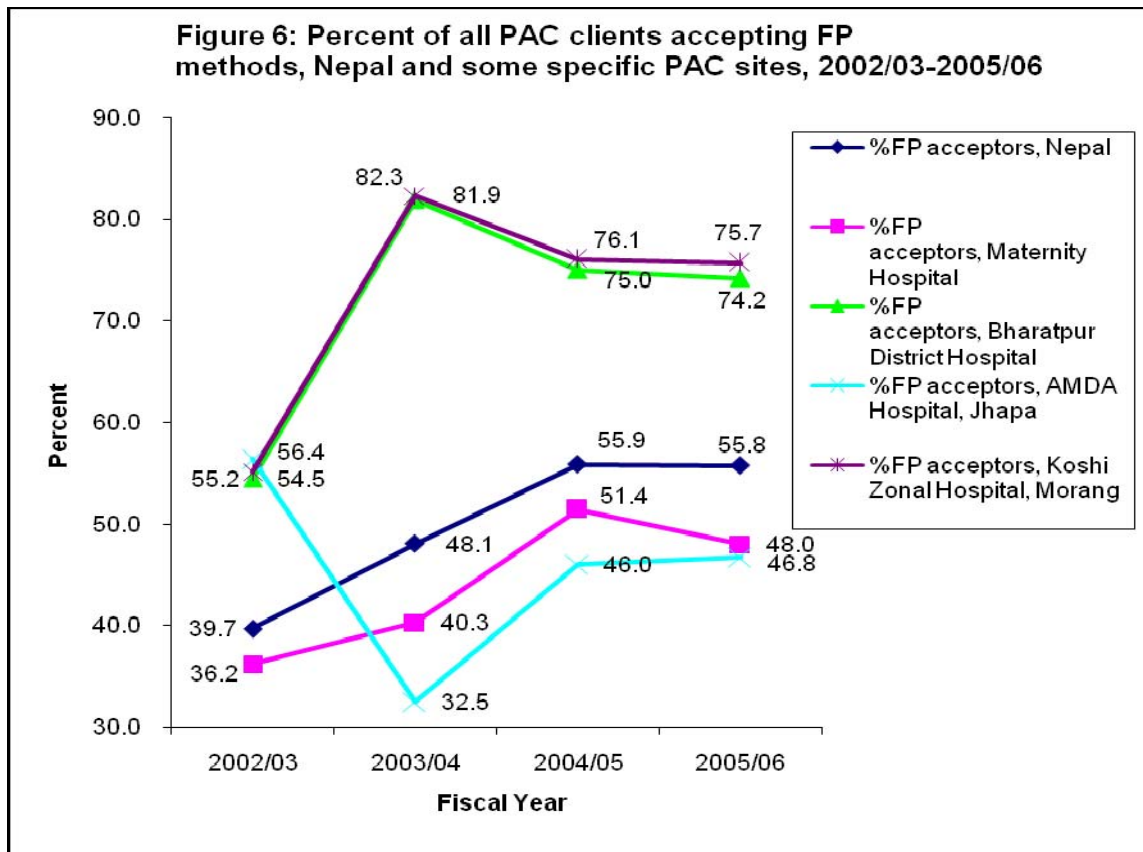
Source: Same as Table 3

It is also seen that in NFHP CPD areas the proportion of MVA clients among all clients has remained higher than in non-CPD areas. In fiscal year 2003/04 the proportion of MVA clients was 68.5%, in the following year it increased to 79.5% and in 2005/06 it reached 81.5% while the corresponding figures in non CPD areas were 57.3%, 65.1% and 72% (**Figure 5**).



5.2 Post Abortion Family planning Counseling and Services

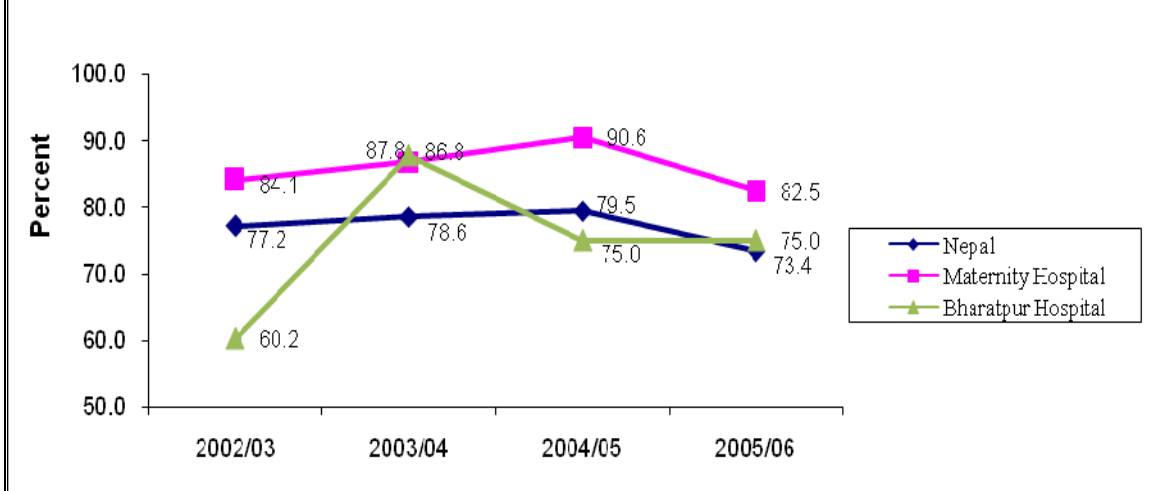
Providing family planning counseling and services to women treated for abortion complications is essential to enable women to prevent repeat unwanted pregnancies and unsafe abortions. Until the PAC interventions of the past several years, this linkage was virtually nonexistent (Cobb, L. et al, 2001). Many research studies have shown high demand for these services and significant increases in the proportion of women receiving FP counseling and methods after PAC interventions were introduced. In Nepal, family planning acceptance by women who have come for PAC service is very encouraging overall. Data from fiscal year 2002/03 to 2005/06 for 78 PAC sites show that the proportion of women receiving PAC service accepting FP after PAC service has increased from 39.7 percent in 2002/03 to 55.8 percent in 2005/06 (**Figure 6**). The increase was steady until 2004/05 and thereafter it has plateaued. FP acceptance trend is also shown for Maternity Hospital (first hospital introducing PAC service) and for Bharatpur District Hospital which is a regional training centre for PAC. Although overall FP acceptance trend is good for the country as a whole, it looks best for Koshi Zonal and Bharatpur District Hospitals where in fiscal year 2002/03 FP acceptance rate was more than 50 percent and in the following year they shot up to over 80 percent and thereafter they appear to have plateaued indicating about 3 women in 4 women accepting FP after PAC procedures.



Acceptance of FP methods by PAC clients can vary depending on the type of service centre. All PAC service sites should have at least 3 FP methods (pills, condoms and Depo) round the year. If the site has a trained IUCD/Norplant service provider then only the IUCD/Norplant services are available. As all 78 PAC service sites do not have all types of FP services available it is reasonable to have variation in the acceptance of FP methods by clients.

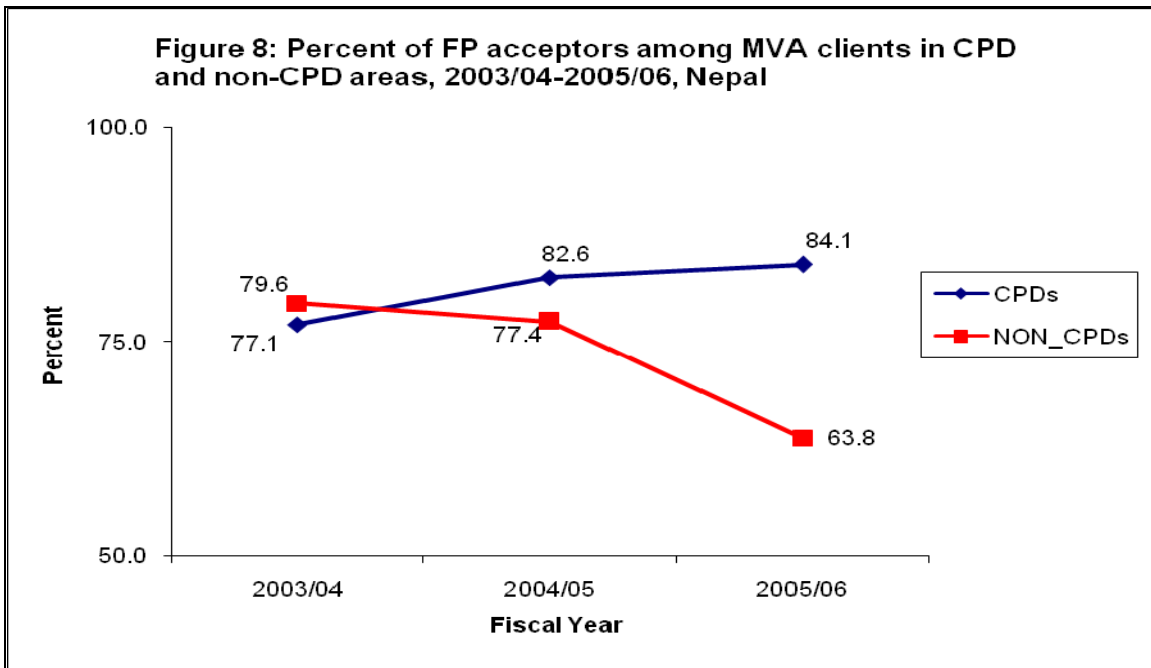
The trend of MVA clients accepting family planning methods has also been examined. Using MVA data from the sites where they were available, it is seen that the proportion of MVA clients accepting FP methods peaked in fiscal year 2004/05 with the exception of Bharatpur hospital (**Figure 7**) where it peaked in the earlier year, i.e., 2003/04. Compared to earlier fiscal years, in 2005/06 the proportion of MVA clients accepting FP methods declined; even in Kathmandu maternity hospital which is taken as the model training and PAC/MVA service centre, this proportion was found declining.

Figure 7: Percent of MVA clients accepting FP methods, 2003/04-2005/06, Nepal and some specific sites



It is mentioned that despite their repeated request to non-CPD PAC sites to send PAC data for inclusion in the roster several non-CPD PAC sites did not heed to them.

Figure 8: Percent of FP acceptors among MVA clients in CPD and non-CPD areas, 2003/04-2005/06, Nepal



6.0 UTILIZATION OF PAC SERVICES AT SIX SITES

In order to look at service utilization data, nine PAC sites were visited by study team members including Gandaki Sub-Regional Hospital in Pokhara, Kaski district; district hospital Myagdi, Dumkauli PHCC, Nawalparasi district; Manohari PHCC, Makwanpur district west of Kathmandu and Koshi zonal hospital, Biratnagar, Morang district; Itahari PHCC, Sunsari district; Mangalbare PHCC, Morang district; district hospital Siraha; and Mirchaiya PHCC, Siraha district. Service utilization data of seven sites were collected³ and they have been analyzed and presented in **Tables 6** and **7**.

Table 6 Abortion complications presenting at seven PAC sites

(a) Gestational dating of PAC cases			(c) Post abortion clients by age group		
Number of weeks	Number	%	Age group (years)	Number	%
8 Weeks or less	569	41.8	15-19	208	15.3
9-12 Weeks	579	42.5	20-24	525	38.6
13 Weeks or more	143	10.5	25-29	318	23.4
No information	70	5.1	30-34	155	11.4
Total	1,361	100.0	35-39	108	7.9
			40-44	31	2.3
			45-49	15	1.6
			Total	1,361	100.0
			Mean age		25.1
			Median age		24.0

(b) Diagnosis of abortion complication cases		
Diagnosis	Number	%
Incomplete abortion	1,182	86.8
Retained POC	109	8.0
PV bleeding	43	3.2
Sepsis	21	1.5
No information	6	0.5
Total	1,361	100.0

The data presented in **Tables 6** and **7** are cumulative data; they include data from the start of service to the time when the research team visited them. For instance, Dumkauli PHCC data cover the period June 3, 2004 to Sept 5, 2005, Siraha district hospital data covers the period from 4th February 2004 to 20 June 2006 and so on (please see **Appendix II** for details).

The major findings from the analysis of the field data include the fact that, about 42 percent of all women presenting before the health facility for PAC care were <9 weeks gestation and about 84% of all cases were ≤12 weeks gestation (**Table 6, panel (a)**). The vast majority of PAC clients (86.8%) were diagnosed as “incomplete abortion” and about

³ Data from Manohari PHCC and Itahari PHCC were not collected because in Manohari cases were only two, and PAC provider in Itahari PHCC was not present at the time the consultants visited them. She locked up the PAC room. Besides, the case load was very low; only 6 PAC cases were treated in last eight months. Data from district hospital Siraha was collected after some days because the PAC provider locked up the PAC room at the time the study team was there. The research team also visited Maternity Hospital, Thapathali, Kathmandu; Tribhuvan University, Teaching Hospital (TUTH), Maharajgunj, Kathmandu but service data were not included for analysis. Besides, TUTH did not maintain data register.

one in 12 cases came to remove POC. Surprisingly, serious cases such as sepsis were not many (1.5% - **Table 6 panel (b)**).

Another key finding was that, on average, one in six postabortion care clients were adolescents aged 15-19 years. Earlier study also showed similar results (Basnet, I., et al, 2004). This would be expected because age at first marriage is low in Nepal and about one in five (18.5 percent) women between the ages of 15 to 19 become mothers (MOHP, New ERA and Macro International Inc, 2007). The median age of PAC clients was estimated at 24 years and the mean age was 25.1 years (**Table 6 panel (c)**). **Appendix II** shows variations and details about these findings by seven field PAC sites.

In PAC training, it is taught that all MVA clients should be given FP counseling and let the client choose a method of contraception. The field data shows that about one in three PAC clients accepted FP methods (**Table 7, panel (a)**) following PAC procedures⁴. Of all the FP methods, condom was the most popular followed by pills and Depo.

Table 7 Type of FP methods accepted by clients, type of providers performing PAC procedures, and length of stay at health facility in seven PAC sites

(a) Family planning methods accepted by PAC clients			(c) Length of stay at health facility		
FP method	Number	%	Discharged:	Number	%
Condom	386	28.4	Same day	1,217	89.4
Pills	285	20.9	After 24 hours	124	9.1
Depo	197	14.5	After 48 hours	15	1.1
Refused	124	9.1	After 72 hours	4	0.3
LAM	18	1.3	After 96 hours	1	0.1
Husband away	13	1.0	Total	1,361	100.0
Minilap	7	0.5			
IUD	4	0.4			
Norplant	2	0.2			
No information	325	23.8			
Total	1,361	100.0			

For details by facility please see **Appendix III**

(b) Type of provider		
Type of provider	Number	%
Nurse	896	65.8
Doctor	464	34.1
No information	1	0.1
Total	1,361	100.0

The field data show that 66 percent of PAC procedures were performed by nurses or senior ANMs (**Table 7, panel (b)**) which implies that PAC program is becoming popular even among lower level medical personnel. Also the government policy of allowing nurses and senior ANMs to perform PAC MVA procedures is perhaps paying off.

Attempt was made to estimate the length of stay at the health facility by examining date of client admission and date of discharge. Nearly 9 in 10 PAC clients were discharged on

⁴ Of all PAC clients 107 were treated with D&C and of them 105 were from Koshi zonal hospital and one each from Mangalbare and Mirchaiya PHCC. D&C records of Gandaki hospital were not made available to the consultants.

the same day (**Table 7, panel (c)**). This finding is comparable with the Mexico study which reported 18.9 hours as an average length of hospital stay (Ana Langer, et al, 1999). However, because the client log book did not record time of admission and time of discharge, it was not possible to estimate length of health facility stay in hours although there was a clear instruction that it should be recorded.

7.0 POLICY ENVIRONMENT FOR PAC

Abortion complications being a major problem in Nepal and some 20% to 27% of maternal deaths in hospitals is attributed to complication of abortion (MOH, Annual Report 2001/02), the government of Nepal made a concerted effort to address this grave situation by promulgating Safe Motherhood Policy 1996 (MOH, 1996). Postabortion Care Services were launched at the Maternity Hospital in Kathmandu as part of Safe Motherhood Program in May 1995.

Nepal has also made a critical policy decision by including PAC in national reproductive health guideline. The National Medical Standard for Reproductive Health 2001 has included Postabortion Contraception as its thirteenth Chapter for use by health cadres of all levels (MOH, August 2001).

8. ORGANIZATION OF PAC SERVICE

8.1 Role of the MOHP

PAC program is managed by the Family health Division under the Department of Health Services, Ministry of Health and Population. The FHD is primarily responsible for initiating program, collaborating with NGOs, INGOs, EDPs and the private sector. It monitors and collects program performance data periodically. It is responsible for implementing the PAC program from the centre to the district and below district level, i.e., up to PHCC level.

8.2 Levels of Service

According to the Annual Report (MOHP, 2006), government health service facilities of all types are 4,100 in number including 88 hospitals, 186 PHCC/HC and 3,826 HP/SHP. PAC service is available at hospital and PHCC levels but lower levels such as HP and SHP carry out EOC on safe motherhood and make referrals in case of pregnancy complications (MOH, 1998). By 2005/06 the coverage of PAC service through health institutions in the country was estimated at 26.3% of health facilities (**Table 8**).

Table 8 Distribution of government health institutions by ecological region and PAC service facility, 2005/06, Nepal

Region	Government Health Facility		PAC service facility available					Total PAC sites
	Hospitals	PHCC/HC	Govt Hosp	PHC C/HC	Zonal, SR, Mat, TUTH & Army Hospitals	Clinic	Pvt Hosp	
MOUNTAIN REGION	15	18	5	1	0	0	0	6
Percentage of health institutions with PAC service			33.3	5.6				18.2
HILL REGION	48	90	21	3	4	1	1	30
Percentage of health institutions with PAC service			43.8	3.3				21.7
TERAI REGION	25	78	11	18	9	0	4	42
Percentage of health institutions with PAC service			44.0	23.1				40.8
NEPAL	88	186	37	22	13	1	5	78
Institutions covered by PAC service			42.0	11.8				28.5
Total PAC service sites excluding 1 clinic & 5 private hospitals								72
Percentage of health institutions with PAC								26.3

SR=Sub Regional

TUTH=Tribhuvan University Teaching Hospital

Mat=Maternity Hospital

Pvt=Private, Govt=Government

Source: Health facility data from MOHP, 2006. Annual Report 2004/05 and PAC data from FHD, MOHP and NFHP, Personal Communication.

PAC service provision by ecological region is very uneven; among 15 district hospitals and 18 PHCCs, only 5 district hospitals and one PHCC are providing PAC service in the

Mountain Region. This means only 18.2% of health facilities in the Mountain Region provide OAC service. In the Hills, among the 48 hospitals, 21 of them provide PAC service and of the 90 PHCC/HCs only 3 provide PAC service. This implies that 21.7% of health facilities provide PAC service in the Hills. In the Terai 20 districts, of the 88 hospitals and 186 PHCC/HCs, 37 hospitals and 22 PHCC/HCs are providing PAC service. In other words, 28.5% of Terai located health facilities provide PAC service. It should be noted that if private facilities providing PAC service are excluded the estimated percentage coverage would be slightly lower.

The proportion of population living in districts having PAC services in Nepal is estimated at 81.9% (**Table 9**) and this varies a great deal between ecological regions. Only a little over a quarter of Mountain population has access to PAC service while nearly 71% of the Hills population does so. In the Terai, population living in any district has access to at least one or more PAC service center.

Table 9 Distribution of government health institutions by ecological region and PAC service facility, 2005/06, Nepal

Ecological Region	Population in Districts with PAC*	Population in Districts without PAC	Percentage of Population in Districts with PAC	% of Total Population
MOUNTAIN	495,552	1,346,676	26.9	7.2
HILL	8,001,229	3,298,333	70.8	44.0
TERAI	12,524,168	0	100.0	48.8
NEPAL	21,020,950	4,645,009	81.9	100.0

*Population data from MOHP. 2006. Annual Report 2004/05. Department of Health Services, Teku, Kathmandu.

Better estimates of PAC service coverage is given by **Table 11** where number of PAC clients served in 2005/06 is compared with number of spontaneous abortion estimates. The number of spontaneous abortions estimated to have taken place in Nepal in 2005/06 was 138,097 (**Table 10, column 4**) based on the worldwide indicator that 15% of all pregnancies end in spontaneous abortion and if survey data is used the total spontaneous abortions comes to 47,874 (**Table 10, column 5**).

Table 10 PAC service coverage for Nepal and its regions, 2005/06

REGION	Number of sites 2005/06	Number of PAC clients 2005/06	*Spontaneous abortions (15% of all pregnancies)	**Spontaneous abortions (5.2% of all pregnancies)	PAC Coverage for 15% Spontaneous Abortion Estimates (in %)	PAC Coverage for 5.2% Spontaneous Abortion Estimates (in %)
MOUNTAIN	6	13	11,532	3,998	0.11	0.33
HILL	42	1,970	66,701	23,123	3.16	9.13
TERAI	30	1,894	59,864	20,753	2.95	8.52
NEPAL	78	3,877	138,097	47,874	2.81	8.10

*Worldwide, at least 15% of all pregnancies end in spontaneous abortion (MOH, January 2005).

** In Nepal, 5.2% of all pregnancies were reported to have ended in spontaneous abortion in 2006 (MOHP, New ERA and Macro International Inc. 2007).

Overall, PAC coverage in Nepal was estimated at 2.81 percent of all spontaneous abortions using the worldwide indicator (15 percent of all pregnancies end in spontaneous abortion) but when the national indicator (5.2 percent pregnant women end in spontaneous abortion) is used it comes to 8.1 percent. Given the sensitivity in reporting abortion cases, it is very likely that these estimates are very conservative. For district wise estimates of PAC coverage please see **Appendix IV**.

The high Mountain region which has the highest burden of mortality measured in terms of u-5 mortality⁵, highest fertility level and lowest contraceptive prevalence (**Table 11**), has few PAC activities. However, it is good that the Terai region which appears to have second highest burden of mortality and high fertility has already been covered by PAC service.

Table 11 Mortality burden in terms of u-5 mortality, TFR and CPR by ecological region, Nepal 2001

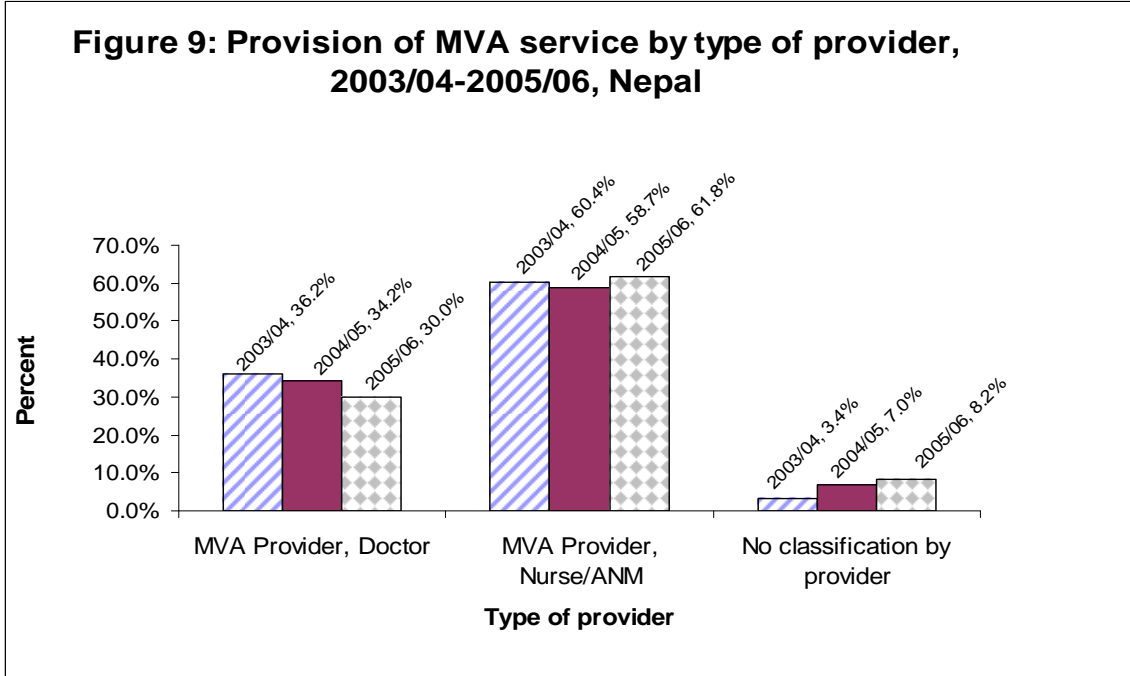
Ecological Zone	U-5MR (10-year period preceding the survey 2001)	TFR (3-year period preceding the survey 2001)	CPR (based on modern methods), 2001
Mountain	157.4	4.8	28.9
Hill	93.9	4.0	39.7
Terai	112.8	4.1	48.3
Nepal	126.2	4.1	43.6

Source: MOH (2002)

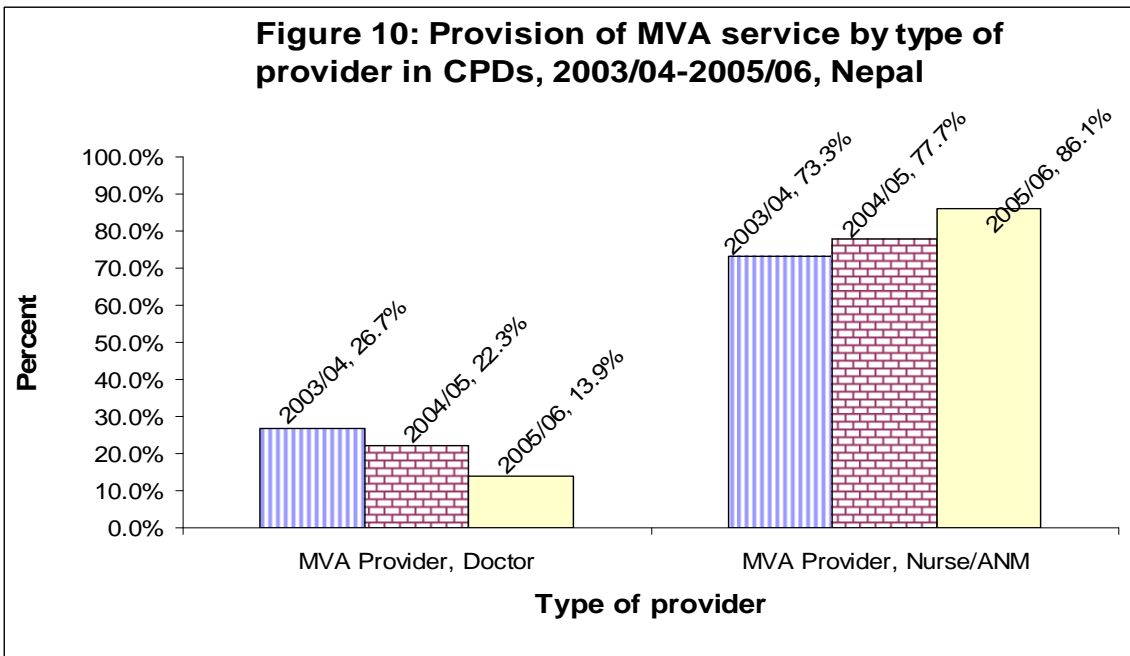
8.3 PAC Providers

A global review of PAC service shows that most countries have focused on physicians as PAC providers (Cobb, L. et al, 2001). In Nepal, however, ANMs, nurses, and doctors are trained in PAC/MVA. Training ANMs and nurses to perform MVA expands access to PAC beyond the availability of physicians in both urban and rural settings. In Nepal where 86.1 percent of the total population lives in rural areas (CBS and UNFPA, 2002) and physicians and nurses are hardly available providing training on PAC to paramedics ensures access to PAC service. Data from PAC sites show decentralized service provision of PAC as it is seen that in fiscal year 2003/04 the proportion of MVA treatment by nurse/ANM was 60.4 percent which slightly declined to 58.7 percent in the following year but again it increased to 61.8 percent in 2005/06 (**Figure 9**).

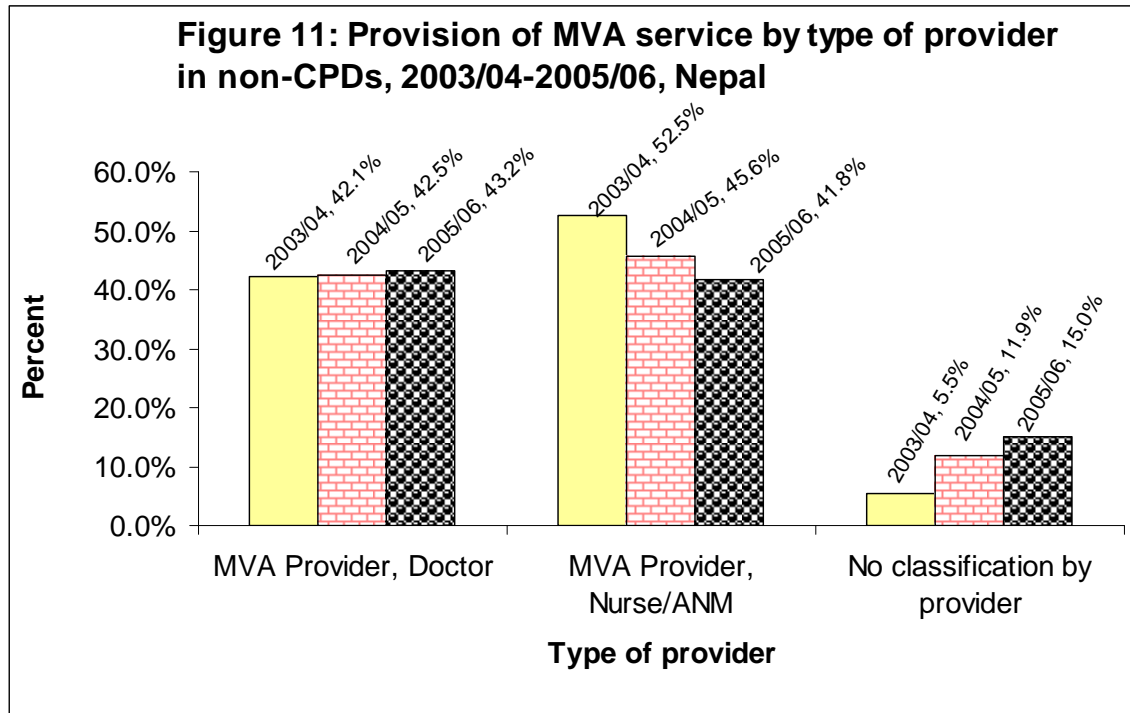
⁵ More appropriate measure would be maternal mortality but as this information is not available, u-5 mortality has been used instead.



Big difference is found between CPD areas and non-CPD areas with respect to provision of MVA services to PAC clients. In CPD areas, the share of nurses and ANMs as providers of MVA procedures was 73.3% in 2003/04 which increased to 77.7% in 2004/05 and further increased to 86.1% by 2005/06 (**Figure 10**). As a result, the proportion of doctors providing MVA procedures declined steadily from 26.7% in 2003/04 to 13.9% by 2005/06.



In contrast, the proportion of nurses/ANMs providing MVA procedures in non-CPD areas declined from 52.5% in 2003/04 to 41.8% by 2005/06 (**Figure 11**). Over the years, recording of MVA providers by type appears to have deteriorated because the proportion of MVA procedures with no classification of provider has increased from 5.5% in 2003/04 to 15% by 2005/06 (**Figure 11**).



9.0 ROLE OF TRAINING IN PROVIDING QUALITY PAC SERVICES

Training is the main aspect that needs to be considered in establishing high quality, comprehensive PAC services in any health facility. The training should be organized in such a way to offer service providers with the knowledge and skill to provide a comprehensive PAC service. A comprehensive PAC service includes the diagnosis of incomplete abortion, management of uncomplicated PAC cases on emergency and routine basis, dissemination of accurate information on MVA procedure, counseling for pre, intra and post MVA procedure, as well as family planning methods, and ability to link PAC with other RH care. This chapter is primarily focused on training curriculum, pre and in-service training, on-job-training, and issues of maintaining service providers' skills after training.

9.1 Curriculum

The training curriculum should provide the trainee with knowledge and skill on, initial assessment of client, provider attitude, initial history taking, FP/history/counseling, initial infection prevention, physical examination, client informed, MVA preparation, MVA procedure, evacuation examination, comfort ensured, post procedure care, and post procedure IP (**Table 12**).

Table 12 Essentials of PAC training

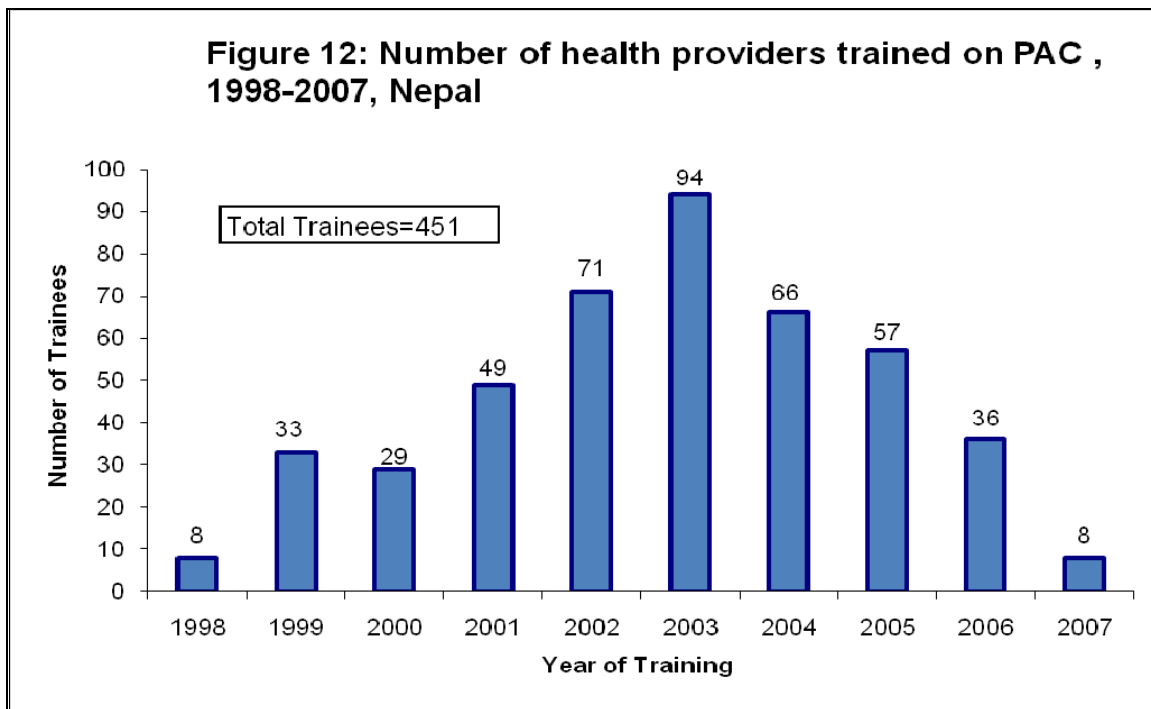
Training components	Competency score
Initial assessment of client	
Provider attitudes	
Initial history taking	
FP History/Counseling	
Initial infection prevention	
Physical examination	
Client informed	
MVA preparations	
MVA procedure	
Evacuation examination	
Comfort ensured	
Post-procedure care	
Post procedure IP	
Record keeping	
Client discharge	
Advise on discharge	

With USAID support the National Health Training Centre, Ministry of Health, has developed *Postabortion Care Course Handbook* both in Nepali and English (MOH, December 2002). Subsequently in 2004 the NHTC with USAID funding developed *Training Course Management Guidelines* to facilitate management needs of FP and PAC training (MOH, 2004). Furthermore, NHTC with funding from USAID developed and published *POSTABORTION CARE – A Reference Manual For Improving Quality Of Care* in 2005 (MOH, January 2005). These materials have greatly enhanced the quality of trainers as well as those of trainees.

9.2 PAC Training

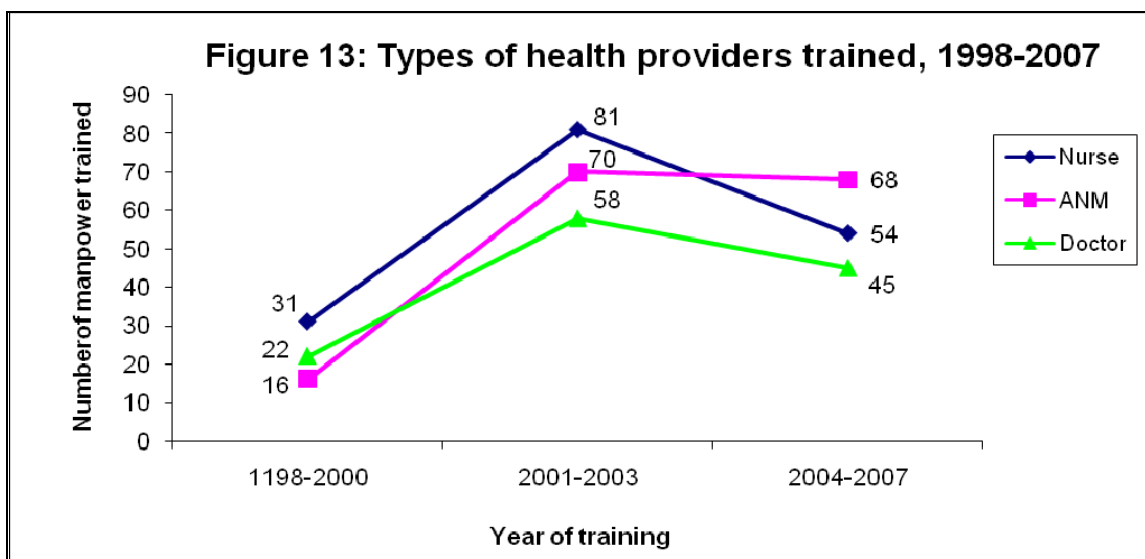
Maternity Hospital was the first PAC training site. There are 4 training sites; two in Central region (Maternity Hospital and Bharatpur Hospital), one in the Eastern (Koshi Zonal Hospital) and one Far Western regions (Seti Zonal Hospital).

Although medical doctors were trained on PAC earlier, the first batch of nurses was trained as PAC service providers from April 1999. Since fiscal year 20004/05, Senior ANMs are also trained as PAC service providers (senior ANM with 10 years experience in maternal health qualify for PAC training). The types of health providers trained include Doctor, matron, sister, staff nurse, public health nurse, senior ANM, ANM, HRDO, training officer, and program associate. Since 1998 to early 2007, in all, 451 health service providers have been trained on PAC; the number of personnel trained on PAC by year is shown in **Figure 12**.



The number of health persons trained started modestly in 1998 and steadily increased to peak in 2003 and thereafter it dropped gradually to a low level. This trend squares well with the establishment of PAC sites shown in **Figure 1** above.

Mainly three types of health service providers i.e. nurse, ANMs and doctors have been trained. Interestingly, in early days, nurses topped the list in getting training on PAC followed by doctors and ANMs but gradually this pattern changed to give way for ANMs (**Figure 13**).



Of the total 75 districts, health service providers from 55 districts have taken part in PAC training during the period from 1998-2007 (**Table 13**). Most health personnel trained on PAC come from Kathmandu district, followed by Morang in Eastern Terai, Chitwan in Central Terai, Jhapa in Eastern Terai, Kailali in Far-West, Rupandehi in Western Terai and so on.

Table 13 Number and percent of health service providers trained on PAC according to district, 1998-2007, Nepal

SN	Working district	No.	%	SN	Working district	No.	%	SN	Working district	No.	%
1	Kathmandu	93	20.6	21	Rautahat	7	1.6	41	Dang	2	0.4
2	Morang	25	5.5	22	Baglung	6	1.3	42	Parbat	2	0.4
3	Chitwan	19	4.2	23	Bara	6	1.3	43	Salyan	2	0.4
4	Jhapa	19	4.2	24	Mustang	5	1.1	44	Darchula	2	0.4
5	Kailali	18	4.0	25	Okhaldhunga	5	1.1	45	Gulmi	2	0.4
6	Rupandehi	17	3.8	26	Myagdi	5	1.1	46	Kaski	2	0.4
7	Lalitpur	14	3.1	27	Jumla	5	1.1	47	Bajura	2	0.4
8	Parsa	13	2.9	28	Dhading	4	0.9	48	Rasuwa	2	0.4
9	Nawalparasi	13	2.9	29	Ilam	4	0.9	49	Achham	1	0.2
10	Surkhet	12	2.7	30	Dailekh	4	0.9	50	Dhankuta	1	0.2
11	Banke	12	2.7	31	Nuwakot	4	0.9	51	Khotang	1	0.2
12	Siraha	11	2.4	32	Pyuthan	4	0.9	52	Dolpa	1	0.2
13	Kanchanpur	11	2.4	33	Bajhang	4	0.9	53	Sindhupalchok	1	0.2
14	Makwanpur	10	2.2	34	Baitadi	3	0.7	54	Sarlahi	1	0.2
15	Dhanusha	10	2.2	35	Humla	3	0.7	55	Taplejung	1	0.2
16	Bhaktapur	9	2.0	36	Gorkha	3	0.7		Total	441	97.8
17	Kavre	8	1.8	37	Dolakha	3	0.7		No information	10	2.2
18	Mahottari	8	1.8	38	Tanahun	2	0.4		Total	451	100
19	Sunsari	8	1.8	39	Kapilvastu	2	0.4				
20	Bardiya	7	1.6	40	Panchthar	2	0.4				

Central Development Region has the highest number of PAC trained health service providers and second highest numbers of trained providers are found in the Eastern Development Region (**Table 14**). By ecological belt, the Terai has the largest number of trained providers followed by the hill region and the Mountain region has only 29 health service providers trained on PAC.

Table 14 Number of health service providers trained on PAC according to development region and ecological belt, 1998-2007, Nepal

Development Region	Ecological Region			Total
	Mountain	Hill	Terai	
Eastern Development Region	1	13	63	77
Central Development Region	6	142	64	212
Western Development Region	5	22	32	59
Mid-Western Development Region	9	22	21	52
Far-Western Development Region	8	4	29	41
Total	29	203	209	441

NOTE: No information for 10 cases

As shown in **Table 15** below, most health service providers taking part in PAC training belonged to Bahun caste. Newar ranked second, Chhetri third, Thakuri fourth, Rai/Subba fifth, Gurung sixth, Magar seventh and so on. Also most health service providers were females.

Table 15 Number of health service providers trained on PAC according to caste/ethnicity, 1998-2007, Nepal

SN	Caste/Ethnicity	Sex			SN	Caste/Ethnicity	Sex		
		Male	Female	Total			Male	Female	Total
1	Bahun	34	135	169	13	Gupta	1	2	3
2	Newar	8	85	93	14	Terai Bahun	1	1	2
3	Chhetri	6	68	74	15	Thakali	0	1	1
4	Thakuri	4	16	20	16	Bengali	0	1	1
5	Rai/Subba	0	19	19	17	Muslem	1	0	1
6	Gurung	0	16	16	18	Bhujel	0	1	1
7	Magar	0	11	11	19	Kushwaha	0	1	1
8	Tharu/Mahato	4	6	10	20	Jirel	0	1	1
9	Yadav/Thakur	3	4	7	21	Dhimal	0	1	1
10	Lama/Tamang	0	6	6		No information	0	7	7
11	Dalit	0	4	4		Total	62	389	451
12	Giri	0	3	3					

Nearly 70% of all trainees were supported by the government to participate in PAC training and the second biggest proportion of trainees was supported by NGOs/INGOs (**Table 16**). The PAC Special Initiative program supported about 4 percent of trainees. OJT program is also supported by the government. Only one trainee from the private sector got training on PAC. It is also seen in **Table 16** that most health service providers got training at the Maternity Hospital in Kathmandu.

Table 16 Distribution of health service providers trained on PAC by support source and training site, 1998-2007, Nepal

Supported by	Training Site				Total
	Maternity hospital	Bharatpur hospital	Seti zonal hospital	Koshi zonal hospital	
Government	270	34	3	0	307
NGO	42	9	0	0	51
INGO	2	0	0	0	2
NFHP	6	0	0	0	6
Private	1	0	0	0	1
PAC SI	12	4	0	0	16
OJT	41	6	5	6	58
No information	10	0	0	0	10
Total	384	53	8	6	451

9.3 Opinions of Trained Service Providers on Training

Review of literature and observation of various levels of health facilities, pointed out that the mid-level health workers are ideal for PAC service provision in developing countries including Nepal. Several studies have shown that the mid-level practitioners such as ANM and midwives can perform MVA efficiently (Billings et al. 1999). They are more committed than physicians towards client-oriented service. In many PHCCs, such as Mangalbare, Mirchaiya and Dumkauli senior ANMs are performing MVA on emergency basis quite efficiently. They are providing 24-hour PAC service. Therefore, there should be a policy to include more senior ANMs in training instead of physicians in order to run 24-hour PAC service in remote areas of Nepal. When service providers were asked about the current duration and curriculum of PAC training course, individuals have various opinions.

“Six-day training session is enough for theory portion, but not to gain practical competency. When I was in training, for three days there was no single PAC case. Later on there were a few cases and we were six participants. I think refresher training should be organized.” (32-year old Senior ANM).

This shows that training should be in small groups ideally 6-8 participants. However, smaller group is not cost effective if caseload is small. On the other hand, in large groups, individuals might not gain competency. There should be a competency-based learning package.

Another staff nurse has different opinion:

“Six-day training is sufficient. We have been doing these services for many years; this training only added the skill to use MVA syringe, which anyone can learn easily.” (25-year old staff nurse)

One more staff nurse interviewed has interesting story to tell:

“PAC training is not only useful for particular PAC service, but it is far more important in changing attitude of RH service provider. Before training I used to hate PAC cases. I had a feeling that they are getting punishment for wrongdoing. I never treated them well. But after training I am totally changed. I treat them as a sufferer but not a culprit.” (34-year old staff nurse)

Experience of Koshi zonal hospital shows that the training has to emphasize essentials of adult learning principles, including participatory learning techniques and focus on skill building, as it can be pre-service, in-service, or in-job-training.

9.4 In-service and Pre-service Training

In-service training is recommended to train service providers in most developing countries. However, international donors as well as ministries of health and education personnel are becoming increasingly aware that in-service training may not be the most cost-effective or efficient way of providing basic RH education and training, especially for clinical procedures. Bringing providers to an in-service course incurs financial costs (training room rental, travel, food/lodging, etc.) and disrupts service provision (providers are required to take temporary leave from their posts to participate in training). Also, providers’ motivation to learn the skills being taught may be lacking.

On the other hand, in the context of fast growing medical and nursing campuses a pre-service training program could be a good option of producing a large number of trained PAC service providers. In the beginning, it might appear costly. However, once established, it can reach a relatively large number of providers at one time. One concern could be of the competency of these newly trained inexperienced medical personnel. These issues and the high cost of developing a PAC pre-service training have been addressed through the use of an on-the-job training (OJT) system.

9.5 On-the-Job Training (OJT)

Maternity Hospital is the only training site for group-based PAC training. However, there is high demand for the training and the capacity is limited. It was thought that by decentralizing training, this demand could be met to a great extent. The nature of decentralization in training could be found in the OJT approach. OJT is the approach that addresses the constraints of group-based training. An OJT approach focuses on training in home institute of the participant. This can be a good strategy as it provides a familiar environment, participants can continue attending training programme without compromising their professional and household duty; it is cost effective, and the participant as well the institute has the feeling of ownership. OJT provides an opportunity with minimal support and reduces movement of staff for training (absenteeism)

OJT program for PAC is a consensus building approach and it helps NHTC, FHD and Training Site to identify their roles and responsibilities because it involves joint planning for initiation of piloting, implementation and monitoring. Some materials are developed locally and as it is the outcome of local commitment it is sustainable. OJT is the best method in countries where there is acute shortage of manpower. The only disadvantage could be the time factor. It might take longer time to achieve competency.

OJT was piloted at Maternity Hospital in FY 2002/03 and expanded to Bharatpur hospital in FY 2003/04, Koshi zonal hospital in FY 04/05 and Seti zonal hospital in FY 05/06. Under OJT, 58 service providers have already been trained (see **Table 17**) in four training centers. OJT was gradually introduced in the centers outside of Kathmandu since 2003/04.

Table 17 Distribution of health service providers trained on PAC by training site and type of providers, 2002/03-2007/08, Nepal

Year	Training site	Type of health service providers trained, 2002/03-2007/08			Total
		Nurse	ANM	Doctor	
2002/03	Maternity hospital	2		2	4
2003/04	Maternity hospital	1		3	4
	Bharatpur hospital	1		1	2
2004/05	Maternity hospital	2		8	10
	Bharatpur hospital	2		0	2
	Koshi zonal hospital	1		1	2
2005/06	Maternity hospital	1	0	1	2
	Bharatpur hospital	2	0	0	2
	Seti zonal hospital	2	0	1	3
	Koshi zonal hospital	1	1	0	2
2006/07	Maternity hospital	2		15	17
2007/08	Maternity hospital	2		2	4
	Seti zonal hospital	2		0	2
	Koshi zonal hospital	2		0	2
Grand total		23	1	34	58

9.6 Issues in Training

Refresher training is essential for maintaining and upgrading service providers' skills after training. Constraints in trainings include the sponsoring donors, political instability, and lack of adequate trainers. In some instances, training has to be continued with minimum number of participants, as donors do not want to sponsor more than two or three participants at a time. In the past few years in Nepal because of political instability, training programs had to be postponed many times or participants could not reach the training sites on time. Even if the participants reached the site, they would be trapped for many days after the complication of training. Similarly, a limited number of trainers make it impossible to provide trainers in shift wise duty. Many times, the trainees have to continue their clinical part without trainers' guidance.

10.0 SETTING QUALITY STANDARDS FOR PAC IN NEPAL

10.1 Facility Perspectives on Quality of Care

The quality of PAC service primarily depends on the nature and quality of standards and protocols for the service delivery. Standards and protocols are operational directives that enable health professionals to plan, manage, deliver and monitor services at a consistent level of quality. Ideally a comprehensive national health policy is the starting point for developing service delivery standards. The national policy determines what should be available to support specific health objectives, and these standards dictate the service delivery procedures where who provides services, with what skills and supplies. Unfortunately, yet there is no national PAC policy in Nepal.

The hospital in-charges and PAC coordinators of all the centers visited has no idea on inventory and control and maintenance mechanism (**Table 18**). However, so far, for all the centers observed, there was no problem of supplies, medicine, and equipments. Equipments observed were in good condition except in Koshi hospital where all four MVA syringes were out of order i.e. unable to create and maintain vacuum.

Table 18 Assessment of standards and protocols for the quality of supplies, medicines, and equipments

Variable	Regional/zonal hospital	District hospital	Primary health center
Inventory control and maintenance	No policy	No policy	No policy
Current status of existing resources	Excellent	Excellent	Excellent
Quality of equipment and supplies	Good	Good	Good
Quantity of equipment and supplies	Adequate	Adequate	Adequate

Infection prevention was excellent at all the centers observed (**Table 19**). However, there were indications that most of the PAC providers were not using pain management appropriately (including use of local anesthesia and analgesics). Only few providers were using oral analgesics. Service hours differ in various centers. Amazingly all the PHCC observed except Itahari, were providing 24-hour services. In contrast, at the higher level centers, such as Gandaki regional and Koshi zonal hospitals, PAC service was available only on fixed hours except for dire emergency cases, like patient in shock or heavy bleeding. In Myagdi district hospital, there was a provision of 24-hour service.

Record keeping was generally incomplete at all the facilities observed, making it difficult to establish reliable statistics. There was no admission time recorded nor discharge time. In some centers, for example, Gandaki regional hospital, for all the PAC cases height of uterus recorded was corresponding to the period of gestation which led to raise doubt on data quality. It was also observed that record keeping was more reliable and complete, including pre and post procedure vitals in PHCCs especially in Mangalbare and Dumkauli.

PAC area set up was satisfactory especially at higher level facilities (**Table 19**). However, PHCC and district hospitals were also not bad in set up compared to the

available physical resources. In each facility there was an MVA procedure room, instrument processing room, pre and postoperative waiting and recovery room and toilet. There was provision of procedure room, waiting beds, toilets and waiting halls. These units were in a complex of maternity or female ward.

Table 19 Assessment of service organization

<u>Services observed</u>	<u>Regional/zonal hospital</u>	<u>District hospital</u>	<u>Primary health center</u>
Infection prevention	Excellent	Excellent	Excellent
Pain management	Not done	Not done	Not done
Service hours	Fixed except for dire emergencies	Fixed as well as-24 hours	24-hours
Record keeping	Incomplete	Incomplete	Incomplete
PAC area set up	Good	Good	Good
Reporting and monitoring system	Inefficient	Inefficient	Inefficient
Referred cases	Received from DH/PHCC	To R/Zonal hospital/M. Stopes	To DH/M. Stopes/FP
Linkage with other RH services	Good	Good	Inadequate
Community involvement	No	No	Yes

Government has put in place PAC reporting and monitoring system, however from the field visit it was found that some of the PAC sites were not recording and reporting PAC service data regularly.

Referrals were received in regional hospitals from district hospitals, PHCC, Marie Stopes and Family Planning Association of Nepal. Family planning services were efficient at all the centers visited; however, there is a need to make improvements in linking PAC service with other RH services, especially at PHCC level.

Community involvement was better at PHCC level compared to the higher level centers. The local people are educated about the availability of PAC service in three ways. PHCC Management Committee members tell their fellow villagers about the availability of PAC service, ANMs conduct group education on health particularly safe motherhood including PAC to women who visit the health facility for ante natal care and FCHVs educate local women about PAC service. This is done in some district hospitals too.

10.2 Provider Perspectives on Quality of Care

Provider perspective on quality of care was assessed focusing on care components such as information and counseling, appropriate technology used, and providers' competency (**Table 20**). Women seeking PAC service need to know about the procedures available, where to get service, who would be the provider, what are the side effects, signs of incomplete abortion, and place for follow-up care. Manual vacuum aspiration is the most commonly used procedure for emergency care for incomplete induced or spontaneous abortion. MVA can be used to treat incomplete abortion up to 12 weeks gestation. MVA can be performed on an outpatient basis using local anesthesia or only verbocane. In Gandaki regional hospital, many clients eligible for MVA were taken to operation theater

instead of MVA, as a result, clients were not receiving essential components of PAC such as FP counseling and methods or RH referral services. In other centers where PAC service providers were staff nurses or senior ANMs, all PAC clients were managed with MVA in PAC unit itself, making it easier to link with other essential PAC service package.

Table 20 Appropriate technology used

<u>Procedures</u>	<u>MVA</u>	<u>D&C</u>	<u>Pre, intra, and post PAC counseling</u>
Physician	Mostly used	Seldom used	Good
Staff nurse	Used	Never used	Excellent
ANM	Used	Never used	Not observed

Provision of appropriate information about PAC technologies is the most important component of quality PAC service. However, the physician although knew the importance of information and counseling, hardly spent time to explain procedure, or answer clients' queries as they have other responsibilities pending. Physicians were not following 27-step criteria of MVA procedure; however, most of the nurse providers were thoroughly following 27-step criteria (**Table 21**).

Table 21 Competency of service provider

<u>Procedures</u>	<u>Physicians</u>	<u>Staff nurses</u>	<u>ANMs</u>
Information and counseling	Inadequate	Excellent	Not observed
Technical performance 27 steps criteria (Scores range from 8 to 24)	8-21	16-24	Not observed

11.0 COST OF INTRODUCING AND MAINTAINING PAC SERVICE

11.1 Needs Assessment Costs

Prior to introducing PAC service in a health facility the FHD/NFHP conducts needs assessment. A Needs Assessment questionnaire (see **Appendix V** for details) is administered to the providers at the facility. Information collected through the form include

- location of facility,
- contact phones,
- types of reproductive health services available,
- client flow,
- blood bank facility,
- case fatality data,
- types of providers,
- types of PAC procedures,
- duration of stay of PAC client at facility,
- cost of procedure (MVA or D&C),
- availability of nearby facility in case of emergency,
- counseling,
- FP services,
- quality of service provision area,
- types of equipment at facility,
- training needs of providers, and
- presence of INGOs/NGOs supporting RH services

According to the FHD and NFHP the needs assessment costs is approximately Rs.11,200/- per PAC site excluding project staff time. As of 2005/06, there were 78 PAC sites which were assessed prior to starting PAC service. Of them USAID supported 57 and the rest were supported by non-USAID organizations. Total costs of conducting Needs Assessment were estimated at Rs.873,600/- for 78 sites.

11.2 Facility Renovation/Upgrading Costs

Depending on the information provided in needs assessment certain facilities need to renovate or upgrade physical facilities which also entails costs. Types of facility upgrading items include but not limited to, cupboards, screens, lights, tables, etc. and transportation cost/porter, vehicle fuel (travel expenses by road). Experience shows that costs of upgrading a facility for establishing PAC service centre are about Rs.92,196/-. For all PAC sites the estimated investment comes to Rs.7,191,288/-.

11.3 Costs of Supply of Materials/Drugs

Part of needs assessment also includes finding out about the types of equipment and materials needed for starting PAC service in a new site. Also some basic drugs are

needed. Initial costs of supply of materials/equipment and drugs needed to run the facility need to be estimated.

It is reported that one MVA set with cannula can last to provide services to about 100 clients. The main equipment needed for a new facility are Momo-cooker, strainer and PAC instrument and per facility the costs of purchasing them is estimated at Rs.61,980/per site. Total investment made so far for equipment comes to Rs.4,834,440/- for 78 sites.

11.4 Costs of Training and Orientation to Human Resources

PAC service needs a gynecologist or a medical doctor to perform D&C who are trained in PAC procedures. For MVA a nurse or a senior ANM if trained can perform it. In addition, one trained ANM assistant is needed. Orientation is given to Social Mobilizers too. Costs of training of providers and PAC program orientation to Social Mobilizers for all 78 sites comes to Rs.1,497,600/-.

11.5 PAC Service Monitoring, Maintenance and Continuity Costs

After equipping a PAC service site with appropriate equipment and providing orientation and training to the human resources, the PAC service begins but it is not left as it is. FHD and NFHP staff do periodic follow-up and monitoring activities. For this a form has been developed which collects relevant information every quarter (see **Appendix VI** for details).

At PAC service site records are maintained for every client receiving PAC service. This logbook was found maintained in most sites but the recorded data were not complete. Particularly missing information included time of admission and time of discharge. Although the instruction to fill the form clearly mentioned about these two variables, nobody recorded them. One of the providers said that the logbook did not have a column to record times of admission and discharge. The study team has improved the logbook and suggests that this be implemented as early as possible (see **Appendix VII**).

PAC service is also evaluated by making field visits and collecting information on client flow, competency of human resources and supplies and equipment are checked. For this a competency check list has been developed (see **Appendix VIII** for details).

Every quarter FHD and NFHP staff collect PAC service statistics and compile them at the Centre in Kathmandu. In this, monthly data are recorded for number of MVA and D&C procedures performed at a facility. Data also include FP acceptors by type of method accepted following PAC procedures and type of provider performing PAC service either doctor or nurse or ANM. For details of the type of information compiled see **Appendix IX**).

In addition, yearly summary progress report called PAC Progress Report is completed for every PAC facility. This provides summary PAC service statistics by month; types of

PAC procedures are specified and FP acceptors are recorded. For details on this format please see **Appendix X**.

11.6 PAC Service Charges

In all PAC sites, the ones that were visited by consultants, fees are charged for PAC service (**Table 22**). However, it appears that except for big hospitals, the money raised thus is not very profitable. The Koshi zonal hospital, however, makes a substantial amount of money – about Rs.200,000/- every year. Other big hospitals have not been studied but it appears that big hospitals can contribute to smaller health facilities.

Table 22 Fees charged to PAC clients and incentives distributed to staff, Nepal

PAC site	Charge	Incentives					Savings/Profit per client	Case load
	Rs.	Dr.	Nurse	ANM	Peon	Total		
Dumkauli, PHCC	1000	250	100	100	50	500	500	In 2 years 5 months 24 cases, on 14th Jan 2007 they revised the charge to Rs.750/-.
Manohari, PHCC	250		70		30	100	150	Began in 2005/06, 2 cases in 8 months in 2006/07
Myagdi district hospital	200	0	0	0	0	0	200	In 2 and half years only 34 cases
Gandaki Sub Regional Hospital	300	0	0	0	0	0	300	In 3 and half years 274 cases
Koshi Zonal Hospital	600	0	0	0	0	0	600	In 3 years 906 cases
Mangalbare, PHCC	500		100	25		125	375	In 2 years and 3 months 67 cases
Itahari, PHCC	500	0	0	0	0	0	500	5 cases in 2005/06 and this fiscal year only 6 cases
Siraha District Hospital	500	0	0	0	0	0	500	15 cases since 2003/04, no cases this fiscal year
Mirchaiya PHCC	500		100	100	50	250	250	In 2 years 31 cases

11.7 Net Savings and Cost-effective Model

Invariably in most hospitals wherever a doctor is present the PAC procedures are performed by the doctor. Except Maternity hospital in Kathmandu, Koshi zonal hospital and Mangalbare PHCC, in all other hospitals the consultants visited, doctor was taking the lead in performing PAC procedures. The “doctor attitude” was very much dominant. However, looking at the costs of provider models of three types namely, model 1 comprising of a Doctor as Provider, Nurse as Assistant and Peon/Cleaner as assistant for manual work; model 2 comprising of a Nurse as Provider, ANM as Assistant and Peon/Cleaner as assistant for manual work; and model 3 comprising of a Senior ANM as Provider, ANM as Assistant and Peon/Cleaner as assistant for manual work, it was found that model 3 was most cost-effective. This was arrived at by using time use data for PAC service by the providers and their commensurate salaries/wages they make.

Using client flow data, fees charged per client, and time use data of provider and assistants, savings by 9 PAC sites are estimated and shown in **Table 23**. Column 2 shows the current composition of human resources providing PAC service. For instance, in Dumkauli PHC, doctor is the main provider and he is assisted by a nurse and a peon. This is called model 1. In Manohari PHCC, Senior ANM is the PAC provider and she is assisted by another ANM and a peon and this is model 3. In the remaining sites doctor is the provider, nurse is an assistant and peon is a helper and this is called model 2.

Table 23 Cost estimates per PAC client using three types of provider models

PAC site	Current model	Providers' charge per client (existing)	Costs of utilities per year	Main tenance costs	Net Savings/profit per year based on model 1	Net Savings/profit per year based on model 2	Net Savings/profit per year based on model 3
Dumkauli, PHCC	Model 1	157.4	1,800	1,200	5,368	5,662	5,747
Manohari, PHCC	Model 3	119.2	1,800	1,200	(2,738)	(2,756)	(2,738)
Myagdi district hospital	Model 1	157.4	1,800	1,200	(2,421)	(2,018)	(1,901)
Gandaki Sub Regional Hospital	Model 1	157.4	1,800	1,200	8,162	10,484	11,154
Koshi Zonal Hospital	Model 2	127.8	1,800	1,200	139,616	139,616	142,203
Mangalbare, PHCC	Model 2	127.8	1,800	1,200	8,084	8,084	8,340
Itahari, PHCC	Model 2	127.8	1,800	1,200	(543)	(543)	(487)
Siraha District Hospital	Model 2	127.8	1,800	1,200	(518)	(518)	(461)
Mirchaiya PHCC	Model 2	127.8	1,800	1,200	2,770	2,770	2,902

Column three of **Table 23** shows costs incurred for human resources for performing PAC procedures per client. Obviously, model 3 is the cheapest and model 1 is the most expensive, of all models. Column 4 shows costs of utilities such as water, gas, electricity, etc. When asked, the providers in different sites said that utilities are not expensive. Similarly costs of maintenance such as painting once in a while, keeping the premises clean; etc was reported to be not very expensive. Besides, they said that these costs are borne by the facility in any case.

As mentioned earlier, savings was the highest in Koshi zonal hospital where model 2 is found operating. Of course, higher the client flow higher the savings. Although Manohari PHCC model is the cheapest one, the net savings was found negative but this is because this PAC centre started only recently. Interviews with the staff indicated that the potential was high. Also it should be noted that these savings do not take into account the initial investments made in terms of training, equipment costs and other start-up costs.

Analysis of costs data and client flow suggest that it takes more than three years for a well functioning PAC centre to elevate to the position of profit. It appears that Koshi zonal hospital is at that level now. However, given that the coverage is low to date, the expansion of PAC service has a big potential.

11.8 Projected Costs of Scaling up PAC Service to National Level

In order to establish PAC sites in 78 health facilities in the country, the government of Nepal with support from USAID and other donors has already made invest worth Rs. 16,001,076/- (**Table 24**). Using the current costs, the future costs are estimated for establishing PAC sites in the remaining district hospitals and PHCCs. The current costs have been inflated by 10 percent to account for inflation. The future need is enormous. Still 51 district hospitals and 166 PHCCs/HCs need to establish PAC sites in the country. The Director of FHD, DOHS, MOHP, has a plan in mind to expand the PAC service throughout the country in the next three years. Although this idea has to be translated into a plan, it is evident that Nepal needs to explore for additional Rs. 48,967,395/- to materialize this plan (**Table 24**).

Table 24 Current and future investments in PAC services in Nepal

Type activity	Investments made in existing sites				Future needs	
	Unit Cost Rs.	Number of USAID supported sites	Number of non-USAID supported sites	Investments made Rs.	Additional sites to support*	Additional investment needed Rs.
Cost of conducting Needs Assessment (Rs.)	11,200	57	21	873,600	217	2,673,440
Cost of upgrading PAC site (Rs.)	92,196	57	21	7,191,288	217	22,007,185
Training of providers and PAC program orientation to Social Mobilizer	19,200	57	21	1,497,600	217	4,583,040
PAC equipment	61,980	57	21	4,834,440	217	14,794,626
FP Commodities (not costed)						
Technical support and monitoring	20,566	57	21	1,604,148	217	4,909,104
Total	205,142			16,001,076		48,967,395

*Additional sites include 51 district hospitals and 166 PHCCs/HCs.

12.0 COMPREHENSIVE ABORTION CARE (CAC) AND PAC

In March 2002, Nepal's Parliament approved a bill amending the law to permit abortion on request during the first 12 weeks of pregnancy for any reason, up to 18 weeks of pregnancy in case of rape or incest and at any time if there is a risk to the woman's life or mental or physical health, or the fetus is deformed.

According to a recent report, the number of abortion clinics operating in the country with government license is 155 (Gorkhapatra, March 7, 2007). Of them, about half are run by government and the remaining clinics are run by NGOs. The FPAN and Marie Stopes International or Sunaulo Pariwar are the main NGOs conducting abortion services.

Government policy is to support both PAC and CAC services to promote Safe Motherhood program. USAID fund prohibits support to CAC. Since legalization of abortion in Nepal, NFHP/FHD utilizing USAID funds has been orienting service providers and the community leaders on Helms Amendment and Mexico City Clause which lay down that PAC service facility must not be used for CAC service. This type of orientation is conducted every time a new PAC service site is established.

There are different views among health professionals with respect to setting up of CAC and PAC services in one health facility. Some say since equipment and manpower are similar for both services it would be cost-effective and prompt to have both services in one room. This is so because

- a) Both facilities are similar;
- b) Skill required to perform these services are similar;
- c) A nurse can perform both services;
- d) Government policy allows a nurse to perform both CAC and PAC services
- e) Both procedures are carried out on a day
- f) Both procedures call for FP counseling
- g) FP methods of client choice can be made available right there
- h) PAC case load is usually low; therefore CAC services would make it well-utilized

Others do not agree and say CAC and PAC services should be kept separately. According to a medical doctor women go for abortion for a different reason.

“CAC service is for a woman who wants to terminate her unwanted pregnancy. Some time ago abortion was illegal and women were afraid of abortion but now it is legal and the government has opened abortion service centers in various places”. (A medical doctor)

Program managers think that CAC and PAC services should not be provided from one room because the clients are different.

“The conditions of PAC and CAC clients are different. CAC client has strong will power and has decided to terminate her pregnancy. A CAC client faces relatively few complications but a PAC client seeks service because of unexpected situation, i.e., spontaneous abortion or miscarriage; she may also have incomplete abortion or sepsis which can be seriously dangerous to the health of the woman. Therefore,

different care and support need to be given to CAC and PAC clients”. (A PAC service manager)

Overall, it appears that CAC and PAC services should be established and developed separately because PAC and CAC clients are different.

13.0 DISCUSSION, SUSTAINABILITY AND SCALING-UP

Global review of postabortion care reveals that Nepal was one of the first countries in the world in introducing postabortion care as early as 1995 (Cobb, L. et al, 2001) and since then this service has been extended to 78 sites in the country. Apparently, most are functioning and about one in four sites are not completing project reports on time and three sites (one hospital and two PHCCs) are not functioning because of the shortage of provider. Overall, therefore, in a health facility where PAC has been started, this service is well taken.

The government of Nepal is committed to scale up the PAC service at the national level. It is evident from the assurance from the Director of FHD, MOHP which states:

“PAC service saves women from life threatening risks and we should aim at bring this service to the grassroots level. The government of Nepal takes the view that PAC should be expanded to all PHCCs, i.e., 188, in the country where there is infrastructure and human resources. The long term goal of the government is to expand it to the Health Post level (697 HPs in all) so that it really reaches the grassroots; at the HP there are ANMs who can be trained to become PAC providers.” (Director, FHD, MOHP).

As shown in **Table 8** above, PAC service covers about 26% of all government health institutions; 42% district hospitals and 11.8% PHCCs. Nevertheless, the government is planning to cover all district hospitals and PHCCs in the next three years.

“We are planning to expand PAC to cover all district hospitals and PHCC in the next three years but the challenge is that the trained human resources are transferred to the centers where they are not appropriate. This is an ongoing problem but still we are determined to go up to PHCC level.” (Director, FHD, MOHP).

With respect to budgets for PAC services, the government has begun to allocate funds to this area as well only recently.

“From this fiscal year we have allocated government budget for MVA service which was not there in the past. It is a humble beginning.” (Director, FHD, MOHP).

However, the government does not rule out external technical and financial support to expand and improve PAC service in the country.

“We need extra help. We need support in training and equipment to start new PAC services in new sites.” (Director, FHD, MOHP).

The Government is thinking of start-up costs while the centers that have already begun providing PAC services are quite confident that they can sustain the program even after the external support is pulled out.

“Sustainability is not a problem. We can manage basic expenses. The only problem is that of trained manpower because when trained staffs are transferred to another hospital the service will be affected.” (Medical Superintendent, Zonal Hospital).

The postabortion care service has made significant achievements, especially at the PHCC level, compared to other RH programs. Despite this success, many problems remain in achieving the highest desirable service at all levels of health facilities. A major problem is that the current guidelines do not provide appropriate information on PAC service. The guidelines of PAC service have to provide the details of how and by whom the services are to be managed and delivered. Therefore, PAC services in Nepal would be effective if a national strategy on quality PAC service is prepared. A sound strategy can establish the groundwork for future expansion efforts. Although, currently, there was no problem in supplies, however, when donors withdraw their support, a situation can arise where there is shortage of supplies and equipments. Policies for supplies and storages need to be reviewed for sustainability. Inventory control and maintenance for accessing supplies should be elucidated so that supplies are available to providers at all times. Most importantly, PAC service hours are extremely limited. This was because of shortage of trained manpower. To address shortage of manpower, use of mid-level providers (senior ANMs) can be an important means. Mid-level providers are committed and can use MVA successfully.

“We have no problem in doing PAC cases at any time. I live in a government house within the hospital compound, so I have no problem in night as well. Moreover, it takes few minutes and the women will be free from problem”. (30-year senior ANM)

More mid-level providers should be trained to ensure a trained PAC provider regularly on duty. Instead of physicians, more nurses need to be trained to become the primary providers for routine PAC cases. Physicians were found to be overconfident and uncooperative towards the national programme.

“Why should I have to show how I am managing PAC cases? Why should I have to take this training? I am a gynecologist and such procedures are taught as a part early from the MBBS course” (28-year old Physician)

As it is proven that senior ANMs are efficient PAC providers, more ANMs should be trained. Firstly, because the Ministry of Health and Population has considerable number of ANMs, secondly, the ANMs are usually not migrating abroad. Thirdly, ANMs are not involved in many training programs which take away service time, as is the case with

staff nurse and fourthly, senior ANM, junior ANM and peon/helper model is most cost-effective as shown earlier. There should be a policy that if a trained manpower is transferred from a certain facility, he/she should be replaced immediately with another trained manpower.

Relationships between physicians and nurses were harmonious in most of the centers, except in some places where nurses were supposed to follow physician's order, but not the provider. For instance, it was found that nurses were themselves not confident to fulfill their duties as PAC providers.

"I don't want to do PAC case because it might be a complicated case and if it is a problem I will have to call the physician". (35-Year old staff nurse)

PAC units of higher level facilities are not fully utilized; clients are taken to the operation theater on a routine basis. This shows that clear guidelines are needed with regard to criteria for MVA or D&C and out-of-service hour emergency services.

The importance of record keeping should be emphasized through constant follow up and supervision. Providers should be provided with a one-day record keeping session, with concept of proper format and importance of keeping records. Facilitated supervisory visits are required on a regular basis. It is important that the providers understand the value of keeping good records and their use in constantly improving the services for the benefit of the clients. This should eventually lead to record keeping in all service sites.

Community commitment is the integral part of PAC service. It was observed that the health facilities with good community linkages are doing well in comparison to the facilities that did not acknowledge community as a powerful catalyst for a quality PAC service. One of the reasons for PAC service not successful up to the expectation in Gandaki zonal hospital is the lack of community linkages. Facility management committee comprising of facility manager/staff and local stakeholders should become the norm. In some lower level facilities this was found but not in district or higher level hospitals. The Committee should meet regularly to update on the PAC service in the facility. The Committee can be the starting point for community mobilization for PAC service promotion.

Closely related to this aspect is the lack of promotional activities for PAC service. Virtually no promotional material or program is available on PAC. FHD should perhaps make some collaboration with the NHEICC to engage in promoting PAC service in the country.

Although in theory almost all providers mentioned about the availability of 24-hour service but in practice this was not found so. There were several reasons for this. Firstly, in several sites trained provider was not available 24-hours. Secondly, in sites where physician was providing this service he/she would usually be available only during regular service hours say from 10 am to 2 pm. thirdly, most interviewees said that even if a client visits the site during off-time, she is asked to wait until the next day. Fourthly, in some sites provider keeps the key to the service room and does not let other providers to

open the service room. In several sites, this has made the service untrustworthy. Surprisingly, this was the case in two sites the team visited. This means that the facilities are not serious about the value of 24-hour service.

In several sites, it was also found that service hampered because either the regular provider retired and she was not replaced immediately by another provider or regular provider was on long leave and alternative arrangement was not made. In these sites client flow drastically declined. Although the local staff argued that private facilities attracted clients from their sites causing reduction in client flow, this argument was not strong because decline in client flow was due to the lack of continued presence of trusted providers.

In order to improve the trained manpower situation, the government has introduced on-the-job-training in several PAC service centers. It is a paradoxical proposition because OJT can only take place in big centers where general client flow is high but high case load also becomes an obstacle to OJT. This has exactly been experienced by a nurse provider in a hospital in East Nepal. She finds it difficult to manage time for both increasing number of clients and OJT trainees. In addition she says the way OJT is managed needs some improvements to attract more nurses or ANMs for OJT.

The solution to reduce manpower shortage for PAC service should include more training to more health providers and improve upon the OJT. More trained providers in a site means that even if someone is transferred or retire or takes a long leave, someone else will be there to continue the PAC service.

The government at the Centre needs to formulate policies and programs to improve PAC service in big hospitals. The study team got the impression that negligence to PAC service is high in big centers. Instead of arguing that clients are attracted to private or INGO clinics, these hospitals should be able to capitalize on what they are famous for, such as big gynecological service; large facilities etc and improve PAC service to attract increasing number of clients. Also in big facilities a patient can enjoy several services without having to go to other places.

The study team observed that providers in PAC service sites were not very much focused on clients. Post-procedure counseling was not found good enough let alone pre-procedure counseling. Although data showed increasing number of clients accepting MVA procedures, nearly one in four clients did not have any information on FP acceptance. The program should aim at reducing this information gap. Emphasis should be put on counseling clients at the facility; apparently client-provider-interaction needs to be strengthened.

Since the legalization of abortion in Nepal, some providers hold the view that PAC has no place now. However, this is totally wrong as data show that some 15% of all pregnancies end in spontaneous abortions that need help through PAC procedures. In addition, as not all abortion procedures end in complete success, some women need PAC service after abortion complications. Increasing number of abortions can also contribute to cases that need PAC service.

Another important issue is about the place (room) where PAC service is provided. In the world of health professionals, opinions vary with respect to whether CAC and PAC services should be provided from the same room or from separate ones. NFHP has convinced the government not to utilize the fund provided for PAC services for CAC services. The PAC service sites established with USAID fund have maintained this requirement however sites established by other stakeholders have not been following this requirement. The study team saw a hospital where both CAC and PAC services were provided from the same room. The site was established by other stakeholder working in the field of Safe Motherhood. The government is silent on this issue.

14.0 RECOMMENDATIONS

Policy

The government of Nepal has a policy to provide PAC service but it is not clear with respect to facility development and supplies. Therefore the government needs to formulate a national policy on PAC to ensure that:

- PAC is gradually expanded to all government hospitals, Health Centers and PHCCs;
- PAC facility is developed separately in a center with clear reasons;
- Supply of equipment is uninterrupted;
- PAC trained service provider is available all the time;
- PAC service is linked to other reproductive health services;
- A policy is in place for inventory control and maintenance and
- FP counseling skills are continuously improved and supply of an array of FP methods uninterrupted.

24-hour service

It must be ensured that all PAC facilities provide 24-hour service. It should be taken as a part of Safe Motherhood service.

Logbook

All PAC service sites should maintain a logbook that captures information on age, date and time of admission, address, gestational age, general condition, pelvic examination, PAC treatment procedures, type of provider, FP acceptance, and date and time of discharge. These data need to be regularly processed and analyzed to monitor program progress. Regular PAC service data should be included in the HMIS.

Training

More providers need training on PAC service provision. Training is needed on MVA procedures, IP and counseling. Training is also needed for data management, processing and analysis. Training issues should also include policy matters. In order to meet the increasing demand for PAC training, training should be decentralized.

Mid-level human resources

The analysis shows that use of mid-level human resources is cost-effective in PAC service provision. Therefore, future expansion should focus on promoting nurse or senior ANM/ AMN provider rather than physicians although the latter should also be given training on PAC service.

Follow-up and monitoring

Ensure that PAC service sites are followed up and monitored at regular intervals by DHO and DHOs in turn by the FHD, at least, every three months. This will help service providers build their confidence in the work they do, review the work and constantly improve the service which will eventually build trust in clients.

The existing PAC service needs to be improved in many places. To ensure 24 hours service 2-trained service providers should be available at the site. Two PAC service providers are necessary because when one provider is absent the other provides the service. This problem was found by the consultants in Myagdi district hospital, Nawalparasi PHCC, Makwanpur PHCC, Siraha district hospital and Itahari PHCC. Absenteeism of service provider spreads negative message to the clients.

Scaling up of PAC Service

Prepare a plan to expand PAC services to the rest of the country. Ensure that a new site is welcoming the opening of PAC service so that every support is given once it is established. Although the government is gradually allocating its own funds to the PAC program still a big fund is needed to expand the PAC services to the rest of the country. Therefore, the government should also have a plan for mobilizing needed resources for service expansion.

Expansion of PAC service below district level is urgent because the service centers below district level have the largest reach of the rural population and the need for service is also more in the rural areas where more spontaneous abortions (5.3 percent) take place than in the urban areas (5.2 percent – MOHP, New ERA and Macro International Inc, 2007) . At the PHCC/HC level a team of nurse and ANM can work together to provide PAC services. The new BOEC policy also takes into account the role of the paramedics in providing PAC services.

This also calls for training of a large number of health professionals and continued follow-ups to ensure good translation of knowledge into practice.

Initiate promotional program

Unlike many other health programs, PAC service lacks promotion program. This will increase access for women in rural areas.

Community mobilization

The local health facilities should make use of decentralized scheme and initiate community mobilization. With new political awakening, this activity can perhaps take place without much difficulty.

References

- Ana Langer, Cecelia Garcla-Barrios, Angela Heimbürger, Lourdes Campero, Karen Stein, Beverly Winikoff, and Vilma Barahona. 1999. "Improving Post Abortion Care with Limited Resources in a Public Hospital in Oaxaca, Mexico". In Huntington, D. and Piet-Pelon, N. J. Edited. *Postabortion Care: Lessons from Operations Research*. Population Council. New York, NY, USA.
- Billings DL, Victor Ankrah, Baird TL, Joseph E. Taylor, Kathlyn P. P. Ababio, and Stephen Ntow. 1999. "Midwives and comprehensive Postabortion Care in Ghana." In Huntington, D. and Piet-Pelon, N. J. Edited. *Postabortion Care: Lessons from Operations Research*. Population Council. New York, NY, USA.
- Basnet, I., Clapham, S., Shakya, G. and McCall M. 2004. "Evolution of postabortion care program in Nepal: the contribution of a National Safe Motherhood Project." *International Journal of Gynecology and Obstetrics* 86, 98-108.
- Central Bureau of Statistics (CBS) & UNFPA. 2002. *Population Census 2001*. National Report. National Planning Commission (NPC). HMG, NPC Secretariat, Singha Durbar, Kathmandu. June.
- Cobb L, Putney P, Rochat R, Solo J, Buono N, Dunlop, Vandembroucke M. 2001. *Global evaluation of USAID's postabortion care program*. Population Technical Assistance Project. Washington, DC. October.
- Engender Health - IPAS. 2001. *Taking Postabortion Care Services to Scale: Quality, Access, Sustainability*. New York, NY, USA.
- Government of Nepal, DFID and Options. 2004. *Nepal Safer Motherhood Project: Sharing Experiences*. Options, CAP House, London.
- Gorkhapatra. 2007. *The Daily Newspaper (Nepali)*. Kathmandu. March 7
- Huntington, D. and Piet-Pelon, N. J. 1999. *Postabortion Care: Lessons from Operations Research*. Population Council. New York, NY, USA.
- Liljestrand, Jerker. No date. "Care for Adolescent pregnancy and Childbirth." *International Journal of Obstetrics and Gynecology*.
- Liskin, Laurie S. 1982. Complications of Abortion in Developing Countries. *Population Reports*, Series F, No. 7
- Malla K, Kishore S, Padhye S, Hughes R, McIntosh N, Tietjen L. Establishing postabortion care services in Nepal. *J Nepal Med Assoc* 1997; 35:104 –110.
- Ministry of Health (MOH), New ERA and DHS. 1997. *Nepal Family Health Survey 1996*. Family Health Division, Department of Health Services, Kathmandu, Nepal, New ERA, Kathmandu and Macro International Inc. Calverton, Maryland: USA. March.
- MOH. 2005. *Postabortion Care – A Reference Manual for Improving Quality of Care*. Second Edition. His Majesty's Government. National Health Training Centre. January.
- MOH. 2004. *Nepal Safe Motherhood Information, Education and Communication Strategy 2004-2008*. Kathmandu. January.
- MOH. 2004. *Training Course management Guidelines*. National Health Training Center.. Kathmandu.

- MOH. 2002. *Nepal Demographic and Health Survey 2001*. Kathmandu, Nepal and Calverton, Maryland: Family Health Division, Nepal; New ERA and ORC Macro, DHS+, Maryland, USA. April.
- MOH. 2006. *Annual Report 2004/05*. Department of Health Services, Teku, Kathmandu. January.
- MOH. 2005. *Annual Report 2003/04*. Department of Health Services, Teku, Kathmandu. January.
- MOH. 2002. *Annual Report 2001/02*. Department of Health Services, Teku, Kathmandu. January.
- MOH. 2001. *National Medical Standard for Reproductive Health. Volume I: Contraceptive Services*. Family Health Division, HMG. August.
- MOH. 1998a. *Maternal Mortality and Morbidity Study*. Family Health Division, Department of Health Services. His Majesty's Government of Nepal. Kathmandu.
- MOH. 1998b. *National Reproductive Health Strategy*. Family Health Division, Department of Health Services. His Majesty's Government of Nepal.
- MOH. 1997. Family Health Division, His Majesty's Government of Nepal. *Postabortion Care Course Notebook for Trainers* JHPIEGO Corporation.
- MOH. 1996. *Safe Motherhood Policy 1996*. Family Health Division. Department of Health Services, Teku, Kathmandu.
- MOH. 1993. *National Health Policy 1991*. HMG, Policy, Planning, Monitoring and Supervision Division, Kathmandu. July, Revised Edition.
- Ministry of Health and Population (MOHP), New ERA and Macro International Inc. 2007. *Nepal Demographic and Health Survey 2006*. Kathmandu, Nepal and Calverton, Maryland: Family Health Division, Nepal; Measure DHS ORC Macro, Maryland, USA.
- MOHP. 2006. *Annual Report 2004/05*. Department of Health Services, Teku, Kathmandu. January.
- Options UK (Nepal Safer Motherhood Project). *Hospital needs assessment, Baglung District Hospital, Surkhet District Hospital, Kailali District Hospital*. Family Health Division, His Majesty's Government of Nepal, 1997.
- Rawlins, B., Brechin, S. J. G. and Giri, K. 2001. *An Assessment of the Quality of Postabortion Care Services in Nepal: The Training and Service Delivery Perspectives*. Family Health Division. Ministry of Health, Kathmandu. November.
- Senderowitz, Judith. 1995. *Adolescent Health: Reassessing the Passage to Adulthood*. World Bank Discussion Paper, No. 271 (Washington DC: World Bank).
- Thapa PJ, Thapa S, Shrestha N. A hospital-based study of abortion in Nepal. *Stud Family Plann* 1992; 23:311 –318.
- UN. 1994. *Programme of Action* adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994. A/CONF.171/13. 18 October.
- UNICEF. 2000. *Progress of Nations*. New York): 17.
- USAID. 2001. *Global Evaluation of USAID's Postabortion Care Program*. LTG Associates, Inc. and TvT Associates, Inc. Washington DC, USA. October.
- WHO. 1998. *Unsafe Abortion: Global and Regional Estimates of Incidence of Unsafe abortion and Associated Mortality in 2000*. Fourth Edition. Geneva: WHO, Division of Reproductive Health.

WHO. 2001. *Sexual Relations among Young People in Developing Countries*. Abstract.
Evidence from WHO Case Studies, WHO/RHR/01.08.

Year	MVA	D & C	Total PAC clients	% MVA	Remarks	FP acceptors	%FP acceptors	% of MVA clients accepting FP	Remarks	MVA Provider, Doctor	MVA Provider, Nurse	No classification by provider	% MVA Nurse provider	Remarks
1 Maternity Hospital, Thapathali, PAC service started in 1995/96														
2002/03	610	806	1,416	43.1		513	36.2	84.1				610		No data
2003/04	674	777	1,451	46.5		585	40.3	86.8		258	416		61.7	
2004/05	922	701	1,623	56.8		835	51.4	90.6		398	524		56.8	
2005/06	839	602	1,441	58.2		692	48.0	82.5		376	463		55.2	
2 Tribhuvan University, Teaching Hospital, PAC service started in 1996/97														
2002/03	44		44	100.0	Incomplete data				No data			44		No data
2003/04	37		37	100.0	Incomplete data				No data			37		No data
2004/05					No data				No data					No data
2005/06					No data				No data					No data
3 Gandaki S. R. Hospital, PAC service started in 1996/97														
2002/03	85	114	199	42.7	Incomplete data	14	7.0	16.5	Incomplete data			85		No data
2003/04	65	0	65	100.0	Incomplete data	13	20.0	20.0	Incomplete data	65	0		0.0	Incomplete data
2004/05	92	0	92	100.0	Incomplete data	2	2.2	2.2	Incomplete data	91	1		1.1	Incomplete data
2005/06	62	0	62	100.0	Incomplete data	10	16.1	16.1	Incomplete data	62	0		0.0	Incomplete data
4 ADRA Clinic, Kavre, PAC service started in 1997/98														
2002/03					No data				No data					No data
2003/04					No data				No data					No data
2004/05					No data				No data					No data
2005/06					No data				No data					No data
5 Birendra Army Hospital, PAC service started in 1998/99														
2002/03					No data				No data					No data
2003/04					No data				No data					No data
2004/05					No data				No data					No data
2005/06					No data				No data					No data

6	Baglung District Hospital, PAC service started in 1998/99													
2002/03	52	12	64	81.3	Incomplete data	17	26.6	32.7	Incomplete data			52		No data
2003/04	42	17	59	71.2		31	52.5	73.8		0	42		100.0	
2004/05					No data				No data					No data
2005/06					No data				No data					No data

Year	MVA	D & C	Total PAC clients	% MVA	Remarks	FP acceptors	%FP acceptors	% of MVA clients accepting FP	Remarks	MVA Provider, Doctor	MVA Provider, Nurse	No classification by provider	% MVA Nurse provider	Remarks
7	Surkhet District Hospital, PAC service started in 1998/99													
2002/03	6	14	20	30.0					No data			6		No data
2003/04	14	11	25	56.0					No data	0	14		100.0	
2004/05					No data				No data					No data
2005/06					No data				No data					No data
8	Seti Zonal Hospital, Kailali, PAC service started in 1998/99													
2002/03	43	138	181	23.8		42	23.2	97.7				43		No data
2003/04	120	92	212	56.6		66	31.1	55.0		5	115		95.8	
2004/05	84	56	140	60.0		63	45.0	75.0		0	84		100.0	
2005/06	141	7	148	95.3		134	90.5	95.0		0	141		100.0	
9	Bhaktapur District Hospital, PAC service started in 1999/00													
2002/03	17	21	38	44.7		9	23.7	52.9				17		No data
2003/04	139	10	149	93.3		122	81.9	87.8		35	104		74.8	
2004/05	74	12	86	86.0		74	86.0	100.0				74		No data
2005/06					No data				No data					No data
10	Makwanpur District Hospital, PAC service started in 1999/00													
2002/03	61	7	68	89.7		42	61.8	68.9				61		No data
2003/04	38	5	43	88.4		38	88.4	100.0		0	38		100.0	
2004/05	40	7	47	85.1		32	68.1	80.0		0	40		100.0	

	2005/06	52	0	52	100.0		52	100.0	100.0		0	52		100.0	
11	Bharatpur District Hospital, PAC service started in 1999/00														
	2002/03	171	18	189	90.5		103	54.5	60.2				171		No data
	2003/04	139	10	149	93.3		122	81.9	87.8		35	104		74.8	
	2004/05	164	0	164	100.0		123	75.0	75.0		26	138		84.1	
	2005/06	192	2	194	99.0		144	74.2	75.0		31	161		83.9	
12	Dhading District Hospital, PAC service started in 1999/00														
	2002/03					No data				No data					No data
	2003/04	27	10	37	73.0	Incomplete data	36	97.3	133.3				27		No data
	2004/05	6	0	6	100.0	Incomplete data				No data			6		No data
	2005/06					No data				No data					No data

Year	MVA	D & C	Total PAC clients	% MVA	Remarks	FP acceptors	%FP acceptors	% of MVA clients accepting FP	Remarks	MVA Provider, Doctor	MVA Provider, Nurse	No classification by provider	% MVA Nurse provider	Remarks
13	Lumbini Zonal Hospital, PAC service started in 1999/00													
	2002/03	36	57	93	38.7	Incomplete data	33	35.5	91.7	Incomplete data			36	No data
	2003/04	39	4	43	90.7		38	88.4	97.4		5	34		87.2
	2004/05	55	0	55	100.0	Incomplete data	43	78.2	78.2	Incomplete data	27	28		50.9
	2005/06	184	0	184	100.0	Incomplete data	54	29.3	29.3	Incomplete data	26	50	108	27.2
14	Bheri Zonal Hospital, PAC service started in 1999/00													
	2002/03	31	16	47	66.0		32	68.1	103.2				31	No data
	2003/04	77	18	95	81.1		55	57.9	71.4		36	41		53.2
	2004/05	113	1	114	99.1		91	79.8	80.5		25	88		77.9
	2005/06	106	4	110	96.4		94	85.5	88.7		3	103		97.2
15	AMDA Hospital, Jhapa, PAC service started in 2000/01													
	2002/03	163	124	287	56.8		162	56.4	99.4				163	No data
	2003/04	211	164	375	56.3		122	32.5	57.8		77	134		63.5

	2004/05	105	97	202	52.0	Incomplete data	93	46.0	88.6	Incomplete data	53	52	49.5	Incomplete data
	2005/06	127	136	263	48.3		123	46.8	96.9		46	81	63.8	
16	Koshi Zonal Hospital, PAC service started in 2000/01													
	2002/03	67	98	165	40.6	Incomplete data	91	55.2	135.8	Incomplete data			67	No data
	2003/04	137	44	181	75.7		149	82.3	108.8		12	125	91.2	
	2004/05	202	32	234	86.3		178	76.1	88.1		35	167	82.7	
	2005/06	254	14	268	94.8		203	75.7	79.9		14	240	94.5	
17	Ilam Dist Hospital, PAC service started in 2000/01													
	2002/03	93	17	110	84.5		97	88.2	104.3				93	No data
	2003/04	102	9	111	91.9	Incomplete data	110	99.1	107.8	Incomplete data	102	0	0.0	
	2004/05	109	12	121	90.1		88	72.7	80.7		40	69	63.3	
	2005/06	92	0	92	100.0	Incomplete data	37	40.2	40.2	Incomplete data	92	0	0.0	Incomplete data
18	Dhulikhel Hospital, PAC service started in 2000/01													
	2002/03					No data				No data				No data
	2003/04					No data				No data				No data
	2004/05					No data				No data				No data
	2005/06					No data				No data				No data

	Year	MVA	D & C	Total PAC clients	% MVA	Remarks	FP acceptors	%FP acceptors	% of MVA clients accepting FP	Remarks	MVA Provider, Doctor	MVA Provider, Nurse	No classification by provider	% MVA Nurse provider	Remarks
19	Prithbi Chandra District Hospital, Nawalparasi, PAC service started in 2000/01														
	2002/03	31	23	54	57.4		35	64.8	112.9				31		No data
	2003/04	31	7	38	81.6		32	84.2	103.2		11	20		64.5	
	2004/05	39	1	40	97.5		30	75.0	76.9		10	29		74.4	
	2005/06	20	6	26	76.9		17	65.4	85.0		5	15		75.0	
20	Bhim District Hospital, Rupandehi, PAC service started in 2000/01														
	2002/03	19	3	22	86.4	Incomplete data	0	0.0	0.0	Incomplete data			19		No data
	2003/04	66	1	67	98.5	Incomplete data	54	80.6	81.8		19	47		71.2	Incomplete data

	2004/05	54	0	54	100.0	Incomplete data	36	66.7	66.7	Incomplete data	20	34		63.0	Incomplete data
	2005/06	52	0	52	100.0	Incomplete data	23	44.2	44.2	Incomplete data	8	44		84.6	Incomplete data
21	AMDA Hospital, Butwal, Rupandehi, PAC service started in 2000/01														
	2002/03	106	92	198	53.5	Incomplete data	157	79.3	148.1	Incomplete data					No data
	2003/04	73	81	154	47.4		80	51.9	109.6		73	0		0.0	
	2004/05	40	81	121	33.1	Incomplete data	42	34.7	105.0	Incomplete data	40	0		0.0	Incomplete data
	2005/06	37	0	37	100.0	Incomplete data	0	0.0	0.0	Incomplete data	36	1		2.7	Incomplete data
22	Sagarmatha Zonal Hospital, Saptari, PAC service started in 2001/02														
	2002/03	45	16	61	73.8	Incomplete data				No data				45	No data
	2003/04	20	63	83	24.1					No data	20	0		0.0	
	2004/05	17	0	17	100.0	Incomplete data				No data				17	No data
	2005/06					No data				No data					No data
23	Janakpur Zonal Hospital, Dhanusha, PAC service started in 2001/02														
	2002/03	0	9	9	0.0	Incomplete data	0	0.0		Incomplete data					No data
	2003/04	4	0	4	100.0	Incomplete data	1	25.0	25.0	Incomplete data	4	0		0.0	Incomplete data
	2004/05	4	27	31	12.9	Incomplete data	0	0.0	0.0	Incomplete data	4	0		0.0	Incomplete data
	2005/06	19	0	19	100.0		10	52.6	52.6		0	19		100.0	Incomplete data
24	Chormara PHCC, Nawalparasi, PAC service started in 2001/02														
	2002/03					No data				No data					No data
	2003/04	12	1	13	92.3		11	84.6	91.7		12	0		0.0	
	2004/05	7	4	11	63.6		6	54.5	85.7		6	1		14.3	
	2005/06	7	0	7	100.0		5	71.4	71.4		2	5		71.4	

Year	MVA	D & C	Total PAC clients	% MVA	Remarks	FP acceptors	%FP acceptors	% of MVA clients accepting FP	Remarks	MVA Provider, Doctor	MVA Provider, Nurse	No classification by provider	% MVA Nurse provider	Remarks	
25	Dumkauli PHCC, Nawalparasi, PAC service started in 2001/02														
	2002/03				No data				No data					No data	
	2003/04	4	0	4	100.0	Incomplete data	4	100.0	100.0	Incomplete data	4	0		0.0	Incomplete data
	2004/05	16	0	16	100.0		14	87.5	87.5		8	8		50.0	

	2005/06	2	0	2	100.0		0	0.0	0.0		1	1		50.0	
26	Parbat District Hospital, PAC service started in 2001/02														
	2002/03	5	4	9	55.6	Incomplete data				No data					No data
	2003/04	12	2	14	85.7	Incomplete data				No data	0	12		100.0	Incomplete data
	2004/05					No data				No data					No data
	2005/06					No data				No data					No data
27	Lumbini PHCC, Kapilvastu, PAC service started in 2001/02														
	2002/03					No data				No data					No data
	2003/04					No data				No data					No data
	2004/05					No data				No data					No data
	2005/06					No data				No data					No data
28	Pyuthan District Hospital, PAC service started in 2001/02														
	2002/03					No data				No data					No data
	2003/04					No data				No data					No data
	2004/05					No data				No data					No data
	2005/06					No data				No data					No data
29	Salyan District Hospital, PAC service started in 2001/02														
	2002/03					No data				No data					No data
	2003/04					No data				No data					No data
	2004/05					No data				No data					No data
	2005/06					No data				No data					No data
30	Dailekh District Hospital, PAC service started in 2001/02														
	2002/03	5	3	8	62.5	Incomplete data				No data			5		No data
	2003/04	8	2	10	80.0					No data	0	8		100.0	
	2004/05	3		3	100.0	Incomplete data				No data					No data
	2005/06					No data				No data					No data

Year	MVA	D & C	Total PAC clients	% MVA	Remarks	FP acceptors	%FP acceptors	% of MVA clients accepting FP	Remarks	MVA Provider, Doctor	MVA Provider, Nurse	No classification by provider	% MVA Nurse provider	Remarks
31 Jumla District Hospital, PAC service started in 2001/02														
2002/03	16	4	20	80.0	Incomplete data				No data			16		No data
2003/04	18	3	21	85.7					No data	0	18		100.0	
2004/05					No data				No data					No data
2005/06					No data				No data					No data
32 Dhulabari PHCC, Jhapa, PAC service started in 2002/03														
2002/03	3	0	3	100.0	Incomplete data	0	0.0	0.0	Incomplete data	3	0		0.0	Incomplete data
2003/04	10	0	10	100.0		7	70.0	70.0		10	0		0.0	
2004/05	18	0	18	100.0		17	94.4	94.4		18	0		0.0	
2005/06	16	0	16	100.0		14	87.5	87.5		16	0		0.0	
33 Mechi Zonal Hospital, Jhapa, PAC service started in 2002/03														
2002/03					No data				No data					No data
2003/04					No data				No data					No data
2004/05	3	0	3	100.0		3	100.0	100.0		1	2		66.7	Incomplete data
2005/06	36	42	78	46.2		25	32.1	69.4		3	33		91.7	Incomplete data
34 Inaruwa Dist Hospital, Sunsari, PAC service started in 2002/03														
2002/03	17	11	28	60.7		8	28.6	47.1				17		No data
2003/04	35	7	42	83.3		31	73.8	88.6		11	24		68.6	
2004/05	15	2	17	88.2		14	82.4	93.3		0	15		100.0	
2005/06	14	10	24	58.3		12	50.0	85.7		0	14		100.0	
35 Kanchanpur PHCC, Saptari, PAC service started in 2002/03														
2002/03	5	1	6	83.3	Incomplete data				No data			5		No data
2003/04	6	10	16	37.5					No data	0	6		100.0	
2004/05	17	0	17	100.0	Incomplete data				No data					No data
2005/06	1	0	1	100.0	Incomplete data				No data					No data

36	Panchthar District Hospital, PAC service started in 2002/03														
	2002/03	0	31	31	0.0	Incomplete data				No data					No data
	2003/04	4	14	18	22.2					No data	4	0		0.0	
	2004/05					No data				No data					No data
	2005/06					No data				No data					No data

Year	MVA	D & C	Total PAC clients	% MVA	Remarks	FP acceptors	%FP acceptors	% of MVA clients accepting FP	Remarks	MVA Provider, Doctor	MVA Provider, Nurse	No classification by provider	% MVA Nurse provider	Remarks	
37	Udayapur District Hospital, PAC service started in 2002/03														
	2002/03				No data				No data					No data	
	2003/04				No data				No data					No data	
	2004/05	20	0	20	100.0	Incomplete data			No data	20			0.0	Incomplete data	
	2005/06				No data				No data					No data	
38	Rumzatar PHCC, Okhaldhunga, PAC service started in 2002/03														
	2002/03				No data				No data					No data	
	2003/04				No data				No data					No data	
	2004/05	9	0	9	100.0	Incomplete data	9	100.0	100.0	Incomplete data		9		No data	
	2005/06	8	0	8	100.0	Incomplete data	8	100.0	100.0	Incomplete data	8	0	0.0	Incomplete data	
39	Narayani Sub. Reg. Hospital, Parsa, PAC service started in 2002/03														
	2002/03	20	16	36	55.6		7	19.4	35.0			20		No data	
	2003/04	60	40	100	60.0		44	44.0	73.3		13	47	78.3		
	2004/05	95	39	134	70.9		66	49.3	69.5		25	70	73.7		
	2005/06	87	70	157	55.4		68	43.3	78.2		11	76	87.4		
40	Trishuli District Hospital, Nuwakot, PAC service started in 2002/03														
	2002/03				No data				No data					No data	
	2003/04	4	18	22	18.2		20	90.9	500.0		0	4	100.0		
	2004/05	9	14	23	39.1		15	65.2	166.7			9		No data	
	2005/06	33	0	33	100.0		18	54.5	54.5			33		No data	
41	Myagdi District Hospital, PAC service started in 2002/03														

2002/03	10	0	10	100.0	Incomplete data	0	0.0	0.0	Incomplete data			10		No data
2003/04	8	3	11	72.7		0	0.0	0.0	Incomplete data	5	3		37.5	Incomplete data
2004/05	8	0	8	100.0		5	62.5	62.5	Incomplete data			8		No data
2005/06	39	0	39	100.0		0	0.0	0.0	Incomplete data	0	39		100.0	Incomplete data
42 Mahendra District Hospital, Dang, PAC service started in 2002/03														
2002/03	3	10	13	23.1	Incomplete data				No data					No data
2003/04	9	20	29	31.0	Incomplete data				No data					No data
2004/05	18	0	18	100.0	Incomplete data				No data					No data
2005/06	18	0	18	100.0	Incomplete data				No data					No data

Year	MVA	D & C	Total PAC clients	% MVA	Remarks	FP acceptors	%FP acceptors	% of MVA clients accepting FP	Remarks	MVA Provider, Doctor	MVA Provider, Nurse	No classification by provider	% MVA Nurse provider	Remarks
43 Tikapur PHCC, Kailali, PAC service started in 2002/03														
2002/03					No data				No data					No data
2003/04					No data				No data					No data
2004/05					No data				No data					No data
2005/06	23	2	25	92.0		13	52.0	56.5		5	18		78.3	
44 Baitadi District Hospital, PAC service started in 2002/03														
2002/03					No data				No data					No data
2003/04					No data				No data					No data
2004/05					No data				No data					No data
2005/06					No data				No data					No data
45 Mangalbare PHCC, Morang, PAC service started in 2003/04														
2002/03					No data				No data					No data
2003/04					No data				No data					No data
2004/05	21	0	21	100.0		17	81.0	81.0		0	21		100.0	
2005/06	46	0	46	100.0		40	87.0	87.0		0	46		100.0	
46 Siraha District Hospital, PAC service started in 2003/04														

	2002/03					No data				No data				No data
	2003/04					No data				No data				No data
	2004/05	13	0	13	100.0		11	84.6	84.6		0	13	100.0	
	2005/06	2	0	2	100.0	Incomplete data	2	100.0	100.0	Incomplete data	0	2	100.0	Incomplete data
47	Itahari PHCC, Sunsari, PAC service started in 2003/04													
	2002/03					No data				No data				No data
	2003/04					No data				No data				No data
	2004/05					No data				No data				No data
	2005/06	5	0	5	100.0	Incomplete data	4	80.0	80.0	Incomplete data	1	4	80.0	Incomplete data
48	Dhankuta District Hospital, PAC service started in 2003/04													
	2002/03					No data				No data				No data
	2003/04	5	1	6	83.3	Incomplete data	6	100.0	120.0	Incomplete data	4	1	20.0	Incomplete data
	2004/05	15	0	15	100.0		13	86.7	86.7			15		No data
	2005/06	22	0	22	100.0	Incomplete data	14	63.6	63.6	Incomplete data	16	6	27.3	Incomplete data

	Year	MVA	D & C	Total PAC clients	% MVA	Remarks	FP acceptors	%FP acceptors	% of MVA clients accepting FP	Remarks	MVA Provider, Doctor	MVA Provider, Nurse	No classification by provider	% MVA Nurse provider	Remarks
49	Kalaiya District Hospital, Bara, PAC service started in 2003/04														
	2002/03					No data				No data					No data
	2003/04	9	0	9	100.0	Incomplete data	8	88.9	88.9	Incomplete data	0	9	100.0	100.0	Incomplete data
	2004/05	31	1	32	96.9		26	81.3	83.9		3	28	90.3	90.3	
	2005/06	34	0	34	100.0		32	94.1	94.1		1	33	97.1	97.1	
50	Gaushala PHCC, Mahottari, PAC service started in 2003/04														
	2002/03					No data				No data					No data
	2003/04					No data				No data					No data
	2004/05					No data				No data					No data
	2005/06					No data				No data					No data
51	Gaur District Hospital, Rautahat, PAC service started in 2003/04														

	2002/03					No data				No data					No data
	2003/04					No data				No data					No data
	2004/05	5	0	5	100.0		5	100.0	100.0		1	4		80.0	
	2005/06	17	3	20	85.0		12	60.0	70.6		11	6		35.3	
52	Gulmi District Hospital, PAC service started in 2003/04														
	2002/03					No data				No data					No data
	2003/04					No data				No data					No data
	2004/05					No data				No data					No data
	2005/06					No data				No data					No data
53	Gorkha District Hospital, PAC service started in 2003/04														
	2002/03					No data				No data					No data
	2003/04					No data				No data					No data
	2004/05					No data				No data					No data
	2005/06	17	0	17	100.0	Incomplete data	17	100.0	100.0	Incomplete data	17	0		0.0	Incomplete data
54	Shivaraj Hospital, Kapilvastu, PAC service started in 2003/04														
	2002/03					No data				No data					No data
	2003/04	10	1	11	90.9					No data	10	0		0.0	Incomplete data
	2004/05	5	0	5	100.0					No data			5		No data
	2005/06					No data				No data					No data

	Year	MVA	D & C	Total PAC clients	% MVA	Remarks	FP acceptors	%FP acceptors	% of MVA clients accepting FP	Remarks	MVA Provider, Doctor	MVA Provider, Nurse	No classification by provider	% MVA Nurse provider	Remarks
55	Prithbi Bir Hospital, Kapilvastu, PAC service started in 2003/04														
	2002/03					No data				No data					No data
	2003/04	4	0	4	100.0					No data	4	0		0.0	Incomplete data
	2004/05	8	0	8	100.0		1	12.5	12.5		0	8		100.0	
	2005/06					No data				No data					No data
56	Bardiya District Hospital, PAC service started in														

2003/04														
2002/03					No data					No data				No data
2003/04	20	2	22	90.9		17	77.3	85.0		7	13		65.0	
2004/05	33	0	33	100.0		23	69.7	69.7		15	18		54.5	
2005/06	16	0	16	100.0		13	81.3	81.3		8	8		50.0	
57 Mahakali Zonal Hospital, Kanchanpur, PAC service started in 2003/04														
2002/03					No data					No data				No data
2003/04	17	22	39	43.6		14	35.9	82.4		0	17		100.0	
2004/05	84	16	100	84.0		86	86.0	102.4		8	76		90.5	
2005/06	103	17	120	85.8		104	86.7	101.0		0	103		100.0	
58 Mirchaiya PHCC, Siraha, PAC service started in 2004/05														
2002/03					Not applicable					Not applicable				Not applicable
2003/04					No data					No data				No data
2004/05	17	1	18	94.4		17	94.4	100.0		0	17		100.0	
2005/06	11	0	11	100.0		10	90.9	90.9		3	8		72.7	
59 Terathum District Hospital, PAC service started in 2004/05														
2002/03					Not applicable					Not applicable				Not applicable
2003/04					No data					No data				No data
2004/05	20	0	20	100.0						20	0		0.0	
2005/06					No data					No data				No data
60 Jaleswor District Hospital, Mahottari, PAC service started in 2004/05														
2002/03					Not applicable					Not applicable				Not applicable
2003/04					No data					No data				No data
2004/05					No data					No data				No data
2005/06	13	0	13	100.0		7	53.8	53.8		0	13		100.0	
Year	MVA	D & C	Total PAC clients	% MVA	Remarks	FP acceptors	%FP acceptors	% of MVA clients accepting FP	Remarks	MVA Provider, Doctor	MVA Provider, Nurse	No classification by provider	% MVA Nurse provider	Remarks

61	Sarlahi District Hospital, PAC service started in 2004/05													
	2002/03				Not applicable				Not applicable					Not applicable
	2003/04				No data				No data					No data
	2004/05				No data				No data					No data
	2005/06				No data				No data					No data
62	Jibjibe PHCC, Rasuwa, PAC service started in 2004/05													
	2002/03				Not applicable				Not applicable					Not applicable
	2003/04				No data				No data					No data
	2004/05				No data				No data					No data
	2005/06				No data				No data					No data
63	Syanga District Hospital, PAC service started in 2004/05													
	2002/03				Not applicable				Not applicable					Not applicable
	2003/04				No data				No data					No data
	2004/05				No data				No data					No data
	2005/06				No data				No data					No data
64	Tanahun District Hospital, PAC service started in 2004/05													
	2002/03				Not applicable				Not applicable					Not applicable
	2003/04				No data				No data					No data
	2004/05				No data				No data					No data
	2005/06	19	0	19	100.0				No data	19	0		0.0	
65	Bajhang Dist Hospital, PAC service started in 2004/05													
	2002/03				Not applicable				Not applicable					Not applicable
	2003/04				No data				No data					No data
	2004/05	3	0	3	100.0				No data			3		No data
	2005/06	3	0	3	100.0	Incomplete data	3	100.0	100.0	Incomplete data	3	0		0.0
66	Suranga PHCC, Jhapa, PAC service started in 2005/06													
	2002/03				Not applicable				Not applicable					Not applicable
	2003/04				Not applicable				Not applicable					Not applicable

2004/05					No data				No data					No data
2005/06	7	0	7	100.0		7	100.0	100.0		5	2		28.6	

Year	MVA	D & C	Total PAC clients	% MVA	Remarks	FP acceptors	%FP acceptors	% of MVA clients accepting FP	Remarks	MVA Provider, Doctor	MVA Provider, Nurse	No classification by provider	% MVA Nurse provider	Remarks
67 Jhurkiya PHCC, Morang, PAC service started in 2005/06														
2002/03					Not applicable				Not applicable					Not applicable
2003/04					Not applicable				Not applicable					Not applicable
2004/05					No data				No data					No data
2005/06	12	0	12	100.0		12	100.0	100.0		0	12		100.0	
68 Letang PHCC, Morang, PAC service started in 2005/06														
2002/03					Not applicable				Not applicable					Not applicable
2003/04					Not applicable				Not applicable					Not applicable
2004/05					No data				No data					No data
2005/06	6	2	8	75.0		4	50.0	66.7		0	6		100.0	
69 Chatara PHCC, Sunsari, PAC service started in 2005/06														
2002/03					Not applicable				Not applicable					Not applicable
2003/04					Not applicable				Not applicable					Not applicable
2004/05					No data				No data					No data
2005/06	5	0	5	100.0		3	60.0	60.0		0	5		100.0	
70 Satbariya PHCC, Parsa, PAC service started in 2005/06														
2002/03					Not applicable				Not applicable					Not applicable
2003/04					Not applicable				Not applicable					Not applicable
2004/05					No data				No data					No data
2005/06	4	0	4	100.0		4	100.0	100.0		0	4		100.0	
71 Manohari PHCC, Makwanpur, PAC service started in 2005/06														
2002/03					Not applicable				Not applicable					Not applicable

2003/04					Not applicable				Not applicable					Not applicable
2004/05					No data				No data					No data
2005/06					No data				No data					No data
72	Palung PHCC, Makwanpur, PAC service started in 2005/06													
2002/03					Not applicable				Not applicable					Not applicable
2003/04					Not applicable				Not applicable					Not applicable
2004/05					No data				No data					No data
2005/06					No data				No data					No data

Year	MVA	D & C	Total PAC clients	% MVA	Remarks	FP acceptors	%FP acceptors	% of MVA clients accepting FP	Remarks	MVA Provider, Doctor	MVA Provider, Nurse	No classification by provider	% MVA Nurse provider	Remarks
73	Simra PHCC, Bara, PAC service started in 2005/06													
2002/03					Not applicable				Not applicable					Not applicable
2003/04					Not applicable				Not applicable					Not applicable
2004/05					No data				No data					No data
2005/06					No data				No data					No data
74	Rasuwa District Hospital, PAC service started in 2005/06													
2002/03					Not applicable				Not applicable					Not applicable
2003/04					Not applicable				Not applicable					Not applicable
2004/05					No data				No data					No data
2005/06					No data				No data					No data
75	Chandranigahapur PHCC, Rautahat, PAC service started in 2005/06													
2002/03					Not applicable				Not applicable					Not applicable
2003/04					Not applicable				Not applicable					Not applicable
2004/05	4	0	4	100.0	?????	1	25.0	25.0		1	3		75.0	
2005/06	26	0	26	100.0		26	100.0	100.0		8	18		69.2	
76	Chaumala PHCC, Kailali, PAC service started in 2005/06													
2002/03					Not applicable				Not applicable					Not applicable

	2003/04					Not applicable				Not applicable				Not applicable
	2004/05					No data				No data				No data
	2005/06	12	0	12	100.0		12	100.0	100.0		3	9		75.0
77	Mugu District Hospital, PAC service started in 2005/06													
	2002/03					Not applicable				Not applicable				Not applicable
	2003/04					Not applicable				Not applicable				Not applicable
	2004/05	3	0	3	100.0	?????	3	100.0	100.0					No data
	2005/06	7	0	7	100.0		7	100.0	100.0		0	7		100.0
78	Bajura District Hospital, PAC service started in 2005/06													
	2002/03					Not applicable				Not applicable				Not applicable
	2003/04					Not applicable				Not applicable				Not applicable
	2004/05					No data				No data				No data
	2005/06	3	0	3	100.0		0	0.0	0.0		3	0		0.0

Appendix II

Table 7 Abortion complications presenting at seven PAC sites																
(a) Post abortion clients by age group																
	Dumkauli PHCC, June 3, 2004-Sept 5, 2006		Myagdi District Hospital, July 29, 2004-Jan 13, 2007		Gandaki Reg Hospital, June 27, 2003-Jan 11, 2007		Koshi Zonal hospital, 14 May 2003-13 March 2007		Mangalbare PHCC, Morang, 20 Dec 2004-9 March 2007		Mirchaiya PHCC, Siraha, 16 Feb 2005-14 March 2007		Siraha District Hospital, 4 Feb 2004-20 June 2006		All 7 sites	
Age group (years)	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%			Number	%
15-19	3	12.5	4	11.8	36	13.1	147	16.2	9	13.4	5	16.1	4	16.0	208	15.3
20-24	13	54.2	17	50.0	101	36.9	352	38.9	24	35.8	8	25.8	10	40.0	525	38.6
25-29	3	12.5	6	17.6	68	24.8	209	23.1	19	28.4	7	22.6	6	24.0	318	23.4
30-34	1	4.2	3	8.8	38	13.9	101	11.1	5	7.5	5	16.1	3	12.0	155	11.4
35-39	3	12.5	3	8.8	20	7.3	66	7.3	10	14.9	4	12.9	2	8.0	108	7.9
40-44	1	4.2	1	2.9	5	1.8	23	2.5	0	0.0	1	3.2	0	0.0	31	2.3
45-49	0	0.0	0	0.0	6	2.2	8	0.9	0	0.0	1	3.2	0	0.0	16	1.2
Total	24	100.0	34	100.0	274	100.0	906	100.0	67	100.0	31	100.0	25	100	1,361	100
Mean age		24.5		24.7		25.7		24.9		25.3		26.5		24.7		25.1
Median age		22.5		23.0		24.5		24.0		25.0		25.0		23.0		24.0
(b) Gestational dating of PAC cases																
	Dumkauli PHCC, June 3, 2004-Sept 5, 2006		Myagdi District Hospital, July 29, 2004-Jan 13, 2007		Gandaki Reg Hospital, June 27, 2003-Jan 11, 2007		Koshi Zonal hospital, 14 May 2003-13 March 2007		Mangalbare PHCC, Morang, 20 Dec 2004-9 March 2007		Mirchaiya PHCC, Siraha, 16 Feb 2005-14 March 2007		Siraha District Hospital, 4 Feb 2004-20 June 2006		All 7 sites	
Number of weeks	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%			Number	%
8 Weeks or less	6	25.0	10	29.4	100	36.5	393	43.4	35	52.2	23	74.2	2	8	569	41.8
9-12 Weeks	8	33.3	16	47.1	128	46.7	372	41.1	29	43.3	7	22.6	19	76	579	42.5
13 Weeks or more	9	37.5	4	11.8	42	15.3	82	9.1	1	1.5	1	3.2	4	16	143	10.5
No information	1	4.2	4	11.8	4	1.5	59	6.5	2	3.0	0	0.0	0	0.0	70	5.1
Total	24	100.0	34	100.0	274	100.0	906	100.0	67	100.0	31	100.0	25	100	1,361	100.0
(c) Diagnosis of abortion complication cases																
	Dumkauli PHCC, June 3, 2004-Sept 5, 2006		Myagdi District Hospital, July 29, 2004-Jan 13, 2007		Gandaki Reg Hospital, June 27, 2003-Jan 11, 2007		Koshi Zonal hospital, 14 May 2003-13 March 2007		Mangalbare PHCC, Morang, 20 Dec 2004-9 March 2007		Mirchaiya PHCC, Siraha, 16 Feb 2005-14 March 2007		Siraha District Hospital, 4 Feb 2004-20 June 2006		All 7 sites	
Diagnosis	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%			Number	%
Incomplete abortion	17	70.8	25	73.5	266	97.1	759	83.8	63	94	27	87.1	25	100.0	1,182	86.8
Retained POC	1	4.2	0	0.0	2	0.7	105	11.6	1	1.5	0	0.0	0	0.0	109	8.0
PV bleeding	1	4.2	8	23.5	2	0.7	5	0.6	2	3	3	9.7	0	0.0	20	1.5
PPH	0	0.0	1	2.9	0	0.0	22	2.4	0	0.0	0	0.0	0	0.0	23	1.7
Sepsis	0	0.0	0	0.0	4	1.5	15	1.7	1	1.5	1	3.2	0	0.0	21	1.5
No information	5	20.8	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	6	0.5
Total	24	100.0	34	100.0	274	100.0	906	100.0	67	100.0	31	100.0	25	100.0	1,361	100.0

Appendix III

Table 8 Type of providers performing PAC procedures, FP methods accepted by clients and length of stay at health facility in seven PAC sites																
	Dumkauli PHCC, June 3, 2004-Sept 5, 2006		Myagdi District Hospital, July 29, 2004-Jan 13, 2007		Gandaki Reg Hospital, June 27, 2003-Jan 11, 2007		Koshi Zonal hospital, 14 May 2003-13 March 2007		Mangalbare PHCC, Morang, 20 Dec 2004-9 March 2007		Mirchaiya PHCC, Siraha, 16 Feb 2005-14 March 2007		Siraha District Hospital, 4 Feb 2004-20 June 2006		All 7 sites	
Type of provider	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Doctor	16	66.7	31	91.2	267	97.4	168	18.5	4	6	8	25.8	25	100.0	464	34.1
Nurse	8	33.3	3	8.8	6	2.2	738	81.5	63	94	23	74.2	0	0.0	896	65.8
No information	0	0.0	0	0.0	1	0.4	0	0.0	0	0.0	0	0.0	0	0.0	1	0.1
Total	24	100.0	34	100.0	274	100.0	906	100	67	100	31	100	25	100.0	1,361	100.0
FP method	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Condom	11	45.8	5	14.7	10	3.6	333	36.8	12	17.9	8	25.8	9	36.0	386	28.4
Pills	1	4.2	0	0.0	4	1.5	231	25.5	27	40.3	18	58.1	4	16.0	285	20.9
Depo	8	33.3	6	17.6	22	8.0	141	15.6	9	13.4	3	9.7	8	32.0	197	14.5
Husband away	1	4.2	0	0.0	2	0.7	3	0.3	7	10.4	0	0.0	0	0.0	13	1.0
Refused	2	8.3	7	20.6	17	6.2	95	10.5	1	1.5	2	6.5	0	0.0	124	9.1
IUD	0	0.0	0	0.0	0	0.0	2	0.2	2	3.0	0	0.0	0	0.0	4	0.3
LAM	0	0.0	0	0.0	0	0.0	18	2.0	0	0.0	0	0.0	0	0.0	18	1.3
Minilap	0	0.0	0	0.0	0	0.0	4	0.4	0	0.0	0	0.0	3	12.0	7	0.5
Norplant	0	0.0	0	0.0	0	0.0	1	0.1	0	0.0	0	0.0	1	4.0	2	0.1
No information	1	4.2	16	47.1	219	79.9	80	8.8	9	13.4	2	6.5	0	0.0	325	23.8
Total	24	100.0	34	100.0	274	100.0	906	100.0	67	100.0	31	100.0	25.0	100.0	1,361	100.0
Length of stay at health facility	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Discharged:																
Same day	23	95.8	16	47.1	256	93.4	804	88.7	65	97.0	28	90.3	25	100.0	1217	89.4
After 24 hours	1	4.2	11	32.4	17	6.2	90	9.9	2	3.0	3	9.7	0.0	0.0	124	9.1
After 48 hours	0	0.0	4	11.8	0	0.0	11	1.2	0	0.0	0	0.0	0.0	0.0	15	1.1
After 72 hours	0	0.0	3	8.8	0	0.0	1	0.1	0	0.0	0	0.0	0.0	0.0	4	0.3
After 96 hours	0	0.0	0	0.0	1	0.4	0	0.0	0	0.0	0	0.0	0.0	0.0	1	0.1
Total	24	100.0	34	100.0	274	100.0	906	100.0	67	100.0	31	100.0	25.0	100.0	1,361	100.0

Appendix IV

		Number of sites 2005/06	Number of PAC clients 2005/06	Spontaneous abortions (15% of all pregnancies)	Spontaneous abortions (5.2% of all pregnancies)	PAC Coverage for 15% Spontaneous Abortion Estimates (in %)	PAC Coverage for 5.2% Spontaneous Abortion Estimates (in %)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	NATIONAL TOTAL	78	3,877	138,097	47,874	2.81	8.10
1	MOUNTAIN REGION	6	13	11,532	3,998	0.11	0.33
2	HILL REGION	42	1,970	66,701	23,123	3.16	9.13
3	TERAI	30	1,894	59,864	20,753	2.95	8.52
	MOUNTAIN REGION						
1	TAPLEJUNG	0	0	875	303	0.00	0.00
2	SANKHUWASABHA	0	0	1,084	376	0.00	0.00
3	SOLUKHUMBU	0	0	728	252	0.00	0.00
4	DOLKHA	0	0	1,378	478	0.00	0.00
5	RASUWA	2	0	293	102	0.00	0.00
6	SINDHUPALCHOWK	0	0	2,027	703	0.00	0.00
7	MANANG	0	0	60	21	0.00	0.00
8	MUSTANG	0	0	92	32	0.00	0.00
9	DOLPA	0	0	224	78	0.00	0.00
10	HUMLA	0	0	282	98	0.00	0.00
11	JUMLA	1	0	641	222	0.00	0.00
12	KALIKOT	0	0	739	256	0.00	0.00
13	MUGU	1	7	308	107	2.27	6.55
14	BAJHANG	1	3	1,171	406	0.26	0.74
15	BAJURA	1	3	767	266	0.39	1.13
16	DARCHULA	0	0	862	299	0.00	0.00
	MOUNTAIN REGION	6	13	11,532	3,998	0.11	0.33
	TERAI						
1	JHAPA	4	364	4,366	1,514	8.34	24.05
2	MORANG	4	334	5,251	1,820	6.36	18.35

3	SUNSARI	3	34	3,885	1,347	0.88	2.52
4	SAPTARI	2	1	3,435	1,191	0.03	0.08
5	SIRAHA	2	13	3,375	1,170	0.39	1.11
6	DHANUSA	1	19	3,939	1,365	0.48	1.39
7	MAHOTTARI	2	13	3,199	1,109	0.41	1.17
8	SARLAHI	1	0	3,645	1,264	0.00	0.00
9	RAUTAHAT	2	46	3,144	1,090	1.46	4.22
10	BARA	2	34	3,255	1,129	1.04	3.01
11	PARSA	2	161	2,867	994	5.62	16.20
12	CHITWAN	1	194	2,894	1,003	6.70	19.34
13	NAWALPARASI	3	35	3,353	1,162	1.04	3.01
14	RUPENDEHI	3	273	4,191	1,453	6.51	18.79
15	KAPILVASTU	3	0	2,763	958	0.00	0.00
16	DANG	1	18	2,744	951	0.66	1.89
17	BANKE	1	110	2,294	795	4.79	13.83
18	BARDIYA	1	16	2,256	782	0.71	2.05
19	KAILALI	3	185	3,612	1,252	5.12	14.77
20	KANCHANPUR	1	120	2,235	775	5.37	15.49
	TERAI	42	1,970	66,701	23,123	2.95	8.52
		Number of sites 2005/06	Number of PAC clients 2005/06	Spontaneous abortions (15% of all pregnancies)	Spontaneous abortions (5.2% of all pregnancies)	PAC Coverage for 15% Spontaneous Abortion Estimates (in %)	PAC Coverage for 5.2% Spontaneous Abortion Estimates (in %)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	HILL REGION						
1	BHOJPUR	0	0	1,158	401	0.00	0.00
2	DHANKUTA	1	22	965	335	2.28	6.58
3	ILAM	1	92	1,664	577	5.53	15.95
4	KHOTANG	0	0	1,292	448	0.00	0.00
5	OKHALDHUNGA	1	8	888	308	0.90	2.60
6	PANCHTHAR	1	0	1,145	397	0.00	0.00
7	TEHARTHUM	1	0	648	225	0.00	0.00
8	UDAYPUR	1	20	1,636	567	1.22	3.53
9	BHAKTAPUR	1	86	1,325	459	6.49	18.72
10	DHADING	1	0	1,929	669	0.00	0.00

11	KATHMANDU	3	1441	4,669	1,619	30.86	89.03
12	KAVRE	2	0	2,194	760	0.00	0.00
13	LALITPUR	0	0	2,116	734	0.00	0.00
14	MAKAWANPUR	3	52	2,193	760	2.37	6.84
15	NUWAKOT	1	33	1,597	554	2.07	5.96
16	RAMECHHAP	0	0	1,216	422	0.00	0.00
17	SINDHULI	0	0	1,548	537	0.00	0.00
18	ARGHAKHANCHI	0	0	1,497	519	0.00	0.00
19	BAGLUNG	1	0	1,595	553	0.00	0.00
20	GORKHA	1	17	1,524	528	1.12	3.22
21	GULMI	1	0	1,748	606	0.00	0.00
22	KASKI	1	62	2,303	798	2.69	7.77
23	LAMJUNG	0	0	1,051	364	0.00	0.00
24	MYAGDI	1	39	677	235	5.76	16.61
25	PALPA	0	0	1,561	541	0.00	0.00
26	PARBAT	1	0	931	323	0.00	0.00
27	SYANGJA	1	0	1,911	662	0.00	0.00
28	TANAHU	1	19	1,892	656	1.00	2.90
29	DAILEKH	1	3	1,497	519	0.20	0.58
30	JAJARKOT	0	0	948	328	0.00	0.00
31	PYUTHAN	1	0	1,547	536	0.00	0.00
32	ROLPA	0	0	1,438	499	0.00	0.00
33	RUKUM	0	0	1,261	437	0.00	0.00
34	SALYAN	1	0	1,464	508	0.00	0.00
35	SURKHET	1	0	1,665	577	0.00	0.00
36	ACHHAM	0	0	1,629	565	0.00	0.00
37	BAITADI	1	0	1,388	481	0.00	0.00
38	DADEL DHURA	0	0	745	258	0.00	0.00
39	DOTI	0	0	1,407	488	0.00	0.00
	HILL REGION	30	1,894	59,864	20,753	3.16	9.13

**POSTABORTION CARE
FACILITY NEEDS ASSESSMENT FORM
FAMILY HEALTH DIVISION
Part I: General Data**

Version:

Date: Day _____ Month _____ Year _____

Assessment conducted by (name): _____

Name of Facility: _____

Address: _____ / _____ / _____
(District) (Region) (Zone)

Phone No: _____ Fax No: _____

1. Which of the following services are offered at this facility? (Tick all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Obstetrics | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Gynaecology | <input type="checkbox"/> Family Planning (FP) |
| <input type="checkbox"/> Antenatal/Postnatal Care | <input type="checkbox"/> Adolescent Health |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Others _____ |

2. Which of the following services receive postabortion patients?(Tick all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Maternity Ward | <input type="checkbox"/> Labour Room | <input type="checkbox"/> Emergency Department |
| <input type="checkbox"/> Gynae Ward | <input type="checkbox"/> Other (specify) _____ | |

3. Number of women admitted for complications of abortion (*Calculate average from 6 month*):

Number perceived by providers: _____/month

Number reflected in clinic records: _____/month

4. Does the hospital have a blood bank facility? (*cross-matching; storing etc*)

- Yes No

5. Are there any maternal mortality data due to complication of abortion?

Yes **No**

If yes,
No of death/yr _____ Source: _____

6. Which of the following personnel treat postabortion patients? (Tick all that apply and please note specially if applicable).

Physician Staff Nurse
 ANM Other (specify) _____

7. How are incomplete abortion patients managed at present?

MVA D&C Observation Expectant

If MVA available who is providing? Expectant

If MVA available who is providing? _____

8. Are D&C/MVA services available 24 hours? Yes No

9. How long do women stay for a D&C procedure? _____

10. How much does a D&C procedure cost? _____

11. Are there other facilities in the area that handle emergencies/referrals?

Yes No

If yes, which ones?

Part II: Services Provision Capabilities

COUNSELING

1.a) Is FP counseling or service offered to postabortion patients?

Yes No Not determined

b) When does this counseling take place?

Before procedure During procedure After procedure

Comments _____

2. Is the counseling area suitably private?

Yes No Not determined

3. Does the site have IEC materials for family planning?

Yes No

FP SERVICES:

4. Check the FP method available in the facility:

Temporary method:

Pills Yes No Condom Yes No Depo Yes No

IUD Yes No Norplant Yes No

Permanent method:

Vasectomy Yes No Comment _____

Minilap Yes No Comment _____

SERVICE PROVISION AREA

5. In this area

	Yes	No	Not determined
Equipped with a sink and a reliable source of water			
Equipped with more than one consultation section			
Sufficiently lit/good source of light			
Equipped with a storage cabinet for contraceptives			
Equipped with buckets/container for mixing chlorine bleach			
Equipped with an autoclave machine			
Equipped with puncture proof container			

Comments: _____

6. Is there a recovery room/area?

Yes No Not determined

Comments _____

7. Does this facility have the following?

	Yes	No	Not determined
Instrument sterilization/High-level disinfection area			
Covered storage space for supplies/equipment			
Local anesthetics			
Analgesics			
Antiseptics			
Tetanus toxiod			
Disinfectants			
Supply of emergency resuscitations drugs			
Antibiotics			
Ambu bag			
Oxytocic			
IV solutions			
Oxygen			
Blood products			

Part III: Other Services/Management Issues

1. What would be an ideal place for introducing PAC services? *(Should ask this question to Medical Superintendent and HOD of Gynae and Obs)*

- Gynae Ward Labour Room Emergency Department
- Maternity Ward Other _____

2. Who needs to be trained at the site? *(list specific names)*

Service provider:
(Name/Title)

Assistants:
(Name/Title)

3. Are there any INGO/NGOs who are supporting for reproductive health in the hospital?

**POSTABORTION CARE
FACILITY FOLLOW UP MONITORING FORM
FAMILY HEALTH DIVISION**

Version: 7 Nov 2001

Name of Facility: _____ Address: _____

Date: Day _____ Month _____ Year _____

Follow up Conducted by (names): _____

PAC Contac Person: _____

Position: _____

Is the participant **currently providing service** using this procedure? Yes No

If yes, what has helped him/her to do this? (Tick **all** that apply)

- Felt confident at the end of the training
- Good management support from the service provision site
- Good logistical support at the service provision site
- Other (specify) _____

If not, why not? (Tick **all** that apply)

- Lack of confidence in skills
- Lack of demand/clients
- The assessed service is not provided in this facility
- Lack of supplies/equipment/instruments
- Moved to a different facility since training,
If so, did s/he provide services before transfer? Yes No
If yes, approximately for how long? _____
- Still at same facility, but no longer in a job position to provide these services,
If yes, has s/he provided service at any time since the training? Yes No
If yes, for approximately how long? _____
- Other (specify) _____

Incomplete abortion cases managed in the following areas (tick all that apply)

- Emergency Department Labour Room Gynae Ward
- Maternity Ward PAC Unit (if available) Operation Theatre
- Other

Date PAC services started _____

Cost of MVA _____

Cost of D&C _____

PAC PROGRAM VERIFICATION CRITERIA

Criteria	Verification tools	Yes	No	Comment
Site receives at least 5-8 cases of Incomplete Abortion per month	<i>PAC Log Book</i>			
Presence of at least two trained providers (physicians or nurses) and one assistant (registered nurse or ANM)				
Physician 1 Preferably trained in PAC but if not, should be supportive of PAC services and willing to provide backup for emergency care	<i>NHTC database Provider observation</i>			
Nurse 1 or 2 staff nurse provider (S/N) and at least one assistant (S/N or ANM) trained in MVA procedure	<i>NHTC database Provider observation</i>			

Criteria	Verification tool	Yes	No	Comment
	<i>Observation of waiting room</i>			
Counseling area private				
Procedure room is clean and comfortable	<i>Observation of procedure room</i>			
Procedure room includes:				
Reliable and regular source of water available (tap, running water, bucket)	<i>Observation of procedure room</i>			
Toilet/sinks adjacent to PAC procedure room for: patients disposal of POC	<i>Observation of procedure room</i>			
FP supplies are stored in the procedure room or the adjacent room	<i>Observation of procedure room</i>			

Criteria	Verification tools	Yes	No	Comment
At least two sets of MVA instruments are accessible and in good working order.	<i>Observation of instruments</i>			
MVA equipment are processed by HLD or by using <i>cede</i> .	<i>Observation of instrument processing</i>			
<i>Discussion on family planning and choosing a method performed prior to and/or after the MVA procedure</i>				
The facility has at least 3 FP methods available: Pills, condoms and injectables (Depo)	<i>Observation of provider counseling client</i>			
FP counseling before and after the MVA procedure explaining vulnerable to pregnancy				
Offers FP method (depo, pills or condom)				
The woman gets a method or if referred is told: Where to go (location) When to go (opening hours) How to go (directions and transportation method)				
Provider assess client's status and what procedure is needed [informs the woman and her attendants (family and friends)]	<i>Patient chart Or Provider observation</i>			
Obtains consent from guardian/patient				
Supply/Commodities:				
MVA equipment				
MVA set (syringe set)				
FP Commodities:				
Pills				
Condoms				
Depo				
IP Commodities:				
Utility gloves				
Virex				
Momo cooker				
Betadine				
Cidex				
Seive or strainer				
Autoclave				
IEC Materials:				
Posters				
Wall charts				
Timing of Services:				

Client receives MVA service immediately or (within 6 hours)				
The facility provides PAC services 7 days a week				
PAC services are provided 24 hours a day				
<i>Record Keeping</i>				
The PAC procedure room contains a logbook with the standard format for recording of services	PAC logbook			
The information from the patient chart is accurately transferred to the logbook	Review sample patient charts with logbook			
The hospital or the maternity section has a policy of conducting hospital statistics review including PAC every six months				
Since starting the services the hospital or maternity section provides PAC services on a regular basis	PAC logbook			

PERSONNEL

Designation	Name	Received training (date/month of training)	Still providing services	Needs Training	Remarks
OBGYN					
Medical Officers					
Assistant (Staff Nurse or ANM)					

PAC LOGBOOK RECORD KEEPING (FHD)

S. No.	Regd. No.	Admission		Name	Age	Address	Age of Gestation from History	Size from PV Exam	Provisional Diagnosis	Anesthesia or Sedation Drugs	PAC Treatment		Provider			FP method accepted	Discharge		Remarks
		Date	Time								MVA	D&C	Dr.	Nurse	ANM		Date	Time	
1																			
2																			
3																			
4																			
5																			
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Appendix VIII

**POSTABORTION CARE
SKILL COMPETENCY CHECKLIST**

FAMILY HEALTH DIVISION

Name of Facility: _____ Location: _____

Date of Visit: Day _____ Month _____ Year _____

Provider's Name: _____ Position: _____

No. of MVA procedures conducted by provider last month _____ in 6 months _____

Assistant's name: _____ Position: _____

Counseling done by Providers Assistant Counselor

Follow up Monitoring Conducted by (names) _____

*NA = not applicable NO = Not observed

Step/Task	Yes	No	NA	NO*	Comments/recommendations
Facility, Supplies and Staffing					
MVA Procedure available on ambulatory basis and admission to ward not required					
Personnel available for procedure, counseling and FP method and discharge and warning signs information					
Private area for counseling and MVA/D&C					
Availability of condoms, pills and DMPA					
Provision facility for IUD and / or Norplant					
Referral protocol for surgical sterilization, IUD, Norplant					
Initial History					
Greets client politely					
Asks about LMP					
Asks about pregnancy symptoms					
Asks about vaginal bleeding					
Lower Abdominal Pain					
Vaginal discharge					
History of other medical problems					
Allergies to Medications					
Asks about FP methods used					

Asks about TT vaccine				
Asks about fever, chills, malaise				
Performs physical examination				
Performs abdominal exam				
Performs speculum exam (bleeding, tears, trauma. infect)				
Performs bi-manual exam				
Assesses lungs and heart				
Takes vital signs				
Notes abnormal findings on any of the above history/physical				
Rules in pregnancy by examination or pregnancy test				
Discusses findings and plan with client regarding MVA				
Discusses risks and benefits of procedure (MVA)				
Client exam/history within protocol guidelines				
If client has complicating factor, referred/treated appropriately				
Obtains verbal or written consent for procedure				
FP Counseling-can occur at any time that is appropriate (before procedure or immediately after completion)				
Step/Task	Yes	No	NA NO*	Comments/recommendations
Treats client with respect				
Privacy maintained				
Uses Two way communication				
Discusses return of fertility may occur within 2 weeks				
Ascertains client's desire to prevent pregnancy				
Discusses that FP methods available before discharge				
Asks about client's previous FP method use				
If client wishes FP method, assists client to choose method by briefly discussing each method				
Describes in detail advantages and disadvantages selected method				
Performing Procedure				
Verifies verbal consent				
Bladder emptied				
Adequate pain control (Analgesia				

administered and/or paracervical block)				
Can perform or describe correctly paracervical block				
Cervix cleansed with Betadine				
No touch technique (curette or cannula)				
Maintains sterile field/technique				
Examine tissue for chorionic villi				
Tissue removed consistent with gestational age				
Careful attention to client throughout				
When procedure completed, instruments removed and cervix examined for bleeding				
If client has chosen IUD, IUD inserted after conclusion of MVA procedure				
Post Surgical Care				
Client helped to recovery area				
Monitored every 15 minutes for 1 hour (VS, Comfort, Bleeding)				
Provision of Family Planning Method – can be supplied at anytime appropriate during the clients stay in PAC area				
If client wishes a FP method, staff explains to client instructions for use, advantages, disadvantages, potential complications, follow up, etc.				
If client chooses FP method that is available in PAC area, service provider supplies client with method and essential information about use. (IUD would be provided after procedure)				
Discharge instructions reviewed				
Activities to avoid				
Warning signs (heavy bleeding, fever, foul discharge, abdominal pain)				
Return for follow up				
Written instructions given				
Step/Task	Yes	No	NA NO*	Comments/recommendations
Records				
Client records are fully completed				
Family Planning provision is recorded				
If referral to other services, noted on chart				
Client's name and information is recorded in registry				
Infection Prevention Practices				
Decontamination solution available and made fresh every 24 hours				

Canals are stored dry in sterile covered container				
HLD of canulas by momo steamer or sterilized using Cidex				
Equipment, table, trolleys wiped down with decontaminating solution after procedure				
Gloves and instruments decontaminated before cleaning				
Instruments and gloves sterilized or HLD				
Syringes are cleaned properly and checked for suction				
Human tissues are disposed of properly				
Sharps are disposed in puncture proof box				
Hand-washing facility is available				

Conclusion from Observation

Suggestions/Recommendation

Follow up or Additional Support/Orientation/Supplies/Equipment Needed:

Appendix X

**Post Abortion Care Programme
Progress Report
Jul 2002- Jul 2003 (Shrawan 2059 –Ashad 2060)**

Services	Jul-Aug	Aug-Sept	Sept-Oct	Oct-Nov	Nov-Dec	Dec- Jan	Jan-Feb	Feb-Mar	Mar-Apr	Apr-May	May-Jun	Jun-July	Total
	Shrawan	Bhadra	Ashoj	Kartik	Mangsir	Paush	Magh	Phalgun	Chaitra	Baishakh	Jestha	Ashad	
MVA													
D &C													
FP Services													
Condom													
Depo													
Pills													
IUD													
Norplant													
Permanent													
Not Accepted													
MVA done by Dr.													
MVA done by Nurse													
Total													

Note:Started form Baishakh
Service Provided by Doctors-
Service Provided by Nurses-

