Summary Report

December 2006

NEPAL

Comprehensive Abortion Care (CAC)

National Facility-based Abortion Study 2006

Government of Nepal
Ministry of Health and Population
Dept. of Health Services
Family Health Division

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CREHPA
Center for Research on Environment
Health and Population Activities (CREHPA)
Nepal

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Protecting women's health
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Abbreviations and Acronyms

CAC	Comprehensive Abortion Care
CREHPA	Center for Research on Environment Health and Population Activities
D&C	Dilatation and Curettage
DMPA	Depo Medroxy Progesterone Acetate
FHD	Family Health Division
FP	Family Planning
FPAN	Family Planning Association of Nepal
GO	Government Organization
IUD	Intra Uterine Device
MH	Maternity Hospital
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
MoHP	Ministry of Health and Population
MSI	Marie Stopes International
MVA	Manual Vacuum Aspiration
NCC	National Consultative Committee
NDHS	Nepal Demographic and Health Survey
NGO	Non-governmental Organization
NHRC	Nepal Health Research Council
PAC	Postabortion Care
POC	Product of Conception
TBA	Traditional Birth Attendant
TCIC	Technical Committee for Implementation of Safe Abortion Care
WHO	World Health Organization

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Executive Summary

Abortion was legalized in Nepal in 2002, the procedural order[1] was passed in 2003, and the first ever Comprehensive Abortion Care (CAC) service was started at the Maternity Hospital, Kathmandu, in March 2004. Two years later (April 2006), there were 122 approved facilities (76 governments and 46 non-governmental organizations) located across 66 districts.

Objective of Study:

The present survey conducted in early 2006 was designed to be a nationally representative benchmark (baseline) to assess patterns of use, client characteristics, and clients' perceptions of services received at facilities providing CAC.

Study Design:

All 87 authorized CAC facilities functioning as CAC sites for at least six months preceding the survey formed the sampling universe. Using stratified random sampling, 13 government and nine non-governmental organization (NGO) facilities were selected for the survey. In addition, the Maternity Hospital, Katmandu was purposively selected into the sample because it is the national tertiary hospital with a large caseload. All CAC clients receiving services at the selected sites during an eight-week observation period from January 10 - March 10, 2006, were interviewed at time of discharge.

CAC Services:

During the survey period, 4,245 clients visited the selected facilities, with the Maternity Hospital receiving an average of 36 clients per day, nearly three times the average caseload at the next busiest facility. A few district-level hospitals received only one or two clients in a week, and one received only two clients during the entire survey period. Only 2,710 clients (64%) actually received services on the same day as their initial visit; the remaining 36% were either asked to return another day or were refused services because they were beyond the gestational limit. While many of the latter were beyond 12 weeks gestation, women with 9-12 weeks gestation were also turned away at several facilities because providers were reluctant to use MVA beyond eight weeks. Over half the clients (54%) visiting the Maternity Hospital on any given day were asked to return for services on another day. On the other hand, at the Family Planning Association of Nepal (FPAN) clinics and Marie Stopes International (MSI) centers over 95% of clients received services on the same day.

Of the 2,710 clients who received services, 2,293 (85%) could be interviewed. Overall only half of them knew that abortion was legal; awareness levels were higher among urban and educated women.

[1] Clinical procedures, service provision facilities, client consent and listing process

The most common reasons women gave for seeking an abortion were that the family was complete, or that an additional child was not wanted at the time because of economic reasons, or because the younger child was still breastfeeding.

Women usually chose a particular facility because the client was referred to it, or because its location was convenient, or because it was expected to be affordable. Actual costs varied considerably from facility to facility and except for MSI Centers, the cost for pain management medication and antibiotic prophylaxis was generally not included in the fees.

Postabortion contraceptive counseling was near universal (98%) and 84-95% of women accepted a contraceptive method; Depomedroxyprogesterone Acetate (DMPA) being the most common method. About half the clients at Maternity Hospital and 45% at other government hospital felt that contraceptive acceptance had been a precondition to their receiving services. Nearly all clients visiting MSI centers (94%) received information explaining that they could become pregnant again immediately, but this information was given much less commonly at other types of facilities.

Recommendations:

Based on the finding of this study, several recommendations action emerged.

Reorganization of available service

In facilities with high caseloads like the Maternity Hospital, service timings and staffing (duty rosters, additional staff) need to be reexamined to ensure that clients are catered to when they arrive, or introduce appropriate referral systems to a nearby CAC center so that the clients do not have to return without a service.

At all facilities, further work needs to be undertaken with providers and facility managers to clarify roles, responsibilities and values regarding service to clients in need.

Allowing staff nurses to be trained as CAC service providers can increase the number of providers available at any given time and can ensure the availability of a trained provider at lower levels of care and in more remote areas, where the regular presence of a trained physician may be difficult to ensure.

Similarly, expanding the range of methods to include medication abortion (MA) as an option for early pregnancy termination would be a way to expand access to CAC for more women and to provide care at more CAC facilities.

Training and provider skills

Providers who are hesitant to serve clients with gestations beyond eight-week should receive additional training on MVA procedures so they are more confidence to handle high gestational cases. Providers should also be aware of appropriately located referral facilities where clients can receive services.

All facilities could enhance training in counseling. In particular, providers need to emphasize messages about how soon after abortion fertility returns and pregnancy can recur.

While contraceptive counseling is necessary and contraception of choice should be available on site, setting preconditions is in violation of the principles of women centered care and should be discouraged.

Providers need to be trained in providing second-trimester abortion services as well so that women who do need care during this period for circumstances permitted under the law are not turned away from CAC centers.

Increasing awareness about safe services

Further work needs to be undertaken to raise public awareness amongst the population of the legality and availability of abortion related services. Each newly listed clinic should be responsible for developing a communications plan to inform the local population of service availability.

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BACKGROUND

Nepal legalized abortion in September 2002 after many years of intensive research, advocacy and lobbying. The new law grants women the right to a legal abortion on the following grounds:

1) Up to 12 weeks of gestation for any woman;
2) Up to 18 weeks of gestation for any woman;
3) At any time during pregnancy, with the advice of a medical practitioner or if the physical or mental health or life of the pregnant woman is at risk or if the fetus is deformed and incompatible with life (*National Safe Abortion Service Policy 2060 B.S.*).

The previous law did not allow abortion under any circumstances (the only exceptions were unintentional termination while undergoing medical treatment); and women who had an abortion were imprisoned.

Nepal has one of the highest maternal mortality ratios (MMR) (539/100,000 live births) in Asia (DHS, 1996), a high unmet need for contraception and a low contraceptive prevalence rate of 39% (NDHS, 2001). Prior to legalization, abortion occurred clandestinely; such abortions contributed significantly to the country's MMR and morbidity figures. According to a study conducted by the Ministry of Health in 1998, 54 % of all maternal deaths occurring in hospitals were due to unsafe abortion. Studies conducted by the Center for Research on Environment Health and Population Activities (CREHPA) in 1997, 1999 and 2000 on postabortion care at 10 major hospitals in the country showed that between 20% and 60% of the women admitted as obstetric and gynecological patients had abortion-related complications (CREHPA, 2000). About 98% of the women admitted with complications of abortion were from poor economic backgrounds.

HEALTH SERVICES

Half to three-quarters of the population depend on the public sector health care delivery system. The Ministry of Health (MOH) was created in 1956. In the 1960s public health services in Nepal consisted of a few urban hospitals and rural dispensaries. When the MOH reorganized in 1987, the country was divided administratively into five regional health directorates with 14 zones, 75 district public health offices, 3,995 village development committees, and 36 municipalities. The district health offices are responsible for providing preventive and some curative services through the five regional hospitals, one specialized maternity hospital, 11 zonal hospitals, 74 district hospitals, 117 primary health care centers (headed by doctors), 754 health posts and 3,187 sub-health posts (each staffed by an auxiliary health worker and a female maternal and child health worker). The public sector also has a network of dispensaries and clinics that provide traditional medicine service through the *Ayurvedic, Unani*, and *homeopathic* systems (Cobb et. al., 2001).

Since 1990 there has also been a rapid growth in private healthcare providers, and there are now more than 9 private hospitals, 74 private nursing homes, 2000 private clinics, and at least 10,000 private pharmacists (Pearson, 1999). Of the

18,000 registered NGOs in Nepal, approximately 250 provide some type of health-care services.

Postabortion care (PAC) facilities were introduced in Nepal at selected hospitals as early as 1995. As per the available data from the Ministry of Health and Population (MoHP) as of July 2005, 57 health facilities, including nine primary healthcare centers and six NGO facilities, had been provided with PAC units. Most government health institutions approved for CAC services also have PAC units.

IDENTIFIED NEED

Universal access to safe abortion services has the potential to significantly reduce the country's high maternal mortality rate. In Nepal, as in many countries where abortion laws have been liberalized the demand for legal and safe services has increased as clients shift away from seeking care from unsafe, untrained providers. Expanding safe abortion services and creating an enabling environment, both at the community and at the facility level for women to access these services is crucial in reducing the incidence of unsafe abortions in the country.

Implementation of the abortion law is guided by the *National Abortion Policy 2002,* which guarantees access to safe and affordable abortion services to every woman without discrimination, and *The Safe Abortion Service Procedure 2003,* which lays down criteria for listing (that is, certifying) a health institution as a Comprehensive Abortion Care (CAC) center.

The Family Health Division (FHD) under the Department of Health Services (DHS), Ministry of Health and Population is the focal point and the main coordinating body for the implementation of the national safe abortion program in the country. The *National Safe Abortion Advisory Committee,* under the chairmanship of the Director General, Department of Health Services, reviews the progress of abortion law implementation and advises the government on abortion policy reforms. The Technical Committee for Implementation of Comprehensive Abortion Care (TCIC), formed in February 2003, is chaired by the FHD/DoHS Director; TCIC members are drawn from key government ministries and departments (Ministry of Health and Population and Ministry of Law and Justice), NGOs, and donors, collectively assist the government in funding and implementation of the country's safe abortion strategy.

The strategy includes training government and NGO health service providers to deliver CAC services from listed CAC centers and increasing public awareness about the abortion law and services. Technical support for training service providers and establishing CAC centers is provided by Ipas and the Support for Safer Motherhood Program (funded by the United Kingdom Department for International Development and managed by Options UK). Two other government bodies under DoHS/MoHP – the National Health Education Information and Communication Center (NHEICC) and The National Health Training Centre (NHTC) work closely with FHD and TCIC, with NHEICC responsible for disseminating public information and NHTC is responsible for training procedures. Ipas served as the primary technical assistance organization, working with the TCIC to establish the standards and guidelines for training and service programs.

PROGRESS TO DATE

Nepal has made considerable progress in implementing of the National Safe Abortion Policy since the first services were started in March 2004 at the Maternity Hospital, Kathmandu. Since then, the number of government-approved facilities has expanded to 122 at the time of the survey[2]. According to the procedural order, both service providers and facilities must be approved and listed. Providers are listed when they receive their certificate of competency at the end of their training. While government sites are de facto considered listed, a system for listing private service sites has been established based on the minimum physical resource requirements for safe services, which includes one trained service provider.

ABOUT THE STUDY AND THE REPORT

This summary report presents the key findings from a national facility-based survey conducted by CREHPA in 2006. The overall objectives of the facility based study were to provide national benchmark (baseline) information on the safe abortion (CAC) services used at legal CAC centers across the country. The study also aimed to inform policy makers and program managers on the quality of care and the barriers to seeking early or timely abortion at these legal CAC centers.

The survey covered CAC facilities, with the following objectives:

CAC Facilities

- Document the characteristics of clients using legal public and private CAC facilities across the country;
- Understand the stages (gestation periods) at which clients seek CAC services, and explore the factors inhibiting clients from seeking to terminate pregnancy within the legally permissible gestation limit of 12 weeks;
- Document clients' perceptions regarding the quality of CAC services in terms of registration process, waiting time, pre and postabortion counseling and service fee;
- Assess the quality of CAC service delivery from the perspectives of the providers.

STUDY DESIGN AND METHODOLOGY

Selection of Sites

The unit of sampling was a facility 'listed' (i.e. certified) to provide CAC services. In order to ensure that selected sites would be fully functional, only centers which had been listed as CAC sites for at least six months preceding the survey (i.e. listed on or before August 2005) were considered in the sampling frame. Accordingly, 87 CAC facilities: 53 government-run and 34 NGO-run facilities fell within the criteria. Of these, **22 CAC facilities (25% of the sampling universe)** were selected using *stratified random sampling*. This sample size was considered adequate to represent the national scenarios.

[2] As of April 30, 2006, 122 health facilities: 76 government-run (GO) facilities and 46 non-governmental organization (NGO) facilities in 66 districts of the country were listed as approved CAC centers.

Selection of the 22 CAC facilities was done in the following manner:

First, all 87 CAC facilities were divided into three strata:

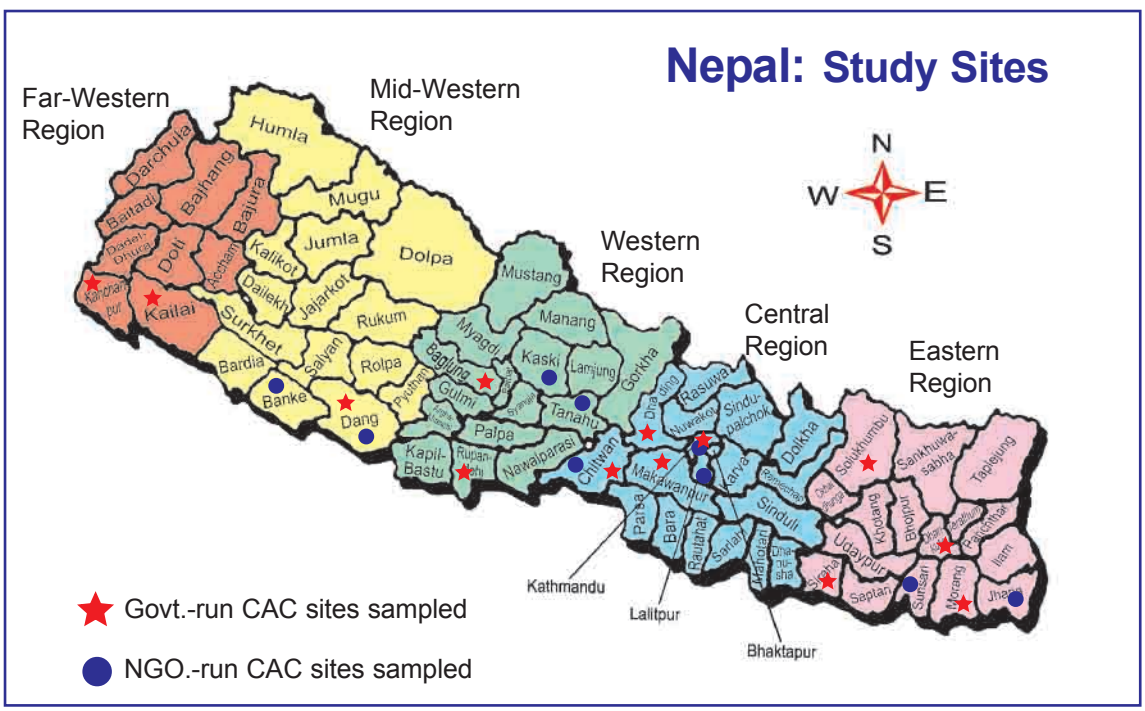
- Government facilities (n=52)
- NGO facilities (n=34) and
- Maternity Hospital, Thapathali (Kathmandu).

We took simple random sample of 12 of the 52 government facilities (with probability of selection 12/52) and a separate simple random sample of nine of the 34 NGO facilities (with probability of selection 9/34). Over-sampling of government CAC facilities was done to compensate for the actuality that some selected facilities may not be providing CAC services despite being listed. The *Thapathali Maternity Hospital,* (in Kathmandu) was purposively sampled since it is the only national-level maternity hospital and has very high caseloads. These 22 sites, including the Maternity Hospital, comprised the study sample.

The 12 government facilities in the sample included five regional/zonal hospitals and seven district hospitals. The nine NGO facilities in the sample included four Marie Stopes (MSI) centers, three FPAN clinics and two private medical colleges (Appendix 1).

One selected government-run facility (*Narayani Anchal Hospital*, Birgunj) had to be replaced after one week of observation because this zonal hospital had not started CAC service despite the hospital having been listed more than six months previously. It was replaced by Bharatpur District Hospital (Chitwan district).

Map shows the geographical spread of selected study sites



Data Collection

All CAC clients receiving services from the sampled facilities during the two month observation period (January 10 to March 10, 2006) were interviewed if they agreed to participate in the study.

Interviews for CAC clients were done at the time of discharge (exit interviews).

The survey used a pre-tested structured questionnaire and this questionnaire was administered by female interviewers. All 24 of the recruited interviewers were university graduates with experience in conducting fieldwork in reproductive and sexual health. They were given a one-week intensive training on technical issues as well as fieldwork. Representatives from TCIC/MoHP, Maternity Hospital and Marie Stopes Center were involved in the training.

In addition, 25 providers (at least one from every selected facility) were interviewed. The interviews solicited information regarding gestation stages at which clients seek to terminate pregnancy, procedures adopted for abortion, availability, skills and adequacy of the staff providing CAC, and their opinion on the risk of complications.

A seven-member *National Consultative Committee* (NCC) led by the Director, Family Health Division, Ministry of Health and Population, guided the research team in all aspects of the study. The study received technical and ethical approval from Nepal Health Research Council (NHRC).

The data collection period (January-March 2006) occurred during the *Jana Aandolan* II (the popular movement for restoration of democracy) and was marked by frequent strikes in different regions of the country. This hampered the ability of the interviewers to move around the country, reduced the efficiency and working of facilities, affected caseloads and in some cases reduced the actual number of days of observation. Data were adjusted for the variations that resulted because of this (Appendix 2).

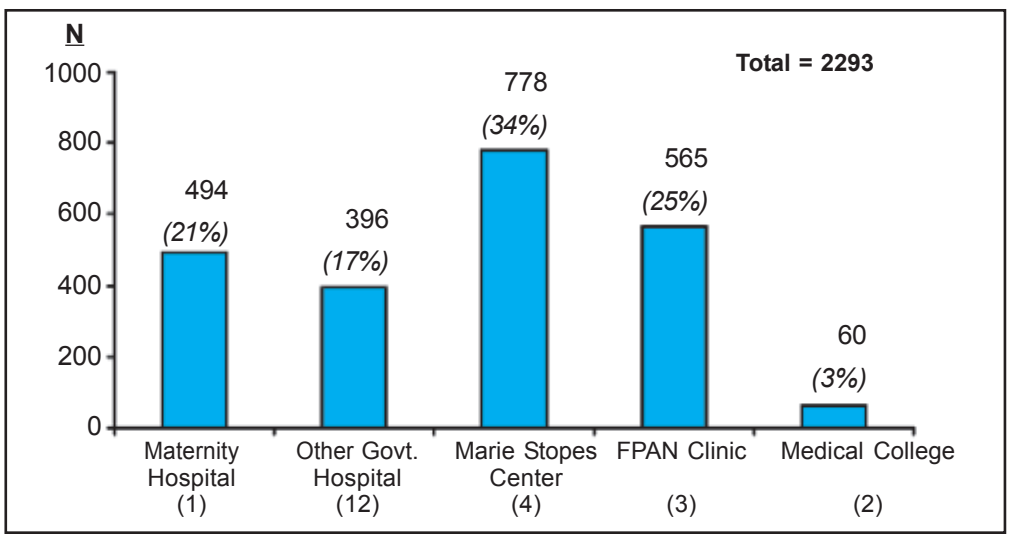
RESULTS

SECTION 1: COMPREHENSIVE ABORTION CARE SERVICE

Number of CAC Clients Interviewed

We interviewed 2,293 CAC clients (85%) out of 2,710 clients who received services on their first clinic visit from the 22 sampled CAC facilities during the two-month observation period. Of the 417 CAC clients who could not be interviewed by the researchers the majority were from MSI centers. In most of these cases, the clients were in a hurry to return to their homes after the procedure and declined to be interviewed. Moreover, one MSI center functioned on Saturdays, where the researchers were not available to conduct interviews.

Figure 1.1 Number of interviews, by type of CAC facility



Service Availability

Most government-run CAC centers (10 out of 13) and all but one NGO-run CAC center (8 out of 9) in the sample provided CAC services six days a week. The two zonal hospitals in Far Western Region (*Seti Zonal Hospital* and *Mahakali Zonal Hospital*) provided CAC services only two days a week while the FPAN clinic at Pokhara (Kaski district) provided service three days per week. The MSI center at Jhapa was the only centre that provided services everyday of the week, including Saturdays.

There was only one regular CAC provider (doctor) at all FPAN and MSI centers. Similarly, the government-run hospitals at Dhankuta (Dhankuta district), Lahan (Siraha district) and Hetauda (Makwanpur district) had just one CAC provider. In the other institutions, the number of providers ranged from two to three. In Maternity Hospital, Kathmandu, although there were 12 doctors trained in CAC services, only two doctors were assigned to serve CAC clients on a regular basis.

Use of Services

Clients seeking abortion services : During the observation period, 22 CAC facilities received 4,245 clients. The 9 NGO-run facilities received 2,116 clients (49.8%) and the 13 government-run facilities including Maternity Hospital received 2,129 Clients (50.2%).

Maternity Hospital had the highest client flow, with an average daily caseload of 36 clients, (1,527 total CAC clients) during the survey period, nearly three times the number of clients received by FPAN, Sunsari with an average daily caseload of nine, the second highest. The caseloads at MSI, Tanahun (daily average = 8), MSI, Jhapa (daily average = 8), and MSI Lalitpur (daily average = 7) were also moderately high.

On the other hand, the district hospitals at Solukhumbu (17 clients over two months) and Siraha (2 clients over two months) and the zonal hospital at Mahendranagar (19 clients over two months) had the lowest caseloads for the study period (Appendix 2).

Clients actually receiving services : Our results showed that not all clients who sought an abortion, actually received services at the facility on the day of their initial visit. Of 4,245 registered clients, only 2,710 (64%) received the service on the day of their initial clinic visit (Figure 1.2).

As many as 552 clients (13%) were denied CAC service mainly because they were more than 12 weeks gestation. This includes one in ten clients (10%) at Maternity Hospital and every fifth client who visited a medical college (22%) or other government hospital (19%) (Figure 1.2). In some government-run CAC facilities, clients whose gestation was more than 9 or 10 weeks or who were *primigravida* were denied service.

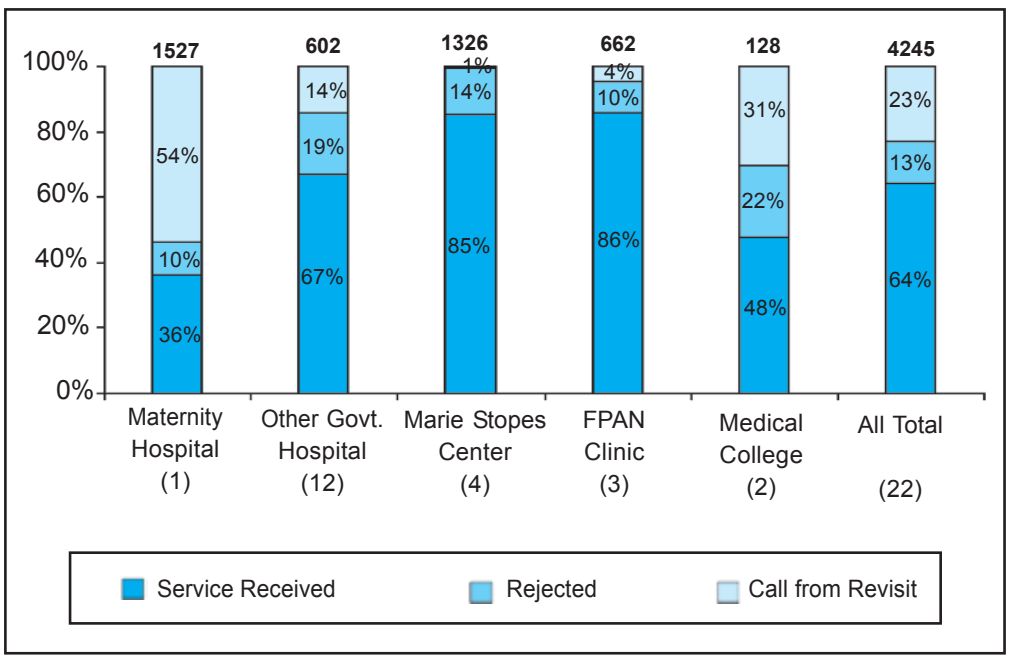
Nearly one in four clients (976 clients, or 23%) were asked to return another day. This happened if the daily quota of clients was already completed or if the client arrived after registration time. In most of the government-run CAC centers, registration closes at noon so clients arriving after 12:00 pm were turned away. At Nepalgunj Medical College, CAC services are provided after 3pm. In a few cases, clients requested for another date because they were unable to wait long hours for the service.

The percentage of clients who were asked to revisit varied considerably among the types of facilities. At Maternity Hospital, owing to very high caseloads, more than half of the clients (54%) coming on any one day were requested to visit another time; each was given an appointment (date and the time) for re-visit based on their reported gestation age. The percentage of clients who were asked to re-visit was considerably higher at the medical colleges (31%) and to some extent at government-run CAC facilities (14%) leaving the clients little option but to wait for the service or go elsewhere. In another government-run facility (Seti Zonal Hospital) services were provided only twice a week and clients were

required to make an initial visit one to two days earlier to register and have a physical examination.

At MSI and FPAN centers however, most clients (85% and 86% respectively) received the service the same day as their initial visit; only a miniscule percentage (1% and 4%, respectively) of clients were asked to re-visit.

Figure 1.2 CAC service accessibility by type of facility



Characteristics of CAC Clients

Of the 2,293 CAC clients interviewed, the majority was between 20 and 29 years old, with the median age being 27. One in twenty (5%) was 19 years or younger.

A little under half (43%) of clients at government-run (other than Maternity Hospital) facilities were illiterate. On the other hand, clients seeking care from medical colleges and NGOs clinics appeared to be better educated.

Almost all clients (97%) were married. However, among those younger than 20, over a quarter (27%) were unmarried. Most (80%) of the clients visiting Maternity Hospital and the majority of those visiting medical colleges (60%) and FPAN clinics (50%) resided in urban areas. In contrast, the large majority of the clients visiting other government CAC centers (70%) and MSI centers (65%) were from the villages.

The majority of the CAC clients (62%) were homemakers, although roughly one in seven was an agricultural laborer and one in ten clients reported that they ran a business. There appeared to be no correlation between a client's occupation and the type of facility she visited (Table 1.1).

Table 1.1 Socio-demographic characteristics of the CAC clients

	Maternity Hospital (1)	Other Govt. Hospital (12)	Govt. Total (13)	Marie Stopes Center (4)	FPAN Clinic (3)	Medical College (2)	NGOs Total (9)	All Total (22)
Age group								
<20	5.7	3.5	4.7	5.4	6.4	5.0	5.8	5.4
20-29	63.2	49.7	57.2	62.5	59.1	50.0	60.5	59.2
30-34	18.2	25.5	21.5	20.1	20.9	26.7	20.7	21.0
35+	13.0	21.2	16.6	12.1	13.6	18.3	13.0	14.4
Median age	***26.0***	***28.0***	***27.0***	***26.0***	***26.0***	***29.0***	***26.0***	***27.0***
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Education								
Never been to school	26.0	43.4	33.7	25.9	29.7	18.3	27.2	29.7
Primary level	14.8	14.6	14.7	13.9	14.5	10.0	14.0	14.3
Lower secondary level	12.3	13.6	12.9	16.2	17.7	13.3	16.7	15.2
Secondary level	27.5	21.2	24.7	34.7	32.2	20.0	33.1	29.8
Intermediate and above	19.4	7.1	13.9	9.3	5.8	38.3	9.1	11.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Marital status								
Never married	2.4	1.8	2.1	3.0	3.5	1.7	3.1	2.7
Married	97.4	97.0	97.2	96.4	96.3	98.3	96.4	96.7
Separated/Divorced/								
Widow	0.2	1.3	0.6	0.7	0.2		0.4	0.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Place of residence								
Urban	80.4	31.1	58.4	35.3	49.6	60.0	42.1	48.5
Rural	19.6	68.9	41.6	64.7	50.4	40.0	57.9	51.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	494	396	890	778	565	60	1403	2293

Pregnancy History

About two-fifths of the clients had at least two living children and about a third had three or more living children. However, nearly a tenth of married client seeking abortion from MSI centers, Maternity Hospital and medical colleges had no surviving children; this includes 74 of clients at MSI centers, 42 at Maternity Hospital, and 4 at medical colleges (Table 1.2).

Table 1.2 Pregnancy history and number of living children among married CAC clients, by percentage

Number of times being pragnant (including current pregnancy)	Maternity Hospital (1)	Other Govt. Hospital (12)	Govt. Total (13)	Marie Stopes Center (4)	FPAN Clinic (3)	Medical College (2)	NGOs Total (9)	All Total (22)
One	8.9	1.8	5.7	8.5	4.6	6.8	6.8	6.4
Two	25.7	16.7	21.7	17.9	18.7	18.6	18.2	19.6
Three	29.7	27.0	28.5	31.4	32.8	30.5	31.9	30.6
Four and more	35.7	54.5	44.1	42.2	43.9	44.0	43.0	43.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of living children								
None	8.7	1.8	5.6	9.8	4.2	6.8	7.4	6.7
One	30.7	17.5	24.8	22.1	22.0	22.0	22.1	23.1
Two	39.8	34.2	37.3	41.3	41.5	33.9	41.1	39.6
Three and more	20.7	46.5	32.3	26.8	32.3	37.3	29.4	30.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	482	389	871	755	545	59	1359	2230

Previous Abortion Experiences

Roughly, one in five (22%) CAC clients visiting NGO-run CAC centers and one in seven (15%) visiting a government-run CAC center had sought induced abortion services in at least one previous pregnancy (Table 1.3).

When asked about the type of facility sought for their past abortion, most women mentioned private clinics/nursing homes. Even among clients currently visiting the government-run CAC centers, the majority of them (58%) had sought abortion service from private clinics/nursing homes previously. Close to half (46%) of the MSI clients had either visited the same MSI center or another MSI center to terminate previous pregnancy. The present study did not ask clients about when they had previous abortion experience.

Table 1.3 Types of provider/facility utilized for termination of previous pregnancies

	Maternity Hospital (1)	Other Govt. Hospital (12)	Govt. Total (13)	Marie Stopes Center (4)	FPAN Clinic (3)	Medical College (2)	NGOs Total (9)	All Total (22)
Had induced abortion previously?								
Yes	15.6	13.9	14.9	23.8	20.7	10.0	21.9	19.2
No	84.4	86.1	85.1	76.1	79.3	90.0	78.1	80.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	494	395	890	778	565	60	1403	2292
Place/facility where previous pregnancies were terminated								
Same place	31.2	9.1	22.0	28.5	8.5	-	20.4	20.9
Government hospital	7.8	10.9	9.1	12.9	8.5	16.7	11.3	10.7
Marie Stopes center	7.8	14.5	10.6	17.2	19.7	-	17.8	15.6
FPAN clinic	1.3	-	0.8	1.1	10.3	-	4.5	3.4
Private clinic/Nursing home	53.2	65.5	58.3	36.6	39.3	100.0	38.8	44.7
Medical shop	2.6	9.1	5.3	7.5	6.8	-	7.1	6.6
Others	1.3	5.5	3.0	6.5	19.7	-	11.3	8.8
Not stated	-	-	-	0.5	-	-	0.3	0.2
N	77	55	132	186	117	6	309	441

Percentages total may exceed 100 due to multiple responses

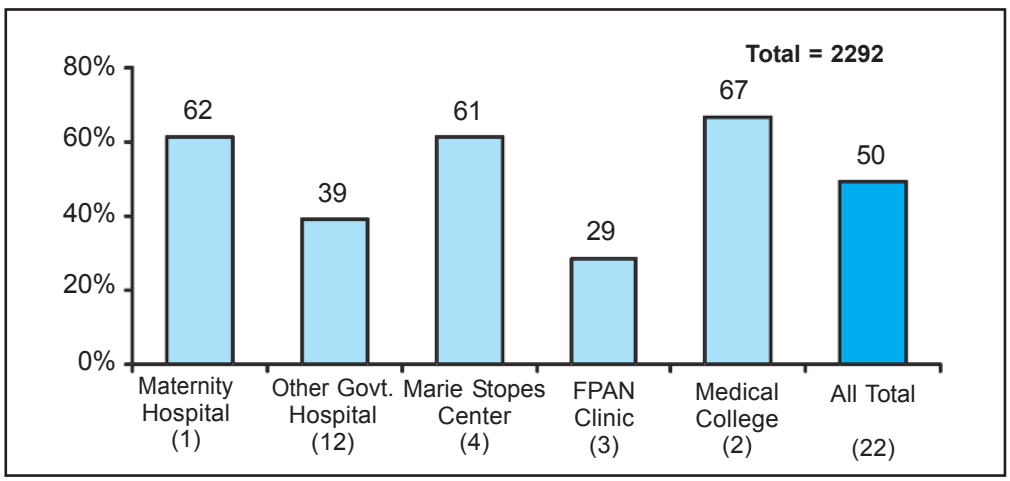
Knowledge about Abortion Law

Awareness of legalization: Only half of all interviewed CAC clients (50%) were aware that abortion was legal in Nepal. Clients residing in urban areas were relatively more aware about legalization than those residing in rural areas (55% compared to 44%). Knowledge also varied by geographical regions. Only about one-third of the clients from Far-western Region (30%) were aware that abortion was legal, compared to over half the clients from the Western Region (55%).

Facility-wide analysis showed that clients visiting Maternity Hospital, MSI centers and medical colleges were more aware of the legalization of abortion than those visiting other government hospitals (Figure 1.3). Although the majority of clients visiting MSI centers lived in rural areas, awareness among them was high. This

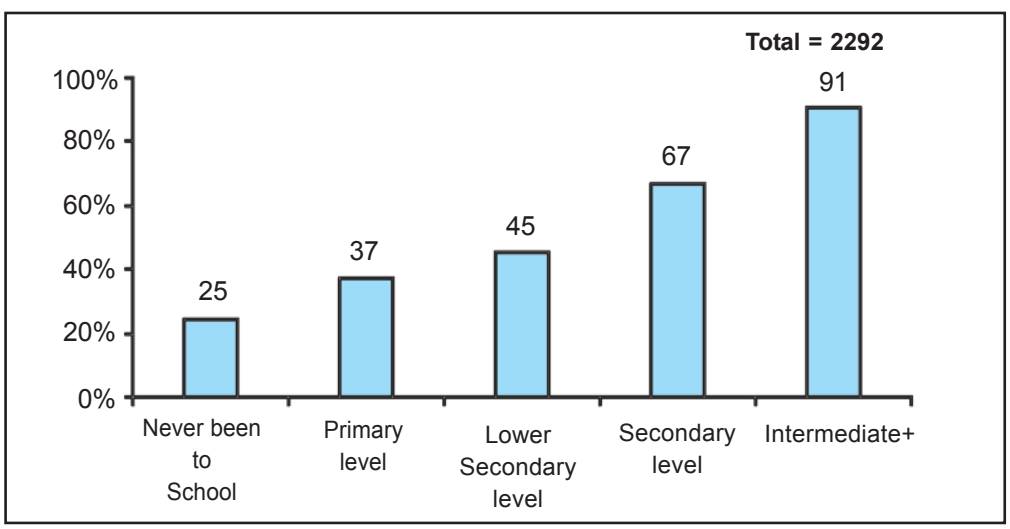
could be because of strong MSI community referral networks, private pharmacy shops that acts as referral agents, and higher percentage of better educated clients at MSI centers (45% of the clients have secondary or higher educational levels). Awareness level was low among clients visiting FPAN clinics (29%) and among clients visiting other government-run facilities (39%). There is no concrete explanation for the low level of awareness about the abortion law among FPAN clients.

Figure 1.3 CAC clients knowledge of abortion law by facility type



Awareness about legalization by educational level: Almost all (91%) clients with intermediate and above educational level were aware that abortion is now legal in Nepal. Awareness decreased as level of education decreased. Only about a quarter (25%) of those with no schooling were aware of the legalization (Figure 1.4).

Figure 1.4 Awareness about legalization according to educational levels of CAC clients



Knowledge about the conditions under which abortion is legal: Among the women who were aware of legalization, less than half (48%) knew that abortion is permitted on request during the first 12 weeks of pregnancy. Few clients (10%) knew that abortion is permitted up to 18 weeks in case of rape or incest and if pregnancy affects the health of mother or the fetus (12%).

Table 1.4 Knowledge about the three conditions for legal abortion among CAC clients

Conditions for legal abortion	Govt. Total (13)	NGOs Total (9)	All Total (22)
Up to 12 weeks of gestation for any women	52.4	44.6	47.8
Up to 18 weeks of gestation if pregnancy resulted from rape or incest	16.4	5.6	10.0
Life of pregnant woman is at risk or if the physical or mental condition of pregnant woman is at risk or if the fetus is deformed or incompatible with life	13.1	11.4	12.1
Not stated/don't know	31.5	50.4	42.7
N	458	677	1135

Percentages total exceed 100 due to multiple responses

Seeking Abortion Care

Decision making for Abortion: The final decision to seek an induced abortion was made jointly by most couples (82%). However, women who are aged 35 years and older (17%), women who had never been to school (14%), and women engaged in farming (17%) were more likely than others to have made the decision on their own (Table 1.5).

Table 1.5 Final abortion decision maker by background characteristics of CAC clients

	Self	Husband/ partner's decision	Joint decision of the couple	Total
Age group				
<25	10.8	8.5	80.7	100.0
25-34	9.5	5.3	85.2	100.0
35+	17.0	5.8	77.3	100.0
N	252	148	1886	2286
Number of living children				
No living children	10.1	7.4	82.6	100.0
One	7.8	5.4	86.8	100.0
Two	10.6	5.3	84.1	100.0
Three and more	12.0	7.3	80.6	100.0
N	230	136	1860	2226
Highest level of education				
Never been to school	13.7	7.2	79.1	100.0
Primary level +lower secondary	10.8	5.5	83.7	100.0
Secondary level	9.7	7.0	83.3	100.0
Intermediate and above	7.9	5.6	86.5	100.0
N	252	148	1886	2286
Main occupation				
House wife	8.4	6.7	84.9	100.0
Farming/Agricultural labor	17.4	6.1	76.5	100.0
Student	14.9	8.3	76.9	100.0
Business	13.5	5.7	80.8	100.0
Other sector	14.4	5.2	80.4	100.0
Total	11.0	6.5	82.5	100.0
N	252	148	1886	2286

Coercion/Forced Abortion: Some women (74 clients or 35%) reported that they had been pressured to have an abortion, of these, 77% said their husband had pressured them.

Time Lag in Seeking Abortion

Except for clients seeking care at Maternity Hospital, most had made their final decision to seek an abortion within six days of their visit to the facility (Table 1.6). In contrast, the majority of the clients (69%) seeking an abortion at Maternity Hospital had made their final decision two weeks before their visit; another 11% had made their decision more than three weeks prior.

Those who had made the final decision more than six days earlier were further asked to state the main reason for the time lag. Financial difficulty in meeting the cost of CAC service was cited as a reason by a third of those who delayed care seeking at MSI centers (33%), by one fifth of those going to medical colleges (21%) and to some extent by clients visiting other government-run hospitals (18%) and FPAN clinics (14%). One in five clients seeking abortion service at FPAN clinics explained that they delayed because their husband was abroad. Others cited distance from the CAC facility as a cause of their delay.

On the other hand, most clients (80%) seeking abortion service at Maternity Hospital and about a quarter of those visiting other government-run CAC centers (24%) said they delayed because the facility did not provide CAC services the day they first visited it (Table 1.6).

Table 1.6 Time lag in seeking abortion at CAC centers after making final decision for abortion and the main reason for the delay

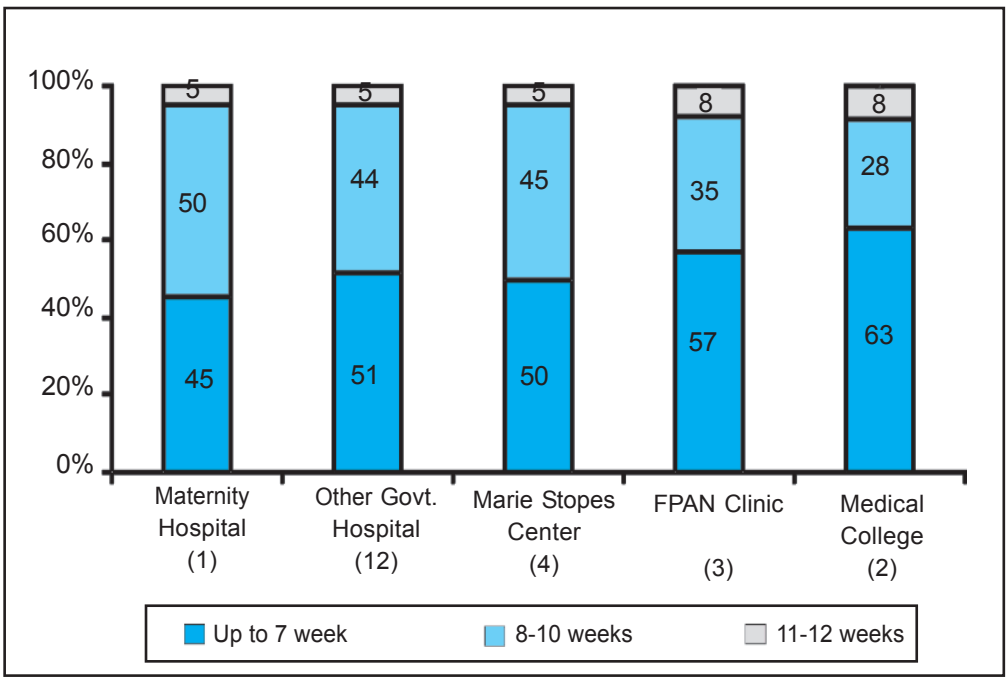
When was the decision to terminate was finally made	Maternity Hospital (1)	Other Govt. Hospital (12)	Govt. Total (13)	Marie Stopes Center (4)	FPAN Clinic (3)	Medical College (2)	NGOs Total (9)	All Total (22)
Within 6 days	26.5	87.3	53.5	74.2	78.1	76.7	75.8	67.2
7-13 days earlier	42.7	10.4	28.3	19.5	18.4	20.0	19.1	22.7
14-20 days earlier	19.2	1.5	11.4	5.0	2.8	1.7	4.0	6.8
21 days or earlier	11.5	0.8	6.7	1.3	0.7	1.7	1.1	3.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	494	395	889	778	565	60	1403	2292
Main reason for delay in seeking abortion*								
Financial problem	3.3	18.0	5.1	33.3	14.5	21.4	26.0	14.5
Husband is abroad	1.7	2.0	1.7	9.5	16.9	7.1	12.1	6.4
Not knowing service provider	1.9	8.0	2.7	10.0	7.3	7.1	8.8	5.5
Visited other places/ Service provider	1.7	6.0	2.2	1.0		7.1	.9	1.6
This facility asked to visit today	80.4	24.0	73.5	2.0	13.7	14.3	6.8	43.4
No regular service in this centre	1.9	10.0	2.9	-	4.0	-	1.5	2.3
This facility is distantly located from home	1.7	20.0	3.9	4.5	2.4	7.1	3.8	3.9
Due to *Nepal bandh*/Strike	0.6	4.0	1.0	6.0	5.6	14.3	6.2	3.3
Had tried medicines for abortion	1.9	2.0	1.9	10.0	5.6	-	8.0	4.7
Busy	2.5	4.0	2.7	16.9	18.5	-	16.8	9.1
Family problems	-	-		1.0	4.8	-	2.4	1.1
Others*	2.5	2.0	1.2	6.0	6.4	21.4	6.8	4.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	362	50	412	201	124	14	339	751

** Asked only to clients who had made final decision for abortion more than six days ago*

Pregnancy Duration at Time of Abortion

At FPAN clinics and the medical colleges, the majority of clients who received services were less than 8 weeks pregnant. At MSI centers and at most government run hospitals about half the clients were less than 8 weeks pregnant. At Maternity Hospital, however, over half the clients (55%) were above 8 weeks gestation, possibly because Maternity Hospital clients sought CAC service later than other clients (Figure 1.5) and because Maternity Hospital often asked clients with early gestations to return for services at a later date.

Figure 1.5 Uterine gestation at the time of receiving CAC service, by type of facility



Reasons for Abortion

The 2,217 currently married women were asked their reasons for wanting to terminate the pregnancy. Over 90% of clients having two or more children said that they did not desire additional children. Close to half of the clients who had no children or just one child responded that the aborted pregnancy was mistimed (47%) or that the youngest child was still small or breastfeeding (42%). A quarter of the clients with two children and a third of those with three or more children cited economic hardship as a reason for their decision (Table 1.7)

We did not probe unmarried women for the specifics of circumstances that led them to seek the abortion.

Table 1.7 Reasons for abortion among currently married women, by number of living children

Reasons for abortion	Number of living children			
	0-1	2	3+	Total
No desire of (additional) children	24.5	91.7	96.4	73.1
Economic problem	11.8	24.9	36.0	24.4
Youngest child small/breastfeeding	42.4	14.7	8.0	20.9
Too early/Mistimed	46.7	3.3	1.0	15.6
Health problem (self)	14.7	8.2	10.4	10.8
Family problem	13.5	6.0	13.3	10.5
Contraceptive failure	2.0	4.8	4.3	3.8
Studying	8.2	0.1	-	2.5
Others	3.3	0.9	1.0	1.7
N	661	880	675	2216

Percentages total may exceed 100 due to multiple responses

Contraception Prior to Pregnancy

The majority of the clients reported that they had used a contraceptive prior to the pregnancy that was terminated at the CAC facility. One in six (17%) relied upon calendar and withdrawal methods and about a third had been using condoms (33%) (Table 1.8).

Table 1.8 Contraceptive use prior to the pregnancy

Contraceptive use prior to the pregnancy	Maternity Hospital (1)	Other Govt. Hospital (12)	Govt. Total (13)	Marie Stopes Center (4)	FPAN Clinic (3)	Medical College (2)	NGOs Total (9)	All Total (22)
Yes	69.6	60.8	65.7	55.7	55.4	53.3	55.5	59.4
No	30.4	39.2	34.3	44.3	44.6	46.7	44.5	40.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	494	395	889	778	565	60	1403	2292
Method used								
Condom	31.4	27.1	29.6	36.7	32.9	53.1	35.9	33.2
Pills	19.5	25.0	21.7	23.1	25.6	21.9	24.0	23.1
Depo provera	29.1	30.0	29.5	16.2	17.6	12.5	16.6	22.1
Withdrawal method	11.9	11.3	11.6	15.2	19.5	9.4	16.7	14.5
Calendar method	1.2	1.3	1.2	5.3	1.6	3.1	3.7	2.6
Male sterilization	1.7	3.8	2.6	2.3	2.2	-	2.2	2.3
IUD	3.5	-	2.1	0.5	-	-	0.3	1.0
Norplant	1.7	1.3	1.5	-	0.6	-	0.3	0.8
Female sterilization	-	0.4	0.2	0.7	-	-	0.4	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	344	240	584	433	313	32	778	1362

Choice of a CAC Facility and Provider

Reasons for preferring the facility: The two most commonly cited reasons for choosing Maternity Hospital were affordability (60%) and presence of a skilled provider (51%). For other government-run facilities, clients cited proximity (57%) and affordability (39%). Maternity Hospital was the first government-managed hospital to start CAC service in Nepal and also the first to levy an affordable abortion fee (Rs 900/$12.75). Most other government hospitals had a higher abortion fee initially (Rs 1,500 or more/$ 21.25 or more), higher than those charged by some NGO facilities.

The large majority of MSI clients (66%) were referred by someone, mostly by private pharmacists with whom MSI has good networks. The main reason for visiting FPAN and medical colleges was the presence of a skilled provider, cited by 43% and 70%, respectively. Clients who choose these two facilities also cited proximity (Table 1.9).

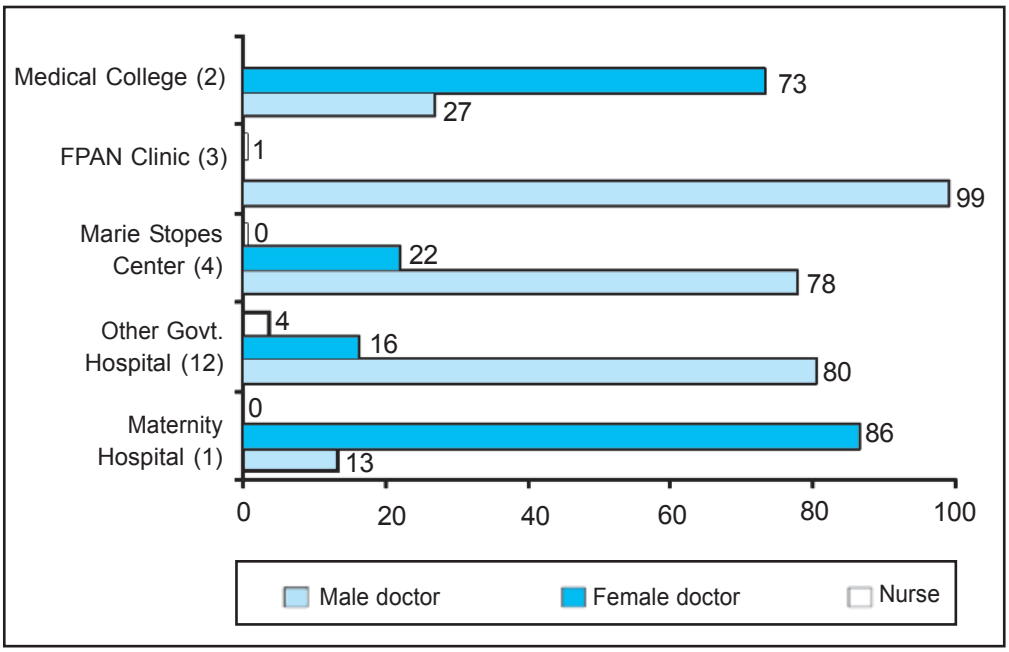
Table 1.9 Reasons for choosing the present CAC facility

Reasons for choosing this particular facility	Maternity Hospital (1)	Other Govt. Hospital (12)	Govt. Total (13)	Marie Stopes Center (4)	FPAN Clinic (3)	Medical College (2)	NGOs Total (9)	All Total (22)
Referred by someone	23.1	22.8	23.0	65.7	30.3	35.0	50.1	39.6
Presence of skilled provider	51.0	17.3	36.0	19.4	42.7	70.0	30.9	32.9
Affordable	60.5	38.6	50.8	17.2	28.8	5.0	21.4	32.8
Proximity	3.6	56.6	27.1	21.0	30.4	43.3	25.7	26.3
Convenience	13.4	8.4	11.1	7.8	3.9	-	5.9	7.9
Confidential	0.6	22.6	10.4	6.4	3.9	1.7	5.2	7.2
Only place available	5.1	10.4	7.4	6.2	1.2	6.7	4.2	5.5
Female service provider	9.3	0.3	5.3	0.4	2.1	-	1.1	2.7
Others	1.4	2.0	1.7	6.6	0.5	3.3	4.0	3.1
Don't know	-	-	-	-	0.4	-	0.1	0.1
N	494	394	888	778	565	60	1403	2291

Percentages total may exceed 100 due to multiple responses

Sex of the Provider : Over three quarter of the clients (77%) preferred female service providers; the rest had no particular preference of service providers. In contrast to clients' preferences, almost all MVA procedures at FPAN clinics (99%) were performed by a male doctor. Male providers were also around in other government-run CAC facilities (80%) and MSI centers (77%). In contrast, at Maternity Hospital and medical colleges, most MVA procedures were handled by female providers (86% and 73%, respectively) (Figure 1.6).

Figure 1.6 Sex of the CAC service provider



Service fee: The fee charged for abortion in government hospitals ranged from Rs. 800 to Rs. 2,000 (US $ 11.33 – US $ 28.33), while those at NGO facilities ranged from Rs. 925 ($ 13.10) to Rs. 1,350 ($ 19.12). Three government-run CAC centers of Dhading, Makwanpur and Lahan district hospitals charged Rs 1,200 (US $ 16), while the one at Chitwan charged Rs 1,325 ($ 18.77). The fee charged by medical colleges ranged from Rs 900 ($ 12.75) to Rs 1,130 ($ 16.00). MSI and FPAN kept a uniform fee of Rs 1,350 ($ 19.12) and Rs 950 ($13.46), respectively. However, all the CAC centers, except MSI, charged additional fees for the costs of medicines (for pain management medication and antibiotic prophylaxis). The amount of the medicine costs ranged from Rs. 50 – Rs 200.

Respondents were also asked questions about the fees (including costs of medicines) charged by the CAC centers. It is evident from Table 1.10 that on average, a client visiting a government-run CAC center paid less (average = Rs 1,005) than those visiting an NGO-run CAC center (Rs 1,005 vs. Rs 1,350). One in eight clients (12%) receiving CAC service from a government-run CAC center had paid more than Rs 1,350.

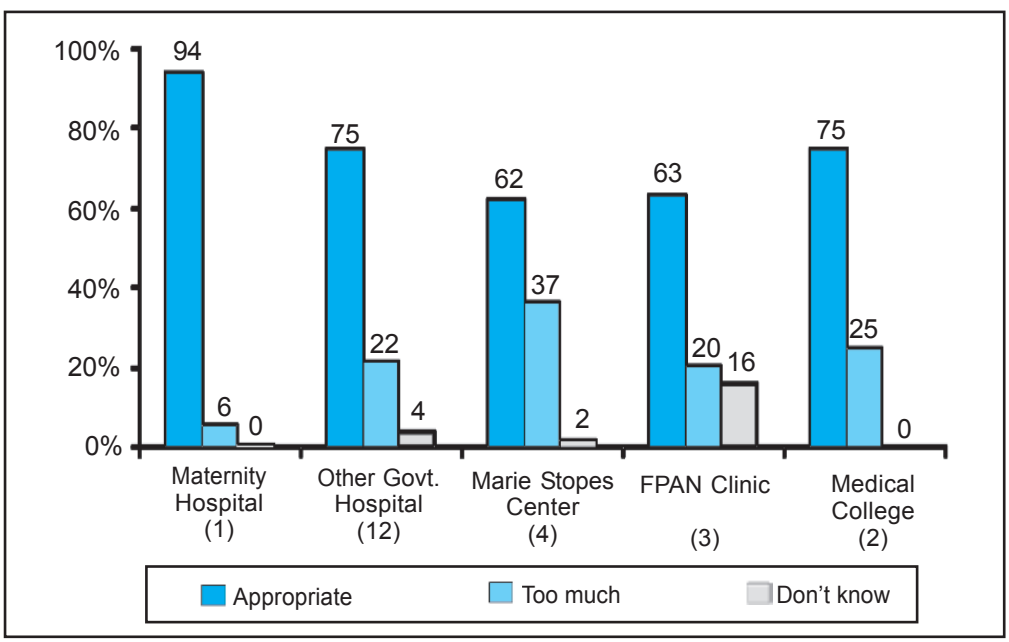
Table 1.10 Service fee paid by CAC clients

Reasons for choosing this particular facility	Maternity Hospital (1)	Other Govt. Hospital (12)	Govt. Total (13)	Marie Stopes Center (4)	FPAN Clinic (3)	Medical College (2)	NGOs Total (9)	All Total (22)
Free of cost/Only registration fee	0.4	1.0	0.7	-	0.4	1.7	0.2	0.4
Up to 1,000	72.7	15.2	47.2	0.8	1.6	3.3	1.2	19.0
1,001 to 1,350	16.0	71.3	40.5	99.1	97.7	48.3	96.4	74.7
More than 1,350	10.9	12.4	11.6	0.1	0.4	46.7	2.2	5.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Median Fee (Nepal Rupee)	**1,000**	**1,200**	**1,005**	**1,350**	**1,115**	**1,341**	**1,350**	**1,175**
N	494	394	888	776	565	60	1401	2289

*2288 total clients interviewed

Nearly all the clients receiving CAC service from the Maternity Hospital (94%) and about three quarter of those receiving service from other government-run CAC centers and medical colleges (75%) felt the service fee to be appropriate. In contrast, only about two-thirds of those receiving services from FPAN (63%) and MSI (62%) centers felt so. More than one third of MSI clients (37%) felt that the fee at MSI was 'too much'.

Figure 1.7 Clients' perception on abortion fee



Waiting time: About half of the clients (49%) in the survey had to wait more than half an hour for their first examination at the health facility. Clients visiting Maternity Hospital and other government hospitals had longer waiting times than those at other facilities. About 90% of the clients at FPAN and 70% at MSI were seen by a provider within one hour of reaching the facility. Irrespective of actual waiting times, an overwhelming percentage of clients thought that the waiting time was appropriate (Table 1.11).

Table 1.11 Waiting time for first examination

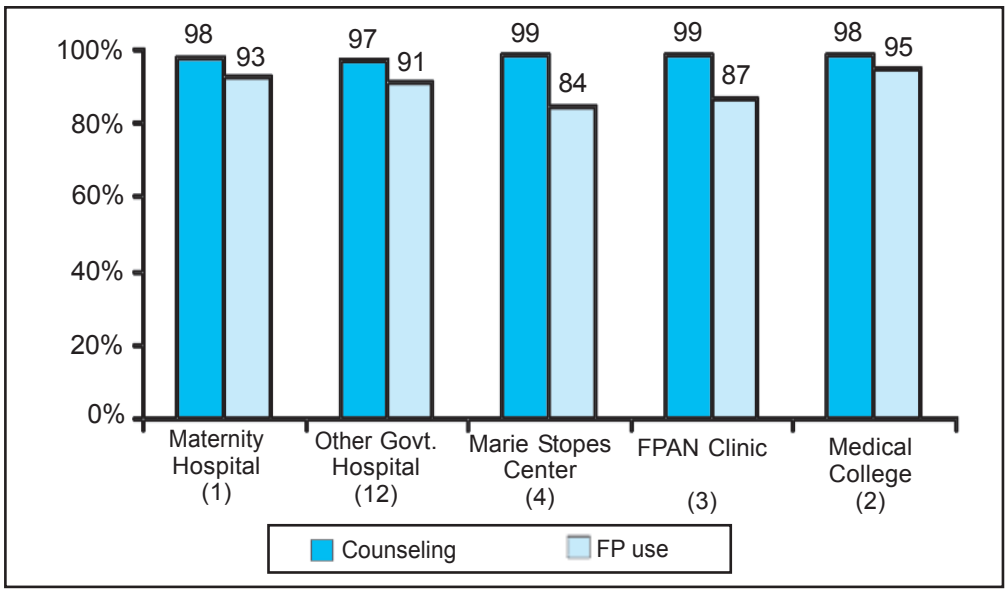
Waiting time from arrival to first examination	Maternity Hospital (1)	Other Govt. Hospital (12)	Govt. Total (13)	Marie Stopes Center (4)	FPAN Clinic (3)	Medical College (2)	NGOs Total (9)	All Total (22)
Less than 10 minutes	10.9	7.9	9.6	7.8	14.0	10.0	10.4	10.1
10 to 29 minutes	26.3	29.7	27.8	38.6	62.8	46.7	48.7	40.6
30 to 59 minutes	21.1	25.4	23.0	24.2	12.7	6.7	18.8	20.4
1 hour or more	41.7	37.1	39.6	29.4	10.4	36.7	22.1	28.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	494	394	888	778	565	60	1403	2291
Perception on waiting time for first examined								
Appropriate	87.0	83.8	85.6	85.9	93.1	73.3	88.2	87.2
Too long	12.6	16.2	14.2	14.1	6.4	26.7	11.5	12.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	494	394	888	778	565	60	1403	2291

Pain management: Hospitals used Diazepam, Fortwin, Voveron, Buscopan, Pethidine, Phenargan in both injection and tablet. Comparatively a lower percentage of clients at FPAN clinics (80%) reported receiving oral medicines for pain control than those receiving CAC services from other private (MSI = 99.5% and medical colleges = 97%) and government hospitals (99%).

Post Procedure

Postabortion contraceptive counseling and method acceptance: Almost all (97-98%) clients received postabortion contraceptive counseling. Most clients accepted a family planning method or left the facility with a method from the CAC facility after the post abortion counseling. Proportionately fewer MSI clients (84%) accepted a contraceptive method (Figure 1.8).

Figure 1.8 Extent Postabortion contraceptive counseling and family planning acceptance



The most common accepted method was DMPA (42%), followed by condom (20%), pills (18%), and IUD (12%). Clients who visited government facilities had a higher use of DMPA than clients at NGOs clinics (55 % versus 33%). In contrast, condom acceptance was higher among clients visiting NGOs clinics (27% versus 10%). A similar finding was observed in the case of oral pills as well. Comparatively, a higher percentage of clients from Maternity Hospital used IUD (25%) than the clients at other government hospitals or NGOs clinics (Table 1.12)

Table 1.12 Types of contraceptive method accepted

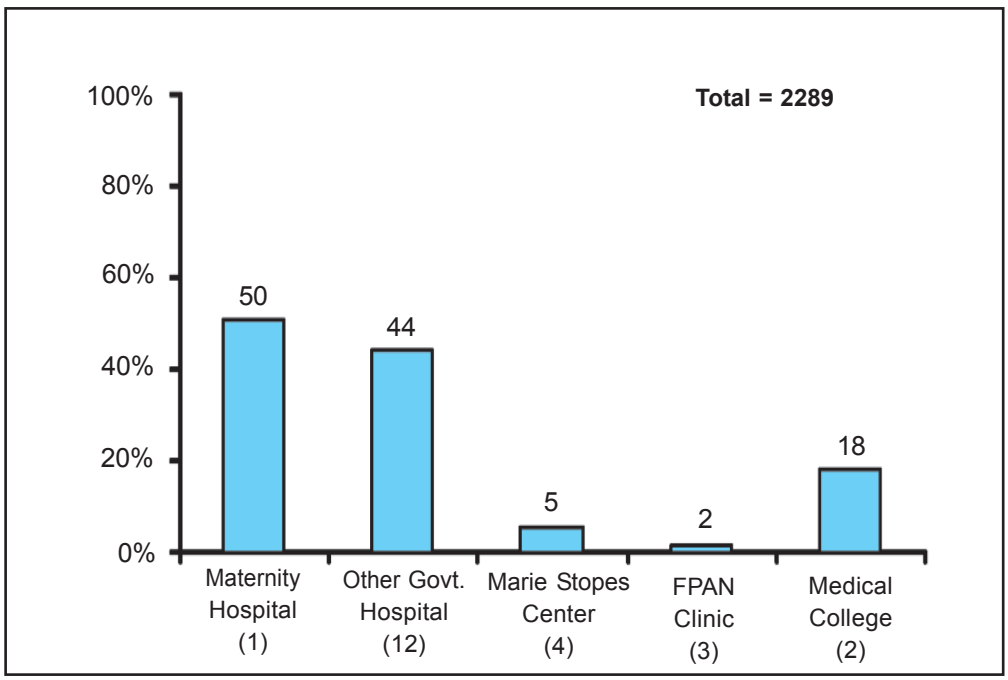
Method accepted	Maternity Hospital (1)	Other Govt. Hospital (12)	Govt. Total (13)	Marie Stopes Center (4)	FPAN Clinic (3)	Medical College (2)	NGOs Total (9)	All Total (22)
DMPA	60.9	47.7	55.1	28.9	38.4	33.9	33.0	41.9
Condom	4.2	16.4	9.5	35.8	17.9	7.1	27.1	20.1
Pills	8.2	15.8	11.5	24.3	20.4	26.8	22.8	18.3
IUD	25.1	9.2	18.2	5.6	9.1	10.7	7.2	11.6
Female sterilization	0.7	4.6	2.4	3.1	5.4	10.7	4.4	3.6
Male sterilization	0.2	3.4	1.6	1.1	3.9	8.9	2.6	2.2
Norplant	0.7	2.6	1.5	0.9	4.3	1.8	2.4	2.0
Withdrawal method	-	-	-	0.3	0.4	-	0.3	0.2
Calendar method	-	0.3	0.1	-	0.2	-	0.1	0.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	450	348	798	646	485	56	1187	1985

Preconditions for Abortion: The survey assessed whether CAC providers set preconditions for abortion, such as compulsory acceptance of contraceptive method by asking following question:

> *"Was your accepting a contraceptive method, a precondition for providing abortion care services by the service provider?"*

Half of the clients receiving CAC service at Maternity Hospital (50%) and 44% of those at other government-run CAC facilities reported that the service provider had set precondition for abortion. Very few (4%) clients of MSI or FPAN reported this to be the case. In medical colleges one in six clients (18%) said providers had set preconditions for receiving CAC service (Figure 1.9).

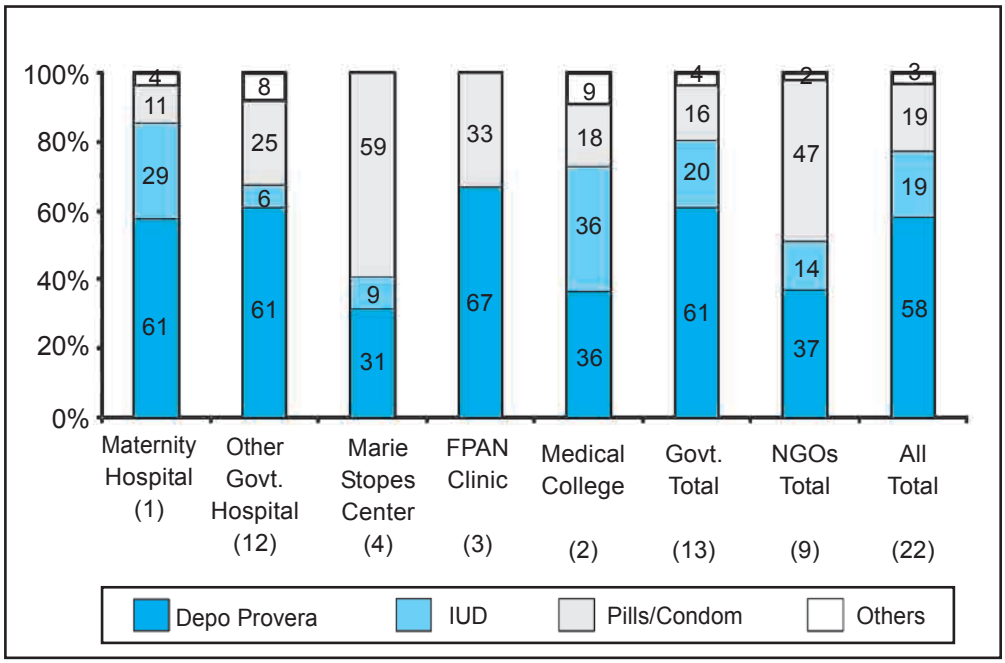
Figure 1.9 Setting of preconditions by CAC providers to clients



Of those respondents whose service provider had set the use of contraception as precondition for abortion, 93% accepted family planning[3] methods; the remaining 7% did not accept any contraception despite the preconditions. In terms of the types of contraceptives accepted, the majority of the clients in Maternity Hospital (60%) were provided DMPA and another 29 percent had IUD inserted. Acceptance of DMPA in other government hospitals (61%) and FPAN clinics (67%) was also very high (Figure 1.10).

[3] Condom, pills, DMPA, Norplant, IUD, Male Sterilization (Vasectomy) and Female Sterilization (Mini-lap)

Figure 1.10 Types of contraceptive methods accepted by clients who were set preconditions by service providers



Follow-up Advice: The practice of asking clients to come for a follow-up visit was common at FPAN clinics (85%) and for the majority at Maternity Hospital (60%). The majority of the clients receiving CAC service at other government-run facilities (51%) and MSI centers (50%) were asked to follow-up only in case of bleeding more than normal; fever or severe pain (Table 1.13).

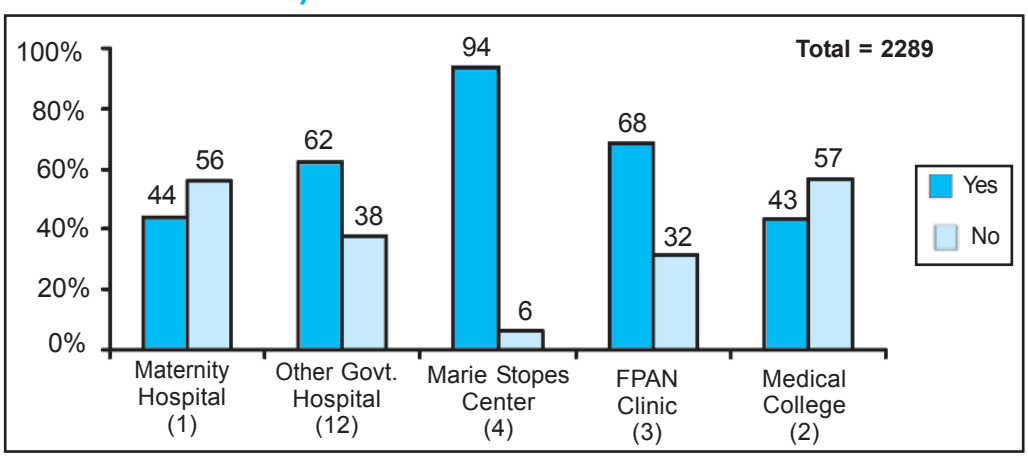
Table 1.13 Follow-up visits advised by CAC providers to clients

Provider advised for follow-up visit	Maternity Hospital (1)	Other Govt. Hospital (12)	Govt. Total (13)	Marie Stopes Center (4)	FPAN Clinic (3)	Medical College (2)	NGOs Total (9)	All Total (22)
Yes	60.3	23.9	44.1	38.1	85.0	30.0	56.7	51.8
No	12.1	24.6	17.7	11.6	9.2	33.3	11.6	13.9
In case of health problems only	27.5	51.5	38.2	50.3	5.8	36.7	31.8	34.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	494	394	888	776	565	60	1401	2289
Conditions when follow-up visit be made								
Bleeding more than normal	96.3	96.6	96.5	97.4	93.9	95.5	97.1	96.8
Severe pain	16.9	52.7	38.3	75.6	72.7	59.1	74.6	58.9
Fever	87.5	8.4	40.1	33.8	3.0	9.1	30.3	34.6
Smelly discharge	-	3.9	2.4	8.2	-	-	7.2	5.1
If menstruation not started after one month	-	-	-	1.0	12.1	-	1.8	1.0
Lower abdominal pain	0.7	-	0.3	1.3	-	-	1.1	0.8
Others*	-	-	-	1.3	-	-	1.0	0.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	136	203	339	390	33	22	445	784

* Swelling body/hands; vomiting; dizziness

Return of fertility: Nearly all clients visiting MSI centers (94%) received information that they could become pregnant again immediately. This information generally was not given as frequently to clients visiting Maternity Hospital (44%) and medical colleges (43%). Two thirds of clients who visited FPAN clinics (68%) and other government-run facilities (62%) received this advice (Figure 1.11)

Figure 1.11 Whether provider explained that you could become pregnant again immediately



DISCUSSIONS AND RECOMMENDATIONS

This study is Nepal's first national survey on facility-based abortion in the post-legalization era, and it establishes a benchmark, with important information about the way services, initiated since inception in 2002 have been delivered in government-run and NGO-run CAC facilities. The survey collected data on clinic functionality, client caseloads, information shared with clients, and clients' perceptions of the service and identified some key issues and challenges in implementing the abortion law and the National Safe Abortion Policy.

The study identified several key issues:

Reorganization of Service Availability

- **The Maternity Hospital, Thapathali; receives very high caseloads which it is currently unable to serve. Almost daily, the hospital persuades half the clients to return at a later date. This may be the reason that a high number of abortions are completed at 10 weeks gestation and more, even though clients came much earlier in their pregnancy for termination. Finding showed that most but not all clients returned to Maternity Hospital. It is not clear if those who did not return found an alternative provider.**

  Recommendations:

  - Maternity Hospital needs to re-examine its service availability and staffing to ensure it services for clients when they arrive, or develop appropriate referral systems to compensate.
  - Allowing staff nurses to be trained as CAC service providers can increase the number of providers available at any given time. The number of hours of CAC services needs to be expanded to accommodate clients who cannot arrive at the facility in time.
  - Both government and NGO managed CAC facilities need to regulate their fee systems. The individual institution's policies for providing free CAC services to poor clients should be translated into practice.

Note: At this time of printing, Maternity Hospital had already made significant progress towards implementation of recommendations.

- **The study found that because of unsympathetic attitudes of some providers towards clients' needs and expectations, most clients seeking services needed to wait for many hours simply because the provider did not want to start the CAC procedure before noon. At Nepalgunj Medical College, for instance, the CAC provider starts serving the clients only after 3pm, leaving the clients no option but to wait for the service. Another government-run facility (Seti Zonal Hospital) which provides CAC service only twice a week, also required clients to make a prior visit one to two days earlier for registration and a physical examination.**

Recommendations:

- Providers and facility managers need to clarify roles, responsibilities and values regarding providing service to clients in need.
- Again, training nurses as CAC service providers will ensure that trained providers are available at lower levels of care and in more remote areas where the regular presence of a trained physician may be difficult to ensure.
- Include medication abortion (with *mifepristone* and *misoprostol*) in the methods offered by providers. This would expand the options and choices available and make abortion more accessible to women and allow services to make CAC service available at lower levels of care.

Note: At the time of printing, the FHD has made significant progress towards permitting Mid-level providers perform medication abortion.

Training and Provider Skills

♦ **Some providers in government-run facilities have a tendency not to serve clients with high uterine gestation (beyond 9-10 weeks). This has deprived clients of their rights to safe and legal abortion up to 12 weeks of gestation from any government-approved facility of her choice**.

Recommendation:

- Give providers who are hesitant to serve any client with higher uterine gestations additional training on MVA procedures to build confidence to handle high gestational cases.

♦ **Certain government-run hospitals including Maternity Hospital tend to set some preconditions for abortion service (compulsory acceptance of a contraceptive method upon receiving CAC service), which is against human rights. The survey revealed that almost all clients in every CAC facility received postabortion contraceptive counseling and there was a very high level of acceptance on family planning method. Unfortunately, clients generally are <u>not</u> given information about how soon their fertility could return.**

Recommendation:

- While contraceptive counseling is necessary and contraception of choice should be available on site, setting preconditions is in violation of the principles of woman-centered care and should be discouraged. On the other hand, it is important for the providers to give each and every client information regarding how soon fertility can return following an abortion and how soon she can become pregnant again.

♦ **The study also revealed that there are clients who do need services beyond 12 weeks and whose needs cannot be served by most current CAC institutions.**

Recommendation:

- Include training in second trimester services for providers and make more centers capable of providing such services.

Note: At the time of printing, the Second trimester Training was in development.

Increasing Awareness

♦ **Clients who seek abortion service from CAC-listed hospitals or clinics are not necessarily aware of legalization. The majority of clients are also not aware of the three legal conditions for abortion.**

Recommendation:

- Raise awareness among the population of the legality and availability of services. Each newly 'listed' clinic should be responsible for developing a communications plan that informs the local population of service availability. The government should work closely with legal experts, rights-based organizations and community networks to expand Information Education and Communication (IEC) to women.

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Appendix 1 Lists of 22 CAC Facilities sampled for the study and their regional distribution

Region	Government Facilities			Non- Government Facilities	Total
	District level	*Zonal/regional level*	*National level*		
Eastern	Dhankuta Koshi Hospital*	Koshi Zonal Hospital*, Biratnagar	-	FPAN, Itahari*	6
	Lahan Hospital, Siraha	-	-	Marie Stopes, Jhapa	
	Phaplu Hospital, Solukhumbu				
Central	Dhading Hospital*, Dhading Bharatpur Hospital		Maternity Hospital*	Marie Stopes, Satdobato, Lalitpur	
	Makwanpur Hospital*, Hetauda	-	-	Kathmandu Medical College, KTM*	7
	-	-	-	FPAN, Chitwan	
Western	Baglung Hospital*	Lumbini Zonal Hospital*, Rupandehi	-	FPAN Pokhara Marie Stopes, Damauli	4
Mid-western		Bheri Zonal Hospital*, Nepalgunj	-	Nepalgunj Medical college, Banke*	3
	-	-	-	Marie Stopes, Tulsipur Dang	
Far-western	-	Mahakali Zonal Hospital*, Kanchanpur	-	-	2
		Seti Zonal hospital, Dhangadi*			
Total sample	7	5	1	9	22

*** has PAC unit**

Appendix 2 Caseloads of clients at specific CAC facility by type of facility

CAC Centers	CAC service days Per week	Number of days CAC service held/ observed	Number of clients visited for service	Number of clients received service	Average CAC clients per day served	Average CAC clients per week served
Maternity Hospital Thapathali	6	42	1527	552	13.14	78.84
Average	**6**	**42**	**-**	**-**	**13.14**	**78.85**
District Hospital, Solukhumbu	6	51	17	17	0.33	1.98
Seti Zonal Hospital, Dhangadi	2	16	41	29	1.81	3.62
District Hospital, Dang	6	47	142	65	1.38	7.8
Mahakali Zonal Hospital, Kailali	2	13	19	4	0.30	0.61
District Hospital, Makwanpur	6	33	34	27	0.81	4.86
District Hospital, Siraha	6	37	2	2	0.05	0.3
District hospital, Chitwan	6	42	44	37	0.88	5.28
District Hospital, Dhading	6	50	114	78	1.56	9.36
Koshi Zonal Hospital, Biratnagar	6	49	25	25	0.51	3.06
District Hospital, Rupandehi	6	50	56	29	0.58	3.48
District Hospital, Dhankuta	2	15	44	36	2.4	4.8
District Hospital, Baglung	6	48	64	52	1.08	6.48
Total	**60**	**451**	**602**	**401**	**0.89**	**4.44**
FPAN Clinic, Pokhara, Kaski	3	21	70	42	2.0	6.0
FPAN Clinic, Chitwan	6	47	230	179	3.80	22.8
FPAN Clinic, Itahari, Sunsari	6	42	362	347	8.26	49.5
Total	**15**	**110**	**662**	**568**	**5.16**	**25.81**
Marie Stopes Center, Jhapa	6.5	54	383	341	6.31	41.0
Marie Stopes Center, Tulsipur, Dang	6	49	225	188	3.83	22.98
Marie Stopes Center, Tanahu	6	48	385	334	6.95	41.7
Marie Stopes Center, Satdobato	6	48	333	265	5.52	33.12
Total	**24.5**	**199**	**1326**	**1128**	**5.67**	**34.69**
Kathmandu Medical College and Teaching Hospital	6	48	75	39	0.81	4.86
Nepalgunj Medical College Kohalpur, Banke	6	50	53	22	0.44	2.64
Total	**12**	**98**	**128**	**61**	**0.62**	**3.73**