

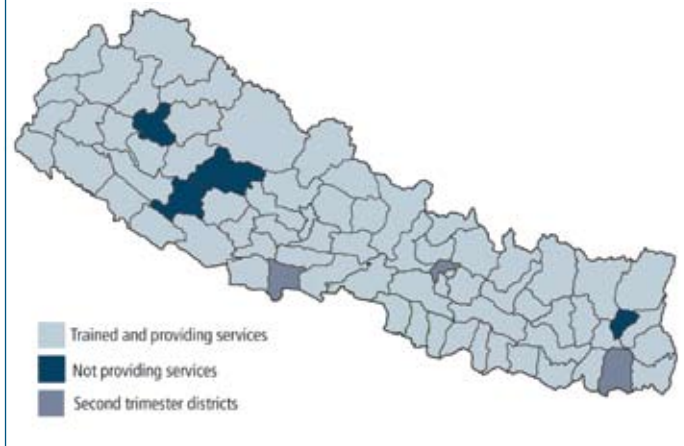
AN EXPLORATORY STUDY OF COMPLICATIONS FROM
Comprehensive Abortion Care (CAC)
IMPROVEMENT OF THE QUALITY OF CAC SERVICES IN NEPAL



BACKGROUND

Nepal began providing comprehensive abortion care (CAC) services in 2004 after abortion became legal in 2002. Between 2004 and 2007, cumulatively 176 CAC service sites — government, non-governmental organizations (NGOs) and private service centers — were established throughout the country (FIGURE 1). Although a national monitoring system of CAC services was implemented, reporting of CAC-related complications was incomplete. An important contributing factor was the independence of CAC and postabortion care reporting.

FIGURE 1: CAC services are available in most administrative regions of Nepal.



METHODS

To better understand the incidence and severity of CAC complications, a prospective study of abortion care was conducted at 30 randomly selected, listed CAC service sites over a three-month period. The purpose of the study was to identify and document the frequency and type of complications that occurred, as well as to suggest strategies to improve the monitoring and management of complications. Complications were determined based on clinical diagnosis recorded in case papers as well as self-reported symptoms that were followed-up, in some cases by a clinical examination. A standard definition of complication was not used, allowing individual providers and sites to make various diagnoses. A majority of the clients were followed-up through phone calls.

FINDINGS

Overall, 7,386 clients received services at 27 participating sites. Among clients, 7,007 (93%) were followed up approximately two weeks post procedure to determine whether they had developed complications. The majority of patients sought care from Marie Stopes International/Sunaolo Parivar Nepal (MSI/SPN) facilities (FIGURE 2). Mean LMP was 7.1 weeks (sd = 1.64).

All patients received first-trimester CAC services using manual vacuum aspiration. Contraceptive counseling occurred with 6,983 (99%) of clients; 5,679 (81%) left with a family planning method (FIGURE 3). Condoms were the most popular method.

The overall complication rate was 2.0 per 100 procedures (95% CI: 0.63 – 3.45) during either the procedure, the follow-up period or both. The most frequently reported post-procedural

FIGURE 2: Clinic use among CAC clients (%)

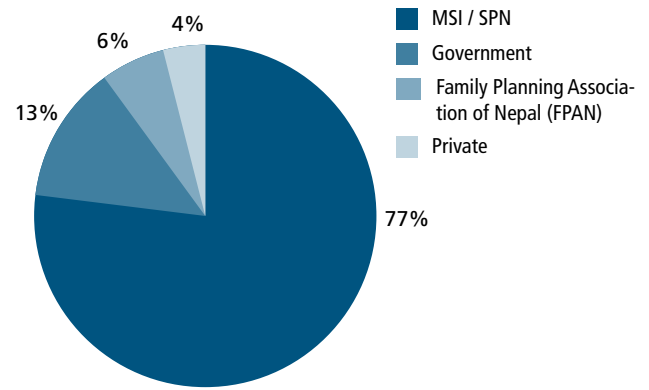
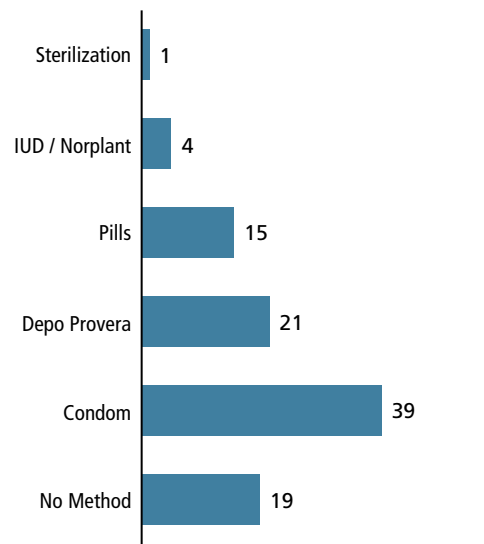


FIGURE 3: Postabortion contraception as a % of 7007 CAC clients



problems were retained products of conception (1%), offensive discharge (<1%), moderate bleeding (<1%) and suspected sepsis (<1%) (FIGURE 4). There were no reported cervical tears/lacerations, uterine perforations or missed ectopic pregnancies.

Using a modified version of the Jewkes scale to measure complication symptom severity, 89 of the 131 clients with post procedure complications (1.3%) experienced low-severity complications; 40 (0.57%) experienced moderate severity and two (0.03%) experienced high-severity complications (FIGURE 5).

Complication rates did not vary significantly by facility or individual patient characteristics such as parity, age or educational status. However, women receiving care at MSI/SPN clinics were significantly less likely to report complications than women receiving abortion care from all other clinic types ($p < .001$) (FIGURE 6). In particular, 1.0% of women receiving care at MSI/SPN clinics experienced abortion-related complications, compared to 5.6% of women accessing care at other types of facilities.

FIGURE 4: Signs, symptoms and complications arising from CAC procedures

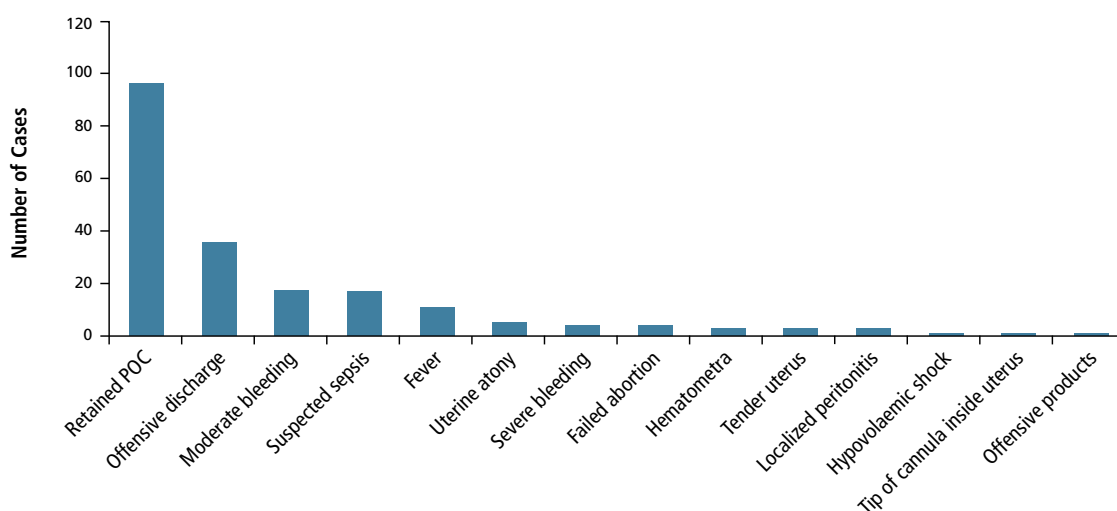


FIGURE 5: Overall complication rates were low (2%) and were of low to moderate severity.

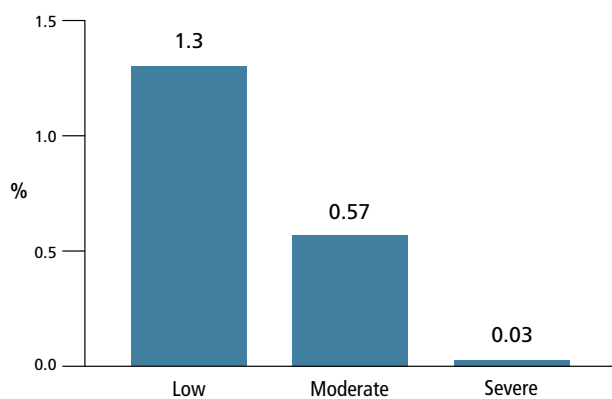
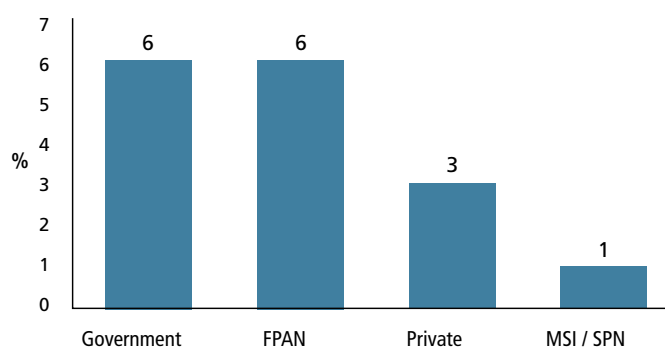


FIGURE 6: Complication rate by facility type, % of 7007 CAC clients



DISCUSSION

The overall complication rate is similar to rates found in other studies (Sheriar et al. 2007)¹, suggesting that CAC services in Nepal are being provided safely. This is most likely a reflection of good provider training and adherence to procedure protocols.

Nurse providers proved to be successful with monitoring and following-up of CAC clients; cell-phone use may have future positive advantages for follow-up in other areas of health.

However the occurrence of complications, particularly for incomplete abortion, can be further reduced by improving training on inspection of products of conception and ensuring light boxes or clear containers and an adequate light source are at all sites. An increase in the administration of antibiotics for signs and symptoms of complications should be ensured. Also, improved communication between referring facilities on patient information will improve monitoring of CAC complications. Client counseling at all facilities should also be strengthened to ensure women have the ability to recognize signs and symptoms of complications.

Finally, the integration of a client complication monitoring system into Nepal's existing CAC register is recommended. This monitoring system does not require every CAC client to be followed-up but instead allows providers the ability to track CAC-related complications when they arise.

PROPOSED MONITORING SYSTEM

The client complication monitoring system has been developed and will be integrated into Nepal's current CAC register under the Health Management Information System (HMIS). The CAC register has been modified to include questions about complications, referral and outcomes of complications so that providers will have all patient information related to CAC in one place. The revised register would require a short period of training for CAC service providers on its use as well as how to monitor and follow-up CAC clients presenting with complications. This monitoring system requires no additional human resources and minimal expense.

¹ Sheriar, Nozer, Tank Jaydeep and Bela Ganatra. 2007. First Trimester MTP using MVA: Report of a FOGSI multicentre study across 27 clinics. *Journal of Obstetrics and Gynecology India*, 57(2): 162-166.

RECOMMENDATIONS

Based on the findings of this study, the following are recommendations to further reduce complications from safe abortion procedures:

1. Provider training and facilitated supervision should encourage trained providers to check products of conception after every CAC procedure, either with a light box or by holding a clear container up to a light source such as natural light or a torch confirm whether or not any tissue remnants remain in utero. These checks should be performed out of the patient's view.
2. Additional work in conjunction with the Health Management Committee of the MOH should ensure that oral antibiotics are a part of treatment protocols for patients presenting with signs and symptoms of complications that require them.

The findings of this study also point to the following recommendations to improve monitoring of CAC complications:

1. Although routine follow-up of all CAC cases is not necessary, a system to track and follow-up women who develop problems is advisable. Refinement and implementation of the proposed client complication monitoring system is recommended.
2. Annual review of the proposed complication monitoring system, once it has been implemented, will ensure trained providers are continuing to provide quality services and that the complication rate remains low.
3. Quarterly review of the CAC complication logbook should be conducted and shared by the Family Health Division and partners. The logbook will record the following information: complication type, treatment of complication, facility type, CAC or postabortion care, technology, client gestation and provider type.
4. The physically challenging terrain and difficult access to health facilities warrant further exploration into different ways cell phones can be helpful with other health issues.

5. Additional health staff are not needed to conduct monitoring and follow-up activities. Instead, efforts should focus on less mobile health staff such as nurse providers and nurse assistants.
6. Collaboration with the government's Logistics Management Division is needed to implement an adequate MVA supply system for public facilities based on actual caseload.
7. Improved communication on patient information between referring facilities will create better monitoring and quality of care for CAC complication cases.
8. Providers must make the time to counsel patients to distinguish between normal signs and symptoms expected after CAC procedures and serious signs and symptoms indicating that medical attention is needed. Providers should also provide patients with information about where and how to seek care or contact the facility in an emergency. Finally, clients should be encouraged to return to the same facility for care.
9. Further investigation should examine client and provider preferences for family planning methods as well as contraceptive availability, which frequently determines choice and acceptance. Continuous reinforcement on the importance of family planning counselling and provision of methods during provider trainings is integral to reducing unwanted pregnancies that result in termination. Small changes at the facility level, such as strategic placement of family planning IEC materials and posters for patients help to create maximum awareness.

FOR MORE DETAILS ON THE METHODOLOGY AND FINDINGS, PLEASE REFER TO:

Karki, Yagya Bahadur, Indira Basnett, Kathryn Andersen Clark, Bela Ganatra and Sarah Stucke. 2009. An Exploratory Study of Complications from CAC: Improvement of the Quality of Comprehensive Abortion Care (CAC) Services in Nepal. Kathmandu, Ipas.



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