Effectiveness of Early Pregnancy Detection and Referral by FCHVs on Women's Use of Safe Abortion Services in Nepal, 2017

Introduction

Early detection of pregnancy is important for initiating antenatal care (ANC) for an intended pregnancy and for seeking safe abortion care for an unintended pregnancy. Lack of certainty about pregnancy status can cause delays in seeking ANC or abortion. Further, early identification of an unwanted pregnancy is important so women can access abortion services before they exceed the legally allowed gestational limit. A recent study in Nepal revealed that only 42% of all abortions are provided legally in government-approved health facilities[1].

Nepal boasts a wide network of Female Community Health Volunteers (FCHVs), who are recognized for providing trusted information about basic maternal, neonatal, and child health care and safe abortion services (SAS) at the community level. Additionally, they serve as a link between communities and public health facilities. FCHVs trained for early pregnancy detection have been identified as a potential channel for referring women to appropriate reproductive health services after a pregnancy test[2]. The effectiveness of early pregnancy detection and referral (EPDR) by FCHVs in hard-to-reach areas of Nepal is yet to be established. This study aimed to assess the additive benefit of an FCHV EPDR intervention on women's use of safe abortion services.

Methodology

The evaluation utilized quantitative and qualitative methodologies and includes perspectives from a variety of stakeholders (women, FCHVs, abortion providers, site in-charges, and health management committees) in two purposively selected hilly districts in the Far West region of Nepal, Achham and Doti. The two districts are comparable in terms of socio-economic status and geography (remote and hard to reach), and they were selected as intervention and comparison areas respectively.

A description of Ipas Nepal's FCHV EPDR intervention package is presented in Box 1. In addition to this intervention, both districts received Ipas's standard technical and programmatic support[3]. Baseline data were collected from March to May 2016, FCHVs were trained in June 2016, and endline data were collected from February to March 2017.

At baseline and endline, client exit interviews were conducted with women who received abortion care from Ipas-supported health facilities to assess changes in abortion knowledge and UPT use and abortion referrals provision by FCHVs. In Achham, 326 women (baseline:161 and endline:165) were interviewed and 281 (baseline:119 and endline:162) were interviewed in Doti. To further explore abortion referral pathways, in-depth interviews were conducted with 15 women from Achham who were referred for safe abortion care by FCHVs. At endline, semi-structured interviews were conducted with key stakeholders (abortion providers, site in-charges, and health management committees) from Achham (45) and Doti (51) to better understand their perspectives on their working relationship with FCHVs and the implementation of the FCHV EPDR intervention. In addition, in-depth interviews were conducted with 15 FCHVs in Achham to better understand their opinions about the intervention.

Box 1: FCHV EPDR Intervention Description

FCHVs were trained to perform urine pregnancy tests (UPTs) and to provide safe abortion information and referrals to women in their catchment area, in addition to their typical duties of contraceptive counseling, provision of condoms and pills to existing users, and providing referrals for ANC and other contraceptive methods (sterilization, injectables, and intrauterine devices). The FCHV EPDR intervention was carried out in 3 steps:

1) A one-day Training of Trainers workshop on performing UPTs and providing abortion referrals was conducted for all health facility in-charges.
2) Health facility in-charges conducted one-day trainings on performing UPTs and abortion referrals for all FCHVs in their catchment area.
3) FCHVs informed women about UPT availability primarily through Mothers Group Meetings.

Upon completion of training, each FCHV was provided with 10 UPT kits for use in her community. FCHVs agreed to charge up to Rs 50 ($0.50) per test. This payment would be used to replenish UPT kits and a small portion would be kept by the FCHV as a financial incentive. After using the initial supply, FCHVs were free either to purchase UPT kits from local chemists or health facility in-charges would facilitate UPT kit procurement.

1 Puri,M et. al. Abortion Incidence and Unintended Pregnancy in Nepal. International Perspectives on Sexual and Reproductive Health. December 2016, 42(4): 197-209.

2 Andersen, K et.al. Early pregnancy detection by female community health volunteers in Nepal facilitated referred for appropriate reproductive health services. Global Health: Science and Practice. November 2013, 1(3):372-381.

3 Comprehensive abortion care training for providers, post-training follow-up and support, site support, Client Oriented Provider Efficient (COPE) and Partnership Defined Quality-Youth (PDQY) activities

All quantitative data were double entered in a CSPro database and data analysis was conducted using STATA 14. Descriptive and bivariate analyses were performed using the Mantel–Haenszel test for categorical variables and non-parametric rank sum test for continuous variables since the normality assumptions were violated. For the qualitative data, interviews were transcribed, translated to English, and analyzed manually using a content analysis. Ethical clearance was obtained from Institutional Review Board (IRB) of Nepal Health Research Council and Allendale Institutional Review Board in the United States.

Table 1: Socio-demographic characteristics of exit clients

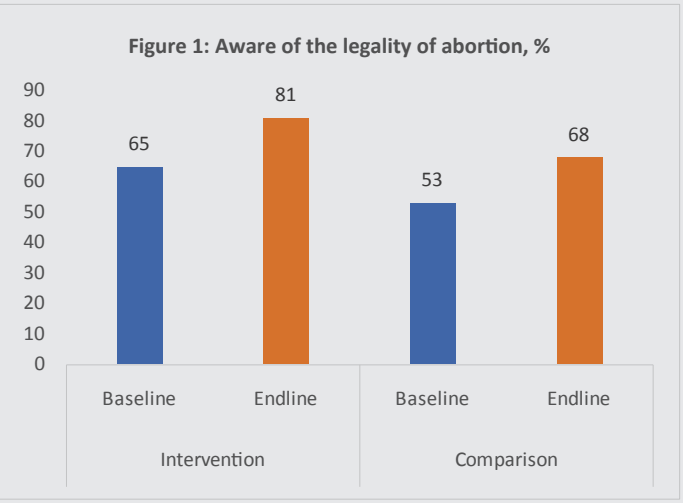
	Intervention Achham		**Comparison** Doti	
	Baseline (n=161)	End line (n=165)	Baseline (n=119)	End line (n=162)
	%	%	%	%
Age (mean year)	28.7	28.7	30.7	30.2
Place of residence[+]				
Rural	60.9	65.5	86.6	90.7
Urban	39.1	34.5	13.4	9.3
Caste of the respondent[+]				
Dalit	23.0	29.7	22.7	25.9
Brahman/Chhetri	72.0	66.7	71.4	69.1
Others*	5.0	3.6	5.9	4.9
Level of education[+]				
Never been to school	55.9	59.1	60.5	66.2
Primary	6.8	7.9	16.0	11.9
Some secondary	23.0	24.4	17.6	11.2
Higher than secondary	14.3	8.5	5.9	10.6
Relationship status[+]				
Married	99.4	100	100	98.8
Unmarried	0.6	0	0	1.2
*Others include Janajatis, Muslims				
[+] p>0.05				

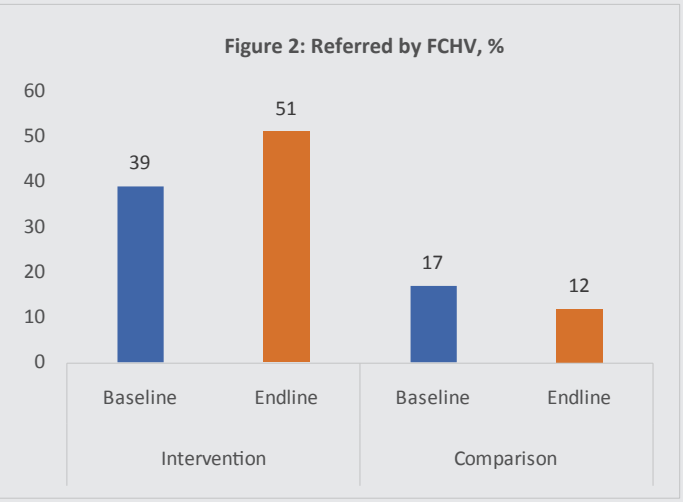
Results:

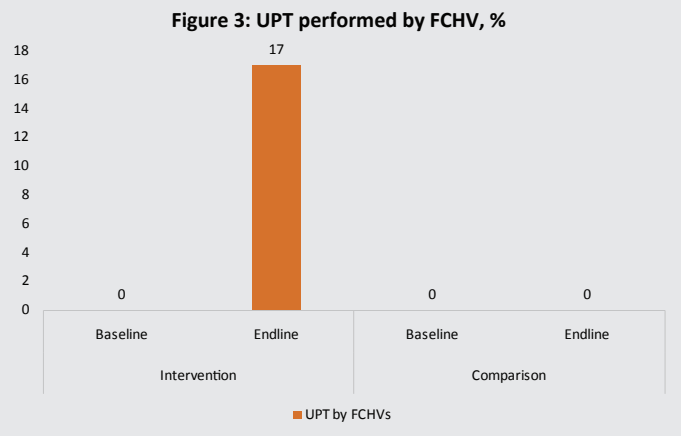
Client exit interviews:

Table 1 presents the socio-demographic characteristics of the women interviewed. There were no statistically significant differences between the baseline and endline respondents in both the intervention and comparison areas. In both districts, a majority of respondents were Brahmin/Chhetri followed by Dalit. In the intervention district, about two-thirds of clients were from rural areas whereas in the comparison district almost nine-tenths of clients were from rural areas. The percentage of clients who had never been to school was slightly higher in the intervention district than in the comparison district. Likewise, the percentage of clients who had higher than secondary level education was slightly higher in the intervention district compared to the comparison district. Almost all clients were married in both the intervention and comparison districts.

Figures 1-3 present the changes in the key outcome indicators from baseline to endline in the intervention and comparison districts. Knowledge about the legality of abortion increased significantly in both districts from baseline to endline, but the increase was slightly higher in the intervention district (Figure 1). The percentage of clients referred by FCHVs increased significantly in the intervention district (baseline:39% and endline:51%), whereas in the comparison district, there was a decrease (baseline: 17% and endline: 12%) (Figure 2). Less than one-fifth (17%) of all women seeking abortion care had a UPT done by a FCHV in the intervention district at endline (Figure 3).

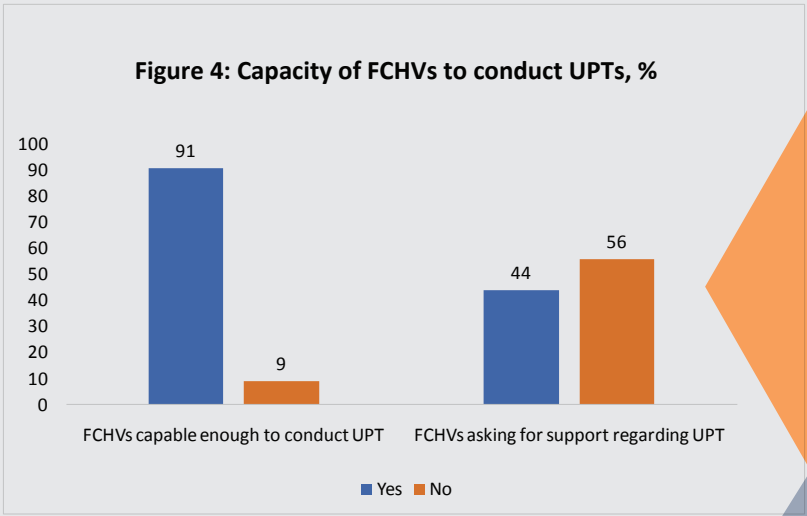






Stakeholder perceptions on the role of FCHVs in abortion care:

Nine-tenths of health service personnel in the intervention district and three-fourths in the comparison district agreed that FCHVs can play an important role in increasing SAS awareness in their community (data not shown). Health personnel were also asked about the importance and capacity of FCHVs to provide UPTs. All respondents reported that there would be a difference in the utilization of SAS if FCHVs were not trained in SAS related information and UPT provision. Respondents mentioned the importance of FCHVs in delivering abortion related messages in the community, performing UPTs, and referring women for SAS. Regarding the FCHVs ability to conduct UPTs, most respondents (91%) reported that FCHVs are capable to perform UPTs (Figure 4). Less than half of the health facility personnel (44%) reported that FCHVs asked for their help and support regarding UPT provision (Figure 4).



FCHVs' experience with the [illegible]DR intervention:

FCHV displaying IEC material.

All FCHVs reported that they were confident in conducting UPTs. They felt they received comprehensive information about abortion and gained skills to conduct UPTs in their training. This allowed them to provide better counselling and referrals for SAS clients. Some FCHVs opined that if health workers from facilities accompanied them once a month to raise awareness regarding reproductive health, including abortion care, linkages between the community and health facilities would be strengthened. Regarding barriers to abortion care, all mentioned that stigma is deeply rooted and impedes women from accessing SAS.

Women's Referral Pathway to Care:

Women's pathway to abortion care was explored by conducting 15 in-depth interviews with women who were referred for SAS care by FCHVs. Information regarding the circumstances that led them to talk to FCHVs about their pregnancy, their decisionmaking process, experience with care received from FCHVs and actions after referral were explored. All women visited FCHVs to confirm their pregnancy by UPT. Most of them knew FCHVs provided UPTs through attendance at mothers group meetings or by receiving information from friends and family members. Most women revealed that they had already thought of aborting their pregnancy, but they preferred to discuss and receive suggestions regarding abortion care from FCHVs. All women were satisfied with the services (UPT and counselling) they received from the FCHVs. Additionally, all visited the health facilities they were referred to because they trusted the FCHVs:

> "I am satisfied with care I received from FCHV. They responded to all queries. It would hav[illegible]tter if they could have provided services (medical abortion) by themselves..."
> - Client referred for SAS by FCHV

Out of 15 clients seeking abortion service, two were denied service because they were beyond the legally allowed gestational limit (12 weeks). One of them planned to continue the pregnancy and the other client said she would find another means to abort the pregnancy.

Conclusions

This study reveals that FCHVs are an effective channel at the community level in remote and hard to reach areas for the dissemination of abortion information and referral following pregnancy confirmation with a UPT. Knowledge regarding the legality of abortion in Nepal increased after the intervention. FCHVs are a primary contact point for women seeking SAS information since they are easily accessible at the community level. Thus, this study recommends the expansion of the FCHV U[illegible]R intervention to other similar settings in Nepal to reach more communities with abortion related information and referrals for safe abortion care. Considering the preference of women to receive abortion services in their community, FCHVs should be further explored as a potential channel for initiating community based medical abortion care services.

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