



Literature Review and Global Lessons Learned on the Development and Implementation of Abortion Policy

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Options

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GLOSSARY

Abortion: the termination of a pregnancy before the fetus is capable of extrauterine life

Induced/therapeutic abortion: the termination of pregnancy through surgical (vacuum aspiration – electrical or manual, dilation and curettage, and dilation and evacuation) or medical means (pharmacological drugs)

Spontaneous abortion (miscarriage): unanticipated loss of pregnancy.

Unsafe abortion: the termination of an unwanted pregnancy either by persons lacking the necessary skills, or in an environment lacking the minimal medical standards, or both. Regardless of whether an abortion is spontaneous or induced, subsequent events and the care received determine whether the abortion is safe or unsafe.

Comprehensive Abortion Care: elective abortion performed at the request of the woman, along with counseling for contraceptive use, medical after-care, and issues relevant to the woman's condition.

Postabortion Care: a package of critical reproductive health services consisting of: emergency treatment for abortion complications, postabortion family planning counseling and services and links between emergency treatment and other reproductive health services.

Menstrual regulation: early uterine evacuation, often without laboratory confirmation of pregnancy, for women who report delayed menses.

Gestational period: the age of a pregnancy counted as the number of weeks from the last menstrual period

First trimester: the first three months or twelve weeks of the gestational period

ACRONYMS

D&C	Dilation and curettage
CAC	Comprehensive Abortion Care
CTOP	Choice in the Termination of Pregnancy Act (South Africa's abortion law)
DFID	Department for International Development (UK)
DoHS	Department of Health Services
FHD	Family Health Division
FP	Family Planning
IUD	Intrauterine Contraceptive Device
HMG/N	His Majesty's Government of Nepal
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
MR	Menstrual Regulation
MTP	Medical Termination of Pregnancy Act (India's abortion law)
MVA	Manual Vacuum Aspiration
NSMP	Nepal Safer Motherhood Project
PAC	Postabortion Care
RH	Reproductive Health
SMP	Safe Motherhood Programme/Plan

1. INTRODUCTION

The Muluki Ain, 2020 (Country Code), the basic legal code for the Kingdom of Nepal, prohibits abortion. Nepal's current law characterizes abortion as an offence against life and makes no exception even when pregnancy threatens a woman's life. Conviction carries a sentence of up to three years in prison for a woman accused of undergoing an abortion, and up to 20 years if she is accused of 'infanticide'¹.

At the time that this report was written (April-June 2002), Nepal's legal framework was under reform with respect to the legalization of abortion and the provision of abortion services. Legislation regarding abortion was presented in the Muluki Ain 11th Amendment Bill, 1997 (commonly referred to as the Women's Property Rights Bill), with a view to amending Nepal's Country Code. The Bill was passed by the Lower House of Parliament on March 14, 2002 and was submitted for Royal Assent. Nepal requires the development of a comprehensive policy and accompanying strategy to enable the Ministry of Health to act within the new legal parameters once the 11th Amendment Bill becomes law.

An initial step in the process of developing Nepal's abortion policy and implementation strategy is to draw upon lessons learned from other countries (in particular those of similar levels of development and which are culturally akin to Nepal) that have passed through the same process. The Family Health Division (FHD) of the Department of Health Services (DoHS) has established a taskforce to lead the process of developing Nepal's abortion policy and implementation strategy. This taskforce, set the terms of reference associated with the two-fold purpose of this report, with support provided by the Nepal Safer Motherhood Project and DFID:

- To document lessons learned on the development of abortion policy and implementation strategies [after legalization of abortion] from regional or related country experiences, and
- Based on an analysis of these lessons learned, present recommendations specific to the Nepal context that can inform HMG/N's emerging abortion policy and implementation strategy.

There are two outputs from this review of lessons learned:

- A short policy support document –submitted separately; and
- A more detailed literature review document – this report.

2. RESEARCH METHODOLOGY

The methodology for researching this report is outlined in the consultant's Terms of Reference (see Appendix A):

a. Comprehensive literature review (see Appendix B for list of literature reviewed in addition to those referenced in this report):

Popline and Medline indexes were searched under key words: abortion induced, abortion legal, abortion law changes, abortion seekers, delivery of health care, developing countries, health services [women], health service evaluation, measurement, organization and administration, program evaluation, quality of care, Southern Asia, and studies.

Further searches were carried out under specific countries of interest - those that had recently liberalized or legalized abortion and those with corresponding levels of development and cultural similarities to Nepal (see Table 1). Further searches were also carried out under the names of authors discovered upon review of index documents. Requests were made for recent and unpublished papers, articles, and other information from key actors and institutions.

b. Liaison with key actors in a selected number of countries (see Appendix C)

c. Liaison with key institutions involved globally in supporting the establishment of abortion services (see Appendix C)

d. Interviews with key personnel in the MOH/FHD, Safer Motherhood Programme staff, NGOs, INGOs, health care providers and activists regarding the Nepal context (see Appendix D)

Table 1: Development and cultural comparisons of key countries in literature review

Country	HDI	GDP/capita (US\$)	% pop. women of repro age (15-44)	% pop. in urban areas	% births in hospital	MMR	Culture & religion
Nepal*	0.480	1237					
India	0.545	1670	47%	26%	34%	459	S. Asian culture 82% Hindu
Bangladesh	0.440	386	20%	20%	5%	420	S. Asian culture 85% Muslim
South Africa	0.667	3044	27%	54%	84%	150	Asian immigrant minority
Guyana	0.701	746	27%	38%	93%	126	33% Hindu
Kenya	0.504	280	40%	38%	42%	365	Tribal cultures, 66% Christian

* Nepal statistics from UNDP Human Development Report 2001 and Nepal National Census 2001, other data from Advocating for Abortion Access (2000) The Johannesburg Initiative.

3. GLOBAL REVIEW OF THE STATUS OF ABORTION

3.1 Global and Regional Review of the Legal Status of Abortion

Currently, 62% of the world's population live in countries where induced abortion is permitted while 26% of all people reside in nations where abortion is generally prohibited. At present, Nepal fits within the minority with restrictive laws but, with the passage of the new law, will join the majority that allow for increased access to safe abortion.

A 1998 review of the world's abortion laws² further separates the legal status of abortion worldwide into five main categories. The following table describes these categories and their distribution worldwide. Member countries of the South Asian Association for Regional Cooperation (SAARC), and other Asian countries that fall into each category, are also shown for the purpose of comparing Nepal with its closest neighbors:

Table 2: Legal Status of Abortion Worldwide by Terms Under Which Abortion is Permitted

Category	Terms under which abortion is permitted	Number of nations (% of world population)	SAARC countries (and other Asian countries) in this category
I	Only to save the woman's life or prohibited altogether	74 (26%)	Bangladesh, Bhutan, Nepal, Sri Lanka (Indonesia, Laos, Myanmar, Philippines)
II	Physical health concerns	33 (9.9%)	Maldives, Pakistan (Thailand)
III	Mental health concerns	20 (2.6%)	(Malaysia, Seychelles)
IV	Socio-economic concerns	14 (20.7%)	India
V	Without restriction as to reason	56 (40.8%)	(Cambodia, China, Singapore, Vietnam)

Note: each higher number category also includes the conditions under the previous category

Following the development of the Programme of Action of the 1994 International Conference on Population and Development (ICPD) in Cairo, at least seven governments have acted to make abortion safer through the passage of more liberal abortion laws. Liberalization of abortion laws has occurred in Albania, Burkina Faso, Cambodia, Germany, Guyana, Seychelles, and South Africa. Only two countries, Poland and El Salvador, have increased legal restrictions on abortion. One country, the United States of America, flouted the ICDP recommendations when, in January 2001, it reinstated the Mexico City Policy (previously in effect from 1984-1993). This legislation, commonly known as the 'global gag rule', disqualifies non-governmental organizations from receiving family planning funding if they provide counseling on abortion, provide safe legal abortion services (except in very narrow circumstances), or participate in political debates surrounding abortion³.

3.2 Prevalence of Abortion

Abortion, defined as the termination of a pregnancy before the fetus is capable of extra-uterine life⁴, is extremely common. It is estimated that one in every five (20%) pregnancies ends in spontaneous (natural) fetal loss. If the products of conception are not completely expelled by the woman's body, she may then experience excessive or prolonged bleeding, pain and infection. This situation is termed an *incomplete spontaneous abortion* and often requires medical intervention to prevent serious illness or even death.

The deliberate termination of an unwanted pregnancy is called *induced abortion*. In 1990, an estimated 30 million legal terminations of pregnancy were performed worldwide⁵. At the same time, millions of illegal abortions are taking place, many of them unsafe. *Unsafe abortion* is defined as a procedure for terminating an unwanted pregnancy either

by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both⁶. Unsafe abortion numbers are under-reported. The existing data on the prevalence of unsafe abortion is scarce and unreliable because legal and ethical/moral constraints hinder collection of this information. Therefore, proxy indicators such as hospital admissions, community surveys, abortion provider surveys and mortality studies are used to develop estimates⁷.

It is estimated that worldwide 57 women die from unsafe abortion for every 100,000 live births and that overall 13% of all maternal deaths are due to the complications of unsafe abortion. In South-Central Asia, the unsafe abortion-related mortality ratio is 72 women/100,000 live births. Nepal has one of the highest maternal mortality rates in Asia, with an official MMR of 539/100,000 live births, and an estimated MMR as high as 1300/100,000 in some remote rural areas. An estimated 15-30% of all maternal mortality and up to 50% of all maternal deaths in hospital in Nepal are attributable to complications of unsafe abortion^{8,9}.

Table 3: Global Annual Estimates of Incidence and Mortality due to Unsafe Abortion

	Incidence rate (number of unsafe abortions per 1000 women 15-49 years)	Mortality ratio (deaths due to unsafe abortion per 100,000 live births)	Proportion of maternal deaths (% of maternal deaths due to unsafe abortion)
World total	13	57	13
More developed regions*	3	4	13
Less developed regions	16	63	13
Africa	27	110	13
Asia	11	48	12
South-central Asia*** (incl. Nepal)	19	72	13
Nepal¹⁰	117	unknown	15 - 50
Europe	5	6	17
Latin America and Caribbean	30	41	21
North America**	-	-	-
Oceania	15	51	8

Adapted from Table 2, Global and regional annual estimate of incidence and mortality, unsafe abortions, United Nations regions, 1995-2000¹¹

* includes North America, Western Europe, Japan, Australia and New Zealand

** incidence negligible, no estimates shown

*** includes Afghanistan, Bangladesh, Bhutan, India, Iran, Kazakhstan, Kyrgyzstan, Nepal, Pakistan, Sri Lanka, Tajikistan, Turkmenistan, Uzbekistan

Although Asia has the lowest abortion rate (11/1000 women of reproductive age) among developing regions, half of the world's unsafe abortions take place in Asia because of the very large numbers of women of reproductive age in this region. Note that the unsafe abortion rates estimated for South-Central Asia and for Nepal are much higher than the average for the region. The mortality ratio for unsafe abortion in South-Central Asia is second only to Africa.

3.3 Global and Regional Impact of Unsafe Abortion

Social costs

The cost of unsafe abortion in terms of human suffering is immense but difficult to quantify. On a global scale, approximately half a million children become motherless each year because of the consequences of unsafe abortion¹². For every woman that dies from abortion complications, many more suffer acute health problems that often require hospitalization and surgery, such as: excessive bleeding, infection, lacerations and perforations to internal

organs, and/or long-term complications such as chronic pelvic pain, increased risk of ectopic (tubal) pregnancy due to tubal occlusion, premature delivery or spontaneous abortion in subsequent pregnancies, and secondary infertility.

Financial Costs

The financial cost to women that seek illegal abortion services and to government health systems that must deal with the complications is enormous. For these women and their families, costs include the actual fees charged by providers (even when services are officially 'free'), the cost of medicines and anesthetic/painkillers, blood transfusion, transportation, and time lost from work. Estimates of the cost of illegal abortion services in Nepal range from NRS 50-300 (~US \$0.65-4.00) for services provided by a traditional birth attendant (*sudeni*) or a nurse,¹³ to NRs 900-10,000 or more (US \$12-130) for a relatively safer abortion performed by a doctor at a private clinic^{14,15}.

The cost to government health systems of caring for the complications of incomplete spontaneous and unsafe induced abortions has been calculated in many ways in studies from countries including Kenya, Malawi, Nigeria, Tanzania, Uganda, Zaire, Sudan, Brazil, Bolivia, Mexico, Bangladesh, Belgium and the USA^{16,17,18,19,20,21}. Some of the indicators used to measure the cost of unsafe abortions include:

- proportion of all admissions to hospital or to obstetrics and gynecology wards;
- length of stay in hospital;
- costs of specific aspects of treatment (anesthetic, doctor's time, equipment, operating room costs);
- cost in comparison with national average monthly salary;
- cost in comparison with the national per capita total expenditure on health; and
- the impact on quality of care and hospital staff morale.

While the actual dollar figures, estimates of costs, and the specifics of these studies vary significantly, all comparisons show that safe services cost significantly less than the consequences of unsafe services - approximately two to ten times less depending upon the indicator. In terms of the length of hospital stay alone, dealing with the complications of unsafe abortion may cost up to ten times more than the cost to deliver safe services.

4. MYTHS AND MISPERCEPTIONS ABOUT ABORTION

While support *against* unsafe abortion is now nearly universal, myths and misperceptions about the potential negative effects of legal abortion, to the individual and to society, are common. Policymakers and gatekeepers to services in a number of countries, perhaps influenced by these mistaken beliefs, have created unduly restrictive rules and regulations or blocked access to services. Such actions can effectively counteract the intent of the original law allowing for legal abortion. Public advocacy campaigns must also address these issues if access to safe abortion is to be maximized. For these reasons, a brief review of some of these common myths and misperceptions versus what the literature reveals to be reality may be useful.

Myth: *Even safe abortion is dangerous.*

Fact: Abortion, when performed by qualified providers with correct techniques and under hygienic conditions, is a relatively safe surgical procedure. In the USA, the death rate for abortion is now 0.6 per 100,000 procedures. This makes the risk of abortion in that setting the same as the risk from an injection of penicillin²². Even in the developing world, a woman faces a much greater chance of dying from complications of voluntary sterilization or from giving birth.

Table 3: Mortality risks associated with pregnancy and selected health procedures

Procedure	Deaths per 100,000 cases	
	USA	Developing countries (est.)
Legal abortion	<1	4-6

Female sterilization	4	10-100
Delivery of a live birth	14	250-800
Cesarean section	41	160-220
Illegal abortion	50	100-1000
Hysterectomy	160	300-400

Modified from: WHO. Unsafe abortion: Global and regional estimates. Third Edition

Claims that even safe abortion holds long-term negative effects on a woman's mental and physical health have been repeatedly proven false. During the openly anti-abortion Reagan administration in the USA, the then Surgeon General, Dr. C. Everett Koop, reviewed 250 articles on the medical and psychological sequelae of therapeutic abortion (the term "therapeutic abortion" is equivalent to "induced abortion") and reported no evidence of adverse effect²³. The potential adverse psychological effect of induced abortion was studied by a WHO panel, which concluded that, "there is now a substantial body of data, reported from many countries after careful and objective follow-up, suggesting frequent psychological benefit and a low incidence of adverse psychological sequelae."²⁴ Recent claims that abortion increases the risk of breast cancer have been scientifically refuted and backed up by the ruling of two different US judges²⁵.

Myth: *Abortion is a technically difficult procedure that requires the skills of an obstetrician/gynecologist.*

Fact: The technical difficulty of the procedure increases with the gestational age of the pregnancy. The most common technique used for early abortion, performed within the first trimester (12 weeks) of a missed menstrual period, is manual vacuum aspiration (MVA). The level of skill required for use of MVA equipment is comparable with that needed to insert an intrauterine contraceptive device. Many nurses and nurse-midwives already possess these skills. Supportive laws and policies have resulted in increasing the role of nurses and midwives (South Africa, Viet Nam and Ghana) and Family Welfare Visitors (Bangladesh) in the legal provision of safe services²⁶.

Myth: *Young and unmarried women are the most frequent users of abortion services.*

Fact: Studies from Asia (including Nepal) have shown that most women who seek abortion services are relatively older, married women with 2 or more children who want to space or stop having children^{27,28,29,30,31}. In urban areas of sub-Saharan Africa and in some more developed countries, a larger proportion of abortion clients are younger, unmarried women. However, in countries with easy access to family planning services for adolescents and unmarried persons (e.g. The Netherlands), this trend is dramatically reduced³².

Myth: *Once abortion is legal, the frequency of abortion will increase and it will be used as a family planning method.*

Fact: Given that it is almost impossible to accurately measure the number of illegal abortions that occur before a change in abortion law, it is equally difficult to say whether or not the number of abortion procedures increases once these procedures are legalized. What is clearly recognized is that legal restrictions do not decrease the frequency of abortion; rather, they tend to foster reliance on unsafe abortion and increase the number of maternal deaths and health problems associated with it. In Romania and Cuba, for example, when the ban on abortion was reversed there was little change to the birth rate but maternal mortality rates dropped dramatically³³.

In countries like Nepal, where a demographic transition is beginning to occur, i.e. an increased desire for smaller family size, there is commonly an increased use of abortion and of contraception at the start of this shift from high to low fertility. In the short-term, a rise in abortion incidence can be expected to continue until access to contraception choices improves. However, global trends point to abortion rates falling once a range of contraceptive methods becomes widely available and effectively used^{34,35}. Even in the Soviet successor states, where long reliance on abortion was said to have led to an "abortion culture", the rapid decrease in abortion rates in these countries has shown that, under the right conditions, contraceptive use can increase rapidly and abortion can decline³⁶.

Myth: *Women (and couples) that choose abortion are irresponsible.*

Fact: The decision to terminate a pregnancy is not easy. Figures show that the majority of women seeking abortion in Asia are married women who cannot afford to raise another child. No birth control method is 100% effective and there

are complex reasons as to why women may choose (or be forced) not to use contraception. By choosing not to have a child that they cannot take care of, these women and couples are making a responsible choice.

Myth: *Legal abortion will incite men to commit rape and incest, and women to become prostitutes.*

Reality: These beliefs denigrate the vast majority of men and women and simply don't make sense. Rape and incest are crimes that occur in all societies and have occurred since the beginning of history. These crimes, though partly hidden from public view, are exceedingly common in Nepal. It is not logical to believe that concern about unwanted pregnancy would have any influence over those who perpetrate such horrific crimes, particularly when relatively easy access to abortion currently exists. Legal abortion is available across the border in India and illegal (but not necessarily unsafe) abortion is available for those in urban areas or who have the money to pay.

It is extremely unlikely that a woman would consider access to legal abortion as an incentive for becoming a prostitute. The reasons why a woman becomes a prostitute, especially in the developing world, include desperate poverty often brought on by widowhood, abandonment, a need to make money to feed her children, lack of education and job skills, or being coerced by family members or traffickers. The life-threatening risks of prostitution, such as sexually transmitted diseases and HIV-AIDS, violence, injury and death, are much greater than that of unwanted pregnancy. This is the case whether legal abortion exists or not.

Myth: *Religion and religious people do not support abortion.*

Reality: Many religious groups and religious leaders support a woman's right to choose how to deal with an unplanned pregnancy – whether it is to accept the pregnancy, give up the baby for adoption or pursue induced abortion. In the USA, the group Catholics for A Free Choice strongly supports a woman's right to choice³⁷. There was no significant opposition to the introduction of the MTP Act in predominantly Hindu India. The earliest (Malla Era) Nepali legal code, based entirely on Hindu religious texts, allowed for abortion when the pregnancy was due to sexual relations between a high caste and a low caste person³⁸.

5. THE CHALLENGE OF MOVING FROM POLICY TO IMPLEMENTATION

The history of abortion policy reform has shown that there are three crosscutting principles that govern the movement from policy to successful implementation of a new abortion law:

1. **Advocacy doesn't end with the passage of a liberal law.**
2. **A progressive law that cannot be implemented is not an improvement.**
3. **Strengthened family planning services must go hand in hand with the new abortion law if a significant reduction in maternal mortality is to be achieved.**

This first principle seems obvious. However, the literature shows that the belief that the battle against unsafe abortion was won with the passage of new law lulled advocates and policymakers in many countries into a sense of complacency - with dire consequences for the women that the new law was meant to serve. The current situations in India, South Africa and Guyana provide clear evidence that new, and even quite liberal, laws do not automatically ensure adequate access to safe and affordable abortion services. Relatively liberal laws have also subsequently been overturned or made more restrictive (Poland, Germany, El Salvador) or their implementation has been weakened by the strenuous efforts of 'anti-choice' lobby groups, and even through the harassment and murder of abortion providers (USA, Canada). The US President's reinstatement of the Mexico City Policy (better known as the 'global gag rule') in 2001 significantly decreased access to safe abortion services in many developing countries that accept US development aid.

The second principle is one that applies to the implementation of nearly any new initiative, particularly one like abortion that is controversial. A liberal law will only be fully implemented if it is accompanied by a strong program and effective practices. This requires political will, resources and a capable team. Those responsible for implementing policy must also be responsible for managing service provision. Most advocates would emphasize the need to integrate abortion services into the essential health care service package. However, when the administrative system is already resource-strained and the initiative is a critical life-saving measure, it may be necessary to provide extra support. The literature from South Africa shows that even in a favorable political and ideological climate, there have been major problems with government agencies, health providers and health institutions accepting ownership and responsibility for implementation.³⁹ Lessons learned from the experience in Guyana suggest that it would have been prudent to assign responsibility for implementation to a specific, small, multi-skilled project team, complete with budget, planning schedule and reporting responsibilities.⁴⁰ One of the greatest challenges facing many countries, including Nepal, is the effective management of its health sector human resources. Complex organizational, political and social forces make it difficult to fill and maintain positions for health professionals in rural and remote areas of the country. Strong, realistic human resource management is one of the most important components necessary for implementation of health policy.

The third principle is that even in countries where abortion has been made legal, there can be a continuing reliance on illegal and unsafe abortion until access to *both* effective contraception (and contraceptive counseling) *and* safe abortion services improves. Many couples are unable to achieve their desired family size because of the unavailability or poor quality of contraceptive services, side effects and complications that exist with all methods, and/or misperceptions about risks and benefits of contraceptive methods. Studies show that even in societies with high contraceptive acceptance rates (Bangladesh), poor understanding of how methods work, their side-effects and proper use leads to high drop-out rates and subsequent unplanned pregnancies. Service providers must become more knowledgeable and skilled in counseling about these factors in order to meet women's and couple's needs and decrease the reliance on (often illegal and unsafe) abortion.

5.1 Summary of Global Lessons Learned

The following section attempts to categorize the lessons learned from global experience. These lessons are listed under key issue headings followed by specific lessons, a brief summary of the evidence for each of these findings, and /or the subsequent general recommendations (designated with a bullet point).

Advocacy, Attitudinal Change and Awareness Raising

Lesson 1: Active continued participation of civil society is important to ensure adequate and appropriate implementation of safe abortion services.

NGO and civil society coalitions in many countries have been able to work together effectively in the relatively short term to advocate for liberalization of abortion laws. It is much more difficult, however, to sustain energy levels and funding for the long haul of implementation. Safe abortion advocates in India have discovered that it is difficult to mobilise the masses around the single issue of abortion when the majority of the population lacks access to the means to satisfy their basic needs. It is also difficult to motivate people's organizations to participate actively and in a sustained way in abortion advocacy campaigns when their efforts and priorities are concentrated around helping people meet their basic needs for survival. In the case of India, women's groups viewed enactment of liberal abortion legislation too optimistically and because of limited human and financial resources, abortion advocacy has had a low priority on their agenda⁴¹.

- Develop strong coalitions with clear terms of reference (specific to implementation of abortion services), goals and targets.
- Secure adequate and specific funding.
- Ensure ongoing research and documentation of the effect of legal change on women's health, provision of RH services and on community perspectives as positive reinforcement of advocacy efforts.
- Identify a few high profile personalities willing to publicly support provision of safe services. In particular, religious leaders, medical professionals and entertainment celebrities can have a big positive impact (e.g. Brazil – women willing to come forward and share the stories of their own abortions; South Africa – tribal/cultural leaders stating that abortion is not against group values, beliefs; USA – Catholics for Choice; Kenya – President of the Medical Association)

Lesson 2: Broad support for the new law is required from the beginning.

Relying solely on the commitment, energy and influence of just one or a few influential politicians or powerful supporters can backfire if and when these persons leave office (Kenya), lose their position of favor, or are forced to make political compromises (Guyana, Mexico). It is essential to engage the administrative and technical cadre of the implementing (health) ministry and other relevant ministries (e.g. education, women's affairs) as part of an effective strategy⁴².

Lesson 3: Advocacy messages need to challenge negative attitudes, be simple and clear and need to reach the most vulnerable, and the most influential, populations.

- Decide on the most culturally and socially appropriate way to frame the issue - public health OR human rights/women's rights perspective?
- Find the words and terms that can help frame the issue in the most emotionally neutral or positive sense.
- Identify the prevailing myths and misperceptions about abortion and prepare to counter these in public awareness and advocacy campaigns.
- Disseminate information about the new law as soon and as widely as possible – use community educators to reach those most vulnerable (rural and poor women)
- Different messages and messengers are appropriate at different stages and for different groups.
- Meet the information needs of the most influential players, especially service providers and health administrators.

Meeting Women's Needs

To ensure access to safe services, abortion services must meet women's priorities, especially those of rural and poor women. I have called these priorities (most clearly identified by studies from Uttar Pradesh^{43,44} and West Bengal⁴⁵) the Five C's: *Convenience, Confidentiality, Care/Comfort, Cost and Contraception*.

Lesson 4: *Convenience/Accessibility* - Abortion services need to be brought as physically close as possible to the homes of the women in need of these services.

- A reasonable minimum goal in many countries has been to have all hospitals (i.e. at least to the Primary Health Care Center level) staffed with trained providers willing to perform abortions.
- Note that access is not always equal to physical proximity for reasons to do with confidentiality concerns (see Lesson 5).

Lesson 5: *Confidentiality* - Client/patient confidentiality must be safeguarded.

Confidentiality is especially important in the case of abortion, where the issue continues to be highly stigmatized. Confidentiality is most important to unmarried women and adolescents, members of certain religious groups (e.g. Muslims), and when the pregnancy is the result of an illicit union or due to rape or incest. In Bangladesh, relatively safe services are available to rural women through trained female providers at Family Welfare Centers. However, the physical layout, location and manner in which services are provided at these centers means that confidentiality does not exist. While attention to privacy within the health center would improve confidentiality to some degree, for many women the simple act of presenting to the local health center located in the center of her village makes anonymity impossible. This leads many women to choose other, often less qualified, local providers as their first resort⁴⁶ or to travel a greater distance to maintain confidentiality⁴⁷.

- Efforts to encourage women to access safer services must find ways to bring current community level providers (often unsafe and unqualified) into the education and referral system for safe abortion services, and provide incentives to these providers for giving up what may be an important source of income.
- Maximize physical privacy for counseling and treatment rooms when designing or renovating health care facilities.
- Improve referral and transport systems (including emergency loan funds) to larger centers for women for access to a range of reproductive health services, including abortion care.

Lesson 6: *Caring/Comfort* - The quality of care, particularly that provided by the public sector, must be improved.

A service provider who is non-judgmental, treats the woman with respect and gives attention to her comfort (e.g. privacy, pain control) is perceived to provide higher quality services. In many countries and settings, private providers are perceived to provide better quality of care.

- Interpersonal communication skills should be emphasized in pre-service training for nurses, doctors and other health workers and in-service training for all health care providers and health care facility support staff.

Lesson 7: *Cost/Affordability* - Fee schedules and payment systems must include provisions for ensuring that no one is denied service due to inability to pay.

A number of studies have shown that some women will pay more for what are perceived to be better quality services⁴⁸. However, what is affordable for a poor woman may amount to as little as a few hundred rupees in the context of Nepal. In most developed countries (with the exception of the USA), abortion services are available without charge under national health insurance schemes while some require nominal payments under some circumstances. In developing countries, legal abortions are usually provided in government facilities in the same way as other health services, i.e. they may be "free" or may require payment of user fees. The clear lesson, however, is that "free is almost never free" with women being charged hidden fees for various components of care (e.g. medicines, doctor's fees).

- Government services must advertise the full cost of services, without hidden fees. A mechanism must be established to allow for free or very low cost services for poor women – or *all* women if the government gives highest priority to decreasing maternal deaths.
- Governments must be aware that certain fee structures can influence the practice of providers and increase the cost to the health system. For example, in Viet Nam the government pays more for a D & C than an MVA procedure. This has led to greater numbers of more expensive and higher risk D & C procedures being performed than is necessary.
- Support the private sector. Global experience has shown that when the private sector is supported, with minimal restrictions, to develop a broad array of competitive services, market forces eventually result in lower cost and higher quality.
- Support the NGO and not-for-profit sector. The organizations working in this sector are most likely to be able to provide high quality, low cost services (e.g. Marie Stopes International) because of their focus on reproductive health services, emphasis on quality of care measures, and donor/organizational support that enables them to keep patient costs to a minimum.

Lesson 8: *Contraception* - Family planning programs must become better equipped to counsel women and couples about real and perceived side effects of contraceptives and to help them choose and continue with the most appropriate method.

Global literature clearly shows that myths and misperceptions about contraceptive methods abound among both users and health care providers. These play a big role in the occurrence of unplanned pregnancies due to improper use and/or early discontinuation of contraception. Many countries have begun to integrate messages about emergency contraception (the “morning after pill”) and legal abortion services into family planning counseling.

Developing Policy and Setting Standards

Lesson 9: The policy associated with the new law must be kept as simple and general as possible.

This lesson cannot be overemphasized: it is important to get the policy right the first time. Although India’s abortion law, the MTP Act of 1972, was landmark legislation and very liberal for its time, the well-intentioned regulations included to safeguard women have actually had the opposite effect and it is proving difficult to change the existing law.

- The details of “by whom and how” comprehensive abortion care services will be developed and provided should be decided through the development of medical guidelines, standards and protocols by panels of local experts. If the policy governing abortion is *general and rigid*, the guidelines, standards and protocols should be *specific but flexible* - open to modification as new information and technologies become available.

Lesson 10: The process of setting standards should be inclusive.

- Ensure that service providers and potential opponents are included strategically, almost from the beginning. It cannot be assumed that medical professionals will be advocates or comply with law (South Africa, Guyana, India, USA).
- Identify and involve other key stakeholders early. Women’s groups, religious leaders, hospital managers and administrators, INGOs/NGOs, private providers, and donors may all provide important support *or* could create serious obstacles to implementation if they feel that they have not been consulted during the policy development process (South Africa, Guyana).

Addressing Health System Barriers

Lesson 11: Health professionals need to know when and where the law permits abortion.

A notification/education program for health professionals (via government orders, workshops, training and orientation programs) must be one of the first steps in an implementation plan.

Lesson 12: Streamline and simplify administrative procedures in both public and private sectors.

Global experience (India, South Africa, Canada, USA, Latin American and European countries) has demonstrated that regulations that require enforced waiting periods; multiple authorizations by doctors or others; spousal or parental consent; that rape and incest victims press charges before receiving services; and minimum age or residency status only increase reliance on unsafe and illegal abortion and increase maternal deaths and unwanted children. Such restrictions and requirements should be avoided to the greatest extent possible. Restrictions on the ability of the private sector to meet the demand for these services should also be limited to the greatest extent possible.

Lesson 13: Ensure the broadest possible time limits on when women can have safe abortion.

Since menstrual regulation (MR) is only done to 10 weeks in Bangladesh, about one-third of women who request MR are rejected due to advanced gestation. Many resort to illegal abortion and one-fifth of maternal mortality continues to be due to traditional unsafe abortion⁴⁹.

Lesson 14: Include as many types of skilled providers as possible.

The service delivery model that most closely mirrors the skills required to perform safe, early (first trimester) abortions is that of the insertion of an intrauterine contraceptive device or IUD, a minor surgical procedure. Many types of health care providers, besides doctors, possess this level of skill. In many countries, there is a range of approved abortion providers including gynaecologists, general practitioners, nurses, midwives and other auxiliary health care workers (South Africa, Ghana, Viet Nam, Bangladesh)⁵⁰.

Lesson 15: Increase the numbers and types of skilled providers as quickly as possible.

- Train medical students, nursing students and paramedics in safe abortion care through pre-service programs.
- Provide in-service training at an appropriate site (e.g. one with sufficient client load) as close to providers and their institutions as possible. On-site training increases the numbers of rural providers that can be trained and decreases disruption of services.
- Postabortion Care (PAC) providers of many types already have the skills needed to provide Comprehensive Abortion Care (CAC). PAC providers can be one of the first sources of skilled human resources to be utilized when implementing Comprehensive Abortion Care Services.

Lesson 16: Ensure the broadest possible range of institutions that can provide abortion services, not just hospitals.

In India, cumbersome institutional registration requirements have led to numerous problems including corruption, ignoring the regulations, and severe restriction of access to services even 30 years after passage of the law,. A review and attempt to change these requirements (and other regulatory obstacles) is now underway in that country⁵¹. The clear lesson from this example and from others (South Africa, many European countries, USA) is that well intentioned but unnecessary regulations often block access.

- Given that the service delivery model for *early* abortion is similar to that for IUD insertion, the amount of institutional regulatory control by government over institutions providing only early abortion services should be similar, i.e. little to none.
- Early (first trimester) abortion services DO NOT require a full operating theatre, or blood bank or general anesthetic services. Complications from safe early abortion are infrequent and very rarely life threatening (i.e. involving cervical laceration, uterine perforation, delayed onset of infection). They can be adequately handled through simple treatment measures and/or appropriate referral to other health facilities.

Lesson 17: Establish 24-hour emergency services for postabortion care.

This will decrease maternal mortality and morbidity from complications of spontaneous and illegal abortion, which will not quickly disappear even after safe abortion is made legal. It will also minimize the waiting time for comprehensive

abortion care since the components and resources needed for PAC and CAC (e.g. counseling, minor OT room, MVA equipment, trained staff) are identical and will be readily available for CAC during office hours.

Lesson 18: Include as many options for kinds of services and procedures as possible and leave room for approval of new procedures/technology.

Provisions for the specific kinds of approved abortion services should NOT be mentioned in policy (legal) documents but should be addressed in medical guidelines and standards that can easily be reviewed and updated as appropriate new and improved technologies, including those for medical abortion, become locally available.

Lesson 19: Government health institutions must not be allowed to exempt themselves from provision of legal abortion services.

In many countries, publicly funded medical professionals are allowed to exempt themselves from providing abortion services for religious or personal reasons. If such personal exemption is allowed, then it is recommended that these providers be obligated to refer to other willing and able providers. Also, such exemption cannot extend to health facilities.

- “Values clarification” workshops have proven useful (South Africa) in encouraging government health workers to view abortion clients more compassionately and to understand the important role that health workers play in providing critically important safe abortion services⁵².

Lesson 20: Include provisions that safeguard patient confidentiality.

See Lesson 5, above.

Lesson 21: Establish sustainable mechanisms for procurement of drugs and equipment.

- Essential drugs and equipment should be made available through both government procurement mechanisms and through the private sector. Some governments have included MVA equipment in the national essential drugs and equipment list, removing import duties and taxes and thus allowing a wider and more rapid distribution of this equipment⁵³.

Costs and Funding

Lesson 22: Minimize patient costs.

See Lesson 7, above.

Lesson 23: Allocate specific funds for safe abortion care service delivery.

To some degree, a lack of funding is responsible for problems regarding access to services in South Africa, even five years after passage of the new law. The South African government mandated free abortion services in public institutions, but at the same time cut allocations for public health⁵⁴. Reliance on donors to fund comprehensive abortion care services as a vertical program puts the program in jeopardy should donor funds decrease or be withdrawn.

Abortion within the Broader Health Policy Framework

Lesson 24: Integrate abortion services into comprehensive reproductive care and primary care package of services.

- Safe abortion services must be accompanied by strengthened FP services.
- Create links between abortion care services and other women’s health services, e.g. violence against women, gynecologic morbidity (uterine prolapse), etc.

Cross-Sectoral Linkages, Policies and Laws

Lesson 25: New laws and policies may need to be developed in support of the new abortion law and prevention of unwanted pregnancies.

- Laws and policies prohibiting the use of abortion for sex-selection may need to be developed and publicized. Note, however, that legislation alone will not have a big impact on sex-selective abortion (India, China, Korea)⁵⁵.
- Review and revise security precautions to minimize risk of potential attacks on providers, service seekers or institutions by “anti-choice” or “pro-life” activists.
- Develop policies to address some of the issues that contribute to unwanted pregnancies, e.g. illiteracy; lack of sexuality education; legal age of consent for marriage; and gender equity.

Partnerships

Lesson 26: While there is obvious value in developing GO-NGO-Private Sector partnerships, the process of establishing mechanisms to allow such collaboration may present significant difficulties.

Concerns about the difficulties in reaching agreement on fair payment, subsidy or tax exemption mechanisms, and favoritism and corruption in government selection of partners, are just some of the issues that can hinder this process.

Lesson 27: The role of donors and international advocacy and technical organizations needs to be made clear as early in the process of implementation as possible.

- The government needs to understand the various donors’ level of commitment and ability to support them, e.g. many donors will fund only infrastructure, training or equipment costs, and not service delivery, due to effect of US global gag rule on what can be funded.
- International networks should be harnessed to build local capacity.

Monitoring and Evaluation

Lesson 28: Special training may be required for monitors and supervisors, especially on measuring, monitoring and evaluating quality of care.

The medical information system of most developing countries focuses on reporting numbers of services against given targets, rather than measuring the quality of services. Quality of care training and monitoring tools exist for other countries and can be used as templates.

Lesson 29: Gradual roll-out or phase-in of services allows for closer monitoring of quality and acceptance by service providers and other stakeholders.

- Work with administrators to develop procedures for monitoring providers, access, quality of services and referrals.
- Work with researchers to do baseline studies and develop research strategies to monitor change in quantity, quality and access to services, and widely disseminate these findings.

Lesson 30: Monitoring of services and research into the effects/impact of implementation allows for development of evidence-based guidelines, standards and protocols through an iterative process.

See Lesson 9, above.

6. THE CONTEXT OF NEPAL

It should be noted that although abortion is currently illegal and the penalties for conviction are harsh, the vast majority of women who obtain services from private clinics or private practitioners are seldom singled out or punished. It is the poor, illiterate and "voiceless" women who are persecuted, often for reasons that have more to do with domestic disputes or personal vendettas^{56,57}. As of May 2002, there are at least 50 women who remain in prison because of abortion/infanticide convictions. It is widely believed that they will be released from prison after the new law receives Royal Assent.

For urban Nepali women and those from the middle and upper classes, relatively safe (although technically illegal) abortion services can be accessed through private practitioners in Kathmandu Valley, in the bigger towns on the Terai and across the border in India or even abroad. It is assumed that many of these providers will become authorized to provide safe and legal services once the law comes into effect. Not-for-profit hospitals and clinics and NGO clinics are also poised to quickly provide low-cost services in certain districts. However, the current socio-cultural, political and economic situation in Nepal presents significant challenges to the goal of making safe services available to the majority of Nepali women who are poor and live in rural areas.

Prevailing patriarchal norms and values promote discrimination against females from birth. The very low status of women in Nepal is reflected in such indicators as life expectancy and literacy rates, which are both lower for women than for men, and high maternal mortality rates. The pregnant woman herself may have little say in how to deal with an unwanted pregnancy. If she lacks support from her husband or mother-in-law, a woman may be forced to continue an unwanted pregnancy or even to abort a pregnancy that she would rather keep, e.g. sex-selective abortion⁵⁸.

Female reproductive biology is linked with religious "pollution". This can lead to such feelings of shame in the woman, and embarrassment even in health care workers, that it makes it difficult for her to seek and obtain accurate information about sexual and reproductive health concerns. During menstruation and during and after childbirth, women in many parts of rural Nepal are isolated in the *chaupati* or cowshed to keep this pollution away from others (particularly the men) in the family. As Dr. Aruna Upretty relates about her experiences in Doti and Achham, "We were told many sad events, recounting times when women had died in the *chaupati* because of health problems, just because no-one dared touch a polluted woman"⁵⁹. The obstacles facing a poor, rural woman trying to reach adequate basic health services begin with lack of education and understanding about her own body and health, lack of decision-making power about when and how to seek care, and lack of access to money and transportation. After these come the obvious barriers presented by the geography of Nepal: extreme weather conditions, poor roads, and the long distance that she must travel to find services. And finally, should she succeed in reaching a health care facility, she is not guaranteed to find adequate services.

In the year 2000, there were 83 public hospitals and 4955 public hospital beds in the country - one for every 3600 population. The ratio of doctors/population was approximately 5/100,000 and for nurses was approximately 22/100,000⁶⁰. These numbers only partly reflect the challenges that face the public health sector in providing basic health services. It is widely acknowledged that these health facilities also suffer chronic problems due to understaffing, absenteeism and lack of resources including basic medicines, water and electricity. While the cost to provide an essential Safe Motherhood and Child Survival Package of services in Nepal has been estimated at US \$4.73/capita, only US \$3.10/capita is currently spent on ALL health services in Nepal (World Bank 2000).

Another complicating factor in Nepal is the high level of insecurity, experienced even more acutely in remote and rural areas, brought on by the Maoist insurgency and so-called "People's War" now in its seventh year. The death toll from this conflict is now more than 3000 and civilians have not been spared. Both the violent conflict and the accompanying State of Emergency declared by HMG/N in November 2001 have resulted in travel restrictions (e.g. roads intermittently closed, travelers subjected to frequent security checks and questioning). Some district hospitals

have reported significant drops in both admissions and outpatient visits for medical problems, including those related to pregnancy, presumably because of the increased risk of traveling⁶¹. In order to combat the insurgents, HMG/N has diverted a significant part of its development budget to fund the security forces.

The insurgency is now also affecting food security – Nepal is the only country in Asia-Pacific region where hunger is increasing. Chronic problems of wide-spread poverty and slow food production have been worsened by farmers fleeing their villages and leaving land fallow, the looting of family and aid project food stocks by insurgents, and difficulties in transporting emergency food aid into conflict zones⁶².

Finally, the future of the government is now highly uncertain. At the end of May 2002, the King, at the request of the Prime Minister, dissolved parliament and declared that elections would take place in November of this year. Without a parliament, it is unclear how any new policies will be passed until a new government is elected.

In summary, the pressing problems facing most rural and poor women in Nepal – increased risk to personal security due to the violent civil conflict, lack of food and lack of basic human rights – make the issue of safe abortion seem small by comparison. However, these same women will continue to suffer and die from complications of pregnancy, including unsafe abortion, while these other terrible events unfold. Even a small improvement in the access to, and quality of abortion services could still make a significant difference in many women's lives, and these efforts must continue even in the face of many other challenges.

7. RECOMMENDATIONS TO THE GOVERNMENT OF NEPAL

The following section lists a variety of recommendations under the same general subject headings as in Chapter 5: Global Lessons Learned. They are not listed in order of priority and while the recommendations are stated as a series of directives, it is up to HMG/N to consider them within the current context and focus on those that they feel are the most important and appropriate.

Advocacy, Attitudinal Change and Awareness Raising

1. **Focus advocacy messages on the public health benefits (decreased maternal death and suffering) of safe abortion.**
2. **Review the current Nepali terminology around the issue of abortion.** Find the most neutral or positive terms and use these consistently in both the legal and public discourse around the new law. Medical anthropologists may be able to assist in finding widely acceptable and clearly understood terminology. In many countries, terms like “menstrual regulation” and “uterine cleansing” are widely accepted.
 - The current blurring of the boundaries between the terms for abortion (*garbhapaat*) and infanticide (*jaatak*) must be remedied.
3. **Develop an awareness raising/attitudinal change campaign, building on the successes of such campaigns in other countries.** Experienced health educators and social marketers should review IEC materials from such organizations as Johns Hopkins University Population Communication Service (JHUPCS) and Marie Stopes International (MSI), for examples that could be appropriate or adapted for Nepal.
4. **Develop appropriate messages and education techniques (e.g. workshops, videos, official notification letters) for different groups:** health administrators, health care providers, law-enforcement officials, politicians, religious leaders, and the general public.
5. **Notify all health professionals as soon as possible** about when and where legal abortion services can be provided, by whom, what kind of training is required, etc.
6. **Use knowledgeable community-level educators and volunteers** to spread key messages of the awareness/attitudinal change campaign as widely and as quickly as possible. A valuable network of such skilled community educators exists in Nepal:
 - Center for Research on Environment Health and Population Activities and its network of local NGOs across 22 district⁶³;
 - Family Planning Association of Nepal's (FPAN) 13,000 volunteers and 2140 staff working in 34 districts⁶⁴;
 - The four national NGOs currently collaborating with various European NGOs under the umbrella of the EC/UNFPA Initiative for Reproductive Health in Nepal (RHI) across 9 districts and two municipalities - Aamaa Milan Kendra (AMK), Environment, Health and Development Advisory Group (EHDAG), Public Health Concern Trust (pfect-Nepal) and Sunaulo Pariwar Nepal (SPN)⁶⁵;
 - The community outreach workers associated with Sunaulo Pariwar Nepal's independent work in 10 districts (soon to expand to 14 districts)⁶⁶;
 - The Safe Motherhood Network's 122 members (92 organizations and 30 individuals) that aim to promote Safe Motherhood (SAMANATA – Institute for Social and Gender Equity - acts as the Network's secretariat);
 - PAC counselors; and
 - Private clinic nurses and family planning counselors.
7. **Plan the awareness/attitudinal change campaign to follow the same pace as the phased roll-out of services.** Experience in other developing countries has shown that it takes a long time for the message about the change in the law to reach the public. Some options for types and timing of messages include:

- Focus initially on the simple message: **“The law has changed”**.
- Link the announcement of the change in law with a list of public and private facilities where services are currently (or will soon be) available. Some women may choose to travel a long distance for safer services.
- **“Earlier is better,”** is the central message that will encourage women to seek services as early in pregnancy as possible. This message should be widely advertised from the start, because it will take a while to reach the most vulnerable women.

8. HMG/N should support the development of a broad-based coalition of abortion advocates from civil society.

- Representatives from such a coalition should be included in the various advisory boards and committees that will be formed as part of the policy development and implementation process.
- The coalition, with support from international funding agencies, can undertake ongoing research and documentation regarding the effect of the change in law on women’s health, the provision of services and on community perspectives as positive reinforcement of advocacy efforts, and as part of the overall monitoring mechanism of implementation.

Meeting Women’s Needs

9. The test of all policies, rules and regulations regarding the provision of safe services should be: “Does it help HMG/N to meet women’s priorities of: Convenience, Confidentiality, Care/Comfort, Cost and Contraception?”

Developing Policy and Setting Standards

10. Resist the tendency to “over-medicalize” abortion policy.

- Create simple and general policies.
- Minimize rules and regulations.
- Leave the development of specific requirements to medical, educational and administrative experts who will design medical guidelines, training and implementation standards and protocols based on the policy framework.

11. Policy development process should be inclusive.

Invite members from key stakeholder groups into the process as early as possible. These key stakeholders include the medical community, NGOs; safe abortion and women’s rights advocates, private sector reproductive and health care providers.

- Include other divisions/departments of the Ministry of Health and Department of Health Services – particularly those with important roles to play in implementation:
 - Management Division (Budget; Human Resources; Monitoring, Evaluation and Quality Control; Management Information System and Building, Construction and Maintenance);
 - Logistic Management (Indent and Procurement, Store/Distribution);
 - the newly formed division in the MoH for monitoring health programs; and
 - the Regional Health Service Directorates responsible for implementing and monitoring activities in all 3 departments of MoH.⁶⁷
 - Other Ministries and commissions such as Ministries of Law and Justice, Social Welfare, and Education.

Addressing Health System Barriers

12. Avoid undue restrictions and cumbersome requirements, specifically:

- AVOID enforced waiting periods.
- AVOID requirement for spousal or parental consent.

- AVOID requirement for multiple authorizations by doctors and others.
- AVOID minimum age or residency requirements.
- DO NOT require rape and incest victims to press charges or file a police report before they can receive abortion services.
- DO NOT require health care providers to notify policy about rape or incest cases if such notification goes against the patient's wishes.
- Ensure patient confidentiality through appropriate privacy, reporting and recording measures and through supporting provision of services at a variety of kinds of sites.
- Ensure mechanisms are in place for procurement of equipment and drugs.

13. Simplify registration or authorization processes for providers.

- Authorization of providers should be based upon their competency only (proof of specific skills), and should not be tied to the type of provider or other years of experience. In this way, more providers of different types can be introduced once appropriate training programs become available.
- PAC providers should be automatically certified to provide CAC services. As of May 2002, a total of 119 providers (77 doctors, and 42 staff nurses) have completed comprehensive postabortion care (PAC) training. At the same time, 70 Auxiliary Nurse Midwives have been trained as PAC assistants. A recent evaluation of the PAC program found that "nurses were observed to be providing services as competently as trained physicians, particularly in situations where they had the full support of physicians and had the opportunity of frequent client care to ensure that their competence was maintained"⁶⁸.

14. Simplify registration or authorization of health care institutions.

- DO NOT REQUIRE any formal authorization or approval process for institutions providing first trimester procedures only. As explained in the Global Lessons Learned section of this report, the accepted service delivery model for early (first trimester) abortion is IUD insertion. In Nepal, there is currently no requirement for institutions to be approved to provide IUD insertion. It may be more efficient, cost-effective and with no greater risk to the client, to focus on recognizing the skills of providers, rather than the institutions in which they work – especially when providers frequently shift location.
- Identify and encourage institutions with qualified PAC service providers (see Appendix E) to prepare to be among the first facilities to provide early abortions in order to get services to the public as quickly as possible.
- DO NOT REQUIRE all centers to have the facilities to deal with advanced gestations and complications, only those that actually provide these advanced services. Base authorization or approval of facilities, other than those limited to first trimester procedures, on the gestational period up to which they provide services.

15. Increase the numbers and types of skilled providers as quickly as possible.

- Health care providers that are trained in Postabortion Care (PAC) have the requisite skills to provide Comprehensive Abortion Care with very little extra training required. At the time of this report, these providers are working at 24 approved PAC service sites across 17 districts (see Appendix E). Included in these are 3 major referral centers in Kathmandu, 4 Zonal Hospitals, 1 Sub-Regional Hospital, 9 District Hospitals, 4 private not-for-profit hospitals/clinics and 3 NGO Clinics. These providers can quickly be oriented to also provide CAC services.
- Increase the number of CAC/PAC trainers as quickly as possible. As of May 2002, there are only eleven PAC trainers (who can be quickly oriented to train on CAC) and only two training sites (Maternity Hospital and TU Teaching Hospital, both in Kathmandu) in the country. These sites have only been able to train 40 providers per year. In the last year, the Maternity Hospital treated an average of 6-7 cases per day. Once abortion is legal, the number of CAC cases should increase the patient-flow enough to allow for a more rapid increase in the numbers of skilled providers trained.

16. Establish 24-hour emergency services for postabortion care in as many centers as possible.

17. **Include as many options for kinds of services and procedures as possible and leave room for approval of new procedures and technology** (including medical abortion) as it becomes available.

Costs and Funding

18. **Allocate and protect specific funds for safe abortion care service delivery.** The MTEP for the Health Sector emphasizes attention to those health issues that account for the greatest burden of disease in Nepal with the objective of protecting EHCS, particularly for poor and marginalized women. It prioritizes family planning, safe motherhood, reproductive health and adolescent reproductive health as Priority 1 Programs⁶⁹. One of the key outcome goals is to reduce MMR to 340 in the mid-term and 300 by the end of the Tenth 5-year plan. The MTEP document states that "The Safer Motherhood Programme will be further improved and expanded." However, neither Postabortion Care (PAC) nor Comprehensive Abortion Care are specifically mentioned as part of the SMP or RH Programs. The current version of the MTEP Health Budget shows only total figures for Family Health, with no amounts specified for Family Planning, Safe Motherhood/RH, Adolescent RH or Female Community Health Volunteers⁷⁰.
 - **Ensure adequate staffing and support of public PAC/CAC units.** Currently, the Maternity Hospital PAC unit has only one staff nurse and one janitor (sweeper) covering both the PAC unit and admissions area for the maternity unit at night. This lack of adequate staffing has meant that up to one-quarter of the evacuation procedures are done as D & C in the operating room, even though they meet the criteria for the safer MVA procedure⁷¹.
19. **Establish, and widely publicize, official fees for abortion services** in public and not-for profit/NGO facilities. Include provisions for free services for the poor.
20. **Emphasize the responsibility of the private sector** to provide abortion services at as low a cost as possible, including provisions for lower cost or free services for the poor.

Abortion within the Broader Health Policy Framework

21. **Allocate human and financial resources to develop a parallel strategy to strengthen the national Family Planning Program** at the same time that the abortion policy and implementation strategy is being developed. It is noted that one of the PRSP/10th Plan outcome targets is the increase of CPR (contraceptive prevalence rate) from the current 39.3 to 47. "Family planning services will be ensured, based on quality of care, informed choice and easy access at the community level"⁷².
22. **Integrate comprehensive abortion care (CAC) services into the national reproductive health (RH) care package of services.** Include CAC guidelines in the National RH Guidelines. Incorporate CAC training into RH training of service providers at all levels.
23. **Create links between CAC and other women's health services** within health institutions, through a referral network and in collaboration with other line agencies and NGOs.

Cross-Sectoral Linkages, Policies and Laws

24. **Develop laws prohibiting illegal and unsafe services, with punishment focused on providers.** However, this law may prove difficult to enforce and the first priority should be to try to identify current community-level providers, including those with requisite qualifications and skills, and enroll them in training programs. Educate others on the new law and their important role in educating and referring their clients for safe abortion services.
25. **Develop appropriate laws and policies prohibiting "sex-selective" abortion.**

Experience has shown that legislation alone does not have a big impact given the overwhelming social and economic forces behind the practice of "sex-selective" abortion. It is also difficult to prosecute providers of sex-determination services such as ultrasound, chorionic villous sampling (CVS) or amniocentesis (as mentioned in the pending law) when there may be no clear link between these tests and the abortion procedure. Education and improvement of the status of women may be more effective in combating sex-selective abortion than attempting to reduce it through further legislation.

26. **Consider developing laws and security recommendations for health facilities that provide protection against harassment or attacks on clients and providers.**
27. **Work with the Ministry of Education to establish and improve sexuality education programs in schools, with MoH for similar programs in health facilities, and with NGOs to develop community-level programs.**

Partnerships

28. **Develop simple, fair and transparent GO-NGO-private sector partnership mechanisms.** The MTEP has placed emphasis on improving the Public-Private-NGO mix in service provision and in Public-Private-NGO Collaboration at the District Level. The MTEP states that formal recognition will need to be given to the important contribution of the private/NGO sectors, including development of appropriate incentives to facilitate the participation of these sectors. It has also been recognized that appropriate and effective strategies will need to be developed to allow for these partnerships⁷³.
29. **Develop NGO and private facilities as CAC training sites,** particularly at the district level. The currently approved PAC service delivery sites, including the Sunaulo Parivar Nepal/Marie Stopes Clinics may be able to quickly gear up to provide CAC training⁷⁴.
30. **Harness the technical expertise and resources of international organizations and networks to build local and government capacity.** IPAS, Marie Stopes International, London Office (and its affiliates in India and Bangladesh), and International Planned Parenthood Federation through its national affiliates in neighboring countries, have all expressed an interest in helping⁷⁵. HMG/N and abortion advocates should seek to develop technical linkages, arrange exchange visits to service sites and learn about other agencies' experiences in training, maximizing efficiency (lowering costs), maximizing quality and developing monitoring and evaluation mechanisms.

Monitoring and Evaluation

31. **Develop training and monitoring tools for evaluating quality of care of Comprehensive Abortion Services.** The guidelines already developed for evaluation of PAC services are a good starting point. Other training materials and evaluation formats are available from a variety of international organizations including IPAS. Ideally, all reproductive health services should be monitored for quality of services through an integrated monitoring system. Use the lessons learned from developing CAC and PAC monitoring systems to create an integrated RH services monitoring system.
32. **Include hospital administrators, service providers and researchers in the process of setting realistic quality of care standards.**
33. **Regularly review monitoring and evaluation findings.** Include feedback on findings in the ongoing quality improvement and policy development process.

34. Disseminate monitoring and evaluation findings to stakeholders.

35. Begin the implementation process with pilot sites that can be closely monitored and evaluated as part of the gradual roll-out of services.

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⁷¹ Personal communication Dr. Kasturi Malla, Maternity Hospital, Thapathali, Kathmandu, May 27, 2002

⁷² see reference 12

⁷³ see reference 12, p. 30

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⁷⁵ Personal communication, Dr. Salma Burton, Programme Officer, SRH, South Asia Region, IPPF, London, May 11, 2002

FAMILY HEALTH DIVISION, DoHS (Contracted through Options Consultancy Services)

Appendix A:

Terms of Reference: Documentation of Learning Related to the Implementation of Abortion Services to Inform Nepal's Abortion Programme

BACKGROUND (situation as of April 2002)

Nepal's legal framework with respect to the provision of abortion services is set to be reformed in the near future. The legalisation of abortion is presented in the Pregnancy Protection component of the Women's Bill. The Bill has been passed through the Lower House of Parliament and shall now be submitted for Royal Assent.

Once the Bill is passed, Nepal will require the development of a comprehensive policy and accompanying strategy with which to enable the MOH to act within the new legal parameters, thus ensuring women have access to appropriate and good quality services which take into account the specific socio-cultural context of Nepal.

An initial step in this process of developing Nepal's abortion policy and implementation strategy is the drawing upon learning from other countries (in particular those of similar levels of development and which are culturally akin to Nepal) who have passed through the same process.

The Family Health Division (FHD) of the Department of Health Services has established a taskforce to head up the process of developing Nepal's abortion policy and implementation strategy. The task force requires the services of a consultant familiar with the delivery of abortion services, particularly in Asia, and conversant with the analysis and strategic planning skills required to inform the development of a national strategy.

PURPOSE OF THE ASSIGNMENT

To document lessons learnt on the development and implementation of abortion policy and implementation strategies, post abortion legalisation, from regional or related country experiences. To draw from an analysis of these, recommendations specific to the Nepal context that can inform HMGN's emerging abortion policy and implementation strategy.

TASKS

1. Be briefed by the Director of FHD and the FHD's task force on the background to and requirements of the consultancy.
2. Document lessons learned on post-abortion legalisation implementation experiences from an extensive analysis of relevant countries (particularly those of a similar nature to Nepal). This requires:
 - a comprehensive literature review
 - liaison with key actors in a selected number of countries (by email)

- liaison with key institutions involved globally in supporting the establishment of abortion services (by email)

The review will cover:

- the limitations, constraints and critical strategic issues countries have faced when strategising and planning services (including any killer assumptions which were made)
 - the cost implications faced
 - experiences in establishing, maintaining and monitoring clinical services
 - experiences in addressing the public/private partnership in service delivery
 - issues of change management of public attitude to abortion
 - experiences in advocacy initiatives
 - key conditions to be met and important strategic and operational stages required (to include any negative lessons)
 - a discussion of key informants and gatekeepers encountered
3. Hold discussions with key personnel in MoH/FHD and any related safe motherhood programme staff with regard to the current situation vis a vis related services, such as post abortion care.
 4. Use the analysis to arrive at recommendations, specific to Nepal, on major strategic areas that the MOH needs to address (policy, planning, advocacy, service provision, capacity building) and multisectoral issues (eg political support, educational or legal aspects).
 5. Present the findings to FHD's taskforce and at any forum that FHD convenes on this agenda.

OUTPUTS

Two reports:

1. A policy support document: 10 pages maximum
2. A longer Lessons Learned on Implementation document, which may be broken down into short sections covering the strategic areas explored and addressed. Sections will depend on the results of the research.

TIMING

A maximum of 20 days, to be worked between April 1st and June 1st 2002.

Appendix B: Comprehensive Literature and Resource Review (alphabetical listing by author)

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Appendix C: Contact list of key actors and institutions involved globally in supporting the establishment of abortion services

Name and Designation	Institution	E-mail address
Mary M. Luke, RN, MBA, Executive Director for Programs	IPAS	lukem@ipas.org
Dr. Heidi Bart Johnston, PhD, Research Division	IPAS	johnstonh@ipas.org
Ms. Charlotte E Hord, Policy Division	IPAS	hordce@ipas.org
Ms. Irene McFarland, JD, MPH, MA, Development Associate	IPAS	mcfarlandi@ipas.org
Ms. Teresa McInerney, BSN, RN, Program Associate, India	IPAS	mcinerneyt@ipas.org
Mr. Don Weeden, Program Director, South Asia Region	IPAS	weedend@ipas.org
Dr. Dale Huntington, Senior Program Associate, Frontiers	Population Council, New Delhi	dhuntington@pcindia.org
Dr. Ubaidur Rob, Program Associate and Resident Representative	Population Council, Bangladesh	urob@pcdhaka.org
Dr. Beverly Winikoff, Program Director, Reproductive Health	Population Council, New York	bwinikoff@popcouncil.org
Ms. Kelly Blanchard, Program Associate	Population Council, Johannesburg, S.A.	kblanchard@pcjoburg.org.za
Batya Elul	Population Council	BELUL@popcouncil.org
Ms. Sue Lambert, Department of Reproductive Health and Research	World Health Organization, Geneva	lamberts@who.ch
Dr. Salma Burton, PhD, Programme Officer, Sexual and Reproductive Health, South Asia Region	International Planned Parenthood Federation (IPPF), London	sburton@ippf.org
Ms. Jill Brennick, MPH, Programme Support Manager, Asia Team	Marie Stopes International (MSI), London	Jill.Brennick@stopes.org.uk
Ms. Sudha Tewari, Managing Director	Parivar Seva Sanstha/MSI, India	sudha_tewari@mantraonline.com
Dr. Sharad Iyengar	Action Research and Training for Health (ARTH), Udaipur, India	arth@softhome.net

Note: attempts were also made to contact all of the Directors of the various national Family Planning Associations/IPPF Affiliates in the South Asia Region but no replies were received.

Appendix D: List of local resource persons interviewed regarding the current situation in Nepal and implementation of the new abortion law

Name and Designation	Institution/Organization
Dr. Laxmi Pathak, Director General	HMG/N, Department of Health Services
Dr. S.S. Jha, Director	HMG/N Family Health Division
Dr. Ganga Shakya, Section Chief, Reproductive Health	HMG/N Family Health Division
Mr. Bhoj Raj Pokharel, Consultant to FHD	Chairman Richoi Associates (Pvt) Ltd. (Former Sec. HMG/N, Ministry of Health)
Susan Clapham, Project Director	Nepal Safer Motherhood Project (Options/DFID)
Dr. Indira Basnet, Human Resource Development Manager	Nepal Safer Motherhood Project
Anne Erpelding, MSc, Team Leader	Health Sector Support Programme (GTZ)
Tiphaine Ravenal Bonetti, PhD., Reproductive Health Advisor	Health Sector Support Programme (GTZ)
Dr. Jan Harnmeijer, MD, MPH, MSc, Chief Technical Advisor	UNFPA (Royal Tropical Institute – The Netherlands)
Dr. Hernando Agudelo, MD, DIS, MPH, Deputy Representative	UNFPA
Dr. Michael O'Dwyer, Senior Health and Population Advisor	DFID Nepal
Dr. Nicolet Hutter, MD, MSc	RHI Umbrella Project, EC/UNFPA Initiative for Reproductive Health
Anand Tamang, Director	Center for Research on Environment Health and Population Activities
Kamala Thapa, Executive Director	Sunaulo Parivar Nepal
Hari P. Khanal, Deputy Director General	Family Planning Association of Nepal (FPAN)
Dr. Tika Man Vaidya, Executive President	Nepal Fertility Care Center (NFCC)
Dr. Bhola Rijal, Senior OB/GYN and President of the Private Practitioner's Association of Nepal	OM Nursing Home
Dr. Kasturi Malla, Deputy Director	Maternity Hospital, Thapathali
Dr. Savitri Kishore, Senior OB/GYN	Maternity Hospital, Thapathali
Anita Gibson, Country Representative	JHPIEGO
Dr. Aruna Uprety, Consultant	
Dr. Shyam Thapa	Family Health International
Dr. Sudha Sharma, President	Nepal Society for Obstetricians and Gynaecologists (NESOG)

Appendix E: List of PAC-Approved Sites in Nepal as of May 2002

District/Municipality	Service Site
Kathmandu	1. Maternity Hospital – Thapatali
	2. Tribhuvan University Teaching Hospital
	3. Military Hospital
	4. Sunalo Parivar Nepal (SPN)/Marie Stopes International Clinic
Kaski	5. Gandaki Zonal Hospital
Kailali	6. Seti Zonal Hospital
Surkhet	7. Surkhet District Hospital
Baglung	8. Baglung District Hospital
Bharatpur	9. SPN/MSI Clinic Chitawan
Makwanpur	10. Hetauda District Hospital
Rupandehi	11. Lumbini Zonal Hospital (Butwal)
	12. AMDA Hospital (Butwal)
	13. Bhim Hospital (Bhairawa)
Bhaktapur	14. Bhaktapur District Hospital
Dhading	15. Dhading District Hospital
Banke	16. Bheri Zonal Hospital
Kavre	17. Dhulikhel Community Hospital (Dhulikhel)
	18. ADRA Clinic (Banepa)
Ilam	19. Ilam District Hospital
Nawalparasi	20. Parasi District Hospital
Magdi	21. Magdi District Hospital
Jhapa	22. AMDA Hospital (Damah)
Parsa	23. Narayani Sub-Regional Hospital (Birgunj)
	24. SPN/MSI Clinic