



Policy Support Paper

Review of Global Lessons Learned and Recommendations to His Majesty's Government of Nepal on the Implementation of Abortion Services

Prepared for HMG/N, Ministry of Health,
Family Health Division

By Dr. Maureen McCall

June 2002

Options

DFID Department for
International
Development

TABLE OF CONTENTS

GLOSSARY	ii
ACRONYMS	iii
EXECUTIVE SUMMARY	1
1. INTRODUCTION	3
2. RESEARCH METHODOLOGY	3
3. CHALLENGES TO MOVING FROM POLICY TO IMPLEMENTATION	4
3.1 Summary of Global Lessons Learned	5
▪ Advocacy, Attitudinal Change and Awareness Raising	5
▪ Meeting Women's Needs	5
▪ Developing Policy and Setting Standards	7
▪ Addressing Health System Barriers	7
▪ Costs and Funding	9
▪ Abortion within the Broader Policy Framework	9
▪ Cross-Sectoral Linkages, Policies and Laws	9
▪ Partnerships	9
▪ Monitoring and Evaluation	10
4. RECOMMENDATIONS TO HMG/N	11
▪ Advocacy, Attitudinal Change and Awareness Raising	11
▪ Meeting Women's Needs	12
▪ Developing Policy and Setting Standards	12
▪ Addressing Health System Barriers	12
▪ Costs and Funding	14
▪ Abortion within the Broader Policy Framework	14
▪ Cross-Sectoral Linkages, Policies and Laws	14
▪ Partnerships	15
▪ Monitoring and Evaluation	15
5. REFERENCES	16
APPENDICES	
Appendix A. Terms of Reference	1/1
Appendix B. Common Myths and Misperceptions about Abortion	2/1
Appendix C. List of Approved PAC Sites in Nepal (May 2002)	3/1

GLOSSARY

Abortion: the termination of a pregnancy before the fetus is capable of extra-uterine 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

EXECUTIVE SUMMARY

This report presents a brief overview of the global lessons learned on the implementation of new abortion law. These lessons were gathered from a detailed literature review and correspondence and meetings with key resource persons from other countries and international organizations.

Three cross-cutting principles were discovered that apply to the move from policy reform to successful implementation of a new abortion law:

1. **Advocacy does not end with the passage of a liberal law**
2. **A progressive law that cannot be fully 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**

Thirty global lessons are described under nine general subject headings:

- Advocacy, Attitudinal Change and Awareness Raising
- Meeting Women's Needs
- Developing Policy and Setting Standards
- Addressing Health System Barriers
- Costs and Funding
- Abortion within the Broader Health Policy Framework
- Cross-Sectoral Linkages
- Policies and Laws
- Partnerships
- Monitoring and Evaluation.

A brief review of the evidence and general recommendations follows each lesson. Please refer to the more detailed report also prepared for Family Health Division entitled, "Literature Review and Lessons Learned on the Development and Implementation of Abortion Policy" for more background and further references.

Finally, thirty-five general and specific recommendations are made to His Majesty's Government of Nepal Ministry of Health regarding the implementation of the new abortion law. These are based on the global lessons learned and how, in the author's opinion, they translate into concrete recommendations for the implementation process in the context of Nepal. The recommendations are listed under the same subject headings as the global lessons learned; they are not listed in order of importance or priority. A few recommendations to be considered for highest priority are summarized below:

- **Review the current Nepali terminology around the issue of abortion. (#2)**
- **Notify all health professionals about the new law as soon as possible. (#5)**
- **The test of all policies 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?" (#9)**
- **Resist the tendency to "over-medicalize" abortion policy—create simple and general policies and leave the development of specific requirements to medical guidelines, training and implementation standards and protocols. (#10)**
- **Simplify registration or authorization processes for providers and institutions. (# 13/14)**

- Increase the numbers and types of skilled providers as quickly as possible. (#15)
- Allocate and protect specific funds for safe abortion care delivery. (#18)
- Allocate resources to strengthen the national family planning program. (#21)
- Integrate comprehensive abortion care into the national reproductive health care package. (#22)
- Develop NGO and private facilities as comprehensive abortion care training sites. (#29)

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 explicit 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 for '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 learning 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; support for this work was 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 – this report; and
- A more detailed literature review document.

2. RESEARCH METHODOLOGY

The methodology for researching this report is outlined in the consultant's Terms of Reference (see Appendix A). The most useful and appropriate information came from India, Bangladesh, South Africa, Guyana, and Kenya, although lessons have been gathered from many other countries. Electronic mail correspondence with key resource persons in many countries and personal conversations with international and national resource persons also gleaned valuable lessons learned additional to the literature review. Please refer to the detailed literature review document for more background on the global status of abortion, more examples and references that support each lesson learned, and for a complete listing of information sources.

3. CHALLENGES TO MOVING FROM POLICY TO IMPLEMENTATION

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

1. **Advocacy does not end with the passage of a liberal law**
2. **A progressive law that cannot be fully 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 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. There is clear evidence that new, and even quite liberal, laws do not automatically ensure adequate access to safe and affordable abortion services (India, South Africa and Guyana). 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 that is controversial like abortion. 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. If those responsible for implementing policy are not also responsible for managing service provision, there will be significant delay in attaining reasonable levels of service delivery. In South Africa, there have been major problems with government agencies, health providers and health institutions not accepting ownership and responsibility for implementation,² and most advocates emphasize the need to integrate abortion services into the essential health care service package. However, when the administrative system is already resource-strained, it may be necessary to provide extra support (Guyana)³. 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. Strong, realistic human resource management is one of the most important components necessary for the successful 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. Studies show that even in societies with high contraceptive acceptance rates (Bangladesh), poor understanding among both users and health care providers about how methods work, their side-effects and proper use, leads to high drop-out rates and subsequent unplanned pregnancies⁴. 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 reliance on abortion.

3.1 Summary of Global Lessons Learned

The following section places lessons learned from global experiences into categories of key issues. They are followed by a brief summary of evidence for each of these findings, and/or recommendations/action point (designated by the arrow heads). More information and some further recommendations may be found in the additional report "Literature Review and Lessons Learned on the Development and Implementation of Abortion Policy" by the same author.

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.

Well-informed coalitions with adequate resources can play a key role as public watchdogs against erosion of the original intent of the law. Such coalitions have sponsored ongoing research and documentation of the effect of legal change on women's health, provision of services and on community perspectives - all of these act as positive reinforcement to advocacy efforts and must be encouraged.

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 strategy⁵.

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 (see Appendix B).
- 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^{6,7} and West Bengal⁸) 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 PHC 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 resort⁹ or to travel a greater distance to maintain confidentiality¹⁰.

- 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 system (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 have higher better quality of care standards.

- Interpersonal communication skills training 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 services¹¹. 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.
- 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 an inclusive one.

- 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 numbers of 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 period for a safe abortion.

Since menstrual regulation 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 abortion practices¹².

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)¹³.

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 the law was passed. A review and attempt to change these requirements (and other regulatory obstacles) is now underway in that country¹⁴. 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 in the type of services and procedures available 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 services¹⁵.

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 these¹⁶.

Costs and Funding

Estimates of the cost of illegal abortion services in Nepal range from NRS 50-300 for services provided by a traditional birth attendant (*sudeni*) or a nurse,¹⁷ to NRs 900-10,000 (or more) for a relatively safer abortion performed by a doctor at a private clinic^{18,19}. 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 Africa, Asia (including Nepal), Latin America, Europe and North America^{20,21,22,23,24, 25}. 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 dealing with 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 of providing safe services.

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 continuing 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 health²⁶. 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 packages 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, gynaecologic 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 for the further 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)²⁷.
- 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, favoritism, and corruption 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, (e.g. due to the effect of the 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.

4. RECOMMENDATIONS TO HMG/N

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 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, such as: 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 districts²⁸,
 - Family Planning Association of Nepal's (FPAN) 13,000 volunteers and 2,140 staff working in 34 districts²⁹,
 - 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)³⁰,
 - The community outreach workers associated with Sunaulo Pariwar Nepal's independent work in 10 districts (soon to expand to 14 districts)³¹,
 - 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. The 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, and 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 MoH³².
- 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 police 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 different kinds of sites.
 - Ensure mechanisms are in place for procurement of equipment and drugs.
13. **Simplify registration or authorization processes for providers.**
- Authorize as many types of providers as possible: 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 years of experience. In this way, more providers of different types can be introduced once appropriate training programs become available.
 - As of May 2002, a total of 119 providers (77 MBBS and post-graduate 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"³³. These providers should be automatically certified to provide CAC services.
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 C) 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 C). Included in these are 3 major referral centers in Kathmandu, 4 Zonal Hospitals, 1 Sub-Regional Hospital, 8-9 District Hospitals, 4 private not-for-profit hospitals/clinics and 2-3 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. In the last year, the Maternity Hospital treated an average of 6-7 cases per day.
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 Programs³⁴. 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 FCHVs³⁵.
 - 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 night³⁶.
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 are 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"³⁷.
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 this practice. 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 partnerships³⁸.
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 training³⁹.
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 Nepal and India, have all expressed an interest in helping⁴⁰. 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. Abortion, as a critically important new service, will require specific attention and close monitoring in the short to medium term. 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 into 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.

REFERENCES

- ¹The Center for Reproductive Law and Policy and Forum for Women Law and Development (2002) *Abortion in Nepal: Women Imprisoned*.
- ² Klugman B and Budlender D, editors (2001) *Advocating for Abortion Access: Eleven Country Studies*. The Johannesburg Initiative. School of Public Health Women's Health Project, University of Witwatersrand. p. 270
- ³ see reference 2, p. 131-132
- ⁴ Piet-Pilon N and Rob U (2002) *When Family Planning Services Fail: Experience from Bangladesh*. Population Council, unpublished, April 2002
- ⁵ see reference 2, p. 131
- ⁶ Johnston HB, Ved R, Lyall N and Agarwal K (2001) *Technical Report #23 Postabortion Complications and their Management: A community assessment conducted in rural Uttar Pradesh, India*. PRIME Project India Region
- ⁷ Johnston HB, Farr S and Ved R (2001) *Abortion care in rural Uttar Pradesh, India: An exploration of household-level decision-making*. Paper presented at the 2001 Annual Meeting of the Population Association of America, Washington, DC
- ⁸ Mathai ST (1999) *A study on prevalence of abortions in Uttar Dinajpur, Dakhshin Dinajpur and Malda*. Unpublished study commissioned by DFID
- ⁹ Rob U, Islam MM and Chakraborty N (2002) *Dynamics of Menstrual Regulation Practice in Bangladesh*, Population Council, March 31, 2002, unpublished
- ¹⁰ Example of a clinic located across from the main railroad station in Mumbai that attracts clients from all over the region because the location provides anonymity to patients – personal communication Teresa McInerney, IPAS
- ¹¹ Ganatra B and Johnston HB (2002) *Reducing abortion related mortality in South Asia – A review of constraints and a roadmap for change*. Draft accepted for publication in *Journal of the American Medical Women's Association*
- ¹² see reference 2, p. 84
- ¹³ IPAS (1999) *Advancing the Role of Midlevel Providers in Abortion and Postabortion Care. A global review and key future actions*. *Issues in Abortion Care* 6.
- ¹⁴ Ministry of Health and Family Welfare, Government of India (2000) *Report on a National Conference on Making Early Abortion Safe and Accessible*. October 11-13, 2000. Agra, India
- ¹⁵ Varkey SJ and Fonn S (2000) *How far are we? Assessing the implementation of abortion services: A review of literature and work-in-progress*. Health Systems Trust. Durban, South Africa. February 2000.
- ¹⁶ personal communication, Mr. Don Weeden, South Asia Regional Director, IPAS, May 20, 2002
- ¹⁷ Thapa S, Thapa PJ and Shrestha N (1994) *Abortion in Nepal: Emerging Insights*, *Journal of the Nepal Medical Association*, Vol 32, pp 175-190
- ¹⁸ Thapa S and Padhye S (2001) *Induced Abortion in Urban Nepal*. *International Family Planning Perspectives*, Vol. 27, No. 3, Sept. 2001
- ¹⁹ Personal communication from various Nepali informants including doctors and anonymous seekers of abortion services, April – May, 2002
- ²⁰ Benson J, Nicholson LA, Gaffikin L and Kinott SN (1996) *Complications of unsafe abortion in sub-Saharan Africa: a review*. *Health Policy and Planning* 11 (2): 117-131
- ²¹ IPAS (1995) *MVA in the treatment of abortion*
- ²² see reference 17
- ²³ Population Action International (1993) *Expanding Access to Safe Abortion: Key Policy Issues*
- ²⁴ Vrancken C (1997) "The complications and compromise of abortion services in Belgium," in *Choices: Sexual Health and Family Planning in Europe*, Vol 26, No 1
- ²⁵ Khan AR, Begum SF, Covington DL, Janowitz B, James S and Potts M, "Risks and Costs of Illegally Induced Abortion in Bangladesh". *Journal of Biosocial Science*, December 1984
- ²⁶ Althaus FA (2000) *Work in Progress: The Expansion of Access to Abortion Services in South Africa Following Legalization*. *International Family Planning Perspectives*, Vol. 26, no. 2, June 2000.
- ²⁷ Oomman N and Ganatra BR (2002) *Roundtable on Sex Selection: The Systematic Elimination of Girls*. *Reproductive Health Matters*, May 2002 (in press)
- ²⁸ Personal communication Anand Tamang, Director, Center for Research on Environment Health and Population Activities (CREPHA), Kathmandu, April 17, 2002
- ²⁹ Family Planning Association of Nepal (2002) *Profile*.
- ³⁰ Personal communication, Dr. Nicolet Hutter, RHI Umbrella Project, EC/UNFPA Initiative for Reproductive Health, Kathmandu, May 1, 2002
- ³¹ Personal communication, Ms. Kamala Thapa, Sunaulo Pariwar Nepal, Kathmandu, May 1, 2002

³² His Majesty's Government of Nepal (2002) Medium Term Expenditure Framework (2002/3-2004/5) Health Sector. Nepal Development Forum – 2002. p. 5

³³ FHD and JHPIEGO (2001) An Assessment of Quality of Postabortion Care Services in Nepal: The Training and Service Delivery Perspectives

³⁴ see reference 32, p. 17

³⁵ see reference 32, p. 24

³⁶ personal communication Dr. Kasturi Malla, Maternity Hospital, Thapathali, Kathmandu, May 27, 2002

³⁷ see reference 32

³⁸ see reference 32, p. 30

³⁹ personal communication, Ms. Jill Brennick, MSI London, May 9, 2002

⁴⁰ 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: Abortion Myths and Misperceptions which may Affect Policy and Public Attitudes

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 penicillin¹. 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 effect². 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"³. Recent claims that abortion increases the risk of breast cancer have been scientifically refuted and backed up by the ruling of two different US judges⁴.

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 services⁵.

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^{6,7,8,9,10}. 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 reduced¹¹.

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 dramatically¹².

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^{13,14}. 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 decline¹⁵.

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 choice¹⁶. 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 person¹⁷.

REFERENCES

- ¹ Wennberg JE (1980) The Need for Assessing the Outcome of Common Medical Practices, *Annual Review of Public Health*, Vol 291
- ² Kulczycki A, Potts M and Rosenfield A (1996) Abortion and Fertility Regulation. *The Lancet*, Vol 347, June 15, 1996, pp 1663-1668
- ³ WHO (1978) Induced Abortion", Technical Report, No. 623, Geneva, 1978, p.22
- ⁴ CRLP (2002) Judge Rejects Abortion - Breast Cancer Scare Tactic. From CRLP website www.crlp.org/pr_02_0328ND.html. March 28, 2002
- ⁵ IPAS (1999) Advancing the Role of Midlevel Providers in Abortion and Postabortion Care: A Global Review and Future Actions. *Issues in Abortion Care* 6
- ⁶ Johnston HB, Ved R, Lyall N and Agarwal K (2001) Technical Report #23 Postabortion Complications and their Management: A community assessment conducted in rural Uttar Pradesh, India. PRIME Project India Region
- ⁷ Johnston HB (2002) Induced Abortion Practice in India: A review of the literature. In press, CEHAT, March 2002
- ⁸ Rob U, Islam MM and Chakroborty N (2002) Dynamics of Menstrual Regulation Practices in Bangladesh. Population Council Bangladesh, unpublished
- ⁹ Henshaw S (1990) Induced Abortion: A World Review, 1990. *Family Planning Perspectives*. Vol 22, No. 2, March-April 1990
- ¹⁰ Tamang A (1996) Induced Abortion and Subsequent Reproductive Behaviour among Women in Urban Areas of Nepal. *Social Change*, Vol 26, Nos. 3-4, Sept-Dec 1996
- ¹¹ see reference 4, p. 1664
- ¹² Population Action International (1993) Expanding Access to Safe Abortion: Key Policy Issues
- ¹³ Henshaw S, Singh S and Haas T (1999) Recent Trends in Abortion Rates Worldwide. *International Family Planning Perspectives*, Vol 25, No. 1, March 1999
- ¹⁴ De Silva I (1994) Ahead of Target: Achievement of Replacement Level Fertility in Sri Lanka before the Year 2000. *Asia-Pacific Population Journal*, Vol. 9, No. 4, December 1994
- ¹⁵ Henshaw S, Singh S and Haas T (1999) Recent Trends in Abortion Rates Worldwide. *International Family Planning Perspectives*, Vol 25, No. 1, March 1999
- ¹⁶ Catholics for a Free Choice (2000) How to Talk About Abortion: A Guide to Successful Communications. Washington, D.C.
- ¹⁷ CREHPA (2000) Women in Prison in Nepal for Abortion: A study on implications of restrictive abortion law on women's social status and health.

Appendix C: 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