

Support to the Safe Motherhood Programme

Strategic Issue Paper

Safe Abortion within Safe Motherhood Programming

January 2007

Summary

The paper describes the progress achieved in implementing the reformed abortion law in Nepal. In a few short years there have been remarkable achievements in terms of training service providers, providing services across the country, with 70 out of the 75 districts now covered and increasing public awareness of women's right to safe abortion services. This has been due to a complex mix of factors, including a pragmatic enabling policy environment; multi-partner inputs (public private partnership); recognition of the part safe abortion services can play in the drive to reduce maternal mortality; and improved education and access to information leading to increased confidence, among younger women in particular. Strong government buy-in has been a key factor and the integration of safe abortion services into safe motherhood programming, for which SSMP has provided support.

1. Background

Prior to reform, Nepal had one of the most strictly enforced anti-abortion laws in the world. Women received lengthy prison sentences for abortion related "crimes" (often labelled as infanticide)¹ and studies suggest that more than half the gynaecological and obstetric hospital admissions were due to complications of unsafe abortion². From small beginnings in the 1980s and through the 1990s the efforts of many individuals and organisations led eventually to reform of the law in March 2002, when abortion was legalised under specified conditions. The DfID/Options supported Nepal Safer Motherhood Project (NSMP) was a key player in the movement for reform, and continued to work with other international and national partners to provide technical support to the Government of Nepal for the development of the policies, strategies and procedures necessary for implementation of the reformed law. In December 2003, the Procedural Order enabling legal abortion services to begin received parliamentary approval. Under the reformed law, which is liberal by any standards, abortion is permitted up to 12 weeks' gestation for any woman above 16 years on her request. For women under 16 years the permission of a guardian is required. Abortion is also permitted up to 18 weeks' gestation if the pregnancy is the result of rape or incest, and at any time on the advice of a medical practitioner if the life or health of the woman is in danger or the foetus is seriously deformed or has a condition that is incompatible with life.

The Technical Committee for the Implementation of Comprehensive Abortion Care (TCIC) was established in late 2002 as a multi-partner forum to advise and support the government in implementing the new law: drafting manuals, establishing a training programme and services with monitoring procedures, and initiating information and behaviour change activities. The

¹ Centre for Reproductive Law and Policy (CRLP), Forum for Women Law and Development (FWLD), 2002, *Abortion in Nepal: Women Imprisoned*.

² Ministry of Health, 1998, *National Maternal Mortality and Morbidity Study*.

TCIC secretariat was initially housed in the Family Health Division, recently moving to larger premises within the main Department of Health Services building. Two multi-partner working groups provide technical advice, one for information dissemination activities and the other for clinical services and training. An Advisory Board, chaired by the Director General of the Department of Health Services is responsible for major strategic decisions and recommendations. Ipas was also a key player in the abortion reform movement and implementation support, and as a partner in Support to the Safe Motherhood Programme (SSMP), continues to provide technical assistance to enable TCIC, working closely with Family Health Division, the National Health Training Centre and National Health Education Information Communication Centre to expand the safe abortion programme country-wide.

In 2003, DfID funded the development of a comprehensive abortion care clinic and training centre at the Maternity Hospital in Kathmandu, with technical assistance from Ipas. The first client received services in March 2004, and the caseload grew quickly to an average of 20 clients per day, reaching a total of 8,072 by September 2006. Training of nurses as service providers was piloted in August 2006, and this will be scaled up in order to increase access to services for women in remote areas, where there are very few doctors. In August 2005 a second training site was approved at the Marie Stopes International (MSI) clinic in Kathmandu. NSMP, SSMP and Ipas have provided support for the establishment of a third training site, at Lumbini Zonal Hospital in Butwal, which will begin training soon.

Safe abortion programme data from April 2004 to December 2006

- **307 doctors** (199 government and 108 NGO/private) trained as service providers
- **4 nurses** (all government) trained as service providers
- **245 nurse assistants** (154 government and 91 NGO/private) trained in counselling and post abortion family planning
- **154 hospitals** and clinics registered for services (88 government and 66 NGO/private)
- **70 districts** of the 75 in Nepal covered
- **85,984 women** across the country received safe abortion services

Other organisations involved in supporting the safe abortion programme include the German Technical Assistance organisation (GTZ), Planned Parenthood Federation of America-International (PPFA-I) and Programme for Appropriate Technology in Health (PATH). National Non Government Organisations (NGO), such as Family Planning Association of Nepal (FPAN), the Nepal branch of MSI, Centre for Research in Environment Health and Population activities (CREHPA), Forum for Women Law and Development (FWLD) and the Safe Motherhood Network Federation (SMNF) have also continued to work as partners to TCIC and the government Through their research, advocacy and coalition building efforts the NGOs played a critical role in creating the momentum that resulted in legal change, and they now act as “watchdogs” to safeguard women’s rights and highlight key issues to be addressed, as well as disseminating information through district level work. FPAN and MSI, also provide reasonably priced alternatives to government hospital services. Private facilities catering to the needs of those able to pay higher prices are also mushrooming, particularly in the cities. All private and NGO services are subject to government regulations and standards, and service providers are required to attend the approved national training course.

Complementing clinical services is a programme of information and education that aims to empower women to make safe reproductive health choices and enable communities and families to explore these issues and address attitudes towards women's health and rights, as a part of the larger picture of women's position in society. This comprises two main areas: (1) the development of Information Education Communication (IEC) materials and mass media (radio and television) broadcasting, supported by Ipas/SSMP; and (2) Behaviour Change Communication (BCC) activities based on interpersonal communication and community group discussions using innovative techniques, supported by PATH.

2. Achievements learning and challenges

2.1 Achievements

In a short time, the national safe abortion programme has moved rapidly, achieving significant buy-in from partners, including government and the NGO/private sector. This has resulted in substantial progress in terms of training, service delivery and information dissemination. After only two and a half years, 69 of the 75 districts of Nepal have at least one service provision site, either public or NGO/private, which is remarkable given the difficult geography and human resource limitations in hill and mountain areas. In a country with very traditional values, a strong religious base and deep rooted societal beliefs and practices that do not support women's right to control or even discuss their reproductive health needs and rights, the establishment and uptake of services is astonishing. The reasons lie in a complex mix of factors that include: a pragmatic enabling policy environment; multi-partner inputs (public private partnership); the drive to reduce maternal mortality and recognition of the part safe abortion services can play; and improved education and access to information leading to increased confidence, among younger women in particular.

Although these are still very early days, there is anecdotal evidence of fewer cases of abortion complications presenting in some emergency departments, and of increased knowledge and understanding of issues related to abortion and women's health. These are promising signs, but it should be acknowledged that it may take many years to achieve universal access to safe abortion services and a significant reduction in maternal mortalities due to unsafe abortion. Contrary to expectations among more conservative groups, facility records show that the overwhelming majority of clients (over 95 percent) are married women who already have children and wish to either limit their family size or space their children more widely. Over 90 percent of clients accept a contraceptive method after the abortion³. A number of women who have been raped have also been provided with safe and confidential abortions.

At facility level the safe abortion programme has pioneered a number of activities and improved approaches which have the potential to impact on other safe motherhood and reproductive health services. The training of nurse service providers, which will be scaled up to improve access to services in remote areas and busy hospitals where there are insufficient doctors, is also a further step towards empowerment of nurses. At the Maternity Hospital clinic, service hours have been extended beyond the normal times and the hospital management has decided to use the service fees for maintenance and improvement of the unit, thus increasing sustainability, and to allocate some of the money for staff incentives, to increase their

³ Ministry of Health, TCIC, Ipas, PATH, CREHPA, FWLD, 2005, *Women's Right to Choose: Partnerships for Safe Abortion in Nepal*.

commitment. Quality assurance monitoring and on-site support, in collaboration with government staff, provides an example for other services.

Enabling policy environment: In developing policies, strategies and procedures, the Nepal government drew on global learning⁴, which highlighted three cross cutting principles: (1) the need for continued advocacy related to access; (2) the need for an enabling environment to support effective implementation; (3) the need for strong links with family planning initiatives. In particular, lessons were learned from the Indian experience where, due to excessive complexity of regulations, a law that was reformed 30 years ago has still not resulted in significant service availability. The fundamental principle adhered to in Nepal has been that of simplicity, making procedures and criteria for approval and listing (registration) of service providers and sites practical and easy to administer and fulfil. The use of evidence based planning and government leadership (through the Family Health Division) with TCIC as a coordinating and advisory body, was also important.

Partnership approach: The multi-partner involvement in advocating for reform has been retained in the implementation of the reformed law, manifested through the advisory role of partners within the TCIC working groups and advisory board and their activities as service providers and information disseminators. Over 80 percent of safe abortion services are now provided by NGO/private clinics trained and listed under the government/TCIC programme and subject to government/TCIC monitoring. The MSI training site is able to train service providers from the NGO/ private sector and the public sector, and the new government training site at Lumbini Zonal Hospital in Butwal plans to work with local MSI and Amda clinics to provide additional clinical practice for trainees. CREHPA was contracted by Ipas to carry out an important baseline study on service utilisation and knowledge of the law⁵. The PPFA-I supported programme Network for Addressing Women's Reproductive Rights in Nepal (NAWRN), comprising FWLD, FPAN, CREHPA and SMNH, works in 15 districts supporting abortion through information dissemination, advocacy and service provision, complementing the government/TCIC programme. Thus there has already been notable interchange of capacity between the public and NGO/private sectors.

Integration with safe motherhood: Acceptance of the concept of legalisation of abortion was strongly linked with acknowledgement of its potential contribution to the national priority of reducing the high maternal mortality ratio in Nepal (estimated at 539 deaths per 100,000 live births⁶), rather than an overtly rights based approach. This ensured government buy-in and helped silence opposition from the more conservative elements of society. Linked with this has been the subsequent integration of safe abortion into wider safe motherhood programming efforts, which has been facilitated by the SSMP/Ipas partnership and government support. Recent concrete examples include incorporation of abortion services into the essential Maternal and Neonatal Health package, the revised Safe Motherhood and Neonatal Health Long Term Plan (2006-2017) and the Health management Information System, and inclusion of abortion related questions for the first time in the 2006 National Demographic and Health Survey. At facility level, no public hospitals are able to provide separate abortion clinics, and initially most hospitals began providing abortion services in maternity units, as an expediency measure that emphasised the common ground between the services. Now however there is a move towards use of outpatient family planning clinics, where the facilities and environment are more

⁴ McCall M., 2002, *Review of Global Lessons Learned and Recommendations to the Government of Nepal on Implementation of Abortion Services*.

⁵ Family Health Division, MoHP, CREHPA, Ipas, 2006, *National Facility Based Abortion Baseline Survey (Draft)*.

⁶ MoH, New Era, 2001, *Nepal Demographic and Health Survey*.

appropriate. The inclusion of Manual Vacuum Aspirators and the medication abortion drugs on the government standard list of reproductive health commodities provides further evidence of the acceptance of abortion services as a normal part of reproductive health services

Education and information dissemination: The CREHPA baseline study (2006) strongly highlighted the need for increased information dissemination efforts, noting that on average only 39 percent of clients interviewed at the sample sites knew that abortion was legal in Nepal and of these only 48 percent knew even one of the legal conditions. Of particular note was effects of education levels on knowledge, as among those with no formal education only 25 percent were aware that abortion is legal, whereas among those with secondary level education 60 percent were aware, and 91 percent of those with intermediate level and above were aware. The SSMP/TCIC/Ipas partnership has supported the development of an IEC strategy and basic materials providing information about abortion issues, legal rights and conditions and availability of safe abortion services. Other safe motherhood stakeholders, including SSMP partners, are involved in meeting the major challenge of ensuring these materials are widely distributed and read.

2.2 Challenges

The effects of the global gag rule on implementation of the safe abortion programme have been and continue to be significant, as any potential partners receiving financial support from USAID are prohibited from working on abortion, either service provision or information dissemination, and any facilities constructed with USAID support cannot be used for abortion services, including government facilities. This is particular difficulty within SSMP as the partner providing technical assistance for IEC/BCC activities, Johns Hopkins University Centre for Communication Programmes (JHU/CCP) is not able to work on abortion materials. The fact that the Safe Motherhood and Neonatal Sub Committee, the main coordination body for safe motherhood programming, is supported by USAID also means that abortion issues cannot be include in meeting agendas. Many of the United Nations agencies are also not able to work directly on abortion issues. For example there have been difficulties in incorporating abortion protocols into the general reproductive health protocol, the development of which has been supported by UNFPA. This situation highlights the importance of SSMP's support for abortion work, with so many larger partners unable to do so.

Despite encouraging progress, many challenges remain in the drive to achieve universal access to safe abortion services and the right of women to choose this. As is the case with other programmes, poor and excluded groups are not being reached due to:

- Cost of services, with even government facilities charging a fee of up to Rs.1,000
- Lack of trained staff, especially doctors, in remote areas
- Low priority given to abortion services by overstretched staff
- Unwillingness of referral hospitals to treat complications of abortions carried out at other facilities
- Public sector doctors preferring to take women as private clients and charging a higher fee
- Lack of information about the law and availability of safe services and dangers of unsafe abortions, linked with lack of education
- Women's low socio-economic status, which means they are not able to make decisions about their own reproductive health and needs.

Strategies for addressing these challenges include training nurses as service providers, piloting medication abortion, encouraging facility management committees to provide more enabling support (subsidies for poor women and incentives for service providers) and the involvement of partners in information dissemination efforts. Perhaps most important is a continued emphasis on integrating safe abortion with safe motherhood programming and services, so that access to services is recognised as a woman's right.

3. Future plans and recommendations

The positive beginning of the safe abortion programme, with government ownership, integration with safe motherhood programming and successful public private partnership, provides a strong base for a sustainable future without the need for external support. The SSMP/TCIC/lpas partnership is well placed to move forward from the initial rapid expansion phase of safe abortion programming to the development of a sustainable model of quality service provision and inclusive access. This will mean continuing to build on existing safe motherhood and health sector reform efforts, continuing to promote the integration of safe abortion under the broader safe motherhood programme and further developing the potential of partnership approaches. Specific plans include:

1. **Specialist services:** As caseloads increase there is a need for a formalised referral system for complications, serving both public and NGO/private clients. Centres of excellence will be developed, initially on a regional basis at regional or zonal hospitals, to deal with referred complications and provide more specialised services, such as second trimester abortions (for special cases) and piloting of medication abortion.
2. **Reaching the poorest:** This has to be a major focus, as poor and excluded women are the most likely to die as a result of unsafe abortion complications. The two key areas to be addressed are cost barriers and IEC/BCC activities. Since these are also key safe motherhood issues, they will be addressed as far as possible through integrated approaches. Links will be developed with cost sharing efforts and facility based subsidy systems and with socially inclusive access efforts under safe motherhood and reproductive health IEC/BCC programmes. Expansion of the nurse training programme will further contribute to the availability of services for women in remote areas and choice for those who prefer a female provider. NGO partners are being strongly encouraged to open clinics in more remote areas, rather than only focusing on urban centres.
3. **Quality assurance:** Monitoring and support visits, combined with performance improvement approaches, will be a major focus of the programme. Government staff from regional and district health offices will be included in visits. Low performing sites and service providers will be tracked to establish the causative factors and develop remedial approaches. Innovative ideas will be shared as an example to be followed. There is potential for these efforts to also positively influence other departments and facilities.
4. **Public private partnerships:** The safe abortion programme has been a leader in making the government commitment to public private partnership a reality, and this will be further developed. Safe abortion services, training, advocacy and IEC/BCC activities are well suited to provision by private/NGO facilities and programmes. There is much to learn from the TCIC experiences and this will be shared more widely to feed into other safe motherhood efforts.

5. **Family planning links:** A safe abortion service providing comprehensive care includes the provision of family planning advice and a reliable contraceptive method, but the programme needs to develop stronger links with family planning programmes and emergency contraception, in order to prevent unwanted pregnancies and avoid the use of abortion as a routine family planning method. The move towards use of family planning clinics for abortion services is a positive development and will be further promoted. IEC/BCC activities will include an emphasis on the importance of using a reliable contraceptive method.