Sexual and Reproductive Health Matters

ISSN: (Print) 2641-0397 (Online) Journal homepage: https://www.tandfonline.com/loi/zrhm21

Increasing safe abortion access through universal health care: promising signs from Nepal and Pakistan

Tanvi Monga, Madhabi Bajracharya, Hina Aziz, Lhamo Yangchen Sherpa, Irum Shaikh, Ghulam Shabbir, Popular Gentle & Ghazaleh Samandari

To cite this article: Tanvi Monga, Madhabi Bajracharya, Hina Aziz, Lhamo Yangchen Sherpa, Irum Shaikh, Ghulam Shabbir, Popular Gentle & Ghazaleh Samandari (2020) Increasing safe abortion access through universal health care: promising signs from Nepal and Pakistan, Sexual and Reproductive Health Matters, 28:2, 1763008, DOI: 10.1080/26410397.2020.1763008

To link to this article: https://doi.org/10.1080/26410397.2020.1763008

Published online: 26 May 2020.

COMMENTARY

Check for updates

SRHM SEXUAL AND REPRODUCTIVE HEALTH MATTERS
MORE THAN A JOURNAL

Increasing safe abortion access through universal health care: promising signs from Nepal and Pakistan

Tanvi Monga,[a] Madhabi Bajracharya,[b] Hina Aziz,[c] Lhamo Yangchen Sherpa,[d] Irum Shaikh,[e] Ghulam Shabbir,[f] Popular Gentle,[g] Ghazaleh Samandari[h]

a Senior Technical Lead, Community Engagement, Ipas, Chapel Hill, NC, USA
b Policy Advisor, Ipas Nepal, Kathmandu, Nepal
c Senior Research & Evaluation Advisor, Ipas Pakistan, Islamabad, Pakistan
d Senior Research & Evaluation Advisor, Ipas Nepal, Kathmandu, Nepal
e Senior Health Systems Strengthening Advisor, Ipas Pakistan, Islamabad, Pakistan
f Country Director, Ipas Pakistan, Islamabad, Pakistan
g Country Director, Ipas Nepal, Kathmandu, Nepal
h Adjunct Professor, University of North Carolina at Chapel Hill, Chapel Hill, NC, USA. *Correspondence:* g.samandari@gmail.com

Background on UHC and SRHR

Universal health coverage (UHC) has been identified as a means of addressing health inequalities to achieve the 2030 Sustainable Development Goals (SDGs).[1] As defined by the World Health Organization (WHO), UHC means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services – from health promotion to prevention, treatment, rehabilitation, and palliative care.[2]

UHC is essential to reducing poverty, and improving educational and economic disparity, gender inequality, and inequitable access to health care, and the World Health Organization (WHO) cites UHC as one of three strategic priorities for providing health and well-being to populations.[3] To date, over 100 nations have made strides to implement aspects of UHC in their health systems, yet disparities in access persist, particularly for women and girls.[4]

Sexual and reproductive health and rights (SRHR) are critical to meeting the health care needs of women and girls and upholding the principles of UHC. Recognising this, the WHO pledged to ensure universal access to SRHR and integrate these services into national strategies and programmes as part of the SDGs.[4] The WHO tracks family planning access as one of 16 signal functions of UHC service provision at the country level, but abortion access is not tracked. Every year, women and girls around the world undergo 56 million abortions, nearly half of which are unsafe, leading to almost 23,000 annual maternal deaths and accounting for 5–13% of all maternal deaths.[5] Full embodiment of the principles of UHC can only be achieved if safe abortion care (SAC) is explicitly integrated into UHC programming.

Despite the urgency of including SRHR in UHC, the 2030 SDGs expressly *exclude* any text that may be interpreted as a right to abortion, largely due to pressure from the US and other conservative governments.[6] This attack on comprehensive SRHR not only threatens the well-being of women and girls everywhere but weakens the mandate of UHC by ignoring the danger posed when safe abortion access is not specifically addressed. Inclusion of SAC in UHC efforts requires persistent and strategic policy advocacy and direct partnership with governments and local actors. Nepal and Pakistan serve as examples of countries pushing to include SAC in UHC programming, despite the lack of clarity in international directives. This commentary provides information on the programmatic learning from efforts to include SAC in UHC packages in Nepal and Pakistan. Our intention is that other country programmes can use these practical models for including SAC in

their own UHC strategies, even though it may be considered controversial or stigmatised.

Nepal and abortion access through UHC

In 2002, the Government of Nepal legalised abortion. The 2018 Safe Motherhood and Reproductive Health Rights Act was approved with indications for abortion up to 12 weeks' gestation upon request, and up to 28 weeks' gestation in cases of rape or incest, in case of threat to the physical or mental well-being of the mother, HIV positive status of the mother, or fetal abnormality.[7] An estimated 137,000 annual abortions are provided through over 1400 government-approved public, private and non-governmental health facilities across the country. Despite progress, almost 70% of women experiencing post-abortion complications in 2014 reported a clandestine abortion, indicating continued barriers to utilising SAC.[8]

To increase access to health services across the country, Nepal included UHC as a strategic pillar in the 2015–2020 Nepal Health Sector Strategy and enshrined it as part of the Nepali Constitution. The Implementation Plan of 2016–2021 operationalised the roll-out of UHC in Nepal and was reinforced by the launch of a National Health Insurance Scheme and drafting of a Basic Health Service Package (BHSP), which mandates that government-prioritised health services be accessible for all.

In the planning and preparation phases of the above health sector schemes, Ipas and civil society organisations (CSO) worked with stakeholders in the Nepali government to integrate access to SAC into the standard of UHC services. When the draft of the BHSP was first being prepared, advocates realised that safe abortion was not explicitly included in the package of free services. To address this gap, CSOs held numerous formal and informal meetings with Nepali policy makers at different levels, including stakeholders at the Department of Health Services (DoHS), the Ministry of Health and Population (MoHP) and the Family Welfare Division (FWD). However, advocates faced setbacks in early gains when SAC coverage was reduced from 12 to 9 weeks' gestation in BHSP draft language.

To persuade leaders of the importance of including SAC in the BHSP, CSOs cited health care statistics on the dangers of unsafe abortion. In Nepal, an estimated 323,000 abortions are performed each year, 7% of maternal deaths are due to complications of abortion and 58% of abortions are clandestine.[8] By using this evidence and citing the constitution, which guarantees equitable access to care for all, advocates made an argument for safe abortion as part of the national health scheme. CSOs also used these data to push for increased access to services by task-shifting abortion from obstetrician-gynaecologists operating in hospitals to auxiliary nurse midwives who operate at health posts at the community level.

It was through diligent advocacy and follow-up with policy makers that Nepali CSOs were able to ensure the BHSP was adjusted to include free safe abortion care up to 12 weeks at public health facilities. Furthermore, in August 2016, the FWD, DOHS and MOHP received the first annual budget to implement "Free Safe Abortion Services", a result of Ipas's direct advocacy with the Ministry of Finance, removing economic barriers to SAC services in public facilities. The Safe Abortion Implementation Guidelines were also revised to incorporate the free safe abortion policy and to address cost barriers to the program. Since the inclusion of SAC in BHSP, Ipas Nepal has worked closely with the Nepali government to provide technical support for budgeting free abortion services nation-wide. In 2019, the government updated the abortion law to require that funding is available to fulfil the government's mandate for free abortion care in public health facilities. Post-abortion contraception is also part of the BHSP, at no cost.

The Nepal Demographic Health Surveys from 2011 and 2016 have shown an increase in safe abortion services from 7.5% to 9%; the proportion of women naming government facilities as a location where they can receive safe abortion increased from 71.4% to 79% in the same period; and people who know abortion is legal increased from 38% to 41%. The caseload of safe abortion services at Ipas-supported government health facilities also increased from 16,769 (2015) to 26,952 (2019). However, a direct causal link between the BHSP and increased abortion services cannot be drawn for several reasons, including concomitant expansion of service sites, larger numbers of trained providers, and lack of national data.

Pakistan and shifts in abortion acceptability through UHC

Prior to 1990 in Pakistan, abortion was a crime punishable by imprisonment unless done to save the life of a woman. The Pakistani Penal Code

was amended to allow abortion in cases of "necessary treatment" up to 12 weeks, leaving indications for legal abortion vague for both providers and women.[9] As a result of this ambiguity, abortion services are not provided in most facilities and women resort to clandestine abortions. Yet, women and girls in Pakistan have limited access to contraceptives, leading to 2.2 million abortions annually, the vast majority of which are unsafe and cause 6–13% of maternal deaths.[10]

In Pakistan, CSOs worked with local stakeholders to destigmatise the topic of SAC and increase access to community-level, quality abortion care. Rather than emphasising coordination with central government agencies, advocates focused efforts on influential professional associations such as the Society of Obstetricians and Gynecologists of Pakistan (SOGP), College of Physicians & Surgeons of Pakistan (CPSP) and Midwifery Association of Pakistan (MAP), who are known for their capability in pushing progressive policies with the Ministry of National Health Services, Regulations and Coordination (MoNHSR&C). Moreover, in 2011, the central Ministry of Health largely devolved policymaking and implementation to the provincial level. Ipas Pakistan, in turn, targeted their abortion advocacy work in Punjab, the highest-populated province in the country.

Using the abortion rate and associated maternal mortality statistics cited above, as well as comprehensive resources on WHO-recommended uterine evacuation (UE) technologies, CSOs were able to convince the Punjab government to establish the Punjab Reproductive Health Technology Assessment Committee (PRHTAC) in December 2012. Housed at the provincial health department, PRHTAC included government partners, UN agencies, donors and CSOs, who worked together to assess the feasibility of introducing UE technology into the Essential Package of Health Services for Primary Health Care (EPHS), a provincial assistance scheme intended to reduce financial barriers to accessing health care in Punjab.[11] Through advocacy with PRHTAC and by linking efforts directly to the EPHS, CSOs were able to persuade the committee to include misoprostol and manual vacuum aspiration (MVA) in the EPHS for both safe UE and post-abortion care (PAC), including post-abortion contraception.

Next, the government and partners in Punjab province undertook a cascade of follow-on activities to ensure accessibility to SAC care, including improving commodity and supply chain processes for abortion drugs and equipment and building provider capacity to prescribe misoprostol for UE and perform MVA. Ipas also worked with both the Pakistan Nursing Council and SOGP to include MVA in the national midwifery curriculum. To assure quality of abortion services and respectful treatment of women seeking SAC, Ipas also held values clarification workshops and worked with the Pakistan Alliance for Post-Abortion Care (a coalition of government, NGO and UN agencies) to create the Service Delivery Standards and Guidelines for High-Quality Safe Uterine Evacuation and Post-Abortion Care, a job aid and quality assurance tool for public health facilities, which was adopted by the Punjab health authorities in 2015. Advocates noted an initial lack of participation by senior and midlevel public health management in setting standards of UE/PAC quality and addressing supply chain and attitudinal barriers. However, by holding numerous consultative conversations with stakeholders, working with providers and policy makers to build SAC capacity and improve attitudes towards abortion, and helping the government mobilise commodity resources for service delivery, CSOs laid the groundwork for improved abortion accessibility in Pakistan.

The policy changes mentioned above have contributed to an enabling environment that improves women's access to SAC/PAC and contraceptive uptake in Pakistan. Over the course of 2013–2019, 806 health care providers were trained on women-centred PAC and these providers treated 55,312 women and girls, of whom almost 64% accepted a contraceptive method.

Lessons learned for SAC expansion through UHC

Leaving SAC out of UHC directives is highly problematic for the protection of women and girls, but countries like Nepal and Pakistan have shown that governments and CSOs have a role to play in addressing this deficiency at the national and provincial levels. Through diligent advocacy and strategic partnerships, SAC can be brought to scale via UHC initiatives. The following are lessons learned from work in both countries that could be applied to other settings:

- Stigma around abortion can make government partners wary of sponsoring policies that include SAC in UHC; by partnering directly with key stakeholders in national and regional health structures, advocates can recruit

powerful allies in the effort to bring SAC into UHC schemes.
- Basing advocacy efforts in direct, local health care and costing evidence can help persuade stakeholders of the urgency of SAC policy change. Technical support for SAC technologies can also show governments that UE and misoprostol are safe and manageable processes to introduce at all levels of the health care system, including primary care.
- Strong relationships with and inclusion of local CSOs, especially women's, youth and professional health associations, can bolster advocacy efforts and increase participation and buy-in from government partners, even in conservative settings like Pakistan. CSO engagement should happen as soon as a country starts to develop its UHC strategy. Many countries will be undergoing this process as they operationalise the Political Declaration from the high-level meeting on UHC, and it is imperative that CSO partners engage early and often to include SRHR within service packages.
- Emphasis on safe technologies, task-shifting, community outreach, referral linkages, quality of care and cost-effectiveness of SAC are essential to demonstrating the promise of safe abortion to meet the health care needs of women and girls.

In both countries, there are continued advocacy and accountability efforts taking place to address ongoing challenges. In Nepal, Ipas and CSOs continue to advocate for full implementation of the UHC SAS package, which includes appropriate budgeting and financing of the BHSP, ensuring availability of proper facilities, supplies and trained staff across the country; they are also pushing for task-shifting of ME service provision to trained auxiliary nurse-midwives. In Pakistan, advocates are still working to ensure a stable supply chain for contraceptives, increase retention of trained staff or development of proper hand-over procedures for trained staff who leave facilities, and to continue combating provider stigma against offering SRHR services to young women and girls.

Conclusion

The potential of UHC cannot be realised without integration of SRHR and, specifically, safe abortion services into national health care initiatives. To truly rise to the mandate of UHC, nations must ensure the rights of every woman and girl to safe abortion care.[4] Countries have this mandate from the SGDs and the Political Declaration from the high-level meeting on UHC. The time is now.

References

1. UN General Assembly. Transforming our world: The 2030 Agenda for sustainable development. A/RES/70/1. [cited 2015 Oct 21]. Available from: https://www.refworld.org/docid/57b6e3e44.html
2. World Health Organization. Universal health coverage fact sheet. Available from: https://www.who.int/en/news-room/fact-sheets/detail/universal-health-coverage-(uhc)
3. Kieny MP, Bekedam H, Dovlo D, et al. Strengthening health systems for universal health coverage and sustainable development. Bull World Health Organ. 2017 Jul 1;95(7):537.
4. World Health Organization. World Bank. Tracking universal health coverage: 2017 global monitoring report. Geneva: World Health Organization.
5. Singh S, Remez L, Sedgh G, et al. Abortion worldwide 2017: uneven progress and unequal access. Available from: https://www.guttmacher.org/report/abortion-worldwide-2017.
6. Monga T. Watered-down words jeopardize women and girls. Global Health Now. Johns Hopkins Bloomberg School of Public Health. [cited 2019 Nov 20]. Available from: https://www.globalhealthnow.org/2019-11/watered-down-words-jeopardize-women-and-girls
7. Nepal Ministry of Health. National safe abortion policy, Kathmandu, Nepal: Ministry of Health; 2002. Available from: http://www.mohp.gov.np/images/pdf/policy/National%20abortion%20Policy.pdf
8. Puri M, Singh S, Sundaram A, et al. Abortion incidence and unintended pregnancy in Nepal. Int Perspect Sex Reprod Health. 2016 Dec 1;42(4):197.
9. Pakistan Penal Code (Act XLV of 1860), Chapter XVI, Section 338(A)-(C).
10. Sathar Z, Singh S, Rashida G, et al. Induced abortions and unintended pregnancies in Pakistan. Stud Fam Plann. 2014 Dec;45(4):471–491.
11. Wright, J. Health Finance & Governance Project. Essential package of health services country Snapshot: Pakistan. Bethesda (MD): Health Finance & Governance Project, Abt Associates; July 2015.