FROM HURDLES TO HOPE: EXAMINING THE EVOLVING LANDSCAPE OF SAFE ABORTION SERVICES IN NEPAL

BACKGROUND

Abortion services in Nepal have undergone significant changes in the last two decades, driven by the recognition of the need to address Nepal's high rates of maternal mortality and morbidity, as well as upholding women's reproductive rights. Prior to 2002, Nepal's abortion laws were highly restrictive, allowing abortion only when the pregnant woman's life was at risk. This led to many women seeking out illegal methods that were often unsafe and carried high risks of complications. By legalizing abortion, the government was able to provide women with safer options for terminating pregnancies, reducing the number of deaths related to unsafe abortions. The country has made notable progress since then, with a rise in the number of abortion service providers, the assignment of duties from medical doctors to auxiliary nurse midwives (ANMs), and the implementation of medical abortion, thus making it simpler for women to access abortion services. In addition, the Government of Nepal has also made abortion services free of charge for all women. The success that Nepal has achieved after the legalization of abortion services is undeniable; maternal mortality has decreased significantly since the legalization of abortion in 2002, and the number of maternal deaths related to abortion complications has been declining. However, the program also faces several challenges, which can be categorized into different systems: healthcare, social, and legal. Despite these challenges, the liberalization of abortion laws and the improvement of access to safe and legal abortion services in Nepal have had a significant impact on the country's maternal health outcomes. While there is still more work to be done to ensure that all women in Nepal have access to safe and legal abortion services, the progress made in the last two decades is a testament to the positive impact that expanding access to abortion can have on maternal health.

SYSTEMATIC REVIEW CONTEXT

The review employed a mixed-method approach, utilizing primary data collected through interviews with policymakers, lawmakers, activists, and others involved in abortion law and policy reforms in Nepal. Purposive sampling was used to select 10 participants. Secondary data was gathered through a review of documents, including laws, policies, constitutional and supreme court decisions, statistics, reports, and literature on abortion in Nepal, using online platforms like Google Scholar and PubMed. The findings were discussed with legal and data expert teams before being reported.

The review also analyzed data from various rounds of the Nepal Demographic Health Survey (NDHS) to examine pregnancy outcomes, such as abortion, delivery, miscarriage, or stillbirth. The concentration index was calculated to assess income-related inequality in abortion service utilization, with a value range of 0 to 1, where zero indicates no income-related inequality.

NEPAL'S ABORTION LAW: A HARD-WON BATTLE FOR REPRODUCTIVE RIGHTS

1. **1970-1980: The Germination Phase of Nepal's Abortion Law-** During the 1970s, Section 130 of the Penal Code proposed conditional abortion rights, but the law was never passed. Advocacy efforts for abortion access included national conferences and the ratification of CEDAW.
2. **1990-2002: The Formulation of Nepal's Abortion Law-** Between 1990 and 2002, various stakeholders contributed to the formulation of Nepal's abortion law. The Muluki Ain's Eleventh Amendment Bill, legalizing abortion with certain conditions, was passed in 2002.
3. **2002-2004: Preparatory Phase for the Implementation of the Safe Abortion Program-** Following legalization, the National Safe Abortion Policy was approved in 2003. The Safe Pregnancy Termination Procedural Order was approved in December 2003, and the first government abortion services began in March 2004.
4. **2004 to 2009: The Expansion Phase of Abortion Services-** Abortion services expanded from 2004 to 2009, leading to the introduction of medical abortion services in 2009. Medical abortion drugs were registered, and mid-level provider training commenced.
5. **2009-2015:** The government expanded access to safe abortion services, including medical abortion training for auxiliary nurse midwives and scaling up medical abortion and post-abortion care. In 2016, the government announced plans to offer free safe abortion services in public clinics.
6. **The 2015 Constitution and the 2018 SMRHR Act:** The Thirteenth Amendment of the Muluki Ain, 2017, recognized women's right to access safe abortion as a reproductive health right. The 2015 Constitution guaranteed safe motherhood and reproductive health rights, and the 2018 SMRHR Act was passed, making specific provisions for various reproductive health rights, including safe abortion.

WITNESSING MAJOR CHANGES

Impact on Maternal Mortality and Morbidity

Table 1 presents the pregnancy outcome trends in Nepal from 1996 to 2016. Overall, it shows that the abortion rate increased by 15.57 percent per annum. The study also reveals that the annual miscarriage reduction rate was 3.1 percent per annum between 1996 to 2016. The rate of change between 2006 and 2016, which was 5.6 percent, implies that the miscarriage rate also went up in the last decade. This is an area that needs further exploration.

Table 1: Trends of pregnancy outcomes from 1996 to 2016

Pregnancy outcomes	NDHS 1996	NDHS 2001	NDHS 2006	NDHS 2011	NDHS 2016	ACR* (1996-2001)	ACR* (2006-2016)	ACR* (1996-2016)
Live birth	92.8	92.3	90.3	84.8	80.6	0.11	1.14	0.70
Still birth	1.9	2.1	2.1	0.9	1.4	-2.00	4.05	1.53
Miscarriage	4.9	4.8	5.2	6.8	9.1	0.41	-5.60	-3.10
Abortion	0.4	0.7	2.4	7.5	9.0	-11.19	-13.22	-15.57
Number of pregnancies in last 10**/5 years	24,224**	15,210**	12,831**	6,356	6,281			
Abortion use in last five years by WRA	6.4	6.2	17.0	33.4	38.3	-0.63	8.12	8.95
Number of WRA	8,429	8,726	10,793	12,674	12,862			

*Annual Change Rate

Equitable Service Utilization

Over the past two decades, Nepal has witnessed significant changes in reproductive health indicators following the legalization of abortion. The total fertility rate (TFR) has experienced a notable decline, decreasing at an annual rate of 3.47 percent between 1996 and 2016. The annual decline rate was 2.3 percent before the legalization of abortion (1996-2001) and increased to 2.98 percent in the period from 2006 to 2016. Despite the rise in the contraceptive prevalence rate (CPR) and modern contraceptive prevalence rate (mCPR), the decline in TFR suggests the presence of other potential factors contributing to this decrease, such as the legalization of abortion. This assertion is further supported by the downward trend in unintended births, including both mistimed and unplanned pregnancies, during the same period. As the data indicates, the legalization of abortion has played a pivotal role in shaping the reproductive health landscape in Nepal.

Table 2: Trends of pregnancy outcomes from 1996 to 2016

	NDHS 1996	NDHS 2001	NDHS 2006	NDHS 2011	NDHS 2016	ACR (1996-2001)	ACR (2006-2016)	ACR (1996-2016)
TFR	4.6	4.1	3.1	2.6	2.3	2.30	2.98	3.47
CPR	28.5	39.3	48	49.7	52.6	-6.43	-0.92	-3.06
mCPR	26	35.4	44.2	43.2	42.8	-6.17	0.32	-2.49
Unmet need	31.4	27.8	24.6	27	23.7	2.44	0.37	1.41
Unintended births								
Mistimed	19.2	13.8	14.4	12.4	11.5	6.60	2.25	2.56
Unplanned	18.1	21.6	16.4	13.3	7.2	-3.54	8.23	4.61
Number of births	5,144	7,729	6,157	6,013	5,595			

Inequalities in the use of Abortion Services

Figure 1 shows the trend of unequal incidences of abortion services within various quintiles over a period of 20 years: 1996 to 2016. It reveals that access to abortion among the poorer and poorest households increased significantly after legalization. In 2001, the use of abortion by the wealthiest households was 19 per 1000 women of reproductive age (WRA) compared to only two per 1000 WRA by the poorest households, the concentration index being 0.475 (p<0.001). However, by 2016, the use of abortion by the wealthiest households had risen to 54 per 1000 WRA and to 32 per 1000 WRA among the poorest households, with the concentration index of 0.108 (p<0.001) The reduction in the concentration index indicates increased access to abortion services by poor, hard to reach communities and rural women. Still, the significant gap in the uptake of abortion services by economic status still demands pro-poor intervention.

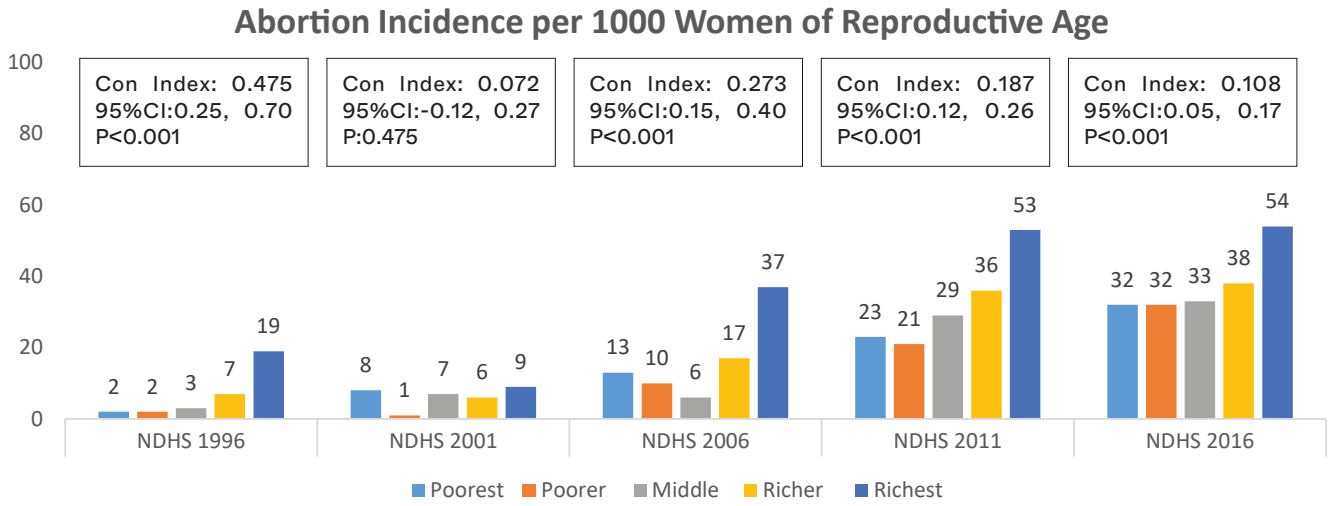

Fig 1: Trends and inequalities in the use of abortion services

CRITICAL REVIEW

In Nepal, the current definition of abortion, which focuses on the induced and spontaneous termination of the fetus, is both inaccurate and insufficient. It is crucial that the definition is revisited to emphasize induced abortion, as it is a significant aspect of reproductive health care for women. Moreover, the requirement for health institutions to be mandatory for medical abortion should be reconsidered, as it may limit access to safe abortion services, especially for women in remote areas.

The SMRHR Act defines "abortion service" as a service performed in a designated health institution by a listed health service provider. However, with advancements in abortion technology and increasing evidence on the safety of medical abortion outside of health facilities, health institutions should not be mandatory for medical abortion.

The recent expansion of legal indications for abortion services upto 28 weeks in cases of pregnancy resulting from rape or incest is a commendable step forward. However, the new regulation which limits the termination of pregnancies due to fetal anomalies and the endangerment of the pregnant woman to 28 weeks conflicts with women's rights and Nepal's adherence to international agreements, such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). This limitation has the potential to adversely affect the physical and emotional well-being of women who may need to terminate pregnancies beyond the 28-week threshold.

The requirement for health workers to be listed after being certified by the National Health Training Centre adds unnecessary procedures. The provision related to the listing of health providers should be removed.

In the current legal framework, the Act does not include provisions for the continuation of abortion services during humanitarian crises. This can result in an interruption of essential services, putting women's health and lives at risk. The need for such provisions is demonstrated by the experiences of recent humanitarian crises such as the Nepal earthquake in 2015 and the COVID-19 pandemic. In these situations, access to healthcare services, including abortion services, can be severely hindered. It is therefore crucial that the Act incorporates special provisions to ensure the continuity of abortion services during times of crisis.

It is evident that prompt measures must be implemented to alter the SMRHR Act, necessitating the decriminalization of abortion in all situations to facilitate more extensive access to legal and safe abortions.

Additionally, while listing trained providers for abortion services is essential, it is crucial to acknowledge that the training itself might be sufficient to ensure safe and accessible abortion care. This implies that the focus should be on enhancing the quality of training and developing a competent workforce that can provide comprehensive abortion care services.

CONCLUSION AND WAY FORWARD

In spite of the considerable advances Nepal has made in providing access to safe and legal abortion facilities, there are still obstacles that must be tackled in order to guarantee that everyone can access these essential services. Strategies for addressing these challenges include advocating for legal reforms, improving access to information and education, and ensuring that all individuals have access to the needed healthcare services.

The Constitution of Nepal 2015 ensured SRHR as fundamental human rights and the Public Health Services Regulation 2020 included Safe Abortion in the basic health services package yet logistical difficulties and a shortage of skilled provider hinder access. Societal attitudes and abortion stigma further hamper service uptake, and illegal, unsafe abortion practices remain a concern. Discrepancies in access to information and socioeconomic disparities also impact individuals' ability to make informed reproductive health decisions. The COVID-19 pandemic exposed the healthcare system's inability to respond to crises in humanitarian settings, causing delays and difficulties in accessing medical services. Addressing these challenges is crucial to ensuring all women in Nepal have access to safe and legal abortion services.

Addressing the challenges of the current abortion law and policy in Nepal

To address the challenges related to Nepal's current abortion law, it is necessary to remove the abortion law from the penal code, transfer the applicable contents to the SMRHR Act 2018, and advocate for reforms that allow greater access to abortion services. Improving access to information and education about abortion laws and services is also crucial.

Mapping the current services and evidence-informed expansion

Identifying areas requiring expansion involves mapping the current availability of abortion services, understanding the services provided, discerning gaps in coverage, and observing the demand for services.

Building capacity to improve service availability and readiness for abortion services under federalism

Improving the quality and availability of safe abortion services requires capacity strengthening of provincial and local governments, expanding service provisions, monitoring service delivery, and building provider capacity. Incorporating training on abortion services into the pre-service curriculum and other reproductive health training for health workers is essential.

Increasing community engagement to address prevailing views on abortion

Addressing abortion stigma requires increasing public awareness, promoting supportive societal attitudes, and improving the trustworthiness of the healthcare system. Developing initiatives that focus on ensuring access to accurate, unbiased information about abortion services is also necessary.

Using values clarification and attitude transformation to reduce stigmatization of abortion

Focusing on values clarification and attitude transformation can help individuals understand and reflect on their values and attitudes towards abortion, promoting reproductive autonomy and understanding the potential negative consequences of stigmatizing abortion.

Encouraging innovation in service delivery

Improving areas related to self-management of medical abortion in the first trimester can enhance the management of unintended pregnancies in Nepal. The government can also align stakeholders to implement services through various delivery mechanisms and prioritize home-based medical and teleabortion services during humanitarian crises.

Building a resilient abortion service system

Building a resilient abortion service system involves developing contingency plans, implementing safety and security measures for providers and beneficiaries, institutionalizing proven practices, and investing in local governments' capacity to respond to crises. In addition, engaging in ongoing monitoring and evaluation is crucial for future planning.

Engaging the private sector

Private sector organizations can contribute to increasing the availability and accessibility of abortion services by providing resources, support, training, and mentoring, and advocating for policies that support the expansion and improvement of these services. Likewise, collaborating with public sector organizations and other stakeholders can help guarantee access to safe, legal, and high-quality abortion services in Nepal.

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