A Critical Analysis of Safe Abortion Road Map in Nepal

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ABSTRACT

Background: Abortion was legalized by the 2002 *Muluki Ain* to combat the surging rates of maternal mortality and morbidity. By 2021, the Maternal Mortality Rate plummeted to 151 from 539 in 1996. The decline in the abortion-related maternal mortality attributes to the implication of progressive abortion policies that includes expanded safe abortion services introduction of medical abortion, constitutional recognition of abortion, the mandates by Safe Motherhood and Reproductive Health Rights Act, and free-of-cost abortion services in government health facilities.

This review study delves into exploring the contemporary abortion policies and its implications on women's access to safe abortion services as well as the factors that affect the access.

Methods: This study incorporates findings from extensive desk review of abortion services in Nepal.

Results: The 2021 safe abortion services Program Implementation Guideline aims to expand safe abortion sites; however, the Nepal's challenging geography ensues its inequitable distribution, especially in mountainous area. Policy provisions on information and financial accessibility to abortion are well navigated by the Safe Motherhood and Reproductive Health Rights Act and regulation but consistent to sporadic gaps in its implementation were comprehended in this study. This paper further discussed the Safe Motherhood and Reproductive Health Rights Act's regressive mandate of 28-week gestational limit at any condition and the role of gender in abortion decision-making under the pretext of factors influencing safe abortion services.

Conclusions: The review study recommends strategies: improving capacity for abortion services under federalism, combating stigma, improving the private sector's readiness, and building a resilient health system.

Keywords: Accessibility; availability; legalization; quality; safe abortion.

INTRODUCTION

The movement for legalizing abortion in Nepal began in the 1970s, but gained significant momentum in 1995, Paropakar Maternity and Women's Hospital began providing Manual Vacuum Aspiration (MVA) for incomplete abortions.[1] In 2002, Nepal liberalized its abortion laws in face of rising MMR.[2] Post the legalization, MMR lowered to 151 in 2021 from 539 in 1996.[3] Legally, first trimester comprehensive abortion care (CAC) using MVA services started in Nepal in 2004 with at or above 13 weeks abortion service in 2007[4] and medical abortion (MA) in 2009.[2]

Free abortion services in government facilities started in 2015 and in 2018 Nepal's Public Health Service Act classified abortion as a basic health service.[5,6] The Safe Motherhood and Reproductive Health Rights (SMRHR) Act (2018) and regulation (2020) further ensured abortion as a fundamental right.[7] And, the Interim Guidance for Reproductive, Maternal, Newborn, and Child Health (RMNCH) (2020) introduced during COVID-19 ensured uninterrupted provision of safe abortion services (SAS).[8]

Considering the transformative abortion roadmap in Nepal, this review aims to explore the abortion policy implications for women's access to SAS.

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METHODS

This review study integrated the findings from mainly secondary data sources. For the secondary data, the till-date abortion laws and policies of Nepal as well as pertinent research publications were reviewed.

RESULTS

Abortion was non-legal and defined as an offence against life before 2002 in Nepal. From 2002 until the most recent document in force governing SAS i.e., the 2021 SAS Program Management Guideline, abortion landscape has changed in Nepal in terms of availability, accessibility, affordability, and quality.

The abortion procedures available in Nepal, as provisioned by the SMRHR Regulation, include MA and MVA for first trimester abortion and Dilation and Evacuation and Medical Induction for at or above 13 weeks abortion service.[9] Till 2019/20, 1516 government-owned abortion sites were listed (912 MA, 604 MA/MVA, and 22 in/after second trimester sites) for providing SAS.[10]

The NHFS 2021 enumerated the availability of CAC in 93.3 percent of federal/provincial level hospitals, 39.7 percent of local hospitals, 69.5 percent of private hospitals, and 31.5 percent of PHCCs. Health posts (HP) did not provide CAC but 19.9 percent of them reported providing MA.[11]

Besides, unauthorized sites, predominantly, the pharmacies have been distributing the MA drugs without prescription. Over the counter MA drugs is not allowed in Nepal but studies have shown that the first point of contact for women seeking MA is pharmacies[12] which is potentially results in complications.

The inaugural 2003 Safe Abortion Policy and the recent 2021 SAS Program Management Guideline have both placed an emphasis on expansion of safe abortion sites to ensure people's access to SAS.[13,14]

Despite the nationwide availability of SAS in all 77 districts of Nepal, geographical difficulties in access exist.[1] Women in remote and mountainous areas face greater challenges, with some having to endure several days of travel on foot to reach health facilities.[1] This has been stated as a primary factor leading to potential delays in seeking SAS and increased gestational ages upon admission.[1]

For uninterrupted access to SAS during the times of COVID-19, Interim RMNCH Guideline, introduced in 2020 provisioned the availability of SAS in all listed sites and accentuated hotline service and self-care for MA.[8]

According to the Safe Pregnancy Termination Procedural Order of 2003, user fees for an induced abortion was 1,000 rupees. This contrasted with the no cost provision of other maternal health services.[15] Exclusion of SAS from subsidized maternal health services was viewed as a barrier in improving maternal health indicators. Free SAS was however provisioned to underprivileged women. But, because of lack of clarity in identification of such group of women, its implementation failed.[15]

Later, in 2009 Lakshmi Devi Dhikta's case brought affordable abortion service to the forefront and in 2015, free abortion services were introduced at government health facilities.[5] Robust implementation of subsidized user fees for SAS in listed government facilities were brought up by key stakeholders onwards.

The 2003 safe abortion policy had prioritized information dissemination on prevention of unwanted pregnancy and unsafe abortion through advocacy and social mobilization.[14] Despite, gaps were evident as the National Demographic Health Survey 2016 showed 41 percent of women aged 15-49 being aware about the legal status of abortion.[16]

Respective of source of information on abortion, friends/ neighbors accounted for the majority or 66 percent while 26.7 percent sought from their family members.[17] Lack of reliable information about safe abortion leads to risky unsafe abortion practice[18] .

The operational SMRHR Act 2018 has enunciated on the right of women to receive education and information related to abortion.[19]

The SMRHR Act and regulation has designated specific sites and professionals to provide SAS to gate keep its quality. HFs must adhere to the prescribed assessment procedure in SMRHR regulation. If they comply with the set standard, they are listed as safe abortion sites.[9]

Health professional must also be listed to provide SAS.[9,19] Trained Auxiliary Nurse Midwifery (ANM) may only perform MA, while staff nurses/ midwives and MBBS doctors are allowed to carry out MA and MVA. MDGPs and gynecologists are eligible to perform both the first trimester and at or above 13 weeks abortion service. Over the years, there has been a change in the delegation of responsibility for providing SAS which has been highlighted.

A total of 4429 abortion service providers (1833 ANMs for MA, 743 nurses and 1853 medical doctors for MA/MVA, and 92 obstetrician-gynecologists or MDGPs for at or / after 13 weeks) were listed until 2019/20.[10]

SMRHR Act 2018 and SMRHR Regulation 2020 is the latest legal document that governs abortion related rights of women in Nepal. The SMRHR Act increased gestational limit for seeking SAS to 28 weeks in cases of pregnancy resulting from rape or incest which was 18 weeks in the 2002 *Muluki Ain*.[7,20] However, certain circumstances that permitted abortion at any stage of gestation in the 2002 *Muluki Ain*, such as fetal anomalies and incurable or fatal maternal morbidity/complication, have now been limited to a 28-week timeframe.[7] While Nepal has introduced progressive abortion laws regressive provisions like that of the SMRHR Act also exists, that is likely to hinder the access to abortion services that restricts women's rights as well as commitment the state made in international forums such as CEDAW. Additionally, the Act mentioned the requirement of consent of guardians or accompanies for adolescents less than 18 years for abortion services. Furthermore, the legislation restricts medical abortions to designated healthcare facilities and licensed providers. This limitation hampers the progress of evolving abortion technologies and practices, such as MA selfcare, which often occur outside traditional healthcare settings.

SMRHR Act 2018 prohibits discrimination in provision of SRH services, including abortion based on ethnicity or socio-cultural attributes.[7] However, ethnicity-based inequities in access to SAS is evident as a study revealed the higher prevalence of unsafe abortion among Dalit, Madhesi and Muslims compared to Brahmin and Chhetri.[21] Socioeconomic inequities, especially for marginalized ethnic groups (Dalit women), affect their access to SAS which has been observed.

The SMRHR Act 2018 has stipulated penal provisions for those who coerce a woman into getting abortion or in any situation where the fetus has been aborted without the consent of women.[19] However, in practice, men play a dominating role in SRH decision-making.

Prior to 2002, Nepal prosecuted women seeking abortion on infanticide charges. Up to one-fifth of the women imprisoned in Nepal at that time were convicted after having an unlawful abortion.[15] Despite the strict anti-abortion laws, numerous non-legal abortions were performed under risky, covert conditions. A significant majority of abortions were performed by inexperienced, unqualified individuals, frequently leading to severe complications.[22]

MMR dropped drastically following the legalization. It went down to 151 in 2021 from 539 in 1996. According to the Maternal and Perinatal Death Surveillance and Response (MPDSR) 2020/21, out of 179 maternal deaths, two percent of these attributed to abortive complications, a declining status.[23]

DISCUSSION

Nepal's difficult geographical terrains is a prominent concern proposed by the this review study as well as other research studies. Geographical challenges has been impacting equitable abortion service utilization.[4] The higher rate of unsafe abortion was reported in mountainous region of Nepal in a survey.[24] In rural and mountainous areas, abortion at or above 13 weeks, which are already scarce nationwide, are difficult to access.[4] Although first-trimester medical and surgical abortion are available at comparably higher number of health facilities, access to it was distinguished as a problem for women living in rural and hilly locations according to a 2017 study.[4]

Similarly, SAS provision from unauthorized HFs, predominantly, by pharmacies was quoted a concern which was also highlighted by a 2022 mystery client study.[12] Similar to what the participants of our study said, the chances of incomplete or inaccurate information and dispensing of unsafe and ineffective MA drugs by untrained pharmacists has been indicated in the mystery client study.[12] Another 2019 study however asserted on the training of pharmacists for their designation as legal providers and ensure the sustainability of safe abortion program in Nepal.[25]

Another key component discussed in this review study is the relation between the legalization of abortion and a drop in the MMR of Nepal. Various research findings have shown that there is an apparent causal relationship between abortion and maternal mortality.[15] Prior to the legalization of abortion, a hospital-based study found that unsafe abortions accounted for more than half of maternal deaths.[15] Furthermore, according to the Ministry of Health's Maternal Mortality and Morbidity survey from 1998, unsafe abortions were the reason for 54% of gynecological and obstetric admissions.[22] But the Government of Nepal has since been able to lower the number of deaths associated with abortions- by broadening the legal grounds for abortion and increasing access to safe abortion services by quick scale up of medical abortion and task-shifting for the training of

non-physicians to expand the SAS providers.[26]

Laws, regulation, and guidelines against or in favor of safe abortion in a country is influenced by the country's political leadership and prioritization.[27] For example, consistent advocacy and lobbying to the government by the activists and policymakers in Nepal since the 1970s led to the liberalization of abortion in 2002. Continuation of such effort led to recognition of abortion as a fundamental right in 2015, institutionalization of free abortion services in government facilities in 2015, and its inclusion in basic health service list in 2018.[28,29] Nonetheless, gaps in implementation of the given provisions persist. For instance, the requirement for listing both trained health workers and facilities adds unnecessary procedural hurdles. Additionally, the current definition of abortion services in the act limits access, particularly for women and girls, including adolescents. This restriction is concerning, especially considering the increasing availability of medical abortion services facilitated by technological advancements, which often occur outside traditional healthcare settings. The emphasis should be placed on the quality of drugs and trained providers rather than the specific location of service delivery.

With the reorganization of the health system after federalization, province and local governments were delegated the majority of responsibility in the delivery of health services including abortion. However, these tiers of government are unaware of their role in implementing abortion programs. A study by CREHPA identified the need of province and local level-specific abortion guideline to enhance SAS within Nepal's federal structure.[30]

This study represents the first nationwide endeavor to chronicle the evolving landscape of abortion services in Nepal spanning the past two decades. It meticulously documents the strides made in enhancing access to abortion services and their consequential impact on the lives of women and girls. One of its paramount strengths lies in its comprehensive portrayal, capturing both the ongoing challenges and the concerted efforts dedicated to provisioning abortion services.

Nevertheless, the study is not exhaustive in its coverage of factors influencing access to abortion services. Owing to a dearth of substantial published literature on the prevalence of unsafe abortion practices beyond formal healthcare facilities, crucial dimensions such as the involvement of pharmacies, unregistered clinics, traditional healers, and instances of self-medication remain unexplored within this study.

CONCLUSIONS

Despite Nepal's significant progress in improving access to safe and legal abortion facilities, challenges persist. Addressing the challenges related to the current abortion laws in Nepal calls for a multifaceted approach that includes advocating for legal reforms, improving access to information and education, and ensuring that all individuals have access to the needed healthcare services.

It is recommended to improve the capacity of local and provincial government in implementing abortion programs and ensuring the private HF's readiness in providing SAS. Extensive focus on increasing the number of trained healthcare providers, and well-equipped service centers particularly in areas where access to SAS is currently limited, is suggested as a primary role of local and provincial government.

MA self-care has been highlighted by RMNCH guideline 2020 as well as SAS program implementation guideline 2021, therefore, planning effective modes of delivery for expansion of MA self-care is recommended at all tiers of government with standard guidelines. Additionally, local governments must prioritize the development of initiatives aimed at ensuring women have access to accurate, unbiased information regarding abortion services, while also working to combat the stigmas associated with it. It is imperative to establish regular and periodic monitoring plans at both local and provincial levels to ensure the delivery of high-quality services.

Figure 1. Timeline of abortion reforms in Nepal (Attached separately as other document)

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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