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Service Readiness for Safe Abortion Services

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ABSTRACT

Background: Health service readiness is a prerequisite to accessing quality services. This study analyzes the readiness of health facilities in Nepal to provide comprehensive abortion services by focusing on the availability and quality of care.

Methods: This is a cross-sectional study, and a multi-stage sampling approach was used to select health facilities. A total of 767 health facilities were surveyed from 30 Municipalities across the country.

Results: In a study of 767 health facilities surveyed, only 223 (29%) offered abortion services. Among them, 92% offered medical abortion, 48% provided manual vacuum aspiration, 18% offered dilation and evacuation and 18% offered medical induction. Approximately 7% of health facilities lacked trained providers yet still provided services and 29% of health facilities providing abortion services were not compliant with legal requirements. Interestingly, 13% of these facilities lacked short-acting contraceptives.

Conclusions: Most health facilities in Nepal lack readiness for Safe Abortion Services (SAS), failing to meet minimum criteria, including to provide abortion legally. Urgent collaborative efforts among policymakers, administrators, and healthcare providers are needed to align with Nepal's Sustainable Development Goals and address gaps in safe abortion service availability. This includes policy updates, strengthening Public-Private Partnerships (PPPs), and ensuring comprehensive SAS implementation and financing as part of essential health services.

Keywords: Health facility; listed facility; post abortion care; safe abortion; service readiness.

INTRODUCTION

Safe abortion service (SAS) is a vital component of Sexual and reproductive health (SRH) care services.[1] Government of Nepal (GoN) legalized abortion in 2002, and Nepal's constitution upholds women's SRH rights.[2,3] Unsafe abortion remains a leading but preventable cause of maternal deaths worldwide.[4,5] Approximately 45 percent of abortions are unsafe, most (97%) of which occur in developing nations.[6] In Nepal, 5 percent of maternal deaths result from abortive outcome[7] The Safe Motherhood and Reproductive Health Rights (SMRHR) Act 2018, outlines the conditions for abortion access in Nepal.[8] The Public Health Act (2018) also ensures to integration of SRH services in basic health facilities.[9] However, as per the Nepal Health Facility Survey (NHFS) 2021, only 19 percent of health facilities (HFs) provide SAS .[10] Key parameters for SAS include the availability of certified providers and HFs, infrastructure, equipment, commodities, Post Abortion Care (PAC), counseling, etc.[11] Thus, this study aims to assess SAS readiness in Nepal for its availability and quality aligned with SRH rights and legal provisions.

METHODS

A cross-sectional design was used to assess the readiness of HFs to provide abortion services in a representative sample in the country. This design allowed for the collection of data from multiple HFs at a single point in time, providing a snapshot of the current state of readiness. The cross-sectional design also facilitated the

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comparison of readiness levels among different types of health facilities including both public and private and those run by non-government organizations.

The study population was all HFs that have the potential to provide abortion and/or PAC services within the selected regions (8724). A multi-stage sampling approach was used to select the HFs for the study.

First, two districts from each province were selected for the facility-based survey, it is based on the proportion of abortion cases reported in HMIS 3.7. Kathmandu and Lalitpur were selected to capture high-volume hospitals. Finally, a total of 30 municipalities were selected for the survey in the second stage, one urban and one rural municipality were selected based on high volume cases from 14 districts and one municipality from Kathmandu and Lalitpur districts. A Census of all HFs that fell under these selected municipalities was done. The purposive selection was also done for HFs those are outside the sampled municipalities and whose case volume was high. This covered the all federal and teaching hospitals and many private hospitals offering abortion services outside the sampled municipalities of Kathmandu and Lalitpur . A total of 767 HFs were surveyed in the year 2022 using a structured questionnaire on the readiness of health facilities.

A validated tool, the "Health Facility Survey Questionnaire-English," which has been previously used in India , was contextualized in health system of Nepal, and employed as the primary data collection instrument. Additionally, other questionnaires such as the Nepal Health Facility Survey 2021, were also referred to obtain the relevant information and ensure a comprehensive assessment of the readiness of HFs in Nepal to provide abortion services. The study was approved by the Nepal Health Research Council.

The data analysis approach for this study involved quantitative methods using Stata 15.0. Descriptive statistics, such as frequencies, and percentages were used to summarize the data and provide an overview of the availability of abortion services across different types of HFs. Comparative analyses were conducted to examine differences in the provision of abortion services among provinces.

This study is part of a larger research project, with additional content and findings to be published in future articles. We assure that there is no duplication of data across these publications.

RESULTS

Among 767 HFs surveyed, less than one-third i.e., 223 of HFs provided SAS. The data revealed that among the surveyed HFs, all provincial hospitals, Marie Stopes International (MSI), and the Family Planning Association of Nepal (FPAN) provided SAS, and this service was also provided in more than 80 percent of federal/teaching hospitals and Government hospitals. More than two-thirds (67.1%) of private hospitals and one-fourth of private clinics (24.8%) had provision of SAS and only one in eight (12.5 %) Basic Health Service Centers (BHSC) provided SAS (Table 1) which includes health posts (HP), urban healthcare centers (UHC) and community health units (CHU).

Table 1. Total health facilities surveyed and number of HFs providing SAS.

Description	Total HFs Surveyed	Number of HFs provided SAS	% of HFs provided SAS
Federal hospitals/ teaching hospitals	**24**	20	83.3
Provincial hospitals	**21**	21	100.0
Local hospitals	**12**	10	83.3
BHSC (HPs, UHCs and CHUs)	**393**	49	12.5
Private hospitals	**82**	55	67.1
Private Clinics	**222**	55	24.8
FPAN and MSI	**13**	13	100.0
Total	**767**	**223**	**29.1**

The proportion of healthcare facilities (HFs) providing abortion services is categorized by types.

Out of the total 223 HFs that provided SAS, 92 percent offered Medical Abortion (MA). Similarly, 48 percent offered Manual Vacuum Aspiration (MVA) and 18 percent offered Dilation and Evacuation (D&E) and Medical Induction (MI) each.

The data highlights variations in the readiness of HFs to provide abortion services. Local Hospitals, and provincial hospitals exhibited higher capabilities compared to other types of HFs. The availability of PAC services was related to the level of HF, only 27 percent of BHSC provided PAC services. The findings revealed that the HFs are providing SAS non-legally(i.e. facility and provider not listed and untrained providers. There was a comparatively poor data management system in both private hospitals and

clinics (Table 2).

The table also provides a comprehensive overview of healthcare facility (HF) readiness across the seven provinces. Notably, provinces like Gandaki and Lumbini demonstrate high readiness across multiple categories, with more than 80% availability in more than half of the parameters. In contrast, Koshi and Sudurpaschim exhibit comparatively lower readiness percentages in several parameters.

Table 2. Availability Percentages of Key Parameters for safe abortion service readiness (n=223).

Description	Trained providers	Listed sites	Exam room	Running water	IP equipment	PAC services	Refer for PAC	Data management	Number of HFs
Federal hospitals/ teaching hospitals	100.0	85.0	100.0	100.0	100.0	95.0	15.0	85.0	20
Provincial hospitals	100.0	100.0	100.0	95.2	100.0	100.0	42.9	100.0	21
Local hospitals	100.0	100.0	100.0	100.0	100.0	60.0	100.0	100.0	10
BHSC (HPs, UHCs and CHUs)	98.0	97.8	98.0	89.8	98.0	26.5	83.8	89.8	49
Private hospitals	98.2	60.0	100.0	98.2	100.0	70.9	50.9	67.3	55
Private Clinics	74.6	29.1	87.3	69.1	60.0	52.7	85.5	20.0	55
FPAN and MSI	100.0	100.0	100.0	100.0	76.9	76.9	92.3	100.0	13
HF readiness by Province									
Koshi	78.3	47.9	91.3	82.6	69.6	60.9	78.3	47.8	20
Madhesh	85.0	65.0	100.0	95.0	75.0	70.0	65.0	55.0	21
Bagmati	93.9	55.1	98.0	93.9	89.8	85.7	32.7	77.6	10
Gandaki	100.0	91.5	96.6	91.5	98.3	44.1	78.0	79.7	49
Lumbini	100.0	84.0	96.0	92.0	100.0	52.0	76.0	72.0	55
Karnali	92.6	66.8	100.0	88.9	88.9	51.9	88.9	59.3	55
Sudurpaschim	85.0	70.0	90.0	70.0	75.0	70.0	70.0	60.0	13
Total	92.8	70.9	96.4	89.2	88.3	61.4	67.3	68.6	223

Among the 107 HFs providing MVA service, the findings reflect strong readiness in terms of the availability of recovery rooms, oxygen, and MVA kits. There was variation in the availability of procedure rooms in all levels of HFs. On the other hand, private clinics exhibit varying capabilities, with a substantial 76.9 percent readiness in Comprehensive Abortion Care (CAC) procedure rooms and 92.3 percent in oxygen availability, but lower availability of recovery rooms (69.2%), tables with stirrups (46.2%), and MVA kit resources (84.6%) (Table 3)

Table 3. Availability Percentages of Key Parameters for MVA Service Readiness Across Diverse Health Facilities (n=107).

Description	CAC procedure room	Recovery room	Table with stirrups	Oxygen	MVA kit	Total number of MVA facilities
Federal hospitals/ teaching hospitals	88.9	100.0	100.0	100.0	100.0	18
Provincial hospitals	83.3	100.0	94.4	100.0	100.0	18
Local hospitals	66.7	100.0	66.7	100.0	100.0	3
BHSC (HPs, UHCs and CHUs)	50.0	0.0	100.0	100.0	100.0	2
Private hospitals	63.6	93.2	93.2	97.7	100.0	44
Private Clinics	76.9	69.2	46.2	92.3	84.6.0	13
FPAN and MSI	88.9	88.9	66.7	100.0	100.0	9

Total	74.8	90.7	86.0	98.1	98.1	107

All the 35 surveyed HF that provide abortion at or above 13 weeks demonstrated a moderate level of readiness although none of the resources were 100 percent available.

A total of nine readiness components were analyzed for D&E health facilities (Table 4). The Federal and Academia who provided these abortion services have all eight readiness components, however, one facility did not have a CAC procedure room. Provincial HFs are providing D&E service without having readiness for blood transfusion arrangements and D&E equipment. More than one-third of private hospitals and more than half of private clinics did not have CAC procedure rooms. Private clinics were not found to have readiness in any components. The blood transfusion arrangements, placenta pit, and stirrups tables were found only in 29 percent of private clinics. In Private facilities, the path of abortion care for at or above 13 weeks abortion service is being provided without having the trained service providers which has been mentioned in the national policy and guidelines. which will compromise the quality of care.

Table 4. Availability Percentages of Key Parameters for at or above 13 weeks of service readiness across Diverse Health Facilities (n=35).

Description	CAC procedure room	Recovery room	Blood transfusion	USG	Placenta pit	Stirrups table	Oxygen	D&E equipment	2nd-trimester provider	Total no. of HFs
Federal and Academia	80.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	5
Provincial	100.0	100.0	88.9	100.0	100.0	100.0	100.0	77.8	100.0	9
Private Hospital	64.3	100.0	85.7	100.0	85.7	100.0	100.0	78.6	92.7	14
Private Clinic	42.9	42.9	28.6	42.9	28.6	28.6	42.9	42.9	57.1	7
Total	71.4	88.6	77.1	88.6	80.0	85.7	88.6	74.3	88.6	35

Among health facilities with SAS, only 61 percent of HFs have one of the long-acting reversible contraception services. A significant percentage (97.3%) of HFs that offer abortion services also offer contraceptive counseling. About 13 percent of the HFs did not have short-acting contraceptives. There was availability of all five methods of contraception in more than half (54.3%) of the health facilities. Around one-fourth of them provide permanent contraceptive methods (Table 5).

Table 5. Availability Percentages of Key.
PAFP Services in Abortion Sites (n=223)

Key PAFP	Availability Percentages in Abortion site (n=223)
Female sterilization	28.3
Vasectomy	23.3
Implant	61.4
IUCD	61.0
Both IUCD and Implants	55.2
Injectables	84.3
Oral Contraceptive Pills	87.0
Condom	88.8
Emergency contraception	76.2
All 5 contraceptive methods (Implant, IUCD, Injectable, OCP, and condom)	54.3
Contraceptive counseling	97.3

Reasons for not providing abortion services (n= 544)

This study provided insights regarding the reasons for the unavailability of abortion services. The primary reasons for service unavailability are the presence of non-listed health facilities (82%), lack of trained healthcare providers (66%), and lack of equipment/supplies (30%). Among the service seekers, MA is the most preferred service (87.9%) compare to MVA (15.8%). Also 8.7% of the service seekers visited the facility for post-abortion complication care. Most of these HFs referred the service seekers to government hospitals (66.2%) while only 12.3 percent referred to private clinics. To those seeking abortion service, the health facility recommended the service seekers obtain the service from listed HF (50%), avoid self-management (30.1%), consult with a doctor (47%), and consider continuation of pregnancy (25.1%) amongst others. (figure not shown)

DISCUSSION

This study explores the service readiness of SAS at HFs in Nepal. Our study reports approximately one-third of the HFs surveyed are providing abortion services. This represents a substantial increase from the 2021 Nepal Health Facility Survey which found only nineteen percent of the HFs providing abortion services at that time.

This study highlights that many government HFs that should be able and ready to provide safe abortion services per the Government of Nepal's Standards and Guidelines are not ready and/or able to deliver these services. The study emphasizes that the mandatory listing of the HFs to provide SAS in Nepal is vital as even after decades of legalization of abortion, this gap of listing persists. Moreover, private hospitals and clinics have reported lower service readiness. Studies have shown that there is a lack of knowledge of the legality and free provision of SAS at government HFs.[12] Therefore, the documented lower service readiness by private hospitals and clinics emphasizes the need to increase service readiness provision by meeting all components for readiness to ensure expanded access to this essential component of healthcare.[13]

It is important to note that the findings of our study show that nearly all the healthcare facilities offering MVA services have an MVA kit. This shows higher readiness in this area compared to the study previously conducted in Nepal.[1] However, only half of the BHSCs that offer abortion services have an MVA room for providing complication management. This, along with other results, suggests that this tier of HFs does not have trained providers who are qualified to provide comprehensive SAS and only offers MVA service for the PAC as part of emergency care. [14]

PAC is an emergency and essential health care to address the impact of abortion complications.[15] On average, PAC services are offered by seven out of ten HFs in this study, which is better than a similar study carried out in Pakistan.[16] Our research findings, however, are in line with a similar study in Zambia suggesting availability and readiness of PAC services in Nepal compared to the other countries appears to be satisfactory.[17]

Furthermore, our findings correlate with a previous study where higher-level HFs are more capable of providing PAC services than lower-level HF.[18] Safe abortion is foremost for the continuity of care and PAC should be one of the integral components of abortion to provide essential care and treatment that arises from abortion complications. Therefore, those lacking behind to provide PAC need to strengthen the referral mechanisms.[19]

Similarly, the findings reveal that almost all healthcare facilities offer counseling to service seekers seeking abortion services which is exceptionally higher than the finding of a previous study.[20] Although the PAFP counseling is exemplary, the availability of contraceptives in the abortion HF is still a challenge. Only five out of nine health facilities providing abortion services have reported the availability of all five types of contraceptive methods. The finding is inconsistent with previously conducted studies where they have reported higher availability of contraceptives.[21] However, the Government of Nepal has committed to ensure the availability of all 5 types of contraceptive methods in all HFs providing SAS.[12] Our findings indicating that the availability of LARC in all HF remains a challenge is consistent with outcomes from a similar study.[22]

The study showed that there are gaps in service readiness to provide safe abortion at or above 13 weeks' gestation, which suggests non-compliance with the Government of Nepal's abortion policy .[12] Availability of ultrasonography (USG) is one of the readiness parameters required which is highlighted in the study conducted in Nepal for providing the service, mostly to know the status of fetal conditions and other pre-conditions to provide the abortion service.[23] In this study, all government HFs were equipped with USG but private hospitals and especially private clinics were found to be lacking.

A substantial portion of HF surveyed did not provide SAS although the National Standards and Guidelines consider SAS an essential basic health service. One of the most common reasons is health facilities not listed and lack of trained providers to provide the service which is similar to findings from the other studies.[24,25] These findings suggest that even while there is a permissive law in Nepal, accessing quality safe abortion services remains a significant challenge.[26]

There are limited studies which explores the readiness of SAS across different HFs in Nepal. This study therefore can serve as a baseline to carry out further other studies which aim to explore the readiness of SAS.

CONCLUSIONS

The study concludes that the majority of HFs in Nepal are not ready to provide comprehensive SAS evidenced by the fact that HFs providing the services do not meet the minimum readiness criteria for the service, including certification. The study's findings suggest that policymakers, administrators, and health care providers at all levels of government should come together to ensure the Government of Nepal is meeting Sustainable development goals of maternal mortality reduced to less than 70 per hundred thousand live births.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

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