safe abortion action fund

Abortion.... Women's Safety First

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Expanding Safe Abortion Access: Concerted Efforts Needed to Overcome Existing Barriers

Summary: Despite the significant progress made in the expansion of comprehensive abortion care (CAC) services in the country, many Nepalese women continue to rely upon illegal and unskilled providers for abortion thereby risking their precious health and lives. Media tracking study of CREHPA revealed that 22 women had lost their lives due to unsafely performed abortions since abortion was legalized in the country in September 2002. Five of these deaths had occurred in the year 2010 alone. Substantive knowledge and service access barriers coupled with socio-cultural and cost related barriers continue to pose programmatic challenges in the prevention of unsafe abortions in the country. Unless universal access to affordable abortion services and free abortion care to poor and socially marginalized women are ensured, many Nepalese women would continue to rely upon unskilled providers or seek abortion services across the border.

Background

The World Health Organization (WHO) has estimated that worldwide 21.6 million unsafe abortions took place in 2008, almost all in developing countries (WHO 2008). Deaths as a result of unsafe abortions remain close to 13% of all maternal deaths. Unsafe abortions, and the deaths and injuries they cause, however, are almost entirely preventable. When performed by a skilled provider under safe conditions and with modern methods, abortion has been recognized by the World Health Organization as one of the safest medical procedures (WHO, 2003).

Nepal legalized abortion in September 2002 to reduce the country's high maternal mortality ratios and prevent abortion related morbidity among women and girls. Significant progress has been made by the Government of Nepal in the expansion of comprehensive abortion care (CAC) services in the country.

Abortion was legalized in September 2002 and the law permits abortion under the following grounds:

With the consent of women

- Up to 12 weeks of gestation for any woman
- Up to 18 weeks of gestation if pregnancy results from rape or incest
- At any time during pregnancy, with the advice of a medical practitioner or if the physical or mental health or life of the pregnant woman is at risk or if the fetus is deformed and incompatible with life.

In January 2009, the government introduced medical abortion (combination of mifepristone and misoprotol tablets) for early first trimester abortion. However, medical abortion method is yet to gain popularity in the country Surgical abortion using manual vacuum aspiration (MVA) which was already available in Nepal since March 2004 is the preferred method of choice among Nepalese women seeking safe abortion from the CAC facilities *(Tamang, A 2011; CREHPA 2010)*.

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Unsafe Abortion: A major challenge

Evidences show, despite the impressive progress in safe abortion service expansion, unsafe abortions continue to occur in the country. Many Nepalese women continue to rely upon illegal and unskilled providers for abortion or procure medical abortion (MA) pills from pharmacy shops and use these pills incorrectly by the women. Although illegal, different brands of MA pills in single or combi-packs (mifepristone and misoprostol) are sold clandestinely by pharmacy shops despite the government efforts to regulate the sales of MA pills. The preliminary data from an on-going research on "Documenting the Effects of Abortion Legalization in Nepal" carried out by CREHPA in four major government hospitals has revealed that every two in three women (68% out of the total 323 women) who had tried to end their unintended pregnancy had used oral medicines and another 10 percent had administered medicines vaginally. Almost all of them had procured the medicines from pharmacy shops. Few clients admitted to these hospitals have also used ineffective traditional system of medicines (ayurvedic) such as *Mensure, Nirjest, Albemda*, etc., for ending their unintended pregnancy.

Media tracking study of CREHPA revealed that 22 women had lost their lives due to unsafely performed abortions since abortion was legalized in the country in September 2002. Five of these deaths alone occurring in a single year i.e., between January and December 2010.

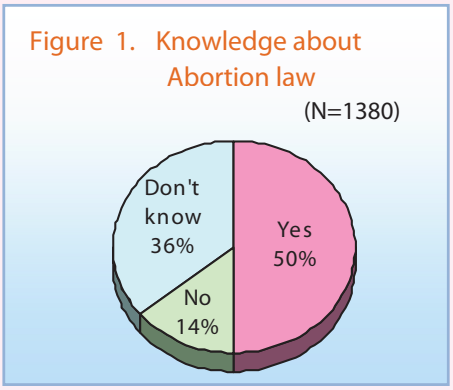
Obstacles in accessing safe abortion services

Nepalese women face substantive barriers in accessing safe abortion care from an approved abortion clinic. These barriers which may make women turn to unsafe abortion can be categorized as: *knowledge barrier, service access and delivery barriers and cost barrier.*

Knowledge barriers

The majority of the Nepalese women are still unaware about the legalization of abortion and many did not know about the circumstances under which abortion is legal in the country. Among the women aware of abortion law, a significant proportion of them have incorrect knowledge about the safe abortion facilities in their districts. The Cross Border Abortion Study 2010 conducted by CREHPA with the funding support of SAAF1 in 11 tarai districts bordering India showed that only 50% of the married women aged 15-44 years residing in urban and peri urban areas were aware about the abortion law (Figure 1). The place for last abortion for a quarter of the women was India. The reasons for visiting India for abortion were: privacy (including confidentiality of marital status), skilled provider, provider is well-known, advised by friends and relatives and for sex determination (CREHPA 2010).

Figure 1. Knowledge about Abortion law



Lack of awareness about CAC facility within the district and gross ignorance about the health risk of resorting abortion from pharmacy shops lead to the death of Shovita B.K of Udaypur in September 2010 (reported by Punarposti a local Newspaper of Udaypur on 28 September 2010) and Sonia Nagarkoti (Lama) in May 2011 in Kathmandu (reported by The Kathmandu Post May 02, 2011) (See box). Unsafe abortions, and the deaths and injuries they cause, however, are almost entirely preventable.

Abortion related death in Kathmandu: The woman died while undergoing abortion from a pharmacist

A 17-year-old married girl died soon after being administered an anaesthetic injection before an abortion process on Monday morning. Newly-married Sonia Nagarkoti (Lama), a resident of Rasuwa, had gone to the Miteri Pharmacy in Goldhunga, Kathmandu to terminate her pregnancy. Lama, who had been currently living in the Goldhunga area with her husband, fell unconscious within minutes after the pharmacy owner administered the anaesthetic that had "expired" to conduct an abortion. Lama was then rushed to the Balaju-based Janamaitri Hospital where she was declared dead. Police said Lama's husband had recently returned home from abroad and they had consulted the pharmacy owner after they decided to carry out an abortion. Police have arrested Min Bahadur KC, the owner of the pharmacy. Police record suggests that the girl died due to administration of date-expired injection. Mr. KC had provided abortion service clandestinely from his pharmacy shop to several women in the past.

Source: The Kathmandu Post (May 02, 2011) (http://www.ekantipur.com)

Service access and delivery barriers

Access to safe abortion services is a challenge for many women in Nepal facing an unwanted pregnancy. Of the total 403 health facilities (government, NGO and private health institutions) approved by the government for providing CAC service (as of March 2011), 276 CAC facilities (68%) are concentrated in urban towns and district headquarters. The remaining 127 CAC facilities (32%) are located in the rural areas of the country where over 80 percent of the country's population lives.

In order to expand safe abortion services in rural locations, the government has listed 41 health posts (government outreach health facility) for provision of MA service through auxiliary nurse midwives (ANMs) who are trained in skilled birth attendance. Nevertheless, as of government record, 14 remote districts (Bajang, Kalikot, Jajarkot, Doti, Dolpa, Darchula, Mugu, Humla, Salyan, Rukum, Manang, Khotang, Okhaldhunga and Bhojpur) have just one CAC facility to serve the entire district population and the retention of trained CAC providers in these districts remains a challenge for the government.

Despite the efforts made by the government (FHD/MoHP), and SAAF project partners, CAC services at government hospitals in Kapilbastu (Prithivi Bir Hospital) and Dhanusha (Janakpur Zonal Hospital) had continued to remain non functional for a long period of time. Only lately the district hospital at Kapilbastu had decided to resume its CAC service.

Although MA was introduced by the government as a means of expanding safe abortion access through SBA trained nurses and ANMs from facilities where physicians are not available, physician attitudes to the independent provision of medical abortion by midlevel providers remain divided and pose an obstacle.

Cost barriers

Universal access to safe and affordable abortion services is fundamental rights for all Nepalese women guaranteed by the abortion law. Unfortunately, existing government policy of charging a high fee even at government CAC facilities for both surgical and medical abortion services has deprived many poor women from availing this right. Abortion fee at government CAC facilities ranges from Rs 800 to Rs. 1000 (US $ 11 to $14) and even higher at NGO managed facilities (ranges from Rs 1150 to Rs 1500) The case of Laxmi Dhikta who hails from an extremely poor household in rural western region of Nepal is a sad example of cost related barrier to accessing safe abortion care. As her husband was unable to deposit the abortion fee asked by the provider at the government hospital of Dadeldhura district, Laxmi was forced to continue with her unintended pregnancy and give birth to her sixth child. Supreme Court Order on Lakshmi Dhikta vs. Government of Nepal case which reaffirms universal access to safe abortion as fundamental rights of every Nepalese women (See Box).

Policy Implications and Recommendations

Unsafe abortion is the third major cause of maternal death in Nepal. According to the World Health Organization, the Millennium Development Goal of reducing maternal mortality ratios (MDG5a) cannot be achieved without addressing the issue of unsafe abortion. Unless safe abortion services are made easy accessible through the expansion of provider base and service fees are affordable or offered free of costs, Nepalese women from poor families will continue to rely on unskilled providers within and across the border. Training non-

Supreme Court Case on Lakshmi Dhikta v. Government of Nepal

On May 20, 2009, the Supreme Court ordered the Nepal government to enact a comprehensive abortion to guarantee that women have access to safe and affordable abortion services. The Court ruling was on the Lakshmi Dhikta v. Government of Nepal, filed as a public interest case in support of the Dhikta's case on February 22, 2007 by Center for Reproductive Rights, New York (Ms Melissa Upreti regional manager and legal adviser for Asia at the Center for Reproductive Rights as petitioner) along with the Center's Nepalese partners- Forum for Women, Law, and Development, the Women Victims Legal Aid Clinic at Kathmandu School of Law, the Forum for Protection of Public Interest (Pro-Public)--and individual attorneys. The court asked the government to set up a fund to cover the cost of abortion for poor and rural women; and invest enough resources to meet the demand for abortion services and to educate the public and health service providers of the existing abortion law. Dhikta, a mother of five children who comes from an extremely poor household in the rural western region of Nepal, could not afford to pay the fee charged for abortion at a public hospital. The doctors asked her for 1130 Nepalese rupees (approximately $15) which she did not have. As a result, she was forced to carry the pregnancy to term and become a mother for the sixth time.

Source: Upreti Melisa, Center for Reproductive Rights
http//reproductive rights.org/en/press.room

physician reproductive health care providers (mid-level providers) in medical abortion with appropriate referral systems would expand access to safe abortion services where there is no doctor and complement a global health systems trend towards task-shifting where physicians are costly and scarce (WHO, 2007).

Recommendations

1. Increase knowledge on abortion law and safe abortion services

Concerted efforts are needed to enhance knowledge about the abortion law and rights in the rural community. Programs for expanding safe abortion service base should prioritize rural areas. NGO and private sectors should be involved in expanding provider base in rural districts.

2. Free abortion services for poor and marginalized

The government should introduced new service modalities that have the potential for expanding safe abortion for the poor and disadvantaged communities free of cost (in line with the Safe Motherhood Program and as per the Supreme Court ruling) and subsidized cost for general population. Discount voucher system could increase the utilization of services among marginalized women.

3. Ensure presence of trained provider in all public sector CAC/MA facilities

Government should ensure that every listed CAC/MA facility has a trained provider in place and offer service including counseling service with equal priority and confidentiality as other reproductive health care services.

4. Formulate policies to engage private mid-level providers

NGOs and private sector health facilities have contributed immensely in increasing safe abortion service access in the country. Their services are available in places where public-sector abortion services are unable to reach or do not function. Utilization of the NGO and private sector clinics by women who have the capacity to pay will also free up resources in the public sector to allow a greater focus on providing services to the poor. Currently, however, the existing policy permits only trained physicians at listed NGO/private clinics to provide MVA and MA services. Policy to engage qualified mid-level providers particularly private staff nurses and ANMs to work as independent safe abortion provider is unclear. Since private sector and NGOs have the potential to expand safe abortion access, new modalities for engaging private midlevel providers should be sketched out.

SAAF is a multi-donor fund hosted by IPPF that provides specific support for in-country initiatives to increase access to safe abortion services for marginalized and vulnerable women.

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