Unsafe Abortion
Nepal Country Profile

2006

Government of Nepal
Ministry of Health and Population
Dept. of Health Services
Family Health Division

World Health Organization
Regional Office for South-East Asia
New Delhi

कृपा
CREHPA
Centre for Research on Environment
Health and Population Activities
Nepal

Unsafe Abortion
Nepal Country Profile

Ministry of Health and Population
Department of Health Services
Family Health Division
Teku, Kathmandu, Nepal

World Health Organization (WHO)
Regional Office for South-East Asia
New Delhi, India

Center for Research on Environment
Health and Population Activities (CREHPA)
Kusunti, Lalitpur, Nepal

July 2006

Government of Nepal
Ministry of Health and Population
Dept. of Health Services
Family Health Division

World Health Organization
Regional Office for South-East Asia
New Delhi

Center for Research on Environment
Health and Population Activities
Nepal

Published by

Government of Nepal
Ministry of Health and Population
Department of Health Services
Family Health Division
Teku

World Health Organization
Regional Office for South-East Asia
New Delhi

Center for Research on Environment
Health and Population Activities (CREHPA)
Kusunti, Lalitpur, Nepal

Report Layout Designed by

Radhika Singh
CREHPA

Printed by

Rasu Printers
Ikhalakhu, Lalitpur-19
Tel: 5550935

Copies

300

Date of Publication

July 2006

DEPARTMENT OF HEALTH SERVICES

Ref No. :

Date :

FOREWORD

Complications of abortions are responsible for roughly fourteen percent of the estimated 585,000 maternal deaths that occur annually worldwide. Nearly nine percent of these deaths occur in the developing world (WHO, 1997). Nepal has one of the highest maternal mortality ratios, with an official estimate of 539 per 100,000 live births. Unsafe abortion contributes to approximately 15-20 percent of maternal deaths and up to 30 percent of all maternal deaths in hospitals are attributable to complications of unsafe abortion. Because of high level of ignorance about the abortion law, social taboos surrounding abortion, and lack of knowledge about safe abortion services, many women and couples with unwanted or mistimed pregnancies seek clandestine abortion services which are ineffective, unsafe and life threatening.

Nepal's abortion law was liberalized in September 2002 after many years of advocacy and lobbying by rights based organizations and activists and supported by evidence-based research. The law guarantees women's rights to make decisions about their unintended pregnancies. Previous laws were highly restrictive in nature and often imprisoned women who had an abortion. The Government is committed to the implementation of this new law and is guided by the Safe Abortion Service Procedure 2059. The Family Health Division under the Department of Health Services, FHD/DoHS is taking the lead, acting as the main coordinating body for the implementation of this national safe abortion program. The first comprehensive abortion care (CAC) service in the country was started at the government run maternity hospital, Paropakar, approximately one year to half years after the legalization. To date, 126 health facilities (80 government and 46 NGO/private facilities) have been listed as such service sites in all of the 75 districts. However, most of these sites are in urban areas and district headquarters, so that the vast majority of rural women have limited access to safe abortion services when compared to those in urban areas. There is a need for a country-wide strategic plan for the prevention and management of unsafe abortion in Nepal. Existing information on unsafe abortion is scanty and dated, although it accounts for a substantial percentage of maternal mortality and morbidity.

I wish to thank the World Health Organization Regional Office for South East Asia (WHO/SEARO) for taking this important initiative of preparing a Country Profile on Unsafe Abortion for Nepal. This Country Profile documents the determinants and the current situation of unsafe abortions in the country, barriers to access safe abortion services and the efforts being made by the government and NGO sector in preventing unsafe abortions. I take this opportunity to thank Center for Research on Environment Health and Population Activities (CREHPA), for its commendable efforts in drafting this Country Profile. I am sure this document will be useful for the development of a strategic country program on prevention and management of unsafe abortion in our country.

Dr. Pramod R. Regmi
Director
Family Health Division

Acknowledgements

The research team would like to thank the World Health Organization, South-East Asia Regional Office, New Delhi (WHO/SEARO) for entrusting this assignment to CREHPA. The research team is particularly grateful to Dr. Ardi Kaptiningsih, Dr Razia Pendse - both from the Reproductive Health and Research, SEARO and Dr Vijaya Manandhar, National Operations Officer, WHO Nepal for their kind support in the preparation of this country profile and also for providing invaluable comments on the draft country profile. The research team is also grateful to Dr Peeyoosh K. Rajendra, Director, Family Health Division for his encouragement to the team and agreeing to act as an advisor. Thanks are also due to Dr Silu Aryal, Senior Medical Officer, Family Health Division (DoHS/ MoHP) and the members of the TCIC, particularly, Ms Cherry Bird, Technical Advisor, Ms Meena Kumari Shrestha, Monitoring and Quality Assurance Advisor and Ms Madhabi Bajracharya, Ipas Program Coordinator, for extending invaluable assistance to the research team. The research team is also grateful to the various individuals and organizations including Ipas, PPFA-International, CRR and PATH for extending necessary assistance in the preparation of this country profile.

- THE RESEARCH TEAM

Preface

With an official maternal mortality estimate of 539 per 100,000 live births, Nepal has one of the highest maternal mortality ratios in SAARC countries. Unsafe abortions contributed significantly to the high maternal mortality figures of the country. Until recent years, abortion was strictly illegal in Nepal and imprisoned women who had an abortion. Criminalization of abortion was one of the main reasons compelling women to seek clandestine abortions and tolerate bodily pains and injuries.

Nepal legalized abortion in September 2002 after many years of advocacy and lobbying and supported by evidence based research. Legalization has been the first step in reducing abortion related maternal mortality and morbidity. However, there are many obstacles those must be overcome before Nepalese women will be able to exercise their rights to safe and legal abortion services and on affordable costs.

Post abortion care (PAC) facilities were introduced in Nepal at selected hospitals since 1995 for management of abortion related complications. Whereas, the first comprehensive abortion care (CAC) service in the country was started at the government run Maternity Hospital located in Kathmandu approximately one and a half year after the legalization (March 2004). Since then, expansion of CAC services has been carried out rapidly throughout the 68 districts out of 75 districts of the country. The difficult geographical terrain and limited access by roads to the vast majority of the rural population continue to hinder CAC service expansion in remote locations and thereby limits rural women's access to legal and safe abortion services.

Information is grossly lacking about the effectiveness of the implementation of the abortion law in the improvement in safe abortion access and in the reduction of unsafe abortions The trend in unsafe abortion for the country is difficult to measure in view of the lack of information or records on induced abortion related admissions at health institutions or lack of population-based surveys on abortion after the legal reform.

There is a need for our country to develop a country-wide strategic plan for prevention and management of unsafe abortion. Therefore, the purpose of the present Nepal Country Profile is to document the information on the current situation of abortion and unsafe abortions in the country and to identify barriers to access services for prevention and management of unsafe abortions. This Country Profile is also intended to serve as a guide for programme design and planning for the Ministry of Health and Population (MoHP) and non-governmental organizations engaged in provision and management of abortion services in the country.

The World Health Organization Regional Office for South East Asia (WHO/SEARO) has taken this initiative to develop a country-specific profile on unsafe abortion and requested Center for Research on Environment Heath and Population Activities (CREHPA) to prepare this profile for Nepal.

CREHPA has closely networked with the Family Health Division, Ministry of Health and Population in the preparation of this Profile. A series of meetings with key government and NGO/INGO stakeholders was organized by the research team of CREHPA to explore the formats and status of the service statistics, types of data considered relevant for the country profile and to ensure stakeholders' support and cooperation during the data collection phase.

Information for this Country Profile has been drawn from service statistics/hospital records, concurrent research studies and survey findings on abortion and the published data such as the Nepal Demographic and Health Surveys (NDHS) and National Census 2001. The research team visited the Maternity Hospital, Thapathali, and some of the zonal and district level hospitals including health institutions run by MSI and FPAN and interviewed the service providers and abortion clients, particularly those with abortion related complications. Focused group discussions were conducted among rural women aged 18-35 years in three districts: Dhanusha, Rupendehi and Banke. The relevant findings from the two recently completed surveys of CREHPA – the National Facility-based Abortion Baseline Survey 2006 conducted on behalf of the MoHP with the financial support of Ipas, and the Baseline Knowledge Attitude and Practice Survey 2005 conducted for NAWRN program and funded by Planned Parenthood Federation of America-International are also included in this Country Profile. It is our hope that this report will help the policy makers, women's rights advocates, program managers and service providers to design appropriate strategies and other measures to overcome the complex issues and challenges surrounding unsafe abortions and ensure women's access to legal, safe and affordable abortion services in the country.

Anand Tamang
Director, CREHPA

Abbreviations and Acronyms

ACOG	American College of Obstetrician and Gynecologists
ATF	Abortion Task Force
BCC	Behavior Change Communication
BWHC	Bangladesh Women's Health Coalition
CAC	Comprehensive Abortion Care
CBS	Center Bureau of Statistics
CPR	Contraceptive Prevalence Rate
CREHPA	Center for Research on Environment Health and Population Activities
CRR	Center for Reproductive Rights
CRLP	Centre for Reproductive Law and Policy
DFID	Department for International Development
DoHS	Department of Health Services
FCI	Family Care International
FDA	Food and Drug Administration
FHD	Family Health Division
FPAN	Family Planning Association of Nepal
FWLD	Forum for Women Law and Development
GTZ	Deutsche Gesellschaft Für Technische Zusammenarbeit (German Development Co-operation)
GO	Government Organization
HA	Health Assistant
HDI	Human Development Index
HSSP	Health Section Support Program
ICPD	International Conference on Population and Development
IUD	Intrauterine Device
IEC	Information Education and Communication
INGO	International Non-governmental Organization
IPPF	International Planned Parenthood Federation
MICU	Maternity Intensive Care Unit
MMR	Maternal Mortality Ratio
MoHP	Ministry of Health and Population
MOPE	Ministry of Population and Environment

MR	Menstruation Regulation
MSI	Marie Stopes International
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
NAWRN	Network for Addressing Women Reproductive Rights in Nepal
NDHS	Nepal Demographic Health Survey
NFHS	Nepal Family Health Survey
NGO	Non-governmental Organization
NHEICC	National Health Education Information and Communication Center
NHTC	National Health Training Centre
NRHS	National Reproductive Health Strategy
NSMP	Nepal Safe Motherhood Project
PAC	Post Abortion Care
PATH	Program for Appropriate Technology in Health
PEAP	Public Education and Advocacy Program
PHCC	Primary Health Care Center
PNGO	Partner Non-governmental Organization
PoA	Program of Action
POC	Product of Conception
PPC	Private Paramedics and Chemist
PPFA-I	Planned Parenthood Federation of America- International
PPH	Post Partum Hemorrhage
PPP	Public-Private Partnership
SMFN	Safe Motherhood Network Federation
SMHEAN	Safe Maternal Health Education and Advocacy Network
SPN	Sunaulo Pariwar Nepal
TBA	Traditional Birth Attendant
TCIC	Technical Committee for the Implementation of Comprehensive Abortion Care Services
UNDP	United Nations Development Programme
USA	United States of America
USAID	United States Agency for International Development
UK	United Kingdom
VDC	Village Development Committee
WHO	World Health Organization

Contents

List of Tables

List of Figures

CHAPTER 1

Introduction

1.1 Background

Each year throughout the world, approximately 210 million women become pregnant and some 130 million of them go on to deliver live-born infants. As many as 80 million pregnancies are unplanned. Of the 210 million pregnancies that occur each year, about 46 million (22 percent) end in induced abortion (Alan Guttmacher Institute, 1999).

According to the World Health Organization (WHO), out of the estimated 46 million pregnancies around the world that are terminated through induced abortion, about 19 million of them occur outside the legal system. Most of these illegal abortions are considered unsafe because they are performed by unskilled providers and/or in unsanitary conditions. Of these women, 36 million live in developing countries, and 10 million in developed countries. Worldwide, about 11% of all women having abortions live in Africa, 58% in Asia and 9% in Latin America and the Caribbean. The remainders live in Europe (17%) and elsewhere in the developed world – Australia, Canada, Japan, New Zealand and the United States (5%). For every 1,000 women of childbearing age, 35 are estimated to have an induced abortion each year. In countries where abortion services are legally restricted, or where the law provides for abortion on many grounds but services are not fully available, women are more likely to have to rely on unsafe abortion methods

Abortion is the termination of a pregnancy before the fetus has attained viability, i.e. become capable of independent extra-uterine life.

Induced abortion is the deliberate termination of a pregnancy before the fetus has attained viability, i.e. become capable of independent exta-uterine life.

Spontaneous abortion is the spontaneous termination of a pregnancy before the fetus has attained viability, i.e. become capable of independent extra-uterine life. This is often referred to as a miscarriage.

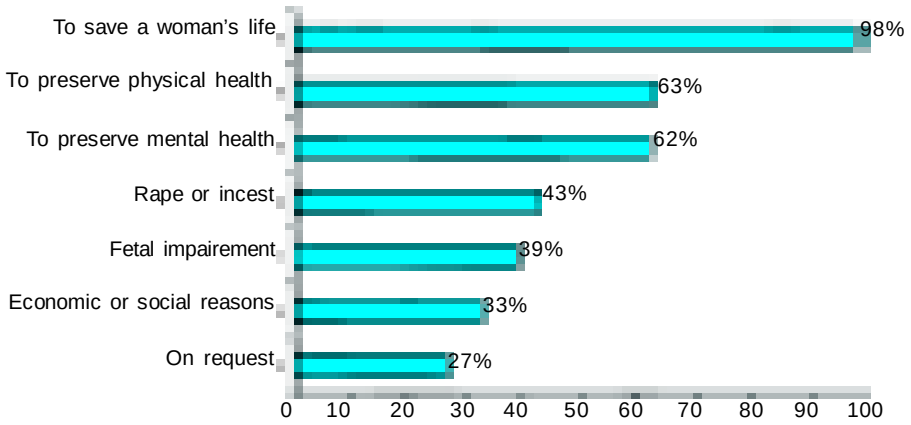
(WHO, 2006)

and unskilled and clandestine providers and thereby risk their lives. In developing countries, the risk of death following complications of unsafe abortion procedures is several hundred times higher than that of an abortion performed professionally under safe conditions (WHO, 2003).

In almost all countries (98%), abortion is permitted to save women's life (Figure 1). In roughly two-thirds of countries, abortion is also permitted to preserve physical and mental health of the woman. In about two fifths of countries (43%), abortion is permitted in case of rape and incest or fetal impairment. One-third of countries allow abortion on economic and social grounds while over a quarter of countries allow abortion on request (United Nations Population Division, 1999). Nepal falls under the category of countries where abortion is allowed on request by a woman.

Despite the fact that abortion is legally permitted in many countries, women continue to face profound barriers that restrict their access to safe abortion services and endanger their health. In developing countries, a lack of trained abortion providers, restrictions in service availability, lack of supplies and equipments, concentrations of qualified abortion providers in cities and long distances to service-delivery sites and high abortion fee continue to present obstacles for women to access safe and legal abortion services early in pregnancy. Yet another key factor that impedes women's access to safe abortion is the social acceptance of abortion. In India, for example, the liberalization of abortion law under Medical Termination of Pregnancy (MTP) Act 1971, has not led to widespread access to safe abortion services, due to restrictions on providers and facilities. In this country, it is estimated that at least three fourths of the abortions are performed by informal and clandestine providers. Since 2000, several legal and policy changes have been introduced in India in order to improve access to safe abortion (Safe Motherhood Inter-Agency Group and Family Care International 2005).

Figure 1 Grounds on which abortion is permitted- percentage of countries



(Source: United Nations Population Division, 1999)

Restrictive abortion laws are associated with a higher incidence of unsafe abortion. In developing countries where abortion is legally restricted, the risk of death from an unsafe abortion may be several hundred times higher than an abortion provided under safe condition (WHO, 2004).

Until recent years, abortion was strictly illegal in Nepal and imprisoned women who had an abortion. Despite the rigid anti-abortion law, many illegal abortions were carried out in clandestine, unsafe circumstances in the country. A large proportion of the abortion was conducted by untrained, unqualified persons, often resulting in serious bodily injuries and complications. Nepal has one of the highest maternal mortality ratios in the world and maternal deaths due to unsafe abortions contributed significantly to the high maternal mortality figures.

Nepal legalized abortion in September 2002. In March 2002, members of the Lower House of the Parliament overwhelmingly approved abortion legislation. This bill became an Act by Royal Assent in September 2002, making a historic achievement for the reproductive health and rights of Nepalese women. The government began providing comprehensive abortion care (CAC) services in March 2004.

Legalization of abortion law was possible after many years of intensive research, advocacy and lobbying. Legal reform has been the first step in reducing maternal mortality and morbidity due to unsafe abortion. However, there are many obstacles those must be overcomed before Nepalese women will be able to exercise their rights to safe and legal abortion services and on affordable costs.

The purpose of this Nepal Country Profile is to gather baseline information on the current situation of unsafe abortion in the country, identify barriers to access legal and safe abortion services, and document the progress made thus far by government and NGO sectors in the prevention and management of unsafe abortions. This country profile can be used as a guide for programme design and planning for the Ministry of Health and Population (MoHP) and non-governmental organizations engaged in provision of safe abortion services in the country.

The sources of information for this Country Profile are the service statistics/hospital records, the Nepal Demographic and Health Surveys (NDHS), National Census 2001 and abortion related studies and reports. The research team traveled to major government hospitals and health institutions of the country to review the service statistics and interview service providers and clients with complications of unsafe abortion admitted at the post-abortion care (PAC) units. The research team also conducted focused group discussions (FGDs) with married and unmarried women aged 15-35 years in three districts - Dhanusa, Rupendehi and Banke. The purpose of the FGDs was to understand the post coital practices to prevent unwanted conception following unprotected sexual intercourse and procedures adopted for abortion in the villages. The relevant findings from the recently completed National Facility-based Abortion Baseline Survey 2006, and NAWRN baseline survey 2005 are also incorporated in the Country Profile.

1.2 About Nepal

Nepal is a small landlocked country nestled in the foothills of the Himalayas. It shares its northern border with the People's Republic of China and its eastern, southern and western borders with India. The country has diverse topography, climates, cultures, traditions, and languages. The total area of the country is 147,181 square kilometers and the population is about 24 million with only about 14 percent of the population living in urban areas.

The country is divided into three distinct ecological zones - mountains, hills and *terai* (or plains). The mountain zone ranges in altitude from 4877 meters to 8848 meters above sea level and because of

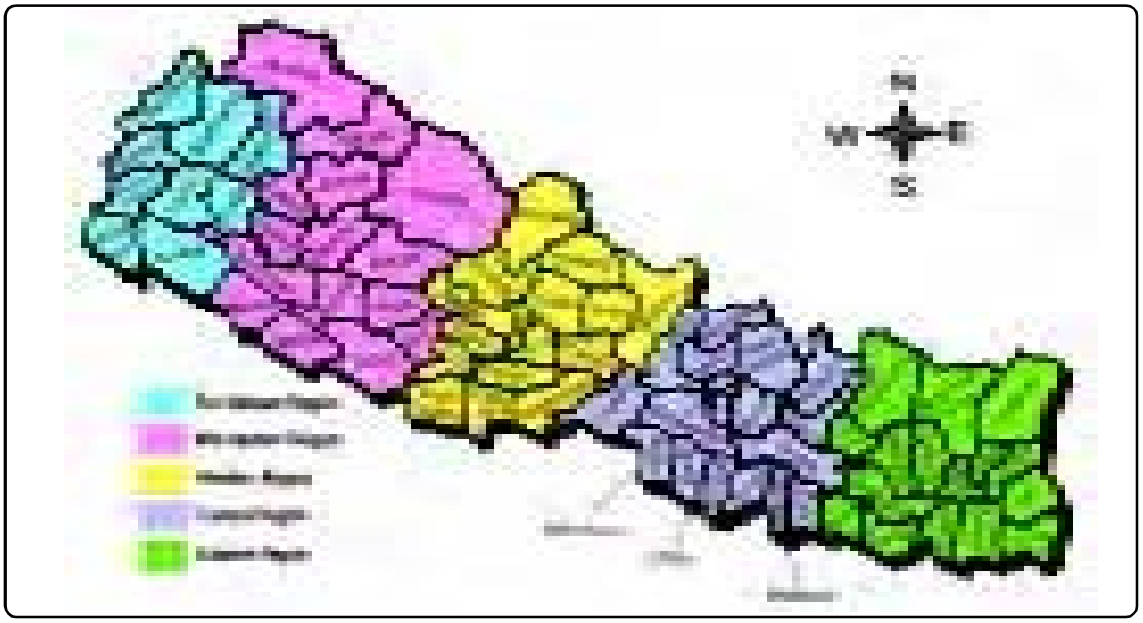
the harsh terrain, transportation and communication facilities in this zone are limited and only about 7 percent of the total population inhabit there. The hill ecological zone is densely populated with about 44 percent of the total population of Nepal living there. This zone also includes a number of fertile valleys such as Kathmandu and Pokhara valleys. Although the terrain is also rugged in this zone, because of the higher concentration of people, transportation and communication are much more developed than in the mountains.

The *terai* zones in the southern part of the country can be regarded as an extension of the relatively flat Gangetic plains. Although it constitutes only about 23% of the total land area in Nepal, 49 percent of the population live there. Transportation and communication facilities are more developed in this zone than in the other two zones of the country, and this has attracted newly emerging industries. As one moves from the *terai* up to the mountains, living conditions and access to health care become increasingly difficult. As a result, there are wide discrepancies in health services in the different regions.

The country has been divided into five developmental regions, 14 zones and 75 districts. The districts are further divided into village development committees (VDCs) and sometimes into urban municipalities. A VDC consists of nine wards, while the number of wards in an urban municipality depends on the size of the population as well as on political decisions made by the municipality itself. At present, there are 3,914 VDCs and 58 urban municipalities in Nepal.

Nepal is a multiethnic and multilingual society. There are over 100 ethnic/caste groups in the country. The ten major ethnicities/castes of Nepal are Chhetri/ Thakuri (15.8%), Hill Brahmin (12.7%), Magar (7.1%), Tharu (6.8%), Tamang (5.6%), Newar (5.6%), Kami (4%), Yadav (4%), Muslims (4.3%), and Rai/Kiranti (2.8%). There are 20 different languages and dialects prevalent in the country. The large majority of the country's population follow Hindu religion (80.6%). Buddhist faith is believed by about one-tenth of the population (10.7%) while the percentage of those following Islam (Muslim) is very low (4.3%) (CBS, 2001).

Map 1 Administrative Map of Nepal



Nepal is a country facing many challenges. More than two fifths (42%) of the population live below the national poverty line. The country is ranked 136th in the 2005 Human Development Report, with human development index (HDI) value of 0.526 in 2003 in the South Asia region (UNDP, 2005). The country's slow social and economic development is a result of endemic poverty exacerbated by rapidly increasing population, insufficient cultivable land, environmental degradation and over a decade of internal political conflict (Maoists' insurgency).

Nepal Demographic Scenarios

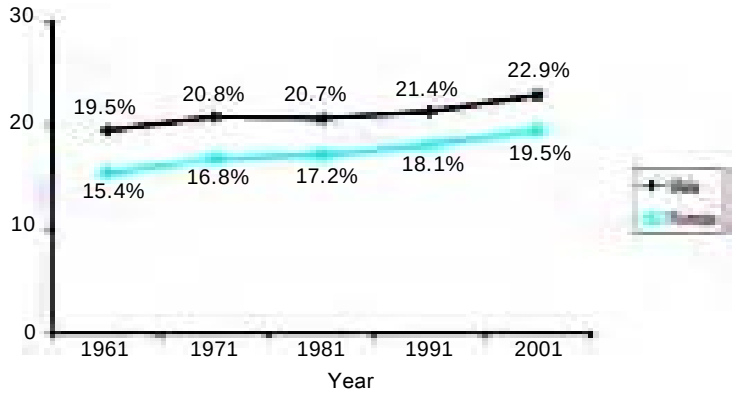
According to the latest census of 2001, Nepal's population was approximately 23 million, out of which the female population comprised of 50 percent. Among the female population, about half of the women (49%) fall in the reproductive age group (15-49 years) (Ministry of Population and Environment, 2004). Nearly a third of the total population is aged 10-24 years. The country's fertility rate of 4.1 (2001 Census) is still high when compared to its neighboring countries and fewer than 40 percent of the currently married women practice contraception (CPR = 39 %).

Despite the law governing age for marriage, early or teenage marriages take place in the country. As per the 1991 and 2001 censuses, the mean age at marriage for boys has increased from 21.4 years to 22.9 years and the mean age at marriage for girls has increased from 18.1 years to 19.5 years.

> The recent amendment of *Muluki Ain* (Civil Code) 2020 increased the legal age at marriage for a girl to keep at par with that of a boy. As per the new Marriage Act it is 18 years with the parental consent and 20 years without parental consent for both a boy and a girl. Prior to the legislation, the legal age at marriage for a girl was 16 years with parental consent and 18 years without parental consent. While for a boy, it was 18 and 21 respectively.
>
> *(MoHP/FHD 2005)*

Figure 2 shows the trends in mean age at marriage for boys and girls from 1961 to 2001. The mean age at marriage has increased by a few years from 1961 to 2001. In 1961 the mean age at marriage for boys was 19.5, which increased to 20.7 and 22.9 respectively in 1991 and 2001. On the contrary, the mean age for marriage for girls in 1961 was 15.4, which increased slightly to 16.8 in 1971, 17.2 in

Figure 2 Trend in mean age at marriage (in years) by sex, Nepal: Census years 1961-2001



Source: Population Monograph of Nepal, Vol. I, CBS, 2003

1981 to 19.5 in 2001(Figure 2). Similarly, the median age at first marriage among ever-married women aged 20-24 years in Nepal is 16.8 years as against 18.7 years for ever married men aged 20-24 years (NDHS, 2001).

Early initiation of sexual activity is becoming common among young people in Nepal. Sexual debut for the vast majority of girls occurs between 15-16 years often within the context of marriage. The median age for sexual debut for males is around 18.8 years (NDHS 2001). A survey among young factory workers in Kathmandu revealed that sexual activity among unmarried girls and boys and with non regular partner was common. One fifth of unmarried boys and one eight of unmarried girls aged 14-19 years were sexually active. The mean age of sexual debut 15 years and was same for both boys and girls (Puri M, 2001).

Nepal has a high level of unintended pregnancies (33%) among currently married women of reproductive age (Ministry of Health Nepal, New ERA and ORC Macro, 2002). Unintended pregnancies among young married women (15-24 years of age) are also significantly high in the country. An unwanted pregnancy in an unmarried adolescent girl can either result in induced abortion or early and unplanned marriage (through elopement, or under coercion by parents). The 'single mother' concept is not yet acceptable in Nepalese society. Because of the social stigma and the fear of being exposed of the abortion act (if performed in health institutions), unintended pregnancies are terminated clandestinely with the assistance of unskilled persons. Moreover, such abortions are likely to take place later in the pregnancy thereby involving greater risks to life, health and future fertility of the young girl. Suicide is the extreme measure taken by a young girl because of an unwanted pregnancy.

Although not all unplanned pregnancies end up in induced abortion, in the "changed (legalized) circumstances, it is likely that a the number of women with unplanned pregnancies seeking safe termination of their unintended pregnancies in government approved public and private health facilities will rise. The proportion of women approaching unqualified practitioners for abortion would also be significantly higher.

CHAPTER 2

Abortion Law in Nepal

2.1 The Previous Laws on Trial and Punishment for Crimes of Abortion and Infanticide

In ancient times, the legal provisions relating to abortion were based on religion, customs and traditions. According to the *Manusmriti*, consumption of any food item touched or served by a woman who has had an abortion was considered as a sin. In the *Kirant Era*, abortion was considered as sin, but no proper system of trial and punishment existed. In the *Lichhchhavi Era*, although no separate legal provision relating abortion existed, the act of abortion was considered to be against morality and the culprit received punishment (Regmi, J.C, 2036 B.S). In the *Malla Era*, law on trial and punishment for crimes of abortion was made quite liberal to protect the interests of the high caste families. During that time abortion was permitted if the pregnancy was due to sexual relations between a high caste and a low caste person. No precise legal provision regarding abortion can be found before the *Shah Era* of 1910 B.S (Muluki Ain 1910 B.S)

The Country Code (*Muluki Ain*) introduced in a written form for the first time in 1910 B.S had a separate legal provision on abortion under the chapter "*Jatakmareko*" (killing of fetus). As per this provision, both the woman and the person performing the abortion could be imprisoned for one year or be released on the payment of amount equivalent to the imprisonment duration. Persons abandoning a live born child could be socially ostracized and if the abandoned child dies due to desertion and exposure, then there was a provision to imprison the accused for six years (Muluki Ain 2020 B.S.).

The Sections 28 to 33 of the present *Muluki Ain* 2020 (Country Code 2020) dealt with the crimes of abortion and infanticide in the chapter on *Jyan* (life) and provides for trial and punishment for these crimes in that chapter. Sec. 31 of the chapter provided for punishment for the crime of abortion. If any person performs an abortion on a pregnant woman with her consent, causing her to miscarry, both the person performing the abortion and the woman would be sentenced for one year to one and a half years imprisonment. The

duration of prison terms depended on whether the fetus was less than six months or over six months old. However for a person who performs an abortion on a woman without her consent the punishment ranged from 2 years for a fetus less than 6 months to 3 years for a fetus over 6 months. Thus, Section 31 prescribed a maximum punishment of one and a half year of prison sentence to a mother who consent to undergo an abortion and a maximum 3 years sentence to a person who causes a pregnant woman to miscarry through his act.

If a woman uses a drug procured from somebody or a device with somebody's help with the intent of aborting the pregnancy and as a result if the fetus is aborted, the maximum punishment for her was one and a half years of imprisonment. But, if a woman expels a live fetus (due to failure of abortion attempts) and it dies naturally, (as a result of the abortive drug or device used), she is accused of abandoning a live-born child and causing its death through exposure. Thus, in accordance with Sec. 18 of the chapter, she would be convicted of murder and liable to life imprisonment plus confiscation of her entire property. It was evident that law did not clearly differentiate between abortion and infanticide or attempt infanticide through abandonment, and invariably, prosecutors tend to choose the latter and rarely the women was represented by a lawyer (CREHPA, 2000).

Despite the law prohibiting abortion, most induced abortions performed under unsafe procedures went undetected. Usually such acts had prior consent or support from their spouse, male partners and relatives. Safe abortions were easily accessible in towns at a price to those who could afford them or across the border in India where abortion has been legal for over three decades. Women who relied upon traditional abortionists in the villages for pregnancy termination and experienced septic or incomplete abortion could easily undergo evacuation procedure and other treatment safely at any government hospitals without any fear of prosecution. Even though it was easy for the clinicians at the hospitals to distinguish between induced abortions and miscarriages, no attempt was made to specify the nature of pregnancy termination in the hospital register. However, utmost care was taken by such patients not to reveal the fact and to register themselves as spontaneous miscarriage (CREHPA, 2000).

A nationwide survey on *women in prison for abortion* conducted by CREHPA in 1997 showed that out of the 406 women who were serving prison terms for different crimes at the time of the survey, 20 percent of them (80 women) were those convicted for abortion-related crimes. On the other hand, very few men (0.3%) have been imprisoned for charges of abortion or infanticide. Nearly one-third of the women were in the prisons since past 3-5 years or even more. Court cases were pending for more half of these women (56%) (Table 1). The study revealed that women especially from rural areas who were poor, illiterate and had low social status, frequently fell victim of exploitation and imprisoned on charges of abortion and infanticides. Since the law did not clearly differentiate between *Garbhapaat* (abortion) and *Jaatak* (infanticide), prosecutors normally chose the latter and rarely, women accused of such acts were represented by a lawyer. Moreover, the cases against these women were in many cases brought by relatives, in-laws, or other people in their communities, often in order to harass and take advantage of their vulnerable status. Although in all circumstances abortions were motivated

and carried out with the assistance of spouse or male partner, in most cases it was the women and not their spouse or male partner, who were convicted for the crime. **Lalita Karki** (unmarried, 20 years) who was in jail for the 2 years (at the time of 1997 women in prison study) was a good example to show that even when a woman aborts a five months old fetus the court convicted her for infanticide. Similar was the case of **Leena Nepali**- an unmarried girl aged 20 years from a low caste family. She had been serving prison terms since the past four years at the time of the survey. During the interview, she stated that she did not know she was pregnant and had taken medicines from a health facility in her village for fever and worm. She has denied that she had tried to terminate the 6 months old pregnancy. She is convicted for infanticide and not for abortion. Male partners normally escaped jail sentences as they were in a position to deny accepting the pregnancy or their direct involvement in the crime. Moreover, unlike women counterparts, men generally received necessary support of their family and relatives. They were also in a position to pay whatever deposits for bail or fine fixed by the court for their crimes. The amount specified by the court ranges between Rs. 5,000 to Rs. 9,000 (US $ 79-US $ 142). Even some male partners bribe the police while under custody and escape prison sentences (CREHPA, 2000).

2.2 Advocacy to Legalize Abortion in Nepal

Effective advocacy for legal reform started in 1996 when Family Planning Association of Nepal (FPAN) introduced *Pregnancy Protection Bill 2053* (1996) and got it registered in the Upper House of the Parliament as a private Bill on 9 July 1996. The Bill clearly defined the roles of government hospitals, recognized health institutions and physicians with respect to legalizing abortion. It also described provisions relating to the protection of pregnancy, circumstances in which abortion may be permitted, the extent to which confidentiality must be maintained,

Table 1 Percentage Distribution of Women Imprisoned for Abortion and Infanticide by Duration of Jail Term at the Time of 1997 Prison Survey

	Abortion	Infanticide
Duration of jail term served		
Less than six months	23.5	11.1
6 months to less than one year	29.4	14.3
1-2 years	23.5	41.3
3-4 years	23.5	22.2
5 years or more	-	9.5
No response	-	1.6
Is the case going on?		
Yes	82.4	49.2
No	17.6	50.8
Total	**100.0**	**100.0**
N	**17**	**63**

(Source: CREHPA, 2000)

special rights and duties of abortion providers, and specific details concerning the government's authority to conduct investigations into illegal abortions. This Bill however, lapsed on Ashad 12, 2056 B.S. (26 June 1999) because the tenure of Mr. Sunil Kumar Bhandari (who had tabled the Bill on behalf of FPAN) as a member of the National Assembly was over (FWLD, 2003).

The Country Code (11th Amendment) Bill, 2054 B.S. (1997 A.D.) was registered in the Parliament on 7 July 1997 (as a government Bill). The 11th Amendment Bill incorporated various rights related to women including the legalization of conditional abortion. The Bill provided for three different instances in which abortion would be allowed, namely, (1) freedom to abort within the first 12 week, with the permission of husband if the woman is married, (2) freedom to abort up until 18th week of pregnancy if the pregnancy is a result of rape or incest, and (3) freedom to abort at any time if in the absence of it the woman's life could be endangered, or harm her physical or mental health or if she is likely to give birth to a deformed baby.

The Bill that was presented to the House of Representatives on 11/8/1997 had passed through several stages before it lapsed as a result of the dissolution of the House of Representatives on 15/1/1999.

The government reintroduced the Bill to the House on 20/9/1999, within a few months of the General Elections in 1999. Amendments to the bill was made when the bill was presented to the Parliament for the second time that proposed, among other things, to make abortion the sole right of the pregnant women and on her own free consent (without the consent of the others) (FWLD, 2003).

Many national NGOs played an important role in the advocacy for legal reform in the late nineties. Center for Research on Environment Health and Population Activities (CREHPA), Forum for Women, Law and Development (FWLD) and FPAN were the key players in the movement. Their advocacy work and that of other individuals and organizations, with support from INGOs, stimulated the interest of women's activist groups, and the issue of abortion gained national profile and momentum.

During the late 90s, a number of studies on the effects of the illegal status of abortion on women's health, reproductive rights and welfare were carried out in the

country. These studies were aimed at updating the database on abortion in the country and complimented the WHO funded research on abortion conducted during 1992-1994. Likewise, following the International Conference on Population and Development (ICPD) 1994, FPAN took the lead in organizing a number of seminars and workshops among various stakeholders of the country to discuss on abortion issues. In 1996, a public opinion poll on abortion was undertaken for the first time in Nepal by CREHPA in order to find out the general tone of public opinion concerning abortion and whether abortion should be legalized or not. In the following years, surveys and opinion polls on abortion related issues were conducted among different segment of the population and stakeholders such as the medical doctors (obs&gyne) paramedics, locally elected representatives in the villages, etc. These surveys showed that practically all segments of Nepali society were in favor of legalizing abortion.

CREHPA initiated *Public Education and Advocacy Program* (PEAP) against unsafe abortion as a national program in 1999 in response to the policy issues raised in their research concerning unsafe and illegal abortions in Nepal. The PEAP was initially implemented intensively in the eastern region of the country with the help of 21 district level non-governmental organizations (NGOs) and was subsequently expanded in remaining part of the country (2000-2002). Funding for the program came from the Ford Foundation.

PEAP was a multi-facet educational and advocacy strategies of CREHPA aimed at building awareness and influence positive public and political opinions on reproductive rights for women. It was a precedent-setting program for developing countries where unsafe abortion practices are common and where access to legal and safe abortion services for women especially in the rural areas, are seriously lacking.

PEAP was aimed at creating positive environment for the legal reform that would reduce the incidences of maternal deaths resulting from unsafe abortions and in empowering women, through community-based education and information activities to make conscious and timely decisions about their fertility. The educational component of PEAP was aimed at educating the public in general and rural women and community leaders in particular about the social and health implications of restrictive abortion laws. The program was in line with HMG's National Reproductive Health Strategy (NRHS) 1998.

PEAP was designed to operate through community-based collaboration with governmental and non-governmental organizations (NGOs) involved in human rights and health interventions. The second aspect of the program was directed to abortion, as women's rights and decriminalization of abortion. The strategy had been to organize networks of NGOs and other agencies in the public education and advocacy program. The advocacy messages were evidence based and made maximum use of the data from the 1997 women in prison study, public opinion polls, facility based studies on unsafe abortions and these were further supported by regional and global research studies published by WHO, Alan Guttamacher Institute, CRLP (CRR), Ipas and abortion-related research papers published in international journals.

The regional and district level activities of PEAP included organizational meetings in selected locations to provide

orientation about unsafe abortions and other relevant information for district-based partner NGOs in 16 districts of eastern Nepal. For example, in the cities of Biratnagar (Morang District) and Dharan (Sunsari District) in eastern Nepal, workshops were held that brought together participating NGOs in a network entitled "Safe Maternal Health Education and Advocacy Network (SMHEAN). All NGOs collaborating with CREHPA in the PEAP program organized district level advocacy workshops in their respective districts. Results from CREHPA's research into abortion issues were presented, and discussions were held about developing public support for legislation to liberalize abortion.

The strategy of the PEAP included a strong emphasis on reaching those health care personnel who are most often playing a bridging role for women concerning health care services, including seeking abortions. In addition to the outreach work with NGOs and other organizations in workshops and meetings, the program made extensive use of the mass media to reach the general public. One of the powerful information channels used was the National Radio of Nepal. The program, entitled "*Mahila Swastha Karyakram*," was designed to bring a series of messages about health implications of unsafe abortion, maternal mortality and morbidity and other sexual and reproductive health issues to the general public. In May 2000, CREHPA organized a press conference at the Hotel Himalaya to present the results of a survey of gynecologists entitled "Sex Determination Tests and Sex Selective Abortions".

Similarly, a "Forum for Journalists" was conducted in Butwal (Rupendehi district) in 2000 organized by Nepal Journalists Forum with the support of CREHPA. The main themes of the workshop were sensitization about the dangers of abortion and the implications of the restrictive law on the health of women.

CREHPA also produced a 45 minute movie entitled "Sachetana" meaning "awareness" (Nepali language, with English sub-titles) graphically depicting the risks and problems involved in unsafe abortions. The film was based on the case histories of the women in prison for abortion and women who had sought clandestine abortion service. Similarly CREHPA made extensive use of IEC materials such as posters, hoarding boards, leaflets and brochures in it's advocacy campaigns and included themes such as "What is Unsafe abortion?", "Need to strengthen hospital resources," "Maternal deaths from unsafe abortions", "Post-legalization challenges and Initiatives", "Why did these women die?", "Unwanted Pregnancy and Unsafe Abortion in Nepal", "Public opinion on unsafe abortion in Nepal etc (CREHPA, 2004b).

Approximately during the same period, FWLD began focusing on the legal implications of the existing abortion law, particularly the suffering of women imprisoned for abortion related offences. While working to help women in prisons around the country on abortion or "infanticide" charges, FWLD published a number of articles and reports in conjunction with other NGOs and INGOs. These publications highlighted the plight of the (mostly poor) women suffering under the effects of the existing discriminatory law, claiming that the illegal status of abortion constituted a violation of human rights. The lack of understanding of difference between abortion and infanticide also meant that women could receive of up to 20 years, although the maximum sentence specified for procuring an abortion was only five years.

FWLD and other concerned national NGO's worked closely with Centre for Reproductive Law and Policy (CRLP), to draft legislation amending laws in the Country Code that discriminated against women, including the criminalization of abortion. In December 2000, the Ministry of Health organized a meeting to formulate a 15 year plan of action concerning "Safe Motherhood." The program of action discussed in the meeting included legalizing abortion, and also increasing community awareness about safe abortion. In connection with the meeting, the Ministry formed a "Network Group" of seven experts from different institutions to advice on the submission of an abortion bill to the Parliament.

In February 2002, *the Abortion Task Force* (ATF) was formed by the Family Health Division (FHD), of the Department of Health Services (DHS) to plan and implement the steps to move from legalization to action. The ATF assisted the FHD/DHS in drafting and finalizing the policy guidance and the safe abortion procedural order. It also directed to form a team for developing medical standards and the implementation plan. Members of the ATF comprised of Nepal Society of Obstetricians and Gynecologists (NESOG), the DFID funded Nepal Safer Motherhood Project (NSMP), GTZ's Health sector Support Programme (HSSP), Center for Research on Environment Health and Population Activities (CREHPA) and the Family Health Division (FHD/DoHS). The ATF received technical assistance from Ipas. The ATF was dissolved in December 2002 after completion of its terms and a new technical committee -Technical Committee for Implementation of Comprehensive Abortion Care or TCIC- was formed in its place in February 2003 to support the implementation of the comprehensive abortion care (CAC) services.

The NGOs were concerned at the delay between the amendment of the law (in March 2002), which meant that abortion was no longer illegal, and the final approval (in December 2003), of the Procedural Order enabling legal services to begin. FWLD wrote a written petition to the Nepal Supreme Court, requesting it to issue directive orders to the government to prioritize service provision. In response the Supreme Court issued a "show cause" notice to the government for not introducing the service procedures. FWLD and CREHPA were among the National Abortion Task Force members invited to give feedback on the draft Procedural Order which was finally approved by the government in December 2003 (Family Health Division, MoHP, CREHPA, FWLD, Ipas, PATH, 2005).

2.3 The Present Law on Abortion in Nepal

Abortion was legalized in Nepal under the 11th amendment to the Country Code (Muluki Ain) in March 2002, receiving royal assent in September 2002. The law enables women's rights to control over and decide on their unintended pregnancies.

Abortion is legal in Nepal on the following grounds: 1) Up to 12 weeks of gestation for any woman; 2) Up to 18 weeks of gestation if pregnancy results from rape or incest; and 3) 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.

Abortion will be punishable on the following two conditions: 1) sex selective abortion; and 2) abortion without the consent of the pregnant woman.

The abortion law safeguards the rights of an unmarried woman to abortion. In case of a minor (below 16 years of age), the presence of a guardian is necessary for any decision regarding abortion. Privacy and confidentiality of the woman receiving abortion services are also guaranteed by the law.

The National Abortion Policy 2002 guarantees access to safe and affordable abortion services to every women without discrimination, while the Safe Abortion Service Procedure 2003 defines clinical procedures for safe pregnancy termination, service provision facilities, client consent and lays down criteria for listing (approving) a health institution as Comprehensive Abortion Care (CAC) center.

The TCIC working group responsible for drafting of the Reference and Training manuals received technical assistance from Ipas to ensure that these manuals conformed fully to the WHO technical and policy guidance on safe abortion. The first CAC service in the country was started at the government run Maternity Hospital located in Kathmandu approximately one and a half year after the legalization (March 2004) Since then, the number of government approved facilities had expanded rapidly to increase wider access to legal and safe abortion services in the country.

Box 1. Key events in the law reform process
Nov 2000: Government Reproductive Health Steering Committee agrees to support submission of a proposal to amend the abortion law.
Nov.2001: Proposal accepted and FHD asked to draft a section on abortion for inclusion in the 11th amendment to the country code.
Feb. 2002: Abortion Task force formed to draft key documents and lay the foundations for implementation once the law was passed.
March 2002: Amendment passed – Abortion no longer illegal.
June 2002: Literature review of global lessons learned in abortion law reform [6], from which basic procedural and programmatic principles were derived.
Sept.2002: Royal Assent given for the new law, but services still cannot begin without approval of the procedural order.
Nov.2002: Multi-stakeholder workshop held to draft a national implementation plan. Abortion Task Force dissolved and the Technical Committee for the implementation of Comprehensive Abortion Services (TCIC) formed as an implementation body within the Family Health Division.
Dec. 2003: Procedural Order Approved, Enabling services to begin.

(Source: Family Health Division, MoHP, CREHPA, FWLD, Ipas, PATH, 2005)

Box 2. Key Documents related to Abortion Law Reform
The procedural Order: Defines clinical procedures, service provision facilities, client consent procedures and listing of approved providers.
Abortion Policy: Link between maternal mortality and unsafe abortion made explicit, and need to respect the right of the women to informed choice about continuing a pregnancy. Specifies that systems must be easy to implement and administer.
Abortion Strategy: Comprehensive abortion services to be introduced as part of the National Reproductive Health Strategy, with the ultimate goal of access at primary health care level. Competency-based training at approved (public and private) training sites to be provided for physicians and nurses. Government made responsible for monitoring standards. Women must be treated respectfully and confidentially. Services must be affordable for all.
Implementation Plan: Two-year implementation plan with the goal of reducing maternal morbidity and mortality from unsafe abortions. Activities under four headings: training; service delivery; information; education, communication/advocacy; and monitoring and evaluation.
Reference and Training manuals: Based on the WHO guidelines, Nepal standards and guidelines were published in the Reference Manual. The Training Manual developed includes clinical protocols and training curricula, covering all aspects of a quality comprehensive abortion care programme, including clinical procedures, counselling guidelines, equipment and facilities.
Pilot Behaviour Change and Communication (BCC) strategy: Outlines a community based approach to behaviour change work to be piloted in two districts

(Source: FHD, MoHP, CREHPA, FWLD, Ipas, PATH, 2005; Shakya et al, 2004)

2.4 Abortion Procedure Promoted by the Government

In compliance to the WHO recommendations for safe first trimester abortion, the Ministry of Health and Population (HMG/MoHP) is promoting manual vacuum aspiration (MVA), a technique for evacuating the contents of the uterus through use of a hand-held vacuum aspirator attached to a plastic cannula.

Safe and effective non-surgical or medication methods of inducing abortion such as a combination of *Mifepristone* and *Misoprostol* (which is now widely accepted as an appropriate method for terminating pregnancies up to 49 days of uterine gestation) is not officially available in the country. However, the introduction of other appropriate methods, such as medical abortion (depending upon the uterine gestation, availability of service and trained provider) has been outlined in the Safe Abortion Service Procedure.

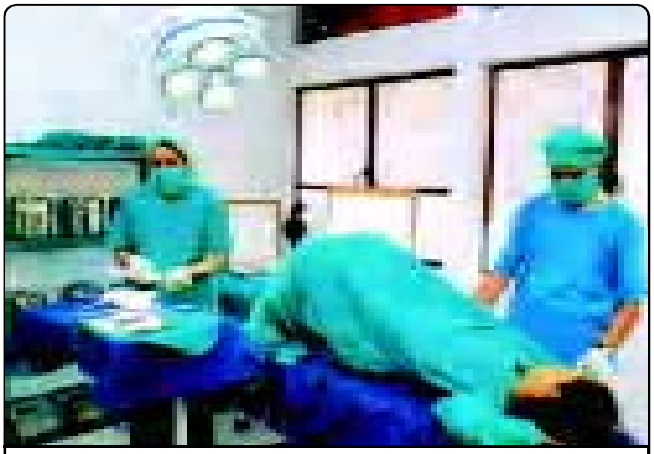


Photo: Preparation for MVA at a CAC Center

2.5 Public Opinion on Abortion Law Reform

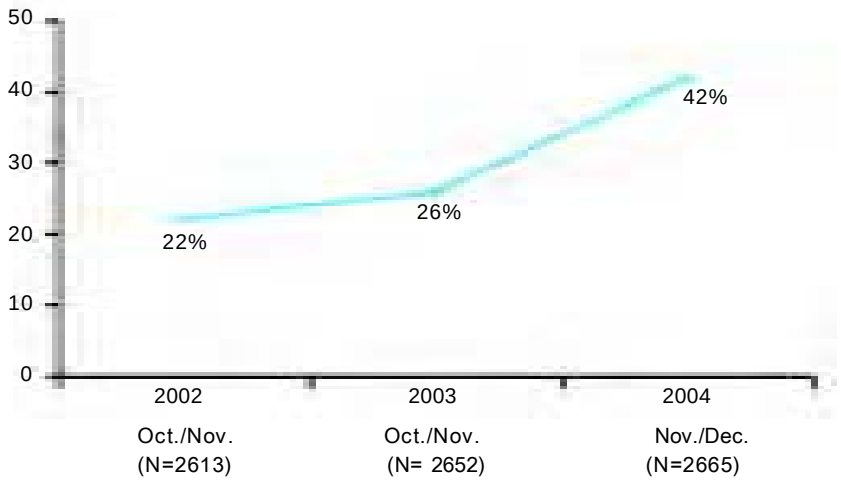
Annual public opinion polls reflect public perceptions and attitudes towards the abortion law that safeguards women's reproductive rights. Opinion polls also echoes public awareness about and acceptance of the policies and programs related to legal and safe abortion services. The Poll results are relevant in designing appropriate IEC and advocacy strategies and behavior change communication (BCC) messages to enable women and couples to make informed decisions about their fertility without fear of social stigma and discrimination.

Public opinion polls were carried out in three consecutive years following legalization (2002, 2003 and 2004) in ten major urban towns of the country to gauge awareness about the legal reform, understand public attitude towards legalization and towards abortion as women's reproductive rights which is granted by the law. In 2002, only 22% were aware about legalization, this percentage increased marginally to 26 percent in 2003 while in the 2004 opinion poll, over two fifths (42%) of the urban public were aware about legalization (Figure 3).

However, despite an increase in awareness about legalization, knowledge on the three legal conditions of abortion is still very low even among both the urban male and female adults. Only 37 percent of the respondents mentioned that abortion is permitted on request during first 12 weeks of pregnancy for any reason. Very few respondents (7%) mentioned that abortion is legal up to 18 weeks of pregnancy in case of rape or incest while and 20 percent are aware that it is permitted if the pregnancy affects the health of the mother or the fetus (CREHPA, 2004a).

The opinion poll results showed very high approval ratings on the need for legalizing abortion in the country. Most of the respondents (81%) opined that maternal mortality rate will decrease due to legalization (CREHPA 2002, 2003, 2004a).

Figure 3 Trend in awareness on legalization of abortion: 2002, 2003 & 2004 (% aware about legalization of abortion law in each annual opinion poll)



(Source: CREHPA, 2004)

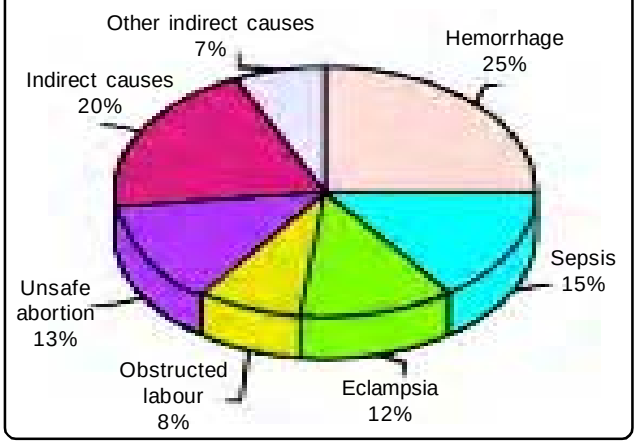
CHAPTER 3

Unsafe Abortion

World Health Organization (WHO) estimates that globally nearly 68,000 women die from complications of unsafe abortion each year. About 95 percent of these women live in developing countries, where abortion is often legally restricted and maternal health care services are lacking (WHO, 1998). About 38,000 women in Asia die due to unsafe abortion each year. In Asia, unsafe abortion accounts for 12 percent of maternal mortality (Ipas and FCI, 2004). In addition to those who die from unsafe abortions, tens of thousands suffer chronic and sometimes irreversible health consequences, including infertility. Globally, there is a ratio of one unsafe abortion for every seven live births, but in Latin America and the Caribbean, there is more than one unsafe abortion for every three live births (WHO, 1998).

> "Unsafe abortion is defined as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both"
> *(WHO, 2003)*

Figure 4 The causes of maternal mortality: Global estimates



(Source: Bi-regional Conference on Reducing Unsafe Abortion, 2005.)

The absolute number of unsafe abortions is highest in Asia, at 10.5 million, accounting for more than half of all unsafe abortions. Over 7 million unsafe abortions occur in South-central Asia alone, which is a reflection of a high abortion incidence in a large population of reproductive age.

Photo: Researcher-Respondent Interaction during an Abortion Survey, 2006

The unsafe abortion rate for Asia is 13 per 1,000 women aged 15-44 years, and the ratio 14 unsafe abortion to 100 live births (WHO, 2004).

The following are the complications from unsafe abortion:

- Sepsis, hemorrhage and uterine perforation, all of which can cause death if left untreated, and often lead to infertility, permanent physical impairment or chronic morbidity.
- Gas gangrene and acute renal failure, which can cause death unless emergency care is available.
- Chronic pelvic pain, pelvic inflammatory diseases, tubal occlusion, secondary infertility as well as a high risk of ectopic pregnancy, premature delivery and future spontaneous abortions (CRR, 2006).
- Reproductive tract infections, some of which are serious enough to cause infertility (WHO, 2003).

3.1 Determinants of Unsafe Abortion

Unsafe abortion is often characterized by inadequacy of skills on the part of the provider and use of hazardous techniques and unsanitary facilities and is one of the highly neglected problems of health care in developing countries. Women therefore resort to clandestine facilities or unqualified providers and put their health and life at risk. Contrary to common belief, the majority of women seeking abortion is married or lives in stable unions. It is possible that women resort to unsafe abortion to limit family size or space births (WHO, 2004). In the International Conference on Population and Development (ICPD) in Cairo, Egypt, in 1994, 179 countries agreed on a 20 year Program of Action (PoA). Accordingly governments agreed that:

"In no case should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health aspect of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved-family planning services. Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counseling. Any measure or changes related to abortion within the health system can only be determined at the national or local level according to the national; legislative process. In circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counseling, education and family-planning services should be offered promptly, which will also help to avoid repeat abortions" (PoA paragraph 8.25).

Unwanted and mistimed pregnancies continue to occur primarily because sexually active women who do not want a child are not using any contraceptive method, but also because all methods have some risks of failure and contraceptives are not always used correctly.

Although unsafe abortion is the most easily preventable cause of maternal death and disability, it has not yet widely integrated into the safe motherhood programmes of several countries. Addressing unsafe abortion effectively requires a comprehensive approach to women's health and rights, and the involvement of a wide range of stakeholders, including government, non-governmental organizations (NGOs), health providers, communities, international agencies and donors.

Unplanned or unwanted pregnancy

The key to preventing abortion-related deaths and disabilities is to reduce the number of unplanned and unwanted pregnancies. It has been estimated that almost two in every five pregnancies worldwide are unplanned and over half of these pregnancies end in abortion, with the majority of unsafe abortions taking place in developing countries. The most common reasons for unwanted pregnancy are contraceptive failure and non-use of contraceptives. When motivation to regulate fertility is strong but effective contraception is largely inaccessible, a large number of unplanned pregnancies occur (WHO, 2004).

Young and unmarried women, in particular, face difficulties in accessing contraceptive methods. Unequal gender roles contribute to the problem by limiting women's control over contraceptives and other reproductive choices (Family Care International Inc. 2005). Similarly, women who are poor, live in isolated areas, are in circumstances vulnerable (such as refugees or internally displaced women), or have been victim of incest and rape are in high risk of unsafe abortion. These women may delay seeking abortion, and they are more likely to rely on unsafe abortion methods and unskilled providers (WHO, 2003).

The 1994 ICPD Programme of Action emphasizes that expanding and improving family planning services can help reduce unintended pregnancy and induced abortion. However, family planning services are frequently able to meet the demand or may be inaccessible or unaffordable, or there maybe a range of social barriers that prevent women and couples from using them. The situation is worse for unmarried women particularly adolescents who rarely have access to reproductive information, counseling and are frequently excluded from contraceptive services.

A woman living in a developing country faces a risk of death up to 250 times greater if she has to seek abortion services from an untrained, unskilled abortionist than if she has access to a skilled provider and hygienic conditions. The risk of death is significantly reduced when women have access to safe and legal abortion services.

Women having undergone an unsafe procedure suffer from severe trauma, such as tear of cervix, perforation of uterus, fever, infection (sepsis), septic shock and severe hemorrhaging. Women with these conditions require immediate medical attention, but many are unable to obtain the care they need.

Abortion techniques in rural areas are more likely to be less safe and emergency service less readily available. Some women are less likely to seek treatment because of fear, embarrassment, shame or poverty.

Abortion techniques in rural areas are more likely to be less safe and emergency service less readily available. Some women are less likely to seek treatment because of fear, embarrassment, shame or poverty. Women are prepared to take considerable risks in order to terminate unwanted pregnancy. Because of the fear of social and economic reasons they subject themselves to high risk of serious bodily injury, sterility, chronic disability and even death. As most clandestine procedures either remain incomplete or they are associated with severe complications including sepsis, these women are left with no choice than to visit hospitals and private nursing homes for medical treatment and spend considerable amount of money for the hospitalization and treatment.

Legal provisions: The incidence of unsafe abortion is affected by legal provisions governing access to safe abortion, the availability and quality of legal abortion services. Restrictive legislation usually results in a high incidence of unsafe abortion. Moreover mortality and morbidity associated with the outcome of complications of unsafe abortion will depend not only on the availability and quality of post-abortion services, but also on women's willingness to turn to hospitals in the event of complications.

Legal and early abortion procedures performed in relatively aseptic surroundings are determinants of low mortality. For instance, in both China and Viet Nam, complications from induced abortions are less common and mortality is low because service delivery outreach is good and the context is legal. On the other hand, in countries where abortion is illegal and access to services remains poor, abortion related deaths poses a serious public health problem. For example, in Myanmar, abortion related morbidity was ranked third among leading causes of morbidity (Ganatra, 2006).

However, in some countries where abortion is legal not all procedures are safe for various reasons—including cost, lack of approved facilities, and lack of awareness among women and health providers of the conditions under which abortion can be legally provided. For example, since the Medical Termination of Pregnancy (MTP) was passed in 1971, first trimester pregnancy has been legal in India for broad range of implications, from risk to the woman's life to contraceptive failure. However, service delivery is drastically impeded by restrictive policies governing where pregnancy termination maybe performed, who must approve it and who may perform it. As a result, unqualified, often unsafe practitioners perform an estimated six times as many abortions as government approved providers. Clearly, in India the legalization of abortion has not been followed by the systematic elimination of unsafe abortions through safe abortion services for the majority of women (Ipas and IHCAR, 2002).

3.2 Unsafe Abortion in Nepal during Pre-Legalization Era

During the 90's, less than 30 percent of the married couple was using family planning methods. More than a third of the couples (37%) were exposed to unwanted pregnancies due to non-use of contraception or method failure (NFHS, 1996). As abortion was illegal, many women were prepared to take great risks to terminate their unwanted pregnancies which were carried out clandestinely in a most barbaric manner and usually performed by unskilled and unqualified providers. Such abortions contributed significantly to the country's high maternal mortality ratio (MMR) and morbidity figures.

A WHO funded prospective study on *Determinants of Induced abortion and subsequent reproductive behavior among*

women in three urban districts of Nepal' carried out during 1992-94 in four government hospitals and one private nursing home of Kathmandu valley (*Tamang,* 1996; *Tamang et al.,* 1999) interviewed 1241 women who visited these five facilities for post abortion care. Of the total 1241 cases, 234 (19%) were induced abortion cases, 814 (66%) were spontaneous abortion cases, 90 (7%) reported taking some medicines – knowingly or unknowingly - and the remaining 103 cases (8%) had symptoms of a possible spontaneous abortion (threatened abortion). The study revealed that the pregnancies of almost all induced abortion cases (95%), over a quarter of the spontaneous abortion cases (27%) and a sixth of the *threatened* abortion cases were unplanned or mistimed. Most women terminating their unplanned pregnancies were young; 20-29 years of age, had two or more sons, better educated, and did not use contraception prior to the conception. In contrast, the large majority of the women with spontaneous abortion were below 25 years of age, had fewer previous pregnancies, and not more than one surviving child. As abortion was strictly illegal, all induced abortion clients had sought the assistance of traditional birth attendants, endogenous medicine practitioners, used abortifacients and other herbal remedies from faith healers or chemists, etc.

Interviews with the women in prison for abortion crimes (CREHPA 2000), revealed that few women had made a number of unsuccessful attempts to terminate the pregnancy by taking abortifacient drugs or even undergoing physical tortures like pressing the abdomen with a heavy grinding stone to kill the baby inside the womb. Moreover, no adequate measures were taken by these women and their accomplice to ensure that the product of the conception is disposed of safely. Due to factors like illiteracy, ignorance (about safe abortion practices), lack of access to safe abortion services, lack of spouse or family support, fear of legal and social sanctions, etc., the majority of these women have resorted to abortion at a very late stage of pregnancy or allowed the unwanted pregnancy to a full term and then abandon or kill the newborn.

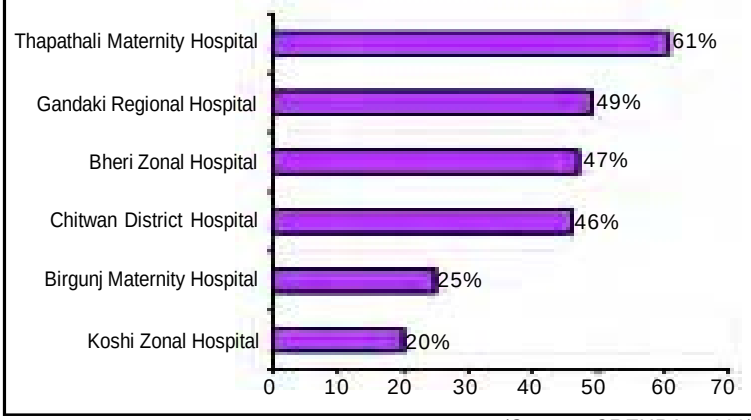
According to a Maternal Mortality and Morbidity study, of the total gynecological and obstetric admissions in hospitals, 54 percent were due to induced abortion complications (MoH, 1998). However hospital based studies do not usually cover women experiencing complications and those who are dying at home due to the accessibility of services and fear of the illegal context. A total of 4478 maternal deaths per year or one death every two hours was also reported in the same study (MoH, 1998). The 1992-1994 prospective study conducted among 1241 women admitted in the hospitals of three urban districts of Kathmandu valley corroborated the above facts.

The treatment of abortion complications in hospitals consumes a significant share of resources, including hospital beds, blood supply, and medication, and often requires access to operating theatres, anesthesia and medical specialist. Thus, the consequences of unsafe abortion place great demands on the scarce clinical, material and financial resources of the hospitals in many developing countries. Moreover, the woman who undergoes unsafe abortion incurs major social, financial and emotional costs.

A study on 'Management of Abortion Related Complications in Hospitals of Nepal- A situational Analysis' conducted by CREHPA in 1999 at six major hospitals of the country showed that between 20%

to 61% of the women admitted as obstetric and gynecological patients were abortion complication cases (Figure 5). The cost of treatment of abortion-related complications in these hospitals ranged from Rs. 1500 to Rs. 10,000 or more (average Rs. 3918 or US $ 52). The nature of treatment required high doses of antibiotics, blood transfusions, IV fluids and sometimes hysterectomy operations. Almost all (98%) the women visiting these hospitals for treatment of abortion complications was married and from poor economic backgrounds. Women who could afford to pay the high fees for abortions are found visiting the private clinics available in these towns.

Figure 5 Abortion cases as percentage of total obstetric & gynecological admissions in selected major hospitals



(Source: CREHPA, 1999)

3.3 Unsafe Procedures Used in the Pre-legalization Era

Studies carried out during the pre-legalization era documented the use of various herbal and harmful substances to abort unwanted pregnancies. Edible food such as white pumpkin, black sesame seed, honey, green papaya and use of non-edible substances such as roots of various herbs, raw vermillion and glass powder were commonly used by women as reported in these studies. Induced abortion clients had sought the assistance of traditional birth attendants, endogenous medicine practitioners, used abortifacients and other herbal remedies from faith healers or chemists, etc.

Photo: A post abortion client being assisted at a district hospital

The actual procedures adopted by untrained providers were dangerous and barbaric. For instance, women admitted in the hospitals for management of abortion related complication were found to have sticks pasted with cow-dung or herbal mixtures inserted inside the uterus, injection of unknown medicines or herbal mixtures into the uterus, insertion of rubber catheter dipped into unidentified substances, etc.

Some women tried to self induced abortion by consuming honey, chemical powder (*sindur* and *nil*) , anti-worm medicines, oral pills, and so on (*Tamang,* 1996; *Tamang et al.,* 1999).

Method failure was the reasons for 20 percent of the women in rural areas and 16 percent among urban married women aged 15-49 for experiencing unwanted pregnancies (Tamang, et.al., 2002). In another study conducted by CREHPA in 2000 titled "Roles Perceived by Private Medical Outlets in Preventing Unsafe Abortions" over 50-60 percent of the private medical outlets mentioned that they receive clients experiencing contraceptive failures. In Pokhara, over one third (35 %) of the PMO's mentioned that they receive more than 10 clients with contraceptive failures (CREHPA, 2000).

There existed an association between levels of education attained by a woman and her husband and the "safe/unsafe" abortion practices. The 1992-94 longitudinal study on determinants of induced abortion showed that majority of women who had sought the assistance of untrained persons for pregnancy termination were illiterate and not many amongst their spouses had attained higher education. Over one-third of them had visited the untrained persons during second trimester, which is considered unsafe for abortion. Contrary to this, most women utilizing the services of trained medical professionals (doctors) for pregnancy were highly educated and even their husband had high educational qualifications. Moreover, educated women sought abortion services at early stages of pregnancy i.e. during the first trimester (Table 2) (Tamang, 1996). Similarly another study conducted in 1997 showed that women obtaining induced abortion in private clinics in Kathmandu were educated (Thapa and Padhya, 2001).

Table 2 Literacy Status of Women and Their Spouses Receiving Abortion Service from Untrained and Trained Personnel

Literacy Status	Service Providers	
	Untrained (N=86)	Trained (N=141)
Client's literacy status		
Illiterate	51.2	14.2
Primary level	15.1	8.5
Secondary level	15.1	12.0
SLC above	18.6	65.2
Husband's literacy status		
Illiterate	9.3	2.8
Primary level	19.8	3.5
Secondary level	33.2	10.6
SLC above	36.5	83.0

(Source: Tamang, 1996)

Goma Bogati's (34 years, married with two children) husband had eloped with his sister-in-law (Bhauju) and deserted Goma. After some years gap, Goma developed relations with a man in her locality. At that time she had no idea about family planning. This man had convinced her saying that he has already undergone family planning operation (vasectomy), hence she should not worry about becoming pregnant. Unfortunately Goma concived. She decided to get rid of the pregnancy though she knew that abortion was illegal. Goma cosumed a bottle of medicine meant for animals which his partner had procured from a veterinary shop. Afterwards, her partner began pressing her belly with a huge stone grinder especially on those spots where he could see the movement of the fetus. Even after this act, they were unable to abort the fetus.

Goma became desperate and decided to procure yet another medicine to terminate the pregnancy. While on her way to the medicine shop, she started bleeding profusely and expelled the fetus. Goma fainted on the road because of the bleeding. The passersby who saw Goma lying on the road reported about her to the police. The policemen took Goma to a health post for medical examination and had an evidence recorded about her intention to abort the pregnancy. Goma was in prison for 1 year and 3 months when she was approached for the interview in 1997.

(Source: CREHPA 2000 Women in Prison Study)

To conclude, the following were main issues concerning abortion which were identified by the research studies in the pre-legalization era (1990s) :

- A large majority of Nepalese women were unaware of the legal status of abortion.
- Women would consume any substance like glass powder, raw vermilion powder, non-edible plants, roots and herbs to terminate unwanted pregnancies without knowing the harmful effect of such an unsafe procedure;
- Those seeking the assistance of unqualified providers suffer seriously from uterine perforation, sepsis and vaginal bleeding due to insertion of sticks sometimes pasted with cow-dung, toothpaste, and other herbal mixtures.
- A large portion of obstetric and gynecological admissions in six major hospitals (between 20 and 60%) was abortion complication cases resulting from unsafe procedures.
- The majority of the government hospitals lacked sufficient manpower, equipment, space, beds, etc, to deal with abortion related complications.
- Although illegal, private medical practitioners provided relatively safe abortion service but access to their services were limited to major towns and cities and the fees charged by them were very high.

3.4 Unsafe Procedures Used in the Post-Legalization Era

In Nepal, legalization of abortion has been the first step for reducing maternal mortality and morbidity due to unsafe abortions. Other key steps to prevent unsafe abortions include i) community education and awareness building about the abortion law; ii) establishment of safe abortion services in hospitals and other health facilities those meeting minimum national standards to provide such a service, iii) creating an enabling environment for women and couples to access safe abortion services, iv) prevention of unskilled practitioners from performing abortions through public vigilance and NGOs' participation in the effort, etc.

In November-December 2005, nineteen doctors working at 10 governments and 5 NGO managed health institutions were interviewed by the research team of CREHPA to understand the induced abortion related complications presented by women at their hospitals/health institutions. Focused group discussions (FGD) were also conducted among rural and peri-urban based married and unmarried women of reproductive age. The natures of complications as mentioned by these doctors were: *hemorrhage, infection, retained POC, sepsis* and *perforated uterus*. Some of these doctors also mentioned about clients with *perforated intestine* and *cervical tear* admitted at their PAC units in recent years.

According to the service providers, the common clandestine procedures which lead to complications or infections were: insertion of sticks, insertion of sharp metal objects, insertion of unknown herbs, and oral administration of unknown medicines. Of these, oral intake of unknown medicines (medicines not revealed by clients) and insertion of sticks were common clandestine method used.

The majority of the doctors (53%) reported that the number of PAC admissions at their health facility with complications of unsafe abortions has decreased in the last one year when compared to the situations 3 years ago. Only a tenth of the doctors felt that there has been an increase in PAC admissions of induced abortion related complications while about a third perceived the situation has been the same. According to these doctors, the large majority of the women with induced abortion related complications were from the villages and socially marginalized communities of urban areas.

The service providers at the post abortion care (PAC) unit of the Maternity Hospital, Kathmandu, reported that their hospital receives 10-15 PAC clients per month. Of these clients, about 10-20% comprised of those having complications of induced abortions. The hospital records of Maternity Hospital for the past one year (Mid-April 2004 – Mid April 2005) showed a total admissions of 1560 PAC clients (spontaneous and induced abortion complications). Of this total, 138 cases (8.8%) were identified as induced abortion related admissions. In the same year, the Comprehensive Abortion Care (CAC) unit of this hospital provided safe abortion (MVA) services to 3,216 clients.

It is evident from Table 3 that out of the 138 induced abortion-related PAC admissions at the Maternity Hospital in one year (Mid-April 2005 to Mid April 2006), about a quarter (25.4%) comprised of those who had sought abortion from private clinics, approximately about one sixth (15.8%) had sought the assistance of unskilled providers or quacks for abortion, one in eight had resorted abortion using unapproved drugs sold by pharmacists/ medicine shops (13.8%) and an equal proportion from other CAC approved NGO clinics (13.8%) and slightly less proportion from the CAC unit (12.3%) of the Maternity Hospital itself. The remaining one fifth (18.8%) had used herbs, unidentified substances and other measures for pregnancy termination (Table 3).

Table 3 Monthly Caseloads of PAC Clients at Maternity Hospital: 2061- 2062 B.S (Mid-April 2005 to Mid-April 2006)

Month	Pvt. Clinics	Maternity Hospital	Other CAC approved NGO clinics	Pharmacy shops	Quacks	Other	Total
Baiskh	5	1	1	7	3	-	17
Jestha	5	4	4	2	3	5	23
Ashad	3	2	4	-	3	2	14
Srawan	2	2	2	1	2	2	11
Bhadra	-	1	3	-	2	5	11
Aswin	2	2	3	-	2	-	9
Kartik	4	-	-	1	1	-	6
Mansir	1	-	-	4	1	-	6
Poush	2	3	-	2	2	7	16
Magh	4	-	2	-	-	-	6
Phalgun	4	-	-	2	2	1	9
Chaitra	3	2	-	-	1	4	10
Total	**35**	**17**	**19**	**19**	**22**	**26**	**138* (8.8%)**
%	*25.4*	*12.3*	*13.8*	*13.8*	*15.9*	*18.8*	*100.0*

(Source: PAC Unit, Maternity Hospital, Thapathali, Kathmandu 2006)

The CAC service provider of the government-managed CAC facility in Ilam district reported that the majority of the women in the district were not aware about CAC service provided at the district hospital and also ignorant about the legal gestation limit. According to him, one in five clients (20%) had to be refused by him for abortion service on the ground of late uterine gestation (beyond 12 weeks). The district hospital received clients with complications of unsafe abortions provided by illegal practitioners and most of these clients did not receive timely referral for post-abortion care. Similarly, the CAC service provider of Dhankuta district hospital mentioned that because of gross ignorance about CAC service availability at the district hospital, there were high number of abortion related complications. According to the service provider, the Dhankuta district hospital received 22 PAC clients in the past one year (2005) out of which 60 percent comprised of unsafe abortion cases. In the same year the hospital provided CAC service to 225 clients and refused CAC service to 39 clients who had sought abortion after their uterine gestation were beyond 12 weeks. Whether or not these 39 clients had proceeded with the pregnancy or sought the service of illegal provider for abortion is not known. In the Maternity Hospital, Kathmandu one in ten abortion clients gets rejected because of high gestation (beyond 12 weeks).

The service provider of Sankhuwasabha district hospital reported about clients with septic abortions due to unsafe procedures adopted by paramedics and other unskilled providers in the villages. In this district the CAC service fee charged by government-managed hospital had remained as one of the highest in the country (Rs. 2,000 or US $ 27).

A recently completed *National Facility-based Abortion Baseline Study 2006* (MoHP/Ipas/CREHPA, 2006), interviewed 503 PAC clients who were admitted at different hospitals and clinics from January 10 to March 10, 2006 (two months). Of these 503 PAC clients, 103 (20%) were diagnosed as complications of induced abortion.

The background characteristics of 98 out of the 103 clients with complications of induced abortion are shown in Table 5. In terms of their demographic characteristics, less than a third of these clients were young; under 24 years of age (30%) and a half of them were aged between 25-34 years (50%). Nearly all of were married (98%) but the husband of one in twelve women were away. The percentage of illiterates was nearly two fifth (39%) while those who have completed higher secondary education comprised about one twelfth (8%) of the total. Women who had no child comprised of a little less than one sixth (14%), over a quarter had two children (29%) while those having three or more children comprised about two fifths of the total clients interviewed (41%) (Table 4).

About half of these women had experienced complications (51%) from the MVA procedure they had undergone at the government and private sector health facilities (Table 5). The types of MVA induced complications were bleeding, perforation of uterus and retained POC (incomplete abortion). This is not surprising if one compares the number of

Table 4 Characteristics of Clients Who Had Complications of Induced Abortion: 2006

Characteristics	Government	NGOs	Total
Age			
15-24	24.1	38.6	30.6
25-34	46.3	52.3	49.9
35+	29.6	9.1	20.4
Median Age	28.5	26.0	27.0
Marital status			
Unmarried	-	4.5	2.0
Married (Living with husband)	92.6	86.4	89.8
Married (Husband living outside)	7.4	9.1	8.2
Education level			
Never been to school	48.2	27.3	38.7
Primary (I-V) grade	18.5	18.2	18.4
Secondary (VI-X) grade	29.7	40.9	34.7
H.S. and above	3.7	13.6	8.2
No. of children			
None	11.1	18.2	14.3
One	14.8	18.2	16.3
Two	20.4	38.6	28.6
Three and more	53.7	25.0	40.8
Total	**100.0**	**100.0**	**100.0**
N	**54**	**44**	**99**

(Source: MoHP/CREHPA/Ipas, 2006)

women receiving MVA (abortion) services from these facilities (during a two months' study period) which was very large – 2717 (the researchers successfully interviewed 2,293 women). The complication rate of MVA procedure is 1.9 (52/2717 x 100) and this complication rate is slightly above the WHO allowance of 1.5%.

According to the CAC service providers, some of the clients tend to underreport their gestation age believing that the abortion fee charged by the service provider is proportionate to the gestation age, while some clients did not know to correctly count the gestation age of their pregnancies. The service providers also mentioned that complications of MVA procedure tends to be higher for higher uterine gestation age while incomplete abortion (retained POC) was possible if MVA is performed on clients with less than six weeks of gestation.

Procedures adopted by PAC clients: The types of the procedures sought by clients with complications of induced abortion were recorded in the study. Of the 103 PAC clients, nearly a sixth of them had orally consumed allopathic and ayurvedic medicines (17%) while less than this percentage had placed unknown herbal substances in the uterus to cause miscarriage (14%). Very few women had catheter or plastic pipes (with or without medicines) placed inside the uterus and there were also very few women who had developed complications after they were given Misoprostol along with MVA or Syntocin injection (Table 5).

As regards the persons assisting the abortion procedure (that resulted into complications), nearly half of the clients (48%) mentioned that the doctor had carried out the procedure. For about a tenth of the women, the procedure was carried out either by a pharmacist or by a staff nurse. Most of these health providers had also prescribed "abortifacient" drugs to women seeking menstrual regulation or abortion (Table 6).

Table 5 Procedure Used for Abortion Resulting into Complication/Incomplete Abortion and Subsequent Admission at PAC units

Procedure Used	No. of clients	%
A. Oral Intake		
- Ayurvedic/Allopathic medicines	9	8.6
- Unknown medicine	9	8.6
B. Uterine/Vaginal device		
- MVA from GO/private clinics/NGO facilities	52	50.6
- Unknown herbal medicine (roots/plants/etc.) in the uterus/vagina	14	13.6
- D&C from private clinics/NGO	8	7.8
- Catheter (plain/Foley's)	3	2.9
- Plastic pipe (with/without medicine)	3	2.9
- Insertion of Cerviprim jell inside the uterus	2	1.9
- MVA & Misoprostol used	1	1.0
- Use of Misoprostol only and inj. syntocin	1	1.0
- Cervical tear by volcelum	1	1.0
Total	**103**	**100.0**

(Source: MoHP/CREHPA/Ipas, 2006)

Table 6 Persons Assisting the Abortion Procedure Resulting into Complication/ Incomplete Abortion and Subsequent Admission at PAC Units

Person assisting in the procedure	No. of clients	%
Doctor	50	48.5
Self-induce	**15**	**14.6**
Pharmacist	9	8.6
Staff Nurse	6	5.8
Doctor (India)	5	4.8
Female acquaintance(TBA/Sudeni)	4	3.9
Husband forced to take medicine	1	1.0
Outreach health provider	1	1.0
Not known/not revealed	*12*	11.6
Total	**103**	**100.0**

(Source: MoHP/CREHPA/Ipas, 2006)

Reasons for Abortion: In the national facility based abortion baseline survey 2006, nearly all married clients with high parity (three or more children) and also those having two children reported that they have sought abortion since they had no desire for additional children. Among those having one child or no child at all, only a quarter of them gave this response. On the contrary, close to half of the clients (47%) having no child or just on child responded that the current pregnancy they had terminated was mistimed and also since their child is small or breastfeeding (42%). The reason that the birth of the child could lead to further economic burden was mentioned by a third of the clients with 3 or more children and a quarter of those having two surviving children (Table 7).

Table 7 Reasons for Terminating Current Pregnancy by Number of Living Children among Currently Married Women

Reasons for terminating this pregnancy	Number of living children			
	0-1	2	3+	Total
No desire of additional children	24.5	91.7	96.4	73.1
Too early/Mistimed	46.7	3.3	1.0	15.6
Contraceptive failure	2.0	4.8	4.3	3.8
Youngest child small/breastfeeding	42.4	14.7	8.0	20.9
Economic problem	11.8	24.9	36.0	24.4
Family problem	13.5	6.0	13.3	10.5
Health problem	14.7	8.2	10.4	10.8
Husband/partner suggested	5.6	3.6	4.4	4.5
Studying	8.2	0.1	-	2.5
Others	3.3	0.9	1.0	1.7
Total	**100.0**	**100.0**	**100.0**	**100.0**
N	**661**	**880**	**675**	**2216**

(Source: MoHP/CREHPA/Ipas 2006)

In the focused group discussions (FGDs), various types of post coital practices were cited by the women. These include oral intake of certain pulses (*Gahat ko daal)* , honey, white pumpkin, bark of Ashoka tree, roots of *Karaute* tree, drinking cow's urine, etc. In one FGD, the participants even cited about the practice of squatting by women after having sex. Most of the FGD participants considered the above practices being ineffective and harmful. They also opined that there could be several other traditional practices being adopted by village women. However such practices were conducted in secrecy and therefore the actual methods adopted for abortion were not known to the community.

The participants cited various means of confirming a pregnancy in the villages. These included: missing of menstruation cycle, crave for food of certain taste, loss of appetite, feeling of giddiness, feeling of abdomen swelling, etc. Almost all FGD participants mentioned that fear of society (stigma) and lack of money generally delayed in seeking abortion by rural women. Other reasons for delays were feeling of shame, fear of side effects/complications, fear of surgical procedure and absence of husband to take timely decisions.

A study conducted to assess the availability and acceptability of *Medical Abortion* in Nepal (Tamang et al. 2005) identified various types of allopathic and indigenous medicines sold in the Nepalese market for menstrual regulation and most of these medicines were also prescribed for inducing an abortion. The most popular medicines which are believed to have abortifacient values are: *EP Forte, Mensure*, *Albendazole, Mensolex, Klot, Ergo tablets, Rajprawantaniwati*, etc. Because of the open border with India, all these products enter Nepal easily. *Mensolex,* a homeopathic drug produced in India, is a good example, which has clear instructions on how to use this drug for abortion and is sold openly on the Nepalese market. There is no study that has examined the safety and efficacy of such drugs for inducing abortion.

Medical abortion has not yet officially been introduced in Nepal, but with the highly porous Indo-Nepal border and the easy availability of *mifepristone* and *misoprostrol* in Indian chemists' shops, it is possible the drugs are entering Nepalese markets. However, there is a low level of awareness about *mifepristone* and *misoprostol* among most of the health care providers interviewed. Use of *misoprostol* for the prevention of post partum hemorrhage (PPH) is currently being piloted in Banke district in Nepal under the Nepal Family Health Program.

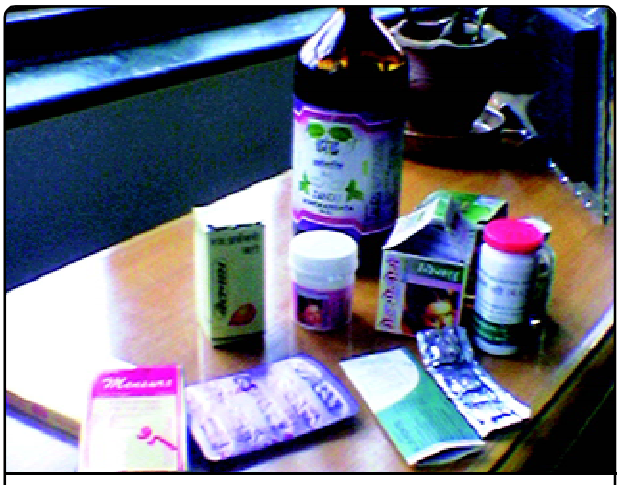


Photo: Some of the popular ayurvedic and homopathic medicines sold in the market and prescribed overdose by private medicine shops for early abortion

In the present study, *In-depth interviews* were carried out with five women who, after resorting to unsafe abortions were admitted at the Maternity Hospital, Kathmandu in serious conditions. The case histories of five women are narrated below. Two women had sought the assistance of a traditional birth attendant (TBA) of their village, one had visited a local female abortionist and another one a local health center. The fifth woman had obtained the abortion service from a nurse working at a local pharmacy. The method used by the TBA was a crude one – insertion of stick. The nurse had also inserted stick pasted with unknown medicine. The local abortionists had inserted a polythene pipe filled with unknown medicine while the health worker had inserted a catheter filled with some medicine (Paraterial oxytenic). All the five women were from the adjoining districts of Kathmandu valley - four of them from the villages.

Case History 1

Mana, 40 years (name changed) is from Khare VDC of Dolakha district. She has been married for 25 years and has eight children, five sons and three daughters. She and her husband works in a farm and earn a monthly income is just about 5,000 rupees. When she learnt that she was pregnant for the ninth time she decided to terminate the pregnancy since she felt that it would be a shame to give birth again. Besides her economic conditions was also very weak Prior to her ninth pregnancy she had been using Depo provera but discontinued using it because of excessive bleeding.

She went to a traditional birth attendant (Sudeni) of her village. The Sudeni inserted a stick inside her uterus. Mana paid 500 rupees for the procedure. Following the insertion of the stick she experienced heavy bleeding for three days and a moderate blood flow for about a month. When she became very weak and pale her son took her to a village health-post. She was admitted in the health-post for two days and during that period she was given I.V fluid some antibiotics. On the third day, she was taken to the district hospital in Dolakha. Due to her conditions (lack of blood) the doctors in the hospital referred her to the Maternity Hospital, Kathmandu. Mana condition was worse and she appeared faint and anemic when she was brought to the Maternity Hospital. She was kept under observation and blood transfusion was done on her. MVA was done on the fourth day of her hospitalization when her condition became stable. Although no POC was retained about 10 ml of fluid was collected from her uterus. Mana said she opted to terminate her pregnancy with the help of a Sundani because she did not have knowledge of any health facility that provided safe abortion services. The cost of her treatment from the hospital was 5000 rupees. She found the cost of her treatment to be very high.

Case History 2

Uma, aged 27 years (name changed) of Chautara VDC of Sindhupulchowk district has been married for 10 years and has three daughters. She and her husband had been using condom after the birth of their youngest daughter. Her husband earns around 6,000 rupees while Uma works in her own farm and earns around 3,000 rupees, which is just enough to sustain the family. When Uma found that she was pregnant for the fourth time, she and her husband made the joint decision to terminate the pregnancy though the decision was quite late. Her pregnancy had crossed 16 weeks. Her sister-in-law took her to a local health centre in Panauti where the health personnel inserted a catheter dipped in some medicine (Paraterial oxytenic). According to Uma, it was a yellowish pipe about the size of her index finger, inside her uterus and told her that it would terminate her pregnancy. Uma and her husband paid 8,000 rupees (Us $ 113) for the abortion.

Uma started bleeding heavily 2 days after the insertion of the catheter. Due to heavy bleeding she was brought to the same local health centre. The health provider administered her I.V. fluid (11 bottles). After five days in the health centre, she started hallucinating, was unable to recognize anyone even her own husband and became unconsciousness. On the sixth day, she rushed to the Maternity Hospital, Kathmandu. According to her husband, a big mass of flesh got expelled inside the ambulance as she was being brought to the hospital. Uma said that she was aware of safe abortion services being provided at the Marie Stopes clinic located in her hometown but since abortion of 16 weeks old pregnancy was illegal, she went to a private clinic for abortion. She further said that if she had kept the pregnancy and given birth, it would have put further economic pressure on her family and hence she was desperate to end the pregnancy.

When Uma was admitted at the Maternity Hospital, she was running in high fever and had developed vomiting tendencies. The doctors put her under I.V drip, antibiotics were given and 2 pints of blood was also transfused on her to stabilize her condition. The doctors at the hospital diagnosed her as a case of septic induced abortion and D&C was performed on her.

Case History 3

Sita, 31 years (name changed) hails from Tharukpa VDC of Sindupalchowk District. She has been pregnant four times and has three sons. Her husband works as a taxi-driver in Kathmandu and earns 9000 rupees a month. Sita has received non-formal education and is able to read and write. Though married for 12 years, Sita and her husband have never used any contraceptives. According to Sita, her husband often did not send her money regularly and it was hard for Sita to look after their children.

When Sita found that she had conceived for the fourth time (she was 6 weeks pregnant) she went to a local woman for abortion. The woman inserted a pipe filled with medicine inside her vagina and the procedure cost her 700 rupees (about 10 US Dollar). The woman told her not to worry about and as soon as the fetus is expelled everything will be fine. On the fourth day following the insertion of the pipe, Sita experienced slight bleeding and on the fifth day she noticed blood clots along with the bleeding. On the same day together with bleeding she passed a big chunk which was the fetus.. After that she experienced moderate bleeding for 15 days but suffered from severe abdominal pain and backache.

Sita became very weak and pale after 15 days of continuous bleeding. The health assistant (HA) from the village was summoned to examine her condition. The HA put her under I.V. drip and she was suggested to rush her to the Maternity Hospital, Kathmandu. She was taken to the Maternity Hospital in an ambulance. At the hospital, Sita was given 2 pint of blood and I.V. The doctors performed D&C to remove the remaining part of the POC retained in the uterus. She was diagnosed as a case of septic induced abortion. Sita blames her husband for her condition because he neither allowed her to use contraceptives nor he agreed to use one. When Sita was discharged from the hospital she had paid Rs 2,260 (about 32 US $) to the hospital as treatment costs.

Case History 4

Kamala, 41 years (name changed) is a resident of Thasing V.D.C of Nuwakot district. She was rushed to the Emergency Room of the Maternity Hospital, Kathmandu at 8.00 am on 10 Feb.06 with complains of severe lower abdomen pain and P.V. bleeding. When she was brought to the hospital she was in unconscious state and her H.B was low; 5.3. She was given higher doses of antibiotics and two pints of blood was transfused within five hours of her arrival in the hospital. After her condition became stable, evacuation was conducted on her.

Kamala has been pregnant 9 times and has four living children (3 daughters and one son). Her husband works as a farmer but his income is meager, it was hardly enough to make both ends meet for the family. With enough mouths to feed already Kamala decided to abort the three weeks old pregnancy which was her tenth pregnancy. She had been using Depo provera in the past and then switched over to Norplant and ultimately discontinued using after using the device for five years.

Kamala had sought the service of a traditional birth attendant (Sudeni) who inserted a stick like herb inside her uterus for which she was charged Rs. 200 (according to her the Suneni was a popular abortionists in her village and she often charged very high fee – between Rs 500 and Rs 1000 to women with unwanted pregnancy due to extra-marital relations). Following the insertion of the stick, Kamala experienced slight bleeding for three days. On the fourth day, when she was fetching drinking water, she experienced heavy bleeding and the stick also fell off. Seeing her condition her husband called a doctor who put her under I.V drip (she was given three bottles of saline water) and some medicines to stop the blood flow. However, heavy bleeding continued and on the ninth day, she expelled some fleshy masses and her condition became more severe. On the 10th day she was rushed to the Maternity Hospital, Kathmandu. Kamala confessed that 3 years ago she had been to the Maternity Hospital in a serious condition and for the same cause – unsafe abortion. Even at that time the she had resorted to the same clandestine abortion procedure (insertion of stick inside her uterus) and had terrible experience. Kamala was aware of safe abortion services being provided in the health facility in her district but due to lack of money, she chose an unskilled provider (TBA) for pregnancy termination.

Case History 5

Bimala, 35 years (name changed) lives in Banepa urban municipality of Kavrepalanchowk district. She and her husband had strong preference for a son. But it was only after they had four daughters, they were blessed with a son. After the birth of her son, Bimala decided to have a mini-laparoscopy but she was advised by her relative to postpone her idea until winter which was considered suitable for such a surgery. She decided to wait and for three months she started taking oral pills and later switched over to intrauterine device (IUD). Unfortunately, Bimala had to remove her IUD after three months on health grounds. Her husband began to use condom thereafter. Once the stock of condom was exhausted, her husband failed to obtain condoms. This resulted to an unwanted pregnancy. In view of their poor economic conditions, she and her husband made a joint decision to terminate the pregnancy. The pregnancy was already eight weeks old.

Bimala contacted a nurse at her medicine shop/pharmacy as per her sister's advice. The nurse inserted a stick that was slightly pointed at one end and a thread was hanging on the other end) inside her vagina. The procedure cost her 3,000 Rupees (US $ 42). The nurse told her that the stick would fall by itself and advised her to meet her again, within few days, if she experienced any complications. The procedure was over within 10 minutes and she did not have to endure any pain on the day. The following morning, she began to experience PV bleeding and slight abdominal pain. The next morning, when she was urinating, the stick fell off. She noticed clots along with the bleeding. The medicines given to her take in case of severe pain in the abdomen fail to work On that day, there was general strike and hence she could not visit any hospital or the medicine shop. Even the ambulance service could not be contacted due to the disconnections of all phone lines and people were afraid they would run over the ambushes laid by the Maoists along the highway Because of six days of continuous P.V. bleeding, Bimala's condition worsened and she fainted. An ambulance was called and she was taken to Shree Memorial Hospital where she was kept for two hours. The hospital referred her to a clinic at Kathmandu (opposite Shanker Dev Campus). The clinic referred her to Maternity hospital, as her blood pressure was very low. When she arrived at the hospital her blood pressure was 60/20 and she was in a state of shock. Her hemoglobin level was 4.1 and her pulse rate was 76 per minute. She had high (101°) fever and was kept in MICU (Maternity Intensive Care Unit) for three days. Since she had lost considerable amount of blood, she was administered two pints of blood. On the fifth day at the hospital, Bimala looked pale and very weak. She was delirious and she could hardly speak. However on the sixth day her conditions improved. Bimala believes that had there been no general strike (Nepal Bandh), she would have received timely medical attention from the hospital. She spent 2,400 rupees for the treatment.

3.4.1 Post-legalization Trends in Unsafe Abortion Practices

The post-legalization trend in unsafe abortion for the country is difficult to measure in view of the lack of information or records on induced abortion related admissions at health institutions. Moreover no large scale population-based surveys on abortion has been carried out to-date after the legalization to study the unsafe abortion practices. The PAC units of most of the government hospitals do not separate out induced abortion cases. Instead, all PAC cases are identified according to their nature of complaints or diagnosis such as spontaneous abortion, missed abortion, threatened abortion, incomplete abortion, inevitable abortion, septic abortion, etc. As a result, the number of unsafe abortions seeking PAC services from these hospitals cannot be correctly ascertained.

Table 8 shows the annual number of PAC admissions in government and non-governmental health facilities located outside Kathmandu valley and the number of induced abortion with complications visiting these health institutions. The information was collected at the time of conducting the *National Facility based Abortion Baseline Survey 2006.* The survey data revealed a decline in the total PAC admissions in most of the government hospitals in the past three years, except in government hospitals located in Dang, Kailali and Baglung districts. In these three districts, the number of PAC admissions has soared over the years. The increase in PAC admissions was also apparent in FPAN clinic of Itahari. As mentioned earlier, whether or not there has been an increase or decline of clients with complications of induced abortion is difficult to judge from this table since most of the facilities do not segregated induced abortion related admissions from the total CAC admissions in their clinic records.

Table 8 Facility-wise Annual Caseloads of PAC Clients in Selected Health Facilities Located Outside the Kathmandu Valley.

Name of the facility	Total PAC clients			% of Induced clients to total PAC clients		
	2003	2004	2005	2003	2004	2005
Government Health Facility						
Western Regional Hospital, Kaski, Pokhara	418	698	273	*	2.7	2.6
Dhading District Hospital, Dhading	18	21	13	*	*	*
Mahendra Hospital, Gorahi, Dang	33	54	64	*	*	*
Seti Zonal Hospital, Dhangadi, Kailali	91	101	57	*	*	*
Mahakali Zonal Hospital, Kanchanpur	42	50	132	*	2.0	*
Koshi Zonal Hospital, Biratnagar, Morang	185	230	171	1.6	3.5	7.0
Bhim Hospital, Bhairahawa, Rupandehi	48	104	57	*	*	*
Dhankuta District Hospital, Dhankuta	34	30	33	*	*	*
Makwanpur District Hospital, Hetauda,Makwanpur	48	43	33	*	*	*
Mahendra Adarsha Chikitshalaya Bharatpur, Chitwan	172	157	137	13.9	19.7	10.2
Lahaan District Hospital, Siraha	11	19	8	*	*	*
Baglung District Hospital, Baglung	47	61	69	2.1	4.9	2.9
Solukhumbu District Hospital, Phalpu	1	2	1	*	*	*
Bheri Zonal Hospital	N.A	N.A	48	N.A	N.A	N.A
Total	**1148**	**1570**	**1096**	**25**	**62**	**35**
Non-government health facility						
MSI, Tulsipur, Dang	N.A	N.A	3	N.A	N.A	*
MSI, Birtamode, Jhapa	N.A	N.A	N.A	N.A	N.A	N.A
MSI, Dumre, Tanahu	N.A	N.A	3	N.A	N.A	*
FPAN, Pokhara	N.A	N.A	4	N.A	N.A	100.0
FPAN, Itahari	35	74	114	*	*	*
FPAN, Chitwan	N.A	N.A	N.A	N.A	N.A	N.A
Nepalgunj Medical College, Kohalpur, Nepalgunj	N.A	68	73	N.A	2.9	5.6
Total	**35**	**142**	**197**	**-**	**2**	**8**

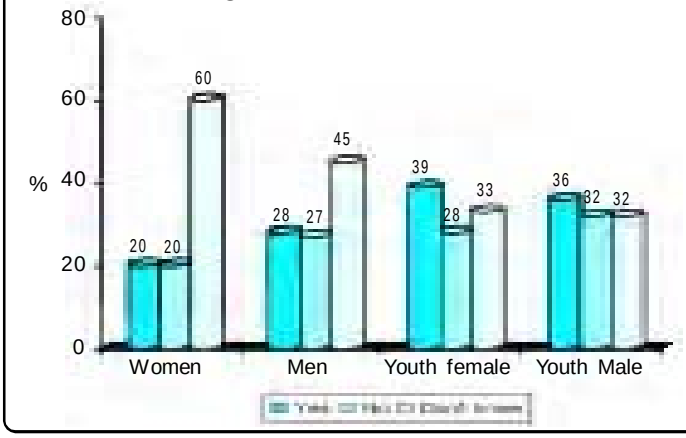
** Records do not segregate induced abortion related admissions from the total PAC admissions in most of the facilities.*
N.A = Information not available

3.5 Reasons for Unsafe Abortions in Nepal

As in many developing countries, unsafe abortion tend to persist in Nepal because of the country's high female illiteracy, ignorance, early marriage and early childbearing, highly fertility, low contraceptive use and poor access to reproductive and sexual health information and services. The act of abortion is still considered as a sin in Nepalese society, and, as a result, women are compelled to resort to backstreet abortions. The practice of visiting India for the sole purpose of abortion is also not uncommon especially in districts along the Indo-Nepal borders. Many women after having undergone abortion from clandestine clinics in India return home with complications. Knowledge about the legal reform and CAC services is low among most of the rural married women. Moreover, most of the approved CAC services are confined to urban towns and district headquarters. As a result, many rural women have low access to safe abortion service.

In the following paragraphs, some of the main reasons for prevalence of unsafe abortion in the country are discussed:

Figure 6 Awareness about legalization of abortion among rural married men and women: 2005



(Source: CREHPA/PPFA-International, 2005)

3.5.1 Ignorance about the law

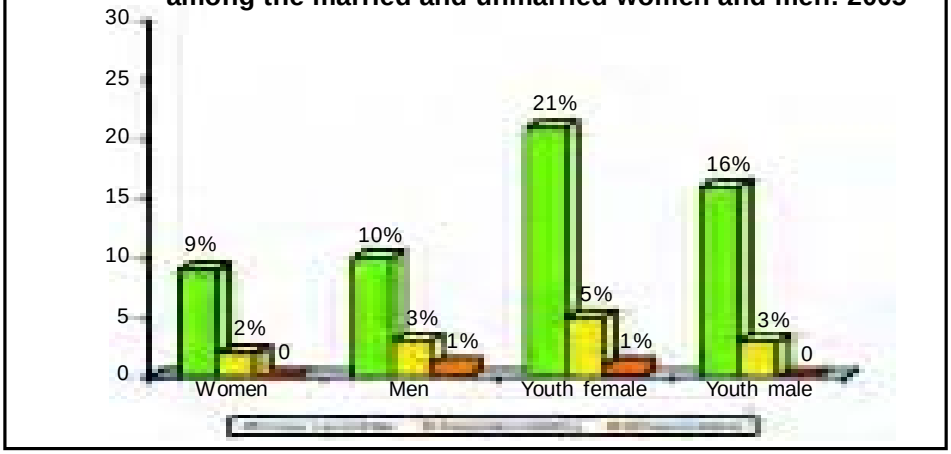
Knowledge about legalization of abortion or lack of it, influences choice of procedure. The possibility of many women who are ignorant of the law to resort to unsafe abortion procedures remains high since these women wish to maintain secrecy of the act for fear of legal and social sanctions. As mentioned in Section 2.5 of this report, more than half of the urban public (58%) interviewed in the 2004 public opinion poll were unaware of the legalization of abortion law in the country. Comparatively, a higher proportion of the adult males (47%) than the adult females (37%) were aware about the legalization. Likewise, urban public who are 'high literates' (59%), read newspapers regularly (55%) or are exposed to radio (47%), or TV (45%) regularly, were more aware of legalization than those who were 'low literates' (25%), never read newspapers (21%) or never listen to the radio (24%) or TV (23%).

The extent to which rural Nepalese men and women are aware of the abortion law was also documented in a large scale baseline survey conducted by CREHPA during August-October 2005 in six districts where *Planned Parenthood Federation of America-International (PPFA-International)* in collaboration with its four Nepalese partners (CREHPA, FPAN, FWLD and SMNF) are implementing a three years' innovative program entitled "Network for advocating women's reproductive rights in Nepal" (NAWRN). The survey interviewed 1145 married women, 526 married men, 128 unmarried males and 208 unmarried female youths (15-24 years of age), residing in the villages. The

results showed that even after three years of legal reform, only 20% of married women and 28% of married men were aware of the legalization of abortion. Interestingly, the unmarried female and male youths were better informed than their married counterparts about the legalization (36-39%) (Figure 6). Among those who are aware of the legalization, less a tenth were able to correctly cite at least one of the three conditions in which abortion is permitted in the country (Figure 7).

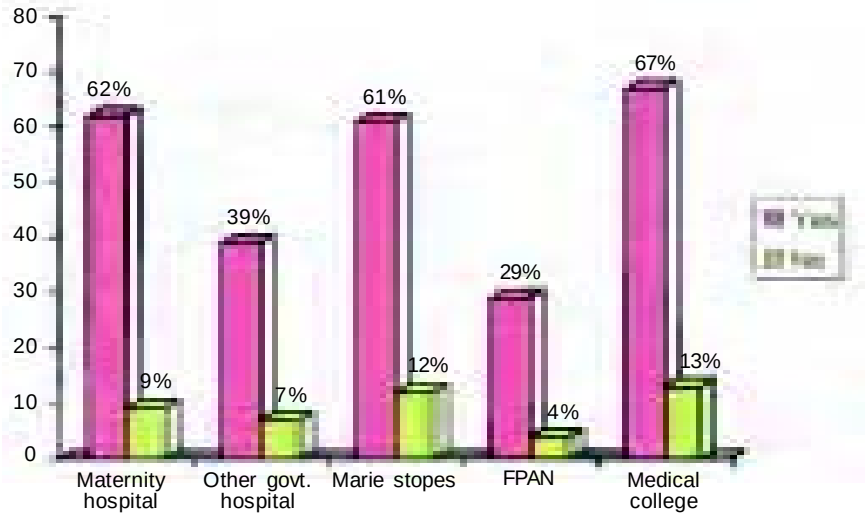
Women who seek safe abortion services from approved CAC facilities are not necessarily aware about legalization of abortion. For instance, only 39 percent of the clients who had received CAC service from government hospitals located outside the Kathmandu valley and 29 percent of clients receiving safe abortion service from FPAN clinics were aware of legalization. Only 62 percent of the clients seeking CAC service from the Maternity Hospital, Kathmandu and nearly and equivalent percentage of those seeking abortion service from MSI centers were aware of the legalization (Figure 8).

Figure 7 Extent of knowledge about the three legal conditions among the married and unmarried women and men: 2005



(Source: CREHPA/PPFA-International, 2005)

Figure 8 Knowledge on legalization of abortion among CAC clients



Those clients giving 'Don't know' reponse not shown in the diagram

(Source: MoHP/CREHPA/Ipas, 2006)

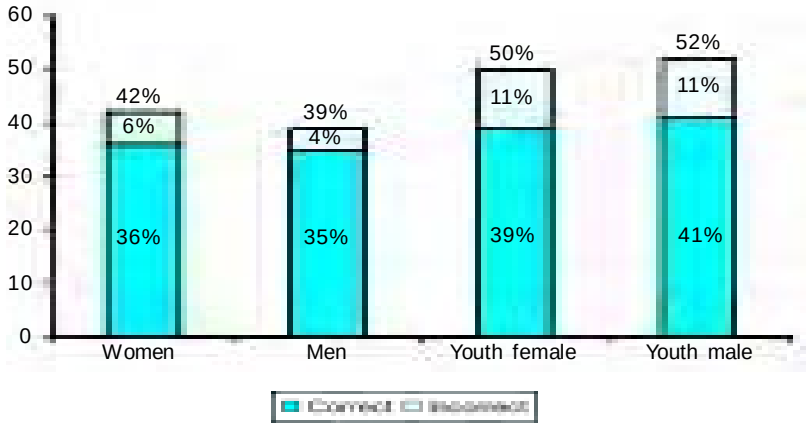
Among the women who were aware of legalization, less than half (48%) had the knowledge that abortion is permitted on request during first 12 weeks of pregnancy. Only about a tenth knew that abortion is permitted up to 18 weeks in case of rape or incest (10%) and if pregnancy affects the health of mother or the fetus (12%). Most of the clients managed to obtain information on CAC services in their district through health workers, chemists, husbands or from their friends.

3.5.2 Ignorance about Approved CAC Facility

Ignorance about the person or place for safe and legal abortion care (CAC) can exert delays in abortion decision making and compels women and couples to resort to unsafe pregnancy termination procedures. A high level of ignorance about the availability of government approved CAC center in the district was evident from the 2004 public opinion poll. Only 43 percent of the respondents in this opinion poll survey were aware that their hospitals or NGO health institutions provide CAC service. Even in the metropolitan city of Kathmandu, only about 60 percent of the public were aware about the availability of CAC service. In districts which did not have an approved CAC center, respondents had a wrong impression about the availability of safe and legal abortion service (CREHPA, 2004a).

The findings of the NAWRN baseline survey further corroborated the above facts. For instance, though all the six baseline districts had at least one approved CAC center (some districts had more than one CAC center), the extent of correct knowledge on such centers was low among all the four categories of the respondents (35-41%) (Figure 9). There were 9 married women in the sample who had terminated their pregnancy in the past 12 months and after their districts had an approved CAC center. Of these 9 women,

Figure 9 Levels of knowledge on approved CAC centers among married and unmarried men and women: 2005



(Source: CREHPA/PPFA-International, 2005)

Despite the law favoring abortion by unmarried women, the majority of the FGD participants in one district (Banke) were opposed to unmarried girls resorting to abortion. Most of them were not aware about the law permitting abortion by unmarried women.

"Our society supports legal abortion by married women but not by unmarried girls. We ourselves do not support abortion by unmarried girls. If we come to learn about this (an unmarried girl seeking abortion service) we will strongly oppose her"

(One FGD participant in Banke district)

3 had sought abortion from CAC approved government hospital and 2 had visited MSI center of their district. The remaining 4 women had resorted to unsafe abortion measures (two from pharmacist, one self induced and one from an unqualified provider). There have been some efforts, mostly from the part of the NGOs, to enhance public awareness about the law and create enabling environment for women to access safe abortion services.

3.5.3 Low Access to Safe and Legal Abortion Services

Universal access to information and services has the potential to significantly reduce the country's maternal mortality ratio, which is one of the highest in the world. Law and provision of services are necessary but not sufficient to guarantee access. As stated earlier, to-date, most of the government approved CAC facilities are confined to urban centers (municipalities) or in district headquarters. Moreover, only medical doctors have been approved so far by the government for providing CAC services. Rural communities have lesser access to legal, safe and affordable abortion services because of this restriction. The difficult geographical terrain and limited access by roads for the vast majority of the rural population continue to hinder CAC service expansion and access. However, plans are underway to expand CAC service at primary healthcare center (PHC) levels and also permit staff nurses to conduct safe abortion procedure.

It is evident from the NAWRN baseline survey 2005 that the district based government hospitals are the preferred choice for less that a fifth of the married women (37%) and a quarter of married men (25%) for abortion services. Some women choose to visit a private clinic/ nursing homes (29%) or travel to India (17%) for abortion. In fact, more men than women preferred to take their spouse to India (42%) for abortion or seek the service from a private clinic/nursing home of their district (Table 9).

Accessibility of CAC service especially for women of low economic status is also determined by the amount of fee charged for abortion and regularity of the service. Contrary to the expectation of the urban public (Public opinion poll 2003, 2004), the abortion fee charged by government hospitals are high, and ranges from a minimum of Rs 800 (Seti Zonal Hospital, Dhangadi in Far West) to Rs. 2000 (Gorkha district Hospital and Sankhuwasabha district hospital) (not shown in the table). Moreover, the fee does not include the costs of the essential medicines (worth of Rs 60-80) for which the clients ought to pay extra.

The amount of abortion fee charged by NGOs and medical institutions ranges from a minimum of Rs 800

Table 9 Places of Termination of the Last Pregnancy among Married Women and Men Who Have Reported of Ever Having Resorted to Abortion

Place	Married (15-49 years)	
	Women (%)	Men (%)
Govt. hospital	36.6	25.0
Private clinic/Nursing home	29.3	33.3
Visited India	17.1	41.7
Bought medicine from medical	7.3	-
Marie Stopes center	4.9	-
Health post	2.4	8.3
FPAN clinic	2.4	-
Total	**100**	**100**
N	**41**	**12**

(Source : CREHPA/PPFA-International, 2005)

(Nepalgunj Medical College) to Rs 1350 (Marie Stopes Centers). The abortion fee charged by FPAN clinics ranges from Rs. 925 (Kavre) to Rs. 1000 (Chitwan). Abortion fee in private clinics and nursing homes are three to four times higher than those charged by the hospitals and NGOs.

The 2003 and 2004 Opinion Polls had solicited public views on the amount of abortion fee a government hospital should charge to clients. The Polls also sought their impression on the minimum fee of Rs 900 being charged by some of the hospitals.

The large majority of the urban public (78%) opined that the government should not charge beyond Rs. 500 for abortion services (Mean = Rs 514 in 2003 and Rs 516 in 2004 opinion polls) and also disagreed (58%) with the view that high abortion fee ensures quality CAC services at government hospitals (CREHPA 2003, 2004a).

The medical staff at the government hospitals claims that they have provision to subsidize the fee or even provide MVA service for free to poor women. However, not a single CAC client among the 2,293 clients interviewed by the CREHPA during a two months study period was benefited by this provision.

Non-availability of CAC service on a regular, 6 days a week basis continue to deny women's accessibility to safe abortion service from most of the government managed CAC centers. These government hospitals provide CAC service on certain days (1-2 days) in a week only. Some of the government hospitals also follow a fixed target (ceiling) for performing MVA procedure (3-5 clients per CAC service day). Moreover, one zonal hospital in Far Western Region of the country follows a strange protocol. This hospital persuades clients to register themselves in advance and also have physical exam done by the clinician of the hospital 1-2 days prior to the CAC service day. Since this hospital does not entertain any client who has not followed this protocol, it has created inconveniences to clients especially those residing in remote locations as each client needs to visit the hospital twice – first time for registration and physical exam and the second time for the procedure. Therefore, those women who can neither afford to pay the high abortion fee charged in private clinics nor can return to the hospital on the day specified for PAC service has no alternative left than to opt for unsafe means of pregnancy termination.

High abortion client flow in country's largest maternity hospital at Thapathali, Kathmandu compels the providers to persuade their clients to re-visit on another day. Moreover, about a tenth of the clients get rejected from this hospital because of the late gestations (surpassing the legal limits of 12 weeks). Apart from the maternity Hospital, the percentage of clients who were asked for re-visits was considerably high in some of the medical colleges and other government managed CAC facilities also.

It is evident from Table 10 and Table 11 that out of the total 18 CAC approved government hospitals assessed by the research team during December 2005 to April 2006, two hospitals (Lumbini and Behri zonal Hospitals) had stopped providing CAC service since few months and one hospital (Lahaan district hospital) had not started the CAC service since it received government approval more than six months ago. Of the remaining 13 government hospitals, only 9 hospitals provided CAC service all the week days (six days) while the remaining 4 hospitals provided only for 2 days per week. In comparison, all the NGO institutions (including medical colleges) provided CAC services six days a week except FPAN clinic of Kaski district which operated its CAC service three days a week.

Table 10 CAC Service Days and Service Fee at Selected Government CAC Centers: CREHPA (December 2005-April 2006)

S. N.	Name of CAC facility	CAC service day	Abortion Fee(Rs)	Remark
1	Maternity Hospital, Kathmandu	All week days	900	Clients loads are very high and hence most clients need to obtain their appointment dates
2	Western Regional Hospital Kaski, Pokhara	Tuesdays & Fridays	1500	Service limited to five clients per service day
3	Dhading District Hospital Dhading	All week days	1200	Excludes costs of medicines
4	Mahendra Hospital Gorahi, Dang	All week days	1000	-
5	Seti Zonal Hospital Dhangadi, Kailali	Tuesday & Friday	800	Clients need to have physical exam 1-2 days in advance from the center
6	Mahakali Zonal Hospital Kanchanpur	Sunday & Friday	900	Caseloads is extremely low
7	Koshi Zonal Hospital Biratnagar, Morang	All week days	950	-
8	Lumbini Zonal Hospital Butwal	Service discontinued	900	CAC service has been stopped because of renovation of the building
9	Bhim Hospital Bhairahawa, Rupandehi	All week days	850	Clients have to pay extra charge for registration and medicines
10	Dhankuta District Hospital Dhankuta	2 days a week	1000	-
11	Makwanpur District Hospital Hetauda, Makwanpur	All week days	1200	Doctor remained absent most of time
12	Mahendra Adarsha Chikitshalaya Bharatpur, Chitwan	All week days	1325	-
13	Lahaan District Hospital, Siraha	Service not started	1200	CAC not formally started
14	Baglung District Hospital, Baglung	All week days	1100	-
15	Solukhumbu District Hospital Phaplu	All week days	1000	Clients have to pay extra charge for medicine
16	Bheri Zonal Hospital	Service not available	800	CAC service was stopped after the CAC providers were transferred
17.	Gorkha District Hospital Gorkha	Not known	2,000	-
18.	Sankhuwasabha District Hospital, Sankhuwasabha	Not known	2,000	-

Table 11 CAC Service Days and Service Fee at Selected Non-governmental CAC Centers: CREHPA (December 2005-April 2006)

S. N.	Name of CAC facility	CAC service day	Abortion Fee (Rs)	Remark
1	MSI, Tulsipur, Dang	All week days	1350	-
2	MSI, Birtamode, Jhapa	All week days	1350	Functions even on off days (Saturdays)
3	MSI, Dumre, Tanahu	All week days	1350	-
4	MSI, Satdobato	All week days	1350	-
5	FPAN, Central (Lalitpur)	Five days a week	950	Open up to 5 PM on Friday
6	FPAN, Valley, Kathmandu	All week days	950	-
7	FPAN, Pokhara	Sunday, Tuesday and Thursday	950	-
8	FPAN, Butwal	All week days	950	-
9	FPAN, Itahari	All week days	950	Daily caseloads is high
10	FPAN, Chitwan	All week days	1000	-
11	FPAN, Kavre	Wednesday	925	Excludes costs of medicines
12	Kathmandu Medical College and Teaching Hospital, Kathmandu	All week days	1050	-
13	Nepalgunj Medical College Kohalpur, Nepalgunj	All week days	1050	Excludes costs of medicines

3.6 Abortion Related Deaths Reported in Printed Media

CREHPA has been monitoring abortion related deaths reported in the leading newspapers of the country since 1997. There has been 10 abortion related deaths reported in newspapers during the *Pre - legalization ERA* (Aug 1997-September 2002) and 4 deaths during the *transitional period* (after the Royal Assent was given to the new abortion law and until the introduction of CAC service by the government). After the government started introducing CAC services no death was reported in the newspapers for two consecutive years (2004-2005). However, two deaths - one on May 23, 2006 and the other on July 12, 2006 were reported in the newspapers.

Of 10 deaths occurring during the Pre-legalization Era, 6 deaths were caused by clandestine abortion practice by private pharmacists. They had used various methods and unknown injection for pregnancy termination. One woman died in the hands of a faithhealer who had inserted some herbs that caused gas gangrene. She died at the hospital. The remaining three deaths were caused by a clandestine abortion provider (1 death) at his illegal abortion clinic, by a private doctor (1 death) and by a government outreach health service provider (1 death).

Of the 4 deaths reported in the newspapers during transitional period, 2 deaths were caused by government outreach health service providers, 1 by a private doctor and the remaining one woman (unmarried woman) had died after her boyfriend took her to a small border town of India (Jogbani) for abortion and later admitted with serious complication at the Koshi zonal hospital in Biratnagar, Nepal.

Of the 2 deaths which were reported in the newspapers recently (May/July 2006), one death was due to an attempt made by a private doctor (Makwanpur district) on a woman with second trimester pregnancy. The second death was caused by a paramedic (Rautahat district). Both the abortions were attempted in a private clinic setting which were not approved for CAC service (Table 12) The short description about the cause of death reported in the newspapers for each of the 16 women is presented in Annex II.

Table 12 Abortion Related Deaths Reported in Printed Media

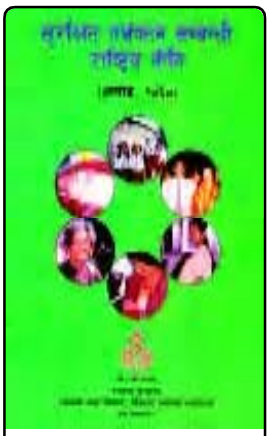
Period	Time frame	No. of deaths reported
Pre-legalization Era	Aug 1997-Sept 2002	10
Transitional period	Oct. 2002-Feb. 2004	4
After the implementation of abortion law (CAC service)	Mar. 2004- July 2006	2

CHAPTER 4

Efforts to Prevent Unsafe Abortions

4.1 Efforts of the Government

Implementation of the abortion law in the country is guided by the *National Abortion Policy 2002* and the *Safe Abortion Service Procedure 2003.* The Family Health Division under the Department of Health Services, Ministry of Health and Population (FHD/DHS/MoHP) is the focal point and the main coordinating body for the implementation of the national safe abortion program in the country. There is a *National Safe Abortion Advisory Committee* under the chairmanship of the Director General, Department of Health Services to review the progress of abortion law implementations and advise the government on abortion policy reforms. The Technical Committee for Implementation of Comprehensive Abortion Care (TCIC), formed in February 2003 is headed by the Director, FHD/DoHS as its chairperson and the members of the TCIC are drawn from key government ministries and departments (Ministry of Health and Population and Ministry of Law and Justice), NGOs, and donors, and collectively assist the government in implementation of the country's safe abortion strategy. The strategy includes training government and NGO health service providers to deliver CAC services from the listed CAC centers and increasing public awareness about the abortion law and services. Under TCIC, a behavior change communication (BCC) working group advises on BCC and IEC matters. Recently it has been involved in the development and implementation of BCC pilot strategy based on interpersonal communication techniques (*Dialogues of Life*), which was implemented in two districts (Rupendehi and Bhaktapur) with the support from PATH and district implementation partners - Namuna Integrated Development Council, Rupendehi and Family Planning Association of Nepal (FPAN), Valley Branch.



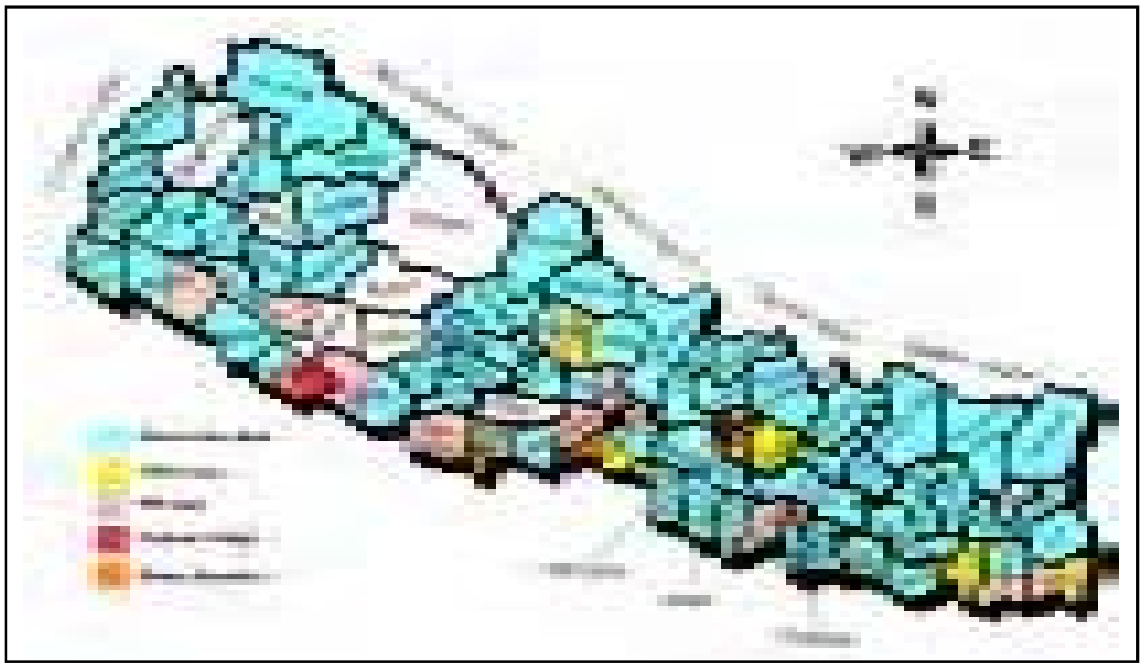
National Safe Abortion Service Policy, 2002

The BCC working group has also been involved in the development of an IEC strategy, including posters, an information leaflet and post procedure information flier for abortion clients. These materials are being distributed countrywide through the National Health Education Information and Communication Center (NHEICC). The National Health Training Centre (NHTC) works closely with FHD and TCIC, with NHEICC responsible for public information dissemination, and, NHTC responsible for training procedures. The Ministry of Health and Population provides guidance at policy and procedural level and the Ministry of Law and Justice provide advice on legal aspects of the reform (FHD/MoHP, CREHPA, FWLD, Ipas, PATH, 2005).

Currently, the government is promoting manual vacuum aspiration (MVA) for safe abortion through CAC approved hospitals, medical institutions and non-governmental organizations (NGOs). MVA technique is not only safe for first trimester abortions but it also complies with the gestation limits of 12 weeks for legal abortion in the country.

Until July 2005, the Maternity Hospital, Thapathali (Kathmandu) was the only government approved CAC training center in the country. In August 2005, the Marie Stopes Center at Saatdobato, Lalitpur was established as the first NGO-run CAC training center with government approval. Efforts are underway to establish a regional level CAC training center at the government Lumbini Zonal Hospital, Butwal in Rupendehi district (Western Terai Region). As of May 30, 2006, 47 batches of the training (including 6 batches of training at MSI, Saatdobato) were conducted for 252 doctors (174 government and 78 NGO/private doctors) and 196 nurse assistants (133 government and 63 NGO/private nurse assistants). The government has listed 128 sites – 80 government affiliated and 48 NGO/private affiliated CAC sites and there is at least one CAC site in 68 districts out of the total 75 districts of the country. The TCIC secretariat provides monitoring support to ensure that services comply with international standards, including proper infection prevention procedures, counseling and a client friendly environment.

Map 2 Listed CAC Sites (April 2006)



(Source: FHD/DoHS)

In the first year, (March 2004 to February 2005), altogether 7,496 women received CAC services out of which 4,279 clients utilized the government facilities and the remaining 3,217 clients (43%) had utilized the non-government facilities. As of April 30, 2006, a total of 43,400 clients have received abortion service, which is a remarkable achievement. The number of clients visiting CAC centers run by NGOs are nearly three times higher (73.1%) than those in government CAC centers (26.9%) (Table 13).

Table 13 Progress Made in CAC Service Expansion and the Number of Clients Receiving the Service

Activity	Govt.	NGO	Total
Total service providers (doctors) trained	164	66	230
Total nurses trained to assist CAC service	126	50	176
Total sites/center listed	76	46	122
Total district having at least one listed CAC site/center	-	-	66
Total CAC clients served (March 2004 to April 2006)	**11,664**	**31,736**	**43,400**

(Source: TCIC/FHD/MoHP, 2006)

In response to the requests by TCIC staff, the CAC Advisory Board in its last meeting made a recommendation to standardize the abortion fee at all the government hospitals and revoked the existing policy that had allowed the respective hospital management committees to set their own abortion fee. The recommended maximum fee for all government CAC centers is Rs. 1000 inclusive of the costs of medicines for normal service. The meeting also agreed to pilot the training of experienced staff nurses as CAC providers, and it is hoped that this will begin within the next two months. This is an important step in enabling women in remote areas, where there are shortages of doctors and no NGO clinics, to access safe abortion services.

In view of the large number of caseloads of patients seeking treatment of abortion related complications mostly incomplete abortions, the hospital established a Post Abortion Care (PAC) Unit in 1995 with the initiation of Ministry of Health and technical assistance from USAID, JHPIEGO, Engendered Health and FHI. This Unit is located at the ground floor of the new emergency block building next to the emergency room to provide easy access to the sick women, The aim of the PAC service was to provide comprehensive post abortion care service which consists of emergency management, uterine evacuation of incomplete abortion with manual vacuum aspiration (MVA), provision of family planning counseling and service and other health care needs of such women.

Maternity Hospital is the only National training center for PAC program in the country. This training is coordinated by National Health Training Center (NHTC), of the Ministry of Health (MoH). As of the year 2001, PAC training program of the hospital had successfully provided competency based skill training to 62 physicians, 27 nurses and 58 assistants.

PAC is one of the important components of Basic Emergency Obstetric Care given to the women. Since Year 2002 doctors and nurses from districts have achieved, Competence in PAC. PAC services are provided at the six centers in Kathmandu

valley and in thirteen centers outside the valley. Besides our own country health personnel, Maternity hospital has trained physicians from South Asia and South-East Asian countries like Pakistani and Indonesians in PAC service.

As of 2004-2005, PAC service sites are established in 42 government hospitals and 9 primary health care centers (PHCC) and 7 NGO health institutions covering 42 districts of the country. Regional wise distribution of the PAC sites is shown in Table 14.

family planning, sexual and reproductive health, safe abortion care and development services in the country. It is committed to the promotion of family planning services as a basic human right as well as a means of ensuring the health and well-being of individuals and families.

In consonance with the new changed context at national and international levels in the field of reproductive health, FPAN has gradually been shifting its emphasis from mere family planning to

Table 14 Number of Post Abortion Care (PAC) Sites by Districts and Development Regions: Nepal (2004-05)

Region	Districts	PAC sites			
		Government Hospital	PHCC	NGO	Total
Eastern region	9	8	3	1	12
Central region	12	11	3	5	19
Western region	10	12	3	1	16
Mid-Western region	8	8	-	-	8
Far-Western region	3	3	-	-	3
Total	42	42	9	7	58

(Source: TCIC/FHD/MoHP, 2006)

4.2 Efforts of the NGOs

4.2.1 FPAN

Family Planning Association of Nepal (FPAN) founded in 1959 became an associate member of the Planned Parenthood Federation (IPPF) in 1960 and full-fledged member in 1969. The family planning services in 1960s were limited to distribution of condoms, pills and insertion of loops. All activities were implemented by volunteers because there were no staff members to assist their work. FPAN started more target-oriented and focused programs in the 1970s. Its programs were expanded from three districts in the 1960s to 15 districts in the 1970s and 32 districts in 2004. Today, FPAN provides a range of comprehensive sexual and reproductive health programs. FPAN is one of the rights based NGOs in Nepal that has been strongly protesting against the Mexico City Policy which is popularly known as Global Gag Rule.

FPAN started safe abortion services in selected clinics in 2004. To date, the government has certified 8 FPAN clinics as CAC centres and they are providing safe abortion services. A total of 2,300 women received safe abortion services from these clinics in (2004) first year. The caseload in these clinics is growing gradually in 2005. FPAN is planning to expand safe abortion services in 5 new districts (Morang, Dhanusha, Makwanpur, Nawalparasi and Dang) under IPPF core fund in 2006.

FPAN adopting IPPF's new Strategic Plan beginning in 2005 has focused on 5 thematic areas including *Advocacy, Access, Adolescents, Abortion, AIDS*. It aims to establish center of excellence in the country as well as in South Asia Region on safe abortion. Although, the detail concept and issues that contain within the center of excellence in safe abortion is still under review, broadly it would address the following issues: 1) Quality of safe abortion services 2) Training 3) IEC/BCC on safe abortion 4) Advocacy 5) Knowledge management and 6) Networking and sphere of influence.

4.2.2 CREHPA

Centre for Research on Environment Health and Population Activities (CREHPA), is a leading research-based NGO with substantial programmatic experience in the areas of unsafe abortion and abortion rights for Nepalese women. It was established in 1994 under Society's Act 2034 as a non -governmental organization (NGO). Its founder members and professional staff have many years of research experiences in the field of public health, population and reproductive health, gender and development (GAD), environment, community development, market research, and management studies.

CREHPA played an active role through research, dissemination and advocacy to decriminalize abortion and support the recent change in the abortion law in Nepal. From 1999 to 2002, CREHPA had networked with 43 district based NGOs of Nepal for implementing its Public Education and Advocacy Project (PEAP) which was aimed at preventing unsafe abortion practices and saving women's lives. In 2000, CREHPA refused to sign the Mexico City Policy (Global Gag Rule).

Since June 2003, CREHPA initiated a new program called "sumarga" (Right Path) in partnership with its districts based NGOs to create enabling environment for women to make informed reproductive decisions and options. It supports the Ministry of Health in developing IEC /advocacy and behavior change communication (BCC) strategies to address unsafe abortion in the country. CREHPA represents the NGOs in the recently formed National Safe Abortion Advisory Committee of the government (MoHP).

CREHPA has been conducting abortion related research studies and opinion polls on abortion in Nepal since it's establishment in 1994. Encouraged by favorable public opinion on abortion rights for women (CREHPA, 1996, 2002, 2003, 2004a), the organization initiated Public Education and Advocacy Program against unsafe abortion (PEAP) in the eastern development region covering 16 districts of the country in 1999 with grant support from the Ford Foundation. The program was aimed at empowering women to make conscious and timely decision about their fertility and advocacy for legal reforms that would reduce the maternal mortality and morbidity resulting from unsafe abortion.

CREHPA with support from Planned Parenthood Federation of America-International (PPFA-I), implemented a one year pilot project entitled " Access to Legal and Safe Abortion Services Through Networks of Private Paramedics and Chemists (PPCs) and Community based Health Care Providers and Volunteers" in the urban and semi-urban areas of six districts. It was the first public-private partnership initiatives aimed at preventing illegal and unsafe abortion practices and increasing women's access to safe abortion services in Nepal. The key project interventions included empowerment of the district based non-governmental organizations (NGOs) for project intervention and monitoring, training and

Photo: NGO Participants of an interactive workshop on *Developing New Strategies in the New Legalized Context, 29-30 March, 2002*

enrolment of 600 private paramedics and chemists in the initiatives, establishment of referral networks between PPC members and comprehensive abortion care (CAC) centers in the district and monitoring of the project performances and implementation. This public-private partnership concept is being replicated by CREHPA under the IPPFA-International supported *"Network for Addressing Women's Reproductive Rights in Nepal" (NAWRN)* program in 15 districts.

In an effort to discourage women and couples from seeking abortion services from clandestine abortionists across the Nepal-India border, CREHPA in collaboration with its implementing partners (local partner NGOs) have installed hoarding boards (total 15) at vantage points along the Indo-Nepal border across the five border districts located between Western and Far-Western terai belts. These five districts are: Rupendehi, Banke, Bardia, Kailali and Kanchanpur. The messages caution about the safety of abortion procedures across the border and inform the readers about legalization of abortion law and about places/health facilities within the district where safe, affordable and legal abortion services are available. The abortion fee charged by different health institutions approved for providing safe abortion services are also spelt out in the hoarding board.

4.2.3 FWLD

Forum for Women, Law and Development (FWLD) was established in 1995 as an NGO to promote and protect human rights of Nepalese women. The mission of FWLD is to eliminate all forms of discrimination against women in Nepal and to protect and promote human rights through research, public education, lobbying to decision makers, advocacy, litigation and providing legal aid. Specific to the abortion FWLD was actively involved for reformation of the criminalized abortion law for the actual realization of women's reproductive health right (with the support of FPAN and CRR). After the legalization of the abortion law FWLD has been contributing for the wide dissemination of information on the legalization of abortion law to the grassroots people and to the law enforcers. It is also involved for the monitoring of effective implementation of the reformed abortion law and promoting social acceptance of abortion as a women's right.

FWLD had advocated for the women who remained in jail on abortion related convictions that pre-date the change of the law, as well as those charged since legalization and released them. FWLD works with other women's rights NGOs to ensure women who need shelter after their release receive appropriate support (with the support of IPAS).

In April 2003, with support from PPFA-International and the Ford Foundation, FWLD initiated a three-year program, Effective Implementation of the Abortion Law, with the objective of making safe legal abortion services accessible for all women, through raising awareness about the amended law and promoting social acceptance of abortion as a women's reproductive rights.

As networking partner of NAWRN program, FWLD is involved in increasing awareness among law enforcers on abortion law and identify legal and policy barriers and gap and potential areas for the law reform and strategies for intervention and develop litigation strategy. FWLD with the help of CRR is in a process of developing a litigation strategy to secure greater protection for women's reproductive rights through courts, to secure legal remedies for women whose reproductive rights have been violated as a result of being denied access to abortion or unsafe abortion procedure due to the absence of skilled providers and safe facilities.

4.2.4 SPN/MSI

Sunaulo Parivar Nepal (SPN), a partner NGO of *Marie Stopes International* was established in 1994 as an NGO. SPN is committed to cover unmet needs of family planning/reproductive health with technical support from Marie Stopes International. SPN works in collaboration with HMG/ Nepal to reduce population growth and improve reproductive health. Its main goal is prevention of unwanted pregnancies/ birth and its mission is to enable people to have children by choice and not by chance. Its aim is to provide high quality client oriented reproductive health services that are accessible, affordable, and reliable to the under-served community.

SPN has been implementing various programs to fulfill the needs of reproductive health services in the country. These include: qualitative reproductive health and family planning services via *Marie Stopes Centres*; free mobile sterilization camps, Social Marketing of family planning product "Jodi Condom", Reproductive Health Training Centre, Youth Friendly Health Information Centre. The organization has also been operating health camps in coordination with government especially in rural areas and far remote areas keeping in mind that health facilities are not available and people in those sector have to travel far distance in order to get the health services.

SPN presently provides safe abortion (CAC) services through its 28 clinic outlets (Marie Stopes Centers) located in 23 districts of the country with technical and financial support from MSI UK. The organization, along with FPAN has been an important safe abortion services provider in the country. All the 28 centers (as of January 2006) received government's approval for providing CAC services. Five of these CAC approved clinics are located in Kathmandu valley. One of its CAC centers located in Saatdobato (Lalitpur) has also upgraded and recognized by the government to serve as the CAC Training Center.

4.3 Contributions of INGOs

4.3.1 Ipas

Ipas is an International Non-governmental Organization which has worked for over three decades to reduce abortion related deaths and injuries; increase women's ability to exercise their sexual and reproductive rights and improve access to reproductive health services, including safe abortion. Ipas's global and country programs include training, research, advocacy, distribution of equipment and supplies for reproductive-halth care, and information dissemination.

In 2002 Ipas and other donor agencies (such as National Safe Motherhood Programme (NSMP), Department for International Development (DFID)/Options, GTZ (German Development Co-operation) supported the planning of the safe abortion programme prior to legalization of abortion in Nepal. Ipas served as the primary technical assistance organization, working with the Government body the Technical Committee for Implementation of Comprehensive Abortion Care (TCIC) to establish the standards and guidelines for training and service programmes. As a partner in the DFID/Options-UK supported Support to the Nepal Safe Motherhood Programme (SSMP), Ipas has worked closely with His Majesty's Government of Nepal and the TCIC since early 2002 to introduce and sustain a safe abortion program in the country. Relying on extensive global and regional experience, and in close partnership with the government and other nongovernmental organizations, Ipas is working to accelerate the pace of implementation of the abortion law and expand access to comprehensive abortion services for women throughout Nepal.

In coordination with PATH, Ipas brings together both technical and financial resources. These organizations (Ipas, NSMP DFID/Options, GTZ, PATH) have links with organizations such as PPFA-International Asia Regional Office based in Bangkok, Thailand and had been providing financial support for both abortion related research and activities for NGO such as Family Planning Association of Nepal (FPAN), CREHPA, Marie Stopes International (MSI-Nepal) and Forum for Women Law and Development (FWLD).

4.3.2 PPFA-International

Founded in 1971, PPFA-International is a part of the Planned Parenthood Federation of America. PPFA-I supports local partner organizations in Africa. Asia and the Pacific, and Latin America and the Caribbean to improve access to and use of critically needed sexual and reproductive health services. PPFA-I is funded entirely through contributions from private foundations and individuals. Its headquarters are located in New York City, USA, with regional offices in Nairobi, Kenya (Africa Region), Bangkok, Thailand (Asia and the Pacific Region), and Miami, USA (Latin America and the Caribbean Region), and country offices in Abujua, Nigeria and Khartoum, Sudan.

In Nepal, since 2002, PPFA-I began working with three partners in Nepal to increase access to safe abortion and awareness regarding the new abortion law among the law enforcers, private paramedics and chemists (PPCs) as well as the community. Based on the success of the previous grant periods, and the need to expand access to CAC services in the rural areas, in November 2005, PPFA-I launched a program entitled *"Network for Addressing Women's Reproductive Rights in Nepal" (NAWRN*) in 15 districts of the country. NAWRN is a three year program - a new concept franchise program being implemented through the concentrated efforts of the four Nepal partners: (1)

Photo: Dr Peeyoosh K. Rajendra, Director, Family Health Division (DoHS/MoHP) appreciating the contributions made by PPFA-International in Nepal in preventing unsafe abortions, at an inaugural meeting of NAWRN program, Nov 10, 2005.

Center for Research on Environment Health and Population Activities (CREHPA), (2) Family Planning Association of Nepal (FPAN), (3) Forum for Women Law and Development (FWLD) and (4) Safe Motherhood Network Federation (SMNF). The program complements the government's efforts in increasing awareness about the abortion law, expanding women's access to CAC services and creating enabling environment for women and couples to make informed reproductive decisions through public private partnerships initiatives. Each of the four partners implements the program of their expertise independently and conduct activities based on their area of expertise to achieve same goal and objective.

4.3.3 PATH

Program for Appropriate Technology for health (PATH) is an international organization dedicated to developing, implementing, and evaluating innovative solutions to public health problems, including issues related to women's access to safe abortion care, treatment of abortion complications and prevention of repeat abortions. Their mission is to improve the health of people around the world by advancing technologies, strengthening systems, and encouraging healthy behavior. Over the past 25 years, PATH has led projects in more than 120 countries, improving the lives of millions of people worldwide.

In Nepal, PATH began assisting the government in 2004 to reduce the social, familial, attitudinal, and knowledge barriers that women and service providers face with respect to safe abortion services in Nepal. This was a two-phase project, which included a literature review and a formative needs assessment, followed by the design of a BCC strategy (Phase I) and a pilot intervention activity (Phase II). PATH took the lead on the literature review and CREHPA conducted the formative needs assessment study. The formative need assessment study was useful in

identifying appropriate information and communication channels those are needed to reduce the social, familial, attitudinal, and knowledge barriers that women face with accessing safe abortion services in Nepal. The results of this study were used for developing a pilot BCC strategy to inform women and communities about safe and legal CAC services and reduce the number of unsafe abortions in Nepal. This pilot project entitled "Dialogues for Life" was implemented in two districts - Lalitpur and Rupendehi. The implementing partners for the pilot intervention were FPAN (in Lalitpur) and NAMUNA (in Rupendehi).

4.3.4 Center for Reproductive Rights (CRR)

Founded in 1992 (as the Center for Reproductive Law and Policy), the Center for Reproductive Rights is a US based non-governmental organization that uses international human rights law to advance the reproductive freedom of women as a fundamental right. CRR has strengthened reproductive health laws and policies across the globe by working with more than 100 organizations in 45 nations in Africa, Asia, East Central Europe, and Latin America and the Caribbean. CRR is funded entirely by private foundations and individual donors and does not receive any funding from the US government.

CRR has been working in Nepal since 2000. In 2001, CRR and FWLD undertook a fact-finding mission to document the impact of Nepal's criminal abortion law. The findings were published in a report entitled *Abortion in Nepal: Women Imprisoned* which constitutes the first in-depth analysis of international legal norms and obligations violated by Nepal's restrictive abortion law and the resulting human rights violations with a focus on women's rights to life, health, equality and non-discrimination, privacy and due process. CRR reviewed and provided comments on the draft 11th Amendment Bill and testimonies gathered during the investigation were used extensively to lobby parliamentarians prior to the official vote on the bill. Using the report as a basis, in 2002, CRR provided technical and financial support to FWLD to launch a public advocacy campaign for the release of women imprisoned under the former ban. This campaign was conceptualized, in part, as an important strategy to de-stigmatize abortion and generate support at the social and policy level for access to safe abortion services. Between 2001-2004, the Center provided pertinent information about the situation in Nepal to international human rights bodies including the Committee on Economic, Social and Cultural Rights, the Committee on the Elimination of Discrimination Against Women and the Human Rights Commission to create international pressure on the government to decriminalize abortion, release women imprisoned for abortion related offenses and to speed up the implementation of the newly amended law.

As of 2005, CRR has begun to focus on law enforcement, law reform and legal accountability. Building on the success of its work over the years, in 2005, CRR helped FWLD establish a Reproductive Rights Unit which will provide legal assistance to women who are denied access to safe abortion services and legal counseling to medical providers about the scope of their rights and obligations under the amended law and new protocols. In collaboration with PPFA-International and local members of the NAWRN network, CRR has been involved in gathering information about issues surrounding access to abortion which will be used to craft recommendations for abortion law and policy reform, to improve access to services through the establishment of stronger legal protections and mechanisms. Recognizing that legal accountability and tangible remedies are

important for ensuring women's access to abortion in the long term, CRR and FWLD, are currently developing a pilot training and future needs assessment program for lawyers to promote the use of legal strategies to secure women's access to abortion through domestic courts, national human rights bodies and international legal mechanisms. Over the years, the Center has also been a vocal critic of the Global Gag Rule which continues to undermine abortion access in Nepal.

CHAPTER 5

Issues, Challenges and Needs

Legalization of abortion has been the right step to bring down the country's high maternal mortality rates and guarantee women's reproductive rights. The legal reform has certainly created a new paradigm requiring the framing of rights based policies and programs by the government to be implemented in collaboration with non-governmental organizations and donors.

Creating an enabling environment for women and couples to access legal and safe abortion service as outlined in the *Safe Abortion Service Procedure 2003* are mammoth tasks. As in many countries where abortion laws were revised from a highly restrictive to a liberal abortion law, the demand for abortion by Nepalese couples is bound to increase for some years and then stabilize.

Most of the government listed CAC centers are concentrated in urban cities and/or district headquarters. Efforts to expand CAC services at peripheral (PHC) levels and in a hospital setting of remote districts continue to pose challenges because of the unwillingness of the doctors to serve at such locations. Even the problems of frequent transfers of government doctors and trained CAC providers from one health facility to another and the delays in providing suitable replacements has been a constant source of frustration. Obviously, women living in remote rural areas are the ones to suffer from the bureaucratic impasse prevailing at health institutions as they have no options but to rely upon unsafe abortion procedures.

Greater challenges are to create community awareness and modify the risk taking behaviours of abortion seekers. Unskilled/clandestine providers within and across the border continue to exploit ignorant women. There is a need to design a comprehensive strategy to uproot illegal abortion practices and this should include public vigilance and monitoring of the illegal sales of banned abortifaciant and harmful drugs within the country, punitive measures to discourage unskilled abortion providers and discouraging women and couples from crossing the border for abortion.

Overcoming the existing bottlenecks in CAC service delivery such as: lack of trained CAC providers on regular basis, short or insufficient time allocated to clients at CAC centers, long waiting hours, high abortion fee, inadequate counseling, etc., are important and require serious attentions. All these interventions cannot be accomplished in a short span of time and by the government sector alone. The active

participation of the private sectors including NGOs, INGOs and donor community is imperative in this respect.

Husbands play crucial role in abortion decision-making including choice of abortion providers. Majority of the rural men are not supportive to women's absolute rights to abortion as guaranteed by the law. It was also discuraging to find certain societies disfavouring abortion by an unmarried woman. Nepal's abortion law guarantees women's absolute rights to abortion and favours abortion by unmarried women. Therefore, future IEC and behaviour change communication programs should target men in creating positive attitudes towards women's abortion rights and involve community based health providers and volunteers to establish referral linkages between women and approved CAC service providers to expand women's access to safe abortion service.

The country's Safe Abortion Procedure 2006 clearly specifies a range of abortion technologies to be adopted by a listed CAC provider or an institution for abortion within 12 weeks of gestation. These are: MVA, EVA, pharmacological and D&C. At currently, only MVA as a surgical method of abortion is being promoted by the government (MoHP). It is equally important is to introduce pharmacological or medical abortion technology in the country so as to provide Nepalese women with an alternative yet safe technology option.

Advances in medical technology have made abortion a very safe procedure. Medical abortion, or the termination of pregnancy using a drug or a combination of drugs, has made it possible for women to induce an abortion without surgical intervention or invasive procedures. In 2005, WHO added *mifepristone* and *misoprostol* to its list of essential medicines.

The government policy has been to concentrate on imparting CAC skills to doctors for handling first timester (within 12 weeks) abortions only. CAC proivders are neither trained nor authorised to handle uterine gestations which are beyond 12 weeks (except Obs&Gyn). Enhancing CAC providers' skills to handle gestations beyond 12 weeks or establishment of higher level CAC referral centers are paramount important to enable CAC providers to deal with abortions up to 18 weeks in case of rape or incest which is legally allowed.

The decision taken by the *National Safe Abortion Advisory Committee* in early 2006 to standardize abortion fee in all government hospitals and also involve staff nurse to provide MVA procedures are highly commendable steps. These are extremely important decisions which can ensure affordability and accessibility of safe abortion service to every woman.

The system of maintaining abortion-related records particularly on PAC admissions due to complications of unsafe abortion at government hospitals pose a serious challenge. In order to establish a post-legalization baseline database on unsafe abortion which can be used for future compassion, it is essential to segregate the records on unsafe abortions from the "unified" PAC clients registers. There is also a need to establish a reliable estimates on national abortion rate for the country through a population based sample survey.

References

Alan Guttamacher Institute, 1999. Sharing Responsibility. Women Society and Abortion Worldwide. New York: The Alan Guttmacher Institute.

"Amazing Year Two of Mifepristone Medical Abortion". 2003. *Mifematters*, 7, p.1. In PPFA-I 2006. Mifepristone: Expanding Women's Options for Early Abortion. [URL: www.plannedparenthood.org/medicalinfo/abortion]

ACOG. 2001. Medical Management of Abortion. ACOG Practice Bulletin, 26: 1-13. American College of Obstetrician and Gynecologists.

Bankole, A., Singh S., Haas T. 2001. Reasons why women have induced Abortion: Evidence from 27 countries. International Family Planning Perspectives. 24(3): 117-127&152.

Boonstra, Heather. 2002. Mifepristone in the United States: Status and Future. The Guttmacher Report on Public Policy. 5(3): 4-7. In PPFA-I 2006. Mifepristone: Expanding Women's Options for Early Abortion. [URL: www.plannedparenthood.org/medicalinfo/abortion]

BWHC, 2002. Menstrual Regulation Training Manual. Akhter N ed. Dhaka: Bangladesh Women's Health Coalition.

Coyaji K, Elul B, Krishna U, Otiv S, Ambardekar S, Bopardika A, Raote V, Ellertson C, Winikoff B, 2002. Mifepristone – Misoprostol Abortion: A Trial in Rural and Urban Maharastra, India. Contraception 66:33-40.

CREHPA, 1996. Public Opinion Survey on Abortion Rights for women. Kathmandu, Nepal: CREHPA.

CREHPA, 1999 Management of Abortion Related Complications in Hospitals of Nepal-A situational Analysis. CREHPA

CREHPA, 2000. Women in Prison in Nepal for Abortion. A Study on Implications of Restrictive Abortion Law on Women's Social Status and Health. CREHPA, Kathmandu.

CREHPA, 2002. Public Opinion Poll on Abortion Law and Service (I). Kathmandu, Nepal.

CREHPA, 2002b. Understanding Culturally Specific Pregnancy Prevention Practices following Unprotected Intercourse among Young Couples of Different ethnic communities of Nepal. Kathmandu: CREHPA, 2002.

CREHPA, 2003. Public Opinion Poll on Abortion Law and Service (II). Kathmandu, Nepal.

CREHPA/Ipas. 2003. Expanding Safe Abortion Services in Nepal: A Rapid Assessment of the Availability and Potential Use of Medical Abortion. Report submitted to Ipas. Kathmandu. 2003.

CREHPA, 2004a. Public Opinion Poll on Abortion Law and Service (III). Kathmandu, Nepal.

CREHPA, 2004b. Report on Translating Research into Policy Advocacy: Public Education and Advocacy Efforts Against Unsafe Abortion Leading to Legal Reforms in Nepal. Kathmandu: CREHPA.

CREHPA, 2005a. Public Education and Advocacy to Enable informed Fertility Decision by Women in Nepal. Year II. Annual Report submitted to the Ford Foundation, New Delhi.

CREHPA/PPFA-International, 2005. Law Enforcers' Knowledge, Attitude and Perceptions about Abortion Law, Women's Reproductive Rights and Safe Abortion. Network for addressing Women's Reproductive Right in Nepal. Kathmandu: CREHPA.

CREHPA/PPFA-International, 2005. Married men and women's Knowledge, Attitude and Perceptions about Abortion Law, Women's Reproductive Rights and Safe Abortion. Network for addressing Women's Reproductive Right in Nepal. Kathmandu: CREHPA.

CRLP and FWLD. 2002. Abortion in Nepal: Women imprisoned. Kathmandu: Center for Reproductive Law and Policy and Forum for Women, Law and Development.

CRR. 2006. Safe abortion: A public health imperative. Accessed from www.reproductiverights.org: Center for Reproductive Rights, April 2006.

Dixon-Mueller, R. 1988. Innovations In reproductive Health Care: Menstrual Regulation Policies And Programs In Bangladesh. Studies in Family Planning Vol.19 (3): 129-140.

Ebrahim, Z. 2003. *Lack of Options in Pakistan: Women Pushed to Abortion.* Shakti: A publication for the 2nd Asia-pacific Conference on Reproductive and Sexual Health. Issue No.1. October 6, 2003. Bangkok, Thailand.

Family Health Division, Ministry of Health and Population, CREHPA, FWLD, Ipas, PATH. 2005. Women's Right to Choose: Partnership for Safe Abortion in Nepal. Bird C ed. Kathmandu: FWLD, 2005

FDA. 2000. *FDA Approves Mifepristone for the termination of Early Pregnancy.* FDA-U.S. Food and Drug Administration. (2000, September 28). Press Release.

FHD/DoHS/MoH 1998 Maternal Mortality and Morbidity Study. Family Health Division, Department of health Services, Ministry of Health, 1998

Family Health Division, Ministry of Health and Population. 2006. Comprehensive Abortion Care listed sites. Kathmandu: Ministry of Health and population, 2006.

FWLD and PPGP, 2003. Struggles to Legalize Abortion in Nepal and Challenges Ahead: Publication No. 70. Kathmandu: Forum for Women, Law and Development and Planned Parenthood Global Partners,

Ganatra B. 2006. Unsafe Abortion is South and South East Asia: A Review of Evidence in Warriner IK and Shah IH, eds., Preventing Unsafe Abortion and its Consequences: Priorities for research and Action, New York: Guttmacher Institute, 2006.

Hewage, P. 1999. Induced abortion in Sri Lanka: Options of Reproductive Health Providers. In: Abortion in the Developing World. Mundigo A, Infriso C, eds. New Delhi: Vistaar Publications; 1999: 321-334.

Hirve, 2004. Abortion Law, Policy and Services in India: A Critical Review. Reproductive Health Matters. 12(24) Supplement: 114-121.

Hirve, S. 2003, *Policy and Practice*. SEMINAR: The monthly symposium. 532:14-19. New Delhi.

Hollander, D. 2000. Most Abortion Patients View Their Experience Favorably, But Medical Abortion Gets a Higher rating than Surgical. *Family Planning Perspectives, 32(5):264.*

Ipas and IHCAR. 2002. Deciding Women's Lives are Worth Saving: Expanding the Role of Midlevel providers in Safe Abortion Care. Chapel Hill, NC, Ipas.

Ipas and FCI. 2004. Paper presented on Addressing Unsafe Abortion: New Guidance on Making High Quality Services Accessible. Ipas and Family Care International. August 2004.

Lakhey B, Tamang A, Gurung R. 2000. Prevention and Management of Septic Abortion in Nepal. Unpublished. Kathmandu: CREHPA.

MoH. 1998. National Maternal and Morbidity Study. Kathmandu: Ministry of Health, 1998.

Ministry of Health (Nepal), New Era, and ORC Macro, 2002. Nepal Demographic Health Survey 2001. Calverton, Maryland, USA.

Ministry of Law, Justice and Parliamentary Affairs, New recommendation on Muluki Ain (National Civil Code) 11th Amendment 2002, Kathmandu: Ministry of Law, Justice and parliamentary Affairs, 1997.

Puri, M. 2001 Sexual risk behaviour and risk perception of unwanted pregnancies and sexually transmitted diseases among young factory workers in Nepal, CREHPA, Kathmandu

Shakya G., Kishore S., Bird C., Barak J. 2004. Abortion Law Reform in Nepal: Women's Right to Life and Health. Reproductive Health Matters. 12(24) Supplement: 75-85.

Shah I. and Ahman E. 2004. Age Patterns of Unsafe Abortion in Developing Country Regions. Reproductive Health Matters 12(24).

Tamang A. 1996. Induced Abortions and Subsequent reproductive behaviour Among Women in urban Areas of Nepal. Social Change. 26(3-4): 271-285.

Tamang A, Lakhey B, Gurung R, 2000. Prevention and management of Septic Abortions in Nepal.

Tamang AK, Puri M, Nepal B, Dahal M, 2000. Women in Prison in Nepal for Abortion. Kathmandu, Nepal.

Tamang AK, Shrestha N, Sharma K. 1999. Determinants of abortion and subsequent reproductive behaviour among women of three urban districts of Nepal. In: Abortion in the Developing World. Mundigo A, Infriso C, eds. New Delhi: Vistaar Publications; 1999: 167-190.

Tamang A and Tamang J. 2005. Availability and Acceptability of Medical Abortion in Nepal: Health Care Providers' Perspectives. Reproductive Health Matters 13(26):110-119.

Thapa S and Padhye S. 2001. Induced Abortion in Urban Nepal. International Family Planning Perspectives. 27(3): 144-147&151.

UNDP, 2005. Human Development Report: International Cooperation at the crossroads. Aid Trade and security in an unequal world. United Nations Development Programme.

United Nations. 2001a. Abortion Policies. A Global Review. Vol. I: Afghanistan to France. New York, United Nations Publication.

United Nations. 2001b. Abortion Policies. A Global Review. Vol. II: Gabon to Norway. New York, United Nations Publication.

United Nations. 2002. Abortion Policies. A Global Review. Vol. III: Oman to Zimbabwe. New York, United Nations Publication.

United Nations Population Division. 1999. World Abortion Policies 1999. New York, United Nations Population Division in World Health Organization. 2003. Safe Abortion: Technical and Policy Guidance for Health Systems. Geneva.

Winikoff B, Sivin I, Coyaji KJ, Cabezas E, Bilian X, Sujuan G, Ming-Kun D, Krishna Ur, Eschen A, Ellertson C, 1997. The Acceptability of Medical Abortion in China, Cuba and India. *International Family Planning Perspectives,* 23:73 – 78 & 89, 1997.

WHO, 1998. Unsafe Abortion: global and regional estimates of incidence of and mortality due to unsafe abortion with a listing of available country data. Geneva, World Health Organization.

WHO, 2003. Safe Abortion: Technical and Policy Guidance for Health Systems. Geneva: World Health Organization.

WHO, 2004. Unsafe Abortion. Global and regional Estimates of the incidence of unsafe abortion and associated mortality. Geneva: World Health Organization.

WHO, 2006. Reproductive Health Indicators , Guidelines for their generation, interpretation and analysis for global montiortion. Geneva: World Health Organization.

Annex I

Abortions in other South Asian Countries: *Law, Policies and Abortion Rates*

1. Bangladesh

Abortion Law in Bangladesh is based on the Penal Code of India 1860. The Penal Code (sections 312-316) permits abortion only for the purpose of saving a woman's life. The law was temporarily waived in 1972 for women who were raped during the war that resulted in the separation of East and West Pakistan and creation of Bangladesh. Despite the restrictive nature of the law, "menstrual regulation" (MR) services have been available in the government's family planning programme. The government does not feel that that this service conflicts with current abortion laws as it provides menstrual regulation as a family planning method and not as an abortifacient (United Nations, 2001a).

The Government of Bangladesh introduced MR services on a limited scale in 1974 and in 1979 it was made available to all government hospitals and health and family planning complexes at the districts and Upzilla levels (Dixon and Muller, 1988). According to the Government regulation, MR can be performed by a paramedic within 8 weeks of missed period and by a doctor within 10 weeks of missed period. MR is widely practiced throughout the country and is available at all levels of health system from district hospital to union level. It is also available at some non-government organizations (NGO) and private clinics.

In Bangladesh, according to a Demographic Health Survey 1993-1994, about 2 percent of a sample of currently married women had unwanted pregnancy which ended in termination and two third of these terminations included Menstrual Regulation and 1.5 percent were induced abortion. It is estimated that 500,000 MR procedures are performed annually in Bangladesh. Most of these MR and induced abortion are conducted by untrained medical personnel and paramedics and also by the traditional indigenous abortion practitioners (BWHC, 2002).

2. Bhutan

Abortion is illegal in Bhutan and the exact status of abortion law in Bhutan is unclear. Because the official state religion of Bhutan is Buddhism, which disapproves of abortion, it is probable that the procedure is allowed only to save the life of the pregnant woman (United Nations, 2001a).

3. India

Abortion is legal in India. The Medical Termination of Pregnancy Act of 1971, which came into effect on 1 of April 1972, significantly liberalized abortion in India. Prior to enactment of the legislation, the Indian Penal Code (Act No. 45 of 1860) permitted abortion only when it was justified for the purpose of saving the life of the woman. The MTP Act of 1971 confers full protection to a registered allopathic medical practitioner against any legal or criminal proceedings for any injury caused to a woman seeking abortion, provided that the abortion was done in good faith under the terms of the Act. The Act allows an

unwanted pregnancy to be terminated up to 20 weeks of pregnancy and requires a second doctor's approval if the pregnancy is beyond 12 weeks. A pregnancy can be terminated if its continuation would involve risk to the life or grave injury to the physical or mental health of the pregnant woman or if there is substantial risk that, if the child were born, it would suffer from physical or mental abnormalities as to be seriously handicapped. The Act also presumes that the anguish caused by the pregnancy resulting from the rape of any woman or from failure of any contraceptive method used either by married woman or her husband for the purpose of limiting the number of children constitutes grave injury to the mental health of the woman.

The law makes exception in the event of abortion to save a woman's life where the doctor need not have the stipulated experience or training but still need to be a registered allopathic medical practitioner, a second opinion is not necessary for abortions beyond 12 weeks and the facility need not have prior certification (Hirve, 2004). Consent of the woman or written consent of the guardian of a woman under the age of 18 or a mentally retarded woman is required before performance of an abortion (United Nations, 2001b).

In India, the annual estimates of abortion vary from 3.9 to 6 million, with some projections claiming upwards of 12 million. Even a conservative 3.9 million annual abortions resulted in about 70 million in the initial 18 years since 1971 compared to official reported figures of 6.3 millions – a gross underestimation suggesting that a majority of abortions are not reported or take place illegally. The abortion ratio (number of induced abortions per 100 pregnancies or per 100 live births) has varied from 1.3 in large scale national surveys to 2.1 based on government statistical sources to about 9 to 14 in micro studies to about 18 to 20 based on projections (Hirve, 2003).

4. Maldives

Abortion is prohibited in the Maldives except for certain certified medical reasons. Abortion is reportedly permitted where Thalassaemia is diagnosed. However, abortion is not permissible in other grounds such as to preserve physical or mental health of the woman, in cases of rape or incest, fetal impairment, economic or social reasons or on request. The consent of the spouse is required for abortion in Maldives (United Nations, 2001b).

5. Pakistan

Until 1990, abortion in Pakistan was regulated by century- old provisions of the Penal Code of 1860, which had been developed in India by the British colonial government and remained in force in Pakistan following independence. Following a 1989 decision of the Pakistan Supreme Court, Pakistan revised its law reformulating a number of its provisions to confirm to the principles of Islamic law. The revised law came into effect provisionally in 1990 and became permanent law in 1997.

Under the new law, abortion offences are divided into categories depending on the stage of pregnancy during which abortion is formed. Abortion carried out before the unborn child's organs have been formed are prohibited except when performed for the purpose of saving a woman's life or for providing necessary treatment. The punishment is the imposition of penalty for a *tazir crime*-that is imprisonment for up to three years if the woman consented and up to ten years if she did not. Abortions carried out after some of the unborn child's organs or limbs have been formed are prohibited unless for the purpose of saving a woman's life. The penalty in general is *diyah*, or compensation to the heirs of the victim by the offender. If the child is born

dead, the amount of *diyah* is one twentieth of that for a full person; if the child is born alive but dies as a result of the act of the offender, a full *diyah* is payable; if the child is born alive, but dies for any other reason, *tazir* shall be imposed consisting of up to seven years imprisonment.

This new law is somewhat ambiguous. It appears to represent an expansion of indications for abortion in early pregnancy. Abortions are allowed not only to save the life of the pregnant woman but also to provide "necessary treatment" a phrase that is likely to encompass threat to health of some sort. On the other hand, the law defines the stages of pregnancy in terms of formulation of organs or limbs according to Islamic law principles. Under the Islamic law, organs and limbs are usually deemed to be formed in a foetus by the forth month of pregnancy. (United Nations, 2002)

Due to lack of data on the incidence of induced abortion, illegal abortion has not been an area of major governmental concern in Pakistan. However, illegal abortion does take place and complications from septic abortions are believed to be a major cause of maternal mortality (United Nations, 2002). Pakistan's maternal mortality ratio is officially reported as 340 per 100,000 live births although the contribution of abortion is unknown. An indication comes from a 10 year old study conducted from 1981 to 1990 by a large hospital in Karachi, which found that one in 10 maternal deaths occurred due to abortion, both spontaneous and induced. Interviews with 499 men and an equal number of women found that though abortion is considered a major sin, induced abortion was the preferred choice for a married couple (Ebrahim, 2003).

6. Sri Lanka

Abortion is generally illegal in Sri Lanka under the Penal Code of 1883. Section 303 of the Penal Code provides that anyone voluntarily causing a woman with child to miscarry is subject to up to three years imprisonment and/or payment of a fine, unless the miscarriage was caused in order to save the life of the mother. The penalty is imprisonment for up to seven years and payment of a fine if the woman is quick with child, a term which refers to an advanced stage of pregnancy when there is perception of fetal movement, as opposed to "woman with child", which simply refers to "being pregnant". A woman who induces her own miscarriage is subject to some penalties. If the miscarriage is caused without the consent of the woman, whether or not she is quick with child, the person causing it is subject to up to 20 years imprisonment and payment of a fine (Section 304). The same penalty is imposed if the woman's death results from any act carried out with the intent to bring about a miscarriage, whether or not the offender knew that the act was likely to cause death (Section 305) (United Nations, 2002).

In 1973, the abortion legalization of the country was studied by a committee of the Medical Legal Society of Sri Lanka, which recommended that the law should be liberalized to allow abortions to be performed to prevent grave injury to the physical and mental health of the mother, in cases where pregnancy resulted from rape or incest, and in cases where there is substantial risk that the child, if born, would suffer from severe physical or mental abnormalities that would cause it to be seriously handicapped for life. No legislative action, however, resulted from these recommendations. (United Nations, 2002)

Despite increased contraceptive use and a highly restrictive abortion law, which allows abortion only for the purpose of saving a woman's life, indirect evidence confirms that widespread practice of induced abortion in Sri Lanka. The Family Health Bureau of Sri Lanka reported 4,279

abortions among 2.4 million women of reproductive age in 1991. According to the medical statistician of the Ministry of Health, however, 25,000 to 30,000 abortions were reported annually throughout the island in the late 1970's and early 80's (Hewage, 1999). Abortion are prevalent mostly among rural and semi-urban women, married women aged 25-39 years, women with two or more children and garment factory workers and FTZ workers (Biregional Conference on Reducing Unsafe Abortion, 2005).

The high incidence of unsafe abortion is a leading cause of maternal morbidity and mortality in Uganda. The abortion rate is particularly high in the north, reflecting in part the increased difficulties faced by women seeking healthcare and contraception because of the civil unrest that has prevailed in the region since 1986, says the study. A recent study entitled "The incidence of induced abortion in Uganda", conducted in December 2005 states "Because women seeking abortions rely primarily on untrained personnel using unsafe methods, a total of 85,000, or 15 out of 1,000 women are treated for abortion-related health complications each year and unsafe abortion is the leading cause of maternal death. The study found that the abortion rate is higher than average at 62 per 1,000 women in the central region of the country's most economically developed area. But it is much higher in the northern region, at 70 per 1,000. The national average stands at 54 per 1,000.

Some women rely on unskilled providers for pregnancy termination, even though medical services are available. While menstrual regulation (MR) is available in rural health facilities in Bangladesh, one study in 1996-1997 showed that only 58 of 143 women seeking abortion first turned to health facilities, while others saw two or three providers; in the end, four of the women had to be referred to the district hospital with serious complications, and one died. For Latin America and the Caribbean, a study found that more than one-half of unsafe abortions occur among women who are in their 20s. This pattern, along with a high rate of sterilization among women in the region to end childbearing when their desired family size is achieved, indicates that many Latin American and Caribbean women turn to unsafe abortion to space births (Mesce, 2005).

Annex II

Reported Abortion related Deaths in the Printed Media

[redacted]

ABORTION RELATED DEATHS DURING PRE-LEGALIZATION ERA (August 1997- September 2002)

ABORTION RELATED DEATHS DURING TRANSITIONAL PERIOD (October 2002-February 2004)

[redacted]

ABORTION RELATED DEATHS AFTER THE INTRODUCTION OF SAFE ABORTION SERVICES (March 2004 – July 2006)

[redacted]

Annex III

Study Team

Principal Investigator
Anand Tamang, Director
Center for Research on Environment Health and Population Activities

Research Associates
Jyotsna Tamang
Bisakha Yonzon Tamang

Field Researchers
Santoshi Thapa
Junee Singh Dangol