Women’s Right to Choose

Partnerships for Safe Abortion in Nepal

2005
WOMEN’S RIGHT TO CHOOSE:

PARTNERSHIPS FOR SAFE
ABORTION IN NEPAL

September 2005

Contributing Organisations:

• Technical Committee for the Implementation of Comprehensive Abortion Care (TCIC), Family Health Division, Department of Health Services, His Majesty’s Government of Nepal
• Centre for Research on Environment Health and Population Activities (CREHPA)
• Forum for Women, Law and Development (FWLD)
• Ipas
• PATH

Editor: Cherry Bird, Project Coordinator, TCIC & Ipas
FOREWORD

Nepal is a small country (area 147,181 square kilometres), with a fast growing population (24,297,059 according to the 2001 census) and a fertility rate of 3.7. The average literacy rate for women is 45% and the median age at marriage for women is 16.6 years. Early marriage and multiple unplanned pregnancies lead many women to seek secret and unsafe abortions. Over the years many women, especially the poor, may have died as a result of complications of unsafe abortions carried out by untrained and unqualified personnel, contributing to the high maternal mortality ratio of the country. In order to address this, abortion was legalised under specified conditions in March 2002, with the Procedural Order enabling the implementation of the new law receiving approval in December 2003. His Majesty’s Government of Nepal, through Ministry of Health, has prioritised the national safe abortion programme, working with many partners, including government departments at central, regional and district level, non-government organisations, public and private sector service providers and international development partners, to implement the new law as quickly as possible and save maternal lives. The government is committed to enabling women across Nepal, regardless of their socio-economic status, to exercise their legal right to access safe abortion services if they have an unwanted pregnancy.

Nepal can take pride in the liberal wording of the new abortion law, which places only the minimum restrictions required in the interests of safety. This has resulted in the establishment of at least one service site (either public or private) in 37 of the 75 districts of the country within the first year of programme implementation. The listing process authorising trained service providers and sites to offer legal safe abortion services is simple, in order to minimise barriers. National standards fully conform to international recommendations and prioritise the needs of women.
Complementing service delivery, the government is also working with partners to disseminate appropriate messages and information about the new law and women’s reproductive health rights. A national behaviour change communication strategy is being piloted in two districts, with the aim of addressing underlying social and attitudinal issues related to abortion.

The achievements of this first year of implementation of the new abortion law have only been possible because of the efforts of many partners and stakeholders, who have worked together for a common cause. The Family Health Division of the Department of Health Services would like to thank all partners who have supported this work in their different ways, including national NGOs such as Center for Research in Environment Health and Population Activities (CREHPA); Forum for Women, Law and Development (FWLD); Family Planning Association of Nepal (FPAN); Marie Stopes International/Sunaulo Parivar Nepal (MSI/SPN) and international development partners such as Ipas, PATH, the Department for International Development (DFID)/Options supported Nepal Safer Motherhood Programme (NSMP) and Support to the Safe Motherhood Programme (SSMP), the GTZ Health Sector Support Programme, and Planned Parenthood Federation of America-International. In sharing some of our learning, we hope this booklet “Women’s Right to Choose: Partnerships for Safe Abortion in Nepal” will help other countries embarking on the process of abortion law reform, and provide useful information for other national programmes working to improve the lives of women.

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Director
Family Health Division
ACKNOWLEDGEMENTS

This booklet is the result of multiple inputs from individuals and different organisations—government and non-government, national and international—reflecting the partnerships involved in the work of implementing the amendment to the Nepal Country Code (*Muluki Ain*) that legalised abortion in Nepal from December 2003. We would like to express appreciation for all the efforts of all those who have been and continue to be involved in the work of making safe abortion services accessible to all women in Nepal, and for their contributions to this booklet. Apart from those organisations listed as direct co-authors—the Technical Committee for the Implementation of Comprehensive Abortion Care (TCIC) of the Family Health Division, Department of Health Services, His Majesty’s Government of Nepal; Center for Research on Environment Health and Population Activities (CREHPA); Forum for Women, Law and Development (FWLD); Ipas; and PATH—other agencies have also made significant contributions to the safe abortion work and the material in this booklet. Chief among these are Marie Stopes International/Sunaulo Parivar Nepal (MSI/SPN); Family Planning Association of Nepal (FPAN); the director and staff of the Maternity Hospital, Kathmandu; the Nepal staff of the British Department for International Development (DFID)/Options Support to the Safe Motherhood Programme (SSMP); Planned Parenthood Federation of America-International’s Asia Regional Office, the Nepal staff of the GTZ Health Sector Support Programme, and the Ford Foundation. Funding for the production and printing of this document was made available by the William and Flora Hewlett Foundation, Fred H. Bixby Foundation and private donors.
# List of Abbreviations

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<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>BCC</td>
<td>Behaviour Change Communication</td>
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<tr>
<td>CAC</td>
<td>Comprehensive Abortion Care</td>
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<td>CBO</td>
<td>Community Based Organisation</td>
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<td>CEDAW</td>
<td>Convention on the Elimination of All Forms of Discrimination Against Women</td>
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<td>CREHPA</td>
<td>Centre for Research in Environment Health and Population Activities</td>
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<td>DFID</td>
<td>Department for International Development</td>
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<td>DHO</td>
<td>District Health Officer</td>
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<td>DoHS</td>
<td>Department of Health Services</td>
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<td>FCHV</td>
<td>Female Community Health Volunteers</td>
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<td>FHD</td>
<td>Family Health Division</td>
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<td>FPAN</td>
<td>Family Planning Association of Nepal</td>
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<td>FWLD</td>
<td>Forum for Women, Law and Development</td>
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<td>GTZ</td>
<td>German Technical Assistance</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<td>IEC</td>
<td>Information, Education, Communication</td>
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<td>INGO</td>
<td>International Non-Government Organisation</td>
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<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<tr>
<td>MBBS</td>
<td>Bachelor of Medicine and Bachelor of Surgery</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>MSI</td>
<td>Marie Stopes International</td>
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<td>MVA</td>
<td>Manual Vacuum Aspiration</td>
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<td>NGO</td>
<td>Non-Government Organisation</td>
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<td>NHEICC</td>
<td>National Health Education Information and Communication Centre</td>
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<td>NHTC</td>
<td>National Health Training Centre</td>
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<td>NSMP</td>
<td>Nepal Safer Motherhood Project</td>
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<td>PAC</td>
<td>Post Abortion Care</td>
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<td>PATH</td>
<td>Program for Appropriate Technology in Health</td>
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<td>PEAP</td>
<td>Public Education and Advocacy Programme</td>
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<td>PHCC</td>
<td>Primary Health Care Centre</td>
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<td>PPFA-I</td>
<td>Planned Parenthood Federation of America-International</td>
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<td>SPN</td>
<td><em>Sunaulo Parivar Nepal</em></td>
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<td>SSMP</td>
<td>Support to the Safe Motherhood Programme</td>
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<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<td>TCIC</td>
<td>Technical Committee for the Implementation of Comprehensive Abortion Care</td>
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<td>ToT</td>
<td>Training of Trainers</td>
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<td>TUTH</td>
<td>Tribhuvan University Teaching Hospital</td>
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<tr>
<td>UCSF</td>
<td>University of California San Francisco</td>
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<td>UK</td>
<td>United Kingdom</td>
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<td>USA</td>
<td>United States of America</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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Introduction and Background

1.1 Introduction

This booklet documents the early steps and achievements in the process of implementing the reformed abortion law in Nepal, highlighting the roles and activities of the many stakeholders involved, which include government departments, local non-government organisations (NGO), the private sector, and international NGOs (INGO). It builds on the material presented in the Forum for Women, Law and Development (FWLD) publication *Struggles to Legalise Abortion in Nepal and Challenges Ahead* [1], forming a companion publication covering the period from September 2002 to April 2005. A range of issues and initiatives are covered, related to the establishment of services, training of staff, monitoring of services, legal points, advocacy and information dissemination, and behaviour change communication (BCC). Reflecting the efforts and input of many partners, it is multi-authored, with each section co-written by those most closely involved in the specific aspect of the work. In this way we hope to present a broad perspective and range of ideas, and to demonstrate the value of a cooperative approach and the potential for fruitful partnership between different organisations working for a common cause, even though they may have very different organisational mandates and ways of working.

Our objectives in compiling this booklet were to:

- Enable the **key stakeholders in Nepal** to review the successes and challenges of implementation of the reformed abortion law to date and identify lessons learned.
Share experiences and lessons learned with other agencies and individuals working in related fields in Nepal (such as programme planners, donors, government representatives and activists).

Share experiences and lessons learned with those in other countries who may be embarking on similar reform processes.

1.2 Background to reform

From a country with one of the most restrictive and strictly enforced abortion laws in the world, where many women received lengthy prison sentences for abortion-related “crimes” [2], Nepal has become a model for change globally. From small beginnings in the 1980s, and increasingly from the mid 1990s, a number of influences were responsible for creating a movement for change. That change finally happened is the result of efforts by many individuals and organisations each of whom, in different ways, recognised the social, financial and human rights costs of the existing law and acknowledged the need for reform. Abortion was finally legalised under the 11th Amendment to the Country Code in March 2002, receiving Royal Assent in September 2002. Fifteen months later, in December 2003, the Procedural Order, which authorises the implementation of legal services and specifies the required conditions and framework, finally received parliamentary approval. Under the new law, which is liberal by any standards, abortion is permitted up to 12 weeks’ gestation for any woman above 16 years on her request. For women under 16 years the permission of a guardian is required, but this is not strictly defined and may be any adult relative or friend. Abortion is also permitted up to 18 weeks’ gestation if the pregnancy is the result of rape or incest, and at any time on the advice of a medical practitioner if the life or health of the woman is in danger or the foetus is seriously deformed or has a condition that is incompatible with life.

Abortion is recognised as a complex social, health, human rights and economic issue, reflecting the multiple threads and influences in the process that led up to legal reform. As detailed in Struggles to Legalise Abortion in Nepal and Challenges Ahead [1], these dimensions refer to:
Public health: Although the exact proportion is not known, unsafe abortions are believed to contribute significantly to Nepal’s high maternal mortality ratio, which is estimated to be 539 per 100,000 live births [3]. In 1998 it was also estimated that more than half of gynaecological and obstetric hospital admissions were due to abortion related complications [4]. Apart from the level of human suffering this represents, the financial implications of treating abortion complications are a huge burden for a developing country with over-stretched resources. The estimated cost of abortion complication management ranges from US$20 to US$133, depending on the severity of the case [5].

Women’s rights: The long prison sentences under harsh conditions meted out for abortion related offences to largely poor and illiterate women, who had no recourse to information or legal support of any kind, constituted a denial of the most basic human rights.

Class: For wealthy urban women, access to relatively safe private (although illegal) abortion services was possible through a loophole provided by the wording of the law and the ability to pay the high fees of private providers or travel to India. Thus the greatest burden from the law was borne by the poorest and most disadvantaged women.

Religious and social values: In a culture where the inferior socio-economic position of women is closely bound to religious beliefs, control of their reproductive health remains with the father or husband and his family. Women are unable to voice any opinion on matters of their own health, still less make any decisions, and are subject to social stigma if they step beyond the accepted norms. The woman often carries the blame for an unwanted pregnancy, even in cases of rape or incest.

Information: Their inferior social position and educational opportunities means women have no access to information about what constitutes a safe abortion, or the difference between abortion and infanticide. Many women imprisoned for “infanticide” had in fact had a spontaneous abortion or miscarriage.

Development: Even after legal reform, the provision of universal access to safe abortion services is a huge undertaking for a developing country such as Nepal, where large segments of the population lack access to basic health services because of shortages of trained staff and resources.
1.3 Preparing for change

From early 2002, when the bill to amend the law was passed by Parliament, the Ministry of Health, through the Family Health Division (FHD) of the Department of Health Services (DoHS), worked to prepare for its mandate to provide safe, affordable legal abortion services. The Abortion Task Force was formed to draft the procedural order for implementation of the amendment and the policy and strategy documents. Membership was drawn from the Nepal Society for Obstetricians and Gynaecologists, the British Department for International Development (DFID) funded Nepal Safer Motherhood Project (NSMP), GTZ’s Health Sector Support Programme, the Centre for Research on Environment Health and Population Activities (CREHPA) and FHD, with technical support provided by Ipas. International papers were reviewed [6] to learn from the experiences of other countries where abortion had been legalised, and many of the recommendations contained in the World Health Organisation (WHO) guidelines [7], available in draft at this time, were incorporated into documentation. Because of this process, the Nepal standards and guidance are among the few around the world that conform to these new standards for safe abortion.
In late 2002, after the amendment had received Royal Assent, the Abortion Task Force was replaced by the Technical Committee for the Implementation of Comprehensive Abortion Care (TCIC), which took on the role of supporting the government in implementing the new law. The TCIC worked with partners to draft the required manuals, organise training, establish listing and monitoring procedures and discuss information and behaviour change issues. A TCIC secretariat was established, initially with three staff: a clinical coordinator, an administrator and a part-time technical advisor. In late 2004 two additional staff members were appointed, a monitoring and evaluation coordinator and a BCC coordinator.

Box 1 summarises the key events in the process leading up to abortion law reform, and Box 2 shows the key associated documents. In line with the lessons learned from the experiences of other countries, such as India, South Africa and Guyana, where many barriers had arisen as a result of complex regulations and lack of health service infrastructure in rural areas [8], the amended law, policies and procedures were kept as simple as possible. The over-arching aim was to ensure that high quality services could be developed quickly in a low resource environment, keeping the needs of women, especially the poorest, as paramount.

<table>
<thead>
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<th>Box 1: Key events in the reform process</th>
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<tr>
<td><strong>Nov 2000</strong>: Government Reproductive Health Steering Committee agrees to support submission of a proposal to amend the abortion law.</td>
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<td><strong>2001</strong>: Proposal accepted and FHD asked to draft a section on abortion for inclusion in the 11th amendment to the country code.</td>
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<td><strong>Feb 2002</strong>: Abortion Task Force formed to draft key documents and lay the foundations for implementation once the law was passed.</td>
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<td><strong>Mar 2002</strong>: Amendment passed – abortion no longer illegal.</td>
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<td><strong>June 2002</strong>: Literature review of global lessons learned in abortion law reform [6], from which basic procedural and programmatic principles were derived.</td>
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<tr>
<td><strong>Sept 2002</strong>: Royal Assent given for the new law, but services still cannot begin without approval of the Procedural Order.</td>
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<tr>
<td><strong>Nov 2002</strong>: 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.</td>
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<tr>
<td><strong>Dec 2003</strong>: Procedural Order approved, enabling services to begin.</td>
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Box 2: Summary of key documents related to abortion law reform

**The Procedural Order:** Defines clinical procedures, service provision facilities, client consent and listing processes.

**The Abortion Policy:** Link between maternal mortality and unsafe abortion made explicit, and need to respect the right of women to informed choice about continuing a pregnancy. Specifies that systems must be easy to implement and administer.

**The Abortion Strategy:** Explains that safe abortion services will 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.

**The Implementation Plan:** Two-year implementation plan drafted, 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 Communication (BCC) strategy:** Outlines a community based approach to behaviour change work to be piloted in two districts.

Core donors involved from the initial stages were Options-UK (through the DFID supported NSMP\(^1\)), GTZ and Ipas, a United States based international NGO focused on safe abortion policy and research, training and services. Other organisations that provided support, mainly working with the NGO sector, were Planned Parenthood Federation of America – International (PPFA-I) and Marie Stopes International (MSI) London. More recently PATH, also United States based, has become a partner, specifically in developing BCC initiatives. National NGOs have also continued to work as partners, collaborating with committed government officials in working towards achieving common goals. Through their

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\(^1\) As of January 2005 NSMP has been replaced by a new DFID funded programme, Support to the Safe Motherhood Programme (SSMP), which continues to support safe abortion efforts.
research, advocacy and coalition building efforts these NGOs played a critical role in creating the momentum that resulted in legal change. **Section 2** explores issues of partnership in more detail.

The success in achieving legal reform and moving rapidly forward with the first stages of implementation owes much to the determination of key players and their willingness to work together. Factors of particular importance were government commitment and leadership; a public health commitment to reducing the high maternal mortality; well organised and committed national and international NGOs; public and political recognition of the significance of the maternal mortality and human rights costs of the previous anti-abortion law; the coming together of partners at the right political moment for a common cause; a comprehensive women’s rights bill that was able to include legal abortion; and an enabling environment strengthened by international treaties, such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Programme of Action of the International Conference on Population and Development in Cairo in 1994. Further details of the reform process and background can be found in *Struggles to Legalise Abortion in Nepal and Challenges Ahead* [1], and also in the paper *Abortion law reform in Nepal: women’s right to life and health* [9].

### 1.4 Initiation of training and services

Although only just over a year has elapsed since abortion services finally became fully legal in December 2003, partners have moved ahead rapidly to implement the new law. Even during the “grey period” between the passing of the bill to amend the law and the final approval of the procedural order, they remained actively involved. Senior and experienced gynaecologists were the first to receive training, in 2003, so that they only required clinical standardisation to begin services. With support from Ipas, a model Comprehensive Abortion Care (CAC) service and training centre was constructed at the Maternity Hospital in Kathmandu. The first client received services on March 18th 2004, and demand grew quickly to an average caseload of 20 clients per day. With support from Ipas and NSMP, a training programme for hospital based physician service providers and nurse assistants was begun at the model centre in April 2004, and there are plans to establish two to
three more training centres within the next year. A simple system has been developed for officially listing trained service providers and sites, and a monitoring system is being developed to ensure that high quality services are maintained.

Service providers have now been trained at 60 sites in 37 districts across the country. Section 3 gives more detail about the training and service delivery programme. Section 4 provides some initial information about clients served in the first year at ten sites across the country.

1.5 Disseminating information and influencing behaviour

In parallel with the provision of services, partners recognised the need to provide accurate information for women and their families about the reformed law, its conditions and provisions, and the availability of services. The need for changes in attitudes and behaviours related to abortion was also recognised, and through the BCC working group of the TCIC these issues were discussed and plans for addressing them drafted. PATH was invited to provide support in the design and piloting of a national BCC strategy (see Section 6) and other partners, such as CREHPA and FWLD, have worked on information dissemination, with the National Health Education Information and Communication Centre (NHEICC) of the DoHS working with FHD to design and disseminate national media messages on radio, TV and through newspapers.

National NGOs have continued their advocacy and information dissemination efforts, both nationally and at district level, through their own programmes and local partners. Both have developed information, education and communication (IEC) materials, which have been shared with the TCIC. The work of CREHPA and FWLD in particular is covered in Section 5.
Partnerships: A Collaborative Approach

2.1 Key issues

Multiple players: From the beginning of the movement for abortion law reform, many different organisations and individuals have been involved in the various processes and activities. Despite their diverse priorities and perspectives, they were united in their commitment to a common cause: to bring change to improve women’s lives. In the early days loose alliances were formed, as individuals and organisations recognised the strength of a united voice. Since legalisation, many of those alliances have grown into longer-term partnerships, with the government taking the lead and acting as the main coordinating body for the national safe abortion programme. The government has a legal mandate to develop policies and strategies that ensure access to quality abortion services for all women. Key responsibilities in designing a comprehensive abortion care programme include: the development of standards, guidelines and curricula for clinical training and services; approval and monitoring of service sites; information and outreach to communities; and behaviour change initiatives. Collaboration with international and national NGOs and the private sector has enabled the government to mobilise resources and move programmes rapidly forward, benefiting from the expertise and resources that partners are able to provide.

Who are the partners?: Key partners active in the national safe abortion programme fall into four main groups:

1. Government bodies: The most directly involved of these are FHD, which carries responsibility for implementation of services, and NHEICC, responsible for public information dissemination. The
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National Health Training Centre (NHTC) is responsible for listing training sites, and the Logistics and Management Division handles the procurement of equipment. Thus although FHD and NHEICC are at the forefront of activities, they are positioned within a complex bureaucracy and subject to the associated regulations and systems. The Ministry of Health provides guidance at policy and procedural level and the Ministry of Law and Justice provides advice on legal aspects of the reform.

2. National advocacy NGOs: CREHPA and FWLD are the most active in abortion related issues among the NGOs. Both play a strong rights based advocacy role, but with a different expertise and focus. FWLD specialises in legal issues at both central and local levels, employing several lawyers with expertise in legal and human rights issues, especially for women. CREHPA carries out research and advocacy on a wide range of health, population and environmental issues. CREHPA’s research has informed policy and played a leading role in documenting the health and economic consequences of illegal abortion on women and the health system (see Section 5). Both organisations have a network of district based partners to support their work at community level, and are thus well placed to support national information dissemination initiatives at district level.

3. Private sector and NGO service providers: There are two local NGO independent affiliates of international NGOs: MSI (local partner Sunaulo Parivar Nepal (SPN)) and the Family Planning Association of Nepal (FPAN), a local affiliate of the International Planned Parenthood Federation (IPPF). Both have headquarters in Kathmandu and branches in different districts. The private sector includes private clinics, hospitals and medical colleges. All of these can be involved in providing abortion services and have resources at their disposal to start up services once providers have received training. Although most of the larger private clinics are based in Kathmandu, a growing number are being established in towns outside the capital, and in particular MSI/SPN and FPAN are establishing a network of clinics in districts across the country (see Section 3). Private/NGO clinics are therefore an important supplement to public sector services.
4. **International NGOs:** Ipas, NSMP (DFID/Options) and GTZ supported planning of the safe abortion programme from pre-legalisation times. Ipas served as the primary technical assistance organisation, working with the TCIC to establish the standards and guidelines for training and service programmes. More recently PATH has begun supporting BCC activities. Ipas and PATH bring both technical assistance and financial resources, although neither has an in-country office and both therefore work directly from their US headquarters. SSMP (the successor to NSMP) and GTZ both provide on the ground day to day support in addition to technical support. Their safe motherhood and reproductive health activities. PPFA-I’s Asia Regional Office based in Bangkok, Thailand, continues to provide technical and financial support for the abortion related activities of local NGOs, such as FPAN, CREHPA and FWLD.

Building a collaborative team: These diverse agencies bring with them a wide range of skills, experiences and resources, which can be complementary or contradictory, depending on the willingness to cooperate and strength of the relationships. Agreement on common goals and a collaborative approach is important to enable stakeholders to share information and work together productively. Clear communication can minimise the competitive aspects of partnerships and reduce the potential for one partner undermining the efforts of others. Partners need to be jointly engaged in the planning process to understand the importance of their role in achieving a balanced, high quality national programme with wider coverage. An early partnership building effort was a joint mapping exercise conducted by the TCIC and partners in 2004, which illustrated the importance of all partners sharing an overview of the broader programme and showed how much individual organisations can contribute.

It is also important to acknowledge the potential impact on programmes of the different styles and approaches of partners. As noted above, the government partners are located within a complex bureaucracy, and decision-making may be slow and cumbersome as a result of the need to observe regulations and systems. On the other hand, the private/NGO sector is more autonomous and able to move ahead with ideas relatively quickly, with little or no external consultation required. The NGOs have the freedom to pursue issues they identify as important,
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and the very nature of their advocacy role may bring them into conflict with government counterparts, or at least they may wish to proceed at a faster pace than is possible for the government.

**Changing roles:** Following legalisation, the roles of at least some of the players changed, so that, even if this was never made explicit, relationships and interactions have needed to be renegotiated. The most striking example of this is the shift on the part of advocacy NGOs, from a position of outright lobbying for legal reform and criticising government policies, to that of supportive partner in the dissemination of information and start up of services. These NGOs also continue to be active in their watchdog role, and are not slow to voice criticisms of the national programme where they feel this is called for. While this may sometimes make for a less comfortable partnership, it does ensure that all partners are kept on their toes, holding everyone, including the government, accountable for progress and solving problems within the programme.

### 2.2 Coordination mechanisms established

**The TCIC and secretariat:** The key mechanism for coordination of safe abortion activities is the TCIC, which is chaired by FHD. The secretariat of four full-time consultants and a part-time advisor is based in FHD and works closely with FHD and NHEICC staff to plan and implement activities. Ultimately the safe abortion work will be completely absorbed into government functions, but at this early stage of intense activity the TCIC secretariat is critical in ensuring rapid roll out of training, services and IEC/BCC activities. The TCIC core group, consisting of the TCIC secretariat, the FHD reproductive health advisor, and representatives from SSMP and GTZ, with technical support from Ipas and PATH, handles most of the planning and management of activities, with the FHD Director responsible for final decisions. The three TCIC coordinators (clinical, monitoring and evaluation and BCC) handle their respective technical areas, with the administrator providing logistical/management services and the advisor giving overall planning and management support and liasing with the donor organisations.

Having fulfilled its advisory role during the start up phase, the full TCIC Committee has now been replaced by a high level government CAC
Advisory Committee, which meets annually to review overall progress and discuss key issues that require policy level action.

The working groups: Originally four working groups were linked to the TCIC, covering four key areas: training, service delivery, IEC/BCC, and monitoring and evaluation. Their purpose was to seek advice from technical experts in order to develop the required detailed plans and materials, and to report back to the main committee for review and approval. Initially the training and service delivery groups, with technical support from Ipas, were very active in coordinating the inputs of clinical experts in the development of training strategies and reference/training manuals and identification of service delivery issues. The monitoring and evaluation group has not been active as a separate group, and this work was in fact covered as part of the training and service delivery programme. Since there was such a clear overlap in the work of the three groups, they have now been replaced by a single training and services group, which meets on a quarterly basis. Now that most of this foundation work has been completed, the focus of planning and management has moved to the secretariat, particularly the clinical coordinator and administrator, and the training and services group plays an advisory role. The monitoring and evaluation coordinator works directly with the clinical coordinator and other relevant government staff, including those within FHD and the DoHS division for Health Management Information System (HMIS), to set up systems and establish a programme of site visits.

Currently the BCC group is very active, meeting at least quarterly. The BCC coordinator is responsible for taking activities forward, with technical support from PATH. This level of activity looks likely to continue for some time, as the BCC pilot strategy will continue to require input by all partners.

Thus in reality two working groups would have been sufficient: one to cover clinical areas and one to cover information dissemination and IEC/BCC.

Partner communications: A flexible approach has been maintained, so that the formal TCIC or working group meetings are generally called in response to an identified need or specific event. This has the advantage of ensuring that people understand that a meeting will only be called if and when there is something of importance to discuss, and they are thus
more likely to make the effort to attend. A potential drawback of this approach is that sometimes there may be long gaps between meetings, with the danger of loss of contact and momentum. In addition to the formal TCIC and working group meetings, extra smaller meetings may be called for specific purposes, as a more efficient way of getting particular pieces of work done. The outcomes of smaller meetings are shared with the larger group, either by email or at a later meeting.

**Building a shared vision:** At formal meetings partners are asked to share details about their own work, and they are involved in reviewing plans, strategies and materials for the national programme. This sharing of ideas and perspectives has been very valuable in generating a common vision and reducing duplication or contradictions between government policy and programmes and private/NGO sector activities. It has also provided a resource base of people to be involved in, for example, the design of materials, mapping of services and IEC/BCC activities, and a foundation on which to build more learning through workshops and other technical meetings that may be arranged.

**Sharing information and resources:** The regular contact and sharing of materials and strategies developed between partners ensures that everyone knows something about the activities of other partners, and can utilise and build on them to maximise the benefits of their applications. A good example of this is the government use of safe abortion materials developed by CREHPA for their Sumarga campaign. Immediately after legalisation, when they first began the programme of district orientation visits, FHD and TCIC were able to hand out these attractively produced information materials before they had time to produce their own specifically designed fliers and leaflets. An additional benefit was the opportunity provided for FHD/TCIC to see the kind of questions asked and the level of understanding in the districts before developing their own materials, enabling them to make these more appropriate, based on local realities.

**Expanding services:** From the beginning of the CAC programme, the private/NGO sector has been ready to provide services, both within the Kathmandu valley and in the districts. It has been a key part of the government policy to work with the private sector, acknowledging the limitations of government resources and the ability of the private sector to fulfil a need (see Section 3).
A national BCC strategy: The process of developing a pilot national BCC strategy is the result of multiple inputs (see Section 6), with PATH carrying out a literature survey, CREHPA undertaking a rapid formative assessment, and government agencies (FHD, NHEICC and District Health Officers [DHO] from selected districts) working with NGO partners (CREHPA, FWLD, PATH and community members) at a number of meetings and workshops. This culminated in a community stakeholder workshop at which perceptions and practices related to abortion were shared and discussed to feed into the draft strategy. Partners will continue to work together to implement the pilot developed in two districts during the next year.

2.3 Challenges

The advantages of working with partners are many, and it is acknowledged that a collaborative approach is likely to result in a better and more widely acceptable final product. However, the path of partnership is not without its challenges.

- **Achieving agreement:** Achieving agreement and understanding between multiple stakeholders, each with differing perspectives and priorities, may be difficult and time consuming. In particular it requires effort to work through fundamental differences in attitude and practice between government and non-government agencies, which arise from their different structures, mandates and ways of working. NGOs may feel frustrated by the slowness and bureaucracy of government systems, while government agencies may feel that NGOs are apt to cut corners in the interests of commercial gain or publicity, and are not willing to comply with proper standards. Given time and the will, each can learn something from the other.

- **Accountability and cohesion:** Ensuring accountability at all levels and a cohesive programme is much more difficult with multiple partners. For example, it is critically important that advocacy and information activities, which may be carried out by both NGOs and government, are matched with service availability, which is currently dependent on government training programmes and registration processes. Creating demand before services are
available may cause public frustration, and it is important to ensure that messages disseminated by NGOs are consistent with those of the government programme.

- **Rapid roll out and quality:** All partners agree that services and information need to be rolled out as quickly as possible, as women’s lives are at stake, and delay may mean more suffering and deaths. However working through partnerships can slow down the pace, because of the review and discussion required and the multiple commitments of partners. The establishment and maintenance of consistent standards of quality is of primary importance, but the approval processes needed to ensure this may cause delays.

- **Resources and time:** For most partners increasing access to safe abortion is only one part of their work, but as a new programme it may demand a disproportionate amount of their time. It is important to acknowledge the reality that other pressing priorities also exist and partners must juggle the demands on their time and resources. Working with the multiple demands on all partners is a major challenge requiring sensitivity, flexibility and careful planning to minimise the burdens on individuals and share responsibilities efficiently and equitably.

- **Distance partnerships:** Since two of the major technical assistance partners, Ipas and PATH, do not have in-country offices, much of the planning and design work has to be done by email, with the occasional international telephone call and short working visits to Nepal two to three times per year. Although this is very cost effective, there is pressure to achieve a great deal during these visits, and careful scheduling is needed to ensure optimal use of time and contact with other partners, who may also have busy travel commitments. The presence of an in-country contact person, who works directly with local staff, acts as a channel for information and ideas, and maintains local relationships, has also proved very helpful. The unstable political situation in Nepal means that carefully laid plans may be disrupted by unexpected strikes or communication difficulties.

- **The global gag rule:** Although there are many agencies working in safe motherhood in Nepal who would be natural partners for the
safe abortion programme, most are unable to work with this issue because US government policy prohibits any non-US NGO that is undertaking abortion related work from receiving US government family planning assistance. This applies to both national and international reproductive health organisations receiving funds from the Office of Family Planning. Some committed national agencies have actually lost United States Agency for International Development (USAID) funding by refusing to discontinue their commitment to safe abortion. Districts are affected by the USAID imposed separation between the CAC and Post Abortion care (PAC) programmes, which means that USAID funded PAC facilities, which are available in more than half the district hospitals across the country, cannot be used for CAC services, although the facilities, equipment and skills required are very similar. In a low resource context such as Nepal this is a serious constraint to the government programme.

- **Mainstreaming safe abortion**: Ultimately safe abortion should be integrated into national reproductive health and safe motherhood programmes, policies and funding allocations. Choices about abortion should be treated as a part of the continuum of a woman’s reproductive life, rather than as a single isolated issue. This may present a challenge as not all partners working in safe motherhood and reproductive health programmes are able or willing to work on abortion, either because of the constraints of the global gag rule or because of their own organisational principles (for example religious mission supported agencies).

### 2.4 Lessons learned

While acknowledging that the partnership approach is not without its challenges, the Nepal safe abortion programme provides an example of how it can work to everyone’s advantage, and how even apparently unlikely partners can work effectively towards a common cause. Our experience shows that a few key points should be borne in mind in order to maximise the benefits and minimise the drawbacks when a diverse group of stakeholders commits to working together. Important requirements are:
A **common vision** that is explicitly agreed and committed to from the beginning. In the case of a national programme such as that for abortion, ultimately the government mandate and responsibility must be respected and supported, although other partners should voice their ideas and advocate for change as needed.

- Willingness to work together as a group and to let organisational and individual **egos take a back seat**.

- **Trust** that all partners will stand by agreements, genuinely work to support the cause and believe in each other’s efforts. This takes time and requires commitment to building relationships.

- **Coordination among donors** to ensure their support is complementary and does not cause confusion or conflicting loyalties within the programme.

- Effective clear and regular **communication**: this means keeping in touch between meetings and sharing ideas and details of activities as well as ensuring open and honest discussion and sharing at meetings.

- A **flexible and adaptable approach** that fosters cooperation and ensures that all partners are willing to adjust their activities and ideas to promote the common goal.

- The **patience and tolerance** to accept that the different perspectives of other partners may be valid and need to be considered fully.

- The evolution of **simple ways of working** together: for specifically agreed tasks small working groups are often more effective, and emails are an easy way to share ideas and discuss plans prior to meetings or as a follow-up.

- Minimising the **number of big meetings** to what is absolutely necessary, as too many can be a burden on busy partners. Generally smaller meetings are more productive, but the outcomes must be shared with the wider group. Conversely it is important to ensure that sufficient meetings (at least quarterly) are held to maintain momentum and a sense of involvement.

- Efficient **secretariat support** is important to ensure that decisions are followed up and arrangements are reliable.
Establishment of Services, Training and Monitoring

3.1 Key issues

When abortion was legalised in Nepal, the priority issue was how to establish high quality safe abortion services across the country as quickly as possible, to ensure that all women could exercise their legal right to choose safe abortion as a reproductive health option. High quality services should incorporate a woman centred comprehensive approach to abortion care, which puts the needs of the woman first in every aspect of the service [10]. Addressing this requires mobilisation of all available resources and the development of an effective strategy for training, service provision and monitoring. In a context of limited health service resources, staff shortages and poor facilities, this presents a major challenge, especially in remote rural areas, where poor communications and transport are the norm, and the effects of the current armed insurgency are seriously affecting health service provision and staff morale. It was agreed that involvement of the private/ NGO sector was critical to the rapid expansion of services, and that it was important to develop an appropriate framework for ensuring consistency of service standards and complementarity.

A second key issue was the need to ensure the support of influential people, such as senior gynaecologists and those with large private practices, who may combine private work with their positions in the public system. It is an unspoken reality that the provision of illegal abortions was a significant source of income for many practitioners, which they are unlikely to relinquish willingly. Opposition on religious and moral grounds was also thought to be a potential barrier, both at central policy level and within communities.
Acknowledging the importance of working with private and NGO service providers to supplement government services and provide a wider choice for women, a third issue was the need to establish simple and robust systems to ensure consistently high standards of quality among all service providers across the country, public and private/NGO and including those in the most remote areas.

### 3.2 Progress achieved

The approach used to address these key issues and begin implementation of services comprised four major components: a training strategy and workplan; establishment of a model service and training centre in Kathmandu; start-up of services at regional, zonal and district hospitals; and design of a simple system for listing both providers and sites and monitoring the quality of services. Planning for the training and services programme was facilitated by two study tours for policymakers and service providers, which enabled them to learn from the model CAC programme in Vietnam, supported by Ipas and PPFA-I.

#### 3.2.1 The training strategy

**Reference and training manuals:** The first step in the development of the CAC training programme was the preparation of national standards and guidelines, which were specified in the procedural order. These were then incorporated into reference and training manuals [11, 12] for trainers and service providers. Ipas worked with the TCIC working group for training to ensure that the reference and training manuals conformed fully to the WHO technical and policy guidance on safe abortion [7], which recommends vacuum aspiration as the preferred method for first trimester (up to 12 weeks) abortions. The reference manual also includes a summary of the abortion law, the reproductive rights of women, and an overview of the different aspects of CAC, such as the use of manual vacuum aspiration (MVA), infection prevention practices, counselling skills and provision of family planning information and services.

**CAC curriculum:** Based on the reference manual, a seven-day competency based training curriculum was designed for teams of physician service providers and nurse assistants from public and private hospitals. Training nurses and doctors together is important in helping the teams
understand the comprehensive nature of the service and how to work together to meet women’s needs. The curriculum was tested during a one-day orientation of senior gynaecologists in government and teaching hospitals to explain the provisions of the reformed law and gain their support for the CAC programme.

**Training of trainers:** Prior to the approval of the procedural order, 20 senior gynaecologists from the Maternity Hospital in Kathmandu, FHD, three medical colleges, two private/NGO clinics (MSI/SPN and FPAN) and five regional/zonal hospitals participated in a nine-day training of trainers (ToT) course, during which they covered material in the CAC training curriculum and clinical training skills. They achieved competency on pelvic models initially, and completed the clinical skills training after the procedural order was approved. Although these senior gynaecologists now serve as model clinicians, providing support and clinical supervision at larger service sites, most have not yet worked as trainers, since the Maternity Hospital is currently the only training site that has been developed. With no opportunity to use the full range of training skills, they will therefore need refresher courses before practising as government approved trainers.

**Selection of service providers:** The first training course for service providers and nurse assistants was organised at the Maternity Hospital centre in April 2004. The main criterion in selecting the first service providers for training was experience with PAC, since PAC service providers are already skilled in pelvic examination and use of MVA. These early trainees were gynaecologists and doctors with bachelor of medicine and bachelor of surgery degrees (MBBS). After achieving competency at the end of the training course, providers and nurses receive a certificate of competency and providers are “listed” by the DoHS, enabling them to legally provide CAC services.

Another key part of the strategy was to select the first providers for training from regional and zonal hospitals, to ensure at least one service delivery point in each of the five regions across the country. Later, teams from district hospitals were included, and the aim is to ensure one to two trained service providers are available at each public hospital in the country by the end of 2006. In the first year of the training programme (May 2004 to April 2005), 25 CAC provider trainings were carried out, each with places for a maximum of four service providers and four nurse assistants (Box 3).
The private and NGO sector: The two non-government organisations most heavily involved from the beginning of the CAC programme are MSI/SPN and FPAN, but there are also many other smaller private clinics and hospitals wishing to provide services, particularly in the Kathmandu Valley. Initially, private/NGO service provider teams were offered free training at the Maternity Hospital centre, provided they met their own travel and accommodation costs. The intention behind this was to encourage them to become listed CAC service providers, thus ensuring consistency of standards across all sectors. This has proved highly successful and there is such a high demand for training from the private clinics and hospitals that separate trainings are arranged for them. It has also been agreed that the private/NGO sector will pay a training fee, thus providing revenue to support public sector training.

Expanding training: Ultimately a decentralised training programme is planned, with training centres in each of the five regions. With support from the DFID/Options supported SSMP, plans are in process for developing the first regional training centre, in the western region. Although the curriculum will be the same, a modular training model will be used, in view of the smaller caseloads and more limited number of clinical staff outside the capital. Trainees will first attend theoretical training sessions in one group, and then divide into smaller groups for clinical practice at different service sites. They will be supported by on-site coaching from experienced local service providers who have received coaching skills training. One to two more public training centres are planned during the next year, with a further two to three the following year. Private/NGO training sites will also be established, provided they conform to the required national standards.

---

Box 3: Training data for the first year of training May 2004 to April 2005

<table>
<thead>
<tr>
<th>25</th>
<th>Trainings have been carried out at Maternity Hospital.</th>
</tr>
</thead>
<tbody>
<tr>
<td>134</td>
<td>Service providers have received training and achieved competency. Of these 102 are from the public sector and 32 from private/NGO clinics.</td>
</tr>
<tr>
<td>89</td>
<td>Nurse assistants have received training, 69 from the public sector and 20 from private/NGO clinics.</td>
</tr>
<tr>
<td>60</td>
<td>Sites are now listed and have at least one trained service provider (39 public hospitals and 21 private/NGO clinics).</td>
</tr>
<tr>
<td>37</td>
<td>Districts now have trained service providers.</td>
</tr>
</tbody>
</table>
Nurse providers: In order to ensure that services are available even in the most remote areas, at primary health care centres (PHCC) and small district hospitals, where there are insufficient doctors, there are plans to begin training nurses as service providers during the next year. The curriculum is being slightly modified to provide additional skills development and practice in areas such as pelvic examinations and assessment.

3.2.2 The model CAC training and service site

A key part of the service provision and training strategy was the early establishment of the model CAC centre at the Maternity Hospital in Kathmandu, with support from Ipas. A disused laboratory was renovated and redesigned to provide a self contained unit with space for a waiting area, private assessment and counselling room, changing room, clinical procedure room (two beds) and recovery area (five beds). There is also a nurses’ station, doctors’ room and training room. Care was taken to design for efficient client flow, client privacy and hygiene.

Orientation was provided for all levels of health workers at the hospital with whom clients might come into contact, to ensure they understand the sensitivity of the issue and treat clients accordingly. Four nurses have been allocated to the unit and have provided excellent support to service providers and trainers in maintaining standards consistent with a model site. All obstetrician/gynaecologists and residents at Maternity Hospital are part of the clinic staff pool and are able to help with services and/or training on a rotational basis. As a result of early outreach and public relations work within the hospital, the hospital administration has been very supportive. Two of the key issues that have been successfully addressed are: avoiding central registration of clients and avoiding their clinical assessment at the general out patient department, both of which may compromise client privacy and increase waiting times.
Services began at the model centre on 18th March 2004, and demand grew very quickly, so that in the first year almost 3,000 women received services, averaging 15 to 20 cases per day. Service is fast and client satisfaction high. Very few complications have been reported and there is almost 100% acceptance of some kind of family planning method, according to the client’s choice.

Collaboration was established with the University of California San Francisco (UCSF) Centre for Reproductive Health Research and Policy. Fellows from the UCSF Family Planning Fellowship programme work with the Maternity Hospital clinic and training programme for periods of a few weeks at a time.

3.2.3 CAC services in the districts

In order to introduce the new programme and inform communities about the change in the law, FHD carries out district orientation visits in selected districts across the country. Key influencecals such as DHOs and other public sector physicians, law enforcers, private sector physicians and managers, women’s group representatives and other community leaders are invited to these half-day events. They are given information about the legal changes and the training programme, and strongly encouraged to begin providing services and disseminating information as quickly as possible. Initially the larger districts were first priority, where services could begin immediately and which could act as a model
For other areas. Later orientation visits have also been used as a way of motivating districts where establishment of services has been delayed for various reasons.

To promote the rapid establishment of services, at the end of the training participant teams develop action plans for their service sites, with guidance from the trainers. They are encouraged to identify key issues they will need to address and think about ways to begin services without waiting for special facilities or resources, which realistically cannot be made available. Existing facilities such as out patient clinics and space within maternity units are commonly used. Three MVA sets are provided for each new site at the end of training, and some sites have also received a basic starter kit to ensure they are able to maintain standards of infection prevention and client comfort.

3.2.4 Private/NGO sector

Both private (for profit) and NGO (not for profit) organisations are eager to participate in government trainings and willing to comply with government standards, in order to ensure their providers and sites are listed under the government system and able to provide legal services. These organisations have moved forward quickly to develop services across the country, and it is clear they can play a valuable role in supplementing over stretched government resources.

FPAN, with support from IPPF and PPFA-I, is currently operating 37 family planning clinics of different sizes and capacity across the country. To date, seven of these have been listed as CAC service sites, two in Kathmandu and five in the districts, and more of the larger sites will be listed as more service providers are trained. Over the next five years a further six clinics are planned, under a new funding agreement with a private donor, and these will also become CAC sites.

MSI/SPN, supported by MSI/London, currently operates 29 clinics in different parts of the country. This was expanded from 18 in January 2004, when abortion services finally became fully legal, and a further 28 new clinics are planned over the next few years, with private funding. Currently ten of the MSI/SPN clinics are listed CAC sites, two in Kathmandu and eight in other districts, and more will be listed as service providers are trained.
The MSI/SPN and FPAN fees are comparable with those charged by public hospitals, and in fact are lower than many (see Section 3.2.8). Their clinics are accessible for rural and urban clients across the country. In the Kathmandu Valley a number of smaller private hospitals and clinics have also sent staff for CAC training and have been listed or are in the process of applying.

Both FPAN and MSI/SPN are also very keen to develop CAC training sites in the near future, which will be an important supplement to the government training programme. Currently there is some frustration that the training capacity at the Maternity Hospital centre is not sufficient to meet the needs of the private/NGO sector, which is causing a bottleneck in their plans for expanding CAC services. MSI/SPN already operates a new and well resourced reproductive health training centre in Kathmandu, which is approved for training doctors and nurses in family planning and sterilisation procedures, infection prevention, counselling and other skills. MSI/SPN has now submitted an application to the Ministry of Health to be registered as a CAC training centre.

3.2.5 Listing of facilities and service providers

According to the procedural order, both service providers and facilities must be approved and listed. Providers are listed when they receive their certificate of competency at the end of their training. A simple system for listing approved service sites (both public and private) has been established, based on the minimum physical resource requirements for safe services, which include at least one trained service provider. Public hospitals are listed automatically once they have a trained provider, but private clinics must be visited by a staff member from TCIC or FHD to check that facilities are adequate. In the case of a large organisation such as MSI/SPN, where all clinics conform to a standard design, an agreement may be reached in the near future whereby this can be waived.

There appears to have been widespread acceptance by hospitals and clinics of the need for safe abortion services, with little overt opposition. As service providers returned from their training, many district public hospitals were able to establish services within a few weeks, although in some places it took longer to make the necessary arrangements. By April 2005, 23 out of the 39 public hospitals and all 18 private/NGO clinics with trained providers were known to have begun providing services. For the remainder, difficulties such as lack of space, staff shortages and
transfer of doctors have delayed service start-up, and in some cases it has not been possible to communicate because of lack of telephone lines.

<table>
<thead>
<tr>
<th>Region</th>
<th>Government sites</th>
<th>Private/NGO sites</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>217</td>
<td>1,007</td>
<td>1,224</td>
</tr>
<tr>
<td>Central</td>
<td>2,994</td>
<td>1,954</td>
<td>4,948</td>
</tr>
<tr>
<td>Western</td>
<td>566</td>
<td>110</td>
<td>676</td>
</tr>
<tr>
<td>Mid Western</td>
<td>338</td>
<td>109</td>
<td>447</td>
</tr>
<tr>
<td>Far Western</td>
<td>130</td>
<td>37</td>
<td>167</td>
</tr>
<tr>
<td>Total</td>
<td>4,245</td>
<td>3,217</td>
<td>7,462</td>
</tr>
</tbody>
</table>

Both the figures in Table 1 and the map shown as Figure 1 highlight the fact that the more accessible central and eastern regions have moved ahead more quickly within the CAC training and service programme, while the remote and less developed western and far western regions still have very limited service availability.

**Figure 1: Map of Nepal showing districts with listed CAC sites**
3.2.6 Monitoring and follow-up

Following the recruitment of a TCIC monitoring coordinator in November 2004, a programme of follow-up support and monitoring visits has begun. CAC monitoring tools have been developed based on existing PAC tools and WHO monitoring principles [13]. More recently the Ipas Performance Improvement tools have also been adapted and introduced. During monitoring visits TCIC staff work with nurses and doctors to identify and address quality of care issues and barriers, focusing particularly on infection prevention procedures, counselling and post abortion family planning. The action plan developed by each team at the end of their training forms a useful base for discussion, and they are encouraged to build on this to improve services.

3.2.7 Clinical equipment and supplies

Initially Ipas supported FHD in obtaining MVA instruments through a local distributor. The first order of 500 sets was funded by DFID/Options under NSMP, and at the end of training, service providers from all newly established government sites receive three MVA sets from this stock, managed through the DoHS logistics and management division. NSMP also provided funding for a more comprehensive set of clinical equipment for the first 12 sites where providers were trained. In future more equipment will be purchased under the DFID/Options Ipas grant, so that less well resourced sites, such as smaller district hospitals and PHCCs, can be given the equipment they need. This will be assessed during follow-up support visits.

3.2.8 Fees for CAC services

The fees charged are set by the individual hospitals and clinics, and among the government sites range from Rs.800 to Rs.1,500, as shown in Table 2 below, which gives a sample of ten sites surveyed across the country. Except in the case of MSI/SPN, the figures shown do not include the cost of drugs, such as painkillers and antibiotics (if needed) and equipment such as gloves and syringes, which averages around Rs.300 extra. Since these additional costs are “hidden”, women do not know in advance exactly what the total cost of the service will be, which may cause problems for those struggling to afford the fee. Records at the Maternity Hospital in Kathmandu show that during the first year of legal CAC services only 13 women received free services. Anecdotal evi-
evidence indicates that very few women receive free or subsidised services in other hospitals, and those who do often have personal connections within the hospital.

### Table 2: List of fees charged for CAC services at a sample of ten sites

<table>
<thead>
<tr>
<th>Institution</th>
<th>Fee (Rs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Koshi Zonal Hospital, Biratnagar</td>
<td>900</td>
</tr>
<tr>
<td>MSI/SPN Biratnagar</td>
<td>1,195</td>
</tr>
<tr>
<td>Dhankhuta District Hospital</td>
<td>900</td>
</tr>
<tr>
<td>Maternity Hospital, Kathmandu</td>
<td>900</td>
</tr>
<tr>
<td>MSI/SPN Chuchhepati, Kathmandu</td>
<td>1,195</td>
</tr>
<tr>
<td>FPAN, Pulchowk, Kathmandu</td>
<td>950</td>
</tr>
<tr>
<td>Dhading District Hospital</td>
<td>1,200</td>
</tr>
<tr>
<td>Western Regional Hospital, Pokhara</td>
<td>1,500</td>
</tr>
<tr>
<td>Lumbini Zonal Hospital, Butwal</td>
<td>900</td>
</tr>
<tr>
<td>Banke Zonal Hospital, Nepalgunj</td>
<td>800</td>
</tr>
<tr>
<td>Seti Zonal Hospital, Kailali</td>
<td>800</td>
</tr>
</tbody>
</table>

### 3.3 Challenges

#### 3.3.1 Training issues

**Dual demands at training centres:** Although the high caseload at the Maternity Hospital unit makes it ideal for competency based training, combining the demands of training and service provision is challenging, placing a great deal of stress on both providers and clients. Supervising the clinical practice needs of trainees slows down services and increases waiting time, often resulting in large numbers of clients in the small waiting room. Planning for adequate coverage of service providers and support teams in the CAC unit requires the commitment of senior administrators, as there is often a shortage of staff and competing demands from other services. This has been addressed by training additional trainers and service providers and negotiating for their release on a rotational
basis from other duties in the hospital. Some financial incentives have also been agreed for trainers.

**Numbers:** Now that the legal requirement for all service providers to receive the approved government training is well understood, it is difficult to keep up with demand for training, especially from the private/NGO sector. More trainers are needed in order to avoid burnout of existing personnel, and more training centres need to be developed to relieve the unit at Maternity Hospital. This is a particular problem for the private/NGO sector, which has expressed frustration at the delays experienced in obtaining places for providers on the training courses, and is part of the rationale for approving private/NGO sites as training centres.

**Release of providers for training:** It is often difficult to get government doctors released for training from small remote district hospitals, since they may be the only doctor on site, serving the whole district. Discussions are underway with Regional Health Offices to establish a system for emergency cover to address this. The situation is exacerbated by the restrictions arising from the global gag rule attached to USAID population funds, which means that it is not possible to combine training for PAC (funded by USAID in Nepal) and CAC, which would save time and maximise use of resources. Training of nurses as providers will help, but this in itself is likely to be challenging, since it will require a longer training period to ensure the nurses are fully competent and confident.

**Nurse empowerment:** Some of the nurse assistants attending the training are quite junior and are not able to influence their seniors and put planned activities into practice, for example regarding infection prevention, when they return to post. Ideally the most senior nurses should be first to receive training, even if they are not directly involved in CAC service provision, so that they can support the programme and ensure services are well managed.

### 3.3.2 Monitoring quality and measuring impact

The monitoring and support visits so far carried out have proved very useful in providing guidance to staff at service provision sites and yielding information about the realities at district level. However, with limited staff and the current insurgency, which makes travelling difficult, it will be very difficult to provide adequate coverage for all 75 districts. A decentralised monitoring system is needed, so that regional training...
centres and regional level staff from different programmes can provide the necessary support.

A critical part of monitoring is the availability of accurate site records, but record keeping is often poor, especially when staff are busy or they rotate between different departments. This area of work is the responsibility of nurses and it will be important to address this during training.

There is also a need for baseline data to measure the impact of the safe abortion programme. Plans are being developed to conduct a nationwide hospital survey to measure the long term impact of the programme on hospital admissions and costs for treatment of complications of unsafe abortion (see Section 4).

3.3.3 Access to services

**Fees:** It has been noted that some public hospitals are charging very high fees, up to Rs.1,500, without regard to the ability of poor women to meet these costs. The need to pay additional costs of around Rs.300 to cover pain management drugs and other surgical equipment, such as gloves, increases this further, and if antibiotics are needed the cost may be even higher. At the very least this situation may add considerably to the stress of a difficult situation for a woman seeking CAC services (see Box 4), and many women may be unable to find the extra money in time. Coupled with this there is a lack of knowledge about systems that may exist for subsidising services for poor women. It has been suggested that this should be addressed by the government setting guidelines for a scale of appropriate fees in public hospitals that is transparent and includes the cost of all the required drugs for a normal case.

**Box 4: The real cost**

The story was told of a woman who went for CAC services at a government hospital, which was an hour’s journey away from her home, having gathered sufficient money to cover her travel costs and the fee, which she knew was Rs.900. When she arrived she was told she would need to pay an extra Rs.300 for the necessary drugs and equipment. This meant she had to spend an hour travelling back to her home and office to borrow more money, and another hour going back to the hospital, where she had her abortion. The lack of clarity about the total fee had added considerably to the stress and expense of her day.
**Gestation period:** At the Maternity Hospital model site, on average, 19% of clients have to be rejected because they present at over 12 weeks’ gestation, which indicates a need for more public information about the meaning of gestation dates and the legal limit of 12 weeks. Although rape victims are legally allowed to have an abortion at up to 18 weeks’ gestation, in the interests of their own well-being, better public education is needed to encourage women with unwanted pregnancies to seek abortion services earlier.

**Quality of care:** It will be important to implement a sustainable performance improvement system that meets local needs and takes account of available resources. Some of the key quality of care issues identified include attention to the need for privacy, infection prevention practices and client counselling. The principles of performance improvement will be introduced during training, with the expectation that it will be an integrated part of each service delivery system and will be linked with the current monitoring and support activities. Given the constraints of distance and travel, implementing this will constitute a challenge.

**Medication abortion:** In order to broaden the choices available to women, medication abortion will be introduced, beginning with a workshop for senior gynaecologists. FHD was concerned that this technology should only be introduced after the MVA technique was widely accepted and available, as it is important to ensure back-up is available for cases in which the drugs do not work or are not appropriate, or for women who wish to make a different choice. There is also a concern that in remote areas where education levels are low the importance of using the drugs very early in the pregnancy may not be fully appreciated.

**Abortion for sex selection:** Already there is a demand for abortion for sex selection purposes, despite the fact that this is illegal. The government must ensure that policies to control this practice, such as enforcing the 12-week limit and prohibiting the use of sonograms for the purpose of sex determination, are implemented effectively.

**Delays in services:** In some areas services have not been established as quickly as hoped, partly because of lack of space and resources, but also linked to resistance by individual doctors who fear loss of revenue from their private services, and see public services as undesirable competition. Some staff view abortion as a non-essential service, since it is an elective procedure, and there is a demand for “incentives” from the fees
charged, in recompense for providing the necessary service. In small hospitals this is easier to address because the doctors providing CAC services have more influence with the hospital management committee, which sets such policies, but in larger hospitals this can be a difficult issue because the CAC service providers are comparatively more junior within the system.

3.4 Lessons learned

3.4.1 Planning and training

**Time:** Everything takes longer than expected, because of barriers and problems that were not predicted. Chief among these in Nepal are the communication difficulties and disruptions caused by the current unstable political situation. More generally, issues such as staff changes, differences in attitudes towards the programme at different levels, and conflicting priorities also have an effect. It is therefore important to build in additional time and contingency plans to account for possible delays. In particular, the establishment of additional training centres outside Kathmandu has been subject to more delays than anticipated, leaving the one training centre at the Maternity Hospital with a heavy training burden.

**High-level support:** Early orientation of senior gynaecologists and district level influential was important in minimising opposition and maximising their support in starting up the programme.

**Training of trainers:** With hindsight, too many trainers were trained too early in the programme, and this should have been left until more training sites were established. Apart from those based at the Maternity Hospital, most of the ToT participants have not had the opportunity to use their training skills and will need a refresher course before working as trainers. For senior physicians outside Kathmandu, a simpler coaching and clinical support course would have been sufficient at that early stage, to enable them to provide support to newly trained more junior service providers.

**Nurse assistants:** Early training of the most senior nurses as provider assistants is important, in order to ensure services run smoothly and sufficient support is available for the service providers.
Follow-up: It is easier to establish an efficient centralised training programme, bringing participants into a training centre, than to provide the required follow-up support from a central base, since this entails a member of staff travelling out to individual service sites. Such visits take time to arrange and carry out, especially if they are in remote locations. For sites where there are difficulties and barriers that require more support, it can be very difficult to keep in touch and ensure the programme moves forward.

Donor coordination: Coordination between the donors involved in the clinical programme, which included Ipas, DFID/Options and GTZ directly, and IPPF and PPFA-I through the NGO sector, was vital to the success of early efforts. Representatives maintained regular communications and were able to complement each other and ensure all gaps were filled. For example, Ipas and PPFA-I co-sponsored the first study tour to Vietnam so that private and public providers could benefit from seeing a high quality CAC programme.

3.4.2 Access to services

Simple systems: The policy of keeping the listing processes simple has paid dividends, as trained providers (both public and private) have been able to begin services quickly without experiencing bureaucratic delays.

Private/NGO sector: Involvement of the private/NGO sector in the service delivery programme is vital. They have the resources and enthusiasm to roll services out quickly and thus ensure maximum geographical coverage and access to services across the country. It is important to ensure these services conform to the national standards and guidelines for consistency in quality.

Fees for services: The government needs to take a strong position in setting guidance for fees in the public sector in order to ensure access for poor women. Hospitals should be encouraged to offer subsidised services for needy women, and to ensure that the set fee is clearly publicised and transparent, including all extra costs, such as pain management drugs and other disposable equipment for a normal case. This should ensure that women know in advance exactly what the total cost will be.
4.1 Key issues

The 11th amendment of the Country Code of Nepal gives all women across the country the right to have access to safe abortion services, whatever their class, caste, family or economic situation, provided the conditions of the law are observed. The Procedural Order specifies that CAC services should be available at reasonable cost and include high quality medical care, with appropriate technologies, counselling and post abortion family planning information and services to prevent future unwanted pregnancies. Services should be centred on the needs of women and ensure they are treated with respect, and their confidentiality and privacy maintained.

In the first year after CAC services began at Maternity Hospital (March 2004 to end of February 2005), a total of 7,462 women received services at 18 public hospitals (4,245 clients) and 21 private hospitals and clinics (3,217 clients) across the country. In order to begin examining the profile of clients who are accessing services, TCIC reviewed data from the records of 577 women from ten selected hospitals and clinics. Although this is not a rigorous piece of research, it provides some initial insight into client profiles and their reasons for seeking CAC services, and a basis on which to build further research. The sample was purposively chosen from among hospitals and clinics where the early caseloads were highest. It represents all five regions and both the public and private sectors, with data from the Maternity Hospital in Kathmandu, six district public hospitals, and three private/NGO clinics (two MSI/SPN and one FPAN), as listed in Table 3.
Table 3: List of CAC service sites from which data were collected

<table>
<thead>
<tr>
<th>Institution</th>
<th>Total cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Koshi Zonal Hospital, Biratnagar</td>
<td>68</td>
</tr>
<tr>
<td>2 MSI/SPN Biratnagar</td>
<td>26</td>
</tr>
<tr>
<td>3 Dhankhuta District Hospital</td>
<td>15</td>
</tr>
<tr>
<td>4 Maternity Hospital, Kathmandu</td>
<td>100</td>
</tr>
<tr>
<td>5 MSI/SPN Chuchhepati, Kathmandu</td>
<td>50</td>
</tr>
<tr>
<td>6 FPAN, Pulchowk, Kathmandu</td>
<td>39</td>
</tr>
<tr>
<td>7 Dhading District Hospital</td>
<td>73</td>
</tr>
<tr>
<td>8 Lumbini Zonal Hospital, Butwal</td>
<td>131</td>
</tr>
<tr>
<td>9 Banke Zonal Hospital, Nepalgunj</td>
<td>20</td>
</tr>
<tr>
<td>10 Seti Zonal Hospital, Kailali</td>
<td>55</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>577</strong></td>
</tr>
</tbody>
</table>

Information about the following client characteristics was collected and analysed:

- Marital status
- Age
- Number of living children
- Reason for seeking termination of pregnancy
- Gestation period at time of presentation
- Caste
- Education level
- Family planning acceptance

Initially the intention was to also look at income levels, but almost without exception clients were recorded as “housewife” with no personal income. The income of the husband or father was not recorded, and it is likely that many women would not know this.

Additional information about issues such as post procedural follow-up and rape cases was also reviewed from the records at Maternity Hospital for the whole year.
4.2 Profile of clients sampled

**Marital status:** The overwhelming majority of clients (98%) are recorded as married, although there is no way of verifying the information given, and it is possible that some clients may feel more comfortable saying they are married even if they are not.

**Age distribution:** Graph 1 shows that the majority of clients (65%) were between the ages of 20 and 30 years, with 20% between 31 and 35 years and 10% above 35 years. Only 4% of clients were aged less than 20 years.

**Number of living children:** Graph 2 shows that only 8% of clients had no living children. About a third had more than five children, 20% only one child, and the remainder (16%, 13% and 8%) had two, three or four children respectively.
Reasons for seeking abortion: Client records were somewhat inconsistent, and it is possible that some women did not want to share their reasons for seeking an abortion. For example 31% simply said it was an “unwanted pregnancy”, without going into more detail about why it was unwanted. The records show that the most commonly cited underlying reasons were “complete family” (50%) and “child spacing” (13%). Failure of family planning method was mentioned by 1% of clients. Other reasons included “socio-economic” (2%), and wishing to continue with their education (2%). (See graph 3). Three cases of rape were recorded. Anecdotal information from Maternity Hospital indicates that some clients appeared to be seeking abortions for sex selection purposes, following a sonogram, although generally they were not explicit about this, and so it does not appear in the records. Since these cases presented at over 12 weeks they did not receive services.

![Graph 3: Reasons for seeking abortion given by national sample of clients, n = 577](image)

Box 5: Access to abortion for a rape victim

One of the rape cases treated at Maternity Hospital was an unmarried girl aged 20 years from the Kathmandu Valley, who became pregnant after being gang raped by thieves who broke into her family home. Her father had heard about the availability of safe abortion services and brought her to the CAC unit. She was clearly still very traumatised by her experience, but her family was grateful that she was at least spared the consequences of carrying a pregnancy to term.

Gestational period: Three quarters of the sample clients presented at eight weeks’ gestation or less, with the remainder presenting at nine to twelve weeks. Detailed records at Maternity Hospital show that during the year 19% of the total number of women seeking abortion services
had to be rejected (and therefore were not included in the service record) because they had passed 12 weeks’ gestation. Hospital staff observed clear indications of the need for better public education about the details of the law, recognition of early signs of pregnancy and the importance of seeking services promptly for both legal and health reasons.

**Caste distribution:** Well over half of the clients (65%) were from the higher castes (Brahmin/Chhetri), with 19% from the Matwali (Tibeto-Burman or hill groups), 8% Newar, and 5% Terai people. Only 4% were from Dalit or occupational castes. This compares with an overall population distribution of these groups of 30% Brahmin/Chhetri, 21% Matwali, 6% Newar, 21% Terai people and 14% Dalit [14]. Although this sample is very small, the indications are that a higher proportion of high caste Brahmin/Chhetri women and a lower proportion of the low caste Dalit groups are accessing services. (See graph 4).

![Graph 4: Caste distribution of national sample of clients, n = 577](image)

**Educational level:** Since the record keeping was inconsistent, with some sites recording only “literate” (which may mean the client attended school or went to literacy classes) while others gave the class level achieved at school, it was impossible to assess the breakdown of educational levels of clients accurately. Overall 30% of clients were recorded as illiterate, 40% were recorded as literate or educated to primary level (class 1-5), 19% were educated to secondary level (class 6-10) and 11% to higher levels (class 11 or 12 or bachelor’s degree). Since the overall national literacy rate for adult women in Nepal is only 28% [15], and these figures indicate that 70% of the women accessing CAC services have had some education, it is clear that proportionately more of the educated population of women (more than double) are accessing safe abortion services, compared with those who have no education. (See Graph 5).
Post abortion family planning acceptance: Almost 89% of clients accepted some form of post procedural family planning method. By far the most popular method is Depo-Provera injections (49%), followed by oral contraceptive pills (16%) and intra uterine devices (15%). Smaller numbers took condoms (6%), Norplant (0.2%) or underwent sterilisation (2%). (See Graph 6).

4.3 Follow-up

Currently the only information available about post procedural follow-up is from Maternity Hospital, where records show that out of the total of 2,874 clients receiving CAC services during the first year, only 133 women (4.6%) returned for some kind of follow-up. In most cases the reasons for follow-up were not serious, and included slight bleeding (24 women), abdominal pain (23 women), and various difficulties with
contraceptive devices. A smaller number (less than 0.5%) had post abortion complications, including infection (3 women) and incomplete evacuation (8 women). In one case a client already had a perforation from a previously attempted abortion, which was successfully diagnosed and repaired, and in another, an ectopic pregnancy was successfully diagnosed and terminated by laparotomy.

4.4 Limitations of the data

Records: One of the key challenges to undertaking this kind of study is the poor standard of record keeping at almost all service sites, especially outside Kathmandu. Records are often incomplete or inaccurate, and this is common to all health services in Nepal. Matters are further complicated by the fact that record keeping systems are still being developed for abortion services so record books have been adapted from other services, such as family planning or obstetric care, without sufficient consideration for their appropriateness.

Timing and weighting of sample cases: Since the caseloads of these sites differ (especially at Maternity Hospital, which is by far the highest), the time period over which the sample clients from different sites received services varies. For the sites with lower caseloads the samples were spread over a longer period, up to six months, but in the case of Maternity Hospital the samples were collected for a period of only a few weeks. Observations during monitoring visits confirm that client profiles do not, at present, appear to differ significantly between sites, and so it is felt that the difference in caseloads at the sample sites does not detract from the validity of the general conclusions drawn from the results. However, there is certainly scope for more detailed research and rigorous analysis in the future, as caseloads build up.

Communications: Under the current unstable political situation, site visits are difficult to carry out, especially for the more remote areas, some of which no longer even have reliable telephone services. Most sites outside Kathmandu do not have email facilities. It is therefore difficult to obtain information from service sites, and even more difficult to verify it. This was a factor in the selection of sites for this survey, since the sites included were those that were easiest to contact and visit.
Client reticence: With a subject as sensitive as abortion, clients are often unwilling to provide any more than the most basic personal information. It is therefore very difficult to be certain about the accuracy of some of the information recorded, for example about marital status and reasons for seeking an abortion. This is compounded by multiple demands on staff time at busy service sites, which are often understaffed, so that client counselling and assessment is given only the minimum amount of time and care.

Reporting of complications: It is particularly difficult to obtain information about post procedural complications, partly because clients may not return to the same site for treatment, and also because records of follow-up may not be clearly linked to those for the abortion service.

4.5 Discussion of results

Access for poor women: One of the key challenges is ensuring that the poorest women have access to services. The data available from this small study provides little information about the socio-economic status of clients, but anecdotal feedback from staff and the information about educational levels and caste/ethnic groups indicates that most of the clients are not from the poorest or most disadvantaged groups, but rather of the middle income levels, with some quite highly educated. There is nothing in the records to indicate whether some services were subsidised and if so how much the women paid, but anecdotal evidence indicates that only a very small number have received free or subsidised services. This highlights the need for a strategy that reaches poor and uneducated women and their families through appropriate information dissemination and subsidy systems.

Public education: This study also reinforces the need for more public education and information campaigns on safe abortion, to ensure that all women, including those from the lower socio-economic groups, receive information about the availability of services, and understand the need to seek services early, the reasons for this and the meaning of “12 weeks’ gestation”.

Social effects of legalising abortion: A concern raised by some of the more conservative policymakers is that easy access to legal abortion may
translate into “loose and immoral behaviour” among unmarried women and girls. This small study shows that the vast majority of women seeking CAC services are married with several children, and wish to limit their family size. Less than 2% of clients were recorded as unmarried, suggesting that, on the basis of this small sample, this concern appears unfounded.

**Sex selection:** There is evidence to suggest that women are seeking abortions for sex selection purposes, and staff at all service sites need to be aware that this is strictly illegal. Policies should make it clear that sonograms should not be used for routine abortion screening, and BCC/IEC materials and posters explaining this should be displayed at all CAC sites.

**Record keeping:** This small study has reinforced the importance of establishing and maintaining good record keeping at service sites and a simple, effective system for collecting key data centrally. Sufficient time must be devoted to explaining this during the training of service providers and nurse assistants, and data requirements should be kept to a minimum to make the task manageable and the data accessible.

### 4.6 Proposed studies

Since abortion care is now a component of the national (government) safe motherhood programme, and has been included under the new DFID/Options programme, SSMP, baseline studies are urgently needed in order to provide a benchmark against which to measure the long-term impact of safe abortion services.

Much of the support for abortion law reform was based on the high maternal mortality ratio in Nepal and the significance of unsafe abortion practices as a contributor to this problem. In order to begin addressing the consequences of unsafe abortion, PAC services were introduced in Nepal in 1995, and are now available in 39 of the 72 hospitals across the country, with a number of agencies (chief among these being USAID) providing support for upgrading facilities and training physicians and nurses at public hospitals. PAC sites provide comprehensive care for women presenting with abortion complications, such as incomplete and septic abortions, whether spontaneous or induced. The availability of
safe, legal and affordable elective abortion services would be expected to reduce the number of women with septic abortion complications presenting at PAC sites and emergency outpatient departments.

4.6.1 The effects of abortion law reform on abortion complications

A proposal is currently being developed by the University of California San Francisco to measure the impact of legalisation by reviewing post abortion complications treated at two major hospitals in Kathmandu, the Maternity Hospital and Tribhuvan University Teaching Hospital (TUTH) over a seven-year period. The research team, comprising representatives from UCSF, the two hospitals, FHD, and local researchers, will review and analyse data from hospital records for three years prior to legalisation and four years afterwards.

The specific objectives of the research are to:

- Document the increase in safe legal abortion services provided in Nepal following implementation of legal abortion services.
- Collect data on abortion complications before and after safe legal abortion services were made available.
- Demonstrate the relationship between the implementation of legal abortion services and complications seen at major hospitals.

4.6.2 Nationwide baseline study/situation analysis

With funding from Ipas and Options-UK, CREHPA will gather national baseline data on abortion seeking behaviour and assess the early impacts of implementation of the new abortion law. A facility-based study will provide national baseline information on safe abortion utilisation rates across the country and assess the impact of the abortion law in reducing the numbers of women with complications of unsafe abortion admitted to hospitals. Data on PAC and CAC cases will be collected over a six-week period from 22 hospitals across the country, selected to cover all five regions and give a representative sample of government and non-government sites and different geographical and social settings. Clients and service providers will be interviewed, and hospital records examined for PAC cases over the last three years and CAC cases since services began.
The main objectives of the survey are to:

- Document the hospital based abortion prevalence rate in CAC facilities and characteristics of clients utilising CAC services.
- Determine the factors facilitating or hindering women utilising CAC services.
- Document clients’ perceptions about the services.
- Assess the extent to which demand for PAC services has increased or decreased as a result of implementation of the new abortion law.

4.6.3 Expected benefits of the research

The results from these proposed studies will help to inform further development of the CAC programme in Nepal in two major ways. Firstly, assessing the impact of the CAC programme in reducing the need for emergency PAC services will indicate whether or not CAC is reaching women with unwanted pregnancies in significant numbers. Secondly, looking at the experiences and perceptions of women who have received CAC services will be an indicator of the quality and accessibility of services, and will provide greater insight into the social realities of these women.

Currently there is very little information available about the true rates of abortion in Nepal, and even less about the providers from whom women have traditionally sought “unsafe” abortions. This means that further research will be needed to give a clearer picture of the situation. The national demographic and health survey planned for 2006 will provide an additional means of gathering nationwide data, which will feed into the development of indicators for monitoring the programme.
The Role of Non-Government Organizations in Advocacy

5.1 Background and key issues

Many national NGOs played an important role in the movement advocating for abortion law reform that grew and developed during the 1990s. Their activities included research, public advocacy and information dissemination, and lobbying of key decision-makers within the government. In particular FPAN, CREHPA and FWLD were key players. From the mid-1990s, their advocacy work and that of other individuals and organisations, with support from INGO partners, stimulated the interest of women’s activist groups, and the issue of abortion gained national profile and momentum.

CREHPA carried out a number of studies on the effects of the illegal status of abortion on women’s rights and welfare, including a survey of prisons in 1997 [16] and a hospital based survey [17]. This work has contributed to a national data base on abortion, complementing a WHO funded longitudinal study carried out in 1992 to 1994 [18] on the types of abortion women undergo in Nepal, and data on the deaths resulting from abortion complications and the cost of post abortion treatment provided at three large Kathmandu hospitals. In 1996, CREHPA conducted a public opinion poll to ascertain the general feeling among the public about legalising abortion [19], establishing that a majority supported the move. CREHPA made extensive use of the press in its campaigns, building advocacy and public education strategies on public health issues, such as maternal deaths and the burden on public hospitals caused by admissions for abortion complications. In 1999 and 2000, members
submitted two policy memoranda to parliament, explaining the case for legalisation of abortion, and in 2001 they worked with FHD on an advocacy paper.

Meanwhile FWLD focused on the legal implications of the existing abortion law, particularly the suffering of women imprisoned for abortion related offences [2]. 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 [20]. 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. A particular issue was the lack of differentiation between induced and spontaneous abortion, which resulted in many women being imprisoned after suffering a spontaneous miscarriage. The lack of understanding of the difference between abortion and infanticide also meant that women could receive sentences of up to 20 years, although the maximum sentence specified for procuring an abortion was only five years. FWLD and other concerned national NGOs worked closely with the INGO, Center for Reproductive Law and Policy2, to draft legislation amending laws in the Country Code that discriminated against women, including the criminalisation of abortion.

After the goal of legalising abortion was achieved, CREHPA and FWLD have continued to work on abortion issues, identifying areas of need and playing the dual role of partner in the government programme (as members of the TCIC group) and watchdog for human rights issues. This requires a delicate balance between advocacy and support, using their campaigning skills, community networks and media contacts to promote the rights of all women in Nepal to make informed reproductive health choices and have access to safe abortion services.

FPAN was also strongly committed to the cause of legalising abortion, working with other stakeholders to lobby decision-makers at policy level. The first bill proposing amendment of the Country Code (Muluki Ain) to legalise abortion was submitted by the Director of FPAN in 1996.

Despite the successful reform of the abortion law, some key issues remain unresolved, and the NGOs have continued to advocate for these.

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2 In 2003 changed its name to Center for Reproductive Rights.
More than two years after the new abortion law received Royal Assent in September 2002, many officials and members of the public still do not know about the legal changes. In some remote areas women are still charged with abortion related offences, and many continue to use unsafe methods in their attempts to terminate an unwanted pregnancy, as highlighted in a study carried out by CREHPA [21]. Information dissemination is therefore a critical need.

The NGOs were also 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. They campaigned actively to highlight the problem and speed up the legal process. FWLD filed a writ petition to the Nepal Supreme Court, requesting it to issue directive orders to the government to prioritise 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 invited to give feedback on the draft Procedural Order, which was finally approved in December 2003.

FWLD has continued its efforts to free women who remain in prison and to provide assistance for those charged with abortion related offences. CREHPA has identified and publicised the high fees charged by some public hospitals as a barrier to poor women accessing services. All partners recognise the importance of ensuring that information dissemination matches the availability of services. Whilst all stakeholders acknowledge the need to advocate against unsafe abortion practices and to spread awareness about the change in the law, it is agreed that creating the expectation of availability of legal abortion services in areas where currently none exist would be irresponsible. A further issue is the importance of ensuring consistency between the messages developed by government and NGO partners.

5.2 Progress and achievements

Since legalisation, the NGOs have joined with government representatives to organise and participate in a number of national health service and policy level workshops. They have continued to carry out studies and public education initiatives, developing a range of advocacy and
information materials that are used in their own programmes and by other partners, including the government. For example FHD has used the CREHPA Sumarga\(^3\) leaflets and posters, as well as FWLD and FPAN materials, as part of its safe abortion district orientation programmes. The energy of these NGOs in maintaining a high public profile for abortion issues and carrying out research, both prior to and since legalisation, has been an important part of national efforts to reduce the suffering of women that results from unsafe abortion practices. They are active members of the TCIC BCC working group and have been key partners in the development of the pilot BCC strategy (see Section 6).

### 5.2.1 CREHPA

In 1999 CREHPA launched the Public Education and Advocacy Programme (PEAP), developing posters and other materials about the prevention of unsafe abortion and organising district level advocacy workshops and community meetings in partnership with 22 district based NGO partners in 16 districts in the eastern region. From 2000, the advocacy strategy was further developed to target the people who most often play a “bridging role” for women seeking advice on health care, including abortions. These include community nurses, paramedics and pharmacists. This strategy recognised the important role such people can play in providing information to guide women away from unsafe abortion practices.

In June 2003, CREHPA initiated a new programme, “Sumarga” (Nepali for “right path”), in partnership with district based NGOs. The objectives include increasing access to information about reproductive health issues and choices, including abortion, creating a positive socio-cultural environment and reducing the stigma associated with abortion, and conducting research to feed into improving abortion programme management. This programme also works with the people who play a bridging role for women, including Female Community Health Volunteers (FCHV) and

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3 Sumarga is the name of the CREHPA safe abortion programme. See Section 5.2.1.
Traditional Birth Attendants (TBA) in rural areas, and public/private networks of paramedics and pharmacists in peri-urban and urban areas. These people receive training to enable them to conduct community group or individual discussions to increase women’s awareness of the new abortion law, the implications of unsafe abortion, and the availability of safe abortion services. To date Sumarga has been implemented in 17 districts across the country, from the east to the far west. As an aid to referral, those in a bridging role are given referral cards to pass on to women who come to them for abortion advice. The women who go to a legal service provider pass on this card, which enables CREHPA to track the number of women who seek safe abortions after receiving information about available services. Follow-up shows that over 50% of the women (approximately 550 out of 1,000) who were provided with these cards used them to access safe abortion services.

**Box 6: A few words**

In one of the Sumarga districts, when CREHPA staff first visited the local police superintendent was heard to say, “Oh, has abortion been legalised? I didn't know”. After explanations had been provided, he was later seen speaking very authoritatively at the public workshop, encouraging all district officials to educate everyone about the new law.

**Box 7: Services provided**

In Bardiya district an unmarried student, who became pregnant as a result of an affair with a fellow student, went to her local FCHV for advice and help. The FCHV referred her to the nearest MSI/SPN clinic. The student later returned to thank the FCHV, saying that the service had been good, there were no complications, everything was confidential and the fees were not too high. She was very happy to be able to continue with her studies.
As part of the process of development of the pilot BCC strategy (see Section 6), CREHPA carried out a major formative assessment research study [22], and will also be involved in carrying out a nationwide baseline study on the effects of the reformed abortion law (see Section 4). CREHPA has conducted three recent public opinion polls on abortion (in 2002, 2003, and 2004) [23, 24, 25] and plans to continue with these on an annual basis as part of the Sumarga campaign.

The most recent poll (2004) shows that, although only 42% of respondents knew abortion had been legalised, the percentage has increased from 26% in 2003 and 22% in 2002, indicating that public information initiatives are having some effect. The level of knowledge about the conditions under which abortion is legal was low (only 37% of the 42% who knew abortion is legal knew about the 12 week limit). Knowledge levels were considerably higher among urban and educated populations, indicating that rural populations need to be targeted. Over half the respondents did not know whether their district hospital had safe abortion services, although three quarters said they would prefer to go to the government hospital rather than a private clinic, mainly because they believed it would be cheaper and a trustworthy service. Almost half expressed willingness to pay a fee, provided it was modest, defined as less than Rs.1,000.

5.2.2 FWLD

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 of decision-makers, advocacy, provision of legal aid and litigation. Specific to abortion, FWLD has taken on the role of monitoring implementation of the reformed abortion law and promoting social acceptance of abortion as a woman’s right.
FWLD has continued to advocate for the women who remain in jail on abortion-related convictions that pre-date the change of the law, as well as those charged since legalisation. Staff have visited districts to gather information from case files about women prisoners, and to interview the women, asking them to sign an authorisation that will allow FWLD representatives to plead their case. Prison staff were also updated about the amended law. Legal arguments were submitted for the release of the women on the basis that abortion is no longer illegal, and the criminalisation of abortion is a violation of human rights that discriminates against women. FWLD successfully represented cases in the Kathmandu District and Appellate Courts and the Supreme Court, and collaborated with the Nepal Bar Association to ensure the provision of legal aid for women in district courts, having followed up cases found to be pending in the district courts.

A memorandum was also submitted to His Majesty the King for a comprehensive pardon of all women in prison on abortion related charges, signed by the women themselves. In June 2003, FWLD identified 58 women who were in prisons across the country for abortion offences. By November 2003 FWLD’s advocacy efforts had secured the release of 23 of these women, and in 2004 a further 21 were released. In April 2005, only 14 remained in prison. 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-I and the Ford Foundation, FWLD initiated a three-year programme, 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 woman’s reproductive right. District level workshops have been conducted in 14 districts to orient law enforcement agencies, such as judges, police and public attorneys, and
doctors about the new abortion law, and to explain abortion related terminologies and international human rights. Police officers and service providers are taught how to handle abortion-related cases within a human rights framework.

In conjunction with the district level workshops, community advocacy discussions are organised through local women’s groups to inform and educate women and their families. The facilitators use interactive “picture board” approaches to explain the life cycle for men and women, highlighting the areas of special need for women and leading on to abortion and its effects. The provisions of the amended law on abortion are explained, and women are told where they can access legal abortion services. This approach is particularly appropriate in communities where many people (especially women) are illiterate or only semi-literate. Following the workshops, many women have approached FWLD for further information about services. Initially the programme districts were selected on the basis of the numbers of women known to be in the district jail on abortion charges, but now they are selected according to government priorities and availability of safe abortion services. This enables FWLD to complement the government district orientation programme.
5.2.3 FPAN and MSI/SPN

As providers of family planning and CAC services, FPAN and MSI/SPN also have local level advocacy and information programmes. The major focus of FPAN is outside Kathmandu, where a network of 37 branch and additional outreach family planning clinics has served the needs of rural communities for many years and provided information about family planning issues. Each clinic uses a team of volunteers, either locally based FCHVs who are paid a small additional travel allowance, or FPAN reproductive health female volunteers, who work in communities providing information and advice. The clinics also have links with local NGOs and community based organisations (CBO) to disseminate information.

The majority of MSI/SPN clinics are also outside Kathmandu, and the numbers are growing rapidly, with an additional 28 clinics planned over the next five years, bringing the total to 57. Like FPAN, MSI/SPN operates outreach clinics on a regular basis, and uses local “promoters” (around 10 per clinic) to disseminate information and refer clients for services.

5.3 Challenges

At a strategic planning workshop on implementation of the abortion law held in Kathmandu in 2004 [26] participants from government and other partner organisations working with abortion identified challenges they perceived to be constraints to effective implementation of the amended law and advocacy about abortion.
5.3.1 Community level issues

- Social attitudes, shyness about reproductive health issues and stigma associated with abortion, especially in rural communities.

- Lack of education and confidence among poor women, coupled with their low status within the family and society—in particular the belief that the husband “owns” the body of his wife.

- Poor knowledge about reproductive health, in particular, lack of understanding of gestational periods and the importance of seeking abortion before 12 weeks.

- Continuing prevalence of non-legal and unsafe but inexpensive services, compared with the currently limited availability and relatively high cost of legal services.

- Communication and travel difficulties in rural areas, where there may be no telephone service and little or no transport.

- The current armed conflict in Nepal, which makes it difficult to move around affected areas and to hold public meetings, and which makes people afraid to speak out.

5.3.2 Legal issues

- Some legal officers say they find the law and Procedural Order difficult to understand and implement. They are not clear about the definitions of terms such as “abortion”, “miscarriage”, “stillbirth” and “infanticide”. FWLD staff observed that many officials are familiar with terminology, but actually have very limited understanding of the concepts that lie behind the words.

- Some officials do not fully understand the link between abortion and human rights.

- Abortion is dealt with under the homicide chapter of the country code, opening the way for abuse of the law and harsh sentences for any abortion related offence.

- It is difficult to determine the truth about incest and rape cases, and often doctors and law enforcers do not know how to handle them. As a result doctors may give vague and confusing reports,
in order to avoid implication in a possible controversy. This may further disadvantage these vulnerable women because the doctor is unwilling to provide support, preferring to “get rid of” the case as quickly as possible.

- Women who have been charged or convicted for abortion related offences constantly change their stories because they are bullied and confused, which makes it difficult to establish the truth of a situation.
- Reporting and record keeping systems are poor in jails and within the court system.
- There is a risk that people will abuse the law by using it for sex selective abortion.

5.3.3 Central level issues

- NGOs find government processes frustratingly slow, which may lead them to be publicly critical, despite agreements to work in partnership.
- NGOs may compete with each other for prestige and funding.

Many of these issues have deep rooted causes, which can only be addressed by sustained efforts at every level. Partners are continuing to implement district and community level orientation and education programmes, using agreed messages and a range of techniques and approaches to reach different sectors of the community. At central level, abortion issues are considered high profile and included in meetings related to broader safe motherhood and reproductive health whenever appropriate. Ultimately abortion needs to be integrated into national safe motherhood efforts, so that messages are spread more widely as part of INGO/donor and government programmes.

5.4 Lessons learned

Despite the challenges outlined in section 5.3, experiences in Nepal show that a government/NGO partnership approach can achieve notable results, even in a relatively short period. The NGOs have wide experience in advocacy and community level work, which can complement
government efforts. The watchdog role of the NGOs is also important in helping government representatives to better understand community issues and attitudes, and to ensure that more appropriate policies and activities are designed and implemented.

- Feedback from the ongoing work of the advocacy NGOs clearly shows that achieving legal change is not the end of the story. Continuing advocacy and education efforts are needed to ensure that women are able to exercise their right to choose safe abortion as a reproductive health right.

- Negative attitudes, whether among high level officials or poor communities, can be changed with the use of appropriate advocacy techniques and dissemination of information. In order to achieve successful results a clear vision, good planning and the use of appropriately designed materials and approaches are essential to generate an environment in which people can speak freely.

- The inclusion of women’s voices in the documentation of legal arguments and the memorandum to the Supreme Court helped to make them more effective. This demonstrates that, with the right support, ordinary women can be empowered as actors in the move for positive change.

- It has been found that, while many people know abortion is legal, perhaps having heard or read something in the media, they have no knowledge about the conditions specified under the law. This indicates the need for sustained multi-media public education efforts.

- Women are willing to pay a modest fee for abortion services, but if the fee is too high it acts as a major barrier for women wishing to access services.

- The experience, knowledge and local networks of NGOs can make an important contribution to government programmes. NGOs have a key role to play in supporting the national programme once legalisation has been achieved.
6.1 Key issues

Experience in many countries has shown that the availability of safe, legal and affordable abortion services is not sufficient to change the care seeking behaviour of women with unwanted pregnancies. In order to encourage women to utilise safe services, and thus achieve the ultimate goal of reducing maternal mortality and morbidity, equal effort needs to be directed towards changing established practices of seeking the unsafe “back street” abortion services that have led to so many deaths and morbidities. BCC, advocacy and public education campaigns are needed to create awareness about the new legislation, modify social attitudes towards abortion, inform women and their families about the availability of safe abortion services and create an enabling environment for them to make informed decisions.

In Nepal, the need to raise awareness about the changes in the legal status of abortion was recognised even before the final approval of the amended abortion law, and the earliest implementation plans included advocacy activities and development of IEC materials. The TCIC BCC working group, which is chaired by FHD and includes representatives from the government, local NGOs and donors, was formed in March 2003 to address the need for national and community level communication initiatives. Since many organisations, including FWLD, CREHPA and FPAN, had already begun disseminating messages about the legal changes and the need to avoid unsafe abortion practices, a key issue was ensuring consistency of information.
Given the deeply entrenched attitudes and behaviours related to unwanted pregnancy and abortion, it was recognised that something more than awareness raising IEC materials would be needed to achieve real change. PATH was invited to provide technical assistance in the development of a national BCC strategy to complement clinical service development and the IEC and advocacy activities of local NGOs. When individuals put their health or the health of others at risk through their behaviour, there is need for a strategic, evidence-based approach to help them reflect critically on alternative attitudes and beliefs and thus adopt new behaviours. This is BCC. A BCC strategy is built on research and understanding of local context, so that the new ideas introduced resonate with individuals throughout the community.

In developing a locally relevant and effective BCC strategy, critical issues are:

- Participation by key stakeholders
- Creating joint ownership
- Understanding the local factors that influence safe abortion access
- Building on available knowledge and experience

All organisations working in communities to raise awareness about health issues look for innovative ways to interest their audience and influence their attitudes and behaviours, and experienced organisations, such as CREHPA and FWLD, have developed their own approaches and techniques. These include research into community knowledge, attitudes and practices in order to identify information gaps and behaviours to target, and working with communities to enable them to develop the messages and approaches they feel are appropriate. To date, interpersonal dialogue approaches, which engage small groups of people who are familiar with each other in non-directive conversations about issues and solutions, have not been widely used in Nepal. Even organisations such as NSMP, which has used interpersonal dialogue approaches to promote other aspects of safe motherhood, has not used these methods to directly address safe abortion access at community level. Thus this approach is new for most of the safe abortion stakeholders.
6.2 Achievements and successes

The BCC working group has played an active role in the development and dissemination of safe abortion messages and the pilot BCC strategy. To address the need for consistency of messages, it was agreed that the group should review all key messages used for awareness raising campaigns and that all messages should be approved by FHD and NHEICC. The first government poster providing basic information about abortion was designed by members of the BCC working group and is being distributed in districts where services are available. It highlights the change in the law, availability of abortion services at sites approved by the government, and the need to seek an abortion before 12 weeks’ gestation if the pregnancy is unwanted.

The pilot BCC strategy has been developed and approved in the space of just over a year, beginning in March 2004. It is based on a process of extensive local participation and consultation, through which a rich body of information has been gathered about attitudes and behaviours related to abortion in Nepal. New approaches and ideas have also been successfully piloted. Through the BCC working group, the process of strategy development has cemented partnerships between advocacy NGOs and government agencies, enabling them to learn together and to each contribute their specific skills and experiences to a common goal.

The essential elements of the pilot BCC strategy developed include raising awareness among professionals and community members through advocacy and IEC materials, and fostering behaviour change through interpersonal dialogue processes, interactive theatre and other communication approaches. All of these efforts are aimed at increasing access to safe abortion care, but use different approaches in response
to the perspectives and experience of the implementing partners and target audiences. The approaches are designed to overlap in ways that reinforce each other rather than duplicate efforts.

The process of developing the BCC pilot strategy can be divided into ten steps, including information gathering (steps 1 to 4), drafting the strategy (step 5), soliciting input from local partners to refine the plan (steps 6 and 7) and meetings, training workshops, and strategy implementation (steps 8 to 10).

**Step 1. Identifying audiences and scope of research:** At a small workshop in February 2004, key government and NGO stakeholders already working on abortion access identified primary and secondary audiences and defined the scope of research needed to assess community based barriers, information needs, and social networks.

**Step 2. Literature review:** This was carried out in April 2004 and helped to identify gaps in information to be addressed through additional research [27]. The results indicated that the main barriers to care were the cost of abortion services, family disapproval of abortion (especially husbands), religious prohibitions, and community censure and stigma. The findings highlighted the need for further exploration of how women and couples make decisions about seeking an abortion, and of the factors that facilitate women’s access to abortion.

**Step 3. Formative assessment:** From July to September 2004, CREHPA and PATH conducted a qualitative formative assessment [22] to fill the information gaps identified at the initial workshop and confirmed in the literature review. The study used data collection methods, such as story-based focus group discussions and key informant interviews, combined with the “figureheads” technique, which proved very effective. In the figureheads approach, one participant plays the role of someone with an abortion or reproductive health related dilemma and solicits advice from a nominated panel of five or six people, each playing the role of a different community figurehead (such as teacher, priest, traditional healer, policeman or doctor). Guided by the facilitator, each figurehead gives advice from the perspective of his/her assumed role, and the remaining participants are encouraged to contribute and build on the advice. This creates a congenial setting in which people feel able to express their views freely.
Step 4. Community stakeholder design workshop: In November 2004, around 60 participants from three districts (Rupandehi, Kathmandu and Bhaktapur), representing a diverse cross-section of both rural and urban communities, spent three days participating in simulations, games, role-play, and discussions [28]. In this informal and unthreatening space participants were able to enact and express their personal views, discuss taboo topics, and share controversial issues and concerns. This was particularly remarkable given the social diversity of the gathering, which included religious leaders (both Hindu and Muslim) and other community elders, high-level local government officers, young wives, mothers-in-law, unmarried young people, female sex workers, and a diverse range of caste and ethnic groups. Only at the end of the workshop were the findings of the formative assessment shared, in order to avoid any bias in discussions. Participants then compared the findings from the workshop with the findings of the formative assessment to identify points of convergence, unsupported findings, and possible gaps. They identified the most credible findings and made strategic recommendations.

Step 5. The draft BCC strategy: Based on the consolidated insights and analyses from the assessment process and the community stakeholder workshop, the draft pilot strategy, “Dialogues for Life” [29], was written immediately after the workshop and passed to partners and stakeholders for feedback. The title reflects the understanding that conversations and decisions about reproductive health and family planning are lifelong endeavours. These dialogues evolve as a couple matures and their family circumstances change.

Step 6. Feedback from partners: The draft document was reviewed within three days by members of the BCC working group, who provided detailed comments and suggestions for improving the strategy based on their experience of working in Nepali communities.
Step 7. Finalising the strategy: Key government and NGO stakeholders who had been involved in step 1 provided feedback on the final draft pilot strategy. It was then reviewed by FHD and NHEICC, and reviewed and approved by the Director General of the DoHS.

Step 8. Implementation plans: In early 2005, detailed activity plans and a timeframe were developed. The implementation plan identifies the specific activities to be carried out and the capacity building needs, and outlines a draft training plan. The process of selecting implementing partners, using a set of agreed criteria, began in March 2005. Namuna, a local NGO, was selected to lead work in Rupandehi district, and FPAN Valley branch to lead in Kathmandu and Bhaktapur, on the basis of their existing experience and programmes in similar work in the areas. They will work through their existing local level contacts and partners. A plan for monitoring and evaluating BCC activities will be developed, which will be further refined by the implementing partners during the pilot phase.

Step 9. Training in BCC skills: The choice of the most appropriate training model was based on available time; number of people to be trained; availability of skilled facilitators; geographical factors (travel difficulties); political considerations (the current Maoist insurgency); social issues, such as absorption capacity and literacy of selected participants; and budget. On this basis, a “drip feed” approach was deemed most appropriate, with training delivered in sequential two- to three-day modules, each building on the previous one and separated by one or two months. Although this approach requires more time, it may be more effective in low-literacy settings, where direct interaction with the primary facilitators is more effective.
Step 10. Implementation: Beginning in summer 2005, interpersonal dialogue groups will be developed, to raise awareness about the new law and generate conversations among women and the people they most trust about reproductive health issues and life choices. Community groups will be trained in the use of “magnet theatre” techniques, which draw people to community spaces to participate in street dramas related to the key areas of behaviour change outlined in the “Dialogues for Life” strategy. These efforts will be coordinated with the IEC and advocacy efforts of groups such as CREHPA and FWLD to ensure message consistency and adequate information dissemination coverage in the pilot sites. After a year of implementation, the project will be evaluated. The results will be shared with the stakeholders consulted in step 1 in order to reach agreement about how to adjust the approach and scale up the effort for wider impact.

6.3 Challenges

The process of developing the pilot BCC strategy has been a steep learning curve for all partners. At the outset, although each partner brought some specific expertise and knowledge to the process, none had a clear view of every aspect. PATH brought international technical experience in research and communication strategies, the advocacy NGOs drew on their Nepal specific community level knowledge, and government partners brought in-depth familiarity with government processes. Partners worked to develop openness and trust, shared their experiences, and worked together to overcome challenges. Specific challenges were related to:

The concept of BCC: Initially most of the Nepal-based stakeholders did not really understand the meaning of “Behaviour Change Communication” and how it is distinct from IEC. It took time for them to accept some of the new techniques and ideas involved.

Selection of community partners: This proved more difficult than anticipated because there were so few community level NGOs with the right kind of experience, capacity and established networks for this BCC work. This was especially true in the Kathmandu Valley, where community structures are not as strong as in rural areas. Even partners with the required experience needed support in learning additional techniques for planning and implementing facilitative dialogue processes.
The BCC processes: Even after understanding of the concept of BCC, community partners find it difficult to accept the long term nature of BCC work, and that it involves more than a one-time awareness raising effort.

The insurgency: The current armed conflict and political instability, which causes sudden strikes and even curfews, has proved a significant constraint in planning visits, workshops and travel to the districts. This is likely to continue to be a key issue for community work, as travel and meetings are often restricted, either by the insurgents or security forces, and people may be afraid to express their ideas openly.

Timing: Linked with the insurgency and other issues, it has proved difficult to maintain the original timeframe envisaged, as plans have been repeatedly delayed by communication difficulties (both nationally and internationally), other demands on the resources of partners, insufficient understanding of the need for official approval processes and how this should be approached, and many other factors.

Human resources: For most of the partner agencies, abortion is only one part of their work, and there are many other demands on their time. This sometimes makes it difficult to arrange meetings, gather input, and review documents quickly. Staff changes are common, particularly in the government sector, and thus experience and institutional memory are lost. It takes time for replacement staff to become fully conversant with all the issues, or for everyone to adjust to a new style of working.

Ownership: Stakeholders need time to achieve sufficient understanding of the issues linked with a BCC initiative to really feel ownership of the process. This is linked with the newness of the concept of BCC, connectedness with community realities, and perhaps a sense of BCC not being part of “my job”.

Linking with safe motherhood: Largely as a result of the global gag rule, which limits the number of agencies that can work on safe abortion issues, but also because of the relative newness of the abortion law reform and the stigma associated with the subject, incorporating abortion into the broader community level safe motherhood initiatives has proved challenging. Safe motherhood groups and activities provide a natural forum for discussions about abortion issues, both at the planning stage and when activities move to community level, and achieving this connection represents a key challenge for the future sustainability of behaviour change related to abortion practices.
6.4 Lessons learned

The BCC working group: This has proved to be a key pivotal mechanism for coordinating activities through an accepted formal base within the government, and legitimising these very new initiatives at each step. The working group has provided a forum for key stakeholders, including both government agencies and national NGOs, to work and learn together and develop a joint sense of ownership. Regular meetings are important in maintaining these connections.

Government processes: Clarity from the outset about the processes required for government endorsement at each stage saves a great deal of time and frustration. It is also important to know which government agencies have responsibility for specific areas and processes, as this may be more complex than originally envisaged.

Ownership: The challenge of generating ownership of the BCC initiative can be approached in two ways: one involves spending a great deal of time talking and explaining, either informally or through workshops, to allow stakeholders to absorb ideas before implementation begins; the other means taking a more proactive line and pushing ahead with activities, so that stakeholders are convinced by seeing the process in action. The Nepal experience has shown that a delicate balance between the two is required. If stakeholders are pushed too hard too soon, then the sense of ownership, and even interest, can be lost, but learning by seeing and doing has also proved very powerful.

Shared commitment: Despite the many challenges, a great deal has been achieved in a relatively short space of time because there has been a shared commitment to the common goal of achieving access to safe abortion services for all women in Nepal, and thus helping to reduce the burden of suffering from maternal mortality and morbidity resulting from unsafe abortion practices.
Challenges for the Future

An enormous amount has been achieved in the relatively short period since abortion services were legalised in Nepal. The passing of the Procedural Order at the end of 2003 enabled the government and its partners to build on preparations already begun and move ahead with the establishment of services, training of service providers, information dissemination, and BCC work. Government and non-government, national and international partners have much to be proud of, not least the success of the partnerships that have been developed and the way in which the different skills, experiences and resources of many organisations have been combined in the development of a holistic programme. The task of building on this positive beginning, to ensure that all women in Nepal know about and are able to choose and access safe legal abortion services when they need them, is considerable, and will require continuing efforts from all partners. This section summarises the key accomplishments and challenges for the future emerging from the preceding sections.

7.1 The context

As one of the least developed countries of the world, Nepal faces fundamental challenges that will take decades to resolve. These include human and financial resource constraints and social and geographical factors that mean public health services are already overstretched and inadequate, particularly in rural areas. The extreme poverty in which a large proportion of the population exists means that women and their families must work unceasingly simply to survive. Levels of education
and access to information are low, and few resources are available for health care, particularly for women’s health. Travel in hill and mountain areas is difficult and time consuming, and communication systems are limited or non-existent. Compounding this, the current political insurgency has totally disrupted the lives of many people, especially in rural areas, making it difficult to move around or hold public meetings. Frequent strikes and general unrest are a significant constraint on all development work.

Against such a background of need and suffering, implementing a new service and introducing new ideas poses a significant challenge. Despite this, the national safe abortion programme has moved ahead, proving that, with support and commitment from different partners, it is possible for CAC services to be established quickly in low resource settings, so that women are able to choose this option for ending an unwanted pregnancy.

7.2 Demand for services

Already it is clear that the demand for abortion services is high, as a result of unmet family planning needs, among other factors. Despite 40 years of work in family planning, it is estimated that only 59% of the demand is being satisfied [30], and only 39% of married women of reproductive age use some form of contraception [30]. Low levels of education and the low status of women in the family and society mean that women have little decision-making power in matters of their reproductive health and little knowledge about their own biology. Under
these circumstances, desperate women faced with another unwanted pregnancy traditionally turn to inexpensive local abortionists, often with tragic results. Partners in the safe abortion work are working to meet the challenge of changing this pattern of behaviour by addressing underlying causes as well as providing access to safe abortion services. This includes programmes at community level to educate women and their families about reproductive biology and providing post-abortion family planning advice and services.

The position of women: Most fundamentally, the low status of women, their poor levels of education and the prevailing attitude that they are “owned” by their husband and his family are major barriers to women’s access to safe abortion services. Along with many safe motherhood initiatives, TCIC and its partners are addressing this by working with families and communities to help people begin to question and ultimately to change these attitudes.

Social acceptance: Although there has been little evidence of overt moral opposition to abortion, evidence gathered by different partners indicates that some stigma is attached to abortion, and that attitudes may be ambivalent, depending on the situation and the individuals involved. For example people might accept the idea of an abortion for their own daughter, to hide family shame over an unwanted pregnancy, but they may have different standards for a daughter-in-law or neighbour. Addressing these subtleties is an important part of community behaviour change work.

Choosing safe services: The stigma associated with abortion means women may be reluctant to go to a public hospital for services, and may prefer to go to a local abortionist, even if the service is unsafe, in the interests of secrecy. An important part of the CAC training programme is ensuring that service providers understand the need for confidentiality and that facilities are set up to support this, for example by enabling women to go straight to the department providing CAC services and avoid central registration and assessment. Cost is also a significant factor for poor women, who may not be able to afford the fees charged for safe services. Facilities are encouraged to keep fees at an affordable level and to offer subsidised services for women who are too poor to pay.

Information dissemination: The first requirement for making an informed decision is accurate information. This should cover: details of the provisions of the law; basic biological facts about reproductive health,
including the meaning of gestational times; and facilities at which legal services are available. The geographical conditions of Nepal, low levels of education in rural areas, and the insurgency mean that designing and implementing strategies that ensure everyone receives this basic information will be challenging. A combined approach is being used that includes the development of a range of appropriate materials; use of different media, especially radio, which has been found very successful in safe motherhood work; and work with community groups and networks. Government and non-government partners will continue to work closely to ensure consistency and complementarity of efforts.

7.3 Access to services

From the moment abortion was legalised in Nepal, it was clear that the key challenge would be to ensure the availability of safe, high quality abortion services for all women in Nepal as quickly as possible. Despite the success of the start-up phase of training and establishment of services, this remains a critical issue, which can be broken down into three major components.

Training service providers: A strategy is currently being developed for scaling up the programme to train sufficient service providers to cover the whole country as quickly as possible, so that listed service providers are accessible to women in all parts of the country, whatever their socio-economic status. In rural areas, where there are insufficient numbers of doctors, this means training nurses as service providers, and ensuring that where nurses are the only service providers there is a clear line of referral to deal with any complications or emergencies. It requires decentralisation, including the establishment of both government and non-government training centres outside Kathmandu to supplement the existing model site at Maternity Hospital, and developing infrastructure and institutions that make it as easy as possible for doctors from rural areas to access training and support.

A strategy will also be developed for introducing medical abortion to make this choice safely available for women.

Improving facilities: The facilities in most hospitals and health posts are limited, and some hospitals have cited lack of space as a reason for not starting services. The prohibition on the use of US government funds
for abortion related activities, which means that existing PAC facilities cannot be used for elective abortion services, removes the possibility of this as a solution. Hospitals are supported through the TCIC monitoring system, to help them identify and develop appropriate spaces that will enable them to provide high quality services.

**Monitoring and standards:** In any programme, monitoring of quality standards poses the greatest challenge, as it requires high inputs of resources and staff time. Currently in Nepal basic standards in many hospitals and health posts are minimal, and there is little appreciation of the importance of such issues as proper infection prevention practices, good record keeping, good client relations and maintenance of privacy and confidentiality. Support is needed to ensure that the internationally accepted standards for high quality safe abortion services are met. Currently this support is provided through the TCIC monitoring system, and there are plans to decentralise this, working through the regional training centres that will be developed and the existing regional health offices, with back-up support provided from the centre in Kathmandu.

Most importantly, as it is scaled up, the safe abortion programme needs to be integrated into broader national safe motherhood initiatives, so that it is accepted as a part of the range of reproductive health choices for women, rather than becoming a “stand-alone” vertical programme. Although many organisations are unable to support abortion work because of the global gag rule, TCIC and FHD are working closely with the DFID/Options programme to promote this integration at the national level.

### 7.4 Legal issues

The passing of a liberal and explicit amendment to the abortion law does not mean that all legal obstacles to safe abortion have been removed. Although the majority of women in prison for abortion related charges have been released, a few unresolved cases remain. There is still confusion among some law enforcement agents about the differences between infanticide, abortion (spontaneous and induced) and stillbirth, and a continuing programme of education will be required. Rape and incest cases pose special problems which many service providers and
law enforcement agents are ill equipped to deal with. The advocacy NGO partners are addressing these issues through their community programmes, complementing the government orientations for district level law enforcement agents and service providers. Finally, anecdotal evidence from the clinics suggests that some women are attempting to procure abortions for sex selection purposes, and it will be important to educate service providers during training, to ensure that this does not become widespread. The current policy of not using sonograms for screening and of ensuring that abortions are performed within the first trimester, in accordance with the provisions of the law, is intended to reduce the potential for sex selective abortion.

7.5 Summary of key lessons learned

7.5.1 Planning and partnerships

- Obtaining high-level support for legal reform and the implementation of services and other activities is essential to success. Individuals and organisations may have different reasons for supporting the liberalisation of abortion law, and it is important to speak to and accept all of these to make the process work.

- Partnerships require a common vision and close coordination, as well as someone to record decisions and remind people of what they promised to do.

- Simple systems at every level are key to rapid roll out of an effective programme. This means setting up simple systems for training and approving providers, and tracking services provided, keeping messages simple and clear (safe abortion services save women’s lives), and having as few big meetings as possible. The TCIC approach has focused on training a minimum number of service providers at all sites over the country before trying to train entire (larger) sites.

- It is more effective to plan for a broad based national programme for services, which includes inputs from all possible partners (public, private and NGO) rather than spending time developing small perfect pilots. It is particularly important to develop services and disseminate information in rural areas, as this is where the need is greatest.
• BCC approaches need to be thought about early, but the full range of activities should not be started until services are in place and can meet the demand created.

7.5.2 Training and services

• Clinical services need to be placed within the framework of women’s reproductive rights and the law.

• After the initial piloting, services should be developed at district level as rapidly as possible, followed by the establishment of decentralised training sites. Simple quality-of-care monitoring systems need to be developed that fit in with existing practices, so that routine monitoring is incorporated with other health facility and service monitoring.

• It is important to think about the process as a whole at the beginning, in order to prepare for the next step and be aware of how the steps link to each other. For example, development of written standards and guidelines for training and services, planning roll out of services, and drafting proposals for baseline studies or needs assessment can begin as soon as it looks as though the reform of the law will be passed.

• Monitoring and evaluation must be included in training and service start-up, to ensure it is understood and accepted from the beginning.

• Including the private/NGO sector as partners from the beginning is important, since they have the capacity to provide services quickly and effectively to supplement government services. Close cooperation is also the best way of ensuring consistency of standards.

• Services need to be geared to the needs of poor women, as they are likely to meet more barriers to accessing services. In particular this means examining the cost of service delivery and setting a government-recommended cost from the beginning. It also means thinking about how to reach the poorest women with information about service availability.

• CAC services need to be integrated within a broader framework of safe motherhood as soon as possible, especially where unsafe abortion is a main contributor to maternal mortality and morbidity.
• Learning from international experiences and following WHO standards and guidelines made it easier to establish high quality services quickly. Focusing initially on the model site at Maternity Hospital worked well, as it was easy to monitor and modify techniques, and doctors who came for training could see and experience a busy CAC unit.

This has been a time of great political conflict and change in Nepal on many levels, yet huge strides have been achieved in the safe abortion effort in a relatively short period. Cooperation between a multiplicity of individuals and organisations resulted in the reform of a very strictly implemented anti-abortion law, and the passing of a liberal amendment that permits abortion in the first trimester for any woman on her request, and beyond the 12-week gestation period under specified conditions. This liberal law and the simple and clear provisions laid out in the Procedural Order laid the foundation for rapid establishment of safe abortion services in districts across the country. Over half of the 75 districts now have at least one trained CAC service provider.

However, there are still major challenges to address. Many of the remaining districts are very remote and some do not have a single doctor, which means that starting services will require more effort and resources. Training nurses as service providers will be a key part of the strategy for reaching these areas. Decentralising training and monitoring, linking, and ultimately incorporating these activities with existing health system structures and safe motherhood initiatives will also be an important focus for the future.

Ensuring that clear information and messages are disseminated to all parts of the country to discourage unsafe abortion practices and to encourage women to choose safe abortion services is also a major challenge. This will be addressed in partnership with advocacy NGOs and those INGO programmes that are able to work on abortion. Linked with this, strategies for scaling up the pilot BCC strategy to all districts will be needed, in order to address some of the deep rooted attitudinal barriers faced by women with unwanted pregnancies.
REFERENCES


