Abortion Incidence and Unintended Pregnancy in Nepal

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150 word abstract:

Although abortion is legal in Nepal, it had until about a decade ago been severely legally restricted. The 2002 amendment to the law made abortion more accessible to women, but abortions continue to be provided by illegal providers in unsafe conditions. There are currently no reliable estimates of abortion incidence. Only incomplete data on legal procedures reported by authorized facilities exist. In this paper we seek to fill this knowledge gap by conducting the first national study of abortion incidence, both legal and unsafe. The study will produce national and regional estimates of incidence of all abortions, of unintended pregnancies, of the incidence of treatment for abortion complications in health facilities, and of barriers to accessing legal abortion and postabortion services. We will obtain a baseline measure of abortion incidence, and provide information for improving policies to reduce unsafe abortion, unintended pregnancy and unmet need for contraception.

1. Introduction

Prior to its amendment in 2002, the abortion law in Nepal was highly restrictive: abortion was permitted only to save a woman's life.[1] According to studies published before 2001, unsafe abortion was prevalent and deaths from abortion-related complications accounted for more than half of maternal deaths that occurred in major hospitals.[2] In 2002, the Penal Code of Nepal was amended to grant all women the right to terminate a pregnancy up to 12 weeks' gestation on demand, up to 18 weeks if the pregnancy is due to rape or incest, and at any gestational age - if the woman is advised by a doctor that the pregnancy poses a danger to her life or physical or mental health, or in cases of fetal abnormality or impairment.[3] The amendment was passed with little opposition. Strategies for implementing the law have been developed in the past decade, including provision of training in abortion services, provision of equipment, and certification of

[1] Henderson JT et al., Effects of abortion legalization in Nepal, 2001-2010, *PLOS One*, 2013, 8(5):e64775.
[2] Henderson JT et al., Effects of abortion legalization in Nepal, 2001-2010, *PLOS One*, 2013, 8(5):e64775; Khanal V et al., Practices and perceptions on contrapceitve acceptance among clients availing safe abortion services in Nepal, *Kathmandu University Medical Journal*, 2011, 35(3): 179-184.
[3] Samandari G et al., Implementation of legal abortion in Nepal: a model for rapid scale-up of high-quality care, *Reproductive Health*, 2012, 9(7).

health facilities to increase coverage of abortion services throughout the country. [4] According to the current law, induced abortion is permitted without restriction as to reason in the first trimester, and this service is expected to be provided at all government approved health facilities, and must be performed by government approved providers. Second and third trimester abortion services can be obtained at government approved facilities only if an approved medical provider authorizes it.[5]

There are no reliable estimates of abortion incidence in Nepal from before the law was changed in 2002, and the estimates since the change are based only on numbers of legal procedures reported by facilities authorized by the Nepal government to provide an abortion. In this paper we seek to fill a major knowledge gap by conducting the first-ever national study of the incidence of induced abortion, both legal and unsafe. The study will produce national and regional estimates of the incidence of legal and of unsafe abortion, and of unintended pregnancy, and national and regional estimates of the incidence of treatment for abortion complications in health facilities. We will also provide information on barriers to accessing legal abortion and postabortion services, and ways to improve coverage and quality of these services.

Without such data, the need to address the issue as a major public health concern would be lacking, as the detrimental consequences of unsafe abortion can easily be ignored.

The difficulty with estimating abortion incidence is that due to fear of stigma, women tend to underreport abortion events, even where abortion is legally permitted under broad conditions, and surveys using women's own reports of abortions typically underestimate abortion incidence. As a result, abortion incidence often has to be estimated indirectly. The Guttmacher Institute has developed a methodology, called the Abortion Incidence Complications Methodology (AICM), to estimate abortion incidence, which has proven to be useful in settings where abortion is severely legally restricted, as well as in contexts where both legal and unsafe abortion are common, such as in Nepal.[6] For this study we build on the Institute's prior experience in estimating abortion incidence across the developing world to estimate the abortion incidence in Nepal.

Data and methods

The application of the AICM depends on information obtained from two surveys: The Health Facility Survey (HFS) and the Health Professionals Survey (HPS). The HFS collects data on the

[4] Rocca CH, Unsafe abortion after legalization in Nepal: a cross-sectional study of women presenting to hospitals, *Epidemiology*, 2013, 120(9): 1075-1083.
[5] Henderson JT et al., Effects of abortion legalization in Nepal, 2001-2010, *PLOS One*, 2013, 8(5):e64775.

[6] Singh S, Remez L and Tartaglione A, eds., *Methodologies for Estimating Abortion Incidence and Abortion-Related Morbidity: A Review*, New York: Guttmacher Institute; and Paris: International Union for the Scientific Study of Population, 2010.

number of women treated for abortion complications as well as the number of abortions provided at a nationally representative sample of public and private health facilities across Nepal. Along with information on postabortion complication care and abortion services provided at the facility, the HFS also obtains information on whether women are rejected for abortion services, the reasons they are rejected, and whether women are referred to other facilities for both abortion services and for treatment of abortion complications. Additionally, the survey collects information on postabortion counseling and the typical family planning methods used by postabortion patients and by women obtaining abortion procedures.

The HPS is a survey of in-country experts knowledgeable about the abortion situation in the country. The survey asks the respondents for their opinions and perceptions in order to collect information on the distribution of women according to the type of providers that they go to for abortion services, the proportion of women who experience complications that need treatment in a facility for each type of provider, and the proportion of women with such complications who will receive care in a health facility. This survey provides information on the conditions under which women access abortion services. It takes into account the varying experiences of poor and better-off women living in both urban and rural areas. This information is used to estimate the proportion receiving facility-based treatment for abortion complications among all women who have an abortion. This information is in turn used to obtain a multiplier or inflation factor to estimate the proportion of women who have unsafe abortions (i.e. experience complications), and do not get medical care at facilities as well as women who have uncomplicated abortions outside of health facilities.

The data from these two surveys combined with information from other sources including age specific fertility rates, the distributions of women of reproductive age and the planning status of recent births from the Demographic and Health Survey and national and regional number of women of reproductive age, allows us to calculate the annual number of induced abortions and the abortion rates (the number of abortions per 1,000 women of reproductive age) and ratios (the number of abortions per 100 live births) in the country as a whole and for the regions.

The surveys are being implemented in a random sample of 27 out of the 75 districts in Nepal. In these 27 districts. The facilities sampled in the Health Facilities Survey include public national hospitals, zonal and district hospitals, primary health care centers, health/sub-health posts, private hospital/facilities, and NGO facilities. The sample includes a census of all the large public facilities in the tertiary sector and a proportion of the facilities in each of the lower categories of health facilities selected using a probability proportional to size (PPS) sampling. Overall, the sample includes approximately 410 health facilities.

The HFS interviews one senior staff member in each selected health facility. The senior staff member is often an OB/GYN, but in the case of smaller facilities, the respondent may be a

medical doctor or nurse who is in a position of authority experienced with the abortion and post abortion care services at the facility.

The HPS collects data in each of the 27 sampled districts from a purposive sample of 125 key informants who are knowledgeable about provision of abortion and postabortion services. The sample mainly includes medical professionals, many of whom are likely to be providing abortion and post abortion care services (e.g., ob-gyns, nurses and midwives) and the rest are professionals other than medical personnel who are knowledgeable about abortion services. (e.g. government health administrators, NGO staff, advocates, researchers and teachers).

Results:

We will provide estimates for the following indicators:

Induced abortion : We will estimate the incidence (number, rate and ratio) of all abortions at the national and regional level We will also provide estimates of the incidence (number rate and ratio) of legal, safe abortions as well as estimates of illegal, safe and unsafe, abortions occurring in the country and in each of the regions.

Abortion complications: We will estimate the number and rates (per 1,000 women of reproductive age) of induced abortion complications and complications treated in facilities nationally and for each region.

Unintended pregnancy: Annual number and rates of all pregnancies and unintended pregnancies as well as the proportion of total pregnancies unintended and the proportion ending in abortion will also be estimated.

We will interpret these findings in light of trends in related proximate determinants, in particular—use of contraception, unmet need for contraception and family size preferences. We anticipate having implications for policies regarding the provision of safe and legal abortion services and quality contraceptive services

Current status of the project

Data collection began in August 2014, and fieldwork is on track to be completed by the end of September 2014. At the time of this abstract submission, nearly all of the HFS interviews and more than half of the HPS interviews have been completed. We expect that data entry should be completed by the end of October 2014 and data analysis will begin in November 2014.