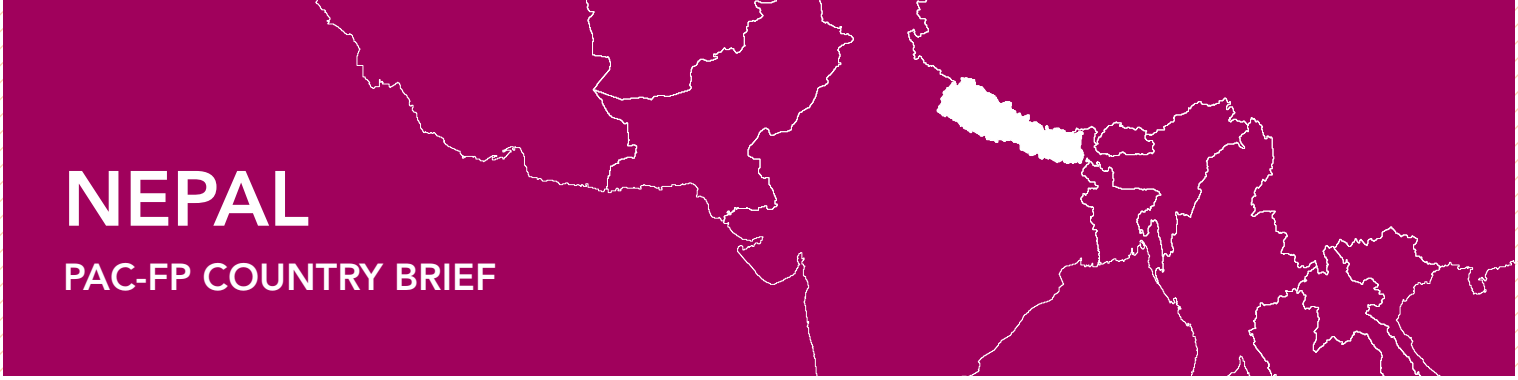

NEPAL

PAC-FP COUNTRY BRIEF

Postabortion care (PAC) provides a comprehensive approach to preventing morbidity and mortality caused by abortion complications (PAC Consortium, 2014). As per the U.S. Agency for International Development (USAID) PAC model, a critical component of PAC is providing access to family planning (FP) counseling and services. Providing these services helps meet the reproductive intentions of women who most clearly demonstrate an unmet need for FP, reduces unintended pregnancies, and prevents repeat abortions, thus reducing maternal deaths (Curtis, Huber, and Moss-Knight, 2010). The information below highlights the Federal Democratic Republic of Nepal's investment in providing PAC and FP services to women in need.

POLICIES, LEADERSHIP, AND GOVERNANCE

The Federal Democratic Republic of Nepal's national policy on family planning (FP) and reproductive health (RH) is outlined in a number of documents, including the National Policy on Skilled Birth Attendant (2006), the National Reproductive Health Research Strategy (2000), the National Adolescent Health and Development Strategy (2000), and the Female Community Health Volunteer (FCHV) strategy (2010). The latter document aims to support the country's health objectives through community involvement and public health activities, with specific emphasis on FP and maternal, neonatal, and child health. Specific guidelines discussing postabortion care (PAC) include the Comprehensive Abortion Care Integrated Reference Manual (2015), the Comprehensive Abortion Care Integrated Trainers Manual (2015), and the National Medical Standards (2003).

Legal Status on Abortion

In Nepal, abortion is legal for up to 12 weeks of gestation at the request of the pregnant women and for up to 18 weeks of gestation in the case of rape or incest. Abortion is legal at any time if the pregnancy is detrimental to the woman's physical and mental health and/or if the fetus is suffering from a severely debilitating or fatal impairment as certified by an expert physician.

PAC TRAINING AND STANDARDS

In 2002, Nepal's Ministry of Health and Population developed an on-the-job PAC training guide in collaboration with Jhpiego. In 2006, the government integrated PAC into the 2006 skilled birth attendant (SBA) training strategy, and, in 2007, integrated the on-the-job PAC training directly into the SBA training package. The key elements of PAC covered in this training package include: (1) counseling and client-provider interactions to identify and respond to women's emotional and physical health needs, (2) treatment of incomplete abortions and complications, and (3) FP counseling and voluntary contraception provided on-site or via referrals to other facilities within provider networks.

While doctors are the only health cadres that can provide dilatation and curettage, doctors, trained auxiliary midwives, and training nurses are all able to offer manual vacuum aspiration. Further, all of these cadres as well as clinical officers and midwives are able to offer misoprostol for PAC.

PAC·FP THE POSTABORTION CARE FAMILY PLANNING PROJECT
Expanding contraceptive methods and informed choice to PAC clients

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STRENGTHENING SERVICE DELIVERY

Nepal has sought to strengthen PAC-dedicated healthcare delivery and services by training and deploying of SBAs with PAC training. The country has expanded services by training nursing staff in the SBA curriculum, increasing the number of birthing centers (approximately 1,800 centers nationwide), and placing SBAs in basic and comprehensive emergency obstetric and newborn care sites where PAC is now available. The government, donors, and implementing partners are committed to further increasing the number of SBA and PAC-trained nurses available in peripheral health facilities to increase access to these services. Since 2017, more than 5,000 nursing staff have completed training in the SBA curriculum.

BARRIERS TO PAC

Women in Nepal face multiple barriers to accessing PAC and FP services. While the country has emphasized the importance of PAC in policy documents, service availability remains limited. While PAC is generally available at tertiary and intermediate facilities, it is less available at community health facilities below primary healthcare centers. Women in rural areas face other obstacles—especially in terms of myths, fears, and misinformation around PAC and FP—in addition to difficulties accessing services (Wang et al, 2015). There are also organizational barriers to PAC and FP services, such as providers' inability to allocate time to providing integrated services and facilities' lack of private rooms for counseling (Wang et al, 2015).

FINANCING MECHANISMS

Nepal initiated a national health insurance that includes FP for postpartum and postabortion women, but is only available in a few districts. PAC services are also free in government health facilities across Nepal.

In 2015–2016, the Ministry of Health procured $0.56 million worth of contraceptives, and spent $2.8 million on logistics for maternal and RH services, including records, registers, and medicines (FP2020, 2016).

NEPAL		Year	Source
Demographic/background indicators			
Country population	29,304,998.0	2017	World Bank Data[1]
Total fertility rate	2.1	2016	
Age at first birth	20.4	2016	Demographic and Health Survey, 2016
Maternal mortality per 100,000 live births	239		
Newborn mortality per 1,000 live births	21		
Infant mortality per 1,000 live births	32		
Under-five child mortality per 1,000 live births	39		
Facility-based deliveries	58.0%		
Proportion of women who received antenatal care from a skilled provider	84.0%		
Proportion of women who received a postnatal check within two days of delivery	57.0%		
Abortion and FP-related indicators			
Number of abortions	323,000	2014	Guttmacher Institute, 2017
Abortions per 1,000 women	42	2014	Guttmacher Institute, 2016
Number of unintended pregnancies	593,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Number of women treated for abortion complications	63,200	2014	Guttmacher Institute, 2016
Number of unintended pregnancies averted due to use of modern contraceptive methods	1,222,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Number of unsafe abortions averted due to use of modern contraceptive methods	489,000		
Number of maternal deaths averted due to use of modern contraceptive methods	1,600		
Modern method contraceptive prevalence rate, all women of reproductive age (WRA)	38.1%		
Knowledge of FP, all WRA	99%	2015–16	Demographic and Health Survey, 2016
Contraceptive use by type		2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Long-acting and permanent methods			
Sterilization (female)	34.8%		
Sterilization (male)	12.6%		
Intrauterine device	3.3%		
Implant	7.8%		
Short-acting methods			
Injection (intramuscular and subcutaneous)	20.7%		
Pill	9.9%		
Condom (male)	9.9%		
Condom (female)	0.0%		
Other modern methods (e.g., cycle beads, and lactational amenorrhea method)	0.3%		
Unmet need for FP[2] (2018)	24.0%	2016	Demographic and Health Survey, 2016
Unmet need for spacing	8.0%		
Unmet need for limiting	16.0%		
Percentage of all women who received FP information during their last visit with a health service provider	20.1%		

[1] Retrieved from: https://databank.worldbank.org/data/reports.aspx?source=2&country=NPL

[2] Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report either not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior.

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