Ipas Protecting women's health Advancing women's reproductive rights

RESEARCH BRIEF


# PATHWAYS TO SAFE ABORTION IN NEPAL

*Indira Basnett, Kathryn Andersen, Shailes Neupane, Keris KrennHrubec, Valerie Acre*

Nepal had one of the highest rates of maternal morbidity and mortality in South Asia with an adjusted maternal mortality ratio of 830 maternal deaths per 100,000 live births in 2002 (UNICEF 2010). More recent estimates place the maternal mortality ratio at 281 and 229 deaths per 100,000 live births, suggesting some success in safe motherhood efforts (NDHS 2006, Suvedi 2009). Despite this, unsafe abortion is still a leading cause of maternal morbidity and mortality in Nepal, accounting for an estimated 54 percent of gynecological and obstetric hospital admissions (Ministry of Health Nepal 1998) and 20 percent of maternal deaths in health facilities (Government of Nepal and UNICEF 2000). A recent national study found that approximately 7 percent of maternal mortality was due to abortion between April 2008 and April 2009 (Suvedi 2009). In addition, contraceptive use is low, with approximately 44 percent of married women of reproductive age using modern contraceptive methods (Ministry of Health and Population [Nepal] 2007).

Prior to 2002, abortion was only legal in Nepal to save the life of the woman and two physicians had to certify the procedure (Shakya 2004). In 2002, the 11th amendment to the Legal Code of Nepal made abortion legal:

- for any woman up to 12 weeks of pregnancy
- up to 18 weeks if the pregnancy is the result of rape or incest
- at any time during the pregnancy if the life, physical or mental health of the woman is at risk or if the fetus is deformed (Shakya 2004)

Consent is not required for women older than age 16, and though consent of the guardian is required for women under this age, the guardian can be any adult (Shakya 2004). Nepal's liberal abortion law is paired with programs that aim to expand access and affordability of safe abortion services.

Intensive provider training and facility support have proven successful strategies for increasing availability of comprehensive abortion care (CAC) services. From March 2004 to June 2009, 245 CAC sites have been certified and all of Nepal's 75 districts have at least one listed CAC facility. As a result, 313,561 safe abortions were performed from March 2004 to June 2009 across all facilities (Shah 2010).

However, little is known about the pathways through which women access safe abortion services — information is needed to design optimal strategies for increasing community education and mobilization activities.

## Methods

Data were collected from a cross-sectional sample of induced abortion clients presenting for CAC services at one of three selected facilities between April 1, 2010 and May 31, 2010. Tandi Marie Stopes International (MSI) Clinic, Seti Zonal Hospital and Tikapur Primary Health Center (PHC) were identified as sites for this study based on the following criteria: (1) choice of medical abortion (MA) and manual vacuum aspiration (MVA) induced abortion services; (2) availability of physician and nurse CAC providers; (3) representation of both urban and rural settings; (4) inclusion of public and private facilities; and (5) assurance of adequate caseload.

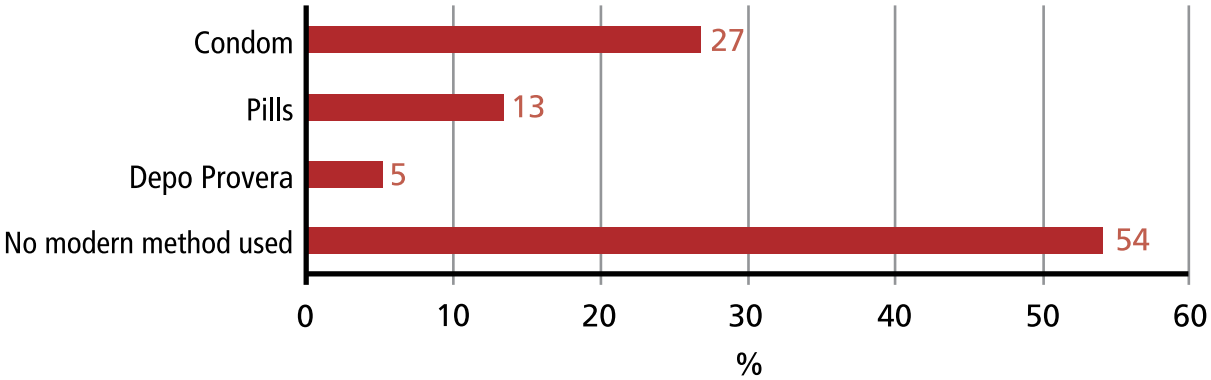
All women ages 16 and older who presented for induced abortion services at $<$ 12 weeks gestation were eligible for inclusion in this study. An interviewer was posted on site during the hours when CAC services were available for the duration of the study. At the time of their initial visit, women were recruited into the study and those who consented were administered a first interview. Women who were not interested in participating were asked to answer five socio-demographic questions for comparison purposes. Women who agreed to study participation were administered a follow-up interview between three and five weeks after their initial visit. There were no statistically significant differences in age, years of schooling completed, marital status, caste/ethnicity and number of live births between participants and nonparticipants.

## Findings

Of the 289 women approached for inclusion in the study at their initial visit, 231 (80 percent) agreed to participate and were included in the follow-up interview. More than half (n=123, 53 percent) of participating women were treated at Tandi MSI Clinic, while 57 women (25 percent) and 51 women (22 percent) were treated at Seti Zonal Hospital and Tikapur PHC, respectively. The average participating woman was 28 years old (range 15–45) and had a gestational age of seven weeks as determined by the bimanual exam (range 0–10).

Sixty women (26 percent) reported a previous induced abortion. At the time of conception, 106 (46 percent) reported using at least one modern contraceptive method. Thirteen percent were using traditional methods, and 41 percent reported using no method at all (Figure 1). The most commonly reported reasons for ending the current pregnancy were that the woman had enough children (71 percent), could not afford another child (58 percent), the husband/partner did not want the child (51 percent), and that the contraceptive failed (40 percent). The most common participants in the decision to have the abortion were the woman herself (97 percent) and her husband (91 percent). The majority (90 percent) of women identified themselves as the main decisionmaker to have the abortion and as the person who made the final decision on the provider and facility at which they received their abortion.

Figure 1.
**Modern contraceptive method used at the time of conception (%)***




*Three women reported using both pills and condoms. These participants were added to pill users at the time of conception for Figure 1.

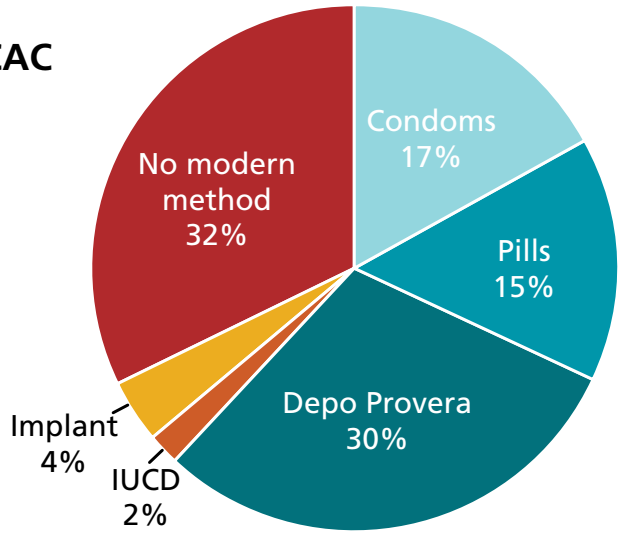
Overall, manual vacuum aspiration was performed more often than medical abortion; 170 (74 percent) women received MVA and 61 (26 percent) women received MA (Table 1). MA was administered more frequently than MVA only in Tikapur PHC, where 59 percent of women received MA (Table 1). Injectable contraception (Depo Provera), condoms and pills were most commonly received by women after CAC in all three facilities (Figure 2). Long-term contraceptive methods (the intrauterine contraceptive device and implant) were most frequently administered in Seti Zonal Hospital (25 percent of Seti Zonal Hosptial clients as compared to 0 percent and 2 percent of Tandi MSI Clinic clients and Tikapur PHC clients, respectively) (Table 1).

Table 1.
**Selected participant characteristics, Nepal community engagement and mobilization (CEM) Client Study, 2010**

| | Total (n=231) | | Tandi MSI Clinic (n=123) | | Seti Zonal Hospital (n=57) | | Tikapur PHC (n=51) | |
|---|---|---|---|---|---|---|---|---|
| | mean | (SD) | mean | (SD) | mean | (SD) | mean | (SD) |
| **Age (years)** | 27.6 | (5.9) | 27.5 | (5.4) | 27.7 | (6.9) | 27.9 | (5.9) |
| **Gestation (weeks)** | 6.7 | (1.6) | 6.7 | (1.1) | 6.5 | (2.4) | 6.9 | (1.4) |
| | n | (%) | n | (%) | n | (%) | n | (%) |
| **Induced abortion procedure** | | | | | | | | |
| MVA | 170 | (74) | 99 | (80) | 50 | (88) | 21 | (41) |
| MA | 61 | (26) | 24 | (20) | 7 | (12) | 30 | (59) |
| **Contraceptive acceptance after CAC** | | | | | | | | |
| At least one modern method | 158 | (68) | 83 | (67) | 41 | (72) | 34 | (67) |
| Short-term method *(Pills, condoms, Depo Provera)* | 143 | (62) | 83 | (67) | 27 | (47) | 33 | (65) |
| Long-term method *(IUCD, implant, sterilizations)* | 15 | (6) | 0 | — | 14 | (25) | 1 | (2) |
| No modern method chosen* | 73 | (32) | 40 | (33) | 16 | (28) | 17 | (33) |

*No modern method chosen includes women who chose no method after CAC and women who chose only withdrawal or periodic abstinence post abortion.

Figure 2.
**Contraceptive acceptance post CAC**



Overall, only 17 percent (n=38) of women talked to a female community health volunteer (FCHV) before going to the facility for their abortion, although 26 percent of women at Tikapur PHC and 21 percent of women at Seti Zonal Hospital talked to a FCHV. The most common topic in all three facilities to discuss with the FCHV was where to go for abortion care. All of the women who spoke with a FCHV recommended that other women in their community who may be pregnant talk with a FCHV. Women who could not read and write or had received only minimal education were more likely to have discussed reproductive health issues with a FCHV (P<.01), as were women who received abortion services at one of the two public facilities (P<.01, Table 2).

Table 2.
**Characteristics of women who spoke to a FCHV, Nepal CEM Client Study, 2010**

| **Did you talk with a FCHV about any reproductive health issues before coming to this facility for your abortion?** | **Yes (n=38)** | | **No (n=192)** | | **Total (n=230)†** | | |
|---|---|---|---|---|---|---|---|
| | **mean** | **(SD)** | **mean** | **(SD)** | **mean** | **(SD)** | **p-value** |
| **Gestational age (weeks measured by exam)** | 6.8 | (1.5) | 6.6 | (1.6) | 6.7 | (1.6) | 0.431 |
| | **n** | **%** | **n** | **%** | **n** | **%** | **p-value** |
| **Induced abortion procedure** | | | | | | | |
| MVA | 28 | (74) | 142 | (74) | 170 | (74) | 0.972 |
| MA | 10 | (26) | 50 | (26) | 60 | (26) | |
| **Education** | | | | | | | |
| Cannot read and write | 15 | (39) | 32 | (17) | 47 | (20) | 0.001* |
| Non-formal/Some primary (grade 1–5) | 14 | (37) | 58 | (30) | 72 | (31) | |
| Some secondary (grade 6–9) | 9 | (24) | 60 | (31) | 69 | (30) | |
| School leaving certificate (high school diploma) and above | 0 | - | 42 | (22) | 42 | (18) | |
| **Exposure to media** | | | | | | | |
| Both radio and television | 26 | (68) | 159 | (83) | 185 | (80) | <0.001* |
| Radio only | 3 | (8) | 18 | (9) | 21 | (9) | |
| TV only | 3 | (8) | 14 | (7) | 17 | (7) | |
| None | 6 | (16) | 1 | (1) | 7 | (3) | |
| **Facility type** | | | | | | | |
| Private (Tandi clinic) | 13 | (34) | 110 | (57) | 123 | (53) | 0.009* |
| Public (Seti Zonal and Tikapur) | 25 | (66) | 82 | (43) | 107 | (47) | |

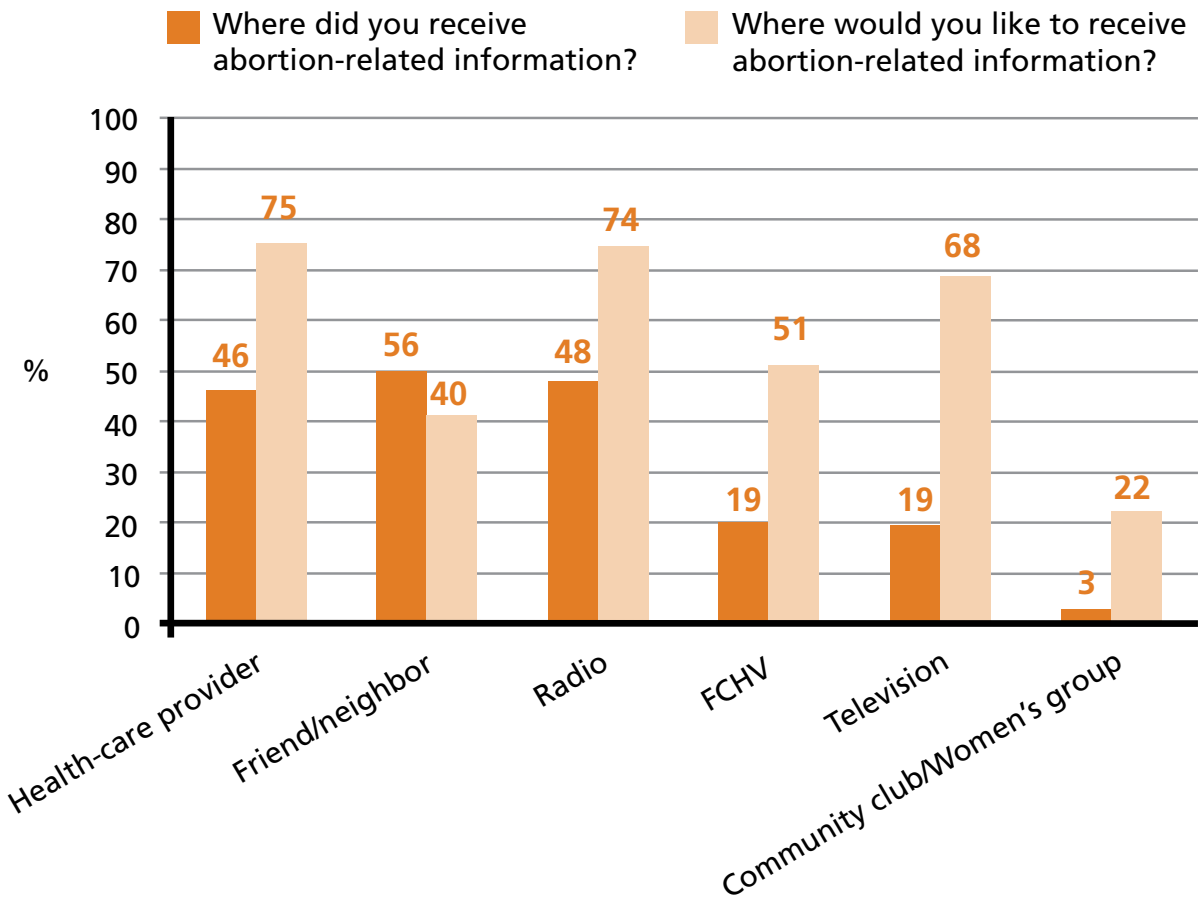
† One woman identified herself as a FCHV and was excluded from this analysis.

* Significant at p<0.05

Among women treated at Tandi MSI clinic, the most common route through which women received information was a friend or neighbor (59 percent), while at Tikapur PHC, most women received abortion information from the radio (82 percent). At Seti Zonal Hospital, husbands were the most common source of information (89 percent). In all facilities, women reported that the most frequently received abortion-related information was where to get a safe abortion. Women reported they would most like to receive information about abortion methods (74 percent) and who can provide safe and legal abortion services (53 percent).

While women said they most often received abortion-related information from a health-care provider, a friend/neighbor, and the radio, they reported they wanted to receive that information from a health-care provider, the radio, and television. Only 44 women reported receiving abortion information from the television, while 158 indicated that they would like to. A similar difference was seen among women who received and wanted to receive information from FCHVs and the radio.

Figure 3.
**Reception route for abortion-related information**



## Discussion

It appears that current message routes for family planning and abortion information are successful among the women seeking safe, legal abortion services in this study, as all women reported receiving family planning and abortion-related information at some time in the previous year. However, there were differences in the routes through which women received that information and the way they *want* to receive that information. More than three times as many women indicated that they want to receive abortion-related information through the television than they currently do, and more than twice as many want to receive it through FCHVs.

## Recommendations

Based on the findings of this study, the following recommendations are made to increase community education and mobilization (CEM) activities:

- Though all women received abortion-related information, it should be targeted more through women's preferred routes, such as through FCHVs and television.
- More women reported wanting to talk to a FCHV than did, so more information should be collected on why a FCHV was not contacted in these cases and increase access to FCHVs accordingly.
- More than half of women had been using a contraceptive method at the time of conception of the aborted pregnancy. CEM activities should focus on increasing education on contraceptive methods and ways to prevent contraceptive failure.

A female community health volunteer counsels a woman in India. [Photo © Richard Lord]


Contraceptive counseling at the Seti Zonal Hospital, Nepal. [Photo © Ipas]

## References


Government of Nepal and UNICEF. 2000. Needs Assessment on the Availability of Emergency Obstetric Care Services. Kathmandu: HMG Nepal/UNICEF.

Ministry of Health and Population (MOHP) [Nepal], New ERA, and Macro International Inc. 2007. Nepal Demographic and Health Survey (NDHS) 2006. Kathmandu, Nepal: Ministry of Health and Population, New ERA, and Macro International Inc.

Ministry of Health Nepal. 1998. National Maternal Mortality and Morbidity Study. Kathmandu: Ministry of Health.

Ministry of Health Nepal and Center for Research on Environment Health and Population Activities (CREHPA). 2007. *Nepal comprehensive abortion care (CAC): National facility-based abortion study 2006*: Summary report. Kathmandu: Ministry of Health and CREHPA.

Shah, Mukta. Unpublished Data: Analysis of National Health Management Information System (HMIS) data for Nepal, 19 March 2010.

Shakya, Ganga, Sabitri Kishore, Cherry Bird and Jennifer Barak. 2004. Abortion law reform in Nepal: Women's right to life and health. *Reproductive Health Matters*, 12(24): 75-84.

Suvedi, Bal Krishna, Ajit Pradhan, Sarah Barnett, Mahesh Puri, Shovana Rai Chitrakar, Pradeep Poudel, Sharad Sharma and Louise Hulton. 2009. Maternal Mortality and Morbidity Study 2008/2009: Summary of Preliminary Findings. Kathmandu, Nepal: Family Health Division, Department of Health Services, Ministry of Health, Government of Nepal.

UNICEF. Nepal Statistics. <http://www.unicef.org/infobycountry/nepal_nepal_statistics.html>.



Ipas *Protecting women's health*
*Advancing women's reproductive rights*

P.O. Box 5027 • Chapel Hill, NC 27514 USA
1.919.967.7052 • ipas@ipas.org
www.ipas.org




The photographs used in this publication are for illustrative purposes only; they do not imply any particular attitudes, behaviors, or actions on the part of the any person who appears in the photographs.


RBPATH-E11