PULSE
UPDATING YOU ON HEALTH DEVELOPMENTS

6. BARRIERS TO ACCESSING SAFE ABORTION SERVICES

SAFE ABORTION SERVICES

The Access to Health Services Study (Thomas et al. 2012) investigated the barriers that poor women face accessing and using safe abortion services. Since 2002, abortion has been legal in Nepal during the first 12 weeks of pregnancy and to 18 weeks in cases of rape, incest, foetal malformation and when women's lives are endangered.

The Nepal Demographic Health Survey, 2011 found that:

- 8% of pregnancies in the five preceding years ended in abortion with abortions more likely amongst 35–49 year olds, as the number of pregnancies increased, in urban areas, and among better-off women.
- 38% of 15–49 years women believed abortion was illegal.
- The proportion of women not knowing the circumstances for legal abortion was higher in Tarai (43%) than hill areas (32%), and amongst women with no education (54%), and was inversely proportional to wealth.
- Nearly half of women who had had an abortion in the previous five years said that they had paid more than 1,500 Nepalese rupees (NPR) for it.

Tamang et al. (2012) found that knowledge of safe abortion services was higher among women in Tarai (65%) than hill areas (50%). They found that many women were not aware of either medical or surgical abortion methods prior to visiting a clinic. This inhibits informed choice. Thus, NDHS 2011 found that the majority of women (69%) using abortion services had not used post-abortion care services.

"Medical safe abortions available 10 am-4pm on all days except public holidays."

THE ACCESS TO HEALTH SERVICES STUDY

A study was carried out in 2012 to understand the socio-cultural, economic and institutional barriers that poor and excluded people face accessing health services in Nepal. It used the rapid participatory ethnographic evaluation and research (rapid PEER) method, which is designed to explore sensitive issues with non- and low literate marginalised populations. Rapid PEER interviews happen in the third person to avoid response biases and are carried out by 'ordinary' members of target groups to elicit frank responses. The study examined experiences of accessing essential health care services at sub-health posts, health posts and outreach clinics.

Six social groups were studied: Chepangs, Muslims, Madhesi Dalits, Other Backward Classes (OBCs or other Madhesi castes), hill Dalits, and poor hill Chhetris and Brahmins, thus covering caste, ethnic, and religious differences. Each group was studied in two districts giving 12 sub-studies with 374 interviews in all.

Eight briefing notes have been produced to disseminate the findings. Note 1 gives the background and methodology while notes 2, 3 and 4 present the findings on the effects on accessing health care of poverty, caste and ethnicity (2); gender (3) and geography (4). Note 5 presents the findings on access to family planning, note 6 on access to safe abortions, note 7 on access to maternal health services and note 8 on access to child immunisation services. The study report (Thomas et al. 2012) is available at http://www.nhssp.org.np/gesi/Nepal%20PEER%20Revised%20Report.pdf

BARRIERS TO SAFE ABORTION SERVICES

The study found that the main reasons for delayed access to abortion services and the increased likelihood of women using unsafe methods, and not using safe abortion services, were:

- social and cultural factors that prohibit abortions;
- the illegality of sex-selective abortions;
- lack of local safe abortion services; and
- the challenges of accessing health facilities.

Social and cultural factors: The study found that the social framing of abortion as immoral inhibits access to safe abortions, compounding the challenges of location and affordability. Abortion was said to be widely associated with suspicion of having relationships outside marriage. There is widespread strong stigmatisation against abortions, with Tarai women reporting that seeking abortion services would lead to them being accused of aborting another man's baby. It was also said to be sinful. This, together with other religious and spiritual beliefs, means that among most study participants abortion was believed to have a negative impact on their current and future lives. It was also widely believed to be illegal, despite abortions of up to 12 week old foetuses being legalised in 2002.

"It is infanticide. Abortion is bad. If the wife suggests aborting, the husband suspects her and quarrels with her that she is carrying the baby of another man."

Male, Dhading

Sex-selective abortions: Abortions were said to take place for a variety of reasons, with a main one being son preference (see also Lamichhane et al. 2011). This reduces the uptake of family planning and increases the covert uptake of sex-selective abortions to limit the number of girls, particularly in areas where the dowry system impacts household finances. An increasing number of sex-selective abortions were also reported in the hills. Deciding to abort a foetus after identifying the sex means that surgical rather than medical abortion is usually necessary, thus increasing health risks for women.

Unavailability and costs: Safe abortion services are only available in urban areas and are often unaffordable due to the costs charged, coupled with the time and cost of travel and loss of household labour. Reports of the level of charges varied and were said to be often compounded by unexpected complications. The costs associated with safe abortion services are a barrier and increase the likelihood of unwanted pregnancies, and the uptake of unsafe abortion services.

"As the tradition of giving dowry increases, people do not want many daughters... they prefer to identify the sex of the foetus and decide whether to give birth or go for abortion."

Female, Saptari.

"There is no safe abortion service at the health post, but one can abort unwanted pregnancies outside the village... or some women take herbal medicine."

Female, Doti

ISSUES TO CONSIDER

1. What can be done to:
   - raise awareness of the availability of safe abortion services and the dangers of unsafe methods?
   - inform families of the illegality of sex-selective abortion and the circumstances where abortion is legal? and
   - increase the preceived value of girls and empower women?

2. What can be done to expand services in strategic locations in remote rural districts to cover populations that live far from safe abortion services?

3. Can communication messages be developed and groups mobilised to address the negative social and cultural beliefs and attitudes around abortion.

4. How to train service providers and develop family planning services to provide client-oriented counselling to counter repeat abortions?

5. How to strengthen monitoring of sex determination testing and restrict access to information on the sex of foetuses?

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