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Induced Abortions and Subsequent Reproductive Behaviour Among Women in Urban Areas of Nepal

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Despite the illegal status of abortion in Nepal, induced abortion is widespread especially in urban areas of the country. This paper analysis the social and cultural context within, which abortion occur, characteristics of the women seeking abortion safe and unsafe abortion services, contraception and impediments to contraceptive use. Of the 234 induced abortion cases initially interviewed, 130 cases were followed up twice in a period of 15 months to study, their post-abortion reproductive behaviour. Most, women utilizing the services of trained medical professionals (doctors) for pregnancy termination were highly educated and sought first trimester pregnancy termination. In contrast, women seeking the services of untrained personnel were prepared to take considerable risks in order to terminate unwanted pregnancies illegally. Although post abortion contraception was high, some women have resorted to repeat abortions due to method failure and other factors. Some diversity in the method, switching pattern have been observed among these women within a period of 15 months for the sake of effectiveness, conveniences, reliability and to avoid side effects of the method. The study suggests the need to strengthen Family Planning services and introduce Post-abortion Family Planning counseling educate women and untrained health practitioners about the danger of clandestine abortions and liberalization of the existing abortion laws.

Background

Unwanted pregnancy and induced abortion occur in every society and inevitably, all Governments and health care systems face the challenge of providing some elements of abortion care, ranging from life-saving care for treatment of abortion to safe, legal induced abortion. The way in which they respond to this challenge depends on the degree to which they and their societies acknowledge the occurrence of unwanted pregnancy and unsafe abortion and directly influences the quality of care women receive. The safety of abortion care available to a woman has a direct impact on her health. Legal restrictions and bureaucratic or other barriers often force women with unwanted pregnancies to seek abortions from unqualified providers. These women risk their lives when they do so. According to World Health Organization, in addition to

approximately 200,000 women who die each year from unsafe abortion, many more suffer serious, often permanent physical impairment from complications including sepsis, hemorrhage, uterine perforation, cervical trauma chronic morbidity, and infertility.

In the developing world, the continuum of governmental/legal responses to the need for abortion care includes three general categories:

- Countries that severely restricts the availability of induced abortion and provides only emergency treatment services for abortion complications.

- Countries that, in addition to emergency care, allow limited access to induced abortion by supporting, services such as menstrual regulation for delayed menses.

- Countries that make induced abortion available on broad grounds.

Nepal falls under the first category mentioned above. Abortion is a highly sensitive and divisive issue. Drawing upon the strict condemnation of abortion in Hindu religious scriptures and its cultural ethos, abortion in Nepal is a criminal act under all circumstances, punishable by imprisonment for both the women undergoing an abortion and abortion service provider. In spite of the strong legal sanctions and general social disapproval of abortions, community attitudes towards abortions seem to be changing into a more tolerant attitude towards women who seek abortions. The IIDS study (IIDS; 1992-1994) and the recently conducted Opinion Poll Survey on Abortion Rights for Women (CREHPA 1996) found a high approval rating, for abortions undergone under specific circumstances. e.g. conceptions due to rape or incest, pregnancies not advisable on health ground, pregnancy due to method failure etc. In fact the Opinion Poll Survey (conducted among 1480 adult men and women in nine towns of Nepal) indicates that a majority of the urban residents are in favour of legalizing abortion in the country.

In response to the concern about the health implications of unsafe induced abortion services and in recognizing, the need to investigate scientifically the determinants and consequences of induced abortion, the Special Programme of Research, Development and Research Training in Human Reproduction, World Health Organization (WHO), in 1991 supported studies in 19 developing countries on behavioral and social factors behind why women resort to induced abortion even when it is performed under unsafe conditions. The present research paper which is based on the study entitled "Determinants of abortion and subsequent reproductive behaviour among women in three urban districts of Nepal" is one of such studies funded by WHO in Nepal (1992-94).

Methodology of the Study

The study was prospective in nature. All women in visiting the four government hospitals and one private clinic in the Kathmandu valley for the management of the abortion complications during, a period of six months constituted the study sample. These women were initially interviewed before they were discharged from the Hospital clinic and then conducted two rounds of follow-up interviews; first round 4 months after the abortion and the second round 15 months after, in order to study the subsequent reproductive behaviour of these women. A series of Focus group discussions and case studies of selected abortion cases were conducted to complement the survey results.

A Medical Advisory Committee (MAC) comprising of senior gynaecologists was constituted to assist the study team in identification of abortion cases, obtaining consents from the women for participation in the study and for decision on all technical matters regarding, abortion classification etc. In order to facilitate the clinicians in abortion identification and classification, a guideline on clinical criteria for diagnosis of abortion was developed and standardized.

The Study sample

Altogether 1241 abortion cases were covered in the study. Of them 234 were induced abortions, 103 threatened abortions and 904 spontaneous abortions. The follow-up interviews were helpful in detecting and correcting misclassification of 12 abortion cases who, during, the case recruitment stage (Initial Study), had refrained from disclosing the fact that they had actually attempted to terminate the unintended pregnancy and as a result of which, they had to be categorized as spontaneous abortion cases. Later these women confided the study team that they had resorted to induce abortion. Likewise, 10 induced abortions had to be reclassified as spontaneous abortion cases since they were confident that their case was not a deliberate attempt to terminate the pregnancy but rather a miscarriage. It may be mentioned that such misreporting, withdrawal of previous confession or misclassification of abortion is not at all surprising considering the sensitiveness of the abortion research in the counts, and where the women always enjoyed the advantage of either to agree or disagree upon the clinician's diagnosis unless supported by sufficient proof in line with the clinical criteria for identification of induced abortion.

The present paper is based on the findings from the initial interviews of 234 women with induced abortions and follow-up interviews conducted for 131 out of these 234 women. Of these 234 women, 89 women had sought the assistance of untrained personnel for abortion while the remaining 145 (62%) have utilized the services of trained medical professionals (Table 1).

Table 1: Types of abortions recruited from government hospitals and private clinics for the Study

Types of abortions	N	%
Spontaneous abortions	814	65.6
Miscarriage due to illness medication	90	7.2
Threatened abortions	103	8.3
Induced abortions	234	18.9
Total	1241	100

Results

Determinants of induced abortions

Most induced cases were women aged between 25-40 Years and had at least 2-3 living children. Son factor or the presence of at least one son as a determinant of completed family size is evident from the fact that a high percentage of women (80%) terminating their unwanted pregnancy had a son already (Table 2). Only one-fourth of the induced abortion cases desired additional children. They have resorted to abortion in order to space births. In some cases, women resorted to abortion if the pregnancy was coming in the way of education or employment or if the pregnancy was out of wedlock or as a result of method failure.

Table 2: Percentage distribution of women according to their number of surviving children and number of living sons: Induced abortion

	Type of abortion	
	Induced by untrained personnel	**Induced by trained medical professional**
Number of Surviving Children None 1 2 3 4 and more	7.0 8.1 29.1 23.3 32.5	8.5 24.1 46.8 10.6 9.9
Total	**86**	**141**
Mean number of surviving	2.8	1.9

SD	1.5	1.2
Number of living sons None 1 2 3 and more	19.8 29.1 41.9 9.3	29.8 49.6 16.3 4.2
Total	**86**	**141**
Mean number of living sons*	1.4	1.0
SD	(1.02)	(0.8)

* Respondents with no living children, or no living sons are assigned zero values.
There exists a positive association between levels of education attained by the woman and her husband and the 'safe' abortion practices. This is evident from the fact that most women utilizing the services of trained medical professionals (doctors) for pregnancy termination were highly educated and even their husband had high educational qualifications. It is also interesting to note that educated women sought abortion services (for pregnancy termination) at early stages of pregnancy i.e. during first trimester. On the contrary, majority of the women who had sought the assistance of untrained persons for pregnancy termination were, illiterates and not many amongst their spouses had attained higher education. Over one-third of them had visited the untrained persons (abortionists) during second trimester which is considered unsafe for abortion (Table 3).

Table 3: Literacy status of woman and their spouse receiving abortion service from untrained and trained personnel

	Service Provides	
	Untrained	**Trained**
Client's Literacy Status Illiterate Primary Level Secondary Level SLC and above	51.2 15.1 15.1 18.6	14.2 8.5 12.0 65.2
Husband's Literacy Status Illiterate Primary Level Secondary Level	9.3 19.8 33.2 36.5	2.8 3.5 10.6 83.0

SLC and above		

The untrained service providers included Sudeni or Traditional Birth Attendant (TBA), Vaidhya (Traditional Ayurvedic Practitioner), Pharmacists/compounder, Nurse/ANM, etc. The abortion procedures followed by most of these untrained providers were dangerous and often barbaric as they involved insertion of either sticks pasted with cow-dung, herbal mixtures, injection of unknown medicines into the uterus, or insertion of rubber catheter dipped in some unknown medicines, etc. Some of the women attempted to self-induce an abortion by orally consuming honey, papaya, simric powder, Nir powder, oral pills and de-worming medicines. As none of the procedures adopted by untrained service providers were safe and complete, all of their clients (abortion seekers) finally landed up in the hospitals. Majority of these women visited the hospitals rather late and on critical conditions and they needed blood transfusions prior to undergoing dilatation and curettage. Recalling the bitter experiences of clandestine abortion one participant said:

"*I will in no case advise anyone to rely on the Didi (untrained TBAS) for pregnancy termination I will never forget the narrow escape of my life from the pains and severe bleeding that I had to undergo after visiting that Didi. I would not have survived if I was not rushed to the hospital*"

Future Contraceptive Use Intentions

Most (89%) induced abortion cases intend to adopt Family Planning methods in future. This is obvious as these women have either completed their family size or do not wish to have the next conception immediately. As regards the method choice, female sterilization (28%) followed by Depo provera injection and male sterilization (12% each) were the three most preferred method for future use among women (Table 4). It may be mentioned that other spacing methods are not popular even among the eligible couples in the country.

Table 4: Future contraceptive use intentions among women and method choice: Induced abortions

	N	%
Yes	202	89.0
No	21	9.2
Undecided	4	1.8
Total	**227**	**100.0**
Pills	11	5.4
IUD	20	9.9

Condom	11	5.4
Injection	25	12.4
Norplant	18	8.9
Female Sterilization	56	27.7
Male Sterilization	25	12.4
Others	7	3.5
Method Undecided	29	14.3
Total	**202**	**100.0**

It may be mentioned that the ever-use of contraceptives (prior to conception and abortion) among the induced abortion cases was high; 76 percent and 58 percent respectively among those utilizing trained professionals and those seeking untrained providers assistance. Negligence, fear of method's side effects, presence of breastfeeding baby and opposition from husband were the major reasons for discouraging rest of the women from contraceptive acceptance. However, some amongst them had intentions to undergo sterilization operation sometime later but failed to prevent the unintended pregnancy.

Previous Abortion Experience

The fact that exposure to previous abortion would increase the chances of repeat abortion is evident from the Table 5. Roughly, one in four induced cases (63 women) had previous experience of abortion (68%) and miscarriages (32%). Moreover, a considerable proportion of these women have been exposed to two or more previous abortions and some four or more abortions. It is imperative that such women receive special pre-natal care to minimize pregnancy complication and maternal risks and they need adequate counselling and motivational efforts to delay subsequent conceptions.

Table 5: Experience of previous abortion/miscarriage among women : Induced abortions

	N	%
Yes	65	27.8
No	169	72.2
Total	**234**	**100**
At least one previous Induced Abortion	44	68.0
At least one spontaneous abortion	21	32.0
Total	**65**	**100**

Awareness and perceptions about abortion's side effects and pregnancy risks

Awareness about the possible side effects of abortion was low (31%). Even the side effects mentioned by those who were aware of the same were restricted to general problems like excessive bleeding (46%), weakness (36%), fever (7%), abdomen pain (4%), etc. The adverse effect of abortion to and reproductive health like secondary infertility, repeat abortion or miscarriage etc. were not considered as abortion related risks, probably due to ignorance among, these women (Table 6).

Table 6: Awareness of possible side effects from abortion and perceived side effects: Induced abortions

	N	**%**
Yes	72	30.8
No	162	69.2
Total	**234**	**100**
If yes, perceived possible side effects	33	45.8
Excessive bleeding	5	6.9
Fever	1	1.4
Sepsis/Infection	26	36.1
Weakness	3	4.2
Abdominal pain	1	1.4
Risk of miscarriage of subsequent pregnancy	2	2.8
Backache	1	1.4
Unable to bear children again/chances of infertility		

The total percentage exceeds 100 due to multiple responses

Post-Abortion Reproductive Behaviour

Of the total 234 induced abortion cases initially interviewed 131 cases could be followed-up after four months (first follow-up study) and 130 after fifteen months (second follow-up study) following abortion for studying the post abortion reproductive behaviour.

Post-Abortion Health Status

Majority, of the women did not have prolonged health complication and they felt that they were feeling physically fine. One in five women (22%) who had utilized clandestine abortion (from untrained providers) services continued to experience some health problems at the time of the second follow up study as against one in six women (15%) who had utilized trained medical professionals help for pregnancy termination (Table 7). Moreover most of the problems cited by the women were non-specific complaints except one woman who reported having, vaginal or uterine infection. Among the non-specific complaints, the majority had suffered from back pain, chess pain followed by lower abdominal pain during menses, menstrual irregularities, headache and weakness. Every, second women facing, such problems associated the problems with induced abortions. Thus, it can be said that induced abortion do have some effect in the health of women, but the range of the effect depends on the type of service provider and the technique used.

Table 7: Post-abortion health status at the time of second follow-up visits: Induced abortion

	Induced by untrained personnel (N = 36)	**Induced by trained medical personnel (N = 94)**
Any Complication Experienced? Yes No	22.2 77.8	14.9 85.1
Percent	**100**	**100**
If yes, type of complaints/complication		
Pain: Backpain, chestpain, pain in limps, muscles/bone	50.0	43.0
Headache, giddiness, weakness	12.5	7.1
Low abdomen pain, pain during menses	25.0	28.6
Cough, cold, fever	--	7.1
Vaginal/Uterus Infection	--	7.1
Irregular menses/heavy bleeding	--	7.1

Other	12.5	--

Reproductive status after abortion

One out of every six women with induced abortion had become pregnant at least once during, the 15 months period following the last abortion. Majority of these pregnancies were unplanned ones (Table 8).

Table 8: Post-abortion reproductive behaviour of woman (during 15 months): Induced abortions

	N	%
Ever been pregnant Yes No	22 108	16.9 83.1
If yes, no. of times pregnant Once Twice	21 1	16.2 0.8
Desiredness of the current/most recent pregnancy* Planned Unplanned	9 14	39.1 60.9
Outcome of pregnancy* Live Birth Spontaneous Induced Currently pregnant	11 1 4 7	47.8 4.3 1.4 30.4

* Total `N' exceeds the number of pregnant women i.e. 22 because one woman had experienced two pregnancies.

This reflects the risk taking behaviour of these women. Four of those pregnant women had to be resorted to abortions to get rid of the unwanted pregnancy. It suggests that induced abortion has remained one of the important measures of fertility, regulation among the urban women of Kathmandu valley. However, some of these unplanned pregnancies were as a result of either irregular use or ineffective/incorrect use of the contraceptives while others were due to either carelessness or opposition by the spouse/family member in method use.

The antenatal check-ups by women, who got pregnant subsequently, were quite impressive. All pregnant women consulted medical doctors either at the private clinic or at the public hospitals for pregnancy confirmation and other necessary

precautions. Since the women represented in the sample are urban dwellers and conscious of safe abortion practices (they were recruited from private clinics), it is natural to find the health care seeking, behaviour of these women to be much better than expected and this finding, should not be generalized.

Majority of the induced cases (60%) would opt for pregnancy, termination In case of accidental or unintended pregnancies if occurred subsequently. Such a stand reflects the increasing awareness among the urban women about their reproductive rights and a high demand for fertility regulation devices and they would even use abortion as a means of fertility control. Thus, it calls for a need for the provision of safe abortion services at least in places where adequate facilities of hygiene and scientific health services and resources are available (Table 9).

Table 9: Desiredness to keep any accidental pregnancy to term : Induced abortions

	Induced by untrained personnel	**Induced by trained medical professional**
Continue full term	11.1	17.0
Terminate	52.8	62.8
Uncertain	33.3	20.2
Not Applicable (Unmarried)	2.8	--
Percent	**100**	**100.0**
N	**36**	**94**

The post-abortion fertility be has, for of these women measured in terms of the differences on fertility preference pattern between the initial case recruitment stage and during, the second round of the follow-up visits shows that the fertility preference (for an additional child) chances with the passage of time depending the demand of existing situation, the health of the mother and child the socioeconomic status and involvement in the non-domestic activities. However the effects of the external factors on the fertility decision making power of the women need more in-depth research and analysis.

Post-Abortion Family Planning Acceptance

The post-abortion contraceptive use among women with induced abortion was extremely high (88%) (Table 10). This is obvious, as most of these women were literate and had utilized private clinics for abortion services and obtained Family Planning information from these sources. Among the various forms of

contraceptives, natural Family Planning methods like calendar and withdrawal methods were mostly used by these women as the first method after undergoing abortion. However, the contraceptive prevalence rate among these women at the time of present study remained at 80%, the rate is same as during the first follow-up survey. It is surprising to find the dominance of natural Family Planning method (Calendar method) in the contraceptive method mix though its use rate has declined from 36 percent during the first follow-up survey to 26 percent during the present study. The Pills (20%) and Condoms (20%) were the next most preferred method followed by female sterilization (10%).

Table 10: Post-abortion ever-use of contraception and first contraceptive method used by woman after abortion : Induced abortions

	N	%
Whether FP method used?	113	87.7
Yes	16	12.3
No	129*	100
Total		
If yes, first method used	30	26.5
Calendar	23	20.4
Pills	23	20.4
Condom	11	9.7
Female sterilization	9	8.0
Depo-provera	6	5.3
Withdrawal	4	3.5
Male sterilization	3	2.6
IUD	2	1.8
Norplant	1	0.9
Foaming tablets	1	0.9
Others		
Total	**113***	**100.0**

* Total `N' excludes one unmarried case.

The study has also found a diversity in the method switching pattern among, these women within a period of 15 months for the sake of effectiveness conveniences reliability, and to avoid side effects of the method. One of the FGD Participants, switched from traditional method (Calendar Method) over to Depo provera (injectable contraceptives) as she realized the ineffectiveness of traditional method. Stating, her reasons for method shift, she said

"I had terminated the pregnancy twice due to the failure of natural birth control measure (calendar method). Now, I don't trust on that."

Altogether, 16 women out of 129 women with induced abortion were not practicing, any contraceptive since last abortion. Similarly, 10 women had discontinued method use at the time of present survey. Majority of these women did not feel it necessary to use a method because of their post-partum amenorrhea stage or their spouse were away from home. For some, spouse opposed to use a method while others were careless in method adoption. Four of them were not using a method due to their health condition. Hence, those women with health condition as impeding factor in contraceptive acceptance should be encourage to use either natural Family Planning, methods or male contraceptives.

Discussions

The study has been able to portray the various factors influencing women to chose abortions as alternative method of fertility regulation, their decisions to either accept or avoid early conceptions following abortions and the consequences of such, decisions. Majority of the women who had an abortion have felt the need for post-abortion contraception as indicated by, the increase in the contraceptive prevalence rate and the proportion of women willing to contracept in near future. However, those women, who have not practiced any contraception and left with the risk of unwanted or mistimed pregnancy, should be targeted for proper and timely Family Planning, counseling services so that they need not resort to repeat induced abortion or experience repeat spontaneous foetal losses. During, the initial stages of the study (Case Recruitment period), the study, team did not find any effort from the clinicians to extend post-abortion Family Planning counseling

Most women who either wish to delay subsequent conception or avoid unwanted conceptions were exposed to the risk of pregnancy as they either refused to accept existing methods or no appropriate contraceptive method mix was available to them.

From the reproductive point of view, it is imperative that all women experiencing abortions postpone subsequent conceptions for at least a year or so in order to minimize the pregnancy-related risk like repeat foetal loss/miscarriage, birth of underweight babies and other pregnancy related complications. The need to extending post-abortion Family Planning to women was stressed by international group of policy makers, health care providers, scientists and women's health advocates at a conference in Bellagio, Italy, in February 1993 which was organized by International Projects Assistance Services

(IPAS). The conference participants urged governments donors, national Family Planning programmes and reproductive health organizations to give a high priority to making fertility regulation more accessible to women experiencing an abortion. The group's main recommendation was that all abortion facilities should offer some of Family Planning service or there should be a mechanism to refer women to another source for such service. (PROGRESS- WHO:1993).

The Case Studies and Focus Group Discussions with selected group of women were able to show that women are prepared to take considerable risks in order to terminate unwanted pregnancies. Because of the fear of legal action and social sanctions, they subject themselves to a high risk of serious bodily injury, sterility, chronic disability or even death. As most clandestine procedures either remain incomplete or they are associated with severe complications including sepsis these women are left with no choice than to visit hospitals and private nursing homes for medical treatment and spent considerable amount of money for the hospitalization and treatment. The study suggests basic strategies to reduce clandestine abortion practices and to discourage women to accept abortion as a measure of fertility regulation. These strategies are a) extending strong, post-abortion Family Planning counseling; b) providing orientation and training, about the danger of clandestine abortions to TBAs and nonqualified health care providers, c) educating, the women and the masses through street dramas radios and TVs on the danger of illegal abortion practices; d) strengthening Family Planning, services and e) make the existing abortion laws to be more flexible to minimize back street abortions and reduce the strain on hospital resources. Keeping in view of the growing, practice of illegal abortions in the country, women's health advocates, in the context of safeguarding women's reproductive rights, have began proposing a more liberal legal code dealing with abortions. The Abortion Bill 2053 B.S. (1996) which is yet to be passed by the parliament stresses on relaxing, existing abortion laws in the country (the Bill was tabled as a Private Bill in the Summer Session of the Parliament) is a good move and highly laudable as the situation has arisen for the revision of the existing abortion laws - a moderate policy that would recognize wider grounds than at present on, which a woman can seek abortion services. However the liberalization of abortion policy alone is not a solution as it will not ensure the availability of safe abortion services in the country. At the moment, dearth of physicians, necessary equipment and medical backup services hinder women's wider accessibility to safe abortion services and effort should be made to improve these situations first before making any bold step towards liberalization of abortion laws.

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