A Study on young people's experience with abortion services in Nepal

2018

RIGHT HERE
RIGHT NOW

This study has been conducted with technical support of Right Here Right Now Nepal platform, which is a strategic partnership between ten likeminded youth led and youth serving organizations, that are advocating for enhanced experience of young people on sexual and reproductive health, focused on three thematic areas - provision of age appropriate comprehensive sexuality education, legalization of same sex marriage and provision of stigma free youth friendly safe abortion services.

Visible Impact, which is a partner organization of Right Here Right Now, is a young, women led organization that aims to bring visible impact on the lives of every women, every girls and every youth by unleashing the social and economic leadership of girls, women and youth through beneficiary-partnered innovative interventions

Authors
Medha Sharma
Shilpa Lamichhane

For further information please contact:

Visible Impact
212/48 Dhapasi Marga, Basundhara

01-4016563 || hello@visim.org
www.visim.org

Right Here Right Now
Secretariat: YUWA
310 Krishna Dhara Marga, Maharajgunj
www.yuwa.org.np

Acknowledgement

The success of this study report is the result of collaboration and support of various agencies, organizations, people and groups.

The need of this study was identified during Right Here Right Now global consortium's first country planning meeting in Nepal, where 16 like-minded organizations stated that there is a need to conduct an updated study regarding abortion services in Nepal. We are grateful to all the platform members for highlighting its need and also supporting its research design. Visible Impact also expresses its deepest gratitude to RHRN Nepal for providing technical and financial resources for the study.

The platform member organizations at the district level have put their relentless effort in coordinating for the data collection - CDS Park Mugu, RUWON Nepal and Youth Development Center and we want to express our gratitude for their valuable coordination throughout the data collection. This research would not have come to this form without their contribution.

In particular, we are very thankful to all young women who gave their time and experience so generously, service providers who agreed being interviewed despite their busy schedule and our in-house team for their continuous support in the planning and facilitation of research. We are immensely obliged to them for their elevating inspiration, encouraging guidance and kind supervision in the completion of the research.

Research Team

Executive Summary

Background

This report presents the results of the study conducted to document the experiences of young people of Nepal regarding abortion services. The main objective of the study was to obtain updated information regarding young people's experience with abortion in three representative districts of Nepal: Mugu, Sindhuli and Sunsari.

Methodology

This study used a descriptive cross sectional study design with more focus on qualitative plot. Young women (18-35 years) who had experienced induced abortions were the major study population. Two Focus Group Discussions (FGDs) with 30 women in Mugu, two FGDs with 35 women in Sunsari and 32 in depth interviews (IDIs) were carried out. Guidelines for FGDs and IDIs were prepared and validated initially through a workshop. In addition, Key Informant Interview (KII) with service providers, pharmacists and observation of the service sites were concluded in all the three districts. Participants for data collection were coordinated by the RHRN district platform members who are operating in the respective districts. FGDs, IDIs and KIIs were audio recorded, transcribed and analyzed thematically.

Results

Age at marriage being quite low in Nepal, most of the abortion services taken up are still by married people in Nepal, and no unmarried young women who had taken up the service in the past could be accessed by the research team. The willingness to share about their experiences about abortion was found more at Mugu then Sindhuli then Sunsari, meaning that the stigma related to abortion is more at urban areas than rural areas. Women usually take up multiple abortion services, and singular abortion service was rare.

Types of services: The traditional unsafe methods of abortion had declined, and the reason to choose between medical and surgical abortion among women depended on: 1. Convenience, meaning that medical abortion was preferred during first abortion as it less invasive method is preferred. For women who had incomplete or multiple abortions in the past chose surgical abortion. 2. Confidentiality, meaning women who valued confidentiality chose medical abortion. Women in urban areas obtained service from other sites than their own locality, while in rural areas where there are only single service site, women did not mind about confidentiality as much. 3. Medical outcome, meaning that women with failed medical abortion due to several reasons chose surgical abortion.

Reason for abortion: The main reasons for use of abortion services were as follows: 1. Family planning - Women who know about family planning but were not using it were using abortion as a means of family planning. The trust in family planning devices was very low in all the three districts. 2. Son or Daughter preference- though this was less likely cause, some women took abortion over son or daughter preference. 3. Patriarchy - Male dominance and acceptance of women as baby producing machine by both men and women.

Affordability The price that the women are paying for abortion greatly differs on the context, type of service chosen, location of the service etc. For medical abortion, the direct cost of the service alone ranged from NPR 1500 to 12,500, while total cost reached up to one lakh. Many women loaned this money. Even with the introduction of free abortion services, there are indirect expenses which are still unaffordable for the women.

Friendliness of service provider and site: The behavior of the service provider was not complained by any respondents who said that the behavior has improved these days. However, it was also noted that abortion does get stigmatized when it is performed multiple times. The service site in Mugu delivered maternity and abortion services from a single room as it did not have enough infrastructures, while separate counseling and service rooms were present in Sindhuli. The pharmacies were providing medical abortion services without registering, as mentioned by the women, but all the pharmacies reached out for the study asserted that they do not provide services and refer requests to other places. In Mugu, women walked two days in average to reach the site, while the sites are much accessible for women in Sindhuli and Sunsari.

Decision making: In most of the cases, both the husband and wife jointly made the decision to undergo abortion. Conversely, women who had not informed their family did not participate in the study. Sometimes women also made the decision on pressure of their husbands.

Confidentiality: No respondents reported of confidentiality breach by the service provider, but feared of the community people seeing them entering the service site. The concern for confidentiality was more in urban areas than rural areas. Most of the respondents from all the three districts said that the consent was not requested by the service center, and they were not asked about their age or marital status.

Knowledge about service site: The young women in Mugu were not aware of what safe abortion service or site meant, and had never noticed the SAS logo in the service site. They visited there for service merely out of words of mouth, and did not understand that abortion services and safe abortion services are different. The decision to choose the service site hugely depended on the person's prior experience with the service site. They chose places where they have delivered their children, are relatives to service providers, or because someone they knew knows about the place.

Follow up: Both the providers and the service seeker agreed that the service provider insisted on visiting the clinic after abortion. Due to hesitancy, health posts being far, lack of indirect costs for travel etc. the patients that came for PAC was very low.

Recommendations

The government should include provision for stigma free and youth friendly free safe abortion services for all women and girls in the Reproductive Health bill and directives to national and provincial level, so that all women and girls can enjoy their rights to abortion.

The Department of Drug Administration should take strict actions against those providing illegal abortion services in medical stores and pharmacies.

The government should increase the human resource and infrastructures for health at all levels, expanding the services on abortion and post abortion care services like increasing the number of listed service sites, to make the service accessible for all.

The civil society organizations, including media, should coordinate towards providing factual information so as to reduce the stigma associated with abortion.

List of Acronyms and Abbreviations

CDS Park	Center for Karnali Rural Promote and Society Development
FGD	Focus Group Discussion
FP	Family Planning
IDI	In-Depth Interview
KII	Key Informant Interview
MA	Medical Abortion
PAC	Post Abortion Care
RHRN	Right Here Right Now
RUWON	Rural Women Organization of Nepal
SA	Surgical Abortion
SAS	Safe Abortion Services
YDC	Youth Development Center

Table of Contents

Chapter 1: Introduction

1.1 Background of the study

This report presents the results of the study conducted to document the experiences of young people of Nepal regarding abortion services.

Right Here Right Now (RHRN) Nepal, which is a strategic partnership between fifteen likeminded youth led and youth serving organizations, that are advocating for enhanced experience of young people on sexual and reproductive health, focused on three thematic areas - provision of age appropriate comprehensive sexuality education, legalization of same sex marriage and provision of stigma free youth friendly safe abortion services, aimed to obtain an updated information on young people's experience with safe abortion services, so that it can serve as a base for its advocacy agenda.

1.2 Rationale of the study

Abortion has been conditionally legalized in Nepal since 2002 and the country has made striking progress in rolling out induced abortion services since then[1]. The relatively liberal law, which allows for legal termination of pregnancy up to 12 weeks of gestation–or up to 18 weeks in cases of rape or incest or at any time if medically indicated, appears to have contributed to an overall national decline in maternal mortality[2]. However, unsafe abortion still remains a major health concern. Abortion accounted for an estimated 14% of maternal deaths at health care facilities in 2008–2009[3], which underscores that even in settings where abortion is legal; women may resort to unsafe procedures. In general, barriers to accessing safe abortion care can include negative provider attitudes, fear of repercussion, lack of access to comprehensive sexuality education, limited financial resources, cost of care, transportation, third-party involvement laws, and concerns over privacy and confidentiality[4].

About one fifth of the total population of Nepal comprises youth (between the ages of 15-24)[5]. While a majority of adolescents (64 %) have their first sexual intercourse between 15 to 17 years of age, only 4.5 percent of adolescent women use a modern form of contraception[6]. This might lead to unwanted teenage pregnancy. While the abortion law has been established[7] in the country, adolescents, in particular, often still face challenges in accessing safe and legal abortion services. Adolescents are more likely to delay seeking help for abortion related complications as a result of stigma surrounding adolescent sexuality. Also, many youth lack the negotiation and decision-making skills necessary for abstaining from unsafe sexual practices. Young people face a number of unique barriers that limit their access to, and use of, safe abortion care, young women are disproportionately affected by unsafe abortion. It is therefore important that efforts to expand young people's access to health care include access to safe abortion care.

Furthermore, abortion experiences and practices focusing on young girls and women have rarely been studied and very few interventions have been done to protect them from the risk of unsafe practices. Therefore, to generate the evidence regarding young people's experience, trends and practices of abortion services in Nepal, Visible Impact on behalf of RHRN Nepal conducted a survey in Mugu, Sindhuli and Sunsari district of Nepal. This research finding will serve as a basis for the platform members of RHRN Nepal, and other actors of the issue, for jointly working to achieve stigma free and youth friendly safe abortion services.

1.3 Purpose of the study

The purpose of this study was to obtain updated information regarding young people's experience with abortion in three representative districts of Nepal. The outcome of the study will provide guideline to the organization of RHRN Nepal to jointly identify the issues for advocacy, including providing evidence to justify their position, so that it can achieve its long term outcome of "By 2020, quality, stigma free and youth friendly safe abortion services are accessible and available at all public health institutions with adequate budget allocation and proper monitoring mechanisms"

1.4 Objectives of the study

The specific objectives of the study were to:

- To document the experiences of young people in regards to abortion from three representative districts of Nepal
- To identify the main issues related to abortion among young people that need attention of policy makers to ensure young people have access to quality, stigma free and youth friendly safe abortion services.
- To provide recommendations on young people's experience with abortion to the call for action to be developed by RHRN Nepal.

Chapter 2: Methodology

2.1 Study Design

This study used cross sectional study design to collect both quantitative and qualitative data through primary data collection. Secondary data were desk reviewed to generate appropriate literatures.

2.2 Study Population

The study was conducted in Mugu, Sindhuli and Sunsari districts of Nepal. Three districts from three different regions of the country were chosen so that the scenario of overall Nepal on abortion services can be generalized. Mugu from Himalayan Region, Sindhuli from Hilly Region and Sunsari from Terai region were targeted. Also, Mugu represents the rural community, Sindhuli represents semi urban community and Sunsari is the urban community.

For in-depth interviews (IDIs) and focus group discussions (FGDs), young women of age 16-35 years who have experienced abortion services within last 5 years were taken into study. This was done with the purpose of documenting recent experiences, and not duplicating with researches that have been done before that. Also, the study tried to obtain information from women who had been denied the safe abortion service, and/or young women who took unsafe abortion services, through IDI; but was not able to find a single respondent that met this criterion. Service providers of registered service sites and pharmacist in the community were also the respondents.

CDS-Park Mugu from Mugu, Rural Women's Network Nepal (RUWON) from Sindhuli and Youth Development Center from Sunsari as the district partner organization of RHRN Nepal helped us coordinate participants.

2.3 Sample Size and technique

The sample size varied in each districts as - 30 women in Mugu, 32 in Sindhuli and 35 in Sunsari district. Women were selected through snowball sampling technique whereby the local coordinator connected the researcher with women they knew had obtained these services, who further brought in more women they knew had taken the services. Cases where it was hard to identify if the women had obtained abortion services in the past, the young women who were most likely to have obtained the services were invited and asked to continue only if they had taken the service.

Table 1 District wise sample size by research tools

Districts	Focus Group Discussions	In-depth Interviews	KII with service providers
Mugu	2 (30 women)		1
Sindhuli		32	1
Sunsari	2 (35 women)		1
Total	**4 (65 women)**	**32**	**3**

2.4 Data collection tools and techniques

Tools for data collection were developed two weeks prior to the study, and were validated through tools development workshop with platform members of RHRN Nepal. The following tools and techniques have been used in the study:

Desk review

Desk review was done prior to the data collection for gaining broad understanding on the country context on abortion, trends among young people and knowledge and awareness regarding abortion among them. This included review of various published and unpublished articles, presentations, published reports and so on.

Focus Group Discussion

Two focus group discussions with 30 women were conducted in Mugu and two FGDs with 35 women were conducted in Sunsari. The FGDs were about 2 hours in length and were audio recorded with informed consent from the participants. The discussion was conducted in the local language and translated by one of the locally based staff of our partner organization. Eight questions were used as guides for the focus group discussion (Annex 1).

In depth Interview

A total of 32 in depth interviews were conducted in Sindhuli District. Women preferred sharing their stories only with the interviewer and refused discussing with a larger group. Each interview took between 20-40 minutes depending upon the interviewee. Identically, all the IDIs were audio recorded with informed consent from the respondents.

Observation of the service site

3 government service sites of three districts were observed based on the checklist developed. The checklist included criterion such as separate/enclosed space for the service, SAS board clearly visible, provision of free abortion services and others (Annex 1).

Key Informant Interview with the Service provider

To supplement the information from FGDs and IDIs, three key informant interviews with service providers were conducted to gain a more detailed reflection of community-held perceptions. This helped in triangulating the information conferred from the respondents who had untaken abortion services.

Picture 1 Focus Group Discussion with Post-abortive women of Mugu

Picture 2 In depth Interview with Post-abortive woman of Sindhuli

2.5 Data Analysis

With regards to qualitative data, all audio tapes and field notes of focus group discussions and in-depth interviews were transcribed and translated into English. A thematic analysis approach was used. In view of the time and resources, the textual data was analyzed manually. After carefully reading the transcripts, the findings were summarized according to key themes and analysis given. Interpretative analysis was then carried out. Other secondary data, findings from desk reviews, observations were simply reviewed and conclusions were drawn.

2.6 Validity of the tools

The tools used for data collection were validated through the workshop with all the RHRN platform members. All the received feedbacks and suggestions were incorporated prior to the study. Whether to go for FGD or IDI was decided upon discussion with the local coordinators, who had experience working in the community and could provide cultural context.

Picture 3: Tools validation workshop with RHRN members

2.7 Ethical Considerations

The study was conducted with full respect of ethical and safety considerations. All the respondents whose responses have been used in the study gave their explicit consent to being interviewed and to being audio-recorded. The following measures were adopted to protect both the respondents and the research team and to ensure privacy and confidentiality of the interviewees:

- Participants were fully informed about the nature of the study, research objectives, confidentiality of the data, and full consent for their participation in the study was obtained. The informed consent form was written in simple Nepali language. This was read aloud to the respondents and a written consent (thumb print if illiterate) was obtained.
- During the introduction, respondents were told that they could skip any question they did not wish to answer. At the end of the interview they were given the opportunity to make comments or ask any questions to the interviewers.
- Individual interviews were conducted in a private and convenient location for the respondent. No one but the interviewer and the respondent were present during the interview.
- Written consent was obtained for photo and video documentation.

2.8 Challenges and Limitations of the study

Getting genuine responses from pharmacist from all the three districts was a major challenge. Also, all the respondents were married. Finding young unmarried women who had untaken abortion services was beyond the bounds of possibility.

As with any research, there were limitations both to data collection and interpretation. Due to the purposeful selection of study districts, findings may not be generalized to a wider population. Although efforts have been made to ensure the reliability and validity of responses, the possibility of under- or over reporting of their abortion experiences could not be entirely ruled out given the patterns of social stigma and fear.

Chapter 3: Results

This section highlights the major findings and observation of the study.

3.1 Who are these young people who access the safe abortion services?

The median age at first marriage for women in Nepal is 17.9 years. Meaning almost half of the young people are already married by the age of 17.9 years in Nepal. During the study, it was largely observed that the young people (considered people under the age of 30 for this research purpose) are in marriage. The case is true for rural district like Mugu, semi urban district like Sindhuli and urban areas like Itahari. So, young people who access this service are mostly married.

It also implies that unmarried girls who are accessing the service are still hidden, were not accessible by the organization working in the community or through snowball sampling. In Mugu, early marriage is the norm and so unmarried people accessing or requiring abortion service was almost nonexistent. For other urban areas, there might have been unmarried young people but they were not willing to come forward for this study.

On the contrary, married young women were willing to share their abortion experiences and were less hesitant about other people in the community knowing about it. Surprisingly, Mugu, where it was assumed that the young women would be unwilling to share about them accessing the service, the women were found to be more lenient and open about it. The main cause for this is rampant abortion cases in the community. Interestingly, in Sindhuli, the service provider shared that the local women who were married only come for the services there, meaning that the unmarried women and girls go to far off places for these services due to the fear of being noticed in the locality.

In all the three districts, these young people are usually aged 18 to 35 years of age. The case of multiple abortions is common rather than singular abortion, because the age at marriage is less, which means the age at first pregnancy is also less, and they reach multiple pregnancies by the age of 30. For instance, in Mugu all the respondents had 2-6 abortions.

3.2 What kind of abortion services are they accessing?

Over the 15 years that abortion services has been legalized in Nepal, the rate of unsafe/traditional abortion services have declined, as it seemed in this study. The research team tried hard to identify and talk to some women who are still using traditional unsafe methods, but were not able to access even one of them in all the three districts.

"*Sitting on hot cow dung or inserting a needle used to be a common method of abortion for my mother's generation. But, we have stopped doing it now as we have access to cleaner, easier and safer methods*" shared a 24 years old woman of Mugu. Another woman from Sunsari shared "*It seems like a story of the past when I hear that our mother's generation used to prick uterus with stick, glasses or other sharp objects. These days I don't think anyone will be willing to do that*"

All the women in the study mentioned that they have not known anyone taking traditional abortion services in the last 4 years. This does not necessarily mean that the traditional unsafe methods are extinct, as there might be hidden cases, especially from vulnerable population, but definitely signals a sharp decline in those cases.

There was a fair distribution in the medical and surgical abortion among the women the research reached out to, and all the individuals had justification for preference of one type over the other. Some of the parameters that were observed when women made choices on the type of abortion are:

a) Convenience:

Medical abortion seemed to be a preferred option when convenience was sought, as the process is less invasive and the recovery period is quicker. Also, women have to deal with less people and so the fear of breaching confidentiality is less.

However, there are women who do not trust medical abortion as surgical abortion ensures complete treatment, unlike medical abortion. Women who had failure with medical abortion in the past, women who had friends who had failure with medical abortion services, or those who had multiple abortions earlier also choose surgical abortion.

But then, most of the women who were undergoing abortion for the first time preferred medical abortion, and after 3-4 medical abortion, chose surgical abortion. Women who chose surgical abortion on the first attempt were very less.

Case Story 1

Kelu Shahi (name changed) is 34 years old and she has attempted five abortions already, the initial three being medical abortion. The fourth one was failure because she attempted abortion during 4th month of her pregnancy, when medical abortion was not recommended. She believed that the "medicine" no longer worked for her and chose surgical abortion on her next abortion. These kinds of cases were not uncommon, and were triangulated by a statement from a service provider "*Incomplete medical cases come for surgical abortion later. Usually 10-12 percent of the cases that come here for SA are incomplete MA cases*"

b) Confidentiality

Most of the women who chose medical abortion did so because they felt that it provided them more confidentiality because the only person they needed to tell about it was the pharmacist "*The pharmacist knows about me already, and he/she know that I have a family and kids already and it is justifiable that I undergo abortion*." shared one 30 years old woman in Sindhuli. However, it also means that if the pharmacist does not know the client, he or she might deny the service.

On the other hand, people have also been found to opt for services away from their home, and this shows that they do not trust that the confidentiality will be maintained by those service sites. In rural areas like Mugu, where there is only one service delivery point, young women were less concerned about confidentiality, as opposed to women in urban areas like Sunsari. Hence, women in urban areas travelled further from homes to access those services.

c) Medical outcome

The women who believed that case management and medical outcome of surgical abortion is better, have found to opt for it. The failure cases of medical abortion were found to be higher than surgical abortion. However in reality, the failure is due to lack of understanding about proper use of medical abortion or the capacity of the service provider.

Women who were past four months of pregnancy, who consumed medical abortion medicine on self prescription, when the cases were not successful, developed distrust with medical

abortion services. Medical abortions that are performed without the supervision of medical personnel were found to lead to bleeding, body aches, nausea and weakness. Hence, the general assumption is that medical abortion yield poor result than surgical abortion, while in reality both of them have equally beneficial results if performed properly.

3.3 Why are they using abortion services?

a) Family Planning

Women who had several babies in the past and did not want any more babies chose abortion as a medium to plan their family size, across all the three districts. What differed was the size when the family was believed to be complete. For eg: In Mugu, when a women had 4 or more babies she considered her family complete, which came down to 2-3 babies in semi urban areas like Sindhuli, and 1-2 babies in urban areas of Sunsari.

All the women interviewed, had heard about family planning devices, and some have been using it too. However, the use of contraceptive was found to be very low as women and their husband did not have trust on the device.

Case Story 2

"I have heard about family planning, but never used it because my husband does not allow me to do so. I cannot do family planning because my husband thinks that it will free me to sleep with other men when he is not at home. Also, family planning will make me weaker to do the household chores. For him, he is hesitant to use condoms as it disrupts the sexual pleasure, and does not want to do vasectomy as it will make him weak. So, the only solution we have is not to use any device and abort children" shared a woman of Sindhuli.

"*Once a man in our community did vasectomy, but it was a failure for some reason. Later, the wife was pregnant, and the man had beaten her very badly. He threw her out of the house believing she had been cheating on him. I am afraid the same thing will happen to me, so I don't want my husband to do vasectomy, only to be blamed myself later*" shared a 28 years old woman of Mugu.

Several women during the research complained of nausea, heavy bleeding, malaise and joint pain due to the use of family planning devices, especially depo and pills, which further reduced their trust in family planning.

The Medical Officer of the Health post in Mugu also agrees. "*The trust with family planning device is very low among women. They believe that if they use depo once, for example, it should work for a year. They do not keep record of when was the last time they took the shot. In the meantime, they become pregnant and let the community know that depo does not work. Then other women also become hesitant to use it*" he shared.

Also, women who have their husband working mostly as foreign labor use family planning devices haphazardly, usually only when they know their husbands are coming. This has led to several unwanted pregnancies and later in abortion cases.

b) Son or daughter preference

Only three cases of sex selective abortion were observed, 1 in each of the three districts. Out of the three, two was for the preference of a daughter, meaning that a woman who had more than 3 sons in the past decided to abort. For the other two, they opted for abortion to change their uterus *"kokh ultaunu"* which means that they hoped that the trend of giving birth to daughter only would break after an abortion. In both the cases, the next child was also a son.

c) Patriarchy

The underlying cause of abortion is the patriarchal system and the acceptance of women as baby producing machine, both by young women and men. "I *sometimes feel like I am a rabbit, because I have given birth to half a dozen children already. Still, every few months I get pregnant and undergo abortion*" says a woman of 28 years in Mugu. She has already attempted 6 abortion services. For her, it is acceptable that her husband has decided not to undertake family planning, for both of them, and that is hampering her health. "*No one can better understand how my health has deteriorated with 6 births and 6 abortions, yet my husband is reluctant to use family planning, and being a woman, I have to accept it. However, I am glad that the service is available to young women like us, else without abortion services, I would have been affected even more*"

3.4 How much are they paying?

The price that the women are paying for abortion greatly differs on the context, type of service chosen, location of the service etc. For medical abortion, the direct cost of the service alone ranged from NPR 1500 to 12,500. In Sunsari, a woman said she paid 20,000 to a private hospital, and a woman in Mugu said she spent around 12,500 directly to the hospital and 80,000 in total that included both the direct and indirect costs. In Mugu, most of the amount was taken as loan from relatives, friends or neighbors, often in very high interest. It may take several years for them to pay the debt. It is not uncommon for women from Mugu travel to Jumla, and women from Sindhuli travel to Janakpur for the services.

Case study3

"Karuna Shahi, 26 years woman from Mugu, never went to school. 3 years ago, she took abortion service because she had 4 daughters already and her friend suggested her to do surgical abortion, that might change the uterus and she might give birth to a son. However, she had to travel to Nepalgunj because Nepalgunj has the service of sex determination of fetus. When she came to know that the fifth child was also a girl, she decided to do abortion. In total, she paid 12500 directly to the hospital, and in total 80,000 NPR.
Moreover, the bleeding continued for 3 months. In the beginning, she tried the herbs found locally and that did not work. Only after 3 months she decided to go to post abortion care, but then her bleeding stopped and she decided not to go. However, if she had to go to Nepalgunj again, she would have to spend another 80,000 again. Since farming is the only occupation, she had to struggle and could pay the debt only in 2 years."

These cases were from few years ago when the services were not provided free of cost. From this Fiscal Year, the government has made abortion services free, meaning they will not have to pay for direct services. However, the indirect costs that are associated with the services are also huge, making abortion services still less affordable for many.

When asked if the cost incurred for the service (both direct and indirect) is expensive, almost all the respondents said yes, it is expensive. While most of the respondents were not aware that the service was provided free of cost at registered service sites, those who knew were happy

that the service has become more affordable because the direct cost has been waived, while at the same time, the need to stay at hospital for multiple days after abortion has also been eliminated, making the service more affordable.

3.5 How friendly is the service site and service provider?

The respondents in Mugu, Sinduli and Sunari shared that they are pleased with the behavior of the service provider and condition of the service site, and also shared that there has been improvement in the service quality over the years.

a) Behavior of the service provider

Women were satisfied with the behavior of the provider in all the sites. Married women were not concerned even if the provider was male. *"I am shy when the provider is male, but often I close my eyes. We only have male doctors here, so that is our need, but he is friendly and supportive"* shared a woman of Mugu. The medical person of Health Post in Mugu agrees on this and says "*This is the only registered service site we have in the entire Mugu district, and so we have to provide service to the seekers in any condition.*

However, it was also noted that abortion does get stigmatized when it is performed multiple times. Women reported that the behavior of the provider changes a little when they come to know that the abortion is the second or the third one. One of the provider agreed "*When women come for abortion multiple times, we counsel them about family planning, and encourage them to use it. Sometimes, when counseling is not enough, we need to threaten them as well. But, when they come for abortion service again in few months, we do get irritated. We are not hesitant to provide the service, but we are concerned about their health."*

b) Service site

Picture: Service Sites: Sindhuli, Mugu and Sunsari

- Hospitals/ Health Post

The government service site in all the three districts differed in their ability to provide services. For eg: Mugu that had very limited infrastructure provided the counseling, abortion and delivery services from a single room. It is not because the medical personnel are not aware about the need for separate space or for separate services, but they are entitled to do it because of lack of infrastructure.

In Sunsari health post, a separate room was allocated for abortion services, while in Sindhuli district hospital, a separate building was allocated for abortion services, with separate

registration, waiting, counseling and abortion rooms, with the ability to maintain confidentiality.

However, all the three sites were found to have taken care of patient's comfort and confidentiality to the best possible within the resources available.

- Pharmacies

The pharmacies were reluctant to share about abortion services in all the three districts. Even after multiple attempts to interrogate them, or mobilizing them through their close friends, it was not possible to gain information from them. The answer that the research team received every time was quite ideal such as "*We are not registered for the abortion services and so we do not provide them abortion medicines. If anyone comes to us, we simply refer them to other organizations like Marie Stopes*". However, when most of the women in the community shared that they are receiving abortion medicines from pharmacies, it is hard to believe these statements.

Picture 1: Interviewing the Pharmacist

The pharmacist in Sunsari insisted that "*The monitoring from DDA (Department of Drug Administration) is quite strict, and if they see that we have these medicines at store, they would void our license. So, we do not take the risk at all*." which seems possible given that Sunsari is urban area. But, monitoring is probably not as strict in rural and semi urban areas like Mugu and Sindhuli.

"*The cases that visit us are complicated cases after improper self medication of medical abortion obtained through unregistered pharmacies*" shared a registered medical person, which implies that the medical abortion that come to these centers are merely tip of iceberg. High numbers of medical abortions are still happening illegally.

c) How accessible are the services?

Women were found to have traveled anywhere from within 15 minutes to 2 days to receive the services. In Mugu, in average a woman walks for 2 days before she can access the service point, and that can go up to 5 days for some woman. Others who go to Jumla, which is the adjoining district, have to allocate at least 3-4 days for the entire trip.

For semi urban areas like Sindhuli, people either opt for service in the pharmacies, health post or hospitals near to them, which is usually within 1 hour reach. If they prefer to go to Janakpur, the adjoining district, in search of better care and confidentiality, they have to allocate anywhere from 2 days to a week. However, these districts are connected by road and so medical tourism is easier. Hence, the medical tourism cases were found rampant in Sindhuli.

Sunsari, being urban area has many options for abortion services. Hence, the service center was accessible for many women, either by road on or foot.

3.6 Who makes the decision?

In most of the cases, both the husband and wife jointly make the decision to undergo abortion. The cases where the women had not discussed this with their husband or family were very rare. Conversely, it could also be that women who did not fear about breaching their confidentially

with the research agreed to join the research. Also, women who had undergone multiple abortions said that their husband pushed them to do abortion, even though they knew about the health consequences. In most of the cases, husbands accompany their wives to the service sites.

In small cases, the couples were found to approach the service provider for the decision and select the alternative suitable for them. Medical services were not available in all the government sites, so surgical abortion was recommended most of the time in these cases. For complicated cases, surgical abortion were found to be recommended by the doctors and hence decided to do it.

3.7 How is confidentiality maintained and perceived?

Confidentiality with the service provider did not seem to be the problem with any of the respondents, as no respondents complained of confidentiality breach. However, people fear that the people who see them while entering the service site will talk about it in the community. Places like Mugu where no other service site is available, people are open about sharing about them taking the service, because every other woman has done it. In semi urban areas like Sindhuli and urban areas like Sunsari, where there are options for service site, people are concerned about their confidentiality more and travel to places away from their home to receive the services.

Most of the respondents from all the three districts said that the consent was not requested by the service center, and they were not asked about their age or marital status. The service provider, however, did ask about family history and childbirth, to suggest about options for abortion services.

One of the service providers shared "*We can often guess if the service seeker is unmarried or if she is under age. Being married is not our concern, but under age abortion could impact her health. But, we do not ask them for their age, because even if we did, they will not answer correctly. So, there is no point in asking them their background information*".

3.8 Do they know if the service site they are accessing is SAS?

The young women in Mugu were not aware what they mean by safe abortion service or site, and have never noticed the SAS logo in the service site. They visit there for service merely out of words of mouth, and do not understand that abortion services and safe abortion services are different.

Some young women also come to receive the information through radio, mother's group meetings, family planning awareness and orientation program conducted by various organizations. However, the information provided did not seem to be updated, complete or legible to the target group. For eg: when asked to women if they know about abortion, they would know, but none of the women had ever heard the word "Safe abortion services". The president of a mother's group shared that the emphasis during meeting is given to family planning, but little information is also given regarding safe abortion. These meetings are not regular, so the ability to deliver these information regularly is a challenge.

The decision to choose the service site hugely depended on the person's prior experience with the service site. They chose places where they have delivered their children, are relatives to service providers, or because someone they know knows about the place.

Case Study 4

"I was bleeding for almost 3 months after abortion. I became so weak that I was not able to stand or sit properly. I then went to Jumla for further treatment" is the case of Shanti (name changed) 32 years old woman of Mugu. "I will now never do abortion", she shared. The problem of Shanti is not as shallow as it seems. She first opted for medical abortion, which was incomplete and later had to do the surgical abortion. When she reached the service center, her case was already complicated. Even when she was asked to visit the service center again for follow up, she did not

3.9 Follow up services

Both the providers and the service seeker agreed that the service provider insist on visiting the clinic after abortion. Due to hesitancy, health posts being far, lack of indirect costs for travel etc. the patients that come for PAC is very low. Usually in season that require working in farms most of the time, women do not find time to come to the clinic for other medical care, let alone PAC which is not at all their priority. Only when the case is complicated, the people come for care. Else, they wait for the case to become life threatening level complicated.

Besides complication, another reason why PAC service should be implemented is to make Family Planning service available for all. "*We try to convince them for Long term contraceptives when they come for abortion, but usually the women say that they need to discuss with their husbands and then do not come back. Only if PAC could be implemented, family planning needs could be met and cases of multiple abortions would decline*" shared a medical personnel of Sindhuli.

3.10 Case studies

Case study 5

Radha Kumari Pandey (name changed), a 28 years old respondent of Sindhuli shared her story "My husband told me that he is taking me for first ANC care, few weeks after we came to know about our pregnancy. Only later I realized that he was actually taking me there for abortion. Since, he had already set everything up with the provider; I was not able to do anything. My husband was in love with another woman and did not want to have children with me. 15 years later, we again went for abortion since we have 3 children already, and this time there was counseling service, both of us provided our consent and the procedure was quicker and lesser invasive. I am amazed by how much the quality of service has improved in these 15 years."

Case Study 6

"I am only 27 year old can you believe it?" Santa Kumari (Name Changed) of Mugu asked us. She had wrinkles over her face, had lean and thin body and virtually looked like a woman into her forties. 5 live births and 6 abortions over a period of 10 years had caused serious consequences to her body. Now she complains of body ache, dizziness, irritation and weakness. 6 abortions out of which 4 were medical and remaining 2 surgical caused her financial, mental and physical problems. Non cooperative husband, lack of awareness and poverty at the extreme level has further added up in deteriorating her living standards.

"I take pills for contraception which causes me weakness and if I quit pills aborting another pregnancy also causes me weakness" says Santa Kumari explaining her paradoxical lifestyle. Two abortion done only 8months apart with hefty bleeding at both cases caused her significant distress and encouraged her in taking oral contraceptive pills. However her inability to adhere to the drug regimen caused failure of the contraceptive and pregnancies resulting in subsequent abortions.

Case Study 7

Sanu Maya (name changed) from Sindhuli already had 2 daughters and a son. Then one day when she found out she was again with a baby she was worried. She was already facing difficulties in feeding and providing proper education to the existing children. She realized another baby would be a burden to her family. So she decided to abort the baby through self medications. She took a gulp of 5/6 medicines she had at home most of which were painkillers. She claims that it did the job and she bled for 10 days then. She aborted another pregnancy through same manners in subsequent months. She said she had used Depo-Provera as a means of contraceptive in past which didn't worked and has done permanent sterilization recently.

Case Study 8

Neera Kumari Poudel (name changed), 32 years, has 3 daughters and 1 son and reports to have 3 cases of induced abortion. First episode was aborted by dilatation and curettage at Marie Stopes Center and latter 2 cases were aborted medically at local health clinics. She doesn't find any difference between the two methods. She used oral contraceptive pills for few months but discontinued it because of headache, dizziness and numbness.

We asked her "What she would do if she got pregnant again?" she swiftly answered "She would terminate the pregnancy". When we advised her that it would be better if she would opt for permanent methods of family planning as her family is complete, she said that she is afraid of the operative procedure and is insisting her husband to do the permanent sterilization while her husband is stressing that she should do it. So without any means of contraception she is still engaged in unprotected sex awaiting her 4th case of abortion.

Case Study 9

Gita Bk (name changed) 26 years old has 5 sons. She started conceiving since she was 13. Her husband is a drug addict who spends all of their family earning in drugs and alcohol. When she had 4 children she got pregnant again. When she was in her third trimester she realized her fetus isn't moving at all. She consulted with few friends in her hometown who advised her that if the child was dead she wouldn't be alive either, so there is nothing to worry. She asked her husband as well who started quarreling with her and beat her. She then went to her father's house where her brother found out her suffering and took her to a government hospital. On examination and investigation doctors found out that the fetus had been dead since several days. She was admitted and labor was induced to remove the products of conception which she defines as the most painful moment in her life.

After the incident, she got pregnant again and this time she underwent surgical abortion. The doctor advised her to take rest for at least 3 weeks but because of her financial crisis and irresponsibility of her husband she started doing heavy labor from the 3rd day which resulted in heavy bleeding. She explains it as near-death experience as she found herself soaked in a pool of blood. Life was a struggle for her which continued no matter how much hardship she had to face. Without using any means of contraception another pregnancy was inevitable. She

had a 5th pregnancy which she thought to abort like the previous one. She again went to the hospital where she was advised medical abortion this time. She took the medicines as instructed but soon vomited afterwards. Abortion was unsuccessful and pregnancy continued. She was carrying the 5th child while explaining all this."I faced so many difficulties during the last 10 years that I cannot even explain. You are an unmarried girl so please don't repeat the mistakes I made'' Gita Bk said to us with tears rolling down her eyes while we left.

Chapter 4: Conclusion and Recommendation

The results of this study indicate that people have been able to notice the improvement in the quality of abortion services in recent years, especially after legalization of abortion. The use of traditional methods of abortion services has declined drastically, the behavior of the service provider has improved, and confidentiality is not a major challenge, women and men are taking more joint decisions regarding abortion and the services have become more affordable with the exemption of direct service fee. Most importantly, young women were found to be able to open themselves up while discussing about abortion.

However, there are several challenges that do still exist. Even though the abortions are happening within marriage, the fact that age at marriage is low, still makes it risky for young people to obtain abortion services if the quality is not apt. Family planning is the main reason for abortion services, which is further influenced by son or daughter preference and patriarchy. Multiple abortions by a woman, in very small span of time poses her life and health at great risk. Also, though the direct service costs are now waived by the government, there are indirect costs associated with it that takes up month for women to pay the loan. Due to lack of proper infrastructures, especially in rural areas, the confidentiality of the women, and the quality of services have not been well maintained. Moreover, the pharmacies are still providing medical abortion services illegally, further risking the life of women. Follow up services still need to improve. Most importantly, women do not have adequate information about safe abortion services and sites.

Recommendations

As such, in light of the discussions presented in this report, the following recommendations have been placed.

- In order to address the existing challenges faced by young people regarding accessing abortion services, there is a need to address it at the policy level. The government should include provision for stigma free and youth friendly free safe abortion services for all women and girls in the Reproductive Health bill and directives to national and provincial level, so that all women and girls can enjoy their rights to abortion.
- The pharmacies are conducting medical abortion services without registration. The Department of Drug Administration should take strict actions against those providing illegal abortion services in medical stores and pharmacies.
- The need to improve the infrastructures and human resource in service sites has been realized. The government should increase the human resource and infrastructures for health at all levels, expanding the services on abortion and post abortion care services like increasing the number of listed service sites, to make the service accessible for all.
- The civil society organizations, including media, should coordinate towards providing factual information so as to reduce the stigma associated with abortion.

ANNEX

Annex 1: Research tools

Tool 1A
Guideline for IDI with young women who have taken the safe abortion service
And/or
IDI with young people who have accompanied another young people for a safe abortion service

For this, try to get to respondents who have taken the safe abortion services themselves to obtain the real stories. In case, these cases cannot be found, try to contact accompanies as most of the time young people are comfortable sharing their own story as their friend's story.

Respondents
Number of participants: 7 -8
Age group: 16 to 30 years
Have taken abortion services recently i.e. less than 5 years

Materials required:
Consent form, guideline questions, notebook, pen

Before the interview

- Request the partner organization at the district to coordinate appropriate participants and the venue. Try to make the group as inclusive as possible on the basis of age, class, ethnicity, etc. Make sure that the participants are well informed if they will be compensated for their time.
- Inform the participants about the time and venue at least 2 days in advance. Convey well to them that they do not need any preparation for the discussion.
- Explain properly the objective of the interview and obtain written consent from the interviewee.

Discussion questions

1. Enquire about the background of the participants [Eg: ethnicity, age, marital status, class, education status, no. of children if any etc.] Note the answers in the remaining part of the discussion and see if you can find any pattern. This question is optional and do not force anyone to reveal the information if they don't want to.

2. Information about Safe abortion services (SAS)
    a. Do you know about SAS? How did you get the information?
    b. Did you know if the place you seeked service is SAS registered?
    c. Who told you about this place?

3. Accessibility and affordability
    a. How far is the SAS from your home or school?
    b. Did you pay any fee? If yes, how much? Is this fee affordable for you? How did you manage the fee?

4. Were you on contraception when the unwanted pregnancy happened? What device did you use?

5. Kind of abortion services undertaken
    a. Medical/Surgical [Note here whether they are married or not]
    b. Where did you receive the service?
    c. When was it? How many months/years back did it happen? Is your background status different from what it was then? (eg: marital status, education status etc.)
    d. Why did you do abortion [Eg: as FP, sex selection, unmarried etc]

6. Decision making
    a. Who decided to undergo abortion? (You, partner, family, friend etc.)
    b. Who decided where should you get this service from?
    c. Who decided what kind of service you should seek (medical/surgical)

7. Youth friendly services
    a. Did anyone come with you to accompany you for the service? Who was s/he? Why did you select him or her to accompany you?
    b. What was the main reason you decided to choose this SAS? [Confidentiality, behavior of the provider etc.]
    c. Did you like the service provided?
        i. Medical outcome
        ii. Behavior of the service provider
        iii. Condition of the service site
        iv. Confidentiality, consent and privacy
        v. PAC services [FP counseling and follow up]
    d. Did they ask you for consent? Did they ask you for your age? Did you need to provide any proof of you or your accompany?

8. Do you have children or not? If yes, how many?

9. Does your family/ community know that you took up this service? If yes, how did they know? Does it affect you that they know?

Tool 1B
IDI with young women who have been denied the safe abortion service, And/or
IDI with young women who took unsafe abortion services, And/or
IDI with young people who have accompanied their friends for unsafe abortion services

Respondents
Number of participants: 7 -8
Age group: 16 to 30 years
Have taken abortion services recently i.e. less than 5 years

Materials required:
Consent form, guideline questions, notebook, pen

Discussion questions

1. Enquire about the background of the participants [Eg: ethnicity, age, marital status, class, education status etc.] Note the answers in the remaining part of the discussion and see if you can find any pattern. This question is optional and do not force anyone to reveal the information if they don't want to.

2. Do you know about SAS? How did you get the information?

If yes, why did you undergo unsafe abortion despite knowing about SAS service?

3. Were you denied safe abortion at any site or did you go for community (avoid using unsafe word here) service directly?
    a. Denied safe abortion service
    b. Went directly

If denied why do you think you were denied of the SAS?
    a. Could not pay fee/affordability
    b. Gender of the service provider
    c. Unmarried and so the provider was hesitant
    d. Was already 12 weeks pregnant
    e. The provider asked for further services such as Ultrasound
    f. Don't know

If went directly, why did you chose this service?
    a. Affordability
    b. Accessibility
    c. Fear of breaching privacy
    d. Attitude of the service provider
    e. Gender of the service provider
    f. Others

4. Kind of abortion services
    a. What was the procedure you undertook?
    b. Where did you receive the service?
    c. When was it? How many months/years back did it happen? Is your background status different from what it was then? (eg: marital status, education status etc.)

d. Did you pay any fee? How much? Is it affordable for you? How did you get the money for the fee?

5. Decision making
    a. Who decided to undergo abortion? (You, partner, family, friend etc.)
    b. Who decided where should you get this service from?

6. Youth friendly services
    a. Did anyone come with you to accompany you for the service? Who was s/he? Why did you select him or her to accompany you?
    b. Did you like the service provided?
        i. Medical outcome
        ii. Behavior of the service provider
        iii. Condition of the service site
        iv. Confidentiality and privacy

7. Do you have children or not? If yes, how many?

8. Does your family/ community know that you took up this service? If yes, how did they know? Does it affect you that they know?

Tool 1C
KII with the service provider and pharmacist

Name of the service provider: _____
Position _____
Service Center _____
Date _____
Gender _____
Service Provided: Medical Abortion/ Manual Vacuum Aspiration

1. What do you understand by young people?
2. How long have you been providing this service?
3. Are you registered for this service, if this center provides surgical abortion?
4. How often do people visit here? How often do young people visit here?
5. Where do young people in the community choose to go for abortion services?
6. Have you noticed any pattern in the young people that visit here?
   [Age, marriage status, economic level, ethnicity, no. of children, multiple abortion]
7. Do these young people usually come alone or with a company? If with a company, what kind of company?
8. Have you ever denied any young people for abortion services? If yes, why?
    a. Could not pay fee/affordability
    b. Unmarried
    c. Was already 12 weeks pregnant
    d. The case was complicated and I had to refer
    e. We only perform medical abortion here, so had to refer for surgical abortion
9. Do you think they are facing any challenges to seek the service? If yes, what could they be?
    a. Accessibility

b. Affordability
c. Privacy
d. Waiting period
e. Behavior of the service provider

10. Is abortion free in this site? If yes, since when have you been providing free service? If no, how have you been managing the expenses? If you charge any fee to the service seeker, what is the fee?
11. How many registered safe abortion practitioners are present in the site?
12. Is counseling and PAC service also available? [Break down into probing phrases like follow up, family planning counseling etc.)
13. Do people who have already taken services from other places, get complication and come to take services?
14. Do you have a record of same woman taking number of safe abortion services?

Additional Questions for Pharmacist

1. Do any denial cases from government health service sites come to seek abortion services from you? If yes, what are the most common reasons of denial? Have you been providing services to those cases?

Tool 1 D
Photo and Video documentation

Material required: Camera, tripod stand, notebook, consent form for taking video or photo, guidelines that are same as the IDI guidelines, recorder, spare batteries

Tool 1E
Observation of the service site

Name of the service site
Location
Type
Date
Service Provided: Surgical abortion/Medical Abortion/ Medical Vacuum Aspiration

1. SAS board clearly visible	☐ Yes ☐ No
2. Availability and number of SAS certified provider	☐ Yes ☐ No
3. Availability and number of SAS certified medicine	☐ Yes ☐ No
4. Separate enclosed room/space for service	☐ Yes ☐ No
5. Sterility and cleanliness of abortion equipments and space	☐ Yes ☐ No
6. Free abortion services	☐ Yes ☐ No

REFERENCES

[1] Adhikari, R. (2016). Knowledge on legislation of abortion and experience of abortion among female youth in Nepal: A cross sectional study. *Reproductive Health, 13*(1), 48.

[2] Andersen, K. L., Khanal, R. C., Teixeira, A., Neupane, S., Sharma, S., Acre, V. N., & Gallo, M. F. (2015). Marital status and abortion among young women in Rupandehi, Nepal. *BMC Women's Health, 15*(1), 17.

[3] Pradhan A, Suvedi BK, Sharma SK, Puri M, Poudel P, Chitrakar SR, et al. Nepal maternal mortality and morbidity study 2008/2009. Kathmandu, Nepal: Family Health Division, Department of Health Services, Ministry of Health and Population, Government of Nepal; 2012.

[4] Turner KL, Börjesson E, Huber A, Mulligan C. Abortion care for young women: a training toolkit. Ipas: Chapel Hill, NC; 2011

[5] CBS . National Population and Housing Census, 2011 (National Report) Kathmandu: Government of Nepal. National Planning Commission Secretariat, Central Bureau of Statistics; 2012.

[6] WHO . Safe Abortion: Technical and Policy Guidance for Health Systems. Geneva: World Health Organization; 2004