Unsafe and safe abortion practices in Nepal after legalization

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Executive Summary

The legalization of abortion in Nepal in 2002 was an important step toward reducing pregnancy-related maternal disability and death in the country. The expansion of safe abortion care, however, is not sufficient for improving the health of women. The provision of post-abortion contraceptive counseling and provision is key for reducing repeat unintended pregnancy and abortion. Although Nepal's safe abortion policy calls for the provision of contraceptive counseling and supplies at the time of abortion, little is known about actual counseling practices or the methods of contraception women receive. Research on women’s experiences with post-abortion contraception is needed to inform efforts to reduce unintended pregnancy rates, as well as to address political concerns that a stagnation in Nepal’s contraceptive prevalence rate over the last decade may be due to the legalization of abortion.

We performed a one-year, longitudinal cohort study of 838 women obtaining legal, elective abortion at four major health facilities (two public hospitals, two private clinics) from March-May 2011. In-depth 6 interviews were performed with women on the day of their abortions, and follow-up visits were conducted 6 and 12 months after baseline.

For this career development grant, I analyzed baseline and 6-month data from the CAC study with the following aims: 1) to describe the contraceptive counseling experiences among women obtaining legal elective abortion; 2) to assess the contraceptive method selected, supplies received, and methods initiated; and 3) to identify factors associated with receipt of counseling and method selection.

The 838 participants were on average 26 years old, and 97% were married. More than half of participants did not want to have another child (59%), and 36% wanted to delay next childbirth for at least two years. Only 5% wanted a child in the next two years. While 80% of participants received an aspiration abortion prior to enrollment, 20% obtained medication abortion.

Two-thirds of women received counseling on at least one effective method at the time of their abortions (68%). Most women received information on one or two methods; 19% received counseling on at least three different methods. Over a third of women received no contraceptive counseling at all.

Overall, 78% of participants completed six-month interviews. About 63% of these participants reported using an effective method in the 6 months after the abortion: 35% used the injectable, 18% the pill, 5% LARC, 1% female or male sterilization, and 4% two or more of these methods. Most women who had selected an effective method at baseline reported initiating the method (64%), or another effective method (20%), over the next 6 months. Although these contraceptive use rates are not directly comparable to the national contraceptive prevalence rate of 30%, our data are unsupportive of the claim that stagnation in contraceptive prevalence in Nepal might be attributable to the availability of legal abortion services. Instead, our data suggest that the provision of legal abortion services through certified facilities can provide an opportunity to improve adoption of contraceptives among women at risk of unwanted pregnancy. We are currently analyzing the longitudinal data from the study to examine continuation rates over the year after abortion.

One quarter of women selected no effective method. The most frequent reasons given for not selecting a method were that the woman’s husband or partner was away or abroad (38%) or that she was having
infrequent sex (19%). Together with our finding that women not living with their partners were less likely to receive counseling, we conclude that women whose husbands are away or who have infrequent sex may face sociocultural barriers to contraceptive use, or provider attitudes and behaviors might contribute. Further research into the contraceptive needs and preferences of these women and into provider attitudes and behaviors towards these women is needed to better meet their needs, in both the post-abortion setting and in reproductive health care settings more broadly.