

Induced Abortion in Urban Nepal

By Shyam Thapa and Saraswati M. Padhye

Context: Most of what is known about women seeking pregnancy termination in Nepal has been learned from women admitted to hospitals with abortion-related complications. Little is known about women who obtain “safe” abortions from trained providers.

Methods: Social and demographic information was collected from women seeking induced abortions from a private clinic in Nepal’s capital city of Kathmandu. These data were analyzed and compared to data from two other sources.

Results: Thirty-six percent of the women were between 25 and 29 years of age, and 43% had two living children. Forty percent had more than a high school education, 91% were from Kathmandu and 48% practiced contraception. The primary motivation for seeking abortion for 34% of the women was the desire for no more children. Women in urban areas who had ever had an induced abortion tended to be younger, of lower parity and more educated than those in rural areas.

Conclusions: Women in Nepal desire a small family size, especially those living in urban areas. Although significant numbers of women practice contraception, induced abortion is also used, primarily to control family size and for birthspacing. Increased promotion and use of contraceptive methods are needed to decrease the number of abortions, especially those that are high-risk and unsafe. International Family Planning Perspectives, 2001, 27(3):144–147 & 151

In countries such as Nepal, where abortion is severely restricted by law, most women seeking abortions and most people providing abortion services must do so clandestinely. Often, women in rural areas and poor women in urban areas who wish to terminate a pregnancy must obtain services from untrained professionals in environments failing to meet basic, minimal medical standards.¹ Most of these abortions may thus be considered “unsafe.”²

Due to the fear of prosecution or social stigma, information relating to abortion is often difficult to obtain from either providers or clients. In countries such as Nepal, patients who present at a hospital with an incomplete abortion or with abortion-related complications cannot be denied care, even though abortions are restricted. Thus, hospitals and clinical facilities serve as logical and convenient places to gather

information regarding abortion, as patients in hospitals and clinics are often more willing to consent to be interviewed and to provide information. For this reason, the limited previous research on abortion in urban Nepal largely focused on patients in hospitals and clinics.

A 1984 study of five hospitals in and around the Kathmandu Valley identified 165 possible cases of induced abortion from among 1,576 abortion-related cases over a one-year period.³ The study also revealed that many abortion service providers in urban areas were untrained, and therefore lacked knowledge about dangerous, unhygienic and sometimes fatal practices.

A six-month prospective study carried out in four public hospitals and one private clinic in Kathmandu in 1992–1994 showed that of 1,241 abortion-related cases, 234 were identified as induced abortion.⁴ The researchers followed up 130 (56%) of the 234 women who had induced abortions twice in the subsequent 15 months to study the women’s reproductive behavior.* Most women receiving

abortion services from trained medical professionals for pregnancy termination were educated and sought first-trimester procedures. In contrast, women seeking services from untrained providers seemed prepared to take considerable risks to terminate unwanted pregnancies. Although postabortion contraceptive use was high, some women resorted to repeat abortions due to method failure or other factors.

Neither of these studies included women who sought early termination of pregnancy. Furthermore, these studies were mostly limited to public hospitals, where the cost of services is considerably lower than in private facilities.

According to a recent survey among health professionals in Asia, approximately one-third of women who undergo abortion develop medical complications requiring hospital admittance.⁵ Therefore, the hospital-based cases, even when respondents provided accurate and full information, represent only one extreme: women who experience complications of abortions. Among those who do not experience complications, the incidence of abortion and the reasons for seeking services remain largely unknown. To develop a comprehensive understanding of the demand for and supply of services, information from this population is also needed.

In this article, we present that side of the story: women in Nepal seeking pregnancy termination from qualified providers working in standard medical facilities. In other words, we report on the incidence of “safe” abortions in Nepal. The percentage of women seeking safe services is

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*Because of the moderate percentage (55.5%) of follow-up, the results need to be interpreted with caution. It is quite likely that the results are biased toward those with complications.

Table 1. Percentage distribution of Nepalese women who obtained an induced abortion from a private clinic, by selected characteristics, Kathmandu, Nepal, 1997 (N=160)

Characteristic	%
Age-group	
17-19	3.1
20-24	18.8
25-29	36.3
30-34	22.5
35-39	13.8
40-48	5.6
No. of living children	
0	8.1
1	21.3
2	43.1
3	15.0
4	10.0
≥5	2.5
No. of living male children	
0	30.0
1	47.5
2	17.5
≥3	5.0
No. of living female children	
0	31.9
1	39.4
2	20.6
≥3	8.1
Education (years)	
0	19.4
1-9	16.9
10	21.9
≥11	41.9
Occupation	
Housewife	67.5
Service/business	21.2
Student	5.0
Missing	6.3
Place of residence	
Within Kathmandu Valley	90.6
Outside Kathmandu Valley	9.4
Total	100.0

most likely considerably smaller than that of women seeking unsafe services. Also, women who receive safe abortions are generally more educated and are from relatively higher economic backgrounds.⁶ Even so, it is still important to understand how and why these women obtain abortions. Only with both perspectives can efforts that encourage women to utilize safe practices be made more effective. We know of no previous studies that provide primary data on women seeking termination of pregnancy in Nepal.

Data and Methods

In 1997, data were collected by interview with and clinical examination of all women who attended a private clinic in Kathmandu to obtain induced abortion. In all, data were collected from 160 women. All of the abortions were by manual suction evacuation, were within 10

weeks of the last menstrual period and were performed by one senior female gynecologist. The average total cost for the services was Rs3,000 (approximately US\$50) per client. After the procedure, patients were advised to return to the clinic after one week for a follow-up visit. During the subsequent visit, they also received contraceptive counseling.

We analyzed the women's social and demographic information and their reasons for seeking early pregnancy termination at the clinic. We compared the women's profiles with those of women from two other data sets: data from the Nepal Family Health Survey, carried out in 1996 as part of the Demographic and Health Surveys project;⁷ and data from 1998 on all gynecology patients admitted to the largest maternity hospital in Kathmandu.⁸

Finally, we examine here the extent to which the fertility behavior of women in Nepal differs from that of a "natural fertility" population (i.e., one in which the practice of contraception or abortion is negligible). In such societies, marital fertility varies by women's age according to a standard pattern. When marital fertility is controlled (through the use of contraceptives or induced abortion), the age-specific birthrate declines more steeply with age than is seen with the standard pattern—i.e., older women prevent births more rigorously than younger women because a higher percentage of the former do not want any more children.⁹ Using a standard age-specific schedule of natural fertility,¹⁰ we can calculate an index of the degree of control of marital fertility, based on age-specific marital fertility rates.* In this analysis, we estimated such indexes for urban and rural women in Nepal and contrasted the resulting patterns with the standard pattern for a natural fertility population.

Results

The frequency with which clients sought induced abortion was highest in mid-November to mid-December, the period immediately following Nepal's biggest national festival, which lasts nearly a month. The festival is a special time for families, as people who have been away often return home to be together. Mid-May to mid-June, the month immediately following the Nepalese New Year, was another period that had a high frequency of clients seeking induced abortions.

Thirty-six percent of the women surveyed were between 25 and 29 years of age (Table 1) and 43% had two children—generally one of each sex (not shown). A majority of the women were somewhat

Table 2. Percentage distribution of Nepalese women who obtained an induced abortion from a private clinic, by contraceptive method used prior to pregnancy and by main reason for seeking induced abortion, Kathmandu, Nepal, 1997

Method and reason	%
Method	
Condom	15.0
Injectable	13.1
Pill	8.1
IUD	5.6
Other	3.1
Hormonal implant	1.9
Diaphragm	0.6
Male sterilization	0.6
None	51.9
Reason	
Too many/no more children	34.4
Previous child too small	16.3
Contraceptive failure	10.6
Poor economic condition	10.0
Unplanned intercourse	7.5
No time to care for child/still a student	6.9
Medical reasons	3.1
Going out of the country	3.1
Unmarried	1.3
All other	5.6
Not stated	1.3
Total	100.0

educated; two-fifths had more than a high school education, while only one-fifth were without any formal education. One-fifth of the women surveyed were employed in the service or business sector. The overwhelming majority (91%) lived within the Kathmandu Valley.

Just under half of the women (48%) reported using some method of contraception prior to becoming pregnant (Table 2). Condoms were the most frequently used method (15%), followed by hormonal injectables (13%), the pill (8%) and the IUD (6%). Three women (2%) reported using hormonal implants and one woman's husband had had a vasectomy (less than 1%).

Thirty-four percent of women surveyed cited the desire for no more children as their primary reason for seeking pregnancy termination (Table 2). Sixteen percent chose to undergo abortion because their most recent child was still too small for them to take care of another. Although birthspac-

*It is known in demography that with different populations in which the practice of contraception or abortion is negligible, the variation in marital fertility with the woman's age follows a common pattern, labeled as "natural fertility." When marital fertility is not affected by measures taken to restrict fertility, the index has a value near 0; when fertility is reduced strongly by contraception or induced abortion, the index value is greater than 2. Negative values of the index result if marital fertility declines more slowly with age than is standard. In natural-fertility populations, the age-specific marital fertility curve is a convex shape, while in controlled-fertility populations it is concave (see reference 10).

Table 3. Percentage distribution of Nepalese women who obtained an induced abortion, by selected characteristics, according to data source and urban-rural residence, Nepal

Characteristic	All of Nepal*		Urban hospital†
	Urban	Rural	
Age-group			
15–19	1.5	7.3	2.7
20–24	17.5	8.4	16.2
25–29	31.0	17.9	24.3
30–34	25.4	29.5	35.1
35–39	13.2	9.4	13.5
40–44	4.5	14.5	8.1
45–49	6.9	13.0	0.0
No. of living children			
0	5.9	2.1	8.1
1	10.4	14.1	12.2
2	38.2	20.8	35.1
3	30.3	18.9	14.9
4	4.5	20.8	13.5
≥ 5	10.7	23.3	16.2
Education			
None	29.2	74.9	51.4
Some primary	15.9	9.8	20.3
Some secondary	13.4	11.5	17.6
High school/higher	41.5	3.7	10.8
Total	100.0	100.0	100.0

*Tabulated from the data tape of the 1996 Nepal Family Health Survey, 1996. Data refer to ever-married women aged 15–49 years (see reference 7). †Data refer to women who were clinically determined to have had an induced abortion, from all gynecologic patients admitted to the largest maternity hospital in the capital during a one-year period, January 1–December 31, 1998. These data were collected for a one-year prospective study on post-abortion care (see reference 8).

ing was the main concern for many of the women surveyed, 10% chose abortion because of poor economic condition, 11% because of contraceptive failure* and 1% because they were not yet married.

For additional perspectives on the so-

*Forty-eight percent of the women surveyed used some form of contraception prior to becoming pregnant. Thus, although nearly half of the women experienced contraceptive failure, many gave other reasons for pregnancy termination (most likely the reasons why they initiated contraceptive use). In this regard, “contraception failure” as a reason may not be strictly comparable to other reasons.

†Because the 1996 data were limited to ever-married women, the data from this survey may not be strictly comparable to data on all women. However, even in the clinical data, the percentage of never-married women is only 1.3%. Also, the age at marriage is quite low in Nepal, and the proportion marrying is quite high. According to a national survey, 85% of Nepalese women are married by age 20, and the median age at marriage is younger than 17, as of 1996 (see reference 7). Thus, the data on ever-married women include the experiences of the majority of women of childbearing age.

‡An incomplete abortion was classified by the attending physician as an induced abortion—either certainly or most probably induced—based on multiple symptoms, including oral history of the problem and its treatment, use or presence of a foreign body in the uterus, tender uterus, malodorous vaginal discharge and septic shock. (More details are given in reference 8.)

cial and demographic characteristics of women who underwent induced abortion, we analyzed data from two other independent sources. The data for both rural and urban Nepal from the Nepal Family Health Survey are presented in Table 3. The survey included questions for ever-married women aged 15–49 to ascertain the prevalence of spontaneous as well as induced abortion.⁷ Few women reported ever having had an induced abortion; given the highly restrictive abortion laws, the data are most likely underreported. Nonetheless, these data refer to the most recent countrywide sample of women of reproductive age, and are presented to help us discern any basic characteristics and patterns.

The 1996 data show that a considerably higher percentage of younger women in urban areas than in rural areas reported ever having had an induced abortion. Since no distinction could be made as to where or from whom the services were obtained, the data most probably include both safe and unsafe abortions. Half of women living in urban areas who reported an abortion were between 15 and 29 years of age, in contrast to 34% of the women in rural areas. Parity was also considerably lower among women living in urban areas: Whereas 55% of women in urban areas who had had an abortion, had fewer than three living children, only 37% women in rural areas did so. Among urban women who ever had had an abortion, 42% had at least a high school education. In contrast, only 4% of women living in rural areas who had had an abortion had a high school education or higher. Although these data are limited, overall they indicate that urban women who report ever having had an abortion were relatively younger, of lower parity and more educated than rural women.

Table 3 also includes data from a 1998 survey of the abortion experiences of all gynecology patients admitted to the largest maternity hospital in Kathmandu. Of the 1,116 women admitted to the hospital because of postabortion complications who were interviewed for the study, 74 (7%) were clinically determined to have had an induced abortions (not shown).⁸

The women in this survey were of similar age and parity as the women of the 1996 all-Nepal survey; however, they differed somewhat with respect to educational background. A greater percentage of women from the 1998 survey than from the urban all-Nepal sample had little or no education (51% vs. 29%). One reason for this difference might be that the par-

ticular hospital is a highly subsidized referral hospital that tends to attract women of low socioeconomic background and from outside the Kathmandu Valley. In the 1998 urban hospital sample, nearly half (49%) of the patients were from outside the capital city; they were most probably referred because appropriate services were unavailable where they lived. Overall, these data clearly indicate a preference for fertility regulation at lower parity among urban women who have ever had an abortion.

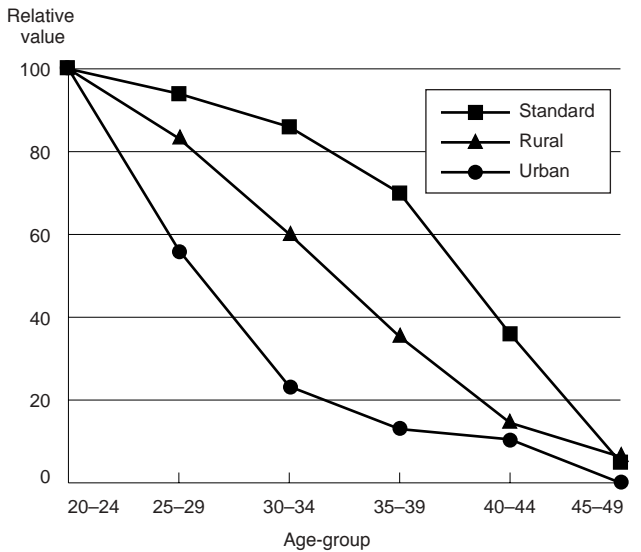
Discussion

Each of the three data sources examined here has relative strengths and weaknesses. Although the clinical data lack the necessary denominators to allow us to estimate the percentage of women seeking services for early termination of pregnancy, those data provide information about women seeking services. The data on women attending clinics and hospitals because of postabortion complications represent only those who experience morbidity, yet they provide insight into what might be happening in the communities. The survey among all women of reproductive age is helpful in that it provides the overall prevalence or incidence of abortion (lifetime or for a specific time period), but surveys of spontaneous and induced abortions are known to suffer from a large degree of underreporting.¹¹ The reported pattern of incidence may be relatively more correct than the level of incidence.

In view of their relative strengths and weaknesses, the three data sources utilized here in understanding the profile of women seeking abortion in urban Nepal should be considered as complementary. They reveal a generally consistent pattern: Women in Nepal seeking abortion services are young, and the majority already have at least one child.

The demand for services must be viewed in the context of changes in reproductive attitudes and preferences, especially in the urban population of Nepal. As of 1996, ever-married women aged 15–49 living in urban areas desired 2.4 children, on average. The total fertility rate among all women (based on data from women aged 15–49 for the three years preceding the survey) was 2.9 lifetime births per woman (although it was 4.8 per woman in rural Nepal). However, the “wanted” fertility rate, which indicates the total fertility rate if all unwanted births were avoided, was only 1.9 lifetime births per woman in urban Nepal.¹² Clearly, there is an important difference between

Figure 1. Age-specific marital fertility rates relative to rate among 20–24-year-olds, urban and rural Nepal, 1996, and standard value



Notes: Urban and rural rates are based on averages for 1994–1996. Each rate is expressed as a ratio to the rate among 20–24-year-olds. Source: Urban and rural Nepal, tabulated from the 1996 Nepal Family Health Survey (see reference 7); standard, see reference 10.

the actual and wanted fertility rate.

A significant percentage of women in urban Nepal are practicing contraception. As of 1996, just over 45% of currently married women of reproductive age in urban areas were using a modern method.¹³ Consequently, the fertility patterns of urban women are very different from those of the “natural fertility” population.* Figure 1 shows just how markedly fertility control has changed among married couples in urban Nepal. The overall degree of fertility control within marriage is 1.5 for urban Nepal (but is 0.6 for rural Nepal), based on the application of the Coale-Trussell model. The pattern of urban Nepal indicates just the opposite of the natural fertility regime, suggesting the emergence of a significant degree of fertility control with-

*Marital fertility for women ages 15–19 is not shown because teenage subfecundity generally has a “large and irregular impact on teenage marital fertility” (see reference 9, p. 66).

†A bill on abortion, which has languished in Nepal’s parliament since 1996, provides for conditional abortion services during the first 12 weeks of pregnancy. However, as it was introduced as part of a comprehensive bill on women’s rights and welfare, it remains bogged down in controversies surrounding other parts of the package that warrant constitutional amendments. A March 2000 seminar on the comprehensive bill, where several lawmakers, women’s rights activists and legal experts were among the participants, revealed a serious lack of consensus, even among lawmakers within the same political party. There is little doubt that deliberations on the abortion bill would have fared better in the parliament had it been introduced separately from the rest of the package. This all-or-nothing approach to legislation has produced a deadlock and zero progress.

in marriage in the urban population.

Obviously, a culture of contraception and small family size has become more common among women in urban Nepal. The data suggest that levels of effective contraceptive use could be even higher if certain improvements were made: If people using contraceptives, particularly those who do not want any more children, would either use more effective methods or use methods, such as condoms, more effectively; if there were increased promotion of emergency contraception to decrease the percentage of women who cite “unplanned” pregnancy as

their primary reason for seeking abortion; and if there were increased availability of contraceptive counseling for those who do not want additional children.

Conclusion

A desired family size of two children is now the norm in urban Nepal. This is a very different situation than 10–15 years ago. Clearly, fertility transition is underway in urban Nepal, with fertility being controlled within marriage by contraceptive use and to some extent by induced abortion. In urban Nepal, a significant percentage of women cite the desire for no more children as their primary reason for seeking pregnancy termination, particularly in the capital city of Kathmandu. The overwhelming majority of women seeking termination have at least one living child.

To improve abortion prevention, the data clearly suggest the need for increased use of contraceptive methods, including emergency contraception. On the curative side, the availability of menstrual regulation by manual vacuum aspiration should be considered the first and foremost policy option for addressing the problem of unwanted pregnancy in Nepal. Menstrual regulation has been acceptable to women around the world, including in countries like Bangladesh, where abortion is not permitted.¹⁴ Easier and regular availability of menstrual regulation services could go a long way toward reducing health problems and misery for many women in Nepal.† Without access to such

services, only a small percentage of Nepalese women, mostly those of better socioeconomic conditions, will have access to safe abortion services; other women will likely have no choice but to submit to the inherently high-risk and high-priced clandestine abortions.

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Resumen

Contexto: Casi toda la información que se dispone acerca de las mujeres que procuran aborto en Nepal, se ha logrado a través de los datos de mujeres que han sido admitidas a los hospitales a causa de las complicaciones relacionadas con el procedimiento. Se tiene muy poco conocimiento acerca de las mujeres que obtienen abortos “seguros” por parte de personal capacitado. **Métodos:** Se recopiló información y datos sobre los aspectos sociales y demográficos de (continued on page 151)

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las mujeres que procuraban aborto inducido en una clínica privada de la ciudad de Katmandú, la capital de Nepal. Estos datos fueron analizados y comparados con otros obtenidos durante la realización de dos estudios previos sobre el aborto en Nepal.

Resultados: En promedio, las mujeres tenían entre 25 y 29 años de edad y tenían dos hijos vivos. El 40% había cursado estudios superiores a enseñanza secundaria, el 91% residía en Katmandú y el 48% practicaba la anticoncepción. El motivo principal del 34% de las mujeres para procurar un aborto, era el deseo de no tener más hijos. Las mujeres de los centros urbanos que alguna vez se habían sometido a un aborto, eran por lo general más jóvenes y presentaban menores niveles de paridad y el mayor nivel de educación que sus pares de las zonas rurales.

Conclusiones: Las mujeres de Nepal desean tener familias poco numerosas, especialmente aquellas que residen en los centros urbanos. Si bien números importantes de mujeres usan anticonceptivos, el aborto inducido también se usa—principalmente para limitar el número de hijos y para espaciar los nacimientos. Es necesario incrementar la promoción del uso de los métodos anticonceptivos para reducir el nú-

mero de abortos, especialmente de aquellos que se realizan en condiciones de alto riesgo y de inseguridad.

Résumé

Contexte: La plupart des informations disponibles sur les femmes cherchant à interrompre volontairement leur grossesse au Népal proviennent de femmes admises dans les hôpitaux pour causes de complications liées à un avortement. Peu sont disponibles sur les femmes qui obtiennent un avortement «sans risques» auprès d'un prestataire compétent.

Méthodes: Les caractéristiques sociodémographiques de femmes cherchant à se faire avorter dans une clinique privée de Katmandou, capitale du pays, ont été recueillies. Ces données ont été analysées et comparées à celles de deux études antérieures de l'avortement au Népal.

Résultats: En moyenne, les femmes étaient âgées de 25 à 29 ans et avaient deux enfants en vie. Quarante pour cent étaient instruites au niveau post-secondaire, 91% étaient originaires de Katmandou et 48% pratiquaient la contraception. Pour 34%, la motivation principale de l'avortement était le désir de ne plus avoir d'enfants. Les femmes des milieux urbains qui avaient jamais eu recours à l'avortement étaient généralement plus jeunes et mieux instruites, et elles avaient une moindre parité que leurs homologues des milieux ruraux.

Conclusions: Les Népalaises désirent peu d'enfants, surtout dans les milieux urbains. Bien que beaucoup pratiquent la contraception, l'avortement provoqué reste une méthode utilisée, principalement, à des fins de limitation et d'espacement des naissances. La promotion et la pratique accrues de la contraception sont nécessaires à la réduction du nombre d'avortements provoqués, dans les circonstances risquées et non médicales surtout.