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Myths and Misconceptions about Abortion among Marginalized Underserved Community

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ABSTRACT

Introduction: Unsafe abortion remains a huge problem in Nepal even after legalization of abortion. Various myths and misconceptions persist which prompt women towards unsafe abortive practices.

Methods: A qualitative study was conducted among different groups of women using focus group discussions and in depth interviews. Perception and understanding of the participants on abortion, methods and place of abortion were evaluated.

Results: A number of misconceptions were prevalent like drinking vegetable and herbal juices, and applying hot pot over the abdomen could abort pregnancy. However, many participants also believed that health care providers should be consulted for abortion.

Conclusions: Although majority of the women knew that they should seek medical aid for abortion, they were still possessed with various misconceptions. Merely legalizing abortion services is not enough to reduce the burden of unsafe abortion. Focus has to be given on creating awareness and proper advocacy in this issue.

Key Words: *abortion, legal abortion, misconceptions, myths*

INTRODUCTION

Nepal's parliament legalized abortion in March 2002 with a belief that access to legal abortion could significantly reduce maternal mortality and morbidity due to unsafe abortion.[1] Prior to it, abortion was equated with infanticide.[2] The abortions that took place were mostly clandestine unsafe abortions[3] and a nationwide survey estimated that 20% of the women in Nepali Jails had been convicted on charges of abortion or infanticide.[4] In 2006, the Maternal Mortality Ratio of Nepal showed to be 281 deaths per 100,000 live birth.[5] Deaths from abortion-related complications accounted for over half of all maternal deaths in a hospital based study.[6]

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However, low level of awareness[7] about safe abortion, limited availability of safe abortion services, social stigmas and especially various myths and misconceptions may impact the utilization of safe abortion services in Nepal. Also, most Nepalese are Hindus and Buddhists and believe that life begins at conception as soul takes form at conception thus feticide is a major sin.[8]

The study aims to reveal the understanding of abortion in Nepal among marginalized, underserved community people as they are more likely to be uneducated and opt for unsafe abortion.[7]

METHODS

A qualitative study using focus group discussions (FGDs) and in depth interviews (IDIs) was conducted from January to April in 2006 in six districts under Family Planning Association of Nepal's (FPAN) Global Comprehensive Abortion Care project (GCACP) viz. Kailali, Kanchanpur, Palpa, Banke, Ilam and Sarlahi. Nine different categories of women from marginalized, underserved communities were identified (Table 1). Nine FGD guidelines were prepared and pre-tested on women with similar characteristics and revised in Kathmandu. Altogether 18 FGDs were planned, two for each group, three to four in each district. Six to eight participants were selected purposively for each FGD from GCAPC/FPAN's list. FGDs were continued till saturation. The sessions were recorded and later transcribed in Nepali. The study findings are limited by the fact that only 13 FGDs could be conducted, no FGDs could be conducted with wives of men having sex with men (MSM) and female intravenous drug users (IDUs) and only one was conducted with women with HIV as women did not consent to take part in the study.

Table 1. Categories of women identified for FGDs and their distribution

SN	Categories (N = 9)	FGDs conducted (N = 13)						
		K	Kan	B	P	S	I	N
1.	Female sex workers (FSW)	1		1				2
2.	Women living with HIV		1		-			1
3.	Female IDUs	-		-				-
4.	Women in ethnic minority					1	1	2
5.	Poor urban women		1			1		2
6.	Poor rural women			1		1		2
7.	Housewives in community		1	1				2
8.	NGO/CBO staff	1			1			2
9.	Wives of MSM	-		-				-
	Total	2	3	2	1	3	2	13

K = Kailali, Kan = Kanchanpur, B = Banke, P = Palpa, S = Sarlahi, I = Ilam, NGO/CBO = Non-Governmental Organization/Community Based Organization.

Sixteen categories of participants were identified for in-depth interviews (IDIs) (Table 2) and two participants were chosen purposively for each, two to three from each district. Notes were taken during the interview by the interviewer.

Table 2. Categories of participants identified for IDIs and district wise distribution

SN	Participants (N = 16)	District	N
1.	NGO service providers	Kailali and Banke	2
2.	Trained birth attendants	Kanchanpur and Banke	2
3.	Traditional birth attendants	Kailali and Sarlahi	2
4.	FCHV	Palpa and Ilam	2
5.	Private chemists	Kanchanpur and Palpa	2
6.	Community leaders (male)	Kailali and Ilam	2
7.	Community leaders (females)	Banke and Sarlahi	2
8.	School teachers	Kachanpur and Palpa	2
9.	Religious teachers	Banke and Palpa	2
10.	Political leaders	Kanchanpur and Ilam	2
11.	Lawyers	Banke and Ilam	2
12.	Police	Kailali and Sarlahi	2
13.	Married youth	Kanchanpur and Sarlahi	2
14.	Married adolescents	Banke and Sarlahi	2
15.	Unmarried youth	Palpa and Ilam	2
16.	Unmarried adolescents	Kailali and Sarlahi	2
	Total		32

Informed consent of all study participants was obtained verbally prior to requesting them to participate in the study. Complete confidentiality was ensured. To maintain confidentiality, the real names have been substituted with other names while quoting. The information collected was manually analyzed, critically reviewed and information collated to generate factual qualitative data and meaningful conclusions.

The data were analyzed using Microsoft excel 2007.

RESULTS

A total of 117 participants (Mean age 31.9, SD = 9.08), 35 in FGDs (Mean age 31.5, SD = 8.03), 32 in IDIs (33.1, SD = 11.49) took part in the study.

All the study participants knew that abortion meant rid of a fetus and most common word being the "Bachcha Giraune" (Table 3). However, their understanding of circumstances and settings of abortion differed. Some said abortion as getting rid of an unwanted child or a contraceptive failure while other said it is a result of immoral deed usually at an early age.

Table 3. Terms used abortion in the community

SN	Terms	No (%)
1	Bachcha Giraune	22 (18.8)
2	Bachcha nikalne	19 (16.2)
3	Bachcha falne	23 (19.6)
4	Garvapatan	15 (12.8)
5	Bachcha Saf Garne	20 (17.09)
6	Miscelleneou (bachcha safai garne, bachcha saphai, bachcha maraune, khulaune, curette, bhrun hatya, garva tuhaune, adhigro falne)	18 (15.3)
	Total	117 (100)

The main source of information on abortion were radio, newspapers, books, family relatives, neighbours, television, health centres and female community health volunteers (FCHVs).

Women mentioned medical abortion, traditional/herbal methods of abortion and health institution based abortion as different methods of abortion (Table 4).

Table 4. Ideas about methods of abortion and practices

SN	Ideas about abortion	No (%)
1.	Medical abortion	43 (36.7)
2.	Traditional/herbal methods	25 (21.3)
3.	Health institution based	39 (33.33)
	Total	117 (100)

Many women believed and practiced measures like drinking juice extracted by squeezing leaves of banana, roots of lime tree and peppermint or using vegetables (Kupindo- pumpkin like fruit), lentils (Gahat), chillies, contraceptive pills (gulaf), honey, sugarcane molasses (gur), chuk (sour stuff), gudpak (sweets), grinded bamboo leaves in lukewarm water, putting cow dung and herbs into the uterus for abortion. Putting a heated clay pot on or pressing stomach with stones, tying a rope tightly around the abdomen, taking medicine for headache and fever were also mentioned. Some women believed taking raw vermilion (kancho sindhur) causes abortion and also helps stop bleeding. They also said some women seek help of Guruba (Tharu traditional healer) and dhami/jhankri (witch doctor), who use herbal medicines to abort.

Some believed that tablets found in Rupediya cost 300; five tablets can be bought, one big and four small. It is secretive and abortion can be done at home. Others asked help from traditional birth attendants (TBA). Some women did it by themselves.

However, a big group of women believed that the above mentioned methods were crude, didn't help much, were unsafe and could cause problems such as perforation of uterus, prolapsed uterus, heavy bleeding, infertility, and even death. They said that crude unsafe methods were practiced in the past because abortion service was not legal and available in government health facilities. However, they said that they could not rule out that such crude methods of abortion are not practiced anymore. Majority believed that abortion is not safe at home and they need to seek hospital service. At a hospital they (medical persons) take responsibility, it is safe and good and mother will not die.

Majority knew that legal abortion can be done within three months of pregnancy, but surprisingly some said that they preferred home and told that only after three months woman should go to a hospital or clinic (Table 5).

Table 5. **Duration for legal abortion**

SN	Duration	No (%)
1.	Less than 3 months	77 (65.8)
2.	More than 3 months	24 (20.5)
3.	No idea	16 (13.6)
	Total	117 (100)

Any woman needing advice and service on abortion sought advice from FCHV, close relatives such as sisters-in-law and other senior women in the community (Table 6).

Table 6. **Source of advice and service for abortion**

SN	Sources	No (%)
1.	Health workers	75 (64.10)
2.	Close relatives	23 (19.65)
3.	Senior women from community	12 (10.25)
4.	Others (friends, neighbours etc.)	7 (5.98)
	Total	117 (100)

The barriers to safe abortion were poverty, disagreement with family members, belief that abortion is a sin, health risk of abortion procedure, possibility of uterus problem, social ostracism, and embarrassment, lack of awareness and lack of privacy (Table 7).

Table 7. **Barriers to safe abortion**

SN	Barriers	No (%)
1.	Unable to afford	21 (17.94)
2.	Abortion is a sin	23 (19.65)
3.	Health hazards of procedure	35 (29.91)
4.	Lack of awareness	36 (30.76)
5.	Others (family problem, embarrassments etc)	2 (1.7)
	Total	117 (100)

The participants mentioned the qualities they look for in a health centre if they have to get abortion viz. safe service, cheap service, near, privacy, trained doctor, good treatment of clients by health providers, and government listed site (Table 8).

Table 8. Qualities of a service centre

SN	Qualities	No (%)	
1.	Safe service	27	(23.07)
2.	Cheap service	28	(23.93)
3.	Nearby	23	(19.65)
4.	Privacy	21	(17.94)
5.	Trained doctor	8	(6.83)
6.	Others (good treatment, government listed site etc.)	10	(8.5)
	Total	117	(100)

DISCUSSION

The accessibility to safe abortion has definitely increased with its legalization. Previously, only a very small proportion of women living in urban or semi-urban areas and able to afford the cost, had access to trained medical practitioners and safe procedures.[3] But the burden of unsafe abortions is still very high. Every year, an estimated 19 million unsafe abortions occur worldwide, resulting in the deaths of about 70,000 women.[9] Unsafe abortion remains a major cause of maternal death in most developing countries.[10-14]

However, lack of knowledge about safe abortion, myths, misconceptions, poverty, and lack of privacy and fear of social ostracism act as barriers to utilization of safe abortion services.

The terms "garvapatan" or "bhrunhatya" used for abortion which mean 'destruction of pregnancy' and 'killing of an embryo' respectively have negative connotations. Local terms such as "garva tuhaune", "bachcha nikalne" (taking the baby out from the womb), "tuhaunu" (expelling) or "adhigro phalne" (getting rid of half grown foetus) also convey negative meaning. In order to promote induced abortion positively there is a need to chose less harsh terms for abortion.

Several myths and misconceptions are tied with abortion. Many women try out different herbs and crude methods of abortion which put them in a dangerous situation. Poverty leading to un-affordability of abortion service and social stigma attached to abortion make women seek age old crude methods of abortion. Eating inedible things, inflicting physical pain could be extremely harmful to the women. There is a need to educate the target audience that old ways are seriously harmful.

Many study participants approve of aborting an unwanted pregnancy but still there are certain sections of the society which do not do so. They think it is a sin to have abortion. The community leaders hold this view. This can affect innocent women who end up in unwanted pregnancy due to forced sex by husbands or partner or failure of contraceptive methods. Proper education programme is needed to address this aspect of abortion.

Many women justified abortion if it was meant to reduce family size or if it was a result of rape. This is justifiable but abortion is not the best solution. First and foremost, the cause of such unintended pregnancies should be controlled.

Since the legalization of abortion and expansion of abortion service to different parts of the country, women in general appear to take it as a common practice. Still many women do not freely share that they have had abortion although it is quite clear that with increasing use of contraception and inevitable failure of some methods women end up with unwanted pregnancy and seek abortion service.

Women from different parts of the country and caste and ethnicity know about induced abortion. Most participants of the study knew that surgical abortion service is available in most parts of the country. However, most of them were of the view that abortion is a personal matter and they prefer to go to a place where confidentiality is highly maintained. That a woman has had abortion is kept highly confidential.

Decision to abort is not necessarily made by the woman alone. It is made by husband and or mother-in-law or jointly although it was also found that decision to get rid of unwanted pregnancy due to illicit relationship is primarily made by the woman alone and it is kept highly confidential.

Although in the past abortion was a clandestine affair and took place in a secret place including woman's own home but nowadays most women prefer to go to a health institution for abortion. However, unwanted pregnancy due to rape, incest or illicit relationship is still tried to get aborted in secret. It is still difficult for such women to come out to a regular abortion service centre, programme need to address this aspect of abortion.

Also cost of abortion apparently is an inhibiting factor for several women which compel them to seek cheap service. Women in border towns or villages seek cheap medical abortion and attempt to abort unwanted pregnancy at home which is subject to high risks.

Therefore there is an urgent need to look into the cost of abortion service and adopt ways to make abortion accessible to women from marginalized communities.

Many study participants held the view that abortion is largely first trimester abortion and most of them seek abortion during the first three months of pregnancy. This is good and it should be strengthened as late time abortions are fraught with higher risks.

CONCLUSIONS

Despite various misconceptions, overall the study participants believed that health care providers should be consulted for abortion. This belief should be strengthened which calls for quality training to providers on abortion counselling including thorough knowledge about abortion law, competency in abortion procedure, infection prevention, post-abortion contraceptive counselling, follow-up and management for possible complications.

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