Availability of Safe Abortion Services and Perspectives of Actors on Right to Safe Abortion

A Project Brief

Background

CommonHealth is part of the "Claiming the Right to Safe Abortion: Strategic Partnership in Asia" project. The project through advocacy aims to strengthen capacities to improve engagement and ensure rights to safe abortion services in Bangladesh, India, Nepal, Cambodia and the Philippines. To develop an appropriate theory of change for guiding advocacy, it is necessary to understand the perspectives of the service providers, potential users and the community. CommonHealth perceived a number of gaps in understanding the barriers to safe abortion services such as inadequate data on the availability of services, community and provider views and attitudes towards abortion rights and services and support from Civil Society Organisations (CSOs) and Community-Based-Organisations (CBOs) to abortion as a women's right.

As a part of the first phase of the project, CommonHealth conducted a baseline assessment to understand the availability and access to safe abortion services and the factors that impact these; and to understand the perspectives of CSOs and CBOs, community leaders, women, and healthcare providers on abortion as a women's rights issue.

CommonHealth, constituted in 2006, is a multi-state coalition of organizations and individuals advocating for better sexual and reproductive health, with a specific focus on maternal health and safe abortion.

Methodology

The baseline assessment involved primary and secondary data collection. Secondary data was sourced from national surveys and studies and from review of existing literature.

Primary data was collected in Nawada district, Bihar and Kancheepuram district, Tamil Nadu. In-depth interviews were conducted with key informants such as frontline workers, community leaders, and health service providers; Focus Group Discussions (FGDs) were conducted with women from marginalised groups and facility surveys were conducted in select government and private facilities.

Trained investigators from Lok Chetna Vikas Kendra, Bihar and Rural Women's Social Education Centre (RUWSEC), Tamil Nadu, both CommonHealth member organisations, undertook the baseline assessment. Semi-structured tools in the local languages (Hindi and Tamil) were developed and used by the field investigation team to collect the primary data.

Ethical approval: The Institutional Ethics Committee of the RUWSEC provided ethical approval for the baseline assessment

State context

Both Bihar and Tamil Nadu are very different in terms of their socio-demographic and health profiles. Bihar is the third most-populous state and is known for its poor economic and socio-demographic indicators and public health infrastructure. There is a significant shortage of gynaecologists and obstetricians in peripheral areas of the State. On the other hand, Tamil Nadu is industrially developed with better socio-demographic and health indicators, and a well-functioning public-health system. Yet, significant gender, rural and urban differentials exist in literacy rate and work participation rates in the State.

Both states had some government initiatives aimed at improving access to safe abortion services, but in neither was abortion a priority health issue. In 2011, the Government of Bihar jointly with IPAS Development Fund (IDF) launched Yukti Yojana, a Public-Private Partnership, to provide low-cost first-trimester abortion services through empanelled private hospitals and involved IDF in the training of providers at the PHC[1] level and equipping facilities to provide first-trimester abortion. The State government also allocated Rs 385.9 lakh in its Project Implementation Plan (PIP) for operationalisation of safe abortion services. In the same year, the Government of Tamil Nadu developed a Comprehensive Abortion Policy (CAP) to increase the availability of safe abortion services and promote spacing methods of contraception at all levels of health care. While a number of doctors and staff nurses in Primary Health Centres and government hospitals in the State were trained in MVA techniques and the Record of Proceedings (ROPs) for 2017-18 allocated funds for training and purchase of medical abortion drug kits for all CEmONC centre, the policy was not adopted in its entirety in the State.

[1] Primary Health Centre

Non-government (NGO) and Civil Society Organisation action in both States was found to be conspicuous by its absence. The local branches of US-funded international NGOs in Bihar being bound by the 'gag rule' and were prevented from being associated with abortion services of any kind. In the recent past, NGO action to prevent sex-selective abortions in the State has gained some momentum following a UNFPA study on the poor implementation of the Pre-Conception and Prenatal Diagnostic Techniques (PCPNDT) Act. In Tamil Nadu, very few NGOs working on women's sexual and reproductive health issues existed. Of these, some were found to be against abortions on moral grounds and many exclusively worked on preventing abortions for gender-biased sex-selection.

Findings

According to the 2015 Guttmacher study, an estimated 1.25 million abortions were performed in Bihar and 0.7 million in Tamil Nadu. These were both safe and unsafe and in health facilities and other settings. In these States, health department's Health Management Information System (HMIS) captured less than a fifth of these for the same period.

Further, there was only one abortion facility for 370,000 people in Nawada, Bihar, and one for 70,000 in Kancheepuram, Tamil Nadu, far lower than the recommended norm of one facility per 20,000. More than 60 per cent of the facilities were private, with most of them run by unqualified providers in Nawada and by qualified medical professionals in Kancheepuram. The public facilities providing abortion services were the district hospital in Nawada and the district, taluk and non-taluk hospitals in Kancheepuram. In both districts, qualified abortion service providers were concentrated in the urban centres, leaving vast rural pockets with hardly any abortion facilities.

Even in public facilities the availability of second-trimester abortions was highly restricted. Unmarried women reported services being denied or they being subjected to abusive and disrespectful care. Other women had to make several visits in order to undergo an abortion. These delays often led to women exceeding the legal gestational limit for a MTP, in which case they were denied the service. In both states, married and unmarried women typically needed to be accompanied by their husbands or 'guardians,' who had to provide consent for the procedure. Also, abortion services in public facilities were conditional on the acceptance of post-abortion contraception.

On the other hand, the cost of private abortion services by a qualified medical professional was very high and ranged from Rs. 1000 to 40,000. The cost being unaffordable, most women from marginalised groups sought out unqualified providers or relied on self-medication with drugs from pharmacists.

There was a low level of awareness on the legal status of abortion. While opinion was divided on the circumstances in which abortion was justified, the general perception in the community was that women seeking abortions were likely to be humiliated, gossiped about, considered immoral, and unlikely to receive any support from peers and family members.

Providers were generally against providing abortion services to married women with an unplanned or mistimed pregnancy but supported provision in the case of foetal anomalies. Attitudes towards abortions for unmarried girls were mixed, with some willing to provide these services and others not, but the overall attitude was one of disdain for the girls, for not having used contraception. The CSO leaders felt that sex-selective abortion ought to be prevented, but without compromising the availability of safe abortion services. In Tami Nadu, the need for abortion services was considered very important to prevent suicides among unmarried girls.

Key Issues

Denial, delays, poor quality of services and negative provider attitudes in government facilities, non-availability of medical abortion at the Primary Health Centre level and the high costs of abortion services in the private hospitals, and low awareness amongst women of the legal status of abortion, appeared to be major barriers to women's, particularly marginalised women's access to safe abortion services.

The baseline assessment findings are expected to guide the advocacy agenda towards making safe abortion services available free of cost to women who need them and towards promoting availability of abortion services as a woman's reproductive right.

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