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"We can lose our life for the abortion": exploring the dynamics shaping abortion care in peri-urban Yangon, Myanmar☆

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Abstract

Objectives: Induced abortion in Myanmar is severely legally restricted and permissible only to save a woman's life. As a result, unsafe abortion is common and contributes significantly to maternal mortality. Our overall study aimed to explore women's reproductive health needs in peri-urban Yangon, a dynamic series of townships on the periphery of the country's largest city characterized by poor infrastructure, slum settlements and a mobile, migrant population. In this paper, we focus specifically on the perceptions, opinions and experiences of both adult women and key informants with respect to induced abortion and postabortion care in peri-urban Yangon.
Study design: In 2014, we conducted 18 key informant interviews with individuals working in reproductive health in peri-urban Yangon and seven focus group discussions with health service providers (n=2) and adult women (n=5). We analyzed these data for content and themes using a multiphased iterative approach.
Results: In peri-urban Yangon, unsafe abortion appears to be common and is largely provided by traditional birth attendants. Women use a range of mechanical, medication and traditional methods, often in combination. Postabortion care is available but misinformation and fear of harassment keep many women from accessing timely care.
Conclusion: Efforts to reform the highly restrictive abortion law in Myanmar combined with implementation of harm reduction strategies have the potential to greatly improve a neglected area of women's health. Future research on the cost of unsafe abortion to the public sector could be instrumental in achieving legal and service delivery reform.
Implications: Measures to increase access to safe, legal abortion care and reduce harm from unsafe abortion need to be expanded. Developing strategies to liberalize Myanmar's abortion law, raising awareness about misoprostol, training clinicians to provide woman-centered postabortion care and documenting the cost of unsafe abortion to the public sector appear warranted.

Keywords: Burma; Reproductive health; Postabortion care; Misoprostol

1. Introduction

In Myanmar, induced abortion is severely legally restricted. The Penal Code of 1860 prohibits abortion unless the procedure is performed to save the life of the woman. Punishment for providing an induced abortion can include a prison sentence of up to 3 years and/or a fine [1]. However, rates of unsafe abortion are high and contribute to at least 10% of maternal deaths across the country and up to half of maternal deaths in conflict-affected regions [1–3]. Even in the urban center of Yangon, the country's largest city and former capital, where health outcomes are generally better than in rural parts of the country, the limited available evidence suggests that up to half of maternal deaths in some of the city's hospitals are attributable to unsafe abortion complications [4]. Fear of criminal repercussions coupled with a religious and cultural valorization of life keep many providers from offering abortion care, even in cases that are legally permissible, and have contributed to a shroud of shame, secrecy and stigma surrounding the procedure [1,5]. These dynamics have also hindered data collection on the practices, patterns and impact of unsafe abortion in the country.

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The rapidly expanding city of Yangon is home to approximately 7.35 million people [6] and is divided into townships that extend into the surrounding countryside. As rural migrants pour into the city seeking economic opportunities, they are increasingly residing in the cheaper townships on the city's periphery, locally known as "peri-urban Yangon." Peri-urban spaces inhabit a continuum between urban and rural areas, distinguished by a unique set of demographic and socioeconomic characteristics [7–9]. Although data are limited, the population residing in these areas is widely believed to have poor reproductive health outcomes, reflecting a confluence of economic, educational, geographic and cultural-ethnic disparities [5,8,9].

In 2014, we conducted a multimethods study to explore and identify the reproductive health needs of women of reproductive age (16–49 years) residing in the townships of peri-urban Yangon. The overall project aimed to shed much needed light on the reproductive health experiences of a highly marginalized population and provide information for service delivery organizations and other local stakeholders. In this paper, we focus specifically on the perceptions, opinions and experiences of both adult women and key informants with respect to induced abortion and postabortion care (PAC) in peri-urban Yangon.

2. Methods

Our multidisciplinary project team conducted a multimethods needs assessment in the summer of 2014. We modeled our design after *Separated by borders, united in need: an assessment of reproductive health on the Thailand-Burma border* [3] and we have provided a detailed description of the methods elsewhere [5]. In brief, our assessment included a systematic review of published articles, grey literature and data provided by local service delivery organizations; interviews with 18 key informants; a service mapping exercise that included orally administered surveys with representatives from 27 facilities; a survey of 147 peri-urban women participating in a microfinance program; and seven focus group discussions (FGDs) with health care providers (n=2) and women (n=5). Although the government of Myanmar does not have official criteria to classify townships, our study centered on nine townships that can be broadly characterized as peri-urban. We provide a map of the study area as Fig. 1. In this article, we draw from our key informant interviews and FGDs and detail these methods and our analytic approach.

2.1. Data collection: key informant interviews

We identified key informants through our study team's networks and online searches. We recruited participants using purposive sampling through emails and phone calls where we explained the purpose of the study. GS conducted interviews with 18 key informants who represented a variety of nongovernmental organizations (NGOs), community-based organizations and government agencies working in the field of reproductive health in peri-urban Yangon. GS recorded interviews when the participant consented, took notes throughout and wrote reflective memos afterwards. Interviews lasted an average of 60 minutes and explored organizational scope and both organizational and individual experiences working in this sector.

2.2. Data collection: FGDs

We also held a series of FGDs with people who live and work in peri-urban Yangon. We recruited participants with the help of several local organizations that used their organizational networks and programing to advertise the study. We used multimodal recruitment techniques including announcements, handouts and participant referrals. The Burmese-language FGDs were co-led by GS and YA, a Burmese medical doctor with extensive facilitation experience. We conducted seven FGDs, five with women residing in peri-urban Yangon (n=27) and two with health care providers working in peri-urban Yangon (n=9). We present basic participant demographics on Table 1. We compensated participants for their time and travel and provided lunch and refreshments. All FGD participants consented for the discussion to be audio recorded and GS wrote notes throughout and reflective memos following each FGD. We held the FGDs at the headquarters and clinics of the local organizations that assisted in recruitment. FGDs lasted 60–90 minutes and explored participants' experiences living and working in the peri-urban townships.

2.3. Data analysis

Using transcripts, notes and memos, we analyzed both the interviews and FGDs for content and themes, using both *a priori* (predetermined) categories and codes based on the research questions, as well as inductive codes that emerged from the data [10,11]. We managed our data using ATLAS.ti and GS served as the primary coder. We used an iterative approach such that analysis occurred simultaneously with data collection. Regular team meetings guided the interpretation of the findings and we resolved differences through discussion. We analyzed each component of the project separately and in the final analytic phase we combined the findings, with specific attention to concordant and discordant results. In February 2015, our study team presented our preliminary findings to stakeholders in Yangon; we incorporated the feedback we received into our final analysis. Triangulation of multiple data sources allowed us to identify prominent themes that we present in the results section.

2.4. Ethics

We received ethics approval from the Health Sciences and Sciences Research Ethics Board at the University of Ottawa (File #H02-14-03). The Board of Directors of the National Young Women's Christian Association of Myanmar also reviewed and approved the study protocol. To protect participant confidentiality, we have removed or masked all personally identifying information throughout this article.