A literature review on Factors influencing abortion in Nepal

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56th Master of Public Health/International Course in Health Development

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A literature review on Factors influencing abortion in Nepal

A thesis submitted in partial fulfilment of the requirement for the degree of Master

by

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Declaration:

Where other people's work has been used (from either a printed source, internet or any other source), this has been carefully acknowledged and referenced in accordance with departmental requirements.

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Operational definitions

Duration or gestational age of pregnancy (gestation): "the number of days or weeks since the first day of the woman's last normal menstrual period (LMP) in women with regular cycles (for women with irregular cycles, the gestational age may need to be determined by physical or ultrasound examination). The first trimester is generally considered to consist of the first 12 or the first 14 weeks of pregnancy" (1)

Medical methods of abortion (medical abortion): "use of pharmacological drugs to terminate pregnancy. Sometimes the terms "non-surgical abortion" or "medication abortion" are also used" (1).

ABBREVIATIONS

CAC:	Comprehensive Abortion care
CBS:	Central Bureau of statistics
DHS:	Department of Health service
FCHVs:	Female Community Health Volunteers
FP:	Family Planning
HP:	Health Post
HWs:	Health Workers
MA:	Medical Abortion
MVA:	Manual Vacuum Aspiration
NDHS:	Nepal Demographic and Health Survey
PHCC:	Primary Health Care Centers
SAS:	Safe abortion service
SRHR:	Sexual and Reproductive Health and Rights
TV:	Television
UN:	United Nations
UNFPA:	United Nations Population Fund
WHO:	World Health Organization
WRA:	Women of Reproductive Age

ABSTRACT

Introduction

Despite legalization of abortion in 2002 and necessary guideline and protocol developed in addition to mitigate the complications and deaths caused by unsafe abortion, abortions performed by untrained personnel or uncertified providers in less safe and least safe environment still remain prevalent in Nepal.

Methodology

A literature review was done. Literature in English and Nepali language between years 2010 to 2020 were selected. A conceptual framework developed by Ernetina and colleagues "A conceptual framework for understanding women's trajectories in seeking abortion-related care" was used in the study.

Results

Women particularly from rural areas with poor socio-economic status face several challenges in terms of access and utilization of available safe abortion service (SAS). Starting from learning their pregnancy to pregnancy termination women deals with range of experiences that influence her decision over abortion (safe or unsafe). Decisions around abortion are not disclosed by many women due to stigma attached to it. Unsafe abortion is highly prevalent in places that are geographically challenged. High unmet need for FP after abortion in the study was due to lack of post abortion care and proper and correct counseling around family planning.

Conclusion and recommendations

Given the high rate of unsafe abortion especially in rural area sensitizing women through massive campaign around SAS sites and legal conditions for abortion through radio, mother's group and FCHVs and collaborating with traditional healers and pharmacies to improve access and referrals to SAS as they are the first line of contact for many rural women.

Key words

Abortion, Nepal, conceptual framework, SAS, access, legal

Word count: 11683

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INTRODUCTION

My thesis topic is factors influencing abortion in Nepal. I have come to choose this topic for my thesis because of having experience of working in this field. As my work experience is concerned I have worked with FAITH (Friends Affected Infected Together in Hands, organization that works for Sexual and Reproductive Health and Rights of Women living with HIV, female Drug Users and female sex workers. During my experience working with FAITH I have opportunities to learn about these groups. They are highly challenged with regard to access to SRHR services. Abortion is also very high among sex workers. However, abortion is highly stigmatized in Nepal. This study does not however not addressing specific group but review the situation in general.

CHAPTER I: BACKGROUND

1. Geographical and administrative distribution:

According to Central Bureau of statistics (CBS) 2011, Nepal is divided into three ecological regions: mountain, hill and terai (2). In 2015, Nepal was administratively divided into seven provinces which are further sub-divided into rural and urban areas (3) with 77 districts (4).

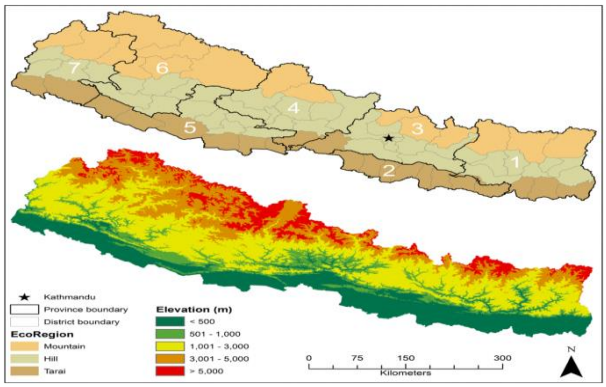
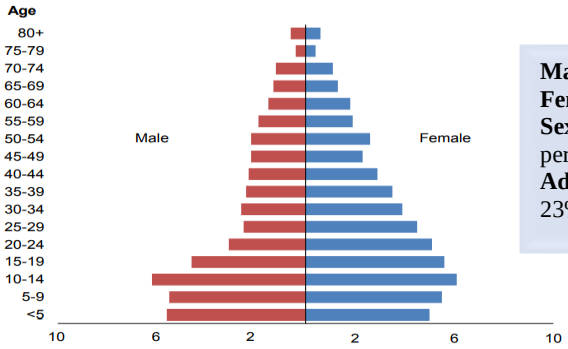


Figure 1: Geographical and administrative map of Nepal (5)

2. Socio-demographic

Population: As of 2011, the population of Nepal stands at 26.5 million with annual growth rate of 1.35 (2). The CBS 2014, estimated the population to raise to 30 million by 2021, and 34 million by 2031 (6) .

Age and sex:



Male: 54%
Female: 46%
Sex ratio: 85 (number of males per 100 female)
Adolescents (10-19 years): 23%

As stated by NDHS 2016, of 46,814 people surveyed, more than half of the population were male.

Figure 2: Population pyramid, NDHS(3)

Education: Male were more literate compared to female. Both male and female were more literate in urban area and hilly region.

SN		Characteristics	Illiterate (%)	Literate (%)	Total		Illiterate (%)	Literate (%)	Total
1	**Female**	Urban	35.2	64.8	13,517	**Male**	16.9	83.1	11,264
2		Rural	46.6	53.5	8965		26.3	73.7	7,091
3		Mountain	44.3	55.7	1462		21.9	78.1	1,188
4		Hill	34.8	65.2	9628		16.0	84	7,914
5		Terai	43.3	56.7	11,392		24.3	75.7	9,254

Population by area, regions, religion and caste/ethnicity: Majority of the population live in rural area, terai region. Nepal has huge diversity within the religion and caste/ethnicity with 10 religions and 126 ethnicities. Majority of the people follow Hindu religion.

SN	Population characteristics	CBS 2011(2)
1	Rural	83%
2	Urban	17%
3	Terai	50.3%
4	Hill	43%
5	Mountain	6.73%
6	Hindu	81.3%
7	Buddhist	9%
8	Muslim	4.4%
9	Chhetri (upper caste)	16.6%
10	Brahman (upper caste)	12.2%
11	Others (ethnic minorities group)	71.2%

3. Socio-economic

Poverty: In Nepal, one-fourth of the population live below the poverty line (7). In 2016, among 188 nations it ranks 144th on Human Development Index of UNDP (8)

Region and area wise poverty, 1996-2011): Poverty in the Mountain zone was most predominant at 42 percent. Despite substantial decrease between the year 1996 and 2004, from 57 percent to 32 percent, it has inclined to 42 percent in 2011. Other ecological zones has relatively lower poverty with Hills 24 percent and Terai 23 percent. Likewise between urban and rural area, the rural area has disproportionately higher poverty(9) .

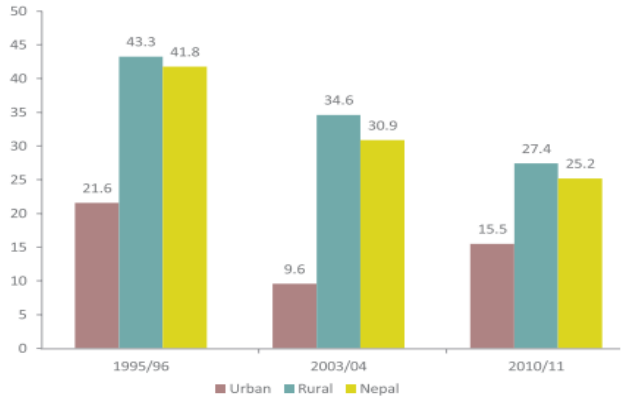


Figure 3: Population (urban and rural) below poverty line, 1995-2011, Nepal (10)

Thirty-five percent of women indicated that they make decisions regarding their own health care jointly with their husband, 29% reported that such decisions are made mainly by their husbands, and 23% indicated that they mainly make these decisions on their own. Men have more of a say than women in making sole decisions about their own health care (53%) (Table 15.9). Women are most likely to make independent decisions on major household purchases (35%). Approximately one-fourth of women (27%) indicated that they can decide on their own regarding visits to their family or relatives.

Health system

Nepal health service delivery functions at different levels: national, regional, zonal, district and community level. The Primary Health Care Centers (PHCC) and Health Posts (HP) functions at community level as first point of contact and provides basic health services and referrals services to the community. The referrals are usually from low level of health care to high level. However, sometimes referral can be higher level to lower level (11)

The Family health division (FHD) is accountable to oversee the sexual and reproductive health of adolescent and women, family planning and child health related activities(12).

Majority of the Nepalese people high out of pocket expenses for health service remains a challenge as 10.7 % people suffered with catastrophic financial loss. Current health expenditure are mostly through out-of-pocket and raised endlessly from 2006 to 2006. Currently, there is a cut down in funds for health from donor's agencies (13).

Health Indicators

	Indicator	**Data (7 years preceding the survey)**
1	Maternal Mortality ratio	239 deaths per 100,000 live births
2	Total Fertility rate (TFR)	2.3 children per women
3	TFR (rural versus urban)	2.9 versus 2.0 children
4	Age-specific fertility rate (ASFR) age group (15-19)	88 births per 1000 women
5	ASFR age group (20-24)	172 births per 1000 women

CHAPTER II: PROBLEM STATEMENT, JUSTIFICATION, OBJECTIVE AND METHODOLOGY

2.1 Introduction to Problem statement

Abortion, also coined as termination of pregnancy is the removal of a fetus or embryo from the uterus or womb (14). Abortion may occur spontaneously or intentionally, the later also known as induced abortion, which may be either safe or unsafe. Globally, around 44% of total pregnancies are unplanned or unintended of which 56% result in an induced abortion (15).

Abortion (especially unsafe) may have serious health implications such as hemorrhage, sepsis and uterine perforation and even disability. Abortion is considered safe if it done by abortion certified professionals following the guidelines, standards and protocols of World Health Organization (WHO). According to WHO unsafe abortion refers to techniques that involve terminating an unintended or unplanned pregnancy, either performed by unskilled persons or done in settings that lack minimum medical conditions, or both. The conditions that describe unsafe abortions are illustrated below:

- Abortion done without proper consultation and counselling
- Performed by unqualified persons, have been done repeatedly under unfavorable or unhealthy environment,
- Abortion brought about by oneself or taking non-medical support by administration of traditional herbs or medicine or harmful substances
- Aggravated by oneself through inserting foreign object into the womb or via traditional practitioner or else induced by rubbing abdomen forcefully.
- Wrong information around the instructions for MA drug or distributed by pharmacist without proper instructions or without any instructions and follow-up.

WHO classification of unsafe abortion has been into two categories "less safe" and "least safe". Abortion is classified less safe if it fulfils only one of the two conditions: (i) abortion carried out by skilled practitioner but performed by the use of techniques that are outdated or unsafe; (ii) Use of safe method (mifepristone and/or misoprostol), however was done with insufficient information or without aid from a skilled provider. Likewise, abortion is classified least safe if performed by unskilled providers by the use of hazardous methods like inserting objects, application of traditional herbs and medicine and administration of caustic substances.

According to World Health Organization (WHO), each year about 56 million induced abortions occurred globally between the year 2010 and 2014. About 45% of the total estimated induced abortions were unsafe of which 31% and 14 % were done in "less safe" and "least safe" settings respectively. Approximately, 97% of the total unsafe abortions occurred in low-income countries including Africa, Asia and Latin America. However, more than half of total unsafe abortions occurred in Asia(16)(17).

As of 2017, nearly 295,000 maternal deaths occurred worldwide that accounts to total maternal mortality ratio of 211 maternal deaths per 100,000 live births. About 94% of these deaths occurred in low-and middle-income countries. Maternal mortality is highly unacceptable because mostly preventable (18). These deaths occur due to complications during pregnancy and child birth. Complications that account to 75% of maternal deaths includes: excessive bleeding (mostly post-partum hemorrhage), sepsis (commonly after childbirth), pre-eclampsia and eclampsia, delivery complications and unsafe abortion (19).

Each year in developing countries, approximately seven million women are admitted to heath facilities due to complications attribute to unsafe abortions (17). Similarly, every year unsafe abortion accounts to maternal deaths ranging from to 4.7% to 13.2% (19). According to Darroch and colleagues the cost of offering abortion related care for developing regions in 2017 is estimated at $1.8 billion that includes both direct (for example: personnel, commodities, drugs and supplies) and indirect (supporting cost for example programme management, monitoring and supervision) service cost (20)(21).

Because of the heightened burden of maternal deaths, morbidity and disability aggravated by unsafe abortion, the International Conference on Population and Development (ICPD) in 1994 in Cairo (Egypt), emphasized unsafe abortion as major public health concern and called for urgent actions including: rapid human, drugs and supplies to deal with unsafe abortion complications, post-abortion consultation and counseling to avoid recurring unsafe abortions to address health implications of unsafe abortion (22)

Grounds on which abortions are permitted:

Grounds on which abortion is permitted	Liberalized	Restricted
a. To save a woman's life	Andorra	Dominican Republic, Nicaragua
b. To preserve a woman's physical health	Benin, Chad, Colombia, Equatorial Guinea, Kenya, Lao People's Democratic Republic, Mexico, Mozambique, Nepal, Niger, Nigeria, Swaziland, Togo, United Arab Emirates	Congo, Iraq, Papua New Guinea
c. To preserve a woman's mental health	Benin, Bhutan, Bolivia (Plurinational State of), Burkina Faso, Burundi, Cameroon, Colombia, Comoros, Costa Rica, Ecuador, Equatorial Guinea, Ethiopia, Kenya, Mexico, Morocco, Mozambique, Nepal, Niger, Nigeria, Peru, Poland, Qatar, Rwanda, Saudi Arabia, Swaziland, Thailand, United Arab Emirates, Uruguay, Vanuatu	Iraq, Japan, Papua New Guinea
d. In case of rape or incest	Argentina, Bahamas, Bahrain, Benin, Bhutan, Burkina Faso, Colombia, Cook Islands, Eritrea, Ethiopia, Fiji, Indonesia, Mali, Monaco, Nepal, Saint Kitts and Nevis, Saint Lucia, Swaziland, Switzerland, Togo, Uganda, Uruguay	Algeria, Belize, Ecuador, Iraq
e. Because of foetal impairment	Bahamas, Benin, Burkina Faso, Chad, Colombia, Eritrea, Ethiopia, Fiji, Indonesia, Iran (Islamic Republic of), Jordan, Mexico, Monaco, Nepal, Niger, Oman, Swaziland, Switzerland, Togo, Uganda, Uruguay	Iraq
f. For economic or social reasons	Bahrain, Fiji, Mexico, Nepal, Portugal, Saint Vincent and the Grenadines, Spain, Switzerland, Uruguay	–
g. On request	Australia, Bahrain, Belgium, Cabo Verde, Italy, Mexico, Nepal, Portugal, Spain, Switzerland, Uruguay	–

Figure 4: Countries that decriminalized or restricted legal grounds under which abortion is allowed, 1996-2013 (23)

Short history of policies implemented in Nepal in relation to abortion

Unsafe abortion occurs the most in the settings where the abortion law is highly restrictive or where abortion is criminalized that in turn deteriorate the health outcomes of mother and child. Restrictions in abortions for instance, gestational bans, long waiting time and parental consent has been evident to undermine the rate of unsafe abortion instead of removal of abortion need (24)(25). Within this regard Nepal has the most liberal law that guarantees the SRHR of women.

Nepal legalized abortion in 2002 in many ways posits a paradigm shift in Nepal: women's reproductive rights are now recognized as fundamental human rights, and abortion is constitutionally protected.

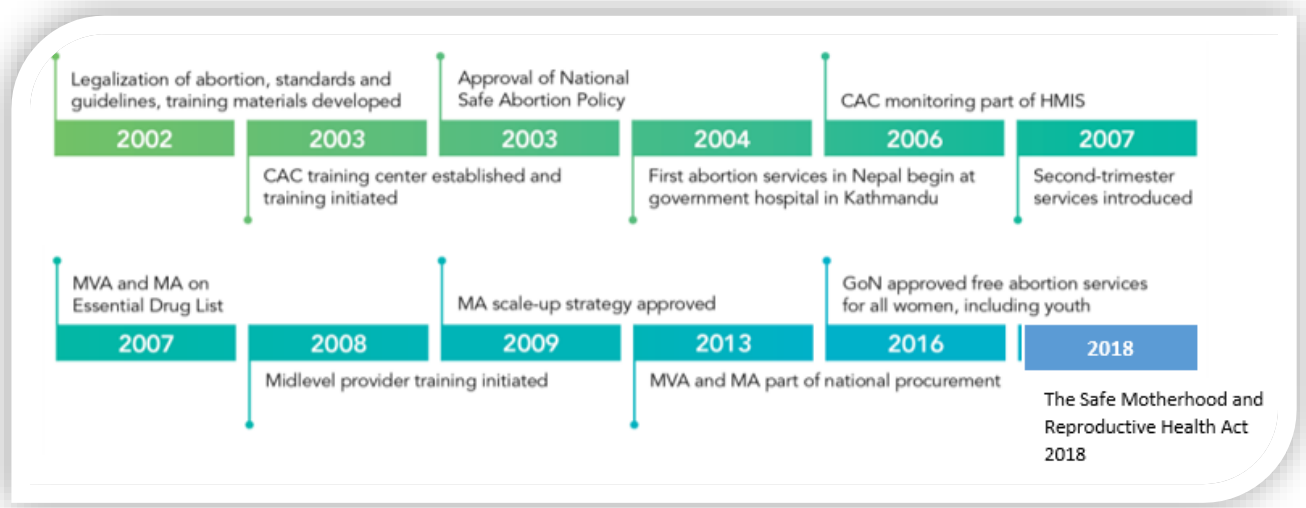


Figure 5: Abortion Milestone, Nepal(26)

In 2004, a Safe abortion service (SAS) was first made available in Paropakar Maternity and Women's Hospital, Kathmandu, Nepal. Around 20 senior physicians were given training on Manual Vacuum Aspiration (MVA) for the purpose. After a year, the government of Nepal (GoN) permitted 87 health facilities including both government and private to offer comprehensive abortion care services (CAC). These facilities covered services in 49 districts (out of 77). However, for women residing in rural and mountainous regions the CAC services were hard to access. In 2007, second-trimester abortion training was given to doctors. As of 2008, staff nurse and auxiliary nurse midwives (ANMs) were qualified to receive training and perform MVA until 8 weeks gestation which had been limited to physicians earlier. Medical abortion (MA) was incorporated in the safe abortion (SA) program (accessible within 9 weeks of gestation) in 2009. More than 1,200 physicians and 500 facilities were licensed to offer SA services at the end of 2011 (27). Likewise, more than 3,000 physicians and 25 hospitals were licensed to perform second-trimester abortion in 2018. Similarly, in 65 districts out of 77, MA facilities were offered by primary health care centers (PHCC) and health posts (HP) in the same year (28)(29)(30).

According to the right to safe motherhood and reproductive health act, 2018 women shall have the right to SA under any of the following conditions with the consent of pregnant women (31):

1. Up to 12 weeks of gestation
2. Up to 28 weeks of gestation, after the suggestion of a certified physician around the risk in the procedure or any threat to health of mother or a child in doing so (suggested not to perform in such case)
3. Up to 28 weeks of gestation in case of rape or incest
4. Up to 28 weeks of gestation in case of HIV status of women or other disease with no cure.

5. Up to 28 weeks of gestation, after the advice of physician that the defect appeared in gestation may incur harm in mother's womb, genetic defect that turns out in disability of fetus and the child cannot survive after birth due to such defects. (fetal abnormalities/ fetal anomalies

In addition, the act does not permit any act of identifying sex of fetus in the womb and performing sex-selective abortion.

2.1.1 Problem statement

Despite legalization of abortion for nearly two decades in Nepal and necessary guideline and protocol developed by WHO in addition to mitigate the complications and deaths caused by unsafe abortion, abortions performed by untrained personnel or uncertified providers in less safe and least safe environment still remain prevalent (32).

Until 2017, the second trimester abortion service had extended to 29 hospitals which was started in 2007. Nevertheless, access to second trimester abortion has remained challenge. So far facilities that provides Comprehensive abortion care are 1 out of 10 and those providing Medical abortion is nearly a quarter. This services were provided by facilities that offered normal delivery service. In rural and mountainous areas availability of SAS of all type (MA, MVA) stays a huge challenge.

In Nepal the facilities that provide Comprehensive abortion care and medical abortion are very limited. In addition the availability and affordability of such services is very limited to certain group of people. About 1 in 10 provides Comprehensive abortion care. Among the five development regions, the abortion rate is high in central development region and low in the west. Abortion rate accounts to 42 per 1000 WRA (15-49). Only about 42 percent of these abortions are legally provided at certified health facilities. Consequently, increasing the demand of SAS, making it easily available, reachable and cost-effective or user friendly for all women with unwanted pregnancies (3).

2.2 Justification of the study

Despite 20 years of enormous development on policies liberalizing abortion, as well as gender position in Nepal, several challenges remain, particularly for certain groups in the population. These challenges exist both on the demand side as well as on the supply side. This thesis aims to contribute to a more systematic analysis to identify the remaining gaps, and advising on adaptations or further policies and strategies to overcome them.

2.3 Study Objectives

2.3.1 General Objective:

To analyze factors influencing abortion-related care-trajectories among women in Nepal to make necessary recommendations to concerned stakeholders and policy makers for scaling up abortion services and programs in order to reduce related morbidity and mortality and guarantee full reproductive rights of women.

2.3.2 Specific Objectives:

1. To analyze different pathways women experience when they need and try to obtain an abortion (starting from awareness of pregnancy to abortion attempt)
2. To analyze the individual characteristics/context influencing abortion care-seeking behavior (safe/unsafe) among women in Nepal
3. To analyze the Nepalese national and subnational context for abortion-related care, (including socio-cultural, legal, institutional and health system related factors)
4. To provide recommendations based on identified enabling and inhibiting factors and best practices for abortion services in the national and international context.

2.4 METHODOLOGY

A literature review was done. Literature in English and Nepali language between years 2010 to 2020 were selected.

Table 1: Search Strategy

Search strategy	**Objective 1**	**Objective 2**	**Objective 3**	**Objective 4**
Databases: VU online library, PubMed **Search engines:** Google Scholar, Google **Websites:** WHO, UNFPA, World Bank, Ipas, FPAN, GoN **Grey literatures:** Ministry of Health and population	Abortion, safe abortion, unsafe abortion, stigma, disclosure, cost, availability, access, family support, gestational, perception, location, types of abortion, counseling, emotions, health, out-of-pocket payment, discrimination, Nepal	knowledge, belief, socio-economic, demographic, fertility, autonomy, contraception , family planning, abortion, methods, legality, discrimination	legal, strategies, policies, access, quality, technology, media, source, norms, gender, fertility, law, abortion, law enforcement, budget, trainings, PAC, SAS, Challenges	International, policies , laws, programs, interventions, Asia, Africa, Global

The results were presented under 3 chapters starting from chapter III. The chapters and sub-chapters have overlap and linkages between each other. Result of the study were classified under 3 chapters with regard to specific objectives of the study (each of the objectives were analyzed under each chapters).A conceptual framework developed by Ernetina and colleagues "A conceptual framework for understanding women's trajectories in seeking abortion-related

care" was used in the study. However, other framework were also explored like socio-ecological model, Dahlgren and Whitehead rainbow framework.

Abortion trajectory is define as "the processes and transitions occurring over time for a pregnancy that ends in abortion". The framework "A conceptual framework for understanding women's trajectories in seeking abortion-related care" was used in this literature review for following reasons:

- It integrates paths women go through, together with individual and various context factors
- It was elaborated in an inductive way, making use of concrete experiences and evidence; besides, it has been subjected to a broad expert consultation
- It combines the process (steps) and socio-ecological approach of factors involved in these processes/steps

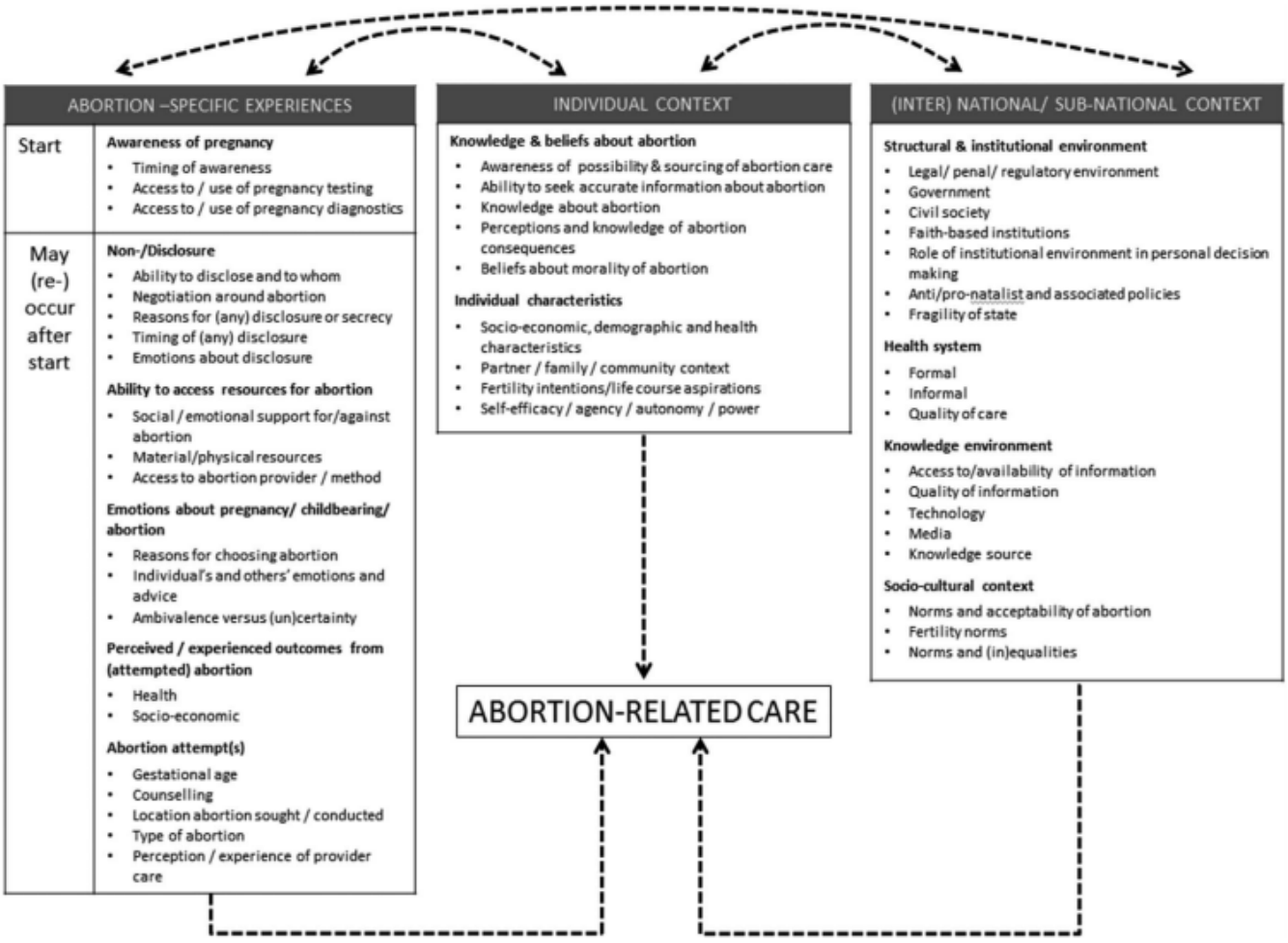


Figure 6: "A conceptual framework for understanding women's trajectories in seeking abortion-related care" (31)

Limitation of the study

- As this study was analyzed based on literature reviews and not primary data collection, it was limited to findings of past only.
- Some elements of the chapters had very limited information due to lack of research done on that area
- Issues of specific-group like women living with HIV, sex-workers and female injecting drug users were not addressed due to lack of studies. These group have higher need as opposed to others due to double stigma and discrimination.

CHAPTER III: ABORTION-SPECIFIC EXPERIENCES

This chapter analyzes different trajectories that women experience while seeking abortion-related care which all start from her awareness around time of pregnancy to abortion attempt. Such experience perhaps may shape her decisions over terminating unwanted pregnancies within the recommended (31) gestational age limit which is easier and safer as opposed to later gestational age. For instance, lack of awareness around timing of pregnancy limits time for decision making around safe abortion care since sometimes it might just be a matter of weeks. Delay in pregnancy awareness may also delay women's access to ANC, such delay may possibly jeopardize her health especially if she is diagnosed with pregnancy complications at later stage that had not been identified so long. A woman at advanced gestational age, diagnosed with fetal anomalies (that may incur harm in her womb and the fetus that cannot survive after birth), is recommended to terminate pregnancy under her consent (permitted by law of Nepal up to 28 weeks especially in such condition). Said that, as the gestational age progresses, abortion procedure becomes more complex and women can make decision around abortion within 28 weeks of gestational age (ultimate legitimate gestational age is up to 28 weeks only apply to conditions when the life of mother and child is in danger).

Furthermore, after pregnancy awareness (either earlier or late) many women are often challenged with disclosing their pregnancy as pregnancy is something that can't be hidden for long. For instance some women may show reluctance to disclose due to fear of reactions, shame and stigma which may lead her to unsafe abortion while for some women disclosure might not be difficult as a result networks and support she has. Likewise, her decisions around abortion might be hindered by her ability to access resources (for example: cost and support) for abortion, her emotions about abortion (for example: health, economic consequences) and her experience to prior abortion attempt (for example: incomplete abortion due to incorrect information). Moreover, these specific pathways of abortion are linked with micro and macro context that influence decision over abortion which will be reflected upon in the subsequent two chapters.

3.1 Awareness of pregnancy

Awareness of pregnancy is the first milestone in abortion specific pathways that is crucial for decision-making around abortion and for some women delay in awareness may have severe repercussion in health of both mother and fetus. This section explores several factors that triggers women's awareness of pregnancy such as knowledge of pregnancy symptoms or pregnancy testing, cost and availability of pregnancy testing, access and availability of pregnancy diagnostics for fetal abnormalities or sex determination. Hence pregnancy awareness is the first step facilitating or hindering further care seeking for abortion.

A study in 2012 on early pregnancy detection by Female Community Volunteers in Nepal stated that SRH services including pregnancy test are accessible at government health facilities however the delay provoked by geographical and social-economic constraints often hinders women's access to such care. The urine pregnancy test kits are also widely available at medical shops still the availability and affordability at rural and remote areas is a constraint. The cost ranges from US$0.58 to 0.70. For most of Nepalese population, this accounts to nearly half of their daily income. However, this study explored the role of Female community Health Volunteer (backbone of health care) and concluded FCHVs as potential agent for early pregnancy detection and referral especially at grassroot level hence improving awareness of

pregnancy at early gestational age (33). This can also relate with ability to access resource for abortion in a way that if women have a strong community network like FCHVs and active women group can improve the access to SAS.

A study in Chitwan valley, Nepal analyzed factors influencing women's knowledge about timing of pregnancy using two datasets: Chitwan Valley Family study and facility based data. It was cited that on an average woman learn about their pregnancy at second trimester (4.6 months). The study showed that despite strong knowledge of pregnancy (including symptoms), access to facilities played a major role in confirming the pregnancy. For those who had prior knowledge about symptoms and lived only a mile further increased the likelihood of confirming their pregnancy by 5% however for those who had prior knowledge about symptoms but lived far from the facilities decreased their likelihood of confirming their pregnancy by 16%. Therefore, distance can be a hindrance to accessing pregnancy test however not influenced by women's prior knowledge about pregnancy symptoms (34)

Furthermore, a qualitative study in four major hospitals with 35 health care providers cited that women who come to their facilities for sex-selective abortion are beyond 12 weeks gestational age (as sex-determination before 12 weeks is not reliable). Since sex-selective abortion is not permitted by law many women perhaps gets denied by service provider after knowing that they are aborting on the basis of sex preferences. However, women seek sex-determination service from one facility and access abortion care from another if a fetus is girl. The provider stated that some women travel India for sex-determination given the cheaper services and easy access and return back to Nepal for abortion. Likewise, some visit private clinics because of its wider availability and acceptance of abortion regardless of reasons as opposed to government facilities. The time for identifying sex would delay the decision around abortion since sex of fetus can be determined at end of first trimester (in some cases however not reliable) or mostly at second trimester taking into account the availability and affordability of the technology (35). This may not be true for all women especially for poor who may not have purchasing capacity, well this has been mentioned in reasons for abortion section. Furthermore, as the pregnancy progresses the risk of performing abortion would be higher and the process would be more complex than first trimester abortion.

3.2 Disclosure

Women may have mixed emotions about knowing her pregnancy status depending upon how the pregnancy was conceived for example an unmarried women might have fear, anxiety and shame after knowing the status as pre-marital sex is unacceptable in some settings. Furthermore, knowing pregnancy status takes women into another level of disclosing her pregnancy. Some women may not want to disclose (as in case of premarital pregnancy) while others may want to this all depends on her ability to disclose (family and community support), networks and circles she has, motives for disclosure, emotions about disclosure (shame, stigma, relief) and timing of disclosure. This section explores some of these aspects of disclosure that influence abortion care (safe or unsafe).

One study conducted in Banke, Nepal reported abortion being unacceptable within the community especially when unmarried and the stigma attached with performing it was even higher. The service provider in the interview cited that women who come to clinic for abortion did not disclose about performing abortion to their husbands or members of the family. Women usually did not consult with family over their decision around abortion. This was mainly because of lack of support and repercussion they could encounter from family and

community when disclosed (36). Stigma prevents women speak about abortion. It also discourages women to raise concerns around abortion, motivate her seeking abortion service of poor quality, influence her decision over disclosing history with care providers and eventually compel her seek unsafe abortion due to high gestational age (37)(38)(39).

3.3 Ability to access resources for abortion

Ability to access resources is another crucial aspect of abortion decision. Even after coming to a point of seeking abortion care several factors might hinder her access such as social and emotional support (that she receives from friends, families and communities), access to physical resources (example: money, transport) and access to abortion methods (MA or MVA) and certified providers (example: distance to care providers, lack of transport facilities). Hence this section analyzes some of these aspects and its linkages with other abortion pathways and both micro and macro environment.

Studies have shown that abortion legalization in Nepal has not benefited all women equally in SAS accessibility (40)(28)(41). Unsafe abortion was still predominant in rural and mountainous parts of the country (42). Several factors come into play like awareness around abortion legalization, lack of knowledge about availability of safe abortion services, absence of SA facilities and transport services in hard to reach areas, financial difficulty (43)(44), deeply rooted patriarchy that often influence decision of women over abortion care, stigma attached with abortion etc (44).

In 2009, the case of Lakshmi Dhikta was brought to the supreme court of Nepal who represented rural Nepalese women who were challenged to pay for abortion. Lakshmi was pregnant for the sixth time and was forced to have the child. However, she choose to abort but had to go through unsafe procedure due to financial constraints. The court accentuated the government to guarantee the right of all women to access affordable safe abortion service (45)(46).

The SAS was incorporated in Essential Health care service Package in Nepal Health sector Programme-2 (2010 to 2015) (47). Only after 2017 the Government of Nepal made all SAS free in public health facilities to improve the access and utilization of those service among poor and marginalized women. Studies have stated that strategies per se may not fully change the scenario. (32)(26). The SAS has not reach 24 districts of the overall 77 districts in Nepal which are mostly rural and geographically challenged (26). Many women do not possess the capacity to manage the indirect cost related to seeking the service like cost of transportation, drug expenses, accommodation and food. Hence the choice of SA method could be altered by women's purchasing capacity (32)(30).

One study in Makawanpur, Nepal that assessed accessibility and availability of safe abortion reported that the barriers associated to cost, geography and distance to SAS hindered their ability to access SAS. The study included both qualitative and quantitative information with 447 women of age group 18-34 years. About 56% women had SAS close to them, 24% did not have service nearby and 24% were not aware about the availability of service. Of those who had service nearby, 55% would reach facility within 30 minute whereas 45% would travel more than 30 min to reach the facility. About 18% women find it difficult to pay for their transportation. The participant who performed medical abortion at PHCC cited that even though the service was free and the distance was half an hour, it was difficult to manage the cost attached with transportation, post-abortion care (PAC), work leave etc. In an in-depth

interview with abortion service provider of public hospital, the provider mentioned that due to financial constraints women choose clandestine abortion and many attain hospital as last resort when complications arise. She mentioned that parts of district have difficult geographical terrain which makes women travel for long, ranging from 30 minutes to 4 hours, pay for transportation, food and accommodation moreover during monsoon it becomes more difficult to travel. Especially young unmarried women who lack family support and challenged financially are the one who perform abortion secretly (48).

3.4 Emotions about pregnancy/childbearing/abortion

Women have varied emotions around pregnancy and abortion (49). In some settings children are considered gifts from god and terminating pregnancy would consider as committing a sin. These emotions are outcome of several factors such as reasons for abortion (example: fetal abnormalities, socio-economic implications, health of mother, HIV, age at pregnancy), emotions and advice of others, conflicting emotions. This stage is very challenging for women as this impacts all stages of abortion-specific experiences.

Several studies report that for majority of the women in Nepal increased desire for fewer children was the main reason for choosing abortion (3)(50). Age of women, son preferences, health issues, economic status, and extra time and care required for other children were some other reasons cited by women over their decision on abortion (51)(52). A qualitative explorative study stated that women residing in rural and mountainous region of Nepal were daunted with the high cost associated with SAS. The inability to pay for the service was reason cited around choosing unsafe abortion (53).

A retrospective study, that analyzed unsafe abortions admitted at BPKIHS hospital, reported that between 2005 April to 2008 September there were 1071 abortion related admissions of which 70 were complications of unsafe abortion. Of those admitted as complications of unsafe abortion, 58% were of high grade and eight died. Additionally, about 13% unsafe abortion were self-induced with herbal twigs and sticks. The reason cited for unsafe abortion by majority (68 out of 70) of the women was unwanted pregnancy and for 2 women it was pregnancy outside marriage (48).

Severity categories	Definition	
Low	Temperature ≤ 37.2 °C	and
	No clinical signs of infection	and
	No system or organ failure	and
	No suspicious finding in evacuation	
Moderate	Temperature 37.3-37.9 °C	or
	Offensive products	or
	Localized peritonitis	
High	Temperature ≥ 38'C	or
	Organ failure	or
	Peritonitis	or
	Pulse≥120	or
	Death	or
	Foreign body/ Mechanical injury	

Figure 7: Unsafe abortion severity category

According to NDHS 2016 of 492 women who underwent abortion in past five years before the survey, half of the women had sought abortion care from authorized facilities. These women were more likely to be rich, residing in urban areas and with secondary or higher education. Likewise, around 30 percent sought abortion care from government and 27 percent from private health facilities. However, about 27 percent conducted abortion at their house. In addition, when it comes to knowing the reason for choosing most recent abortion care,

majority (50%) reported not having desire for more children followed by delay child-bearing (11.7%) however only 3.7% of the women aborted because of partner's decision. Some of these reasons could overlap, for instance not wanting more children could be associated with lack of money to raise more children, or health of mother (3).

Table 2: Reasons for choosing most recent abortion (in past 5 years), NDHS 2016(3)

SN	Context	Health of the mother (%)	Lack of money to raise the child (%)	Delay child-bearing (%)	No more children (%)	Birth spacing (%)	Decision of husband (%)	Sex of child (%)	Total
1	Urban	10.9	4.3	11.4	51.0	8.5	2	7	336
2	Rural	8.9	4.2	12.5	48.8	11.0	7.4	5.6	156
3	Mountain	6.3	4.9	15.3	64.5	4.4	0	3.5	33
4	Hill	10.8	3.8	12.7	51.0	8.1	2.0	6.9	236
5	Terai	10.3	4.6	10.2	47.4	11.3	6.1	6.7	224
6	Illiterate	7.7	8.6	5.0	60.6	4.7	6	7.3	133
7	Primary	5.1	8.6	5.0	60.6	4.7	6.0	7.3	133
8	Sec &above	15	1.5	25.1	31.3	15.6	0.0	5.3	108
9	Poor	10.9	7.6	9.5	63.5	4.7	0.3	3.5	69
10	Rich	13.8	2.9	17.5	40.2	7.7	2.3	7.4	151
11	Total	10.3	4.3	11.7	50.3	9.3	3.7	6.5	492

Note: Only some selected background characteristics were presented in the table. The total number projected in the table is the total number of women who had abortion in the past five years preceding the survey.

3.5 Abortion attempt(s)

Eventually a women decides to terminate her pregnancy after all the turmoil she comes across in her decision making process. However, she may not find it easy to go through the procedure or it would not work that way. She has to further confront with some more decision making process. For instance what would be her options around the type of abortion she would likely perform (example: safe/ unsafe, legal/illegal, MA, MVA, self-induced), where would she go for abortion (certified/uncertified facilities, home) and why. Her decision of abortion type, sites is also influenced by her gestational age for example women tend to have self-induced or unsafe abortions taking into consideration gestational age limitations, if women cross that gestational age she might not be permitted to SAS that perhaps might compel her to perform unsafe abortion. Moreover, her experience with care provider (example: attitude of care provider, maintaining confidentiality, harassment). Some of the factors like crossing gestational age limit, abortion location sought can be linked with knowledge environment at macro level. For instance access to information or quality of information in the macro level can affect her knowledge around certified abortion sites and the existing services.

In Nepal half of the pregnancies were reported to be unplanned of which around thirty percent result in abortion (54)**.** In 2014 a survey was carried out to estimate the incidence of legal and illegal abortion in Nepal with 386 nationally representative facilities that offered

authorized abortion or PAC. Total abortion reported was 323,095 of which around 60 percent were illegal (performed by uncertified facilities or providers). Of the total illegal abortion 30% resulted in treated complications. Total number of facilities participated were 386 that provided legal abortion care. However, Availability of service (abortion or PAC) was much higher among private (hospitals, medical college, clinic) facilities and NGOs (100%)(55).

Table 3: Service provision, by type of facilities, Nepal, 2014

SN	Type of facility providing legal services	No of facilities participating that provide legal abortion	% of facilities that provide abortion or PAC	No of abortions performed	No of PAC
1	Public	283	57	50,509	33,469
2	Private	88	76	40,281	35,698
3	NGO	15	100	46,161	11,683
4	Total	386	63	136,951	80,469

The acceptance of different types of pregnancy termination methods among Nepalese women depend on the nature of methods. Women at school and work would prefer manual vacuum aspiration (MVA) because it takes less time. However, medical abortion was the most frequently used of all types and common among women with no employment and education (3)(56).

A study in Nepal has shown that when women are well informed about the options around methods of abortion they are more likely to be confident about making their own decision. For more than half of the women who had received complete and adequate information around different options of abortion procedures from the clinic, MA was their informed choice of method. Similarly if they thought the information was not sufficient, only few women underwent MA. This was because during the survey these women had prior knowledge about surgical or MVA or had performed MVA before and were more confident about the method and also MA was new to them. Likewise, majority of the women choose MA who had no predetermined option after counseling. In addition women with previous history of abortions with MA were comparatively more likely to decide MA over MVA (56).

The service provider's attitude towards abortion by unmarried women also discourages unmarried women from seeking SA care. This is mainly because they see sex before marriage as immoral (53)(57).

A qualitative study among women who were denied services from two facilities in Nepal reported many women endured unsafe abortion when they were turned back from certified facilities due to higher gestational age (51). So, this could be linked to lack of access to abortion up to 28 weeks, knowledge about gestational age for abortion, knowledge about location and geographical constraints, stigma that delays access to safe abortion care.

3.6 Perceived/experienced outcomes from (attempted) abortion

After pregnancy termination a woman may have physical, mental and socio-economic complications. Physical consequences includes pain, side effects, infertility and may even lead to death. This may also have linkages with abortion experience. For instance a woman's prior experience of incomplete abortions at uncertified facilities might lead her to safe procedure in another attempt. Mental consequences includes sadness, guiltiness and disgrace also

sometimes aggravated by stigma. But for some it can also be case of relief. Socio-cultural implications include out-of pocket payments, legal implications. Some of these aspects have are explored in this section.

A qualitative study that explored prior experience of 20 women on abortion cited that women shared varied experiences about their challenges and success while performing abortion in the past. The study involved in-depth interviews with 10 women who attended abortion care at certified facilities and 10 women who were assisted by pharmacies. Challenges they had encountered while receiving MA service from pharmacies were lack of accurate information about the procedure that lead to incomplete abortion for four women, inadequate medical support and referral in case of complication. Whereas for those who received abortion care from certified facilities it was other way around, women were satisfied with the service. Moreover, they had fear and doubt around the competencies of care providers at pharmacies that might have implications on health. However, for those who received care from pharmacies, despite fear of complications, they were compelled to choose MA at pharmacies due to unavailability of SAS near them (52). This can be link with women's ability to access the care, abortion attempt, knowledge environment at macro level.

CHAPTER IV: INDIVIDUAL CONTEXT

This level explores knowledge and beliefs of women about abortion and individual characteristics of a woman (socio-economic, demographic, health, husband/ family/community context, autonomy) that interferes with abortion decision making and obtaining care.

4.1 Knowledge and beliefs about abortion

This level analyze various aspects of knowledge and beliefs about abortion and not just limit to knowledge methods and legalization but also perception of implications. Possible factors that influence her knowledge and beliefs are awareness of options and source of information of abortion care, ability to look for correct information around SAS, knowledge about methods and legalization of abortion, perception of implications (risks, benefits, socio-economic, relationship) and beliefs around abortion morality.

A study in Nepal reported that many women have scare or no awareness around legalization of abortion, conditions under which abortion is permitted and location/facilities where SAS are provided. These women have either restriction in exercising their sexual and reproductive health or rights or are living in geographically challenged area or both (44).

Women's reasons for choosing abortion, their level of knowledge about certified abortion sites and understanding of the terms under which abortion is allowed was considerably linked with the type of abortion women seek. Unsafe abortion was common among women who reported child spacing or delay pregnancy as a reason for abortion. Women who cited having understanding of legal terms under which abortion is permitted though not aware about the SA sites were more likely to carry out unsafe abortion compared to women who cited having knowledge of both SA sites and legal conditions (58).

A study amongst women admitted at hospital due to complications from abortion cited that most of the complications were as a result of self-induced abortion from the use of medicines

obtained from unlicensed providers. Women who reported complications as a result of unsafe abortion practice had very limited knowledge about the abortion legalization in Nepal compared to women who practiced SA care (59).

Studies have shown that more than half of the women of reproductive age did not know about the SA provision sites and abortion legalization in Nepal (30)(59)(56). There has not been much progress around improving level of knowledge of women when compared to NDHS 2011. Between NDHS 2011 and NDHS 2016 the level of knowledge of women had increased by three percent only. Poor and illiterate women residing in rural areas had limited or no knowledge about abortion legalization and SA sites (30).

4.2 Individual characteristics

This section analyze sever potential factors at individual level that is related to decision making about abortion care (safe, unsafe) such as socio-demographic and health characteristics, context of her surrounding (husband/family/community), fertility intentions (sex of foetus, not using family planning services), autonomy, power.

A nationwide cross-sectional study in Nepal among 2395 women who had ever performed abortion reported that women who are young, illiterate, poor, living in rural area are most-at-risk to endure unsafe abortion. Women with most recent abortion were only elicited in the findings. Of 940 older women of age group 25-34 years about 33 percent had abortion. Likewise, of 303 young women age 15-24 years, about 27 percent ever had abortion. However, unsafe abortion was mostly performed by younger women which was 20% compared to 14% in older women. Abortion was low (12%) among women with no education however unsafe abortion was relatively high (23%) in this group compared to higher education (9%). Abortion was high (27%) among women in richest wealth quintile however unsafe abortion was more prevalent (33%) among poor women compared to rich (10%). Abortion was high (24%) among Brahmin and chhetri ethnicity (high cast) however unsafe abortion was high (20%) among Dalit ethnicity (low cast) compared to Brahmin and Chhetri (16%) and Janajati (13%). Abortion was high (22%) among Buddhist religion however unsafe abortion was high (19%) in Muslim religion compared to Buddhist (3%). Abortion was high (22%) among women residing in hill and terai however unsafe abortion practice was high among women residing in mountain region (22%) compared to women living in hill (17%) and terai (14%). Likewise, women from urban area are more likely (25%) to carry out abortion however unsafe abortion is more prevalent (17%) among women residing in rural area compared to urban women (14%). Moreover, those who reported having knowledge of legal abortion and safe places where abortion is performed were less likely to carry unsafe abortion. (60).

Women from terai region who belonged to Dalit, Muslim and Madeshi ethnic group were reported relatively poor compared to other groups that undermine their access and utilization to SAS. Furthermore, abortion was highly stigmatized in Muslim groups due to religion whereas in Dalit and Madeshi group abortion was considered taboo (58) .

According to NDHS 2016, factors contributing to increased unintended pregnancy was mainly low contraceptive prevalence rate accompanied by high unmet need for family planning (FP). This was also linked as possible factor for unsafe abortion (3).

Inadequate access to contraception was quoted as a reason that women perform abortion as a means to delay pregnancy or birth-spacing. Said that inadequate knowledge about safe abortion sites and terms and conditions for abortion for instance gestational age could still be the reason for not seeking SAS (61).

One study reported that women from poor socio-economic groups have high rate of unsafe abortion. This was mainly because women who are socioeconomically deprived were tend to have low contraceptive prevalence rate and thus greater unmet need for contraception (62)

The task shifting for first-trimester abortion care by skilled auxiliary nurse midwives (ANM) in Nepal has significantly improved the service accessibility (63). However, the country's difficult terrain has posed a challenge in making the service equitable for all women. For example: women residing in rural areas and mountains continue to have limited or no access to and utilization of available facilities (64)(65). It takes them days to week to reach the facility because SAS have not reached many districts of mountain region or are highly concentrated in district hospitals. Hence some women reach facilities with later gestational age (27) while some choose unsafe abortion due to such delay exacerbated by geographical constraint (60)(64).

CHAPTER V: (INTER) NATIONAL/SUB-NATIONAL CONTEXT

This chapter analyzes the Nepalese national and subnational context for abortion related care. Women's decision around abortion is strongly influenced by the context where the decision has to be made for instance where does she come from, how liberal is the abortion law, and how fragile is the state. Elements of this macro environment are socio-cultural, legal, institutional and health system. These elements have linkages between each other as well as with abortion-specific experiences and individual context.

5.1 Structural and institutional environment

This section analyzes the gaps and strength within the structural and institutional environment that hinder or facilitate women's abortion pathways. For instance the restrictive law around abortion or decriminalization of abortion affects women's decision and so far from the experiences of countries with both liberal and rigid law around abortion we have witness that in countries with restrictive law on abortion prevalence of abortion is even higher compared to countries with liberal law. Other factors that come in play are commitment to regional/international treaties, treatment guidelines, law enforcement, civil society influence, anti/pro-natalist and associated policies, conflict and crisis.

In 2008, the Department of Drug Administration of Nepal permitted only four different MA drug brands (combined regime of mifepristone and misoprostol). Only government-certified professionals and clinics are authorized to prescribe these drugs. Off-label supply of such drugs are prohibited. However, the sale of both registered and unregistered brands at pharmacies remain (52)(66). The open border between India and Nepal facilitates the entry of such unapproved brands. It was reported that 18 different MA drug brands were sold in two districts of Nepal by pharmacies. In addition the traditional medicines and herbs that have pregnancy termination properties were illicitly sold in pharmacies (66).

Less than four percent of the national budget goes for health sector which also includes SAS. Although the government specified in National Health Sector Strategy Plan about an allocation of 10 percent in health sector. In addition the government fails to establish a clear strategy around expansion of health care centers and providers (26). This could also relate to one study in Nepal that stated Stigma exists at all levels: individual, community, structural and institutional level. Although a long history of liberalization of abortion, some policy makers still holds strong judgmental and discriminative opinion around abortion service consequently make bias decisions over budget allocation with regard to abortion services, trainings and programs (30).

One study highlighted on complexity of understanding that both access to abortion care and sex-selective abortion are part of system that perpetuate deeply entrenched gender inequality even though they are both stand-alone issues. Women especially poor and underprivileged have high expectation from their society to have a boy child therefore opt to have multiple children unless she has a boy or seek for abortion care. However, for several reasons as discussed in earlier chapters hinders women's access to SAS for example denial for sex-selective abortion due to restrictive law around sex-selective abortion (31) which place both women and health providers into very critical situation as it may end in unsafe abortion. Therefore, policies that focuses only one issue need to be acted carefully otherwise poor and marginalized women will be hard hit (32).

5.2 Health system

This section describes the formal and informal health system, analyze its elements and potential gaps, challenge and strength that undermine or influence the abortion trajectories. Some of the elements of formal health system includes: finance, infrastructure, governance, health information, human resource, commodities, stigma experienced by providers, quality of care. Likewise, elements of informal health system includes Illegal providers such as traditional healers, pharmacists, self-induced abortion, unlicensed doctors.

The steady expansion of CAC certified providers and facilities that started in 2004 had reached over 2000 clinicians and 532 facilities in 2017 and 3000 clinicians and 532 facilities in 2018 (29)(28). However, with regard to facilities certified for CAC at urban and semi-urban regions only seven facilities out of nine monitored by Beyond Beijing Committee (BBC) had capacity to operate full time and the rest two had shortage of providers (67).

The post-abortion care (PAC) has been viewed as central to scale back maternal mortality and morbidity associated with abortion complications with provision of post-abortion counseling around contraception services to avoid the recurrence of unintended pregnancies and abortions (68)The Government of Nepal outlined the SAS guideline in 2003 that included the PAC services (69). Irrespective of it studies have shown little progress in post-abortion counseling and contraceptive uptake (3)(70). A study with around 700 induced abortion cited that considerably greater number of women stopped use of contraception after post abortion. Nearly 45 percent of women did not start any method of contraception in one year subsequently (70). Similarly, according to NDHS 2016 only half of the women received post-abortion counseling on contraceptive method and the use of such method within two weeks was reported one in four (3).

A study that explored factors influencing SAS in rural and mountainous region cited that the government policy around training compulsion on SAS has challenged the training centers as well as hospitals and clinics that also offered trainings. This was because of insufficient training centers to fulfill the need of increased demand for trainings. Likewise, increased workload of hospitals and clinics due to dual demands of providing regular service and SAS trainings. In rural health settings the service providers were challenged to receive the training because of geographical constraint. Furthermore, high turnover of staff in the rural health facilities also hindered the expansion of SAS at rural and mountainous region (27). Therefore, the unavailability of certified facilities and skilled staff (due to high turnover of facilities at urban area) predominantly in rural facilities caused substantial delay for women in accessing abortion care within the legal timeframe. (27)(67).

Another study (qualitative) in Nepal with health providers reported various challenges related to inadequate access and utilization of SAS remains particularly in rural and mountainous region due to lack of proper infrastructure (roads and transport), lack of commodities (drugs, supplies and equipment's) , inadequate and demotivated staffs, high turnover of trained providers at rural facilities, lack of motives (trainings and incentives) and judgmental and biased service provision (53).

In Nepal, access to correct and complete health data around abortion from various facilities remained a challenge. This was reported mainly because of the lack of motivation of government staff to add complete information of a client as well as no reporting and recording mandates for private institutions. The data from impact assessment of a program was cited

as essential to identify the implications of abortion services in long-run (27). Constraints around provision of SAS in rural and mountainous regions were absence of skilled providers in the facilities, lack or inadequate medicines and equipment (58).

The success of pharmacies had been evident as vital in improving availability of post –abortion contraceptives in Nepal. It was stated that abortion service provision by certified nurses and ANMs from pharmacy sites could be another strategy to improve access and utilization of MA (71)(72). An observational study carried out in Nepal among women age 16 to 49 reported both pharmacies and certified facilities were equally capable of providing post-abortion contraceptive as the utilization was seen high among women within 14 to 21 days of MA (71). However, this contradict with another study discussed in previous chapter where women had fear and doubt around the competencies of pharmacies (52). But, this could be because of the presence of skilled and qualified ANMs in the pharmacies or through provision of MA trainings (71). However, WHO discourage the provision of MA by pharmacies (73).

A qualitative study in two districts of Nepal done among 19 pharmacy owners reported high confidence of owners to deliver safe, accessible, affordable and confidential MA services in their region (74). The long opening hours of pharmacies as opposed to government certified facilities gives some flexibility to women to access the service especially in rural and remote areas where pharmacy is the first-line of contact for women requiring SRH related information and care. Hence, permitting pharmacies as legal MA providers and streamline referrals with continued provision of training was considered beneficial(74)(66). This could link with knowledge environment which is discussed in subsequent section.

5.2.3 Knowledge environment

This element of structural and institutional environment captures constitutes: access to information (safety, availability, legal), quality of that information (correct/incorrect), technology (mobile) and also knowledge source including: politicians, community leaders, health professions, peer educators, journalist and all these factors influences women's abortion pathways. This element could be link with individual factors as such that education and socio-economic and area of residence (rural, urban area) could hinder access to information.

Studies have indicated radio and television (TV) as essential pathways to disseminate information around health (3)(44). However, programs and interventions that targets all group of women with differing preferences and access should involve other strategies to more effectively convey message around abortion law and different sites that provide SAS (44). It was cited that compared to poor the significant number of rich women had access to information from TV and health workers. Although TV was preferred by most of the women from both rural and urban areas only 80 percent of women from urban area watched TV. Women in hill and mountain regions had more access to information via radios compared to women in teria region. Likewise, women with higher education had access to information via radio compared to women with no education. Majority of the women preferred FM radio over national radio (3)(44). Furthermore, other platforms that offer women opportunities to jointly discuss policies and programs includes: mother's group meetings, micro-finance and co-operatives programs, non-formal education and trainings and citizen forum. Nonetheless,

interventions as such are very intense and costly when compared with radio and TV programs (44).

According to NDHS 2016, 50% of the women who had an abortion 5 years prior to the survey received FP counseling and consultation during post-abortion care. However, only one in four women who had received counseling used FP method within 14 days of abortion (3).

Table 4: Information and Counseling on FP during post-abortion visit (3)

SN	Background	Percentage of women informed on FP during post-abortion period	Percentage of women who used FP within 14 days after abortion	No of women
1	Urban	53.3	25.5	352
2	Rural	48.9	24.7	159
3	Mountain	68.7	22.7	33
4	Hill	54.0	24.6	248
5	Terai	47.2	26.3	230
6	No education	52.6	20.6	137
7	Primary	51.1	28.0	112
8	Some secondary	42.9	28.7	147
9	Above	63.4	23.8	115

5.4 Socio-cultural context

The socio-cultural context constitutes several elements that triggers abortion pathways that includes norms and abortion acceptability (stigma, shame), fertility norms (family size, sex-preference) and inequalities (gender, wealth). This context is strongly related to other elements at the macro level for instance the restrictive law around sex-selective abortion confines health workers duty of care or readiness to offer SAS even being aware of the fact that the denial would lead to unsafe abortion. Gender norms applies unfairly between men and women and women are disproportionately affected when it comes to sexual behavior of men and women for instance, pre-marital sex is highly unacceptable and are shamed however the rule does not apply the same for male. The stigma around marriage can hinder unmarried women's access to SRHR services particularly family planning and SAS. In societies with inequitable gender norms, men act as gatekeepers, preventing seeking SRH information and services. This can also be linked with women's ability to access resources for abortion which has been explained in previous chapter. This power distribution between husband and wife or sexual partners ends in poor communication around sex and contraception. This sections explores some of these factors that facilitate or hinder abortion trajectories.

In a qualitative study, health workers (HWs) perspective on sex-selective abortion in Nepal, the provider stated that sex-selective abortion situate health workers in ethical dilemma for being a legal gatekeeper. Mainly because if women were denied the SAS for the reason (sex-selective abortion) than women might resort to unsafe abortion providers. Women's health and safety had been huge concern to the providers. Furthermore, the providers also had an understanding around social pressure on women to bear son that contributed to abortion. (35). Son preferences are embedded within a Nepalese culture, for instance in Hindu culture

funeral rites are allotted by sons on the other hand daughters are looked as burden because of the dowry system or wedding rituals (property or money given to husband during marriage. Consequently, that generates the demand for son (35)(76)(77).

Stigma around abortion infringes women's rights and autonomy. A project implemented in two districts of Nepal by Ipas reported that stigma was highly prevalent within the districts that hindered women's access to SAS. Women from the project cited fear of shame and disgrace from society, feeling of rejections and not having the ability to disclose about abortion with family because of stigma. Furthermore, it was reported that abortion care providers were also stigmatized for providing the service (78).

CHAPTER VI: DISCUSSION, CONCLUSION AND RECOMMENDATIONS

6.1 Discussion

This chapter analyzes linkages and discusses the results with regard to different abortion related pathways women experience; individual characteristics and context influencing abortion care-seeking behavior and Nepalese national and subnational context for abortion-related care as well as best practices for abortion services in the national and international context.

Women have differed experience at each pathways which all start from her pregnancy awareness to attempting abortion. Such experience play a role in decision making on terminating unwanted pregnancies within the recommended timeframe. If the decisions are made at early gestational age it is likely to be easier and safer compared to later gestational age. For instance, lack of awareness around timing of pregnancy limits time for decision making around safe abortion care since sometimes it might just be a matter of weeks. When the gestational age progresses, abortion procedure becomes more complex. After pregnancy awareness many women are often challenged with disclosing their pregnancy due to fear of reactions, shame and stigma while some disclosure due to strong networks and support. Likewise, her decisions could be hindered by her ability to access resources for abortion, her emotions about abortion and her experience prior to abortion attempt (for example: incomplete abortion due to incorrect information). These specific pathways of abortion are linked and influenced by micro and macro context.

Abortion specific experience is influenced by knowledge and beliefs of women about abortion and individual characteristics of a woman (socio-economic, demographic, health, husband/ family/community context, autonomy) that interferes with abortion decision making and obtaining care. Women's decision around abortion is strongly influenced by the context where the decision has to be made (where does she come from), how liberal is the abortion law, and how fragile is the state. Components of macro environment are socio-cultural, legal, institutional and health system. These elements have linkages between each other as well as with abortion-specific experiences and individual context.

The first milestone around healthy pregnancy or safe abortion relies on women's awareness of pregnancy (79). For instance her prior knowledge about being pregnant, access to or use of pregnancy testing or diagnostics service. The cost of pregnancy testing, difficult geographical terrain accompanied by distance perhaps plays a vital role for women to appear in health facilities within the gestational age limit for abortion. This is consistent with two other studies (80)(81)(82) but is not consistent with a previous study by Amy and Katherine (80) that examined self-reported data from National Survey of family growth among 406 women aged 15-44 years. The timing of pregnancy awareness was 5.5 weeks for all the reported pregnancies.

Reasons for the differences could be the settings where the studies were carried out in relation to women's knowledge, accessibility, affordability and availability of service. It could also be related to the time study was done. As the study was carried out from 1997 to 2006, which is more than decade ago and done in one only one district of Nepal. Therefore, more research is required to understand the present context considering changes in socio-economic, national health policies and political situation. Both studies in Nepal and Madagascar had evidence and

emphasized on mobilizing community health volunteers (Female Community Health Volunteers) in case of Nepal to improve the access to pregnancy test kits.

Decisions around abortion are kept confidential with friends and even within family members especially when women are not married due to substantial stigma attached to it. Those who are unmarried but pregnant or had aborted pregnancy experience huge repercussions that lead to isolation, feeling of shame and guilt or are otherwise subjected to injury or death from unsafe abortion practice. This finding was consistent with qualitative studies in India and Kenya (83). This can be linked with beliefs about abortion and socio-cultural norms in other domains as pregnancy before marriage appears to be unacceptable as explained in the study. Therefore, in that case marriage is often used as a solution to legitimize pregnancy and moreover, also first place alternative to abortion.

On timing of disclosure of abortion not a lot of literature was found in relation to Nepal but can be a very important component as this may influence women's decision making around safe or unsafe abortion . A qualitative study in the UK reported that the attitudes toward non-/disclosure was linked with women's beliefs over abortion as self-stigmatized act also undermined by macro environment that may result in embarrassment, isolation, confidentiality, discrimination etc. (84).

Half of the women had sought abortion care from authorized facilities. These women were more likely to be rich, residing in urban areas and with secondary or higher education.The reasons from choosing abortion was not wanting to have a child for majority of the women in Nepal. Age of women, son preferences, health issues, economic status, and extra time and care required for other children were some other reasons cited by women over their decision on abortion. Women residing in rural and mountainous region of Nepal were daunted with the high cost associated with SAS. The inability to pay for the service was reason cited around choosing unsafe abortion. This findings was consistent to (13) a nationally representative data from 14 nations. It was reported that the frequent answer for reason for choosing abortion were limiting childbirth. In study in Nepal the reasons were categorized under several topics like heath, financial constraint however each reasons could link with each other. For instance women may not want to have more children due to financial hardship or due to her health

In Nepal, unsafe abortion is highly prevalent in isolated, inaccessible places. This study finding was consistent with report of United Nations convention on the elimination of all forms of discrimination against women which cited that in developing countries women in rural areas are more likely to resort unsafe abortion. (85).

This is related to other factors in micro and macro level such as high unmet need for FP associated with purchasing power, knowledge and access, Knowledge and awareness around SA sites and legalization of abortion was often quoted as important factor by many studies. Also young women are often subjected to unsafe abortion because of their financial dependency and limited support from their husband or partner, denial of service due to high gestational age, long waiting periods and unavailability of health care providers at facilities. Another study from Zambia shows that indirect cost associated with abortion accounts to huge burden among women. Indirect payments account for the largest part of the burden.

Unsafe abortion was associated with socio-economic and demographic characteristic of an individual. Women who were young, illiterate, poor, physically and geographically disadvantaged, Dalit and Muslim had high likely to perform abortion in clandestine or with uncertified providers. This study was consistent with other studies (86)(87) (88). One study

in Ghana that analyzed maternal health survey data to identify socio-demographic characteristics of women with abortion.

Another study that estimated the incidence and rate of unsafe abortion among women of reproductive age in developing countries reported that unsafe abortion accounts to 41 percent in young women age 15-24 years of age in developing countries. In developing countries, over one out of three unsafe abortions is carried by young women. Likewise in Africa, one out of two unsafe abortions is carried by young women. Young women were more likely to have unsafe abortion was due to high unmet need of family planning and SAS. The high figure of unsafe abortion among these group of women could be linked with several micro and macro factors such as knowledge environment (low level of awareness around SAS), structural and institutional environment (restrictions criteria to perform authorized abortion service), gender norms (son preferences, early marriage), ability to access resources for abortion (financial constraints) etc. rich has more control over resources and hence have privilege to purchase safe abortion service.

Access and availability of correct information is very crucial to have knowledge and awareness around safety, availability, legality of abortion. Women in rural areas were not as equally advantaged as women in urban areas. Women in urban area tend to be more advantaged with regard to having varied options for different sources of information. Majority of the women preferred radio as source of information however they had comparatively limited knowledge around legality and sites of SAS. Programs and interventions should come with different strategies taking into account the preferences of women. Guttmacher institute (89) emphasizes on disseminating correct and right messages around SRHR services including safe abortion care, actively through innovative campaigns and widely spread through multiple sources of information like traditional media, websites, and social media. AND Encourage use of mobile phones and computers to improve the reach to correct information.

For many reasons, abortion in recent years tends to be safer. This could be due to growing demand of pharmaceutical drugs as opposed to more invasive procedures, liberalization of abortion laws in many regions, task shifting of abortion care to mid-level providers particularly where there is shortage of physicians (43).

The present study shows high unmet need for both family planning and safe abortion care among women who performed abortion. Post abortion care is not available at all facilities. Only half of the abortion cases receive counseling and of those only quarter of them start contraception. This could also be due to lack of proper counseling The most common reasons for performing abortion was not wanting more children however not using any means of family planning. This was consistent with findings from other studies (90). One study cited that post-abortion counseling was related with improved utilization of family planning service in countries with low resources settings. Although many countries have guidelines that mandate family planning counseling at time of post-abortion care implementation of such guidelines remains questionable. Another study reported women extend their post-partum care after delivery because many women think they would not get pregnant this soon, hence unmet need for family planning stays high during this period.

Stigma is deeply rooted in Nepal, stigma attached to abortion has severe repercussions. Stigma can be found at every level individual, structural and institutional. Health workers had negative attitudes towards stigma and some try to avoid the procedure. The health care providers who were willing to help were also stigmatized by family and communities. This was consistent with one of the studies done in similar setting (92)(93) . A systematic review

reported that health workers decision around providing the safe abortion care or not is influenced by the existence of stigma hence impacting women's access to SAS and making them vulnerable to unsafe abortion. In majority of the countries in Southeast Asia and Sub-Saharan Africa, health providers had negative perceptions towards abortion. Also stigmatization of health workers who provide abortion care was very strong, often from the families, friends and society. Another study showed that health workers denial to operate abortion procedure delays access to abortion care for many women. Stigma is very sensitive topic that may hinder women's access to safe abortion care (37) .

Nepal has a long history of liberalization of abortion law and has made tremendous effort to increase the number of trained human resources however unsafe abortions continue. Abortion legalization in countries does not assure women's access to safe abortion care. Countries need to strengthen human resources via financing in capacity building/trainings of health workers and guarantee that safe and confidential care has been offered by these providers. In addition, raising awareness of women around their SRHR rights including their right to safe abortion care (95). Studies have shown that countries that are more progressive around legal ground for abortion, tend to have safer abortions (96). Countries with liberal law and without liberal law, abortion rate is essentially same. However, countries that has non-liberal law, abortions are less safe most of the time(89).

6.2 Conclusion

This study analyzed different abortion specific experience of women her individual context and national and international context to understand women's trajectories in seeking abortion-related care. Elements at both micro and macro level as well as abortion specific experiences were linked with each other as well had inter-relationships among each other. Women particularly from rural areas with poor socio-economic status face several challenges in terms of access and utilization of available SAS. Starting from learning their pregnancy to pregnancy termination women deals with range of experiences that influence her decision over abortion (safe or unsafe). Women's awareness around pregnancy could be due to her prior knowledge about symptoms, availability, affordability of pregnancy diagnostic kits and social Network. This could be linked to women's arrival at health facilities during late gestational age sometimes more than recommended timeframe. Decisions around abortion are not disclosed by many women due to stigma attached to it especially when it is an unmarried it is viewed as double stigma and leads to huge repercussions (isolation, feeling of shame, subject to injury or death from unsafe abortion practice). This could be linked with beliefs about abortion and socio-cultural norms. Unsafe abortion is highly prevalent in places that are geographically challenged. This could related to institutional and structural factor. For example: (i) gaps in health system to address high unmet need for FP, denial of service due to high gestational age, long waiting periods and unavailability of health care providers at facilities (ii) poor socio demographic characteristics such as economic status that could undermine purchasing power, education that could undermine Knowledge and awareness around SA sites and legalization of abortion, age (young women are vulnerable due to their economic dependency and therefore women in this category are more likely to perform

abortion in clandestine placing her with high risk. Knowledge and awareness around safety, availability, legality of abortion Access and availability of correct information is very crucial ability to access such information could be link with individual characteristics again. For instance Women in urban area are more advantaged due to varied options like radio, television, internet and mobile. For majority of the women reasons for performing abortion was not to have more children. This High unmet need for FP after abortion in the study was due to lack of post abortion care and proper and correct counseling around family planning. The health care providers who had willingness to help legally bind as some women showed up at late gestational age while some came for sex-selective abortion. Likewise, some health workers had negative attitude towards abortion. Stigma around abortion could happen at all level: individual, structural and institutional and is deeply rooted in Nepal. Nepal with its long history of liberalization of abortion had succeeded in increasing trained human resources .However unsafe abortion exists this could be due to setting some grounds for abortion based on sex-determination. Abortion legalization in countries does not assure women's access to safe abortion care. Innovative interventions in tackling the underlying factors of sex-selective abortion are mostly done through NGOs and INGOs along. Some legal steps taken by government in banning dowry has also been some of the good practices in Nepal. However, interventions per se requires strong enforcement and should be enhanced to ensure health and well-being of women and girls.

6.3 Recommendation

- Women especially in the rural area had low awareness on the legalization of abortion law and the locations that provides SAS. Therefore, awareness raising programs should be carried out under the guidance and supervision of NHEICC (National Health Education Information Communication Center
- Given the fact that traditional healers and pharmacist were the first point of contact especially in remote areas with limited opening hours for health facilities, collaborating with these group to extend services through referrals could be another scope
- Some providers have less competent over probing the history of abortion or provide incorrect information about the safety, strengthen the capacity of health workers around post-abortion counseling through provision of trainings (including stigma)
- Strengthening family planning and pregnancy testing service and facilities to more wider community
- Increase the number of certified safe abortion sites and the provision of safe abortion services especially in the remote and rural areas.
- Shortage of skilled providers particularly in rural areas therefore provide trainings and supportive supervision for retention and motivation of the staff in the remote areas of Nepal
- Revise government policy around the indirect cost associated with abortion and provide incentives for transportation and accommodation so as to ensure no one is left behind
- Strengthen monitoring and evaluation system
- As stigma is very sensitive issue when it comes to abortion. Very few studies have been done. However, it has huge impact in individual health. Therefore, there is a huge scope for further research on abortion and Stigma

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Annex