CHAPTER - I

1.1 Background:

Safe motherhood is the topic of hot debate all around the globe. Many factors contribute for safe motherhood. Age, education, financial status, access to health services, maternal care, parental care, nutrition during pregnancy and after child delivery, family care and so many factors affect motherhood.

To promote safe motherhood and to decrease maternal mortality rate, reproductive health is vital. Abortion is, no doubt, one of the important parts of reproductive health. Abortion is the termination of pregnancy before the fetus has attained viability, i.e. become capable of independent survival in extra uterine life. It is the ending of pregnancy by removing a fetus or embryo before it can survive outside the uterus.

An abortion which occurs spontaneously is also known as a miscarriage. An abortion may be caused purposely and is then called an induced abortion, or less frequently, "induced miscarriage". The word abortion is often used to mean only induced abortions. A similar procedure after the fetus could potentially survive outside the womb is known as a "late termination of pregnancy." (Cunningham FG; Leveno, KJ; Bloom)

If a pregnancy has occurred, once you've made one of two choices - remaining pregnant or terminating your pregnancy, there are three more basic choices to make. Parenthood, abortion or adoption are equally viable, legal (in most locations) and valid choices, any of which may be the best choice for someone at a given time, and no one of those choices is any simpler or easier to make than another.

When a person becomes pregnant but does not want to remain pregnant or become a parent, they have the option of abortion, a medical procedure which terminates a pregnancy. We have documentation of abortions as early as 500 BC, and every reason to strongly suspect it existed well before that time. We also know

that even when abortion was not legal or regulated that many people still terminated their pregnancies, but they have to endanger their health or their lives to do so.

Legal abortion is performed within a clinic, hospital or doctor's office, usually on an outpatient basis, and most often within the first trimester of pregnancy. Legal abortion procedures are safe: statistically, health risks are far greater for carrying a pregnancy to term and delivering than for abortion. With abortion still so controversial among many people and politicians, it can be taught to choose it, or even think clearly and objectivity about abortion as a choice. All sorts of people have had or do have abortions across all racial, economic age, marital and other social lines.

When allowed by local law, abortion in the developed world is one of the safest procedures in medicine. Modern methods use medication or surgery for abortions. The drug misery stone in combination with prostaglandin appears to be as safe and effective as surgery during the first and second trimester of pregnancy. When performed legally and safety, induced abortions do not increase the risk of long-term mental or physical problems. In contrast, unsafe abortions cause deaths. The World Health Organization recommends safe and legal abortions are available to all women. (Wikipedia.org)

Since ancient times, abortions have been done using herbal medicines, sharp tools, with force, or through other traditional methods. Abortion laws and cultural and religious views of abortions are different around the world. In some areas abortion is legal only in specific cases such as rape, problems with fetus, poverty, risk to a women's health or incest. In many places there is much debate over the moral, ethical, and legal issues of abortion.

Induced abortion has long history, and can be traced back to civilizations as varied as China under Shennong. (C.2700 BCE), Ancient Egyp with its Ebers Papyrus (C.1550 BCE), and the Roman Empire in the time of Juvenal (C.200 CE). There is evidence to suggest that pregnancies were terminated through a number of methods, including the administration of abortifacient herbs, the use of sharpened implements, the application of abdominal pressure and other techniques. (https://en.wikipedia.org/wiki/abortion)

Some medical scholars and abortion opponents have suggested that the stippocratic Oath Forbade Ancient Greek physicians from performing abortions. Aristotle in his treatise on government politics (350 BCE), condemns infanticide as a means of population control. He preferred abortion in such cases, with restriction " (that it) must be practiced on it before it has developed sensation and life, for the line between lawful and unlawful abortion will be marked by the fact of having sensation and being alive." (wikipedia.org)

Induced abortion has long been the source of considerable debate. Ethical, moral, philosophical, biological, religious and legal issues surrounding abortion are related to value systems. Options of abortion may be about fetal rights; governmental authority and women's rights.

The development of sonography and amniocentesis technologies in the field of Medical Science have led to sex - selective abortion, or the determination of a fetus based on sex. The selective termination of a female fetus is most common.

Many countries have taken legislative steps to reduce the incidence of sex - selective abortion. At the International Conference on Population and Development in 1994 over 180 states agreed to eliminate "all forms of discrimination against the girl child and the root causes of son preference", conditions which were condemned by a PACE resolution in 2011. (Wikipedia.org)

In a number of cases, abortion providers and these facilities have been subjected to various forms of violence, including murder, attempted murder, kidnapping, stalking, assault arson and bombing. Anti abortion violence is classified by both governmental and scholarly sources as terrorism.

In the United States, four physicians who performed abortions have been murdered: David Gunn (1993), John Britton (1994), Barnett Slepian (1998), and George Tiller (2009). Hundreds of bombings, arsons, acid attacks, invasions and incidents of vandalism against abortion providers have occurred. (Wikipedia.org)

Those who oppose abortion often maintain that an embryo or fetus is a human with a right to life and may compare abortion the murder. Those who favour the legality of abortion often hold that a woman has a right to make decisions about her own body.

Legal abortions are both safe and effective. At this time, there are two main options for legal abortion in most areas: medical abortion or surgical abortion. There are even some herbs and supplements which have capacity to terminate pregnancy. There are certainly also other physical ways to attempt abortion. But these methods are neither as safe nor effective as legal, medical options. So long as medical or surgical abortion remain legal and accessible, those are the methods anyone seeking an abortion would be encouraged to seek out. Certainly medical or surgical abortion are costly, but built into that cost are a lot of safeguards for your health and well-being.

Medical abortion is one of the alternatives of abortion. Medical abortion is sometimes called RU486, M&M or "the abortion pill". It is not widely available as surgical abortion but is now available from many providers. Medical Abortion is effective up to around 60 days after the last menstrual period, or up until around 10 weeks of pregnancy. It doesn't require surgery, but instead, is a combination of medications (usually mifepristone and misoprostol) given and supervised by a clinician, which causes a termination identical to a miscarriage. (corina, Heather)

Medical abortion consists of using drugs to terminate a pregnancy. It is an important alternative to surgical methods. Medical abortions are those induced by abortifacient pharmaceuticals. Medical abortion became an alternative method of abortion with the availability of prostaglandian analogs in the 1970s and the antiprogesto in mifepristone (also known as RU-486) in the 1980s. (https://en.wikipedia;org/wiki/Abortion)

The most common early first-trimester medical abortion regimens use mifepristone in combination with a prostaglandin analog (misoprostal or gemeprost) upto 9 weeks gestational age, methotrexate in combination with a prostogladin analog upto 7 weeks gestation or a prostaglandian analog alone. Mifepristone - misoprostol combination regimen is considered to be more effective than surgical abortion (vacuum aspirational) especially when clinical practice doesn't include detailed inspection of aspirated tissue.

Early medical abortions account for the majority of abortions before 9 weeks gestation in Britain, France, Switzerland and the Nordic countries. In the United

States; the percentage of early medical abortions is for lower. Medical abortions regimens using mifepristone in combination with prostaglandin analog are the most common methods used for second trimester abortions in Canada, most of Europe, China and India in contrast to the United States where 96% of second trimester abortions are performed surgically dilation and evacuation. (http://en.wikipedia.org/wikki/Abortion)

According to the 2006 WHO frequently asked clinical questions about medical abortion, regarding factors that should be taken into account when counseling a woman about her choice between medical and surgical abortion.

There is little, if any, difference between medical and surgical abortion in terms of safety and efficacy. Thus, both methods are similar from a medical point of view and there are only very few situations where a recommendation for one or the other method for medical reasons can be given.

Medical abortion may be preferred if it is the women's preference, in very early gestation; upto 49 days of gestation, medical abortion is considered to be more effective than surgical abortion, especially when clinical practice does not include detailed inspection of aspirated tissue. If the women is severely obese (body mass index greater than 30) but doesn't have other cardiovascular risk factors, as surgical treatment may be technically more difficult if the women have uterine malformations or a fibroid uterus, or has previously had cervical surgery (which may make surgical abortion technically more difficult.) if the women wants to avoid a surgical intervention. (Bulletin of the World Health Organization 2011). If performed in the first 9 weeks, a medical abortion carries a very small risk of complications. This risk is the same when a woman has a miscarriage. A doctor can easily treat these problems. Out of every 100 women who do medical abortion, 2 or 3 will have to go to a doctor, first aid or hospital to receive further medical care. (wikiedia.org)

A table in the 2010 Handbook of obstemic and Gynecologic Emergencies, 4th edition lists these possible complications of medical abortion:

Hemmorrhage, Incomplete abortion, Uterine or pelvic infection, ongoing interactive pregnancy, requiring a surgical abortions for completion, misdiagnosed/unrecognized ectopic pregnancy.

According to the 2006 WHO frequently asked clinical questions about medical abortions, there are very few obsolute contra indications to medical abortion. They include previous allergic reaction to one of the drugs involved, inherited porphyria, chronic adrenal failure, known or suspected ectopic pregnancy. Caution is required in a range of circumstances including;

If the woman is on long term corticosteroid therapy (including those with severe, uncontrolled asthma), if she has a hemorrhagic disorder, if she has severe aneima, if she has pre-existing heart disease or cardiovascular risk factors (e.g. hypertension and smoking)

Women in Nepal are vulnerable to several health-related problems due to several socio-economic factors. Maternal mortality ration in Nepal is still high. One of the significant attributable factors of maternal deaths and injuries is unsafe abortion. In all other cases, the law equated pregnancy termination with homicide until 1963, when the act (Muluki Ain 1854) banned abortion except when the women's life was at risk. Back then women were prosecuted and sent to prison under charges of infanticide. Upto one-fifth of women in Nepali prisons before 2002 were convicted on the basis of illegal abortion. (Nepl Journal od Obstetrics and Gynaecology)

In March 2002, the Nepali Parliament passed a breakthrough legislation contrary to its abortion law. Under the new Abortion Policy 2002, the government granted women legal access to abortion, which came into affect in 2003. Women are permitted abortion for upto 12 weeks of gestation on request and under certain medical/legal conditions. The law permits abortion in the context of Nepal, under the following grounds;

With the consent of women, upto 12 weeks of gestation for any women, upto 18 weeks of gestation if pregnancy results from rape or incest. At any time during pregnancy, with the advice of a medical practioner or if the physical or mental health

or life of the pregnant woman is at risk or if the fetus is deformed and incompatible with life. (Reproductive Health Research Policy Brief, 2011)

Nepal has committed to the Millennium Development Goals (MGDs) and has developed various policies and strategies to Safe Motherhood and maternal Health Care. The MGD targets for a three fourths reduction in maternal mortality by the year 2015. The ministry of Health and Population is working together with WHO, UNICEF, UNFPA, DFID, USAID, GTZ and other NGOs toward better access and higher quality service to improve infrastructural development through comprehensive emergency obstmic care, basic emergency obstetric care, birthing centres and human resource development. (Adhikari)

Education is one of the most influential factors affecting an individual's attitude, knowledge and behavior in various factors of life. Not not surprisingly, educational attainment in Nepal is very low among women, who are much more disadvantaged than men. Overall literacy rate (5 years and above) has increased 54.1 percentage in 2001 to 65.9 % in 2011. Male literacy is 75.1 percent compared to female literacy rate of 57.4 percent. Education has been found to influence reproductive behavior, the use contraceptives, the health of mothers and children and hygienic habits. Social prejudices against female education, restriction on mobility of females in formal education are the main reasons for low female literacy rate

The estimated number of youths/adolescents between the age group of 10-24 is 9 million. According to the census of 2006 AD, the adolescents under 15 is 33%. The records prove that one out of five under 15 Nepalese involves in sexual activities. One out of five between the age group 15-19 adolescents either become a mother or the first time pregnant 20% of adolescents girls within the age of 15-19 either become pregnant or mother against their will. National Health Training Centre (2068).

The major causes for the above mentioned incidents are, first of all, the females have low level of social reputation or respect in the comparison of the male counterparts. The females are dependent upon the males for decision making. In the context of Nepal, the females have less access to every level of formal education

than the males. The women are very often not paid or even if they are paid, it is not in cash but in the form of some commodities, for the 68% of labour contribution.

The users of family planning contraceptives have increased by 70 percentage. From 26% in 1996 AD, by the year 2006 the number of contraceptive users have increased 44%. According to Nepal Demographic Health Survey 2006, nearly 44% of recently or newly married women have been using contraceptives. Majority of them have been using modern means of contraceptives. According to the survey, 96% of the Baseline survey and almost each of them has the idea or information about the means of family planning at the end line survey. National Health Training at the end line survey. National Health Training Centre, 2068.

The government of Nepal had officially introduced MA (Medical Abortion) in the fiscal year 2065/066 (2009 AD) in six districts (Jhapa, Dhading, Chitwan, Tanahu, Surkhet and Kailali) on a pilot basis. Recently it is being scaled-up to rural and remote and remote health facilities as well (Journal of Kathmandu Medical College, 2012)

Currently, the Medical Abortion service is being discharged from the health centres of all 75 districts. The government of Nepal has also issued the Reference Book 2068 with the aim of providing detail information about medical abortion. From the year 2069, medical abortion service has been initiated from 14 health centres of Morang district. (Sijan Rai, Official Morang Public Health Office, Biratnagar)

According to District Health Report (2072/073) Morang, in the year 2071/072 thirty three women underwent Medical abortion from Dadarbairiya Health Post, Morang. Among them, 5 were under the age of 20, whereas 28 of them were above 20 years old. Likewise, of the total 38 in the year 2072/073, three of them were under 20 and 35 were above 20 years old. During the four months of 2073 (from Shrawan to Kartik), 13 women practiced Medical abortion and all of them belonged to 20 years above. The data given above refers to the total number of medical abortion service receivers from Dadarbairiya VDC, Health post located in the Dadarbairiya VDC, Morang. (District Health Report, 2072/073, Morang)

This research is based on the knowledge, practice and effectiveness of Medical abortion among the people of Dadarbairiya VDC ward number 1, Morang where medical abortion service is available from the Dadarbairiya Health Post.

1.2 Statement of the Problem:

Abortion being one of the important components of female reproductive health and safe motherhood, it has been practiced from the fiscal year 2065/066. In countries such as Nepal, where abortion is severely restricted by law, most women seeking abortions and most people providing abortion services must do so clandestinely.

Due to the fear of prosecution or social stigma, information relating to abortion is often difficult to obtain from either providers or clients. Medical abortion does have complications. However, they can be avoided provided that the service providers are trained and after-abortion care are at hand. The educational level, health awareness and the support of the family members of the clients have also great contribution to make medical abortion practice successful.

Medical abortions must be coupled with follow-up visits to the providers to assure a complete termination did occur and that a patient is in sound health afterwards. Medical abortions are not quite as effective as surgical abortions they are around 95-98% effective at terminating a pregnancy - so occasionally an additional surgical abortion will be necessary to successfully terminate a pregnancy.

Medical abortion services are being provided from private and public health centres all around the country. No doubt, it's a break through to promote Reproductive Health and safe motherhood. But there are still many things to improve. Thus, the study attempts to gather information about how far the service is effective. How far the women find medical service convenient or best option? Since abortion is a matter of social, religious and cultural stigma, the study also attempts to find out how far the family members and the society are flexible and supportive towards the medical abortion practice? The researcher has felt that medical abortion is a matter of problem the viewpoint of its effectiveness, attitude and knowledge of the clients and the social, cultural and religious norms and values where they live.

1.3 Objectives of the study:

The overall objectives of this study are to identify the medical abortion practices by the women of Dadarbairiya VDC, Morang. The specific objectives of this study are as follows:

i. To find out the socio-economic and demographic characteristics among the women of Dadarbairiya VDC.
ii. To find out the status of medical abortion practices in terms of behavior, practices and attitudes of the community.
iii. To examine the relationship between medical abortion practices and educational status of the Women of Dadarbairiya VDC, Morang.

1.4 Research Questions:

On the basis of above discussions made in statement of the problems and objectives, following research questions can be formulated. This study will attempt to provide the answers of the following research questions:

i. Do the women of target study area have the knowledge of abortion?
ii. Have they ever practiced abortion?
iii. Do they know about the medical abortion service available in their own locality?
iv. Is the society supportive enough for abortion practice?

1.5 Significance of the Study:

The main aim of the study is to identify the knowledge, practice and effectiveness of medical abortion among the women of Dadarbairiya VDC, Morang. This study is important to extent general awareness among reproductive age women of the area.

Some significance of the study are as follows:

i. This study will help to explore the situation of medical abortion practice and effectiveness.
ii. This study will help to find health problems of post-abortions.

iii. The study will help to gain information about the causes of abortions.

iv. The findings of the study will be useful for policy makers and planners of different kinds of INGOs, NGOs, government to plan and implement the programmes.

1.6 Delimitations of the Study:

Followings are the delimitations of the current study:

i. This study is limited to the women of Dadarbairiya VDC ward No. 1, Morang. The results can't be generalized to other places. It may not represent for all areas of Nepal.

ii. The target population of this study will be married women aged 15-49 years.

iii. This study will cover only some variables of medical abortion. Therefore, predications for all components of reproductive health cannot be made from this study.

1.7 Definitions of the terms used:

i. Abortion : termination of unwanted pregnancy

ii. Mifepristone : one of the abortifacients

iii. Misoprostol : one of the abortifacients

iv. Gestation : the process of carrying a young baby inside the mother's body

v. Reproductive : a process of birth

vi. Knowledge : a clear and certain mental perception and understandings

CHAPTER - II

This chapter attempts to present some literatures related to medical abortion practices in Nepal as well as global reference. Medical abortion is one of the alternatives of surgical abortion. It has very short history starting from the fiscal year 2065/066 in the context of Nepal. Nepal established special safe motherhood task force in 1993 to develop a national plan of action. Abortion and its various practices are the inevitable parts of safe motherhood.

2.1 Theoretical Review:

The international conference on population and development (ICPD) held in Cario in 1994 intensified worldwide focus on the reproductive health. So, ICDP is a milestone to guide the efforts regarding the reproductive health of women. According to ICDP document, the reproductive health is defined as - "A state of complete physical, mental and social well-being and not merely the absence of diseases or infirmity in all matters relating to its functions and process. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and they have capability to reproduce and the freedom to decide if when and how to do so." (UN, 1994-95)

Maternal deaths and illness not only affect women but it also affects her spouse, children and communities in many ways. The economic costs of mother's death includes her lost contributions to the family and its survivals. It increases mortality among her children, increased burdens of home maintenance and child care to the survivors and additional impact on communities and society, children are more likely to die if their parents die but much more, likely if it is mother. (UNFPA, 1995)

Twenty-five years have passed since the global community agreed in Nairobi to address the high maternal mortality by implementing the Safe Motherhood Initiative. However, every year around 22 million women seek

unsafe abortion in developing countries. Globally, the unsafe abortion accounts for 13% maternal deaths. (Bhandari & Dangal)

According to the World Health Organization (WHO), every 8 minutes a woman in a developing nation will die of complications arising from an unsafe abortion. An unsafe abortion is defined as "a procedure for terminating an unintended pregnancy skills or in an environment that doesn't confirm to minimal medical standards, or both." The fifth United Nations Millennium Development Goal recommends a 75% reduction in maternal mortality by 2015. WHO deems unsafe abortion one of the easiest preventive causes of maternal mortality and a staggering public health issues. (WHO Mortality Database, 2001)

2.2 Empirical Review:

Research has shown that very few complications result from medical abortions in comparison to the number of women who experience successful medical abortions. 2 or 3 out of every 100 women that have medical abortions will need to go to a local doctor, first aid centre, on hospital to receive further medical care such as vacuum aspiration. This risk is equal to that of requiring medical care for an allergic reaction after using penicillin.

In low resource settings and where access to other safe abortion methods in limited, MA has the potential to dramatically reduce maternal morbidity ad mortality. The Government of Nepal is also planning to add Mifepristone and Misoprostol in essential drug list. (Poudel N.)

In January 2009, the government introduced medicinal abortion for early first trimester abortion. However, medical abortion method is yet to gain popularity in the country. Surgical abortion using manual vacuum aspiration (MVA) which was already available in Nepal since March 2004 is the preferred method of choice among Nepalese women seeking safe abortion from the comprehensive abortion care (CAC). (CREHPA, 2011)

Medical Abortion is safe, effective, easy and private method in termination of early pregnancy. The outcome of method is good and the immediate impact of the Medical Abortion on women's health is positive. Most of

the clients are satisfied with this method and they will recommend this method to others in future. (Poudel N. 2012)

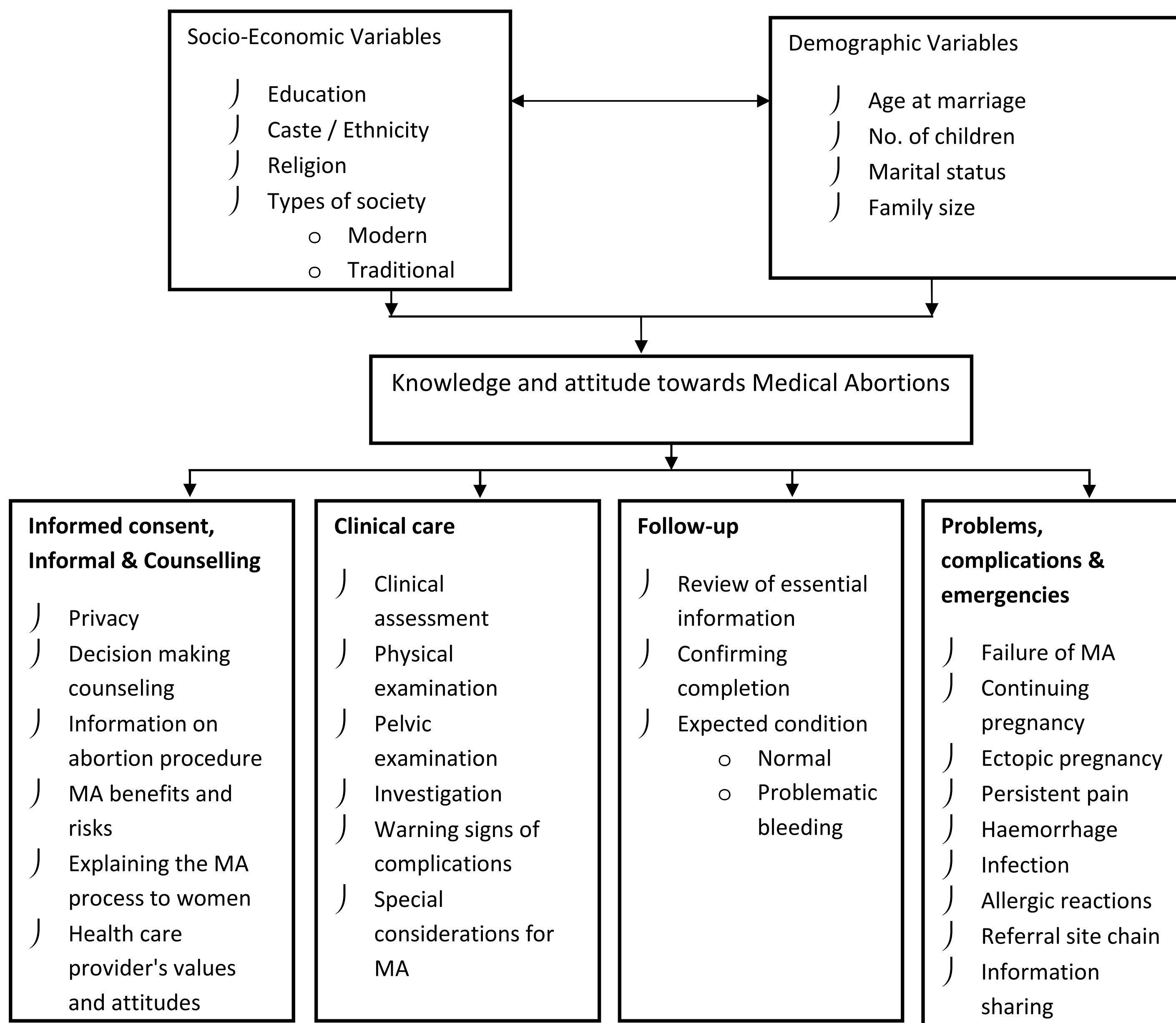
Shrivastava (2007), forward a long list of reasons why medical abortion has potential use in Nepal. Some of them are no hassle in using confidentially, saves money, can be made available at affordable prices, no need to use equipment or surgery, easily available, very effective, works faster, less chance of complication, high demand, saves money, safe method and fewer side effects. She future says that those who do not have a positive view of the potential of medical abortion believe that it causes side effects and carries a risk of incomplete abortion. Some also feel that introduction of medical abortion i.e. pre-martial sex among young girls.

All women should have access to safe abortion in their communities and should be able to benefit equally from new and improved technologies. Medical abortion, a proven but underutilized method, is truly transformative. Medical abortion has the potential to enable women, even in remote communities with little access to health services, to end unwanted pregnancies safely, confidentially and affordably. Making this a reality requires more than working with doctors and policy makers. It requires collaborating with women as well as with the community members that women turn to and trust. (Anderson, 2007)

2.3 Conceptual Framework:

The concept framework includes socio-economic and demographic variables as independent variables for determining the person's attitude towards medical abortions (dependent variable). It should be noted that the effect of these two variables on medical abortion practices through the knowledge and access of health services.

Figure - 1 : Conceptual framework for the study of Medical Abortion in Nepal:



CHAPTER - III

Methodology of the Study

Researcher can use various types of research methods to collect reliable data from research area. Methods may be different from one problem to another. This is description type of research design. The following section describes the methodology adopted in the study.

3.1 The Study Area:

The married women between the age group 15-49 living in Dadarbairiya VDC ward number 1 Morang was purposively selected. The VDC lies approximately 12 km east from Biratnagar sub-metropolitan city.

3.2 Site Selection and Target Population:

Dadarbairiya VDC ward number 1 is the main study area. The study was based on the information from married women of age group 15-49 years who have experienced medical abortions.

3.3 Sources of Data:

The sources of data was based on the primary and secondary data. This data was obtained by using direct interview among married women having at least single time medical abortion practice.

The survey was conducted through structured interview, the household type information will be collected from the member of the household who had at least single time medical abortion.

3.4 Sample Design:

The data for this study was collected from women of age group 15-49 years who have at least single time medical abortion. There are 208 households

throughout the Dadrbairiya VDC ward number 1. The total sample of the study will be 25 percent of the total households.

The systematic sampling procedure was used for sample selection of the respondents. The respondents for the study was selected from different households in each interval of 4. For this, the households were imaginatively numbered and respondents were ranked in the interval of 4. If there was either of respondents in the ranking households, or respondents not living with their household, the nearest, household was taken for interview.

3.5 Data Collection:

Quantitative techniques of data collection was used. Questionnaire is the main tool of obtaining the information from research area and respondents. So, questionnaire was designed to obtain two types of information i.e. household information and individual information.

Individual questionnaire was designed to obtain the information on medical abortion practices and educational status of women. On the other hand, household questionnaire was designed to obtain the information on age, sex, education and demographic features of the household members.

In field survey a few case histories was conducted to obtain in depth information on their past and present experience of medical abortion practices faced in their life. And some key informant interview was also done on how social norms and behaviours affect towards medical abortion practice and to know the attitude and behaviour towards medical abortion practices.

3.6 Data Management:

The study was based on primary data and secondary data. Primary data was collected from field observation and secondary data was collected from district public health office, Morang. After completion of information was processed by myself without using computer. It was boring and time consuming work to manage the collected questionnaires. Different types of dummy tables were used for the data analysis. Data was classified and tabulated in the designed

model and then the interpretation of tables was done based on cases count, percentage distribution and frequency tables.

CHAPTER - IV

Result and Discussion

Demographic and Socio-economic characteristics of the Study Population

This chapter presents the socio-economic and demographic characteristics of the people of Dadarbairiya VDC ward no. 1 Morang district. Demographic and socio-economic characteristics play vital role in the development of the society. Socio-economic characteristics include household composition, educational attainment, occupation and size of land holding. Demographic characteristics include age-sex structure of household population, marital status, age at marriage of respondents.

4.1 Demographic Characteristics

4.1.1 Age of Respondents of marriage:

The respondents of this study are currently married women of reproductive age (15-49) years. This age composition of female population is one of the major demographic indicators for fertility performance. If the population is higher in the age group 20-35 the fertility rate might be higher because it is considered as the most fertile period of reproductive span.

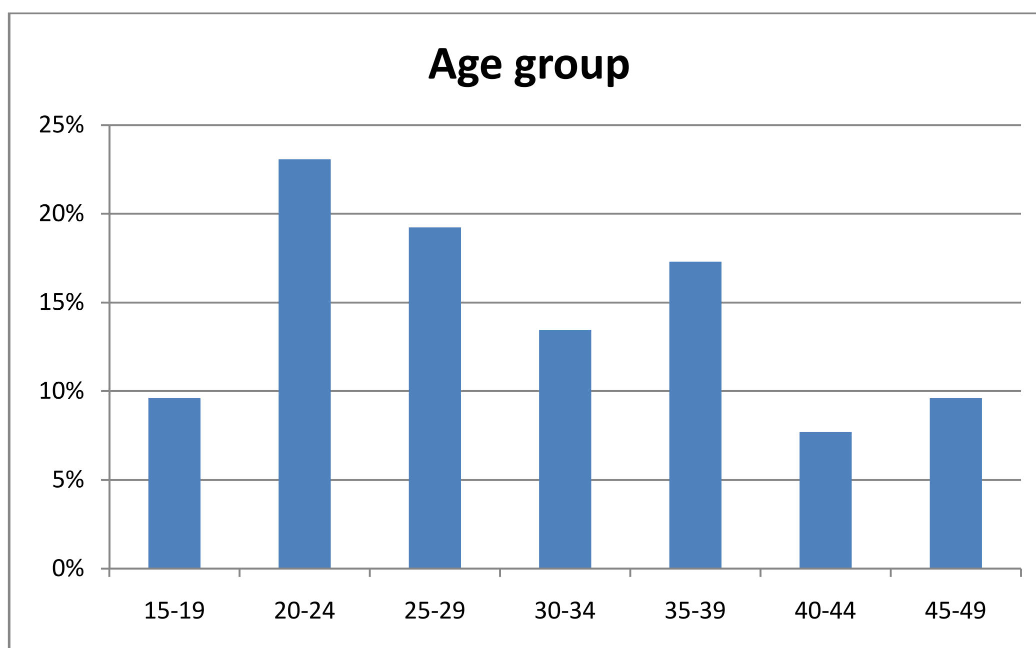
Table - 1 : Percentage Distribution of Respondents by Age of marriage

S.N.	Age group	No. of Respondents	Percentage
1	15 - 19	5	9.61
2	20 - 24	12	23.09
3	25 - 29	10	19.23
4	30 - 34	7	13.47
5	35 - 39	9	17.31
6	40 - 44	4	7.7
7	45 - 49	5	9.61
	Total	52	100%

Table no. 1 shows that the highest proportion of respondents were found in age group 20-24. The percentage of the respondents of this age group was 23.09 percentage. It is followed by 25 - 29 age group i.e. 19.23 %, 35-39 age group 17.31%, 30-34 age group 13.47%, 15-19 age group 9.61%, 40-44 age group 7.70% and 45-49 age group 9.61%.

Most of the respondents who belonged to the age group of 15-19 were found to be absent. When asked, I came to know that most of them were busy in the following chores. Some of them went to colleges for higher education. I found that the respondents of age group 20-24 were helpful and frank enough to talk and they were available easily. The women above 30 were hesitating to respond and most of them were not open-minded, too.

Figure - 2 : Percentage Distribution of Respondents by 5 Years Age Group



4.1.2 Children Ever Born (CEB):

CEB is another demographic characteristics of any population.

Table - 2 : Number of Children Ever Born

S.N.	No. of CEB	No. of Respondents	Percentage
1	≤ 2 children	17	32.69
2	3 - 4 children	28	53.84
3	5+ children	7	13.46
4	Total	52	100%

Table 2 shows that 32.69% women had ever born 2 children. It is followed by 13.46% women who had ever born 5 or more children. Majority of women (53.84%) had ever born 3-4 children.

due to the existing socio-cultural norms and values, special emphasis upon the son children was found to given. Consequently, most of the respondents had 3-4 children.

4.2 Socio-Economic Characteristics:

4.2.1 Educational Status of Respondents:

It is very important to examine the educational status of respondents because it affects to the personal perception towards abortion. Many mothers are unknown about their personal hygienic activities. It is considered that educated mothers are aware on the issue of maintaining the quality of their health and their children than non-educated.

Table - 3 : Percentage Distribution of Educational Status of Respondents

S.N.	**Educational status**	**No. of Respondents**	**Percentage**
1	Illiterate	19	36.54
2	Literate	33	63.46
3	Total	52	100

Since the educational institutes both private and public of various levels are available near the study area, the literacy rate and mass awareness about many aspects of

health was found to increasing slowly and gradually. Similarly, attraction towards higher education was also of greater degree.

Figure - 3 : Percentage Distribution of Respondents by Literacy

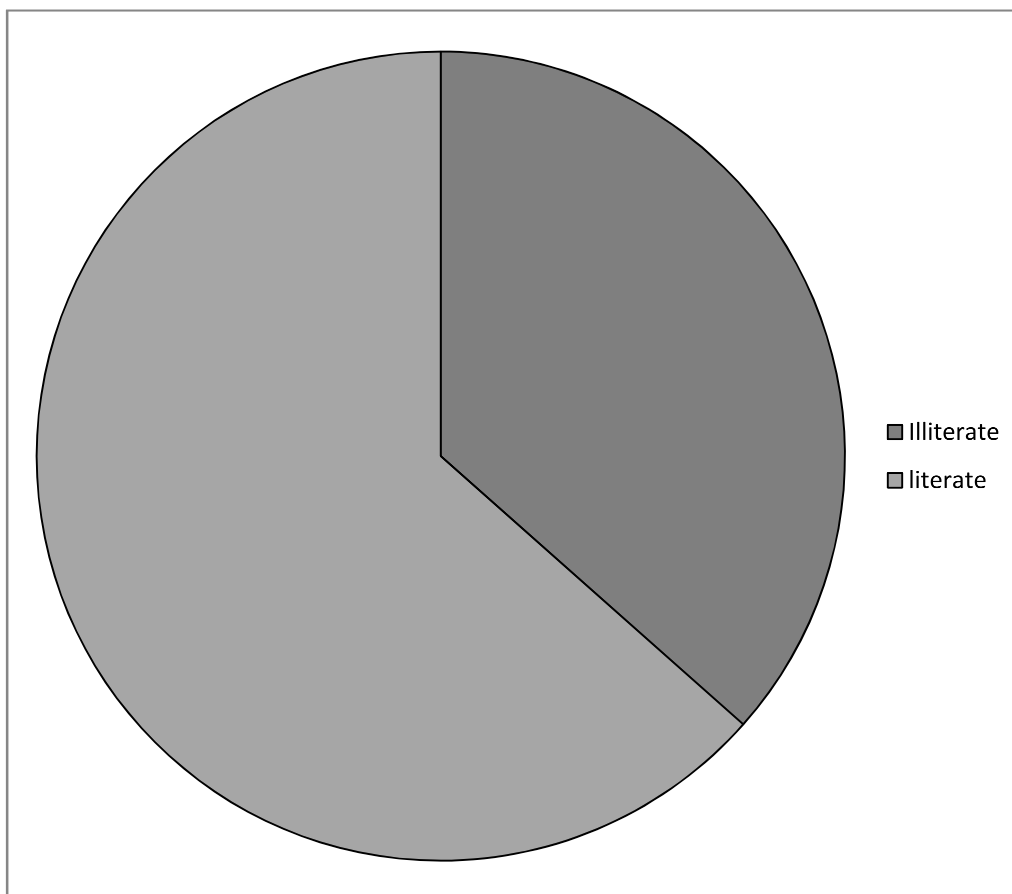


Table - 4 : Level of Education

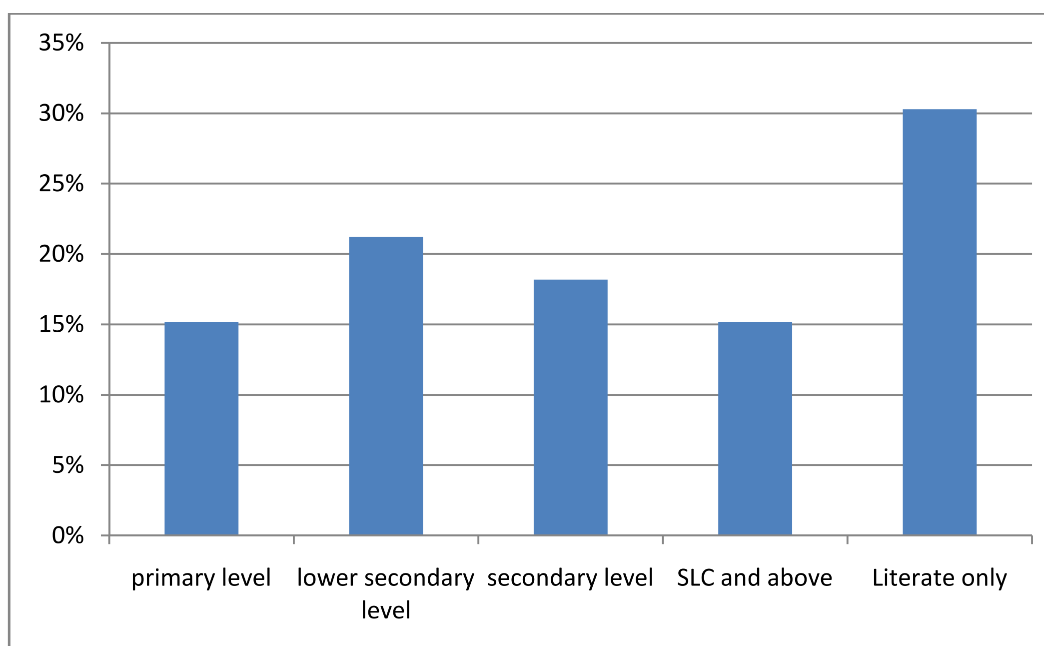
S.N.	Level	No. of Respondents	Percentage
1	Primary level	5	15.15
2	Lower secondary level	7	21.21
3	Secondary level	6	18.18
4	SLC and above	5	15.15
5	Literate only	10	30.30

Table 4 shows that higher percent of respondents 30.30% are literate followed by lower secondary level 21.21% illiterate out of total respondents. The

above table vividly shows that as the level of education increases the number of respondent decreases. Number of respondents varies inversely with the level of education.

Due to the shortage of job opportunities on the one hand, narrow-thinking of the society towards the women, on the other hand, most of the respondents of the study area were engaged in the agriculture. But the scenario was found to be changing in the sense that attraction towards the service and some other occupations was greater due to the reservation provisions for the women.

Figure - 4 : Percentage Distribution of Respondents by level of Education



4.2.2 Distribution of Respondents by Source of Income

Occupational status of households and quality of life has positive relationships with demographic indicators. Occupation is important factor which influence the social, economic, cultural, political and religious variables. Occupational status is associated with the life standard of individual. Occupational status plays vital role in promotion of individual health as well as community health.

Table - 5 : Percentage Distribution of Household Population aged 10 years and above by major occupations

S.N.	Major occupation	No. of Respondents	Percentage
1	Agriculture	22	42.30
2	Service	09	17.30
3	Business	7	13.46
4	Daily wages	10	19.23
5	House wife	4	7.70
	Total	52	100

Table 5 given above shows that highest % of respondents 42.30% depend on agriculture. Although this figure is remarkable less than the national average. After agriculture the % of respondents depending upon daily wages is 19.22%. Next to it 17.30% of them are involved in service. According to the table, very less % of the respondents were limited within the four boundaries of the kitchen as the household.

4.2.3 Language:

Nepal is a multi-religious and multi-ethnic society. Data on language spoken at home is usually analyzed through mother tongue. A mother tounge is defined a one spoken by a person in his/her early childhood. According to the interview results, the respondents used two major languages. They were respectively Rajbanshi and Gangai but almost all of them can communicate Nepali fairly well.

4.2.4 Religion:

From the field survey in the sample area, most of the households in the sample area reported to have been Hindus. Some of them even belonged to Muslims and Christians.

4.2.5 Size of Land Holding:

Nepal is an agricultural country where almost 80% people are dependent in agricultural sector (CBS 2011). Hence, the size of the land holding also represents the level of economic status of people. From the study it is find out that majority of the respondents have very less holding upon the fertile land. Some of them work in other's farm as the agro labourers. The size of the land holding by the household under study is presented in the table.

Table - 6 : Percentage of Distribution of Cultivated Land among the Respondents

S.N.	Size of land	No. of Respondents	Percentage
1	Landless	7	13.46
2	Less than 1 kattha	19	36.53
3	1 - 10 kattha	14	26.93
4	10 - 20 kattha	10	19.23
5	20 + kattha	2	3.84
	Total	52	100%

Table 6 shows that there were still 13.46% people have no any land of their own. 36.53% of people have less than 1 kattha where they have built their small house made of bamboo, mud and wood. It is seen that majority of the respondents are managing their life under the poverty line which ultimately hamper the safe motherhood and mortality.

4.2.6 Information Level of Legal Provisions about Abortion among the Respondents:

Access to information resources has remarkable contribution so far as the abortion practice and safe motherhood is concerned. Abundant information

dissemination from the various concerned authorities is a must. The table given below shows how far the respondents know about the level provisions about the abortion.

Table - 7 : Percentage Distribution of Respondents about the Legal Provision of Abortion

S.N.	Provision of Abortion	No. of Respondents	Percentage
1	Yes	34	65.38
2	No	18	34.62
	Total	52	100

The above table shows that 65.38% of the respondents of the study area who know about the legal provisions of abortion in different circumstances. Still 34.62% of them are ignorant about it. The scenario is changing due to effective information dissemination.

4.2.7 Practice of Various Types of Abortion:

In this survey, 52 married women in age group 15-49 were taken as the eligible respondents and individual questionnaire was asked about the practice of different types of abortion. Younger women are more likely to utilize abortion services.

Table - 8 : Percentage Distribution of Respondents by the Types of Abortion Practice

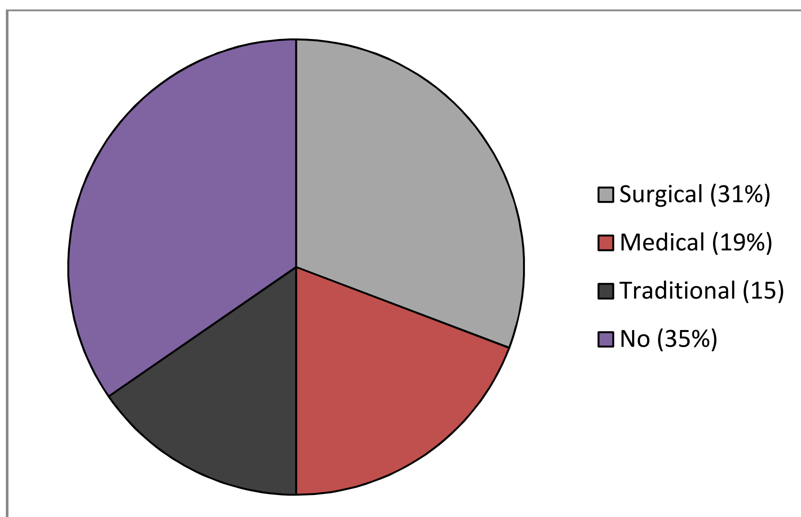
S.N.	Types of Abortion	No. of Respondents	Percentage
1	Surgical	16	30.76
2	Medical	10	19.23
3	Traditional	8	15.38
4	No	18	34.61
	Total	52	100%

Table 8 shows that out of 52 respondents 65.39% has not gone through the practice of abortion. Instead of abortion, they utilize some other contraceptives of family planning. After interview and questionnaire reports, it is known that

30.76% of the respondents have practiced surgical abortion which is followed by medical i.e. 19.23%. For the secrecy purpose, they were found to practice traditional methods i.e. 15.38%.

The percent of medical abortion (19.23%) practised by the respondents was comparatively lower than the surgical one. The study showed that it was so because the medical abortion is the new practised and it has still not gained popularity as well as the trust of the common people (respondents only). On the other hand media has also not given enough space for the information of medical abortion. Respondents have been still practising surgical abortion on the other hand.

Figure - 5 : Percentage Distribution of Respondents by the Types of Abortion Practice



4.2.8 Place visited for Abortion Services:

Abortion services can be received from hospital, primary healthcare centre, health post and private clinics. The study shows that institutional abortion practices is comparatively less.

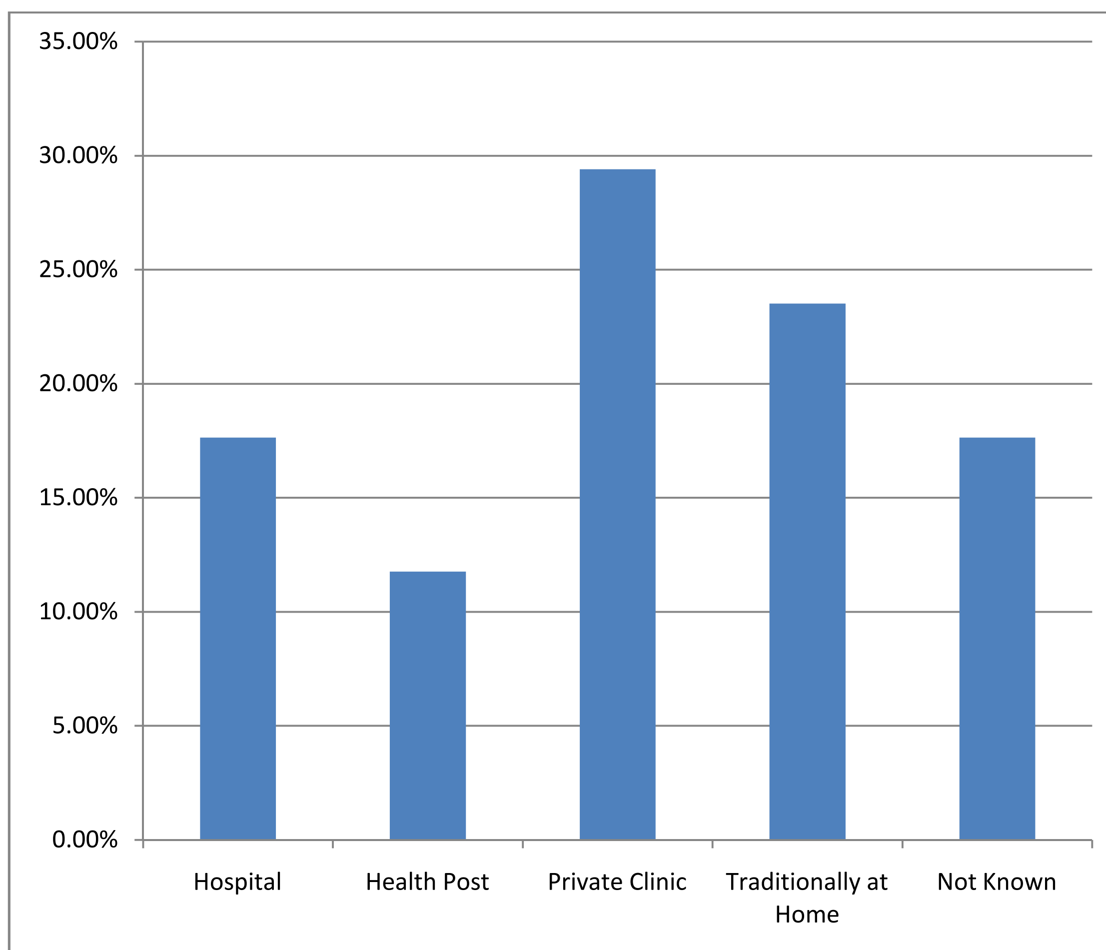
Table - 9 : Percentage Distribution of Respondents by Place Visited for Abortion Services

S.N.	Place of Abortion Service	Respondents	Percentage
1	Hospital	6	17.64
2	Health post	4	11.76
3	Private clinic	10	29.41
4	Traditionally at Home	8	23.52
5	At home	6	17.64
	Total	34	100%

Out of 34 respondents who underwent abortion practice, the greatest number (29.41%) were found to have private clinic. It was followed by 23.52% who applied traditional methods of home and reasons behind it were secrecy and illiteracy. Next 17.64% visited hospital. It was really surprising and upsetting that the 11.76% of the total respondents visited the nearby health post where medical abortion service was available.

The most upsetting and surprising finding of the study was that even in this 21st century of the modern world, some of the respondents (23.52%) practised abortion traditionally at home. The research revealed that it was chiefly because of the weaker service discharge of the nearby health post on the one hand and the other hand sufficient advertisements of the medical abortion service.

Figure - 6 : Percentage Distribution of Respondents by Place Visited for Abortion Services



4.2.9 Age and the Medical Abortion:

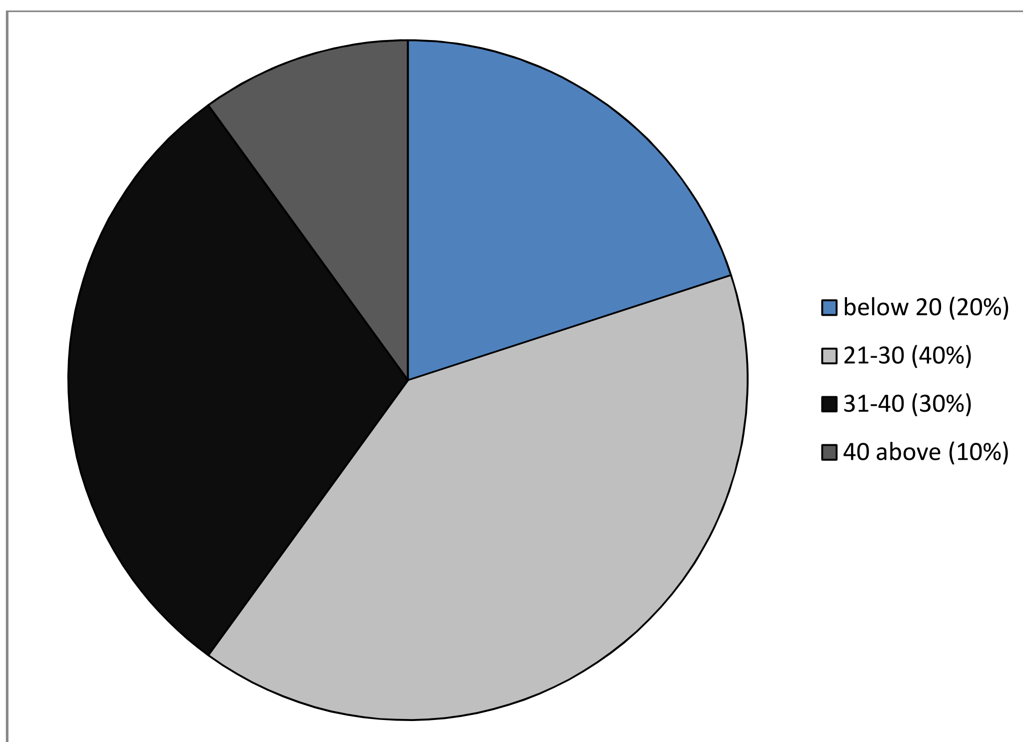
Table - 10 : Percentage Distribution of the Respondents by the Age of Medical Abortion:

S.N.	Age	Respondents	Percentage
1	<20	2	20
2	21-30	4	40
3	31-40	3	30
4	40 above	1	10
	Total	10	100%

Table no. 10 shows the age-wise percentage distribution of the respondents. The highest percent (40%) of the respondents who practised Medical Abortion belonged to the age group of 20-30 years old and it was followed by the age group of 31-40 years old i.e. 30%. The least percent (10%) belonged to 40 above. Only 20% of them were found to undergo medical abortion.

After the reasearch study, it was found that the respondents below 20 years were comparatively well-aware about different aspects of abortion and the ways and means of avoiding unwanted pregnancy by using various contraceptives of family planning. High reproductive capability, unsafe sexual relations and sex-selective abortion trends were the main causes of highest percent (40%) of medical abortions by the respondents of age group 20-30.

Figure - 7 : Percentage Distribution of the Respondents by the Age of Medical Abortion



4.2.10 Causes behind the Medical Abortion:

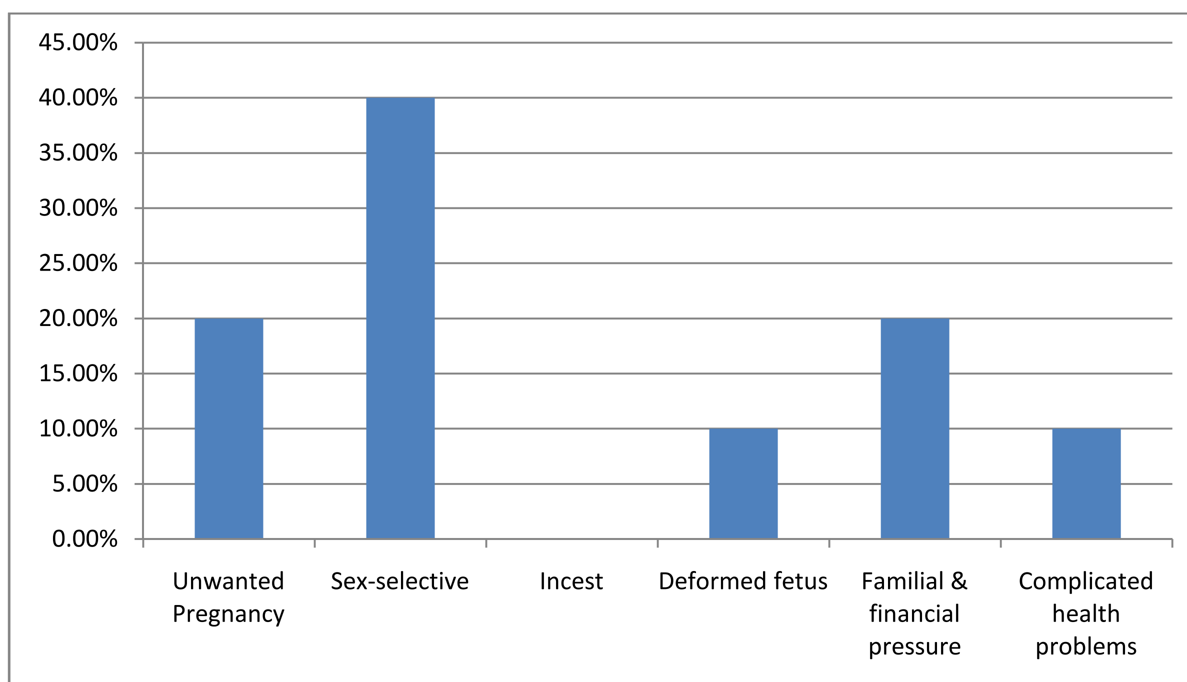
Table - 11 : Percentage Distribution of Respondents of Medical Abortion Cause-wise:

S.N.	Causes	Respondents	Percentage
1	Unwanted pregnancy	2	20
2	Sex-selective	4	40
3	Incest	0	0
4	Deformed Fetus	1	10
5	Familial and financial pressure	2	20
6	Complicated health problems	1	10
		10	100%

Table no. 11 shows that highest percent (40%) of medical abortion was sex-selective. It was followed by unwanted pregnancy i.e. (20%) and familial and financial pressure (20%). Next, the abortion was also done due to deformed fetus and complicated health problems 10 percent each.

Because of various socio-cultural and economic factors such as dowry custom and excessive emphasis to sons, sex-selective abortion was prevailed in the study area.

Figure - 8 : Percentage Distribution of Respondents of Medical Abortion Cause-wise



4.3 Information, Counseling and Practice of Medical Abortion:

Information and counseling provided abundantly before the practice of medical abortion also determines the effectiveness of it. Attitude and psychological preparation has significant role. The service providers need to provide better information to the service receivers without irritation and botheration.

4.3.1 Respondents Receiving Information and Counseling:

Table - 12 : Percentage Distribution of the Respondents of Medical Service Receiving by Information and Counseling before the Practice of Medical Abortion

S.N.	Information & Counseling	Respondents	Sources of Information and Counseling	Percentage
1	Yes	6	Service providers Rural Health Workers	60%
2	No	4	-	40%
	Total	10	-	100%

From the above table, it is clear that out of 10 medical abortion service receivers 60% received well information and counseling from the service providers and rural health workers before they went through the abortion, whereas, 40% practiced medical information without being well informed and counseled.

4.3.2 Reasons for the Selection of Medical Abortion:

Table - 13 : Percentage Distribution Reason Wise

S.N.	Reasons	Respondents	Percentage
1	Secrecy well maintained	2	20
2	No surgery needed	5	50
3	Locally available	3	30
	Total	10	100%

From among the 10 respondents who were found to have practiced medical abortion within the study area, the table no. 13 above shows that the reasons behind the selection of medical abortion. The highest percentage i.e. 50% opted for medical abortion so that they didn't have to bear the surgical pain. It was followed by 30% who preferred medical abortion since it was locally available and reliable as well. 20% of them chose it for secrecy purpose which could be maintained well medical abortion practiced.

4.3.3 Ways or Methods of Applying Medical Abortion:

The successful effect of Medical Abortion surely depends upon its application methods. If applied under the guidance and supervision of medical personnel at health centres public or private, the degree of reliability can be higher. However, if it is practiced personally without being well informed and well guided, its reliability can be lower on the one hand and complications may arise on the other hand.

Table - 14 : Percentage Distribution of the Respondents as per the Methods of Application:

S.N.	Methods	Respondents	Percentage
1	Personally	6	60
2	Under the guidance of medical personnel	4	40
	Total	10	100%

The above table shows that 40% of the medical abortion service receivers practiced it under the proper guidance and supervision of the medical abortion providers of the health centres nearby the study area. But 60% of them practiced it personally at home due to the reasons of secrecy.

4.3.4 Duration of Medical Abortion:

Generally medical abortion service be categorized as the short term or the long term from the view point of its duration. Some of them opt for short term and

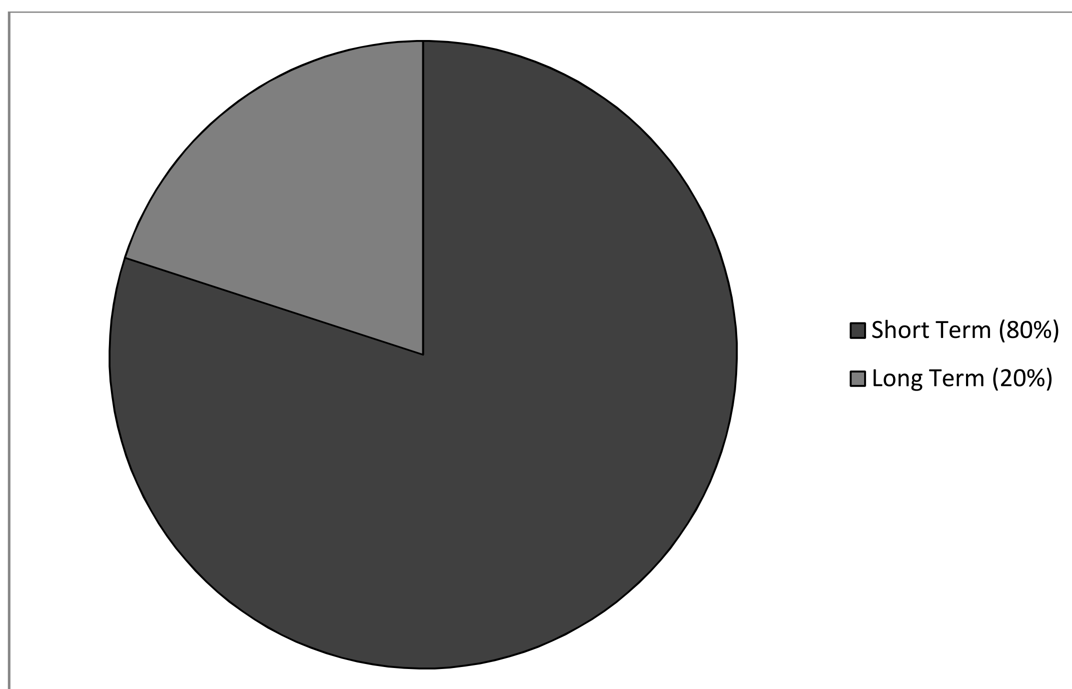
some of them opt for long term application of medical abortion along with the use of family planning contraceptives. The table below shows it clearly.

Table - 15 : Percentage Distribution of Respondents on the basis of short term and long term use of contraceptives after Medical abortion:

S.N.	Duration	Respondents	Percentage
1	Short term	8	80%
2	Long term	2	20%
	Total	10	100%

Table no. 15 depicts that 80% of the medical abortion service receivers opted for short term and 20% of them used contraceptives for long term.

Figure - 9 : Percentage Distribution of Respondents on the basis of short term and long term use of contraceptives after medical abortion:



4.3.5 Post Medical Abortion Care Service:

Regular follow up visit to the medical personalities in the health centres after medical abortion ensures the reliability and the health of the service

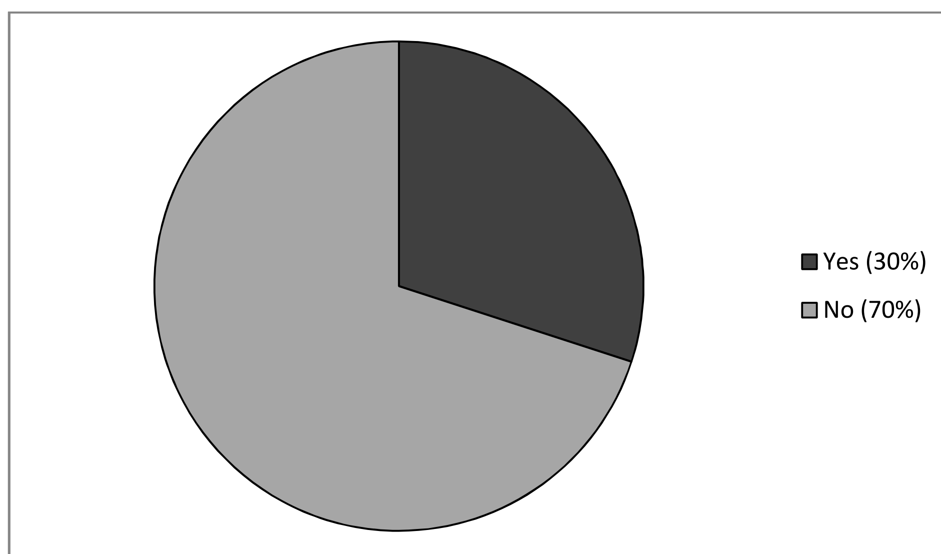
receivers. Co-operation and care provided by family members also have great role to comfort the pains of the service receivers both physically and emotionally after abortion.

Table - 16 : Percentage Distribution of the Respondents according to Regular Follow ups and Family Care After Medical Abortion

S.N.	Regular follow ups and family care	Respondents	Percentage
1	Yes	3	30%
2	No	7	70%
	Total	10	100%

The table above shows that those who went for regular follow ups and receiving family care after medical abortion was only 30%. It was really very upsetting. Similarly 70% of them didn't visit health centres for post abortion follow ups. They also didn't get proper support and care from their family members.

Figure - 10 : Percentage Distribution of the Respondents according to Regular Follow ups and Family Care After Medical Abortion



4.3.6 Post Medical Abortion Complications:

As mentioned earlier the background part the thesis, medical abortion is 96% effective to terminate the pregnancy upto 60 days or 10 weeks. In some

cases the service receivers have to face some complications after medical abortion such as haemorrhage, infection, allergic reaction and emergencies.

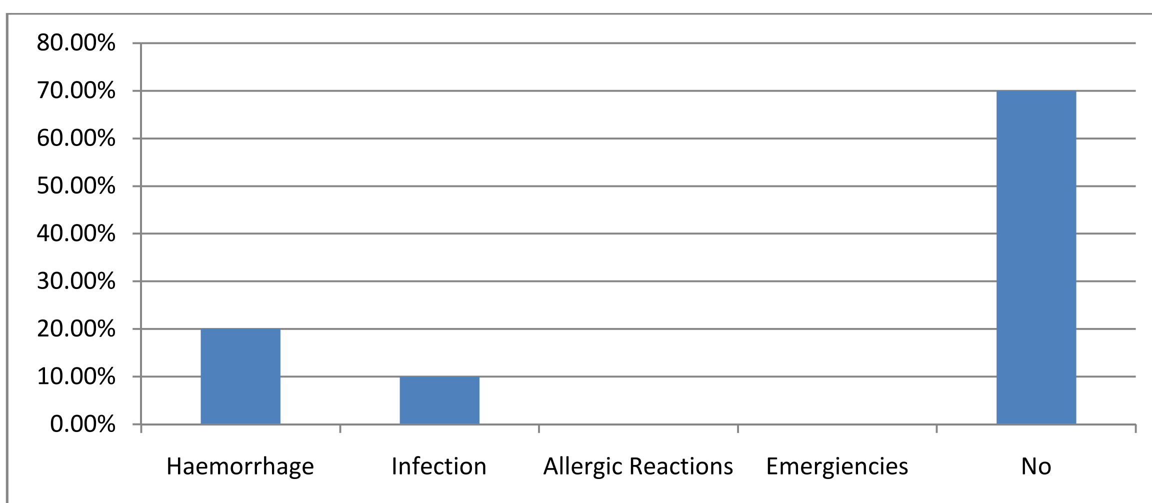
Table - 17 : Percentage Distributions of Respondents of Post Medical Abortion Complications:

S.N.	Complications	Respondents	Percentage
1	Haemorrhage	2	20%
2	Infection	1	10%
3	Allergic Reactions	0	0
4	Emergencies	0	0
5	No	7	70%
	Total	10	100%

Table no. 17 shows that the highest percent (70%) of the respondents didn't face any complications after Medical Abortion. Just 10% of them suffered from minor infections. Just 20% had to face the serious health complications such as haemorrhage and emergencies because after abortion they did not take rest and did heavy household works like chopping firewood, harvesting crops etc.

The study really showed that 96% certainity of medical abortion, provided that the information and awareness about Medical Abortion is spread all over the country.

Figure - 11 : Percentage Distributions of Respondents of Post Medical Abortion Complications



4.4 Findings of the Study:-

Followings are the major findings of the study:

1. The majority of the respondents belonged to the age group of 20-24 years.
2. The majority of the respondents had got married in above 20 years old.
3. Nearly 54 percent of the respondents reported that average number of Child Ever Born (CEB) is 3-4.
4. Nearly 63 percent respondents were literate and 37 percent were illiterate in the study area.
5. Almost all the respondents were reported to have been Hindus.
6. About 43 percent people in the study area were involved in agriculture followed by daily wages 19%
7. Out of 52 respondents 34 of them were found to have information about the legal provision of abortion.
8. The majority of the respondents about 31% were found to have practiced surgical abortion which was followed by medical abortion 19%
9. Highest percentage i.e. about 30% of the respondents were found to have visited private clinics for the purpose of abortion.
10. 40% of the respondents who practiced medical abortion were found to have good information and counseling from the medical staffs and rural health workers before hand.
11. Nearby 50% of the medical abortion practitioners were found to have selected it for avoiding the surgical pain.
12. The 40% of the respondents were found to have applied medical abortion under the guidance of medical staffs in the health centres.
13. Majority of the respondents (80%) received short-term medical abortion along with the use of family planning contraceptives.
14. 70 percentage of the medical abortion practitioners were not found to have gone for regular follow ups.
15. Only 3% out of 10 respondents who practiced medical abortion faced minor complication of infection after medical abortion.

16. 40% of the respondents who practised medical abortion belonged to the age group of 20-30, the most fertile period.
17. The highest percent (40%) of the medical abortion was sex-selective.

CHAPTER - V

Summary, Conclusion and Recommendation

5.1 Summary:-

This study is based on both quantitative and qualitative data. Primary and secondary data have been used to complete this study. Data for this study have been collected from field observation. This study has been designed to find out the practice of Medical abortion among the women (age 15-49) of Dadarbairiya VDC ward no. 1 of Morang district. The main purpose of this study was to find out the knowledge, practice and complications of medical abortion.

5.2 Conclusions:

The study focused on the practice of medical abortion in Dadarbairya VDC Morang ward no. 1 by the married women of age group 15 to 49. Although the government of Nepal introduced MA (Medical Abortion) in the fiscal year

2065/066 (2009 AD), it has not been able to produce desired effects. From the year 2069, Medical abortion service is available from 16 Health Centres of Morang district. Among them Dadarbairiya Health Post. The study shows that there is a long way to go to attract and convince the people about the effectiveness of medical abortion.

Following conclusions are drawn from the study:

1. Socio-economic starts of an individual plays a strong role in determining the health status and perception.
2. A positive relationship is observed between the level of education and Safe Abortion Services. Educated women are much more likely to have the advantage of madically supervised abortion services.
3. Due to socio-cultural factors attitude of the general people towards abortion is still very narrow and negative.
4. Although abortion has been legalized and the service is available all over the country, some women are still found following the traditional method of abortion.
5. Better counseling provided before the medical abortion has positive impact upon the mind of the service receiver.
6. Although medical abortion is 96% reliable in its effect, majority of the women practice surgical abortion.
7. Medical abortion seems to be a boon for the sex-selective abortion.

5.3 Recommendations:

Following are the recommendations for the policy makers and planners:

5.3.1 Planning and Policy Level

1. It is found that the people of the study area are much deprived of physical facilities. Therefore, planning should be made to improve the infrastructures of physical facilities.
2. To eradicate misconception among the people about abortion in the study area, appropriate plans and programmes must be devised and carried out as soon as possible.

3. Plans and programmes about Safe Motherhood and its various components should be carried out.
4. Educational and economic status of the people and Safe Motherhood are like nail and flesh. Therefore, poverty alleviation programmes and provisions of higher education should be done in the society area.
5. Attraction towards private practice by the public health workers should be discouraged.
6. Widespread information dissemination about medical abortion with the help of mass media is urgently felt.

5.3.2 Practice Level

1. The practice of abortion after being well informed before hand is very essential for Safe Motherhood.
2. The practice of traditional abortion method has so many risks. Therefore, so far as possible it should be avoided.
3. Early marriage and low birth spacing should be avoided so that abortion rate ratio can also be decreased.
4. Frequent follow ups and family care after medical abortion have greater positive impacts. Therefore, medical staffs involved and family members should realize its importance.
5. After medical abortion practice, the proper maintenance of hygiene and the use of family planning devices are practically important.

5.3.3 Further Study Level

1. This study is delimited in Dadarbairiya VDC Morang ward no. 1. Thus, this study alone cannot explore the actual situation of the practice of Medical Abortion. So, the detail study in national level is necessary to invoke the actual situation of Medical abortion in Nepal.
2. This study only covers the female gender. There are so many other aspects and issues related abortion and medical abortion itself. So, the researchers will explore about the topic.

3. It is recommended that other study could also be done comparatively in other places both in urban and rural areas.

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Questionnaires

A Survey Questionnaire for knowledge, Practice and Effectiveness of Medical Abortion

Group - A [General Information]

Name of Respondent	Age	Caste	Religion	Literate	Illiterate

1. Have you ever attended school?
   a. Yes ( ) b. No ( )
2. If yes, what was the highest grade you completed?
   a. Primary school ( ) b. Secondary level ( )
   b. SLC ( ) d. 10+2 ( )
   c. Above ( )
3. If not, what was the main reason, you stopped attending school?
   a. School not accessible ( ) b. Poverty ( )
   b. Other causes ( ) d. Family needed help in agriculture ( )
4. How many members are there in your family?
   a. 4 ( ) b. 5 ( ) c. 6 ( ) d. Above ( )
5. Are they all literate?
   a. Yes ( ) b. No ( )
6. Are you just a housewife or any jobholder?
   a. Housewife ( ) b. Jobholder ( )
7. Is your husband literate?
   a. Yes ( ) b. No ( )

Group - B [Socio-Economic Information]

8. What is the type of your family?
   a. Single ( ) b. Joint ( )