CHAPTER-I

INTRODUCTION

1.1 General Background

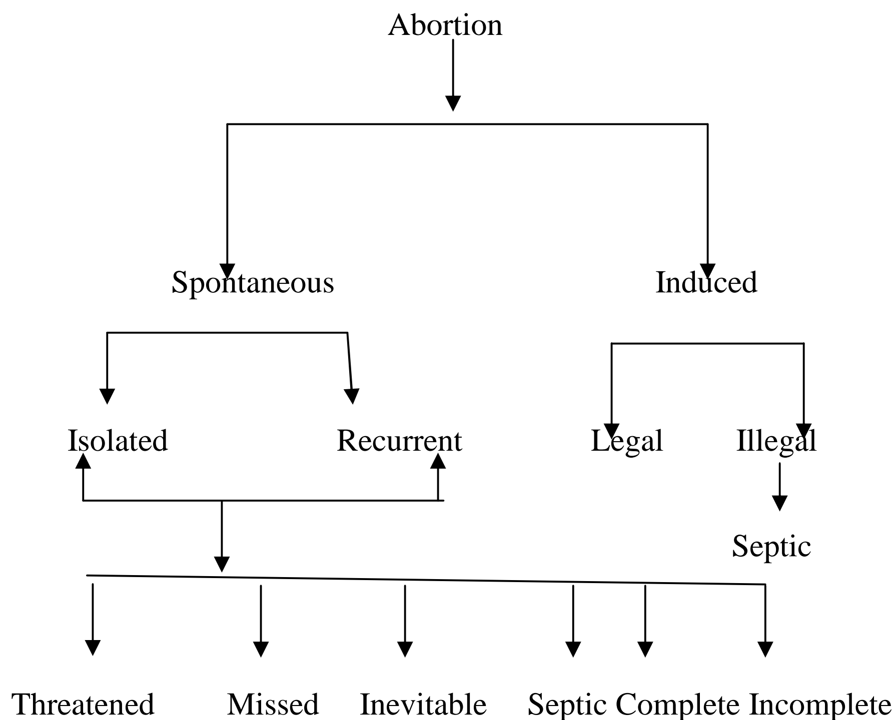
Safe abortion care (services) is an approach to provide abortion service that addresses the various factors of women health needs like physical mental well-being and her personal circumstances as well as her ability to access services. Comprehensive (safe) abortion is an important component of the reproductive health for women. Comprehensive abortion care includes affordable and accessible abortion service and other reproductive services, such as counselling and informed consent for the termination of pregnancy, informed choice for post abortion contraception, identification and treatment of sexually transmitted infection, reproductive track infection and other similar aspects of reproductive health.

WHO has defined abortion as: The term abortion refers to the termination of pregnancy from whatever cause, before the foetus is capable to extra uterine life (WHO, 1994).

Abortion refers to termination of pregnancy before the foetus becomes viable. Age of viability varies from country to country. In case of Nepal, age of viability is considered as 28 weeks. So termination of pregnancy after 28 week is not considered as abortion, rather it is considered as still birth.

Abortion is one of the methods of controlling fertility. Practice of abortion is as old as the origin of society itself. Although women’s access to induced abortion was restricted by law and prohibited by religion and custom in Nepal, it is a being practiced since then as many studies have found that abortion is widely practiced from the beginning of socialization. However, due to the fear of legal punishment or social prohibition majority of women seek abortion clandestinely. Most of them consult unskilled health person for abortion resulting in complications and it most leading to death of the mother.

The type of abortion would clear by the following diagram.



(Source: Dutta, 2002:170)

Spontaneous abortion is the expulsion of an embryo or foetus due to accidental trauma or natural causes before approximately the twenty two weeks of gestation. In case of Nepal it is considered as twenty eight weeks. In another word spontaneous abortion is also known as miscarriage. The most common cause of spontaneous abortion during first trimester is due to incorrect replication of chromosomes; they can also be caused by environmental factors. Spontaneous may be isolated or recurrent.

Threatened abortion is a type where process of abortion took place but could be prevented. In inevitable abortion it could not be prevented or stop from process of abortion. Complete abortion means completion of abortion process. There is no any foetal tissue inside uterus. In incomplete abortion there is still few product of conception retained inside uterus which need to be expelled out. Missed abortion is a process where foetus becomes dead inside uterus and remains inside the uterus for variable period.

Induced abortion is a process by which pregnancy is terminated either medically or surgically before foetus is viable. Abortion provided by the listed trainees' personnel in the listed site in aseptic way is safe abortion. Abortion is defined as the loss of

pregnancy foetal viability of 22 weeks gestation, in case of Nepal it is defined as 28 weeks. A pregnancy can be intentionally aborted in many ways. The manner selected depends chiefly upon the gestation age of the foetus, availability of services and doctor-patient preference. Reasons for procuring induced abortion are typically characterized as either therapeutic or elective. An abortion is medically referred as therapeutic when it is performed to:

- Save the life of pregnant women;
- Preserve the women's physical or mental health;
- Terminate pregnancy that would result in a child born with a congenital disorder that would be fatal or associated with significant morbidity; and
- Selectively reduce the number of foetuses to lessen health risk associated with multiple pregnancies.

An abortion referred to be elective when it is performed at the request of the women, for reason other than maternal health or fatal disease. Unsafe abortion pregnancy termination attempted by an untrained person in unhygienic way which often leads to complications. The WHO defines an unsafe abortion as being "a procedure carried out by persons lacking the necessary skill or in an environment that doesn't conform to minimal medical standards or both."

An induced abortion is safe, if it carried out by a registered provider of the government certified place with the consent of women and fulfils the following criteria.

- Up to 12 weeks of gestation with the request of the pregnant women.
- Up to 18 weeks of gestation in case of rape or incest with request of the pregnant women.
- At any gestation, if the pregnancy is harmful to the pregnant women's physical or mental health, as certified by an expert physician.
- At any gestation, if the foetus is suffering from a severely debilitating or fatal deformity or disease, as certified by an expert physician.
- Listed medical practitioners (Health Service Provider) will provide comprehensive care services.

- Only the pregnant women hold the right to choose to continue or discontinue the pregnancy. If the pregnant woman is minor (less than 16 years of age) or not in a position to give consent (mentally incompetent) the nearest guardian or relative can give consent for abortion services.
- The low prohibits termination of pregnancy of any gestation for the sole purpose of sex selection.

Community attitude towards abortion in the context of religion shows prohibition in Nepal. The religious context of Nepal in regard to abortion is linked with Hindu sculptures. Hinduism places a high value on female fertility and at the same time seeks to rigidly control female sexuality, which shows strict prohibitions against abortion (Sturley, 1998). It is estimated that about 20-48 percent of women admitted in government hospital as an obstetric and gynaecology patients are cause of abortion complication (Upreti et al, 1999).

According to Hindu religion a women who intentionally terminates her pregnancy is denoted traditional funeral rites and is doomed to be punishing in hell. Other family and community member are required to treat her as a social outcast. A husband who helps his wife to terminate a pregnancy is also considered to have committed a sin; a husband who is involved in helping his wife to terminate her pregnancy requires abandoning her. Hinduism censure of abortion extends to miscarriages as well. A woman who miscarries is considering ritually polluted after miscarriage for a period of time equal to length of pregnancy (FWLD, 2003). In Nepal unwanted pregnancy and unsafe abortion practice are highly correlated. There are growing numbers of women who want no more children or want to space birth. Many women in Nepal often do not have access to family planning service when they want to space their pregnancy or limit their family size. Implicitly 25 percent of currently married women have unmet need for family planning service of which 9 percent have a need for spacing and 15 percent for limiting birth (NDHS, 2006). Majority of induced abortion were often illegally by unqualified provider which further of aggravated abortion complication.

Despite the termination of unwanted pregnancy, sex selective abortion is growing phenomenon among urban women over the last few years. A mini survey 61 leading gynaecologist working in private clinic, nursing home in 11 town in Nepal shows about one fifth of pregnant women visiting their clinic in Kathmandu valley and about

a half in other town are interested to know the sex of foetus. The doctor inform a large proportion of women refer to terminate their pregnancy if sex determination test shows the foetus is a girl. Such practice is against the abortion policy and should be strictly prohibited at any cost (Tamang and Nepal, 2000)

There are two type of comprehensive abortion. Surgical abortion method and medical abortion method. Surgical methods are used to terminate first trimester and early second trimester pregnancies where the products of conception are removed by use of an aspiration technique. Vacuum aspiration is consider an essential service by many national and international authorities. World Health Organization (WHO) and The International Federation of Gynaecology and obstetric declares one should adopt aspiration method which might be either a manual vacuum or a electric vacuum aspiration as a surgical method.

Electric vacuum aspiration is manual extraction of POC (product of conception) with use of ovum forceps in first and second trimester pregnancy. This method of termination uses an electric pump or suction machine. Because of the high initial cost of an electric vacuum aspiration machine its use is less in developing countries. Electric vacuum aspiration is typically used in centralized setting where higher number of client follows.

Manual vacuum aspiration (MVA) is most common method used world wide for aspirating below 12 weeks pregnancy using vacuum aspiration .This method is safe and simple. This technique is performed by aspirating the product of conception using a plastic cannulae attached to a hand filled plastic aspirator with minimal scraping of uterus.

Medical abortion is also a safe way for terminating the pregnancy. Certain medications are prescribed from authorised centre for terminating upto 9 weeks . Mifepristone and Misoprostol are the medicine prescribed as abortion method for women whose pregnancy is of 63 days or less. Mifepristone (use orally) block the hormone progesterone needed to maintain the pregnancy. As a result decidual lining begins to shed and the cervix begins to soften and bleeding may occur. As Misoprostol is inserted into the vagina, the uterus begins to contracts and the pregnancy is usually expelled with in 6-8 hours. Follow up exam is necessary for up to 2 weeks to sure that the process is completed and no more POC is present within

uterus. If pregnancy is continue after this medication there is a high risk of foetal deformities. Side effects with misoprostol are heavy bleeding, diarrhoea, nausea, vomiting and heavy cramping (JNHRC, 2008). It is safe method than sharp curettage. Though the complications are rare there may be chance of prolonged or heavy bleeding, which is experienced by one out of hundred women incomplete abortion .There have been no reports of long term risks medical abortion and it will not affect future fertility, menstrual cycle or sexual activity. It is simple and easy to use and it doesn't require refrigeration for storage. It is non surgical method, it can be safely delivered by mid level service providers .But patient must be under the follow-up of health service provider(such as, doctor, nurse/midwife, or other health service providers)

1.2 Statement of the problem

Globally estimated that 15-30 percent of the total pregnancy related death result from abortion and its complication. An average of 15 percent of all pregnancy ends in spontaneous abortion (WHO,1995). Although accurate data on the impact of unsafe abortion in maternal death is lacking, WHO estimated 20 million unsafe abortion occur world wide 70000 women die each year as a result of complications following unsafe abortion. They are responsible for 1 in 8maternal death. Globally 1 unsafe abortion takes place for every 7 births. Between 10-15 percent of women who undergo unsafe abortion need medical care for treatment of complication which consumes 50 percent of total hospital budget. In the developing world (excluding China) the death from abortion (safe or unsafe) is 330 maternal death for100000 abortions (AGI, 1999).

Abortion rates were lowest in Europe (12 per1000 women) ,17 per 1000 women in northern Europe , 18 per 1000 women in southern Europe and 21 per 1000 women in northern America. In 2003 48 percent of all abortion worlds were unsafe abortion and more then 97 percent of all unsafe abortion were in developing countries (Elsevier, 2009).

The WHO reports each year nearly 42 million women faced with an unintended pregnancy have an abortion and according to the 2007 estimates conducted

collaboratively by the WHO and Guttmacher Institute ,20 million unsafe abortion take place each year ,most in countries where abortion is illegal (New York Times,2007).

According to WHO and Guttmacher approximately 68,000 women die annually as result of complications of unsafe abortion and between two million and seven million women each year survive unsafe abortion but sustain long term damage or disease (incomplete abortion, infection (sepsis), haemorrhage and injury to the internal organs, such as puncturing or tearing of the uterus). They also conclude abortion is safe in countries where it's legal but dangerous in countries where it's outlawed and performed clandestinely. The WHO reports that in developed regions, nearly all abortion (92%) are safe, whereas in developing countries more than half (55%) are unsafe (WHO, 2010).

Abortion rates were lowest in Europe (12 per1000 women) ,17 per 1000 women in northern Europe , 18 per 1000 women in southern Europe and 21 per 1000 women in northern America. About 48 percent of the total abortions in the world were unsafe abortion till 2003 and more then 97 percent of all unsafe abortion were in developing countries (Elsevier 2009).

According to ministry of health maternal morbidity and mortality study of 1998, approximately 5.4 percent of all maternal death are due to abortion complication Nepal also had one of the highest rates of pregnancy related death in the late 1990's .In Nepal 281 women die due to pregnancy and delivery (child birth) related complication for every 100000 live birth (NDHS, 2006). Women are frequently not able to determine and control all circumstances of their lives. Socio economic cultural psychological and social factor play a vital role for abortion.

In Nepal abortion is legal at first trimester in the will of mother for any reason but in second trimester it is only for cases of rape and incest and at any gestation when life of mother is risk or foetus is deformed.

Thus the study is oriented to investigate the following research questions.

What are the causes of abortion?

What are the methods of abortion?

What are the socioeconomic and demographic conditions of the women who take safe abortion services?

1.3 Objective of the study

The general objective of the study is to find out the safe abortion practice in Kailali district. However, following are the specific objectives of this study.

- To find out socioeconomic and demographic condition of the women who take the safe abortion service ;
- To find out the knowledge about the safe abortion service and practice;
- To analyze the situation of safe abortion service and practice in study area;
- To find out whether women are more interested in medical method or surgical method for abortion;
- To find out the causes of abortion;

1.4 Significance of the Study

The study will give the insights of safe abortion practice in study area, which can contribute for governmental agencies and non-governmental organization to make district level community health programmes which might help in decreasing abortion related complication in reducing the maternal death. This study also helps focusing on which groups of women are practicing unsafe abortion. The study helps the women aware to the practice of safe abortion service and achieves knowledge about the legality of the abortion. This study is also fruitful for policy makers, programme planner, legislature programme implementers and demographers.

Research and the study area ,safe abortion practice, especially included area of Global Comprehensive Abortion Care project, which was started in 2007 for5 year covering six districts vij.Bank, Ilam, Kailali, Kanchanpur Palpa and Sarlahai. The information on the study of safe abortion practice and affecting factor behind that is really helpful for reducing unsafe abortion practice. So, the information obtained after this study will be more useful as a feed back for the policy maker of the concerned authorities to improve the health status of reproductive age group women by implementing health program and eliminating the unsafe abortion practice.

1.5 Limitation of the Study

This study may be information bias .This study will include only hospital based study to estimate the incidence and magnitude of the tragic problem the women admitted for safe abortion. This study cannot define and represent the whole area of Nepal because of the small number of the sample size and small area of study area.

1.6 Organization of the Study

This study is divided into six chapters. The first chapter include the general background of the studies, statement of the problem, objective of the study, significance of the study, limitation of the study and organization of the study.

The second chapter includes the literature review, national policy and programme and conceptual framework. The third chapter includes the study area, research design, sample design, questionnaire design, variable identify, method of data collection and data analysis. The fourth and fifth chapter includes the data analysis.

The sixth chapter includes summary, recommendation and conclusion.

CHAPTER –II

LITERATURE REVIEW

2.1 Theoretical Literature Review

Access to high quality abortion care is essential for women's reproductive health as evidence by the dramatic decrease in pregnancy related morbidity and mortality since the legalization of abortion. Abortion is an important option for pregnant women who have serious medical condition or foetal abnormalities. The foetal reduction techniques are now well-integrated into infertility treatment to reduce the risk of multiple pregnancy resulting from assisted reproduction.

The view that abortion is responsible for criminal act was first expressed explicitly in religion law. The first instance of secular law concerning abortion was included in England in 1803. In civil law, first widely adopted statue concerning induced abortion appeared in Napoleonic code of 1810. The subsequent reform in 1920 and 1923 changed abortion from a crime to a misdemeanour, although there are still harsh sentences. The Napoleonic code from the basis of abortion legalize in many countries with civil law systems. Reflecting its civil-Law origins, social law prior to 1920 considered abortion as a crime (UN, 1992).

Soviet Union government legalize the induced abortion for the first time in 1920. In 1995 law was liberalized once more in recognition of the increased maternal mortality and morbidity resulting from illegal induced abortion (UN, 1992).

Abortion has been developed as the most controversial issue and human right issue especially after ICPD, 1994 and fourth women conference in Beijing declaration 1995. In the platform for action numbers 93 and 97 of Beijing declaration in the chapter IV, about unsafe abortion, following is stated: "The trend towards early sexually experience, combined with a lack of information and services, increase the risk of unwanted and early pregnancy, HIV infection and other STDs, as well as unsafe abortions. Unsafe abortion threaten the lives of a large number of women representing a great public health problems as it is primarily the poorest and youngest who take the highest risk. Most of these deaths, health problem and injuries are preventable through improved access to adequate health care services, including safe

and effective, affordable and acceptable method of family planning of their choice as well as other method of their choice for regulation of fertility which are against the law Similarly, in the ICPD, 1994, in Para 8.25, about abortion, following is stated; “In no case should abortion be promoted as a method of family planning. All government and non-governmental organizations are urged to strengthen their commitment to women’s health to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded improved family planning services. Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion” (UN, 1995).

Since 1995 when the United Nation women’s conference in Beijing plate form for action called on governments to deal with the health impact of unsafe abortion a major public health concern, 17 countries representing all major region of that world have removed legal registration on abortion. As an extension of the incidence and severity of unsafe abortion is increasing, it is seen as a matter of human rights. Amnesty International has now taken a stand on the issue after a long review and consultative process among its affiliates world wide. As it’s biennial meeting this past ,August ,which by coincidence took place in Mexico city the renowned human right organization declared that it would work to “support the decriminalization of abortion to ensure women have access to abortion when their (physical)health or human rights are in danger’’. “This policy is binding upon all country members including in countries where abortion is illegal” (Guttmachar policy review 2007).

Government of Nepal amended the Nepal criminal code (MULIKI AIN) on first chaitra 2058(16th march 2002); Royal Assent was given on 10th Asoj 2059 (27th September 2002). The procedural process for the safe abortion was approved by the cabinet on 10th Poush 2060(25th December 2003) for the implementation of the safe abortion law. It legalizes the termination of pregnancy up to 12 weeks of gestation on request by pregnant women and up to 18 weeks in case of rape and incest and pregnancies of any duration with the recommendation of an authorized medical practitioner if the life of mother is in risk, if her physical or mental health is in risk, or if foetus is deformed (MOH, 2004,). UNPD has classified the countries that approved abortion to preserve physical and mental health of women, in case of rape or incest of

foetal impairment, poor economic and the request of women for abortion .Nepal falls under the category of countries where abortion is allowed on request by a women.

Prior to 2002, abortion was totally illegal. The Legal Code 1963 (Muliki Ain) of Nepal did not permit the termination of pregnancy even if it were the result of rape or incest or threatened the women's life. In this environment, women who sought abortion and providers who provided abortion necessarily did so clandestinely. Most of the abortion that took place were unsafe; only a very small proportion of women, mostly those living in urban or semi- urban areas and able to afford the cost, had access to trained medical practitioners and safe procedures (Thapa and Pandhya, 2001).

As part of safe motherhood programmes IPAS work with government and technical committee for comprehensive abortion care to institutionalize comprehensive abortion care, a model that include pre-and post abortion counselling as well as provision of contraceptive to prevent repeat unwanted pregnancies throughout the country. By December 2006, 71 of Nepal's district even those in relatively remote region have trained abortion providers a remarkable achievement of national training programme in which IPAS has been instrumental. This helps managing the trained staff including government operates family planning clinic, those operates by non-governmental organization as Marie stopes international and private clinics. This flyer describes women-centred comprehensive abortion care as a model of care that includes a range of medical and related health service to support women in exercising their sexual and reproductive right and health (IPAS, 2003). Comprehensive abortion care services includes examination by the doctor or health worker counselling on abortion and family planning options and services , abortion services using Manual vacuum aspiration effective pain management and other reproductive health services if needed.

According to the ICPD, Reproductive health is a state of complete physical, mental and social well being not merely absence of disease or deformity in all matter relating to the reproductive system and to its function and process. In Nepal the ministry of health and population adopted the national Reproductive health and strategy in 1998A.D. Following points are the commitment made at the ICPD. The NRHS does not view a reproductive health as a new programme instead it is a new approach that seeks to strengthen the existing safe motherhood. Thus the basic component of

reproductive health care with reference to Nepal can be based on the essential element of comprehensive RH care adopted by the NRHS which includes as follows.

1. Family Planning
2. adolescent sexual Reproductive health
3. Infertility
4. Reproductive Tract Infection
5. Neonatal Care
6. Abortion
7. Maternal Care, and
8. Elderly Care

Abortion also includes as a RH package as well as includes the RH right. For the purpose of abortion government has provided safe and accessible service in the Central, Regional and District Hospital.

2.1.1 National Policy and Programmes

The Government of Nepal has developed the National policy, July2003 statement of Comprehensive Abortion care services:

- Comprehensive abortion care services will be safe, accessible and affordable.
- Comprehensive abortion care will be provided through service providers listed as per the safe pregnancy termination order.
- An effort will be made to offer a choice of available method; Medical and surgical.
- The process associated with listing the institutions and individuals practitioners authorised to provide comprehensive abortion care service will be made a simple as possible.
- Referral linkage will be established between health institution providing comprehensive abortion care service for first trimester(primary health

centre and district hospitals) and those health institution (Zone, regional, and maternity referral hospitals) that can provide CAC for second trimester and capable of managing post CAC complications.

- Comprehensive abortion care service will be expanded through private sector (primary health centre and district hospital) and semi-autonomous institutions, NGO's and the private sector to maximize accessibility.
- Authorized CAC service providers performing these services in good faith will be protected under the law.
- Pregnancy termination shall not be used as a method of family planning .Pregnancy termination shall not be performed based on sex selection.
- Community based health workers will play an important role in helping women avoid unwanted pregnancy through providing information and contraceptives, and informing them about the consequences o0f unsafe abortion, informing women how to obtain safe, legal abortion care without undue delay and referring women with complication of unsafe abortion for appropriate care(MOH,2007).

According to eleventh three year interim plan governments start to provide safe abortion services cooperative with Marie stops. This plan also to fulfil the target of MDG's.

2.2 Empirical Literature.

The NDHS shows that out of 100 percent, 10 percent ends on still birth where as 90 percent pregnancy results in a live birth, about 5 percent women reported abortion as spontaneous and 2 percent reported as induced abortion.

As most of the abortion related death due to complication of unsafe abortion which are preventable. ICPD 1994, called for access to safe abortion services , access to compassionate quality service for complication arising from abortion, post abortion counselling and family planning services At 1994 international conference on population and development(ICPD) ,the world's nations agreed that unsafe abortion is a major public health concern and that government should work to eliminate unsafe abortion and make abortion safer in countries where it is legal (UN,1994;WHO 1998).

Nepal is fully committed to implement the programme of action of ICPD and MDG's. As evidence, long term effect of legalization abortion cut the rate of maternal death and injuries. Official recognition of the moral imperative to reduce maternal mortality has been intensifying by 2000. Along with Nepal 189 countries adopted the United Nations Millennium Development goal (MDG's).One of the eight goal also adopted , is to improve maternal health, with a specific target to reduce the ratio of maternal death to live birth by three quarter between 1990 and 2015 (UN ,2001).

Among192 countries of the world, abortion has been restricted in all grounds in 4 countries, while it has been permitted to save the life of pregnant women in 188 countries, 122 countries have permitted abortion to preserve physical health of pregnant women and 100 countries have allowed it to preserve also the mental health of the pregnant women. Similarly, 76 countries have permitted abortion legally, if the pregnancy was the result of rape or incest, 77 countries have permitted abortion in the ground that foetal impairment, 63 countries have allowed it in economic or social reasons and only 55 countries have permitted abortion legally on request of the pregnant women. Among 192 countries, only 52 countries have permitted abortion in all seven grounds mentioned above (UN, 2001).

Each year, it has been estimated that 19 million unsafe abortions happening worldwide, most of them in low-income countries. About 5.2 million of these women are hospitalized for serious complications, while an unknown but possibly equal number of women suffer similarly serious complications but can not obtain treatment. As a result, around 68000 women die each year, making unsafe abortion a significant cause of maternal mortality (WHO, 2010).

Since Nepal liberalized its abortion laws in 2002 and introduce comprehensive care to its citizens more than 105000 safe abortions have been performed. Those statistics are more than just a number; they represent what can be done when governments, non-governmental organization and health sector work together guarantee women's reproductive health and save countless lives. In Nepal the provision of safe abortion care make great progress accomplished during a time of civil unrest between government and Maoist rebels. Nepal's also had one of the Asia's highest ratios of pregnancy related deaths, in 1990's the MMR 530death per 100000 live birth and in 1998 it was 596-683 (MMMS, 1998, MOH). It was more than half of gynaecological and ostrich hospital admission were due to abortion related complication .By 2006

NDHS way reached the MMR plummeted 281 Dr B.K Subedi ,director of Nepal's family health division has said that availability and use of safe abortion care might one of the factor in the significant decrease.

A hospital based study conducted at five major hospitals and around Kathmandu valley reported 1576 causes of abortion related complication, among them 90 percent cases were spontaneous abortion 8 percent were induced abortion and a further percent were possibly induced abortion (Thapa, 1992).

In FY2063/64, 114 doctors were trained as service providers and 36 new sites from both public and private were listed for service delivery. During this fiscal year 77,235 women received service from 167 sites from government hospital; Marie stops internationals, family planning association, medical college, private hospitals and nursing home. CAC services is made available in 70/75 districts (MOH, 2006).

Nepal has a high level of unintended pregnancies among currently married women of reproductive age which is about 33 percent (MOH, 2007). Beside other factors, the increasing safe abortion practice should also have contributed to mortality decline in Nepal (Karki et al, 2008). Despite legalization of abortion, many women still fall prey to unsafe abortion practice and put themselves at high risk of maternal mortality and morbidity. In Nepal, the number of annual unwanted pregnancies is estimated at 200000 births (FPAN, 2008).

By June 2009, the number of listed health institutions providing SAS will be increased to 245 and covers all districts. A total of 704 health service providers have been trained on MVA procedures. In all, 229583 women have benefited from SAS since March 2004 to June 2008 (CREHPA, 2009).

Access to safe abortion care service in Nepal is hampered because we do not have sufficient trained CAC service provider .Poor transportation facilities hampered treatment in tertiary clinic. We need to involve more private clinic and teaching hospitals .Women have to less access to education, health ,economic opportunities and social services then men in our country which can lead to health related disparities. Linkage between community and service provider is a key factor in preventing unwanted pregnancies and abortion, this linkage is lacking in out countries because if the distributed political situation at present and other social factor.

2.3 Conceptual framework

There are many factors affecting knowledge attitude and behaviour of women towards safe abortion services. Following framework has been developed to study which are considered here as their independent variable.

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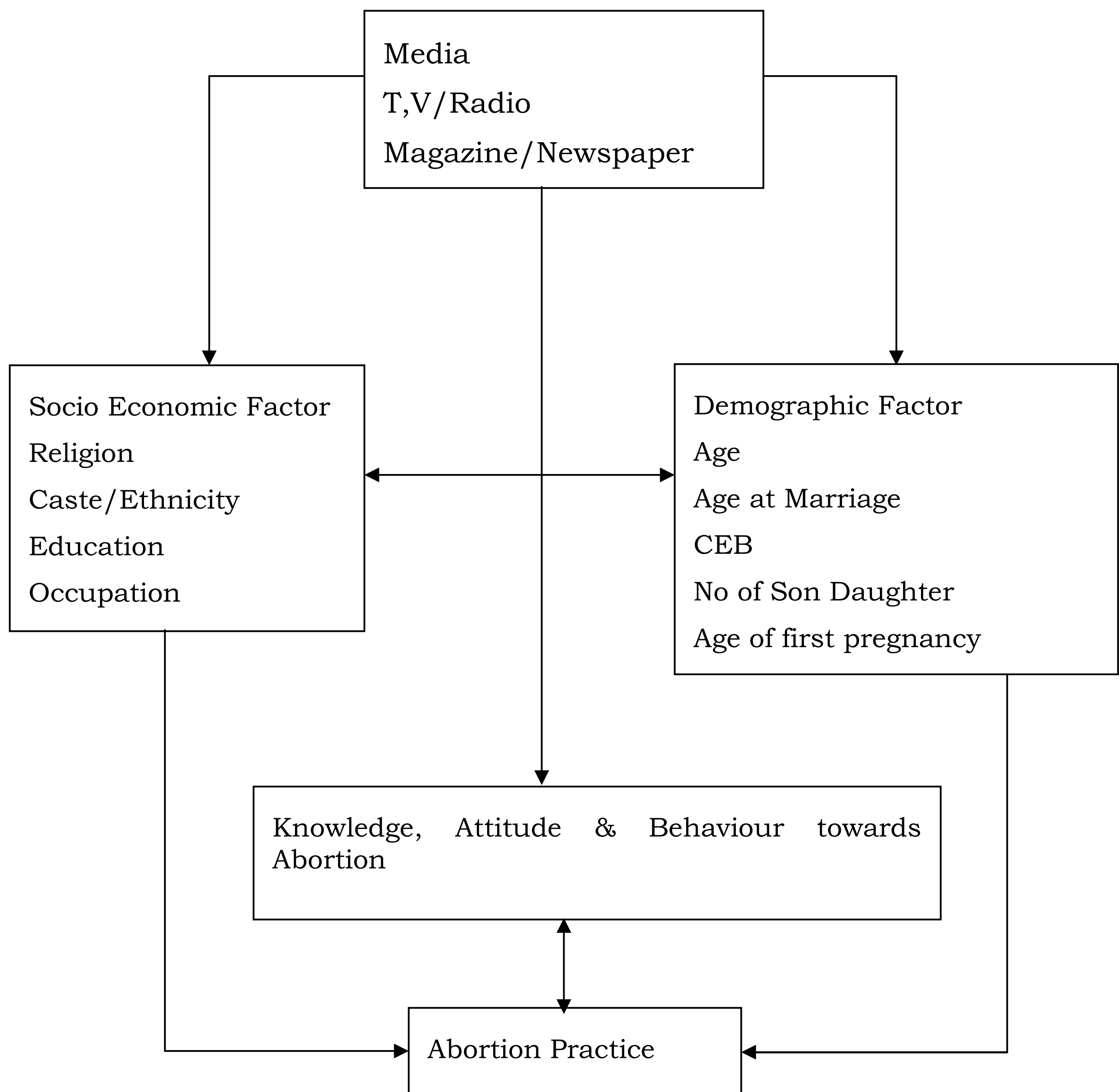
There are many factors to affecting knowledge attitude and behaviour towards safe abortion services. Following framework has been developed to study which are considered here as their independent variable.



CHAPTER -III

METHODOLOGY

3.1 The study area

The study was conducted to explore and describe the safe abortion care and practices .The study was conducted in Tikapur Municipality of Kailali district. This is situated in far western region of Nepal. Total population of Tikapur Municipality was 38722 and female population was 19275. Tharu are higher than other caste, which are 42.15 percent 11.36 percent are Brahmin and 46.49 are other caste. Most of people (96.43%) are adopted Hindu religion. Out of total population 53.13 percent of population used Nepali language, 37.75 percent used Tharu language and 63.66 percent people are literate (CBS, 2001).

3.2 Research design

The study was conducted in Tikapur Hospital and private clinic like NainaTara clinic and Chandimai Hospital and Research Centre where abortion service are available .The hospital and the private clinics have purposively selected for study .

3.3 Sample Selection

All women who presents in hospital and clinics for abortion service were included. Total sample size taken as 90 women from hospital and other private clinic. Duration of this research was from 26th Bhadra to 7th Mansir of 2065 B.S. In this that period of time ninety women had come to take safe abortion service and practice at hospital and clinic.

3.4 Source of Data

This study based on primary data collection from different Hospitals and Private Clinic in Tikapur Municipality of Kailal District. Data were collected from primary source. Respondents of the study include the women who present for abortion. Data

are collected from 90 women by direct structured interview with client. The entire questionnaire fulfilled by primary source with face to face interview from respondents.

3.5 Questionnaire design

The questionnaire was prepared as per the suggestion and guidelines of the research supervisor and also by reviewing the questionnaire of previous studies on the related topics and it was fully guided by the study objectives. Individual type questionnaire included in the study.

3.6 Method of data collection

Quantitative data were collected for the study. These questions were asked to the respondents before and at the time of procedure. This questionnaire covered information about safe abortion services, age at marriage age at first pregnancy, and children ever born.

3.7 Method of data analysis

Analysis of the research has been done with help of frequency table and cross tabulation to clear the scenario of study and to conclude the finding.

3.8 Variable identification

Practice of abortion in Nepal is done for different setting. At one side it is safely done for maintaining wanted family size in case of failure of contraception where as at the other side it is taken as method of contraception. Some people even practice it as a result of illegal intercourse or rape. Some group of people believe that abortion should not be done since it is a crime. They believe that abortion is killing of a unborn life. The practice of abortion thus might depend on some independent variable such as, socio economic, demographic and knowledge. There is quite different in practice of abortion at safe site and unsafe site, which is influenced by caste, place of resident, occupation and different education level.

Middle age women who married at younger age might have more children. They have abortion practice for spacing of child. Some women practice the abortion at the local level by the use of local herbs, sticks or other material resulting in high morbidity and mortality. These use by untrained person resulting complication leads to higher degree of suffering to the women. They even don't know the knowledge of unsafe abortion and also unaware of safe abortion site. They don't want to come to the safe abortion service site due to fear of exposing with other people. They believe that, this practice shouldn't be known to the community because of fear of social restriction.

Dependent variable

Safe abortion practice

Independent variable

1. Socio economic variable

   Caste/ethnicity

   Place of residence

   Education

   Occupation

2. Demographic variable

   Age

   Age at marriage

   Contraception

   Previous child loss/abortion experience

   Age of first pregnancy

   Parity

3. Knowledge related variable

   Knowledge on danger of unsafe abortion

   Knowledge about safe site for abortion practice

4. Service related variable

   Availability of health service

CHAPTER –IV

SOCIO ECONOMIC AND DEMOGRAPHIC CHARACTERSTICS OF THE RESPONDENTS

Socio economic and demographic characteristics play vital role for the development of society .This chapter deals with social economic and demographic status of target population.

4.1 Demographic Characteristics

Demographic Characteristics includes size of population, age structure of the respondents and distribution of respondent. Demographic Characteristics of this study area are presented as different table in below.

4.1.1 Distribution of Respondents by Age Group

Age sex composition plays an important role in determining the population distribution. This study was conducted mainly to analyze the safe abortion practice of women. The age of the respondents was categories by 5 year age group.

Table 1: Distribution of Respondents by Age Group

Age group	Respondents	
	Number	Percent
15-19	5	5.56
20-24	31	34.44
25-29	33	36.67
30-34	11	12.22
35-39	6	6.67
40+	4	4.44
Total	90	100

Field survey: 2009

Large number of respondents occupied 25-29 years i.e.36.67 percent and followed by 20-24 age groups (34.44), 30-34 (6.67 %),15-19 (5.56%) and the lowest number of respondent 40 years and above i.e. 4.44 percent.

4.1.2 Marital Status

In our society only the married couple are allowed for sexual behaviour. If a women without being married becomes a pregnant she will not be accepted in society. Even she will not be allowed to participate in social function. So there is chance of practicing unsafe abortion from a quake.

Table 2: Distribution of the Respondents by Marital Status

Marital status	Respondent	
	Number	Percent
Unmarried	3	3.33
Currently married	86	95.56
Divorce/separate	1	1.11
Total	90	100

Source: Field survey 2009

Table 2 shows that majority of the respondents are currently married, which is 95.56 percent, 3.33 percent of the respondents are unmarried and 1.11 percent of respondents is separate, who have forced to abort.

4.1.3 Age at Marriage of Respondent

Marriage is a main component of population dynamics. Marriage is universal and still early marriage can be observed in Nepal. Age at marriage is important factor for safe abortion which leads to safe motherhood. As shown Table 3 the age at marriage of respondents has been divided in four age groups.

Table 3: Distribution of Respondent by Age at Marriage

Age at Marriage	**Respondents**	
Age Group	Number	Percent
<15 yrs	3	3.45
15-19 yrs	47	54.02
20-24 yrs	34	39.08
Don’t know	3	3.45
Total	87	100

Source: Field survey 2009

Women who married at earlier age (15-19) have higher percentage of safe abortion practice (54.02%) than who married at later age. This might be because of need of spacing or delaying the first child. Table 3 shows that 3.45 percent got married at age group less than 15 years. About 39 percent of the respondents married at age group 20-24 year. This might be for wanting the control of number of children. There are 3.45 percent of respondent, who cannot remember their age at marriage.

4.1.4 Educational Level and Age at Marriage

Level of education helps women to know about physical and mental maturity about her. So, they want to get late marriage. Higher the education level greater the age at marriage. Uneducated woman get early marriage and engage in household work and they won't get chance to know about opportunity

Table 4: Distribution of Respondents by Educational Level and Age at Marriage

Education	Age at Marriage Group								Total	
	Don't know		Less then 15		15-19		20-24			
	No	%	No	%	No	%	No	%	No	%
Illiterate	3	7.9	3	7.9	21	53.58	12	30.77	39	100
Literate but not schooling	-	-	-	-	1	20	4	80	5	100
Primary	-	-	-	-	4	66.67	2	33.33	6	100
Lower secondary	-	-	-	-	6	60	4	40	10	100
Secondary	-	-	-	-	6	66.67	3	33.33	9	100
S.L.C	-	-	-	-	3	37.5	5	62.5	8	100
Certificate and above	-	-	-	-	6	60	4	40	10	100
Total	3	3.45	3	3.45	47	54.02	34	39.8	87	100

Source: Field survey 2009

Table 4 shows that most of the illiterate respondents and the respondent having Primary lower secondary and secondary level education have got married at age between 15-19 years, it's shows that early marriage. The respondent having S.L.C level and literate have got married at age between 20-24 years. Out of all respondents, most of the respondents have got early marriage, which is around 60 percent.

4.1.5 Age at First Pregnancy of Respondents

There is close relationship between age at first pregnancy and safe abortion practice. Therefore, the respondents were asked their age at first pregnancy. It is proved that pregnancy at early age and late age has more complication so that suitable time period for get pregnancy is age between 20-30 years.

Table 5: Distribution of Respondents by Age at First Pregnancy

Age at First pregnancy	**Respondents**	
	Number	Percent
15-19	39	43.33
20-24	48	53.33
Don't know	3	3.33
Total	90	100

Source: Field survey 2009

Table 5 shows that 43.33 percent respondents conceive their first gravida at age group of 15-19,in study area mother and child health condition seems to be good 53.33 percent respondent conceived their first pregnancy at age group 20-24 which is idle age of first child birth . About 3 percent respondent, who have neither know their age at marriage nor know their first pregnancy date.

4.1.6 Educational Level and Age at First Pregnancy

Women becoming pregnant before the age of 20 years might suffer from a physical and mental trauma. They are not receptive fully for these change and they are mentally and physically weak. Pelvic structures are not fully developed. This leads to

many complications like mental stress, postpartum psychosis, injury to pelvic organs post- partum hemorrhage, ante-partum hemorrhage etc. If the women are educated, they will become pregnant after the age of 20 years. They will be physically strong and mentally stable. They can decide their need of child. They won't give birth to a child on social and family pressure but give birth at their own interest.

Table 6: Distribution of Respondent by Educational level and Age at First Pregnancy

Education	**Age first pregnancy group**						**Total**	
	Don't know		15-19		20-24			
	No.	%	No.	%	No.	%	No.	%
Illiterate	3	7.69	15	38.46	21	53.89	39	100
Literate but not schooling	-	-	1	20	4	80	5	100
Primary	-	-	4	66.67	2	33.33	6	100
Lower secondary	-	-	3	30	7	70	10	100
Secondary	-	-	7	63.64	4	36.36	11	100
S.L.C	-	-	2	25	6	75	8	100
Certificate and above	-	-	7	63.64	4	36.36	11	100
Total	3	3.45	39	43.34	48	53.33	90	100

Source: Field survey 2009

Table 6 shows that 53.89 percent of illiterate have got first pregnancy at age between 20-24 years which seems that contradiction .There is also shows that 63.64 percent of having certificate and above education have conceived first pregnancy at age between 15-19 years, which is early age at pregnancy. About 75 percent of respondents having S.L.C level education have got first pregnancy age at 20-24 years. Most of the respondents with primary level and secondary level education have pregnancy at age less then 20 years. From the table there is not valid rule "higher the educations lower the early pregnancy" for the study area.

4.1.7 Distribution of Respondent by Children Ever Born

CEB is the total number of live birth born by a woman during her reproductive age until the date of enumeration. This study also included the respondents by their children ever born in following table

Table 7: Distribution of Respondents by CEB

No. of Children	Respondents	
	Number	Percents
0	7	7.78
1	28	31.11
2	30	33.33
3	17	18.89
4	3	3.33
5	4	4.44
7	1	1.11
Total	90	100

Source: Field survey 2009

It is found that the children ever born (CEB) are 2 in the larger number of respondent that is 33.33percent. it is followed by CEB of 1 i.e.31.11 percent and 1.11percentage of respondent's CEB is7. Those who have 2 children and at least 1 male child are practicing safe abortion. Knowledge and practice of SAS is increasing among those without child, which is 7.78 percent. It might because of the want delay in first child because of their age carrier.

4.1.8 Gestation at the Time of Abortion

The pick age of gestation for abortion among the client is 8 weeks. Table 8 shows that 26.67 percent of respondents age of gestation is 8 weeks,16.67 percent clients have 7 weeks gestation and 14.44 percent clients have 6 weeks gestation. Health person also focused them to come after 6 weeks and before 10 weeks.

Table 8: Distribution of Respondents by age of Gestation a Time of Abortion

Age of gestation by Last menstrual period	Respondents	
	Number	Percent
4 weeks	6	6.67
5 weeks	6	6.67
6 weeks	13	14.44
7 weeks	15	16.67
8 weeks	24	26.67
9 weeks	6	6.67
10 weeks	8	8.89
11 weeks	2	2.22
12 weeks	9	10
12 weeks and above	1	1.11
Total	90	100

Source: Field survey 2009

4.1.9 Gravida of Respondent

Most of the clients are having living children either 2 or 1. Those who have 2 children and at least 1 male child are having practice of safe abortion services. Knowledge and practice of safe abortion service increasing among those without child. It might because of the want delay born child because of their age or carrier or busy in their own work.

Table 9: Distribution of Respondents by their Gravida

Gravida	Number of Respondent	
	Number	Percent
1	7	7.78
2	28	31.11
3	23	25.56
4	21	23.33
5	6	6.67
6	4	4.44
8	1	1.11
Total	90	100

Source: Field survey 2009

Most of the woman aborted second gravida which is 31.11 percent ,it is followed by third gravida which is 25.56 percent ,23.33 fourth gravida,6.67 fifth gravida,4.44 sixth gravida and 1.11 is eighth gravida respectively.

Most of women want to complete their family. Less no of child allow them for better growth education and further studies and development. Highest number of women aborted second gravida ,out of them most of respondents said that they wanted to practice abortion for birth spacing, but it might be for their sex selective abortion. Seven respondents had aborted first gravida, out of them three were unmarried and one was separated. It might result from modernization and open society. Some respondent said that their husbands were out of the home at the time of abortion. It might be illegal gravida.

Tikapur hospital is situated in eastern part of kailali district in far western region. The population of Tharu community is denser within the coverage of this hospital. After the Tharu, Brahmin Chettri and Thakuri come. Clients of the hospital for the safe abortion service were more number of Tharu. After the Tharu, Brahmin Chettri and Thakuri recived the service. Clients who were literate and above practice the safe abortion service. Husband of the most client were also literate and above. The main source of income of the client and their husband was agriculture. Though the age at marriage of most client was less than 20 (15-19 years) , age at first pregnancy was more then 20 (20-24 years). Educated women married at later age then uneducated women. Most of women reached the hospital to abort their 2nd child for the need of spacing. When they reach the hospital to abort most had 8th week gestation.

4.2 Social and Economic Characteristics

Social characteristics include caste/ethnicity, education and occupation. They are presented below.

4.2.1 Caste of Respondents

The issue of abortion is one of the controversial subjects of the day. The use and knowledge of contraception is depending on caste and religion. This will influence the

act of SAS. Some caste may have belief that abortion of foetus is a sin. The census of 2001 has listed 103 caste/ethnic (social) groups unidentified group in Nepal. Table 1 presented the caste/ethnic group of respondents in this area.

Table 10: Distribution of Respondents by Caste

Caste	Respondents	
	Number	Percent
Tharu	30	33.33
Brahmin	28	31.11
Chhetri	14	15.56
Thakuri	6	6.67
Magar	4	4.44
Dalits	3	3.33
Other	5	5.56
Total	90	100

Source: Field Survey 2009

Majority of the population belongs to Tharu and Brahmin caste. Table 1 shows that largest of the respondents are Tharu which is 33.33 percent and followed by Brahmin caste which is 31.11 percent and third largest number of the respondents are Chhetri which is 15.56 percent .As shown in table 10, 6.67 percent is Thakuri ,4.44 percent is Mager ,3.33 percent is Dalits and 5.56 percent is other caste.

4.2.2 Literacy Status of Respondents

Education is considered as an instrument to change the traditional attitude of an individual towards the modernization. It is one of the most important factor which affect all aspect of human life. Educated people are more conscious for their personal health and their family also community health. So education status of respondents presented in following table.

Table 11 Distribution of Respondent by Literacy Status

Literacy	Respondents	
	Number	Percent
Illiterate	39	43.33
Literate	51	56.67
Total	90	100

Source: Field survey 2009

Most of the respondents are literate. About 57 percent of respondents are literate. From the table about 43.33 percent respondents were illiterate.

4.2.3 Level of Education

Education play vital role for the individual and social living standard of human being. It is one of the most important factors which affect all aspect of human life. Illiterate or lower level education attended person might to-do struggle for their life. Higher level educated person can change their life style and makes their status. Educated person are more conscious then uneducated person for their individual health, so education level is one important factor for safe abortion practice.

Table12: Distribution of Respondent by Level of Education

Education	Respondents	
	Number	Percent
Literate but not schooling	5	9.80
Primary	6	11.76
Lower secondary	10	19.61
Secondary	11	21.57
S.L.C	8	15.69
Certificate and above	11	21.57
Total	51	100

Field survey: 2009

Education is one of the most important factors that directly affect the practice of safe abortion. Table 12 shows that highest number of educated respondent's education level is secondary and certificate and above which is 12.22 percents. Table shows that 5.56 percent respondents are literate, 6.67 percents complete primary level, 11.11 percent complete lower secondary level and 8.89 percent respondents are complete SLC level .Larger number of the respondents are illiterate (43.33 percent).

4.2.4 Husbands Education

Husband's education will play vital role for safe abortion practice. Nepal has a patriarchy society, where males play role in decision making. Even a use of method of contraception by female is decided solely by male. If husband is educated he will be aware of spacing child and delayed the first pregnancy. He will know different method of contraception that is suitable to his family. Because of this the rate of unsafe abortion will decline.

Table 13: Distribution of the Respondent by level of Education of Their Husbands

Education	**Respondents**	
	Number	Percent
Illiterate	16	18.60
Literate but not schooling	7	8.14
Primary	13	15.12
Lower secondary	9	10.47
Secondary	7	8.14
S.L.C	7	8.14
Certificate and above	26	30.23
Don't know	1	1.16
Total	86	100

Source: Field survey 2009

Family education play role in safe abortion practice. The husband with level of education certificate and above has higher practice of safe abortion. There is increasing knowledge and practice of safe abortion according to hierarchy of

education. As shown in tables 4, in the total respondent only 18.60 percent were illiterate and 81.4 percent were literate. Among the literate population, 30.23 percent had certificate level and above, 15.12 percent passed primary level, 10.47 percent passed lower secondary level.

4.2.5 Occupational Status of Respondents

Occupation not only gives a social and economic identification but also determines the hierarchies of the people and the status. It plays vital role in the promotion and protection of individual as well as community health. A women who has engaged in better occupation, has better chance of utilization of safe abortion practice. Safe abortion practice of the clients has also depended on their husband's education level and occupational status. The occupational statuses of respondents are given below.

Table 14: Distribution of Respondents by Occupation

Occupation	Respondents	
	Number	Percent
Agriculture	40	44.44
Housewife	32	35.56
Business	4	4.44
Service	2	2.22
Studies	12	13.33
Total	90	100

Source: Field survey 2009

Table 14 shows that larger numbers of clients are engaged in agriculture, which is 44.45 percents. From the table 35.56 percent of respondents depend in household work.13.33 percent respondents are students, 4.44 percent are engaged in business. The lowest 2.22 percent are depending on services. The largest number of respondents is dependents on agriculture; the respondents engage other then agriculture might have taken service from higher center than local center because of social factor.

4.2.6 Husband Occupation

Husband's occupation plays important role for safe abortion practice. A husband who has engaged in better occupation has better chance for safe abortion practice. Husband's occupation status of respondents is given below

Table 15: Distribution of Respondents by their Husband Occupation

Occupation	**Respondents**	
	Number	Percent
Agriculture	37	43.02
Business	20	23.26
Service	27	31.40
Others	2	2.33
Total	86	100

Source: Field survey 2009

The practice of safe abortion is more among spouse of those husband who are engage in agriculture .It might be because that spouse of those husband do not have knowledge of contraceptive use .The spouse of husband other than agriculture might have taken service from higher center than local center , because of social factor. About 43 percent husband of respondents was involved in agriculture. Where as 31.40 percent were engaged in service, 23.26 percent were engaged in business and 2.33 percent were involved in other services.

CHAPTER –V

KNOWLEDGE AND UTILIZATION OF SAFE ABORTION SERVICE

Abortion is one of the proximate determinant of the fertility, practice of abortion affecting unknowingly affect the level of fertility in particular area. Unsafe abortion is a great health problem in developing countries like Nepal. This chapter deals about knowledge of safe abortion, and use of safe abortion practice in study area .This chapter also deals about knowledge and use of unsafe abortion.

5.1 Knowledge about Safe Abortion.

Abortion in a listed health institution by a listed service provider under the lawful criteria in a will of pregnant woman is safe abortion .Abortion done other then this condition is an unsafe abortion. Those women who knew the safe abortion service told that it is called safe when abortion is done by trained health person.

Table 16: Distribution of Respondents by Knowledge about Safe Abortion

Knowledge about safe abortion	**Respondents**	
	Number	Percent
Yes	27	30
No	63	70
Total	90	100

Source: Field survey 2009

In the study, knowledge of safe abortion is seems not satisfactory. Table 16 shows that only 30 percent respondents are reported as they have knowledge about safe abortion. Seventy percent clients are unknown about safe abortion. Most of respondents came in hospital and private clinic for abortion service by the help of their husband and FCHW.

5.2: Knowledge and Level of Education

Education play vital role for gain knowledge about safe abortion. Educated person get knowledge from different sources such as, book, newspaper group discussion. Educated person are more care then uneducated person about their physical and mental health.

Table 17: Knowledge of Safe Abortion by Level of Education

Education	Knowledge about safe abortion					
	Yes		No		Total	
	No.	Percent	No.	Percent	No.	Percent
Illiterate			39	100.0	39	100
Literate but not schooling	2	40.0	3	60	5	100
Primary	-	-	6	100.0	6	100
Lower secondary	4	40.o	6	60.0	10	100
Secondary	4	36.36	7	63.64	11	100
S.L.C	7	87.50	1	12.50	8	100
Certificate and above	10	90.91	1	9.09	11	100
Total	27	30.0	63	70.0	90	100

Source: Field survey 2009

Even an illiterate women took safe abortion service, they are unaware of knowledge of safe abortion service .They are being informed and counseled by female health worker and friends /relatives. Women with studying S.L.C and above know about safe abortion service then other women. Table 17 shows that most of the illiterate respondents do not have knowledge about safe abortion. About 63.64 percent of respondent having secondary level education do not have knowledge about safe abortion.

5.3: Knowledge and Occupation

Occupation makes change the life style of persons. Occupation also play vital role for knowledge about safe abortion. It plays vital role in the promotion and protection of

individual as well as community health .A women who has engaged in better occupation, has better chance of utilization of safe abortion practice.

Table 18: Knowledge of Safe Abortion by Occupation

Occupation	Knowledge about safe abortion				Total	
	Yes		No			
	No.	Percent	No.	Percent	No.	Percent
Agriculture	2	5.0	38	95.0	40	100
House wife	11	34.38	21	65.63	32	100
Business	3	75.0	1	25.0	4	100
Service	2	100.0	-	-	2	100
Study	9	75.0	3	25.0	12	100
Total	27	30.0	63	70.0	90	100

Source: Field survey 2009

Table 18 shows women working at out of home environment know about safe abortion practice then women who are engaged in agriculture and housewife. Ninety percent respondents who have been engaged as farmer do not have knowledge about safe abortion. Only 34.38 percent housewife are aware from safe abortion .The respondents who are studying have knowledge about safe abortion practice.

5.4 Knowledge about Unsafe Abortion

In the study knowledge of unsafe abortion is seems satisfactory than the knowledge about safe abortion service .Women heard about complication of unsafe abortion, but they do not know about fact meaning of safe abortion service. Unsafe abortion refer to done abortion by unlisted person or at unlisted site or against the will of woman or with out fulfilling the lawful criteria.

Table 19: shows that, few of illiterate women also know about unsafe abortion but they do not know fact of safe abortion. Table shows that having higher education of women has knowledge about unsafe abortion. 100 percent of the respondents having education S.L.C and above are known about unsafe abortion. Level of education

affect the knowledge of practice of unsafe abortion and their complication. Study shows that respondents have knowledge about unsafe abortion then the knowledge about safe abortion practice .53.33 percent of respondents are known about unsafe abortion.

Table 19: Knowledge of Unsafe Abortion by Education level

Education	Knowledge about Unsafe abortion					
	Yes		No		Total	
	No.	Percent	No.	Percent	No.	Percent
Illiterate	10	25.64	29	74.36	39	100
Literate but not schooling	3	60.0	2	40.0	5	100
Primary	1	16.67	5	83.33	6	100
Lower secondary	7	70.0	3	30.0	10	100
Secondary	8	72.73	3	27.27	11	100
S.L.C	8	100	-	-	8	100
Certificate and above	11	100	-	-	11	100
Total	48	53.33	42	46.67	90	100

Source: Field survey 2009

5.5 Occupations and Knowledge of Unsafe Abortion

Occupation not only gives a social and economic identification but also determines the hierarchies of the people and the status. It plays vital role in the promotion and protection of individual as well as community health.

Table 20 shows the knowledge about unsafe abortion according to respondents occupation .Table shows that, all the respondents who are engaged in service and study have knowledge about unsafe abortion .77.5 percent respondents who have been engaged as agriculture do not have knowledge about unsafe abortion .75 percent of house wife have knowledge about unsafe abortion .About 75 percent women who engaged in business haven’t knowledge about unsafe abortion.

Table 20: Knowledge of Unsafe Abortion by Occupation

Occupation	Knowledge about Unsafe abortion				Total	
	Yes		No			
	No.	Percent	No.	Percent	No.	Percent
Agriculture	9	22.5	31	77.5	40	100
House wife	24	75.0	8	25.0	32	100
Business	1	25.0	3	75.0	4	100
Service	2	100.0	-	-	2	100
Study	12	100.0	-	-	12	100
Total	48	53.33	42	46.67	90	100

Source: Field survey 2009

5.6 Effect of Unsafe Abortion Practice

Immediate effect of unsafe abortion are; incomplete abortion, bleeding, infection, trauma in local parts, perforation of uterus and viscera. These complication leads to need of more extensive surgery e.g. hysterectomy, exploratory laparatomy. Late complications are lower abdominal pain, infertility, mental and social problem. Some of the complication may leads to death.

Table 21: Distribution of Respondents by Knowledge about Effect of Unsafe Abortion Practice

Effects	Respondents	
	Number	Percent
Weakness	19	39.59
Death	4	8.33
Infertility	12	25.0
Heavy bleeding	13	27.08
Total	48	100

Source: Field survey 2009

Table 21 shows that, the client who knows about the effect of unsafe abortion focus on weakness, heavy bleeding and infertility. 39.58 percent of respondents focus on weakness, 27.08 percent has focus on heavy bleeding. In reality heavy bleeding, infertility and weakness are major risk for unsafe abortion.

5.7 Knowledge of Legal Process of Abortion

In Nepal abortion is legalized after 2002 .According to law, pregnancy below 12 weeks every woman has choice to abort is legal process of abortion. In case of incest, rape or possibility of physical and mental trauma to women or possibility of severe congenital disorder it could be done below 18 weeks. On study the question was asked “Does abortion is legal in Nepal ?” that response was “Yes” or “No” , if yes the question was “Do you know about abortion act launched by government in recent year?” these were the two question to know about legal abortion.

Table 22: Distribution of Respondents by Knowledge about Legal process of abortion

Know about legal process	Respondents	
	Number	Percent
Yes	19	21.11
No	71	78.88
Total	90	100

Source: Field survey 2009

About 78.88 percent of respondents do not know about legal process of abortion. Only 21.11 percent of clients are heard about legal process.

5.8 Knowledge about Abortion Process

There are two types of abortion process-spontaneous and induced. Spontaneous means the expulsion of an embryo or fetus due to accidental trauma or natural cases before approximately the 22 weeks gestation. In case of Nepal it is consider 28 weeks. Induced abortion is a process by which pregnancy is terminated either medical or surgically before fetus is viable. Abortion provided by the listed trainees personnel’s in the listed site in hygienic way is safe abortion.

Table 23: Distribution of Respondents by Knowledge of Type of Abortion Process

Type	Respondents	
	Number	Percent
Spontaneous	2	2.22
Induced	11	12.22
Both	77	85.56
Total	90	100

Source: Field survey 2009

Table 23 shows that most of the clients knows about reality of abortion which could be due to spontaneous or induced.

5.9 Use of Safe Abortion Site of Service Available

The public are aware about safe abortion site by trained manpower .The reach of Hospital Service is increasing to the public. Those reaching clinic are also reaching to the most believable clinic.

Table 24: Distribution of Respondents by Safe Site of Safe Abortion service available

Place of abortion	Respondents	
	Number	Percent
Hospital	59	65.56
Clinic	31	34.44
Total	90	100

Source: Field survey 2009

Table 24 shows that 65.56 percent of clients choose the hospital for safe abortion practice and 34.44 percent of clients choose the clinic for safe abortion.

5.10 Causes to Choose Hospital for Abortion

Here hospital refers to Tikapur hospital, a legal institution recognized by government of Nepal. This hospital is listed for safe abortion service site. There are 1 doctor and 1 staff nurse listed in safe abortion service provider.

Table 25: Distribution of Respondents by Their Causes to choose Hospital for Abortion

Cause for choice	Respondents	
	Number	Percent
Legal Institute	15	25.44
Trusty	11	18.64
Cost effective/Cheap	25	42.36
Other	8	13.56
Total	59	100

Source: Field survey 2009

Even though the clients know about safe site of abortion they are focusing to the site with cost effective .Cost is more priority then the legal institute and trust worthy. 42.36 percent respondents choose the hospital for abortion practice, because of being cheap then other site for abortion. Above table shows that 25.44 percent clients choose in Hospital being for legal institute. About 19 percent choose hospital because of trusty institute.

5.11Causes to Choose Clinic for Abortion

Here clinics refer to private clinic in Tikapur municipality where service is provided by listed doctor and nurse. Client may choose the clinic for the secrecy and fast service.

Respondents reaching clinic want more secrecy. There is still a taboo in society that women should not do abort .They do not want to expose with society .They also want extra care than government hospital. Table 26 shows that 58.08 percent of clients choose the clinic for secrecy. About 32 percent clients choose clinic for more care at the time of abortion.

Table 26: Distribution of Respondents by their Causes to choose Clinic

Cause for choice	Respondents	
	Number	Percent
Secrecy	18	58.08
More care	10	32.26
Other	3	9.68
Total	31	100

Source: Field survey 2009

5.12 Source of Information

Clients of safe abortion service need the information from any source to reach the service site. If they got the right information, they will reach the safe abortion service site. Some of the client may got wrong information and they will be the victim of quack of the village and suffer from the different complication.

Table 27: Distribution of Respondents by Source of Information of Safe Abortion Service Site

Source	Respondents	
	Number	Percent
Newspaper/Book	2	2.22
Health person/Community Female health worker	29	32.22
Health institute	13	14.44
Friends/Relatives	26	29
Husband	13	14.44
Self	3	3.33
Other	4	4.44
Total	90	100

Source: Field survey 2009

Community female health worker and health person are important in providing information of safe abortion service. Country needs to train for community female

health worker and health person for better result. Table 27 shows that around 29 percent of clients are get information about safe abortion service site from their friends and relatives. About14.44 percent clients have known from health institute and14.44 percent know from their husband.

5.13 Cause of Abortion

Nepal is patriarchal society. Many people give important towards male child then female child, so son preference (sex preference) is root cause of abortion practice. Women seem interested to abort second or third gravida, whether they have at least one or two female child. Because of societies going on modernization and legality of abortion, there might be increasing rate of abortion. Women may not use contraceptive methods because they might have unmet need of contraceptive or not being counseled properly. There are many cause of abortion, which is given in table no 28.

Table 28: Distribution of Respondents by Cause of Abortion

Cause of Abortion	Respondents	
	Number	Percent
Unwanted pregnancy	61	67.78
Physical problem	4	4.44
Sex selective abortion	15	16.67
Other	10	11.11
Total	90	100

Source: Field survey 2009

The practice of safe abortion service is usually for unwanted pregnancy which may lead to failure of family planning or not knowing of contraception. Table 28 shows that 67.78 percent of respondents have got unwanted pregnancy. 16.67 percent of abortion is sex selective. Our society is patriarchal till now, so women have forced to abort .Table28 shows that only 4.44 percent abortion have physical problems.

5.14 Cause of Unwanted Pregnancy

Women comes to the site of abortion to abort because either they do not know the role of contraception or they do not use it even they knew it or in some case failure of

contraception or tear of condoms. They want spacing for their preparedness for next child. The born child gets mature in next few years.

Table 29: Distribution of Respondents by Cause of Unwanted Pregnancy

Cause of Unwanted Pregnancy	Respondents	
	Number	Percent
Contractive failure	26	42.62
Not use Contraceptive	30	49.18
Other	5	8.20
Total	61	100

Source: Field survey 2009

Above table shows that unwanted pregnancy leads to contraceptive failure and not use means of contraceptive .Table no. 29 shows that 49.18 percent unwanted pregnancy conceive from not use family planning method, 42.62 percent of unwanted pregnancy having failure of family planning method. Out of Higher failure of family planning is condom which is 75 percent and 25 percent are other method.

5.15 Cause of Not Using Family Planning Method

Women may not use the contraception because they might have heard about possibility of side effect or do not heard about it or not being counseled properly**.**

Table 30: Distribution of Respondent by Cause of Not Use Family Planning Method

Cause of Not Using Method	Respondents	
	Number	Percent
Side Effect	9	30
Fear from Contraceptive	1	3.33
Not available	2	6.67
Do not know about method	13	43.33
Other	5	16.67
Total	30	100

Source: Field survey 2009

Table 30 shows that 43.33 percent of respondent do not use contraception, who haven't know about family planning method,30 percent respondents are suffer from side effect of contraceptive method . About6.67 percent are unmet need of family planning and 3.33 percent of clients are fear from the contraception method. The government policy to strength the knowledge of contraceptive should increase. Most of women still don't know method of contraception .Those who knows it also does not know in detail. They are only focus for side effect.

5.16 Use Method for Abortion

Women have right to choice the method for safe abortion service. Medical method could be applied for 9 weeks and surgical for any weeks of gestation. Available medicine that is legalized is mifepristone and misopristol. In surgical available method is manual vacuum aspiration.

Table 31: Distribution of Respondent by Use Method for Abortion

Method	**Respondents**	
	Number	Percent
Medicine/medical	36	40
Surgical	54	60
Total	90	100

Source: Field survey 2009

Table 31 shows that the respondent chooses method for abortion. Most of women are choosing surgical than medical, because by surgical method completion can be conformed on the spot. By medicine she should follow up at regular interval for 14 days. Above table shows that 60 percent women choose surgical method and 40 percent of clients choose medical method for abortion.

5.17 The Attendant Persons

Persons attending the respondent at the service site are important in respect to counseling , future use of contraception, post procedure care and to attend to further referral centre in case of any serious complication at the time of procedure**.**

Table 32 shows that 90 percent respondents are come with help person in the time of abortion. 75.31 percent come with their husband, 16.05 percent clients have come with friends and relatives and 7.41 percent come with their father in law and mother in law.

Table 32: Distribution of Respondent by the Attendant Persons

Attendant person	Respondents	
	Number	Percent
Husband	61	75.31
Father/mother in law	6	7.41
Friends/Relatives	13	16.05
Other	1	1.23
Total	81	100

Source: Field survey 2009

5.18 Use Safe Abortion Practice before then now

Women may abort for more than one time for different reason. This might be because of failure or not use of contraception or other reasons.

Table 33: Distribution of Respondent to use Safe Abortion Practice before then now

Use or Not	Respondent	
	Number	Percent
Yes	9	10
No	81	90
Total	90	100

Source: Field survey 2009

Table 33 shows that only 10 percent clients are use safe abortion practice before the survey time.

5.19 Use of local Method at Home for abortion

Women may use different method for induced abortion at home for fear of hospital method or shyness to face in institution. They might have motivated by local quack about the local septic method as method of choice done at home. Some might use local herbs locally or some other eatable and non-eatable substances. These substances play a vital role in septic abortion and abortion related complication.

Table 34: Distribution of Respondent to Use Home Method for Abortion

Method use	Respondent	
	Number	Percent
Yes	4	4.44
No	86	95.56
Total	90	100

Source: Field survey 2009

Table 34 shows that only 4.44 percent respondent use local method for abortion. Some called use wooden in the cervix and some called eat herbs for abortion.

5.20 Use Family Planning Method in Future

Failure of contraception or not use of contraception is a vital role in develop an unwanted pregnancy. Some might lack the continuity of contraception because of possible side effect resulting in an unwanted pregnancy. Now they may want to use contraceptive method. Table 35 Distribution of Respondent by want to use Family Planning Method in future.

Table 35: Distribution of Respondent by their Interest to Use Contraception in Euture

Want to Use or Not	Respondent	
	No	%
Yes	80	88.89
No	10	11.11
Total	90	100

Source: Field survey 2009

Table 35 shows most of the respondents want to use family planning method in future for control birth and birth spacing

5.21 Choice of Family Planning Method

To avoid future unwanted pregnancy respondent need to use either temporary or permanent method of contraception. Vasectomy for male and minilap for female are the method of permanent sterilization. Many hormonal, non hormonal and barrier method are available as method of temporary contraception. They need counseled about different method of contraception that is suitable to their pair. They can choose any method of contraception available i.e. right to choice.

Table 36: Distribution of Respondent by choice of Family Planning Method

Method of Contraception	**Respondents**	
	Number	Percent
Dipo	30	37.5
Pills	12	15.0
Vasectomy	4	5.0
Minilaparatomy	10	12.5
Condom	3	3.75
Norplant	9	11.25
Cupper-T	5	6.25
Other	7	8.75
Total	80	100

Source: Field survey 2009

Since family planning method are explained during the process counseling of safe abortion service, the most of respondents are interested in use of future family planning method .Most of women wants to use dipo pills and Norplant on their choice for contraceptive method. 37.5 percent respondents wants to use dipo, 12.5 percent women want to use permanent method minilaparatomy. Only 5 percent respondents husband are wants to do use vasectomy.

Most of the respondent do not know completely about safe abortion but are aware of some type of effect of unsafe abortion. Literate and above women and women involved in business service and student are aware of safe abortion and know the legal

process. They are known about type of abortion and choose hospital for cost effective and clinic for secrecy. Most of the respondents are aware for weakness and bleeding as an effect of unsafe abortion. Many respondents heard about site from female community health worker and came to the service site with their husband. This unwanted pregnancy resulted from lack of knowledge of contraception method but now they know it and want to use depo provera as their choice.

Since legalization for abortion there is a trend of practicing of safe abortion service at site safe site of by a trained manpower .In the time when there was no legalization, it used to be done by illegal process. According to the health staff of Tikapur Hospital, before the legalization, people came in sepsis hemorrhage trauma to private part because of unnatural object plumed in cervix. There was also trend of doing abortion by putting red-ht object at abdomen. They also put some medical and toxic herb inside vagina and wooden object inside cervix.

This all process are decreasing. Today usual trend is that those who are educated and know about safe abortion services do safe abortion for spacing or delay child.

CHAPTER –VI

SUMMARY, CONCLUSION AND RECOMMENDATION

6.1 Summary

This dissertation is case study of the situation of safe abortion practice in Tikapur municipality, Kailali. The study is based on some selected dependent and independent variable and they are primary in nature. The major finding of the study is as follows.

- Total number of respondent of study area was 90.
- Average number of respondent size found to be 33.33 percent Tharu, 31.11 percent Brahmin, 15.56 Chhetri, 6.67 percent Takuri, 4.44 percent Magar, 3.33 percent Dalits, and 5.56 percent other caste.
- In the study out of 90 respondent 43.33 percent were illiterate and only 12.22 percent were obtaining certificate level and above level of education.
- Most of the respondent involved in agriculture, which was 44.44 percent. About 35.56 percent were housewife and 13.33 percent involved in study.
- In the studies found that 3.56 percent was age between 15-19 uears,34.44 percent 20-24,36.67 percent 25-29, 12.22 percent 30-34, 6.67 35-39 year and only 4.44 percent respondent were age 40 years and above.
- Most of the respondents were currently married which was 95.56 percent.
- In this area 3.45 percent mean age at marriage was under 15 years, 54.02 percent 15-19, 39.08 20-24 and 3.45 were not stated.
- It was found that, 53.58 percent illiterate respondents got marriage at age 15-19 years.Higher level educated respondents married in age between 20-24 years.
- Majority of the respondents age at first pregnancy was 20-24 years, which was 53.33 percent, 43.33 percent was conception first pregnancy at age between 20-24 years and 3.33 percent was not stated.

- Most of the respondent's CEB was 2 which were 33.33 percent. About 31.11 percent had 1 CEB.
- The pick age of gestation for abortion found that 8 weeks, which was 26.67 percent. About 16.67 percent had 7 weeks, 14.44 percent had 6 weeks.
- Most of the respondent aborted second gravida, which was 31.11 percent . about 26 percent was third and 23.33 percent was found fourth gravida.
- In this studies found that 70 percent respondents hadn't known about meaning of safe abortion. Only 30 percent respondents had known about safe abortion practice.
- About 62.96 percent higher level educated respondents had known about safe abortion practice.
- Respondent depend on agriculture hadn't known about SAS, 75 percent respondent who were studying had knowledge about SAS.
- About 53.33 percent respondent known about effect about unsafe abortion.
- Only 21.11 percent respondent had known about legal process of abortion.
- Most of respondent choose hospital for abortion, which was 65.56 percent and 34.44 percent was choose private clinic for abortion.
- In study found that most of the respondent got information about SAS site from the CFHW, which was 32.22 percent.
- Majority of the respondent aborted by cause of unwanted pregnancy, which was67.78 percent and 16.67 percent sex selective abortion.
- Most of the respondent chooses surgical method for abortion, which was 60 per cent.

6.2 Conclusion

On the basis of data analysis, safe abortion practice in Tikapur municipality Kailali found in various result. The study shows that most educated and respondent involved in business and other service know about safe and unsafe abortion.

All caste women practice the safe abortion. They are going to the hospital not for safe purpose but for cost-effective. But people are slight aware of some effect of unsafe abortion.

There is family support for those women and they are now motivated and being counseled for future use of contraception.

Most women want spacing and delayed the next child to born. There are still societies who want sex determined abortion for the need of male child.

Women choose the surgical method for fast recovery and medical for cheap. They reach hospital for cost effective even and clinic for secrecy.

Even single/unmarried women who become pregnant due to various reason are practicing the safe abortion. Since there more Tharu community in the municipality, the Tharu women are practicing the SAS. There is still trend in using local home made technique and material for abortion purpose.

The NDHS shows that about one third of pregnancies are unplanned. Women often seek abortion under such circumstances. Despite the legalization of abortion, complication of unsafe abortion is responsible for many maternal deaths. Thus a safe abortion service is considered as the central part of maternal reproductive health to reduce maternal death.

6.3 Recommendation

The prevailing maternal mortality due to complication of abortion is the multiple reason of socio-economic educational demographic and psychological factors. To achieve the target factor of eleventh three year interim plan on maternal mortality on, along with other safe motherhood programs, some suggestion related to safe abortion recommended to the policy makers, planners Gos/NGos and local authorities for implementation.

6.3.1 Recommendations for policy implication

On the basis of the conclusion the recommendation for policy implication and future area of research are suggest as follows:

- Awareness raising programs about maternal health education of female should launch to increase the education level of women.
- IEC programs should be conducted related to abortion to make people aware about legal process abortion and safe abortion practice in Nepal.
- Abortion counseling should be given to the reproductive age's women along with the family planning counseling.
- Media should be promoted to give the well information about the condition of legal abortion practice as well as other aspect of abortion.
- The training of safe abortion service and post abortion care should be given to all health personal who are working in the local level health institution.
- MCHV, CFHW and other health person should be trained to give good counseling about the advantage of safe abortion.
- Easy cheap and reliable safe abortion service center should be establishing at least one in every district hospital.
- Counseling programs related to the safe abortion should be organized through the mother group and youth groups which are active in every ward of V.D.C and municipality.
- Abortion related questionnaire should be includes in NFHS, NDHS and national population census to collect the standard national level data.

6.3.2 Recommendation of future area of research

Due to the lack of scientific and reliable research about abortion, there seems to be various problems related to safe abortion practice and safe motherhood. Researchers who are interested to study the safe abortion practice in this area in the future, following are some recommendation for them:

- This study only examined few selected socio economic variables, thus
- Further studies might include other variables such as culture, income etc.
- Study should be including whole district in future.
- National level survey should be conducted.
- To find out various facts related to abortion should be studied separately.

REFERENCES

Central Bureau of Static (CBS), 2002, Population of Nepal, *“Far Western Development Region”,* (Kathmandu: CBS)

CREHPA, (2009), *Medical Abortion in Six Pilot Districts of Nepal Implementation Result.* (Kathmandu: CREHPA).

Dutta, D.C. et al, (2002), *Test Book of Obstetric*, (Kolkotta: New Centre Book Agency).

Elsevier, (2009), *Abortion Practice in world,* December, 2009, www.elsevier.com 2009.

Forum for Women, Law and Development (FWLD), 2003, “*Struggle to Liberalize Abortion in Nepal: Challenges Ahead”* (New York: FWLD).

Guttmocher Policy Review, (2007).Volume 10, November 4.

IPAS, (2003),“ *Nepal achieves Milestone in Safe Abortion”.* (Kathmandu: CREHPA).

Karki,Chanda,(2008), “*Acceptability and feasibility of medical abortion in Nepal”.* International Journal of Gynaecology and Obstetrics.

Kathmandu University Medical Journal, (2005).*Vol 3 No.3 Issue 11, page225-229* International Journal of Gynaecology and Obstetrics.

Ministry of Health (MOH),1998, *Maternal mortality and Morbidity Study* (MMMS 1998); Kathmandu: MOH,Nepal)

Ministry of Health (MOH), 2004, Annual *Report 2002/03* (Kathmandu: MOH, Department of Health Services.)

Ministry of Health (MOH), 2007, *Annual Report 2006/2007*, (Kathmandu: MOH, Department of Health Services, Nepal)

- Ministry of Health (MOH), 2007, *Reproductive Health, Clinical Protocol,* (Kathmandu: MOH, Department of Family Health Division, Nepal)
- Ministry of Health (MOH), 2008, Journal *of Nepal Health Research Council, vol 6,* Kathmandu: MOH, Department of Health Service.)
- Ministry of Law and Justice, (1963), *Muluki Ain*, *2020(Legal Code, 1963), (*Kathmandu: Ministry of Law and Justice)
- Rosenthal, Elisabeth (October 2007), "*Legal or Not, Abortion Rates Compare*".
- *New York Times*. http://www.nytimes.com/2007/10/12/world/12abortion.html.
- Retrieved 2009-30-6.
- Sturely, A,(1998), "*Perception of Contraception in Rural area Nepal",* Unpublished
- PhD, Dissertation, (Hawail: University of Hawail, USA).
- Tamang, A and B Nepal, (2000), *Unwanted Pregnancy, Sex Determination Test and*
- *Sex Selective Test and Sex Selective Abortion in Urban Area of Nepal:* Medical Practitioners Perspective (Kathmandu: CREHPA).
- Thapa, P.J. Thapa,S. And Shrestha,N.(1992), *A hospital based study of abortion in Nepal studies in Family Planning*, 23(5),311-318.
- The Alan Guttmacher Institute (AGI),2003, *Addressing The Sexual and Reproductive Health Need of Men World Wide* (New York : AGI).
- The National Policy (MOH), July 2003: *Statement of Comprehensive abortion Care* (CAC) Services, (Kathmandu: Nepal)
- United Nations (UN), (1992), *Abortion policies:* A Global Review, Vol. I (New York: UN).
- (2001,) *Abortion policies:* A Global Review, Vol. I, II and III (New York: UN).

- (1996), *Programme of Action: Adopted at the ICPD,* Cairo, 5-13 September 1994 (New York:UN).
- Upreti, A, A, Tamang, B Nepal and R Gurung,*(*1999). *Management of Abortion Related Complication in Hospital of Nepal: A Situation Analysis (*Kathmandu : CREHPA).
- Vadiya, A and Giri, (2008), "*An Unsafe abortion a Neglect Tragedy*." Journal of Nepal
- Health Research Council, 2008 (Kathmandu: Nepal)

- Wikipedia, (2010), Safe *Abortion Practice*, February 2010 www.id21.org.com
- January 4, 2009.
- World Health Organization (WHO), 1995, *Complication of Abortion*: *Technical*
- *and managerial guidelines for prevention and treatment (*Geneva.WHO)
- World Health Organization, (WHO), 2010*, Reproductive health and unsafe abortion,*
- from http://www.who.int/reproductivehealth/topics/unsafe_abortion/en/index.html

QUESTIONNAIRE

SECTION A: INTRODUCTORY QUESTION

1. Name of the respondent:
2. Address:

   District:

   VDC/ Municipality:
3. Caste/Ethnicity:
4. Religion:

SECTION B: Respondents Background

Question no.	Questions	Coding category	skip
1.	How old are you?	Complete age …….	
2.	Are you literate?	Yes………………1 No……………......2	→
3.	What is your education level?	Complete level…….	
4.	What is your occupation?	Studies……………1 House wife………..2 Agriculture………..3 Business…………..4 Service…………….5 Other(specify)……..6	
5.	What is your marital status?	Unmarried…………1 Currently married….2 Single……………...3 Widow ……………4 Divorce……………5 Separate…………...6	

6.	If currently married, what is your husband education level?	Uneducated……….1 Primary……………2 Lower secondary….3 Secondary level……4 S.L.C. ……………..5 Certificate…………6 Bachelor…………...7 Masters…………….8 Others(specify)…….9	
7.	What is your husband occupation?	Agriculture…………1 Business…………….2 Service ……………..3 Other(specify)……….4	
8.	When did you get married?	…………………….	
9.	How old are you when you got married?	Complete age………	

Section C: Reproduction

Question no.	Questions	Coding category	Skip
1.	What is your gravida?	1st…………………………………..1 2nd…………………………………2 3rd…………………………………..3 4th…………………………………..4 Other (specify)…………5	
2.	How many child do you have?	No. of son ……………1 No. of daughter…………2	
3.	Have your child died?	Yes……………………...1 No………………………2	
4.	If yes, how many child died?	No. of dead child……	

5.	How old are you when you become pregnant for first time?	Complete age……….	

SECTION D: CONCEPT AND KNOWLEDGE ABOUT SAFE ABORTION SERVICE

Question No.	Questions	Coding category	Skip
1.	Do you know about safe abortion service?	Yes…………………………1 No…………………………2	→ 3
2.	If yes, what do you know about safe abortion service?		
3.	From which source do you know about safe abortion service site?	T.V/ radio…………………1 Book /Newspaper………….2 Health person………………3 Health institute……………4 Friends/Relative……………5 Other(specify)………………6	
4.	Do you know about the effect of unsafe abortion?	Yes…………………………1 No…………………………2	
5.	If yes what are the effect of unsafe abortion?	Death………………………1 Weakness…………………..2 Infertility……………………3 Other (specify)……………4	
6.	What type of abortion do you know?	Spontaneous………………1 Induced……………………..2 Both…………………………3	
7.	Does abortion is legal in Nepal?	Yes…………………………1	

		No……………………….2 →	9
8.	If yes, do you know about abortion act launched by government in recent years?	Yes……………………….1 No……………………….2	
9.	what type of service is needed for safe abortion service in your openion?		
10.	In your view, where is the safe site for safe abortion services?	Home ……………………1 Hospital ………………….2 Private clinic ……………….3 Meries stops………………..4 Don't know ………………5 Other (specify) …………….6	
11	If say, hospital why you choose the hospital for safe abortion services ?	Legal institution …………..1 Trusty ……………………..2 Cheap/cost effective……….3 Other (specify) ……..……..4	
12	If say, private clinic why you choose the private clinic for safe abortion service site?	Secrecy…………………….1 More care………………….2 Other(specify) …………….3	

SECTION E: USE OF SAFE ABORTION SERVICES

Question no.	Questions	Coding category	Skip
1	Did you practice abortion earlier?	Yes…………………….1 No…………………….2 →	9
2	If yes, how many times did you	Episode………………	

	practice?		
3	When did you have abortion last time?	Months before…………	
4	Where had you go to practice abortion?	Home…………………1 Hospital ………………..2 Clinic…………………….3 Other(Specify)…………4	
5	Who help you aborted?	Doctor………………..1 Nurse ………………2 Other (Specify)…………3	
6	What method of abortion was applied?		
7	How did you feel about proficiency of service provider?	Satisfactory ……………1 Not satisfactory…………2 Other (Specify)…………3	
8	Was there any side effect after abortion?		
9	Do you want to say anything about safe abortion service available in your neighbors?		
10	Why do you want to aborted?	Unwanted pregnancy ……1 Physical problem ………2 Other (Specify)…………3	
11	If unwanted pregnancy how concept it?	Failure of contraceptive….1 Not use contraceptive……2 Other (specify)…………3	→ 13
12	If failure of contraceptive, which		

	method use for contraception		
13	Why did not use any method of contraceptive?	Side effect……………….1 Fear from contraceptive…2 Unmet need ……………3 Other (specify)…………4	
14	How long your gestation?	Four weeks………………1 Five weeks………………2 Six weeks………………3 Eight weeks ……………4 12 weeks…………………5 Other (specify)…………6	
15	Do you know the method of abortion?	Yes ………………………1 No………………………2	
16	Which method do you want to use for abortion	Medicine…………………1 Surgery…………………2	
17	If choose medicine why choose medicine for abortion?	Surgical may make injury……………………1 Fear to do surgical………2 Other (specify)………….3	
18	If choose surgical, why choose surgical for abortion?	More secret then medicine………………..1 Difficulty in use of Medicines………………2 Other (specify)…………3	
19	Anybody help to you for a abortion?	Yes ……………………..1 No……………………….2	

20	If yes, who helps for you?	Husband…………………1 Father /mother in law……2 Other (specify)…………..3	
21	Have you use any method for use abortion at home?	Yes………………………1 No……………………….2	
22	If yes which method use at home for abortion?		
23	Do you want to check-up after abortion practice?	Yes ………………………1 No………………………..2	
24	If no, why don't want check-up after abortion?	Want to rest at home ……1 Other (specify)…………………2	
25	Do you want to use any family planning method in future?	Yes………………………1 No……………………….2	
26	If yes, which method you want to use?	Depo……………………..1 Pills………………………2 Vaxctomy………………..3 Minilap…………………..4 Condom…………………..5 Norplant…………………6 Cupper-T…………………7 Other (specify)…………...8	
27	What feedback do you get from this health institution?	Good…………………….1 Bad……………………….2 Other (specify)…………...3	

28	Please, specify any weak of this institution		

Thank you