Centre for International Health

Adequate Access to Contraception and Sexual and Reproductive Health (SRH) Information Post-Abortion: A Case Study from Nepal

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This thesis is presented for the Degree of
Doctor of Philosophy
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DECLARATION

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made.

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007), updated March 2014. The proposed research study received human research ethics approval from the Curtin University Human Research Ethics Committee (EC00262), Approval Number HR #17/2014 and the Nepal Health Research Council, Approval Number # 20/2014.

Claire Ellen Rogers

18 December 2018

"Please don't forget us. Please share our stories."

The parting comment of a research participant at the end of her interview
April 2016

Sexual and Reproductive Health and Rights are Human Rights

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DEDICATION

For Erin

who taught me how to fight the good fight

ABSTRACT

Of the 55.7 million abortions that occur worldwide each year, 30.6 million (54.9%) are safe, and 25.1 million (45.1%) are considered unsafe. Of the unsafe abortions occurring annually, 24.3 million (97%) occur in developing countries. Since the legalisation of abortion in Nepal in 2002 and the availability of medical abortion in 2009, Nepal has demonstrated significant progress in the expansion of safe abortion and family planning services. However, a significant number of women continue to access unsafe abortions in the country. An estimated 60% of all abortions performed in 2014 were unsafe, with unsafe abortion continuing to be a leading contributor to maternal mortality. Despite medical abortion access being solely permitted through government accredited safe abortion services, medical abortion pills are readily available for illegal purchase at pharmacies throughout the country.

Efficient and equitable access to high quality safe abortion services as well as effective and culturally appropriate post-abortion care is essential for positive health outcomes for women and for the prevention of future unintended pregnancies. However, in Nepal, women accessing medical abortion through pharmacies do not systematically receive any form of abortion care or support such as: adequate information regarding the administration of medical abortion pills, sexual and reproductive health (SRH) information, family planning and contraceptive counselling, post-abortion contraception; or effective and timely health care referral.

This qualitative, exploratory study conducted 29 in-depth open-ended interviews in the Kathmandu Valley and Sunsari District of Nepal to explore and examine the post-abortion experiences of Nepali women, and their access and uptake of safe abortion services; unsafe abortion; post-abortion contraception; and sexual and reproductive health information. Research participants included a cross-section of Sexual and Reproductive Health and Rights (SRHR) professionals; women who accessed medical abortion through an accredited safe abortion service; and women who accessed illegal and unsafe medical abortion through pharmacies.

This study utilised an Assets Focused Rapid Participatory Appraisal research methodology underpinned by a health information pyramid conceptual framework, referred to as an Assets Focused Rapid Participatory Assessment Cycle. The research design was grounded in the desire to utilise community recognised assets to support outcomes and recommendations as well as to base the research within a positive and participatory context that ensured culturally sensitive and contextually rich data collection.

Thematic content analysis revealed emerging themes relating to barriers to access and uptake of high quality safe abortion services, comprehensive family planning counselling and post-abortion contraception as well as the decision-making when seeking safe or unsafe medical abortion. Findings emphasised the interconnectivity of sexual and reproductive health and rights; gender discrimination; reproductive coercion; education; poverty; geographical isolation; spousal separation; and women's personal, social and economic empowerment.

Effective and ongoing sector-wide monitoring and evaluation of safe abortion services and their staff is essential if women in Nepal are to have adequate access to safe abortion services and post-abortion care as well as to ensure countrywide adherence to the current Safe Abortion Policy. While barriers to safe abortion services persist, so will the continued demand for medical abortion provision through pharmacies. Innovative and effective harm reduction implementation combined with medical abortion access and information expansion strategies offer the potential to increase access to safe medical abortion while decreasing adverse health outcomes for women.

LIST OF INCLUDED PUBLICATIONS AND MANUSCRIPTS

PUBLISHED PAPERS

Rogers, C., & Dantas, J. A. R. (2017). Access to contraception and sexual and reproductive health information post-abortion: a systematic review of literature from low- and middle-income countries. *Journal of Family Planning and Reproductive Health Care, 43*(4), 309-318. doi:10.1136/jfprhc-2016-101469

Rogers, C., Sapkota, S., Tako, A., & Dantas, J. A. R. (2019). Abortion in Nepal: perspectives of a cross-section of sexual and reproductive health and rights professionals. *BMC Women's Health, 19*(40). doi:10.1186/s12905-019-0734-1

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NON-PEER REVIEWED PUBLICATIONS

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Rogers, C., (March 2016). The Amazing Women and Girls of Nepal. *Goanet-Femnet: An online network for women, by women*, March, Issue 48, 4-5.

Rogers, C. (June 2015). Emergency Humanitarian Crisis in Nepal: How the earthquakes have impacted the sexual and reproductive health and rights (SRHR) of Nepali women and girls. *InTouch: Newsletter of the Public Health Association of Australia*, June, Issue 32, 3-4.

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LIST OF ABBREVIATIONS

ABCD	Asset Based Community Development
AFRPA	Assets Focused Rapid Participatory Appraisal
AFRPAC	Assets Focused Rapid Participatory Assessment Cycle
AIDS	Acquired Immunodeficiency Syndrome
CAC	Comprehensive Abortion Care
CC	Clinic Clients
CRED	Committee on the Elimination of Racial Discrimination
D&C	Dilatation and Curettage
D&E	Dilatation and Evacuation
EC	Emergency Contraception
EVA	Electric Vacuum Aspiration
FCHV	Female Community Health Volunteer
FPAN	Family Planning Association of Nepal
GDP	Gross Domestic Product
GNI	Gross National Income
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
I/NGO	International Nongovernment Organisation
IUD	Intrauterine Device
LARC	Long-Acting Reversible Contraception
LMP	Last Menstrual Period
MA	Medical Abortion
MDGs	Millennium Development Goals

MOH	Ministry of Health
MSC	Marie Stopes Centre
MSI	Marie Stopes International
MVA	Manual Vacuum Aspiration
NGO	Nongovernment Organisation
NHDS	Nepal Health and Demographic Survey
NHRC	Nepal Health Research Council
OCP	Oral Contraceptive Pill
PAC	Post-Abortion Care
PC	Pharmacy Clients
PICOS	P (patient, population or disease being addressed); I (intervention or exposure); C (comparator group); O (outcome); S (study design)
PLA	Participatory Learning and Action
POC	Products of Conception
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
COREQ	Consolidated Criteria for Reporting Qualitative Studies
RPA	Rapid Participatory Appraisals
SDGs	Sustainable Development Goals
SPN/MSN	Sunaulo Parivar Nepal, implementing partner of Marie Stopes International Nepal
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund

UNICEF	United Nations Children's Fund
VA	Vacuum Aspiration
VCAT	Values Clarification and Attitude Transformation
WHO	World Health Organization

DEFINITIONS

Assets: within the context of the Assets Focused Rapid Participatory Assessment Cycle the term 'asset' can be an individual, organisation, programs or infrastructure that has been identified as positively contributing to the community (Pepall, James, & Earnest, 2006)

Contraception: the terms contraception, contraceptive and modern contraceptive methods have been used interchangeably throughout this thesis and include: emergency contraception, barrier methods, short-term methods, long-acting reversible contraceptives, and permanent methods (Family Planning New South Wales, Family Planning Queensland, & Family Planning Victoria, 2012).

Contraception access and uptake: within the context of this thesis, relates to physical access to a wide range of contraceptive methods with the ability for women to make informed decisions on the choice of method they wish to use, based on detailed and accurate information, and to use this method (Rogers & Dantas, 2017).

Duration or gestational age of pregnancy: The number of days or weeks since the first day of the woman's last normal menstrual period (LMP) in women with regular cycles (for women with irregular cycles, the gestational age may need to be determined by physical or ultrasound examination) (World Health Organization, 2012a). p. 51

Family planning counselling and SRH information provision: are broad terms used throughout this thesis to encompass the provision of information, education and counselling relating to: reproductive health, such as fertility return, fertility intention, child-spacing, prevention of unwanted pregnancies, contraception methods and contraception use; SRH advice, including information on signs of post-abortion complications and normal post-abortion symptoms, return to sexual activity advice, hygiene, STI/HIV prevention, testing and treatment information; and information or referral, or both to relevant and quality health services if needed (Rogers & Dantas, 2017).

Family planning services: SRH services that provide comprehensive family planning counselling; SRH information provision; and contraceptive counselling, as well as access to and—if required—insertion of modern methods of contraception (Rogers & Dantas, 2017).

Fecund: a female who is physically capable of becoming pregnant (Sedgh, Ashford, & Hussain, 2016). p. 42

Medical abortion: the use of pharmacological drugs to terminate a pregnancy (World Health Organization, 2012a).

Research Participation: throughout this thesis, the terminology used to refer to individuals participating in the research project include interviewees, participants, research participants and respondents.

Safe abortion: A medical, aspiration, or surgical abortion that conforms to WHO guidelines (Darney et al., 2018).

Safe abortion services: SRH services that provide comprehensive abortion care (CAC) and post-abortion care (PAC) (World Health Organization, 2015a). In Nepal safe abortion services must have Government of Nepal accreditation to legally operate (Government of Nepal, 2002).

Surgical abortion: the use of transcervical procedures for terminating pregnancy, including vacuum aspiration, dilatation and evacuation, and dilatation and curettage (World Health Organization, 2012a).

Unsafe abortion: within this thesis unsafe abortion incorporates the categories *less safe* and *least safe,* as defined by Ganatra et. al. 2017:

> ***Less safe*:** the abortion was performed by a trained provider, however, an outdated or unsafe method was utilised or a safe method of abortion was used but was administered without adequate information or support from a trained provider.

Least safe: the abortion was provided by untrained individuals using dangerous methods such as ingestion of caustic substances, insertion of foreign objects, or the use of traditional herbal mixtures or tonics (Ganatra, Gerdts, et al., 2017)

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CHAPTER 1

INTRODUCTION AND OVERVIEW

Introduction to the Chapter

This chapter commences with the rationale for conducting the research that will be presented throughout this thesis. It will then progress to a brief overview of sexual and reproductive health and rights in Nepal. The aims and objectives of the study will be discussed, and key findings shared. The chapter will then provide a description of the thesis style and outline the contents of the thesis chapters. The first chapter will conclude with a summary of the chapter. This chapter will be presented in a first person narrative from the perspective of the PhD candidate.

1.1 Prologue and Rationale for Exploring Women's Post-Abortion Access to Contraception and SRH Information in Nepal

'Why Nepal?' I feel this is the most appropriate place to start my thesis as this tends to be the first question people ask when discussing my studies. My interest in Nepal started when I was a very young girl and through experience and study led me to conduct my PhD research in the country. Throughout my life, my father spent decades traveling the world for his work, predominantly to South Asia, East Asia and the Pacific. He would tell me stories of his travels and of all the countries he visited; Nepal was his favourite. This instilled in me the desire to visit Nepal, an opportunity I would get for the first time in 2007.

After finishing my Bachelor of Biomedical Science and having worked for a while in histology, as is the want of many young Australians, I left home with my backpack to explore the world. It was during the next three years that I travelled to many low- and middle-income countries in the Middle Eastern, European and Asia Pacific regions and spoke to many women and girls there about their lives, their plans for the future and their dreams. Their stories had a profound impact on me and opened my eyes to the reality of life as a female in the developing world. Realising that perhaps I was not suited to a career working in a pathology laboratory, I decided to combine my two

great passions in life, women's health and working in an international context, and thus I enrolled in a Master of International Health with Curtin University.

Just prior to commencing my postgraduate studies, in 2007, I travelled to Nepal to undertake a voluntary internship with a local nongovernment organisation (NGO). Less than a year before my arrival, Nepal's ten-year civil war had officially ended. This was my first experience with the country's ongoing civil and political instability as well as the entrenched gender discrimination that continues to undermine prosperity within the country. My time there also deepened my interest, attachment and my enduring respect for Nepal and its people. In 2007, driving to the airport at the end of my internship, I felt I had unfinished business and that one day I would return to Nepal.

Throughout my Master of International Health course work, I focused many assignments on the health and well-being of women in Nepal. Towards the end of my degree in 2012, I concluded there was very little evidence-based research on women's access to post-abortion contraception, particularly access to, and uptake of, long-acting reversible contraception (LARC). Several journal articles on abortion in Nepal published around that time called for further research to be conducted. Acknowledging the gap in the literature, this concept would go on to form the basis of my PhD research project (Puri et al., 2012; Samandari, Wolf, Basnett, Hyman, & Andersen, 2012; Shrestha, Shrestha, & Ghimire, 2012).

It was also evident that there was scarce qualitative research informing sexual and reproductive health and rights (SRHR) in Nepal with the overwhelming preference, if not only, being for quantitative research. My master's research project on SRHR with women from migrant and refugee backgrounds living in Australia, gave me a keen awareness of the desire of women to share their SRHR experiences and to have their voices heard. The importance and the need for qualitative research within the complex and multifaceted SRHR evidence base of Nepal would inform my doctoral research paradigm.

It was during my first week of fieldwork in 2014, that I gained a deeper understanding of factors impacting access and uptake of LARC in Nepal. Issues relating to sociocultural attitudes as well as fears and misconceptions towards contraceptive use

in general, are prevalent within Nepali society and are well documented (Padmadas, Lyons-Amos, & Thapa, 2014; Puri, Henderson, et al., 2015; Rogers & Dantas, 2017; Shrestha et al., 2012). Compounding these inhibitors, at the provider level, lack of access to trained health professionals for LARC insertion as well as issues with contraceptive commodity supply chains were, and continue to be, further barriers to post-abortion contraception. In 2011, Jadelle (two-rod hormonal implant) replaced Norplant (six-rod hormonal implant). However, governmental policy on LARC regulation and brand registration delayed access to and uptake of Implanon (one-rod hormonal implant), with registration of the implant only occurring in 2016. Inconsistencies in post-abortion care service provision, particularly family planning counselling, within government, I/NGO and private clinics were also a contributing factor in low post-abortion contraception access and uptake (Puri, Henderson, et al., 2015; Rocca et al., 2014; Thapa & Neupane, 2013a). Over the proceeding years, more and more literature has become available on post-abortion contraception in Nepal. While there have been minor increases in post-abortion contraception access and uptake in recent years (Government of Nepal, 2018), it remains relatively low, particularly post-abortion LARC insertion.

In my first week of fieldwork in Nepal, I realised that pharmacy-provided MA was illegal, despite the way colleagues and sexual and reproductive health (SRH) professionals spoke about medical abortion (MA) being available through health clinics and pharmacies. It was such a common thing in the country that everyone assumed I knew. Having spent a tremendous amount of time researching abortion and contraception in Nepal prior to this trip, I was surprised I had not once come across a journal article or report documenting this important issue. During my first in-depth interview, the impact of pharmacy-provided MA in Nepal became evident, not only on post-abortion contraception access and uptake but on the mortality and morbidity of women. This issue was revealed to be a primary concern for people working within the SRHR sector, and I was told of the difficulties SRHR researchers were facing in attempting to explore the topic. It was during this pivotal week of my PhD journey that post-abortion contraception access and uptake within both safe and unsafe contexts became the principal focus of my research.

As examined in the literature in chapter 4, a myriad of barriers to post-abortion contraception and SRH information exist within a health service provider context. These barriers can include contraceptive supply limitation, lack of comprehensive education and counselling, lack of skilled post-abortion care (PAC) providers and abortion stigma. This posed the question: What are the barriers to post-abortion contraception and SRH information within the unsafe abortion context of Nepali women accessing MA through pharmacies?

As discussed in chapter 3, research conducted on MA provision through pharmacies in Nepal remains scarce. Building on their previous study (Tamang, Puri, Lama, & Shrestha, 2015) utilising harm reduction training strategies, Tamang et al. (2018) explored the safety and effectiveness of MA provided by pharmacy workers trained within a harm reduction framework (Tamang et al., 2018). They found that trained pharmacy workers can dispense MA safely and effectively to the satisfaction of almost all women clients. They also established the positive results of harm reduction training from their previous study had continued several years later.

Effective and safe MA provision by non-physician clinicians is well documented (Berer, 2009; Olavarrieta et al., 2015; Warriner et al., 2011; Yarnall, Swica, & Winikoff, 2009). Puri et al. (2018) and Rocca et al. (2018) conducted a study between October 2014 and September 2015 investigating MA provision in pharmacies by auxiliary nurse-midwives (Puri, Harper, Maharjan, Blum, & Rocca, 2018; Rocca et al., 2018). The researchers demonstrated that MA is as effective and safe when provided by trained auxiliary nurse-midwives at pharmacies as at government certified health facilities. The study also highlights that contraceptive care is not compromised within the context of auxiliary nurse-midwife provided MA at pharmacies.

This present study seeks to add to the literature on pharmacy-provided MA and post-abortion contraception and SRH information access by qualitatively exploring: barriers to safe abortion and post-abortion family planning services; women's abortion seeking decision making processes; MA access, uptake and experience at safe abortion services and pharmacies; post-abortion contraception and SRH information access and uptake at safe abortion services, pharmacies and within the community.

1.2 Sexual and Reproductive Health and Rights in Nepal

Nepal is a low-income country: maintaining an effective health care sector has always been a challenge for the financially poor nation (Government of Nepal, 2015c; Justice et al., 2016). Decades of civil and political unrest has further intensified problems with the country's already fragile health system. Political will (and its associated funding) towards SRHR waxes and wanes with the ever-changing political parties who hold power within the government. Over the last three decades, there have been marked advances in SRHR for women and girls in Nepal, such as the steady decline of the maternal mortality ratio, effective and sustained implementation of family planning and safe motherhood programs, the legalisation of abortion in 2002, and the establishment and expansion of safe abortion services. However, these improvements mask continued inequities within Nepal's gender-biased society, and disparities between ethnic/caste groups, geographical regions and wealth quintiles continue to impede equitable, countrywide progress (United Nations Population Fund, 2017).

1.3 Overview of the Study

The data that informed this qualitative exploratory study were collected from 29 in-depth, open-ended interviews in Kathmandu and the Sunsari Districts of Nepal between 2014 and 2016. An Assets Focused Rapid Participatory Appraisal (AFRPA) research methodology, underpinned by a health information pyramid conceptual framework formed the Assets Focused Rapid Participatory Assessment Cycle (AFRPAC) utilised throughout this research (Pepall et al., 2006).

The decision to use Pepall et al.'s (2006) AFRPAC was grounded in the desire to utilise community recognised assets to inform and support research outcomes and recommendations. Policy and practice recommendations from the High-Level Task Force for the International Conference on Population and Development, the Sustainable Development Goals, and The Guttmacher-Lancet Commission, form a contextual rights-based framework for the aims and outcomes of this research for action study (Galati, 2015; High-Level Task Force for ICPD, 2013; Starrs et al., 2018).

The research aimed to explore the post-abortion SRHR experiences of Nepali women, and their access and uptake of safe abortion services; unsafe abortion (MA) through pharmacies; post-abortion contraception; and SRH information. This was achieved

through the examination of safe abortion service provision as well as barriers to these services. Issues impacting and facilitating unsafe abortion practices were also explored. Post-abortion contraception and SRH information access and uptake through both safe abortion services and unsafe abortion services were investigated. Nine individual informal conversations were conducted with community members located in the Sunsari District to inform in-depth interview questioning and to help discover perceived community and national assets. Complementing the qualitative findings, an analysis of current government and nongovernment SRH policy and clinical practices was concurrently undertaken.

Ethical approval for this study was granted by the Curtin University Human Research Ethics Committee (HR 17/2014) and the Nepal Health Research Council (NHRC 20/2014) (Appendices A and B).

1.4 Key Findings

Presented within the findings, abortion seeking behaviour and post-abortion contraception decision making processes emphasise the interconnectivity of SRHR, reproductive coercion, education, poverty, spousal separation, geographical isolation, and women's personal, social and economic empowerment. Expansion of safe abortion services as well as effective and ongoing sector-wide monitoring and evaluation of safe abortion services, safe abortion service providers and contraceptive commodity supply chains, are essential for women in Nepal to have adequate:

- accessible, effective and efficient safe abortion services
- access to comprehensive post-abortion contraception and family planning counselling
- access to a broad choice of contraceptive methods
- and to ensure adherence to Nepal Safe Abortion Policy.

The findings highlight that while barriers to safe abortion services persist, so will the continued demand for the unsafe provision of MA through pharmacies. Innovative and effective harm reduction initiatives combined with information expansion strategies offer the potential to increase access to MA, particularly for women in rural and remote areas, while decreasing adverse health outcomes for women.

1.5 Overview of the Thesis and Chapters

This thesis is a 'hybrid' thesis which comprises of a combination of traditional typescript thesis, published papers and unpublished manuscripts. Within this thesis, I have used both the first person (subjective) and third person (objective) narrative. A first person narrative is used throughout chapter 1: Introduction and Overview, chapter 5: Research Design and Methods, and within the Postscript and Epilogue in chapter 8. The third person has been used throughout the remaining chapters.

Chapter 2 commences with an overview of Nepal's demographic, economic and geographical characteristics before exploring the social, religious and political ideologies that have helped shape the Himalayan nation throughout history to present day Nepal. With this context, human rights and gender rights within the socio-political and legal frameworks of the country will be explored, and the place of women and girls within Nepali society discussed.

Chapter 3 provides a synopsis of SRHR within the global and Nepali context and an in-depth analysis will be presented of global SRHR, contraception and abortion within the frameworks of human rights, legal and clinical practice. SRHR (specifically contraception and safe abortion care) within Nepal's health and legal systems will be reviewed.

Chapter 4 presents Article 1, a systematic review of literature relating to the accessibility of contraception and SRH information for women living in low- and middle-income countries who have undergone an abortion. The published version of Article 1 and accompanying documents are located in Appendices C, D and E.

In **Chapter 5** the research methodology, conceptual framework and study design utilised throughout this research is discussed. An overview of the aims and objectives of the study, data collection and analysis mechanisms, and ethical considerations for this study will be explored. A condensed manuscript based on chapter 5 (Article 2) is currently under preparation and supporting documents for this chapter can be found in Appendices F to CC.

Chapter 6, presented in the format of Article 3, details the perspectives of 9 SRHR professionals and their opinions on abortion access and uptake within the country. The published version of Article 3 is located in Appendix DD.

Building on these findings, **chapter 7**, is presented in the format of Article 4, explores the MA, post-abortion contraception, and SRHR experiences of 10 women who accessed MA through an accredited safe abortion service, and 10 women who accessed unsafe MA through pharmacies. Chapter 7 contain the contents of a manuscript (Article 4), currently under peer review.

Chapter 8 provides an overarching review of our research journey. An overview of the research design is discussed as well as the aims and objectives achieved in the study. The recommendations and research output based on the findings are presented. The limitations and significance of the research will be examined before the concluding comments.

Non-peer reviewed publications and journal article author and co-author statements can be found in Appendices EE and FF, respectively.

The decision to produce a hybrid thesis was based on the desire for timely and accessible research information dissemination to people in Nepal, as well as other low- and middle-income countries. Nepal is a developing country where access to major online journal databases and libraries is financially prohibitive for most people, including those working in government, nongovernment and academic organisations. It was important that the findings and recommendations should be available to all people in Nepal, particularly those working within the SRHR sector and those who directly impact SRHR policy and program design. It is for this reason that Articles 3 and 4 will be available as open access upon publication. Article 1 is currently available for free download through *BMJ Sexual and Reproductive Health* (formally called the Journal of Family Planning and Reproductive Health Care).

1.7 Summary of the Chapter

In chapter 1, I have provided a framework for which this thesis will be presented. The rationale for conducting the research as well as a brief overview of SRHR in Nepal was provided. An outline of the study and key findings was presented, and an overview of the thesis design and thesis chapters were detailed prior to my concluding comment. To understand SRHR in Nepal, it is essential that the historical, social and political context in which women and girls live is understood and this is discussed in detail in chapter 2.

CHAPTER 2
THE COUNTRY OF NEPAL

Introduction to the Chapter

This chapter commences with a brief overview of Nepal's demographic and economic background before exploring the country's geographical characteristics. Nepal's diverse multilinguistic, multireligious and multiethnic/caste society will then be reviewed, and the political complexities of the country's past and present discussed. Human rights within the context of Nepal's legal, political and social frameworks will be examined (human rights as applies to abortion will be discussed in chapter 3) followed by an examination of gender rights within the patriarchal society.

2.1 Country Context

2.1.1 Background

Nepal is a landlocked Himalayan nation situated between Tibet (China) to the north and India to the east, south and west, and has a total land area of 147, 181 square kilometres. Approximately 28.5 million people reside in the country, which has a predominantly agrarian economy (World Bank Group, 2018). Nepal is classified as a low-income country and in 2016 had a gross national income (GNI) per capita of US$730 and a gross domestic product (GDP) of US$21.13 billion (World Bank, n.d.). The proportion of Nepali households living in poverty (as measured by the international extreme poverty line) fell from 46% in 1996 to 15% in 2011 (World Bank Group, 2018). However, the proportion of households counted as vulnerable to poverty increased from 28% in 1996 to 45% in 2011 (World Bank Group, 2018). The position of these households remains precarious given the country's high levels of exposure to natural disasters, political instability and conflict.

Nepal consists of 75 districts distributed across three ecological zones and five development regions (Eastern, Central, Mid-Western and Far-Western) as detailed in Figure 2.1 (Ministry of Health Nepal, New ERA, & ICF, 2017b). Administratively Nepal is divided into seven provinces (or states), with each province further sub-divided into urban and rural areas (Ministry of Health Nepal et al., 2017b).

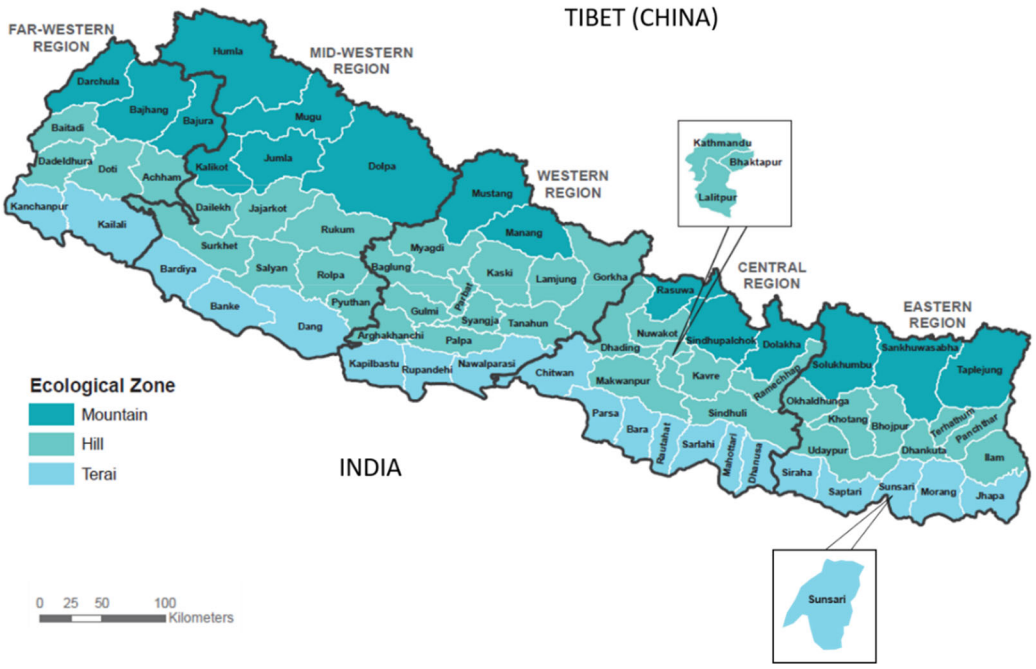


Figure 2.1 Map of Nepal

(Adapted from: Ministry of Health and Population Nepal, New ERA, & ICF, 2012, p. 1)

2.2 Geographical, Social and Political Contexts

2.2.1 Geography

Topographically, Nepal is divided into three distinct ecological zones: mountain, hill and Terai. Due to the harsh terrain and limited transportation, infrastructure and communication facilities, approximately 6.73% of the total population of Nepal live in the northern mountain zone that borders Tibet (Government of Nepal, 2012; Intensive Study and Research Centre, 2014). In contrast, the hill ecological zone consists of approximately 43% of the total population and includes the Kathmandu Valley, the country's most urbanised area (Government of Nepal, 2012; Intensive Study and Research Centre, 2014). The population distribution within the hill ecological zone varies, with more densely occupied regions within the valleys and progressively less population density occurring towards the mountain zone and with increasing altitude. Although transportation, infrastructure and communication facilities are more developed in this region, in comparison to the mountain ecological zone, outside of the Kathmandu Valley rugged terrain can inhibit access to services (Intensive Study and Research Centre, 2014).

The southern Terai ecological zone (or plains) shares a border with India and is home to 50.27% of Nepali people (Government of Nepal, 2012; Intensive Study and Research Centre, 2014). While constituting only 17% of the total land area of Nepal, the flat terrain of the region and its proximity to the Indian border has facilitated more significant development of transportation, infrastructure and communication facilities as well as commerce and trade in comparison to the hill and mountain ecological zones (Intensive Study and Research Centre, 2014).

The climate in Nepal varies substantially from tropical and subtropical temperatures in the Terai to the subarctic conditions in the mountain ecological zone (Intensive Study and Research Centre, 2014). This diverse topography and climate exposes the country to regular flooding, landslides, and drought (World Bank Group, 2018). As well as seasonal ecological hardship faced by the Nepali people, the Himalayan mountains are an area of intense seismic activity making Nepal the 11th most earthquake-prone country in the world (World Bank Group, 2018).

2.2.2 2015 Nepal Earthquakes

On April 25, 2015, a 7.8 magnitude earthquake struck Nepal's Gorka District, north-west of Kathmandu. It is estimated the country suffered over 300 aftershocks before experiencing another major earthquake just over two weeks later on May 12, 2015, at the border of the Dolakha and Sindhupalchowk Districts. Nearly 9,000 people were killed, and over 22,000 others were injured (United Nations Population Fund, 2015). At the height of the crisis, an estimated 188,900 people were displaced, with around 600,000 houses destroyed and an additional 290,000 damaged (United Nations Population Fund, 2015). Of the 75 districts of Nepal, 35 districts were affected by the earthquake, with the most destruction occurring in 14 districts.

Within the 14 most affected districts around 5.6 million people were impacted by the earthquakes; of those 1.4 million were women of reproductive age (United Nations Population Fund, 2015). An estimated 93,000 pregnant women were among those most affected (United Nations Population Fund, 2015). Within the first three months of the earthquake, approximately 10,000 women were expected to give birth each month, with around 1,500 women at risk each month of pregnancy related

complications requiring emergency obstetric care (United Nations Population Fund, 2015). The financial impact of the destruction from the earthquakes and aftershocks is an estimated US$5.2 billion, approximately one-quarter of the country's GDP for the previous financial year (World Bank Group, 2018).

2.2.3 Indian-Nepal Border Blockade

Four months after the second major earthquake struck, the new constitution was promulgated on 20 September 2015 through Nepal's Constituent Assembly (National Human Rights Commission, 2015). While it was hoped approval of the new constitution would allow for political focus to return to the earthquake recovery effort, the declaration triggered a four-and-a-half-month blockade at the India-Nepal border (Human Rights Watch, 2017b; Rogers, Dantas, & Lohani, 2016). The instigation of violent response to the new constitution from Terai-based indigenous and minority groups, supported by political parties opposing the new constitution, was based mainly on the groups feeling their longstanding calls for equal rights, provincial delineations, and devolution of power had continued to be ignored within the new constitutional framework (Human Rights Watch, 2017b; Slavu, 2012).

The blockade resulted in the restricted importation of essential humanitarian goods as well as daily living supplies such as fuel, cooking gas, food and medicines from India, further exacerbating Nepal's slow earthquake recovery response (Human Rights Watch, 2017b; National Human Rights Commission, 2015). More than 45 people were killed during the conflict and the health and well-being of millions of Nepalis, many of whom were still vulnerable from the earthquakes, was negatively impacted during the harsh winter months the blockade was in place (UN News Centre, 2015).

2.2.4 Caste/Ethnic System, Language and Religion

In Nepal, the term "caste" refers to those groups whose social structure is hierarchical in nature, dependent upon family heritage and strongly embedded in Hindu religious values (Government of Nepal, 2014). The hierarchical structure of the caste system places an individual or group at the top of the social hierarchy and other individuals or groups of people at progressively lower tiers (Government of Nepal, 2014). Almost all Hindu groups of Nepal (such as Brahman, Chhetri, Sanyasi, Maithil Brahman, Rajpur Kayastha and Dalits) come under the "caste" category. The term "ethnicity"

encompasses certain types of cultural characteristics such as a collective family name, a common story or myth of descent, a shared history, or an association with a specific territory or place. Almost all of Nepal's Janajati (indigenous) groups fall under this classification (Government of Nepal, 2014).

Nepal's population is composed of over 125 caste/ethnic groups, each with a distinct language and culture (Government of Nepal, 2012). As depicted in Figure 2.2, these groups are broadly categorised into nine major groupings: Chhetri, Bahun, Hill Janajati, Terai Janajati, Terai Other Castes, Hill Dalit, Terai Dalit, Newar and Muslim (Government of Nepal, 2012; United Nations Population Fund, 2017). In addition to the identified groups, the Central Bureau of Statistics also includes Dalit Others, Janajati Others, Terai Others, Undefined Others and Foreigners (Government of Nepal, 2012; United Nations Population Fund, 2017).

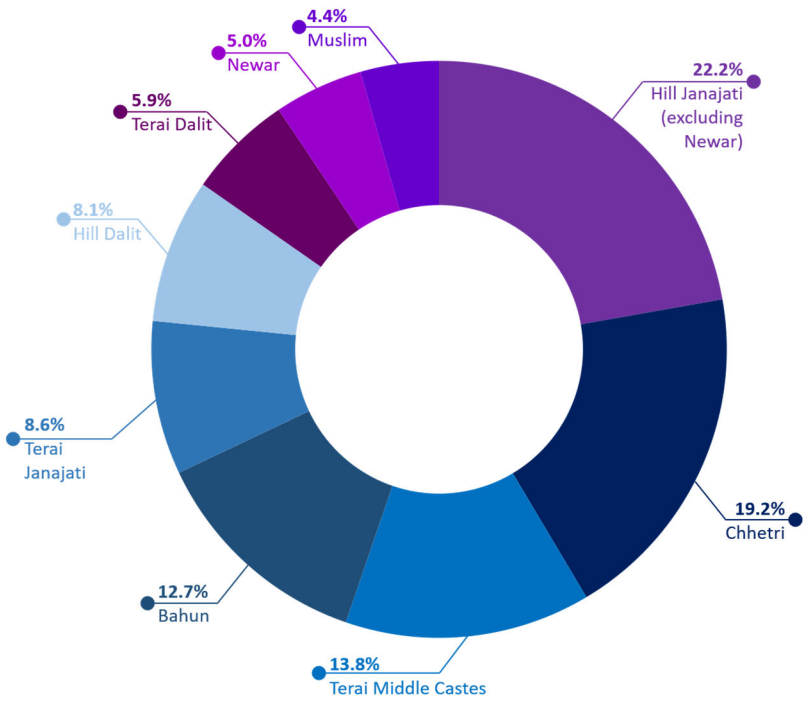


Figure 2.2 Major caste/ethnic groups in Nepal

(Source: Ministry of Health Nepal, New ERA, & ICF, 2017a)

There are 123 recorded languages spoken in Nepal, which are thought to have originated from two major groups: the Indo-Europeans and the Sino-Tibetans (Intensive Study and Research Centre, 2014). Some of these languages have their own

script while many languages of smaller ethnic groups are almost extinct (Lawoti, 2012). Nepali is the country's official language and is the most prevalent spoken language, used and understood by most people in the country (Intensive Study and Research Centre, 2014). Figure 2.3 details the ten most commonly spoken languages in Nepal.

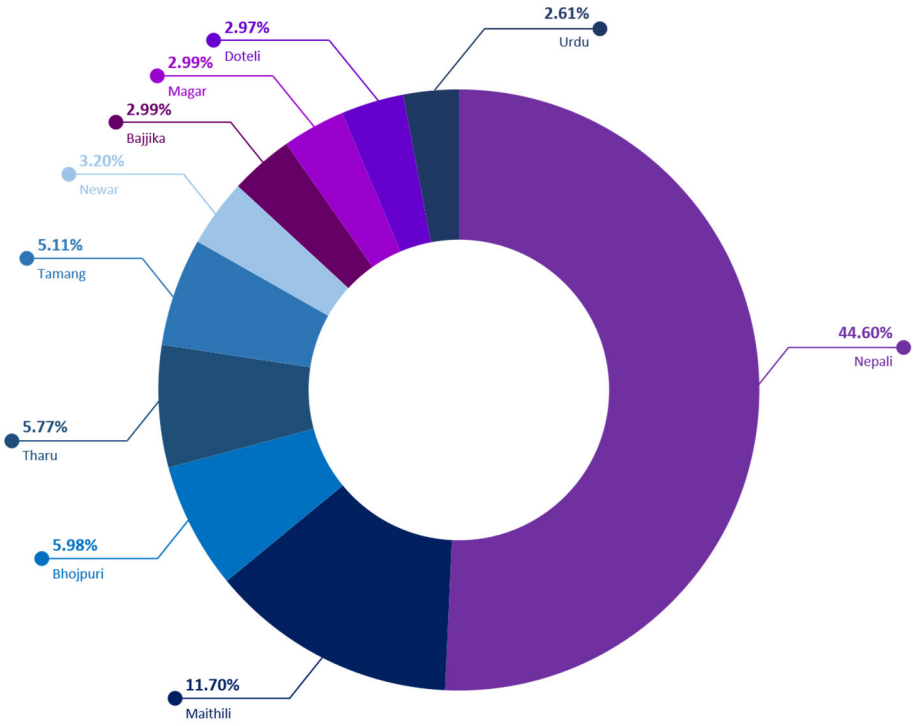


Figure 2.3 Major languages of Nepal

(Source: Ministry of Health Nepal et al., 2017a)

As shown in Figure 2.4, Hinduism is the most predominant religion in Nepal (81.3%) followed by Buddhism (9%) and Islam (4.4%) (Government of Nepal, 2012). In 2007, Nepal became a secular state under the Interim Constitution, and while ratified within the 2015 Constitution, there remains much debate regarding the definition of secularity within the constitutional framework (Lawoti, 2017).

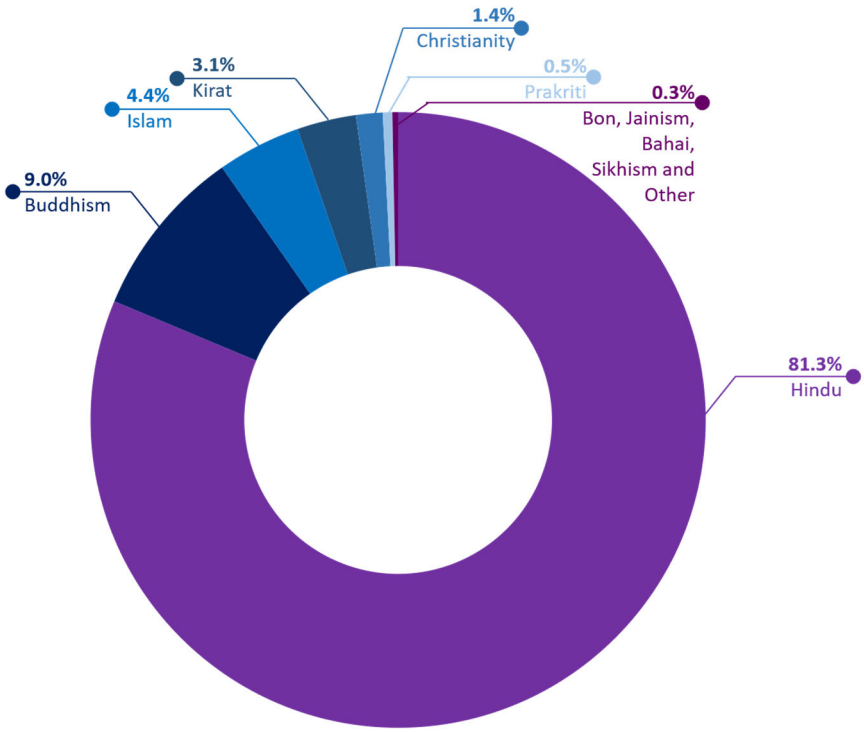


Figure 2.4 Major religions in Nepal

(Source: Government of Nepal, 2012)

2.2.4 Monarchy and Democracy

Historically divided into small principalities or states, Nepal has always been a hierarchically governed society. In 1769 King Prithvi Narayan Shah, through diplomacy and war, unified the multicultural, multiethnic and multilingual states of Nepal. The Shah monarchy would rule until 1846 when a bloody coup instituted the Rana autocracy that would rule for the next 104 years (von Einsiedel, Malone, & Pradhan, 2012). In 1854 the Rana monarchy established the *Muluki Ain*, a national code of civil behaviour, law and punishment. Within its framework, the Rana rulers continued the high-caste Hindu dominance of the Shah reign by further institutionalising the caste/ethnic system with the inclusion of a codification of all Hindu and non-Hindu groups in Nepal into a social, political and religious hierarchy (von Einsiedel et al., 2012). The Rana rule would officially end in 1951 and, for the first time, Nepal became a democratic country.

However, over the next several decades, members of the Shah and Rana dynasties, and newly forming political parties, continued to grapple for power, keeping the country in a constant state of political turmoil (von Einsiedel et al., 2012). Under the Shah King

Birendra's constitutional monarchy rule, a new constitution was promulgated in 1990 confirming Nepal as a Hindu state and the king as supreme commander of the armed forces, however political instability continued to ensue (von Einsiedel et al., 2012). It was in this volatile political environment the Communist Party of Nepal-Maoist (CPN-M) launched their ten-year civil war in 1996 (Whitfield, 2012).

2.2.5 Civil War

The Nepali Civil war, also called the People's War or Maoist Insurgency, commenced in February 1996 and culminated in December 2006 with the signing of the Comprehensive Peace Agreement (CPA) between the Seven Party Alliance and the Communist Party of Nepal-Maoist (Sthapit & Doneys, 2017; von Einsiedel et al., 2012; Whitfield, 2012). The most significant structural catalysts for the violent conflict were endemic poverty, sociocultural inequality and identity politics (Lawoti, 2012; von Einsiedel et al., 2012). In 1996, the year the civil war commenced, 42% of the population was living under the national poverty line, with the rural poverty rate almost twice as high as the urban (von Einsiedel et al., 2012). That same year, Nepal ranked in the bottom 12% of the Human Development Index, a summary measure of average achievement in critical dimensions of human development: a long and healthy life (life expectancy); being knowledgeable (literacy and education); and having a decent standard of living (GNI per capita) (United Nations Development Programme, n.d.; von Einsiedel et al., 2012).

An estimated 15,000 people were killed during the civil war with human rights violations including abduction, torture and sexual violence rampant throughout the time (Sthapit & Doneys, 2017; von Einsiedel et al., 2012). The civil war saw men, women and children (Maoist-inducted child soldiers) take up arms against the Nepal Police Force, then later the Royal Nepalese Army, and engage in guerrilla warfare tactics for the Maoist People's Liberation Army (Sthapit & Doneys, 2017; von Einsiedel et al., 2012). Although it has been over 10 years since the peace accord was signed, the structural causes that helped precipitate the civil war remain firmly entrenched in Nepal's political and sociocultural systems (von Einsiedel et al., 2012).

2.2.6 Politics

Prior to the signing of the CPA, Nepal had been ruled under a constitutional monarchy

since 1972. In June of 2001, Crown Prince Dipendra allegedly shot and killed 10 members of the royal house including his father, King Birendra, and mother, Queen Aishwarya, before taking his own life (Whitfield, 2012). Three days after the palace massacre, the deceased king's brother, Gyanendra, succeeded to the throne and within several months deployed the Royal Nepalese Army to join with the Nepal Police Force in combatting Maoist insurgents (Whitfield, 2012). During his reign, King Gyanendra carried out twin coups in October 2002 and February 2005, at both times forcing the country from its complicated democratic rule to a return to absolute monarchy (Muni, 2012). In April 2006, international pressure combined with the demands of the unified political parties to force King Gyanendra to reinstate the Nepali parliament's House of Representatives that he had dismissed in 2002, as well as install a new prime minister chosen by the mainstream political parties (Muni, 2012). The backlash to the king's autocratic manoeuvring also resulted in the divestment of all his executive and political powers (Muni, 2012).

Following two years of political negotiations, elections to the Nepal Constituent Assembly were held in April 2008 (Slavu, 2012). With an unexpected majority win of 38% of elected seats, Pushp Kumar Dahal, head of the Communist Party of Nepal-Maoist and leader of the Maoist People's Liberation Army during the civil war, was elected Nepal's new Prime Minister (Martin, 2012; Rai, 2018; Slavu, 2012). One month later in May, at the opening session of the Constituent Assembly, Nepali political parties overwhelming voted (by a margin of 560 to 4) to abolish the 239 year old monarchy, declaring Nepal a federal democratic republican state (Martin, 2012; von Einsiedel et al., 2012).

In the 10 years since the establishment of the Constituent Assembly, Nepal's transition to peace and democracy continues to be beleaguered by frequent changes in governing political parties, institutional incapacity, political instability and civil conflict (von Einsiedel et al., 2012). The Constituent Assembly negotiated for seven years before promulgating the new Constitution in 2015. In response, the conflict that followed during the India-Nepal border blockade gives testament to the continuation of Nepal's fragile and volatile political system and the ongoing impact this has on the human rights of the Nepali people (National Human Rights Commission, 2015).

In line with the new constitution, new criminal and civil codes were enacted on 17 August 2018, separating and updating the *Muluki Ain* into the *Muluki Civil Code* (2017) and Muluki Criminal Code (2017) (Dahal, 2018; Luitel, 2018). While the new set of laws have been hailed by many within the Nepali political and governmental systems, concerns regarding the lack of input from members of the public and key stakeholders in the drafting of the laws have been raised (Maharjan, 2018). Issues of gender equality and how the new laws will directly and indirectly impact the lives of women and girls in Nepal have also been of vital concern for women's rights and advocacy groups (UNDP Nepal, 2017).

2.3 Human Rights

Social determinants of health, inequality and exclusion in Nepal must be understood within the context of ethnic diversity, social stratification and gender politics (von Einsiedel et al., 2012). From the earliest days as a nation, sociocultural discrimination and marginalisation have been ingrained within Nepali society. Social exclusion and discrimination against Dalits ('untouchables'), Janajatis (indigenous peoples), Muslims and Madhesis (Terai caste), has been well documented throughout Nepal's history. Since its first iteration in 1854, there have been 11 amendments to the *Muluki Ain* with the civil code formally replaced in 1960. However, the Committee on the Elimination of Racial Discrimination's (CERD) 2018 report details continued concerns relating to caste, ethnic and gender discrimination entrenched in Nepal's political system and legal frameworks, and within the very fabric of Nepali society (Committee on the Elimination of Racial Discrimination, 2018).

2.3.1 Human Rights and the Law

The legal framework in Nepal is based on the Hindu religion and can discriminate against ethnic and religious minorities (Lawoti, 2017). Once such example is the criminalisation of cow slaughter. For many indigenous groups in Nepal, eating beef holds cultural significance, however under the law they face life imprisonment for killing cows (Committee on the Elimination of Racial Discrimination, 2018; Lawoti, 2017). Domestic legislation in Nepal currently recognises only 59 out of the 81 indigenous peoples of Nepal, and there is an absence of laws guaranteeing the rights of indigenous peoples to own, use and develop their traditional lands and resources

(Committee on the Elimination of Racial Discrimination, 2018).

While the 'Caste-based Discrimination and Untouchability (Offence and Punishment) Act, 2011' seeks to address issues of discrimination and marginalisation in Nepal, the CERD report states the Act does not prohibit discrimination based on colour or national or ethnic origin, and does not expressly prohibit both direct and indirect forms of discrimination (Committee on the Elimination of Racial Discrimination, 2018; Nepal Law Commission, 2011). Under this Act, complaints can be filed only within three months of an alleged violation. From 2016 to 2017, 659 caste-based discrimination complaints came before the Supreme Court resulting in only 39 convictions, raising concerns of the efficacy of the Act's implementation (Committee on the Elimination of Racial Discrimination, 2018). The CERD report also found that law enforcement officials are often reluctant to act upon allegations of caste-based discrimination and do not consistently file first information reports with a view to initiating criminal investigations.

2.3.2 Human Rights and the Constitution

Within the 2015 Constitution, secularism was qualified as the protection and promotion of religions from the ancient past. However, many minority indigenous and religious groups felt this definition indirectly placed primacy on Hinduism over other religions in Nepal (Lawoti, 2017). The CRED report also brings into focus the exclusion of many indigenous and ethnic groups experienced by not being able to participate in the drafting of the 2015 Constitution meaningfully. Anger towards this exclusion, particularly within the Terai region, was compounded by reports that adult Madheshi, whose parents received citizenship by birth before the constitution's promulgation, had now been denied citizenship by descent (Committee on the Elimination of Racial Discrimination, 2018). The anger expressed in response to this exclusion and discrimination was the catalyst for the 2015 India-Nepal border blockade.

2.3.3 Human Rights and Society

Although caste-based segregation is prohibited under Nepali law, it continues in practice. This segregation can prevent marginalised castes from safely accessing places of worship, public spaces, public sources of food and water, and educational

facilities (Committee on the Elimination of Racial Discrimination, 2018). This ingrained discrimination also impacts the ability for women and men to safely marry members of different castes and even visit homes occupied by members of other castes (Committee on the Elimination of Racial Discrimination, 2018). Occupational specialisations designated within the cast/ethnic hierarchy in Nepal inhibits socioeconomic mobility and often allocates certain castes to degrading or exploitative occupations in order to earn a living wage (Committee on the Elimination of Racial Discrimination, 2018). The 2018 CERD report also stated that marginalised castes and ethnic groups were disproportionately affected by the 2015 earthquakes and were less likely to receive humanitarian aid during the crisis and in the post-crisis recovery phase.

2.4 Gender Rights

While women and girls experience similar caste, ethnic and religious minority discrimination as their male counterparts, their marginalisation is compounded by Nepal's patriarchal society. The disparity in education access between males and females is one of many ways in which Nepali women and girls face discrimination. Approximately one-third of Nepali women do not receive any formal education, and approximately 7 in 10 women (69%) are classified as literate (Ministry of Health Nepal, New ERA, & ICF, 2017c). Other human rights violations such as unequal access to employment, leadership and decision making contribute to the myriad of societal norms that impede the dignity, well-being and empowerment of women and girls in Nepal (United Nations Population Fund, 2017).

2.4.1 Son Preference

Gender bias in favour of boys is another symptom of pervasive sociocultural, political and economic injustices against women and girls in Nepal (United Nations Population Fund, 2017). The need to have a son (male child) stems from long-held patriarchal and religious traditions as well as the continuation of inheritance and land rights favouring males (Puri & Tamang, 2015). While daughters leave the family home to live with her husband's family after marriage, sociocultural expectation requires sons to eventually take on the role of head of house to care and provide for their ageing parents (Puri & Tamang, 2015). Preference for a son is often closely linked with reproductive coercion

(the impeding of a woman's sexual and reproductive autonomy) and coupled with the availability of sex determination technology (ultrasonography) can enable sex-selective abortions (Barot, 2012; Grace & Fleming, 2016; Puri & Tamang, 2015). While there is limited empirical evidence on the practice of sex-selective abortion in Nepal, preliminary data suggests it occurs and could potentially have a significant impact on future population dynamics, as seen in other Asian countries (Barot, 2012; Hesketh, Lu, & Wei Xing, 2011; Puri & Tamang, 2015; United Nations Population Fund, 2017)

2.4.2 Gender-Based Violence

In Nepal, approximately 1 in 5 women experience physical violence, and 1 in 8 women experience sexual violence throughout their lives (United Nations Population Fund, 2017). Most often the perpetrators of this violence are their intimate partners (United Nations Population Fund, 2017). A 2016 study found that women from underprivileged castes and ethnic groups were 52% to 190% more likely to experience intimate partner violence than 'high-caste' Hindu women (Atteraya, Murugan, & Pandey, 2016). Women with low levels of education and women who were married as a child are significantly more likely to experience intimate partner violence throughout their lives (Atteraya, Murugan, & Pandey, 2016; UNICEF South Asia & UNFPA Asia, 2017; United Nations Population Fund, 2017).

2.4.3 Chhaupadi

The cultural practice of chhaupadi has its roots in ancient Hindu scriptures, the belief being that menstruating and postnatal women are impure (Kadariya & Aro, 2015). Restrictions on women and girls during these times can take various forms with the less extreme involving women and girls not being allowed in the kitchen or places where religious rituals are being conducted (U.S. Department of State, 2016). However, the practice often takes a more extreme form where women, girls and expectant mothers are expelled from their homes to reside in isolation in cow sheds or 'chhaupadi huts' (Ranabhat et al., 2015). Nepal's Supreme Court banned chhaupadi in 2005, and the practice was further criminalised under the law in 2017, punishing enforcers of the tradition with a jail sentence of 3 months and possibly a fine of 3,000 rupees (US$30) (BBC News, 2017; Preiss, 2017b; The Kathmandu Post, 2017). Despite this, the practice remains widespread, particularly in the mid- and far-western

regions of Nepal (Dhungana, 2018; Preiss, 2017a; Ranabhat et al., 2015).

The practice of chhaupadi puts women and adolescent girls at risk of exposure to extreme elements, animal attacks and sexual violence as well as a myriad of life-threatening health problems such as pneumonia, diarrhoea, chest infection, respiratory tract infection and suffocation from smoke inhalation (Kadariya & Aro, 2015; UN Women, 2017). In recent years, dozens of women and girls have died as a result of chhaupadi (Sharma & Gettleman, 2018). Women can also be forced to give birth in chhaupadi huts, remaining in isolation for up to 2 weeks and jeopardising the health and wellbeing of mothers and infants. (UN Women, 2017). The rate of prolapsed uterus, as well as neonatal and maternal morbidity and mortality, is high in the regions where chhaupadi is commonly practised (Kadariya & Aro, 2015).

A 2014 study conducted in the mid- and far-western districts of Bardiya and Kailali found that one-fifth (21%) of households in these districts practised chhaupadi (Ranabhat et al., 2015). A 2017 survey of 995 households in the mid-western district of Jumla showed that approximately 74% of women in the district are still forced to live in sheds during menstruation, and while 26% of women are allowed to stay in their homes during menstruation, they are forbidden from entering the kitchen during this time (Buda, 2017). Chhaupadi not only impacts the physical and psychosocial health and well-being of women and girls, but it also interrupts and limits girls' access to education, and inhibits women's rights to be respected and engaged members of their families and communities (Kadariya & Aro, 2015; UN Women, 2017).

2.4.4 Child Marriage

The practice of child marriage can be viewed within the framework of Nepal's hierarchical society and patriarchal culture and multiple contributing factors including poverty, son preference and lack of education (UNICEF South Asia & UNFPA Asia, 2017). In a 2016 revision of the *Muluki Ain*, the minimum legal age for marriage became 20 years for both males and females, with or without parental consent (United Nations Population Fund, 2017). Despite laws banning early or child marriage, the practice persists, particularly in rural and remote areas of Nepal (UNICEF South Asia & UNFPA Asia, 2017).

Utilising data from the 2011 NHDS, a study found that of the 9,783 married women surveyed, approximately one-third of the women were married before the age of 16, and 78% were married before 20 years of age (Pandey, 2017). The research data showed Madeshi and 'low caste' Hindu women were significantly more likely to marry before turning 16 years of age compared with their 'high-caste' Hindu counterparts (Pandey, 2017). Married girls in Nepal are 10 times more likely to not be in school and are more likely to experience abuse and violence compared with their unmarried peers (UNICEF South Asia & UNFPA Asia, 2017). It is estimated that just over 1 in 8 Nepali women has given birth before the age of 18, putting them at an increased risk of death or injury during childbirth (UNICEF South Asia & UNFPA Asia, 2017). The primary cause of death for girls 15–19 years old is complications from pregnancy and childbirth, with an estimated 1 in 5 married adolescents dying from this cause (United Nations Population Fund, 2017).

2.5 Summary of the Chapter

This chapter has provided an insight into the complexities of life in Nepal. The history of this country reveals a nation mired in concepts of social stratification and gender discrimination, laying the foundation for the political turmoil, civil conflict, social marginalisation and gender-based discrimination we see today. It is through this lens that the sexual and reproductive health and rights (SRHR) of the women and girls of Nepal must be understood. It will be within this context, complemented by an analysis of global SRHR, that the SRHR of women and girls in Nepal will be deliberated in chapter 3.

CHAPTER 3

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Introduction to the Chapter

This chapter commences with an overview of the Millennium Development Goals within both the global and Nepali contexts, with specific reference to Goal 5: Improve Maternal Health. It will then proceed to outline the Sustainable Development Goals with a focus on Targets 3.7 and 5.6 and reflecting on the Sexual and Reproductive Health and Rights (SRHR) implications both worldwide and in Nepal. An in-depth analysis of SRHR will then take place, and the impact of the Global Gag Rule explored. Finally, SRHR (specifically contraception and safe abortion care) within the context of Nepal's health and legal systems will be examined.

3.1 The Global Goals

3.1.1 Millennium Development Goals

The new millennium saw a global mobilisation to combat poverty's multifaceted impact and the Millennium Development Goals (MDGs) were established. From 2000 to 2015, the eight goals, as shown in Figure 3.1, provided a framework for global, regional, national and local stakeholders to improve the lives of the world's most vulnerable populations (United Nations, 2015b).

Figure 3.1 Millennium Development Goals (MDGs)
(Source: United Nations, n.d.-a)

Although significant achievements were seen throughout the 15 years, progress to meet many of the MDG targets was uneven across regions and developing countries (United Nations, 2015a, 2015b). Although no goal or target specifically referred to sexual and reproductive health or SRHR, maternal health within the developing world was targeted by MDG 5: Improve Maternal Health, as detailed in Table 3.1.

Table 3.1 Millennium Development Goal 5: Improve Maternal Health

Target	Indicator
5.A Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	**5.1** Maternal mortality ratio **5.2** Proportion of births attended by skilled health personnel
5.B Achieve, by 2015, universal access to reproductive health	**5.3** Contraceptive prevalence rate **5.4** Adolescent birth rate **5.5** Antenatal care coverage (at least one visit and at least four visits) **5.6** Unmet need for family planning

(Source: United Nations, 2015b)

MDGs and SRHR: Global

Between 1990 and 2013, the global Maternal Mortality Ratio (MMR) dropped by 45% worldwide from 380 maternal deaths per 100,000 live births to 210, with significant progress seen in Southern Asia (64% decline) (United Nations, 2015b). Despite this success, inequalities in access to and use of reproductive health services persisted within the developing world, particularly for women living in rural or remote areas (United Nations, 2015b).

In 2013, approximately 800 women died each day due to childbirth-related complications, with the majority of these deaths (86%) occurring in sub-Saharan Africa and Southern Asia (United Nations, 2015b). Between 1990 and 2015, the proportion of women aged 15–49 who were using a modern method of contraception increased from 55% to 64% (United Nations, 2015b). However in 2015, the unmet need for contraception remained high with 12% of women worldwide wanting to delay or avoid pregnancy but were not using contraception (United Nations, 2015b).

While significant progress was made in Goal 5's effort to reduce maternal deaths and increase access to reproductive health services, it fell short of the intended global goal

and targets. The 2015 United Nations 2015 MDG Report highlighted that the fundamental causes for inequality between men and women must be addressed, moving forward from the MDGs, to achieve universal realisation of gender equality and universal access to sexual and reproductive health care.

MDGs and SRHR: Nepal

Before the implementation of the MDG's framework, Nepal had one of the highest global MMR at 850 deaths per 100,000 live births in 1990 (National Planning Commission, 2016). During the 15 years of the MDGs, the MMR declined dramatically to 258 per 100,000 live births in 2015, only just falling short of their MDG target of 213 per 100,000 live births (National Planning Commission, 2016). Nepal also showed considerable progress in the proportion of deliveries attended by skilled health personnel with nearly an eight-fold increase from 7% in 1990 to 55.6% in 2014, again, only narrowly missing their MDG target of 60% (National Planning Commission, 2016). However, these improvements were not uniformly seen across all regions of the country, with significant disparities between rural and urban areas and among ecological zones (mountain, hill and Terai) and caste/ethnic groups (National Planning Commission, 2016).

Although Nepal's progress in Target 5.A was considerable, the country's Target 5.B status was relatively weak when compared with other South Asian countries, as shown in Table 3.2 (National Planning Commission, 2016).

Table 3.2 South Asian Countries MGD Outcomes 2015 (Targets 5.A and 5.B)

Country	MMR*	SBA# (%)	CPR^ (%)	Unmet Need+ (%)
Sri Lanka	35	99	68	7.3
Maldives	60	95	34.7	n.a.
Bhutan	180	58	66	6.5
India	200	58	56.3	12.8
Bangladesh	240	27	55.5	16.8
Nepal	258	55.6	49.6	25.2

*Maternal Mortality Ratio (MMR) per 100, 000 live births
Percentage of births attended by a Skilled Birth Attendant (SBA)
^ Contraceptive Prevalence Rate (CPR)

+ Unmet Need for Family Planning

(Adapted from: National Planning Commission, 2016, pp. 76 and 82)

Whereas the CPR increased from 24% in 1990 to 49.6% in 2015, it did not meet the MDG target of 67% (National Planning Commission, 2016). Similarly, the unmet need for family planning saw only a slight decrease from 26.5% in 2000 to 25.2% in 2015, falling considerably short of the MDG target of 15% (National Planning Commission, 2016). As with Target 5.A, considerable disparities were seen between urban, rural and remote regions of the country and within differing sociocultural, religious and ethnic populations (National Planning Commission, 2017a).

Post-2015 Agenda

At their conclusion, the MDGs were hailed as the most successful anti-poverty campaign in history. However, progress was mixed leading to significant gaps in development (Galati, 2015; United Nations, 2015a). During the 15 year tenure of the MDGs, success was seen through the reduction of the number of people living in extreme poverty by more than half and the improved access to sanitation for over 2 billion people (Galati, 2015; United Nations, 2015a). Targeted investments in fighting diseases, such as tuberculosis, malaria and HIV/AIDS brought unprecedented global results, and gender parity in primary school was achieved in the majority of countries (United Nations, 2015a). However, the MDGs were significantly less successful in meeting the SRHR needs of women and girls around the world (Galati, 2015).

Galati (2015) argues this may be at least partially attributed to the fact the original MDG framework did not take into consideration the significance of SRHR and its role in improving health and in promoting gender and economic empowerment for women and girls. It was not until 2007 that the UN specified achieving universal access to reproductive health by 2015 (Target 5.B) was an essential component of achieving global improvements in maternal health (Galati, 2015). The narrow focus of Goal 5 also failed to reflect the much broader SRHR agenda that has been in development since the mid-1990s through the Programme of Action of the International Conference on Population and Development (ICPD) in Cairo and the Beijing Platform of Action (Galati, 2015; United Nations, 1995; United Nations Population Fund, 2014). With the

establishment of new global goals in 2015, international SRHR experts, research and policy organisations advocated for the inclusion of a comprehensive SRHR agenda in the framework that will define international development until at least 2030 when the Sustainable Development Goals campaign concludes (Guttmacher Institute, 2015; Starrs et al., 2018).

3.1.2 Sustainable Development Goals (SDGs)

Informed by analysis of strengths and weaknesses of the MDGs and after a global collaborative process, the Sustainable Development Goals (SDGs), shown in Figure 3.2, were formally adopted in September 2015 (Guttmacher Institute, 2015; UN System Task Team on the Post-2015 UN Development Agenda, 2012). While building on the progress of the MDGs, the SDGs differ from the preceding framework by focusing not only on meeting the needs of the world's poorest people, but also on sustainable development (Galati, 2015). An ambitious campaign concluding in 2030, the SDGs consists of 17 goals and 169 targets aiming to eradicate poverty, promote human dignity and rights, and protect the environment (Guttmacher Institute, 2015).

Figure 3.2 Sustainable Development Goals (SDGs)

(Source: United Nations, 2017b)

SDGs and SRHR: Global

SDG 3: Good Health and Well-being, is a more encompassing health goal than its MDG forerunners. The goal addresses all major health priorities, including

reproductive, maternal and child health; communicable, non-communicable and environmental diseases; universal health coverage; and access for all to safe, effective, quality and affordable medicines and vaccines (United Nations, 2016). Target 3.1 addresses the goal to reduce the global MMR, with MMR and SBA indicators as for MDG 5. Gender equality goals have also seen an expansion with SDG 5 taking on a wider scope of issues including: ending all forms of discrimination, violence and harmful practices against women and girls; recognition of unpaid care and domestic work; ensuring women's participation and equal opportunities for leadership in political, economic and public life; and ensuring universal access to sexual and reproductive health and reproductive rights (United Nations, 2016).

Within the SDG framework, two targets (Target 3.7 and Target 5.6) explicitly mention sexual and reproductive health as shown in Table 3.3. While these targets form a foundation for progression towards the 2030 goals, the Guttmacher-Lancet Commission on Sexual and Reproductive Health and Rights' 2018 report argues they do not offer an effectively comprehensive global SRHR agenda (Guttmacher Institute, 2018c; Starrs et al., 2018).

Table 3.3 Sustainable Development Goals and SRHR

Goal 3: Ensure healthy lives and promote well-being for all at all ages	
Target	**Indicators**
3.7 By 2030, ensure universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes	**3.7.1** Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods **3.7.2** Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group
Goal 5: Achieve gender equality and empower all women and girls	
Target	**Indicators**
5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences	**5.6.1** Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care **5.6.2** Number of countries with laws and regulations that guarantee women aged 15-49 years access to sexual and

	reproductive health care, information and education

(Source: United Nations, n.d, n.d.-b)

SRHR are essential contributors to global sustainable development due to their interconnective impact on gender equality and women's well-being; maternal, newborn and adolescent health; and economic development and environmental sustainability (Cost, 2009; Guttmacher Institute, 2017; Starbird, Norton, & Marcus, 2016; Starrs et al., 2018). Health and development initiatives over the last several decades, including the SDGs, have focused upon siloed components of SRHR, while other areas have remained neglected. While progress has shown to be inequitable amongst regions and countries, areas such as contraception, maternal and newborn health and HIV/AIDS have seen significant gains over the last few decades (Starrs et al., 2018). The Guttmacher-Lancet Commission advocates for a holistic view of SRHR and for the necessity of global goals to address previously neglected SRHR issues such as gender-based violence, abortion, adolescent sexuality and diversity in sexual orientations and gender identities (Starrs et al., 2018).

SDGs and SRHR: Nepal

Nepal's SDG Baseline Report (2017) underscores the country's MDG shortcomings in closing development gaps relating to gender, ethnic/caste groups and geographic location and highlights the vital role the SDGs play in moving towards a more inclusive society (National Planning Commission, 2017a). For Nepal to reach their SDG goals and to achieve its 2020 aim of graduating from Least Developed Country status (1 of 48 countries worldwide), the vital role SRHR plays in gender parity, economic growth and environmental stability must be acknowledged and acted upon. (National Planning Commission, 2017). While the preliminary national report on SDGs was developed in 2015, many indicators still need to be developed with others requiring revision and refinement (Dhimal et al., 2017; National Planning Commission, 2017b). Table 3.4 details Nepal's current indicators and yearly goals for Target 3.7 and Target 5.6, highlighting this lack of SDG target development for SRHR, particularly for Target 5.6.

Table 3.4 Sustainable Development Goals and SRHR in Nepal

Target 3.7 By 2030, ensure universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes					
Indicators	**2015**	**2019**	**2022**	**2025**	**2030**
3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods	66	71	74	76	80
a. Contraceptive prevalence rate (modern methods) (%)	47.1	52	53	56	60
b. Total Fertility Rate (TFR) (births per women aged 15-49 years)	2.3	2.1	2.1	2.1	2.1
3.7.2 Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group	71	56	51	43	30
Target 5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences					
Indicators	**2015**	**2019**	**2022**	**2025**	**2030**
5.6.1 Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care	-	-	-	-	-
a. Awareness about reproductive rights among girls and women (%)	59.5	68	74	80	90
b. Receiving specific support and service provisions related to sexual health care to the poor, discriminated and marginalised groups (%)	-	-	-	-	-
5.6.2 Number of countries with laws and regulations that guarantee women aged 15-49 years access to sexual and reproductive health care, information and education	-	-	-	-	-

(Adapted from: National Planning Commission, 2017b, pp. 46, 47 and 54)

Outlined as a major target of SDG 3, Nepal's Target 3.1 aims to reduce the MMR to 70 per 100,000 live births with the support of Indicator 3.1.2, increasing the proportion of births attended by skilled health personnel to 90% by 2030 (National Planning Commission, 2017b). While indicators for adolescent birth rate, CPR and total fertility rate are detailed within Target 3.7, a target addressing a decrease in the unmet need for family planning is not specified for this goal.

Within Nepal's SDG framework, the primary targets for SDG 5 are stated to include:

- elimination of wage discrimination for similar work

- elimination of physical/ sexual violence
- eliminating all harmful practices against women and girls (such as child, early and forced marriage and chhaupadi)
- increasing seats held by women in the national parliament
- and increasing women's share in public service decision making positions (National Planning Commission, 2017a, 2017b).

Notably, absent within these major goals is any reference to Target 5.6. While most indicators for Target 5.6 are still awaiting development, there is an absence of any indicators referencing safe abortion and post-abortion contraception.

Considering Nepal's globally lauded success in abortion legalisation and service implementation, combined with recently introduced governmental policy on free safe abortion services, the exclusion of these issues seems a missed opportunity to build on and to highlight the country's progress (Government of Nepal, 2016; Henderson et al., 2013; Ipas, 2016; Samandari et al., 2012; Wu, Maru, Regmi, & Basnett, 2017).

Towards the 2030 Agenda

Goal 5, Target 5.7 calls for 'universal access to sexual and reproductive health and reproductive rights' in accordance with the Cairo and Beijing agreements, two landmark agreements establishing SRHR for the first time within global development and human rights frameworks (Center for Reproductive Rights & UNFPA, 2013; United Nations, 1994, 1995). The Guttmacher-Lancet Commission's 2018 report argues that while the wording for Target 5.7 denotes the principles and commitments of these milestone agreements, it also encompasses the lack of consensus among countries to go beyond them (Starrs et al., 2018). One of the most notable SRHR issues impacted by this relates to safe abortion care.

The consensus from the ICPD in Cairo called for abortion to be safe 'where abortion is not against the law' with the Beijing agreement further adding language calling for a review of laws criminalising abortion. Since 2013, regional consensus agreements from around the world have utilised SRHR in place of more outdated terminology and within the SRHR framework, have included a broader range of issues (Starrs et al.,

2018). Regional consensus agreements such as the African Union's Maputo Plan of Action have used more progressive language relating to safe abortion care and its inclusion as an essential component of SRHR (The African Union Commission, 2016).

Without clearly defined SDG indicators relating to safe abortion care, it is all too easy for countries to overlook this essential component of reproductive health and rights, even for countries with liberal abortion laws such as Nepal. The absence of safe abortion care as a reproductive health and rights issue within Nepal's SDG framework is testament to the need for a more holistic approach towards SRHR within the global goals. There is a pressing need for the global narrative around SRHR to change and for consensus on the inclusion of all components of SRHR as vital in the achievement of the 2030 agenda (Adewole & Gavira, 2018; Starrs et al., 2018).

3.2 Sexual and Reproductive Health and Rights: Global

3.2.1 Background

Over the last three decades, language around SRHR has changed considerably, and the intersectoral components of SRHR have evolved and expanded. No longer are the sexual and reproductive health needs of women and girls consolidated beneath the all-encompassing banner of maternal and child health. The 1994 ICPD Programme of Action heralded agreement, for the first time in history, that reproductive rights are human rights (Center for Reproductive Rights & UNFPA, 2013; United Nations, 1994). Since that time, SRHR organisations have worked to establish an inclusive and comprehensive framework of SRHR components able to highlight the principle areas of reproductive and sexual health and their accompanying human rights (Starrs et al., 2018). Figure 3.3 details the seven components of SRHR, as defined by The Guttmacher-Lancet Commission, as well as often overlooked populations within reproductive and sexual health implementations.

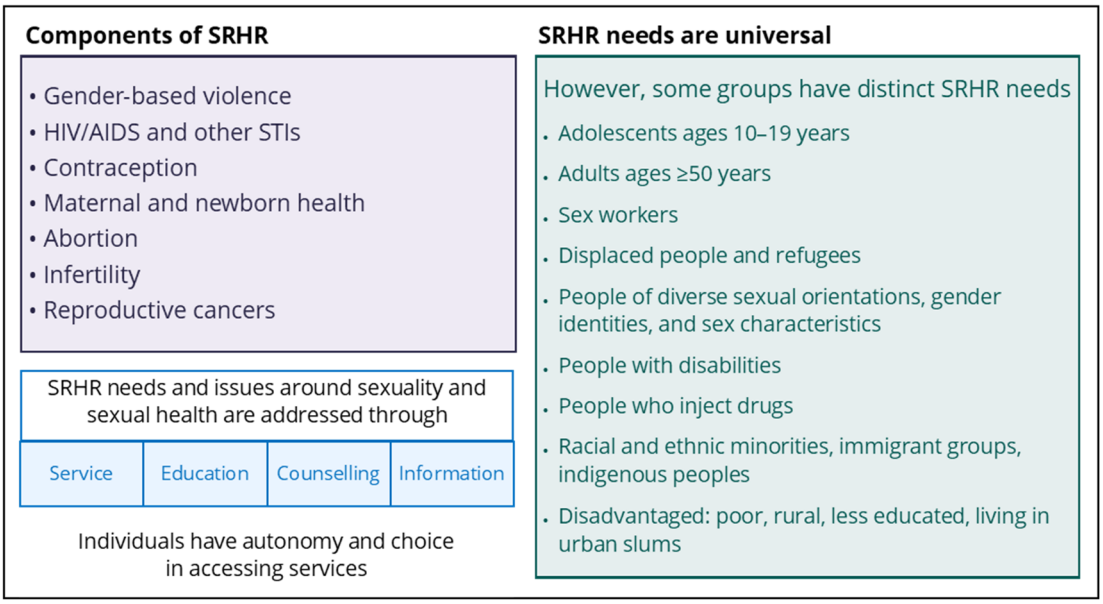


Figure 3.3 Components of SRHR and populations in need

(Source: Starrs et al., 2018, p.17)

3.2.2 Defining SRHR for All

Building on regional and global agreements, WHO publications, and on international human rights principles and treaties, in 2018 The Guttmacher-Lancet Commission announced a new comprehensive and integrated definition of SRHR (Starrs et al., 2018). As detailed in Figure 3.4, the definition is broad and inclusive with human rights at its foundation. Although the definition relates to all people, the issues are specifically germane for women and girls due to biological factors, socially defined gender roles and gender-based discrimination (Starrs et al., 2018). Individual autonomy and choice are the central core of SRHR. However, the fulfilment of these fundamental rights take place within a broader sociocultural, political, legal, economic and healthcare context (Starrs et al., 2018).

Integrated definition of sexual and reproductive health and rights

Sexual and reproductive health is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognise the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing.

All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realisation of sexual and reproductive rights, which are based on the human rights of all individuals to:

- have their bodily integrity, privacy, and personal autonomy respected;
- freely define their own sexuality, including sexual orientation and gender identity and expression;
- decide whether and when to be sexually active;
- choose their sexual partners;
- have safe and pleasurable sexual experiences;
- decide whether, when, and whom to marry;
- decide whether, when, and by what means to have a child or children, and how many children to have;
- have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence.

Essential sexual and reproductive health services must meet public health and human rights standards, including the "Availability, Accessibility, Acceptability, and Quality" framework of the right to health. The services should include:

- accurate information and counselling on sexual and reproductive health, including evidence-based, comprehensive sexuality education;
- information, counselling, and care related to sexual function and satisfaction;
- prevention, detection, and management of sexual and gender-based violence and coercion;
- a choice of safe and effective contraceptive methods;
- safe and effective antenatal, childbirth, and postnatal care;
- safe and effective abortion services and care;
- prevention, management, and treatment of infertility;
- prevention, detection, and treatment of sexually transmitted infections, including HIV, and of reproductive tract infections; and
- prevention, detection, and treatment of reproductive cancers.

Figure 3.4 Guttmacher-Lancet Commission on Sexual and Reproductive Health and Rights

(Source: Starrs et al., 2018, Panel 3, p. 11)

The WHO estimates approximately 830 women die each day from preventable causes related to pregnancy and childbirth with 99% of these deaths occurring in developing countries (World Health Organization, 2018b). Within developing regions in 2017, it was estimated that 214 million women of reproductive age had an unmet need for modern contraception and of the estimated 206 million pregnancies in these regions, 43% were unintended (Guttmacher Institute, 2017). Of the 55.7 million abortions that occurred worldwide each year between 2010 and 2014, an estimated 25.1 million

(45.1%) were unsafe, with 24.3 million (97%) of these occurring in developing countries (Ganatra, Gerdts, et al., 2017).

Globally, almost 4.3 billion people of reproductive age will have inadequate access to reproductive and sexual health services throughout their lifetime (Starrs et al., 2018). Each year, over 30 million women in developing regions do not give birth in a health facility, and more than 45 million women do not have adequate access to antenatal care (Starrs et al., 2018). Worldwide, more than 350 million men and women need treatment for STIs, and nearly 2 million are newly infected with HIV every year (Starrs et al., 2018). Recently, WHO estimated that 1 in 3 women experience either physical and/or sexual intimate partner violence or non-partner sexual violence within their lifetime (World Health Organization, 2017). Other global estimates for reproductive and sexual health concerns continue to remain relatively unknown, such as the number of couples affected by infertility or the number of people dying annually from reproductive cancers (Starrs et al., 2018).

Decades of research shows that equitable access to quality sexual and reproductive healthcare services: saves lives; improves health and well-being; promotes gender equality; increases access to education; increases socioeconomic status and has multigenerational benefits by improving children's health and overall well-being as well increasing as their access to education (Patierno, Feranil, & Reidy, 2018; Singh, Darroch, & Ashford, 2014; Starrs et al., 2018). In 2017 it was estimated that an investment of US$53.5 billion annually, or US$8.54 per person per year, for the contraceptive, maternal and newborn health care needs of women in developing regions would help ensure all women receive access to these essential SRHR services (Guttmacher Institute, 2017). Such an investment could result in maternal deaths in developing regions dropping from 308,000 to 84,000 per year, and newborn deaths from 2.7 million to 541,000 per year (Guttmacher Institute, 2017).

The next sections of the chapter will now primarily focus on two components of SRHR: contraception and abortion.

3.3 Contraception

Family planning is a broad term that encompasses an individual's reproductive rights to obtain their desired number of children, determine the spacing of pregnancies as well as the right for prevention and treatment of infertility (Starrs et al., 2018; World Health Organization, 2018a). Contraception plays a pivotal role in addressing women's reproductive autonomy and ensuring their SRHR (Starrs et al., 2018). Modern contraceptive methods include emergency contraception (EC), barrier methods, short-term methods, long-acting reversible contraceptives (LARCs), and permanent methods.

3.3.1 Contraceptive Methods

Emergency contraception (EC)

EC reduces the risk of pregnancy after unprotected sexual intercourse, inadequately protected sexual intercourse, or potential contraceptive failure (Family Planning New South Wales et al., 2012; International Consortium for Emergency Contraception & International Federation of Gynecology and Obstetrics, 2012). Hormonal EC (sometimes referred to as *the morning after pill* or *plan B*) involves the administration of a single or multiple dose hormone containing pill to prevent or delay ovulation. EC manufacturers commonly use either a combination of ethinyl estradiol and levonorgestrel, levonorgestrel only or ulipristal acetate (Family Planning New South Wales et al., 2012; Gemzell-Danielsson, Rabe, & Cheng, 2013). Studies from China have also shown Mifepristone to be an effective EC (Gemzell-Danielsson et al., 2013). Efficacy of EC decreases with time and—depending on the EC regime—the first dose must be taken within 72–120 hours after unprotected sexual intercourse (Gemzell-Danielsson et al., 2013).

Non-hormonal EC involves the insertion of a copper IUD within five days after unprotected sexual intercourse. This method of EC is immediately effective as the copper in the IUD is toxic to ovum and sperm and works primarily by inhibiting fertilisation (Gemzell-Danielsson et al., 2013). As well as being an effective EC, this method also offers the advantage of providing immediate and long-term contraception (Family Planning New South Wales et al., 2012).

Barrier methods

As well as providing a barrier to ejaculate, pre-ejaculate secretions and cervico-vaginal secretions, the male condom and female condom are the only contraceptive methods that also decrease the risk of HIV/AIDS and STI transmission (Family Planning New South Wales et al., 2012). The male condom is currently the only available temporary contraceptive method available to men and has an efficacy of 82% (Amory, 2016; Your Life, 2018b). Other barrier methods include the diaphragm (a dome shaped silicone cup that fits in the vagina, covering the cervix) and the cervical caps (a smaller dome, inserted deeper than diaphragms) that have an efficacy of approximately 88% and 84% respectively (Family Planning New South Wales et al., 2012; Your Life, 2018b).

Short-term methods

Taken once a day, the oral contraceptive pill (OCP) is the most well-known of the short-term methods. It comes in the form of the combined oral contraceptive pill, often referred to as *the pill* and the progestogen only contraceptive pill, often called *the mini-pill* (Family Planning New South Wales et al., 2012). In recent years, new developments in combined hormonal contraceptive methods such as the transdermal contraceptive patch and the contraceptive vaginal ring have been gaining in popularity within developed regions (Family Planning New South Wales et al., 2012; Jakimiuk et al., 2011; Kerns & Darney, 2011). These short-term methods are considered highly effective contraceptive methods with efficacy ranging from approximately 91% to 94% (Your Life, 2018a)

Long-acting reversible contraceptives (LARCs)

LARCs are defined as contraceptive methods requiring administration less than once a month (Harvey, McNamee, & Stewart, 2013; Temple-Smith & Sanci, 2017). Although the intramuscular or subcutaneous progestogen injection depot-medroxyprogesterone acetate (often called DMPA or *depo*) is administered every 3 months, there is debate as to whether this method falls into the LARC category, the short-term methods group or is in a category of its own (Ferreira et al., 2016; Harvey et al., 2013; Hubacher, Spector, Monteith, Chen, & Hart, 2017; Tibaijuka et al., 2017).

Progestogen-only subdermal implants (sometimes referred to as *the rod* or *the implant*) have evolved since first introduced in the early 1980s (Meirik, Fraser, & d'Arcangues, 2003; Rowlands & Searle, 2014). The first implants consisted of six silicone capsules with later developments producing two silicone rods and one silicone rod designs (Rowlands & Searle, 2014). Inserted in the arm with a specialised applicator, the subdermal implant prevents ovulation, inhibits sperm penetration of the cervical mucus and prevents implantation by thinning the endometrium (Rowlands & Searle, 2014). Depending on the type of subdermal implant, efficacy ranges from 3–5 years (Rowlands & Searle, 2014).

Intrauterine contraceptive devices (IUDs) are small flexible devices made of metal and/or plastic which is inserted through the cervix into the uterus (Family Planning New South Wales et al., 2012). They can be inert, or they may release copper or a hormone. IUDs impede sperm migration to the upper genital tract, inhibit ovum transport and prevent implantation (Harvey et al., 2013). In addition to this, hormonal IUDs also cause endometrial changes, thickening of cervical mucus and can prevent or delay ovulation in some users (Harvey et al., 2013). Depending on the type, IUDs have a 3–10 year efficacy (Temple-Smith & Sanci, 2017). With an efficacy of 99% to 99.9%, hormonal implants and IUDs are considered the most effective form of contraception (Your Life, 2018a)

Permanent methods

Female sterilisation is achieved through techniques that occlude or disrupt patency of the fallopian tubes, preventing sperm from fertilising the ovum (Family Planning New South Wales et al., 2012). Tubal obstruction methods include: ligating or removing a section of the fallopian tubes; mechanical blockage of the fallopian tubes using clips, rings, coils or plugs; and coagulation-induced blockage in the fallopian tubes using chemical agents or electrical current (Family Planning New South Wales et al., 2012). Depending on the type of procedure, female sterilisation can be reversed in some cases. However, after a reversal, only 50% of women will achieve pregnancy, and the risk of ectopic pregnancy is significantly increased (Family Planning New South Wales et al., 2012).

Male sterilisation, or vasectomy, involves the occlusion of the vas deferens by cutting or sealing the tubes. This disruption inhibits spermatozoa from combining with prostatic and seminal vesicle fluids resulting in the absence of sperm within ejaculate (Family Planning New South Wales et al., 2012). This procedure can be reversed with microsurgical techniques, however only 60% of couples achieve pregnancy after reversal (Family Planning New South Wales et al., 2012).

3.3.2 Contraception: Global

Equitable access to the full range of modern contraceptives methods is essential for the health and empowerment of all women (Mukasa, Ali, Farron, & Van de Weerdt, 2017; World Health Organization, 2012b). Extensive global research has shown that access to contraception and family planning services has a significant impact on a woman's educational attainment level and for that of her children (Erfani, 2015; Singh, Darroch, et al., 2014; Starbird et al., 2016; Stoebenau, Pande, & Malhotra, 2013; United Nations Population Fund & United Nations Children's Fund, 2017; Weitzman, 2017). Reproductive autonomy is closely linked with women's increased access to employment opportunities as well as socioeconomic, sociocultural and sociopolitical empowerment (Bloom, Canning, Fink, & Finlay, 2009; Canning & Schultz, 2012; Patierno et al., 2018; Starbird et al., 2016; United Nations Population Fund, 2017; Westeneng & D'exelle, 2015).

As well as the myriad of positive impacts contraceptive use has for the individual women and her family, communities and countries also benefit. With rapid population growth and rapid urbanisation creating social, structural, economic and environmental complications for the world's poorest countries, equitable access to family planning services is an established driver in fertility rate decline (Guttmacher Institute, 2017; Patierno et al., 2018; Singh, Darroch, et al., 2014; Starbird et al., 2016; Stephenson, Newman, & Mayhew, 2010). Within the SDG framework, contraceptive access and use plays a pivotal and intersectoral, role in the progress towards meeting all 17 Sustainable Development Goals by 2030. However, the unmet need for contraception continues to remain unacceptably high throughout the developing world (Sedgh et al., 2016).

3.3.3 Unmet Need: Global

In 2012, Bradley, Croft and Fishel established a standard definition of unmet need for contraception to ensure consistency in estimations across countries and over time within Demographic and Health Surveys (DHS) (Bradley, Croft, & Fishel, 2012).

A woman of reproductive age (15-49 years) has an unmet need for contraception if:

- she is married (legally married, cohabiting or in a consensual union) or unmarried and sexually active
- she is not using any method of contraception, either modern or traditional
- she is fecund
- she does not want to have a child (or another child) in the next two years or at all (Bradley et al., 2012; Sedgh et al., 2016).

The unmet need for contraception in developing regions has seen a decrease in recent years from 225 million women of reproductive age in 2014, to recent estimates of 214 million (Guttmacher Institute, 2017; Sedgh et al., 2016). However, efforts to identify populations where unmet need remains high continues to remain a global SRHR focus (Sedgh et al., 2016). In their Demographic and Health Survey study of 52 countries between 2005 and 2014, Sedge, Ashford and Husain (2016) reveal the most frequently cited reasons for women not using contraception, despite wanting to avoid pregnancy include:

- concerns about contraceptive side effects and health risks (25%)
- infrequent or no sexual intercourse (24%)
- women themselves or others close to them oppose contraceptive use (23%)
- breastfeeding and/or haven't resumed menstruation after birth (20%).

As well as ensuring equitable access to SRH services, Sedgh et al. (2016) highlight SRH service providers must place priority on providing a broad range of contraceptive methods, comprehensive contraceptive information provision and effective family planning counselling (Sedgh et al., 2016). Family Planning 2020, more commonly referred to as FP2020, is a global initiative born out of the 2012 London Summit on Family Planning. FP2020 currently operates in 69 of the world's poorest countries with the aim to expand access to family planning and contraceptive services,

information and supplies to an additional 120 million women and girls by 2020 (FP2020, 2018).

Implications of the continuing levels of global unmet need have a profound impact on the number of unintended pregnancies. Estimates from 2017 show that within developing regions, women with an unmet need for contraception account for 84% of all unintended pregnancies (Guttmacher Institute, 2017). The Guttmacher Institute (2017) estimates that fully meeting the unmet need for modern contraception would result in an estimated 76,000 fewer maternal deaths each year. Expanding and improving SRH services to adequately address the unmet need for contraception in developing countries would cost approximately US$11.9 billion annually (including both direct and indirect costs), or approximately US$1.90 per person per year (Guttmacher Institute, 2017).

Closely linked with unmet need for contraception and unintended pregnancy is the need for access to safe, legal and affordable abortion services (Singh, Remez, Sedgh, Kwok, & Onda, 2018). It has been seen in developing regions that when the desire for smaller families is strong, but access to family planning services is limited and contraceptive use is low, the abortion rate within these regions increases (Starrs et al., 2018).

3.4 Abortion

While access to safe abortion care is an essential component of reproductive health and rights for women, girls and people with a uterus, it continues to remain the most emotive and contentious issue within SRHR in both developed and developing regions (Guttmacher Institute, 2018c; Shah, Ahman, & Ortayli, 2014).

3.4.1 History of Abortion Laws

Systems under which abortion is legally restricted are divided into three main categories that were primarily developed during the period of colonialism from the sixteenth century onwards (Berer, 2017). These legal systems include Common Law, Civil Law and Islamic Law as detailed in Table 3.5.

Table 3.5 Historical global abortion law within legal systems

Legal System	Countries/Regions
Common Law	The United Kingdom and most of its former colonies: Australia, Bangladesh, Canada, India, Ireland, Malaysia, New Zealand, Pakistan, Singapore, the United States, and the Anglophone countries of Africa, the Caribbean, and Oceania
Civil Law	Most of the rest of Europe, including Belgium, France, Portugal, Spain, and their former colonies, Turkey and Japan, most of Latin America, non-Anglophone sub-Saharan Africa, and the former Soviet republics of Central and Western Asia. In addition, the laws of several North African and Middle Eastern countries have been influenced by French civil law
Islamic law	The countries of North Africa and Western Asia and others with predominantly Muslim populations, and having an influence on personal law, for example, Bangladesh, Indonesia, Malaysia, and Pakistan

(Source: Berer, 2017, p. 14)

Berer (2017) states that historically, restrictions on abortion access and provision were introduced into legal frameworks for three main reasons:

1. Mortality and morbidity: Women risked their lives and health procuring abortions performed by untrained individuals in unsafe and unsanitary conditions.
2. Religion: Abortion was considered a sin or transgression of morality, with laws established to punish as well as act as deterrents for women and abortionists.
3. Foetal life: Laws were enacted to restrict abortion to protect foetal life in some or all circumstances.

By the end of the nineteenth century, almost every country in the world restricted abortion within their legal frameworks (Berer, 2017). With the advancement of modern medicine and provision of safe abortion, current laws restricting abortion can be viewed within disciplinary and deterrent frameworks, or within morality based contexts that place foetal life over that of women's lives (Berer, 2017).

3.4.2 Current Global Abortion Laws

Since the early 1900s, progressive abortion law reform has been initiated within countries throughout the world on the basis of public health and human rights requirements (Berer, 2017). Broadly, there are six main grounds under which countries implement abortion laws (Berer, 2017; Singh et al., 2018). This continuum of laws

ranges from complete illegality to the availability of safe abortion services without restriction or reason (Singh et al., 2018) as follows:

1. Abortion is illegal on all grounds.
2. Abortion is legal to save a woman's life.
3. Abortion is legal to save a woman's life and preserve physical health.
4. Abortion is legal to save a woman's life and preserve physical and/or mental health.
5. Abortion is legal to save a woman's life, preserve physical and/or mental health and for socioeconomic reasons.
6. Abortion is legal without restriction as to reason, with gestational and other requirements.

Many countries also permit abortion on at least one of the following additional grounds: if the pregnancy resulted from rape or incest, or if there is a severe foetal anomaly (Singh et al., 2018).

With the enactment of new legislation enabling progression on the continuum of grounds 1 to 6, the number of deaths relating to unsafe abortion has shown to decrease (Berer, 2017; Singh et al., 2018). As depicted in Figure 3.5, between 2000 and 2017, a total of 28 countries moved along the continuum of grounds 1 to 6 by at least one of the 6 categories. All but one country, Nicaragua, broadened current legal grounds for safe abortion access (Singh et al., 2018).

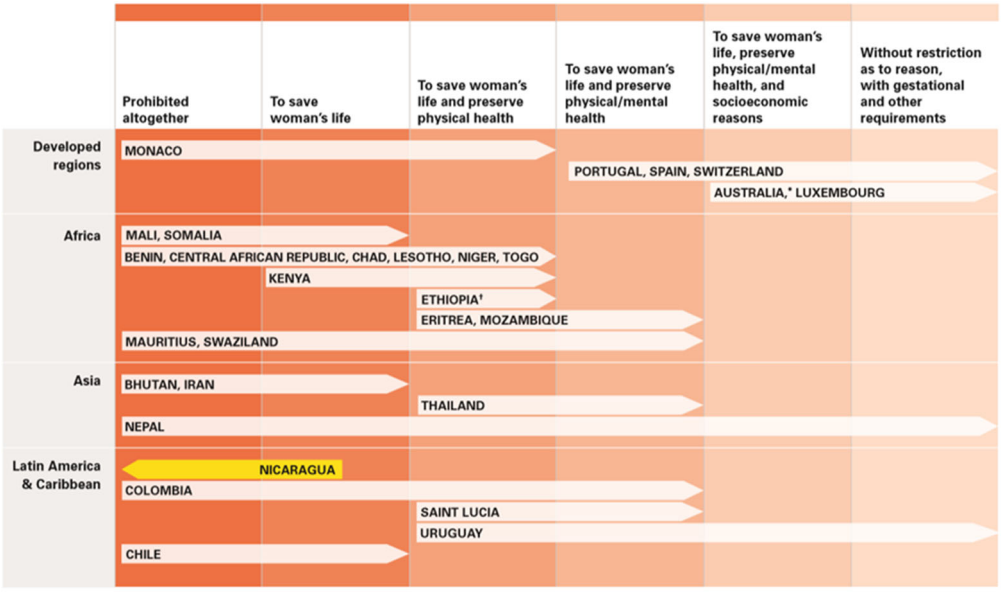


Figure 3.5 Countries that have changed categories within the legal continuum for abortion (2000 – 2017)

(Source: Singh et al., 2018 p. 18)

As depicted in Figure 3.5, of all countries detailed, Nepal has seen the most dramatic shift in abortion legislation since 2000 from 'prohibited altogether' status to 'without restriction as to reason, with gestational and other requirements' (Singh et al, 2018). Figure 3.6 presents the status of the world's 193 countries and six territories or nonstates, by six abortion-legality categories and three additional legal grounds under which abortion was allowed in 2017.

Legality category	DEVELOPED REGIONS	DEVELOPING REGIONS: Africa		DEVELOPING REGIONS: Asia & Oceania		DEVELOPING REGIONS: Latin America & Caribbean
1 Prohibited altogether (no explicit legal exception)	Andorra Malta San Marino	Angola Congo-Brazzaville Congo-Kinshasa Egypt Gabon	Guinea-Bissau Madagascar Mauritania Sao Tome & Principe Senegal	Iraq Laos Marshall Islands Micronesia	Palau Philippines Tonga	Dominican Republic El Salvador Haiti Honduras Nicaragua Suriname
2 To save life of woman	Ireland	Côte d'Ivoire Libya Malawi Mali (r,i) Nigeria Somalia South Sudan Sudan (r) Tanzania Uganda		Afghanistan Bangladesh Bhutan (r,i) Brunei Darussalam Indonesia* (r,f) Iran (f) Kiribati Lebanon Myanmar Oman	Papua New Guinea Solomon Islands Sri Lanka Syria*,† Timor-Leste† Tuvalu United Arab Emirates*,† West Bank & Gaza Yemen	Antigua & Barbuda Brazil (r) Chile (r,f) Dominica Guatemala Mexico (r,f) Panama† (r,f) Paraguay Venezuela
3 To save life of woman/preserve physical health	Liechtenstein Monaco (r,i,f) Poland† (r,i,f)	Benin (r,i,f) Burkina Faso (r,i,f) Burundi Cameroon (r) Cen. African Rep. (r,i,f) Chad (f) Comoros Djibouti Equatorial Guinea*,†	Ethiopia (r,i,f) Guinea (r,i,f) Kenya Lesotho (r,i,f) Morocco* Niger (f) Rwanda (r,i,f) Togo (r,i,f) Zimbabwe (r,i,f)	Jordan Kuwait*,† (f) Maldives* Pakistan Qatar (f) Saudi Arabia*,† South Korea* (r,i,f) Vanuatu		Argentina (r) Bahamas Bolivia (r,i) Costa Rica Ecuador Grenada Peru
4 To save life of woman/ preserve physical/ mental health	New Zealand (i,f) Northern Ireland	Algeria Botswana (r,i,f) Eritrea (r,i) Gambia Ghana (r,i,f) Liberia (r,i,f)	Mauritius† (r,i,f) Mozambique (r,i,f) Namibia (r,i,f) Seychelles (r,i,f) Sierra Leone Swaziland (r,i,f)	Israel (r,i,f) Malaysia Nauru Samoa Thailand (r,f)		Colombia (r,i,f) Jamaica St. Kitts & Nevis St. Lucia (r,i) Trinidad & Tobago
5 To save life of woman/preserve physical/mental health/ on socioeconomic grounds	Finland (r,f) Great Britain (f) Iceland (r,i,f) Japan* (r)	Zambia (f)		Cyprus (r,f) Fiji† (r,i,f) Hong Kong (r,i,f) India† (r,f) Taiwan*,† (r,i,f)		Barbados† (r,i,f) Belize (f) St. Vincent & Grenadines (r,i,f)
6 No restriction as to reason (with gestational and other requirements)	Albania† Australia Austria‡ Belarus Belgium‡ Bosnia-Herzegovina† Bulgaria Canada‡‡ Croatia† Czech Republic† Denmark† Estonia France‡ Germany‡ Greece† Hungary Italy** Kosovo†,*†	Latvia† Lithuania† Luxembourg‡ Macedonia† Moldova† Montenegro† Netherlands†† Norway† Portugal†,*† Romania‡ Russian Fed. Serbia† Slovakia† Slovenia† Spain†,‡ Sweden*‡ Switzerland Ukraine United States†,††	Cabo Verde South Africa Tunisia**	Armenia† Azerbaijan Bahrain Cambodia†,‡ China‡‡ Georgia† Kazakhstan Kyrgyzstan Mongolia** Nepal North Korea‡‡ Singapore§§ Tajikistan Turkey*,†, *† Turkmenistan Uzbekistan Vietnam‡‡		Cuba† Guyana§ Puerto Rico†† Uruguay†

Notes: Three additional legal grounds denoted by: r=rape, i=incest and f=fetal anomaly. Gestational-limit data are available only for countries in legality category 6. For these countries, unless indicated otherwise (i.e., by symbols ‡ through *‡ designated below), abortion is legally allowed through the 12th week of gestation; the 12-week limit applies to 37 countries. *Spousal authorization required. †Parental authorization/notification required. ‡Gestational age limit through 14th week. §Gestational-age limit through 8th week. **Gestational-age limit through 90 days/three months. ††No gestational-age limit for previability abortion. ‡‡Law does not indicate gestational-age limit. §§Gestational-age limit through 24th week. *†Gestational-age limit through 10th week. *‡Gestational-age limit through 18th week. *Sources:* references 56, 57 and 89; and Ministry of Health and Welfare, Republic of China, Genetic Health Act of 1985, amended as of 2009, Taipei, Taiwan; and Republic of Mozambique, Lei nº 35/2014, Lei da revisão do Código Penal, Artigo 168, Aborto não punível, Maputo, Mozambique, 2014.

Legality categories 1–4: Highly legally restricted

Legality categories 5 and 6: Broadly legal

Figure 3.6 Global abortion laws

(Source: Singh et al., 2018, p. 50)

In May 2018, 66.4% of Irish people voted to repeal the Eighth Amendment, a 1983 constitutional inclusion that banned abortion in almost all circumstances (Reidy, 2018). Restrictive abortion laws in Ireland have been the focus of much international

scrutiny over the last two decades, with both the United Nations Human Rights Committee and European Court of Human Rights ruling the laws were a violation of women's human rights (Centre for Reproductive Rights, 2017; Qadir, 2013; Reidy, 2018). New legislation allowing terminations within the first 12 weeks of pregnancy, and up to 24 weeks in exceptional circumstances, has been signed into law with expectations that services will be in place by early 2019 (BBC News, 2018; Sherwood, 2018).

In June of 2018, Argentina's House of Representatives approved a bill to decriminalise abortion during the first 14 weeks of pregnancy (Human Rights Watch, 2018). In a country where women and girls have been subjected to criminal prosecution for seeking an abortion, the bill would have decriminalised abortion on the grounds of rape if the life and health of the women or girl are at risk, or in the case of severe foetal abnormality (Human Rights Watch, 2018). Despite this advancement, the Senate rejected the bill (Human Rights Watch, 2018; Singh et al., 2018). The majority (93%) of countries with highly restrictive abortion laws are within developing regions (Singh et al., 2018). In contrast, liberal abortion laws are found in nearly all countries in Europe and Northern America, as well as in several countries in Asia (Guttmacher Institute, 2018b). However, liberal abortion laws may not be consistent throughout the country.

On 17 October, 2018, members of Queensland's parliament in Australia voted to remove the 119 year old 'morality' section of the state's criminal code, aligning the state with other progressive abortion laws in the country (Children by Choice, 2018; Smee, 2018). Under the 1899 Criminal Code, abortion had been a crime in the state of Queensland (Children by Choice, 2018; Queensland Health, 2018). Although abortion had been generally regarded as lawful in Queensland if performed to prevent grave danger to the woman's physical or mental health, two cases were brought before the courts, in 1985 and 2010, relating to the provision and procurement of abortion (Children by Choice, 2018). Within the the new legislative framework, abortion will be legal until 22 weeks gestation, and thereafter with the approval of two doctors. Similar to the Norther Territory, Tasmania and Victoria, safe access zones will be implemented within 150 meters of abortion clinics (Children by Choice, 2018; Smee, 2018). Doctors will be allowed to object to the provision of abortion on moral grounds,

however, they will be legally required to refer women seeking abortions to another medical practitioner (Children by Choice, 2018; Smee, 2018). The state of New South Wales is currently the only state or territory in Australia where abortion remains in the criminal code (Children by Choice, 2018)

The liberalisation of abortion laws plays a fundamental role in access to safe abortion services, but must work in concert with permissive sociocultural attitudes and within supportive political environments (Berer, 2017). In recent years, countries with liberal laws, such as the United States, Turkey and several countries within the former Soviet bloc or sphere of influence (e.g., Latvia, Macedonia, the Russian Federation and the Slovak Republic), have increasingly added restrictions that aim to inhibit access to legal abortion (Guttmacher Institute, 2018b; Rivkin-Fish, 2017).

In the United States between 2010 and 2016, 32 states collectively passed 338 laws impeding access to legal abortion services, with the state of Iowa enacting one of the most restrictive abortion laws in the developed world in 2018 (Glenza, 2018; Singh et al., 2018). In the contentious political climate currently surrounding the appointment of a new Supreme Court justice, US state policymakers, SRHR organisations and advocacy groups are concerned for the potential overturn of the Supreme Court decision, *Roe v. Wade* (Guttmacher Institute, 2018a). If the landmark 1973 Supreme Court case that established access to safe abortion as a constitutional right is overturned, 22 states could ban abortion outright, with eight states at high risk of losing abortion rights (Center for Reproductive Rights, 2018).

Poland is yet another example of the progression and regression of safe abortion laws. Following the Soviet Union, in 1932 Poland was the second country to legalise abortion, progressively extending the grounds upon which it could be legally accessed (Hussein, Cottingham, Nowicka, & Kismodi, 2018). However, in the early 1990s religious and political pressure saw these laws regress with increasingly severe requirements placed on abortion access. In 1993 a change in political power and the subsequent reinstatement of liberal abortion laws until 1997 when rulings by the Polish Constitutional Court resulted, again, in the regression of abortion laws (Berer, 2017; Hussein et al., 2018). Poland's current abortion laws, some of the most restrictive in Europe, date from this time, and since 2011 there have been repeated efforts to ban

abortion entirely (Berer, 2017; Hussein et al., 2018; Singh et al., 2018). In defiance of the continuing attack on their SRHR, tens of thousands of Polish citizens staged protests opposing the "Stop Abortion" bill in March 2018. If passed, the bill will enact legislation furthering restricting Poland's current abortion laws, significantly increasing barriers to safe abortion access and further impeding the SRHR of women and girls (Hussein et al., 2018).

Criminalising abortion or implementing restrictive abortion laws does not stop abortions from occurring, it just makes them unsafe. Abortions occur as frequently in countries with the two most restrictive legal categories (banned outright or allowed only to save the woman's life) as in countries that have laws aligning with the least-restrictive category (without restriction as to reason), approximately 37 and 34 per 1,000 women, respectively (Guttmacher Institute, 2018b). Berer (2017) argues that what makes abortion safe is irrefutable and straightforward: when it is universally affordable, accessible and available upon request. While many countries have made significant advancements in the legalisation or decriminalisation of abortion, for others abortion law reform remains a long and challenging process (Berer, 2017; Singh et al., 2018). To ensure positive and long-lasting change, safe abortion advocates must approach law reform within sociocultural frameworks and in the context of the political, health, legal and judicial systems of their country (Berer, 2017).

3.4.3 Abortion Procedures

The procedures for abortion are classified into two methods, surgical and medical, with the most appropriate method depending upon the duration (or gestational age) of the pregnancy (World Health Organization, 2012a).

Surgical Methods of Abortion

- Vacuum Aspiration (VA): the removal of products of conception (POC) through a plastic or metal cannula, attached to a vacuum source.
    - Electric vacuum aspiration (EVA): uses an electric vacuum pump.
    - Manual vacuum aspiration (MVA): creates a vacuum using a hand-held, hand-activated, plastic aspirator (syringe).

- Dilatation and Evacuation (D&E): preparation of the cervix using osmotic dilators or pharmacological agents and evacuating the uterus contents using EVA and long forceps.
- Dilatation and Curettage (D&C): the dilation of the cervix with mechanical dilators or pharmacological agents and the use of sharp metal curettes to scrape the walls of the uterus.

Abortion with VA takes from 3 to 10 minutes, depending on the gestational age of the pregnancy and is considered an extremely safe and effective procedure when provided in accordance with WHO protocol (World Health Organization, 2012a, 2015a). VA is the WHO recommend surgical method for up to 12–14 weeks since the last menstrual period (LMP). D&E is the recommended surgical method of abortion for 12–14 weeks since the LMP. Where skilled, experienced providers are available, D&E is the safest and most effective surgical technique for later abortion and takes approximately 30 minutes to perform (World Health Organization, 2012a). WHO (2012) states that D&C is not as safe as VA and considerably more painful for women. WHO technical guidelines recommend VA replace D&C where this method is still in practice, and where no safe abortion services are currently offered, VA should be the surgical method introduced (World Health Organization, 2012a).

Medical Methods of Abortion

- Mifepristone and misoprostol: combined regime of an initial dose of the antiprogestogen, mifepristone, followed by administration of a synthetic prostaglandin analogue, misoprostol.
- Misoprostol: repeated doses of misoprostol.

The administration of medical abortion (MA) is most effective within the combined regimen and is 95% to 98% effective in terminating pregnancies when used correctly (ESHRE Capri Workshop Group, 2017; World Health Organization, 2012a). This involves an initial dose of the drug mifepristone, which binds to progesterone receptors, inhibiting the action of progesterone and therefore interfering with the continuation of pregnancy (World Health Organization, 2012a). Following this, misoprostol is then administered, which enhances uterine contractions and aids in

expelling the uterine content (World Health Organization, 2012a). The combined regime is the most effective, well tolerated and cost-effective MA regime in the first and second trimesters of pregnancy (ESHRE Capri Workshop Group, 2017). Up to 90% of women will expel the POC over the 4–6 hours following misoprostol administration. Table 3.6 details the WHO (2012) recommended dosages and routes for the combined regime.

Table 3.6 Dosages and routes of administration for mifepristone followed by misoprostol

For pregnancies of gestational age up to 9 weeks (63 days)
▪ 200 mg **mifepristone** administered orally. ▪ Administration of **misoprostol** is recommended 1 to 2 days (24–48 hours) following ingestion of mifepristone. ▪ For vaginal, buccal or sublingual routes, the recommended dose of misoprostol is 800µg. ▪ For oral administration, the recommended dose of misoprostol is 400µg. ▪ With gestations up to **7 weeks** (49 days) misoprostol may be administered by vaginal, buccal, sublingual or oral routes. After 7 weeks of gestation, oral administration of misoprostol should not be used. ▪ With gestations up to **9 weeks** (63 days) misoprostol can be administered by vaginal, buccal or sublingual routes.
For pregnancies of gestational age 9–12 weeks (63–84 days)
▪ 200mg **mifepristone** administered orally, followed after 36 to 48 hours by: ▪ 800µg vaginal **misoprostol**, administered in a healthcare facility. A maximum of four further doses of misoprostol 400µg may be administered at three-hourly intervals, vaginally or sublingually.
For pregnancies of gestational age over 12 weeks (>84 days)
▪ 200mg **mifepristone** administered orally, followed after 36 to 48hours by: ▪ 400µg oral or 800µg **vaginal misoprostol** followed by 400µg **vaginal or sublingual misoprostol** every 3 hours up to a maximum of five doses, administered in a healthcare facility. For pregnancies of gestational age greater than 24 weeks, the dose of misoprostol should be reduced due to the greater sensitivity of the uterus to prostaglandins, but the lack of clinical studies precludes specific dosing recommendations.

(Adapted from: World Health Organization, 2012a, p. 43)

In comparison to the combined regime, the effectiveness of the misoprostol alone regimen is lower at 75% to 90%, the time to complete abortion is longer, and the process is more painful. However, the use of misoprostol alone is common where mifepristone is unavailable (Shah & Weinberger, 2012; World Health Organization, 2012a). Due to misoprostol's wide availability and low costs, particularly in countries where abortion laws are restrictive, misoprostol alone provides a safer alternative to

unsafe abortion methods (ESHRE Capri Workshop Group, 2017; Shah & Weinberger, 2012; World Health Organization, 2012a). For pregnancies of gestational age up to 12 weeks (84 days), WHO (2012) recommends 800μg of misoprostol administered vaginally or sublingually and repeated at intervals no less than 3 hours but no more than 12 hours for up to three doses. This regimen is 75% to 90% effective in completing abortion, with oral administration not recommended due to low efficacy. For pregnancies of gestational age over 12 weeks (84 days), the recommended regimen is 400μg of vaginal or sublingual misoprostol every 3hours for up to five doses (World Health Organization, 2012a). Due to the lack of clinical studies, the WHO *Safe Abortion: Technical policy guidance for health systems* does not have misoprostol only regimen recommendations for pregnancies over 24 weeks' gestation (World Health Organization, 2012a).

3.4.4 Abortion Complications

When performed by appropriately trained health professionals under modern medical conditions, complications arising from abortion are extremely rare, and the risk of death is negligible (World Health Organization, 2012a). However, complications such as haemorrhage, infection and uterine perforation can occur in extremely rare cases (World Health Organization, 2012a). The most common complications of abortion are ongoing pregnancy and incomplete abortion (ESHRE Capri Workshop Group, 2017). Ongoing pregnancy requires confirmation through ultrasound examination, while a diagnosis of incomplete abortion (retained POC) is made on clinical grounds (ESHRE Capri Workshop Group, 2017). Approximately 2% to 5% of women using the combined MA regime will require intervention to resolve incomplete abortion, terminate a continuing pregnancy or control bleeding (ESHRE Capri Workshop Group, 2017). Women who have an incomplete abortion following MA can show symptoms including excessive vaginal bleeding and abdominal pain, as well as signs of infection (Pawde, Ambadkar, & Chauhan, 2016; World Health Organization, 2012a). WHO (2012) recommends incomplete abortion be treated using either VA or misoprostol based on the clinical condition of the woman and her preference for treatment.

The ESHRE Capri Workshop Group (2017) note that few long-term sequelae are evident after abortion, and mortality and morbidity are lower than with pregnancies

carried to term. Surgical and medical methods of abortion have not been associated with an increased risk of ectopic pregnancy, infertility, miscarriage or placenta praevia, and studies have shown no correlation with an increased risk of breast cancer (ESHRE Capri Workshop Group, 2017; Royal College of Obstetricians and Gynaecologists, 2011). While abortion is globally viewed as one of the safest medical procedures, access to this essential component of SRHR continues to be hampered by antiquated laws and stigma.

3.4.5 Unsafe Abortion

Abortion is considered one of the safest medical procedures when performed in accordance with WHO guidelines (World Health Organization, 2012a). However, each year between 4.7% and 13.2% of maternal deaths are attributed to complications from unsafe abortion (Say et al., 2014; World Health Organization, 2018c). Even where abortion is broadly legal, conditions leading to unsafe abortion are numerous and multifaceted and can be impacted by the legal context of abortion access, the availability and accessibility of safe abortion services, socioeconomic factors, and sociocultural issues particularly abortion related stigma (Ganatra, Gerdts, et al., 2017; Singh et al., 2018).

A recent reconceptualisation of the framework and methods for estimating unsafe abortion has divided the WHO classification of *unsafe* abortion into two further categories, *less safe* and *least safe* (Ganatra, Gerdts, et al., 2017). In their 2017 study, Ganatra et al. classified abortions as *less safe* if only 1 of 2 criteria were met:

1. the abortion was performed by a trained provider, however, an outdated or unsafe method (e.g., sharp curettage) was utilised or
2. a safe method of abortion (e.g., mifepristone or misoprostol or both) was used but was administered without adequate information or support from a trained provider.

Least safe abortions are classified as abortions provided by untrained individuals using dangerous methods such as ingestion of caustic substances, insertion of foreign objects, and the use of traditional herbal mixtures or tonics (Ganatra, Gerdts, et al., 2017). A comprehensive list of traditional and non-medical methods of *least safe* abortion are detailed in Figure 3.7 (Singh et al., 2018).

BOX

Traditional abortion methods can be damaging to women's health

Women and untrained providers use many types of traditional and nonmedical methods to end unintended pregnancies. Not only do these methods often fail, they can lead to severe complications. The main categories of these methods, with examples from studies published over the past 10 years, are summarized below.

- Inserting into the vagina or cervix a catheter or other foreign object, such as cassava sticks, parsley stems, tree roots, crushed herbs, ground seeds, chicken bones, pencils, metal probes, wires, coat hangers, knitting needles, bicycle spokes, crushed bottles, potassium nitrate (saltpeter) or potassium permanganate tablets.[1–8]
- Introducing liquids into the vagina, such as saline solutions (saline instillation), concentrated herbal concoctions prepared with water or alcohol, soapy solutions, detergent or bleach.[1,2,7]
- Drinking alcohol, detergent, laundry bluing, fabric softener, bleach, acid, methylated spirits, castor oil, turpentine, tea brewed with livestock feces, blood tonics, concentrates of traditional plants[2,4,9–15] or, in South Africa, Dutch remedies (i.e., alcohol-based products containing small amounts of active ingredients).[13]
- Ingesting pharmaceutical products, including aspirin, painkillers, flu medicine, laxatives, chloroquine, nivaquine, quinine, panadol, ergometrine (ergot alkaloids), oral hormonal medications or injectable oxytocin.[1,2,16–19]
- Manipulating the abdomen, by locating the fetal mass through external palpations and then attempting to dislodge it by massaging or beating the lower abdomen.[2,4,10,11,19,20]
- Engaging in traumatic or injurious physical activity, such as jumping from the top of the stairs or roof, falling, lifting heavy objects or exercising excessively.[2,11,19,21]
- Trying other folk techniques, such as inserting a tube to blow air into the uterus to induce labor or placing a hot stone on the abdomen to "melt" the fetus.[20]

Figure 3.7 Traditional and non-medical abortion methods

(Source: Singh et al., 2018, p. 22)

Of all 25 million unsafe abortions (45% of all abortions) that occurred annually between 2010 and 2014, an estimated 17 million (31%) were considered *less safe* and 8 million (14%) were *least safe* (Ganatra, Gerdts, et al., 2017; World Health Organization & Guttmacher Institute, 2017).

3.4.6 Unsafe Abortion Complications

Recent estimates suggest that within 14 developing countries where unsafe abortion is prevalent, approximately 40 percent of women develop complications requiring medical intervention as a result of unsafe abortion (Singh et al., 2018). Within the developing world (excluding Eastern Asia) in 2012, an estimated 7 million women and girls were treated for complications from unsafe abortion (Singh & Maddow-Zimet, 2016; Singh et al., 2018). Complications from unsafe abortion can include:

- incomplete abortion (failure to completely expel pregnancy tissue from the uterus)
- haemorrhage
- vaginal, cervical and uterine injury
- septic and haemorrhagic shock
- infection and sepsis
- death (Singh et al., 2018; World Health Organization & Guttmacher Institute, 2017).

In accordance with the 1994 Cairo Programme of action, even countries with highly restrictive abortion laws include post-abortion care within their healthcare provision frameworks (Singh et al., 2018; United Nations, 1994). However, where abortion laws are restrictive, often post-abortion care services are far below the WHO standards and women often delay or do not seek care due to shame, stigma and fear of legal repercussions (Berer, 2017; Singh et al., 2018).

In highly restrictive contexts or where safe abortion services are not accessible, international studies indicate a decrease in severe complications from unsafe abortion with the increased availability and use of misoprostol, relative to more invasive and dangerous techniques (Briozzo, Gómez Ponce de León, Tomasso, & Faúndes, 2016; Costa, 1998; Ganatra, Guest, & Berer, 2017; Henderson et al., 2013; Miller et al., 2005; Singh et al., 2018). However, without the necessary information and support, women using misoprostol to self-induce abortion remain at risk of negative health outcomes (Singh et al., 2018).

3.4.7 Unsafe Abortion in Humanitarian Crisis Settings

Although the necessity of providing SRH services in humanitarian crisis settings has gained greater recognition over the last decade, safe abortion services are still rarely provided within this context (McGinn & Casey, 2016; Rogers, Sapkota, & Dantas, 2018). Within humanitarian crisis settings (both environmental and human caused) women and girls are at increased risk of sexual and gender-based violence (McGinn & Casey, 2016). Throughout history, the intergenerational and traumatic impact of conflict-related sexual violence against women and girls has been well documented (United Nations Security Council, 2018).

Evidence of the Myanmar Army's systematic and widespread sexual violence, rape, gang-rape and mass rape of Rohingya religious minorities during the 2017 conflict in the Rakhine State has been reported by the United Nations as well as human rights and humanitarian organisations (Ahmed, 2018; Global Justice Center, 2018; Human Rights Watch, 2017a; United Nations, 2017a; United Nations Security Council, 2018). In March 2018, the United Nations Secretary-General officially included Myanmar Armed Forces (Tatmadaw) on the watchlist of security forces and armed groups who are credibly suspected of conflict-related sexual violence (Ahmed, 2018; United Nations Security Council, 2018).

Within weeks of the violence commencing, incidences of Rohingya women and girls attempting to self-terminate pregnancies resulting in incomplete or septic abortions were reported by humanitarian aid workers in the region (Ahmed, 2018; Human Rights Watch, 2017a). The number of Rohingya rape survivors is unclear, as is the number of women and girls who have died or have suffered severe injuries from attempting unsafe abortion (Ahmed, 2018; Human Rights Watch, 2017a). Healthcare workers are concerned many survivors may not have reported rapes and be hiding pregnancies, and may risk giving birth in secret or abandoning their babies due to fear, shame and stigma (Ahmed, 2018).

3.5 The Global Gag Rule

3.5.1 Background

In 1973, The Helms Amendment was passed banning the use of United States of America (U.S.) funding, under the Foreign Assistance Act, to be used 'for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortion' (Blanchfield, 2017). To further restrict U.S. international aid in the provision of global SRHR, in 1984 the Mexico City Policy, more commonly known as the Global Gag Rule, was established under the administration of President Ronald Reagan (Starrs, 2017). Although the Helms Amendment has been in place in U.S. foreign policy since its inception in 1973, the Global Gag Rule has been rescinded and reinstated by subsequent Republican and Democratic Presidents. Prior to its latest iteration, the last implementation of the Global Gag Rule was during the George W. Bush administration from 2001 to 2009. On January 23, 2017, three days after his inauguration, U.S. President, Donald Trump passed an executive order reinstating and expanding the Global Gag Rule, now officially known as the Protecting Life in Global Health Assistance Policy (The White House, 2017; U.S. Department of State, 2017).

3.5.2 Global Impact

Combined with restrictions of the Helms Amendment, the Global Gag Rule enacts the banning of U.S. family planning funding from contributing to foreign nongovernmental organisations (NGOs) that provide abortion services, counselling or referrals, or participate in abortion legalisation advocacy, even if the NGOs do not use U.S. government funds for these activities (Starrs, 2017). By further expanding the Global Gag Rule, foreign NGOs receiving U.S. funding may potentially be subject to decreased funding and restrictions for their work on a range of health programmes including, but not limited to maternal and child health, nutrition, HIV/AIDS, the Zika virus, Ebola, malaria and tuberculosis (Centre for Reproductive Rights, 2018; Starrs, 2017; U.S. Department of State, 2017). It is estimated that approximately US$575 million bilateral family planning assistance will be removed with the extended policy potentially impacting an estimated US$9.5 billion in US foreign aid (Starrs, 2017). Compounding this loss of international aid is the Trump Administration's efforts to defund the United Nations Population Fund (UNFPA) (Barot & Cohen, 2015).

International studies show during previous enactments of the Global Gag Rule the rate of unsafe abortion and number of unwanted pregnancies increased comparatively to years when the policy was not in place (Barot & Cohen, 2015; Bingenheimer & Skuster, 2017). As a direct result of the enactment in 2001, international health services providing a range of sexual, reproductive, maternal and child health care; HIV and STI testing and counselling; and cervical cancer screening were forced to close (Center for Reproductive Rights, 2017). As in 2001, Nepal based I/NGOs refused to abide by the 2017 Global Gag Rule terms, with the expectation that again, SRH and safe abortion services as well as the women they serve will suffer (Barot & Cohen, 2015; Population Action International, 2005; Ryan, 2017; Shrestha, 2017).

In a direct violation of human rights, the Global Gag Rule undermines gender equality, inhibits free speech and will reverse years of global development progress in sexual and reproductive health and rights (Bingenheimer & Skuster, 2017; Centre for Reproductive Rights, 2018). Within six months of the announcement the global political campaign, *SheDecides,* secured more than US$390 million from international donors to help support programs that have been defunded. However, more funding was urgently needed (She Decides, 2017).

While the full impact of its implementation has yet to be seen, The Global Gag rule places the health and lives of women and girls all over the world at risk. Restricting access to family planning and safe abortion services does not stop abortions from occurring, it merely makes them unsafe (Barot & Cohen, 2015). While inevitably increasing the number of unplanned pregnancies within the developing world, the Protecting Life in Global Health Assistance Policy will predictively, and ironically, increase the number of abortions it aims to prevent (Bingenheimer & Skuster, 2017; Iversen, 2017).

3.6 Sexual and Reproductive Health and Rights: Nepal

3.6.1 Background

With a focus on decreasing the fertility rate and supporting women to space and time births, the Nepal Family Planning Program commenced in 1981. In 1988, the program began working in coordination with the newly established Female Community Health

Volunteers (FCHV) Program (Justice et al., 2016). It would not be until the early 1990s that "Safe Motherhood" would become a priority, with the upgrades and expansion of basic primary health services in rural areas and the establishment of modern medical facilities at the village level (Justice et al., 2016). In 1997 the Nepal Safe Motherhood Program commenced. Over subsequent years under the Department of Health Services, Family Health Division, SRH-focused programs would go on to include the Comprehensive Abortion Care program in 2002 and the Adolescent Sexual and Reproductive Health program in 2011 (Government of Nepal, 2018). Along with the progressive decline of the maternal mortality ratio, as depicted in Figure 3.8, over the last three decades the fertility rate in Nepal fell by 63% between 1976 and 2014, from 6.3 children per women to 2.3 (United Nations Population Fund, 2017).

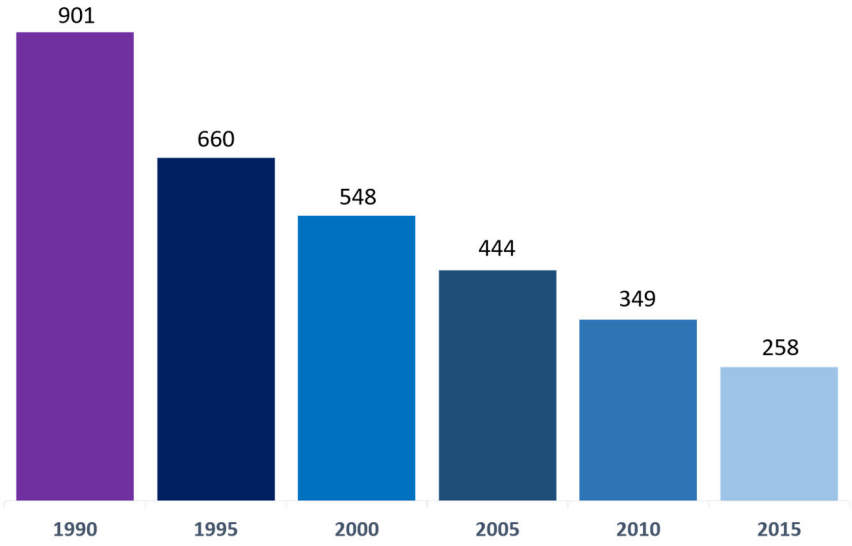


Figure 3.8 Maternal Mortality Ratio (per 100 000 live births) in Nepal (1990–2015)

(Source: World Health Organization, 2015b)

Over the last three decades there have been marked advances in SRHR for women and girls in Nepal, however, these improvements mask continued inequities (United Nations Population Fund, 2017). The gender-biased society, disparities between geographical regions, ethnic/caste groups and wealth quintiles continue to hinder equitable, countrywide progress (United Nations Population Fund, 2017).

3.6.2 Contraception

As a committed FP2020 member country, and in line with the Nepal Health Sector Strategy (2015-2020), the Government of Nepal places family planning (including voluntary contraception) as a priority program within the Ministry of Health (FP2020, 2018; Government of Nepal, 2018). In Nepal, family planning and contraceptive information and services are provided through government, social marketing, I/NGO and the private sector. Table 3.7 details the contraceptive methods available through government health facilitates.

Table 3.7 Contraceptive method availability through government facilities

	FCHV#	Outreach Clinics+	Health Post	PHC^	District Hospital	Regional Hospitals
Condoms	✓	✓	✓	✓	✓	✓
OCP[1]	✓**	✓	✓	✓	✓	✓
Injectables	✗	✓	✓	✓	✓	✓
Implants	✗	✗	✓*	✓*	✓	✓
IUD[2]	✗	✗	✓*	✓*	✓	✓

Female Community Health Volunteer
+ Primary Healthcare Outreach Clinics
^Primary Healthcare Centre
[1] Oral Contraceptive Pill Intrauterine Device
[2] Intrauterine Device
** FCHVs can only provide OCP to women who are already using the method. They do not screen and counsel first time OCP users.
* Due to unavailability of trained service providers and stock outs, these services may not be consistently available at all facilities.

(Source: Government of Nepal, 2015a)

Permanent methods (sterilisation) are available from the hospital level upwards or through scheduled seasonal or mobile outreach services, often run in conjunction with I/NGO SRH services (Government of Nepal, 2015a), and are the most frequently accessed method of contraception in Nepal, as detailed in Figure 3.9.

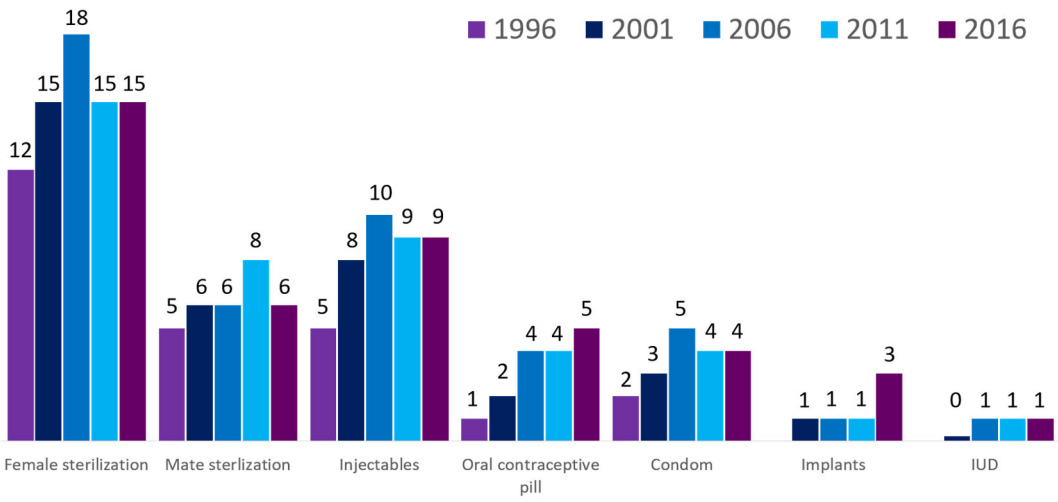


Figure 3.9 Contraceptive method use in Nepal

(Source: Ministry of Health and Population Nepal et al., 2012; Ministry of Health Nepal et al., 2017b)

I/NGO SRH services and most private sector services offer the full range of contraceptive methods to clients as detailed in Figure 3.9. Condoms and oral contraceptive pills (and sometimes injectables) are available through pharmacies in Nepal with pharmacies being the principal source for EC (Thapa, 2016). Figure 3.10 depicts the sources of modern contraceptive methods in Nepal.

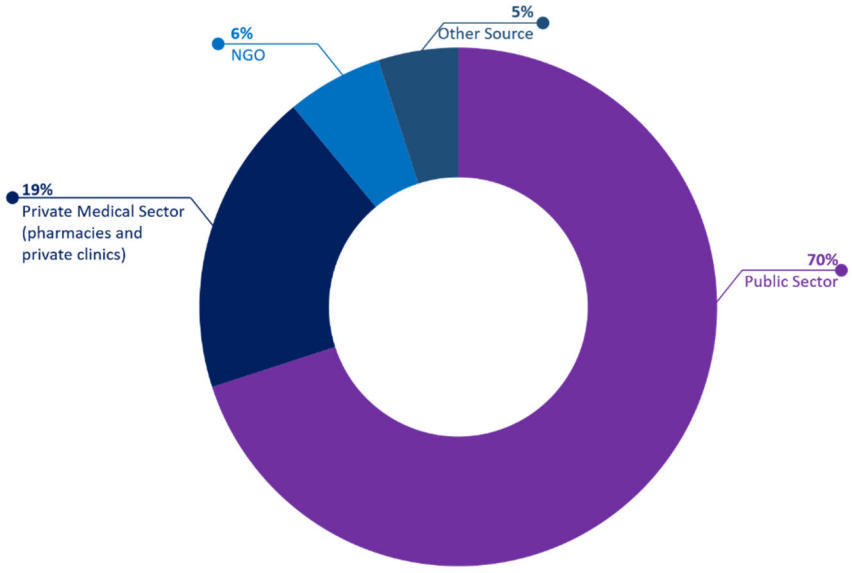


Figure 3.10 Sources of modern contraceptive methods in Nepal

(Source: Ministry of Health Nepal et al., 2017b)

Recent estimates suggest that 24% or 1 in 4 women in Nepal have an unmet need for family planning (Ministry of Health Nepal et al., 2017c). In 2014, the unintended pregnancy rate for Nepal was 68 per 1,000 women of reproductive age (Puri et al., 2016). That same year, approximately half of all pregnancies were unintended (either unwanted or mistimed), and close to one-third (31%) of all pregnancies ended in abortion (Puri et al., 2016).

As shown in Figure 3.11, the contraceptive prevalence rate (CPR) has plateaued over recent years, with data from the National Demographic Health Survey (NDHS) reporting a decrease in the use of modern contraceptive methods and an increase of traditional contraceptive methods (Government of Nepal, 2015a; Ministry of Health Nepal et al., 2017b).

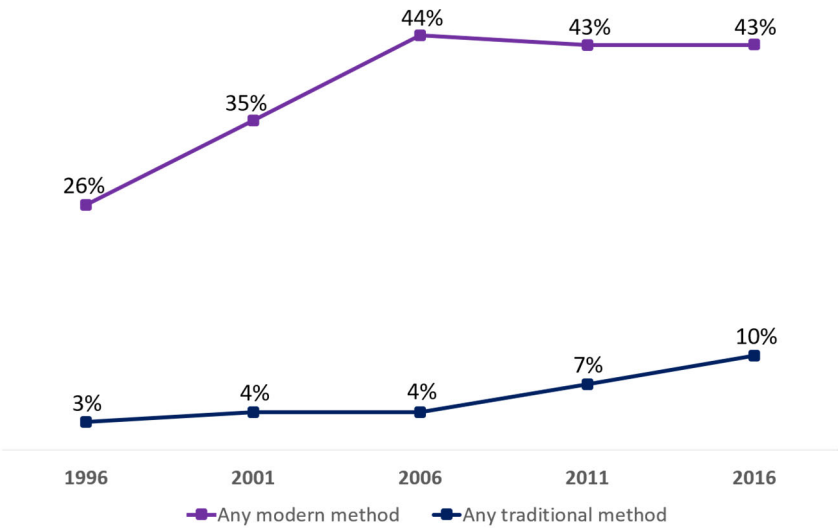


Figure 3.11 Contraceptive prevalence rate (modern methods vs traditional methods)

(Adapted from: Ministry of Health Nepal et al., 2017b, p. 5)

3.6.3 Abortion

History of Nepal's Abortion Laws

With the premise of adhering to Hindu religious texts, in 1854 abortion was officially criminalised in Nepal within the *Muluki Ain* (Upreti, 2014). Within the code, abortion was characterised as an offence against life, making no exception for its occurrence, even when pregnancy threatens a woman's life (Government of Nepal, 2002). In subsequent years the criminal ban on abortion resulted in severe and negative health

consequences for women and girls in Nepal, and created strain on the country's judicial and health systems (Dahal, 2004; Samandari et al., 2012; Thapa, Thapa, & Shrestha, 1992; Upreti, 2014).

Women accused of seeking or procuring an abortion faced up to five years in prison, and in some cases, women faced life imprisonment under charges of infanticide (Center for Reproductive Law and Policy & Forum for Women, 2002; Government of Nepal, 2002; Samandari et al., 2012; Thapa, 2004). Before legalisation, up to 1 in 5 women in Nepali prisons had been convicted on the grounds of illegal abortion or infanticide (Government of Nepal, 2002; Samandari et al., 2012).

By 1994, the unsafe abortion rate in Nepal was estimated at 117 per 100,000 women with abortion related mortality and morbidity high (Government of Nepal, 2015b; Samandari et al., 2012). A 1992 hospital-based study reported that deaths resulting from abortion related complications represented more than half of all pregnancy related deaths in the hospital (Thapa et al., 1992). A maternal mortality and morbidity study conducted in 1998 indicated that over half (54%) of obstetrics and gynaecology hospital admissions were due to complications from unsafe abortion (Government of Nepal, 2015b; Pathak, Malla, Pradhan, & Rajlawat, 1998). The criminal ban on abortion prevailed within Nepal's legal system for 148 years before the *Muluki Ain* was amended in 2002.

Nepal's Current Abortion Laws

After more than four decades of political and social advocacy from the medical and public health communities, combined with pressure from a growing women's rights movement, Nepal legalised abortion under the 11th Amendment to the *Muluki Ain* on 27 September, 2002 (Government of Nepal, 2002, 2009; Upreti, 2014). The landmark case, *Lakshmi Dhikta v. Government of Nepal* in 2009, further acknowledged women's reproductive rights as fundamental human rights and access to safe abortion as a constitutional right (Centre for Reproductive Rights, 2011; Upreti, 2014).

The Nepal Ministry of Health's National Safe Abortion Policy (2002, p. 7) states abortion is legal under the following conditions:

- up to 12 weeks for any woman with the pregnant woman's consent

- up to 18 weeks of gestation if the pregnancy results from rape or incest with the pregnant woman's consent
- at any time during pregnancy, if the life, physical or mental health of the mother are at risk or if the foetus is deformed, with the advice of a medical practitioner and the consent of the pregnant woman.

The law prohibits sex-selective abortions and abortions performed under coercion (e.g., without the consent of the woman). Both cases carry jail terms for the individuals deemed responsible. Terms of imprisonment are 1 to 5 years for coercion, 3 to 6 months for the act of identifying the sex of the foetus (with the intention of terminating pregnancy), and 6 months to 2 years for providing a sex-selective abortion (Government of Nepal, 2006a). For females under the age of 16 years, the presence of a guardian is required for any decisions regarding abortion (Government of Nepal, 2002).

Safe Abortion Services in Nepal

In 2004, the first government run Comprehensive Abortion Care (CAC) services opened in Nepal, with nongovernment organisation (NGO), international nongovernment organisation (INGO) and private sector services following shortly after (Andersen et al., 2012; Henderson et al., 2013). Initially, only doctors were able to provide surgical abortion, however through the decentralisation of safe abortion service provision, since 2008 mid-level providers have been authorised to provide manual vacuum aspiration (MVA) up to 8 weeks' gestation (Government of Nepal, 2015b; Wu et al., 2017). In accordance with WHO guidelines, MVA is the government recommended method of surgical abortion over sharp curettage techniques, however, dilatation and curettage (D&C) is available (Government of Nepal, 2015b; Ministry of Health Nepal et al., 2017b).

Since 2009, medical abortion (MA) in the form of mifepristone and misoprostol (often referred to as the *combi-pack*) has been available from accredited safe abortion services (Government of Nepal, 2015b; Tamang et al., 2015). There are currently four registered brands of MA approved by the Department of Drug Administration: Medabon, Mariprist, Isovent, and Zitotec (Fernandez, Coeytaux, Gomez Ponce de León, & Harrison, 2009). Despite restrictions prohibiting the provision of MA through

unaccredited facilities, both registered and unregistered brands of MA are readily available for purchase at pharmacies throughout Nepal (Fernandez et al., 2009; Puri et al., 2016; Tamang et al., 2015). Data from the 2016 Nepal Demographic and Health Survey (NDHS) indicates the most common method of abortion is MA, with approximately 7 in 10 abortions occurring via this method (Ministry of Health Nepal et al., 2017b). Figure 3.12 depicts the frequency of types of abortions occurring in Nepal as reported by the 2016 NDHS.

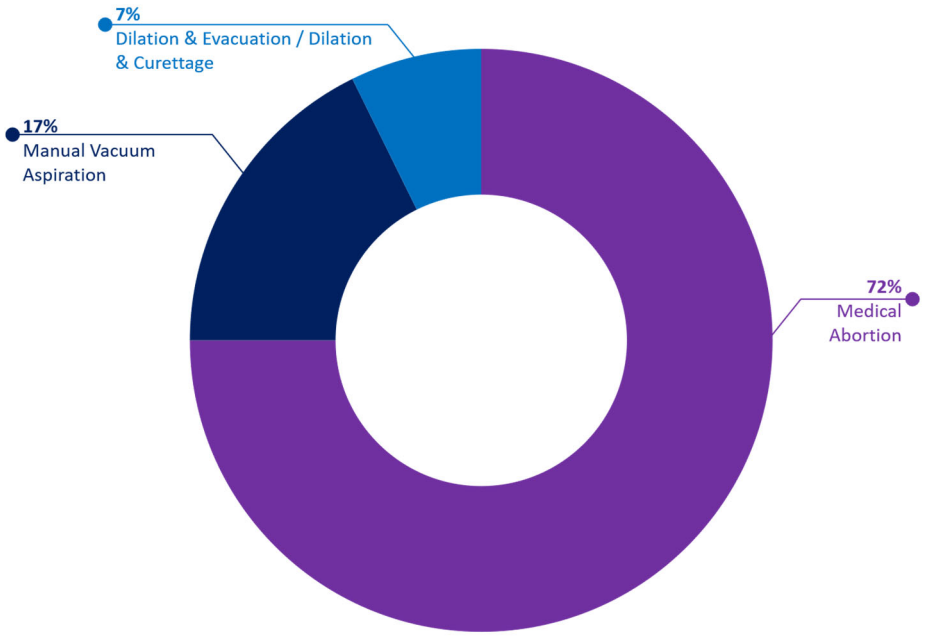


Figure 3.12 Frequency of type of abortion in Nepal

(Source: Ministry of Health Nepal et al., 2017b)

All government accredited safe abortion services are approved to perform first trimester abortions, with lower-level facilities, such as health post, approved only to provide MA up to 9 weeks gestation (Puri et al., 2016). For approved services to provide second-trimester abortion, additional accreditation and training are required (Puri et al., 2016). Currently, over 2,000 trained personnel provide safe abortion services in all 75 districts in Nepal (Wu et al., 2017). Since the implementation of safe abortion services, more than 1,005,000 Nepali women have received safe abortions from certified service sites (Government of Nepal, 2018). In 2014 alone, an estimated 323,100 abortions were performed, of which approximately 137,000 (42%) were

legally provided in government certified facilities as shown in Figure 3.13 (Puri et al., 2016).

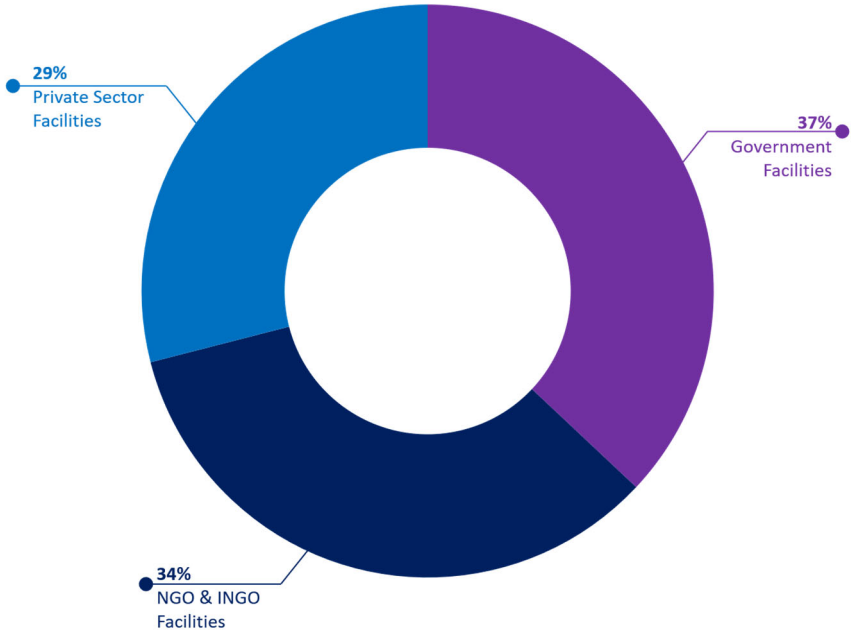


Figure 3.13 Place of abortion access (Government of Nepal certified facilities) in 2014

(Source: Puri et al., 2016)

The remaining 186,100 (58%) abortions were clandestine, less safe and least safe procedures, self-induced by the pregnant women or provided by untrained or unapproved providers (Puri et al., 2016).

Unsafe Abortion in Nepal

Despite the continued expansion of safe abortion services since legalisation in 2002, unsafe abortion (at 7%) remains the third highest direct cause of maternal death in Nepal (Pradhan et al., 2010). In 2014, of the 80,500 women who received post-abortion care, 68% were treated for complications from unsafe abortion (Puri et al., 2016). A 2010 study of 527 women presenting with post-abortion complications found that 291 (81%) of medical abortions and 50 (30%) of surgical abortions were obtained from uncertified sources (Rocca et al., 2013). The study highlighted that women accessing abortion through uncertified providers were less aware of the legal status of abortion in Nepal (Rocca et al., 2013).

Data from the 2016 NHDS reported only 2 women in 5 (41%) were aware that abortion is legal in Nepal, with women in urban areas more likely to be aware than their rural counterparts (Ministry of Health Nepal et al., 2017b). Across Nepal, 48% of women reported knowing a place where safe abortions can be obtained, with knowledge of a source for a safe abortion higher among urban, educated, and wealthy women (Ministry of Health Nepal et al., 2017b). Compounding these issues of safe abortion access, women in rural and mountainous regions face further barriers due to geographical and transportation factors (Wu et al., 2017). Gender norms inhibiting women's autonomy, combined with sociocultural attitudes on sexual behaviour and immorality, continue to perpetuate stigma and fear around safe abortion access (Rocca et al., 2013).

While the direct impact of abortion legalisation on the decline in maternal mortality remains unclear, definitive evidence shows that since legalisation, there has been a downtrend in the proportion of serious abortion related complications (Henderson et al., 2013; Wu, Maru, Regmi, & Basnett, 2017). The liberalisation of abortion laws and the continued expansion of safe abortion services has shown the government of Nepal's commitment to the health and welfare of Nepali women. However, effective assessment of services and programs continues to be lacking with efficacy in the translation of safe abortion policy into clinical practice remaining a challenge (Bell, Zimmerman, Choi, & Hindin, 2018; United Nations Population Fund, 2017).

Efficient and equitable provision of PAC plays an essential role in facilitating positive health outcomes for women who access safe abortion services (Andersen et al., 2012; Barot, 2014; Bell et al., 2018; Government of Nepal, 2006b; PAC Consortium Service Delivery Task Force, 2014; Rogers & Dantas, 2017; Wang, Puri, Rocca, Blum, & Henderson, 2016). Within PAC service provision, effective and comprehensive post-abortion family planning counselling is vital for women to make informed choices regarding their post-abortion contraceptive use and for the prevention of future unintended pregnancies (Rogers & Dantas, 2017). However, accessing effective and comphresive safe abortion services remains a significant challenge for many Nepali women (Bell et al., 2018).

Despite laws restricting the provision of MA, registered and unregisterd brands are readily available for illegal purchase at pharmacies throughout Nepal (Puri et al., 2016; Tamang et al., 2015). While pharmacies are more accessible than safe abortion services, particularly in rural and remote areas and for women who have limited mobility and autonomy (Tamang et al., 2015), they do not systematically provide any form of PAC (Rogers, Sapkota, Tako, et al., 2018).

3.7 Summary of the Chapter

This chapter has provided background on the global goals, laws and challenges impacting SRHR on an international level, particularly relating to safe abortion care. It details how the global status and understanding of SRHR correlates with SRHR policy and program implementation within Nepal. The provision of Post-Abortion Care (PAC) within the global and Nepali context will be analysed in chapter 4 and within Article 1: Access to contraception and sexual and reproductive health information post-abortion: a systematic review of literature from low- and middle-income countries.

CHAPTER 4

A SYSTEMATIC REVIEW OF POST-ABORTION ACCESSS TO CONTRACEPTION AND SRH INFORMATION

Introduction to the Chapter

This chapter contains the first peer reviewed journal article included in this thesis. A systematic review of literature from low-and middle-income countries was conducted to obtain a global understanding of women's access to post-abortion contraception and SRH information, and the Nepali context within this global picture. The review highlighted barriers to effective PAC service provision, informing the development of qualitative data collection tools and supporting research recommendations.

Rogers, C., & Dantas, J. A. R. (2017). Access to contraception and sexual and reproductive health information post-abortion: a systematic review of literature from low- and middle-income countries. *Journal of Family Planning and Reproductive Health Care, 43*(4), 309-318. doi:10.1136/jfprhc-2016-101469

This manuscript was accepted for publication in the ***Journal of Family Planning and Reproductive Health Care*** on 25 January 2017 (Appendix C).

4.1 Article 1: Access to contraception and sexual and reproductive health information post-abortion: a systematic review of literature from low- and middle-income countries

4.1.1 Abstract

Aim: This systematic literature review documented, analysed and critiqued the accessibility of contraception and sexual and reproductive health (SRH) information for women living in low- and middle-income countries who have undergone medical or surgical abortion.

Methodology: This review systematically collated relevant and recent empirical evidence regarding women's access to contraception and SRH information post-abortion within low- and middle-income countries. The PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) framework Guidelines, Flow Diagram and Checklist were utilised to undertake the review. The Ovid (MEDLINE), ProQuest, Science Direct, Web of Science, PUBMED and CINAHL databases were searched and studies that met edibility criteria were assessed for validity and analysis. A narrative synthesis of characteristics and results of the included studies is presented.

Findings: After detailed assessment of available and relevant literature, nine studies were selected for inclusion in the review. Studies highlighted barriers to contraception and SRH information including supply limitation, lack of comprehensive education and counselling, lack of skilled Post Abortion Care (PAC) providers and abortion stigma.

Conclusion: The review found that with access to a wide range of contraceptive methods combined with comprehensive SRH information and education, contraception uptake in women post-abortion does increase. The review also highlights the inconsistencies in clinic-reported *counselling* and what this term actually involves within a PAC setting.

Key Message Points

- A lack of comprehensive SRH information and education as well as negative provider attitudes are key barriers for women accessing post-abortion contraception.
- When women are offered a broad range of contraceptive methods and are provided effective contraceptive counselling, the likelihood of them accepting post-abortion contraception increases.
- Clarification of term the counselling is needed within PAC services to ensure comprehensive information provision and effective support for women.

4.2 Introduction

4.2.1 Post-Abortion Care

Of the 38 million abortions performed annually in low- and middle-income countries, more than half are unsafe (Shah et al., 2014; Singh, Jacqueline E. Darroch, & Lori S.

Ashford, 2014). Post-Abortion Care (PAC), is an essential component of Comprehensive Abortion Care (CAC), and refers to a set of interventions designed to respond to the specific needs of women who have miscarried or induced an abortion (Barot, 2014; Hyman & Kumar, 2004; Ipas, 2018). The PAC Consortium (2014) states the following five essential elements of PAC necessary for effective and equitable provision of PAC services:

1. **Community and service provider partnerships is vital** for prevention of unwanted pregnancies and unsafe abortion, mobilisation of resources to help women receive appropriate and timely care for complications from abortion, and to ensure that health services reflect and meet community expectations and needs.
2. **Counselling** of women to identify and respond to women's emotional and physical health needs and SRH concerns is also a critical component of care.
3. **Treatment** of incomplete and unsafe abortion and complications that are potentially life-threatening needs to be addressed during PAC provision.
4. **Contraceptive and family planning services** are needed to help women prevent an unwanted pregnancy or practice birth spacing.
5. **Reproductive and other health services** that are preferably provided on-site or via referrals to accessible and quality facilities in provider' networks are needed to holistically meet women's PAC needs (PAC Consortium Community Task Force, 2002; PAC Consortium Service Delivery Task Force, 2014).

Even in low- and middle-income countries, such as Nepal and Viet Nam, where abortion laws are legal, unsafe abortion still occurs due to lack of skilled providers, limited access to safe abortion services, and sociocultural and socioeconomic inhibitors (Shah et al., 2014). In countries where abortion is prohibited and illegal and laws are restrictive, such as Dominican Republic and Sri Lanka, unsafe practices are undertaken and women face an even greater need for accessible, affordable and comprehensive PAC services (Adinma, 2011; Rasch, 2011; Shah et al., 2014).

The objective of this review was to systematically collate and synthesise recent and relevant research evidence on PAC services provided to women from low- and middle-income countries and their ability to access contraception and SRH information. The findings from this systematic review aim to support global understanding of women's

post-abortion experiences relating to access of contraception and SRH information, and to highlight areas that continue to require further research.

4.3 Methods

This systematic review evaluated studies relating to the post-abortion experiences of women living in low- and middle-income countries and their ability to access contraception and SRH information. Owing to the fact that PAC services are vital in all countries, even those where abortion laws are restrictive or prohibited, all studies situated in low- and middle-income countries have been considered for inclusion (PAC Consortium Community Task Force, 2002; Rasch, 2011). Low- and middle-income countries and geographical regions have been defined using the World Bank classification system for the 2016 fiscal year (The World Bank Group, 2015).

The PICOS approach was used to develop the research question for this systematic review (Liberati et al., 2009).

P (patient, population or disease being addressed): in this review these were women who were in the process of obtaining or had obtained PAC services as well as PAC providers.

I (intervention or exposure): in this case access to PAC services, specifically contraception and SRH information.

C (comparator group): the reported lack of access to PAC services in this review.

O (outcome): adequate access to contraception and SRH information post-abortion.

S (study design): qualitative, quantitative and mixed method studies were included in this review.

The research question the review sought to address was: Does adequate access to post-abortion contraception and SRH increase uptake of contraception and SRH information in low- and middle-income countries?

Based on the Assessing the Risk of Bias of Individual Studies in Systematic Reviews of Health Care Interventions guidelines (Viswanathan et al., 2012), the methods used for assessing risk of bias in the articles selected for review included:

1. checking the internal validity or conduct of the studies

2. the external validity or applicability of the studies
3. study design
4. reporting of results
5. fidelity of intervention if any
6. choice of outcome measures
7. conflict of interest reported.

4.3.1 Information sources

Using the PRISMA Guidelines, Flow Diagram and Checklist, a systematic literature search was conducted by the first author from April to November 2014, a second search was carried out in May 2015, and a final search was conducted in June 2016, in order to identify new papers (Liberati et al., 2009). Databases accessed in the search were: Ovid (MEDLINE), ProQuest, Science Direct, Web of Science, PUBMED and CINAHL, with additional articles sourced from the authors' records. References for the review were managed by the bibliographic software, Endnote X7 and a standard form was used to assist in data extraction (Daly et al., 2007; Harris, Quatman, Manring, Siston, & Flanigan, 2013). Appendix D highlights the strategy used for the Ovid (MEDLINE) database search, which was used as a framework for subsequent database searches.

4.3.2 Study selection

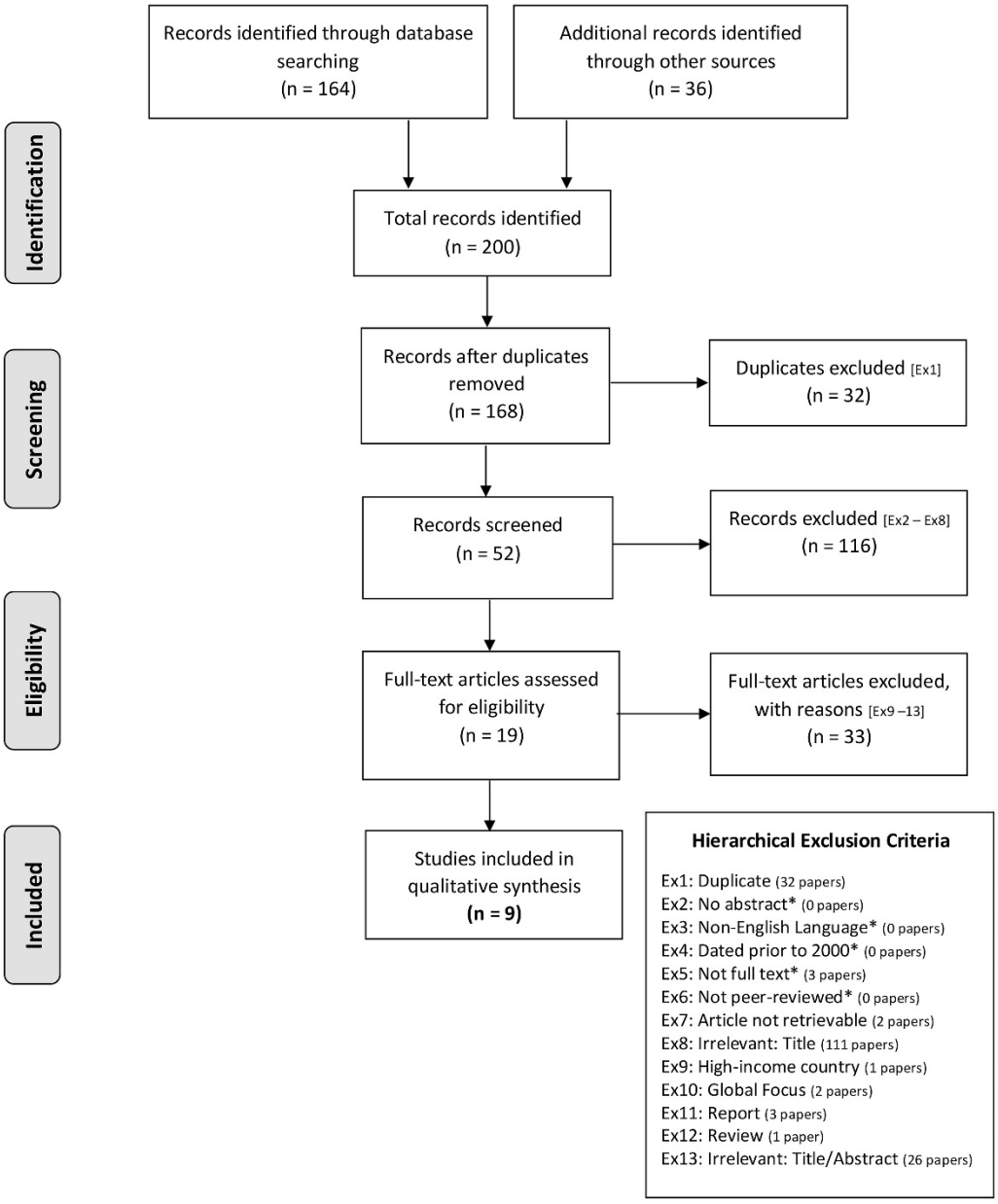
Access to contraception within the context of this study, relates to access to a wide range of contraceptive methods that present women with the ability to make an informed decision based on detailed and accurate information about the method she feels would suit her best (World Health Organization, 2014a, 2015a). *SHR information* is a broad term used to encompass the provision of information, education and counselling relating to: reproductive health, such as fertility return, fertility intention, child-spacing, prevention of unwanted pregnancies, contraception methods and contraception use; sexual health advice, including information on signs of post-abortion complications and normal post-abortion symptoms, return to sexual activity advice, hygiene, STI/HIV prevention, testing and treatment information; and information and/or referral to relevant and quality health services if needed (PAC Consortium Community Task Force, 2002; World Health Organization, 2014a, 2015c).

The following search terms were used in combination to guide the study: post-abortion, post-abortion care, contraception; family planning, sexual and reproductive health information, sexual and reproductive health and rights, and comprehensive abortion care. Searches were restricted to English language only papers published between 2000 and 2016 and to peer reviewed journal articles through database filters.

4.4 Data Collection, Analysis, Extraction and Assessment

An initial 164 articles were identified by the first author from the six databases and an additional 36 articles from the authors' personal files were added to the review for a combined total of 200 articles. After removal of duplicates, the remaining 168 papers were assessed based on Title with a resulting 114 articles removed as they did not meet the inclusion/exclusion criteria. Manuscripts without abstracts were excluded as they were non-research papers. Two articles were not retrievable, however, on further review of their Title and Abstract information, it was decided that the papers were not relevant to the study as their reported findings did not specifically relate to the research question.

Fifty-two full text papers relevant to the review were assessed based on Title and Abstract information, leading to the inclusion of 19 papers for full article review and data extraction (Acharya & Kalyanwala, 2012; Arambepola, Rajapaksa, & Galwaduge, 2014; Azmat, Shaikh, Mustafa, Hameed, & Bilgrami, 2012; Becker, Díaz Olavarrieta, Garcia, & Harper, 2013; Esber, Foraker, Hemed, & Norris, 2014; Etuk, Ebong, & Okonofua, 2003; Evens et al., 2014; Gallo et al., 2004; Htay, Sauvarin, & Khan, 2003; Jackson, Johnson, Gebreselassie, Kangaude, & Mhango, 2011; Kalu, Umeora, & Sunday-Adeoye, 2012; Kinaro, Tag Elsir, Schlangen, & Mack, 2009; McCarraher et al., 2010; Nguyễn, Gammeltoft, & Rasch, 2007; Paul, Gemzell-Danielsson, Kiggundu, Namugenyi, & Klingberg-Allvin, 2014; Rocca et al., 2014; Tavrow, Withers, & McMullen, 2012; Tesfaye & Oljira, 2013). Figure 4.1 presents the PRISMA Flow Diagram relating to this study and hierarchical exclusion criteria for article selection.



*When possible, selected as filters during initial database searches

Figure 4.1 Systematic framework of the literature review process

(Source: Liberati et al., 2009)

Both authors reviewed data extraction and synthesis for the final 19 articles selected for potential inclusion as well as the final nine selected papers. Appendix E displays the data extraction and synthesis of the 19 articles with potentiality for inclusion in the systematic review. Each of the 19 articles were examined to identify the roles contraception access and the provision of SRH information for women post-abortion

had within the study design and findings. Analysis of the articles involved the extraction and synthesis of relevant data into a standard form, which was reviewed by both authors. As well as the detailed exclusion criteria, all articles underwent quality assessment relating to the relevance of the study, the appropriateness of the research design and methodology, ethical considerations and the journals in which the articles were published (Harris et al., 2013).

4.6 Results

After detailed appraisal, nine studies were selected for inclusion in the systematic review (Table 4.1) (Arambepola et al., 2014; Becker et al., 2013; Evens et al., 2014; Gallo et al., 2004; McCarraher et al., 2010; Nguyễn et al., 2007; Rocca et al., 2014; Tavrow et al., 2012; Tesfaye & Oljira, 2013). These studies were undertaken in four different geographical regions and within seven different countries. While there were varying legal implications with regards to obtaining an abortion within the study settings, all nine studies were conducted within PAC services or facilities. These included 94 government/public facilities (63 hospitals and 31 clinics); four nongovernmental facilities (two hospitals and two clinics); and one privately owned medical clinic.

Table 4.1 Articles included for systematic review

	Region	Country	Authors	Year	Title/Journal	Policy/Law	Setting /Design/Sample	Quality Indictors
1	South Asia	Sri Lanka	Arambepola *et al.* (Arambepola et al., 2014)	2014	Usual hospital care versus post-abortion care for women with unsafe abortion: a case control study from Sri Lanka *BMC Health Services Research*	Heavily restricted[1] (Centre for Reproductive Rights, 2014)	Nine government hospitals in eight out of the 24 districts of Sri Lanka Quantitative: Unmatched case–control study • 171 cases (unsafe abortion) • 638 control Group 1 (spontaneous abortion) • 600 control Group 2 (term unintended pregnancy)	• Ethical approval stated • Representation of Muslim and Tamil populations assisting generalizability • Limitations of study not adequately highlighted • No competing interests • Funding stated • Reported findings relevant to review
2	South Asia	Nepal	Rocca *et al.* (Rocca et al., 2014)	2014	Postabortion contraception a decade after legalization of abortion in Nepal *International Journal of Gynecology & Obstetrics*	Legal[2] (Centre for Reproductive Rights, 2011a)	Two non-government clinics and two public hospitals in Kathmandu and Terai region Quantitative: Prospective cohort study • 838 questionnaires with women post abortion (baseline and 6 months)	• Ethical approval stated • Diverse recruitment sites and large sample assisting generalizability • Limitations of study acknowledged • No competing interests • Funding stated • Reported findings relevant to review
3	East Asia & Pacific	Viet Nam	Nguyễn *et al.* (Nguyễn et al., 2007)	2007	Situation analysis of quality of abortion care in the Main Maternity Hospital in Hải Phòng, Viet Nam *Reproductive Health Matters*	Legal[3] (Centre for Reproductive Rights, 2014)	One public hospital (Phu-San Hospital) Qualitative and Quantitative: Evaluation • 748 structured survey pre/post-abortion • 20 IDIs post-abortion • 7 informal interviews with health care staff • 100 participant observations	• Ethical approval stated, informed consent stated as obtained • Quantitative data double entered by two different operators • Limitations of study not adequately highlighted • Competing interests/funding not stated • Reported findings relevant to review

[1] Sri Lanka: abortion is illegal with the explicit exception to save the women's life

[22] Nepal: abortion is legal without restriction as to reason during the first 12 weeks of pregnancy, and thereafter on specific grounds

Latin America & the Caribbean	Mexico	Becker *et al.* (Becker et al., 2013)	2013	Women's reports on postabortion family-planning services provided by the public-sector legal abortion program in Mexico City *International Journal of Gynecology & Obstetrics*	Legal in study setting[4] (Centre for Reproductive Rights, 2011a, 2014)	Three government facilities: general hospital, maternity hospital and primary health centre Quantitative • Survey of 402 women seeking first-trimester abortion care	• Ethical approval stated, informed consent stated as obtained • Limitations of study discussed and recommendations for future studies given • No competing interests • Funding stated • Reported findings relevant to review
Latin America & the Caribbean	Dominican Republic	McCarraher *et al.* (McCarraher et al., 2010)	2010	Meeting the needs of adolescent post-abortion care patients in the Dominican Republic *Journal of Biosocial Science*	Strictly illegal[5] (Centre for Reproductive Rights, 2011a, 2014)	Three public hospitals in Santo Domingo and one in La Romana Qualitative: Evaluation of intervention Non-experimental pre/post-test design • 88 IDI with providers • 88 IDI follow-up with providers • Survey 140 adolescent PAC patients (12–19y) • Survey 134 PAC patients (20–35y)	• Ethical approval stated • Limitations of study discussed and recommendations for future studies given • Competing interests not stated • Funding stated • Reported findings relevant to review
Sub-Saharan Africa	Kenya	Tavrow *et al.* (Tavrow et al., 2012)	2012	Age matters: differential impact of service quality on contraceptive uptake among post-abortion clients in Kenya *Culture Health & Sexuality*	Legal with provisions[6] (Centre for Reproductive Rights, 2011a)	One private medical clinic Quantitative and Quantitative • Data from 1080 post-abortion clients • 2 IDI with doctor	• Ethical approval stated • Limited qualitative data, however, it serves to support the quantitative data • Only one study site which impacts generalizability • Limitations of study stated • Competing interests not stated • Funding stated • Reported findings relevant to review

[3] Viet Nam: abortion is legal without restriction as to reason; law does not indicate gestational limit

[4] Mexico: federal system in which abortion law is determined at state level; in Mexico City abortion is legal without restriction during the first 12 weeks of pregnancy

[5] Dominican Republic: abortion, for any reason, is strictly prohibited

[6] Kenya: abortion is legal to save a woman's life or health or where emergency treatment is needed

7	Sub-Saharan Africa	Kenya	Evens *et al.* (Evens et al., 2014)	2014	Post-Abortion Care services for youth and adult clients in Kenya: a comparison of services, client satisfaction and provider attitudes *Journal of Biosocial Science*	Legal with provisions[6] (Centre for Reproductive Rights, 2011a)	Eight public hospitals in Central and Nairobi provinces Qualitative • 283 IDI with PAC clients (structured phone interviews) • 20 IDIs with providers (1 in person, 19 by phone)	• Ethical approval not clearly stated for this post-intervention study • Limitations of study discussed and recommendations for future studies given • Competing interests not stated • Funding stated • Reported findings relevant to review
8	Sub-Saharan Africa	Mozambique	Gallo *et al.(Gallo et al., 2004)*	2004	An Assessment of Abortion Services in Public Health Facilities in Mozambique: Women's and Providers' Perspectives *Reproductive Health Matters*	Legal[7] (Centre for Reproductive Rights, 2014) *NB: abortion was legal with provisions at the time of study*	37 public hospitals and four health centres in the ten provinces of Mozambique Quantitative: Interviews with closed-ended questionnaires • 461 interviews with women receiving treatment for abortion-related complications • 128 interviews with providers • 18 interviews with specialised providers	• Ethical approval not clearly stated, informed consent stated as obtained • Limitations of study not adequately discussed • Competing interests/funding not stated • Reported findings relevant to review
9	Sub-Saharan Africa	Ethiopia	Tesfaye and Oljira (Tesfaye & Oljira, 2013)	2013	Post abortion care quality status in health facilities of Guraghe zone, Ethiopia *Reproductive Health*	Legal with provisions[8] (Centre for Reproductive Rights, 2011a)	26 centres, one public hospital, two non-government hospitals in Guraghe zone Qualitative and Quantitative: Cross-sectional study • 422 IDIs with women seeking PAC service (Client Exit Interviews)	• Ethical approval stated, informed consent stated as obtained • Limitations of study stated • No competing interests • Reported findings relevant to review

[7] Mozambique: in 2014 abortion was legalised without restriction as to reason during the first 12 weeks of pregnancy, and thereafter on specific grounds. In 2004 when the study was conducted, it was legal only to save the women's life

[8] Ethiopia: abortion is legal to save a woman's life, to protect her health or in cases of rape, incest, or foetal impairment. Also permitted when a woman is a minor, or physically or mentally injured or disabled

4.6.1 Study characteristics

The review found that studies did not specifically address access to contraception and SRH information post-abortion as the primary topic of research: the studies all discussed components of contraception access and uptake and the provision of various facets of SRH information to women post-abortion and were therefore selected for review. Although studies concentrating on PAC provision for *spontaneous abortion* (miscarriage) and *term unintended pregnancies* (women admitted for delivery of an unintended pregnancy carried to term) were excluded from selection, one study included women from these two sets as Control Groups to compare with women seeking PAC services after unsafe abortion, and was therefore included (Arambepola et al., 2014).

Participants in the nine studies were:

1. Women who were obtaining or had obtained PAC services only (Arambepola et al., 2014; Becker et al., 2013; Evens et al., 2014; Rocca et al., 2014).
2. Women who were obtaining or had obtained PAC services as well as PAC providers (including medical staff, doctors, nurses and health care workers) (Gallo et al., 2004; McCarraher et al., 2010; Nguyễn et al., 2007; Tavrow et al., 2012; Tesfaye & Oljira, 2013).

No PAC provider-only studies were included (Harris et al., 2013; Liberati et al., 2009). Three of the 9 studies focused on post-abortion family planning services/contraception provision post-abortion (Becker et al., 2013; Rocca et al., 2014; Tavrow et al., 2012) and six studies focused on PAC as a whole (Arambepola et al., 2014; Evens et al., 2014; Gallo et al., 2004; McCarraher et al., 2010; Nguyễn et al., 2007; Tesfaye & Oljira, 2013), two of which incorporated generational aspects in their research (Evens et al., 2014; McCarraher et al., 2010).

The research methodology employed in the articles included three quantitative studies (Arambepola et al., 2014; Becker et al., 2013; Rocca et al., 2014), three qualitative studies (Evens et al., 2014; Gallo et al., 2004; McCarraher et al., 2010), and three mixed-methods studies (Nguyễn et al., 2007; Tavrow et al., 2012; Tesfaye & Oljira, 2013). Nguyễn et al. (2007) and McCarraher et al. (2010) were research evaluations

of PAC services which were components of larger implementation specifically designed to increase CAC (the Comprehensive Abortion Care Project and CONECTA project, respectively) (McCarraher et al., 2010; Nguyễn et al., 2007). In total, quantitative data was obtained from 4,595 individuals and qualitative data was provided by 1,116 individuals across 8 countries within the nine studies selected for this systematic review.

4.6.2 Narrative synthesis of article content

Owing to the relatively small number of studies found with specific reference to SRH information and contraception provision post-abortion, as well as the heterogeneity of the studies reviewed, a narrative synthesis of relevant outcomes reported in the chosen studies is presented (Harris et al., 2013).

4.6.3 Access to contraception post-abortion

Barriers to contraception access for women who have undergone abortion are multifaceted and far reaching. In resource-poor settings physical access to a range of contraceptive methods can often be the first inhibitor for access for women (Gallo et al., 2004; McCarraher et al., 2010; Rocca et al., 2014; Tesfaye & Oljira, 2013). In their 2010 evaluation of PAC services in the Dominican Republic, McCarraher et al. found that contraception was not available to PAC clients in some of the PAC facilities and one-quarter of the study facilities visited, were out of stock of one of more contraceptive methods. Twenty-one percent of older women (aged 20–35 years) and 11% of adolescents (under 19 years of age) reported leaving the hospital without a contraceptive because the hospital did not have the type they wanted (the contraceptive methods were not specified) (McCarraher et al., 2010). The lack of contraceptive method availability combined with an absence of comprehensive contraception information and counselling has been highlighted as a barrier to contraception access and uptake (Arambepola et al., 2014; McCarraher et al., 2010; Nguyễn et al., 2007; Rocca et al., 2014; Tavrow et al., 2012).

In Nepal, Rocca et al. (2014) found that of the total sample population (n = 838), one-third of the participants received no information or education of contraception choices with over half of the sample population leaving abortion facilities without an effective method of contraception (Rocca et al., 2014). Inadequate time for counselling, patient

overcrowding, space limitations and lack of privacy are obstacles in the provision of effective counselling on post-abortion contraception (Arambepola et al., 2014; Rocca et al., 2014). These barriers are often compounded by lack of PAC provider training, insufficient knowledge of staff and socio-culturally insensitive communication skills further impacts access to information for women who need to make an informed decision regarding contraceptive use (Arambepola et al., 2014; Becker et al., 2013; Evens et al., 2014; Nguyễn et al., 2007). Rocca et al. (2014) also noted that only 19% of research participants received information on three or more contraceptive methods and approximately 31% received information on two methods, while two-thirds of women reported receiving information on at least one effective method of contraception (Rocca et al., 2014). Lack of personalised contraceptive counselling, specifically relevant to the woman's life situation and previous contraceptive experiences, were also inhibitors to contraception uptake post-abortion (Becker et al., 2013; Nguyễn et al., 2007).

Arambepola et al. (2014), in their Sir Lankan study, demonstrated that women who accessed inpatient PAC services at a large public hospital in Sri Lanka, did not receive sufficient post-abortion access to contraception when compared with the study Control Groups (spontaneous abortion and term unintended pregnancies) and that contraceptive uptake and use was less at 6–8 weeks after hospital discharge (Arambepola et al., 2014). Attitudes of health care staff towards of women accessing PAC services, particularly in countries where abortion is illegal or restricted, contribute to the barriers women face when accessing contraception information and methods post-abortion (Arambepola et al., 2014; Becker et al., 2013; McCarraher et al., 2010; Nguyễn et al., 2007; Tesfaye & Oljira, 2013).

The type of health service (i.e., government, nongovernment or private) has also shown to have a direct link with post-abortion contraception access. Women utilising nongovernment or private facilities are more likely to receive information on contraceptive choices compared to women who attended public or government facilities (Becker et al., 2013; Rocca et al., 2014; Tavrow et al., 2012). The type of abortion procedure also shows correlation with lack of contraception access and uptake, with women accessing surgical abortions were more likely to receive

information on, and access to, contraceptive methods compared to women having medical abortions (Becker et al., 2013; Rocca et al., 2014).

The reviewed studies also highlighted other barriers to access of contraceptive methods, information and education, such as: the gender of health care providers (Becker et al., 2013), if the woman's husband is away for extended periods (Rocca et al., 2014), misconceptions regarding contraception (Tavrow et al., 2012), if a woman is not sexually active (Becker et al., 2013), or if the woman is an adolescent (Evens et al., 2014; McCarraher et al., 2010; Tavrow et al., 2012).

4.6.4 Access to SRH information post-abortion

The provision of SRH information as an integral component of quality PAC services, is often overlooked by service providers. Along with education regarding contraceptive options, discussing return to fertility is also an essential element of PAC (Barot, 2014; PAC Consortium Community Task Force, 2002). Rocca et al. (2014) found that only half of their study sample population were informed about fertility return during their PAC visit, and in their Mexico City study, Becker et al. (2013) reported 68% of their total research participants (n = 402) were educated on return to fertility information.

In a study undertaken in the Dominican Republic in 2010, a high proportion of PAC service providers (> 70%) reported they routinely asked PAC patients about their fertility intentions and counselled them on contraception, STI/HIV and post-abortion complications. However, compared with provider reports, far fewer PAC patients indicated they had received counselling and information on risk of pregnancy, fertility intentions, STI/HIV risk, contraception availability and post-abortion complication (McCarraher et al., 2010). Similar discrepancies between provider and patient reporting was also detailed in a 2014 Kenyan study and 2004 study in Mozambique (Gallo et al., 2004). When asked about information provision, just over half of the participants in Evens et al. (2014) study reported their provider had discussed return to fertility, HIV/STI information and testing, or provided information and access to contraception. In contrast, the vast majority of providers reported they routinely provide these services.

All studies reviewed revealed that post-abortion access to SRH information regarding SRH concerns and issues were inconsistently conveyed by PAC providers, if indeed, at all. Gallo et al. (2004) highlight that PAC clients in Mozambique have been shown to have high STI rates, yet few of their research participants reported receiving condoms or information regarding their sexual health and STI/HIV testing, treatment and prevention. Several studies also documented lack of information provision on important SRH issues including: fertility return and intention, child-spacing, preventing unwanted pregnancies, contraceptive methods and use, information on emergency contraception, information on danger signs of post-abortion complications and normal post-abortion symptoms, return to sexual activity advice, and post-procedure hygiene (Becker et al., 2013; Evens et al., 2014; Gallo et al., 2004; McCarraher et al., 2010; Rocca et al., 2014; Tesfaye & Oljira, 2013).

4.7 Discussion

A number of significant and intersecting themes concerning inhibitors to access of contraception and SRH information post-abortion emerged in the narrative content synthesis of the review. These include: lack of comprehensive information and education on a broad choice of contraception methods, insufficient commodity supply, provider attitudes, the type of service provider (government/public, nongovernment, private), as well as lack of effective and consistent SRH information and education provision to women post-abortion.

Similar to findings documented in several of the papers in review (Arambepola et al., 2014; Becker et al., 2013; Rocca et al., 2014), a six country USAID study on interventions to strengthen contraceptive counselling and services also found that with effective contraceptive counselling, there is a marked increase in the number of women accepting contraception post-abortion (High Impact Practices in Family Planning, 2012; Shah et al., 2014). However, as McCarraher et al. (2010) state, improved contraceptive counselling is only one strategy to increase contraceptive uptake, availability of a broad range of contraceptive methods through consistent and effective commodity supply is fundamental for women in accessing their contraceptive method of choice post-abortion.

Judgemental (or perceived judgemental) provider attitudes has been shown to create barriers to access of contraception and SRH information post-abortion. Abortion related stigma stems from the challenges abortion presents to social, cultural and religious beliefs (Gold, Hurley, Wachsmann, & Wilkins, 2015; Hanschmidt, Linde, Hilbert, Riedel-Heller, & Kersting, 2016). This stigma permits myths about abortion to propagate, can lead to shame and harassment and, particularly in countries where abortion is illegal or restricted, can be a barrier to women accessing high quality PAC services (Gold et al., 2015; Hanschmidt et al., 2016; Shah et al., 2014). Inconsistencies in service provision across various provider facilities (government/public, nongovernment and private) has also been found to create barriers to access to contraception and SRH information post-abortion. While private facilities may offer comprehensive PAC, their provider fees deter women from accessing services. Alternatively, services provided (often free of charge) from government facilities, lack the human resources to effectively provide adequate time to clients and may lack trained PAC providers.

Throughout the literature, the provision of SRH information in the form of counselling is inconsistently described. *Counselling* has been used to describe the provision of information and education specifically on contraception, while at other times, the term has been used to describe more comprehensive provision of SRH information, closely related to the PAC Consortium definition of the term (PAC Consortium Community Task Force, 2002; PAC Consortium Service Delivery Task Force, 2014). While all nine studies emphasised issues relating to the provision of contraception and contraception counselling in PAC, no papers comprehensively addressed the provision of SRH information to PAC clients. However, 5 of the nine papers investigated components of SRH information (other than contraception information). This information related to: return to fertility or fertility intentions (Evens et al., 2014; Gallo et al., 2004; McCarraher et al., 2010; Rocca et al., 2014), STI/HIV information and/or testing (Becker et al., 2013; McCarraher et al., 2010), post-abortion complications (Becker et al., 2013; Gallo et al., 2004; McCarraher et al., 2010; Tesfaye & Oljira, 2013), and emergency contraception (Becker et al., 2013). The paucity of literature specifically relating to the provision of SRH information to women post-abortion is testament to the need for greater research on this topic.

4.7.1 Limitations

Lack of generalisability was a consistent limitation within all the reviewed studies, with several studies highlighting sampling and data collection difficulties such as participant recruitment and sample size as impacting the ability for generalisation to the wider population (Arambepola et al., 2014; Becker et al., 2013; Evens et al., 2014; Tavrow et al., 2012). The use of self-reporting questionnaires within several of the studies has the potential to create social desirability and response bias (Arambepola et al., 2014; Becker et al., 2013; Kinaro et al., 2009; Nguyễn et al., 2007; Tesfaye & Oljira, 2013). Interviewer and response bias may also play a role within the qualitative aspects of several of the studies (Evens et al., 2014; Kinaro et al., 2009; McCarraher et al., 2010; Nguyễn et al., 2007; Tavrow et al., 2012). The sensitive nature of the topic and sociocultural beliefs regarding abortion may have been limitation factors within these studies, however, none of the papers reviewed addressed this issue adequately. The review was also restricted to articles published in English and only the first author performed the first round of screening. While every consideration has been given to the context, characteristics and quality of the studies appraised, the findings of this systematic review must be considered within the parameters of studies from various demographic regions and countries, with varying policies regarding the legality of access to abortion services.

4.7.2 Recommendations

This systematic review highlights the lack of current literature relating to women's access to contraception and SRH information post-abortion. While the findings reiterate much of the current understanding regarding the complexities surrounding women's access to contraception post-abortion, they also uniquely highlight the inconsistencies relating to what providers consider *counselling* and SRH provision in PAC services (PAC Consortium Community Task Force, 2002). Further research on the type and quality of SRH information provided during PAC counselling is urgently needed to determine the scope and consistency of counselling currently being provided. This information has the potential to inform detailed PAC counselling frameworks that can assist PAC providers to more effectively meet women's post-abortion information and educational needs.

The review indicated that with access to a wide range of contraceptive methods together with comprehensive SRH information and education, contraception uptake in women post-abortion was shown to increase. However, inconsistency in effective service provision, judgemental (or perceived judgemental) attitude of service providers to patients, restricted access to services and comprehensive SRH information, and the lack of availability of a broad range of contraceptive choices, continues to inhibit women's access to contraception and SRH information, post-abortion. Further research is needed to examine and document these barriers to post-abortion contraception and SRH information and to highlight the need for effective and equitable PAC provision for women and girls in low- and middle-income countries.

4.8 Conclusion

Abortions, whether legal or restricted, continue to impact the health and lives of women and girls around the world. This review highlights that access to affordable, equitable and high quality PAC services reduces morbidity and mortality resulting from incomplete and unsafe abortion and post-abortion complications. Through effective and equitable PAC, timely access to contraceptive methods and comprehensive SRH information is a key factor in assisting women to space births, prevent unintended pregnancies, avert unsafe abortions, and support women to make informed decisions and take control of their sexual and reproductive health and rights.

4.9 Summary of the Chapter

The chapter, a publication in the ***Journal of Family Planning and Reproductive Health Care,*** has explored the major factors impacting women's adequate access to post-abortion contraception and SRH information. The next chapter will outline the research aims, objectives, research methodology and conceptual framework utilised within this research project. Data collection and data analysis techniques will be also be reviewed, and ethical considerations deliberated.

CHAPTER 5

RESEARCH DESIGN AND METHODS

Introduction to the Chapter

This chapter details the research methodology and study design utilised for this PhD research project, having discussed the rationale behind conducting this specific research, highlighting factors influencing the design and trajectory of the study, in chapter 1. The chapter will commence with an overview of research aims, objectives, research methodology and conceptual framework. Data collection and data analysis techniques will be reviewed, and ethical considerations discussed. This chapter is presented in the first person.

Article 2, a condensed version of this chapter, has been submitted to the ***Asia Pacific Journal of Public Health*** on 15 December 2018.

Rogers, C., Sapkota, S., & Dantas, J. A. R. (2018). Conducting qualitative sexual and reproductive health and rights (SRHR) research in resource poor settings: experiences from Nepal *Manuscript under review*

5.1 Research Aims and Objectives

5.1.1 The aim of the study

This PhD research aimed to explore the post-abortion SRHR experiences of Nepali women, and their access and uptake of safe abortion services; unsafe abortion (MA) through pharmacies; post-abortion contraception; and SRH information.

5.1.2 The objectives of the study

The main objectives of the study were:

1. To explore the provision of Comprehensive Abortion Care (CAC) and Post-Abortion Care (PAC) in Nepal.
2. To identify barriers to safe abortion services.
3. To provide an overview of unsafe abortion practices in Nepal.

4. To explore access and uptake of post-abortion contraception and SRH information through: a) safe abortion services (MA) and b) unsafe abortion services (MA through pharmacies).
5. To appraise current safe abortion frameworks and strategies for contraception distribution and SRH information dissemination (current government and nongovernment SRH policy and clinical practice).
6. To suggest practical and innovative strategies for increased access and uptake of safe abortion services and post-abortion contraception and SRH information.

5.1.3 Sexual and Reproductive Health and Rights Framework

Policy and practice recommendations from the High-Level Task Force for the International Conference on Population and Development (ICPD) (High-Level Task Force for ICPD, 2013), the Sustainable Development Goals (SDGs) (Galati, 2015), and The Guttmacher-Lancet Commission (Starrs et al., 2018), form the contextual framework that underpinned the aims and outcomes of this research. Specific focus is placed on key recommendations from the ICPD, SDGs and the Guttmacher-Lancet Commission to assess the adequacy of current contraception and SRH information provision to Nepali women, post-abortion. The key recommendations are:

High-Level Task Force for the ICPD (High-Level Task Force for ICPD, 2013), p. 3

- Respecting, protecting and fulfilling sexual and reproductive rights for all through public education and legal and policy reforms.
- Achieving universal access to quality, comprehensive and integrated sexual and reproductive health information, education and services.

Sustainable Development Goal 5 Target 5.6 (Galati, 2015), p. 81

- Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the ICPD and the Beijing Platform for Action and the outcome documents of their review processes.

The Guttmacher-Lancet Commission (Starrs et al., 2018), p. 7

- Everyone has a right to make decisions that govern their bodies, free of stigma, discrimination, and coercion. These decisions include those related to sexuality, reproduction, and the use of sexual and reproductive health services.
- SRHR information and services should be accessible and affordable to all individuals who need them regardless of their age, marital status, socioeconomic status, race or ethnicity, sexual orientation, or gender identity.
- Countries must also take actions beyond the health sector to change social norms, laws, and policies to uphold human rights. The most crucial reforms are those that promote gender equality and give women greater control over their bodies and lives.

5.2 Research Methodology

Using an Assets Focused Rapid Participatory Appraisal research methodology, underpinned by a Health Information Pyramid conceptual framework, this qualitative exploratory study was undertaken in Kathmandu and the Sunsari Districts of Nepal between 2014 and 2016. The decision to use an Assets Focused Rapid Participatory Assessment Cycle conceptual framework, was built on the desire to utilise community-recognised assets to support research outcomes and recommendations. Undertaking the research within a participatory context ensured cultural sensitive and contextually rich data collection (Mack, Woodsong, MacQueen, Guest, & Namey, 2005). In total, 29 in-depth, open-ended interviews of approximately an hour in length were conducted. With quantitative research methods predominantly used for studies conducted in Nepal, the need for qualitative SRHR data collection was an important attribute of this research and its contribution to SRHR literature and knowledge in Nepal.

5.2.1 Assets Focused Rapid Participatory Assessment Cycle

In their 2006 Guidelines for conducting Rapid Participatory Appraisals (RPA) in developing countries, Pepall et al. (2006) propose an innovative research methodology, known as the Assets Focused Rapid Participatory Assessment Cycle (National Collaborating Centre for Methods and Tools, 2017; Pepall, Earnest, &

James, 2007; Pepall et al., 2006). Developed by Annett and Rifkin in 1995, RPA is founded on three main principles:

1. Collect only necessary and relevant data.
2. Adjust investigations to reflect local conditions and specific situations.
3. Involve the community in both defining community needs and seeking possible solutions (Annett & Rifkin, 1995).

The RPA research methodology facilitates rapid assessment of community identified health needs as well as evaluating health status, knowledge and sociocultural issues (Annett & Rifkin, 1995; Rifkin, 1996; Pepall et al., 2006). RPAs require a multi-sectoral team approach with a team comprised of individuals who are responsible for community resources necessary to address documented issues (Annett & Rifkin, 1995; Pepall et al., 2006). Research conducted in low- and middle-income countries, and within vulnerable communities, have demonstrated RPA to be an effective, timely, reliable, relevant and cost-effective community assessment technique (Al-Qdah & Lacroix, 2017; Annett & Rifkin, 1995; Brown, Lloyd, & Murray, 2006; Palmer, 1999; Pepall et al., 2007; Swain, Swain, Nair, Gupta, & Nandan, 2008).

To improve on the traditional RPA framework, Pepall et. al., (2006) drew on elements of other established and relevant methodologies to create a composite research methodology:

1. Action Research: "look, think, act" (Stringer, 1996).
2. Asset Based Community Development (ABCD): assess community assets, skills and capacity (Reardon, 2014).
3. Participatory Learning and Action (PLA): community self-analysis of issues and decision making regarding potential solutions and outcomes (Kenton, 2014).

Pepall et al. state that this composite model, known as an Assets Focused Rapid Participatory Appraisal **(**Figure 5.1**),** has the potential to improve efficacy of planning and implementation in comparison to the traditional RPA methodology (Annett & Rifkin, 1995; Coghlan & Brydon-Miller, 2014; National Collaborating Centre for Methods and Tools, 2017; Pepall et al., 2006; Stringer, 1996; World Health Organization, 2014b). The term 'asset' relates to factors that have been identified as positively contributing to the community and that can subsequently support research

outcomes and recommendations. These community-identified assets can include, but are not limited to, an individual; local groups or associations; organisations or programs; and physical space and infrastructure (Coghlan & Brydon-Miller, 2014; Peppal et., al., 2006; Reardon, 2014).

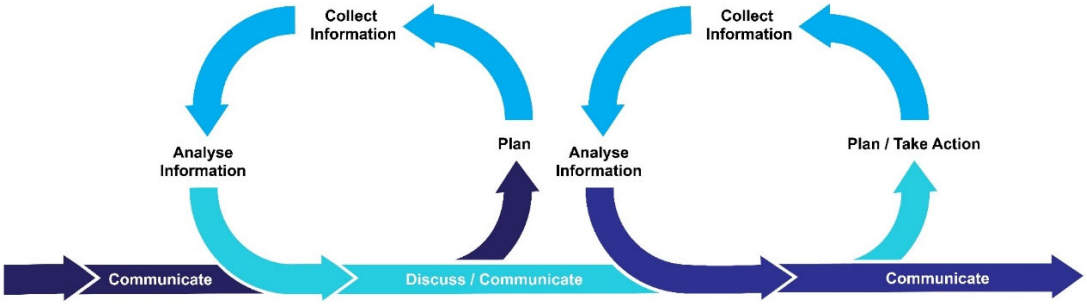


Figure 5.1 Assets Focused Rapid Participatory Appraisal (AFRPA)

(Adapted from: Pepall et al., 2006, p. 45)

To assist in collection and interpretation of data when working in cross-cultural and low-resources setting, RPA Guidelines advocate for the use of visual diagrams and pictures (Annett & Rifkin, 1995). Underpinning the AFRPA methodology with Annett and Rifkin's (1995) Health Information Pyramid Conceptual Framework (Figure 5.2), enables grounding of data collection and interpretation within a framework of four tiers and 10 components (Annett & Rifkin, 1995).

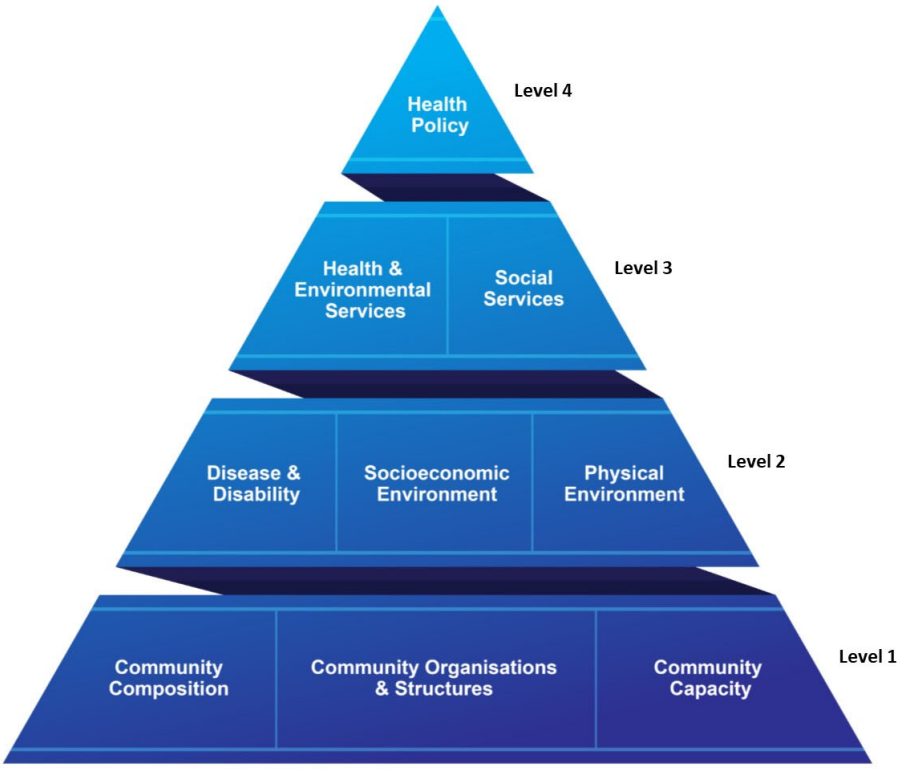


Figure 5.2 Annett and Rifkin's Health Information Pyramid Conceptual Framework

(Adapted from: Annett & Rifkin, 1995, p. 10)

Annett and Rifkin (1995) highlight the three main characteristics of the health information conceptual framework:

1. based on community identified needs
2. constructed on data collected from: governmental and nongovernment documentation, dialogue exchange between the Research Team, key stakeholders, community members, and from field observations
3. flexible to the changeable nature of community structure, cohesion and needs, facilitating the capacity to evolve as new information is gathered.

Integrating fundamental steps of research planning, data collection, data analysis, communication and action enables a cyclical discovery process where evaluation and modification is ongoing, rather than a static uni-directional progression (Coghlan & Brydon-Miller, 2014; Pepall et al., 2006). Pepall et al. (2006) refer to this dynamic

process as the Assets Focused Rapid Participatory Assessment Cycle (AFRPAC) demonstrated in Figure 5.3.

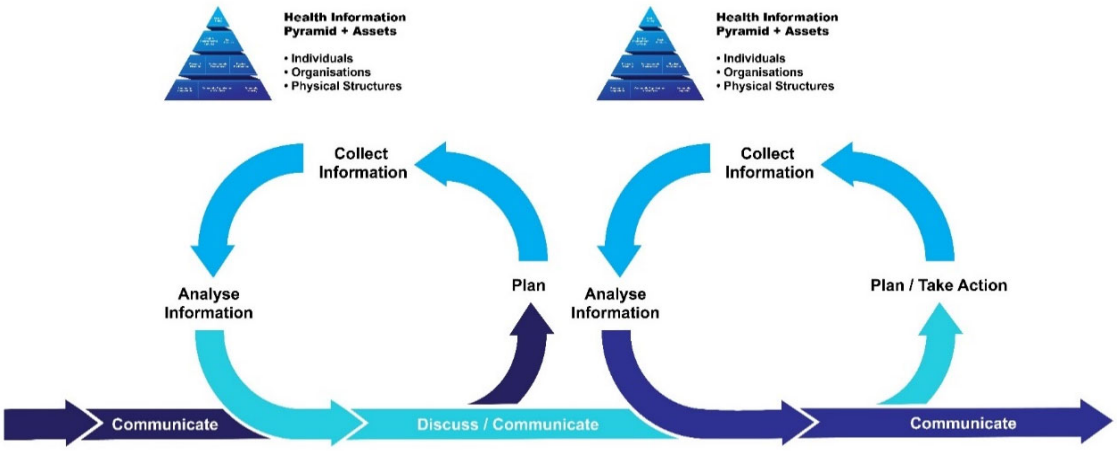


Figure 5.3 Assets Focused Rapid Participatory Assessment Cycle (AFRPAC)

(Adapted from: Pepall et al., 2006, p. 45)

This cyclical methodology is an effective means to prioritise community needs and identify existing community assets that may help contribute to social change and development (Pepall et al., 2006). Emphasis on assets ensures that outcomes are concurrently solution- and problem-focused, as opposed to merely the identification of problems. The 2006 guidelines also place importance on community participation within the research team, where appropriate and possible, as well as within the research process (Pepall et al., 2006). As a composite model, the AFRPAC has incorporated three additional key elements into the traditional RPA methodology, as described by the National Collaborating Centre for Methods and Tools in Table 5.1.

Table 5.1 Assets Focused Rapid Participatory Assessment Cycle: Additional key elements

Planning	• Use a cyclical process • Be problem-focused and involve community leaders and stakeholders • Be solution-focused including considering resources and holistic perspectives to population, health, extent of relationships and community participation
Data Collection	• Increase time for data collection and use mapping techniques
Communication	• Ensure regular and systematic communication, using visual aids or other

- Provide a final report that includes intervention-based proposals for action

(Source: National Collaborating Centre for Methods and Tools, 2017, p. 2)

5.2.2 Study Design

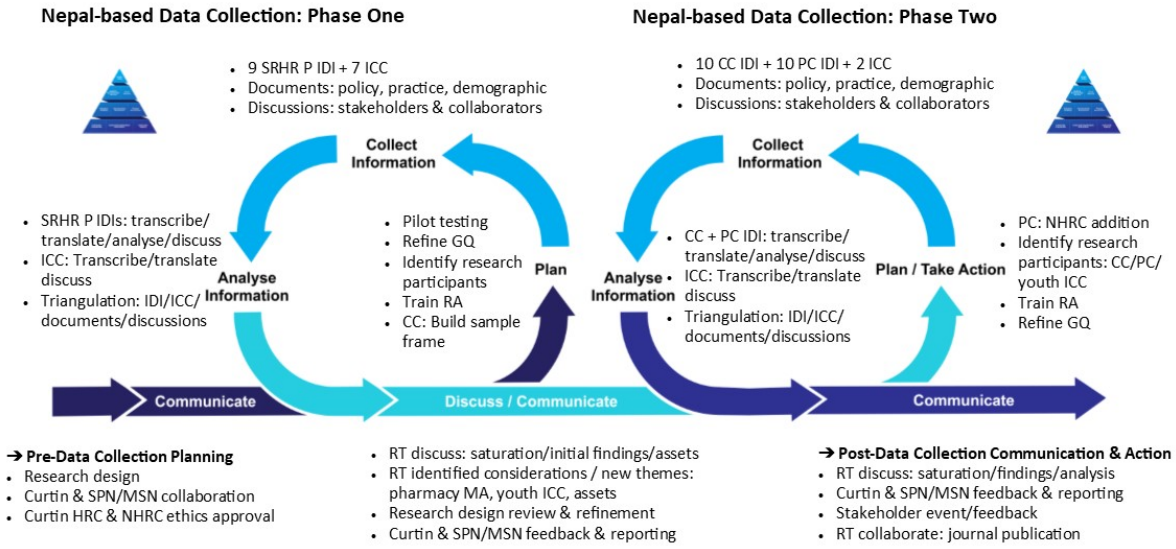
From its inception, close collaboration between Curtin University, Australia, and Sunaulo Parivar Nepal, the implementing partner of Marie Stopes International Nepal (SPN/MSN), was the cornerstone of this research project (Appendix F)**.** Based on an extensive literature review and the identification of need, the study was conceptualised and developed by myself as the PhD student, with my primary supervisor based at Curtin University, Western Australia. Other members of the research team included my associate supervisor based at SPN/MSN in Kathmandu, and two Nepali Research Assistants (RAs). Throughout the research process, support and guidance was provided by SPN/MSN staff members at the Itahari Marie Stopes Centre (MSC) in the Sunsari District (including Female Community Health Volunteers associated with the MSC), and staff located at the SPN/MSN Head Office located in Kathmandu. Key SRHR stakeholders (clinical, educational, research, governmental and nongovernmental), sourced through SPN/MSN and public health networks in Kathmandu and the Sunsari Districts, provided input throughout the research process.

This ensured that not only was the study conducted within a framework of *knowledge for action,* but that ownership and outcomes of the research were embedded firmly and tangibly within the context of women's SRHR in Nepal. The collaborative research process will ensure that there is support to implement key recommendations from the research and that findings will be disseminated.

5.2.3 Assets Focused Rapid Participatory Assessment Cycle in the Study Context

Within the context of this research project, the strength of the chosen methodology was demonstrated in the cyclical process that enabled flexibility to respond and adapt to the emergence of new themes (Pepall et al., 2006). Throughout the course of the research, the cyclical approach to communication, planning, data collection, information analysis and feedback was an ongoing process occurring in response to various data points, often concurrently. Figure 5.4 illustrates a stylised and

summarised representation of the AFRPAC throughout the primary Nepal-based data collection process (informal community conversations and in-depth interviews) which occurred in two phases, Phase One (June to August 2014) and Phase Two (April to May 2016).



CC: Clinic Clients
Curtin: Curtin University
GQ: Guiding Questions
ICC: Informal Community Conversations
IDI: In-depth Interviews
PC: Pharmacy Clients
RA: Research Assistant
RT: Research Team
SRHR P: Sexual and Reproductive Health and Rights Professionals
SPN/MSN: Sunaulo Parivar Nepal / Marie Stopes Nepal

Figure 5.4 Assets Focused Rapid Participatory Assessment Cycle (AFRPAC): Data Collection Phases One and Two

(Adapted from: Pepall et al., 2006, p. 45)

As demonstrated in Figure 5.4, a qualitative approach to data collection is particularly effective within the AFRPAC. As gathering of information relevant to the research progresses throughout the cyclical process of planning, data collection, data analysis and communication, it allows for the evaluation and modification of the research to address the emergence of new themes.

As discussed in chapter 1, during the early stages of Phase One data collection, the issue of illegal pharmacy-provided MA was discussed with my associate supervisor

(based at SPN/MSN) and SPN/MSN collaborators (managerial staff in Kathmandu and clinical and managerial staff from the Itahari MSC) regarding their experiences as well as feedback they had received from other professionals within the SRHR sector. Although no research literature or policy documentation around the issue was available at that time, the theme was triangulated through data collected during in-depth interview with a cross-section of SRHR professionals.

To gain contextual understanding on how pharmacy-provided MA is impacting women in Nepal and how their SRHR experience differ from women seeking safe abortion services through the Itahari MSC (clinic clients), it was decided that women who had accessed pharmacy-provided MA (pharmacy clients) would also be sampled during Phase Two of in-country data collection. The AFRPAC facilitated the capacity to evolve and refine the research design to address the emergence of this new and important theme and ethical approval to include this additional sample of participants was granted.

Another strength in the utilisation of the AFRPAC and its capacity for ongoing discovery, evaluation and modification, was highlighted through the adaptation of data analysis perspectives and research recommendation in response to the Government of Nepal's announcement for the planned implementation of free abortion services within public clinics (Government of Nepal, 2016, 2018; Ipas, 2016). The August 2016 announcement, 3 months post-Phase Two of Nepal-based data collection, provided new socioeconomic and policy context to safe abortion access (levels 2, 3 and 4 of the Health Information Pyramid) and within SRHR professional in-depth interview analysis, and will be further discussed in chapters 6 and 8.

Underpinning the AFRPAC, the four tiers and 10 components of the Health Information Pyramid provided a checklist for information required and a framework for analysis of data gathered (Annett & Rifkin, 1995). As a visual aid during data collection phases (Appendix G), the pyramid assisted in identification and mapping of sources of information (individuals, services, organisations and documentation) relevant to the SRHR of women in Nepal and aided in triangulation of data. Post-it notes in colours corresponding to the four tiers were placed around the pyramid detailing information gathered or needed; emerging themes and their links to research

objectives; assessment of data saturation; assets identified; collaborator and stakeholder discussions; and field observations relating to the 10 components. The use of coloured post-it notes was an effective tool to visually group data points. This facilitated regular dialogue between myself and the RA on data collection progress. Notes where taken and reflections discussed further with my associate supervisor for clarity and input, as required. Table 5.2 provides a brief overview of the pyramid's application throughout the research project.

Table 5.2 Health Information Pyramid: Study context

Level	Component	Data Point
1	Community Composition Community Organisation & Structure Community Capacity	**Community identified assets relating to individuals, organisations and structures** • Informal Community Conversations • CC + PC In-depth Interviews • Collaborator engagement (Itahari MSC) • Stakeholder engagement (Sunsari District) • Government documentation on population demographics • Field observations
2	Physical Environment Socioeconomic Environment Disease & Disability	**Cultural, religious, economic, infrastructure & environmental factors impacting women in Nepal** • Informal Community Conversations • CC + PC In-depth Interviews • SRHR Professional In-depth Interviews • Government, Donor, NGO, I/NGO reporting • Collaborator / SRHR stakeholder engagement • Field observations
3	Health & Environmental Services Social Services	**Coverage, accessibility & acceptability of SRHR services + abortion and contraceptive uptake** • Informal Community Conversations • CC + PC In-depth Interviews • SRHR Professional In-depth Interviews • Government, Donor, NGO, I/NGO documents—SRHR: research, policy, practice, programming • Collaborator / SRHR stakeholder engagement • Field observations
4	Health Policy	**SRHR Policy in Nepal** • SRHR Professional in-depth interviews • Government documents—SRHR: research, policy, practice, programming, legislation. General: gender, health policy & population demographics • Collaborator / SRHR stakeholder engagement

(Adapted from: Annett & Rifkin, 1995, p. 10-11)

Research Assistants

Before both stages of Nepal-based data collection (Phase One and Phase Two) an RA position with the project was advertised through SPN/MSN and B.P. Koirala Institute of Health Sciences networks. Candidates were required to have a Master of Public Health (or similar), be fluent in both written and spoken English and have experience conducting research. Due to the sensitive nature of the research, only Nepali females were considered for the RA position.

Research Booklets (Appendix G) were provided to the RAs and included relevant information about ethical approval, the research summary, fieldwork timelines, consent forms, information sheets and a list of guiding questions. To support their pre-data collection training, the booklets also contained detailed information on data collection methodology, study design and relevant journal articles on qualitative research with vulnerable populations.

Capacity building and mentoring for the RAs was incorporated into the fieldwork with further training and guidance provided before commencement of data collection (Collumbien, Busza, Cleland, & Campbell, 2012). Emphasis was placed on cross-cultural and bi-lingual interviewing techniques to ensure all interviews were effectively and efficiently conducted (Shimpuku & Norr, 2012). Visuals aids depicting the AFRPA, Health Information Pyramid and AFRPAC were an effective tool in training and data collection, and were displayed in working areas throughout the research process (Appendix G) (Annett & Rifkin, 1995; Pepall et al., 2006).

Both RAs participated in cultural mediation and language interpretation throughout pilot testing and data collection, and were collaborators in thematic analysis and interpretation of results. As well as capacity building, it was also important the research assistants gained valuable experience and transferable skills from their involvement with the research. The RAs were invited to be co-authors when writing the journal articles and contributed to the revision and approval of manuscripts for peer review (see chapter 6 and 7 of thesis).

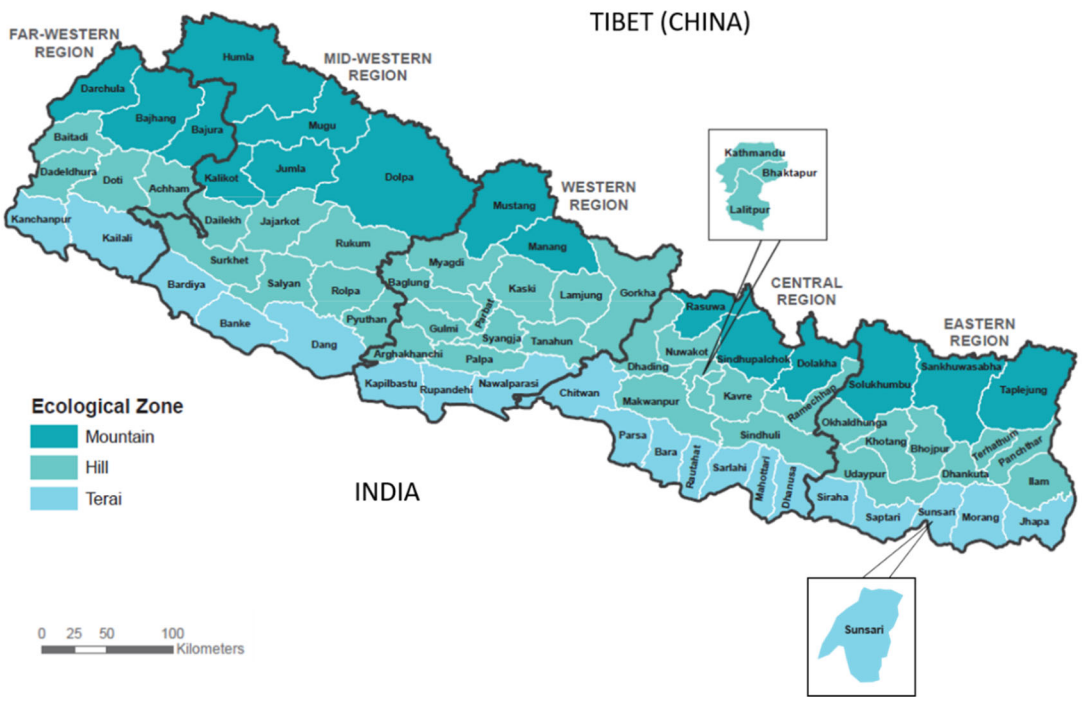


Figure 5.5 Kathmandu Valley and Sunsari District

(Adapted from: Ministry of Health and Population Nepal et al., 2012, p. 1)

Study Sites

Kathmandu, the capital of Nepal, is located in the Bagmati Zone of the Central Development Region and has a population of 2 million people (Intensive Study and Research Centre, 2014). The majority of the public, private and nongovernment health workforce are centralised in the Kathmandu Valley area (Government of Nepal, 2015c). Kathmandu was an essential study site as it gave access to the SPN/MSN head office as well as to a diverse population of SRHR professionals. All large SRHR and health organisations (government and nongovernment) have head offices in Kathmandu and access to these offices and government departments was necessary for communication with health professionals and obtain support for the research.

The Sunsari District of Nepal is located in the Easter Development Region in the Koshi Zone with topography ranging from mid-mountain to Terai, where it borders with India. The district covers 1257 square kilometres and is home to approximately 734, 000 people (Intensive Study and Research Centre, 2014). The city of Itahari is the largest city in Sunsari District with a population of 140,517 people (Government of Nepal, 2012). The city centre acts as a cross-road for the east-west Mahendra Highway and the north-south Koshi Highway, making Itahari an important transportation hub.

Through ease of access from India, anecdotal evidence provided to SPN/MSN from community-based SRH health personnel and community members, suggests pharmacy-supplied MA is an increasing problem in the area. In comparison to MSCs in other regions of the country, the Itahari MSC experiences a large amount of post-abortion complications due to pharmacy-provided MA. It is for this reason the Itahari MSC and the Sunsari District were selected as study sites for this research.

5.3 A Brief Overview of Qualitative Research

Quantitative research methods have traditionally dominated public health and international development research. However, over the last 20 years, qualitative methods have increasingly gained recognition as valuable tools in obtaining culturally specific insights and contextually rich data (Czymoniewicz-Klippel, Brijnath, & Crockett, 2010; Mack et al., 2005; Taylor, Bogdan, & DeVault, 2015). Having come from a biomedical science background, learning about qualitative research methods during my master's degree was a new and exciting concept. Years later, when explaining my PhD research, people would often comment "You can't interview women about that! It's such a sensitive topic, no one will speak with you!" From my previous experience of conducting qualitative SRHR research, I knew this was not true. Women want to share their stories, they want their voices to be heard. However, this is only possible within a respectful, ethical and cultural safe environment (Sanjari, Bahramnezhad, Fomani, Shoghi, & Cheraghi, 2014; Shimpuku & Norr, 2012).

Along with the privilege of having women sharing personal experiences with me, I was aware of the ethical responsibility I had in how I listened to, learned about their experiences, shared their stories and what is done with the information so generously shared. Within an overarching SRHR and human rights framework, combined with a knowledge for action research strategy, ethical considerations are fundamental throughout the AFRPAC research process.

5.4 Research Participants

In-depth interviews were undertaken with nine SRHR professionals (Phase One), 10 clinic clients (women who accessed MA from the Itahari MSC) and 10 pharmacy clients (women who accessed MA from a pharmacy in the Sunsari District) (Phase

Two). Nine informal community conversations were conducted with a cross-section of community members from the Sunsari District (Phase One and Two).

5.4.1 In-depth Interviews with Sexual and Reproductive Health and Rights Professionals

In-depth interviews with a cross-section of SRHR professionals, conducted during Phase One, provided extensive and multifaceted insights into their experiences and knowledge regarding women's abortion and post-abortion experiences in Nepal – see chapter 6 (Rogers, Sapkota, Tako, & Dantas, 2019).

Participant Recruitment

Utilising the Health Information Pyramid's four levels and 10 components as a guide, discussion regarding participant recruitment between myself, my associate supervisor and Phase One RA involved identifying individuals that could inform data collection through their expertise and experience in: SRH clinical practice (levels 2 and 3); SRH service and contraception access and uptake (levels 2 and 3); and SRHR health policy and advocacy (level 4). With assistance from my associate supervisor and Phase One RA, participants were purposively recruited from a diverse range of SRHR professionals representing varying SRHR sectors and professions as detailed in Table 5.2.

Table 5.3 In-depth interview participants (SRHR Professionals)

	Title	Organisation	Work Location
IDI 1.	Service provider	SRH Clinic, I/NGO[1](a)	Kathmandu
IDI 2.	Senior service provider	SRH Clinic, I/NGO(a)	Kathmandu
IDI 3.	SRHR research consultant	Independent	Nepal
IDI 4.	Senior service provider	CAC[2] Unit, Public Health Facility(b)	Kathmandu
IDI 5.	Safe Abortion Policy Advisor	SRH I/NGO(c)	Nepal
IDI 6.	Service provider	SRH Clinic, I/NGO(a)	Sunsari District
IDI 7.	Program Manager	SRH NGO[3](d)	Nepal
IDI 8.	Senior Officer	SRH NGO(e)	Nepal
IDI 9.	Senior Officer	Ministry of Health, GON(b)	Nepal

[1]International Nongovernment Organisation

[2]Comprehensive Abortion Care
[3]Nongovernment Organisation
(a) SRH I/NGO providing clinical and educational services
(b) Government of Nepal
(c) SRH I/NGO providing advisory and educational services
(d) SRH NGO providing clinical and educational services
(e) SRH NGO providing research, advocacy and educational services

Representing varying SRHR organisations and professions, the participants included: clinical staff; researchers; advisors; advocacy officers; government officials; international and local nongovernment organisation staff; and international donor personnel. By design, many of the participants are high-ranking officials or senior members within their organisations, able to provide country wide context and multi-profession perspectives on SRHR in Nepal. While their organisations are represented throughout Nepal, many of the participants work from their organisational headquarters in Kathmandu, therefore all but one of the interviews were held in Kathmandu from a practical perspective.

Participants were contacted via telephone and/or email and were provided a Consent Form (Appendices H and I) and a Research Information Sheet in both Nepali and English prior to their interview (Appendices J and K). With informed consent, interviews of approximately an hour in length were conducted at a time, date and location that the participant preferred.

The utilisation of the AFRPA underpinned by the Health Information Pyramid emphasised key concerns of the SRHR sector, as well as perceived assets relating to safe abortion, unsafe abortion, medical abortion access through pharmacies, post-abortion family planning, sex-selective abortion and SRH information access in Nepal. The participants focussed both on current problems relating to these concerns, as well as the formulation of potential solutions for these issues.

5.4.2 Informal Community Conversations

Within the AFRPAC framework, community identified assets and strengths are an integral part of data collection, data synthesis, translation of findings and development of recommendations (Pepall et al., 2006). Informal community conversations differed from IDI's as the conversations were utilised as data points within the Health Information Pyramid framework to inform IDI questioning, triangulate data relating

to perceived community assets, and to enable the research team to gain a more holistic understanding of women's health within the community context, as well as Nepal in general (Pepall et., al 2006). Guiding questions for informal community conversations focused on the community, health and women generally, rather than the specific focus on abortion, contraception and SRH information as in the in-depth interviews.

Participant Recruitment

Guided by level 1, 2 and 3 of the Health Information Pyramid, collaboration between myself, the RA and a staff member of the Itahari MSC facilitated the identification of key community contacts able to provide diverse perspectives on community perceived concerns and assets. During Phase One of data collection, seven key contacts were identified, purposively recruited, and informal community conversations undertaken. Upon reflection of data gathered from these conversations, the research team felt it was important to also include the voice of young people; thus, two additional informal community conversations were conducted in Itahari during Phase Two of the research.

With assistance from the staff at the Itahari MSC, purposive sampling was used to recruit a total of nine key contacts from within the local Itahari community to participate in informal conversations. The community members came from a range of backgrounds and were of various ages and genders (Table 5.3) (Annett & Rifkin, 1995; Collumbien et al., 2012).

Table 5.4 Informal community conversation participants

	Occupation	Sex	Age	Phase
1.	Shop owner & homemaker	F	43	1
2.	Social worker & political leader	M	71	1
3.	Business owner	F	30	1
4.	Religious leader & heath volunteer	F	50	1
5.	Supervisor, district health office	M	50	1
6.	Associate Professor, academic institution	F	53	1
7.	Additional professor, university	M	43	1
8.	Student	M	17	2
9.	Student	F	16	2

Community members were read a Research Information Sheet (Appendices L and M) describing the research and informed consent was obtained (Appendices H and I). The conversations of approximately 30 minutes in duration were held at participants' homes or a location of their choice. To thank them for their time, each participant was given a box of chocolates.

5.4.3 In-depth Interviews with Clinic Clients and Pharmacy Clients

A rich and in-depth examination of the post-abortion SRHR experiences of women in Nepal was undertaken for this PhD. Informed by information gathered throughout the AFRPAC process in Phase One of data collection, combined with in-depth interviews with Itahari MSC clinic clients, women who had accessed MA through pharmacies in the Sunsari district were essential participants to this research. Approval to include pharmacy clients was obtained from the Nepal Health Research Council (NHRC). Interviews of approximately one hour were held after informed consent was obtained.

Table 5.5 Inclusion criteria for research participation

Clinic Clients and Pharmacy Clients
Female
Aged between 15 and 49 years
Able to speak and understand Nepali
Able to give informed consent
Live within local district of pilot community
Accessed medical abortion for the termination of a pregnancy

Participant Recruitment: Clinic Clients

During Phase One of Nepal-based data collection, a sampling frame for potential clinic client participation was established in preparation for Phase Two data collection. Between September 2014 and April 2016, women attending the Itahari MSC for safe abortion services were informed of the study with 112 women consenting to be contacted for potential research participation (Appendices N to Q). To help mitigate recall bias, women who had accessed MA 3 to 6 months prior to Phase Two data collection were selected from the sample of 112, resulting in 46 women for potential participation. From these 42 women, participants were purposively selected for age

diversity. With assistance from Itahari MSC staff members, contact was attempted with 23 women with a final 10 women participating in the research. Ethical requirements for conducting this research (Appendix A and B), ensure that participants or potential participants can decline to take part, or withdraw, from the research at any time and for any reason. There could be many factors impacting women's decision to decline research participation, such as sociocultural or time constraint factors, however, reasons cannot be presumed. The MA provided at the Ithari MSC is a Nepal-government registered brand of MA (mifepristone and misoprostol combi-pack).

Participant Recruitment: Pharmacy Clients

Between April and May of 2016, Female Community Health Volunteers (FCHVs) who were working closely with the Itahari MSC in the Sunsari District, approached women from within the community who they knew to have previously accessed MA through a pharmacy, informed them of the research and asked if they would like to participate. Through the FCHVs' trusted, community-based networks and with support of MSC staff, ultimately 10 women who met the inclusion criteria (Table 5.4), were purposively recruited for their specific experience of having accessed MA illegally through a pharmacy. Due to difficulties with recruitment from this hard to reach community-based population, MA access prior to data collection for pharmacy clients ranged between approximately 3 weeks to 2 years. The medication that pharmacy clients obtained from a pharmacy for terminating their pregnancy is referred to as MA. However, it was impossible to ascertain whether they received a Nepal registered brand of MA, an unregistered but legitimate brand of MA, counterfeit MA or a type of ayurvedic medicine with abortive properties (Tamang et al., 2015b).

5.5 Data Collection

A holistic approach to understanding the SRHR needs of women in Nepal was achieved throughout the course of this research. Apart from the 29 in-depth interviews and nine community conversations, field observations, a review of government and nongovernment SRH and safe abortion policy and practice was undertaken to maintain awareness of changes within the sector. As presented in chapter 4, a systematic review of current and relevant literature utilising the PRISMA guidelines was also conducted. Data collection sites included Kathmandu and the Sunsari Districts of Nepal between

2014 and 2016.

Phase One

Phase One was conducted between June and August 2014. The first month was spent in Kathmandu, coordinating with team members, hiring and training the Phase One RA, communicating with supporting SPN/MSN staff, making field observations, collecting relevant government and nongovernment documentation for review, and conducting pilot testing of guiding questions. In-depth interviews with SRHR professionals also began during this time.

During the second month of Phase One, my RA and I travelled to the Sunsari District (specifically the towns of Itahari and Dharan). Preparations for participant recruitment during Phase Two was undertaken in collaboration with the Itahari MSC before returning to Kathmandu for completion of Phase One in-depth interviews. Conducting the AFRPAC within the two districts was essential owing to the location of participants and the need for personal communication with various SRHR stakeholders.

Phase Two

Phase Two of the research project was originally planned for September to December in 2015. However, political turmoil at the India/Nepal border in 2015, as detailed in chapter 2, necessitated the postponement of Phase Two until 2016. After extensive preparation for the second phase of data collection in 2015, I arrived in Kathmandu a week after the promulgation of the new constitution. While the country was still recovering from the recent earthquakes, political and civil unrest was escalating at a rapid pace. Due to safety concerns, it was decided to hold off on travel to the Terai until things settled. However, over the coming weeks, the violence did not abate, and I decided to return to Australia, postponing Phase Two until the next year. Field observations of the blockade's impact on the SRHR of women in Nepal formed the basis of the News Deeply online publication: Nepal Quakes Leave Women's Healthcare in Crisis (Appendix EE).

Phase Two was conducted in Nepal between April and May 2016. The first component of Phase Two (9 days) took place in Kathmandu. Collaboration and communication with research team members and key SRHR stakeholders, as well as the recruitment

and training of a new research assistant occurred during this time. Data collection was then conducted in the Sunsari district and included two informal community conversations and 20 in-depth interviews with women who had previously accessed medical abortion (clinic clients and pharmacy clients).

Field Observations

Throughout Phases One and Two of Nepal-based data collection informal field observations were undertaken with RAs facilitating cultural interpretation, gender contextualisation and assisting with reflective field note taking. As recommended by Pepall et al. (2016), increasing time for in-field data collection can assist in gaining greater contextual understanding of issues impacting individuals at the community level (see Table 5.1). Guided by components within levels 1 to 3 of the Health Information Pyramid, time was incorporated into Phases One and Two field-work in the Kathmandu Valley and Sunsari District to observe: health facility infrastructure (government, nongovernment and SPN/MSN), pharmacy proliferation, religious sites and events, community events (government and SPN/MSN), transportation infrastructure as well as the physical (home and public) and ecological environments of the regions.

Within the AFRPAC, informal field observations facilitated dialogue between myself, RAs and my associated supervisor and assisted in me gaining greater understanding of the issues impacting women and girls in Nepal, and the role they play within society. Reflective notes were taken outlining thoughts and discussions of these informal interactions in the community; and within the Health Information Pyramid framework assisted in the understanding of Nepali life and its contextualisation in data collection and analysis of informal community conversations and in-depth interviews.

5.5.1 In-depth Interviews and Informal Community Conversations

In-depth interviews are an effective data collection tool for gaining insight into individuals' unique perspectives and experiences, and in the context of this study particularly explored sensitive topics (Given, 2008; Mack et al., 2005). Informal community conversations provided triangulation and contextualisation of in-depth interview data, enabling a deeper and nuanced understanding of the subject matter.

5.5.2 Data Collection Method

The aims and objectives of the research informed the development of the guiding questions that were utilised during the open-ended, semi-structured in-depth interviews and the informal community conversations (Appendices R to Y) (Curtis & Curtis, 2011). The guiding questions were open-ended, but the interviews concluded with two unstructured questions: *"Do you have any questions you would like to ask? Do you have anything else you would like to add?"* (Curtis & Curtis, 2011). The guiding questions for the 20 women who accessed medical abortion also contained questions relating to demographic data (Curtis & Curtis, 2011). Guiding questions for in-depth interviews and informal community conversations were pilot tested, refined and finalised by research team members prior to data collection. With assistance of SPN/MSN staff, participants were recruited for the pilot testing and included a medical doctor and clinic client from the Gongabu MSC in Kathmandu as well as community member from the Gongabu area (Curtis & Curtis, 2011). Through the AFRPAC process, guiding questions were further refined by the research team to address the emergence of new themes, specifically pharmacy-provided MA.

In-depth interviews and informal conversations were conducted by myself and either the Phase One or Phase Two RA. All participants were asked if they would prefer to speak in Nepali or English during their interviews. Seven SRHR professional interviews were conducted in English by me. Although one SRHR professional interviewee was questioned in English, responses were sometimes given in Nepali as they could express themselves more accurately. One SRHR professional interview was entirely conducted in Nepali, with the RA leading the questioning and translating responses.

Consent to audio record in-depth interviews and informal conversations was confirmed prior to commencement. One SRHR professional participant requested their interview not be recorded, and notes were taken by myself and the Phase One RA during this interview. All other participants consented to be recorded. Both RAs translated and transcribed interviews verbatim shortly after they were conducted. The Phase One RA transcribed interview content in Nepali then translated it to English, whereas the Phase Two RA, translated and transcribed simultaneously. Because of timeframe constraints and the quantity of interviews conducted during Phase Two,

additional translation and transcription support was required. A professional translator, who works closely with the Executive Team at SPN/MSN, was employed. As Phase One transcripts were in both Nepali and English, review of both versions was undertaken by my associate supervisor to ensure accuracy in translation.

5.6 Data Analysis

Informed by the Health Information Pyramid conceptual framework within the AFRPAC, the process of data collection and thematic analysis was cyclical and ongoing. Mills et. al., (2010) argue one of the advantages of an inductive approach to thematic analysis is that it eliminates the risks of the rigidity and premature closure that can occur through a deductive approach. An inductive approach to thematic content analysis facilitated the examination of emergent themes within the data, enabling the synthesis of overarching themes and sub-themes (Barnett-Page & Thomas, 2009; Given, 2008; Mills, Durepos, & Wiebe, 2010).

Informal Community Conversations

Community conversation allowed the research team to gain valuable insights into the community's own perspectives of their health needs. Local and national assets, such as individuals, organisations, programs and infrastructure able to support these needs were also discussed (Pepall et al., 2006). On completion of each informal community conversation in Phase One, the RA transcribed (Nepali) and translated (English) the audio recording and time was set aside to review the transcripts. Using the Health Information Pyramid as a visual aid, the transcripts guided discussion and reflection of data and the interview process with attention given to community perceived assets. It provided the opportunity for the RA, in their role of cultural interpreter, to ensure I had a clear understanding of community life and the issues impacting women, as detailed by participants. Notes were also taken to ensure a record of these reflections were available for future reference or to discuss with my associate supervisor, if required.

As a form of member checking, we returned to the participants and provided the transcript (in Nepali) for them to read which allowed us the opportunity to ask participants if they had anything further to add. Due to time constraints in Phase Two,

it was not deemed a priority to translate and transcribe the two youth informal community conversations immediately after the interviews. However, a similar post-interview process, as detailed in Phase One, was undertaken during Phase Two using notes taken throughout the interviews to guide discussion.

Within the Health Information Pyramid framework, data gathered from the informal community conversations informed understanding of community composition and gender roles (level 1); skills and capacity of individuals and organisations within the community (level 1); cultural and religious aspects of community life (level 1); the physical environment and its impact on health (level 2); the sociocultural and socioeconomic status of women (levels 1, 2 and 3); and health service access and uptake (levels 1, 2 and 3).

Throughout the informal community conversations, the most frequently shared community health concerns related to the high level of pollution and pesticides used in Nepal and the impact this has on people's health.

Regarding women's health in general, concerns relating to women's lower social status in Nepal's traditionally patriarchal society were highlighted. The difficulties women face in accessing SRH services due to sociocultural stigma was the most frequently reiterated concern. The focus of health services within urban centres, impacting access for rural women and girls, was also a key concern of participants.

Participants enthusiastically shared their opinions of their community's and country's greatest assets. Although a predominantly Hindu country, pride in the inclusive nature of the various religions in Nepal (Figure 2.4, p. 15) as well as religious sites was stated by many of the respondents as being a positive and essential part of being Nepali.

Participants stated that people actively enjoy community-based education events and look to their community leaders for knowledge and guidance. The role of community-based health workers was consistently highlighted as being an incredibly important community asset, especially in rural and remote regions of Nepal.

The informal community conversations provided an essential component of data triangulation. The conversations also helped shape research progression as well as contextualisation of community identified assets and provided context for synthesis and analysis of in-depth interview data.

In-depth Interviews

After each in-depth interview was conducted, myself and the Phase One or Phase Two RA would take time to discuss any thoughts and observations we had on the interview. We utilised the Health Information Pyramid as a visual aid to: identify emerging themes and clarify or make note of discrepancies relating to data already gathered on the four levels and 10 components; discuss linkage to research aims and objectives; contextualise stakeholder or collaborator information gathered or conversations needed; identify documentation (government, NGO and I/NGO) required for review; contextualise field observations reflective notes; assess data saturation; triangulate data and make additional reflective field notes that were later discussed with my associate supervisor, as required. For interviews conducted by the RAs in Nepali, and translated throughout in English, these post-interview discussions were essential in ensuring I had an accurate understanding of the information gathered. These sessions also ensured inductive thematic analysis progression while the process of translation and transcription of audio recordings was being undertaken.

Informed by post-interview discussion reflective notes and community identified assets, detailed thematic analysis of in-depth interview transcripts was conducted after Phase One and Phase Two of data collection. To minimise subjectivity of analysis and to ensure cultural understanding and meaning of data, transcripts were also read by the RAs and my associate supervisor in Nepal (Oliveira, Bitencourt, Zanardo dos Santos, & Teixeira, 2016). After initial review of transcripts, I then re-read the transcripts, taking notes of themes and the frequency with which these themes emerged. Through the inductive approach to coding, themes were compared, collated and condensed, revealing a cursory thematic structure. I then read the transcripts a third time before collaboration with the research team for discussion on data saturation confirmation and refinement of themes (Appendices Z and AA). Throughout the thematic content analysis of transcripts, the Health Information Pyramid informed data analysis and provided guidance for the identification of new or updated documents (government,

NGO, I/NGO and research) needed to inform the study and to triangulate in-depth interview data. A detailed analysis of in-depth interviews can be found in chapters 6 and 7.

Assets

Within the AFRPAC, the identification of community assets can assist in the formulation of recommendations and outcomes able to contribute to social change and development (Pepall et al., 2006). Throughout data collection, two prominent health-based assets were identified:

1. Community-based health workers, such as FCHVs (informal community conversations and in-depth interviews with clinic clients and pharmacy clients, with input from SPN/MSN collaborators).
2. Government of Nepal SRHR Policy (in-depth interviews with SRHR professionals).

Details on these assets and how they contributed to recommendations outlined in this thesis will be discussed in chapters 6, 7 and 8.

5.7 Rigour in Research

Sharts-Hopko (2002) states the main criticisms of qualitative research relate to smaller participant sample size and to the use of convenience or purposive sampling in contrast to random selection. They argue that maintaining rigour within qualitative studies must be a priority of researchers (Sharts-Hopko, 2002). Rigour in qualitative research is evaluated within the context of credibility, confirmability, dependability and transferability, with trustworthiness an important aspect in demonstrating validity and reliability (Cohen & Crabtree, 2008; Graneheim & Lundman, 2004; Malterud, 2001).

5.7.1 Triangulation

Within qualitative research, the process of triangulation allows researchers to identify, explore and gain cultural understanding of issues surrounding their topic and participants, enabling an enrichment of interpretation and a strengthening of findings (Given, 2008). Triangulation of data sources was used throughout the research. Guided by the Health Information Pyramid conceptual framework and in combination with data collected from in-depth interviews and informal community conversations every

attempt was made to enhance the credibility and overall trustworthiness of the data. Research triangulation was achieved through systematic review of current SRHR frameworks (government and nongovernment) and government health policy, observed clinical practice, field observations, ongoing interpretation of data and review of current and relevant literature.

5.7.2 Member Checking

Member checking, also called respondent or participant validation, is a technique used to assess the trustworthiness of qualitative data by receiving feedback from participants (Birt, Scott, Cavers, Campbell, & Walter, 2016; Thomas, 2017). All SRHR professional and informal community conversation participants received a copy of their interview transcript for review and feedback. To ensure accuracy of direct quotes, a second round of member checks with SRHR professionals was conducted between June and July of 2017 prior to submission of the journal article for peer review (Birt et al., 2016). While member checking is an effective method of data validation, the process raised ethical concerns around the protection and safety of clinic client and pharmacy client participants, it was decided by the research team to not share the themes but to share the overall results and recommendations with the clinic and pharmacy client participants (Birt et al., 2016).

5.7.3 Audit Trail

An audit trail was ensured throughout this study relating to the study design, methods and analysis. Within qualitative research, audit trails facilitate the recording of the steps of research progression and provides a mechanism for retroactive assessment of the process to support study rigour (Given, 2008; Salkind, 2007). A detailed fieldwork diary was kept to document emails sent, phone calls made, meetings and other daily administrative requirements to assist in the organisation of research, as well as to provide a detailed update of progress to the research team. A travel diary was also essential in the collation of travel and accommodation logistics for myself and my RAs. For the regular reporting of research progress to the Nepal Health Research Council and Curtin University, annual progress reports were completed.

5.7.4 Stakeholder Feedback

In September 2016, initial findings from the research were discussed at a presentation

for community stakeholders in Itahari. In attendance were 22 Sunsari District based health professionals from both government and nongovernment organisations as well as male and female community health volunteers. A brief report of key findings (in Nepali) was presented. Through feedback on initial findings, key community stakeholders were able to contribute their opinions and thoughts on the research, as well as contribute to analysis of research outcomes and recommendations. The stakeholders expressed enthusiasm for the research and initial finding, however noted that research recommendations and outcomes must have a positive impact on women living in rural and remote regions of Nepal, as well as their urban counterparts.

5.8 Ethical Considerations

Ethical approval for this study was granted by the Nepal Health Research Council (NHRC 20/2014) and the Curtin University Human Research Ethics Committee (HR 17/2014) (Appendices A and B). The Australian Code for the Responsible Conduct of Research was adhered to during all aspects of this research was conducted (National Health and Medical Research Council, Australian Research Council, & Universities Australia, 2007).

5.8.1 Inclusion Criteria Age Range

As detailed in chapter 2, while the minimum legal age for marriage in Nepal is 20 years for both males and females, the practice of child and early marriage persists in the county and was a considered factor when defining inclusion criteria for research participation (Ministry of Health Nepal et al., 2017a; United Nations Population Fund, 2017). Data from the 2016 NDHS shows the median ages at both first marriage and first sexual intercourse among Nepali women is 17.9 years. The survey also found that of women age 25-49, 11% had initiated sexual intercourse by age 15. In Nepal, 17% of women age 15-19 have begun childbearing; 13% have had a live birth, and 4% are pregnant with their first child (Ministry of Health Nepal et al., 2017a). For women aged 15 – 49 years, unmet need for contraception is highest among the 15 – 19 years age bracket with only 15% currently using a modern method of contraception (Ministry of Health Nepal et al., 2017a). In light of these issues and to align the inclusion criteria age range with NDHS data collection age range, ethical permission for sought and granted from the Nepal Health Research Council and the Curtin

University Human Research Ethics Committee to include women between 15 – 49 years in the research in accordance with their guidelines.

5.8.2 Informed Consent

To ensure all participants had a clear understanding of the purpose of the research and their role, an Information Sheet in Nepali or English (Appendices J to O) was provided to participants prior to their interviews, with the RA reading through the form and engaging participants in discussion. The Consent Form in Nepali or English (Appendices H and I) was then read to the participants ensuring they understood the voluntary nature of their participation, had the right to withdraw from the study at any time, and that their information will be kept confidential.

In some settings, the act of obtaining written informed consent can be culturally inappropriate (Czymoniewicz-Klippel et al., 2010). While this is not the case in Nepal, informed consent was verbal or written, depending on literacy level of participants. All SRHR professionals gave written informed consent; 8 clinic client participants provided written informed consent and 2 provided verbal informed consent; 10 pharmacy client participants gave written informed consent, and all 9 informal community conversation participants provided written informed consent (Czymoniewicz-Klippel et al., 2010).

To ensure the confidentiality of participants, participant-chosen pseudonyms have been used throughout the research (Mack et al., 2005). The only place participant names and pseudonyms/titles are documented together are on the Consent Forms. As presented in the guiding questions (Appendices R to Y), a pre-and post-interview checklist ensured a systematic and ethical process for gaining informed consent. This checklist also gave participant and researchers the opportunity to make small talk and relax.

Before commencement of interviews conducted in Nepali, the interview process and how translation of responses would occur was clearly explained and enabled participants to be comfortable with the questioning progression. To facilitate free flowing responses, translation of comments was only done when the participant took a break in the conversation. The RA would make brief reflective notes during

participant responses to ensure accurate translation.

5.8.3 Cross-Cultural/Linguistic Research

With qualitative research methods becoming increasing popular in cross-cultural and cross-linguistic environments, the role, impact and ethical considerations when employing the use of translators and interpreters has been gaining critical focus (Berman & Tyyskä, 2011; Shimpuku & Norr, 2012; Temple, 2002; Wilson & Neville, 2009). The role of the RA within the context of this study was designed to be one of cultural interpreter, translator and most importantly, a partner throughout the research process (Berman & Tyyskä, 2011). The triangular method of questioning, response and translation, used throughout interviews was facilitated by my complete involvement, with myself and my RA working to ensure effective data collection. This was particularly important when conducting in-depth interviews with clinic client and pharmacy client participants owing to the extensive guiding questions and accompanying in-depth exploration designed to elicit thoughtful answers.

5.8.4 Power Dynamics and Cultural Safety

Due to the very nature of qualitative research and the relationship established between researchers and participants, ethical issues arise when conducting qualitative SRHR research data collection (Sanjari et al., 2014). The concept of power dynamics, particularly with clinic client and pharmacy clients, was discussed extensively during interview preparation and RA training, with strategies formulated to mitigate its impact (Edwards & Mauthner, 2012). Establishing a culturally safe environment for participants to comfortably and voluntarily share their stories was paramount for ethical data collection (Wilson & Neville, 2009) and helped mitigate differences and their impact on power dynamics between researchers and participants.

I was also acutely aware of the perceived power imbalance of being a foreigner conducting research for an Australian university, particularly with our clinic client and pharmacy client participants. To help put participants at ease, during the pre-interview phase where we would share a light meal and refreshments, I would offer participants food and beverages speaking in Nepali. With my Australian accent and limited Nepali language skills, this would always draw laughter. We found this simple way to break down power dynamics between myself, an Australian woman, and my RA, a Nepali

woman, and put participants at ease. Within the context of culturally safe research, a concept closely aligned with ethical principle of beneficence, Wilson and Neville (2009) highlight the importance of researchers expressing a sense of humility.

5.8.5 Justice, Beneficence and Non-Maleficence

Ensuring we conducted culturally safe data collection, it was essential that participants felt they were respected, and could trust us with their stories and had a clear understanding of how the information they shared would be used (Wilson & Neville, 2009). It was particularly emphasised to clinic client and pharmacy client participants that without the knowledge, and experiences they shared, there would be no research project. Ensuring participants understood that their participation would precipitate outcomes was integral to the knowledge for action strategy of this study. Respondents were informed of how their participation would assist the development of tangible SRHR policy and practice outcomes.

As many clinic client and pharmacy client participants had to travel to contribute to the research, all respondents received 500 Nepali Rupees (NPR) of transport reimbursement, as well as a light meal with refreshments before the interviews. To thank respondents for their time, all received two vouchers, redeemable at the Itahari MSC. One was for a free health check-up (a general health check-up and valued at 150 NPR) and one voucher was for a 'women's health check-up' (and included a pregnancy test and valued at 100 NPR). At the end of interviews, participants were asked if they had any other questions for us, and at this point several asked medical questions relating to their SRH. Adhering to the ethical principle of non-maleficence, interviews with pharmacy client participants did not address the illegality of MA supply through pharmacies so as not to cause distress to participants (Collumbien et al., 2012; Mack et al., 2005).

5.9 Data Storage

While conducting Nepal-based field-work, electronic data were stored on a password protected laptop and all paperwork was always kept in the possession of myself or the RA. To ensure the protection of participant privacy and confidentiality of data all research documentation is currently kept in a secure location. All paper records

including consent forms, hand written notes, interview transcripts and guiding questions with field notes, are stored in a locked filing cabinet. All electronic data collection including the NVivo database, is stored on a password protected computer. Upon completion of research reporting, all research documentation will be securely kept for five years from the date of thesis publication as required by the guidelines of the Australian Code for the Responsible Conduct of Research (National Health and Medical Research Council et al., 2007).

5.10 Summary of the Chapter

This chapter has provided an overview of the research design, methodology and implementation of the study as well as data collection and analysis processes and ethical considerations undertaken during the research. The next chapter presents the qualitative findings from in-depth interviews conducted with SRHR professional participants.

CHAPTER 6

ABORTION IN NEPAL

Introduction to the Chapter

From the review of the literature, the quality and effectiveness of post-abortion access to contraception and SRH information varies markedly within different safe abortion service providers. As detailed in chapter 5, this inconsistency is noted within both the global and Nepali contexts. Hence, this chapter is dedicated to exploring the perspectives of a cross-section of Nepal based SRHR professionals and their opinions on abortion access and uptake within the country. This chapter presents the manuscript for Article 3 and is structured to the formatting of this thesis.

Rogers, C., Sapkota, S., Tako, A., & Dantas, J. A. R. (2019). Abortion in Nepal: perspectives of a cross-section of sexual and reproductive health and rights professionals. *BMC Women's Health, 19*(40). doi:10.1186/s12905-019-0734-1

This manuscript was accepted for publication in ***BMC Women's Health*** on 15 February 2019 (Appendix DD).

6.1 Article 3: Abortion in Nepal: Perspectives of a cross-section of sexual and reproductive health and rights professionals

6.1.1 Abstract

Globally, women face many barriers in the attainment of sexual and reproductive health and rights (SRHR). Since 2002, there has been significant progress in the expansion of safe abortion and family planning services in Nepal because of the legalisation of abortion. This qualitative, exploratory study was conducted in 2014 and uses 9 in-depth, open-ended interviews with a cross-section of SRHR professionals, to explore their perspectives on abortion in Nepal. The study was underpinned by the Assets Focused Rapid Participatory Appraisal (AFRPA) research methodology and used the health information pyramid conceptual framework. Thematic content analysis

revealed emerging themes relating to barriers to access and uptake of skilled safe abortion services and post-abortion family planning. Findings also emphasised current practical and legal components relating to the provision of medical abortion through pharmacies and highlighted issues of sex-selective abortion within the predominantly patriarchal society. Effective and ongoing sector-wide monitoring and evaluation of safe abortion services and their staff is essential for women in Nepal to have adequate access to effective and efficient safe abortion services, access to contraception and sexual and reproductive health (SRH) information post-abortion and to ensure adherence to current Safe Abortion Policy. It is critical that the unsafe (less and least safe) provision of medical abortion through pharmacies and sex-selective abortion continues to be investigated and that innovative strategies are formulated to ensure the cultural, reproductive and sexual health and rights of Nepali women are realised.

Keywords: abortion, contraception, family planning, sexual and reproductive health and rights (SRHR), Nepal

6.2 Background

An estimated 56 million abortions occur each year worldwide, with women in developing countries having a higher likelihood of accessing abortion than their counterparts in developed regions (Guttmacher Institute, 2016). World Health Organization (WHO) classifications of safe and unsafe abortion categorise abortion into a three-tiered model of safe and unsafe, with unsafe abortion being further divided into less safe and least safe (Ganatra, Gerdts, et al.). It is estimated that of the total abortions occurring worldwide each year between 2010 and 2014, approximately twenty-five million were categorised as unsafe (17.1 million less safe and 8 million least safe) with 24.3 million (97%) of unsafe abortions occurring in developing countries (Ganatra, Gerdts, et al., 2017). Complications from unsafe abortions are especially common in developing countries with an estimated seven million women annually requiring medical treatment after an unsafe abortion (Guttmacher Institute, 2016).

Prior to 2002, abortion was illegal in Nepal, unsafe abortion was common and deaths from abortion related complications attributed to more than half of maternal deaths

occurring in major hospitals (Government of Nepal, 2002, 2015b; Puri et al., 2016; Thapa et al., 1992). Over the last two decades, Nepal has undergone a sector-wide government approach to family planning and safe motherhood, complementing the legalisation of abortion in 2002 and the availability of medical abortion (mifepristone and misoprostol) since 2009 (Bell et al., 2018; Government of Nepal, 2015b). Through a concerted effort to reduce maternal deaths, Nepal has also seen a dramatic decrease in its maternal mortality rate (MMR) during this time, declining from 901 per 100,000 live births in 1990 to 258 per 100,00 live births in 2015 (Government of Nepal, 2015a; World Health Organization, 2015b).

Data from the Nepal Department of Health Annual Report (2014/2015) demonstrates that since the implementation of safe abortion services, a total of 819,690 women have received safe abortions from certified service sites. However, the Department of Health Annual Report also details that utilisation of these safe abortion services has plateaued over the last few years (Government of Nepal, 2015a). The contraceptive prevalence rate (CPR) has also plateaued over recent years, with data from the most recent National Demographic Health Survey (NDHS), reporting a decrease in the use of modern contraceptive methods from 44% in 2006 to 43% in 2011 and remaining stagnate at 43% in 2016 (Government of Nepal, 2015a; Ministry of Health Nepal et al., 2017b). The unmet need for contraception in Nepal continues to remain high (having declined countrywide from 32% in 1996 to 24% in 2016), particularly for married women aged 15–19 years (34.9%) and for women living in rural and remote regions of Nepal (25.3%) (Ministry of Health Nepal et al., 2017b). The low status of women, lack of education, poverty, isolation and the socioeconomic and sociocultural consequences of the caste system all remain significant barriers to SRH care access and service utilisation (Ministry of Health Nepal et al., 2017b; Shrestha et al., 2012).

In August 2016, the Government of Nepal announced a plan to implement free safe abortion services in public clinics, in combination with the provision of free family planning services, to help overcome the economic burden of accessing safe abortion services (Government of Nepal, 2016; Ipas, 2015, 2016). However, even with access to free services in public facilities, costs associated with transportation, accommodation, logistics, medicines and additional medical fees remain prohibitive factors for poor women accessing services, particularly those in rural and remote

regions (Bell et al., 2018; Puri et al., 2016). Additionally, women seeking services through the nongovernment and private sectors are required to pay for safe abortion services out of pocket (Bell et al., 2018).

A Nepal based study of 527 women presenting at hospitals due to complications from unsafe abortion reported that 68% of respondents induced termination through medication (any substance or drug taken orally or inserted vaginally) while 32% used instrumentation (insertion of instruments into the vagina including aspiration, dilation and curettage or foreign objects) (Rocca et al., 2013). An estimated 323,000 abortions were performed in Nepal in 2014 and, of these, over half (58%) are considered clandestine procedures, provided by untrained or unregistered providers or self-induced (Guttmacher Institute & CREHPA, 2017). Of the estimated 137,000 legal abortions performed in Nepal, the public sector provided 37% of procedures, 34% were provided at NGO facilities and 29% were obtained at private sector clinics (Guttmacher Institute & CREHPA, 2017). According to the most recent countrywide NDHS (2016), of the women who recorded having an abortion in the five years preceding the survey (n = 492), 72% opted for medical abortion (MA), 17%, manual vacuum aspiration and 7% dilation and evacuation/dilation and curettage.

The majority reported attending a doctor, nurse, or auxiliary nurse-midwife (71%) for their most recent abortion and 19% received services from a pharmacy or medical shop as they alternatively known. Rural residents and women with no education were more likely to report the use of MA than their urban counterparts. Half of the women surveyed reported obtaining an abortion as they did not want more children, while 12% said that they wanted to delay childbearing. Health concerns were cited by 10% of women, 9% wanted to space their births, and 7% reported that the sex of the child was undesired (Ministry of Health Nepal et al., 2017b).

While it has been 15 years since the legalisation of abortion in Nepal, unsafe abortion remains the third highest (7%) direct cause of maternal death in Nepal; significant numbers of Nepali women remain unaware of the legal status of abortion and have limited or no knowledge of where to obtain safe abortion services (Bell et al., 2018; Center for Research on Environment Health and Population Activities, 2011; Ministry of Health Nepal et al., 2017b; Suvedi et al., 2010; Thapa, Sharma, & Khatiwada, 2014).

Efficient and equitable provision of Comprehensive Abortion Care (CAC), which includes Post-Abortion Care (PAC), plays a pivotal role in positive health outcomes and prevention of future unintended pregnancies for women who access safe abortion services (Andersen et al., 2012; Barot, 2014; Bell et al., 2018; Government of Nepal, 2006b; PAC Consortium Service Delivery Task Force, 2014; Rogers & Dantas, 2017; Wang, Puri, Rocca, Blum, & Henderson, 2016).

By providing a platform for SRHR professionals to share their extensive experience and knowledge, this qualitative exploratory study aims to enhance the current understanding of abortion in Nepal from their perspective and, to the authors' knowledge, is the first of its kind to be conducted in Nepal with such a diverse group of professionals. Informed by participant suggested strategies, we propose recommendations on how SRH and CAC services can assist Nepali women to navigate cultural and sexual norms to more effectively and holistically exercise their reproductive health rights.

6.3 Methods

Using an Assets Focused Rapid Participatory Appraisal (AFRPA) research methodology, underpinned by a health information pyramid conceptual framework, this qualitative exploratory study utilised data collected from in-depth, open-ended interviews with nine SRH professionals located in Kathmandu valley and Sunsari districts of Nepal (Annett & Rifkin, 1995; Pepall et al., 2006). Building on the Rapid Participatory Appraisal methodology, Pepall et al. (2006) describe AFRPA as an effective means of prioritising needs and identify existing community assets that may help contribute to social change and development. Emphasis on assets ensures that findings are concurrently solution- and problem-focused, as opposed to merely the identification of problems. Supporting this methodology with Annett and Rifkin's (1995) health information pyramid conceptual framework, grounded data collection within a four-tiered framework: 1. community composition, organisation and structure, and capacity to act; 2. physical environment, socioeconomic environment, and disease and disability; 3. health and environmental services, and social services; and 4. health policy. Pepall et al. (2006) refer to this composite process as an Assets Focused Rapid Participatory Assessment Cycle (AFRPAC).

Throughout the research project, nine individual informal conversations were also conducted with community members located in the Sunsari District including: business owners, homemakers, political and religious leaders, academic professionals, and young people to inform in-depth interview questioning and to enable the research team to acquire a greater understanding of people's perception of women's health within the context of their community, as well as Nepal in general. These informal conversations also helped to highlight perceived community and national assets, such as individuals, organisations, programs and infrastructure. As well as supporting in-depth interviews, this component of AFRPA allows researchers to gain insight into a community's own perspective of its needs; helps facilitate the translation of overall findings into action; and assists in enabling the establishment and ongoing relationship between service providers and local communities (Pepall et al., 2006).

Due to the cyclical nature of the AFRPAC, evaluation and modification of the research process were ongoing. The utilisation of the AFRPA research methodology and health information pyramid conceptual framework enabled the evolution of information collection and analysis to accentuate key issues concerning the SRHR sector, as well as perceived assets relating to safe abortion and post-abortion family planning and SRH information access in Nepal. This enabled participants to focus both on current problems relating to access to safe abortion, post-abortion family planning and SRH information, as well as the formulation of potential solutions for these issues. Complementing the qualitative findings, analysis of current government and nongovernment SRH policy and clinical practices was also undertaken concurrently.

Ethical approval for this study was granted by the Nepal Health Research Council (NHRC 20/2014) and the Curtin University Human Research Ethics Committee (HR 17/2014). With assistance from in-country contacts within the SRHR sector, participants were purposively recruited, via telephone and email, from a cross-section of professionals for their expertise within the SRHR field in Nepal. Representing varying SRHR organisations and professions, the diverse range of participants included: clinical staff, researchers, advisors, advocacy officers, government officials, international and local nongovernment organisation staff, and international donor personnel. By design, many of the participants are high-ranking officials or senior

members within their organisations and were able to provide countrywide context (urban, rural and remote) to SRHR and wide-ranging perspectives to SRHR in Nepal. While their organisations are represented throughout Nepal, many of the participants work from their organisational headquarters in Kathmandu, therefore the majority of interviews were held in Kathmandu from a practical perspective.

The hour-long interviews were conducted with participants (at a location of the participant's choosing) between June and August, 2014, by the first and third authors who are both females. A research information sheet and informed consent form were provided to all participants for review prior to interviews, and participants were encouraged to ask questions about the study or any component of the research. Participants chose either Nepali or English as their preferred language for communication. Eight of the interviews were audio recorded, and one interview was transcribed on location. Audio files were transcribed after the interviews, and all participants received a copy of their interview transcript for review and feedback and as a form of member checking. A second round of member checks was conducted between June and July, 2017.

A thematic analysis of in-depth interviews was undertaken with the first three authors reading the transcripts and discussing data saturation before collaboration and refinement of themes. Thematic analysis enabled the examination of patterns of experience within the data, facilitating the synthesis of themes and sub-themes within the context of overarching commonalities of access to safe, less safe and least safe abortion in Nepal (Given, 2008; Mills et al., 2010). To ensure the confidentiality of participants, generic job titles have been used throughout this paper and the sex of the participants withheld.

Rigour in qualitative research is assessed within the context of dependability, credibility, confirmability and transferability, with trustworthiness a significant factor in the research's ability to demonstrate reliability and validity (Cohen & Crabtree, 2008; Graneheim & Lundman, 2004; Malterud, 2001). To enhance the credibility and overall trustworthiness of this research, systematic checking, ongoing interpretation of data and an audit trail were utilised to ensure information relating to the study design, methods and analysis were documented, transparent and could be replicated (Birt et

al., 2016; Denzin & Lincoln, 2008; Rodgers & Cowles, 1993; Sharts-Hopko, 2002). Pilot testing of interview questions was conducted with all authors assisting in the refinement and finalisation of the guiding questions prior to the interviews. Member checking, the process of sharing interview findings with research participants to ensure data accuracy, was undertaken to validate results and themes and enhance the trustworthiness of the data (Birt et al., 2016; Sharts-Hopko, 2002). The second round of member checks conducted in 2017 was also an effective method of ensuing the continued relevance of respondent quotes (Birt et al., 2016). Participants were also asked if they would like to provide additional information or insights into any developments in SRHR policy and practice in Nepal. As a component of the ongoing AFRPAC research process, the second round of member checks ensured findings are contemporary and relevant to issues impacting SRHR in Nepal.

6.4 Results

The research participants worked within various sectors of SRHR in Nepal and provided extensive and multifaceted insights into their experiences and knowledge regarding women's abortion and post-abortion experiences in Nepal. As detailed in Table 6.1, eight participants were interviewed in Kathmandu, and to gain understanding of SRHR issues within a clinical environment outside of Kathmandu, one was interviewed in the Sunsari District.

Table 6.1 In-depth Interview (IDI) participants (n = 9)

	Title	Organisation	Work Location
IDI 1.	Service provider	SRH Clinic, I/NGO[1](a)	Kathmandu
IDI 2.	Senior service provider	SRH Clinic, I/NGO(a)	Kathmandu
IDI 3.	SRHR research consultant	Independent	Nepal
IDI 4.	Senior service provider	CAC[2] Unit, Public Health Facility(b)	Kathmandu
IDI 5.	Safe Abortion Policy Advisor	SRH I/NGO(c)	Nepal
IDI 6.	Service provider	SRH Clinic, I/NGO(a)	Sunsari District
IDI 7.	Program Manager	SRH NGO[3](d)	Nepal
IDI 8.	Senior Officer	SRH NGO(e)	Nepal
IDI 9.	Senior Officer	Ministry of Health, GON(b)	Nepal

[1]International Nongovernment Organisation
[2]Comprehensive Abortion Care

[3]Nongovernment Organisation
(a) SRH I/NGO providing clinical and educational services
(b) Government of Nepal
(c) SRH I/NGO providing advisory and educational services
(d) SRH NGO providing clinical and educational services
(e) SRH NGO providing research, advocacy and educational services

Three overarching themes emerged from the thematic analysis:

1. barriers to access and uptake of skilled safe abortion services
2. barriers to access and uptake post-abortion family planning services (contraception and SRH information provision)
3. the provision of MA through pharmacies.

There were several sub-themes relating to each of the overarching themes and are listed in Table 6.2. Participants also recommended strategies to improve access and uptake of post-abortion family planning services and skilled safe abortion services in Nepal.

Table 6.2 Thematic analysis of interview data

Main Themes	Sub-themes
Barriers: Access and uptake of skilled safe abortion services	
	Sociocultural attitudes
	Socioeconomic constraints
	Geographic isolation
	Translating policy into practice
Barriers: Access and uptake of post-abortion family planning services	
	Misconceptions and cultural barriers
	Geographic remoteness
	Policy, practice and monitoring
Concerns about medical abortion provision through pharmacies	
	The evolution of unsafe (less safe and least safe) abortion and medical abortion
	Obstacles to safe abortion services
	Challenges of monitoring unsafe (less safe and least safe) pharmacy-provided medical abortions

6.5.1 Barriers: Access and uptake of skilled safe abortion services

Sociocultural attitudes

Participants highlighted the impact of sociocultural attitudes, religious beliefs, cultural norms relating to sexual and reproductive health and the influence of Nepal's patriarchal society on women's access to and uptake of skilled safe abortion services. Stigma associated with accessing safe abortion services was stated as a key barrier to women not utilising safe abortion services.

> "Stigma in the community is the first barrier to women accessing safe abortion services. A woman can say that she is going to a health service for a delivery, but she can't say she is going for abortion services." **IDI 5. Safe Abortion Policy Advisor, I/NGO, Nepal**

Negative service provider attitudes towards women seeking safe abortion services were also expressed and this impeded woman from up taking services. Several participants stated that unmarried women have further increased difficulties in accessing and use of safe abortion services due to negative cultural attitudes towards sex outside of marriage. One participant stated that this impacts women who often seek unsafe abortions.

> "Although abortion is legal in Nepal, many women are still getting unsafe abortions; we see less unmarried women attending safe abortion services (due to sociocultural reasons)." **IDI 6. Service Provider, SRH Clinic, I/NGO, Sunsari District**

Socioeconomic constraints

The complex socioeconomic disparities between women who are married and unmarried women seeking safe abortion services compound barriers to access.

> "Barriers exist between married and unmarried women seeking abortions…The majority of women using safe abortion services are typically from economically relatively well-off families. Poor women experience a greater financial barrier to accessing abortion services." **IDI 3. SRH Research Consultant, Independent, Nepal**

The financial burden experienced by women seeking safe abortion services (including appointment and procedure fees as well as travel) was also a reoccurring theme

throughout the interviews. Several participants stated that the cost of safe abortion services deters women from accessing these facilities and is a deciding factor for many women to procure unsafe abortions. The inability to afford safe abortion services is often exacerbated for women living in rural and remote regions of Nepal.

> "Another barrier to access and uptake of skilled safe abortion services is the abortion fee… 1000 Nepali Rupees ($9.50 USD) is a very big amount for rural women." **IDI 8. Senior Officer, SRH NGO, Nepal**

Geographic isolation

The health services in Nepal are located in the Central Development Region and along the Terai belt (the low land region in Southern Nepal), to the detriment of those living in the remote hill and mountain regions.

> "In Nepal, approximately one in five people live in urban areas where both surgical and MA services are available. In rural areas and districts, however, access to abortion services remains problematic. In such areas, women may not have any option but to resort unsafe abortion practices that could have serious health consequences." **IDI 3. SRH Research Consultant, Independent, Nepal**

Issues relating to lack of access to health care services, safe abortion services and trained medical professionals in rural and remote regions was a reoccurring theme throughout the interviews.

> "I come from the rural area, but I don't choose to work in my hometown because I cannot earn as much money providing services there… Few health professionals remain in remote areas and very few I/NGOs are providing training for those professionals." **IDI 2. Senior Service Provider, SRH Clinic, I/NGO, Kathmandu**

Interview participants revealed numerous inhibiting factors relating to lack of access and uptake of safe abortion services in rural and remote regions of Nepal including: lack of infrastructure, both health services as well as road and transportation issues; administrative issues relating to lack of sufficient numbers of trained staff able to provide non-judgmental safe abortion services during regular working hours; lack of training and ongoing capacity building of services providers; and lack of incentives for trained personnel to work within rural and remote regions.

Translating policy into practice

Participants reported their experiences with the conflicting nature of practice versus the Ministry of Health National Safe Abortion Policy relating to effective and equitable SRH service provision in Nepal.

> "I think the written policy is very good, but in practice, it's not applicable…The Government has a concrete plan of action, but they lack the knowledge and skills on where to implement and how to implement." **IDI 7. Program Manager, SRH NGO, Nepal**

While current Government policy states that safe abortion services are available across Nepal, several participants stated a lack of awareness of abortion laws and available services continues to inhibit women from access and uptake of safe abortion services.

> "CAC services are available in all ecological areas; however, due to difficult geographical locations, women are facing difficulty in accessing services. Also, many women in these remote locations are not aware of safe abortion services." **IDI 4. Senior Service Provider, CAC Unit, Public Health Facility, Kathmandu**

Geographic isolation was stated as being a deterrent for trained health care professionals, who do not want to work in remote and rural regions.

> "The Government has health policy that clearly states the need for doctors and medical staff in remote areas, but the incentives are very low. In public facilities, a trained medical doctor and nurse positions are allocated up to the Primary Health Care Centre (PHCC) level, but the positions are often vacant." **IDI 7. Program Manager, SRH NGO, Nepal**

Participants reported that monitoring and evaluation mechanisms of safe abortion services to maintain quality of care and ensuring CAC service data is accurately recorded and reported, are inconsistent across public, I/NGO and private services.

> "The main cause of inconsistency is the lack of a monitoring mechanism... There are no regular monitoring visits in some NGOs as well as in the public sector. Monitoring is very weak." **IDI 5. Safe Abortion Policy Advisor, I/NGO, Nepal**

Effective and consistent monitoring and evaluation processes of I/NGO safe abortion services in Nepal was reported to be currently undertaken within I/NGO SRH clinics. However, lack of trained professionals to conduct monitoring and evaluation of safe abortion services provided by public and private facilities was sighted as being the key component of inconsistent services provision, impacting women's ability to access and utilize safe, effective and comprehensive abortion services.

> "Here (Government Office) we are only two staff members, one doctor and one Public Health Nurse (PHN), we can't go to every district to monitor sites so (SRHR I/NGO) is supporting the Government with monitoring. In the districts, we have a PHN as a focal person who should monitor the district hospital and other private clinics. She should go from time to time (to monitor services), but in some districts, it is lacking. It depends on how active PHN is." **IDI 9. Senior Officer, Ministry of Health, GON, Nepal**

Current translation of policy into practice and monitoring of safe abortion services in Nepal are intrinsically linked and have a substantial impact on access to safe abortion services with trained and culturally sensitive health professionals. Increasingly, the Government is establishing a memorandum of understanding (MoU) with I/NGOs to overcome the lack of resources and expertise they lack for monitoring and evaluation of safe abortion services. While the vast majority of participants shared their positive perceptions of Government SRH and Safe Abortion Policy in Nepal, lack of effective monitoring inhibits the translation of policy into practice.

> "It's not so much the policy, rather the implementation that must be looked at. Implementation of the guidelines needs to be monitored… The Government needs to have a regulating body to assess, evaluate and monitor the standard of abortion provision services." **IDI 3. SRH Research Consultant, Independent, Nepal**

6.5.2 Barriers: Access and uptake of post-abortion family planning services

Misconceptions and cultural barriers

In Nepal, contraception is free of charge and consequently, socioeconomic issues relating to access and uptake of post-abortion contraception did not emerge in our interviews. However, sociocultural factors impacting post-abortion contraception decision making were a prominent theme discussed by all participants. Prevailing

misconceptions relating to the use of modern contraception was a critical factor in women deciding not to use post-abortion contraception.

> "There are many misconceptions regarding the use of contraception like excessive bleeding will occur, weight gain will happen, or they will get cancer through the use of contraceptive methods." **IDI 6. Service Provider, SRH Clinic, I/NGO, Sunsari District**

Effective provision of post-abortion SRH information and contraceptive education through counselling was stated as an important component of increasing uptake of post-abortion contraception. However, challenges were reported.

> "Good counsellors have a key role to play in reducing the misconceptions around contraception. If a counsellor is well trained and knowledgeable, they will motivate the client to use contraception and provide comprehensive information. Half information leads to misconception." **IDI 7. Program Manager, SRH NGO, Nepal**

The difficulty of discussing post-abortion contraception support and services with husbands and mothers-in-law is a cultural barrier.

> "Cultural and social barriers are the most common barriers for women accessing post-abortion contraception….in some cases, women still cannot share their SRH related problems with their husbands." **IDI 1. Service Provider, SRH Clinic, I/NGO, Kathmandu**

While our participants shared many examples of barriers to uptake of post-abortion contraception and SRH information, the most frequently cited inhibiting factor to the uptake of post-abortion family planning services was the large number of women whose husbands work outside of Nepal or away from their home districts.

> "In our country, mostly the males (husbands) are migrant workers, who occasionally come home to visit their wives. That is one of the main reasons for women not accepting contraception (post-abortion)." **IDI 5. Safe Abortion Policy Advisor, I/NGO, Nepal**

All participants shared their thoughts relating to the ever-increasing male migrant worker population and the impact it is having on women using contraception and post-abortion contraception.

Geographic remoteness

Issues with timely procurement and supply of contraceptives was also a barrier to women receiving a broad choice of contraceptive options post-abortion. Reported contraceptive supply chain challenges include lack of trained logistical staff and insufficient human resources; lack of adequate storage and timely transportation from district centres to peripheral health facilities; and an absence of accountability mechanisms for stock-outs and commodity delays. Along with a lack of supply, geographical isolation also impacted the availability of trained safe abortion service providers able to provide women with comprehensive post-abortion family planning services and SRH information.

> "At rural and remote sites (safe abortion services), contraceptive commodity and trained human resources are not always available. If a woman comes to the service site and wants an implant, due to lack of trained human resources and commodity she can't get an implant. That gap of commodity and trained staff means women are not getting contraceptive method of their choice and the counselling will be biased in that case. The service provider will counsel on those methods which are available at the site." **IDI 5. Safe Abortion Policy Advisor, I/NGO, Nepal**

Policy, practice and monitoring

Participants spoke of the juxtaposition between Government policy that requires clinics to have five different methods of contraception available to clients and the reality of the limited choice, perhaps only two or three contraceptive methods, available at many public clinics.

> "According to Government Policy, at the Health Post level, there must always be the availability of five contraceptive methods (condom, pills, Depo (injectable), IUD and implant). But, there are not all five methods available at all the government Health Posts in Nepal." **IDI 9. Senior Officer, Ministry of Health, GON, Nepal**

While the current Government policy states all SRH facilities should follow the same guidelines, service provision continues to vary due to poor contraceptive supply, lack of trained service providers and a high level of staff turnover resulting in clinic

closures. This lack of comprehensive education and knowledge provision among health professionals across facilities was reported to be a key inhibitor of post-abortion contraception uptake and continuation.

> "Women need to be informed and educated so they can make an informed decision…Most abortion clinics offer contraception in an almost a ritual way… Through counselling and discussion, the service provider must ensure that the women's individual contraceptive needs are met… Counsellors should really focus on the women's fertility goals and desires and see what the best way for her to achieve that is." **IDI 3. SRH Research Consultant, Independent, Nepal**

Although current Government SRH and Safe Abortion Policy addresses the SRHR needs of Nepali women on paper, it was emphasized there is ineffective translation and application of policy into practice.

> "In Nepal, implementation of policy into action leaves a lot to be desired." **IDI 3. SRH Research Consultant, Independent, Nepal**

6.5.3 Concerns about medical abortion provision through pharmacies

The evolution of unsafe (less and least safe) abortion and medical abortion

All interviewees commented on the increasing trend of women accessing both registered (Government approved) and unregistered brands of mifepristone and misoprostol (MA pills) illegally through pharmacies, sometimes referred to as chemists or medical shops. Respondents also raised concerns that not only are registered and unregistered MA tablets sold through pharmacies, but potentially drugs of unknown chemical composition are also being provided to induce abortion. One participant elucidated the evolution of unsafe abortion in Nepal and its impact on negative health outcomes for women.

> "Before the legalization of abortion, women practised harmful abortion methods such as taking herbs and extensive massage which could cause complication and the need for hospital admission. Now, because of the availability of abortion pills, women go to pharmacies, take the pills, have incomplete abortion or complications and need to go to the hospital." **IDI 8. Senior Officer, SRH NGO, Nepal**

Several participants reported that a high number of women accessed safe abortion services after experiencing an incomplete abortion as a result of accessing MA illegally through pharmacies.

> "Most of our incomplete abortion cases come from medical shops." **IDI 4. Senior Service Provider, CAC Unit, Public Health Facility, Kathmandu**

The participants shared the reality of women accessing MA through pharmacies and the lack of SRH information relating to the administration of MA as well as the lack of post-abortion care and post-abortion family planning.

> "Pharmacy staff are not aware of the eligibility criteria for the provision of abortion services, what is the route of administration, what is the expected outcome and side effects, what are adverse side effects. They are just selling medical abortion pills." **IDI 8. Senior Officer, SRH NGO, Nepal**

Several reasons for women choosing to access abortion through pharmacies instead of going to health facilities for safe abortion services were cited during the interviews. Negative sociocultural attitudes towards abortion and privacy issues relating to accessing abortion were reported to be a key reason why women chose pharmacies.

> "Abortion is very stigmatized in Nepali culture, so they scared of losing their privacy… in chemist shop they don't have to give any answers regarding the abortion they can get pills very easily." **IDI 5. Safe Abortion Policy Advisor, I/NGO, Nepal**

Obstacles to safe abortion services

Geographical isolation and the health service provision implications were also reported as key influences in women choosing to access MA through pharmacies. Participants shared that women will often seek MA through pharmacies as there is no health facility that provides safe abortion service located near them or there are no trained safe abortion service providers in their local community.

> "The reason for women choosing medical shops over safe abortion services (from registered clinics) may be due to the lack of abortion services in government health facilities in their area." **IDI 8. Senior Officer, SRH NGO, Nepal**

Challenges of monitoring unsafe (less and least safe) medical abortion

Participants spoke of numerous challenges when trying to stop the sale of MAs through pharmacies in Nepal.

> "In current Government policy, it is stated that medical abortion should not be provided through chemist shops, it should be provided through permitted (registered) clinics only. But the demand is very high…The clients don't care about World Health Organization (WHO) standards and protocol, they just want prompt service." **IDI 5. Safe Abortion Policy Advisor, I/NGO, Nepal**

The difficulties the Government Drug Administration Department faces trying to monitor and halt the flow of MA pills through pharmacies was reiterated throughout the interviews. Human resource capacity was cited as being a major barrier to the effective monitoring of MA drugs within the market.

> "Medical abortion obtained from medical shop should stop. We have approached the Department of Drug Administration but they can't control it, and this is a great concern." **IDI 9. Senior Officer, Ministry of Health, GON, Nepal**

Several spoke of collaboration between Government, I/NGOs and the private sector to establish a committee to implement monitoring of pharmacies. However, this has proven challenging with inconsistent results seen across areas of implementation. While MA can only legally be prescribed by a safe abortion service provider in the first trimester in Nepal, it was suggested that women might have a sex-selective MA through pharmacies after the first trimester.

> "There are currently no regulatory body on sex-selection issues in Nepal. Technology (ultrasound) has made it easier for couples to test for the sex of their child… It needs to be audited and evaluated; sex-selection is emerging as a big concern with the increase of accessibility to medical abortion as well. The MoH (Ministry of Health) needs to set up an independent body to ensure that ultrasound is not used for sex-selective abortion in the country." **IDI 3. SRH Research Consultant, Independent, Nepal**

One participant stated that within the context of sociocultural practices and beliefs, the motivation behind sex-selection abortion and the legalization of safe abortion (both

surgical and medical), should be not be viewed as mutually dependent. They commented that the legalization of abortion in Nepal is not the causation factor of sex-selection abortion practices but is a component of entrenched cultural beliefs.

> "Sex selection is related to the social, economic and patriarchal pattern of society. It has been done for many years prior to the legalisation of abortion. Linking the legalisation of abortion services and sex selection is wrong. If we educate the community people on the value of the girl child, if boys and girl are equally valued, sex selection abortion will decrease, it takes time, it won't change overnight." **IDI 5. Safe Abortion Policy Advisor, I/NGO, Nepal**

Interviewees shared their views on the current state of MA provision in Nepal and on how unsafe provision of MA can decrease.

> "Medical abortion has left the clinic, left the doctors. Technology has outpaced everything, so we have to find a way to engage the non-conventional facilities. Medical shops are increasing medical abortion provision; however, they are just dispensing the drugs and are not counselling the women… Medical shops are evolving their role in Nepal. Globally, the function of medical shops has enlarged and is recognized by the World Health Organization (WHO) as well." **IDI 3. SRH Research Consultant, Independent, Nepal**

While one research participant stated that MA pills should only be administered by professionals that are able to perform pelvic or vaginal examinations, several participants shared their views of a more harm reduction approach through education and training of safe MA provision to pharmacy staff.

> "For medical shops that don't have medical professionals, we should provide at least basic harm reduction training." **IDI 7. Program Manager, SRH NGO, Nepal**

Several participants highlighted the need for Government policymakers to carefully consider the role pharmacies currently play in the provision of MA and how current policy must be revised to reflect this.

> "(The Government of Nepal) should revise policy as we can't stop chemist shop from selling the pills (medical abortion). If more restrictions are made, they will, of course, sell the pills under the table… Rather than stopping chemist

> shops and stopping women visiting chemist shops we should give information on the right dose and right time or complete information of taking pills in case of abortion." **IDI 5. Safe Abortion Policy Advisor, I/NGO, Nepal**

Pharmacy specific harm reduction strategies such as training of non-medical staff, as well as the potential for qualified pharmacy staff receiving further education on MA provision through pharmacies, was noted as a potential governmental approach to increase access to safe MA as well as theoretically reducing the incidence of complications resulting from unsafe MA provision.

> "Through training, medical abortion services can be expanded, and those who are eligible to provide medical abortion could provide services. For those who don't meet the edibility, their business selling medical abortion will decrease, and therefore complications of medical abortion will be reduced." **IDI 8. Senior Officer, SRH NGO, Nepal**

The certainty that pharmacy staff will continue to sell MA tablets regardless of illegality was reiterated by research participants. The majority of participants also stated the need to review and revise current government policy relating to MA provision through pharmacies to help reduce mortality and morbidity associated with the practice.

6.6 Discussion

The intersectoral and multifaceted nature of barriers associated with access and uptake of skilled safe abortion services and post-abortion family planning are highlighted throughout our findings. Insight and knowledge shared by the SRHR professionals is underscored with recommendations on ways to improve access and uptake of skilled safe abortion services and post-abortion family planning, as well as strategies to decrease the level of mortality and morbidity. Our findings emphasise the breaking down of sociocultural stigma and entrenched cultural beliefs and gender inequality, related to abortion and contraceptive use, as key to supporting women to access and uptake safe abortion services and post-abortion family planning, a concept collaborated with previous SRHR research (Padmadas et al., 2014; Rocca et al., 2014; Thapa & Neupane, 2013b; Wang et al., 2016). While the Government of Nepal has

focused on improving access to health care services through the strengthening community-based health interventions (Government of Nepal, 2015c), our findings demonstrate the continued gap in community level safe abortion and family planning education and knowledge.

Through collaboration with I/NGO and private sector, the Government of Nepal must increase awareness campaigns relating to access and uptake of safe abortion and family planning services at the community and national level. Within the *Nepal Health Sector Strategy 2015–2020* framework, it is essential that community-based SRHR and safe abortion education and awareness campaigns focus on families, women, males, youth, community leaders and service providers (Adhikari, 2016; Government of Nepal, 2015c; Khanal, Sanjel, & Chalise, 2014; Thapa et al., 2014). The need for policy to address the status of women within Nepal's patriarchal society is recommended as a means to ensure women's SRHR, as well as their human rights, are met.

Several respondents reported the increasing use of sex-selective abortions and the sociocultural attitudes that prefer a male child are responsible for this practice. Indeed, there has been global research into the consequence of son-preference and sex-selective abortion, most notably in China, South Korea and parts of India (Hesketh et al., 2011). Currently in Nepal research on sex-selective abortion remains scarce and is needed to inform community educational and behavioural change interventions and policies (Centre for Research on Environment Health and Population Activities & University of Oxford, 2015). Increased activities addressing and shifting culturally entrenched attitudes towards girls and women within Nepali society must increase (National Planning Commission, 2017a).

In the last decade, Nepal has experienced an unpredicted level of male workforce migration, both within Nepal and to overseas countries, predominantly the Middle East and India (Adhikari & Hobley, 2015; Government of Nepal, 2015c; Justice et al., 2016; Ministry of Health Nepal et al., 2017b). Several studies conducted in Nepal have demonstrated that the increasing male migrant workforce could potentially play a role in Nepal's stagnated contraceptive prevalence rate, highlighting spousal separation as a key factor that will influence womens' decisions to access, continue and/or discontinue contraception (Ban, Karki, Shrestha, & Hodgins, 2012; Dahal & Subedi,

2012; Padmadas et al., 2014; Puri, Henderson, et al., 2015; Rocca et al., 2014; Shrestha et al., 2012; Wang et al., 2016). SRH policy and practice stakeholders must establish strategies to decrease the cultural stigma surrounding women accessing contraception while their husbands work away from the family home, and to ensure service providers effectively counsel women on contraceptive choices that suit their circumstance. More research into the association between contraceptive use among women and the migrating male workforce is needed.

Supporting our findings, previous studies show that knowledge on the legalisation of abortion in Nepal and the awareness of where to access safe abortion services remains low, particularly for young women, women from rural or remote regions, and for women from lower socioeconomic backgrounds (Adhikari, 2016; Khanal et al., 2014; Thapa & Sharma, 2015; Thapa et al., 2014). Misconceptions and myths related to family planning (such as fear of side-effects) have been shown to play an inhibiting role in a woman's decision to uptake post-abortion contraception (Diamond-Smith, Campbell, & Madan, 2012). Effective and comprehensive abortion and post-abortion counselling skills enables providers to support women's SRH information and education needs, dispel misconceptions and discuss concerns relating to contraceptive use and side-effects, encourages discussion of fertility goals, facilitates referral to other health services if needed, encourages post-abortion follow up, and assists women in making informed decision regarding post-abortion contraception (Berin, Sundell, Karki, Brynhildsen, & Hammar, 2014; Diamond-Smith et al., 2012; Padmadas et al., 2014; Rocca et al., 2014; Rogers & Dantas, 2017; Wang et al., 2016).

Effective and equitable training and capacity building for all SRH professionals, regardless of geographic location or type of clinic they work in (public, private or I/NGO), is an important component in the provision of high quality, safe abortion services, and was a reoccurring recommendation throughout our research. The provision of adequate staffing numbers and positive service provider attitudes are important components of high quality, safe abortion care and effective post-abortion counselling (Rocca et al., 2014; Wang et al., 2016). The recruitment and retention of trained health care providers working in rural and remote facilities in Nepal continues to be a challenge across all sectors of health (Government of Nepal, 2015c; Shankar,

2010; Shankar & Thapa, 2012), with our findings highlighting the specific concerns relating to safe abortion services.

While the National Safe Abortion Policy states that safe, accessible and affordable abortion services should be 'available with equity and equality for all women', many Nepali women still do not have adequate access to such abortion services (Government of Nepal, 2002; Puri et al., 2016). This key finding corresponds with findings by Puri et al. (2016), that despite expansion of safe abortion services in Nepal, there remains a vital need to increase access and availability to high quality, safe abortion services to all Nepali women, regardless of geographical location. The Government of Nepal, I/NGO and private practice SRH services must re-evaluate current incentives and strategies for health professionals to retain them in rural and remote regions (Ganatra, Guest, et al., 2017). Collaboration with universities and medical training facilities is recommended to formulate strategies to increase the number of trained health professionals choosing and continuing to work in rural and remote regions.

Women in Nepal face numerous socioeconomic barriers to accessing safe abortion services, particularly those who live in rural and remote regions. To help mitigate the financial barriers to accessing safe abortion services, the Government of Nepal has recently committed to provide free access to safe abortion services from public health facilities (Ipas, 2015, 2016). However, without effective monitoring and evaluation of safe abortion services already being provided in public health facilities, ensuring a high level of quality care in these services remains impossible (World Health Organization, 2012a). Therefore, a strategy for consistent and comprehensive monitoring and evaluation of these services must be rolled out simultaneously for this implementation to truly provide effective and equitable provision of comprehensive safe abortion services.

The WHO *Safe Abortion: Technical policy guidance for health systems* (2012) emphasises that quality safe abortion care depends upon effective operational processes for monitoring, evaluation and the effective implementation of rights-based SRHR policy. Along with maintaining quality of care, the accurate collection and reporting of service statistics are essential for the analysis and synthesis of population data relating to abortion in Nepal (Government of Nepal, 2002, 2015b; World Health

Organization, 2012a). In Nepal and around the world, there is an urgent need to increase the availability of accurate information on gender equality and women's and girls' SRHR to inform rights-based policy and decision making. (National Planning Commission, 2017a; UN Women, 2016; World Health Organization, 2007). Effective monitoring and evaluation of safe abortion service facilities and health care providers is essential to facilitate a quality of care standard throughout Nepal and to ensure: adequate numbers of staff are located at clinics to deal with: work flow, up to date training and maintenance of professional competency of all staff, maintenance of administration and infrastructure to policy standards, and equitable distribution of contraceptive commodity supplies through an established and well-resourced supply chain.

Similar to findings of previous SRH research in Nepal, our participants expressed concern over the differing levels of consistency (between public, private, I/NGO in urban/remote areas) in providing access to a broad choice of contraceptives, as well as effective family planning information regarding a broad range of methods (Government of Nepal, 2015b; Puri, Henderson, et al., 2015; Rocca et al., 2014; Wang et al., 2016). USAID's 2016 report, *Twenty-Five Year Review of Assistance to Nepal's Health Sector*, indicates the Nepal health sector procurement system and supply chain management remains weak throughout the health system, resulting in resource inefficiencies and frequent stock-outs of drugs and commodities at health facilities (Justice et al., 2016). Our findings highlight the specific and current impact ineffective contraceptive commodity supply chains has on family planning services, particularly in rural and remote regions. Ensuring the close monitoring of commodity supply to facilitate the effective and equitable distribution of contraceptives, especially to remote regions, is a key element to ensuring uptake and access to post-abortion contraception services (Mukasa et al., 2017).

The provision of MA in the form of mifepristone and misoprostol where MA is legal (or misoprostol alone where mifepristone is not legal or available), is a proven, acceptable, safe and effective way to terminate an unwanted pregnancy up to nine weeks of gestational age (Ganatra, Guest, et al., 2017; Skuster, 2017; World Health Organization, 2012a). Studies from countries where abortion is highly restrictive have credited, at least partially, a decline in rates of severe complications and mortality

resulting from unsafe abortion with increased use of misoprostol (Fiol, Briozzo, Labandera, Recchi, & Pineyro, 2012; Harper, Blanchard, Grossman, Henderson, & Darney, 2007; Hyman, Blanchard, Coeytaux, Grossman, & Teixeira, 2013; Miller et al., 2005; Shah & Weinberger, 2012; Sherris et al., 2005). Although data is limited, global research tentatively indicates the effectiveness of MA self-management with remote support (telephone hotlines or mobile phone messages) (Constant, de Tolly, Harries, & Myer, 2014; Hajri et al., 2004; Hyman et al., 2013; Jelinska & Yanow, 2017; Paul et al., 2015). Current WHO guidelines do not recommend pharmacy workers and lay health workers independently provide MA, because there is insufficient evidence of safety and effectiveness (World Health Organization, 2015a). Indeed, studies conducted in low- and middle-income countries have demonstrated that without professional development or training of staff, women accessing MA through pharmacies rarely receive adequate information regarding the administration of the drug, post-abortion care, SRH information, post-abortion family planning or any form of follow-up (Ganatra, Guest, et al., 2017; Hendrickson et al., 2016; Lara, Garcia, Wilson, & Paz, 2011; Mishra, Yadav, Malik, Purwar, & Kumari, 2016; Reiss, Footman, Akora, Liambila, & Ngo, 2016; Sneeringer, Billings, Ganatra, & Baird, 2012).

However, with appropriate training, several studies have documented that pharmacy workers and lay health workers are able to: assess clients for MA eligibility; provide adequate information on MA administration; provide information on, and management of side-effects; assess for abortion completion; provide post-abortion contraceptive and capably provide clinic-based referral when needed (Puri, Harper, Maharjan, Blum, & Rocca, 2018; Puri, Tamang, Shrestha, & Joshi, 2015; Sherris et al., 2005; Sneeringer et al., 2012; Tamang, Puri, Lama, & Shrestha, 2015; Tamang et al., 2018).

Our findings highlight the impact MA provision through pharmacies is having on mortality and morbidity from unsafe abortion in Nepal. We recommend harm reduction strategies, such as training pharmacy staff in safe MA provision and post-abortion family planning and care referral mechanisms, to decrease complications (Sneeringer et al., 2012; Tamang et al., 2015; Tamang et al., 2018). Respondents shared that the professional development training and certifying of eligible pharmacy staff in the provision of MA could not only decrease unsafe abortion and its potential

consequences, but also increase access to MA, particularly in remote and rural settings that currently lack safe abortion facilities (Andersen et al., 2016; Ganatra, 2015; Puri, Regmi, Tamang, & Shrestha, 2014; Sneeringer et al., 2012). With increasing access to pharmacy-provided MA in the developing world, our findings highlight the importance of harm reduction strategies to decrease mortality and morbidity from unsafe abortion, even within countries with permissive abortion laws (Bell et al., 2018; Hyman et al., 2013; Puri, Harper, et al., 2018).

It is essential that the Government of Nepal acknowledge the role pharmacies currently play in the provision of MA, and establish practical strategies and policies to decrease negative health outcomes for women (Tamang et al., 2015b; Tamang et al., 2018). A comprehensive evidence base relating to MA provision through pharmacies is needed to inform effective policy within Nepal. Further research is also necessary to differentiate the proliferation of MA distribution through pharmacies under current laws underpinned by the WHO framework of Safe Abortion, Less Safe Abortion and Least Safe Abortion (Ganatra, Gerdts, et al., 2017).

Participants in this study recommended that through collaboration of public, I/NGO and private practice, SRHR policy and programmatic issues must be looked at critically to ensure robust and proactive policy for family planning and safe abortion service provision. While our findings suggest SRHR professionals are highly supportive of the current Safe Abortion Policy in Nepal, the need to translate and implement this policy into practice is yet to be achieved (Government of Nepal, 2002, 2015b). Within the country's recently drafted Sustainable Development Goals strategies (National Planning Commission, 2017a), the omission of specific indicators addressing safe abortion service access and uptake in Nepal seems a missed opportunity, particularly in the light of the country's globally lauded success of legal safe abortion service implementation over the last 15 years (Alanna J. Galati, 2015; Henderson et al., 2013; Samandari et al., 2012).

While every effort was made to mitigate bias within the study and to enhance credibility and trustworthiness, the study has several limitations. Financial and time constraints for this exploratory study restricted time in the field. Practicalities relating to access of participants meant the study was limited to the Kathmandu area and did

not include multiple participants from outside the region from government and nongovernment backgrounds. Due to time constraints and access, SRH clinic-based service providers were sampled from only one SRH I/NGO (one Senior Service Provider and two Service Providers) and one Government facility (one Senior Service Provider). However, data saturation was achieved with our small number of participants and enabled detailed analysis. As this is a qualitative study, we have ensured that the depth and richness of information collected, and an audit trail, will ensure transferability.

6.7 Conclusion

Nepal's change from restrictive abortion laws to liberalisation in 2002, and the country's experience in expanding safe abortion services over the last 15 years, offers significant lessons for other low- and middle-income countries seeking to reduce mortality and morbidity from unsafe abortion (Wu et al., 2017). However, as demonstrated within the Nepal context, even in countries where abortion is legalised, unsafe abortion is practiced. This cross-sectional, exploratory study highlights the numerous factors impacting the access to and uptake of safe abortion services and post-abortion family planning. These factors have global applicability in other resource-poor setting like Nepal. Sociocultural, socioeconomic and geographic barriers have highlighted the difficulties women in Nepal face when accessing safe abortion and post-abortion family planning services.

Our findings suggest that without effective and ongoing sector-wide monitoring and evaluation of SRH and safe abortion services and their staff, not all women in Nepal will have adequate access to quality safe abortion services and post-abortion family planning. It is vital that issues relating to the least safe provision of MA through pharmacies and sex-selective abortion continue to be investigated with innovative strategies formulated to ensure the sexual and reproductive health and rights of Nepali women are realised. Our findings detail the necessity for the translation of current Safe Abortion Policy into practice and for safe abortion service access and uptake to play a more prominent role in ongoing Nepal health sector strategies and Sustainable Development Goal frameworks.

6.8 Summary of the Chapter

This chapter, a publication in ***BMC Women's Health,*** presents analysis and themes from interviews with nine SRHR Professionals and their perspectives on abortion in Nepal. Building on this knowledge, chapter 7 explores the post-abortion SRHR experiences of Nepali women who have accessed medical abortion.

CHAPTER 7
MEDICAL ABORTION IN NEPAL

Introduction to the Chapter

This chapter explores the SRHR experiences of women who have accessed medical abortion through safe abortion services and unsafe medical abortion through pharmacies in Nepal. The chapter is presented as the manuscript, Article 4, and is structured to the formatting of this thesis.

Rogers, C., Sapkota, S., Paudel, R., & Dantas, J. A. R. (2018). Medical abortion in Nepal: a qualitative study on women's experiences at safe abortion services and pharmacies *Manuscript under review.*

This manuscript has been submitted for peer review to ***Reproductive Health*** on 6 November 2018.

7.1 Article 4: Medical Abortion in Nepal: A qualitative study on women's experiences at safe abortion services and pharmacies

7.1.1 Abstract

Although Nepal legalised abortion in 2002, a significant number of women continue to access unsafe abortions. An estimated 60% of all abortions performed in 2014 were unsafe, with unsafe abortion continuing to be a leading contributor to maternal mortality. Despite medical abortion access being solely permitted through government accredited safe abortion services, medical abortion pills are readily available for illegal purchase at pharmacies throughout the country. Utilising an Assets Focused Rapid Participatory Appraisal (AFRPA) research methodology, underpinned by a health information pyramid conceptual framework, this qualitative exploratory study collected data from in-depth, open-ended interviews. The study explored the medical abortion and sexual and reproductive health experiences of 10 women who accessed medical abortion through an accredited safe abortion service, and 10 women who accessed unsafe medical abortion through pharmacies. Thematic content analysis

revealed emerging themes relating to decision-making processes in accessing safe or unsafe medical abortion; knowledge of safe abortion services; and SRH information access and post-abortion contraceptive counselling. Findings emphasised the interconnectivity of sexual and reproductive health and rights; reproductive coercion; education; poverty; spousal separation; and women's personal, social and economic empowerment. While barriers to safe abortion services persist, so will the continued demand for medical abortion provision through pharmacies. Innovated and effective harm reduction implementations combined with access and information expansion strategies offer the potential to increase access to safe medical abortion while decreasing adverse health outcomes for women.

Key Words: Safe Abortion, Medical Abortion, Post-Abortion Care, Contraception, Pharmacy, Nepal, SRHR

7.1.2 Plain English Summary

Although abortion is legal in Nepal, unsafe abortion is one of the leading causes of maternal death. Abortions are only allowed to be provided by trained health professionals at government approved services. Despite this restriction, medical abortion pills can be easily purchased at pharmacies throughout the country.

To understand the experiences of women who have had a medical abortion, 20 women were interviewed: 10 who went to a safe abortion clinic and 10 women who purchased medical abortion pills from a pharmacy. The interviews showed themes relating to why women go to safe or unsafe places to get a medical abortion, how women learned where to get the medical abortion pills from, what health information women were given, and if they were offered contraception at the time. The findings highlighted that many factors impact a woman's decision to have a medical abortion, where she will get it from and if she will use contraception.

While women continue to face barriers to safe abortion services, there will be a demand for pharmacies to illegally sell medical abortion pills. Strategies are vitally needed to reduce the harm women face by purchasing medical abortion through pharmacies, as well as expanding ways information about safe medical abortion can be provided.

7.2 Background

The World Health Organization (WHO) and Guttmacher Institute estimate that between 2010 and 2014, 56 million induced abortions occurred each year worldwide (Guttmacher Institute, 2016). Of these abortions, 25 million unsafe abortions (45% of all abortions) occurred globally every year, with the majority of unsafe abortions (97%) occurring in developing countries in Africa, Asia and Latin America (World Health Organization & Guttmacher Institute, 2017). Abortion is considered *safe* when it is performed in accordance with WHO guidelines and standards, performed by a trained health worker using WHO-recommended methods appropriate to the pregnancy duration (Ganatra, Gerdts, et al., 2017; World Health Organization, 2012a, 2015a; World Health Organization & Guttmacher Institute, 2017).

Reconceptualization of the framework and methodology for estimating unsafe abortion has further divided the WHO classification of *unsafe* abortion into two categories of *less safe* and *least safe* (Ganatra, Gerdts, et al., 2017). In their 2017 study, Ganatra et al. classified abortions as less safe if only one of two criteria were met: (1) the abortion was performed by a trained provider, however an outdated or unsafe method (e.g., sharp curettage) was utilised or (2) a safe method of abortion (e.g., mifepristone and/or misoprostol) was used, but was administered without adequate information or support from a trained provider. Least safe abortions are classified as abortions provided by untrained individuals using dangerous methods such as ingestion of caustic substances, insertion of foreign objects, and the use of traditional herbal mixtures or tonics (Ganatra, Gerdts, et al., 2017). Of the 25 million unsafe abortions (45% of all abortions) that occurred annually between 2010 and 2014, an estimated 17 million (31%) were considered less safe, and 8 million (14%) were least safe (Ganatra, Gerdts, et al., 2017; World Health Organization & Guttmacher Institute, 2017).

For over four decades, political and social advocates from Nepal's medical and public health communities, supported by women's rights activists, pushed for the liberalisation of Nepal's restrictive abortion laws, finally resulting in the legalisation of surgical abortion (manual vacuum aspiration) in 2002 and the legalisation of medical abortion (mifepristone and misoprostol) in 2009 (Upreti, 2014). Under the

current law, abortion is permitted up to 12 weeks of gestational age on the request of the pregnant women, up to 18 weeks of gestational age in the case of rape or incest and at any gestational age if the pregnancy is detrimental to the women's health and life or if there is foetal impairment (Government of Nepal, 2002; Upreti, 2014).

In Nepal, medical abortion (MA) is the most frequently accessed method of pregnancy termination (79%), followed by manual vacuum aspiration (17%) and dilation and evacuation/dilation and curettage (7%) (Ministry of Health Nepal et al., 2017b). However, legalisation of abortion alone has not been adequate to facilitate access to safe abortion services for all women, and many barriers to services remain (Bell et al., 2018; Pradhan et al., 2010; Puri, Raifman, Khanal, Maharjan, & Foster, 2018; Rocca et al., 2013; Rogers, Sapkota, Tako, et al., 2018). Of the estimated 323,100 abortions performed in Nepal during 2014, nearly 60% (186,100) were considered unsafe, having been carried out by untrained or unregistered providers or self-induced (Puri et al., 2016).

Faced with a number of social and cultural factors such as a patriarchal society, limited sexual reproductive health and rights (SRHR) autonomy and knowledge, geographic isolation as well as abortion stigma, many Nepali women remain unaware of the legal status of abortion and have limited or no knowledge of where to access safe abortion services (Pradhan et al., 2010; Puri et al., 2014; Thapa et al., 2014). In August 2016, the Government of Nepal announced a strategy to provide free safe abortion services in Government clinics, in combination with the provision of free family planning services, to help mitigate financial barriers to accessing safe abortion services (Government of Nepal, 2016; Ipas, 2015, 2016). However, without simultaneously implementing consistent and comprehensive monitoring and evaluation of services, it remains unclear if this strategy can genuinely provide high quality, effective and equitable safe abortion services to the women of Nepal (Rogers, Sapkota, Tako, et al., 2018).

The Government of Nepal registered MA brands (combined regime of mifepristone and misoprostol), have been available only on prescription through Government accredited safe abortion providers since 2009 (Government of Nepal, 2016; Tamang et al., 2015). Despite these restrictions, registered and unregistered brands of MA are

readily available for purchase at pharmacies, often referred to as chemists or medical shops (Puri et al., 2016). The porous border between Nepal and India enables the illegal entry of unregistered MA brands as well as ayurvedic and traditional medicines with supposedly abortive properties, many of which are then sold illegally through pharmacies (Tamang et al., 2015b; Tamang & Tamang, 2005). Recent NHDS data shows that 19% of women who had an abortion reported receiving MA pills from a pharmacist (Ministry of Health Nepal et al., 2017b). While the Department of Drug Administration and collaborations between the Government, I/NGOs and the private sector have sought to reduce the illegal possession and sale of MA through pharmacies, it has proven challenging and, to date, has been unsuccessful (Rogers, Sapkota, Tako, et al., 2018; Tamang et al., 2015). Regardless of illegality, women in Nepal will continue to access MA through pharmacies, and while there is a high demand, pharmacies will continue to sell the pills (Rogers, Sapkota, Tako, et al., 2018). Although it has been 15 years since the legalisation of abortion in Nepal, unsafe abortion remains the third highest (7%) direct cause of maternal death in Nepal (Pradhan et al., 2010).

Efficient and equitable provision of Post-Abortion Care (PAC) is an essential component for positive health outcomes for women who access safe abortion services and for the prevention of future unintended pregnancies (Barot, 2014; PAC Consortium Community Task Force, 2002; Rogers & Dantas, 2017). However, in Nepal, women accessing MA through pharmacies do not systematically receive any form of PAC including adequate information regarding the administration of the drugs, SRH information, post-abortion family planning counselling or health care referral (Rogers, Sapkota, Tako, et al., 2018).

This qualitative, exploratory study aimed to provide a unique and in-depth analysis of the post-abortion experiences of women who have accessed MA through safe abortion services and women who have accessed unsafe MA by illegally obtaining the medication through pharmacies. This study is the first in Nepal to explore post-abortion contraceptive counselling, access and use of contraception among women who purchased MA through pharmacies, and offers a rich and detailed examination of their experiences and SRHR needs.

7.3 Methods

Using an Assets Focused Rapid Participatory Appraisal (AFRPA) research methodology, underpinned by a health information pyramid conceptual framework, known as the Assets Focused Rapid Participatory Assessment Cycle (AFRPAC), this qualitative exploratory study utilised data collected from in-depth, open-ended interviews with 20 women from the Sunsari District of Nepal (Annett & Rifkin, 1995; Pepall et al., 2007; Pepall et al., 2006). Participants included 10 women who had accessed MA through a Marie Stopes Center (Clinic Clients), operated by Sunaulo Parivar Nepal, an implementing partner of Marie Stopes International Nepal (SPN/MSN) and 10 women who had accessed medical abortion by illegally obtaining the tablets through pharmacies (Pharmacy Clients).

The methodology used in the study has an emphasis on assets and ensures that findings are concurrently solution- and problem-focused, as opposed to the identification of problems. Drawing on the perspectives of SRHR professionals and conversations with a cross-section of community members enabled the researchers to acquire a greater understanding of issues impacting women's and girls' SRHR within the local and national contexts and helped inform interview questions. (Collumbien et al., 2012; Rogers, Sapkota, Tako, et al., 2018). Complementing the qualitative findings, an analysis of current Government and nongovernment SRH policy and clinical practices was concurrently undertaken.

7.4 Participants

Inclusion criteria for participation in this study required women to be 15 to 49 years of age, able to speak and understand Nepali, able to give informed consent, live within the Sunsari District and have previously obtained MA pills for the termination of a pregnancy.

7.4.1 Clinic Clients (CC)

Between September 2014 and April 2016 women attending the Itahari Marie Stopes Centre (MSC) for safe abortion services were informed of the study by clinic staff. Of those women, 112 shared their contact details and consented to be contacted by telephone for potential research participation. Participants were purposively recruited

from this sample of potential participants with 46 of these women meeting the inclusion criteria. To help mitigate recall bias, women who had accessed MA three to six months prior to data collection were selected. Contact was attempted with 23 women with a final 10 women participating in the research. Clinic Client (CC) participants received Mariprist, a Nepal Government registered brand of MA (mifepristone and misoprostol combi-pack).

7.4.2 Pharmacy Clients (PC)

Between April and May, 2016, Female Community Health Volunteers (FCHVs) who were working closely with the MSC utilised their contacts within the study community to purposively recruit 10 women who met the inclusion criteria. Due to difficulties with participant recruitment from this hard to reach community-based population (some lived in hilly and remote regions and some could no longer be contacted by phone), MA access prior to data collection for PC ranged between approximately 3 weeks to 2 years. The medication PC participants obtained from a pharmacy for terminating their unwanted pregnancy is referred to as MA throughout this paper. However, it is impossible to ascertain whether they received a Nepal registered brand of MA, an unregistered, but legitimate brand of MA, counterfeit MA or a type of ayurvedic medicine with abortive properties in pill form (Tamang et al., 2015b).

7.5 Data Collection

The interviews were conducted between April and May, 2016, by the first and third authors, who are both female. A research information sheet, detailing the purpose and process of the study as well as an informed consent form was provided to all participants for review prior to interviews. Participants were encouraged to ask questions relating to their role in the study as well as any component of the research. After obtaining written or verbal informed consent, interviews of approximately 1 hour in duration were conducted with the participants in a convenient, private location. Eighteen women provided written informed consent and two women, who were not literate, provided verbal informed consent. All interviews were conducted in Nepali as this was the preferred language of the participants. Throughout the interviews, the third author (fluent in both Nepali and English) translated interviewee responses in English to ensure both interviewers were able to ask questions and had a comprehensive

understanding of the participants' responses. Reflective field notes were taken throughout the interviews.

7.6 Data Analysis

Audio files were translated and transcribed after the interviews by the third author and a professional transcriptionist. A thematic analysis of in-depth interview content utilising NVivo Software was undertaken by the first author, with the first three authors reading the transcripts and discussing data saturation before collaboration and refinement of themes (Oliveira et al., 2016). Thematic analysis enabled the examination of emergent themes within the data, facilitating the synthesis of overarching themes, themes and sub-themes (Given, 2008; Mills et al., 2010). Analysis of interview content produced five overarching themes, 12 themes and 59 sub-themes as detailed in Appendix AA.

Rigour in qualitative research is assessed within the context of dependability, credibility, confirmability and transferability, and trustworthiness (Cohen & Crabtree, 2008; Graneheim & Lundman, 2004; Malterud, 2001). To enhance the credibility and overall trustworthiness of this research, systematic checking, ongoing interpretation of data and an audit trail ensured information relating to the study design, methods and analysis were documented to allow for future replication (Birt et al., 2016; Denzin & Lincoln, 2008; Rodgers & Cowles, 1993). Pilot testing of guiding questions was conducted with all authors assisting in the refinement and finalisation of the questions prior to the interviews.

7.7 Ethical Considerations

Ethical approval for this study was granted by the Nepal Health Research Council (NHRC 20/2014) as well as the Curtin University Human Research Ethics Committee (HR 17/2014), and informed consent was a prerequisite of research participation (Mack et al., 2005). Ensuring cultural safety (aligned with beneficence), was of paramount importance, and it was essential that participants felt their voices were heard, that they were respected, and that they felt safe within the context of the research process (Collumbien et al., 2012; Mack et al., 2005; Wilson & Neville, 2009).

Keeping with the ethical principal of non-maleficence, interviews with PC respondents did not focus on the legality of MA supply through pharmacies so as not to cause discomfort or distress to participants. As well as confirming respondents had a clear understanding of their role within the research and the purpose of the research, to ensure the ethical principles of justice and beneficence were adhered to they were also informed of how their participation will assist the development of tangible SRHR policy and practice outcomes (Collumbien et al., 2012; Mack et al., 2005). To ensure the confidentiality of participants, generic titles detailing whether the participant was a CC or PC, a participant chosen pseudonym and a participant's reported age, have been used throughout this article (Mack et al., 2005). As many participants had to travel to contribute to the research, all respondents received 500 Nepali Rupees (NPR) of transport reimbursement as well as a light meal with refreshments before the interviews. To thank respondents for their time, all received a voucher for a free health check-up (detailed as a 'general health check-up and valued at 150 NPR) and free pregnancy test (for privacy reasons, detailed as 'women's health check-up' and valued at 100 NPR) at the NGO collaborating with the research. Initial findings of the research were disseminated at a community and stakeholder event in July 2016 in the Sunsari District.

7.8 Results

Thematic content analysis of the in-depth interviews revealed emerging themes relating to safe abortion service provision, knowledge of safe abortion services, SRH information access, contraception counselling, geographical isolation, as well as socioeconomic and sociocultural factors. Research findings highlight the interconnectivity of SRHR; gender-based violence in the form of reproductive coercion and son-preference; education; poverty; spousal separation; and women's personal, social and economic empowerment. Table 7.1 details participant demographic information and Table 7.2 presents participant reproductive health information.

Table 7.1 Participant demographic information

	Clinic Clients *(n = 10)*	Pharmacy Clients *(n = 10)*	ALL Participants *(n = 20)*
Age			
20–25 years	3	3	6
26–30 years	4	3	7
31–35 years	1	2	3
36–40 years	2	2	4
Married			
Yes	10	10	20
Husband Works Away*			
Yes	4	6	10
No	6	4	10
Family Structure+			
Single	6	6	12
Joint	4	4	8
Highest Level of Education			
No Primary	0	1	1
Some Primary	2	2	4
Some High School	3	5	8
Obtained SLC^	4	1	5
Obtained Bachelor's Degree	1	0	1
Obtained Master's Degree	0	1	1
Language/s Spoken at Home			
Nepali	7	9	16
Nepali and Maithili	2	1	3
Nepali and Hindi	1	0	1
Religion			
Hindu	10	8	18
Kirat Mundhum	0	1	1
Buddhist	0	1	1

* Husband works away from the family home either within Nepal or overseas
+ Single Family comprised of husband, wife and children. Joint Family comprised of husband, wife and children as well as members of the extended family (e.g. grandparents, uncles, aunties, nephews, nieces etc.) living in the one family home
^ School Leaving Certificate obtained on completion of high school

Table 7.2 Participant's reproductive health information

	Clinic Clients *(n = 10)*	Pharmacy Clients *(n = 10)*	ALL Participants *(n = 20)*
MA use prior to interview[#]			
< 3 months	0	2	2
3–6 months	10	2	12
6 months to 1 year	0	1	1
1–2 years	0	3	3
2–3 years	0	2	2
Incomplete abortion after MA use			
Yes	1	3	4
No	9	7	16
Contraceptive use directly prior to MA			
Yes	**3**	**1**	**4**
OCP[a]	1	0	1
Intermittent OCP	1	1	1
Intermittent Injectable[b]	1	0	1
No	**7**	**9**	**16**
No: wanted to conceive[*]	1	0	1
Contraceptive use directly after MA			
Yes	**10**	**2**	**12**
Condoms	1	0	1
OCP	5	0	5
Injectable (Depo[bb])	0	1	1
Implant[c] (Norplant[cc])	4	0	4
IUD[d] (Copper T[dd])	0	1[+]	1
No	**0**	**8**	**8**
Current contraceptive use			
Yes	**8**	**3**	**11**
Condoms	1	0	1
Intermittent OCP	2	0	1
OCP	1	0	2
Depo	0	1	1
Norplant	4	1	5
Copper T	0	1	1
No	**2**	**7**	**9**
No: wants to conceive [^]	0	1	1
Previous abortion/s			

None	8	9	17
One	1	1	2
Two	1	0	1
Previous miscarriage/s			
None	6	10	16
One	4	0	4
Number of deceased children			
None	10	8	18
One	0	1	1
Two	0	1	1
Number of living children			
One	4	2	6
Two	5	6	11
Three	0	1	1
Four	1	1	2
Child/children sex-mix			
Female and Male	3	5	8
Only Female	4	3	7
Only Male	3	2	5
Age when married			
Under 18 years	2	2	4
18–20 years	4	5	9
21–23 years	4	0	4
24–26 years	0	1	1
Not recorded	0	2	2
Age at birth of first child			
Under 18 years	1	1	2
18–20 years	3	4	7
21–23 years	4	2	6
24–26 years	2	1	3
Not recorded	0	2	2

7.8.1 Abortion Decision-Making Process

Both CC and PC respondents shared their reasons for obtaining an abortion and the driving forces behind their decision to terminate their pregnancies. Of the 20 women who accessed MA, 19 were due to unplanned pregnancies, and one (CC participant) required a termination as the foetus was no longer viable. Respondents highlighted the interconnectivity of sociocultural and socioeconomic factors that informed their decision-making process. Child spacing was a deciding factor for several participants living within both single and joint families. Participants emphasised the difficulties

faced by women in their community to maintain expected gender roles within the home environment, while also striving for personal and economic empowerment.

> "I was pregnant too soon. My husband also did not want to have (another) baby immediately… We have many members in our family, women like us have to manage the house, so it was difficult." **PC IDI 10, Uma, 25 years**

It is seen as a women's duty to be the primary carer of children in Nepal and, although many joint households have multiple female family members to support, many other mothers undertake parenting duties alone. One participant shared her experience of being the sole carer of her children while pregnant and suffering from health concerns.

> "I had very young children. I had continuous vomiting. I had to be admitted to hospital, and it was difficult to take care of my children, so I aborted." **PC IDI 8, Munna, 30 years**

Financial implications of an unwanted pregnancy were highlighted as a key motivator in the abortion decision-making process for many of the respondents. One participant shared her experience of financial insecurity when her son was born and the impact this experience had on her decision to terminate her next pregnancy.

> "I have no money. I already had son. I had to take loans during his birth… We had to keep him in the intensive care unit. I had to invest a lot of money, I have taken loans, so I do not want to give birth again. If I give birth again, it will cost." **CC IDI 8, Katrina, 20 years**

For participants from lower socioeconomic families, their unexpected pregnancy was a cause of financial anxiety. Being able to financially provide for children was a recurring theme throughout the interviews, with multiple respondents sharing their inability to care for and educate the children they have if they were to have another. Several participants expressed the necessity for their children to have access to schooling that they did not have, in order for their children to have a happy and successful life.

> "I did not want any more children, I have son and daughter… We are poor people, we should manage food for those children. Giving birth is not enough, we have to care for them, educate them." **PC IDI 4, Parvati, 30 years**

Themes of reproductive coercion were frequently reiterated throughout interviews with both CC and PC participants. One respondent highlighted the sociocultural struggle many women in Nepal face when it comes to their reproductive autonomy and their ability to decide if, and when, they wish to fall pregnant.

> "My daughters and son are already grown up, but my husband still thinks I should (continue) to give birth... I thought that if it will be aborted with medicine, despite there will be bleeding, I'll use that… I did not tell this to my husband." **PC IDI 2, Reena, 40 years**

Within the patriarchal Nepali society, son-preference is common, and participants frequently commented on the pressure from husbands and mothers-in-law to conceive sons. Several respondents shared their happiness with only having daughters. While they did not personally feel they needed to have sons, one participant spoke of her husband's concern of isolation they will experience in later life when their daughters get married and leave home.

> "My husband says: 'don't use (contraception) since we have only daughters'… Such desires will be in males only, he wants a son. For woman like me, it's equal… Even if I don't have desire (for more children), because of the force of husband, I need to give birth. Among four daughters two already got married. Another two also will go. After they go, only we two will be alone. Males think that way. I already have a granddaughter, I don't want (more children)." **PC IDI 1, Sapana, 36 years**

While none of the 20 respondents based their personal abortion decision-making process from having learnt the sex of the foetus through ultrasound technology, several participants shared stories relating to sex-selective abortions within their communities or extended families.

7.8.2 Medical Abortion Access and Uptake: Safe abortion services vs pharmacies

Clinic Clients

CC participants frequently stated that advice from friends and family members played a determining factor in their decision to access MA through a safe abortion provider.

> "My friend knew about the clinic (MSC). I shared my problem with her, so she suggested that I go there." **CC IDI 10, Pratima, 25 years**

One CC participant shared that advice from a health care professional helped her decision making regarding where to access MA.

> "I initially thought about taking medicine from local medical store but there is a doctor living in our home, he explained to me that it is not safe to take medicine this way and suggested I go here (MSC)." **CC IDI 5, Geeta, 28 years**

Fear of negative health outcomes from accessing MA through a pharmacy played a key role in the decision-making process for several CC participants. This fear was often the result of learning of others' negative experiences with pharmacy-supplied MA. Concerns of inadequate medical support and referral mechanisms (should they encounter complications) at pharmacies was reiterated by respondents as key factors in their decision to attend a safe abortion service.

> "First, I did not know about the clinic (MSC). My friends took medicine (MA) from a pharmacy. For one of my friends it worked, and for my other friend it did not. When it was not completely aborted, the same pharmacy where she purchased the medicine (MA) suggested her to go to (MSC)… It's not good practice to go to the pharmacy for such medicine (MA)... After we give them money the pharmacy people will give us medicine. Whether it will be completely aborted or not will be at our own risk." **CC IDI 10, Pratima, 25 years**

Concerns regarding the perceived dangers of inducing an abortion as well as the medical competency of those administering MA also played into the decision-making process for several participants to attend a safe abortion service for their abortion.

> "If the service is taken in a good place after consulting with an expert in this area, it is safer…We have heard many people saying somebody took medicine for abortion and is dead because of it or is having heavy bleeding now… Does that pharmacy person have enough idea about the medication to use, current month of pregnancy? No. So it is nowhere comparable with the consultation in hospitals or clinics with experts." **CC IDI 4, Roghini, 32 years**

Previous experience of accessing MA through a pharmacy and having an incomplete abortion was also stated as being a driving force behind one CC participant attending the MSC for her second abortion.

> "(For my) first abortion some of my friends said that they used medicine from pharmacy for abortion, so they told me: 'why you will go to hospital, go in the pharmacy and take it'… They (pharmacy) did not tell (me) anything about family planning. They just gave medicine for abortion… When I took medicine, it was not aborted completely, so I asked them 'what to do?' They suggested I go here (MSC)." **CC IDI 8, Katrina, 20 years**

The participant goes on to explain that her positive experience at the MSC for her previous incomplete abortion affected her decision making when she had a second unplanned pregnancy.

> "It is far (to travel) but here the service is good. They provide proper counselling which I cannot find in pharmacy. Whether here (MSC) or there (pharmacy), I have to pay, so I'll come here." **CC IDI 8, Katrina, 20 years**

Nine CC respondents attended the MSC to obtain their MA in the first instance, and one CC participant attended the MSC for MA due to an incomplete abortion after taking pharmacy-provided MA.

Pharmacy Clients

Similar to the CC participants, advice from people within the community regarding MA access was a considerable influence on PC respondents' abortion seeking behaviour. One PC participant shared that a FCHV informed her she could purchase MA through a pharmacy. Another PC respondent was told of the ability to access MA through a pharmacy by a member of the pharmacy staff.

> "While buying the pregnancy test kit (at the pharmacy), I came to know (through information provided by a staff member) that I can buy that medicine (MA) there." **PC IDI 8, Munna, 30 years**

Positive experiences of friends, family and neighbours in accessing MA through pharmacies was repeatedly stated as a deciding factor for PC participants choosing to purchase MA through a pharmacy.

> "I felt that will be easier. I had heard from others that they had taken (MA) and it worked well, so I thought it will be effective." **PC IDI 8, Munna, 30 years**

Lack of nearby safe abortion services was highlighted by several PC participants as the reason they decided to access MA through a local pharmacy, with one participant highlighting the fear and worry associated with not being able to access SRH services.

> "I was alone that time, in a remote place. I did not have friends to take me to the hospital… I had a friend (working) in pharmacy so I got (MA) through them… If I have another unplanned pregnancy maybe I'll go to a place with more facilities but if I am in a remote place, I will again have to go to a pharmacy." **PC IDI 9, Bipana, 31 years**

Five of the 10 PC participants did not physically purchase the MA from the pharmacy themselves. Instead, their husbands (three respondents), a female neighbour (one respondent) and a female friend who works at a pharmacy (one respondent) purchased the pills and relayed information to the women.

> "I did not know that we could buy those (MA) in government hospitals, I knew that it can be found in medicals (pharmacies)… I requested one sister (female friend) to bring… she works in that pharmacy." **PC IDI 9, Bipana, 31 years**

7.8.2 Medical Abortion Experience: Safe abortion services vs pharmacies

CC and PC participants shared their experiences of obtaining MA and their thoughts and emotions towards the process. Universally, CC participants reported feeling supported and informed at the time of their clinic appointment and while several respondents spoke of feeling scared, said MSC clinic staff were able to reassure them. Fear of complications was also reported by PC participants who generally reported that their fear subsided only when the abortion was complete.

> "I was worried what problems might arise. I was also scared whether it will be completely aborted or not. I had heard of some women's death due to complications." **PC IDI 9, Bipana, 31 years**

In contrast, one PC participant shared how support from her husband and the pharmacy worker providing the MA (combined with information provided to her husband by the

pharmacy worker), reassured her that her fear of post-abortion complications was unwarranted.

> "I was scared of taking that medicine (MA). He (husband) gave me consolation not to be scared (and told me the) pharmacy people said that it won't be that bad." **PC IDI 5, Sita, 25 years**

While all CC participants said they would access a safe abortion services again should they have a future unplanned pregnancy they wished to terminate, PC participants responses varied regarding future MA access. While most PC participants noted they would attend a safe abortion service, one participant shared that due to limited access to safe abortion services she would again access MA through a pharmacy, and one PC participant shared she would purchase MA through a pharmacy again due to her positive previous experience.

> "If in case (of another unplanned pregnancy), maybe I'll go to the same place (pharmacy) because it worked well for me." **PC IDI 8, Munna, 30 years**

Three PC participants had incomplete abortions after taking pharmacy-provided MA requiring access to medical facilities. One PC participant shared her experience of taking multiple doses of MA before going to a health facility.

> "It (MA) did not work. I thought it might take time. I told the person who brought it (female friend) and they said that it will be aborted after 2-3 days. But it was not aborted. So that person gave me another medicine. It was not aborted even with next dose of medicine… I thought it will be easily aborted but it did not happen." **PC IDI 4, Parvati, 30 years**

Several PC respondents highlighted the lack of medical referral information in the case of post-abortion complications. Concerns regarding the saftey and effectiveness of pharmacy-provided MA were raised, as was the medical competency of those providing it.

> "They (pharmacy workers) should not do (administer MA) according to guess… There should be trained health worker working there. Some women's life might be at risk… due to such medicines." **PC IDI 2, Reena, 40 years**

7.8.3 Post-Abortion Contraception and SRH Information Access and Uptake: Safe abortion services vs. pharmacies

Clinic Clients

All CC respondents reported receiving SRH information and contraceptive counselling during their appointment at the MSC (such as MA administration, what to expect from taking MA and possible side-effects, post-abortion follow up, contraceptive use education, and fertility desire discussions) with many displaying detailed recall of SRH information provided during their appointment. Several participants expressed the empowerment they now feel regarding their sexual and reproductive health.

> "(At my appointment) I became more knowledgeable about reproductive health. I am able to make self-decisions now. I can plan my family accordingly… They (MSC staff) gave detailed counselling… and information about contraceptives." **CC IDI 5, Geeta, 28 years**

Several participants highlighted the impact post-abortion family planning counselling had on relieving their concerns around contraceptive use such as side-effects and fear of future unplanned pregnancies.

> "There were many things I did not know before which I learnt through this information… I don't have to be scared (of unplanned pregnancy) while in sexual relation after the use of Norplant (Implant)." **CC IDI 1, Sabitri, 36 years**

Of the 10 CC participants, four took up LARC (long-acting reversible contraception) and six accepted short-term modern contraceptive methods post-MA. Four had implants inserted immediately after taking the first MA tablet, and all reported continuing the method at the time of their interview. One CC participant accessed condoms after their MA and reported continuing to use this method. Five CC participants accepted OCP at the time of their MA, with one reporting continuous current use, two intermittent use and two currently not using any form of contraception.

Pharmacy Clients

Although women in the CC sample expressed relatively similar experiences relating to SRH information and contraceptive counselling provided by clinic staff during their

appointments, the PC participants who purchased the MA themselves shared varied accounts of SRH information provision. Several respondents reported they received no SRH information other than when to take the MA tablets, which at the time, caused them concern.

> "He asked me why I wanted to use medicine. I answered him the reason that my child was small, so he gave the medicine. He did not give me any other information… He just told me that it will work for some persons and for some it will not… I think that I should have gotten more information… Like the side effects of using that medicine." **PC IDI 3, Sita, 28 years**

In contrast, other PC respondents reported being provided with SRH information at the time they purchased the MA such as MA administration, what to expect from taking MA and possible side-effects, and what to do if the abortion is incomplete (e.g., return to the pharmacy, go to a health clinic or hospital or call the pharmacy for support. However, only two participants discussed post-abortion contraceptive use with the pharmacy staff providing their MA.

> "They gave information on how to take the medicine… and side effects… They said that this medicine works for some people and for some people it won't be completely aborted so in such case should go to hospital… Because of that (information) I have knowledge now. They suggested I use Depo (Injectable)… so I used Depo but it did not react well with me...now I use Norplant (Implant)." **PC IDI 6, Bharati, 25 years**

One PC client shared her experience of accessing MA through a pharmacy with her husband and highlighted the necessity for effective, culturally appropriate contraceptive counselling. The couple received information on MA administration, what to expect and what to do should complications arise, as well as information about contraception. However, while the respondent felt the information on MA was useful, she expressed distress regarding the MA provider's reaction to her not wanting to use post-abortion contraception.

> "They (pharmacy staff) informed us (about MA)… They told us (about contraception) and showed us the different methods. I already had used them and they (had) caused problems so we replied that we would discuss the matter… They yelled at us 'why are you are not using contraceptives and are

> doing abortion?' They (pharmacy staff) were angry with us for not using contraception." **PC IDI 7, Kalpana, 35 years**

While other PC respondents stated they would have like to have received advice on post-abortion contraception at the time of their MA and indeed, post-abortion contraception information should have been provided to them, two PC participants stated they did not expect to receive this type of information from a pharmacy worker. Similar to the women who purchased the MA themselves, SRH information access varied in content for participants who did not purchase the MA. Several women reported only being told when to take the pills and to expect heavy bleeding, while other participants recollected more detailed SRH information provision and support from pharmacy workers.

Only one of the 10 PC participants reported accessing a pharmacy-provided method of contraception post-MA. This PC participant accessed pharmacy-provided injectables, reporting they later changed to an implant (inserted at a health clinic). One PC respondent had an intrauterine device (IUD) inserted at a health clinic shortly after her MA and was still using this contraceptive method. Eight PC respondents reported no contraception use post-MA.

Both CC and PC participants shared their post-abortion contraceptive decision-making process. Overwhelmingly, PC participants reported similar reasons for not using a modern method of contraception post-abortion, the recurring themes being previous negative contraception experiences and not having found a method that suited them.

> "(My) sister in law told me to use injection so I used injection. But I had excessive bleeding. I used pills, it also did not work. They inserted something (Implant) but I did not like it and I haven't used anything after that. **PC IDI 1, Sapana, 36 years**

PC respondents also reiterated fear of perceived side effects and lack of information about contraception as a reason for not accessing post-abortion contraception. In contrast to PC participants, CC respondents reported information and support they received through contraceptive counselling during their SRH clinic appointment, reassured them of their ability to choose a contraceptive method that would suit them.

> "They (MSC staff) counselled me about various methods like pills, Norplant (Implant), Copper-T (IUD) etc. I wanted to try pills first and if it doesn't suit me I can go for other alternatives as well… Now I know which of the family planning methods suit me. Otherwise I might not use contraceptives, I might again be pregnant, and have to go for another abortion." **CC IDI 4, Roghini, 32 years**

Half of all respondents (CC = 4, PC = 6) shared that their husbands did not typically reside at the family home due to work commitments. Inconsistent contraceptive use, specifically OCP, or no contraceptive use due to spousal separation was a recurring theme for several participants both before and after their unwanted pregnancies.

> "I got pregnant when I was still on pills (OCP). It's been around 5-6 years (I've been using pills). Whenever my husband is here I take pills and when he goes abroad I stop taking it… You know my husband lives around one month here and the next three months abroad, so I don't prefer Depo (Injectables) or Copper-T (IUD)." **CC IDI 1, Sabitri, 36 years**

At the time of their interviews, of the 10 participants whose husbands work away from the family home (either in another part of the country or overseas), four reported being on no form of contraception (CC = 1, PC = 3). Two respondents reported intermittent OCP use (CC = 2), three were using LARCs: two had an implant inserted (CC = 1, PC = 1) and one participant had an IUD (PC = 1), and one participant was not using contraception as they wished to fall pregnant (PC = 1).

PC respondents reported overall limited contraceptive use at the time of data collection in comparison to their CC counterparts (CC = 8 and PC = 2). At the time of their interviews, one PC respondent was not using any contraceptive method as she wanted to conceive, and one respondent reported current use of injectables. Of the 10 PC respondents, six reported currently not using a modern contraceptive method, although they did not currently wish to conceive.

7.8.4 Contraception and SRH Information Access and Uptake: General

The contrast in contraceptive and SRH information access between the CC and PC groups at the time of accessing MA highlights the difference in quality and consistency

of service provision. Participants from both groups shared their experience and opinions relating to contraception and SRH information access and uptake outside of their immediate MA experience. Both CC and PC participants reported various reasons for not using contraception prior to their unwanted pregnancy, with the majority citing previous negative experiences with contraception use. Many participants also spoke of their continuing concerns based on the negative contraceptive experiences of other women.

> "I heard that pills will cause injuries in uterus. I heard that three months injection causes heavy bleeding. I heard that Norplant (Implant) will cause cancer, so I haven't used any of these." **PC IDI 8, Munna, 30 years**

Along with issues of reproductive coercion, the sociocultural pressure for Nepali women to have children was also frequently reported by both CC and PC respondents. Pressure from husbands relating to contraceptive use was also a reported factor for both CC and PC participants not using a modern method of contraception prior to their unplanned pregnancy and for several respondents, after their MA.

> "I told my husband that I'll use the injection, but he did not allow… he said that we will be cautious, so I didn't use (any contraception)." **PC IDI 5, Sita, 25 years**

Participants shared they will often base reproductive health decision, such as the type of contraceptive method they wish to use or where to access this method from, on information they receive from female family members and friends. Conversations with husbands and family (specifically mothers, mothers-in-law, sisters and sisters-in-law) as well as friends were reported as a means of acquiring information on SRH. Outside of an SRH clinic (government, I/NGO or private) or hospital environment, participants stated other ways they receive SRH information and SRH service provider information included TV, radio, facebook and advertising signs and billboards.

> "(I learnt about MSC services) from TV, radio and it is also written on signboards… Also, one of our friends keeps on searching and sharing… (SRH) information on Facebook which I feel very informative and useful." **CC IDI 1, Sabitri, 36 years**

However, several participants highlighted the socioeconomic disparities in SRH and contraception information access, particularly for those living in rural and remote regions.

> "We don't have TV or radio. (Female Community Health Volunteer) provides me information about contraceptives, but my husband does not want me to use." **PC IDI 4, Parvati, 30 years**

Female Community Health Volunteers (FCHVs) were the most frequently cited source of SRH information and education as well as contraceptive access. Both CC and PC respondents emphasised the importance of FCHV within their communities, and how they felt supported and comfortable with them.

> "I get information from health volunteers (FCHV). They are from our community, we will be close with them and can share." **PC IDI 7, Kalpana, 35 years**

Participants also spoke of the critical role FCHVs play in providing SRH services to women living in rural and remote regions.

> "She (FCHV) works in a health post. She asks us if we have any problem and she travels around." **PC IDI 1, Sapana, 36 years**

Many CC and PC participants expressed an overall lack of access to SRH information within their daily lives, with sociocultural issues including gender discrimination and SRH stigma stated as key inhibitors to SRH information access.

7.9 Discussion

Women-centred safe abortion services support women to holistically exercise their SRHR by providing them with information, education and choice (Government of Nepal, 2015b). In contrast to unsafe services, they address both the physical and emotional reproductive needs of women, including contraceptive counselling, to support women in their MA journey (Government of Nepal, 2015b). Whether accessing MA through a safe abortion service or by unsafe means, reasons informing a woman's decision to seek an abortion often highlight the intersectoral nature of SRHR, cultural and gender roles, and socioeconomic status (Barot, 2012; Chae, Desai,

Crowell, Sedgh, & Singh, 2017; Kirkman, Rowe, Hardiman, Mallett, & Rosenthal, 2009; Ministry of Health Nepal et al., 2017b).

Although the literature shows continuation of education as a prominent factor in abortion-seeking decision making, particularly for younger women, our findings highlight the desire to ensure access to education for the children that women already have, and is closely linked with concerns regarding the capacity to financially provide the same for another child (Chae et al., 2017; Ministry of Health Nepal et al., 2017b). Findings from a 2017 study across 14 countries show that while women have abortions for a variety of reasons, the most frequently cited reasons for having an abortion are socioeconomic concerns or limiting childbearing (Chae et al., 2017).

Reproductive coercion is behaviour that inhibits a woman's sexual and reproductive autonomy (Grace & Fleming, 2016) and in Nepal, like many other developing countries in Asia, is often linked with son-preference (Barot, 2012; Centre for Research on Environment Health and Population Activities & University of Oxford, 2015; Grace & Fleming, 2016; Hesketh et al., 2011; Lamichhane et al., 2011; Rai et al., 2014). Our findings highlight the complexity reproductive coercion has on women's abortion seeking decision making. Research on sex-selective abortion in Nepal remains scarce. However, emerging evidence suggests such abortions are becoming increasingly common and therefore must be a consideration within all safe abortion and post-abortion family planning strategies (Centre for Research on Environment Health and Population Activities & University of Oxford, 2015; Frost, Puri, & Hinde, 2013; Puri & Tamang, 2015; Rogers, Sapkota, Tako, et al., 2018).

Effective culturally-safe contraceptive counselling is an essential component of PAC and assists women to space births, prevent future unwanted pregnancies and avoid unsafe abortion (Barot, 2014; Rogers & Dantas, 2017). It also plays an essential role in ensuring women's concerns relating to contraceptive use are addressed, enabling women to make informed decisions regarding which method best suits them (Puri, Henderson, et al., 2015). Informed choice increases the likelihood of post-abortion contraceptive use and empowerment to change methods, rather than total contraceptive discontinuation (PAC Consortium Community Task Force, 2002; Puri, Harper, et al., 2018; Puri, Henderson, et al., 2015; Rocca et al., 2014).

With access to a wide range of contraceptive methods combined with comprehensive SRH information and education, contraception uptake in women post-abortion has shown to increase, however many barriers remain (Rogers & Dantas, 2017). Multiple studies conducted in Nepal on post-abortion contraception access and uptake through government, private and NGO SRH services highlight that even at registered safe abortion services, post-abortion contraception access and uptake remains a challenging aspect of effective PAC provision in Nepal (Padmadas, Lyons-Amos, & Thapa, 2014; Puri, Henderson, et al., 2015; Rocca et al., 2014; Wang, Puri, Rocca, Blum, & Henderson, 2016).

Effective and safe MA provision by non-physician clinicians is well documented (Berer, 2009; Olavarrieta et al., 2015; Puri, Tamang, et al., 2015; Rocca et al., 2018; Warriner et al., 2011; Yarnall et al., 2009). Puri et al. (2018) and Rocca et. al (2018) demonstrate in their study on auxiliary nurse/midwife-provided MA through pharmacies, that when pharmacy-provided MA is administered by qualified health professionals effective and safe MA provision can be accomplished without compromising contraceptive care (Puri, Harper, et al., 2018). With many mid-level health providers (nurses and auxiliary nurse/midwives) proprietors of pharmacies in Nepal, their study details another promising avenue for safe and convenient MA provision and expansion through pharmacies (Puri, Harper, et al., 2018; Rocca et al., 2018).

Between 2000 and 2014, trends across Asia showed the most frequently cited reason for women not using contraception was infrequent or no sex, with the prevalence of this reason substantially increasing in Nepal, Bangladesh and the Philippines, most likely due to increasing labour migration (Sedgh et al., 2016). The 2016 NDHS stated approximately one-third of women in Nepal indicated their spouse lives away from the family home (Ministry of Health Nepal et al., 2017b). Multiple studies from Nepal suggest spousal separation, due to increasing male migrant workforce, is a prominent influencer of women's uptake, continuation and/or discontinuation of contraception, and could potentially play a role in Nepal's stagnated contraceptive prevalence rate (Ban et al., 2012; Dahal & Subedi, 2012; Padmadas et al., 2014; Puri, Henderson, et al., 2015; Rocca et al., 2014; Shrestha et al., 2012; Wang et al., 2016). To ensure the

contraceptive needs of Nepali women are met, family planning programs, SRH services and FCHVs must adjust their strategies to address the SRH needs of these couples (Ban et al., 2012; Sedgh et al., 2016).

Our findings document how women seek out safe or unsafe abortion services based on positive personal experiences or from the advice of the positive experiences of family and friends, with ease of access to services, concerns regarding confidentiality and economic burden also playing a role. Despite permissive laws and the government's commitment to provide free safe abortion services, multiple Nepal based studies show awareness of the legal status of abortion and knowledge of safe abortion services remains low (Adhikari, 2016; Khanal et al., 2014; Ministry of Health Nepal et al., 2017b; Thapa & Sharma, 2015). Combined with lack of knowledge, barriers to access and uptake of safe abortion services will continue to facilitate demand for MA provision through pharmacies in Nepal (Rogers, Sapkota, Tako, et al., 2018). It is essential SRH policymakers acknowledge the role pharmacies continue to play in the provision of MA and establish practical strategies to decrease negative health outcomes for women and increase access and referrals to safe MA (Rocca et al., 2018; Tamang et al., 2015; Tamang et al., 2018).

The SRH and contraceptive information provided to women who seek MA through pharmacies is often inconsistent, inaccurate or non-existent with staff at times dispensing unsafe or ineffective forms of the drug (Erdman, Jelinska, & Yanow, 2018; Sneeringer et al., 2012). However, our study shows there is a proven desire for some pharmacy workers to provide support and quality of care for women seeking MA. Studies conducted in Nepal (Tamang et al., 2015b; Tamang et al., 2018) and other low- and middle-income countries (Fetters et al., 2015; Footman et al., 2018; Hendrickson et al., 2016; Huda et al., 2018; Lara et al., 2011; Reiss et al., 2016; Sneeringer et al., 2012), highlight the challenges of implementing effective pharmacy-based harm reduction strategies such as training and education of staff to help mitigate adverse health outcomes for women. Interventions to train pharmacy workers in harm reduction strategies in Zambia and Nepal demonstrated improvement in knowledge and referral practices (Fetters et al., 2015; Tamang et al., 2015; Tamang et al., 2018), however, due to insufficient evidence of safety and effectiveness, current WHO

guidelines do not recommend pharmacy staff provide MA (World Health Organization, 2015a).

While harm reduction strategies have the potential to increase accurate information provision and support relating to pharmacy-supplied MA (Tamang et al., 2015b; Tamang et al., 2018), the sale of counterfeit brands or traditional medicines with purported abortive ingredients in the place of authentic MA will continue to contribute to the access of unsafe or ineffective medicine (Tamang et al., 2015b). It is imperative that education regarding authentic Nepali registered brands, authentic but unregistered in Nepal brands, counterfeit MA brands and unsafe abortive medicines be a component of any pharmacy-based harm reduction training. Currently, there is limited global data on the types of MA pharmacies are providing within the WHO *less safe* and *least safe* framework (Ganatra, Gerdts, et al., 2017; Harvey, 2015). In Nepal, it is essential this be investigated within a broader, and much needed, comprehensive evidence base relating to MA provision through pharmacies to inform effective and functional policy. Pharmacy-based harm reduction strategies have the potential to decrease morbidity and mortality relating to unsafe abortion as well as increasing access to MA, particularly in remote and rural settings that lack safe abortion services (Rogers, Sapkota, Tako, et al., 2018; Tamang et al., 2015; Tamang et al., 2018). However, it is essential that effective contraceptive counselling including information provision, access to a range of contraceptive methods and established SRH service referral mechanisms for LARC insertion or permanent methods, be incorporated into these strategies to ensure women's post-abortion contraceptive needs are met.

Global research has shown the effectiveness of MA self-management and remote support through telephone helplines, with approximately 20 safe abortion helplines currently active throughout Africa, Europe, Asia, and Latin America (Constant et al., 2014; Erdman et al., 2018; Hajri et al., 2004; Hyman et al., 2013; Jelinska & Yanow, 2017; Paul et al., 2015). With nearly all households in Nepal (93%) having access to at least one mobile telephone, remote support may provide another avenue of MA support for women and pharmacy workers (Ministry of Health Nepal et al., 2017b).

Nepal based SRH helplines such as SPN/MSN's *Meri Saathi* helpline can provide support to women and pharmacy workers with advice and information provided by

trained SRH counsellors and clinical experts (Cousins, 2016; Marie Stopes Nepal, n.d.). As well as providing accurate SRH and MA information, trained and qualified counsellors can also ensure women receive comprehensive post-abortion contraception counselling along with referral to health facilities for contraceptive access and post-abortion complication support. Community-based health care workers such as FCHVs may also benefit from access to additional support through helpline services, ensuring their provision of accurate SRH and safe abortion information to women.

Our findings underscore the important role FCHVs play in the dissemination of SRH information within the community, with community-based health workers being the dominant community-based health *asset* cited throughout the cyclical AFRPAC framework of this study. Nepal based studies on FCHVs ability to assess MA eligibility and determine MA success concluded further refinement of tools are needed before effective and widespread use could be implemented (Andersen et al., 2018; Andersen et al., 2017). However, research shows that with effective SRHR training and ongoing education, community-based health care workers like FCHVs can play a pivotal role in community-based SRH information provision, contraceptive counselling and access, and increasing awareness of safe abortion services and service referral (Azmat et al., 2012; Puri, Tamang, et al., 2015).

While every effort was made to mitigate bias in the research and to enhance credibility and trustworthiness, the study had some limitations. Although not by design, only married women who had already had at least one child at the time of MA access participated in interviews. Also, due to time constraints and access, CC participants were only sampled from one NGO SRH service (MSC) and did not include women who have accessed MA through government or private services. Recall bias due to the variable MA access timeline for PC respondents in comparison to CC participants is acknowledged.

7.10 Conclusion

This qualitative research is an essential contribution to Nepal's scarce evidence base on MA provision through pharmacies, providing a unique and in-depth analysis of the

post-abortion experiences of women. The findings highlight the current disparity in the post-abortion care provision through safe abortion services and pharmacies in Nepal. Under current Nepali legislation, MA provision through pharmacies is considered unsafe and illegal, however through the implementation of innovative and effective harm reduction strategies, as well as access and information expansion strategies, the potential for increased access to safe MA throughout Nepal is evident. It is essential that post-abortion contraceptive counselling, access to a variety of contraceptive methods, and effective referral mechanisms to SRH services be a component of any strategies addressing MA provision through pharmacies.

7.11 Summary of the Chapter

This chapter contained the manuscript for Article 4, currently under peer review with ***Reproductive Health***. The chapter highlights the need for effective PAC provision for women seeking to terminate pregnancies. The concluding chapter of this thesis will provide an overview of the research design and methodology, discuss the response to the objectives of the study, propose recommendations and present the research output based on the findings. The limitations and significance of the study will also be discussed before the concluding remarks are made

CHAPTER 8

REFLECTIONS, RECOMMENDATIONS, AND CONCLUSION

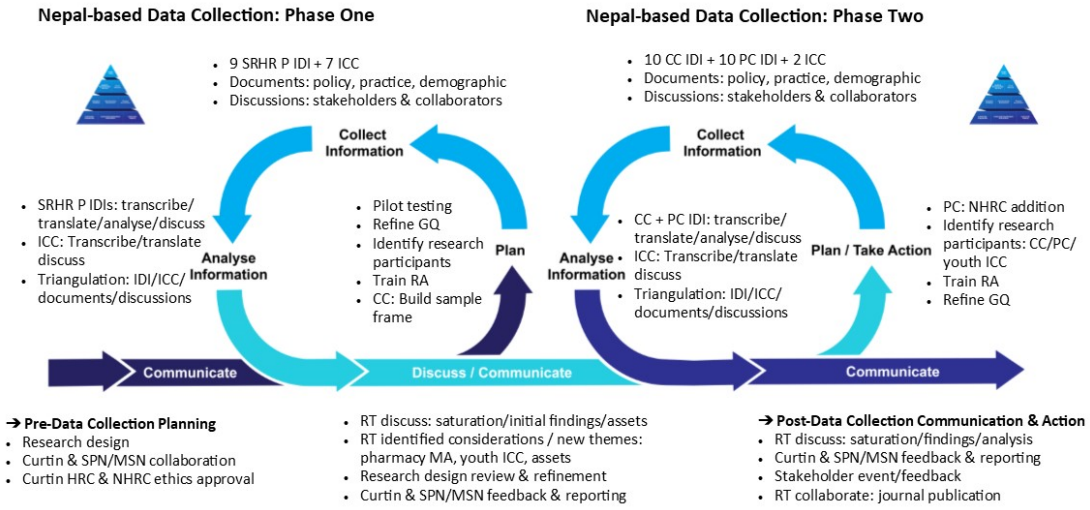
Introduction to the Chapter

The final chapter commences with a brief reflection on the research design, before responding to the aims and objectives of the study. Recommendations based on research findings are proposed, followed by the presentation of a framework for action as an important research output of the study. The limitations of the study are then discussed, and the significance of the research highlighted. The chapter concludes with some personal reflections on the research process.

8.1 Reflection on the Research Design

The conceptualisation, planning, implementation and outcomes of this research project had its foundation in the core belief that sexual and reproductive health and rights (SRHR) are fundamental human rights that especially impact women. Policy and practice recommendations from the High-Level Task Force for the International Conference on Population and Development (ICPD) (High-Level Task Force for ICPD, 2013), the Sustainable Development Goals (SDGs) (Galati, 2015), and the Guttmacher-Lancet Commission (Starrs et al., 2018) underpinned the rights-based conceptual framework within which this research was conducted.

Using an Assets Based Rapid Participatory Appraisal (AFRPA) research methodology, and supported by the Health Information Pyramid framework, this qualitative exploratory study employed the dynamic process of the Assets Focused Rapid Participatory Assessment Cycle (AFRPAC) as depicted in the summarised and stylised representation of Phases One and Two of Nepal-based data collection in Figure 8.1. The cyclical process based this knowledge for action research within a participatory context ensuring cultural sensitivity and contextually rich data collection.



CC: Clinic Clients
Curtin: Curtin University
GQ: Guiding Questions
ICC: Informal Community Conversations
IDI: In-depth Interviews
PC: Pharmacy Clients
RA: Research Assistant
RT: Research Team
SRHR P: Sexual and Reproductive Health and Rights Professionals
SPN/MSN: Sunaulo Parivar Nepal / Marie Stopes Nepal

Figure 8.1 Assets Focused Rapid Participatory Assessment Cycle (AFRPAC)

(Adapted from: Pepall et al., 2006, p. 45)

This study highlighted the strength of the cyclical process and the flexibility to respond and adapt to new and emerging themes throughout the analysis. The early emergence of pharmacy-supplied medical abortion (MA) being a key concern within Nepal's SRHR sector was particularly important to the findings and recommendations. With the 2016 Government of Nepal announcement to implement policy enacting the provision of free safe abortion services through public clinics, the AFRPAC allowed this new dimension to safe abortion provision in Nepal to be contextualised and incorporated into data synthesis and analysis; enabling recommendations relevant to the policy's eventual 2018 implementation (Government of Nepal, 2018).

Underpinning the AFRPAC, the four tiers and 10 components of the Health Information Pyramid provided a checklist for information required and a framework for analysis of data gathered (Annett & Rifkin, 1995). As detailed in chapter 5, the

pyramid assisted in the identification, mapping and collection of data relevant to the aims and objectives of the research and aided in triangulation of data. Recommendations that have the potential to contribute to social change and development were shaped by a research focus on community assets, with the identification of community-based health workers as a recognised asset, and supported by a strong Safe Abortion Policy (although not effectively implemented in Nepal).

This qualitative research enabled the thoughts, experiences and expertise of participants to be shared. At all times, emphasis was placed on listening to participants' voices and sharing their stories in an ethical and respectful way. Outcomes of the research are grounded firmly and tangibly within the context of women's and girls' SRHR in Nepal. The collaboration between Curtin University and Sunaulo Parivar Nepal/Marie Stopes International Nepal (SPN/MSN) will ensure that results from study are disseminated extensively in Nepal, South Asia and globally, we will also advocate for the availability and use of resources to support the implementation of key recommendations and to coordinate the dissemination of findings within Nepal, and globally.

Capacity building and mentoring of the two research assistants played an important and vital role within the participatory and collaborative context of this research (Pepall et al., 2006). Ownership of the research was established through their consistent involvement with data collection and analysis, as well as their contribution as co-authors of two of the peer reviewed journal articles presented as a part of this thesis. Working within the qualitative paradigm, particularly with research of a sensitive nature such as SRHR, provided both research assistants with valuable experience and skills that will be transferable to future research and SRHR project roles.

8.2 Discussion and Response to Research Objectives

This research aimed to explore the post-abortion SRHR experiences of Nepali women, and access to and uptake of safe abortion services; unsafe abortion (MA) through pharmacies; post-abortion contraception; and SRH information. The findings of the study are now presented.

Objective 1: To explore the provision of Comprehensive Abortion Care (CAC) and Post-Abortion Care (PAC) in Nepal.
Objective 2: To identify barriers to safe abortion services.
Objective 3: To provide an overview of unsafe abortion practices in Nepal.

In accordance with WHO safe abortion guidelines, Nepal's CAC strategy and National Safe Abortion Policy attempts to ensure the provision of safe, accessible and affordable abortion services to all women (Government of Nepal, 2002, 2015b, 2015c, 2017). However, the research findings suggest that there are many barriers to the provision of effective and equitable CAC and PAC.

Although the Government of Nepal reports that safe abortion services are available in all 75 districts of the country (Government of Nepal, 2017, 2018), the findings (across all in-depth interview groups and reiterated in stakeholder feedback – see page 116) show that geographical isolation and lack of rural and remote CAC services remain a key factor in the access to services and uptake of unsafe abortion, particularly MA through pharmacies. Despite the expansion of safe abortion services in Nepal since 2002, there remains a vital need to increase the availability of and access to safe abortion services to all Nepali women, regardless of geographical location (Government of Nepal, 2017). In rural and remote settings, the inability for government, private and I/NGO safe abortion services to recruit and retain trained medical professionals also remains a challenge in the provision of high quality safe abortion services. Findings from the SRHR professional interviews demonstrate, that along with effective monitoring and evaluation of services, continued training and capacity building for safe abortion service providers is essential for the provision of a high level of quality care regardless of geographic location or type of clinic they work in (government, private or I/NGO).

To help mitigate the financial barriers to accessing safe abortion services, in 2016 the Government of Nepal committed to providing free access to safe abortion services from public health facilities (Ipas, 2016). In 2018 Nepal's safe abortion service implementation guidelines were finalised to incorporate the free safe abortion policy (Government of Nepal, 2018; Shrestha, Regmi & Dangle, 2018), and free services provided through public clinics commenced (Singh, 2018). However, the findings of

the present study demonstrate that without effective monitoring and evaluation of safe abortion services already provided in government health facilities, ensuring a high level of quality care in these free services will remain challenging (World Health Organization, 2012a). It is essential that a strategy for consistent and comprehensive monitoring and evaluation of these services be incorporated within the implementation to truly provide effective and equitable provision of comprehensive safe abortion services.

The most recent Nepal Department of Health Annual Report (2016/17) states that since the implementation of safe abortion services, more than 1,005,000 Nepali women have received safe abortions from certified service sites. However, the records of health facilities in Nepal, as in many other developing countries, are often incomplete or inaccurate; therefore statistics may underestimate the actual number of legal abortions performed each year (Puri et al., 2016). Also, as only abortions provided through government accredited facilities are recorded, the number of illegal abortions occurring are not documented.

The only study to estimate the incidence of abortion in Nepal, both legal and illegal, was conducted between August and November 2014, utilising a modified version of the Abortion Incidence Complications Methodology (AICM) (Puri et al., 2016). The study found that an estimated 323,100 abortions were performed in 2014, of which approximately 42% were legally provided in government certified facilities and 58% illegally performed through unsafe methods (Ganatra, Gerdts, et al., 2017; Puri et al., 2016). The findings, as highlighted in SRHR professional and pharmacy client in-depth interview groups, demonstrate the accessibility of illegal pharmacy-provided MA in Nepal and the acceptability in which women view procurement of MA through pharmacies.

Within Nepal's patriarchal society, sociocultural attitudes, religious beliefs and cultural norms relating to SRHR continue to inhibit women's access and uptake of safe abortion services. As highlighted in the clinic client and pharmacy client in-depth interviews, the findings demonstrate that women seek out safe or unsafe abortion services based on personal experiences or from the advice of experiences of family and friends, ease of access to services, concerns regarding confidentiality, and

economic burden. Despite permissive laws and the government's commitment to provide free safe abortion services, as with previous Nepal based studies (Adhikari, 2016; Khanal et al., 2014; Thapa & Sharma, 2015; Thapa et al., 2014) the findings highlight the low awareness of the legal status of abortion and knowledge of safe abortion services. The findings demonstrate that women's abortion-seeking decision making processes are complex, and highlight the intersectoral nature of SRHR, cultural and gender roles, reproductive coercion and socioeconomic status.

Ingrained societal stigma towards abortion often prevents policymakers or community leaders from supporting safe abortion service provision, compounding negative service provider attitude and impeding women's access and uptake of safe abortion services and post-abortion contraception (Rogers & Dantas, 2017; Turner, Pearson, George, & Andersen, 2018). The World Health Organization recommends the use of values clarification interventions as an essential component in the training of safe abortion providers to ensure the provision of high quality care (World Health Organization, 2012). Values Clarification and Attitude Transformation (VCAT) workshops conducted with abortion providers, trainers, and policymakers in 12 countries in Asia, Africa, and Latin America have shown the effectiveness of value clarification interventions with safe abortion stakeholders (Turner et al., 2018). Analysis of workshop outcomes demonstrate the impact VCAT has in improving participants' knowledge and attitudes about abortion as well as their intentions to support safe abortion care, especially among participants who initially attended the workshops with the least knowledge and most negative attitudes towards abortion (Turner et al., 2018).

Ongoing barriers to access and uptake of safe abortion services in Nepal will facilitate the sustained demand for the provision of unsafe MA through pharmacies. Disparities between safe abortion services and unsafe abortion provision through pharmacies were highlighted within the clinic client and pharmacy client in-depth interview findings; and were supported by evidence detailed within the SRHR professional interviews. However, the findings of this present study also document a desire for some pharmacy workers to provide support and quality of care to women seeking MA as detailed within pharmacy client and SRHR professional interviews.

Objective 4: To explore access and uptake of post-abortion contraception and SRH information through:

a. safe abortion services (MA)
b. unsafe abortion services (MA through pharmacies).

Effective and culturally safe contraceptive counselling is an essential component of PAC and assists women to space births, prevent unwanted pregnancies and avoid unsafe abortion (Barot, 2014; Rogers & Dantas, 2017). The findings of this study also demonstrate that counselling also plays an essential role in ensuring that women's concerns relating to contraceptive use, such as fear of side-effects or misconceptions, are addressed, enabling women to make informed decisions regarding which method best suits them.

Contraception uptake in women post-abortion has been shown to increase because of access to a wide range of contraceptive methods, combined with comprehensive SRH information and education (Rogers & Dantas, 2017). Supporting the findings of previous Nepal based studies (Padmadas, Lyons-Amos, & Thapa, 2014; Puri, Henderson, et al., 2015; Rocca et al., 2014; Wang, et al., 2016), the present findings demonstrate that post-abortion contraception access and uptake through registered safe abortion services (government, private and I/NGO) remains a challenging aspect of effective PAC provision in Nepal.

Inconsistencies were noted between different safe abortion service providers (government, private, I/NGO in urban and remote areas) and their effectiveness in providing comprehensive post-abortion contraceptive counselling. Ineffective contraceptive commodity supply chains, particularly to rural and remote regions, were also highlighted as an inhibitor to women's post-abortion access to a broad choice of contraceptive methods, including LARC (Puri, Henderson, et al., 2015; Wang et al., 2016). In their 2011 study on post-abortion contraception access and uptake at two nongovernment SRH clinics and two government hospitals, Rocca et al. (2014) found that of the 838 participants, over half left safe abortion facilities without an effective contraceptive method. One-third of participants received no form of contraceptive counselling, with qualitative data from study sites indicating service barriers to post-abortion access and uptake included inadequate time for counselling, limitations in

space and privacy, and shortages in supplies and trained staff (Rocca et al., 2014). Figure 8.2 presents the trend of post-abortion contraception uptake (short-term methods, LARC or no method) from 2014 to 2017 at government facilities.

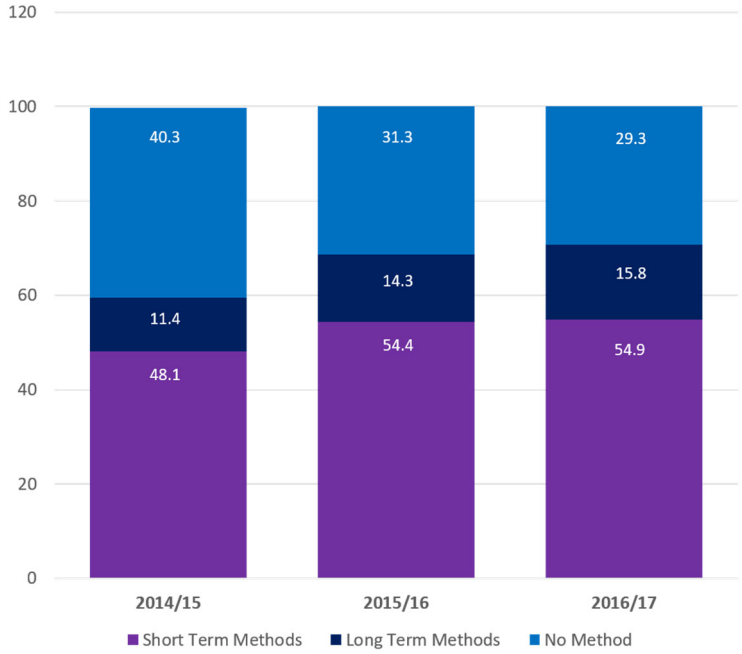


Figure 8.2 Trend of post-abortion contraceptive use at government facilities (%)

(Adapted from: Government of Nepal, 2018, p. 86)

The findings of this research reveal the complexities relating to access and uptake of post-abortion contraception, and highlight the impact that reproductive coercion, sociocultural attitudes, fear and spousal separation has on women's post-abortion contraceptive decision-making processes.

The findings highlight inconsistent, inaccurate or non-existent SRH and contraceptive information provided to women who seek MA through pharmacies in Nepal, with staff potentially dispensing unsafe or ineffective forms of the drug (Erdman, Jelinska, & Yanow, 2018; Sneeringer, Billings, Ganatra, & Baird, 2012). However, a 2014 to 2016 non-inferiority study conducted in the Chitwan and Jhapa districts of the Terai region in Nepal, shows that MA is as effective and safe when provided by trained auxiliary nurse-midwives at pharmacies as at government certified health facilities and does not compromise pharmacy client contraceptive care (Puri, Harper, et al., 2018; Rocca et al., 2018).

Objective 5: To appraise current safe abortion frameworks and strategies for contraception distribution and SRH information dissemination (current government/nongovernment SRH policy and clinical practice).

Community-based health workers were the most frequently cited community health-based asset identified by in-depth interview and informal community conversation participants. The findings underscore the important role community-based health workers such as Female Community Health Volunteers (FCHVs) play in the dissemination of SRH and contraceptive information within the community.

While the findings suggest SRHR professionals are highly supportive of current National Safe Abortion Policy in Nepal, an identified asset, it was reported that the need to effectively translate and implement this policy into practice is yet to be achieved. Within the country's recently drafted Sustainable Development Goals strategies (National Planning Commission, 2017b), the omission of specific indicators addressing safe abortion service access and uptake and post-abortion contraception is a missed opportunity, particularly in the light of the country's globally lauded success in implementing safe abortion services over the last 15 years.

Objective 6. To suggest practical and innovative strategies for increased access and uptake of safe abortion services and post-abortion contraception and SRH information.

Despite legislation restricting MA access solely through government accredited safe abortion services, MA pills are readily available for illegal purchase at pharmacies throughout the country, although limited research has been conducted on the issue (Puri, Harper, et al., 2018; Puri, Tamang, et al., 2015; Tamang et al., 2015; Tamang et al., 2018). In Nepal, two studies on pharmacy-provided MA using harm reduction strategies have demonstrated that trained pharmacy workers can dispense MA safely and effectively (Tamang et al., 2015b; Tamang et al., 2018).

There is currently no government or I/NGO policy or clinical practice strategies to address the issue of pharmacy-provided MA in Nepal. However, established SRH and contraceptive information dissemination strategies such as SPN/MSN's *Meri Saathi* helpline could provide support and information to women accessing pharmacy-

provided MA as well as to the pharmacy workers themselves. Global research has shown the effectiveness of MA self-management and remote support through telephone helplines (Constant et al., 2014; Erdman et al., 2018; Hajri et al., 2004; Hyman et al., 2013; Jelinska & Yanow, 2017; Paul et al., 2015). With nearly all households in Nepal (93%) having access to at least one mobile telephone (Ministry of Health Nepal et al., 2017b), remote support through mHealth programs may provide another avenue of MA support for women and pharmacy workers.

Strategies for harm reduction training addressing pharmacy-provided MA must include post-abortion contraception counselling and access as well as effective and timely referral to health facilities for LARC insertion and post-abortion complication care. Also, education regarding authentic Nepali registered MA brands, authentic but unregistered in Nepal MA brands, counterfeit MA brands, and unsafe abortive medicines, must be a component of any pharmacy-based harm reduction training.

8.3 Recommendations

Based on the research findings, the following recommendations are proposed:

8.3.1 Recommendations for policy and practice

Access and Uptake of Safe Abortion Services and Post-Abortion Contraception

Although Nepal has seen continued advancements in safe abortion service provision since legalisation in 2002, equitable access of high quality safe abortion services and post-abortion contraception remains challenging for many Nepali women.

The following recommendations are proposed:

1. Implement programs and policies aimed to reduce rates of unintended pregnancy and unsafe abortion (short to mid-term goal).
2. Develop strategies to increase access to high quality post-abortion contraceptive care and counselling, particularly LARC (short-term goal).
3. Expand safe abortion services across the country (short to mid-term goal).

Global Goals

Nepal's globally recognised success in abortion legalisation and service implementation, combined with recently introduced governmental policy on free safe abortion services, demonstrates the country's global leadership in SRH. However, specific targets relating to safe abortion and post-abortion contraception are not detailed within the Sustainable Development Goals strategies.

4. Government and SRH stakeholders collaborate to establish specific abortion and post-abortion contraception related achievable targets within Nepal's Sustainable Development Goals framework (short-term goal).

Monitoring and Evaluation

High quality safe abortion care depends upon effective operational processes for monitoring, evaluation and the effective implementation of rights-based SRHR policy (World Health Organization, 2012a). Along with maintaining quality of care, the accurate collection and reporting of service statistics is essential for the analysis of abortion related data, and to inform rights-based policy and decision making. The findings demonstrate that although consistent and standardised monitoring and evaluation occurs within I/NGO safe abortion services, monitoring and evaluation in government and private safe abortion services was reported to be inconsistent across the country. Effective monitoring and evaluation strategies are needed to:

5. Ensure quality of service provision and capacity of service providers of government and private safe abortion services (short-term goal).
6. Implement the National Safe Abortion Policy (Government of Nepal, 2002) within the clinical environment (short-term goal).
7. Monitor contraceptive commodity supply chains to ensure equitable distribution of contraceptives, especially to rural and remote regions (short-term goal).

Rural and Remote

The disparities in quality health care access for women living in rural and remote regions compared with their urban counterparts was frequently highlighted during this study. Equitable training and capacity building for providers living in remote regions is recommended.

8. Government, I/NGO and private sector SRH services must re-evaluate current incentives and strategies for health professional recruitment and retainment in rural and remote regions (short-term goal).
9. Government, SRH stakeholders, universities and medical training facilities must collaborate to implement strategies to increase the number of trained health professionals to work in rural and remote regions (short to mid-term goal).

Gender Discrimination

Nepal's pervasive and entrenched sociocultural, economic and political prejudices against women and girls is often expressed as gender bias in favour of boys (United Nations Population Fund, 2017). Within Nepali society, preference for a son (male child) can be associated with reproductive coercion, a frequently cited issue in this study. The findings highlight the diverse implications reproductive coercion can have on women's abortion seeking behaviours as well as contraceptive use decision making processes. Despite political commitment and legal and policy frameworks, discrimination and violence against women and girls continues in Nepal (United Nations Population Fund, 2017). The implementation of policies is recommended to:

10. Address the status of women and girls to ensure women's and girls' SRHR as well as their human rights are acknowledged and met.
11. Assist stakeholders to develop strategies, such as values clarification interventions, to reduce cultural stigma surrounding women accessing contraception and safe abortion services (short-term goal).
12. Promote the use of mHeath interventions to provide women with knowledge about contraceptive choices and SRH information (short-term goal).

Pharmacy-provided Medical Abortion

Throughout this study, the implications and complexities around pharmacy-provided MA was a key focus and extensively explored. Recommendations from participants in this present investigation support those earlier studies (Tamang et al., 2015b; Tamang et al., 2018) that identified the potential for harm reduction strategies to decrease morbidity and mortality relating to unsafe abortion in Nepal. It was also suggested that this approach could increase access to MA, particularly in remote and rural settings that lack safe abortion services. In support of previous Nepal based studies, the present research findings indicate that harm reduction strategies decrease negative health

outcomes for women accessing MA through pharmacies as well as increase access to MA, particularly in settings that currently lack safe abortion facilities. A multi-sectoral collaborative approach is recommended.

13. Where government, I/NGO and private sector SRH stakeholders and policymakers work together to implement innovative and evidence-based strategies to decrease unsafe abortion through pharmacy-provided MA (short-term goal).
14. To expand safe abortion services, particularly in rural and remote regions, with the aim of decreasing unsafe abortion in Nepal (short to mid-term goal).
15. To increase safe abortion awareness campaigns to address the lack of knowledge of safe services and the legality of abortion in Nepal (short-term goal).

8.3.2 Recommendations for community organisations and community health workers

The literature documents that with comprehensive and repeated SRHR training, community-based health care workers can play an essential role in community level SRH information provision, contraceptive counselling and access, and increasing awareness of safe abortion services (Azmat, Shaikh, Mustafa, Hameed, & Bilgrami, 2012; Puri, Tamang, et al., 2015). Through the AFRPAC process, the present research findings underscore the important role community-based health care workers, such as Female Community Health Volunteers (FCHVs), play in the dissemination of SRH and contraceptive information. To ensure the provision of accurate SRH and safe abortion information, community-based health care workers also benefit from access to additional support through SRH helpline services. Within this context, the following recommendations are proposed:

1. Link community-based health workers with community based SRH organisations to increase community awareness of safe abortion services (short to mid-term goal).
2. Link community-based health workers with established SRH information dissemination implementations to ensure accurate and timely abortion and SRH information provision (short to mid-term goal).

8.3.3 Recommendations for future research

This study was not able to extensively explore all issues relating to post-abortion contraception and SRH information provision in Nepal and therefore recommends the

following areas for further investigation for the development of long-term SRHR goals:

Safe and Unsafe Abortion in Nepal

The 2014 findings from Puri et al.'s (2016) study on the incidence of legal abortion, illegal abortion and unintended pregnancy in Nepal are currently the only evidence-based estimates of abortion in Nepal. More research on illegal and unsafe abortion in Nepal is vitally needed.

Pharmacy-provided MA

With a paucity of available data, the generation of a comprehensive evidence base relating to MA provision through pharmacies is vitally needed to provide greater understanding of the issue and to inform effective and functional policy within Nepal. Suggested areas of future research include:

1. The inclusion of contraceptive counselling in pharmacy-based harm reduction training strategies.
2. Contraceptive access and uptake of women accessing pharmacy-provided MA.
3. The type of MA available through pharmacies including government registered brands, non-registered brands, counterfeit MA and traditional ayurvedic medicines with abortive properties.

Sex-Selective Abortion

Research into sex-selective abortion in Nepal remains limited and with emerging evidence (Centre for Research on Environment Health and Population Activities & University of Oxford, 2015) suggesting they are becoming more frequent, research is needed to inform behavioural change campaigns as well as safe abortion policy and practice.

Spousal Separation and Contraceptive Use

With an ever-increasing migrating male workforce, and the continued stagnation of the contraceptive prevalence rate in Nepal, further research is needed on the association between contraceptive use among women and spousal separation to determine how to best meet the contraceptive needs of those women.

Abortion and Contraception Stigma

Further research on the impact of sociocultural stigma, entrenched cultural beliefs and gender inequality on women's abortion and contraceptive decision-making processes is needed to inform practice and policy that supports women's SRHR autonomy.

Post-abortion Contraception

Despite Nepal's family planning policy and commitment to FP2020 goals, continued collection on post-abortion contraception data is needed to effectively inform policy and practice. Areas of data collection at clinics and in pharmacies should include the post-abortion contraceptive counselling information women receive, the methods they choose and use, continuation and discontinuation of post-abortion contraception, and barriers to access and uptake of post-abortion contraception.

8.3.4 Dissemination of Findings and Recommendations

On completion of this study, community and key stakeholder events will be held in both Kathmandu and Itahari to disseminate findings and recommendations in 2019. The Itahari event will not only include key SRHR and health stakeholders within the Sunsari District, but also community members and participants. Key findings and actions moving forward will be presented, with an SRHR education component incorporated into the event schedule. Key government and nongovernment SRHR stakeholders in Kathmandu will be invited to participate to discuss current SRHR issues, with SRHR stakeholders invited to make presentations on their research and projects within Nepal. An executive summary of this present research will be provided, and reports provided to relevant Government of Nepal offices, the SPN/MSN country director and the Nepal Health Research Council. Electronic and hardcopies of the international peer reviewed journal articles produced from this study will also be shared with SRHR stakeholders.

8.4 Sexual and Reproductive Health and Rights Conceptual Framework

One of the outcomes of this study is the development of an SRHR Conceptual Framework based on the research experience and drawing on the voices of participants. To strengthen SRH services, policies and programs, continued research,

program monitoring and evaluation, and obtaining evidence at the grass-roots level must occur. Inspired by the Core Humanitarian Standard on Quality and Accountability (The Core Humanitarian Standard, 2014), informed by knowledge gained throughout the AFRPAC process of this study (Pepall et al., 2006) (Figure 8.1), and based on the core principle that SRHR are fundamental human rights (Guttmacher Institute, 2018c), this conceptual framework, detailed below in Figure 8.3, provides structure and guidance for SRHR research and program implementation within cross-cultural and low resource settings.

While SRHR are intrinsically linked to health and well-being, economic development, and to the welfare of the global community, they continue to remain a contentious and often politicised area of health care provision (Starrs et al., 2018). Women, adolescents and minority populations within low- and middle-income countries are particularly vulnerable to the cultural, religious and political sensitivities that impede the holistic attainment of SRHR.

Figure 8.3 Sexual and Reproductive Health and Rights Conceptual Framework

The framework comprises seven criteria with supporting key actions. The overlapping circles of the criteria highlight the inter-connected nature of the framework. The dynamic process of the AFRPAC informs actions within key components of the investigative and research process, program implementation and monitoring and evaluation. They include: community-based investigation, collaboration, communication, planning, data collection and analysis, information dissemination, outcomes and implementations, and continuous monitoring and evaluation. The cyclical planning, discovery, and action process ensures feedback, evaluation and modification is continuous, enabling the capacity to evolve and adapt as new information is gathered (Pepall et al., 2006).

8.4.1 SRHR Framework Criteria and Key Actions

Criteria 1: Knowledge for Action

Ensure that ownership and outcomes of investigations, research and implementations will be of tangible benefit to the community.

Key Actions

- Establish resources needed to support the implementation of research recommendations and maintain consistent monitoring and evaluation with community feedback.
- Coordinate the ongoing dissemination of research findings and encourage feedback from: research team members and participants, SRHR stakeholders, staff and community members involved in implementing outcomes.

Criteria 2: Appropriate and Relevant

Ensure that the research and implementations are appropriate and relevant to the chosen community.

Key Actions:

- Conduct systematic, objective and ongoing investigations of community context, needs and stakeholders as well as vulnerable populations.
- Assess cultural, religious and political sensitivities to the research and planned outcomes.
- Adjust research, interventions and implementations to reflect local conditions.

Criteria 3: Participatory and Collaborative

Ensure that the investigations, research and implementations are participatory in nature with effective collaboration and communication.

Key Actions:

- Establish a multi-sectoral team including members with cultural and linguistic backgrounds as well as gender and sexuality identities relevant to the project.
- Engage and collaborate with community members and community-based staff within the investigation, research and implementation process.

Criteria 4: Capacity Building and Mentoring

Ensure members of the research team, community-based staff, and people within the community gain valuable and transferable skills from their involvement.

Key Actions:

- Ensure all research members, community-based staff and community members are active collaborators throughout all stages of the planning, implementing and outcome processes.

Criteria 5: Cultural Safety

Ensure all components of the investigation, research and implementation are conducted in a respectful and culturally appropriate manner.

Key Actions:

- Communicate in languages, formats and media that are easily understood, are community specific and culturally respectful.
- Ensure the protection of collaborators' values and beliefs through participation, knowledge exchange and respectful dialogue.

Criteria 6: Assets Focused

Ensure outcomes are concurrently solution- and problem-focused through the identification of existing community-based assets.

- Identify community-based assets through community member participation, ongoing investigations and participant interaction.
- Utilise community recognised assets to support outcomes, recommendations and implementations.

Criteria 7: Human Rights

Ensure all components of the process are conducted within an ethical, rights-based context.

Key Actions:

- Throughout all stages of this cyclical, participatory and collaborative process, investigation and research, ensure the core foundation of all actions are based on the principle that sexual and reproductive health and rights are human rights, and must be afforded to all.

8.5 Limitations

While every effort was made to mitigate bias within the study and to enhance credibility and trustworthiness, the study had some limitations. Financial and time

constraints for this exploratory study restricted my time in the field. Practicalities relating to access of SRHR professional participants in Phase One meant the study was limited to the Kathmandu area and did not include multiple participants from outside the region with government and nongovernment backgrounds. Difficulty in accessing participants within the government SRHR sector resulting in only two government participants; with the other seven being recruited from the NGO, I/NGO, independent (SRHR research) and donor sectors.

Due to time constraints and access, SRH clinic-based service providers were only sampled from one SRH I/NGO (SPN/MSN) and one government facility. Although not by design, only married women who already had at least one child at the time of MA access participated in interviews. Also, due to time constraints and access, CC participants were only sampled from one SRH I/NGO service (Itahari MSC, SPN/MSN) and did not include women who have accessed MA through government or private services. While all members of the research team involved in interviews were collaboratively involved with the refinement of guiding questions, and were experienced with the qualitative interview process, a bias for leading questions cannot be ruled out.

Recall bias due to the variable MA access timeline for PC respondents in comparison to CC participants is acknowledged. While the cultural safety of participants was of paramount importance, sensitivity bias, particularly for the CC and PC respondents, may have occurred. Through the transparent process of providing information sheets and granting informed consent, all participants were aware the research was conducted in collaboration with Curtin University and SPN/MSN, therefore sponsor bias may have occurred. For PC clients, closely linked with sponsor bias was the potential for social acceptance bias specifically when they were asked if they would access MA through a pharmacy if they had a future unwanted pregnancy.

8.6 Significance of the Study

The need for qualitative SRHR data collection in Nepal was timely and an important attribute of this research and its contribution to SRHR literature and knowledge in Nepal. With very few studies conducted in Nepal on the provision of MA through

pharmacies, the findings and recommendations of this study contribute to a small pool of evidence based knowledge. In their study on auxiliary nurse-midwife provided MA through pharmacies, Puri et al. (2018) found post-abortion contraceptive care was not compromised within the pharmacy environment. Their research and the current study are the only studies conducted in Nepal on the post-abortion contraception experiences of women who accessed MA through a pharmacy. This study is unique, because it is the first to have conducted an in-depth qualitative analysis of post-abortion contraceptive and SRHR experiences with women who have accessed MA through a pharmacy, as well as women who have accessed MA through a safe abortion service.

8.7 Conclusion

This exploratory study highlights the multiple factors impacting women's adequate access to post-abortion contraception and SRH information. The decision-making process women in Nepal undergo when accessing safe or unsafe MA and post-abortion contraception emphasise the intersectionality of SRHR, reproductive coercion, gender discrimination, stigma, poverty, spousal separation, and women's reproductive autonomy. Regardless of illegality and safety, women in Nepal will continue to access MA through pharmacies, and while there is high demand pharmacies will continue to provide the pills. Collaborations to reduce the illegal possession and sale of MA through pharmacies between the Department of Drug Administration, the Government of Nepal, I/NGOs and the private sector, have proven challenging and to date, have been unsuccessful.

Therefore, innovative and effective strategies, policies and implementation need to be developed to address the burden of unsafe abortion on the women of Nepal. Harm reduction implementations combined with access and information expansion strategies offer the potential to increase the provision of safe and effective MA. They also offer the potential to increase the provision of effective post-abortion contraception counselling and contraceptive access, decrease adverse health outcomes for women, and expand safe MA provision to rural and remote regions. When Nepal legalised abortion in 2002, the country made a commitment to improve the lives, health and well-being of women and girls in the country. They must continue this commitment

by ensuring all women in Nepal have access to equitable, effective and high quality safe abortion services.

8.8 Postscript and Epilogue

Over the 10 years I have worked and studied in the field of SRH, family planning and international health, I have seen SRHR progress and expand internationally. So too the global recognition that women's and girls' reproductive and sexual health are much more than just their pregnancy and birth experiences. The acknowledgement that being a mother is but one facet of the unique lives and identities of women and girls around the world is essential for empowerment and the achievement of our fullest potentials. Equitable access to a broad range of contraceptive options is a key component of this empowerment, enabling us the ability to decide when, with whom or if we wish to become pregnant.

Over these years, I have also witnessed the liberalisation, as well as regression, of safe abortion laws around the world. When finalising this thesis, it was with delight that I updated my writing on abortion laws in Ireland (where I lived for two years in my early twenties) and my home state of Queensland, Australia. Both places listened to the voices of the people, especially women and removed regressive and harmful abortion laws. It is my hope that countries will learn from Nepal's safe abortion provision successes, as well as their continued challenges, to guide countries away from restrictive and harmful abortion laws and provide women and girls with the access and human rights they deserve.

Since the first time I visited Nepal in 2007, I have spent close to two years in the country conducting this research, working as an SRHR consultant and getting to know the incredible people that live there. The thought of what I have experienced and achieved as well as the ethical and rights-based framework that I have conducted myself gives me a sense of pride. Thinking about what comes next, and what matters the most to me, will be when I return to Nepal in 2019, to share the stories, to translate the research into action and to keep my promise to the wonderful women of Nepal.

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Every reasonable effort has been made to acknowledge the owners of copyright material. I would be pleased to hear from any copyright owner who has been omitted or incorrectly acknowledged.

APPENDICES

Appendix A.

Curtin University Human Research Ethics Committee Approval

Curtin University

Memorandum

To	Associate Professor Jaya Earnest, Nursing and Midwifery - Centre for International Health
From	Professor Peter O'Leary, Chair Human Research Ethics Committee
Subject	Protocol Approval **HR 17/2014**
Date	25 February 2014
Copy	Ms Claire Rogers Nursing and Midwifery - Centre for International Health Dr Ravani Duggan Nursing and Midwifery - Centre for International Health

Office of Research and Development
Human Research Ethics Committee

TELEPHONE 9266 2784
FACSIMILE 9266 3793
EMAIL hrec@curtin.edu.au

Thank you for providing the additional information for the project titled "*Adequate access to contraception and sexual and reproductive health (SRH) information post abortion: a case study from Nepal*". The information you have provided has satisfactorily addressed the queries raised by the Committee. Your application is now **approved**.

- You have ethics clearance to undertake the research as stated in your proposal.
- The approval number for your project is **HR 17/2014.** *Please quote this number in any future correspondence*.
- Approval of this project is for a period of four years **25-02-2014** to **25-02-2018**.
- Your approval has the following conditions:
  i) Annual progress reports on the project must be submitted to the Ethics Office.
- **It is your responsibility, as the researcher, to meet the conditions outlined above and to retain the necessary records demonstrating that these have been completed.**

Applicants should note the following:

It is the policy of the HREC to conduct random audits on a percentage of approved projects. These audits may be conducted at any time after the project starts. In cases where the HREC considers that there may be a risk of adverse events, or where participants may be especially vulnerable, the HREC may request the chief investigator to provide an outcomes report, including information on follow-up of participants.

The attached **Progress Report** should be completed and returned to the Secretary, HREC, C/- Office of Research & Development annually.

Our website https://research.curtin.edu.au/guides/ethics/non_low_risk_hrec_forms.cfm contains all other relevant forms including:

- Completion Report (to be completed when a project has ceased)
- Amendment Request (to be completed at any time changes/amendments occur)
- Adverse Event Notification Form (If a serious or unexpected adverse event occurs)

Yours sincerely

Professor Peter O'Leary
Chair Human Research Ethics Committee

Appendix B.

Nepal Health Research Council: Ethics Approval

Nepal Health Research Council
Estd. 1991

Ref. No.: 1029

12 March 2014

Dr. Ellen Claire Rogers
Principal Investigator
Curtin University
Australia

Ref: **Approval of Research Proposal** entitled **Adequate access to contraception and sexual and reproductive health (SRH) information post abortion: a case study from Nepal**

Dear Dr. Rogers ,

It is my pleasure to inform you that the above-mentioned proposal submitted on 26 January 2014 (**Reg. no. 20/2014** please use this Reg. No. during further correspondence) has been approved by NHRC Ethical Review Board on 11 March 2014 (2070-11- 27).

As per NHRC rules and regulations, the investigator has to strictly follow the protocol stipulated in the proposal. Any change in objective(s), problem statement, research question or hypothesis, methodology, implementation procedure, data management and budget that may be necessary in course of the implementation of the research proposal can only be made so and implemented after prior approval from this council. Thus, it is compulsory to submit the detail of such changes intended or desired with justification prior to actual change in the protocol.

If the researcher requires transfer of the bio samples to other countries, the investigator should apply to the NHRC for the permission.

Further, the researchers are directed to strictly abide by the National Ethical Guidelines published by NHRC during the implementation of their research proposal and submit progress report and full or summary report upon completion.

As per your research proposal, the total research amount is **US$ 8,720.00** and accordingly the processing fee amounts to **NRs- 10,060.00.** It is acknowledged that the above-mentioned processing fee has been received at NHRC.

If you have any questions, please contact the research section of NHRC.

Thanking you.

.....
Dr. Guna Raj Lohani
Executive Chief

Tel.+977-1-4254220, 4227460, Fax: +977-1-4262469, Ramshah Path, P.O. Box 7626, Kathmandu, Nepal.
Website: http://www.nhrc.org.np, Email : nhrc@nhrc.org.np

Appendix C.

Article 1: Access to contraception and sexual and reproductive health information post-abortion: a systematic review of literature from low- and middle-income countries

Rogers, C., & Dantas, J. A. R. (2017). Access to contraception and sexual and reproductive health information post-abortion: a systematic review of literature from low- and middle-income countries. *Journal of Family Planning and Reproductive Health Care, 43*(4), 309-318. doi:10.1136/jfprhc-2016-101469

This article has been accepted for publication in the *Journal of Family Planning and Reproductive Health Care 2017* following peer review, and the Version of Record can be accessed online at http://dx.doi.org/10.1136/jfprhc-2016-101469

Access to contraception and sexual and reproductive health information post-abortion: a systematic review of literature from low- and middle-income countries

Claire Rogers, Jaya A R Dantas

▶ Additional material is published online only. To view please visit the journal online (http://dx.doi.org/10.1136/jfprhc-2016-101469).

International Health Programme, School of Nursing, Midwifery and Paramedicine, Faculty of Health Sciences, Curtin University, Perth, Western Australia, Australia

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ABSTRACT

Aim This systematic literature review documented, analysed and critiqued the accessibility of contraception and sexual and reproductive health (SRH) information for women living in low- and middle-income countries who have undergone medical or surgical abortion.

Methodology This review systematically collated relevant and recent empirical evidence regarding women's access to contraception and SRH information post-abortion within low- and middle-income countries. The PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) framework Guidelines, Flow Diagram and Checklist were utilised to undertake the review. The Ovid (MEDLINE), ProQuest, Science Direct, Web of Science, PUBMED and CINAHL databases were searched and studies that met edibility criteria were assessed for validity and analysis. A narrative synthesis of characteristics and results of the included studies is presented.

Findings After detailed assessment of available and relevant literature, nine studies were selected for inclusion in the review. Studies highlighted barriers to contraception and SRH information including supply limitation, lack of comprehensive education and counselling, lack of skilled post-abortion care (PAC) providers and abortion stigma.

Conclusions The review found that with access to a wide range of contraceptive methods combined with comprehensive SRH information and education, contraception uptake in women post-abortion does increase. The review also highlights the inconsistencies in clinic-reported 'counselling' and what this term actually involves within a PAC setting.

Key message points

- The results of the review highlight that a lack of comprehensive sexual and reproductive health information and education as well as negative provider attitudes are key barriers for women accessing post-abortion contraception in low- and middle-income countries.
- When women are offered a broad range of contraceptive methods and are provided with effective culturally safe contraceptive counselling, the likelihood of them accepting post-abortion contraception increases.
- A clearer understanding of 'counselling' and 'cultural safety and sensitivity' is needed within post-abortion care services to ensure comprehensive information provision and effective support for women.

INTRODUCTION

Post-abortion care

Of the 38 million abortions performed annually in low- and middle-income countries, more than half are unsafe.[1 2] Post-abortion care (PAC) is an essential component of comprehensive abortion care (CAC), and refers to a set of interventions designed to respond to the specific needs of women who have miscarried or induced an abortion.[3–5] The PAC Consortium (2014) states the following five essential elements of PAC necessary for effective and equitable provision of PAC services:

1 *Community and service provider partnerships are vital* for prevention of unwanted pregnancies and unsafe abortion; mobilisation of resources to help women receive appropriate and timely care for complications from abortion; and to ensure that health services reflect and meet community expectations and needs.
2 *Counselling* of women to identify and respond to women's emotional and physical health needs and sexual and reproductive health (SRH) concerns is also a critical component of care.
3 *Treatment* of incomplete and unsafe abortion and complications that are potentially life-threatening need to be addressed during PAC provision.
4 *Contraceptive and family planning services* are needed to help women prevent an unwanted pregnancy or practise birth spacing.
5 *Reproductive and other health services* that are preferably provided on-site or via referrals to accessible and quality facilities in provider' networks are needed to holistically meet women's PAC needs.[6 7]

Even in low- and middle-income countries, such as Nepal and Vietnam, where abortion laws are liberal, unsafe abortion still occurs due to lack of skilled providers, limited access to safe abortion services, and sociocultural and socioeconomic inhibitors.[2] In countries where abortion is prohibited and illegal and laws are restrictive, such as the Dominican Republic and Sri Lanka, unsafe practices are undertaken and women face an even greater need for accessible, affordable and comprehensive PAC services.[2 8 9]

The objective of this review was to systematically collate and synthesise recent and relevant research evidence on PAC services provided to women from low- and middle-income countries and their ability to access contraception and SRH information. The findings from this systematic review aim to support global understanding of women's post-abortion experiences relating to access of contraception and SRH information and to highlight areas that continue to require further research.

METHODS

This systematic review evaluated studies relating to the post-abortion experiences of women living in low- and middle-income countries and their ability to access contraception and SRH information. Owing to the fact that PAC services are vital in all countries, even those where abortion laws are restrictive or prohibited, all studies situated in low- and middle-income countries have been considered for inclusion.[7 8] Low- and middle-income counties and geographical regions have been defined using the Word Bank classification system for the 2016 fiscal year.[10]

The PICOS approach was used to develop the research question for this systematic review.[11]

- *P* (refers to the patient, population or disease being addressed): in this review these were women who were obtaining or had obtained PAC services as well as PAC providers.
- *I* (relates to the intervention or exposure): in this case access to PAC services – specifically contraception and SRH information.
- *C* (is the comparator group): the reported lack of access to PAC services in this review.
- *O* (refers to the outcome): adequate access to contraception and SRH information post-abortion.
- *S* (the study design): qualitative, quantitative and mixed-method studies were included in this review.

The research question the review sought to address was:

Does adequate access to post-abortion contraception and SRH increase uptake of contraception and SRH information in low- and middle-income counties?

Based on the *Assessing the Risk of Bias of Individual Studies in Systematic Reviews of Healthcare Interventions* guidelines,[12] the methods used for assessing risk of bias in the articles selected for review included:

1 Checking the internal validity or conduct of the studies
2 The external validity or applicability of the studies
3 Study design
4 The reporting of results
5 Fidelity of intervention if any
6 Choice of outcome measures
7 Conflict of interest reported.

Information sources

Using the PRISMA Guidelines, Flow Diagram and Checklist, a systematic literature search was conducted by the first author from April to November 2014, a second search carried out in May 2015, and a final search conducted in June 2016 in order to identify new papers.[11] Databases accessed in the search were: Ovid (MEDLINE), ProQuest, Science Direct, Web of Science, PUBMED and CINAHL, with additional articles sourced from the authors' records. References for the review were managed by the bibliographic software, Endnote X7, and a standard form was used to assist in data extraction.[13 14] Online supplementary Appendix 1 highlights the strategy used for the Ovid (MEDLINE) database search, which was used as a framework for subsequent database searches.

Study selection

Access to contraception within the context of this study relates to access to a wide range of contraceptive methods with the ability for a woman to make an informed decision, based on detailed and accurate information, regarding the method she feels would suit her best.[15 16] *SRH information* is a broad term and has been used to encompass the provision of information, education and counselling relating to: reproductive health, such as fertility return, fertility intention, child-spacing, prevention

of unwanted pregnancies, contraception methods and contraception use; sexual health advice, including information on signs of post-abortion complications and normal post-abortion symptoms, return to sexual activity advice, hygiene, sexually transmitted infection (STI)/HIV prevention, testing and treatment information; and information and/or referral to relevant and quality health services if needed.[7 15 17]

The following search terms were used in combination to guide the study: post-abortion; post-abortion care; contraception; family planning; sexual and reproductive health information; sexual and reproductive health and rights; and comprehensive abortion care. Searches were restricted to English language only papers published between 2000 and 2016, and restricted to peer-reviewed journal articles through database filters.

Data collection, analysis, extraction and assessment

An initial 164 articles were identified by the first author from the six databases and an additional 36 articles from the authors' personal files were added to the review for a combined total of 200 articles. After removal of duplicates, the remaining 168 papers were assessed based on Title with a resulting 114 articles removed as they did not meet the inclusion/exclusion criteria. Manuscripts without abstracts were excluded as they were non-research papers. Two articles were not retrievable; however, on further review of their Title and Abstract information it was decided that the papers were not relevant to the study as their reported findings did not specifically relate to the research question. Some 52 full-text papers relevant to the review were assessed based on Title and Abstract information, leading to the inclusion of 19 papers for full article review and data extraction.[18–35] Figure 1 presents the

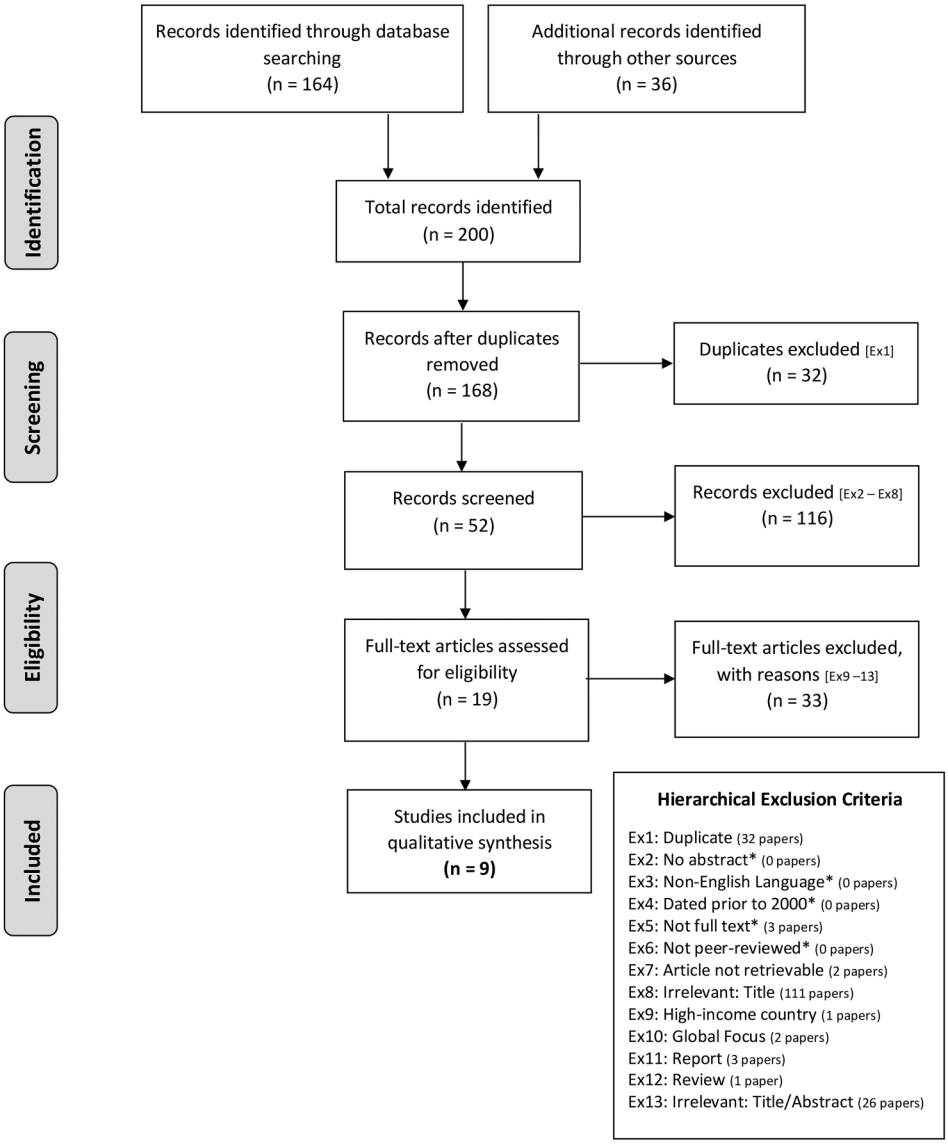

Figure 1 Systematic framework of the literature review process[11] (*when possible, selected as filters during initial database searches).

PRISMA Flow Diagram relating to this study and hierarchical exclusion criteria for article selection.

Both authors reviewed data extraction and synthesis for the final 19 articles selected for potential inclusion as well as the final nine selected papers. Online supplementary Appendix 2 displays the data extraction and synthesis of the 19 articles with potentiality for inclusion in the systematic review. Each of the 19 articles was examined to identify the role contraception access and the provision of SRH information for women post-abortion had within the study design and findings. Analysis of the articles involved the extraction and synthesis of relevant data into a standard form that was reviewed by both authors. As well as the detailed exclusion criteria, all articles also underwent quality assessment relating to the relevance of the study, the appropriateness of the research design and methodology, ethical considerations, and the journals in which the articles were published.[14]

RESULTS

After detailed appraisal, nine studies in total were selected for inclusion in the systematic review and are presented in Table 1.[19 21 23–25 29–31 35] These studies were undertaken in four different geographical regions and within seven different countries. While there were varying legal implications with regards to obtaining an abortion within the study settings, all nine studies were conducted within PAC services or facilities. These included 94 government/public facilities (63 hospitals and 31 clinics); four non-governmental facilities (two hospitals and two clinics); and one privately owned medical clinic.

Study characteristics

The review highlighted that studies did not specifically address access to contraception and SRH information post-abortion as the primary topic of research, the studies all discussed components of contraception access and uptake and the provision of various facets of SRH information to women post-abortion and were therefore selected for review. While studies concentrating on PAC provision for *spontaneous abortion* (miscarriage) and *term unintended pregnancies* (women admitted for delivery of an unintended pregnancy carried to term) were excluded from selection, one study included women from these two sets as control groups to compare with women seeking PAC services after unsafe abortion, and was therefore included.[19]

Participants in the nine studies were:

1 Women who were obtaining or had obtained PAC services only.[19 21 24 30]
2 Women who were obtaining or had obtained PAC services as well as PAC providers (including medical staff, doctors, nurses and healthcare workers).[23 25 29 31 35]

No PAC provider-only studies were included.[11 14] Three of the nine studies focused on post-abortion family planning services/contraception provision post-abortion[21 24 29] and six studies focused on PAC as a whole,[19 23 25 30 31 35] two of which incorporated generational aspects in their research.[25 30]

The research methodology employed in the articles included three quantitative studies;[19 21 24] three qualitative studies;[25 30 31] and three mixed-methods studies.[23 29 35] Nguyễn *et al*.[23] and McCarraher *et al*.[25] were research evaluations of PAC services which were components of larger implementation specifically designed to increase CAC (the CAC Project and CONECTA project, respectively). In total, quantitative data was obtained from 4595 individuals and qualitative data was provided by 1116 individuals across eight countries within the nine studies selected for this systematic review.

Narrative synthesis of article content

Owing to the relatively small number of studies found with specific reference to SRH information and contraception provision post-abortion, as well as the heterogeneity of the studies reviewed, a narrative synthesis of relevant outcomes reported in the chosen studies is presented.[14]

Access to contraception post-abortion

Barriers to contraception access for women who have undergone abortion are multifaceted and far reaching. In resource-poor settings physical access to a range of contraceptive methods can often be the first inhibitor for access for women.[21 25 31 35] In their 2010 evaluation of PAC services in the Dominican Republic, McCarraher *et al*. found that contraception was not available to PAC clients in some of the PAC facilities, and one-quarter of the study facilities visited were out of stock of one or more contraceptive methods. Some 21% of older women (aged 20–35 years) and 11% of adolescents (under 19 years of age) reported leaving the hospital without a contraceptive because the hospital did not have the type they wanted (the contraceptive methods were not specified).[25] The lack of contraceptive method availability combined with an absence of comprehensive contraception information and counselling has been highlighted as a barrier to contraception access and uptake.[19 21 23 25 29]

In Nepal, Rocca *et al*.[21] found that of the total sample population (n=838), one-third of the participants received no information or education on contraception choices, with over half of the sample population leaving abortion facilities without an effective method of contraception. Inadequate time for counselling, patient overcrowding, space limitations and lack of privacy are obstacles in the provision of effective counselling on post-abortion contraception.[19 21] These barriers are often compounded by lack of PAC provider training, insufficient knowledge of staff, and socioculturally insensitive communication

Table 1 Articles included for systematic review (for more detail please see online supplementary Appendix 2)

	Region	Country	Authors	Year	Title/journal	Policy/law	Setting/design/sample	Quality indicators
1	South Asia	Sri Lanka	Arambepola *et al.*[19]	2014	Usual hospital care vs post-abortion care for women with unsafe abortion: a case-control study from Sri Lanka *BMC Health Services Research*	Heavily restricted*[36]	Nine government hospitals in 8/24 districts of Sri Lanka Quantitative: unmatched case-control study ▶ 171 cases (unsafe abortion) ▶ 638 control Group 1 (spontaneous abortion) ▶ 600 control Group 2 (term unintended pregnancy)	▶ Ethical approval stated ▶ Representation of Muslim and Tamil populations assisting generalisability ▶ Limitations of study not adequately highlighted ▶ No competing interests ▶ Funding stated ▶ Reported findings relevant to review
2	South Asia	Nepal	Rocca *et al.*[21]	2014	Post-abortion contraception a decade after legalisation of abortion in Nepal *International Journal of Gynecology & Obstetrics*	Legal†[37]	Two non-government clinics and two public hospitals in Kathmandu and Terai region Quantitative: Prospective cohort study ▶ 838 questionnaires with women post-abortion (baseline and 6 months)	▶ Ethical approval stated ▶ Diverse recruitment sites and large sample assisting generalisability ▶ Limitations of study acknowledged ▶ No competing interests ▶ Funding stated ▶ Reported findings relevant to review
3	East Asia and Pacific	Vietnam	Nguyễn *et al.*[23]	2007	Situation analysis of quality of abortion care in the Main Maternity Hospital in Hải Phòng, Viet Nam *Reproductive Health Matters*	Legal‡[36]	One public hospital (Phu-San Hospital) Qualitative and quantitative: evaluation ▶ 748 structured survey pre/post-abortion ▶ 20 IDIs post-abortion ▶ 7 informal interviews with healthcare staff ▶ 100 participant observations	▶ Ethical approval stated, informed consent stated as obtained ▶ Quantitative data double entered by two different operators ▶ Limitations of study not adequately highlighted ▶ Competing interests/funding not stated ▶ Reported findings relevant to review
4	Latin America and the Caribbean	Mexico	Becker *et al.*[24]	2013	Women's reports on post-abortion family-planning services provided by the public sector legal abortion program in Mexico City *International Journal of Gynecology & Obstetrics*	Legal in study setting§[36 37]	Three government facilities: general hospital, maternity hospital and primary health centre Quantitative ▶ Survey of 402 women seeking first-trimester abortion care	▶ Ethical approval stated, informed consent stated as obtained ▶ Limitations of study discussed and recommendations for future studies given ▶ No competing interests ▶ Funding stated ▶ Reported findings relevant to review

Continued

Table 1 Continued

	Region	Country	Authors	Year	Title/journal	Policy/law	Setting/design/sample	Quality indicators
5	Latin America and the Caribbean	Dominican Republic	McCarraher *et al.*[25]	2010	Meeting the needs of adolescent post-abortion care patients in the Dominican Republic *Journal of Biosocial Science*	Strictly illegal¶[36 37]	Three public hospitals in Santo Domingo and one in La Romana Qualitative: evaluation of intervention Non-experimental pre/post-test design ▶ 88 IDI with providers ▶ 88 IDI follow-up with providers ▶ Survey 140 adolescent PAC patients (12–19 years) ▶ Survey 134 PAC patients (20–35 years)	▶ Ethical approval stated ▶ Limitations of study discussed and recommendations for future studies given ▶ Competing interests not stated ▶ Funding stated ▶ Reported findings relevant to review
6	Sub-Saharan Africa	Kenya	Tavrow *et al.*[29]	2012	Age matters: differential impact of service quality on contraceptive uptake among post-abortion clients in Kenya *Culture Health & Sexuality*	Legal with provisions**[37]	One private medical clinic Quantitative and quantitative ▶ Data from 1080 post-abortion clients ▶ 2 IDI with doctor	▶ Ethical approval stated ▶ Limited qualitative data, however, it serves to support the quantitative data ▶ Only one study site which impacts generalizability ▶ Limitations of study stated ▶ Competing interests not stated ▶ Funding stated ▶ Reported findings relevant to review
7	Sub-Saharan Africa	Kenya	Evens *et al.*[30]	2014	Post-abortion care services for youth and adult clients in Kenya: a comparison of services, client satisfaction and provider attitudes *Journal of Biosocial Science*	Legal with provisions[6 37]	Eight public hospitals in Central and Nairobi provinces Qualitative ▶ 283 IDI with PAC clients (structured phone interviews) ▶ 20 IDIs with providers (1 in person, 19 by phone)	▶ Ethical approval not clearly stated for this post-intervention study ▶ Limitations of study discussed and recommendations for future studies given ▶ Competing interests not stated ▶ Funding stated ▶ Reported findings relevant to review
8	Sub-Saharan Africa	Mozambique	Gallo *et al.*[31]	2004	An assessment of abortion services in public health facilities in Mozambique: women's and providers' perspectives *Reproductive Health Matters*	Legal††[36] *[NB. Abortion was legal with provisions at the time of the study.]*	37 public hospitals and four health centres in the 10 provinces of Mozambique Quantitative: interviews with closed-ended questionnaires ▶ 461 interviews with women receiving treatment for abortion-related complications ▶ 128 interviews with providers ▶ 18 interviews with specialised providers	▶ Ethical approval not clearly stated, informed consent stated as obtained ▶ Limitations of study not adequately discussed ▶ Competing interests/funding not stated ▶ Reported findings relevant to review

Continued

Table 1 Continued

	Region	Country	Authors	Year	Title/journal	Policy/law	Setting/design/sample	Quality indicators
9	Sub-Saharan Africa	Ethiopia	Tesfaye and Oljira[35]	2013	Post-abortion care quality status in health facilities of Guraghe zone, Ethiopia *Reproductive Health*	Legal with provisions‡‡[37]	26 centres, one public hospital, two non-government hospitals in Guraghe zone Qualitative and quantitative: cross-sectional study ▲ 422 IDIs with women seeking PAC service (client exit interviews)	▲ Ethical approval stated, informed consent stated as obtained ▲ Limitations of study stated ▲ No competing interests ▲ Reported findings relevant to review

*Sri Lanka: abortion is illegal with the explicit exception to save the women's life.
†Nepal: abortion is legal without restriction as to reason during the first 12 weeks of pregnancy, and thereafter on specific grounds.
‡Vietnam: abortion is legal without restriction as to reason; law does not indicate gestational limit.
§Mexico: federal system in which abortion law is determined at state level; in Mexico City abortion is legal without restriction during the first 12 weeks of pregnancy.
¶Dominican Republic: abortion, for any reason, is strictly prohibited.
**Kenya: abortion is legal to save a woman's life or health or where emergency treatment is needed.
††Mozambique: in 2014 abortion was legalised without restriction as to reason during the first 12 weeks of pregnancy, and thereafter on specific grounds. In 2004 when the study was conducted, it was legal only to save the women's life.
‡‡Ethiopia: abortion is legal to save a woman's life, to protect her health or in cases of rape, incest or fetal impairment. Also permitted when a woman is a minor, or physically or mentally injured or disabled.
IDI, in-depth interview; PAC, post-abortion care.

skills, which further impact access to information for women who need to make an informed decision regarding contraceptive use.[19 23 24 30] Rocca *et al*.[21] also noted that only 19% of research participants received information on three or more contraceptive methods and approximately 31% received information on two methods, while two-thirds of women reported receiving information on at least one effective method of contraception.[21] Lack of personalised contraceptive counselling, specifically relevant to the woman's life situation and previous contraceptive experiences, were also inhibitors to contraception uptake post-abortion.[23 24]

Arambepola *et al*.,[19] in their Sir Lankan study, demonstrated that women who accessed in-patient PAC services at a large public hospital in Sri Lanka did not receive sufficient post-abortion access to contraception when compared with the study control groups (spontaneous abortion and term unintended pregnancies) and that contraceptive uptake and use was less at 6–8 weeks after hospital discharge. Attitudes of healthcare staff towards of women accessing PAC services, particularly in counties where abortion is illegal or restricted, contribute to the barriers women face when accessing contraception information and methods post-abortion.[19 23–25 35]

The type of health service (i.e. government, non-government or private) has also been shown to have a direct link with post-abortion contraception access. Women utilising non-government or private facilities are more likely to receive information on contraceptive choices compared to women who attended public or government facilities.[21 24 29] The type of abortion procedure also shows correlation with lack of contraception access and uptake, with women accessing surgical abortions being more likely to receive information on, and access to, contraceptive methods compared to women having medical abortions.[21 24]

The reviewed studies also highlighted other barriers to access of contraceptive methods, information and education, such as: the gender of healthcare providers;[24] if the woman's husband is away for extended periods;[21] misconceptions regarding contraception;[29] if a woman is not sexually active;[24] or if the woman is an adolescent.[25 29 30]

Access to SRH information post-abortion

The provision of SRH information as an integral component of quality PAC services is often overlooked by service providers. Along with education regarding contraceptive options, discussing return to fertility is also an essential element of PAC.[3 7] Rocca *et al*.[21] found that only half of their study sample population were informed about fertility return during their PAC visit, and in their Mexico City study Becker *et al*.[24] reported 68% of their total research participants (n=402) were educated on return to fertility information.

In a study undertaken in the Dominican Republic in 2010, a high proportion of PAC service providers (>70%) reported they routinely asked PAC patients about their fertility intentions and counselled them on contraception, STI/HIV and post-abortion complications. However, compared with provider reports, far fewer PAC patients indicated they had received counselling and information on risk of pregnancy, fertility intentions, STI/HIV risk, contraception availability and post-abortion complication.[25] Similar discrepancies between provider and patient reporting was also detailed in a 2014 Kenyan study and 2004 study in Mozambique.[31] When asked about information provision, just over half of the participants in Evens *et al*.'s[30] study reported their provider had discussed return to fertility, HIV/STI information and testing, or provided information and access to contraception. In contrast, the vast majority of providers reported they routinely provide these services.

All studies reviewed revealed that post-abortion access to SRH information regarding SRH concerns and issues were inconsistently conveyed by PAC providers, if indeed at all. Gallo *et al*.[31] highlight that PAC clients in Mozambique have been shown to have high STI rates, yet few of their research participants reported receiving condoms or information regarding their sexual health and STI/HIV testing, treatment and prevention. Several studies also documented lack of information provision on important SRH issues including: fertility return and intention; child-spacing; preventing unwanted pregnancies; contraceptive methods and use; information on emergency contraception; information on danger signs of post-abortion complications and normal post-abortion symptoms; return to sexual activity advice; and post-procedure hygiene.[21 24 25 30 31 35]

DISCUSSION

A number of significant and intersecting themes concerning inhibitors to access of contraception and SRH information post-abortion emerged in the narrative content synthesis of the review. These include: lack of comprehensive information and education on a broad choice of contraception methods; insufficient commodity supply; provider attitudes; the type of service provider (government/public, nongovernment, private); as well as lack of effective and consistent SRH information and education provision to women post-abortion.

Similar to findings documented in several of the papers in review,[19 21 24] a six country United States Agency for International Development (USAID) study on interventions to strengthen contraceptive counselling and services also found that with effective contraceptive counselling, there is a marked increase in the number of women accepting contraception post-abortion.[2 38] However, as McCarraher *et al*.[25] state, improved contraceptive counselling is only one strategy to increase contraceptive uptake; availability of a broad range of contraceptive methods through consistent and effective commodity supply is fundamental for women in accessing their contraceptive method of choice post-abortion.

Judgmental (or perceived judgmental) provider attitudes have been shown to create barriers to access of contraception and SRH information post-abortion. Abortion-related stigma stems from the challenges abortion presents to social, cultural and religious beliefs.[39 40] This stigma permits myths about abortion to propagate, can lead to shame and harassment and, particularly in countries where abortion is illegal or restricted, can be a barrier to women accessing high-quality PAC services.[2 39 40] Inconsistencies in service provision across various provider facilities (government/public, non-government and private) has also been found to create barriers to access to contraception and SRH information post-abortion. While private facilities may offer comprehensive PAC, their provider fees deter women from accessing services. Alternatively, services provided (often free of charge) from government facilities lack the human resources to effectively provide adequate time to clients and may lack trained PAC providers.

Throughout the literature, the provision of SRH information in the form of counselling is inconsistently described. *Counselling* has been used to describe the provision of information and education specifically on contraception, while at other times the term has been used to describe more comprehensive provision of SRH information, closely related to the PAC Consortium definition of the term.[6 7] While all nine studies emphasised issues relating to the provision of contraception and contraception counselling in PAC, no papers comprehensively addressed the provision of SRH information to PAC clients. However, five of the nine papers investigated components of SRH information (other than contraception information). This information related to: return to fertility or fertility intentions;[21 25 30 31] STI/HIV information and/or testing;[24 25] post-abortion complications;[24 25 31 35] and emergency contraception.[24] The paucity of literature specifically relating to the provision of SRH information to women post-abortion is testament to the need for greater research on this topic.

Limitations

Lack of generalisability was a consistent limitation within all the reviewed studies, with several studies highlighting sampling and data collection difficulties such as participant recruitment and sample size as impacting the ability for generalisation to the wider population.[19 24 29 30] The use of self-reporting questionnaires within several of the studies has the potential to create social desirability and response bias.[19 23 24 33 35] Interviewer and response bias may also play a role within the qualitative aspects of

several of the studies.[23 25 29 30 33] The sensitive nature of the topic and sociocultural beliefs regarding abortion may have been limiting factors within these studies, however, none of the papers reviewed addressed this issue adequately. The review was also restricted to articles published in English, and only the first author performed the first round of screening. While every consideration has been given to the context, characteristics and quality of the studies appraised, as this systematic review reports on studies from various demographic regions and countries, with varying policy regarding the legality of access to abortion services, the findings of this review must be considered within these parameters.

Recommendations

This systematic review highlights the lack of current literature relating to women's access to contraception and SRH information post-abortion. While the findings reiterate much of the current understanding regarding the complexities surrounding women's access to contraception post-abortion, they also uniquely highlight the inconsistencies relating to what providers consider *counselling* and SRH provision in PAC services.[7] Further research on the type and quality of SRH information provided during PAC counselling is urgently needed to determine the scope and consistency of counselling currently being provided. This information has the potential to inform detailed PAC counselling frameworks that can assist PAC providers to more effectively meet women's post-abortion information and educational needs.

The review indicated that with access to a wide range of contraceptive methods together with comprehensive SRH information and education, contraception uptake in women post-abortion was shown to increase. However, inconsistency in effective service provision; judgmental (or perceived judgmental) attitude of service providers to patients; restricted access to services and comprehensive SRH information; and the lack of availability of a broad range of contraceptive choices, continue to inhibit women's access to contraception and SRH information, post-abortion. Further research is needed to examine and document these barriers to post-abortion contraception and SRH information and to highlight the need for effective and equitable PAC provision for women and girls in low- and middle-income countries.

CONCLUSION

Abortions continue to impact the health and lives of women and girls around the world whether legally allowed or restricted. This review highlights a critical need and that access to affordable, equitable and high-quality PAC services reduces morbidity and mortality resulting from incomplete and unsafe abortion and post-abortion complications. Through effective and equitable PAC, timely access to contraceptive methods and comprehensive SRH information is a key factor in assisting women to space births, prevent unintended pregnancies, avert unsafe abortions, and support women to make informed decisions and take control of their SRH and rights.

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Appendix D.

Search Strategy Example: Ovid (MEDLINE)

	Search Strategy	Articles Retrieved
1	post abortion care.mp.	111
2	postabortion care.mp.	114
3	post-abortion care.mp.	111
4	comprehensive abortion care.mp.	19
5	postabortion.mp.	677
6	post-abortion.mp.	508
7	post abortion.mp.	508
8	1 or 2 or 3 or 4 or 5 or 6 or 7	1159
9	contraception/	17242
10	contracept*.tw.	56161
11	family planning/	23264
12	family planning.tw.	17647
13	(sexual and reproductive health information).mp.	67
14	(sexual and reproductive health and rights).mp.	492
15	9 or 10 or 11 or 12 or 13 or 14	77925
16	developing country/	67790
17	low-and middle-income countries.mp.	3330
18	15 or 16	137164
19	8 and 15 and 18	556
20	limit 19 to (English language and full text and yr="2000 - 2015")	**26**

The 20 step Medline (OVID) search strategy yielded 26 relevant articles. The example and search terminology were used as a framework for subsequent ProQuest, Science Direct, Web of Science, PUBMED and CINAHL database searches.

Ovid (MEDLINE) Search Strategy Key[1]:

<term>.mp. The fields searched by a .mp. include Title, Original Title, Abstract, Subject Heading, Name of Substance, and Registry Word fields.

<term>/ In databases with a controlled vocabulary this command searches a known subject heading directly, bypassing mapping.

<term>* or <term>$ Unlimited truncation retrieves all possible suffix variations of the root word indicated.

<term>tw The Text Word (TW) index is an alias for all of the fields in a database which contain text words and which are appropriate for a subject search. The Textword index in Ovid MEDLINE (R) includes Title (TI) and Abstract (AB).

1. Ovid MEDLINE 2016 Database Guide. Secondary 2016 Database Guide 2016. http://ospguides.ovid.com/OSPguides/medline.htm#stopwords.

Appendix E.

Quality assessment of the 19 studies reviewed for possible inclusion in the systematic review

Study	Region	Location and Policy/Law	Design and Quality Indictors	Sample/Participants and Setting	Aim	Key Findings
Acharya and Kalyanwala (2012) [1]	**South Asia**	India (abortion legal but limited access)	Quantitative Structured questionnaire • Ethical approval stated • Only service providers sampled – study focus on providers' knowledge, attitudes and practices of abortion provision • Contraception provision and SRH information not detailed in key findings of article • No competing interests • Funding stated • **Reported findings do not adequately relate to research question**	• 170 IDIs with physicians who were certified as abortion providers • Location: Bihar and Maharashtra states	To explore Indian abortion providers' knowledge of medical abortion (MA), their personal experiences and practices of providing medical abortion, and their attitudes toward providing MA to eligible women who were poor, uneducated, and/or from rural areas.	• 97% providers discussed contraception (no difference between rural and urban providers). • Providers counselled their patients about contraception on the day MA was administered. • Providers also advised women about a range of contraceptive methods, including permanent methods. • Despite their counselling, most providers estimated that no more than half of their patients had opted for a method of contraception, and used it following an abortion.
Arambepola *et al.* (2014) [2]	**South Asia**	Sri Lanka	Quantitative	• 171 Cases following unsafe abortion	To assess PAC given to women following	• Cases were dissatisfied with their overall care during hospital stay, predominantly due

STUDY 1		(abortion illegal/heavily restricted)	Unmatched case–control study • Ethical approval stated • Representation of Muslim and Tamil populations assisting generalisability • Limitations of study not adequately highlighted • No competing interests • Funding stated • **Reported findings relevant to review**	• 638 controls following spontaneous abortion (SA-controls) • 600 women following delivery of an unintended pregnancy (TUP-controls) • Location: 9 hospitals in eight out of 24 districts.	an unsafe abortion, compared to the routine hospital care following spontaneous abortion (SA) or unintended pregnancy carried to term (TUP).	to verbal harassment of health-care-providers on their abortion status (57.9% versus 19.3% SA-controls, $p < 0.05$). • Ward-midwives did not contribute to family planning care of Cases. At 6–8 weeks, 48.9% of Cases were on contraceptive methods, predominantly short-term, compared to 85.3% of TUP-controls, predominantly long-term methods ($p < 0.01$). • Despite equitable emergency treatment, care following unsafe abortion was deficient in post-abortion counselling, education and family planning services.
Azmat *et al.* (2012) [3]	**South Asia**	Pakistan (abortion is illegal - legal only to save women's life)	Qualitative • Ethical approval stated, informed consent stated as obtained • Impact of contraception and SRH information provision post-abortion not clearly detailed in key findings of article • Limitations of study not adequately addressed • No competing interests • Funding stated • **Reported findings do not adequately relate to research question**	• 8 FGD with PAC clients • 15 IDIs with RHVs • 76 quantitative exit interview questionnaire with clients. • Location: 6 randomly selected districts of Sindh and Punjab	Establish the socio-demographic profile of clients, determine their preferred method of treatment, explore their perceptions of the barriers to accessing post-abortion services and to understand the challenges faced by RHVs.	• Medical, rather than surgical, treatment for incomplete and unsafe abortions preferred. • Household economics influence women's decision-making on seeking post-abortion care. • Other restraining factors include: objection by husbands and in-laws, restrictions on female mobility, the views of religious clerics and a lack of transport.

Rocca *et al.* (2014)[4] **STUDY 2**	**South Asia**	Nepal (abortion legal)	Quantitative Prospective cohort study • Ethical approval stated • Diverse recruitment sites and large sample assisting generalisability • Limitations of study acknowledged • No competing interests • Funding stated • **Reported findings relevant to review**	• 838 questionnaires with women post abortion (baseline and 6 months) • Location: Two non-government clinics and two public hospitals in Kathmandu and Terai region	To assess the contraceptive information received and methods chosen, received, and used among women having abortions one decade after legalization of abortion in Nepal	• 1/3 of participants received no information on effective methods • 56% left facilities without a method. • Levels of contraceptive use after medical abortion were on par with those after aspiration abortion. • Nulliparous women were far less likely than parous women to receive information and use methods. • Women living without husbands or partners were also less likely to receive information and supplies, or to use methods.
Htay *et al.* (2003) [5]	**East Asia and Pacific**	Myanmar (abortion is illegal - legal only to save women's life)	Qualitative and Quantitative • Ethical approval not clearly stated • Key findings focused on SRH policy • Data collection and analysis methodology not clearly detailed • Limitations of study not adequately addressed • Competing interests/funding not stated • **Reported findings do not adequately relate to research question**	• 170 surveys with women treated for post-abortion complications • 122 surveys with hospital and clinic staff • 163 surveys with volunteer community health providers • n? focus group discussions hospital/ clinic staff and village volunteer health staff • Location: Bago Division.	To assess the quality of post-abortion care by the Department of Health, using a baseline survey of health providers and post-abortion women	Key findings focused on SRH policy. Other relevant findings: • Village women delay seeking care for post-abortion complications after an induced abortion for two main reasons: fear of neighbours knowing and fear that health staff in the hospital would blame them. • The cost of treatment was not a big factor in the decision to delay seeking care. • Of the women with post-abortion complications • Of those who wished to practise family planning, most (93%) received a contraceptive method before discharge from hospital. Of these, 98.3% had the method options explained to them by staff but 5.3% did not get the contraceptive method they preferred.

Nguyễn *et al.* (2007)[6] **STUDY 3**	**East Asia and Pacific**	Vietnam (abortion legal)	Qualitative and Quantitative Evaluation • Ethical approval stated, informed consent stated as obtained • Quantitative data Double entered by two different operators • Limitations of study not adequately highlighted • Competing interests/funding not stated • **Reported findings relevant to review**	• 748 structured survey with women before and after abortion • 20 IDIs with women just after abortion • 7 informal interviews with health care staff • 100 participant observations • Location: Main maternity hospital in Ha¸i Pho`ng, Northern Viet Nam	Explored the interaction between providers and women seeking abortion and how cultural values influenced quality of care.	• Insufficient knowledge and skills had a negative impact on provision of information and good quality counselling in relation to understanding and uptake of contraception, treating reproductive tract infection and preventing post-abortion infection. • Training programmes are needed that integrate counselling and clinical skills and address the cultural factors that hinder health staff and women from interacting in an equitable manner.
Becker *et al.* (2013)[7] **STUDY 4**	**Latin America and the Caribbean**	Mexico (abortion strictly regulated - Mexico City, is the only city where abortion is legal - within first trimester)	Quantitative • Ethical approval stated, informed consent stated as obtained • Limitations of study discussed and recommendations for future studies given • No competing interests • Funding stated • **Reported findings relevant to review**	• Survey of 402 women seeking first-trimester abortion care • Location: Public facilities in Mexico City	To investigate patients' views of family planning services provided during abortion care and their acceptance of post-abortion contraception.	• 328 women (81.6%) reported being offered contraception at their visit and • 359 (89.5%) selected a contraceptive method for post-abortion use • Women who underwent surgical abortion were more likely than those who underwent medical abortion to report being offered contraception (Pb0.001) • Women attended by a female physician were more likely than those attended by a male physician to report being offered contraception (Pb0.05).

						• Women who attended the general hospital were less likely to report being offered contraception (Pb0.001).
McCarraher *et al.* (2010) [8] **STUDY 5**	**Latin America and the Caribbean**	Dominican Republic (abortion illegal)	Qualitative Evaluation of intervention Non-experimental pre/post-test design (analysis: SAS 9.1) • Ethical approval stated • Limitations of study discussed and recommendations for future studies given • Competing interests not stated • Funding stated • **Reported findings relevant to review**	• 88 IDI with providers • 88 IDI follow-up with providers • Survey 140 adolescent PAC patients (12–19y) • Survey 134 PAC patients (20–35y) • Location: 4 public hospitals in the Dominican Republic where PAC services are not being routinely offered	Evaluate an intervention whose goal was to improve the counselling and contraceptive uptake of PAC patients, with special attention given to the needs of adolescent patients.	• No changes noted in provider-reported PAC counselling behaviours, 70% of providers reporting they routinely assess patients' fertility intentions, discuss contraception, assess STI/HIV risk and discuss post-abortion complications. • Adolescent and older PAC patients reported receiving PAC counselling messages at similar rates. • 40% of adolescent PAC patients and 45% of older PAC patients who wanted to delay pregnancy were discharged with a contraceptive method. • Adolescents more likely to receive an injectable contraceptive method whereas older women were discharged with a variety of methods.
Esber *et al.* (2014) [9]	**Sub-Saharan Africa**	Tanzania (abortion illegal, except to save life or physical/mental health)	Quantitative Cross-sectional, clinic-based study • Ethical approval stated, informed consent stated as obtained • Limitations of study addressed • Funding stated	• 193 women surveyed • Location: 1 large public hospital in Zanzibar	Examined the effect of partner approval of contraception on intention to use contraception among women obtaining post-abortion care in Zanzibar.	• 23% of participants had used a contraceptive method in the past • 66% reported intending to use contraception in the future. • Partner approval of contraception and ever having used contraception in the past were each associated with intending to use contraception in the future. • Partner approval of contraception was associated with 20 times the odds of intending to use contraception.

			• Key findings do not address SRH information provision by service provider • **Reported findings do not adequately relate to research question**			
Kalu *et al.* (2012)[10]	**Sub-Saharan Africa**	Nigeria (abortion illegal, except to save life or physical/mental health)	Quantitative Descriptive study • Ethical approval not clearly stated • Limitations of study addressed • Competing interests/funding not stated • Key findings do not specifically address post-abortion contraception and SRH information provision • **Reported findings do not adequately relate to research question**	• Data on PAC over a 5-year period analyzed • Standardized questionnaire administered to 45 direct PAC service providers. • Location: Ebonyi State University Teaching Hospital, Abakaliki, Nigeria.	Review the implementation of PAC and effective linkage to other post abortion services.	• Abortion complications constituted 41.4% of all Gynaecological admissions. • Maternal mortality from complications of abortion was 11.5% of all the maternal mortality at the centre. • 37 women aged ≥19 years and 132 single women constituted 25.3% of all cases. • Around 31% of the PAC care providers had formal training in PAC provision. • 15% of the care givers were satisfied with the linkage between PAC and the Family Planning services.
Etuk *et al.* (2003)[11]	**Sub-Saharan Africa**	Nigeria	Qualitative	• 48 private practitioners interviewed using structured questionnaire	Examined the knowledge, attitude and practice of	• 22.9% of the doctors routinely terminate unwanted pregnancies when requested by women.

		(abortion illegal, except to save life or physical/mental health)	• Ethical approval not clearly stated, informed consent stated as obtained • Small sample size (n=48) • Funding stated • Competing interests not declared or denied • Data analysis methodology not detailed • While the reported findings are relevant to the research questions as Ethical approval for the research cannot be confirmed, data analysis methodology was not stated and the sample size was extremely small, this article is not included for review.		private medical practitioners in Calabar on abortion, post-abortion care and post-abortion family planning	• Reasons for not wanting to terminate pregnancy (practitioner): religious, moral and ethical considerations, rather than Nigerian law. • Many did not routinely practice integrated post abortion family planning and STD management.
Tavrow *et al.* (2012)[12] **STUDY 6**	**Sub-Saharan Africa**	Kenya (abortion illegal, except to save life or physical/mental health)	Quantitative and Quantitative • Ethical approval stated • Limited qualitative data, however, it serves to support the quantitative data	• Data from 1080 post-abortion clients • 2 IDI with doctor • Location: private clinic in a small Kenyan town	Analyses the impact of high quality, user-friendly, comprehensive sliding-scale post-abortion services on clients' uptake of contraception.	• All clients received confidential family planning counselling and were offered a complete range of contraceptives at no additional cost. • Prior to the abortion, no client aged 10–18 years reported having used contraception, as compared to 60% of clients aged 27–46 years.

			• Only one study site which impacts generalizability • Limitations of study stated • Competing interests not stated • Funding stated • **Reported findings relevant to review**			• After the abortion and family planning counselling session, only 6% of clients aged 10–18 chose a method, as compared to 96% of clients aged 27–46, even though contraception was free. • Significant predictors of contraceptive uptake post-abortion were: having a child, a previous termination, prior contraceptive use and being older than 21.
Evens *et al.* (2014)[13] **STUDY 7**	**Sub-Saharan Africa**	Kenya (abortion illegal, except to save life or physical/mental health)	Qualitative • Ethical approval not clearly stated for this post-intervention study • Limitations of study discussed and recommendations for future studies given • Competing interests not stated • Funding stated • **Reported findings relevant to review**	• 283 IDI with PAC clients (structured phone interviews) • 20 IDIs with providers (1 in person, 19 by phone) • Location: 8 health facilities in Kenya's Central and Nairobi provinces (or participant contacted by phone)	Examine receipt of PAC services by client age, client satisfaction and provider attitudes.	• Delivery of PAC treatment, pain management, HIV and STI services and violence screening did not vary by age. • Fewer youth between the ages of 15 and 24 received a contraceptive method compared with adult clients (35% versus 48%; p ¼ 0.02). • Forty-nine per cent of youth reported not using a family planning method due to fears of infertility, side-effects or lack of knowledge compared with 22% of adults.
Gallo *et al.* (2004) [14] **STUDY 8**	**Sub-Saharan Africa**	Mozambique (at time of study: abortion illegal, except to save life	Quantitative Interviews with closed-ended questionnaires	• 461 interviews with women receiving treatment for abortion-related complications • 128 interviews with providers	Baseline assessment of abortion care services in the public health sector to inform efforts to reduce maternal	• Less than half the women said they received follow-up care information. • 27% of women wanting to avoid pregnancy said they had received a contraceptive method.

		or physical/mental health. Legalised in 2014)	• Ethical approval not clearly stated, informed consent stated as obtained • Limitations of study not adequately discussed • Competing interests/funding not stated • **Reported findings relevant to review**	• 18 interviews with specialised providers • Location: 37 public hospitals and four health centres in the ten provinces of Mozambique.	morbidity and mortality.	• Clinical procedures such as universal precautions to prevent infection were less than adequate, in-service training was less than comprehensive in most cases, and few facilities reviewed major complications or deaths. Use of dilatation and curettage was far more common than medical or aspiration abortion methods.
Jackson, *et al.* (2011)[15]	**Sub-Saharan Africa**	Malawi (abortion illegal, except to save life or physical/mental health)	Qualitative • Ethical approval not clearly stated • Strategic Assessment • Limitations of study not adequately addressed • Funding stated • Key findings do not specifically focus on post-abortion contraception and SRH information provision • **Reported findings do not adequately relate to research question**	• IDIs with 485 people in 10 of Malawi's 28 districts	To assess sexual and reproductive health, maternal mortality and unsafe abortion, conducted with Malawians from all parts of the country and social strata.	• Legal abortion believed to be rare, provided at the discretion of specialists, available only at the tertiary care level, and entailed cumbersome approval processes. • Prevention of unintended pregnancy is necessary to reducing abortion-related mortality in Malawi • Contraception use limited (access, misconceptions)

Kinaro *et al.* (2009)[16]	**Sub-Saharan Africa**	Sudan (abortion illegal, except to save life or in the case of rape)	Qualitative and Quantitative • Ethical approval stated, informed consent stated as obtained • Limitations of study not addressed • Data analysis methods not adequately detailed • Competing interests/funding not stated • Key findings do not address SRH information provision by service provider (other than contraceptive counselling) • **Reported findings do not adequately relate to research question**	• 726 Women surveyed (15-49y), seeking abortion or post-abortion care (during 3-month study period) • Collection of data from their hospital medical records • 2 FDG with community leaders (7 men, 8 women) • 1 IDI with a mid-level provider. • Location: Khartoum, Sudan	Gather new information on safe abortion services and PAC in Sudan, the quality of care provided, the methods of abortion used, and the characteristics of the women seeking services. Discover abortion related attitudes and knowledge of community leaders.	• Small number of doctors providing abortion and PAC in hospital setting, mid-level providers, (nurses and midwives), are accessible at the community level and are often the first choice of women needing abortions. • Only 1/3 of the women in this study were provided with contraceptive counselling and information and only 12.3% of women went home with a method. • Long waiting times in hospital an issue: 14.5% had to wait for 5-8 hours and 7.3% for 9-12 hours.
Paul *et al.* (2014)[17]	**Sub-Saharan Africa**	Uganda (abortion illegal, except to save life or physical/mental health)	Qualitative • Ethical approval stated, informed consent stated as obtained • Only service providers sampled – study focus on providers' knowledge, attitudes and practices of PAC	• 27 IDIs with health care providers of post-abortion care • Location: 7 health facilities in the Central Region of Uganda.	Explore physicians' and midwives' perceptions of post-abortion care, with regard to professional competences, methods, contraceptive counselling and task	• Post-abortion care was perceived as necessary, albeit controversial and difficult to provide. • Task sharing was generally taking place and midwives were identified as the main providers, although they would rarely have the proper training in post-abortion care. • Midwives were sometimes forced to provide services outside their defined task area, due to the absence of doctors.

			provision as well as PAC task-sharing • Limitations of study detailed • Post-abortion contraception and SRH information provision not specifically detailed in key findings • No competing interests or funding for the study • **Reported findings do not adequately address research question**		shifting/sharing in PAC.	
Tagoe-Darko (2013)[18]	**Sub-Saharan Africa**	Ghana (abortion illegal, except to save life or physical/mental health)	Qualitative • Ethical approval not clearly stated, informed consent stated as obtained • Data analysis methodology not adequately detailed • Limitations of study discussed • Competing interests/funding not stated • Contraception provision and SRH information	• 6 FGD with 50 participants in total • 10 narratives • Location: Komfo Anokye Teaching Hospital in Kumasi, Ghana	Explore evidence of social stigma as a factor in post abortion car	• Distinction between contraception and abortion not always clear. • Misconception and limited uptake on contraception. • Social stigma as a significant factor in the process of pre-marital sex, abortion and post abortion care. • At the individual level there was fear, shame and embarrassment. • Medical staff were perceived as judgmental, indifferent and/or showing disdain.

			not detailed in key findings of article • **Reported findings do not adequately address research question**			
Tesfaye (2013) [19] **STUDY 9**	**Sub-Saharan Africa**	Ethiopia (abortion illegal, except to save life or physical/mental health and rape)	Qualitative and Quantitative Cross-sectional study • Ethical approval stated, informed consent stated as obtained • Limitations of study stated • No competing interests • **Reported findings relevant to review**	• 422 women seeking PAC service IDI • Location: 8 health facilities in Guraghe zone, Ethiopia.	Assess post abortion care quality status in health facilities of Guraghe zone.	• More than half 226(56.5%) of the clients have received post abortion family planning. • Overall, 83.5% of the patients were satisfied with the services. • Those who said waiting time was long were less satisfied and unemployed women were more satisfied than others. • Information provision: 302(75.5%) of the post abortion cases received information on current illness and family planning counselling,

Refereces

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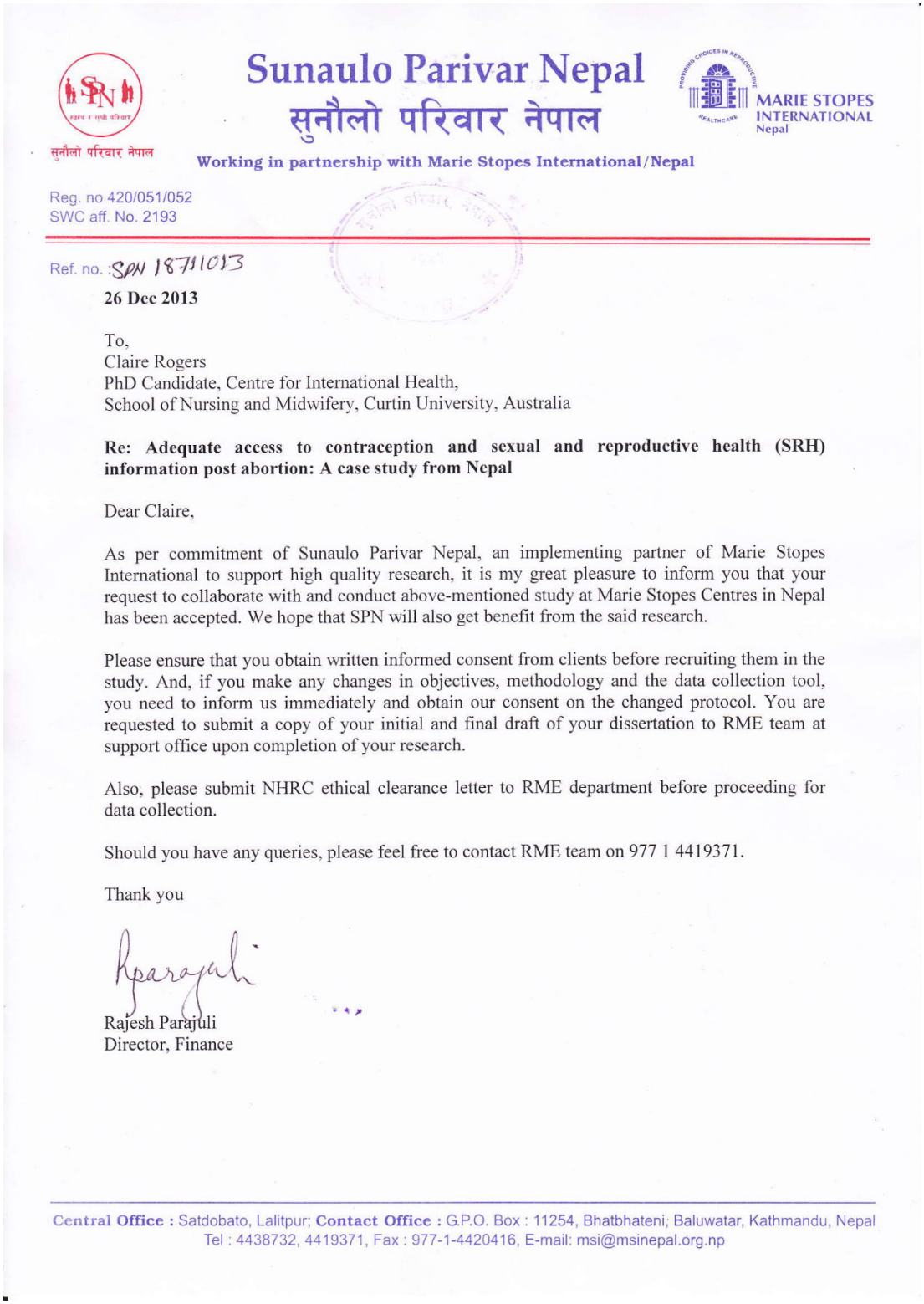
Appendix F.

Letter of Collaboration: Sunaulo Parivar Nepal/Marie Stopes International Nepal



Sunaulo Parivar Nepal
सुनौलो परिवार नेपाल

सुनौलो परिवार नेपाल

MARIE STOPES INTERNATIONAL Nepal

Working in partnership with Marie Stopes International/Nepal

Reg. no 420/051/052
SWC aff. No. 2193

Ref. no. :SPN 18711013

26 Dec 2013

To,
Claire Rogers
PhD Candidate, Centre for International Health,
School of Nursing and Midwifery, Curtin University, Australia

Re: Adequate access to contraception and sexual and reproductive health (SRH) information post abortion: A case study from Nepal

Dear Claire,

As per commitment of Sunaulo Parivar Nepal, an implementing partner of Marie Stopes International to support high quality research, it is my great pleasure to inform you that your request to collaborate with and conduct above-mentioned study at Marie Stopes Centres in Nepal has been accepted. We hope that SPN will also get benefit from the said research.

Please ensure that you obtain written informed consent from clients before recruiting them in the study. And, if you make any changes in objectives, methodology and the data collection tool, you need to inform us immediately and obtain our consent on the changed protocol. You are requested to submit a copy of your initial and final draft of your dissertation to RME team at support office upon completion of your research.

Also, please submit NHRC ethical clearance letter to RME department before proceeding for data collection.

Should you have any queries, please feel free to contact RME team on 977 1 4419371.

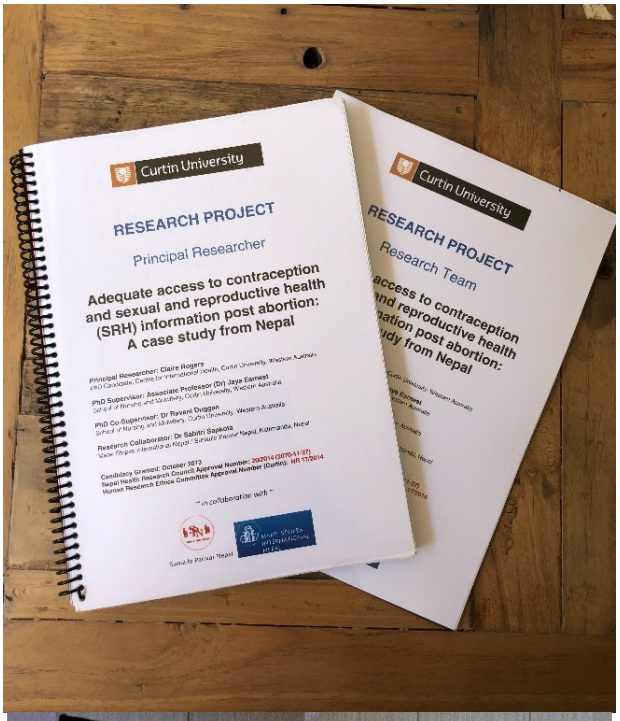
Thank you

Rajesh Parajuli
Director, Finance

Central Office : Satdobato, Lalitpur; Contact Office : G.P.O. Box : 11254, Bhatbhateni; Baluwatar, Kathmandu, Nepal
Tel : 4438732, 4419371, Fax : 977-1-4420416, E-mail: msi@msinepal.org.np

Appendix G.

Research Booklets and Phase 2 Working Area, Itahari, Sunsari District (photographs)



Appendix H.

Informed Consent Form (English)

Centre for International Health
School of Nursing and Midwifery
Faculty of Health Sciences

Adequate access to contraception and sexual and reproductive health (SRH) information post abortion: A case study from Nepal

Consent Form for Participants

Claire Rogers and Associate Professor Jaya Earnest from the Centre for International Health are the lead researcher and supervisor for this research, respectively.

- I have read the information sheet for this project and have agreed to participate in the study.
- I am participating voluntarily and understand that I can withdraw from the study at any time.
- I am sharing information with the understanding that my answers will be kept confidential and that my name will not be associated with my answers.
- I am able to ask questions of the project at any time

I understand that my answers will be added together with answers from other participants and our answers may be used in reports and publications and I agree to this as long as my name or any other information that identifies me is not used.

I am happy for this Interview to be recorded. □ YES □ NO

Signed …….

Print Name……

Date……/……/

Appendix I.

Informed Consent Form (Nepali)

कर्टिन विश्वविद्यालय
अन्तर्राष्ट्रिय स्वास्थ्य केन्द्र
नर्सिङ तथा प्रसुती विज्ञ विभाग
स्वास्थ्य विज्ञान संकांय

गर्भपतन पश्चात् यौन, प्रजनन् स्वास्थ्य र गर्भधारण निरोधक विधि सम्बन्धी पर्याप्त पहुच : नेपाल सम्बन्धी एक घटना अध्ययन

सहभागीहरुको लागि मञ्जुरीपत्र

मिति : .....

Claire Rogers र सहप्राध्यापक Jaya Earnest यस अनुसन्धान सम्बन्धी अन्तर्राष्ट्रिय स्वास्थ्य केन्द्रका क्रमशः मुख्य अनुसन्धानकर्ता र सुपरीवेक्षक हुनुहुन्छ ।

- मैले यस अनुसन्धान सम्बन्धी विभिन्न जानकारीहरुको अध्ययन गरेको छु र यस अध्ययनमा सहभागी हुन मञ्जुर छु ।

- मेरो आनो स्वेच्छाले यस कार्यक्रममा भाग लिएको छु र कुनै पनि बेला यदि नचाहेमा सहभागी हुनबाट आफूलाई फिर्ता गर्न सक्नेछु ।

- मैले राम्ररी बुझेर मेरा जानकारीहरु प्रदान गरेको छु किनकी, मेरा सम्पूर्ण जानकारीहरु गोप्य राखिनेछन् र मेरो परिचय मेरो प्रश्नोत्तरसग सम्बन्धित हुने छैन ।

- मैले यस परियोजना सम्बन्धी कुनै पनि बेला आफूलाई लागेका जिज्ञासाहरु राख्न सक्नेछु ।

मलाई विश्वास छ, मेरा उत्तरहरु अरु सहभागीहरुका उत्तरहरुसागै समावेश गरिने छ र मैले दिएका जानकारीहरु र विवरणहरु प्रकाशित हुने छन् । यसका साथसाथै मलाई विश्वास छ मेरो परिचय र मैले दिएका जानकारीहरु गोप्य रुपमा प्रकाशित हुनेछन् ।

मेरो अन्तरवार्ता रेकर्ड गर्नको लागि म सहमत छु : छु ☐ छैन ☐

दस्तखत : .....

नाम : .....

मिति : .....

Appendix J.

SRHR Professional Participant Information Sheet (English)

Centre for International Health
School of Nursing and Midwifery
Faculty of Health Sciences

Participant Information Sheet

SRHR Professionals

Adequate access to contraception and sexual and reproductive health (SRH) information post abortion: A case study from Nepal

I am undertaking a participatory study that aims to explore, document and examine the post abortion SRH experiences of Nepalese women and their access to contraception and sexual and reproductive health (SRH) information. My name is **Claire Rogers from the Centre for International Health, Curtin University, Western Australia** and I am the lead investigators for this project.

The **main aim** of this research is to hear the stories and experiences of women who have had an abortion and what their opinions and views are regarding access to contraception and SRH information after they have had the procedure.

Your experiences and opinions gained through working SRH in Nepal are a valuable insight into the current state of women's health.

We would be most grateful if you could spare the time to assist in this project. This would involve:

- Participating in a 60 minute interview (refreshments will be provided)
- Being asked questions regarding your perspective and experiences working in SRH.

Any information you share with us will be treated in the strictest confidence and you will not be identified in the resulting report. You are free to stop participating in the project at any time or to decline to answer any particular questions. A copy of the report and results will be shared with you.

Please feel free to contact the researchers, if you have any questions or anything further you would like to add.

THANK YOU VERY MUCH FOR TAKING THE TIME TO TALK TO US

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This study has been approved by the Curtin University Human Research Ethics Committee (Approval Number HR17/2014). The Committee is comprised of members of the public, academics, lawyers, doctors and pastoral carers. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University, GPO Box U1987, Perth 6845 or by telephoning 9266 9223 or by emailing hrec@curtin.ed

Appendix K.

SRHR Professional Participant Information Sheet (Nepali)

कर्टिन विश्वविद्यालय
अन्तर्राष्ट्रिय स्वास्थ्य केन्द्र
नर्सिङ तथा प्रसुती विज्ञ विभाग
स्वास्थ्य विज्ञान संकाय

गर्भपतन पश्चात् यौन, प्रजनन् स्वास्थ्य र गर्भधारण निरोधक विधि सम्बन्धी पर्याप्त पहुँचुँच : नेपेपाल सम्बन्धी एक घटना अध्ययन

सहभागीहरुको लागि जानकारी पत्र

जानकारी दिने मुख्य व्यक्तिको अन्तरवार्ता : यौनैन तथा प्रजजनन् स्वास्थ्य पेशा सम्बन्धी व्यक्तिहरु

मेरो अध्ययनले नेपाली महिलाहरुको गर्भपतन पश्चात् हुने यौन र प्रजनन् स्वास्थ्य सम्बन्धी खोज, प्रामणिक लेखोट र परीक्षण गरी तिनीहरुको गर्भनिरोधक विधि सम्बन्धी पहुँच, यौन र प्रजनन् स्वास्थ्य सम्बन्धी जानकारी दिनेछ । **मेरो नाम Claire Rogers हो । म अन्तर्राष्ट्रिय स्वास्थ्य केन्द्र, कर्टिन विश्वविद्यालय, पश्चिम अष्ट्रेलियाबाट एक मुख्य अनुसन्धानकर्ताको रुपमा यस घटना अध्ययनसँग सम्बन्धित छु ।**

मेरो शोधपत्रको **मुख्य उद्देश्य** ति महिलाहरु जसले गर्भपतन गराएका छन् र उनीहरुको अनुभव र अनुभूती सुनेर गर्भनिरोधक विधि र यौन प्रजनन् स्वास्थ्य सम्बन्धी पहुँचको धारणा र अवस्था पत्ता लगाउनु हो ।

तपाईका अनुभव र विचारहरुले हामीलाई नेपाली महिलाहरुको यौन तथा प्रजनन् स्वास्थ्य सम्बन्धी हालको वास्तविक अवस्था पत्ता लगाउन सहयोग पुऱ्याउने छ ।

तपाईले आफ्नो अमूल्य समय दिएर यस अध्ययनमा सहयोग गरिदिनुभएकोमा हामी आभारी छौं ।

- यस अध्ययनमा तपाईले दिएका उत्तरहरु, विचार, विमर्शहरु र अनुभवहरु समावेश गरिनेछ । यो
- अन्तरवार्ता करिब १ घण्टाको हुनेछ र जलपानको व्यवस्था पनि गरिनेछ ।

यहाँले प्रदान गर्नुभएका कुनै पनि जानकारीहरु गोप्य राखिनेछ र यदि कुनै कारणवश यस कार्यक्रममा सहभागी हुन नचाहेमा स्वतस्फूर्त रुपमा कार्यक्रम छाड्न सक्नुहुनेछ र कुनै प्रश्नको उत्तर दिन नचाहेमा यहाँलाई बाध्य गरिने छैन । हाम्रो अध्ययनको नतिजा सहितका एक प्रति यहाँलाई उपलब्ध गराइनेछ ।

यदि यहाँका कुनै जिज्ञासा तथा जानकारीहरु भएमा निशङ्कोच अनुसन्धानकर्तासँग सम्पर्क गर्न सक्नुहुनेछ । यहाँको अमूल्य समय हामीलाई प्रदान गर्नुभएकोमा आभार प्रकट गर्दछौं ।

Claire Rogers
विद्यावारिधि शोधकर्ता
अन्तर्राष्ट्रिय स्वास्थ्य केन्द्र
स्वास्थ्य विज्ञान संकाय
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फोन नं. : ००६१४२२०१२६६७ फोन नं. : ००६१८९२६६४१५१
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Appendix L.

Informal Community Conversations Information Sheet (English)

Centre for International Health
School of Nursing and Midwifery
Faculty of Health Sciences

Participant Information Sheet
Informal Community Conversations

Adequate access to contraception and sexual and reproductive health (SRH) information post abortion: A case study from Nepal

I am undertaking a participatory study that aims to explore, document and examine the post abortion SRH experiences of Nepalese women and their access to contraception and sexual and reproductive health (SRH) information. My name is **Claire Rogers from the Centre for International Health, Curtin University, Western Australia** and I am the lead investigators for this project.

The **main aim** of this research is to hear the stories and experiences of women who have had an abortion and what their opinions and views are regarding access to contraception and SRH information after they have had the procedure.

Community input is vital in understanding how services and processes can be better improved to help women effectively and holistically access their reproductive health rights.

We would be most grateful if you could spare the time to assist in this project. This would involve:

- Participating in a 60 minute interview (refreshments will be provided)
- Being asked questions regarding your perspective about the current concerns and issues affecting your community.

Any information you share with us will be treated in the strictest confidence and you will not be identified in the resulting report. You are free to stop participating in the

project at any time or to decline to answer any particular questions. A copy of the report and results will be shared with you.

Please feel free to contact the researchers, if you have any questions or anything further you would like to add.

THANK YOU VERY MUCH FOR TAKING THE TIME TO TALK TO US

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This study has been approved by the Curtin University Human Research Ethics Committee (Approval Number HR17/2014). The Committee is comprised of members of the public, academics, lawyers, doctors and pastoral carers. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University, GPO Box U1987, Perth 6845 or by telephoning 9266 9223 or by emailing hrec@curtin.edu.au

Appendix M.

Informal Community Conversations Information Sheet (Nepali)

कर्टिन विश्वविद्यालय
अन्तर्राष्ट्रिय स्वास्थ्य केन्द्र
नर्सिङ तथा प्रसुती विज्ञ विभाग
स्वास्थ्य विज्ञान संकाय

गर्भपतन पश्चात् यौन, प्रजनन् स्वास्थ्य र गर्भधारण निरोधक विधि सम्बन्धी पर्याप्त पहुँचुँच : नेपेपाल सम्बन्धी एक घटना अध्ययन

सहभागीहरुको लागि जानकारी पत्र

जानकारी दिने मुख्य व्यक्तिको अन्तरवार्ता : सम्बन्धी व्यक्तिहरु

मेरो अध्ययनले नेपाली महिलाहरुको गर्भपतन पश्चात् हुने यौन र प्रजनन् स्वास्थ्य सम्बन्धी खोज, प्रामणिक लेखोट र परीक्षण गरी तिनीहरुको गर्भनिरोधक विधि सम्बन्धी पहुँच, यौन र प्रजनन् स्वास्थ्य सम्बन्धी जानकारी दिनेछ । **मेरो नाम Claire Rogers हो । म अन्तर्राष्ट्रिय स्वास्थ्य केन्द्र, कर्टिन विश्वविद्यालय, पश्चिम अष्ट्रेलियाबाट एक मुख्य अनुसन्धानकर्ताको रुपमा यस घटना अध्ययनसँग सम्बन्धित छु ।**

मेरो शोधपत्रको **मुख्य उद्देश्य** ति महिलाहरु जसले गर्भपतन गराएका छन् र उनीहरुको अनुभव र अनुभूती सुनेर गर्भनिरोधक विधि र यौन प्रजनन् स्वास्थ्य सम्बन्धी पहुँचको धारणा र अवस्था पत्ता लगाउनु हो ।

***समुदायको* अनुभव र विचारहरु** हामीलाई नेपाली महिलाहरुको यौन तथा प्रजनन् स्वास्थ्य सम्बन्धी हालको वास्तविक अवस्था पत्ता लगाउन सहयोग पुऱ्याउने छ ।

तपाईले आफ्नो अमूल्य समय दिएर यस अध्ययनमा सहयोग गरिदिनुभएकोमा हामी आभारी छौं ।

- यस अध्ययनमा तपाईले दिएका उत्तरहरु, विचार, विमर्शहरु र अनुभवहरु समावेश गरिनेछ । यो
- अन्तरवार्ता करिब १ घण्टाको हुनेछ र जलपानको व्यवस्था पनि गरिनेछ ।

यहाँले प्रदान गर्नुभएका कुनै पनि जानकारीहरु गोप्य राखिनेछ र यदि कुनै कारणवश यस कार्यक्रममा सहभागी हुन नचाहेमा स्वतस्फूर्त रुपमा कार्यक्रम छाड्न सक्नुहुनेछ र कुनै प्रश्नको उत्तर दिन नचाहेमा यहाँलाई बाध्य गरिने छैन । हाम्रो अध्ययनको नतिजा सहितका एक प्रति यहाँलाई उपलब्ध गराइनेछ ।

यदि यहाँका कुनै जिज्ञासा तथा जानकारीहरु भएमा निशङ्कोच अनुसन्धानकर्तासँग सम्पर्क गर्न सक्नुहुनेछ । यहाँको अमूल्य समय हामीलाई प्रदान गर्नुभएकोमा आभार प्रकट गर्दछौं ।

Claire Rogers
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Appendix N.

Medical Abortion Participants Information Sheet (English)

Centre for International Health
School of Nursing and Midwifery
Faculty of Health Sciences

Participant Information Sheet

Abortion Research Participants

Adequate access to contraception and sexual and reproductive health (SRH) information post abortion: A case study from Nepal

'Sexual and Reproductive Health' or 'SRH': To be informed and to have access to safe, effective, affordable and acceptable methods of family planning, and the right to access appropriate healthcare services.

'Contraception': Contraceptive methods are used to delay or stop pregnancy. Examples include: condoms, oral contraceptive pills, intrauterine devices, contraceptive implants and injectables.

I am undertaking a participatory study that aims to explore, document and examine the post abortion SRH experiences of Nepalese women and their access to contraception and sexual and reproductive health (SRH) information. My name is **Claire Rogers from the Centre for International Health, Curtin University, Western Australia** and I am the lead investigators for this project.

The **main aim** of this research is to hear the stories and experiences of women who have had an abortion and what their opinions and views are regarding access to contraception and SRH information after they have had the procedure.

We would be most grateful if you could spare the time to assist in this project. This would involve:

- Participating in a 60 minute interview.
- Being asked questions regarding your perspective and experiences with contraception and SRH information access.

Any information you share with us will be treated in the strictest confidence and you will not be identified in the resulting report. You are free to stop participating in the project at any time or to decline to answer any particular questions. A copy of the report and results will be shared with you.

Refreshments will be supplied and if they wish, after the interview, participants will receive a free health check by one of our qualified nurses.

If you would like to participate, our clinic research team member will follow up with you so we can arrange a suitable time for your interview.

Please feel free to contact the researchers, if you have any questions or anything further you would like to add.

THANK YOU VERY MUCH FOR TAKING THE TIME TO TALK TO US

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Appendix O.

Medical Abortion Participants Information Sheet (Nepali)

कर्टिन विश्वविद्यालय
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नर्सिङ तथा प्रसुती विज्ञ विभाग
स्वास्थ्य विज्ञान संकाय

गर्भपतन पश्चात् यौन, प्रजननन् स्वास्थ्य र गर्भधारण निरोधक विधि सम्बन्धी पर्याप्त पहुँच : नेपाल सम्बन्धी एक घटना अध्ययन
सहभागीहरुको लागि जानकारी पत्र

यौन तथा प्रजननन् स्वास्थ्य : सुरक्षित र सन्तोषजनक यौन जीवन, इच्छा अनुसार सन्तान प्राप्ती र गर्भावस्थाको अन्तर सम्बन्धी ज्ञान र योग्यता । परिवार नियोजन सम्बन्धी सुरक्षित, प्रभावशाली, पहुँचयोग्य र स्वीकारयोग्य विधिहरु सूचित गर्नु । महिलाहरुको सुरक्षित गर्भावस्था र सुत्केरी सम्बन्धी आवश्यक स्वास्थ्य सेवाको पहुँच र अधिकार जसले गर्दा दम्पत्तिले स्वस्थ शिशु प्राप्त गर्न सकुन् ।

गर्भनिरोधक : गर्भनिरोधक विधिहरु चाहेको बेलामा सन्तान प्राप्त गर्न र गर्भधारण रोक्न प्रयोग गर्ने विधिहरु हुन् । उदाहरण : ढाल, पिल्स, सुई र पाठेघरमा प्रयोग गर्ने साधनहरु ।

मेरो अध्ययनले नेपाली महिलाहरुको गर्भपतन पश्चात् हुने यौन र प्रजनन् स्वास्थ्य सम्बन्धी खोज, प्रामणिक लेखोट र परीक्षण गरी तिनीहरुको गर्भनिरोधक विधि सम्बन्धी पहुँच, यौन र प्रजनन् स्वास्थ्य सम्बन्धी जानकारी दिनेछ । **मेरो नाम Claire Rogers हो । म अन्तर्राष्ट्रिय स्वास्थ्य केन्द्र, कर्टिन विश्वविद्यालय, पश्चिम अष्ट्रेलियाबाट एक मुख्य अनुसन्धानकर्ताको रुपमा यस घटना अध्ययनसँग सम्बन्धित छु ।**

मेरो शोधपत्रको **मुख्य उद्देश्य** ति महिलाहरु जसले गर्भपतन गराएका छन् र उनीहरुको अनुभव र अनुभूती सुनेर गर्भनिरोधक विधि र यौन प्रजनन् स्वास्थ्य सम्बन्धी पहुँचको धारणा र अवस्था पत्ता लगाउनु हो ।

तपाईले आफ्नो अमूल्य समय दिएर यस शोधपत्रमा सहयोग गरिदिनुभयमा हामी आभारी छौं ।

- यो शोधपत्रमा तपाईका गर्भनिरोध र यौन तथा प्रजनन् स्वास्थ्य सम्बन्धी अमूल्य विचार, दृष्टिकोण अनुभवहरु सँगाल्ने कोशिस गरिनेछ ।
- अन्तरवार्ता करिब एक घण्टाको हुनेछ ।

तपाईद्वारा आदान प्रदान गरिएका कुनै पनि विचार, अनुभव र दृष्टिकोणहरु अत्यन्त गोप्य राखिनेछ र कुनै पनि विवरण तपाईको परिचयद्वारा सार्वजनिक गरिने छैन । तपाईको स्वेच्छा अनुसार कुनै पनि बेला हाम्रो कार्यक्रममा भाग लिन नचाहेमा र यदि कुनै प्रश्नको उत्तर दिन नचाहेमा इन्कार गर्न सक्नुहुनेछ । यस अध्ययन सम्बन्धी सम्पूर्ण विवरण र परिणाम तपाईसँग आदानप्रदान गर्न सकिनेछ ।

अन्तरवार्ता पश्चात्, यदि चाहेमा, जलपानको व्यवस्था मिलाउन सकिने छ र सहभागीले हाम्रो अनुभवी नर्सहरुद्वारा स्वास्थ्य परीक्षणको लाभ लिन सक्नेछन् ।

यदि तपाईं हाम्रो स्वास्थ्य अनुसन्धानमा भाग लिन चाहनुहुन्छ भने हाम्रो समूह सदस्यद्वारा तपाईको उपयुक्त समयमा अन्तरवार्ताको व्यवस्था मिलाउन सकिने छ ।

यदि यहाँका कुनै जिज्ञासा र विचार यस अध्ययनसँग समावेश गर्न चाहेमा निशङ्कोच अनुसन्धानकर्ताहरुसँग सम्पर्क गर्न सक्नुहुनेछ ।

यहाँको अमूल्य समय हामीलाई प्रदान गर्नुभएकोमा आभार प्रकट गर्दछौं ।

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पर्थ, पश्चिम अष्ट्रेलिया
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पर्थ, पश्चिम अष्ट्रेलिया
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ईमेल : j.earnest@curtin.edu.au

Appendix P.

Medical Abortion Participant Contact Form (English)

Centre for International Health
School of Nursing and Midwifery
Faculty of Health Sciences

Adequate access to contraception and sexual and reproductive health (SRH) information post abortion: A case study from Nepal

PARTICIPANT FOLLOW UP INFORMATION

MSIN/SPN Clinic Sampled Research Participants

Name:

Age:

Marital Status: □ Single □ in Relationship □ Married □ Divorced □ Widowed

Language spoken and comprehended:

Date of last clinic appointment:

Address:

Please include a brief description of location (near-by local landmarks, main roads etc):

Other contact details if available:

Phone:

Email:

Please Note: This information is gathered during research Phase 1 and is to be kept in a secure location. This information is used purely for the purpose of follow up with potential research participants during Phase 2. Once participation has been confirmed or denied, this form must be destroyed. At no time will potential participants or active participants names' or contact details be directly or indirectly associated with the research gathered.

Appendix Q.

Medical Abortion Participant Contact Form (Nepali)

कर्टिन विश्वविद्यालय
अन्तर्राष्ट्रिय स्वास्थ्य केन्द्र
नर्सिङ तथा प्रसुती विज्ञ विभाग
स्वास्थ्य विज्ञान संकाय

गर्भपतन पश्चात् यौन, प्रजनन् स्वास्थ्य र गर्भधारण निरोधक विधि सम्बन्धी पर्याप्त पहुँच : नेपाल सम्बन्धी एक घटना अध्ययन

MSIN/SPN सहभागीहरुको फ्लोअप जानकारी

नाम : .....

उमेर : .....

वैवाहिक स्थिति : एकल ☐ सम्बन्धमा ☐ विवाहित ☐ सम्बन्धविच्छेद ☐ विधवा ☐

भाषा : .....

स्वास्थ्य परीक्षण गराएको मिति : .....

ठेगाना : .....

स्थान विशेष : .....

अन्य सम्पर्क यदि भएमा : .....

फोन न : .....

ईमेल : .....

Appendix R.

Guiding Questions: SRHR Professional Participants (English)

Centre for International Health
School of Nursing and Midwifery
Faculty of Health Sciences

Adequate access to contraception and sexual and reproductive health (SRH) information post abortion: A case study from Nepal

Guiding Questions
Key Informant Interview: SRHR Professional

Pre-Interview checklist:

□ the participant has a clear understanding of why the discussion is being recorded and what happens with this audio recording

□ the participant has chosen a pseudonym / generic title and understand the purpose of its use

□ the participant has read and understands the information form

□ the participant has read, understands and signed their consent form

Informed consent is a prerequisite for research participation.

Guiding Questions

A. Abortion services in Nepal

1. As SRH care providers, what are your current perception of abortion services in Nepal?
    a. Access and uptake of services
    b. Standard of care
    c. Standard of post abortion care
    d. How can these services improve?

2. Do you have concerns about abortion services/access?

B. Contraception use of women post abortion

1. Are women offered contraception post abortion?
2. Do women use contraception post abortion? If not, why?
3. What information do women receive about contraception during their appointment/post abortion?
4. What other ways could women be given access to contraception information?

C. SRH information access post abortion

1. What SRH information (other than contraception information) do women receive post abortion?
2. What other ways could women be given access to SRH information?

D. Barriers

1. What are the barriers to contraception and SRH information for women post abortion?
2. How can these barriers be addressed?
3. What are the barriers to women accessing abortion services?

Do you have any questions you would like to ask? Do you have anything else you would like to add?

Thank you for your time

Appendix S.

Guiding Questions: SRHR Professional Participants (Nepali)

कर्टिन विश्वविद्यालय
अन्तर्राष्ट्रिय स्वास्थ्य केन्द्र
नर्सिङ तथा प्रसुती विज्ञ विभाग
स्वास्थ्य विज्ञान संकाय

गर्भपतन पश्चात् यौन, प्रजनन् स्वास्थ्य र गर्भाधारण निरोधक विधी सम्बन्धी
पर्याप्त पहुँच : नेपाल सम्बन्धी एक घटना अध्ययन

सहयोगी प्रश्नहरु
प्रमुख उत्तरदातासँग अन्तरवाता : SRH व्यवसाय सम्बन्धी

अन्तरवार्ता परीक्षण सूची :

- सहभागीलाई यो कुरा रामोसँग थाहा छ की उनको अन्तरवार्ता रेकर्ड गरिएको छ र यो किन रेकर्ड गरिएको छ ।
- सहभागीले उपनाम प्रयोग गर्न चाहन्छन् र यसको प्रयोगको उद्देश्य पनि रामरी थाहा छ ।
- सहभागीले जानकारी पत्र रामरी पढेका र बुझेका छन् ।
- सहभागीले मन्जुरीपत्र रामरी पढेर र बुझेर मात्र हस्ताक्षर गरेका छन् ।

यस अनुसन्धानको निमित्त मन्जुरी हुनको लागि पूर्व जानकारी आवश्यक छ ।

सहयोगी प्रश्नहरु :

क) नेपालमा गर्भपतन सेवा

१. SRH सेवा प्रदायकको रुपमा नेपालमा हालसालै देखापरेका गर्भपतन सेवा सम्बन्धी तपाईको के विचार छ ?
   अ) सेवा सम्बन्धी पहुँच र पर्याप्तता
   आ) स्तरीय सेवा
   इ) गर्भपतन पश्चात् स्तरीय सेवा
   ई) यी सेवाहरुलाई कसरी सुधार गर्न सकिन्छ ?
२. के तपाईलाई गर्भपतन सेवा र पहुँच सम्बन्धी जानकारी छ ?

ख) गर्भपतन पश्चात् महिलाहरुमा गर्भनिरोधक विधिको प्रयोग

१. के महिलाहरुलाई गर्भपतन पश्चात् गर्भनिरोधक विधि सम्बन्धी जानकारी दिइन्छ ?
२. के महिलाहरुले गर्भपतन पश्चात् गर्भनिरोधक विधिहरु अपनाउँछन ? किन ?
३. गर्भपतन पश्चात् महिलाहरुले गर्भनिरोधक विधि सम्बन्धी के कस्ता जानकारीहरु प्राप्त गर्दछन् ?
४. के महिलाहरुलाई यी विधिहरु सम्बन्धी पहुँचको बारेमा जानकारी गराइन्छ ?

ग) गर्भपतन पश्चात् SRH सम्बन्धी जानकारी

१. महिलाहरुले गर्भपतन पश्चात् SRH सम्बन्धी के कस्ता जानकारीहरु प्राप्त गर्छन् ?
२. गर्भपतन पश्चात् महिलाहरुले SRH पहुँच सम्बन्धी के कस्ता जानकारीहरु प्राप्त गर्दछन् ?

घ) बाधा अड्चनहरु

१. गर्भपतन पश्चात् महिलाहरुका लागि गर्भनिरोधक विधि र SRH सम्बन्धी जानकारीका लागि के कस्ता बाधाहरु आइपर्छन् ?
२. यि बाधाहरुलाई कसरी सम्बोधन गरिन्छ ?
३. महिलाहरुको लागि गर्भपतन सेवा सम्बन्धी पहुँचको निमित्त के कस्ता बाधा अड्चनहरु आइपर्दछन् ?

तपाईसँग यस सम्बन्धमा अन्य कुनै प्रश्नहरु वा कुनै जिज्ञासा भएमा निर्धक्कोच सोध्न र केही कुरा थप्न सक्नुहुनेछ ।

सहयोगको लागि धन्यवाद

Appendix T.

Guiding Questions: Informal Community Conversation Participants (English)

Curtin University
Centre for International Health
School of Nursing and Midwifery
Faculty of Health Sciences

Adequate access to contraception and sexual and reproductive health (SRH) information post abortion: A case study from Nepal

Guiding Questions
Informal Community Conversations

Pre-interview checklist:

□ the participant has a clear understanding of why the interview is being recorded and what happens with this audio recording

□ the participant has chosen a pseudonym and understands the purpose of its use

□ the participant has read and understands the information form

□ the participant has read, understands and signed the consent form

Informed consent is a prerequisite for research participation.

Guiding Questions

A. Demographics

1. Language spoken and comprehended
2. Age
3. Religion
4. Marital status
5. Family Structure
6. Education

B. Background and Work

1. Please tell us something about your background and work
2. What do you perceive to be the biggest problems/issues in the community?
3. How do you think these issues could be addressed?
4. What are your community's greatest assets?

C. Health: General

1. What do you think the biggest health concerns for your community are?
2. How do you think these issues could be addressed?

D. Health: Women

1. What do you think are the biggest issues effecting women's health in the community?
2. How do you think these issues could be addressed?

Do you have any questions you would like to ask? Do you have anything else you would like to add?

Thank you for your time

Appendix U.

Guiding Questions: Informal Community Conversation Participants (Nepali)

कर्टिन विश्वविद्यालय
अन्तर्राष्ट्रिय स्वास्थ्य केन्द्र
नर्सिङ तथा प्रसुती विज्ञ विभाग
स्वास्थ्य विज्ञान संकाय

गर्भपतन पश्चात् यौन, प्रजनन् स्वास्थ्य र गर्भाधारण निरोधक विधी सम्बन्धी पर्याप्त पहुँच : नेपाल सम्बन्धी एक घटना अध्ययन

सहयोगी प्रश्नहरु
प्रमुख उत्तरदातासँग अन्तरवार्ता : मुख्य बुँदाहरु

पुर्व अन्तरवार्ता परीक्षण सूची :

- सहभागीलाई यो कुरा राम्रोसँग थाहा छ की उनको अन्तरवार्ता रेकर्ड गरिएको छ र यो किन रेकर्ड गरिएको छ ।
- सहभागीले उपनाम प्रयोग गर्न चाहन्छन् र यसको प्रयोगको उद्देश्य पनि राम्री थाहा छ ।
- सहभागीले जानकारी पत्र राम्री पढेका र बुझेका छन् ।
- सहभागीले मन्जुरीपत्र राम्री पढेर र बुझेर मात्र हस्ताक्षर गरेका छन् ।

यस अनुसन्धानको निमित मन्जुरी हुनको लागि पूर्व जानकारी आवश्यक छ ।

सहयोगी प्रश्नहरु :

क) जनसंख्याको अध्ययन

१. भाषागत ज्ञान २. उमेर ३. धर्म
४. वैवाहिक स्थिती ५. पारिवारीक संरचना ६. शिक्षा

ख) पृष्ठभूमी र कार्य

१. कृपया तपाईको पृष्ठभूमी र कार्यको बारेमा बताउनुहोस् ।
२. तपाईको विचारमा समुदायमा सबैभन्दा ठूलो समस्या के हो ?
३. तपाईको विचारमा यि समस्याहरुलाई कसरी सम्बोधन गरिनुपर्छ ?
४. तपाईको समुदायको सबैभन्दा ठूलो पूँजी के हो ?

ग) स्वास्थ्य सम्बन्धी सामान्य जानकारी

१. तपाईको विचारमा समुदायको लागि सबैभन्दा ठूलो स्वास्थ्य सम्बन्धी चासोको विषय के हो ?
२. तपाईको विचारमा यी विचारहरुलाई कसरी सम्बोधन गरिनु पर्दछ ?

घ) महिला स्वास्थ्य सम्बन्धी जानकारी

१. तपाईको विचारमा समुदायमा महिला स्वास्थ्यमा असर पार्ने तत्वहरु के के हुन् ?
२. तपाईको विचारमा यी समस्याहरुलाई कसरी समाधान गर्न सकिन्छ ?

तपाईसँग यस सम्बन्धमा अन्य कुनै प्रश्नहरु वा कुनै जिज्ञासा भएमा निशङ्कोच सोध्न र केही कुरा भन्न सक्नुहुनेछ ।

सहयोगको लागि धन्यवाद

Appendix V.

Guiding Questions: Clinic Client Participants (English)

Centre for International Health
School of Nursing, Midwifery and Paramedicine
Faculty of Health Sciences

Adequate access to contraception and sexual and reproductive health (SRH) information post abortion: A case study from Nepal

Guiding Questions
SPN/MSN Clinic Sampled Research Participants

Pre-Interview Checklist:

□ the participant has been offered light refreshment and is comfortable in their surroundings.

□ the participant has read and understands the information form.

□ the participant has chosen a pseudonym / generic title and understand the purpose of its use.

□ the participant has a clear understanding of why the discussion is being recorded and what happens with this audio recording.

□ the participant understands the process of Member Checks and has consented to being contacted.

□ the participant is asked if they have any questions regarding the research or interview.

□ the participant has read, understands and signed their consent form (or verbal consent given and noted on form).

Informed consent is a prerequisite for research participation.

Guiding Questions

A. Background and Demographics

1. Language/s spoken and comprehended
2. Age
3. Religion
4. Education
5. Marital status
6. If married, age when married
7. Does husband live/work away
8. Family Structure
9. Number of children
10. Number of pregnancies
11. Age at first child's birth
12. Distance from the Itahari Clinic (walking)
13. How did you hear about MSC Ithari or MSIN/SPN services?

B. Contraceptive use/access

2. Are you currently using a method of contraception?
    - **a. Yes**
        - i. Is it a modern method or traditional method? *(give examples of methods if needed and explain difference between modern/traditional)*
        - ii. Are you happy/unhappy with this method?
        - iii. When did you first start using this method?
        - iv. Were you using this method when you became pregnant?
        - v. Where do you access your chosen method of contraception from?
        - vi. What do you feel are barriers to women in your community using/accessing contraception?
    - **b. No**
        - i. Are you interested in using contraception now?
        - ii. Have you used contraception in the past? What methods?
        - iii. Were you using contraception when you became pregnant?
        - iv. What do you feel are barriers to you using/accessing contraception?

C. SRH information access

[Interviewer to explain what 'SRH information' means – the term SRH will not be used specifically as it has little meaning to participants, rather an understanding of what SRH is should be conveyed.]

1. Do you feel you have adequate access to SRH information?
2. Where do you receive information about SRH from?

D. Post abortion use/access to contraception and SRH information

1. What was the reason you obtained an abortion?
2. After your appointment at the MSC Itahari clinic did you receive SRH information?
    - **a. Yes**
        - i. What information were you given?
        - ii. Did you find the information useful?
        - iii. In what way has this information helped you?
        - iv. Would you like to receive more SRH information?
    - **b. No**
        - i. Would you have liked to receive SRH information at the time of your appointment?
        - ii. Would you like to receive SRH information now?
        - iii. How do you think SRH information would help you?

3. Were you offered contraception at your appointment?
    - **a. Yes**
        - i. What methods were you offered?
        - ii. Did you receive adequate information about these methods?
    - **b. No**
        - i. Would you have like to have been offered contraception?

4. Did you accept and use the contraception?
    - **a. Yes**
        - i. Are you still using this method? If not, how long did you use it for and why did you choose to stop?
        - ii. Did you receive adequate information about this method?
        - iii. Are you happy with this method?
    - **b. No**
        - i. Why did you choose to not accept and use the contraception offered?
        - ii. Would you like to start using contraception now?

5. What was your experience with this the MSC Itahari clinic?
6. Would you access this service again? Why/why not?
7. How do you think these services could be improved?
8. Was this the first time you have accessed SRH clinic services (either MSIN/SPN or other SRH clinic) for an abortion?
9. In your opinion and experience, what is the difference between INGO/NGO, private and government SRH services?
10. Have you ever accessed abortion (MA) through a pharmacy/medical shop?
    - **a. Yes**
        - i. Why did you decide to go to a pharmacy for MA pills that time instead of a clinic?
        - ii. Were you given any SRH information?
        - iii. Were you offered contraception?
        - iv. Did the abortion happen as you expected it would?

v. Did you have to seek SRH/medical services after you had taken the MA for any reason?

b. No

i. Do you have any thoughts about women accessing abortion through pharmacies/medical shops?

11. Do you have any questions you would like to ask? Do you have anything else you would like to add?

Post-Interview checklist:

 the participant has been given contact details for MSIN/SPN Staff and Research Team if they have any questions/concerns/follow-up from the interview

 the participant understands the process of Member Checks and agrees to be contacted

 the participant has been offered a *MSC Itahari Clinic: Free Health Check-Up Voucher* (general health check-up)

 the participant has been offered a *MSC Itahari Clinic: Free Women's Health Check-Up Voucher* (pregnancy test)

 the participant has been informed that contraception is free at the MSC Itahari clinic

 the participant has been reimbursed 500 NPR for travel expenses

 the participant has been thanked for their time and for generously sharing their experience and thoughts to help with the study.

Appendix W.

Guiding Questions: Clinic Client Participants (Nepali)

ञभनवबभ ायच ढ्लवभचलबवष्लबी अभवित्र
ल्बअयया ग्रा ल्ायकष्लन, :ष्अवभचषभ
बलम एबचकभमष्अभ
ँभगवित्र या ज्ञभवित्र क्षभलअभक

ब्भत्रगवतभ बअबभकक तय बयलतच्बअभउतष्यल बलम कभहगबी बलम चभउचयमगअतष्खभ जभबतिज ९क्च्ज० ष्लायचकबतष्यल उयकत बदयचतष्यलस् ँ बअबकभ कतगमथ ायक ल्भउबी

गर्भपतनपछि गर्भनिरोधक र यौन तथा प्रजनन स्वास्थ्य ९ क्च्ज ० सम्वन्धि जानकारी को पर्याप्त पहुँच ू नेपालबाट एउटा अध्ययन

नगष्मष्लन तगभकतष्यलक
मार्ग दर्शक प्रश्नहरु

:क्ष्ल्रक्एल ञ्ष्लिष्अ क्ष्उभिम च्भकभबचअज एबचतष्अष्उबलतक
स्टोपस् क्लिनिक इटहरी वा मेरी स्टोपस् अन्तरास्ट्रिय नेपालः सुनौलो परिवारबाट अनुसन्धानमा छानिएका सहभागीहरुः

एचभ(ष्लतभचखष्भध ञ्जभअपष्कितः
अन्तर्वार्तापुर्व पुरा गर्नुपर्ने सूचीहरु

☐तजभ उबचतष्अष्उबलत जबक दभभल याभचभम ष्लिजत चभाचभकजभलत बलम ष्क थकायचतबदभि ष्ल तजभष्च कगचचयगलमष्लनक।
सहभागीहरुलाई सामान्य खानेकुरा दिइएको छ र उहांहरु उपस्थित वातावरणमा सहज हुनुहुन्छ।

☐ तजभ उबचतष्अष्उबलत जबक चभबम बलम गलमभचकतबलमक तजभ ष्लायचकबतष्यल ायचक।
सहभागी हरु ले अनुसन्धान सम्बन्धि सम्पूर्ण जानकारी पढ्नुभएको छ र बुझ्नु भएको छ।

☐ तजभ उबचतष्अष्उबलत जबक थजयकभल ब उकभगमयलथ र नभलभचष्अ तष्तभि बलम गलमभचकतबलम तजभ उगचउयकभ या ष्त क गकभ।
सहभागीले अनुसन्धानको निम्ति नक्कली नामः सामान्य शिर्षक छान्नु भएको छ र यसको उद्धेश्य बुझ्नु भएको छ।

☐ तजभ उबचतष्अष्उबलत जबक व थभिबच गलमभचकतबलमष्लन या धजथ तजभ मष्कथगककष्यल ष्क दभष्लन चभथयचमभम बलम धजबत जबउउभलक धष्तज तजष्क बगमष्य चभथयचमष्लन।
सहभागीले हामीले किन हाम्रो छलफल रेकर्ड गरिरहेको छौ र यो अडियो रेकर्डको उपयोगको बारे स्पष्ट बुझ्नुभएको छ।

☐ तजभ उबचतष्अष्उबलत गलमभचकतबलमक तजभ उचयथभकक या :भदभच ञ्जभथपक बलम जबक थयलकभलतभम तय दभष्लन थयलतबथतभम।
सहभागीले अनुसन्धानमा संकलित जानकारीहरु बुझ्ने र प्रतिक्रिया दिने प्रक्रिया को बारे बुझ्नु भएको छ र पछि सम्पर्क गर्न सहमति दिनु भएको छ।

तजभ उबचतष्अष्उबलत ष्क बकपभम ष तजभथ जबखभ बलथ ञगभकतष्यलक चभनबचमष्लन तजभ चभकभबचथज यच ष्लतभचखष्भध।
सहभागीलाइ अनुसन्धान वा अन्तर्वार्ता सम्बन्धि उहाँहरुको केहि प्रश्न छ भनि सोधिएको छ र प्रश्न गर्ने मौका दिइएको छ।

☐ तजभ उबचतष्अष्उबलत जबक चभबम, गलमभचकतबलमक बलम कष्नलभम तजभष्च थयलकभलत ायचक ९यच खभचदबी थयलकभलत नष्खभल बलम लयतभम यल ायचक०।
सहभागीले सहमति फारम पढेर, बुझेर हस्तेः हस्ताक्षर गर्नु भएको छ।

क्लायचकभम अयलकभलत ष्क ब उचभचभत्रगाष्कष्तभ ायच चभकभबचअज उबचतष्अष्उबतष्यल।
अनुसन्धानमा सहभागी हुन सहमति फारम अत्यन्त जरुरि हुन्छ।

नाष्मष्लन त्तगभकतष्यलक

मार्गदर्शक प्रश्नहरु

ब द्यबअपनचयगलम बलम म्फयनचबउजष्अक

क। सहभागीको पृष्ठभुमि र अन्य तथ्यांकहरु

ज्ञा ीबलनगबनभरक कउयपभल बलम अफउचभजभलमभम

१। बोल्ने तथा बुझ्ने भाषा

द्व। ब्नभ

२। उमेर

घा। च्भष्निष्यल

३। धर्म

द्ध। बचष्तबा कतबतगक

४। वैवाहिक स्थिति

छ्ा। म्यभक जगकदबलम ष्खिभरद्धयचप बद्धबथ

५। श्रीमान संगै बस्ने वा अन्य कतै काम गर्ने

टा ँकर्षथि क्तचगअतगचभ

६। पारिवारिक संरचना

ठा। भ्मगअबतष्यल

७। शिक्षा

ड। ज्यद्ध मष्म थयग जभबच बदयगत क्कृ क्षतजबचष यच क्ल्रक्एल कभचखष्अभकरु

ड। तपाई ले मेरी स्टोपस् क्लिनिक इटहरी वा मेरी स्टोपस् अन्तरास्ट्रिय नेपाल र सुनौलो परिवारको सेवा बारे कसरि थाहा पाउनुभयो

द्य। ऋयलतचबअभउतष्खभ गकभरबअअभकक

ख। गर्भनिरोधक प्रयोगरुपहुँच

ज्ञा। ब्चभ थयग अगचचभलतथि गकष्लन ब नभतजयम या अयलतचबअभउतष्यलरु

१। के तपाई हाल कुनै गर्भनिरोधक प्रयोग गर्नु हुन्छरु

बा। ष्अक

क। प्रयोग गरिरहेको छु

ष क्ष्क ष्त ब नयमभचल नभतजयम यच तचबमष्तष्यलबा नभतजयमरु ९नष्खभ भहकउभिक या नभतजयमक ष लभभमभम बलम भहउबिष्ल मषाभचभलअभ दभतद्धभभल नयमभचलरतचबमष्तष्यलबा०

१। के यो आधुनिक विधि वा परम्परागत विधि होरु ९गर्भानिरोधनको विधिहरुको उदाहरण दिनुहोस् र आधुनिक विधि र परम्परागत विधिको फरक खुलाउनुहोस् ०

ष्प ब्चभ थयग जबउउथरगलजबउउथ ध्यष्तज तजष्क नभतजयमरु

२। के तपाईले प्रयोग गर्नुभएको गर्भनिरोधक विधि बाट खुशीरबेखुशी हुनुहुन्छरु

ष्ष्य ध्जभल मष्म थयग ाष्चकत कतबचत गकष्लन तजष्क नभतजयमरु

३। तपाईले कहिलेबाट यो विधि अपनाउन शुरु गर्नु भएको हो रु

ष्खा ध्भचभ थयग गकष्लन तजष्क नभतजयम ध्जभल थयग दभअकभ उचभनलबलतरु

४। के तपाई गर्भवती हुँदा यो विधि प्रयोग गरिरहनु भएको थियो रु

ख। ध्जभचभ मय थयग बअअभकक थयगच अजयकभल नभतजयम या अयलतचबअभउतष्यल ाचकरु

५। तपाईले यो गर्भनिरोधक विधि कहाँबाट लिनुहुन्छ रु
खष ध्जबत मय थयग ाभर्भा बचभ दबचचष्भचक तय ध्यकभल ष्ल थयगच अक्कगलष्तथ गकष्लनरबअअभककष्लन अयलतचबअभउतष्यलरु
६। तपाईको विचारमा तपाईको गाउँसमुदायमा गर्भनिरोधक पाउन के के बाधा हुन सक्छन्रु

द। ल्य

ख। प्रयोग गर्दिन

ष ब्चभ थयग ष्लतभचभकतभम ष्ल गकष्लन अयलतचबअभउतष्यल लयधरु
१। के तपाई अब गर्भनिरोधक प्रयोग गर्न इच्छुक हुनुहुन्छ रु
ष्ष ज्बखभ थयग गकभम अयलतचबअभउतष्यल ष्ल तजभ उबकतरु ध्जबत नभतजयमकरु
२। के तपाईंले विगतमा गर्भनिरोधक प्रयोग गर्नु भएको छ रु कस्ता तरिकाहरू प्रयोग गर्नु भएको थियो रु
ष्ष्य ष्भचभ थयग गकष्लन अयलतचबअभउतष्यल ध्जभल थयग दभअकभ उचभनलबलतरु
३। के तपाई गर्भवती हुँदा गर्भनिरोधक विधि प्रयोग गरिरहनु भएको थियो रु
ष्ख। ध्जबत मय थयग ाभर्भा बचभ दबचचष्भचक तय थयग गकष्लनरबअअभककष्लन अयलतचबअभउतष्यलरु
४। तपाईको विचारमा तपाईको गाउँसमुदायमा गर्भनिरोधक पाउन के के बाधा हुन सक्छन्रु

ऋ। क्च्ज ष्लायक्कबतष्यल बअअभकक

ग। यौन तथा प्रजनन स्वास्थ्यसम्बन्धि जानकारीको पहुँच

क्ष्लतभचखष्भधभच तय भहउबिष्ल ध्जबत "क्च्ज ष्लायक्कबतष्यल" नभबलक्क - तजभ तभक्क क्च्ज ध्यर्षी लयत दभ गकभम कउभअषष्अर्बाथि बक ष्त जबक ष्तितभि नभबलष्लन तय उबचतष्अष्उबलतक, चबतजभच बल गलमभचकतबलमष्लन या ध्जबत क्च्ज ष्क कजयगमि दभ अयलखभथभमो।

प्रश्नकर्ताले यौन तथा प्रजनन स्वास्थ्यसम्बन्धि जानकारी को अर्थको व्याख्या (सहभागीलाइ यौन तथा प्रजनन स्वास्थ्य भन्ने शब्दहरुको खासै अर्थ नरहने हुनाले उक्त शब्दहरु विशेषरुपमा प्रयोग हुँदैनन् बरु यसभित्र के के पर्छन भनि सहभागीले बुझ्ने गरि सामान्य भाषामा व्याख्या गर्नुपर्नेछ।

ज्ञ। म्य थयग ाभर्भा थयग जबखभ बमभत्रगबतभ बअअभकक तय क्च्ज (ष्लायक्कबतष्यलरु
१। के तपाईले यौन तथा प्रजनन स्वास्थ्यसम्बन्धि जानकारी पर्याप्त रुपमा पाएको जस्तो लाग्छ रु
ह्। ध्जभचभ मय थयग चभअभष्खभ ष्लायक्कबतष्यल बदयगत क्च्ज ाचकरु
२। तपाई ले यौन तथा प्रजनन स्वास्थ्यसम्बन्धि जानकारी कहाँबाट प्राप्त गर्नु हुन्छरु

म एयकत बदयचतष्यल गकभरबअअभकक तय अयलतचबअभउतष्यल बलम क्च्ज ष्लायक्कबतष्यल

घ। गर्भपतन पछाडी गर्भनिरोधक को प्रयोगरपहुँच तथा यौन तथा प्रजनन स्वास्थ्यसम्बन्धि जानकारी

ज्ञ। बतभच थयगच बउउयष्लक्तभलत बत तजभ क्क्ष क्षतबजबचष अष्लिष्अ मष्म थयग चभअभष्खभ क्च्ज ष्लायक्कबतष्यलरु
के तपाईले मेरी स्टोपस् क्लिनिक इटहरीमा सेवा लिंदा यौन तथा प्रजनन स्वास्थ्य सम्बन्धि जानकारी पाउनुभयो रु

ब। ाभक
ब। पाएँ

ष ध्जबत ष्लायक्बतष्यल ध्भचभ थयग नष्खभलरु

१। तपाईलाई यौन तथा प्रजनन स्वास्थ्य सम्बन्धि के के जानकारीहरु दिइएको थियो रु

ष्ष म्प्म थयग ाष्लम तजभ ष्लायक्बतष्यल गकभागरि

२। के तपाईलाई उक्त जानकारीहरु उपयुक्त थिए रु

ष्ष्ष ध्क्ल ध्जबत ध्बथ जबक तजष्क ष्लायक्बतष्यल जभउिभम थयगरु

३। तपाइलाई उक्त जानकारीहरुले कसरि सहयोग पुर्यायो रु

ष्ख। ध्यगमि थयग ष्पिभ तय चभअभष्खभ ग्यचभ क्च्ज ष्लायक्बतष्यलरु

४। के तपाई अझ बढी यौन तथा प्रजनन स्वास्थ्य सम्बन्धि जानकारीहरु लिन चाहनुहुन्छ रु

द्। ल्य

द्। पाइन

ष ध्यगमि थयग जबखभ ष्पिभम तय चभअभष्खभ क्च्ज ष्लायक्बतष्यल बत तजभ तष्भ या थयगच बउउयष्लक्भलतरु

१। के तपाईलाई क्लिनिकमा तपाईको जांचको समयमा यौन तथा प्रजनन स्वास्थ्य सम्बन्धि जानकारीहरु दिएको भए हुन्थ्यो जस्तो लाग्छरु

२। ध्यगमि थयग ष्पिभ तय चभअभष्खभ क्च्ज ष्लायक्बतष्यल लयध्रु

के तपाई अहिले यौन तथा प्रजनन स्वास्थ्य सम्बन्धि जानकारीहरु लिन चाहनुहुन्छरु

३। ज्यध्र मय थयग तजष्लप क्च्ज ष्लायक्बतष्यल ध्रयगमि जभउि थयगरु

तपाईको विचारमा यौन तथा प्रजनन स्वास्थ्य सम्बन्धि जानकारीहरुले तपाईलाई कसरि सहयोग गर्छ जस्तो लाग्छरु

द्। ध्भचभ थयग याभचभम अयलतचबअभउतष्यल बत थयगच बउउयष्लक्भलतरु

द्। के तपाईले गर्भपतन गर्ने चक्की लिँदा तपाईलाई फार्मेसीरऔषधि पसलले गर्भनिरोधक साधन पनि प्रस्ताव गरिएको थियो रु

ब। थ्भक

ब। थियो

ष ध्जबत ग्भतजयमक ध्भचभ थयग याभचभमरु

तपाईलाई कुन साधन प्रयोग गर्न प्रस्ताव गरिएको थियो

ष्ष म्प्म थयग चभअभष्खभ बमभत्रगबतभ ष्लायक्बतष्यल बदयगत तजभक्भ ग्भतजयमकरु

तपाई ले त्यो साधन बारे पर्याप्त जानकारी पाउनु भयोरु

द। ल्य

ष ध्यगमि थयग जबखभ ष्पिभ तय जबखभ दभभल याभचभम अयलतचबअभउतष्यलरु

ष के तपाईलाई गर्भनिरोधक पनि संगै प्रस्ताव गरिएको भए हुने भन्ने लाग्छ रु

घ। म्प्म थयग बअअभउत बलम गकभ तजभ अयलतचबअभउतष्यलरु ध्लतभचखष्भधभच तय अयलाष्क ाचफ ध्जभचभ तजभ अयलतचबअभउतष्यल ध्बक चभअभष्खभम ष लयत ाचफ तजभ ककभ उजबक्बअथे

के तपाई ले गर्भनिरोधक साधन स्वीकारेर प्रयोग गर्नु भयो रु प्रश्नकर्ताले यदि उही फार्मेसीरऔषधि पसलबाट लिएको हो होइन, गर्भनिरोधक साधन कहाँबाट पाएको हो निक्र्यौल गर्नु पर्नेछ।

ब। थ्भक

ब। प्रयोग गरे

ष ब्चभ थयग कतर्षी गकष्लन तजष्क ग्भतजयमरु क्ष लयत, जयध्र यिलन मष्म थयग गकभ ष्त ायच बलम ध्जथ मष्म थयग अजययकभ तय कतयउरु

के तपाई अहिले पनि उक्त विधि प्रयोग गरिरहनु भएको छ रु यदि छैन भने, कति समय को को लागि प्रयोग गर्नु भयो र किन प्रयोग रोक्न रोज्नुभयो रु

ष्य म्प्म थयग चभअभष्खभ बमभत्रगबतभ प्लायक्कबतष्यल बदयगत तजष्क नभतजयमरु

के तपाई ले उक्त गर्भनिरोधक विधि को बारे पर्याप्त जानकारी पाउनुभएको थियो रु

ष्ष्य ब्चभ थयग जबउउथ धष्तज तजष्क नभतजयमरु

के तपाई यो विधि बाट खुशी हुनुहुन्छरु

द्य ल्य

द्य प्रयोग गरेको छैन

ष ध्जथ मष्म थयग अजययकभ तय लयत बअअभउत बलम गकभ तजभ अयलतचबअभउतष्यल याभचभमरु

किन तपाईले तपाईलाई दिइएको गर्भनिरोधक साधन प्रयोग नगर्न रोज्नुभयो

ष्य ध्यगमि थयग ष्पिभ तय कतबचत गकष्लन अयलतचबअभउतष्यल लयधरु

के तपाई अब कुनै गर्भनिरोधक साधन प्रयोग गर्न चाहनु हुन्छरु

द्व ध्जबत ध्बक थयगच भहउभचष्भलअभ धष्तज तजष्क तजभ :क्ष्ण क्षतबजबचष् अष्लिष्अरु

४। तपाईको मेरी स्टोपस् क्लिनिक को अनुभव कस्तो रह्यो रु

छ्र ध्यगमि थयग बअअभकक तजष्क कभचखष्अभ बनबष्लरु ध्जथरध्जथ लयतरु

५। के तपाई अझै यस मेरी स्टोपस् क्लिनिकको सेवा लिन चाहनुहुन्छरु किन चाहनुहुन्छ र किन चाहनुहुन्नरु

टाज्यद्य मय थयग तजष्लप तजभकभ कभचखष्अभक अयगमि दभ ष्उचयखभमरु

तपाईको विचारमा तपाईले लिएको सेवाहरु कसरि सुधार गर्न सकिन्छ रु

ठा ध्बक तजष्क तजभ ाच्चकत तष्भ थयग जबखभ बअअभककभम क्च्ज अष्लिष्अ कभचखष्अभक ९भष्तजभच :क्ल्रक्एल यच यतजभच क्च्ज अष्लिष्अ० ायच बल बदयचतष्यलरु

के यो तपाईले यौन तथा प्रजनन स्वास्थ्य क्लिनिक ९मेरी स्टोपस् अन्तरास्ट्रिय नेपाल वा अन्य क्लिनिक० बाट गर्भपतन सेवा लिएको पहिलो पल्ट हो रु

ड। ज्वखभ थयग भखभच बअअभककभम बदयचतष्यल ९.ब० तजचयगनज ब उजबक्कबअथरुभमष्अबा कजयउरु

के तपाईले कहिल्यै फार्मेसीरऔषधि पसलबाट गर्भपतन गर्ने औषधि लिनु भएको छ रु

बा श्भक

बा लिएको छु

ष ध्जथ मष्म थयग मभअष्मभ तय नय तय ब उजबक्कबअथ ायच :ब उर्षाकि तजबत तष्भ प्लकतभबम या ब अष्लिष्अरु

तपाई क्लिनिकको सट्टा फार्मेसीरऔषधि पसल जाने निर्णय किन गर्नुभयो रु

ष्य ध्भचभ थयग नष्खभल बलथ क्च्ज प्लायक्कबतष्यलरु

के तपाई लाई यौन तथा प्रजनन स्वास्थ्यसम्बन्धि जानकारी दिइयो रु

ष्ष्य ध्भचभ थयग याभचभम अयलतचबअभउतष्यलरु

के तपाई लाई गर्भनिरोधक साधन हरु प्रयोग गर्ने सुझावर प्रस्ताव दिइयो रु

ष्ख। म्प्म तजभ बदयचतष्यल जबउउभल बक थयग भहउभअतभम ष्त धयगमिरु

के उक्त औषधिले तपाईले सोचे जसरि नै गर्भपतन भयो रु

ख। म्प्म थयग जबखभ तय कभभप क्च्ज्रुभमष्अबा कभचखष्अभक बातभच थयग जबम तबपभल तजभ :ब ायच बलथ चभबकयलरु

के तपाईले गर्भपतन गर्ने चक्की लिईसकेपछि कुनैपनि कारणको निम्ति यौन तथा प्रजनन स्वास्थ्यसम्बन्धि जानकारी वा अन्य स्वास्थ्यसम्बन्धि सेवा लिनुपरेको थियो?

द्या ल्य

द्या लिएको छैन

ष म्य थयग जबखभ बलथ तजयगनजतक बदयगत धयकभल बअअभककष्लन बदयचतष्यल तजचयगनज उजबचकबअष्भकरुभमष्अर्बा कजयउकरु

के तपाईले फार्मेसी?औषधि पसलबाट गर्भपतन गर्ने महिलाहरुको बारे मा कहिल्यै सोच्नुभयो ?

ज्ञण म्य थयग जबखभ बलथ त्रगभकतष्यलक थयग धयगमि ष्पिभ तय बकपरु म्य थयग जबखभ बलथतजष्लन भकिभ थयग धयगमि ष्पिभ तय बममरु

के तपाईलाई केहि प्रश्न सोध्न मन लागेको छ? के तपाईलाई केहि कुराहरु थप्न मन छ ?

एयकत(क्ष्लतभचखष्भध अजभअपष्कितस्

अन्तर्वार्ता पछिका सुचीहरु

☐तजभ उबचतष्अष्उबलत जबक दभभल नष्खभल अयलतबअत मभतबर्षक ायच :क्ष्ल्रक्एल क्तबाा बलम च्भकभबचअज त्भक ष तजभथ जबखभ बलथ

त्रगभकतष्यलकरअयलअभचलकरार्यायिध(गउ ाचफ तजभ ष्लतभचखष्भध

सहभागीहरुलाई केहि प्रश्न?कुराकानी भएमा मेरी स्टोपस् नेपाल? सुनौलो परिवार नेपाल र अनुसन्धान समूहका सम्पर्क ठेगाना दिइएको छ

तजभ उबचतष्अष्उबलत गलमभचकतबलमक तजभ उचयअभकक या भकदभच ऋजभअपक बलम बनचभभक तय दभ अयलतबअतभम

सहभागीले अनुसन्धानमा संकलित जानकारीहरु बुझ्ने र प्रतिक्रिया दिने प्रक्रियाकोबारे बुझ्नुभएको छ र फेरी सम्पर्क गर्न मन्जुरी दिनु भएको छ।

☐ तजभ उबचतष्अष्उबलत जबक दभभल याभचभम ब :क्ष्ल क्ष्तबजबचष् ऋष्लिष्अस्ँचभभ ज्भबतिज ऋजभअप(गउ ख्यगअजभच ९नभलभचबा जभबतिज अजभअप(गउ०

सहभागीलाई मेरी स्टोप्स इटहरी क्लिनिकमा सामान्य स्वास्थ्य परिक्षणको लागि निशुल्क स्वास्थ्य परिक्षण भौचर दिइएको छ।

☐ तजभ उबचतष्अष्उबलत जबक दभभल याभचभम ब :क्ष्ल क्ष्तबजबचष् ऋष्लिष्अस्ँचभभ ध्यकभल'क ज्भबतिज ऋजभअप(गउ ख्यगअजभच ९उचभनलबलअथ तभकत०

सहभागीलाई मेरी स्टोप्स इटहरी क्लिनिकमा निशुल्क महिला स्वास्थ्य परिक्षण भौचर दिइएको छ जसमा गर्भवती जांच पर्छ।

☐ तजभ उबचतष्अष्उबलत जबक दभभल प्लायक्भम तजबत अयलतचबअभउतष्यल प्क ाचभभ बत तजभ :क्ष्ल क्ष्तबजबचष् अष्लिष्अ

सहभागीलाई गर्भनिरोधक साधनहरु मेरी स्टोप्स इटहरी क्लिनिकमा निशुल्क पाईने जानकारी गरायौ।

☐ तजभ उबचतष्अष्उबलत जबक दभभल चभष्दगचकभम छण्ण ल्एच ायच तचबखभा भहउभलकभक

सहभागीलाई यात्रा खर्चको लागि ने। रु। ५०० दिइयो

☐ तजभ उबचतष्अष्उबलत जबक दभभल तजबलपभम ायच तजभष्च तष्भ बलम ायच नभलभचयगकथि कजबचष्लन तजभष्च भहउभचष्भलअभ बलम तजयगनजतक तय जभउि ध्यतज तजभ कतगमथ।

सहभागीलाई उहाँको अमुल्य समय र आफ्नो अनुभव, विचार बांडेर अनुसन्धानमा सहयोग पुर्याएकोमा धन्यवाद प्रदान गरियो।

Appendix X.

Guiding Questions: Pharmacy Client Participants (English)

Centre for International Health
School of Nursing, Midwifery
and Paramedicine
Faculty of Health Sciences

Adequate access to contraception and sexual and reproductive health (SRH) information post abortion: A case study from Nepal

Guiding Questions
Community Sampled Research Participants:
Women who have accessed MA through a pharmacy

Pre-Interview Checklist:

□ the participant has been offered light refreshment and is comfortable in their surroundings.

□ the participant has read and understands the information form.

□ the participant has chosen a pseudonym / generic title and understand the purpose of its use.

□ the participant has a clear understanding of why the discussion is being recorded and what happens with this audio recording.

□ the participant understands the process of Member Checks and has consented to being contacted.

□ the participant is asked if they have any questions regarding the research or interview.

□ the participant has read, understands and signed their consent form (or verbal consent given and noted on form).

Informed consent is a prerequisite for research participation.

Guiding Questions

B. Background and Demographics

14. Language/s spoken and comprehended
15. Age
16. Religion
17. Education
18. Marital status
19. If married, age when married
20. Does husband live/work away
21. Family structure
22. Number of children
23. Number of pregnancies
24. Age at first child's birth
25. Distance from the Itahari town centre (walking)
26. Distance from the nearest pharmacy/medical shop (walking)

B. Contraceptive use/access

3. Are you currently using a method of contraception?
    - **a. Yes**
        - i. Is it a modern method or traditional method? *(give examples of methods if needed and explain difference between modern/traditional)*
        - ii. Are you happy/unhappy with this method?
        - iii. When did you first start using this method?
        - iv. Were you using this method when you became pregnant?
        - v. Where do you access your chosen method of contraception from?
        - vi. What do you feel are barriers to women in your community using/accessing contraception?
    - **b. No**
        - i. Why are you not using contraception?
        - ii. Are you interested in using contraception now?
        - iii. Have you used contraception in the past? What methods?
        - iv. Were you using contraception when you became pregnant?
        - v. What do you feel are barriers to you using/accessing contraception?

C. SRH information access

[Interviewer to explain what 'SRH information' means – the term SRH will not be used specifically as it has little meaning to participants, rather an understanding of what SRH is should be conveyed.]

3. Do you feel you have adequate access to SRH information?
4. Where do you receive information about SRH from?

D. Post abortion use/access to contraception and SRH information

12. What was the reason you decided to have an abortion?
13. How did you know to go to a pharmacy to get MA pills?
14. Did you know you could go to a government/private/INGO health service to get the MA pills?
15. Did you get the MA pills from the pharmacy yourself?
    - **a. Yes**
    - **b. No**
        - i. Who got the MA pills for you?
        - ii. What information did they receive when they got the pills?
        - iii. Did you understand all the information?
        - iv. Were they offered any contraception or information about contraception?
        - v. Why did you not get the pills yourself?
16. After you accessed MA from the pharmacy/medical shop did you receive SRH information?
    - **a. Yes**
        - i. What information were you given?
        - ii. Did you find the information useful?
        - iii. In what way has this information helped you?
        - iv. Would you like to receive more SRH information?
    - **b. No**
        - i. Would you have liked to receive SRH information when you accessed MA?
        - ii. Would you like to receive SRH information now?
        - iii. How do you think SRH information would help you?
17. Were you offered contraception when you accessed MA from the pharmacy/medical shop?
    - **a. Yes**
        - i. What methods were you offered?
        - ii. Did you receive adequate information about these methods?
    - **b. No**
        - i. Would you have like to have been offered contraception? **(Go to Q8)**
18. Did you accept and use one of the contraception methods you were offered at the pharmacy? *[Interviewer to confirm from where post-abortion contraception was received if not from the same pharmacy]*
    - **a. Yes**
        - i. Are you still using this method? If not, how long did you use it for and why did you choose to stop?
        - ii. Are you happy with this method?
    - **b. No**
        - i. Why did you choose to not accept and use the contraception offered?

ii. Would you like to start using contraception now?

19. What was your experience with accessing MA from a pharmacy/medical shop?
    i. Did the abortion happen as you expected it would?
    ii. Did you have to seek SRH/medical services after you had taken the MA for any reason?

20. Was this the first time you have accessed MA through a pharmacy/medical shop?

21. Why did you choose to access MA through a pharmacy/medical shop instead of a SRH clinic?

22. Would you access MA through a pharmacy/medical shop again? Why/why not?

23. How do you think accessing MA through a pharmacy/medical shop could be improved?

24. Do you have any questions you would like to ask? Do you have anything else you would like to add?

Post-Interview checklist:

□ the participant has been given contact details for MSIN/SPN Staff and Research Team if they have any questions/concerns/follow-up from the interview

□ the participant understands the process of Member Checks and agrees to be contacted

□ the participant has been offered a *MSC Itahari Clinic: Free Health Check-Up Voucher* (general health check-up)

□ the participant has been offered a *MSC Itahari Clinic: Free Women's Health Check-Up Voucher* (pregnancy test)

□ the participant has been informed that contraception is free at the MSC Itahari clinic

□ the participant has been reimbursed 500 NPR for travel expenses

□ the participant has been thanked for their time and for generously sharing their experience and thoughts to help with the study.

Appendix Y.

Guiding Questions: Pharmacy Client Participants (Nepali)

Curtin University

स्भनतचभ ाित ध्लतभचलबतष्मलबा ज्भबितज
ब्जयर्या मा ल्ायकज्लन, :ष्किभमभच
बलम एबमकाभमष्कभ
"भभगवित या ज्भबितज स्किभलथभक

स्भत्रगबदभ यथभकक दय थयलदयभषभउदष्मल बलम क्भहगर्वा बलम चभउचयमगअदष्भ ज्भबवित ९क्ज्ञ
ज्ञायकभदष्मज उपकद दबयभदष्लर ः थभकम कदगमध ाभक क्ष्ज्जर्ा

गर्भपतनपछि गर्भनिरोधक र यौन तथा प्रजनन स्वास्थ्य ९ ज्ञ० सम्वन्धि जानकारी को पर्याप्त पहुँच ः नेपालबाट एउटा अध्ययन

न्ाष्मष्लन तगभकतष्यलक
मार्ग दर्शक प्रश्नहरु
न्यिकगलष्ताथ क्कउभिम च्भकभबचथज एबचतष्थष्उबलतकः ध्कभल धजय जबख्भ बथथभककभम :ब तजचयगनज ब उजबचकबथथरुभमष्थबा किजयउ
समुदायबाट अनुसन्धानमा छानिएका सहभागीहरुः जसले फार्मेसी वा औषधि पसलबाट औषधिद्वारा गरिने गर्भपतन गराएका छन्

एचभ(ष्लतभचखष्भध न्जभथपष्किकतः
अन्तर्वार्ता पुर्व पुरा गर्नुपर्ने सूचीहरु

☐ तजभ उबचतष्थष्उबलत जबक दभभल याभचभम ष्जित चभाचभकजभलत बलम ष्क थफायचतबदभि ष्ल तजभष्च कगचचयगलमष्लनक।
सहभागीहरुलाई सामान्य खानेकुरा दिइएको छ र उहांहरु उपस्थित वातावरणमा सहज हुनुहुन्छ।
☐ तजभ उबचतष्थष्उबलत जबक चभबम बलम गलमभचकतबलमक तजभ ष्लायकबतष्यल ायचक।
सहभागी हरु ले अनुसन्धान सम्बन्धि सम्पूर्ण जानकारी पढ्नुभएको छ र बुझ्नु भएको छ।
☐ तजभ उबचतष्थष्उबलत जबक थजयकभल ब उकभगमयलथ र नभलभचष्थ तष्तभि बलम गलमभचकतबलम तजभ उगचउयकभ या ष्तक गकभ।
सहभागीले अनुसन्धानको निम्ति नक्कली नामः सामान्य शिर्षक छान्नु भएको छ र यसको उद्धेश्य बुझ्नु भएको छ।
☐ तजभ उबचतष्थष्उबलत जबक ब थभिबच गलमभचकतबलमष्लन या धजथ तजभ मष्कथगककष्यल ष्क दभष्लन चभथयचमभम बलम धजबत जबउउभलक धष्तज तजष्क बगमष्य चभथयचमष्लन।
सहभागीले हामीले किन हाम्रो छलफल रेकर्ड गरिरहेको छौ र यो अडियो रेकर्डको उपयोगको बारे स्पष्ट बुझ्नुभएको छ।
☐ तजभ उबचतष्थष्उबलत गलमभचकतबलमक तजभ उचयथभकक या :ष्कदभच न्जभथपक बलम जबक थयलकभलतभम तय दभष्लन थयलतबथतभम।
सहभागीले अनुसन्धानमा संकलित जानकारीहरु बुझ्ने र प्रतिक्रिया दिने प्रक्रिया को बारे बुझ्नु भएको छ र पछि सम्पर्क गर्न सहमति दिनु भएको छ।
☐ तजभ उबचतष्थष्उबलत ष्क बकपभम ष तजभथ जबख्भ बलथ त्रगभकतष्यलक चभनबचमष्लन तजभ चभकभबचथज यच ष्लतभचखष्भध।
सहभागीलाइ अनुसन्धान वा अन्तर्वार्ता सम्बन्धि उहाँहरुको केहि प्रश्न छ भनि सोधिएको छ र प्रश्न गर्ने मौका दिइएको छ।
☐ तजभ उबचतष्थष्उबलत जबक चभबम, गलमभचकतबलमक बलम कष्लभम तजभष्च थयलकभलत ायचक ९यच खभचदबा थयलकभलत नष्खभल बलम लयतभम यल ायचक०।
सहभागीले सहमति फारम पढेर, बुझेर हस्तेः हस्ताक्षर गर्नु भएको छ।

क्लायक्कभम अयलकभलत ष्क ब उचभचभत्रगष्कष्तभ ायच चभकभबचअज उबचतष्अष्उबतष्यल।
अनुसन्धानमा सहभागी हुन सहमति फारम अत्यन्त जरुरि हुन्छ।

न्याष्लन त्तगभकतष्यलक

मार्गदर्शक प्रश्नहरु

ब द्यबअपनचयगलम बलम म्फयनचबउजष्अक

क। सहभागी को पृष्ठभुमि र अन्य तथ्यांकहरु

ज्ञा ाबलनगबनभरक कउयपभल बलम अफउचभजभलमभम

१। बोल्ने तथा बुझ्ने भाषा

द्व। ब्नभ

२। उमेर

घा। च्भष्निष्यल

३। धर्म

द्व। बचष्तबा कतबतगक

४। वैवाहिक स्थिति

छ्ा। म्यभक जगकदबलम ष्खिभरध्यचप बध्बथ

५। श्रीमान संगै बस्ने वा अन्य कतै काम गर्ने

टा ँकर्षथ क्तचगअतगचभ

६। पारिवारिक संरचना

ठा भ्मगअबतष्यल

७। शिक्षा

द्या ऋयलतचबअभउतष्खभ गकभरबअअभकक

ख। गर्भनिरोधक प्रयोगरुपहुँच

ज्ञा ब्चभ थयग अगचचभलतथि गकष्लन ब नभतजयम या अयलतचबअभउतष्यलरु

१। के तपाई हाल कुनै गर्भनिरोधक प्रयोग गर्नु हुन्छरु

बा ष्अक

क। प्रयोग गरिरहेको छु

ष क्क ष्त ब नयमभचल नभतजयम यच तचबमष्तष्यलबा नभतजयमरु ९नष्खभ भहकउभिक या नभतजयमक ष लभभमभम बलम भहउबिष्ल मषाभचभलअभ दभतध्यभभल नयमभचलरतचबमष्तष्यलबा०

१। के यो आधुनिक विधि वा परम्परागत विधि होरु ९गर्भानिरोधनको विधिहरुको उदाहरण दिनुहोस् र आधुनिक विधि र परम्परागत विधिको फरक खुलाउनुहोस् ०

ष्ष ब्चभ थयग जबउउथरगलजबउउथ ध्यष्तज तजष्क नभतजयमरु

२। के तपाईले प्रयोग गर्नुभएको गर्भनिरोधक विधि बाट खुशीरबेखुशी हुनुहुन्छरु

ष्ष्य ध्जभल मष्म थयग ाच्चकत कतबचत गकष्लन तजष्क नभतजयमरु

३। तपाईले कहिलेबाट यो विधि अपनाउन शुरु गर्नु भएको हो रु

ष्खा ध्भचभ थयग गकष्लन तजष्क नभतजयम ध्जभल थयग दभअकभ उचभनलबलतरु

४। के तपाई गर्भवती हुँदा यो विधि प्रयोग गरिरहनु भएको थियो रु

खा ध्जभचभ मय थयग बअअभकक थयगच अजयकभल नभतजयम या अयलतचबअभउतष्यल ाचकरु

५। तपाईले यो गर्भनिरोधक विधि कहाँबाट लिनुहुन्छ रु

खष ध्जबत मय थयग ाभभा बचभ दबचचष्भचक तय ध्यकभल ष्ल थयगच अफगलष्तथ गकष्लनरबअअभककष्लन अयलतचबअभउतष्यलरु

६। तपाईको विचारमा तपाईको गाउँ समाजमा गर्भनिरोधक पाउन के के बाधा हुन सक्छन्?

द। ल्य

ख। प्रयोग गर्दिन

ष ब्चभ थयग ष्लतभचभकतभम ष्ल गकष्लन अयलतचबअभउतष्यल लयधरु

१। के तपाई अब गर्भनिरोधक प्रयोग गर्न इच्छुक हुनुहुन्छ रु

ष्ष ज्बखभ थयग गकभम अयलतचबअभउतष्यल ष्ल तजभ उबकतरु ध्जबत नभतजयमकरु

२। के तपाईंले विगतमा गर्भनिरोधक प्रयोग गर्नु भएको छ रु कस्ता तरिकाहरू प्रयोग गर्नु भएको थियो रु

ष्ष्ष ध्भचभ थयग गकष्लन अयलतचबअभउतष्यल ध्जभल थयग दभअकभ उचभनलबलतरु

३। के तपाई गर्भवती हुँदा गर्भनिरोधक विधि प्रयोग गरिरहनु भएको थियो रु

ष्ख। ध्जबत मय थयग ाभर्भा बचभ दबचचष्भचक तय थयग गकष्लनरबअअभककष्लन अयलतचबअभउतष्यलरु

४। तपाईको विचारमा तपाईको गाउँ समुदायमा गर्भनिरोधक पाउन के के बाधा हुन सक्छन्?

ऋ। क्च्ज ष्लायक्बतष्यल बअअभकक

ग। यौन तथा प्रजनन स्वास्थ्यसम्बन्धि जानकारीको पहुँच

ृक्लतभचखष्भधभच तय भहउविष्ल ध्जबत ंक्च्ज ष्लायक्बतष्यल ँभबलक - तजभ तभक्क क्च्ज धर्षी लयत दभ गकभम कउभअषष्अर्बाथि बक ष्त जबक ष्तितभि नभबलष्लन तय उबचतष्अष्उबलतक, चबतजभच बल गलमभचकतबलमष्लन या ध्जबत क्च्ज ष्क कजयगमि दभ अयलखभथभमो

प्रश्नकर्ताले यौन तथा प्रजनन स्वास्थ्यसम्बन्धि जानकारी को अर्थको व्याख्या (सहभागीलाइ यौन तथा प्रजनन स्वास्थ्य भन्ने शब्दहरुको खासै अर्थ नरहने हुनाले उक्त शब्दहरु विशेषरुपमा प्रयोग हुँदैनन् बरु यसभित्र के के पर्छन भनि सहभागीले बुझ्ने गरि सामान्य भाषामा व्याख्या गर्नु पर्नेछ।

ज्ञा म्य थयग ाभर्भा थयग जबखभ बमभत्रगबतभ बअअभकक तय क्च्ज (ष्लायक्बतष्यलरु

१। के तपाईले यौन तथा प्रजनन स्वास्थ्यसम्बन्धि जानकारी पर्याप्त रुपमा पाएको जस्तो लाग्छ रु

ह्। ध्जभचभ मय थयग चभअभष्खभ ष्लायक्बतष्यल बदयगत क्च्ज ाचकरु

२। तपाईले यौन तथा प्रजनन स्वास्थ्यसम्बन्धि जानकारी कहाँबाट प्राप्त गर्नु हुन्छरु

म एयकत बदयचतष्यल गक्भरबअअभकक तय अयलतचबअभउतष्यल बलम क्च्ज ष्लायक्बतष्यल

गर्भपतन पछाडी गर्भनिरोधक को प्रयोगरपहुँच तथा यौन तथा प्रजनन स्वास्थ्यसम्बन्धि जानकारी

ज्ञा म्ष्म थयग बउउचयबअज तजभ उजबक्कबअथ ायच ंब उर्षीकिरु

१। के तपाई फार्मेसीर औषधि पसलबाट गर्भपतन गराउने चक्की लिन जानुभयो रु

ब। भ्मक

द। ल्य

गईन ९ल्य०

ष ध्जय नयत तजभ ंब उर्षीकि ायच थयगरु

अ। तपाईलाई गर्भपतन गराउने चक्की कसले उपलब्ध गरायो रु

ष्ष ध्जबत ष्लायक्बतष्यल मष्म तजभथ चभअभष्खभ ध्जभल तजभथ नयत तजभ उर्षीकिरु

आ। उहाँहरुले गर्भपतन गराउने चक्की संगै अन्य के के जानकारीहरु पाउनुभयो रु

ष्ष्ष म्प्म थयग गलमभचकतबलम बाीं तजभ प्लायचकबतप्यलरु

ई। के तपाईले उक्त सम्पूर्ण जानकारीहरु बुझ्नुभयोरु

प्ख। ध्भचभ तजभथ याभचभम बलथ अयलतचबअभउतप्यल यच प्लायचकबतप्यल बदयगत अयलतचबअभउतप्यलरु

के उहाँहरुले गर्भनिरोधन वा गर्भनिरोधक सम्बन्धि जानकारीहरु पाउनुभयो रु

ख। ध्जथ मप्म थयग लयत नभत तजभ उर्षकि थयगचकभारु

तपाई आफैंले किन गर्भपतन गर्ने चक्की लिन जानुभएन रु

९ अक०

ह्। बतभच थयग बअअभककभम ःब ाचक तजभ उजबचकबअथरुभमष्अबा कजयउ मप्म थयग चभअभष्खभ क्च्ज प्लायचकबतप्यलरु

तपाईले गर्भ पतन गर्ने चक्की फार्मेसी र औषधि पसलबाट लिईसके पछि के तपाईले यौन तथा प्रजनन स्वास्थ्यसम्बन्धि जानकारी पाउनु भयोरु

बा। अक

बा। पाए

ष ध्जबत प्लायचकबतप्यल ध्भचभ थयग नष्खभलरु

१। तपाईलाई यौन तथा प्रजनन स्वास्थ्य सम्बन्धि के के जानकारीहरु दिइएको थियो रु

प्ष म्प्म थयग ाप्लम तजभ प्लायचकबतप्यल गकभागरि

के तपाईलाइ दिइएको जानकारीहरु उपयोगी पाउनुभयोरु

प्ष्ष क्ल ध्जबत ध्बथ जबक तजष्क प्लायचकबतप्यल जभउिभम थयगरु

तपाईलाई कसरी ति जानकारीहरुले सहयोग गर्योरु

प्ख। ध्यगमि थयग प्पिभ तय चभअभष्खभ ऋयचभ क्च्ज प्लायचकबतप्यलरु

के तपाई अझ बढी यौन तथा प्रजनन स्वास्थ्य सम्बन्धि जानकारीहरु लिन चाहनुहुन्छ रु

दाल्य

दा। पाइन

ष ध्यगमि थयग जबखभ प्पिभम तय चभअभष्खभ क्च्ज प्लायचकबतप्यल ध्जभल थयग बअअभककभम ःब

के तपाई गर्भपतन गराउने चक्कीसंगै अन्य यौन तथा प्रजनन स्वास्थ्यसम्बन्धि जानकारी पाउन चाहनु हुन्थ्योरु

प्ष ध्यगमि थयग प्पिभ तय चभअभष्खभ क्च्ज प्लायचकबतप्यल लयध्रु

के तपाई हाल यौन तथा प्रजनन स्वास्थ्यसम्बन्धि जानकारी लिन चाहनुहुन्छ रु

प्ष्ष ज्यध्र मय थयग तजप्लप क्च्ज प्लायचकबतप्यल ध्यगमि जभउि थयगरु

तपाईको विचारमा यौन तथा प्रजनन स्वास्थ्यसम्बन्धि जानकारीले कसरि मद्धत पुर्याउन सक्छ रु

घा। ध्भचभ थयग याभचभम अयलतचबअभउतप्यल ध्जभल थयग बअअभककभम ःब ाचक तजभ उजबचकबअथरुभमष्अबा कजयउरु

के तपाईले गर्भपतन गर्ने चक्की लिँदा तपाईलाई फार्मेसीरऔषधि पसलले गर्भनिरोधक साधन पनि प्रस्ताव गरिएको थियोरु

बा। अक

अ। हो

ष ध्जबत ऋभतजयमक ध्भचभ थयग याभचभमरु

तपाईलाई कुन साधन प्रयोग गर्न प्रस्ताव गरिएको थियो

प्ष म्प्म थयग चभअभष्खभ बमभत्रगबतभ प्लायचकबतप्यल बदयगत तजभकभ ऋभतजयमकरु

तपाईले त्यो साधनबारे पर्याप्त जानकारी पाउनु भयोरु

दा। होइन

ष ध्यगमि थयग जबखभ प्पिभ तय जबखभ दभभल याभचभम अयलतचबअभउतप्यलरु

के तपाईलाई गर्भनिरोधक पनि संगै प्रस्ताव गरिएको भए हुने भन्ने लाग्छ रु

द्घा ष्प्म थयग बअअभउत बलम गकभ तजभ अयलतचबअभउतष्यलरु क्लतभचखष्भधभच तय अयलाष्क ाचक धजभचभ तजभ अयलतचबअभउतष्यल धबक चभअभष्खभम ष लयत ाचक तजभ ककभ उजबक्कबअथे

के तपाई ले गर्भनिरोधक साधन स्वीकारेर प्रयोग गर्नु भयो रु प्रश्नकर्ताले यदि उही फार्मेसीरऔषधि पसलबाट लिएको हो होइन, गर्भनिरोधक साधन कहाँबाट पाएको हो निर्क्यौल गर्नु पर्नेछ।

बा अक

बा प्रयोग गरे

ष ब्चभ थयग कतर्षी गकष्लन तजष्क नभतजयमरु क्ष लयत, जयध यिलन मष्म थयग गकभ ष्त ायच बलम धजथ मष्म थयग अजययकभ तय कतयउरु

के तपाई अहिले पनि उक्त विधि प्रयोग गरिरहनु भएको छ रु यदि छैन भने, कति समय को को लागि प्रयोग गर्नु भयो र किन प्रयोग रोक्न रोज्नुभयो रु

ष्प मष्म थयग चभअभष्खभ बमभत्रगबतभ ष्लायक्कबतष्यल बदयगत तजष्क नभतजयमरु

के तपाई ले उक्त गर्भनिरोधक विधि को बारे पर्याप्त जानकारी पाउनुभएको थियो रु

ष्ष्य ब्चभ थयग जबउउथ धष्तज तजष्क नभतजयमरु

के तपाई यो विधि बाट खुशी हुनुहुन्छरु

दा ल्य

दा प्रयोग गरेको छैन

ष धजथ मष्म थयग अजययकभ तय लयत बअअभउत बलम गकभ तजभ अयलतचबअभउतष्यल याभचभमरु

किन तपाईले तपाईलाई दिइएको गर्भनिरोधक साधन प्रयोग नगर्न रोज्नुभयो

ष्यध्यगमि थयग ष्पिभ तय कतबचत गकष्लन अयलतचबअभउतष्यल लयधरु

के तपाई अब कुनै गर्भनिरोधक साधन प्रयोग गर्न चाहनु हुन्छरु

छा धजबत धबक थयगच भहउभचष्भलअभ धष्तज बअअभककष्लन ब ाचक ब उजबक्कबअथरुभमष्अबा कजयउरु

फार्मेसीरऔषधि पसलबाट गर्भपतन गर्ने चक्की लिन जाँदाको तपाइको अनुभव कस्तो रह्योरु

ष ष्प्म तजभ बदयचतष्यल जबउउभल बक थयग भहउभअतभम ष्त धयगमिरु

के तपाईले आशा गरे जस्तै गरि गर्भपतन भयो रु

ष्प ष्प्म थयग जबखभ तय कभभप क्च्ज्रुभमष्अबा कभचखष्अभक बातभच थयग जबम तबपभल तजभ ब ायच बलथ चभबकयलरु

के तपाईले गर्भपतन गर्ने चक्की लिईसकेपछि कुनैपनि कारणको निम्ति यौन तथा प्रजनन स्वास्थ्यसम्बन्धि जानकारी वा अन्य स्वास्थ्यसम्बन्धि सेवा लिनुपरेको थियोरु

टा धबक तजष्क तजभ ाच्चकत तष्भ थयग जबखभ बअअभककभम ब तजचयगनज ब उजबक्कबअथरुभमष्अबा कजयउरु

के तपाईले फार्मेसीरऔषधि पसलबाट गर्भपतन गर्ने चक्की लिएको यो पहिलो पल्ट हो रु

ठा धजथ मष्म थयग अजययकभ तय बअअभकक ब तजचयगनज ब उजबक्कबअथरुभमष्अबा कजयउ ष्लकतभबम या ब क्च्ज अष्लिष्अरु

तपाई ले किन गर्भपतन गर्ने चक्की लिन यौन तथा प्रजनन स्वास्थ्यसम्बन्धि क्लिनिकको सट्टा फार्मेसीरऔषधि पसल नै रोज्नु भयोरु

डा ध्यगमि थयग बअअभकक ब तजचयगनज ब उजबक्कबअथरुभमष्अबा कजयउ बनबष्लरु धजथरधजथ लयतरु

के तपाई फेरी गर्भपतन गराउन पर्ने भएमा तपाई फार्मेसीरऔषधि पसलबाट नै गर्भपतन गर्ने चक्की लिन चाहनुहुन्छरु किन चाहन्छु र या किन चाहन्नरु

ढा ज्यध मय थयग तजष्लप बअअभककष्लन ब तजचयगनज ब उजबक्कबअथरुभमष्अबा कजयउ अयगमि दभ ष्कउचयखभमरु

के तपाईको विचारमा फार्मेसीरऔषधि पसलबाट गर्भपतन गर्ने चक्की र सुविधा अझ सुधार गर्न सकिन्छ जस्तो लाग्छरु

ज्ञण। म्य थयग जबखभ बलथ त्रगभकतष्यलक थयग धयगमि ष्पिभ तय बकपरु म्य थयग जबखभ बलथतजष्लन भकिभ थयग धयगमि ष्पिभ तय बममरु

के तपाईलाई केहि प्रश्न सोध्न मन लागेको छरु के तपाईलाई केहि कुराहरु थप्न मन छ रु

एयकत(क्ष्लतभचखष्भध अजभअपष्कितर

अन्तर्वार्ता पछिका सुचीहरु

त्जभ उबचतष्भष्उबलत जबक दभभल नष्खभल अयलतबअत मभतबर्षक ायच :क्ष्ल्रक्एल क्तबाा बलम च्भकभबचअज त्भक ष तजभथ जबखभ बलथ

त्रगभकतष्यलकरअयलअभचलकरार्यायिध(गउ ाचफ तजभ प्लतभचखष्भध

सहभागीहरुलाई केहि प्रश्नरकुराकानी भएमा मेरी स्टोपस् नेपालर सुनौलो परिवार नेपाल र अनुसन्धान समूहका सम्पर्क ठेगाना दिइएको छ

त्जभ उबचतष्भष्उबलत गलमभचकतबलमक तजभ उचयअभकक या :फदभच ऋजभअपक बलम बनचभभक तय दभ अयलतबअतभम

सहभागीले अनुसन्धानमा संकलित जानकारीहरु बुझ्ने र प्रतिक्रिया दिने प्रक्रिया कोबारे बुझ्नुभएको छ र फेरी सम्पर्क गर्न मन्जुरी दिनु भएको छ।

त्जभ उबचतष्भष्उबलत जबक दभभल याभचभम ब :क्ष्ल क्ष्तबजबचष ऋष्लिष्भरँचभभ ज्भबतिज ऋजभअप(ग्उ ख्यगअजभच ९नभलभचबा जभबतिज अजभअप(गउ०

सहभागीलाई मेरी स्टोप्स इटहरी क्लिनिकमा सामान्य स्वास्थ्य परिक्षणको लागि निशुल्क स्वास्थ्य परिक्षण भौचर दिइएको छ।

त्जभ उबचतष्भष्उबलत जबक दभभल याभचभम ब :क्ष्ल क्ष्तबजबचष ऋष्लिष्भरँचभभ ध्कभल'क ज्भबतिज ऋजभअप(ग्उ ख्यगअजभच ९उचभनलबलअथ तभकत०

सहभागीलाई मेरी स्टोप्स इटहरी क्लिनिकमा निशुल्क महिला स्वास्थ्य परिक्षण भौचर दिइएको छ जसमा गर्भवती जांच पर्छ।

त्जभ उबचतष्भष्उबलत जबक दभभल प्लायक्भम तजबत अयलतचबअभउतष्यल प्क ाचभभ बत तजभ :क्ष्ल क्ष्तबजबचष अष्लिष्भ

सहभागीलाई गर्भनिरोधक साधनहरु मेरी स्टोप्स इटहरी क्लिनिकमा निशुल्क पाईने जानकारी गरायौ।

त्जभ उबचतष्भष्उबलत जबक दभभल चभष्दगचकभम छ्रण्ण ल्एच ायच तचबखभा भहउभलकभक

सहभागीलाई यात्रा खर्चको लागि ने। रु। ५०० दिइयो

त्जभ उबचतष्भष्उबलत जबक दभभल तजबलपभम ायच तजभष्च तष्भ बलम ायच नभलभचयगकथि कजबचष्लन तजभष्च भहउभचष्भलअभ बलम तजयगनजतक तय जभाि ध्यतज तजभ कतगमथ।

सहभागीलाई उहाँको अमुल्य समय र आफ्नो अनुभव, विचार बांडेर अनुसन्धानमा सहयोग पुर्याएकोमा धन्यवाद प्रदान गरियो।

Appendix Z.

Thematic Content Analysis of SRHR Professional's Interview Transcripts (n=9)

Themes	Sub-themes
1. Barriers: Access and uptake of skilled safe abortion services	
	1. Sociocultural attitudes
	2. Socioeconomic constraints
	3. Geographic isolation
	4. Translating policy into practice
2. Barriers: Access and uptake of post-abortion family planning services	
	5. Misconceptions and cultural barriers
	6. Geographic remoteness
	7. Policy, practice and monitoring
3. Concerns about medical abortion provision through pharmacies	
	8. The evolution of unsafe (less safe and least safe) abortion and medical abortion
	9. Obstacles to safe abortion services
	10. Challenges of monitoring unsafe (less safe and least safe) pharmacy provided medical abortions

Appendix AA.

Thematic Content Analysis of Clinic Client and Pharmacy Client Interview Transcripts (n=20)

Overarching Themes
1. Abortion Decision-Making Process 2. Medical Abortion Access and Uptake: Safe abortion services vs pharmacies 3. Medical Abortion Experience: Safe abortion services vs pharmacies 4. Post-Abortion Contraception and SRH Information Access and Uptake: Safe abortion services vs pharmacies 5. Contraception and SRH Information Access and Uptake: General

Themes	Sub-Themes
Abortion	
1. Abortion Decision Making Process	1. Sociocultural: Sex-Selection/Son Preference/2nd Trimester 2. Sociocultural: Reproductive Coercion 3. Socioeconomic: Poverty 4. Socioeconomic: Education (of live children) 5. Socioeconomic/Cultural: Empowerment 6. Socioeconomic/Reproductive Health/Gender Roles: Child spacing 7. Reason for Going to Clinic 8. Reason for Going to Pharmacy 9. MA Access Clinic: Participant Thoughts/Suggestions 10. MA Access Pharmacy: Participant Thoughts/Suggestions

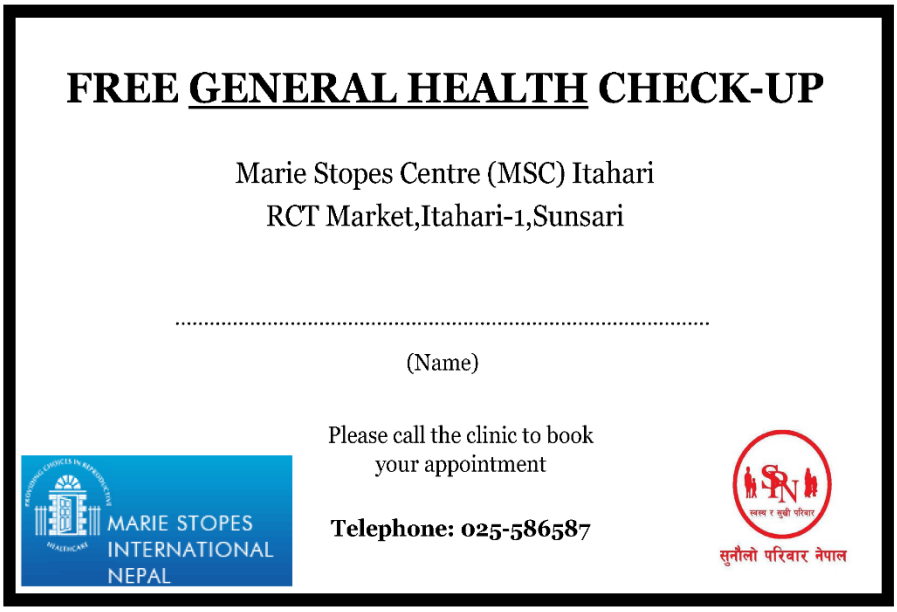
2. Medical Abortion Experience	11. Negative Abortion Experience: Pharmacy 12. Negative Abortion Experience: Clinic 13. Neutral Abortion Experience: Pharmacy 14. Neutral Abortion Experience: Clinic 15. Positive Abortion Experience: Pharmacy 16. Positive Abortion Experience: Clinic 17. MA Pharmacy: Complications Needing Follow-up at Clinic/Hospital
3. Barriers to Safe Abortion Services (PC)	18. Sociocultural: Stigma 19. Socioeconomic: Poverty 20. Geographic Isolation 21. Governmental Policy 22. Knowledge of Safe Abortion Services 23. Unsafe Abortion: Participant Thoughts/Suggestions
Contraception	
4. Contraception Use (Past and Current)	24. Negative Contraception Use Experience 25. Neutral Contraceptive Use Experience 26. Positive Contraception Use Experience 27. Consistently Using Contraception 28. Inconsistently Using Contraception
5. Contraception Use at Conception	29. Using Contraception When Fell Pregnant 30. Not Consistently Using Contraception When Fell Pregnant 31. Not Using Contraception When Fell Pregnant

6. Contraception Information Access (MA use)	32. Contraception Information: Clinic 33. Contraception Information: Pharmacy 34. No Contraception Information: Pharmacy
7. Contraception Information Access (general)	35. Professional: Medical (health post/clinic, SRH clinic, hospital) 36. Professional: FCHV 37. Non-Professional: Family, Friends, Neighbours 38. Media
8. Barriers to Contraception Access and Uptake	39. Sociocultural: Reproductive Coercion 40. Sociocultural: Gender Discrimination 41. Socioeconomic: Poverty 42. Geographic Isolation 43. Governmental Policy 44. Participant Thoughts/Suggestions
9. Spousal Separation	45. Husband Works in Local Community (lives in family home) 46. Husband Works in Nepal (predominantly away from family home) 47. Husband Works Internationally (predominantly away from family home)
SRH Information	
10. SRH Information Access (at time of MA)	48. SRH Information: Clinic 49. SRH Information: Pharmacy

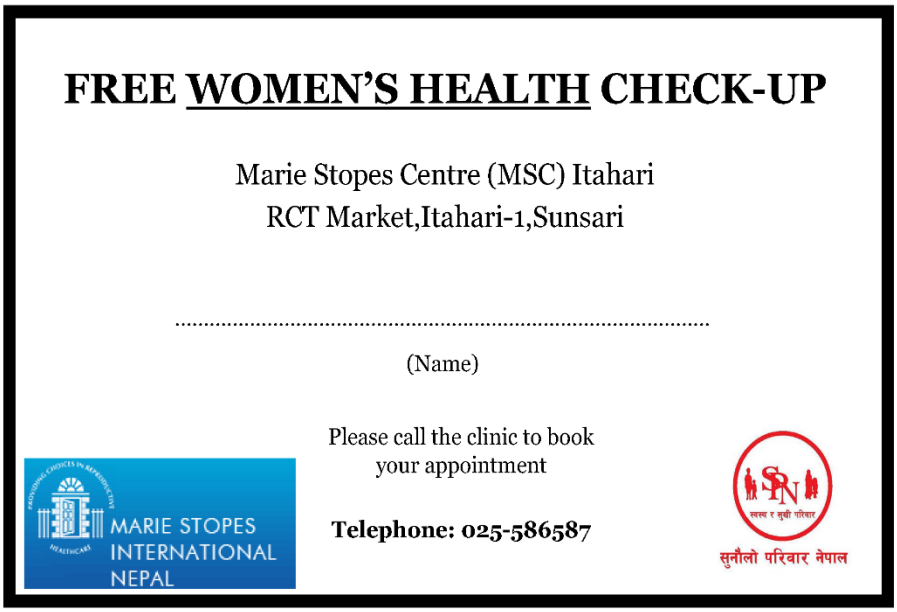
	50. No SRH Information: Pharmacy
11. SRH Information Access (general)	51. Professional: Medical (health post/clinic, SRH clinic, hospital) 52. Professional: FCHV 53. Non-Professional: Family, Friends, Neighbours 54. Media
12. Barriers to SRH Information	55. Sociocultural: Gender Discrimination 56. Socioeconomic: Poverty 57. Geographic Isolation 58. Governmental Policy 59. Participant Thoughts/Suggestions

Appendix BB.

Participant Vouchers: Free Health Check-up and Free Pregnancy Test (English)



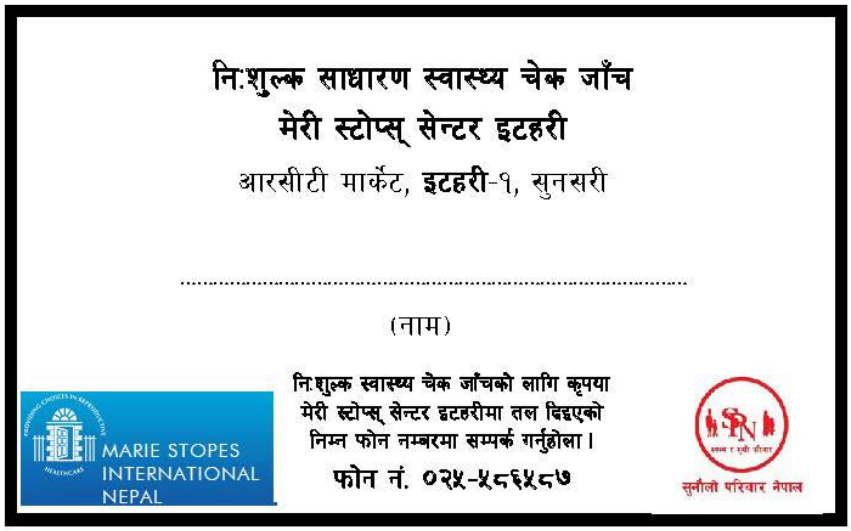
General Health Check-Up Vouchers:
Please provide a general health check-up to women who hand in this voucher.
Given to women who have participated in PhD research.
150 RPN paid for each voucher by Claire Rogers (Curtin University PhD Student) to cover cost of clinic appointment.



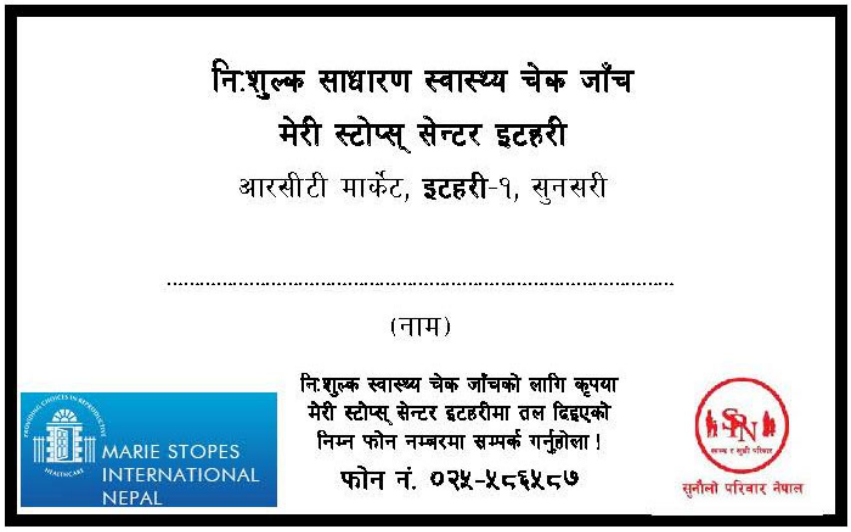
Women's Health Check-Up Vouchers:
Please provide a pregnancy test to women who hand in this voucher.
Given to women who have participated in PhD research.
100 RPN paid for each voucher by Claire Rogers (Curtin University PhD Student) to cover cost of pregnancy test.

Appendix CC.

Participant Vouchers: Free Health Check-up and Free Pregnancy Test (Nepali)



साधारण स्वास्थ्य चेक जाँच भौचर :
कृपया यो भौचर लिएर आउने महिलालाई साधारण स्वास्थ्य चेक जाँच गरिदिनु होला।
यो भौचर पि. एच. डि अनुसन्धानमा सहभागि भएका महिलाहरुलाई दिइएको छ।
कर्टिन विश्वविद्यालय पि.एच.डि विद्यार्थी, क्लेयर रोजर्स द्वारा महिलाको साधारण स्वास्थ्य चेक जाँचको लागि लाग्ने हरेक भौचरको शुल्क रु. १५० भरपाई गर्नेछ।



साधारण स्वास्थ्य चेक जाँच भौचर :
कृपया यो भौचर लिएर आउने महिलालाई साधारण स्वास्थ्य चेक जाँच गरिदिनु होला।
यो भौचर पि. एच. डि अनुसन्धानमा सहभागि भएका महिलाहरुलाई दिइएको छ।
कर्टिन विश्वविद्यालय पि.एच.डि विद्यार्थी, क्लेयर रोजर्स द्वारा महिलाको साधारण स्वास्थ्य चेक जाँचको लागि लाग्ने हरेक भौचरको शुल्क रु. १५० भरपाई गर्नेछ।

Appendix DD.

Article 3: Abortion in Nepal: perspectives of a cross-section of sexual and reproductive health and rights professionals

Rogers, C., Sapkota, S., Tako, A., & Dantas, J. A. R. (2019). Abortion in Nepal: perspectives of a cross-section of sexual and reproductive health and rights professionals. *BMC Women's Health, 19*(40). doi:10.1186/s12905-019-0734-1

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Rogers et al. BMC Women's Health (2019) 19:40
https://doi.org/10.1186/s12905-019-0734-1

BMC Women's Health

RESEARCH ARTICLE Open Access

Abortion in Nepal: perspectives of a cross-section of sexual and reproductive health and rights professionals

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Abstract

Background: Globally, women face many barriers in the attainment of sexual and reproductive health and rights (SRHR). Since 2002, the legalisation of abortion in Nepal has seen significant progress in the expansion of safe abortion and family planning services.

Methods: This qualitative, exploratory study was conducted in 2014 and uses nine in-depth, open-ended interviews with a cross-section of SRHR professionals, to explore their perspectives on abortion in Nepal. The study was underpinned by the Assets Focused Rapid Participatory Appraisal (AFRPA) research methodology and used the health information pyramid conceptual framework.

Results: Thematic content analysis revealed emerging themes relating to barriers to access and uptake of skilled safe abortion services and post-abortion family planning. Findings also emphasised current practical and legal components relating to the provision of medical abortion through pharmacies and highlighted issues of sex-selective abortion within the predominantly patriarchal society.

Conclusion: Effective and ongoing sector-wide monitoring and evaluation of safe abortion services and their staff is essential for women in Nepal to have adequate access to effective and efficient safe abortion services, access to contraception and sexual and reproductive health (SRH) information post-abortion and to ensure adherence to current Safe Abortion Policy. It is critical that the unsafe (less and least safe) provision of medical abortion through pharmacies and sex-selective abortion continues to be investigated and that innovative strategies are formulated to ensure the cultural, reproductive and sexual health and rights of Nepali women are realised.

Keywords: Abortion, Contraception, Family planning, Sexual and reproductive health and rights (SRHR), Nepal

Background

An estimated 56 million abortions occur each year worldwide, with women in developing countries having a higher likelihood of accessing abortion than their counterparts in developed regions [1]. World Health Organization (WHO) classifications of safe and unsafe abortion categorise abortion into a three-tiered model of safe and unsafe, with unsafe abortion being further divided into less safe and least safe [2]. It is estimated that of the total abortions occurring worldwide each year between 2010 and 2014, approximately 25.1 million were categorised as unsafe (17.1 million less safe and 8 million least safe) with 24.3 million, or 97%, of unsafe abortions occurring in developing countries [2]. Complications from unsafe abortions are especially common in developing countries with an estimated 6.9 million women annually requiring medical treatment after an unsafe abortion [1].

Prior to 2002, abortion was illegal in Nepal, unsafe abortion was common and deaths from abortion-related complications attributed to more than half of maternal deaths occurring in major hospitals [3–6]. Over the last two decades, Nepal has undergone a sector-wide government approach to family planning and safe motherhood, complementing the legalisation of abortion in 2002 and the availability of medical abortion (mifepristone and

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misoprostol) since 2009 [6, 7]. Through a concerted effort to reduce maternal deaths, Nepal has seen a dramatic decrease in its maternal mortality rate (MMR) over the last twenty years, declining from 901 per 100,000 live births in 1990 to 258 per 100,00 live births in 2015 [8, 9].

Data from the Nepal Department of Health Annual Report (2014/2015) demonstrates that since the implementation of safe abortion services, a total of 819,690 women have received safe abortions from certified service sites. However, the Department of Health Annual Report also details that utilisation of these safe abortion services has plateaued over the last few years [8]. The contraceptive prevalence rate (CPR) has also plateaued over recent years, with data from the most recent National Demographic Health Survey (NDHS), reporting a decrease in the use of modern contraceptive methods from 44% in 2006 to 43% in 2011 and remaining stagnate at 43% in 2016 [8, 10]. The unmet need for contraception in Nepal continues to remain high (having declined country wide from 32% in 1996 to 24% in 2016), particularly for married women aged 15–19 years (34.9%) and for women living in rural and remote regions of Nepal (25.3%) [10]. The low status of women, lack of education, poverty, isolation and the socioeconomic and sociocultural consequences of the caste system all remain significant barriers to SRH care access and service utilisation [10, 11].

In August 2016, the Government of Nepal announced a plan to implement free safe abortion services in public clinics, in combination with the provision of free family planning services, to help overcome the economic burden of accessing safe abortion services [12–14]. However, even with access to free services in public facilities, costs associated with transportation, accommodation, logistics, medicines and additional medical fees remain prohibitive factors for poor women accessing services, particularly those in rural and remote regions [4, 7]. Additionally, women seeking services through the non-government and private sectors are required to pay for safe abortion services out of pocket [7].

A Nepal based study of 527 women presenting at hospitals due to complications from unsafe abortion detailed that 68% of respondents induced termination through medication (any substance or drug taken orally or inserted vaginally) while 32% used instrumentation (insertion of instruments into the vagina including aspiration, dilation and curettage or foreign objects) [15]. An estimated 323, 000 abortions were performed in Nepal in 2014, and of these, over half (58%) are considered clandestine procedures, provided by untrained or unregistered providers or self-induced [16]. Of the estimated 137, 000 legal abortions performed in Nepal, the public sector provided 37% of procedures, 34% were provided at NGO facilities and 29% were obtained at private-sector clinics [16]. According to the most recent country-wide NDHS (2016), of the women who recorded having an abortion in the five years preceding the survey ($n = 492$), 72% opted for medical abortion (MA), 17%, manual vacuum aspiration and 7% dilation and evacuation/dilation and curettage. The majority reported attending a doctor, nurse, or auxiliary nurse midwife (71%) for their most recent abortion and 19% received services from a pharmacist or medical shop. Rural residents and women with no education were more likely to report the use of MA than their urban counterparts. Half of the women surveyed reported obtaining an abortion as they did not want more children, while 12% said that they wanted to delay childbearing. Health concerns were cited by 10% of women, 9% wanted to space their births, and 7% reported that the sex of the child was undesired [10].

While it has been 15 years since the legalisation of abortion in Nepal, unsafe abortion remains the third highest (7%) direct cause of maternal death in Nepal and significant numbers of Nepali women remain unaware of the legal status of abortion and have limited or no knowledge of where to obtain safe abortion services [7, 10, 17–19]. Efficient and equitable provision of Comprehensive Abortion Care (CAC), which includes Post-Abortion Care (PAC), plays a pivotal role in positive health outcomes and prevention of future unintended pregnancies for women who access safe abortion services [7, 20–25].

By providing a platform for SRHR professionals to share their extensive experience and knowledge, this qualitative exploratory study aims to enhance the current understanding of abortion in Nepal from their perspective and, to the authors' knowledge, is the first of its kind to be conducted in Nepal with such a diverse group of professionals. Informed by participant suggested strategies, we propose recommendations on how SRH and CAC services can assist Nepali women to navigate cultural and sexual norms to more effectively and holistically exercise their reproductive health rights.

Methods

Using an Assets Focused Rapid Participatory Appraisal (AFRPA) research methodology, underpinned by a health information pyramid conceptual framework, this qualitative exploratory study utilised data collected from in-depth, open-ended interviews with nine SRH professionals located in Kathmandu valley and Sunsari districts of Nepal [26, 27]. Building on the Rapid Participatory Appraisal methodology, Pepall et al. (2006) describe AFRPA as an effective means of prioritising needs and identify existing community assets that may help contribute to social change and development. Emphasis on

assets ensures that findings are concurrently solution- and problem-focused, as opposed to merely the identification of problems. Supporting this methodology with the Annett and Rifkin's (1995) health information pyramid conceptual framework, grounded data collection within a four-tiered framework: 1. community composition, organisation and structure, and capacity to act; 2. physical environment, socioeconomic environment, and disease and disability; 3. health and environmental services, and social services; and 4. health policy. Pepall et al. (2006) refer to this composite process as an Assets Focused Rapid Participatory Assessment Cycle (AFRPAC).

Throughout the research project, nine individual informal conversations were also conducted with community members located in the Sunsari District including: business owners; homemakers; political and religious leaders; academic professionals; and young people, to inform in-depth interview questioning and to enable the research team to acquire a greater understanding of people's perception of women's health within the context of their community, as well as Nepal in general. These informal conversations also helped to highlight perceived community and national assets, such as individuals, organisations, programs and infrastructure. As well as supporting in-depth interviews, this component of AFRPA allows researchers to gain insight into a community's own perspective of its needs; helps facilitate the translation of overall findings into action; and assists in enabling the establishment and ongoing relationship between service providers and local communities [27].

Due to the cyclical nature of the AFRPAC, evaluation and modification of the research process were on-going. The utilisation of the AFRPA research methodology and health information pyramid conceptual framework enabled the evolution of information collection and analysis to accentuate key issues concerning the SRHR sector, as well as perceived assets relating to safe abortion and post-abortion family planning and SRH information access in Nepal. This enabled participants to focus both on current problems relating to access to safe abortion, post-abortion family planning and SRH information, as well as the formulation of potential solutions for these issues. Complementing the qualitative findings, analysis of current government and non-government SRH policy and clinical practices was also undertaken concurrently.

Ethical approval for this study was granted by the Nepal Health Research Council (NHRC 20/2014) and the Curtin University Human Research Ethics Committee (HR 17/2014). With assistance from in-country contacts within the SRHR sector, research participants were purposively recruited, via telephone and email, from a cross-section of professionals for their expertise within the SRHR field in Nepal. Representing varying SRHR organisations and professions, the diverse range of research participants included: clinical staff; researchers; advisors; advocacy officers; government officials; international and local non-government organisation staff; and international donor personnel. By design, many of the research participants are high-ranking officials or senior members within their organisations and were able to provide country wide context (urban, rural and remote) to SRHR and wide-ranging perspectives to SRHR in Nepal. While their organisations are represented throughout Nepal, many of the participants work from their organisational headquarters in Kathmandu, therefore the majority of interviews were held in Kathmandu from a practical perspective.

The hour-long interviews were conducted with participants (at a location of the participant's choosing) between June and August of 2014 by the first and third authors who are both females. A research information sheet and informed consent form were provided to all participants for review prior to interviews and participants were encouraged to ask questions about the study or any component of the research. Participants choose either Nepali or English as their preferred language for communication. Informed written consent was provided by all research participants. Eight of the interviews were audio recorded, and one interview was transcribed on location. Audio files were transcribed after the interviews, and all participants received a copy of their interview transcript for review and feedback and as a form of member checking. A second round of member checks was conducted between June and July of 2017.

A thematic analysis of in-depth interviews was undertaken with the first three authors reading the transcripts and discussing data saturation before collaboration and refinement of themes. Thematic analysis enabled the examination of patterns of experience within the data, facilitating the synthesis of themes and sub-themes within the context of over-arching commonalities of access to safe, less safe and least safe abortion in Nepal [28, 29]. To ensure the confidentiality of participants, generic job titles have been used throughout this paper and the sex of the participants withheld.

Rigour in qualitative research is assessed within the context of dependability, credibility, confirmability and transferability, with trustworthiness a significant factor in the research's ability to demonstrate reliability and validity [30–32]. To enhance the credibility and overall trustworthiness of this research, systematic checking, ongoing interpretation of data and an audit trail were utilised to ensure information relating to the study design, methods and analysis were documented, transparent and could be replicated [33–36]. Pilot testing of interview questions was conducted with all authors assisting in the refinement and finalisation of the guiding questions prior to the interviews. Member checking, the

process of sharing interview findings with research participants to ensure data accuracy, was undertaken to validate results and themes and enhance the trustworthiness of the data [34, 36]. The second round of member checks conducted in 2017 was also an effective method of ensuing the continued relevance of respondent quotes [36]. Participants were also asked if they would like to provide additional information or insights into any developments in SRHR policy and practice in Nepal. As a component of the ongoing AFRPAC research process, the second round of member checks ensured findings are contemporary and relevant to issues impacting SRHR in Nepal.

Results

The research participants worked within various sectors of SRHR in Nepal and provided extensive and multifaceted insights into their experiences and knowledge regarding women's abortion and post-abortion experiences in Nepal. Eight participants were interviewed in Kathmandu, and to gain understanding of SRHR issues within a clinical environment outside of Kathmandu, one was interviewed in the Sunsari District (see Table 1).

Three overarching themes emerged from the thematic analysis relating to 1. barriers to access and uptake of skilled safe abortion services, 2. barriers to access and uptake post-abortion family planning services (contraception and SRH information provision) and 3. the provision of MA through pharmacies. There were several sub-themes relating to each of the overarching themes and are listed in Table 2. Participants also recommended strategies to improve access and uptake of post-abortion family planning services and skilled safe abortion services in Nepal.

Barriers: Access and uptake of skilled safe abortion services

Sociocultural attitudes

Participants highlighted the impact of sociocultural attitudes, religious beliefs, cultural norms relating to sexual and reproductive health and the influence of Nepal's patriarchal society on women's access to and uptake of skilled safe abortion services. Stigma associated with accessing safe abortion services was stated as a key barrier to women not utilising safe abortion services.

Stigma in the community is the first barrier to women accessing safe abortion services. A woman can say that she is going to a health service for a delivery, but she can't say she is going for abortion services. *IDI 5. Safe Abortion Policy Advisor, I/NGO, Nepal.*

Negative service provider attitudes towards women seeking safe abortion services were also expressed and this impeded woman from up taking services. Several participants stated that unmarried women have further increased difficulties in accessing and use of safe abortion services due to negative cultural attitudes towards sex outside of marriage. One participant stated that this impacts women who often seek unsafe abortions.

Although abortion is legal in Nepal, many women are still getting unsafe abortions; we see less unmarried women attending safe abortion services (due to sociocultural reasons). *IDI 6. Service Provider, SRH Clinic, I/NGO, Sunsari District.*

Socioeconomic constraints

The complex socioeconomic disparities between women who are married and unmarried women seeking safe abortion services compound barriers to access.

Table 1 In-depth Interview (IDI) Participants ($n = 9$)

	Title	Organisation	Work Location
IDI 1.	Service Provider	SRH Clinic, I/NGO[1](a)	Kathmandu
IDI 2.	Senior Service Provider	SRH Clinic, I/NGO(a)	Kathmandu
IDI 3.	SRHR Research Consultant	Independent	Nepal
IDI 4.	Senior Service Provider	CAC[2] Unit, Public Health Facility	Kathmandu
IDI 5.	Safe Abortion Policy Advisor	SRH I/NGO(b)	Nepal
IDI 6.	Service Provider	SRH Clinic, I/NGO(a)	Sunsari District
IDI 7.	Program Manager	SRH NGO[4](c)	Nepal
IDI 8.	Senior Officer	SRH NGO(d)	Nepal
IDI 9.	Senior Officer	Ministry of Health, GON	Nepal

[1]International Non-Government Organisation
[2]Comprehensive Abortion Care
[3]Government of Nepal
[4]Non-Government Organisation
(a) SRH I/NGO providing clinical and educational services
(b) SRH I/NGO providing advisory and educational services
(c) SRH NGO providing clinical and educational services
(d) SRH NGO providing research, advocacy and educational services

Table 2 Thematic Analysis of Interview Data

Main Themes	Sub-themes
Barriers: Access and uptake of skilled safe abortion services	
	Sociocultural attitudes
	Socioeconomic constraints
	Geographic isolation
	Translating policy into practice
Barriers: Access and uptake of post-abortion family planning services	
	Misconceptions and cultural barriers
	Geographic remoteness
	Policy, practice and monitoring
Concerns about medical abortion provision through pharmacies	
	The evolution of unsafe (less safe and least safe) abortion and medical abortion
	Obstacles to safe abortion services
	Challenges of monitoring unsafe (less safe and least safe) pharmacy provided medical abortions

Barriers exist between married and unmarried women seeking abortions…The majority of women using safe abortion services are typically from economically relatively well-off families. Poor women experience a greater financial barrier to accessing abortion services. *IDI 3. SRH Research Consultant, Independent, Nepal.*

The financial burden experienced by women seeking safe abortion services (including appointment and procedure fees as well as travel) was also a reoccurring theme throughout the interviews. Several participants stated that the cost of safe abortion services deters women from accessing these facilities and is a deciding factor for many women to procure unsafe abortions. The inability to afford safe abortion services is often exacerbated for women living in rural and remote regions of Nepal.

Another barrier to access and uptake of skilled safe abortion services is the abortion fee… 1000 Nepali Rupees ($9.50 USD) is a very big amount for rural women. *IDI 8. Senior Officer, SRH NGO, Nepal.*

Geographic isolation

The health services in Nepal are located in the Central Development Region and along the Terai belt (the low land region in Southern Nepal), to the detriment of those living in the remote hill and mountain regions.

In Nepal, approximately one in five people live in urban areas where both surgical and MA services are available. In rural areas and districts, however, access to abortion services remains problematic. In such areas, women may not have any option but to resort unsafe abortion practices that could have serious health consequences. *IDI 3. SRH Research Consultant, Independent, Nepal.*

Issues relating to lack of access to health care services, safe abortion services and trained medical professionals in rural and remote regions was a reoccurring theme throughout the interviews.

I come from the rural area, but I don't choose to work in my hometown because I cannot earn as much money providing services there… Few health professionals remain in remote areas and very few I/NGOs are providing training for those professionals. *IDI 2. Senior Service Provider, SRH Clinic, I/NGO, Kathmandu.*

Interview participants revealed numerous inhibiting factors relating to lack of access and uptake of safe abortion services in rural and remote regions of Nepal including: lack of infrastructure, both health services as well as road and transportation issues; administrative issues relating to lack of sufficient numbers of trained staff able to provide non-judgmental safe abortion services during regular working hours; lack of training and on-going capacity building of services providers; and lack of incentives for trained personnel to work within rural and remote regions.

Translating policy into practice

Participants reported their experiences with the conflicting nature of practice versus the Ministry of Health National Safe Abortion Policy relating to effective and equitable SRH service provision in Nepal.

I think the written policy is very good, but in practice, it's not applicable…The Government has a concrete plan of action, but they lack the knowledge and skills on where to implement and how to implement. *IDI 7. Program Manager, SRH NGO, Nepal.*

While current Government policy states that safe abortion services are available across Nepal, several participants stated that lack of awareness of abortion laws and available services continues to inhibit women from access and uptake of safe abortion services.

CAC services are available in all ecological areas; however, due to difficult geographical locations, women are facing difficulty in accessing services. Also, many women in these remote locations are not aware of safe abortion services. *IDI 4. Senior Service Provider, CAC Unit, Public Health Facility, Kathmandu.*

Geographic isolation was stated as being a deterrent for trained health care professionals, who do not want to work in remote and rural regions.

The Government has health policy that clearly states the need for doctors and medical staff in remote areas, but the incentives are very low. In public facilities, a trained medical doctor and nurse positions are allocated up to the Primary Health Care Centre (PHCC) level, but the positions are often vacant. *IDI 7. Program Manager, SRH NGO, Nepal.*

Participants reported that monitoring and evaluation mechanisms of safe abortion services to maintain quality of care and ensuring CAC service data is accurately recorded and reported, are inconsistent across public, I/NGO and private services.

The main cause of inconsistency is the lack of a monitoring mechanism… There are no regular monitoring visits in some NGOs as well as in the public sector. Monitoring is very weak. *IDI 5. Safe Abortion Policy Advisor, I/NGO, Nepal.*

Effective and consistent monitoring and evaluation processes of I/NGO safe abortion services in Nepal was reported to be currently undertaken within I/NGO SRH clinics. However, lack of trained professionals to conduct monitoring and evaluation of safe abortion services provided by public and private facilities was sighted as being the key component of inconsistent services provision, impacting women's ability to access and utilize safe, effective and comprehensive abortion services.

Here (Government Office) we are only two staff members, one doctor and one Public Health Nurse (PHN), we can't go to every district to monitor sites so (SRHR I/NGO) is supporting the Government with monitoring. In the districts, we have a PHN as a focal person who should monitor the district hospital and other private clinics. She should go from time to time (to monitor services), but in some districts, it is lacking. It depends on how active PHN is. *IDI 9. Senior Officer, Ministry of Health, GON, Nepal.*

Current translation of policy into practice and monitoring of safe abortion services in Nepal are intrinsically linked and have a substantial impact on access to safe abortion services with trained and culturally sensitive health professionals. Increasingly, the Government is establishing a memorandum of understanding (MoU) with I/NGOs to overcome the lack of resources and expertise they lack for monitoring and evaluation of safe abortion services. While the vast majority of participants shared their positive perceptions of Government SRH and Safe Abortion Policy in Nepal, lack of effective monitoring inhibits the translation of policy into practice.

It's not so much the policy, rather the implementation that must be looked at. Implementation of the guidelines needs to be monitored… The Government needs to have a regulating body to assess, evaluate and monitor the standard of abortion provision services. *IDI 3. SRH Research Consultant, Independent, Nepal.*

Barriers: Access and uptake of post-abortion family planning services

Misconceptions and cultural barriers

In Nepal, contraception is free of charge and consequently, socioeconomic issues relating to access and uptake of post-abortion contraception did not emerge in our interviews. However, sociocultural factors impacting post-abortion contraception decision making were a prominent theme discussed by all participants. Prevailing misconceptions relating to the use of modern contraception was a critical factor in women deciding not to use post-abortion contraception.

There are many misconceptions regarding the use of contraception like excessive bleeding will occur, weight gain will happen, or they will get cancer through the use of contraceptive methods. *IDI 6. Service Provider, SRH Clinic, I/NGO, Sunsari District.*

Effective provision of post-abortion SRH information and contraceptive education through counselling was stated as an important component of increasing uptake of post-abortion contraception. However, challenges were reported.

Good counsellors have key role to play in reducing the misconceptions around contraception. If a counsellor is well trained and knowledgeable, they will motivate the client to use contraception and provide comprehensive information. Half information leads to misconception. *IDI 7. Program Manager, SRH NGO, Nepal.*

The difficulty of discussing post-abortion contraception support and services with husbands and mothers-in-law is a cultural barrier.

Cultural and social barriers are the most common barriers for women accessing post-abortion contraception….in some cases, women still cannot share their SRH related problems with their husbands. *IDI 1. Service Provider, SRH Clinic, I/NGO, Kathmandu.*

While our participants shared many examples of barriers to uptake of post-abortion contraception and SRH information, the most frequently cited inhibiting factor to the uptake of post-abortion family planning services was the large number of women whose husbands work outside of Nepal or away from their home districts.

In our country, mostly the males (husbands) are migrant workers, who occasionally come home to visit their wives. That is one of the main reasons for women not accepting contraception (post-abortion). *IDI 5. Safe Abortion Policy Advisor, I/NGO, Nepal.*

All participants shared their thoughts relating to the ever-increasing male migrant worker population and the impact it is having on women using contraception and post-abortion contraception.

Geographic remoteness

Issues with timely procurement and supply of contraceptives was also a barrier to women receiving a broad choice of contraceptive options post-abortion. Reported contraceptive supply chain challenges include lack of trained logistical staff and insufficient human resources; lack of adequate storage and timely transportation from district centres to peripheral health facilities; and an

absence of accountability mechanisms for stockouts and commodity delays. Along with a lack of supply, geographical isolation also impacted the availability of trained safe abortion service providers able to provide women with comprehensive post-abortion family planning services and SRH information.

At rural and remote sites (safe abortion services), contraceptive commodity and trained human resources are not always available. If a woman comes to the service site and wants an Implant, due to lack of trained human resources and commodity she can't get an Implant. That gap of commodity and trained staff means women are not getting contraceptive method of their choice and the counselling will be biased in that case. The service provider will counsel on those methods which are available at the site. *IDI 5. Safe Abortion Policy Advisor, I/NGO, Nepal.*

Policy, practice and monitoring

Participants spoke of the juxtaposition between Government policy that requires clinics to have five different methods of contraception available to clients and the reality of the limited choice, perhaps only two or three contraceptive methods, available at many public clinics.

According to Government Policy, at the Health Post level, there must always be the availability of five contraceptive methods (condom, pills, Depo (injectable), IUD and implant). But, there are not all five methods available at all the government Health Posts in Nepal. *IDI 9. Senior Officer, Ministry of Health, GON, Nepal.*

While the current Government policy states all SRH facilities should follow the same guidelines, service provision continues to vary due to poor contraceptive supply, lack of trained service providers and a high level of staff turnover resulting in clinic closures. This lack of comprehensive education and knowledge provision among health professionals across facilities was reported to be a key inhibitor of post-abortion contraception uptake and continuation.

Women need to be informed and educated so they can make an informed decision…Most abortion clinics offer contraception in an almost a ritual way… Through counselling and discussion, the service provider must ensure that the women's individual contraceptive needs are met… Counsellors should really focus on the women's fertility goals and desires and see what the best way for her to achieve that is. *IDI 3. SRH Research Consultant, Independent, Nepal.*

Although current Government SRH and Safe Abortion Policy addresses the SRHR needs of Nepali women on paper, it was emphasized there is ineffective translation and application of policy into practice.

In Nepal, implementation of policy into action leaves a lot to be desired. *IDI 3. SRH Research Consultant, Independent, Nepal.*

Concerns about medical abortion provision through pharmacies

The evolution of unsafe (less and least safe) abortion and medical abortion

All interviewees commented on the increasing trend of women accessing both registered (Government approved) and unregistered brands of mifepristone and misoprostol (MA pills) illegally through pharmacies, sometimes referred to as chemists or medical shops. Respondents also raised concerns that not only are registered and unregistered MA tablets sold through pharmacies, but potentially drugs of unknown chemical composition are also being provided to induce abortion. One participant elucidated the evolution of unsafe abortion in Nepal and its impact on negative health outcomes for women.

Before the legalization of abortion, women practised harmful abortion methods such as taking herbs and extensive massage which could cause complication and the need for hospital admission. Now, because of the availability of abortion pills, women go to pharmacies, take the pills, have incomplete abortion or complications and need to go to the hospital. *IDI 8. Senior Officer, SRH NGO, Nepal.*

Several participants reported that a high number of women accessed safe abortion services after experiencing an incomplete abortion as a result of accessing MA illegally through pharmacies.

Most of our incomplete abortion cases come from medical shops. *IDI 4. Senior Service Provider, CAC Unit, Public Health Facility, Kathmandu.*

The participants shared the reality of women accessing MA through pharmacies and the lack of SRH information relating to the administration of MA as well as the lack of post-abortion care and post-abortion family planning.

Pharmacy staff are not aware of the eligibility criteria for the provision of abortion services, what is the route of administration, what is the expected outcome and side effects, what are adverse side effects. They are just selling medical abortion pills. *IDI 8. Senior Officer, SRH NGO, Nepal.*

Several reasons for women choosing to access abortion through pharmacies instead of going to health facilities for safe abortion services were cited during the interviews. Negative sociocultural attitudes towards abortion and privacy issues relating to accessing abortion were reported to be a key reason why women chose pharmacies.

Abortion is very stigmatized in Nepali culture, so they scared of losing their privacy… in chemist shop they don't have to give any answers regarding the abortion they can get pills very easily. *IDI 5. Safe Abortion Policy Advisor, I/NGO, Nepal.*

Obstacles to safe abortion services

Geographical isolation and the health service provision implications were also reported as key influences in women choosing to access MA through pharmacies. Participants shared that women will often seek MA through pharmacies as there is no health facility that provides safe abortion service located near them or there are no trained safe abortion service providers in their local community.

The reason for women choosing medical shops over safe abortion services (from registered clinics) may be due to the lack of abortion services in government health facilities in their area. *IDI 8. Senior Officer, SRH NGO, Nepal.*

Challenges of monitoring unsafe (less and least safe) medical abortion

Participants spoke of numerous challenges when trying to stop the sale of MAs through pharmacies in Nepal.

In current Government policy, it is stated that medical abortion should not be provided through chemist shops, it should be provided through permitted (registered) clinics only. But the demand is very high…The clients don't care about World Health Organization (WHO) standards and protocol, they just want prompt service. *IDI 5. Safe Abortion Policy Advisor, I/NGO, Nepal.*

The difficulties the Government Drug Administration Department faces trying to monitor and halt the flow of MA pills through pharmacies was reiterated throughout the interviews. Human resource capacity was cited as being a major barrier to the effective monitoring of MA drugs within the market.

Medical abortion obtained from medical shop should stop. We have approached the Department of Drug Administration but they can't control it, and this is a great concern. *IDI 9. Senior Officer, Ministry of Health, GON, Nepal.*

Several spoke of collaboration between Government, I/NGOs and the private sector to establish a committee to implement monitoring of pharmacies. However, this has proven challenging with inconsistent results seen across areas of implementation. While MA can only legally be prescribed by a safe abortion service provider in the first trimester in Nepal, it was suggested that women might have a sex-selective MA through pharmacies after the first trimester.

There are currently no regulatory body on sex-selection issues in Nepal. Technology (ultrasound) has made it easier for couples to test for the sex of their child… It needs to be audited and evaluated; sex-selection is emerging as a big concern with the increase of accessibility to medical abortion as well. The MoH (Ministry of Health) needs to set up an independent body to ensure that ultrasound is not used for sex-selective abortion in the country. *IDI 3. SRH Research Consultant, Independent, Nepal.*

One participant stated that within the context of sociocultural practices and beliefs, the motivation behind sex-selection abortion and the legalization of safe abortion (both surgical and medical), should be not be viewed as mutually dependent. They commented that the legalization of abortion in Nepal is not the causation factor of sex-selection abortion practices but is a component of entrenched cultural beliefs.

Sex selection is related to the social, economic and patriarchal pattern of society. It has been done for many years prior to the legalisation of abortion. Linking the legalisation of abortion services and sex selection is wrong. If we educate the community people on the value of the girl child, if boys and girl are equally valued, sex selection abortion will decrease, it takes time, it won't change overnight. *IDI 5. Safe Abortion Policy Advisor, I/NGO, Nepal.*

Interviewees shared their views on the current state of MA provision in Nepal and on how unsafe provision of MA can decrease.

Medical abortion has left the clinic, left the doctors. Technology has outpaced everything, so we have to find a way to engage the non-conventional facilities. Medical shops are increasing medical abortion provision; however, they are just dispensing the drugs and are not counselling the women… Medical shops are evolving their role in Nepal. Globally, the function of medical shops has enlarged and is recognized by the World Health Organization (WHO) as well. *IDI 3. SRH Research Consultant, Independent, Nepal.*

While one research participant stated that MA pills should only be administered by professionals that are able to perform pelvic or vaginal examinations, several participants shared their views of a more harm reduction approach through education and training of safe MA provision to pharmacy staff.

For medical shops that don't have medical professionals, we should provide at least basic harm reduction training. *IDI 7. Program Manager, SRH NGO, Nepal.*

Several participants highlighted the need for Government policymakers to carefully consider the role pharmacies currently play in the provision of MA and how current policy must be revised to reflect this.

(The Government of Nepal) should revise policy as we can't stop chemist shop from selling the pills (medical abortion). If more restrictions are made, they will, of

course, sell the pills under the table… Rather than stopping chemist shops and stopping women visiting chemist shops we should give information on the right dose and right time or complete information of taking pills in case of abortion. *IDI 5. Safe Abortion Policy Advisor, I/NGO, Nepal.*

Pharmacy specific harm reduction strategies such as training of non-medical staff, as well as the potential for qualified pharmacy staff receiving further education on MA provision through pharmacies, was noted as a potential governmental approach to increase access to safe MA as well as theoretically reducing the incidence of complications resulting from unsafe MA provision.

Through training, medical abortion services can be expanded, and those who are eligible to provide medical abortion could provide services. For those who don't meet the edibility, their business selling medical abortion will decrease, and therefore complications of medical abortion will be reduced. *IDI 8. Senior Officer, SRH NGO, Nepal.*

The certainty that pharmacy staff will continue to sell MA tablets regardless of illegality was reiterated by research participants. The majority of participants also stated the need to review and revise current government policy relating to MA provision through pharmacies to help reduce mortality and morbidity associated with the practice.

Discussion

The intersectoral and multifaceted nature of barriers associated with access and uptake of skilled safe abortion services and post-abortion family planning are highlighted throughout our findings. Insight and knowledge shared by the SRHR professionals is underscored with recommendations on ways to improve access and uptake of skilled safe abortion services and post-abortion family planning, as well as strategies to decrease the level of mortality and morbidity. Our findings emphasise the breaking down of sociocultural stigma and entrenched cultural beliefs and gender inequality, related to abortion and contraceptive use, as key to supporting women to access and uptake safe abortion services and post-abortion family planning, a concept collaborated with previous SRHR research [22, 37–39]. While the Government of Nepal has focused on improving access to health care services through the strengthening community-based health interventions [40], our findings demonstrate the continued gap in community-level safe abortion and family planning education and knowledge.

Through collaboration with I/NGO and private sector, the Government of Nepal must increase awareness campaigns relating to access and uptake of safe abortion and family planning services at the community and national level. Within the *Nepal Health Sector Strategy 2015–2020* framework, it is essential that community-based SRHR and safe abortion education and awareness campaigns focus on families, women, males, youth, community leaders and service providers [17, 40–42]. The need for policy to address the status of women within Nepal's patriarchal society is recommended as a means to ensure women's SRHR, as well as their human rights, are met.

Several respondents reported the increasing use of sex-selective abortions and the sociocultural attitudes that prefer a male child that are responsible for this practice. Indeed, there has been global research into the consequence of son-preference and sex-selective abortion, most notably in China, South Korea and parts of India [43]. Currently in Nepal research on sex-selective abortion remains scare and is needed to inform community educational and behavioural change interventions and policies [44]. Increased activities addressing and shifting culturally entrenched attitudes towards girls and women within Nepali society must increase [45].

In the last decade, Nepal has experienced an unpredicted level of male workforce migration, both within Nepal and to overseas countries, predominantly The Middle East and India [10, 40, 46, 47]. Several studies conducted in Nepal have demonstrated that the increasing male migrant workforce could potentially play a role in Nepal's stagnated contraceptive prevalence rate, highlighting a key factor to whether women decide to access, continue and/or discontinue contraception is greatly influenced by issues relating to spousal separation [11, 22, 37, 39, 48–50]. SRH policy and practice stakeholders must establish strategies to decrease the cultural stigma surrounding women accessing contraception while their husbands work away from the family home and to ensure service providers effectively counsel women on contraceptive choices that suit their circumstance. More research into the association between contraceptive use among women and the migrating male workforce is needed.

Supporting our findings, previous studies show that knowledge on the legalisation of abortion in Nepal and the awareness of where to access safe abortion services remains low, particularly for young women, women from rural or remote regions and for women from lower socioeconomic backgrounds [17, 41, 42, 51]. Misconceptions and myths related to family planning (such as fear of side-effects) have been shown to play an inhibiting role in a woman's decision to uptake post-abortion contraception [52]. Effective and comprehensive abortion and post-abortion counselling skills enables providers to support women's SRH information and education needs; dispel misconceptions and discuss concerns relating to contraceptive use and side-effects; encourages discussion of fertility goals; facilitates referral to other health services if needed; encourages post-abortion follow up; and assists

women in making informed decision regarding post-abortion contraception [22, 23, 37, 39, 52, 53].

The importance of effective and equitable training and capacity building for all SRH professionals, regardless of geographic location or type of clinic they work in (public, private or I/NGO), is an important component in the provision of high-quality, safe abortion services and was a reoccurring recommendation throughout our research. The provision of adequate staffing numbers and positive service provider attitudes are important components of high-quality, safe abortion care and effective post-abortion counselling [22, 37]. The recruitment and retention of trained health care providers working in rural and remote facilities in Nepal continues to be a challenge across all sectors of health [40, 54, 55], with our findings highlighting the specific concerns relating to safe abortion services.

While the National Safe Abortion Policy states that safe, accessible and affordable abortion services should be 'available with equity and equality for all women', many Nepali women still do not have adequate access to such abortion services [4, 5]. This key finding corresponds with findings by Puri et al. (2016), that despite expansion of safe abortion services in Nepal, there remains a vital need to increase access and availability to high-quality, safe abortion services to all Nepali women, regardless of geographical location. The Government of Nepal, I/NGO and private practice SRH services must re-evaluate current incentives and strategies for health professionals to retain them in rural and remote regions [56]. Collaboration with universities and medical training facilities is recommended to formulate strategies to increase the number of trained health professionals choosing and continuing to work in rural and remote regions.

Women in Nepal face numerous socioeconomic barriers to accessing safe abortion services, particularly those who live in rural and remote regions. To help mitigate the financial barriers to accessing safe abortion services, the Government of Nepal has recently committed to provide free access to safe abortion services from public health facilities [12, 13]. However, without effective monitoring and evaluation of safe abortion services that are already being provided in public health facilities, ensuring a high level of quality care in these services remains impossible [57]. Therefore, a strategy for consistent and comprehensive monitoring and evaluation of these services must be rolled out simultaneously for this implementation to truly provide effective and equitable provision of comprehensive safe abortion services.

The WHO *Safe Abortion: Technical policy guidance for health systems* (2012) emphasises that quality safe abortion care depends upon effective operational processes for monitoring, evaluation and the effective implementation of rights-based SRHR policy. Along with maintaining quality of care, the accurate collection and reporting of service statistics are essential for the analysis and synthesis of population data relating to abortion in Nepal [5, 6, 57]. In Nepal and around the world, there is an urgent need to increase the availability of accurate information on gender equality and women's and girls' SRHR to inform rights-based policy and decision making. [45, 58, 59]. Effective monitoring and evaluation of safe abortion service facilities and health care providers is essential to facilitate a quality of care standard throughout Nepal and to ensure: adequate numbers of staff are located at clinics to deal with work flow; up to date training and maintenance of professional competency of all staff; administration and infrastructure is maintained to policy standards; and equitable distribution of contraceptive commodity supplies through an established and well-resourced supply chain.

Similar to findings of previous SRH research in Nepal, our participants expressed concern over the differing levels of consistency (between public, private, I/NGO in urban/remote areas) in providing access to a broad choice of contraceptives as well as effective family planning information regarding a broad range of methods [6, 22, 37, 50]. USAID's 2016 report *Twenty-Five Year Review of Assistance to Nepal's Health Sector* indicates the Nepal health sector procurement system and supply chain management remains weak throughout the health system, resulting in resource inefficiencies and frequent stock-outs of drugs and commodities at health facilities [47]. Our findings highlight the specific and current impact ineffective contraceptive commodity supply chains has on family planning services, particularly in rural and remote regions. Ensuring the close monitoring of commodity supply to facilitate the effective and equitable distribution of contraceptives, especially to remote regions, is a key element to ensuring uptake and access to post-abortion contraception services [60].

The provision of MA in the form of mifepristone and misoprostol where MA is legal (or misoprostol alone where mifepristone is not legal or available), is a proven, acceptable, safe and effective way to terminate an unwanted pregnancy up to nine weeks of gestational age [56, 57, 61]. Studies from countries where abortion is highly restrictive have credited, at least partially, a decline in rates of severe complications and mortality resulting from unsafe abortion with increased use of misoprostol [62–67]. While data is still limited, global research indicates the effectiveness of MA self-management and remote support (telephone hotlines or mobile phone messages) [67–71]. Current WHO guidelines do not recommend pharmacy workers and lay health workers independently provide MA due to insufficient evidence of safety and effectiveness [72]. Indeed, studies conducted in low and middle-income countries have demonstrated that without professional

development or training of staff, women accessing MA through pharmacies rarely receive adequate information regarding the administration of the drug, post-abortion care, SRH information, post-abortion family planning or any form of follow-up [56, 73–77]. However, with appropriate training, several studies have documented that pharmacy workers and lay health workers are able to: assess clients for MA eligibility; provide adequate information on MA administration; provide information on, and management of side-effects; assess for abortion completion; provide post-abortion contraceptive and capably provide clinic-based referral when needed [66, 73, 78–81].

Our findings indicate there is a potential impact MA provision through pharmacies is having on mortality and morbidity from unsafe abortion in Nepal, and recommend harm reduction strategies, such as training pharmacy staff in safe MA provision and post-abortion family planning and care referral mechanisms, to decrease complications [73, 80, 82]. Respondents shared that the professional development training and certifying of eligible pharmacy staff in the provision of MA could not only decrease unsafe abortion and its potential consequences but also increase access to MA, particularly in remote and rural settings that currently lack safe abortion facilities [73, 83–85]. With increasing access to pharmacy provided MA in the developing world, our findings highlight the importance of harm reduction strategies to decrease mortality and morbidity from unsafe abortion, even within countries with permissive abortion laws [7, 67, 81].

It is essential that the Government of Nepal acknowledge the role pharmacies currently play in the provision of MA and establish practical strategies and policies to decrease negative health outcomes for women [80, 82]. A comprehensive evidence base relating to MA provision through pharmacies is needed to inform effective policy within Nepal. Further research is also necessary to differentiate the proliferation of MA distribution through pharmacies under current laws underpinned by the WHO framework of Safe Abortion, Less Safe Abortion and Least Safe Abortion [2].

Participants in this study recommended that through collaboration of public, I/NGO and private practice, SRHR policy and programmatic issues must be looked at critically to ensure robust and proactive policy for family planning and safe abortion service provision. While our findings suggest SRHR professionals are highly supportive of current National Safe Abortion Policy in Nepal, the need to translate and implement this policy into practice is still yet to be achieved [5, 6]. Within the country's recently drafted Sustainable Development Goals strategies [45], the omission of specific indicators addressing safe abortion service access and uptake in Nepal seems a missed opportunity, particularly in the light of the country's globally lauded success of legal safe abortion service implementation over the last 15 years [86–88].

While every effort was made to mitigate bias within the study and to enhance credibility and trustworthiness, the study has several limitations. Financial and time constraints for this exploratory study restricted time in the field. Practicalities relating to access of participants meant the study was limited to the Kathmandu area and did not include multiple participants from outside the region from government and non-government backgrounds. Due to time restraints and access, SRH clinic-based service providers were only sampled from one SRH I/NGO (one Senior Service Provider and two Service Providers) and one Government facility (one Senior Service Provider). However, data saturation was achieved with our small number of participants and enabled detailed analysis. As this is a qualitative study, we have ensured that the depth and richness of information collected, and an audit trail, will ensure transferability.

Conclusion

Nepal's change from restrictive abortion laws to liberalisation in 2002, and the country's experience in expanding safe abortion services over the last 15 years, offers significant lessons for other low-and middle-income countries seeking to reduce mortality and morbidity from unsafe abortion [85]. However, as demonstrated within the Nepal context, even in countries where abortion is legalised, unsafe abortion is practiced. This cross-sectional, exploratory study highlights the numerous factors impacting the access to and uptake of safe abortion services and post-abortion family planning. These factors hold global applicability within in other resource-poor setting like Nepal. Sociocultural, socioeconomic and geographic barriers have highlighted the difficulties women in Nepal face when accessing safe abortion and post-abortion family planning services.

Our findings suggest that without effective and ongoing sector-wide monitoring and evaluation of SRH and safe abortion services and their staff, not all women in Nepal will have adequate access to quality safe abortion services and post-abortion family planning. It is vital that issues relating to the least safe provision of MA through pharmacies and sex-selective abortion continue to be investigated with innovated strategies formulated to ensure the sexual and reproductive health and rights of Nepali women are realised. Our findings detail the necessity for the translation of current Safe Abortion Policy into practice and for safe abortion service access and uptake to play a more prominent role in ongoing Nepal Health Sector Strategies and Sustainable Development Goal frameworks.

Abbreviations
AFRPA: Assets Focused Rapid Participatory Appraisal; AFRPAC: Assets Focused Rapid Participatory Assessment Cycle; CAC: Comprehensive Abortion Care; MA: Medical Abortion; PAC: Post-Abortion Care; SRH: Sexual and Reproductive Health; SRHR: Sexual and Reproductive Health and Rights

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Availability of data and materials
The qualitative data transcripts that support the findings of this study are not publicly available due to their content containing information that could compromise research participant privacy and consent. However, redacted versions may be made available from the corresponding author upon reasonable request.

Authors' contributions
CR, JD and SS contributed to study design, CR and AT conducted data collection and CR, AT and SS collaborated on analysis and interpretation of results. CR was responsible for the initial drafting of the paper and CR, JD and SS for critically revising the manuscript. All authors reviewed the final manuscript and gave approval for submission.

Ethics approval and consent to participate
Ethical approval for this study was granted by the Nepal Health Research Council (NHRC 20/2014) and the Curtin University Human Research Ethics Committee (HR 17/2014). Informed consent was a prerequisite of research participation. All participants provided written informed consent.

Consent for publication
Not applicable.

Competing interests
The authors declare that they have no competing interests.

Publisher's Note

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Appendix EE.

Non-Peer Reviewed Publications

Rogers, C., Sapkota, S., & Dantas, J. (2018). Abortion and Reproductive Health in the Aftermath of a Natural Disaster: The case of Nepal. *Australian Nursing & Midwifery Journal*, 25(9).

Rogers, C., Dantas, J. A. R., & Lohani, S. (20 July 2016). Nepal Quakes Leave Women's Healthcare in Crisis. *NewsDeeply: Women & Girls Hub.* Retrieved from https://www.newsdeeply.com/womenandgirls/nepal-quakes-leave-womens-healthcare-in-crisis/

Rogers, C., (March 2016). The Amazing Women and Girls of Nepal. *Goanet-Femnet: An online network for women, by women*, March, Issue 48, 4-5.

Rogers, C. (June 2015). Emergency Humanitarian Crisis in Nepal: How the earthquakes have impacted the sexual and reproductive health and rights (SRHR) of Nepali women and girls. *InTouch: Newsletter of the Public Health Association of Australia*, June, Issue 32, 3-4.

ABORTION AND REPRODUCTIVE HEALTH IN THE AFTERMATH OF A NATURAL DISASTER: THE CASE OF NEPAL

By Claire Rogers, Sabitri Sapkota and Jaya Dantas

In April and May of 2015, the Himalayan nation of Nepal was struck by two major earthquakes and multiple aftershocks. An estimated 9,000 people died as a result, with UNFPA (2015) estimating around 1.4 million women and girls of reproductive age were affected.

Shortly after the first earthquake, reports of increased numbers of abortion cases began appearing in the news as were reports of women seeking to terminate otherwise wanted pregnancies due to fear that the tremors would cause deformity to the foetus (Sanghani 2015).

To address mounting concerns regarding women's decision making processes around abortion being impacted by misinformation, Marie Stopes Nepal Clinics (having re-opened just days after the first quake), tailored their abortion counselling to ensure women could make informed decisions regarding their choice to terminate their pregnancy. Subsequent qualitative research in the four worst hit areas was conducted to gain contextual understanding and explore knowledge, attitudes and beliefs of pregnant women during the aftermath of major earthquakes to inform evidence based counselling, program and intervention strategies for crisis settings (Rogers et al. 2017).

The research, presented at the World Congress on Public Health in Melbourne, Australia in 2017 and soon to be published internationally, highlights the sociocultural and religious factors impacting abortion seeking decision making during a crisis. It demonstrates that service providers are not always equipped with accurate information to support women in times of crises. Therefore, it is important to ensure that providers' counselling is evidence based and tailored so that women in need can make informed decisions. While the findings are particularly relevant to countries where safe abortion services are legal, women unable to access accurate information and safe abortion services where laws are restrictive, face even greater challenges to their sexual and reproductive health and rights. The study also showed that it is indeed possible to provide safe abortion services within a crisis setting and that women have a proven desire for these services.

The necessity of providing sexual and reproductive health (SRH) services in humanitarian crisis settings has been gaining greater recognition over the last decade, however, safe abortion services are still rarely provided within this context (McGinn and Casey 2016). In November 2017, the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) included language around safe abortion in the Minimum Initial Service Package (MISP) for Reproductive Health guidelines for the first time (Edwards 2017). While this is a forward step towards achieving the inclusion of safe abortion services in SRH humanitarian response frameworks, sustained political opposition and sensitivity to abortion will continue to derail support for formal inclusion in the MISP. Globally, 25·1 million unsafe abortions occur each year with 97% of these in developing countries (Ganatra et al. 2017).

WHILE DEVELOPING COUNTRIES CONTINUE TO BEAR THE BURDEN OF NATURAL DISASTERS AND CIVIL CONFLICT, WOMEN WILL CONTINUE TO SEEK UNSAFE MEANS OF TERMINATING PREGNANCIES AND CONTINUE TO LOSE THEIR LIVES.

While developing countries continue to bear the burden of natural disasters and civil conflict, women will continue to seek unsafe means of terminating pregnancies and continue to lose their lives. There is a vital and global need to provide safe abortion services and access to culturally appropriate SRH care to all women.

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Nepal Quakes Leave Women's Healthcare in Crisis

After Nepal's devastating earthquakes last year, the nation was embroiled in a border conflict with India. Health experts Claire Rogers, Jaya Dantas and Shilpa Lohani explain how these events continue to impact the sexual and reproductive health of Nepali women.

Written by Claire Rogers, Jaya Dantas, Shilpa Lohani Published on July 20, 2016 Read time Approx. 3 minutes

A Nepalese woman salvages her belongings from her house damaged in the earthquake in Khokana, Nepal, in a photo taken April 30, 2015. The 7.8-magnitude earthquake left countless towns and villages across central Nepal in shambles. Almost one year later, many are still devastated. *AP/Niranjan Shrestha*

It has been over a year since the 7.8 and 7.4 Richter scale-magnitude earthquakes struck the small Himalayan nation of Nepal. The earthquakes, as well as multiple aftershocks, resulted in the deaths of more than 9,000 people and injured more than 22,000 men, women and children.

The disaster exacerbated vulnerabilities in a country that already suffers from poor infrastructure and health service delivery. According to the United Nations Population Fund (UNFPA), the 2015 earthquakes negatively impacted 1.4 million women and girls of reproductive age, and an estimated 93,000 who were pregnant at the time of the first quake.

Since then, about 10,000 pregnant women each month have delivered babies that required emergency obstetric care, and 1,000 to 1,500 women were at risk of pregnancy-related complications and needed Caesarean sections, according to UNFPA.

Many health facilities in the hardest hit areas of Sindhupalchok and Gorkha districts are still operating in tents and damaged buildings. This is a significant barrier for women, especially pregnant women, from accessing safe and reliable health services.

In April 2016, the International Federation of Red Cross and Red Crescent Societies (IFRC) reported that "an estimated four million (Nepali) people were still living in sub-standard temporary shelters in conditions that pose a threat to their health and wellbeing." The country's National Reconstruction Authority, the agency tasked with rebuilding homes, only began its work in January 2016, after months of political negotiation. So far, it has only committed $1 billion of the $4.1 billion pool of international donor pledges.

Institutional incapacity, political instability, civil conflict and the four-and-a-half-month blockade at the India-Nepal border have impeded the country's ability to rebuild following the devastation caused by the earthquakes. This has severely restricted the ability of women and girls to access reproductive health services, education and family planning, resulting in an even greater impact.

Many hoped the approval of Nepal's constitution in September 2015 would finally return focus to rebuilding efforts and speed up the distribution of funds to those most in need. However, politically motivated, volatile clashes at the India-Nepal

border in response to the new constitution triggered a blockade, restricting the import of essential humanitarian goods as well as daily living supplies such as fuel, cooking gas, food and medicines from India.

Within hard-hit areas in Nepal, fuel shortages caused by the unofficial blockade dramatically cut the availability of contraception and maternal health medications. NGOs working on family planning had to look into other funding and procurement methods.

The price of fuel, which became exorbitant due to the shortage, doubled and tripled the cost of providing sexual and reproductive health camps in earthquake-affected hilly and remote regions. In Nepal, the winter months of November to February are the peak time for the government and NGOs to run these health camps in Nepal. However, the blockade led to the cancellation of many of these camps, greatly disrupting many NGO projects and activities. This includes piloting new contraceptive methods and training government health workers in sexual and reproductive health needs. Throughout Nepal, essential reproductive health supplies, medicine and equipment were cut, with clinics and hospitals reporting an inability to provide adequate services.

Even in areas unaffected by the earthquake, such as the flat Terai region, fuel shortages limited transportation. This made it very difficult for healthcare providers to commute to towns and villages where women and girls depend on their services.

When access to contraceptive supplies is restricted, women and adolescent girls lose their ability to make choices about getting pregnant. The lack of availability and access to sanitary items also impacts women's personal dignity and health, further affecting their sexual and reproductive health rights.

The Nepal National Human Rights Commission's 2015 report, Key Concerns and Urgent Appeal Regarding Humanitarian Crisis and Its Impact on Human Rights in Nepal, highlighted the impact of border tensions on the people of Nepal, emphasizing the harmful impact on women's rights and reproductive health. Even though the blockade ended in February 2016, the political instability that ignited the conflict at the border has yet to be resolved.

While Nepal is desperate to rebuild, the continued conflict at the India-Nepal border has intensified a growing health emergency in the disaster-weary country. The complexities of the current situation in Nepal are multifaceted, leading to decreased access to sexual and reproductive health services and family planning services. This impact on the human rights of adolescent girls and women in Nepal cannot be underestimated and needs to be addressed.

The views expressed in this article belong to the authors and may not reflect those of Women & Girls Hub.

#BORDER CONFLICTS #CLAIRE ROGERS #GORKHA #JAYA DANTAS #NATURAL DISASTER #NEPAL #NEPAL EARTHQUAKE #SEXUAL AND REPRODUCTIVE HEALTH #SHILPA LOHANI #SINDHUPALCHOK

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SPICE MAMA: A CULINARY HISTORY

Shaheen Hughes *(Perth, Western Australia)*

Shaheen Hughes was born in Bombay and lived there till she was eight. She has lived around the world, studying for her Bachelors and Masters degrees in the UK before moving to Perth nearly 20 years ago. In 2015, Shaheen founded Spice Mama, a culinary history project aimed at celebrating the memory of her grandmother Zena De Souza, sharing old recipes collected by generations of amazing cooks in the family.

From the moment Proust tasted his famous madeleine, we have had an understanding of the importance of food to our memories. The sight, the smell, the taste of a particular food can bring back with crystal clarity a memory from long ago. Many migrants use food as a way to reconnect with their past, a source of nostalgia and to satisfy a longing for home.

I left India permanently when I was eight years old, but my stock of memories of life in Bombay was generous. My grandparents had a large and airy flat just off Colaba Causeway, and when I was young I spent hours hanging of the verandah watching the hawkers and chai sellers and street food vendors sell their wares.

I remember my granny sitting imperially on the verandah with her tea every morning discussing the important subject of the days food, after which her cooks would head to the market and lunch preparations would begin: freshly ground coconut, roasted masala; I would still have chicken curry, rice, cutlets and potatoes for lunch every day if I could.

Moving to Australia was hard at first: the food, particularly, was not the same. The cold, sterile supermarket, the noise, colour, taste and atmosphere of shared enjoyment was missing. We would always look forward to my granny visiting so she could bring us food from home, most special was the East Indian Bottle Masala that we all grew up on.

When she died three years ago, I inherited all of my granny's old handwritten recipe books, that both she and her mother Olive had carefully kept. Cooking from these books made me feel closer to her again, and I soon learned to make the masalas I remembered from my childhood.

I began Spice Mama in 2015 as a tribute to her, and I now make and sell my own bottle masala and vindaloo masala online and through shops in Perth. I love that people are enjoying our traditional home food again. When I'm in my kitchen roasting and grinding masala, I can hear the voices of my female ancestors, telling stories as I cook.

I love that I have found a way of connecting with the past despite living so far away. I love reading my granny's own memoirs of life in Girgaum when she was young, and the sad story of her father Valentine Fernandes, who went to World War One as a surgeon and died in Mesopotamia in 1915, never having met her. I still have all the letters he wrote to Olive from the war, so poignant and full of love.

I am learning about my diverse ancestry, Indian, Portuguese, Indonesian, Dutch. I want to go back and see where my grandparents grew up, in Bombay and in Goa, where the house my grandfather was born in still stands.

By cooking all our traditional foods again, coconut curries, spicy vindaloos, hot cutlets, melting potato chops, green chutney, aromatic pilaus... I am sharing my memories and my stories with my own family, and ensuring the traditional knowledge I have gets passed down to a new generation.

(You can read about my great grandfather's letters and my Bombay stories on www.spicemama.com.au)

THE AMAZING WOMEN AND GIRLS OF NEPAL

Claire Rogers *(Queensland, Australia)*

Claire is currently pursuing her PhD in International Health and is a passionate advocate for women's sexual and reproductive health and rights. @ClaireRogersttN

Nepal is a country of soaring snow-capped mountain ranges, hillsides dense with lush, green forests and flat tropical planes that seem to stretch on forever. While the vast and varied splendour of this country is clearly evident, it is the beauty and warmth of her people that has made Nepal feel like home to me. Although I am from Australia, I have had the privilege to visit and work in Nepal over the last nine years.

A small landlocked country, Nepal lies between India and Tibet and is home to around 29.3 million people. Nepal has suffered from a 10-year civil war that ended in 2006; horrific earthquakes that devastated the country in April and May of 2015 killing nearly 9,000 people and injuring more than 22,000 more; and more recently, blockades at the India/Nepal border that have restricted the import of essential living supplies. However, throughout these hardships, I have always been amazed by the strength, resilience, humour and generosity of Nepali women.

When the first earthquake struck on April 25 April, 2015, many men within the hardest hit regions were working in foreign countries at the time, a common practice for men of working age in Nepal.

Women in the fields in Nepal

In communities throughout Nepal, women have lead the recovery effort by coordinating with grassroots organisations to distribute essential living supplies, establish space spaces for women and children, clear rubble, reunite children who had become separated from their families and help support their fellow community members while waiting for government aid and support

The Amazing Women and Girls of Nepal - *continued*

to arrive. Admits the pain and suffering, there have been many stories shared of the leadership, compassion and fortitude Nepali women and girls have displayed during this time of horrific natural disaster.

Although Nepal still has much improvement to make in gender equality, since my first visit to Nepal in 2007, I have seen slow progress away from its traditional patriarchal culture towards a more inclusive society. Over the last 15 years, emphasis placed on the sexual and reproductive health of women has helped to dramatically decrease the maternal mortality rate and to increase positive health outcomes for women and girls. During the time I have spent in this wonderful country, I have seen more and more Nepali women stake claim to their rightful place in society and share their skills and wisdom for the betterment of all Nepali people.

Through my studies in women's health in Nepal, I have had the privilege of speaking with women and girls throughout the country, learning about their lives, their families, their work and their plans for the future. It is a humbling and often profound experience to be allowed a glimpse into the thoughts and experiences they so generously share with me. To paraphrase a little sign, I saw hanging in a colourful shop in Kathmandu many, many years ago: "Travellers will come to Nepal for her mountains, but will return for her people".

A Mural of a Nepali Woman

LET HER WORKS PRAISE HER

Chari Kingsbury *(Athi River, Kenya)*

A lot is said these days about women being able to be whatever they want in life – to aim for top positions as CEOs of companies, to aim, literally for the stars as astronauts, to become renowned doctors, researchers, literally anything. This conjures up visions of super women – always strong, and of course very famous. This is great. I strongly believe that every girl should be taught from the time she is born, that she can and should strive to be whatever God has placed in her heart to be. But sometimes, I suspect that there are women who are left out of the limelight that should be there. They are left out simply because they chose to stay at home, to make raising a family their primary calling in life. In this age of women CEOs and surgeons, lawyers and politicians, the 'ordinary' stay at home mother can feel rather like a dinosaur. They are the unsung heroes of our day. Today, I want to sing a song of praise for those influential women that helped shape me, helped make me the woman I am today.

I remember my Granny Burleigh as a rather loud woman, her voice shrill in my little ears as she spoke in that rapid fire way of hers. As a quiet, shy girl, I wondered why she always shouted… until I realized my grandfather was deaf as a post! Granny B was my very favourite grandparent; unorthodox, always moving with a lot of energy, and she loved us kids. I loved the big old barn style house my grandparents lived in up in the country. To this day when I catch a whiff of old, polished wood, worn smooth from years of wear, my mind goes immediately to Granny B's place and all the fun we had with this fiery old lady. This woman endured many difficult years with an alcoholic husband and sons, but she persevered, never stopping in her devotion and never losing her zest for life. I always admired her strength, perseverance and indomitable spirit – even when she succumbed to severe dementia in her old age and could no longer recognize who I was. She lived well into her 90s.

Then, there's Mom – another strong woman, though she would laugh at the idea. She suffered abuse at the hands of older alcoholic brothers, occasional beatings from a husband and suffered the relinquishing of her own dreams of being an artist in order to stay home and raise her four children. My mother was a strict disciplinarian, yet, I never doubted she loved me. She was never one for mushy words or sentimentality. Her love, you just knew was there – a fact, like the very air we breathed. My mom taught cooking, health, about keeping an organized and smooth running home – all of which help me in my work today. Mom also taught me how to persevere and how to preserve an optimistic view of life. Somewhere around my late teens, my mother became more than mom… she became my friend. We would go out for mother/daughter dates, have lunch together, shop and then sit in the car a long time talking about life. Sadly, Mom has gone down the same road of dementia as her own mother did. I miss our chats and our girls' day out.

These two women, though they never had amazing, high powered careers, have touched lives in the most intimate and powerful ways – just by being at home and influencing their children – teaching and loving them. Who knows what my grandmother and mother could have become had they been able to pursue their dreams? Nevertheless, I want to honour them among the great women achievers, so sing the praises of these unsung heroes. "Her children arise and call her blessed… give her the reward she has earned, and let her works bring her praise."

Emergency Humanitarian Crisis in Nepal: How the earthquakes have impacted the sexual and reproductive health and rights (SRHR) of Nepali women and girls

~ ACCESS ~ SAFETY ~ DIGNITY ~

By Claire Rogers, PhD (International Health) Candidate, Curtin University, WA & International Health SIG member, PHAA

Photo credits: IPPF/Nepal/ Sharbendu De

SPRINT staff at an IPPF mobile health clinic providing SRH care to a Nepali women after the 25th April earthquake in Nepal

Sexual and reproductive health (SRH) needs and rights do not magically cease to exist during a time of humanitarian crisis, be it conflict or disasters. Babies continue to be born, women and girls continue to menstruate and SRH services and professionals continue to be needed. However, sexual and reproductive health and rights (SRHR) are often overlooked by the wider humanitarian aid community during a humanitarian crisis, particularly during the acute response phase.

The United Nations Population Fund (UNFPA) estimates around two million women of reproductive age have been affected by the 7.8 and 7.3 magnitude earthquakes and subsequent aftershocks, that rocked Nepal in April and May 2015. Of these, there are approximately 126,000 currently pregnant women who are in urgent need of clean delivery and reproductive health care services.

Worldwide, more than a third of maternal deaths occur in crisis settings due to a lack of access to skilled health professionals and basic emergency-obstetric services. While the maternal mortality rate in Nepal has significantly decreased in recent years as a response to the Millennium Development Goals, for women, particularly those in rural and remoter regions, access to safe delivery services is often difficult at the best of times. In the aftermath of the earthquakes, health facilities in Nepal are overwhelmed, and in many of the earthquake affected areas, damaged or completely destroyed. Clean delivery kits are essential to provide women with basic and hygienic supplies to assist in delivery. It is also essential that effective referral hierarchies are established to transfer and transport high risk or complicated deliveries.

SRH services and trained health care professionals are needed to provide women with access to sanitary items, contraceptives (particularly condoms and oral and injectable contraception during the acute phase and incorporating intrauterine devices (IUDs) during the long-term phase), treatment for sexually transmitted infections (STIs) and management of miscarriage and complications of abortion.

During times of humanitarian crisis, sexual and gender based violence surges and the vulnerability of already disadvantaged populations, dramatically increases. UNFPA estimates approximately 40,000 Nepali women of reproductive age, including those at camps for the displaced, are at an increased risk of sexual and gender based violence. For women and girls, the psychological impact of living through a natural disaster, to then be compounded by the emotional and physical impact of sexual violence, is devastating. Strategic and practical measures must be taken to keep women and girls safe from trafficking and abuse, and to ensure women and girls who experience sexual assault can access trained healthcare professionals, emergency contraception, counselling, medical abortion (mifepristone and misoprostol tablets, legal in Nepal), and post-exposure prophylaxis for HIV and STIs.

Along with the cry for water, oral rehydration tablets, tents and food, in the aftermath of the earthquakes, the call has gone out many times on social media to provide women's sanitary items to those who have lost everything. UNFPA 'Dignity Kits' have been distributed to women in the affected areas and contain items such as reusable sanitary napkins, new clothes, a torch, towels, soap and other essential hygiene supplies that women and girls desperately need.

In response to the 25th April earthquake, UNFPA has entered into partnerships with International Planned Parenthood Federation (IPPF) in conjunction with the Department of Foreign Affairs, Australian Government (DFAT) through the SPRINT Initiative (**S**exual and Reproductive Health **PR**ogramme **IN** crisis and post-crisis si**T**uations) and UN Women. The organisations are working with in-country and regional partners to ensure that the need for sexual and reproductive health care of young girls, women, pregnant women and lactating mothers is urgently addressed in the wake of the earthquakes' devastation. Along with the distribution of Dignity Kits and Reproductive Health Kits, mobile medical camps have been established in affected areas to provide critical SRH services,

Continued on next page

Emergency Humanitarian Crisis in Nepal: How the earthquakes have impacted the sexual and reproductive health and rights (SRHR) of Nepali women and girls

Continued from prevous page

counselling, medical examinations and medicine. Sexual and reproductive health and rights are not a privilege – they are basic human rights and should be afforded to all, regardless of race, religion, socio-economic status, country or circumstance.

The earthquakes and subsequent aftershocks have claimed approximately 8,583 lives with more than 21,045 people injured. The impending monsoon season is compounding fears of further devastation and loss of life in the region. When the media crews pack their bags and the global community turns its attention away, vital lifesaving medical care, including sexual and reproductive health and services, will continue to be needed in Nepal for a long time to come.

An article from the President

By Heather Yeatman, PHAA National President

It is with great pleasure that I award a PHAA President's award to Melissa Sweet for recognition of outstanding journalism in the development and ongoing sustainability of the 'Croakey' blog and building public health capacity in social media.

Melissa has been a long-term health journalist in both mainstream and social media. She is the founder and manager of the Croakey Blog, a forum for debate and discussion about health issues and policy. Melissa has worked very closely with PHAA to ensure health ideas, innovations and stories receive appropriate exposure and engagement.

Melissa's group of "champions" includes many PHAA members who are encouraged to write thoughtful and insightful comments. The nature of her blog is that there often is strong public health content and further comment from interested parties is encouraged.

Melissa has been using the Croakey blog to drive change. She has been an active participant at a number of PHAA conferences and workshops (as well as with other organisations) explaining the advantages of and making more and more people familiar with the many social media tools. The influence of Melissa Sweet has helped to ensure the success of PHAA's Twitter account and our growing engagement in social media.

Melissa Sweet

Melissa Sweet has made a major contribution to public health and to the PHAA. She is a deserving recipient of the PHAA President's Award.

Appendix FF.

Author and Co-Author Statements

Article 1: Author and Co-Author Statement

To Whom It May Concern: I, Claire Ellen Rogers contributed to the published journal article entitled: **Access to contraception and sexual and reproductive health information post-abortion: a systematic review of literature from low- and middle-income countries,** which has been published in the ***Journal of Family Planning and Reproductive Health Care.***

The author contributions are listed below:

- CR conceptualised the study, developed objectives, framework and search strategy.
- JARD supported the design of the study and article.
- CR developed protocol, searched and reviewed articles within the designated framework and prepared the first draft.
- JARD verified the reviewed articles, draft manuscript and added contextual applications.
- CR and JARD read and mutually approved the final manuscript

I, as a Co-Author, endorse that this level of contribution by the candidate indicated above is appropriate.

Professor Jaya A. R. Dantas (Co-Author)

Article 2: Author and Co-Author Statement

To Whom It May Concern: I, Claire Ellen Rogers contributed to the manuscript which under preparation entitled: **Conducting qualitative sexual and reproductive health and rights (SRHR) research in resource poor settings: experiences from Nepal,** which is currently under preparation.

The author contributions are listed below:

- CR conceptualised the study, developed objectives, framework and design of article.
- JARD supported the design of the study and article.
- JARD and SS contributed to study design.
- CR prepared the drafts of the article.
- JARD and SS revised and commented on the article as required.
- All authors will read and mutually approved the final manuscript.

I, as a Co-Author, endorse that this level of contribution by the candidate indicated above is appropriate.

Dr Sabitri Sapkota (Co-Author 1)

Professor Jaya A. R. Dantas (Co-Author 2)

Article 3: Author and Co-Author Statement

To Whom It May: Concern I, Claire Ellen Rogers contributed to the manuscript entitled: **Abortion in Nepal: perspectives of a cross-section of sexual and reproductive health and rights professionals,** which has been published in ***BMC Women's Health.***

The author contributions are listed below:

- CR conceptualised the study.
- JARD and SS contributed to study design.
- CR and AT conducted data collection.
- CR, AT and SS collaborated on analysis and interpretation of results.
- CR was responsible for the drafting, reviewing and revising of the paper and CR, JARD and SS for critically revising the manuscript.
- All authors reviewed the final manuscript and gave approval for submission.

I, as a Co-Author, endorse that this level of contribution by the candidate indicated above is appropriate.

Dr Sabitri Sapkota (Co-Author 1)

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Professor Jaya A. R. Dantas (Co-Author 3)

Article 4: Author and Co-Author Statement

To Whom It May Concern: I, Claire Ellen Rogers contributed to the manuscript entitled: **Medical Abortion in Nepal: A qualitative study on women's experiences at safe abortion services and pharmacies,** which has been submitted to ***Reproductive Health*** and is under review.

The author contributions are listed below:

- CR designed the study and the article.
- JARD and SS contributed to study design.
- CR and RP conducted data collection.
- CR, RP and SS collaborated on analysis and interpretation of results.
- CR was responsible for the drafting, reviewing and revising of the paper and CR, JARD and SS for critically revising the manuscript.
- All authors reviewed the final manuscript and gave approval for submission.

I, as a Co-Author, endorse that this level of contribution by the candidate indicated above is appropriate.

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