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ASSESSMENT OF POST ABORTION CONTRACEPTIVE USE AMONG WOMEN OF DISTRICT KAILALI, NEPAL

BY

JAYA RAJ OJHA

BS15MPH003

CENTRE FOR PUBLIC HEALTH AND HEALTHCARE ADMINISTRATION

AKAL COLLEGE OF HEALTH & ALLIED SCIENCES

ETERNAL UNIVERSITY, BARU SAHIB,

HIMACHAL PRADESH, INDIA

Abstract

A cross sectional study was carried out assesses the post abortion contraceptive use among women of District Kailali Nepal, using self-administered questionnaire technique. Data was entered and analyzed using SPSS version 23. Majority 97.6% of respondents have unwanted pregnancy. Most of women have 9th weeks of gestation. Most of respondents 28.1%have taken abortion service at 3rd trimester. Majority 80.74% of respondents have taken abortion service from INGO/NGO hospitals. Marie Stopes Centre and Family Planning Association of Nepal (FPAN) have provided abortion service to them.

Majority of respondents 91.3% used contraceptive after abortion.The problem of improper use of contraceptives and failure rate was high in study population. About 4.54% of study population suffered from complication during or after abortion.

It was observed that there was statistical significant association between level of educational of the respondents (p= 0.035) andethnic groups (p=0.048) with contraceptive users. No statistical significant association was observed between ageof respondents (p=0.617), age at married (p-=0.887), age at first pregnancy, decision on health seeking behaviour (p=0.932), sources of information about CAC (p=0538) and occupation (p=0.685) with contraceptives users.

Key words: Post abortion, Contraceptive use among women.

CHAPTER I

INTRODUCTION

Nepal made a historic decision to promote safe motherhood by legalizing abortion a decade ago. This has led to a decrease in unsafe abortion, and also attributed to a significant decrease in maternal mortality and morbidity in the country.The typical users of abortion services at the clinic age of 20-24 years old with two living children, mostly married, with the majority not wanting to have more children. About half of them used a contraceptive method-mostly condoms, withdrawal, the pill and rhythm-in the month of unintended pregnancy, suggesting failures with these methods. Health concerns, not availability of methods, and perceived low risk of pregnancy were common reasons for not using a contraceptive method **(CREHPA2000**).

In Zimbabwe in standard practice, abortion clients had to obtain contraceptives from a nearby maternal and child health facility for a nominal fee. A study found that clients receiving standard PAC services were more than three times as likely to experience an unplanned pregnancy in the 12 months following an abortion as PAC clients who were offered ward-based family planning services and methods for free, after adjusting for marital status; desire to have another child, and previous contraceptive use (**Johnson et al., 2002).**

Program implementers note that providing additional family planning counselling at follow-up visits is also an important factor in reducing repeat abortions.There is closely relationship between modern contraception and abortion services. Over the decade, researchers found increase in both contraceptive prevalence and abortion rates around the world.This phenomenon is commonly attributed to rapid reductions in desired fertility, which in turn increase demand for all methods of birth control **(Marston and Cleland 2003**)

Post abortion family planning reduces unplanned pregnancy and repeat abortion. Studies show that providing family planning services as part of post abortion care can increase contraceptive use and reduce repeat abortions (**Fisher,WA et, al 2005)**

Post abortion clients are women and girls with a clear need for family planning. Even if a woman wants to have a child immediately, WHO guidelines recommend she wait at least six months after an abortion before getting pregnant again **(WHO, 2006).** Post abortion care (PAC) includes three components:

(1) Emergency treatment for complications of spontaneous or induced abortion.

(2) Family planning counselling and service provision and, where financial and human resources are available, evaluation and treatment for sexually transmitted infections (STIs) as well as HIV counselling and/or referral for testing (VCT)of post abortion women.

(3) Community empowerment through community awareness and mobilization

In 2002, Nepal broadly legalized abortion,(**Bhandari G.P, etal,2006)** taking a major step towards reducing high levels of maternal death, disability and illness. Safe abortion, however, is necessary but not sufficient to address maternal morbidity and mortality. The provision of post-abortion contraception is critical for preventing future unintended pregnancies and repeat abortion.With the expansion of safe abortion care in Nepal, there are new possibilities for improving the health of women. At the same time, maternal mortality remains high (280 per 100,000), **(CREHPA2007**)and women continue to suffer significant levels of morbidity and mortality from pregnancy, unsafe abortion, and delivery . A key aspect of safe abortion care that has profound potential to improve the health and lives of women and their children is post-abortion contraception. In a country where pregnancy, unsafe abortion, and childbirth

put women's lives at great risk, access to contraception, and counselling to help address barriers to use, are essential to prevent morbidity and mortality from unwanted pregnancy.

Unsafe abortion is a major contributor to maternal morbidity and mortality in developing countries. The global efforts, in 2008, 47,000 women died from complications of unsafe abortion, and the percent of maternal deaths attributed to unsafe abortion at 13% worldwide (**WHO, 2011**).

Adolescents, in particular, often face challenges in accessing abortion. Young women who obtain abortion care tend to access it later in pregnancy than older women and are more likely to delay seeking help for abortion-related complications. These delays are attributable, at least in part, to social stigma surrounding adolescent sexuality. Many youth lack the negotiation and decision-making skills necessary for abstaining from unsafe sexual practices. In Nepal, only 4.2% of adolescents report using modern methods of contraception, and youth could not discuss about sexual health with their parents, relatives and senior community members.

Despites wide accessibility and availability of contraceptive methods, abortion and repeated abortions continue to rise. Unsafe abortion is a major contributor to maternal morbidity and mortality in developing countries. The global efforts, in 2008, 47,000 women died from complications of unsafe abortion, and the percent of maternal deaths attributed to unsafe abortion at 13% worldwide (**WHO, 2011**)

In general, women who have had abortions are motivated to use contraceptives to prevent future unintended pregnancies. It was about post abortion contraceptive use at the national level in Nepal or how it compares with postpartum contraceptive use. To address this gap, researchers used calendar data from the 2011 Nepal Demographic and Health Survey to examine the timing of contraceptive initiation and the rates of method discontinuation after an abortion or delivery.

Consequences of unsafe abortion may be more severe for the disadvantaged groups (poor). Several studies show higher complication rates and mortality from unsafe abortion among women of low socioeconomic status. In 2008, nearly all abortions in Africa were unsafe (**Sedgh et al., 2012)** and 41% of unsafe abortions in developing regions were among young women ages 15 to 24 years (**Shah and Ahman, 2012**).

Abortions—safe and unsafe—and miscarriages or spontaneous abortions are common in World. In 2008, 21% of pregnancies, or 44 million, were voluntarily terminated worldwide. Nearly half of those were considered unsafe (**Sedgh et al., 2012**). An estimated 25% of all pregnancies result in miscarriage within the first six weeks. Unmet need for family planning is high among post abortion care clients. A review of PAC report from different studies found that, on average, nearly 20% of post abortion clients report having had a previous induced abortion.

It is necessary to promote contraceptive in the country because abortion should not be considered as an alternative to contraceptive use**(Thapa, 2015).**

RELEVANCE OF STUDY AND ITS NATIONAL IMPORTANCE

The study aims to identify the associated risk factors of repeat abortions and post-abortion contraceptive use among women in Nepal. Nepal legalized abortion due to promote safe motherhood. Safe abortion was attributed to be one of the contributing factors to a sharp decline of maternal mortality and morbidity in the country. It is expected from this study to give proper counselling the clients, who have lack of knowledge in rural area of Nepal.

Nepal has highly rate of maternal mortality and morbidity but current user of family planning methods were in less numbers .Near about 46% of women are using post abortion family planning methods and most of them were not using long term methods of Family Planning.

Country is investing more money to manage the complication of post abortion women .In this way Nepal have to make ectopic complication free in Zonal Hospitals where MDGP doctor's are working .The study gives high priority to female health and right of women. The research of the study will identify gaps and lacking in the cases of post abortion contraceptive using behaviour of clients. This study press the Government (MoH) and it's department (family Health Department) to modify policy of post abortion where is lacking and weakness in implementation of programme.

AIM OF THE STUDY

Assessment of post abortion contraceptive use among women, Kailalidistrict,Nepal

OBJECTIVES OF THE STUDY

- To assess the use of contraceptive methods among post abortion women.
- To assess the complications after the abortion services among the women.

EXPECTED NEW KNOWLEDGE

From this study it is expected to reveal thatthe situation of Comprehensive Abortion Care (CAC) and Post Abortion Care (PAC) services and their utilization. The study may help in generating information related to use of contraceptives after abortion. The result of the study will help policy makers' government organizations, NGOs and INGOs to implement effective programs and policy regarding contraceptive use in collaboration with other institutes and organizations (Female community health volunteer, Government. Health facility, Family planning Association of Nepal, Private hospitals and medical stores)

CHAPTER II

REVIEW OF LITERATURE

The study problem was selected after literature search and discussion with teachers and colleagues. The associated information for this study was taken from different sources such as different sites of World Health Organization (WHO), United States Agency for International Development (USAID) and national and international journal articles from the internet search through the use of Pub Med, Google Scholar and Google. Literature search was done throughout the study period. Post Abortion family Planning (PAFP) is an emerging public health problem of women worldwide,

The cross-sectional study was done by (**Vinita goyalet, al 2017**)data showed that women 97.4% accepted at least one contraceptive method. Most of them (73.4%) had no previous abortion history. Most of the women who had undergone a previous abortion, 47.5% reported undergoing unsafe abortion. Slightly more than half of the pregnancies (52%) were unwanted. All women had knowledge of the use of condoms, oral contraceptives and injectable. The most chosen method was injectable, followed by oral contraceptives and condoms. Only one woman chose an intrauterine device.

The acceptance rate of post-abortion contraceptive methods was greater and the most chosen method was the best-known one. Implementing a specialized family planning post abortion service may promote an acceptance, regardless of the chosen method. Most important is they *do* receive contraception if they do not wish for an immediate pregnancy,

The cross-sectional study was done by **(Aadele et al,2017)** in Kenya showed that most women (80%) presented with incomplete abortion. Approximately 34% of the women had reached the second trimester of pregnancy. Adolescents (14–19 years old) accounted for approximately 16% of the study sample. Manual vacuum aspiration was used to manage 80% of first trimester cases. The projected annual number of women with abortion complications admitted to public hospitals in Kenya is 20,893. The case fatality rate was estimated to be 0.87% (95% CI 0.71–1.02%), so an estimated 182 (95% CI 148–213) of these women die annually. The annual incidence of incomplete abortion and other abortion-related complications per 1000 women aged 15 to 49 years is projected to be 3.03. The high rate of abortion-related morbidity and mortality documented in the study highlights the critical need to address the issue of unsafe abortion in Kenya.

Another cross-sectional study by (**RA Akin et al,2017)** that describes contraceptive uptake in 319,385 women seeking abortion in 2326 public-sector health facilities in eight African and Asian countries from 2011 to 2013. Ministries of Health integrated contraceptive and abortion services, with technical assistance from Ipas, an international non-governmental organization. Interventions included updating national guidelines, upgrading facilities, supplying contraceptive methods, and training providers. We conducted unadjusted and adjusted associations between facility level, client age, and gestational age and receipt of contraception at the time of abortion. Overall, post abortion contraceptive uptake was 73%. Factors contributing to uptake included care at a primary-level facility, having an induced abortion, first-trimester gestation, age ≥25, and use of vacuum aspiration for uterine evacuation. Uptake of long-acting, reversible contraception was low in most countries. These findings demonstrate high contraceptive uptake when it is delivered at the time of the abortion, a wide range of contraceptive commodities is available, and ongoing monitoring of services occurs. Improving availability of long-acting contraception, strengthening services in hospitals, and increasing access for young women are areas for improvement

The present study has shown post abortion contraceptive behavior among currently married women.

The study revealed that the women aged 25-34 are more likely to use contraceptive methods than the women aged between 15-24(**Benson J. et al, 2016)**

The study by (**Jody Lori J et al20I5)**From Ghana in developing countries, including Ghana, approximately 26% of maternal deaths occur among young women aged 15–19 (Patton *et al.* 2013). Many pregnancies in this age group are unplanned and unwanted; resulting in high rates of induced abortion, many of which are unsafe. There were an estimated 5.5 million unsafe abortions in sub-Saharan Africa every year (WHO 2011) and although the overall number of abortions is declining, the proportion of all abortions that were unsafe is rising. The abortion law in Ghana is one of the most liberal on the continent allowing for abortion by a qualified health worker in a registered facility if the pregnancy is the result of rape or incest, if there is fetal malformation or if the continuation of the pregnancy will risk the mental or physical health of the mother. The total fertility rate in Ghana has fallen from between 4.5 and 5 births per woman in 1985 to around 3 per woman in 2006, a higher decline than can be explained by the contraception prevalence rate in the country. However, it was less clear what impact the liberalization of the law has had on Ghanaian women's ability and willingness to access a safe abortion. Further, regardless of the law governing abortion, it remains a highly stigmatized procedure and relaxing a law may not, without additional steps, reduce this stigmatization.

(Ana Laura et al,2015)A cross-sectional study was carried out from July to October 2008, enrolling 150 low income women to receive post-abortion care at a family planning clinic in a public hospital located in Recife, Brazil. The subjects were invited to take part of the study before receiving hospital leave from five different public maternities. An appointment was made for them at a family planning clinic at IMIP from the 8th to the 15th day after they had undergone an abortion. Every woman received information on contraceptive methods, side effects and fertility. Counseling was individualized and addressed them about feelings, expectations and motivations regarding contraception. All women had knowledge of the use of condoms, oral contraceptives and injectable. The most chosen method was injectable, followed by oral contraceptives and condoms. Few women chose an intrauterine device.

In Ethiopia, the proportion that received contraceptive methods was 56 %. In Brazil, study assessed the quality of post-abortion care suggests that the situation may even be worse in this country, as only 7.9 % of women received a prescription for a contraceptive before hospital discharge and spontaneous abortion (**Aquino et al, 2012**)

Unmet need for family planning is high among post abortion care clients, on average, nearly 20% of post abortion contraceptives use in Asia. Studies showed that, more than a quarter (27%) of PAC clients wanted to wait more than two years to have additional children. Furthermore, more than half of PAC clients expressed an interest in using contraception, yet only about one-quarter (27%) left the facility with a contraceptive method**(Shah et al,2012).**

Unsafe abortion is a major contributor to maternal morbidity and mortality in developing countries. Despite global efforts, in 2008, 47,000 women died from complications of unsafe abortion, and the percent of maternal deaths attributed to unsafe abortion remains unchanged at 13% worldwide (**SuvediB.K etal, 2009**)

In 2008, nearly all abortions in Africa were unsafe, and 41% of unsafe abortions in developing regions were among young women ages 15 to 24 year**.**In Nigeria, for instance, 20 % of post-abortion women received family planning counseling, whereas only 3 % received contraceptive methods(**Blanchard et al, 2005).**

During post-abortion services, 86% of women adopted some method of contraception in Ethiopia. The methods most commonly adopted were pills, injectables, and condoms(**Ethiopia Demographic and Health Survey 2005. Addis Ababa, Ethiopia)**

Study reported that consequences of unsafe abortion may be more severe for the disadvantaged. Several studies document higher complication rates and mortality from unsafe abortion among women of low socioeconomic status**.** Women are at risk of pregnancy almost immediately after abortion. Fertility returns as soon as one week after an

abortion. Timely family planning services can prevent a subsequent unplanned pregnancy. Spacing between pregnancies is important for women's and children's health. After a miscarriage or an induced abortion, women should wait at least six months before becoming pregnant again to reduce the incidence of maternal anemia, premature rupture of membranes, low birth weight, and preterm delivery in the next pregnancy **(Thorp JM et al, 2003)**

CHAPTER III

METHODOLOGY

Study Design:

Cross-sectional study design was adopted.

Study Method:

The study method was quantitative and qualitative. Focus group discussion was used collecting information with formulation of relevant validated by experts with questions regarding knowledge and attitude on each participants groups as for related guidelines.

Study Area:

The study areas included Marie Stopes Center Attariya, Family planning Association of Nepal KailaliBranch, Padma Hospital and MalakhetiHopitalKailali,Nepal

Study Duration:

The study duration was from 1st January 2017 to 31st July 2017.

Study Population

The study population for this research study was age of 15-49 year, married or unmarried females who took the abortion service in a year 2016 from different hospitalsof District, Kailali Nepal.

SAMPLING

Sampling Frame:

The sampling frame for this research study were the total number female population age of 15-49 years from four hospitals.

Sampling Unit:

The sampling unit was individual client who availed of comprehensive abortion care and post abortion care.

Sample Size Calculation:

$$n = \frac{N Z^2 P (1-P)}{d^2(N-1)+Z^2 p(1-P)}$$

Where,

n= required sample size

N=Population (14180)

d= degree of accuracy (p=0.05)

p=Estimated proportion (0.5)

Z = standard normal deviation at 95% level of confidence =1.96

By using the formula for finite population (< 50,000 population)

$$n= \frac{14180 X (1.96)^2 X 0.5(1-0.5)}{(0.05)^2 X (14180-1) + (1.96)^2 x 0.5(1-0.5)}$$

n= 374

SAMPLING TECHNIQUES

The studywas adopted byconvenient sampling techniques. In the study, two hospitals were selected from the private and public hospitals .One NGO and one INGO wereselected fromKailalidistrict, Nepal by using convenient sampling technique.

INCLUSION AND EXCLUSION CRITERIA

Only Post abortion care (PAC) clients were included. Those who refused to participate or were absent at the time of data collection in the study and who participated in pilot study were excluded.

DATA COLLECTION TOOLS AND TECHNIQUES

Structured questionnaire as well as **Focus Group Discussion** was for collecting information regarding demographic characteristics for Knowledge and attitude about abortion respectively. Four questionnaires framed for FGD as per standard guidelines.

VALIDITY AND RELIABILITY

Literature review was done throughout the study period. Questionnaire was constructed taking reference of various research guide lines. Pretesting and modifications of questionnaire were done.

STATISTICAL ANALYSIS

The data collected was entered and analyzed in SPSS-23version. Data checking and correction were done. Frequency distribution and cross tabulation between dependent and independent variables were done for meaningful result. Chi square test was used to show association between socio demographic characteristics and other variables.

ETHICAL CONSIDERATIONS

Approval was also taken from Centre for Public Health and Health care Administration, Eternal University Baru Sahib H.P. for conduction of research. Approval was taken from administration of respective public and private hospital of Kailali District, Nepal including NGOsand INGOs. Written informed consent was taken from women participants who were involved in the study. Confidentiality of each respondents were be maintained strictly and data was used only for research purpose.

PILOT STUDY

Pilot test trial was done among 15 post abortion women of kailali district in Nepa**l.**

COLLABORATION

Marie Stopes Centre, Kailali

District public Health Office Kailali

Family Planning Association of Nepal (FPAN)

Padma hospital Kailali andMalakheti Hospital Kailali, Nepal.

CHAPTER IV

RESULTS AND DISCUSSION

4.1 RESULTS

This study was conductedin 4 selected public, private, NGO and INGO hospitals in Kailali District ofNepal. Data was collected from 374 of age of 15-49 years who had availed of abortion service during 2016. This chapter contains descriptive and inferential statistical analysis of post abortion contraceptive use among women.

Socio Demographic Characteristics of Respondents

Table: 1 Socio Demographic characteristics of the respondents:

Variables	**Frequency(N=374)**	**Percentage (%)**
Age group		
20-25	65	17.4
26-30	202	54.0
31-35	67	17.9
36-40	36	9.6.
40above	4	1.1
Age at marriage		
18-20	135	36.1
21-23	188	50.3
24-26	49	13.1
27above	1	0.3
Age at first pregnancy		
18-20	27	7.2
21-23	169	45.2
24-26	143	38.2
27 and above	35	9.4
Ethnic group		
Dalit	31	8.3
Madesi	1	0.3
Muslim	1	0.3
Janjti	124	33.2
Kshatri	126	33.7
Bramin/Thakuri	91	24.3
Occupation		

Gov, job	39	10.4
Private job	33	8.8
Business	47	12.6
School teacher	84	22.5
House wife	171	45.7
Educational level		
Illiterate	46	12.3
Primary level	124	33.2
Higher secondary	67	17.9
Bachelor	90	24.1
Master or above	47	12.6
Gravid a		
1(prime)	1	0.3
2(multi)	119	31.8
3 (multi)	125	33.4
4 or more	129	34.2
Para		
1	126	33.7
2	136	36.4
3	94	25.1
4 or more	16	4.5
No. of children		
1	130	34.9
2	141	37.7
3	97	25.9
4or more	4	1.1
Decision on Health seeking behaviour.		
Husband	262	70.1
Father	1	0.3
Mother	1	0.3
Self	110	29.3
Husband/partner living with respondent		
Yes	371	99.2
No	3	0.8

Table-1 reveals the socio demographic characteristics of the respondents. More than half of the respondents, 54.0% were in age of 26-30 years, followed by 17.9% was in age of 31-35 years. The mean age of respondents was 28.98 years. More than half of study population age at married was in 21-23 years50.3% .45.2% of respondents had the first pregnancy in age of 21-23 years.38.2% were in age of 24-26 years. About one third of study population was Kshatri 33.7% followed by Janjati 33.2%). 45.7% of the respondents were house wives followed by school. Teacher 22.5% and

respondents who had government job were 10.4%. About 1/3 of study population had primary level education and Bachelor were 24.1%.

Table: 2 Contraceptive used by respondents

Source of Information of CAC services	**Frequency**	**Percentage**
Family members	137	36.6
Health profession	57	15.2
TV and Radio	128	34.2
School	52	13.9
Abortion service availed (earlier)		
Yes	369	98.7
No	5	1.3
Types of Abortion		
Medical	191	51.1
Surgical	178	47.6
No. of earlier abortion services		
1	282	75.4
2	85	22.7
3	2	0.5
Use of emergency contraceptive after unsafe sex		
Yes	186	49.7
No	188	50.3
Method of Emergency Contraceptives (EC)		
Oral pills	123	32.9
DMPA	34	9.1
Intra Uterine Contraceptive Device (IUCD)	29	7.5
Causes of not use (E.C.)		
Not know	26	7.0
Not available	63	16.8
Fear of side effects	84	24.3
Other causes	15	4.0
Institution/hospital did you take contraceptives (E.C.)		
Public hospital	76	20.3
Private hospital	43	10.7
Medical stores	35	9.4
Pharmacy	32	8.0
Causes of abortion		
Unwanted pregnancy	365	97.6
Medical indication	9	2.4

The table-2 reveals that 36.6% of respondents have taken information by family members than TV/radio 34.2% .13.9% of respondents have taken information from schools. Most of study population 98.7% of respondents have taken prior abortion services from different centers(Hospitals, Nursing homes). Only 1.3% of respondents have not taken CAC service. mostly 75.4% of respondents have taken earlier abortion service (Excluding it) once, than two times 22.7% and few 0.5% of respondents have taken three times (CAC/PAC services). More than half 50.3% of respondents have not used emergency contraceptives. 49.7% of respondents have taken contraceptive.32.9% of respondents have used oral pills than DMPA 9.1% and few7.5% of respondents have used IUCD. 24.3% of respondents did not use emergency contraceptive because of fear of side effects. Only 4.0% respondents did not use other causes.Majority 97.6 % of respondents have cause of abortion was unwanted pregnancy.4% of respondent had medical indication.

Table: 3 Conditions related of abortion services.

Legal/Safe	**Frequency**	**Percentage**
Yes	374	100
Weeks of gestation		
5	2	0.5
6	47	12.6
7	86	23.0
8	83	22.2
9	101	27.0
10	32	8.6
11	22	5.9
12	1	0.3
Discussed about abortion with spouse/Family members		
Yes	372	99.5
No	2	0.5
From which Health Facilities you have taken abortion service.		
INGO	152	40.6
NGO	150	40.1
Public hospital	48	12.8
Private hospital	24	6.4
Condition of abortion		
Complete	191	51.1
Incomplete	183	48.9
Minor problems managed by primary treatment		
Bleeding	93	24.9
Haematoma	78	20.9
Infection	94	25.1
Discharge	109	29.1
Treatment Cost provided by		
From family member	187	50.0
Father/Mother	12	3.2
Self	164	43.9
Others	11	2.9
Felt any pain during abortion		
Yes	269	71.9
No	105	28.1
Used contraceptive after abortion		
Yes	341	91.2
No	33	8.8
Methods of contraceptive after abortion.		

Condom	2	0.5
Pills	64	17.1
DMPA	49	13.6
Implant	36	9.6
IUCD	12	3.2
Time of contraceptive use who decided late		
Within 3 days	47	12.6
One week after	91	24.3
Before two weeks	40	10.6
Not use	33	8.8
Facilities did you receive contraceptives		
Gov. hospital	32	8.6
Private hospital	57	15.2
Medical stores	41	11.8
FCHV	48	13.1

Above table reveals that 27%of respondents have 9th weeks of gestation than7th weeks of gestation 23% and relatively few 0.3% of respondents have 12th weeks of gestation .35.8% of respondents had LMP date between April- June months than July- September 28.1% . 40.6% of respondents have taken abortion service from INGO than public hospital 12.8%.Only 6.4% of respondents have taken abortion service from private hospital.8.6% respondents had LMP date between January-March months.29.1% of respondents have problem of discharge after abortion than infection were25.1%. 20.9% of respondents have problem of haematoma. 50% (half of respondents) have managed the treatment cost by family members than self were 43.9% and 2% of respondents managed the cost by others. Majority 71.9% of respondents felt abortion painful and 28.1% of respondents did not fell abortion painful.

More than half (56.7%) of respondents received contraceptive after abortion and more than one third (43.3%) of respondents did not take contraceptive after abortion. 17.1% of respondents took oral pills after abortion than DMPA were 13.6%. And only 0.5% of respondents took condom.

24.3% of respondents received contraceptives within 3 days (who did not decide at the time abortion) at the time of CAC service than two weeks after12.6% and few8.8 % of respondents did not take any contraceptive after abortion. 15.25%of respondents received contraceptive from private hospital than fromFCHV were 13.1% and few 8.65 of respondents took from Government hospital.

Table: 4Complication due to abortion

Major Complication after abortion	**Frequency**	**Percentage**
Yes	17	4.54
No	357	95.45
Complication during or after Abortion service		
Haemorrhage	4	1.1
Sepsis	11	2.9
Ectopic rupture	1	0.3

Other	1	0.3
Treatment Cost managed by		
Referral centre	17	4.54
Self	0	0
Other	0	0

Majority of 98.4%respondents not needto USG .only 1.3% of respondent who took USG services after /before abortion. Most of study population 72.5% had not complication after abortion only 4.5% of respondents had complication among them 2.9% of respondents have problem of sepsis after abortion than haemorrhage 1.2% and few 0.3% of respondent had ectopic rupture.

Only4.5% of respondents were treated for complication in referral centre and 0.3% of respondent were in regional hospital zonal hospital. 3.3% of respondents wereprovided treatmentcost by service centre for complication management than self were 1.2%. Only 0.6% of respondents were treated by other.

Table: 5 Ectopic cases only

Where you had got treatment(ectopic case only)	**Frequency**	**Percentage**
Referral centre	1	0.3
Types of treatment		
Operation	1	0.3

Table 5 showed that, 0.3% of respondentswere referred from service centre to referral centre, only 0.3% of respondent need to operation.

Table: 6 Association between socio-demographic variables and Emergency contraceptive users

Age	**Used E. contraceptives**	**Not used contraceptives**	**Fisher's test/ Chi-square**	**p-value**
20-25	37(51.4)	28(48.1)	2.669*	0.617
26-30	96(47.5)	106(52.5)		
31-35	31(46.3)	36(53.7)		
36-40	20(55.6)	16(44.4)		
40+	2(50)	2(50)		
Age at marriage			1.179*	0.887
18-20	69(50.7)	67(49.3)		
21-23	91(48.4)	97(51.6)		
24-26	25(51)	24(49)		
27+	1(100)	0(0)		
Ethnic groups				
Dalit	16(51.6)	15(48.4)	9.768*	0.048
Madesi	(0)	1(100)		
Muslim	1(100)	0(0)		
Janjati	64(51.6)	60(48.4)		

Kshatri	51(40.5)	75(59.5)		
Bramin/Thakuri	54(59.3)	37(40.7)		
Education level				
Primary	60(48.4)	64(51.6)	10.379*	0.035
Higher secondary	35(52.2)	32(47.8)		
Bachelor	34(37.8)	56(62.2)		
Master or above	29(61.7)	18(38.3)		
Decision on health seeking behaviour.				
Husband	131(50)	131(50)	1.900*	0.932
Father	0	1(100)		
Mother	1(100)	0		
Self	54(49.1)	56(50.9)		
Source of information about CAC				
Family members	74(54)	63(46)	2.169#	0.538
Medical professional	26(45.6)	31(54.4)		
TV/Radio	59(46.1)	69(53.9)		
School	27(51.9)	25(48.1)		
Occupation				
Working	87(50.9)	84(49.1%)	0.165#	0.685
Not working	99(49.7)	104(50.3%)		
Age at first pregnancy				
18-20	16(59.3%)	11(40.7%)	3.483	0.323
21-23	88(52.1%)	81(47.9%)		
24-26	63(44.1%)	80(55.9%)		
27 and above	19(54.3%)	16(45.7%)		

Fisher Exact=* Chi-square=#

Likewise the association between age of respondents and emergency contraceptives users were not significant (p= 0.617). The association between age at married and contraceptive users were no significant (.p=0.887).Likewise the association between age at first pregnancy and emergency contraceptive users were no significant (p-=0.323).The association between ethnic groups and emergency Contraceptive users were significant (p =0.048). Likewise the association between educational level and emergencycontraceptive users were significant (p-=0.035).

From the table the association between decision on health seeking behaviour and emergency contraceptive users wereno significant (p=0.932.)Likewise the association between sources of information about CAC services and emergency

contraceptiveusers werenosignificant (p=0.538).The association between occupation and emergency contraceptive users were on significant. (p=0.685).

Table-7Result of group-A

Name of respondents	What is the social cultural thinking about abortion?	What is safe and legal abortion?	Where are abortion services available and how much does it costs?	What are the complication of abortion and how it is managed?
Kamala ojha	**0**	**0**	**1**	**0**
Kalawatisaud	**1**	**0**	**1**	**1**
Durgadevibohara	**0**	**1**	**1**	**1**
Basudevi Saud	**0**	**1**	**1**	**0**
Ganga devi Saud	**0**	**0**	**1**	**1**
Shanti Pandey	**1**	**1**	**1**	**1**
Anita Sarki	**0**	**0**	**0**	**1**
Ashachaudhary	**0**	**1**	**1**	**1**
AsmitaKathayat	**0**	**1**	**1**	**1**
Total	**2**	**5**	**8**	**7**

0= Negative(Not knowledge)

1=positive (Knowledge)

Result of group-B

Name of respondents	What are the social cultural thinking about abortion?	What is safe and legal abortion?	Where abortion services are available and how much does it cost?	What are the complication of abortion and how it is managed?
Ayushachaudhary	**0**	**1**	**1**	1
Laxmi Air	**1**	**1**	**1**	**1**
Saritachaudhary	**1**	**1**	**1**	**1**
Rakshathapa	**1**	**1**	**1**	**1**
Roma joshi	**1**	**1**	**0**	**1**
Shanti joshi	**1**	**1**	**1**	**1**
Anita kusmi	**0**	**1**	**1**	**1**
Pardesnichaudhary	**1**	**1**	**1**	**1**
Januka shah	**1**	**1**	**1**	**1**
Total	**7**	**9**	**8**	**9**

0=Negative (Not knowledge

1= positive (Knowledge)

Result of Focus Group Discussion

S.N.	**Q.No.1**	**Q.No.2**	**Q.No.3**	**Q.No.4**
Yes	9	14	16	16
No	9	4	2	2

From this study the attitude of respondents (by Q. No-1) were not good to abortion services there were negative concept about abortion in community of Nepal 9 out of (50%).The knowledge of focus group discussion among two(Q,No.-2) groups were very better 14 out of 18 (77.77%). They had known about the safe and legal abortion. Most of respondents had known about (Q.No.-3) the place of abortion services and cost of it (88.8%). At the last majority of respondents of

focus group discussion have knowledge about complication after abortion (88.8% by Q.No-4).Among two focus groups, Group-A had less knowledge than Group-B so Group- B had good knowledge and good attitude about abortion services.

4.2 DISCUSSION

A cross sectional study was carried out to assess the post abortion contraceptive use among women of District Kailali Nepal, using self administered questionnaire technique. Data was entered and analyzed using SPSS version 23. This study was conducted to assess the post abortion contraceptive use among women in reproductive age (15-49 years).

Majority 97.6% of respondents had unwanted pregnancy. Most of women have 9th weeks of gestation who took service at 3rd trimester. More than three –fourth of respondents had taken abortion service from INGO/NGO hospitals (80.74%). They had takenabortion service from Marie Stopes Centre and Family Planning Association of Nepal (FPAN). Near about half of respondents (43.3%)had received post abortion contraceptive method from service centre and 47.5% had not received contraceptive immediately but they received contraceptives after abortion service. Majority of 91.3% clients have taken post abortion contraceptives. Only 8.7% of clients have not taken any contraceptives after abortion.

The complications among the respondents were 4.54% at during or after abortion. 1.1% of respondents had hemorrhage and 2.9%.sepsis.The ectopicrupture 0.3%and other complication 0.3% among total respondents. The service centre provided treatment cost to manage complications.

The study of African countries shows that age of client shows significant association with post abortion family planning utilization in which clients with the age of 15-19, 25–29, and 30-34 had 1.4, 1.6and 1.04 times higher odds of PAFP utilization, than the 20-24 age clients respectively and age group above 35 had 0.55 times. Lower PAFP retention than 20-24 age groups. This result is in line with the study done in three big regions of the country namely Amhara, Oromiya (**Palaverelu LM et al,2017**).which shows age group 20–24 and 25-29 had 1.63 and 1.07 higher odds of PAFP utilization and > 40 had 0.48 times lower odds of PAFP utilization.

In Nepal data shows that side effects or health concerns, inconvenience of use, and not living with a husband or partner at the time of the abortion, and infrequent sex were four major reasons for discontinuing the contraceptive methods after abortion. The program was not able to provide contraception accommodated the concerns and situations women's experience. Data also suggest that stagnation in contraceptive prevalence in the last five years could be related to increases in employment-related migration by men in Nepal (**In the 2011 Demographic and Health Surveys)** 37% of Nepali households had a male who had migrated in the prior year, and work was the most common reason for male migration. Women whose husbands are away or who have infrequent sex may face socio cultural barriers to contraceptive use or took abortion services, including provider attitudes.

Among the respondents who had heard about EC, 87.5% correctly knew its definition and 75% knew correct time of its effective use. These findings were in sharp contrast to the findings of the studies in Nepal and Nigeria ,where in 17% correctly knew its definition and 10% knew correct time of its effective use (subedi, 2012) and in another study 18% correctly knew its definition and correct time of its effective use (Aziken et al., 2003) respectively. In the study, among 30% of the respondents who knew about IUDs, majority of them 39.6% knew the correct timing of insertion of IUDs which showed almost similar rate in the similar study carried out in female college students, where 6.5% reported correct timing of insertion of IUDs (Nibabe et al., 2014)

In any case, these women may have unique contraceptive needs. Further research into the preferences of these women and into provider attitudes and practices is needed to design program approaches to better meet their needs, in both the

post-abortion setting and in reproductive health care settingsalso. By different countries' data no method of contraception was provided at the time of abortion but post abortion contraceptive uptake was 73% overall and ranged from 42% in South Africa to 86% in Ethiopia (**Awol et al, 2012**). Among women who received some form of contraception, sterilization was rare and accounted for ≤2% of all acceptors .In India the proportion of contraceptive use was 24%. Injectablesmethods.African countries ranging from 37% in Ghana to 88% in South Africa (**Olarereta CD et al, 2014**). Implants were used by 24% of acceptors in Ethiopia, 15% in Ghana, and 8% in Zambia (**Yilma et al, 2010**). IUCDs were provided to 12% of acceptors in Asia and 6% in Africa. Oral contraceptive pills were the most common method in Asia (42%). Condoms consisted of more than 20% of contraceptive users in Ghana and India and 38% in Nepal.

The study shows that post-abortion family planning care is poorly delivered. In fact, very few women were provided with contraceptive prescription while hospitalized, just as was observed by (**Aquino et al,2012)** in three Brazilian capitals. In a review study about PAC initiatives in Latin America, other researchers have pointed out the reasons for the lack of contraceptive services during the hospitalization included the physical and administrative separation between the ward or area where emergency treatment services are provided and on-site family planning clinics, limited accessibility to contraceptive methods for staff not working in the family planning clinic, and minimal staff knowledge about post-abortion contraception". Regardless of the reasons why post-abortion delivery of contraceptives was so low, PAC should not focus only on the treatment of complications for incomplete abortion, but also on preventing repeat unintended pregnancy. In contrary the study done in Desire didn't show significant association with age.

Thestudy in Ethiopia revealed that the women aged 25-34 are more likely to use contraceptive methods than the women aged between 15-24. Literacy among both husband and wife increases the contraception use after abortion among women. Exposure to mass media is also playing a determining factor of use of contraception after abortion among women. High contraceptive use among repeat abortion clients likely reflects stronger desires to control fertility, more active family planning efforts and persistent difficulties in achieving fertility goals (**Otseak, 2007**). Ethiopia, and more specifically Addis Ababa, appears to be following a pattern observed in six other countries where contraceptive use and abortion incidence rose simultaneously during a period of fertility transition because increases in contraceptive prevalence were insufficient to meet needs stemming from an increasing desire to limit fertility11. In these countries, abortion incidence eventually fell and contraceptive use remained high. The study from India(**Duggal et al,2004**) Indiaanalyzed individual records of some 292,508 women from nearly 2,500 facilities where IPAS implemented a comprehensive abortion care model in partnership with the public sector in six states, and the authors note that 81% of women initiated contraception immediately following the procedure (**Banerjee et al, 2014**).

Another study from Bangladesh, again drawing on 498 women who sought menstrual regulation service or post-abortion care from 16 facilities in which IPAS had trained providers, reports that 72% of women initiated use immediately following the procedure (**Pearson et al, 2014**).

Finally, a study of women who sought abortion services from four facilities in Mexico City shows that 67% of women adopted contraception immediately following the procedure (**Olavarrieta et al, 2014**).About 80 million of unintended pregnancies are estimated to occur worldwide. In developing countries more than one-third of all pregnancies are considered Unintended and about 19% will end up in abortion, which are most often unsafe accounting for13% of all maternal death globally (**Guttmacher institute 2007, Marston 2004).**

Unwanted pregnancies are affected by number of factors including personal beliefs, social Services, religious and cultural values as well as the existing laws in the community. Most of the time unwanted pregnancies started as

unplanned pregnancy, but occasionally the planned Pregnancy may end up into being unwanted pregnancy **(Baginsk, 2007**).It is also shown that out of 210 million pregnancies occurring in the world annually, about 80 million are estimated to be unintended, of these more than 50% end up in abortion(**Bongarts& West off,2000**).The World Health Organization estimates that at least 33% of all women seeking hospital care for complications related to abortions are less than 20 years of age. This may be explained by the fact that adolescents' fertility rate is very high, this affects not only these young women but also their children's health; because birth to women aged 15-19 years have the highest risks of infant and child mortality as well as high risk of maternal mortality **(WHO**). Most of the respondents, 51.3 % had heard of i-pill. This might be because of the increased advertisement of this product on a large scale. 55.8 % respondents reported that EC are available in pharmacy and 41 % government health facilities. The study findings get support from the similar study in Ethiopia which found 54% respondents get EC from pharmacy, 42.7% from government hospitalsbut contrasted with the findings in another similar study in Ethiopia where 87% reported pharmacy to be available source for EC (**Kagashe et al., 2014)**

Only 13 percent of married adolescences (15-19) age use contraception in sub-Saharan Africa In South Africa, 61 percent of sexually active women used a modern contraceptive**, .**Method, yet 53 % of all births were reported as mistimed or unwanted and 78 percent of births to women aged 19 or younger were unplanned **(Blanchard et al, 2005**).

In Australia among women presenting for an abortion, 56% reported having used some form of modern contraception with most women using condoms or the oral contraceptive pills at the time of conception. Only 1.7%women reported using a LARC (Long acting reversible contraceptives) method pre-abortion. Only 27.4% choose (**De Oliveria2004**) a LARC method for use after abortion and of those immediate provision occurred in 71%. Women aged 20-24 were more likely to choose a LARC method. Women in the lowest socio-economic quintile were the least likely to get the LARC method inserted. LARC provision occurred more often after surgical abortion **(WHO, 2011).**

CHAPTER V

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 SUMMARY

In my study more than one third 43.3% of respondents have taken post abortion contraceptive method withinhalf an hour and 47.59% have got contraceptives after abortion service. Majority 91.3% respondents have taken post abortion contraceptives. Only 8.7% of study population have not taken any contraceptives after abortion. There were problem of proper use of contraceptive and failure rate was alsovery high. The complications among the respondents were 4.54% at during or after abortion. 1.1% of respondents had haemorrhage and the sepsis was 2.3%, Ectopic rupture 0.3% and other complication was also 0.3% among total respondents. Complication managed by service centre by proving treatment cost. It was managed by operation

The association between educational level and emergency contraceptive users were significant (p=0.035).There were significant among ethnic groups and contraceptive usersalso (p=0.048). Age of respondentsand contraceptives users were nosignificant (p=0.617).

Age at marriage (p- =0.887) and Age at first pregnancy was also non significant. Decision on health seeking behaviour (p=0.932), sources of information about CAC and contraceptive users were no significant (p=0538) and occupation and EC users were also non significant (p=0.685).

5.2 CONCLUSION

The study concluded that there was low prevalence of contraceptive use among post abortion women. There was lack of post abortion counselling services to the women who had abortion. There was significant association between the occupation and educational level of women with the post abortion contraceptive users was significant. Haemorrhage Sepsis, Ectopic rupture were the major complication after having an abortion services among women.

5.3 RECOMMENDATIONS

- There is a need to incorporate post abortion contraceptive counselling as part of comprehensive abortion care.
- Most of women want long term contraceptive methods after two or more than two abortion so LARC is necessary to these clients.
- Training of health care providers in abortion care is also a necessary to providing abortion care services of good quality.
- The low contraceptive utilization among the youths can be improved upon by providing adolescent-friendly sexual education and reproductive and contraceptive services to the unmarried youths.
- There is also a need to translate high contraceptive awareness to an increased use in order to bridge the large gap of unmet need.

There is a need to demystify misinformation about contraception. A significant component of any family planning program for Nepal would have to be concentrated on community health education to reduce misconceptions about the side effects of modern contraceptives which is the most common reason for non-use of modern contraceptives after abortion in Nepal.

5.4 Limitations

- The study has many limitations although efforts were made to make it the best. First, the study was cross sectional and might not reflect the status of whole population as sample size was small. It was taken a in Kailali district a huge number of samples but in this study only 374 were collected so there might be some bias.
- Second, the study was based on self-administered questionnaire and hence reporting bias cannot be totally eliminated questionnaire didn't include.
- Third, the questionnaire didn't include detail about failure of contraceptives, and was based on convenient sampling which might have more or less affected the result of the study.

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ANNEXURE I

QUESTIONNAIRE

ASSESSMENT OF POST ABORTIONCONTRACEPTIVEUSE AMONG WOMEN OF KAILALI DISTRICT, NEPAL

Consent Form,

Namaste, My name is Jaya Raj Ojha I am on student of Akal College of Health and Allied Science, Eternal University Baru Sahib District Sirmour H.P. I will be interaction with you on post abortion contraceptive use among women. The information you will give will be treated as confidential because it is just for the study. It depends on your wish to participate or not to in the study.

Yes..... No.....

Respondent Identification S. Number.....

Interviewer.....

Date. Time..... Signature....

Please Tick at Appropriate Options

(A)Socio Demographic Variables.

(1)Name of Respondent.....

(2) Age of Respondent.....

(3) What was the age at marriage time?

Year.....

(4) What was the age at time of first pregnancy?

Age...

(5) What is the ethnic group?

(a) Dalit (b)Madesi(c)Muslim (d)Janjati(e)Kshatri(f) Brahmin/Thakuri

(6) What is your occupant?

a)GovtJob b)Private job c)Business d) school teachere)House wife.

(7) What is your educational level?

a)Illiterate b) primary level c) higher secondary level d) Bachelor

e) Master or above.

8)What is your gravida?

a)1 b) 2 c) 3 d)4or More.

9)What is your para?

a) 1 b) 2 c) 3 d) 4 or more

10)Does your husband /partner live with you?

a) Yes b) No

11)How many live children have you got?

a) 1 b) 2 c) 3 d) 4 or more

12) Decision for health seeking behaviour.

a)Husband b) father c) mother d) self

History of contraceptive use

1) What is source of information about CAC?

a) Family member b) Medical profession c) T.V and radio d)School

2) When was your LMP?

Date of LMP.....

3) Did you have abortion?

a) Yes b) No

4) If yes, which abortion service did you have?

a) Medical b) Surgical

5) Number of earlier abortion excluding the current?

a) 1 b) 2 c) 3 d) 4ormore

6) Have you used emergency contraceptive?

a) Yes b) No

7) Which method did you used?

a) Oral pills. b) DMPA c) IUCD d) other

8) If not why did not you use?

a) Not know b) not available. c) Fear of side effects d) other causes

9) Where do you take the contraceptive?

a)Public hospital. b) Private hospital c) medical stores. d) Pharmacy e) other.

10) What was the cause of abortion?

a) Unwanted pregnancy b) Medial indications.(Physical or mental problem)

c) Complications d) Rape.

Abortion Related

1) Was abortion legal or safe?

a) Yes b) no

2) What are the weeks of gestation?

Week... (Under 12 only)

3) Did your partner /husband give permission to abortion ?

a) yes b) no

4) Which facility do you take abortion services?

a) Public hospital b) Private hospital c) INGO d) NGO.

5) What was condition of abortion?

a) completeb) incomplete

6)What happened after abortion ?

a)bleedingb)haematoma c)infection d) discharge

7) How did you manage abortion cost?

a) from family member b) father /mother c)self d) other

8) Did you feel Abortion painful?

a) Yes b)no

9) Will you take contraceptive after abortion?

a) Yes b) No

10) If yes, which method?

a) Condom b)Oral pills c)DMPA d) implant e)IUCD f) other

11) If not decided, when will you take?

a) One week b) Two weeks after c) After 3 days d) Not

12) From which facility will you take contraceptive method?

a) Medical stores. b) Public hospital. c) Private clinics.

d) FCHV. e) other.

Complication Related

1) Have you got counselling service before abortion?

a) Yes b) no

2) Did you need to have ultra sound after abortion?

a) yes b) no

3) Did you had any complication after abortion?

a)Yes b) No

4) If yes, what problem?

a) Haemorrhage b) Sepsis. c) Ectopic rupture. d)perforation e) other

5) Which facility you were treated for complication?

a)Referalcentre.b)Zonalhospital.c)Regional hospital.d)other

6) Who paid for the expenditure for complication management

a) service centre. b) self c)welfare organization d)other.

Only in case of ectopic pregnancy

7) If ectopic pregnancy, where have you got treatment from?

a) Referral centre. b) Medical college. c) Zonal hospital d) other

8) What kind of treatment?

a) blood transfusion b) operation c)Medical management d)other.

ANNEXURE II

FOCUS GROUP DISCUSSION GUIDELINE

Consent Form

Namaste, My name is Jaya Raj Ojha I am on student of Akal College of Health and Allied Science, Eternal University Baru Sahib District Sirmour H.P. I will be interaction with you on post abortion contraceptive use among women. The information you will give will be treated as confidential because it is just for the study. It depends on your wish to participate or not to in the study.

Name of participants

No. of participants; (9)

Topic of Discussion; Post abortion contraceptive use among women in Kailali District Nepal

Name of Supervisor; Jaya Raj Ojha

Name of Time Keeper; Shanti Joshi

Name of Recorder; Fanendra Joshi

Thank you for agreeing to participate. We are very interested to hear your valuable opinion on assessment of post abortion women use the contraceptive methods.

1-Welcome

All participants

2-Introduction – Introduction of all the participants who join FGD.

- Who we are and what we're trying to do?
- What will be done with this information?
- Why we asked you to participate?

3-Explanation of the process- Question answer discussion.

Ask the group if anyone has participated in a focus group before. Explain that focus groups are being used more and more often in health and human services research

4-Ground Rules

In this programme we are doing both questionnaires and focus group discussions. The reason for using both of these tools is that we can get more in-depth information from a smaller group of people in focus groups. This allows us to understand the context behind the answers given in the written survey and helps us explore topics in more detail than we can do in a written survey.

5- About focus groups

- Everyone should participate.
- Information provided in the focus group must be kept confidential
- Stay with the group and please don't have side conversations
- Turn off cell phones if possible
- Have fun

6-About logistics

- Group will last about one hour
- Feel free to move around

7-Turn on Video Recorder

Ask the group if there are any questions before we get started, and address those questions.

Ask the group if there are any questions before we get started, and address those questions

8-Questions:

1 What is the socio cultural thinking about abortion?

2 What is the safe and legal abortion?

3 Where these abortion services are available and how much does it cost?

4 What are the complications of abortion and how it is managed?

Possible discussion

9-Materials and supplies for focus groups

- Sign-in sheet
- Consent forms (one copy for participants, one copy for the team)
- Evaluation sheets, one for each participant
- Name tents
- Pads & Pencils for each participant
- Focus Group Discussion Guide for Facilitator
- 1 recording device
- Batteries for recording device
- Extra tapes for recording device
- Permanent marker for marking tapes with FGD name, facility, and date

Notebook for note-taking and Refreshments.

Group-A

AsmitaKathayat said about the Q. No.1 what are the social cultural thinking about abortion? educated people or higher level families have not any problem but in uneducated families thought negative about abortion in the society. It depends upon in their socio- economic condition also. The answer of same question **AshaChaudhary**said ,People in the village blamed only to women not men ,they are physically and mentally tortured by families and husbands if she has got abortion service The answer of what is the safe and legal abortion? She said ,there are two criteria to measure safe and legal abortion.

1- Registered Medical professionals.

2-Registered Institutions.

No.1 is related to any medical professional(Doctors, Nurses' and other)and No. 2. Is related the institution where Government give permission to provide abortion services.

Anita Sarkisaid Question of what is social cultural thinking about abortion ? that people in our society , thought God gives us children "they are blessed by God" so abortion is not necessary to prevent child birth. She said about the Q.No.3 Where abortion services are available and how much does it cost? " I came first time in this institution" so do not know about the service cost. **Shanti Pandey**said about Q. No.4 what are the complication of abortion and how it is managed? if women have got problem they have to solve their problem alone in lower level of family .Nobody is ready to help them. Some female have severe bleeding and many other problems(discharge, and Haematoma, Pain abdomen perforation),.At first they try to take service from private medical if serious they go to hospital. Some clients asked for help to third party who are related to social welfare organization in local level for tertiary level treatment.

Ganga Devi Saud said aboutwhat are the complication after abortion and how it is managed? I have not faced complication after abortion if yes, I have very good relation with my family no any problems I had to face .We discussed about problems in our family and solve it in proper way but i had heard about complication.. Q no. 1.what are the social cultural thinking about abortion? She said i heard there was problem in my society after abortion because her husband was working outside and the client had money problem. It made serious problem that female have to manage their treatment cost. The family members did not help her.

Basu Devi SaudQ no. 2 what is safe and legal abortion? She said i have not knowledge about but I know after this discussion .She said answer of Q. No. 2 where these abortion service available and how much cost ?that where are the LOGO of save abortion service these institution provided abortion service in our area.

Durga Devi Boharasaid of Q.No.2 what is safe and legal abortion ?Safe and legal abortion is that, it is provided by trained health professional(Gynaecologist, other trained nurses) and the institution that is selected by Gov. Of Nepal ,Department of Health Services .It must be

- less than 12 weeks in normal condition

- less than 18 weeks for rape and

- other medical indications the service is given any times.

Kalawati Saud said about where abortion service is available? Different organizations are providing abortion services.They are divided in

-INGOs

-NGOs

- Public Hospitals

-Private Hospitals or other zonal,regional and central hospitals.

Kamala Ojhasaid about how much cost of this service?the cost of abortion service is depend upon rules of different Organization but in Marie Stopes centre the cost of abortion services are:
Surgical=1900Rs.
Medical=1300Rs.(Including all FP services)

Name of participants:

1-Kamala Ojha
2-Kalawati Saud
3-Durga Devi Bohara
4-Basu Devi Saud
5Ganga Devi Saud
6-Shanti Pandey
7-Anita Sarki
8-Asha Chaudhary
9-Asmita Kathayat

Group-B

AayushaChaudharysaid, Q No. 1 what are social cultural thinking about abortion? If women had taken abortion service women are dominated by women because mother in law thought she waste money they cannot fight with male members but fight with each other (Female with female). It is problem to convince old members in family. They had not got sufficient rest and diet because of low diet female had nutritional deficiency problem also. Q no.2what is safe and legal abortion? She said the service of gynaecologist doctor's and other trained health professional is called safe abortion .She thought about legal abortion is that where government gave authority to provide abortion services(person and

institutions).In same question **Laxmi Air** said, that Abortion that is less than 12 weeks is safe to women .In some societies women can not to do worship the God at the time of means and after abortion and also they cannot inter in kitchen because of cultural norms.

SaritaChaudharysaid, about Q.No. 2. that Safe abortion is legal when the institute is selected by Gov.of Nepal Department of Health Services and low of Nepal .There are some signs and LOGO of safe abortion services which is provided by government organizations. **RakshaThapa**said Q no.1.what are the social cultural thinking about abortion? Some society there was problem of superstitions and bad aspects about health so abortion services is not allowed in these society (Muslims). We have to move forward against that society where people thought negative about abortion services. It is our right to regular the menstruation. It is provided by women welfare related organization in all over the world.

Roma joshisaid, Q No.3.where these services are available and how much does it cost? I came in this institution first time but i knew that this institution provided abortion services. Somebody said it gives well service and i came to take abortion service. Marie StopeCenterprovide abortion service including family planning services (condom, OCP,Implant, and IUCD) in low costs. **Shanti Joshi**said, Q No. 1.what are the social cultural thinking about abortion? people mostly live in village had negative or positive thinking about abortion which is depend upon educational level, economic condition and occupation .Mostly uneducated mother in low, middle level of society thought that her daughter in low wasting money but educated people has known about birth spacing ,maternal morbidity and mortality due to abortion.

Anita Kusmisaid, Q No.1. Somebody thought that they are killing the new born baby one by one by abortion service .sometimes it made great problem in society. They were not aware about female health. She also said Q No. 4 what are the complication of abortion and how it is managed? She said i have seen complication by abortion there was heavy bleeding and clients was died by complication of abortion so it is very danger condition to prevent clients.

PardesniChaudharysaid Q No.3. where these abortion services are available and how much does it costs?Safe abortion service provided by manyhospitals but there are selected hospitalsthey have a LOGO of safe abortion services. The facility has able to manage emergency condition of clients Likes

- Blood transfusion
- Oxygen
- Operation
- Other complication management.

Januka Shah said , about complication I have seen ectopic rupture in my village .She had severe bleeding and she has to do operation of fallopian tube but it is managed by service centre .Patient was in poor condition .She did not pay for operation and another charges (Expenditure) so service centre help her for whole treatment cost. She was alive now. Other thing Q. No 2..What is safe and legal abortion? She said there are two criteria about safe and legal abortion.

- Institutional
- Personal

The institution which government of Nepal gives permission to abortion service. There is facility of infrastructure and technical staffs.

Name of participants:

1-Aayusha Chaudhary

2-Laxmi Air

3-Sarita Chaudhary

4-Raksha Thapa

5-Roma Joshi

6-Shanti Joshi

7-Anita Kusmi

8-Pardesni Chaudhary

9-Januka Shah

Table-**A**

Name of respondents	What is the social cultural thinking about abortion?	What is safe and legal abortion?	Where are abortion services available and how much does it costs?	What are the complication of abortion and how it is managed?
Kamala ojha	**0**	**0**	**1**	**0**
Kalawatisaud	**1**	**0**	**1**	**1**
Durgadevibohara	**0**	**1**	**1**	**1**
Basudevi Saud	**0**	**1**	**1**	**0**
Ganga devi Saud	**0**	**0**	**1**	**1**
Shanti Pandey	**1**	**1**	**1**	**1**
Anita Sarki	**0**	**0**	**0**	**1**
Ashachaudhary	**0**	**1**	**1**	**1**
AsmitaKathayat	**0**	**1**	**1**	**1**
Total	**2**	**5**	**8**	**7**

0= Negative (Not knowledge)

1= Positive (Knowledge)

Table- B

Name of respondents	What are the social cultural thinking about abortion?	What is safe and legal abortion?	Where abortion services are available and how much does it cost?	What are the complication of abortion and how it is managed?
Ayushachaudhary	**0**	**1**	**1**	1
Laxmi Air	**1**	**1**	**1**	**1**
Saritachaudhary	**1**	**1**	**1**	**1**
Rakshathapa	**1**	**1**	**1**	**1**
Roma joshi	**1**	**1**	**0**	**1**
Shanti joshi	**1**	**1**	**1**	**1**
Anita kusmi	**0**	**1**	**1**	**1**
Pardesnichaudhary	**1**	**1**	**1**	**1**
Januka shah	**1**	**1**	**1**	**1**
Total	**7**	**9**	**8**	**9**

0=Negative (Not knowledge

1= positive (Knowledge)

Result of Focus Group Discussion

S.N.	Q.No.1	Q.No.2	Q.No.3	Q.No.4
Yes	9	14	16	16
No	9	4	2	2

From this study the attitude of respondents (by Q. No-1) were not good to abortion services there were negative concept about abortion in community of Nepal 9 out of (50%).The knowledge of focus group discussion among two(Q,No.-2) groups were very better 14 out of 18 (77.77%) . they had known about the safe and legal abortion. Most of respondents had known about (Q.No.-3) the place of abortion services and cost of it (88.8%). At the last Majority of respondents of focus group discussion have a knowledge about complication after abortion(88.8%) by Q.No-.4.

At the end among two focus groups, Group-1 had less knowledge than Group-2 so Group second had good knowledge and good attitude in abortion services.

RECOMMENDATIONS

Focus group discussions revealed these main findings:

- Confusion about contraceptive methods.
- Young women consider multiple factors when making decisions about post abortion contraceptive,
- Young women have/do not have a preferred communication channel for accessing information on contraception, It depend upon geographical area and level of family.
- Young women want interventions to help increase contraception knowledge.

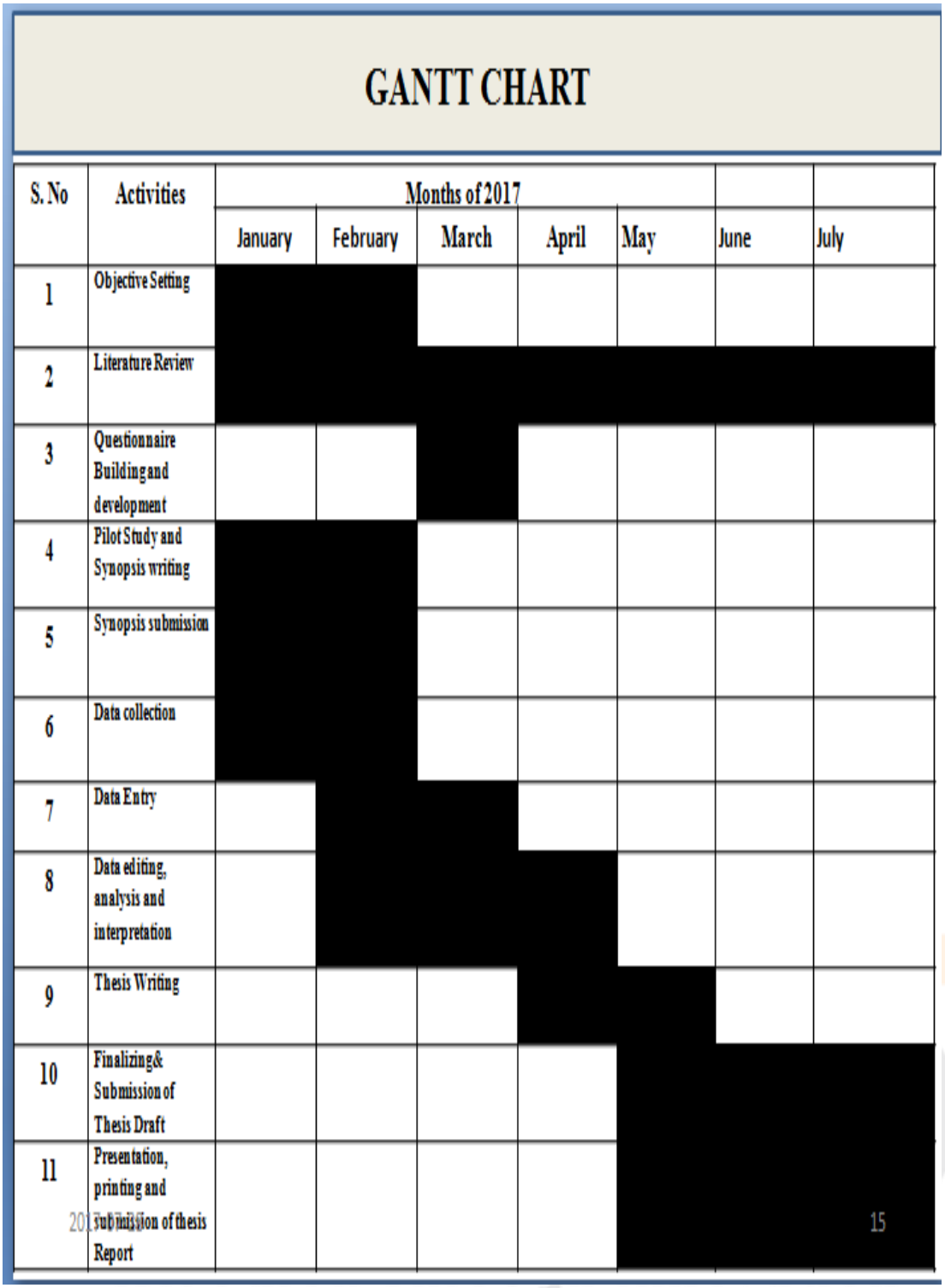
The majority of these findings agree with previous knowledge about contraceptives. Future research should examine a possible relationship between contraception knowledge and confusion over contraction use. The role of FCHV plays in decisions, and specific interventions. A better understanding of contraception use and its role in contraception decisions could help to receive contraceptive after abortion. As a result it prevents unplanned pregnancy and unmet need of family planning.

LIMITATIONS

The uses of a focus group discussion offered many benefits to the study design, it created several limitations. Most importantly, the opinions and ideas of a few cannot be generalized to a larger audience. In addition, focus groups may not always be appropriate to examine sensitive topics, like contraception and sex so it is difficult to use focus groups to examine these topics. Some participants may have a hard time discussing these topics in a group setting. It is also very difficult to male researcher to take help of female participants.

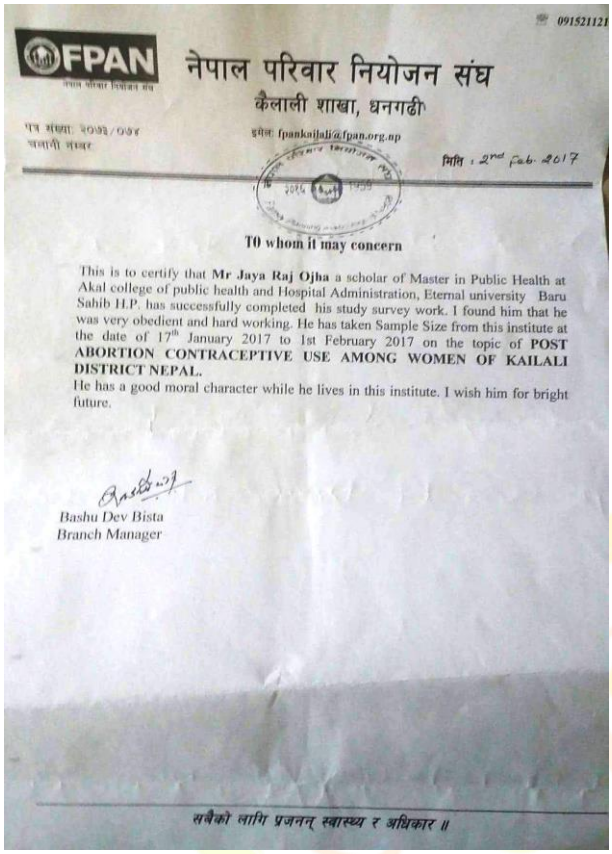
ANNEXURE III

TIMELINE AND ACTION PLAN OF THIS THESIS WORK: GANTT CHART



ANNEXURE IV

LETTERS FROM ORGANIZATIONS



FPAN

नेपाल परिवार नियोजन संघ

कैलाली शाखा, धनगढी

पत्र संख्या: २०७३/०७४

चलानी नम्बर

इमेल: fpankailali@fpan.org.np

मिति : 2nd Feb. 2017

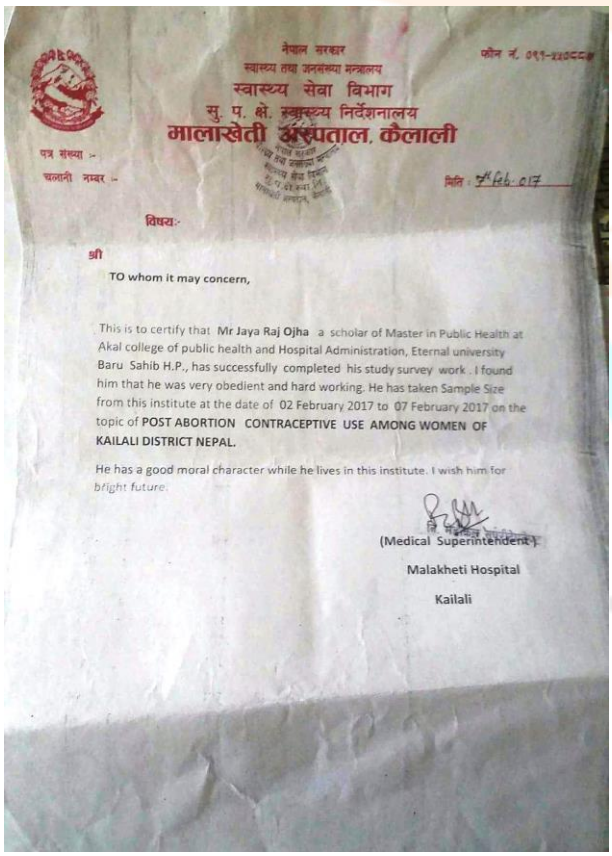
TO whom it may concern

This is to certify that **Mr Jaya Raj Ojha** a scholar of Master in Public Health at Akal college of public health and Hospital Administration, Eternal university Baru Sahib H.P. has successfully completed his study survey work. I found him that he was very obedient and hard working. He has taken Sample Size from this institute at the date of 17th January 2017 to 1st February 2017 on the topic of **POST ABORTION CONTRACEPTIVE USE AMONG WOMEN OF KAILALI DISTRICT NEPAL.**

He has a good moral character while he lives in this institute. I wish him for bright future.

Bashu Dev Bista
Branch Manager

सबैको लागि प्रजनन् स्वास्थ्य र अधिकार ॥



नेपाल सरकार

स्वास्थ्य तथा जनसंख्या मन्त्रालय

स्वास्थ्य सेवा विभाग

सु. प. क्षे. स्वास्थ्य निर्देशनालय

मालाखेती अस्पताल, कैलाली

पत्र संख्या :-

चलानी नम्बर :-

मिति : 3rd Feb. 017

विषय:-

श्री

TO whom it may concern,

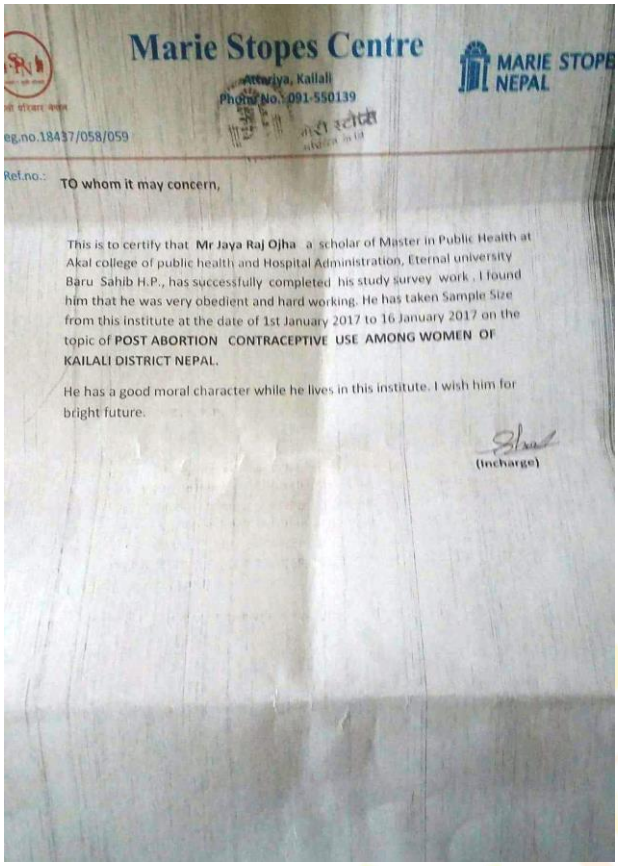
This is to certify that **Mr Jaya Raj Ojha** a scholar of Master in Public Health at Akal college of public health and Hospital Administration, Eternal university Baru Sahib H.P., has successfully completed his study survey work. I found him that he was very obedient and hard working. He has taken Sample Size from this institute at the date of 02 February 2017 to 07 February 2017 on the topic of **POST ABORTION CONTRACEPTIVE USE AMONG WOMEN OF KAILALI DISTRICT NEPAL.**

He has a good moral character while he lives in this institute. I wish him for bright future.

(Medical Superintendent)

Malakheti Hospital

Kailali



Marie Stopes Centre

Attariya, Kailali
Phone No. 091-550139

MARIE STOPES NEPAL

Reg.no.18437/058/059

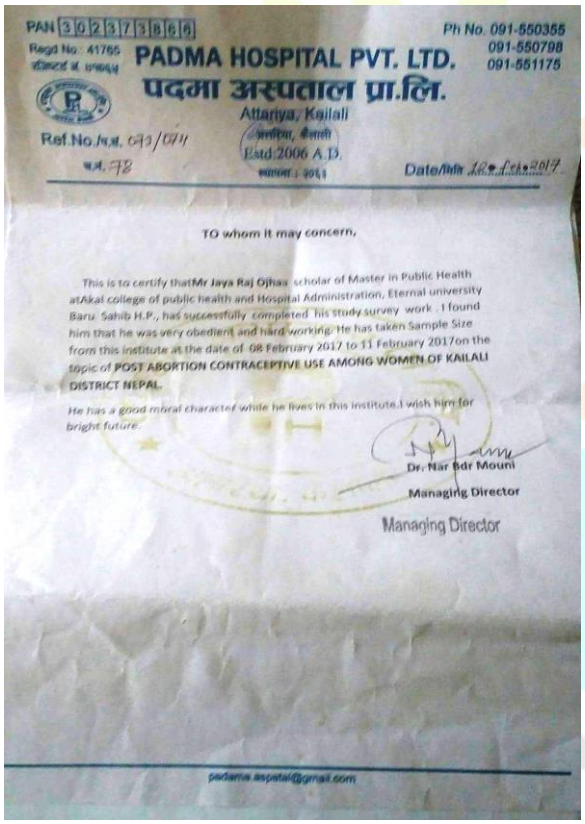
Ref.no.:

TO whom it may concern,

This is to certify that **Mr Jaya Raj Ojha** a scholar of Master in Public Health at Akal college of public health and Hospital Administration, Eternal university Baru Sahib H.P., has successfully completed his study survey work . I found him that he was very obedient and hard working. He has taken Sample Size from this institute at the date of 1st January 2017 to 16 January 2017 on the topic of **POST ABORTION CONTRACEPTIVE USE AMONG WOMEN OF KAILALI DISTRICT NEPAL.**

He has a good moral character while he lives in this institute. I wish him for bright future.

(Incharge)



PAN 302373866

Regd No: 41765

PADMA HOSPITAL PVT. LTD.

पदमा अस्पताल प्रा.लि.

Attariya, Kailali

Estd:2006 A.D.

Ph No. 091-550355
091-550798
091-551175

Ref.No.

Date/मिति 12 Feb 2017

TO whom it may concern,

This is to certify that**Mr Jaya Raj Ojha** scholar of Master in Public Health atAkal college of public health and Hospital Administration, Eternal university Baru Sahib H.P., has successfully completed his study survey work . I found him that he was very obedient and hard working. He has taken Sample Size from this institute at the date of 08 February 2017 to 11 February 2017on the topic of **POST ABORTION CONTRACEPTIVE USE AMONG WOMEN OF KAILALI DISTRICT NEPAL.**

He has a good moral character while he lives in this institute.I wish him for bright future.

Dr. Nar Bdr Mouni
Managing Director

Managing Director

padamahospital@gmail.com

ANNEXURE V

SOME PHOTOGRAPHS DURING FGD