KNOWLEDGE AND ATTITUDE TOWARDS ABORTION AND CONTRACEPTIVE SERVICES AMONG WOMEN OF REPRODUCTIVE AGE IN KALIKOT DISTRICT

End-line Survey Report

Submitted to

Action Works Nepal

Thapathali, Kathmandu

Submitted by

Gobind Prasad Pant

Research Consultant

September 2021

ACKNOWLEDGEMENTS

Behind the successful accomplishment of this study, there lie the sincere contributions and precious support of many individuals and institutions. I would like to extend my profound gratitude to Action Works Nepal (AWON) for entrusting this important responsibility to me. I gratefully acknowledge all the members of the study team for providing technical support and guidance at every step of designing and conducting this study. The technical and managerial support provided by Action Works Nepal was invaluable.

I would particularly like to mention Mr. Nar Bahadur Saud (Project Manager) and Ramesh Pandey (Admin and Finance Officer), among others. Moreover, I cordially gratify Sanjaya Bahadur Chand and Nayan Bahadur Rokaya for facilitating and supervising the fieldwork.

District Health Office, Kalikot, Health Facility In-charge and local body representatives of seven palikas (Palata, Raskot, Tilagufa, Kalika, Naraharinath, Pachal Jaharana and Sanmi Triveni) are gratefully acknowledged for their support and coordination in the selection of study sites and conduction of this study.

Likewise, I would also appreciate the contribution of the study team members Basundhara BK, Darshana Kumari Bista, Dharma Shahi, Kasha Bam, Gita Shahi, Rukubina Sijawal and Chhaila Shahi in collecting data from various hard to reach areas of Kalikot district.

Last but not least, I would like to gratify all those whose direct and indirect contributions have contributed immensely to the outcomes of this study.

Gobind Prasad Pant
Consultant

SUMMARY

Background: Action Works Nepal (AWON), a non-profit non-government organization has been working on issues of safe abortion since 2014 with a focus on uncovered areas of Karnali province. This endline study was part of AWON's three-year project (2018-2021) entitled “Access to safe abortion and contraceptive services for vulnerable, marginalized and uncovered areas in the Karnali region of Nepal”. The purpose of this study was to assess the awareness and knowledge on abortion law and contraceptive methods and attitude towards abortion among women of reproductive age in Kalikot district. **Method:** Descriptive cross-sectional study was carried out in 15 pre-existing VDCs (7 Palikas) of Kalikot district. Probability proportionate sampling was used to get a random sample of 210 participants. The data was collected from women of reproductive age (15-49 years) by seven female enumerators through face to face interviews using a structured questionnaire. The collected data were entered in MS Excel Entry and analyzed using SPSS version 16.0. Descriptive statistics were used to report the distribution of study participants. **Results:** The findings of our study demonstrate that most of the women (90.5%) age 15-49 were found aware of the legality of abortion in Nepal. Of the entire respondents who were aware of the legalization of abortion, 55.7% knew that abortion is legal for any woman up to 12 weeks gestation. Women were least aware of the legal conditions for abortion at later stages of pregnancy. 95.2% of women age 15-49 reported having knowledge of a place where safe abortion services can be obtained. Moreover, the awareness of family planning methods was nearly universal with 98.6% of women aware of at least one method of family planning. Mother groups, friends and health providers were the most important sources of information for both safe abortion and family planning. The negative stereotype, discrimination and exclusion and fear of contagion towards abortion services were found in decrease ways. **Conclusion:** The study indicates that knowledge of women toward the legalization of abortion was very satisfactory. The participants had found good knowledge and attitudes regarding family planning. The main sources of information found mothers groups and FCHVs. Stills abortion-related stigmatizing attitudes were found at the community level so there is needed considerable emphasis on awareness and comprehensive behavior change communication programs on a local basis.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

AWON	Action Works Nepal
CI	Confidence Interval
FCHV	Female Community Health Volunteer
FP	Family Planning
MA	Medical Abortion
MMR	Maternal Mortality Ratio
NDHS	Nepal Demographic and Health Survey
NHRC	Nepal Health Research Council
PPS	Probability Proportionate to Size
PSU	Primary Sampling Unit
SABAS	Stigmatizing Attitudes, Beliefs and Actions Scale
SAS	Safe Abortion Service
SPSS	Statistical Package for Social Sciences
SRHR	Sexual and Reproductive Health Rights
VDC	Village Development Committee
WRA	Women of Reproductive Age

CHAPTER I: INTRODUCTION

1.1. Background

Nepal is struggling to reduce maternal death to reach the sustainable goal of less than 70 per hundred thousand live births[1]. In the last two decades, there has been appreciable progress in maternal health indicators. More mothers in their pregnancy and period of childbirths are surviving than ever before with a sharp decline in maternal mortality ratio (MMR) from 543 deaths per 100,000 live births in 1996 to 239 per 100,000 live births in 2016[2]. Despite these achievements, Nepal still bears some of the highest mortality and morbidity rates amongst other developing countries[3] and additional efforts are required to universalize maternal health services.

The government of Nepal has made commitments to improve the maternal health services as evidenced by the provision of health as a fundamental human right guaranteed by the Constitution of Nepal 2015, the nation's commitment towards universal health coverage through new health policy 2014 and sustainable development goals. Considerable attention has also been placed by the country towards developing and expanding access to safe abortion services by all women. In Nepal, abortion law was liberalized in 2002. The current law allows abortion to perform under request and consent of women up to 12 weeks of gestation for any indication, up to 18 weeks of gestation in the cases of pregnancy resulting of rape or incest, and at any time during pregnancy with the recommendation of an authorized medical practitioner, if the life or physical/mental health of the pregnant woman is at risk or if the fetus is deformed and incompatible with life[4]. Ever since the liberalization of abortion law, Safe Abortion Services (SAS) have been an essential component of the national safe motherhood program[5]. The need for equitable access of safe abortion services to female of reproductive age has also been emphasized by several plans, policies and national documents such as National Safe Abortion Policy, Medical Abortion Scale-Up Strategy and National Safe Abortion Service Implementation Guidelines[4, 6].

Despite the liberalization of abortion law and favorable policy environments in place, the practice of unsafe abortion in Nepal remains unabated. A study done by CREPHA in 2014 reported that about six in ten (58%) abortions were illegal. In the mid-western

region, the proportion of illegal abortion was 51 percent[7]. Unsafe abortion remains a third leading cause of maternal mortality in Nepal and accounts for 7% of all maternal deaths[8].

The utilization of safe and legal abortion services could be constrained by several factors including lack of awareness on the legal status of abortion, availability and location of safe abortion services; unfavorable socio-cultural beliefs towards abortion and fear of stigma[9-11]. Fifteen years have passed since the national safe abortion policy in 2003 emphasized a need to raise awareness on new abortion policy, counter stigma and address unsafe abortion[4]. Yet only a few women age 15-49 are aware that abortion is legal in Nepal[2, 12-14]. The awareness is even lower among population sub-groups; women in the lowest wealth quintile, with lower education and living in rural areas are least aware of abortion law compared to their counterparts[2, 12].

The demographic and health survey of Nepal 2016 reported poor knowledge among reproductive-age women regarding specific circumstances under which abortion is legal. Less than one in four women knew that abortion is legal for pregnancies up to 12 weeks gestation without any indication. The study also reported that half of women age 15-49 years knew places where safe abortion services are available[2]. Poor awareness and associated stigmas can have several negative implications for women. It could lead women to pursue medical abortion pills from unreliable sources or clandestinely undertake unsafe abortion procedures[11, 15]. Many authors have highlighted the need to intensify efforts to educate women about abortion law, location for safe abortion services and in the meantime address the prevailing stigmas[10, 12, 14, 16].

Action Works Nepal (AWON), a non-profit non-government organization has been working on issues of safe abortion since 2014 with a focus on uncovered areas of Karnali province. AWON launched a three-year project (2018-2021) on "Access to safe abortion and contraceptive services for vulnerable, marginalized and uncovered areas in the Karnali region of Nepal". This project aimed to functionalize the health facilities with quality family planning (FP) services and Medical Abortion (MA) services at 15 pre-existing Village Development Committees (VDCs) which represent 5 rural municipalities and 2 municipalities according to a new local administrative structure. The project supported to development of skills of health workers through

training and support equipment and other logistics for uninterrupted quality services provision. It also aimed to improve the knowledge of accessible safe abortion and family planning services for women and girls as well as reduce abortion stigma by educating on sexual and reproductive health rights. Women who need FP and safe abortion services can be benefitted from the utilization of quality FP and safe abortion services at the nearest health facilities and also during mobile health camps organized at selected places from time to time.

Prior to project implementation, this study considered the baseline information on knowledge status and attitude towards abortion and identify the awareness of abortion rights as well as contraceptive methods. Project activities that focused on improving knowledge and attitude include, bi-monthly meetings of women's health groups and health management committees to discuss the issues of awareness-raising and quality service delivery on safe abortion and contraceptive services; door to door visits for interpersonal communication and awareness-raising; provide SRHR education (focusing to comprehensive sexuality education) to school students (grade 8 to 12) targeting to adolescents girls/boys; media mobilization and Public Service Announcement (PSA)s from local radio/FMs; campaigning activities for awareness on SRHR focusing to the abortion rights and publication and distribution of awareness materials (i.e. leaflets/pamphlets etc.) to inform the community about abortion rights and contraceptive education.

1.2. Statement of the problem and rationale / Justification of the study

Few national-level surveys have provided national and provincial level estimated data on the awareness and knowledge on abortion law and contraceptive methods[2]. However, the awareness and knowledge on abortion and contraceptives vary widely based on geographical region, wealth, and/or education level[12, 16]. Considering the unique geography, socio-cultural context and health system status, the awareness of reproductive age women on abortion might differ from that of national and provincial average and precise estimates are necessary for planning successful project interventions. Also, very little is known about the abortion-related attitudes and stigmatizing beliefs among reproductive-age women as evidenced by a limited number of works of literature available for Nepal. Finally, this study aimed to

generate contextual evidence for filling a knowledge gap in the Kalikot district in terms of women's awareness and knowledge of abortion and contraceptive services.

1.3. Research objectives

The general objective of the study was to assess the awareness and knowledge on abortion law and contraceptive methods and attitude towards abortion among women of reproductive age in Kalikot district, whereas the specific objectives are to estimate the proportion of WRA with awareness and knowledge on abortion law; to assess stigmatizing attitude towards abortion among women of reproductive age, and to estimate the proportion WRA with knowledge on contraception methods

1.4.Study variables

Dependent variable

a. Awareness and Knowledge on abortion law
   - Awareness that abortion is legal
   - Knowledge of legal conditions for abortion
   - Conditions on which abortion is illegal
   - Age limit for abortion without parental consent
   - Knowledge whether abortion is legal for unmarried
   - Knowledge on places that provide safe abortion

b. Stigmatizing attitude towards abortion
   - Negative stereotype
   - Discrimination and exclusion
   - Fear of contagion

c. Awareness and knowledge on contraceptive methods
   - Awareness of contraceptive methods
   - Knowledge on types of contraceptive methods
   - Knowledge on places that provide contraceptive methods

Independent variables

a. Socio-Demographic variables include age, marital status, education, education of spouse/partner, occupation, occupation of spouse/partner, ethnicity
b. Exposure to information sources
c. Access to abortion and contraceptive services
d. Past experience of abortion and contraceptive use

1.5.Conceptual framework

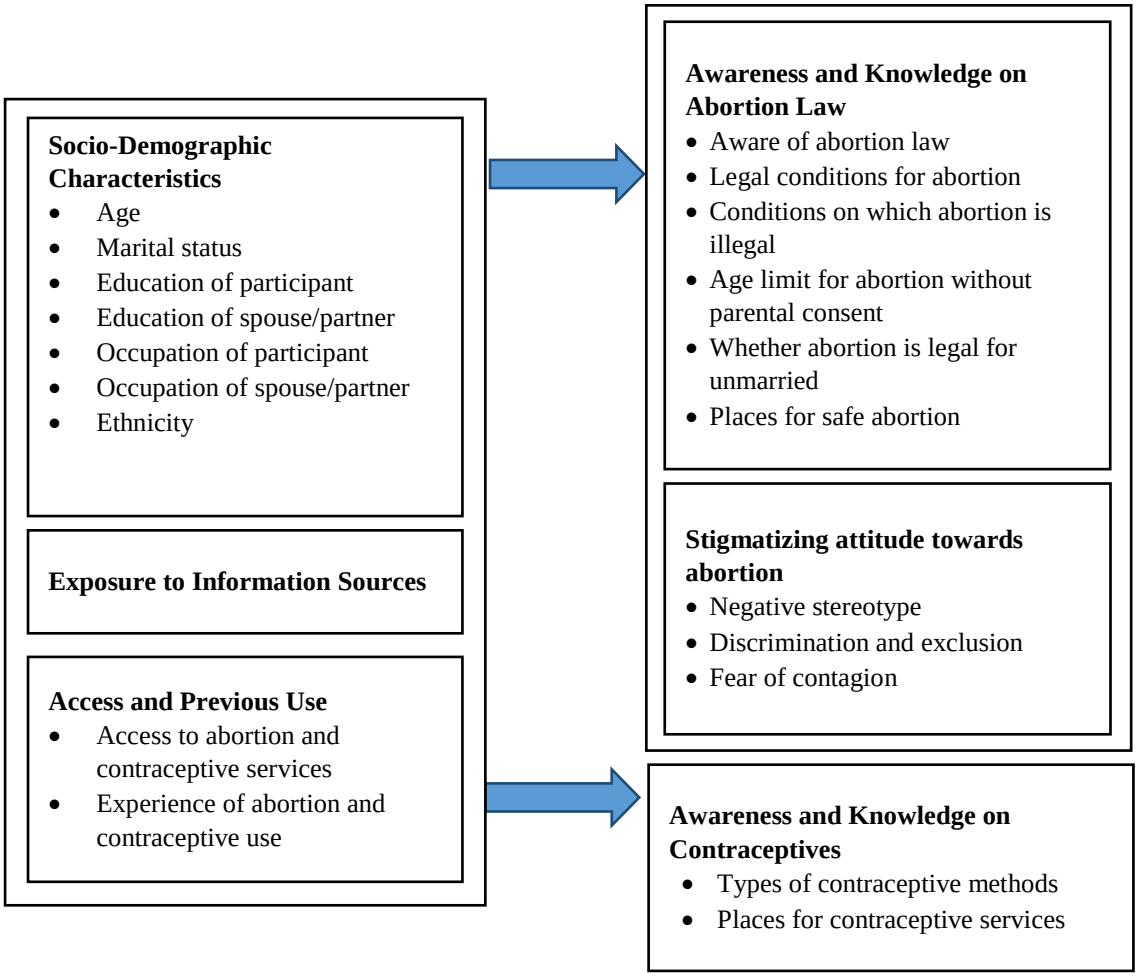

Figure 1: Conceptual framework of the study

1.6. Operational definitions

Ethnicity: Ethnicity was categorized into six groups: dalit, disadvantaged janajatis, disadvantaged non-dalit terai people, religious minorities, relatively advantaged

janajatis and upper-caste people[34]. The ethnicity classification card (Annex V) was used to classify families into each ethnic group. For further analysis, it was dichotomized as privileged and underprivileged ethnic groups. Privileged ethnic groups comprised of upper caste people and relatively advantaged janajatis while underprivileged groups included dalit, disadvantaged janajatis, disadvantaged non-Dalit terai people, and religious minorities.

Stigmatizing attitude: The stigmatizing attitude of women was measured for each of the 18 items in the SABAS tool. The scores ranging from strongly disagree (score 1) to strongly agree (score 5) were dichotomized. Those scoring 3-5 (agree) were considered having stigmatizing attitudes, and scores of 1-2 (disagree) were considered non-stigmatizing attitudes. For the statement "a woman who has had an abortion might encourage other women to get abortions", the item scores were revered before dichotomization.

Negative stereotyping: The negative stereotyping attitude of women was measured using five points Likert Scale (strongly disagree, disagree, neutral, agree and strongly agree) and included eight statements from the SABAS tool. The score obtained by the participant in each statement was added; the minimum score to be obtained by the participant was 8 and the maximum score was 40. Those who scored more than or equal to 24 were considered to have a negative stereotype.

Exclusion and discrimination: The exclusion and discrimination attitude of women was measured using five points Likert Scale (strongly disagree, disagree, neutral, agree, and strongly agree) and included seven statements from the SABAS tool. The seventh statement had a positive statement and hence its score was reversed. The score obtained by the participant in each statement was added; the minimum score to be obtained by the participant was 7 and the maximum score was 35. Those who scored more than or equal to 21 was considered to have exclusion and discriminatory attitude.

Fear of contagion: The fear of contagion was measured using five points Likert Scale (strongly disagree, disagree, neutral, agree, and strongly agree) and included three statements from the SABAS tool. The score obtained by the participant in each

statement was added; the minimum score to be obtained by the participant was 3 and the maximum score was 15. Those who scored more than or equal to 9 were considered to have fear of contagion.

CHAPTER II: METHODOLOGY

2.1.Study method

Among the multiple methods of research, this study has followed a quantitative method to collect relevant information.

2.2.Type of study

This study has followed a descriptive cross-sectional method using primary and secondary data.

2.3.Study site and its justification:

Kalikot district was selected for this study. Kalikot is one among ten districts of Karnali province, a mid-western hilly region. The district has an area of 1741 square kilometers with a population of 136587. It is one of the districts with the lowest human development index (0.374)[17]. The district is administratively divided into three municipalities and six rural municipalities[18] This study was carried in 15 pre-existing VDCs of Kalikot district which recently represents five rural municipalities and two municipalities of the district. The list of study sites has been presented in Annex IV. These study sites were chosen to represent the project implementation areas of Action Works Nepal for its project to increase access to safe abortion and contraceptive services.

2.4.Study population

The study population included women of reproductive age (15-49 years) residing in 15 pre-existing Village Development Committees (VDCs) of Kalikot. The sampling unit was households and the study unit was a woman of reproductive age.

2.5.Sample size

The sample size calculation was based on the single population proportion formula[19]. Using a reliability coefficient of 1.96 at 95% level of confidence, absolute degree of precision of 0.10, the proportion of females age 15-49 with awareness on legalization of abortion 41% (NDHS,2016), design effect 2 and non-response rate of 10%, a sample size of 205 was calculated.

2.6.Sampling method

The study used probability proportionate to size (PPS) sampling to get a representative sample. Altogether 30 wards, the primary sampling units (PSU) were selected (Annex VII). For selecting the PSU, a list of wards of all fifteen pre-existing VDCs was created and the desired number of clusters (30) was withdrawn. Following the selection of clusters, a list of all households of the selected clusters was prepared by enumerators for sampling frames. Seven sampling units (households) were selected from each cluster by systematic random sampling method using the available list. One eligible respondent was recruited per household. Where more than one eligible WRA was found in the selected household, a lottery method was used to determine a woman to be interviewed. Where the eligible participant was not found in a systematically selected house, the nearest household in either of the direction was included.

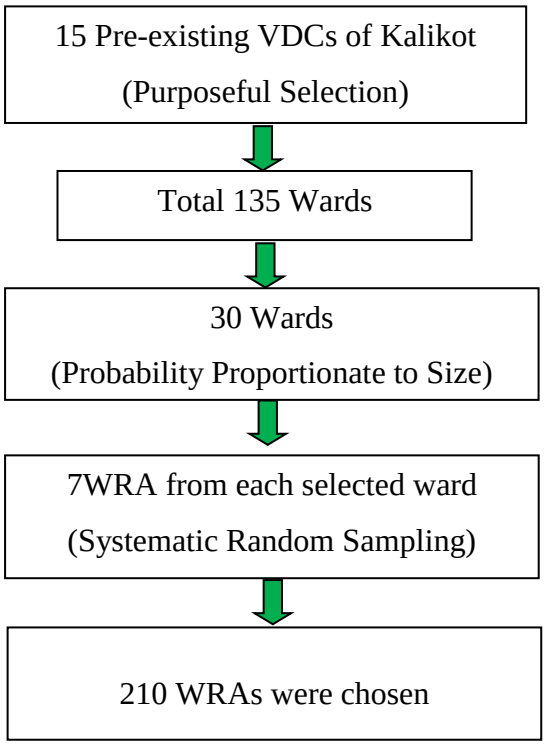

Figure 2: Sampling flow

2.7. Criteria for sample selection

2.7.1. Inclusion criteria

Females of reproductive age (15-49 years) irrespective of marital status were included in the study.

2.7.2. Exclusion criteria

Females with serious illness, including those who could not talk and hear and who were involuntary during the time of data collection, were excluded as their awareness and knowledge status could not be measured adequately.

2.8. Data collection tool

Data collection tool was adapted and developed based on Stigmatizing Attitudes, Beliefs and Actions Scale (SABAS) tool, Nepal Demographic and Health Survey (NDHS) questionnaire, and other published articles on safe abortion[2, 12, 20]. The study tool was divided into four major sections; basic information, socio-demographic characteristics, questions relating to abortion and questions relating to contraceptive methods and services.

2.9. Data collection method and technique

The data collection was performed in November 2018. Seven field enumerators who are residents of Kalikot with prior field experience in data collection and with a minimum of a diploma level education were deployed for obtaining consent and collecting data. Enumerators were provided with three days' orientation on overall methodology as well as interview techniques, handling ethical issues and communication skills. A structured questionnaire was administered to participants using face to face interview technique by conducting household visits. Prior to data collection, all women aged 15-49 years living in the selected households were requested to participate in the study. However, only one woman per household was selected for the interview. The purpose of the study was explained to the study participants or parents and written informed consent was secured. Assurance for privacy and confidentiality was also done. Confidentiality of the information was ensured by coding the questionnaire. In order to ensure privacy, the interview was undertaken privately in a separate area. No remuneration was provided to the participants.

2.10. Validity and reliability of study tool

A Stigmatizing Attitudes, Beliefs and Actions Scale (SABAS) with a coefficient alpha of 0.9 was used for measuring belief and attitude towards abortion[20]. This scale has the potential for application in different country settings. For awareness and knowledge on abortion and contraceptive methods, pertinent questions were adapted from a standardized Nepal Demographic and Health Survey 2016 questionnaire[2]. In order to enhance the face and content validity of the tool, a questionnaire was assessed by experts for its content, organization, appropriateness as well as logical flow of the instrument. An extensive literature review also enhanced the validity of the study tool.

The tool was pretested among 20 female participants at Manma, Kalikot during which the translation and understanding of the questionnaire were checked and corrections were made to the wording of questions and overall layout to clarify meaning. Internal consistency of SABAS scale in local setting was ascertained by calculating Cronbach's alpha using IBM SPSS. We obtained Cronbach's alpha value of 0.76. This value was higher than the conventionally accepted value of 0.70 or higher, hence it was accepted. The tool was translated in the Nepali language for administration and back-translated into English.

2.11. Data management and analysis

The questionnaires were checked for completeness and consistency immediately after filling up by respective enumerators. The data were recorded using a numerically assigned code (one code to each participant throughout the study period) and all other identifiers (for instance, name) were removed. The data were entered and analyzed in Statistical Package for Social Sciences (SPSS) version 16. Before subjecting the data to analysis, inconsistencies were addressed and outliers were dropped. Descriptive statistics (frequency and percentage) were used to describe the distribution of the study participants and the study variables. Similarly, the distribution of outcomes and the major independent variable was presented in frequency and percentage.

2.12. Limitation of the study

Since this survey is limited to 15 pre-existing VDCs of Kalikot chosen purposefully due to its remoteness and its relevance with the AWON project, the findings may not

be generalize-able to the entire Karnali region. Measuring attitudes and beliefs quantitatively is complex, and may be seen to be oversimplifying complex phenomena.

2.13. Supervision and monitoring

The enumerators were closely supervised by Kalikot based Capacity Building and Advocacy Officer of AWON who was assigned as a local supervisor to ensure data quality on a daily basis. During supervision, data were checked for completeness and accuracy. Incorrect, unacceptable and doubtful responses were assessed again.

2.14. Ethical considerations

Ethical approval was obtained from an independent Ethical Review Board (ERB) at Nepal Health Research Council (NHRC). Formal permission to conduct this study was also obtained from District Health Office, Kalikot, and respective (rural) municipalities. Prior to data collection, written consent was taken from the participants. In the case of participants aged 15-18 years, written consent was also taken from their parent or legal guardian. For obtaining informed consent, the participants and/or parents were thoroughly explained about the purpose and procedures of the study. They were also informed about their right to voluntary participation.

Coding and aggregate reporting were used to eliminate participants' identification and to ensure anonymity. Those participants who were not aware of the legalization of abortion were provided with correct information after filling the questionnaire.

CHAPTER III: RESULTS

This chapter has been organized into four broad sections. In the first section, general characteristics of the study population are presented. In the second section, the awareness and knowledge of women on abortion law has been described. The awareness of women on contraceptive methods has been presented in the third section. The fourth section describes the stigmatizing attitudes and beliefs of women of reproductive age towards abortion based on the findings of the survey.

3.1. Socio-demographic characteristics of the study population

Table 1 presents the description of the socio-demographic characteristics of the study population. The mean age of respondents was 29.1 years (standard deviation; SD= 8.3 years). The majority of 86.7 percent of participants belonged to the advantage ethnic group and only 13.3% of participants belonged to a disadvantaged ethnic group; the majority of whom were Dalits (the oppressed). One-fourth of the respondents were illiterate and a similar proportion (28.1%) of women had less than/primary education. Most of the women (82.4%) engaged in the agriculture sector with additional roles as household work and only 5.8% of women worked in governmental and NGOs.

A majority (93.3%) of the respondents in this study were married. Most of the married women (79.1%) responded that their husbands had primary level and above education only 10.2 % were illiterate. While more than half (64.8%) of the married women had their husbands engaged in the agricultural sector, about one in three (31.1%) husbands were engaged in non-agricultural works such as petty business, government, non-government service and labor works.

Table 1: Socio-demographic characteristics of the study population

n=210

Socio-Demographic Characteristics	Number	Percent
Age (in years)		
Less than 20	14	6.7
20-24	63	30.0
25-29	43	20.5
30-34	28	13.3

35-39	31	14.8
More than 40	31	14.8
Ethnicity		
Disadvantaged ethnic group	28	13.3
Advantaged ethnic group	182	86.7
Education status		
Illiterate	57	27.1
Non-formal education	33	15.7
Less than primary	6	2.9
Primary Level	20	9.5
Lower Secondary Level	25	11.9
Secondary Level	35	16.7
Higher Secondary Level	34	16.2
Occupation Status		
Agriculture	173	82.4
Business	10	4.8
Governmental job	10	4.8
Non-governmental Job	2	1.0
Household Works	5	2.4
Marital Status		
Married	196	93.3
Unmarried	9	4.3
Divorced/separated	5	2.4
Husband's Education (n=196)		
Illiterate	20	10.2
Non-formal education	16	8.2
Less than primary	5	2.6
Primary Level	18	9.2
Lower Secondary Level	23	11.7
Secondary Level	40	20.4
Higher Secondary Level	67	34.2
Bachelor or Plush	7	3.6
Husband’s Occupation (n=196)		

Agriculture	127	64.8
Business	22	11.2
Government Job	13	6.6
Non-government Job	3	1.5
Labor/ Wages	15	7.7
Household Works	7	3.6
Student	6	3.1
Unemployed	2	1.0
Others (Foreign labor)	1	0.5

3.2. Awareness and knowledge on abortion law

The end-line survey shows that most of the women (90.5%) age 15-49 were aware that abortion is legal in Nepal which is increase by around two times (53.8%) than baseline survey (36.7%). Women who thought that abortion is legal in Nepal were further asked about the circumstances allowing legal abortion. More than half (55.7%) of women age 15-49 knew that abortion is legal for any woman with pregnancies up to 12 weeks gestation.

Similarly, 58.1% of women age 15-49 knew that abortion is legal for a pregnancy of 18 weeks if it is a result of rape or incest. Furthermore, 42.9% of respondents knew that abortion is legal for pregnancy of any duration in a mother's life is at risk, 39.5% of participants were aware of pregnancy of any duration if mother's physical and mental health is at risk and 39% of respondents knew that abortion is legal for pregnancy if a fetus is deformed. More than half (64.8%) of women reported that abortions can be performed if a woman has too many children (Table 2).

According to the baseline survey, limited women have had knowledge of abortion legal in Nepal, such as 27.3% of women age 15-49 knew that abortion is legal for any women with pregnancies up to 12 weeks gestation, 13% knew that abortion is legal for pregnancies up to 18 weeks gestation in the case of rape or incest 9.1% respondents knew that abortion is legal for pregnancy of any duration in mother's life is at risk and more than two in five (42.9%) women knew that abortions can be performed if a woman has too many children (Baseline survey-Action works Nepal).

Moreover, the end-line survey shows that the women who were aware that abortion is legal in Nepal were asked about the circumstances in which abortion is prohibited by the law. Most of (77.1%) women reported that abortion would be illegal for sex selection where the mass was very low (11%) during the baseline survey. Similarly, 65.2% responded that abortion would be illegal if it was done without the consent of the woman the percentage was increased by six times than baseline survey (9.5%) and 30.5% reported that abortion would be illegal if conditions other than those prescribed by law (Table 2).

Before the launching of the project (baseline survey) by Action Works Nepal, more than two in five (42.9%) women who were aware of the liberalization of abortion thought that abortion was legal only for married women but at the end of the project, it was reduced by 15.3%. Current only 27.6% of women who are thinking abortion is legal for only married (Table 2).

Table 2: Awareness and knowledge on abortion law

n=210

Characteristics	**Number**	**Percent**
Awareness that abortion is legal	190	90.5
Knowledge of legal conditions for abortion (n=190)		
Pregnancy of 12 weeks of less gestation for any woman	117	61.6
Pregnancy of 18 weeks if it is a result of rape or incest	122	64.2
Pregnancy of any duration if mother's life is at risk	90	47.4
Pregnancy of any duration if mother's physical and mental health is at risk	83	43.7
If a fetus is deformed	82	43.2
If one has too many children	136	71.6
Knowledge on conditions in which abortion is illegal (n=190)		
Sex-selective abortion	162	77.1

Without the consent of a pregnant woman	137	65.2
Conditions other than those prescribed by the law	64	33.7
Women who thought that abortion is legal for only married (n=190)	58	30.5

Note: Multiple respondents

From the perspective of knowledge of place for safe abortion, 95.2% of women age 15-49 reported having knowledge of a place where safe abortion services can be obtained. Among these women who reported knowing places for safe abortion, the majority of participants mentioned the governmental sector such as (91.5%) mentioned the health post, 30.5% mentioned the government hospital/clinic, 24% primary health care center and only 2% had mentioned mobile camp.

Similarly, more than one-fourth (28.5%) of women reported that abortion services can be obtained from private sector hospitals, nursing homes, or pharmacies. There was more than one fifth (23.5%) of women reported knowing non-government facilities (Marie Stopes Center) where safe abortion services can be obtained (Table 3).

Before launching the project in Kalikot the baseline survey was conducted by Action Works Nepal, at that time the overall 69% of women age 15-49 reported knew a place where safe abortion services can be obtained. It means the percentage of knowledge was increased by 26%. It is a big achievement for the project.

Table 3: Knowledge of places for safe abortion

n=210

Characteristics	**Number**	**Percent**
Knowledge of places for safe abortion	200	95.2
Places of safe abortion(n=200)		
Government hospital/clinic	61	30.5
Primary health care center	48	24
Health post	183	91.5
PHC Outreach Clinic	5	2.5

Mobile camp	4	2
FCHV	33	16.5
Marie Stopes	47	23.5
Private hospital/nursing home	3	1.5
Pharmacy	54	27

Note: Multiple respondents

Table 4 shows the sources of information from which women reported hearing about safe abortion services. The majority of women (82.9%) age 15-49 reported hearing about safe abortion services from mother groups, 61.4% women age 15-49 reported hearing from friends and 55.2% women age 15-49 reported hearing from health workers. A similar proportion (52.4%) of women heard about abortion services from FCHVs.

Furthermore, 27.1% of women age 15-49 reported hearing safe abortion service from radio/television, 17.1% of women reported hearing safe abortion service from a pharmacist and 10% of women reported hearing safe abortion service from Pamphlets/IEC/SBCC materials. Just 13% of the women reported hearing about abortion services through a poster, newspaper and internet.

According to the baseline survey of Action Works Nepal, the main source of information was friends/neighbors (60.5%). At that time the FCHV's (22.9%) and mother groups (5.7%) were had spread low information because of low knowledge and limit mother group functional in the project areas.

Similarly, the radio and TV (8.6%) had spread the information on safe abortion during the baseline survey which is currently increased by 18.5% in the Kalikot district.

Table 4: Sources of information on safe abortion services

n=210

Characteristics	Number	Percent
Friends	129	61.4
Family members	57	27.1
Health providers	116	55.2
Pharmacist	36	17.1

FCHV	110	52.4
Radio/ Television	57	27.1
Internet	7	3.3
Newspaper	6	2.9
Poster/billboard	12	5.7
Pamphlets/IEC/SBCC materials	21	10
Women's group/mother's group	174	82.9
Others	15	7.1

Note: Multiple respondents

3.3. Awareness and knowledge of FP methods

The awareness of FP methods among women age 15-49 is nearly universal. According to the end-line survey 98.6%, women had heard about family planning where 98.1% of women had heard about family planning in the baseline survey. Women who were aware of family planning were further asked about different methods of contraceptives they had known. The most commonly known methods were injectable (100%) and pills (100%) followed by a male condom (99.5%), Female sterilization (96.6%), Male sterilization (96.6%), the implant (96.1%) and IUCD (93.7%). However, only 58.9% of women had known about the lactation amenorrhea method (LAM) and 19.8% percent had known about emergency contraceptives (Table 5).

Comparably, the awareness and knowledge level on family planning methods among women age 15-49 were seen increased during end-line survey than baseline survey. Women had low knowledge of emergency contraceptives (14.1%) and LAM (20.9%) than other family planning methods during the baseline survey. But currently, the number is increasing by 2-3 times.

Table 5: Awareness and knowledge on family planning methods

n=210

Characteristics	Number	Percent
Heard about the FP method	207	98.6

Knowledge of types of FP methods (n=207)		
Female sterilization	200	96.6
Male sterilization	200	96.6
IUCD	194	93.7
Implant	199	96.1
Injectable (Depo)	207	100
Pills	207	100
Condom	206	99.5
Emergency Contraceptives	41	19.8
LAM	122	58.9

Note: Multiple respondents

Of 207 female participants who were aware of FP methods, 98.6% reported having knowledge of a place where such FP services can be obtained. The majority of women (97%) mentioned that family planning services can be obtained from health posts, 59.4% from FCHVs, 29.5% from government hospitals/clinics and 25.6% from a pharmacy.

Similarly, 23% of women reported that family planning services can be obtained from Primary health care center, Mariestopes (20.8%) and private clinic (20.8%). Only 8% of women reported knowing from other sources such as PHC Outreach Clinic, Mobile camp, FPAN, Private hospital/clinic and other NGO facilities.

The knowledge on the availability of FP was increased than baseline survey. During the baseline survey, 86.9% of women were known where the family planning service was available. The number of women who knew the private sector (37.4%) and NGO sector (12.8%) is placed where available family planning was also increased during the end-line survey.

Table 6: Knowledge of places for family planning

n=210

Characteristics	Number	Percent
Knowledge of places for FP	207	98.6

Places of safe abortion(n=207)

Government hospital/clinic	61	29.5
Primary health care center	48	23
Health post	201	97
PHC Outreach Clinic	6	2.9
Mobile camp	4	1.9
FCHV	123	59.4
FPAN	2	1
Marie Stopes	43	20.8
Other NGO facilities	2	1
Private hospital/nursing home	3	1.4
Private clinic	43	20.8
Pharmacy	53	25.6

Note: Multiple respondents

Table 7 shows the sources of information from which women reported hearing about family planning methods and services. The majority of women (73.8%) age 15-49 reported hearing about family planning from women/mother groups and 61% of women reported hearing from friends. Also, health workers (61%) and FCHVs (60.5%) were chief sources of information for family planning at community levels.

Similarly, radio/television (33.3%), family members (26.2%), pharmacists (21.9%) and IEC materials such as posters, pamphlets and billboards were the least likely sources of information (17%). And only 10.9% of women aged 15-19 reported hearing about family planning from newspapers and the internet (Table 7).

During the baseline survey, the main sources of information were friends/neighbors (67.5%) and FCHVs (65.5%). At that time the only 12.6% of the mother were hearing about FP from mother groups. But currently, the main source of information was mother groups it's because the mother groups were formation, reformation and capacity building them and support to a regular monthly meeting via Action Works Nepal (Source: Baseline Survey).

The FCHV's and media also became a key source of information due to the weekly broadcasting of safe abortion-related massage and capacity building of FCHV's

Table 7: Sources of information on family planning methods

n=206

Characteristics	Number	Percent
Friends	128	61
Family members	55	26.2
Health Workers	128	61
Pharmacist	46	21.9
FCHV	127	60.5
Radio/ Television	70	33.3
Internet	15	7.1
Newspaper	8	3.8
Poster/billboard	11	5.2
Pamphlets/IEC/SBCC materials	25	11.9
Women's group/mother's group	155	73.8
Others	14	6.7

Note: Multiple respondents

3.4. Attitude towards abortion

Attitudes and beliefs of the study participants towards a woman who has had an abortion were measured using a SABAS tool based on five points Likert scale.

3.4.1. Negative stereotyping

Of 210 participants, more than one-fourth (27.1%) believed that the woman who has an abortion is committing a sin and 23.8% of women agreed to the statement that a woman who once undertakes an abortion, would make it a habit. Also, the respondents agreed that the woman who has an abortion brings shame to her family (13.3%), and community (21.9%) and such a woman cannot be trusted (23.8%). 26.7% of women said that a woman who experiences abortion might also encourage other women to get such services. Similarly, 26.2% of the respondents believed that the health of a woman who undertakes an abortion will never be good as it was before the abortion (Table 9).

According to the baseline report, nearly one in two (45.2%) believed that the woman who has an abortion is committing a sin, one in three (29.0%) women agreed to the statement that a woman who once undertakes an abortion, would make it a habit, the

respondents agreed that the woman who has an abortion brings shame to her family (30.5%), community (29.5%) and such woman cannot be trusted (32.4%). Three in ten (31.4%) women said that a woman who experiences abortion might also encourage other women to get such services. More than half (55.7%) of the respondents were found during the baseline survey believed that the health of a woman who undertakes an abortion will never be good as it was before the abortion (Source: Baseline survey).

Currently the negative stereotyping regarding abortion were seems to decrease way than the baseline survey. Which we can compare the baseline survey's data and end-line survey's data.

Table 8: Stereotyping attitudes towards women who have an abortion

n=210

Statements	Stigmatizing attitude (Score 3-5) n (%)	Non-stigmatizing attitude (Score 1-2) n (%)
A woman who has an abortion is committing a sin	57 (27.1)	153 (72.9)
Once a woman has an abortion, she will make it a habit	50 (23.8)	160 (76.2)
A woman who has had an abortion cannot be trusted	50 (23.8)	160 (76.2)
A woman who has an abortion brings shame to her family	28 (13.3)	166 (79.0)
The health of a woman who has an abortion is never as good as it was before the abortion	55 (26.2)	155 (73.8)
A woman who has had an abortion might encourage other women to get abortions	56 (26.7)	154 (73.3)
A woman who has an abortion is a bad mother	46 (21.9)	164 (78.1)
A woman who has an abortion brings shame to her community	46 (21.9)	164 (78.1)

Note: Multiple respondents

3.4.2. Exclusion and discrimination

The exclusion and discriminatory attitudes of the participants toward women who have an abortion were assessed using seven statements based on five points Likert scale. Nearly half (21.4%) of the respondents agreed that women with abortions should be excluded from availing of religious services. Furthermore, the respondents said that they would tease women (19.0%) and disgrace them in the community for

having an abortion (20.5%) and stop being a friend with them (22.9%). One in three women (21.9%) believed that a man should not marry a woman having an abortion as she would not be able to bear children. Moreover, most of the respondents (90.5%) disagreed for a woman with abortion to be treated the same as everyone else (Table 9).

During the baseline survey, the exclusion and discriminatory attitudes were high than the endline survey. 47.6% of the respondents agreed that women with abortion should be excluded from availing religious services, 19.0% agreed to disgrace them in the community for having an abortion (21.4%) and stop being a friend with them (23.8%) and 29.5% of women believed that a man should not marry women having an abortion as she would not be able to bear children. During that period only 33.3% of respondents disagreed for a woman with abortion to be treated the same as everyone else (Source: Baseline survey).

Table 9: Exclusion and discriminatory attitudes towards a woman who has an abortion

n=210

Statements	**Stigmatizing attitude (Score 3-5) n (%)**	**Non-stigmatizing attitude (Score 1-2) n (%)**
A woman who has had an abortion should be prohibited from going to religious services	45 (21.4)	165 (78.6)
I would tease a woman who has had an abortion so that she will be ashamed of her decision	40 (19.0)	170 (81.0)
I would try to disgrace a woman in my community if I found out she'd had an abortion	43 (20.5)	167 (79.5)
A man should not marry a woman who has had an abortion because she may not be able to bear children	46 (21.9)	164 (78.1)
I would stop being friends with someone if I found out that she had an abortion	48 (22.9)	162 (77.1)
I would point my fingers at a woman who had an abortion so that other people would know what she has done	44 (21.0)	166 (79)
A woman who has an abortion should be treated the same as everyone else	190 (90.5)	20 (9.5)

Note: Multiple respondents

3.4.3. Fear of contagion

The respondent's fear of contagion from women who have an abortion was assessed using three statements based on five points Likert scale. One-fifth (20.5%) of respondents believed that a woman with an abortion could make other people fall ill. A similar proportion (20.0%) of respondents agreed that a woman who has an abortion should be isolated from other people for a month. Similarly, 26.7% of women believed that a man would be infected with a disease if he had sex with women who had an abortion (Table 10).

According to the baseline survey, one third (33.3%) respondents believed that a woman with abortion could make other people fall ill, 33.8% of respondents agreed that a woman who has an abortion should be isolated from other people for a month and out two in five women (41.9%) believed that a man would be infected with a disease if he had sex with women who had an abortion. (Source: Baseline survey).

The respondent's fear of contagion from women who has an abortion also decreased than baseline survey its due to the conducted awareness activities in communities level via providing training to the stakeholders, conducted regular mother and men group meeting, youth dialogue, etc.

Table 40: Fear of contagion from women who has an abortion

n=210

Statements	Stigmatizing attitude (Score 3-5) n (%)	Non-stigmatizing attitude (Score 1-2) n (%)
A woman who has an abortion can make other people fall ill or get sick	43 (20.5)	167 (79.5)
A woman who has an abortion should be isolated from other people in the community for at least 1 month after having an abortion	42 (20.0)	168 (80.0)
If a man has sex with a woman who has had an abortion, he will become infected with a disease	56 (26.7)	154 (73.3)

Note: Multiple respondents

CHAPTER IV: DISCUSSIONS

Action works Nepal had conducted this study to assess the awareness and knowledge on abortion law and contraceptive methods and their attitude towards abortion among women of reproductive age in Kalikot district. The end-line survey's findings show better than baseline survey finding in perspective of knowledge on the legal status of abortion and moderate to high levels of stigmatizing attitudes and beliefs among women of reproductive age.

Access to safe abortion is mediated by women's awareness of the law. However, after the launching, the safe abortion-related activities in the Kalikot district, the people of Kalilot were aware of liberalized abortion. In the end-line survey, most of the women (90.5%) knew that abortion is legal in Nepal. Before the launching of the project in Kalikot, only 36.7% of women knew that abortion is legal in Nepal. The baseline finding was comparably similar to the results of the demographic and Health Survey 2016 which reported that 33% of women in Karnali province were aware of the legalization of abortion[21].

Nevertheless, a considerable proportion of women lack in-depth knowledge of the legal conditions of abortion. Although more than one-fourth of women with awareness on legal abortion knew that abortion is legal for any women up to 12 weeks' pregnancy in 2018 (baseline survey), now a day's more than half (55.7%) women aware of legal abortion knew that abortion is legal for any women upto 12 weeks' pregnancy. Similarly, only one-tenth knew that abortion is allowed at any stage of pregnancy to save the life of a pregnant woman during the baseline survey but current it is increasing and reach around half. Poor awareness might often be the result of factors such as poor information, illiteracy and lack of access to services. The adult literacy rate in Kalikot is only 45.30 percent which is nearly half compared to Kathmandu (the national capital)[17]. Such poor literacy might have contributed to poor knowledge on the conditions of abortion law.

Although Nepal has a liberal legal framework for safe abortion, the existing poor knowledge and stigmatizing attitudes can become a significant bottleneck for women's access to safe abortion and reproductive health services. For example, in Ethiopia, despite the legalization of safe abortion services, over 50% of all women

seek abortions outside of health facilities and outside the reach of trained health workers[22]. Also, in India, 78% of abortions occur outside of health facilities despite abortion law and the majority of them do not meet the conditions for legality[23]. Even in Nepal, although abortion has been legal for more than a decade, unsafe abortions are estimated to be 58%. This could be attributable to many significant barriers such as inadequate access to public-sector facilities coupled with stigma, and poor understanding of the law among women[15, 24, 25].

A considerable proportion of women in this study were found to have stigmatizing beliefs and attitudes towards safe abortion. Stigmatization of the topic is likely to prevent women from seeking abortion-related information[26]. The efforts of government and non-government organizations towards changing community knowledge and attitudes can be challenging particularly when the topic is stigmatized. Thus, interventions to disseminate accurate information on the legal context are necessary. A study from Jharkhand, India indicated that behavior change communication can be an effective method in improving knowledge and perceptions of women in settings where abortions are stigmatized[27].

In our end-line study, most women age15-49 reported the mother's group as their source of information for safe abortion and family planning. This is a good way to spread the knowledge at the community level and it is also a symbol of the functioning of the health mother's groups in the study areas. Studies from low and middle-income countries including Nepal also suggest that community mobilization involving women's groups can provide promising results in terms of improving awareness and use of maternal health services including abortion and family planning in rural settings[28-30]. Therefore in rural settings like Kalikot, continue mobilization of the health mother's group and engaging them in the participatory actions are more likely to build positive outcomes.

In our end-line survey, more than half (52.2%) participants reported that they had heard about safe abortion services from FCHVs. It means the FCHVs are the mean source of information at the community level. However, Nepal has an established system of Female Community Health Volunteers (FCHVs), who, if trained and engaged effectively, have the potential to improve awareness of legal abortion and referrals to safe abortion sites. Community health workers like FCHVs can serve as

important change agents in improving awareness and decreasing stigma and abortion in rural areas[31].

In developing countries, about three-quarters of all unintended pregnancies occur among women using no method of contraception[32]. Greater contraceptive knowledge, its access, and use can thus drastically reduce safe and unsafe abortion by reducing unintended pregnancies. In our study, the contraceptives' awareness of Kalikot women was found nearly universal. A similar finding was reported by demographic and health survey 2016 at the national and provincial levels.[2] Also, the majority of women (98.6%) reported knowing a place where contraceptive services are available. Although this is encouraging from the public health point of view, in rural settings, the factors such as contraceptive security, socio-cultural barriers, and concerns about possible risks and side effects coupled with FP myths and misconceptions could constrain women's access to and use of contraceptives. Interventions to address barriers at both demand and supply sides might be necessary[33].

To the best of our knowledge, this is one of the first few studies attempting to assess the stigmatizing attitudes of WRA using a SABAS scale. Therefore, we couldn't relate our findings to other published works of literature owing to the limited number of studies available on a related topic. Considering the literacy rate of the study population, we didn’t consider it feasible to self-administer the SABAS questionnaire. Thus, the interviewer was privy to the information disclosed and respondents may have been influenced into making more positive statements through social desirability bias. Moreover, abortion stigma is a complex phenomenon and operates in a variety of ways[34]. Therefore, cautions might be necessary when interpreting the results given the quantitative nature of the study and the use of a limited set of questions. Despite these limitations, the results of this study will be useful for district and palika health authorities, program decision-makers and those in academia.

CHAPTER V: CONCLUSIONS

In conclusion, our study indicated that the knowledge and attitude of women about the legalization of abortion were very satisfactory. And the findings also provided a deep understanding of contraceptives access, availability in the local health facilities, and knowledge of women about contraceptives methods. This information will assist in planning interventions and focused on increasing safe abortion and contraceptives methods and reducing maternal and child mortality.

In addition, the result of this study underscores the perception of abortion in the rural community of Kalikot district. This information should be used during the planning, policy-making, and implementation of the same kinds of programs in the national, sub-national, and district levels including remote areas.

Moreover, still, significant proportions of women have stigmatizing attitudes toward abortion. Thus, it is recommended that considerable emphasis should be given to awareness creation and comprehensive behavior change communication programs on a local basis. Engaging governmental bodies, non-governmental organizations, community health volunteers, health mother groups, men groups, and youth clubs through participatory actions could be some feasible and practicable options for the Kalikot district.

REFERENCES

1. NPC. Nepal's sustainable development goals status and road map: 2016-20. Kathmandu, Nepal: National Planning Commission, Government of Nepal; 2017.
2. MOHP, Era N, International I. Nepal demographic and health survey 2011. Kathmandu, Nepal: Ministry of Health and Population, New ERA, and ICF International, 2012.
3. Country comparison:maternal mortality rate: IndexMundi; 2018 [19 Sep 2018]. Available from: https://www.indexmundi.com/g/r.aspx?v=2223.
4. MOH. National safe abortion policy. Kathmandu, Nepal: Department of Health Services, Ministry of Health; 2003.
5. MOH. Annual report for 2015/2016. Kathmandu, Nepal: Department of Health Services, Ministry of Health and Population; 2017.
6. MOH. Safe abortion services program implementation guidelines. Kathmandu, Nepal: Family Health Division, Department of Health Services, Ministry of Health; 2016.
7. Puri M, Singh S, Sundaram A, Hussain R, Tamang A, Crowell M. Abortion incidence and unintended pregnancy in Nepal. International perspectives on sexual and reproductive health. 2016;42(4):197.
8. Suvedi BK, Pradhan A, Barnett S, Puri M, Chitrakar SR, Poudel P, et al. Nepal maternal mortality and morbidity study 2008/2009: summary of preliminary findings. Kathmandu, Nepal: Family Health division, Department of Health Services, Ministry of Health, Government of Nepal. 2009.
9. Puri M, Ingham R, Matthews Z. Factors affecting abortion decisions among young couples in Nepal. Journal of Adolescent Health. 2007;40(6):535-42.
10. Shrestha DR, Regmi SC, Dangal G. Abortion: Still Unfinished Agenda in Nepal. Journal of Nepal Health Research Council. 2018;16(1):93-8.
11. Rocca C, Puri M, Dulal B, Bajracharya L, Harper C, Blum M, et al. Unsafe abortion after legalisation in Nepal: a cross-sectional study of women presenting to hospitals. BJOG: An International Journal of Obstetrics & Gynaecology. 2013;120(9):1075-84.
12. Thapa S, Sharma SK, Khatiwada N. Women's knowledge of abortion law and availability of services in Nepal. Journal of biosocial science. 2014;46(2):266-77.

13. Yogi A, Prakash K, Neupane S. Prevalence and factors associated with abortion and unsafe abortion in Nepal: a nationwide cross-sectional study. BMC Pregnancy and Childbirth. 2018;18(1):376.
14. Adhikari R. Knowledge on legislation of abortion and experience of abortion among female youth in Nepal: A cross sectional study. Reproductive health. 2016;13(1):48.
15. Wu W-J, Maru S, Regmi K, Basnett I. Abortion Care in Nepal, 15 Years after Legalization: Gaps in Access, Equity, and Quality. Health and human rights. 2017;19(1):221.
16. Khanal P, Sanjel K, Chalise HN. Knowledge and Practice of Abortion among Women in Nepal. Asia-Pacific E-Journal of Health Sciences. 2014;3(1).
17. Sharma P, Guha-Khasnobis B, Khanal DR. Nepal human development report 2014: Beyond georgaphy- unlocking human potential. Kathmandu: National Planning Commission, Government of Nepal; 2014.
18. MOFALD. Gaupalika tatha nagarpalika sankshipta parichaya pustika [in Nepali]. Kathmandu, Nepal: Federal Affairs Section, Ministry of Federal Affairs and Local Development; 2017.
19. Arifin WN. Introduction to sample size calculation. Education in Medicine Journal. 2013;5(2).
20. Shellenberg KM, Hessini L, Levandowski BA. Developing a scale to measure stigmatizing attitudes and beliefs about women who have abortions: results from Ghana and Zambia. Women & health. 2014;54(7):599-616.
21. MOHP, NewERA, ICF. Nepal demographic and health survey 2016. Kathmandu, Nepal: Ministry of Health, 2017.
22. Mesce D, Clifton D. Abortion: Facts and figures. Population Reference Bureau; 2011.
23. Singh S, Shekhar C, Acharya R, Moore AM, Stillman M, Pradhan MR, et al. The incidence of abortion and unintended pregnancy in India, 2015. The Lancet Global Health. 2018;6(1):e111-e20.
24. Puri M, Lamichhane P, Harken T, Blum M, Harper CC, Darney PD, et al. "Sometimes they used to whisper in our ears": health care workers' perceptions of the effects of abortion legalization in Nepal. BMC Public Health. 2012;12(1):297.
25. Abortion and unintended pregnancy in Nepal 2017. Center for Research on Environment Heath and Population Activities and Guttmacher Institute.

26. Assifi AR, Berger B, Tunçalp Ö, Khosla R, Ganatra B. Women's awareness and knowledge of abortion laws: A systematic review. PloS one. 2016;11(3):e0152224.
27. Banerjee SK, Andersen KL, Warvadekar J, Pearson E. Effectiveness of a behavior change communication intervention to improve knowledge and perceptions about abortion in Bihar and Jharkhand, India. International perspectives on sexual and reproductive health. 2013:142-51.
28. Sondaal AE, Tumbahangphe KM, Neupane R, Manandhar DS, Costello A, Morrison J. Sustainability of community-based women's groups: reflections from a participatory intervention for newborn and maternal health in Nepal. Community Development Journal. 2018.
29. Undie CC, Van Lith LM, Wahome M, Obare F, Oloo E, Curtis C. Community mobilization and service strengthening to increase awareness and use of postabortion care and family planning in Kenya. International Journal of Gynecology & Obstetrics. 2014;126(1):8-13.
30. Manandhar DS, Osrin D, Shrestha BP, Mesko N, Morrison J, Tumbahangphe KM, et al. Effect of a participatory intervention with women's groups on birth outcomes in Nepal: cluster-randomised controlled trial. The Lancet. 2004;364(9438):970-9.
31. Puri M, Tamang A, Shrestha P, Joshi D. The role of auxiliary nurse-midwives and community health volunteers in expanding access to medical abortion in rural Nepal. Reproductive health matters. 2014;22(sup44):94-103.
32. Darroch JE, Audam S, Biddlecom A, Kopplin G, Riley T, Singh S, et al. Adding it up. Investing in contraception and maternal and newborn health, 2017 New York, NY: Guttmacher Institute; 2017 [2018 Dec 27].
33. Muanda MF, Ndongo GP, Messina LJ, Bertrand JT. Barriers to modern contraceptive use in rural areas in DRC. Culture, health & sexuality. 2017;19(9):1011-23.
34. Hanschmidt F, Linde K, Hilbert A, Riedel-Heller SG, Kersting A. Abortion stigma: a systematic review. Perspectives on sexual and reproductive health. 2016;48(4):169-77.

Annex I: Consent and assent forms

कालिकोट जिल्लाका निश्चित नगरपालिका र गाउँपालिकामा रहेका प्रजनन् उमेर (१५-४९ बर्ष) का महिलाहरुमा गर्भपतन र परिवार नियोजनका साधनहरु सम्बन्धी ज्ञान र धारणाको अध्ययन-२०७८

सुसूचित सहमति फारम

नमस्कार, मेरो नाम ..... हो । म हाल एक्सन वर्क्स नेपाल भन्ने संस्थामा सामुदायिक सहजकर्ताको रूपमा कार्यरत छु । यस संस्थाले कालिकोट जिल्लाका केही नगरपालिका र गाउँपालिकामा रहेका प्रजनन् उमेरका महिलाहरुमा गर्भपतन र परिवार नियोजनका साधनहरु सम्बन्धी ज्ञान र धारणा कस्तो छ भन्ने बिषयमा अध्ययन गरिरहेको छ । त्यसै क्रममा म यहाँ तथ्यांक लिन आएको हुँ ।

यस अध्ययनमा भाग लिन अनुरोध गर्दै म तपाइलाई केही जानकारी दिन लागिरहेको छु । यो अध्ययनको लक्षित समुह प्रजनन् उमेर (१५-४९) का महिलाहरु हुनेछन् । म तपाईसँग व्यक्तिगत सामाजिक र जनसांख्यिक विवरणका साथै गर्भपतन र परिवार नियोजनका बारेमा ज्ञान र धारणासंग संम्बन्धित केही प्रश्नहरु सोध्नेछु ।

अध्ययनको सिलसिलामा तपाईं र तपाईको पारिवारको बारेमा प्राप्त जानकारीको पूर्ण गोपनियता कायम गरिनेछ । यो सूचना यो अध्ययनको उदेश्यको लागि मात्र प्रयोग गरिनेछ र अध्ययनसंग सम्बन्धित नभएको कुनै पनि व्यक्ति वा संस्थासंग यो सूचना बाडिने छैन । नामको सट्टामा कोड को प्रयोग गरि तपाईका परिचय गोप्य राखिनेछ ।

यस अनुसन्धानमा भाग लिने वा नलिने निर्णय गर्न तपाई स्वतन्त्र हुनुहुन्छ । तपाँई निर्बाध रूपमा कुनै पनि बेला अन्तर्वार्ताबाट अलग हुन सक्नुहुनेछ साथै कुनै विनिर्दिष्ट प्रश्नको उत्तर नदिन पनि सक्नुहुन्छ ।

यो अन्तरवार्ता लगभग २० देखि २५ मिनेटको हुनेछ । तपाईंहरुलाई यस बारेमा केही सोध्नु छ ?

के तपाईं सहभागी हुन चाहनुहुन्छ ?

चाहन्न..... अन्तरवार्ता वा छलफल यही टुङ्गयाउने र धन्यवाददिने
चाहन्छु .....अन्तरवार्ता वा छलफल शुरु गर्न मन्जुरीनामामा सहि लिने र सुरु गर्ने ।

सहभागीको सही .....

सहभागीको नाम थर .....

मिति २०७८/...../.....

निरक्षर सहभागीको लागि एक जना साक्षर साक्षिले हस्ताक्षर गर्नुपर्ने छ र निरक्षर सहभागीले औंठा छाप लगाएको हुनुपर्ने छ ।

साक्षीको सही .....

साक्षीको नाम थर .....

सहभागीसँगको नाता .....

मिति २०७८/...../.....

सहभागीको बुढीऔंलाको ल्याप्चे	
दायाँ	बायाँ

कालिकोट जिल्लाका निश्चित नगरपालिका र गाउँपालिकामा रहेका प्रजनन् उमेर (१५-४९ बर्ष) का महिलाहरुमा गर्भपतन र परिवार नियोजनका साधनहरु सम्बन्धी ज्ञान र धारणाको अध्ययन-२०७८

अभिभावकको सुसूचित सहमति फारम

नमस्कार, मेरो नाम ..... हो । म हाल एक्सन वर्क्स नेपाल भन्ने संस्थामा सामुदायिक सहजकर्ताको रूपमा कार्यरत छु । यस संस्थाले कालिकोट जिल्लाका केही नगरपालिका र गाउँपालिकामा रहेका प्रजनन् उमेरका महिलाहरुमा गर्भपतन र परिवार नियोजनका साधनहरु सम्बन्धी ज्ञान र धारणा कस्तो छ भन्ने बिषयमा अध्ययन गरिरहेको छ । त्यसै क्रममा म यहाँ तथ्यांक लिन आएको हुँ ।

यो अध्ययनमा तपाई आफ्नो छारीलाई भाग लिन अनुमति दिनुहोस भनि अनुरोध गर्दै म तपाइलाई जानकारी दिन लागिरहेको छु । यो अध्ययनको लक्षित समुह प्रजनन् उमेर (१५-४९) का महिलाहरु हुनेछन् । म तपाईकी छोरीसँग व्यक्तिगत सामाजिक र जनसांख्यिक विवरणका साथै गर्भपतन र परिवार नियोजनका बारेमा ज्ञान र धारणासंग संम्बन्धित केही प्रश्नहरु सोध्नेछु ।

अध्ययनको सिलसिलामा तपाईको पारिवारिक र तपाईकी छोरीका बारेमा प्राप्त जानकारीको पूर्ण गोपनियता कायम गरिनेछ । यो सूचना यो अध्ययनको उदेश्यको लागि मात्र प्रयोग गरिनेछ र अध्ययनसंग सम्बन्धित नभएको कुनै पनि व्यक्ति वा संस्थासंग यो सूचना बाडिने छैन । नामको सट्टामा कोडको प्रयोग गरि परिचय गोप्य राखिनेछ ।

यस अध्ययनमा तपाईकी छोरीलाइ सहभागी गराउने वा नगराउने निर्णय गर्न तपाई स्वतन्त्र हुनुहुन्छ । तपाँईकी छोरी निर्बाध रूपमा कुनै पनि बेला अन्तर्वार्ताबाट अलग हुन सक्नुहुनेछ साथसाथै कुनै विनिर्दिष्ट प्रश्नको उत्तर नदिन पनि सक्नुहुन्छ । अहिले भाग लिने निर्णय गरेपछी मन फेरियो भने तपाईंले कुनै पनि बेला अध्ययनबाट आफ्नो छोरीलाइ भाग लिनबाट रोक्न सक्नु हुनेछ ।

यो अन्तरवार्ता लगभग २० देखि २५ मिनेटको हुनेछ । तपाईंहरुलाई यस बारेमा केही सोध्नु छ ?

के तपाईं यस अध्ययनमा आफ्नो छारीलाई भाग लिन अनुमति दिनुहुन्छ ?

दिन्न..... अन्तरवार्ता वा छलफल यही टुङ्गयाउने र धन्यवाद दिने
दिन्छु .....अन्तरवार्ता वा छलफल शुरु गर्न मन्जुरीनामामा सहि लिने र सुरु गर्ने ।

अभिभावकको बुढीऔंलाको ल्याप्चे	

दायाँ	बायाँ

आमा/बाबु/अभिभावकको सही .....

आमा/बाबु/अभिभावकको नाम थर .....

सहभागीसँगको नाता (यदि अभिभावक भएमा) .....

सहभागीको नाम थर .....

मिति २०७८/...../.....

निरक्षर अभिभावकको लागि एक जना साक्षर साक्षिले हस्ताक्षर गर्नुपर्ने छ र निरक्षर अभिभावकले औंठा छाप लगाएको हुनुपर्ने छ ।

साक्षीको सही .....

साक्षीको नाम थर .....

सहभागीसँगको नाता .....

Annex II: Nepali Questionnaire

कालिकोट जिल्लाकाप्रजनन् उमेरका (१५-४९बर्षका) महिलाहरुलाई गर्भपतन र परिवार नियोजनको बारेमा सोधिने प्रश्नावली

क. सर्वेक्षण सम्बन्धिजानकारी	
१.१ साविकको गा.वि.स.	
१.२ वार्ड नं:	☐☐
१.३ अन्तरवार्ता मिती	दिन ☐☐ महिना ☐☐ वर्ष ☐☐☐☐
१.४ उत्तरदाताको पहिचान नं:	☐☐☐☐
१.५ गणकको नाम:	

ख.जनसांख्यीकतथा सामाजिकविवरण				
प्र.नं.	**प्रश्नहरु**	**जवाफहरु**	**कोडिङ**	**स्किप**
२.१	तपाईं कति वर्षको हुनु भयो? *थप सोधखोज गर्नुहोस् :* पछिल्लो जन्मदिनमा तपाईं कति वर्षकी हुनुहुन्थ्यो ?	उमेर(पूरा गरेको वर्ष).....		
२.२	तपाईको जाती के हो? (जातिय बर्गिकरण कार्ड प्रयोग गर्ने)	द्यलित	१	
		पहुँच नभएक ाजनजाति	२	
		पहुँच नभएका गैर दलित तराई जाति समुह	३	
		धार्मिक रुपले अल्पसंख्यक	४	
		तुलनात्मक रुपले पहुँच भएका जनजाति	५	
		उपल्लो जाति	६	
२.३	तपाईंले उतीर्ण गर्नु भएको सबैभन्दा माथिल्लो शिक्षा कति हो ?	निरक्षर	१	
		अनौपचारिक शिक्षा	२	
		प्राथमिक तह भन्दा कम	३	
		प्राथमिक तह (कक्षा ५ उर्तीण)	४	
		निम्न माध्यमिक तह (कक्षा ८ उर्तीण)	५	
		माध्यमिक तह (कक्षा १० उर्तीण)	६	
		उच्च माध्यमिक (+२ वा सो सरह उर्तीण)	७	
		स्नातक वा सो भन्दा माथी	८	
२.४	तपाईको पेशा के हो? (कुनै एक मुख्य पेशामा मात्र चिन्ह लगाउनु होस)	कृषि	१	
		व्यापार	२	
		सरकारी जागिर	३	
		गैर सरकारी जागिर	४	
		ज्यालादारी	५	
		घरायसी काम	६	
		विद्यार्थी	७	
		बेरोजगार	८	
		अन्य (खुलाउने).....	९	

२.५	तपाईको वैवाहिक स्थिती के हो?	ीविवाहित	१	
		अविवाहित	२	
		छुट्टिएको/सम्बन्ध विच्छेद	३	→२.१
		विधुवा	४	
२.६	तपाईंको श्रीमानले उतीर्ण गर्नु भएको सबै भन्दा माथिल्लो शिक्षा कति हो ?	निरक्षर	१	
		अनौपचारिक शिक्षा	२	
		प्राथमिक तह भन्दा कम	३	
		प्राथमिक तह (कक्षा ५ उर्तीण)	४	
		निम्न माध्यमिक तह (कक्षा ८ उर्तीण)	५	
		माध्यमिक तह (कक्षा १० उर्तीण)	६	
		उच्च माध्यमिक (+२ वा सो सरह उर्तीण)	७	
		स्नातक वा सो भन्दा माथी	८	
२.७	तपाईको श्रीमानको पेशा के हो? (कुनै एक मुख्य पेशामा मात्र चिन्ह लगाउनुहोस)	कृषि	१	
		व्यापार	२	
		सरकारी जागिर	३	
		गैरसरकारी जागिर	४	
		ज्यालादारी	५	
		घरायसीकाम	६	
		बिद्यार्थी	७	
		बेरोजगार	८	
		अन्य (खुलाउने)	९	

ग. गर्भपतन सम्बन्धि चेतना र ज्ञान

प्र.नं.	प्रश्नहरु	जवाफहरु	कोडिङ	स्किप
३.१	के हाम्रो देशमा गर्भपतन सेवाले कानुनी मान्यता पाएको छ?	छ	१	
		छैन	२	
		थाहा छैन	३	
३.२	नेपालमा एउटा महिलाले कुन कुन अवस्थामा गर्भपतन गराउन सक्छिन ? (एक भन्दा बढी उत्तर सम्भव छ) (कृपया पहिले उत्तरदातालाई उत्तर दिन लगाउनुहोस र तदनुसार जवाफहरू छनोट गर्नुहोस)	१२ हप्ता (३ महिना) वासो भन्दाकम समयको गर्भ भएमा	१	
		२८ हप्तासम्मको गर्भ यदि त्यो बलात्कार वा हाडनाता करणी बाटभएको छ भने	२	
		जुनसुकै अवस्थाको गर्भ यदि आमाको जीवन जोखिममा छ भने	३	
		जुनसुकै अवस्थाको गर्भ यदि आमाको शारीरिक र मानसिक स्वास्थ्य जोखिममा छ भने	४	
		गर्भमा रहेको बच्चामा बिकृती देखिएमा	५	
		यदी धेरै बच्चा छ भने	६	
		अन्य (खुलाउने)	७	
		थाहा छैन	८	
३.३	नेपालमाकुनकुनअवस्थामागर्भपतनगर्न कानुनले प्रतिबन्धितगरेको छ? (एक भन्दा बढी उत्तर सम्भव छ)	भ्रुणको लिङ्गको पहिचान गरि	१	
		गर्भवती महिलाको मन्जुरी बिना	२	
		कानुनले तोकेका अवस्था र अवधी बाहेक	३	
		अन्य उल्लेख गर्नुहोस.....	४	
		थाहा छैन	५	
३.४	के तपाईको विचारमा गर्भपतन विवाहित महिलाको लागि मात्र कानुनी मान्यता प्राप्त हो	हो	१	
		होइन	२	
		थाहा छैन	३	

३.५	तपाईंलाई सुरक्षित गर्भपतन गराउने कुनै ठाउँको बारेमा जानकारी छ ?	छ	१	
		छैन	२	→ ३.७
३.६	उक्त गर्भपतन गराउने ठाउँ कहाँ छ ? अरु कुनै ठाउँ ?	***सरकारी श्रोत***		
		सरकारी अस्पताल क्लिनिक	१	
		प्राथमिक स्वास्थ्य सेवा केन्द्र	२	
		स्वास्थ्यचौकी	३	
		प्राथमिक स्वास्थ्य सेवा केन्द्र गाउँघर क्लिनिक	४	
		घुम्ती शिविर	५	
		महिला स्वास्थ्य स्वयमं सेविका	६	
		स्याटलाईट क्लिनिक	७	
		अन्य सरकारी संस्था (खुलाउने)	८	
		गैर सरकारी (एनजिओ) श्रोत		
		नेपाल परिवार नियोजन संघ	९	
		मेरी स्टोप्स	१०	
		अन्य गैर सरकारी संस्था (खुलाउने).....	११	
		निजी स्वास्थ्य संस्था		
		निज अस्पताल नर्सिङ होम	१२	
		निजीक्लिनिक	१३	
		औषधीपसल	१४	
		अन्यनिजी स्वास्थ्य संस्था (खुलाउने).....	१५	
३.७	सुरक्षित गर्भपतन सम्बन्धी जानकारी तपाइले कहाँबाट पाउनु भयो	साथीहरु	१	
		परिवारका सदस्यहरु	२	
		स्वास्थ्यकर्मीहरु	३	
		औषधीपसले	४	
		म.स्वा.स्व.से	५	
		रेडियो टेलिभिजन	६	
		ईन्टरनेट	७	
		पत्रीका	८	
		पोस्टर बिल्वोर्ड	९	
		पम्प्लेट आइ इ सि एस बि सि सि सामाग्री	१०	
		महिलाआमा समुह	११	
		अन्य (खुलाउने).....	१२	

घ. परिवार नियोजन सम्बन्धि चेतना र ज्ञान

	प्रश्नहरु	**जवाफहरु**	**कोडिङ**	**स्किप**
४.१	अब म तपाईंलाई बच्चा ढिलो पाउनवाबच्चा नै नपाउनको लागि दम्पतीले प्रयोग गर्न सक्ने विभिन्न किसिमका साधन वा तरिकाहरुकाबारेमा कुरा गर्न चाहन्छु । तपाइले परिवार नियोजनको साधनबारे कहिल्यै सुन्नु भएको छ ?	छ	१	
		छैन	२	→ ५.१
४.२	**तपाइलेतपशीलका (साधन) बारे कहिल्यै सुन्नु भएको छ ?**			
४.२.१	महिला बन्ध्याकरण *प्रोव बच्चा नहोस भन्नको लागी महिलाहरुले गर्ने स्थायी अपरेसन । (जस्तै मिनिल्याप, ल्याप्रोस्कोपी*	छ	१	
		छैन	२	
४.२.२	पुरुष बन्ध्याकरण	छ	१	

	प्रोव बच्चा नहोस भन्नको लागी पुरुषहरुले गर्ने स्थायी अपरेसन । (जस्तै भ्यासेक्टोम्री)	छैन	२	
४.२.३	आइ यू डी /आइ यू सी डी *प्रोव. डाक्टर वानर्शद्वारा महिलाहरुको पाठेघरमा राखिने कपर टी*	छ	१	
		छैन	२	
४.२.४	नरप्लान्ट *प्रोव: डाक्टर वानर्शको सहायतालै महिलाहरुले पाखुराको माथिल्लो भागमा राखिने एक वा बढी स साना क्याप्सुलहरु जसले ३ वा सो भन्दाअ बढी बर्षसम्म गर्भ रहनबाट जोगाउँछ*	छ	१	
		छैन	२	
४.२.५	इन्जेक्सन *प्रोव: एक वा सो भन्दा बढी महिनसम्म गर्भ रहना नदिन स्वास्थ्यकर्मीले महिलाहरुलाई दिने सुइ । जस्तै संगिनी डिपोप्रोभेरा*	छ	१	
		छैन	२	
४.२.६	पिल्स *प्रोव गर्भ नरहोस भन्नका लागी महिलाहरुले हरेक दिन खाने चक्की*	छ	१	
		छैन	२	
४.२.७	कण्डम *प्रोव पुरुषहरुले संभोग गर्दा लिङमा लगाउने रबरको खोल जस्तै ढाल*	छ	१	
		छैन	२	
४.२.८	आकस्मिक तरिका *प्रोव असुरक्षित यौनसम्पर्क पछिको तीन दिन भित्र महिलाहरुले खाने विशेष प्रकारको चक्की जस्ले गर्भ रहनबाट जोगाँउछ । (जस्तै:आईपिल, इकोन)*	छ	१	
		छैन	२	
४.२.९	स्तनपानविधी(LAM) *प्रोव:बच्चाजन्मेको ६ महिनसम्म र महिनावारी हुनु अगाडी महिलाले प्रयोग गर्ने एक प्रकारको विधी जसमा आमाले निरन्तर रुपमादिन र रातमा स्तनपान गराउँछ*	छ	१	
		छैन	२	

प्र.नं.	प्रश्नहरु	जवाफहरु	कोडिङ	स्किप
४.३	तपाईंलाई परिवार नियोजनका साधनपाउने कुनै ठाउँको बारेमाजानकारी छ	छ	१	
		छैन	२ →	४.५
४.४	उक्त साधन पाइने ठाउँ कहाँ छ ? अरु कुनै ठाउँ ?	***सरकारी श्रोत***		
		सरकारी अस्पताल क्लिनिक	१	
		प्राथमिक स्वास्थ्य सेवा केन्द्र	२	
		स्वास्थ्यचौकी	३	
		प्राथमिक स्वास्थ्य सेवा केन्द्र गाउँघर क्लिनिक	४	
		घुम्ती शिविर	५	
		महिला स्वास्थ्य स्वयमं सेविका	६	
		स्याटलाईट क्लिनिक	७	
		अन्य सरकारी संस्था (खुलाउने)	८	
		गैर सरकारी (एनजिओ) श्रोत		
		नेपाल परिवार नियोजन संघ	९	
		मेरी स्टोप्स	१०	
		अन्य गैर सरकारी संस्था (खुलाउने).....	११	
		निजी स्वास्थ्य संस्था		
		निजी अस्पताल/नर्सिङ होम/निजीक्लिनिक	१२	

		औषधी पसल	१३	
		संगीनी आउटलेट	१४	
		अन्यनिजी स्वास्थ्य संस्था (खुलाउने).....	१५	

४.५	परिवार नियोजन सम्बन्धी जानकारी तपाइले कहाँबाट पाउनु भयो	साथीहरु	१	
		परिवारका सदस्यहरु	२	
		स्वास्थ्यकर्मीहरु	३	
		औषधीपसले	४	
		म.स्वा.स्व.से	५	
		रेडियो टेलिभिजन	६	
		ईन्टरनेट	७	
		पत्रीका	८	
		पोस्टर बिल्वोर्ड	९	
		पम्प्लेट आइ इ सि एस बि सि सि सामाग्री	१०	
		महिलाआमा समुह	११	
		अन्य (खुलाउने).....	१२	

ङ. गर्भपतन सम्बन्धिधारणा

प्र.नं.	प्रश्नहरु	अत्यन्तअसहमत	असहमत	थाहाभएन	सहमत	पुरै सहमत
५.१	तपाईं तपसिलका भनाइहरु प्रतिकत्तिको सहमत हुनुहुन्छ?					
	नकरात्मकअन्धविश्वास (Negative Stereotyping)					
५.१.१	गर्भपतन गरेकीमहिलाले पाप गरेकी हुन्छे					
५.१.२	महिलालेएक पटक गर्भपतन गरेपछि त्यसलाई बानी बनाउछे					
५.१.३	गर्भपतन गरेकी महिलालाई विश्वास गर्न सकिन्न					
५.१.४	गर्भपतन गरेकी महिलाले आफ्नो परिवारलाई लज्जित बनाउछे					
५.१.५	गर्भपतन गरेकी महिलाको स्वास्थ्य अवस्था गर्भपतन गर्नु अघि जस्तो कहिल्यै राम्रो हुँदैन					
५.१.६	गर्भपतन गरेकी महिलाले अन्य महिलाहरुलाई पनि गर्भपतन गर्न प्रोत्साहनगर्न सक्छे					
५.१.७	गर्भपतन गरेकी महिला खराब आमा हो					
५.१.८	गर्भपतन गरेकीमहिलाले आफ्नो समुदायलाई लज्जित बनाउछे					
	बहिष्करण र भेदभाव (Exclusion and discrimination)					
५.१.९	गर्भपतन गरेकी महिलालाई धार्मिक स्थानहरुमा जान निषेधित गर्नुपर्छ					
५.१.१०	म गर्भपतन गरेकी महिलालाई जिस्काउछु ताकी उ आफ्नो निर्णय बाट लज्जितहोस्					
५.१.११	यदी मेरो समुदायमा कुनै महिलाले गर्भपतन गराएको थाहापाए भने म उसको अपमान गर्ने प्रयास गर्छु					
५.१.१२	पुरुषले गर्भपतन गरेको महिलासँग विवाह गर्नु हुँदैन किनकिउ बच्चा जन्माउन असक्षम भएको हुनसक्छे					

५.१.१३	यदी मेरो साथिले गर्भपतन गरेको थाहा पाए भने म उसलाई मान्दिन					
५.१.१४	म गर्भपतन गरेकोमहिलालाई औंल्याँउछु ताकी अन्य मानिसहरुले उसले के गरेकी छ भन्ने कुरा थाहापाउन्					
५.१.१५	गर्भपतन गरेकीमहिलालाई अरु महिलालाई जस्तै समान व्यवहार गर्नुपर्छ					
	रोग सर्ने भय (Fear of contagion)					
५.१.१६	गर्भपतन गरेकी महिलालाले अन्य मानिसलाई बिरामी वा रोगी बनाउन सक्छे					
५.१.१७	गर्भपतन गरेकी महिलालाई गर्भपतन गरेको कम्तीमा पनि १ महिनासम्म समुदायकाअन्य मानिसहरुबाट छुट्टै राख्नुपर्छ					
५.१.१८	यदी पुरुषले गर्भपतन गरेकी महिलासँग शारिरिक सम्पर्क राख्यो भने उ रोगबाट संक्रमित हुन सक्छ					

सहभागिताको लागि धन्यवाद

Annex III: English Questionnaire

Questionnaire on Knowledge and Attitude towards Abortion and Contraceptive Services among Women of Reproductive Age in Kalikot District

A. Survey Information	
1.1 Previous VDC	……..
1.2 Ward no. of previous VDC	
1.3 Current (rural) municipality	……..
1.4 Ward no. of current (rural) municipality	
1.5 Date of Interview	Day | Month | Year
1.6 Respondent ID	
1.7 Name of Interviewer	

B. Socio-Demographic Information				
Q.no.	**Questions**	**Categories**	**Codes**	**Skip**
2.1	What is your age (in completed years)?			
2.2	What is your caste/ethnicity …….(caste) (Use ethnicity classification card)	Dalit	1	
		Disadvantaged janajatis	2	
		Disadvantaged non dalit terai caste	3	
		Religious minorities	4	
		Relatively advantaged janajatis	5	
		Upper caste	6	
2.3	What is the highest education level you have completed?	Illiterate	1	
		Non-formal education	2	
		Less than primary	3	
		Primary Level	4	
		Lower Secondary Level	5	
		Secondary Level	6	
		Higher Secondary Level	7	
		Bachelor and Above	8	
2.4	What is your main occupation? (Please select one which is main occupation)	Agriculture	1	
		Business	2	
		Government Job	3	
		Non-government Job	4	
		Labour/ Wages	5	
		Homemaker	6	
		Student	7	
		Unemployed	8	
		Others (Specify)…….	9	
2.5	What is your current marital status	Currently married	1	
		Divorced/separated	2	Go to 3.1
		Widowed	3	Go to 3.1
		Never married	4	Go to 3.1

2.6	What is educational status of Spouse/partner	Illiterate	1	
		Non-formal education	2	
		Less than primary	3	
		Primary Level	4	
		Lower Secondary Level	5	
		Secondary Level	6	
		Higher Secondary Level	7	
		Bachelor and Above	8	
2.7	What is the occupational status of your partner/spouse?	Agriculture	1	
		Business	2	
		Government Job	3	
		Non-government Job	4	
		Labour/ Wages	5	
		Household Works	6	
		Student	7	
		Unemployed	8	
		Others (Specify)…….	9	
C. Awareness and Knowledge on Abortion				
Q.no.	**Questions**	**Categories**	**Codes**	**Skip**
3.1	Is abortion legal in Nepal?	Yes	1	
		No	2	
		Don't know	9	
3.2	What are the conditions on which a woman can have abortion in Nepal?	Pregnancy of 12 weeks or less gestation for any woman	1	
		Pregnancy of 18 weeks if it is a result of rape or incest	2	
		Pregnancy of any duration if life of mother is at risk	3	
		Pregnancy of any duration if mother's physical and mental health is at risk.	4	
		Fetus is deformed	5	
		If one has too many children	6	
		Others (Specify)…….	7	
		Don't know	9	
3.3	What are the conditions on which abortion is prohibited by law	Sex-selective abortion	1	
		Without the consent of pregnant woman	2	
		Conditions other than those prescribed by law	3	
		Others (Specify) ……	4	
		Don't know	9	
3.4	Do you think abortion is legal only for a married woman?	Yes	1	
		No	2	
		Don't know	9	
3.5	Do you know of a place where woman can go to get safe abortion?	Yes	1	
		No	2	Go to 3.7

3.6	Where is the place?	***Public sector***		
		Government hospital/clinic	1	
		Primary health care center	2	
		Health post	3	
		PHC Outreach Clinic	4	
		Mobile camp	5	
		FCHV	6	
		Satellite clinic	7	
		Other government facility (specify)	8	
		NGO sector		
		FPAN	9	
		Marie Stopes	10	
		Other NGO facilities (specify)….	11	
		Private sector		
		Private hospital/nursing home	12	
		Private clinic	13	
		Pharmacy	14	
		Other private facility (specify)….	15	
3.7	From where did you receive information about safe abortion services?	Friends	1	
		Family members	2	
		Health providers	3	
		Pharmacist	4	
		FCHV	5	
		Radio/ Television	6	
		Internet	7	
		Newspaper	8	
		Poster/billboard	9	
		Pamphlets/IEC/SBCC materials	10	
		Women's group/mother's group	11	
		Others……	12	
D. Awareness and Knowledge on FP				
	Questions	**Categories**	**Codes**	**Skip**
4.1	Have you heard about family planning methods	Yes	1	
		No	2	Go to 5.1
4.2	Can you tell us about the names of different family planning methods			
4.2.1	Female sterilization	Yes	1	
		No	2	
4.2.2	Male sterilization	Yes	1	
		No	2	
4.2.3	IUCD	Yes	1	
		No	2	
4.2.4	Injectable	Yes	1	
		No	2	
4.2.5	Implants	Yes	1	
		No	2	

4.2.6	Pill	Yes	1	
		No	2	
4.2.7	Condom	Yes	1	
		No	2	
4.2.8	Emergency contraception	Yes	1	
		No	2	
4.2.9	Lactation amenorrhea method	Yes	1	
		No	2	
4.3	Do you know of a place where woman can get family planning methods?	Yes	1	
		No	2	Go to 4.5
4.4	Where is the place?	***Public sector***		
		Government hospital/clinic	1	
		Primary health care center	2	
		Health post	3	
		PHC Outreach Clinic	4	
		Mobile camp	5	
		FCHV	6	
		Satellite clinic	7	
		Other government facility (specify)	8	
		NGO Sector		
		FPAN	9	
		Marie Stopes	10	
		Other NGO facilities (specify)	11	
		Private sector		
		Private hospital/clinic/nursing home	12	
		Pharmacy	13	
		Sangini outlet	14	
		Other private facility (specify)	15	
		Shop		
		Friend/relative		
4.5	From where did you receive information about family planning?	Friends	1	
		Family members	2	
		Health providers	3	
		Pharmacist	4	
		FCHV	5	
		Radio/ Television	6	
		Internet	7	
		Newspaper	8	
		Poster/billboard	9	
		Pamphlets/IEC/SBCC materials	10	
		Women's group/mother's group	11	
		Others……	12	

E. Attitudes towards Abortion						
Q.no.	**Statements**	**Strongly disagree**	**Disagree**	**Unsure**	**Agree**	**Strongly agree**
5.1	Please indicate how much you agree or disagree with the following statement					
	Negative Stereotyping					
5.1.1	A woman who has an abortion is committing a sin	1	2	3	4	5
5.1.2	Once a woman has an abortion, she will make it a habit					
5.1.3	A woman who has had an abortion cannot be trusted	1	2	3	4	5
5.1.4	A woman who has an abortion brings shame to her family	1	2	3	4	5
5.1.5	The health of a woman who has an abortion is never as good as it was before the abortion	1	2	3	4	5
5.1.6	A woman who has had an abortion might encourage other women to get abortions	1	2	3	4	5
5.1.7	A woman who has an abortion is a bad mother	1	2	3	4	5
5.1.8	A woman who has an abortion brings shame to her community	1	2	3	4	5
	Exclusion and discrimination SABAS items					
5.1.9	A woman who has had an abortion should be prohibited from going to religious services	1	2	3	4	5
5.1.10	I would tease a woman who has had an abortion so that she will be ashamed about her decision	1	2	3	4	5
5.1.11	I would try to disgrace a woman in my community if I found out she'd had an abortion	1	2	3	4	5
5.1.12	A man should not marry a woman who has had an abortion because she may not be able to bear children	1	2	3	4	5
5.1.13	I would stop being friends with someone if I found out that she had an abortion	1	2	3	4	5
5.1.14	I would point my fingers at a woman who had an abortion so that other people would know what she has done	1	2	3	4	5
5.1.15	A woman who has an abortion should be treated the same as everyone else	1	2	3	4	5
	Negative stereotyping and exclusion/discrimination of young women					
5.1.16	A woman who has an abortion can make other people fall ill or get sick	1	2	3	4	5
5.1.17	A woman who has an abortion should be isolated from other people in the community for at least 1 month after having an abortion	1	2	3	4	5
5.1.18	If a man has sex with a woman who has had an abortion, he will become infected with a disease	1	2	3	4	5

Thank you for your participation

Annex IV: List of Study Sites

Current (Rural) Municipality	Pre-Existing VDC
• Palata Municipality	• Dhaulagoha and Kheena
• Raskot Municipality	• Sipkhana
• Tilagupha Municipality	• Chhapre, Chilkhaya, Jubitha andRachuli
• Kalika Rural Municipality	• Sukatiya
• Naraharinath Rural Municipality	• Rupsa, Lalu and Kotbada
• Pachal-Jharana Rural Municipality	• Badalkot and Ramnakot
• Sanmi Triveni Rural Municipality	• Mumrakot and Mehalmudi

Annex V: Ethnicity Classification

Caste/ Ethnic Groupings

1. Dalit
• Hill: Kami, Damai, Sarki, Gaine, Badi • Terai: Chamar, Mushar, Dhusah/Paswan, Tatma, Kahtway, Bantar, Dom, Chiadimar, Dhobi, Halkhor
2. Disadvantaged Janajati
• Hill: Magar, Tamang, Rai, Limbu, Sherpa, Bhote, Walung, Byansi, Hyolmo, Garti/Bhujek, Kuuumal, Sunar, Baramu, Pahari, Yakkah, Jirel, Darai, Dura, Majhi, Danuwar, Thami, Lepcha, Chepang, Bote, Raji, Hayu, Raute, Kusunda • Terai: Tharu, Dhanuk, Rajnansi, Gangai, Dhimarl, Meche, Santhal/Satar, Dhangad/Jhangad, Koche, Pattarkatta/Kusbadiay
3. Disadvantaged Non-Dalit Terai Caste Groups
• Yadav, Teli, Kalwar, Sudi, Sonar, Lohar, Koiri, Kurmi, Kanu, Haluwai, Hajam/Thakur, Badhe, Bahae, Rajba, Kewat, Malah, Nuniya, Kumhar, Kahar, Lodhar, Bing/Banda, Bhediyar, Mali, Kumar, Dhunia
4. Religious Minorities
• Muslims, Churoute
5. Relatively Advantaged Janajatis
• Newar, Thakali, Gurung
6. Upper Caste Groups
• Brahman (hill), Chhetri, Thakuri, Sanyasi, Brahman (Terai), Rajput, Kayastha, Baniya, Jaine, Nuraang, Bengali

Annex VI: Approval of Protocol from Ethical Review Board

Government of Nepal

Nepal Health Research Council (NHRC)

Estd. 1991

Ref. No.: 3544

Date: 15 June 2021

Mr. Sanjaya Bahadur Chand
Principal Investigator
Action Works Nepal
Kathmandu

Ref: Approval of research proposal

Dear Mr. Chand,

This is to certify that the following protocol and related documents have been reviewed and granted approval by the Expedited Review Sub-Committee for implementation.

ERB Protocol Registration No.	305/2021 P	**Sponsor Protocol No**	NA
Principal Investigator/s	Mr. Sanjaya Bahadur Chand	**Sponsor Institution**	NA
Title	Knowledge and attitude towards abortion and contraceptive services among women of reproductive age in Kalikot District		
Protocol Version No	NA	**Version Date**	NA
Other Documents	1. Data collection tools 2. Acceptance letter from the study site 3. Assent form	**Risk Category**	Minimal risk
Study Team Member	1. Mr. Nar Bahadur Saud		
Expedited Review	Proposal √ Amendment ☐ Re-submitted ☐ **Meeting Date:** 14 June 2021	**Duration of Approval** 15 June 2021 to 15 June 2022	**Frequency of continuing review**
Total budget of research	**NRs 2,73,500.00**		
Ethical review processing fee	**NRs 10,000.00**		
Investigator Responsibilities : • Any amendments shall be approved from the ERB before implementing them			

Tel: +977 1 4254220, Fax: +977 1 4262469, Ramshah Path, PO Box: 7626, Kathmandu, Nepal
Website: http://www.nhrc.gov.np, E-mail: nhrc@nhrc.gov.np

Annex VII: Selected clusters (former wards) with household size

Current (Rural) Municipality	Former VDC ID	Former VDC	Ward No.	Cluster ID	No. of selected Households for survey
Naraharinatha	1	Lalu	3	1	7
Naraharinatha	1	Lalu	6	2	7
Naraharinatha	2	Kotbada	6	3	7
Naraharinatha	2	Kotbada	3	4	7
Naraharinatha	3	Rupsa	5	5	7
Naraharinatha	3	Rupsa	6	6	7
Sannitribeni	4	Mehalmudi	9	7	7
Sannitribeni	4	Mehalmudi	5	8	7
Sannitribeni	5	Mumra	9	9	7
Sannitribeni	5	Mumra	5	10	7
Raskot	6	Sipkhana	3	11	7
Raskot	6	Sipkhana	1	12	7
Pachaljharna	7	Ramnakot	7	13	7
Pachaljharna	7	Ramnakot	9	14	7
Pachaljharna	8	Badalkot	6	15	7
Pachaljharna	8	Badalkot	5	16	7
Palata	9	Dhaulagoha	1	17	7
Palata	9	Dhaulagoha	4	18	7
Palata	10	Kheena	6	19	7
Palata	10	Kheena	5	20	7
ShuvKalika	11	Sukatiya	5	21	7
Shuvkalika	11	Sukatiya	7	22	7
Tilagufa	12	Chilkhaya	6	23	7
Tilagufa	12	Chilkhaya	7	24	7
Tilagufa	13	Chhapre	5	25	7
Tilagufa	13	Chhapre	6	26	7
Tilagufa	14	Jubitha	2	27	7
Tilagufa	15	Jubitha	3	28	7
Tilagufa	15	Rachuli	3	29	7
Tilagufa	15	Rachuli	1	30	7

Annex VIII: List of study team

Principal Investigators	
Govind Prasad Panta	
Sanjaya Bahadur Chand	
Field Research Supervisors	
Nar Bahadur Saud	
Nayan Chhetri Rokaya	
Enumerators	**Assigned area for data collection (Formal VDC)**
Gita Shahi	Rachuli and Jubitha
Basundhara BK	Dhaulagoha and Kheena
Darshana Kumari Bista	Lalu, Kotbada and Rupsa
Rukubina Sijwal	Ramnakot and Badalkot
Kasha Bam	Mehalmudi, Mumra and Sipkhana
Dharma Shahi	Sukatiya
Chhaila Shahi	Chilkhaya and Chhapre

Annex IX: Detailed distribution of respondents by stigmatizing attitudes and beliefs towards abortion

n=210

Statements	Strongly Disagree n(%)	Disagree n(%)	Neutral n(%)	Agree n(%)	Strongly Agree n(%)
Negative Stereotyping					
A woman who has an abortion is committing a sin	116(55.2)	37(17.6)	3(1.4)	33(15.7)	21(10)
Once a woman has an abortion, she will make it a habit	101(48.1)	59(28.1)	3(1.4)	29(13.8)	18(8.6)
A woman who has had an abortion cannot be trusted	119(56.7)	41(19.5)	3(1.4)	30(14.3)	17(8.1)
A woman who has an abortion brings shame to her family	126(60)	40(19)	0(0.0)	28(13.3)	16(7.6)
The health of a woman who has an abortion is never as good as it was before the abortion	95(45.2)	60(28.6)	4(1.9)	36(17.1)	15(7.1)
A woman who has had an abortion might encourage other women to get abortions	111(52.9)	43(20.5)	6(2.9)	27(12.9)	23(11)
A woman who has an abortion is a bad mother	106(50.5)	58(27.6)	4(1.9)	22(10.5)	20(9.5)
A woman who has an abortion brings shame to her community	118(56.2)	46 (21.9)	3 (1.4)	23 (11.0)	20 (9.5)
Exclusion and discrimination					
A woman who has had an abortion should be prohibited from going to religious services	120 (57.6)	45 (23.3)	6 (2.9)	32 (15.2)	7 (3.3)
I would tease a woman who has had an abortion so that she will be ashamed about her decision	121 (57.6)	49 (23.3)	5 (2.4)	26 (12.4)	9 (4.3)
I would try to disgrace a woman in my community if I found out she'd had an abortion	123 (58.6)	44 (21.0)	1 (0.5)	30 (14.3)	12 (5.7)
A man should not marry a woman who has had an abortion because she may not be able to bear children	113 (53.8)	51 (24.3)	4 (1.9)	26 (12.4)	16 (7.6)

Statements	Strongly Disagree n(%)	Disagree n(%)	Neutral n(%)	Agree n(%)	Strongly Agree n(%)
I would stop being friends with someone if I found out that she had an abortion	119 (56.7)	43 (20.5)	2(1.0)	32 (15.2)	14 (6.7)
I would point my fingers at a woman who had an abortion so that other people would know what she has done	116(55.2)	50 (23.8)	1 (0.5)	25(11.9)	18 (8.6)
A woman who has an abortion should be treated the same as everyone else	16 (7.6)	4 (1.9)	1 (0.5)	88 (41.9)	101 (48.1)
Fear of contagion					
A woman who has an abortion can make other people fall ill or get sick	12 1 (57.6)	46 (21.9)	1 (0.5)	25 (11.9)	17 (8.1)
A woman who has an abortion should be isolated from other people in the community for at least 1 month after having an abortion	123(58.6)	45 (21.4)	3 (1.4)	22 (10.5)	17 (8.1)
If a man has sex with a woman who has had an abortion, he will become infected with a disease	115(54.8)	39 (18.6)	5 (2.4)	39 (18.6)	12 (5.7)