Legal yet unsafe: A qualitative study on perceptions and attitudes of premarital abortion among unmarried Nepalese women living in Norway

By: Sewika Sulpe
Supervisor: Heidi Fjeld

Department of Community Medicine
Institute of Health and Society
Faculty of Medicine
University of Oslo, Norway

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Abstract

Background: Abortion was equated with infanticide and other forms of crime in Nepal before it was legalized in 2002. Even, after two decades of liberalization, the subject of abortion continues to carry moral, emotional, cultural, and social arguments in Nepal. With higher average age of getting married, the risk of unwanted pregnancies and abortion increases. Many studies have been published about abortion and its related issues, however, studies including unmarried women and their perception on abortion-related care and safe abortion services are limited. ***Objectives:*** The main aim of the study was to explore the perceptions and attitudes on premarital pregnancy and abortion among unmarried Nepalese women living in Norway. Furthermore, it was to understand the expectations for safe abortion services, socio-cultural influence, and suggestions for comprehensive sexual and reproductive healthcare for unmarried women in Nepali context. ***Methods:*** A qualitative research study was conducted using in-depth interviews with 14 educated and unmarried Nepalese women aged 23 to 30 years living in Norway. The two domains, Individual context and (Inter)national context of conceptual framework on women's trajectories on seeking abortion-related care, guided the analysis and interpretation of the findings. ***Findings:*** The participants acknowledged a limitation in abortion knowledge, methods, services, and discussion in Nepalese society. There was a general acceptability on premarital sex and adequate knowledge on contraceptive use to avoid unwanted pregnancy and abortion. However, the participants noted that these consequences were not unheard of. Despite knowledge on legalization of abortion, participants were aware of the socio-cultural norms hindering the optimal utilization of abortion-related care for unmarried women. The prioritization for autonomy and independence was reflected in knowledge and acceptance about sexual and reproductive health rights of unmarried women. Their idea of safe abortion comprised of personal, medical, legal, financial, and social safety integrating interconnection of two domains of the framework. ***Conclusion:*** The study findings suggest importance of including unmarried women's perspectives for optimal utilization of available healthcare services. Joint efforts to initiate and normalize sexual and reproductive health discussions in the society were emphasized.

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Abbreviations

ANMs- Auxiliary Nurse Midwives

COVID-19- CoronaVirus Disease 2019

CREHPA- Centre for Research on Environment, Health and Population Activities

DoHS- Department of Health Services

FPAN- Family Planning Association of Nepal

ICPD- International Conference on Population and Development

INGOs- International Non-Governmental Organizations

IT- Information Technology

MA- Medical Abortion

MoH- Ministry of Health

MVA- Manual Vacuum Aspiration

NDHS- National Demographic Health Survey

NESCO- Nepalese Student's Community in Oslo

NGOs- Non-Governmental Organizations

NSD- Norsk senter for forskningsdata/ Norwegian Center for Research Data

NOW- Nepal Women's Organization

PHCCs- Primary Healthcare Centres

PSI- Population Services International

SAS- Safe Abortion Services

SDG- Sustainable Development Goals

SPN- Sunaulo Pariwar Nepal

STDs- Sexually Transmitted Diseases

TSD- Service for Sensitive Data/ Tjenester for Sensitive Data

UN- United Nations

WHO- World Health Organization

CHAPTER 1: INTRODUCTION AND RATIONALE

Introduction

Abortion is considered safe when performed with a method recommended by the World Health Organization (WHO) that is appropriate to the pregnancy duration and if the person providing or supporting the abortion is trained and done in legal setting with little/no stigma (Sedgh et al., 2016; WHO, 2019). The right and freedom to receive safe and legal abortion is one of the fundamental reproductive rights of all women (Cohen & Richards, 1994). However, abortion practice is regulated with varying personal, political, social, and cultural contexts worldwide. In Nepal, abortion was fully legalized in 2002 and to improve accessibility, government- approved hospitals started to provide free abortion services from 2016. However, even after legalization, the topic of abortion continues to be associated with moral, emotional, cultural, and social controversies in Nepal.

At present, the young Nepalese youth have been on an evolving trend towards rapid modernisation and social transformation while adopting western/modern cultural practices, beliefs, and lifestyles (Joshi, 2015). The increased exposure to open communication, social media, urbanization, and migration has introduced new socio-cultural ideas and environment into the Nepalese society (Dhungel, 2019; Rao, 2010; Regmi, Simkhada, & Van Teijlingen, 2007). In Asia, the age of first marriage is increasing, driven by changes in education, career goals and employment opportunities, which has expanded the period to engage in premarital sexual activity (Greenspan, 1992; Regmi et al., 2007). The increase in education opportunities and exposure to global networking platforms/social media have allowed easier access to a diverse array of information regarding sexual behaviour and practice (Joshi, 2015). Although a socio-cultural stigma in the Nepalese communities, prevalence of premarital sex is not an uncommon phenomenon (Hald & Sondergaard, 2014). Consequently this increases the risk for unsafe sexual practices, unwanted pregnancies, STIs and unsafe abortions (Puri, Vohra, Gerdts, & Foster, 2015; Regmi et al., 2007).

The existing uneven balance between genders and an archaic male dominated approach often predisposes women in the Nepalese society. The issue of social disapproval and control is particularly strong for unmarried women, which makes them vulnerable (Hald & Sondergaard, 2014). In Nepalese communities, where marital status plays a significant

role that regulates a woman's status as well as her families', discussion about sexual health issues before marriage is unheard of. In that context, it is not surprising that unmarried women seeking abortion care are strongly subjected to negative stigma at all levels (Shrestha, Regmi, & Dangal, 2018). This fear of social repercussions makes women less inclined to seek safe sexual and reproductive health information and services. This has social, psychological, and physical consequences (Hald & Sondergaard, 2014; Puri et al., 2015). Thus, including the voices of unmarried Nepalese women and their understanding of sexual and reproductive health is paramount to optimize utilization of safe reproductive healthcare services. In line with the main objectives presented below, this study aims to explore perception and attitudes of premarital sex, pregnancy, and induced abortion among unmarried women.

Rationale

Globally, 27% of the abortion cases from the year 2010 to- 2014 involved unmarried females, who represented 35% of the total females from the reproductive age 15 -49 years (Sedgh et al., 2016). This indicates the gap in information within this age group that would otherwise have allowed unmarried women and their partner in preventing and managing unwanted pregnancies and abortions. The lingering stigma on sensitive issues like sex, contraceptives, or abortion, especially among unmarried youths, makes the studies and researches challenging. In Nepal, unmarried women making decisions related to abortion is even less explored, with women-hesitating to seek safe abortion services mainly due to sociocultural reasons, and secondly, due to abortion being a culturally sensitive subject for discussion (Rogers, Sapkota, Tako, & Dantas, 2019). It makes these groups under-represented and muted while developing health policy and programs thus, making them even more vulnerable.

Being a young, educated Nepalese woman myself, I have observed the changing patterns of intimate relationships among youths in my own social networks. Over the years, I have followed the development of sexual and reproductive health rights, sexual education, and healthcare services for women in Nepal, with a particular interest in safe abortion practices. This motivated me to explore how young Nepalese women perceive premarital sex and its potential consequences, i.e. premarital pregnancy, and induced abortion. Additionally, I am strongly driven to contribute to improving unmarried women's reproductive rights and

developing holistic and sustainable health programs throughout Nepal. I also find it important to advocate freedom to make informed decisions with mutual respect and without coercion. My aim is that this study will contribute to bring forth women's voices on access to, and perceptions of available abortion services. The effective utilization of limited resources particularly of unmarried women who should also be accounted to receive safe abortion service in Nepal is paramount. This data can also contribute to the formulation of well-informed, accurate, applicable, and sustainable strategies and programmes for quality bias-free services and possibly bridge the gap between law and practice.

CHAPTER 2: BACKGROUND

Abortion: Global

Abortion is one of the most common gynaecological experiences in the world (Kumar, Hessini, & Mitchell, 2009). In the period from 2015 to- 2019, there were 121 million unintended pregnancies-- this equates to 64 unintended pregnancies per 1000 women between the age of 15- 49 years. Among the unintended pregnancies, 73.3 million ended in abortion, corresponding to 39 abortions per 1000 women aged 15- 49 years. This relates that globally, 61% of unintended pregnancies end in abortion (Bearak et al., 2020). A paper published in *The Lancet* in 2020, estimated that the rate of unintended pregnancy was declining from 2015 to-2019 whereas the rate of abortion remained roughly equal (Bearak et al., 2020). A comprehensive report on abortion worldwide from 2017 estimated that from 2010 to-2014, there were 56 million induced abortions. Of these, 55% of abortions were safe, 31% less safe and 14% least safe as per WHO standard, where most unsafe abortions were done in countries with restrictive laws and low-middle income countries (Singh, Remez, Sedgh, Kwok, & Onda, 2018). The abortion rate was higher in developing countries of Asia, Africa, and Latin America, where 88% of all abortions took place. These regions still have high maternal mortality rates and are also the regions with almost 97% of unsafe abortion practices (WHO, 2019).

On a global level, a maternal mortality of 8% due to unsafe abortion was estimated by a WHO systematic analysis paper (Say et al., 2014). They noted that it was underreported given legal, religious, and cultural perceptions varying across countries deferring reports for mortality and disability related to unsafe abortion. 87% of safe abortions occurred in countries where it was available on request compared to 25% where some forms of restrictions were present (Guillaume, Rossier, & Reeve, 2018). Moreover, there are multifaceted issues with unsafe abortion such as medical risks, restrictive laws and policies, socio-economic factors, availability and accessibility of services, perception and stigma and low resource settings (Ganatra et al., 2017; Sedgh, 2016). Continuous efforts are made throughout the world to provide safe and righteous sexual and reproductive healthcare to reduce the global maternal mortality rate (Grimes et al., 2006).

Abortion: Asia

Asia has diverse legislations and practices surrounding abortion. All countries in Asia allow abortion to save a woman`s life, but only a third allow abortion upon request of women (Guillaume et al., 2018). The legislations differ as action to population control policies like in China, response to high maternal morbidity and mortality like in India, to save women`s lives, or in cases of incest, rape or mental health problems like in Bhutan, et cetera. This diversity reflects differences in socio-political and demographic contexts within Asia (Guillaume et al., 2018). An article published in *The Lancet* in 2017 reported that eastern Asia (including China) share similar safe abortion distribution as other developed regions, while only south-eastern Asia and western Asia exceed 50% proportion of safe abortion. In south-central Asia fewer than one in two abortions were considered safe (Ganatra et al., 2017). The percentage of unintended pregnancies ending in abortion increased by 59% in central and south Asia, 16% in east and south east Asia while it declined in west Asia by 14% in 2015 to-2019 compared with 1990 to-1994 (Bearak et al., 2020). The rate of abortion was estimated to be 36 per 1000 for married women and 25 per 1000 for unmarried women in reproductive age 15 -49 years (Sedgh et al., 2016).

In most Asian and African regions, socio-cultural values discourage unmarried women from engaging in sexual behaviours, nor in discussions of the matter, until they are married. This also causes the exclusion of unmarried women from surveys and policies on sexual and reproductive research studies. Additionally, it also dismisses them from getting access to contraceptives, proper sex education and counselling, and reproductive healthcare (Aisha N. Z., Philipp, & Vladimíra, 2017).

Abortion: Nepal

Socio-political framework on abortion

Historical achievements were made on abortion laws in 2002 when Muluki Ain, the country code of Nepal granted liberal laws on specific grounds for abortion. Before 2002, women were imprisoned and punished to various degrees if found to have undergone abortion or abortion -related acts (Shakya, Kishore, Bird, & Barak, 2004). Earlier, abortion was equated with infanticide, homicide, other kinds of wilful killings or murders, some form of crime, even if it was spontaneous (Thapa, 2004). The changes in the law came after decades of effort by various public and private

actors. During the 1970s, it was first initiated by Family Planning Association Nepal (FPAN), an affiliate of International Planned Parenthood Federation and large non-governmental organization (NGO) still working in Nepal's health sector. The initial discussion focused on medical rational and legal accessibility of abortion to women with unwanted pregnancies. Around the same time, the National Commission on Population discussed the role of abortion as an effective method of regulating fertility and recommended government actors to make abortion legal for pregnancies resulting from contraceptive failures. These abortion discussions were therefore closely related to efforts to control fertility.

Furthermore, over the next decade, Nepal Women's Organization (NWO) argued for legalization of abortion in cases of pregnancy from rape or incest or where women's lives may be at risk. However, these recommendations did not come to the legislature due to a lack of momentum from the organization. Subsequently, in the1990s, the efforts to reform the abortion law reached a new height. Nepal's involvement with safe motherhood initiated by the WHO and participation in International Conference on Population and Development(ICPD) in 1994 and the Beijing Conference on Women in 1995 initiated wider international impetus and momentum on the women's rights movement, which incorporated availability and access to safe abortion services. NGOs along with private and public sector organizations banded together and were able to liaise with the Nepal government that put the reform movement in context of saving women's lives and to reduce maternal deaths and morbidity.

Further, there were studies done around the 2000s among women in prison accused of murders, serving sentences for crimes and murders they did not commit. This also motivated social and human rights activists to push abortion law reform in the country. After intensive discussions and much efforts, the abortion reform bill was finally passed in 2002 and was a profound victory for women of Nepal and all sectors involved (Ministry of health MoH, 2003). Nepal's liberalization law ensures safe motherhood and women's rights with high quality family planning services, including safe abortion services (Thapa, 2004).

Now after decades of the new amendments, the law (Nepal Law Commission, 2018) allows women the right to terminate a pregnancy without regard to their past or present marital status for :-

1) Fetus (gestation) up to twelve weeks, with the consent of the pregnant woman,

2) Fetus (gestation) up to twenty-eight weeks, as per the consent of such woman, after the opinion of the licensed doctor that there may be danger upon the life of the pregnant woman or her physical or mental health may deteriorate or disabled infant may be born in case the abortion is not performed,

3) Fetus (gestation) remained due to rape or incest, fetus (gestation) up to twenty-eight weeks with the consent of the pregnant woman,

4) Fetus (gestation) up to twenty-eight weeks with the consent of the woman who is suffering from H.I.V. or other incurable disease of such nature,

5) Fetus (gestation) up to twenty -eight weeks with the consent of the woman, as per the opinion of the health worker involved in the treatment that damage may occur in the womb due to defects occurred in the fetus (gestation), or that there is such defect in the fetus of the womb that it cannot live even after the birth, that there is condition of disability in the fetus (gestation) due to genetic defect or any other cause. Additionally, abortion for sex preference, forceful or coerced abortion, and without consent of women is illegal in the country (Nepal Law Commission, 2018).

Reproductive rights for women in Nepal

During the 1990s, following democratic reform in the country, many women's rights groups were formed with an increase in international networking for similar goals. These women's groups grew stronger and put pressure on the Nepal government to protect and promote many rights of women, including safe abortion. The Ministry of Women and Social welfare (now the Ministry of Women, Children and Social welfare) was also formed in the 1990s to ensure rights and protection for women (Thapa, 2004). Unlike other restrictive countries with varying laws on abortion, in the context of Nepal, there was no strong opposition or pressing charges nor massive support for the reform. The reason for this was proposed by Thapa (2004) first due to limited resources for large movement campaigns. Another was due to influence of the neighbouring country, India where abortion was already liberalized and practiced. Reports suggest that before liberalization in Nepal, Nepalese women from urban and high-income communities travelled to India for abortion (Puri et al., 2012).

Redefining and reinterpreting female power and position slowly takes its form, though it is extremely difficult and is a long process (Sarkar, 2014). Nepal adopted reproductive health rights as a fundamental right for the first time in its interim constitution 2007 under article 'Rights of Women' (Interim Constitution of Nepal, 2007). Many efforts are being made and executed to ensure reproductive health rights and services for women and for better gender equality and women's empowerment (National Planning Commission, 2020). Joint efforts of various NGOs, INGOs, public-private stakeholders and partners are constantly working alongside the Government of Nepal, Ministry of Health and Population to protect rights and services for women. Some NGOs dedicated for family planning and safe abortion are Family Planning Association of Nepal (FPAN) and Sunaulo Parivar Nepal (SPN). Some notable INGOs are Population Services International (PSI) Nepal, Marie Stopes International, Ipas Nepal, Cooperative for Assistance and Relief Everywhere (CARE) (DoHS, 2074/75 (2017/18)) .

Safe abortion services

The liberalization of abortion law has largely improved reproductive healthcare for Nepalese women. There has been a significant decline in maternal mortality in Nepal from 539 deaths per 100,000 live births in 1996, to 258 in 2015, and now 239 in 2018/19 (National Planning Commission, 2020). Tremendous positive advancements in abortion policies and service provisions for Safe Abortion Services (SAS) has been developed in Nepal since 2002.

Surgical abortion-- Manual Vacuum Aspiration (MVA)-- was legalized in 2002 and Medical Abortion (MA)-- mifepristone and misoprostol-- in 2008. To expand services to women in all areas, training of staff nurses for MVA was started in 2006. SAS after 12 weeks/ second trimester service was also initiated in 2007. National guidelines implementation for SAS was developed in 2011and free provision of SAS was initiated in government health facilities from 2016 (Shrestha et al., 2018). Now, MVA services are available in all 75 districts and the majority of Primary Healthcare Centres (PHCCs), second trimester abortion services in 30 hospitals and with international approval on MA, this service expanded to 60 districts in Nepal (DoHS, 2074/75 (2017/18)). Continuous training programs, task shifting to the expand role of health workers gradually from gynaecologist to Axillary

Nurse Midwives (ANMs) in low resource settings like Nepal, and efforts to improve knowledge on abortion laws and services are implemented. The SAS package was also incorporated into a national health coverage scheme that supports universal health coverage efforts in Nepal (Monga et al., 2020).

Despite the progression and increase in service utilization for SAS, one of the direct causes of maternal mortality and obstetric complications in Nepal remain unsafe abortions (Population Monograph of Nepal, 2014). Puri et al. (2016) estimated that among 300,000 abortions performed in 2014, 60% of them were illegal (done by untrained or unregistered providers or self-induced). Medical abortion (72%) was found to be the most accessed method of abortion in Nepal (Ministry of Health, 2017). Use of MA from pharmacies, without counselling and medical advices, and use of unapproved drugs resulting in incomplete abortions and its complications were also reported (Puri et al., 2012). The approximation of the estimates seemed to have significant coverage to provide baseline data for the status of abortion in the country. It was evident from the statistics that still many women are reluctant to use available services for a variety of reasons.

According to the MoH, despite continuous efforts, only two in five (41%) women aged 15-49 years were aware of legalization and 48% knew of a safe place for abortion services (Ministry of Health, 2017). Abortion is still a subject of moral and socio-cultural disapproval in many contexts in Nepal. Barriers such as negative attitudes of community and health providers, fear of repercussion, lingering abortion stigma and culture, lack of access to comprehensive sexual education, limited financial resources, issues of accessibility, unmet contraceptives and family planning needs, and concerns over privacy and confidentiality exist (Kc et al., 2021; Puri et al., 2012; Puri et al., 2015; Rogers et al., 2019). Additionally, in Nepalese society, marital status stands as an important check point when it comes to abortion, despite the liberal legislation (Andersen et al., 2015; Hald & Sondergaard, 2014). This also increase the risk for many to seek illegal or clandestine abortion done by untrained or unapproved providers (Dahal, 2004; Puri et al., 2015).

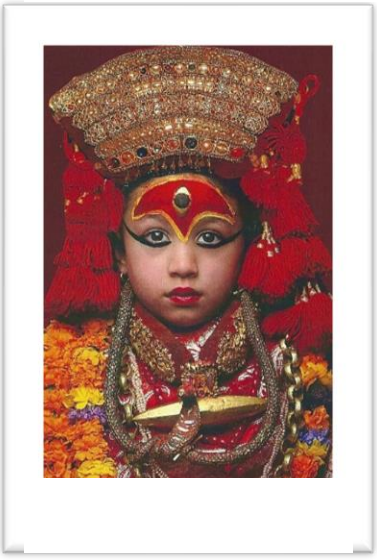
Social structure and control in Nepal

Gender in socio-cultural context

Abortion perceptions and practices, as well as attitudes towards premarital sex, should be seen in the context of gender models and norms in Nepal. In South Asia, sets of gender relations are central to family structure, decision making, mobility and migration, education, health system assessment, and economy, among many other aspects of social lives (Mahato, Sheppard, van Teijlingen, & De Souza, 2020; Rao, 2010). Gender norms are often set by individual societies which vary significantly across regions and cultures.

Nepali society is in the process of transition- politically, economically, and socio-culturally. In these processes, the conditions and position of women are gradually improving. However, discrimination and subordination of women still exists in varying ways and magnitude (Pandey, 2016) with a strong cultural continuity in perception about women's status. In Nepali society, the cultural tradition portrays females in two distinct and opposing ways. Being a culturally rich country with mostly Hindu devotees, worshiping female goddesses is common. This provides women with a strong, creative, and powerful identity. On the other hand, women also face discrimination and deprivation of voice and opportunities due to deep-rooted patriarchy.

Figure 1. Photo of Kumari Devi (Jontes, 2016)



Nepali communities are widely known for their strong and long-standing tradition of worshipping the living goddess, *'Kumari,'* meaning virgin girl. Along with historical, religious, and traditional beliefs attached with this cultural institution, it has also created an expectation for Nepalese women to have the qualities of goddess *Kumari* in order to meet the moral standard of womanhood in the society. The *'Kumari'* signifies the pre-menstrual period as peaceful, rich with inherent purity and chastity (Bhat, 2016). In this perspective, women are expected to be docile, reserved and are tainted with negative identity, if societal norms are not followed unlike for men. It highlights gender stereotypes, influences self-esteem and reinforces the cycle of stigmas (Kumar et al., 2009; Lundgren, Beckman, Chaurasiya, Subhedi, & Kerner, 2013; Mahato et al., 2020). This affects the

positive track of feminist development in such societies. The praise and worship of female deities can be empowering but it can also be used as a tool of oppression, especially in patriarchal countries like India and Nepal (Pandey, 2016; Sarkar, 2014).

It is also apparent in other societies, such as in some communities in Africa, where religious arguments, traditional values, and social life idealizes premarital abstinence, regulating the moral standings of a woman and her family (Kebede, Hilden, & Middelthon, 2014). Parents and partners' decisions often override the woman's decision for pregnancy continuation, abortion seeking and post abortion care in many Asian countries (Jejeebhoy, Kalyanwala, Zavier, Kumar, & Jha, 2010; Olsson & Wijewardena, 2010). An unmarried woman would not normally have an option to keep the baby and remain supported by her family even if she wants to continue the pregnancy (Olsson & Wijewardena, 2010; Smith, 2002). This governs the gender inequalities which affects marriage, sexual and reproductive health and rights, decision-making, fertility controls, contraceptives and family planning, accessibility, and service utilization (Lundgren et al., 2013; Mahato et al., 2020; Namasivayam, Osuorah, Syed, & Antai, 2012).

Stigma on abortion

Kumar et al. (2009) define abortion stigma as "a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood" (Kumar et al., 2009, p. 628). Abortion stigmas are locally created in the context of social and cultural relationships which are reinforced by individuals' perceptions, government factors for laws and policies, language and communication mediums used to describe abortion (Kumar et al., 2009).

Women who abort are stereotyped as outsiders who are deviant from normal. They are expected to be vaguely apologetic even when exercising their own rights of sexual and reproductive health (Kumar et al., 2009). Linking her to set of undesirable names and characteristics, negatively tainting her name and family, demolishing her future and prospects of opportunities for marriage or finding a good man, prohibiting them to engage with society and other discriminations exist (Ciren & Fjeld, 2020; Hald & Sondergaard, 2014; Shrestha et al., 2018). Sometimes abortions may take place hideously to preserve the health and wellbeing of family members, which in turn adds to existing stigma on abortion. Exclusion,

silencing and judgement for others who speak out and support abortion is another reason for sustaining negative attitudes on abortion (Kumar et al., 2009). This is more severe in cases of unmarried females. In Nepal, due to certain norms on sexual behaviour, premarital sex and abortion are highly stigmatized, despite being a common phenomenon (Hald & Sondergaard, 2014).

Out of desperation, some pregnant women commit suicide, run away to avoid shame, try harmful self-induced abortion methods, or seek clandestine abortions even in settings where abortions are legal (Chemlal & Russo, 2019; Smith, 2002). This has negative effects on their physical, mental, psychological, and social health and wellbeing (Hald & Sondergaard, 2014). The studies on abortion show that the medical and physical dangers that come with illegal abortion are outweighed by the fear over social safety and desperation for protection of reputation (Chemlal & Russo, 2019; Jejeebhoy et al., 2010). The circumstances are found similar in studies done in Nepal as well, where despite legalization, illegal abortion remains a major problem (Puri, Raifman, Khanal, Maharjan, & Foster, 2018; Rogers et al., 2019; Yogi, K, & Neupane, 2018). Unmarried females, their position to get obliged with social norms, and social sanctions against premarital sexuality, experiences, socio-economic resources, and stigma unlike that for men hinders prompt access to reproductive health services and creates gaps in law and practice (Grimes et al., 2006; Hald & Sondergaard, 2014).

Institution of marriage and reproductive healthcare

Marital bond is formed by society's approval granting legal contract for two people to cohabitate and reproduce (Thapa & Kattel, 2019). It is one of the universal social institution established to control and regulate the sex lives of human beings. Moreover, marital status is one of the influential factors when it comes to abortion and reproductive health seeking behaviour in many developing countries (Makleff et al., 2019).

High stigma relates directly with higher unsafe abortion practice and increases complication risk and mortality (Makleff et al., 2019). Individuals' positions along with social norms and stigma, become barriers to seek timely abortion care and decision making- especially for unmarried women. Young women are hardly informed about contraceptives, sex, or abortions, as they are considered too sensitive to talk about in many societies. This

leads to limited access to accurate information and skills to negotiate sex and societal roles (Makleff et al., 2019; Olsson & Wijewardena, 2010; Williamson, Parkes, Wight, Petticrew, & Hart, 2009). Also, married young women seek abortion services much earlier than unmarried young women, showing that marital status comes before other criteria when seeking reproductive health care in South Asian countries (Jejeebhoy et al., 2010). These contexts relate with Nepalese youth and society as well (Kafle, Pakuryal, Regmi, & Luintel, 2010; Puri et al., 2015).

Although Nepali socio-cultural values are gradually modernizing, women's marital status still affects family position and dignity. Premarital pregnancy could destroy the future of young unmarried females in all aspects, making them social outcasts, even by their own families (Smith, 2002). Society designates young and unmarried females as 'minors' and immature (Lie, Robson, & May, 2008), especially relating to teenage pregnancy. But regardless of age, after a female gets married, she gets the rights and privileges of an adult in Nepalese society (Kanchan, Atreya, & Nepal, 2018). The feeling of internalized stigma of guilt and shame that comes along with premarital sex and abortion puts huge pressure on unmarried females (Bhandari & Dangal, 2015). It increases the risk to seek clandestine abortion even if legal services are available (Bhandari & Dangal, 2015; Puri, Ingham, & Matthews, 2007; Puri et al., 2012).

Nepal in transition: Feminization of migration

Female autonomy, decision making abilities and women's ability to migrate are changing as the society is evolving into modernization and communities are adapting new ideas in Nepal. For unmarried women, the restrictions in travelling alone still exist where families want their daughters to travel with their husbands after marriage, which is often disguised as 'protection' against their will. Many women in modern Nepali society want freedom from the stereotypical cultural, gender norms and forced choices (Rajbhandari, 2016).

The trend of 'feminization of migration' is also apparent in Nepal as presented in a qualitative study done by Dhungel (2019). The study shows that earlier women used to migrate as dependent on their husbands after marriage, but recent trends show emerging women migration with their own initiatives. Women themselves view out-migration as means

for independence, financial freedom and autonomy, social status, and importantly personal development. However, though women were given more liberty, they were still bound to follow certain norms and to conform to traditional family-defined roles. For unmarried females the primary cause of their return to Nepal from abroad was to marry, enforced by their parents, which they believed could not have been the case for a son in the family. Women who are educated and highly skilled wanted freedom from restrictions and social expectations and were found to struggle with resettlement and negotiation of traditions with their learned skills. The study summarized that traditional gender roles are still prevalent in families and educated women are initiating for social changes in Nepal (Dhungel, 2019). The dualism where women are taught to be strong and bold like men, yet are constantly held to their obligations as daughters in the house was also noted in the Nepalese society (Rajbhandari, 2016).

Unsafe abortion as a public health concern

Even after 50 years of World Health Assembly (1967) recognizing unsafe abortion as serious public health problem, uneven progression in the world calls for joint action from all areas (Fathalla, 2020). With an increase in number of women in reproductive age globally, it has direct effect in increasing demands for contraceptives as well as rising abortion rates (Singh et al., 2018) . Collectively, the healthcare burden of unsafe abortions and its management provides strong rationale for comprehensive and sustainable public health actions to prevent unnecessary use of available limited resources (Fathalla, 2020).

In Nepal, the target commitment to ensure universal access to sexual and reproductive health and rights by 2030 incorporates the United Nations (UN) Sustainable Development Goals (SDG) 3 for health equity as well as strengthening women's empowerment for SDG 5 (National Planning Commission, 2020). This means equal and effective access to sexual and reproductive healthcare and services for all, irrespective of any factors. Women's empowerment is interrelated with access to modern contraceptives and abortion services. This helps in reducing unwanted pregnancies and unsafe abortions, which directly reduces maternal and child health morbidity and mortality (Kc et al., 2021). Even after the two decades long liberalization of abortion laws in Nepal, the healthcare burden and impacts by unsafe abortions are still prevalent. There is a long way to go, but safe abortion services for

all are indeed achievable when the barriers and limitations are addressed and equitable involvement of all women in reproductive health services are ensured.

As Grimes et al. (2006) stated that, “the availability of modern contraceptives can reduce but never eliminate the need for abortion” (Grimes et al., 2006, p. 1908). Abortion is not an uncommon phenomenon and will continue to be so for many reasons which highlights the need for safe and comprehensive abortion services. The consequences of unsafe abortion not only affect individual women and their families, but also affect society and nations since the already limited budget must be diverted for abortion complications management and risks mortality (Shrestha et al., 2018). This hinders a country like Nepal from achieving UN goals and progress for better development. Thus, comprehensive, and collective efforts including all women are valuable.

CHAPTER 3: LITERATURE REVIEW

This chapter is comprised of relevant literature about induced abortion and its related topics in Nepal. The literature searches were done throughout the research preparation, data collection, and analysing period. Databases such as PubMed, Scopus and Web of Science were used. In addition, the 'Google scholar' search tool was also explored to promote the inclusion of all relevant literature. The websites of Ministry of Health, Government of Nepal, WHO, Women on Web, Guttmacher Institute, Sexual Health Reproductive Health, Ipas Nepal were also used to search for reports, status, and updates related to abortion.

The review of literature relating to this research is presented in the following section. Understanding the status of premarital sex and contraceptives provides a relevant base in understanding how premarital pregnancy and induced abortion are shaped and exist in Nepali society. The review begins with discussion of the prevalence of premarital sex and contraceptive use among youths in Nepal. Further, explicit literature reviews on induced abortion status, perception and practice will be discussed. Finally, justification for the research study will be presented.

Premarital sex and contraceptives in Nepal

Premarital sexual activity is not an uncommon practice in Nepalese society, given its changing societal patterns and modernization (Kafle et al., 2010). Despite social chastity in premarital sex, double standard in sexual behaviour is apparent in Nepali societal practice (Puri & Cleland, 2006). Several studies done in Nepal highlight this trend.

Puri (2001) conducted a survey study among 550 girls and 500 boys followed by in-depth interviews of 23 respondents (12 girls and 11 boys) in 2001 in Kathmandu among young factory workers aged 14-19 years. Most of the participants were migrants from 45 districts from Nepal and some from India, most were uneducated and were from economically poor conditions. This study highlighted the high-risk sexual behaviour among young disadvantaged youths. They found that one fourth (38%) of unmarried participants had already experienced sexual activity, where 38% were boys and 18% were girls. Frequency of casual sex was higher among unmarried than married participants. Most of them knew about

the common contraceptives, condoms, but its usage was scant among males. The increased exposure to unwanted pregnancy was quite high with 26% of girls experiencing at least one unwanted pregnancy and 11% aborted their last unwanted pregnancy. Despite social perception about engagement in sex prior to marriage, factors such as social networks, peer behaviour, substance use and media influenced sexual behaviour among the respondents, increasing participants' sexual health risks (Puri, 2001).

On similar line, a 2009 cross-sectional study done through self-administered questionnaire among 573 male college students in Kathmandu indicated that despite socio-cultural restrictions, 39% of unmarried participants were engaged in premarital sex while romance, sexual fantasy, social media usage for sexual contents, relationships, kissing, and touching sexual parts were relatively common among adolescents. The risk for unsafe sexual behaviour was seen with inconsistent use of contraceptives among the participants (Adhikari & Tamang, 2009). Another study also done among college students (573 males and 564 females) to investigate knowledge and factors related to emergency contraceptives showed that more males (72%) than females (64%) were aware of emergency contraceptives. Most of the respondents had experienced unprotected sex and unintended pregnancies. More knowledge about contraceptives among participants living with friends than those living with families showed limitation of sexual health related discussion with family than peers (Adhikari, 2009). These studies done among educated youths also show limitations in safe sexual health practice resulting in undesirable consequences.

Likewise, another cross-sectional study was done to understand role of marital status on abortion among 600 women aged 16-24 in Rupandehi district, Nepal. 54% of the participants were unmarried while 45% were married. They found that only 2% of unmarried females admitted to engaging in premarital sex themselves, while 49% of them reported having a friend they know engaged in a romantic relationship and 20% engaged in sexual activity (Andersen et al., 2015). These studies suggest that despite prevailing social norms, romantic and sexual activity among unmarried youths are relatively common, and women often underreport their engagement in sexual behaviour, likely due to preconceived stigma.

Premarital pregnancy and abortion in Nepal

Increasing premarital sexual activity among youths increases the risk for unsafe practices and limited use of contraceptives, especially in contexts where restrictions due to socio-cultural norms exist. This in turn surges the occurrence of unwanted pregnancies and unsafe abortions (Adhikari, 2009). Like premarital sex, women seeking or practicing abortion are at more risk for experiencing the stigma of abortion.

In an important paper by Hald and Sondergaard (2013) a mixed method study was conducted in village area of Makwanpur district, Nepal to understand the gap between law and practice of abortion after a decade of liberalization. This study aimed to understand the local community's knowledge of law and perception of unmarried women's access to abortion services. Along with the analysis of 55 questionnaires, 9 men and 7 women of the community were interviewed where most of them were married. None of the participants reported abortion to be unlawful while most of them did not have adequate knowledge about specific laws under it. In this study, age was found to be a more accurate indicator of limited abortion law knowledge than marital status unlike the study by Anderson et al. (2015) where unmarried women were more updated with abortion laws than married. Though both men and women participants believed abortion to be a fundamental right for women, they agreed on prevalence of negative attitudes and behaviour by society, health professionals and family towards unmarried women seeking abortion, leading to negative social consequences, self-harm, and discrepancy in access to legal SAS. Hence, the paper summarized the insoluble problem that unmarried women face in Nepali society that leads to personal and social consequences and limited option for practicing their right to safe abortion despite liberal laws. This study addresses the difficulty in openly discussing the sensitive topic among participants and suggests that providing thorough assurance and briefing of topic and frame of study before the participation will be helpful to overcome this limitation. The authors also recommended similar studies to be done in different parts of the country to represent the situation of Nepal on this issue (Hald & Sondergaard, 2014).

A cross-sectional study among 600 women by Anderson et al. (2015) drew the attention towards differences in service provision and information to unmarried women regarding access to contraception, and abortion care in Nepal. It was found that women were expected to act inferior and their choices were defined by long- held ideals of subordination

to societal needs, especially unmarried women. 45% of respondents were aware of legality for safe abortion while they were not confident on the details of legal provision. Interestingly, ever- married women were less informed than never- married women about abortion laws, provisions, and services. Further, in the study, never- married women were found to be more comfortable with the idea of abortion and supported it than married, to discuss with peers and were confident about their ability to help a friend find abortion services if needed. However, the likelihood of negative judgement from health professionals, family, and friends, expecting unfair and expensive service costs for unmarried women seeking abortion was higher. Stronger societal condemnation of unmarried women seeking abortion than married was agreed upon. This paper emphasized the involvement of unmarried women as well in the mainstream of reproductive health care and services and efforts to provide equitable access to all (Andersen et al., 2015). A qualitative study to find in-depth data on the findings would supplement the research on unmarried women.

Reasons to seek abortion

Multiple internal and external influencing factors are responsible for women to decide and seek abortion in addition to laws and regulations. A systematic review of 16 qualitative studies by Chemlal and Russo (2019) was done to understand the reasons why women who lived in settings where abortion was legal end up having informal abortions in many parts of the world. It outlined ten key reasons which were: privacy concerns, cost, lack of knowledge on abortion laws, women's social networking and recommendations, regulations of services, staff's unwillingness to provide abortion, the trend of self- management in homes and time and distance to receive the services. Regarding marital status, unmarried women expressed socioeconomic reasons to be of concern whereas married women expressed the need to limit the family size (Guillaume et al., 2018).

Regarding reasons for women seeking abortion in the legalised context of Nepal, the mixed method study by Puri et al. (2007) with married 997 women (aged 15-24 years) and 499 men (aged 15-27 years) and case study of 11 men and 19 women showed that in total 49% women and 32% men had ever experienced unintended pregnancy while only 11 men and 27 women sought abortions while others decided to carry on with their pregnancy. The reasons to select the option of abortion were dynamic and depended upon the circumstances and specific contexts the women were in. Despite the high prevalence of unintended

pregnancies among young married couples, they did not tend to go for abortion due to religious/ cultural beliefs such as abortion being a sinful act, pressure for a child by family, social stigmatization of abortion, fear of sterility and other ill-consequences. Additionally, it was found that due to abortion stigma, women seeking or receiving abortion services felt less empowered to ask questions, opt out of poor treatment, disclose medical or reproductive histories, and thus women often tend to visit unsafe clinics (Puri et al., 2007).

Another study also supported that there was no difference in rate of abortion in urban and rural residents, but the likelihood of women in urban areas to undergo unsafe abortion was higher than rural women in Nepal. This could be due to stigma associated with open discussion about abortion, but the study recommends detailed in-depth qualitative study among women addressing cultural taboos (Yogi et al., 2018). This highlights that confidentiality is prioritized over physical health when it comes to abortion for unmarried females.

Perspectives of healthcare workers on abortion services in Nepal

A qualitative study done by Puri et al. (2012) with 35 healthcare workers from 4 government hospitals involved in abortion care in Nepal summarized that, providers believed positive impact of legalization of laws that contributed to decrease maternal mortality, abortion complications and women with histories of unsafe abortions. However, they were concerned on risks involved with increasing post abortion complications following improper use of MA. This showed that though MA provides significant benefit in terms of coverage, privacy, and finance, it has added risks to it if not done safely with medical consultations. Additionally, though legally accepted, the abortion service providers had moral and social concerns for unmarried women seeking care. The health providers also reported that unmarried females tend to conceal their abortion or medical history due to fear of judgement or mistreatment by providers, fear of poor confidentiality and cultural stigma (Puri et al., 2012). It shows that decisions for abortion are moderated by value systems of the society/ community in Nepal.

Another qualitative study done in Nepal by Rogers et al. (2019) among 9 health professionals from Kathmandu and Sunsari district along with informal conversations with local stakeholders. They emphasized the interconnectivity of sexual and reproductive health

and rights with coercion in decision-making, education, poverty, spousal relationship, and women's personal, social, and economic empowerment role in abortion seeking behaviour. Similarly, health professionals expressed that the key reason for women seeking pharmacies for self-abortion or unsafe abortion clinics was due to negative socio-cultural attitudes and privacy concerns.

The abortion cost, service and acceptability differ based on marital status of women involved (Andersen et al., 2015). Likewise, in another cross-sectional study (Puri et al., 2018), it was found out that about one -third of service providers had denied abortion services if women were nulliparous, unaccompanied, unmarried, or adolescent. These reasons have no basis in the law or clinical standards for abortion service provision in the country. Hence, the study suggests additional investigation for richer insights to fill the gaps in provider knowledge, preferred strategies and trainings for comprehensive abortion care- which can be achieved through value clarifications to provide all women with what they need in terms of safe abortion to the full extent of the law (Puri et al., 2018). The limitation addressed in these studies recruiting unmarried women and their perception and expectations in the research creates a gap in effective implementation and efficacy of policies and programs for abortion services to all women in Nepal.

Justification of study

The context of individual women's internal and external factors, underlying patriarchal values and relations, existing abortion stigmas, and gaps in legal and practical service utilization are interrelated and forms the basis for abortion decision making and health seeking behaviour. Most studies include married women, their experience and perception to seek and undergo abortion in Nepal. With increase in marital age and premarital sexual activity, this creates a gap in the literature focusing on young unmarried women and their perceptions and attitudes on safe sexual and reproductive healthcare, specially abortion and its practice in Nepal.

Research about the incidence and prevalence of abortion and its services among teenagers and unmarried women are not adequate to comprehend the situation and extent in detail. Thus, we need to understand the in-depth context of how these unmarried women's knowledge, perception, and health seeking behaviours are influenced relating to abortion. This

was deemed important since knowledge and understanding are essential for quality care and service implementation.

An estimation study done in Nepal (Puri et al., 2016, p. 12) acknowledged that "direct, good-quality data from women themselves would be better" to improve access and care of reproductive services to unmarried sexually active adolescents. Exploring the perceptions, attitudes, and understandings that young women have regarding premarital sex, pregnancy and abortion can provide valuable information to manage and develop the sexual and reproductive health programs for young unmarried females in the country. The aim of this study is therefore to contribute to fill the gap to add voices of educated unmarried women and their sexual and reproductive health perceptions and expectations. To get a deeper understanding of this, a qualitative methodology for a rich and in-depth source of data was used.

CHAPTER 4: METHODOLOGY

Research Question and Objectives

Research Question

How is premarital pregnancy and induced abortion perceived among educated unmarried Nepalese women living in Norway?

Objective

The main objective of the study is to explore perceptions and attitudes on pre-marital sex and its consequences: premarital pregnancy and induced abortion among educated unmarried Nepalese women living abroad.

Sub-Objectives

1. To map the expectations of safe abortion services for unmarried Nepalese women.
2. To explore how socio-cultural factors influence perceptions of premarital abortion.
3. To highlight the barriers felt and suggestions for comprehensive sexual and reproductive health among unmarried women in Nepal.

Conceptual framework

This section discusses the conceptual framework that has inspired the analysis and interpretation of the findings in this study. The process of abortion decision making and care seeking by women is understood to involve various complexities and challenges. It is evident that women make tough decisions about their bodies and lives while considering how their choices might be judged or responded to by others when it comes to abortion-care (Haaland, Mumba Zulu, Moland, Haukanes, & Astrid, 2020).

Research has found that inequalities in abortion care are influenced by individual characteristics such as age, marital status, economic constraints, gender roles, autonomy, and education. These factors are interconnected with broader contexts of legality, health systems and socio-cultural atmospheres (Andersen et al., 2015; Hald & Sondergaard, 2014; Kc et al.,

2021; Kebede et al., 2014; Shrestha et al., 2018). This study takes an exploratory approach to understand educated unmarried women's knowledge and perceptions of premarital abortion. To comprehend the participants' positions and ambivalence in understanding premarital abortion and expectations for safe abortion, a theoretical lens based on conceptual framework for understanding women's trajectories in seeking abortion-related care (Coast, Norris, Moore, & Freeman, 2018) was used.

This robust framework developed by Coast et al. (2018) puts together the intricate processes and factors based on three temporal and spatial dimensions. The first domain starts with timing and awareness of pregnancy and experiences related to seeking abortion care. Multiple events in between such as (non)-disclosure, negotiation for decision, ability to access resources, emotions relating to pregnancy/abortion, and attempts for abortion are considered in this dimension. The second domain focuses on individual characteristics that influence if, where and how abortion-related care is obtained. The experiences, context at that point of time, knowledge and beliefs about abortion and interpersonal networks are included. The larger macro-level domain describes the context within which women and abortion-related care are situated. It is comprised of the structural environments, legality issues, accessibility, healthcare systems and normative constructs of fertility and abortion in communities, as well as the regional and (inter)national levels (Coast et al., 2018).

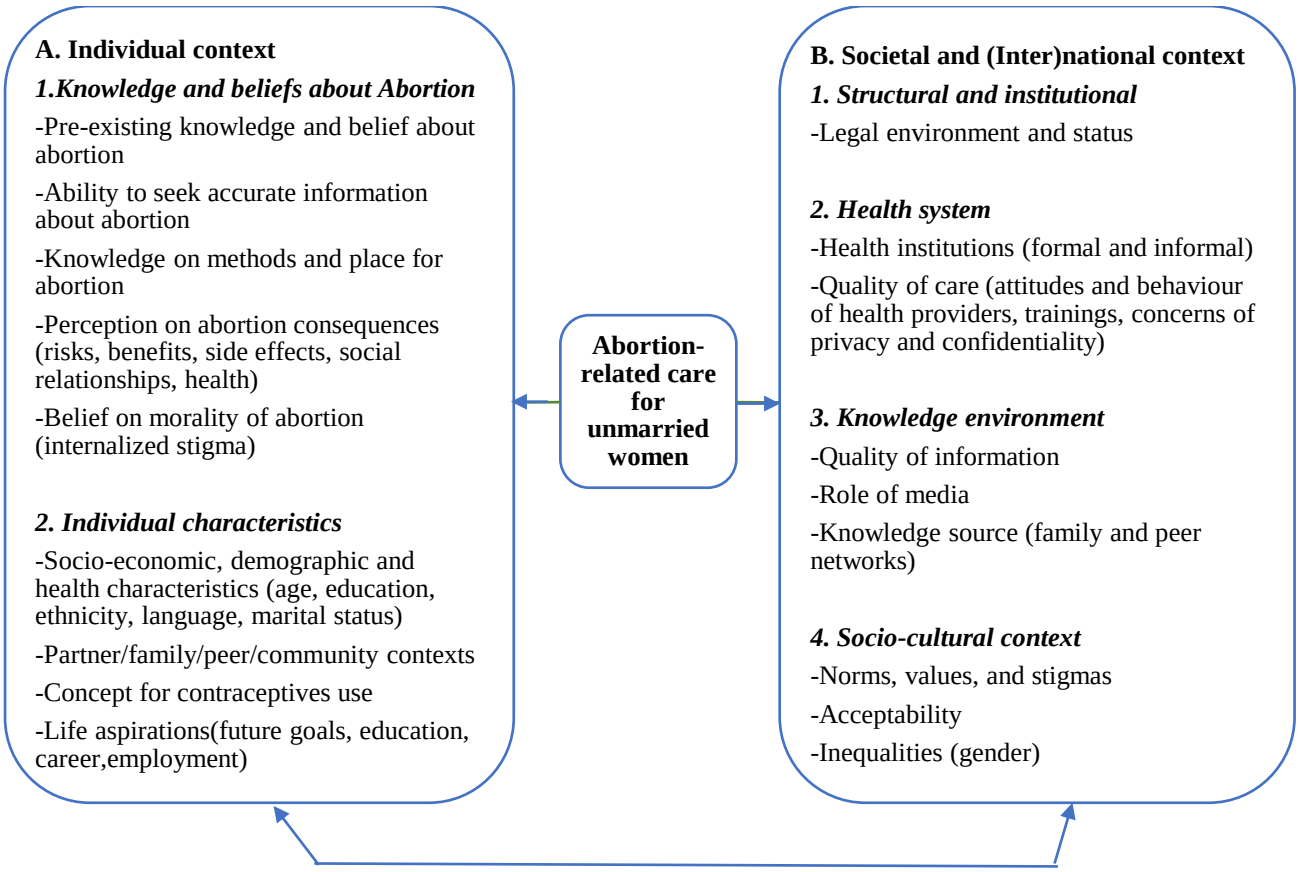
The scope of this study does not include the time and experience aspect of abortion-care; thus, the first domain will not be used in the analysis and interpretation of results. However, contents covered by the other two domains will be framed to understand how perception and knowledge about abortion are shaped among educated unmarried females in the context of Nepal.

This framework helps in understanding how individual contexts and factors are combined and affected by other larger factors that informs perceptions and possible practices for unmarried educated women in this study. In the individual context, factors such as participants' knowledge and perceptions of premarital abortion, the concept of safe abortion while unmarried, individual characteristics in decision making, future consequences, partners and social support are described. Larger contexts of legality, health system provisions and experiences, the impact of social media, and importantly, socio-cultural controls and consequences for premarital sex, contraceptive use, premarital pregnancy, and abortion are

framed under (Inter)national/ sub-national contexts. This framework helped in exploring the interconnectedness and roles of internal and external factors influencing educated and unmarried young women's understanding and expectations for safe abortion care in Nepal.

The two dimensions of the framework (Coast et al., 2018) which became central inspiration for conceptual framework in this study are presented in figure 2 below:

Figure 2. Two domains influencing abortion- related care for unmarried women



Methods and Materials

This section describes how data collection was done for the study. The field work was conducted in and around Oslo, as well as south-eastern parts (Østlandet), from mid-August until December 2020.

Study design

The main objective of the study was to explore the perceptions and attitudes towards premarital induced abortion among educated unmarried Nepalese women living in Norway. To accomplish this objective, this study used exploratory qualitative research methodology. Moen and Middelthon (2015) explain this methodology as aiming to "provide researchers with approaches that can be used to discover and examine the ways in which interconnected people encounter, perceive, understand and bring into being processes, practices, and phenomena" (Moen & Middelthon, 2015, p. 322). This holds true for my project's main objective as well.

Given the sensitive nature of the topic, getting access to this information involves social and cultural negotiations. Hence, a qualitative design gives me the flexibility needed to explore the issues in ways that will best generate information- rich data.

Study settings

The study was conducted in the south eastern part of Norway, primarily Oslo and the greater Oslo area. Originally, the study site was planned to be in Kathmandu, Nepal. However, to adjust with the regulations of worldwide pandemic, COVID-19, the study site was changed to the premises of Oslo, Norway, the residence place of the researcher at the time of study.

Yearly, there are a large number of Nepalese students who migrate to Norway for higher education, especially post-graduate, and PhD programs. Oslo, being a capital city with two big universities, has a large group of international students every year, also from Nepal. For the study, I approached potential participants living in Oslo and its greater Oslo area, as well as Hamar and Lillestrøm.

Study participants and sample size

My aim was to explore attitudes and perceptions among educated and unmarried Nepalese women temporarily residing in Norway for study purposes. The qualitative methodological design includes purposive sampling, aiming for information depth and richness.

The inclusion criteria were set to be:

1) Nepalese citizen,
2) Unmarried,
3) Having at least bachelor's degree,
4) Living in Norway for 5 years or less, and
5) Consenting to participate in the study.

In Nepal, women with less education marry 4-6 years earlier than women with education (Ministry of Health, 2017). In the process of migration, it is most common that women go abroad after marriage as a dependent (Vohra et al., 2019). Thus, I decided to set the criteria to be unmarried women migrating for higher education, at least a bachelor's degree. Aiming to explore recent health interventions in Nepal, I only included women living in

Norway for not more than 5 years, so that they remained in close contact with the Nepalese community back home.

Purposive sampling allows the researcher to identify and create a criteria or phenomenon of the study and select participants who consent to participate to provide required information by virtue of knowledge or experience (Etikan, 2016). My aim was maximum variation in the sample. When recruiting, I tried to maintain variation through different educational backgrounds, religious beliefs, places of origin and last areas of residence in Nepal, current living status (alone/ with friends or family), and relationship status. This allowed me to produce a heterogeneous sample.

I interviewed fourteen women, until a sense of saturation of the data was reached. Saturation of the data depends on richness and depth of the data in which no new relevant data or codes emerges for the study (Fusch & Ness, 2015; Kielmann, Cataldo, & Seeley, 2011). Data saturation was ensured through triangulation of the summary findings with the main supervisor of the study.

Recruitment

After ethical clearance was provided by Norsk senter for forskningsdata (NSD) and Helsam (see Appendix E and F), I approached the Nepalese Student Community in Oslo (NESCO), an association representing Nepalese students in Oslo. After explaining the project, the leader of the association agreed to help in the recruitment of the members. NESCO was able to provide me with lists of persons I could approach. NESCO contacted the potential participants first and assured that I could contact them directly. The association also posted a Facebook advertisement on their Facebook page, reaching a larger Nepalese population in Oslo and Norway. Through this advert, I was able to contact a few participants who had recently moved from Trondheim to Oslo. In addition, and following these initial efforts, I recruited through snowballing and personal connections. For personal connections, I asked people around to contact me if they knew someone willing to participate in the study.

After the initial contact from NESCO and snowballing, I approached the participants directly. The first interaction to reach out participants was either face to face or through phone call. I verbally described the overall purpose of the study individually, and also explained

voluntariness to participate and express themselves, as well as the data collection methods, the benefits, possible risks, strategies used to ensure confidentiality, and participants' rights more broadly. When they agreed to participate, I met them face-to-face for further process.

Before starting the interview, the objectives, rights, and voluntariness of the participants were again described, and a written information sheet (Appendix A and B) was given. Afterwards, a written informed consent form (Appendix A and B) was given for them to sign. Both documents were provided in Nepali, participants' native language. The place of interview, date and time were all chosen by the participants themselves. Two interviews were done in the researcher's apartment, due to practicalities such as the participants being in the same area, or privacy such as when the participant shared a room with other friends. Other interviews were taken in the respective participant's room with their consent and comfort. All interviews lasted between 40- 60 minutes. Some interviews went incredibly in-depth and were very explorative with intense discussion while some were less descriptive. However, I felt that the rapport built with the participants created an open and neutral space to talk about their highs and lows about the topics of the interview.

Conducting interviews

The study's aim and objectives were sensitive topics, sexual and reproductive health and their moral understanding of premarital sex and pregnancy. Also, the acceptance of premarital abortion in the community are all issues that needs to be approached carefully in Nepali communities. As my aim was to explore perceptions potentially shared by the participants, I found semi-structured interviews to be most relevant. This allowed for an openness and flexibility important for the dynamics of the conversation, as I wanted to investigate perception and attitudes of the participants in their socio-cultural contexts. Providing participants the opportunity to openly share their views, experiences, and examples in their own words and in a chronology decided by themselves was paramount in this investigation and understanding of the context.

I prepared a semi-structured interview guide (Appendix C) with the main themes for the interview, as well as other less structured probes, to give direction to the interaction during the interview. Openness of the questions was ensured to provide flexibility to describe their opinions and views as they perceived or experienced it, rather than limiting the answers. The

interview guide included three main themes: premarital sex and intimacy, contraceptives, and induced abortion. I used open-ended questions with occasional probing questions and reactions to encourage the participants to describe more, to gain clearer responses and to make sure that the conversation covered the themes. All the participants consented to record the interviews. They were recorded with the TSD- Service for Sensitive Data at the University of Oslo- Diktafon service. Through this service the taped interviews were directly transferred to the TSD platform from the recording app to ensure confidentiality and privacy. Along with these audio recordings, I also took brief fieldnotes with key words to remember the thoughts encountered or significant emotions or gestures noted during the interviews.

Kielmann et al. (2011, p.26) emphasize that interviewees' behaviour, and responses are influenced by the level of intimacy or familiarity that the interviewer, as the researcher, have with the interviewee and their social and physical environments. Thus, throughout the interview, I tried to remain attentive to the participants' concerns, comfort, and willingness to talk. The privacy was ensured. Since participants and the researcher shared the same mother tongue, the interview was conducted in Nepali, the primary language in Nepal, with occasional English conversations. Sharing similar experiences of living abroad and being unmarried, I was able to engage participants in informal conversation before beginning the formal interview. This helped us build strong rapport so that the themes and interview guides were explored and adjusted for the participants to ensure quality data.

Data analysis and management

As mentioned, all the interviews were audio recorded in my TSD account directly via diktafon. I transcribed the data into Nepali and then translated it to English. The field notes and key words written at the time of interviews were mostly in English. I prepared a summary of how the interview went immediately after the interview. The translation of the interviews was done as soon as possible (1-3 days after conducting the interview). This allowed me to understand and relate the relevant themes and contextualise findings.

As the study was exploratively designed, the analysis process started during the data collection and translation and continued throughout the process. In a process of thematic content analysis (Braun & Clarke, 2006; Clarke & Braun, 2016) through repetitive process reading and re-reading transcripts, organizing and getting familiar with the contents, I

identified relevant recurring and significant themes. The data were then coded into categories using the Nvivo software. The coded categories were re-read again to organize the contents. Some categories and subcategories were merged, separated, added, or removed. The data was coded openly to avoid assumptions for emerging themes. In total 41 categories were identified with some sub-categories. The list of codes generated is attached in the appendix (Appendix D). Lastly, three major areas of focus were kept relevant and categorized for explanation. The themes relating with the sexual and reproductive health needs, perspectives and rights were identified and interpreted further to generate findings and conclusion of the study.

Ethical considerations

Ethical clearance was obtained from the University of Oslo, Institute of Health and Society and NSD, Norway. A TSD account was made and used for data storage to ensure confidentiality and privacy for sensitive information. The study was done in compliance with ethical regulations in the Helsinki Declaration.

I was sincere and clear in the discussion of the objectives, benefits, and possible risks of the study; participant's rights, voluntariness, confidentiality measures, data storage and utilization, and how results would be reported and disseminated. Since the participants were educated, written consent forms and information sheets in English were also given to them to ensure they understood their role in the study. Adequate time was given to address any questions or misunderstandings that arose. The voluntariness of participation and the freedom to express as much as they want were constantly emphasized verbally in Nepali language before, during and after the interview. Consent for tape-recording of the interviews was also taken throughout. Each participant was individually encouraged to ask to clarify their concerns and willingness. After this, verbal consent was given followed by the signing of a written consent form to confirm their voluntariness and acceptance for participation in the study. All the participants seemed satisfied with their participation in the discussions and interviews.

With the exploratory nature of the study and given the sensitivity of the topic to discuss sexual and reproductive health, privacy and confidentiality were highly considered. The interviews took place where participants chose. All the interviews took place in a private setting with only the researcher (myself) and interviewee present to safeguard privacy. I did not include personal identifying information of the participants in the recordings, drafts, or final

reports of the study. The participant's rights were ensured throughout the interview session. The transcripts and recordings were coded with numbers, removing all personal details. Only the researcher had access to the code list link with participants' real names and data. All the data were stored in TSD, which is a platform in the University of Oslo network to ensure high security for sensitive data storage and management. The researcher did not link the respondents' responses or quotes from interviews to personal details. As a part of personal reflection of the researcher being an insider, attention was given to identify the research participants only to the extent necessary during data collection, analysis and writing of the report. All copies of fieldnotes, tape recordings and data will be destroyed upon thesis completion.

Reflexivity

Malterud (2001) states ''A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions'' (Malterud, 2001, pp. 483-484). Qualitative research is enriched with reflexivity in all the stages. Likewise, in this study, I consider myself as an insider initially. A young Nepalese woman growing up in Nepal myself, speaking the same mother tongue, sharing similar societal contexts, cultural norms, and values, and constantly adapting to modernization and recent migration abroad for higher studies. I believe these allowed participants to share their thoughts and concerns easily and comfortably with me, an insider. Also, my background of working in the health sector and having understanding and knowledge of women's health and rights was also noted. Considering the sensitivity and stigma of the research topic, it was indeed significant to develop a comfortable space and safety for the participants to share their opinions and experiences. I tried to develop connections and mitigate the concern of privacy and confidentiality by spending enough quality time with participants before I started the interviews. The participants and I spent time together over lunch discussing the pandemic situation and how it has affected our lives here, the situation in our country, our families, education and living expenses abroad for single females, difficulties, and all. However, this might also have influenced how I perceived and understood the interview excerpts. It might have made me over or under analyse the situation or issue, creating difficulties in identifying and considering problems in the research setting. This may have probably been easier to realize by an outsider. I tried to balance familiarizing myself with participants while establishing my

role as a researcher to gain the trust and comfort for the interview and to be a good listener. I also tried not to impose participants' opinions based on my background and understanding.

Before commencing my fieldwork, I predicted that my position as another Nepalese female would limit participants' openness to express themselves because of fear of judgement. However, my position of sharing a similar context of living abroad made the participants feel more comfortable. In fact, for many, it was the first time they had had such extensive discussions on their reproductive health issues and were appreciative of the platform to express themselves with someone who shared a similar context. Nonetheless, positioning myself as a researcher was important to distance myself from anything that could impede the research quality and extent. So, I introduced myself as a master's student doing thesis research here. As soon as the informal conversations were over, I stood back to avoid my own expression about the topic and gave adequate space and time for participants to speak without any form of outside hints or direction.

I used a combined insider and outsider perspective to engage closely with what the participants were expressing. During the interviews, I tried to phrase the interview questions asking for 'your opinion' when individuals' perceptions were of concern and used 'our community' to inquire about the societal context of Nepal. I critically evaluated my own interpretations of their expressions throughout the process. I listened to the interviews giving enough time and space for the participants to express themselves in their own words, with only occasional probes to clarify some statements. To ensure that my pre-established theoretical framework and preconceptions did not affect the research direction, I systematically wrote reflexive memo notes before, during and after the research study and interviews. A thorough timeline of my research activity and perceptions were noted. After each interview, a reflective summary about how the interview was, my expectations from the interview and how I felt throughout was noted. I reflected upon my field note summaries and notes on my own perspective with the descriptive transcripts from the interviews throughout the study project, during interpretation and analysis and thesis writing and tried not to overlap them. I also invited others, such as female peers and classmates, to discuss the issues within my interpretation and analysis, to minimize the risk of misrepresentation.

CHAPTER 7: FINDINGS

This chapter presents the findings produced through fieldwork. The findings have emerged primarily from in-depth interviews, but also from informal conversations with the participants, and fieldnotes. The findings are categorized into three main themes:

- Premarital sex and contraceptives choices
- Premarital pregnancy
- Induced abortion

The themes are further subdivided according to different categories that were identified and deemed significant to understand in detail (see Appendix D for code lists).

The data findings in this study explores how these unmarried, educated women describe their own understanding of sexual health knowledge, experiences, reflections and their societal influences. Overall, the data progressively maps the interrelationship between perceptions on premarital sex, contraceptive choices with premarital pregnancy, and abortion among unmarried women in Nepalese society. Also, the diverse impact of long- held cultural and traditional beliefs and continuous negotiation with society that shape sexual and reproductive health issues in Nepal is presented.

Demographic characteristics

All 14 participants were unmarried females who migrated to Norway for purpose of higher education. Participants' age ranged from 23 years to 30 years with an average of 26,5 years. All the participants had migrated in recent years (1,7 years) from Nepal to Norway for graduate degree courses. Five were recent master's degree graduates and nine were ongoing master's degree students at the time of interview. All women were doing part-time work to cover their living expenses. Nine of them stayed in individual rooms (student housings) while two shared a flat with a friend, two lived with a host family, and one lived with her partner.

Eight stated their relationship status as single as of the time of interview, six of them had a history of previous engagement, while two had never been in a relationship. The remaining six stated themselves to be in a long-term relationship with their partners at the time.

With regards to place of origin or area where they grew up, seven of the participants came from the central region of Nepal, three from the eastern region, one from the south eastern region and one from the western region of Nepal. 13 of the participants described their last area of residence in Kathmandu, the capital city located in the central region of Nepal. Almost all the participants said they lived in Kathmandu or migrated from their hometown for education or work before coming to Norway.

While in Nepal, participants had varying work experiences. Five had experience of working in hospitals or private laboratories, two worked with NGOs in communities, two in governmental public health projects, two in the IT sector, one as a hospital nurse and two had no working experience and were continuing their education.

The religious affiliations among the participants and their families' beliefs and practices were Hinduism and Christianity. Of the two participants identifying as Christian, one still strongly associated herself with the biblical teachings and practices while the other stated that she used to be more devoted but was now more open to expand her religious beliefs. Those identifying as Hindu emphasised that religious activities had a strong impact on the household practices in the families, while they themselves were involved only to a certain extent.

Concerning the participants' relationships with the Nepalese community in Norway, three described their relation as both very good and being tightly knitted into these networks, nine expressed that they were only close with their own circles of friends but not with others, while two of them said they had very limited connections with other Nepalese outside their immediate circles.

Table 1. Background information of the participants.

S.N	Age (Years)	Religious affiliation	Education Status*	Years of stay in Norway (Years)	Current residence	Place of origin in Nepal	Work experience in Nepal	Relationship status	Residency in Norway
1.	24	Hindu	Student	1	Single room	Sunsari (Eastern)	Private laboratory	Single	Hamar,
2.	30	Christian	Graduate (Job seeking)	3	Single room	Itahari (Eastern)	NGO	Single	Oslo
3.	23	Hindu	Student	1	Single room	Pokhara (Western)	Private laboratory	In relationship	Hamar
4.	27	Hindu	Student	2	Singles room	Bhaktapur (Central)	Hospital laboratory	Single	Oslo
5.	25	Christian	Student	1	Host family	Dhadhing (Central)	NGO	In relationship	Oslo
6.	26	Hindu	Student	1	Singles room	Simara (South eastern)	IT sector	In relationship	Oslo
7.	27	Hindu	Student	1	Singles room	Sindhupalchowk (Central)	Public Health office	Single	Oslo
8.	29	Hindu	Graduate (Job seeking)	2	Host family	Chitwan (Central)	Private laboratory	Single	Lillehamer
9.	30	Hindu	Graduate (Job seeking)	4	With partner	Bhaktapur (Central)	Public Health office	In relationship	Oslo
10.	27	Hindu	Student	1	With friend	Kathmandu (Central)	Hospital laboratory	Single	Hamar
11.	26	Hindu	Graduate (Job seeking)	2	Singles room	Jhapa (Eastern)	IT sector	Single	Trondheim
12.	29	Hindu	Graduate (Job seeking)	3	With friend	Sindhuli (Central)	Hospital nurse	In relationship	Oslo
13.	24	Hindu	Student	1	Singles room	Kathmandu (Central)	Continuing education	In relationship	Trondheim
14.	25	Hindu	Student	1	Singles room	Kathmandu (Central)	Continuing education	Single	Trondheim

* Education status: Masters' graduate or ongoing masters' student in Norway

Section One: Premarital Sex and Contraceptives

I will start presenting participants' perceptions of premarital sex and contraceptive. Further, I will also present how they understand social norms and reactions towards unmarried females and their engagement in premarital sex and contraceptive usage. This forms a foundation for understanding perceptions and attitudes of premarital pregnancy, abortion, and abortion related care among unmarried women.

I found a consistent acceptance and non-judgmental attitude on the practice of premarital sex and intimacy among the participants. The knowledge and availability of contraceptives appeared fair as well. At the same time, they clearly expressed the lingering taboos and cultural beliefs about marital status and its relationship with sexual practice, which appears to influence the unmarried women's sexual behaviour and choices. Following are the subcategories to understand this theme in-depth.

1.1. Individual and societal understanding of sex

During the interviews, the participants emphasized sex as a biological need and that it is a natural part of life. An important contextual point that formed the discussion of premarital sex was the age for marriage in Nepal, changing the lives young women live and the gender relations they form. One of the participants explained,

> *Our parents' generation got married already at 18-20 years. Their circumstances were like that. But their mentality does not relate now because we grew up in different circumstances. We are young, unmarried, moving abroad and studying before settling down… I think young women nowadays want to be independent and have freedom. So, till then it takes years, maybe 25-26. And obviously women get sexually driven by then and becoming involved in intimate relationships is natural and is a part of life and relationships. (Participant 1)*

All the participants were open and accepting for individuals' choices to engage in premarital sex. Though some of them choose not to get involved in it personally, they showed no form of hesitancy to accept others' choices.

> *I was Christian from my teenage years so because of my religious understanding and perspectives, biblically, we are not allowed to have sexual relationships before marriage. We have had teachings like that since our childhood so due to my religious*

view I don't agree. But also, if someone else does it, I don't judge. It is fine, I don't judge them, it is their own choice, but because of my own ethical values, I don't agree for myself. (Participant 2)

Moreover, a prioritization of individual choice on sexual rights and behaviour was seen among the participants. Many women were also open to these practices based on free-will if safety was considered. One participant said,

Have sex... be careful… that's my concept...you have your biological excitement and you want to experience... it is pleasing yes!!! Just be careful with protection… know what you are doing… not just romanticise intercourse and be ready to bear that responsibility if something happens. (Participant 5)

The state of quandary that the word 'sex' creates in the Nepalese society was explicitly mentioned in the interviews. One participant described how through many generations, sex was portrayed as something negative and how it has been passed through generations that affected the overall concept of sexual health. Another participant supported this in her narratives as,

So when we talk about sex...the first thing that comes in the mind is vulgarity...`foor jokes'[dirty jokes]. We don't say ' yaounik jokes'[sexual joke]..we always say dirty jokes.. You know the phrasing itself is so wrong...in both English and Nepali.... 'foor kura'[dirty thing]...'foor chitra heryo'[sees dirty picture]..so I don't think there is space for exploring sex as a pleasurable feeling. (Participant 5)

Moreover, though sex was considered a basic need, the strained position of women with regards to her marital status was marked. Furthermore, the portrayal of virginity as a standard for unmarried women to maintain was highly mentioned throughout the interviews. This was supported by the participants as they described how difficult it is to openly discuss it.

That notion of purity…our mindset is so rooted in it… virginity of women is more precious than diamonds and gold….That's why it's not simple...it's so integrated and so engorged in our culture, in our thought process and mindset (Participant 6)

This theme was explicitly supported by another participant as,

It is compared more on women than men about virginity.... I also think many of it is also because we worship 'Kumari Devi' *[virgin girl] there is a different level of respect and dignity for girls before menstruation and then unmarried. (Participant 7)*

The participants also acknowledged the difficulties that builds up while discussing or opening about sex and related topics especially when it comes to unmarried women. The research participant described,

That taboos or beliefs has become values. The value of our society is that you get married first. More for girls… boys are given some liberty. For girls, you have the responsibility to maintain the prestige of your parents, like without having anything with anyone, you get married, that's it. (Participant 9)

The perception on premarital sex seemed liberal and evolving among educated young participants. However, social control of female sexuality and its influence were apparent. It was also clear from the data excerpt that terminologies play a huge role in interpreting sex and related issues.

1.2. Dilemma while accessing contraceptive

To understand the perceptions of abortion and health seeking behaviour, in-depth understanding of how involved these unmarried women are with the concept of contraceptive was important.

All the participants seemed to have at least the basic knowledge and information about contraceptive, especially condoms and emergency pills. There was a sense of valuing the importance of using contraceptives by everyone to avoid the future consequences like unwanted pregnancy, STDs, or abortion. The openness and flexibility to learn about contraceptive, even as a general knowledge was noted. This showed that the concept of contraceptive was not new or difficult to comprehend for educated unmarried females. One participant explained:

Nowadays, there is knowledge of contraception and contraceptive in Nepal, I think. But they lack knowledge in utilization. One thing is people are embarrassed to go and buy contraceptives. Also, for some I feel like it is also being mis- utilised for not knowing to use it properly like for emergency pills. (Participant 9)

The availability of contraceptives was fairly agreed to be adequate, however, the issue of utilization was argued upon. While trying to map the reason for differences in utilization and availability, two distinct reasons emerged. First was insufficiency of sex education and its discussion among youths. Almost all the interviewees mentioned that they did not get proper sexual health education during school and it was one of the reasons why they felt they did not have adequate information and were hesitant to discuss sex and contraceptives. This was supported by one participant's response,

> *From our school level, if the sex education would have been strong all along, a young 12 -year old girl would know that she should not have been pregnant or recognizes its symptoms when to seek help isn't it? (Participant 2)*

The second was the fear. The external fear and judgement of societal reaction as well as an internal battle with one's own conscience were evident. Those who had not yet experienced buying contraceptives themselves were concerned about the dilemma they might face and the response they might get from the society. One of the participants said,

> *They will fear what if other people will know…. ohh I am unmarried, I went to buy it, what if someone saw me, what will they say... Or like what if someone I know will see me and tell my family that I have sex even though I am unmarried…I think they will feel that. (Participant 11)*

Though only few shared their own experience of accessing contraceptives in Nepal, they had a common notion of internal overthinking and distress. An excerpt example is briefly put here,

> *I remember I had to get myself that courage to go and say Can I have a condom? so then I thought..*'baan ko bhoot vanda mann ko bhoot le marcha' [the ghost of fear inside your heart will kill you rather than the ghost in the jungle] . *So, it's more about the internal fight you know… Contraceptives are there...it's nice and important and everybody knows it...but because it's not socially talked about and accepted…you still have to fight with the dilemma... Isn't it so complex!!! (Sighs) (Participant 5)*

1.3. Gender roles while accessing contraceptive

With regards to sexual and reproductive health behaviours, there was a consensus that men have different levels of freedom of choice and conduct than females, especially

unmarried females in this context. The dynamics of patriarchy in the society was displayed with the position of men and women accessing contraceptive as well. As it was found that men use contraceptive (condoms) more than females using any other form of contraceptive, it was clear that one of the reasons was because men, rather than women, typically buy the contraceptive because of easiness. One participant added,

> *In Nepal the most common might be the ones that guys use…that is condom because of how it is easier for a guy to go and buy condoms and how no one will judge him. He has different pride even if he is only buying condoms but for girls it's different. (Participant 7)*

This concept was supported by another participant where she described that even for emergency pills used by women, men go to buy it for them.

> *I have heard that the guy goes to the pharmacies and buys it for them… but I have never heard that a girl went to the pharmacy themselves and had it. I think it is because of how people see if a woman buys it. (Participant 3)*

Moreover, the increased ease to access, discuss and use contraceptive once a woman gets married was emphasized. While for unmarried the need for deceiving the society for accessing basic contraceptive were identified in the interviews. This supplemented the gendered role of men in buying contraceptive compared to women. One participant described,

> *Like they view you as a married or unmarried. I have heard girls putting* 'sindoor*'* [crimson colour which is symbolic representation for being married in Hindu culture] *on their forehead, covering their face and head with a scarf to look married to get contraceptives or i- pills so that the person in the medical store would not judge her. (Participant 6)*

The participants' positions in their society as unmarried females and the influence of gender norms were noted. It was noticeable how the participant expressed women valuing societal and cultural norms while trying to navigate and adjust their opinions and needs on sexual health and behaviour.

1.4. Societal norms

The participants believed that the root cause for all the reluctancy and unacceptability for reproductive health needs and matters of an individual was situated within the wider context of Nepalese community values and practices.

'What will people say' was the most common phrase used by the participants throughout the interview discussions. It carried both positive and negative connotations. Two of them said that the societal regulations and judgement are indeed helpful in some ways to prevent the uncontrolled violation of freedom due to fear of what people will say. One of them said,

> *I think that if we agree to premarital sex, the society will not go in an orderly fashion. I think there are certain orders and ethical values for a society to run and I think it won't go smoothly if we promote this (premarital sex). If people will go out of the limit and line of societal orders, then human behave in different ways. (Participant 2)*

While most of the others think this fear has stigmatised the discussion of important issues related to sexual behaviour and practices. This then leads to undesirable consequences in an individual's life and relationship with society. As the participant explained,

> *Our society does not accept it and doesn't discuss it… Like rape, pregnancy, abortion, health risks due to abortion in small ages, mental health problems and all that…so to avoid it…discussion from family and society is needed…. But we don't have it...that's the problem. (Participant 3)*

Furthermore, the challenges of women's position in the wider social context in Nepalese society was noted. The constant struggle to maintain one's prestige or dignity being an unmarried woman seemed apparent in the interviews. The hierarchy based on gender roles and expectations living in Nepalese society was highlighted in the response of the participants as,

> *In Nepalese society, whatever men do, it is okay. Whatever they talk about or whenever they do it is fine. But even the men themselves, when they must marry, want a virgin woman. It is because society made them grow like that. I have seen many guys, even my age, treat women like they are second-hand items when a woman breaks up with a guy. Even the educated guys talk like that. So, it is very difficult in a*

society like ours to be a girl because those same guys will be men in the future when they grow up and make society. (Participant 1)

The insights and experiences shared in the interviews show how being unmarried shapes females' decision making, self-confidence, health seeking behaviour and their position in the patriarchal society. Exploring different insights on premarital sex and contraceptives among unmarried educated females gave a better direction to understand the status and perception of premarital induced abortion in Nepal.

Section two: Premarital pregnancy and its consequences

This section will address premarital pregnancy as a consequence of unsafe premarital sex and/or contraceptive failure. All the participants supported that pregnancy is inevitable, if not careful or sometimes even due to failure. They agreed that it was natural that unmet needs of contraceptive or their failure results in pregnancy. The heaviness and complexity of discussing unmarried women and premarital pregnancy was felt throughout the interviews with participants. The following sections presents some insights on attitudes towards premarital pregnancy among unmarried Nepalese women.

2.1. Perception on premarital pregnancy

When asked about their opinions on unmarried women and pregnancy, participants gave intriguing responses. All the participants agreed that being unmarried and pregnant, irrespective of any reasons, was an extremely sensitive and complex issue in the societal context of Nepal. Participants expressed their sympathy for women who had to face unwanted pregnancy. They claimed that premarital pregnancy was not something that any unmarried woman would want. They suggested that it would be the result of either contraceptive failure or lack of sex education in Nepal. This was supported in one participant's interview excerpt where she said,

They are biologically growing and are so curious about sex, but they don't really understand the consequences of sex or cases of being pregnant or about how to be careful… (Participant 5)

Their own perceptions of premarital pregnancy were not to get pregnant if possible. Participants said that they had not seen or heard about unmarried women giving birth and

living in Nepalese society as single mothers. However, two participants accepted that unfortunate events could happen, and being pregnant was a normal consequence of having a sexual relationship. The acceptance was reflected because of broadening the vision and beliefs by being involved in different societal contexts, as in here, migration to a European society. The interviewee expressed,

> *Premarital pregnancy is kind of like, not accepted in our society, right? But then I have seen and lived in a different world and society now. So, for me individually I accept. I mean like there should be the condition where you are not suffering. So, if you are not suffering, its ok. I think it's totally alright for me. (Participant 6)*

While most of the others did not completely support the consequence. Some of them said that they are okay with it if the guy was ready to take responsibility and get married. While some were not supportive because of the fear of health risks and others were more concerned about the fear of societal judgement and discrimination. One participant responded,

> *That is the most terrible experience to be a single woman and pregnant in Nepal. First you are not financially independent and strong, second your family won't support you, society will talk nonsense about you, you will even be happier to be a lower caste than be a pregnant single mother in Nepal, it's like second death to unmarried women.(Participant 2)*

It is apparent that participants' perceptions of premarital pregnancy were complex and backed up by regulations and what was considered normal in the society they grew up in.

2.2. Marital Institution

Though the participants supported the unmarried pregnant women or had some exceptions, it appeared that marriage was an ultimate resort. It was clear in the interviews that in the Nepalese context, marriage, or marital status has a significant impact on the sexual and reproductive health rights, needs and consequences of women.

There was a general agreement on how readily the families and society accepts marriage after knowing about pregnancy or premarital sex. The sense of *'jimma lagaidiney'*

[handing out responsibility] which in this context means the families make the girl marry the man who impregnated her, so the family won't be shamed in the society.

One participant gave examples of others whom she knew have eloped or their families made them marry right away as a solution or for the sake of the baby. This was narrated in the interview as,

> 'Aaajayej' [illegitimate]- *its illegitimate—unless it is from the man you married or if you are not going to marry—its* 'aajayej balak' [illegitimate child],—*then that woman's everything is gone- she is done. That's the perception…so they marry off so early so that they won't have the pressure or naming of* 'aajayej'— *(Participant 5)*

It was distinct that society's response and reactions played a critical role in how regulations and practices are articulated in the Nepalese context. It was clear from the narratives that a woman's decision was often overshadowed by her own family, leaving her no option but to marry. In one of the examples given by the participant, she said,

> *Even my own cousin who had a premarital pregnancy…and many others in my village…some marry off so early… my cousin was just 15 years— they forced her to marry—so if she is pregnant, there is no chance of abortion because of social and religious factors— they married her off as soon as they found out. (Participant 5)*

The participants mentioned that premarital pregnancy was perceived as a crime in Nepalese society. The participants voiced concern about the decision-making power and futures of unmarried women that remain in jeopardy when unfortunate events like premarital pregnancy happens. Another consequence mentioned was induced abortion, particularly when it comes to unmarried women. This will be explicitly focused on the next section.

Section Three: Premarital Induced abortion

Exploring the dynamic relationship of premarital sex, contraceptive and premarital pregnancy with the deep-rooted cultural values and personal reflections presented the base to discuss induced abortion. Given the sensitivity of the topic, discussing abortion was relatively complex. The subthemes in this section will collectively present interesting findings on the knowledge, perceptions and expectations of young educated and unmarried women about abortion and abortion related care in Nepal.

3.1. Knowledge about induced abortion and its services in Nepal

While asking what they know about abortion, only a few participants gave clear accounts of their understandings of abortion practice and its safety. Most of the participants claimed they did not have adequate knowledge about abortion and never thought learning about or discussing it. The information they had about abortion was only based on the stories they had heard or read anonymously. While describing what she knows about abortion, one participant described,

> *I really don't know…. it is called* 'bachha falney' [in literal translation 'throwing baby'/ to take out the baby from womb] *Abortion has a certain timeframe like if it is beyond a certain week of the pregnancy then it is considered as forceful abortion … also, there are some places which provide abortions without looking at the age, they do it only for money… there are mothers dying because of it… that's what I have heard. (Participant 3)*

Moreover, similar information was obtained when methods of abortion and knowledge about its services and accessibility were discussed in the interview. Besides a few of them who had worked in Nepal in the community health sector, others admitted they have never talked or discussed or tried to learn about abortion or its related issues, which made them unable to openly discuss it in the interviews. Some of the methods mentioned in the interviews were invasive procedures like surgery, curettage and drainage, and vacuum suctions. Non-invasive methods or medicine-induced abortions were also mentioned by a few participants. The majority of them mentioned surgery and described it as being too risky for women. One participant said,

Hmm…vacuum takes out the baby? I don't know well... That's all I know from movies and songs…(laughs)… in different positions… doctors inserting hands there which looked really uncomfortable… that's all I know. (Participant 3)

Myths about abortion were also widely present among participants' knowledge. A lack of adequate information and misinformation were very evident with the way participants described abortion and how it is done. Information like cutting all the limbs of foetus to abort, infertility after abortion, serious reproductive health problems, life-long pain, and deaths after abortion characterized the events and stories that some participants had heard associated with abortion. One participant expressed,

I heard they insert the scissors and cut the limbs of the baby. And another is the women takes pills and the baby dies and comes out, that I know. (Participant 10)

When asked about where to access abortion services, all the participants mentioned hospitals and health posts that provide the service. The majority of them also named 'Marie Stopes Nepal' which is an International NGO, working in Nepal to provide contraceptives and safe abortion services to women. No other specific names were given, but the participants knew that hospitals do offer the services. The participants described knowing about the organization through seeing the organization names on the buildings, through advertisements and one of them through a project she had worked on.

Regardless of knowing the name of the organization, most participants did not have proper information about the services it provided. This was an interesting finding and while digging in deep to find the cause of a lack of knowledge and information, I found that most of them have never even thought about it. They felt that there is no need to know unless it is needed for themselves, never paid attention to learn about it and had no one to discuss it with because of the interconnectedness with premarital sex and contraceptive perceptions in the society. One of the participants said,

…. Even myself, being educated I have no knowledge about it. So, I think there is a huge gap about information regarding abortion, myths related to it and society's perceptions because no one talks about it. (Participant 1)

Therefore, it was apparent that service availability and its usage in Nepal were unmet relating to knowledge of abortion and its services among unmarried women. It thus seems

relevant to explore more concrete and practical issues related to abortion and attitudes among unmarried educated females.

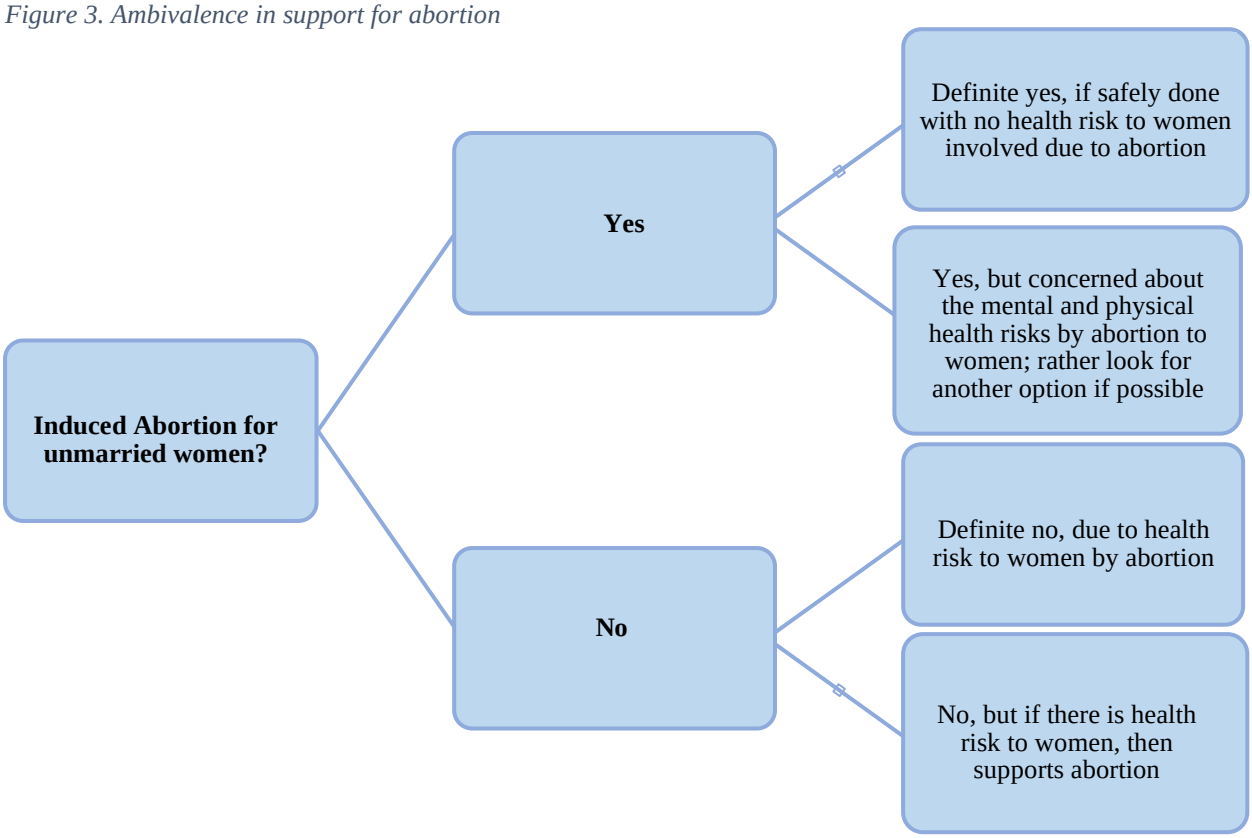
3.2. Perception on Induced Abortion

For many of the participants, it was obvious that their perceptions and support of induced abortion were based on the information they possessed. Almost none of the participants mentioned that their families would allow for abortion in Nepal. Three of the participants expressed that they would rather prefer and suggest that the women get married and have the child rather than abort. This was because of their strong beliefs against abortion.

However, for others, they were fine with abortion, given no health risk to the woman but still advocated that they do not choose abortion if they could.

The ambivalence of perceptions of the participants towards abortion can be concisely displayed in the figure below (figure 3):

Figure 3. Ambivalence in support for abortion



The figure summarises the variation in opinions given by the participants. All the participants emphasized the role of health effects of abortion on women's mental and physical wellbeing rather than other factors like religion or culture. In the opinions given by the participants, it was clear that despite the varied perspectives, sound health of women was a paramount need.

3.3. Legality of abortion and its perception

Considerable time has passed since the legalization of abortion in Nepal. The majority of the participants knew that abortion was legal in the country and supported the liberal laws related to abortion as they claimed it a woman's right. However, one of their concerns was about how it has been executed and perceived in the society. One participant shared her concern about the illegal practices happening in the country and how they are affecting women's health. She illustrated the complexities of societal and religious turmoil associated with abortion among unmarried females. She narrated,

> *All these women's deaths are due to unsafe abortions. In Nepal it is not safe and it's not accepted so many people do it illegally in private clinics and other places… and in Nepal you won't say to anyone that you will go for abortion because you can't say it...there is a lot of mental issues to it. Government has legalized it, but our society's opinion has made it illegal. (Participant 2)*

Another concern presented by a few was their mixed opinion about the legality of abortion and its utilization. Two of them mentioned the carelessness by some women while utilizing abortion services. They were afraid about repeat abortions, especially by teenagers, and the health risks associated with it. As one of them said,

> *Hmm in one way being legal is fine because rather than making the child in dismay it is better to do abortion in time but on the other hand people are misusing it. So, for that misuse I think being legal is not right. If it is made legal, abortion cases will increase. So, I have mixed opinions. If it is not forced, if it is with consent then it is fine but if it is a teenager pregnancy then both teenager pregnancy and abortion are not good, I think. (Participant 12)*

While a minority of participants thought abortion was illegal in Nepal, they admitted that a lot of abortions happen anyway, so they want it to be legalized rather than risking life.

Except one participant who said she wants it to remain illegal since she does not support anyone receiving an abortion. As she mentioned,

> *Hmmm even if abortion is illegal, there are people doing it as well…outside in clinics doing it illegally. But yeah, for me I think abortion should be illegal and no one should do it. (Participant 10)*

However, most participants wanted the legal status of abortion to flourish to decrease the chance of illegal risky abortions that affect women's lives.

3.4. Illegal practices in abortion seeking

It was noted that many are not entitled to choose their specific abortion provider. While another participant described, how for some women choosing illegal or unsafe places, usually far from home where nobody knows them were much easier options when it comes to premarital abortion. Also, the consequences leading to unsafe illegal practice was described by one participant as,

> *I have heard news like women used to have babies and later throw them in dustbins or leave them in jungles. Also, many of them go to those unsafe places where they do it with razors blades or herbs and due to problem with clearance of foetus, they have miscarriages, problems with conceiving later and all. So, what is the benefit even if its legal? (Participant 9)*

Moreover, the prevalence of black markets and illegal abortion clinics reflected how abortion was perceived in the society. One of the examples shared by one participant illustrated the relationship of societal perceptions and their impact on personal choices,

> *Medication abortion is quite common in Nepal. I have seen how it is illegally sold. I am not sure how much it takes otherwise...200-500rs something? I don't know ... but when one of my friends bought it, she gave 1200 or something to buy it. Illegally! Since it is not doctor prescribed, she brought it illegally. It was like rather than going through the taboos associated with abortion, it was better to rather pay 500rs extra and get the same medication to get the work done. (Participant 7)*

The negative attitudes and illegal practices have as well contributed to myths and stigmas associated with abortion in general. Thus, their idea of power for decision making for safe abortion, if the participants themselves must go through one was explored further.

3.5. Decision making role and valid reasons to opt for abortion

During the conversations about whose role matters for decision making if unmarried women must go for an abortion, excitingly all the participants said, foremost it should be up to the women themselves. Unless the girl is under 18, the participants focused solely on women's decision-making power. This claim was shared by all the participants regardless of their perceptions about abortion. Further, the participants considered their partner's opinion to matter as well after their own.

Beyond this, only a few mentioned that family support should also be there. None of them mentioned the significance of the role of society in decision making. One participant said that if the family will support her, then she can strongly face the society and it will not affect her. The following excerpt supports this as,

> *… if she wants to have an abortion and thinks it is the right decision for her then yeah. First, she should have the courage herself…it matters a lot... And then her partner... Like whatever happens I will be there for you kind of support then I think the strength gets double and then comes family and their opinion. (Participant 7)*

However, despite one's individual stand, the decision for abortion seemed to be manipulated by the wider context. Though abortion rights have legal support from a political perspective, the cultural and societal aspects appeared to play a significant role in its execution as emphasised in the interviews. The obligations set up by the society pressures women to choose different options, even if they want to or not. One of the participants shared an example which relates this issue. She narrated,

> *My cousin had an option to abort, they didn't have to rush her to marry…but they wanted to avoid that, and it is a religious sin to kill a baby. And my other cousin, she had a bad relationship with her husband… marital rape… which is another huge thing in Nepal—and she got pregnant and of course she had the option to abort but then she gave birth anyways as well. So, by saying how young girls are okay with giving birth or marrying and not abortion reflects the society we are in. (Participant 5)*

Moreover, one participant described that if a family will know about the premarital pregnancy, if marriage is not an option then the family makes the girl abort the child in secret to maintain the level of respect and hierarchy in the society. Two participants said that the woman's chances of getting married in the future will be in jeopardy if the society will find out about her pregnancy.

In the interviews, varying points were highlighted regarding the perception of valid reasons to opt for safe abortion, if they must. As one's own choice of not wanting to give birth at the moment was the most mentioned and accepted reason, other valid reasons to opt for abortion as per the study participants were: *not being able to take the responsibility of baby right away* (Participant 12), *not being ready to marry at the moment and not ready financially, mentally and physically to go through pregnancy and childbirth* (Participant 10), *failure of contraceptives or not knowing what to do next* (Participant 3), *cases of rape, forceful sex and medical conditions* (Participant 3, 14) were also valid reasons to opt for abortion. Similarly, another participant added that if you are *unmarried and pregnant*, abortion was the right option to avoid all the negative attitudes towards her and her family due to cultural reasons (Participant 7).

However, one of the participants expressed that being unmarried, though they choose to do abortion for valid reasons, high chances are that women might not seek safe abortion services because of stigmas and fear attached to it. So, discussion on what comprises a safe abortion for unmarried females in Nepalese context became the focus of the interview.

3.6. Safe abortion for unmarried women in Nepal

As with knowledge about safe abortion services in Nepal, their understanding of safe abortion, if one must go through it themselves seemed necessary. Identifying educated unmarried women's idea of safe abortion services was also one of the objectives of the study. Through the interviews, participants described what could be safe abortion for them and how individuals, health systems and society can provide safe abortions.

To be able to complete abortions in right time and within a certain established week of pregnancy to reduce health risk was a main concern that participants discussed. The ability to make decisions for oneself, without the fear of family and society was also described.

Privacy was considered most important also to the ensure personal and social safety of the women receiving an abortion. Another was to be able to go to the hospital and be assured to do it confidentially. One interviewee argued that the obligation to bring a partner or family members was also a breach of privacy which can make women feel unsafe, unless there is a health risk involved. The narrative goes as,

> *I think it should be private at first. Also, there should be no provision to need parents or guardians' consent to do it because what if she does not want to talk about it outside. I think the one who decides to have abortion- should be able to go and do it by herself. (Participant 1)*

Another interviewee shares similar context,

> *If I choose safe abortion then for me there should not be any obligation to bring my boyfriend or my family unless my health has a big hazard then only my family involvement should be there… because of those cultural values associated, it will rather make me feel more unsafe and in initial weeks and months it is not even that dangerous so I think they should not get involved. (Participant 7)*

Further, medical criteria such as accessing licensed and legal hospitals and clinics, proper counselling by health professionals, proper health education and services pre and post abortion, transparent and non-judgemental attitudes of health professionals, and the need for proper medical equipment were considered. This was influenced by the priority that women seeking abortion should experience no health risks or danger. Some examples from the interview are,

> *First is health. It should not be affected. The people there (in the hospital) should not behave bad or differently with her…maybe it happens now as well in hospitals. Like not thinking bad and changing behaviour towards her when she is there. She will have mental stress from that. (Participant 4)*

> *…another is also you should do it from authorized personnel. Like in licenced places…not anywhere or from anyone. I think there might also be situations where they fear that society will know. That fear will make them look for places where others won't find out and it can be wrong places anywhere…which increases the health risk. (Participant 3)*

Most participants believed that legality provides assurance of having licenced and skilled trained health professionals who know what they are doing. A legal framework was mentioned in the interview discussions as,

> *I think when the government makes it legal it is safe to go hospitals and do it. The doctors will do it safely because they can do it like any other surgeries and provide counselling to make it safe. There will be proper communication and information accessibility. (Participant 2)*

Financial safety was also mentioned by many participants to build the confidence to seek safe abortion. Some participants pointed out that being financially ready and stable was important and others added that the services themselves should be cheaper or free of cost to access easily and safely. As one participant stated,

> *Financially it should be affordable. How are my finances going to be affected? Like for me okay I am financially able to do that. But there are many females who cannot do that, they are poor and financially dependent. So, it should be affordable price range for everyone. (Participant 10)*

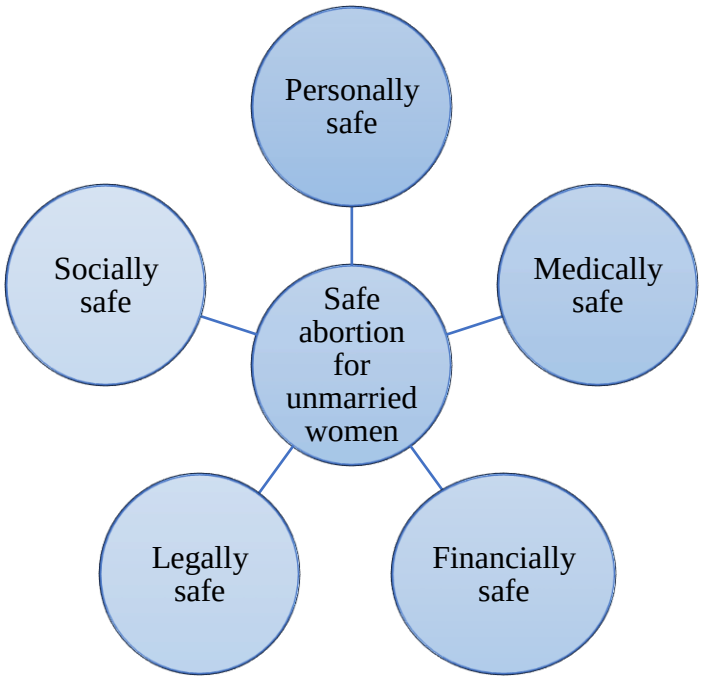
The theme of social control and safety was mostly discussed in the interviews as its association with societal perceptions of premarital sex, contraceptives and pregnancy was inevitable. Because of the lingering stigma and taboos about abortion, the participants claimed that the more open and accepting the society becomes, the safer the abortion practices will be. One participant argued that if there is support from family, then she will have more confidence in choosing the right option for herself.

> *For me safe abortion starts from my family. Like, if I am going to abort, my family's thinking towards me is important. Because if my family is supportive, I would not have any tension, isn't it? I can do it openly. From there, I will be applying one of the safe measures, isn't it? So, family support is one of the main things. If you have this, we go towards safety measures. I will go at least. If I do not have family support, I will go privately and that is not safe abortion. Family, medical equipment, attitude of medical personnel, and then economically, financially (budget is to be average). This is what I think. (Participant 9)*

Moreover, the discrepancy in societal acceptance in issues like abortion was also discussed by the participants which highlighted that social safety is one of the major focus when safe abortion is planned and executed.

This overall explanation by the participants can be presented in figure as the understandings of needs for safe abortion for unmarried women in Nepalese society, (figure 4)

Figure 4. Expectations and need for safe abortion for unmarried women



Therefore, the understanding of safe abortion, accessibility and services can be summarised as having physically and mentally sound choices and circumstances to make appropriate decisions. Identifying the participant's own understanding and perspectives of safe abortion can be helpful in creating safe spaces for opening discussions about abortion.

3.7. Identifying and removing barriers to safe abortion

In the interviews, the participants had joint consensus on the limitations of discussions about safe sex, contraceptives, and safe abortion in the society as the main barriers to safe

abortion. The cyclic process of barriers revolving around individuals, families and within society was discovered.

The participants admitted that they had a lack of knowledge also because no one talked about it and their discussion was limited to self-learning or with friends only. The comfort, security and easiness of sharing and discussing with close friends was mentioned by all the participants. It was acknowledged that peer support does provide mental strength, but close friends are in a similar societal context where it is not discussed so their level of support for selecting the right choices and decision making can be brittle. As one participant mentioned,

> *Because of age we have somehow the same mindset. We will have similar phases in life and it is easier to understand and talk to with friends. If someone will slightly hint something, everyone will share and add the experiences… and the feeling of ohh we are on the same page makes us relate more with the situation. But it is risky too as we might not have proper information. (Participant 7)*

As family support was mentioned as a core component for safe abortion, it was also discussed as a barrier that leads to unsafe abortion. A few participants agreed that family support was crucial to choose safe abortion from the start without stress, while some also expressed the concern about how family themselves hide the pregnancy and make women get abortions in secret, even in unsafe places so that society won't know and talk about them.

Likewise, society's influence as a barrier on a large scale was also explicitly discussed. Along the line, one participant said,

> *It is needed of course! (discussion)… no other woman should be compelled to throw her baby in the forest next… Baby's health, the health of those women who leave the baby and go somewhere, premature delivery, maternal mortality and all. So, for all this, discussion should be there. (Participant 7)*

Moreover, in the societal context of Nepal, 'women for women' essence was implied as both positive and negative in terms of sexual and reproductive health behaviour in this study. There seemed a widespread reluctancy to accept the reproductive health issues, especially of unmarried females among women in the society. The fear of what other people will say revolved around the stigma spread by women themselves. One participant put it as,

I think it is us ourselves who are pushing those women to go for unsafe abortion to save her future life in society. We ourselves get judgemental and guilty about intimacy and sex that it is difficult to grow open-mindedness in the community. We women ourselves are putting each other down by talking bad about each other. (Participate 1)

The negative attitudes and lack of openness to talk, listen and comprehend the needs and problems about sexual and reproductive health issues makes the misinformation spread more quickly. Hence, the participants advocated for openness in discussion with family, teachers in school, health professionals and society to create a safe space. One participant admitted that if she had these discussions earlier, she would have much more knowledge and help her decision-making rather than only researching in websites. Another participant shared similar suggestion as,

Education should start much earlier. Also, to avoid child molestation, teenage rape and pregnancy, the education about reproduction and sexual health is important. At a certain level, parents themselves should teach children about these things about what is okay and not and how to talk about sexual and reproductive problems. If this will continue then our society will grow slowly, and things will be normalized. It is going to take time. All things should slowly grow as we go along. It is a long process. I think our generation can make it. It is not only government and policies, it's the society that will take years to change. (Participant 1)

The interview discussion ended with participants suggesting various ways to start the initiation of discussion about unmarried women's sexual health needs. Many suggested education to be the foremost step. Others were awareness and education through school curriculum and its effective implementation, creating space for discussion as any other health issue in schools, family and with health professionals, normalize advertisement and clear information through media and social websites, workshops about services and its significance targeted to teenagers, youths and parent's generation. As one participant said,

So, when it is discussed and normalized...then only will people be more accessible to safe abortion. Like accessible for real. (Participant 7)

This section provided a comprehensive rich data finding from the interview data set. There was an active participation and open discussion with the participants which contributed

in highlighting main issues related to sexual and reproductive health in Nepal, focusing on safe abortion. These were perceptions and attitudes towards premarital sex, contraceptive and unwanted pregnancy, and abortion. Further, the participants discussed on how societal control and maneuverer such as marriage, family obligations, gender role, and autonomy effects on decision making and health seeking behaviour of young unmarried women. The following discussion chapter will further interpret these themes.

CHAPTER 8: DISCUSSION

The objective of this study was to explore the perceptions and attitudes of premarital pregnancy, and induced abortion among educated and unmarried Nepalese women. Also, it was aimed to understand the morality, socio-cultural impacts, and identifying barriers and suggestions for safe and compatible use of abortion services in the Nepalese context. To meet these objectives, in-depth interviews were done. The findings were analysed and interpreted guided by two domains of the conceptual framework on trajectories of women seeking abortion- related care. Though the framework incorporates women seeking abortion care and their trajectories, the finding from this study about how unmarried women's perception on abortion are situated in wider context can be implied through this framework as well. This study found that unmarried Nepalese females have varying perceptions depending upon the context. The majority of the participants valued their own decisions and choices despite existing socio-cultural norms of the society they belonged to. The socio-cultural norms, gender inequities, legal setting and illegal practices, information source, health providers' attitudes and their own knowledge and perceptions of being unmarried educated women seemed to influence safe and compatible sexual and reproductive services in Nepal. The participants shared their opinions, experiences, and stories that formed a foundation for future changes and needs.

We can see from the core findings and interpretation of the data -set that the participants in this study were approachable and explicitly open to discuss sexual and reproductive health issues. Unlike the premonition that I, as a researcher, had at the beginning of the study about restriction in sharing opinions, the participants were actively engaged and enthusiastic to explore the aspects that the interview covered. Many participants admitted that they had never discussed or thought in-depth about the issues of safe abortion for unmarried women. They were highly interested to be able to partake in initiating an open discussion platform through participation in this study. Although for generations it has been widespread that women should not be allowed to speak for their own health needs, the easiness and enthusiasm while discussing by participants in this study gives a positive reinforcement for these kinds of studies.

Individual context

This domain incorporates individual women's circumstances that lie within the wider context of macro-level structures which influence the trajectories for abortion-related care. To understand how premarital sex, pregnancy and abortion are perceived among unmarried women, their understanding of individuals' role and contexts is important. The participants in this study present their individual characteristics and situations and describe how their position links within the wider context of their society. The participants in this study had diverse backgrounds in terms of work and study experience, community/ regions they belonged to, relationship status, and engagement with wider networks. While being unmarried Nepalese females, educated and migration abroad from Nepal were common grounds shared by the participants to meet the objectives of the study. Such circumstances and perception of the participants are interpreted below.

A common phenomenon, but unmet utilization

In this study, participants considered sex as a basic need and recognized the increasing age gap for marriage naturally increasing sex drive and involvement in premarital sex which is consistent with other studies (Greenspan, 1992; Hald & Sondergaard, 2014; P. Khanal, 2013; Puri, 2001; Regmi et al., 2007). They expressed no other form of judgement or negative attitudes about premarital sexual involvement. However, they acknowledged the deep-rooted existence of socio-cultural norms and regulations women are bound to follow. This was similar to many previous research studies done in Nepalese society where they found that premarital sex was indeed a common practice among youths but was still stigmatized by the society (Adhikari, 2009; Hald & Sondergaard, 2014; Menger, Kaufman, Harman, Tsang, & Shrestha, 2015).

Most of the participants agreed that the society does not define a standard for men unlike for women regarding their sexual behaviours. It was noted that men buy contraceptives for themselves, or for their partners, especially when they are unmarried. As one study in Nepal suggests condoms and injectables to be one of the preferable forms of modern contraceptives (Baatsen, Jahan, & Subedi, 2018) these forms of contraceptives were also commonly mentioned by participants in the present study. Even though the participants' familiarity with knowledge and awareness of contraceptives was admirable, they voiced the concern of unmet utilization and knowledge of contraceptives by many youths. This

supported other studies regarding low contraceptives utilization by Nepalese population (Berin, Sundell, Karki, Brynhildsen, & Hammar, 2014; Khanal, Joshi, Neupane, & Karkee, 2011; Shrestha et al., 2018). This contributes to the unmet contraceptive need among adolescents, leading to unintended pregnancies, and possibly resorting to unsafe abortions despite the efforts and provisions by the policy developers in the country.

Autonomy and independence with social negotiations

According to participants in this study, they were ambivalent to decide whether to support abortion based on its possible health risks. Importantly, women's' autonomy to decide for abortion was mainstreamed. They were aware of the existing pressure of societal norms and values despite the individual self being liberal and accepting. Although the participants held no opposition to premarital sex as long as it was safe and with consent; they shared a common concern for any unmarried females not become pregnant or have abortions. One participant expressed that this situation is taken as a crime in Nepalese society. Many others justified this with the physical, mental, psychological, and social trauma and possible abandonment by family and/or society following premarital pregnancy and abortion in Nepal. These personal and social consequences of unsafe abortions on young women were described in other studies as well (Bankole, Singh, & Haas, 1998; Bennett, 2001; Hald & Sondergaard, 2014; Kebede, Middelthon, & Hilden, 2018).

As for the participants in this study, abortion decision making would largely depend on individuals' life trajectories as well as the societal context they were in which also complemented the findings by Puri et al. (2002) among married Nepalese women about abortion. Even though safe abortion had been widely available in the country for two decades at the time of the study, adequate knowledge and utilization of services among women was significantly lacking as in other studies done in Nepal (Puri et al., 2015; Thapa, Neupana, Basnett, Ramnarayan, & Read, 2012). In this study, the participants' knowledge about abortion seemed to be shaped by the myths and stories they knew related to abortion. A lack of adequate information and misinformation was very evident with the way participants described abortion and how it was done. In the country where abortion law was liberalized two decades ago, information like cutting all the limbs of foetus to abort, infertility after abortion, serious reproductive health problems, life-long pain, and deaths after abortion were the events and stories in the society the participants had heard associated with abortion.

Abortion myths and related misinformation are common in societies with restrictive abortion laws and culture (Kumar et al., 2009). This was apparent in this study as well.

This lack of proper knowledge resulted in ambivalence in participants' support for or against abortion. Their sources of information were mostly social media and stories they heard from their networks. They also argued about the illegal practices and black market of abortion drugs (Mifepristone and Misoprostol) happening in the country, which is common in the context of Nepal (Kc et al., 2021; Shrestha et al., 2018). Overall, the perception of premarital abortion was narrowed down by general concern associated with health risk when deciding to choose for abortion, regardless of any other factors. This signifies the role of community and society as one that shapes the individuals' understandings and communicates proper information about abortion.

Concerning moral aspects of abortion, one participant in this study thought it was a necessity relating to cultural and religious reasons. She explained that to avoid the cultural and religious struggle and defaming that an unmarried female would have to go through in the society due to their abortion, or merely engagement in premarital sexual activity, choosing abortion, and if possible in a clandestine place was a better choice. This was consistent with other studies which voiced the role of culture and religion leading to unsafe abortions in Africa and Asia (Macleod, Sigcau, & Luwaca, 2011; Whittaker, 2010).

Moreover, the status of being mentally ready, financially stable, work/ career focused, and willing to give birth or start a family right away were the core focuses of the study participants for deciding on the appropriateness of abortion. While the questions of *What will people say? What if they tell it to someone else or their parents? How will they judge? How will I face them?* were fears mentioned by the participants whether to receive an abortion and where to seek it. This fear to save self- dignity, family prestige and chances for one's future might lead to unsafe and clandestine abortions. This was also supported by other studies in communities with strong moral discourses of abortion (Ciren & Fjeld, 2020; Hald & Sondergaard, 2014; Kebede et al., 2018). Distance to travel to achieve the services was not discussed explicitly by the participants unlike other studies in Nepal where long distances to reach services was considered as an important barrier for women living in rural areas (CREHPA, 2006). This may be attributed to most participants' location in city areas, allowing them to access reproductive health services in their proximity.

The phenomena of teenage pregnancy and unmarried women undergoing abortions are not uncommon in Nepal (Hald & Sondergaard, 2014; Kc et al., 2021; Puri et al., 2012). Similarly, regardless of personal perceptions or the knowledge and information the participants had on abortion, it was clear that they knew abortion was happening among teenagers and unmarried women in Nepal.

Improved position of Nepalese women

The participants in this study were educated unmarried women who migrated recently from different parts of Nepal to Norway for higher education. This was a part of an increase in female migration abroad independently, showing changing patterns of migration and improvement in female liberty (Vohra et al., 2019).

Dhungel (2019) reported an increase in women's aspirations for social and physical mobility specifically for personal development in recent years, irrespective of marital status. The participants in our study as well stated to have expanded their acceptance and broadened their mindset towards values and norms about sexual and reproductive rights and needs compared to while they were in Nepal. One participant described that she practices her liberty to its full extent in European society where she feels she is not judged based on trivial criteria such as her relationship status, wardrobe, being friendly with men or merely being a woman. At the same time, she also admitted that she didn't talk about how she lives here and often avoids such conversations with her family and some friends. She attributed it to the conservative concept in Nepali society which believes that women get off track when they migrate alone, unmarried.

Interestingly, the strong debate of saving the lives of women or foetuses relating to abortion was not present in the conversations with the participants in this study. There was an ambivalence on the decision based on women's health risk due to abortion. As described by Rye and Underhill (2020) the majority of the participants in their study fell under the intermediate group of situationists who did not fall explicitly into pro-life or pro-choice attitudes (Rye & Underhill, 2020). This situationist concept was also present among the participants in this study. A possible reason explaining the ambivalence among the

participants in this study may be Nepalese women's attempt to position and prioritize themselves in the long-held patriarchal society and progressive liberal perceptions.

The tangled relationship between progressive modern women who want to make right decisions for themselves but are still bound by societal expectations from them was reflected in the interviews. It was evident that the participants in this study who are educated, unmarried, skilled, and independent women, were carefully trying to position themselves in the Nepali society which was apparent in their perceptions and attitudes. This state of constant negotiation with society regarding sexual behaviour was also summarized in other studies including an investigation of unmarried young women in Ethiopia (Kebede et al., 2014) and educated modern women (Dhungel, 2019) as well as marginalized groups of women with less education and opportunities in Nepal (Kc et al., 2021).

What constitutes 'Safe abortion' for unmarried women in Nepal?

Induced abortion or abortion in general carries a negative notion in the Nepalese society, especially when it comes to unmarried women (Andersen et al., 2015; Hald & Sondergaard, 2014). Nonetheless, safe abortion was considered as a much-needed issue to be discussed, mainstreamed, and executed by the participants in this study. Five headings were derived from the understanding of need and expectations on safe abortion for unmarried women. In the context of having full political and governmental support for safe abortion, the participants described what might constitute feeling safe for themselves when it comes to abortion while unmarried in Nepal.

The primary concern was for it to be personal safety. A study in India showed that unmarried women are usually not the part of decision-making for abortion (Jejeebhoy et al., 2010). Having autonomy, privacy, confidentiality, and liberty to exercise one's own sexual health rights were of core focus by the participants in this study. The significance of privacy and confidentiality are highlighted in other studies as well (Jejeebhoy et al., 2010; Puri et al., 2012).

Medical safety was considered when unmarried women could access abortion with no health risks, with certified and licensed professionals, safe medical procedures, and care. Importantly, attitudes of health professionals to be judgement free and transparent while

providing services was emphasized by the participants. This narrative supports the study done by Puri et al. (2018) on providers' perspectives for safe abortion in Nepal where they summarized the importance of abortion law knowledge, adequate training, and value clarification training of health providers for easy access of abortion services and information by women. Health professionals have a huge social responsibility to educate, gain trust and support women to claim their human rights and health rights (Fathalla, 2020).

According to NDHS (2016) three-fifths (59%) of Nepalese women aged 15-49 years did not know about abortion laws and 52% did not know about a place for safe abortion in Nepal. Almost all the participants in our study advocated for legal safety to be an essential component and the majority had knowledge about the legality of abortion and supported it like the participants from Hald and Sondgaard (2013) study on community perspective on unmarried women seeking abortion. The significance of legal regulations for safe abortion care and services has always been relevant (Bearak et al., 2020; Fathalla, 2020; Ganatra et al., 2017; Singh et al., 2018). One's education level also affects their knowledge on abortion laws and services, which may be the reason for adequate knowledge about the abortion law among participants in this study.

Moreover, socio-economic factors are considered as one of the barriers to access safe abortion services (Rogers et al., 2019), as reason to seek abortion among unmarried women (Guillaume et al., 2018), and low economic conditions leading to less knowledge, unsafe abortions or seeking alternatives especially in rural and remote places (Puri et al., 2012). Likewise, the participants in this study mentioned being financially stable themselves and everyone's ability to afford safe abortion services as an essential.

Finally, the most difficult and controversial issue worldwide when it comes to abortion, to be socially safe (Kebede et al., 2018; Kumar et al., 2009; Macleod et al., 2011; Puri et al., 2012; Puri et al., 2015; Singh et al., 2018) was explicitly noted by the participants in this study as well. One participant expressed her worry of how society is quicker to develop negative attitudes and judge other women who abort their children or give birth and leave them in the jungle. While they never discuss how she should have gone about receiving a safe abortion or protect herself and the child's health or what possible issues might had made her take that path. She reflected on the ridicule of the society where female goddesses are worshiped for being strong, powerful, and vibrant, while on the other side, women are

constantly struggling to position themselves in the society which has also been noted by other authors (Bhat, 2016; Sarkar, 2014). The participants also stressed the enormous role of socio-cultural impacts on the continuation of abortion stigma and tendency to seek unsafe or clandestine abortions by unmarried women as reported in other studies as well (Kebede et al., 2014; Kebede et al., 2018; Kumar et al., 2009; Puri et al., 2016); thus, highlighting social safety as the most significant aspect of abortion where legal services are available.

Collectively, the participants suggested physically, mentally, psychologically sound, and importantly, socially safe platforms to utilize available services. Most of them said that as youths nowadays are sexually active, they were worried that many may have wrong or half knowledge about critical issues of safe sex and contraceptive use. This can lead to the harmful consequences of teenage pregnancy, early or forceful marriage, and coercive or unsafe abortions in a context like Nepal (Hald & Sondergaard, 2014; Kafle et al., 2010; Rogers et al., 2019). Thus, the present findings signify dissemination of knowledge and awareness to initiate normalizing the discussion and acceptance of safe abortion in this society.

Societal and (Inter)national context

The macro- level domain of the context where women and their understandings are based on prevailing social and national structures are described further in this section. The different phases and circumstances that women encounter to exercise given legal rights to abortion are explored. As the participants were from low-income countries, rich in socio-cultural values, and migrating to European society, strong political bases for their perceptions about abortion were not apparent. Rather, exclusive discussions on social control and ways to manoeuvre to fit into socially defined standards were focused upon.

Legal yet unsafe: Social control and manoeuvring

Social atmosphere

The language and wordings used to express about abortion shape individuals' perceptions, attitudes, and lifestyles within the society (Kumar et al., 2009). This phenomenon that contributes in abortion stigma was also evident in this study. One participant explained how phrasing of the word sex in Nepalese society has enormously taken the space for opening positive discussions. She explained that denoting sex or sexual activity

using words such as '*foor kura'* which literally means *dirty thing* can carry negative meaning. Also, defining abortion understanding as *'bachha falney'* (throwing baby out of womb) conveys a negative meaning of the process making it difficult to normalize and initiate healthy discussions. It has narrowed down the flexibility and acceptance about sex and abortion. This might reflect a continuation of sensitization related to even talking about sexual activity, needs, desires and problems. This context was also mentioned in the study discussing myths and misconceptions of abortion among Nepalese women (Thapa, Karki, & Bista, 2009).

Kebede et al. (2014) discussed how young unmarried women were expected not to discuss their sexual behaviour and experiences with their mothers and society as a naturalized gesture of respect and regards towards others. She explained the unmarried women in Ethiopia negotiating silence as an expression to acknowledge one's action as a shameful mistake that should respectfully remain hidden. Likewise, in this study, participants discussed how the negative phrasing and language used to denote sex promotes stigma and forbids unmarried women from talking about it. The participants said that it would reflect one's being off track and ruin their image of being 'eligible and decent women' in the society.

In Nepalese context, utilization and accessibility of contraceptives is largely driven underground within societal regulation and practices (Adhikari, 2009). The unmet contraceptive need results in unwanted pregnancies (Shrestha et al., 2018) that might or might not result in abortion. The difficulty in accessing and discussing contraceptives was narrated by this study's participants as well. The double standard of society and its norms was reflected in quotes such as "*Contraceptives are there…it's nice and important and everybody knows it...but because it's not socially talked about and accepted…you still have to fight with the dilemma"*. This shows the interrelation of social roles with individual decision making.

Gender roles and inequities

The participants described patriarchal influences and gender relations that form the base for shaping the perceptions, attitudes, and regulations in Nepali society mirroring practices in other Asian and African countries (Kebede et al., 2018; Kumar et al., 2009; Whittaker, 2010).

As all the participants in this study were unmarried, the constant battle of employing feminism and independent choices with the unspoken obligation to fulfil long-held socio-cultural norms was noted. Regardless of their individual perceptions or education level and experience, participants admitted that their duties towards family and society were defined and they were bound to follow. This was typically not an obligation for their male counterparts. This was similar to reports by Dhungel (2019) where unmarried women had to return home from abroad for marriage, enforced by their families against their will. It showed that purity, character, and value of a female and even her parent's upbringings are measured based on socially set disciplines and moral standards rather than education or career. The participants in this study also described the role of gender which created the difference in sexual and reproductive needs and freedom between men and women. They described that slut-shaming, devaluing women's dignity, judgement, and disapproval were casual and widely accepted reactions from the society towards unmarried women going for abortion or engaging in premarital sex, while men proudly shared their sexual behaviour without hesitation. These negative reactions and belittling of women based on their sexual activity and consequences by both men and women in communities are evident in other studies done in Nepal as well (Hald & Sondergaard, 2014; Puri et al., 2007).

The understanding of societal perceptions as a major barrier was expressed by all the participants. Their thoughts regarding their counterparts, - educated men in modern society, and their understanding of how men respond to issues like this gave interesting reports. Many participants agreed that men engage in premarital sex often irrespective of cultural or social restrictions. This was believed to be limited to males, supporting other studies done among Nepalese youths (Adhikari, 2009; Khanal et al., 2011; Puri, 2001). Interestingly, a few participants narrated the hypocritic duality given by the same men on practical basis who still follows beliefs of judging women who engage in premarital sex and choose virgin women when it was their time to marry. These might also be responsible for hindering positive progression towards liberty and feminist causes of women in Nepal.

Additionally, while the participants recognised the influence of the patriarchy, interestingly, a few of them shared how women themselves tend to spread the stigmatization of women's open sexual expression in Nepali society. Middle aged women, neighbour aunties and female relatives were mentioned as those to be careful of as the participants

understood them to spread negative images and judgements of women. This was unlike the study by Hald and Sondgaard (2013) where predominantly men had negative social attitudes towards unmarried women's abortion. As directed in this study, this atmosphere might lead to fear and oppressive decision-making resulting in undesirable consequences such as discrimination, add patriarchy, difficulty in open discussion and creating safe space, women seeking clandestine health services, mental health issues such as depression, suicides and many more. The negative consequences for unmarried women in unsupportive societies are also supported by many other studies (Ciren & Fjeld, 2020; Hald & Sondergaard, 2014; Kumar et al., 2009; Macleod et al., 2011).

Changing social roles

The participants discussed the changes in social roles among themselves despite the confined atmosphere to express their needs and opinions. They admitted the comfort to share and discuss premarital sex, contraceptives or help in case of premarital pregnancy or abortion with peers rather than with family members. The inclination to confide in peer groups rather than family when it comes to sexual and reproductive behaviours were also noted in study by Adhikari and Tamang (2009) among young men in Nepal. Unlike studies showing peer influence/ pressure resulting in increasing sexual activity among youths in Nepal (Adhikari & Tamang, 2009; Regmi, Simkhada, & Van Teijlingen, 2010), participants in our study described their own opinions about decisions to engage in premarital sexual activity. They also admit that peer support was not adequate and sometimes may be misleading since peers share similar societal contexts and levels of knowledge. This may influence them to take a secondary path, which might be harmful to their physical, mental, and psychological wellbeing only to protect their social image. These consequences were also discussed in study by Kebede et al. (2018) on Ethiopian unmarried women's negotiation with society on premarital abstinence and abortion decision making.

Marriage as a checkpoint and a solution

The institution of marriage is a strong practice worldwide that often abides by religious and cultural bindings (Thapa & Kattel, 2019). In this study, the participants admitted that their families and communities in Nepal consider the institution of marriage as an integral duty of all females to fulfil when they attain a certain age, similar to study by Dhungel (2019). The participants said that expressing sexual and reproductive health issues

after marriage, irrespective of age, was socially accepted. It supported the findings of Thapa and Kattel (2019) that marital bonds approved by society were established to control and regulate the sexual practices of humankind. The participants expressed that the first and most common resort of Nepali families and society regarding premarital pregnancy was to make the woman marry the man who had impregnated her, regardless of woman's choice or will. The prime reason for this act, as per our participants described, was families trying to maintain the respect and dignity in the society and to avoid ill-naming and disruption of the future of the woman and her family. This may also be one of the reasons for the occurrence of early marriage and early pregnancy among Nepalese women.

In Nepal, women's decision-making was mostly handled by families if they are unmarried (Dhungel, 2019), and by their partners when they get married (Puri et al., 2007). Likewise, unmarried women were bound to adjust within defined norms set by their local society in Nepal (Dhungel, 2019; Hald & Sondergaard, 2014). In this study, a few participants discussed how the use of contraceptives were also affected by one's marital position as they mentioned, women prefer long term contraceptives when they are married and are open to talk about them and access them themselves. The participants admitted the atmosphere of ease in discussion about contraceptives with family and health providers when women get married. Also, to get contraceptives, deceiving society as being married by using symbolic representation like '*sindoor '* or getting them from foreign places where nobody knows them was also noted to be common practice in the restrictive society of Nepal. This shows that women are trying to find their way around existing norms, carefully navigating their needs and activities.

Moreover, our participants also shared that if marriage was not an option, families try to terminate the pregnancy in secret, so that others won't become aware of it. Shrestha et al. (2018) reported that families and even spouses of abortive women are stigmatized and perceived badly in Nepalese society, which supports this study participants' concerns as well. Another option was women themselves trying to hide from family and society to avoid negative responses and backlash. The future prospect of marriage is often compromised for these unmarried women, if found undergoing abortion, having a child out of wedlock, or merely not abstaining from premarital sex. These concerns were also faced by unmarried women in Ethiopia (Kebede et al., 2018) and the neighbouring country Lhasa (Ciren & Fjeld, 2020) where socio-cultural norms and religion enormously regulated societal practices. This

might also be contributing to prevalence of unsafe and clandestine abortions in Nepal, irrespective of liberal laws and free, safe abortion provision.

Societal changes and adjustments

Nepalese society has experienced many social and cultural transformations with progressive development and modernization (Dhungel, 2019; Thapa & Kattel, 2019). Changes and adaptations on various gender- specific rules and norms have taken place in recent years (Lundgren et al., 2013). However, when it comes to sexual and reproductive issues, these adaptations seem to take a slower progression (Baatsen et al., 2018). The participants mentioned the dilemma of being social animals themselves, to be able to fit in the society and the struggle to voice their concerns and needs amidst the lingering stigma about abortion and other sexual health issues. Here, we can understand the simple yet complex dynamics of societal roles in individuals' choices and perceptions.

Moreover, the participants noted that the teenagers are actively engaged in sexual activities, hugely due to changing patterns of society and media influence. They accepted that their society was open to embrace modern/ western life choices, yet they struggled to balance the cultural notions of liberal practices that come along with it. The general increase in knowledge and use of contraceptives was admitted by the participants compared to earlier times which was consistent with one study where the prevalence of use of contraceptives was estimated to have doubled in the last 20 years in Nepal (Baatsen et al., 2018). The recurring information about the availability of contraceptives in all the pharmacies, health posts and even in some regular shops and supermarkets showed an encouraging path to where Nepalese society was heading. Also, a significant number of participants discussed the contraceptive availability and openness in the Western/ European context and admired it. The distribution of condoms in colleges and universities and people openly embracing the need of contraceptives was mentioned. However, some also acknowledged that this swift openness does not fit in with the societal context back home and needs to progress slowly in Nepal for better adaptation.

An important issue discussed was of compulsory sex education in schools, but on the other hand, the tendency to skip this chapter or leave it for self-study and no discussion, shutting down the queries of anything related to it by parents or family, tendency of students

themselves to make fun of the subject were also some problems mentioned by the participants. These reluctancies even in presence of a compulsory sex education curriculum was also mentioned in other studies (Menger et al., 2015; Pokharel, Kulczycki, & Shakya, 2006). This showed the differences in step of society toward progression as well as reluctancy to accept change resulting in a lack of comprehensive sex education.

One participant stated that due to a lack of open discussion about sex and contraceptives, the cases of rape, crime, and unsafe abortions were happening which affects the lives and futures of women. It was felt that the participants were bothered by the ignorance of society to turn a blind eye to the significance of opening and discussing in the name of culture and societal values. Although the society knows its benefits and importance, the general silence of not talking about anything related to sex was clear. These issues of societal roles in sexual health and behaviours were also mentioned in other studies (Hald & Sondergaard, 2014; Kebede et al., 2018). It was noticed that though modern society was paving its path, the cultural and societal values have lingered all along halting the progression of change. This view was echoed by many participants as they acknowledged that groups and societal values are determined more than literacy and awareness in the Nepalese context.

Like other studies done in Nepal (Adhikari & Tamang, 2009; Andersen et al., 2015; Hald & Sondergaard, 2014; Menger et al., 2015; Puri et al., 2016; Regmi et al., 2010; Yogi et al., 2018), on the positive note, all the participants stressed the need of strengthening education and awareness of contraceptive and safe sex practices among all. The participants focused especially on youths to avoid future negative consequences for their mental, physical, psychological, and social health and wellbeing. It was suggested by some that parents or family should be responsible mainly to initiate these discussions, while others also emphasized on schools, teachers, and curriculum to have equal role. Few of them also mentioned the role of multimedia, internet, the government, and NGOs programs to highlight this issue. In addition, they enforced that the important step to avoid unwanted pregnancy and abortion for unmarried females is to have adequate information and create a safe space to discuss about it within family and society. Nevertheless, they were also hopeful that this generations' parents and that the coming generation will be more open to discuss and learn about safe sex, contraceptives, and abortion services.

CHAPTER 9: METHODOLOGICAL CONSIDERATIONS

Limitations of the Study

This study was aimed to explore and understand the perceptions and attitudes on premarital pregnancy and induced abortion among educated unmarried Nepalese women living in Norway. The experience of unmarried women seeking abortion-care and their decision-making trajectories were not covered by this study. The rich description of premarital sex, contraceptives status, and premarital pregnancy contributed to in-depth understandings about safe abortion perceptions among these women. Although the study sample was comprised of educated unmarried women themselves, being the central sample of the study, triangulation using other groups such as their counterparts- unmarried males, community members, healthcare professionals, and family members would have strengthened the findings by providing a more comprehensive status of the context. The responses from the other side to support or challenge the participants' perceptions would have been insightful. More focus on the role of health systems and individuals' experiences within them were not covered with the participants in the interviews, which could have provided a comprehensive picture of the practice.

To comply with travel restrictions due to COVID-19, the original plan to travel to Kathmandu, Nepal and including young unmarried women for the study was halted and the researcher had to change the planned data collection methods of this study. Focus group discussions among health professionals working in different sectors in abortion-care in Nepal were also not possible, which would have been beneficial to complement the findings and better understand the context.

The participants are women living in Norway who do not share the similar contexts and experiences, cultural exposures, societal acceptance, liberal practices and easy access to reproductive health services compared to other unmarried women in Nepal who have not travelled abroad or are in rural parts or in different circumstances. This limits the generalization of study findings.

Recruitment was conducted using personal networks and snowballing posed both a limitation and a strength. It might have limited the probable heterogeneity of the sample but

on the other hand, familiarity with the network helped me build good rapport with the participants given the sensitivity of the topic.

Strengths of the study

There are limited studies published about unmarried women and their perceptions of sexual and reproductive health issues in Nepal amidst the societal progression and cultural norms. Given the sensitive nature of the topic and themes, the researcher provided adequate and frequent assurance for confidentiality, given space to answer any questions and tried to build strong rapport with the participants. This helped in overcoming limitations of reluctance to open for discussion, which is highly notable. This suggests that unmarried women are approachable for research studies on these sensitive issues, given adequate preparation and assurance beforehand. Also, so as not to lead or force the participants to share personal experiences, interview guides and probes were presented meticulously using open-ended questions. There were minor deviations in translations of the scripts due to self-translation of interviews and fieldnotes from the original language, minimizing the risk of misinterpretation as there might be with a translator. However, the potential bias of the best translation as with professional translators are acknowledged. Audio recordings and feedback loops from some participants on transcripts ensured that direct quotes used as excerpts were accurately reflected. The anonymous finding excerpts were discussed with classmates from different ethnic and educational backgrounds to get their insights on coding and analysis. This helped in improving the credibility of the findings and interpretations.

The rich descriptions and varied responses given by the participants in detail and as the participants' descriptions and settings were described in as much detail as possible, hence, transferability of the study methods to other similar contexts may be easily determined.

Implications and Recommendations for future studies

Based on the findings and responses by the women in this study other research including experiences of unmarried women undergoing abortion decision-making, service seeking, and post abortion care seem feasible, given adequate assurance and confidentiality beforehand. It was noted that these educated and unmarried women want their voices to be heard and are optimistic to open discussion and future changes. In addition, programs and efforts specifically focusing on youths need to be strengthened. Monitoring and

implementation of comprehensive sexual and reproductive health rights and education in school curriculum is emphasized. These findings suggest that programs that promote the involvement of community in normalizing discussion, mitigating misinformation, myths and stigma about sexual health and behaviour, including abortion could be beneficial. Also, value clarification trainings and inclusive service attitudes among health policy makers, service providers and all stakeholders are critical in improving Nepalese women's access to contraceptives and abortion related care.

Future studies may investigate the experiences and trajectories of navigation and challenges among unmarried women undergoing abortion care in Nepal. Studies focusing on sexual and reproductive health policies and service utilization and barriers faced by unmarried women undergoing abortion could enhance understanding of the gap between law and practice. Also, research studies addressing differences in the geographical situation in Nepal, education and empowerment among Nepalese women and its impact on sexual and reproductive health could provide robust insights.

CHAPTER 10: CONCLUSION

The study aimed at exploring perceptions and attitudes of premarital sex and its consequences, premarital pregnancy, and abortion. The expectations for safe abortion services, socio-cultural influence and barriers felt and suggestions for safe abortion services in Nepal among educated unmarried Nepalese women living in Norway was also explored. Participants acknowledged the increasing trend of premarital sex among youths in Nepal. The participants had adequate knowledge and acceptability about premarital sex and contraceptives while the gap due to unmet needs and utilization of contraceptives resulting unwanted pregnancy and abortion was recognized. Engaging in marital bond was considered as a resort to manage unwanted pregnancy by families and society in Nepal. There was general ambivalence among the participants in support to undergo abortion concerning health risks rather than cultural or religious factor for young unmarried women. However, socio-cultural influence, gender inequalities and discrepancy in unmarried women seeking abortion and reproductive health care services was apparent. Personal, medical, legal, financial, and social safety was of paramount importance considering safe abortion for unmarried women in Nepali context. Education, empowerment, and independence among Nepalese women and their optimism for gradual change in society was reflected in their perceptions and attitudes. The individuals' position and needs were clearly regulated and influenced by the wider context of socio-cultural norms and the health system environment. Further, incorporating unmarried women in informed, inclusive, applicable, and sustainable policies and programs for safe maternal and reproductive health outcomes in the long term were emphasized in the study.

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APPENDICES

Appendix A- Informed consent and Information sheet (English)

***adapted from the Norwegian Regional Ethics Committee informed consent template**

Are you interested in taking part in the research project? 'Safe abortion for unmarried women'-Perception and attitudes on induced abortion among unmarried Nepalese women living in Norway: A qualitative study

This is an inquiry about participation in a research project where the main purpose is to learn about the perceptions and attitudes about abortion among educated unmarried Nepalese women, currently living in Norway. In this letter we will give you information about the purpose of the project and what your participation will involve.

Purpose of the project

I am Sewika Sulpe and I am a student in the Master programme in *International Community Health* at the University of Oslo. As a part of my master program, I am conducting a study that aims to learn about perceptions and attitudes that educated unmarried Nepalese women residing in Norway have about premarital induced abortion and abortion services in Nepal. Since 2011, women above 18 years of age has the right to decide for herself to choose abortion services legally in Nepal. However, premarital sex, pregnancy and abortion remains a sensitive issue in Nepalese society. I want to learn about unmarried women's perception and attitudes towards abortion, but also about premarital sex, pregnancy, and use of contraception. I believe that knowing more about the perceptions and concerns of unmarried women themselves can inform the discussions about safe abortion services in Nepal.

Who is responsible for the research project?

University of Oslo is the institution responsible for the project.

Why are you being asked to participate?

We are recruiting twenty unmarried and educated Nepalese women under the age of 30 living in Norway. You are being invited to take part in this research because you fit these inclusion criteria and we would like to ask you to share your thoughts and ideas about premarital sex, pregnancy and abortion with the research team.

We have asked Nepali Students Association in Oslo (NESCO) to help us approach potential participants, and we are also recruiting through our own networks in Norway.

What does participation involve for you?

If you choose to participate in the study, you will be asked to take part in a one-to-one in-depth interview with me. It will take approximately one hour. The interview will be done in the Nepali language and be recorded on tape (accessible only to me, Sewika Sulpe). Everything you say will be confidential. We would request you not to mention specific name or detail of anyone that comes up during our interview. When we transcribe the interview, it will be anonymized, and the tape recordings will be deleted.

Participation is voluntary Participation in the study is voluntary. If you chose to participate, you can withdraw your consent at any time without giving a reason. All information about you will then be

made anonymous. There will be no negative consequences for you if you chose not to participate or later decide to withdraw.

Your personal privacy – how we will store and use your personal data
We will only use your personal data for the purpose specified in this information letter. We will process your personal data confidentially and in accordance with data protection legislation (the General Data Protection Regulation and Personal Data Act).
• All the information will be kept in Services for sensitive data (TSD), the password- protected secure computer platform provided by the University of Oslo.
• The information that we collect from this study will be kept private. Any personal information about you will be replaced by a number. Only I will know what your number is, and I will secure the identification key in TSD. The information will not be shared with anyone.
• No personal data will be made recognizable upon publication of the study.

What will happen to your personal data at the end of the research project?
The project is scheduled to end 31.12.2021. When the project ends, all the personal information collected will be anonymized and the identification key will be deleted, personal data will be removed, and the tape recordings will be deleted.

Your rights
So long as you can be identified in the collected data, you have the right to:
- access the personal data that is being processed about you
- request that your personal data is deleted
- request that incorrect personal data about you is corrected/rectified
- receive a copy of your personal data (data portability), and
- send a complaint to the Data Protection Officer or The Norwegian Data Protection Authority regarding the processing of your personal data

What gives us the right to process your personal data?
We will process your personal data based on your consent.
Based on an agreement with University of Oslo, NSD – The Norwegian Centre for Research Data AS has assessed that the processing of personal data in this project is in accordance with data protection legislation.

Where can I find out more?
If you have questions about the project, or want to exercise your rights, contact:

- University of Oslo (Institute of Health and Society): Heidi Fjeld (Project supervisor) by email: h.e.fjeld@medisin.uio.no or Phone: +47 22850603 and Sewika Sulpe (Student) by email: sewika.sulpe@studmed.uio.no or Phone: +47 96707583
- Our Data Protection Officer*:* Roger Markgraf -Bye Phone: +47 90822826
- NSD – The Norwegian Centre for Research Data AS, by email: (personverntjenester@nsd.no) or by telephone: +47 55 58 21 17.

Yours sincerely,

Project Leader	Student
Heidi Fjeld	**Sewika Sulpe**
(Supervisor)	

Consent form

I have received and understood information about the project "Perceptions of unmarried Nepali women on premarital induced abortion. A qualitative study. "and have been given the opportunity to ask questions. I give consent:

- ☐ To participate in in-depth interview.

I give consent for my personal data to be processed until the end date of the project, 31.12.2021 at the latest.

- ----------
- (Signed by participant, date)

Appendix B- Informed consent and Information sheet (Nepali)

के तपाईं अनुसन्धान परियोजनामा भाग लिन इच्छुक हुनुहुन्छ?

« नर्वेमा बसोबास गर्ने नेपाली महिलामा प्रेरित गर्भपतनको धारणा : गुणात्मक अध्ययन"?

हाल नर्वेमा बसोबास गर्दै आएका शिक्षित अविवाहित नेपाली महिलाबीच गर्भपतनसम्बन्धी धारणा र मनोवृत्तिबारे जानकारी लिनु नै मुख्य उद्देश्य रहेको एउटा अनुसन्धान परियोजनामा सहभागिताका बारेमा सोधखोज गरिएको हो । यस पत्रमा हामी तपाईंलाई परियोजनाको उद्देश्य र तपाईंको सहभागिताको बारेमा जानकारी दिनेछौं।

परियोजनाको उद्देश्य

म सेविका सल्प हुँ र म ओस्लो विश्वविद्यालयमा अन्तर्राष्ट्रिय सामुदायिक स्वास्थ्यको मास्टर कार्यक्रममा विद्यार्थी हुँ। मेरो मास्टर कार्यक्रमको एक भागको रुपमा, नर्वेमा बसोबास गर्ने शिक्षित अविवाहित नेपाली महिलाहरूले नेपालमा विवाह पूर्व प्रेरित गर्भपतन र गर्भपतन सेवाबारे गरेको धारणा र मनोवृत्तिको बारेमा सिक्ने उद्देश्यले एउटा अध्ययन सञ्चालन गर्दैछु। सन् २०११ देखि १८ वर्ष भन्दा माथिका महिलाले नेपालमा कानुनी रुपमा गर्भपतन सेवा छनोट गर्ने निर्णय गर्ने अधिकार पाएका छन् । तर, विवाह पूर्व यौन सम्पर्क, गर्भाधारण र गर्भपतन नेपाली समाजमा संवेदनशील विषय रहेको छ । म अविवाहित महिलाहरूको गर्भपतनप्रतिको धारणा र मनोवृत्तिबारे सिक्न चाहन्छु तर विवाहपूर्व यौन सम्बन्ध, गर्भावस्था र गर्भ निरोधको प्रयोगबारे पनि सिक्न चाहन्छु। . अविवाहित महिलाहरूको धारणा र चिन्ताबारे अझ बढी जान्ने हो भने नेपालमा सुरक्षित गर्भपतन सेवाबारे छलफल गर्न सकिन्छ भन्ने मेरो विश्वास छ।

अनुसन्धान परियोजनाको जिम्मेवारी कसको हो ?

ओस्लो विश्वविद्यालय यस परियोजनाको लागि जिम्मेवार संस्था हो।

तपाईंलाई किन सहभागी हुन भनिँदैछ ?

हामी नर्वेमा बस्दै आएका ३० वर्ष मुनिका अविवाहित तथा शिक्षित नेपाली महिलाहरुलाई भर्ती गर्दैछौं । तपाईंलाई यस अनुसन्धानमा भाग लिन आमन्त्रित गरिएको छ किनभने तपाईं यी समावेशन मापदण्डहरू अनुरूप हुनुहुन्छ र हामी तपाईंलाई विवाहपूर्व यौन, गर्भावस्था र गर्भपतनसम्बन्धी तपाईंको विचार र विचारहरू अनुसन्धान टोलीसँग बाँड्न आग्रह गर्न चाहन्छौं। हामीले ओस्लोमा नेपाली विद्यार्थी संघ (NESCO) लाई सम्भावित सहभागीहरुसँग नजिक हुन सहयोग गर्न आग्रह गरेका छौं। नर्वेमा पनि हामीले आफ्नै नेटवर्कमार्फत भर्ती गरिरहेका छौं।

सहभागी हुनुमा तपाईंको लागि के समावेश छ?

यदि तपाईं अध्ययनमा भाग लिने छनौट गर्नुहुन्छ भने, तपाईंलाई मसँग एक-एक गहन अन्तरवार्तामा भाग लिन आग्रह गरिनेछ। यसको लागि लगभग एक घण्टा लाग्छ। अन्तरवार्ता नेपाली भाषामा गरिनेछ र टेपमा रेकर्ड गरिनेछ (मेरो लागि मात्र सुलभ, सेविका सुल्पे)। तपाईंले भन् नुभएका सबै कुरा गोप्य हुनेछन् ।

हाम्रो अन्तरवार्ताको दौडान आउने कुनै पनि व्यक्तिको खास नाम वा विस्तृत विवरण उल्लेख नगर्न हामी तपाईंहरूलाई अनुरोध गर्छौं। हामीले अन्तरवार्ता लेख्दा त्यसको नाम ै खुलाइनेछ र टेप रेकर्डिङहरू मेटाइनेछन्।

भाग लिनु स्वेच्छिक हो?

अध्ययनमा भाग लिनु स्वेच्छिक छ। यदि तपाईंले भाग लिने छनौट गर्नुभयो भने कुनै कारण ै नदिई कुनै पनि बेला आफ्नो सहमति हटाउन सक्नुहुन्छ। त्यसपछि तपाईंको बारेमा सबै जानकारी गुप्त बनाइनेछ । यदि तपाईंले भाग नलिने वा पछि हट् ने निर्णय गर्नुभयो भने तपाईंको लागि कुनै नकारात्मक नतिजा हुनेछैन।

तपाईंको व्यक्तिगत गोपनीयता – हामी कसरी भण्डारण र तपाईंको व्यक्तिगत डाटा प्रयोग हुनेछ

यस सूचना पत्रमा उल्लेखित उद्देश्यका लागि मात्र हामी तपाईंको व्यक्तिगत डेटा प्रयोग गर्नेछौं। हामी तपाईंको व्यक्तिगत डेटा गोप्य रूपमा र डेटा सुरक्षा विधान (सामान्य डेटा सुरक्षा नियमन र व्यक्तिगत डेटा ऐन) बमोजिम प्रक्रिया गर्नेछौं।

- सबै जानकारी संवेदनशील डेटा (TSD), ओस्लो विश्वविद्यालय द्वारा प्रदान गरिएको पासवर्ड सुरक्षित सुरक्षित कम्प्युटर प्लेटफर्म को लागि सेवाहरूमा राखिनेछ।
- यस अध्ययनबाट हामीले संकलन गरेको जानकारी गोप्य राखिनेछ । तपाईंको बारेमा कुनै पनि व्यक्तिगत जानकारी सङ्ख्याद्वारा प्रतिस्थापन गरिनेछ । म मात्र तपाईंको नम्बर के हो थाहा हुनेछ, र म TSD मा पहिचान कुञ्जी सुरक्षित गर्नेछ। जानकारी कसैसँग बाँडिनेछ ।
- अध्ययन को प्रकाशन मा कुनै पनि व्यक्तिगत डाटा पहिचान योग्य बनाइने छैन।

अनुसन्धान परियोजनाको अन्त्यमा तपाईको व्यक्तिगत तथ्यांक के हुनेछ ?

आयोजनाको काम ३१.१२.२०७१ अन्त्य हुने कार्यक्रम रहेको छ । जब परियोजना समाप्त हुन्छ, सङ्कलन गरिएका सबै व्यक्तिगत जानकारी गुमनाम गरिनेछ र पहिचान कुञ्जी मेटिनेछ, व्यक्तिगत डेटा हटाइनेछ, र टेप रेकर्डिङहरू मेटिनेछ ।

तपाईँको अधिकार

सङ्कलन गरिएको डेटामा जबसम्म तपाईं पहिचान गर्न सक्नुहुन्छ, तपाईंसँग यसको अधिकार छ:

- तपाईंको बारेमा प्रशोधन भइरहेको व्यक्तिगत डेटा पहुँच गर्नुहोस्

- अनुरोध छ कि तपाईंको व्यक्तिगत डाटा मेटिएको छ

- अनुरोध छ कि तपाईंको बारेमा गलत व्यक्तिगत डेटा सुधार गरियो/सुधार गरियो

- तपाईंको व्यक्तिगत डाटा (डाटा पोर्टेबिलिटी) को प्रतिलिपि प्राप्त गर्नुहोस्, र

- तपाईंको व्यक्तिगत डाटा को प्रोसेसिङ को बारेमा डेटा सुरक्षा अधिकारी वा द नर्वेजियन डाटा सुरक्षा प्राधिकरण मा एक गुनासो पठाउनुहोस्

तपाईंको व्यक्तिगत डेटा प्रक्रिया गर्ने अधिकार हामीलाई कुन कुराले दिन्छ?

हामी तपाईंको सहमतिको आधारमा तपाईंको व्यक्तिगत डेटा प्रक्रिया गर्नेछौं। ओस्लो विश्वविद्यालय, एनएसडी – नर्वेजियन सेन्टर फर रिसर्च डाटा ए एस सँगको सम्झौताको आधारमा यस परियोजनामा व्यक्तिगत डेटाको प्रशोधन डेटा सुरक्षा विधान बमोजिम भएको आकलन गरेको छ।

म अझ धेरै कुरा कहाँ पाउन सक्छु?

यदि तपाईंसँग परियोजनाको बारेमा प्रश्नहरू छन्, वा आफ्नो अधिकारको प्रयोग गर्न चाहनुहुन्छ भने, सम्पर्क गर्नुहोस्:

- ओस्लो विश्वविद्यालय (स्वास्थ्य र समाज को संस्थान): **Heidi Fjeld** (परियोजना पर्यवेक्षक) इमेल द्वारा: **h.e.fjeld@medisin.uio.no** वा फोन: **+47 22850603**
- **Sewika Sulpe** (विद्यार्थी) इमेल द्वारा: **sewika.sulpe@studmed.uio.no** वा फोन: **+47 96707583**

• हाम्रो डाटा सुरक्षा अधिकारी: Roger Markgraf -Bye फोन: +४७ ९०८२२८२६

· एन.एस.डी- नार्वेजियन सेन्टर फर रिसर्च डाटा AS, इमेलद्वारा: (personverntjenester@nsd.no) वा टेलिफोनद्वारा: +४७ ५५ ५८ २१ १७।

साँचो हृदयले,

परियोजना	अगुवा विद्यार्थी
हेइडी एफजेलड(Heidi Fjeld)	सेविका सुल्पे(Sewika Sulpe)
(सुपरभाइजर)	

सहमति फारम

मैले यस परियोजनाको बारेमा जानकारी प्राप्त गरेको छु र बुझेको छु " विवाह पूर्व प्रेरित गर्भपतनसम्बन्धी अविवाहित नेपाली महिलाहरूको धारणा। गुणात्मक अध्ययन । "अनि प्रश्न सोध्ने मौका पाएका छौं। म सहमति दिन्छु:

☐ गहन अन्तर्वार्तामा सहभागी हुन ।

परियोजनाको अन्तिम मिति, ३१.१२.२०२१ सम्म मेरो व्यक्तिगत डेटा प्रशोधन गर्नका लागि म सहमति दिन्छु।

(सहभागीद्वारा हस्ताक्षरित, मिति)

Appendix C- Interview guide

Thematic interview guide

1. Background information

a. Age
b. Housing and household information
c. Relationship status and relationship history
d. Education level
e. Place of origin and last area of residence in Nepal
f. Religious affiliations/ beliefs
g. How would you describe your relation to Nepalese communities in Norway?

2. Perception about premarital sex and pregnancy

a. What is in your opinion about intimate relationships before marriage?
b. How about in your community and social network in Nepal?
   i. *Do you have anyone you know of engaged in intimate relationship before marriage? What do you feel about this?*
c. In your experience, how acceptable is this among your community?
   i. *Can unmarried couples be open about being sexually active?*
   ii. *Can they be open about premarital pregnancy?*
d. How do you think premarital sex and pregnancy might affect a women's future life?

3. Perception on Contraceptives access and use, focusing on Nepal

a. Do you know the types of contraceptives available in your place of residence in Nepal?
   i. *And where to get it in Nepal? How did you come to know about it?*
b. Have you accessed or used contraceptives when you were in Nepal*?*
   i. *If yes, how did you access it? Was it easy to get it?*
   ii. *Did you face barrier to access and use it? What are those barriers and how do you feel about it?*
c. Do you think the community you lived in has a stigma or negative attitudes towards unmarried females accessing or discussing contraceptives?
d. Have you felt or experienced any form of discrimation or judgement when accessing or discussing about contraceptives in your society in Nepal? How do you describe it?
e. Do you discuss about contraceptives with others?
   i. *Friends/ Parents/ Siblings? If YES, how do you feel to talk about it?*
   ii. *Do you think it is necessary to discuss it? Who do you think should know about it more?*
f. From your experiences, what are the need for contraceptives availability in Nepal?

4. Perception about abortion

a. What do you know about abortion and safe abortion?

b. What do you know about the legal situation about abortion in Nepal?
   i. *What is your opinion about the legalization of abortion?*
c. Do you know how to access abortion in your community?
   i. *Do you know who provides the services and who can access it?*
   ii. *What are the methods of abortion available in your community?*
   iii. *Where did you get the information from?*
d. What you think about unmarried women in Nepal getting abortion?
e. What do you think is a safe abortion in NEPALESE COMMUNITY? (morally, medically, legally, socially, economically?)
f. How do you think the relationship of unmarried female going through abortion will change or should change?
g. Who should play important role in abortion decision making for an unmarried female?
h. Do you think the community you are part of in Nepal has a stigma or negative attitudes towards unmarried females accessing or discussing abortion? How do you describe it?
i. Do you think negative attitudes should change?
   i. *If so, how do you think we can change these attitudes?*

Appendix D- List of codes

Name	Description	Files	References
Contraceptives and contraception		0	0
Barriers on use of contraceptives		13	41
Community's perception on use of contraceptives	opinions on use and accessibility of contraceptives by unmarried females	14	43
Discussion, Suggestions on Contraceptives use and education		14	82
Gender roles on contraceptives		12	28
Knowledge on Contraceptives		10	18
Own perception and experience on contraceptives		13	40
Perception on Availability and Accessibility of contraceptives		14	34
Types of contraceptives		14	31
Dilemma to buy		3	4
Education and abortion		7	7
Examples	examples given during interviews about personal stories, things they heard, experiences or general examples	9	14
General comments on interview		7	9
Generation gaps		10	31
Induced Abortion		0	0
Abortion Knowledge		7	9
Community perception		13	48
Decision making		7	18
Discussion		6	12
Family support		14	38
Illegal practice		4	8
legality and perception		14	32
Methods to do abortion		10	17
myths and unsafe practices		7	14
Own perception		14	89
Peer support		13	27
safe abortion and valid reasons		14	44
valid reasons for abortion		9	14
Services and availability		12	26
Suggestions		11	38
Marriage as solution		9	14
Premarital intimacy and sex		0	0
Barriers for premarital intimacy		7	16
Community (Societal) response to premarital sex		14	69
Perception on premarital sex and intimacy		14	88
Premarital pregnancy and its perception		11	21
Reasons for stigma		12	43
Sex as basic need		8	14
Significance of discussion about premarital sex		13	35
Social structure (gender based)		11	36
Unsafe abortions stories		5	5

Appendix E-Ethical Clearance from NSD

NSD NORSK SENTER FOR FORSKNINGSDATA

NSD's assessment

Project title

Attitudes to induced abortion among Nepali women living in Norway: A qualitative study

Reference number

489681

Registered

02.07.2020 av Sewika Sulpe - smilers.sewika@gmail.com

Data controller (institution responsible for the project)

Universitetet i Oslo / Det medisinske fakultet / Institutt for helse og samfunn

Project leader (academic employee/supervisor or PhD candidate)

Heidi Fjeld, h.e.fjeld@medisin.uio.no, tlf: 22850603

Type of project

Student project, Master's thesis

Contact information, student

Sewika Sulpe, sewika.sulpe@studmed.uio.no, tlf: 96707583

Project period

01.08.2020 - 31.12.2021

Status

15.07.2020 - Assessed

Assessment (2)

15.07.2020 - Assessed

In reference to the changes registered on 14.07.2020. We cannot see that you have made any changes to the Notification From or attachments that will affect NSD's assessment of how personal data are processed in this project.

Read more about which changes should be notified to NSD before you send in changes in the future: https://nsd.no/personvernombud/en/notify/notifying_changes.html

FOLLOW-UP OF THE PROJECT
NSD will follow-up the project at the planned end date in order to determine whether the processing of personal data has been concluded.

Good luck with the project!

Contact person at NSD: Tore A. K. Fjeldsbø
Data Protection Services for Research: +47 55 58 21 17 (press 1)

10.07.2020 - Assessed

Our assessment is that the processing of personal data in this project will comply with data protection legislation, so long as it is carried out in accordance with what is documented in the Notification Form and attachments, dated 10.07.2020, as well as in correspondence with NSD. Everything is in place for the processing to begin.

NOTIFY CHANGES
If you intend to make changes to the processing of personal data in this project it may be necessary to notify NSD. This is done by updating the Notification Form. On our website we explain which changes must be notified. Wait until you receive an answer from us before you carry out the changes.

TYPE OF DATA AND DURATION
The project will be processing special categories of personal data about ethnic origin, religious beliefs, health data, sex life or sexual orientation, and general categories of personal data, until 31.12.2021.

LEGAL BASIS
The project will gain consent from data subjects to process their personal data. We find that consent will meet the necessary requirements under art. 4 (11) and 7, in that it will be a freely given, specific, informed and unambiguous statement or action, which will be documented and can be withdrawn.

The legal basis for processing special categories of personal data is therefore explicit consent given by the data subject, cf. the General Data Protection Regulation art. 6.1 a), cf. art. 9.2 a), cf. the Personal Data Act § 10, cf. § 9 (2).

PRINCIPLES RELATING TO PROCESSING PERSONAL DATA
NSD finds that the planned processing of personal data will be in accordance with the principles under the General Data Protection Regulation regarding:

- lawfulness, fairness and transparency (art. 5.1 a), in that data subjects will receive sufficient information about the processing and will give their consent
- purpose limitation (art. 5.1 b), in that personal data will be collected for specified, explicit and legitimate purposes, and will not be processed for new, incompatible purposes
- data minimisation (art. 5.1 c), in that only personal data which are adequate, relevant and necessary for the purpose of the project will be processed
- storage limitation (art. 5.1 e), in that personal data will not be stored for longer than is necessary to fulfil the project's purpose

THE RIGHTS OF DATA SUBJECTS
Data subjects will have the following rights in this project: transparency (art. 12), information (art. 13), access (art. 15), rectification (art. 16), erasure (art. 17), restriction of processing (art. 18), notification (art. 19), data portability (art. 20). NB! Any exceptions must be justified and have a legal basis. These rights apply so long as the data subject can be identified in the collected data. (refer to arts. 21-22 if applicable).

NSD finds that the information that will be given to data subjects about the processing of their personal data will meet the legal requirements for form and content, cf. art. 12.1 and art. 13.

We remind you that if a data subject contacts you about their rights, the data controller has a duty to reply within a month.

FOLLOW YOUR INSTITUTION'S GUIDELINES
NSD presupposes that the project will meet the requirements of accuracy (art. 5.1 d), integrity and

confidentiality (art. 5.1 f) and security (art. 32) when processing personal data.

To ensure that these requirements are met you must follow your institution's internal guidelines and/or consult with your institution (i.e. the institution responsible for the project).

FOLLOW-UP OF THE PROJECT
NSD will follow up the progress of the project at the planned end date in order to determine whether the processing of personal data has been concluded.

Good luck with the project!

Contact person at NSD: Tore Andre Kjetland Fjeldsbø
Data Protection Services for Research: +47 55 58 21 17 (press 1)

Appendix F-Ethical Clearance from Helsam

UiO : Faculty of Medicine
University of Oslo

Sewika Sulpe

Date: 14 July 2020

Statement from the Program Ethical Committee

The Program Ethical Committee have processed your application, number 7919130, about your project "Unmarried women's perspectives on premarital induced abortion in Kathmandu, Nepal. A qualitative study".

The committee believe your project does not fall under the Norwegian Health Research Law (helseforskningsloven and forskningsetikkloven) and you do not need to apply to the Regional Committees for Medical and Health Research Ethic (REC). However, person sensitive information might be collected and therefore you need to apply to Norwegian Centre for Research Data (NSD) for approval.

If your project is to be conducted outside of Norway, you also need to submit the project to local authorities for approval.

Supervisors for Sewika Sulpe's master project is:

- Heidi Fjeld, Associate professor at Institute of Health and Society at UIO.

Sincerely yours

Elia John Mmbaga
Associate professor, MD, PhD
Program leader
elia.mmbaga@medisin.uio.no

Terese Eriksen
Senior Executive Officer
terese.eriksen@medisin.uio.no
+47 22850526 or +47 22850550

Institute of Health and Society
Department of Community Medicine
Postal addr.: PO Box 1130 Blindern, 0318 Oslo
Visiting addr.: Frederik Holsts hus, Kirkeveien 166, 0850 Oslo

Phone: (+47) 22 85 05 50
Telefax: (+47) 22 85 05 90
postmottak@medisin.uio.no
www.med.uio.no/helsam
Org. no.: 971 035 854