



MINISTRY OF HEALTH

ESWATINI HEALTH REPORT

STRATEGIC ASSESSMENT ON UNINTENDED PREGNANCIES, CONTRACEPTION AND POST ABORTION CARE



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Operational definitions

Abortion	Expulsion of the products of conception completely or in part before 28 weeks of gestation regardless of the cause
Comprehensive abortion care	Provision of information, abortion management (including induced abortion and care related to pregnancy loss), and post-abortion care.
Ill-timed pregnancy	A pregnancy that occurs outside of the preferred time by either partners (man or woman). It may or may not be wanted
Post abortion care	Care provided to a woman who has abortive disease or a miscarriage before 28 weeks gestation. It includes care to a woman who expelled products of conception completely or in part before 28 weeks gestation
Post-natal care	Care provided after a woman gives birth to a viable foetus/ baby up to 28 days post-delivery. This is regardless of whether the baby is alive or dead (e.g. FSB, MSB)
Unintended pregnancy	Conception that occurs when not planned or willed by the partners (man and woman). It may or may not be unwanted
Unsafe abortion	A termination of a pregnancy by someone without skills through the use of hazardous methods or substances; or the termination of a pregnancy in a hazardous environment (such as lacking basic medical standards).
Unwanted pregnancy	A pregnancy that occurs but is not desired by either parties responsible (man or woman)

Synopsis Of the study

Background

The majority of unintended pregnancies are estimated to end up in abortions globally, and predominantly as unsafe abortions in low and middle income countries (LMICs) with subsequent poor maternal outcomes. In Eswatini, abortions are the 3rd leading cause of maternal deaths according to the Eswatini confidential enquiry into maternal deaths report. Since abortion is legally restricted in the country, nearly all abortions are recorded as spontaneous in health facilities, and are from women who come in with complications of abortion/ abortive disease. The magnitude of unsafe abortions in the country remains unknown therefore. Access to post abortion care for women who present with abortion complications in health facilities or the details of post abortion care received also remains unexplored. There is a need to explore and describe access to post abortion care, describe the demand for post abortion care in health facilities, and the demand and drivers of abortion. This will help the Ministry of Health to develop strategies to improve access to PAC before severe complications from abortive disease occur. Investigating the drivers of unintended pregnancies, is also needed to inform policy strategies that can prevent them in the Eswatini context, and subsequently reduce unsafe abortions that occur from unintended pregnancies. Eswatini offers free contraception to women at the point of use. Reasons why women continue to have unintended pregnancies are not well understood.

Purpose

This study sought to explore and describe the contextual drivers of unintended pregnancies, non-use of modern contraception, and comprehensive abortion care, in particular PAC in Eswatini.

Methods

An overarching participatory research design was used to investigate community perspectives on unplanned pregnancies, contraception, comprehensive abortion, and postnatal care. Eswatini stakeholders involved in sexual and reproductive health and rights (SRHR) services were engaged in all stages of the research process. The Ministry of Health (MoH) identified and convened these stakeholders.

A mixed methods study design was used. Qualitative approaches (focus group discussions and key informant interviews) were utilised to explore and describe community perspectives on unintended pregnancies, contraception, and comprehensive abortion care with emphasis on PAC. A two-stage inductive thematic analysis was used. In the first stage, researchers (who also collected data) summarised interviews for the day in teams, and came up with preliminary themes; this occurred daily. In the second stage, the principal investigator collated themes and categorised findings into broad themes and sub-themes. Emerging themes were then discussed with all researchers and consensus reached.

Quantitative approaches were used to describe post abortion care received by women who presented in nine health facilities countrywide. Contraceptive services received by women, HIV services, and the screening of STIs were also explored. Data were analysed descriptively, and presented in proportions, ratios, rates, and graphs.

Results

Abortion, Post Abortion Care and Post Natal Care received by women

Nine health facilities were included in the study, from which 83 women who had either had abortions (n=25) or delivered a baby (n=58) were recruited. The majority of pregnancies of women seeking PAC and PNC were unintended at (76%) and (59%) respectively. Eight

percent of women had contraception initiated during PAC and 32.0% were given information on pregnancy prevention. Screening for sexually transmitted infections (STIs) was done in only 28% of women post abortion. About 32% of women seeking PNC services were given health information on pregnancy prevention. Just one woman (1.7%) had contraception initiated while the majority (67%) were referred to government public health facilities for contraceptive initiation. STI screening was low for PAC (28%) and PNC (14%) women groups. The prevalence of abortion was 16%.

Unintended pregnancy

A total of 163 participants were interviewed. Unintended pregnancies were common in all women of childbearing age (adolescents, single women, married women). Drivers of unintended pregnancies included poverty/ low economic status; lack of accessible reliable information on sexuality and contraception; gaps in the implementation of the Sexual and Reproductive Health (SRH) program of the country; gender based violence; non-use of modern contraceptives; and COVID-19 related disruption in the provision of SRH services.

Contraception

Two broad themes were uncovered namely: the Eswatini policy and environment and barriers to utilisation of modern contraceptives. The policy environment in Eswatini was found to mostly provide for the provision of contraceptive care. However, there were gaps in policy to enable contraception and these were: implementation challenges of the SRH program in providing contraception care; and missed opportunities in the provision of contraceptive care; non-participation of men in contraceptive care; and gender based violence. Barriers in the utilisation of modern contraceptives were: lack of readily accessible information on contraceptives; contraceptive commodity stock-outs/ intermittent availability of contraceptive commodities; loss of the condom as a contraceptive device; and contraceptive side effects.

Comprehensive abortion care

Abortion

Four broad themes were identified, with corresponding sub-themes. These were; the environment, barriers to legal and safe abortions, drivers of abortion; and community sources of abortion.

Post abortion care

Two broad themes emerged namely access to post abortion care (PAC) and barriers to PAC utilisation. Subthemes in the access to PAC theme were: emergency life-saving care accessible; and demand for PAC. Sub-themes of the barriers to PAC utilisation were: health system limitations in providing PAC; SRH program implementation gaps; no guidelines on PAC; contraceptives not routinely offered to post abortion women as part of PAC; and delays in seeking PAC by women.

Conclusions

The prevalence of unintended pregnancies among the group of women in the study was found to be high and their use of modern contraception suboptimal. Barriers to contraceptive use among this group ranged from gaps in the implementation of SRH services in health facilities to community barriers, fuelled by lack of readily accessible information on contraceptive care, poverty, non-participation of men in contraceptive care, gender based violence, and implementation gaps of country policy on SRH. This status quo leads to poor maternal outcomes. As a result, unsafe abortions from unintended pregnancy are common in Eswatini communities and are present in populations of women in all reproductive age groups, not just adolescents. The prevalence of abortion was found to be (14.8%) among the women in the study group. Women who presented themselves at health facilities with PAC symptoms were offered PAC services. However, challenges related to women delaying seeking PAC and health system limitations in health facilities undermine the effectiveness of PAC.

Key words:

Unintended pregnancy, contraception, comprehensive abortion, post abortion care, strategic assessment, Eswatini

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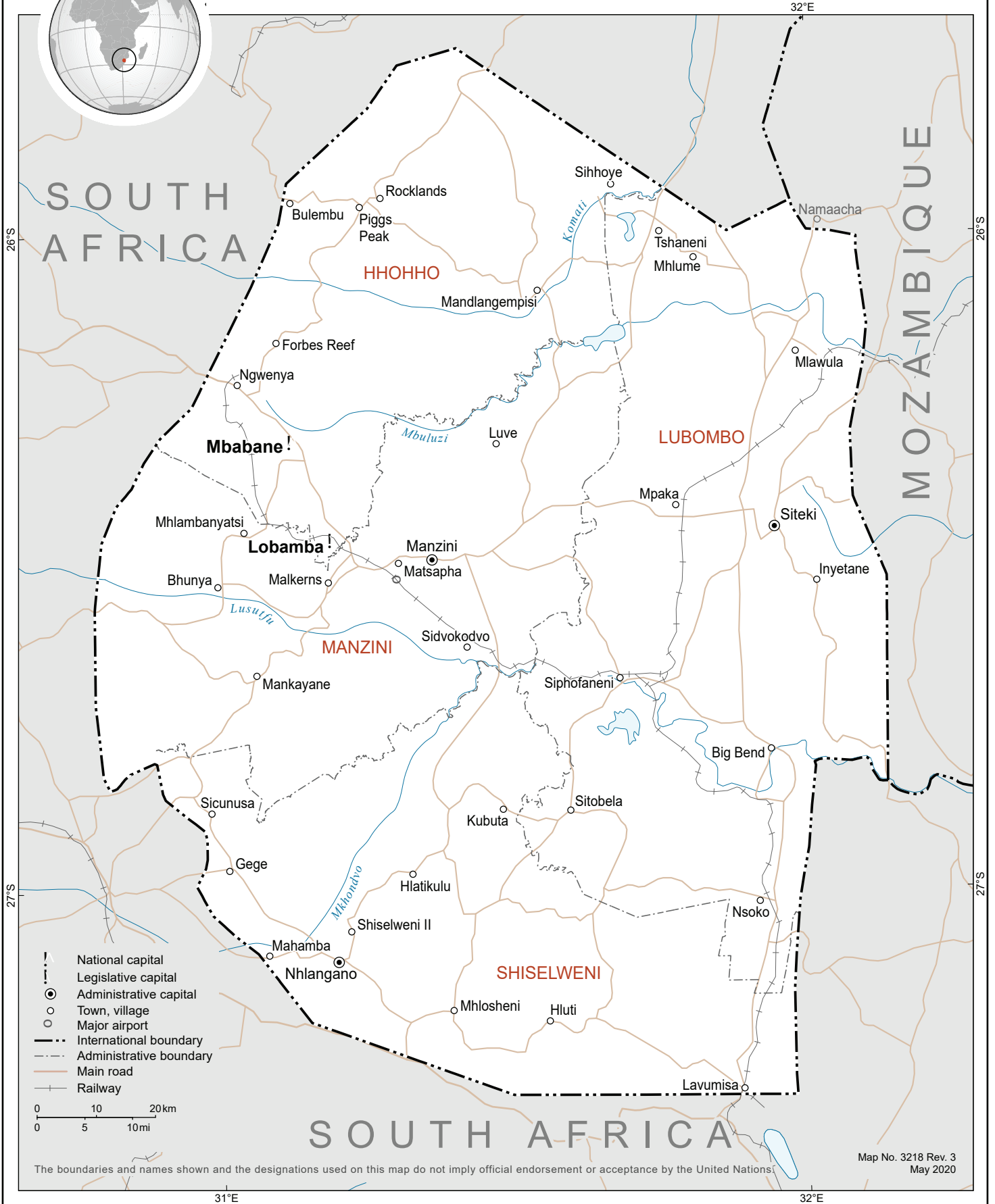
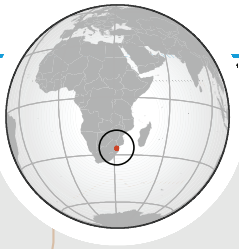
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Map No. 3218 Rev. 3
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Background

Pregnancy when unintended often invokes socio-economic challenges on both women and men [1, 2] and also has consequences on the perinatal outcomes of both mother and baby [3, 4]. To improve and sustain the health of women and children therefore, minimising or eliminating unintended pregnancies is therefore a public health goal. Unintended pregnancies have been observed to have adverse social and economic consequences particularly on adolescents who get pushed into unfavourable socio-demographics as the pregnancy interrupts education and other life building plans [2]. Bearak et al [5] estimate that a significant proportion of unintended pregnancies (61%) globally end in abortions. Sedgwick and colleagues [6] also estimated that 50% of unintended pregnancies ended in abortions. Scholars add that unintended pregnancies of women with low income are found more likely to end in abortion compared to women with higher income [5]. There is a significant relationship between non-use of contraception, and unintended pregnancy. For example, up to 60% of women with unplanned pregnancies had not used or discontinued contraception in 36 low and middle income countries (LMICs) [7]. Therefore, women who do not access contraceptives for whatever reason tend to have unintended pregnancies. When pregnancy is unplanned, unsafe abortions commonly occur, and these are known to predispose women to high chances of direct pregnancy causes of maternal mortality [8, 9].

Contraception is useful to prevent complications that could result from unintended or ill-timed pregnancies such as unsafe abortions or and psycho-social difficulties that ensue when women (e.g. adolescents) experience a disruption in life plans (e.g. education) because of an unwanted or ill-timed pregnancy [2]. Modern contraceptives in particular, are highly effective in preventing unintended pregnancies [10]. They benefit users by giving them the power to prevent pregnancy or delay it until desired. Traditional contraceptives are also useful in preventing unintended pregnancies, however, they are not as effective as modern contraceptives [11]. The use of modern contraceptives is therefore highly encouraged. Users in the reproductive age (men and women) often report non-use of modern contraceptives because of fears of side effects, misconceptions, lack of knowledge, limited contraceptive options or even low geographic coverage of contraceptives in a population [12, 13]. These barriers need to be addressed to improve utilisation of contraception to meet population needs.

Globally, leading direct causes of maternal deaths include haemorrhage, sepsis, hypertensive disorders, and abortion [14]. The Eswatini confidential enquiry into maternal death (CEMD) triennial report shows that women die more from direct causes (53%) of pregnancy compared to indirect causes (38%) [15]. In Eswatini, haemorrhage is the leading cause of maternal death, while septic abortion of is one of the major causes [15]. This is despite the Eswatini governments' progress in implementing interventions that contribute to the overall reduction of the MMR. To meet the sustainable goal (SDG) of reducing the MMR to less than 70 births per 100000 live births by the year 2030 [16], an even greater effort needs to be applied in Eswatini. Like many sub-Saharan countries, Eswatini did reduce its MMR slightly, but missed its overall millennium development goal (MDG) to reduce the MMR by at least 75% [17]. Furthermore, acceleration in the implementation of contraceptives, comprehensive abortion care, and postnatal care is important in order to realise the health goals of women and girls, as well as meet several SDGs on women's rights, including SDG 5.6 that promotes universal access to sexual and reproductive health and rights.

Existing evidence in the country point to multiple factors that may contribute to the persistently high MMR. Sub-optimal adolescent sexual and reproductive health (ASRH) is one of the known contributors, where the unmet need for family planning is twice as high in adolescents (30%) compared to the general Swati population (15.2%) [15]. Insufficient ASRH is one of the known drivers of maternal deaths in the country [15]. As much as 47.8% of adolescents in Eswatini have their sexual debut by the time they turn 18 years old [18]. The demographic health survey record that as much as 45% of all women were pregnant with their first baby by the time they reached 19 years of age [18, 19]. Moreover, a third of Eswatini children experience sexual violence by the time they are 18 years old, showing a high incidence of gender based violence (GBV) early on in their lives [20]. Meanwhile, intimate partner violence of Swati women in general is also common, and attributed to cultural norms in part [21]. Empirical evidence shows a direct relationship between GBV and unintended pregnancies [22, 23]. Moreover, even though some pregnancies cannot be prevented because of environmental factors among others (e.g. GBV), provision and access to contraceptives (including emergency contraceptives) to adolescents is ethically compelling, even in a culturally conservative country like Eswatini.

When women of reproductive age or their partners do not use contraception, unintended pregnancies result and often result in abortions. Macleod and Reynolds noted the need to investigate unintended pregnancies in the country and its drivers in Eswatini [24]. Given the significant population's unmet need for family planning (15.2%), which is more marked for adolescents (30%) [15, 25], and underutilisation of SRH services especially by adolescents [26], an empirical study on access issues and the delivery of contraceptive care is warranted. Although a systematic recording of legal abortions or how women access them is yet to be recorded, high rates of unsafe abortions in a population pre-dispose women to high occurrences of severe morbidity and deaths. Since access to abortion is limited to specific circumstances, and not available on request, the necessity to prevent unintended pregnancies throughout the reproductive age cannot be over emphasised.

Problem statement

Unintended pregnancies are a public health concern because of adverse maternal and neonatal outcomes. A significant proportion (61%) of unintended pregnancies are estimated to end up in abortion globally, resulting in increased maternal morbidity and mortality from direct causes of maternal deaths [5]. This is of particular concern in Eswatini given the persistent high MMR from direct causes of maternal deaths. In Eswatini, haemorrhage is the leading cause of maternal death, while septic abortion is ranked third [15]. This is despite Eswatini's impressive skilled birth attendance of 88% which contradicts the finding on high unmet need for contraception, soon after delivery or at post abortion. Furthermore, an assessment by the Ministry of Health (MOH) [26] shows suboptimal delivery of adolescent SRH services by health facilities, and a general underutilisation of the services by the target population when available in Eswatini. Contraception is a scientifically proven effective strategy that prevents unintended pregnancies. Reasons behind the unmet need for family planning that are specific for Eswatini have not been explored. Investigating the drivers of unintended pregnancies, reasons behind interrupted access to contraceptive care, non-utilisation of contraceptives where available, as well as post abortion care access and utilisation is therefore warranted. This will potentially inform strategies that can prevent them and subsequently reduce unsafe abortions.

Purpose/ broad objective

To explore and describe the contextual drivers of unintended pregnancies, non-use of modern contraception, comprehensive abortion care, in particular post abortion care, in the Kingdom of Eswatini.

Specific objectives

1. To explore and describe community perceptions

on unintended pregnancies, contraception, comprehensive abortion care, with emphasis on post abortion care

2. To explore and describe the drivers of unintended pregnancy and contraceptive use from the perspectives of health care providers and facility managers in the delivery of SRH services

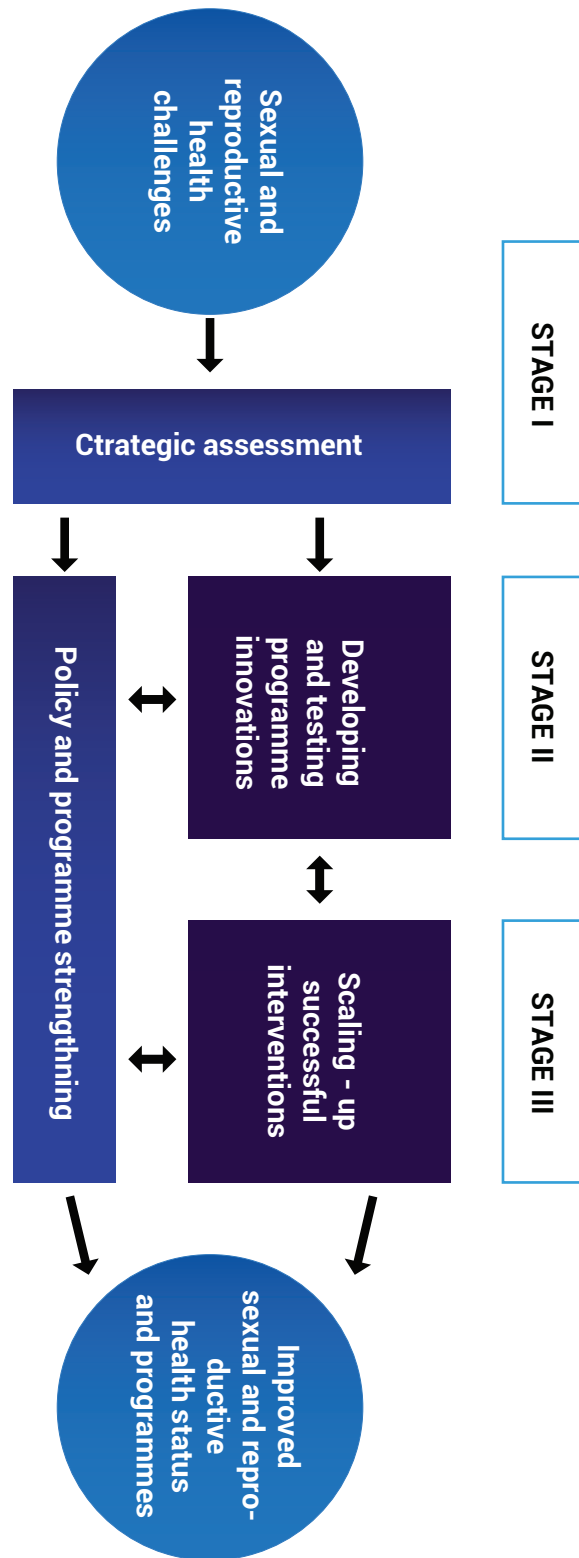
3. To explore and describe contraceptive services for post abortion and post-natal care given to women in health facilities of Eswatini

4. To describe the prevalence of abortion in public health facilities of the Kingdom of Eswatini

The WHO Sexual and Reproductive Health Framework

This study shall combine quantitative methods with the WHO strategic assessment approach. This approach has been designed to involve key stakeholders in the assessment from conceptualisation of the study, to the development of the research process and tools, to implementation and analysis. The Ministry of Health (MoH) as the coordinating partner, takes the lead in identifying and convening country stakeholders with support from its consultants and partners (UNFPA and WHO). Such an approach to the assessment fosters ownership by government and its stakeholders, putting them in charge of any implementation recommendations that may arise from the study. In this study, the strategic assessment approach shall be used to investigate sexual and reproductive health of populations in the East and Southern Africa region in relation to unplanned pregnancies, contraception, unsafe abortion, and post abortion care. The WHO in collaboration with UNFPA, supports governments to strengthen the evidence obtained for programmatic planning, using the strategic assessment approach. Figure 1 shows the strategic implementation process to be used in this work [27].

FIGURE 1.
THE STRATEGIC APPROACH IMPLEMENTATION PROCESS



Methodology

Study approach and design

An overarching participatory research design was used to investigate community perspectives on unintended pregnancies, contraception and comprehensive abortion care, including post abortion care. The WHO strategic assessment framework was used to structure the study. Eswatini stakeholders involved in sexual and reproductive health and rights (SRHR) services were engaged in all stages of the research process. The Ministry of Health (MoH) identified and convened of these stakeholders. A mixed methods study design was utilized (qualitative and quantitative);

- a) Qualitative approaches (focus group discussions and key informant interviews) were utilised to explore and describe community perspectives on unplanned pregnancies, abortions, modern contraceptives, post abortion care.
- b) Quantitative approaches were used to describe clinical outcomes of women who have had abortions, describe the characteristics of the women that have had abortions, describe post abortion care given to women in health facilities, and measure the prevalence of abortions in the Eswatini health facilities.

Study Setting

The study was conducted in rural and urban communities in Eswatini. At least two Tinkhundla were selected per administrative region making a total of 8. Qualitative interviews were held in 10 health facilities, which offered maternity care and treated women with complications of abortion were included. These included health centres (HCs), regional hospitals, and the national referring hospital.

Quantitative approach

Qualitative approaches were used to explore and describe community perceptions on unintended pregnancies, contraception, and comprehensive abortion care including post abortion care. The perspectives of health facility managers and health care workers in their administration of sexual and reproductive health services (SRH) were also be qualitatively explored.

Study design

A cross-sectional qualitative approach was used. Key informant interviews (KIs) and focus group discussions (FDGs) were used to explore and describe perceptions of community leaders, community health workers (CHWs), general population on their views of unintended pregnancy, the use of contraception, comprehensive abortion, post abortion care, and explored any barriers to access. KIs were used to explore and describe perceptions and experiences and perceptions in relation to unintended pregnancies, comprehensive abortion care, post abortion care access, and the administration of contraception in health facilities. Hindrances to the provision of care within health facilities were explored. Health provider perceptions of what the key drivers of unintended pregnancies were also explored.

Study sites

The study was conducted in two Tinkhundla from each of the four regions of Eswatini (8 Tinkhundla clusters total). An Inkhundla is a traditional zone/ area that comprises of multiple chiefdoms under it. In each Inkhundla, a rural setting (e.g. rural village) and an urban setting (e.g. urban/peri-urban area) shall be selected to provide a basis for comparison.

Chiefdoms, Community Youth Centers and Gogo Centers also formed part of the study sites within these Tinkhundla. Health facility interviews were conducted in 10 health facilities in which women that have just given birth, required comprehensive abortion services, or needed contraceptive services were looked after countrywide were included in the study. Health facility study sites comprised of community health centers, regional hospitals, and national referral hospital

Sampling techniques:

Purposive sampling was employed to select tinkhundla clusters. Within the selected clusters, chiefdoms and zones (for urban study sites) were selected from which to recruit participants for the study. Participants were selected because they were able to give the required information on contraception services, comprehensive abortion care access including post abortion care (PAC) and their perceptions on unintended pregnancies. In health facilities, health care workers in health facilities that oversaw maternity, gynaecology and contraception services were also purposively selected. These included senior heads of department (obs./gyn./medical officer) (1 per facility), labour ward nurse, and gynae ward nurse.

Inclusion and exclusion criteria:

Inclusion:

- Policy makers
- Members of Parliament
- Representative of Inner Councils
- Health Care Workers
- In and Out of school young people
- Community Health Care Workers
- Men and women in communities
- Civil society Organisation

Exclusion:

- Every potential participant that will refuse to

partake regardless of being informed of the study.

- Younger than consenting age without parental or guardian approval or consent or assent.

Sample size:

A total of 163 participants were enrolled. In each health facility, a minimum of two health providers that administered care to gynaecology women or maternity women were recruited.

Data collection tools

Tools for the qualitative data collection were developed collectively by researchers. Findings from the WHO strategic assessment background paper done by Macleod and Reynolds [24] were used along with stakeholder input from the feedback workshop on the background paper. These semi-structured interview guides were then piloted at Mlindazwe, a chiefdom with similar characteristics to earmarked study sites. Modifications on the interview guides were made following the pilot study experience where necessary. Interview guides were used to explore participant perceptions and experiences of unintended pregnancy, contraception, and comprehensive abortion care. These themes were explored in all participants, and the interview adapted to the type of participant on hand at the time. The strategic assessment tools according to each participant type are annexed. In health facilities health care workers used the same interview schedule. This interview schedule had open-ended questions on successes and challenges in supporting the health facility to provide sexual and reproductive health services; their experiences and perceptions on caring for women with unplanned pregnancies and their complications; and their experiences on integrating contraception as part of comprehensive abortion care.

Data collection

Interviews were conducted by 8 teams consisting of at least 2 trained researchers and a driver per team. Each team of researchers were assigned an Inkhundla cluster to collect data from the different strata of participant. In each community, researchers

performed key informant interviews with the Member of Parliament (MP) and indvuna (chief's right hand man). Focus group discussions were held with rural health motivators (RHMs), adult men, adult women, adolescent women, and adolescent men. In health facilities, key informant interviews were conducted with interviewed heads of department (obs/gynae), labour ward nurse-managers, and gynae ward nurse-managers. One researcher conducted the audio-taped interview while another documented field notes and non-verbal cues that may be important in the discussion. Interviews (whether KIs or FDGs) were audio-taped with participant permission. A driver took researchers from place to place. Interviews were conducted in English or Siswati depending on participant preference.

At the end of each data collection day, each team of researchers in all regions met at to review each day's interviews. Throughout this process, researchers were co-creators of the data while using learned concepts from previous interviews to test and explore them in subsequent interviews. This was an iterative process throughout. Data collection in all regions was concurrent and lasted 2 weeks. Interviews were conducted in various places within local communities as negotiated between researchers and participants preferably at umphakatsi (chief's kraal), enkhundleni (political administrative Centre) or Youth Centres, or Gogo Centres (community soup kitchens). Interviews took place in the hospital offices, in private where participants have the liberty to express themselves comfortably. In all interactions (whether focus group discussions or key informant interviews) with participants, COVID-19 guidelines (e.g. wearing of masks, social distancing, and sanitation) will be observed.

Analysis

At the end of each data-collection day, researchers met to discuss the day's interviews, and reflected on the questionnaire (tool). Interesting themes or concepts from previous interviews were picked up by the research team and explored in the interviews of the next day. Thus data collection and analysis happened concurrently. A two-stage inductive thematic analysis

was used. In the first stage, researchers (who also collected data) summarised interviews for the day in teams from overall impressions of the day interviews, including anything they found useful, insightful, or interesting, and came up with preliminary themes; this occurred daily. In the second stage, the principal investigator collated themes and categorised findings into broad themes and sub-themes. Emerging themes were then discussed with all researchers and consensus reached.

Audio-recorded tapes were transcribed in the language in which they were recorded to preserve meaning. Transcribed manuscripts were initially inductively coded, by the researchers who then validated identified themes. Transcription of audio-recorded data was done as is by a trained research assistant. Where SiSwati was used by participants, translation was done at analysis by the researchers to retain the original meaning as much as possible. Inductive thematic analysis was conducted to bring out the views and experiences of health care workers on unplanned pregnancies, comprehensive abortion-care, and contraception. Initial coding shall take place to identify key terms. Like terms shall be grouped together to form themes. Similar/ related themes shall be organised into sub-themes, and main themes. The SRH strategic assessment framework shall then be applied to reorganise the emergent themes into broad categories.

Quantitative methodologies

Quantitative approaches were used to audit complications of abortion and measure their burden on the Eswatini health system; describe comprehensive abortion care given to women in Eswatini health facilities; as well as explore contraception health care of women in Eswatini health facilities. These methods fulfilled objectives 3, and 4.

Study design

A comparative rapid audit of abortions seen in hospitals, and the characteristics of the women receiving post abortion care in health facilities around the country was conducted. The audit compared the

current Covid-19 era to the pre-Covid-19 era of 2019 to account for biases in the utilisation of abortion services. This audit will measure the prevalence of abortions in the Eswatini health system. An appraisal of health facilities was done on the type of comprehensive abortion services given, and whether these prevented future unintended pregnancies for women.

Sampling techniques

All women seen for abortions and miscarriages between January to December 2019 and January to December 2020 were enrolled. Nine health facilities were appraised on the type of post-abortion services they provided. All women with abortifacient disease found at data collection time in health facilities were included.

Inclusion and exclusion criteria:

Inclusions:

- Women that had been seen for abortion in outpatients (OPD), maternity, casualty, gynaecology clinic, gynaecology ward, and maternity ward will be enrolled.
- Only abortions that were seen within the 3 months of April to June of the years 2019 and 2020 were included.
- All women found in health facilities during the data collection period that had abortifacient disease were eligible for inclusion in the study.

Exclusion

- Pre-term deliveries (from non-abortifacient causes/ not related to abortion) were excluded.

Sample size

A total of 83 women across all data collection sites were recruited for the survey on PAC and PNC received. All eligible women who had abortifacient disease and were willing to participate were included in the short data collection period of two days. All women who had given birth and were in the postnatal period, and were willing to participate were also included.

Data collection tools

A facility survey tool with closed-ended questions will be used to survey women on post-termination of pregnancy care received (see annex). This included information on whether the terminated pregnancy had been planned or not, contraceptive care given, any family planning referrals, HIV services received, STI screening and treatment services received, contraceptive counselling received, etc. The questionnaire was researcher-administered either in English or Siswati depending on the language preference of the participants.

A health facility checklist was used to record the type of post-abortion care given to women. Pregnancy prevention care given to postnatal women who have just given birth in maternity was also recorded using a checklist. Information gathered included contraceptive care given to prevent future unintended pregnancies. Information collected will also include the type of contraceptive care given to prevent future unplanned pregnancies for these high-risk women.

An audit tool with close-ended-questions was used to extract data from the registers. Data collected included women's demographic details (e.g. age, parity, etc.); diagnosis; care/management given; and outcomes (alive/dead). In gynae wards within hospitals, no formal registers were found. Ward staff used record books drawn by hand in some hospitals, where there was a variation in the indicators recorded within the pages of the same record book. In some hospitals, record books were sometimes not kept. This made systematic collection of data across the hospitals difficult, as they were often missing in many study sites. Data on complications of abortion, for example, was abandoned because of the scarcity or inconsistent recording of the data.

The total number of women of reproductive age seen in each department (e.g. OPD or gynae) was recorded in each hospital. In the in-patient wards (e.g. gynae or maternity), the total number of women who admitted in the months of April to June in the years 2019 and 2021 because of abortifacient disease will be recorded.

TABLE 1
SUMMARY OF DATA COLLECTION TOOLS

DATA COLLECTION TOOL	PURPOSE / OBJECTIVE	DATA REQUIRED	SOURCE
Survey (abortion services)	To record abortion services received from the health facility	Type of care given to women; HIV services received, STIs, contraceptive care,	Women that access comprehensive abortion services
Survey (PNC)	To record postnatal services received	Contraceptive services, and information given received	Women that delivered a baby
Health facility checklist - comprehensive abortion care	Record comprehensive abortion care given to women in the health facility	Post abortion care given to women who have had abortive disease	Gynae ward nursing sister / equivalent, maternity ward nursing sister / equivalent
Health facility checklist - postnatal care	Record postnatal care received by women after delivery	Type of postnatal care given to women after delivery	Maternity ward nursing sister / equivalent
Health facility audit tool	Record data for denominators when calculating indicators	Record overall births, number of pregnant women seen in health facility, total of all women seen for abortive disease	Gynae ward registers, maternity registers, outpatient department registers, operating theatre registers,

Data collection

To identify abortion cases for the audit, maternity, gynae ward, outpatients, and casualty registers will be used to find cases from women that had presented in health facilities for comprehensive abortion care services which included post abortion care.

Trained researchers perused all registers from the 1st of April to 30th June 2019 as well as the 1st of April 2019 to the 30th of June 2020. All women that were seen in the health facilities for abortion during these time periods will be recorded. The researchers will use gynae outpatient clinic, casualty, gynae ward, and maternity ward registers. From these registers, researchers recorded the women's biographic and obstetric characteristics, e.g.; age, marital status, gestation, parity, diagnosis, etc. Where information was incomplete or unavailable in registers, patient files were retrieved where possible. All data was collected digitally into the software EPIINFO, using i-pads.

To conduct the health facility appraisal on comprehensive abortion services and post-natal services given, researchers interviewed labour ward and maternity ward nurse managers or their equivalents the type of care to prevent future unplanned pregnancies that they give women after giving birth or having an abortion. Where no care for the prevention of unintended pregnancies. All women with abortive disease in hospitals were included in the study if willing to participate.

Data analysis

Data was extracted from EPINFO, transferred to EXCEL spreadsheets. Data were then imported onto STATA14 for data cleaning and analysis. Descriptive statistics (frequency tables, proportions, bar graphs, etc.) were used to summarize data. The proportion of health facilities that did give post-natal and post abortion care to prevent unplanned pregnancies to women to high risk for unintended pregnancy again. The type of post abortion and post-natal care will also be described. Bar graphs and box plot graphs will be used to display the data.

Ethical considerations

Ethical clearance was sought from the Government of Eswatini Ethics Review Board. Permission to conduct the study was obtained from the management of each of the 10 health facilities to be included in the study. Written informed consent to participate in the study was sought from all health providers (nurses and doctors) in each health facility.

In the communities, permission to conduct the study was asked from the chiefs overseeing those communities. Once obtained, written informed consent was sought from every individual that participates in the study. Participants that could not read or write had the information on what the study is all about explained by fieldworkers verbally. Once satisfied, prospective participants were given an opportunity to consent by signing consent forms with their right thumb print. Permission to audio-record interviews was sought from all participants. Interviews were conducted in either English or SiSwati, depending on the preference of participants.

All participants were assured of their right to withdraw from the study at any point, without incurring any prejudice from researchers or incurring any penalties. Participants were assured of confidentiality of information by researchers. Identifying characteristics of participants (such as their names) would not be published at the time of reporting or dissemination of information. Participants were not be paid to participate, but were asked to volunteer participation. They were informed upfront that participation will not benefit them directly, but was aimed at finding information that may inform planning of health interventions.

COVID-19 guidelines were observed during data collection where researchers interact with participants. The provision of personal protective equipment (PPE) (masks, gowns where needed, and portable sanitisers) were provided and researchers strongly encouraged to observe COVID protocols strictly. These included social distancing between researchers and participants, hand washing and sanitising, as well as the wearing masks. Interviews took between 45 minutes and 1 hour 30 minutes at the very most to limit exposure of researchers and participants. Wherever feasible, interviews were taken

place outside in open spaces rather than indoors (e.g. on the verandah/ front porch of a house or under a tree rather than the living room. This was done to maximise air circulation.

The research team

The research team consisted of local and international researchers that worked collaboratively throughout the research process. Internationally, the study will be supported by co-principal investigators from the UNFPA regional office and the WHO office in Geneva. These researchers worked with local researchers from the Sexual Reproductive Health Unit (SRHU) of the Ministry of Health, a local co-principal investigator from the University of Eswatini, and UNFPA country office researchers. These researchers conceptualised this study collectively, participated in the modification of research tools, data collection, analysis, and reporting as the participatory design of this study mandated. Conceptualisation and design of the study was the responsibility of the local team of researchers, with input from the international co-investigators. The international researchers also provided oversight at implementation of the study.

Training of fieldworkers and research assistants

A 5-day workshop was held by the local co-principal researcher to train local researchers on the implementation of strategic assessment research

process, development of qualitative tools, piloting the study and pretesting quantitative tools, conducting fieldwork, and the generation of daily summaries. Training also included theory sessions and practical data collection exercises in the field to develop competency.

Piloting the study and pre-testing tools

The study was piloted at Ezulwini (Mlindazwe). Findings from the pilot were used to modify and strengthen the research process and tools as necessary.

Dissemination of Results and Publication Policy

Results from this study were disseminated to the policy makers of the Ministry of Health (i.e. the ministry personal secretary (PS) or equivalent, the directorate of the ministry of Health, and other relevant officers); stakeholders in the SRHR domain e.g. (Family Life Association Swaziland-FLAS); and the communities from which participants came from. A research report was also prepared and shared with the Ministry of Health, the EHHRRB, and funders (UNFPA, and WHO).

Funding

The study was funded by the UNFPA and WHO agencies.

Limitations of the study

The following were limitations encountered in the study;

- This study did not explore in detail, reasons for contraceptive commodity stock-outs or the strategies to address commodity stock-outs. The objectives of this study were broad and sought to uncover the overall national and community specific drivers of unintended pregnancies, non-contraceptive use, and the status of post abortion care in the country. Details around each of the barriers of contraceptive care (e.g. contraceptive commodity stock-outs) or post abortion care were out of the scope the study. Nevertheless, systematic study of contraceptive commodity stock-outs is an important area warranting further empirical enquiry, with a view to uncover any bottle necks in the logistics of the supply chain of the health system.
- In this study, the participation of school teachers, and school principals was not possible because data collection occurred during school examination time. These prospective respondents were therefore unavailable to participate.
- Data on some of the SRH indicators of interest in this study was not available in health facilities. This was because the data were either not routinely recorded in registers; or were not consistently recorded; or the registers with the data were lost; or there was no filing system in the archives department such that retrieving required registers for data capturing was impossible in the life of the study.
- One health facility did not have registers for the years needed to do the comparative analysis for the years 2019 and 2020 at all. Neither were the registers for the year 2021, or any register for years before 2020 found. This health facility, although it was offering PAC and PNC services to women, was excluded from the study.

Results

This section shows results from the surveys on PAC and PNC in nine hospitals countrywide, and the perceptions of the Swati people on unintended pregnancies, contraception, and postnatal care.

Abortion, PAC, and PNC in Nine Eswatini Hospitals: An overview

Characteristics of the health facilities

Nine health facilities comprised of 6 hospitals and 3 health centres (HCs) were rapidly audited to observe the contents of post abortion care (PAC) and contraceptive care in the immediate postnatal period given to women in Eswatini public health facilities. Two of these

hospitals were Christian missionary hospitals, while the remaining were government hospitals. All HCs were government health facilities. Table 2 shows the number of live births across all study health facilities, the number of abortions seen, maternal deaths overall, and maternal deaths from abortions. There were limitations in this data as some registers were either lost, incomplete, or were not kept in some facilities. This means a possible under count of indicators, including abortions in the time periods captured in this study. Maternal deaths, deliveries, and abortions were recorded for the full 12 months period of 2019 and 2020. Indicators showed a slight decline in utilisation of maternal health services in the year 2020 compared to the year 2019. This could be attributed mostly to the lockdown effects in Eswatini at the start of the pandemic, that limited human travel, including travelling to access health care in hospitals.

TABLE 2
SUMMARY BIRTHS, DEATHS, AND ABORTIONS IN HEALTH FACILITIES

Indicator	2019 (year)	2020 (year)
Deliveries	28187	27313
Maternal deaths	26	30
Abortions	5457	4221
Abortion prevalence rate	16.2%	13.4%
Institutional maternal mortality ratio (iMMR)	107 per 100 000	92 per 100 000

*Abortion prevalence rate= $\text{abortions} \div (\text{Abortions} + \text{deliveries})$

Prevalence of abortion in the health system

The total number of abortion cases seen across all study's public health facilities (6 hospitals and 3HCs) in

the periods of 2019 and 2020 were 9678. During this time, there were 55 500 deliveries across the 9 health facilities. Overall therefore, the prevalence of abortion cases seen in health facilities was about 14.8% in the 2 years of 2019 and 2020. In the year 2019, at least

16.2% of pregnancies resulted in abortions. These abortions were largely recorded as spontaneous in hospital records. In the year 2020, 13.4% of pregnancies ended in abortions seen in health facilities. It is important to note that these abortions were not initiated in hospitals, but were women with complications of abortion (e.g. incomplete abortion) who came in for post abortion care (PAC). The institutional maternal mortality ratio (iMMR) for the years 2019 and 2020 were 107 per 100 000 live births and 92 per 100 000 live births respectively.

Pregnancy prevention of high risk groups in the 10 health facilities

Only 36% (n=30) of pregnancies were intended among postnatal and post abortion care women in the hospitals. This showed a high prevalence of unintended pregnancies at 64% (n=53). Women that received information on pregnancy prevention from health

facilities before discharge were only 35% (n=29). About 23% (n=19) of women were referred by health facilities for contraceptive care to public health clinics, while just 4% (n=3) had contraception initiated within facilities before discharge. The results also show a missed opportunity in screening for sexually transmitted infections (STIs). Just 18% (n=15) of women were screened for STIs and yet they were a population group that was high risk because of exposure to unprotected sex. Furthermore, the results revealed that while participants were given HIV services, coverage within facilities was suboptimal. For example, only 21% (n=17) were given information on HIV, rather than all participants. Nevertheless, since HIV services were given to the same population as that requiring contraceptive care, there exists an opportunity for integration of the two health services (HIV and sexual reproductive health/ contraception) to potentially improve the coverage of contraception. Table 3 shows PAC and PNC services given to women who sought either PAC or PNC across the 10 health facilities.

TABLE 3
POST ABORTION CARE AND POST-NATAL CARE RECEIVED

Indicator (N=83)	Value
Mean days since end of pregnancy + SD	1.9+ 2.1 days
Mean gestational age at end of pregnancy	30.9+ 12.2 weeks
Contraceptive initiated	3 (3.6%)
HIV treatment	7 (8.4%)
HIV testing	9 (10.8%)
HIV prophylaxis	14 (16.9%)
STI screening	15 (18.1%)
HIV information	17 (20.5%)
Referral for contraceptive care	19 (22.9%)
HIV counselling	22 (26.5%)
Information on pregnancy prevention	29 (34.9%)
Pregnancy intended	30 (36.1%)
Danger signs taught	40 (48.2%)
Head to toe exam	42 (50.6%)

Post abortion care received

A total of 25 women who accessed PAC services were recruited from the 10 hospitals. The mean gestational age for women accessing PAC interviewed was about 31 weeks (12.7 + 8.0), while the mean number of days from the termination of pregnancy was about 3 days (2.8 + 2.9). 76% of the pregnancies in this group of women had been unintended. Only 8.0% of women

had contraception initiated during PAC, while just 32.0% were given information on pregnancy prevention or offered contraceptive care in the health facility as shown in Figure 3. Screening for sexually transmitted infections (STIs) was done in only 28% of women, and this was much lower than expected as all women should ideally be screened to out rule STIs as part of PAC. This was therefore a missed opportunity for care on a high risk group.

FIGURE 3:
PAC RECEIVED BY WOMEN WHO HAD ABORTIONS (GESTATIONAL AGE <=28 WEEKS)

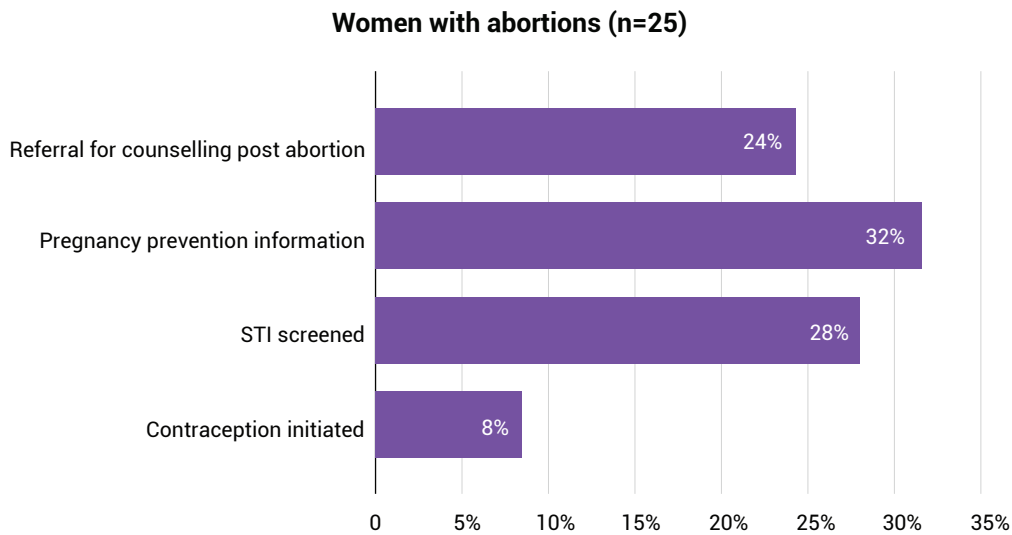
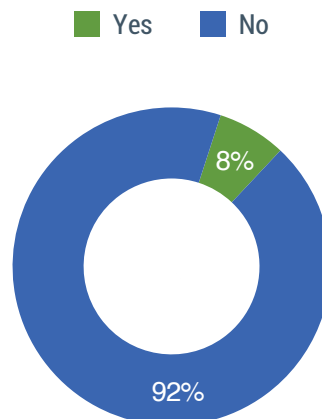


FIGURE 4:
CONTRACEPTION INITIATED TO POST ABOTION & POST - NATAL WOMEN

Contraceptives Initiated in PAC Women N=25 (%)

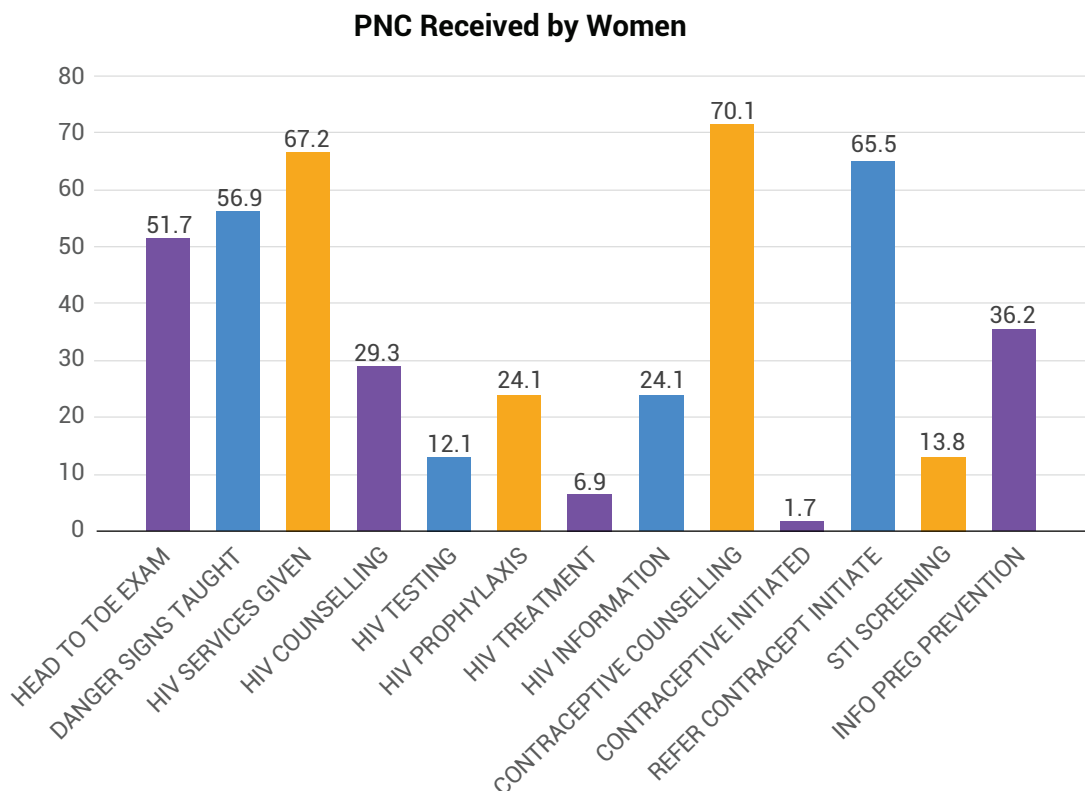


Post - natal care recieved

From the ten hospitals surveyed, 58 women who had given birth and were in the post-natal period were recruited. The mean gestational age of women recruited was about 13 weeks (38.7+1.5). PNC women were within 2 days (1.5+ 1.4) post-delivery. Most (58.6%) of the women that delivered had not intended to have the pregnancy. Just 32% of these women were given health information on pregnancy prevention. Only one woman (1.7%) had contraception initiated while the majority (66%) were referred to government public health facilities for contraceptive initiation. Only about 14% of PNC women received

screening for STI and this was suboptimal. These results show a missed opportunity in screening for sexually transmitted infections (STIs) on a population group that is high risk because they have had unprotected sex. On the other hand, most (67%) of these PNC women received HIV services in the health facilities before discharge. While still less than ideal (100%), more women received HIV services than other SRH services, especially contraception. This showed another missed opportunity for the provision of contraceptive care on a population that is at high risk for subsequent pregnancies. . Figure 5 shows PNC services received by women.

FIGURE 5:
PNC RECEIVED BY WOMEN



Perceptions on unintended pregnancies; contraception challenges; abortion; and post abortion care: A qualitative review

Characteristics of participants

A total of 163 participants were recruited for qualitative interviews. The range of the age of participant was from 14 years to 71 years. Overall, the mean age of participant was 39 years + 15 years. About 75% of participants had secondary school education or lower and 25% had tertiary education. Those that had never been to school were marginal at just 2.7% had never been to school. Participants included those at policy level at the Ministry of Health; Ministry of Education; representatives from civil society organisations (includ-

ed people with disabilities, sex workers, people living with HIV, law associations, etc.); faith based organisation members; members of parliament; traditional community leaders; ordinary adult men (≥ 25 years) in communities; rural health motivators (RHMTs) who were community health workers; ordinary adult women (≥ 25 years) in communities; adolescent young women (12-24 years) ; adolescent young men (12-24 years); nurse managers or their equivalent; and heads of department in obstetrics and gynaecology or their equivalent.

TABLE 4:
PARTICIPANTS

Participant characteristics	N=163	
Sex	Male	40.5%
	Female	59.5%
Mean age	All participants	38.5 + 14.7 years
Age range	All participants	17 -71 years
Education Level	Secondary education or lower	74.7%
	Tertiary education	25.3%

Emerging themes

The broad categories of unintended pregnancies, contraception, post abortion care, and abortion all had identified themes that emerged in each category. Themes had corresponding sub-themes, that all explained the main theme. Table 3 shows all themes and sub-themes identified in each category.

TABLE 5:
SUMMARY OF RESULTS

Broad Categories	Themes	Sub themes
Unintended pregnancies	unintended pregnancies common	In-school adolescents
		Out of school adolescents
	Drivers of unintended pregnancies	All women and Married women
		Poverty and unemployment
		Lack of reliable information on sexuality and contraception
		In-school adolescents
		The social environment
		SRH Program gaps:
		Gender based violence
		COVID-19 related disruptions
Non-utilisation of modern contraceptives		
Contraception	Policy environment	Policy environment supportive of contraception
		Implementation challenges of the contraception policy
		Policy gaps in the provision of contraceptives
		Missed opportunities in policy to provide contraception
	Barriers to utilisation of modern contraceptives	Lack of information/ misinformation
		Commodity stock-outs/ intermittent availability of commodities
		Loss of the condom as a contraceptive device
		Men against contraceptive use
		Implementation gaps of contraceptive programs
Abortion	Environment	Policy environment
		Cultural and religious environments
		Civil society view on abortions
	Barriers to legal and safe abortion	Lack of knowledge
		Technical barriers
	Drivers of abortion	Poverty
		Gender based violence
		Unwanted pregnancy
		Uncertainty of paternity of the conceptus
	Male partners that deny responsibility	

Broad Categories	Themes	Sub themes
Abortion	Methods of unsafe abortion in communities	Misoprostol drug
		Traditional medicines and herbs
		Mechanical methods
		Homemade chemical concoctions
Post Abortion care	Access to post abortion care	Emergency life saving care accessible
		Clientele for PAC
	Barriers to quality PAC	No guidelines on PAC
		Contraceptives not routinely offered post abortion
		SRH programming gaps
		Delays in seeking PAC
		Health system limitations in providing PAC
Health information system deficiencies	Data on contraceptive care and use	
	Data on post abortion care	
	Legal grounds for restricted abortion unknown	

Unintended pregnancies:

All participants felt that unintended pregnancies were a common occurrence in the Eswatini community as a whole and this was in both adults and adolescents. Health providers in health facilities also reported seeing unintended pregnancies in all age groups. Women over the age of 30 and adolescents were reportedly the worst affected. The worst affected groups were said to be in-school and out of school adolescents. For the Eswatini community, adolescent pregnancies were problematic because they interfered with continuing education of the girl, and her subsequent ability to have economic independence. Out-of-school adolescent pregnancies were regrettable because these

young women did not feel ready to start families by then, and had not yet developed the economic muscle to raise a child or children. These young women reportedly resorted to self-induced abortions at times, or bore the financial and societal difficulties that came with having an unintended pregnancy while considered underage or not ready.

Married women were also said to experience unintended pregnancies, but were less frowned upon in societally because of the natural expectation for married women to bear children. Some of these women bore morbidities associated with the pregnancy being unintended. These included depression antenatal, postpartum, and abortions.



In married women we don't know what drives this because in married situations you do find women pregnant without intending to do so. Some get into depression because of it. Some get out of the depression, some do not. It's interesting because some even have the means to go to the clinic for contraceptives. Some are educated and well informed about contraceptive use, and have used it before. So we need to investigate this phenomenon.



SRH implementation partner



Many end up with babies named 'Gift'. You tend to find depression problems in these women, and the husbands often desert these women, accusing them of removing the pregnancy 'goalkeepers'. We see this happens in circles that we know. It indicates that the problem does exist. Women even though advanced in age/ of age suddenly behave as if it's a teenage pregnancy, and become afraid to interact with peers, afraid that the big pregnancy stomach show."



SRH implementation partner

Drivers of unintended pregnancies

Drivers of unintended pregnancies were said to be poverty; gaps in the implementation of the SRH program; patriarchy; intermittent availability of contraceptive commodities; gender based violence; and the debilitating (economically and health wise) impact of unintended pregnancies on women's lives.

Poverty and unemployment

Unintended pregnancies in all age group were said to be propagated by economic challenges and poverty. Married women were said to engage in extra-marital affairs that often culminated in unwanted pregnancies because of the economic benefit that came with these affairs. The youth (in-school and out of school) also commonly faced material needs, that were easily met by men who were older and financially able to supply these needs.

In communities, some participants (adult parent women) reported that pregnancies of underage girls were tolerated in homes because of the financial benefit for the homestead that came with it. Such support mainly involved food items that the responsible man (usually an older more financially independent individual) would bring. In addition, rural health motivators (RHMT's) reported seeing pregnancies of underage girls with increasing frequency in the current COVID-19 era. Multiple and concurrent relationships were also reported, as a means to raise more funds to cover necessities like groceries for homes (in adult women), clothes, toiletries and fast foods in adolescents. These relationships were common in all women categories (adolescents in and out of school, adult community women, and commercial sex workers). Moreover, RHMTs stated that some parents tolerated sexual activity of their young girls because it brought financial benefits to afford food items for families.



Young girls commonly get pregnant because they look for sugar daddies to provide for their financial needs... Our peers' get tempted because there is hunger in families at homes. So they get into relationships with older men looking for financial support to buy food and other necessities...



Adolescent girls



"In child headed households, the young girl child is forced to do sex work to provide for her younger siblings..."



Sex workers

Having multiple sexual partners is not only done by unemployed women. Some do work but the pay is not enough to cover their needs. Some are married but to have enough to feed their families. So they end up forces to supplement with sex from a sponsor..."

Women



Lack of reliable information on human sexuality

Adolescent girls reported an information deficit on human sexuality, including how sex is done, its conse-

quences, safe sex, and how to disclose to parents that a pregnancy has occurred. Girls reported using multiple sources for information, with questionable reliability. These sources included peers and any folklore

stories circulating around communities. The adolescent girls expressed interest in weekly lessons on sexuality, safe sex, and contraceptives at school. Rural health motivators (RHMs) reported the need for community campaigns on contraceptives as they and

community members needed help in understanding modern contraception. The youth (adolescent boys and girls) stated that the media used to reach them should not just be mainstream media, but more social media which they readily access on a daily basis.



... I think having just your peers is not enough. There is a very real risk they you may deceive one another. There should be someone older in there, who can help the group and steer us to the truth. That person would give us the right direction.... We also need to learn about contraception methods and how to do it. How to prevent STI and AIDS, including knowledge on what to do not to get pregnant...



Adolescent girls

In schools, adolescents have the subject 'Life Skills Education' (LSE) that is intended to cover human sexuality among other topics on a weekly basis. However, teachers do not teach this course consistently in schools. Participants reported that other school core subjects are prioritised over LSE, and the time allocated for LSE is used to catch up on other subjects. Thus, gaps in human sexuality knowledge including pregnancy result. Furthermore, teachers mandated to teach LSE felt uncomfortable discussing LSE, and stated that they were not trained to deal with the subject.

The social environment

Environmental factors such as excessive or

indiscriminate alcohol use and housing conditions promoted the occurrence of unintended pregnancies.

Poor housing

Participants living in informal settlement communities reported poor housing as one of the drivers of unintended pregnancy particularly on the youth. In these communities, entire families lived in one-roomed flats. This meant adults sleeping in the same space as the children or youths. When consenting adults engaged in sexual activities at night, the older children or youths reportedly observed, and their curiosities spurred them to engage in sexual activity of their own, unaware of the consequences that might occur.



"Where I live, many families live in one-roomed flats. They live with the people they are in love with many times, with their children some of whom may be a little grown. Mothers of these children live with men some of whom are the fathers of the children or may be boyfriends that they will have found. So when they engage in sexual encounters at night, the children will be watching. So eventually, the child may think, 'my mom seems to be enjoying whatever she is doing with this man. I need to try it out too under the guava tree, and see if I will get the pleasure she seems to be getting.' I'm just trying to say the places we now live and end environments we grow in also contribute greatly to our sexual behaviour. It's unlike in a proper home setting or in the olden days where the girls slept alone in their hut and the boys slept alone in theirs too. We also live in communities riddled with drinking spots/ sheebens and the communities drink a lot"



Adolescent girls

Alcohol

Participants reported that rife alcohol use in their communities encouraged unsafe sexual practices that often ended in unintended pregnancies. Discretion of partners when drunk was not optimal according to participants, and this resulted unprotected sex many a

times. Some communities reported that gender-based violence and unsafe sexual practices were especially rife during the cultural maganu [marula] season countrywide, where the adults (men and women) and youths imbibed in the alcoholic drink freely.



“There many alcohol drinking sprees or taverns and some of them are informal [sheebens]. This exacerbate abuse [GBV] because when the people are drunk they become violent and promote unacceptable sexual behaviour which lead to unwanted pregnancies



Community women



GBV was not as common, but during the Maganu season people have started raping and abusing children and women...



Women

Implementation gaps in the SRH programme:

Three sub-themes emerged from this theme. These were sexual and reproductive health gaps in the implementation of the SRH program for people with disabilities, youth (out-of-school and in-school adolescents), and men (adolescents and adults).

Implementation gaps in SRH program for people with disabilities

The Ministry of Health (MoH) is of the view that people with disabilities (PWD) adequately receive all sexual reproductive health (SRH) services including contraception from the mainstream SRH facilities. PWD however, expressed difficulties with access to

contraceptives from mainstream health facilities. The MoH implementation partners and health facilities also reported difficulties of giving contraceptive services to PWD. Challenges included communication difficulties between health providers and clients with disabilities; and mobility issues that interfere with clients accessing health facilities for contraceptives; complexity of the different kinds of disabilities that require specialised training; and unavailability of specialised equipment that may be sometimes needed to administer SRH services to some of the people with disabilities. PWD therefore ended up with unintended pregnancies because of inaccessibility of SRH services.



When it comes to persons with disability, a huge gap exists in terms of accessing family planning and all SRH services. Our service providers do not have the skills or competency to assist those who are deaf and dumb, visually impaired and so on. The disability becomes a barrier for the person to come to the facility



SRH implementation partner

Implementation gaps in SRH program for adolescent out of school youth

Out of school adolescents were reportedly vulnerable to unintended pregnancies because they were usually lost from targeted adolescent SRH programs that targeted school goers. In addition, these adolescents did not yet have the financial resources to support themselves, fund their reproductive choices, and had difficulty in accessing contraceptive services from mainstream health facilities. These out-of-school adolescents often also ceased to enjoy parental or

guardian financial support as they would have while still in school as priority shifted to those still in school. Therefore out of school adolescents’ reported commonly engaging in romantic relationships to support themselves. The result would often be unintended pregnancies that at times ended in unsafe abortions. According to these youth, difficulty in accessing main stream SRH services was largely because SRH service was not youth friendly. Perceived health provider attitudes was one of the barriers.



There is also a programming gap, whereas the MoH, focus is on school youth, and adults. There are no targeted interventions for out of school youths be they in colleges or still at home.



SRH implementation partner



More especially the out of school youth. Normally parents try hard to look after their children while still at school, though difficult financially or when we have the means. However, once a child finishes school, or is at university, parents suddenly drop tem and start looking only after the younger ones still at school. The university or college youth, or the one out of school suddenly has no one to ask for basic necessities from including bath soap, lotion etc. This encourages these young girls to get into relationships. Initially, these girls don't ask for the money, but the older men readily give it. Then the girls get used to the idea, realising that if they have a man in their lives, they get looked after.



Policy maker

Implementation gaps in the SRH program for adult men and adolescent boys

Men expressed that they were seemingly excluded from biomedical health programs on health education regarding prevention of unintended pregnancies and contraception. As such, formal information from health authorities regarding these was scarce, and they relied from opinions from their peers on modern contraception. They reported resorting to traditional medicine and means to deal with fertility and contraceptive issues as men in the communities. Male adolescent youth in communities also held the perspectives of the older men on the prevention of pregnancy, and were more versed with traditional

means than modern means. Adolescent men claimed that they heard about traditional contraception from the senior men in their communities. Community leaders, who were mostly male (88%) (tindvuna/ chief's right hand men), also expressed a need to learn about modern contraception. Not much was known about preventing unintended pregnancies by either the adolescent men or the adult men, and they generally regarded access to contraceptives in health facilities as a woman activity or problem. These men (both adolescents and adults) also reported discouraging their women partners from using biomedical contraceptives because they believed that it interfered with the sexual experience and pleasure.



What can be done to make sure that the boys are also involved in pregnancy consequences and contraception? It shouldn't be just the girls taught, the boys should be taught as well...



Adolescent girls

Difficult access of contraceptives for in-school adolescents

Adolescents reported difficult access to contraceptives in mainstream sexual and reproductive health (SRH) facilities. This was reportedly because mainstream health facilities were mostly not user-friendly to them. Cultural difficulties of health care workers as parents themselves having to issue contraceptives to girls the age of their daughters was reportedly confronting. The experience was said to be uncomfortable for both users (adolescents) as they felt

judged, and health providers who struggled with the morality of providing the service. A call to youth friendly sections within mainstream health facilities was made.

Some non-governmental organisations called for the provision of contraceptives in schools or within school programs as an alternative to provision in mainstream health facilities. Government however held a different opinion, citing challenges that come with giving invasive substances into the body systems of underage children without parental consent.



The difficulty on the younger ones (teenagers/ adolescents), is that coming for contraceptives, they find health workers who have children as young as them. It becomes confronting that they now have to give a contraceptive service to someone as young as their child. So it is recommended that teenagers have their own separate SRH services. The service providers has to be provided by specially trained people to be friendly towards teenagers.



Nursing sister

Gender based violence

Sexual violence against girls, and especially adolescents, was said to be rife in Eswatini communities. Actors in the education sector reported that some adolescent girls were impregnated by prominent male members of communities such as teachers, politicians, businessmen, or even family members within homesteads. Incest from uncles, cousins, or even own fathers with under-age girls was reportedly common and drove unintended pregnancies. This was said to be regrettable, and unfortunately for the victims, quite difficult to end or prosecute the perpetrators. Although the Eswatini law protecting individuals from gender-based violence is in existence, reporting individuals in positions of power,

be it domestically (e.g. perpetrating father at home), powerful businessmen or politicians who also helped the community with their livelihoods was difficult. Community members were often conflicted, and while they did want the violation of women and girls to stop, they also feared not getting financial help when in need by getting the source of their livelihoods arrested. Culturally, acts like GBV in families were considered ‘tibi tendlu’, loosely translated, ‘the family’s dirty linen is not to be aired in public for all and sundry to see’. Because of these reasons, GBV was said to be allowed to fester in communities, and often culminated in unintended pregnancies with dire consequences like dropping out of school, unsafe abortions, and poor maternal outcomes. A participant from the education sector explained;



Incest in the country is rife. And its' not talked about. Kutsiwa tibi tendlu (a Siswati expression)...We have powerful men in communities perpetrating GBV and having underage sexual relations...The SODV law came with so much promise. As the MOET, we worked with teachers and victims to report the men that were impregnating girls in schools, having sexual relations with minors as defined by the law. The DPM's office was very supportive of this initiative and encouraged it. But when the report got to the DPM's office, it was discovered that very senior and prominent men would get arrested. A whole lot of them in country. Since then, it's unclear where things are in the DPM's office. Even when you enquire. The exercise to bring these men to account and protect adolescent girls while teaching a lesson to the Eswatini community has died a natural death...This is so frustrating. Especially because you continually see more of these children as victims of sexual violence in schools, and nothing can be done. The SODV law is very good. It even states that if you suspect that someone is experiencing GBV you must report. It is a crime to know about it and not report. But no one does report because the people responsible are powerful men in the Eswatini society...In another meeting with community leaders where we were discussing GBV to create awareness in communities, one of the chiefs raised his hand and said to me; ‘when you are done with this meeting, come to the kraal in my constituency. I have a well-known wealthy man who has made many of these underage girls pregnant in my community. I am discouraged from bringing him to book by the community itself because he has money and is generous with it. You need to tell us what to do in such circumstances. The girls themselves want his money, and poverty is rife’. I was shaken because these are the realities of GBV and unintended pregnancies among the school going adolescents.



Policy maker

COVID-19 related disruptions

Participants reported that country lockdowns related to the COVID-19 pandemic since the year 2020, disrupted day-to-day life, including travelling. Visits to health facilities were also disrupted, unless an emergency or life-threatening situation existed. Sexual and reproductive health services, including contraception, were said to have also borne the brunt of this status quo.

Participants reported a perception of increased occurrences of unintended pregnancies therefore, and attributed the increase to lack of access to

contraceptives due to the lockdowns. Though no figures were available yet, participants from the Ministry of Education and Training (MOET) also reported increasingly common reports of adolescent girls dropping out of school because of unintended pregnancy countrywide. The situation has been so dire that the MOET has crafted a new policy to allow pregnant girls to continue going to school until they deliver. Nurses and doctors also reported that they saw reduced numbers of clients who came in for contraceptive services during lockdowns. This was attributed to COVID-19 restrictions on travel.



...we've seen a marked reduction of women coming in for contraception services during the COVID-19 lockdown. We think it's due to travel restrictions which have probably limited women's ability to seek non-emergency care.



Medical officer

Non-utilisation of contraceptives

Rural health motivators reported that some women in their communities did not use modern contraceptives, or had interruptions in their use for different reasons. Unintended pregnancy was often the observable outcome in these instances. Women in communities also reported occurrences of unintended pregnancy when they did not use contraceptive means. There were a number of reasons reported for not using modern contraceptives particularly. These included lack of information on contraceptives; poor understanding or information on the side effects of modern contraceptives; misconceptions or myths about modern contraceptives; opposition of modern contraceptive use by sexual partners; as well as provision of information on contraceptive use to adolescents in schools without providing the service (contraceptive administration). These rendered modern contraceptives inaccessible to women.

Doctors and nurse participants stated that women that have just given birth, or had an ectopic pregnancy, or an abortion were not routinely offered contraceptives on site within health facilities. Gynaecology and maternity wards did not routinely offer contraceptive care to women, unless it was a rape case, where they would offer emergency contraceptives. Women were reportedly referred to public health clinics, outside of hospitals. Participants also reported that it was not uncommon to see women that had referred for contraception to public health clinics coming back to hospitals for post abortion care or to deliver babies from subsequent unintended pregnancies. According to the health providers (doctors and nurses), these women would not go to the referred clinic to access contraceptive services as recommended. Consequently, unintended pregnancy would result.



"Family planning services and commodities are more available in the PHU [public health units] than in the hospitals.... Emergency contraceptives are only provided to rape cases in the hospital. Patients with other indications for emergency contraceptives are referred to the PHU to access them.



Medical officer

Contraception:

Two main themes were identified in this category. These were the policy environment and barriers to the utilisation of modern contraceptives. Each of these themes had corresponding sub-themes as follows;

Policy Environment

Policy environment supportive of contraception

According to participants, the policy environment was favourable for the promotion and administration of all contraceptive commodities. Participants from non-governmental organisations (NGO's) felt that the government SHR strategic plan, involvement of all

partners in the coordination SRH services including contraception, and the Sexual Offences and Violence Act (SODV) Act provided for contraceptive service provision in the country. Some of government's policy partners had themes on contraception with supporting budgets, while other partners worked predominantly in offering contraceptive services. Eswatini Government's SRH strategic policy made provision for free contraceptive service provision in all public health clinics of the country. In these clinics various contraceptive commodities were offered at the choice of clients (when available). Clients had the option of both short-term and long acting contraceptives.



Policy environment in Eswatini conducive for implementing FP is conducive because an SRH policy exists, along with an SRH strategy. At national level, a Youth Policy exists that includes FP as a multi-sectoral issue, because FP is not just a health issue...



SRH implementation partner

Implementation challenges of the contraceptive policy

Implementation of what was promised by policy was a problem according to participants. Inconsistent availability of contraceptive commodities in government facilities where the service is free meant an unmet need for family planning for many women. This also backtracked confidence in the reliability of these contraceptives with women resorting to traditional means or foregoing contraception altogether. Where a pregnancy had occurred and where abortion was allowed based on the circumstances set out in the law in the country, access to such abortion was difficult. Technical issues like the need to have two medical officers approve and perform the abortion was deemed impractical by clinicians and therefore prohibitive.

Policy gaps in the provision of contraceptives

There were also policy gaps in the provision of contraception. The country policy is such that all family planning and contraception is accessed in mainstream health facilities. This has the benefit of non-discrimination or stigmatisation of all users such as sex workers. However, some of the important groups of the population such as people with disabilities and adolescents struggle to access contraception in the mainstream model. Participants in the policy making space admitted that this was a gap, and that there was currently no policy focus on the SRH of people with disabilities in the country.

Missed Opportunities in policy to provide contraception

There was however a missed opportunity in the policy.

This was the non-involvement of community health workers, called rural health motivators (RHMTs) in the country. RHMT's were potentially an effective structure for community related to contraception and could help with contraceptive issuance and information sharing. Lessons were said to be readily available from the HIV program that enlisted RHMT's, and this brought a turn-around in the country's ability and success at providing HIV services at community level. Another missed opportunity was reportedly the non-provision of contraceptive services in school programs that sought to prevent unintended pregnancies. Participants felt that provision of information without a

service was a wasted opportunity to improve access to contraceptive commodities to school going adolescents.

The resource of traditional structures and influential community individuals was also said to be untapped as far as contraception was concerned. The absence of a policy strategy to enlist community leaders like chiefs, bucopho (chiefs' governing council), men, and other available individuals to champion contraception were a missed opportunity. This was more so because experience in other programs like HIV had shown their effectiveness in improving acceptability of services, utilisation, and access by community members.



"...We do not give pregnancy prevention pills. We usually tell women to go to the clinic to see the nurses..."

Rural health motivators



Barriers to the utilisation of modern contraceptives

There were however, barriers to the utilisation of contraceptive services in the country. These were lack of information and myths or mis-information; contraceptive commodity stock-outs/ intermittent availability of contraceptive commodities; loss of the condom as a contraceptive device; patriarchy; suboptimal implementation of contraceptive programs; men opposed to the use of modern contraceptives.

Lack of information/ myths/misconceptions about contraceptives

Participants in communities felt that they needed more information on contraceptives including how they worked and their corresponding side effects. The lack of reliable readily available information from health authorities or their representatives meant the Eswatini population had to rely on secondary and less reliable sources like friends, family, or peers. Scarcity of information on modern contraceptives was reported by all women age groups. These included adolescents' in-school, out of school adolescents, and adult women within communities. Women reported learning about modern contraceptives from family or friends in use of it. They therefore took

whatever opinion or experience of these sources as factual. Where sources experienced side-effects, the information was transmitted by word of mouth to friends and family, and this discouraged others from taking up modern contraceptive commodities.

Participant men in this study (men in leadership and ordinary community members) also expressed the need for information on modern contraception. They were concerned of the common occurrence of pregnant adolescent girls in their communities and felt that they could benefit from contraception. These men were not opposed to learning about contraception. They did however believe myths about modern contraceptives; many believed that it interfered with sexual pleasure during sexual intercourse or caused infertility, while the injectable contraceptive was believed to cause cancer. These men admittedly discouraged the use of modern contraception by their women partners. They believed contraceptives made women's sexual organ muscles lose, providing a loose grip during intercourse, thus lessening their sexual stimulation. Men also believed that modern contraceptives made women 'wet', i.e. have excessive fluid secretions during intercourse, and this was said to also interfere with the sexual experience. Some men therefore encouraged women to use traditional herbal concoctions rather than modern contraceptives.



...we [adolescent boys] also don't know much about pregnancy prevention and contraception. We need opportunities to be taught also, otherwise there are no spaces to learn these things. We heard that they have clubs called "Joyful Hearts" in Luyengo now. They go about teaching young people on issues of sex and pregnancy prevention. We need this kind of information. We usually try to learn from what we see others doing or from other people's mistakes...



Adolescent boys

The misinformed stance by men that modern contraceptives reduced sexual pleasure scared women off contraception. Women stated that they valued how their male partners felt about them and wished to be desirable to them sexually. Women

discontinued contraception when their men partners complained. Some however, continued with modern contraception, but kept this information from the knowledge of their male sexual partners.



...I keep my contraceptives in my drawer of underwear. I know he [the male partner] never opens there, so he does not know, and our sex life continues as normal.



Women

Adolescent girl participants in this study reported a lack of readily available trustworthy information on safe sex and contraception. Their source of information on this subject were peers. Some adolescents were aware of different contraceptive devices, but believed that they all caused weight gain. This was an issue for the girls because they were mindful of their looks and feared being mocked by peers because they had grown fat. As a result, these girls avoided modern contraception. Adolescent boys, just like adult men, were not in favour of the use of contraceptives by young girls. While they admitted to not knowing much about modern contraception, they disliked the idea of their sexual partners using it, fearing decreased sexual pleasure.

Commodity stock-outs or intermittent availability of contraceptive commodities

Actors on the supply side of contraceptive services including participants in the policy making space, participants representing government SRH implementing partners, RHMTs and adult women in communities, all declared that contraceptive commodity stock-outs were common, and a threat to the uptake of contraception. These stock-outs made

contraception availability intermittent and reduced their reliability for many women. Policy makers and health practitioners (nurses and doctors) felt that the lack of consistent availability was regrettable, but felt helpless in this situation as it was out of their hands. This was particularly problematic as it also interfered with the choice of contraception for women. While Eswatini, in principle, offers different types of contraceptive commodities at the client's choice, this is not so in reality because it often depends on what commodity is available when a woman needs one. As a result, those women that did utilise contraceptive commodities were at times forced to change a method because the one they were comfortable with was out of stock at the time. Contraceptive stock-outs also caused problems when women experienced side effects and had to switch from one method to another. This limited women's choices and often discouraged them from using contraceptives altogether.

Users of consumers on the demand side of contraceptive services in communities (women) also expressed concern that at times, contraceptives were unavailable in health facilities. This brought on a sense of undependability, which they shared with peers, friends, and family.



...In the last year alone...contraceptive commodities were out of stock from March for the rest of the year...'



Nursing sister

Contraceptive side effects

Women reported experiencing side effects with modern contraceptives, and this led to a discontinuation of their use. These side effects included bleeding tendencies, amenorrhoea, a feeling of excessive vaginal wetness, weight gain, headaches,

and a reduced sex drive for women. Women reported commonly discontinuing the use of contraceptives once they experienced side effects. Some women reported not bothering to go to hospital once they experienced these because they did not feel confident that the hospital will be able to treat these effectively.



People do use contraceptives, especially the young people. The only issue is when they begin to experience problems from side effects. This is why people do not use contraceptives or discontinue them. The biggest problem are these side effects such as gaining weight, excessive wetness vaginally [kuyamchechisa], or bleeding. Once someone has side effects, they usually stop using the contraceptives at this point, and do not even go back to the hospital to report that they are now facing problems. It is quite common for women to stop contraceptives once they experience side effects.



Rural health motivators



The side effects of the contraceptives especially the injectable which can cause bleeding yet they are using their body for work, also the loss of libido with the contraceptives...



Sex workers

Loss of the condom as a contraceptive device

Government partners in the SRH implementation space bemoaned the loss of the male condom as a contraceptive device in the Swati nation. Condoms were widely available, mostly free to use, and almost never ran out of stock in the country. If the perception was right, condoms could therefore be a viable contraceptive commodity. However, participants reported that HIV prevention marketed the condom aggressively as a transmission prevention method. The Eswatini public has since shifted their perspective from using it as a contraceptive method to almost exclusively regarding it as an HIV prevention device. Focus group discussions with women in communities confirmed that the male condom was mainly considered as an HIV prevention device and not a contraceptive method. Consequently, women did not consider negotiating with their male partners for the use of the male condom during contraceptive commodity stock-outs, in particular because once the

trust between sexual partners had grown, condom use is discontinued. Men also considered it exclusively as an HIV prevention device. Some men stated that they can use a condom when having sex outside marriage or their steady partners, but they refuse to sleep with their wives or trusted partners with a condom.

Furthermore, men complain that the use of a condom interfered with the sexual act. Some men reportedly suffered from penile erection problems. For these men, swiftness to penetrate the woman once they had erection was of the essence as they had difficulty sustaining it. The application of the male condom threatened the substance of the erection, and therefore the sexual experience of the partners. The male condom was thus viewed as prohibitive in the sexual encounter.

The female condom was regarded as unpopular with women in Eswatini. Usage and demand for it was

therefore very low. Participants representing SRH implementing partners stated that the female condom had not been marketed as extensively as the male condom, supposing that that was the reason for the low uptake. In addition, women did not consider the

female condom to be a contraceptive device, but rather viewed it as an HIV transmission prevention device. There was also low level of knowledge of the female condom in communities, as participants reported not knowing about it.

“

In the fight against HIV and AIDS, we [implementers in the SRH space] worked hard to market the condom as an HIV transmission preventive device. During this time, the pregnancy prevention function was neglected...

”

SRH implementation partner

“

...I cannot use the condom at home [with wife or steady female partner]...

”

Men

Men opposing modern contraceptive use

Women reported that their men (male) sexual partners dissuade them from using modern contraceptive commodities. Men complained that their sexual experience was less pleasurable when women used modern contraceptives. They also complained that their women partners experienced side effects from contraceptives. Since women had a desire to have

sexual appeal to their male partners, they discontinued contraceptive use. One doctor added that men seemed to fear of exposing their partners to contraception because of fear of side effects like infertility or bleeding tendencies on the woman. Women also reported that men favoured traditional medicine mostly, and traditional methods of contraception rather than modern methods.

“

...the problems with contraception is; when you have intercourse with your wife, you find that she is too wet. When you get to her you even begin to lose the erection because she feels like she was with another man when she wasn't. So this hurts you as a man. And if your wife uses contraceptives at home, and you get out of home to have a sexual encounter with someone who does not use contraceptives you feel the difference. Because this thing depends on how the heart feels. Once you feel that the contraceptives have altered how the woman feels to you, there isn't anything you will do. You simply lose the erection. You begin to feel lazy even when you had intended to have a pleasurable encounter with your woman. You lose the strength for it. The battery goes flat. It will not charge quickly because of the wetness you found there...

”

Men

Adolescent men were also against the use of contraceptives by their young girlfriends. Their reasons were the same as those of older men. These boys relied on peers for information on contraception, and it was scanty or vague according to them. Modern contraception was therefore not understood. Adolescent men also felt that contraception and pregnancy was a woman's business. While they did not wish to make their sexual partners pregnant, they believed it was the woman's/ girls' responsibility to make sure that they avoided pregnancy. Health facilities as places of information of contraceptives were unreliable according to boys because of poor

reception by health providers. The young men therefore felt that the quality of reproductive health services was uncertain as it depended on the health provider on duty the day one visits.

In addition, some men reportedly incentivised non-use of condoms (a contraceptive device) during sexual encounters. Young girls who were considerably younger compared to their male counterparts were reportedly more vulnerable to such practices. Women sex workers reported men paying a higher price if sex encounters were without the use of a condom.



In intergenerational sex where the girls are considerably younger than the male clients, it is common that when you have sex without a condom the pay is much higher than when using the protection

Sex workers



Emergency contraceptives

Some adolescent girls were aware of emergency contraception. Girls reported that emergency contraceptives were very expensive and therefore unaffordable to them. These were reportedly only available in pharmacies. According to young girls, young boys who were their sexual partners did not seem to care much about contraception. They were said to be only interested in intercourse, without much thought to pregnancy as a consequence. Adolescent girls were not aware that emergency contraceptives were freely available in government public health clinics, along with other contraceptive commodities.

Hospitals reportedly did not routinely provide emergency contraceptives on demand, except for rape cases. Emergency contraceptives for other causes were reportedly available in public health unit clinics at no cost to the user, and on demand. The barrier was that most women were not aware that they could access emergency contraceptives from public clinics and at no cost. Most believed one had to have money for the expensive 'morning after' pill from the pharmacy, and often could not afford it and ended up

with unintended pregnancies.

Implementation gaps of contraceptive programs

Government was responsive at policy level and therefore the policy environment was favourable, but implementation was a problem. To prevent adolescent unintended pregnancies, and promote contraception, the Eswatini Government crafted a Life Skills Education (LSE) subject to be taught to all high school pupils. But because this subject was reportedly not examinable, school teachers tended not to prioritise it. Participants stated that the LSE study period would often be used to catch up or teach material on the examinable courses. Thus, this subject had arguably become optional for teachers, resulting in the information on pregnancy prevention and contraception not reaching the at-risk adolescents consistently if at all. Furthermore, some teachers were reportedly uncomfortable with talking about human sexuality to in-school adolescent girls, and they were not trained to do so. This was part of the stated reason for the avoidance of LSE for some.

“

Some teachers do not value LSE and continue to teach core subjects during LSE time, since it is not examinable. It competes with core curriculum...Other teachers don't feel comfortable to talk about human sexuality because they are not competent on issues of human sexuality...

”

Policy maker

Abortion

Young people stated that abortion is common among their peers. Most of the abortion was unsafe abortion, which they reported as spontaneous in hospitals for fear of health providers calling the police on them and facing prosecution. Adult women and RHMs (community health workers) also reported that abortion did occur among their peers and was sometimes from unintended pregnancies. Five main themes identified were, three of which had corresponding sub-themes. These were: the policy environment concerning abortion; cultural and religious environment; civil society views; barriers to safe abortion; and drivers of abortion.

The policy environment concerning abortion

The constitution of the Kingdom of Eswatini provides for grounds of legal abortion. When declared legal,



It is difficult to access legal abortion because of the requirement of two doctors to approve and perform the abortion in hospitals...there should be at least a specification on the two doctors and the designated hospital where these abortions can be safely done.



Nursing sister

Cultural and religious environment regarding abortion

Eswatini culture and customs valued all life (regardless of age or status) and therefore abortion was reportedly considered taboo, angers the ancestors, and brought

health facilities are able to perform abortions in a safe manner. Grounds stipulated by the constitution include when the pregnancy is a product of sexual violence (e.g. rape), or when the life of the pregnant woman is in danger if the pregnancy is allowed to continue. However, participant clinicians reported that technical provisions of the law made abortion inaccessible or difficult to women who require the service. For example, participants within hospitals (doctors and nurses) stated how when an abortion is indicated (e.g. rape), two doctors have to approve the decision to terminate the pregnancy, and two doctors must be present at the termination. This requirement reportedly made it difficult to implement safe abortion in the Eswatini health system. For example, participants reported the difficulty of making even the restricted legal abortion accessible because it was not easy to find two doctors to approve and perform an abortion for each client all the time in an environment plagued by scarcity of all health care workers in general, and doctors in particular.

bad luck or curses from them. Tindvuna (chief's right hand men), men and women in communities, the Swati traditional custom is pro pregnancy and multiplication of families and communities. Abortions were therefore considered killing of an actual baby before its birth and anti-population growth. Anyone who has had an abortion was therefore regarded with

stigma in the Eswatini culture according to participants. Women participants also perceived abortions as taboo, but were understanding of the circumstances that led to some opting for abortions (e.g. extreme poverty).

The kingdom of Eswatini was also predominantly Christian by religion, and believed in the sanctity of all life. Abortion, regardless of the age of the conceptus was considered murder, and was immoral or sinful the same way killing a born human being is according to religious and traditional participants. Religious and traditional views (from traditional community leaders, and men in communities) therefore considered that anyone who induced an abortion, or was party to an abortion performed were to be punishable by the law of the land. Both traditional cultural and religious views were that life began at conception, not at birth. Participants from religious organisations were of the view that all abortion is illegal in the country and were not aware that there was restricted provision for abortion in the law. Women, men, and rural health motivators in communities were also not aware that

there were legal grounds for abortion in the country.

Religious leaders admitted that pastors at times encouraged abortion when they had impregnated their congregants and wished to conceal the occurrence of the pregnancy. They also reported knowing women who had died from complications of abortion in their churches. However, they maintained that this was wrong according to the bible and was therefore condemned, not condoned. Pastors were reportedly in support of laws punished those that had abortions. Religious leader participants also reported that the church had no support system for those that had committed abortions, and other than preaching reform from abortion, did not do much to help these women. There was however, an expression of interest to collaborate with the Ministry of Health to prevent unintended pregnancies by religious leaders. As leaders of congregants, religious leaders understood their power of influence over communities and believed that when empowered with health information, they could contribute to the prevention of unintended pregnancies.



...our congregations listen to us...to everything we tell them to do they take it...we just need information on family planning to be able to share with them. Some of what we say against family planning could simply be out of ignorance...wi the correct information, we can partner with the Ministry of Health to prevent pregnancies...

Religious leader ”



...There is no community support for post abortion because it [abortion] is still considered to be a taboo and not legalized so the community do not talk about it... Currently the illegal state of abortion makes it difficult to address head-on.

Civil society organization ”

Civil society views on abortion

Civil society participants in this study were for the unrestricted allowance of abortion in the land at the demand of women. They argued that the abortions occurred regardless of beliefs or the legal status that

either accepted or outlawed it. Rather, women had abortions regardless of the law and often using unsafe means. Consequently, policies restricting abortion promoted unsafe abortion practices as an unintended policy outcome and against cultural and religious norms. Social pressures beyond the control of women (e.g. poverty, sexual violence) led to unintended

pregnancies that women found difficult to keep. Therefore, civil society participants advocated for the non-restricting of abortion to allow women to access safe abortion and limit the existing deaths, severe illness, and sometimes disability that they saw in communities endured by women who had committed unsafe abortions. Young people in communities also expressed a wish for the removal of restrictions in abortions to help them access safe abortion without fear of perceived penalties from the law in the land.

Barriers to legal and safe abortion

Participants reported that the Eswatini, the constitution allowed for restricted abortion. However,

barriers to access of this limited abortion were reported. These barriers (sub-themes) were either technical, or had to do with lack of awareness that the law did provide for legal abortion in certain circumstances. These are detailed as follows;

Lack of knowledge or awareness of the provisions of the constitution and the law

Community elders (bucopho) interviewed were of the view that all abortion was completely illegal in the country Eswatini. They were not aware that the constitution provided for restricted abortion under certain circumstances. Adolescents (men and women) interviewed were also not aware of provisions for abortion by the law.



...abortion is a crime. It is not allowed by law...



Community elders

Technical barriers to getting legal abortion

Clinical barriers

Health provider participants (doctors and nurses) reported that two medical officers (doctors) were supposed to confirm the indication for the abortion, and that two doctors should perform the abortion procedure was prohibitive to legal abortion access for women. Scarcity of resources, including shortage of

health providers (especially doctors) made it difficult to always find two doctors at a time that can confirm the need for the abortion, and perform it together. Health provider participants therefore called for the simplification of this process to make legal abortion accessible. Health providers also reported that it was challenging to get a legal safe abortion approved. The administrative processes were long, and often result with advancing of the pregnancy till term before an official approval to terminate is secured.



Swazi law on abortions does allow for abortions in life threatening conditions for the mother and baby like eclampsia, congenital malformations. But the main challenge in the country is that it takes too long to get authorization for the safe and legal abortion. It hardly takes less than 3 months to get the authorization...



Medical officer



The law on restricted abortion is okay but what needs to be revised is the process to authorize for an abortion so the time can be shortened so it can benefit the clients as currently most if not all the clients end up delivering without having gotten the abortion as an intervention.



Medical officer

Legal process barriers

The arm of the law was reportedly too slow in bringing perpetrators of GBV (e.g. sexual assault, incest, or unlawful intercourse) to book even when all the evidence was present and all requirements from the victim had been met to report the offence. Participants reported that it did not help that often, powerful men in communities were the perpetrators of GBV, and sometimes against minors. It gave the impression that GBV perpetrators had impunity before the law, and made the plight of victims who had dared to come forward and their supporters feel powerless and defeated. One of the causes of the slow pace of prosecuting perpetrators was too few magistrates

tasked to sit for GBV cases countrywide. According to participants in the legal space, only two magistrates bore this responsibility, and yet the sheer volume of GBS cases they had to deal with was enormous and increasing. These magistrates although hardworking, are overwhelmed with the workload.

Furthermore, GBV victims reported difficulty in engaging with law enforcement agencies when reporting GBV cases. In one such incidence, the law enforcement agents (policemen) ruled that an underage victim of sexual violence who had fallen pregnant should not have an abortion as the baby to be born would serve as an exhibit that the accused did indeed sexually assault the victim.



...the volume of GBV cases, including sexual assault are numerous. There are only two magistrates countrywide responsible for presiding over such cases. They are overwhelmed, and cannot sit through all these cases speedily. This delays justice for the victims, and many end up giving up on the case to focus on healing and moving on...



Civil society

Drivers of abortion

Poverty

Poverty was reported to be one of the most common motivator to have an abortion. Women (adult and youth alike), stated that not having sufficient means to live put sustaining a pregnancy and a subsequent baby out of the question. The realities of not having enough means to support oneself, suggested greater economic hardship when the baby was born. As a result, women resorted to abortion. Women who were

commercial sex workers also cited poverty as a driver of unintended pregnancy among their population. It was economic hardship that coerced them to enter commercial sex work, and men offered to pay more when they agreed to have sex with them without a condom. The result would be at times an unintended pregnancy, for which abortion was the solution for commercial sex workers. Some women came from child headed households, and used transactional sex with men as a means to support themselves and their families. Other women, even if in stable sexual relationships (e.g. married) resorted to multiple sexual



...due to poor economic status then young people resort to abortion. Feeding and rising a child when you can't even feed yourself is difficult. Abortion is a solution when an unwanted pregnancy has occurred...

Women



Gender Based Violence

Unintended pregnancies which are product of gender-based violence often culminate in abortion. In Eswatini, the constitution provides for legal abortions when the pregnancy is a product of GBV (e.g. rape, incest or unlawful sex) for instance. Women are sometimes forced into unprotected sex because the men (especially steady partners or husbands) refuse to wear condoms when having sex with their partners,

or coerce women to discontinue the use of contraceptives. Incest and other forms of undesirable sexual advances against vulnerable women e.g. young girls, children at home, women facing powerful/influential men often culminate in a pregnancy that will not be wanted by the woman. Unsafe abortion is usually the go-to solution to prevent having a baby with an abuser, or having the baby as a constant reminder of the perpetrator of the violence.

Unwanted pregnancy

Women that became pregnant without intending to do so often resorted to abortions in communities according to participants. RHM's, women, and the youth reported that abortion was a solution where the pregnancy had not been intended and perceived to disrupt future plans of the woman like continuation with education or career. Men who impregnated

women without intending to do so reportedly encouraged them to have abortions and gave them the financial support to do so, including travel to have the procedure done in South Africa where abortion on demand was legal up to 12 weeks gestation. In many instances, men reportedly motivated their partners or pressured them to perform unsafe abortions because they did not want the responsibility of the pregnancy.

“

...It is a man that induces an abortion. A woman simply perfects what the man will have already started...the man will threaten the woman to have an abortion or else...

Women

”

Female sex workers reportedly felt that abortion was the only solution to unintended pregnancy, which they were very prone to. The reasons reported were that modern contraceptives led to inconvenient side effects such as bleeding, and yet sex worker bodies were required for work and clients offered to pay more for sex sessions without a condom.

“

The side effects of the contraceptives especially the injectable which can cause bleeding yet they are using their body for work, also the loss of libido with the contraceptives... If you have the side effects it means loss of income, and the flesh to flesh has more money compared to using the protection...abortion is the only solution...

Sex workers

”

Paternity issues

Uncertain paternity

Women were reportedly more likely to have an abortion when the paternity of the pregnancy was uncertain. Health providers reported that some women did admit to deliberate termination of their pregnancies. These were women reportedly had

multiple concurrent partners who happened to be faced with unintended pregnancies, and therefore had uncertainty over who the father is. Unsafe abortion was usually considered the solution in such a pregnancy. Young women (adolescents) also reported that unsafe abortions were likely when paternity of the pregnancy was uncertain.

Male sexual partners denying paternity

At times, male sexual partners denied responsibility of the pregnancy, and this reportedly pressured women into having abortions. Some women, more commonly among the adolescents became pregnant and when disclosing to the responsible male partners, the men either denied paternity, or immediately terminated the relationship with the woman, refusing to participate in raising the child. In such instances, women reported feeling compelled to terminate the pregnancy because

of the burden of financial, emotional, and societal burden raising a child single-handedly without a partner's support. Health providers attested to seeing women in such predicaments. One of the participants even declared that it is actually men that initiate and perpetrate abortions.



...when you have multiple sexual partners then a pregnancy occurs, the paternity of the child will be unknown to you. An abortion helps to get rid of the problem.



Adolescent girls

Community sources of unsafe abortion

Cytotec (misoprostol) was reportedly commonly used drug used by women to unsafely induce abortions in communities according to participants. Although access was restricted, members of the public were able to get it fairly easily on the black market in Eswatini according to some health providers.

Suppliers included, but were not limited to; Indian individuals, Chinese shops, and some pharmacies according to participants. Mechanical objects were also reportedly used such as clothes hanger wires used to pierce the amniotic sac, Vaseline to lubricate the wire, and forcing the mouth of the cervix open to insert foreign objects. Some participants reported sourcing traditional concoctions to induce abortion.

Post abortion care

Demand for PAC

Both doctors and nurses reported seeing women in all age groups coming in for PAC. Adolescents were common according to participants. Health providers also reported seeing women above 30 years coming in for PAC increasingly more. According to women in communities, all age groups had abortions, though the practice was said to be most common among the youth. Older women reported poverty as the main motivator for having an abortion for which they would seek post abortion care from health facilities. Rural health motivators (RHMs) also reported that the youth

in their communities generally did not use contraceptives, and resorted to abortion to prevent the pregnancy from interfering with their future plans such as education and career.

RHMs reported that traditional medicine was used to treat complications of abortion like pelvic-bleeding. Young people confirmed that they mostly used traditional healers for care post abortion. Hospitals were accessed as they last resort, when they couldn't resolve post abortion complications at home or with traditional healers.

Accessibility to life-saving post abortion care

From the perspective of health providers (doctors and nurses) and SRH service providers, post abortion health care was accessible in public hospitals once women presented themselves. These women commonly presented once serious complications had set in or required emergency care. Women seeking PAC almost always reported spontaneous abortions, and hardly anyone came into hospital for induced abortion. According to women participants in communities' health providers were known to be receptive and non-judgemental towards women who came in seeking care post abortively. None of the participants reported discrimination from health

providers for having had an abortion. This was as long as women reported the abortion as spontaneous. Once an abortion was reported as self-induced, it was branded criminal and it meant health providers had to report the case to the police because abortion is illegal in the country, and only allowed in restricted circumstances. As a result, women mostly kept away from health facilities unless a complication from their abortion set in.

There were however reports of discontinued aspects of emergency PAC in some hospitals because of wear and tear of instruments used. Women would then be referred to another health facility to receive the service. In one health facility, the sterilising equipment for minor uterine evacuation procedures had broken down for some time and had not been fixed.

Barriers to quality post abortion care

No guidelines on PAC

Nurses voiced the need for guiding documents on the minimum health care package for PAC. This according to participants, would ensure uniformity in

the quality of PAC that women receive. At the moment, nurses reported giving whatever care they deemed necessary. Nurses and doctors stated noticeable gaps in the quality of PAC as some essential elements of care were often missed, such as contraception if desired by the woman and ultrasound examination because of inadequacy of staff skills.

Of the 10 health facilities capable of offering PAC services, some of the health centres were not consistently able to offer PAC and had to refer women. The disadvantage of these referrals was the long distance from the referring hospital to the referral hospital. The unavailability of ambulances (largely few compared to country demand), meant women either had to use their own transport, or had to wait for longer period before transport was available for the referral, during which time complications of the

abortion progressed. The reasons for inconsistency of PAC provision in these hospitals were largely due to health system problems. These included staff shortages; lack of bed space for PAC clients as the ward was small and included all women and children in admission; malfunctioning equipment (e.g. autoclave needing fixing), and sometimes nursing staff on duty without the skills set to look after gynaecology patients.



We have limitations in providing PAC. These include lack of guidelines on the minimum package to give, lack of skill capacity to use ultrasound, no gynae department at all, unavailable equipment, very far off distance to refer our patients seeking PAC, and staff shortages in this health facility...

Medical officer



Contraceptives not routinely offered as part of PAC in health facilities

In all 10 health facilities included in this study, participant health providers (doctors and nurses) reported not offering contraceptive services as part of PAC to women seen in gynaecology wards or as outpatients. Information on contraceptives was not routinely offered, nor were clients asked if they wished to contracept or not. They did however refer clients to government public health unit (PHU) clinics at

discharge from maternity wards.

One hospital had reportedly advocated to have permission from the MoH to stock intra-uterine contraceptive devices (IUCDs), so that they could give it to women that had given birth in maternity. This was said to have been agreed to in principle, and would soon be implemented. Maternity hospitals were not stocked with contraceptives routinely, except for emergency contraceptives to be offered to sexual assault victims as per policy.



We refer our PAC patients to the public health unit for contraceptive care.

Nursing sister



SRH Program implementation gaps

Doctors lamented that according to the SRH program policy, contraceptives were offered in public health clinics around the country, and not in hospitals. This was the predominant reason why hospitals did not offer contraceptives to women during PAC or in the

puerperium after giving birth. In hospitals, emergency contraception was only administered when the woman presented as a rape victim. Not much of these contraceptives were therefore stocked to routinely give on all women who which for contraception as part of their PAC.



We do not stock contraceptives in this hospital, except for emergencies for rape patients. It is the public health policy to give contraceptive care exclusively in public health clinics, except for emergencies.

Medical officer



Supportive post abortion care unavailable

Health care provided post-abortively was usually limited to life-saving emergency care for the women. Participants reported that contraceptive care to prevent future unintended pregnancies, post abortion counselling when indicated, and reproductive health education were not routinely given as part of PAC in health facilities. In adolescents seeking PAC, no information on pregnancy prevention, safe sex, or contraception was given despite being the most common group utilising PAC. Only sexual assault (rape) cases were privy to referral for counselling with social. Other women who had sought PAC were excluded, and not given the benefit of opting for it.

Avoidance and delays in seeking PAC in health facilities

Because abortion was perceived to be completely illegal in the country, women reported avoiding seeking health care in health facilities unless the situation was dire, with no relief elsewhere. These were the women who ended up in health facilities seeking emergency care to save their lives. Doctors reported that women presented for PAC late in the disease process such as after they had bled excessively and for days, or some sepsis had set in. Delays in seeking PAC therefore led to unnecessary morbid complications that threatened the life of the women. Reasons for the delay in seeking PAC were reportedly due to fear and shame of the stigma of having had an abortion by women. Women also reported fear of health providers calling the police on them as they perceived abortion to be completely illegal in the country. These women were fearful of being jailed.

One participant reported;



...delays post any form of abortion are because of fear of being stigmatized, accused of intentionally termination even when they didn't or fear health providers will call police on you. As such, they present having bleed a lot for days...

Medical officer



Health system limitations in providing post abortion care

In all health facilities, there were no guidelines or clinical protocols available to support the provision of PAC. This was problematic because many of the health facilities were low resourced in terms of health providers. Lower level cadres needed clinical guidance through guidelines or clinical protocols to assure the quality of PAC rendered.

There were also skill deficiencies in health providers

giving PAC in many health facilities. A pelvic or abdominal ultrasound was usually indicated in PAC, and yet the majority of clinicians reportedly in lower level hospitals like health centres and sometimes regional hospitals did not have the skill to perform it. This meant referral mostly to higher level health facilities, with the unintended consequence of centralising care, and potentially overwhelming these hospitals with demand for PAC services unnecessarily.

Referral centres for PAC were sometimes very far for women. In the absence of inter-facility ambulances, patients/ women had the responsibility to transport themselves to the referred facility. Many of these women reportedly did not go, as they did not have the means to travel to access care. This was a barrier to PAC. Others reportedly ended up staying longer in lower level facilities, while the complications graduated to more serious complications that threatened the woman's life. Therefore, accessibility to PAC was undermined by these health system limitations.

Gender based violence

Gender based violence (GBV) emerged as a common occurrence in Eswatini communities. All participants reported it as something that often occurred in relationships, had always occurred but was now registering more as something that should not happen because of the media attention and attention by civil society organisations (CSOs). Different types of intimate partner violence were reported by participants including physical assault, sexual violence, emotional abuse, financial abuse, and

Doctors reported the problem of shortage of diagnostic equipment in many facilities (e.g. ultrasound). This meant women had to be referred. Some health facilities did not have even a gynaecology ward, and women were admitted in general or medical wards and this was not ideal. Shortages of staff to monitor and care for women in gynaecology and general wards was another problem threatening PAC. Data on PAC was also not systematically captured to inform planning in the SRH program, and this was a threat to PAC.

psychological manipulations. GBV was reportedly seen most commonly perpetrated by men on women, but sometimes did happen to men perpetrated by women. Health providers reported seeing GBV cases, mostly with men violent against women.

Young people reported that GBV was common in their relationships and was mostly of a sexual nature. This violence went unreported largely because of the fear of humiliation that one faced in the hands of the police and society when opening up about it.



GBV is common in this community, but we don't really talk about it unless something bad or a death happens...

Adolescent girls



Health care package for GBV victims unclear

Health care worker participants stated that the care package for victims of GBV patients was unclear. The referral pathways were not well defined either. After initial assessment and care at a health facility, health care workers were unsure what else to do for victims. Health workers were aware that victims still needed

care beyond physical wellness, in particular psychosocial care as well. Referral pathways for such health care were unclear however. Health facilities only knew of government provided social workers that are sometimes available for referral. It was also unclear what constituted a GBV care package, and care was left up to health providers who were mostly proficient in physical care and not the other aspects of an individual's health.



Referral pathways are not known except use of social worker. What happens there after is not known

Nursing sister



Legal grounds for restricted abortion unknown

Men and women in communities stated lack of knowledge of any grounds under which abortion was legal in Eswatini. The youth (boy and girl adolescent participants), RHMs (community health workers), and some health workers held the view that all abortion was illegal in the country. As a result, women did not

seek safe abortion from health facilities even when they could obtain it under the law. In health facilities, some health providers were aware that abortion was legally provided for in some instances, such as threatened wellbeing of the mother. However, some unknowledgeable health providers were also reluctant to induce an abortion for fear of being in trouble with the law.

Health information system deficiencies

Recording of information on sexual reproductive health services offered or profiling information on the type of clients and services sought was not well captured in all facilities. This included the absence of consistent recording of demographic and reproductive data like age, parity, etc. Registers in key areas (e.g. gynaecology ward,) had very scanty recordings of SRH indicators. These registers mostly captured HIV, birth/ delivery, and neonatal status indicators. Other SRH indicators like abortion and abortion complications, parity of gynaecology patients, type of post abortion care given, or the outcome of the abortion were not captured. Outcomes were captured only if it was a maternal death. There was an assumption in referring health facilities that outcomes of women referred would be captured in the higher-level host health facility. This was observed not to be the case, unless it became a maternal death.

Data on contraceptive care and use

Formal registers in gynaecology departments missed essential columns of indicators in which health

providers could record abortion and miscarriage related information. Information on abortion type (e.g. missed abortion, septic abortion, blighted ovum, etc.) was not captured in registers. In some hospitals, there wasn't even a formal register. Ward nurses used a regular notebook, and captured information like patient name and place of residence, sometimes age. The limitation was, this register was not completed by all ward staff, as they felt it was optional. Neither was there consistency in the quality of information captured (e.g. age).

Data on post abortion care

Information on post abortion services given, and the outcome thereof was also not routinely captured in health facilities. There were no formal registers to capture this information. Thus, the type of post abortion care given, diagnosis of women needing the care and maternal outcomes (except for maternal deaths), or the characteristics of the women receiving PAC were not captured. Neither was information on sexually transmitted infections (STIs) captured. This was despite the relatively well capturing of HIV information and maternal health information on the same population group.

Discussion

This section presents cross-cutting themes that are findings of the study. It also, and gives the implications of the findings and offers recommendations to improve the prevention of unintended pregnancies, meet the contraceptive needs of women, and improve post abortion care. In Eswatini, abortion is legally restricted, and only post abortion care (PAC) is permitted to all women without restrictions. Post abortion care services are therefore the focus in this study, rather than comprehensive

Summary of main findings

The study found poor maternal outcomes as shown by the iMMR 99.5/ 100 000, and high prevalence of abortion (14.8%). There was a high prevalence of unintended pregnancies (76%) in women that presented for PAC. More than half (58.6%) of women who had delivered babies and were in the post-natal

period also had unintended pregnancies. Cross cutting themes common in the broad categories of unintended pregnancies, contraception, abortion and post abortion care were: the policy environment; SRH program implementation gaps; lack of reliable information on contraceptive use; gender based violence; and health information deficiencies on SRH data.

Maternal outcomes and the state of post abortion care in Eswatini

In the year 2019, the annual institutional maternal mortality ratio (MMR) was 107 per 100 000 live births and dropped to 92 per 100 000 live births in the year 2020 in the 9 health facilities of the study. This can be largely attributed to a reduction in the utilisation of maternal, sexual and reproductive health services by women because of the COVID-19 pandemic related hard lockdowns of 2020 that limited movement of the Eswatini population. For this reason, it is anticipated that fewer women than usual presented in health facilities for maternal or abortion complications, hence the reduction in part in institutional maternal deaths and abortions.

Some abortions seen in health facilities resulted in maternal deaths. These women had the abortion induced before coming to health facilities, and typically reported it as spontaneous abortion when presenting for PAC due to complications. Such

practice is common as women in geographical areas with restricted legality of abortion are known to under report or misreport induced abortions as spontaneous [28]. Because of the restricted legality of abortion in Eswatini, women would not seek medical care for abortion related health problems unless compelled by a perceived life threatening complication that they could not ignore. This has been observed in other settings with restricted legal abortions [8, 29]. Even so, it is quite possible that some women died from abortion related complications without accessing health care from hospitals for fear of imprisonment. It is noteworthy that maternal deaths that occur in communities are not reported the iMMR statistic formally used in the country. Maternal deaths from unsafe abortions are common and considered unnecessary because biomedical health care has the technological know-how to prevent deaths from abortions [8]. During qualitative interviews in this study, women did admit to reluctance in seeking health care from hospitals due to fear of being in trouble with the law. In Eswatini, the confidential enquiries into maternal deaths committee reports

complications of abortion as the 3rd leading cause of maternal deaths [15].

In this study, as the majority (76%) of pregnancies were reported as unintended for women seeking post abortion care across the health facilities surveyed. 68% of women seeing PAC were not given information to prevent future unintended pregnancies. Just 8% of this women-initiated contraception in hospitals, while 24% were referred for contraceptive care in public health facilities. Screening for STIs was also low at 28% for PAC women. This was an important missed opportunity for care on a high-risk group for subsequent unintended pregnancies and STIs. These women came in already having abortions, and came in for post abortion care. Because self-induced abortion is legally restricted in the country, women did not come to health facilities for abortions, but for post abortion care possibly from complications of unsafe abortion. This prevalence, although high, was therefore probably an under count to the prevalence at population level and outside of health facilities. Meanwhile, all women seeking PAC were offered HIV

services demonstrating the feasibility of integrating other SRH related care (e.g. contraception, STIs, etc.).

Women seeking PNC services also had a high prevalence of unintended pregnancies at 59%. Only 1.7% of these women-initiated contraceptives in a health facility before discharge. Most (63%) women in PNC did not receive information to prevent the occurrence of future pregnancies, while 66% were referred to public health clinics for contraceptive care. Screening for STIs on women seeking PNC was also low at about 14%. This showed more gaps where women at risk for pregnancy were being missed by the health system even when they presented in health facilities for care. Meanwhile, HIV services were given to at least 67% of women seeking PNC. In addition, HIV services were given to all women seeking PAC and to most women seeking PNC. This shows that health facilities did better at offering HIV services than at administering the rest of SRH services. A closer integration of HIV services with the rest of SRH services needs to be considered to improve consistency in their administration like HIV.

Cross-cutting themes

1. Poverty: This theme was identified as the leading cause for unintended pregnancies, non-use of or inconsistent use of contraception, perpetrated unsafe abortions, and pre-disposed women to gender-based violence.

2. SRH program implementation gaps: In this theme, missed opportunities to prevent unintended pregnancies; gaps in the provision of contraception; missed opportunities in provision of post abortion care; uncertain and non-uniform quality of PAC provided; as well as SRH program gaps in the delivery of contraceptive care to special populations like people with disability and out of school adolescents.

3. Policy gaps: The enabling policy environment for SRH in general, and contraception in particular is discussed. Policy gaps in the prevention of unintended pregnancies; and the provision of

contraception to key populations namely adolescents (in and out of school) and people with disabilities; adolescent boys, and men; as well as post abortion care are explored

4. Lack of reliable information/ knowledge: The lack of reliable information on pregnancy prevention, biomedical contraception care; and the country laws pertaining to access to comprehensive abortion care; and the provision of post abortion care is explored.

5. Gender Based Violence: GBV emerged as a cross cutting theme that influenced unintended pregnancies, contraception, GBV, PAC and abortion.

6. The intersection of GBV, unintended pregnancies, contraception, and post abortion care

7. Health information system deficiencies of SRH indicators

TABLE 6.1:

CROSS CUTTING THEMES IN THE STUDY

Broad Categories	Key findings
Study themes	<ul style="list-style-type: none"> - Country SRH policy favourable for contraception provision - GBV cases backlog: Not enough magistrates dealing with GV cases - Difficult to implement SODV because powerful people are perpetrators of GBV - Lack of public awareness on restricted legal abortion
SRH Program implementation gaps	<ul style="list-style-type: none"> - Unmet need for contraception in health facilities - Underutilisation/ non-utilisation of key community structures for contraception (e.g. RHMs, chiefs, other opinion leaders, etc.) - Information not disseminated on prevention pregnancy and contraception by health facilities/ health system - Missed groups in planning SRH services; PLWD, young men, adult men, in and out of school youth, community leaders - Unmet need of contraceptives in SRH clinics, and health facilities on high risk groups. Contraceptives not routinely provided in hospitals, and commodity stock outs in SRH clinics - Male involvement in contraceptive issues (opportunities in male circumcision clinics, male wellness clinics, routine community gatherings, etc.)
Gender based violence	<ul style="list-style-type: none"> - sexual violence against minors at homes (incest - sexual violence against women by their male partners - power and its role in protecting perpetrators of GBV, in spite of the law/ making the law difficult to implement
Poverty	<ul style="list-style-type: none"> - intergenerational sex of underage girls with older men - sex workers encouraged to have sex without protection to collect a higher fee by clients - multiple concurrent partners to supplement income by both single and married women
Lack of reliable information or knowledge	<ul style="list-style-type: none"> - information on pregnancy prevention in general - information on modern contraceptives - information abortion permissible by the law - information on the contents of SODV - community leaders express the need on information on contraception
Intersection of unintended pregnancy, contraception, post abortion care and GBV	<ul style="list-style-type: none"> - PAC - Abortion - Unintended pregnancy - non-use of contraception - Gender based violence
SRH Health information system deficiencies	<ul style="list-style-type: none"> - Data on contraceptive care and use - Data on STIs - Data on post abortion care - Data on abortion

Policy environment

The policy environment in Eswatini is conducive for the provision of contraception and there is no law against contraception. The MoH through the Sexual and Reproductive Health Unit (SRHU) in its current strategic plan [30] that supports and promotes the provision of contraceptive services. The MoH policy allows sexually active minors (adolescents less than 18 years) to access contraceptives on demand and without consent from guardians or parents. Civil Society Organisations (CSOs) in the contraception and family planning space and MoH development partners also attested that the policy environment in Eswatini was favourable for SRH, and this included the provision of contraceptives for the prevention of unintended pregnancies. Barriers in accessing, utilisation, and giving of contraceptive services existing therefore, had more to do with implementation of contraceptive services, than policies that prohibited use. Some of these policies have been in place for some time however, and warrant an evaluation to determine progress and expose limitations to their full implementation (e.g. National Development Strategy (NDS) 1997-2022 [31] and the National Youth Policy [32]). The NDS defined the overall developmental direction in Eswatini, and has reached maturity as it has run its full 25 year projection [31].

The National Development Strategy (NDS) on Population, Health, and Social Welfare Strategies (1997-2020) for Eswatini captures the intention of the country to provide contraception and post abortion care, while preventing unintended pregnancy to improve the health of the Swati people [31]. The NDS was forward and foundational in creating an environment intended to galvanise the sexual and reproductive health services as part of the promotion and development of the human capital of the people of Eswatini. All other sectoral strategic plans were then formed to align with the NDS. Specifically, uptake of SRH services by adolescents and promotion of programmes targeting the increase of uptake of SRH programmes was explicitly stated by the NDS [31]. Programming to redress gender based violence and other social conditions that lead to poor health was also catered for by the NDS[31]. These policy

strengths of the NDS policy were also noted by Macleod and Reynolds in their assessment of the policy environment to deliver contraception and abortion services in Eswatini [24]. Other sector policy that aligned with the NDS in its outlook to support SRH, gender equality, mitigate gender based violence and promote outcomes of the Eswatini population include the National Youth Policy of 2009 [32] from the Ministry of Youth, Sports, and Culture. This policy provided for youth friendly sexual and reproductive health and other interventions to prevent adolescent pregnancy and early sexual debut [32]. A successive policy published in 2019 maintained this mission, and added GBV, and other health problems of young people [33]. The SRH strategy of the MoH is also supportive of pregnancy prevention and contraception in all women of sexual and reproductive age group [34]. Through the policies mentioned here, the Eswatini government has shown commitment to reducing maternal mortality and to promote the sexual and reproductive health of its people. Unfortunately, the maternal mortality ratio (MMR) remains persistently high in Eswatini. There are slight reductions in the MMR, largely credited to the successful implementation of the prevention of mother to child transmission of HIV (PMTCT), which has reduced maternal deaths from indirect causes (infections). However, deaths from direct causes of maternal deaths remain high, with deaths from abortions being the 3rd highest direct cause in the country [15]. This underscores the need to fully implement the favourable policies of Eswatini to reduce unintended pregnancies, promote contraceptive use, and improve access to post abortion care services.

In this study, we observed abortions to be **as** much 16.2% in the year 2019, before the COVID-19 pandemic disrupted access to health services. Scholars assert that up to 60% of unintended pregnancies end up in abortions, showing the strong relationship between unintended pregnancies and abortions [35]. Unintended pregnancies were found to be as high as 60% among women seen in health facilities in this study. This rate is much higher than the global estimated rate of unintended pregnancies of 44% [35]. It shows the gravity of unsafe abortion as a maternal cause of death, bearing in mind that is most

probably an under count since women only came for PAC from complications of abortion. Since legal abortion is restricted in the country, women generally perceived it as illegal, and feared going to health facilities to avoid being in trouble with the law. Women that did show up for care did so in desperation, and reported the abortion as spontaneous. Full implementation of the constitutional provision of legal abortion would see all women becoming aware of the legal grounds for safe abortion, coming to hospital for such cases. Because country policies allow for post abortion care, health facilities and professionals were able to give PAC to women that came on demand and without any barriers. This is positive and gives credit to the supportive policy space.

From a policy perspective, the sharing of information on pregnancy prevention is also supported to all women of reproductive age, including adolescents. Adolescents are able (according to policy) to access contraceptives at will and without authorisation or consent from their parents in the clinic. The MoH was not in support of contraceptive commodities or contraceptive services being offered in schools however. According to participants in the policy space, this was due to cultural and parental pressure that brought in question the provision of invasive medication like contraceptives to school going adolescents without the consent of their parents. The MoH therefore held the position that information on pregnancy prevention and contraception would be provided in schools, but the commodity would not be offered, opting to create out of school programmes like Youth Friendly Corners in health facilities and the DREAMS on WHEELS program. Contraceptive information therefore only went as far as information. Participant experiences, especially in the civil society space in this study, pointed to a need for contraceptive commodities to be provided to school-going adolescents in schools.

The Eswatini constitution is in support of health or well citizens. The constitution provides for legal abortion/termination of pregnancy under restricted circumstances, which include rape, incest, the woman's mental health, the woman's life or the unborn baby's life at risk [24]. However, some health workers, and the general public showed lack of

awareness of any grounds under which abortion is legal in Eswatini. This contributed to difficult or lack of access of safe abortion services to women. Even when safe abortion would have been legal, women resorted to unsafe means due to lack of knowledge that hospitals could provide the services, where resources were available. Some health providers who were aware of the grounds under which abortion was legal reported cumbersome procedures legislated by country law to do with the number of doctors who must agree to the indication and perform the procedure.

SRH program implementation gaps

School going adolescents, out of school adolescents, people with disabilities (PWD), men (adolescents and adults), and community leaders were the population groups in which SRH programming gaps were identified. Since Eswatini has a mainstream approach to the provision of all SRH services, out of school adolescents were not targeted in strategy implementing contraceptive services to the youth. These young people were missed in messaging/information targeting the youth as it was often limited to in school programmes like Life Skills Education (LSE). Out of school youth were also missed in contraceptive education and implementation while they were now at the age where most of them considered themselves free to be sexually active as young adults that had either finished school or were not in school. These young adults however, did not have sufficient knowledge to protect themselves from unintended pregnancies nor were they empowered to negotiate safe sex. Furthermore, out of school adolescents still did not feel comfortable enough to discuss sexual issues with their parents or guardians or gather more reliable information from them. Discomfort with discussing sexual and reproductive matters of adolescents with parents was said to be socio-cultural. Socio-cultural barriers are some of the known barriers to access of SRH services by out of school youth in communities [36, 37]. In this study, out of school adolescents also reported cessation of regular financial support from parents and guardians,

who now concentrated on younger children still at school. Out of school adolescents then used transactional sexual relationships as a means to gain income, placing them at a higher risk for unintended pregnancies and their consequence, and this has also been observed in other settings [2, 38, 39]. Other scholars have also found that economic challenges faced by out of school adolescents are one of the barriers to their access of SRH services, including contraception from the mainstream health facilities in countries [36]. The SRH programme therefore needs to consider inclusion of targeted interventions to cover this age group when implementing sexual and reproductive health interventions, including contraception. There is evidence to support pregnancy prevention and the use of contraception at first intercourse in young women (including adolescents) that have had sex education [40].

In-school adolescents reportedly did receive some sex education information, and potentially pregnancy prevention information through the LSE program in schools. It is known that about pregnancy prevention is associated with the use of contraceptives and practice of pregnancy prevention [40, 41]. However, lack of access to sexual and reproductive health services for in-school adolescents is known to occur even when they have sound knowledge of contraception and pregnancy prevention [40]. This is attributed to socio-cultural barriers to do with young people accessing reproductive health services, poor attitudes of health providers towards, and community stigma of accessing SRH services while still at school [41, 42]. Daapah and colleagues [43] echoed that SRH and contraception services provided in mainstream health facilities had limited accessibility because of socio-cultural issues, health provider attitudes, and discomfort of adolescents in being seen in accessing these health services. It is therefore recommended that contraception and other SRH services be provided in strategic places for young people within communities, where the staff and service is tailored specifically for them [43]. In this study, young people reported similar socio-cultural, health provider, and perceived community stigma barriers to accessing contraception and other SRH services in mainstream health facilities. It is unsurprising therefore that the recorded unmet need for contraception in Eswatini is

highest among adolescents at 28.6% [25].

Eswatini SRH program currently provides information and knowledge on sexuality and pregnancy prevention through the Life Skills Education (LSE) program, and this is implemented by school teachers of the Ministry of Education and training (MOET). There are gaps in implementation however, as teachers tend not to prioritise this course. Neither do teachers give the course the same weight as the other examinable subjects, considering it to be of lesser importance. As a result, teachers often taught other subject content to do with the other examinable subjects during LSE time or made it a free period for pupils. The SRH program of the Ministry of Health (MoH), has neither say nor oversight over the implementation of LSE. Teachers were also reportedly uncomfortable talking about sexuality to adolescents and felt inept as they were not trained to teach about human sexuality, but were rather content experts of the other school subjects, not LSE. This is a SRH program gap that does not deliver information on pregnancy prevention and contraception as intended.

In this study, people with disabilities (PWD) reported almost absolute lack of access to other contraception and SRH services because of difficult access to mainstream SRH care in health facilities. It is unsurprising therefore that PWD contributed to the high proportion (15.2%) of reproductive age women with an unmet need for contraception in Eswatini [25]. Challenges in access were numerous, and the degree of difficulty in accessing contraceptives was related to the type of disability and severity of disability. These included communication barriers with health providers where auditory and speech disabilities existed, vision impairment, mobility disabilities, cognitive challenges, and more. PWD expressed a wish for specialised health facilities that could cater for them, where the infrastructure and staff giving care were better prepared to care for them. Health providers, SRH implementation partners, and people in the policy space all echoed palpable need to reach PWD with contraception, and prevent unintended pregnancies. Similarly, Mosher and colleagues found that there were inequities in access to contraceptive care in PWD, and the severity of the lack of access depended on the type and severity of disabilities [44].

To address the multitude of challenges faced by PWD in accessing contraception care Ganle and colleagues [45] suggested multi-level interventions to cater for the diverse range of problems.

Stock-outs of contraceptive commodities were a serious gap in SRH programming that did much to discourage clients from using contraceptive. It is concerning that while all participants conceded that commodity stock-outs disrupted continuity of contraceptive use by clients already in use and was a barrier initiation of contraceptives, policy makers and implementing partners of SRH did not seem to have a solution on how to prevent further commodity stock outs. Contraceptive commodity stock outs contribute to the prevailing high unmet need for contraception in Eswatini [25]. In Senegal, a tailored program was developed to address contraceptive commodity stock-outs, and the utilisation of contraception rose by 91% over 35 months [46]. In many settings, contraceptive stock-outs were largely due to logistics issues in the supply chain of commodities [46, 47]. In Eswatini, the reasons for contraceptive commodity stock-outs have not yet been explored systematically and are therefore unclear. It would benefit SRH program to study stock-out problems, in order to develop and implement a tailored program to eliminate commodity stock-outs in the future. This would go a long way to reducing the prevalence of the unmet need for contraception among women of reproductive age in Eswatini.

Lack of reliable information or knowledge

Access and utilisation of SRH services is dependent on the knowledge of targeted users about these services. Where information is unavailable, sparse, incorrect, or unreliable, utilization of contraceptives tends to be suboptimal. Shah and colleagues [48] observed that low awareness of contraception among reproductive women and their male counterparts co-existed with low usage of contraception. Similarly, an Ethiopian study observed significantly low use of modern contraceptives where there were high proportions of people who did not know about modern contraceptive methods or aware of the

existence of modern contraception [49]. Some scholars argue that lack of information of contraception constitutes the unmet need for contraception [48].

In this study, lack of or inadequate information was persistently reported by all participants. SRH implementing partners admitted that information on contraceptives did not reach all in the Eswatini community. Unsurprisingly, men were almost completely excluded from knowledge and information shared about modern contraceptives. unsurprisingly, men had misconceptions about modern contraceptives and believed they lessened sexual pleasure. They therefore discouraged their women sexual partners from initiating or continuing to use modern contraceptives. Adult men either preferred traditional contraceptives or simply did not concern themselves with the occurrence of an unintended pregnancy, believing that it was the woman's job to avoid it. Similarly, a Ugandan study found that men believed modern contraceptives had side effects that lessened sexual pleasure and discouraged its use by their sexual partners [50].

Young men (out of school adolescents) held the view of their seniors regarding contraceptives and unintended pregnancy. This view was from information that was passed on from seniors to the juniors, as well as modelled by their senior men in the community. In addition young men in this study were of the view that contraception was women's business and they did not need to concern themselves with it, even though they were not intending to father any children. Such perspectives were also observed in men in a Ugandan study [50] and in Nepal [51]. Utilisation of contraceptives by women did not persist when their male partners criticised it or told them that they were less sexually desirable or enjoyable because of it. The non-use of contraceptives by women because they are discredited by their sexual partners has also been observed in other settings [52, 53].

Women in all age groups (in or out of school adolescents, adult women), reported a scarcity of reliable factual information on contraceptives. Women relied on information from friends, relatives, or hearsay in communities. Information received was often

riddled with false information or mis-truths such as contraceptives making women lose fertility, making women ill, making their vaginal muscles loose thereby interfering with sexual pleasure, and making women have excessive vaginal secretions which also interfered with sexual pleasure. Inaccurate information on contraceptives use led to mis-trust of women on contraceptive use, deterring them from utilisation. Mistrust of contraceptives is a known barrier to contraceptive use by women [12]. In Guinea, Dioubate and colleagues found that fear of side effects and incorrect rumour-related information deterred urban adolescents from using contraceptives to prevent unwanted pregnancies [54]. It might be useful for the MoH in Eswatini has to consider a contraception and pregnancy prevention communication strategy that will assure indiscriminate universal access of information on contraception to prevent unintended pregnancies. Contraception is part and parcel of the promotion of women's health in all reproductive age groups [55].

It is an advantage that that men were not averse to knowing about contraception and pregnancy prevention. They did perceive pregnancy prevention largely as women's business but expressed willingness to learn about it. Their main complaint was the scarcity of reliable information about contraception, and men friendly spaces in which to receive it. Community leaders also expressed the need for community health education on contraception and contraceptive uses. Community leaders observed with concern, the increased occurrences of pregnancies especially among adolescents, the occurrences of unsafe abortions in communities, and felt that contraception could be a solution.

Poverty

In this study, economic challenges (poverty) emerged as an important driver of unintended pregnancies, and non-use of contraception. To support or supplement themselves economically, both adolescent and adult women engaged in transactional sex, which sometimes resulted in unintended pregnancies. Even women that were employed reported commonly

supplementing their income with transactional sex. Multiple concurrent sexual partners were reportedly often motivated by the need to supplement or generate income. It was also not uncommon for married women to also have other sexual partners for the purposes of generating or supplementing their income according to participants. Hultstrand and colleagues performed a study to investigate the underlying causes of unintended pregnancies in Eswatini, and found that poverty perpetuated the cycle of unintended pregnancies [56]. Unintended pregnancies themselves often have consequences of interrupted education or career advancement. This in-turn predisposes women with unintended pregnancies to lower skilled jobs and reduces their capacity to earn an income that can adequately support their cost of living in future [2]. Contraceptive use is a known determinant of improved socio-economic status of women in itself [57]. Non-use of contraceptives therefore means perpetuating the poverty cycle for the offspring of women therefore.

Women have difficulty negotiating for safer sex when power in the relationship is shifted to the partner with the financial muscle [58]. When sexual relations are transactional, men are able to use finance as a source of bargaining power for unsafe sex that may lead to unintended pregnancy [59]. In this study, men were largely against contraceptive use by their women partners as they claimed contraceptives interfered with sexual pleasure and this discouraged contraceptive use by women who then either discontinued use, or used it covertly. Similarly, Nigerian scholars observed that power imbalance in relationships, and when skewed towards men, meaning women either did not use contraceptives when their partners disapprove of them, or use continued use them discreetly [60]. In this study, women obliged to either reconsidering initiating contraceptive use, or discontinued its use where it was already in place. Some women continued to use contraceptive against their partners will but secretly. This was because they wanted to feel sexually desirable by their male partners, and this was more so where financial transactions were for sex were in question.

For sex workers in this study, the need to earn a living from transactional sex meant sexual clients could bargain for unsafe sex by promising to pay a higher fee. Because of the desperation brought on by poverty, sex workers did concede to this arrangement, even though they may have been aware of the health risks associated including unintended pregnancies. Sex workers also reported supplementing their income with sex work to survive economically. Financial disadvantage therefore drove unintended pregnancies in this population group this way. In Kenya, female sex workers reported difficulties in consistent use of barrier methods of contraception, because their male clients would sometimes prefer non-use of the condom, or threaten to reduce payment because they believed the condom interfered with sexual pleasure [61]. Fear of losing clients has also been observed as one of the reasons for non-use of contraceptives among female sex workers [61].

Scholars commonly find GBV associated with poverty where women burdened by economic lack find themselves at the mercy of their male partners from whom they depend for an economic living [62]. Poor economic status tends to induce low self-esteem on the economically challenged and shifts power to negotiate for a better sexual experience or protected sex. Unintended pregnancy is commonly one of the outcomes of GBV, where the violent male forces himself on the female without consideration for contraception or pregnancy as a consequence.

Gender Based Violence

From this study, we see how GBV leads to more common occurrences of unintended pregnancies. GBV from incest in families causes early unintended childhood pregnancies of adolescent girls, and dropping out from school. This means prospective participation in the economy for a low income that will likely not keep up with the cost of living. Poverty becomes inevitable for GBV victims that will likely also subject the offspring of the victim to socio-economic circumstances and the litany of health problems it comes with.

When GBV is common, the use of contraceptives is less common among women. A Nigerian study found an increased likelihood of non-use of contraceptives in women exposed to GBV [63]. Other studies have also found that the use of contraception is less likely when GBV is present among sexual partners [64-66]. In this study, GBV was reportedly a commonly observed phenomenon in communities by all participants. Sexual and physical violence was reportedly a common occurrence among young people. Violence and non-use of contraception co-existed among young people, making unintended pregnancies common. Because the pregnancies were conceived unintentional and in circumstances marred by violence, women resorted to unsafe abortions. They were unaware that the law of the Kingdom of Eswatini made provisions for legal abortions in some circumstances such as in rape or incest.

Intersection between unintended pregnancies, contraception, gender-based violence and post abortion care

From this study, we see how unintended pregnancies, contraception, GBV, and post abortion care were found to be all interlinked. Each of these concepts have a knock-on effect on one another, where there is a domino effect if a problem or bottle neck occurs in one of them. The ultimate results are poor maternal outcomes, and more deaths related to abortions in women. In this study for instance, the abortion case fatality rate in all facilities surveyed was 25%. The overall prevalence of abortion stood at 14.8%, while the iMMR was considerably high at 99.5 per 100 000 live births. According to the confidential enquiry into maternal deaths in Eswatini, abortion is the 3rd most common direct cause of maternal deaths [15]. When contraception is not used in sexual encounters, unintended pregnancy is highly likely [67], and if unintended will likely result in an abortion [68], this will in turn require post abortion care. It is estimated that at least 60% of all pregnancies end up in an abortion globally [5, 35]. GBV has the scourge of

disempowering victims, making them lose their ability to bargain or negotiate safe sex or the use of contraception [69]. Again, unintended pregnancies result with women (more commonly the receptors of GBV in Eswatini) often opting to terminate the pregnancy. Thus, unsafe abortion becomes highly likely and subsequent poor maternal outcomes [8, 70]. In the Eswatini context, women do not go to health facilities for a safe abortion even when permitted by law. This is because of a lack of awareness to the provisions of the law, and fear of stigmatisation from society.

Participants in this study stated that women opted for unsafe procedures outside health facilities, and endured complications, still afraid to come to health facilities. Those who eventually showed up, did so when unbearable complications had set in, or when alternatives to medicine had failed outside the biomedical health system. By the time these women present in health facilities, the situation is usually complicated to where fatalities are unavoidable (e.g. septic abortion with multiple organ failure presenting for the first time, or massive haemorrhage which is sometimes not responsive to resuscitation, or excessive haemorrhage complicated by sepsis, etc.). Barnes-Josiah, Myntti, and Augustine detailed the graduation of complications from minor to severe, and even emergencies when women delay in presenting to health facilities to access care [71]. In low income settings like Eswatini, the best cure is prevention. When unintended pregnancies are prevented by the use of contraception, in an environment free from GBV, and where women are able to access timely post abortion care without fear of intimidation and stigmatisation, loss women's lives from abortive disease will be less likely to occur.

In this study, unintended pregnancies were as high as 60% among women who either had given birth or had an abortion. Contraception in Eswatini health facilities is free at the point of use, making access easier for women. When contraceptives are not used yet needed, unintended pregnancies are highly likely to occur. However, program implementation issues like commodity stock-outs, lack of reliable information on contraceptives, non-use of community health workers (RHMs) in promoting and utilisation of contraceptive

services, scarcity of health information on contraception, as well as the general exclusion of men and traditional community structures in contraceptive care are effective bottle necks that are preventable found by this study. Contraceptive commodity stock-outs are a known deterrent to contraceptive use by women [46]. While contraceptive stock-outs are known to contribute to the unmet need for contraception in Eswatini [25, 72], empirical studies are needed to look into the reasons for stock outs in more detail, with the view of coming up with recommendations to eliminate stock outs and improve contraceptive service delivery. Information and knowledge of contraceptives is a critical step towards utilisation of contraceptives by women as scholars have found [73, 74]. The MoH through the SRH program and implementing partners need to address the shortage in contraception information in communities to boost uptake.

In Eswatini, the constituents of post abortion care are not formally defined by policy such as guidelines and clinical protocols. In larger facilities, where there are more highly trained health professionals like gynaecologists and other clinical consultants, a policy defined PAC is not as acutely needed. However, Eswatini is a typical LMIC with a shortage in human resources for health, and task shifting of some physician clinical responsibilities to lower cadres. Shortage in suitably trained health professional is one of the limitations in giving PAC observed in many low and middle income countries (LMICs) [75]. The need for policy guidelines for PAC is therefore crucial to safeguard the quality of care. Guidelines that would spell PAC would help to standardise the quality of care, by creating a minimum standard that all health facilities must adhere to, thus ensuring access to quality services for all women, regardless of the geographical location or health facility [76]. Guidelines on PAC would also enable monitoring and evaluation of PAC possible since a standard framework required to be met by all facilities would have been defined [77]. In all the health facilities seen in this study, there was no local (health facility generated) guideline or protocol on PAC. It is unsurprising therefore that basic care like offering women contraceptives to women when required them post abortion was mostly not done. Only 3.6% of women-initiated contraception post

abortion in all nine health facilities included in this study.

Like GBV, poverty is disempowering to women, and robs them of power to negotiate for safe practices in sexual partnerships [78]. When women are disempowered in sexual partnerships, they are easily taken advantage of, and their choices of contraception use or protected sex are easily overlooked [79]. Unintended pregnancies therefore commonly occur, with an increased likelihood for unsafe abortion and its subsequent poor outcomes in maternal health. In some tough economic circumstances, women were reportedly coerced into unprotected sex by sexual partners who would threaten to withdraw financial support, should the women insist on contraception or condom use. It would be useful to revive or revitalise women economic empowerment drives to lessen the burden of financial reliance of sexual partners. All women age groups in this study were affected by the scourge of poverty, and predisposed to non-contraceptive use (to appease sexual partners) and unprotected sex. The risk of unintended pregnancies is more pronounced in the presence of poverty [2, 80].

Since men (adult men and adolescents) were mostly excluded from SRH services that promote or gave contraception, they continued to be deterrents to the use of modern contraceptives, preferring traditional methods that are less effective, and traditional medicine. These men were not opposed to being included in the conversation on contraceptives, they simply hadn't been invited it seemed. Studies have shown that involvement of male partners in sexual and reproductive health matters boosts utilisation of these services including contraception [81]. As a result, men in Eswatini communities discouraged their sexual partners from contraceptive use, believing that it lessened their sexual pleasure. Women, because they did wish to be desirable sexually, abandoned the use of contraceptives as a result, and unintended pregnancies result. Or in some instances, women continued to use contraceptives but covertly. Similarly, Kiel and colleagues found that the views of men on contraception had an influence on whether women used contraceptives or not [52]. In this study, young men (adolescents) were found to have adopted the mentality of their superiors (adult men) regarding contraceptives, and discourage their girlfriends from using contraceptives.

FIGURE 6:
RELATIONSHIPS BETWEEN UNINTENDED PREGNANCY, CONTRACEPTION, PAC, AND MATERNAL OUTCOMES

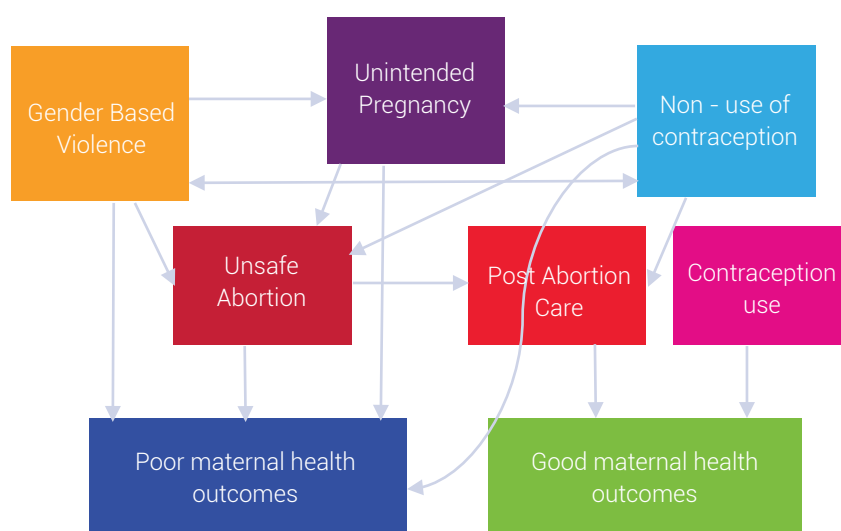


Figure 6 shows how unintended pregnancy is almost an instigator of a cascade of events that lead to poor maternal outcomes. Unsafe abortion is highly likely when pregnancy is unintended, and the subsequent maternal outcomes tend to be poor. When post abortion care is received timeously after unsafe abortion, and depending on the degree of maternal damage from the unsafe abortion used, more favourable maternal outcome may occur. However, unintended pregnancies a risk factor for severe maternal outcomes. Gender based violence tended to lead to unintended pregnancies and all its consequences. The presence of GBV is also likely to lead to non-use of contraceptives, the outcome of which would be an unintended pregnancy and its subsequent outcomes. Non-use of contraception predisposes women to unsafe abortion with or without subsequent post abortion care, with corresponding poor maternal outcomes.

Health information system deficiencies

The experience in this study has shown that indicators on contraceptive services given or sought is not well captured by the health system. In health facilities, maternity registers were kept well, and these recorded parameters on the mother and baby born, and how the birth event fared. Gynaecology ward registers however were much less kept. There were no formal registers recording gynaecology information (e.g. sexually transmitted infections screening and treatment, post abortion care, etc.) strategically from the gynaecology wards, or outpatient departments (where abortion patients were sometimes seen), operating theatres. Information on abortions, onset (spontaneous or induced) of abortion, type of abortion (e.g. missed, complete, incomplete, septic, etc.), parity, etc. on the woman were missing. In some health facilities, there were no dedicated data clerks

for systematic collection and archiving of records. Lost registers and misplaced patient files were a common occurrence therefore. Therefore, SRH information captured and kept well in health facilities and in the country's health information system (HMIS) was that relating to maternal and neonatal health, and HIV. While the capturing of this information is commendable, more needs to be done to capture information on other SRH indicators to help track services rendered, identify gaps, and have the information timeously to inform planning of health services delivery. Ultimately, the goal is to reduce the persistently high MMR, and that is possible only if attention is paid to all SRH indicators that may inform why and where we may have high incidences or prevalence of some of the direct causes for example (e.g. abortion, sexually transmitted infections). Furthermore, contraceptive services need to be better captured in health facilities. This would help with tracking on who (demographic characteristics) utilises contraceptives, which contraceptive commodities they use more commonly, document side effects, and how women cope with them. All this information is not readily available from hospital records as they are currently collected. Further empirical enquiry is recommended therefore to capture information on these variables. Information on the prevalence of ectopic pregnancy admissions for example, could not be captured because that information is not captured in gynaecology registers. These uncaptured SRH indicators, would be useful as process indicators for maternal health. They would help detect early if things were on track in the implementation of SRH to achieve the ultimate outcome of the MMR reduction. Routine collection of data on indicators that inform service delivery, utilisation, and outcomes is important to improve the quality of care given, as well as to enable evaluation of services rendered [82]. The quality of the data in health information systems is also plays an important role improving health outcomes [83, 84].

Implications

The following are the implications of the findings of this study;

SRH program Implementation

Implementation gaps in preventing unintended pregnancies and providing universal access to contraceptive care in the country for the SRH program are;

- Current mainstreaming of SRH services such as contraception for women with disabilities is a barrier to their access of pregnancy prevention care. This is because people with disabilities (PWD) have special needs that require multi-level interventions including infrastructure adjustment to allow mobility and access; specialised health provider training to cope with the vast array of disabilities; and care giving modalities (including gadgets) that are specialised for the various disabilities.
- Out of school adolescents require targeted interventions to access pregnancy prevention and SRH services. At the moment, out of school adolescents are largely missed, and only seen after an unintended pregnancy has occurred. This population group requires information on pregnancy prevention, contraception, and SRH in general. A communication strategy to reach them should be considered
- In-school adolescents also require targeted information on human sexuality, pregnancy prevention, and contraception. Dependence on the current school teacher agent of the subject life Skills education (LSE) is yielding suboptimal results. The MoH in partnership with MOET should revisit the LSE programme and consider implementation changes for it to be effective. Furthermore, youth friendly corners in SRH clinics needs to be revived to encourage in-school adolescents to utilise them. Mainstream delivery of contraceptives currently does not work for this population group. In addition, the media strategy should consider more social media or the internet (e.g. YouTube) for the in-school adolescent group rather than mainstream radio or television,
- The MoH should address policy gaps in giving contraceptive services to special populations (e.g. women with disabilities). Guidelines and clinical standard operating procedures (SOPs) should be developed for health practitioners that can assist them in giving care to special populations (e.g. PWD).
- Men in communities must be part of the conversation on contraceptives and sexual and reproductive health in general. Men have influence over the use of contraceptives by women. The MoH must consider community platforms for adult men and adolescent boys to learn about contraception, and dispel the currently pervasive myths about contraceptive side effects and interference with the sexual experience. Adolescent boys need to be targeted impart knowledge on human sexuality, prevention of pregnancy, and the benefits and safety of contraceptive use.
- Traditional structures in communities should be used as vehicles for the promotion of contraceptive use. Successes in other programs like HIV are an indication that enabling community traditional leaders, opinion leaders, and influential people can do much to dispel fears on contraceptive use and encourage its embrace by target populations. Traditional leaders (e.g. bucophu) interviewed in this study are not opposed to the idea, seeing the community need to deal with particularly adolescent pregnancies and unsafe abortions.

- The MoH needs to perform further empirical enquiry on the reasons for contraceptive commodity stock-outs. Bottle-necks in the supply chain should be uncovered, and tailored strategies to eliminate commodity stock-outs developed. These strategies can be piloted for testing in a smaller geographical area, with a view to rapid scale-up should they prove useful.
- Poverty is one of the main drivers of unintended pregnancies, and unsafe abortions. The kingdom of Eswatini has a strong policy environment in the National Development Policy (NDS) intended to alleviate poverty of the Swati people. Since the NDS has run its course (1998-2022), an evaluation of the policy strategies and implementation is in order. This will help uncover gaps in implementation, and give lessons for changes in strategy to more tailored approaches to alleviate poverty.
- Low economic status of women in this study predisposed them to high risk behaviours (e.g. multiple concurrent sexual partners, and engaging in transactional sex to generate or supplement income). Poverty alleviation strategies and community income generating projects for women need to be either initiated, revisited, or revitalised to reduce economic dependence of women on sexual partners. This will do much to reclaim power for women to negotiate safer sex practices, give them the space to choose whether or when to have children, including the freedom to use of contraceptives at will. NDS policy objectives should be revisited to reduce poverty and improve women economic empowerment. An evaluation of the policy and its implementation programs, might be useful
- The Eswatini policy environment supports prevention of pregnancy and the use of contraceptives by all women of reproductive age. Full implementation of these policies is recommended to realise the policy objects of reducing unintended pregnancies and eliminating the unmet need for contraception. These policies include but are not limited to; the NDS, National Youth Policy, and SRH strategy. Addressing implementation gaps would help to bring down the prevalence of unintended pregnancies, improve contraceptive use among adolescents and women living with disabilities, and other population groups as well.
- Contraceptive information dissemination strategy: The absence of readily available/ accessible information on contraception was echoed by all participant groups in this study. The MoH therefore needs to develop a contraception information dissemination strategy targeting the various population groups. Community leaders, older men, and women for example rely on main media for information on health and other subjects, as well as formal community meetings. Regular information on these avenues, plus others (e.g. men only spaces like Kwakha Indvodza program) could possibly be effective. Adolescent men and women however, might need a different strategy because they do not access information the same way. The use of social media for example might be more important, in addition to other avenues like community youth groups like the 'Young heroes' program. Possibly, a combination of all the information dissemination strategies might be useful as well.
- The male condom has mostly lost its identity of being a contraceptive according to community perceptions. It is now considered more of an HIV prevention measure in communities. Health messaging therefore needs to revive the use of the condom as a barrier method of contraception to communities. Men in particular, seem to disfavour the condom, associating it with unfaithfulness in relationships (therefore dislike using it on steady partners or wives), or claim that it interferes with the sexual experience. More work is needed to promote condom use to prevent unintended pregnancies among men therefore. The female condom although effective in preventing unintended pregnancies and HIV, is not popular among women, who are the targeted users. The reasons why remain unclear. The MoH should therefore consider marketing the female condom. In addition, studies of experiences of women with the female condom might be useful to uncover its limitations or client difficulties. This

would help tailor interventions to help women find the female condom more user friendly.

- There is room for integration of SRH services as the HIV program has done, to improve access to care and improve utilisation such as contraceptive services and the treating of STIs.

Post abortion care (PAC):

Women that present in health facilities seeking PAC are given the care and this is a strength of the Eswatini health system. However, women either do not come for PAC, or come when they experience unbearable complications, by which time it might be too late in the disease process to prevent death or adverse outcomes. This is because of fear of stigmatisation by health providers and the community, and fear of getting in trouble with the law. Therefore;

- The MoH should do information campaigns to educate the Swati people on the importance of prompt presentation to a health facility in the event of an abortion.
- Women should be reassured that they will not be prosecuted when they come to hospital for PAC
- Social awareness of abortion as a painful but normal human life event in societies should be created to women and the Swati people to reduce the social stigma around abortion.
- Women and the public should be alerted that not all abortion is criminal in Eswatini.
- Guidelines or clinical protocols are needed to support the provision of PAC in all health facilities. This is especially so because many of the health facilities are low resourced in terms of health providers. Lower level cadres need clinical guidance through guidelines or clinical protocols to assure the quality of PAC rendered.
- There are skill deficiencies in health providers giving PAC in many health facilities. For example, a pelvic or abdominal ultrasound was usually indicated in PAC, and yet the majority of clinicians reportedly in lower level hospitals like health centres and sometimes regional hospitals did not

have the skill to perform it. This means referral mostly to higher level health facilities, with the unintended consequence of centralising care, and potentially overwhelming these hospitals with demand for PAC services unnecessarily.

- There is a shortage of diagnostic equipment in many facilities (e.g. ultrasound). This means women have to be referred, and centralises care to fewer health facilities, potentially overwhelming them. Some health facilities did not have even a gynaecology ward, and women were admitted in general or medical wards and this was not ideal.
- Shortages of staff to monitor and care for women in gynaecology and general wards was another problem threatening PAC.

Abortion:

The policy environment in Eswatini allows for restricted abortion. However, the people of the Kingdom of Eswatini are largely unaware of this status quo. In some instances, health providers are also not aware that abortion is not completely outlawed, but is restricted. Neither are the circumstances around legally permitted abortion known. Therefore;

- The MoH should educate health providers and the general public on the grounds under which abortion is permitted and disallowed, in order to create awareness and encourage people to present to health facilities for safe abortions where permissible. More needs to be done to alert the public and practitioners of policies that guide provision of care and access/ utilisation of SRH services.
- Health system issues like HMIS, record keeping of information on the broader sexual and reproductive health activities. Contraceptive use variables and abortion variables not captured. There are no tools (registers) that capture this data systematically. Neither are the developed indicators to track service delivery, utilisation, or outcomes on these SRH services.
- Simplify the process for legal abortion: Where abortion is legal, women still struggle to access it

because of difficult technical operational processes that are prohibitive and undermine provision of the service. The requirement of at least two medical officers to rule that abortion is indicated, and for at least two surgeons to perform the abortion is unrealistic in an LMIC setting like Eswatini. All health providers, and especially doctors are a scarce resource in Eswatini, and to find two of them to okay and perform an abortion procedure is unrealistic. This is particularly so because the diagnosis and procedure itself is usually straightforward, and can be performed by one clinician safely/ reliably. The MoH operational guidelines should make implementation of the constitution easier with regards to abortion access.

- Health information system and data capturing: Indicators on contraceptive commodities given, contraception care services given, along with ages, parity, complications/ side effects, and management thereof should be routinely captured in the country's HMIS (health management information system). At the moment, SRH data captured more completely relates mostly to maternal health and HIV. The following should also be considered;
 - Formal registers on contraception care given, and the characteristics of recipients.
 - Formal registers on comprehensive abortion care, which includes post abortion care. Complications of abortion care for example, are either not consistently captured or not captured at all in registers of health facilities.

As health providers use make shift registers, the information captured or not captured varies from one health facility to another. Since the registers are not formally given by the MoH, the perception among some staff is that it is not essential. Therefore, capturing of data is dependent on whoever is on duty, and their perception of the importance of such data.

- Data clerks need to be trained to archive hospital records. In some health facilities, there was no filing system at all, and the archive room resembled a dump, where it was impossible to find anything.
- There should be systems in place to follow up routine data capturing for accurately, completeness, and for the correct storing of these records.
- GBV: Perpetrators of GBV should be prosecuted as the SODV law dictates. However, the following needs to be addressed to make this a reality;
 - Too few magistrates handle GBV cases. There are only two countrywide, and it is unsurprising that GBV cases take a long time before they are dealt with and finalised by the law. This discourages GBV victims seeking justice. It gives the sense that perpetrators are able to get away with the offense despite the law. More magistrates (perhaps all of them) need to preside over GBV cases to allow the justice system to take effect.
 - More education in handling GBV cases and victims is needed for law enforcement agencies.

Recommendations

SRH Program Implementation Level	
Contraception and unintended pregnancies	Plan specialised SRH service care points for women with disabilities
	Develop a strategy on out of school and in-school youth friendly services to target this population groups
	The Ministry of Health should engage the Ministry of Education to revisit the LSE programme and consider implementation changes for it to be effective.
	Develop an SRH communication strategy to give reliable and accessible information on contraception, and reproductive health. The strategy should encompass all media in order to be inclusive of all population groups and opinion leaders (e.g. people with disability, community leaders, religious leaders, older men, youth, and women). Social media and online platforms (e.g. YouTube) should be considered as they are increasingly more effective to reach the youth.
	Guidelines giving contraceptive care to women with disabilities should be developed
	The MoH to engage the Ministry of Economic Planning to share the evaluation report on the National Development strategy which has run its course (1990-2022). Policy implementation lessons learnt on SRHR specific policy targets and those on women empowerment will be considered in order to inform strategic planning on for SRH to reduce unintended pregnancies and promote contraceptive usage.
	The MoH to engage the Min of Economic Planning and other relevant ministries of government to revitalise and promote empowerment programs for women such poverty alleviating programs to grant them economic support. This will empower women to be able to negotiate for safe sex practices.
	Develop policies that include men in the conversation on contraception and reproductive health
	Data clerks need to be trained on the archiving of hospital records. In some health facilities, there was no filing system at all, and the archive room resembled a dump, where it was impossible to find anything. Data clerks should be hired in all facilities for quality of record keeping and collection of data
	Address policy implementation gaps would help to bring down the prevalence of unintended pregnancies, improve contraceptive use among adolescents and women living with disabilities, and other population groups as well. The Eswatini policy environment supports prevention of pregnancy and the use of contraceptives by all women of reproductive age. Full implementation of these policies is recommended to realise the policy objects of reducing unintended pregnancies and eliminating the unmet need for contraception. These policies include but are not limited to; the NDS, National Youth Policy, and the SRH strategy. Addressing implementation gaps would help to bring down the prevalence of unintended pregnancies, improve contraceptive use among adolescents and women living with disabilities, and other population groups as well

SRH Program Implementation Level

PAC and abortion	Upgrade the health information system to provide standardised and integrated data capturing tools at obstetrics and gynaecology departments that capture information on other SRH interventions such as abortion, PAC, contraception, and other gynaecologic data
	Develop guidelines and clinical protocols with a clearly defined essential PAC package and be made available in all health facilities to promote quality PAC.
	Equipment procurement policies for health facilities should be reviewed to include specialised diagnostic and management material for PAC
	Address health systems issues that hinder the provision of PAC. These include low staffing levels for gynaecology departments, lack of equipment for PAC. Decentralise PAC services to lower level facilities (health centres) that could provide the service effectively if well supported
	Integrate all SRH services such as contraception, screening and treatment of STIs, PAC, and postnatal care to improve access to women and utilisation. Integration lessons can be learnt from the HIV programme which has successfully implemented it
	he MoH and implementing partners should conduct information campaigns to educate women about the importance of prompt presentation to health facilities in the event of an abortion for post abortion care
	Conduct communication campaigns to reassure women so that they will not be prosecuted when they come to hospital for PAC services
	Revise routine indicators on key sexual and reproductive health areas such as family planning, abortion, and post abortion care
	Diagnostic equipment for managing PAC should be procured for health facilities (e.g. ultrasounds, MVA)
	Print and operationalize the safe abortion SOP.
	Train (in-service) health providers in health facilities on PAC
GBV	The MoH should engage the Ministry of Justice and advocate for the development of strategies that can help to expedite GBV cases to allow justice for the survivors. These could include (but be not limited to) more magistrates (perhaps all of them) to preside over GBV cases to allow the justice system to take effect rather than just two currently serving the whole country
	Finalise GBV standard operating procedures (SOPs) for survivors of GBV requiring SRH services. These SOPs should be made available in all health facilities from the lowest level of care to the highest level
	Strengthen collaboration in handling GBV cases and victims by law enforcement agencies (e.g. police)
	Train health providers (nurses and doctors) on initial clinical care on GBV patient/ client when they present in health facilities.

SRH Program Implementation Level	
Improving contraception use and preventing unintended pregnancies	Capacitate health care workers on disability inclusiveness in the provision of SRHR services. These should include provision of the required equipment to enable people with special needs to access SRH services.
	Appoint disability specialists that can support SRH services within health facilities. Clear referral pathways should be drawn in case health facilities need to refer women with special needs for more SRH services.
	Reinvigorate and scale up youth friendly SRH services for in and out of school youth.
	Implement SRH communication strategy to reach out of school youth
	Establish community platforms for men and adolescent boys to learn about contraception, and dispel the currently pervasive myths about contraceptive side effects and interference with the sexual experience. Adolescent boys need to be targeted impart knowledge on human sexuality, prevention of pregnancy, and the benefits and safety of contraceptive use
	Mobilize traditional structures in communities to promote SRHR services including ways of preventing unwanted pregnancies.
	The male condom as a contraceptive device needs to be re-introduced. More work is needed to promote condom use by men to prevent unintended pregnancies.
	Empirical studies should be conducted to unpack why the female condom remains unpopular among women in Eswatini. This will help to develop targeted interventions to improve utilisation, and reduce subsequent unintended pregnancies
	o participate in the development of the up-coming NDS in order to inform poverty alleviation strategies that empower women to use contraceptive services and prevent unintended pregnancies.

Conclusion

This study sought out health provider, community people, policy makers, and implementers' perspectives of unintended pregnancy, contraception, and post abortion care. The drivers of unintended pregnancies and non-use of contraception were explored. Findings revealed SRH programming gaps in contraceptive provision; lack of knowledge on contraception reaching intended users of contraception; poverty as an important driver; gender based violence; and data gaps in contraceptive and post abortion care data in the HMIS. The policy environment in Eswatini was found favourable to support interventions that reduce unintended pregnancies, promote contraception, and give post abortion care. There were however policy implementation gaps that limited the access and utilisation of contraception and PAC. Recommendations to address these barriers include full implementation of the favourable Eswatini policies; evaluation of those that have matured to learn lessons to reduce unintended pregnancies; develop a contraceptive dissemination and information strategy, and advocacy to deal with the scourge of GBV at a multi-sectoral level. While mainstreaming of SRH services is a positive policy strategy, there are groups that fall within the cracks such as women with disability, out of school youth, and men. Targeted interventions for these population groups need to be considered.

References

1. Omani-Samani, R., et al., Socio-economic inequality of unintended pregnancy in the Iranian population: a decomposition approach. *BMC Public Health*, 2018. 18(607).
2. YAZDKHASTI, M., et al., Unintended Pregnancy and Its Adverse Social and Economic Consequences on Health System: A Narrative Review Article. *Iran J Public Health*, 2015. 44(1): p. 12-2.
3. Omani-Samani, R., et al., Impact of Unintended Pregnancy on Maternal and Neonatal Outcomes. *J Obstet Gynaecol India*, 2019. 69(2): p. 136-141.
4. Hall, J.A., et al., Reassessing pregnancy intention and its relation to maternal, perinatal and neonatal outcomes in a low-income setting: A cohort study. *Plos ONE*, 2019. 13(10): p. e0205487.
5. Bearak, J., et al., Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019. *Lancet Global Health*, 2020. 8(9).
6. Sedgh, G., S. Singh, and R. Hussain, Intended and Unintended Pregnancies Worldwide in 2012 and Recent Trends. *Stud Fam Plann*, 2014. 45(3): p. 301-314.
7. Bellizzia, S., et al., Reasons for discontinuation of contraception among women with a current unintended pregnancy in 36 low and middle-income countries. *Contraception*, 2020. 101(1): p. 26-33.
8. Haddad, L.B. and N.M. Nour, Unsafe Abortion: Unnecessary Maternal Mortality. *Rev Obstet Gynecol*, 2009 2(2): p. 122-126.
9. Dragoman, M., et al., Overview of abortion cases with severe maternal outcomes in the WHO Multicountry Survey on Maternal and Newborn Health: a descriptive analysis. *BJOG*, 2014 121(Suppl. 1): p. 25-31.
10. Fathalla, M.F., Contraception and women's health. *Br Med Bull*, 1993. 49(1): p. 245-51.
11. Ajayi, A.I., O.V. Adeniyi, and W. Akpan, Use of traditional and modern contraceptives among childbearing women: findings from a mixed methods study in two southwestern Nigerian states. *BMC Public Health*, 2018. 18(604).
12. Chernick, L.S., et al., Barriers to and enablers of contraceptive use among adolescent females and their interest in an emergency department based intervention. *International Journal Reproductive Health*, 2015. 91(3): p. 217-225.
13. Babigumira, J.B., et al., Potential Cost-Effectiveness of Universal Access to Modern Contraceptives in Uganda. *Plos ONE*, 2012. 7(2): p. e30735.
14. Say, L., et al., Global causes of maternal death: a WHO systematic analysis. *Lancet Glob Health*, 2014. 2(6): p. e323-33.
15. Sikana, P., et al., Confidential Enquiry into Maternal deaths: Triennial Report 2014-2016. 3rd ed. 3rd Edition. 2018, Mbabane: Ministry of Health.
16. UN, Transforming our world: the 2030 agenda for sustainable development goals. 2015, United Nations: Geneva.
17. UNDP, MDG Report: Lessons Learn in Implementing the MDGs, in *Assessing Progress in Africa Toward The Millenium Development Goals 2015*, UNDP: Geneva.
18. CSO, Swaziland Demographic Health Survey. 2007, Ministry of Economic Planning and Development: Mbabane.
19. Development, M.o.E.P.a., Swaziland Millenium Development Goals Report. 2010, Population Unit: Mbabane.
20. CSO, Multiple Indicator Cluster Survey. . 2010, Ministry of Economic Planning and Development: Mbabane.
21. Brear, M. and D. Bessarab, Perspectives on intimate partner violence in Swaziland amongst 18-29-year-old men undergoing medical circumcision. *Culture Health & Sexuality*, 2011. 14(1): p. 31-43.
22. Ajayi, A.I. and H.C. Ezegbe, Association between sexual violence and unintended pregnancy among adolescent girls and young women in South Africa. *BMC Public Health*, 2020. 20(1370).
23. Acharya, K., Y.R. Paudel, and P. Silwal, Sexual violence as a predictor of unintended pregnancy among married young women: evidence from the 2016 Nepal demographic and health survey. *BMC Pregnancy and Childbirth*, 2019. 19(196).

24. Macleod, C.I. and J.H. Reynolds, Strategic assessment of policies, programmes, and research on unintended pregnancies, contraception, unsafe abortion and abortion services in Eswatini. 2020, Ministry Of Health: Mbabane.
25. CSO and UNICEF, Swaziland Multiple Indicator Cluster survey 2014: Final Report, in MICS. 2016, Central Statistics office, UNICEF: Mbabane.
26. MoH, Eswatini National Adolescent and Youth Friendly Health Services, in Baseline Report. 2019, Ministry of Health: Mbabane.
27. Phologolo, T., Strategic assessment of unintended pregnancies, contraception, unsafe abortion, and abortion services in Botswana. 2020, Ministry of Health and Wellness, UNFPA, WHO: Gaborone.
28. Sousa, A., R. Lozano, and E. Gakidou, Exploring the determinants of unsafe abortion: improving the evidence base in Mexico. *Health Policy and Planning*, 2010. 25(4): p. 300-10.
29. Singh, S., et al., *Abortion worldwide 2017: unequal progress and uneven access*. 2017, Guttmacher Institute: Washington DC.
30. MoH, Sexual, Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition Strategic Plan 2019-2023, in SRMNCAH&N Strategic Plan. 2019, Government of Eswatini: Mbabane.
31. Economic Planning, a.D., *The National Development Strategy (NDS) 1990*, Eswatini Ministry of Economic Planning and Development: Mbabane.
32. Min Youth Sports Culture, E., *The National Youth Policy 2007*. 2007, Ministry of Youth Sports and Culture: Mbabane.
33. Ministry of Education and Training, E., *Eswatini National Education and Training Sector Policy*44. 2018, Ministry of Youth Sports and Culture: Mbabane.
34. MoH, *Eswatini sexual and reproductive health strategic plan*. 2019, Sexual and reproductive Health unit, Eswatini: Mbabane.
35. Bearak, J., et al., Global, regional, and subregional trends in unintended pregnancy and its outcomes from 1990 to 2014: estimates from a Bayesian hierarchical model. *Lancet Glob Health*, 2018. 6(4): p. E380-E389.
36. Hailemariam, S., et al., Challenges faced by female out-of-school adolescents in accessing and utilizing sexual and reproductive health service: a qualitative exploratory study in Southwest, Ethiopia. *J Prim Care Community Health*, 2021. 12(21501327211018936).
37. Seifu, A., M. Fantahun, and A. Worku, Reproductive health needs of out-of-school adolescents: A cross-sectional. *Ethiopian Journal of Health Development* 2006. 20(1).
38. Inoue, K., et al., *Out-of-school youth in Sub-Saharan Africa a policy perspective 2015*, World Bank: Washington.
39. Mumah, J.N., et al., Adolescents' narratives of coping with unintended pregnancy in Nairobi's informal settlements. *PLoS ONE*, 2020. 15(10): p. e0240797.
40. Seidu, A.A., et al., Sexual and reproductive health education and its association with ever use of contraception: a cross-sectional study among women in urban slums, Accra. *Reproductive Health*, 2022. 19(7).
41. Amankwaa, G., A. Kabila, and R.M. Gyasi, In-school adolescents' knowledge, access to and use of sexual and reproductive health services in Metropolitan Kumasi, Ghana. *Journal of Public Health*, 2018. 26(1).
42. Hagan, J. and C. Buxton, Contraceptive knowledge, perceptions and use among adolescents in selected senior high schools in the central region of Ghana. *J Sociol Res* 2012. 3(2): p. 170-180.
43. Dapaah, J., et al., Does facility based sexual and reproductive health services meet the needs of young persons? Views from cross section of Ghanaian youth. *Sci Res*, 2015. 5(3): p. 61-71.
44. Mosher, W., et al., *Disabil Health J*, 2017 10(3): p. 394-399.
45. Ganle, J.K., et al., Barriers facing persons with disability in accessing sexual and reproductive health services in sub-Saharan Africa: A systematic review. *Plos ONE*, 2021.
46. Hasselback, L., et al., Understanding and addressing contraceptive stockouts to increase family planning access and uptake in Senegal. *BMC Health Services Research*, 2017. 17(373).
47. Mukasa, B., et al., *Contraception supply chain challenges: a review of evidence from low- and middle-income*

- countries. *The European Journal of Contraception & Reproductive Health Care*, 2017. 22(5): p. 384-390.
48. Shah, N.A., N. Nisar, and M.H. Qadri, Awareness and pattern of utilizing family planning services among women attending family planning services among women attending urban health care centre Azizabad Sukkur. *Pak J Med Sci*, 2008. 24(4): p. 550-5.
 49. Megabiaw, B., Awareness and utilization of modern contraceptives among street women in North-West Ethiopia. *BMC Women's Health*, 2012. 12(31).
 50. Kabagenyi, A., et al., Barriers to male involvement in contraceptive uptake and reproductive health services: a qualitative study of men and women's perceptions in two rural districts in Uganda. *Reproductive Health*, 2014. 11(21).
 51. Lewis, S., A. Lee, and P. Simkhada, The role of husbands in maternal health and safe childbirth in rural Nepal: a qualitative study. *BMC Pregnancy and Childbirth*, 2015. 15(162).
 52. Kriel, Y., et al., Male partner influence on family planning and contraceptive use: perspectives from community members and healthcare providers in KwaZulu-Natal, South Africa. *Reproductive Health*, 2019. 16(89).
 53. Dudgeon, M.R. and M.C. Inhorn, Men's influences on women's reproductive health: medical anthropological perspectives. *Soc Sci Med*, 2004. 59(7): p. 1379-95.
 54. Dioubaté, N., et al., Barriers to Contraceptive Use Among Urban Adolescents and Youth in Conakry, in 2019, Guinea. *Front. Glob. Womens Health*, 2021. 2(655929).
 55. Ruhl, C., Contraception is Health Promotion. *Nursing for Women s Health* 2012. 16(1): p. 73-7.
 56. Hultstrand, J.N., et al., The perpetuating cycle of unplanned pregnancy: underlying causes and implications in Eswatini. *Cult Health Sex*, 2021. 23(12): p. 1656-71.
 57. Unumeri, G., et al., Contraceptive use and its socio-economic determinants among women in North-East and North-West Regions of Nigeria: A Comparative Analysis *African Population Studies*, 2015. 29(2).
 58. Varga, C.A., Sexual decision-making and negotiation in the midst of AIDS: youth in KwaZulu/Natal, South Africa. *Health Transition Review*, 1997. 7(3): p. 45-67.
 59. Seidu, A.-A., et al., Women's autonomy in household decision-making and safer sex negotiation in sub-Saharan Africa: An analysis of data from 27 Demographic and Health Surveys. *Population Health*, 2021. 14(100773).
 60. Adanikin, A.I., N. McGrath, and S.S. Padmadas, Power relations and negotiations in contraceptive decision-making when husbands oppose family planning: analysis of ethnographic vignette couple data in Southwest Nigeria. *Cult Health Sex*, 2019. 21(12): p. 1439-1451.
 61. Ochako, R., et al., Female sex workers experiences of using contraceptive methods: a qualitative study in Kenya. *BMC Womens Health*, 2018. 18(105).
 62. Ouedraogo, R. and D. Stenzel, The Heavy Economic Toll of Gender-based Violence: Evidence from SubSaharan Africa, in WP/21/277. 2021, International Monetary Fund African Department: Washington DC.
 63. Bishwajit, G. and S. Yaya, Domestic violence: a hidden barrier to contraceptive use among women in Nigeria. *Open Access Journal of Contraception*, 2018. 2018(9): p. 21–28.
 64. Chena, G.L., et al., A cross-sectional analysis of intimate partner violence and family planning use in rural India. *EClinica I Medicine Journal*, 2020. 21(100318).
 65. Ahinkorah, B.O., et al., Sexual violence and unmet need for contraception among married and cohabiting women in sub-Saharan Africa: Evidence from demographic and health surveys. *PLoS ONE*, 2020. 15(11): p. e0240556.
 66. Dadras, O., et al., Intimate partner violence and unmet need for family planning in Afghan women: the implication for policy and practice. *Reproductive Health*, 2022. 19(52).
 67. Wondie, A.G., The association between unmet need for contraception and unintended pregnancy among reproductive-age women in Ethiopia. *Access to Sexual Health Services*, 2021. 5: p. 1-5.
 68. Puri, M., et al., Abortion Incidence and unintended pregnancy in Nepal. *Int Perspect Sex Reprod Health*, 2016. 42(4): p. 197-209.
 69. UNPFPA and UNIFEM, Combating gender-based violence: a key to achieving the MDGS. 2005, UNFPA: Geneva.

70. de Araújo, T.V.B., et al., Delays in access to care for abortion-related complications: the experience of women in Northeast Brazil. *Cad. Saúde Pública*, 2018. 36(4).
71. Barnes-Josiah, D., C. Myntti, and A. Augustin, The "three delays" as a framework for examining maternal mortality in Haiti. *Soc Sci Med*, 1998. 46(8): p. 981-93.
72. CSO, Swaziland Demographic Health Survey 2006-2007. 2007, Central statistics Office: Mbabane.
73. Oluwasanu, M.M., et al., Access to information on family planning and use of modern contraceptives among married Igbo women in Southeast, Nigeria. *Int Q Community Health Educ*, 2019. 39(4): p. 233-243.
74. Antarini, A., Factors influencing the use of modern contraception among reproductive aged women in Bangka Belitung Province, Indonesia. *Pan Afr Med J*, 2021. 13(39): p. 39.
75. Owolabi, O.O., A. Biddlecom, and H.S. Whitehead, Health systems' capacity to provide post-abortion care: a multicountry analysis using signal functions. *The Lancet Glob Health*, 2019. 7(1): p. E110-E118.
76. Grol, R., Standards of Care or Standard Care? Guidelines in general practice. *Scandinavian Journal of Primary Health Care*, 1993. 11(1): p. 26-31.
77. Donabedian, A., The quality of care. How can it be assessed? *JAMA*, 1988. 260(12): p. 1743-8.
78. Staveteig, S., T. Gebreselassie, and K.T. Kampa, Absolute poverty, fertility preferences, and family planning use in FP2020 focus countries in DHS Comparative Reports No. 48. 2018, USAID, ICF: Pockville, Maryland.
79. Yaya, S., et al., Women empowerment as an enabling factor of contraceptive use in sub-Saharan Africa: a multilevel analysis of cross-sectional surveys of 32 countries. *Reproductive Health* 2018. 15(214).
80. Guttmacher Institute, Unintended Pregnancy in the United States, in Fact Sheet. 2019, Guttmacher Institute: USA.
81. Davis, J., et al., *Male involvement in reproductive, maternal and child health: a qualitative study of policymaker and practitioner perspectives in the Pacific*. *Reproductive Health* 2016. 13(81).
82. Lemma, S., et al., *Improving quality and use of routine health information system data in low- and middle-income countries: A scoping review*. *PLoS One*, 2020. 15(10): p. e0239683.
83. Witt, W.P., *The Future of Maternal and Child Health Data in the United States*. *Am J Public Health*, 2018. 108(10): p. 1277-79.
84. Chappel, A., et al. *Addressing The Maternal Health Crisis Through Improved Data Infrastructure: Guiding Principles For Progress*. 2021 [cited 2022 27/05/2022].

