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Shreya Sharma April 12, 2022

A Political Economy Approach to Understanding Abortion in Nepal

by

Shreya Sharma

Dr. Craig Hadley
Adviser

Anthropology

Dr. Craig Hadley
Adviser

Dr. Kristin Phillips
Committee Member

Dr. Jessica Ham
Committee Member

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Abstract

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This research explores the cultural and political factors influencing access to abortion in Nepal. Such factors range from foreign influence by means of external funding and foreign policies such as the U.S. Global Gag Rule, to prevailing cultural and religious Nepali norms that inform a spectrum of attitudes towards sexual practice, contraceptive use, and abortions. Methods for this study employed ethnographic practices in a virtual setting, through seven semi-structured interviews with Nepali individuals across time zones. Existing research fails to address possible explanations behind prevailing high rates of illegal abortions in Nepal despite a progressive legal environment. This study hence allows for a nuanced understanding on the issue of abortion and why legal access may still be difficult to achieve, in context of Nepal's specific circumstances. Ultimately, through data analysis and investigation, we come to address the question: *are legal status and affordability enough to ensure access to abortion in Nepal?*

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Chapter 1: Introduction to Abortion in Nepal

1. Narrative Statement of Personal Interest

Conversations about abortion spark controversies, disagreements, ethical and moral quarrels, and a host of debates about one's right and ability to abort: *Is this decision reserved for the mother of the child, for religion, or perhaps even for the government? Is abortion perceived as a human right, or instead as a tool for murder? Is abortion accessible, or must one resort to unsafe, illegal methods to receive one? Should abortions cost money?* The list is perhaps never-ending, varying in length and scrutiny depending on the cultural and contextual circumstance within which it is being studied. Consequently, this makes abortion an especially fascinating topic to unpack, given the varying narratives that exist regarding the situational, historical evolution of abortion across different pockets of the world.

My research explores the abortion landscape specific to Nepal — a nation infamously known for its booming tourism industry, picturesque mountainous landscapes, and rich religious and cultural history, as well as its corrupt and unstable government and record as one of the poorest nations in the world. Nepal is a landlocked country located in South Asia sandwiched between global superpowers India and China (specifically, the Tibetan region of China). It is situated on the southern end of the Himalayan Mountain range, peppering the outskirts of the country with its hilly terrain. This surrounding rural and hilly terrain converges in the center of the country to create *Kathmandu Valley*, home to the most densely populated region of Nepal, as well as the capital city of Kathmandu. Politically, Nepal has always remained an independent state free of colonial history. However, during the years of colonial rule across South Asia, Nepal served as a buffer state between Imperial China and British India and formed a brief alliance with the British

Empire, making it subject to the corresponding changes impacting trade and the economy. Nepal was a Hindu monarchy until 2008, after which the Nepali civil war resulted in the establishment of a secular republic. This civil war was one that shook the country — an armed conflict between the Government of Nepal and the Communist Party of Nepal (the *Maoists*, inspired by the teachings of Chinese Mao Zedong) — resulting in what is now the only country in the world that is a multi-party, fully democratic nation ruled by a communist party.

According to the most recent census performed by the United Nations, Nepal is the 49th most populous country in the world, behind Yemen and in front of Venezuela, with a total country population of 30,378,055 million as of 2021. Nepal is incredibly diverse consisting of 125 ethnic groups and 123 mother-tongue languages. Aside from Nepali, the official and most spoken language in Nepal, Newari (*Nepali Bhasa*), Maithili, Bhojpuri, Tharu, and Tamang are also widely spoken. Hinduism is the religion most popularly practiced by Nepalis, as one can find Hindu temples and other remnants of historic Hindusim on almost every street in Kathmandu. Buddhism is also popular, pointing to the southern city of Lumbini, Nepal as the birthplace and place of residence of *Siddhartha Gautama* (Buddha). Nepal's complex layers of ethnic, cultural, and religious diversity also contributed to the maintenance of a caste system — reflecting nuances in socioeconomic stratification, job roles, family values, and cultural traditions. As one could imagine, these larger structures of culture, religion, and caste have had an incredible impact on issues of gender equality and women's rights in Nepal, a topic we will revisit later in this chapter. Laws and law enforcement in Nepal, also constructed on the basis of these larger structures, are regarded to be generally progressive with respect to other nations in a similar economic bracket. To name a few, the death penalty in Nepal has been

significant progress towards LGBTQ+ rights in recent years, land inheritance laws have been modified to benefit both sons and daughters, and laws on abortion are generally regarded as liberal (this will be further explored in later chapters). Despite the presence of seemingly progressive laws in Nepal, however, there are certainly debates regarding the establishment of—or lack thereof — systems to help reinforce the legal system. Systemic institutions of culture, religion, and tradition prevail in ways that inhibit accessibility to so-called liberal policies, creating an illusion of what progressivity in Nepal *truly indicates*.

Nepal has one of the fastest-growing economies in the world, with the tourism industry supporting the brunt of economic growth and employment opportunities in the country. Yet, Nepal is one of the poorest countries in the world, bearing the low-income title. Leading up to and after the Nepali civil war, as well as the impact of the 7.8 magnitude 2015 earthquake, the Nepali economy has undergone drastic changes leading to fractured opportunities for economic sustainability. As a result, Nepal has inadvertently outsourced much of its labor in recent years, with the Department of Foreign Employment issuing over 4 million migrant labor approvals to Nepali workers in the last decade (Nepal Labour Migration Report 2020). These Nepalis often leave the country with the intent to send remittances back home but due to exploitative, corrupt contract agreements in foreign countries, much of this income is never secured. This is only one of the many ways Nepal is dependent on foreign neighbors, as financial aid from foreign donors also contributes significantly to both Nepal's economy and social justice efforts. As we will explore later in this chapter, foreign aid comprises a significant portion of Nepal's internal country initiatives. Nepali healthcare, in particular, is over 50% financially supported by foreign donors, notably the United States, the U.K., and Germany. This makes the inner workings and

productivity of the healthcare system in Nepal particularly interesting to understand given its unwavering dependence on foreign aid, mixed with an unstable economic system, communist yet democratic government, and seemingly socially progressive laws and policies.

Ultimately, it was this complex nature of Nepal's politics, culture, and political economy atmosphere that sparked my interest to study Nepal for my thesis research. As a student intrigued by public health within a global context, I tried my best to keep up to date with foreign policies, initiatives pioneered by multilateral organizations and NGOs, and other related news impacting global health. More specifically, I was consistent to keep an eye out for such global health issues impacting Nepal. Having been raised speaking Nepali, celebrating the traditions, and as involved in Nepali culture as a child being raised in America could be, I came to the realization that my understanding of Nepal as a country was quite limited to only what I was taught by my parents. Although I may have been well-versed in major holidays, traditional mannerisms, and cultural values, I knew little about how Nepal operated as a country. My first introduction to the Global Gag Rule, however, thanks to my persistent habit of perusing through public health news, was when I first became introduced to the notion of foreign dependency for healthcare in Nepal. Upon further reading, I learned that this type of financial dependency directly impacted healthcare rights not only for abortion but for so many other health-related issues. The Global Gag Rule was known for inhibiting access to and discussion of abortion in countries that were U.S. funding to promote abortion-related services and programming—thereby directly limiting reproductive healthcare rights abroad (PAI 2022). I always had a basic understanding of Nepal as a rather poorer country dependent on its weather neighbors but being introduced to a specific example through the Global Gag Rule fascinated me. What I knew about Nepal's adherence to

gender norms and notions of female autonomy, coupled with what I recently read about the Global Gag Rule's ability to directly impact access to abortion in Nepal, led me on this journey to further explore abortion in Nepal.

On a personal note, this research journey has given me the opportunity to connect with my ethnic heritage in a meaningful way. Having been born and raised in the United States, I've always struggled with my identity as a Nepali American. I often found myself caught in an in-between, feeling either not *American enough* or not *Nepali enough* to fit in. The chance to interview individuals across Nepal has allowed me to improve my Nepali language skills, develop a deeper understanding of Nepali culture and tradition, and have brought immense joy to both my parents and older members of my family. In particular, having the opportunity to better understand an issue so closely related to women's rights in Nepal has proven especially rewarding. Growing up, the common narrative from my mother would be to *study hard and not get distracted,* so as to not be viewed as an unmotivated, unambitious woman. For the longest time, I had not a clue what my mother meant by this. It was only later that I learned that she grew up in a culture where, unless women actively sought to be educated, their families would arrange for them to be married off— often as young as 17 years old. Nepali and Hindu traditions largely viewed the primary goal and responsibility of a woman to bear children above all else. As in many societies across history where this was the case, women were consequently treated as subordinate, unintelligent, and perceived as offering little value other than serving as a wife and mother. Education quickly became an outlet through which women could seek both financial dependence and autonomy, shedding hope on the possibility of living in a world where women would be treated with respect. My mother and grandmother relentlessly advocated for this autonomy,

regardless of societal and cultural pressure to marry and bear children early. Given the history of women in my family, I feel incredibly privileged to live a life free from the ponderous burden of such strict gender norms. Understanding the issue of abortion in context to Nepali gender norms has illuminated the struggles that so many of the women in my family must have faced— a facet of the *Nepali woman identity* that I, being a Nepali American, never had to endure.

My honors thesis research seeks to explore and clarify the role that foreign aid plays in impacting a woman's access to abortion in Nepal, juxtaposed against the barriers to access Nepali women face amidst widespread cultural and religious beliefs. I interviewed seven individuals who understand abortion access in Nepal through their line of work, academic research, or community involvement. In addition to these conversations, I conducted a thorough review of existing literature on abortion access in Nepal, supplemented by personal knowledge gained from conversations with Nepali families and friends. I hope that by engaging in conversation with those central to abortion issues in Nepal, we will be better equipped to understand abortion in the context of prevailing cultural and religious attitudes, evolving legal policies, and the surrounding political economy of Nepal. From a preliminary standpoint, I predict that further research into Nepali attitudes towards abortion and Nepal's financial dependency may unveil how access to abortion is more limited than one might perceive. Before a detailed analysis begins, let's first explore Nepal's history with abortion to better understand how the country's legal journey with abortion has evolved over the years.

2. Overview of Abortion History

2.1 Pre-Legalization and Legalization of Abortion

Contrary to what one might perceive based upon sociocontextual assumptions of the country, Nepal has more progressive laws on abortion than countries with comparative religious and cultural norms, perceptions of gender equity, and similar economic standing (Center for Reproductive Rights 2021). Abortions in Nepal are legal and available free of cost at government health centers located in every district across the country, from the *pahar* to the *terai*. But can progressive laws and affordable services alone imply that accessing abortion is easy and available?

To illustrate a brief history, abortion was first legalized in Nepal in 2002. Prior to 2002, Nepal had extremely strict anti-abortion laws considered to be inspired by Hindu precepts found in related texts, specifically the *Rigveda* and the *Atharvaveda* (Upreti 2014, 283). These anti-abortion laws meant that receiving an abortion was considered an imprisonable offense, for both women seeking an abortion and for their family members. Nearly one-fifth of all incarcerated women in Nepal were imprisoned for an abortion-related offense (Wu et al. 2017), and nearly 70% of women who were prosecuted for abortion-related offenses were convicted (Upreti 2014, 284). Legal analysts note that this is an unusually high number in comparison to other criminal cases involving women in Nepal and that in many of these cases, miscarriages were also regarded as infanticide.

Nonetheless, historical accounts illustrate that the possibility of imprisonment was no barrier to Nepali women, as they were still actively seeking abortions through illegal, generally unsafe

methods, accounting for nearly one-half of maternal deaths each year. The maternal mortality rate in Nepal was so high, that legalization in 2002 contributed to a 71% decline in Nepal's maternal mortality ratio between the years 1990-2015 taking the maternal mortality ratio from 901 deaths per 100,000 live births, down to 258 (Thapa 2021). Common methods of unsafe, illegal abortion methods at this time ranged from oral ingestion of inedible or harmful herbs to the insertion of foreign objects (such as sticks) coated in cow dung (Upreti 2014, 283). In the well-known case of Min Min Lama, a Nepali girl was incarcerated in 1999 at the age of fourteen for receiving an illegal abortion and is often cited as the prompt for widespread advocacy and eventual legalization of abortions in Nepal. However, what brought this case overwhelming attention was that her unintended pregnancy was a result of rape by a close family member. The enumerable human rights violations in Min Min Lama's case, the staggering threat to women's health and safety caused by unsafe methods of abortion, along with the alarming rate of maternal mortality, is what led to the advocacy for and eventual legalization of abortions in Nepal.

Despite the official legalization of abortion in 2002, however, this action did not necessarily portend a landscape of widely accepted and easily accessible abortions for all Nepali women. Originally, abortion legalization in Nepal stated that: a*bortion could be performed up to 12 weeks' gestation on request, up to 18 weeks' gestation in cases of rape or incest, and at any time if the pregnancy poses a danger to the women's life, physical or mental health, or if there is a fetal abnormality* (Wu et al. 2017). According to Nepal's current policies on abortion, it is illegal to conduct abortions that are performed outside government-approved centers or to perform abortions that are self-induced. Consequently, if government-approved centers are only in urban areas, in areas of high density, or in other condition-specific locations most convenient for the

government to support, naturally, a large number of Nepali women seeking abortion services will not experience a similar level of accessibility (Khanal 2014). These densely populated areas would primarily include Kathmandu Valley, excluding the *terai* and *pahar* regions surrounding it. Additionally, in a country where sexual assault, human trafficking, and childhood marriages are high (Human Rights Watch 2016), a woman's decision whether to seek an abortion may be tied to precarious circumstances, further complicating their decision.

2.2 Safe Motherhood Program

The Safe Motherhood Program of Nepal was first implemented in 1997, with slight modifications made in the years that followed. This program initially began in response to high rates of maternal morbidity and mortality in Nepal which sparked a series of policy changes advocating for women's health rights and eventually, led to the legalization of abortion in 2002. Nepal's Ministry of Health and Population (MoHP), recognizes the goal of the Safe Motherhood Program to:

> "Reduce maternal and neonatal morbidity and mortality and to improve the maternal and neonatal health through preventive and promotive activities as well as by addressing avoidable factors that cause death during pregnancy, childbirth, and postpartum period. Evidence suggest that three delays are important factors behind the maternal and newborn."

Services covered under the Safe Motherhood Program primarily only concern prenatal care, pregnancy, and post-natal care. There is no mention of providing safe abortion care, information distribution about safe abortion access, nor any other resources to prepare for abortion, should a

woman choose to terminate her pregnancy. The Safe Motherhood Program only provides services to manage complications that result from an abortion when blood transfusion is necessary or to cover Laparotomy for perforation due to abortion complications. Although safe abortion is provided across all districts in Nepal free of cost, the fact that the Safe Motherhood Program does not explicitly advocate for safe abortion services may speak to the lingering stigma against abortion that widely remains across Nepal today.

In 2018, Nepal implemented the Safe Motherhood and Reproductive Health Rights (SMRHR) Act, which was intended to "respect, protect, and fulfill women's reproductive health rights and recognize access to abortion as a right to reproductive health" (Center for Reproductive Rights 2021). This program was extended to provide protections for women seeking an abortion, which was a step forward from the program initially implemented in 1997. Advocates of safe abortion hoped that this policy would lead to the formal decriminalization of abortion in Nepal, but much to their disappointment, the policy failed to do so.

2.3 Lakshmi Dhikta v. Government of Nepal

The 2009 *Lakshmi Dhikta v. Government of Nepal* supreme court decision was pivotal in the movement toward recognizing Nepali women's constitutional right to access abortion services in an equitable fashion. In context, this issue was raised in court based on a variety of institutionalized actions that were discriminatory towards women primarily on the basis of financial aptitude, social status, and gender. This surrounding context which disadvantaged the rights of Nepali women from the late 1900s to the early 2000's not only led to this court case, but also the prominent *Meera Dhungana v. Ministry of Law, Justice, and Parliamentary Affairs,*

which disputed paternal property rights. The Dhikta case in particular was brought to court in response to the personal experience of a woman named Lakshmi Dhikta. Lakshmi Dhikta, a mother of five from Dadeldhura— a hilly, rural district in western Nepal— desperately sought an abortion for her sixth pregnancy. However, when she and her husband visited the nearest government hospital to receive the procedure, they were denied access to abort based on their inability to afford the service. The cost of the abortion service they were seeking was Rs 1130 ($12 U.S. dollars). This case sought to recognize barriers to access to abortion including lack of information, lack of financial resources, and lack of proximity to quality services (Upreti 2014, 281). The Dhikta case delimits that abortion is a matter of personal choice and in doing so, advocates women have the right and the final say regarding decisions about her own body. Melissa Upreti, a prominent scholar of abortion rights in South Asia, concludes that "It repudiates traditional stereotypes of women that reduce them to the role of bearers of children and self-sacrificing mothers" (Upreti 2014, 279). This is especially true given the fact that Nepal's legal system is largely viewed as patriarchal in character, rooted in outdated interpretations of Hinduism on gender. Nepali law extends to categorize women based on their sexual and marital status, often included in Nepali legal codes as *kanya* or virgin, *bihe nagareko* or never married, *lyayeko* or brought as a wife but not yet formally married, *bahira rakheko* or kept informally outside the home, *santan hune/nahune* or whether a woman capable of bearing offspring or not, and *bidhawa* or widow. As is apparent, a Nepali woman's reproductive status overwhelmingly determines her legal rights (Upreti 2014, 289).

Through the Dhikta case, the Nepali government not only regards the women's right to abort but extends to define Nepal's position on the legal status of the fetus. The Nepal Court denotes that

"not every stage of fetal development can be equated with human life" and that "only a born-alive child who has reached a certain stage of development is granted the status of human life" (Upreti 2014, 292). Given this clarification, the court doesn't believe that fetal interests should prevail over women's rights, despite recognizing fetal interests as worthy of protection. Article 20 of the Nepali Constitution further clarifies by stating: "It is only when one's reproductive health is in a good state that one can fully enjoy their reproductive rights; similarly, it is only when one has reproductive rights that their reproductive health can be fully protected" (Upreti 2014, 293).

Beyond Lakshmi's specific circumstance, what corroborated this case further was evidence of how incredibly common situations such as Lakshmi's were. The case illuminated the stark disparities that exist between the financially advantaged and disadvantaged across Nepal. Prior to the legalization of abortion, Nepali women who were educated, had well-paying jobs, and were well-connected had financial leverage to seek out experienced doctors to receive an abortion—circumventing the law and gaining preference excusal by the government (Wu et.al 2017). In contrast, those residing in rural areas who were less educated and financially disadvantaged were tended to by untrained professionals (or attempted an alternative method of abortion by themselves), often leading to unsafe abortions, imprisonment, and death (Wu et.al 2017). Even after abortion was legalized, these same circumstantial conditions continue to reflect the ability of a wealthier woman to have both increased access and feasibility to pay for abortion, whereas a poorer woman in a rural district may not have the competency for either (Wu et.al 2017). This palpable dichotomy illustrates how the criminal abortion ban was disproportionately felt by the

socially and financially disadvantaged historically, with its effects lasting even until after abortion was legalized.

It was not until the court ruled that denying abortion based on a woman's inability to pay was a violation of women's rights, that substantial legal action took place. Prior to this government case, abortion was not identified by the Nepali government as a *fundamental human right.* As a result of the Dhikta case, the Nepali government was required to regard it as such and to provide abortion services free of charge and decentralize abortion services across districts to enhance equitable access. In a landscape where abortion was criminalized both legally and socially for numerous decades, this court case reflected a shift from regarding abortion as a crime, to instead regarding it as an issue of women's rights. The Dhikta case served to illustrate the critical role that financial ability and geographic proximity play in a woman's access to receive an abortion in Nepal (Upreti 2014).

2.4 Legalization vs. Decriminalization of Abortion in Nepal

Although abortion was legalized in Nepal in 2002, Nepal did not formally agree to decriminalize abortion until nearly twenty years later, in September of 2021. By decriminalizing abortion, Nepal formally agreed to protect the sexual and reproductive health rights (SRHR) of women and girls. Prior to decriminalization, Nepali women continued to face the risk of prosecution for abortion care — a protection that was not ensured through the process of legalization. Nepal's Executive Director of the Forum for Women, Law, and Development, Sabin Shrestha, shared that "women and girls were still being imprisoned if they took medical abortion tablets from a health service provider and/or health setting, not on the government's approved list." Many

women and girls choose to receive medical abortion pills from their nearby pharmacies for ease of accessibility. However, if a pharmacist sells them a particular pill that does not make Nepal's legal shortlist, these women face the consequences. According to Nepal's penal code, women faced up to one year in prison and a maximum fine of Rs 10,000 (about $135 US) for abortion up to 12 weeks, three years in prison, and a maximum fine of Rs 30,000 (about $404 US) for abortion after 12 weeks and up to 25 weeks, and up to five years in prison and a maximum fine of Rs 50,000 (about $673 US) for abortion after 25 weeks of pregnancy (Center for Reproductive Rights Factsheet 2021).

Consequently, although legalization did increase access to abortions from a legal standpoint, women did not necessarily have a "free pass". The criminalization of abortion remained in the chapter of the Nepal Country Code denoting criminal punishments for crimes against human life, such as homicide. Many interpreted abortions as a form of homicide, making the lines unclear for what truly was legal (Upreti 2014). However, the Dhikta case played a significant role in clarifying Nepal's position on the legal standing of a fetus. The Nepali Court later explained that "since the Chapter does not define human life and in the absence of a constitutional or other legal provision that recognizes a fetal right to life, the fetus is not recognized as a human life, or person, in Nepalese law" (Upreti 2014, 292).

Now that abortion is decriminalized in Nepal, women face a significantly reduced risk of persecution for exercising their right to terminate an unwanted pregnancy. I place emphasis on *reduced* because although there may no longer be any legal implications of receiving abortion

care, existing stigmas against abortion (Shrestha, 2018) in Nepal coupled with a poor system of national legal enforcement, women may not be entirely risk-free.

2.5 Regional Comparisons

Amongst its South Asian neighbors, Nepali laws on abortion are regarded as accepting of a woman's choice to abort. India was the first to legalize abortion in the South Asian region, in 1971. As of now, Indian women may choose to abort up to 24 weeks of pregnancy and all public sector abortion services are offered free of cost. On the other hand, in Bangladesh, Bhutan, and Sri Lanka, induced abortions are entirely illegal except when the woman is at risk of dying. Similarly, Pakistani laws on abortion state that abortion is only legal during the early stages of pregnancy in order to preserve the woman's health (Center for Reproductive Rights 2021).

The Center for Reproductive Rights divides countries' abortion laws into five categories, from most constrictive to most liberal: 1) Prohibited altogether, 2) To save a woman's life, 3) To preserve health, 4) Broad Social or Economic Grounds, and 5) On request. Guyana, Albania, South Africa, and Cambodia were among the first countries in the world to transition their abortion laws from one of the more constricting categories to *on request*, between the years of 1995 and 1997. At the same time when Nepal transitioned its laws on abortion from *prohibited altogether* to *on request* in 2002, Switzerland also transitioned its laws from to *preserve health* to *on request*. Similar to Nepal, seventy-three other countries fall under the category in which abortions are granted *on request* as of 2021, some of which include Argentina, Armenia, Cambodia, Ireland, Mongolia, Mozambique, Russia, Turkey, and Vietnam. On the other side of

the spectrum, twenty-four countries fall under the category in which abortion is *prohibited altogether*, including Egypt, El Salvador, Iraq, Laos, and the Philippines, to name a few.

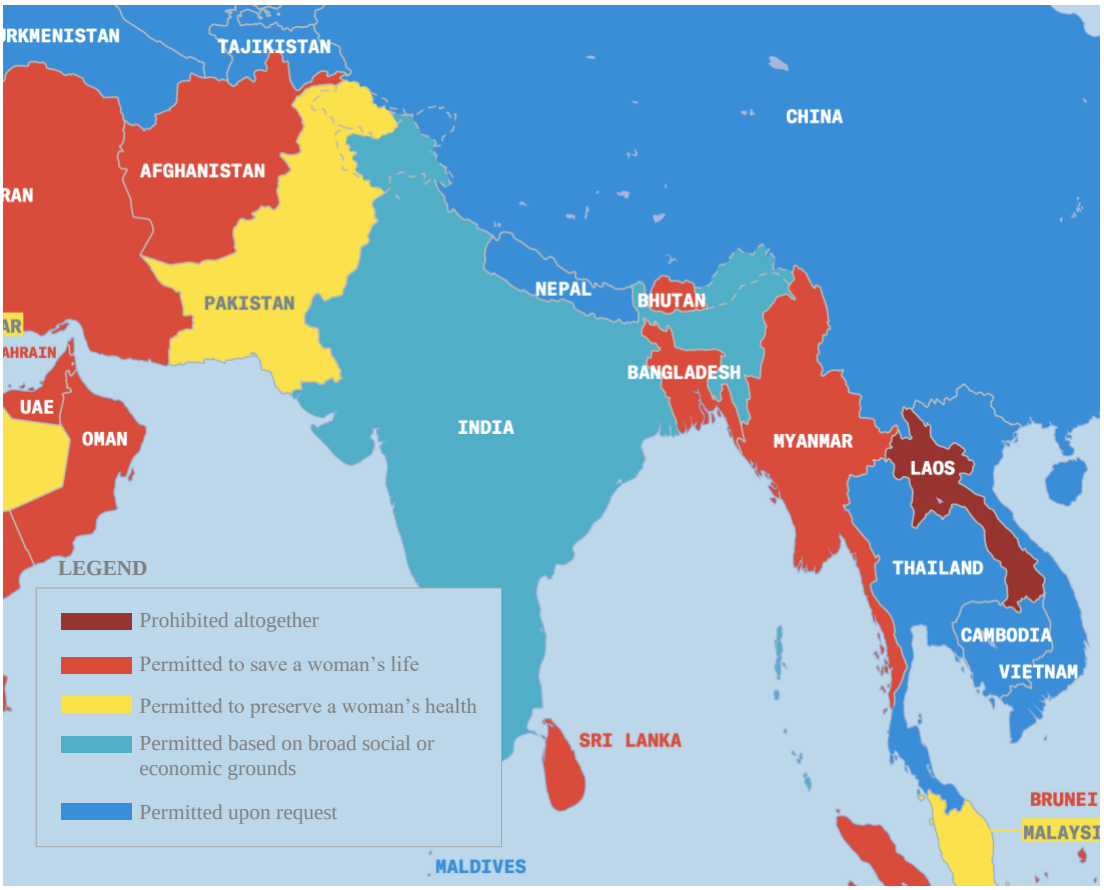

Figure 1. **Legal status of abortion in South Asia.** The legend above illustrates the legal status of abortion across different countries in South and Southeast Asia. *Center for Reproductive Rights*.

With respect to the *legalization* vs. *decriminalization* debate, the meaning and effect of these words are sometimes used interchangeably in other parts of the world with respect to abortion rights specifically: "Instead, the two terms are used interchangeably—that is, abortion may be legalized or decriminalized on *some* or *all* grounds" (Berer 2017). So, although Nepali women struggled to achieve complete rights to abortion until decriminalization, this distinction may not

hold the same degree of importance in other countries, therefore making legalization and decriminalization poor indicators upon which to compare countries' progress.

More recent data on the incidence of unsafe abortions shows there were 21.6 million incidents of unsafe abortions and 47,000 subsequent deaths in 2008. These data illustrate that 1 in every 10 pregnancies end in unsafe abortion, and that "almost all unsafe abortions take place in developing countries" (World Health Organization 2008). Metrics on the incidence of unsafe abortions might serve as helpful to understanding barriers to access to safe abortion, especially in places like Nepal, where abortion laws are progressive. However, measuring an indicator like this is challenging, especially given the fact that many methods of unsafe abortion occur outside of a hospital or medical-related setting.

3. Women's Rights and Healthcare Infrastructure in Nepal

3.1 Women's Rights

We cannot truly uncover access to abortion in Nepal without first understanding the nuances in gender inequality and women's rights that exist within the country. Some argue that the end of the Nepali civil war in 2006 was monumental in creating a shift toward women's activism (Khanal and Bracarense 2020). The sudden surge of citizen-level activism and free speech engendered by the Maoist Party (a.k.a. the Third People's Party), provided a sense of empowerment to Nepali women, both urban and rural, who sought to do the same for themselves (Khanal and Bracarense 2020). Part of this is also attributed to the large scale of women and girls who participated in the Maoist movement, with nearly 5,000 combatants who were female (Pant and Standing 2011). This is not particularly surprising, given that the Maoist movement gained

popularity on the basis that they would fight toward land reform and equal property rights for marginalized groups and women. This newfound empowerment created changes in gender roles and activism, challenging gender norms set forth by a historically patriarchal Nepali society. A feminist movement emerged shortly after working to legally and socially empower women, particularly with regard to citizenship rights. Yet, given the Maoists party's disruptive and aggressive intervention of the government in 2006, records of rape, child abduction, and other forms of abuse discredit the Maoists as "heroes" of any kind. Instead, many Nepalis view the Maoist regime as one that is harmful, despite the seemingly progressive platform they ran on. From my interpretation, it was not the party's platform and messaging that created a shift toward women's rights, but instead, a movement of anger fueled by the pain felt by so many women amidst the political transition (Crawford et al 2007). On the matter of abortion particularly, no recorded evidence indicates that the Maoist party is collectively in favor of abortion despite their forward platform for women's rights. It is apparent that abortion is not a partisan issue in Nepal, as it often is in the United States and in other countries.

Since the inadvertent women's activism that arose through the transition to a Maoist government, various legal steps have been taken to ensure women's equality in citizenship and rights. It was not until the establishment of the Constitutional Assembly in Nepal in the late 2000s that there was a legal effort to recognize full and equal citizenship rights for Nepali women. Following that, a law passed in 2007 during the period of interim governance required at least 33% participation of women in every organ of Nepal, and additionally, repealed discriminatory citizenship laws toward women (Pant and Standing 2011). In the years that followed, various other legal changes to citizenship have been advocated for and changed, with aspirations for

Nepali women to achieve genuine equity. However, despite efforts to create legal change, the reality is that Nepal's patriarchal society and associated perceptions of gender, override any performative action to "legalize" gender equality. This is an issue that although improved, through increased numbers of female representation in government and changes to women's citizenship status, widely exists to this day (Pant and Standing 2011). Not to mention, promises preached by the communist Maoist party to achieve gender equity and provide citizenship rights to women remain largely unfulfilled, an unfortunate reality given the scale of Nepali women who marched alongside this political party to promote their cause (Pettigrew and Schneiderman 2004).

Fundamentally, a history of patriarchy can be accredited to the gender norms widely regarded across Nepal today (although there certainly may have been other factors contributing to the rise of patriarchy, too). Gender inequality in Nepal is often interpreted as based upon differential treatment toward sons and daughters. Amongst some Nepali families, daughters can be seen as burdensome. Daughters traditionally tended to the home, were responsible for cooking and house tasks, were discouraged from education, and were believed to ultimately inflict financial suffering upon their parents (Watson et al. 2020). One of such instances is through the dowry, where a bride's family is expected to provide the spouse's family with riches upon their marriage. Such an emphasis on marriage implied the notion that once married, the daughter is no longer part of her birth family, meaning her responsibility lies in serving the parents of her husband. Another prominent issue in Nepal, that has now been legally reversed, is land inheritance. Property rights were always given to sons, so daughters also proved less valuable in the context of maintaining ancestral land. There is also significant pressure for daughters to be

married off quickly. This is partly because marrying older daughters is seen as undesirable, but also because parents seek to minimize the time during which she might be likely to elope, have a *love marriage*, engage in premarital sex, or engage in other activity which is not supported in Nepali culture as to not bring shame to her parents. A related pressure with marriage and prestige is divorce, which is also seen as a rebellious activity in Nepali society, the blame of which often falls on the woman (Watson et al. 2020). Perceptions of patriarchy and differential gender norms may vary across Nepal depending on one's personal interpretations of related issues.

Perhaps a more aggressive form of discrimination against women can be seen through the continued high rates of childhood marriage and sex trafficking across Nepal. Nepal has the third-highest rate of child marriage in Asia, behind India and Bangladesh. Although both young boys and girls face the possibility of childhood marriage, girls tend to be at higher risk, as thirty-seven percent of Nepali girls marry before the age of eighteen and ten percent of Nepali girls marry before the age of fifteen, whereas thirty-four percent of Nepali boys marry before the age of nineteen (Human Rights Watch 2016). Childhood marriages typically are the result of arranged marriages, poverty and food insecurity, child labor, and cultural pressures to marry after puberty—these are just a few of the many possible factors. Disproportionately, childhood marriages affect those of the Dalit *jaat* and those living in *Terai* regions as opposed to children living within the Kathmandu Valley. On the other hand, sex trafficking is common in Nepal, as traffickers often use Nepal's open border with India as a path to transport Nepali women to illegal activity in India. Traffickers are active not only in Nepal's rural areas but even within Kathmandu Valley, as they often approach victims at dance bars, massage parlors, or trick women into working falsely advertised waitressing positions (US Dept. of State 2021). Much of

this activity is either not preferred or not consensual and could lead to high rates of unintended pregnancies and further implications for women seeking an abortion.

3.2 Healthcare Infrastructure and Financing

Abortion services could not successfully operate in Nepal in the absence of adequate funding and management of subsequent services. Given that such funding and management is almost entirely controlled by foreign organizations, instead of by the Nepali government, understanding how Nepal's healthcare infrastructure and spending is utilized can provide further context to what basic healthcare needs Nepal is independently able to provide.

Services for healthcare in Nepal, similarly to other countries, vary drastically based on one's socioeconomic status and geographical location. Rural healthcare access pales in comparison to urban healthcare access closer to Kathmandu, making poorer rural communities more likely to have lower health outcomes with regard to infection, malnutrition, mortality, and communicable diseases. Nepal provides healthcare services through both the public and private sectors and is regarded to have one of the poorest healthcare systems in the world. Nepal's unique topographical location makes it more susceptible to landslides, floods, forest fires, and earthquakes, also posing a greater danger to health through environmental causes.

Recent efforts have been made to improve healthcare in Nepal, with significant emphasis placed on addressing maternal health, as maternal and neonatal health remains a priority for the Ministry of Health and Population in Nepal (MoHP). This, along with the implementation of the Safe Motherhood Programme in 1997, was part of Nepal's major efforts to attack maternal

healthcare (safe abortion services as part of this initiative). In 2018, per capita, government expenditure on health was $57.85, about 1.7 times higher than that of low-income countries ($34.60) but 19 times less than the global average ($1110.82) (World Health Organization Global Health Expenditure Database 2021).

Nepal's healthcare system exists in the private sector, public sector, as well as alternative methods. As of 2012, the private health sector comprised around 60% of Nepal's total health expenditure (World Health Organization Global Health Expenditure Database 2021). The public sector is predominantly responsible for providing preventative services compared to other sectors (Adhikari 2015). Both the private and public sectors serve different roles in providing healthcare across Nepal yet acknowledge more work can be done to better integrate the two systems (Adhikari 2015).

In 2002, healthcare costs amounted to $2.30 U.S. dollars or Rs 280.45 per person, with 70% of health expenditure out of pocket. As indicated in the 2021 tax report, healthcare comprised merely 7.45% of the Nepali government's budget. As of 2019, 125 hospitals were in operation across Nepal. Out-of-pocket payment (OOP) remains the principal source of health financing, with OOP comprising 50% of the total current health expenditure in the nation in 2018. Health services provided in Nepal by the MoHP, the provinces, and municipalities, are financed by taxes. Nearly half of the financing for healthcare in Nepal is not pooled, as comes directly in the form of out-of-pocket expenditure. On the other hand, many family members pay contributions, treated as premiums, that are placed in a shared pooled for public use—similarly to how many health insurance companies work in the United States. The major sources of revenue for health

insurance in Nepal come from these contributions collected from family members and the tax funds provision-financed by the Ministry of Finance (MOF). The Basic Health Care Package (BHCP) helps cover preventive care, clinical services, basic inpatient services, delivery services, and certain listed medicines. With regard to abortion care, reproductive health care, and maternal health care, certain capacitation-based payments are in place for public programs including the safe motherhood program, BHCP, and free health care. Cash incentives are also being used for the safe motherhood program (Lancet 2006).

4. Nepal's historical and financial dependence on NGOs and foreign aid

4.1 Nepal and Foreign Aid

For the nearly sixty years since World War 2 (Britannica 2021), billions of dollars have been spent on international development efforts to enhance the economic and social well-being of citizens in low-middle-income nations (Statista 2021). Critics of international development such as Dambisa Moyo, Andrea Cornwall, and David Mosse, among others, argue these initiatives fail to demonstrate sustained success. The field of development was initially driven by the desire for western nations to deploy resources into poorer nations they believed were underdeveloped, all in the effort to aggrandize power in the anti-communism movement, with the simultaneous intention to uplift poorer nations out of poverty. As these critics of international development would argue, the subsequent creation of international organizations such as the IMF, World Bank, and United Nations to spearhead this effort towards international development created an inherent, misleading notion that wealthier nations had both the right and the ability to exert a westernized market economy framework onto less wealthy nations that were not up to standard in the global economy (Cornwall 2007). This is not to say that development efforts are ill-

intentioned, but rather to bring attention to the fact that some development efforts may employ a lens of superiority, harboring the implicit goal of transforming the global south economically, politically, and socially. For example, in *Credits between Cultures*, Parker Shipton writes about a World Bank initiative to implement a new system of credit into the Luo community in Kenya in an attempt to standardize their economy to align with western forms of credit. In the process, Parker Shipton explains how the World Bank misinterpreted Luo's moral obligations of kinship while distributing loans as a form of nepotism instead, disrupting the World Bank's intentions for their initiative. Parker argues that this misunderstanding of the significance of Luo culture as intrinsic to their economic practices ultimately left the initiative to be unsuccessful (for both the World Bank and the Luo people) (Shipton 2011). Examples like this one serve to illustrate how some international development initiatives have ignored the significance of cultural context and the acknowledgment that all communities have unique ways of operating—ways that often don't fit into the square mold of western market economies and societies.

In the context of Nepal, specifically, development efforts have grown tremendously since the mid-1900s when they first began. Between the years 1977 and 2014, a total of 39,759 Non-Governmental Organizations (NGOs) were operating in Nepal. Of the NGOs registered to operate in Nepal, 26 different countries were represented — 53 NGOs from the United States, 29 from the United Kingdom, and 12 from Germany. These organizations spanned the sectors of health, agriculture, poverty alleviation, and good governance (Karkee 2016). However, despite this seemingly concerted effort to "develop" Nepal, it remains one of the poorest countries in South Asia and in the world. When compared to its regional neighbors, the increased rate of poverty is inconsistent with the increased amount of foreign aid. In comparison to the five

biggest nations of the SAARC Seven (South Asian Association for Region Cooperation), “Nepal is the only country where the official development assistance as a percentage of GNP has increased between 1980 and 1996. Nepal’s ratio increased from 8.3% in 1980 to 8.9% in 1996 after reaching 12% in 1991, while for every other country in the group there has been a drastic decline in this period” (Pandey 1998, 63-64). Additionally, Pandey argues that past development efforts have done little to alter the structure of economic and socioeconomic relationships across different industries of production. Consequently, the overall production sizes of these industries have remained stagnant or in some cases declined — contradicting the booming population growth in Nepal and subsequent increases in domestic market demands. This begs the question: *Are financial aid and donor support alone enough to sustain development, or does the issue lie instead in the management and execution of external funds?*

From a historical context, Nepal has been a low-income nation for centuries, accompanied by a weak and unstable system of governance, poor resources, and high unemployment. Nepal is considered to be a nation that is aid-dependent by a number of scholars, including Yashoda Karki and Rajendra Karkee, among others. National budgets to autonomously support universal health and education coverage are inadequate in Nepal, leading to an influx of dependence on NGOs and foreign aid. According to Devendra Raj Pandey, Nepali sociologist, and former finance secretary, “The multitude of Nepal’s development partners plays a very important role in charting the course and implementing the programs of socio-economic development in the country… [Nepal’s dependence] on foreign aid is not limited to the need of development; it seems that social peace and even the survival of the nation also increasingly depend on it.” (Pandey 1998, 287-288). Pandey argues that the emergence of NGOs in Nepal is largely at fault

for the increasing influx and adherence to aid not only for the government but also for everyday organizations and independently operating professionals (Pandey 1998, 63-64).

In order for an NGO to operate in Nepal, it must be registered at the District Administration Office in Nepal and it must be affiliated with, and gain approval from, the Social Welfare Council of the Government of Nepal. Essentially, development initiatives supported by these non-governmental and foreign organizations cannot operate in Nepal without approval and hence cannot operate without the political government's consent to operate in Nepal. Development efforts have been historically accepted by past Nepali political leaders, illustrating that the approach to development in Nepal is indeed mutually agreed upon (Karkee 2016). Pandey regards this mutually-agreed-upon divergence to aid as significantly harmful: "The critical point is that NGOs, directly or indirectly, receive the support of the same partners as the government. Both have surrendered their autonomy, to some extent, to an external agent. Yet there seems to be a lack of willingness on both sides to brace themselves up for the development of a healthy and constructive mutual relationship in support of democratic governance" (Pandey 1998, 134). Centuries of foreign aid and assistance have become interwoven into Nepal's necessity to operate as a country, possibly preventing it from learning how to govern as an autonomous entity.

As recent as the 2010s, nearly 50% of Nepal's health budget comprised international aid, with the majority financial contribution from External Development Partners (EDPs) (Karkee and Comfort 2016). The United States, in particular, has governed much of this donor budget

towards health initiatives in Nepal through foreign policies such as the Global Gag Rule and the Helms Amendment, not to mention the subsequent effects from these interventions as well.

4.2 Global Gag Rule Policy and Helms Amendment

Despite the potentially harmful long-term effects that the reliance on foreign aid may suggest, Nepal's financial and operational dependence on its wealthier, more sovereign allies has created opportunities for poverty alleviation, access to healthcare, and other basic humanitarian needs. However, such a binding reliance can also simultaneously reinforce power dynamics and cycles of dependency, making Nepal subject to inescapable subordination and loss of autonomy regarding its own country's development and decision-making processes. One nation to reinforce such a policy in recent years was the United States.

Under President Trump's term from 2016 to 2020, the Global Gag Rule policy was reinstated after its last reinstatement during the Bush Administration. This policy challenged efforts toward women's reproductive health empowerment worldwide and threatened the choice to abort for millions of women. The Global Gag Rule (GGR) policy, originally named the Mexico City policy, was created in 1984 under President Ronald Reagan, and since has been reinstated by each republican administration that followed and rescinded by each democratic administration (KKF Mexico City Policy Report 2021). GGR intended to prohibit all NGOs that provided abortion-related services such as counseling or referrals, or that advocated the expansion and decriminalization of abortion, from receiving any U.S. federal funding. In effect, this impacted some of the most essential players in the fight for abortions, such as the International Planned

Parenthood Foundation (which lost over 20% of its funding shortly after this policy was instituted in 2017). When Donald Trump became president, he not only reinstated this policy but expanded it, also limiting funding for organizations that advocated access to contraception, prevention of HIV/AIDS, efforts to combat malaria, as well as efforts to improve maternal and child health.

From a development perspective, this policy represents a paradigm in the ongoing discourse by many anthropologists, arguing that humanitarian efforts approached from a foreign perspective sometimes fail to acknowledge the social and cultural motivations within the country of interest. Lack of cultural sensitivity meant the Global Gag Rule served only to promote western, conservative agendas — perpetuating the power dynamics at play. In a country like Nepal, where laws on abortion and reproductive health rights are relatively progressive in comparison to its South Asian neighbors, the impact of the Global Gag Rule was especially harmful in the fight to mitigate disparate gaps in access to abortion services. Given Nepal's unique geographical and socioeconomic landscape, access to abortion (and awareness about the possibility of receiving an abortion) varies drastically for different women across Kathmandu. Consequently, despite policy-driven initiatives by the Nepali government to make abortions accessible, the nation's poor economic status and inability to successfully self-sustain public health initiatives make its reliance on foreign aid from the U.S. harmful to desired progress. For women who sought an abortion, the restrictions imposed upon Nepal during the times the Global Gag Rule was in place served as harmful to their right to choose. In the cases where women seeking abortions may have been raped, victims of human trafficking, battling severe poverty, or experiencing another life-

compromising circumstance, it becomes even more critical to question who has the power to control one's access to abortion.

In addition to the Global Gag Rule, another United States policy that has played a role in limiting access to abortions is the Helms Amendment. The Helms Amendment is a U.S. law passed in 1973 that prohibits the use of U.S. foreign aid for abortions as a "method of family planning or to motivate or coerce any person to practice abortions," impacting both private organizations and government-affiliated entities seeking to provide safe abortion services (Wu et al. 2017). Following the legalization of abortion in 2002, the Helms Amendment was the first legal and financial barrier that hindered the implementation of safe, nationwide abortion services in Nepal and continues to do so. The amendment not only impedes the full integration of abortion care into reproductive health services but also limits the use of resources for organizations receiving funds from USAID. By limiting access to legal abortions through restricted funding, the Helms Amendment may force women to seek abortion through less safe, illegal methods.

A large issue created by the Helms Amendment is the rhetoric stating "as a method of family planning", which implies that the amendment only prohibits abortions in situations disregarding rape, incest, or when a women's health is in danger. However, an overly cautious interpretation of the amendment has precluded abortions regardless of those circumstances. This means that even if the local national policy has legalized abortions in the instance of rape, incest, or potential danger to health—like Nepal has done post-legalization—limitation in funding controlled by the Helms Amendment overrides any local protections in place for safe abortions (Skuster and Wolf 2010). The Helms Amendment also further complicates matters by limiting

female community health volunteers who work for organizations funded by the USAID from incorporating safe-abortion advocacy into their counseling services, making it even more difficult for women to be educated about the opportunity to receive a legal abortion.

Another prominent issue taken by critics is that the limitations placed by the amendment force the USAID to selectively support only *post-abortion care*, as opposed to *comprehensive abortion care*. This is odd, especially considering post-abortion care utilizes the same manual vacuum aspirator that could easily be used to perform abortions. Consequently, women seeking abortions are turned away from clinics, in spite of them having the proper equipment to perform a legal abortion. Clinics funded by the USAID are also forbidden from purchasing manual vacuum aspirator instruments for purposes other than post-abortion care, contributing to equipment shortages in performing safe abortions in Nepal (Samandari et al. 2012).

The Helms Amendment differs from the Global Gag Rule by restricting the use of U.S. funding solely for providing abortion services, whereas the Global Gag Rule additionally prohibits the use of U.S. funding to NGOs that advocate for, counsel on, and provide referrals for abortions funded by non-U.S. donors (regardless of whether abortion is legal in the acting country). What makes the Helms Amendment perhaps more of a threat to accessing abortions is that it can only be reversed by an act of congress and therefore remains in effect, whereas the Global Gag Rule policy may be rescinded in any presidential term, as it has been historically (Skuster and Wolf 2010).

While Nepal has made conscious efforts to reduce the presence of USAID funding for family planning-related services within the country, this doesn't alleviate the impact on family planning clinics that continue to receive funding from the U.S. (Samandari et al. 2012). Ultimately, the power of the Helms Amendment serves to illustrate how the U.S. government has used its leverage as a donor to promote its own agenda in other nations by institutionalizing stigma toward abortions. This has been happening ever since the early 1970s, for nearly five decades (Crane and Dusenberry 2004). The United States, being the largest bilateral donor to international family planning efforts in the world, truly does make a colossal imprint on NGOs, United Nations agencies, and governments in the "developing world" through its policies to hinder abortion, impeding local efforts to mitigate unsafe abortions in the process. The cultural, social, and economic impacts of this are vast and unprecedented and are issues I hope to further unpack through my interviews with policymakers and community leaders in Nepal.

5. Outstanding Issues and Existing Questions

5.1 Perceived Gaps to Equitable Abortion Access

The largest facets of inequality in Nepal lie in geographical differences, gender equity, and caste differentiation. Poverty is reported to be highest in the mountainous regions, with higher poverty in the hilly region, *pahar,* than in the flatlands, *terai* as illustrated by the ecological terrain map in Figure 2. When describing Nepal by groupings of districts, these regions are typically separated using the following labels: Far-western, mid-western, western, central, and eastern, as illustrated in Figure 3. It is apparent that households in western regions of Nepal are considerably poorer than in the central and eastern regions, which could likely be attributed to population and

household income distributions. Figure 4 below illustrates population distribution in Nepal by district, and Figure 5 illustrates per capita household income in Nepal by district.

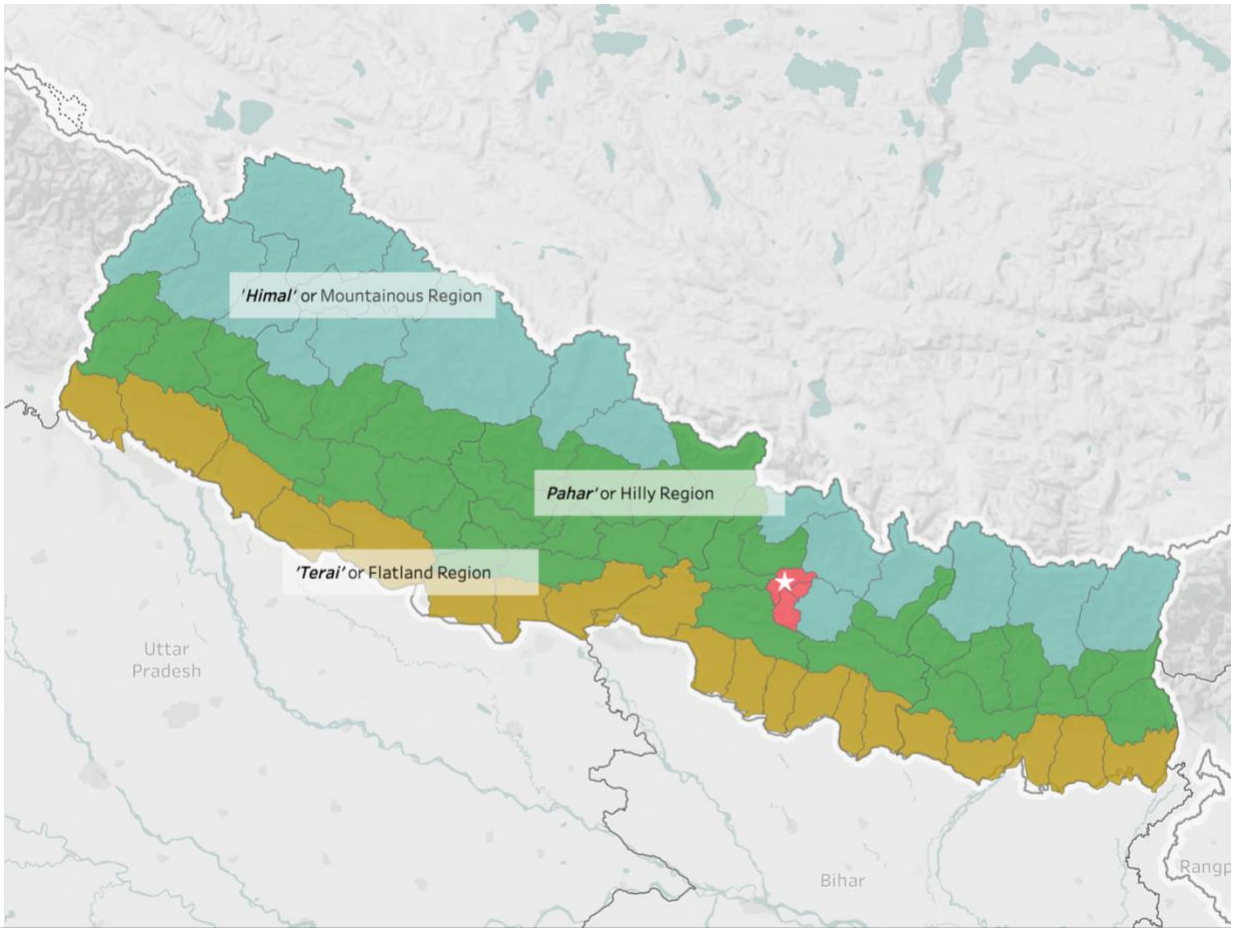

Figure 2. **Ecological Terrain of Nepal by District** The mountainous, hilly, and flatland regions are all represented on this map of Nepal from north to south, respectively. The region highlighted in red represents the three districts that comprise the *Kathmandu Valley*, the region of Nepal with the highest population density, and wherein lies the capital city of Kathmandu. *WWF Nepal*.

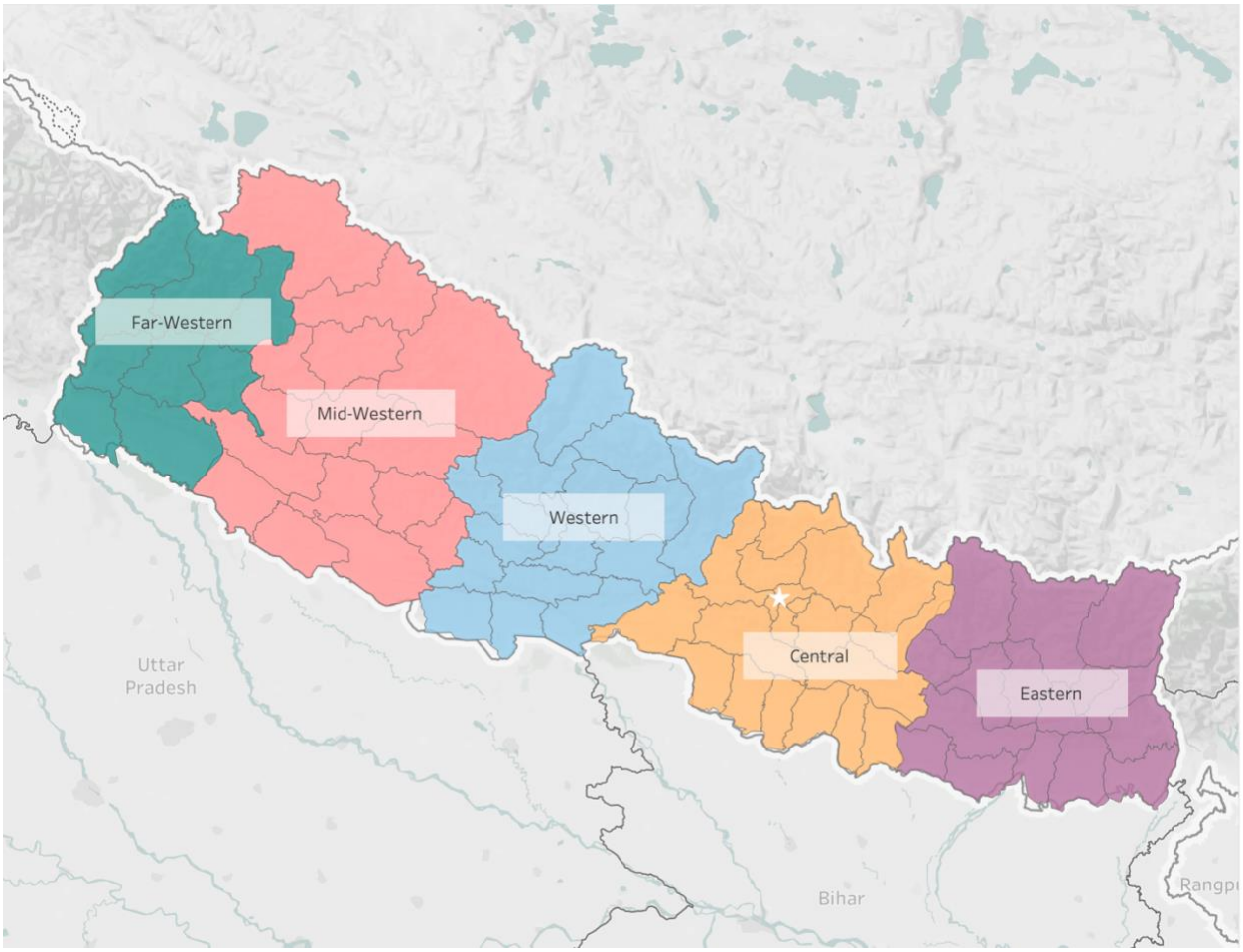

Figure 3. **Division of Nepali Districts by Region** The labels far-western, mid-western, western, central, and eastern are used to describe different regions of Nepal by grouping geographically proximal districts. The white star in the central region represents Nepal's capital city of Kathmandu.

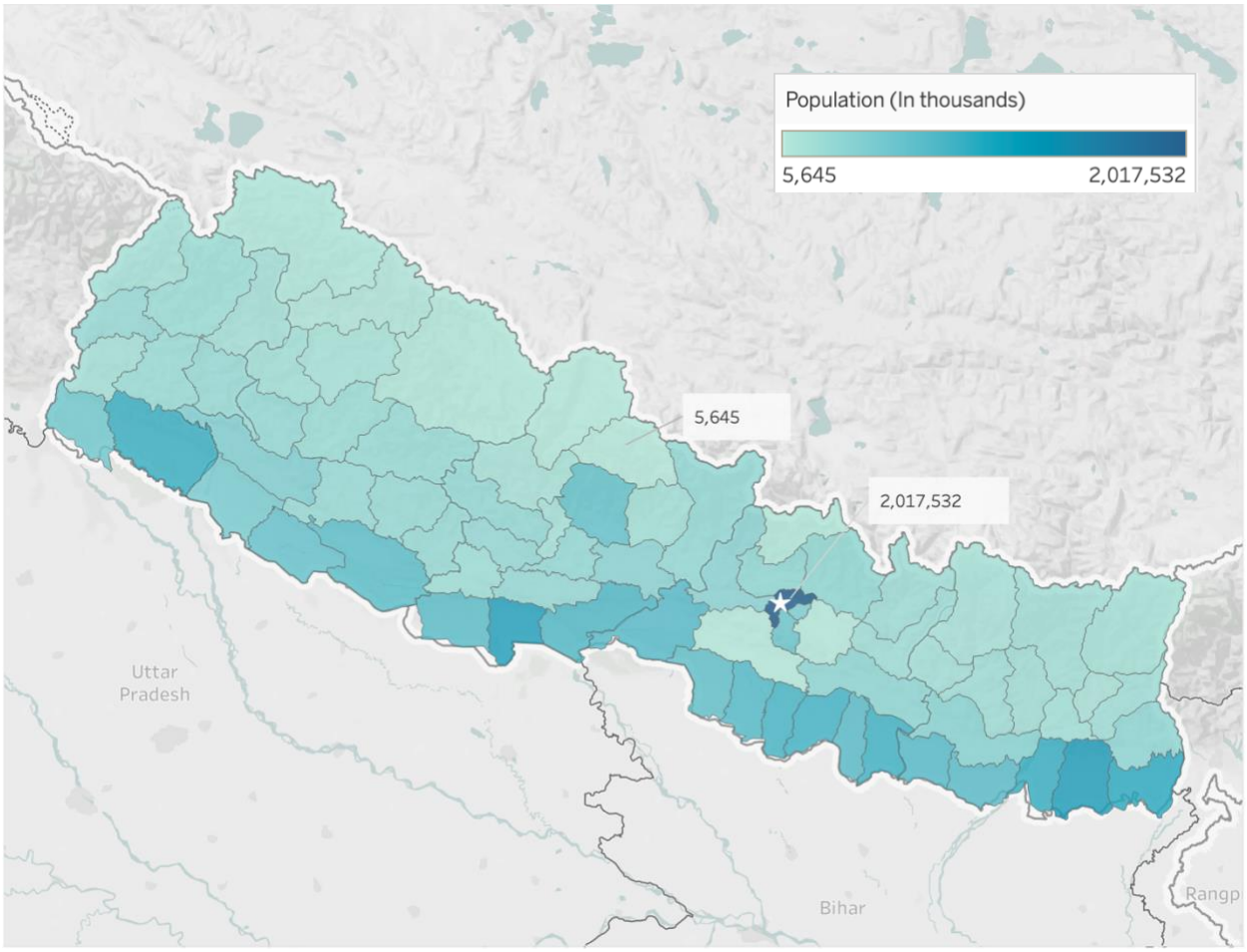

Figure 4. **Population Distribution of Nepal by District (2021)** This map illustrates the population distribution of Nepal by district according to 2021 census data. A gradient of light blue to dark blue is used to illustrate least populated to most populated areas, respectively, as indicated on the legend in the top right corner of the map. The most populated district of Nepal is Kathmandu, with a total population of 2,017,532 and the least populated district of Nepal is Manang, with a total population of 5,645. Inaccurate population data can be attributed to failure of the census to gather accurate indications of population, particularly in rural districts. *Nepal Outlook.*

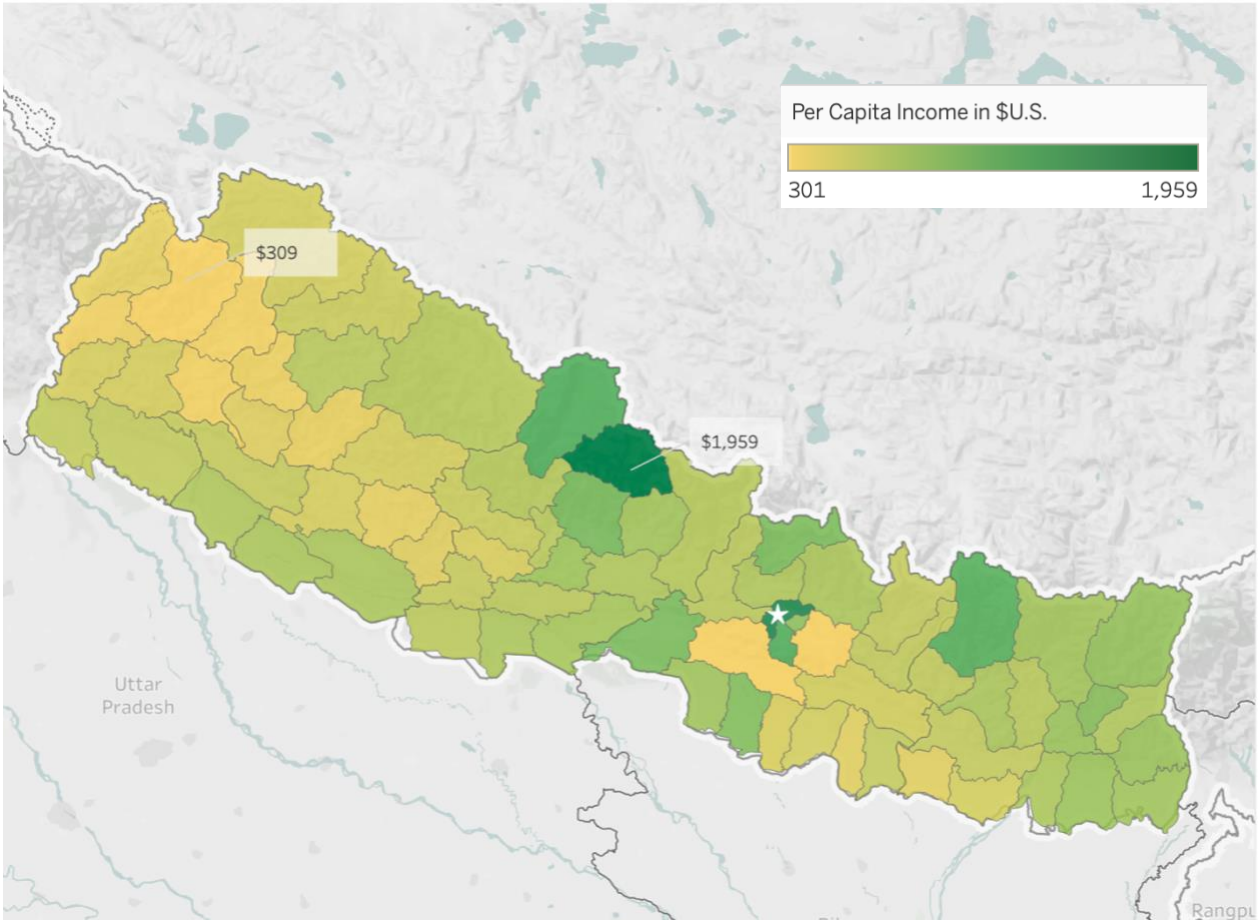

Figure 5. **Per Capita Income in Nepal by District (2014)** This map illustrates average per capita household income in Nepal by district according to data gathered in 2014. A gradient of light green to dark green is used to illustrate low-income levels to high income levels respectively, as indicated on the legend in the top right corner of the map. The district with the highest average per capita income is Manang at $1,959, and the district with the lowest average per capita income is Bajhang at $309. Inaccurate data can be attributed to failure of the census to gather accurate indications of household income, particularly in rural districts. *Open Nepal.*

Academics Pandey and Paul Collier both provide perspectives that contextualize persisting inequality and poverty in Nepal. Pandey regards poverty in Nepal to largely be a product of the "historical effect of unequal distribution of assets and social and economic status among

different groups of citizens including the caste-related and gender-related biases" (Pandey, 74-75). Paul Collier argues that "the centralized infrastructural development and state planning has resulted in vast income disparity between rural and urban citizens, often giving rise to relative and absolute poverty" (Collier 2012). Both perspectives support possible explanations that could be attributed to Nepal's current situation of poverty, which we come to unveil and question throughout later chapters.

Despite the limited financial access to abortion care that was addressed by the Lakshmi Dhikta vs. Nepal case, there continue to exist several obstacles that bar Nepali women from accessing safe abortion, if desired. It seems the most prominent barriers arise by way of geographical terrain (oftentimes conflated with socioeconomic and literacy status), and shortcomings in legal policies that neglect differential access. Abortions in Nepal may be performed at two points in time during the pregnancy: during the first trimester or during the second trimester. First-trimester abortions may be achieved through medication abortion or vacuum aspiration (surgical abortion), whereas second-trimester abortions may also be achieved through medication abortion but are more typically administered through dilation and evacuation surgery. More emphasis has been placed on making first-trimester abortions medication abortions available and accessible in recent years, given that medication abortions can be provided with more ease in rural areas. However, rural areas also face the risk of stock-outs as a result of poorly managed supply chain systems for medication abortion. As of 2015, over 50% of abortions in Nepal were being performed through medication abortion. Typically, these facilities providing first-trimester medical abortions do not also need to have surgical abortion capacity (Wu et al. 2017).

As of 2009, decentralization within the healthcare system allowed mid-level providers (nurses and auxiliary nurse midwives), to be trained in providing abortion services, in addition to just physicians. Mid-level providers have been authorized to provide both medication abortions and manual vacuum aspiration up to eight weeks gestation (Wu et al. 2017). This indicates that there has been an effort to increase the number of providers who can provide abortions. Among the 77 districts in Nepal, all have access to first-trimester medication and surgical abortion services at the hospital level, and 33 districts have access to first-trimester medication abortion services at the health-post level (lowest level of clinical care).

Nonetheless, the *presence of services* is not necessarily synonymous with *accessibility to services*. Nepal's unique geographic terrain from north to south, traversing from mountains to flatlands, poses physical, geographical barriers to women who reside far from their district hospitals. Many of these women reside in rural villages and rely solely on transportation by foot. As a result, increased travel time and physical demand to reach the abortion clinic may prevent women from accessing abortion entirely. This would place women in rural, mountainous areas at a disadvantage, oftentimes forcing them to receive a second-trimester abortion instead. Second-trimester abortions tend to be more expensive than first trimester abortions and given that women in mountainous regions belong to a lower socioeconomic status, this creates a difficult financial strain on their potential ability to abort. Additionally, if complications arise after the abortion is completed, such as cervical damage or excessive bleeding, post-abortion care would prove just as difficult to access.

Current Nepali government policies are extremely specific, and as some may argue, unnecessary and obstructive. The policies mandate that all facilities providing second-trimester services must provide comprehensive obstetric and neonatal care 24/7, contain a functional operating room, services for blood transfusion, and obstetric providers trained to provide cesarean services. These impositions, as per critics, are exceptionally strict in comparison to international safe abortion standards for facilities that provided second-trimester abortions. International guidelines state that abortions in the second trimester may be provided in both hospital and out-patient settings, given that the facility has a similar operating capacity to clinics providing first-trimester abortions and systems in place for emergency referrals. However, unlike Nepal, international standards require no mandate on transfusions or emergency neonatal and obstetric care. The demanding and expensive restrictions placed upon providers disincentivizes them from providing this second-trimester abortion care, further limiting ease of accessibility.

Upon reflection of the limited accessibility to second-trimester abortion care, many may wonder why second-trimester abortions are even significant — especially if first-trimester abortions are generally more accessible, both geographically and financially. Recent studies illustrate that second-trimester abortions are gaining popularity in response to cultural norms that reinforce notions of male preference over female preference for newborn children. This creates intense pressure for Nepali women to give birth to male sons, leading sex-selective abortions to become endemic (Lamichhane et al. 2011). Years of gender discrimination in Nepal are rooted in political laws such as inheritance and land rights policy that favor sons, and cultural traditions such as the dowry which impose economic hardship upon families of daughters. Hindu society

has historically placed significant value on women's fertility, and particularly, on their ability to bear sons over daughters (Upreti 2014, 283).

5.2 Existing Gaps and Further Questions

Decades of research by academics, NGOs, and government health organizations affirm the topic of abortion in Nepal as an area of study hardly neglected, yet gaps in research still exist. I sought anthropology, and its related methods, as the discipline through which to analyze and understand such gaps to understanding abortion access in Nepal for this very specific reason. Despite the qualitative statistics and interview data that widely exist, I believed that engaging in interviews with those working in areas related to abortion could help provide a more developed perspective to build upon what we have already learned from Nepali women. Although directly speaking with Nepali women may glean insight into the struggles, they face in accessing abortion, speaking with those in the intermediary can help us understand the larger factors impacting access, such as funding, cultural attitudes, and misconceptions. Some anthropologists view interview data as *thick data*—data that fills in the gaps to the unanswered questions that arise from statistics and numbers. Through my literature review and initial research, I identified some prominent gaps in the research that I sought to make more comprehensive, or *thick,* through my conversation with interviewees about the following topics:

1) To begin, abortion services and abortion care in Nepal is primarily externally funded and foreign policies are in place to restrict access. *Given that such funding and policies have been in place for decades, are the impacts of these external factors realistically felt? Did women accessing abortions feel less supported during the years the restrictive policies*

were in place? Further, given the significant role foreign actors play in the conversation about abortions, it is unclear how this involvement compares to the role of the Nepali government. *Does the Nepali government openly promote abortions? What about contraceptive use?*

2) Furthermore, although Nepali abortion laws have discernably become more progressive over the past twenty years, we still are not clear about whether this necessarily portends a shift in greater acceptance towards abortions. *What stigmas exist about abortion? What are the attitudes of medical providers, what are the attitudes of those living in the pahar and terai regions, and how do attitudes vary based on socioeconomic status and caste affiliation? What does the pro-life movement and perspective look like in Nepal? Does the concept of pregnancy as a "woman's responsibility" still hold weight? How might Hinduism and other religions have lingering impacts on abortion attitudes?*

3) Lastly and perhaps most importantly, contraceptive use is promoted through Nepal's family planning efforts, just as abortions have been made legal and nearly free of cost in most districts. *So then, why does there continue to be high numbers of illegal abortions across Nepal? Why do women choose to abort illegally if legal methods are affordable and accessible? What does the term 'illegal' denote, and are these methods safe or unsafe?*

As an overview, Chapter 2 will discuss the methodology used in conducting this research, Chapters 3, 4, and 5 will provide the findings from interviewee data, Chapter 6 will engage in

discussion of the findings against previous literature, and Chapter 7 will provide implications, limitations, and possible future research opportunities. I hope that the discoveries from this research will provide further insight and clarity to any lingering questions about abortion access in Nepal. In defining the external and local factors inhibiting access to abortion, it is my wish that this research could be used to advocate for a Nepali woman's ease of access, should they choose to seek out an abortion. This certainly will not serve as a comprehensive overview of the numerous factors impacting access to abortion, but I foresee that interviewee statements might pepper additional color and understanding to what we already know.

Chapter 2: Methodology

1. Narrative Statement on Research Process

Originally, I planned to travel to Kathmandu for two to three weeks to conduct in-person research, but unfortunately, this trip was canceled due to the onset of COVID-19 Delta cases rampant across the United States and South Asia. This last-minute change undoubtedly derailed my initial plans to conduct this research abroad, leading me to brainstorm possible alternative research methods. There was a period in time when I questioned whether or not I should continue to choose Nepal as my research site, as I was apprehensive to conduct research virtually. I was fearful that distance would create an inauthentic representation of issues on the ground in Nepal, especially given Anthropology's emphasis on the importance of in-person, participant observation as critical to disciplinary work. After much deliberation, I realized that in my position as a Nepali American who is fluent in the language, I felt confident in my abilities to conduct this research.

Given the indisputable circumstances, I began contemplating ways that I might still be able to conduct research in Nepal while remaining true to the ethics and morals promoted by anthropological research. Initially, I hoped to interview two sets of people: 1) Nepalis working in NGOs, local communities, clinics, and other spaces central to the conversation about abortion, and 2) Nepali women who were seeking abortions or had recently received one. Ultimately, I only interviewed the first set of individuals, as I felt that engaging in conversation with Nepali women on such a sensitive topic through virtual methods, didn't reach ethical and moral standards. It took until November of 2021 to finalize this decision, as I initially felt that speaking

to women directly would be the only way to get as close to participant observation as possible, particularly in this virtual setting. The women I sought to interview did not speak English and came from a lower socioeconomic status. It was unclear whether these women had access to the internet, and there was increasing speculation about how they would reach a computer, access zoom, who would be assisting them, and whether or not they would feel (or be) liable to those assisting them. Additionally, there were aspects of their involvement in this project that I had little to no control over: *Would her significant other or husband be in the room with her during the interview? Would someone else's presence impact her responses? How can her privacy be protected? How would she be adequately compensated? Could asking sensitive questions about her decision to abort, possibly put her in a position of harm?* Further, it was apparent that not all Nepali women had the same level of knowledge regarding abortion literacy. By interviewing them, I ran the risk of inadvertently taking advantage of their perspective, when I could instead be in a position to further educate them about their choices and their rights. Ultimately, I realized it was not worth sacrificing the precarious position of these women, especially amidst a deadly pandemic, merely to advance my personal research agenda.

Of the interviews I did conduct, most went smoothly apart from a few minor inconveniences. My primary method of communication with most interviewees was over Facebook Messenger, What's App, or email. For most individuals, it took nearly one to two weeks to get an initial response, and another one to two weeks to finally schedule a time to meet. This was unexpected, as I figured I would hear back from them at a quicker pace. I was also surprised to find that many of the interviewees skipped or forgot interviews frequently. It is also important to note that Atlanta, GA, and Kathmandu are in completely different time zones (4:30 pm EST is 5:45 am in

KTM). So, when interviews were scheduled, they were typically conducted around 6:00-11:00 am EST time, or during the interviewees' evening time. Given that I was taught Nepali in the United States, interviewing Nepalis with different accents and vocabulary proved a bit challenging. There were multiple words that I needed to ask for clarification on either during the interview or after, and many times, the pace at which some interviewees spoke was too fast for me to easily comprehend. Most of the interviewees could speak English, which certainly helped with this process. Upon reflection, however, perhaps the fact that they could speak English, and therefore had exposure to Western culture in some way, may have impacted and shaped their perspective on abortion in Nepal. When speaking to the interviewees, I used their first name followed by the suffix "Ji" as a sign of respect (just as they often referred to me as *Shreya Ji).* Although I have multiple family members living in Nepal, including my grandparents, I decided not to interview them for the purposes of this research. I felt that my close relationship may have impacted both the environment in which the interview took place, as well as elicited biases in their responses.

2. Preparation, Data Collection, and Data Analysis

Prior to beginning research, all necessary Emory Institutional Review Board approvals were obtained for this study. The Emory IRB classified this study as exempt from review. Although this study was entirely performed through virtual methods, the research site of interest is in Kathmandu, Nepal. Most of the interviews relay information regarding access to abortion within and just outside the *Kathmandu Valley,* the area of Nepal's most densely populated. Some interviews also relay information regarding access to abortions in the *pahar*, *terai,* and mountainous regions of Nepal, although the primary focus resides in Kathmandu Valley.

Before conducting interviews, an extensive literature review took place in order to gather existing data on abortion access in Nepal. Nepali journals, books, and articles were consulted, alongside data from multinational organizations. This background research created a foundation from which I developed my research questions for this study and insight into what types of interviewees would be most helpful for the purposes of this study.

2.1 Semi-Structured Interviews

Semi-structured interviews were conducted with seven Nepali individuals on the recording platform Zoom within the timeframe of October 2021 to January 2022. Participants were chosen was on the basis of whether their daily work or personal activities involved abortion-related issues. Given that all participants had to be recruited virtually, I used a personal contact in August to help connect me with individuals who fit the criteria. From there, I continued to expand my network through connections with new contacts. The other method used to recruit participants was through cold searches on LinkedIn, Google, and international news platforms including BBC and CNN.

A verbal consent passage was formatted according to Emory IRB standards. At the outset of each interview, verbal consent was obtained through the recording function on Zoom. Additionally, an interview guide was created to help direct the interviews and to provide a space for notetaking. Questions were predominantly asked to participants in Nepali, to establish rapport and trust in the interview-interviewee dynamic. In some cases, English was used when participants asked for further clarification. Most of the interviewees spoke entirely in Nepali or a combination of both

English and Nepali. All direct quotations from participants have been translated to English for the purposes of this paper. Participants were asked whether they would prefer their name and place of work to remain anonymized. If participants chose to keep their identity hidden, they have been assigned a pseudonym to ensure confidentiality.

The semi-structured interview formatting allowed for a more detailed, nuanced, and comprehensive understanding of the research questions, as it allowed for flexibility in what questions could be asked. The profiles of each interviewee are described in Table 1 below:

Table 1. Research Participants by Interviewee Name and Occupation.

Interviewee	**Occupation**
Tushar Kunwar	OB resident at Tribhuvan Hospital. Has performed abortions as part of his residency training.
Dai	Works for a prominent Nepali public health organization. Conducts research on abortion indications Nepal-wide.
Bhadrayo Chari	Professor of Feminist Theory with MPH and degree in Dentistry. Teaches safe contraceptive use and safe sex at local schools.
Prabhakar Shrestha	Lawyer working for an international organization advocating reproductive rights and safe abortion laws. Conducts research on abortion indications and legal history of abortion Nepal-wide.
Basana Bista	Works as a Female Community Health Volunteer (FCHV) for the

	Nepali Government to help provide basic health and education services to rural, low-income women and their children.
Preet Shah	Previously worked with adult entertainment workers in Kathmandu and in rural areas of Nepal.
Soman	Pro-life advocate and founder of Voice of the Fetus Nepal. Visits local schools and teaches the science behind abortion, advocating for the right of the fetus through his teachings.

2.2 Interview Data Analysis

All seven interview audio recordings were downloaded from Zoom and uploaded into the MaxQDA software for coding. Open coding was performed by listening to each audio file from start to finish and by categorizing interviewee responses to the corresponding code. There were larger code “families” for broader topics, and each family consisted of more specific, focused codes. This coding system allowed for organization and helped identify differences in interviewee responses while writing the results and discussion sections of the paper.

Chapter 3: Access to Abortions

Throughout the next few chapters, *Chapter 3: Access to Abortions, Chapter 4: Attitudes and Judgement Regarding Abortion, and Chapter 5: Illegal Abortions*, interviewee responses to the semi-structured questions about abortion access will be discussed in depth. We will begin by exploring interviewee perceptions about the frequency and availability of abortion and contraceptive services, how a woman's socioeconomic positionality may impact her access to abortion, and the role of the Nepali government, NGOs, and other actors in the promotion of abortion services, contraceptive usage, and family planning. After a foundation of differential abortion access and the promotion of related services is established in Chapter 3, we will transition to a discussion on attitudes towards abortion across Nepal in Chapter 4. Chapter 4 will introduce common community sentiments, religious and cultural norms, *jaat*-based differences, and perceptions of medical providers to illustrate how such attitudes may serve a role in impacting a woman's access to abortion. Lastly, Chapter 5 will discuss the prevalence of illegal abortions in Nepal, the different ways in which an illegal abortion may take place, and a conversation on the factors that may elicit a situation where a woman might seek an illegal abortion. The following chapters include direct quotes from interviewee responses in both Nepali and the English translation, to account for any possible misinterpretations.

1. Occurrence of Abortion and Prevalence of Abortion Sites

To better understand accessibility to abortion services across Nepal, all participants were asked about the prevalence of abortion sites as well as whether they consider abortions services to be frequently used by the public. All participants agreed to the fact that abortion has grown in popularity over the past seven to ten years after legalization enabled the opportunity for the

creation of additional service sites. Participants also acknowledged that medical abortions (medication abortion pills) are considerably more popular in both preference and availability than are surgical abortions (manual vacuum aspiration). As *Dai* mentioned in his interview, medical abortions appear to present fewer barriers for women than surgical abortions. This is because MVA procedures require a recovery period preventing women from attending work and house tasks.

Respondents' views on the prevalence of abortion varied widely. When *Bhadrayo* was asked about her perception regarding the prevalence of abortions in Nepal, she responded with a recent dialogue she had with a friend working at a nearby clinic: "I asked my friend, how many abortions are there usually? She was like '80'. And I asked, 'Oh, so 80 abortions a month?' She said, 'No, a day". Bhadrayo proceeds to share her perspective that: "Aile ko [nowawdays] people are not using contraceptives, they are just using abortion as a birth control," indicating that she believes abortion use is indeed common and that high rates of abortion may be a result of lack of contraceptive use (the relationship between contraceptive use and the prevalence of abortion is a debate that continues and will be further explored in Chapter 4). *Preet* seemed to partially share Bhadrayo's perspective on the prevalence of abortions, as she explains:

> "I wouldn't say common, but it's not very less either. Not a rare phenomenon. At least in Kathmandu, more and more people are open to the hook-up culture, or the culture of casual sex. For married people also, they understand that it is okay to abort if you don't want a child,"

illustrating that perhaps attitudes towards abortions for married couples have become more progressive in recent years. Preet explained abortion access in terms of how it differs for married

and unmarried women. This distinction is commonly emphasized in Nepali communities, as pre-marital sex is often stigmatized. *Basana* described the following when referring to abortion prevalence:

> "Abortion, ta, chana ta cha [there surely is abortion], hamilai sunda kasto bhani [when we hear about it, it is usually because], santaan ko rahar chaina, [they don't have intentions for a family] abha kosai ko na chayheyena bhane abortion garnu pouncha, haina [now if someone doesn't want a child, they can do an abortion]".

When I asked Basana if she takes women to get abortions often through her work, she responded with:

> "Hundhena, abhibhaeet ta hamro, gown ghar ma, laz ali ho, arulai thapounchan bhanerai [Not really. For our unmarried women in rural areas, they get embarrassed that others might find out.] Yo barsa ma yeota case, dweeta, theenta case, testho hunasakcha [In one year, we might get one, two, maybe three cases of abortion]".

Basana's answer varies drastically from that of both Bhadrayo and Preet, as Basana claimed abortions are quite rare. It is crucial to note that Bhadrayo and Preet both reside within the Kathmandu Valley, whereas Basana resides in a rural town just outside of Kathmandu where the population is sparser. *Prabhakar* provides data stating of the one million women pregnant in Nepal each year, nearly 300,000 receive abortions. This data may not be comprehensive, however, as there are likely illegal, unsafe, and/or unrecorded abortions excluded from this metric.

Participants seem to agree that Nepali health centers are increasingly becoming adolescent-friendly centers, especially regarding reproductive health. Should they wish to, all adolescents

are able to access information about sexual health and receive abortion services, said Bhadrayo. *Tushar* stated that he has provided abortions for girls and women aged 13 to 42. Especially given the high rates of childhood marriages in rural areas of Nepal where Tushar worked, treating patients under the age of 18 was not uncommon for him. Most patients he provided abortions for were between the ages of 25 and 35 years old. Tushar doesn't perceive first-trimester treatment (typically medical abortion) as inaccessible for most Nepalis but believes the true issue lies in inadequate education regarding abortion and reproductive health services. Prabhakar supports this argument by stating that "only 42 percent of married women of reproductive age are aware that abortion is legal in Nepal and that only 48% of these women know where to get safe abortion services".

All participants agreed that abortion services were provided either free of cost or at a very low and affordable cost if administered through government health services. If administered through services provided by an NGO such as FPAN or Marie Stopes, abortions may cost anywhere from 1200 Rs to 1300 Rs (roughly $10 USD). The cost of an abortion is typically more expensive in a private hospital or clinic. Each participant widely regarded both the cost and availability of abortion services as a direct result of foreign aid and foreign relationships, a topic we will explore in a later section.

2. Demographic Impact on Differential Access

2.1 Prominent Barriers

Interviewees described several commonly reported barriers to achieving an abortion. When I asked whether abortion access differed for women based on *jaat*, age, socioeconomic status, or

geographic location, all interviewees mentioned geographical location and socioeconomic status as the predominant barriers. The consensus among interviewees was that most Nepalis in the low-income bracket receive abortions at government hospitals where service is free of cost, whereas Nepalis in higher socioeconomic brackets receive abortions in private centers at a higher cost. Regarding geographical access, most participants felt that abortion access was considerably lower outside of Kathmandu Valley (in rural areas including the *terai* and *pahar*) both in terms of physical access and institutionalized access. On this topic, Preet noted that rural women's voices are among the most marginalized, specifically stating that provinces 3, 4, and 7 —all areas close to the *terai*—exhibit limited abortion accessibility. Women in rural areas of Kathmandu may need to travel by foot and be required to wait anywhere from days to weeks to find the time to reach an abortion site. She mentioned that compared to rural facilities, facilities in Kathmandu may be better equipped with the medical knowledge necessary to advise patients about gestation, possible complications, where to seek care in the instance of post-abortion complications, and other related information. Preet also acknowledged how inaccessibility and cost-related issues may prevent women from seeking legal abortions and may instead encourage them to resort to unsafe methods.

Tushar also felt strongly that rural areas were disproportionately impacted, mentioning that urban areas typically have greater *"skilled manpower"* along with a more expansive variety of institutions with the legal authority to provide abortions services. In rural areas, only NGOs and government facilities are available to provide legal abortion services. With reference to the capacity and ability of rural facilities, Tushar shared those rural areas lack skilled doctors to provide abortions and those services are often only administered by auxiliary nurse midwives or

CMEs: “in rural areas, although providers are skilled, patients are not treated by those with the highest level of skilled power”. He also stated that many rural facilities are not equipped to administer surgical abortions due to lack of skilled labor capacity.

Lack of knowledge dissemination—or inconsistent knowledge dissemination—was also regarded as a prominent barrier to abortion access. As Bhadrayo stated, “There are often gaps in information because we have limited ability in Nepal to do grassroots-level campaigns. Lots of times people don’t have the information, or people might have to go so far to access the information”. Dai extended this argument to regional differences, saying that lack of knowledge is not only the case in rural areas but to an extent in Kathmandu as well. Dai mentioned that people in Kathmandu may be aware of the legality of abortion, but oftentimes are not aware of where to receive one: “They have an idea that abortion is around and legal, but don’t know specific information”. Through Bhadrayo’s work teaching school kids about practices of safe touch and consent, she noticed a stark difference in the information students receive in public schools versus in private schools. Apparently, children in private schools receive less information about safe sex than kids who are in public schools. In private schools, the sexual education curriculum is up to their discretion, whereas in public schools, there exist criteria for sexual education training mandated by the Nepali government. Bhadrayo explained how the discrepancy in children’s knowledge about safe sex through their school teaching may serve as a possible explanation for any gap between knowledge and practice.

In the conversation of differential abortion access, cultural traditions, religious concerns, and Nepali norms also serve as significant factors inhibiting access. How attitudes towards abortion serve to restrict abortion access for women is a topic that will be further explored in Chapter 4.

2.2 Experience of Commercial Sex-Workers

Another key theme that emerged in the interviews was the experience of commercial sex workers in Nepal, and how matters of abortion often played a role in their line of work. When I interviewed Preet about her experience working with such women in the adult entertainment industry, she was able to provide context into a subset of Nepali women experiencing a uniquely difficult relationship to unintended pregnancies and abortion—a relationship these women often had little to no control over. Most of these women migrated from outside of Kathmandu Valley and came to Kathmandu in search of better opportunities to earn money (and in some cases, to provide for their children). After arriving, many were naively coerced into commercial sex work and subsequently trapped in a cycle that became difficult to break out of.

According to Preet, women working in the adult entertainment industry were not aware of their rights, couldn't quite understand what gender-based violence meant, and were not able to recognize when they were being exploited:

> "Sex was a huge part of their career— unprotected sex was a common ordeal for them. The sex that we are talking about is not the gentle type or the type where there is consent always. It is more about work, and sometimes it is physically abusive. They did not think they were important enough to have any rights".

Given that sex was central to their daily work the opportunity for unintended pregnancies and the need for a potential abortion was also incredibly high: “Abortion was considered very often. There were very few people who were ever hesitant. They knew they would get in a lot of trouble. Because they didn’t have a husband, or their husband has gone somewhere, so everyone would know that it wasn't their husband’s”. Preet mentioned that most of these women were unaware of how to receive a free abortion and unaware of how to access organizations like IPAS and Marie Stopes, which intended to support women in such precarious situations. Consequently, most of these women paid for medical abortion pills or resorted to other methods of abortion, remaining unaware of their rights to receive a free and legal abortion.

The experience of women working in the adult entertainment industry illustrates their vulnerability to being discriminated against on a variety of fronts— for both their work in the adult entertainment sector and for seeking an abortion. Their situation sheds light on how the need for abortion looks different for so many, and that access to safe, affordable abortions can ensure that women have options available (should they seek them).

3. Promotion of Abortion, Contraceptive Use, and Family Planning

3.1 Government Initiatives

In the conversation about abortion prevalence, the promotion of contraceptives along with the frequency of contraceptive use is critical to understanding this issue within context. Contraceptives are designed to reduce the risk of unintended pregnancies and abortions are designed to prevent such unintended pregnancies from happening. So, some could argue that with proper contraceptive use, the need for abortion would not exist— however, interviewee data

serves to challenge this assumption. Throughout this section, we will further explore respondents' insights, touching on varying sides of this debate.

There are conflicting debates around the relationship between contraceptive use and the prevalence of abortions. Bhadrayo claimed, "people are not using contraceptives [in Nepal], they are just using abortion as a birth control". To add to Bhadrayo's statement, Prabhakar mentioned that people often say that "Abortion rate ko major kaaran chai [but, the major reason for the abortion rate in Nepal is], failure of contraceptive programming Nepal ma [failure of contraceptive programming in Nepal]". On the other hand, Tushar said: "It's not that the government isn't promoting pills, it's just that couples find contraceptives difficult to keep up with". Such adamant statements could be reducing what is, in reality, a complex relationship between contraceptives and abortion. As a result, I sought to better understand how abortions are being promoted in Nepal in parallel to the promotion of contraceptive use.

Each interviewee responded that contraceptive use is promoted in Nepal but just to different degrees of effectiveness. Most of the effort to promote contraceptives is in response to family planning initiatives and contraceptive awareness campaigns that have been formally implemented in Nepal for nearly 70 years. Bhadrayo assured that contraceptive pills and condoms are encouraged by the government and that the most common brands are *Depo-Provera* and *Norplant*. Preet mentioned that she often hears contraceptive use promoted through family planning jingles, radio messages, and TV advertisements. She described one TV advertisement in particular: "There is a village set up, a woman walked to nearby clinic showing how it was accessible, they showed how the couple already had two kids and how they want to focus on

that, then the couple decided it ends here with the two kids." As Preet mentioned, this advertisement was not at all related to causal sex, given the existing taboos around such activity, but instead focused on a married couple: "still promoting the idea that people only have sex to have children". This emphasis on contraceptive use primarily for married couples shows the existing cultural stigmas against premarital sex, and hence prevailing attitudes that may prevent unmarried couples from seeking contraceptive use in public spaces. Interviewees also mentioned other methods of promoting contraceptive use, such as going to army camps and teaching men about family planning or organizing programs that take rural women on picnics to teach them about family planning and nutritional health.

Although most interviewees regarded the promotion of abortions as significantly less than the promotion of contraceptive use, they all agree that some form of promotion does exist. Preet mentioned that some TV advertisements promote abortions by saying: "You can get an abortion, here are the places you can call. They say that out loud." and that radio messages also promote abortions: "You can call XYZ number to get an abortion" sharing information about where you could get one and who you could contact. Soman also regarded public media as promoting abortions but held a slightly different viewpoint on the issue. He mentioned that the government advertisements and radios advocate for abortions: "Yo mahila ko adhikar ho [this is a woman's right], khula information deeyeeraakhekocha [they are openly giving out information] saying that abortion is not a crime, it is already legalized". Given Soman's positionality as a pro-life advocate, he felt that such messaging is normalizing abortion and fails to show the possible risks involved with getting an abortion. Soman also argued such rhetoric could have negative consequences on the health of women and unborn babies. He said:

> "By normalizing abortions, Nepal has given women the impression that abortions are not a big issue. By saying 'abortion easy cha' [abortion is easy], 'safe cha'[it's safe], unierlai family planning measures use garna chordcha [these women will stop using family planning methods]".

As Prabhakar mentioned, the organizations that work to promote abortions and the organizations that work to promote contraceptives are different. Although the Nepali government leads the effort for the promotion of both abortions and contraceptives, the funds for such programming are typically donor driven. Donors include Marie Stopes, USAID, WHO, as well as other NGOs and INGOs. It appears that organizations promoting abortions will provide some information about contraceptive use and post-abortion contraception use, whereas organizations promoting contraceptives will not promote abortions. This is because many of them are externally funded by the U.S. and prevailing effects from the Global Gag Rule policy impact what organizations in Nepal are allowed to discuss with U.S. funding. Foreign aid has a discernable effect on what messages are promoted in Nepal, bringing us to further unpack the role of NGOs, INGOs, and foreign aid as it impacts abortions.

3.2 Impact of INGOs and Foreign Aid

By all interviewees, foreign aid is regarded as essential to ensuring the operation of abortion-related services and programs. The way Dai put it, "Without foreign aid, Nepali abortion services would not be self-sustainable". Bhadrayo supported this notion and said, "I would say Nepal is completely dependent on foreign aid because we don't have people with social and political will that is required … if we looked for resources within Nepal, we would find it". Interviewees identified the USAID, WHO, DFID, United Nations, European Union, United Nations Fund for

Population Activities, International Planned Parenthood Fund, Australian Aid, and private organizations like the Gates Foundation and Buffet Foundation as primary donors, with most funds coming from the USAID.

As most participants describe it, funds are sent by these international donors to Nepali NGOs such as PSI, the Family Planning Association of Nepal, and Marie Stopes, who work alongside the Nepali government to implement abortion and reproductive health programming. Prabhakar mentioned that although the Nepali government has allocated money for abortions and contraceptive services, the implementation of services, advocacy, and awareness campaigns are almost entirely funded externally. More specifically, Tushar described that while the Nepali government takes the cost of abortion, providing it to Nepali citizens for free through government health services, the medical kits, equipment, contraceptives including implants, and medicines required to ensure abortion services are all donated by foreign sources (either physically or monetarily).

Interviewee responses provided further clarification that international autonomy over funds has a direct impact on how abortion services are promoted in Nepal. Given that INGOs administer most of the funding, the way such funds are used and distributed is up to their discretion. For instance, Tushar described how many NGOs choose not to provide services in sparsely populated areas because the demand for abortion is not as high, and the number of clients fails to meet target goals. Ultimately, this disadvantages those living in rural areas of Nepal and could hamper access to services. Tushar also explained how Nepali NGOs are not working in family planning as often as they are in abortion, because efforts for abortion were emphasized post-legalization.

We can also see the tangible impact of foreign ideas through the impact of foreign policy, notably as a product of the US. Global Gag Rule.

3.3 Lasting Impact of the Global Gag Rule

Given that USAID is the predominant donor of abortion aid in Nepal, the onset of the Global Gag Rule (GGR) had a discernible impact on abortion capacity during the years of the Trump Administration. Although some participants either had no idea what GGR was, such as Preet and Basana, or didn't feel a significant change because of it, such as Bhadrayo, other participants felt that GGR restricted abortion access. Prabhakar noted that GGR not only reduced expansion efforts of abortion services but halted services in clinics that were already established. Soman added to this and said that at the beginning of GGR's implementation, many clinics were shut down and employees of NGOs working to service abortion were quickly losing their jobs. He mentioned that organizations had to drastically restructure their operations and staff to accommodate for the loss in funding:

> "United States ma Trump hundakheri [When the United States had Trump], Nepal ma clinics and abortion centers shut down bhakotheyo [clinics and abortion centers in Nepal were shut down]. Je fund haru thyo, tyo bandha bhayo [whatever funds there were, they were all shut down]".

Tushar shared that when he was working with the family planning association in Nepal, a program was designed to frequently visit local villages in every district to provide health camps offering basic health services. After the GGR, this program was almost completely shut down, and visits were only made once or twice a year. On the other hand, Dai felt that the impact of GGR had less of an effect on restricting abortion access for women, and instead had a greater

impact on restricting advocacy, awareness, and promotion of contraceptive use. Soman supported this notion by explaining how many parliament members were suddenly forced to control their public dialogue and could no longer speak freely in support of abortion, as they were fearful of possible implications for donor funding.

All interviews were conducted after the rescindment of GGR by the Biden Administration in 2021. When participants were asked whether the impact of rescindment has been felt in Nepal, participants had mixed responses stating that either change has begun, or that the change has yet to be felt. Additionally, those participants who noted the GGR had little effect on abortion access voiced that perhaps difficulty in accessing abortions and implementing abortion programming was a result of the COVID-19 pandemic, instead.

The Helms Amendment was also mentioned in the interviews, but most did not know what the amendment was or acknowledge its impact. Perhaps the fact that the Helms Amendment has been in effect for so long, makes it difficult to assess its impact on inhibiting abortion programming.

Chapter 4: Attitudes and Judgment Regarding Abortion

Given what the interviewees revealed about differential abortion access, abortion and contraceptive service availability, and the promotion of related services as potential barriers to access, this section will discuss prevailing attitudes and judgments towards abortion across Nepal. In particular, we will discuss perceptions of general attitudes towards abortion, pro-life attitudes in Nepal, cultural norms and traditions, *jaat*-based or class-based differences, religious impact, and attitudes of medical providers.

1. General Attitudes

As previously established, centuries of deep-rooted patriarchal values and religious norms have undoubtedly contributed to any negative stigma that exists towards abortion in Nepal today. Perhaps part of this struggle includes the widespread taboo on pre-marital sexual relations and the occurrence of unintended pregnancy with someone one does not intend to have a family with. The idea of a traditional, nuclear family —a family consisting of a father, mother, and one or more children — is central to Nepal's values, and the prevalence of contraceptive methods and abortion services may suggest that unmarried couples are engaging in sexual activity — which realistically, is the case. However, although this stigma is still widespread, it is apparent that a subset of Nepalis has grown significantly to accept abortion in the past twenty-two years since abortion was legalized. All participants interviewed strongly agree that stigmas and negative attitudes towards abortions have indeed decreased in recent years, apart from a few competing arguments.

According to the interviewees, general attitudes towards abortion amongst Nepalis suggest that people are accepting of abortions, but only if completely necessary. Basana shared that in the past people would say, “pap lagcha [it is bad luck/ it is a sin], bhagwan le baccha deyeko [god has given you a child], jati bhaye pani baccha pauni [regardless of how many kids, you should have them all]”, but now, the rhetoric has shifted to: “baccha dhere janmouna hundena [you shouldn’t have too many kids]”. In the rural area where Basana is from, she feels that views on abortion are certainly less modern than compared to in Kathmandu, as she still widely hears the common saying: “Gown ghar ma bhancha, dweeta ta chaincha [People in the gown say, you need at least two kids]”. Soman believes that across Nepal, there are either those who believe “Nagareko ramro [It’s better if you don’t]. Abortion gareko ramro haina [It is not good to do an abortion]”, or on the other end, people who believe “situational abortion tik cha [abortions are fine depending on the situation]”. He said that most people kaaran leendena or don’t really care unless they are part of an activist group for one side or the other. Even amongst women who receive abortions, Soman mentioned that women are not openly proud of their decision or willing to tell anyone, but still choose to keep the decision private.

The concern for privacy surrounding abortions in Nepal is incredibly common, if not the norm. As Tushar and Bhadrayo mentioned in their interviews, women still don’t talk about abortion in their families or with their relatives and lots of women have abortions without letting their elders know. This suggests that stigmas against abortion, although ostensibly reduced, persist across Nepal in different forms. One taboo still widely shared in Nepal is that “Ramro character bhako manchaiharulai abortion gardena [People with good character don’t do abortions],” as Prabhakar shared with me, and another is, “It is more of a taboo to get pregnant without the intention of

being a mother," as Preet shared with me. However, it is also apparent that although some Nepalis may judge a woman for getting an abortion, they may very likely do it themselves and just keep it a secret. Prabhakar mentioned he has seen countless cases where families will be judgmental about women receiving abortions, but when an unintended situation arises within their own family, they go through with the procedure and remain "hush-hush".

This issue of privacy also extends to the abortion procedure itself. When women seek abortions, even if there is a clinic within walking distance, they will still choose to travel to an entirely different city to keep their identity hidden. In local health centers, women feel they run too high of a risk of being noticed and consequently subject to local-town gossip. Not only this, but women are also hesitant about documentation at the time of the procedure, fearful that their information will not be kept confidential. As a result, women fake personal information on government documentation, or risk not getting an abortion at all. Tushar, who previously administered abortions at a government clinic, assures that the documentation is entirely confidential with only the woman's surname and random Client ID number formally recorded. Consequently, the hesitation for many women is not fear of getting an abortion but instead the fear of documentation and privacy.

Regarding law enforcers, policymakers, and other public influencers, Prabhakar believes that these individuals can't seem to internalize the meaning of abortion rights, but merely accept it on the surface for the purpose of passing legislation. Prabhakar suggested this behavior can be harmful to the true progression of women's rights in Nepal, and that de-stigmatization needs to happen on a deeper level. As Preet said, this is certainly a topic that makes most people feel

hesitant to discuss. Among most groups in Nepal, interviewees say that the harshest, most conservative stigma against abortions is heard by uneducated communities, semi-elite families, those who are extremely poor and susceptible to misconceptions, or those who are extremely wealthy and fear not being able to conceive again after an abortion.

1.1 Pro-Life Perspective

Of the interviewees, Soman was the only participant who outwardly identified as *pro-life*. In our conversation, he revealed his thoughts on abortion, how he felt it impacted the rights of the fetus, and what he believes access to abortion services looks like in Nepal today. As the founder and CEO of *Voice of the Fetus Nepal,* Soman and his team visits schools across Nepal and South Asia, teaching students about the science of abortion and pregnancy. Through these school lessons, Soman always begins his sessions with a pre-test and post-post assessing students on their beliefs about their perception of when life begins. He said that almost consistently, school students begin the session believing that life only begins after the baby is born. In the post-test, after his brief presentation about the development of a baby, most students shift their opinion to say that life only first begins at conception. Soman assures that through his sessions, "The teaching is not aggressive, not judgmental, not extreme, but to say that there are living-saving options and prevention options". Essentially, his pro-life teaching promotes the practice of avoiding abortions by encouraging people to prevent putting themselves in situations where they might feel inclined to receive one. The organization's work emphasizes education and awareness in sexual wholeness and sexual abstinence training as opposed to lobbying to edit or reverse abortion legalization. Voice of the Fetus Nepal also created a maternity home where they provide shelter, online classes, and counseling for women with unintended pregnancies. His organization

is established as a volunteer-based organization merely intended to explain the reality of abortion through his teachings and explain possible options for the prevention of abortions. Soman explains that compared to in the United States and elsewhere, the pro-life attitude in Nepal doesn't take an *"extremist approach".*

Contrasting Soman's pro-life perspective, Prabhakar believes that "the opposition [pro-life perspective] is manipulating people. Those who are not much aware are providing evidence that only young girls are undertaking abortion in Nepal. Then what would the community think?". Although Prabhakar's response may not be a direct commentary on Soman's perspective, Prabhakar felt that some pro-life groups are spreading a tarnished or incomplete representation of what abortion looks like and is used for. He also points to common misconceptions amongst pro-life groups, that:

> "If young couples are using contraceptives, they are becoming infertile. If you use injectable contraceptives, you become fat. If you use too many birth control pills, you will get breast cancer or uterus cancer. The most common [misconception] is that people will get fat."

In understanding abortion attitudes and representation in the Nepali Parliament, Soman shared that no member of the government is necessarily 100% pro-life or 100% pro-choice. He said, "only those members who attend conferences in which pro-choice slogans are spoken about such as 'my body my choice, my uterus my choice' may be influenced to be 100% pro-choice. Dai, on the other hand, assessed the attitudes of Nepali parliament members through his research and found that there are two schools of thought. Either people feel that abortion legalization is a positive thing, or they feel that Nepal should reverse abortion law entirely, saying: "why allow it,

just emphasize family planning efforts". Dai mentioned that whenever an amendment is proposed to the existing abortion law, it becomes chaos within the political framework. Although most people do advocate for women's rights, it is a difficult topic for other cultural and religious reasons. Interestingly, Prabhakar mentioned that despite abortion being a slightly charged topic today, there was no formal or outright opposition in the early 2000s during the advocacy for abortion legalization.

2. Culture and Tradition

2.1 Religious Impact and Jaat-Based Differences

Religion, namely Hinduism and Buddhism, along with the classification of Nepali identities through *jaat*, are concepts integral to the culture and everyday lives of Nepali people. Given that both religion and *jaat* are so deeply ingrained into many Nepali ways of life, understanding how these factors may influence Nepali attitudes towards abortion can help better unveil the perceptions that fuel differential access to abortion. Across responses that touched on the impact of religious views on abortion attitudes, most interviewees shared that Hindus had no strict opinions on abortions, Buddhists believe abortion should be avoided where possible, whereas Christians and Muslims believed abortion should not be done. One interviewee stated that "those who do more dharma karma [are more religious] have more stigma against it". These are generalizations for groups of people who belong to the same religious faith but are certainly not all-encompassing, as there exists further nuance and variation to abortion attitudes than mere religion.

For much of Nepal's history, Hinduism and Buddhism have been the dominant religions in the country. In recent years, after the onset of missionary groups and globalization, Christianity has also rapidly grown in popularity— especially in rural areas. Many Christian groups travel to Nepal from South Korea, the United States, and across Europe to spread the Christian faith, both among Nepalis in Kathmandu and poorer Nepalis living in rural areas. These Christian groups are largely pro-life, strongly discourage abortion use, and in some cases, discourage contraceptive use as well. Although these groups do not implement pro-life programming in Nepal, they generate impact through social media, seminars, and public demonstrations. In his interview, Prabhakar mentioned a public demonstration by a Christian pro-life group where the organization placed plastic fetuses on a popular Nepali river, to spread the message that abortion is killing babies. Afterward, this group demonstration was disseminated into local and national news, painting a negative light on abortions. As Prabhakar later clarified, Nepali Christian groups typically try to keep a low profile and avoid provoking to prevent from getting targeted and attacked for their views.

Beyond religion, the Hindu caste system has been engrained into Nepal's society for most of its history, heavily influencing cultural norms and values. *Bahun* (or *Brahmin)* and *Chetriya* are typically regarded as the higher castes or higher *jaat haru* and tend to comprise Nepal's elite and wealthy in society. *Tamang*, *Magar*, *Rai*, and *Limbu* are regarded as lower castes. Of course, a formal caste system is no longer functioning in Nepali society in the capacity it was centuries ago. However, caste-specific traditions, values, and beliefs have been generationally passed down over the years, making different groups of Nepalis culturally distinct from one another.

In her interview response, Bhadrayo explained how *Bahun-Chetriya* tends to stigmatize abortion more than other *jaat haru*. She extends her point to include how *Tamang*, *Magar*, and similar cultures historically have not taken issue with pre-marital sex the same way *Bahun-Chetriya* have. However, as Bhadrayo explained, the dawn of *Brahmanization* commenced a process of re-conditioning minority cultures to align with *Brahmin* standards, given *Bhrahmin* groups have historically held the highest social power and influence in Nepali society. As a result, some members of *Tamang* and *Magar* groups who previously approved of pre-marital sexual relations and abortions may now align more closely with *Bahun-Chetriya* beliefs today. The way Preet described it, "The Bhramin caste is the epitome for what stands for Hinduism*",* relating the dominance of *Brahmin/Bahun-Chetriya* to intrinsically Hindu values. Concerning communities that typically reside outside of Kathmandu, Prabhakar shared that abortion stigma is prevalent amongst rural, *Terai,* and *Madheesai* communities, and Tushar shared how women belonging to lower *jaat haru* tend not to be as open to abortion and contraceptive use. Many interviewees emphasized that although minor distinctions do exist between caste identities, most Nepalis belonging to different *jaat haru* coexist so closely that differences in beliefs lie predominantly in education levels, geographical location, upbringing, and career choices.

2.2 Nepali Norms and Values

For many Nepalis, it appears that adherence to traditional values is critical to connecting with the Nepali identity, which much of these values having been informed by religious beliefs and perceptions of gender norms and patriarchy. Hence, we return to this notion of patriarchal standards as central to Nepali culture, as it continues to influence multiple levels of abortion-related decision-making. Most interviewees stated that it is not uncommon for additional family

members, aside from the woman and her partner, to be involved in the decision-making process for getting an abortion. Oftentimes, the woman's in-laws also contribute to the decision to abort, in which case it would not be surprising if in-laws were given precedence over the woman's final choice. In traditional Nepali culture after a woman is married, she is no longer part of her childhood family but instead belongs completely to her husband's family. What this transition may indicate in some circumstances, is that the woman may be placed in positions entirely subject to the rules and decisions dictated in her new household, giving her little autonomy (through a western feminist interpretation). As Prabhakar mentioned in his interview,

> "Women lai right bhayo pani [Despite women having the legal right], thyo right lai exercise garno lagyo bhani [in order for the woman to exercise her right], permission chai ko sanga leena paryo bhane [she needs to first get permission] husband sanga leena paryo, nabhe mother in law sanga leena paryo… [either from her husband or from her mother-in-law…]".

Even if Nepali women are empowered with legal rights to receive an abortion, they still don't *truly* hold full power over this decision.

Nuclear Nepali family set-ups place more significance on the son than the daughter, for reasons explained previously. This is partially why sex-selective abortions are still so prevalent in Nepal, to prioritize male children over female children. In his interview, Tushar voiced the following:

> "Ama buwa bhaneko, chori ko ghar ma gayerai basdena [For a mother and father, they cannot go and stay in the daughter's home]— chora ke ghar me gayerai basni [they must stay at their son's home]. There is no concept of social security in Nepal… Their [parents'] whole lives are for kids and they get the girl married off, chora bhayena bhani khoslai hercha [If parents don't give birth to a son, who will look after them]?"

In addition to such cultural norms for sons, the expectation for daughters is placed on their ability to achieve motherhood. As Preet mentioned in her interview,

> "Motherhood, in general, is given an insane amount of pressure. It is put onto a pedestal where motherhood means being a woman — means you are complete as a woman. I think this a huge part of our culture. When a woman does not want a baby, it means she is denying being a woman, she is not a good woman, and she is not going to be looked at in society as a woman".

If a woman feels that she is not able to raise a child or becomes subject to unintended pregnancy, she faces an additional burden to uphold Nepal standards of motherhood as to not bring shame upon her family.

Transitioning away from the focus on patriarchal norms, Prabhakar shared a fascinating insight into what he calls an *abortion season* in Nepal. Of the major Nepali holidays, *Dashain* is the biggest and most widely celebrated. During *Dashain* time, workers are given two, maybe three weeks off work to celebrate with their families. This means that migrant workers in Nepal use this holiday to briefly return back home:

> "Nepal ma, abortion ko season huncha [In Nepal, there is an abortion season]. Two or three months after dashain, then the abortion rate is quite high in Nepal. Kina bhane Dashain ma dherai migrant worker haru auncha, they are not using contraceptives [This is because during Dashain, many migrant workers return home and don't use contraceptives]".

Labor migration from Nepal is predominantly male with more than 80% of the total labor migrant population in recent years of reproductive age, between the ages of 18 and 35. Between the years 2009 and 2019, the Department of Foreign Employment (DOFE) has issued over 4

million labor approvals to Nepali workers (Nepal Labour Migration Report 2020). Prabhakar suggests that the sudden influx of abortion rates appears to align with the high numbers of migrant workers. Figure 6 below illustrates the female to male population ratio across Nepal according to 2021 census data. Most districts across Nepal appear to exhibit a higher population of female to males, which could likely be indicative of high numbers of migrant male workers leaving the country.

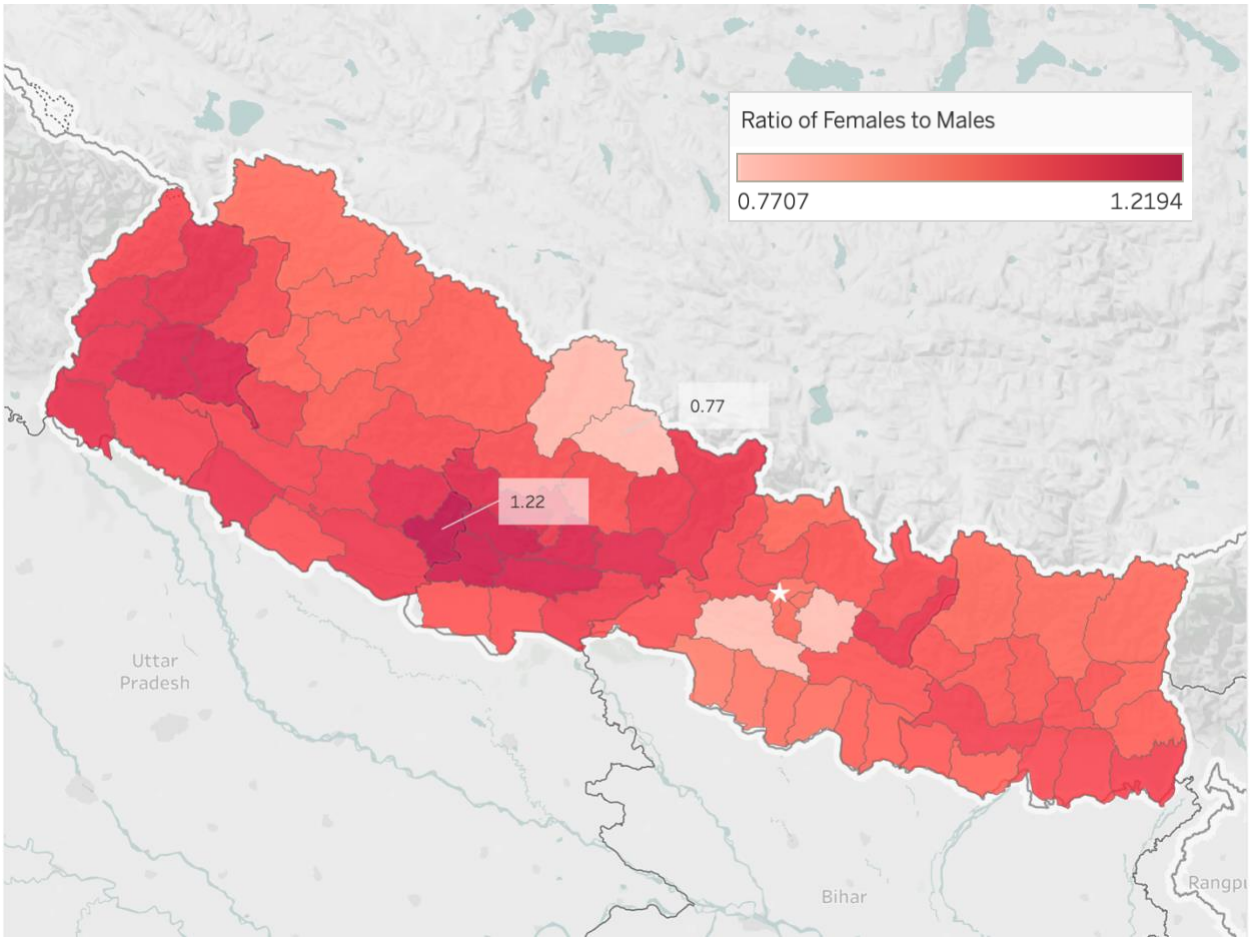

Figure 6. **Female to Male Population Ratio in Nepal by District (2021)** This map illustrates the ratio of total female population to total male population across different districts of Nepal, according to 2021 census data. A gradient of light red to dark red is used to illustrate a low ratio to high ratio respectively, as indicated on the legend in the top right corner of the map. The district with the highest ratio of females to

males is in Pyuthan at 1.22, and the district with the lowest ratio of females to males is in Manang at 0.77. Inaccurate data can be attributed to failure of the census to gather accurate indications of population, particularly in rural districts. *Nepal Outlook*.

3. Contraceptive Usage

Contraceptives are important to the conversation on abortion, as they are often viewed as a protective device from the opportunity of pregnancy. From what was revealed through my conversations about contraceptive usage with interviewees, most participants agreed that contraceptives are used within the Nepali population. Bhadrayo believes that "A lot of women do use contraceptives. It is quite commonly used," and Basana shared how "Ausdeisadhan haru ta ekdame use huncha [Contraceptives are used a lot]," and how nowadays, there are up to six varieties of contraceptive pills methods available. In his interview, Dai supported their statements and suggested that the widespread use is linked to how people in urban areas are more career-focused and likely to use birth control to delay having a child until the couple is ready. He compares this to how people in the *Terai* and rural areas won't hesitate as much to have a child, especially if the husband leaves to pursue work abroad. To an extent, Soman also agreed that contraceptive methods have become common and normalized in Nepal, but more specifically in reference to IPills (emergency contraceptive pills). He said, "Manche harulai makai bhatmaas jasto khayo [people eat it like corns and beans!]", a saying meant to describe a common Nepali snack. He mentioned that many unmarried people and young students dressed in uniform frequently seek contraceptives —an occurrence that Soman feels the government is quite bothered with as well. Soman believes that consuming emergency contraceptives with this degree of effortlessness will surely increase infertility and cause women to experience unnatural symptoms.

This view was not held by all. Prabhakar, on the other hand, disagreed with the notion that contraceptive use is common and introduces the idea that "The reason why contraceptive use isn't common is because the contraceptive prevalence rate is quite low, very low, and the unmet need is quite high. More than 50% of pregnancies are unintended pregnancies. Abortion ko unmet need cha Nepal ma [There is an unmet need for abortion in Nepal]". Prabhakar argued that there is an unmet need for both contraceptives and for abortions, indicating his opinion that current progress on these fronts has proven insufficient. Figure 7 below illustrates the percentage of unintended pregnancies in Nepal by region, according to data collected in 2014.

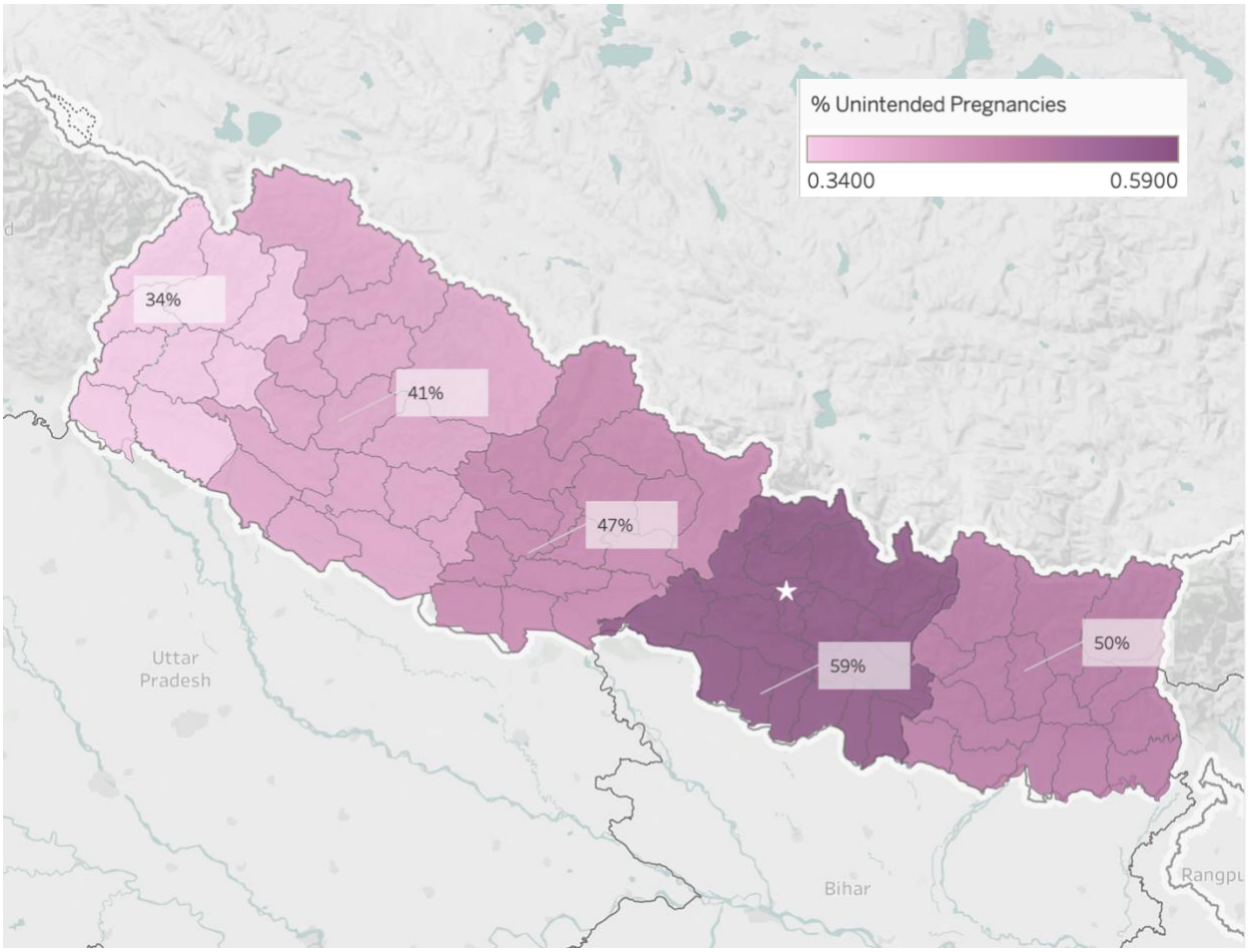

Figure 7. **Percent of Unintended Pregnancies in Nepal by Region (2014)** This map illustrates the percent of unintended pregnancies that occurred within each region of Nepal, according to data collected

in 2014. A gradient of light purple to dark purple is used to illustrate a low percentage to high percentage respectively, as indicated on the legend in the top right corner of the map. The region with the highest percentage of unintended pregnancies is in the central region at 59%, and the region with the lowest percentage of unintended pregnancies is in the far-western region at 34%. Inaccurate data can be attributed to failure to gather comprehensive data on pregnancies, as many pregnancies occur outside of formal hospital and health post settings (Puri 2014).

Prabhakar continues his argument to reveal that especially in young couples, contraceptive prevalence is quite low. He mentioned:

> "The Contraceptive Prevalence Rate in Nepal is 43%. Only 15% of people aged 15-19 are using contraceptives. In this group, both unintended pregnancy rates and abortion rates are very high. They haven't yet been able to target young couples and migrant workers couples, and rural areas. Contraceptive use has increased in Nepal [more] than before, but not in the group that it is supposed to".

This indicates that contraceptive use is not popular because it fails to be promoted, particularly amongst young couples, migrant workers, and those residing in rural areas.

Dai returned to the assumptions addressed at the outset, commenting that in west Nepal, some people do perceive abortion as a method of family planning. He stated that he has personally witnessed cases where women have repeatedly aborted up to five times. Tushar voiced something similar, "some women have used abortion as a form of contraceptive. I have seen some women who have aborted for 6 or 7 times. Every year they come for abortion, or every six months they come for abortion". So, in understanding contraceptive use in Nepal, Dai and Tushar agreed with the perception that in some cases, perhaps contraceptive methods are not

used as frequently, causing patients to receive abortions instead. Tushar stated how treating these women puts him in a difficult position because Nepali law prohibits him from denying any woman an abortion and from pressing contraceptive use on a patient as an alternative to abortions. His abilities are merely limited to counseling.

On the other hand, Basana revealed that another issue with contraceptive usage lies in the consistency of use. In reference to the use of birth control pills specifically, she said, "Uniharulai, ausdeisadhan pre garda garde [For them, to keep using the method], abha kaile tyo ausdeisadhan jhukera [it is a matter of time before they forget], ek, twe, teen, dhela jharo [they might end up going one, two, three days late]". For other methods of birth control such as *Norplant,* Basana described that it is common that women may forget the date they received their implant, or happen to lose their paperwork denoting the date of appointment, ultimately resulting in unintended pregnancies. Tushar appeared to agree with Basana's statement, saying that "it's not that the government isn't promoting pills, it's just that couples find contraceptives difficult to keep up with". He made the argument that the case is not that contraceptives are not available, but instead that people fail to use contraceptive methods such as birth control pills and condoms at a consistent rate. Tushar also added that for long-term contraceptives such as implants, patients either fear potential side effects, deterring them from receiving the implant, or there is a lack of skilled manpower to provide them the implant if desired.

Prabhakar mentioned that some women resort to traditional contraceptive methods, an occurrence that has recently become more popular. Some of these approaches include "breast-

feeding, withdraw methods, and calendar methods," all of which he regarded as ineffective methods to prevent conception.

During Preet's interview, she returned to the prevalence of stigma associated with abortion and contraceptive use. She voiced that even if people are using contraceptives, this doesn't necessarily portend that they are entirely comfortable with the idea: *"*People are still not confident going to the pharmacist being like 'give me an IPill, give me a condom'. You would seldom find any woman doing this. Man, maybe." Ultimately, it appears as though despite all interviewees agreeing that contraceptives are used amongst Nepalis, there exists nuance in perspectives regarding who uses them most frequently, how often they are being used, what groups aren't being reached, and how people feel about using contraceptives. Given that

4. Medical Providers

Medical providers often play a crucial role in advising patients about critical decisions concerning their bodies, including the decision to abort a baby. For this reason, I sought to better understand how Nepali medical providers' perceptions on abortion may vary, whether they display judgment towards the patient for their decision, and the degree of influence medical providers realistically have. Through conversations with interviewees, it became evident that another barrier to accessing abortions lies in the judgment and opinion of medical providers. In some cases, a medical provider's personal stigmas against abortion can make the patient feel uncomfortable about their decision to receive an abortion, ultimately deterring them from receiving one at all. Interviewees note that this judgment occurs on different levels, whether it be towards all women or towards unmarried women in particular.

In his interview, Dai mentioned how doctors outside of Kathmandu have said, “First pregnancy terminate garebhani chai [If you terminate your first pregnancy], pheri conceive na hula, hai [you might never conceive again, okay?]”. Due to such misconceptions, Dai claimed that even women who visited the doctor to receive an abortion, ultimately left without getting one. He said that doctors in government hospitals tend to display pre-judgment and that even the government’s top doctors, typically those of the older generation, are often against abortion. Regarding outright judgments, Bhadrayo shared that “Doctors would probably provide the abortion but make the lady getting the abortion feel as bad as possible and probably lecture them,” imposing their personal beliefs onto the patient. Preet added to this, saying that most Nepali doctors are judgmental about pre-marital sex, impacting how they consult the patient. For instance, after asking her friends about their recent doctor visits one friend replied with, “It was awkward. It wasn’t easy. I got questioned like, because I’m not married, I shouldn’t be having sex”. Again, the stigma against pre-marital sex seems to prevail amongst many Nepali doctors. In his interview, Prabhakar shared a similar occurrence where doctors will often tell patients “Abortion garnu hundena [you should’t have abortions!],” and those doctors discourage abortions not upon the basis of marital status, but instead because they are abortions are risky for the woman’s health. To this, Prabhakar replied: “Abortions may be risk, but pregnancy is 100 times more risk than abortion”.

Some of the interviewees were frustrated why doctors are *still* so judgmental, even after legal strides have been made to advocate for women’s reproductive health rights. A couple of interviewees share their perspectives on possible explanations. Prabhakar voiced that “many

service providers have also become more pro-life in response to recent pro-life advocacy," perhaps in reference to the influx of Christian groups promoting pro-life ideals or the lingering effects of Brahminization. In contrast, Preet noted that most of these doctors were educated in Nepali and Indian medical schools and that Nepalis who studied medicine elsewhere tend to reside outside of Nepal either in the U.S. or in Europe. Preet argued that this *brain drain* effect perpetuates an echo chamber of sorts for traditional values, whereas those with progressive views on abortion leave to practice medicine outside of Nepal.

Soman regarded that not all doctors are anti-abortion, but that instead there exists two schools of thought. He gave an example: "Say there is a couple newly married and pursuing career and they want an abortion" one doctor might say, "baccha lai chance deu [give the child a chance], timro paila baccha ho [it is only your first child]. Baccha janmako ramrai ho [It is best if you have the child]" whereas another doctor might say, "abortion garne parcha [you need to do an abortion]". On the other hand, Basana interpreted possible judgments and inquiries by doctors merely as standard procedures. She said that doctors may ask uncomfortable questions, but that this is part of the process. In the specific example that she provided, when taking a woman living in a rural area to get an abortion, the doctor refused to provide the abortion because the woman was at 13 weeks' gestation (past the 12-week cutoff). Instead of directing patients to other methods where they could still receive an abortion, most likely illegally, the doctor said the patient must have the baby.

Although medical providers generally avoid advocating for abortions, they do appear to strongly advocate for contraceptive use. In his interview, Dai said how "No doctors outright encourage

abortions. Doctors will always encourage contraceptive use" and that "Sakaisaman janmaounailai encourage garcha [Whenever possible, they will encourage them to have the baby]". Prabhakar suggested that this behavior may be a result of ingenuine intentions, and that "Service providers are influenced by those working for contraceptive organizations which have a lot of money and if they [doctors] prescribe contraceptive services, the doctors get money in return. So, doctors promote contraceptive use and post-abortion contraceptive use". Is money the incentive for doctors, or do they prioritize the well-being of the patient? Soman also appears to believe that Nepali doctors are undeniably motivated by monetary incentives. He voiced, "There are some who ask, why do some doctors have so many properties, 4-5 houses across Nepal? It is because they are providing abortions. They provide abortions in the clinic and outside, many doctors provide abortion because of the great money it brings in". As revealed through later interviews, these pro-bono abortions are not always legally provided. In some situations, doctors can charge high prices for those seeking sex-determination abortions—a decision still commonly made widely across Nepal.

Chapter 5: Prevalence of Illegal Abortions Despite Legalization

The discussion of differential access to abortion both physically and financially, the availability of abortion-related services, and potentially inhibiting attitudes and judgments towards abortion, ultimately leads to the conversation on the existing prevalence of illegal abortions in Nepal. *Why are there illegal abortions in a country where abortion is legal?* It appears the answer to this question is not so simple, as such issues in differential access and stigmatization towards abortion oftentimes may push Nepali women away from seeking abortions through legal methods—another critical dimension impacting access. For context on the numerical prevalence of illegal abortions, Figure 8 below illustrates the percentage of illegal abortions that occurred in Nepal by region according to data collected in 2014.

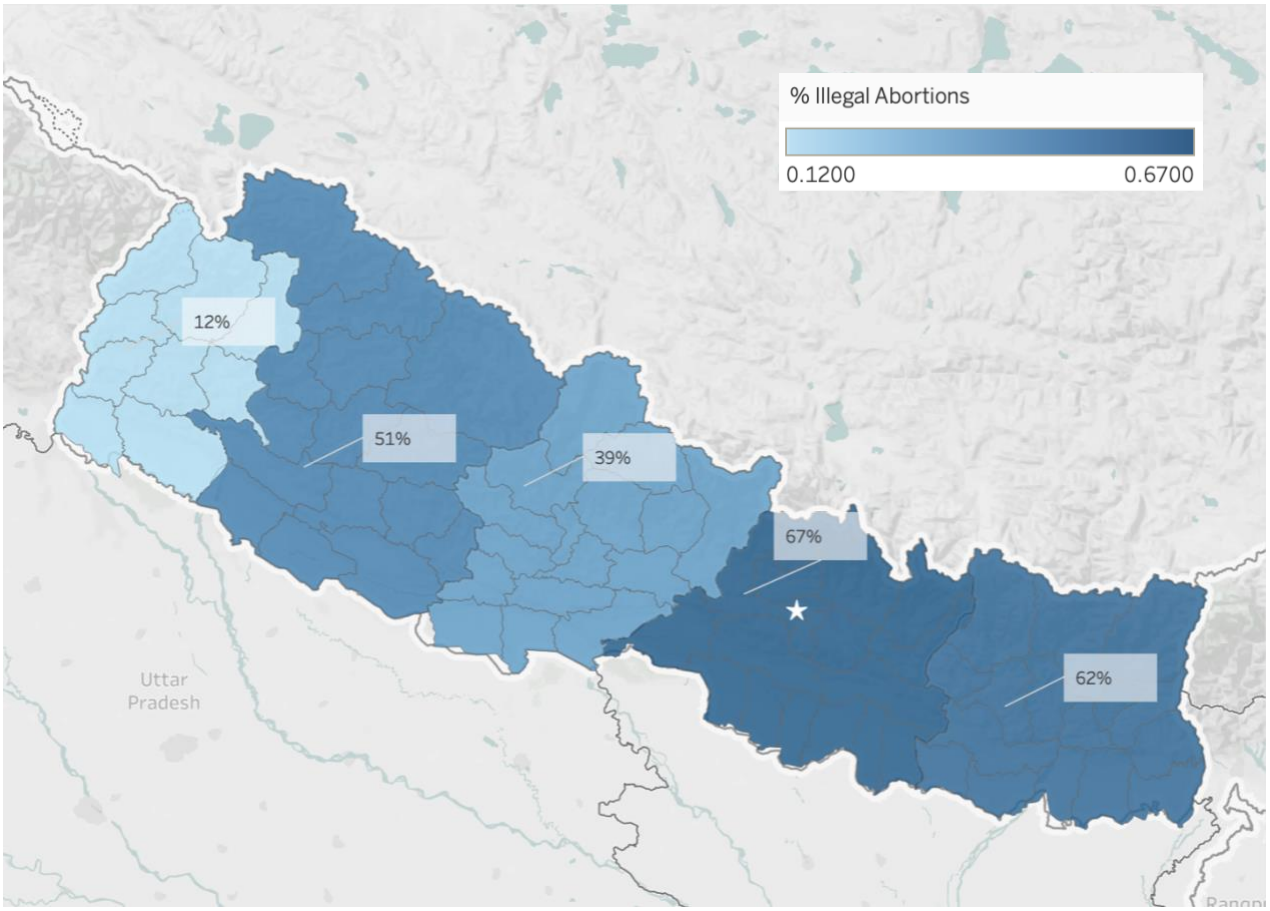

Figure 8. **Percent of Illegal Abortions in Nepal by Region (2014)** This map illustrates the percent of illegal abortions that occurred within each region of Nepal, according to data collected in 2014. A gradient of light blue to dark blue is used to illustrate a low percentage to high percentage respectively, as indicated on the legend in the top right corner of the map. The region with the highest percentage of illegal abortions is in the central region at 67%, and the region with the lowest percentage of illegal abortions is in the far-western region at 12%. Inaccurate data can be attributed to failure to gather comprehensive data on abortions, as many abortions occur outside of formal hospital and health post settings (Puri 2014).

1. What is Considered "Illegal"?

Despite formal abortion legalization in 2002 and approval of abortion decriminalization in 2021, there remains an extremely high rate of illegal abortions in Nepal. If abortions are provided free

of cost at each government health facility in every district of Nepal, why are illegal abortions as common as they are? From the interviews, it became apparent to understand what the term *illegal* truly denotes in practice.

From what participants shared, it appears there are two primary methods that would constitute an illegal abortion in Nepal. The first method is determined upon listed medication. As written by the Nepali government, there are only particular brands of abortion pills that may be prescribed to patients, and these pills may only be administered by those who have legal clearing to do so. It is evident from the interviews that many of these *illegal* abortion medications are sought out in local pharmacies that sell *unlisted medication abortions* that are both affordable and accessible. The second method that could constitute an illegal abortion is determined upon gestational period. According to Nepali law, abortions may only be performed up to 12 weeks' gestation. However, many of the interviewees revealed that Nepali doctors will administer abortions after 12 weeks for a high cost, and oftentimes will administer such abortions for purposes of sex-selection.

Aside from unlisted abortions and abortions for the purposes of sex-determination, methods to self-abort also exist in some rural parts of Nepal and even in Kathmandu. As Preet noted, "People are experimental, they eat ash gourd [a fruit common to South Asia], etc. They think IPill [emergency contraceptive pill] is a way of aborting. They will eat medicine that burns the stomach, hurting their intestines) ... People may go to quack doctors". According to other interviews, homeopathic remedies including the consumption of ayurvedic herbs, poisonous fruits, or harmful chemicals or inedible items are sometimes also sought out. Basana shared what

abortion used to look like in the rural, *gown ghar* areas of Nepal before legal, safe abortion methods became popular: “Sisa phuterai khanee rai [women would break glass and eat it], bachha phalnulai jhar buti haru khani [to rid of the baby they would eat harmful herbs], baccha janu bhanda ama maurni [before the baby would go, the mother would die]”.

1.1 Pharmacy Debate

Given the high rate of illegal abortions that occur from unlisted pharmacy medication abortions, there have been recent debates within the Nepali government to impose further restrictions on pharmacies for these reasons. From what the interviewees shared, going to a corner pharmacy to purchase an unlisted medical abortion pill is among the most common ways that people seek abortions. To get an idea of how common this occurrence might be, Prabhakar acknowledged:

> “The pharmacies are much more popular compared to those health facilities providing the abortion services… Only those who are listed for providing safe abortion services can provide. The listing limits service expansion. Only 42% of abortions are taken in those health facilities. The other 58% are happening outside of legal centers”.

Prabhakar regarded the restrictions on unlisted medication within the law to be limiting to abortion service expansion. This leads us to the question, even if these medications are unlisted, are they still safe to use?

The recognition of whether an abortion service is safe is dependent on two factors: the safety medication itself, and the safety of the process of medication administration. Many interviewees commented on the second factor as a possible reason why unlisted abortion medications may be considered unsafe. Tushar mentioned how the health workers providing these medications are

not skillful and trained, they don't have prescriptions to sell abortion medication, and they also do not have the right to sell these medications. He said, "Women don't know that abortion should be taken with skilled health workers. They prefer to take medication abortions on their own will from an unskilled person because they don't know that services are provided in their villages". Given that these pharmacists don't have prescriptions and are not equipped with the proper knowledge to assist patients, Tushar said that these pharmacists may provide medications to women outside the proper gestational period that is safe, they might not be able to help women with potential complications post-abortion and could be selling medications to patients who are not even pregnant. Prabhakar added to Tushar's statements, saying how:

> "These pharmacists don't know how to administer these medical abortion pills: for which gestational age, how to use the pill, interval period for taking first dose and second doses, what is the expected outcome, what are the adverse effects, what are the side effects. They are just providing the pills".

Regarding possible complications because of this, he says, "When women face adverse effects/complications from improper usage of the pill, they go to hospitals for post-abortion critical care, and the service providers blame the pharmacists". According to Tushar and Prabhakar, if the pharmacist is untrained in how best to provide the medications and if it is improperly administered, seeking unlisted abortion medications from a corner pharmacy may be considered an unsafe method.

Preet and Soman contributed to the narrative that receiving abortion medication from an untrained pharmacist may be unsafe. Preet said, if people have complications after illegal methods such as unlisted abortion medication, they usually don't seek out post-abortion care. In

many of these situations, she said it results in miscarriage. On the other hand, Soman shared that people who get hospitalized from illegal medical abortion use, they ultimately receive a surgical abortion at which point medical providers become aware that they used an unlisted medication abortion. He said these providers become aware because “doctors end up removing parts of the fetus”. Dai proceeded to share similar information that many of these pharmacists don’t run tests and that they charge very high for medication abortions, often between 1300 and 1800 Rs. Most interviewees say that Nepali pharmacists purchase these unlisted abortion medications from India.

About the safety of the medication itself, Dai mentioned that “Illegal doesn’t necessarily mean unsafe it’s just unlisted”. Soman also voiced that given his pro-life perspective on abortions, he does not view abortions as “legal or illegal or safe or unsafe”.

If receiving an unlisted abortion medication could be unsafe, why do women continue to visit pharmacies to receive them? It appears we return once more to the prevalence of stigma and cultural values to answer this question. Preet said, “It is difficult breaking through the stigma of abortion, so women seek the easier route which does not tamper their or their families' reputation*”* and many times, there is no formal documentation required for visiting pharmacies for the unlisted medication. Soman mentioned something similar, “Normally people don’t go to listed service providers to get an abortion. People fear questioning and potential documentation,” again indicating that seeking abortion medications at unlisted service providers at pharmacies is easier for women to avoid questioning and documentation to maintain their privacy. To add, Bhadrayo mentioned that women prefer these pharmacies because patients are not required to

ask whether it is okay to receive the pill, as they will receive it no questions asked. She said that women still hold the residual fear that receiving medication abortion will not be confidential at a government facility, so paying for an unlisted abortion at a pharmacy where they don't question patients is often the preferred alternative.

1.2 Sex-selective Abortions

Gestational age, specifically with concern to sex-selective abortion methods, also serves as a barrier to women accessing legal abortions. From most respondents, it seems that in terms of illegal abortions, it is popular to abort after 12 weeks. This is both the legal cutoff and the time after which one would be able to determine the sex of the child. According to Bhadrayo, many women even have abortions closer to seven to eight months. According to the itnerviewees, it appears that sex-selective abortions are common amongst higher socio-economic groups and Nepalis who have the propensity to pay. Respondents revealed that doctors who perform sex-determination abortions charge very high rates, typically attracting wealthier and more educated populations in Kathmandu. There are also some cases where those of lower socioeconomic classes residing in rural areas also undergo sex-selective abortions. Tushar shared an example of his friend, a doctor performing sex-selective abortions in a rural area of Kathmandu. He explained that the friend underwent ultrasound training and soon began managing and operating out of a clinic complete with a team of doctors and nurses that exclusively perform sex determination. Tushar proceeded to say that the Nepali government and civil authorities are aware of his friend's clinic, which is illegal under Nepali law, but that everyone seems to turn a blind eye.

The motivation behind sex-selective abortions is rooted in the religious and cultural preference for male babies over female babies, as mentioned previously. As Preet reiterated, “There are plenty of people who abort because they were going to have a second daughter”. It is not uncommon for this pressure to abort a female baby to come from the woman’s in-laws and her husband. According to the Center for Reproductive Rights, there are only four countries in the world where sex-selective abortions are common, these countries being Nepal, China, Kosovo, and Montenegro (Center for Reproductive Rights 2016).

Chapter 6: Discussion

1. Does Legality Ensure Access?

This research sought to identify the various political, economic, and cultural factors impacting access to abortion in Nepal. In doing so, it defined the players that fund abortion access, the promotion of both abortion and contraceptive use by Nepali actors, differential access to abortion, as well as prevailing cultural and religious norms that influence attitudes towards abortion. A review of existing literature on this topic, knowledge from personal experiences with Nepali family and friends, and thorough, semi-structured interviews with seven individuals in Nepal, revealed factors impacting abortion access in Nepal today.

From the data, we discover that despite the legalization of abortion and efforts to make abortion physically accessible and affordable across Nepal, many women are still unable to freely exercise their right to abortion. Conversations with interviewees disclosed potential explanations to this juxtaposition:

1) Nepal remains almost entirely dependent on foreign funding in order to implement abortion programming, indicating that Nepali actors alone lack the power to ensure abortion access.
2) Prevailing cultural norms stigmatize contraceptive use and abortion access, deterring women from using contraceptives, from receiving abortions legally, or from seeking abortions entirely.

Analysis of these explanations unveiled prominent themes that help better contextualize the factors that inhibit abortion access. Such themes include the magnitude of power dynamics and the prevalence of both gender norms and expectations for sexual relations.

1.1 Power Dynamics

Interviews revealed that power dynamics operating on multiple levels and at different degrees have a discernable impact on abortion access. On an international scale, we see how the United States, along with other foreign entities, hold influence over Nepal's decision-making and implementation of abortion services. As discussed in Chapter 3, Sections 3.2 and 3.3, interviewees shared that the majority of funding for abortion-related services comes from the United States. Consequently, United States policies such as the Global Gag Rule, which restricts abortion funding when reinstated, directly obstruct abortion programming (and hence, discussion regarding the promotion of abortion services). Further, when I asked the interviewees about the Helms Amendment, a policy arguably more restrictive than the Global Gag Rule Policy, no interviewee mentioned its impact. Not to mention, interviewees appeared to acknowledge international funding for abortion and public health programming as the norm for Nepal, with no apparent advocacy to make Nepal financially self-sufficient for such services. Could this indicate that because development is so intrinsic to Nepal's abortion-related operations, the impact of policies such as the Helms Amendment is not felt, or why interviewees do not feel strongly that Nepal should work to autonomously finance abortion programming? The dependency that Nepal has on foreign aid perpetuates the notion that wealth and power are synonymous entities. The power that the United States, for instance, holds in puppeteering Nepal's abortion policies lies in

the fact that they hold financial leverage, enabling the U.S. to promote their own political agendas abroad.

Power dynamics are also apparent between socioeconomic classes in Nepal, as discussed in Chapter 2, Section 2.1, and Chapter 5, Section 1.2. Wealthier Nepalis and Nepalis living in Kathmandu Valley have both a greater financial propensity to pay for abortion procedures in addition to more suitable physical accessibility to abortion services. This narrative is extended when talking about commercial sex workers in Nepal, whose awareness and access to abortion services are disadvantaged due to their low social status and financial inability. Ultimately, such power imbalances can serve to constrain abortion access for Nepali women, whether it be upon the basis of socioeconomic status or upon Nepal's dependence on foreign support.

1.2 Gender Norms and Expectations for Sexual Relations

As observed in Chapters 4 and 5, Nepali gender norms as well as expectations for sexual relations, prevail over decision-making and judgment regarding abortions and contraceptive use. We learn through the interviews that traditionally, Nepali culture shames the concept of sex before marriage. Consequently, this has generated negative stigmas towards both abortion use and contraceptive use for unmarried couples, making it challenging for unmarried individuals to openly access related services. Although awareness campaigns and government health centers are becoming more adolescent-friendly, cultural stigma still prevails.

In the discussion of existing taboos and stigmas, we are introduced to societal expectations created for Nepali women which were constructed by historical gender norms. As interviewees

noted, the expectation for a woman is to become a mother with the person she intends to marry. This perpetuates notions that sex is intended for married couples and that it is a women's utmost responsibility to bear children. Further, we learn how when illegally sex-selecting an unborn child, Nepalis hold a preference for male children over female children. This is based upon the belief that a male child serves greater value for the parents, given that female children are later married off to another family. In Chapter 4, Section 4, it becomes apparent that these deep-rooted gender norms are embraced by the older generations, but also by the medical community. Interviewees shared how judgment from doctors and other medical professionals, fueled by such traditional views, often serves to dissuade a woman from seeking abortion-related care. With such judgment rampant within local communities and women's families, even if she wants to receive an abortion, fear of shame and gossip prevents a woman from comfortably accessing care. Such gender norms and expectations ultimately serve as barriers to accessing abortion, as strict stigmatization can deter women from seeking abortions and contraceptives legally (or at all).

Indisputably, this research affirms that for many Nepali women, merely legalizing abortion is not enough to ensure abortion accessibility. Globally, there is a consequential emphasis placed on national laws, policies, and regulations with the intent to administer solutions to issues such as insufficient access to abortion. Yet, amidst the towering layers of political relationships, financial power, gender norms, cultural expectations, among other factors, the significance of abortion legality regarding Nepal specifically, suddenly appears rather inconsequential.

Chapter 7: Conclusion

1. Statement of Conclusion

This study suggests that access to abortion in Nepal can be understood by recognizing the financial entities and cultural assumptions which impact a Nepali woman's ability and propensity to receive an abortion. Results from this study illustrate that although abortion is legal and ostensibly accessible through means of affordable pricing and frequent service sites, many Nepali women are not able to freely exercise their right to legally abort. This interpretation is supported by the acknowledgment of prominent factors found to inhibit abortion access: Nepal's financial dependence on foreign aid and Nepal's cultural, religious, and *jaat*-based stigmatization of abortion. Reasons for an unusually high prevalence of illegal abortions can be attributed to the presence of these inhibiting factors. Though the findings of this research may not speak to the experience of all Nepali women, information shared by interviewees along with data collected through literature reviews, support the notion that some Nepali women continue to face difficulty in accessing abortion.

2. Implications, Limitations, and Future Research

Understanding how abortion access for Nepali women can be restrictive within certain contexts create a platform for both public health officials and Nepali citizens to better grasp the difficulties women face in exercising their legal right to abort. This research discloses contradicting assumptions about abortions and introduces us to opposing narratives on differential abortion access across Nepal. It is my intent that this nuance in perspective can provide a textured overview of abortion access in Nepal and dispel any preconceived or harmful assumptions. The sociocontextual analysis of abortion this paper employs can help readers

understand that the issue of abortion is complex in nature and may encourage any attempt to alter abortion access in Nepal to remain cognizant of this complexity. Lastly, the argument this research voices, concerning the dissonance between legal rights and accessibility, may serve to protect the rights and well-being of Nepali women seeking abortion care in future endeavors.

Possible limitations in this study may have contributed to an incomplete or narrow interpretation of abortion issues in Nepal. The small number of study participants (seven total) and the methodology by which participants were sampled (through word of mouth and online searches), may have constricted the diversity of participants selected. A larger number of study participants selected at random could have reduced potential biases and captured a wider range of perspectives, backgrounds, professions, and beliefs. Additionally, attitudes towards abortion access were analyzed in a country where issues of poverty, hunger, and education often preside over issues of reproductive health rights for women. This may have consequently impacted interpretations and the perceived significance of abortion as a topic of urgency in Nepal. Lastly, virtual research may have limited the ability to attract a wider selection of interviewees and may have hampered the ability to connect with Nepali women through methods of participant observation and in-person ethnography.

Further studies should aim to address issues of study participant representation and the surrounding context of abortion in Nepal in an effort to depict a more accurate narrative of dialogues regarding abortion access for Nepali women.

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