

# Abortion Care in Nepal, 15 Years after Legalization: Gaps in Access, Equity, and Quality

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## Historical context

*Reproductive rights are considered to be an inseparable part of women's human rights and within that the right to abortion is seen to hold an important place.*

—Lakshmi Dhikta v. Nepal, Supreme Court of Nepal, 2009<sup>1</sup>

Nepal is often heralded as a model of the successful implementation and rapid scale-up of safe abortion services. Prior to 2002, Nepal had very restrictive abortion laws that prosecuted and imprisoned women and their family members for undergoing pregnancy terminations. Up to one-fifth of incarcerated women were convicted for abortion-related crimes.<sup>2</sup> Despite the restrictive laws and legal implications, many unsafe abortions were still performed by untrained providers throughout the country.<sup>3</sup> Government data from 1998 indicated that 54% of gynecologic and obstetric hospital admissions were due to unsafe abortions.<sup>4</sup> Data from one hospital-based study attributed more than half of maternal deaths during the one-year study period to abortion-related complications.<sup>5</sup>

Nepal legalized abortion in 2002 in response to advocacy efforts that emphasized the high rates of maternal morbidity and mortality attributed to unsafe abortions. First-trimester surgical abortions were made available throughout the country in 2004. Second-trimester abortion training began in 2007, and medical abortions were introduced in 2009. The law permits abortion with the consent of the pregnant woman for any indication up to 12 weeks' gestation and up to 18 weeks' gestation in cases of rape and incest. Abortion is legal at any gestational age if a medical practitioner declares that the women's mental or physical health is at risk or that the fetus is deformed. In cases of women who are younger than 16 or are not mentally competent, consent of the woman's nearest relative or immediate guardian is required.<sup>6</sup>

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The landmark 2009 Supreme Court decision in *Lakshmi Dhikta v. Nepal* not only reinforced the right to abortion but also emphasized that access to abortion is a human right. The case centered on a poor, rural woman who was forced to give birth to her sixth child due to her inability to afford the required fees for an abortion (approximately US\$20). The decision outlined that abortion should no longer be a criminal matter regulated under criminal law but rather an issue of women's human rights that warrants protection under a comprehensive, special piece of legislation.<sup>7</sup> The court stated that abortion rights are a part of reproductive rights and essential to realizing the right to self-determination. Forced pregnancy constitutes violence against women and may become a cause of inequality between men and women. The court held the government accountable for building the necessary institutions and implementing policies to make abortion services affordable and accessible.<sup>8</sup>

#### *Implementation of safe abortion services*

Strong government leadership established the foundation for safe abortion service implementation in Nepal. This leadership engaged the Abortion Task Force, a multisectoral task force of public and private stakeholders, including national and international nongovernmental organizations, to develop policy and key strategies for training and implementation. The Nepal Society of Obstetricians and Gynaecologists provided important technical support in the development of standardized protocols and training guidelines. The Abortion Task Force was dissolved in 2004 and replaced by the Technical Committee for Implementation of Comprehensive Abortion Care. This committee worked to ensure that abortion policy was grounded in public health and scientific evidence, and adapted accordingly as new data emerged.<sup>9</sup>

Nepal's Safe Motherhood Initiative, launched in 1997, was well established by the time abortion was legalized, and it put in place systems for post-abortion care. There was a cadre of providers already familiar with manual vacuum aspiration, the main technique used for both post-abortion care and

surgical abortions.<sup>10</sup> During the initial implementation of safe abortion services in 2004, however, only physicians were trained in safe abortion practices. Family planning literature from several other countries provided data on the safety and efficacy of shifting abortion care to mid-level providers.<sup>11</sup> In response, Nepal decentralized services by training nurses and auxiliary nurse midwives as providers. Since 2008, mid-level providers have been authorized to provide manual vacuum aspiration up to eight weeks' gestation. Auxiliary nurse midwives have been providing medical abortions since 2009.<sup>12</sup>

Fifteen years after legalization, safe abortion services are present in all 75 districts. Currently, there are over 2,000 trained providers, and between 2011 and 2016, over 2,000 trained providers, and government data between 2011 and 2016 reported over 400,000 abortions were performed at legal, safe abortion sites.<sup>13</sup> Maternal mortality in Nepal decreased from 548 deaths per 100,000 live births in 2000 to 258 deaths per 100,000 live births in 2015.<sup>14</sup> It is unclear exactly how much of this decline can be attributed to abortion legalization, as data show a decline in maternal mortality beginning in 1995, even prior to legal abortion.<sup>15</sup> The data, however, do support the conclusion that since legalization there has been a downtrend in the proportion of serious complications, including septic abortions, relative to all abortion-related complications. This decline was most markedly seen during 2007–2010.<sup>16</sup>

Abortion legalization in many ways posits a paradigm shift in Nepal: women's reproductive rights are now recognized as fundamental human rights, and abortion is constitutionally protected.<sup>17</sup> Despite the legal reforms, however, further improvement in protocols and infrastructure is necessary to ensure that all women truly have equal access to affordable services. Second-trimester services, for example, remain extremely limited, with many women still lacking access. Moreover, abortions by illegal or uncertified providers remain prevalent.<sup>18</sup> This paper discusses such challenges to safe abortion implementation in Nepal, 15 years after legalization, where gaps in access, equity, and quality threaten the realization of reproductive rights.

## Gaps in access

### *Second-trimester services*

Globally, only about 10% of abortions take place at or after 13 weeks' gestation. Risk factors for second-trimester abortions include lack of access to early care, late recognition of symptoms of pregnancy, adolescence, poverty, lack of awareness of abortion laws, substance use, fear of stigma, fetal anomalies, and maternal medical conditions.<sup>19</sup> Data indicate that even in settings with high access to first-trimester services, the rate of second-trimester procedures remains relatively stable over time, indicating an ongoing need.<sup>20</sup> While great strides have been made to improve access to first-trimester services in Nepal, access to second-trimester services remains more restricted. Given that women who seek second-trimester abortions are often the most vulnerable and socially disadvantaged, it is imperative that policies focus on expanding equal access to second-trimester services.

The Government of Nepal initiated second-trimester abortion training in 2007, and services grew eightfold from 2007 to 2012.<sup>21</sup> As of 2014, there were 22 hospitals providing second-trimester abortions.<sup>22</sup> Forty-six providers had been trained and over 1,800 women had been served.<sup>23</sup> While the initial rollout appeared promising, there have been delays in training additional providers and expanding services. Provider training for second-trimester abortions were temporarily discontinued in 2015, in part due to controversial sex-selective abortion cases, and resumed only in January 2017.

Government-imposed requirements for facilities providing second-trimester abortions (both medical and surgical) have contributed to the slow scale-up. These regulations mandate that certain resources be made available, including 24/7 comprehensive emergency obstetric and neonatal care, a functional operating room, blood transfusion services, and obstetric providers capable of providing caesarean sections.<sup>24</sup> In contrast, international safe abortion guidelines state that second-trimester abortions can be safely provided in both hospital and outpatient clinic settings, as long as these facil-

ities are properly equipped and have clear referral mechanisms in place for emergencies. These international guidelines recommend that second-trimester sites have at least the same basic facilities as those required for first-trimester procedures, and there are no stipulations for transfusion services or comprehensive emergency obstetric and neonatal care.<sup>25</sup> The Government of Nepal's regulations impose standards for second-trimester abortion services that are not required of other medical procedures of similar acuity and risk imposing burdens that many facilities, including some government district hospitals, cannot bear. Accordingly, these regulations likely do not provide safer services for women but instead may hinder the decentralization of services and further limit access.

### *Sex-selective abortion*

The introduction of second-trimester abortions has heightened concerns around sex-selective abortion. The drivers of sex-selective abortion are complex. Deeply entrenched societal gender discrimination manifests in religious beliefs that value men more highly than women and in inheritance and land rights laws that favor men. Additionally, the dowry system in Nepal forces economic hardships on parents with daughters.<sup>26</sup>

In Nepal, the law explicitly prohibits abortion for sex selection and restricts the use of antenatal technology to determine fetal sex.<sup>27</sup> However, with increased access to ultrasound services and a higher prevalence of routine ultrasonography during antenatal care, this law is rarely enforced effectively. Women may obtain an illegal sex-determination ultrasound at one clinic and then go to a different facility for their abortion. It is difficult to determine the true number of women who present for sex-selective abortions, as women's decision making and indications for pregnancy termination are complex and multifaceted. In one qualitative study, providers expressed concerns that women were being denied abortion services. The providers acknowledged social pressures on women to bear sons and feared that women who are denied sex-selective abortion may turn to unsafe termination alternatives.<sup>28</sup>

There is inherent tension between support for unrestricted abortion access and opposition to sex-selective abortion. Efforts to reduce sex-selective abortion may affect efforts to improve access to abortion services. It is critical, however, to recognize that while abortion access and sex selection are two separate and independent issues, they are both manifestations of systems that perpetuate gender inequality. Broader anti-discrimination initiatives and comprehensive efforts to address women's rights and gender-based violence are needed to address both issues simultaneously. Regulations that target one issue and not the other should be implemented with caution, as they risk disproportionately inflicting harm on the most socially disadvantaged women. These women face the greatest societal pressures to have male infants yet have the least access to abortion services and the most compromised right to self-determination.

#### *Medical abortion services*

Implementing first-trimester medical abortion services has been an important strategy to further expand abortion access, since medical abortion can be more easily provided in rural areas. Medical abortions now constitute over 50% of all abortions in Nepal.<sup>29</sup> Facilities providing first-trimester medical abortions do not need to have surgical abortion capacity.<sup>30</sup>

Studies have demonstrated that first-trimester medical abortions can be safely provided by mid-level providers, such as auxiliary nurse midwives, even in remote health care clinics.<sup>31</sup> Auxiliary nurse midwives working in the public sector who are trained as skilled birth attendants are authorized to provide medical abortions. Many private sector auxiliary nurse midwives, however, are not trained as skilled birth attendants and are therefore not authorized to provide medical abortions.<sup>32</sup> A commitment to scaling up the role of both public and private auxiliary nurse midwives in abortion care can further decentralize abortion services and improve access in remote areas.<sup>33</sup> Similarly, the expansion of medical abortion for second-trimester abortions may also improve access in remote rural

areas where there are no trained surgical providers available. Based on the 2016 Safe Abortion Service Guidelines, however, second-trimester medical abortions can be performed only in facilities with comprehensive emergency obstetric and neonatal care, which includes surgical staff.<sup>34</sup>

Preventing medication stock-outs at remote health care facilities is critical. In some areas, the supply chain for medical abortions has been poorly managed and there are reports of women being denied legal abortions due to a lack of abortion medications.<sup>35</sup> This has been further complicated by the black market for medical abortion medications, especially along the Indian border.<sup>36</sup> These medications are often of unclear quality, dosage, and efficacy, and, as a result, may lead to abortion complications.<sup>37</sup>

Private pharmacies have emerged as a prevalent dispenser of medical abortion medications, although most pharmacists are not approved by the government to do so and have not had adequate training on medical abortion counseling.<sup>38</sup> Increased efforts to regulate, train, and support pharmacists to provide medical abortions may help reduce illegal abortions, further decentralize services, and improve access to appropriate medications. Pharmacies in most rural communities have successfully delivered other reproductive medications, including oral contraceptive pills, condoms, treatment for sexually transmitted infections, and emergency contraception.<sup>39</sup> Strengthening partnerships and referral systems between community pharmacists and clinic providers may be an important opportunity to improve access. As the demand for medical abortion continues to increase, it will be imperative to invest in parallel efforts, such as task shifting, supply-chain management, and collaboration with community pharmacies, to ensure that these services are widely available, well regulated, and of high quality.

#### *Post-abortion contraceptive services*

Despite being included as a priority area in the National Safe Abortion Policy of 2003, post-abortion contraceptive update in Nepal remains low.

Population-based data from 2011 indicated only 56% of women who had an abortion within the previous five years used any contraceptive method during the first year post-abortion, and almost half discontinued their method within the first year.<sup>40</sup> A prospective study of four facilities providing legal abortions showed that one-third of women received no counseling on effective methods of contraception. Nulliparous women and women who were not currently living with their husbands were less likely to receive contraceptive counseling. Many women who desired a long-acting reversible contraceptive or permanent sterilization at a later time did not leave the facility with an effective short-term method to use in the interim. Only 44% of women who desired a long-acting reversible contraceptive at the time of abortion actually had the contraceptive placed within six months after the abortion. This study highlighted several gaps in post-abortion contraceptive counseling, follow-up, and access.<sup>41</sup>

The substantial increase in first-trimester medical abortions also presents new challenges for post-abortion contraceptive use. Some effective contraceptive methods, such as the intrauterine device, cannot be placed until the abortion has been confirmed complete; therefore, a follow-up appointment is necessary.<sup>42</sup> Follow-up, however, may be difficult for some women, especially those living in rural, mountainous areas. Medical abortions are also increasingly being provided at lower-level facilities, which typically offer only short-term contraceptive methods. Because discontinuation rates for short-acting methods in Nepal are high, improved access to long-acting reversible contraceptive methods is critical.<sup>43</sup> There is a need to increase the number of lower-level health care facilities equipped with long-acting contraceptive methods and trained providers who can place them. Better data on follow-up rates, women's preferences for contraceptive methods, and barriers to access can help guide improvements in service delivery. Access to the range of effective post-abortion contraceptive methods will contribute to lower rates of repeat abortions and the prevention of unintended pregnancies.

## Gaps in equity

### *Geography*

Nepal's diverse terrain creates geographic barriers that make the equitable distribution of services difficult. While first-trimester medical and surgical abortion services are available at the hospital level in all 75 districts, women in rural and mountainous areas still face barriers to access. In mountainous areas, women may be required to walk several days to access safe abortion services, which are available only at the district hospital.<sup>44</sup> First-trimester medical abortions are available at the health-post level (the second-lowest tier of Nepal's public health care system) in only 39 of the 75 districts.<sup>45</sup> These physical obstacles to access may cause women in remote areas to delay seeking services and present at later gestational ages. Second-trimester services, already limited nationwide, are even less accessible in rural, mountainous regions.

### *Cost, awareness, and stigma*

In the past, government policies mandated a small fee—ranging from 800 to 1200 Nepali rupees (US\$8 to 12)—for abortion. This cost did not include pain medications, antibiotics, gloves, or syringes.<sup>46</sup> Abortion was purposely separated from the package of free maternal care services, which includes ante- and post-natal care, contraception, and post-abortion care, out of concern that inclusion may promote abortion as a method of contraception.<sup>47</sup> While the landmark 2009 Supreme Court decision established the legal framework for the government to mandate free and accessible abortion services in the public sector, there was no policy to implement safe abortion services until the passage of the Safe Abortion Service Guidelines of 2016. Under these guidelines, all government facilities should provide free abortion services. However, the provider reimbursement scheme outlined in the guidelines is less profitable for providers than it was when women paid out of pocket.<sup>48</sup> It remains to be seen whether these new guidelines thus create monetary incentives that encourage providers to shift abortion provision from the public to the

private sector, thereby adversely affecting access at public facilities.

Additional barriers to equitable access include women's limited awareness of the availability and location of safe abortion services.<sup>49</sup> According to Nepal's 2011 Demographic and Health Survey, only 38% of women of reproductive age were aware of the legal status of abortion. Awareness of legal abortion was inversely related to wealth, with only 22% of women in the lowest wealth quintile recognizing the legal status of abortion.<sup>50</sup> This lack of awareness may lead women to pursue black-market sources for medications that are unnamed and whose dosages are unknown.<sup>51</sup> Indeed, despite the legalization of abortion and improvements in access to safe services, one study using indirect estimation methods calculated that of the 300,000 abortions performed in Nepal in 2014, nearly 60% were illegal procedures performed by unregistered providers.<sup>52</sup> Fear of stigma also prevents some women from seeking abortion services.<sup>53</sup> According to one study focused on young women, many such women do not seek abortion for an unintended pregnancy due to several factors, including partner and family influences as well as limited socioeconomic resources.<sup>54</sup>

Nepal has an established system of female community health workers who, if trained and engaged effectively, have the potential to improve early detection of pregnancy, awareness of legal abortion, and referrals to services. While this has been partially implemented in some districts with positive results, it has not yet been widely implemented.<sup>55</sup> Programs employing community health workers have successfully demonstrated that these workers can be trained to perform pregnancy tests and counsel on the prevention of unintended pregnancy, abortion law and rights, and how to access safe medical and surgical abortions.<sup>56</sup> By normalizing conversations around abortion laws and access, community health workers may be important change agents in improving awareness and decreasing stigma around abortion.<sup>57</sup>

## Gaps in quality

### *Integration of abortion services into the health care system*

The successful implementation and rapid scale-up of first-trimester abortion services can be partly attributed to deliberate efforts to integrate services into the existing health care system. Staff nurses and auxiliary nurse midwives were trained to provide services, while in some districts female community health workers were employed to disseminate information and provide referrals. The existing Health Management Information System was used for monitoring and evaluation. This monitoring system provided frequent updates on the state of services in the country (including service uptake) and complication rates. Policymakers and health officials were able to respond directly to data, perform frequent audits, and devise solutions to address ongoing challenges.<sup>58</sup> The centralized monitoring system greatly enhanced the government's ability to regulate service quality.

Second-trimester services, however, have not been as well integrated into the existing health care system. Currently, these services are not explicitly tracked in the government's Health Management Information System; therefore, there is limited up-to-date information on the state of service provision. Private facilities are not bound by the same requirements to monitor their service provision, nor are they required to provide routine data to the government.<sup>59</sup> Without real-time and transparent data, government officials are limited in their ability to effectively regulate and ensure service quality.

Recent policies passed by the Ministry of Health have also called into question the government's current and future commitment to integrate abortion services into mainstream health care provision. The ministry's Nepal Health Sector Strategy 2015–2020 is a comprehensive plan aimed at achieving universal coverage of essential health care services. It is a five-year plan that takes a multi-sectoral approach to reform the health care system, provide quality services, and improve equity. It lists

33 basic health care services that will be provided for free, as they are considered a “fundamental right guaranteed by the Constitution.” The expansive list includes a range of services, from preventative care to mental health care. While maternal health care services, family planning services, and post-abortion care are listed, safe abortion services are notably absent from the list.<sup>60</sup> Free abortion services were later addressed through the separate Safe Abortion Service Guidelines of 2016.

It is difficult to predict the implications of this separation of abortion services from the remainder of basic health care services. It could lead to a lack of integration of abortion services with other reproductive health care services and to the development of separate, vertical programs. This silo effect could affect access and quality. Furthermore, it indirectly implies that safe abortion services are not included in the package of constitutionally protected health rights.

### *Impact of foreign aid*

US foreign policy continues to influence the implementation of safe abortion services in Nepal. The Helms Amendment, passed in 1973, is a US law that limits the use of foreign aid for abortion “as a method of family planning.”<sup>61</sup> As a consequence of this law, United States Agency for International Development (USAID) funding streams prevent the integration of abortion services into reproductive health care services. Many government and nonprofit clinics receiving USAID funding cannot provide abortions, and women seeking services at these clinics have to be referred to higher-level centers. The distance and cost of transportation to these higher-level centers often prevent women from accessing abortion services.<sup>62</sup>

USAID selectively supports post-abortion care and artificially separates it from comprehensive abortion care. While the same manual vacuum aspirator can be used to perform both abortions and post-abortion care, many USAID-supported clinics will perform only the latter while turning away women seeking services for the former.<sup>63</sup> These funding restrictions marginalize abortion

services from the existing health care system and create clinics that provide less efficient care.<sup>64</sup>

Abortion services in Nepal will likely also be significantly affected by the recent reinstatement of the Mexico Policy, also known as the Global Gag Rule. While the Helms Act restricts the use of US funding directly for abortion services, the Global Gag Rule denies US funding to nongovernmental organizations that advocate, counsel on, or provide referrals for abortions, even if these activities are funded by other non-US donors and are performed in countries where abortion is legal. In the early 2000s, when the Global Gag Rule was active, several Nepali organizations rejected the terms of the rule and, in turn, suffered significant funding losses that resulted in program cutbacks and layoffs. The Global Gag Rule was rescinded by President Obama in 2009 and revived by the Trump administration in 2017.<sup>65</sup> While the full impact remains to be seen, the Global Gag Rule will likely create unnecessary barriers for women in Nepal who seek access to abortion services—services deemed by the Nepali government and courts to be legal and fundamental to the realization of a woman’s reproductive rights.

### Conclusion: Closing the gaps

Nepal has achieved considerable successes in the 15 years after the legalization of abortion, but many challenges remain. Women in many parts of the country continue to lack access to safe abortion services, especially second-trimester services. Given the important geographic barriers within the country, it will be critical to continue to prioritize the decentralization of services and increase the number of health-posts and sub-health posts with the capacity to provide first-trimester medical abortions. Additional efforts are needed to safely expand the provision of second-trimester abortions. Decentralization will need to be accompanied by an investment in technical support for providers in rural areas and referral networks to tertiary centers as needed. Early implementation successes offer valuable lessons on the importance

of data-driven, evidence-based policies and the integration of abortion services into existing health care provision in order to provide high-quality and responsive care. It will be important for policymakers and health officials to build on these previous successes in order to strengthen monitoring systems, react to data, and continue to innovate.

There are substantial data suggesting that the inclusion of additional health care personnel in abortion provision may help enhance abortion service delivery. Medical abortion access may increase with the inclusion of pharmacists as legal providers of the medications. Authorization of the role of pharmacists will also facilitate the government's ability to regulate, train, and ensure quality. Moreover, since many women prefer to seek care at private clinics, the inclusion of private sector auxiliary nurse midwives as medical abortion providers will be critical. Community health workers could also play important roles in improving awareness of legal abortion and the locations of safe services, as well as in beginning to address stigma around this issue.

To promote equitable access as ordered by the Supreme Court decision, safe abortion services should be safeguarded as a fundamental right. To do so, policymakers must begin by including abortion as a part of the package of basic health care services and integrating safe abortion services into the continuum of reproductive health care. The unmet need for post-abortion contraception continues to be an important missed opportunity, and improved access will be important for decreasing the number of unintended pregnancies. Furthermore, policies restricting sex-selective abortion need to be accompanied by broader initiatives to address structural forces that perpetuate gender inequality. Understanding the context in which policies are being implemented is paramount, and government policies need to protect the most marginalized and vulnerable women in society. By failing to understand the lived realities of women who are affected by restrictive abortion laws, we risk once again placing an undue burden on women and limiting their reproductive self-determination.

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## References

1. Supreme Court of Nepal, *Lakshmi Dhikta v. Government of Nepal*, Writ petition no. WO-0757, 2067 (2009). Available at <https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Lakshmi%20Dhikta%20-%20English%20translation.pdf>.
2. Center for Research on Environment Health and Population Activities (CREHPA), *Women in prison in Nepal for abortion: A study on the implications of restrictive abortion law on women's social status and health* (Kathmandu: CREHPA, 2002); M. Puri and P. Chaudhary, *Situational analysis of unsafe abortion in Nepal* (Kathmandu: Family Health Division/Nepal Society of Obstetricians and Gynaecologists, 2008). Available at [www.figo.org/sites/default/files/NEPAL.doc](http://www.figo.org/sites/default/files/NEPAL.doc).
3. CREHPA, *Unsafe abortion: Nepal country profile* (Kathmandu: CREHPA, 2006).
4. I. Basnett, K. Andersen, S. Neupane, et al., *Pathways to safe abortion Nepal* (Chapel Hill, NC: Ipas, 2011).
5. P. Thapa, S. Thapa, and N. Shrestha, "A hospital-based study of abortion in Nepal," *Studies in Family Planning* 23/5 (1992), pp. 311–318.
6. G. Samandari, M. Wolf, I. Basnett, et al., "Implementation of legal abortion in Nepal: A model for rapid scale-up of high-quality care," *Reproductive Health* 9/7 (2012); Ministry of Health and Population, Department of Health Services, Family Health Division, *National safe abortion policy* (Kathmandu: Ministry of Health and Population, 2003).
7. M. Upreti, "Abortion law reform in Nepal," *International Journal of Gynecology and Obstetrics* 126/2 (2014), pp. 193–197.
8. *Lakshmi Dhikta v. Government of Nepal* (see note 1).
9. Samandari et al. (see note 6).
10. Ibid.
11. J. Yarnall, Y. Swica, and B. Winikoff, "Non-physician clinicians can safely provide first trimester medical abortion," *Reproductive Health Matters* 17/33 (2009), pp. 61–69.



12. I. Warriner, D. Wang, N. Huong, et al., "Can midlevel health-care providers administer early medical abortion as safely and effectively as doctors? Randomized controlled equivalence trial in Nepal," *The Lancet* 377/9722 (2011), pp. 1155–1161.
13. Government of Nepal, Ministry of Health, Department of Health Services, *Abortion utilization data 2011–2016* (Kathmandu: Department of Health Services, 2016). Available at <http://dohs.gov.np/publications>.
14. World Health Organization, *Maternal mortality in 1990–2015* (Geneva: World Health Organization, 2015).
15. J. Hussein, J. Bell, M. Dar Iang, et al., "An appraisal of the maternal mortality decline in Nepal," *PLoS ONE* 6/5 (2011), p. e19898.
16. J. Henderson, M. Puri, M. Blum, et al., "Effects of abortion legalization in Nepal, 2001–2010," *PLoS ONE* (2013), p. e64775.
17. Upreti (see note 7)
18. M. Puri, S. Singh, A. Sundaram, et al., "Abortion incidence and unintended pregnancy in Nepal," *International Perspectives on Sexual and Reproductive Health* (2016).
19. J. Harries, P. Orner, M. Gabriel, E. Mitchell, "Delays in seeking an abortion until the second trimester: a qualitative study in South Africa," *Reproductive Health* 4/7 (2007), pp. 197–209; L. Harris and D. Grossman, "Confronting the challenge of unsafe second-trimester abortion," *International Journal of Gynecology and Obstetrics* 115 (2011), pp. 77–79; American College of Obstetricians and Gynecologists, "Practice bulletin no 135: Second trimester abortion," *Obstetrics and Gynecology* 121/6 (2013), pp. 1394–1406.
20. K. Pazol, A. Creanga, and D. Jamieson, "Abortion surveillance: United States, 2012," *MMWR Surveillance Summary* 58/8 (2009), pp. 1–35.
21. M. Baldwin, I. Basnett, D. Dangol, et al., "Notes from the field: Expanding abortion services into the second trimester of pregnancy in Nepal (2007–2012)," *Contraception* 90/6 (2014), pp. 562–564.
22. Nepal Ministry of Health, *Annual Report 2014–2015* (Kathmandu: Department of Health, 2015). Available at [http://dohs.gov.np/wp-content/uploads/2016/06/Annual\\_Report\\_FY\\_2071\\_72.pdf](http://dohs.gov.np/wp-content/uploads/2016/06/Annual_Report_FY_2071_72.pdf)
23. Baldwin et al. (see note 21)
24. Family Health Division, *Safe abortion implementation guide* (Kathmandu: Ministry of Health, 2014).
25. T. Baird, L. Castleman, A. Hyman, et al., *Clinicians' guide for second trimester abortion, second edition* (Chapel Hill, NC: Ipas, 2007); World Health Organization, *Safe abortion: Technical and policy guidance for health systems, second edition* (Geneva: World Health Organization, 2012).
26. M. Puri and A. Tamang, *Assessment of intervention on sex selection in Nepal: Literature review* (Kathmandu: CREHPA, 2015).
27. Ibid.
28. P. Lamichhane, T. Harken, M. Puri, et al., "Sex selective abortion in Nepal: A qualitative study of health workers' perspectives," *Women's Health Issues* 21/3 Suppl (2011), pp. S37–S41.
29. Government of Nepal, Department of Health Services, *Annual Report 2071/72* (Kathmandu: Ministry of Health, 2015), p. 90.
30. K. Andersen, I. Basnett, D. Shrestha, et al., "Expansion of safe abortion services in Nepal through auxiliary nurse-midwife provision of medical abortion, 2011–2013," *Journal of Midwifery and Women's Health* 61/2 (2016), pp. 177–184; I. Warriner, D. Wang, N. Huong, K. Thapa, et al., "Can midlevel health-care providers administer early medical abortion as safely and effectively as doctors? Randomized controlled equivalence trial in Nepal," *The Lancet* 377/9722 (2011), pp. 1155–1161
31. Andersen et al. (2016, see note 30).
32. Family Health Division, *Safe abortion services implementation guide* (Kathmandu: Ministry of Health, 2016). Available at <http://fhd.gov.np/index.php/en/publication-1/140-2016-11-25-06-30-41>.
33. Andersen et al. (2016, see note 30).
34. Family Health Division (2016, see note 32).
35. Samandari et al. (see note 6); CREHPA, "Effects of being denied legal abortion in Nepal," *Reproductive Health Research Policy Brief 20* (Kathmandu: CREHPA, 2015).
36. Samandari et al. (see note 6).
37. C. Rocca, M. Puri, B. Dulal, et al., "Unsafe abortion after legalisation in Nepal: A cross-sectional study of women presenting to hospitals," *British Journal of Obstetrics and Gynecology* 120 (2013), pp. 1075–1084.
38. A. Tamang, M. Puri, and P. Shrestha, "Pharmacy workers in Nepal can provide the correct information about using mifepristone and misoprostol to women seeking abortion to induce abortion," *Reproductive Health Matters* 44/Suppl 1 (2015), pp. 104–115.
39. P. Garcia, J. Hughes, C. Carcamo, K. Holmes, "Training pharmacy workers in recognition, management, and prevention of STDs: District-randomized controlled trial," *Bulletin of World Health Organization* 81 (2003), pp. 806–814; R. Sneeringer, D. Billings, B. Ganatra, and T. Baird, "Roles of pharmacists in expanding access to safe and effective medical abortion in developing countries: A review of the literature," *Journal of Public Health Policy* 33/2 (2012), pp. 218–229.
40. S. Padmadas, M. Lyons-Amos, and S. Thapa, "Contraceptive behavior among women after abortion in Nepal," *International Journal of Obstetrics and Gynecology* 127/2 (2014), pp. 132–137.
41. C. Rocca, M. Puri, C. Harper, et al., "Postabortion

contraception a decade after legalization of abortion in Nepal,” *International Journal of Obstetrics and Gynecology* 126 (2014), pp. 170–174.

42. D. Brahmi (ed), *Clinical updates in reproductive health* (Chapel Hill, NC: Ipas, 2017).

43. M. Puri, J. Henderson, C. Harper, et al., “Contraceptive discontinuation and pregnancy postabortion in Nepal: A longitudinal cohort study,” *Contraception* 91 (2015), pp. 301–307.

44. Samandari et al. (see note 6).

45. Government of Nepal, Department of Health Services (2015, see note 29).

46. Guttmacher Institute, *Making abortion services accessible in the wake of legal reforms: A framework and six case studies* (New York: Guttmacher Institute, 2012).

47. Samandari et al. (see note 6).

48. Family Health Division (2016, see note 32).

49. M. Puri, S. Regmi, A. Tamang, and P. Shrestha, “Road map to scaling-up: Translating operations research study’s results into actions for expanding medical abortion services in rural health facilities in Nepal,” *Health Research Policy and Systems* 12/24 (2014); Rocca et al. (see note 37); M. Puri, D. Vohra, C. Gerdt, and D. Greene Foster, “‘I need to terminate this pregnancy even if it will take my life’: A qualitative study of the effect of being denied legal abortion on women’s lives in Nepal,” *BMC Women’s Health* 15/85 (2015).

50. Ministry of Health and Population, *Nepal Demographic and Health Survey 2011* (Kathmandu: Ministry of Health and Population, 2012).

51. Rocca et al. (see note 37).

52. Puri et al. (2016, see note 18).

53. M. Puri, P. Lamichhane, T. Harken, et al., “‘Sometimes they used to whisper in our ears’: Health care workers’ perceptions of the effects of abortion legalization in Nepal,” *BMC Public Health* 12/297 (2012).

54. M. Puri, R. Ingham, and Z. Matthews, “Factors affecting abortion decisions among young couples in Nepal,” *Journal of Adolescent Health* 40/6 (2007), pp. 532–542.

55. M. Puri, A. Tamang, P. Shrestha, and D. Joshi, “The role of auxiliary nurse-midwives and community health volunteers in expanding access to medical abortion in rural Nepal,” *Reproductive Health Matters* 44/22 (2015), pp. 94–103.

56. Ibid; Puri et al. (2014, see note 49); K. Andersen, A. Singh, M. Shrestha, et al., “Early pregnancy detection by female community health volunteers in Nepal facilitated referral for appropriate reproductive health services,” *Global Health Science and Practice* 1/3 (2013), pp. 372–381.

57. Puri et al. (2015, see note 55).

58. Samandari et al. (see note 6).

59. Ibid.

60. Nepal Ministry of Health, *Nepal Health Sector Strategy 2015–2020* (Kathmandu: Ministry of Health, 2016).

Available at <http://nhsp.org.np/wp-content/uploads/2016/05/NHSS-English-Book-Inside-final.pdf>.

61. Kaiser Family Foundation, *The US government and international family planning and reproductive health: Statutory requirements and policies* (Washington, DC: 2016).

62. Ipas, *US foreign policy and abortion in Nepal: Barriers to saving women’s lives* (Chapel Hill, NC: Ipas, 2010).

63. Ipas, *The impact of US foreign policy on safe abortion in Nepal* (Chapel Hill, NC: Ipas, 2010).

64. Ibid.

65. Population Action International, *The impact of the Global Gag Rule in Nepal* (Washington, DC: Population Action International, 2006).