

What Works?

Integrating Gender into Government Health Programmes in Africa, South Asia, and Southeast Asia

CASE STUDY SUMMARY REPORT:

Right to Safe Abortion in Nepal



Regional promising practice project overview

Strengthening health systems in order to improve health and gender-equality outcomes requires robust country leadership and governance. Widespread commitments have been made to integrate gender into health, yet substantial gaps remain in intent, level of investment, and implementation. There is a pressing need for more contextualised, practice-based evidence of the pathways along which gender integration can be institutionalised and sustainably resourced in government health programmes.

The United Nations University International Institute for Global Health (UNU-IIGH), in partnership with the School of Public Health at the University of Western Cape in South Africa, and the Public Health Foundation of India through the Ramalingaswami Centre on Equity and Social Determinants of Health in India, co-led a collaboration to document and analyse six diverse and promising practices of gender integration in government health programmes. The resultant case study series consists of six stand-alone summaries with key findings spanning policy, systems, institutional, and community levels. Detailed case study reports are forthcoming.

Gender based violence service provision in primary health care, Ethiopia (systems level)

Gender integration in medical education in Maharashtra and other states, India (systems level)

Right to safe abortion, Nepal (policy level)

Gender integration in Baguio General Hospital and Medical Center, Philippines (institutional level)

The “Ecole des Maris” programme – bringing men into reproductive health, Niger (community level)

The Gender Guidance Clinics of Tamil Nadu – meeting the healthcare needs of the transgender community, India (institutional level)

The right to safe abortion in Nepal

This case study focuses on the legislative reforms for safe abortion in Nepal. It was selected as a promising case, as it offers insights into the factors and forces that drove the country to affirm gender equality and reproductive rights, especially the right to safe abortion, during a radical political transition.

The study was carried out by the Ramalingaswami Centre on Equity & Social Determinants of Health, at the Public Health Foundation of India, Bangalore, in partnership with the Beyond Beijing Committee,

Kathmandu. It was led by Renu Khanna and Aditi Iyer, with support from Shreelata Rao Seshadri, as well as Laxmi Tamang, Ranjeeta Silwal, and Aruna Uprety in Kathmandu, and Sreelakshmi Pydi, Aswathy Ram and Anaaha Jaishankar in Bangalore. Based on analyses of in-depth interviews and a review of published materials, the study identifies the actors and contextual factors that enabled the legalisation of abortion in Nepal, the mechanisms supporting and sustaining change, as well as the continuing challenges to implementation of the law (see Figure 1).

1. Background

Abortion bans and restrictive abortion laws

Globally, gender equality, women's rights to autonomy, and sexual and reproductive rights are facing an unprecedented backlash. Recently, the Polish government spearheaded laws and policies that undermine women's and girls' reproductive rights (Kehmová, 2023). In the United States, the Supreme Court and several states have heavily restricted, if not banned, access to legal abortions. According to the World Population Review, as of 2021, there are 24 countries in which abortion is illegal in any and all circumstances, including the Philippines and the Lao People's Democratic Republic¹. Criminalising abortion denies women their right to reproductive self-determination, and ultimately jeopardises their lives, health, and wellbeing.

In this context, the decriminalisation of abortion in Nepal in 2002, the incorporation of reproductive rights

into the new constitution of 2015, and the new penal code of 2017 culminating in the Safe Motherhood and Reproductive Health Rights (SMRHR) Act of 2018 are significant. This is especially so, given the magnitude of gender inequality and injustice in Nepalese society.

The lives of Nepalese girls and women, especially among low income groups, have been characterised by curtailed schooling, limited opportunities to be economically independent and unshared burdens of unpaid work (T. Dahal et al., 2023; Ghosh et al., 2017). Gender norms and values serve to undermine women's personal autonomy and agency (Yount et al., 2024). Early marriage and childbearing are common (Scott et al., 2021), which increases their vulnerability to violence and abuse (Adhikari, 2018; P. Dahal et al., 2022). Over time, recognition of women's needs and rights has undoubtedly grown, but the result has been inconsistent across the socio-economic spectrum and between regions (Scott et al., 2021).

¹ <https://worldpopulationreview.com/country-rankings/countries-where-abortion-is-illegal>

Women's rights to safe abortion in Nepal

Prior to 2002, abortion was considered a criminal act (homicide) in Nepal's National Code (Muluki Ain), a vestige of monarchical rule. The law, exacerbated by disempowering gender relations, effectively pushed women with unwanted pregnancies to have unsafe abortions and risk a lengthy prison sentence. Typically, such women were poor with no legal recourse, and abandoned by their families. Their partners, or the offender in cases of sexual violence, were almost never brought to book.

In the 1990s, against the backdrop of pro-democracy struggles, sustained advocacy by women's rights and health activists, medical professionals, and journalists was actively supported by national and international NGOs calling for the law to be revoked. Obstetrician-gynaecologists who witnessed the devastating consequences of unsafe abortions joined the struggle. Their efforts eventually resulted in abortion being legalised in 2002. The National Safe Abortion Policy and Strategy of 2002 viewed unsafe abortion as a major contributor to maternal mortality (Ministry of Health, 2002). The subsequent recognition that abortion is a woman's reproductive and health right came later, when the new constitution was passed in 2015 (Constituent Assembly Secretariat, Singha Durbar, 2015), replacing the interim constitution of 2007.

The constitution mandated that commensurate laws be enacted to substantively define and specify the remit of fundamental rights. This led to the adoption of the SMRHR Act and the Public Health Act in 2018. According to the SMRHR Act, all women, even adolescents, have a

right to abortion services up to 12 weeks of pregnancy. Beyond 12 weeks, this right becomes conditional. Between 12 and 28 weeks, abortions are limited to pregnancies resulting from rape or incest. Between 18 and 28 weeks, abortion is legal only if an obstetrician-gynaecologist deems the life of the woman, or the foetus, to be in danger (Regulation on the Right to Safe Motherhood and Reproductive Health, 2077, 2020; The Right to Safe Motherhood and Reproductive Health Act, 2075 (2018)).

According to guidelines released in 2021 (Family Welfare Division, 2021), pregnancies up to 10 weeks can be terminated using either of two methods – medical abortion or manual vacuum aspiration – by a trained nurse, midwife, MBBS doctor or specialist (obstetrician-gynaecologist or medical doctors in general practice) in listed health facilities. Between 10 to 12 weeks, a trained MBBS doctor is required to carry out manual vacuum aspirations. Between 13 and 18 weeks, pregnancies can be terminated by specialists via medical induction (MI) or dilation and evacuation (D&E) in listed health facilities that also offer comprehensive emergency obstetric and neonatal care. Between 18 and 28 weeks, trained specialists are required to terminate pregnancies via MI/D&E in a listed speciality, super-speciality or teaching hospital.

Currently, the process of amending the Act is underway in response to demand from obstetrician-gynaecologists for removal of the upper limit of 28 weeks to save the lives of women or viable foetuses. The limitation had been incorporated in the SMRHR Act without consultation.

2. What has been achieved?

Based on interviews and reviews of documents, progress in advancing Nepalese women's rights to reproductive self-determination has included the following:

- **Legislative reforms for safe abortion.** The biggest achievement has been Nepal's recognition of women's rights to safe abortion services in the face of cultural and socio-economic barriers to gender equality. Sustained policy advocacy, public action and legal activism for safe abortion and reproductive rights, coinciding with the country's political transition into a federal democracy, has resulted in constitutional guarantees that cannot be easily overturned.
- **Increased accessibility to safe abortion services.** Since 2016, abortion services have been free in public health facilities as a result of a landmark court ruling in favour of Lakshmi Dhikta, a poor mother of five children from Dadeldhura in western Nepal. Lakshmi went with her husband to a government hospital within the 12 week cut-off but was denied an abortion because of their inability to pay the fee of NPR 1130 (USD 12.00) (*Lakshmi Dhikta v Government of Nepal, Writ No. 0757, Nepal Kanoon Patrika (Supreme Court) 2067, 2009*).

Access to safe abortion services has also increased by training mid-level providers, task shifting and

increasing the number of certified health facilities. As of 2022, there were 6,310 health institutions (4,155 governmental and 2,155 non-governmental) providing abortions (Ministry of Health and Population, 2022). Safe abortion users numbered 90,733 in 2020–21, of whom 7 per cent were women under the age of 20 years (Ministry of Health and Population, 2022).

- **Improved quality of abortion services.** Safer methods include medical abortions and manual vacuum aspiration for early abortions. There has also been a downtrend in the proportion of serious complications, including septic abortions, relative to all abortion-related complications (Wu et al., 2017). The rollout of training focused on clarifying values, and changed attitudes have contributed to higher-quality services, as health providers have become less judgmental in their interactions with women.
- **Staff training.** Inroads have been made into medical, nursing and midwifery pre-service training, albeit in project mode, by expanding curricula to include modules on sexual and reproductive health and rights (SRHR), including one on safe abortion, as well as competency-based training on SRHR (World Health Organization & Family Welfare Division, n.d.).

3. What contextual factors facilitated the legalisation of abortion in Nepal?

It has taken more than 25 years of sustained advocacy, public action and legal activism for Nepal to revoke legislation criminalising abortion and pass new legislation that frames reproductive health as a woman's right. This journey continues with further legal reforms currently underway. The national and global factors that have enabled change have varied in form, and degree of influence, over time.

National level

Receptive political and legal environment

- The pro-democracy movement in the 1990s involved all sections of Nepalese society (S. Thapa, 2004), leading to a churn that challenged not just the political order but also established practices, power hierarchies and modes of thinking. An openness for discussion and dialogue among policymakers, and a changing legal system facilitated and supported the decriminalisation of abortion in 2002.
- Around 2005, the second people's movement and struggle for a new constitution began. The interim constitution in 2007 that recognised reproductive rights was considered very progressive. During this period, the courts were very responsive. Even so, safe abortion was framed in terms of its contribution to much-needed reductions in maternal mortality, rather than as a right.

Growing concern about the toll of unsafe abortions on women's lives

- Established in 1959, the Family Planning Association of Nepal (FPAN) was Nepal's first national family planning service delivery and advocacy organisation. The genesis of the legalisation of

abortion lies in a couple of conferences in the 1974 organised by FPAN with others concerned about the toll unsafe abortions were taking on the lives of women (Upreti, 2014).

- By the 1990s, the public health community was concerned about very high levels of maternal mortality. Obstetrician-gynaecologists were concerned about life-threatening abortion-related morbidities, and deaths due to unsafe abortions. One hospital-based study revealed that more than half of all maternal deaths could be attributed to unsafe abortions (P. J. Thapa et al., 1992). Another study found that unsafe abortions constituted 54 per cent of hospital admissions requiring the attention of obstetrician-gynaecologists (Family Health Division, 1998).
- The human rights community was concerned about women jailed for illegal abortions. A 2000 study of women in prisons played a significant role in the advocacy for legalising abortion (CREHPA, 2000). The study followed a scrutiny of registration records of the Supreme Court and the police, which showed that many women were jailed for abortion following active reporting by their families. They found that most women in prison were incarcerated for trafficking and for abortion, and that 20 per cent of women in prison had been convicted for abortion or infanticide. The study also showed that women in prisons for abortion were largely uneducated, very poor and from remote rural areas, establishing abortion as both a gender and a class issue.

Growing strength of women's rights activists

- In the 1980s, the National Women's Organisation convened an important gathering of jurists,

administrators, social workers, and others to consider the legality of abortion. This led to a series of activities, including draft recommendations to make abortion legal in cases of pregnancies resulting from rape or incest, or where a pregnant woman's life was at risk. These efforts did not gain momentum at the time, but the foundations for change were laid.

- With the restoration of democracy in 1990, literally hundreds of NGOs seeking a role in the social change process sprang up across the country. In the 1990s, women's rights activists sought to dismantle discriminatory laws in parallel with the pro-democracy movement, and this became the launching pad for a renewed and strengthened voice for legalisation of abortion.

International pressure to regulate population growth

- In the late 1970s, US-based organisations were engaged with the Nepalese government on policies and programmes to regulate population through family planning programmes. One idea mooted was to legalise abortion as a method to control fertility.

Absence of significant opposition

- The absence of any significant opposition to the movement for abortion law reform was as important

as overt support. In fact, there was never much organised opposition to the proposed reforms, either from the public or the private sector. Another reason may be that abortion had become relatively acceptable in Nepal because it had already been legal for many years in neighbouring India.

Global

International campaigns for women's rights, including reproductive rights, and for the elimination of discrimination against women

- The International Conference on Population and Development in 1994 and the UN Conference on Women in Beijing in 1995, created a reproductive and sexual health and rights discourse that influenced the Nepalese government. These paved the way for international human rights instruments and processes.

Provisions for abortion in neighbouring countries

- In Bangladesh, termination of pregnancy was allowed through a procedure called menstrual regulation within two months of gestation. From India, the government and women's health advocates learned that any legislation to legalise abortion had to be kept simple for ease of implementation.

4. What catalysed the legalisation of abortion in Nepal?

Certain catalysts, including changes in the internal or external context, opened windows of opportunity over different points in Nepal's history over 25-30 years, which were seized by specific actors at different points. These factors included:

- **Cross-sectoral collaboration.** The struggle for abortion rights coinciding with the pro-democracy

movement brought together multiple supporters of gender equality and reproductive health and rights, including the public health community, women's rights' activists, and lawyers. The concerted collaborative effort sensitised parliamentarians on emerging issues as supporters advocated for change.

- **Journalists and activists** played a key role in the early stages through their reports of abortion-related gender injustices. Amplifying marginalised women’s voices, they contributed to changing public opinion on the need to decriminalise abortion, based on feminists’ and doctors’ testimonies.
- **Timely research-based evidence and opinion polls** at different stages provided a boost to ongoing advocacy. The landmark study on women in prison (Center for Research on Environmental Health, Population Activities (CREHPA), 2000) helped galvanise public action against criminalised abortion. This study showed that 20 per cent of women in prison were convicted of abortion or infanticide. After abortion was decriminalised, research studies on the modalities of expanding access to safe abortion services (Government of Nepal & Center for Research on Environment, Health and Population Activities (CREHPA), 2006) resulted in mid-level providers being trained to provide medical abortion and manual vacuum aspiration (for pregnancies up to 10 weeks).
- **Consistent legal advocacy and court rulings on individual cases** led to positive outcomes at different stages. For example, advocacy around the Supreme Court’s 2009 judgment in the Lakshmi Dhikta case resulted in free abortion services at public-sector health facilities (*Lakshmi Dhikta v. Government of Nepal, Writ No. 0757, Nepal Kanoon Patrika (Supreme Court) 2067, 2009*).
- **International human rights instruments and processes** (like CEDAW and the Universal Periodic Review (UPR)) also served to apply external pressure on the government to reform the law.

5. What actions allowed the changes to be sustained over time?

- **Technical support from multilateral organisations and international NGOs.** UN agencies, such as WHO and UNFPA, and international NGOs, such as IPAS, the Centre for Reproductive Rights, Marie Stopes and Population Services International, have played a constructive role by providing technical assistance to strengthen implementation of the abortion law or by offering their services to tackle stigma and other barriers to abortion-related access. IPAS, DFID and the Centre for Reproductive Rights, as well as WHO and UNFPA have also consistently engaged with other sexual and reproductive health issues and continue to support the government’s health-sector reforms.
- Nepal’s alignment with international human rights instruments and processes (CEDAW and UPR) offers continued protection to women against violations of the law and is leveraged by advocates to press for reforms to the legal and health systems.
- **The Reproductive Health Working Group (RHWG)**, with around 15 national and international NGOs, is chaired by the National Women’s Commission. The Forum for Women, Law and Development serves as the secretariat. The RHWG steers policy reforms, reviews the situation on the ground, and chalks out plans to strengthen programme implementation. It has become an important sustaining force.
- **Technical Committee for Implementation of Comprehensive Abortion Care (TCIC)**, formerly the Abortion Task Force, is another ongoing government initiative consisting of members drawn from key government ministries and departments (Ministry of Health and Population, the Ministry of Law and Justice) as well as NGOs and donors.

The TCIC is chaired by the Family Health Division/ Department of Health Services Director and assists the government in funding and implementation of the safe abortion strategy. This includes developing guidelines and strengthening the expansion of

abortion services to the periphery. For example, the group has developed guidelines for implementing reforms through local government, and the creation of online monitoring and tracking systems.

6. What were the missed opportunities and challenges?

Although strides have been made in legalising abortion and providing services free of charge, there are important opportunities that could have been seized to strengthen both the abortion law and its implementation. Broadly these can be grouped into following main areas:

Opportunities to increase acceptability

- Journalists, who helped build public opinion in the lead-up to decriminalising abortion, do not cover abortion-related issues unless a sensational case presents itself. Yet, they have an important role to play in making abortions more accessible, along with other content creators in social media, community radio, etc. They can raise awareness about the legality of abortion and women's rights to services, and address the roots of stigma, especially in rural and remote regions of the country. This can be done by sensitising the media to rights-based reporting.
- The discourse around reproductive health rights currently focuses on girls and women. It needs to be widened to include men's and boys' responsibilities towards their partners' personal autonomy and bodily integrity, within the context of consensual relationships.
- Abortion is positioned within the SRHR continuum in the law, but this idea is not adequately reinforced in medical and nursing training. Medical and nursing students can be sensitised to women's SRHR needs,

and their responsibilities for service provision, by incorporating relevant content into their curricula, and by strengthening accountability measures, including instituting grievance mechanisms.

Opportunities to increase accessibility

- Access to abortion is easiest when women are in their first trimester. Training and other approaches to improve body literacy may enable women and girls to recognise pregnancy at an early stage.
- While great strides have been made to improve access to first-trimester services in Nepal, accessibility begins to fade as one moves further away from the capital city. Access to second-trimester services remains even more restricted. Leveraging private-sector service providers, including facilities and mid-level providers, and increasing the remit of task-shifting may help address the shortages in health providers in small towns and rural areas. Authorising trained pharmacists, with regulations and referral backup, may also help.
- With increased access to ultrasound services and a higher prevalence of routine ultrasonography during antenatal care, it is believed that sex selection is on the rise. Delinking sex selection from abortion is thus urgently required. Framing sex selection as a gender-discrimination issue, and abortion as a separate reproductive rights issue, could help.

Opportunities to enhance quality

- Abortion needs to be framed within the SRHR continuum within medical practice. Data from 2011 indicated that only 56 per cent of women who had an abortion within the previous 5 years used any contraceptive method during the first year post-abortion, and almost half discontinued contraception within the first year.
- Regular and continuing medical education on SRHR, including abortion, for healthcare providers – both public and private – can help ensure that provider attitudes match women’s right to respectful care.

Challenges

Making abortion a substantive right for women across socio-economic and regional divides requires a health system that has the readiness and capacity to provide uniformly good quality services. Equally important are gender power relations that support their personal autonomy and bodily integrity. Nepal faces challenges with respect to both requirements:

- Its resource-poor public health system requires a significant infusion of funds. However, it is currently moving in the opposite direction, with reduced spending by both the government and international donors. Dependence on external aid is tricky because of changing donor priorities. For example, the global gag rule (also known as the Mexico City policy) had an impact on funding for Nepal’s implementation of the abortion law (Tamang et al., 2020; Wu et al., 2017).
- Another challenge arises from the inherited histories of Nepal’s provinces, with some (e.g. the western provinces) being relatively poorly developed and more gender-adverse for women

than the rest of the country. These regional variations are evident in the health sector as well, which get compounded by the country’s lack of federal oversight. According to the 2015 constitution, health is the responsibility of local governments with the central health department providing little support or supervision. These structural factors directly affect the availability and quality of abortion services through public health institutions across the provinces. This means that the right to abortion is not uniformly upheld or experienced by women across the country.

- Gender power relations across socio-economic and regional divides also challenge the translation of legal provisions into substantive rights to abortion. This is especially so for women who are doubly or triply disadvantaged by poverty and socio-cultural subordination. The women’s movement in Nepal has undoubtedly had an impact. However, the champions for gender equality tend to be clustered in a few areas, away from villages and remote regions where women are still held back by regressive forces that shape gender norms and disempower them.
- Health providers can play a role by removing socio-cultural barriers to access, but this would depend on them being trained to think differently, and on facilities being equipped to offer services. As one moves away from the capital city and other urban centres into rural areas, both providers and facilities get scarce, and stigma continues to prevail. This drives women to approach uncertified facilities and professionals for expensive care of poor quality (Khapung, 2020). Consequently, unsafe abortions continue to take place (Puri et al., 2016), although there have been a reduction in unsafe abortions since they were legalised.

7. Conclusions

This case has illustrated how sustained, long-term, and considered advocacy and legislative action, with support from multiple stakeholders and contextualised solutions, culminated in abortion and other reproductive rights getting enshrined in Nepal's constitution. It shows how the development and enactment of legal frameworks can advance women's reproductive health and rights, even when gender power relations militate against gender equality. Nepal has ensured that the law does not only remain on paper, but that it gets implemented on the ground where the health system, with its socio-economic and cultural challenges, must be addressed. It will take time for these challenges to be fully met, but at least a beginning has been made.

The advisory and technical working groups engaged with abortion-related amendments in the SMRHR Act of 2018, and on developing protocols and guidelines for service delivery, have helped institutionalise the law into the health department. The inclusion of policy actors from outside the health sector in the working groups, notably the National Women's Commission, and the

resonating presence of the Gender Equality and Social Inclusion Policy, provide additional support.

Nepal's 2015 constitution and the 2018 SMRHR Act are gender-specific, in that pregnancy and abortion are concerned with female bodies. They are also gender-responsive, since they challenge the normalisation of maternal mortality and violations to women's right to life. The Act is also gender-transformative to the extent that it recognises reproductive rights, and women's consent and control over her body. Recognition in the Act of marginalisation arising from intersecting sources of disadvantage – women with disabilities and single women – points to a much-needed nuance. Yet, silence on the role and responsibilities of men vis-à-vis women's reproductive health and rights weakens the Act's potential for gender transformation. Additionally, challenges from the health system and society continue to stigmatise and curtail access to services, meaning that gender transformation is still a distant, though probably achievable, goal.

8. References

- Adhikari, R. (2018). Child Marriage and Physical Violence: Results from a Nationally Representative Study in Nepal. *Journal of Health Promotion*, 6(1), 49–59.
- Center for Research on Environmental Health, Population Activities (CREHPA). (2000). *Women in Prison in Nepal for Abortion. A Study on Implications of Restrictive Abortion Law on Women's Social Status and Health*. CREHPA.
- Constituent Assembly Secretariat, Singha Durbar. (2015). *Constitution of Nepal 2015*. Unofficial Translation by Nepal Law Society, IDEA, UNDP.
- Dahal, P., Joshi, S. K., & Swahnberg, K. (2022). A qualitative study on gender inequality and gender-based violence in Nepal. *BMC Public Health*, 22(1), 2005. <https://doi.org/10.1186/s12889-022-14389-x>
- Dahal, T., Topping, K., & Levy, S. (2023). Patriarchy, gender norms and female student dropout from high schools in Nepal. *Compare: A Journal of Comparative and International Education*, 53(6), 1005–1023. <https://doi.org/10.1080/03057925.2021.1987191>
- Family Health Division. (1998). *Maternal mortality and morbidity study*. Department of Health Services, Ministry of Health.
- Family Welfare Division. (2021). *Safe Abortion Service Program Management Guideline 2021*. Department of Health Services, Ministry of Health and Population.
- Ghosh, A., Singh, A., Chigateri, S., Chopra, D., & Müller, C. (2017). *A Trapeze Act: Balancing Unpaid Care Work and Paid Work by Women in Nepal* (Working Paper 500; IDS Working Paper 500). Institute of Development Studies.
- Government of Nepal, & Center for Research on Environment, Health and Population Activities (CREHPA). (2006). *Comprehensive Abortion Care: National Facility-based Abortion Study*. Government of Nepal, CREHPA and IPAS.
- Kehmová, S. (2023). Towards a total ban on abortion? The factors shaping Polish perception of the right to abortion and reproductive injustice in Poland. *SN Social Sciences*, 3(9), 153. <https://doi.org/10.1007/s43545-023-00742-3>
- Khapung, S. (2020). *A literature review on factors influencing abortion in Nepal* [KIT - Royal Tropical Institute]. <https://bibalex.org/baifa/en/resources/document/476642>
- Lakshmi Dhikta v. Government of Nepal, Writ no. 0757, Nepal Kanoon Patrika (Supreme Court) 2067* (pp. 1551–1579). (2009).
- Ministry of Health. (2002). *National Safe Abortion Policy*. His Majesty's Government, Ministry of Health, Department of Health Services, Family Health Division.
- Ministry of Health and Population. (2022). *Annual Report FY 2021/22*. Department of Health Services, Ministry of Health and Population.
- Puri, M., Singh, S., Sundaram, A., Hussain, R., Tamang, A., & Crowell, M. (2016). Abortion Incidence and Unintended Pregnancy in Nepal. *International Perspectives on Sexual and Reproductive Health*, 42(4), 197–209. <https://doi.org/10.1363/42e2116>
- Regulation on the Right to Safe Motherhood and Reproductive Health, 2077, Government of Nepal, The Ministry of Health and Population (2020).
- Scott, S., Nguyen, P. H., Neupane, S., Pramanik, P., Nanda, P., Bhutta, Z. A., Afsana, K., & Menon, P. (2021). Early marriage and early childbearing in South Asia: Trends, inequalities, and drivers from 2005 to 2018. *Annals of the New York Academy of Sciences*, 1491(1), 60–73. <https://doi.org/10.1111/nyas.14531>

Tamang, J., Khanal, A., Tamang, A., Gaspard, N., Magee, M., Schaaf, M., McGovern, T., & Maistrellis, E. (Directors). (2020, December). *Foreign ideology vs. National priority: Impacts of the US Global Gag Rule on Nepal's sexual and reproductive healthcare system*. (Vol. 28, Issue 3). <https://doi.org/10.1080/26410397.2020.1831717>

Thapa, P. J., Thapa, S., & Shrestha, N. (1992). A hospital-based study of abortion in Nepal. *Studies in Family Planning*, 23(5), 311–318.

Thapa, S. (2004). Abortion law in Nepal: The road to reform. *Reproductive Health Matters*, 12(24 Suppl), 85–94. [https://doi.org/10.1016/s0968-8080\(04\)24006-x](https://doi.org/10.1016/s0968-8080(04)24006-x)

The Right to Safe Motherhood and Reproductive Health Act, 2075 (2018), Act Number 9 of the year 2075 (2018), Law Commission of Nepal, An Act Made to Provide for the Right to Safe Motherhood and Reproductive Health (2018). <https://lawcommission.gov.np/en/wp-content/uploads/2019/07/The-Right-to-Safe-Motherhood-and-Reproductive-Health-Act-2075-2018.pdf>

Upreti, M. (2014). Abortion law reform in Nepal. *International Journal of Gynecology & Obstetrics*, 126, 193–197. <https://doi.org/10.1016/j.ijgo.2014.05.001>

World Health Organization, & Family Welfare Division. (n.d.). *Achieving universal access to sexual and reproductive health and rights in Nepal. 2019-2022*.

World Health Organization and Family Welfare Division, Department of Health Services, Ministry of Health and Population.

Wu, W.-J., Maru, S., Regmi, K., & Basnett, I. (2017). Abortion Care in Nepal, 15 Years after Legalization: Gaps in Access, Equity, and Quality. *Health and Human Rights*, 19(1), 221–230.

Yount, K. M., Durr, R. L., Bergenfeld, I., Clark, C. J., Khan, Z., Lateralra, A., Pokhrel, P., & Sharma, S. (2024). Community Gender Norms and Gender Gaps in Adolescent Agency in Nepal. *Youth & Society*, 56(1), 117–142. <https://doi.org/10.1177/0044118X221140928>

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Figure 1: Key catalysts, contextual enablers and sustaining mechanisms for legislative reforms for safe abortion in Nepal

