Abortion Stigma and its Effect on Women in Nepal
The Status of Abortion Stigma and its Effect on Women in Nepal 2015
About this Study

This baseline study was conducted by Beyond Beijing Committee (BBC) as a part of the activities of the project named "Understanding and Reducing Abortion Stigma in Nepal" which was funded by International Network for the Reduction of the Abortion Discrimination and Stigma (Inroads). The findings of the study contribute to ending abortion stigma in Nepal, which is one of BBC’s objectives in achieving gender equality and human rights of women.

About Beyond Beijing Committee

Beyond Beijing Committee (BBC) is a feminist national network organization committed to achieving gender equality, sustainable development, and women's human rights.

BBC supports local communities, civil society organizations, international non-government organizations, and government organizations to implement the Beijing Declaration, the Platform of Action, CEDAW, CRC, ICPD POA, SDGs, and other human rights instruments in achieving gender equality and the empowerment of women and girls. BBC uses a four-pronged approach to achieve our goals of gender equality, sustainable development, and women’s rights:

a) Policy advocacy: Influence governments and other partners to review existing policies and adopt strategies to achieve greater and better participation of women in development

b) Grass-root advocacy: Build public awareness of the rights of women so that people themselves can take responsibility to collectively advocate for gender equality

c) Program development in partnership: Develop and promote models of based on BPFA’s 12 critical areas of concern through research, education, training and development programs

d) Network and alliances: Build alliances and networks at local, national, regional and international levels to advance agendas in pursuit of human rights for all

With the goal of achieving gender equality and women’s human rights, BBC has, since its establishment, addressed the issue of abortion. As a result of BBC’s and other organizations’ efforts, abortion was legalized in Nepal in 2002. Since 2003, BBC has been implementing Women's Health and Rights Advocacy Partnership (WHRAP) program in Nepal with the support from the Asia-Pacific Research and Resource Center on Women (ARROW) and advocating for safe abortion.

Together with community–based organizations, BBC has been advocating for context-specific, rights–based Continuum of Quality Care (CQC) for women and specifically quality Comprehensive Abortion Care (CAC) in Nepal. BBC has been organizing Community Health Education Sessions (CHES) in the communities to empower women with knowledge and skills on sexual and reproductive health and rights (SRHR) and safe abortion.
Acknowledgement

We would like to thank our CBO partner, Youth Welfare Society (YWS), for the overall coordination of our field work in the study sites by communicating with the WHRAP Focal Persons (FPs) and guiding the Data Collectors (DCs) in collecting the required data for this study. We would also like to offer our sincere thanks to all our key informants and Focus Group Discussion (FGD) participants. We also acknowledge our WHRAP focal persons Kabita Bal of Sarikhet VDC, Jog Maya Lama of Raksirang VDC, Sanu Maya Lama of Bhimphedi VDC, Renu Pudasaine of Manahari VDC, Phul Maya Lama of Bhainse VDC, Radhika Bastola of Nibuwatar VDC, Sarita Basnet of Markhu VDC, Ambika Poudel of Handikhola VDC, Anili Bal of Kulekhani VDC and Kalpana Adhikari of Hetauda Sub-Municipality, Anili Bal- Kulekhani VDC for creating a conducive environment for interviews and FGDs even in the disastrous post-earthquake situation.

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Shanta Laxmi Shrestha
Lead Researcher
Beyond Beijing Committee - Nepal
Abbreviations

BPfA : Beijing Platform for Action  
CAC : Comprehensive Abortion Care  
CRC : Convention on the Rights of the Child  
CEDAW: Convention on the Elimination of all Forms of Discrimination Against Women  
CQC : Continuum of Quality Care  
CHES : Community Health Education Session  
CREHPA: Center for Research on Environment Health and Population Activities  
DC : Data Collector  
DoHS : Department of Health Services  
FCHV : Female Community Health Volunteer  
FGD : Focus Group Discussion  
FP : Focal Person  
FPAN : Family Planning Association of Nepal  
GDI : Gender Development Index  
HDI : Human Development Index  
HSP : Health Service Provider  
ICPD : International Conference on Population and Development  
KII : Key Informant Interview  
MA : Medical Abortion  
MoHP : Ministry of Health and Population  
MVA : Manual Vacuum Abortion  
NI : Number of Informants  
NR : Number of Responses  
PAW : Post Abortive Woman  
PHCC : Primary Health Care Centre  
POA : Plan of Action  
RH : Reproductive Health  
RL : Religious Leader  
SA : Safe Abortion  
SAS : Safe Abortion Service  
SDGs : Sustainable Development Goals  
SPAW : Spouse of Post Abortive Woman  
SRHR : Sexual and Reproductive Health and Rights  
SMDC : Sub-Municipality Development Committee  
VDC : Village Development Committee  
WHRAP: Women’s Health and Rights Advocacy Partnership  
WFP : WHRAP focal person  
YWS : Youth Welfare Society
Executive Summary

It has been more than a decade since abortion was legalized in Nepal. In the government budget for fiscal year 2015/16, free abortion services in public health facilities was announced. Despite the legalization of abortion and availability of services in all government institutes like Primary Health Care, Health post and Sub health post in all 75 districts, women in need of this service are yet to achieve it. A lack of safe options results in range of negative consequences.

One of the main reasons that women cannot access safe abortion services is stigmatization. Thus, a preliminary baseline study was conducted within the project "Understanding and Reducing Abortion Stigma in Nepal". The study is a complement to the Women Health Rights Advocacy Partnership (WHRAP) program’s Community Health Education Session (CHES) in Makwanpur district and it further contributes to BBC’s work of reducing abortion stigma in Nepal.

This study aims to understand prevailing abortion stigma in Nepal, its causes and consequences, and to map the support services in communities that exist to reduce stigma and enable women to access safe abortion services. This study was conducted in nine VDCs and one sub-municipality of Makwanpur district using Key Informant Interviews (KII) and Focus Group Discussions (FGD) tools to collect data from purposively-selected informants of the Women Health Rights Advocacy Partnership program sites in Makwanpur, Nepal. A total of 40 key informants and 107 FGD participants partook in the study. Data were collected and analyzed in four major thematic areas: a) knowledge of abortion, b) abortion stigma, c) causes and consequences of abortion stigma, and d) support and services aiming to eliminate abortion stigma in a community.

Key findings

- All the respondents were familiar with the term abortion, called ‘garvapatan’ in the Nepali language. However, the majority thought it means disposing of a baby (bachha falnu), wasting a pregnancy (garva khera janu), killing a fetus (bhruna
hatya), or removing an immature fetus (aparipakwa bhruna nikanlu), and did not
distinguish between induced and spontaneous abortion (miscarriage).
• The majority of respondents were aware of some of the legal criteria for
abortion, Safe Abortion Service (SAS), and the abortion service centers that exist in
Makwanpur, but only few of the respondents knew all the criteria and conditions.
• Due to fear of disparagement women do not obtain SAS.
• Most informants think that abortion can be a good choice in case of an unwanted
pregnancy.
• The community has a negative attitude and behavior towards post-abortive
women (PAW) and others associated with abortion. PAWs are labeled as: sinner
(papini), ill-luck (alichhini), murderer (jyanmaara), and fetus killer (garbhaghati).
They are humiliated, isolated, insulted, and excluded from religious rites.
• Post Abortive Women are stigmatized most but Abortion service providers (ASPs)
and spouses of PAWs (SPAW) are also stigmatized in varying degree.
• Root causes of abortion stigma are based in the Hindu belief system which
classifies abortion as a sinful and immoral act. The lack of scientific knowledge,
prevalence of health myths, and a male-dominated society that wishes to control
women likewise play an important role in creating abortion stigma.
• Due to stigma, women either seek an unsafe abortion, or continue their pregnancy
and give birth against their will, or face negative treatment by a community that
results in implications for a woman’s health, social life and economic status.
• External support and service to PAWs addressing abortion stigma is almost
non-existent locally. All community organizations, including ASPs, lack skills and
knowledge to address abortion stigma. PAWs struggle to resist stigma by tolerating
stigmatizing comments, visiting their natal home after having an abortion, and
lying that they having a monthly period.

Recommendations

For integrating abortion stigma into ongoing WHRAP program
• Equip women with adequate scientific knowledge about their own body, RH rights,
abortion and stigma to eliminate self stigma.
• Organize/strengthen women’s groups to act against ‘abortion stigma’.
• Raise voice about abortion stigma and demand to end it.
• Produce simple IEC materials on abortion in a non-stigmatized language.
• Sensitize district line agencies, Religious Leaders and other local groups on
abortion stigma as an important social, educational and political issue that should be addressed in an integrated manner.

- Educate the community that abortion is a women’s choice and a last resort to end their unwanted/unintended pregnancy before the fetus is viable.

**For advocacy to reduce abortion stigma in Nepal:**

- Advocate that accurate, scientific-based information and knowledge about abortion is incorporated into the educational curriculum to de-mystify abortion, challenge myths and enable the youth to make informed choice in a responsible manner.
- Provide technical guidance to produce IEC materials on safe abortion in a non-stigmatizing language.
- Lobby to include ‘ending the abortion stigma’ as a measure in the National safe abortion implementation guide.
- Lobby to integrate the concept of abortion stigma into the Reproductive Health Components to educate all health professionals/workers - particularly FCHVs – on how to reduce the stigma.
- Sensitize religious leaders and elderly citizens not to perpetuate the traditional notion of abortion and the discriminatory behaviors they practice.
- Lobby and advocate enacting an act against ‘Stigmatization/discrimination against abortive women’ like the act on cast discrimination in Nepal.
- Build the national network to raise issue of abortion stigma in Nepal.
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Chapter 1: Introduction

The introduction discusses the context and rationale for the study. It also presents a brief historical overview of abortion from legalization to free services. It further presents the objectives of the project and of the study. Finally, it describes the structure of this report.

1.1 Context

Nepal is a multiethnic, multicultural, multilingual, sovereign Federal Democratic Republic with diverse topography, ranging from the high snow-clad mountains, through the hills to the subtropical plains of the Terai. Its topography, economy, patriarchal society, and unstable political situation exacerbate health conditions of the people, particularly Nepali women. Even though reproductive health and rights have been enshrined in the constitution of Nepal since 2007 and the government has implemented various programs, the status of the sexual and reproductive health situation is still bleak, especially in the rural areas of Nepal where the majority of women live (Table 1).

Maternal Mortality Ratio (MMR), a typical indicator of reproductive health, was 170 per 100,000 live births in Nepal in 2013 (NPC & UN Country Team Nepal, 2013), higher than the average of 75 per 100,000 live births in the East Asia and Pacific (EAP) region.

In Nepal, unsafe abortion is still one of the major causes of maternal death. About 8% of all pregnancies in Nepal end in abortion (MoHP et.al, 2012). According to an annual report, a total

**Table 1. Some facts and figures**

<table>
<thead>
<tr>
<th>Fact and Figure</th>
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<tbody>
<tr>
<td>67% of births in rural areas happen in homes.</td>
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<tr>
<td>23% women birthed their first child by age 18 and 2% by age 15.</td>
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<td>Women in the poorest households have more than twice as many children as women in the wealthiest households (4.1 versus 1.5 children per woman).</td>
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<td>Eighteen percent of women age 25-49 in Nepal are married by age 15, and more than half (55%) by age 18.</td>
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<td>About half of women and one-quarter of men age 25-49 had their first sexual intercourse by the age of 18.</td>
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<tr>
<td>27% of married women have an unmet need for family planning-10% for spacing and 17% for limiting the number of children.</td>
</tr>
<tr>
<td>Only 38% of women know that abortion is legal in Nepal.</td>
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<tr>
<td>Almost one-third (32%) of ever-married women have suffered from spousal or partner abuse at some point in time, whether physical, emotional, or sexual.</td>
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Source: (National Demographic Health Survey, Ministry of Health & Population, 2012)
of 90,468 comprehensive abortion care (CAC) services were provided in fiscal year 2013/14 in Nepal. Of these, 984 CAC services were provided in Makwanpur. (DoHS, 2015). Despite this prevalence, abortion carries a social stigma that can affect anyone associated with abortion, including patients, their partners, providers, and researchers (Norris, et al., 2011).

1.2 Status of Abortion Laws in Nepal

Nepal has come a long way in its legalization of abortion services (see Table 2). Currently, the abortion law under the 12th amendment of the National Civil Code allows women to terminate their pregnancy under the following conditions: pregnancies of 12 weeks gestation or less for any woman by her own decision; pregnancies of 18 weeks gestation if the pregnancy is a result of rape or incest; and pregnancies of any duration with the recommendation of an authorized medical practitioner if the life of the mother is at risk, if her physical or mental health is at risk, or if the fetus is deformed (MoHP et.al, 2012).

According to Nepal’s law, comprehensive abortion care (CAC) is to be safe, accessible, and affordable, and is to be available with equity and equality for all women belonging to different social and economic groups. In addition, only doctors and health workers who are specially trained on safe abortion care can provide these services. However, the law prohibits abortions conducted without the consent of the woman, sex-selective abortions, and abortions performed outside the legally permissible criteria (MoHP et.al, 2012).

### Table 2. History of Abortion Legalization and Service Provision in Nepal

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>2002</td>
<td>Abortion legalization</td>
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<td>2003</td>
<td>Procedural order and National Safe Abortion Policy</td>
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<tr>
<td>2004</td>
<td>National standards, protocol, guidelines, training materials and training centers; first SAS in Maternity Hospital</td>
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<tr>
<td>2007</td>
<td>Introduction of CAC by nurses</td>
</tr>
<tr>
<td>2008</td>
<td>Introduction of second trimester services</td>
</tr>
<tr>
<td>2009</td>
<td>National MA scale-up strategy</td>
</tr>
<tr>
<td>2011</td>
<td>National SAS implementation guideline</td>
</tr>
<tr>
<td>2015</td>
<td>Announcement of free services by GON</td>
</tr>
</tbody>
</table>

Source: Presentation by Dr. Chaudhary, Director, Family Health Division, MOHP on 25th September, 2015, the first Safe Abortion Day celebration.
The liberalization of the law led to the formulation of the National Safe Abortion Policy in 2003. This does not guarantee access to safe and affordable abortion services to women without discrimination. The Government issued a Safe Abortion Service Procedure and began providing comprehensive abortion care (CAC) services from March 2004. CAC includes safe, high-quality abortion, post abortion care, family planning and other sexual or reproductive health services.

There are 776 registered service provision sites covering all 75 districts of the country (MOHP et.al, 2012). However, a study found that the number of abortions performed by unregistered providers in 2008 was likely equal to those done by registered providers (Sedgh et al., 2011). Hence, it is likely that an estimated 100,000 unregistered, unsafe abortions were undertaken in Nepal in 2008 (Hald and Sondergaard, 2013).

The Government has trained more than 2,245 health care providers in SA care by 2014; women are provided SA care services and post-abortion contraception. Medical abortions and other services were also introduced progressively as shown in the Table 2. In fiscal year 2013/14, 90,468 CAC services (MVA and MA) alone were provided from 776 listed sites, of which 984 CAC services were provided in Makwanpur district (DoHS, 2015).

The legal provisions for abortion currently reside in the chapter on life in the National Civil Code (Muluki Ain) even after its 11th amendment in 2002. Punishments for crimes against human life such as murder are also found in this section, implicitly identifying abortion as a crime akin to murder. Currently, Abortion is punishable on the following two conditions: 1) sex selective abortion, and 2) abortion without the consent of the pregnant woman (MoHP et. al, 2006).

The Supreme Court of Nepal ruled that the government must guarantee access to safe and affordable abortion services in the landmark case of Lakshmi Dhkita vs. Nepal Government. The Supreme Court states that legal provisions of abortion must be contained in a separate law and disassociated from the discussion of murder. On May 20th 2009, the Supreme Court directed the government – specifically the Office of the Prime Minister and the Cabinet, the Ministry of Health and Population, the Ministry of Law, Justice and Constituent Assembly Affairs, and the Ministry of Women, Children, and Social Welfare - to enact a comprehensive law and to take several necessary measures to guarantee women’s right to SAS.
A draft bill entitled ‘Bill for making provision of Safe Abortion Service’ has been tabled and is under discussion at the Ministry of Population and Health. On July 14th 2015, Honorable Ram Sharan Mahat, Finance Minister, announced at the parliamentary budget speech for FY 2015/16. “Abortion services at government-run health institutions will be free.”

1.3 Rationale of Study

Though the percentage of unintended pregnancies is declining (Figure 1) from 37% in 1996 to 25% in 2011, the work to increase access to SAS and reduce unsafe abortion practices by women, especially in rural areas, is a major challenge in Nepal. The legality of safe abortion and availability of services do not guarantee that all women with unintended pregnancies will have access to SAS. Only 38% women know that abortion is legal in Nepal. Knowledge is very low among people with no education (20%) and within the lowest wealth quintile (22%). One-fourth of pregnancies (25%) are still unintended in Nepal (Figure 1, MoHP et.al., 2012). However, because abortion is seen as a “sinful act” that leads to a public loss of prestige (Puri et.al. 2007), most couples continue unwanted pregnancies rather than using available SAS.

Nepal is a religious country in which about 80% of the population is Hindu. The Hindu beliefs affect private and public life and restrict women from enjoying their rights over their own bodies and minds. It cultivates the notion that women’s bodies are impure and unclean during menstruation, birth, and the postpartum period. The Hindu religious beliefs also indoctrinate that ‘abortion is akin to killing’ and is therefore a sinful act. According to the Manusmriti (ancient Hindu Law Book), consumption of any food item touched or served by a woman who has had an abortion is considered a sin.

The concept of abortion as a ‘sin’ contributes to abortion stigma in the society of Nepal even today (MoHP, et.al, 2006). The term ‘feticide’ (killing a fetus) is still retained in the 11th amendment of the civil code. Such stigmatizing language associated with abortion affects anyone associated with abortions, including patients, their partners,
providers, advocates, and researchers (Norris, et.al. 2011). Women who cannot access SAS instead have clandestine, risky procedures and then avoid seeking treatment for complications due to the stigma and fear of disparagement from the community (Ipas, 2015). Thus, it is imperative to eliminate abortion stigma so as to enable women to get quality Comprehensive Abortion Care (CAC) services while they are in dire need as a last resort. To begin, it is essential to understand the current status of abortion stigma.

Hither to in Nepal, no study has been conducted on abortion stigma. Thus, this study is being conducted prior to the start of interventions within ongoing WHRAP program areas of Makwanpur district. Based on the findings of this study, appropriate Community Health Education Sessions (CHES) will be designed to reduce abortion stigma.

1.4 Objectives of the Baseline Study
The overall objective of the baseline study is to find out the status of abortion stigma and its effect on women. The specific objectives are:

- To assess knowledge about abortion
- To identify the individual attributes and scale of abortion stigma
- To identify the causes and consequences of abortion stigma within communities
- To identify the prevailing services, support, and the ways to address abortion stigma
- To assess the skills of women and health providers to resist stigma
Chapter 2: Methodology

This chapter describes the overall study design and process, the study coverage, the data collection methods and tools, the informants, and data management and analysis techniques. It further discusses ethical considerations of the study, limitations, and challenges.

2.1 Study Design

The study is designed to achieve its objectives. The ‘Diagram A’ given in next page summarizes the overall study design.

As shown in diagram A, the study began with a consultation meeting with the partner and program staff. Relevant documents such as the project proposal, Inroads documents, the Nepal abortion country profile, and others were studied. The literature review proved to justify the rationale of the study, as there had been no previous study undertaken on abortion stigma in Nepal.

After the document review, researchers consulted the YWS and paid an informal visit to initial VDCs to listen to the views of WHRAP Focal Persons (WFPs) and Female Community Health Volunteers (FCHVs) on Abortion Stigma (AS), and the possibilities of finding required informants from all specified groups. Since ‘Abortion Stigma’ is a concealed, special gender issue we decided to collect data from key informants. After confirming that the required number of informants was available for the study and gathering initial viewpoints on AS through informal listening surveys, we developed tools for data collection. The training of the study team and the Data Collectors (DCs) was thereafter organized in Makwanpur district.

The training was organized at the Avocado Hotel in Hetauda, Makwanpur, from the 10th to 12th of June 2015. Training emphasized data collection procedures and guidelines and included a pre-testing of the questionnaire and FGD guidelines for four (two female and two male) experienced data collectors, YWS Focal Persons, and other staff. The DCs were selected by YWS. The training included a presentation of the objectives, process, methodology and tools of the study and covered the necessary skills needed to conduct the study, including interview and facilitation techniques. The research tools were pre-tested amongst women of Hadikhola VDC and Hetauda Municipality.

After finalizing tools, the field work began. The WFPs stationed in every site were oriented about the study and the criteria for selecting the informants for interviews and FGDs. Each WFP provided a list of potential key informants to YWS for further identifying the required number for both KIIIs and FGDs. FGDs consisting
of different types of informants were conducted in different sites based on the availability of informants. WFPs in each site ensured a conducive environment for data collection. Female DCs collected data from female informants and male DCs collected data from male informants. Teams of two were involved in collecting data at each site: one served as note taker and the other an interviewer.

Diagram A: Research design and flow chart
2.2 Study Sites and Population
The baseline study was carried out in 9 VDCs and 1 Hetauda, Sub-Metropolitan City of Makwanpur District in the central region of Nepal. The district has a population of 420,477, out of which 213,766 are in of reproductive age (CBS, 2011). The human development and gender equality both are low in this district. The Human Development Index of this district is 0.31 and Gender Development Index is 0.23. Topographically, Makwanpur includes both hill (Pahaad) and plain (Terai) areas. Most residents are engaged in agriculture and the ethnic composition is mixed: of at least 15 ethnic identities, the largest group is Tamang, a predominantly Buddhist Tibeto-Burman group.

In terms of health facilities, there is a District Hospital located in the district headquarter, Hetauda. Maternity services at this hospital are of limited quality, without a caesarean section facility. Perinatal health care services are provided by health personnel from Sub-Health Posts or Health Posts at the VDC level, as well as by Primary Health Centers and the District Hospital. Traditional Birth Attendants (TBAs) are available in all localities.

Safe abortion services (SAS) are available at the District Hospital and private sites run by Sunaulo Bhavisya, Marie Stopes Center, and FPAN in Hetauda. PHCCs of Bhimphedi, Palung, Chhattiwan and Manahari are also listed as providing abortion services, but due to a lack of human resources and facilities, they are not providing the promised SAS.

Makwanpur district consists of 35 VDCs, one Municipal Development Committee, and one sub-metropolitan city committee. The WHRAP’s project WFPs selected informants purposively from their working VDCs and a sub-metropolitan city committee to collect data for this study based on the following criteria: a local person or working in the community being studied; knowledgeable about women’s health situation in the communities; willingness to respond; and willing to give consent to include information with anonymity. Details about the study site coverage, key informants and FGD participants are given in Table 3.
As shown in the table 3, five different types of informants were selected: 1) PAW from married women’s groups; 2) SPAW from PAWs’ spouses, 3) RLs from Dhami Jhakri (those who are believed to conduct black magic), and Pandits (those who perform the rituals for Hindus) and 4) HSP from Health Personnel individuals, including Senior Auxiliary Health Workers, Auxiliary Nurse Midwives, Health Assistants, and Senior Health Assistant Officers and 5) Male and female youth in the age 20-30.

2.3 Data Collection Methods and Tools
This study used document review, Key Informant Interviews (KII), and Focus Group Discussions (FGD) as the major data collection methods. To collect qualitative and quantitative data questionnaires and FGD guidelines were developed. Table 4 summarizes the data collection methods, tools, informants, and topics covered.
2.3.1 Document Review
Documents were collected from websites, libraries and relevant agencies and persons, and reviewed to understand the concept of abortion stigma, and explore studies conducted on abortion in Nepal, and tools and techniques of abortion studies.

2.3.2 KII Questionnaire
A set of interview questionnaires for key informants was developed and administered in Nepali based on the objectives of the study, the document review, and information gathered during the listening survey in the study sites. The questionnaire was revised after training in the district and then pre-tested with a group of women and FCHVs. This pre-testing and revision cycle helped ensure the appropriateness and flow of the survey language.

The questionnaire consisted of both closed-ended multiple choice questions (Group A) and open-ended guiding questions (Group B) for KII. The ‘Group A’ questions helped to generate quantitative data on: 1) knowledge of abortion and SAS; 2) knowledge of abortion stigma and its attributes; and 3) the scale of abortion stigma. The responses were recorded in the questionnaires by coding them as per preset guidelines. Group B questions consisted of open-ended questions to generate qualitative data on: 1) the

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<table>
<thead>
<tr>
<th>Methods used</th>
<th>Tools used</th>
<th>Informants</th>
<th>Topics covered</th>
</tr>
</thead>
</table>
| Key Informant Interview (KII) | Questionnaire | PAW SPAW RL HP                                  | 1) Knowledge on abortion and safe abortion services  
2) Individual attitudes toward abortion stigma  
3) Measure of abortion stigma  
4) Causes and consequences of abortion stigma  
5) Existing services and support to eliminate abortion stigma  
6) Prevailing skills of women and service providers to resist abortion stigma |
| Focus Group Discussion (FGD) | FGD Guiding questions | PAW SPAW RL FY MY                                 | 1) Knowledge on abortion  
2) Individual attitudes toward the abortion stigma  
3) Measure of abortion stigma  
4) Causes and consequences of abortion stigma  
5) Existing services and support to eliminate abortion stigma  
6) Prevailing skills of women and service providers to resist abortion stigma |
causes and consequences of the abortion stigma; 2) the existing services and support to eliminate the abortion stigma; and 3) the prevailing skills of women to resist abortion stigma. This questionnaire was administered among 40 key informants in four groups from 10 sites.

Interviews with different groups were held in different places. The interviews with the Health Personnel were held at health facilities. Religious leaders and SPAW interviews were conducted either at their homes or in local places where privacy was possible. Interviews with PAW were conducted at the homes of the WFPs for the participants’ comfort.

2.3.3 Focus Group Discussions (FGDs)
The purpose of FGD was to triangulate information derived from KIIIs and to gather qualitative information. A set of guiding questions were developed to conduct FGDs. Facilitators were trained in introducing topics with the use of models for telling stories related to women’s reproductive health and abortion. FGDs were conducted at meeting halls of cooperatives, health centers, VDC offices, school halls, temporary learning centers and temporary shelters (tents) of health centers.

2.4 Data Collection, Management and Analysis
The four trained interviewers (2 male and 2 female) collected data in July and August 2015 under the supervision of the YWS Focal Person and BBC’s Project Officer. The supervisors ensured informed consent, confidentiality, and privacy of the subjects. After obtaining informed verbal consent to participate in the study to record the conversation as well as to take photographs during the KII, the female interviewers conducted face-to-face interviews of approximately one hour each with the female KII participants. The male interviewers conducted interviews with the male KII participants. Similarly, the female interviewers facilitated FGDs of PAWs and FYs while the male interviewers facilitated the FGDs of SPAW, MY and religious leaders (all male). The length of FGDs was about two to 2.5 hours. Note-takers recorded observations and responses in both KIIIs and FGDs. To ensure the quality of methodology and resulting data, supervisors oversaw the interview setting, reviewed completed questionnaires, and made recommendations to the interviewers. The data management and analysis undertaken was as follows:

- Close-ended interview data were noted on interview questionnaires and open-ended data were noted in a book and also recorded. FGD data was recorded as well as noted in a separate notebook. Data entry began immediately after data collection was complete.
- Quantitative data were coded, verified, and entered into Microsoft Excel for analysis.
• Qualitative data was first transcribed from the audio records, then typed and grouped into thematic sections.
• Data were categorized by studying each group’s and each key informant’s response thematically and analyzed to draw findings. This analysis was supplemented with information from the literature review wherever possible.
• Based on the analysis, findings and recommendations were developed under each objective.

2.5 Ethical Considerations
Ethical standards were established and maintained throughout the study. Before all interactions, participants were informed about the study’s objectives, the use of the findings, and expectations of the participant. Only participants those who gave consent were included in the study. Names of the informants have not been used in this report for confidentiality. Photos and audio recordings were taken only with consent with the participants. In interviews with health personnel, approval for conducting interviews was obtained from the District Public Health Office in Makwanpur.

2.6 Limitations and Challenges
This study deals exclusively with experiences and perceptions of abortion and abortion stigma in 9 VDCs and a Sub-Metropolitan City of Makwanpur also the WHRAP project’s sites. It does not deal with the technical, medical aspects of abortion. Participants were not chosen randomly and results are not statistically representative of a wider population. The study was conducted amidst financial and human capacity constraints.

The study team faced many challenges. The subject of the study, ‘The Status of Abortion Stigma and its Effect on Women,’ is contentious, especially in the context of Nepal. Identifying key informants familiar with abortion issue was challenging, as was facilitating open dialogue about this topic. Further, the devastating earthquake of April 2015 and subsequent aftershocks, monsoon rains of 2015, unstable political situation, strikes, and a Nepal-India border blockade created logistical constraints.
Chapter 3: Socio-Demographic Characteristics of Informants

This study was carried out with 107 participants in 9 VDCs (Markhu, Kulekhani, Manahari, and Bhimphedi, Handikhola, Raksirang, Sarikhet, Nibuwatar, Bhaise) and a sub-metropolitan city Hetauda. Participant demographics, including age, sex, marital status, caste and ethnic (CE) group, religion, education and occupations, are given in the table below.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>KII</th>
<th></th>
<th>FGD</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-39</td>
<td>22</td>
<td>55</td>
<td>73</td>
<td>69</td>
</tr>
<tr>
<td>40-64</td>
<td>11</td>
<td>28</td>
<td>34</td>
<td>31</td>
</tr>
<tr>
<td>65 and above</td>
<td>7</td>
<td>17</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>15</td>
<td>38</td>
<td>70</td>
<td>65</td>
</tr>
<tr>
<td>Male</td>
<td>25</td>
<td>63</td>
<td>37</td>
<td>35</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>40</td>
<td>100</td>
<td>104</td>
<td>97</td>
</tr>
<tr>
<td>Unmarried</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>Caste</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brahmin</td>
<td>20</td>
<td>50</td>
<td>29</td>
<td>27</td>
</tr>
<tr>
<td>Tamang</td>
<td>12</td>
<td>30</td>
<td>40</td>
<td>37</td>
</tr>
<tr>
<td>Chhetri</td>
<td>3</td>
<td>8</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>Other : Newar, Magar, Chepang and Dalit</td>
<td>5</td>
<td>13</td>
<td>22</td>
<td>21</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hinduism</td>
<td>26</td>
<td>65</td>
<td>59</td>
<td>55</td>
</tr>
<tr>
<td>Buddhism</td>
<td>11</td>
<td>28</td>
<td>42</td>
<td>39</td>
</tr>
<tr>
<td>Christianity</td>
<td>3</td>
<td>8</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Literate</td>
<td>14</td>
<td>35</td>
<td>51</td>
<td>48</td>
</tr>
<tr>
<td>Primary</td>
<td>5</td>
<td>13</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Lower Secondary</td>
<td>1</td>
<td>3</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>Secondary</td>
<td>5</td>
<td>13</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>Higher Secondary</td>
<td>11</td>
<td>28</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Bachelor</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Master</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agriculture</td>
<td>24</td>
<td>60</td>
<td>89</td>
<td>83</td>
</tr>
<tr>
<td>Health</td>
<td>10</td>
<td>25</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Business</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Teaching</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>House wife</td>
<td>4</td>
<td>10</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Student</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>
The table 5 shows that the age of informants ranged from 15 to 65 years. A majority of KII and FGD participants were under age 40; only 17% of informants were age 65 and above. All KII and 97% of FGD participants were married.

The majority of respondents were upper caste Brahmins (50% of KII and 27% of FGD participants), followed by the Janajati ethnic group of Tamang. Other CE groups represented were Chhetri (upper caste), Newar, Magar, Chepang, and Dalit. The majority of respondents were Hindu, followed by Buddhists; a small number were Christian.

The majority of respondents made a living in agriculture. A small amount of respondents were engaged in business, teaching, learning (students), and domestic work (housewives).
4.1 Knowledge on Abortion and Safe Abortion Services

This chapter summarizes participants’ perceptions of abortion, knowledge of the legality of abortion in Nepal, SAS, service centers, reasons for not obtaining SAS, and whether abortion is a choice in case of unwanted pregnancy.

4.1.1 Perceptions of Abortion

The informants were familiar with the term “abortion,” without making distinction between induced and spontaneous abortions. For a majority, abortion meant “disposing of a baby” (bachha phalnu), followed by “wasting pregnancy” (garva khera janu), “killing a fetus” (bhruna hatya) and “removing a fetus” (aparipakwa bhrun nikanlu). Only 3% said they did not know what abortion was (figure 3).

All participants except a few youth considered abortion to mean “disposing of” or “killing a baby.” A few male and female youth participants referred to abortion as “termination of pregnancy.”

4.1.2 Knowledge Abortion Law

When informants were asked whether abortion is legalized in Nepal, 60% informants (PAWs and few SPAWs and RLs) said ‘yes’ and 3% said ‘no’ and 37% ‘do not know’. However, the informants who knew that abortion is legal did not have complete knowledge about legal criteria (table 5).

Of the total Informants who knew abortion is legal, only 33% of knew that women can have an abortion within 12 weeks of the gestational period. Similarly, 28% of informants knew the criteria of 18 weeks of gestational period in cases of rape or incest. Smaller percentages of informants knew that women can have abortion at any gestational period if the pregnancy is harmful for the mother’s life, if the fetus is severely...
debilitated or fatally deformed, and if the pregnancy is harmful to mother’s physical and mental health. The FGD also revealed that most women were aware of the legal status of abortion. However, they did not know the specific legal criteria except that abortion is legal in the first 12 weeks of the gestational period with the consent of the woman. The majority of male FGD participants was unaware of the legal criteria for abortion, and expressed the opinion that they do not need to know since abortion is the concern of women.

A SPAW informant from Manahari VDC shared, “I have no idea regarding abortion or its legal aspects. I was not involved at all while my wife had an abortion so I do not know about it.” The RLs were also unaware about the legal criteria, but they knew that the practice of aborting using traditional methods is illegal. A few of them shared that they do utilize traditional methods of abortion using locally available herbs even though they know it is illegal to do so.

4.1.3 Knowledge on Safe Abortion Criteria and Safe Abortion Services (SAS).

Table 7 shows that only 8% of the informants had full knowledge of all safe abortion criteria. The rest of the informants knew about one or more individual criteria, while 13% had no knowledge about any SAS criteria.

Table 7 also indicates that 75% of informants knew the government run District Hospital in Hetauda is a SAS provider. Over half of the informants knew of Sunaulo Bhavisya, and various numbers of informants knew of other facilities. However, they thought that privately run centers, such as Sunaulo Bhavisya, are more reliable than the public hospital and health centers. Ten percent of informants responded that they do not know about safe abortion service centers.

**Table 6. Knowledge on Legal Abortion Criteria**

<table>
<thead>
<tr>
<th>Criteria of Abortion Law</th>
<th>NR = 25</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) 12 weeks of gestational period in any condition with the consent of the woman</td>
<td>6</td>
<td>33</td>
</tr>
<tr>
<td>b) 18 weeks of pregnancy in case of incest</td>
<td>5</td>
<td>28</td>
</tr>
<tr>
<td>c) 18 weeks of pregnancy in case of rape</td>
<td>5</td>
<td>28</td>
</tr>
<tr>
<td>d) At any gestational period if the pregnancy is harmful for the mother's life</td>
<td>4</td>
<td>22</td>
</tr>
<tr>
<td>e) At any gestational period if the fetus is severely debilitated or fatal deformed</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>f) At any gestational period if the pregnancy is harmful to mother's physical and mental health</td>
<td>2</td>
<td>12</td>
</tr>
</tbody>
</table>
The FGD also revealed that majority of informants including women have no knowledge of the criteria of safe abortion. They expressed that abortion can be considered safe only if the services are provided without harming women’s health, regardless of the type of procedure (medical or traditional). Most RLs believed that traditional methods (the use of herbs) were safe. Most of the male youth are aware that abortion should only be done at recognized health centers though they are unaware of safe abortion criteria. The majority of FGD participants including women did not recognize the need of women’s consent as a criterion of safe abortion.

### 4.1.4 Reasons for not obtaining SAS

When asked why women do not obtain SAS, the main reason offered was the fear of disparagement by the community.

<table>
<thead>
<tr>
<th>Criteria of Safe Abortion (NI= 40 Multiple responses)</th>
<th>NR=92</th>
<th>%</th>
<th>Known SAS centers (NI=40 Multiple responses)</th>
<th>NR=108</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) With the consent of women</td>
<td>24</td>
<td>60</td>
<td>a) District Hospital, Hetauda</td>
<td>30</td>
<td>75</td>
</tr>
<tr>
<td>b) Service by trained personnel at registered health facility</td>
<td>20</td>
<td>50</td>
<td>b) Sunaulo Bhavisya</td>
<td>21</td>
<td>53</td>
</tr>
<tr>
<td>c) Without any harm to the pregnant woman</td>
<td>15</td>
<td>38</td>
<td>c) Primary Health Care Center</td>
<td>17</td>
<td>43</td>
</tr>
<tr>
<td>d) Under the legal circumstances</td>
<td>17</td>
<td>42</td>
<td>d) Health facilities with logo</td>
<td>12</td>
<td>30</td>
</tr>
<tr>
<td>e) With the standard level of clinical procedure</td>
<td>8</td>
<td>20</td>
<td>e) Marie Stopes</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td>f) All of the above</td>
<td>3</td>
<td>8</td>
<td>f) Health Post</td>
<td>7</td>
<td>18</td>
</tr>
<tr>
<td>g) Do not know any criteria</td>
<td>5</td>
<td>13</td>
<td>g) FPAN</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>h) Others (Ayurvedic at Bharatpur)</td>
<td>2</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Do not know any SAS centers</td>
<td>4</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In FGDs, the majority of PAW expressed disparagement from the community being the major reason of not seeking SAS. They said that community considers abortion as a sin and is something wrong to do it. PAWs shared that they feel obliged to give birth against their will or go for unsafe abortion.

Religious leaders believed that women believe abortion is against religion so they do not seek SAS even in the crucial circumstances. “Being pregnant is lucky and a blessing and should not ignore it by aborting in any circumstances” said one of the Religious leaders.

Most of the male and female youth believed that lack of knowledge on abortion and various social barriers are the reasons that women do not seek SAS.

4.1.5 Is Abortion a Good Choice in Unwanted Pregnancies?
All the KII informants including some RLs opined that abortion is a correct choice in the case of unwanted pregnancy (figure 6). 70% RL opined ‘No’ and 10% opined ‘Do not know’.

In the FDGs too, PAWs opined that abortion is a good choice for any unintended pregnancy. But, SPAWs opined that abortion is a good choice only for married women in crucial

![Figure 5. Reasons for women not obtaining SAS](image-url)
circumstances. A few SPAW even expressed that an abortion could risk women’s life, so having a child is a better option than having an abortion because of the health risks to the mother. Religious leaders in FGDs expressed that abortion brings malignancy (bikriti) to society and should not be an option.

4.2 Abortion Stigma
This section presents a picture of abortion stigma and its characterization by the community, i.e., attitudes toward PAWs and Abortion Service Providers (ASPs) and blames associated with abortion. It also presents a degree of stigma prevailing in the communities.

4.2.1 Attitude of community towards abortion, PAW and ASPs
All the informants were asked about the attitude of their community towards abortion. Majority of informants (92%) including HSP think that their communities have a negative attitude towards abortion. No informant responded that communities have positive attitude towards abortion. PAWs and ASPs responded that they do not know (figure 7).

FGD participants also thought that community attitudes about abortion was negative. A few opined that a community considers abortion acceptable if a woman’s spouse supports her.

All the Informants were asked about the labels given by the community
towards PAW and ASPs. As shown in the Figure 8, the informants expressed that communities label PAWs and ASPs as sinner, ill luck, murderer, wicked, fetus destroyer, and characterless.

PAWs were labeled more negatively than the ASPs.

In FGD, PAW shared that they were labeled as a sinner, murderer and baifale (woman with multiple sexual partners besides her spouse), especially by their mother-in-laws and elderly people of the community.

Other informants expressed that ‘abortion’ itself is conceived as negative, thus it is obvious to have negative attitude towards PAW and hence label them as sinner, murderer or baifale.

A few SPAW expressed that they also had been labeled as joitingrey (husband who does what his wife says). Most female youth expressed that females, regardless of their marital status, are taunted and labeled as over-smart or baifale if they talk about SRHR, especially abortion.

Most FGD participants expressed that though there are not positive attitudes towards ASPs as to other health service providers, they were not publicly labeled.

**Case Study 1: Sapan**a

Sapan is a married, literate woman whose husband works in the army. She got pregnant while her husband was at home during his vacation, but she was not willing to continue her pregnancy as she thought it would be very difficult for her to rear the child without her husband’s regular presence and support at home. Knowing her husband and her family would not support her desire to have an abortion, she sought counseling from the local health service provider. As suggested by the health service provider, she had a medical abortion without telling her husband and family. When Sapan’s mother-in-law came to know about her abortion, the mother-in-law became so furious that she called her son to inform him about Sapan’s abortion. She blamed Sapan for being characterless and accused her of terminating a pregnancy that was from “another person,” implying that Sapan had an extramarital affair. Sapan felt humiliated. Her husband disagreed with her decision to abort the pregnancy and a family conflict erupted. Now there is a bitter relationship between Sapan and her husband, and he is seeking to marry someone else.
4.2.2 Behavior of the community towards People Associated with Abortion

Both KII and FGD findings and Case Study 1 clearly indicate that behavior towards PAW were negative.

The figure 9 indicates that communities behave PAWs badly. They are humiliated, excluded in religious practices, they are isolated in the community, behaved meanly, and they are insulted, used bad words to them, excluded in different social functions and were given extra workload as a punishment. Only 3% SPAWs opined that PAWs are behaved normally.

The communities’ negative behavior to PAWs is confirmed from the FDGs too. “Exclusion of PAWs in the religious ceremonies is no different from the exclusion to menstruating women” uttered in PAWs and FY FGDs. Even the PAWs themselves expressed “We exclude ourselves from religious functions as we are afraid and feel guilty going against their religion and culture”. Most of the PAWs expressed in grief that they were taunted and humiliated by their in-laws, and a few PAW shared that even their spouse was against the decision to have an abortion, for which some women were physically assaulted. One of the PAWs shared, “I had my abortion around three years ago. After, I went to my maternal home so that no one in my husband’s home knew about my
abortion. My own brother stopped talking with me after learning that I had an abortion. Now whenever I visit my maternal home for a stay he taunts me. I feel that I cannot even visit my own mother’s home.”

It is found that behavior toward ASP was not as bad as toward PAWs. The figure 10 shows that ASPs were behaved positively with ‘good will’. It is the response primarily made by SPAW. A quarter of all KII informants responded that ASPs were hated. Interestingly enough, HSPs themselves expressed that they were viewed as people who provide abortion services primarily for the sake of money.

FGDs with SPAW revealed that ASPs are not viewed negatively by the societies; instead SPAWs feel that they are negatively viewed by society when they support their spouses. They opined that they feel insult when they overhear comments such as, “That person’s son took his wife for such a negative thing.”

### 4.2.3 Who the communities blame if a woman has an abortion

When asked who the communities usually blame if a woman has an abortion, the majority of informants (88%) said “the PAWs”. The figure 11 shows that all the PAWs, HSP and majority of SPAWs and LRs have responded that community blame PAWs. Next to PAWs are FCHV (45%), Family of PAW (38%), ASP (35%), organization or person supporting abortion and SPAW.
In FGDs too, participants opined that abortion is a female issue and is done in female body, therefore women are the one who get blame the most.

Informants who answered that PAW gets blamed by a community were further asked about the reasons behind this blame. A majority said that women get blamed due to the assumption that women did not “take precautions” and became pregnant. Another reasons mentioned were: a) getting an abortion service without consulting their spouse/family, b) thinking that women seek abortion when they get pregnant from extra-marital relation c) due to male domination and d) lack of knowledge.

In the FGD too participants said that women are blamed for not using contraception, leading to the need for an abortion. Few participants of the female youth group expressed that male domination is the reason women get blame from the community. But male and female youth both unanimously opined that lack of education is at the root of blame. One PAW expressed, “Women are the victim of the male dominated culture. They blame women if anything goes wrong regardless who or what the cause is. Due to this culture, women get blamed for having abortions whatever may be the reason behind this.”

4.3 Prevalence of Abortion Stigma
The study revealed that abortion stigma is very high in study sites evidenced by the negative attitude, behaviors, and the labels applied to PAW and ASPs. Informants were asked to rate the prevalence of stigmas derived from the KIIs, rating the prevalence from “Immensely” to “Not at all.” Findings are presented in Figure 12.

4.3.1 Prevalence of Stigma towards Abortion and PAW
KII informants believed that different abortion stigmas exist in the communities in varying degree. The figure 12 indicates that all six stigmas - abortion is sinful act, abortion is social crime, abortive women and characterless, abortive women are excluded in
religious practices, abortive women are isolated, and abortive women are humiliated - are prevailed in the communities in a large scale. Only small percentage range from 2 to 11% of respondents mentioned that these stigmas are not at all prevailed.

In FGDs too, most of the participants shared that abortion is considered a sin and is prevailed “in a large scale,” especially among elderly people who believed that abortion violated religion and culture, which could lead to something wrong in their lives. The majority of PAW and RLs opined that the concept of abortion as a social crime is also prevailed in their community “in a large scale” due to religious belief and cultural practices. Similarly, majority of SPAW and RLs opined that the PAWs are considered characterless because the community has a belief that only women who have an abortion engage in extramarital relationships. PAW concurred with SPAW’ and RLs’ opinion regarding this stigma, but they stressed that this belief is completely unfounded.

High exclusion of PAW in religious function was mentioned by almost all types of respondents. The RLs asserted that they do not allow PAW in temples and at religious functions, especially for about five days—bleeding time as they consider PAW are impure during those days as of menstruation. SPAW acknowledged this exclusion, while some male and female disagreed with this thinking but noted that the practice of excluding is widely practiced in their community.

PAW expressed that they avoided going to religious places or functions even in their own home for at least for 4-5 days after having abortion due to self-stigma and the fear of being harmful to oneself and others.

“Isolation is practiced “in a large scale” in almost every household, especially by elderly people within their family, similar to menstrual and post-birth isolation practices” said the FDGs participants. When asked about the issue of humiliation, the majority of informants shared that PAW are humiliated and taunted “in a large scale” by their family members, especially by in-laws and spouses if not seek their consent.

4.3.2 Prevalence of Stigma towards Abortion Service Providers
The study revealed that stigma toward the ASPs also exists, but not immensely (Figure 13). Most KII informants expressed that ASPs were stigmatized “slightly” or “not at all.”
FGD participants opined that authorized ASPs, such as health centers and private clinics, are not stigmatized implicitly, but attitudes toward them are not entirely positive regarding the abortion services provided at these centers.

Participants thought that CAC services should not be separated from other health services so as to provide confidentiality to abortion seekers.

4.4 Causes and Consequences of Abortion Stigma

This study investigated the causes and consequences of stigma and also explored the skills of PAW and ASPs to resist stigma. This chapter presents views on causes and consequences of abortion stigma towards PAW, SPAW and ASP.

4.4.1 Causes of abortion stigma

The responses gleaned from the KII and FGDs regarding causes of abortion stigma were religion, lack of education, prevailing health myths, and a male dominated social system.

a) Religion

Both KII and FGD findings indicate that participants believe that the Hindu religion is the number one cause of abortion stigma. A religious belief that abortion is a sin and is impure is rampant in the study sites. RLs noted that in Hindu religion, “People take a form of human being after many life cycles; terminating the form is a sin.”

Abortion is called “Garbhapatan” in the Nepali language. RLs articulated that in the Hindu religion, the word “patan” means falling down or dropping, which is considered something bad or malicious. Characterizing abortion as a “dropping of a fetus” has negative connotations, implying an impure and sinful practice. Abortion being against the Hindu religion, there is a superstitious belief that practicing abortion will result in
unpleasant incident in the family. Women having an abortion are considered untouchable according to traditional and cultural beliefs.

However, some of the RLs supported abortion while discussing about it, but they said that they cannot express such view to others as it contradicts with their religious traits and also due to the fear of being rejected in the society to perform their religious performances, and ceremonies, which are their sources of income and status in the communities.

b) Lack of Knowledge
Lack of accurate and scientific knowledge on abortion and its legal provisions was mentioned strongly as another cause of stigma. A fetus is considered to be a person, due to which abortion is considered murder. Most respondents believed that abortion is against the law in Nepal, characterizing it as a crime akin to murder. This could likely be because laws governing abortion reside in the same chapter in the civil code in which punishments for crimes against human life, such as murder, are found. This implicitly identifies abortion as killing.

c) Health Myths
HSP noted about abortion is mistakenly affiliated with health problems such as uterine cancer, breast cancer, infertility, and lower life expectancy. These myths persist even if abortion is performed safely in an authorized health centers.

A majority of SPAW opined that abortion carries high health risks and can cause maternal mortality even if the procedure is safe, therefore pregnancy should not be aborted.

In the FGDs, most respondents cited different health hazards, including mental trauma (depression, psychosis, emotional instability) and physical trauma (infections, hemorrhage) even if abortions are performed in safe circumstances in authorized centers. Respondents felt that having an abortion has higher health risks than continuing a pregnancy and giving birth to a child. A misconception that an ‘abortion leads to infertility’ prevails.

d) Male dominated social system
RLs expressed that, “If abortive women are not stigmatized enough to prevent abortion, female might get empowered over the men.” This shocking statement implies that women’s sexuality should be controlled by stigmatizing and shaming them.

A PAW remarked that, “Women are classified as second class citizen in the society. And
as an abortion is performed by the women, it is considered against the social norms and values.”

4.4.2 Consequences of abortion stigma
Both KII and FGD findings clearly indicate that people are quite aware of the consequences of abortion stigma. There was a general consensus in FGDs and amongst key informants that PAWs are highly affected by stigmatizing beliefs. Similarly, most informants and respondents believed that the spouse and the family of PAW are also affected by stigma, and few respondents considered ASPs to be affected by stigma.

i) Consequences on PAW

Table 8. Consequences of Abortion Stigma on Women’s Lives

<table>
<thead>
<tr>
<th>Health</th>
<th>Social</th>
<th>Financial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsafe abortion</td>
<td>Exclusion from society</td>
<td>Deprived of money</td>
</tr>
<tr>
<td>Pressure to continue pregnancy</td>
<td>Thrown out of family</td>
<td>Lack of opportunities</td>
</tr>
<tr>
<td>Live with negative attitude</td>
<td>Left with no social support</td>
<td>-</td>
</tr>
<tr>
<td>Emotional trauma</td>
<td>Scolded</td>
<td>-</td>
</tr>
<tr>
<td>Lack of post-abortion care</td>
<td>Restriction of movement</td>
<td>-</td>
</tr>
<tr>
<td>Lack of general rest and care</td>
<td>Problems in marriage</td>
<td>-</td>
</tr>
<tr>
<td>Overloaded with work by the family</td>
<td>Feel guilty of ending life</td>
<td>-</td>
</tr>
<tr>
<td>Maternal mortality</td>
<td>Deprived of education</td>
<td>-</td>
</tr>
<tr>
<td>Psychiatric and mental illness</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Suicide</td>
<td></td>
<td>-</td>
</tr>
</tbody>
</table>

Once stigma is applied to a PAW, it results in a host of negative consequences in various aspects of women’s lives (Table 8). These consequences as identified by KII informants are below.

a) Health consequences

Respondents thought that abortion stigma leads women to have unsafe abortions or continue an unwanted pregnancy, leading to physical and psychological stress in the short and long term. Other health risks include maternal mortality and being deprived of post-abortion rest and care by their family, who may have disagreed
with the decision to abort a pregnancy. Stigma also prevents women from visiting SAS to receive post-abortion care due to fear of being recognized by the community.

b) Social consequences
Due to social norms, PAWs are secluded, disparaged, scolded, and occasionally thrown out of a family, denying them familial or social support. Some PAWs are not allowed to walk freely in a community. PAW expressed that women are deprived of getting education at colleges and schools if recognized as a woman who had an abortion. Families may restrict the mobility of PAW, regardless of her marital status, and sometimes schools do not allow PAW to seek an education. Unmarried PAWs find difficulties getting married. According to the few youth men in the FGD, PAWs are even ignored by their friends. However, they believed that most of the time women themselves are responsible for this type of behavior towards women.

c) Financial consequences
Access to financial resources for PAW is negligible. In Nepal, most women do unpaid housework and depend on men for economic support. It was shared that after having an abortion, men and SPAW discontinue giving money, assuming that she will use it for another abortion.

Case Study
Ratna was a married 28-year old woman from an underdeveloped part of Makawanpur district. She had two children and her husband was a farmer. Several years after having her second child, she got pregnant again. Due to her financial constraints, she did not want to increase burden in the family

She did not want to continue her pregnancy and wanted to get an abortion. But she was also afraid to get recognized of having abortion by the community and her relatives. Due to this, she had an abortion using locally available herbs which was given by traditional healer of the community. After few days, she had a serious abdominal pain. She was immediately hospitalized at Makwanpur district hospital. After different diagnosis, they got to know that she had an incomplete abortion due to the use of the herbal medicine. She was admitted in ICU for several days. She was transferred to Bharatpur hospital. But even after many attempt, she died two days after admitting at Bharatpur hospital.

Her husband as well her family felt that only if she had not had unsafe abortion due to the fear of getting recognized and had aborted safely, she would not have died.
ii) Consequences of Abortion Stigma on the Spouse and the Family of the PAW

Both KII and FGD participants opined that abortion stigma has an effect on SPAW and family of PAW. They mentioned two types of consequences (table 9). The loss of status is the most common factor articulated as a direct consequence. Conflict between family members was also mentioned. “The stigma affected their marital relationships as well. Most of the in-laws wanted their son to get married again when they recognized that their daughters-in-law have had an abortion,” said PAW. They further shared that their spouses were labeled as “Joitingre” (One who does everything his wife says), “Namarda” (one who do not act as man), notably if the spouse supported his wife for having an abortion. Families with PAW may also be excluded from community religious ceremonies. Respondents in the KII, especially RLs, also said that if a community finds that if one member of a family had an abortion, then the daughter of that family is not considered marriageable.

<table>
<thead>
<tr>
<th>Table 9. Consequences on SPAW and family of PAW</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Direct</strong></td>
</tr>
<tr>
<td>Status loss</td>
</tr>
<tr>
<td>Emotional Trauma</td>
</tr>
<tr>
<td>Conflict in the family</td>
</tr>
<tr>
<td>Difficulty in starting in new relationships</td>
</tr>
<tr>
<td><strong>Indirect</strong></td>
</tr>
<tr>
<td>Lack of care of the family and children</td>
</tr>
<tr>
<td>Effect on economy due to expensive treatment of unsafe abortion and post abortion care</td>
</tr>
</tbody>
</table>

iii) Consequences on Abortion Service Providers and organization supporting Abortion

HSP respondents shared their difficulties with anti-abortion groups, including threats and harassment. They stressed “Elderly women and men oppose the idea of implementing the awareness programs on abortion.” They further cautioned that anti-abortion groups are quite strong and ASPs fear getting harassed (Table 10).

<table>
<thead>
<tr>
<th>Table 10. Consequences of abortion stigma on ASP and organizations supporting abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Oppose the organization to implement the programs on abortion</td>
</tr>
<tr>
<td><strong>2</strong> Conflict with anti abortion groups</td>
</tr>
<tr>
<td><strong>3</strong> Threatened by anti abortion groups</td>
</tr>
<tr>
<td><strong>4</strong> Harassed</td>
</tr>
<tr>
<td><strong>5</strong> Mental Stress and fear of getting harassed</td>
</tr>
</tbody>
</table>
4.5 Supports, Services and Skills to Resist Abortion Stigma

Abortion stigma is a neglected issue. Although many programs related to abortion have been conducted, myths and stigma have not been addressed as an important topic. This chapter presents the services, support and skills to eliminate or reduce abortion stigma.

4.5.1 Existing Services and Supports

“FCHVs stationed in the villages are the most available source of support to the people,” said PAW (Table 11). However, other key informants thought the existing awareness and counseling services provided by FCHVs at the individual level do not particularly address abortion stigma. Similarly, there are many organizations, such as Beyond Beijing Committee (BBC), YWS, FPAN, PLAN, Marie Stopes Nepal, Sunaulo Bhavisya, Asmita Nepal which have been organizing awareness programs on safe abortion, but not specifically on abortion stigma. Informants also shared that governmental organizations such as health posts, PHCCs, and district hospitals provide awareness program and conduct workshops and meetings to provide information on abortion, but these too do not specifically focus on the reduction of abortion stigma. However, informants opined that the legalization of abortion, provision of SAS centers, free services, and nationwide media broadcasts help to minimize abortion stigma indirectly.

This study revealed that RLs, SPAW, and male youth were not aware of abortion services. In the FGD, PAW opined that this is due to lack of men’s participation in abortion-related awareness programs. Participants also stressed that local governmental bodies, such as VDCs, ignore abortion as an important aspect of women’s health.

4.5.2 Skills and Supports to resist the stigma

When asked what skills PAWs and HSP/ASPs posses to resist stigma, only few responses were generated (Table 12). The majority of PAWs expressed that they do not have any special skills to resist stigma other than concealment by 1) tolerating stigmatizing
behavior and continuing daily life; 2) visiting one’s natal home after having an abortion; and 3) lying about having a monthly period. “These ways or skills for resisting the stigma are effective so no one finds the truth of having an abortion,” said female key informants. FGD participants also referred to “lie or leave home,” meaning that women leave their marital home (their husband’s family home) to go stay their natal home for rest or concealment. Some women also said that they ignore stigmatizing statements and even try to explain that abortion is a woman’s right, not a sin.

A majority of HSPs shared that the skills they use to resist stigma were: 1) advocacy on women’s reproductive health rights as enshrined in the constitution; 2) counseling on legal and safe abortion; and 3) performing abortion confidentially. They said that they provide counseling services to couples so that they can make informed decisions. HSPs also take women seeking abortion into their confidence by maintaining confidentiality, reducing the possibility for stigmatization of the women and the providers.

This study also questioned whether governmental and NGOs provide support to PAW and HSP/ASPs to resist abortion stigma. PAW said there is no support system other than counseling services at private clinics. More than half of ASPs shared that they have not received any assistance that would help them resist stigmatization, but the rest said that they received training on how to provide counseling services to couples from District Public Health Office and other private abortion service providers. Both PAW and ASPs said that they are yet to get training on resisting abortion stigma.
### 4.5.3 Efforts to reduce stigma

When asked what efforts or activities required to reduce abortion stigma, the informants suggested various activities for different stakeholders: individuals, families, communities, and the government. The recommended activities for each are shown in table 13.

<table>
<thead>
<tr>
<th>Government Organizations</th>
<th>Civic Society Organizations</th>
<th>Mass Media</th>
<th>Individual, Family &amp; Community Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase budget allocation</td>
<td>Conduct awareness program especially focusing on Men, Youth and Elderly Population</td>
<td>Awareness of abortion and its stigma</td>
<td>Sharing of information individually</td>
</tr>
<tr>
<td>Increase access to safe abortion in rural areas</td>
<td>Lobby government to address abortion stigma</td>
<td>Street drama in the rural areas</td>
<td>Protesting against rituals and beliefs against abortion stigma</td>
</tr>
<tr>
<td>Develop and implement law to eradicate abortion stigma</td>
<td>Conduct awareness program especially focusing on Men, Youth and Elderly Population</td>
<td>Campaign through traditional and social media</td>
<td>Formation of &quot;Combating Abortion Stigma&quot; groups</td>
</tr>
<tr>
<td>Coordination with different local governmental bodies</td>
<td></td>
<td></td>
<td>Awareness program by community</td>
</tr>
<tr>
<td>Abortion and abortion stigma in the education syllabus along with SRHR</td>
<td></td>
<td></td>
<td>Encourage organizations to implement programs in the community</td>
</tr>
</tbody>
</table>

### 1) Government Organization

A majority of key informants, particularly PAW and ASPs, said that government should allocate an adequate budget prioritizing abortion as an important aspect of women’s health. They also demanded an act to reduce the stigmatization of abortion, demolish negative religious, traditional and cultural beliefs through implementation of different
programs, and provision of SAS in rural areas. Other participants suggested strong coordination between governmental bodies such as DHO, MOWCSW, DDC, VDC and CDO for smooth implementation of programs and laws. Likewise, youth male and female participants suggested that government should address abortion stigma by incorporating SRHR issues in all educational syllabi.

2) Civic Society Organizations
Most of the key informants suggested that CSOs should initiate strategies to reduce abortion stigma, particularly awareness programs and comprehensive SAS. Most respondents, especially PAW, insisted that CSOs working on abortion issues must focus on providing awareness on stigma to men, youth, and elderly people, along with women, to eliminate abortion myths. Informants suggested that CSOs lobby the government to address abortion stigma. RLs suggested awareness about abortion as a last resort to ease the blame placed on PAW. Awareness programs among health personnel as well as local government bodies should be conducted to change their attitude so that women get access to safe abortion without being stigmatized said the youth and PAW. The SPAW said awareness program to the couple together should also be conducted to educate both. A male youth participant said, “Rather than only focusing on women, organizations should organize programs for new generations of youth – both male and female -- to bring change.”

3) Mass Media
Informants suggested promotion of safe abortion and an anti-stigma campaign through radio, television, and traditional media, such as street dramas in rural areas. Different campaigns through traditional and social media should be done to obligate government to address abortion stigma and safe abortion.

4) Individual, Family and Community
Participants suggested reducing abortion stigma by encouraging and supporting open discussions about abortion. Families should support PAW by letting her rest, providing care and support just as they do during birth. People also should reject harmful traditional beliefs, which encourage stigma around abortion. Most HSPs and youth respondents expressed that each community should form an ‘Abortion Stigma Ending Committee.’ Male and female youth added that such a committee would encourage CSOs to conduct awareness and interaction programs on abortion stigma.
This chapter presents the key findings drawn from the analysis of data presented in the earlier chapters.

**Key findings:**

**Knowledge on Abortion**
- All the respondents are familiar with the term abortion, called ‘Garvapatan’ in the Nepali language. However, the majority of them think it means disposing a baby (Bachha Falnu), wasting a pregnancy (Garva khera Janu), killing a fetus (Bhruna Hatya), or removing an immature fetus (aparipakwa bhruna nikalnu), and don’t distinguishing between induced and spontaneous abortion (miscarriage).
- The majority of respondents are aware of the legal criteria of abortion, SAS and the abortion service centers that exist in Makwanpur, but only few of the respondents know all the criteria and conditions.
- Despite the poor knowledge on abortion and SAS, the majority of key informants believe abortion is a correct choice for the unwanted abortion. However, the FGD participants except for the PAW feel abortion is not a correct choice but can be exercised by married women only in the crucial circumstances.
- All respondents except Religious leaders know both public and private SAS centers available in the District.

**Reasons of not Obtaining SAS**
- One of the main reasons why women do not obtain SAS are due to fear of disparage. The other reasons are, concept that abortion is wrong, family/spouse pressure to continue pregnancy, son preference in the family, lack of access to abortion service, lack of other choices, and lack of knowledge.
- Despite their poor knowledge of abortion, the informants believe that abortion can be a correct choice. However, a majority of the FGD participants do not think abortion is a correct choice – not even in case of an unwanted pregnancy.
- Vast majority do not think abortion is a correct choice even in case of unwanted pregnancy.
Attributes of Abortion Stigma

- The community has a negative attitude and behavior towards PAW and others associated with ‘abortion’. PAW are labeled as; Sinner (papini), Illluck (alichhini), Murderer (Jyanmaara), fetus killer (Garbhaghati), aberrant/wicked (kulangaar). PAWs are treated badly through humiliation, isolation, insults and exclusion from religious performances.
- PAWs are behaved disgustingly. They are humiliated, isolated, insulted, behaved meanly, used bad words and excluded in religious performances.
- Abortion service providers are also labeled negatively but less compare to PAW. They are also behaved negatively. They are hated, humiliated, meanly behaved and used bad words and are viewed as people who provide such service for the sake of money.
- Other people associated with abortion i.e., FCHV, Family of SPAW, and ASP are also blamed, but minimal compare to PAW.
- An opinion that ‘women have used abortion as the means of contraception’ prevails.
- PAWs are stigmatized in a large scale. SPAW and ASPs are also stigmatized but less.

Causes of abortion stigma

- A root cause of the abortion stigma is the patriarchal religion that indoctrinates abortion as a sinful and immoral act. The lack of scientific knowledge, prevalence of health myths and the male dominated social system that wish to control women likewise play an important role in the abortion stigma.
- Male dominated social system that wish to control women by stigmatizing abortion, which has always been one means for women to take control of their lives is also expressed by many.

Consequences of abortion stigma

- Respondents are quite aware of consequences of abortion stigma on women, their spouse and families. All agree that the women who had an abortion gets affected the most affecting negatively on their health, social life and financial condition.
- Due to the stigma women either have to get an unsafe abortion, continue the pregnancy and give birth against her will, or face a negative treatment by her community that results in implication for her health, social life and economic condition.
- Loss of status, loss of relationship, loss of money, and get label as “Joitingre (One who does everything as her wife says), Namarda (Who do not act as man) etc are some manifestation of affect of abortion stigma on SPAW. Daughters of
SPAW post are not considered marriageable is another manifestation of abortion stigma’s affect on family.

- ASPs are to live with fear of getting harassed resulting stress and trauma. They face difficulties in implementing programs in their health facilities. Anti-abortion groups are quite strong in study sites.

Service and supports to resist stigma

- External support and services to PAW addressing ‘abortion stigma’ is almost non-existent. All the organizations - including ASP - lack skills and knowledge to address abortion stigma specifically.
- FCHVs stationed in the villages are the most available source of service and support to the women in need of abortion at the individual level.
- Government and NGOs lack programs to develop skills and knowledge to address abortion stigma specifically.
- Legalization of abortion, provision of SAS centers, free services and information broadcasted through various media at the national level help in minimizing abortion stigma indirectly is a view of respondents.

Skills to resist stigma

- PAWs do not have any special skill to resist the stigma other than concealing by being tolerant and continuing their daily work as usual, or visiting the natal home after having an abortion, and lying that they are having their monthly period.
- ASPs use constitutional provision of Reproductive health rights of women as a tool along with safe abortion law to resist abortion stigma. Counseling to the couples on abortion and maintaining confidentiality are also used to resist abortion stigma.
- Both PAW and ASPs have not received support and skills training to resist the stigma from government and non-government organizations other than counseling training on abortion.
- No program implemented by any organization directly addresses abortion stigma.
- Different programs are to be implemented at different levels – from individual, family, community, CSOs, media and the government.

This chapter presents the conclusion and some recommendations derived from the analysis of findings presented in previous chapters. Based on the findings of the study, conclusion is drawn and recommendations are derived for 1) integrating abortion stigma into ongoing WHRAP program and 2) for advocacy to reduce abortion stigma in Nepal.
6.1 Conclusion
In conclusion, it can be said that abortion stigma prevails highly in the study sites as majority of respondents conceive abortion, ‘Garvapatan,’ as “disposing of a baby” (Bachha Falnu), “wasting pregnancy” (Garva khera Janu), “killing fetus” (Bhruna Hatya), and “removing fetus” (aparipakwa bhrun nikalnu). Stigma exists because of the lack of accurate knowledge on abortion as well as religious beliefs that consider abortion a sinful and immoral act. Though abortion has been legal in Nepal since 2002, people lack full knowledge on legal abortion criteria. As a result, community-wide attitudes toward abortion, abortion seekers and service providers is still noticeably negative, despite safe abortion services being available in Makwanpur district.

Stigma toward PAW and other people associated with abortion is noted by labels such as sinner (Papini), bad luck (alichini), murderer (Jyanmaara, aberrant or wicked (kulangaar), fetus destroyer (Garbhashuti), characterless (charitrahin), witch (boksi), and prostitute (Randi). PAW are also humiliated, excluded from religious ceremonies, isolated, and insulted. The consequences of this stigmatization on women, their spouses and families are very negative. Women try to conceal abortions by getting an unsafe abortion or carrying out an unwanted pregnancy. SPAW may notice detrimental effects on their community status and family relations. Even abortion service providers are labeled negatively, making their work difficult and stressful.

Neither the Government of Nepal nor NGOs provide services to PAWs and ASPs addressing abortion stigma. Neither women nor ASPs have sufficient skills to resist stigma. Women feel no choice other than to conceal an abortion. ASPs said they use the constitutional provision of reproductive health rights of women and legal criteria of abortion as tools to resist stigma, but noted the absence of a separate comprehensive safe abortion bill in Nepal.

Hence, efforts are needed at all levels - individual, family, community, government, civic society and media - to enable people to access accurate information to demystify and de-stigmatize abortion, challenge misconceptions, and address the root causes of abortion stigma.

6.2 Recommendations
For integrating abortion stigma into ongoing program

- Equip women with adequate scientific knowledge about their own body, RH rights, abortion and stigma by developing sessions for CHES program.
• Organize/strengthen women’s groups to act against ‘abortion stigma’.
• Raise voice about stigma and demand to end it.
• Produce simple IEC materials on abortion in a non-stigmatized language.
• Sensitize CBOs, government and non-government organizations to address abortion stigma along with the accessibility of safe abortion service.
• Sensitize district line agencies, Religious Leaders and other local groups on abortion stigma as an important social, educational and political issue that should be addressed in an integrated manner.
• Empower communities to enhance their ability to resist the stigma along with educating and informing people that abortion is a last resort to women to end their unwanted/unintended pregnancy before the fetus is viable to eliminate the self stigma.

For advocacy to reduce abortion stigma in Nepal:
• Advocate that accurate, scientific-based information and knowledge about abortion is incorporated into the educational curriculum to de-mystify abortion, challenge myths and enable the youth to practice responsible behaviors.
• Provide technical guidance to produce and widely disseminate IEC materials on abortion in a non-stigmatizing language, and provide services denoting the necessity of safe abortion to safeguard SRHR of women and healthy lives of humans.
• Lobby to include ‘ending the abortion stigma’ as a measure in the National safe abortion implementation guide.
• Lobby to integrate the concept of abortion stigma into the Reproductive Health Components to educate all health professionals/workers - particularly FCHVs - on how to reduce the stigma.
• Sensitize religious leaders and early citizens not to perpetuate the traditional notion of abortion and the discriminatory behaviors they practice.
• Lobby and advocate enacting an act against ‘Stigmatization/discrimination against abortive women’ like the act on cast discrimination in Nepal.
• Build a network to end the abortion stigma.
• Advocate developing awareness raising programs to all (men and women) in a regular basis to de-mystify abortion, challenge myth and enable youth to practice responsive behaviors.
• Lobby to incorporate reducing stigma while developing any manuals or informative materials on abortion by government agencies such as family health division or national health education information communication center and NGOs.
References


Ipas (2015). Women’s access to safe abortion in the 2030 Agenda for Sustainable Development: Advancing maternal health, gender equality, and reproductive right.


Glimpses of the study

Orientation on Abortion Stigma project

Visit to Makwanpur District Listening Survey WHRAP focal person- April, 2015
Glimpses of the study

Training to Study Team

[Images of training sessions]
Glimpses of the study

Orientation of WHRAP Focal Person
Glimpses of the study

Key Informant Interview
Focus Group Discussion

Glimpses of the study