

RIGHT HERE, RIGHT NOW NEPAL

BRIEFING PAPER TO THE CEDAW
COMMITTEE: 71 ST SESSION, ARTICLE
12, RIGHT TO HEALTH
DISCRIMINATION ON SEXUAL AND
REPRODUCTIVE HEALTH AND RIGHTS:
WOMEN AND GIRLS IN NEPAL

1st October, 2018

NEPAL



RIGHT HERE
RIGHT NOW

1. Introduction

This briefing paper highlights issues for Article 12- Right to Health on discrimination and violence faced by women and girls in Nepal related to their sexual and reproductive health and rights (SRHR) and provides recommendations to the government and CEDAW Committee for the seventh reporting cycle of Nepal.

Nepal is a progressive country in South Asia with many laws and policies addressing women and girls SRHR. However, Nepal has been unable to make progress or remains stagnant in many areas of SRHR. This brief, shows progress made by the Government of Nepal (GoN), gaps that remain in the health sector, steps needed to ensure women's SRHR and recommendations.

This briefing paper was produced by Right Here, Right Now- Nepal platform. Beyond Beijing Committee- Nepal took the lead in organizing consultation in different provinces, covering the seven provinces from February-September 2018, to gather information on women and girls SRHR and drafting the paper.

The paper has three sections: 1) information on political, social and cultural status, 2) highlights issues from the provincial level consultations, on socio-cultural effects women's SRHR choices and decisions, the barriers to quality services and 3) issues that has been addressed by RHRN platform.

The issues that were identified impact and influence women's and girls' SRHR, not in isolation. These issues should be seen as intersecting throughout the lifecycle. Secondary resources have also been used.

2. About Right Here, Right Now Platform - Nepal

RHRN Nepal is a strategic partnership of fifteen¹ women-led and youth-led civil society organizations, advocating on three thematic issues: comprehensive sexuality education (CSE), marriage equality and safe abortion. Beyond Beijing Committee² Nepal is one of the member of the Right Here Right Now Platform.

3. Concluding Observations (COs) for Article 12 from Nepal CEDAW Review in fourth and fifth reports³

- a) Ensure access to basic health care and health-related services, within the framework of the Committee's general recommendation No. 24, in particular for poor and rural women and women with disabilities, and enhance the number of medical staff, including female doctors and other health care providers;
- b) Develop and pursue effective policies and programs to further reduce maternal mortality rate;

1 Including, Association of Youth Organization Nepal , Beyond Beijing Committee, Blue Diamond Society, CDS PARK Mugu, Family Planning Association of Nepal, Federation of Sexual and Gender Minorities Nepal, Human Protection and Environment Protection Forum, Loom Nepal, Restless Development, Rural Women's Network Nepal, Visible Impact, Youth Action Nepal, Youth Development Center, YUWA, Yuwalaya

2 Beyond Beijing Committee Nepal is a Feminist Network organization of over 180 women led organizations in Nepal. It was established in 1998 and have been using Policy advocacy as one of the major approaches for Gender equality and Empowerment of Women and Girls in Nepal.

3 United Nation, 2011, Concluding observations of the Committee on the Elimination of Discrimination against Women Committee on the Elimination Discrimination against Women Forty-ninth session 11 – 29 July 2011.

- c) Prioritize programmes that ensure access to a full range of maternal health services, including antenatal, postnatal, and emergency obstetric care, particularly for poor women, rural women, and young mothers;
- d) Address discriminatory and harmful practices against women and girls such as the lack of provision of sufficient food and the Chaupadi practice, which jeopardize well-being and health, including reproductive health;
- e) In order to combat the problem of uterine prolapse, take preventive measures, such as adequate access to contraception, awareness raising and training under the already-existing Safe Motherhood programmes, and ensure sufficient allocation of funds for quality corrective surgeries and follow up visits, which prevent post-operative complications such as fistula and other health conditions;
- f) Improve access to abortion services throughout the country; and address unmet need for contraception by prioritizing universal access to the full range of contraceptive methods, information, and services, including emergency contraception, with a particular focus on rural and poor women, and adolescent girls.

Particular issues related to SRHR was raised as a key issue of concern during the last review. Many of these remain unmet while some areas have regressed. The GoN has done little to promote public awareness on women's SRHR and accessibility of all the services. Implementation of new policies is limited.

4. SRHR in Nepal

SRHR is related to multiple human rights, including the right to life, bodily autonomy, to be free from coercion and torture, to health, to privacy and to be free from gender discrimination and violence and have been included in key conventions. CEDAW includes SRHR largely within the ambit of Article 12 at core of the Convention. As such States have obligations to respect, protect and fulfill rights related to SRHR. Despite these obligations, violations are frequent and take many different forms. Women's SRHR are at risk when they are subjected to harmful practices and for Nepal this includes child marriage and Chaupadi. A largely patriarchal society, gender discrimination has immediate implications for health and wellbeing. Socio-cultural aspects impact women and girls lives, affecting their choices and decision-making power regarding SRHR. Most decisions are made by male and the family. These issues and implications of related discrimination needs to be prioritized while being addressed in a holistic and comprehensive manner.

5. Country Context

The total population of Nepal is 31 million, women consist of 51.5% of the total population, men consist of 48.5% and the youth consist of 24% of the total population⁴. Nepal is a diverse country, consisting of 125 caste/ethnic groups with 123 languages spoken as mother tongue, Nepali language being the most commonly used with 44.6% of the total population. There are 10 types of religion in Nepal; Hinduism (81.3%), Buddhism (9.0%), Islam (4.4%), Kirat (3.1%), Christianity (1.4%) and other

⁴Government of Nepal, National Planning Commission Secretariat, Central Bureau of Statistics.2012. *National Population and Housing Census 2011 (National Report)*. National Planning Commission Secretariat, Central Bureau of Statistics. Kathmandu, Nepal.

religions⁵. Overall literacy rate (for population aged 5 years and above) has increased from 54.1% in 2001 to 65.9% in 2011⁶. Male literacy rate is 75.1% compared to female (57.4%). Working age population (aged 15 to 59 years) has increased from 54% (12,310,968) in 2001 to 57% (15,091,848) in 2011.⁷

Despite being a low-income country, it has rich natural resources⁸. Nepal’s Human Development Index (HDI) value for 2015 was 0.558 (medium human development).⁹

In 2015, Nepal ranked 115 of 159 countries on the Gender Inequality Index (GII). 29.5% of parliamentary seats are held by women. Female participation in the labor market was 79.7% and 86.8% for men¹⁰.

Nepal has made progress in Gross National Income (GNI) per capita; from gross national per capita income (PPP USD\$) in 1990 of USD\$ 1,168 to USD\$ 2,337 in 2015.¹¹ 26.6% of the population are multidimensionally poor while an additional 14.4% risk living in multidimensional poverty¹².

Politically, Nepal transitioned into Federal Democratic Republic after the promulgation of 2015 constitution. It has been federated into seven provinces with three tiers of government system: federal, provincial and local. This is a response to the inability of the central government to deliver the type of inclusive social contract and progress that Nepal’s citizens desire.¹³ However, the roles and responsibility of multiple entities at federal, provincial and local level government machinery remains unclear, posing risk to effective functioning of government.

Table 1: Nepal’s International Human Rights Commitments focusing on SRHR

International Human Rights Treaties and Women and Girls’ SRHR Commitments	International Adoption	Ratification by Nepal
CEDAW	1979	1991
CESCR	1966	1991
CRC	1989	1990
CEPD	1965	1971
ICCPR	1966	1991
CRPD	2006	2010
Optional Protocol to CEDAW	1999	2007

⁵ Ibid.

⁶ Ibid.

⁷ Ibid.

⁸World Bank Group. 2018. Nepal Systematic Country Diagnostic: A New Approach to a Federal Nepal. World Bank, Washington, DC. World Bank

⁹United Nation Development Program. 2016.Human Development for Everyone: Brief note for countries on the 2016 Human Development Report. United Nation Development Programme.

¹⁰ Ibid.

¹¹ Ibid.

¹²Ibid.

¹³World Bank Group. 2018. Nepal Systematic Country Diagnostic: A New Approach to a Federal Nepal. World Bank, Washington, DC. World Bank. <https://openknowledge.worldbank.org/handle/10986/29421> License: CC BY 3.0 IGO.”

Key International Development Commitments on Women and Girls' SRHR	Year of Adoption	
International Conference on Population and Development Programme of Action (ICPD PoA)	1994	
Beijing Declaration on Women Platform for Action	1995	
Paris Declaration	2005	
Global Strategy for Women & Children's Health	2010	
2030 Agenda for Sustainable Development	2015	

The current constitution presents basic health care services as a fundamental right¹⁴ and have addressed women's right to safe motherhood and reproductive health; therefore, special measures in terms of laws, policy programs are being taken. GoN has developed and amended existing laws and policies in conjunction to the constitution such as Child Marriage (2016), Chaupadi (2017), Safe Motherhood and Reproductive Health bill (2018) etc. GoN has formulated National Safe Motherhood Policy 1998, National Family Planning Program, the National Safe Abortion Policy 2002, the Safe Abortion Directives 2016, National Policy on HIV and AIDS 2007, National Adolescent Health and Development Strategy (2000), National Safe Motherhood and Newborn Health Long Term Plan (2006-2017).

6. Critical issues on SRHR

The knowledge about contraceptive was universal in 2016¹⁵. Yet the contraceptive prevalence rate (CPR) has remained stagnant in the last five years; in 2011 (50.0%) and in 2016 (53.0%). CPR for the modern method has not changed since 2006 (44.0% in 2006, 43.0% in 2011 and 43.0% in 2016).¹⁶ CPR also varies with age (only 23% of married women age 15-19, 69% among women age 35-44, and 15% of currently married women age 15-19) use modern contraceptive methods.¹⁷ This indicates that a large proportion of young people do not use contraceptive¹⁸, and are at higher risks of unintended pregnancies and exposure to STI and HIV/AIDS. This could be attributed to high unmet need for contraceptives (24% in 2006, 27% in 2011 and 24% in 2006). Unintended pregnancies rate remains high (19.0% in 2016 and 25.0% in 2011). The total wanted fertility rate is 1.7 children per woman, while the actual total fertility rate is 2.3 children per woman indicating women are unable to plan births and practice birth spacing.¹⁹

¹⁴ Dulal, Ram Krishna. (2009). Health Federalism: The Role of Health Care Professionals in Nepal. JNMA; journal of the Nepal Medical Association. 48. 191-5. 10.31729/jnma.243.

¹⁵ Ministry of Health, Nepal; New ERA; and ICF. 2017. *Nepal Demographic and Health Survey 2016*. Kathmandu, Nepal: Ministry of Health, Nepal.

¹⁶ Ibid.

¹⁷ Condoms, contraceptive pills, etc.

¹⁸ Department of Health Services. 2016. Annual Report, Kathmandu, Nepal: Ministry of Health, Department of Health Services, Nepal.

¹⁹ Ministry of Health, Nepal; New ERA; and ICF. 2017. *Nepal Demographic and Health Survey 2016*. Kathmandu, Nepal: Ministry of Health, Nepal.

Comprehensive knowledge on HIV is limited among young people (only 21.0% young women and 27.0% young men age 15-24) and indicate wide regional disparities.²⁰

Child marriage is still common and the medium age at the first marriage for women (age 25-49) has not changed since 1996(1996-16.2, 2001-16.7 2006-17.0, 2011-17.5 and in 2016- 17.9)²¹.

Son preference

The term son preference refers to the attitude that sons are more valuable than daughters²². Nepal has been classified as having considerable levels of son preference²³. It is a direct result of patriarchal notions, discrimination and violence against women in all aspects of family and community life²⁴. Parents prize sons for economic, social and cultural reasons²⁵, while daughters are seen as liability being more prevalent in Tharu, Dalit and Muslim communities.

Son preference intersect with violence against women (VAW) and violates women's SRHR. It impacts women's fertility, contraceptive use and unsafe abortion. In 2010, a study found that about 11.0% of women residing in border areas visited India for sex -elective abortion²⁶. This was also raised during CEDAW consultation in Province 2. Women feel pressure from husbands and family to produce at least one son. Additionally, discriminatory inheritance rights²⁷, marriage, rape²⁸, and citizenship^{29,30} rights perpetuate the condition.

Recommendations

1. Repeal discriminatory laws.
2. Develop programmes that ensure women's and girls's empowerment.
3. Ensure that efforts to end son preference do not marginalize and threaten every woman's right to safe abortion in Nepal.

²⁰ Department of Health Services. 2016. Annual Report, Kathmandu, Nepal: Ministry of Health, Department of Health Services, Nepal.

²¹ Ministry of Health, Nepal; New ERA; and ICF. 2017. *Nepal Demographic and Health Survey 2016*. Kathmandu, Nepal: Ministry of Health, Nepal.

²² Clark S, Son preference and sex composition of children: evidence from India, *Demography*, 2000, 37(1):95–108.

²³ Nanda Priya, Gautam Abhishek, Verma Ravi, Hong Khuat Thu, Puri Mahesh, Linh Tran Giang, Tamang Jyotsna, Lamichhane Prabhat (2012). "Study on Gender, Masculinity and Son Preference in Nepal and Vietnam". New Delhi, International Center for Research on Women.

²⁴ Ibid.

²⁵ For example: sons role in continuing the family lineage, performing cultural rituals such as lighting the funeral pyre, old age security.

²⁶ CREHPA (2010). Cross-border Abortions: perceptions of private pharmacists and medicines sellers in Nepal. A paper presented at the dissemination workshop organized by CREHPA, 19 March, 2010. Kathmandu, Nepal.

²⁷ Even though Muluki Ain states: There shall be no gender discrimination regarding the right to parental property with regard to all family members, address the equal right of son and daughter to inherit the property, it has not been implemented. Many women face problems to attain their inheritance; especially if they are married while the sons are entitled from the birth.

²⁸ According to the criminal code 2017, no person is allowed to force woman or girl to have sex without her consent or even with consent the person is not allowed to have sex if the girl is below 18 years of age. If done so, it will be stated as rape. In case of rape on girl below the age of 10 years, a jail for 16- 20 years will be sentenced to the perpetrator, while if it is for girl of 10 years or below 14 years, a jail of 14- 16 years will be sentenced.

²⁹ Muluki Ain states: No Nepali citizen shall be denied the right to acquire citizenship, in practice this is not the case, many children of single mothers, widows, transgender and intersex people face challenges in receiving citizenships, also the implementation of the law depends on individuals rather than enforcement of existing law. The requirement that only under the fathers name a citizenship is issued as an immense impact on women's and children's right.

³⁰ Nanda Priya, Gautam Abhishek, Verma Ravi, Hong Khuat Thu, Puri Mahesh, Linh Tran Giang, Tamang Jyotsna, Lamichhane Prabhat (2012). "Study on Gender, Masculinity and Son Preference in Nepal and Vietnam". New Delhi, International Center for Research on Women.

4. Ensure every woman and girl have access to adequate information and services that protect and promote their reproductive health and rights.

Menstrual Stigma

Legal provision

- In a 2005 judgment, the Supreme Court declared the practice of *Chhaupadi* to be a violation of women's rights and directed government to take action to combat the practice.
- In response, the Ministry of Women developed a "*Chhaupadi* Practice Elimination" Directive in 2007.
- In 2017, Nepal passed a Criminal Code that criminalizes *Chhaupadi* or any other forms of discrimination during menstruation.
- Article 168 of the Criminal Code, 2017- that anyone should not conduct or compel others to conduct any discriminatory behavior to menstruating women, and if does will be subject to three-months jail sentence or a 3,000 rupee (USD \$30) fine or both.³¹

Chhaupadi is a social tradition associated with the menstrual taboo in different parts of Nepal especially in mid and far western region³². Women and girls are banished during menstruation from their residence due to perceived impurity³³. The discrimination stems from the patriarchal Hindu notions considering menstruating women as 'impure' or 'unclean' and prohibiting them from participating in normal activities and having ordinary food³⁴. *Chhaupadi* is prevalent in many communities but the degree of severity differs. A similar practice called '*Nachhune*' (Untouchability) is also practiced.³⁵

Majority of girls (89%) has experienced some form of restrictions and exclusion³⁶. This can impact young girls' self-esteem/value and identity. Restrictions to take bath, change clothes, comb hair and enter holy places and dietary restrictions (taboo on consumption of food like rice, curd, milk, lassi, potato, onion, sugarcane etc.), touch male member of the family persists³⁷.

This practice makes women vulnerable to sexual violence and to hazards and attacks by wild animals and snakes. It also impacts women's health, in a 2015 study, 68% reported excessive bleeding in cowshed, 52% suffered reproductive tract infection, 34% had pneumonia and body aches, 17% suffered a prolapsed uterus (as a consequence of having to do heavy labor despite the lack of nutritious diet and adequate rest) and 11.36% had suffered anemia³⁸.

³¹ The Criminal Code, 2017 of Nepal.

³² Shrestha, L. S, 2013: Study on Chhaupadi Practice in the Far and Mid-Western Regions of Nepal, Foundation for Educational Change Maitidevi, Kathmandu.

³³ Kadariya, Shanti & Aro, Arja. (2015). Chhaupadi practice in Nepal – analysis of ethical aspects. *Medicolegal and Bioethics*. 53. 10.2147/MB.S83825.

³⁴ Shrestha, L. S, 2013: Study on Chhaupadi Practice in the Far and Mid-Western Regions of Nepal, Foundation for Educational Change Maitidevi, Kathmandu.

³⁵ Shrestha, L. S, 2013: Study on Chhaupadi Practice in the Far and Mid-Western Regions of Nepal, Foundation for Educational Change Maitidevi, Kathmandu.

³⁶ Karki, K. B., Poudel, P. C., Rothchild, J., Pope, N., Bobin, N. C., Gurung, Y., Basnet, M., Poudel, M., Sherpa, L. Y. SCOPING REVIEW AND PRELIMINARY MAPPING Menstrual Health and Hygiene Management in Nepal (pp. 1-96).

³⁷ Sapkota, D., Sharma, D., Pokharel, H., Budhathoki, S. S., & Khanal, V. K. (2013). Knowledge and practices regarding menstruation among school going adolescents of rural Nepal. *Journal of Kathmandu medical college*, 2(3), 122-128.

³⁸ Joshi LR. (2015). Chhaupadi Pratha: Sociocultural Violence against women in Far western region of Nepal. *JNEPHA*,6-7-6,22-32

This practice also extends during post-natal period, women and young mothers have to live in isolation after giving birth, this hampers their overall health³⁹. The law is extremely difficult to implement, as it requires prosecution of parents.

Additionally, many adolescents lack comprehensive understanding on menstruation and Menstrual Hygiene Management (MHM) due to lack of consistent access to education on SRH and menstrual health and lack of basic understanding of the biological process of menstruation⁴⁰. Poor sanitation facilities and unavailability of water supply has exacerbated poor menstrual hygiene among adolescent girls⁴¹. Many Nepalese girls (53%) have often been found to remain absent from school during menstruation due to lack of proper sanitary facilities such as lock on toilet doors, dustbins, adequate water supply and sanitary pads, hampering their education. Also, government has included sanitary pad in luxury item so a high taxation is charged making it inaccessible for many girls and women. Most girls use reusable pad so accessibility to girl-friendly toilet is a necessity.

Recommendations

1. Enforce and monitor the existing law.
2. Ensure a holistic approach by including gender, education, health and hygiene and sanitation as well as menstrual stigma and the patriarchal interpretation of religious codes, to address such practices.
3. Integrate menstrual health and hygiene (MHH) components with sexual and reproductive information and education on menarche, healthy menstrual practices and associated health benefits, increased access to menstrual aids such as sanitary napkins, and management of menstrual disorders.
4. Ensure that teachers and community actors are equipped to tackle the effects of the practice on girls, including engaging them in monitoring implementation of the law, addressing stigma related to perpetuating and enabling the practice and dealing with broader gender equality issues.
5. Remove sanitary pad from luxury item so that it is tax free and accessible to all the girls and women.
6. Allocate budget for girl friendly toilet in a separate budget line, to ensure each school have girl friendly toilet in schools.

Child, Early and forced marriage

Legal provision

- The Constitution of Nepal, 2015, explicitly prohibits child marriage as a punishable offense and establishes victims' right to compensation for violations from perpetrators⁴².
- The current law sets the minimum age of marriage at 20 for both men and women⁴³.

³⁹Shrestha, L. S, 2013: Study on Chhaupadi Practice in the Far and Mid-Western Regions of Nepal, Foundation for Educational Change Maitidevi, Kathmandu.

⁴⁰ Karki, K. B., Poudel, P. C., Rothchild, J., Pope, N., Bobin, N. C., Gurung, Y., Basnet, M., Poudel, M., Sherpa, L. Y. SCOPING REVIEW AND PRELIMINARY MAPPING Menstrual Health and Hygiene Management in Nepal (pp. 1-96).

⁴¹ Ibid.

⁴² Central for Reproductive Rights, 2016: Policy Brief: Ending Impunity for Child Marriage in Nepal: A Review of Normative and implementation gaps.

⁴³Central for Reproductive Rights, 2016: Policy Brief: Ending Impunity for Child Marriage in Nepal: A Review of Normative and implementation gaps.

- Arranging a child marriage or marrying a child is punishable by imprisonment and fines, which vary depending on the age and gender of the child involved⁴⁴.

In Nepal, child marriage is prevalent among marginalized communities and is result of various factors including poverty, lack of access to education, child labor, social pressures and harmful practices⁴⁵. Nepal has the third-highest rate of child marriage in Asia, with 37.0% of girls marrying before age 18, and 10.0% before 15, though the minimum age of marriage for both women and men is 20 under Nepali law⁴⁶. Child marriage is an intricate issue with multiple facets that impacts women and girls throughout their life cycle.

Child marriage has range of adverse consequences such as termination of education, domestic violence and abandonment, sexual violence and impact of girls' SRH⁴⁷. Early childbearing is risky for both mother and child, and many girls and their babies suffer devastating health consequences such as unintended pregnancy, limited use of maternal health services, low levels of contraceptive use, increasing the risk of HIV and sexual transmitted disease⁴⁸, increased maternal and infant health risks and maternal morbidity and mortality⁴⁹. When girls get married early, they are not equipped with the knowledge and life skills needed to make informed decisions about pregnancy and parenthood⁵⁰. Young girls are malleable or are pressured/ coerced to bear children from their husband, in-laws and society. Due to physical immaturity young girls are susceptible to obstetric fistula.

Recommendations

- Birth registration should be made compulsory and free of charge to validate a child's age at the time of marriage.
- Pre-marriage registration should be compulsory to monitor child marriage and validate a marriage.
- Religious leaders, Priests, matchmakers, and other abettors should be orientated on child marriage and held accountable.
- Provide information on SRHR including- family planning, sexual violence, early pregnancy etc. to young brides and couples.
- Recognize and put in place mechanisms that can ensure the wellbeing of those already affected by child marriage as part of a multi-pronged strategy to address the root causes of child marriage including poverty reduction, access to health and education services and opportunities for girls to realize their potential.

⁴⁴ Central for Reproductive Rights, 2016: Policy Brief: Ending Impunity for Child Marriage in Nepal: A Review of Normative and implementation gaps.

⁴⁵Human Rights Watch, 2016. "Our Time to Sing and Play" Child marriage in Nepal.

⁴⁶ Ibid.

⁴⁷ Ibid.

⁴⁸ WHO, Child Marriage- a threat to health. <http://www.euro.who.int/en/health-topics/Life-stages/sexual-and-reproductive-health/news/news/2012/12/child-marriage-a-threat-to-health>.

⁴⁹ Malhotra, A. 2010: The Causes, Consequences and Solutions to The Causes, Consequences and Solutions to Forced Child Marriage Child Marriage Child Marriage in the Developing World, International Centre for Research on women.

⁵⁰ Girls not Bride: CHILD MARRIAGE HAS DEVASTATING CONSEQUENCES ON A GIRL'S HEALTH. <https://www.girlsnotbrides.org/themes/health/>

Gender based violence and Sexual and Reproductive Rights (SRR)

Legal provision

The Constitution of Nepal 2015 recognizes women's right to be free from all forms of violence. The government has developed different mechanism:

- 2008 Domestic Violence (Offence and Punishment) Act (May 2009)
- 2010 National Action Plan against gender-based violence that intends to provide integrated services to survivors by establishing hospital-based one-stop crisis management centers (OCMC)
- 2012/13–2016/17 National Strategy and Action Plan for Gender Empowerment to End Gender Based Violence aimed at ending gender-based violence.⁵¹

Another form of violence raised during the consultations is obstetric violence. The definition of obstetric violence is "...the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women."⁵² Obstetric violence is an intersection between institutional violence and violence against women during: pregnancy, childbirth and postpartum and occurs in both private and public spheres.⁵³ Obstetric violence manifest through: invasive practices, denial of treatment during childbirth, unnecessary use of medication, forced or coerced medical interventions, dehumanizing or rude treatment, detention in facilities for failure to pay and disregard of women's needs and pain.⁵⁴ Such practices may have adverse consequences for both mother and infant.⁵⁵ This constitutes a violation of trust between women and their health-care providers and can also be a powerful disincentive for women to seek and use maternal health care services⁵⁶. The Safe motherhood program provides free institutional delivering at the health institutes, provides free transportation in emergency cases, encourages for 4 ANC visit etc. However, the institutional deliveries as a percentage of expected live births has only increased by 4% with 55% in the fiscal year of 2072/73 to 59.0% in 2073/74⁵⁷.

There is a huge disparity in the accessibility and availability of Comprehensive Emergency Obstetric Care in Nepal. C-Section rate in province number 1 and 3 is higher than maximum desirable rate 10% while that of province 2, 6 and 7 is lower than minimum acceptable rate of 5 percent.⁵⁸ This indicates limited availability of C-Section services in mountain areas with almost 1% of pregnant women (of expected live births) from these areas getting service out of their districts.⁵⁹ The continuum of care in maternal and newborn health care services shows that there needs to be more

⁵¹ Ministry of Law and Justice (MOLJ) Nepal. 2009. Domestic Violence (Offence and Punishment) A 2009. <http://www.lawcommission.gov.np/en/documents/2015/08/domestic-violence-crime-andpunishment-act-2066-2009.pdf>.

⁵² https://www.researchgate.net/post/Has_obstetric_violence_been_studied_sufficiently

⁵³ <http://www.may28.org/obstetric-violence/>

⁵⁴ <http://www.may28.org/obstetric-violence/>

⁵⁵ World Health Organization, 2015: The prevention and elimination of disrespect and abuse during facility-based childbirth; Department of Reproductive Health and Research, World Health Organization. http://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf;jsessionid=196DE4F9CA0AF94F3F1F6B460106B1E1?sequence=1

⁵⁶ Ibid.

⁵⁷ Department of Health Services. 2016. Annual Report, Kathmandu, Nepal: Ministry of Health, Department of Health Services, Nepal.

⁵⁸ Ibid.

⁵⁹ Ibid.

awareness and encouragement of pregnant women to seek timely first antenatal care, improve quality of counselling during antenatal care, improved access to delivery care services and post-natal care services.⁶⁰ Also, delivery by caesarean section is highest among births by urban women (15%), births to mothers in the highest wealth quintile (14%), highly educated mothers (13%), and first births (7%).⁶¹

Many participants raised the issue of rape and SRR. Rape cases is increasing in great number in Nepal, the rape victims have been of minor age, making it very difficult to prosecute the preparators, as many victims fall silent. The victims have no knowledge about the available services and in many cases the service providers are not equipped or trained to handle these sensitive cases. Thus, many girls and women seek services only after days/weeks making it difficult to gather evidence. Due to the lack of support for victim many women and girls suffer in silence. This case is even worse when a disable women is victimized.

Recommendation

1. Develop guidelines on obstetric violence so, women receive dignified services and are able to make informed decision during pregnancy, childbirth and postpartum.
2. Information on dignified maternity service to all women visiting health service is must.
3. Monitor the status of C-section on both private and public sector and develop evidence-based regulations.
4. Ensure that service providers in OCMC needs to be sensitive to the issue and should have the capacity to handle the sensitive issues like rape including disable women.
5. Develop strict guidelines for OCMC, to ensure that the survivors receive opt most care and assist in justice.

Barriers to quality services

Lack of resources

The Constitution of Nepal declared the free provision of basic health care services as a fundamental right.⁶² This declaration has given an increased responsibility to the government to meet the needs by increasing the spending in the health sector to ensure health systems remain effective. However, the allocated budget in health sector is minuscule. Out of total National Budget only 3.86% were allocated for the health sector during the fiscal year of 2073/2074 (2016/2017)⁶³. Also, very less budget is allocated in National Health Training Centre programs, 1.8% so, the availability of services could be lacking⁶⁴.

Furthermore, the government allocates more budget in curative measures rather than preventive and promotive services. Thus, many health facilities put other issues in priority to women's SRHR⁶⁵. The hospital construction/ Management information system receives the second highest budget in

⁶⁰ Ibid.

⁶¹Tamang Laxmi, 2012: Hospital Birth in Nepal; World Pulse <https://www.worldpulse.com/en/community/users/laxmi-tamang/posts/21506>.

⁶² The Constitution of Nepal, 20 September, 2015.

⁶³Department of Health Services. 2016. Annual Report, Kathmandu, Nepal: Ministry of Health, Department of Health Services, Nepal.

⁶⁴ Ibid.

⁶⁵ Dulal, Ram Krishna & Magar, Angel & Dulal Karki, Shreejana & Khatiwada, Dipendra & Hamal, P.K.. (2014). Analysis of Health Sector Budget of Nepal. Journal of Nepal Medical Association. 52. 811-821. 10.31729/jnma.2757.

terms of allocation with 19.67%⁶⁶ yet, the infrastructure lacks of basic facilities such as lighting, heating system, regular water supply and a placenta pit⁶⁷.

Evidence suggests that three delays are important factors for maternal and newborn morbidity and mortality in Nepal (delays in seeking care, reaching care and receiving care)⁶⁸. One of the contributing factors could be financing. Health Financing in Nepal primarily relies on out of pocket payment with 60% (plus and minus) out of the total health expenditure⁶⁹, which has a huge impact on poor, marginalized and disable women accessing health facilities.

The government has made an effort with National ASRH program to gradually scale up to 70 of the 75 districts covering 1134 health facilities till the end of current fiscal year 2073/74⁷⁰, although these health facilities are inadequate and unequipped and limited to married girls. Stigma and discrimination seems to be one of the barriers for young people to the existing health facilities.

Recommendation:

1. Increase the national budget on health sector.
2. Include sufficient resource to ensure the provision of SRH services and information, including youth friendly services.
3. Ensure that youth have access to these services without judgement.
4. Ensure healthcare providers are quipped to provide unbiased and stigma free services to every women and girl.
5. Adolescent ASHR program have enough funding and services are attainable without to youth free from discrimination and stigma.
6. Regulate private medical institutions on the charges of the services to reduce the out of pocket expenses.

Comprehensive sexuality education

There is no separate CSE curriculum and it has been integrated in Environment, Health and Population (EHP)⁷¹. Though it has been made mandatory course for the students, the content does not cover the whole aspects of SRHR. Sexuality education is limited and sexual health is not all conceptualized in the sexuality education and is not comprehensive. Additionally, it does not cover all the components of CSE as defined by IPPF or UNFPA⁷². The contents are driven more in health perspectives rather integrating with gender and human rights and doesn't always contain information about the availability of services and service sites⁷³.

⁶⁶ Department of Health Services. 2016. Annual Report, Kathmandu, Nepal: Ministry of Health, Department of Health Services, Nepal.

⁶⁷ Khatri RB, Dangi TP, Gautam R, Shrestha KN, Homer CSE (2017) Barriers to utilization of childbirth services of a rural birthing center in Nepal: A qualitative study. PLOS ONE 12(5): e0177602. <https://doi.org/10.1371/journal.pone.0177602>.

⁶⁸ Department of Health Services. 2016. Annual Report, Kathmandu, Nepal: Ministry of Health, Department of Health Services, Nepal.

⁶⁹ Shiva Raj Adhikari. An Evaluation of Nepal's Free Health Care Schemes: Evidence from a Quasi-Experimental Design. (Working paper). July, 2013. Available from: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2289344.

⁷⁰ Department of Health Services. 2016. Annual Report, Kathmandu, Nepal: Ministry of Health, Department of Health Services, Nepal.

⁷¹ Amit TimilSina, Kamal Gautam, Jyotsna Maskay, 2017: COMPREHENSIVE SEXUALITY EDUCATION: THE WAY FORWARD, Country Advocacy Brief, ARROW.

⁷² Ibid.

⁷³ Ibid.

Even though, EHP is a compulsory subject that needs to be taught both in private and in public schools, many public schools do not have qualified teachers or designated teacher for the subject⁷⁴. Many teachers are untrained and do not use rights-based approach but rather allow their perceptions and attitudes to affect how information is delivered to students and some skips the topic related to SRHR^{75,76}. Also, Non-Formal Education Centre (NFEC) for out of school young people does not include CSE⁷⁷; thus, they are missed out of basic information and right about SRHR. Recently, the Curriculum Development Centre has removed EHP from the curriculum of class 9 & 10, which is a huge step backwards.

Safe abortion

Legal Provision

- Safe Motherhood and Reproductive Health act (2018)
- Safe Abortion Service Program Guideline 2016

Safe abortion services are present in all 75 districts. Currently, there are over 2,000 abortion trained providers⁷⁸. The GoN has increased the availability of service for safe abortion service by the end of 2015/2016, 466 health facilities were listed for providing medical abortion (MA) services, 538 health facilities were listed as Manual Vacuum Abortion (MVA) service sites and additional training of SBA with the support of various partners. The safe abortion program was prioritized to ensure the availability of five modern contraceptive methods at all safe abortion sites⁷⁹.

However, there are still pertaining issues related to abortion services such as lack of knowledge, stigma and unclarity on the existing laws and policies. Women still turning to unsafe abortion as they are still unaware about abortion being legalized. Only 48% of women age 15-49 report knowing a place where a safe abortion can be obtained. According to the abortion incidence study in 2014, the abortion rate is 42 per 1,000 women aged 15–49. Among them fewer than half (42.0%) of all abortions were provided legally in government-approved facilities. The remainder (58.0%) were clandestine procedures provided by untrained or unapproved providers or induced by the pregnant woman herself.

There is a need to encourage women for post abortion care (PAC) as only 10.0% women are receiving PAC as per the annual report 2016/17. GoN implemented Maternal and Perinatal Death Surveillance and Response (MPDSR) in 2017, which suggested among the direct maternal deaths, 13% were due to abortion related complications^{80,81}. 54.0% of the total gynecological and obstetric admissions in hospitals were due to induced abortion complications according to MMMS 1998⁸². The

⁷⁴United Nation Family Planning Association, 2014: Review of Curricula in the Context of Comprehensive Sexuality Education (CSE) in Nepal, 2014, UNFPA

⁷⁵ Ibid.

⁷⁶ Amit Timilsina, Kamal Gautam, Jyotsna Maskay, 2017: COMPREHENSIVE SEXUALITY EDUCATION: THE WAY FORWARD, Country Advocacy Brief, ARROW.

⁷⁷ United Nation Family Planning Association, 2014: Review of Curricula in the Context of Comprehensive Sexuality Education (CSE) in Nepal, 2014, UNFPA

⁷⁸ Wan-ju wu, Maru.S, kiran regmi, and Basnett.I. 2017. *Abortion Care in Nepal, 15 Years after Legalization: Gaps in Access, Equity, and Quality.*(19).1.

⁷⁹ Ibid.

⁸⁰ Department of Health Services. 2016. Annual Report, Kathmandu, Nepal: Ministry of Health, Department of Health Services, Nepal.

⁸¹ Pradhan, A., Suvedi,BK., Barnett,S., Sharma, SK., Puri, M., Poudel, P., Chitrakar, SR.,KC.,NP.,Hulton,L.2010.Nepal Maternal Mortality Morbidity Study 2008.2009.Family Health Division, Department of Health Services, Minsitry of Health, Government of Nepal, Kathmandu, Nepal.

⁸² Ministry of Health. 1998. National Maternal and Morbidity Study 1998. Kathmandu: Ministry of Health, 1998.

obstetric morbidities by abortion complication was 56 per 1000 birth at Emergency Obstetric Facilities (EOC) as per MMMS 2008/2009⁸³.

Sexual Orientation and Gender Identity

Legal process

- Same-sex relations or LBT identities are not a criminal offence in Nepal⁸⁴.
- Activists are concerned by recent proposed amendments to the Civil and Criminal Code (which will update and replace the current “Muluki Ain”) prepared by the Ministry of Law and Justice, including not recognizing same-sex marriage and whether the vague reference to “unnatural sex” could be used against LBT people⁸⁵.
- In 2007, four LGBT NGOs were successful in a petition against the government in Sunil Babu Pant and Others v. Government of Nepal and Others, resulting in the verdict calling on the government to scrap laws that discriminate on the basis of SOGI, to recognize a third gender category, and to establish a committee to explore the legalization of same-sex marriage⁸⁶.

LBTIQ face various forms of discrimination and stigma in every social, political and economic sphere, including attaining official documents and national identity card. This form of discrimination and stigma extends in health sectors, the limited accessibility and acceptability of the rights of LBTIQ from individuals, family and society forces many them to hide their identity and the ones who identify themselves as one are disowned. The constant discrimination and stigma results in them not wanting to disclose their identity. Also, for many the lack of information and knowledge about LBT, hinder them to identify their sexuality or gender orientation, making them an outcast in society. Access to health care is a problem particularly for transgender individuals. For instance, much remains unknown about the overall status of sexual and gender minorities on mental and psychological health issues. The specific needs of transgender men and lesbians including reproductive health are seldom discussed or explored^{87,88}. Further, trans women and men have limited access to health care providers as the health care services does not fully accommodate their needs such as: hormone therapy. Many lesbians and gay do not disclose their sexual orientation due to the fear of privacy and confidentiality from the service providers. Additionally, HIV epidemic disproportionately affects MSM, with more than one-fifth HIV prevalence among this sub-population⁸⁹. The government has limited consideration for the importance of sexual rights even though, the constitution has recognized third gender. More information and research are needed into the health needs of the broader LBT community including mental health issues, reproductive health issues among lesbians, and the usage of hormones by transgender people⁹⁰.

Recommendation:

⁸³Pradhan, A., Suvedi, BK., Barnett, S., Sharma, SK., Puri, M., Poudel, P., Chitrakar, SR., KC., NP., Hulton, L. 2010. Nepal Maternal Mortality Morbidity Study 2008.2009. Family Health Division, Department of Health Services, Ministry of Health, Government of Nepal, Kathmandu, Nepal.

⁸⁴ UNDP, USAID (2014). Being LGBT in Asia: Nepal Country Report. Bangkok.

⁸⁵ Ibid.

⁸⁶ Ibid.

⁸⁷ UNDP, USAID (2014). Being LGBT in Asia: Nepal Country Report. Bangkok

⁸⁸ Rabin, Pathak & Regmi, Pramod & Pant, Puspa Raj & Simkhada, Padam & Douglas, Flora & Stephens, Jane. (2010). Gender Identity: Challenges to Access Social and Health Care Services for Lesbians in Nepal. Global Journal of Health Science. 2. 10.5539/gjhs.v2n2p207.

⁸⁹ UNDP, USAID (2014). Being LGBT in Asia: Nepal Country Report. Bangkok

⁹⁰ Ibid.

1. CSE should be made compulsory and should be age appropriate with an integration of sexual and reproductive rights.
2. Designate a focal teacher who is trained that can provide CSE in both public and private schools.
3. Provide awareness programs on abortion to reduce unsafe abortion.
4. Abortion stigma should be addressed by providing value clarification to health care providers.
5. Encourage women to attain PAC services and utilization of contraceptive.
6. Develop provision to maintain confidentiality and privacy of service seeker on safe abortion.
7. Recognize and address the stigma and discrimination that is faced by people of diverse sexualities and gender identities.
8. Provide counselling and health services that focus on acceptability and rights of people of diverse sexualities and gender identities.
9. Provide information resources on sexuality and gender diversity issues including sex education and safe sex practices. This information is currently limited.