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National Alliance for Pelvic Organ Prolapse Management - Nepal

NEPAL

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This briefing is submitted to the United Nations (UN) Committee on Economic, Social and Cultural Rights (the Committee) by Amnesty International and the National Alliance for Pelvic Organ Prolapse Management, an alliance of 17 Nepali NGOs working on sexual and reproductive rights. See Annex 1 for more information.

A. Introduction

The focus of this submission is on the violations of economic, social and cultural rights that result in large numbers of women in Nepal suffering from the reproductive health condition uterine prolapse.

The information in this submission is based on the long experience that member organisations of the National Alliance for Pelvic Organ Prolapse Management (National Alliance) have of working on the issue in Nepal and on Amnesty International's 2014 report *Unnecessary Burden: Gender discrimination and uterine prolapse in Nepal*.¹ It demonstrates inadequate efforts by the government of Nepal to implement articles 2, 3, 7, 9, 10, 11 and 12 of the International Covenant on Economic, Social and Cultural Rights (the Covenant).

Uterine prolapse

Pelvic organ prolapse, of which uterine prolapse is one form, occurs when the pelvic muscles are unable to support the uterus causing it to move from its normal position or 'prolapse'. In the most severe manifestation of this condition, the uterus can come out of the vagina altogether. It can affect the bladder and/or bowel causing leakage of urine and/or faeces. Women with uterine prolapse may experience a range of problems including severe pain, difficulty sitting, walking and conducting daily tasks, difficulties in passing urine or faeces and sexual dysfunction. They may also be subjected to further discrimination and increased violence because they have the condition.² A UNFPA study in

¹ Amnesty International, *Unnecessary Burden: Gender discrimination and uterine prolapse in Nepal*, AI Index ASA/31/001/2014, February 2014

² Nepal National Medical Standard for Reproductive Health, Volume II: Other Reproductive Health Issues, Family Health Division, 2003, part 6 on genital prolapse. In addition, women suffering from uterine prolapse are often unable to carry out their work in the same way they had before they experienced the condition. Women told Amnesty International that family members

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2006 estimated that approximately 10% of and women in Nepal suffer from uterine prolapse.³ Studies conducted on a smaller scale by members of the National Alliance have found prevalence rates of up to 42% in some districts. In Nepal the condition affects relatively young women (under 30) whereas in developed countries women who develop uterine prolapse tend to experience it after the menopause.⁴ The experience of members of the National Alliance shows that higher prevalence rates are found in regions, caste and ethnic groups where women and girls experience higher levels of gender discrimination.

The accepted risk factors for uterine prolapse include adolescent pregnancy, lack of rest during and immediately after pregnancy - including carrying heavy loads, improper birthing practices used by unskilled birth attendants, inadequate nutrition, multiple pregnancies and pregnancies close together due to lack of access to contraception.⁵ Gender discrimination against women and girls and the violation of economic, social and cultural rights lie at the root of many of these risk factors.

B. Articles 2 and 3, Right To Equality and Non-Discrimination

The high prevalence of uterine prolapse and the relatively young age at which women in Nepal experience the condition reflect systemic patterns of discrimination faced by women and girls, such as gender-based violence, gender stereotyping, child marriage and harmful practices justified by culture or tradition, and the lack of effective governmental action to address this discrimination. The government of Nepal has, in addition to the Covenant, ratified many other international human rights treaties which guarantee the right to equality and non-discrimination.⁶ The government of Nepal, therefore, must take all appropriate measures to end discrimination against women and girls committed by any person, organization or enterprise. As the Committee has stated, the right to non-discrimination is an immediate and cross-cutting obligation and that State Parties must “immediately adopt the necessary measures to prevent, diminish and eliminate the conditions and attitudes which cause or perpetuate substantive or de facto discrimination” on any of the prohibited grounds.⁷

Adolescent pregnancy linked to child marriage

Adolescent pregnancy is a risk factor for uterine prolapse because the pelvis of adolescent girls may not yet be fully developed which leads to an increase risk of prolonged or difficult labour. That in turn increases the chance of damage to the pelvic muscles causing uterine prolapse. In Nepal, adolescent pregnancy is closely linked to child marriage. Government figures from the Demographic and Health Survey, 2011 show that of the 29.1% of adolescent girls reporting recent sexual activity, 28.8% were

complained that they did not work enough and were lazy, sometimes forcing them to work, when the reality was that they were in great pain. This condition also causes women pain during sex, and husbands then complained about this. For example, one woman told Amnesty International that her husband beat her and forced her to have sex.

³ UNFPA, *Status of Reproductive Morbidities in Nepal*, Institute of Medicine, Kathmandu 2006. There has been no comprehensive study on the prevalence of uterine prolapse in Nepal and the different methodologies used in the studies which have been conducted mean the prevalence rates they found vary. Studies have either been conducted on a small scale in specific districts in Nepal (population based studies), or amongst patients in identified health centres (facility based studies).

⁴ Pradhan, S. “Unheeded Agonies - A Study on Uterine Prolapse Prevalence and its Causes in Siraha and Saptari Districts”, Women's Reproductive Rights Program (WRRP), Centre for Agro-Ecology and Development (CAED), Kathmandu, Nepal, 2007

⁵ National Medical Standard for Reproductive Health, Volume II: Other Reproductive Health Issues, Family Health Division, 2003, part 6 on genital prolapse

⁶ These include article 2(1) of the International Covenant on Civil and Political Rights; the International Convention on the Elimination of All Forms of Racial Discrimination; the Convention on the Elimination of All Forms of Discrimination against Women; article 2(1), Convention on the Rights of the Child; article 4(1) of the Convention on the Rights of Persons with Disabilities

⁷ Committee on Economic Social and Cultural Rights (CESCR), General Comment 20 on Non-discrimination in economic, social and cultural rights, UN Doc. E/C.12/GC/20, Para 8

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married.⁸ The same survey found that 10.5% of 17 year old girls, 4.9% of 16 year old girls and 0.9% of 15 year old girls were pregnant or had given birth to their first child.⁹

The law in Nepal requires men and women to freely consent to the marriage and be at least 18 years old if they have permission of their guardian and at least 20 years old without that permission. Although census data from 2011 showed that nearly 30% of adolescent girls and 7% of adolescent boys aged 15-19 were already married,¹⁰ figures from the Nepal police show only 19 cases of child marriage were registered by the police between 2012 and 2013.¹¹ In the 2006 case of *Sapana Pradhan and Others v. Prime Minister and Council of Ministers and Others*, the Supreme Court heard from the Ministry of Women and the Ministry of Law, Justice and Parliamentary Management that the law was being implemented because there had been a few prosecutions for child marriage. However, the court looked at statistics on child marriage and said the practice remained a problem in the country and that it did not agree “that the law has been implemented effectively”. The court called for the government to pay “urgent attention” to prevention of child marriage and “to implement and cause to be implemented effectively the relevant laws”.¹² However, it did not specify which Ministries should take the lead in this implementation.

Staff from the Department of Women and Children within the Ministry of Women told Amnesty International that there is a community awareness programme, originally an NGO initiative called “Choose your Future”, now run by the government. The programme is for girls aged between 11 and 19 and targets out of school girls. They receive training on issues including the health consequences of child marriage and early pregnancies and related laws. However, it is a small-scale programme. Less than 3,000 girls received the training between 2010 and 2011, the last year for which the Ministry provided Amnesty International with figures.¹³ By targeting girls it may be effective in reducing the numbers of girls who elope and marry. However, the decision on marriage of an adolescent girl is often made by her parents or other family members and a programme focusing on girls may not be effective in addressing their lack of decision making. The Ministry did not provide any information on the impact of the programme in reducing early marriage and adolescent pregnancy.

Gender-based violence

Gender-based violence against women and girls is widely prevalent in Nepal.¹⁴ There is a widespread belief among women and men in Nepal that a wife should not refuse to have sex with her husband. This results in marital rape being very common and women regarding it as something they just have to live with. Any sexual act without full, free consent of both parties is rape, and criminalised under Nepali law, although the law provides for lower penalties for marital rape.¹⁵ The inability of women to control sexual activity means they risk becoming pregnant more often or sooner than they would like. Also, they risk increased pain and discomfort from being compelled to engage in sex before their body has completely recovered from childbirth. A 2013 UNFPA study of women who had undergone surgery for uterine prolapse found that 72% believed that “having to yield to husband’s demand for sex” was a

⁸ Nepal Demographic and Health Survey 2011 (DHS 2011), Ministry of Health and Population, Kathmandu, March 2012, p.65 and 72

⁹ DHS 2011, p.84

¹⁰ DHS 2011, p.65

¹¹ Nepal Police, Women and Children Services Directorate, Table of Crime Data, available at:

<http://www.nepalpolice.gov.np/women-children-service-directorate.html>

¹² *Sapana Pradhan & Others v. Prime Minister & Council of Ministers & Others*, decision no. 7659, N.K.P. 2063, Vol. 3 at 289 (2006)

¹³ Interview with Shantha Paudwal, Mina Kathel, Seeta Adhikari and Rajkumari Rai, Women Development Officers, Department of Women and Children of the Ministry of Women, Children and Social Welfare, 23 January 2014, Kathmandu

¹⁴ A Study on Gender-Based Violence Conducted in Selected Rural Districts of Nepal, Office of the Prime Minister and Council of Ministers, Kathmandu (OPMCM, Study on Gender-Based Violence), November 2012

¹⁵ Muluki Ain (National Code), Chapter 14.

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factor which caused their condition.¹⁶ A 2012 government study found that only 9% of women knew that marital rape was a crime.¹⁷

*The Committee has requested information on “the effectiveness of steps taken to implement and enforce the Domestic Violence Act (2009)”.*¹⁸

Domestic violence remains a serious problem with government efforts so far failing to overcome obstacles that result in many women being unaware of their rights and/or unwilling to report violence to the authorities.

Many women are unable or unwilling to report violence because they are afraid of social stigma and are often economically dependent on their husband and in-laws. Data on instances of gender-based violence are collected in different ways: through the police, the National Women’s Commission and NGOs. The Ministry of Women also collects data on numbers of women using the safe houses they run. There is no system for combining the figures to produce comprehensive national data. The National Women’s Commission told Amnesty International that between August 2012 and July 2013 they had received a total of 369 cases of gender-based violence of which 243 cases were of domestic violence. No cases of marital rape were registered with the Commission; however, they said that sometimes, after investigation, they found domestic violence cases which included marital rape but they kept the case under the domestic violence category.¹⁹ Figures from the Nepal police show that in 2012-13 there were 1,800 cases of domestic violence and 677 cases of rape reported to the police.²⁰ There is no separate category for marital rape so it is not clear whether any of the domestic violence or rape cases include marital rape or whether no cases were reported.

Government data from the 2012 survey on gender-based violence found that 83% of women who had experienced violence from an intimate partner did not seek any form of help.²¹ Those who did seek help for any form of violence were most likely to turn to relatives or friends. Less than 1% had sought help from the police, social workers or health service providers.²² The most common reason for not seeking help was “embarrassment” followed by a belief that “nothing can be done” to help.²³

The government has a “National Strategy and Plan of Action related to Gender Empowerment and Ending Gender Based Violence 2012-2017”. It sets out a range of actions for different government ministries, including the Ministry of Women and Ministry of Health, to take. The Plan commits the Ministry of Women to undertaking activities to raise awareness among “ordinary people” on “domestic violence laws and other laws relating to women” and on “how to seek justice”.²⁴ It also requires the ministry to ensure laws and policies are in line with international standards and to provide training to local service providers to enable them to address gender-based violence. It mentions that “men and youth” should be mobilised as “partners of the programme” but does not contain any details on how this will be done. The government needs to do much more to ensure the effective implementation and monitoring of the strategy. The Ministry of Women runs shelters for survivors of violence in 15 out of 75 districts in Nepal. There is also a small programme of training for couples that is run by the ministry. At least one training event for 15 couples should be held in each of the 75 districts per year. The training covers gender and gender roles and issues relating to violence against women. Staff from the Department of Women and Children told Amnesty International that the programme had been running for many years and when selecting participants they try to focus on couples whose relationship

¹⁶ Health Related Quality of Life of Women Suffering from Pelvic Organ Prolapse: before and 9 to 11 months after surgical interventions, Ministry of Health and Population and United Nations Population Fund, 2013, (UNFPA, Quality of Life), p.xiv

¹⁷ OPMCM, Study on Gender-Based Violence, p.34

¹⁸ Para 16, List of issues in relation to the third periodic report of Nepal, 18 December 2013, E/C.12/NPL/Q/3.

¹⁹ AI Nepal meeting with National Women’s Commission, 12 December 2013

²⁰ Nepal Police, Women and Children Services Directorate, Table of Crime Data, available at:

<http://www.nepalpolice.gov.np/women-children-service-directorate.html>

²¹ OPMCM, Study on Gender-Based Violence, p.68

²² OPMCM, Study on Gender-Based Violence, p.69

²³ OPMCM, Study on Gender-Based Violence, p.69 The most common barriers to seeking help were embarrassment (52.5%), nothing can be done (25.2%), did not trust anyone (12.3%) and fear of rejection by family or friends (12%)

²⁴ National Strategy and Plan of Action related to Gender Empowerment and Ending Gender Based Violence 2012-2017, Text in Nepali on file with AI Nepal

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is thought to be abusive. However, they also said that the numbers who could be trained were very low because the budget was small and their priority training programme was one which focused solely on women.²⁵

Harmful practices justified by culture, religion and tradition

*The Committee has requested information on the “steps taken to address the continued prevalence of harmful traditional practices, such as ... chhaupadi (prohibiting women from participating in family activities, living in the home or eating food other than dried foods during menstruation)”.*²⁶

The practice of chaupadi²⁷ results in women and girls being forced to leave their house and live in a cowshed or in a separate hut after childbirth or during menstruation. It is mainly practiced in the mid-western and far-western regions of Nepal and is more prevalent among the dominant Brahmin and Chhetri groups and among Dalits. These sheds are frequently dirty, insecure, lack protection from severe weather and leave their occupants at risk of snake, scorpion and other animal attacks. Deaths of women and girls staying in these sheds are reported every year and there are reports of rape and other forms of sexual violence against women and girls linked to the practice.²⁸

In a 2005 judgement in the case of Dil Bahadur Bishwakarma v Government of Nepal, the Supreme Court declared the practice of chaupadi to be a violation of women’s rights. The Court directed the government to take action to combat the practice.²⁹ In response, the Ministry of Women developed a “Chaupadi Practice Elimination” Directive in 2007. It calls for the establishment of local committees to develop action plans for implementing programmes to raise public awareness about practice and its negative impacts. It also specifies the local agencies that should be represented on the committees. However, although the Ministry of Women developed the directive, it has not taken on responsibility for ensuring it is implemented as required by the Supreme Court. In a section on accountability the directive states that “people in public positions” shall be accountable.³⁰

Multiple and intersecting forms of discrimination

The Committee has stressed that discrimination on the basis of more than one of the prohibited grounds has a cumulative and specific impact on the groups and individuals affected.³¹

As parts D and E of this briefing discuss (see below), government data shows that specific groups of women - especially Muslim women and Terai Dalit women – have significantly lower access to skilled birth attendants, higher malnutrition and higher levels of “unmet need” for contraception. The effects of caste, religious and ethnic differences continue to exacerbate inequalities in Nepali society. The government has acknowledged this in its report to the UN Human Rights Committee. It stated that caste discrimination “is found on the ground in some forms, negatively affecting the dignity of people belonging to the Dalit community”.³²

²⁵ Interview with Shantha Paudwal, Mina Kathel, Seeta Adhikari and Rajkumari Rai, Women Development Officers, Department of Women and Children of the Ministry of Women, Children and Social Welfare, 23 January 2014, Kathmandu

²⁶ Para 13, List of issues in relation to the third periodic report of Nepal, 18 December 2013, E/C.12/NPL/Q/3.

²⁷ Lack of access to skilled birth attendants increases the likelihood of women experiencing uterine prolapse. Women who suffer discrimination resulting in them being forced to give birth in cowsheds are more likely to have unskilled people to assist them.

²⁸ United Nations Resident and Humanitarian Coordinator’s Office, “Chaupadi in the Far West”, April 2011, p.2 and A Study on Gender-Based Violence Conducted in Selected Rural Districts of Nepal, Office of the Prime Minister and Council of Ministers, Kathmandu, November 2012, p.63

²⁹ Dil Bahadur Bishwakarma v Government of Nepal, Writ Petition 3303 of 2004, Judgement 2 May 2006, Text in Nepali on file with AI Nepal

³⁰ Chaupadi Elimination Guidelines, Ministry of Women, Children and Social Welfare, Text in Nepali on file with AI Nepal

³¹ Committee on Economic Social and Cultural Rights (CESCR), General Comment 20 on Non-discrimination in Economic, Social and Cultural Rights, UN. Doc E/C.12/GC/20, 2009, para 17

³² Government of Nepal, Second Periodic Report to the Human Rights Committee, UN. Doc CCPR/C/NPL/2, June 2012, p.24

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The Government must take steps to ensure caste, ethnic or religious discrimination does not deny some women and girls access to programmes designed to improve sexual and reproductive health or prevent them from benefiting as other groups do. In 2009, the Ministry of Health published a Health Sector Gender Equality and Social Inclusion Strategy. As a part of its objectives, this strategy sought to “Enhance the capacity of service providers and ensure equitable access and use of health services by the poor, vulnerable and marginalized castes and ethnic groups using a rights-based approach” and to “improve health-seeking behaviour of the poor, vulnerable and marginalized castes and ethnic groups using a rights-based approach”. In August 2013 the government published a Progress Review of the strategy. It noted positive developments in the collection of disaggregated data, sensitization of health workers and an increase in the budget for gender equality and social inclusion activities. However, the 2013 review does not contain any information about whether this policy has led more people from disadvantaged groups to access health services, or whether it has improved their health outcomes.

C. Articles 7, 9 and 10, Right to Safe and Healthy Working Conditions and to Special Protection to Mothers before and after Childbirth

As the Committee stressed in General Comment 19 on the right to social security “Paid maternity leave should be granted to all women, including those involved in atypical work, and benefits should be provided for an adequate period”³³ and that “States parties must take steps to the maximum of their available resources to ensure that the social security systems cover those persons working in the informal economy”.³⁴

In Nepal the majority of women work in the informal sector and do not have access to paid maternity leave or social security benefits. According to the government of Nepal, 75% of working women in Nepal were employed in the agricultural sector.³⁵ More than three-quarters of those were unpaid and were mostly employed by family members.³⁶ The overwhelming majority of women and girls interviewed by Amnesty International worked as agricultural labour, carrying cement, porters, and stone crushers. All these activities are part of the “informal” or “atypical” sector, and is not regulated so workers are not protected by Nepali labour laws or the minimum wage.

Lack of access to maternity leave and benefits

Lifting heavy objects and carrying heavy loads can strain the pelvic muscles particularly during pregnancy and soon after women give birth.³⁷ Consequently, undertaking physical labour involving heavy lifting during and after pregnancy is a risk factor for uterine prolapse. The government reports that the majority of women work in the informal agricultural sector and that women work on average 36.3 hours per week on economic activities outside the house and 25.1 hours on unpaid work at home. In comparison men work on average 42.6 hours per week on economic activities outside the home and 9.7 hours at home.³⁸

The 2013 UNFPA study of women who had undergone surgery for uterine prolapse found that on average women rested for 20.4 days following the birth after which they experienced symptoms of prolapse, just under half the government recommended six week rest period. Almost 60% of women from the Hills and Mountains rested for between 13 and 15 days and none rested for less than seven

³³ Committee on Economic Social and Cultural Rights (CESCR), General Comment 19 on the Right to Social Security, UN.Doc E/C.12/GC/19, 2008, para 19

³⁴ Committee on Economic Social and Cultural Rights (CESCR), General Comment 19 on the Right to Social Security, UN.Doc E/C.12/GC/19, 2008, para 34

³⁵ Government of Nepal report to CEDAW, p.39-40

³⁶ Nepal Demographic and Health Survey 2011 (DHS 2011), Ministry of Health and Population, March 2012, p58-60

³⁷ Sancharika Samuha, Booklet on Uterine Prolapse, UNFPA, 2007, p.22

³⁸ Government of Nepal report to CEDAW, p.39-40

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days. 34.7% of women from the Terai only rested for between five and seven days.³⁹ Every woman from the Hills and Mountains and 98% of women from the Terai reported carrying heavy loads following giving birth. In the Hills and Mountains about 80% of women had resumed “heavy physical work”, such as farm work, within two to three weeks of giving birth. In the Terai 34% resumed “heavy physical work” within one week and another 40% within two to three weeks.⁴⁰

Women interviewed by Amnesty International said that several factors influenced the number of days they could rest after giving birth. Women usually live with their husband and his parents and sometimes his brothers, their wives and children too. One factor was the presence of other women in the household who can undertake her household work. Another factor is the economic situation of the household. In poorer households women have to return to work sooner in order to earn money for the family. In addition to economic circumstances requiring them to start work soon after giving birth, the majority of women who spoke to Amnesty International said that they must do whatever work their husband and his family asked them. The amount of rest women could take depended on the knowledge and sensitivity of their families, particularly other women in the family, not on their own knowledge and decision-making.

In its List of Issues, the Committee has asked the government of Nepal to provide information on “steps taken by the State party to reduce the informal sector of the economy and on measures taken to ensure that workers in the informal sector have access to basic services and social protection”.⁴¹

The government acknowledged in its report to the Committee that “The inspection and monitoring of labour in the informal or unorganized sector need to be legally provided for”.⁴² However, it has yet to happen. In 2005, Nepal’s Ministry of Labour and Employment issued the Labour and Employment Policy. Amongst other things, it committed to developing a social security system that extended to the informal sector, promoting and developing occupational safety and health, and ensuring equal access of women to employment.⁴³ More specific commitments included making the workplace safe by “promoting and developing occupational health and safety and reproductive health as inherent aspects of all organizations and workplaces”,⁴⁴ and developing a “comprehensive and integrated system of social security... with the gradual inclusion of the informal sector”.⁴⁵ However, in 2013 representatives of the Ministry of Labour and Employment told Amnesty International that there were no concrete plans to revise the Labour Act and Rules to extend them to the informal sector.⁴⁶ No tangible progress has yet been made on implementing aspects of the Labour and Employment Policy 2005 which committed to developing a social security system that extended to the informal sector.

D. Article 11, the right to an adequate standard of living, including the right to adequate food and the right of everyone to be free from hunger

As the Committee emphasised in General Comment 12 on the right to adequate food, the “core content” includes “[t]he availability of food in a quantity and quality sufficient to satisfy the dietary needs of individuals” and that “dietary needs implies that the diet as a whole contains a mix of nutrients for physical and mental growth, development and maintenance, and physical activity that are in compliance with human physiological needs at all stages throughout the life cycle and according to

³⁹ UNFPA, Quality of Life, p.24

⁴⁰ UNFPA, Quality of Life, p.25

⁴¹ Para 7, List of issues in relation to the third periodic report of Nepal, 18 December 2013, E/C.12/NPL/Q/3.

⁴² Para 208, Implementation of the International Covenant on Economic, Social and Cultural Rights, Third periodic reports submitted by States parties under articles 16 and 17 of the Covenant, Nepal, 29 October 2012, E/C.12/NPL/3

⁴³ Labour and Employment Policy, 2005, p.3, http://www.moltm.gov.np/uploads/document/Labour%20policy-Eng-2062_20110904014004.pdf

⁴⁴ Labour and Employment Policy, p.6, para 3.3.4

⁴⁵ Labour and Employment Policy, p.6, para 3.3.2

⁴⁶ Interview with Amnesty International Nepal, 28 October 2013

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gender and occupation”. The Committee also stated that any discrimination in access to food constituted a violation, including when that discrimination occurred through state “failure to regulate activities of individuals or groups so as to prevent them from violating the right to food of others”.⁴⁷

When women do not have access to sufficient nutritious food their body and muscles do not develop fully, which can result in weaker pelvic muscles and a greater risk of uterine prolapse. Malnutrition and under-nourishment caused by a lack of nutritious food during and after pregnancy are risk factors for uterine prolapse in Nepal.⁴⁸ Gender discrimination results in women being denied equal access to food and this, combined with food shortages at particular times of year, results in under-nourishment or malnutrition. Women from the Terai told Amnesty International that men often ate before women even when the woman was pregnant. This means men are more likely to get more food overall and also the best pieces of meat or vegetables when these are in short supply. Some Dalit women told Amnesty International about a myth especially prevalent among older women that women who have just given birth should not eat fresh vegetables “because it will make her sick”. This results in women being denied vegetables even when plenty are available.

The Committee has requested the government to “provide information on steps taken to address the problem of food insecurity, reportedly faced by 3.5 million people, in particular disadvantaged and marginalized groups.”⁴⁹

According to the Nepal Demographic and Health Survey from 2011 households in the Terai are more likely to have access to sufficient food and not worry about food shortages than households in the Hills and Mountains.⁵⁰ However, further analysis of this data by region, caste and ethnicity showed that the percentage of undernourished women in the Terai (measured as those having a Body Mass Index of less than 18.5) was much higher than in the Hills. Overall 31.7% of all Terai women were undernourished whereas the figure for all Hill and Mountain women was 13.2%.⁵¹ This suggests that the inequality in food distribution in the Terai disadvantages Terai women more than general food shortages affect Hill and Mountain women. The groups with the highest percentage of undernourished women were Terai Dalits (45%), Muslims (36%), Other Terai Castes (33%), Terai Janajati (26%) and Terai Brahmin/Chhetri (25%). The figures for malnutrition among Hill Brahmin and Chhetri and Hill Dalits were close to the national average of 18.2%. Only 8.5% of Hill Janajati women were undernourished.⁵²

In 2012 the government adopted a “Multi-Sector Nutrition Plan for Accelerating the Reduction of Maternal and Child Under-Nutrition (2013 – 2017)”.⁵³ One of the eight key outputs of the plan is the increased availability and consumption of appropriate foods for pregnant women and adolescent girls, and a reduction of women’s workloads.⁵⁴ Stated methods of achieving this output include radio programmes to encourage a reduction in the workload of women, subsidies for installing improved cooking stoves that reduce women’s exposure to indoor pollution and their need to carry heavy loads of wood for fuel, and expanding an existing programme which provides financial support to families to cover nutrition during pregnancy and for young children.⁵⁵ This strategy, which involves cooperation between different government ministries, has the potential to improve the nutritional status of women in Nepal, and reduce their risk of uterine prolapse. However, while it outlines a multi-pronged

⁴⁷ Committee on Economic Social and Cultural Rights (CESCR), General Comment 12 on the Right to Adequate Food, UN. Doc E/C/12/1999/5, 1999, paras 8-9 and 18-19

⁴⁸ UNFPA booklet p.20

⁴⁹ List of issues in relation to the third periodic report of Nepal, 18 December 2013, E/C.12/NPL/Q/3, para 20

⁵⁰ DHS 2011, p.37. 52.1% of households in the Terai are “food secure” in comparison with 47.2% in the Hills and 40.5% in the Mountains. 29% of Hill households and 26% of Mountain households are “moderately food insecure” in comparison with 18% of Terai households. However, more Terai households are “severely food insecure” (18.6%) in comparison to 15.1% of Mountain households and 11.8% of Hill households.

⁵¹ MoHP, Effects of Caste, Ethnicity and Regional Identity, p.22

⁵² MoHP, Effects of Caste, Ethnicity and Regional Identity, p.22

⁵³ Multi-Sectoral Nutrition Plan: For Accelerating the Reduction of Maternal and Child Under-Nutrition in Nepal 2013-2017, (Multi-Sectoral Nutrition Plan) National Planning Commission, 2012 http://scalingupnutrition.org/wp-content/uploads/2013/03/Nepal_MSNP_2013-2017.pdf

⁵⁴ Multi-Sectoral Nutrition Plan, output 6 page 9

⁵⁵ Multi-Sectoral Nutrition Plan, p.38

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approach to improve maternal and child malnutrition, particularly through provision of food supplements, it does not address many of the underlying causes for why malnutrition is so common amongst women in Nepal. For example, it makes little mention of the discriminatory attitudes (women having to eat last) or inaccurate beliefs (particular nutritious foods being bad for pregnant women) which contribute to malnutrition. The only reference to this is where the Plan mandates research to “look into the traditional beliefs, taboos and traditions that are common in Nepal around the issues and causes of maternal and child under-nutrition”.⁵⁶ However, it does not specify who is responsible for conducting the research nor does it commit to challenging those beliefs which are detrimental to the nutritional health of women and girls following the research. No information is yet available about implementation of the Plan.

E. Article 12, the enjoyment of the highest attainable standard of physical and mental health

As the committee stated in General Comment 14, the right of all persons to the enjoyment of the highest attainable standard of physical and mental health is an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, including, access to health-related education and information, including on sexual and reproductive health.⁵⁷ The government of Nepal is failing to meet a number of its core obligations under the right to health as set out by the Committee. Particularly relevant to uterine prolapse are the obligations to ensure access health facilities, goods and services without any discrimination; ensure reproductive, maternal (pre-natal as well as post-natal) and child health care including contraception and access to skilled birth attendants; the provision of health education and access to information concerning the main health problems in the community, including methods of preventing and controlling them; and to monitor the impact of laws, policies and programmes.⁵⁸

*The Committee has requested information on “steps taken to improve the non-discriminatory access to, availability and quality of basic health-care services in rural areas” and on “steps taken to prevent and combat discrimination in access to health services based on ethnicity or caste status”.*⁵⁹

Government data shows an overall improvement in access to contraception and skilled birth attendants; however, current policies and programme have failed to effectively reduce inequality in access to health care and there remain large disparities in access in different caste, religious and ethnic groups.

Access to contraception

The risk of uterine prolapse increases the more children a woman has. If she has already developed the condition, it may become more severe with subsequent pregnancies.⁶⁰ Each time a woman gives birth, the pelvic and vaginal muscles stretch, and can weaken. This is exacerbated when women have many children within a short span of time because their muscles often do not have time to recover.⁶¹ Unsafe abortion can also damage the pelvic muscles and increase the risk of uterine prolapse.

⁵⁶ Multi-Sectoral Nutrition Plan, p.57

⁵⁷ CESCR, General Comment 14 on the highest attainable standard of health, UN Doc. E/C.12/2000/4

⁵⁸ CESCR, General Comment 14 on the highest attainable standard of health, UN Doc. E/C.12/2000/4, para 43-44

⁵⁹ List of issues in relation to the third periodic report of Nepal, 18 December 2013, E/C.12/NPL/Q/3, para 23

⁶⁰ Royal College of Obstetricians and Gynaecologists, Information leaflet, March 2013, http://www.rcog.org.uk/files/rcog-corp/2013-03-20_Pelvic_organ_prolapse.pdf

⁶¹ UNFPA, Status of Reproductive Morbidities, p.22

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The government's Demographic and Health Survey of 2011 found that 50% of married women aged 15-49 used a form of contraception and that 43% of those used a "modern method".⁶² This reflects an increase, from 26% using a modern method of contraception in 1996 and 35% in 2001. Despite the increase in contraceptive use, there are many women who do not use contraception but who do not want to get pregnant. Across Nepal, 27.5% of women had an "unmet need" for contraception, according to the survey. The figures showing the effects of caste and ethnicity on maternal health revealed that between 34% and 39% percent of Hill Janajati, Hill Dalit and Muslim women had an unmet need for contraception.⁶³ However, these figures only reflect the responses of married women of reproductive age who are not using any form of contraception and who want to postpone their next birth or stop childbearing, or pregnant women whose last birth was "mistimed" or unwanted. They do not include unmarried, widowed, separated or divorced women; consequently the "unmet need" may be higher than these government data suggest.⁶⁴

In its 2010 report to the Committee on the Elimination of Discrimination Against Women, the government acknowledged the pressure on women to have more children due to traditional preferences for sons over daughters: "Because of son-preferred society, women are compelled (irrespective of consent of women as there is an indirect influence imposed by society) to try [for] at least one living son."⁶⁵

Many of the women interviewed by Amnesty International were denied their right to choose freely when and how many children to have by their husbands and in-laws. Some of the women interviewed, who used contraception, said that they had taken advice from their husbands and jointly decided to use it. Others spoke about the pressure they come under to have sons. Across the different communities and districts, the reason for wanting to have a son was the same - to take care of the parents, inherit family property, and provide for the family.

The 2011 National Family Planning Policy aims to "fulfil the family planning needs of all men and women in all parts of Nepal". It also states that men and women from different castes, ethnicities, religions and geographical locations will have equal access to family planning services.⁶⁶ Despite this, a number of documents imply contraception is only for those who are married. These include the Demographic and Health Survey which, as already mentioned, defines "unmet need" for contraception as married women who wish to delay their next child or stop child-bearing and the training curriculum for frontline community health workers (Female Community Health Volunteers) which uses exclusionary language, for example stating that "husband and wife should plan when and how many children to have". It does not specify that adolescents and unmarried people are entitled to access contraception.⁶⁷

A 2007 policy on Adolescent Sexual and Reproductive Health established "Adolescent Friendly Health Services". The services should fulfil criteria which include provision of information and of particular services, including contraception, by appropriately trained personnel. There is also a requirement to conduct outreach programmes with local schools and in the community.⁶⁸ When Amnesty International asked the Ministry of Health about how the success of the programme was being monitored, officials referred to the ministry's annual report. However, it does not contain any information on the numbers of adolescents using the facilities or the quality of the services being provided.⁶⁹

⁶² Modern methods are listed as male and female sterilization, pill, "injectables", condom, implants, IUD. 6.5% used a "traditional method" defined as rhythm and withdrawal. DHS 2011, p.97

⁶³ MoHP, Effects of Caste, Ethnicity and Regional Identity, p.14 The rates of unmet need for contraception were 33.6% for Hill Janajati, 35.2% for Hill Dalit and 39.3% for Muslim women

⁶⁴ DHS 2011, p.103

⁶⁵ Government of Nepal report to the UN Committee on the Elimination of Discrimination Against Women (CEDAW), UN Doc. CEDAW/C/NPL/4-5, November 2010, para 201

⁶⁶ National Medical Standard for Reproductive Health, Volume 1: Contraceptive Services, Ministry of Health and Population, 2010, Section 17.3

⁶⁷ Female Community Health Volunteer training, Text in Nepali on file with AI Nepal

⁶⁸ Implementation Guidelines on Adolescent Sexual and Reproductive Health, 2007, p.24 and 36

⁶⁹ Department of Health Service, Annual Report 2010/2011, Ministry of Health and Population, p.86-88

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Access to skilled birth attendants

Unsafe birth practices contribute to the risk of uterine prolapse. UNFPA states that pressing the abdomen in an attempt to speed up delivery, pressing of the lower abdomen after child birth to expel the placenta⁷⁰ and encouraging women to push before the cervix is fully dilated⁷¹ all increase the strain on pelvic muscles, potentially weakening them. Having a skilled birth attendant assist with the delivery reduces the risk of uterine prolapse.

Although government data over a period of time shows that increasing numbers of Nepali women give birth in health facilities (hospital or “birthing centre”) assisted by skilled birth attendants⁷² more than half of Nepali women still do not give birth with a skilled assistant. According to the 2011 Demographic Health Survey, nationally 36% of live births were assisted by a skilled attendant.⁷³

Figures disaggregated by ethnicity and caste showed large differences in access to skilled attendants. Women from the relatively advantaged Newari and Hill Brahmin groups were most likely to have a skilled person assist them (71% and 65% respectively). In sharp contrast only 22% of Terai Dalit women, 30% of Hill Dalit women, 28% of Hill and Terai Janajati women and 33% of Muslim women were assisted by a skilled birth attendant in the five years up to 2011.⁷⁴

A study published by the Ministry of Health in 2012 examined barriers to accessing health services among particular categories of the population and had a particular focus on access to reproductive health services. The groups studied were: women, Madhesi and Hill Dalits, Janajatis, Muslims and poor Brahmins and Chhetris. It found that barriers to women accessing health services started with their family, specifically: women needing permission to leave the house; older women who had given birth without any healthcare viewing treatment as “unnecessary”; and families requiring women to work at the time the health facility was open. Community-related barriers included religious or social requirements for women not to travel alone or mix with non-related men. Another barrier was the distance to the health facility along with availability and cost of transport. In addition, for Dalits, caste based discrimination amongst health service providers was another barrier which resulted in them not obtaining services and discouraged them from trying to access services.⁷⁵

Government figures from the 2011 Demographic and Health Survey show that on average 58% of women receive antenatal care from a skilled provider (doctor, nurse or midwife) but again there are differences in access among caste and ethnic groups.⁷⁶ Eighty two percent of Newari women and 80% of Hill Brahmin women had at least four antenatal visits during their last pregnancy. In contrast just 23% of Terai Dalit women and 34% of Muslim women receive full antenatal care.⁷⁷ The younger women interviewed during Amnesty International research were much more likely to have received some antenatal care than the older women which reflected national trends.

Whether or not women receive healthcare is often dependent on them being given permission by their husbands or other men in the family to visit a health facility. Government figures confirmed this. It showed that across Nepal an average of 35% of women were not able to participate in decisions about their own healthcare. This figure rose to 55% for Muslim women. Women from all groups in the Terai

⁷⁰ UNFPA booklet, p.20 & 22

⁷¹ UNFPA, Status of Reproductive Morbidities, p.24

⁷² The Demographic and Health Survey 2006 showed 17.7% of births in the previous 5 years had taken place in a health facility, rising to 35% in 2011.

⁷³ DHS 2011, p. 127

⁷⁴ MoHP, Effects of Caste, Ethnicity and Regional Identity, p.16

⁷⁵ Voices from the Community: Access to Health Services, A Rapid Participatory Ethnographic Evaluation and Research (PEER) Study, Nepal, Ministry of Health and Population, 2012

⁷⁶ DHS 2011, p.120

⁷⁷ MoHP, Effects of Caste, Ethnicity and Regional Identity, p.15. The figures for other groups were higher but still significantly less than for Newari Hill Brahmin women. 54% of Hill Chhetri, 51% of Terai Janajati, 44% of Hill Janajati and 48% of Hill Dalit women made four antenatal visits.

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were less likely to be able to participate in decision making about their own healthcare than women from the Hills.⁷⁸

Nepal has been successful in reducing the overall rate of maternal mortality although significant caste and ethnic disparities remain.⁷⁹ A policy for Safe Motherhood 2006-2017 sets out government plans for improving “maternal and neonatal health and survival”.⁸⁰ It seeks to increase the numbers of women giving birth in health facilities or with the assistance of skilled birth attendants through improving the training of health personnel and the provision of quality services.⁸¹ A key goal is the empowerment of “poor and excluded” groups. Social exclusion is defined as deriving from “exclusionary relationships based on power” that “may relate to caste, ethnicity, religion or gender status”.⁸² Planned activities to make this happen include social mobilization and activities to encourage changes in behaviour. However, of the five indicators to measure improvements in “equity and access” only two relate to improvements among “disadvantaged groups”. The other three measure increased access to safe motherhood services in general and fail to require improvements among “disadvantaged groups” to be made or measured.⁸³ Under the Safe Motherhood Programme, the Aama programme provides financial incentives for delivery in government health facilities, including the reimbursement of transport expenses for women who use these services, and incentives to health workers who provide these services within communities.⁸⁴

The government frequently points to the Safe Motherhood Programme as evidence that it is addressing the prevention of uterine prolapse. While having a skilled attendant assist with labour is an important factor in reducing the risk of uterine prolapse; it not sufficient because it does not address all the risk factors. For the Safe Motherhood programme to be effective in reducing women’s exposure to uterine prolapse, it would need to address all the other risk factors as well.

The obligation to ensure preventive services

While the most serious cases of uterine prolapse are likely to require surgical treatment, current government policies and programmes focus overwhelmingly on surgeries rather than on actions to reduce the exposure of women and girls to the underlying risk factors which could prevent them needing surgery in the long term.

In its judgment in the case *Prakash Mani Sharma v. Government of Nepal (2008)*, the Supreme Court noted that the Interim Constitution “prescribes reproductive health as a fundamental right”, the Supreme Court stated that “in the absence of proper protection of reproductive health, the problem of uterus prolapse has been far reaching and as such the said right can be deemed to have been violated”. It therefore ordered the Office of the Prime Minister and Council of Ministers to hold a consultation with experts and civil society and draft a bill on reproductive health to submit to Parliament. It also directed the Ministry of Women, Children and Social Welfare and the Ministry of Health and Population to “provide free consultation, treatment, health services and facilities” to

⁷⁸ MoHP, Effects of Caste, Ethnicity and Regional Identity, p.25. The percentage of women who said their husbands or others made all decisions about their healthcare was 43% for Terai Dalit women, 39% for Terai Brahmin and Chhetri women, and 29% for Terai Janajati women.

⁷⁹ Nepal: Millennium Development Goals, Progress Report, UNDP, Sept 2013, p.45-46. Available at:

http://www.undp.org/content/dam/nepal/docs/reports/millennium%20development%20goals/MDG_Report_2013_Final.pdf The overall rate of maternal mortality has reduced from 415 per 100,000 live births in 2000 to 170 in 2013 surpassing the MDG target of 213 by 2015. This target has now been reduced to 134. However, these reductions have not happened across all communities. The highest rates of maternal mortality are found among Muslims (318 per 100,000 live births), Madhesi (307) and Dalits (273).

⁸⁰ National Safe Motherhood and Newborn Health Long Term Plan 2006 – 2017,

http://www.unfpa.org/sowmy/resources/docs/library/R092_MOHNepal_2006_SafeMotherhoodLongTermPlan.pdf

⁸¹ Essential Safe Motherhood services include at least 4 ante-natal check ups, at least 3 post natal check ups, knowledge of the law on abortion and how to access safe abortion services, and knowledge of post delivery care.

⁸² National Safe Motherhood and Newborn Health Long Term Plan 2006 – 2017, p.4

⁸³ National Safe Motherhood and Newborn Health Long Term Plan 2006 – 2017, p.18-19

⁸⁴ Safe Motherhood Programme “Operational Guideline” 2008, revised 2012 and Ministry of Health and Population, “Rapid Assessment of the Demand Side Financing Schemes: Aama Programme and 4ANC”, p.6

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women suffering from uterine prolapse, and to “initiate effective programs with the aim of raising public awareness on problems relating to reproductive health of women and the problem of uterus prolapse”.⁸⁵

In its report to the Committee, the government of Nepal mentioned the existence of its free surgery programme for uterine prolapse but did not provide information on efforts to raise awareness on the issue in line with the Supreme Court decision.⁸⁶

*In its List of Issues the Committee asked the government to clarify “whether the State party has taken steps to enact effective laws and policies to reduce the exposure of women and girls to the risk factors for uterine prolapse and to implement the Supreme Court ruling in Prakash Mani Sharma v. Government of Nepal (2008)”.*⁸⁷

There was a Government effort to design a strategy which included some preventative measures; however it subsequently stalled. In 2008, a “final draft” of a National Multi-Sectoral Strategic Plan for the Prevention and Management of Uterine Prolapse 2008 – 2017 (Multi-Sectoral Plan) was completed.⁸⁸ Coordinated by the National Planning Commission, it was developed with the participation of government ministries (including the Ministry of Health and the Ministry of Women) and non-governmental stakeholders. UNFPA provided financial and technical support to the process including a consultant to prepare the draft.⁸⁹ The draft Multi-Sectoral Plan was a positive step that acknowledged that tackling the problem of uterine prolapse required prevention efforts to be coordinated across ministries in the government. The final draft of the plan includes letters of endorsement from senior officials in the Ministry of Health and Population, the National Planning Commission, the Family Health Division and the Department of Health Services. However, despite this official support, nearly six years later the Multi-Sectoral Plan remains a draft and has not been adopted as government policy.

In July 2014 the Government released its 4th Five Year Human Rights National Action Plan. It includes, in the section on reproductive health, the intention of the Ministry of Health and Population to “adopt preventive measures to end Uterine Prolapse”. This is a very welcome step; however it does not specify in detail what those measures will be or how their implementation will be monitored.⁹⁰

The obligation to provide health-related information

The majority of women with uterine prolapse interviewed by Amnesty International had not heard about the condition before they developed it. Several women said that at first, they thought it happened to every woman who had a baby. Thinking that the pain and discomfort they experienced was normal, many women waited years before seeking help for their condition.

Frontline health volunteers in have a huge responsibility to provide information and an outreach service to local communities. They have wide-ranging responsibilities, high workloads and receive little support in return. The curriculum for training new Female Community Health Volunteers, last revised in 2010, contains a chapter on uterine prolapse. It defines the condition and lists pregnancy under 18, insufficient nutrition, giving birth every year, carrying loads after childbirth and lack of a skilled birth attendant as the causes. It informs the Volunteers that to prevent uterine prolapse, women should marry and have a baby after the age of 20, eat sufficient nutritious food, leave two years between children, avoid pressing the abdomen during labour, not carry loads and take sufficient rest.⁹¹ That the

⁸⁵ Prakash Mani Sharma and Others v GON, Office of Prime Minister and Council of Ministers and Others, Writ Petition 064, June 2008

⁸⁶ Para 280, Implementation of the International Covenant on Economic, Social and Cultural Rights, Third periodic reports submitted by States parties under articles 16 and 17 of the Covenant, Nepal, 29 October 2012, E/C.12/NPL/3

⁸⁷ Para 26, List of issues in relation to the third periodic report of Nepal, 18 December 2013, E/C.12/NPL/Q/3

⁸⁸ National Multi-Sectoral Strategic Plan for the Prevention and Management of Uterine Prolapse 2008– 2017

⁸⁹ Email from UNFPA to Amnesty International 30 August 2013

⁹⁰ Fourth Five Year Human Rights National Action Plan 2014/15-2019/20, July 2014, Text in Nepali on file with AI Nepal

⁹¹ Female Community Health Volunteer curriculum, text in Nepali on file with AI Nepal

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curriculum includes uterine prolapse is positive. However, it is not sufficient to ensure Volunteers have the knowledge and confidence to address the condition. The curriculum contains 20 substantial chapters with a huge amount of information to learn. A government survey of Volunteers in 2007 found that 38% are illiterate.⁹² Volunteers interviewed by Amnesty International said that they needed “refresher training” so they do not forget all the information. The initial training course is for a total of 18 days and since 2003 Volunteers should receive a five day “refresher” every five years.⁹³ District Health Offices organise training for Volunteers in their District when there is a new government programme being introduced and NGOs sometimes hold training programmes on specific themes; however, Volunteers told Amnesty International that their knowledge of uterine prolapse was not sufficient.

The obligation to monitor the impact of laws and policies

As already mentioned, local government officials do not collect data on the caste or ethnic origin of women with uterine prolapse who seek assistance from health facilities. However, the government has published data from the Demographic and Health Survey, disaggregated by caste, ethnicity and region which covers indicators relevant to uterine prolapse such as the prevalence of contraception use, presence of a skilled birth attendant during labour and nutritional status. This disaggregated data (as was discussed throughout chapter three) shows that there are groups of women – especially Muslim women and Terai Dalit women – who have significantly lower access to skilled birth attendants, higher malnutrition and higher levels of “unmet need” for contraception.

It is not sufficient for the government to say that its programmes are for all women, it must also take steps to ensure caste, ethnic or religious discrimination does not deny some women access to those programmes or prevent them from benefiting as other groups do. While some policies do include the aim of addressing inequality in access to services, monitoring of their implementation is weak. In 2009, the Ministry of Health published a Health Sector Gender Equality and Social Inclusion Strategy. As a part of its objectives, this strategy sought to “Enhance the capacity of service providers and ensure equitable access and use of health services by the poor, vulnerable and marginalized castes and ethnic groups using a rights-based approach” and to “improve health-seeking behaviour of the poor, vulnerable and marginalized castes and ethnic groups using a rights-based approach”. In August 2013 the government published a Progress Review of the strategy. It noted positive developments in the collection of disaggregated data, sensitization of health workers and an increase in the budget for gender equality and social inclusion activities. However, the 2013 review does not contain any information about whether this policy has led more people from disadvantaged groups to access health services, or whether it has improved their health outcomes.

The experience of members of the National Alliance who are involved in delivery of sexual and reproductive health services is that the government has not taken sufficient steps to monitor the quality of healthcare interventions, including surgery for uterine prolapse. A number of private institutions and non-governmental organizations provide reproductive health services including surgical treatment for uterine prolapse, abortion services and contraceptive services. These institutions and NGOs either raise their own funds for this work or receive funding from the government through a Public-Private Partnership. Some members of the National Alliance have raised concerns that the quality of some care providing in this way, especially surgery for uterine prolapse, is of inadequate quality and that improved monitoring by the government of the quality of services is required.

F. Conclusion and recommendations

Adolescent pregnancy, lack of control over sexual conduct, multiple pregnancies and a lack of control over reproduction, physical labour during and after pregnancy, lack of access to skilled birth attendants and a lack of adequate nutrition are all accepted risk factors for uterine prolapse. Research by and the

⁹² Analytical Report on National Survey of Female Community Health Volunteers of Nepal, Government of Nepal, 2007. p.7

⁹³ Analytical Report on National Survey of Female Community Health Volunteers of Nepal, p.18

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experience of the NGOs submitting this report, combined with existing governmental quantitative data and reports by inter-governmental organizations, demonstrate that these risk factors are widespread and systemic in Nepal and are closely linked to pervasive gender-based discrimination. Women are frequently not aware of which factors increase their risk of uterine prolapse. Even when they are aware, they are often unable to exercise control over their lives and reduce their exposure to the risk. Caste, ethnic, religious, and regional identities have a significant effect on how women and girls experience these risk factors, frequently exacerbating their impact.

While the government of Nepal has laws, policies and programmes in place to address some elements of the individual risk factors, these are insufficient to reduce women's and girls' exposure to uterine prolapse. The governmental policies and programmes are either insufficient or inadequately implemented. Some programmes have the potential to make a positive impact on the lives of women and girls; however, these are implemented on a very small scale. Furthermore, data assessing the quality and impact of governmental initiatives is often unavailable. The July 2014 inclusion of uterine prolapse prevention in the National Human Rights Action Plan is welcome and the government should ensure that steps are taken immediately to put in place a comprehensive prevention programme which addresses the gender discrimination which leads to the condition.

The NGOs making this submission recommend:

Articles 2 and 3

- Relevant government ministries, including the Ministry of Health and Population, the Ministry of Women, Children and Social Welfare, the Ministry of Labour and Employment and the Ministry of Federal Affairs and Local Development should cooperate in order to ensure women, girls, men and boys know the laws in Nepal related to the minimum age of marriage.
- The government of Nepal should revise the Muluki Ain to ensure that it fully complies with Nepal's obligations under international human rights laws. Specifically it should ensure that the definition of rape reflects evolving international standards and that the penalty for rape committed by a husband or an intimate partner is equal to the penalty when the crime is committed by a non-partner.
- The Ministry of Women, Children and Social Welfare should develop, fund and implement effective programmes to ensure that women, girls, men and boys understand and respect the right to bodily autonomy and to be free from all forms of violence. The programmes should include education on all legal provisions relating to gender-based violence and how those affected by violence can seek help. The programmes should also tackle attitudes which blame women and girls for the violence they suffer and address women's economic dependence on their abusive husband.
- The government should ensure that the police provide a safe and confidential environment for women and girls to report incidents of violence, including sexual violence, and ensure that all such complaints are recorded and promptly, impartially and effectively investigated and take appropriate action against police who fail to record cases or investigate allegations of human rights violations, including gender-based violence against women and girls.
- The government of Nepal should put in place a comprehensive strategy, with concrete goals and timetables, to eliminate patriarchal attitudes and stereotypes that discriminate against women and girls, in line with the concluding observations of the CEDAW Committee on Nepal in 2011, Relevant government ministries including the Ministry of Women, Children and Social Welfare and the Ministry of Home Affairs should cooperate to fully implement the recommendations contained in the 2008 concluding observations of CESCR and the 2011 concluding observations of CEDAW on the elimination of harmful practices or beliefs, justified by culture, tradition or religion, that adversely impact women's reproductive health and access to necessary maternal health services, such as chaupadi

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Articles 7, 9 and 10

- The government should ratify the following without delay: ILO Convention No 183 - the Maternity Protection Convention of 2000, ILO Convention No 129 - the Labour Inspection (Agriculture) Convention of 1969 and ILO Convention No 81 - the Labour Inspection Convention of 1947 and revise relevant national laws and policies to implement these instruments.
- The government should amend the Labour Act and Rules to ensure that maternity benefits and social security protections comply with Nepal's international obligations under the Covenant by extending labour protections and paid maternity leave to all women and girls, including those working in the informal or atypical sector.
- The Ministry of Labour and Employment should fully implement the Labour and Employment Policy, 2005 and develop a social security system that extends to the informal sector, and which ensures the equal access of women to employment.
- The Ministry of Health and Population and the Ministry of Women, Children and Social Welfare should develop and implement education programs that target men, parents-in-laws, and other family members to generate awareness around the negative health impacts for women and girls of carrying heavy loads before, during and after pregnancy, and encouraging a more equitable share of work among family members.

Article 11

- The Ministry of Health and Population should implement the provisions of the National Multi-Sector Nutrition Plan for improving maternal and child nutrition, in particular paying attention to improving nutrition amongst women and girls from marginalized groups.
- The Ministry of Health and Population should implement the provision of the National Multi-Sector Nutrition Plan for improving maternal and child nutrition which calls for research into the traditional beliefs, taboos and traditions in Nepal which impact the nutritional status of women and girls and develop programmes to address these practices.

Article 12

- The Ministry of Health and Population, the National Health Training Centre and the National Health Education, Information and Communication Centre should strengthen their awareness-raising and educational efforts, targeted at women, girls, men and boys on all available options for contraception and legal abortion. It should include the rights of women and girls to freely decide if, when and how many children to have. Such programmes should not, under any circumstances, result in women and girls being coerced or pressurised to make particular decisions on contraception.
- Relevant government ministries, including Ministry of Women, Children and Social Welfare and the Ministry of Health and Population should cooperate to address persistent beliefs justified by culture, tradition or religion, such as the preference for sons that adversely impact women's control over decisions around if, when and how many children to have.
- The Ministry of Health and Population should increase its efforts to address the "unmet need" for contraception by prioritizing universal access to the full range of contraceptive methods,

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information, and services, including emergency contraception and ensure that women and girls are not excluded because of their age, marital status, sexual orientation or any other factor which contributes to them experiencing discrimination.

- The government of Nepal should develop, adopt, fund and implement a comprehensive strategy to prevent uterine prolapse. The strategy must include steps to ensure that women and girls know and understand their rights. It should also address the underlying gender discrimination to ensure women and girls can take control over their lives.
- Relevant government ministries including the Ministry of Health and Population, Ministry of Women, Children and Social Welfare, and Ministry of Labour and Employment must recognize that cross-governmental cooperation is vital to addressing gender discrimination and preventing uterine prolapse. Ministries must urgently put in place effective means of collaboration in order to improve the effectiveness of their policies and programmes and to meet the government's international human rights obligations.
- The Ministry of Education should revise the school textbooks relating to health for class 6 upwards to include age-appropriate information about sexual and reproductive rights, the right to equality and non-discrimination, including the right to be free from violence. It should also include scientific, evidence-based information on uterine prolapse, its risk factors, the link between uterine prolapse and discrimination and what can be done to help prevent it.
- The Ministry of Health and Population should ensure that all health workers and Female Community Health Volunteers are adequately trained and have the knowledge, skills and confidence to provide women and girls with accurate and accessible information about uterine prolapse, and its prevention. It should ensure that health workers and volunteers provide this information to all women and girls, free of any form of discrimination.
- The Ministry of Health and Population should develop, fund and implement mass communication programmes, including through the radio, newspapers, television and posters, to educate the population about uterine prolapse, its risk factors, links to discrimination and how different members of the community can help prevent it. These programmes should be developed and implemented in a way that ensures the inclusion of marginalised communities and women and girls who are illiterate or do not attend school.
- The Ministry of Health and Population should adapt its incentive scheme which encourages women to visit health facilities for antenatal care and to give birth, to also encourage women who are unable to go to a health facility to give birth with the assistance of a skilled attendant at home. It should monitor the implementation of the programme and take pro-active steps to investigate and correct imbalances where data suggests that it is not reaching specific groups of women and girls.
- All government ministries should monitor the impact of all policies and programmes and collect and disaggregate data to ensure that the policy or programme is of benefit to all women and girls, without any form of discrimination. They should take action without delay to improve the situation where data suggests that women and girls from specific groups are excluded from the benefits of the policy or programme or are not enjoying the benefits equally with others.

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Annex 1: Membership of the National Alliance for Pelvic Organ Prolapse Management

About the National Alliance

The National Alliance for Pelvic Organ Prolapse Management is a coalition of civil society organizations working in the area of pelvic organ prolapse, reproductive rights, women's rights and overall gender justice issues in Nepal. Its current membership is 17 Nepali NGOs.

Initially formed in 2007, the alliance was called the Uterine Prolapse Alliance. In 2013 it expanded its membership, revised its internal organization and was renamed the National Alliance for Pelvic Organ Prolapse Management.

Goal

Preventing Pelvic Organ Prolapse amongst Nepali women through a rights-based approach so they can live quality lives without any suffering or violence

Major objective

- To advocate to the concerned authorities at all levels for comprehensive and quality management of Pelvic Organ Prolapse.

Specific objectives

- a. Bring the issue to the attention of concerned stakeholders such as policy makers, parliamentarians, government representatives, service providers, donors, civil society, media and the public in general in order to address this issue through a multi-sectoral strategic plan and relevant programs;
- b. Bring concerned organizations together for greater solidarity in order to have a stronger voice for advocacy;
- c. Follow up and monitor government policies, strategies, plans and programs for management of pelvic organ prolapse and act as a watchdog to ensure proper funding and implementation.

NGO members of the National Alliance (indicates member of the Core Coordinating Committee)*

Aama Milan Kendra (AMK) *

Amnesty International Nepal

Association of Youth Organizations Nepal (AYON)

Beyond Beijing Committee (BBC)

Center for Agro-Ecology and Development - Women's Reproductive Rights Programme (CAED-WRRP) *

Community Service Academy Nepal (COSAN) *

Feminist Dalit Organisation (FEDO) *

Justice For All (J4A)

NAHUDA Well Women Clinic

National Alliance of Women Human Rights Defenders (NAWHRD)

National Inter-Religious Network Nepal on Violence Against Women (NIRN-Nepal)

Nepal Public Health Foundation (NPHF) *

Public Health Concern Trust Nepal (Phect- Nepal)

Rural Health and Education Service Trust (RHEST Nepal) *

Safe Motherhood Network Federation (SMNF Nepal) *

Women's Rehabilitation Center (WOREC Nepal) *

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Youth Peer Education Network (Y-Peer Nepal)

Youth Action Nepal *