

UNNECESSARY BURDEN

GENDER DISCRIMINATION
AND UTERINE PROLAPSE
IN NEPAL

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1. INTRODUCTION AND OVERVIEW

“I gave birth to my first daughter and after six days I went to bring millet from the farm. I was carrying the load of millet and I felt that something was coming out [of my vagina].”

Kesar Kala Malla, Mugu District¹

Women and girls in Nepal suffer from high rates of uterine prolapse. This is a painful and debilitating condition in which the pelvic muscles are unable to support the uterus and it starts to descend into the vagina. Medically established factors which increase the likelihood of a woman developing uterine prolapse include giving birth at a young age, having many children within a short space of time, inadequate nutrition, lack of rest during and immediately after pregnancy and prolonged or difficult labour, including use of harmful birthing practices.² Many women and girls in Nepal are exposed to several or all of these.

KOPILA³

Women in Nepal frequently experience many of the risk factors for uterine prolapse

Kopila is a 30 year old Brahmin woman living in Kailali district. She married when she was 17 and had her first child one year later. At the time spoke to Amnesty International, she had four children aged between six and 12. Although Brahmins are the dominant group in the caste hierarchy, Kopila is from a poor family and she never went to school. The family has a small amount of land and Kopila works in the fields and looks after the cattle. She also does all the household work and takes care of her four children. In her family the practice is that Kopila feeds the children first, then her husband eats and finally she eats.

If Kopila is feeling unwell, it is her husband who decides whether the problem is serious enough to go to the local health post. Kopila said that she had other pregnancies after her youngest child was born and her husband decided she should end those pregnancies through abortion.

Three of her four children were born at home and one was born in hospital. Kopila explained to Amnesty International that she was only able to take between 10 and 12 days rest after giving birth before she had to start working again. She had to carry heavy loads, including wood, grass and cow dung throughout her pregnancies and soon after giving birth.

Kopila first experienced uterine prolapse when she was 24. She told Amnesty International “Twelve days after the birth, I was cutting wood with an axe. My husband came and asked for water and we had an argument. He

beat me hard. I don't know whether my uterus came out during the time I was cutting wood or after I was beaten. It was the same day that I first got the problem. That was six years ago.

"After that I started feeling back pain and stomach pain and I couldn't stand straight or sit or do work. I feel pain in my lower abdomen and generally I have back pain when I work hard." Kopila said her husband forces her to have sex when she does not want to. And when she tries to refuse, he beats her.

The only time Kopila had sought any medical assistance for uterine prolapse was shortly after she first experienced the condition. Her husband had gone away and she asked her brother to accompany her to see a doctor. She said "I showed the problem to the doctor and he pushed my uterus back inside. He said that if it came out again he would insert a ring pessary." This is a device inserted into the vagina to support the uterus. "The doctor told me to rest but I can't because I have a lot of work to do - work in the field, look after the cattle, take care of the children, heavy work. I didn't go back when my uterus came out again". Kopila explained that previously when she had sought medical help for a different condition while her husband was away, he found out and beat her so badly that she was frightened to go back to the doctor.

Uterine prolapse causes pain and difficulties in undertaking everyday tasks. Women interviewed by Amnesty International reported constant back pain and severe pain when they had to carry heavy loads such as of water or wood – a common necessity. They also reported difficulties in walking, sitting and working. Some faced threats or insults such as their husband threatening to marry someone else, family members complaining they are lazy because of their difficulty in undertaking work or neighbours calling them names because of their condition.

Nepal has a dedicated and vibrant women's rights movement which has for many years worked to bring government and donor attention to issues of sexual and reproductive rights, including uterine prolapse. Some of the very first studies on uterine prolapse which identified the condition as a particular problem in Nepal were conducted by Nepali women human rights defenders interviewed for this report. Women's rights defenders were crucial in advocating for a gender equality act in 2006, which amended many of the laws that discriminated against women and girls and they have consistently highlighted violations of the rights of women and girls across the country. They have also secured notable successes on women's equality and sexual and reproductive rights through public interest litigation at the Supreme Court. The aim of this report is to bring international focus to the human rights dimension of uterine prolapse in order to support the ongoing work of the Nepali women's movement.

OVERVIEW OF NEPAL

Ten years of armed conflict in Nepal ended in 2006 with the signing of a Comprehensive Peace Agreement between the government and the Communist Party of Nepal (Maoist). In 2008 a Constituent Assembly was elected to draft a Constitution within two years. The Constituent Assembly was dissolved in May 2012 before completing the new Constitution, as political parties failed to reach a consensus on several key issues despite four years of negotiations. Elections of a new Constituent Assembly (with 33% of seats reserved for women) were held in November 2013 and the Assembly met for the first time on 22 January 2014. The political vacuum between May 2012 and January 2014 meant the normal legislative process was put on hold. It remains to be seen whether the Constituent Assembly will be able to reach agreement on a new Constitution and end the political instability.

Responsibility for health policy lies with the Ministry of Health and Population (Ministry of Health). The Family Health Division within the Ministry of Health is responsible for reproductive health, including provision of contraception and reduction of maternal mortality and morbidity. In each of the 75 districts in Nepal there is a District Health Office which oversees the provision of services within that district. The health sector in Nepal receives substantial funding from a range of multi-lateral donors including the United Nations Population Fund (UNFPA), World Bank, World Health Organisation (WHO) and United Nations Children's Fund (UNICEF) and from national development agencies in countries including Germany, the UK and the US.⁴

A HUMAN RIGHTS ISSUE

This report provides an overview of uterine prolapse, its causes and consequences. An examination of the accepted risk factors for uterine prolapse and the reasons for their prevalence in Nepal expose the strong links between the condition and widespread gender discrimination.

The UN Committee on the Elimination of all forms of Discrimination against Women (CEDAW) has said that governments have the obligation to:

"implement a comprehensive national strategy to promote women's health throughout their lifespan. This will include interventions aimed at both the prevention and treatment of diseases and conditions affecting women, as well as responding to violence against women, and will ensure universal access for all women to a full range of high-quality and affordable health care, including sexual and reproductive health services".⁵

A Public Interest Litigation case heard by the Supreme Court of Nepal in 2008 (see chapter four) drew the attention of the government to uterine prolapse as a human rights issue and criticised both the lack of an effective response by the government and a lack of coordination between different government ministries. Nearly six years after the judgement, Amnesty International's research found little has changed.

The government of Nepal's failure to effectively address gender-based discrimination is a human rights violation in itself. This report reveals how discrimination experienced by many women and girls limits their ability to make informed decisions about sexuality and reproduction and to control their exposure to the risk factors for uterine prolapse. In particular:

- Women frequently experience pressure from their husbands and his family to have children, particularly sons, which means they are unable to choose whether or not to have children or to limit the number or increase the space between their pregnancies.
- There is a widespread belief among women and men 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 have to live with. Women are unable to complain because they are afraid of social stigma and are often economically dependent on their husband and in-laws.
- Women are unable to control how much rest they take during pregnancy and after they

give birth to a child. Rural women typically have to carry very heavy loads of wood, water or agricultural crops within a few days of giving birth. Sometimes economic reasons mean they must go back to work immediately and sometimes they are unable to refuse to undertake tasks given to them by family members.

- Discriminatory attitudes (particularly in some regions and among certain communities) lead to women and girls eating after other family members, eating less and eating food of lower quality thereby suffering increased levels of malnutrition. Specific beliefs, prevalent in particular areas, sometimes lead to pregnant women being denied certain types of nutritious food, including in the period immediately after they give birth.
- A lack of decision-making power means women are often unable to access health care services without permission from family members. There are significant disparities between caste and ethnic groups which demonstrate that women from some groups face additional barriers in accessing maternal health care. Specific beliefs in particular areas of Nepal lead to women being forced to give birth in insanitary cowsheds.

Amnesty International's research found that the government has put in place a number of policies and programmes to address some of the risk factors for uterine prolapse. However, there is no comprehensive prevention strategy for the condition. Many government officials interviewed by Amnesty International stated their commitment to tackling the high levels of uterine prolapse in the country but there was also a tendency for officials to pass the responsibility for addressing particular risk factors to other government departments. Efforts by the government specifically related to uterine prolapse have been, to date, inadequate. A lack of government commitment to tackle what is a serious condition affecting hundreds of thousands of women has led to failure to take any action to adopt a strategy, drafted in 2008, which stipulated coordination between government ministries to improve prevention of uterine prolapse.

The government response has predominantly focussed on providing treatment – almost exclusively surgery (hysterectomy) for the most severe forms of the condition. While surgery may be necessary for women with the most serious forms of uterine prolapse, to meet its human rights obligations, the government must also take measures to prevent the condition. There have been some governmental initiatives which, if implemented effectively, could contribute to preventing uterine prolapse; however, this action is undermined by a lack of cooperation and coherence across ministries and a lack of monitoring of its impact.

NEPAL'S INTERNATIONAL LEGAL OBLIGATIONS

Nepal has ratified a number of international human rights instruments including: the International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Covenant on Civil and Political Rights (ICCPR), and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the International Convention on the Elimination of all forms of Racial Discrimination (ICERD) and the Convention on the Rights of the Child (CRC). These instruments protect a range of human rights including:

The right to be free from all forms of discrimination and violence

The right to control of sexuality and to make informed choices, without coercion, about reproduction

The right to access appropriate health information and services to prevent conditions affecting the population

KEY RECOMMENDATIONS

The government of Nepal should acknowledge that the high prevalence of uterine prolapse in Nepal is a human rights issue; specifically it is a consequence of patterns of widespread and systemic gender-based discrimination. The government must demonstrate its commitment to addressing this underlying discrimination, so as to reduce the risk of women and girls developing the condition and to comply with its international human rights obligations.

The government should develop, adopt, fund and implement a comprehensive strategy to prevent uterine prolapse. This strategy should ensure that women and girls know about their sexual and reproductive rights, including the risk factors for uterine prolapse and the links between gender discrimination and uterine prolapse. It should ensure that women and girls understand how they can reduce their risk of developing the condition and ensure that men and boys understand the rights of women and girls and how they can support them and help prevent the condition.

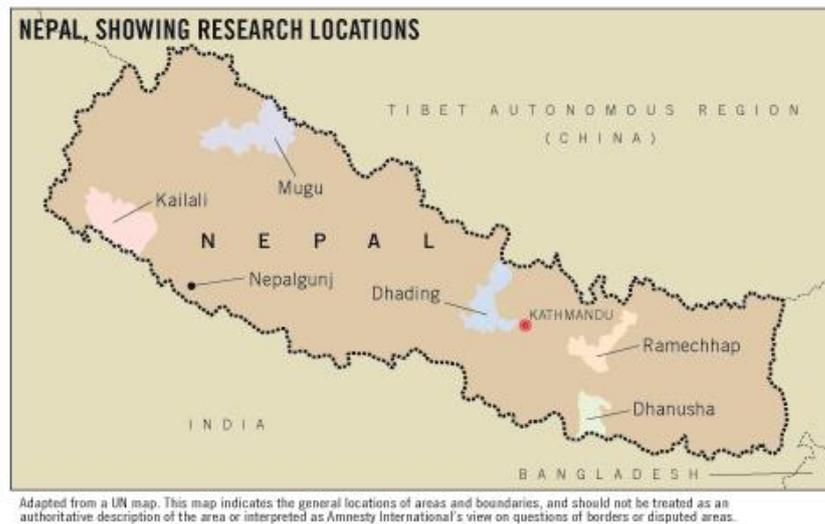
In addition to ensuring that women and girls have information about the condition, the prevention strategy must, as a matter of urgency, address the underlying discrimination. Immediate measures are needed to empower women and girls to make their own decisions in relation to their sexual and reproductive health and to control their exposure to the risk factors for uterine prolapse.

METHODOLOGY

This report is based on information gathered by Amnesty International during four visits to Nepal between March 2011 and January 2014 and through desk research and ongoing communication with experts on uterine prolapse both inside and outside Nepal. Amnesty International took the factors generally considered by medical experts to contribute to the condition and examined the relationship between those factors and human rights, in particular the right to non-discrimination. The aim of the research was to understand how discrimination affects the lives of women and girls and its link to uterine prolapse. The research also examined the effectiveness of action taken by the authorities to prevent uterine prolapse from occurring.

In March 2011 Amnesty International met with government representatives, national NGOs, international organisations and academics in order to understand the overall situation with respect to maternal health and sexual and reproductive rights in Nepal. The issue of uterine prolapse and the underlying gender discrimination emerged as one of the key issues. A second research visit in September 2012 focused on testing specific research and data-collection tools. It included meetings with government officials, national NGOs, inter-governmental organisations and a field visit to Dhading district in the central region of the country. Amnesty International observed a screening camp for women with reproductive health problems in Dhading district and interviewed 12 women suffering from uterine prolapse. The visit was conducted with assistance and cooperation from gynaecologist Professor Mitra Singh and public health expert Binjwala Shrestha of the Institute of Medicine, Tribhuvan University, Kathmandu and the NGO Rural Health Education Services Trust (RHEST) which has worked on reproductive health issues for over 10 years with a particular focus on uterine prolapse.

The main field research was conducted during a third visit in April and May 2013 when Amnesty International researchers visited four districts – Kailali, Mugu, Ramechhap and Dhanusha – and Nepalgunj city. These districts were selected to ensure information was gathered from different regions (far western, mid-western and central) and geographical terrain (mountains, hills and Terai - or plains) in order to assess if women and girls in these different areas are experiencing similar human rights violations and patterns of gender discrimination. Amnesty International planned to visit Siraha in the eastern Terai; however, a *bandh* (protest involving in road blocks on the highway to Siraha) meant the delegation had to cancel the visit and, at very short notice, make arrangements to conduct interviews in the neighbouring district of Dhanusha instead.



GOVERNMENT MEETINGS

Over the course of the research Amnesty International met multiple times with government officials from the Ministry of Health, the Family Health Division (a division within the Ministry of Health) and the Ministry of Women, Children and Social Welfare (Ministry of Women) and received additional information from these ministries by email between meetings. Researchers also met with the National Planning Commission, the Office of the Prime Minister and Council of Ministers, the National Health Education, Information and Communication Centre and the Ministry of Labour and Employment. In January 2014 researchers met representatives from the Ministry of Health and the Ministry of Women again to present preliminary findings and seek clarifications on specific points.

In the research districts (except Dhanusha) Amnesty International researchers met with local government health officials. This included the heads of the District (Public) Health Offices in Dhading, Kailali, Mugu and Ramechhap, Public Health Nurses in Kailali and Mugu and Female Community Health Volunteers (FCHV)⁶ in Dhading, Kailali, Mugu and Ramechhap.

The delegation spoke to staff of health facilities – either a Health Post or a Sub-Health Post – in Dhading, Kailali, Mugu and Ramechhap. The delegation was unable to meet with government health officials in Dhanusha due to lack of time following the cancellation of the visit to Siraha.

MEETINGS WITH MEDICAL AND HUMAN RIGHTS EXPERTS

Researchers met with representatives of the National Human Rights Commission, the National Women's Commission, the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), UN Women and the World Health Organisation (WHO).

Throughout the research Amnesty International met and consulted with representatives of Nepali civil society, especially individual activists and NGOs working on women's rights. The delegation met with: human rights organisations including the Forum for Women, Law and Development (FWLD), Women's Rehabilitation Centre (WOREC), Feminist Dalit Organisation (FEDO), Terai Human Rights Defenders Alliance (THRD), Backward Society Education (BASE) and organisations working specifically on issues related to uterine prolapse including, Centre for Agro-Ecology and Development (CAED), Rural Health Education Services Trust (RHEST), Community Support Association of Nepal (COSAN), Safe Motherhood Federation, Legal Aid and Consultancy Center (LACC), Adventist Development and Relief Agency (ADRA), Nepal Public Health Foundation (NPHF) and Nepal Society of Gynaecologists (NESOG). Amnesty International also met with individual medical and public health experts.

REVIEW OF LAWS, POLICIES, AND OTHER RELEVANT LITERATURE

Amnesty International reviewed the main body of existing qualitative and quantitative research on uterine prolapse in Nepal, including research carried out by civil society organizations, UN agencies and the government of Nepal; available studies on uterine prolapse prevalence in other countries; general medical literature on the causes, consequences and treatment for uterine prolapse; and relevant international human rights law and standards. The organization also referred to Nepal's Demographic and Health Survey and the 2011 census for key statistics and data.

Amnesty International analysed the relevant laws and policies of the government of Nepal⁷ and reviewed judgements of the Supreme Court of Nepal related to gender discrimination and reproductive health.

QUALITATIVE RESEARCH

During the main field research in April and May 2013, Amnesty International researchers held focus group discussions with 160 women (see table below for the profile of participants) from different ethnic and caste groups to identify (i) how much they knew about uterine prolapse, (ii) from which sources they received information about uterine prolapse, (iii) their experiences of gender discrimination and links to the risk factors for uterine prolapse, and iv) the extent to which women are able to change their risk factors if they know about them.

Researchers conducted 17 in-depth interviews with women experiencing uterine prolapse to understand the underlining gender discrimination associated with the risk factors that they had experienced and the impact of the condition on their lives. In addition, researchers held focus group discussions with 39 adolescent girls and with 38 men from different ethnic and caste groups to identify their knowledge of gender discrimination, women's rights and uterine

prolapse.

Representatives of local NGOs working in the research districts and local women human rights defenders assisted Amnesty International in finding participants for general focus group discussions about gender discrimination and knowledge of uterine prolapse. Amnesty International requested them to look for people of a particular age, marital status and community. The NGO representatives and women human rights defenders informed local women, girls and men about the research and identified potential participants.

Caste and Ethnicity

The Nepal government recognises 126 different ethnic or caste groups.⁸ The Ministry of Health divides those groups into six categories based on relative social advantage and disadvantage.⁹ Two categories are for Indigenous Peoples, known as Janajatis and one is for religious minorities. The other three categories relate to the Hindu caste system: Dalits – the so-called “untouchables” excluded from the caste system, disadvantaged caste groups who are not Dalit and so-called “upper” caste or dominant groups.

In order to include a cross section of the population in the research, Amnesty International aimed to ensure interviews were conducted with range of groups across these categories. Participants were asked to voluntarily specify the group with which they identified.

| Table showing the location of interviews and the number of people interviewed at each location by community | | | | |
|--|--|--|--|---|
| Location | Focus Group Discussion with Women | Focus Group Discussion with Adolescent Girls | Focus Group Discussion with Men | Individual Interviews with Women with Uterine Prolapse |
| Kailali district | (a) Terai Dalit: 15 (b) Janajati (Tharu): 12 (c) Hill Dalit (mixed): 13 (d) Hill Dalit (Badi): 20 | (a) Janajati (Tharu who were former Kamlari or bonded labourers): 12 (b) Janajati (Tharu who were former Kamlari or bonded labourers): 12 | (a) Janajati (Tharu who were former Kamaiya or bonded labourers) 11 (b) Hill Dalit: 9 | (a) Dominant Caste (Brahmin): 2 (b) Janajati (Tharu): 2 (c) Janajati (Tharu - Kamlari): 1 (d) Terai Dalit: 1 (e) Non-Dalit Terai caste: 2 |
| Nepalgunj city | (a) Religious Minority (Muslim): 8 | - | - | - |
| Mugu district | (a) Hill Dalit (mixed): 12 (b) Dominant caste (Chhetri/Thakuri): 9 (c) Janajati (Lama): 9 | (a) Dominant caste (Chhetri/Thakuri): 5 | (a) Dominant caste (Thakuri): 7 | (a) Dominant Caste (Thakuri): 2 (b) Hill Dalit: 1 |
| Ramechhap district | (a) Janajati (Magar): 9 (b) Janajati (Tamang): 11 (c) Dominant caste (Brahmin): 10 | (a) Janajati (mixed but majority Magar): 10 | (a) Janajati (Magar): 6 | (a) Janajati (Magar): 1 (b) Janajati (Tamang): 1 (c) Janajati (Newar)*: 1 |

| | | | | |
|-------------------|--|-----------|-----------------------------|--|
| Dhanusha district | (a) Terai Dalit (Chamar): 19 (b) Terai Dalit (Mushahar): 13 | - | (a) Terai Dalit (Chamar): 5 | (a) Terai Dalit (Dhanuk): 1 (b) Terai Dalit (Mushahar): 2 |
| Total | 160 | 39 | 38 | 17 |

* Newar comes under the Ministry of Health and Population category “Relatively advantaged Janajati” all other Janajati groups are “Disadvantaged Janajati”

Although Amnesty International gathered information from diverse communities and regions, the sample size was limited. In addition to the qualitative data gathered through interviews with women, girls, and men in the research districts, Amnesty International examined extensive quantitative data sets and relevant government studies on uterine prolapse and women’s rights in Nepal. Researchers also conducted interviews with health workers and experts who have worked on uterine prolapse for many years.

Profile of Interviewees

Women taking part in focus group discussions were all either married or widowed. The majority of women were between 20 and 45 years old. There were three married adolescents, aged 16, 17 and 18, one each in three different focus group discussions. All three were Dalits. Only 21 out of the 160 women who participated in the focus group discussions had received any formal schooling. In six of the 13 focus groups (four Dalit and two Janajati), all the participants were illiterate. The Brahmin focus group in Ramechhap district was the only one where the majority of the participants had attended school.¹⁰ The vast majority of the women lived in rural areas; however, the group of Muslim women lived in the city of Nepalgunj.

The 17 individual women interviewed about their experience of uterine prolapse were aged between 24 and 67 and all were married or widowed. Two of the Dalit women had attended school, one up to grade 6 and one to grade 8. All the others were illiterate although two, both Thakuri, said they knew how to write their names. The women all lived in rural areas. The women with uterine prolapse whose experience is described in the case studies had all been told they had the condition by a health worker – doctor, midwife or head of the local Health Post or Sub-Health Post.¹¹ All 17 had experienced several of the factors considered by medical experts to increase the likelihood of developing uterine prolapse (discussed in detail in chapter two). It is impossible to know whether any one factor caused their condition. Their cases, featured throughout the report, illustrate the levels of discrimination commonly experienced by Nepali women and girls and which might have contributed to their developing uterine prolapse.

Adolescent girls taking part in focus group discussions were aged between 14 and 19 and all attended school. The level they had reached at school varied from Class 4 up to Class 11. One 18 year old from the Tharu community was married, the others were all unmarried.

All the men participating in focus group discussions with Amnesty International were married, except one 24 year old in Dhanusha district. They were aged between 22 and 66 years old. Twelve of the 38 men were illiterate, ten had education between grade 10 and University and the others described themselves as literate or with an education up to grade 3. Levels of education were highest among the Thakuri men interviewed in Mugu district and among the Magar men interviewed in Ramechhap district.

ACKNOWLEDGEMENTS

Amnesty International would like to thank the women suffering from uterine prolapse who generously shared their experiences with researchers, and the many women, girls and men who gave their time to participate in focus group discussions. We would also like to thank the numerous representatives of NGOs who shared their knowledge and experience with the organisation. In particular we are grateful to Binjwala Shrestha and Professor Mitra Singh for advice and for collaboration on testing the research methodology in Dhading district in September 2012 along with the Institute of Medicine, Tribhuvan University, Kathmandu and Rural Health Education Services Trust (RHEST) and to the local women human rights defenders and to the NGOs – Women’s Rehabilitation Centre (WOREC), Feminist Dalit Organisation (FEDO) and Backward Society Education (BASE) – who provided practical assistance to help Amnesty International organize focus group discussions and individual interviews in April and May 2013. Finally, special thanks goes to Bimala Das for her translation of focus group discussions and individual interviews.

2. UTERINE PROLAPSE IN NEPAL

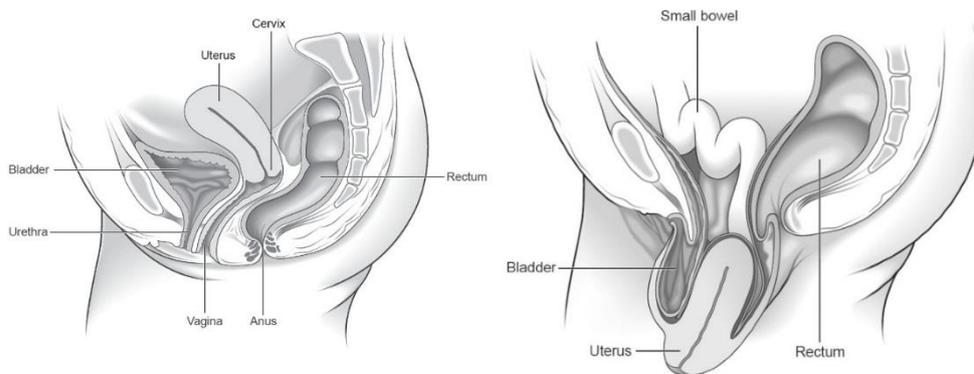
“I felt a lot of difficulty all the time: when I was sitting, walking, working. I experienced a lot of back pain. It felt like a bigger portion of my uterus came out when I was working”.

Radha Sada, Dhanusha District¹²

WHAT IS UTERINE PROLAPSE?

A woman's uterus, bladder and rectum are held in place by muscles and ligaments known as the pelvic floor. When these muscles and ligaments weaken, these organs can begin to move out of place or 'prolapse'. This condition is known as pelvic organ prolapse or genital prolapse.¹³ UNFPA defines pelvic organ prolapse as “[t]he descent or herniation of the pelvic organ, uterus, rectum or bladder into the vagina”.¹⁴ When it is the uterus that is affected, the condition is called uterine prolapse. There are three stages of severity of uterine prolapse. In the most severe stage, the uterus may come out of the vagina completely.

Diagram showing normal pelvic anatomy (left) and severe uterine prolapse (right):



Reproduced from: Royal College of Obstetricians and Gynaecologists. Pelvic Organ Prolapse. Patient Information. London: RCOG; 2013, with the permission of the Royal College of Obstetricians and Gynaecologists

Depending on the severity of the prolapse, different treatments may be effective. In stage one cases exercises to strengthen the muscles of the pelvic floor could improve the condition or stop it getting worse. In more severe cases a low cost device called a ring pessary can be

inserted into the vagina to help support the pelvic organs and keep the uterus in place. Surgery may be necessary to treat the most severe cases of prolapse. It could take the form of a “pelvic floor repair” in which the walls of the vagina are “tightened” to better support the uterus, bladder and bowel. Surgery can also take the form of a hysterectomy to remove the uterus completely.¹⁵

CAUSES OF UTERINE PROLAPSE

A number of factors put women at risk of developing this condition. Medical studies cite the following: prolonged or difficult labour; higher numbers of births; strain on pelvic muscles caused by constipation, obesity, persistent coughing or lifting heavy objects; older age; hormonal changes after menopause; insufficiently developed pelvic muscles due to malnutrition; and inappropriate birthing practices (such as pushing down on the abdomen) during labour.¹⁶ Women in different countries are exposed differently to some of these factors, for example strain on muscles through obesity is more common in developed countries.

A manual for health service providers published by the government of Nepal lists the following causal factors as relevant to Nepali women: prolonged or difficult labour, including use of harmful birthing practices (such as bearing down before the full dilation of the cervix, and excessive and inappropriate downward pressure on the stomach to expel the baby, placenta or blood clots); multiple pregnancies and births, and short time periods between births; insufficiently developed pelvic muscles due to malnutrition and increased abdominal pressure due to a cough, constipation, obesity or hard physical exertion.¹⁷ In a 2006 judgement in the case of *Prakash Mani Sharma v Government of Nepal*, brought by a legal organisation to clarify the government’s responsibilities on the issue of uterine prolapse (see chapter 4 for more information), the Supreme Court of Nepal summed up the evidence it had received and cited a lack of nutritious food, lack of access to family planning, lack of awareness about reproductive rights, lack of public awareness about care during pregnancy and the immediate period following birth (post-natal), and violence against women as contributing to the high rate of uterine prolapse in Nepal.¹⁸ A document produced by UNFPA on risk factors for uterine prolapse in Nepal cites “early pregnancies” as a further risk factor, in addition to the many noted above.¹⁹

CONSEQUENCES OF UTERINE PROLAPSE

“When I sneeze, my uterus comes out.”

Kopila, Kailali District²⁰

The physical symptoms of uterine prolapse depend on the severity of the condition. These can include the sensation of a lump coming down the vagina, heaviness in the lower abdomen or the feeling that something is coming out of the vagina. In severe cases the uterus may be visible outside the body, leading to increased risk of infection. Other symptoms include backache, difficulty in walking, sitting, lifting objects and carrying out daily tasks. Where the prolapse has also affected the bladder or rectum, symptoms may include difficulty in passing urine or faeces; urine leaking, especially when coughing or lifting heavy objects or changing position; discharge from the vagina; ulcers on the prolapsed part of the uterus; and discomfort or difficulty during sexual intercourse.²¹

“SHAME”, SOCIAL STIGMA AND VIOLENCE

In addition to physical symptoms of pain and discomfort, women in Nepal told Amnesty International about the negative impact of the condition on women’s mental health and about emotional and physical abuse women sometimes suffer as a consequence of experiencing uterine prolapse. This testimony was supported by representatives of NGOs and medical professionals who spoke to Amnesty International and by other studies. For example, in 2013 UNFPA interviewed 357 women across 11 districts who had undergone surgery for uterine prolapse about their experience of the condition. 80% said that after developing the condition they “lost hope in life”. An average of 5% of respondents said that “their mother-in-law and family members started hating them” because of their uterine prolapse and this figure was as high as 23% in some districts.²²

“There is an old woman nearby who has severe uterine prolapse and almost her entire uterus has come out. But she will not seek treatment because of the shame. We told her to go for a check-up but she refused because she felt ashamed.”

Laxmi Tamang, Ramechhap District²³

Women told Amnesty International that often it is embarrassing to discuss issues related to women’s reproductive organs, even with other women. This can lead to women hiding their uterine prolapse, even from their family and friends. A study by the Centre for Agro-Ecology and Development (CAED) in 2007 reported that: “Women suffering from uterus prolapse are considered impure and looked down upon by husbands, families and society, which isolates them from social activities”. The study found that 32% of respondents had initially not told anyone about their uterine prolapse. Of those, 66% said they had not spoken about it to anyone because they were “embarrassed” and 10% thought that it was normal for women to have the condition.²⁴

RADHA SADA²⁵

Women with uterine prolapse often live with the condition for many years and sometime decades before telling a health worker

Radha Sada is a 50 year old Dalit woman from the Mushahar community who lives in Dhanusha district. She was 16 years old when she got married and she has four children.

She experienced uterine prolapse one month after she gave birth to her first child, a daughter. She said “a little portion of my uterus came out. It got worse after my later pregnancies... I felt a lot of difficulty all the time: when I was sitting, walking, working. I experienced a lot of back pain. It felt like a bigger portion of my uterus came out when I was working”.

Radha lived with the pain and difficulty in doing daily tasks for many years. “At first I didn't tell anyone. But later, I started to attend trainings and meetings [run by NGOs]. At those meetings I came to know that I can share my experiences and pain with other women. So after that I told someone about my problem”. By the time she eventually told an NGO worker about her uterine prolapse Radha was a grandmother. Her eldest daughter – whose birth had first triggered Radha's condition – had married and had her own children.

This reluctance to speak about the condition results in some women not approaching healthcare workers until the condition has reached the most serious stage. This is especially

the case when the healthcare workers are men. An Indigenous woman from Mugu said “Generally in our community women feel ashamed to talk about this problem”.²⁶ Another woman, interviewed by Amnesty International in Ramechhap district, said “I feel ashamed to talk to the doctors. They are all men”.²⁷ The Nepal Demographic and Health Survey in 2006 asked women about the factors that made them less likely to seek medical care. Over 50% of women said expressed concern that no female health service provider would be available.²⁸ Results, published by the Ministry of Health, of a 2011 study examining the implementation of Nepal’s health programmes found that of the Health Posts (local health facilities) surveyed, all the Auxiliary Nurse Midwives were women but the other health workers were overwhelmingly men.²⁹ It also found that only small proportions of Janajatis, Dalits and Muslims held positions in health facilities and these were more likely to be at the lower level.³⁰

Promod Raj Dahal, District Coordinator for Mugu from the NGO Centre for Agro-Ecology and Development (CAED) which has been working on uterine prolapse in Nepal since 1999 told Amnesty International that women treat uterine prolapse as a “secret”. He said that there is a lot of stigma and gossip about women who are known to have uterine prolapse because communities often see uterine prolapse as “disabling” women by preventing them from carrying out the work their families expect them to do.³¹

Amnesty International heard from women with uterine prolapse who said that they faced complaints and sometimes violence from members of their families after they developed the condition. In some cases, women said that their family members accused them of laziness and complained they did not work enough when the reality was that they were in great pain and unable to carry out the work in the same way they had before. Many women said that the condition caused them pain during sex and their husbands complained about them consequently not wanting to have sex. One woman³² said that her husband accused her of having an affair because she was reluctant to have sex with him. Another said her husband beat her and forced her to have sex.³³ The 2013 study by UNFPA found that 23% of women reported having sex “unwillingly” after they developed uterine prolapse.³⁴

PREVALENCE OF UTERINE PROLAPSE

In Nepal and around the world determining how many women suffer from uterine prolapse has proved difficult. The UNFPA estimates that the global prevalence of uterine prolapse is anywhere between 2% and 20% among women below 45 years of age.³⁵ Based on studies conducted in Nepal (see below) at least 10% of Nepali women experience some form of uterine prolapse and the true figure could be much higher in some areas.³⁶

LACK OF COMPREHENSIVE DATA

Different research methods have been used to collect data on prevalence of uterine prolapse making it difficult to compare the results.

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 that they found different prevalence rates.

Studies have either been conducted on a small scale in specific districts in Nepal (population-based studies),

or among patients in identified health centres (facility-based studies).³⁷ Population-based studies take a sample from a cross-section of women living in that area and question them on their reproductive health. Some studies may involve medical examinations to confirm diagnosis of uterine prolapse but many rely on women's descriptions of their symptoms to judge whether they have prolapse. Facility-based studies examine women attending health centres, thereby including medically confirmed cases of uterine prolapse, but they exclude women who do not or cannot visit health facilities.

The most commonly quoted study on uterine prolapse in Nepal is a population-based study conducted in 2006 by UNFPA and the Institute of Medicine in Kathmandu. In this study, researchers examined 2,070 women from eight districts and found that 10% had uterine prolapse. The study concluded that almost one third of those women had second or third stage prolapse and required surgery.³⁸ From these findings, a calculation was done which put the number of women suffering from uterine prolapse in Nepal at 600,000, of which an estimated 200,000 need surgery.³⁹

Some small scale population studies have found higher rates. For example, a 2007 study by CAED in two districts in Nepal reported a prevalence rate of 30% in Siraha district and 42% in Saptari district, giving an average prevalence level of 37%.⁴⁰ Facility-based studies have found prevalence rates of between 9% and 20% among women attending health clinics.⁴¹ In 2006, the Nepal Demographic and Health Survey asked a sample of women aged between 15 and 49 about uterine prolapse, and 7% reported experiencing symptoms of the condition.⁴² In 2011, the same survey reported that 6% of women who had ever given birth said they had experienced symptoms of uterine prolapse.⁴³

YOUNGER WOMEN AFFECTED

A striking factor about the pattern of uterine prolapse prevalence in Nepal is that it affects relatively young women. Globally, older women, usually above reproductive age, are at greatest risk of getting this condition.⁴⁴ As mentioned previously, increasing age is a common risk factor: one study of women in the USA found the median age of women seeking treatment for uterine prolapse to be 61 years.⁴⁵

A 2013 UNFPA study of Nepali women who had undergone surgery for uterine prolapse found the median age at which they had first experienced the condition was 26 years.⁴⁶ The UNFPA study in 2006 found that 44% of the women with prolapse were aged between 20 and 29 years and 2.8 % were aged between 15 and 19. Amnesty International's interviews with women also found a similar pattern. Three out of 17 of the women with uterine prolapse interviewed by Amnesty International across the research districts were aged 30 or younger. Four of the older women interviewed had developed uterine prolapse just after the birth of their first child when they were in their late teens or early twenties.

CASTE, ETHNIC AND REGIONAL DIFFERENCES

Dr Aruna Uprety, founder of the NGO Rural Health Education Services Trust (RHEST) that has worked on reproductive health, including uterine prolapse, and on trafficking and gender-based violence in Nepal for over 20 years told Amnesty International that at the time researchers began examining the issue, people had believed that uterine prolapse was a problem confined to hilly areas but this was not the case.⁴⁷ The available studies now show that the geographic regions, caste groups or communities with high levels of gender discrimination tend to have higher rates of uterine prolapse. For example, although the 2006

UNFPA study found an overall prevalence rate of 10%, it found a much higher rate in the Terai (plains) districts included in the study. Two Terai districts, Rautahat and Saptari, had prevalence rates of 44.5% and 27.6% respectively.⁴⁸

Experts on uterine prolapse described to Amnesty International the trends among different caste and ethnic groups that they have noted while working on the issue over more than 20 years. Dr Aruna Uprety said that in her experience there were some Janajati (indigenous) communities with lower than average rates of uterine prolapse. Among 200 women from the Sherpa community that she had examined in Mustang district, she had not seen any cases of uterine prolapse. Dr Uprety suggested that this was because gender relations within the Sherpa (indigenous) community were more equal, women were well looked after following childbirth and women had more control over their lives. She also said that levels of uterine prolapse were higher among Dalit communities, because of high levels of gender discrimination.⁴⁹ Dr Renu Rajbhandari, founder of the Women's Rehabilitation Centre (WOREC), a leading women's rights NGO established in 1991 and which has conducted substantial work on issues of maternal health, including uterine prolapse, said that in the experience of the organisation Tharu (indigenous) women had lower rates of uterine prolapse than Brahmin and Chhetri (dominant caste) women whose lives were more controlled by their families and through traditional cultural practices. She also said rates of uterine prolapse were high among poor Dalit women who suffer discrimination on the basis of their caste, gender and poverty.⁵⁰

Public health nurses in Kailali and Mugu districts believe that uterine prolapse is a particular problem for Dalit women in their districts. Saroja Ghimire, a public health nurse in Mugu district, also said that Dalit women were more reluctant to speak to health professionals about uterine prolapse than women from other communities.⁵¹

Brish Bahadur Shahi, the District Health Officer in Mugu district, told Amnesty International that health facilities do not systematically collect data on the caste or ethnic origin of women screened or treated for uterine prolapse at their facilities.⁵² Comprehensive government data on prevalence in different communities and regions, and on which groups are most likely to seek health care, therefore does not exist. This makes it difficult, if not impossible, for the government to monitor effectively the impact of its policies and programmes on women from different ethnic and caste groups. (This will be discussed in more detail in chapter four.)

3. GENDER DISCRIMINATION: AN UNDERLYING CAUSE OF UTERINE PROLAPSE

“On the one hand, we see that women work much harder than men. On the other hand, the men scold and beat women. I get so angry when I see this.”

Nandakumari Shrestha, Female Community Health Volunteer, Ramechhap District⁵³

This chapter gives an overview of the situation of women and girls in Nepal and the discrimination they face. It then assesses each of the main accepted risk factors for uterine prolapse in Nepal, the relationship between gender discrimination and these risk factors, and the effectiveness of actions taken by the government. In addition to examining the link between the risk factors and gender discrimination, this chapter also examines how gender discrimination combines with other forms of discrimination – particularly discrimination on the grounds of ethnicity and caste – to affect some women differently.

GENDER DISCRIMINATION IN NEPAL

For Nepali women, gender discrimination is both a cause and a consequence of uterine prolapse. Nepali women experience high rates of uterine prolapse and many experience it at a younger age because gender discrimination in their daily lives exposes them to multiple risk factors for the condition. Gender discrimination limits their ability to control their sexuality and make choices related to reproduction, including use of contraception; to challenge early marriages; to ensure adequate antenatal care; and to access sufficient nutritious food. It also puts them at risk of domestic violence, including marital rape. Women with uterine prolapse are then at risk of suffering further discrimination and gender-based violence because their condition may prevent them from engaging in physically hard work or in sexual activity that is expected of them.

DEFINITIONS

Gender refers to the socially constructed roles, behaviours, activities and attributes that a society considers appropriate for women and men.

Discrimination occurs when a person is unable to enjoy his or her human rights or other legal rights on an equal basis with others because of an unjustified distinction made in policy, law, or treatment based on any of the prohibited grounds. Prohibited grounds under international law include race, religion, sex, gender, sexual orientation, national or social origin, language, age and disability.

Multiple or intersecting discrimination is discrimination based on more than one prohibited ground that combines to produce disadvantages distinct from any one ground of discrimination standing alone, for example discrimination because of gender and ethnicity.

Government figures show women and girls are disadvantaged in comparison to men and boys in key socio-economic indicators. According to census figures from 2011, 40% of women and girls in Nepal are illiterate. The rate for men and boys, while still significant, is much lower at 22%.⁵⁴ In two of the research districts - Mugu and Dhanusha - levels of illiteracy for women and girls are at least 16% higher than the national average.⁵⁵ According to the Demographic and Health Survey of 2011 girls under the age of five are more likely to be anaemic than boys.⁵⁶ A 2012 study commissioned by UNFPA found that gender discrimination affects women and girls in Nepal throughout their lives, starting with many families' preference for sons over daughters.⁵⁷ Government data from 2011 also found that women lack ownership of family assets. In 79% of households, women owned neither the house nor the land.⁵⁸

Government data has also exposed widespread gender-based violence against women and girls in Nepal. A study by the Office of the Prime Minister and Council of Ministers in November 2012 found that gender-based violence and in particular domestic violence is prevalent and rarely reported. 48% of women had experienced violence at some time in their lives with 28% experiencing violence in the previous 12 months.⁵⁹ 41% of women with an intimate partner had experienced violence from that partner at some point and 19% had experienced violence within the previous 12 months.⁶⁰ Just over 60% of women had not sought any form of help after experiencing violence. Where women did seek help, only 0.9% went to the police.⁶¹ The groups of women who were more likely to have experienced violence were women from Dalit communities and religious minorities, women with no education or only primary education, women with no decision making power over large family purchases and women from the Terai and Hill regions.⁶²

Other aspects of women's identity including caste, ethnicity, religion, region of residence, age, disability, sexual orientation and gender identity can combine with gender discrimination to affect women from various groups in different and often more severe ways. For example, data from the Nepal Demographic and Health Survey of 2011 on women's education were disaggregated by geographical region and caste/ethnicity. It showed that 83% of Terai Dalit women had received no education followed by 76% of Muslim women, figures considerably higher than the national average.⁶³

The government of Nepal has acknowledged that gender discrimination seriously affects women and girls in Nepal and that despite their efforts to reduce discrimination much more remains to be done to ensure equality. Reporting to the UN Committee on the Elimination of Discrimination Against Women (CEDAW) in 2010, the government said:

"The cultural, religious and traditional values often tend to perpetuate gender discrimination

and violations of women's rights. Insufficient political commitment, weak institutional capabilities of delivery and regulatory mechanisms... have contributed to women's deprivation of their rights".⁶⁴

ADOLESCENT PREGNANCY

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.⁶⁵ That in turn increases the chance of damage to the pelvic muscles causing uterine prolapse.

According to the Nepal government's 2011 Demographic and Health Survey 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.⁶⁶ However, the adolescent birth rate has been steadily declining over the last 15 years from 127 births per 1,000 adolescents aged 15-19 in 1996 to 81 births per 1,000 adolescents in the same age group in 2011.⁶⁷ Overall fertility rates have been declining since the 1970s when the first family planning programmes were introduced.

The Demographic and Health Survey showed a strong similarity between the percentages of girls aged 15-19 who reported recent sexual activity (29.1%) and those who were married (28.8%).⁶⁸ In comparison only 6.9% of adolescent boys aged 15-19 were married but a much higher proportion – 20.8% – reported recent sexual activity.⁶⁹ This reflects social stigma around female sexuality in Nepal. It is not considered acceptable for an adolescent girl to be sexually active without being married. If an adolescent girl has, or is thought to have, a boyfriend, she may come under pressure from her parents to marry in order to make the relationship socially acceptable. Alternatively, the couple may elope together and get married, believing that to be the only other option for them to continue their relationship. 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.⁷⁰

The 2006 study by UNFPA found the average age of marriage of respondents to be 15 years. Only 8% had married over the age of 20. The vast majority (74%) had given birth to their first child by the age of 19.⁷¹ The 2013 UNFPA study of 357 women who had undergone surgery for stage three uterine prolapse found the median age of marriage was 14 years and median age of first pregnancy was 18.⁷²

Hira Moti Bishwakarma, a 35 year old Dalit woman from Mugu district, was forced by her parents to get married when she was just 13 years old. By the age of 15 she had her first baby. She said "My now brother-in-law brought a proposal [of marriage on behalf of his brother] and at first my parents didn't agree. They told him, 'No, our daughter is very young'. But they came under pressure from my brother-in-law and I had to get married".⁷³

Sikrani Devi Choudhary, a Tharu (indigenous) woman from Kailali eloped, married and had her first child when she was 15. Aged 22 when she met Amnesty International researchers, she was mother to three young children. She said "I liked him and that's why I eloped". When asked why the couple did not wait until she was older before they married, she said "I didn't have the knowledge and I wasn't mature enough to think about this".⁷⁴

Many of the women participating in focus group discussions with Amnesty International who were over 40 years old had married and had their first child between the ages of 15 and 18. There were also women under the age of 25 across the research districts who had married aged 15 or 16 and had their first child soon after.

Seventeen year old Somani Sada, a Dalit girl in Dhanusha, told Amnesty International that she eloped and married aged 16 and now has a baby.⁷⁵ Hira Devi Bishwakarma, a 16 year old Dalit girl from Mugu had recently married.⁷⁶ Unlike Sikrani and Somani, when Amnesty International met Hira, she did not have a baby and she and her husband were still going to school.

Among the women participating in focus group discussions with Amnesty International, Janajati (indigenous) women from the hills and mountains in general reported marrying and have their first child above the age of 20. Government analysis of the 2006 Demographic Health Survey showed that 30% of adolescent Dalit girls had begun childbearing compared to 15% of Janajati adolescent girls. There was also a regional variation. 21% of adolescent girls from the Terai had begun childbearing compared to 17% of adolescent girls from the Hills and Mountains.⁷⁷

When asked to list factors they thought led to uterine prolapse, women in only one of the focus groups (Chhetri and Thakuri women in Mugu district) mentioned adolescent pregnancy associated with early marriage. When asked the same question, adolescent girls from the same communities in Mugu also said that pregnancy when a young girl's body is not mature could be a factor in her experiencing uterine prolapse. It is not clear why women and girls in this district were aware of this risk factor.

NIRMAYA SHRESTHA⁷⁸

Giving birth to a child while still an adolescent increases the risk of getting uterine prolapse later.

Nirmaya Shrestha is about 30 years old and comes from the Newar community. She lives in Ramechhap district with her husband and his extended family. She did not go to school. Nirmaya thinks she was about 17 years old when her parents and brother arranged her marriage.

Nirmaya had her first child within a year of her marriage. Her eldest son is now 12 years old. She also has three younger children aged between two and nine years. Her eldest and youngest children were born in hospital and the middle two were born at home with the help of family members. She rested for about three weeks after each birth before she had to return to work, which included carrying heavy loads.

When she was pregnant with her fourth child, Nirmaya had a cough and felt that a small portion of her uterus was coming out. She had never heard of uterine prolapse and did not know what had happened to her. She told her husband about the problem but said "I felt ashamed to talk about it with other people".

There was a reproductive health screening camp in the district and her husband told her to go. The doctors at the camp diagnosed Nirmaya with uterine prolapse and advised her to use a ring pessary but she said that she was afraid and so she refused. She later visited the local hospital to take her daughter for a check-up and talked to the staff there about her uterine prolapse. She agreed that a nurse could insert a ring pessary for her.

While her husband was supportive and helped her to seek treatment, Nirmaya's condition has also been a source of tension: "Sometimes my husband gets angry and tells me 'Other wives work harder than you, but you are sitting around and doing nothing'."

Women and girls interviewed by Amnesty International mostly knew that the minimum age for marriage was over 18 but they said that marriages continue to take place below that age. Although census data from 2011 showed that nearly 30% of adolescent girls and 7% of adolescent boys aged 15-19 were already married,⁷⁹ figures from the Nepal police show only 19 cases of child marriage were registered by the police between 2012 and 2013.⁸⁰

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".⁸¹ However, it did not specify which Ministries should take the lead in this implementation.

Upendra Prasad Adhikary of the Ministry of Women told Amnesty International in May 2013 that generally child marriage was not a problem anymore and said that "maybe in some remote areas in some ethnicities it still happens" but in urban areas it was "usually ok". Amnesty International asked what the Ministry was doing to implement the law and he replied that "directly we do not respond to the age of marriage issue. It is not our responsibility". However, in a meeting with researchers in January 2014 he confirmed that child marriage is a problem, especially in the Terai, and that the ministry runs a community awareness programme.⁸²

Staff from the Department of Women and Children within the Ministry of Women told Amnesty International that this community awareness programme was originally an NGO initiative called "Choose your Future" but it has been taken over 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 has figures available.⁸³ The ministry did not provide any information on the impact of the programme in reducing early marriage and adolescent pregnancy. 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 control.

The grade 9 school textbook for "Health, Population and Environment", 2008 (reprinted Jan 2013) covers Nepali laws on the minimum age of marriage and the right to choice of spouse. It has chapters on "family life education" and on "adolescent sexual education". These include information that unsafe sex and sex before marriage could result in pregnancy or have adverse effects on health. It also states that in Nepal there is a problem of early marriage and cultural beliefs that early marriage is beneficial to girls. It states that these beliefs negatively

affect the education and health of girls. It mentions adolescent pregnancy as one of the outcomes of early marriage and states that this can lead to a higher risk of miscarriage or the baby dying because the reproductive organs are not fully developed. It does not mention uterine prolapse as one of the possible health effects.⁸⁴

If children started school on time and did not repeat any grades, they would study grade 9 at the age of 14-15. Yet girls, especially girls from marginalised communities, are more likely to start school late or drop out before reaching grade 9 when they receive this information.⁸⁵ For example, 16 year old Hira Devi Bishwakarma from Mugu district was in grade 6 when she spoke to Amnesty International and was already married.

Another source of information for adolescents are Female Community Health Volunteers. These Volunteers provide outreach and health information to women and girls in the area in which they live. The local District Health Office is responsible for overseeing their work. Before starting work they receive basic training. The training curriculum for Female Community Health Volunteers informs Volunteers that pregnancy before the age of 20 is a risk factor for uterine prolapse but it contains incorrect information on the legal minimum age of marriage. It states the minimum age for marriage is 20 for men and 18 for women when in fact it is the same for both.⁸⁶

LACK OF CONTROL OVER SEXUAL CONDUCT: MARITAL RAPE

"Our husbands always force us to have sex even when we have no desire."

Dalit woman, Mugu District⁸⁷

All women and girls have the right to be free from unwanted sexual activity, including unwanted sexual activity with their husband. When Amnesty International asked focus groups of women about types of violence that they had heard about women experiencing in their communities, many groups mentioned examples of physical violence and said the main perpetrators were husbands. None mentioned sexual violence. However, when Amnesty International asked whether husbands ever insisted on having sexual relations with their wives when their wives did not want sex, the majority of the focus groups said that this was very common. They saw this type of serious abuse as "normal" and "something women have to bear". Yet any sexual act without full, free consent of both parties is rape and marital rape is criminalised under Nepali law.⁸⁸

Marital rape denies women's right to autonomy over their own bodies and reinforces unequal power relations between men and women. The inability of women to control sexual activity means they risk increased pain and discomfort from being compelled to engage in sex before their body has completely recovered from childbirth. It also means they may become pregnant more often or sooner than they would like. In Nepal, the Supreme Court in the Prakash Mani Sharma case (see chapter four), summarised the reasons why Nepali women suffer from uterine prolapse in large numbers. The list included "violence against women".⁸⁹ Likewise a draft government policy on prevention and management of uterine prolapse (discussed in detail in chapter four) refers in several places to a link between uterine prolapse and gender-based violence.⁹⁰

A 2013 study by UNFPA asked women who had undergone surgery for uterine prolapse about what they thought had caused their condition. 88% of respondents cited "physical violence"

by their husband and 72% said they believed “having to yield to husband’s demand for sex” was a factor.⁹¹ A few women in the focus group discussions mentioned sexual activity soon after giving birth as a factor they thought led to women getting uterine prolapse. A Dalit woman in Kailali said that sex soon after giving birth was a cause of uterine prolapse but that “some husbands do not let their wives rest after delivery [of the baby]. They insist on having a physical relationship”.⁹²

Rupsila, a Thakuri woman from Mugu district, who spoke to Amnesty International about her experience of uterine prolapse, said that she had not experienced any form of violence from her husband. However when asked whether her husband ever had sex with her when she did not want to she said “My husband forced me so many times. I came to know that it is not good to have this [sexual] relationship immediately after giving birth but my husband didn’t agree. But it didn’t happen for the first 20 days.”⁹³

Women often do not have control over the amount of time between when they give birth and when they have sexual intercourse with their husband. A woman living in Kailali district who spoke to Amnesty International about her experience of uterine prolapse said that after the birth of each of her children, the amount of time before she resumed sexual relations with her husband varied between one week (when her husband was at home) and one month (when he was away).⁹⁴

Dalit women from the Mushahar community in Dhanusha told Amnesty International that it was very common for husbands to beat their wives. They said “husbands insisting on sex” was “the reason behind the violence in our community”; husbands “force us to have sex” and women were beaten by their husbands if they tried to refuse.⁹⁵

The 2012 study of 900 women and girls by the Office of the Prime Minister found that only 9% had heard about the law on marital rape.⁹⁶ Likewise, few of the women participating in focus group discussions knew that a woman’s right to choose whether or not to have sex, including with her husband, is protected by Nepali law. The group of Chhetri and Thakuri women in Mugu was the only one where many of the participants had heard about the law. Those participants who knew about the law said that it made no difference to their ability to say no to their husbands. Narayani Shahi said “We know that if women don’t have the desire to, men shouldn’t have sex with them. We know it. But this is not what happens in practice”.⁹⁷ When Amnesty International outlined the law to those who did not know, they also expressed doubt that it could have any influence on their lives.

“We might have a law with the government but we have no law in our community. No one listens to us here”.⁹⁸

Dalit woman, Kailali district

Men who participated in focus group discussions overwhelmingly thought that women should not refuse to have sex with their husbands. Participants in two groups said that they had never experienced being denied sex by their wives and one man said that it would be “surprising” if a woman refused.⁹⁹ The vast majority of participants thought that if a husband had sex with his wife against her will, it was not rape and they did not know what Nepali law said on the matter. Two participants in one focus group thought it might be against the law for a husband to force his wife to have sex; however, they said there should not be such a

“strange law”.¹⁰⁰

“Working with men and boys to prevent violence and for a shift in understanding of masculinity is also essential.”

Government of Nepal, Second Periodic Report to the UN Human Rights Committee¹⁰¹

In one focus group discussion with women, after Amnesty International informed participants about the law on marital rape, one woman said: “Explain this law to the men. That would be much better for us.”¹⁰²

INABILITY TO SEEK REDRESS

The government has an obligation to ensure that anyone who has experienced violence can obtain a remedy. Women and girls must have access to an effective mechanism which can impartially investigate all cases of violence and ensure they are protected from further discrimination or violence.

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.¹⁰³ 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.¹⁰⁴ 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.

Amnesty International has previously reported on barriers faced by women and girls in seeking justice for gender-based violence. A 2013 report highlighted how impunity for perpetrators of gender-based violence is the norm. Women rarely file complaints about domestic violence because of “fear of stigma, lack of resources or legal literacy, lack of safe shelter alternatives and other support services, dependence on male relatives to access the legal system, and fear of repercussions, including further abuse”. The report also noted instances where women who had reported violence faced obstruction by the authorities.¹⁰⁵

“We have his children, we live in his house, he earns for us. We’ll have to be ready to leave his house if we want to make a complaint. We don’t have means to support ourselves. So whatever he does, we have to tolerate it somehow.”

Hill Dalit woman, Kailali district talking about husbands in the area¹⁰⁶

Figures from the Office of the Prime Minister’s 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.¹⁰⁷ 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.¹⁰⁸ The most common reason for not seeking help was “embarrassment” followed by a belief that “nothing can be done” to help.¹⁰⁹

Nandakumari Shrestha, a Female Community Health Volunteer from Ramechhap district said that women do not usually complain about any type of violence they experience because they have to live with their husband's family and if they speak out, the "prestige of the husband's family will reduce".¹¹⁰ The reasons women gave Amnesty International for thinking that the law would not help them in cases of marital rape were consistent across the research districts: control exercised over a married woman's life by her husband and his family.

Dr Arzu Rana Deuba, Chairperson of the Safe Motherhood Federation, an NGO which has been working on maternal mortality and neo-natal health in Nepal since 1996, told Amnesty International that in Nepal, a woman's identity is linked to that of a man so for married women, their identity is bound to that of their husband. Divorce, for the majority of women, is the last choice.¹¹¹ The statistics reflect this. The 2011 Demographic and Health Survey found that only 0.1% of women and 0.4% of men are divorced while 0.7% of women and 0.6% of men are separated.¹¹²

When asked why women generally do not report any type of violence by their husband to the authorities, one woman from a Dalit community said "We are scared that if we go to the police, our husbands will leave us".¹¹³ Kopila, who had suffered abuse from her husband (see introduction), explained the difficulty of going to the police: "I would prefer not to cause a scandal by reporting to the police. I have so many kids. I could go to the police – but only if I leave my husband and my kids".¹¹⁴ Women human rights defenders working to assist survivors of violence have also faced threats, harassment and violence because of their work and an ineffective response from the police.¹¹⁵

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".¹¹⁶ 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.¹¹⁷ The National Strategy sets out that the Ministry of Health will provide training for doctors, nurses and Female Community Health Volunteers on gender-based violence and develop materials on gender discrimination to raise awareness of the population. However, the government needs to do much more to ensure the effective implementation and monitoring of the strategy.

Uendra Prasad Adhikary from the Ministry of Women explained that with respect to gender-based violence, the main activity of the Ministry was to run shelters for survivors of violence in 15 out of 75 districts in Nepal. When Amnesty International asked what the Ministry was doing about the problem of marital rape, Uendra Prasad Adhikary did not answer the question but instead explained again why it is difficult for women to challenge abusive partners. He said that usually there were only three or four women living in the shelters as any one time because "women in the remote areas are not economically empowered. They have to go to their husbands' place and rely on him for their livelihoods so they don't report violence".¹¹⁸ He also told Amnesty International that they do "not have programmes for

men”.

There is 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 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.¹¹⁹

MULTIPLE PREGNANCIES AND LACK OF CONTROL OVER REPRODUCTION

“We need a son. And so until we have a baby boy, we keep having children.”

Dalit woman, Kailali District¹²⁰

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.¹²¹ 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.¹²² Unsafe abortion can also damage the pelvic muscles and increase the risk of uterine prolapse.

KESAR KALA MALLA¹²³

If women have more children after they develop uterine prolapse, the condition can get worse.

Kesar Kala Malla from the Thakuri community lives in Mugu district. She is 48 years old and had no schooling but she can write her name.

Kesar was 20 years old when she got married. She has five children – three daughters aged 20, 18 and 15 and two sons aged 14 and 12. She had five miscarriages, including three before her eldest daughter was born. She developed uterine prolapse while carrying a load of millet six days later. Kesar said “My uterine prolapse got worse after my later pregnancies. Before my eldest daughter’s birth I was alright. Afterwards it was a little [of the uterus which had slipped out of place], and after my other children were born it got worse.”

Kesar said that after her daughters were born “my neighbours were talking hatefully about me because I only had daughters”. Her children were all born at home. Once, Kesar started walking to the hospital when she felt labour pains. She said “Internally I wanted to go to the hospital but I was too scared. I turned back towards my home and I gave birth by the road.”

Uterine prolapse has caused difficulties in Kesar’s daily life. “I felt difficulties when I had my other children. I felt something coming out [of my vagina] but even in that situation I still gave birth to four more children. I had weakness and back pain. We can only carry light loads. Carrying heavy loads becomes difficult. We have to carry heavy loads and work hard and if I do that for one day, I have to rest for 4-5 days to recover. I can’t work well. We have to work to feed ourselves but we don’t have enough strength. I have pain in my backbone when I carry loads.”

Kesar told Amnesty International how her husband and some members of the community had treated her after

she developed uterine prolapse. “My husband treated me indifferently in the sense that he used to say he would bring another wife” she said. “He would say: ‘I am not satisfied with you, I will bring another wife’. He didn’t do it but he threatened it.” Other people in the community call women with uterine prolapse names. “They call us an ‘ass’ or ‘donkey’ because our uterus has come out. They compare us with an ass’s or a donkey’s reproductive organs”.

Kesar suffered from uterine prolapse for 15 years before she had surgery five years ago.

Five of the women interviewed individually by Amnesty International about their experience of uterine prolapse had been pregnant nine or more times, including pregnancies ending in miscarriage or abortion. The majority of the women interviewed both in focus group discussions and individually, said that they and their husbands had never used any form of contraception.

The younger women who participated in focus group discussions were more likely to be using contraception or have used it at some point in the past than the older women. Laxmi Tamang, the coordinator of a network of mothers’ groups in Ramechhap district said “Earlier women had many children (6-12), but now things have changed. Mothers’ groups and Female Community Health Volunteers have increased awareness and women now use contraceptives. So women in their 30s and 40s now have smaller families”.¹²⁴

The government’s Demographic and Health Survey of 2011 confirms this trend. It found that 50% of married women aged 15-49 used a form of contraception and that 43% of those used a “modern method”.¹²⁵ 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.¹²⁶ 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.¹²⁷

Women and girls have the right to make informed decisions on all matters relating to sexual and reproductive health, including use of contraception, free from any form of coercion. However, many of the women interviewed by Amnesty International were denied that choice 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. Shanti Sejwal, who spoke to Amnesty International in Mugu district said: “Women usually have a lot of children, until they have a baby boy” and pointed out another woman in the group who had three daughters and was pregnant again solely in the hope of having a son. Teacher, Vishnu Mata Kumayi, described having a boy as “compulsory but the preference is to have two sons” because of the culture and practice in the community. Across the different communities and districts, the reason for wanting to have a son was the same: “A son will take care of us. He can inherit property, he

will provide for us, he can perform all the rites and rituals, in particular the last rituals [when parents die],” explained Janaki Shah.¹²⁸

“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.”

Government of Nepal report to the UN Committee on the Elimination of Discrimination Against Women (CEDAW), 2010¹²⁹

The Nepal Living Standards Survey 2010-2011 asked women about the extent to which they were involved in decision-making on the number of children they had. It found that 66% of women made a decision jointly with their husband but 11% of women said their husband made the decision alone.¹³⁰

The focus group discussions that Amnesty International held with men underlined women’s lack of decision-making power. Men from the Thakuri community in Mugu district said that the number of children a couple has depends on the sex of the children. If the first or second child was a boy then the couple would not have more; however a strong preference for sons would mean they would continue to have more children if the first babies were girls.¹³¹ Magar men in Ramechhap also had the same view.¹³² Both groups stressed that men take the final decision on whether to try to have another baby and women cannot defy this.

None of the women taking part in focus groups mentioned having many pregnancies close together as a risk factor for uterine prolapse when asked to name factors of which they were aware. One focus group of adolescent girls mentioned having many children as a factor that they had heard about.

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. The 2010 National Medical Standards for Reproductive Health volume relating to contraception is designed to provide health service providers with guidance on the reproductive health services they should be giving. With respect to adolescents, it states that “both married and unmarried boys and girls are welcomed and served”.¹³³ Despite these statements, a number of other documents imply contraception is only for those who are married. As already mentioned the Demographic and Health Survey defines “unmet need” for contraception as married women who wish to delay their next child or stop child-bearing.

The training curriculum for Female Community Health Volunteers has a chapter on “family planning” which includes information on types of contraception and how to use them. However, the language is exclusionary. For example, it states that “husband and wife should plan when and how many children to have” and that a “husband needs to use a condom if his wife forgets to take pills for two or more consecutive days”.¹³⁴ It does not specify that unmarried people are entitled to access contraception nor does it specifically mention adolescents or that the Volunteers should provide advice to adolescents. It does not provide Volunteers with information about the sexual and reproductive rights of women and girls, including the right to decide about and access contraception without the agreement of their husband or other family members.

The government points to the school curricula as the means by which it disseminates

information about reproduction, including contraception, to young people. Dr Baburam Marasini from the Ministry of Health told Amnesty International that reproductive health was covered in the school curriculum for students in grades 8, 9 and 10. The most relevant information is contained in the grade 9 textbook on Health, Population and Environment. It has information about sexual and reproductive rights and minimal information on contraception. It states that women need to be provided with information on family planning but it does not say where adolescents can get the information. It contains a section on reproductive rights in which it lists the rights contained in UN instruments including the right to choose to marry or not, to choose to have children or not, and the right to make decisions on sexual and reproductive health. It does not mention uterine prolapse, but it states that having many children within a short time “will make the body weak”.¹³⁵

Dr Marasini of the Ministry of Health told Amnesty International in April 2013 that if students drop out of school before completing those grades, they do not generally receive any health information. He said “just now we have not launched any programmes related to [out of school] adolescents. There are some sporadic programmes launched by local initiatives. I don’t like to say we have not done anything, there are some local initiatives in some areas but a national programme is not there.”¹³⁶

However, in a subsequent interview, different officials from the Ministry of Health told Amnesty International about a government initiative currently operating in specific areas of 49 out of 75 districts.¹³⁷ 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.¹³⁸ When Amnesty International asked 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.¹³⁹

UNDERTAKING PHYSICAL LABOUR DURING AND AFTER PREGNANCY

“Our family tells us that if we don’t do any work and just sit around, we will have difficulty in delivering the baby.”

Bhamaya Ali Magar, Ramechhap District¹⁴⁰

Lifting heavy objects and carrying heavy loads can strain the pelvic muscles particularly during pregnancy and soon after women give birth.¹⁴¹ Consequently, undertaking physical labour involving heavy lifting during and after pregnancy is a risk factor for uterine prolapse. The Nepal National Medical Standards for Reproductive Health instructs health workers to advise women not to carry heavy loads or perform heavy physical work for at least six weeks after giving birth.¹⁴² Yet most of the women who spoke to Amnesty International said that although they understood the risk associated with their work, they had no choice but do to it.

MANTHARA BHOOL¹⁴³

Lack of legal protection of informal workers and failure to address gender discrimination in wages and working conditions means many women have to undertake heavy manual labour increasing their risk of uterine prolapse.

Manthara Bhool, a 45 year old Dalit woman is originally from the hill district of Achham but has lived in Kailali district for 14 years. She cannot read or write. She thinks she was about 16 when she got married. Her husband died 7 years ago.

Manthara works in her family's fields looking after cattle and goats. The land produces enough food for the family to eat for only two or three months a year. For the rest of the year she has to work carrying bricks for a daily wage of 200 NPR (approx 2 USD). Sometimes she gets work breaking large rocks into smaller stones. This is very hard work and it takes her two months to produce enough small stones to earn 1700 NPR (17 USD).

She was 18 when she became pregnant for the first time and now she has four children aged between 13 and 22. She had another two children who died. All her children were born with only the help of her neighbours.

Manthara's youngest child was the only one to be born in Kailali. When she lived in the hill district she had to work almost immediately after giving birth. "After 3-4 days I worked at home and after 7 days I had to work outside the house."

Manthara first experienced uterine prolapse two years ago. "I'm suffering from this condition due to carrying heavy loads. I have to carry rice and flour in the traditional way and in the hills I had to carry water. I had to take a big pot and go from place to place to find water because in the hills there is a shortage of water".

The government reports that the majority of women work in the 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.¹⁴⁴

The overwhelming majority of women and girls interviewed by Amnesty International did a lot of manual labour and carried heavy loads as part of their daily life. Only the Muslim women interviewed in Nepalgunj city said that they did not carry heavy loads. The most common loads women and girls carried were water, wood to burn for cooking, grass to feed cattle and crops such as wheat, rice or millet harvested from the fields.

Depending on the amount of land their families had, the women and girls sometimes did paid work (cash or in kind) on land belonging to richer people or worked for a daily wage doing construction jobs. This was particularly the case for Dalit women in all the districts in which they were interviewed, who had to carry heavy loads to earn money for their families both during pregnancy and soon after giving birth. This type of "informal"¹⁴⁵ work is not regulated so workers are not protected by labour laws or the minimum wage (NPR 318 per day (approx USD 3.20) for formal sector workers).¹⁴⁶ Women belonging to hill Dalit communities in Kailali district told Amnesty International that they worked as labourers and stone crushers and were paid 150 Nepali Rupees per day (approx USD 1.50) while men were paid 200-300 NPR per day for the same work.¹⁴⁷ A Terai Dalit woman in another part of Kailali said that they work on other people's farms for eight hours a day, earning 100 NPR and that if they did not do this "our children will be hungry and will sleep without eating dinner".¹⁴⁸ In Mugu district, the Dalit women interviewed by Amnesty International worked as porters carrying heavy loads mainly from the airport to the main town or surrounding villages because the district is virtually inaccessible by vehicle.

The adolescent Tharu girls who were former bonded labourers (known as Kamalari)¹⁴⁹ told

Amnesty International that when they were not at school, they worked on land belonging to richer neighbours for eight hours a day, earning 150 NPR. This work included harvesting crops and working in construction and involved carrying heavy loads such as wheat and cement.¹⁵⁰

NO REST

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 days. 34.7% of women from the Terai only rested for between five and seven days.¹⁵¹ 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.¹⁵²

The vast majority of women interviewed by Amnesty International had taken significantly less rest than is recommended by the government. They 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. Chhetri and Thakuri women in Mugu said that women living in the town rest for an average of one week before resuming household work. One woman said “Because I was in my parents’ house I could rest for a month. But if you are in your husband’s house you can’t do that. You won’t even get five days rest as you have to work and cook for the family”.¹⁵³ A Dalit woman in Dhanusha said “Six days after my delivery I started working because I had no older women in my house [to help].”¹⁵⁴

Another factor is the economic situation of the household. Neerja Dahal, a Brahmin woman from Ramechhap, said “If the family is well off, the woman can take more rest.” If a family is poor, she said that women go back to work, including carrying loads of wood and fertilizer, after just 22 days.¹⁵⁵ Women from Hill Dalit communities in Kailali told Amnesty International that they take rest for an average of 9-10 days. One said “I rest until I can stand and can start working.”¹⁵⁶

“If we don’t carry heavy loads, we won’t have money. We know we shouldn’t carry heavy loads but for us it’s compulsory”.

Dalit woman, Mugu District¹⁵⁷

In Mugu district, an additional factor influencing the amount of rest rural women took after giving birth was the time of year and the seasonal requirements for farm work. Rupsila, who experienced uterine prolapse after the birth of her third child, told Amnesty International that generally women can rest for 20 days, only looking after the baby and after 12 days cooking food during that period. But she said:

“I usually gave birth to my babies during monsoon or harvesting season and both of these are the seasons for our work. So when all the other people [in my household] went out for

planting or harvesting then I was compelled to do work at home like drying the harvest outside the house and gathering them in because I was alone in the house and others were out at work".¹⁵⁸

When Amnesty International asked women participating in the focus group discussions what they knew about the risk factors for uterine prolapse, more women cited "carrying heavy loads" and "not taking rest" than any other risk factors. The majority said they had received this information mainly from women they knew who had experienced uterine prolapse. Women in two focus groups (in Kailali and Mugu districts) said they had heard from an NGO and several groups were not sure where they had heard the information.

This increased knowledge had led to changes in some areas. In Ramechhap district, Janajati women spoke of how women were taking slightly more rest after giving birth now than they had in the past. The Tamang women interviewed by Amnesty International had taken between three and seven days rest when they had their children but said the average now was one month.¹⁵⁹ Magar women also said they now get one month rest whereas before it was only 11-12 days.¹⁶⁰

Although many women knew that they should avoid carrying heavy loads during and after pregnancy and that they should rest after giving birth, they said they had no control over this. 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. Even in focus groups where participants said that the amount of rest had generally increased families still had a big influence. A Tamang woman said that if women are not working "our mother in law and sisters in law will criticise us".¹⁶¹

"My husband's family will say 'why are you sitting around like this? You are not a government employee. Who do you think will feed you?'"

Magar woman, Ramechhap district¹⁶²

Nepal's Ministry of Labour and Employment is responsible for a range of regulatory functions related to labour policy and employment, including the "social safety of labour".¹⁶³ In 2005, the Ministry issued the "Labour and Employment Policy". The stated long-term goal of the policy was to provide "productive, non-discriminatory, exploitation-free, decent, safe and healthy work opportunities for citizens".¹⁶⁴ 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.¹⁶⁵ More specific commitments included making the workplace safe by "by promoting and developing occupational health and safety and reproductive health as inherent aspects of all organizations and workplaces",¹⁶⁶ reviewing the current framework of occupational safety and health,¹⁶⁷ developing a "comprehensive and integrated system of social security... with the gradual inclusion of the informal sector",¹⁶⁸ and creating a "women and family friendly" work environment by the provision of "maternal safety, security and suitable leave facilities".¹⁶⁹

In October 2013, Purushottom Poudel, the Joint Secretary and Spokesperson of the Ministry

of Labour told Amnesty International that there were no concrete plans to revise the Labour Act and Rules to extend them to the informal sector.¹⁷⁰ No tangible progress had 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.

In its report to the UN Committee on Economic, Social and Cultural Rights submitted in 2012 and due to be considered by the Committee in November 2014, the government of Nepal acknowledged that “The inspection and monitoring of labour in the informal or unorganized sector need to be legally provided for”.¹⁷¹

LACK OF 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 placenta¹⁷² and encouraging women to push before the cervix is fully dilated¹⁷³ 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 caused by these practices, yet none of the women interviewed by Amnesty International knew this. International human rights law obliges governments to ensure that women and girls have access to reproductive health services, including maternal (pre-natal as well as post-natal) health care without any form of discrimination.

Women participating in focus group discussions told Amnesty International that the majority of women they know give birth at home with untrained helpers (usually Traditional Birth Attendants or older women from the local area). 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 attendants¹⁷⁴ more than half of Nepali women still do not give birth with a skilled assistant.¹⁷⁵

According to the 2011 Demographic Health Survey, nationally 36% of live births were assisted by a skilled attendant.¹⁷⁶ 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 2011.¹⁷⁷ 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.¹⁷⁸

In Kailali, Mugu and Dhanusha districts the majority of the younger women interviewed by Amnesty International had neither given birth in a health facility nor had a skilled person assisting them. Indigenous women in Mugu said that very few women in their community give birth in a health facility, reflecting the remote areas they live in and the long distances they have to travel to access healthcare.¹⁷⁹ Among Dalit communities in Kailali and Dhanusha districts, Amnesty International heard that women would only be taken to a health facility if there were serious problems during labour, otherwise they would have unskilled women from the local area assist them at home. Rajkumari, a 24 year old Dalit woman from Dhanusha described the caste discrimination she experienced when she gave birth with women from the local area to assist: “Experienced women in the village came and sat next to me during the delivery. They cut the umbilical cord but because I am Dalit, they did not touch me at all”.¹⁸⁰

Dhurba Kumar Magar is the head of the recently opened Sub-Health Post in Okhrenei in Ramechhap district, which serves approximately 8,000 people. He told Amnesty International that in the previous year all pregnant women in the area had given birth at the health facility with the assistance of a skilled person.¹⁸¹ Amnesty International held a focus group discussion with Indigenous Magar women living nearby. The two women who had given birth since the Sub-Health Post opened had gone to there and been assisted by a skilled attendant.¹⁸² Those who had had their children before the facility opened had given birth at home. Apart from the women interviewed in Ramechhap, the only other group with a high proportion of deliveries in a health facility were the Muslim women interviewed in the city of Nepalgunj. Social worker Shajola Halwai said: “Almost all women go to the hospital for delivery. Sometimes they go to a private nursing home and sometimes to the government hospital. In some cases where they do not have resources to go to the hospital, they give birth at home”.¹⁸³ National statistics showed the percentage of Muslim women who gave birth with a skilled birth attendant was low (33%).¹⁸⁴

None of the women or girls who participated in focus group discussions with Amnesty International knew that giving birth without a skilled attendant increased the risk of developing uterine prolapse.

GIVING BIRTH IN THE COWSHED

The traditional practice known as *chaupadi* starkly illustrates the gender discrimination faced by many Nepali women and girls that puts their health, and sometimes their lives, at risk. There is a common belief, particularly in western Nepal, that women and girls are “impure” and “untouchable” after childbirth and during menstruation. As a result, families and communities regulate what and whom women and girls may touch during this time. They are forced to leave their house and live in a cowshed or in a separate hut constructed specifically for that purpose. 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 year¹⁸⁵ and there are reports of rape and other forms of sexual violence against women and girls linked to the practice.¹⁸⁶

Chaupadi is mainly practiced in the mid-western and far-western regions of Nepal, including the research districts of Kailali and Mugu, and is more prevalent among the dominant Brahmin and Chhetri groups and among Dalits. Amnesty International research also found adapted forms of the practice – where women had to stay in a separate room inside their houses and were prohibited from entering the kitchen – in the central districts of Ramechhap

and Dhanusha.

KHUMENI BISHWAKARMA¹⁸⁷

The traditional practice of *chaupadi* meant that Khumeni gave birth to eight children in a cowshed without a skilled health worker to help her.

Khumeni Bishwakarma, a Dalit woman from Mugu district, is the treasurer of the Mugu district branch of the Feminist Dalit Organisation (FEDO) NGO. She estimates that she is about 50 years old and she studied at school up until grade 8. She does farm work, household work and sometimes acts as a community representative and is called on to do social work in the community.

Khumeni was 15 years old when her parents decided it was time for her to get married and she was 18 the first time she got pregnant. Altogether she had 10 pregnancies. Two pregnancies ended in miscarriage and three children died. Now she has five children aged between 11 and 21. *Chaupadi* (see above) is practiced in Mugu. Khumeni had to give birth to all her children in the cowshed. There was no skilled birth attendant to help deliver her children so older women from the village helped her.

Khumeni had to carry heavy loads, especially of water, during her pregnancies and soon after giving birth to her children. Sometimes she took 15 days rest before returning to her farming work but it depended on the time of year and the type of agriculture work that had to be done in that season. She said, "When I gave birth during the monsoon season I had to go to work sooner. I could only rest for one week then I had to dig the fields and plant the crops".

Khumeni developed uterine prolapse 11 years ago, after the birth of her youngest daughter. She had surgery three years ago.

The Dalit women participating in the focus group discussion in Mugu district told Amnesty International that most of them had given birth to their children in the insanitary conditions of the cowshed without a skilled birth attendant although a few had gone to the district hospital. Six months before the interview, a new "birthing centre" opened next to their village, built by an NGO. The two women in the focus group, who had very young babies with them, said they had given birth in the new centre with a skilled health worker assisting them.¹⁸⁸ Saroj Ghimire, the district's Public Health Nurse told Amnesty International that women were permitted to stay in the birthing centre for 10 days after their baby was born which meant they could avoid having to go with their babies to the cowshed.¹⁸⁹ Menstruating women and girls in the village still stay in cowsheds.

Women who suffer discrimination resulting in being compelled to give birth in a cowshed are more likely to have unskilled people to assist them and therefore be at greater risk of experiencing the unsafe birth practices which can lead to uterine prolapse.

ANTENATAL CARE

Government figures from 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.¹⁹⁰ 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.¹⁹¹ The younger women interviewed by Amnesty International 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. Muslim women in Nepalgunj told Amnesty International that they cannot leave the house without the permission of their husband. One said: “We take our husband’s suggestion to go visit the doctor. If we go without his agreement and he asks us why, what will we say? It won’t be good for us”.¹⁹²

The majority of men participating in focus group discussions said that within the family it is men who decide whether a family member should visit a health facility. However, men in those groups also said that if a woman was pregnant she might consult a traditional birth attendant or Female Community Health Volunteer. The group of Magar (indigenous) men interviewed in Ramechhap said that the decision was made jointly by men and women¹⁹³ and the Tharu (indigenous) men interviewed in Kailali said that women were sometimes consulted about the decision.¹⁹⁴

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 were less likely to be able to participate in decision making about their own healthcare than women from the Hills. Hill Janajati women were most likely to make their own decisions on their healthcare; 31% could decide without consulting any family members.¹⁹⁵

Nepal has been successful in reducing the overall rate of maternal mortality although significant caste and ethnic disparities remain.¹⁹⁶ A policy for Safe Motherhood sets out government plans for improving “maternal and neonatal health and survival”.¹⁹⁷ 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.¹⁹⁸ 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”.¹⁹⁹ 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.²⁰⁰ 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.²⁰¹

In meetings with Amnesty International, officials at the Ministry of Health and the Family Health Division referred to these policies in the context of uterine prolapse prevention. In answer to a question about what his division had done to prevent uterine prolapse, Dr Upreti, of the Family Health Division told Amnesty International about a ‘birth preparedness package’, which aimed to “teach a pregnant mother what should they do and what are the

preparations they should make when going for delivery, and what are the danger signs during pregnancy, childbirth and post natal period".²⁰² The Division has a card with illustrations which they provide to pregnant women through Female Community Health Volunteers and local health facilities. This card has pictures showing things to do and prepare during pregnancy and warning signs such as excess blood loss or prolonged labour which mean that a woman should seek immediate medical help. It is important, particularly in the efforts to reduce maternal mortality; however, with respect to uterine prolapse, it not sufficient because it does not address all the risk factors nor explain what the condition is and how a woman can reduce her risk.

The World Health Organisation recommends women visit a health facility for antenatal care at least four times during pregnancy.²⁰³ The Aama programme also provides incentives to women who attend four antenatal visits; they are entitled to 400 NPR after the birth of the child.²⁰⁴ These visits would provide a good opportunity for health workers to inform women about the risk factors for uterine prolapse and make recommendations on how women can lower their risk of getting the condition, if they had the knowledge to do so.

"The safe motherhood policy is not enough to address uterine prolapse. The risk factors for uterine prolapse are different. It is a problem associated with discrimination and lack of empowerment as well as lack of health services so it should be dealt with keeping all those issues in mind while making policies to reduce cases."

Dr Aruna Uprety, public health and human rights expert and founder member of the NGO Rural Health Education Services Trust (RHEST)²⁰⁵

Having a skilled attendant assist with labour is an important factor in reducing the risk of uterine prolapse; however, for the Safe Motherhood programme to be effective in reducing women's exposure to uterine prolapse, it would need to address the other risk factors as well. Maternal morbidity is not mentioned at all in the Safe Motherhood plan.

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.²⁰⁶ 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 merely state that "people in public positions" shall be accountable.²⁰⁷ The annual report of the Department for Women and Children of the Ministry of Women describes a programme run in three districts between 2007 and 2012 which aimed to ensure "people from these districts will be aware of the negative effects of *chaupadi* and women will be treated as humans".²⁰⁸ Representatives of the Ministry of Women told Amnesty International that some specific areas of those districts are now "*chaupadi* free". They also said they have conducted a comprehensive study of the practice and a report is due to be released later in 2014.²⁰⁹

LACK OF ADEQUATE NUTRITION

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.²¹⁰ 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.

“My father in law and mother in law eat first. Then all the other male family members eat and then the women eat last.”

Rajkumari Devi, a 24 year old Dalit woman who lives with 10 members of her husband's family in Dhanusha district²¹¹

The majority of women, girls and men interviewed by Amnesty International lived in rural areas and said that the land their families had for farming provided them with crops for part of the year but was not sufficient. During the rest of the year they had to buy food if it was available and if they had money. In Ramechhap district, women said that they generally had food for six months of the year. During the other six months some of them would borrow rice which they would pay back when they harvested their next crops, others would have funds to buy food.²¹² The problem was more severe in the mountain region. Dalit women in Mugu said they only had enough food for about three months of the year. The rest of the time they had to buy food using money earned from working in other people's fields or as porters carrying heavy loads.²¹³ Seasonal variations in availability of food, particularly fresh vegetables meant that even where people had money, food was not always available. Chhetri and Thakuri women living next to the market in the town of Gamgadhi in Mugu district told Amnesty International that at certain times of year vegetables were not available in the market but when they were, they bought them.²¹⁴

Dalit women in Dhanusha told Amnesty International about a myth especially prevalent among older women. They tell the younger women that a woman who has just given birth should not eat fresh vegetables “because it will make her sick” and so women are frequently “not allowed to eat vegetables even though they have plenty of green vegetables growing in their garden”.²¹⁵

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. Four of the women interviewed about their experience of uterine prolapse, all living in the Terai, said that it was traditional for women to eat last in their families.²¹⁶ Kopila (see introduction) from Kailali was only able to eat after her husband and four children. Gangajali from Kailali said that her husband and her sons eat first and then she and her daughter-in-law eat.²¹⁷ Tharu women participating in a focus group discussion in Kailali had differing experiences. Some said their families ate together but others described how their husbands and sons ate first.²¹⁸

“...general health problems such as anaemia and malnutrition... is yet to be adequately addressed.”

Government of Nepal report to the UN Committee on the Elimination of Discrimination Against Women (CEDAW), 2010²¹⁹

According to the 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.²²⁰ 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%.²²¹ 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.²²²

At least one woman in four of the focus group discussions mentioned lack of nutritious food as a factor relating to uterine prolapse when asked what they knew about the condition. However, it was not a well-known risk factor. Governments have the obligation to ensure that women and girls are not discriminated against in access to sufficient nutritious food at all times and especially during pregnancy and in the immediate post-natal period.

The National Nutritional Policy and Strategy of 2004 (updated in 2008) outlined the government of Nepal's approach towards addressing malnutrition. A specific objective of this policy is: "To reduce the risk factors for under-nutrition in women, particularly pregnant and lactating women", by raising awareness about good nutritional practices, reducing the workload of pregnant and breastfeeding women, preventing early pregnancies and encouraging increased spacing of births, and by providing community and social support towards maintaining good nutritional practices. The plan sought to achieve this objective through awareness raising and activities directed at changing the behaviour and attitudes of target groups regarding nutrition, which included women, families, and health workers.²²³

However, over time, the government realized that a nutrition-specific strategy was "unlikely to improve the nutritional status".²²⁴ In 2012 it adopted a "Multi-Sector Nutrition Plan for Accelerating the Reduction of Maternal and Child Under-Nutrition (2013 – 2017)".²²⁵ 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.²²⁶ 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 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.²²⁷

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 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 widespread 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".²²⁸ 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.

THE NEED FOR ADEQUATE INFORMATION

"My cousin had [uterine prolapse]. We called the doctor but the doctor did not come. My uncle asked me and my aunt who is a Community Health Volunteer if we can do anything. I had seen my uncle working with cows that had uterine prolapse. He would push their uterus back in. I did the same thing to her, I pushed her uterus back in."

Shanda Shahi, Mugu District²²⁹

Amongst the women Amnesty International spoke with in Nepal who had uterine prolapse, the majority had not heard about the condition before they experienced it. One said she had heard about uterine prolapse from other women in her neighbourhood before she experienced it. Several women said that at first when they experienced uterine prolapse, they thought it happened to every woman who had a baby. This lack of understanding that the pain and discomfort they experienced was not normal was a factor in some women not seeking medical help for many years.

Not many women who participated in focus group discussions with Amnesty International knew what uterine prolapse was. In each focus group there were one or two women who said they had heard about the condition but very few could explain what happened to a woman's body when she had uterine prolapse. The focus group of Chhetri and Thakuri women interviewed in Mugu was the only group where all the women had heard about uterine prolapse. Among adolescent girls participating in focus group discussions with Amnesty International, in three groups one or two of the girls had heard about the condition from women in their families or from neighbours. In one focus group with Janajati girls in Ramechhap, none of them had heard of uterine prolapse. Knowledge about uterine prolapse amongst the men who participated in focus group discussions with Amnesty International varied. In three of the focus groups (with Dalit men in Kailali and Dhanusha and with Janajati men in Ramechhap) none of them had heard about the condition. Among Tharu men in Kailali and Thakuri men in Mugu several had heard of the condition. One man said he knew about it because his wife suffered from uterine prolapse.

Women whom Amnesty International spoke with in focus group discussions who had heard about the condition had mainly got information from other women in their neighbourhood or knew about it because they had a family member or friend with the condition. Several women mentioned Female Community Health Volunteers and NGOs as sources of information about uterine prolapse.

The adolescent girls participating in focus group discussions with Amnesty International, who knew about uterine prolapse, had received the information through informal channels of family, friends and NGOs. However, they said they had received information about reproduction and contraception at school but they had not been educated about uterine prolapse.

“We have not received any training on uterine prolapse. If we received such training, we would be better able to ask women to tell us about their uterine prolapse related problems. We are not trained so we feel hesitant to advise women”.

Indini Hayu, “Female Community Health Volunteer”, Ramechhap district

Female Community Health Volunteers interviewed by Amnesty International all knew what uterine prolapse was but expressed concerns that they did not have sufficient information or training to give advice to women in their local areas. 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.²³⁰

That the 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.²³¹ 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.²³² 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.

In Kailali district Female Community Health Volunteers mentioned that a government run training they received had included a presentation on uterine prolapse but not practical training on how to advise women about the risk factors or inform them about what treatment was available. Volunteers in Mugu district said they had received some information during trainings under the government’s Safe Motherhood programme or from NGOs when they ran screening camps but they felt ill-equipped to talk to women about prevention of uterine prolapse beyond advising them not to carry heavy loads during and immediately after pregnancy. In Mugu and in Ramechhap districts the information distributed to women by Female Community Health Volunteers was predominantly about the date and location of screening camps.

Representatives from Nepali civil society told Amnesty International that they had been involved in a consultation on revision of the grade 9 school curriculum. They said that it was agreed that information on uterine prolapse and its risk factors would be included.²³³ As of January 2014 Amnesty International had not seen any revised curriculum text. Even after revisions to the curriculum it can take a long time for the textbooks to be revised to reflect the new curriculum. Officials from the Ministry of Health were uncertain about the status of the curriculum and Tirtha Raj Burlakoti, Chief of the Policy, Planning and International Cooperation Division of the Ministry of Health told Amnesty International that students in grades 8, 9 and 10 were too young to receive information about uterine prolapse.²³⁴

FAILURE TO EFFECTIVELY ADDRESS THE GENDER DISCRIMINATION AT THE ROOT OF UTERINE PROLAPSE

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. Qualitative interviews by Amnesty International, combined with existing governmental quantitative data and reports by non-governmental and 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 action is either inadequate or not well 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 next chapter examines the policies and programmes the government has put in place to specifically address uterine prolapse.

4. AN INADEQUATE GOVERNMENT RESPONSE

“We don’t have any preventative programmes in the public sector.”

Dr Padam Bahadur Chand, Head of International Cooperation and Planning, Ministry of Health and Population

Nepali civil society, especially women’s rights NGOs, have been instrumental in bringing the issue of uterine prolapse to the attention of the Nepali government and in continuously advocating for improvements to the way it is addressed.

Following publication of reports on uterine prolapse before 2005 by organisations including the Women’s Rehabilitation Centre (WOREC) and the Safe Motherhood Network, the legal organisation Pro Public sent advocacy letters to the government requesting a response. After waiting a year for the response, Pro Public filed a Public Interest Litigation with the Supreme Court of Nepal.²³⁵ In its judgement in 2008 on the case of *Prakash Mani Sharma v Government of Nepal*, the Supreme Court held: “Although, right to reproductive health has been termed as a matter of health, this has to be linked with the right to life, right to freedom, right to equality, right against torture, right to privacy and right to social justice and right of woman”.²³⁶

The court stated that “mere recognition” of the right to reproductive health in the constitution was not sufficient and that in the “absence of any legal, institutional, procedural and result oriented infrastructure, this right would be limited to formalities”. It held that to realise the right to reproductive health “efforts should be made towards the formulation of policies (including formulation of laws), drafting of plans, its subsequent implementation, extension and evaluation.”²³⁷

The Supreme Court asked different government ministries to submit written responses outlining what they were doing to address uterine prolapse. The Ministry of Health said the Ministry had not violated the rights of the petitioners and the petition should be quashed. The Ministry of Women said “the subject matter of health does not fall within the ambit of this Ministry”. In its judgement the Supreme Court said the response of both Ministries was “insensitive”.²³⁸ It went on to say that:

“pursuant to the division of labor there is a tendency between the Ministry of Health and the Ministry of Women, Children and Social Welfare of alienating themselves from their responsibility. Pursuant to the current infrastructure, it is natural that the Ministry of Health... be health centric and Ministry of Women be women centric, but nevertheless, there

should be cooperation between and coordination between the two Ministries on matters relating to health services of women. Unfortunately, neither has the Ministry of Health made reproductive health as its focal point nor has the Ministry of Women made any effort towards addressing the matter relating to the health of a woman.”

The court noted that no law, policy or programmes in Nepal had produced “tangible results” in relation to reproductive health. Noting 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 Population and Health to “provide free consultation, treatment, health services and facilities” to 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”.²³⁹

“The essential problem is a lack of understanding. Uterine prolapse is not treated as a human rights issue, but as a health issue. And therefore the quality of interventions and tackling of root causes is insufficient.”

Dr Renu Rajbhandari, Founder Chair WOREC and Chair of National Alliance of Women Human Rights Defenders (NAWHRD)²⁴⁰

CURRENT POLICY FRAMEWORK AND RECENT INITIATIVES

The 2008 Supreme Court case focused the attention of the government on uterine prolapse as a human rights issue and Nepali civil society has continued to press the government on its obligations and to advocate for government action to implement the decision. Government officials interviewed by Amnesty International described policies and initiatives to address aspects of the problem.

Nepal’s core government planning document is the Three Year Interim Plan, 2010-2013. It sets out government strategy and priorities for this period. The Plan states that “New programs will be implemented to improve the effectiveness and access to women health, sexual health, reproductive health, neonatal and infant health and family planning services. Additionally, regular and mobile services will be provided for women suffering from uterine prolapsed problem”.²⁴¹ However, there has been little governmental focus on the prevention aspect of uterine prolapse by addressing the gender-based discrimination which underlies the risk factors for this condition.

FOCUS ON SURGERY NOT PREVENTION

“Prevention is not a priority. The government has given weight only to uterine prolapse surgery, and not advocacy or awareness.”

Jai Bahadur Karki, District Public Health Officer, Kailali District²⁴²

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.

Representatives of the Ministry of Health and the Family Health Division told Amnesty International that they had fully complied with the Supreme Court Decision by conducting programmes of surgeries. However, neither they, nor the representative of the Ministry of Women, provided Amnesty International with evidence of any concrete steps they had undertaken to initiate programmes to raise public awareness of the issue in response to the directions of the Supreme Court. Reports on the status of implementation of Supreme Court Judgements from the Office of the Prime Minister and the National Women's Commission list actions taken to implement the judgement. They list provision of uterine prolapse surgery and development or revision of guidelines but contain no initiatives taken by the government on prevention. The report by the National Women's Commission said that the surgery and treatment services offered are not "effective or accessible to all", and that the quality of surgery provided "has been compromised".²⁴³

Dr Padam Bahadur Chand of the Ministry of Health told Amnesty International, "As such we don't have any preventive programme on uterine prolapse in the public sector ... [yet] we do understand the magnitude of the problem".²⁴⁴ This means that for district health officials, they are only able to conduct screening and surgery camps. Basu Dev Pandey, District Health Officer of Ramechhap district, told Amnesty International that his office did not have a budget for uterine prolapse awareness or prevention. He said that the Ministry of Health provides District Health Offices with funding to conduct screening and surgery camps only. "If there is no camp, then there is no uterine prolapse information... we have no [public] messages about the consequences of uterine prolapse, what happens during uterine prolapse, nothing."²⁴⁵ Jai Bahadur Karki the District Health Officer in Kailali said the same. If the office was to do anything to raise awareness about uterine prolapse then they needed money to provide education materials and information.²⁴⁶ While government representatives told Amnesty International that their main programmes were related to surgery, they also recognised the importance of prevention. Dr Chand of the Ministry of Health said "We will continue to carry out surgical interventions but at the same time we think we should switch over to preventative programmes".²⁴⁷

UTERINE PROLAPSE AND THE SURGICAL RESPONSE

The government of Nepal has based its surgery programme on a 2006 UNFPA study which found that one third of women with uterine prolapse required surgery. Based on the UN figures the government's assumption is that 600,000 women in Nepal suffer from uterine prolapse and 200,000 need surgery.

The government has established a fund for surgeries for uterine prolapse: up to 2010 the fund supported 26,000 surgeries.²⁴⁸ In 2010, 14,041 surgeries were performed – double the number (around 7000) of women who were treated through non-surgical methods.²⁴⁹ The government's current health plan, the Nepal Health Sector Support Plan II, plans to gradually increase the number of surgeries conducted annually, from 12,000 surgeries in 2010-11 up to 40,000 in 2014-15.²⁵⁰ Each of these surgeries costs 19,000 Nepali Rupees (approx 186 USD). It also plans to treat 135,000 women with ring pessaries, at a cost of 304 Rupees (approx 3 USD) per ring insertion.²⁵¹

Officials from the Ministry of Health and the Family Health Division confirmed their intention to continue the surgery programme to Amnesty International. Dr Marasini of the Ministry of Health said the target for 2013 was 14,000 surgeries.²⁵² Taking the figure of 200,000 women needing surgery as accurate, the government response has been inadequate; large numbers of women are still waiting for surgery almost eight years after

the UNFPA study, and many others will have developed uterine prolapse during that time because of the lack of attention paid to preventing the condition.

Most of these surgeries are conducted through temporary surgical and screening camps, and not in institutional settings like health centres or hospitals.²⁵³ Representatives from NGOs told Amnesty International of their suspicions that because surgery providers were paid by number of surgeries conducted some women were being operated on unnecessarily and sometimes the quality of surgery was low.²⁵⁴ It was beyond the scope of this research for Amnesty International to investigate this allegation in detail; however, when asked about whether some women were being operated on unnecessarily, Dr Upreti of the Family Health Division said that they had been hearing the same and that it “may not be untrue” but that they “don’t have a figure”.

The Nepal Health Sector Support Plan II committed to scaling up services related to uterine prolapse prevention and treatment in the period between 2010 and 2015.²⁵⁵ However, the document overwhelmingly refers to provision of surgery. The only reference to action on prevention states that “health education messages to others is not explicitly costed” in the Plan.²⁵⁶ Yet investing in programmes to address gender discrimination and prevent women from developing uterine prolapse will, in the long run, avoid the need for costly surgery.

AN INCOMPLETE EFFORT AT A PREVENTION STRATEGY

“There are issues related to whether we will be able to tackle all of the problems by providing surgery or shouldn’t we [also] work for prevention so that no surgery is required? Why not educate regarding the causes of uterine prolapse and the method of preventing it?”

Dr Senedra Raj Upreti, Director, Family Health Division²⁵⁷

There was an 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. 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.²⁵⁸

The draft Multi-Sector Plan provided a framework for how the Ministry of Health and Population, the Ministry of Education and Sports, the Ministry of Women, Children and Social Welfare, the Ministry of Local Development, and the Ministry of Labour and Employment would work together, and what specific actions would be taken by each of these ministries to prevent and treat this condition. On uterine prolapse prevention specifically, the Multi-Sectoral Plan specified that the Ministry of Education and Sports would increase awareness about the causes of uterine prolapse through amending the general school curriculum, non-formal education course materials, and vocational medical courses. The Ministry of Women, Children, and Social Welfare would integrate knowledge (social and medical) about uterine prolapse prevention in its adolescent sexual and reproductive health programs and address the issue from a rights perspective as “a consequence of gender based violence and a violation of reproductive rights”.²⁵⁹ The Ministry of Labour and Employment would improve access to rest for women working in the informal sector through media-based awareness raising and by implementing laws that provide women working in informal sector jobs, such as agriculture and construction, with maternity benefits. The Ministry of Health and Population would conduct awareness raising programmes at the local level and support the

media to spread appropriate health messages.

The draft Multi-Sector 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 measures included in the draft Plan on awareness raising and provision of information are all important steps which should be implemented; however additional measures not included in the draft Plan are also required if women and girls are to be able to exercise control over their lives and reduce their exposure to the risk factors, for example changing societal attitudes that prevent women from making reproductive choices.

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-Sector Plan remains a draft and has not been adopted as government policy.

WHAT HAPPENED TO THE DRAFT MULTI-SECTOR PLAN?

During the research, Amnesty International met with relevant government ministries to ask what they knew about the current status of the draft Multi-Sectoral Plan and what had happened after it was finalised in 2008.

Amnesty International received a consistent message from the different government officials in the relevant ministries: no one knew what had happened to the draft multi-sector or why it had not been adopted. The reason most officials gave for this lack of knowledge was that most of the staff at the ministries had changed since the draft was finalised in 2008, so they had not been involved personally in the process.

Purushettam Ghimire, Joint Secretary of the National Planning Commission explained the usual process for Multi Sector Plans. He said that the Commission acts as the coordinating body. There is one Ministry who is the “leader”. “The lead Ministry drafts the plan then it goes to different line ministries. If there are financial implications, then it goes to the Ministry of Finance. [Relevant] Ministries will amend the draft. Then the final document goes to the Cabinet.”²⁶⁰

Dr Senendra Upreti, the Director of the Family Health Division confirmed that the Division had been involved in the discussions of the draft Multi-Sector Plan and said “If things [are to] remain sustainable, then the plan has to be endorsed. We are in favour of the Multi-Sectoral plan.” However, despite the letter of acknowledgement from the former Director of the Family Health Division at the beginning of the draft Plan, Dr Upreti also said that he did not “know what is the objective of development of that multi-sectoral plan and what are the responsibilities of the Family Health Division.” Dr Upreti said that he did not know why the plan had not been endorsed in the period since 2008.

Representatives of the Ministry of Health were also unaware of the current status of the draft plan. Dr Marasini spoke of the difficulty of getting different Ministries to work together in Nepal. He advised Amnesty International to find the “lead agency” or Ministry to get an update on the plan. However in his view there was no lead agency identified and he did not think that the Ministry of Health was the lead Ministry. He said that the Plan had been prepared by “an NGO” who “discussed with the donors” and “sent [the draft Plan] to Ministries”. In fact a 12-member steering committee “was formed with the initiation of the Government of Nepal”.²⁶¹ This steering committee was coordinated by the National Planning Commission and included representatives from the Ministry of Health, the Family Health Division and the Ministry of Women. UNFPA and

the Uterine Prolapse Alliance, an umbrella organisation of NGOs were also on the Committee.²⁶²

The Office of the Prime Minister and Council of Ministers provides leadership to the civil service, directs and supervises its performance and leads governance reforms.²⁶³ The representatives did not know what had happened to the Multi Sectoral Plan. Raju Man Singh Malla, Secretary said “Health related issues are handled by the Ministry of Health.” Keshab Prasad Bastola, the Under Secretary said, “Gender related issues come to my office, health related issues come to other secretaries and when asked about the draft Multi Sector Plan, he referred Amnesty International back to the Ministry of Health. Upendra Prasad Adhikary, Joint Secretary from the Ministry of Women, another key ministry mentioned in the draft Plan, told Amnesty International that women’s health is not their responsibility. He said “We will know about [the Plan] after it’s passed by the cabinet”. Purushottam Ghimire of the National Planning Commission did not know what had happened to the draft Plan on uterine prolapse either. He said that the Planning Commission was not “the leading agency”.

Representatives from other Ministries said that the Ministry of Health was responsible for the Draft Plan but as mentioned, Dr Marasini did not agree that the Ministry of Health was the “lead agency” responsible for ensuring the Plan’s adoption. UNFPA played a prominent role in organising the consultations and drafting of the plan and they received thanks for this role in the messages and acknowledgements from the Ministries that accompanied the draft. UNFPA told Amnesty International that as far as they were aware the draft Plan is waiting endorsement by the Ministry of Health.²⁶⁴ From the interviews Amnesty International held, it appears that despite their involvement in the steering committee, none of the government Ministries had sufficient ownership of the draft Plan to take it forward and ensure it was adopted as policy once UNFPA finished providing its technical assistance to the process. On the other hand once the draft was complete, UNFPA did not continue to push for its adoption. Instead, UNFPA told Amnesty International that “our support has shifted to supporting the development of protocols and standards, in response to concerns about the quality of [Pelvic Organ Prolapse] care”.²⁶⁵

At best the inability of any government official to explain the status of the draft Multi-Sector Plan indicates a lack of an effective mechanism within the government to ensure continuity when officials are moved to different posts. Multi-Sector Plans have been adopted since 2008, for example one on nutrition was launched in 2013. This suggests a serious lack of government concern over a debilitating condition affecting hundreds of thousands of Nepali women.

There are other policy initiatives which could have a positive impact on uterine prolapse prevention or early treatment but, likewise, these have not been finalised or implemented. The Nepal Health Sector Program II (2010-2015) – the document outlining the vision, priorities and plans of the Ministry of Health for a five year period – states that the “prevention and treatment of uterine prolapse” will be added to Nepal’s Essential Health Care Services (ECHS) package between 2010 and 2015; however it does not give any details on what this prevention and treatment will include.²⁶⁶ The Essential Health Care Services package is specified as “prevention, clinic services, basic inpatient services, delivery services, and a list of essential drugs” that are provided free of cost by the government in certain areas and to certain groups.²⁶⁷ Despite this commitment in the plan, it has not yet been implemented. Dr Marasini of the Ministry of Health told Amnesty International in April 2013 that “we are in the process of integrating that”.²⁶⁸ As of January 2014, the Family Health Division confirmed to Amnesty International that no progress has been made on the implementation.²⁶⁹

The government has also developed a document titled the “Clinical Protocol for the

Management of Pelvic Organ Prolapse”, dated December 2012.²⁷⁰ Intended as a tool for health workers in Nepal, the document contains a section on uterine prolapse prevention. It provides recommendations for what should be done by community members, families, health workers, and the government to help prevent uterine prolapse. For example, it states that community members and families can: empower women with education and employment; create awareness about the legal age of marriage; discourage child marriage, adolescent pregnancies, and early childbirth; and ensure that girls and “pregnant and lactating mothers” have access to nutritious food. Similarly, steps the government health sector should take include educating women that malnutrition and carrying heavy loads are risk factors for uterine prolapse, encouraging couples, families and communities to reduce women’s exposure to these risk factors, teaching women pelvic floor exercises, and ensuring access to necessary health services.²⁷¹

These are all necessary steps; however, as a prevention strategy, the Protocol is not sufficient. It is not a rights-based document and often does not look at the risk factors for uterine prolapse from the perspective of the government’s obligations. For example, it does not prescribe any responsibility to the government to address the issue of child marriage. Additionally, while there is a lot of emphasis on education and awareness, the Protocol does not address the issue of women and girls’ control over their lives. Many women will not be able to make the suggested behaviour changes even if they are aware of what needs to be done and want to do it because control of decisions fundamental to their sexuality, reproduction, and health is exercised by their family members. The Protocol also focuses on the Ministry of Health but does not specify a time line for implementation, budget or accountability mechanisms.

While the document is not a comprehensive prevention plan, in the absence of any other prevention strategy, it is a welcome first step. By January 2014, the Adventist Development and Relief Agency had disseminated the Protocol on behalf of the Ministry of Health to health workers in five regions of Nepal for use during prolapse surgeries.²⁷²

EVASION OF OBLIGATIONS

Complex medical issues like uterine prolapse, which are caused by a variety of underlying factors, require an effective coordinated response by all relevant government ministries. In the context of uterine prolapse specifically, the manifestation of the condition is treated as a health issue, while the underlying causes of the condition (which as discussed in the previous chapter are linked to gender discrimination) are considered separately. This leads to the issue falling between different ministries with each declaring that another institution is responsible.

Despite the Supreme Court criticising the government in 2008 in the Prakash Mani Sharma case for the lack of cooperation between the Ministry of Health and the Ministry of Women, Amnesty International found that the situation has not markedly changed. Government representatives from both ministries informed Amnesty International not only that their ministry was not responsible for making progress on the draft Multi-Sector Plan but in some cases that they were not responsible for specific risk factors. Instead they appear to view their responsibilities very narrowly.

The Ministry of Health confirmed that some elements related to of prevention of health

problems were within their responsibility. For example, they were working on education programmes about the negative health effects of smoking and drinking alcohol. However, on uterine prolapse, Dr Marasini said that the Ministry had implemented their responsibilities under the draft Multi-Sectoral Plan by conducting surgeries. He said “the difficult and costly one [surgery] we implemented it. The less difficult and less costly one, other ministries should have done.” He was also quick to say that education on adolescent pregnancy linked to child marriage, a key risk factor for uterine prolapse, was not their responsibility despite recognising it is linked to negative health consequences.²⁷³

Upendra Prasad Adhikary from the Ministry of Women said “Health issue is our concern yes, but not our responsibility. There’s a health post and sub health post in each district, they and the district hospital should be doing this work”.²⁷⁴

INSUFFICIENT ATTENTION TO MULTIPLE FORMS OF DISCRIMINATION

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.

When Amnesty International asked what the government was doing to ensure that women suffering from multiple forms of discrimination such as Dalit women and Muslim women benefited from government programmes, Upendra Prasad Adhikary from the Ministry of Women said that the Ministry’s programmes are targeted at the rural poor. He pointed out that there are poor Brahmins and rich Dalits in Nepal and said “you want to look through the lens of the caste system. That doesn’t work in this situation”.²⁷⁵ It is certainly true that poverty affects some people from dominant castes and Amnesty International interviewed poor Brahmins for this report. However, that fact does not diminish or negate the continuing impact of caste across Nepali society and the urgent need to address disparities.

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”.²⁷⁶ 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.

The response from the Family Health Division was more positive. Dr Senendra Raj Upreti said that ensuring marginalised groups can access health services was “not an easy question”. He said that the Division’s work was with women and that they try to take their health services as close to the local people as possible “so that the people who are marginalised, who are poor, can come and have access to the service”.²⁷⁷ That he recognised the need to ensure access to women from marginalised groups is good, but the continuing disparities in key indicators related to risk factors for uterine prolapse, including access to skilled birth attendants and to

contraception, among particular groups of women suggests that the issue requires more attention.

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.

CONTINUING INACTION

In 2008 in the case of Prakash Mani Sharma v Government of Nepal the Supreme Court of Nepal stated that the scale of the prevalence of uterine prolapse in Nepal indicated that the constitutionally guaranteed right to reproductive health had been violated. Amongst other priority measures, it directed the Ministry of Women and the Ministry of Health to raise public awareness about uterine prolapse in Nepal.

However, the government’s focus has consistently been on devising and implementing large scale surgical programs to identify and treat advanced cases of uterine prolapse. There has been little government attention on preventing uterine prolapse by addressing the underlying gender discrimination, and despite the order of the Supreme Court, little has been done to raise awareness of the condition. Effective governmental action to prevent uterine prolapse by addressing the underlying gender discrimination is essential for Nepal to meet its international human rights obligations and would also, in the long term, reduce the need for expensive surgeries.

Many governmental initiatives which could have a positive impact on uterine prolapse prevention have either not been finalized or implemented and government officials are unable to explain why. A significant part of the problem is that government ministries are quick to pass on responsibility for preventing uterine prolapse to each other.

5. UTERINE PROLAPSE: A HUMAN RIGHTS ISSUE

“Every woman shall have the right to reproductive health and other reproductive rights.”

Article 20, Interim Constitution of Nepal²⁷⁸

The lack of effective action by the government of Nepal to reduce the exposure of women and girls to the discrimination underlying the risk factors of uterine prolapse represents violations of numerous rights, including to equality and non-discrimination both in itself and combined with other rights including, the right to physical and mental integrity, sexual and reproductive rights, and the right to the highest attainable standard of physical and mental health.

The government has ratified or acceded to a range of international human rights instruments which guarantee these rights, including the International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Covenant on Civil and Political Rights (ICCPR), and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the International Convention on the Elimination of all forms of Racial Discrimination (ICERD) and the Convention on the Rights of the Child (CRC). Once a treaty has been ratified, its provisions are enforceable and have the force of Nepali law.²⁷⁹ Therefore, the government has legal obligations to respect, protect, and fulfil these rights.

Within Nepal, human rights are protected under the Interim Constitution and specific domestic laws. However, some of these protections (for example the definition of discrimination) are not fully in line with international law and enforcement of the laws is frequently weak or ineffective.

THE RIGHT TO EQUALITY AND NON-DISCRIMINATION

“Uterine prolapse is one outcome of differential power relations between men and women in our society”

Dushala Adhikari, Centre for Agro-Ecology and Development²⁸⁰

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 the lack of effective governmental action to address this discrimination.

The government of Nepal has ratified many international human rights treaties which guarantee the right to equality and non-discrimination.²⁸¹ These include the Convention on

the Elimination of all forms of Discrimination Against Women (CEDAW) and the government of Nepal must take all appropriate measures to end discrimination against women committed by any person, organization or enterprise.²⁸²

The right to non-discrimination is an immediate and cross-cutting obligation and applies to the exercise of each and every human right guaranteed under international law even during periods of conflict or political instability. The Committee on Economic, Social, and Cultural Rights (CESCR) which monitors implementation of the ICESCR has said 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.²⁸³

Patriarchal attitudes and gender stereotypes often perpetuate and entrench practices that are harmful to women and girls. States also have a legal obligation to take all appropriate measures to “modify... social and cultural patterns of conduct”, and eliminate “prejudices, and customary and all other practices”, which are based on stereotyped roles for men and women.²⁸⁴ The CEDAW Committee, which monitors state compliance with the treaty, is clear that the fact that discrimination (including violence) against women is frequently supported by interpretations of custom or tradition and these cannot ever justify it or make it acceptable.²⁸⁵ Article 2(f) requires states to “[t]o take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women.”²⁸⁶ In 2011 the CEDAW Committee recommended that the government of Nepal “put in place without delay a comprehensive strategy, with concrete goals and timetables, to eliminate patriarchal attitudes and stereotypes that discriminate against women”.²⁸⁷

THE OBLIGATION TO PREVENT DISCRIMINATION BY PRIVATE INDIVIDUALS

In addition to the obligation to refrain from committing discriminatory acts themselves, states have the obligation to protect individuals within their jurisdiction from discrimination committed by private individuals.

States have an obligation to respect, protect, and fulfil human rights, including the right to equality and non-discrimination. The obligation to protect requires states to “take measures that prevent third parties from interfering with ... guarantees”.²⁸⁸ This obligation goes beyond prohibiting discriminatory state action to require state to prevent discrimination by non-state actors such as family members, companies and community members. In General Comment 20 on non-discrimination in economic, social and cultural rights, the CESCR said that State Parties must “adopt measures, which should include legislation, to ensure that individuals and entities in the private sphere do not discriminate on prohibited grounds”²⁸⁹.

With respect to gender discrimination, article 2(e) of CEDAW requires states to take all appropriate measures to eliminate discrimination against women and girls by any person, organization or enterprise. Gender-based violence against women, which includes marital rape, is a form of discrimination against women.²⁹⁰ According to the CEDAW Committee, states may be responsible for the acts of private individuals if they fail to act with “due diligence” to prevent violations such as those committed by husbands, parents and other family members.²⁹¹ Similarly, the 1993 UN Declaration on the Elimination of Violence against Women requires states to “Exercise due diligence to prevent, investigate and, in accordance with national legislation, punish acts of

violence against women, whether those acts are perpetrated by the State or by private persons”.²⁹² In her 2006 report, the Special Rapporteur on Violence against Women said “it can be concluded that there is a rule of customary international law that obliges States to prevent and respond to acts of violence against women with due diligence”.²⁹³

The International Convention on the Elimination of all forms of Racial Discrimination requires State Parties to “prohibit and bring to an end, by all appropriate means, including legislation as required by circumstances, racial discrimination by any persons, group or organization”.²⁹⁴ In addition to discrimination on the basis of ethnicity which can affect members of Janajati groups, discrimination on the basis of caste also falls under the definition of racial discrimination contained in Article 1.1 of the Convention.²⁹⁵

“Racial discrimination does not always affect women and men equally or in the same way. There are circumstances in which racial discrimination only or primarily affects women, or affects women in a different way, or to a different degree than men”.²⁹⁶

UN Committee on the Elimination of Racial Discrimination (CERD)

Article 13 of the Interim Constitution of Nepal provides that all citizens are equal before the law, and that “The State shall not discriminate among citizens on grounds of religion, race, caste, tribe, sex, origin, language or ideological conviction or any of these”. Article 20 states that “No one shall be discriminated in any form merely for being a woman”.²⁹⁷

In its concluding observations on Nepal in 2011, however, the CEDAW Committee found that these definitions of discrimination in the interim constitution were limited. It recommended that any new Constitution of Nepal should include “the principle of equality between women and men [and] provisions prohibiting discrimination against women” and “a definition of discrimination that encompasses both direct and indirect discrimination and discrimination in the public and private spheres”.²⁹⁸ The Committee also recommended that the government repeal all remaining discriminatory laws or provisions.²⁹⁹

THE RIGHT TO HEALTH

Article 12 of the ICESCR recognizes the right of all persons to the enjoyment of the highest attainable standard of physical and mental health. The CESCR has interpreted this as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, including, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.³⁰⁰

While under article 2 of the ICESCR states have committed to take steps towards “achieving progressively the full realization of the rights” in the covenant, some obligations within the right to health, known as core obligations, are of immediate effect. According to the CESCR “a State Party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations.”³⁰¹ These core obligations include the right to access health facilities, goods and services without any discrimination; the obligation to ensure reproductive, maternal (pre-natal as well as post-natal) and child health care; the right of access to minimum essential food which is nutritionally adequate and safe; and the right to health education and access to information concerning the main health problems in the community, including methods of preventing and controlling them.³⁰²

THE OBLIGATION TO ENSURE PREVENTIVE SERVICES

It is not sufficient that states merely put in place policies and services to treat health conditions that impact their population; states must also provide access to basic preventive, curative, and rehabilitative health services.³⁰³ The CESCR has said that “Investments should not disproportionately favour expensive curative health services”. Instead, states should focus on “primary and preventive health care, benefiting a far larger part of the population”.³⁰⁴ It has also noted the importance of undertaking “preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights”.³⁰⁵ Article 20 of the UN Convention on the Rights of the Child (CRC) requires states to take appropriate steps to “develop preventive health care”.³⁰⁶ The CEDAW Committee holds that measures to eliminate discrimination against women are inappropriate if “a health care system lacks services to prevent, detect and treat illnesses specific to women”.³⁰⁷ During its review of Nepal's report in 2011, the CEDAW Committee stressed that it was important that the government of Nepal address measures to prevent uterine prolapse as well as treatment:

“Take preventive measures to combat the problem of uterine prolapse, such as adequate access to family planning, awareness-raising and training under existing safe motherhood programmes, and ensure sufficient allocation of funds for quality corrective surgeries and follow-up visits,”

Recommendation from the CEDAW Committee to the government of Nepal in 2011³⁰⁸

States have an obligation to respect the right to health by providing access to health facilities, goods and services without discrimination, including access to preventive services.³⁰⁹ The right to equality and non-discrimination is particularly relevant to women who face multiple forms of discrimination linked not only to their gender, but to race, ethnic or religious identity, language, disability, age, class, caste, sexual orientation, gender identity, or other factors.

According to the Special Rapporteur on the right to health, “Social inequalities, fuelled by discrimination and marginalization of particular groups, shape both the distribution of diseases and the course of health outcomes amongst those afflicted”.³¹⁰ Thus, women who face discrimination on more than one ground often bear an increased burden of ill-health in society. States are required to recognise the impact of this multiple discrimination and act to address it. The CESCR has said that states must “take measures to protect all vulnerable or marginalized groups of society” and ensure that “health services are culturally appropriate and that health care staff are trained to recognize and respond to the specific needs of vulnerable or marginalized groups”.³¹¹ All health services, including preventive services, provided by the government must therefore be available and accessible and take into account the different experiences women face as a result of their different and multiple identities.

The Interim Constitution of Nepal states in article 16 that “Every citizen shall have the right to get basic health service free of cost from the State as provided for in the law”. Article 20 provides that every woman has the right to reproductive health, and article 22 states that every child has the right to “get nurtured, basic health, and social security”.³¹² Constitutional guarantees are given legal effect through various other domestic laws and policies. Presently, the right to reproductive health and the right to basic health services have not been further elaborated in any domestic laws.

THE OBLIGATION TO PROVIDE HEALTH RELATED INFORMATION

The government of Nepal has to ensure that all health facilities are accessible, available, acceptable, and of good quality.³¹³ According to the CESCR, access to information is an important aspect of accessibility and the government of Nepal must provide its population with information on health, particularly on sexual and reproductive health, harmful traditional practices, and domestic violence.³¹⁴ The CESCR has also stated that the obligation to “provide education and access to information concerning the main health problems in the community, including methods of *preventing* [emphasis added] and controlling them” is a core obligation.³¹⁵

Given the prevalence and impact of uterine prolapse in Nepal, it is one of the main health problems affecting women and provision of information on the risk factors for the condition and how women can reduce their exposure to them is an essential aspect of efforts to prevent it. Furthermore, the Committee on the Rights of the Child has said that “the right of adolescents to access appropriate information is crucial” including information on family planning and protection from harmful traditional practices.³¹⁶

THE OBLIGATION TO MONITOR THE IMPACT OF LAWS AND POLICIES

States have an obligation to monitor their laws and policies to ensure they are effective and do not have an adverse impact on particular groups. States should also monitor the effectiveness of measures they put in place to address discrimination. This monitoring “should assess both the steps taken and the results achieved in the elimination of discrimination”.³¹⁷ Data, disaggregated by gender and other prohibited grounds of discrimination including ethnicity and caste, allows states to identify and redress any de facto discrimination. The CEDAW committee urged the government of Nepal to:

*“prioritize combating multiple forms of discrimination against women from various disadvantaged groups through the collection of data on the situation of these women and the adoption of legal provisions and comprehensive programmes, including public education and awareness-raising campaigns involving the mass media and community and religious leaders”.*³¹⁸

SEXUAL AND REPRODUCTIVE RIGHTS RELATING TO THE RISK FACTORS FOR UTERINE PROLAPSE

“The right to reproductive health, recognized as a fundamental right, needs to be protected whereby the problem of uterus prolapse as stated by the petitioners would be effectively addressed.”

Supreme Court of Nepal in *Prakash Mani Sharma v Government of Nepal*³¹⁹

Sexual and reproductive rights encompass a range of freedoms and entitlements that protect the ability of individuals to make and enforce informed choices about their sexuality and reproduction, free from violence, coercion or discrimination. They include the freedom to choose whether or not to be sexually active,³²⁰ the right to choose whether, when and how often to have children,³²¹ the right to access information and services on family planning,³²² the right to health education, including for children and adolescents,³²³ the right to the goods and services necessary to prevent avoidable maternal death and illness,³²⁴ the right to choose whether or not to marry,³²⁵ and the right to live free from rape and other forms of violence including forced pregnancy, forced abortion, forced sterilization and harmful traditional practices endangering sexual and reproductive health.³²⁶

These rights are protected in a variety of international human rights instruments which the government of Nepal has ratified.³²⁷ In addition to a provision in the Interim Constitution for women's reproductive rights, aspects of sexual and reproductive rights are protected in a range of domestic laws discussed in more detail below. However, there are gaps in that protection. There are draft laws related to sexual and reproductive rights that, if in line with Nepal's international human rights obligations, could enable women and girls to better exercise these rights. These include a draft bill on "Harmful Social Practices", and a draft "Safe Motherhood" Bill.³²⁸ Nepal was without an elected assembly from May 2012 until January 2014 which means that no progress was possible on any draft legislation. Elections for the Constituent Assembly were held in November 2013. The Assembly held its first meeting on 22 January 2014. Its main task will be to agree a new Constitution but it also could act on the draft bills.

THE RIGHT TO CHOOSE WHETHER, WHEN AND HOW MANY CHILDREN TO HAVE

The government of Nepal has an obligation to ensure that women are able to exercise their right to choose when and how many children they want to have³²⁹ and to provide the information, education and means to enable them to exercise these rights.³³⁰ According to the CEDAW Committee, the state must ensure that "Decisions to have children or not, while preferably made in consultation with spouse or partner, must not nevertheless be limited by spouse, parent, partner or Government".³³¹ Failure to ensure that women and girls are able to make decisions free from outside interference, such as from members of their families, about whether to have children, how many children to have, and when to have them is a violation of international human rights law.

In Nepal, adolescent pregnancy is closely associated with early marriage as government data and testimony from women and girls has shown. The CEDAW Committee has stated that the betrothal and marriage of a child must have no legal effect. States must take all necessary action, including legislation, to specify a minimum age for marriage and to make the official registration of marriages compulsory. In interpreting this article, the CEDAW Committee has said that "a woman's right to choose when, if, and whom she will marry must be protected and enforced at law".³³²

The *Muluki Ain* (General Code) states that "No marriage shall be solemnized or arranged without the consent of both the male and the female parties thereto" and a marriage without consent of both parties will be void.³³³ It also states that marriages must not occur below the age of 18 with the consent of a guardian or the age of 20 without consent of a guardian and provides for punishment of those who marry or "cause to be married" a girl under that age.³³⁴

THE RIGHT TO SAFE WORK AND WORKING CONDITIONS ESPECIALLY DURING AND AFTER PREGNANCY

The government of Nepal has an obligation to take steps to ensure that women are not forced to perform work that is harmful to them while they are pregnant or during the immediate post-natal period. According to CEDAW, states must provide special protection to women during pregnancy in types of work proved to be harmful to them.³³⁵ Safeguarding the health of women in the workplace while they are pregnant and breastfeeding is an important part of the right to equality and non-discrimination in the context of employment and work. The CEDAW states that states must guarantee "The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction".³³⁶

The Labour Act of 1992 in Nepal prescribes some benefits for pregnant and breastfeeding women in a chapter titled “Welfare Arrangements”. These include maternity leave, and the provision of childcare.³³⁷ However, the limited provisions of this act only apply to “any factory, organisation, institution or firm, or group thereof, established under current law with the objective of operating any industry, enterprise or service, and employing ten or more workers or employees”.³³⁸ This excludes the informal labour force, and with it, the majority of women who work in Nepal. The 2011 Demographic and Health Survey found that 75% of working women in Nepal were employed in the agricultural sector. More than three-quarters of those were unpaid and were mostly employed by family members.³³⁹ In its concluding observations on Nepal, the CEDAW Committee noted the high number of women working in the informal sector in Nepal, and the lack of governmental oversight over this sector, and recommended the government “Regulate the informal sector to ensure that women in this sector are not exploited”.³⁴⁰

THE RIGHT TO BE FREE FROM DISCRIMINATION AND VIOLENCE, INCLUDING HARMFUL PRACTICES JUSTIFIED BY “CUSTOM” OR “CULTURE”

Sexual and gender-based violence against women and girls, including harmful practices justified by “custom” or “culture”, is a form of discrimination against women and girls that also impacts their ability to enjoy other human rights. States should take all effective legal measures, including penal sanctions, civil remedies and compensatory provisions, to protect women against all kinds of violence.³⁴¹ Tradition, culture or religion cannot ever justify violence against women and girls. The UN Special Rapporteur on Violence against Women, its Causes and Consequences has said that governments violate the CEDAW when they “fail to pursue, by all appropriate means and without delay, a policy to eliminate such violence, regardless of whether the violence is grounded in traditional, religious or cultural practice”.³⁴²

The links between violence and the ability of women and girls to enjoy the right to health particularly has been highlighted by CEDAW and the UN Special Rapporteur on the Right to Health.³⁴³ Violence, including harmful practices justified by “custom” or “culture”, often lead to physical injuries that are health risks in themselves and place women at higher risk of contracting HIV/AIDS and other sexually transmitted diseases.³⁴⁴ Harmful practices such as *chaupadi* also have a negative impact on the health of women and girls. Combined with patriarchal attitudes, they can create an environment in which women are prevented from accessing health care or reluctant to access necessary health care because of the existence of, or the fear of, physical or mental harm.

The Interim Constitution (article 13 (3)) states that “The State shall not discriminate among citizens on grounds of religion, race, caste, tribe, sex, origin, language or ideological conviction or any of these”, and article 33 makes it a responsibility of the state to “repeal all discriminatory laws”.³⁴⁵ The *Muluki Ain* (National Code) criminalizes rape and sexual assault.³⁴⁶ Consensual sex with a girl under the age of 16 is considered rape. Amendments in 2006 removed a clause which exempted a husband who had non-consensual sexual intercourse with his wife thereby criminalizing marital rape. However, it still provides for unequal penalties for rape by a husband compared with rape by someone other than a husband.³⁴⁷

The Domestic Violence (Crime and Punishment) Act was passed in 2009. Under the act, no one can commit, aid, abet or incite an act of domestic violence,³⁴⁸ which is defined as “any

form of physical, mental, sexual and economic abuse perpetrated by any person to the other person with whom he/she has a family relationship.” The definition also covers acts of “reprimand or emotional abuse”.³⁴⁹ Perpetrators of domestic violence can be punished with a fine of up to 25,000 Nepali rupees (250 USD), or six months imprisonment, or both.³⁵⁰ In some situations, the court can also pass compensation orders in favour of the survivor.³⁵¹

The CEDAW Committee expressed its concern at the lack of implementation of laws including the Domestic Violence Act.³⁵²

“Ensure the effective implementation of the Domestic Violence Act, 2009 and other existing legislation and the proper prosecution and punishment of perpetrators of such violence; Develop a nationwide data collection programme on cases of violence against women; ... undertake wider awareness-raising programs in all communities, including Dalit community, specifically targeting men and boys”.³⁵³

Committee on the Elimination of Discrimination Against Women, Recommendation to the government of Nepal, 2011

The Supreme Court of Nepal has addressed various aspects of sexual and reproductive rights. Particularly relevant is a case, decided in 2005, which dealt with the practice of *chaupadi*.³⁵⁴ The Supreme Court declared this practice to be discriminatory and a violation of women’s rights.³⁵⁵ The Supreme Court directed the Office of the Prime Minister to declare *chaupadi* to be a “harmful practice” and directed several government ministries to act to address the practice. In 2011 the CEDAW Committee recommended that the government “Put in place without delay a comprehensive strategy, with comprehensive goals and timetables, to eliminate patriarchal attitudes and stereotypes that discriminate against women.”³⁵⁶

Specifically referring to *chaupadi*, and its impact on health, the Committee urged the government to: “Address discriminatory and harmful practices against women and girls, such as the lack of provision of sufficient food and the *chaupadi* practice, which jeopardize the well-being and health of women and girls, including reproductive health”.³⁵⁷

6. CONCLUSIONS AND RECOMMENDATIONS

The government of Nepal has obligations under international human rights law, to respect, protect and fulfil the rights of women and girls to the highest attainable standard of physical and mental health, and to prohibit gender-based discrimination. In order to discharge these legal obligations the government must, as a matter of priority, put in place a comprehensive and effective strategy to prevent uterine prolapse and address the underlying gender-based discrimination that increases the risk of women and girls developing this condition. The high prevalence of uterine prolapse in Nepal, and the lack of an effective governmental strategy to address the root causes of this condition, constitute serious violations of a number of human rights of women and girls.

While existing policies on sexual and reproductive health in Nepal would go some way to addressing the risk factors for uterine prolapse if fully implemented, they are not sufficient. Since the Supreme Court emphasised that uterine prolapse is a human rights issue in 2008 the government has failed to adopt and implement an effective prevention strategy. A commitment from all levels of the government to cooperate to tackle gender discrimination is essential.

It is essential that the government of Nepal prioritise this issue and put in place a strong, effective and comprehensive prevention plan for uterine prolapse that addresses the underlying gender discrimination. The plan must provide women, girls, men and boys with information about the risk factors for uterine prolapse and how women and girls can reduce their exposure to them. It must also ensure that all women and girls have agency and control over their lives, free from threat, coercion, or interference from third parties. Only then will they be able to make free and informed decisions and choices about their sexual and reproductive health and be able to fully realise their human rights and live life of dignity.

Recommendations to the government of Nepal

The government of Nepal must acknowledge that the high prevalence of uterine prolapse in Nepal is a human rights issue and that this prevalence is a consequence of patterns of gender-based discrimination. The government should commit to addressing this underlying discrimination, so as to reduce the risk of women and girls developing the condition and to comply with its international human rights obligations.

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.

Information / Awareness

The government of Nepal should ensure that women and girls know about their sexual and reproductive rights, including the risk factors for uterine prolapse and the links between

gender discrimination and uterine prolapse. It is essential for the government to ensure that women and girls understand how they can reduce their risk of developing uterine prolapse and ensure that men and boys understand the rights of women and girls and how they can support them and help prevent the condition. This provision of information should include:

- Revision of the school health curriculum for class 6 upwards by the Ministry of Education, 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 National Health Training Centre must ensure that the curriculum for all health workers and Female Community Health Volunteers contains relevant information about uterine prolapse, its risk factors, prevention and treatment and also on what information health workers or Volunteers should be providing to women and girls.
- 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.

Empowerment of women and girls to make informed decisions on their sexual and reproductive rights

The government of Nepal should ensure that women and girls are empowered to take decisions and actions in relation their exposure to the risk factors for uterine prolapse. This should include challenging discriminatory attitudes and beliefs, particularly of husbands and parents-in-law.

The government should support and facilitate women and girls' ability to take decisions independently and control their lives by taking the following steps regarding each risk factor of uterine prolapse:

Addressing control over reproduction

- 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

and choice of spouse and the negative health consequences of adolescent pregnancy.

- 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, 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.
- 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, 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.

Protecting women's right to bodily autonomy and reducing gender-based violence

- The government of Nepal should revise the *Muluki Ain* to ensure that they fully comply 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 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
- 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.
- 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

Reducing excessive workloads, particularly during and immediately after pregnancy

- 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 of Nepal must amend the Labour Act and Rules to ensure that maternity benefits and social security protections comply with Nepal's international obligations under instruments such as the CEDAW and CESCRC 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 programmes that target men, parents-in-law 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.

Improving access to skilled birth attendants

- 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.
- Relevant government ministries including the Ministry of Women, Children and Social Welfare and the Ministry of Home Affairs should cooperate to fully implement the 2011 CEDAW recommendation 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*.

Improving nutrition

- 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.

Improving cooperation and accountability

- 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 disproportionately disadvantaged or excluded from the benefits of the policy or programme.
- 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 government of Nepal should respect and protect the right of human rights defenders working on sexual and reproductive rights, especially women human rights defenders, to conduct their work without hindrance, intimidation or harassment in line with the UN Declaration on Human Rights Defenders.

Recommendations to donor governments and International Agencies

- Donors to the government of Nepal should ensure their technical and financial assistance is directed towards ensuring that the human right to the highest attainable standard of physical and mental health, the right to equality and non-discrimination, and all sexual and reproductive rights in Nepal are respected, protected and fulfilled. Technical and financial assistance should be focused on the prevention of uterine prolapse by addressing the risk factors for this condition and work with the various government ministries with responsibility on the issue to ensure that the necessary reforms are both effectively planned and implemented.
- Donors and agencies should ensure that all international assistance and cooperation to the government of Nepal is directed and distributed in a non-discriminatory manner, promotes gender equality and prioritises the most disadvantaged.

ENDNOTES

- ¹ Interview with Amnesty International, 10 May 2013, Mugu district
- ² National Medical Standard for Reproductive Health, Volume II: Other Reproductive Health Issues, Family Health Division, Ministry of Health and Population, Kathmandu 2003, part 6 on genital prolapse
- ³ Name changed to protect identity, Interview with Amnesty International, April 2013, Kailali district
- ⁴ Annual Report 2010-2011, Department of Health Services, Ministry of Health and Population, Kathmandu, 2012, p.212-221
- ⁵ CEDAW General Recommendation 24 on Women and health, UN. Doc A/54/38/Rev.1, 1999, para 29
- ⁶ Female Community Health Volunteers provide an outreach service and health information to the local community under the supervision of the District Health Office.
- ⁷ These include the Interim Constitution, *Muluki Ain* (General Code), labour laws, policies related to sexual and reproductive health, gender-based violence, working conditions and nutrition.
- ⁸ National Population and Housing Census 2011 (National Census 2011), Central Bureau of Statistics, Kathmandu, November 2012, p. 4.
http://unstats.un.org/unsd/demographic/sources/census/2010_PHC/Nepal/Nepal-Census-2011-Vol1.pdf
[accessed 24 January 2014]
- ⁹ 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. 110. These categories are: 1) "Dalits" (sub divided into groups who predominantly live in the Hills and Terai). These are groups considered to be at the bottom of, or excluded from, the caste system - the so-called 'untouchables'; 2) "Disadvantaged Janajatis" (also sub divided into Hill and Terai groups). These groups are Indigenous peoples; 3) "Disadvantaged non-Dalit Terai caste groups". These are groups considered to be above Dalits but below the dominant groups in the caste hierarchy; 4) "Religious minorities"; 5) "Relatively advantaged Janajatis"; 6) "Upper caste groups" (sub divided into Hill and Terai groups. These groups are considered to be at the top of the caste hierarchy and the most socially and economically advantaged.
- ¹⁰ The 2011 Demographic and Health Survey states that 66.7% of women in Nepal are literate (defined as women who attended secondary school or higher and women who can read all or part of a sentence. In comparison, 87% of men are literate. Nepal Demographic and Health Survey 2011 (DHS 2011), Ministry of Health and Population, Kathmandu, March 2012, p.47-48
- ¹¹ Staff of district Health Posts and Sub-Health Posts are not qualified medical doctors. The official in charge of a Health Post undertakes a three year diploma course to qualify as a Health Assistant. The official in charge of a Sub-Health Post undertakes 15 months of training to become a Community Health Worker and passes an examination for government employment.
- ¹² Interview with Amnesty International, 24 May 2013, Dhanusha district
- ¹³ Royal College of Obstetricians and Gynaecologists, Information leaflet, March 2013, (RCOG, Information leaflet) http://www.rcog.org.uk/files/rcog-corp/2013-03-20_Pelvic_organ_prolapse.pdf, accessed 18 December 2013

- ¹⁴ UNFPA, *Status of Reproductive Morbidities in Nepal*, Institute of Medicine, Kathmandu 2006, (UNFPA, Status of Reproductive Morbidities) p.15
- ¹⁵ RCOG, Information leaflet
- ¹⁶ National Medical Standard for Reproductive Health, Volume II: Other Reproductive Health Issues, Family Health Division, 2003, part 6 on genital prolapse
- ¹⁷ National Medical Standard for Reproductive Health, Volume II, part 6 on genital prolapse
- ¹⁸ Prakash Mani Sharma and Others v GON, Office of Prime Minister and Council of Ministers and Others, Writ Petition 064, June 2008 (Prakash Mani case)
- ¹⁹ Sancharika Samuha, Booklet on Uterine Prolapse, UNFPA, 2007 (UNFPA booklet), page 20
- ²⁰ Name changed to protect identity, Interview with Amnesty International, April 2013, Kailali district
- ²¹ National Medical Standard for Reproductive Health, Volume II, part 6
- ²² 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.47 Kapilvastu had a rate of 23.1% and the rate in Dang was 20%.
- ²³ Focus group discussion with Amnesty International, 20 May 2013, Ramechhap district
- ²⁴ 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, (CAED, Unheeded Agonies), p.29
- ²⁵ Interview with Amnesty International, 24 May 2013, Dhanusha district
- ²⁶ Focus group discussion with Amnesty International, 12 May 2013, Mugu district
- ²⁷ Name withheld to protect identity, Interview in Ramechhap district, May 2013
- ²⁸ Nepal Demographic and Health Survey 2006, Ministry of Health and Population, Kathmandu, May 2007 (DHS 2006), p.155
- ²⁹ Service Tracking Survey 2011, Ministry of Health and Population, Kathmandu, 2012, p.91. Only 18% of Health Assistants, 14% of Auxiliary Health Workers and 17% of Village Health Workers were women
- ³⁰ Service Tracking Survey 2011, p.97
- ³¹ Interview with Amnesty International, 10 May 2013, Mugu district
- ³² Name and location withheld to protect identity
- ³³ Name and location withheld to protect identity
- ³⁴ UNFPA, Quality of life, p.48. The figure in Darchula district was much higher, at 36%.
- ³⁵ UNFPA, Quality of life, p.1
- ³⁶ UNFPA, Status of Reproductive Morbidities
- ³⁷ A crucial limitation of facility based studies is that they rely on women visiting health centres. Given

the stigma associated with uterine prolapse and the testimony given to Amnesty International by women who were reluctant to seek treatment, it is likely that only a relatively small percentage of women experiencing the symptoms of uterine prolapse actually visit a health centre. The measurement of diversity in facility based studies can also be skewed by other societal factors: health centres may be more accessible to women from particular regions, classes and castes, for example, which can skew data to suggest that the experience of prolapse is higher in these groups.

³⁸ UNFPA, Status of Reproductive Morbidities, p.71 and 76.

³⁹ Email communication from UNFPA Nepal to Amnesty International, 30 August 2013.

⁴⁰ CAED, Unheeded Agonies, p.37

⁴¹ Ranabhat R. "Study in risk factors belief, and care practices of women with utero-vaginal prolapse". Unpublished dissertation, Tribhuvan University, Kathmandu, Nepal, 1996 *as cited in* "UNFPA, Status of Reproductive Morbidities found a rate of 9.6%; T R Bonetti et al, "Reproductive Morbidity: A Neglected Issue? A Report of a Clinic Based Study held in far-western Nepal" Kathmandu Nepal: Ministry of Health, UNFPA, Gtz. The data from this study was further analysed in a second study, specifically on uterine prolapse titled T R Bonetti et al, "Listening to "Felt Needs": Investigating Genital Prolapse in Western Nepal" Reproductive Health Matters 2004; 12(23):166–175 and found a rate of 20%. Deuba A R & Rana P S, "Uterine Prolapse: A Key Maternal Morbidity Factor Amongst Nepali Women.", Safe Motherhood Network Federation of Nepal, Kathmandu, 2005 found a prevalence of 9.2% among women attending health camps rather than health facilities

⁴² DHS 2006, p.146. The DHS 2011 did not find any fresh data on this.

⁴³ DHS 2011 p.143

⁴⁴ UNFPA, Status of Reproductive Morbidities, p.76 "Unlike in the developed world where POP is commonly seen in the postmenopausal age group unrelated to childbirth, POP was found in the younger population" [in Nepal]. The Royal College of Obstetricians and Gynaecologists states that half of women over 50 would have some symptoms of pelvic organ prolapse. RCOG, Information Leaflet, http://www.rcog.org.uk/files/rcog-corp/2013-03-20_Pelvic_organ_prolapse.pdf

⁴⁵ American Journal of Obstetrics and Gynaecology 184 (7) 1496 – June 2001

⁴⁶ UNFPA, Quality of Life, p.22

⁴⁷ Interview with Amnesty International Nepal 23 September 2012

⁴⁸ UNFPA Status of Reproductive Morbidities, p.71

⁴⁹ Interview with Amnesty International, 28 April 2013, Kathmandu

⁵⁰ Interview with Amnesty International, 26 April 2013, Kathmandu

⁵¹ Interview with Amnesty International, 9 May 2013, Mugu district

⁵² Interview with Amnesty International, 9 May 2013, Mugu district

⁵³ Focus group discussion with Amnesty International, 20 May 2013, Ramechhap district

⁵⁴ Percentage calculated from the population (aged over 5 years) listed on the census as unable to read and write. Census figures from 2011 show that overall 31.4% of Nepal's total population over the age of

5 years cannot read or write. Government of Nepal, Central Bureau of Statistics, "National Population & Housing Census 2011", November 2012, p.226-234 (percentages calculated from figures in Table 25). Available at: http://unstats.un.org/unsd/demographic/sources/census/2010_PHC/Nepal/Nepal-Census-2011-Vol1.pdf

⁵⁵ Census 2011, p.226-234 (percentages calculated from figures in Table 25). In Mugu, 58% of women and girls cannot read or write and in Dhanusha the figure is 56%.

⁵⁶ DHS 2011, p.178. 49% of girls in the sample were anaemic compared to 43% of boys.

⁵⁷ Study on Gender, Masculinity and Son Preference in Nepal and Vietnam, p.7, http://vietnam.unfpa.org/webdav/site/vietnam/shared/Masculinity_Report_Nepal_VietNam_ENG.pdf

⁵⁸ Census 2011, p.35 (percentage calculated from figures in Table 10)

⁵⁹ Office of the Prime Minister and Council of Ministers "A Study on Gender-Based Violence Conducted in Selected Rural Districts of Nepal" (OPMCM, Study on Gender-Based Violence), November 2012, p. ix and p. 50

⁶⁰ OPMCM, Study on Gender-Based Violence, p.59-60

⁶¹ OPMCM, Study on Gender-Based Violence, p.69

⁶² OPMCM, Study on Gender-Based Violence, p.53-57

⁶³ Maternal and Child Health in Nepal: The Effects of Caste, Ethnicity and Regional Identity, Ministry of Health and Population, Kathmandu, March 2013, (MoHP, Effects of Caste, Ethnicity and Regional Identity) p.11

⁶⁴ Government report to CEDAW, UN Doc. CEDAW/C/NPL/4-5, para 60

⁶⁵ Adolescent Pregnancy: Issues in Adolescent Health and Development, Department of Child and Adolescent Development, World Health Organisation, 2004, http://whqlibdoc.who.int/publications/2004/9241591455_eng.pdf

⁶⁶ DHS 2011, p.84

⁶⁷ DHS 2011, p.78

⁶⁸ DHS 2011, p.65 and 72

⁶⁹ DHS 2011, p.65 and 73

⁷⁰ Muluki Ain (General Code), Chapter 17 (2) and (7) as amended by the Sixth Amendment

⁷¹ UNFPA Status of Reproductive Morbidities, p.48-49

⁷² UNFPA, Quality of Life p.20

⁷³ Focus group discussion with Amnesty International, 11 May 2013, Mugu district

⁷⁴ Focus group discussion with Amnesty International, 3 May 2013, Kailali district

⁷⁵ Focus group discussion with Amnesty International, 24 May 2013, Dhanusha district

⁷⁶ Focus group discussion with Amnesty International, 11 May 2013, Mugu district

- ⁷⁷ Caste, Ethnic and Regional Identity in Nepal: Further Analysis of the 2006 Nepal Demographic and Health Survey, September 2008, p.20
- ⁷⁸ Interview with Amnesty International, 19 May 2013, Ramechhap district
- ⁷⁹ DHS 2011, p.65
- ⁸⁰ Nepal Police, Women and Children Services Directorate, Table of Crime Data, available at: <http://www.nepalpolice.gov.np/women-children-service-directorate.html> [accessed 22 January 2014]
- ⁸¹ Sapana Pradhan & Others v. Prime Minister & Council of Ministers & Others, decision no. 7659, N.K.P. 2063, Vol. 3 at 289 (2006)
- ⁸² Interview with Amnesty International, 23 January 2014
- ⁸³ 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
- ⁸⁴ Text in Nepali on file with AI Nepal, Civil society representatives told Amnesty International that this textbook is being revised. This will be discussed in more detail later in this chapter
- ⁸⁵ Late Comers in School: The Status of Dalit Girls Education, Feminist Dalit Organisation, 2011
- ⁸⁶ FCHV curriculum, text in Nepali on file with AI Nepal
- ⁸⁷ Focus group discussion with Amnesty International, 11 May 2013, Mugu district (name withheld)
- ⁸⁸ Muluki Ain (National Code), Chapter 14
- ⁸⁹ Prakash Mani case
- ⁹⁰ Draft Multi-Sectoral Strategic Plan for Prevention and Management of Uterine Prolapse 2008-2017, Ministry of Health and Population, 2008, (Draft Multi-Sectoral Plan) p.5 and 9. The draft Plan lists actions for the Ministry of Women to take in order to reach the following outcome: "Magnitude of uterine prolapse reduced by addressing it as a consequence of GBV [gender based violence]". The draft Plan also states that there is a legal and policy "gap" in addressing "sexual and gender based violence which has a causal relationship with uterine prolapse".
- ⁹¹ UNFPA, Quality of Life, p.xiv
- ⁹² Focus group discussion with Amnesty International, 5 May 2013, Kailali district
- ⁹³ Name changed to protect identity. Interview with Amnesty International, May 2013, Mugu district
- ⁹⁴ Interview with Amnesty International, 4 May 2013, Kailali district
- ⁹⁵ Focus group discussion with Amnesty International, 24 May 2013, Dhanusha district
- ⁹⁶ OPMCM, Study on Gender-Based Violence, p.34
- ⁹⁷ Focus group discussion with Amnesty International, 11 May 2013, Mugu district
- ⁹⁸ Focus group discussion with Amnesty International, 5 May 2013, Kailali district
- ⁹⁹ Focus group discussions with Amnesty International, 2 May 2013, Kailali district, 24 May 2013,

Dhanusha district and 4 May 2013, Kailali district

¹⁰⁰ Focus group discussion with Amnesty International, 4 May 2013, Kailali district

¹⁰¹ Government of Nepal, Second Periodic Report to the UN Human Rights Committee, UN Doc. CCPR/C/NPL/2, para 60

¹⁰² Focus group discussion with Amnesty International, May 2013, Ramechhap district

¹⁰³ AI Nepal meeting with National Women's Commission, 12 December 2013

¹⁰⁴ Nepal Police, Women and Children Services Directorate, Table of Crime Data, available at: <http://www.nepalpolice.gov.np/women-children-service-directorate.html>. accessed 12 December 2013

¹⁰⁵ Amnesty International, *Nepal: The search for justice*, (Index: ASA 31/001/2013), p.15

¹⁰⁶ Focus group discussion with Amnesty International, 5 May 2013, Kailali district

¹⁰⁷ OPMCM, Study on Gender-Based Violence, p.68

¹⁰⁸ OPMCM, Study on Gender-Based Violence, p.69

¹⁰⁹ 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%)

¹¹⁰ Focus group discussion with Amnesty International, 20 May 2013, Ramechhap district

¹¹¹ Interview with Amnesty International, 17 May 2013, Kathmandu

¹¹² DHS 2011, p.65

¹¹³ Focus group discussion with Amnesty International, 5 May 2013, Kailali district

¹¹⁴ Interview with Amnesty International, April 2013, Kailali district

¹¹⁵ See for example Amnesty International, AI Index: ASA 31/010/2008 and <http://www.amnesty.org/en/news-and-updates/news/nepal-government-fails-protect-women-human-rights-activists-20090410> See also Association for Women's Rights in Development <http://awid.org/eng/Get-Involved/Urgent-Actions3/NEPAL-Women-human-rights-defenders-are-facing-threats-and-harassment-for-protecting-a-victim-of-domestic-violence>

¹¹⁶ 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

¹¹⁷ 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

¹¹⁸ Interview with Amnesty International, Kathmandu, 16 May 2013

¹¹⁹ 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

¹²⁰ Focus group discussion with Amnesty International, 11 May 2013, Mugu district

- ¹²¹ RCOG, Information leaflet
- ¹²² UNFPA, Status of Reproductive Morbidities, p.22
- ¹²³ Interview with Amnesty International, 10 May 2013, Mugu district
- ¹²⁴ Focus group discussion with Amnesty International, 20 May 2013, Ramechhap district
- ¹²⁵ 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
- ¹²⁶ 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
- ¹²⁷ DHS 2011, p.103,
- ¹²⁸ Focus group discussion with Amnesty International, 11 May 2013, Mugu district
- ¹²⁹ 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
- ¹³⁰ Nepal Living Standards Survey 2010/2011, p.130
- ¹³¹ Focus group discussion with Amnesty International, 10 May 2013, Mugu district
- ¹³² Focus group discussion with Amnesty International, 20 May 2013, Ramechhap district
- ¹³³ National Medical Standard for Reproductive Health, Volume 1: Contraceptive Services, Ministry of Health and Population, 2010, Section 17.3
- ¹³⁴ Female Community Health Volunteer training, Text in Nepali on file with AI Nepal
- ¹³⁵ School textbooks, Grades 6-9 in Nepali. Text on file with AI Nepal
- ¹³⁶ Interview with Amnesty International, 28 April 2013, Kathmandu
- ¹³⁷ Interview with Dr Badri Pohkrel, Joint Secretary, Population Division, Tirth Raj Burlakoti, Chief, Policy, Planning and International Cooperation Division and Dr Rojen Shreshta, Chief Specialist, Public Health Administration, Monitoring and Evaluation Division, Ministry of Health and Population, 22 January 2014, Kathmandu
- ¹³⁸ Implementation Guidelines on Adolescent Sexual and Reproductive Health, 2007, p.24 and 36
- ¹³⁹ Department of Health Service, Annual Report 2010/2011, Ministry of Health and Population, p.86-88
- ¹⁴⁰ Focus group discussion with Amnesty International, 20 May 2013, Ramechhap district
- ¹⁴¹ UNFPA booklet p 22
- ¹⁴² National Medical Standards for Reproductive Health, Volume II, Family Health Division, 2003, section 6-6
- ¹⁴³ Interview with Amnesty International, 4 May 2013, Kailali district
- ¹⁴⁴ Government of Nepal report to CEDAW, p.39-40

¹⁴⁵ The Ministry of Labour and Employment defines the “informal sector” as the sector which is not registered and there is no provision for tax. Interview with Amnesty International Nepal, 28 October 2013

¹⁴⁶ The Minimum Wage Determination Committee made up of the government, employers and trade unions raised the minimum daily wage to 318NPR and the monthly wage to 8000NPR in June 2013. <http://www.ekantipur.com/2013/06/13/business/govt-officially-endorses-workers-minimum-salary-of-rs-8000/373194.html>, accessed 19 December 2013

¹⁴⁷ Focus group discussion with Amnesty International, 5 May 2013, Kailali district

¹⁴⁸ Focus group discussion with Amnesty International, 2 May 2013, Kailali district

¹⁴⁹ Kamalari is the name given to Tharu girls who are or were affected by a system of bonded labour called Kamaiya. Found mainly in the western Terai, the system was formally abolished by the government in 2000.

¹⁵⁰ Focus group discussion with Amnesty International, 3 May 2013, Kailali district

¹⁵¹ UNFPA, Quality of Life, p.24

¹⁵² UNFPA, Quality of Life, p.25

¹⁵³ Focus group discussion with Amnesty International, 11 May 2013, Mugu district

¹⁵⁴ Focus group discussion with Amnesty International, 24 May 2013, Dhanusha district

¹⁵⁵ Focus group discussion with Amnesty International, 21 May 2013, Ramechhap district

¹⁵⁶ Focus group discussion with Amnesty International, 5 May 2013, Kailali district

¹⁵⁷ Focus group discussion with Amnesty International, 11 May 2013, Mugu district

¹⁵⁸ Interview with Amnesty International, May 2013, Mugu district, name changed to protect identity

¹⁵⁹ Focus group discussion with Amnesty International, 20 May 2013, Ramechhap district

¹⁶⁰ Focus group discussion with Amnesty International, 20 May 2013, Ramechhap district

¹⁶¹ Focus group discussion with Amnesty International, 20 May 2013, Ramechhap district

¹⁶² Focus group discussion with Amnesty International, 20 May 2013, Ramechhap district

¹⁶³ A full list of the Ministry’s responsibilities is as follows: Labour policy and Work completion, Study, investigation, data collection and verification of labour power and labour market, Contact and relationship development of labour with national and international chambers and corporations, Relationship between Labour and management, Help Employee and Labour supply. Foreign Employments, Promotion, supply and organize vocational trainings, Training on child, women and disabled labours, Trade unions, social safety of Labour, Permission for Foreign Employees, Labour Administration and Management, Bonus, Manage, organize Transportation (Air transport not included) Policies and Planning, Regulations and Work completions, Manage, organize Transportation (Air transport not included) with other chambers and corporation, Relationship between Transportation (Air transport not included) with other related and managed international corporations. See <http://www.moltm.gov.np/en/Introduction/9/>

- ¹⁶⁴ Labour and Employment Policy, 2005, p.2,
http://www.moltm.gov.np/uploads/document/Labour%20policy-Eng-2062_20110904014004.pdf
- ¹⁶⁵ Labour and Employment Policy, p.3
- ¹⁶⁶ Labour and Employment Policy, p.6, para 3.3.4
- ¹⁶⁷ Labour and Employment Policy, p.6, para 3.3.6
- ¹⁶⁸ Labour and Employment Policy, p.6, para 3.3.2
- ¹⁶⁹ Labour and Employment Policy, p.9, para 3.5.10
- ¹⁷⁰ Interview with Amnesty International Nepal, 28 October 2013
- ¹⁷¹ Government of Nepal report to the UN Committee on Economic, Social and Cultural Rights, UN Doc. E/C.12/NPL/3, October 2012, para 208
- ¹⁷² UNFPA booklet, p.20 & 22
- ¹⁷³ UNFPA, Status of Reproductive Morbidities, p.24
- ¹⁷⁴ 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.
- ¹⁷⁵ DHS 2011
- ¹⁷⁶ DHS 2011, p. 127
- ¹⁷⁷ MoHP, Effects of Caste, Ethnicity and Regional Identity, p.16
- ¹⁷⁸ Voices from the Community: Access to Health Services, A Rapid Participatory Ethnographic Evaluation and Research (PEER) Study, Nepal, Ministry of Health and Population, 2012
- ¹⁷⁹ Focus group discussion with Amnesty International, 12 May 2013, Mugu district
- ¹⁸⁰ Interview with Amnesty International, 23 May 2013, Dhanusha district
- ¹⁸¹ Interview with Amnesty International, 19 May 2013, Ramechhap district
- ¹⁸² Focus group discussions with Amnesty International, 20 May 2013, Ramechhap district
- ¹⁸³ Focus group discussion with Amnesty International, 7 May 2013, Nepalgunj city
- ¹⁸⁴ MoHP, Effects of Caste, Ethnicity and Regional Identity, p.16
- ¹⁸⁵ United Nations Resident and Humanitarian Coordinator's Office, "Chaupadi in the Far West", April 2011, p.2
- ¹⁸⁶ 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
- ¹⁸⁷ Interview with Amnesty International, 12 May 2013, Mugu district
- ¹⁸⁸ Focus group discussion with Amnesty International, 11 May 2013, Mugu district
- ¹⁸⁹ Interview with Amnesty International, 9 May 2013, Mugu district

¹⁹⁰ DHS 2011, p.120

¹⁹¹ 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.

¹⁹² Focus group discussion with Amnesty International, 7 May 2013, Nepalgunj city

¹⁹³ Focus group discussion with Amnesty International, 20 May 2013, Ramechhap district

¹⁹⁴ Focus group discussion with Amnesty International, 2 May 2013, Kailali district

¹⁹⁵ 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.

¹⁹⁶ 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), Madhesis (307) and Dalits (273).

¹⁹⁷ National Safe Motherhood and Newborn Health Long Term Plan 2006 – 2017, http://www.unfpa.org/sowmy/resources/docs/library/RO92_MOHNepal_2006_SafeMotherhoodLongTermPlan.pdf

¹⁹⁸ 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.

¹⁹⁹ National Safe Motherhood and Newborn Health Long Term Plan 2006 – 2017, p.4

²⁰⁰ National Safe Motherhood and Newborn Health Long Term Plan 2006 – 2017, p.18-19

²⁰¹ 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

²⁰² Interview with Amnesty International 28 April 2013, Kathmandu

²⁰³ Global Health Observatory, Antenatal Care, www.who.int/gho/maternal_health/reproductive_health/antenatal_care_text/en/, accessed 23 January 2014

²⁰⁴ Ministry of Health and Population, “Rapid Assessment of the Demand Side Financing Schemes: Aama Programme and 4ANC”, p.6

²⁰⁵ Interview with Amnesty International, 28 April 2013, Kathmandu

²⁰⁶ Dil Bahadur Bishwakarma v Government of Nepal, Writ Petition 3303 of 2004, Judgement 2 May 2006, Text in Nepali on file with AI Nepal

- ²⁰⁷ Chaupadi Elimination Guidelines, Ministry of Women, Children and Social Welfare, Text in Nepali on file with AI Nepal
- ²⁰⁸ Annual report of the Department for Women and Children, Ministry of Women, Children and Social Welfare, 2012. Document in Nepali on file with AI Nepal
- ²⁰⁹ Interview with Amnesty International, 23 January 2014, Kathmandu
- ²¹⁰ UNFPA booklet 20
- ²¹¹ Interview with Amnesty International, 23 May 2013, Dhanusha district
- ²¹² Focus group discussions with Amnesty International, 20 and 21 May 2013, Ramechhap district
- ²¹³ Focus group discussion with Amnesty International, 11 May 2013, Mugu district
- ²¹⁴ Focus group discussion with Amnesty International, 11 May 2013, Mugu district
- ²¹⁵ Focus group discussion with Amnesty International, 24 May 2013, Dhanusha district
- ²¹⁶ Interviews with Amnesty International, April and May 2013, Kailali and Dhanusha districts
- ²¹⁷ Interviews with Amnesty International, April 2013, Kailali district
- ²¹⁸ Focus group discussion with Amnesty International, 3 May 2013, Kailali district
- ²¹⁹ Government of Nepal report to CEDAW, UN Doc. CEDAW/C/NPL/4-5, para 164
- ²²⁰ 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.
- ²²¹ MoHP, Effects of Caste, Ethnicity and Regional Identity, p.22.
- ²²² MoHP, Effects of Caste, Ethnicity and Regional Identity, p.22
- ²²³ National Nutritional Policy and Strategy of 2004, p.22
- ²²⁴ 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, p.16
http://scalingupnutrition.org/wp-content/uploads/2013/03/Nepal_MSNP_2013-2017.pdf
- ²²⁵ Multi-Sectoral Nutrition Plan
- ²²⁶ Multi-Sectoral Nutrition Plan, output 6 page 9
- ²²⁷ Multi-Sectoral Nutrition Plan, p.38
- ²²⁸ Multi-Sectoral Nutrition Plan, p.57
- ²²⁹ Focus group discussion with Amnesty International, 11 May 2013, Mugu district. The doctor referred to here may not be a qualified medical doctor. Staff in rural health facilities (Health Post and Sub-Health Post) are not doctors qualified doctors although the women interviewed by Amnesty International called them doctors. The highest qualification of an official in a Health Post is that of “Health Assistant”. In a

Sub-Health Post the highest qualification is that of “Community Health Worker”.

²³⁰ Female Community Health Volunteer curriculum, text in Nepali on file with AI Nepal

²³¹ Analytical Report on National Survey of Female Community Health Volunteers of Nepal, Government of Nepal, 2007. p.7

²³² Analytical Report on National Survey of Female Community Health Volunteers of Nepal, p.18

²³³ Meeting with Amnesty International and representatives of civil society organisations, 14 January 2014, Kathmandu

²³⁴ Interview with Amnesty International, 22 January 2014, Kathmandu

²³⁵ Shah, P. “Uterine Prolapse and Maternal Morbidity in Nepal: A Human Rights Imperative” in *Drexal Law Review*, Vol 2, 2010, p.518

²³⁶ Prakash Mani Sharma and Others v GON, Office of Prime Minister and Council of Ministers and Others, Writ Petition 064, June 2008

²³⁷ Prakash Mani Sharma case, p.153

²³⁸ Prakash Mani Sharma case

²³⁹ Prakash Mani Sharma case

²⁴⁰ Interview with Amnesty International, 26 April 2013, Kathmandu

²⁴¹ Three Year Interim Plan, 2010- 2013, section 7, http://nepalpolicy.net.com/images/periodic_plan/Three%20Yr%20Plan_2012.pdf (unofficial translation) In the previous Three Year Interim Plan 2007 - 2010, the direction on uterine prolapse prevention was more direct: “Preventive, diagnostic, promotive and curative health services will be continued, with additional emphasis on surgery, safe motherhood (reproductive and sexually transmitted diseases, *uterus collapsed* [emphasis added])”, p.283, http://www.npc.gov.np/new/uploadedFiles/allFiles/11tyip_eng.pdf

²⁴² Interview with Amnesty International, 4 May 2013, Kailali district

²⁴³ Progress report on implementation of Supreme Court Judgements, Office of the Prime Minister and Council of Ministers (OPMCM), 2012 and National Women’s Commission, Status of Implementation of Supreme Court Judgment related to Reproductive Health Rights, 2012, Text in Nepali on file with AI Nepal.

²⁴⁴ Interview with Amnesty International, 29 April 2013, Kathmandu

²⁴⁵ Interview with Amnesty International, 19 May 2013, Ramechhap district

²⁴⁶ Interview with Amnesty International, 3 May 2013, Kailali district

²⁴⁷ Interview with Amnesty International, 29 April 2013, Kathmandu

²⁴⁸ Annual Report of the Ministry of Health and Population 2010-2011, p.63-64

²⁴⁹ Annual Report of the Ministry of Health and Population, p.63

²⁵⁰ Nepal Health Sector Programme II (2010-2015), Ministry of Health Population, p.126 (Document on file with Amnesty International)

²⁵¹ Nepal Health Sector Programme II (2010-2015), Ministry of Health Population, p.126

²⁵² Interview with Amnesty International, 29 April 2013

²⁵³ The government provides the District Health Offices with money to conduct a specified number of 'screening camps' that is, ad hoc, temporary medical facilities set up in target communities where women are examined to assess if they have uterine prolapse, and what stage of the condition they have. Regional Health Directorates are given money to conduct surgery camps: similar ad hoc set ups in communities where women are operated on.

²⁵⁴ Interviews with civil society representatives, April and May 2013, Kathmandu

²⁵⁵ The Three Year Interim Plan is Nepal's core planning document, which is prepared by the National Planning Commission in Nepal, and lists governmental priorities across sectors. The Nepal Health Sector Support Plan II is a more detailed document, and is prepared by the Ministry of Health and Population (responsible for health services in Nepal). It lays out the government's vision and implementation plan for the health sector between 2010 and 2015.

²⁵⁶ Nepal Health Sector Programme II (2010-2015), Ministry of Health Population, p.126

²⁵⁷ Interview with Amnesty International, 28 April 2013, Kathmandu

²⁵⁸ Email from UNFPA to Amnesty International 30 August 2013

²⁵⁹ National Multi-Sectoral Strategic Plan for the Prevention and Management of Uterine Prolapse 2008 – 2017 (Multi-Sector Plan) section 2.2.3.(i), p.9

²⁶⁰ Interview with Amnesty International, 17 May 2013

²⁶¹ Multi-Sector Plan, Annex 5 on Process of the Development of the National Multi-Sectoral Strategic Plan

²⁶² Multi-Sector Plan, Annex 5

²⁶³ A guide to government in Nepal: structures, functions, and practices, The Asia Foundation and the Enabling State Programme, 2012, p.9

²⁶⁴ Email from UNFPA to Amnesty International 30 August 2013

²⁶⁵ Email from UNFPA to Amnesty International, 18 December 2013

²⁶⁶ Nepal Health Sector Programme II (2010-2015), Ministry of Health Population

²⁶⁷ EHCS are priority public health measures and are essential clinical and curative services for the appropriate treatment of common diseases. These services are provided free of cost to all citizens at health posts, sub-health posts, and primary health care centres. At District Hospitals, they are free for "specified target groups" which include the poor, destitute, elderly, and disabled. Nepal Health Sector Programme II (2010-2015), Ministry of Health Population, p.42

²⁶⁸ Interview with Amnesty International, 29 April 2013, Kathmandu

²⁶⁹ Email communication from the Family Health Division, 13 January 2014

²⁷⁰ Copy of the document provided to Amnesty International by the Family Health Division

²⁷¹ Copy of the document provided to Amnesty International by the Family Health Division

²⁷² Email communication to Amnesty International from ADRA, January 2014

²⁷³ Interview with Amnesty International, 29 April 2013, Kathmandu

²⁷⁴ Interview with Amnesty International, 16 May 2013, Kathmandu

²⁷⁵ Interview with Amnesty International, 16 May 2013, Kathmandu

²⁷⁶ Government of Nepal, Second Periodic Report to the Human Rights Committee, UN. Doc CCPR/C/NPL/2, June 2012, p.24

²⁷⁷ Interview with Amnesty International, Kathmandu, 28 April 2013

²⁷⁸ Interim Constitution of Nepal, 2007, translation by UNDP, January 2008, nic.gov.np/files/download/109 accessed 20 December 2013

²⁷⁹ Section 9 of the Treaty Act 1990 states that “In case of the provisions of a treaty to which the Kingdom of Nepal or HMG has become a party following its ratification accession, acceptance or approval by the Parliament conflict with the provisions of current laws, the latter shall be held invalid to the extent of such conflict for the purpose of that treaty, and the provisions of the treaty shall be applicable in that connection as Nepal laws”. Many Supreme Court judgments have read this provision to mean that international conventions to which Nepal is a party are applicable on Nepal as Nepali law. See for example, *Women, Law and Development Forum v Office of the Prime Minister and the Council of Ministers*, Special Writ No. 64 of the Year 2061(2004); *Advocate Achyut Prasad Kharel v Office of Prime-minister and Council of Ministers*, Writ No. 3352 of the year 2061 (2004).

²⁸⁰ Interview with Amnesty International, 25 April 2013, Kathmandu

²⁸¹ This includes article 2(1) of the International Covenant on Civil and Political Rights; article 2(2) of the International Covenant on Economic, Social and Cultural 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.

²⁸² Convention on the Elimination of all forms of Discrimination against Women (CEDAW), GA res 34/180, 18 December 1979, Article 2(e)

²⁸³ 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

²⁸⁴ CEDAW, Article 5(a)

²⁸⁵ CEDAW, General Recommendation 19 on Violence against women, UN Doc. A/47/381992, Para 24

²⁸⁶ CEDAW, Article 2(f)

²⁸⁷ CEDAW, Concluding Observations on Nepal, UN Doc. CEDAW/C/NPL/CO/4-5, 2011, para 18

²⁸⁸ CESCR, General Comment 14 on the highest attainable standard of health, UN Doc. E/C.12/2000/4, para 33

²⁸⁹ CESCR, General Comment 20, July 2009

²⁹⁰ See generally CEDAW, General Recommendation 19

²⁹¹ CEDAW, General Recommendation 19, para 9

²⁹² UN Declaration on the Elimination on the Elimination of Violence against Women, GA Res. 48/104, 20 December 1993, Article 4(c)

²⁹³ Report of the UN Special Rapporteur on violence against women, its causes and consequences, UN Doc. E/CN.4/2006/61, 2006, para 29

²⁹⁴ International Convention on the Elimination of all forms of Racial Discrimination (ICERD), GA Res. 2106 (XX), 21 December 1965, Article 2

²⁹⁵ Committee on the Elimination of all forms of Racial Discrimination (CERD), General Recommendation 29 on Article 1.1 (Descent), UN Doc. A/57/18, 2002

²⁹⁶ CERD, General recommendation 25 on gender-related dimensions of racial discrimination, UN Doc. A/55/18, 2000, para 1

²⁹⁷ Interim Constitution of Nepal, Article 13(1) and (3) and Article 20 (1)

²⁹⁸ CEDAW, Concluding Observations on Nepal, para 10

²⁹⁹ CEDAW, Concluding Observations on Nepal, para 12

³⁰⁰ CESCR, General Comment 14

³⁰¹ CESCR, General Comment 14, para 47

³⁰² CESCR, General Comment 14, para 43-44

³⁰³ CESCR, General Comment 14, para 17

³⁰⁴ CESCR, General Comment 14, para 19

³⁰⁵ CESCR, General Comment 14, para 21

³⁰⁶ UN Convention on the Rights of the Child (CRC), GA res 40/25, 1989, Article 20

³⁰⁷ CEDAW General Recommendation 24 on Women and health, A/54/38/Rev.1, 1999, para 11

³⁰⁸ CEDAW, Concluding Observations on Nepal, para 32 (e)

³⁰⁹ CESCR, General Comment 14, para 34

³¹⁰ Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. E/CN.4/2003/58, 2003, para 59

³¹¹ CESCR, General Comment 14, para 37

³¹² Interim Constitution of Nepal, Articles 16(2), 20(2) and 22(2)

³¹³ CESCR, General Comment 14, para 12

³¹⁴ CESCR, General Comment 14, para 36

³¹⁵ CESCR, General Comment 14, para 44

³¹⁶ Committee, on the Rights of the Child, General Comment 5 on Adolescent health and development in the context of the Convention on the Rights of the Child, UN Doc. CRC/GC/2003/4, 2003, para 10

³¹⁷ CESCR, General Comment 14, para 41

³¹⁸ CEDAW, Concluding Observations on Nepal, para 40

³¹⁹ Prakash Mani Sharma and Others v GON, Office of Prime Minister and Council of Ministers and Others, Writ Petition 064, June 2008

³²⁰ International Covenant on Civil and Political Rights (ICCPR), GA Res 2200A (XXI), 16 December 1966, article 17, CEDAW article 2

³²¹ CEDAW, article 16 (e)

³²² CEDAW articles 10 (h) & 12

³²³ Convention on the Rights of the Child (CRC), GA Res. 44/25, 20 November 1989, article 24 (e)

³²⁴ "Report of the Office of the United National High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights", UN Doc. A/HRC/14/39, April 2010

³²⁵ CEDAW, article 16 (a) and 16 (b)

³²⁶ CEDAW General Recommendation 19 and General Recommendation 24

³²⁷ Nepal has ratified the ICCPR, ICESCR, CEDAW and CRC

³²⁸ Drafts of these bills in Nepali on file with Amnesty International Nepal

³²⁹ CEDAW, article 16 (1) (e)

³³⁰ CEDAW, article 16 (1) (e)

³³¹ CEDAW, General Recommendation 21 on Equality in marriage and family relations, UN Doc. A/47/38, 1994, para 22

³³² CEDAW, General Recommendation 21

³³³ Muluki Ain (General Code), Chapter 17 (7) as amended by the Sixth Amendment

³³⁴ Muluki Ain (General Code), Chapter 17(2) as amended by the Eleventh Amendment of 2002
Punishments vary according to the age of the girl. Punishment for someone who marries or causes the marriage of an underage boy is significantly lower.

³³⁵ CEDAW, article 11(2)

³³⁶ CEDAW, article 11(1) (f)

³³⁷ Nepal Labour Act, 1992 <http://www.ilo.org/dyn/natlex/docs/WEBTEXT/30019/64854/E92NPL01.htm>

³³⁸ Nepal Labour Act Article 2 (b) read with section 40 and 41

³³⁹ DHS 2011, p58-60

³⁴⁰ CEDAW, Concluding Observations on Nepal, para 30(b)

³⁴¹ CEDAW General Recommendation 19

³⁴² Report of the Special Rapporteur on Violence against Women, Its Causes and Consequences on Intersections between Culture and Violence against Women, January 2007, UN Doc. A/HRC/4/34, 2007, para 28

³⁴³ CEDAW Committee, General Recommendation 19; and Report of the Special Rapporteur on the Right to Health, UN Doc. E/CN.4/2004/49, 2004, para 25 which states “Rape and other forms of sexual violence ... represent serious breaches of sexual and reproductive freedoms, and are fundamentally and inherently inconsistent with the right to health”.

³⁴⁴ CEDAW General Recommendation 24, para 18

³⁴⁵ Article 13 (4) of the Interim Constitution of Nepal also says that “No discrimination in regard to remuneration and social security shall be made between men and women for the same work”.

³⁴⁶ Muluki Ain (General Code), Chapter 13 and 14, as amended by “Some Nepal Acts to Maintain Gender Equality” of 2006. Although an improvement on the previous version of the Code, the provisions are not consistent with evolving international standards on rape and sexual assault.

³⁴⁷ Muluki Ain, Chapter 14.3 lists punishments for rape are as follows: For the rape of a girl of ten years of age or below, from ten years to fifteen years imprisonment; for the rape of a girl above the age of ten years but below the age of fourteen years, from eight to twelve years imprisonment; for the rape of a girl above the age of fourteen years but below the age of sixteen years, from six to ten years; for the rape of a girl of or above the age of sixteen years but below the age of twenty years, from five to eight years; and for the rape of a woman of 20 years or more, from five to seven years. However, the punishment for when a husband rapes his wife is between three months and six months.

³⁴⁸ Domestic Violence (Offence and Punishment) Act, 2009, Section 3(1), http://www.lawcommission.gov.np/index.php?option=com_remository&Itemid=18&func=fileinfo&id=424&lang=en accessed 23 December 2013

³⁴⁹ Domestic Violence Act, Section 2(a)

³⁵⁰ Domestic Violence Act, Section 13. Attempt, abetment and incitement is given half the punishment. According to section 13 of the act, “Whoever has been punished once for the offence of domestic violence shall be liable to double the punishment upon every repetition of the offence”, and “If a public servant commits the offence of domestic violence, he shall be liable to an additional ten percent punishment over and above the prescribed punishment”.

³⁵¹ Domestic Violence Act, Section 10 states that “The Court may, depending on the nature of the act of domestic violence, its degree, the pain undergone by the aggrieved person, and also taking into account the economic and social status of the perpetrator and aggrieved person, order the perpetrator to pay appropriate compensation to the aggrieved person”.

³⁵² CEDAW Concluding Observations on Nepal, para 20

³⁵³ CEDAW Concluding Observations Nepal, para 20 (a), (b) and (d)

³⁵⁴ Dil Badhudur Bishwakarma, v Government of Nepal, Writ Petition 3303 of 2004, Judgement May 2005

³⁵⁵ Government of Nepal, Second Periodic Report to the Human Rights Committee, UN Doc. CCPR/C/NPL/2, June 2012, para 59

³⁵⁶ CEDAW Concluding Observations on Nepal, para 18 (a) and (c)

³⁵⁷ CEDAW Concluding Observations on Nepal, para 32 (d)

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