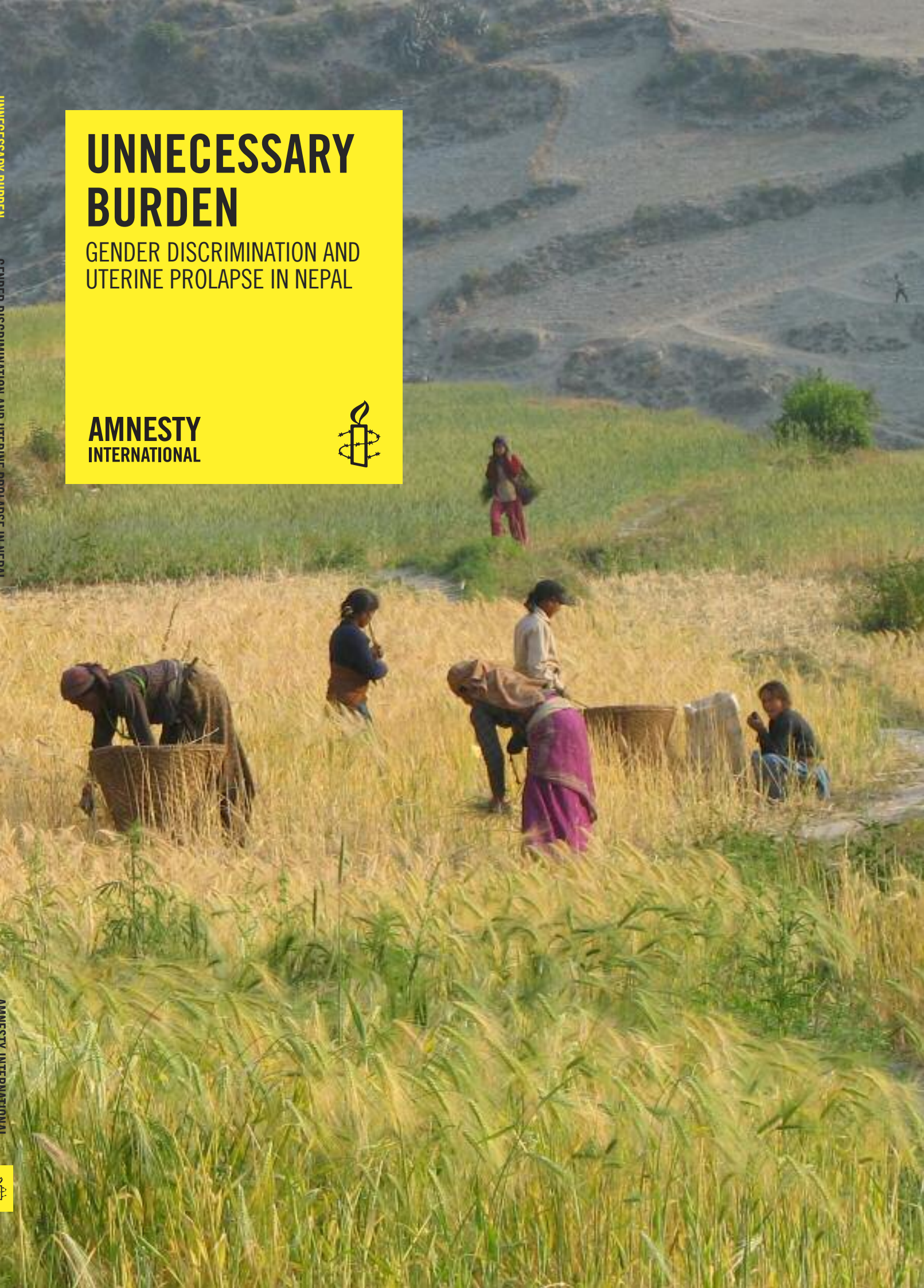
UNNECESSARY BURDEN

GENDER DISCRIMINATION AND UTERINE PROLAPSE IN NEPAL

AMNESTY INTERNATIONAL



UNNECESSARY BURDEN GENDER DISCRIMINATION AND UTERINE PROLAPSE IN NEPAL AMNESTY INTERNATIONAL

Amnesty International is a global movement of more than 3 million supporters, members and activists in more than 150 countries and territories who campaign to end grave abuses of human rights.

Our vision is for every person to enjoy all the rights enshrined in the Universal Declaration of Human Rights and other international human rights standards.

We are independent of any government, political ideology, economic interest or religion and are funded mainly by our membership and public donations.

AMNESTY
INTERNATIONAL

First published in 2014 by
Amnesty International Ltd
Peter Benenson House
1 Easton Street
London WC1X 0DW
United Kingdom

Index: ASA 31/001/2014 English
Original language: English
Printed by Amnesty International,
International Secretariat, United Kingdom

Cover photo: Women agricultural workers in Mugu district, Nepal, May 2013.

amnesty.org

CONTENTS

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 District[1]

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.

KOPILA[3]

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

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

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 Mita 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 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 Nepal[7] 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

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.

2. UTERINE PROLAPSE IN NEPAL

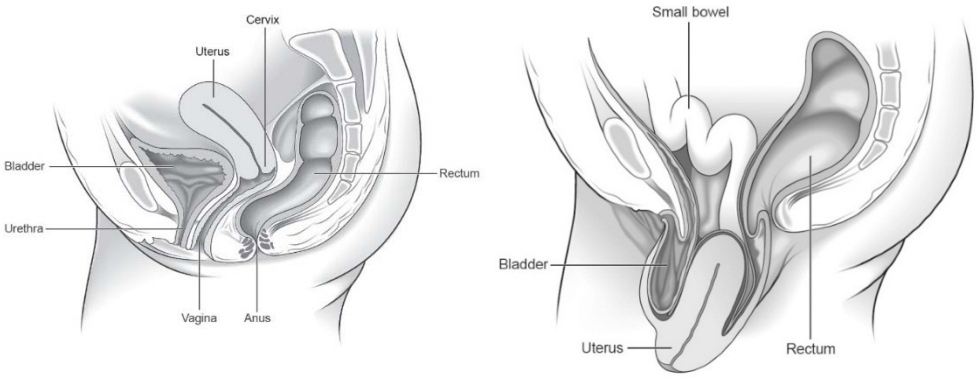
"I felt a lot of difficulty all the time: when I was sitting, walking, working. I experienced a lot of back pain. It felt like a bigger portion of my uterus came out when I was working".

Radha Sada, Dhanusha District[12]

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

"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 District[23]

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 SADA[25]

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

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

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 District[53]

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.

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]

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

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

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.

Upendra 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, Upendra 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

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

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 District[140]

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 BHOOL[143]

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.

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 District[157]

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

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 placenta[172] and encouraging women to push before the cervix is fully dilated[173] 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 attendants[174] 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]

and Dhanusha.

KHUMENI BISHWAKARMA[187]

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

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]

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 though 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

Many women in Nepal carry a painful burden that they are often too embarrassed to talk about. They are living with uterine prolapse, a debilitating condition in which the pelvic muscles give way, allowing the uterus to descend into the vagina. It affects relatively young women in Nepal – those aged below 30.

The causes are many – having a lot of children within a short space of time, poor nutrition, and lifting heavy loads while or just after being pregnant. But underpinning these causes is the gender discrimination that prevails at almost every level in Nepal.

If the government met its obligations to address this discrimination, it would go a long way towards preventing the condition. The net result of this failure is a large proportion of women whose daily decisions about their bodies and sexuality are controlled by the people around them – their husbands and in-laws.

Janajati (Indigenous) participants from Amnesty focus group discussions on gender discrimination in Ramechhap district, Nepal, May 2013.

"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]… My husband treated me indifferently. He used to say: 'I am not satisfied with you, I will bring another wife'."

image and quote, left: **Kesar Kala Malla, aged 48, Mugu district, Nepal, May 2013. Married at the age of 20, she had three miscarriages before having her first child. She then had four more children and another two miscarriages. "My uterine prolapse got worse after my later pregnancies," she said. Although a draft strategy to address uterine prolapse exists in Nepal, the government has so far not adopted it as policy.**

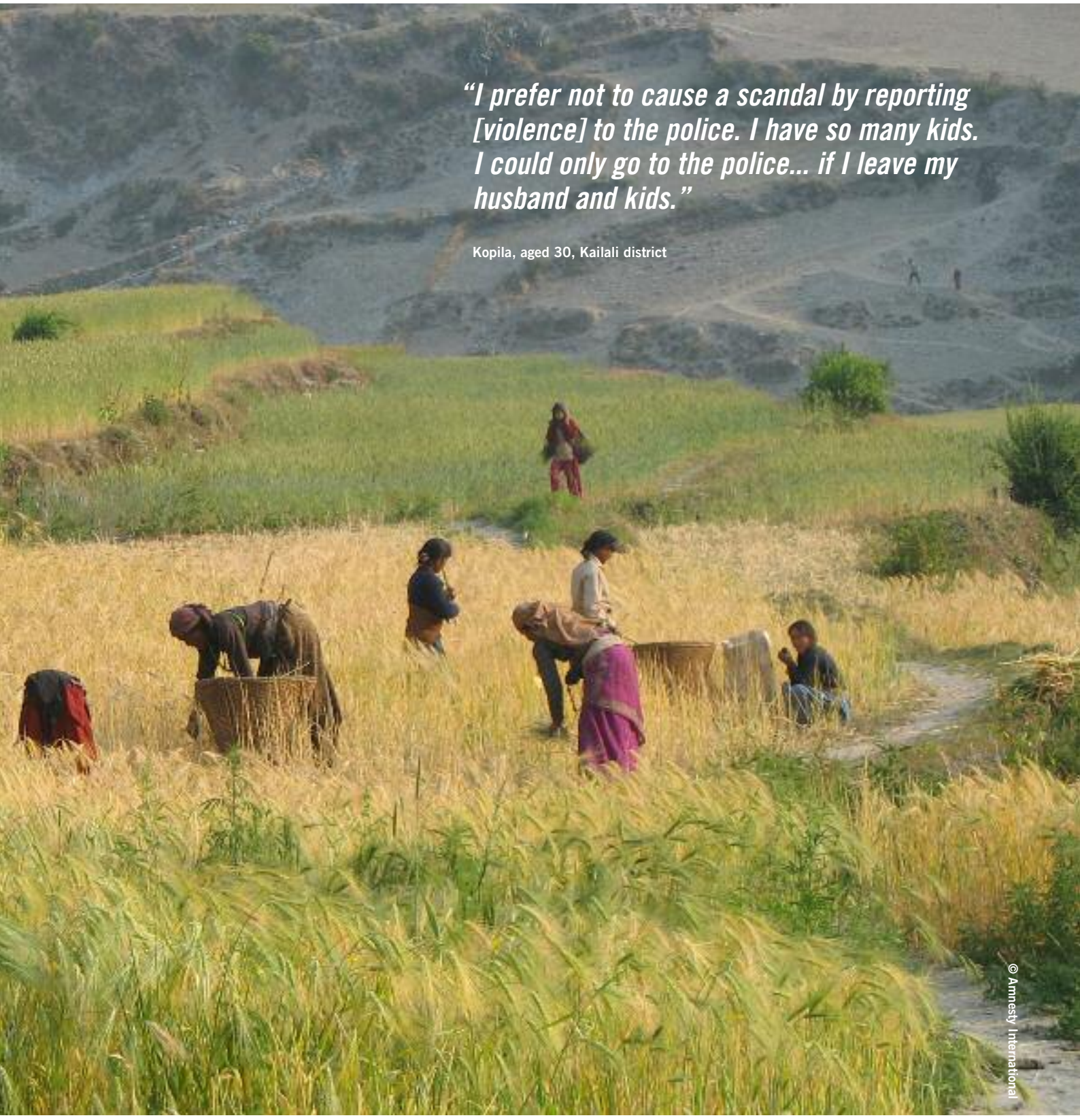
image and quote, below: **Radha Sada, aged 50, Dhanusha district, May 2013. Married at 16, Radha Sada developed uterine prolapse after the birth of her first child. The stigma associated with the condition and the lack of information about it meant that she lived with the pain for decades before finally seeking help – by which point she was a grandmother.**

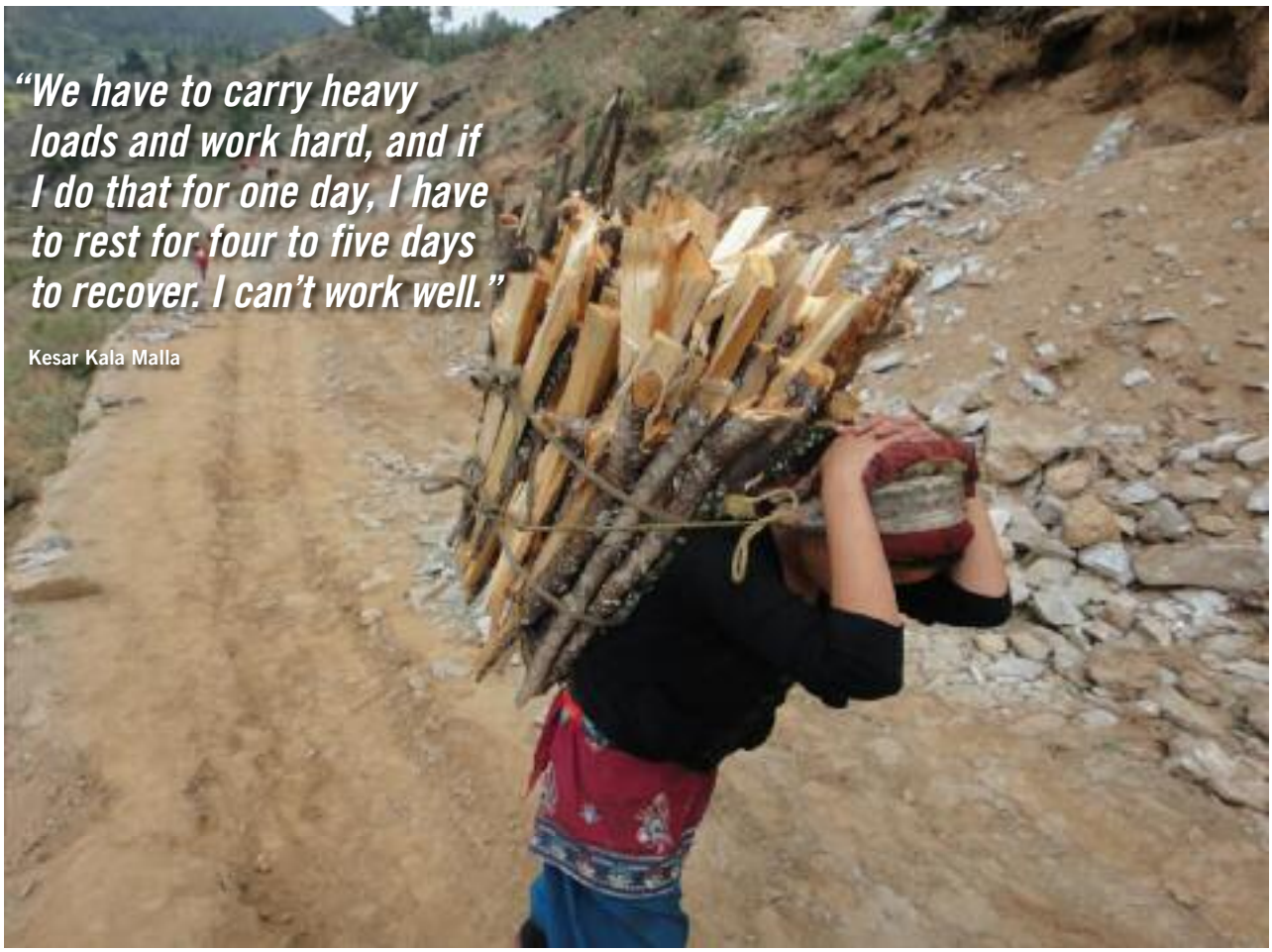
"At first I didn't tell anyone. But later, I started to attend trainings and meetings [run by NGOs]. I came to know that I can share my experiences and pain with other women. So after that I told someone about my problem."

image and quote, below: **Khumeni Bishwakarma, aged about 50, is Treasurer of the Mugu branch of the Feminist Dalit Organization. She was just 15 when her parents decided she had to marry. She developed uterine prolapse after her 10th pregnancy. The risk of developing the condition increases the more children a woman has. Many of the women Amnesty International interviewed said that they had no choice over whether or when to have children, let alone how many. Use of contraception is often controlled by a woman's husband or in-laws.**

"When I gave birth during the monsoon season I… could only rest for one week, then I had to dig the fields and plant the crops."

right: **Women agricultural workers in Mugu district, May 2013. Domestic violence, including marital rape, is common in Nepal. Women who have uterine prolapse sometimes experience more violence because of their condition. Although there are laws against domestic violence and marital rape, many women are either unaware of them or feel powerless to complain.**


"I prefer not to cause a scandal by reporting [violence] to the police. I have so many kids. I could only go to the police... if I leave my husband and kids."
Kopila, aged 30, Kailali district
© Amnesty International



above: A woman carries wood in Mugu district, May 2013. As Kesar Kala Malla points out, although some women know they should not carry heavy loads during or just after pregnancy, their economic circumstances or pressure from their families mean that they have no choice. Carrying heavy loads strains the pelvic muscles and can cause uterine prolapse. The government of Nepal is required to protect women's right to safe work and working conditions, especially while pregnant.

right: Sita Devi Choudhary with her baby, Kailali district. She married when she was 17. Government figures show that 29.1% of adolescent girls are sexually active, of whom 28.8% are married. 17% are pregnant or have already had a baby. Adolescent pregnancy is one of the risk factors for uterine prolapse.

image and quote, above: **Rajkumari Devi, aged 24 and living with uterine prolapse, Dhanusha district, May 2013. Traditional practices in some families mean that younger women and girls eat last. Poor nutrition can lead to poor muscle development and, consequently, weaker pelvic muscles, thus increasing the risk of uterine prolapse.**

Lal Sheela Bishwakarma and her children outside their home, May 2013. Her son was born in the cowshed (bottom right corner of picture). Her daughter was born in a hospital. A belief – held in certain parts of Nepal – that women are "unclean" after giving birth and during menstruation means they are forced to stay in cowsheds during those times. The practice is known as *chaupadi*.

"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]

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

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

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

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

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.

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

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 2011[308]

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.

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 have[329] 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]

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 c*haupadi*.[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]

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:

<u>Addressing control over reproduction</u>

- 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

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 CESCR 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

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

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

[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 Helath 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,

[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

[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

[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

[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

[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

[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

I WANT TO HELP

WHETHER IN A HIGH-PROFILE CONFLICT OR A FORGOTTEN CORNER OF THE GLOBE, **AMNESTY INTERNATIONAL** CAMPAIGNS FOR JUSTICE, FREEDOM AND DIGNITY FOR ALL AND SEEKS TO GALVANIZE PUBLIC SUPPORT TO BUILD A BETTER WORLD

WHAT CAN YOU DO?

Activists around the world have shown that it is possible to resist the dangerous forces that are undermining human rights. Be part of this movement. Combat those who peddle fear and hate.

- Join Amnesty International and become part of a worldwide movement campaigning for an end to human rights violations. Help us make a difference.
- Make a donation to support Amnesty International's work.

Together we can make our voices heard.

☐ I am interested in receiving further information on becoming a member of Amnesty International

name

address

country

email

☐ I wish to make a donation to Amnesty International (donations will be taken in UK£, US$ or €)

amount

please debit my Visa ☐ Mastercard ☐

number

expiry date

signature

amnesty.org

Please return this form to the Amnesty International office in your country.

For Amnesty International offices worldwide: www.amnesty.org/en/worldwide-sites
If there is not an Amnesty International office in your country, please return this form to:

Amnesty International, International Secretariat, Peter Benenson House,
1 Easton Street, London WC1X 0DW, United Kingdom

UNNECESSARY BURDEN

GENDER DISCRIMINATION AND UTERINE PROLAPSE IN NEPAL

Many women in Nepal are carrying a severe burden, with some suffering for years before finding the means to get help. They are living with uterine prolapse, a painful, debilitating condition in which the pelvic muscles give way, allowing the uterus to descend into the vagina. It is both a cause and consequence of the gender discrimination that prevails throughout Nepali society.

All too often, women are expected to marry young, have multiple pregnancies within a short period of time because they have no control over contraception, and have to carry heavy loads while pregnant. These are all factors that increase women's risk of developing uterine prolapse which, unusually, affects a large number of women under the age of 30 in Nepal.

Addressing the gender discrimination that underlies the causes of uterine prolapse would go a long way towards preventing it. Yet the government has so far failed to do this and, as Amnesty International documents in this report, it is failing to ensure Nepali women can exercise their sexual and reproductive rights. Nepal is legally obliged to tackle gender discrimination and work to prevent uterine prolapse. Until it does, women will continue to be denied their human rights and to suffer unnecessarily.

amnesty.org

Index: ASA 31/001/2014
February 2014

AMNESTY
INTERNATIONAL