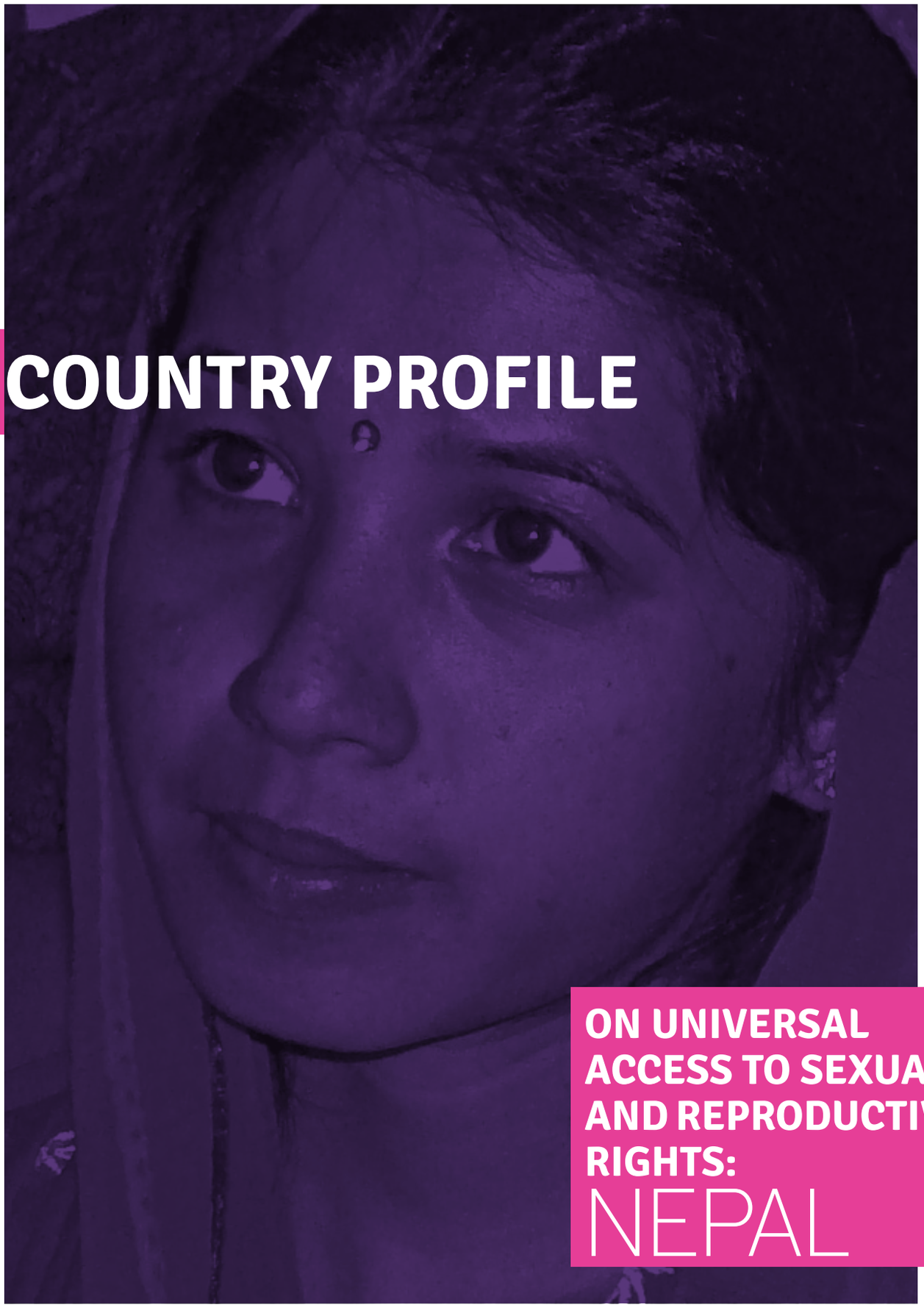

COUNTRY PROFILE

ON UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE RIGHTS: NEPAL

Introduction

Nepal is a land-locked country located at the foothills of the Himalayas. It lies in between 26º 22' to 30º 27' North latitudes and 80º 4' to 88 º 12' East longitudes with elevation ranging from 60 to 8,848 meters. The country is bordered by India to the east, south, west, and China to the north. Nepal is rectangular and stretches 885 kilometers in length (east to west) and 193 kilometers in width (north to south). The total land area of the country is 147,181 square kilometers. Nepal is divided into three distinct ecological regions: Mountainous region, Hilly region and Terai (or plains) region (SDINN, 2008) and five development regions according to its accessibility/remoteness: Far Western Development Region, Mid-Western Development Region, Western Development Region, Central Development Region, and Eastern Development Region.

According to the 2011 census, the population of the Nepal reached 26.6 million; with an increase of 3.5 million since the last census conducted in 2001.Under scrutinized observation, the population has more than doubled in the last 40 years. The population grew at a rapid rate between 1971 and 1981 from 2.1 % to 2.6 % but it receded to just over 2 % in 1991 and 1.4 % in 2011. The population density of Nepal is estimated to be 181 per square kilometers. The total male population according to the 2011 census was 12.8 million whereas the total female population was 13.6 million. In 2011, approximately 20.7% of the total population was in between 0-9 years of age and 23.5% of the total population belonged to 10-19 age group. Young adults aged 20–34 years comprised 24.1% and adults aged 35–59 years comprised 22.4% of the total population respectively. Persons 60 years of age and above comprised 7.3% of the population (NPCS & CBS, 2011).

Among 13.6 million women, about 49 % were in reproductive age (NPCS & CBS, 2011). Nepal was able to achieve greatly in terms of human and gender development indicators. The Gender Development Indicators (GDI) increased from 0.312 in the 1990s to 0.912 in 2013 in Nepal (UNDP, 2014), and female/male disparities have also noticeably reduced. There has been significant progress in women's access to education and health resources (UNFPA, 2007).

Nepal recently emerged from a decade-long armed conflict (1996 to 2006). This conflict had an effect on both the population's health and the health care system. Over 1,000 health posts in rural areas were destroyed, more than a dozen health workers were killed and many others were harassed, kidnapped, threatened and prosecuted by the warring factions. The conflict aggravated the already poor health services as one third of Nepal's health centers lie in rural areas (where some of the fighting was fierce). Consequently, health centers often operated without health staff. Torture and sexual-abuse related to insurgency were also prominent, and the conflict hindered health programs implemented by non-governmental organizations too (Devkota & Teijlingen, 2010). The Shah dynasty that unified and ruled Nepal for the last 240 years, often through bloodshed came to a peaceful end in 2008. On May 28, 2008, Nepal was declared a Federal Democratic Republic (Dhakal, 2008).

Even during the conflict period with low/zero economic growth and poor health care services, socio-economic and health indicators have improved progressively and continues to do so even in post conflict times. Some of the important factors that have contributed in improvisation of SRHR are:

a) People's acute consciousness and desire to improve their own and family health;

b) Women have been found to be resourceful in making all kinds of arrangements to access education and health care services for their children and for themselves. Even during the conflict times women have negotiated with Maoists for the security, education and health of their children – although there is no systematic

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study, a number of cases have been reported in the experiences of different Non-governmental organizations (NGOs), International Non-governmental organizations (INGOs) and local institutes;

c) It has been reported that local health workers have played an important role in providing health care services even in absence of government health officials and local institutional health care services and

d) Indeed, remittance is one of the significant factors but only to the extent that people are health conscious to make the choice to spend it on health care. In rural Nepal, it is apparent that women have made the decision to spend part of the remittances that they receive on education for their children and health care. With overwhelming majority of the male migrants in rural households, the women significantly appear as decision makers.

Despite the political unrest, Nepal was successful in receiving Millennium Development Goal (MDG) award in 2010 (Baral, 2009). Maternal Mortality Ratio (MMR) has been significantly declined from 270 in 2005 to 190 in 2013 per 100,000 live births in Southern Asia (DRHR, 2014). Despite these achievements, women still face difficulties as some of the malpractices even exist today. They are commonly known as dowry, son preference, social acceptance of domestic and public violence against women, polygamy, early widowhood and associated exclusion like the payment of dowry (reinforced by new consumerism), *Deuki* (An ancient custom practiced in the far western regions of Nepal in which a young girl is offered to the local Hindu temple to gain religious merit), *Chhaupadi* (women are secluded, excluded and discriminated during their menstruation and post-partum period by forcing them to stay in the nearby shed and not allowed to enter their own home) and *Boksi* (witch or a woman who practices black magic). These factors continue to restrict women in accessing the services provided in their communities.

Health workers as well as teachers are seen to be reluctant to discuss issues on sexual and reproductive health (SRH) (Pokharel, kulczycki & Shakya, 2006). The government of Nepal has included chapters related to sexual and reproductive health in their selective course books to educate students and their parents who often take this as a taboo. The teacher's capacity of knowledge regarding sexual and reproductive health seems to be significantly inadequate because of which they make students read these chapters on their own. As a result, adolescents and young people are not well-informed on sexual and reproductive health (Pokharel, kulczycki& Shakya, 2006).

Based on data from the World Health Organization (WHO), the life expectancy of males and females in Nepal in 2012 was 67 and 69 years, respectively. In 2012, the Nepali Gross National Income (GNI), expressed as per capita purchasing power parity (PPP) converted to US dollars was $1,470. The mortality rate for children less than five years of age was 42 per 1,000 live births. For males and females between 15 and 60 years of age, the mortality rate was 183 and 157 per 1,000, respectively. The total expenditure on health per capita was $68 (2011, US dollars). In 2012 health expenditures comprised 5.5% of the Gross Domestic Product (GDP) (WHO, 2012).

Nepal Health Sector Programme (NHSP-II) 2010/15 projects that the share of total government budget for health will rise from around 7% in FY 2010/11 to 9.6% in FY 2014/15. In FY 2010/11 Government of Nepal (GoN) has allocated 7.1% of the total national budget to the health sector. The national budget, including the health budget, increased from 6.2% in 2009/10 to 7.1% in 2010/11. Of the total budget, 33.5% was allocated to the health sector in 2010/11 which was an increase from 19.4% in 2009/10 (MoHP, 2011).

This profile will discuss the current status of sexual and reproductive rights (SRR) in Nepal, as well as current legislation, policies and strategies pertaining to sexual and reproductive rights in Nepal. It will examine the status of implementation and enforcement of the laws, policies and strategies and make recommendation to assess SRR in the country.

The data were collected through literature review; assessment and/or analysis of governmental and other reports and data; and by interviewing key persons of different NGOs, International INGOs and government agencies working in Sexual and Reproductive Health and Right (SRHR).

The status of sexual and reproductive health rights in Nepal

The Government of Nepal has ratified nine core international human rights treaties including the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Rights of the Child (CRC). These nine treaties address economic rights, social/cultural rights, civil/political rights, racial/gender discrimination, protection against torture and forced disappearance and the rights of particularly vulnerable populations including women, children, migrant workers and people with disabilities. Nepal has signed five of these treaties and has ratified four others (More detail in Annex 1). These international treaties require governments to respect, protect and fulfill women's SRHR. Further, Nepal has pledged to effective implementation of important global and regional policy commitments on SRHR and gender equality notably, the Programme of Action (PoA) of the International Conference on Population and Development (ICPD) and the Beijing Declaration and the Beijing Platform for Action (BPfA).

Overview of the policies on sexual and reproductive health and rights

In 1993, prior to the abolition of Nepal's monarchy, His Majesty's Government initiated a comprehensive strategic focused to improve the situation of Nepali women through a national safe motherhood program. Since then a number of other programs have been introduced. National efforts to reduce maternal morbidity and mortality are carried out in various divisions of the Ministry of Health and Population (MoHP). Reproductive health is also included in the Tenth five-year health Plan (2003-2007). Training sessions have been conducted for female community health volunteers (FCHV) in many health facilities. Maternal and child health (MCH), safe motherhood programs and family planning programs have been launched.

Besides these, a 20-year Population Perspective Plan (PPP; 2010–2031) was launched in 2011. The multifocal plan aims to ensure access to health care for poor and vulnerable groups; right-based comprehensive reproductive health care; universal access to quality primary education; gender equality and empowerment of women, and decentralized governance with community participation to better address geographic pockets of poverty and hard to reach population groups. It aims to integrate population with economic and social structures, focusing primarily on poverty reduction, gender mainstreaming and social inclusion. The PPP also attempts to address Nepal's commitment to endorse a plan of action relating to its population issues in various international forums, particularly as described in the 1994 International Conference on Population Development (ICPD) and in the 2000–2015 Millennium Development Goals (MDG) (MoHP, 2010).

The national health policy was adopted in the year 1991 to improve the health conditions of Nepalese people. Tenth five-year health Plan (2003-2007) emphasized on the protection of reproductive health. Although, Nepal does not have any single integrated sexual and reproductive health legislation, policy or strategy, key issues are addressed in numerous related plans, policies and regulations. They are as follows: National Population Policy 1991, Second Long-term Health Plan (SLTHP) (1997–2017), National Safe Motherhood Plan(2002–2017),

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National Reproductive Health Commodity Security Strategy (RHCS; 2007–2011), Poverty Reduction Strategy Paper (2002–2007), National Reproductive Health Strategy (2004), Health Sector Strategy- An Agenda for Reform (2004), Nepal Health Sector Program-Implementation Plan (2004–2009),Vulnerable Community Development Plan for Nepal Health Sector Program Implementation Plan (2004/5–2008/9), Revised Safe Motherhood Plan and Neonatal Health Long-term Plan (2006–2017), National Skill Birth Attendants 2006, National Standards & Clinical Protocols for Family Planning & Reproductive Health, National Adolescent Health and Development Strategy 2000, Amendment of Civil Code (Muluki Ain) that legalized abortion in September 2002 such as the National Safe Abortion Policy 2003 and Directives, 2004, and National Policy on HIV.

The above policies identify different SRHR issues, which include family planning with special emphasis on preventing unwanted pregnancies; safe motherhood; care of newborns; prevention and management of reproductive tract infections (RTI), sexually transmitted diseases (STDs), HIV and AIDs; abortion; maternal health; gender equality; and problems of aging population. Reproductive health services are provided throughout the country under the directives of the Department of Health Service (DoHS), which has the responsibility of delivering preventive and curative health services, as well as educational and promotional activities (MoHP & DoHS, 2006).

Sexuality education is another important topic that is incorporated in the secondary level school syllabus intended to educate the children about their sexual and reproductive health. Recognizing its importance, government has included the sexuality education as a compulsory chapter in Environment, Population and Health (EPH) subject introduced from class 6 to 10. The subject was first introduced in 1992 with the objective to have a comprehensive school health program to facilitate students' health-related knowledge, attitudes, and practice and to have a practical impact upon their daily lives (Sharma & Uprety, 2012).

The multifocal SRHR program has been in place since the national health policy was enacted in 1991. Despite these policies and programs noted earlier, women's health, sexual health and reproductive rights are not yet satisfactorily implemented in Nepal. For example, older women suffer from menopausal symptoms and reproductive cancers but almost no research has been undertaken in this regard as well as problems/issues in other areas of women's health. In addition, Nepal's Demographic and Health Survey (NDHS) does not address any of these issues. Not unexpectedly, the burden of reproductive ill health is more in women than in men (Sharma, 2004).

Status of sexual and reproductive rights

The Ministry of Health and Population (MoHP) in Nepal has committed to improve maternal morbidity and mortality rates. Most recently, high priority has been given to the National Safe Motherhood Programme (NSMP) within the Nepal Health Sector Strategy Plan. The Nepal health sector has set a goal of meeting the MDG to reduce the maternal mortality ratio (MMR) by 75% by 2015. The national policy on Skilled Birth Attendants (SBA), 2006 aims to increase the percentage of births assisted by SBA including expansion in the number of the training sites in the country to meet the required training needs.

The main objective of the national policies on SBA was to reduce maternal morbidity and mortality by ensuring the access and utilization of skilled care at every birth. Nepal government has committed to achieve 60% deliveries by SBA by 2015. Deliveries assisted by SBAs have increased from 32% in 2009/10 to 44% in 2011/12 (DoHS, 2013). Currently, approximately six of every 10 pregnant women (60%) receive antenatal care (ANC) from a skilled provider, a significant improvement from 24% in 1996. Reports have revealed that there is a strong relationship between a mother's education and delivery by SBA. Similarly, assistance during delivery by SBA varies by women's economic status as well i. e., higher economic status is associated with an increased likelihood of SBA assistance (MoHP, 2012). This clearly shows that there are still major disparities in women's access to SBA services. Women with education and those who are economically strong have better access to SBA services compared to women who are illiterate/less educated and poor. Further women's access to SBA greatly varies with geographical and rural/urban areas and their ethnicity.

The Contraceptive Prevalence Rate (CPR) has been stagnant over the last three years. The CPR of Nepal in 2009/10, 2010/11 and 2011/12 was 43%, 44% and 43% respectively. CPR by district reveals a distinct pattern. Parsa has the CPR above 67 % which is highest among the districts and

has reached the Nepal Millennium Development Goals (MDG) target. Other nine districts, including Rautahat, Makwanpur, Saptari, Dhanusa, Sarlahi, Morang, Mahottari and Lalitpur, have a CPR between 55% and 67%. These districts have the capacity to meet the MDG target of 67% with modest intensification of the existing programs. More than half of the districts i.e. 43 have a moderate CPR between 30% and 55 %, whereas the other 22 districts have a substantially lower CPR. This reveals that CPR varies significantly between districts that are remotely situated and those with easy access to services/facilities. Thus the program needs to focus on districts with low and moderate CPR (DoHS, 2013).

CASE STUDY

Sumitra was 36-year-old pregnant woman. She was literate and the mother of five children. She intended to obtain an abortion from an auxiliary nurse. She went alone and did not inform her family about the termination. Later that night around midnight she developed severe abdominal pain. Because it was so late and ambulance costs so high, her relatives decided to wait until morning. At eight o'clock the next morning, they took her to a health facility.

She was admitted to the emergency ward. The doctor informed the family that there was nothing to fear. However, her laboratory results revealed that she needed an emergency operation. After the surgery, the doctors disclosed to her relatives that Sumitra had septicemia and that they had to remove her uterus. She regained consciousness a few hours after her operation but was unable to speak. Twenty-four days later she died, due to septic shock secondary to her termination attempt.

"My mummy could have been saved if we had recognized her problem earlier and taken her to a better health facility sooner," says her daughter who was with her at the time of her treatment and death. "If we had been informed prior to her abortion attempt, we could have taken her to a better health facility instead of the medical shop. The nurse who assisted her should have informed us about the risks instead of being selfishly money-minded. Actually it was the nurse who took her life."
(Suvedi, 2009)

There are many socio-political, cultural, governmental and economic barriers to the successful implementation of the SRHR policies. Implementation is a particular challenge at the district level, where there is limited awareness about the actual laws and policies as well as inadequate infrastructure and effective lines of responsibility to coordinate the policies and to ensure implementation. In principle, the Chief District Officer (CDO), District Public Health Office(DPHO)/ District Health Office (DHO) and other governmental organizations are responsible for coordination between agencies, but in practice, there is often little collaboration across sectors (UK AID et al., 2014). Though the situation of sexual and reproductive health has been progressive than before, the results are not even and changes have been too slow. Still biggest challenge in Nepal is to change society's perception of not only of women's body but also of her role in society, more generally of their sex and sexuality.

Although there are numerous collaborative efforts attempting to change these attitudes and perceptions, such changes often challenge fundamental cultural belief/value system and practices that are difficult and takes a long time to change. Therefore, there is a need to raise voices and empower women on sexual rights as the issue has frequently been silenced even in progressive and politically correct spaces (WOREC, 2013).

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Abortion

Nepal legalized abortion in September, 2002 after many years of intensive research, advocacy and lobbying (Tamang et. al., 2007). Before 2002, there was a provision of punishment to any woman if recognized that she had an abortion. This resulted in many women committing infanticide or undergoing unsafe abortions (see "Case Study").

In 1970, two NGOs—the Family Planning Association of Nepal (FPAN) and the International Planned Parenthood Federation (IPPF) led a high level advocacy conference for the legalization of the abortion but largely concentrated on the control of fertility rather than as an issue of maternal health and rights.

During the 1980s, Center for Research on Environment Health and Population Activities (CREHPA) began a research program and documented unsafe abortion as a significant public health issue. At the same time, a Post Abortion Care (PAC) program was also started that gave the Family Health Division (FHD) of the Ministry of Health and Population (MoHP) an opportunity to better understand the problem of unsafe abortion. Around the same time, the national women's movement was gaining momentum and many women's organizations (district, national, and international) were receiving support from private donors as well as from United Nations (UN) and other governmental agencies in order to advance the core women's issues and to push for gender equality and rights.

In 1990, the NGOs and INGOs came together to advocate against the imprisonment of women for abortion. After nearly constant lobbying and advocacy in 2001–2002, the 11th amendment of Muluki Ain (Nepali General Code) was passed in 2002. This bill on gender equality granted women rights and liberalized the abortion law under the following conditions (Samandari et.al., 2012).

- Up to 12 weeks of gestation on the request of the pregnant women.
- Up to 18 weeks of gestation in case of rape or incest.
- At any gestation period, if the pregnancy is harmful to the pregnant women's physical and mental health as certified by an expert physician.
- At any gestation period, if the fetus is suffering from a severely debilitating or fatal deformity as certified by an expert physician.

(JNMA, 2005)

To guide implementation of the law, in February 2002, the Ministry Of Health and Population, FHD created the Abortion Task Force (ATF), which comprised of the Nepal Society of Gynecology & Obstetricians (NESOG), the Centre for Research on Environment Health and Population Activities (CREHPA), German Technical Assistance (GTZ) and Ipas (FHD et al., 2005).

Subsequent liberalization of the abortion law led to specific efforts beginning in March 2004 to provide comprehensive abortion care (CAC) services with 245 CAC service sites set up in the country by 2008/09. In a prospective study of abortion care, conducted in 30 randomly selected CAC service sites over a three-month period, the majority of patients were found to seek care from Marie Stopes International (MSI)/Sunaolo Parivar Nepal (SPN) abortion facilities. Of those surveyed, contraceptive counseling was provided to 6,983 (99%) of the women and 5,679 (81%) left with a family planning method (Ipas, 2009).

Table 1: Comprehensive Abortion Care (CAC) Coverage

Year	Total No. of CAC Services Received	Treatment of Abortion Complications	Post Abortion Care	No. of FP Users after Abortion Care
2008/09	83,978	1,810	8,694	45,136
2009/10	88,938	2,063	9,134	49,876
2010/11	95,306	1,750	11,762	40,310
2011/12	91,696	1,095	12,699	34,085

Source: Annual Reports, Department of Health Services

In 2008/09, a training initiative was incepted to improve the safety of abortion services. In 2009/10, 180 providers were trained in both medical abortion (MA) and manual vacuum aspiration (MVA) techniques, scaling up MA in 75 districts. By 2010/11, a total of 192 providers including 74 nurses had been trained in safe abortion services (SAS); by 2011/12 a total of 297 providers including nurses had been trained (DoHS, 2013).

Before the abortion law came into effect, Nepal had one of the highest maternal mortality rates in the world with a significant proportion of maternal deaths and injuries attributable to unsafe abortion practices (Samandari et.al., 2012). In the period just before legal reform, Nepal's maternal mortality rate was 539 deaths per 100,000 live births (MoH, 1998). According to the Ministry of Health and Population's maternal mortality and morbidity study of 1998, approximately 5.4% of all maternal deaths were due to abortion complications (JNMA, 2005). In 1998 it was also estimated that more than half of gynecological and obstetric hospital admitted patients were due to abortion-related complications (MoH, 1998). In another hospital-based study by the government, investigators showed that Traditional Birth Attendants (TBAs) were the primary providers of 40% of the unsafe abortions (MoH, 1998).

An initial assessment suggests that much of the increase in mortality is likely to be attributable to increased reporting of cases since abortion was legalized in 2002. However, it is also possible that there has been a significant increase in the number of abortions performed since legalization; the underlying reasons for the increase need is to be investigated (Subedi et.al., 2009).

In a developing country like Nepal, the fact that abortion is legal does not and cannot guarantee that women have access to adequate and supportive abortion facilities. There are too many constraints such as:

- lack of knowledge about the legalization of abortion
- lack of human resources such as certified doctors and nurses in many parts of Nepal particularly in the rural and remote areas
- lack of confidence of women and their own perception
- financial obstacles due to regulation on the fee for abortion especially in the private sector
- a male-dominant society
- culture and social taboo
- geographical barriers

In particular, women in rural areas have less access to information on abortion services compared with women in urban areas. Access to information on availability of services and benefits is central to ensuring context specific right –based continuum of quality care (CQC) for safe abortion. The legal safe abortion is a service for marginalized women who needs it as the last resort for them to survive with dignity.

According to Nepal's abortion law, comprehensive abortion care is to be safe, accessible and affordable, and is to be available with equity and equality for all women belonging to different social and economic groups. In addition, only specially trained doctors and health workers can provide these services. The increasing trend in the utilization of abortion services shows that large number of women are seeking safe abortion services (DoHS, 2013).

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Quality abortion services must incorporate counseling, training, prevention from infectious practices and adequate logistic support. These services should also provide contraceptive services to prevent further unwanted pregnancies (JNMA, 2005). Due to insufficient training in counseling, the counseling services have not been very successful. Other challenges in providing quality abortion services include the high turnover of medical doctors, limited service center/facilities (sites), limited access to services in rural and remote communities, inadequate use of trained nurses to provide services, frequent changes in governmental oversight (Director of FHD), delays in governmental approval of safe abortion sites, insufficient governmental monitoring of abortion sites, inconsistencies in the fee structures for abortion services, and the continuation of illegal and unregulated sites offering abortion services.

The legal provisions for abortion currently reside in the chapter on life in the National Code (Muluki Ain). Punishments for crimes against human life such as murder are also found in this section, implicitly identifying abortion as a crime akin to murder.

In Laksmi Dhital Vs Nepal Government case, Supreme Court states that legal provisions on abortion must be contained in a separate law and disassociated from discussion of murder. The court has not recognized the fetus as a human life. Therefore, the government must introduce a comprehensive abortion law that codifies the legal principles and establishes a concrete, rights based legal framework for ensuring access to affordable and high-quality safe abortion services (CRR, 2011).

HIV and AIDS

Human immunodeficiency virus (HIV) in Nepal is characterized as a concentrated epidemic with the majority of infections (more than four in every five new infections) transmitted through sexual intercourse. People who inject drugs, men who have sex with female sex workers, female sex workers (FSW), Male who have sex with male (MSM) and transgender sexual practices are at particularly increased risk of HIV and acquired immunodeficiency syndrome (AIDS) in Nepal. Thus, prevention of HIV and AIDS in Nepal targets these populations with programmatic preventive strategies, while providing quality treatment, care and support for those infected with HIV and AIDS (DoHS, 2013). In countries like Nepal where sexuality is a social taboo, prejudice and discrimination towards people living with HIV (PLHIV) is more pronounced. This discrimination is most prevalent among females, children, and marginalized populations.

Nepal's response against HIV and AIDS began with the launch of first National AIDS Prevention and Control Program in 1988. The 1995 National HIV and AIDS Policy consisted of 12 key policy statements as well as a number of supportive structures such as the National AIDS Coordinating Committee (NACC) and the District AIDS Coordination Committee (DACC), which are keys in coordinating the response at the central and district levels. As directed by the National HIV and AIDS Policy, the NACC is chaired by the Minister of Health and Population and includes representatives from different ministries, the civil society and the private sector. It was established to coordinate, support and monitor the activities implemented through the National Centre for AIDS and STD Control (NCASC). Similarly, the DACC was established to coordinate and monitor HIV/AIDS activities at district level. In 2002, National AIDS Council (NAC) was established, chaired by the Prime Minister, to raise the profile of HIV and AIDS and to supply over all guidance and direction to the national response about AIDS in Nepal. In June 2011, Nepal reinforced its commitment to eliminating HIV and AIDS in Nepal in its political declaration on HIV/AIDS: Intensifying our efforts to eliminate HIV and AIDS (DoHS, 2013).

Nepal has already implemented three strategic plans, including the following:

- 1997–2001: Strategic Plan for HIV/AIDS Prevention
- 2002–2006: National HIV/AIDS Strategic Plan
- 2006–2011: National HIV/AIDS Strategic Plan

More recently, Nepal's National HIV/AIDS strategy 2011–2016 laid out a concrete road map for planning, programmatic activities, and reviewing the national response to the epidemic of HIV and AIDS (DoHS, 2013).

People living with HIV and AIDS face discrimination and rejection in every aspect of the society. They are discriminated at work places, educational institutions, family gatherings and even at health care centers. Despite the infection, PLHIV often remain healthy for many years and, with appropriate antiviral treatment, can live relatively normal and longer lives. Nevertheless, lack of understanding about HIV and AIDS coupled with fear and inaccurate cultural beliefs about the disease and/or perceptions about who gets the disease often result in rampant discrimination against those living with HIV and AIDS, creating

major problems for PLHIV in the workplace as well as in other aspects of society, such as renting housing (MoLTM, 2007).

In 2007, the national policy on HIV/AIDS in the workplace was formulated. This policy incorporates principles of the International Labor Organization's (ILO) program on HIV and AIDS in the workplace which (1) promotes accepting people living with HIV/AIDS, (2) prohibits discrimination, (3) internalizes gender equality, (4) creates a healthy working environment, (5) promotes social dialogue, (6) prohibits HIV/AIDS testing with an objective to remove an infected person from employment or work, (7) respects the rights of infected people to confidentiality, and (8) guarantees the continuity of employment until one cannot perform normal work. The program also teaches prevention and supports appropriate treatment for those infected.

Similarly, the 2008–11 Nepal national advocacy plan on HIV and AIDS was established to enhance the 2008–11 national action plan on AIDS, which in turn was based on the 2006–11 National HIV/AIDS Strategy. This has been pertained to be one of the stronger efforts toward bringing attitudes of acceptance of PLHIV among the general population, and of reducing the prevailing stigma and discrimination against PLHIV especially in healthcare settings.

The more recent 2011–16 National HIV/AIDS Strategy advocates the "establishment of systems to enable the Most at Risk Populations (MARPs) and People Living with HIV (PLHIV) to address the issue of stigma/discrimination and other violations of their rights" (DoHS, 2013).

Nepal has also signed an international agreement, "Declaration of Commitment on HIV/ AIDS," which affirms that the realization of human rights and fundamental freedom for all is essential for reducing vulnerability to HIV and for protecting the rights of the PLHIV (FPAN, 2011).

Although different kinds of policies and plans have been formulated by the government and policies makers, the stigma and discrimination of PLHIV in the society is still a major problem (FPAN, 2011).

Lack of sensitivity to gender issues, lack of understanding of the needs and rights by the vulnerable people by the health care providers have hindered access to care (Sharma, 2004). Men who have sex with men (MSM) are one of the vulnerable population groups with higher risk of HIV and AIDS who often face discrimination. Despite the international experience in tackling the HIV and AIDS epidemic, after persistent lobbying by Blue diamond society in 2002, MSM were factored into the National HIV/AIDS strategic plan for Nepal only after14 years of infected reported case of the treacherous virus. In 2009, HIV/AIDS Control Board formed a thematic group on MSM to address the HIV and AIDS problem among homosexuals (BDS, 2014).

Adolescent sexual and reproductive health services

Nepal has been committed to provide adolescent sexual and reproductive health (ASRH) services since the signing of the POA of the ICPD in 1994. Adolescent sexual and reproductive health services poses a major challenge in Nepal, in part because Nepal is particularly a young country, with adolescents comprising 24.5% of the total population in 2011. The number of adolescents is also increasing (adolescents comprised 22% of the population in 2002) (MPCS & CBS, 2011).

In 2000, Nepal developed and published a National Adolescent Health and Development Strategy, and in 2007, developed an implementation guideline on Adolescent Sexual and Reproductive Health (ASRH) to support district health managers in implementing the strategy. In 2008, a draft of a national ASRH program under the leadership of Family Health Division was developed with the support of Deutsche Gesellschaft für Internationale Zusammenarbeit. This national ASRH program was piloted in 2009 in 26 public health facilities in Bardiya, Surkhet, Dailekh, Jumla and Baitadi districts (DoHS, 2013).

Based on the findings from the pilot interventions, a national ASRH program was designed in 2011. This program is now being implemented nationwide with the intent of meeting the goals of the Nepal Health Sector Program (NHSP) II (2010–2015), which aims to introduce 1,000 adolescent-friendly services (AFS) in Nepal by 2015. As of December 2012, total 542 health facilities with AFS had been built (DoHS, 2013).

The Department of Health Services (DoHS) is in the process of developing several additional initiatives to address the goals of the National Adolescent Health and Development Strategy. Two initiatives, in particular are likely to create significant impact on adolescent reproductive health in Nepal. First, the National Reproductive Health Program Steering Committee has endorsed a policy stating that adolescents should not be

denied family planning services, irrespective of their marital status. Second, the House of Representatives passed the 11th amendment of the country's civil code, which enabled women to legally terminate unwanted pregnancies under certain circumstances (Pradhan & Strachan, 2003).

The National Health Policy (1991), Mid Term Strategic Plans, and Nepal Health Sector Program II (NHSP II, 2010–14) outlined broad strategies for adolescent reproductive health in Nepal. As noted earlier, the NHSP II calls for establishing Adolescent Friendly Services in1,000 health facilities by 2015. The National Adolescent Sexual and Reproductive Health Program addresses key issues related to adolescents and youth at the national level seeking integration concerns regarding adolescents and youth into several other programs that provide specific services, including safe motherhood, family planning, HIV/AIDS, and sexually transmitted infection (STI) programs (khatiwada et.al., 2013).

A new HIV/AIDS National Strategy (2011–15) has recently been developed and approved by the government. Additional policies for research; information, education, and communication (IEC); safe motherhood; and adolescent reproductive health have also been developed as operational guidelines for reproductive health care at all levels (khatiwada et.al., 2013).

The national ASRH program has currently been implemented in 38 districts across Nepal and has secured a long-term financial commitment from Family Health Division (FHD) to help ensure sustainability of the program. The ASRH program requires that the adolescent sexual and reproductive services be available irrespective of marital status. It also specifies that parental consent is not required in order to utilize ASRH services by adolescents. In countries such as Nepal where talking about sex and reproductive health is often discouraged and considered as taboo, utilizing the services of the ASRH program freely and without hesitation is probably unrealistic. For this reason, an important dimension of the ASRH program is to raise awareness of the program itself and to dispel some of the cultural and societal customs that interfere with appropriate and needed sexual and reproductive health education and medical services among adolescent boys and girls in Nepal (DoHS, 2013).

Median vs. legal age of marriage

In Nepal, the legal age to marry for both girls and boys is 18 years (with parental consent) or 20 years (without parental consent). According to the 2011 Nepal Demographic Health Survey (NDHS), among women 25-49 years who were surveyed, 55% said that they were married by the age of 18 years and 74 % were married by age 20. The median age at which these women were married was 17.5. In the 2006 NDHS, the median age of marriage was 17.2 years. Based on the 2011 survey, the age of a woman's first marriage is increasing, with 24% of those between 45–49 years of age having married by age 15, while 5% of those between 15–19 years of age were married (MoHP, 2012 & 2007).

Among men, the median age at first marriage among those 25–49 years of age was 21.6 years according to the 2011 NDHS and 20.2 years according to the 2006 NDHS. This suggests that men are approximately 4 years older than women, when they first marry. Similarly, 34% of 25–29 year-old men were married by the age of 20 years, compared with 69% of women in the same age group. Among 20-24 year-old men in the survey, only 11% were married by age 18, compared with 41% of women in the same age group. By the age of 25 years, 8 % of men between the age of 45 and 49 years were married, compared with 95% of the women. Urban women in general married one year later than rural women, and women from the hill region marry about one year later than women from the terai and mountain regions (MoHP et al., 2012).

... National ASRH Program also specifies that parental consent is not required in order to utilize ASRH services by adolescents.

The legal age of marriage and the median age of marriage are similar in most urban areas of Nepal. In rural areas, girls and boys typically marry before the age of 18 year. However, early and "child marriage" are still acceptable and prevalent in many parts of rural areas of Nepal, and in some parts it is a socially established practice. From a perspective of women's health and reproductive rights, child marriage presents to be a challenge because it "directly threatens health and wellbeing"of the girls.

Gender-based Violence

Violence against women and girls (VAWG) is a common and widespread form of gender biases and subjugation of women in Nepal. Gender-based violence is disproportionately experienced by women and perpetrated predominantly by their male counterpart (Office of the Prime Minister and Council of Ministers, 2009).

Forced and early marriage is still a pervasive practice in Nepal, despite the legal age for marriage being 18. Forms of VAWG range from paternalistic protection and verbal abuse to extreme forms of physical violence such as rape, sexual abuse, sexual harassment in the workplace, trafficking of women and girls and traditional practices, such as the payment of dowry, *deuki* (An ancient custom practiced in the far western regions of Nepal in which a young girl is offered to the local Hindu temple to gain religious merit), *chhaupadi* (women are forced to spend their menstrual days in the nearby shed and not allowed to enter their own home) and/or *boksi*(witch or a woman who practices black magic) to the groom or her family as part of the marriage agreement, which fundamentally undermines the concept of gender equality (Office of the Prime Minister and Council of Ministers, 2009).

According to the Nepal Demographic Health Survey, 2006, 22% of men and 23% of women between 15 and 49 years of age reported that physical violence against women is justifiable. More specifically, the survey found that for them it was acceptable for a man to beat his wife if (1) she burnt the food or (2) she argued with him, (3) she went out without informing him, (4) she neglected their children or (5) she refused to have sexual intercourse with her husband (MoHP, 2007).

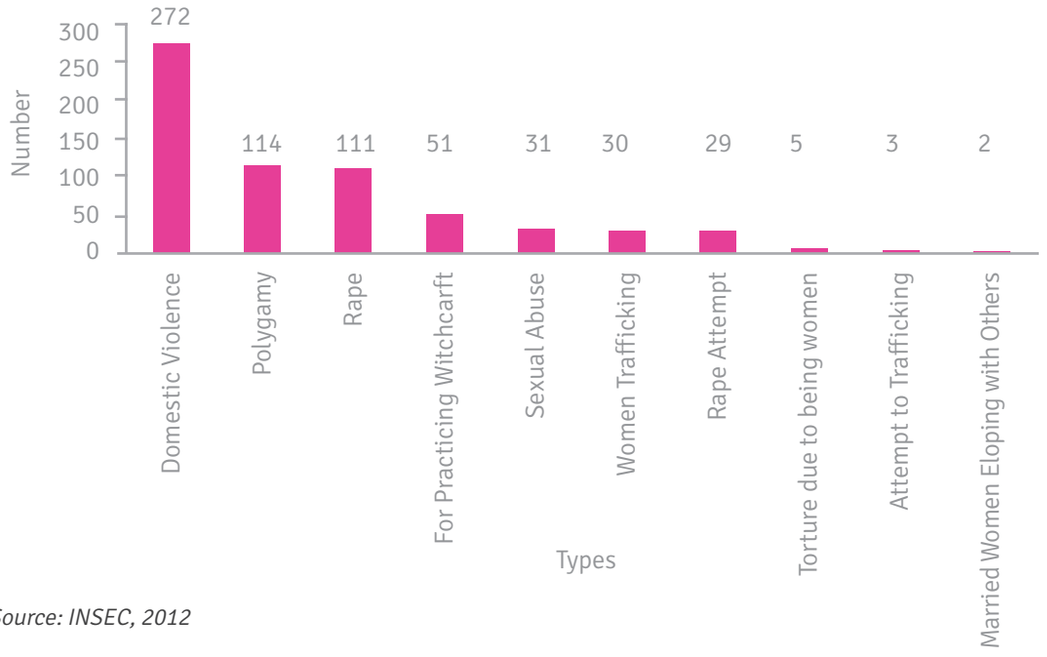
In a subsequent 2011 governmental survey, 12% of women between 15 and 49 years of age reported that they had experienced sexual violence at least once in their lifetime. About one-third of ever-married women between 15 and 49 years of age reported that they had experienced emotional, physical, and/or sexual violence from their spouse; and 17% reported having experienced one or more of these forms of violence in the past 12 months. Of these, 40% (two in every five women) reported having experienced physical injuries as the result of spousal violence (MoHP, 2012).

The most commonly reported physical violence among ever-married women is spousal violence. However, former husbands and in-laws were cited as the perpetrators of physical violence by 7% and 6% of survey respondents, respectively. Unmarried women also experienced significant sexual and other violence. Of those reporting violence since age 15, 38% was perpetrated by their siblings, 36% by fathers or stepfathers, and 30% by mothers or stepmothers (MoHP, 2012).

As noted earlier, Nepal is a signatory to various international conventions on gender equality and women's empowerment that address violence against women, including the Convention for the Elimination of all Forms of Discrimination Against Women (CEDAW), the UN Millennium Development Goals (MDGs), the Beijing Platform of Action (BPfA) and PoA of the ICPD.

... More specifically, the survey found that for them it was acceptable for a man to beat his wife if (1) she burnt the food or (2) she argued with him, (3) she went out without informing him, (4) she neglected their children, or (5) she refused to have sexual intercourse with her husband

Figure 1. Violence Against Women by Event Type in 2011



Source: INSEC, 2012

In addition, the 2006 Three-Year (2007–10) Interim Constitution of Nepal explicitly states that all Nepali citizens, regardless of gender, have fundamental right to equality. As a corollary to this fundamental right, sexual violence has been declared a punishable crime and ending gender-based violence (GBV) has been identified as a key objective to end violence in general. The Domestic Violence (Crime and Punishment) Act of 2009 as well as other national and international laws and conventions, mandate the government work more purposefully to address GBV. Recognizing that GBV is a fundamental violation of human rights that exacts considerable human and economic costs for families, communities and the nation, the Prime Minister of Nepal declared 2010 as the "Year against Gender Based Violence" (Office of the Prime Minister and Council of Ministers, 2009).

Rape laws in Nepal are different for different conditions. Before 2006, a husband who had forced sex with his wife without her consent was not defined as rape. However, in 2006 the Supreme Court declared that sex without the wife´s consent is rape and is punishable by law. According to the current law, anyone convicted of marital rape can be sentenced to 3–6 months in jail. Even though many women suffer from sexual violence at the hands of their husbands, only a few women have dared to seek legal remedy because talking about sex is still a taboo in Nepal.

Furthermore, Nepalese women migrants often face physical and sexual violence in the countries of their destination and there is a serious lack of state protection of their rights. This serious human rights issue needs serious attention of the government, civil society and all concerned development agencies.

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Legislation on sexual orientation

The American University International Human Rights Law Clinic on behalf of global initiative for sexuality and human rights and the Blue Diamond Society (BDS), produced a list identifying ongoing human rights violations against persons of diverse sexual orientation in Nepal. Despite the fact that the people have different sexual orientation, a natural phenomenon, the existing society mistrusts their existence (BDS, 2013). Recognizing the human rights of Lesbian, gay, bisexual, transgender and intersex (LGBTI) people, the state made a remarkable legal provision to protect the rights of the people regarding the sexual orientation and gender identity by acknowledging the same legal rights that are to be benefited by every citizen of Nepal in 2007 by constant lobbying and advocacy by different NGOs and INGOs.

According to the interim constitution there is provision under Article 12(2) that states that except for the provision in law no person shall be deprived of his/her personal liberty. The liberty guaranteed in the Article 12 is a right to live or right to life; this right is an inalienable right for every human being. In short, the liberty of this kind, are equally bestowed to all human being on the basis of humanity.

On 18th November 2008, the Supreme Court directed the government to enact laws enabling equal rights to LGBTI citizens. In 2012 Nepal's Supreme Court recognized a live-in relationship between two lesbians despite the objection of one of the families to separate them (Shrestha, 2012). On November 17, 2008, Nepal's Supreme Court ruled in favor of laws to guarantee full rights to LGBTI. It states that all gender minorities must be defined as "natural people" under the law; this also included the right to marry irrespective of sexual orientation. If any legal provisions restrict these people from enjoying fundamental rights and other human rights provided by Part III of the Constitution and international conventions, the Supreme Court has considered such provisions as an act of arbitrary, unreasonable and discriminatory. Similarly, the action of the state that enforces such laws shall also be considered as arbitrary, unreasonable and discriminatory (Pant, 2008). Nepal is the only country in South Asia to have recognized third gender rights.According to Nepal census, conducted in May 2011 by the Central Bureau of Statistics officially recognized a third gender in addition to male and female (UNDP, 2011). Nepal is the first Asian nation to legalize same sex marriage as well (Feder, 2013).

The Supreme Court has recognized the rights of LGBTI, however, the society of Nepal is not open-minded toward it. Due to the society's recalcitrant behavior, people do not tend to open up about his or her sexual orientation. And those who dare to open up, are either punished or isolated in the society. Though there are organizations such as blue diamond society which addresses these kinds of problem, these problems are so deep rooted in people's mentality that it can be completely eradicated with collaborated effort with the concerned sectors.

... Nepal is the first Asian nation to legalize same sex marriage as well. The Supreme Court has recognized the rights of LGBTI, however, the society of Nepal is not open-minded toward it. Due to the society's recalcitrant behavior, people do not tend to open up about his or her sexual orientation. And those who dare to open up, are either punished or isolated in the society...

Legislation on gender identity

After consistent lobbying and advocacy, the Supreme Court of Nepal in 2007 issued directive orders to the Government of Nepal to end discrimination against people of different sexual orientation and gender identity. The court took the unique approach in establishing a third-gender category. Nepalese official documents afford citizens three gender options: male, female and others. The third gender in Nepal is an identity-based category for people who do not identify themselves as either male or female. There are other countries that have third-gender policies, but none nearly as comprehensive as Nepal (Knight, 2012).

In 2001, Sunil Pant registered Nepal's first LGBTI organization, the Blue Diamond Society (BDS). Most of the BDS's initial members were transgender sex workers-considered to be male at birth, but performing a feminine gender role. After the court decision, the third gender began to appear in various administrative nodes of the government. The Election Commission of Nepal allowed voters to register as third-gender as well as many trekking permit applications added a third-gender in their category as well. The Ministry of Youth and Sports added third-gender to its National Youth Policy in 2010. The most sweeping implementation of the category was in 2011 when the federal census allowed citizens to self-identify as male, female or third-gender (Knight, 2012).

Conclusion

The Ministry of Health and Population has committed to improve maternal morbidity and mortality rates. The Nepal health sector has set a target of meeting the MDG to reduce the MMR by 75% by 2015. The multifocal SRHR program has been in place since the National Health Policy was enacted in 1991. Despite these policies and programs noted earlier, women's health sexual and reproductive health and rights are not yet satisfactorily implemented in Nepal. There are many socio-political, cultural, governmental and economic barriers to the successful implementation of the SRHR policies. Implementation is a particular challenge at the district level, where there is limited awareness about the actual laws and policies as well as inadequate infrastructure. Although there are numerous collaborative efforts attempting to change these attitudes and perceptions, such changes often challenge fundamental cultural belief/value system and practices that are difficult and takes a long time to change. The government must recommit themselves to achieving the goals by addressing the gaps and strengthening the loop-holes.

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Recommendations

We call up on the government to follow the following recommendations:

1. Intensify Contraceptive Prevalence Rate (CPR) program to meet the MDG target of 67% across all districts, targeting those with the lowest rates.

2. Take specific efforts, such as by increasing the number and quality of trained health care and administrative personnel, to improve the quality of health care delivery senior citizen women suffering from different SRHR problems such as menopausal and uterine prolapsed.

3. Intensify Citizen Charter (CC) mechanisms to address problems in the access and delivery of sexual and reproductive health services, focusing on clarity, efficiency and transparency throughout all sectors of Nepal.

4. Readily available and affordable safe abortion quality services to women in need of it. This means services should be available at primary care level, with referral systems in place for all required higher-level care. Increase the number of CAC providers and trained health professionals at CAC centers and ensure their presence in facilities by allocating the necessary budget and improving monitoring systems for good-quality care.

5. Popularize CAC policies and services through authentic information and communications means via citizen charters in health facilities of the government and non-governments, electronic, print and other forms of media so as to increase access to information on availability of services and benefits ensuring context specific right –based continuum of quality care (CQC) for safe abortion.

6. Introduce a comprehensive abortion law that codifies the legal principles and establishes a concrete, rights based legal framework for ensuring access to affordable and high-quality safe abortion services.

7. Intensify educational program about HIV, treatment of HIV/AIDS and the legal rights especially in the workplace (including healthcare facilities), accompanied by clear guidelines and an awareness of the legal consequences of noncompliance.

8. Provide universal comprehensive sexuality education (CSE) and youth-friendly health services (YFHS) in a gender-responsive manner at all levels of formal education and informal education.

9. Implement Adolescent Sexual and Reproductive Health (ASRH) program in all 75 districts of the country.

10. Overcome local customs and laws, which are not in the favor of nation regarding early and child marriage, focusing on rural setting by empowering women such as providing free education at all level and job opportunities for girls.

11. Implement strong regulations against traditional harmful practices to women and girls such as *Chhaupadi*, child marriage, and various sexual rituals by educating and creating awareness on such practices.

12. Intensify educational program and increase compliance on marital rape a prosecutable crime as per Supreme Court decision, 2006.

13. Place a clear procedure for redress of discrimination against LGBTI which should be in place.

14. Fulfill the Women's right to Context-Specific, Rights-Based Continuum of Quality Care for Women's Reproductive Health in Nepal.

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Annex 1

Core International Human Rights Treaties

International human rights treaties	Signed Date	Ratification Date, Accession(a)
CERD - International Convention on the Elimination of All Forms of Racial Discrimination		30 Jan 1971 (a)
CRC - Convention on the Rights of the Child	26 Jan 1990	14 Sep 1990
CEDAW-Convention on the Elimination of All Forms of Discrimination against Women	05 Feb 1991	22 Apr 1991
CAT-Convention against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment		14 May 1991 (a)
CCPR - International Covenant on Civil and Political Rights		14 May 1991 (a)
CESCR - International Covenant on Economic, Social and Cultural Rights		14 May 1991 (a)
CCPR-OP2-DP - Second Optional Protocol to the International Covenant on Civil and Political Rights aiming to the abolition of the death penalty		04 Mar 1998 (a)
CRC-OP-SC - Optional Protocol to the Convention on the Rights of the Child on the sale of children child prostitution and child pornography	08 Sep 2000	20 Jan 2006
CRC-OP-AC - Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict	08 Sep 2000	03 Jan 2007
CRPD - Convention on the Rights of Persons with Disabilities	03 Jan 2008	07 May 2010

Source: University of Minnesota, Human Rights Library

About BBC

Beyond Beijing Committee (BBC) is a feminist human rights National Network Organization dedicated for achieving women rights, gender equality and sustainable development. It has grown from small seeds planted during the preparation for Pre-Beijing conference in 1994 by the then women rights activists and professionals of Nepal. Currently, it has over 182 NGOs members working for human rights of women and children. It is one of the founding members of South Asia Women Watch (SAWW) and Asia Pacific Women Watch (APWW). It is also the convener of Nepal Women Watch (NWW) formed in November, 2014.

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