

HUMAN RIGHTS PATHWAYS FOR A NEW SOCIAL CONTRACT

**Analysis of selected content of core and
other obligations under the right to health
in Nepal**

**Human Rights Pathways for a New Social
Contract:
Analysis of selected content of core and other
obligations under the right to health in Nepal**

This report is dedicated to all women who continue to face stigma, discrimination, and marginalization just because of where they live and work.



Human Rights Pathways for a New Social Contract: Analysis of selected content of core and other obligations under the right to health in Nepal

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(The research was completed in 2022, but its publication was delayed due to the COVID-19 pandemic and the extended publication timeline; nonetheless, the findings remain urgent and highly relevant today.)

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House no. 446/70, Amarawati Gate, Kumarigal, Gaurighat, Kathmandu

Email: communication@tarangini.org.np, advocacy@tarangini.org.np

Website: www.tarangini.org.np

Contact: 01-4114303

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PREFACE TO THE REPORT

“Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity”. This definition, adopted by the WHO in 1948, broadened the understanding of health beyond the absence of illness. Yet, even after 87 years of its adoption, health is still largely focused on illness and the means to address it. The denial of social determinants, which are largely responsible for a high percentage of illnesses and the limited cure for those illnesses, has played and continues to play an important role in preventing the commitment to “Health for All” from being realized.

According to the WHO, addressing the social determinants of health equity is fundamental to improving health and reducing long-standing inequalities. However, in a country like ours, despite health being constitutionally recognized as a fundamental right, there is still a long way to go before people’s right to health can be ensured or even before people begin to feel that they have an environment in which they can enjoy this right. This applies to all citizens of the country, but for women, who are often treated as a subordinate and marginalized group socially and even politically, the situation is far worse.

It is a well-known fact that women are not a homogeneous community; those from marginalized communities or engaged in marginalized and socially disapproved professions suffer the most. This research focuses on four groups of women: (i) women in the entertainment sector, (ii) sex workers, (iii) domestic workers, (iv) women affected by sexual violence during the conflict. The primary purpose of this report was to make these groups of women and their realities as visible as possible. By highlighting violations of their rights in their own voices and by shedding light on their health needs, the report attempts to center the rights of “women in the shadows.” More specifically, the study set out to identify a Minimum Essential Package (MEP) of sexual and reproductive health (SRH) for these four groups of women. To this end, it draws on their testimonies and analyzes their issues within a human rights framework.

In attempting to identify the key elements of the Minimum Essential Levels (MEL) of the right to health for the purpose of costing a minimum health package, it became apparent that this task is far more complex and complicated than initially envisaged.

It became evident that these groups have been marginalized, stigmatized by society and ignored by mainstream politics, the government, and even within the women's movement. In Nepal, women's work, struggles, and suffering are largely hidden in the shadows. The unpaid care work performed by women daily remains unrecognized and undervalued. Nepali women carry a "double" or "triple" burden of earning, caregiving, and housekeeping. Countless rural women endure such heavy workloads that uterine prolapse has become pervasive among them. On the other hand, the legacy of war still haunts many of them. Rape and sexual violence during the internal armed conflict (1996-2006) went largely ignored by the State for the longest time and is still not adequately addressed even today. Nepali women have shown extraordinary strength and resistance throughout history, but patriarchy, conflict, and poverty have long tried to drown these voices. This report springs from that lived experience: we refuse to let another generation forget what women in Nepal have endured.

Nepal's laws formally promise health and equality. Article 35 of the Constitution guarantees every citizen "the right to free basic health services", and other provisions explicitly protect women's dignity, safe motherhood, and freedom from violence. Yet, in practice, despite some sincere government efforts that have led to positive outcomes such as reduced maternal mortality, many groups of women are still treated as if they do not exist. Police routinely harass sex workers over possession of condoms, policing women's bodies instead of protecting their health. Nearly half a million domestic workers in Kathmandu earn a few thousand rupees a month and toil long hours, often denied even basic facilities like toilets or nutritious food. So is the case for women in the entertainment sector and women affected by the decade-long conflict.

In our focus groups during the research phase of this report, we saw how control over bodies, identities, and labor collide to devalue women. Domestic workers in slums, often poor, migrants, or from marginalized castes, grind day and night for meager pay, suffering chronic pain, reproductive disorders, and constant anxiety. Women in the entertainment sector, many underage or single mothers, are treated as disposable. One told us she had "neither citizenship nor a registered marriage," her husband abandoned her for working, and even while pregnant, she was forced to drink for clients. Female sex workers, frequently escaping violence or starvation, live under a cloud of shame as society labels them as diseased or criminal. And in remote districts like

Rukum, conflict survivors carry trauma in their bodies and face mental health crises; yet there is no adequate, appropriate, and accessible support for them.

In every case, stigma seals their lips. One woman admitted she felt “ashamed even to discuss any symptoms” because of her poverty and status and believed she was suffering because of wrongdoings in a past life. These women’s sufferings are not incidental. They reveal how caste, class, work, and other structural barriers make a woman’s life disposable in our society.

The evidence in this report is clear and uncompromising. Women’s stories are hidden no more, and we demand that Nepal’s social contract finally serve them. The Constitution’s guarantees must be realized, and the right to health cannot be a luxury for the well-to-do only. It is crucial that the government focus on these groups, who have waited far too long to be recognized as equal citizens, workers, and above all, human beings with the right to live with dignity and respect. The right to health cannot be realized without addressing social determinants such as recognizing women’s work as work, treating them as workers and citizens with citizenship, ensuring proper working conditions, access to nutritious food, and an environment free from humiliation, stigma, and violence in both public and private life. Policymakers must recognize this and act accordingly. Otherwise, investing millions of dollars in health and developing a minimum essential package (MEP) with the intention of fulfilling people’s right to health will not yield desired outcomes. Without addressing these issues, the government cannot fulfill its human rights obligations under the various human rights treaties to which Nepal is a party.

Through this publication, we center the rights of “women in the shadows,” who can now see themselves reflected in these pages. We call on all levels of government to invest in addressing social determinants so that their commitment to the right to health can finally become a reality.

This report is a joint effort of Nepal Mahila Ekata Samaj (NMES), Jagriti Mahila Maha Sangh (JMMS), and Women Forum for Women in Nepal (WOFOWON) working together on this research. Tarangini Foundation extends heartfelt gratitude to the board members and staff of our partner organizations for making this research possible, even in a very difficult period. This collaboration with self-representative organizations is proof that these findings are not merely academic but lived realities.

I would also like to thank WOREC Nepal's Rukum West team for their facilitation at the local level. My heartfelt appreciation goes to Late Bhupendra Budha Magar, who is sadly no longer with us, for her tireless efforts to reach women affected by conflict and to collect information through individual interviews and focus group discussions. As we publish this report, we deeply feel her absence. May she rest in peace. Without their support, it would have been difficult to reach the women still living with the pain and trauma of conflict in their bodies, struggling to be recognized as a conflict-affected group.

Special gratitude goes to Tarangini team members, Lumanti Siddhi Bajracharya and Ayushi Bam for their hard work in making this research possible. With everyone's efforts, Tarangini Foundation presents this report to catalyze the change we have all been demanding for years.

It would also be unfair to claim that this report is solely the product of activists' work. A substantial portion of the report was prepared by Dr. Dadhi Adhikari, Economist, who calculated the government's resource requirements to ensure the availability of SRHR services for all citizens. His framework, rigorous analysis, and in-depth research, particularly in identifying the key elements of the Minimum Essential Package (MEP) of obligations and related budget allocations and laid the foundation of this report. We sincerely thank him for his hard work and contributions.

Finally, this report would not have been possible without the financial and technical support of the Office of the High Commissioner for Human Rights (OHCHR). Our special thanks go to the OHCHR ESCR/Surge Team for their multiple rounds of review, editing, and analytical input. I extend particular gratitude to Dr. Jyoti Sanghera for dedicating her time to this report and for consistently centering marginalized perspectives. As always, I am deeply grateful to her. I also thank Swarnima Bhandari of UNDP Nepal for her coordination, support, and encouragement throughout the research period and beyond.

It took a long time to publish this report for various reasons, but we are glad it is finally out, even three years after the research. We acknowledge that several years have passed since we collected the information, yet the evidence strongly shows that the context and situation of the women interviewed have not changed. Thus, the recommendations in this research remain valid and grounded.

Mr. Pradeep Wagle, Head of the ESCR Division, OHCHR Geneva, deserves special thanks. Without his support and facilitation, we could not have brought this report to this stage. I also want to express deep gratitude and appreciation to Ashlesha Joshi from Tarangini Foundation for her tireless efforts to edit, design, and push for this publication. Finally, I thank all who were directly or indirectly involved in this research and publication for helping bring it to this shape and stage.

Let us hope this report serves as a tool for transformation for all of us working to create an environment where every citizen can enjoy their right to health.

Sincerely,

A handwritten signature in black ink, appearing to read 'Renu Adhikari', with a horizontal line underneath.

Dr. Renu Adhikari

Founder

Tarangini Foundation



HAUT-COMMISSARIAT AUX DROITS DE L'HOMME • OFFICE OF THE HIGH COMMISSIONER FOR HUMAN RIGHTS

PALAIS DES NATIONS • 1211 GENEVA 10, SWITZERLAND

www.ohchr.org • TEL: +41 22 917 9000 • FAX: +41 22 917 9008 • E-MAIL: ohchr-registry@un.org

Foreword by Mr. Pradeep Wagle, Chief of ECSR Section, OHCHR

As a fundamental human right, enshrined in international human rights law, the right to health requires States to ensure that all individuals – without discrimination - have access to quality, affordable, acceptable and timely health services. Sexual and reproductive health is a key component of the right to health. It is at the core of women’s right to make their own choices about their bodies and lives, free from discrimination, violence and coercion.

Yet, for many, life-saving care, including vaccines, essential medicines, mental health support, and sexual and reproductive health services, remains out of reach. This is not only a public health crisis, but a human rights failure, deeply rooted in inequalities, discrimination and the denial of rights. The right to health, therefore, requires going further: it demands action to dismantle systemic barriers, address underlying determinants, and empower those most at risk.

As a party to the International Covenant on Economic, Social and Cultural Rights, Nepal has translated its international right to health obligations into its Constitution, which recognizes the right to safe motherhood and reproductive health, further protected under key legislation, such as the Public Health Service Act or the Right to Safe Motherhood and Reproductive Health Act. However, the intersecting impacts of poverty, informal labour, and social stigma create serious barriers to access to sexual and reproductive health care. In this report, supported by the OHCHR, the Tarangini Foundation sheds light on the lived experiences of women engaged in sex work, domestic work, and entertainment work and who are most at risk of discrimination and marginalization, and whose health needs are consistently overlooked in policies and the provision of health services. The Tarangini Foundation’s leadership in this area reflects its deep commitment to advancing women’s rights through community-based research, trauma-informed care, and practical, rights-based policy engagement.

The findings in this report highlight the existing gap between Nepal's international human rights obligations and the lived realities of women left the farthest behind. They offer a solid evidence base for policy makers and advocates and should serve as a catalyst for concrete action towards advancing the right to health for all in Nepal. As the report underscores, doing so will require addressing broader social determinants, such as access to food, housing, water and sanitation, decent work, and protection from discrimination and violence. Concretely, the findings and recommendations from the report can ensure that future policies and allocation of resources are informed by international human rights standards, particularly efforts to further define and implement a minimum essential package of sexual and reproductive health.

Moving forward, our Office remains committed to continued collaboration with civil society and national actors to further elevating the voices of those at heightened risk of right to health violations and to transform this important research into policy and practice.

P. Wagle

4 August 2025

ABOUT THE COLLABORATING ORGANIZATIONS OF THIS RESEARCH

Nepal Mahila Ekata Samaj (NMES) is a national network of women from landless and informal settlements, working across 40 districts of Nepal. NMES is working as a network recognizing the deep discrimination faced by landless women, who are often doubly marginalized for both their gender and housing status. The organization focuses on social, economic, and political empowerment, skill and capacity development, resisting forced displacement, and challenging patriarchal norms so that landless women can live with dignity and create a just society for all.

Jagriti Mahila Maha Sangh (JMMS) is a national, peer-led federation of women working in the sex industry, bringing together 33 community-based organizations across 25 districts of Nepal. Entirely led by women sex workers, JMMS works to protect their rights, improve occupational safety, and ensure fair access to health care and HIV prevention services. The federation advocates for the recognition of sex work as legitimate work, calls for its decriminalization, and actively confronts stigma, discrimination, and violence from police, institutions, clients, and society. By amplifying the voices of sex workers and building collective strength, JMMS strives to secure respect, rights, and equality for all women in the sex industry.

Women Forum for Women in Nepal (WOFOWON) is the first non-governmental organization in Nepal dedicated to protecting and promoting the rights of women working in the entertainment and hospitality sectors, such as dance bars, dohori restaurants, cabin restaurants, spas/massage centers, and snack houses. Established in 2008, WOFOWON has been at the forefront of the fight against violence, exploitation, harassment, and discrimination faced by women workers, striving to ensure safe, dignified, and violence-free workplaces. Through public awareness campaigns, capacity-building programs, advocacy, and by organizing women workers into unions and groups, WOFOWON empowers them to defend their rights, challenge deeply rooted patriarchal practices, and create a future where women can work with dignity—free from violence, exploitation, and in social justice.

TABLE OF CONTENTS

ABBREVIATIONS	3
LIST OF TABLES	iii
1. BACKGROUND	6
1. HUMAN RIGHTS FRAMEWORK AND CONTEXT	9
1.1 Development Status of Nepal	11
1.2 Sexual and Reproductive Health and Rights in Nepal	13
1.3 COVID-19 and Women’s Health	15
2. METHODOLOGY	17
2.1 Focus Group Discussions	18
3. PROFILES OF WOMEN IN THE STUDY	19
3.1 Women in the Entertainment Sector	19
3.2 Sex Workers	20
3.3 Domestic Workers	21
3.4 Conflict-Affected Women	21
4. Key Findings of the Focus Group Discussions	23
4.1 Sexual and Reproductive Health Issues	23
4.2 Additional Issues (Social and Economic)	28
4.3 Specific Issues of Conflict-affected Women	30
4.4 Health-seeking Behavior	30
4.4.1 Alternative remedies	31
4.4.2 Home remedies	31
4.5 Healthcare Expenditure	34
5. DEFINING A MINIMUM ESSENTIAL PACKAGE FOR SEXUAL AND REPRODUCTIVE HEALTH	36
5.1 International Standards and Recommendations	38
5.2 Nepal’s Legal and Policy Frameworks	38
5.3 Proposed Minimum Essential Package for Sexual and Reproductive Health Services	40

6. OVERVIEW OF NEPAL'S HEALTH SYSTEM.....	41
7. PUBLIC EXPENDITURE ON HEALTH AND SEXUAL AND REPRODUCTIVE HEALTH.....	51
7.1 Health Sector Budget and Expenditure	53
7.2 Sexual and Reproductive Health and Expenditure	55
7.3 Ayurveda and Alternative Medicine Budget and Expenditure.....	56
8. DISCUSSION AND CONCLUSION.....	57
9. RECOMMENDATIONS.....	61
9.1 General Recommendations	61
9.2 Recommendations for Entertainment Sector Workers and Female Sex Workers 61	
9.2.1 Sexual and Reproductive Health.....	62
9.2.2 Nutrition.....	62
9.2.3 Curative Services	64
9.3 Recommendations for Domestic Workers	64
9.3.1 Sexual and Reproductive Health.....	64
9.3.2 Nutrition.....	64
9.3.3 Curative Services	65
9.4 Recommendations for Conflict-affected Women	65
9.4.1 Sexual and Reproductive Health.....	65
9.4.2 Curative Services and NCD Control.....	65
9.5 Recommendations for SRH Budgeting	66
<i>Annex 1: Constitutional Rights Pertaining to Women in Nepal.....</i>	<i>68</i>
<i>Annex 2: Guttmacher-Lancet Commission's recommendation</i>	<i>79</i>

ABBREVIATIONS

AIDS	: Acquired Immunodeficiency Syndrome
APWLD	: Asia Pacific Forum on Women, Law and Development
CBS	: Central Bureau of Statistics
CEDAW	: Convention on the Elimination of all Forms of Discrimination Against Women
CESCR	: Committee on Economic, Social and Cultural Rights
COVID	: Corona Virus Disease
CSO	: Civil Society Organization
DHS	: Demographic Health Survey
FGD	: Focus Group Discussion
FPAN	: Family Planning Association Nepal
GBV	: Gender Based Violence
GDP	: Gross Domestic Product
GEFONT	: General Federation of Nepalese Trade Union
GoN	: Government of Nepal
HDI	: Human Development Index
HIV	: Human Immunodeficiency Virus
HMIS	: Health Management Information System
HP	: Health Post
ICESR	: International Covenant on Economic, Social, and Cultural Rights
IHDI	: Inequality-adjusted Human Development Index
IHME	: Institute for Health Metrics and Evaluation
INGO	: International Non-governmental Organization
JMMS	: Jagriti Mahila Maha Sangh
LMBIS	: Line Ministry's Budget Information System
MEP	: Minimum Essential Package
MNH	: Maternal and Newborn Health
MoHP	: Ministry of Health and Population
MSI	: MSI Reproductive Choices
NCD	: Noncommunicable Disease

NGO	: Non-Governmental Organization
NHSSP	: Nepal Health Sector Support Program
NLSS	: Nepal Living Standard Survey
NMES	: Nepal Mahila Ekta Samaj
NPISH	: Non-Profit Institutions Serving Households
NPR	: Nepalese Rupee (Currency of Nepal)
NSRU	: National Strategy for Reaching the Unreached
NWC	: National Women Commission
OHCHR	: Office of the United Nations High Commissioner for Human Rights
OOP	: Out of Pocket Expenditure
POP	: Pelvic Organ Prolapse
RCO	: Resident Coordinator's Office
SDG	: Sustainable Development Goal
SDH	: Social Determinants of Health
SRH	: Sexual and Reproductive Health
SRHR	: Sexual and Reproductive Health Rights
STI	: Sexually Transmitted Infection
SuTRA	: Subnational Treasury Regulatory Application
UNSCR	: United Nations Security Council Resolution
UP	: Uterine Prolapse
USD	: United States Dollar
WDI	: World Development Indicator
WHO	: World Health Organization
WOFOWON	: Women Forum for Women in Nepal
WRA	: Women of Reproductive Age

LIST OF TABLES

Table 1: Number of Participants and Place of FGD	13
Table 2: SRH related issues based on focus group discussion	17
Table 3: Health care service utilization cost based on information shared by FGD participants	28
Table 4: Functions of Responsibilities of Three Tiers of Government	35
Table 5: Selected health sector indicators over time	42
Table 6: Health Sector Budget and Expenditure	47
Table 7: Per WRA SRH budget and expenditure-2019/20	50

1. BACKGROUND

This report is an analysis of the reproductive and sexual health rights of four of the most marginalized and discriminated groups of women in Nepal. Confined to the deepest and most exploitative layers of work in the informal and unorganized sectors, this study examines the plight

of women in sex work, entertainment work and domestic work in accessing their health needs. Additionally, it sheds light on a fourth category of women – those affected by sexual violence during the decade-long political armed conflict in Nepal in the remote region of Rukum. All four groups remain marginalized and invisible due to their social, economic, and geographic location, which prevents them from accessing government policies and

*“In the summer, due to COVID-19, my employer told me that they planned to do all their domestic chores by themselves. They asked me not to report to work anymore. It became difficult to sustain myself and my children as I had no other livelihood options. However, with the onset of winter, Kathmandu gets really cold, and people don’t want to do their daily household chores by themselves. I received several offers for household work. In my line of work, I have to leave my children alone at home all day, otherwise I can’t feed them. Due to heavy household chores, washing clothes with cold water, I began to suffer from lower back pain and excessive bleeding during menstruation. Despite the pain, I had no option but to continue with my work. Even though my wages are very low, my work is heavy and very much stigmatized (people look down on me) I need to feed myself and my children. I fear that if I ask for a wage increase, I will be laid off. At present I earn Nepali Rupees (NPR) 4,000 from working at the Montessori school and NPR 8,000 from my domestic work job. My insecure situation gives me sleepless nights. I worry all the time for the future of my children and suffer from constant anxiety and ill health.” – **Testimony of a domestic worker.***

health schemes. This report aims to give voice to the realities and health concerns of these women, who have been left the farthest behind during Nepal’s development journey.

The duration of the COVID-19 pandemic was particularly deadly for the groups of women included in this study – sex workers, entertainment workers and domestic workers, who provide specialized, intimate, and personalized services in private or domestic settings, for whom, the possibility of remote work for them is not an option. Consequently, the precarity of their work

conditions was further exacerbated by intimate contact with customers and employers during this time. The women were rendered even more vulnerable through physical contact with customers and employers to either infections or loss of livelihoods with a fall in clientele or lay-offs. They also reported that, on account of a decline in their bargaining abilities during the pandemic, they were either forced to endure violence, forced unprotected sex or suffer a loss of income.

*“Earlier, my working hours in the entertainment sector were from 6 pm to 10:30 am, but due to COVID-19, now we must complete our work by 10 pm. Payment has been arranged according to the ability of each person. There is no provision for leave. Salary ranges from NPR 8,000 to 15,000. We receive an identity card and transportation to drop us home. If the working environment in the entertainment sector could be good, it would be easy for us to move forward. It is not possible to save much by working, but there is no need for me to depend on anyone, I can earn and look after my child. Everything has changed because of the pandemic. Room rent has been raised. I have not been able to pay my rent for three months. Not being able to go to work due to the lockdown, not being able to sing and perform is causing me great economic and mental stress.” – **Testimony of an entertainment sector worker.***

Lockdowns forced the women in sex work and the entertainment sector to go ‘underground’ to find customers and, as a result, expose themselves further to precarious work environments. Domestic workers reported being laid off during the height of the pandemic. The COVID-19 pandemic further initiated an added burden on the women of conflict-affected areas, as there was no access to sexual and reproductive health facilities.

This report discusses the several barriers these women face in realizing their right to health, particularly, sexual and reproductive health. Whilst their specific occupations render them especially vulnerable to health problems, their obvious key concerns and barriers relate to poverty, lack of secure employment, and discrimination. Women in sex and entertainment work are particularly vulnerable to stigma and therefore, live hidden lives on account of the shame directed towards them due to the nature of their work. Consequently, all women in this study are at a higher risk of sexual violence due to their social status. Their invisibility as marginalized women renders them invisible even to government health schemes and service providers who perpetuate the same level of discrimination and exclusion as society does.

The primary purpose of this report is to make these groups of women and their realities as visible as possible. By highlighting violations of their rights as relayed to us in their own voices, and by

*“My husband left me when my son was 7 years old. To support my son and myself, I started to work as a sex worker. During the 2nd wave of lockdown, I could not earn anything, and I also spent a small saving on my treatment. Life was very tough as there was no food for us. At that time, one of my old clients called me for work which was a big relief. I earned NPR 1,000 that day and bought some rice, groceries, and my medicine for diabetes. As I arrived home my landlord was standing inside the gate and demanded the house rent which was 3 months overdue.” – **Testimony of a sex worker.***

shedding light on their health needs, an attempt is made to center the rights of “women in the shadows”.

More specifically, this study started by aiming to identify Minimum Essential Package

(MEP) of sexual and reproductive health (SRH) of the four groups of women, namely, female sex workers, entertainment sector workers, domestic workers, and conflict-affected women. For this purpose, the study focuses on live testimonies of the women and analyzes their issues within a human rights framework.

In attempting to identify the key elements of the Minimum Essential Levels (MEL) of the right to health for the purpose of costing a minimum health package, it became apparent that this task is far more complex and complicated than initially envisaged. The limited time allocated to the study and non-availability of data did not help. However, the major considerations that hindered the process were several underlying determinants of the right to sexual and reproductive health of the concerned women. The right to nutritious food, safe water and sanitation, land, adequate housing, and property, decent work and an adequate standard of living, social security and freedom from violence and abuse, all emerged as significant and essential determinants for the realization of their right to health and SRH. Above all, discrimination and stigma were listed as a prime problem which affected their right to health. All these determinants are difficult to concretely factor into a minimum health package and be assigned a monetary value.

Consequently, the report signals some important substantive elements for a Minimum Essential Package and discusses the Government of Nepal (GoN)’s budget allocation consideration for the right to health and sexual and reproductive health. To achieve a degree of standardization, a review

of the macroeconomic situation, health status and legal environment for sexual and reproductive health in the country is presented, followed by the identification of a suggested Minimum Essential Package based on international standards, domestic legal provisions and recommendations gleaned from discussions with the affected women themselves. Finally, the report analyzes allocation of resources in the sexual and reproductive health sector, followed by a discussion on the recommendations.

1. HUMAN RIGHTS FRAMEWORK AND CONTEXT

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

- World Health Organization (WHO) Constitution

The Constitution of Nepal and other sectorial provisions in the law enshrine this principle with regard to health. Nepal's Constitution marks the right to health as a fundamental human right. According to Article 35, "Every citizen shall have the right to free basic health services from the State, and no one shall be deprived of emergency health services".¹ It clearly mentions the basic policies related to health that the government should adopt in order to fulfill this fundamental right of all citizens.² The Constitution also enshrines different provisions to ensure the human rights of Nepali citizens and to some extent to non-citizens, including the right to live with dignity (Article 16), freedom (Article 17) and equality (Article 18), and it guarantees specific rights to women such as safe motherhood and reproductive health (Article 38.2), and protection from various forms of violence (Article 38.3) to address specific issues and concerns.³

Nepal is also party to various legally binding international human rights treaties including the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) (1979), and the International Covenant on Economic, Social, and Cultural Rights (ICESR) (1966). These two treaties are key in terms of implementing the right to health and bind Nepal to abide by the rights enshrined in them, the recommendations of the treaty bodies as well as to present regular reports. In addition, Nepal has committed to support to the rights of women through measures to

¹ Constitution of Nepal. Part 3, Article 35(1), 2015.

² Constitution of Nepal. Part 3, Article 51(h), 2015.

³ Details of these constitutional rights are listed in Annex 1 of this report.

realize the Universal Declaration of Human Rights (1948), The International Conference on Population and Development, Cairo, 1994 and the Beijing Declaration and platform for Action, adopted at the fourth world conference on women in September 1995, Beijing and the 2030 Agenda for Sustainable Development including its related goals. Nepal is also a party to seven of the core nine human rights treaties.⁴

The right to health is determined by several factors, including but not limited to: equality of opportunity for everyone to enjoy the highest attainable level of health⁵; right to preventive care, treatment and control of diseases; access to essential medicines; equal and timely access to basic, affordable quality health services including a range of “social determinants.” The World Health Organization’s Commission on the Social Determinants of Health (SDH) has defined them as “the conditions in which people are born, grow, live, work and age” and “the fundamental drivers of these conditions.”⁶ The term “social determinants” often evokes health-related features of neighborhoods and food (e.g., walkability, recreational areas, and accessibility to nutritious foods), which can influence health-related behaviors. Evidence has been accumulated, pointing to socioeconomic factors such as income, wealth, and education as the fundamental causes of a wide range of health outcomes. Recent surveys reveal that there are clear discrepancies in health service utilization by sex, age, education level, geography, and wealth quintile.⁷

Considering time and resource constraints, this study explores measures taken by the government to realize the right to the health of: (a) female sex workers; (b) women working in the entertainment sectors; (c) women who are living in the slum areas of metropolitan Kathmandu and working as domestic workers; and (d) conflict-affected women⁸ with a focus on their sexual and reproductive health and rights. The major objective of this study is to identify the Minimum Essential Package

⁴ All treaties except the International Convention on the Rights of Migrant Workers and Members of Their Families and the Convention on the Protection of Victims of Enforced Disappearances.

⁵ United Nations. *International Covenant on Economic, Social and Cultural Rights*. Article 12, 1966.

⁶ Braveman, P., and Gottlieb, L. The Social Determinants of Health: It’s Time to Consider the Causes of the Causes. *Public Health Reports*, 129(1_suppl2), 2014, pp. 19–31. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863696/>

⁷ World Health Organization. *Measuring and addressing health inequities in Nepal*. 2021. <https://www.who.int/news-room/feature-stories/detail/nepal2021>

⁸ Located in the western hilly district Rukum of Nepal, residents of these villages were severely affected by the decade long conflict up to the early 2000s. Women and girls, in particular, were affected by the conflict-related sexual violence with ongoing grievous impacts on mental health.

of sexual and reproductive health and rights (SRHR) interventions that move towards the full realization of the right to health for these four groups of women.

For this purpose, this study compares the Minimum Essential Package suggested by international standards, Nepal's legal and policy framework, and the focus group discussions.

This study also analyzes the public expenditure on the health sector allocated to SRH.⁹ The analysis has been carried out for all three levels of government: federal, provincial, and local. Since Ayurvedic and alternative medicines are also widely used in Nepal, entailing a lot of women's knowledge and traditional healing practices, and in line with the government's encouragement of their use, the public expenditure in Ayurveda and alternative medicines has also been analyzed.

1.1 Development Status of Nepal

Nepal is ranked amongst the Least Developed Countries; it is expected to graduate to a (lower) middle-income country by December 2026. As of 2020, the Gross Domestic Product (GDP) per capita of Nepal was USD 1,155¹⁰ and the latest estimated Gini Coefficient was 0.3¹¹. The country's Human Development Index (HDI) and Inequality-adjusted HDI (IHDI) in 2019 were 0.587 and 0.444 respectively¹². Although the HDI and IHDI values are improving gradually, there is a wide disparity among geographical regions and provinces. For example, while the IHDI for Bagmati province, which contains the capital city of the country, is 0.502, it is only 0.375 for the Karnali province.¹³ Similarly, while the IHDI value for the mountain region is 0.405, it is 0.453 for the hill region.¹⁴

The annual average growth rate of the real GDP for the period of 1990-2020 remained only 4.4%, about one percent less than the average annual growth rate of the South Asian region¹⁵. However, the average annual growth rate in the first three years after the devastating earthquake in 2015

⁹ In the beginning this study aimed to estimate the cost required to provide MEP of SRH. However, due to lack of time, and monetary resource, difficulty on finding a medical expert having experience in the SRH issues of the study group the idea of estimating cost was abandoned.

¹⁰ World Bank. *GDP per capita (current US\$) – Nepal*. 2020. Available at <https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=NP>

¹¹ National Planning Commission, Government of Nepal, and United Nations Development Programme (UNDP). *Nepal Human Development Report 2020*. Kathmandu, Nepal: National Planning Commission and UNDP, 2020. Available at: <https://hdr.undp.org/system/files/documents/nhdr2020nepal.pdf>

¹² Ibid.

¹³ Ibid.

¹⁴ Ibid.

¹⁵ Calculated using WDI data.

exceeded 7%, owing to heavy reconstruction investment. But the COVID-19 pandemic led to a reduction again of the growth rate to negative 2% in 2020.

The poverty rate in the country is declining gradually. While 25.16% of the total population was below the poverty line in 2009-10¹⁶, it declined to 18.7 % in 2017-18¹⁷. Similarly, as of 2019, 4.3% of the employed population are living below \$1.9 PPP a day¹⁸. However, it is expected that the COVID-19 pandemic has pushed many more families below the poverty line.

The unemployment rate in the country has marginally declined from 3.1% of the total labor force in 2015 to 3.09% in 2019. However, mostly due to COVID-19 containment measures, the unemployment rate increased to 4.72% in 2020 – an all-time high since 1991¹⁹. There is a marginal gender disparity in the unemployment rate. The International Labor Organization’s estimate shows that the female unemployment rate (% of the female labor force) increased from 2.88% in 2015 to 4.53% in 2020 whilst the male unemployment rate (% of the male labor force) increased from 3.38% to 4.96% during the same period²⁰.

Nepal’s public expenditure, after the adoption of federal system of governance, is increasing rapidly. Total national expenditure that includes the expenditure made by all three levels of government increased from NPR 601 billion (USD 5.7 billion) in 2015/16 to NPR 1,284 billion (USD 113.81 billion)²¹. Furthermore, the share of local and provincial level government’s expenditure on total expenditure also increased from 17.1% in 2017/18 to 30.4% in 2019/20.²² In terms of ratio with GDP, national expenditure as the percentage of GDP increased from 27% in 2015/16 to 42% in 2019/20.

¹⁶ Central Bureau of Statistics. *Poverty in Nepal: A Brief Report Based on Nepal Living Standard Survey–III (2009–10)*. Central Bureau of Statistics, 2011. Kathmandu.

¹⁷ Government of Nepal, Ministry of Finance. *Economic Survey 2019/20*. Singh Durbar, Kathmandu, May 2020. Available at: https://old.mof.gov.np/uploads/document/file/Economic%20Survey%202019_20201125024153.pdf

¹⁸ Asian Development Bank. *Poverty in Nepal*. Asian Development Bank. Available at <https://www.adb.org/where-we-work/nepal/poverty#accordion-0-0>

¹⁹ World Bank. *Unemployment, total (% of total labor force) (modeled ILO estimate) – Nepal*. 2024. Available at <https://data.worldbank.org/indicator/SL.UEM.TOTL.ZS?locations=NP>

²⁰ World Bank. *Unemployment, Male (% of total male labor force) (modeled ILO estimate) – Nepal*. 2024. Available at <https://data.worldbank.org/indicator/SL.UEM.TOTL.MA.ZS?locations=NP>

²¹ Calculated using data available from the budget details of the federal government, provincial government and local level governments.

²² Ibid.

1.2 Sexual and Reproductive Health and Rights in Nepal

Efforts to improve the overall status of women has brought significant changes in women's health in Nepal. For example, 34.5 percent of women in 2016 (compared to only 12.1 percent in 2001) reportedly make decisions about their own health individually or jointly with their intimate partners.²³ Similarly, an increase in education levels and access to mobile phones have contributed to better health outcomes for women.²⁴

Due to gendered roles and responsibilities, women bear the primary responsibility of managing households in Nepal. Results from a survey carried out by the Himalayan Climate Initiative²⁵ show that 28% of the total women faced increased household workload due to COVID-19 lockdowns, and 35% women faced challenges in balancing their income-generating activities with household responsibilities. Resource constraints, increased household work burden, unemployment, and the ensuing poverty increased stress levels for women.²⁶

Analysis from this study points out that women who constitute the primary focus of this inquiry, i.e., women domestic workers, entertainers, sex workers, and women affected by the conflict in Rukum, especially those with chronic diseases, have been hit the hardest. Strong taboos surrounding sexuality and reproductive health have produced further adverse impacts on these women.²⁷

In Nepal, teenage pregnancy is fairly high, at 17 percent between the ages of 15-19 years.²⁸ Child marriage is prevalent in both rural and urban areas. The percentage of child marriage (under 18 years) in urban areas is 35.5% and in rural areas is 41.5% according to the 2019 Multiple Cluster

²³ Ministry of Health and Population (Nepal), New ERA, and ICF. *Nepal Demographic and Health Survey 2016*. Kathmandu, Nepal: Ministry of Health and Population, 2017. Available at: <https://www.dhsprogram.com/pubs/pdf/fr336/fr336.pdf>

²⁴ Ibid.

²⁵ The Asia Foundation and Himalayan Climate Initiative. *COVID-19 & The New Normal for Women in the Economy in Nepal*. 2021. Available at: <https://asiafoundation.org/wp-content/uploads/2021/03/Covid-19-The-New-Normal-for-Women-in-the-Economy-in-Nepal.pdf>

²⁶ Ibid.

²⁷ Rothchild, J., and Piya, P.S. Rituals, Taboos, and Seclusion: Life Stories of Women Navigating Culture and Pushing for Change in Nepal. In: Bobel, C., Winkler, I.T., Fahs, B., Hasson, K.A., Kissling, E.A., and Roberts, T.A., editors. *The Palgrave Handbook of Critical Menstruation Studies*. Singapore: Palgrave Macmillan, 2020. Available at: https://doi.org/10.1007/978-981-15-0614-7_66

²⁸ Pokharel, S., and Adhikari, A. Adolescent Sexuality Education in Nepal: Current Perspectives. *Creative Education*, 12(7), 2021, pp. 1744–1754.

Indicator Survey conducted by the Government of Nepal²⁹. Teenage mothers have poor knowledge of reproductive health and hygiene, which puts their life and that of the newborn at risk.³⁰ Adolescents mostly obtain knowledge on sex education, HIV/AIDs, abortion, and menstrual hygiene from magazines and their peers.

Unpaid care work, which has traditionally been done by women, is as unrecognized and undervalued in Nepal as in other parts of the world. During COVID, women had to suffer a triple work burden – women are expected to look after the family and household chores, those working outside their home and engaged in agriculture have the responsibility to earn for their livelihood and thirdly due to the pandemic, women have extra responsibility to look after their family members at home. Suffering under this triple work burden, women in rural areas carry heavy loads and are prone to uterine prolapse (UP). UP is pervasive across Nepal, with more than one million women affected.³¹ In the rural and remote regions of Nepal in particular, women suffer from problems such as Sexually Transmitted Infections (STI), Pelvic Organ Prolapse (POP), menstrual disorders, and subfertility. The situation is even worse for women working in sectors which are not recognized and stigmatized such as women domestic workers, sex workers, and entertainers.

Gender-based violence against women is a persistent phenomenon.³² Gender-based violence has been included as one of the elements within reproductive health services to be covered by the Government of Nepal. However, these services are either limited or absent, and of very low in quality when provided. Sexual violence is an increasing trend. Survivors of sexual violence during the conflict (1996-2006) have, however, not been considered as a specific group entitled to remedy and redress. The government's interim relief package which came out in 2008³³ as a first step in carrying out the Comprehensive Peace Agreement's (CPA) obligations for providing relief to

²⁹ Central Bureau of Statistics (CBS) and UNICEF Nepal. Nepal Multiple Indicator Cluster Survey 2019: Survey Findings Report. Kathmandu, Nepal: Central Bureau of Statistics, 2020. Available at: <https://www.unicef.org/nepal/media/11081/file/Nepal%20MICS%202019%20Final%20Report.pdf>

³⁰ Shrestha, S. Sexual and Reproductive Health of Adolescent in Nepal. *Journal of Karnali Academy of Health and Science*, 2(2), 2018, pp. 65–66.

³¹ Shrestha, B., Devkota, B., Khadka, B.B., Choulagai, B., Pahari, D.P., Onta, S., Petzold, M., and Krettek, A. Knowledge on uterine prolapse among married women of reproductive age in Nepal. *International Journal of Women's Health*, 6, 2014, pp. 771–779. Available at: <https://doi.org/10.2147/IJWH.S65508>

³² The Borgen Project. Domestic Violence in Nepal. Available at: <https://borgenproject.org/domestic-violence-nepal/>

³³ International Organization for Migration (IOM). Mapping Exercise and Preliminary Gap Analysis of Interim Relief and Rehabilitation Programme. IOM, 2010. Available at: <https://www.iom.int/sites/g/files/tmzbdl2616/files/2018-07/Mapping-Excercise-of-Interim-Relief-and-Rehabilitation-to-the-Victims-of-Nepals-Armed-Conflict.pdf>

displaced individuals and other conflict victims³⁴, did not consider survivors of sexual violence during the conflict as persons illegible to get reparations. Despite this, 326 cases of sexual violence have been registered in the government-formed Truth and Reconciliation Commission. As the Commission's impartiality and functioning has been seriously questioned by the human rights community, a lot of women hesitated to report the cases out of fear for their anonymity. This situation has created an environment to foster impunity, leading to evermore increasing sexual violence, which creates a vicious cycle and even more barriers to justice for the survivors of sexual violence. These issues further augment women's sexual, reproductive and mental health concerns.

While the Second National Action Plan related to UNSCR 1325 an 1820 has been approved by the government, making cases of conflict-related sexual violence eligible to be considered for reparations, the modality of its implementation and function still remains ambiguous.

1.3 COVID-19 and Women's Health

The COVID-19 pandemic adversely affected Nepal's health system. On the one hand, lockdowns forced several health facilities to shut down and on the other, lack of transportation and other facilities prohibited patients from accessing health centers providing treatment and services. Similarly, impromptu shutdowns of the informal sector work sites affected women's livelihoods and consequently, their mental health. Malnutrition, mental health, gender-based violence and other social problems have been reported by studies during the course of the pandemic.³⁵

One report highlights that the 24-hour toll-free helpline run by Nepal's National Women Commission (NWC)³⁶ received 885 calls related to domestic violence from April to June 2020. This is over twice the number of calls received within the same period prior to the lockdown.³⁷ An increase in maternal and newborn deaths during the lockdown period also indicates the fragility of

³⁴ Advocacy Forum. *Discriminations and Irregularities: A Painful Tale of Interim Relief in Nepal*. 2010.

³⁵ Poudel, K., and Subedi, P. Impact of COVID-19 pandemic on socioeconomic and mental health aspects in Nepal. *International Journal of Social Psychiatry*, 66(8), 2020, pp. 748–755. Available at: <https://doi.org/10.1177/0020764020942247>; Khanal, P., Devkota, N., Dahal, M., et al. Mental health impacts among health workers during COVID-19 in a low resource setting: a cross-sectional survey from Nepal. *Research Square*, 2020 (preprint). Available at: <https://doi.org/10.21203/rs.3.rs-40089/v1>

³⁶ Sharma, J. In Nepal, a helpline serves as a lifeline for survivors during COVID-19 lockdown. *World Bank Blogs*, July 31, 2020. Available at: <https://blogs.worldbank.org/en/endpovertyinsouthasia/nepal-helpline-serves-lifeline-survivors-during-covid-19-lockdown>

³⁷ Ibid.

the health system in Nepal. In an article published in The Lancet Journal, the authors compared childbirth care before and during the lockdown period in Nepal and showed that the number of institutional births decreased by 52.4% during the first two months of the lockdown. Women in relatively marginalized ethnic and social groups were found to be more affected than those in the advantaged groups, indicating a widening equity gap in accessibility due to COVID-19. The study reported that the use of childbirth services by women of the relatively advantageous ethnic group

“Four sex workers who were sharing a room were evicted from their rented rooms during this second wave of the COVID-19 lockdown. Due to lockdown, they could not go out for their usual work and had no choice but to contact the clients and bring them to their rooms for work. Several male clients started to come into the house which was noticed by the landlord. Not only this, but the clients also caused disturbance by talking loudly, playing loud music, being rowdy and dancing. In the same flat, there was another group of women who worked in restaurants but after lockdown they stayed in their own rooms as the restaurants were closed and followed COVID-19 related guidelines announced by the government. This led to the sex workers’ eviction by the landlord.”

Brahmin and Chhetri during lockdown was high as compared to before lockdown (33.9% and 30.7% respectively). However, decrease in attendance was seen among the more disadvantageous Madhesi ethnic group during lockdown as compared with before lockdown (17.1% and 21.5%) respectively.³⁸ As there is no precise data on the number of conflict-affected women, domestic workers, sex workers and entertainers working in Kathmandu – groups that constitute the focus of this study, it is difficult to indicate the exact impact on these groups. However, the ground reality and communication with women during the first wave of COVID-19, i.e. from January 2020 to February 2021,³⁹ indicate that women domestic work, sex work and entertainment sectors were the major victims during COVID-19 amongst all the marginalized women in Kathmandu.

³⁸ KC, A., Gurung, R., Kinney, M.V., et al. Effect of the COVID-19 pandemic response on intrapartum care, stillbirth, and neonatal mortality outcomes in Nepal: a prospective observational study. *The Lancet Global Health*, 8(10), e1273–e1281, 2020. Available at: [https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(20\)30345-4/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(20)30345-4/fulltext)

³⁹ Feminist Participatory Action Research by Tarangini /APWLD with domestic workers (2021).

2. METHODOLOGY

As mentioned earlier, the objective of this study was to determine the MEP for SRH in Nepal. To this end, it analyses public resources available for the SRH with a focus on four groups of women: (a) female sex workers, (b) entertainment sector workers, (c) domestic workers, and (d) conflict-affected women. This study follows a mixed method of analysis where both qualitative and quantitative information have been utilized. Qualitative information has been derived from focus group discussions (FGD) with the four groups of women.

Coordination and management of this project were undertaken by the Office of the High Commissioner for Human Rights (OHCHR) through the UN Resident Coordinator's Office (RCO) and the National Human Rights Advisor within the RCO. A Steering Committee was established to accompany the project substantively to support the RCO and the National Human Rights Advisor. Tarangini Foundation, a non-profit organization focused on women's rights in Nepal, is dedicated to documenting feminist movements, enhancing integrated security, and feminist mentoring. Tarangini's work revolves around three issues: women's identity, body, and work and we envision creating an enabling environment for feminists and our movements to be strengthened, recognized, and visible. Tarangini coordinated the research project at the local level by setting up a Steering Committee with representatives of the self-representative organizations.

The methodology of the qualitative part of this study is unique. Its strength lays in the fact that those who conducted the focus group discussions – the outreach workers, and those who designed the set of questions for the discussions, were all women who belonged to self-representative organizations of the women who constituted the focus of this study.

In other words, the qualitative information collected for this study was designed and gathered by the women themselves. This enabled the data to be close to the realities of the women. These women provided recommendations for improving access to their own right to sexual and reproductive health. This study relied on a bottom-up methodology, with affected women and their organizations, leading the process of design, qualitative data collection, interpretation of data and recommendations.

The quantitative part of the study relied on desk research, analysis of relevant research data and government records as well as discussions with relevant professional and government authorities.

2.1 Focus Group Discussions

For the purpose of the focus group discussions (FGD) specifically, a separate Advisory Committee was established by the Tarangini Foundation (a feminist civil society organization) consisting of the Project Coordinator/s, a board member, as well as three representatives from each selected self-representative organization, i.e. Jagriti Mahila Maha Sangh (JMMS, an organization working with female sex workers), Women Forum for Women in Nepal (WOFOWON, an organization working with women in the entertainment sector), and Nepal Mahila Ekta Samaj (NMES, an organization working with domestic women workers). The outreach workers under the direct supervision of the Project Coordinator were selected by the Steering Committee in coordination with representative organizations and trained by the Project Coordinator and Tarangini Foundation. The FGDs were conducted by these outreach workers based on pre-designed guidelines. Since the outreach workers were selected from the representative organizations and were “insiders”, they had ready access to the rightsholders to conduct the FGDs with ease and confidentiality. The discussions covered SRH issues, health-seeking behavior, treatment cost, and expectations from the government regarding the sexual and reproductive health issues.

2.1.1 Number of Participants in FGDs

There is no precise data on the population of the selected study group. Therefore, this study utilizes the formula suggested by Lwanga and Lemeshow⁴⁰ to determine the numbers of participants for the focus group discussion. This formula is suitable to determine sample size when there is no information on the population size.

$$n = \frac{Z^2 p(1 - p)}{d^2}$$

where,

n = Sample size

Z = Level of confidence according to the standard normal distribution = 1.96

p = Estimated proportion of the population that presents the characteristics = 0.5

⁴⁰ Lwanga, S.K., Lemeshow, S., and World Health Organization. *Sample Size Determination in Health Studies: A Practical Manual*. Geneva: World Health Organization, 1991. Available at: <https://iris.who.int/handle/10665/40062>

$d = \text{Tolerated margin of error} = 10\%$

This formula calculates the sample size if the population is unknown or infinitely large.

The above formula suggests the estimated sample size be at least 96. The Table below shows the actual number of participants and place of FGD for different study group, with about 150 women from each group participating.

Table 1: Number of participants and place of FGD

Study Group	Place	No. of Participants
Female Sex Workers	Kathmandu	150
Entertainment Workers	Kathmandu	143
Domestic Workers	Kathmandu	150
Conflict-Affected Women	Rukum	147

3. PROFILES OF WOMEN IN THE STUDY

3.1 Women in the Entertainment Sector

There is no specific data on the number of women working in the entertainment sector. The 2018 Labor Force Survey shows that out of a total 4.4 million informal sector workers, 1.8 million are women.⁴¹ The Ministry of Women, Children and Social Welfare reported that there were 30,000 to

“I started making a decent enough living as a singer at a bar, but the pandemic changed everything. I must start again. Last year, everything, including our workplace, was closed due to the pandemic. All of my savings were spent on medical treatment and day to day survival. With no savings, it's hard to pay room rent. I am stressed about my survival. If the entertainment field shuts down, people like us suffer. Last year, I was provided some help because I am member of Dohori Song Pratisthan (Singers Association). It was a big relief for me especially in the time of pandemic.” – Testimony of an entertainment sector worker

⁴¹ Central Bureau of Statistics. *Report on the Nepal Labour Force Survey, 2017/18*. Kathmandu, Nepal: Central Bureau of Statistics, 2018. Available at: https://nepalindata.com/media/resources/items/20/bNLFS-III_Final-Report.pdf

40,000 women workers in entertainment industry.⁴² Similarly, a comprehensive situation analysis of the entertainment sector in Nepal by Frederick et. al.⁴³ mentions that under-age service providers make up one-fifth to one-third of all women employees in Nepal's entertainment and sex sectors. Up to one in ten women workers are between the ages of 12 and 15. Nearly half of all women employed in the entertainment sector start their careers before turning 18.

3.2 Sex Workers

While exact numbers are not available, it is estimated that at the time of this research, there are around 40,000 sex workers in Nepal. Of them, around 13,000 are said to be HIV positive.⁴⁴ Health is a primary concern among women sex workers. According to one study, the major health problems of sex workers in Nepal include Sexually Transmitted Infections (STIs), fever, back pain, headache, and diarrhea.⁴⁵ Sex workers encounter a serious set of additional hurdles on account of the fact that sex work is illegal.⁴⁶ As a result, harassment and violence even by state officials is routine, including police action for mere possession of condoms.⁴⁷ Most sex workers come from low socioeconomic backgrounds, and marginalized social and ethnic groups, and many engage in sex work to secure a livelihood and, often, to escape domestic violence and abuse⁴⁸.

Grave social stigma against sex work results in societal and police harassment of sex workers. Stigma therefore constitutes a dominant social determinant for the health of women in sex work. Though the government has expanded health services, it is not easy for sex workers to access those services. According to International Planned Parenthood Federation (IPPF)⁴⁹, sex workers in Nepal face several obstacles including accessibility (sex workers prefer health facilities at a distance from

⁴² MoWCSW. *Study Report about Cabin, Dance Restaurant, and Massage Parlours*. Kathmandu, Nepal: Ministry of Women, Children and Social Welfare, 2008.

⁴³ Frederick, J., Basnyat, M., and Aguetant, J.L. *Trafficking and Exploitation in the Entertainment and Sex Industries in Nepal: Handbook for Decision Makers*. Kathmandu, Nepal: Terre des hommes Foundation, 2010.

⁴⁴ Family Planning Association of Nepal (FPAN). There are around 40,000 sex workers in Nepal. Around 1,300 are living with HIV. IPPF. Available at: <https://www.ippf.org/stories/there-are-around-40000-sex-workers-nepal-around-1300-are-living-hiv>

⁴⁵ Ghimire, L., Smith, W.C.S., and van Teijlingen, E.R. Utilisation of sexual health services by female sex workers in Nepal. *BMC Health Services Research*, 11, 2011, p. 79. Available at: <https://doi.org/10.1186/1472-6963-11-79>

⁴⁶ Human Trafficking and Transportation (Control) Act, 2008 (2064) defines prostitution as human trafficking and criminalizes it.

⁴⁷ See citation 44.

⁴⁸ Balfour, R., and Allen, J. *A Review of the Literature on Sex Workers and Social Exclusion*. London: UCL Institute of Health Equity for Inclusion Health, Department of Health, April 2014.

⁴⁹ See citation 44.

their areas of work and residence for reasons of confidentiality), waiting time, affordability, lack of trust (including in effective service), fear of breach of privacy, and mistreatment by health workers.

3.3 Domestic Workers

According to the Labor Force Survey 2018, there are as many as 464,000 domestic workers in Nepal.⁵⁰ A study by General Federation of Nepalese Trade Union (GEFONT) revealed that the nature of work and the workplace in Nepal put women domestic workers at risk.⁵¹ As per the report, domestic workers receive low wages and face discrimination on several fronts including denial of access to toilets at the workplace. Sexual abuse and violence are reported to be high. Back pain, rheumatic pain, bladder infections and inflammation of hands are some of the common health issues of domestic workers.

3.4 Conflict-Affected Women

Reportedly, women were sexually abused both by the security forces and the Maoist rebels during the decade-long Maoist insurgency in Nepal (1996-2006).⁵² It was extremely challenging for rape survivors to obtain any potential medical proof because there were no medical or psychosocial services available during or after the conflict.⁵³ There is also no official record of the exact numbers of women victims of sexual violence nor of their health issues. And yet, unofficial sources indicate that a large number of women were affected by CRSV. Non-recognition of these crimes as well as absence of remedial action at all levels (judicial, social, medical, economic) has led to deep, unhealed and festering wounds requiring immediate responses, including psychosocial and medical support.

⁵⁰ Central Bureau of Statistics (CBS), Government of Nepal. Report on the Nepal Labour Force Survey 2017/18. Kathmandu: CBS; 2019.

⁵¹ WIEGO, IDWF, Home Workers Union of Nepal, and GEFONT. Domestic Workers, Risk and Social Protection in Nepal. WIEGO Policy Brief No. 20, October 2020.

⁵² Human Rights Watch. Silenced and Forgotten: Survivors of Nepal's Conflict-Era Sexual Violence. Kathmandu: Human Rights Watch, 23 September 2014. Available at: <https://www.hrw.org/report/2014/09/23/silenced-and-forgotten/survivors-nepals-conflict-era-sexual-violence>

⁵³ Ibid.

After a decade-long conflict, the country changed in many ways, and everyone moved on, but 57-year-old Sarita Damai (name changed) continues to suffer from social and legal injustice, and reflects signs of serious trauma:

“My ill-fate began with the outbreak of an armed conflict. Maoist combatants would barge into my home and consume whatever food they could find. The army soldiers would then punish us for feeding the Maoists. One evening, the People's Liberation Army combatants were making garments in my home. When the army learned about it, they stormed in to search the residence. They began hitting everyone and then raped me. Then they drove my family out and set my house on fire. My life took a horrific turn.

I stood in front of my burning house, clutching onto my wailing children and a wounded husband, raped and helpless. My husband took to drinking and would blame me for the rape and for inviting the attention of the soldiers. He began to physically and verbally abuse me. He fell ill because of his drinking habits, and after spending loads of money on medicine for his depression, he committed suicide. Caring for my children was an excruciating ordeal as my community began to blame me as well. I have not been able to get any support from the government either for my family nor for my physical and mental health problems. I am unable to sleep all night; I cry all the time and constantly suffer from feelings of helplessness. I also suffer from lower backache, menstrual disorder and uterine prolapse. I must work very hard in my own little agricultural field to sustain myself and my children. I also do agricultural work for others. I know if I go to the nearby health post I might not even see the health worker. They come in late and sometimes not at all. And even if I find a health worker there will not be any medicines for my type of problems. I don't have money to travel to Musikot (capital of that district) nor any place to stay there. I cannot afford to be away for long as for me taking care of my children and managing food for them is much more important than treating myself.”

Like numerous of other survivors of conflict-related sexual violence (CRSV), she is left behind since the government still lacks a clear process for the providing support to survivors and victims.

4. Key Findings of the Focus Group Discussions

4.1 Sexual and Reproductive Health Issues

Participants of the FGD revealed many health issues related to SRH. Some of these health concerns are common to all four groups whilst others are group specific. The table below lists the common and group-specific SRH issues.

Entertainment Workers	Female Sex Workers	Domestic Workers	Conflict-affected Women
<ul style="list-style-type: none"> ■ Irregular menstruation and white discharge ■ Lack of access to Contraceptives ■ Sexually Transmitted Infections (STI) ■ Lack of access to safe abortion services ■ Sexual harassment and violence at workplace ■ Pelvic inflammatory infections ■ Lack of proper toilets and changing rooms in workplace ■ Mental health issues 	<ul style="list-style-type: none"> ■ Irregular menstruation along with lack of proper toilets and changing rooms in work areas ■ Lack of access to contraceptives and family planning services ■ Sexually Transmitted Infections ■ Unsafe abortion and deteriorated health after such abortion ■ Sexual harassment and violence at workplace ■ Sexually Transmitted Diseases as well as 	<ul style="list-style-type: none"> ■ Lack of proper toilets and changing rooms in workplace ■ Heavy bleeding during menstruation due to heavy work load ■ Lack of access to family planning services and contraceptives ■ Sexual harassment and violence at workplace ■ Uterine prolapse ■ Inadequate nutrition during pregnancy ■ Mental health issues 	<ul style="list-style-type: none"> ■ Low menstrual hygiene ■ Lack of access to family planning services ■ Lack of access to safe abortion services ■ Physical and sexual assault ■ Domestic violence ■ Uterine prolapse ■ Mental health issues

	other infectious diseases ■ Mental health issues		
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Table 2: SRH related issues based on focus group discussion

Menstrual health issues are common to all four groups of women. Menstrual pain, irregular cycle, heavy bleeding, unusual bleeding, and missing periods were problems stated by all the participants.

Entertainment sector workers said that irregular menstruation and white discharge are common

“I asked my employer for time off due to menstrual cramps, but I was not provided leave. when they found out that I was on my period, I was not allowed to enter the kitchen. Rather, I had to sit outside the house and clean larger utensils. I even had to carry heavy furniture during my period.” – FGD dated 16.09.2021, participant 3

and yet, they seldom seek medical attention due to lack of affordable services. Most of the women use sanitary pads when they are at work and utilize cloth when at home. Several women shared that there were times when they were compelled to use napkins, unclean cloth, even pieces of jute bags, shopping bags and other unsanitary materials during the sudden onset of

menstruation while at work as sanitary pads are not available at the workplace. Entertainment sector workers mentioned that they generally do not change sanitary pads for over 8 hours and some even use one pad per day due to lack of funds and a proper toilet facilities.

As for domestic workers, many reported that they are unable to change their sanitary pads due to lack of proper and private facilities including washrooms and toilets. Domestic workers are not allowed to enter most parts of the employer’s home during their menstruation as generally, menstruating women are considered unclean. However, this does not mean that their workload is reduced. They are given heavier work outside of the kitchen and many women reported that they have experienced lower abdominal pain and are sometimes not able to control micturition due to the heavier loads.

Access to family planning services and the use of contraceptives is another common challenge for all four groups of women. Condoms, depo, Copper T, oral hormonal contraceptives are

common contraceptives used by the women, when available. Some of the participants mentioned that they refrain from using contraceptives until giving birth to at least one male child.

Female sex workers sometimes use emergency contraceptives. As a result, they experience multiple side effects linked to these strong contraceptives including heavy bleeding, irregular menstruation, weight gain, and acne. They added that risky contraceptives could be avoided if it was mandatory for their customers to use condoms.

Sexually transmitted infections (STI) are the major health problems encountered by entertainment sector workers and sex workers. Many women reported that, were it not for the demeaning attitude and treatment of the health service providers coupled with the long waiting periods, they would prefer to visit government hospitals for check-ups as these were more affordable. Private hospitals are very expensive, so consultations are infrequent, and follow-up visits are generally skipped. Many women said that they visit Family Planning Association Nepal (FPAN) through recommendations of certain organizations for STI testing. However, this service is not available to them at all times. Sex workers hesitate visiting FPAN as they believe that STIs generally indicate HIV/AIDS and many are fearful of facing the prospect of AIDS.

Only a few women get tested for HIV/AIDS, out of fear of the stigma surrounding it. There is even stigma in consulting a gynecologist regarding STIs or white discharge/fungal infection. A mere visit to a medical facility if spotted by family, friends, or even strangers evoke fear of the women carrying HIV/AIDS. Such a severe fear of stigma and social ostracization affects their overall physical as well as mental health. Some *Dohori Saajhs* (live music bars) organize HIV tests in collaboration with NGOs, and these are much preferred by the women.

Access to safe abortion services is another common challenge for entertainment workers, sex workers, and conflict-affected women. Whereas women are sometimes forced by male partners and family members to undertake sex-selective abortion due to preference for a male child, safe abortion when really required, is not easily accessible. Nepal's law allows for medical termination of pregnancy up to 12 weeks and up to 28 weeks under specific conditions⁵⁴. However, these services are not easily available or affordable. For example, women from conflict-affected areas

⁵⁴ In cases of threat to the pregnant woman's life, physical or mental health, rape or incest, HIV or similar incurable disease, or if the child is likely to be born handicapped.

acquire this service either in local medical clinics or in hospitals in distant cities such as Dang, Nepalgunj, or Kathmandu. The distance makes these services difficult to access.

The FGD indicated that abortion is common among sex workers due to unwanted pregnancies as a result of unprotected sex. Many sex workers said that clients rarely agree to use contraception and may often resort to abuse and violence if sex workers insist on condoms. Customers routinely pay less when they are made to use contraceptives and if a customer pays less, the difference is deducted from the sex worker's wages by the pimp or brothel/bar owner.

Women in sex work reported having had between four and nine abortions per woman. While some are able to use the services of the Marie Stopes⁵⁵ clinics, most

“A new client offered to provide me NPR 10,000 to stay the night with him. When I went with him, I saw two additional men who were his friends. All of them were drunk. They locked the door from inside and had sex with me all night. They did not give me a single rupee. Furthermore, they told me that they had recorded my video and threatened to leak the video. I could not complain to anyone. As sex workers, we are compelled to go through this kind of violence frequently.” - Testimony of a sex worker.

reported that they approach pharmacies and medicals stores for medication for abortion purposes. Arguably, resorting to over-the-counter medication often leads to complications including excessive bleeding, constant pain in the lower abdomen region, bleeding and pain during intercourse, miscarriage and infertility.

Physical and sexual assault are common for all groups of women of the study. Women from conflict-affected areas in Rukum experienced violence from both parties: Nepal Army and the rebels, as mentioned above. Many of them who were pregnant during the conflict period reported that they faced violence including being kicked in the stomach by the soldiers. And, at present, majority of them shared that they are facing domestic violence.

Further, women in entertainment, sex work and domestic work are all vulnerable to sexual harassment and assault, mainly from their customers and employers. Groping, sexual harassment and abusive language are routinely common to all. Fear of loss of work compels women in these three work sectors to remain silent and desist from complaining.

⁵⁵ A non-profit healthcare provider specializing in safe abortion, family planning, and sexual and reproductive health services. <https://www.mariestopes.org.np/>

Lack of access to nutritious food in general, and during pregnancy in particular, was listed as a serious problem, especially by domestic workers. Most domestic workers (especially live-in domestic workers) rely on their employers for food and their meal times are not fixed. Consequently, there are long gaps between meals and often this consists of leftovers. Most women told us that they cannot afford proper nutritious food during pregnancy due to lack of funds. They also continue to work until the final trimester of their pregnancy without proper access to rest and sufficient nutrition in the workplace and at home.

Lack of proper toilets and changing rooms in the work area are serious problems for all women particularly and for entertainment and sex sector workers. Lack of washing facilities as well as clean water causes genital itching and rashes, white discharge, and other similar infections.

Uterine prolapse and pelvic inflammatory infections are common in most of the women in the study group. During the FGD, participants suspected that heavy workload during menstruation and pregnancy, as well as compromised menstrual and gynecological hygiene are the cause of uterine prolapse and pelvic inflammatory infections. However, the women (especially those affected by conflict) rarely go for medical checkups or get their uterine rings changed. The barriers to medical attention listed by the women included distance to the nearest health post and poor medical services provided by male health workers. One of the FGD participants reported that she did not change her uterine ring for 10 years leading to severe genital infection.

Mental health issues are common to all groups of women albeit for different reasons. While women affected by conflict experience mental health issues due to past sexual violence and trauma, women in other sectors of work develop mental health conditions on account of social stigma, discrimination and poverty. Most of the sex workers and entertainment sector workers hide their identity due to the stigma. In general, ill treatment by clients and employers, societal attitudes, verbal abuse, low wages, insecurity of work, lack of decent working conditions as well as lack of recognition of work contributed to severe mental strain in all the working women interviewed. Anxiety and mental stress were reported by all four groups of women.

4.2 Additional Issues (Social and Economic)

Participants in the FGD also shared their views on issues other than specific sexual and

“While working as an entertainer, I went to Dhangadhi, Khasa and sometimes also to Pokhara to work, which helped me to generate a good income but I could not deposit my earnings in a bank because I didn’t have citizenship. Sometimes I suffered violence, detention, labor abuse, but there was no place to file a complaint because often we are harassed by the security personnel who are assigned to protect people. As a woman, I have had to deal with all kinds of sexual proposals, uncomfortable advances, groping, and police harassment. For the third time, from the Dance Bar, I was, along with the other women, detained in the Hanuman Dhoka police station for lack of proof of citizenship as I could not prove my age and identity.” - Entertainment sector worker

reproductive health concerns. Some of these problems were social, economic, and legal issues that have a direct bearing with sexual and reproductive health.

Issues due to citizenship inequality: Many women working in the entertainment sector as well as sex workers and domestic workers did not have citizenship themselves due to several reasons such as running away from home at an early age, father unwilling to grant

citizenship in the absence of the mother after her death, lack of birth registration from being born out of wedlock, among others. Many of these women, along with women who had citizenship, reported that difficulties in the process of citizenship arose not only towards them but also towards their children due to several factors like details of father and other procedural barriers, which hindered their ability to register the birth of their children.

“Receiving any subsidies or allowances require proof of citizenship, but not everyone has a citizenship. Even receiving a COVID-19 vaccine required proof of citizenship.” – FGD no. 9, Participant 4

Citizenship for children and women is curtailed by demise or lack of identity of the father, or social ostracism by the family. Several women with children who are currently not residing with their

husbands⁵⁶ face problems in registering the birth of their children because of refusal by the father to recognize his children. Furthermore, many women gave birth to children while they were in a

One time during this pandemic, I used to have severe tremors in my hands especially during the evening. Since the employer would not give me sick leave, I had to say that I was down with COVID-19.” – FGD dated 16.09.2021, participant 7

live-in relationship and not able to present a marriage certificate. Absence of birth registration of children deprives them of various government services and facilities including free essential health care, disability card, inheritance of parental property, and educational

allowance, all of which are constitutional guarantees.

Unsafe, unhealthy and unsanitary work conditions: Smoking and drinking in closed spaces with inadequate ventilation and loud music for a long duration of time has resulted in severe physical and mental health issues, especially for women in the entertainment and sex sector. Chronic cough, fatigue, difficulty in hearing, varicose veins, chronic headaches were some of the symptoms shared by the participants. Joint pain and backache due to standing for long hours were also identified as common problems. Women in domestic work and the entertainment sector do not get any holidays

*“I have neither citizenship nor a registered marriage. There is no legal evidence that I got married with my husband while I was working. I have not been able to continue my education. I am physically and mentally tired as my younger son is 3 months old. My husband did not want to accept our child because I work in the entertainment sector. He left me when my older son was 7 years old. During my pregnancy, I faced lot of problem working in dohori. The guests abuse us and even though I was pregnant I was forced to drink alcohol. I had to stay with clients and make them happy. My salary is low. I used to save small amounts and send money to my mother, but after COVID-19, most of the workplaces closed down. It has become very difficult for me to sustain my daily life. I am raising my son alone, facing many responsibilities. Even though I am married and have a husband, I am living my life as single woman.” **Entertainment sector worker***

or sick leave. If they ask for leave, they are often threatened with being laid off. Employers prefer

⁵⁶ Husband left them after knowing their work, or due to domestic violence, for not being able to earn enough to fulfill their demands, the husband didn't feel that they are attractive enough, women were sick and tired with them and left them after they started to work were some of the reasons shared by them.

to hire younger girls and women (generally below 15 years of age) as they can be made to work for lower remuneration. Young underage girls are also considered to be more attractive to the customers. This practice leads to chronic health issues as girls are initiated into drinking, smoking, and sex at a very early age and forced to use emergency contraceptives and antibiotics. Furthermore, the women must rely on tips to augment their low earnings, which, per the women, are based on smoking and drinking with clients, as well as consenting to sexual favors.

4.3 Specific Issues of Conflict-affected Women

Injuries are very common among the women affected by conflict including unhealed wounds from being tortured/assaulted during the conflict. Some women continue to have pieces of bullets and shrapnel lodged in their bodies causing them constant pain. These women require urgent medical help but are often unable to access health facilities due to endemic poverty.

Other than the direct and indirect health impacts of the conflict, many women (at least two in 10) said that they suffer from gall bladder and/or kidney stones. As some women reported, the reasons for this could be that the source of water was at a distance from their homes and they were afraid to go out in the open during the conflict period and consequently, did not drink even 500ml of water a day. Intake of insufficient water, now a habit, may have caused the formation of these crystals and stones.

One key challenge these women face is the increased care burden, as they may be expected to provide care for family members who have deteriorated mental health conditions. Several of their family members, including husbands, experience mental health issues due to the conflict and require immediate treatment. In addition, several women reported that their husbands abused them regularly and often severely. These women lack psycho-social assistance and other support mechanisms for themselves and their kin. One of the major barriers to seeking mental and physical health support is poverty.

4.4 Health-seeking Behavior

This section, based on the FGDs, describes the health-seeking behavior of women in the study group.

4.4.1 Alternative remedies

Ayurveda and alternative medicine have been deep-rooted in Nepalese society. Using turmeric for colds, resorting to natural remedies and ingredients as well as taking advice from traditional healers, are common health seeking practices. Most people first try home remedies for their health problems. Many people take both Ayurvedic and allopathic medicines together with the belief that the Ayurvedic medicines have no side effects and cure the disease at its root. Some people also

“Since I don’t have the money to go for medical checkups, I feel ashamed even discussing any symptoms or thinking about visiting a hospital” – **FGD 8, Participant 3**

have faith in traditional healers such as *dhami-jhakri*, and some women believe in them to also address sexual and reproductive health issues such as fertility.

The Nepal Health Policy 2019⁵⁷ as well as the Fifteenth Plan of the Government of Nepal (2019/20-2023/24)⁵⁸ seek to develop and expand Ayurveda and natural medicine. Similarly, the Local Governance Act 2017⁵⁹ has

given the right to local level governments to promote and manage Ayurveda and alternative medicines and treatment.

4.4.2 Home remedies

Most women in the FGD reported that they use home remedies and pain killers as a first resort. Popular home remedies include drinking hot water with ginger, turmeric, neem, and cumin seeds. Home remedies do not have any additional costs and are readily available. Women also frequently use Nims (Nimesulide), Paracetamol, Ibuprofen, Disprin (Aspirin/Acetyl Salicylic Acid) – popular pain killers – without consulting a doctor, for headaches, stomach aches, cramps, body pain, and other minor problems.

Only when their health problems turn acute (i.e., obstruct their daily work), do they seek out pharmacies or hospitals. Most of the women choose to go to local clinics as hospitals charge money for various tests before prescribing medicine. On the other hand, local pharmacies provide medicine without such tests. In addition, corruption in the health sector is an impediment to access to health care, as evidenced in the following statement:

⁵⁷ Government of Nepal. *National Health Policy, 2076 (2019)*.

⁵⁸ Government of Nepal. *The 15th Periodic Plan of Nepal (FY2019/20–FY2023/24)*.

⁵⁹ Government of Nepal. *Local Government Operation Act, 2074 (2017)*.

“In order to get good treatment in government hospitals, one needs to have power and a network. Since we have neither power nor network, we don’t get good treatment.” – FGD 4, Participant 6

In general, the women prefer to go to government hospitals because of affordability. However, there are long queues and waiting time in government hospitals as influential patients receive preferential treatment. As mentioned previously, women in sex work and the entertainment sector are reportedly humiliated and ill-treated by medical personnel in government hospitals.

“I didn’t even have NPR 2,000 in my pocket, so I turned back from the hospital gate” – FGD 2, participant 3

Arguably, over-the-counter medication without proper diagnosis and prescription is not free from risk. Sometimes this practice increases the severity of the problem.

“I was scolded by the doctor who said “You sleep with whoever you want and now you are complaining! You should be ashamed.” – FGD 1, participant 7

Many sex workers borrow money to access hospitals. However, social stigma and absence of work security inhibits their ability to seek loans for medical purposes. Some rely on savings, but for the most part, women seek out small loans from

“I went to the Teaching Hospital (government) by myself for excessive menstrual bleeding but was humiliated by the doctor who told me why I came when I was and menstruating and dirty”- FGD 3,

cooperatives or ask for donations from women’s groups for medical treatment.

The discriminatory behavior of doctors and service providers is demeaning as sex workers and entertainment workers are treated as “untouchables”. The women in this study believe that the

“I am scared to go to the hospital because generally, they charge NPR 5,000 – 6,000 per visit. The doctors first ask for various tests such as blood tests, urine tests, X-rays, and sometimes video X-rays (ultrasound) before they prescribe any medicine. The cost might be even higher sometimes. We don’t have a fixed income and have barely enough to pay for food and children’s education. Therefore, we prefer to visit pharmacies and clinics that prescribe medicine without tests” – Participant 1, FGD 2 and Participant 2, FGD 4

medical professionals at government hospitals are more experienced and skilled, however, the delivery of service takes a very long time in addition to the other obstacles mentioned above.

The women clearly stated that they prefer to be checked by female doctors. In government hospitals there are limited options for choice between male and female doctors.

A serious concern is that some women visit government hospitals only when accompanied by their male partners because the service providers ask who their companions are. If their husbands or

“I had gastritis and couldn't afford to go to the hospital as I didn't have any money, so I got some medicines over the counter at my nearby medical store. As the condition worsened, I later found out that I had stomach ulcer” – FGD 2, participant 1

male partners are absent, then women may prefer to go to the local pharmacy.

Another matter of grave concern is the health-seeking behavior of women affected by conflict in Rukum. These women seldom seek health services as they cannot afford to spend money on health care. They reported that they simply ignore or put up with their health problems and wait to get better.

Most of the women in Rukum we spoke to are engaged in subsistence agriculture and are the breadwinners of the family. They told us that their

“It costs a lot of money to go to the hospital, and I have tried but not been able to collect enough funds to do so. Hence, I just hide my health problems and symptoms.”- FGD dated 12.06.078, Participant 5

“The health post personnel do not care about us and do not give us enough time”. –FGD dated 14.06.078, Participant 3

“They also ignore the waiting patients and are on their phones all the time”. –FGD dated 14.06.078, Participant 5

“The health post is mostly closed during the mornings, and I am not able to go during the daytime as I have to attend to the fields, hence I have not visited the health post.” –FGD dated 17.06.078, Participant 9

husbands do not help with agriculture and are mostly busy drinking alcohol. This is also one of the reasons of high incidence of domestic violence amongst these women. Traditional healers are very

common among women for all types of health issues in this remote area as women sustain a strong belief in them and ease of access is an advantage. All the women who participated in the FGD said that they use local herbs to treat various health problems including lower abdominal pain, white discharge, foul vaginal infections and odors. Local NGOs working in Rukum teach them about the use of appropriate herbs.

Many women reported that they would like to visit the local health posts (HP), but the staff do not provide enough time to patients and the posts invariably run out of free medicines.

One of the main reasons women in Rukum do not visit the Health Post for sexual and reproductive

“I went to the health post to get medical help for my sexual and reproductive health problems but since the staff in-charge was male, I couldn’t share my problems and simply returned with medicines for a headache”- FGD dated 19.06.2078, Participant 7

health problems is the presence of male staff. These rural women feel uncomfortable to share their SRH problems with male professionals. Concerns around confidentiality is a pressing and serious deterrent.

The women have also reported that they visit local pharmacies for faster service and availability of all kinds of medicines. Few can afford travel to larger city hospitals for checkups and advanced medical services. Lack of public transportation facilities, time off from their busy schedules, and cost inhibit travel by rural women of Rukum to hospitals in urban centres.

4.5 Healthcare Expenditure

The question ‘how much are the women in the study groups spending for their sexual and reproductive health needs?’ is a pertinent one. Based on the FGDs, most of the women do not visit any health facilities until their health problems become serious. At that point, they first approach local medicals and pharmacies and only subsequently visit hospitals. The cost of medical care, poverty, stigma, long waiting time, and perceived poor-quality services act as multiple deterrents. Many women reported that they were unaware that the local health facilities are required to provide basic health services free of cost. They reported that they borrowed money from relatives and local money lenders at more than 30% interest rate to visit hospitals and for medical services.

Table 3 below shows the health care utilization cost borne by participants in 2021. These costs include costs of both public and private health facilities. Public health facilities are relatively cheaper than private ones.

Table 3: Health care service utilization cost based on information shared by FGD participants

	Entertainment sector workers	Female sex workers	Domestic workers	Women affected by conflict
1. One-time cost for basic services	NPR 5000-6000	NPR 5000-6000	NPR 5000-6000	NPR 2500-3000
a. Out patient (OPD) Registration Fee	NPR 500-600	NPR 500-600	NPR 400-500	
b. Doctor's Fee	NPR 1000	NPR 600-1200	NPR 600-1200	
c. X-rays, lab tests	NPR 1500-2000	NPR 1500-3000	NPR 1500-3000	
d. Medicines	NPR 2000+	NPR 2000+	NPR 2000+	
2. More advanced services (Surgery, CT scan, and specialized doctors visit)	NPR 50,000	NPR 50,000-60,000		NPR 10,000-15,000
3. Abortion pills		NPR 1500	NPR 1500	
4. Abortion cost		NPR 3000-4000		
5. Traditional healers			NPR 1000-15,000	

Table 3: Health care service utilization cost based on information shared by FGD participants

This table shows that entertainment sector workers, sex workers, and domestic workers incurred about NPR 5,000-6,000 per visit to health facilities. Women affected by conflict, on the other hand spend about NPR 2,500-3,000 regularly on medicines. If they are in need of more advanced services, then they pay NPR 50,000-60,000. The cost increases further if they visit city hospitals.

Sex workers and domestic workers indicated the cost they incurred on medical terminations of pregnancy as well. This amounts to approximately NPR 3,000-4,000 per case and in case of abortion pills the cost is NPR 1,500. It is important to note that safe abortion and post-abortion services are provided free of cost in Nepal. The women are often unaware of this.

There is no costing exercise or study for SRH interventions in Nepal although there are few studies that cost different aspects of health services in Nepal. The present report aimed to estimate the cost of SRH for the particular study group women. However, several limitations including time constraints, complexities of WHO's essential health package, and data gathering, as well as complex calculations involved prevented a detailed costing of SRH interventions for the women involved.

5. DEFINING A MINIMUM ESSENTIAL PACKAGE FOR SEXUAL AND REPRODUCTIVE HEALTH

This section looks at one element of the core obligations under the right to health identified by the CESCR Committee in its non-exhaustive list, corresponding to a national strategy and action plan, with adequate budget allocation, on sexual and reproductive health.⁶⁰ The section analyses domestic legal and policy frameworks, the minimum essential package of sexual and reproductive health in light of international good practices, namely, the Guttmacher-Lancet Commission's recommendation⁶¹ and the WHO recommended components⁶² in SRH interventions, as well as findings from FGD.

In its General comment No. 14: the right to the highest attainable standard of health,⁶³ the CESCR Committee defines core obligations as stated below:

⁶⁰ Committee on Economic, Social and Cultural Rights (CESCR). General Comment No. 22: The Right to Sexual and Reproductive Health, para. 49(b).

⁶¹ Sadinsky, S. *Sexual and Reproductive Health Care Is Key to Achieving Universal Health Coverage*. Guttmacher Institute, July 2021. Available at: <https://www.guttmacher.org/article/2021/07/sexual-and-reproductive-health-care-key-achieving-universal-health-coverage>

⁶² World Health Organization (WHO). *Advancing Universal Access to Comprehensive Sexual and Reproductive Health Services in the Context of Universal Health Coverage: Sexual and Reproductive Health Interventions in the WHO UHC Compendium*. Technical Document, 5 April 2021. Available at: <https://www.who.int/publications/i/item/WHO-UHC-Compendium-SRH-Interventions>

⁶³ Committee on Economic, Social and Cultural Rights (CESCR). General Comment No. 14: The Right to the Highest Attainable Standard of Health, E/C.12/2000/4, para. 43.

“States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care. Accordingly, in the Committee’s view, these core obligations include at least the following obligations:

- (a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
- (b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
- (c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
- (d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
- (e) To ensure equitable distribution of all health facilities, goods and services;
- (f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.”

Similarly, paragraph 44 of General Comment no. 14 also confirms that the following are the obligations of comparable priority:

- (a) To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;
- (b) To provide immunization against the major infectious diseases occurring in the community;
- (c) To take measures to prevent, treat and control epidemic and endemic diseases;
- (d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;

(e) To provide appropriate training for health personnel, including education on health and human rights.

Likewise, Para 49 (g) of General Comment no. 22 confirms the core obligation to provide medicines, equipment and technologies essential to Sexual and Reproductive Health including based on the WHO Model List of Essential Medicines.

5.1 International Standards and Recommendations

The Guttmacher-Lancet Commission's report and the WHO describe sexual and reproductive health interventions that have been shown to be effective in improving individuals' health and well-being. By merging the common elements of the above-mentioned recommendations, we get the following package of interventions:

- Comprehensive sexuality education
- Counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods
- Antenatal, childbirth, and postnatal care, including emergency obstetric and newborn care, ectopic pregnancy
- Safe abortion services and treatment of complications of unsafe abortion
- Prevention and treatment of HIV and other sexually transmitted infections
- Prevention, detection, immediate services, and referrals for cases of sexual and gender-based violence
- Prevention, detection, and management of reproductive cancers
- Information, counselling, and services for subfertility and infertility
- Information, counselling, and services for sexual health and well-being

5.2 Nepal's Legal and Policy Frameworks

The Right to Safe Motherhood and Reproductive Health Act 2018 underscores some of the important issues of SRH that are not included in the components recommended by WHO and Guttmacher-Lancet Commission but are highly important for the study group, especially for the female sex workers. The first issue is related to confidentiality. Sex workers in general prefer to

visit health providers located at a distance from their locality due to the fear of stigma and lack of confidentiality.

According to the Nepal Health Sector Support Program (NHSSP)-2 Implementation Plan 2010-2015,⁶⁴ the following components are included in essential health care services in Nepal (that would pertain to the four research groups):

- a) Reproductive Health
 - Family planning
 - Safe motherhood (SM), including newborn care (free institutional deliveries nationwide for all)
 - Medical safe abortion piloting and scaling up partnerships with I/NGOs (MSI, FPAN, and others) and private clinics and hospitals
- b) Communicable Disease Control
 - HIV/AIDS/STI control
- c) Non-communicable Diseases (NCD) Control
 - Community-based mental health programme (including for GBV)
 - Health promotion for NCD control
- d) Rehabilitation of the Disabled
 - Rehabilitation, surgery, and therapy
- e) Curative Care
 - Outpatient care at district facilities

The NHSSP 2016-21 Implementation Plan, on the other hand, does not pronounce essential health as in the previous plan but includes a program to expand HIV programs to hidden populations including female sex workers.⁶⁵

⁶⁴ Government of Nepal. Nepal Health Sector Programme-2 Implementation Plan (2010–2015). Kathmandu, Nepal: Ministry of Health and Population, 2010. Available at: <https://www.nhssp.org.np/Resources/HPP/health%20policy/Consolidated%20NHSP-2%20IP%20092812%20QA.pdf>

⁶⁵ Government of Nepal. Nepal Health Sector Strategy Implementation Plan 2016–2021. Kathmandu, Nepal: Ministry of Health and Population, 2017. Available at: https://www.nhssp.org.np/NHSSP_Archives/health_policy/NHSS_implementation_plan_2016_2021_february2017.pdf

5.3 Proposed Minimum Essential Package for Sexual and Reproductive Health Services

This study identifies the following set of possible components for a package of essential SRH interventions for Nepal by combining the elements contained in the international standards, domestic legal provisions, and components highlighted in the FGD. This package can serve as the benchmark for resource allocation and policy formulation for the government and for monitoring and advocacy for civil society and I/NGOs. This list is unique to for the context of Nepal because it includes issues raised by right holders of this study:

- Education, information, counselling, and facilities, goods and services relating to sexual and reproductive health including subfertility, infertility, sexual health, contraceptives, and general well-being
- Antenatal, childbirth, and postnatal care facilities, goods and services, including emergency obstetric and new-born care, ectopic pregnancy
- Safe abortion services, post abortion care service and treatment of complications of unsafe abortion
- Prevention and treatment of HIV and other sexually transmitted infections
- Prevention, detection, immediate services, and referrals for cases of sexual and gender-based violence
- Prevention, detection, and management of gynaecologic cancers
- Nutritious, balanced diet and physical rest during the condition of pregnancy and childbirth, and morbidity
- Work health and safety such as regular check-ups, proper toilets, changing rooms and safe water and other sanitation facilities
- Mental health services and arrangement of a psychosocial counsellor in each ward by the government and proper reference mechanism.

The components included in the package above are mainly related with medical requirements for protecting and fulfilling the right to health.

However, human rights are indivisible and interdependent. Failure to protect and fulfil one right affects other rights adversely. Therefore, the government needs to be agile in protecting and

fulfilling other economic, social and cultural rights which constitute the underlying determinants of the right to health including the right to food, right to adequate standard of living, rights to education, housing, water, sanitation and social security. Not only economic, social and cultural rights, but the protection of certain civil and political rights are required, too. For example, the right to birth registration and nationality, freedom from violence, equality in marriage, right to participation in decision-making. Interpretation by the Human Rights Committee on the right to life (General Comment No. 36) recognizes that the protection of SRH is required to guarantee the right to life.⁶⁶

6. OVERVIEW OF NEPAL'S HEALTH SYSTEM

The Constitution has incorporated health as a concurrent power among all three levels of government and defines the respective powers of federal, state, and local government.⁶⁷ The responsibilities entrusted exclusively to the federal government are formulating health policies, health services, health standards, quality and monitoring, national or specialized service providing hospitals, traditional treatment services, and communicable disease control. Local governments have the responsibility of providing all basic health services and sanitation. Basic health services have a list of 17 different types of services ranging from immunization to family planning to nutrition. The responsibilities related to drugs and family planning, and population management are concurrent for the provinces and the federal government. (Table 4 shows the various responsibilities of federal, provincial, and local level governments).

Although local and provincial level governments have enormous responsibilities in providing health services to citizens, they are heavily dependent on the federal government for financial resources. The federal government provides four types of grants to provincial and local level governments whose own source of revenue is minimal. Besides that, these governments receive a proportion from revenue sharing.

⁶⁶ Human Rights Committee (CCPR). General Comment No. 36: Article 6 (Right to Life), CCPR/C/GC/36, para. 8.

⁶⁷ Schedule 5, 6, and 8 of the Constitution of Nepal 2015.

Table 4: Functions of Responsibilities of Three Tiers of Government

Source	Federal Government	Provincial Government	Local Level Government	Concurrent Power
Constitution	Health policies, health services, health standards, quality and monitoring, national or specialized service providing hospitals, traditional treatment services and communicable disease control	Health services	Basic Health	Health, Drugs, Ayurveda
Unbundling of functions and responsibilities	<ol style="list-style-type: none"> 1. National level health policies, laws and standard 2. Establishment, operation, and regulation of national and central level hospitals and health academy 	<ol style="list-style-type: none"> 1. Development of policy, acts, standards, plan formulation, implementation and M&S relating to health services and nutrition, 2. Management of required preventive, curative and 	<ol style="list-style-type: none"> 1. Formulation, implementation, monitoring, evaluation and regulation of policies, laws, standards and plans related to basic health 2. Operation and promotion of basic health, reproductive 	

<p>3. Accreditation of hospital and health facilities</p> <p>4. Health insurance and social health security</p> <p>5. Monitoring and regulation of drugs</p> <p>6. Supply and management of vaccine and contraceptives</p> <p>7. Establishment, operation, and regulation of national reference laboratory and testing centres</p> <p>8. Public health emergencies, disaster in health sector, and management of pandemic</p>	<p>rehabilitative health services,</p> <p>3. Registration, licensing and M&S of province level professional, commercial and occupational health related organization and institutions.</p> <p>4. Standard setting, M&S of province level health services</p> <p>5. Registration, licensing and M&S of province level pharmaceutical industries, standards setting and quality control and retail price fixation</p> <p>6. Registration, licensing as per national standards of nursing homes, cure centres, treatment centres and other health</p>	<p>health, and nutrition services,</p> <p>3.Establishment and operation of hospitals and other health institutions,</p> <p>4.Physical infrastructure development and management for health services,</p> <p>5.Blood transfusion service, and local and urban health services,</p> <p>6.Permission, monitoring and regulation of pharmacies/medicine shops operation,</p> <p>7.Services, permits, monitoring, and regulation related to family-planning and mother-child welfare</p> <p>8.Reduction, prevention, control and management of malnutrition in women and children.</p>	
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		<p>service delivery organization including laboratory registration and M&S at province level.</p> <p>7. Management and monitoring and supervision of health insurance programme</p> <p>8. Province level health sector manpower development and management</p> <p>9. Drug surveillance, right use of drugs and minimization of antimicrobial resistance</p> <p>10. Immunization and family planning</p> <p>11. Procurement and supply chain management of sensitive drugs and other health materials</p>	
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		<p>12. Health-related study and research, information system, health audit system and information flow</p> <p>13. Tobacco, alcohol and drugs standard setting and control and supervision</p> <p>14. Emergency, disaster and epidemic control health services and buffer stock of drugs at province level</p> <p>15. Control and treatment of communicable and non-communicable disease</p> <p>16. Development and management of health-related physical infrastructure as per national standards</p>	
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		<p>17. Standard setting of health disposals</p> <p>18. Province level standard setting and M&S of Ayurveda, Unani, Amchi, Homeopathy including traditional medicine</p> <p>19. Management of Provincial Health Science Academy</p>	
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In the last few years, Nepal has made progress on indicators in the health sector and yet, these indicators are not very encouraging. For example, although the maternal mortality ratio declined from 750 in 1996 to 250 in 2017,⁶⁸ it is one of the highest in South Asia. Similarly, births attended by skilled health staff increased from 7.4% in 1991 to 53.4% in 2017,⁶⁹ and is still the lowest in South Asia. Only 11 percent of the population in Nepal is enrolled in health insurance.⁷⁰

<i>Variable</i>	Value (Year)	Value (Year)	Source
<i>Physicians (Per 1000 people)</i>	0.1 (1990)	0.8 (2019)	WDI
<i>Nurses and Midwives (per 1000 people)</i>	0.5 (2004)	3.3 (2019)	WDI
<i>Hospital beds (Per 1000 people)</i>	0.2 (1990)	14 (2019)	WDI for 1990 and estimated using information available at Annual Health Report-219/20
<i>Life expectancy at birth</i>	54 (1990)	71 (2020)	WDI
<i>Health expenditure per capita (USD)</i>	8.55 (2000)	53.25 (2019)	WDI
<i>Out-of-pocket (OOP) expenditure per capita (USD)</i>	4.77 (2000)	30.84 (2019)	WDI
<i>UHC effective coverage index⁷¹</i>	29.3 (1990)	47.3 (2019)	IHME

⁶⁸ World Bank. *Maternal Mortality Ratio (modeled estimate, per 100,000 live births)*. Available at: <https://data.worldbank.org/indicator/SH.STA.MMRT.NE?locations=NP-IN-PK-BD-LK-BT>

⁶⁹ World Bank. *Births attended by skilled health staff (% of total)*. Available at: <https://data.worldbank.org/indicator/SH.STA.BRTC.ZS?locations=NP-IN-PK-BD-BT-MV-LK-AF>

⁷⁰ Ranabhat, C.L., Subedi, R., and Karn, S. Status and determinants of enrollment and dropout of health insurance in Nepal: an explorative study. *Cost Effectiveness and Resource Allocation*, 18, 2020, p. 40. Available at: <https://doi.org/10.1186/s12962-020-00227-7>

⁷¹ The Universal Health Coverage (UHC) effective coverage index aims to represent service coverage across population health needs and how much these services could contribute to improved health.

<i>Number of public health facilities</i>	1098 (1990)	7686 (2022)	Economic Survery for 1990 and Nepal Health Facility Registry for 2022
<i>Number of private/NGOs health facilities</i>	16 (1990)	2257 (2022)	Adikari et al. (2021) for 1990 and Nepal Health Facility Registry for 2022
<i>Percentage of HH having health facilities within 30-minute travel time</i>	45 (1995)	80 (2021)	NLSS I for 1995 and Cao et al. (2021)

Table 5: Selected health sector indicators over time

Basic elements of access to healthcare include coverage, services, timeliness, and adequate workforce.⁷² Despite improvement in access to overall healthcare indicators the situation is still not up to the mark. There are only 3.5 nurses, and 0.4 hospital beds per 1,000 persons in the country.⁷³ Only 61.8 percent of the total population (59 percent in rural areas, and 85.9 percent in urban settings) can reach a health post by foot in under 30 minutes.⁷⁴ This percentage goes down when income/consumption levels decline. Similarly, per capita health expenditure is just USD 58 in comparison to USD 73 for India and USD 501 for China. The doctor-patient ratio is 0.17 per

⁷² Agency for Healthcare Research and Quality (AHRQ). *Chartbook on Access to Health Care*. Available at: <https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/access/index.html>

⁷³ World Bank. *Nurses and midwives (per 1,000 people)*. Available at: <https://data.worldbank.org/indicator/SH.MED.NUMW.P3?locations=NP>; World Bank. *Hospital beds (per 1,000 people)*. Available at: <https://data.worldbank.org/indicator/SH.MED.BEDS.ZS?locations=NP>

⁷⁴ CBS. *Nepal Living Standard Survey-2010/11: Statistical Report Vol. I*. Central Bureau of Statistics, 2011.

1,000, which is substantially lower than the WHO recommendation of 2.3 doctors per 1,000 population.⁷⁵ Access to health is determined not only by geographical location and income but also by caste, ethnicity, sex and gender. For example, the under-five mortality rate is 31 for the Brahmin/Chhetri castes in comparison to 51 for Dalits.⁷⁶

Access to healthcare and the right to health have worsened further during COVID-19. There have been many adverse economic, social, and health implications of COVID-19, which are likely to cause several long-term consequences. A recent estimate of the National Planning Commission shows that the loss in GDP in Nepal has been equivalent to NPR 200 billion due to the direct and indirect impact of COVID-19.⁷⁷ Similarly, 1.6 million people lost their jobs and an additional 1.2 million have been pushed below the poverty line due to the pandemic.⁷⁸ It is expected that the poverty rate will further increase and it will be difficult to achieve the Sustainable Development Goals in the stipulated time. COVID-19 related disruptions in livelihoods and the contraction in household income and consumption are expected to disproportionately affect those living in conditions of poverty, vulnerability, and those engaged in informal sector activities.⁷⁹

Despite the government's efforts to enhance the quality of care, a Demographic Health Survey (DHS) shows that the majority of people are not satisfied with the services they receive.⁸⁰ Another study carried out by the South Asian Institute for Policy Analysis and Leadership (SAIPAL)⁸¹ revealed that there was a severe problem in labor-management, staffing and infection prevention in the health facilities that were implementing Safe Motherhood Program (Aama Surakshya Program).⁸²

⁷⁵ Central Bureau of Statistics. Government of Nepal. National population and housing census 2011 (National Report). November 2012.

⁷⁶ Ghimire, U., Manandhar, J., Gautam, A., Tuladhar, S., Prasai, Y., and Gebreselassie, T. Inequalities in Health Outcomes and Access to Services by Caste/Ethnicity, Province, and Wealth Quintile in Nepal. *DHS Further Analysis Reports No. 117*. Rockville, Maryland, USA: ICF, 2019.

⁷⁷ Acharya, K. "कोरोनाले जीडीपीमा २ खर्ब क्षति." *Kantipur*, 5 November 2020. Available at: <https://ekantipur.com/news/2020/11/05/160453834768582797.html>

⁷⁸ Ibid.

⁷⁹ World Bank. Nepal Overview. Available at: <https://www.worldbank.org/en/country/nepal/overview>

⁸⁰ Acharya, S., Sharma, S., Dulal, B., and Aryal, K. Quality of Care and Client Satisfaction with Maternal Health Services in Nepal: Further Analysis of the 2015 Nepal Health Facility Survey. *DHS Further Analysis Reports No. 112*. Rockville, Maryland, USA: ICF, 2018.

⁸¹ Devkota, M., Adhikari, D., and Bhatt, H. Readiness of health facilities to provide quality maternal and newborn services. Kathmandu, Nepal: South Asian Institute for Policy Analysis and Leadership, 2019.

⁸² Launched by Health Service Department, Department of Health Services of Government of Nepal to increase the rate of institutional deliveries, thereby improving maternal and child health.

And yet, it has to be acknowledged that Nepal has made progress in quantity and quality of health service provision after the restoration of democracy in 1990. Improvements in Nepal's health sector performance are reflected in improvements of the SDG 3 indicators. For example, the maternal mortality ratio decreased from 553.0 per 100,000 live births in 2000 to 186.0 per 100,000 live births in 2017 and the proportion of women of reproductive age who have their need for family planning satisfied with modern methods increased from 52.8 % in 2001 to 56.0% in 2017.⁸³

Several factors are responsible for the improved performance of the health sector in Nepal including progress in policy formulation and implementation, growth in health facilities and access to health services.

Table 5 above shows some factors that might be responsible for bringing a change in the health sector performance in Nepal. Progress in access to health service in Nepal continues to be rather uneven especially between rural and urban areas. Rural people rely on traditional healers, home remedies and local pharmacy prescriptions. Local pharmacies can sell even antibiotics, steroids, and other similar medicines without as prescriptions over the counter.

The health sector and SRH related budget and expenditure have been analyzed for all three levels of government for the period of 2015/16-2019/20. Major data sources for the budget analysis include the federal government's budget details (red book), consolidated financial statements, and the line ministry's budget information system (LMBIS).

The provincial government's budget and expenditure data have been derived from their annual budget speech. The local government's budget and expenditure have been obtained from the Subnational Treasury Regulatory Application (SuTRA).⁸⁴

The Government of Nepal estimated the cost of achieving SDG 3 in 2018 based on the costing exercise carried out by Gautam and Azzam (2015),⁸⁵ which estimates the cost of implementing the Nepal Health Sector Strategy Plan (2015-2020). According to the SDG costing, on an average, the country needs to invest NPR 134.2 billion per year for achieving the SDG target. This amount is

⁸³ United Nations Statistics Division (UNSD). Nepal SDG Country Profile. Available at: <https://unstats.un.org/sdgs/dataportal/countryprofiles/npl#goal-3>

⁸⁴ Government of Nepal, Financial Comptroller General Office (FCGO). Sub-National Treasury Regulatory Application (SuTRA). Available at: <https://sutra.fcgo.gov.np/index.asp>

⁸⁵ Gautam, G., and Azzam, O. *Nepal Health Sector Strategy 2015 – 2020 Estimation of the Implementation Cost*. Kathmandu, Nepal: World Health Organization, 2015.

about 3.9% of the GDP and approximately NPR 4,597 per capita.⁸⁶ Out of the total investment required, 64% investment is expected to be made by the government, 27% by the private sector, and remaining 9% by households.

This costing exercise however, does not estimate the cost for SRH separately.

Sundaram et.al.(2019)⁸⁷ estimated the cost of providing contraceptive and maternal health needs of women as well as the newborn health needs in Nepal. According to the estimate, providing for both modern contraception as well as maternal and newborn health care (MNH) would require an investment of USD 131 million per year of which Maternal and Newborn Health (MNH) care would amount to USD 96 million per year or NPR 11.5 billion.

Gartaula et. al. (2020)⁸⁸ estimated the out-of-pocket (OOP) expenditure on health service delivery at the Paropakar Maternity and Women's Hospital- a public tertiary hospital. The study found that the median OOP expenditure of the participants for maternal delivery was NPR 11,720. Although this estimate may vary by region it clearly indicates that there are heavy OOP expenses borne by individuals beyond the government's free health services.

7. PUBLIC EXPENDITURE ON HEALTH AND SEXUAL AND REPRODUCTIVE HEALTH

Article 35 of the Constitution of Nepal ensures the right to free basic health services for every citizen by the State. SDG 3 aims to ensure healthy lives and promote well-being for all, at all ages. Ensuring affordable and quality health care is the long-term national strategy.⁸⁹ The government has announced several programs to provide health services to its citizens. Free basic health

⁸⁶ Based on 2018/19 GDP and population according to 2021 Census i.e. 29,192,480.

⁸⁷ Sundaram, A., Puri, M., Douglas-Hall, A., Wagle, K., Castle, K., & Weissman, E. Adding It Up: Costs and Benefits of Meeting the Contraceptive and Maternal and Newborn Health Needs of Women in Nepal. Kathmandu, Nepal: Guttmacher Institute, March 2019. Available at: <https://www.guttmacher.org/report/adding-it-up-meeting-contraceptive-mnh-needs-nepal>

⁸⁸ Gartaula, P., Neupane, S., Thakur, D.N., and Sangroula, R.K. Out of pocket expenditure on health service delivery at a tertiary care women's hospital: A descriptive cross-sectional study. *JNMA Journal of the Nepal Medical Association*, 58(232), 2020, pp. 1024–1027. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8028534/>

⁸⁹ Government of Nepal. *The 15th Periodic Plan of Nepal (FY2019/20–FY2023/24)*.

services,⁹⁰, medical treatment of “deprived citizens”,⁹¹ the Safe Motherhood Programme,⁹² and health insurance programme are some such programs. The policy and programme environments are being improved consistently. Some of the recent key policies include the National Strategy for Reaching the Unreached 2016-2030 (NSRU), Safe motherhood and Reproductive Rights Act 2018, Public Health Act 2018, and the MNH Roadmap 2030.

The NSRU considers those living in remote areas, historically excluded communities of different castes and ethnic groups, religious minorities, people living in poverty, older persons, persons with disabilities, sexual and gender minorities, prisoners, refugees, and informal sector workers as the unreached populations. The strategy recognizes the importance of availability, accessibility, affordability, and quality of health services by aiming to increase the number of health facilities, human resources, improving transportation and ambulance facilities, creating funds to provide financial support for those who cannot afford the services, improving access to information, and maintaining quality services. The strategy also addresses the issue of food supply and group friendly health facilities as components of increasing access to health services.

Despite the appropriate policy environment, lack of resources, both financial and human, remain a major obstacle. How much investment a country needs to fulfil the right to health of all in general, and SRHR in particular, requires evidence-based analysis. The international community has attempted to suggest estimates in this regard. However, the extent to which these estimates fulfil the entire range of the right to health in a particular context is unclear. For example, the WHO 2010 World Health Report states that if a country's combined total expenditure on the health sector from government revenue and compulsory health insurance is less than 5-6% of GDP then the country will struggle to ensure health service coverage for the poor.⁹³ Similarly, the WHO Regional Office for the Americas advocates an allocation of 6% of the GDP in order to aim for universal health coverage. Table 6 shows that Nepal's government expenditure on health however is less than 2% of the GDP and less than 5% of the total expenditure (2015-2019).

⁹⁰ Department of Health Services (DoHS), Ministry of Health and Population (MoHP), Government of Nepal. Basic Health Service Package 2075. Kathmandu, Nepal: DoHS, MoHP, 2018.

⁹¹ *Poor patients to get grant for treatment*. Kathmandu, Nepal: The Himalayan Times, February 8, 2019. Available at: <https://thehimalayantimes.com/kathmandu/poor-patients-to-get-grant-for-treatment>

⁹² Family Welfare Division, Ministry of Health and Population, Government of Nepal. *Nepal Safe Motherhood and Newborn Health Road Map 2030*. Kathmandu, Nepal: Ministry of Health and Population, September 2019.

⁹³ World Health Organization. *Health Systems Financing: The Path to Universal Coverage*. Geneva: WHO, 2010. Available at: https://iris.who.int/bitstream/handle/10665/44371/9789241564021_eng.pdf?sequence=1&isAllowed=y

7.1 Health Sector Budget and Expenditure

	2015/16	2016/17	2017/18	2018/19	2019/20
Health Budget					
<i>Federal Budget</i>	41.3	48.4	41.1	65.3	52.3
<i>Provincial Budget</i>			0.2	8.7	8.5
<i>Local Level Budget</i>			18.5	24.9	31.7
<i>Total National Health Budget</i>	41.3	48.4	59.8	99.0	92.4
<i>National Health Budget (% of Total Budget)</i>	5.1%	4.7%	3.4%	4.7%	4.1%
Health Expenditure					
<i>Federal Expenditure</i>	34.0	45.4	35.9	36.0	40.2
<i>Provincial Expenditure</i>			0.1	5.3	6.5
<i>Local Level Expenditure</i>			14.2	18.6	24.1
<i>Total Health Expenditure</i>	34.0	45.4	50.3	59.8	70.8
<i>Health Expenditure (% of Total Expenditure)</i>	5.7%	5.4%	3.8%	3.9%	4.5%
<i>Health Expenditure (% of GDP)</i>	1.5%	1.7%	1.7%	1.7%	1.9%
SRH Budget					
<i>Federal SRH Budget (billion NPR)</i>	0.69	0.95	1.60	0.79	0.91
<i>Provincial SRH Budget (billion NPR)</i>			0.00	0.48	0.77
<i>Local Level SRH Budget (billion NPR)</i>			2.76	1.31	6.72
<i>National SRH Budget (billion NPR)</i>	0.69	0.95	4.36	2.58	8.40
<i>Per WRA SRH Budget (NPR)</i>			559.17	352.17	1027.2
Ayurveda and Alternative Medicine Budget					
<i>Federal Level Budget (billion NPR)</i>	1.12	1.29	0.72	0.39	0.3
<i>Local Level Budget (billion NPR)</i>			0.62	NA	1.71

Table 6: Health Sector Budget and Expenditure⁹⁴ (NPR in Billion)

Source: (a) Federal Budget- Redbook, (b) Federal expenditure- Consolidated Financial Statement, (c) Province Health Budget- Province LMBIS, (d) Local-level budget, and expenditure-

⁹⁴ Budget and expenditure of provincial and local level government is highly dependent on federal grants. Federal government provides four types of grants- Fiscal equalization grant, conditional grant, special grant and complementary grant. While fiscal equalization grant is based on formula, other grants are determined by different types of criteria but not by formula.

estimated using SuTra Data, (e) Provincial Health Expenditure- Estimated by multiplying the budget by the ratio of federal and local level health expenditure to their health budget.

The country's current health expenditure as a percentage of GDP is less than 2% - considerably less than the 6% that WHO estimates is required as minimum⁹⁵ - with out-of-pocket (OOP) expenditure for the year 2019 at about 58% of the current health expenditure⁹⁶. Thapa (2017), using Nepal Living Standard Survey-2011 data, found that OOP cost for the poorest 20% of households is 20.5% of non-food expenditure and 5.65% of consumption expenditure. This share was only 3.22% and 1.96% respectively for the richest 20% of households.⁹⁷ Thapa (2017) also estimated that poverty increases by 2.9% if OOP expenditure is adjusted to households' consumption basket.⁹⁸ WHO reported the incidence of catastrophic expenditure, defined as the percentage of the population whose OOP spending exceeds 10% and 25% of consumption or income in Nepal for the year 2016 was 10.7% and 2.1% respectively.⁹⁹

A high OOP expenditure exacerbates poverty and inequality and is one of the major barriers for the enjoyment of the right to health as well as for meeting the targets of Universal Health Coverage.¹⁰⁰

Besides OOP expenditure, Nepal's current health expenditure is largely dependent on non-profit institutions serving households (NPISH) including donors. The proportion of NPISH in current health expenditure in Nepal increased from 9.2% in 2015 to 18.7% in 2019.¹⁰¹ The increasing share of NPISH is worrisome in the context of the right to health as it signals that the provision on health care is not sustainable.

⁹⁵ World Bank. Current health expenditure (% of GDP). Available at:

<https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=NP>

⁹⁶ World Health Organization. *National Health Accounts database indicators*. Available at:

<https://apps.who.int/nha/database/ViewData/Indicators/en>

⁹⁷ Thapa, A.K. An Assessment of Household's Out of Pocket Healthcare Payment and Impoverishment in Nepal: Evidence from Nepal Living Standard Survey III. *Journal of Development and Social Engineering*, 3(1), 2017, pp. 17–24.

⁹⁸ Ibid.

⁹⁹ Global monitoring report on financial protection in health 2021. Geneva, Switzerland: World Health Organization and International Bank for Reconstruction and Development / The World Bank, 2021.

¹⁰⁰ Balarajan, Y., Selvaraj, S., and Subramanian, S. V. Health care and equity in India. *The Lancet*, 377(9764), 2011, pp. 505–515.

¹⁰¹ See citation 96.

7.2 Sexual and Reproductive Health and Expenditure

The public budget for the sexual and reproductive health sector increased from NPR 0.69 billion in 2015/16 to NPR 8.56 billion in 2019/20, a twelvefold increase (Table 7). The SRH budget increased rapidly once the country adopted a federal system of governance. In terms of cost per Women of Reproductive Age (WRA) (15-49 years) the SRH budget was about NPR 1,027 for the year 2019/20. If the actual expenditure is assumed to be 77% (health sector absorption capacity for the year 2019/20) of the total budget then the per WRA expenditure comes to be NPR 791 (approx. USD 6.6). This is only 73% of the required SRH expenditure as suggested by Guttmacher-Lancett Commission¹⁰² which states that "in developing regions, an estimated US\$9 per capita annually would cover the total cost of fully meeting women's needs for modern contraception and providing health services recommended by the World Health Organization to all pregnant women (including those who have miscarriages, still births or abortions as well as live births) and to newborns."

Not only is the SRH budget and expenditure low compared to that recommended but more importantly, the distribution measured in terms of per WRA is unequal. From our research, it is found that there are certain number of girls below 15 years who have been working in entertainment sector and as sex workers which reflects that the budget with accordance to WRA is not justifiable and needs to be analyzed. Table shows that per WRA budget varies from NPR 84 (Hill sub metropolis) to NPR 1599 (Mountain rural municipality). Similarly, per WRA expenditure varies from NPR. 16.6 (Hill sub metropolis) to NPR. 1161 (Mountain rural municipality).

a. Budget

Per WRA Budget-2019/20			
	Mountain	Hill	Terai
Metropolis		264.9	604.9
Sub metropolis		84.4	228.8
Municipality	1059.4	795.3	594.7
Rural Municipality	1599.1	1108.9	763.8

¹⁰² Guttmacher–Lancet Commission. *Accelerate Progress: Sexual and Reproductive Health and Rights for All – Executive Summary*. Guttmacher Institute, 2018. Available at: https://www.guttmacher.org/sites/default/files/page_files/accelerate-progress-executive-summary.pdf

b. Expenditure

Per Capita Expenditure-2019/20			
	Mountain	Hill	Terai
Metropolis		145.7	440.1
Sub metropolis		16.6	174.8
Municipality	848.3	647.0	451.2
Rural Municipality	1161.1	775.6	561.3

Table 7: Per WRA SRH budget and expenditure-2019/20 (Source: Calculated using the data from SuTRA and HMIS)

Although a rough picture can be acquired of the public expenditure on health, including SRH, there is no clear data available to analyze how much the government spends for the women in the respective study group categories. However, based on the information derived from FGD, it can be inferred that the public expenditure on SRH on sex workers, the entertainment sector workers, domestic workers, and women affected by conflict is far less than the per WRA expenditure reported in Table. This is based on the assumption that these groups of women use public health services at a minimum due to several obstacles they encounter.

7.3 Ayurveda and Alternative Medicine Budget and Expenditure

Table 6 shows the federal level budget for Ayurveda and alternative medicine. This budget is falling over the years. It declined from NPR 1.12 billion in 2015/16 to NPR 0.30 billion in 2019/20. One possible reason for the declining federal level budget could be that the federal system of governance in which most of the Ayurveda and alternative medicine-related responsibilities were located have now been shifted to local level governments. Local-level budget for Ayurveda and alternative medicine increased from NPR 0.62 billion in 2017/18 to NPR 1.71 billion in 2019/20.¹⁰³

¹⁰³ Local level budget for the year 2018/19 has not been included due to inconsistency in data entry for that year. For example, budget on regular office expenditure and water quality monitoring have also been included in the Ayurveda and alternative medicine sector. Similarly, provincial level data has also not been included due to unavailability of the data.

8. DISCUSSION AND CONCLUSION

The Constitution of Nepal has provisioned the right to free basic health services for all. Similarly, it has also established the right to safe motherhood and reproductive health as fundamental rights. These rights are in conformity with the international human rights treaties that Nepal has voluntarily ratified. The government has also passed and implemented various laws, including the Constitution and directives, that align with its human rights obligations.

All individuals are entitled to the enjoyment of the highest attainable standard of health.¹⁰⁴ Different studies and countries have identified a package of interventions that have positive outcomes for women's sexual and reproductive health. Using the Gutmacher-Lancet Commission's recommendation¹⁰⁵, WHO recommendations, national legal and policy provisions, and FGD, this study identified nine elements that could be included in the package of SRH interventions in Nepal, in relation to sex workers, entertainment sector workers, domestic workers, and conflict-affected women.

The overall health situation measured in terms of access to health, health indicators, and public expenditure on health has improved in the country. In other words, there is increased access to health facilities. The Constitution of the country deems it illegal to discriminate in the provision of health services i.e., it advocates for equality of opportunity for all. However, the findings of the study indicated that there is still a long way to go to ensure equality in terms of the outcome of the right to health for all.

General Comment 15 of the Committee on ESCR¹⁰⁶ makes it clear that the right to health contains four elements: availability, accessibility, acceptability, and quality.

Availability: This study found that there is gradual improvement in the availability of facilities, goods and services necessary for the enjoyment of the right to health including for SRH. As mentioned in the General Comment, the availability of hospitals, clinics, and other health-related

¹⁰⁴ Committee on Economic, Social and Cultural Rights (CESCR). *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, E/C.12/2000/4. United Nations Economic and Social Council, 11 August 2000.

¹⁰⁵ See citation 61.

¹⁰⁶ Committee on Economic, Social and Cultural Rights (CESCR). *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, E/C.12/2000/4, para 12. United Nations Economic and Social Council, 11 August 2000.

buildings, safe and potable drinking water, suitable sanitary facilities, qualified medical and professional staff earning domestically competitive incomes, and necessary medications, are continuously improving.

Workplace health and safety are other serious issues for women. Long working hours, lack of rest, lack of changing rooms, absence of clean water and sanitation including proper toilets, smokey and noisy work environment (entertainment sector), and verbal and sexual abuse are common problems for domestic workers, entertainment sector workers, and female sex workers. The Government is reluctant to monitor and regulate these sectors.

Accessibility: Contrary to availability, accessibility remains weak. Non-discrimination, physical accessibility, affordability, and access to information are the key components of accessibility. The women of the study group are facing several accessibility barriers. Some of the barriers are common to all four groups of women and others are specific to a particular group. Low level income is the most common barrier to access the health care services, followed by social stigma and discrimination and lack of awareness of services.

Poverty and low-income levels force the women to either remain uncared for in terms of SRH or use substandard and uncertified health services. Most women who cannot afford treatment rely on home remedies and local pharmacies. Many women afflicted by conflict are forced to go for years without medical care due to remoteness of health facilities and lack of funds.

Stigma against sex work and entertainment work poses a strong and often insurmountable barrier to the enjoyment the right to SRH. Women hesitate to visit the nearest hospital for medical services due to the fear of stigma and degrading treatment. In this situation, they either conceal their health problems or visit a distant hospital where there is no possibility of being identified. Here, it is essential to note that accessing distant health facilities increases the cost of medical services as many of these services are also in private hospitals.

Physical distance to health posts and centres is a major barrier for women, especially women affected by conflict. In order to access specialized and advanced health care services they need to visit either the capital city or other nearest city hospitals.

The culture of shaming women with sexual and reproductive health ailments¹⁰⁷ forces women to remain silent and refrain from accessing medical support and care. Women with reproductive health issues often find it difficult to discuss them openly. The problems of lack of privacy, absence of female doctors at health facilities, and remoteness of health centres as faced by equally by adolescent girls and women of all ages and all geographical locations. These challenges particularly affect the groups of women in focus of this study.

Although the government provides free basic health services, many women of this study were not aware of this fact. They continue to suffer and live without any treatment out of fear that they lack sufficient funds to pay for the medical costs. Many have not visited any health facilities where they could get free consultations and treatment. In many cases, women have borrowed money at a very high-interest rates for their treatment. Several studies including this one found that women are paying for those services which are supposed to be free of cost at public hospitals. For example, a rapid assessment of Safe Motherhood Program in Nepal found that 13 percent of surveyed women paid some amount of money for their delivery even when the delivery service is free in the country.¹⁰⁸

Furthermore, women have little knowledge about SRH. Most of the participants in the FGD knew only about HIV/AIDs and/or uterine prolapse and/or pregnancy and linked them with SRH. Since the women themselves were not aware of what SRH entailed, there was underreporting of their health problems and symptoms related to SRH.

Acceptability: All medical facilities, products, and services must be respectful of medical ethics and culturally acceptable in order for the right to health to be fully enjoyed.¹⁰⁹ In Nepal, the new Criminal (Code) Act 2017 criminalizes advertising and providing facilities for sex work in the section concerning crimes against the public good. Therefore, sex workers are largely treated by government authorities as criminals. As a result, sex workers remain silent and rely on clandestine methods to get medical support when they need it. Stigma by all actors has grievously affected

¹⁰⁷ N. R. Thapa. *Factors Influencing the Use of Reproductive Health Services Among Young Women in Nepal: Analysis of the 2016 Nepal Demographic and Health Survey*. *Reproductive Health*, 17(102), 2020, pp. 1–12. <https://doi.org/10.1186/s12978-020-00937-7>.

¹⁰⁸ Acharya, S., Pande, S., KC, V., and Singh, N. *Rapid Assessment of Aama Surkashya Programmeme: Round X*. Technical Report, May 2017.

¹⁰⁹ Committee on Economic, Social and Cultural Rights (CESCR). General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), E/C.12/2000/4, 11 August 2000.

their personality, self-worth, dignity and mental health. This situation has forced them to struggle for their livelihood whilst making their health issues secondary. Their health-seeking behavior has been severely impacted by these barriers. Fear of adverse effects of stigma on their children and families compels them to constantly camouflage their identity and adopt clandestine as well as disempowering ways to negotiate with clients, employers, and even police to keep their identity secret. This has a gravely deleterious effect on their health-seeking practices.

The condition of women affected by conflict who were victim of sexual violence is also ridden with harm and suffering. Repeated and ongoing abuse has affected their physical, mental, and sexual health. Existing SRH policies and programmes seem to be ineffective and do not speak to the realities of women. Their struggle to sustain their lives and ignorance of available possibilities have pushed their health needs to the margins. Furthermore, it is difficult to address their health needs without creating trust amongst women regarding existing state structures. Their right to health is intertwined with other rights and lack of citizenship is also prohibiting many women, especially single mothers, to avail of the health benefits and schemes provided by the government. Moreover, the health care provider in most cases in rural Nepal are male and women have, more often than not, returned without getting care due to same reason as they feel uncomfortable to share their SRH issues with the opposite gender. In addition to this, stigma related to being the survivor of conflict related sexual violence also becomes a barrier to the women seeking sexual health care.

Hiding pain, using home remedies, and visiting traditional healers are common practices among women the FGD. However, there are no any guidelines, norms, or standards for using alternative medical systems, home remedies and traditional healers. There have been instances of charlatans posing as traditional healers to exploit women. Although the government has made of activities such as witchcraft illegal, several women still follow them who employ such practices.

Protecting the right to health is the government's responsibility. The government, with the support of other actors, must facilitate access of all to essential health services to ensure that the right to health is protected and no one is left behind. It also needs to ensure the progressive realization of the right to health. This means that the government needs to take appropriate measures to monitor and review resource allocation towards the full realization of the right to health to the maximum

of its available resources.¹¹⁰ One indicator of the progressive realization of the right to health is to monitor the trend of budget allocation and expenditure. The data shows that both the health sector budget and SRH budget while on the increase, are much lower than the recommended expenditure and nowhere near fully accessible to the most left behind and marginalized women, as shown by this study.

Allocating maximum available resources for progressive realization of SRH: Being a party to the ICESCR, it is the obligation of the Government of Nepal to allocate the maximum available resources for ensuring the progressive realization of SRH. The public budget and expenditure on SRH is well below the recommended health sector expenditure of 5%-6% of the GDP. The 2019/20 data shows that the government spent only 1.9% of the GDP on the health sector although the allocated budget was 4.1%. It implies that budget allocation needs to be matched by the government's ability to improve its spending and operational capacity.

Raising the budget every year does not ensure that there is progressive realization of SRH. It is important at the same time to ensure that no one is left behind.

Additionally, although SRH services are free in the country, women are paying for them. This indicates that the monitoring mechanisms are not efficient. On one hand, the budget is not being spent giving priority to economic, social and cultural rights, notably SRH, on the other hand, people are paying for the services that are free. It means that either the health sector budget has not been allocated properly or there is an inefficient monitoring mechanism and dissemination of information, or both. The government needs to improve these issues including by public awareness of the services so that the health related information is easily accessible to the general people.

9. RECOMMENDATIONS

9.1 General Recommendations

- Recognize women's work as work and ensure the registration of women workers across all sectors and levels of employment, including the protection of their occupational safety and health rights.

¹¹⁰ International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 2(1). United Nations General Assembly, 1966.

- Strengthen justice mechanisms to improve women's access to justice and state institutions.
- Integrate comprehensive sexuality education into compulsory education, ensure the participation of rights-holders and their representative organizations in decision-making, and improve dissemination of health service information to targeted groups of women.
- Build the capacity of health workers to provide non-discriminatory services, including respecting women's autonomy in accessing health care without requiring accompaniment by male partners.
- Improve women's access to the full enjoyment of legally guaranteed rights.

9.2 Recommendations for Entertainment Sector Workers and Female Sex Workers

9.2.1 Sexual and Reproductive Health

- All family planning services and goods, including products such as condoms, pills, Norplant, and hormonal implants, need to be affordable for all and provided free of charge by local governments and government health service providers based on the principle of equality, ensuring no disproportionate financial burden.
- Accessible information on SRH should be provided. This could be done in collaboration with community-based organizations, as sex workers may be wary of identifying themselves due to social stigma and the criminalization of sex work.
- Civil society organizations should provide awareness campaigns on safe sex for sex workers to prevent unwanted pregnancies and related complications.
- Unsafe abortions need to be prevented, and safe abortion services and post-abortion care must be available and accessible at adequate government health facilities. Health care workers should be trained in respectful attitudes toward these women and in safeguarding their privacy.
- Entertainment sector workers and sex workers should have access to affordable, acceptable, and quality SRH services, goods, and facilities, including regular

gynecological check-ups for STIs, uterine prolapse, HIV, and cysts. These services should be ensured by the Ministry of Health and Population (MoHP).

- Measures should be taken, through public hospitals or mobile health camps, to ensure that women can access counseling services without fear of stigma or discrimination based on their occupation. This includes counseling for gender-based violence and mental health support.
- The government should provide essential education, information, counseling, and facilities related to sexual and reproductive health, including services for subfertility, infertility, sexual health, contraceptives, and general well-being.
- Employers must maintain work health and safety standards, including regular check-ups, proper toilets, changing rooms, safe water, and other sanitation facilities.
- Specialized female doctors or medical staff should be available so that women can freely discuss their health issues and receive professional care. Health workers should be trained in non-discriminatory service provision, respecting women's autonomy in accessing health care without requiring accompaniment by male partners.
- Comprehensive sexuality education should be included and strengthened in compulsory education. Rights-holders and their representative organizations should participate in decision-making. Health service information should be better disseminated to targeted groups of women, and access to birth registration, citizenship, and nationality should be improved by the central government and the Ministry of Health and Population.

9.2.2 Nutrition

- Ensure equal access to nutritiously safe food by enabling a separate provision specifically focusing on pregnant and lactating mothers. The action needs to be taken by local governments through social protection measures such as monthly distribution of food baskets or nutritious food allowance to the women who are pregnant and lactating.

9.2.3 Curative Services

- Services such as X-rays, blood tests, urine tests, video X-rays, CT scans, and surgeries should be affordable, acceptable and of good quality for entertainment sector and sex workers (as well as for their children) or free of charge based on the principle of equality.

9.3 Recommendations for Domestic Workers

9.3.1 Sexual and Reproductive Health

- All family planning services and goods, including products such as condoms, pills, and hormonal implants, need to be affordable for all and provided free of cost based on the principle of equality, ensuring that no disproportionate financial burdens fall on women. Accessible information on SRH also needs to be provided.
- Unsafe abortions need to be prevented, and safe abortion services and post-abortion care must be available and accessible at adequate government facilities. Public information should be widely disseminated so that women are aware of where and how to access these services.
- Affordable, acceptable, and quality SRH services, goods, and facilities, including regular overall health check-ups and specific gynecological examinations (for STIs, uterine prolapse, HIV, cysts), should be organized by local governments in coordination with women's organizations, relevant CSOs, and ward personnel.
- Civil society organizations and NGOs should provide learning sessions and awareness campaigns for domestic workers to help them understand their rights, eliminate gender-based violence, and create safe spaces to speak about their issues.
- Measures should be taken, through public hospitals or regular mobile health camps, to ensure that domestic workers can access counseling services without fear of stigma and discrimination based on their occupation. This includes counseling and appropriate responses for gender-based violence as well as mental health support.
- Proper regulation of safe and healthy working conditions for domestic workers, including the provision of paid sick and maternity leave, social security coverage, and

effective complaint/redress mechanisms needs to be ensured by all three tiers of government: local, provincial, and central.

9.3.2 Nutrition

- Provision of safe and nutritious food to domestic workers through their employers needs to be ensured by local government bodies, using social protection measures such as monthly food baskets or a nutritious food allowance, alongside safe and healthy working conditions.

9.3.3 Curative Services

- The government must ratify ILO Convention 189 on domestic workers to promote decent work, recognize their contribution to the economy, and supplement general labor standards with specific protections so that domestic workers can fully enjoy their rights.
- Provision of services such as X-rays, blood tests, urine tests, video X-rays, CT scans, and surgeries needs to be affordable, acceptable, and of good quality for domestic workers and their children or provided free of charge in line with the principle of equality.
- Safe and healthy working conditions and environments, as part of the right to decent work, are essential to ensure that domestic workers can fully enjoy their right to health.

9.4 Recommendations for Conflict-affected Women

9.4.1 Sexual and Reproductive Health

- Access to affordable, acceptable, and quality SRH services, goods, and facilities, including uterine prolapse check-ups and treatment, should be provided at adequate facilities.
- Unsafe abortions must be prevented, and safe abortion services and post-abortion care should be available and accessible at adequate government facilities.
- Affordable, acceptable, and quality SRH services, goods, and facilities, including regular overall health check-ups and specific gynecological examinations (especially for STIs, uterine prolapse, HIV, and cysts), should be provided through mobile health camps in coordination with women's organizations, relevant CSOs, and ward personnel.

- Counseling and rehabilitation services for gender-based violence, domestic violence, and mental health conditions, including PTSD from the conflict, need to be established within accessible distance for all women.
- Measures should be taken to ensure that SRH care providers treat all individuals seeking care in a respectful and non-discriminatory manner, taking into account acceptability regarding the gender composition of health staff, such as ensuring the presence of specialized female doctors or medical staff so that women can openly discuss their health concerns and receive professional support.

9.4.2 Curative Services and NCD Control

- Provision of services such as X-rays, blood tests, urine tests, video X-rays, CT scans, and surgeries must be affordable, acceptable, and of good quality for women and their children, or provided free of charge in line with the principle of equality.
- Disaggregated health and socio-economic data on women should be systematically collected by local governments to identify and address inequalities in health and other underlying determinants. This includes data on education services for children and access to the most relevant health interventions.
- Progressive measures must be taken to ensure that health facilities, goods, and services, including affordable ambulance services, are within safe physical reach for all sections of the population, particularly vulnerable and marginalized groups.
- Affordable, acceptable, and quality SRH services, goods, and facilities must be ensured, including regular overall health check-ups and specific gynecological examinations for STIs, uterine prolapse, gynecological cancers, HIV, cysts, and chronic conditions such as gallbladder and kidney stones.

9.5 Recommendations for SRH Budgeting

- The Ministry of Finance should increase investments in the public health sector budget as well as in SRH subsectors. While allocations appear close to WHO recommendations, actual expenditures remain below the allocated amounts. To address this, the government, with parliamentary approval, needs to improve both spending capacity and allocation

processes. Ring-fencing is also necessary to ensure that budget allocations are not diverted or reduced.

- The government should allocate budgets for the SRH sector based on the actual costs of prevalent and required services. Since costs vary by region, education, and socioeconomic status of women, budget formulation and implementation **must** be transparent and participatory. Participation of rights-holders in budget processes is essential to realizing the right to SRH.
- The government must address barriers to accessing health services beyond income and supply-side factors. It has a specific human rights obligation to ensure equality of access and to provide essential health care and services to those who cannot otherwise afford them.
- Data collection and analysis processes must include marginalized groups of women. Data should be disaggregated and results systematically used for policymaking.
- Access to decent work must be recognized as integral to realizing SRH rights, reflecting the interrelatedness and indivisibility of human rights.
- The Ministry of Health must ensure that VAT is not applied to sanitary pads.
- Civil society organizations and INGOs should strengthen monitoring of SRH budgets and advocate to close the gap between policymaking and implementation, ensuring SRH services are accessible and available to all.

Annex 1: Constitutional Rights Pertaining to Women in Nepal

Section	Article	Clause	Provisions
Preamble			Ending gender discrimination, determination to create an egalitarian society on the basis of the principles of proportional inclusion and participation, to ensure equitable economy, prosperity and social justice.
Part 2: Citizenship	10. Citizenship not to be denied	1	No Nepali citizen shall be denied the right to acquire citizenship.
	11. Nepali citizen to be deemed	2	Any person whose father or mother was a citizen of Nepal at the birth of such a person and have permanent domicile in Nepal shall be deemed to be citizens of Nepal by descent.
		3	A child of a citizen who has acquired citizenship of Nepal by birth before the commencement of this Constitution shall, if his/her father and mother both are the citizens of Nepal, shall be entitled to Nepali citizenship by descent upon his/her attaining the age of majority.
		5	A person born to a Nepali citizen mother and having his/her domicile in Nepal but whose father is not traced,

			shall be conferred the Nepali citizenship by descent.
		6	If a foreign woman married to a Nepali citizen so wishes, she may acquire naturalized citizenship of Nepal as provided for in a federal law.
		7	Notwithstanding anything contained elsewhere in this Article, in case of a person born to Nepali woman citizen married to a foreign citizen, he/she may acquire naturalized citizenship of Nepal as provided for by a federal law if he/she is having the permanent domicile in Nepal and he/she has not acquired citizenship of the foreign country.
	12. Citizenship based on descent and with gender identity		The person who is entitled to the citizenship of Nepal by descent may obtain the citizenship certificate of Nepal from name of his/her mother or father along with gender identity.
Part 3: Fundamental Rights and Duties	16. Right to live with dignity	1	Each person shall have the right to live with dignity.
	17. Right to freedom	1	Except as provided for by law no person shall be deprived of her/his personal liberty

18. Right to equality	1	All citizens shall be equal before law. No person shall be denied the equal protection of law.
	2	There shall be no discrimination in the application of general laws on the grounds of origin, religion, race, caste, tribe, sex, physical conditions, disability, health condition, matrimonial status, pregnancy, economic condition, language or geographical region, or ideology or any other such grounds.
	3	The state shall not discriminate among citizens on grounds of origin, religion, race, caste, tribe, sex, economic condition, language or geographical region, ideology and such other matters. However, government may make laws to protect, empower, and for advancement of women lagging behind socially and culturally,..., and pregnant.
	4	There shall not be any gender discriminations regarding remuneration for the same work and social security.
	5	There shall be no gender discrimination regarding the right to

		parental property with regard to all family members.
21. Right to victim of crime	1	The victim of crime shall have the right to be informed about the investigation and proceedings of the case regarding his/her victimization.
	2	The victim of crime shall have the right to social rehabilitation and justice with compensation as provided for by law.
28. Right to privacy		Except in circumstances provided by law, privacy in relation to the person, and their residence, property, documents, records, statistics and correspondence, and their reputation are inviolable.
29. Right against exploitation	1	Every person shall have the right against exploitation.
	2	No person shall be subjected to any kind of exploitation on the basis of religion, custom, tradition, culture, practices or any other bases.
	3	No person shall be subjected to human trafficking or bonded labor, and such an act shall be punishable by law.
	4	No person shall be subjected to forced labor. However, this clause will not prevent for enacting laws requiring

			citizens to be engaged in compulsory service for public purposes.
		5	Any act contrary to clause (3) and (4) shall be punishable by law and the victim of such an act shall have the right to compensation from the perpetrator.
33. Right to employment	1		Every citizen shall have the right to employment. Terms and conditions of employment and unemployment benefits shall be as determined by Federal law.
		2	Every citizen shall have the right to select employment.
38. Right of women	1		Every woman shall have equal right to lineage without any gender discriminations.
		2	Every woman shall have the right relating to safe motherhood and reproductive health.
		3	There shall not be any physical, mental, sexual or psychological or any other kind of violence against women, or any kind of oppression based on religious, social and cultural tradition, and other practices. Such an act shall be punishable by law and the victim

			shall have the right to be compensation as provided for in law.
		4	Women shall have the right to access participate in all state structures and bodies on the basis of the principle of proportional inclusion.
		5	Women shall have the right to special opportunity in the spheres of education, health, employment and social security on the basis of positive discrimination.
		6	Both the spouses shall have equal rights in property and family affairs
	42. Right to social justice	1	Socially backward women and others shall have the right to employment in state structures on the basis of the principle of inclusion.
	43. Right to social security		Economically poor, physically incapacitated and helpless person, helpless single women shall have the right to social security as provided for by law.
	51. State Policies j. Policies regarding social justice and inclusion	1.	Making appropriate arrangements of livelihoods by prioritizing employment for single women who are in helpless conditions on the basis of skill, capability and merit.

		2	Making women self-reliant who are vulnerable, victims of conflict, excluded by family and the society, by making necessary arrangements of rehabilitation, protection and empowerment for them.
		3	Ensuring the use of necessary services and facilities during the reproductive stage
		4	Economically evaluating the works and contribution in regard to child care and care for the family.
		6	Rehabilitation of kamaiya (bonded laborers), kamlari, haruwa, charuwa, haliya, the landless and the squatters by identifying them, and making arrangements of housing, or providing small plot of land or house, employment, or arable land for their livelihoods.
		12	Giving priority to the very poor within all communities, regions, and gender, while providing social security and social justice.
Part 6: President and Vice-President	70. President and Vice-President to belong to different		While conducting election of the President and Vice-President under this constitution, the election shall be

	gender and community		held so as to represent different gender or communities.
Part 8: Federal Parliament	84. Constitution of House of Representatives	2	Provision shall be made according to Federal law for the representation of political parties to file candidacy for the election of the House of Representatives for proportional representation system through closed list of women... Balance in geography and province shall be considered for such candidacy.
	86. Constitution of National Assembly and terms of members	2	There shall be fifty-nine members in the National Assembly as follows:- a. Fifty six members elected from an Electoral College comprising members of Provincial Assembly and chairpersons and vice chairpersons of Village councils and Mayors and Deputy Mayors of Municipal councils, with different weights of votes for each, with eight members from each province, including at least three women, one Dalit, one person with disability or minority; b. Three members, including at least one woman, to be nominated by the President on the

			recommendation of Government of Nepal.
	91. Speaker and Deputy-Speaker of the House of Representatives	2	While electing Speaker and Deputy Speaker, either Speaker or Deputy Speaker shall be a woman and belong to different parties.
	92. Chairperson and Vice-Chairperson of National Assembly	2	While electing chairperson or vice chairperson of national assembly, either Chairperson or Vice chairperson Chairman of the National Assembly shall be a woman.
Part 14: Provincial Legislature	176. Formation of the Provincial Assembly	6	When a political party nominates a candidate for the provincial assembly election under the proportional representation system, women and others will be represented on the basis of closed list on the basis of population and in accordance with federal law. While giving such candidature, the geographical balance of the concerned province should also be taken into consideration.
		9	At least one third of the total number of members to be elected from each political party to the Provincial Assembly shall have to be women.
	182. Speaker and Deputy Speaker of	2	While electing speaker and deputy speaker, either of Speaker or Deputy

	the Provincial Assembly		Speaker shall be woman and they shall belong to different parties.
Part 17: Local Executive	215. Provisions related to Head and Deputy Head of Village Executive	4	Four women members that are elected by the Village Assembly members from among themselves shall also be members of the Village executive and this election shall be held within 15 days following the final result of the election of Village Assembly
	216. Provisions related to Mayor and Deputy Mayor of Municipality	4	Five women members that are elected by the Municipal Assembly members from among themselves shall also be members of the Municipal executive and this election shall be held within 15 days following the final result of the election of Municipal Assembly
Part 18: Local Legislature	222. Formation of Village Assembly	3	The Village Assembly shall have the representation of at least two women from every Ward of the Village Council.
	223. Constitution of Municipal Assembly	3	The Municipal Assembly shall have the representation of at least two women from every Ward of the Municipality.
Part 27: Other Commissions	252. National Women Commission	1	There shall be a National Women Commission in Nepal consisting of a Chairperson and four other members.

			6	a. A woman who has made a significant contribution for the rights, interest of women or gender justice or women development or in the field of human rights and law for at least ten years is eligible to be appointed as the Chairperson or member of National Women Commission
Part 32: Miscellaneous	282. Nepali Ambassadors and Emissaries		1	The President shall appoint ambassadors of Nepal and other emissaries for specified purposes based on the principle of inclusion.
	283. Appointment to be made on inclusive principles			Appointment to the constitutional bodies and agencies shall be made based on the principles of inclusion.
	285. Formation of the government service		2	Positions of all federal governmental services shall be fulfilled through competitive examinations on the basis of the principle of open and proportional inclusion according to Federal law.

Annex 2: Guttmacher-Lancet Commission's recommendation

According to Guttmacher-Lancet Commission's recommendation, the following are the components of the essential package.

- Comprehensive sexuality education,
- Counseling and services for a range of modern contraceptives, with a defined minimum number and types of methods,
- Antenatal, childbirth, and postnatal care, including emergency obstetric and new-born care,
- Safe abortion services and treatment of complications of unsafe abortion,
- Prevention and treatment of HIV and other sexually transmitted infections,
- Prevention, detection, immediate services, and referrals for cases of sexual and gender-based violence,
- Prevention, detection, and management of reproductive cancers, especially cervical cancer,
- Information, counseling, and services for subfertility and infertility,
- Information, counseling, and services for sexual health and well-being.

Similarly, the WHO recommends eighteen components in SRH interventions. The interventional categories are:

- Antenatal care
- Labor and childbirth care
- Postnatal care
- Abortion
- Ectopic pregnancy
- Contraception and family planning
- Infertility
- Sexual health
- Female genital mutilation
- Intimate partner and sexual violence
- Comprehensive sexuality education
- Breast cancer

- Cervical cancer
- Prostate cancer
- Ovarian Cancer
- Uterine cancer
- HIV
- Sexually transmitted infections.





HUMAN RIGHTS PATHWAYS FOR A NEW SOCIAL CONTRACT

Analysis of selected content of core
and other obligations under the right
to health in Nepal