

Reproductive Rights of Nepalese Women: Current Status and Future Directions

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The International Conference on Population and Development (ICPD) in Cairo in 1994 for the first time introduced the concept of Reproductive Health (RH) through a life cycle approach. Reproductive health was explained as a state of complete mental, physical and social well being in all matters of reproductive systems, its functions and processes. It means being able to have a satisfying and safe sexual life and capability to have children and the freedom to decide if when and how often to do so. Nepal has defined the National Reproductive Health Policy, and has formulated a strategy which encompasses safe motherhood and neonatal care, family planning, management of complications of abortions, STI/HIV and AIDS, infertility, adolescent reproductive health, and reproductive health of the elderly including cancers as the essential components of the national RH package.

It is well known that the burden of reproductive ill health is more in women when compared to men. Both ICPD and the Fourth World Conference on Women (FWCW) in Beijing in 1995 affirmed the human rights of women in the area of reproductive and sexual health. The Cairo conference agreed, "Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain highest standard of sexual and reproductive health" (United Nations 1995, paragraph 7.3)¹. In Beijing Governments agreed "the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences (United Nations 1996, paragraph 96)².

As a signatory to the declarations made in these conferences, HMG of Nepal is committed to provide RH care as human rights to the Nepalese people. Human Rights have been described as universal, indivisible, interdependent and interrelated. Human dignity and non-discrimination are the values inherent in human rights. Principles of rights based approach to programming for health have been adopted by some development agencies; others could share the experiences and scale up these approaches. The key principles of human rights based approach to programming are responsibility and accountability, participation, transparency, empowerment.³

Some Indicators of the Status of Nepalese Women

According to the NDHS 2001 the median age of marriage for women and men in the age group of 20-24 at the time of survey was 16.8 and 18.7 years, respectively. The differences were more in the rural areas and for uneducated women. The median ages at marriage for rural women, women with no education and with SLC or above were 16.5, 16.3 and 19.5 years, respectively.⁴ As per NMSS 1998, 24.7% of women had BMI less than 18.5 (WHO Cut off 20), and the prevalence of low BMI in the Terai region was 36.9%. Prevalence of anaemia in pregnant and non-pregnant women was 74.6% and 66.7%, respectively. Discrimination in household distribution of food with preference to males, food taboos in pregnancy, and post delivery contribute to this picture⁵

Reproductive Rights

Based on international human rights documents and other consensus documents, the Charter of International Planned Parenthood Federation (IPPF)⁶ has outlined 12 elements of Reproductive Rights. Some of them will be outlined in the following sections indicating the current status of enjoyment of these Rights by the Nepalese women.

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Right to Equality and to be Free from Discrimination

Females are discriminated against since early childhood and it goes on till their adult reproductive years and beyond. Biologically early childhood death of males is higher than that for females, and as expected' the neonatal mortality rate in Nepal is higher for males: 52 per thousand births as compared to 43.3 for females. High under 5 mortality rates of 112.4 for females as compared with 104.8 for males indicates gender discrimination in child rearing practices and health care seeking for female children.⁴

Mostly the women take the burden of preventing unwanted pregnancies in Nepal. 16.5% of female have adopted voluntary sterilization for family planning as compared to 7% of males. Use of contraception also varied widely with geographic distribution and education level. 56.35% of urban women used any modern method of contraception in comparison to 33.2 percent of rural women. The use of any modern method of contraception ranged from 27.3% by the mountain women to 32.7%, and 38.6 % by the women in the hills and Terai, respectively. Irrespective of geographic region, on an average 33.5% women with no education use contraceptives as compared to 46.4 % of women with education level of SLC and above. The status of women's empowerment affects their use of contraception. The use of modern method of contraception was found to vary with the number of decisions in the household in which the women had the final say. This ranged from 19.1% when women had no decision making to 51.8 % when the women had a final say in 3-4 decisions at the household level.⁴

Right to Life

Abortion complications constitute almost 40% of the total gynaecological admissions in Maternity Hospital and 10% of them have a history of induced abortion⁷. One case study is presented here to illustrate some important issues. A 28-year-old mother of two baby girls was admitted in Maternity Hospital with incomplete abortion following an induced abortion, after foetal sex determination by ultra sonogram, of a 15 weeks' pregnancy. Following resuscitation and aggressive antibiotic therapy, a laparotomy was done which showed perforation in the posterior wall of the uterus, with recto-sigmoid transection. Evacuation of the uterus and repair of uterine perforation, closure of the bowel injury and colostomy saved the life of the woman, but she is yet to undergo a major surgery to reconstruct the damage done to her bowel. The issues highlighted by this case are loss of life of a female foetus, unskilled

provider, crossed legal limits of gestational age for abortion, and serious risk to the mother's life. The law prohibits selective feticide and the legal limit for termination of pregnancy with the woman's consent is 12 weeks. The law also requires that a trained and listed provider should provide abortion services; all these requirements were violated in this case. This case report also points to the need of monitoring and evaluation of our services.

Right to Sexual and Reproductive Security

In Nepal 6.6% of births occur in women under the age of 18 years. The risk to the life and health of the mother and the foetus is 2.24 times higher in such cases as compared to women over the age of 18 years. Antenatal care has been traditionally provided for risk detection and for the prevention and treatment of anaemia and for immunization against tetanus. However 17.6 % urban and 53.4% rural Nepalese women do not get any antenatal care. Only 48.4% of urban and 11.8% of rural women get the prescribed 4 antenatal visits.⁴ Maternal Mortality Ratio is 539/100,000 Live Births in Nepal (NFHS 1996).⁸ This means one maternal death occurs every 2 hours. 70.5% of maternal deaths in the community are due to direct causes like haemorrhage, obstructed labour, pre/eclampsia, sepsis, abortion, ectopic pregnancy: obstetric complications that are preventable⁹. Several delays leading to maternal deaths were identified by the study. Delays occurred because of non-recognition of danger signs of complications by the families, lack of transport, decision making by the husband and unavailability of trained personnel with life saving skills. It is known that for each maternal death, there are at least 16- 20 morbidities including prolapse, injuries to the birth canal, fistulae, urine and faecal incontinence, backache, menstrual disturbances, reproductive tract infections, anaemia etc. Early resumption of activities with inadequate rest in the post partum period, too soon and too many pregnancies add to reproductive morbidities.

Nepal is the only country in the world where life expectancy of females is lower than that for males. Elderly women suffer from menopausal symptoms, osteoporosis, cancers and heart disease. Very little research is done in this area and NDHS does not address these issues. About 25 % of women attending a gynae camp in Doti and Achham had prolapse of uterus. Most women had suffered from prolapse for more than 10 years, Majority of these women had delivered at home, without trained assistant, had very little rest before and after delivery, carried heavy loads, and had low BMI.¹⁰

Right to Privacy and Confidentiality

Crowded out patient departments in the hospitals making it impossible or difficult to have privacy, lack of adequate training of the health care provider to maintain confidentiality and privacy are issues that deter women from seeking care. Adolescents RH are known to suffer because of the unfriendly attitude of the service providers, difficult access and lack of privacy. Stigma and discriminatory practices towards people with HIV and AIDS due to breaches in confidentiality are known to occur frequently. Lack of sensitivity to gender issues and lack of understanding of the needs and rights of vulnerable people by the health care provider have hindered access to care.¹¹

Future Directions

Low status of women in societies, and denial of reproductive rights lead to severe detrimental consequences to the mental and physical health of the women. Information and Education messages regarding reproductive health needs of women should reach the husbands, and the families, as they are the main decision makers. Continuous advocacy efforts are essential to reduce gender discrimination and violence against women. Equity in the provision of quality reproductive health care including family planning services and emergency obstetric care should get priority attention from all the stakeholders. Abortion services should be made accessible to women, and issues of training to the provider, expanding available services, monitoring of service delivery to meet the legal requirements should be done as a priority. Vulnerable groups like young people, poor, rural and uneducated people should get special attention. As educated women fare better in their reproductive health, we should advocate for compulsory education to girls. Making education free and compulsory to the girls will enable the future generation to get education and support at homes, and will enable them to demand quality reproductive health care, and to exercise their reproductive rights. Gender mainstreaming should form a core component of our health management and education systems, the health systems should develop a rights based rather than a need based approach to reproductive health.

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