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# REPRODUCTIVE RIGHTS ARE FUNDAMENTAL RIGHTS

## A Commentary on Safe Motherhood and Reproductive Health Rights Act 2075 Nepal

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# INTRODUCTION

After years of toil by various stakeholders and continuous efforts by civil society, NGOs and the government, the Safe Motherhood and Reproductive Health Rights Act, 2018 ('SMRHRA' or the 'Act') came into force on 18 September 2018 to (1) make various services relating to motherhood and reproductive health safe, qualitative, easy and accessible; (2) for respecting, protecting and fulfilling the rights related to safe motherhood and reproductive health as guaranteed by the Constitution of Nepal.[1]

This paper provides a set of key recommendations in relation to the Act then proceeds to analyse the different provisions of the Act to determine if the legislation is equipped to support the reproductive rights of women in Nepal adequately. This covers the legal history and background to the implementation of the Act, international obligations of the Government, Constitutional basis for reproductive rights in Nepal, the social barriers that restrict the realisation of reproductive rights in Nepal, evaluation of the relevant provisions of the Act and recommendations to ensure better implementation by the various stakeholders. This also includes a brief note on Covid 19 implication on sexual and reproductive rights to highlight the gendered experiences of the pandemic.

***This paper is part of a series of legislative reviews on economic, social and cultural rights in Nepal written by the authors with the support of Mariam Faruqi, South Asia Regional Director, iProbono and Meenakshi Menon, South Asia Program Analyst, iProbono. It received support from the Law and Policy Forum for Social Justice and the Alliance for Social Dialogue (ASD) in Nepal.***

***This paper was edited by Prof Rehan Abeyratne, Prof Bui Ngoc Son, and Prof Mara Malagodi from the Faculty of Law at the Chinese University of Hong Kong under the Project Impact Enhancement Fund (PIEF).***

***This paper has received financial and technical support from Advocates for International Development's Rule of Law Expertise (ROLE UK) Programme and UK Aid.***

[1] Preamble, Safe Motherhood and Reproductive Health Rights Act 2075, available at: https://publichealthupdate.com/safe-motherhood-reproductive-health-right-act-2075/ [accessed 4th January 2019]

# RECOMMENDATIONS

1. The Government should immediately frame a national strategy to ensure enjoyment of the right to reproductive health, based on human rights principles. Such a strategy should perform alongside policies and the corresponding right to health indicators and benchmarks. It should also identify the resources available to attain defined objectives, as well as the most efficient ways of using those resources.
2. Mechanisms must be developed to strictly check and eliminate discrimination prevailing in health institutions, including but not limited to the treatment women and children infected by HIV/AIDS and/or Leprosy.
3. Effective community action plans involving local communities should be implemented to set priorities, plan, and action strategies to achieve the highest standards of reproductive health and safe motherhood.
4. A victim of a violation of the right to reproductive health should have easy and reliable access to effective judicial or other remedies at all three levels of the state. Victim's restitution, compensation, satisfaction or guarantees of non-repetition should be a central focus while formulating laws and developing strategies.
5. All stakeholders, who can contribute to SM and RH services directly or indirectly should be made aware of their roles and trained to identify violations of these rights.
6. Health System safety measures should be upgraded especially in rural and remote areas where there is the lack of proper reproductive health services and family planning, and strict monitoring should be done for taking action against anyone discriminating patients due to their other health conditions (like HIV/AIDS or Leprosy)
7. A focus should be placed upon developing social awareness and building a liberal, flexible and more open RH and SM environment through education and awareness raising.
8. Deep-rooted patriarchal values generate inequality making women particularly vulnerable to insecure and unsafe sexual practices, leading to increased exposure to STIs including HIV. A 'Program of Action' should be developed systematically to protect women and other vulnerable groups thereby achieving landmark goals over time.
9. Progressive, rehabilitative, and reliable strong mechanisms for victim protection should be ensured including compensation and rehabilitation.
10. Stakeholders like NGOs should identify cases where abortion is interpreted as a criminal offence based on the restrictive provisions of SMRHRA and should (1) advocate for decriminalisation based on previous jurisprudence and (2) comment on the budget allocations made by the Central and Local governments for SM and RH services. This will improve accessibility to safe abortion services.

# BACKGROUND

Reproductive Health (RH), is a state of complete physical, mental and social well-being - not just absence of disease, frailty or illness, and should be achieved in all matters relating to the reproductive system and its functions and processes.[2] Reproductive rights form a cluster of human rights that have long been recognized by national, international human rights legislation, documents, treaties and conventions. Reproductive health rights provide to opportunity to have a satisfying and safe sex life and the capacity to reproduce with the freedom to decide when and how often to do so.[3] Reproductive and sexual health rights are rights of all people, regardless of age, gender and other features. It grants all persons the right to make choices regarding their sexuality and reproduction, upon the condition that they respect the same right of others.[4]

During the development of modern legal jurisprudence, the right to health was considered to belong to a group of rights known as economic, social and cultural rights as expressed in the ICESCR. During the mid- 1990s international institutions, including United Nations Population Fund (UNFPA), World Health Organization (WHO) and International Planned Parenthood Association (IFFP) enhanced those rights through a Charter of Sexual and Reproductive Rights attempting to bring together not only the relevant economic and social rights but also civil and political rights for augmenting sexual and reproductive rights. A long jurisprudential discourse occurred about the primary nature of civil and political right's dominance over economic, social and cultural rights but it was agreed that all human rights are indivisible. The balance between these sets of rights was partly recognised as a result of the Vienna Declaration, adopted by the World Conference on Human Rights on 25 June 1993, which confirmed that human rights are indivisible, interdependent and interrelated.

Nepal is a developing country which recorded a high number of infant and maternal mortality rates in the past, but after continuous efforts of the Government and various NGOs & INGOs working domestically, current statistics show that the infant Mortality rate is 27.9 deaths per 1000 live births while the Maternal Mortality Rate is 258 deaths/100,000 live births.[5] The preliminary basis for the enactment of SMRHRA can be found in the 1975-1990 long-term health plan which focused on consistency and functionality of the health services. The Government focused on extending health

[2] UN Population Fund (UNFPA), Report of the International Conference on Population and Development, Cairo, 5-13 September 1994, 1995, A/CONF.171/13/Rev.1, available at: https://www.refworld.org/docid/4a54bc080.html [accessed 25 January 2018], para 7.2, p. 40

[3] Dhaher E. *Reproductive health human rights: women's knowledge, attitude, and practices toward their reproductive health rights in Palestine*, Bielefeld (Germany): Bielefeld University; 2008, p. 1 [Available at: https://pub.uni-bielefeld.de/record/2303407, accessed: 7th Jan 2018

[4] Adinew YM, Worku AG, Mengesha ZB. Knowledge of reproductive and sexual rights among University students in Ethiopia: institution-based cross-sectional, BMC International Health Human Rights, 2013, National Center for Biotechnology Information, U.S. National Library of Medicine, doi: 10.1186/1472-698X-13-12.,

[5] Nepal Demographic Profile 2018, CIA World Factbook, cited from: Index Mundi (available at: https://www.indexmundi.com/nepal/demographics_profile.html) accessed: 5th Jan 2018)

services to rural areas as pregnancy-related complexities resulting in infant and maternal deaths were more severe in the underdeveloped villages during the final years of this long-term plan. The National Health Policy, 1991 covered almost all villages with primary health structures, in the form of sub-health posts, which promoted access to modern health facilities in nooks and corners of the nation. During 1990 to 1991, Nepal ratified CRC,[6] ICCPR,[7] ICESCR,[8] CEDAW.[9] As a result, extension of maternal and child health care and family planning was one of the major objectives in the five-year plan of 1992-1997. Finally, the second long-term health plan effective from 1997 to 2017 focused on the development of far-reaching basic health services, especially for the rural population. It was in 1997 when the National Safe Motherhood Program started with the goal to reduce maternal and neonatal morbidity, mortality and to improve the maternal and neonatal health.[10] Nepal ratified First and Second optional protocol on ICCPR in 1998 and Optional Protocol on CEDAW in 2001. Abortion was legalized in 2002, and over the next several years, women gained rights to abortion however complete legalisation was pending.[11]

The Safe Delivery Incentive Program, started in 2005, in districts with a low human development index (HDI) to provide incentive payments to women to get them to attend health facilities. In 2006, the Ministry of Health and Population introduced the Skilled Birth Attendants (SBA) Program which provided 862 SBAs including 454 ANMs, 298 Staff Nurses, 84 Doctors and 26 pre-service till 2009 in health facilities across the nation.[12] There were numerous prosecutions and imprisonment of women for terminating a pregnancy until 2009, unsafe abortion used to be a source of more than half of all gynaecological and obstetric hospital admissions, accountable for extremely high maternal mortality rates. Two landmark rulings of the Supreme Court of Nepal are of significance in relation to safe motherhood and reproductive health, the first one being *Prakash Mani Sharma v. Government of*

[6] UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, p. 3, available at: https://www.refworld.org/docid/3ae6b38f0.html [accessed 8 January 2019], ratified on 14 September 2014

[7] UN General Assembly, *International Covenant on Civil and Political Rights*, 16 December 1966, United Nations, Treaty Series, vol. 999, p. 171, available at: https://www.refworld.org/docid/3ae6b3aa0.html [accessed 8 January 2019]; Ratified on 14 May 1991

[8] UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3, available at: https://www.refworld.org/docid/3ae6b36c0.html [accessed 8 January 2019]; Ratified on 14 May 1991

[9] UN General Assembly, *Convention on the Elimination of All Forms of Discrimination Against Women*, 18 December 1979, United Nations, Treaty Series, vol. 1249, p. 13, available at: https://www.refworld.org/docid/3ae6b3970.html [accessed 8 January 2019]; Ratified on 22 Apr 1991

[10] Safe Motherhood Programme, Ministry of Health and Population, available at: http://mohp.gov.np/eng/program/reproductive-maternal-health/safe-motherhood-programme [accessed 7 January 2019]

[11] In the case of Lakshmi Dhikta V. Nepal Government (NKP 2067, Vol. 9, Decision no. 8464), the Supreme Court held the government accountable for failing to ensure affordability of abortion services and directs the government to take measures to guarantee that no woman is denied abortion services on financial grounds.

[12] Report on Status of Skilled Birth Attendants (SBAs) in Nepal, Nepal Health Research Council, Kathmandu, 2009, available at: http://library.nhrc.gov.np:8080/nhrc/bitstream/handle/123456789/93/594.pdf?sequence=1 [accessed 7 January 2019]

*Nepal*[13] decided on 4 June 2008 confirmed Nepal's legal commitments under the Constitution for effectively implementing the right to reproductive health. The court relied upon the international health and human rights principles for defining women's rights to reproductive health and the obligation of the state to ensure the fulfilment of these set of rights. The second key decision was, *Lakshmi Dhikta v. Nepal*[14] decided in 2009 which reinforced woman's right to abortion, emphasizing abortion as a human right. The Long-Term Plan (2006-2017) relating to Safe Motherhood and Neonatal Health strengthened and extended the number of births conducted by SBAs, focused on improving basic and comprehensive obstetric care services and a functional referral system. Finally, in 2018 SMRHRA was enacted for bringing in all the protective laws and policies under one umbrella.

Access to safe abortion services is comparatively much easier in urban areas and the statistics show that approx. only 20% of the total population dwells in the cities. Such distribution of population and deeply rooted social psychology nurtured by superstitious beliefs and traditions, poor and unsystematic distribution of infrastructure, low level of awareness of rural population and questionable level of conformity with the safety rules need to be considered for proper evaluation of SMRHRA. The Government along with NGOs like Family Planning Association of Nepal (FPAN) and the Nepal Red Cross Society are continuously working for improving the status of SM and RH rights and increasing accessibility of related health services across the nation, and SMRHA is a spark of hope for better protection of the women during the vulnerable stages of pregnancy and childbirth.

[13] NKP 2065, Vol 8, Part 50, Decision no 8001 [Decision Date: 2065/02/22]

[14] NKP 2067, Vol 9, Part 52, Decision no 8464 [Decision Date: 2066/02/06]

# INTERNATIONAL HUMAN RIGHTS LAW ON SAFE MOTHERHOOD AND REPRODUCTIVE HEALTH

Improvements in women's health need more than just scientific technologies and health care, State action is required to correct inequalities and injustices against women. It is a well-understood fact amongst the global community that state action can assist in achieving a satisfactory level of outcome from Safe Motherhood and Reproductive health programs, policies and legislation. The whole process is not only limited to building infrastructure and allocating budget, but also extends to the significant amount of work necessary for achieving respect and protection of fundamental human rights of women in relation to giving birth to another human life. It was during the mid-1990s, the use of Human Rights for expanding RR and SMR got a push through UN programs like the Cairo Program of Action and Beijing conference. Nepal has acknowledged the need for implementation of the progressive rules for making SM and RH rights accessible to its citizens and aims to fulfill its obligations in this regard.

The term 'reproductive rights' was coined in a non-institutional framework, by the First International Meeting on Women and Health in Amsterdam (1984), was primarily associated to addressing the struggle for the rights to legal abortion and contraception in developed countries.[15] The International Conference on Population and Development amplified this approach and introduced the concept of reproductive rights to the international community and adopted an extensive definition. Firstly, it conceptualized reproductive rights as the 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 secondly, the right to attain the highest standard of sexual and reproductive health.[16] SM and RH rights are commonly expressed through numerous specific human rights which are legally established. These human rights can be collectively and collaboratively used to advance the national interest in promoting safe motherhood and reproductive health. The following set of rights can be referred to while discussing Safe Motherhood.

- rights relating to life, survival and security of the person;[17]
- rights relating to maternity and health;[18]

[15] Laura Davis Mattar, Legal Recognition of Sexual Rights: A comparative analysis with reproductive rights, 2008, Rev. int. direitos human, vol. 5., no. 8, Sao Paulo, ISSN 1983-3342

[16] ICPD, Supra 2, p. 41-42

[17] Article 3, UN General Assembly, Universal Declaration of Human Rights, 10 December 1948, 217 A (III), available at: https://www.refworld.org/docid/3ae6b3712c.html [accessed 28 January 2019]
Article 6 ICCPR, n (4), Article 6 CRC, n (3)

[18] International Labor Organization, Convention concerning the revision of the Maternity Protection Convention (Revised), 1952, 07 Feb 2002, available at: https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_CODE:C183 [accessed 10 January 2019]

• rights to non-discrimination and due respect for difference;[19] and

• rights relating to information and education[20]

Failures to address maternal disability, morbidity and mortality signify extreme social injustice in today's world. A human rights approach to this problem shows that maternal mortality and morbidity is not related to one disadvantage but is the result of a series of rights violations. Apart from the international treaties and conventions, improving maternal health was highlighted in the fifth and eighth Millennium Development Goals (MDGs) which aimed to reduce Maternal Mortality Ratio by three quarters between 1990 and 2015,[21] which has also been prioritized under Goal 3 of the Sustainable Development Goals agenda through 2030 which focuses on ensuring healthy lives and promoting well-being for all at all ages.[22]

Fulfillment of the above-mentioned rights is directly or indirectly connected to the protection of women for safe motherhood and their reproductive health. The right to life, survival and security is directly associated with maternal mortality, morbidity, neonatal and antenatal care. The rights relating to maternity and health covers a wide range of rights including labour rights of women, right to choose marriageable age and time of pregnancy, access to effective health services during and after pregnancy, access to effective and safe contraceptives etc. The rights related to non-discrimination helps check sex-selective abortion and directs the stakeholders to evaluate each situation as per gravity and seriousness. The rights concerning education and employment can help to provide women with education and employment opportunities which helps them attain adequate independence in regard to marriage, to select and use appropriate contraceptive methods, and to gain access to maternal health services.

Constitutions and regional and international human rights instruments set out a series of obligations that can be divided into three broad categories, i.e.:

- the obligation to respect rights, which requires states to refrain from interfering with the enjoyment of rights;
- the obligation to protect rights, which requires states to act to prevent violations of human rights by third parties;
- the obligation to fulfil, which requires states to take positive action to facilitate the enjoyment of basic human rights.

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[19] Article 1(2) (3), 2(1), 13(1)(b) United Nations, Charter of the United Nations, 24 October 1945, 1 UNTS XVI, available at: https://www.refworld.org/docid/3ae6b3930.html [accessed 10 January 2019]; Article 1,2,7 of UDHR, n(11); Article 26 of ICCPR, n(4); Article 2(2) of ICESCR, n(5)

[20] Human Rights Council Resolution June 2009: Preventable maternal mortality and morbidity and human rights, Eleventh Session, para 2; Article 25 of UDHR, n(11); Article 18.4 of ICCPR, n(4); Article 10 and 13 of ICESCR, n(5); Article 5(b), 16.1 (e) of CEDAW, n(6)

[21] UN. The Millennium Development Goals Report United Nations Department of Economic and Social Affairs. New York, 2008.

[22] United Nations, Sustainable Development Goals, Goal 3: Ensure healthy lives and promote well-being for all at all ages, available at: https://www.un.org/sustainabledevelopment/health/ [accessed 5 January 2019]

# CONSTITUTIONAL BASIS FOR SM AND RH RIGHTS IN NEPAL

Prior to implementation of Nepal's Interim Constitution, 2006, reproductive health rights were not clearly laid down as fundamental rights in the Constitution. Even though the Constitution of Nepal 1990 incorporated explanatory provisions for addressing these rights within the scope of the right to health, it required extensive interpretation. Safe motherhood and reproductive health rights were incorporated as the fundamental right of every woman in the prevailing Constitution of Nepal implemented in 2015.[23] Article 38(2) prescribes that every woman has the right to safe motherhood and reproductive health while Article 38(3) prohibits discrimination in any way on the basis of gender. Upholding the protectionist approach, any violence against women including physical and mental violence is made punishable by the Constitution and these fundamental rights paved the path for the enactment of specific law related to SM and RH.

[23] *Constitution of Nepal* [Nepal], 2015 (2072.6.3), 20 September 2015, available at https://www.refworld.org/docid/561625364.html [accessed 25 January 2018]

# SOCIAL BARRIERS TO SAFE MOTHERHOOD AND REPRODUCTIVE HEALTH IN NEPAL

Nepal has also made efforts through various policies, plans and legislation to prioritise women's reproductive health but the journey towards the full realisation of these rights is not free from challenges. Obstacles include:

1) Psychological factors: psychological factors are those which are deeply rooted in the conscience and understanding of the people in relation to reproductive health, pregnancy and motherhood. Even though the consciousness of people has progressed compared to the past, however, cultural and indigenous practices continue in the least developed areas. The practice of '*Chhaupadi*' (segregating women going through menstruation away from their home) in the western villages of Nepal is one of many examples where Nepali girls and women are exposed to physical and emotional harm and risk. Women (especially those in rural areas) are introverted and shy even to disclose their problems within their families, let alone discuss it with a stranger. Deep-rooted superstitions and indigenous practices add to psychological barriers hindering the process of safe motherhood and reproductive health.

2) Social Factors: lack of awareness about basic reproductive health, where the use of unsanitary methods during menstruation, improper use or non-use of contraceptives make the problem more complex when it finally reaches the health facilities. Prevalence of various social disparities hinder women's access to safe motherhood and reproductive health services. Low socioeconomic status of women leads them to become dependent on family or their husband who are often unsupportive and reluctant to understand women's health. Such situations are common in early marriage where poor knowledge or access to facilities and services related to safe motherhood and reproductive health lead to complications during pregnancy.

3) Health system factors: The Government of Nepal has made various plans and policies and tried to expand adequate health services across the nation, however, efforts to make prenatal and postnatal services accessible to the whole population are neither adequate nor fully functional at this point of time, This is exacerbated by an outdated infrastructure built in the early 1990s.[24] Unequal distribution of resources creates a grave problem in places where neither infrastructure nor health workers are available. The health posts/sub-health posts lack privacy for discussing health issues, health workers are not well trained which makes the women reluctant to share their problems. It is important to note that generally it is not health

[24] Trading Economics, Nepal-Postnatal Care coverage (% mothers), available at: https://tradingeconomics.com/nepal/postnatal-care-coverage-percent-mothers-wb-data.html [accessed: 5 January 2019]

services but travel to the health facility that is costly for patients in rural areas, access to medicine and other supplies are similarly an obstacle to use maternal health services.[25] A 2014 report[26] states that more than half of all abortions in Nepal were performed illegally, noting women continue to be prosecuted, and sometimes even imprisoned for criminal abortion.[27] It is problematic; why would women expose themselves to unsafe and illegal means through which they can be even imprisoned even after so many efforts from the Government and other non-state actors for improving access to safe abortion? Health institutions have also been found denying necessary reproductive health services to the HIV AIDS infected women even in Kathmandu valley. Hospitals normally do not admit women who are identified with a severe disease like HIV AIDS and leprosy.[28] And adding to this scenario, most trained and competent health workers are unwilling to serve in rural areas which hinders the rights of those rural women to get quality reproductive health services.

4) Political factors: Apart from the obstacles mentioned above, another obstacle in the continuous progress in the development of SM and RH in Nepal is unstable government. Plans and policies made by the government also quiver when the government collapses. The agenda of Safe Motherhood and Reproductive Health rarely find a place in political debates. And even if it luckily grabs the attention, lack of proper planning makes it ineffective. The present federal context of the nation has made the scenario more arduous for the government to properly set goals and effectively implement the policies which have long been pending in the papers.

[25] Gehendra M Asweto C. Cao K. Ali AM, Sebastian A, Barr J. et al. Utilization of ANC and PNC services in Nepal, a multivariate analysis based on Nepal Demographic Health Survey 2001 and 2006. Am J health Res 2015;3(6):318-27. Cited from: Research gate available at: https://www.researchgate.net/publication/296596779_Maternal_health_and_its_affecting_factors_in_Nepal [accessed 7 January 2019]

[26] Guttmacher Institute, Abortion and Unintended Pregnancy in Nepal, Fact Sheet, February 2017, available at: https://www.guttmacher.org/fact-sheet/abortion-unintended-pregnancy-in-nepal [accessed 8 January 2019]

[27] IPAS, A big step toward full reproductive rights in Nepal, published date: 26 October 2018, available at: https://www.ipas.org/news/2018/October/a-big-step-toward-full-reproductive-rights-in-nepal [accessed: 8 January 2019]

[28] Fatima Banu, Discrimination towards HIV infected, Kantipur National Daily, February 3, 2019, p. 5, [available at: https://epaper.ekantipur.com/kantipur/2019-02-03]

# EVALUATION OF THE ACT

After the above discussion and evaluation of the premises under which SMRHRA is going to be implemented, this commentary will argue that the SMRHRA consists of many loopholes and therefore will generate numerous challenges and potential litigation in its implementation. It is not adequately framed to reach the expected outcome.

**The Cluster of Rights of Women and Services to be provided under the Act:**

There are various rights which are very precise and reformist as put forward by the Act. The realisation of which would drastically improve the current situation and will help create a safer environment for Motherhood and Reproductive health. The cluster of rights in SMRHRA focuses on the youth and women and states that they should get education, information and counseling about reproductive health and should have access to information on the use of contraceptives and awareness about the consequences. Women should have access to services which are indispensable during neo-natal and post-natal stages of childbirth and for the care of the newborn. The services and rights of individuals for achieving this end as reflected in the Act is discussed below:

## Legal Abortion:

After abortion was legalised in 2002, Nepal achieved remarkable progress developing policies, guidelines, task shifting, training human resources and increasing access to services. Despite this access to safe abortion is still a challenge, women from rural and remote areas may face more complications than peers based in urban areas. The existence of stigma against abortion and paradigm shift in the government's structure from unitary to federal in absence of specific and clear provisions on ways to integrate, regulate and extend safe abortion service under local government structure can be observed as a major challenge for sustaining recent developments.

Every woman has the right to receive legal abortion services, the Mother has the right to choose in situations of morbidity. The law regarding Safe Abortion is reinforced by the Act as allows abortion up to 12 weeks. Abortion up to 28 weeks is permitted in complex cases, pregnancy due to rape or incest and also in cases where the mother is suffering from diseases like HIV, with the mother's consent and if there is a valid reason to believe that the new-born will be weak, deformed, will have genetic disorders. Supreme Court decision supports decriminalization of abortion, by restricting the abortion of fetus which is more than 28 weeks the SMRHRA has stipulated a restrictive and inconsistent provision. The SMRHRA does not consider previous jurisprudential developments and carries forward restrictive and harsh laws instead of taking a more liberal approach towards abortion. Forced abortion is penalised along with negligence or incitement of such illegal abortion. Penalties include 3-6 months' imprisonment and a fifty thousand rupees fine for forced abortion or forced contraception.

Safe Abortion Services are to be provided by licensed health institutions or health practitioners fulfilling specified criteria and qualification. Use of appropriate technology and procedure should be followed after receiving the letter of consent from the pregnant woman. If the pregnant woman lacks capacity to give consent and/or is a minor below the age of 18 years then the consent of her guardian shall be enough to allow an abortion. The Act provides for the welfare of girls below 18.

Even though gender revealing and sex-selective abortion is restricted, there is widespread practice of gender identification of fetus which may or may not be for the purpose of abortion. Many countries do not criminalise gender identification, however, this provision is necessary for nations with high rates of sex-selective abortion. It is contended that gender identification of the fetus should be permitted as society is progressive enough not to misuse it, however, looking at the overall scenario in Nepal and as there cannot be different laws for different regions, this provision makes sense.

## SM and RH Services:

There are several other rights quoted in relation to RH and SM including rights to nutritious food and balanced diet, counseling, receiving prenatal and postnatal services, receiving family planning services, emergency services, fundamental services, comprehensive care, new-born care, right to choose reproductive health service etc.

The act provides for pregnancy-related services including a woman's right to test for pregnancy. It is made mandatory in normal situations for a woman to attend at least 4 health checkups during pregnancy, apart from that and in specified circumstances, the number of checkups should be increased as per doctor's or health worker's advice. A pregnant woman is to be provided with proper health care, counseling services and should receive applicable safety measures and minimum services during pregnancy. The above-listed services are to be carried out through skilled or trained health workers.

This legislation is an achievement because previously there was no law incorporating minimum standards in relation to SM and RH. The policies encourage women to have 4 mandatory check-ups through motivational schemes that provide transport facilities or covering other expenses. The realization of these rights is quite effective in infrastructure rich urban areas but there are remote corners (for example Many villagers in Bajura District still have to travel for days just to reach a health post for primary care) where the promises made by the Act seems beyond rural woman's wildest dreams. Having these provisions also calls for a proper record-keeping system of check-ups and counseling services. It will be a tough task to ascertain whether every woman in fact received safety measures and counseling services as required by the Act.

The services as discussed above are to be provided by government and community health institutions through emergency pregnancy services and newborn care facilities. Even though availability and outreach of primary health care facilities has improved, Nepal's health system lacks adequate infrastructure, equipment and trained health professionals for providing these services. Under these circumstances, it can generally be understood that health institutions situated in urban areas may

adapt to this regulation soon but it is still a long way to go for the health institutions which are already facing a crisis and located in remote areas. Many health posts in rural areas do not have birthing centres or special care for pregnancy or delivery of the newborn.

In situations where the health institution first contacted by the pregnant woman is incapable of providing requested services the Act provides a referral system in situations; it should refer them to a health institution where the service is available. This kind of referral system gives preference to government or community hospitals and this provision will be efficient only when they are well-equipped and they have proper health institutions to refer to in proximity, however, in emergency situations often there are no suitable options available for making a referral for and difficulty in the transportation of patients. Health institutions lack adequate infrastructure (e.g. beds) therefore, it is first necessary to develop the accessibility of people to well-equipped health institutions. A proper system for identifying instances of health institutions referring ineligible patients and action against such health institutions is indispensable. The patient who is incorrectly referred to another institution must appear with proof of denial despite capability by the Health Institution. The victimized person will need legal and social support to a great extent if this provision of the Act is to be implemented as per its spirit.

The Act requires that every birth, miscarriage and number of maternal deaths is recorded. This not only helps collecting statistics of live birth but also identifies areas (geographical, social, health-system) that require special attention.

The Act reinforces that every person should have information, choice and access to family planning services and restricts forced family planning or forced use of contraceptives. forceful use of temporary or permanent contraceptives on anyone, or performing family planning services constitutes a crime, thereby, not only the individuals but also health institutions and/or health practitioners should be careful about consent while using family planning methods on anyone.

The Crime and Punishment chapter of SMRHRA criminalises various acts of individuals and health institutions and sets punishments for discrimination, non-certification, denial of services as set forth by the Act and as discussed above with 6 months of imprisonment or 50 thousand rupees fine or both punishments.

Evaluating the implementation of the above SM and RH services, health posts, and other government-managed health institutions have not been made accessible to the local governments yet. Principally, previous health functions delivered through District Health Offices should now be integrated into the new government structure at the sub-national level for avoiding jurisdictional conflict. Deputed health personnel at local levels (like paramedics at service outlets) are only primarily trained to offer health services and therefore, they lack skills in management and procurement in complex situations. Therefore, extensive capacity building pertaining to planning, monitoring, evaluation and overall management of the health service delivery and a tailor-made health service delivery structures along with proper staffing is critical for upholding aspirations of the constitution.

## Service Fees:

Government and government health institutions should provide the above-mentioned services free of charge, however, it will be a wrong assumption that they won't attract any expense of the service seekers. It is generally found that the service seekers have to pay for the pharmaceutical products and medicines necessary for receiving the services. The act is not very clear about this situation and therefore there is a great chance that this provision will be abused. It is therefore upon the civil society and the stakeholders to check the efficiency of this provision.

Also, the Act states that the private, non-government and community hospitals may take fees as specified by the government. The specifications are not readily available even if they exist and often the health institutions will not abide by the government set service fees. Also, in relation to the free quota to be made available in private, non-governmental and community hospitals, it will be a challenge to monitor and regulate these legislative provisions even after the criteria of free quota and limit of the fees is applied. The Policy on Skilled Birth Attendants was endorsed in 2006 by the Ministry of Health and Population. However, complaints prevail pointing out that the financial assistance for travel to the health post is not adequate and therefore ineffective. In addition to this the government began *Aama Surakchhya* (Maternal Protection) Program with two components, firstly free institutional delivery care which was launched in January 2009 and secondly, safe delivery incentive program which was initiated in 2005 with the support of DFID. These programs provide direct cash to women who deliver in government hospitals, and in some cases in non-government hospitals as well, and work effectively for providing free delivery care in health facilities. In January 2009 a goal was set for increasing access of people to reproductive health service irrespective of their financial status. Many programs have failed to achieve their targeted end. In such circumstances, even though SMRHRA has included provisions for safe abortion services and has restrictively allowed abortion of fetus of up to 28 weeks, financial weaknesses of women may become a reason rendering them unable to seek safe abortion services in time. This gap in law and reality may seem less problematic, however, it may cause grave injustices when situations as such, which are very likely to occur and do actually occur.

## Protection of confidentiality:

Right to privacy is a constitutional right of every citizen and therefore confidentiality of the information, documents, counseling and service records of family planning, abortion, obstetric or other related services received by any person should be treated confidentially.[29] It can only be revealed for official investigation and hearing as per the demand of courts, for study and research purposes without disclosing identity, and if the woman herself asks for it. The reproductive health services are purely a private matter of every individual, therefore individual privacy as granted by the constitution needs to be respected at all times of the service. However, this protection is easier said than done, because most of the hospitals do not even have confidentiality agreements with their

[29] Article 28, *Constitution of Nepal* [Nepal], 2015 (2072.6.3), 20 September 2015, available at: https://www.refworld.org/docid/561625364.html [accessed 7 January 2019]

own staff. The obligation of maintaining confidentiality is not just limited to non-disclosure of information but extends to the responsibility to maintain all the records securely. Generally, in instances related to breach of confidentiality, the stakeholders may just deny their involvement and it would be very hard to prove that who breached the confidentiality of sensitive information. A proper set of rules classifying the confidential records and rules for maintaining them should be developed by all the health institutions for proper handling of their Client's sensitive information.

## Leave Facility:

For making pregnancy and newborn care easy for the parents, the Act has reinforced the provisions for Pregnancy/Maternity leave whereby providing 98 days of leave with salary, and up to one year of leave without salary as per the recommendation of the Health practitioner. The Act also states that a mother should be provided with an environment conducive to breastfeeding up to two years. However, the standard for breastfeeding environment is not available, the realization of this kind of environment in every workplace is very challenging because even the government offices and big enterprises do not have separate breastfeeding areas designated in their premises. The provision, therefore, is a step forward which calls out for better regulation and criteria for building a new-mother friendly work environment. The spouse of a pregnant or new mother is granted pregnancy care leave of 15 days with salary and if the situation of the mother becomes morbid then, the spouse has the right to have up to 30 days of leave without salary. These provisions are also reflected in the Labor Act of Nepal 2074 which forms a basis for non-discrimination of women sec 6.2(b), pregnancy leave of 98 days has been granted and further it has been made mandatory for a mother to take 14 days' leave prior to delivery and 42 days' leave after delivery as per sec. 45 of the Labor Act. 15 days of pregnancy care leave for spouses have also been included in sec. 45.7 of the Labor Act, however, neither the Labor Act nor the Regulation includes provisions for designated breastfeeding areas.

## Morbidity:

Legal provision for morbidity is introduced for the first time in Nepal in the Act; women now have the right to testing, counseling and treatment related to morbidity. It is the responsibility of the concerned health institution to give comprehensive information about the situation to the patient. The social attitudes have long been an enemy of pregnant women facing morbidity, as the society considered it a fault in the women, and there were many instances of displacement or expulsion of the women who face morbidity. However, this situation has been checked by the Act and therefore, it has been provided that morbidity cannot be a reason for displacement, divorce or expulsion. A person is punishable by up to one year of imprisonment and up to one hundred thousand rupees fine or both for displacement/divorce as a reaction to morbidity.

## Budget:

All the services mentioned above require adequate budget for proper implementation. The Act urges the Federal government to allocate a part of the budget as a local level grant every year for SM and RH. Local government is directed to use the budget for the welfare of extremely poor women's motherhood and reproductive health as specified. The specification related to this is not framed yet therefore, even though there is a provision it would not be wise to expect the results soon. The

challenge in this regard for the Federal government, on the one hand, is that the requirement of the budget is huge and there are many local levels which need assistance. A properly planned and centrally operated project is necessary to address the situation properly otherwise, even if budget is supplied, it will not be able to effectively address the need of the time. On the other hand, there is no mechanism to check if the grant allocated by the Federal Level will be used as per the intention or be misused because of lack of planning as it has been happening in the past. Realization of the SM and RH rights requires not only a budget but also long term plans and strategies, the local governments may not have a proper understanding of the issue and therefore just giving out grants would not be a proper way to go if we need results as imagined by the Act. A key concern associated with implementing federalism is the de-prioritization of reproductive health, over other needs. This has been clearly seen in the allocation of the national budget in the past few years after the promulgation of the Constitution in Nepal. A small amount, if centrally applied with care, might work much efficiently rather than distributing huge amounts among numerous local levels, many of which do not have the capacity, understanding or plan to address the issues related to SM and RH.

The Act calls for the local level to allocate budget for government and/or community health institutions; this is a progressive step, however, the method of allocation, prioritization and amount can be a matter of debate once the provision is implemented. In the case of *Laxmi Dhikta v. Nepal Government*[30] the Supreme Court held the government accountable to ensure affordability and it seems that this accountability has now been divided between the central government and local levels; this has the potential to create a situation where tussles relating to budget allocation may victimize more women especially belonging to weaker and poorer sections of society.

## Victim Compensation:

The Act has provided for compensation to victims who suffer from disregard of the actions stipulated under the Act. The amount of compensation is not fixed; therefore, the courts will decide on quantum.

## Youth and disabled friendly services:

The act encourages stakeholders, mainly health institutions to ensure services related to family planning, reproductive health, safe motherhood, abortion, emergency obstetric care and new-born care and morbidity are accessible to young girls and disabled people. Under this provision, if any person does not receive appropriate service then, it would amount to the denial of the rights as set out by the Act but in the current situation, not all health institutions and the services are equipped. Effort must be made to develop infrastructure, training of the health professionals and techniques for proper implementation of this Act.

## Non-Discrimination:

The Act strengthens the constitutional right to equality and non-discrimination[31] and explains that individuals should not be discriminated against for gender identification, physical status, marital

[30] Laxmi Dhikta v Nepal Government, Supra 11

[31] Article 18, Constitution of Nepal, n (21)

status, philosophical inclination, suffering from diseases, morbidity, personal relation and so on. Discriminatory acts have been made punishable by one year of imprisonment and up to one hundred thousand rupees fine or both.

## Protection Home:

The Act has called upon for the coordination of the federation, states and local governments for building protection home for safeguarding SM and RH rights of mentally challenged, victims of discrimination, rape. It is a positive step in Nepalese legislation but the coordination as called upon is still hard to achieve and even if infrastructures get built in some places, a great deal of lobbying and activism is necessary from the part of NGOs, civil society and other stakeholders for reminding the government about this commitment.

## Government Party Case:

If any health institution/individual denies SM and RH services, wrongly refers the patient to another institution, denies a birth certificate, conducts forced contraception or family planning, performs an illegal abortion, performs gender identification and/or aborts such identified fetus, breaches confidentiality, displaces the patient or acts in a discriminatory manner then, all these are considered punishable offences where the State will be a party. The victim will just need to file the FIR for picking up a case against the perpetrator. This provision is put forward for avoiding complexities of litigation for the victims and is based on the principle of criminal law which considers such offences as a crime against the public at large. The state has taken the guardianship of the victims through this provision and is, therefore, an appreciable step.

## Pregnancy Allowance:

The Act has provided for pregnancy allowance for women from poor backgrounds. This provision also is not as simple to implement as it sounds, even though it is a very progressive and necessary step but because the government will have a very limited budget available for this purpose, and such is to be distributed through the health institutions, a proper mechanism for identifying the needy and keeping record should be developed. There have been instances in the past where similar allowances were denied to the service seekers and the whole point of giving allowance went in vain. It is necessary to make the system more transparent and direct rather than relying on the discretion of individuals for providing allowances.

# IMPLICATIONS OF COVID 19 ON SEXUAL AND REPRODUCTIVE HEALTH RIGHTS (SRHR)

The direct impact of the COVID 19 pandemic is evident in every aspect of society including the sexual and reproductive rights of the people. Though people from all age groups and genders are exposed to the risk of infection, pregnant women particularly are experiencing immense stress, anxiety over the virus affecting the health of the fetus, uncertainty regarding access to health facilities and unavailability of quality medical services in case of complications during this period. In Nepal, where roads and transportation facilities are faulty or inadequate, it is difficult for pregnant women and new mothers to regularly consult the ANMs, nurses, and doctors for pre and postnatal health check-ups even during normal times.[32] The nationwide lockdown that restricts travel, and the need to share limited resources including hospital beds and ICU services with the rising number of COVID patients, puts the health of pregnant women at extra risk.

Moreover, as abortions are not defined as an "essential service" in Nepal, many women are not able to access abortion services on time during the lockdown. As the Act has imposed time limits to determine the legality of an abortion, the delay resulting from the lockdown has significant consequences for pregnant women. This additional burden resulting from the criminalisation of abortion can affect women physically and emotionally at this time.

The COVID crisis has affected the SRH rights in ways the Act could never envision. The functioning of SRHR related services, management of emergency transport, and protection from threats during a crisis is not addressed within the legislation. It is important to deal with these loopholes to ensure effective implementation of the Act going forward.

[32] 'Before the pandemic, only 58% of the births in Nepal were attended by skilled health personnel' Santosh Chhetri, 'In Nepal, COVID-19 turning pregnancy excitement into fear', UNFPA, May 2020, retrieved from https://www.unfpa.org/news/nepal-covid-19-turning-pregnancy-excitement-fear.

# CONCLUSION

From the above evaluation, it can be concluded that this reformist legislation incorporates provisions that are long overdue to ensure improved protection of SM and RH rights in Nepal. As a developing country with a majority population living in rural areas where there is poor awareness and scarcity of health facilities, strong legislation is a must and the decision of the Government to implement law is laudable. The Act is brought forward as an umbrella legislation to cover all aspects of SM and RH but it is still incomplete as noted below.

(a) There is a need for framing regulation relating to the Act for the health institutions and practitioners to perform safe abortions, to provide newborn care, implement free quota system, and ensure conducive environment for new-mothers etc. Additionally, it requires infrastructural, technical and human resource support for proper implementation.

(b) The Act calls for an important role of the judiciary and police for the protection of the victims, these roles can only be effectively fulfilled when common people are aware of their rights and are capable of holding relevant authorities accountable when their rights are denied. This can be achieved through consistent awareness campaigns throughout the country. T

(c) The guarantee of various SM and RH related services and free quota form one part of potential litigation and the crime and punishment form another part. Each denial of service and each violation of rights should firstly be reported by the victim so that the issues reach the courts, and this is only possible when people are aware of their rights and are not reluctant to report unlawful acts against them.

(d) The provision on legal abortion looks very promising but still has some grey areas which may cause grave injustices if restrictively interpreted. The Act retains provisions stipulating imprisonment for women undergoing abortion in certain cases, considerable efforts are required to ensure proper use of the provisions as per the legislative intent.

(e) We must also note that even though the Act provides for annual budget allocation for SM and RH services by the Central and Local Level governments, this kind of allocation has not been observed in previous budgets which came after the implementation of SMRHRA. As morning shows the day, there may be many instances where women will again be denied SM and RH services including safe abortion services because of their financial incapability, and the insensitivity of the Government leading to a long and tedious process of claiming rights was recognized by the Supreme Court.

The Act is an achievement to a certain extent as it has embedded reproductive, maternal and newborn health and health rights as per the sentiment of the Constitution, and it tries to explicitly protect the health and rights of women, girls, adolescents and newborns, therefore, it indeed is a big step towards fulfilling Nepal's international commitments. We can see a silver lining in the Act which addresses the untimely deaths and long-term injuries suffered by women and girls who would be compelled to resort to unsafe and illegal abortion as in the past if not for this legislation.

The efforts of the Government to improve the SM and RH of women are notable but just formulating laws related to the right to reproductive health along with accompanying policies and programs, is not in itself sufficient to protect women's reproductive health in real situations. It is equally important that those laws and policies be effectively implemented in society. In the current socio-political scenario, many women are not able to exercise their right to determine their own reproductive health and are in a true sense very far from having universal access to services as imagined by the government. It is, therefore, necessary, if we seek to achieve goals through legislative initiations, that extensive programs be made to address the practical obstacles that are deep-rooted in the socio-politico-legal context as evaluated by this paper.

# APPENDIX 1 – LIST OF CHAPTERS IN SMRHRA

Chapter 1: of the Act titled 'Preliminary' deals with the name and definitions of key words including Emergency Pregnancy Services, Fundamental Emergency Pregnancy Services, Youth, Abortion, Contraception, Contraceptives, Abortion Services, Pregnancy Services, Pregnancy, Specified, New-born Essential Care, New-born Emergency Care, Family Planning, Reproductive Health, Reproductive Health Rights, Reproductive Health Morbidity, Pregnancy Health Worker, Comprehensive Emergency Obstetric Care, Safe Motherhood, and Health Institutions.

Chapter 2 on: 'Reproductive Health Rights' define the various rights in detail, for instance, rights to counselling and information related to reproductive health, right of the mother for abortion, rights in conditions of morbidity including a nutritious balanced diet and physical rest. It recognizes women's rights to pregnancy services and family planning, receiving emergency and fundamental services, comprehensive care and newborn care in an easy, acceptable and safe manner. This chapter also protects the confidentiality of the reproductive health services received by any person and also deals with the right to choose reproductive health services.

Chapter 3 on 'Safe Motherhood and New Born Child' relates to various rights of a woman during pregnancy and care of a newly born child including pregnancy check, right to receive minimum four health check-ups and other basic safety measures. These services are to be provided through certified health institutions and skilled health workers. This chapter also includes emergency services to be provided for the mother and the newborn by the health institution and also provides for record-keeping of births, miscarriages and pregnant women. This chapter calls for access to information and services related to family planning and restricts forced family planning and forced use of contraceptives and vows for pregnancy/maternity and maternity care leave.

Chapter 4 on 'Safe Abortion' deals with safe abortion and criminalizes forced abortion, gender revealing and sex-selective abortion and various kinds of discrimination related to it. Chapter 5 on 'Reproductive Health Morbidity' deals with the rights of women to receive services related to reproductive health morbidity. It also prohibits displacement of individuals on the basis of such morbidity. Chapter 6 on 'Budget allotment and grant for Motherhood and Reproductive Health' makes it obligatory for the Nepal Government and the federal governments to allot grants through the budget for every local level government, where the local level should also allot a budget for the same purpose. This chapter also provides for a Reproductive Health Coordination Committee which includes Secretary-level officials of different Ministries for developing plans, policies and programmes related to reproductive health.

Chapter 7 on 'Crime and Punishment' determines crimes which include deprivation from or denial of pregnancy services, referring to another institution while the service is available, denial of birth certificate, forceful family planning or contraceptives, illegal abortion, gender identification of fetus, sex-selective abortion, breach of confidentiality, displacement and discrimination. In these aforementioned offences, the punishment ranges from 6 months to one year of imprisonment and

up to one hundred thousand Nepali rupees as fine. There is also a provision for compensation to the victim.

Chapter 8 titled 'Miscellaneous' includes various provisions which call for services suitable for differently-abled, non-discrimination, coordination of all levels of government for the establishment of safety home for mentally challenged, discriminated and victims of rape; this chapter also advocates for free services from government-operated or government-supported health institutions and aims to regulate service fees in private, non-governmental and community health institutions. It also obliges the government for giving pregnancy allowance to extremely poor women, protects the actions done with good intention and makes all the cases related to this act as a state party case and finally gives the right to frame regulation for implementation to Nepal government and the right to issue circulars to the Ministry of Health.

# ABOUT THE AUTHORS

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