GTZ cross-sectoral project: “Realizing Human Rights in German Development Cooperation”

Strengthening a Human Rights-Based Approach in the Health Sector Support Programme (MoHP/GTZ) in Nepal

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Acronyms and Abbreviations

BMZ	German Federal Ministry of Economic Cooperation and Development
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CESCR	Committee on Economic, Social and Cultural Rights
CRBD	Convention on the Rights of Persons with Disabilities
CRC	Convention on the Rights of the Child
CRPD	Convention of the Rights of Persons with Disabilities
EDP	External Development Partners
GTZ	German Technical Cooperation (Gesellschaft für Technische Zusammenarbeit)
HRBA	Human rights-based approach
HSSP	Health Sector Support Programme
ICCPR	International Covenant of Civil and Political Rights
ICERD	International Convention on the Elimination of all Forms of Racial Discrimination
IHP	International Health Partnership
ICESCR	International Covenant on Economic, Social and Cultural Rights
MoHP	Ministry of Health and Population
NHRC	National Human Rights Commission
NHRI	National Human Rights Institutions
NHSP-IP	Nepal Health Sector Programme Implementation Plan
OHCHR	Office of the United Nations High Commissioner for Human Rights
RHCC	Reproductive Health Coordination Committee
SRHR	Sexual and Reproductive Health and Rights
SWAp	Sector-wide approach
WHO	World Health Organization

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1 Introduction

Following a decade of armed conflicts, the Government of Nepal has in recent years markedly increased its commitment to respect, protect and fulfill human rights, including social, economic and cultural rights. The Government of Nepal recognizes health as a fundamental human right, as enshrined in the Interim Constitution of 2007, and has incorporated health related human rights in its national legal and policy framework. Yet, implementation challenges to progressively realize the *"right to the highest attainable standard of physical and mental health"* (short: right to health) for the whole population and to operationalize a human rights-based approach (HRBA) in the health sector are great.

The joint Health Sector Support Programme (HSSP) aims to improve the access to effective health services, especially for disadvantaged population groups of Nepal. HSSP is executed under the overall coordination of the Ministry of Health and Population (MoHP) and in joint responsibility with the German Agency for Technical Development (GTZ). In its present phase (June 2007- July 2010), HSSP focuses on systemic quality improvement and decentralisation, improving access to health services and fair financing, and sexual and reproductive health and rights (SRHR) with a focus on young people. In accordance both with Nepal's human rights commitments and with the Development Policy of the German Government,[1] HSSP aims at strengthening a HRBA in its present and forthcoming programme.

Against this background, HSSP, with the advisory assistance of the GTZ sector project "Realizing Human Rights in Development Cooperation", took the initiative to assess how far it has already gone in applying a HRBA to health and to identify entry points to strengthen this approach.

Therefore, the main objective of the assignment was to provide advice to HSSP on how to enhance a HRBA in the ongoing GTZ supported strategies and processes. A further objective was to provide recommendations to HSSP for future strategic partnerships to promote a HRBA in HSSP, based on identified synergies with other actors and within the scope of GTZ support to HSSP.

The consultancy of the short term expert took place between May 18th and 29th in Nepal. It started with a one-day start-up workshop with GTZ staff, in which the conceptual framework of a HRBA to health was discussed and set in relation to the HSSP programme set-up. Following the workshop, interviews and focus group discussions were held with partners and other stakeholders at national and district level to understand their perspective of a HRBA to health. Furthermore, the consultant had the opportunity to engage in intensive discussions with GTZ staff members about their advocacy role in promoting a HRBA. A wrap-up meeting for GTZ staff was held at the end of the mission.

A HRBA to development is now widely understood as a framework normatively rooted in human rights standards (e.g. the right to health) and principles (non-discrimination/equality of opportunities; participation/empowerment and accountability/transparency). It contributes to develop the capacities of "duty-bearers" (partners) to meet their obligations and of "right-holders" (target groups) to claim their rights.[2] As GTZ mainly supports partners to steer, implement and monitor reform processes in the health sector, a focus was set on assessing the capacity of duty-bearers to apply a HRBA to health. Elements of a human rights-based

[1] BMZ (2008): Development Policy Action Plan on Human Rights 2008-2010.
[2] See *inter alia* BMZ Development Policy Action Plan on Human Rights and the "UN Interagency Common Understanding on a Human Rights-based Approach to Development Programming (2003)."

capacity analysis,[3] i.e. knowledge, awareness and understanding of health related rights, authority, leadership and motivation to promote a HRBA to health and ability to communicate with rights-holders, served as guideline for the interviews and discussions.

The following report gives a brief analysis of the legal and policy framework,[4] summarizes the discussions held during the consultancy and presents options to consider in the ongoing and forthcoming programme phase of HSSP. It does not deal in depth with the underlying conditions and determinants of health and human rights in Nepal, as most readers are familiar with the context.

I would like to thank all interview partners for their interest in the issue, their patience and their willingness to give their personal view on the challenges at stake to promote a HRBA to health in Nepal. Particular thanks to Dr. Susanne Grimm and to Mrs Pushpa Lata Pandey for their support in organising the mission and assistance in analysing key documents.

2 National legal and policy framework

2.1 State commitments to international human rights treaties

The Universal Declaration of Human Rights of 1948 incorporates civil, political, economic and social and economic rights and includes health as part of the right to an adequate standard of living. The Universal Declaration has been followed by several international human rights treaties, many of which recognize the right to health, gender equality and other health related human rights.

Nepal has signed and ratified most of these human rights treaties, including the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC). Nepal has signed the recent Convention on the Rights of Persons with Disabilities (CRBD), but has not ratified it yet.

The enforcement of the provisions of the international human rights treaties is monitored at international level by the UN treaty bodies. Once a State has ratified a human rights treaty, it is required to submit regular reports to the respective treaty body with explanations as to the extent it has been working towards the realization of the rights enshrined in that treaty. The treaty bodies review the State party reports, discuss them with Government representatives and then provide observations and recommendations regarding the progress of implementation of the State party human rights commitments.

The most recent State party reports submitted by the Government of Nepal to the treaty bodies include the report on the elimination of all forms of racial discrimination (2000), the report on the elimination of all forms of discrimination against women (2002), the report on the rights of the child (2003) and the report on economic, social and cultural rights (2006). Delays in the submission of reports to the treaty bodies were in Nepal partly due to the conflict situation and the political transformation process. The last report on civil and political rights was submitted in 1994.

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[3] For the conceptual framework of a human rights-based capacity gap analysis see Jonsonn, Urban (2003): Human Rights Approach to Development Programing; UN (2008): Common Training Package on a HRBA; WHO/InWEnt (2008): E-learning course on health and human rights.

[4] For the analysis of the legal and policy framework the draft analytic tool on „Human Rights and Gender Equality in Health Strategies“, developed by WHO and SIDA (2008), was used.

The analysis of the respective State party reports and of the concluding health-related observations and recommendations of the treaty bodies[5] show that:

- In recent years, Nepal has gone a long way in the adoption of laws and policies aiming at enhancing the implementation of core human rights provisions, particularly regarding non-discrimination, gender equality and the protection of children against violence, abuse and exploitation. These developments were welcomed by the respective treaty bodies.
- Issues of concern expressed by the treaty bodies relate to the persistence in society of discriminatory practices against traditionally marginalized groups, including caste-based discrimination, the persistence of harmful traditional practices violating the rights of women and girls, high rates of domestic violence, trafficking and sexual exploitation of children and women, high maternal and infant mortality rates, limited access of women, particularly in remote rural areas, to reproductive health services and insufficient concern given to adolescent health issues.
- Accordingly the treaty bodies recurrently recommend intensifying efforts to implement laws prohibiting discriminatory practices, strengthening awareness raising efforts towards men and women, and enhancing measures to improve the access to health information and services, particularly in rural areas.

2.2 Constitution

Nepal's Interim Constitution (2007) was drafted in the wake of the comprehensive peace agreement signed between conflict parties in 2006. It will remain in force until the Constituent Assembly elected in 2008 has formulated and passed a new constitution.

The Interim Constitution guarantees a range of fundamental rights related to health. These include provisions on the right to equality and the prohibition of discrimination on grounds of religion, race, caste, tribe, sex, origin, language or ideological conviction (Art. 13 and Art. 14). Art. 14.2 specifically states that *"no person, shall, on the ground of caste or tribe, be deprived of the use of public services (…)."*

Furthermore several articles are directly related to health. Art. 16 guarantees to every person the right to "live in clean environment" and to every citizen "the right to get basic health service free of cost from the State as provided by the law." Art. 20 guarantees to women "the right to reproductive health" and art. 22 to each child "the right to get nurtured, basic health and social security" as well as the right to be protected against physical, mental or any other form of exploitation.

Art. 32 guarantees for all these fundamental rights constitutional remedy, i.e. Nepali citizens are entitled to claim these rights at the Supreme Court.

The formulation of a new constitution by the Constituent Assembly is a lengthy process, which is not surprising, as crucial matters for Nepal's future are linked with the constitutional debate, such as the structure of the state (federalism), the division of powers, and the consolidation of democratic institutions. The Committee in charge of drafting the constitution is currently also discussing how to guarantee and define the right to health. There is obviously a consensus to include it as a fundamental right, which implies it can be evoked in a court. The debate now focuses on how detailed and prescriptive a constitutional provision on the right to health should be, with some proponents arguing for a right to comprehensive health care free of charge. Little attention is yet being paid to the character of social and economic rights as being subject to **progressive realisation**, which requires that the State

[5] See annex 2 for a detailed overview and analysis.

must take concrete and targeted measures to realize the right to health, but acknowledges the constraints due to the limits of available resources.[6]

2.3 Health sector policies and strategies

According to the UN Committee on Economic, Social and Cultural Rights (CESCR), State parties have the core obligation 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 should be devised, and periodically reviewed, on the basis of a participatory and transparent process. The design process as well as the content should give particular attention to vulnerable and marginalized groups.[7]

The main policies and strategies framing the health sector in Nepal are the National Health Policy (1991), the Nepal Health Sector Programme Implementation Plan 2004-2009 (NHSP-IP) the ten point policy guideline (2007) and the three-year Interim Plan 2007-2010. A brief analysis of these documents reveals that they incorporate key elements of the right to health (availability, accessibility, acceptability and quality of health services and information), gradually incorporate human rights principles and increasingly pay attention to vulnerable groups.

The main goal of the NHSP-IP is *"to increase the coverage and raise the quality of Essential Health Services with a special emphasis on improved access for poor and vulnerable groups…"*. The recognition that the NHSP-IP reflected a poverty focus but lacked a clear definition of vulnerability, led to the parallel development and adoption of a "Vulnerable Community Development Plan" by the Ministry of Health in 2004. The plan defines vulnerable groups as women, Dalits (lower castes) and Janajatis (indigenous population groups) and recommends detailed actions at central, district and programme level to overcome access barriers and promote social inclusion. The three-year interim plan 2007-2010 refers to the Interim Constitution of 2007 and emphasizes that rights to free basic health services to each citizen will gradually be established, and that special priorities will be given to promote the health status of the poor, women, marginalized, Dalit, Indigenous groups and the people with disabilities.

Participation, transparency and accountability are primarily addressed in the context of decentralisation and health sector management. NHSP-IP includes one output and respective indicators related to the management of health facilities by local bodies in a participative, accountable and transparent way. The three-year Interim Plan includes as one indicator for coordinated and consistent sector management the availability of Annual Work and Budget Plans, inclusive of district, external development partners (EDP) and civil society participation.

The provision of the Interim Constitution on the "right to basic health care free of cost" has not yet been translated into a law. Hence, what basic health care is and by which financing or/and social security mechanisms free health care is to be ensured, is not legally specified. Notwithstanding this legal gap, a policy of free health care has been gradually implemented since 2006. Since October 2007 health services at health posts and sub-health posts have been declared free of charge to all users. Furthermore, selected health services at higher

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[6] See for an interpretation of the Right to Health and of the meaning of progressive realisation by UN treaty bodies General Comment No. 14 (2000) of the Committee on Economic, Social and Cultural Rights (CESCR) on the Right to the Highest Attainablie Standard of Health, Art. 12 of ICESCR, E/C.12/2000/4, 4 July 2000. See also OHCHR/WHO (2009): Fact Sheet No. 31 on the Right to Health as well as several reports of the former UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (http://www2.ohchr.org/english/issues/health/right/annual.htm).

[7] CESCR (2000), General Comment No. 14.

level are offered free of charge to specific groups (poor and destitute, elderly, disabled people and female community health volunteers).

Nepal's Government has recently started the planning process for the second national health sector plan. A guiding framework including key questions and overarching principles as well as thematic areas was developed with the support of GTZ and other EDP. "Health Rights" are explicitly mentioned as an overarching principle together with equity and social justice. Accountability of all health sector actors to the people is a key framing question.[8] The challenge will be to operationalise these key questions and principles and incorporate them into the proposed thematic areas as well as to discuss and set priorities in a participatory and transparent process.

2.4 National human rights mechanisms

Besides administrative and political mechanisms, courts and national human rights institutions (NHRI) can play an important role to hold a State accountable to its human rights obligations.

In Nepal, the Supreme Court has recently issued far-reaching judgements on non-discrimination, gender equality and health. These include directives ordering the government to enact a law on reproductive rights (2007), to amend prevailing laws to allow sexual minorities to enjoy their rights without discrimination (2007) and to review the law on marital rape (2008). In accordance with the legalisation of abortion proclaimed in 2002, the Supreme Court most recently ordered the Government to enact a separate Act on abortion to guarantee that women have access to safe and affordable abortion services (2009). In some statements the Supreme Court has directly referred to international human rights treaties, which is possible in Nepal, as ratified treaties have domestic effect even if they have not yet been translated in national law.

The National Human Rights Commission (NHRC) of Nepal was established in 2000. Its mandate as an institution responsible to ensure the respect, protection and promotion of human rights is guaranteed by the Interim Constitution. It comprises *inter alia* to conduct inquiries and investigate complaints on human rights violations; to enhance awareness on human rights; to review prevailing laws relating to human rights and recommend necessary amendments and to monitor the implementation of international human rights treaties. The Chairperson and the four commissioners are appointed for six years by the Prime Minister at the recommendation of the Constitutional Council. The NHRC has received accreditation by the International Coordinating Committee of NHRI, as it complies with the "Paris principles" on the statute of NHRI, which were adopted by the UN General Assembly in 1993.

In view of the conflict situation prevalent until 2006, the NHRC has focused its work on violations of civil and political rights (mainly related to abduction, disappearance, killings and torture), and only recently paid more attention to social, economic and cultural rights. Its last strategic plan includes among many other tasks the monitoring of the right to health care. Capacity and resources to engage in extensive advocacy and monitoring activities are still very limited, as there is only one desk in Kathmandu dealing with economic, social and cultural rights. The bulk of the NHRC work is still event-, complaint- and enquiry-based, and in the commission itself there is an ongoing debate on the extent to which economic, social and cultural rights should be considered. Nevertheless, the NHRC has in recent years come up with several activities related to health. These include the investigation of violations of the rights of children and women, a review of existing laws and acts on people with disabilities, a report on health care in prisons, the consideration of the right to health in reports on induced displacement of civilians, and a report on trafficking of women and children. In 2008, the

[8] MoHP, Government of Nepal (January 2009): Process Design for the Next Five-year Health Sector Strategic Plan of Nepal.

NHRC received training by the Office of the United Nations High Commissioner for Human Rights (OHCHR) on the monitoring of economic and social rights.

Other institutions with a mandate related to the rights of particular groups include the National Women's Commission, the National Dalit Commission and the National Foundation for the Development of Indigenous Nationalities.

Furthermore there are several human rights and women's rights organisations, such as the Forum for Women, Law and Development, that have successfully advocated for legal and policy change at national level, such as the legalisation of abortion in 2002 and the most recent endorsement by parliament of a law on domestic violence. Some of these organisations also have branches at local level, with so-called paralegal officers providing awareness-raising on rights and legal aid services.

3 Implementation challenges

3.1 Barriers to access health services and information

Many studies exist on social exclusion and access barriers to health services in Nepal, including a meta-analysis commissioned by GTZ.[9]

While in average child and maternal mortality in Nepal have significantly decreased in recent years, various and cross-cutting inequalities in the use of health services and health outcomes remain. Caste and ethnic status are important, but not the sole determinants of access to health care. For example, analysis of data on the use of maternal health services in recent years indicate that, while Dalit groups are still well below the average, privileged indigenous groups such as the Newar and Thakali rank better than the high caste Brahmin and Chetri groups.

The main barriers to access health services and information are the following:

- Remoteness and physical inaccessibility of health facilities, particularly in mountain areas;
- Affordability of health services, including costs of drugs and transport. Income poverty is very often but not always linked to ethnic or caste status. Despite many challenges (e.g. stock-out of drugs, sustainable financing mechanisms), the free health care policy has enhanced the access of poor and disadvantaged groups to health services.[10]
- Socio-cultural barriers to communication between ethnic groups and castes. While overt discrimination (e.g. refusal to touch or treat a Dalit) has decreased, communication between health staff and users coming from different groups and their mutual acceptance still is a problem. Likewise, in some communities, particularly ethnic and religious minorities, there is still a low acceptance of practices such as family planning, that are not legitimized by dominant cultural values or religious beliefs.
- Gender inequality, domestic violence and discriminatory practices against women and girls. The ability of women to decide if and when to seek services is still restricted. For example, studies indicate that although abortion has been legalized in

[9] Magherini, Dr. Lucilla and Mrs Binjwala Shrestha (2009): Analysing Existing Studies on the Identification of Excluded Groups and Access Barriers to Health Care.
[10] RTI International (2009): Examining the Impact of Nepal's Free Health Care Policy: First Facility Survey Report.

Nepal, normally husbands are the major decision-makers as to whether to terminate a pregnancy.[11]

3.2 Capacity of duty-bearers to implement a HRBA to health

Understanding of the right to health and a HRBA

Interviews held during the mission with stakeholders of the MoHP at central and district level indicate that the right to health is mainly understood as the right to have free health care. Hence, the free health care policy, coupled with the improvement of health services in facilities, is seen as the main instrument to overcome access barriers. The focus on addressing financial barriers to health services is understandable in view of the fact that many vulnerable and marginalized groups are poor. Affordability is a key component of accessibility to health services and information, yet not the only one. Set in a broader perspective, the right to health embraces the promotion of conditions in which women and men can lead a healthy life, including disease prevention, health information and education, as well as measures to eradicate harmful traditional practices.[12]

Likewise, improving the quality of health services, while respecting the rights of clients, is a key factor in progressively realizing the right to health. The MoHP is gradually implementing a "Policy on Quality Health Services" that foresees raising the awareness of consumer's rights and responsibilities and establishing quality assurance committees at district level with the participation of consumers' representatives.[13] A "citizen charter" exists that is displayed in health facilities to inform clients on the available services and fees, the persons in charge, and whom to complain to, in case the services are not provided. However, the charter does not provide an overview of client's rights and related duties of services providers with regard for example to privacy, confidentiality, choice and informed consent. Boxes have been put in most facilities for clients to express their written complaints or improvement proposals, but apparently they are not being widely used. In view of the still wide-spread communication barriers between castes and ethnic groups, which can lead to discriminatory attitudes of service providers, the improvement of the relationship between clients and service providers by taking into consideration the above mentioned rights is a challenge that needs to be addressed with more impetus.

On general terms, in Nepal, the discussions on how to apply a HRBA to health are very much linked with the debate on social inclusion. Particularly since 2006, social inclusion has been on the agenda of the Government and was included as one of the strategic pillars of the three-year Interim Plan. Following concepts developed by DFID and the World Bank, the MoHP defines social inclusion as a *"process by which those disadvantaged groups are able to enjoy the services rendered by the state without discrimination"* and operationally, as *"the removal of institutional barriers and the enhancement of incentives to increase the access of diverse individuals and groups to development opportunities."* [14]These concepts, while not based on the framework given by international human rights law, show strong similarities with key human rights principles of a HRBA. Interviews held during the mission indicate that the concept of social inclusion is well known by officials of the MoHP. What it means in practice, i.e. which approaches beyond providing free health care could be taken to remove

[11] Centre for Research on Environment Health and Population Activities (2007): The Influence of Male Partners in Pregnancy Decision-Making and Outcomes in Nepal.
[12] CESCR (2000), General Comment No. 14.

[13] MoHP, Government of Nepal (2007): Policy on Quality Health Services 2064 (2007).
[14] MoHP, Government of Nepal (2004): Vulnerable Community Development Plan for Nepal Health Sector Programme Implementation Plan (2004/5 – 2008/9) and MoHP, Government of Nepal (2009): Concept Paper – Social Inclusion Information System in the Context of Nepalese Public Health Informatics.

barriers and enhance the inclusion of disadvantaged groups, is, particularly for stakeholders at district level, less evident.

Both from the social inclusion and the human rights perspective, collecting and analysing disaggregate data is a prerequisite to develop evidence-based inclusive approaches. With support from EDP, the MoHP is gradually developing its health monitoring information system, in order to more accurately reflect the extent to which different population groups have access to health services. In 2007 reporting tools were revised to incorporate, besides age and sex, caste and ethnicity of health service users. Disaggregate data is now being collected at health service level. The extent to which data collection respects confidentiality could not be thoroughly assessed in the mission, but most interview partners did not consider lack of confidentiality as a problem. A concept on developing a "social inclusion information system in the health sector" has recently been developed by the MoHP and will be piloted in 10 districts. The main challenge is to integrate disaggregate data in the health information system, and use the results of the analysis to identify which actions should be taken, in order to better address disparities in the provision of health information and services.

Leadership, authority and motivation

In practice, applying a HRBA to health also means changing relationships between health service providers and health users. Widening social and health systems to ensure better access of vulnerable groups is often a controversial task, as it implies re-defining and re-balancing power relationships in society.

In Nepal, leadership and motivation of duty-bearers to promote a HRBA to health and make the health system more responsive to rights-holders is increasing at all levels, but is still very much dependent on initiatives of pro-active individuals. Institutional culture as a whole is still very much structured as to safeguard the status-quo, i.e. satisfying one's superiors is usually the most rewarding strategy. Prevailing formal and informal hierarchies are not supportive of accountability of civil servants and health service providers to health service users. Motivation to allocate and use resources in a transparent way is still low in view of wide-spread corruption and what has been called a "culture of impunity".

Nepal's post-conflict peace process is fragile. It is also characterized by the politicization of ethnic, caste and regional identities. Legitimate claims of disadvantaged groups to equal access to services and assets as well as to greater representation in State institutions are increasingly being channelled through party politics. Unsurprisingly, the motivation of health officials to overtly adopt a HRBA is constrained by the fear of a "rights" language being misused in the battle for political power, and of being confronted with claims they are unable to fulfill immediately.

On the other hand, democratically legitimized participation mechanisms at local level are still weak. Local bodies, such as District Development Committees, Village Development Committees and Health Facility Management Committees are in place, but, due to the absence of local elections in recent years, not working to their full potential.

In such a situation, the challenge is to promote a HRBA to health without doing harm by exacerbating political conflicts. One entry point is to facilitate a dialogue and foster mutual agreements between stakeholders at different levels, including representatives of vulnerable groups, on the priorities that, taking in consideration limited resources, should be set in order to overcome access barriers and gradually develop an inclusive health system.

Promoting reproductive and sexual rights of young people

As GTZ supports Nepal's Government in the implementation of its adolescent health strategy, it was important to specifically assess how partners understand the "reproductive rights" of young people and how they intend to promote them.

A range of human rights enshrined in the core human rights treaties are relevant to the reproductive and sexual health of young people. These include the right to be free from discrimination, the right to privacy, the right to decide freely on the number and spacing of one's children, the right to education and information, the right to health, the right to express one's views as a child and the right to be protected against violence and harmful practices.

Based on these human rights, and following the International Conference on Population and Development in 1994, to which Nepal is signatory, the assurance of the reproductive rights of young people is frequently identified as one of the pre-conditions necessary for a full realization of their reproductive health. According to the CESCR, the right to health also obliges State parties to provide a safe and supportive environment for adolescents as well as appropriate reproductive and sexual health services.[15]

Nepal was one of the first Asian countries to adopt an adolescent health and development strategy in 2000. Besides increasing the availability and access to reproductive health information and services, this strategy aims at creating a safe and supportive environment for adolescents by adopting a multi-sectoral approach. According to several interview partners, implementation of the strategy has up to now been very slow. In 2007 an implementation guide for the health sector was developed by the Family Health Division in the MoHP. The guide addresses reproductive rights of young people in the context of access to information, education and services as well as of treatment of sexual abuse. Besides developing youth-friendly services in health facilities it foresees awareness-raising activities at local level in collaboration with schools and community-based organisations.[16] At district level, responsibility for the coordination of these activities lies with the reproductive health coordination committee (RHCC), which is led by the District Health Officer and involves members of Government institutions, non-governmental and community-based organisations.

Interviews held during the assignment indicate that both at central and district level health officials see their main duty as to provide youth-friendly services. Awareness-raising on reproductive health and rights of young people is mainly seen as the responsibility of non-governmental organisations. In the two districts visited during the mission, the function of the RHCC and the division of roles between partners was not clear, and the importance of addressing the reproductive health and rights of young people alongside with other reproductive health matters not yet acknowledged by all members.

Nevertheless, in one district sensitization activities involving female teachers were planned by a Health Facility Management Committee. The idea is to support young school girls to seek advice and counselling in the health facilities offering youth-friendly services. Similar activities targeted at young men are not yet foreseen.

In general, the motivation to engage in a gender-sensitive dialogue on the above mentioned rights of young people is still very much restricted by the fear to break with dominant cultural values that legitimize arranged marriages by parents, condemn pre-marital sexual relationships and restrict the ability of young unmarried people and women to decide if and when to seek information and services. However, the rising incidence of HIV among young men migrating to India, is gradually putting the issue of "prevention" on board, and is an issue of concern among communities and women groups. Domestic and sexual violence is increasingly seen as a human rights violation. Yet, medical professionals often lack the skills to recognize signs of violence. Psychosocial support groups and legal aid services are still rare at local level, and, where they exist, referral links still need to be established.

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[15] CESCR (2000), General Comment No. 14.

[16] MoHP, Government of Nepal (2007): Implementation Guide on Adolescent Sexual and Reproductive Health.

4 Support of GTZ

4.1 Overall programme approach

Overall objective of HSSP
Access to effective health care services is improved, especially for disadvantaged groups.

In accordance with Nepali Health Plans, the overall objective of HSSP explicitly addresses a key element of the right to health (accessibility) and implicitly the key human rights principle of non-discrimination and equality of opportunities. Ensuring access to health information and services for vulnerable groups is a core obligation of State parties to the ICESCR. The extent to which women, poor and disadvantaged groups (e.g. lower castes, ethnic minorities) use health services is also reflected in the indicators, which are taken from the NHSP-IP.

In its present phase (2007 – 2010) HSSP contains three main thematic areas: Decentralization and quality improvement, easier access to health care services (social inclusion and fair financing) and sexual and reproductive health and rights of young people. The programme is being implemented in cooperation with the KfW. It is present at both national and decentralised level and involves nine out of a total of 75 districts. It supports Government partners in the health sector, (managers of the MoHP and district officials), representatives of local government (district and village development committees) and of civil society organisations.

During the decade of armed conflicts, GTZ, in addition to supporting the health reform agenda of the MoHP, adjusted its modes of delivery to the environment by adopting features of humanitarian aid such as direct service delivery and focussed interventions to vulnerable and marginalized communities.[17] The peace process and the transition to a post-conflict period enabled GTZ to re-focus its support in HSSP. Supporting change processes and the development of innovations in the health system as well as strengthening governance are now key features of GTZ´s approach across all three thematic areas. In recent years, coordination with other EDP and actors in the context of the sector-wide approach (SWAp) has gained importance.

Basically, this approach is in line with a HRBA and the key human rights principles of accountability and participation. GTZ´s comparative advantage of supporting and working with a broad range of actors at different levels gives the opportunity to facilitate a dialogue on a HRBA to health in the Nepali context and foster mutual agreements between stakeholders (duty-bearers and rights-holders).

4.2 Thematic areas

Decentralization and quality improvement

Objective
The capacity of the Ministry of Health and its subordinate authorities is strengthened in the fields of decentralisation and quality improvement.

The objective addresses a key element of the right to health, i.e. quality of health services.

[17] Sudip Pokhrel, K.K. Singh, Friedeger Stierle (2008): GTZ's Modes of Delivery in the Joint Cooperation Project Health Sector Support Programme (HSSP) during the Armed Conflict in Nepal.

From a human rights-based perspective a promising practice is the support to small scale health infrastructure development in 9 districts, including health facilities in remote areas. Since 2001 a start-up fund financed by KfW was administered by GTZ . In 2008, the implementation modality was changed from direct support to health facilities to local subsidy contracts with District Development Committees. Planning of the infrastructure measures follows a bottom-up process from the community to the district level. The Health Facility Management Committees are responsible for the implementation and get technical support from the district offices. Recently, a public audit initiative was started to enable the participation of the population in the control of the use of these funds. GTZ supports partners at the different levels with management and technical advice. Although it is faced with many challenges, including the absence of local elections in recent years, the start-up fund, by supporting the management capacity of local bodies recognized by Nepali law under the Local Governance Act (1999), contributes to strengthen accountability and participation.

Furthermore, in view of the above mentioned implementation challenges (see 3.2) , the following entry points to strengthen a HRBA were identified and discussed with the GTZ team:

- Intensify advice to incorporate user's rights in quality improvement processes, including the improvement of communication between health service providers and health service users.
- Intensify advice to integrate disaggregate data into health information system (provided this is not already being done by other EDP) and strengthen capacity at district level to use data analysis results for the development of district plans and/or targeted activities to gradually overcome disparities and improve access of vulnerable groups to health information and services.

Easier access to health care services (social inclusion and fair financing)

Objective
Options are developed to overcome obstacles preventing access to effective health care services

The objective addresses a key element of the right to health, accessibility.

In this thematic area, three aspects have been merged together: social inclusion, drug management and health care financing. While all these aspects have human rights implications (e.g. which financing or social security mechanisms are appropriate to ensure that health services are affordable for all), the discussions during the assignment focused on the issue of social inclusion.

GTZ has supported a range of activities, such as the set-up of a task team in the MoHP on social inclusion and fair financing, the review of existing studies on identifying barriers to health care services and workshops at district level to train stakeholders on the concept of social inclusion and develop their capacity to plan inclusive measures. The impression gained by interviews at district level was that these workshops have increased the awareness of partners on the theoretical concept of social inclusion, but that they still need support to translate this knowledge into practicable options. Therefore, and in view of the above mentioned challenges, the following entry points were identified:

- Social inclusion is a cross-cutting approach and has many similarities with a HRBA. The GTZ team should therefore continue discussing how to link both approaches in the programme. In view of the focus currently laid by partners on overcoming financial barriers as the main instrument to achieve social inclusion, GTZ should continue to advocate for taking into consideration gender-specific and socio-cultural barriers to access and promote the development of innovative mechanisms to overcome them.

- At district level, strengthen the capacity of stakeholders to generate and apply practical knowledge on how to gradually overcome disparities. Many access barriers, particularly those related to gender and socio-cultural practices can not be overcome by the health sector alone, but require intersectoral collaboration as well as coordination with non-governmental actors. Therefore, GTZ should continue to support and facilitate participatory processes involving relevant stakeholders.

Sexual and reproductive rights of young people

Objective
A comprehensive approach is introduced to promote sexual and reproductive health, especially among young people

While the objective, as stated in the programme offer to BMZ, does not explicitly mention the reproductive rights of young people, the current understanding of the thematic area is that it includes both reproductive health and rights.

The main focus of current activities is to support the implementation of the adolescent reproductive health strategy, including the establishment of youth-friendly services in 26 government health facilities of 5 districts. In some of these districts, GTZ will also support awareness-raising activities to increase the demand of youth for these services. Furthermore youth-oriented information, education and communication approaches, developed by GTZ in other countries, such as the “Join in Circuit” in schools or the participatory production of booklets on reproductive health and rights, are being or will be adapted to the Nepali context.

In view of the above mentioned challenges, the following entry points to strengthen a HRBA were identified and discussed:

- As some of the reproductive rights of young people are still very controversial in Nepali society, GTZ should first facilitate a dialogue on those rights that are better accepted. At community level, it is certainly easier to talk about rights by addressing the need to protect young people from unwanted pregnancies or HIV and their right to be informed and have access to services, rather than by focusing on reproductive freedoms. Likewise, one could contribute to promote the eradication of harmful traditional practices by linking human rights, such as the right to be protected from violence and abuse, to positive cultural values condemning these practices.
- For the same reason, awareness-raising activities through existing structures to increase the demand of young people for reproductive health services and their acceptance in the community are very important. Particularly in those communities, in which the authority of parents still plays a significant role, activities should not only target young people, but involve adults as well. GTZ should also actively promote gender-sensitive approaches, that aim at attracting young men to seek information and services and engage them in a reflection on responsible sexual behaviour.
- Strengthen the capacity of the RHCC and the leadership of district health officials to coordinate reproductive health programmes, including activities related to youth. Advocating for the enhanced participation of young people in the RHCC is certainly important but will probably not be very effective as long as the structures as such are weak.

4.3 Synergies and future strategic partnerships

National partners

Following is a very brief assessment of potential partnerships with human rights organisations:

- In some countries NHRI play an important role in holding governments accountable for realizing social and economic rights, including the right to health. One of the measures of the BMZ Development Policy Action Plan on Human Rights (2008-2010) is the strengthening of human rights institutions at national and regional level. The NHRC in Nepal is still building its capacity to address social and economic rights. Its pro-active engagement in this regard will very much depend on the post-conflict peace process in the near future and the extent to which violations of civil and political rights decrease. Furthermore, a focus on one right or one sector, in this case health, may overstretch the capacities of the NHRC. Therefore, depending on the institutional development of the NHRC and the support of EDP usually active in this field (OHCHR and other UN agencies), GTZ may consider facilitating a dialogue between the MoHP and the NHRC on State commitments to progressively realize the right to health.
- At national level GTZ should continue to inform itself on the health-related advocacy activities of human and women's rights organisations. At regional and district level, and particularly in the thematic area of reproductive health and rights, GTZ could assess the potential of organisations providing support and legal aid to victims of human rights violations such as domestic violence and, if where such support exists, facilitate links with the health sector.

External Development Partners

Since 2004 The Government of Nepal and major EDP have coordinated development aid in the health sector through a SWAp. Nepal is also one of the first countries to have entered the International Health Partnership (IHP), which commits national and external development partners to accelerate progress on achieving the health-related Millennium Development Goals. The most recent IHP signed in January 2009 by the Government and most of the EDP includes the advancement of citizen's rights, of equity and social inclusion as key commitment areas.[18]

A comprehensive assessment of how different EDP understand a HRBA to health was not done in the mission. However, literature review and interviews indicate that:

- Major EDP in the health sector, such as World Bank and DFID, use the concept of social inclusion rather than the concept of a HRBA.[19]
- While officially committed to the UN "common understanding on a HRBA to development programming", the extent to which UN agencies in Nepal promote a HRBA in practice, remains to be assessed. With a focus on environmental health, WHO has started on a small scale to engage civil society organisations, MoHP stakeholders and the NHRC in a policy dialogue on the "right to sanitation" and the "right to clean indoor air."
- International NGO´s such as CARE and Action Aid, have since the end of the nineties made a shift from direct service delivery to a rights-based approach aimed at raising the awareness of local communities and disadvantaged groups on their rights and empowering them to claim these rights from the Government and service providers.

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[18] IHP National ‚Compact' between Ministry of Health and Population, Federal Democratic Republic of Nepal and External Development Partners, January 2009.

[19] See the report for the human rights task team of the OECD-DAC Network on Governance by Claire Ferguson (2008) on „Linking Human Rights and Aid Effectiveness for Better Development Results: Practical Experience from the Health Sector", with a case study on Nepal.

While this approach has strengths, as it promotes social change, it also carries political risks. Both organisations are now, besides raising awareness of rights at community level, also emphasizing the need for dialogue and constructive partnerships between rights-holders and duty-bearers. They have also developed and adapted to the Nepali context interesting participatory tools.

In the SWAp context, GTZ should continue to discuss with other EDP and national partners the understanding and implications of a HRBA and of the social inclusion concept. Rather than creating parallel discourses, one should aim at using a common language, while being aware of the complementarities and differences between both approaches.

4.4 Advocacy role of GTZ team

Although not explicitly based on a human rights framework, HSSP has in its current phase, already achieved much, by promoting key principles of a HRBA. This assessment has shown that an explicit dialogue on health-related rights is challenging but not impossible, even in a sensitive political and socio-cultural context. In the practice of development cooperation, a HRBA is also about working together to gradually change relationships between duty-bearers (partners) and rights-holders (target groups).

Therefore, in their advice to partners and their advocacy work,
GTZ staff may consider the following points:

- Be process-oriented and continue to reflect on how to incorporate human rights principles in your work;
- Be explicit on what human rights are, and continuously facilitate a dialogue on rights, but no dot expect from partners to suddenly accept what may have taken you a long time to accept;
- Use opportunities for a common reflection in the team on the implications of a HRBA to health in and across the thematic areas supported by GTZ.

Annex 1

Mission schedule

Date	Activities
Mo, 18.05.09	Meeting with Mrs. Susanne Grimm, Team Leader Quality Improvement and Decentralisation Component, HSSP/GTZ Meeting with GTZ staff: Presentation of HSSP, discussion
Tue, 19.05.09	Workshop preparation Discussion on current status of debate on HRBA to health in Nepal*
Wed, 20.05.09	Workshop
Thu, 21.05.09	Meetings with stakeholders in MoHP: Mr. Parshuram Shrestha, Senior Public Health Administrator, Management Division, Department of Health Services Mr. Kedar Parajuli – Public Health Administrator, Management Division, Department of Health Services Mrs. Shilu Aryal – Family Health Division, Department of Health Services Mr. Baburam Marasini – Coordinator Health Sector Reform Unit Discussions with GTZ staff
Fri, 22.05.09	Travel to Dhading District Meetings with: Mr. Mohammad Daud, Senior Public Health Administrator Mr. Ramesh Kumar Adhikari, Local Development Officer, District Development Committee Mr. Krishna Prasad Dahal, Head of local branch of Nepal Human Rights Organisation
Sat, 23.05.09	Week-end
So, 24.05.09	Flight to Nepalgunj and travel to Bardiya district Meeting with Mr. Bal Bahadur Mahat, Senior Public Health Administrator Meetings with members of RHCC** Visit to Sub-health post in Bardiya district and discussion with health staff and female community health volunteer
Mo, 25.05.09	Discussions with GTZ staff in Nepalgunj Flight back to Kathmandu
Tue, 26.05.09	Meetings with: Mr. Anand Tamang, Director Center for Research on Environment and Population Activities Mr. Shree Ram Adhikari, Human Rights Protection Officer, National Human Rights Commission, Nepal Mrs. Alka S. Pathak, Country Director Care Nepal; Mrs Nirmala Sharma Coordinator Health Program, Care Nepal; Mrs Janet Meyers, Senior Advisor SRH Care International Mr Sabin Shreshta, Director Forum for Women, Law and Development, Nepal Mr Gagan Thapa, Member of Consistuent Assembly and of committee in charge of drafting constitutional provision on the right to health; Mr. Friedeger Stierle, Programme Manager, HSSP; Mrs Susanne Grimm; Mr Sudip Pokhrel, HSSP/GTZ Advisor
Wed, 27.05.09	Work with Mrs. Pandey Pushpa, HSSP/GTZ Advisor Preparation of wrap-up meeting Meetings with Mr. Bimal Kumar Phnuyal, Country Director, Action Aid Nepal Mr. Han Heijnen, Environmental Health Advisor, WHO Nepal; Mr. Keshav Sharma, Policy Advocacy Officer, Practical Action NGO Nepal; Mr Shiva Acharya, Forum for Justice NGO, Nepal
Thu, 28.05.09	Wrap-up meeting with GTZ staff, Kathmandu
Fri, 29.05.09	De-briefing Mr Friedeger Stierle; Mrs Susanne Grimm; Mrs Eva Schildbach, Team Leader SRHR component HSSP/GTZ; Mr Wolfhard Hammer, GTZ/Eschborn

*Participants to discussion on current status of debate on HRBA to health in Nepal:
Mrs Sonali Regmi, Thematic Advisor Discrimination and ESCR Team, OHCHR Nepal
Mrs Gynn Shrestha, IEC officer, UNFPA
Mr Basanta Pokharel, Head of Policy and Themes Department, Action Aid, Nepal
Mrs Karuna Onta, Care Nepal
Mr Shanta Ram Mulmi, National Researcher on International Health Partnership, Resource Centre for Primary Health Care
Mr K.P. Dhakal, Country Representative, Netherlands Leprosy Relief, Nepal

**Participants to discussion with RHCC, Bardiya district:
Mr Bal Bahadur Mahat, Senior Public Health Administrator, Bardiya
Mrs Kavita Rana, Mary Stopes, Bardiya
Mrs Urmila Thapa, Coordinator Concern Worldwide, Bardiya
Mr Dipak Gyawali, Nepal Red Cross Society, Bardiya
Mr Khim Bahadur K.C, Chair Person, Helping Hand, Bardiya (Association of People living with AIDS)
Mr Yadav Acharya, Member, Helping Hand, Bardiya
Mrs Bishnu Sapkota, Nurse, District Health Hospital, Bardiya

Annex 2
Nepal – Overview and analysis of health-relevant State commitments to human rights and gender equality
Pushpa Lata Pandey , HSSP/GTZ

1. Ratification of international human rights treaties

Treaty	Year of ratification
International Convention on the Elimination of all forms of Racial Discrimination (ICERD)	1971 with reservations
Convention on the Rights of the Child (CRC)	1990
International Covenant on Civil and Political Rights (ICCPR)	1991
International Covenant on Economic, Social and Cultural Rights (ICESCR)	1991
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)	1991
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)	1991
Convention on the Rights of Persons with Disabilities (CPRD)	Signed 3.01.2008, not yet ratified
International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (ICRMW)	Not signed

2. Analysis of selected State party reports, concluding observations and recommendations of UN treaty bodies

International Convention on the Elimination of all Forms of Racial Discrimination (CERD)	
Has the State ratified the treaty?	**Yes on 1st March 1971**
Has the State made any reservations to the treaty?	Reservations to article 4 (related to condemnation of propaganda and organisations based on ideas or theories of superiority of one race or group of persons or one colour or ethnic origin), article 6 (related to effective protection and remedies against any acts or racial discrimination) and article 22 (related to the referral of disputes between State parties to the International Court of Justice).
Date of last state party report	**2000**
Date of concluding observations of treaty body	**2003**

International Convention on the Elimination of all Forms of Racial Discrimination (CERD)	
Did the treaty body provide any recommendations to the State relating to the right to health, and/or gender equality?	The committee recommends that: 1. The State party, as a matter of priority, take measures to prevent, prohibit and eliminate private and public practices that consitute segregation of any kind, and make determined efforts to ensure the practical and effective implementation of these measures. 2. The State party consider issues of political representation, personal security, employment and education, in line with general recommendations XXV (2000) on gender-related dimensions of racial discrimination and XXIX (2002) on descent-based discrimination, in taking measures to eliminate multiple discrimination against women who belong to vulnerable groups. The Committee further requests the State party to include in its next report the measures taken in this regard, including specific action taken to eradicate forced prostitution of Badi girls and women.
Has the State taken any specific actions in response to these recommendations?	Actions taken in response to recommendations: 1. Interim Constitution of Nepal 2007 includes the right against untouchability and racial discrimination, and the provision that "groups, such as Women, Dalit, indigenous tribes, madheshi community, oppressed groups, the poor peasant and labourers, who are economically, socially or educationally backward, shall have the right to participate in the state mechanism on the basis of proportional inclusive principles." 2. Amendment of election laws to ensure broad representation of previously marginalised groups, adoption of several laws and measures to end traditional discriminatory practices, e.g. ban of the use of bonded labour.

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)	
Has the State ratified the treaty?	**Yes on 22nd May 1991**
Has the State made any reservations to the treaty related to the right to health and/or gender equality?	**None**
Date of the last state party report	**2002**
Date of concluding observations of Treaty body	**2004**
Did the last report to the treaty body address the right to health and/or gender equality?	The last report has addressed gender equality as follows: 1. Since the ratification of the Convention in 1991, women's socio-economic empowerment was well under way, gender issues were being integrated into sectoral development policies, and development partners agreed on the need to place gender issues at the top of the national agenda. 2. Equality between women and men, women's empowerment and gender mainstreaming were targets of overall development. To achieve those targets, several policies and strategies had been implemented, including formulation of the National Plan of Action on Gender Equality and Women's Empowerment; approval of a plan of action on the Convention; formulation of a national human rights action plan; approval of the National Strategy on .Education for All., aimed at eliminating gender disparity in education by 2005 and achieving gender equality by 2015; review of the existing Plan of Action against Trafficking; and preparation and finalization of the South Asian Association for Regional Cooperation Social Charter.

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)	
Did the treaty body provide any recommendations to the State relating to the right to health, and/or gender equality?	The committee recommends that: 1. The State party strengthen the existing national machinery for the advancement of women, inter alia, by providing it with adequate financial and human resources. 2. Ensure full and equal participation of women in the process of conflict resolution and peace-building and allocate sufficient resources to meet the needs of women who have suffered damage as a result of the conflict and to ensure their security and protection from violence 3. Intensify efforts to address the literacy gap between men and women so that the goals established in the National Plan on Education in regard to equality in education can be achieved, particularly in rural areas and among disadvantaged castes and ethnic groups and strengthen efforts to ensure equal access of girls and women to all levels of education and to take all appropriate measures to prevent girls from dropping out of school. 4. Intensify efforts to eliminate discriminatory cultural practices and stereotypes. The State Party should take comprehensive and effective measures, including the training of the judiciary and law enforcement officials and public awareness-raising campaigns aimed at eliminating these practices. The State party should encourage men to share family responsibilities and direct its awareness raising programmes to men as well as women, take action to change stereotypical attitudes and perceptions as to men's and women's roles and responsibilities. Media should be encouraged to project a positive image of women and of the equal status and responsibilities of women and men in both the private and public spheres. 5. The State party should adopt measures against domestic violence and provide information in its next report about progress in relation to the draft bill on domestic violence. 6. Measures should be taken to improve the access of women, particularly rural women, to health-related services and information, including in regard to sexual and reproductive health, in an effort to reduce maternal mortality. Programmes and policies should be adopted to increase knowledge of and access to contraceptive methods, bearing in mind that family planning should be the responsibility of both partners. Similarly, sex education should be widely promoted, particularly targeting boys and girls, with special attention to the prevention and further control of sexually transmitted diseases and HIV/AIDS.

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)	
Has the State taken any specific actions in response to these recommendations?	Actions taken in response to recommendations: 1. Interim constitution of Nepal 2007 includes law that no physical, mental or any other form of violence shall be inflicted to any woman, and such an act shall be punishable by law. 2. Adoption and implementation of health strategies and programmes, with an emphasis on maternal health 3. A comprehensive bill on domestic violence, including referral mechanisms was adopted by parliament in April 2009

Convention on the Rights of the Child (CRC)	
Has the State ratified the treaty?	**Yes on 14th Oct 1990**
Has the State made any reservations?	**None**
Date of last state party report	**2003**
Date of concluding observations of Treaty body	**2005**
Did the last report to the treaty body address the right to health and/or gender equality?	1. Establishment of a working group to implement the Integrated Management of Childhood Illness Strategy in 1997, efforts in improving the immunization coverage for children under 5, including the recent completion of the comprehensive measles vaccination campaign. 2. The health and social services are under tremendous resource constraints and that the overall quality and availability of health care available to children in the state is seriously inadequate, in particular among poor families and in rural areas. 3. Establishment of the National Centre for AIDS and Sexually Transmitted Diseases Control

Convention on the Rights of the Child (CRC)	
Did the treaty body provide any recommendations to the State relating to the right to health, and/or gender equality?	The Committee is concerned about 1. High rates of infant, under-five mortality and maternal mortality , and the low life expectancy 2. Continuing threats to survival and development of children by preventable childhood diseases 3. Inadequate sanitation and access to safe and clean water, in particular in rural areas, which generally suffers from lack of services 4. Inadequate prenatal and post-natal care which also constitute factors hindering child survival and development 5. Low awareness about health, hygiene and sanitation particularly in rural areas and prevalence of traditional practices which could be harmful to the health of children, eg. consulting witch doctors for children with diarrhoea rather going to medical facility. 6. Insufficient attention to the particular health vulnerabilities and needs of children at risk, including children with disabilities, street children, child labourers, child sex workers and Dalit children 7. Insufficient attention to adolescent health issues, including developmental, mental and reproductive health concerns. Adolescence face particular physical and mental health risks including sexual abuse, violence, drug and alcohol abuse and STD including HIV/AIDS and low level of awareness on reproductive health issues 8. the custom of early marriage, although the minimum age of marriage for girls is 18 years, which is still widespread in practice, in particular within certain ethnic and religious communities. 9. About the fact that certain harmful traditional practices such as the deuki (dedicating girls to a goddess), badi (widespread practice of prostitution among Badi caste), chaupadi (isolating a woman during menstruation) continue to prevail, causing health hazards and cruelty to girl children. 10. The persistence of child trafficking and the large number of children being sexually exploitated, particularly children belonging to lower castes. Recommendations from the Committee: 1. Facilitate greater access to primary health-care services and targetrural areas in particular. 2. Continue strengthening its efforts to extend immunization coverage to all parts of country 3. Continue strengthening measures to combat childhood illnesses, paying particular attention to the needs of children belonging to high-risk groups 4. Engage in awareness raising efforts to provide the general public, in particular, families, children and health –care providers, including traditional health practitioners, with appropriate knowledge of basic first aid and health care

	5. Undertake a comprehensive study to assess the nature and extent of adolescent health problems with full participation of adolescents and formulation of adolescent health policies and programmes with particular focus on prevention of STD, in particular through RH education and child-sensitive counselling services. Take measures to incorporate RH education in the school curriculum and conduct awareness-raising campaigns to fully inform adolescents of RH rights, including prevention of STD, HIV/AIDS and early pregnancies. 6. Integrate respect for the rights of the child into the development and implementation of its HIV/AIDS policies and strategies on behalf of children infected with and affected by HIV/AIDS, as well as their families. 7. Take all measures to eradicate all traditional practices harmful to the physical and psychological well-being of children, by strengthening awareness-raising programmes and adopting legislation prohibiting these practices. Develop sensitization programmes, involving communities and religious leaders and societies at large, including children themselves, to curb the practice of early marriage. 8. Enact legislation that protects from sexual abuse and exploitation.
Has the State taken any specific actions in response to these recommendations?	1. The Interim Constitution includes the right of women to be free from discrimination, the right to reproductive health, and the prohibition of physical, mental and any other form of violence. It also includes the right of every child to get nurtured, basic health and social security and to be protected against physical, mental or any other form of exploitation. 2. Following the National Adolescent Health and Development Strategy 2000 (NAHD), the Ministry of Health has developed an Guide on Adolescent Sexual and Reproductive Health for district health managers in 2007, which will now be implemented in several districts.

International Covenant on Economic, Social and Cultural Rights (ICESCR)	
Has the State ratified the treaty?	**Yes on 14th August 1991**
Has the State made any reservations to the treaty related to the right to health and/or gender equality?	**None**
Date of last state party report	**2006**
Date of concluding observations of Treaty body	**2008**
Did the last State party report to the treaty body address the right to health and/or gender equality?	The last report addressed the following issues related to health and gender equality : 1. The eleventh amendment of the Country Code, which came into force on 26 September 2002, abolished inequalities between women and men in the field of inheritance. The amendment has also removed the condition that a woman must attain 35 years of age and must complete 15 years of marriage before she can live separately from her husband and get her share of property. Even a divorced woman shall be entitled to a share of the family property. It also grants the right to food, clothing, appropriate education and healthcare to daughters as in the case for sons. The children are also entitled to the maintenance (food, clothing, appropriate education and health care) from their father in case of divorce. A divorcee and widow can remarry. 2. Improvements in access to health services over the past decade. The current tenth year health plan includes strategies on increasing investment to provide essential health services to the poor and the backward communities. GON has been conducting special package programme to ensure health services for the people of 25 districts having low health development indicators. Of the 25 districts, 14 districts are found to have lowest health development indicators. Under this programme, the GON has been initiating several programmes, which include: sending doctors to the low health development indicators districts by making special appointments. 3. Adoption and implementation of health strategies and programmes, with special emphasis on reducing maternal mortality and neonatal mortality. 4. GON has been taking several measures to reduce infant and child mortality rate and malnutrition. Despite huge efforts a large number of children are still suffering from malnutrition in the rural areas. In order to cope with these problems, the GON is seeking to invest a large amount in the sector with the technical support of the UN bodies and donor agencies for the programmes like vitamin A supplement and distributors of nutritional food to children and pregnant mothers.

	5. GON has been taking legal and remedial measures to reduce the high rates of maternal mortality in the country owing mainly to unsafe and illegal abortion. The Country Code (Eleventh Amendment 2002) allows abortion in various grounds. In addition, expanded coverage of family planning services and intensification of Information, Education and Communication (IEC) programmes focused on reproductive health have reduced the risks of unwanted pregnancies. 6. Nepal has established a mental hospital for the rehabilitation of mentally retarded people. 7. GON has been taking several policy measures for the control of HIV/AIDS. GON has adopted a National Policy on AIDS/STD (sexually transmitted diseases) Control in 1995, with 12 key policy statements focusing mainly on multi-sectoral, preventive activities in partnership with NGOs in an integrated and decentralized manner. GON has adopted a National Strategy on HIV/AIDS 2002-2006. It has overall objectives of containing the HIV/AIDS epidemic among vulnerable groups giving focus on young people, mobile populations, female sex workers, migrant sex workers, injecting drug users, and children. A National Action Plan for 2005-2006 has been adopted. This Plan makes provisions on access to services and improvement of multiple partners, especially in affected communities.

International Covenant on Economic, Social and Cultural Rights (ICESCR)	
Did the treaty body provide any recommendations to the State relating to the right to health, and/or gender equality?	The committee recommends: 1. Higher priority be accorded to reducing maternal and infant mortality rates and that due consideration be given to the need for integrating into general health care system, mental health services and programmes aimed at preventing and treating HIV/AIDS. 2. As part of the general improvement in the national health care system, physical and economic access to reproductive health care and contraceptives be given high priority, particularly in rural areas and that specific measure are taken to enable women to give birth in the care of trained health-care professionals. 3. The Committee is concerned at the high rate of domestic violence and the absences of specific legislationin this field. It urges the State party to adopt without delay specific legislation on domestic violence, and to undertake a major information campaign to raise awareness about such legislation. It further urges the State party to take measures to develop procedures and educate law enforcement officials, judges, lawyers, social workers and medical professionals to enable them to protect effectively victims of domestic violence. 4. The Committee urges the State party to strictly enforce the law prohibiting harmful practices that violate the rights of women and girls such as deuki, badi, chaupadi, marring child brides and witchcraft. The Committee requests that the State party provide detailed information on the extent of these practices and the measures being taken to strictly enforce its laws for the protection of women and girls from such harmful practices. 5. The Committee is concerned by the denial of access of persons belonging to lower castes to public wells, thereby directly threating their right to an adequate standard of living and to the highest attainable standard of health. The Committee recommends the immediate application of the Interim Consitution and laws prohibiting caste-based discrimination and segregation in cases of denial of access to public water sources. It recommends that access to public wells be closely monitored by the District Development Committees or by another appropriate local body.
Has the State taken any specific actions in response to these recommendations?	A comprehensive bill on domestic violence, including referral mechanisms was adopted by parliament in April 2009