



WOMEN'S HEALTH STATUS IN NEPAL: APPRAISING CONTINUITY AND CHANGE

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Abstract

Utilising data from Nepal Demographic and Health Survey from 1996-2016 and some landmark verdicts of the Supreme Court on reproductive rights since the early 1990s, this article evaluates the pace of continuity and change in women's health status, particularly of reproductive rights of women. Thus, this study aims to identify sociocultural factors that influence women's health, particularly their reproductive health. Although in the last few decades, Nepal has made substantial achievements in reproductive health service delivery and reduction of childhood mortality, however, performance is rather slow in achieving nutritional and health seeking behaviour. for family planning services, elimination of harmful and discriminatory practices that influences on girls and women's health adversely. The Supreme Court of Nepal through its series of verdicts has greatly contributed to safeguarding women's reproductive health progressively, although the full implementation of these landmark verdicts has yet to be materialised. Key findings of this analysis show that health remains gendered in Nepal, from childhood. A major breakthrough could be possible only by removing the social determinants of women's health.

Keywords

Women's health, harmful practices, reproductive health, women's health in Nepal, Nepal Supreme Court and health of women.

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Introduction

Nothing better can resonate with the frightened voice of a female child, born in the twenty-first century in Nepal, than a poem, composed by Muna, a seventeen-year-old girl.¹

I am a Daughter
*You want to close my eyes before I get to see the world,
 You want to sell me and do a business of me as if I am a mere object.*

...
*As I was growing from babyhood to the adolescent stage,
 You locked me up in a cowshed during my first menstruation.
 My tears were revealing my pains and suffering to you,
 But did you hear the plight of this daughter?
 You try to capture my body and my soul in your hands
 And, you consider it as masculinity, don't you?
 I am screaming and crying in pain due to your torture,
 We are facing cruelty in excess;
 please try to understand our appeal,
 Only if you respect me and I respect you,
 is human existence possible!*

The above poem, which is indeed an appeal by girls in Nepal, caught in a life-threatening web, urges an empirical investigation to determine the current status of women health in Nepal. This paper examines and assesses the status of women's health with the help of national and international reports, media coverage, and more importantly, women's voices. The majority of women in Nepal are forced, under the weight of the country's geo-economic setting and traditions nurtured by male supremacy, to live a life of extreme deprivation. Hope for freedom for women, though is not lost. The above-quoted poem, which is extracted from the first-ever Girl-led Report on CEDAW, prepared by 527 girls, in addition to 110 boys and two sexual minorities from 47 districts representing all seven provinces of Nepal, is indeed a ray of this hope.

The Constitution of Nepal recognises basic health services, including reproductive health services as the fundamental rights of citizens of Nepal. Women's health, especially reproductive health, came into greater focus when Nepal entered the Multi-Party Democratic system in the early 1990s. In the 90s decade, Nepal also participated in different international conferences related to population and development, women's and human rights. Nepal has already ratified more than 22 human rights-related international instruments, including the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of Children (CRC). Since

the International Conference on Population and Development in 1994 and the Fourth World Women's Conference in 1995, the Government of Nepal, in collaboration with UN Organisations, International Non-Governmental Organisations (I/NGOs) and the civil society and media in Nepal, has remained engaged with women's health improvement strategies and plans.

This paper examines and assesses the status of women's health with the help of national and international reports, media coverage, and more importantly, women's voices. In this broader context of these efforts, this paper aims to critically review the current health status of women, by adopting the life-course health framework promoted by the World Health Organisation, (WHO 2009). A life-course approach, with emphasis on an individual's age and social background, takes into account an individual's or a cohort's life experiences, often looking at the patterns of health and disease in past generations. Thus, health conditions are shaped by the wider social, economic and cultural forces of the past and the present. A life-course approach is the most effective and realistic tool to study the physical and social hazards that arise during gestation, childhood, adolescence, young adulthood and midlife resulting in chronic disease risk and health outcomes in later life. The advantage of this approach is to reveal health conditions of women in different stages of life: early childhood (< =9 years), adolescence (10-19 years), and adult (20-59 years), including the reproductive years of women (15-49 years) and elderly women (60 and above). Here our approach is to explain the general health conditions of women rather than focusing on a specific women's health issue or health concern of a specific age group. However, due to the unavailability of adequate literature and data on elderly women's health, we have not discussed elderly women's health status here.

Data and Methods

The article utilises both quantitative and qualitative data/information to evaluate women's health status in Nepal. The Nepal Demographic Health Surveys (NDHS), conducted from 1996 in each five-year interval till 2016, assess progress made in women's health status, especially in the early childhood stage, adolescent stage and reproductive years (15-49 years of age) in the last two decades, 1996-2016. Funded by the United States Agency for International Development (USAID) and conducted by New Era,² under the direction of the Ministry of Health and Population, the NDHS data are regarded as highly robust in assessing the health status of children, adolescents and adult women in Nepal. In this data, comparison among indicators over the years is also methodologically robust, as the same type of survey question (s) have been measured in all the surveys. The following indicators have been used for our analysis:

- Early childhood: infant mortality rate (IMR), under-5 mortality rate (U-5 Mortality rate), child mortality rate and children's nutritional status (stunted, wasted or obese).
- Adolescent stage - menstruation seclusion, child marriage, adolescent childbearing, adolescent use of contraception and adolescents' unmet need for family planning.
- Adult women (20-59 years), including married women of 15-49 years - Pregnancy and unwanted pregnancy, safe motherhood care (Anti-Natal Care- ANC, delivery and Post-Natal Care - PNC), the prevalence of anaemia, nutritional status, uterus prolapse, fertility, contraceptive use and unmet need, violence against women and girls and harmful practices like witchcraft accusation.

In addition to the NDHS data, this article also uses different secondary sources, including research studies, media reports. Also, some landmark decisions of the Supreme Court of Nepal regarding the protection of women's health have been reviewed.

For the quantitative data, we draw upon the Nepal Demographic Health Surveys. For qualitative methods, this paper has utilised secondary studies based upon qualitative methods. The paper also draws upon the first author's fieldwork observations in connection with on-going research. In societies where women's lives are still less researched and documented and where women avoid contact with strangers, both men and women, the observation method is the best-suited one (van Teijlingen et al. 2019).

Women's Health Status from Early Childhood to Adolescence and Adult Years ***The Early Childhood: Discrimination Still Persists***

Health is gendered from early childhood in Nepal. The discriminatory practices of intra-household distribution of basic endowments like food, caring and rearing, health care and practices of son preference over daughters, continue. NDHS data shows that gender variation in mortality still exists in Nepalese society - a female child is in a more disadvantaged position, as compared to a male child (see Table 1). This gender variation exists when one measures factors that result in child morbidity and mortality through child mortality and U-5 mortality measures. The 2016 NDHS data shows that the probability of dying within the first year of life is greater for a female child compared to a male child (34 deaths for females against 31 deaths for males per 1000 live births). This data also reveals that female child mortality has been persistently higher than male child mortality. Although child mortality, in general, has consistently declined, the gender variation in child mortality still exists as reflected by figures of 7 deaths per 1000 live births for females against 5 for males in 2016. Similarly, the U-5 mortality has been persistently higher for females over males after 2001. In 2001, U-5 mortality for females was 112 per 1,000 live

births against 105 for males, and the comparable figures were 41 and 36 in 2016, respectively.

Gender variation in child nutritional status, however, has narrowed over the years. For instance, 50% of female children as against 47% of male children were reported to be stunted in 1996, whereas in 2016, the comparable figure was 36% for both male and female children. While only 10% of children are reported to have wasted in 2016, the proportion holds true for both male and female children. Nearly half of the females, i.e., 48% and 46% of male children were observed to be underweight in 1996; the figure came down to 27% for both male and female children in 2016.

Adolescent Girls (10-19 years): Emerging Concerns about Harmful Practices, Child Marriage and Adolescent Pregnancy

Adolescence is 10 -19 years of age in which significant physical, social and emotional changes occur in the human body.³ Studies conducted through the psychological lens (Silwal et al. 2016; Chaulagain et al. 2019; Banstola, Ogino, & Inoue. 2020) reveal that adolescent girls are more vulnerable to mental health issues, which the NDHS defines as emotional violence against young girls.⁴ Indeed, Banstola, Ogino, & Inoue's recently conducted (2020) survey-based study indicates that not only more girls, as compared to boys, suffer from low self-esteem but are also prone to higher suicidal tendencies.⁵ Around half of all mental illnesses begin at the age of 14 years, and in some instances, even earlier. A study conducted by Adhikari et al. in 2017 in which data was generated by interviewing 11,477 adolescents of whom 5,720 were girls with ages ranging from 10 to 19 at the time of data collection, with a mean age of 14. 2, reports higher mental problems.⁶ Post-traumatic stress symptoms, emotional and behavioural problems, autism spectrum disorders, anxiety disorders, and attention-deficit hyperactivity disorder are common mental health problems reported among children and adolescents in Nepal (Chaulagain et al., 2019).

The CEDAW Shadow Report on the Sixth Periodic Report of Nepal (2018), prepared in a participatory manner involving a coalition of ninety-three civil society organizations, most of which represent women's strong voices, a documented continuation of several harmful and discriminatory practices against women/girl, guided by sex and stereotypes under the disguise of religion, tradition, and ethnicity. Among these, are included polygamy, gender-selective abortion, dowry, marriage at a tender age. Some of these life-threatening practices are child marriage, witchcraft, and *chhaupadi*. Nepalese society imposes different traditional harmful practices on a girl when she reaches puberty. The notion of purity-pollution attached to menstruation is still practiced, especially in western Nepal. The *chaupadi* system is one of the extreme forms of untouchability applied to menstruating girls/women who

are placed in a separate shed or a hut for at least four days. In the case of the first menstruation for a girl, she is placed up to seven days. During this period, she is not allowed to see her senior male family members and will have interaction only with female family members. She is not permitted to take cow's milk; worshipping God is prohibited to her. This ritual debars her from passing by a God/Goddess temple. *Chaupadi* system entails major, often fatal hazards, for the life of women and girls, such as snake bites or attack by wild animals. Left alone, in a deserted shack, these females remain prone to rape and even death due to suffocation and other unhygienic causes. The *Girl-Led Report on the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) Nepal*, in strong words, appealed against this infringement of their human rights.⁷

Child marriage, now universally condemned, continues to be the most dreadful experience of women. The term 'marriage', here refers to both marriages in general and another marriage-related custom, the *Gauna* system. *Gauna* is associated with the consummation of marriage within the Hindu religion and is a custom typically associated with child marriage. After a young girl is officially married, she stays at her parents' home until the day of her *gauna*, which marks the start of her conjugal life following menarche. The gap between marriage and *gauna* varies (between one and several years) and depends on the age at which the girl is married.⁸ An important breakdown in the data on married adolescents is both the age of marriage and the age of *gauna*, for both girls and boys. In Nepal's Terai, in Madeshi communities, daughters are married off at an early age but are not sent to the husband's house immediately after marriage if they are at a tender age. They may be sent to the husband's house when considered to have become 'adult' and when the bride's family has paid off all the dowry amount, agreed prior, to the bridegrooms' families.

As a result of this gap between marriage and *gauna*, some girls are forced to the life of a *baikalya* in their childhood. *Baikalya* refers to a married girl whose husband dies before she is sent to her husband's house by the performance of the *gauna* ritual. The term *baikalya* is also applied to a girl who is married off but whose *gauna* could not take place due to non-payment of dowry, or abandonment by the bridegroom's family. In advocate Kabita Pandey's legal case, *Kabita Pandey for Pro Public v. Office of the Prime Minister and Council of Ministers and others* (Writ No. 066; decision date, May 17, 2011), the Supreme Court of Nepal viewed this practice as one that prevents women's development, hinders their empowerment and results in inequality. The Supreme Court ordered the Government of Nepal to outlaw the *Baikalya* system and establish an institutional mechanism to understand the system as well as to decrease support for child marriage and the dowry system (FWLD and ICJ, 2013).

Another feature of marriages in the Terai Madeshi communities is that the groom's families are always considered superior to the bride's families, because of the

widespread practice of a dowry system in which a handsome gift of cash or kinds or both, is expected to be provided to the bridegrooms' families by the brides' families. Daughters are generally married off at an early age to avoid any impending 'impurity' coming to the family due to the fear of a girls' loss of virginity by pre-marital sex or rape. The force of the traditional notion of *kanyadan* (giving away a virgin girl as a gift in marriage) is so tenacious that parents are left with little options but to marry off their little daughters and send them off with dowries.

The prevalence of early and child marriage practice is also established by the data of NDHS. Although the harmful trend shows a trend of slight decline (see Table 2), however, the statistics warrant careful monitoring and intervention. for its control. For example, the NDHS 2016 data show that of the total current 20-24 years' old young women, 7% get married by the exact age of 15 years, nearly 40% by 18 years' age and 59% by their exact age of 20 years. On the other hand, only 1% of men aged 20-24 years get married by exact the age of 15 years, 10% by 18 years and 23% by 20 years. Thus, child marriage is synonymously understood as girl-child marriage in Nepal. The prevalence of early and child marriage is high among some disadvantaged communities such as Muslims, Madeshi Dalit, Dalit and other marginalised groups, including those in Karnali Province and Province 2 of Nepal (Bennett, Dahal and Govindasamy 2008; Yogi 2020).

As a result of child and early marriage, a remarkable number of adolescent girls become mothers in their teens-inviting several immediate and long- term health adverse health consequences. A study by UNFPA Nepal (2017) estimates that about 227,000 girls aged of 15- 19 years giving birth every year in Nepal. It also warns that young-age pregnancies present greater health risks for mothers and babies and also poses the risk of being infected with sexually transmitted infections. Early-age childbirth is also prone to result in uterine prolapse, pelvic pain, urinary tract infections and urinary infections.

As reflected by the NDHS data (see Table 3), the rate of adolescent childbearing (becoming pregnant or already having at least one-child) has been consistently declining in Nepal. Yet the rate of 17% as reported in 2016 is still noticeable and alarming. There are several reasons for this high adolescent childbearing age, including the lack of information about and service-delivery of contraceptives. A recent study (Pandey e al., 2019) records that adolescent girls face shame and feel embarrassed when they visit a health centre to receive a contraceptive device because a large majority of health workers are males. Further, girls have no access to education regarding their body and sexuality and are unlikely to use contraceptives even when they are married. Only 23% of the adolescent married girls (15- 19 years) were using a contraceptive method in 2016; thus unmet needs for family planning have remained very high and stagnant (35% to 40% between 1996 and 2016). The technical definition of unmet need for family planning is a complex one, but for the

sake of simplicity, it is the state in which women are not using any contraceptive method, even if they wish to postpone their next births. Thus, the higher the value of unmet need, the less likely a family planning programme reached the targeted groups to satisfy the demand of family planning, and vice-versa.

The Health Mosaic of Adult Women of Reproductive Years Status of Safe Motherhood Care

The Guttmacher Institute (2017), a prestigious research and documentation centre of reproductive health worldwide, estimates that 1,048,000 pregnant women, or 68 per 1,000, had unintended pregnancies in Nepal. There has been some degree of progress in maternal health conditions over the last few decades (see Table 4). In 1996, only 9% of pregnant women had 4 + ANC visits to a health facility, which increased to 69% in 2016. The proportion of skilled health providers (doctors, nurses, auxiliary nurses and midwives) for ANC also increased from as low as 24% in 1996 to 84% in 2016. In 1996, only 8% of deliveries took place at a health facility while they increased to 57% in 2016. Institution-based deliveries are directly and positively associated with the wealth quintile of the women's household and education of women. Whereas only one-third of deliveries were reported at a health facility among the lowest wealth quintal, deliveries to as high as 90% were reported for the richest wealth quintal households.

Similarly, in the case of women's education, the proportion of women giving birth at a health facility increases from as low as 38% for women with no education to 50% for women with primary education, to 70% for those with some secondary education and 85% for women with SLC and more education. The percentage of women with a postpartum check-up within 2 days after the delivery increased from 17% in 2001 to 57% in 2016. Khatri and Karkee (2018) found that limited means of transport, unequal access to health facilities, and lack of awareness, social exclusion, poor daily living conditions, and poor family support for care-seeking behaviour of health services are the core barriers to safe motherhood services.

Women's Nutritional Status and Prevalence of Anaemia

The NDHS measures women's nutritional status using Body Mass Index (BMI) measures: thin, average and obese⁹ Data reveal that whereas the proportion of women having nutritional deficiency (thin) has been declining in Nepal over the last 20 years, the proportion of women who remained in the obesity bracket has been increasing (see Table 5). In 1996, 28% of women were thin for their height, a figure which declined to 17% in 2016. The proportion of obese women increased to 22% in 2016 from merely 1% in 1996. The proportion of women in anaemic situation ranged from 35% to 41% between 1996

and 2016 - suggesting little progress in this health dimension of women. Studies suggest that a woman with poor nutritional status, short stature, anaemia, or other micronutrient deficiencies has at a higher risk of obstructed labour, low birth weight, low breast milk production, postpartum haemorrhage, and morbidity for herself and her infant (UNFPA Nepal, 2017).

Reproductive Health Morbidities and Maternal Mortality

According to the Concluding Observation of the CEDAW Committee of Nepal in 2018, one in every ten adult and elderly women suffer from uterine prolapse. Box 1 summarises some leading studies conducted to assess the reproductive health morbidity situation in Nepal for the last 20 years.

Box 1. An overview of the prevalence of reproductive health morbidities from different studies, Nepal

Studies	Sample coverage	Prevalence of RH morbidities
1 Family Planning Association of Nepal, 2000*	Two districts: Doti and Achham 3,000 women visited the mobile camps	25% women of uterus prolapse cases
2 Safe Motherhood Network, 2005*	10 districts 4,518 women visited the health camps	415 or 9.2% affected by uterus prolapse cases
3 UNFPA Nepal, 2015 **	15 districts 4,277 women visited the health camps 3,831 women screened for cervical cancer 4,031 women tested for obstetric fistula 3,464 women clinically screened for HPV 16 and 18	6.4% tested with pelvic organ prolapse (POP) 1.6% tested with positive Visual Inspection with Acetic Acid (VIA) 3 cases of obstetric fistula 3.6% with HPV 16 and 2% with HPV 18
4 Groen et al., 2015	A national-wide Surgeons Over-Seas Assessment of Surgical Need 1,259 women	5.2% uterine prolapse with high unmet need for evaluation and possible surgery

Note: * Prakash Mani v Government of Nepal (Writ No. 064/WO 02230, decision data: June 4, 2008) and ** MoHP, UNFPA Nepal and JHPIEGO, 2015.

According to the findings of these studies, the prevalence rate of uterus prolapses ranges from at least 5% to as high as 25% in some cases in Nepal. The high rate is mainly reported in remote, poor and disadvantaged communities. The high rate is mainly reported in remote, poor and disadvantaged communities. Some of the main reasons for the high rates of uterus prolapse are lack of nutritious food during pregnancy, compulsion to engage in hard work immediately after delivery, child marriage, a large number of children, lack of adequate ANC and delivery care and services, unsafe abortion and unscientific and prolonged labour for delivery. From 2009 to 2016, the maternal mortality ratio was 236 deaths; the main reasons for high maternal mortality were haemorrhage, sepsis, unsafe abortion, obstructed labour and co-morbidities associated with pregnancy like malaria, anaemia, heart disease and hepatitis, that worsened pregnancy and its management.

Low Fertility but Gendered Method-Mix of Contraceptive Use

The onset of fertility transition took place in Nepal in the early 1990s, and the decline since then has continued throughout the last two decades (1996-2016). The Total Fertility Rate (TFR) per woman declined from 4.6 in 1996 to 2.3 in 2016. Of the four proximate determinants in the John Bongaarts' model of fertility, namely, contraceptive use, abortion, proportion never married and post-partum period, the first two factors have a much large contribution to fertility reduction in Nepal (Subedi, 2020). Further, spousal separation due to migration of youth is another crucial social factor that caused a decline in fertility and even a low contraceptive use of 53% in 2016 (see Table 6). Low fertility and the use of modern contraceptives must have had positive consequences on women's health.

However, there is a widespread use of emergency contraceptive pills, especially among adolescents and young women as an urgent means to prevent unwanted pregnancies. With the regular taking of pills, females are at risk for bleeding, anaemia, infertility in later life; moreover, emergency pills do not protect them from sexually transmitted infections, HIV/AIDS (Rijal, 2020). Further, examining the method-mix of contraceptive use for the last 20 years, it is obvious that the use of contraception largely falls as a burden onto women. In 2016, the share of female methods (female sterilization, injectable, pills, implants, IUD) was as and still, the highest prevalence rate share of modern methods prevalence rate is attributed to female sterilization (35%). high as 77%, This trend has not significantly changed over the last twenty years.

Unsafe Abortion and Emerging Phenomenon 'Missing Girls'

Although Nepal legalised conditional abortion in 2002 as well as free and safe abortion services from Government health facilities from 2012 and also enacted the *Safe Motherhood and Reproductive Rights Act* in 2018, the magnitude of unsafe abortions is overwhelming.

The Guttmacher Institute (2017) estimates that 323,000 abortions were performed annually in Nepal in 2014. Of these, 58% took place outside of authorised health facilities. There has been widespread media reporting of some women undergoing frequent abortions – resulting in adverse health consequences. The statement that ‘abortion should not be taken as a contraceptive method’ has yet to be realised in Nepal.

Some studies, such as that by Frost et al. (2013) argue that sex-selective abortion has increased tremendously in Nepal over the last few decades. Utilising NDHS data of 1996, 2001, 2006 and 2011, they concluded that the cases of sex-selective abortion have been increasing; the sex ratio at birth shows greater imbalances in recent years than that of in the past; the sex ratio falls sharply with the increase in parity and when the previous children were females. Thus, data reveal that Nepal has been entering into the ‘missing girl’ phenomenon. For example, during the period from 1992/94 and to 2007/10, the sex ratio at birth ranged from 950 to 975 females per 1000 males in the case of firstborn. For the second-born, the ratio declined to 822 when the firstborn was male and 742 when the firstborn was female. For the third born, in 2007-2010, the sex ratio was 892 when both previous children were males and 767 when both previous children were females.

Spousal and Domestic Violence and Harmful Traditional Practices

The records of the One-Stop-Crisis Management Centres (OCMCs)¹⁰ show an alarming situation of gender-based violence (GBV) in the country. The total number of GBV cases reported in the 44 districts OCMC during 2012/13-2017/18 accounted for 13,400 with an annual average number of 2,233 (Department of Health Services, 2018). An overwhelming majority of the survivors (92%) constituted females and the rest were males. Nearly one-third of GBV survivors were victims of rape/attempt rape. And all of these survivors were females. Another 54% of survivors were related experienced to physical/domestic violence and 13% were related to experienced mental torture. The NDHS survey also confirms the painfully high prevalence of spousal violence against women in Nepal. The prevalence rates of any forms of spousal violence (physical or sexual or emotional violence) were 31.5% and 27% in NDHS 2011 and NDHS 2016, respectively. The specific rates for physical violence, sexual violence and emotional violence were 23%, 14% and 16%, respectively, in NDHS 2016, respectively and about one-third of women report that they have been controlled by their husbands.

Women are also the victims of witchcraft accusations, and superstition concerning ghosts, and charges of *dhami-jhankri* (traditional healers). The *dhami-jhankri* system strongly prevails much in and around the Janakpur areas of Terai-Madesh of Nepal (Pham2020). These traditional healing practices often cause foetal deaths and severe injuries to the expectant mothers (Paudel 2018). The first author of this paper, during fieldwork and data

collection, has observed that such cases are mostly under-reported or unreported. Most people do not talk about these matters. However, during fieldwork in 2018, one case was reported to the author in the Janakpur area of two women who went to a *dhami-jhankri* for treatment of headaches. During the 'treatment' process, the women's breasts were severely bitten by the *dhami-jhankri*, causing infections. The women who had to spend about Rs. 25,000 for this treatment, did not lodge any report about it. In another case that occurred in 2017, a girl studying in grade eleven fell sick. Her parents took her for treatment by a *dhami-jhankri*. Unfortunately, after a few days, she died, and the cause of death was kept secret.

On some cultural occasions, women become victims of violence in the name of escaping from a ghost. In the Mahottari District, it is observed that in the Sonamai Sthan goddess temple of Aaurahi Rural Municipality and Kamala river in the Siraha district, on the day of *Kartik Purnima* (full moon of October month), people gather for escaping from fear of ghost. Women come from villages, wearing saffron-coloured *sadi* and carrying lit earthen lamps (*dhakana*), to the Kamala river. In the name of treatment of women, the *dhami-jhankri* injure women. Some women who undergo torture and are physically exploited during the treatment process, also develop mental health problems; those not cured are called derogatory names, such as witch (*daina*). These women get greatly stigmatised and live in a state of vulnerability in the community; sometimes, they may be victims of extreme forms of violence such as forcefully being fed human excreta.

One of the effects of the prevalence and acceptance of the above-mentioned healing practices, as also noted by Panday et al. (2019) is that it creates 'a lack of trust in volunteer services' (p. 17) that work for better health and thus results in underutilisation of healthcare facilities. Thus, traditional healing practices act as 'a barrier to accessing healthcare by women' (Panday et al. 2019, p. 12).

Analysis of the Supreme Court's Verdicts on Promotion of Reproductive Health of Women

The process of change for improvement in women's health, however, is noticeable in Nepal, albeit the pace is slow. These changes are happening because of certain initiatives taken by different governmental and non-governmental agencies, including the verdicts of the Supreme Court to uphold the reproductive rights of women in Nepal. Analysing some of the key verdicts of the Supreme Court FWLD and IJC (2013), it seems that Nepal's judicial system has largely reoriented itself towards granting and ensuring the rights of reproductive health of women as per the different international human rights instruments, CEDAW, the Constitution of Nepal. In each of the cases that we have extracted, the Supreme Court enquired the opponents the reasons for not implementing the laws and constitutional provisions.

In *Prakash Mani Sharma v Government of Nepal* (Writ No.064/WO-02230) case of demanding free and urgent access to uterus prolapse treatment, the Supreme Court of Nepal has considered uterus prolapse as the major RH rights of women in its verdict on June 4, 2008, and ordered the Minister of Health and Minister of Women and Children to make a special action plan to provide free counselling services, treatment, health services and health facilities to the affected women and extend the health services to different health centres and health posts and also increase awareness in to eliminate the problem of uterus prolapse.

In *Annapurna Rana v Gorakh Sumsher of Writ No. 2187* (September 10, 1998) of property division between brother, sister and mother, the petitioner (Annapurna) pleaded to the Supreme Court to reverse the decision of the Kathmandu district court and the Appellate Court, Patan that she had to undergo gynaecological test of her vagina, uterus and other parts of her body, to verify whether she was married or not. The Supreme Court nullified the Kathmandu District Court's decision, thus upholding a woman's dignity.

Similarly, in *Bimala Khadka of Women Law and Development Forum Kathmandu v Government of Nepal* (Writ No. 0748 and decision on 2008), the petitioner demanded the reproductive health rights of women living with disabilities as per the constitutional provision. The court ordered that the Government must allocate a budget from the coming fiscal year for the promotion of reproductive health of women living with disabilities and formulate appropriate policies and programmes to make hospitals, public transport and other public places disabled-friendly. In another ground-breaking verdict, regarding Writ No. 1222 (decision date 2009) of the *Suraj and Chhotani Devi v Government of Nepal case*, in which the petitioners demanded that their reproductive rights be enjoyed even from jail in accordance with Article 20 (2) of the Interim Constitution 2007 stating that 'every woman shall have the rights to her reproductive health' and this clause must be equally applicable to the convicted prisoners. The Court's verdict directed the Government to make appropriate provisions for family visits including conjugal visits to those who can be identified as husband and wife by checking their citizenship and marriage certificate.

In *Laxmi Devi Dhikta of Dadeldhura District V. Government of Nepal* (Writ No. WA-7757, verdict date: May 20, 2009), the applicant pleaded that she was from a backward district and because of lack of awareness, ignorance and poverty, she has already had five children. She also got another pregnancy and did not want to give birth. Hearing the availability of free abortion services from a Government health facility, the applicant with her husband went to the Dadeldhura District Hospital to undergo an abortion. But the hospital administration informed them that they should pay Rs. 1,130 as abortion service charges. They did not have that sum of money and because of that, she had to have an unwanted birth. She claimed that by not getting free abortion services, she had to have an

unwanted birth. This is a violation of the rights of reproductive health according to the fundamental right of the Constitution (Article 20.2). The Apex Court came out with a historic observation that 'If one accepts that a woman must give birth, even if she is not willing to do so or she is at risk of having a birth, this implies that she has lost control over her own body' and that 'violation of the right of abortion or denial of abortion services or services of the low standard are a violation of the reproductive rights of women'.

Although the above interventions by the Supreme Court have yet to acquire public approval and recognition by the policymakers, however, they mark a way forward for change.

Financing in Health

The Government has adopted a three-pillar policy on providing health services to people – the public sector, the private sector and the cooperative sector. Of these three sectors, it is only the private sector that has greatly flourished as reflected by a mushrooming of private nursing homes, hospitals, pharmaceuticals and medical colleges established in the country within the last fifteen to twenty years. The private sector's growth is largely skewed in urban areas, especially in the Kathmandu valley; it is also expensive and not affordable by the masses. The growth of the private sector in health has not been advantageous to a large section of people, including women living in poverty and exclusion.

On the other hand, the public sector is still not able to provide basic health services and reproductive health services to women. The Government's health spending is far below the recommended spending by the WHO. In 2017/18, the budget allocated to the health sector was less than 2% of GDP against the recommended 6% of GDP; the share of health spending was 5% against the recommended 8% of the national budget and the current annual per capita public spending on health of US \$ 17.7 is five-folds lower than that of the recommended annual per capita spending of US\$ 86 (MoHP, 2019). As a result, access to and availability of free abortion services, free treatment of uterus prolapse, cervical cancer, breast cancer, and reproductive tract infection has not materialised. While some specific health problems of women, like uterus prolapse, are a major health concern for both adult and elderly women, it also invites family dissolution between husband and wife and many polygamous cases in Nepal may be linked to this phenomenon.

Discussion

Our analysis shows that over the past few decades, Nepali women's overall health status has made considerable improvement. However, there are several complex factors affecting women's health in Nepal – encompassing cultural factors, economic factors, educational

and programmatic factors. The life of women is strongly influenced by fathers and husbands, as the majority of Nepal's communities are patriarchal in their construct. Early marriages and preference for male children are still a dominant feature across the country (Asian Development Bank, 1999). Women have little control over their bodies. Traditionally, women are generally worshiped for their fertility; and infertile women are cursed. Women's secondary education has been closely related to the greater use of health services. The mechanism by which education affects women's health is complex and indirect. With a few years of education or no education, women are ignorant about the availability of health information and services, which in turn leads to poor health outcomes (Budhathoki et al. 2017). As discussed, various types of discrimination continue like *chaupadi*, child marriage, dowry, and economic dependency on males, which poses obstacles to pursuing health care and threatens women's health. Concerning programmatic factors, there is a lack of adequate health services; moreover, geographical inaccessibility, unpaid work and, unemployment caused women and girls to suffer from poor health.

With the exception of the current COVID-19 pandemic situation in the country, today, early childhood is much safer than it was a few decades ago: the nutritional status of children has improved, immunization of children has reached more than 80% and childhood mortality has substantially declined. Until a few years back, Nepal was listed as one of the poorest countries where females live shorter lives than males. Today, females live longer than males according to measured life expectancy at birth: the average female lives nearly 3 years longer than the average male. In 2018, the female and male life expectancy at birth were 71.9 years and 69 years, respectively for Nepal (UNDP, 2019).

Gender inequality in health persists and social and economic inequalities are directly linked to demographic and development outcomes such as age at marriage, first initiation of sex, desired family size, use of contraceptive methods, anti-natal care visits, malnutrition of children, vaccination of children and child mortality (Gavins, 2020). The patriarchal values are still intact in both public and private domains - in private domains its manifestation can be seen through different discriminatory practices observed between sons and daughters. Daughters' survival and cognitive development may be compromised especially in the context of extreme poverty, conflicts and general health crisis in the family. In the public domain, the supply side of health has been restrained due to the lacking of physical infrastructure that requires to address the problem of health of women living with disabilities. The Concluding Observation of CEDAW Committee on 2018 raised the issue of health-equity as of grave concern in the case of Nepal because a large section of communities like the poor, Dalit, Muslims, minority groups and people living in disability, those living in remote and geographical inaccessible areas, mostly lack the basic health services and they are deprived of enjoying the fundamental rights of health envisioned in the Constitution of Nepal.

The growth of the private sector in health has not been advantageous to a large section of people, including women living in poverty and exclusion. The Government has adopted a three-pillar policy on providing health services to the people – the public sector, the private sector and the cooperative sector. Of these three sectors, it is only the private sector that has greatly flourished as reflected by a mushrooming number of private nursing homes, hospitals, pharmaceutical and medical colleges established in the country within 15 to 20 years. Private sector's growth is largely skewed in urban areas, especially in Kathmandu valley; it is also expensive and not affordable by the masses.

On the other hand, the public sector is still not able to provide basic health services and reproductive health services to women. The Government's health spending is far below the recommended spending by the WHO and other studies. In 2017/18, the budget allocated to the health sector was less than 2% of GDP against the recommended 6% of GDP; the share of health spending was 5% against the recommended 8% of the national budget and the current US \$ 17.7 is five-folds lower than that of the recommended US\$ 86 (MoHP, 2019). As a result, access to and availability of free abortion services, free treatment of uterus prolapse, cervical cancer, breast cancer, and reproductive tract infection has not materialised. While some of women's specific health problems like uterus prolapse are a major health concern for both adult and elderly women, it also invites family dissolution between husband and wife and many polygamous cases in Nepal may be linked to these phenomena.

As fertility has almost reached a replacement level by the early 2020s, it is expected that more and more women would lead a healthy life in their adulthood because a small number of births would release them from frequent pregnancy and delivery complications. On the contrary, the RH of women, as measured by uterus prolapse, frequent and unsafe abortion, spousal and domestic violence and the increase of new reproductive health morbidities, is not improving. Reviewing the court responses on women's reproductive health, it is evident that Nepal's judicial system has profoundly marched towards ensuring the rights of women's health.

Conclusions

The findings of this study offer a strong argument to undertake fresh initiatives adopt for women's health improvement in consultation with policymakers and opinion-makers. To conclude, this paper's basic premises is that unless gender inequalities are minimised, an unfair hold of power by males is erased, and awareness among women about their human rights remains elusive, success will remain at a distance. The paper ends with a strong argument in favour of developing and implementing a shared understanding among all the stakeholders of the health sector users and providers, including local and international

volunteers and aid providers, that there is a strong and urgent need to create awareness of how social inequalities result in health inequalities which finally act as a major threat to the process of national growth.

Table 1 Gender variation in childhood mortality and nutritional status of children, 1996-2016, Nepal

Indicators	NFHS 1996	NDHS 2001	NDHS 2006	NDHS 2011	NDHS 2016
Mortality					
Infant mortality rate (in per 1000 live births)					
Female	83.7	75.2	61	52	34
Male	101.9	79.2	60	54	31
Child mortality rate (in per 1000 live births)					
Female	56.5	40.2	18	10	7
Male	45.5	27.8	21	9	5
U-5 mortality rate (in per 1000 live births)					
Female	135.5	112.4	78	62	41
Male	142.8	104.8	80	63	36
Child nutrition					
(in % of children < 5 years of age)					
Children stunted (height-for-age)					
Female	50.2	51.8	49.6	39.5	35.7
Male	46.6	49.2	49.0	41.4	36.0
Children wasted (weight-for-height)					
Female	10.2	8.7	12.3	9.7	9.6
Male	12.3	10.6	12.9	12.0	9.5
Children underweight					
Female	48.0	50.5	39.7	28.0	27.4
Male	45.8	46.1	37.5	29.6	26.7

Source: His Majesty's Government Kathmandu, Nepal New ERA, Nepal Macro International Inc. (1997).

Ministry of Health, New ERA, and ORC Macro. (2002).

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Table 2 Gender variation in age at first marriage among young people aged 20-24 years, 2006-2016, Nepal (in %)

Marriage by exact age (in years)	NDHS 2006		NDHS 2011		NDHS 2016	
	Female	Male	Female	Male	Female	Male
15	10.2	1.8	10.1	0.0	7.0	1.2
18	51.4	15.5	40.7	11.1	39.5	10.3
20	70.9	32.9	59.8	23.7	59.2	22.7

Source: The same as in Table 1 from three to five sources but not the former two sources.

Table 3. Adolescent girls 15-19 years' pregnancy/motherhood, contraceptive use and unmet need, 1996-2016, Nepal (in %)

	NFHS 1996	NDHS 2001	NDHS 2006	NDHS 2011	NDHS 2016
Pregnant or at least one-child	23.9	21.4	18.5	16.7	16.7
Contraceptive use (any method)	Na	Na	16.0	17.6	23.1
Unmet need for family planning	40.5	41.5	37.9	35.6	34.9

Source: The same as in Table 1.

Table 4 Status of safe motherhood care (selected indicators), 1996-2016, Nepal

	NFHS 1996	NDHS 2001	NDHS 2006	NDHS 2011	NDHS 2016
Anti-Natal Care (ANC)					
% had 4 + ANC visits	9	16	29	50	69
% had ANC visits in the first trimester	Na	14	28	50	65
% received any ANC from skilled providers	24	28	44	58	84
Place of Delivery (in %)					
At home	92	89	81	63	41
At a health facility	8	9	18	35	57
Post-Natal Care (PNC)					
% Postnatal check-up within 2 days	Na	17.1	31.4	45.0	57.0

Note: NA refers to not-availability.

Source: The same as in Table 1.

Table 5 Women's nutritional status and prevalence of anaemia, 1996-2016, Nepal

	NFHS 1996	NDHS 2001	NDHS 2006	NDHS 2011	NDHS 2016
% anaemia prevalence all women (15-49 years)	35.0	35.0	35.0	35.0	41.0
Women's nutritional status (in %)					
Thin (BMI < 18.5)	28.0	26.7	24.0	18.0	17.0
Overweight/obese (BMI > 30.0)	1.0	5.5	9.0	13.0	22.0
Normal BMI (mean score)	19.8	20.3	20.6	21.4	22.2

Source: The same as in Table 1.

Table 6. Contraceptive prevalence rate, unmet need for family planning and TFR, 1996-2016, Nepal

	NFHS 1996	NDHS 2001	NDHS 2006	NDHS 2011	NDHS 2016
Any traditional methods (in %)	3.0	4.0	4.0	7.0	10.0
Any modern methods (in %)	26.0	35.4	44.2	43.2	42.8
Unmet need family planning (in %)	21.2	27.8	24.6	27.0	23.7
Total Fertility Rate (per woman)	4.6	4.1	3.1	2.6	2.3

Source: The same as in Table 1.

Endnotes

- ¹ *Girls of Nepal. Girl-Led Report on the Convention on the Elimination of all forms of Discrimination against Women (CEDAW) Nepal, a Report Submitted to UN Committee on the Convention on the Elimination of Discrimination against Women, 1 October 2018. Kathmandu, 2018, p. xi.*
- ² The New ERA is Nepal's first non-government, non-profit research organization founded in 1971.

- ³ Ministry of Health, Nepal; New ERA; and ICF. 2017. Nepal Demographic and Health Survey (NDHS) 2016. Kathmandu: Ministry of Health, Nepal; New ERA; and ICF, p. 13.
- ⁴ Nepal Demographic and Health Survey (NDHS) 2016, p. xxix.
- ⁵ Banstola R. S., T. Ogino, and S. Inoue. 2020. "Impact of Parents' Knowledge about the Development of Self-Esteem in Adolescents and Their Parenting Practice on the Self-Esteem and Suicidal Behavior of Urban High School Students in Nepal". *International Journal of Environmental Research and Public Health*. 17 (17), p. 1, 12,13.
- ⁶ Adhikari R.P., N. Upadhaya, B.R. Suwal, P. K. Subedi, and M.P. Shrestha. 2017. "Factors associated with perceived psychosocial problems and help-seeking practices among adolescents in Nepal". *Journal of Population and Social Studies*. 25 (1), p. 3 & 7.
- ⁷ *Girl-Led Report*, p. xii.
- ⁸ For more details, see CARE Nepal. 2016. *The Cultural Context of Child Marriage in Nepal and Bangladesh: Findings from CARE's Tipping Point Project Community Participatory Analysis. Findings from CARE's Tipping Point Project Community Participatory Analysis*. Kathmandu
- ⁹ The Body Mass Index (BMI) is defined as weight in kilograms divided by the square of the height in meters. For the value of BMI < 18.5, it refers to chronic energy deficiency; BMI > 30 are overweight or obese and those falling in between 18.5 and 30 values of BMI are the normal nutritional status.
- ¹⁰ OCMCs were established in 2011 are mandated to provide a comprehensive service to the survivors of the GBV: health services, psychosocial counselling, legal advice/assistants, safe houses and rehabilitation in the communities.

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