Written Submission on behalf of Civil Society Organization (CSOs) Following the Call for Submissions of the Committee on the E limination of Racial Discrimination (CERD Committee) for The General Discussion on

"Racial Discrimination and the Right to Health"

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INTRODUCTION

Racial Discrimination and Right to Health

According to International Dalit Solidarity Network (IDSN)'s 2022 updated Compilation of UN References on "Caste Discrimination and Human Rights", Nepal is among the countries where racial discrimination exists.[1] The most notable form of racial discrimination in Nepal, as well as in its neighboring country, India, is present in the form of the caste system and ethnic divisions –one of the oldest ongoing social hierarchies.

Nepal's Demographic and Health Survey (NDHS) has listed the existence of more than five ethnic groups in Nepal among which ***Dalits*** (so-called lower caste), ***Janajait*** (indigenous), and ***Muslims*** (religious minority also recognized as a separate ethnic group with unique identity)[2] belong to the ethnic groups that have historically faced social and structural discrimination and disadvantages.[3] In the context of Nepal, these groups fulfill the scope of "racial discrimination" as covered by the International Convention against all forms of Racial Discrimination (ICERD)[4].

Nepal has made some progress in addressing caste-based discrimination, however, people belonging to a community of Dalit, Muslim, Janajati, and Terai continue to face some form of discrimination based on their ethnicity, origin, race, and /or even color. Even more vulnerable within this group are the women, adolescent girls, and people who can get pregnant. Discrimination on the rights to sexual and reproductive health is one of the prominent areas that women/girls/people who can get pregnant from these groups continue to face.

In 1990, after the Constitutional guarantee of rights against caste-based discrimination and untouchability, positive change was anticipated. However, in 2001, a study by Action Aid Nepal on discrimination based on caste identified over 205 forms of discriminatory practices based on the caste that continued to be practiced across the country. In 2011, the Caste Based Discrimination and Untouchability (Offense and Punishment) Act (CBDU Act) was enacted which prohibited caste-based discrimination 'in any public or private place'. The Act made caste-based discrimination a crime against the State. The introduction of this Act and various plans and programs had actually contributed in reducing maternal health care issues such as

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1 International Dalit Solidarity Network (IDSN)'s 2022 updated Compilation of UN References on "Caste Discrimination and Human Rights", https://idsn.org/wp-content/uploads/2022/01/UNcompilation-Jan-2022-Web.pdf.

2 Nepal Demographic and Health Survey, 2016, (Table 3.1: Background characteristics of respondents), P 50, https://www.dhsprogram.com/pubs/pdf/fr336/fr336.pdf.

3 ICERD, Article 1 - the term "racial discrimination" shall mean any distinction, exclusion, restriction or preference based on **race**, **color**, **descent**, or **national** or **ethnic origin** which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life.

4 **General Recommendation 23 and 27:** Through General Recommendations, this Committee has affirmed that discrimination against **indigenous peoples**, Roma, people of African descent, **migrants**, **refugees**, **asylum-seekers**, undocumented non-citizens and **"persons who cannot establish the nationality of the State on whose territory they live,"** among others, falls under the scope of the Convention. This Committee has further clarified that "**discrimination based on 'descent**' includes discrimination against members of communities based on forms of social stratification such as **caste** and analogous systems of inherited status which nullify or impair their equal enjoyment of human rights."

maternal mortality and a rise in antenatal care tests (ANC) among pregnant women. The progress included the establishment of constitutional bodies such as the National Dalit Commission, the National Tharu Commission, and the National Human Rights Commission. These bodies are mandated to ensure the protection, promotion, and fulfillment of human rights of the Dalits, indigenous, and ethnic minorities.

Despite the various positive legal, policy, and social reforms along with multiple institutional mechanisms, the caste system, and ethnic discrimination strongly influence Nepali society, still today.[5] As many as 80 cases of caste-based discrimination were reported in 2020 alone, an increase of 50 percent compared to 2019.[6] People belonging to a community of *Dalit, Muslim, Janajati, and Terai* continue to face some form of discrimination based on their 'ethnicity origin', 'descent', 'race', and/or even 'color'.

CERD in its Concluding Observations, 2018 to Nepal had expressed its concerns regarding the legal gap in CBDU Act as it does not expressly prohibit both indirect and direct forms of discrimination. It further stated that the Act does not prohibit discrimination based on color or national or ethnic origin as well.

In 2019, a positive step was taken by the Government of Madhesh Province. The Province Government enacted a special legislation "Act to make arrangements for Dalit empowerment". It intends to make arrangements for punishment and prohibition of caste discrimination and also envisions a province-based committee for this purpose. However, as expressed by CERD, it still fails to incorporate other forms of racial discrimination that exist and are evident within Nepali society.

Though the Government of Nepal has repeatedly expressed a commitment to eliminate caste-based discrimination from the country through its periodic reports submitted under the CERD, the practice of untouchability, rooted in the caste system, continues to stigmatize and dehumanize the 4.5 million[1] Dalits in Nepal as 'polluted' or 'impure'. In Many places (rural and urban) *Dalits* are still not allowed to enter the house of upper-caste people, enter temples, or use water from the same public taps, and as Tusasa Sunar, deputy chief of Gaumukhi Rural Municipality in Pyuthan district had stated, 'people still deny her entry into their homes and refuse to eat with her'[7], it is evident that State's obligation in achieving equality in terms of racial discrimination is far from achieved.

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5 The Kathmandu Post, national newspaper, *Discrimination against Dalits continue to Stain Nepal's Social Fabric,* https://kathmandupost.com/national/2020/06/03/discrimination-against-dalits-continues-to-stain-nepal-s-social-fabric.

6 https://kathmandupost.com/national/2021/06/05/discrimination-cases-got-worse-during-pandemic-dalit-rights-advocates-say

1 See: REPORT ON INTERNATIONAL AGENCIES AND DALIT IN NEPAL, DALIT NGO FEDERATION 2005 AT 11).

7 The Kathmandu Post, national newspaper, 3 June, 2020, https://kathmandupost.com/national/2020/06/03/discrimination-against-dalits-continues-to-stain-nepal-s-social-fabric.

Case Study 1: Rukum Homicide Case[8]

In 2020, five youths of Jajrkot, Rukum District of Nepal were killed by a mob of villagers. The cause for killing - one of the five deceased wanted to marry a girl who belonged to the village of so-called upper caste people. When he arrived in the village with his five friends, they were chased, bitten, and killed and their bodies were thrown in the nearby river by the groups of 19 villagers.
The United Nations had condemned the killings and called for a fair investigation. Reports suggest during the nationwide Covid-19 lockdown alone, there had been 31 documented cases of physical violence against *Dalits*. The above case and data are simply a glimpse of larger and deep-rooted discriminatory social attitudes towards people of so-called lower caste or ethnicity.

The health sector, in particular **sexual and reproductive health**, is not free from racial discrimination. The discrimination is deeply rooted in socio-cultural, political, and economic perspectives affecting the belief system and approach of health service providers and thus affecting individuals' access and utilization of health services. The discriminatory experiences have been an underlying and often ignored barrier to health service usage among the most deprived people in society. It leads to imbalanced access to quality health services along with other civil, political, and human rights. Although, women and girls from ***Dalit, Muslim, Janajati,*** *and* ***Terai*** *communities, are* protected under CERD guarantees. However, they face discrimination, denial, and violations of SRHR. These women and girls also confront intersectional discrimination and experience SRHR violations in disproportionate and distinct ways.

Across the globe, higher rates of discrimination are linked with poor health outcomes such as lower life expectancy, lower birth weight, higher infant mortality rate, and a higher level of depression rates. It leads to a significant reduction in health status.

The CERD's Concluding Observations to Nepal, 2018[9] had placed following concerns related to Dalit women's SRHR:

- Sexual and other forms of violence against Dalit women are common and often unpunished.
- Due to existing caste disparities in reproductive health and maternal mortality, Dalit women are far less likely to have access to a skilled birth attendant.

Studies show that two-thirds of the most disadvantaged Dalit population of Nepal still do not deliver in health facilities despite impressive success in maternal health.[10] As such, the impressive gains in maternal and child health in Nepal are observed to be unevenly distributed, where ***Dalits***,

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8 Kantipur, national newspaper, 2 June 2020, https://ekantipur.com/news/2020/06/02/159110667883648610.html.

9 International Dalit Solidarity Network (IDSN)'s 2022 updated Compilation of UN References on "Caste Discrimination and Human Rights", P- 42, https://idsn.org/wp-content/uploads/2022/01/UNcompilation-Jan-2022-Web.pdf.

10 Two-thirds of the most disadvantaged Dalit population of Nepal still do not deliver in health facilities despite impressive success in maternal health, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6546215/.

Muslims, and some ethnicities from Terai are the most disadvantaged caste/ethnic groups in terms of benefitting from the advances in maternal health service.

Intersectional Discrimination and Sexual and Reproductive Health Rights (SRHR)

The maternal health care reports show a pattern that better-off groups (those who live in urban areas and better educated) tend to seek care from doctors and nurses/midwives, while poorer and disadvantaged groups with lower social status depend more on lower-level health workers.[11] Dalits (especially from the Tarai/Madhesh), Tara/Madhesi other Castes, Janajatis and Muslims all use the services of Health Workers, Maternal and Child Health Workers and village Health Workers at a higher rate than Brahmans or Newars. These data show, although not conclusive, that these categories of health workers do not discriminate against "low caste" or Muslim women (at least in terms of delivery or antenatal care).[12] It can also be drawn that, the health service providers such as doctors, nurses or midwifes in government as well as private hospitals and health centers of more urban areas have (perhaps unintentionally) created an environment that restricts the disadvantaged groups' access in multiple ways.

Intersectional discrimination in accessing SRHR by women, girls, and people who can get pregnant is observed to have three dimensions. [The first dimension] is biased health care facilities that not only include a lack of physical access to health services but also a lack of financial access, information and counseling, enabling environment, equitable attitude, and informed consent among other indicators. [The second dimension] includes various indicators of discrimination such as discrimination in education, work, income, housing (poor), and other social and environmental determinants that unequally impact racially discriminated groups. [The third dimension] includes behavioral disparity based on an individual's age, education status, disability, gender, and economic status. Multiple discrimination based on these three dimensions intersects to create a unique experience of intersectional discrimination[13] that stands as a huge barrier blocking individuals to achieve the highest achievable standard of health. It ultimately impacts the SRHR of women, adolescents, and people who can get pregnant along with the health of a newborn, belonging to racially discriminated groups.

According to the 2011 Census, the average literacy rate in Nepal is 65.97 percent, with 57.53 percent for females.[14] Women from all Dalit groups have lower literacy rates compared to the national average and their male counterparts, i.e., 45.5 percent.[15] While women from Musahar

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11 Further Analysis of the 2006 NDHS, p – 10, https://dhsprogram.com/pubs/pdf/FA58/FA58.pdf.

12 Ibid.

13 Paragraph 7 of CERD's General Recommendation NO. 32 (2009) reads, "The 'grounds' of discrimination are extended in practice by the notion of 'intersectionality' whereby the Committee addresses situations of double or multiple discrimination - such as discrimination on grounds of gender or religion – when discrimination on such a ground appears to exist in combination with a ground or grounds listed in Article 1 of the Convention."

14 Since complete data of latest Census of 2021 is not yet published by the Government, for the purpose of this submission, the nearest Census data is used.

15 National Population and Housing Census, 2011, Government of Nepal, https://unstats.un.org/unsd/demographic-social/census/documents/Nepal/Nepal-Census-2011-Vol1.pdf.

and Dom communities are at the bottom, with 17.4 percent literacy rates, respectively[16]. Thus, with the gendered and patriarchal mindset coupled with casteist uptake, a large population of Dalit women and girls has still fallen behind. This in turn leads to lower awareness, lack of decision-making power, violation of the right to informed consent, and overall lack of agency to enjoy one's rightful sexual and reproductive health rights.

Studies show that among others, people belonging to a community of ***Dalit***, ***Muslims***[17], **and people of other castes/ethnicity of Terai regions** are most vulnerable in terms of acquiring maternal health care in Nepal. Observation of the 2016 survey on Maternal Health Care in Nepal: Trends and Determinants clearly show this difference. For instance, among women who had four antenatal care visits per protocol during their pregnancy – Brahmin/Chhetri women were 60%, while women from Terai were 40.8%, Muslim – 44.5%, and Dalits 55.3%. Similar is the data for other indicators of maternal health care as provided in this national data. This difference in Dalit women accessing ANC[18] or institutional delivery is despite the availability of free services and financial incentives for transportation in many areas. The common reason as mothers did not find it necessary to travel long distances, especially in areas that lack proper transportation facilities along with possibilities of other associated costs that come attached apart from the direct service.[19]

Women of Dalit, Muslims, and other ethnic minorities of the Terai region still face many difficulties in accessing health services. The target set by the Health Plan of Nepal, 1997 to 2017 stipulated to provide basic health care services to 90% of the population within 30 minutes of walking. The progress however has only been made up to 58% of *Dalits*, and only 39% of Hill *Dalits* have access to health facilities within 30 minutes of walking distance. 55.5% of people in Nepal cannot afford medical treatment but even fewer *Dalits* – 60.5% of Hill *Dalits* and 66.1% of Terai Madhesi *Dalits*.[20]

Therefore, while there may not be any reported cases of direct denial of sexual and reproductive health services by providers or health centers to individuals or groups on the basis of race, descent, ethnicity, nationality, or origin, it is imperative to address the underlying indirect and intersectional causes poor SRHR among racially discriminated groups. It is essential

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16 Nepal Social Inclusion Survey (NSIS)2012, Central Department of Sociology/Anthropology, Tribhuvan University, Nepal.; 2National Census 2011, Central Bureau of Statistics, Nepal, http://cbs.gov.np/sectoral_statistics/population/caste_ethnicity.

17 Religion, Ethnicity and Racial Discrimination: CERD has expressed its view that the Committee "would be competent to consider a claim of "double" discrimination on the basis of religion and another ground specifically provided for in Article 1 of the Convention, including national or ethnic origin", https://tbinternet.ohchr.org/Treaties/CERD/Shared%20Documents/1_Global/INT_CERD_INF_7827_E.pdf.

18 Ante-Natal Care

19 Surendra Prasad Chaurasiya, and others, *Two thirds of the most disadvantaged Dalit population of Nepal still do not deliver in health facilities despite impressive success in maternal health*, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6546215/.

20 Nepal Social Inclusion Survey (NSIS) 2012, Central Department of Sociology/Anthropology, Tribhuvan University, Nepal; Submission to the UN UPR of Nepal, 2015, *Human Rights Situation of Dalit community in Nepal,* https://idsn.org/wp-content/uploads/2015/11/Nepal-UPR-2015-Dalit-Coalition-and-IDSN-report.pdf; Report of Dalit Women of Nepal on CEDAW Convention, 2018, https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/NPL/INT_CEDAW_CSS_NPL_32516_E.pdf.

in order to ensure proper health standards to achieve healthy lives for all irrespective of caste, descent, or any racial differences.

Disaggregated data by gender, caste and ethnicity to give a picture of *Dalit* women and other groups that are discriminated against on the basis of ethnic origin is scarce. But available data depicts that *Dalits'* position in all major health indicators is very low. For example, under-five mortality in the *Dalit* group is 90 deaths per 1000 live births compared with an all Nepal level of 68. Nepal has immunization coverage of 83% whereas immunization rates for Dalits are 13 points below the average. In 2011, around 31.0 percent of children under five have a low weight-for-age ratio. Disaggregated results across ethnic and caste groups depicts that the proportion of underweight children is highest among Madhesi *Dalits* (36.3 percent).[21] This is a clear indicator of a problems of access to nutritious food for *Dalit* groups among others. Uterus prolapse is a major problem among many *Dalit* women of rural areas with high morbidity rates. Child marriage, early pregnancy and reproductive health issues are other problems faced by *Dalit* women.[22]

Despite decades of legal and social efforts to end the racial discrimination based on caste and ethnicity - in civil, political, cultural and economic grounds, its habitual end towards equal opportunity and access to health care cannot be easily achieved. Therefore, socially discriminated groups, such as ***Dalit*** women, Muslims, indigenous, refugees, and persons who cannot establish the nationality of the State on whose territory they live (stateless), specifically those who fall under varying disadvantageous positions or have special needs, such as women, adolescent girls, economically poor, LGBTIQ, and women with disability, suffer a whole new experience of discrimination. This intersectionality exacerbates the challenges and barriers already being faced by individuals, in accessing SRHR, for the reason of belonging to a particular group (covered by ICERD).

Informed Consent

Informed Consent is generally understood as a communication process between the service seeker and provider that includes the right to receive complete information about the health service sought and the health seeker's agreement or permission for care, treatment, or services. It refers to every patient's right to get information and ask questions before procedures and treatments.

Various organizations working for the rights of poor, vulnerable, marginalized women, girls, and people capable of getting pregnant falling have reported that, these people, especially those who fall under the racially discriminated groups are often denied of informed consent in its true sense. Lack of agency among these groups to question and demand complete information and pre-meditated biasness among service providers towards these groups often lead to violation of this right. The socially existing power relation among people of lower caste or minority groups and those belonging to higher or privileged classes tend to impact the

21 Ibid.
22 Ibid.

practice of informed consent. This in turn create an environment of perpetual ignorance that hinders an individual's right to make a fully mature and informed consent.

Recommendations

The State has obligation to ensure, through its legal framework, policies and programs, equal opportunities and equitable access to SRHR by the racial and ethnic minority groups who are fallen behind due to social stratification. Only by reaching the unreachable and leaving no one behind, will the government's obligation under ICERD will be fulfilled.

Thus, we the civil society would like to present following recommendations for CERD's consideration while drafting its General Recommendation on Article 5(e)(iv):

- The Caste-based Discrimination and Untouchability (Offence and Punishment) Act, 2011 should also prohibit racial discrimination other than caste-based discrimination. Other forms of racial discrimination such as, on the basis of national or ethnic origin, should also be included.
- The said Act should also include a provision prohibiting both indirect and direct forms of discrimination.
- While Madhesh Province has enacted its provincial law to ensure Dalit in its area, a similar step (with more progressive provisions) should be adopted by other local and provincial governments as well, in order to ensure ownership of the issue.
- The national human rights institutional mechanisms such as National Dalit Commissions, Indigenous Nationality Commission, Tharu Commission, and National Human Rights Commission should function more actively in the monitoring of the implementation status of health services, including sexual and reproductive health, at the local to the national level, ensuring awareness among general people about the legal consequences of discriminatory behaviors, and conducting extensive research (both quantitative and qualitative) to produce disaggregated data of SRHR not only among Dalit, Muslims and Terai people, but also of adolescents, women with disabilities, and LGBTIQ among those racially discriminated.
- The 2016 national surveys have derived disaggregated data of ***Dalit***, ***Muslims***, ***Janajati*** (indigenous), and other people of Terai in terms of maternal health care. However, disaggregated data for other discriminated communities, such as refugees, stateless people, SOGISC[23], adolescents, and people (women) with disabilities are largely missing. The State should simultaneously gather and keep records of these other communities of people as well, in order to acquire a complete picture of uniforms and equal achievement or acquisition of guaranteed SRHR rights.
- The State should also produce annual research reports based on the demographic health survey and maternity health care data in order to analyze the progress or impact of government and private sector intervention in ensuring SRHR for women, girls, and people who can get pregnant. This analysis should also analyze the status separately for individual groups.

[23] Sexual Orientation, Gender Identity and Sexual Characteristics (referring to and inclusive of people from LGBTIQA community)

- In producing Health Facility Survey, the government should focus beyond physical infrastructure or services. Other indicators such as enabling environment, room for breastfeeding, awareness level, information desk for maternity or safe abortion seekers, adolescent-friendly, disability friendly, the practice of informed consent, and equitable behavior by service providers/centers to people who are racially discriminated in society, should all also be considered.
- The State should take all possible measures to ensure the overall and multidimensional upliftment against racial discrimination – which includes education of Dalit boys and girls, ensuring a society free of stigma, reducing poverty among Dalits, including by providing income-generating skills and training, and ensuring service that is free from any forms of discriminatory mindsets.
- Increase access of Dalit women to skilled birth attendants and proper ante-natal care and nutrition.
- Ensure meaningful participation of Dalit women in political sectors to ensure that they themselves (also) have a say in the issues that concern their lives and SRHR.
- Governments (local, provincial, and federal) should conduct (in collaboration with non-governmental actors) extensive training, capacity-building programs, and stigma reduction workshops by mobilizing local leaders and youths, especially health service providers in order to create a health system that is free from any forms of racial biases.
- The Professional Code of ethics of both public and private professional institutions should take action against any forms of racially discriminatory behaviors. This should be monitored by concerned national human rights institutions.