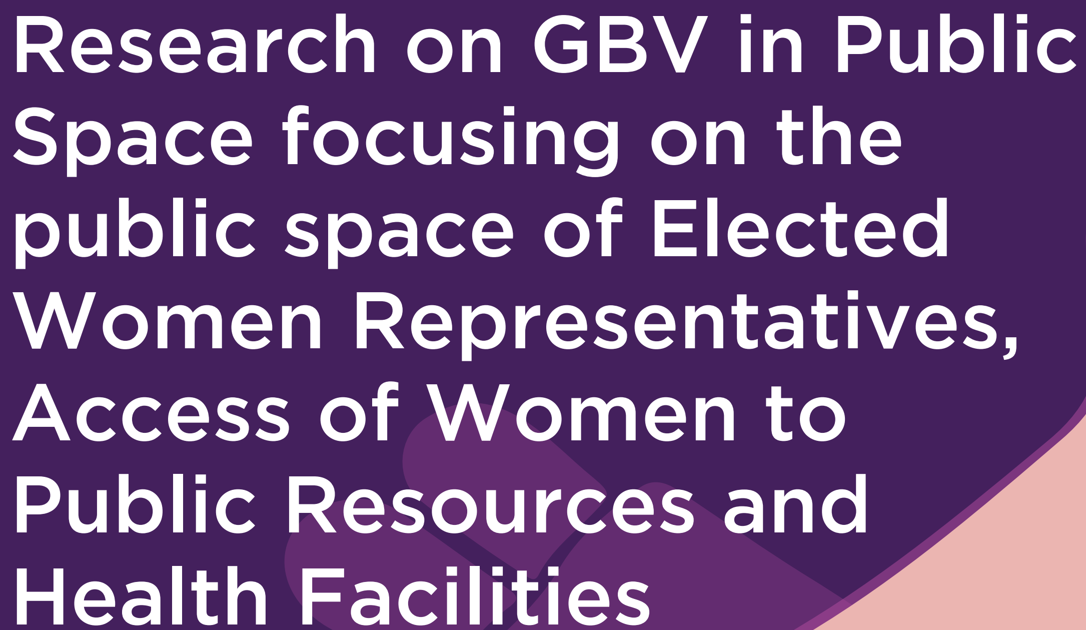
Research on GBV in Public Space focusing on the public space of Elected Women Representatives, Access of Women to Public Resources and Health Facilities



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This report is an outcome of Research on GBV in Public Space focusing on the public space of Elected Women Representatives, Access of Women to Public Resources and Health Facilities

Research Team: Goma Bhandari, Pampha Puri, Lubha Raj Neupane, Sunita Mainali, Prabha Paudyal, Susma Chhinal and Ishwori Thapa.

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Women's Rehabilitation Centre (WOREC)

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EXECUTIVE SUMMARY

Gender-based violence (GBV) is rooted in gender inequality that constitutes violence (physical, mental, economic, social, and sexual violence) directed at an individual based on gender. The forms of GBV range from violence against LGBTIQA+ people, Intimate partner violence, Domestic Violence, Sexual Violence, and Indirect (Structural) Violence. GBV is often used interchangeably with violence against women (VAW).

The World Health Organization (WHO) estimates that one in three women worldwide suffers from violence during their lifetime. According to the National Demographic Health Survey of 2016, 1 in 5 women in Nepal has experienced physical violence in their lifetime. Similarly, according to the same survey, the percentage of women between the ages of 15 and 49 who have experienced physical or sexual violence is as follows: 66% had never asked for help, never had told anyone, 22% had asked for help to stop the violence, and 12% had never asked for help but had told someone. The violence is often perpetuated through power inequalities rooted in the social construction of gender. Due to gender inequality, women, girls, and people belonging to sexual and gender minorities (SGM) are a target of GBV in private and public spaces.

Due to the criminogenic environment facilitated by public spaces, public spaces are often the hotspot for numerous crimes and violence. The violence and crimes committed in public spaces range from pickpocketing, trolling, cyber harassment, stalking, online sexual exploitation, and robbery to sexual misconduct, harassment, and assault. Furthermore, the gravity of the violence is also based on the gender role constructed by society. In a society where gender inequalities are reflected in social, cultural, economic, and political aspects, the public spaces become a forum for gender-based violence that is presented in nuances of social practices. These crimes and violence affect and limit the person's agency and movement. Irrevocably changing the individual's sense of security and autonomy and ultimately curtailing their rights, especially for SGM, girls, and women. These groups are often targeted based on their gender.

Thus, it is essential to study gender identities and decipher the role played by each gender in cultivating gender-based violence. For instance, in a patriarchal society, masculinity plays a massive role in setting the boundaries of other gender minorities. Masculinity shapes the cultural and social traditions that need to be followed by other genders, especially in public settings and forums. Thus the reflection of patriarchal ideology and structure in public spaces makes them more vulnerable to women, girls, and SGM.

Furthermore, the GBV in private spaces has been well-documented, researched, and analyzed, and that particular area of research has been growing. For instance, due to the advancement in research and documentation of domestic violence, there have been developments in international and national protocols and standards to eliminate domestic violence, including advocacy and outreach programs for implementing such programs. However, there has been limited research on GBV in public spaces due to lack of data, unreported incidents in public spaces, and stigmatization surrounding the violence.

In Nepal, the rise of violence in public spaces has been a serious concern that has been sidelined and is in shadow. GBV case documentation done by Women's Rehabilitation Center (WOREC) on 'women and girls' safety in public spaces and mobility across community settings' in 2020 recorded 600 cases of violence against women and girls in public spaces (ANBESHI 2021). Activists in Nepal believe that the number of cases might be more than recorded. Many incidents of sexual harassment are not reported due to the stigmatization and the culture of victim-blaming (WOREC, 2020).

A sample study on the prevalence of violence against women and girls in public places was conducted by WOREC and included 321 respondents (women and girls). Forty percent of the respondents have experienced violence on public transport. Similarly, ten percent are on the road, nine percent in educational institutions, seven percent in the crowd, and six percent in isolated spaces. Also, five percent have experienced violence in marketplaces, four percent in health facilities, three percent in financial institutions and hotels, pubs, and dance bars, and two percent in the workplace. Eleven percent of respondents said that violence occurred in playgrounds, parks, and shops.

At present, the participation and role of women in various opportunities outside the home are increasing. As their activism in outside activities increased, the structured mask of violence followed them in those places. The tendency to abuse has also increased. This is how toxic masculinity is overpowered in all the spheres of women and girls to strengthen patriarchy to prevent women from participating in the network and to see them in the traditional discriminatory gender roles. Thoughts have grown up in the values that the patriarchal social structure has eroded.

The Social Norms Analysis Plot (SNAP) has been an important tool to assess and study the GBV in public spaces, mainly focusing on the public spaces of elected women representatives, access of women to shared resources, and the status of public spaces in health sectors. Overall, this study assessed gender-based violence in public spaces in Nepal's three districts: Dang, Morang, and Udayapur.

Furthermore, the study was done with the facailitation of various stakeholders, from service providers to individuals in the districts who participated in the study. It helped the team to assess and sample the cases and patterns of gender-based violence in public spaces in Nepal.

LIST OF ACRONYM

CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
FGD	Focus Group Discussion
GBVAW	Gender-based violence against women
GBVAWG	Gender-based violence against women and girls
GBV	Gender-based violence
KII	Key Informant Interview
SNAP	Social Norms Analysis Plot
OCMC	One-stop crisis management center
OPD	Outpatient department
SGM	Sexual and Gender Minorities
SRHR	Sexual and reproductive health rights
UPR	Universal Periodic Review
VAW	Violence Against Women
WCSC	Women, Children and Senior Citizen Service Center

LIST OF FIGURE

Figure 1: The situation of GBVAW of Dang, District Police Office, Dang, November 2021(Mangsir 2078)

Figure 2: The situation of GBVAWG of Morang, District Police Office, Morang, December 2021(Mangsir 2078)

INTRODUCTION

Background

GBV is one of the most widespread forms of human rights violations. It is a kind of violence where a person's gender puts them at disposal to violence more disproportionally. GBV can take the form of physical, sexual, psychological, or economic harm. The violence perpetrated against women and girls has several physical, mental and socioeconomic costs.

Women, girls, and SGM who face such violence are not just prevented from enjoying their fundamental human rights, but their full participation in society and mobility rights are hindered. Such violence can directly impact women, girls, and SGM's physical and mental health. The trauma associated with the violence can affect SGM, girls, and women's performance in schools and the workplace. Consequently, this subdues efforts to achieve gender equality.

GBV is understood to be a result of unequal power relations in society and the norms that justify such inequalities. There is a myriad of cultural, economic, and even legal reasons why women fall inferior in such equations. Additionally, these factors interplay with other intersectional dynamics like class, religion, and caste, putting women and girls in a more vulnerable position.

The World Bank currently estimates that 35% of women (The World Bank, 2019) worldwide have experienced some form of physical and sexual violence. In Nepal, the number is even higher, as 48% of women (D'Orlando, 2021) claim to have faced such violence at some point in their lifetime. Gender-based violence against women and girls (GBVAWG) in Nepal commonly manifests in the form of domestic violence, marital rape, dowry-related violence, child marriage, polygamy, female infanticide, violence against women accusing as witches, chaaupadi, and sex trafficking (UNFPA, 2020). The patriarchal structure of society, lack of access to information and mechanisms to redress, and unavailability of women-friendly spaces or methods prevent women from seeking recourse. Further, individuals belonging to SGM have additional barriers that curtail their rights. Moreover, the fear of stigmatization creates further obstacles for women, girls, and SGM to get support.

Gender-based Violence in Public Spaces

GBVA occurs in both private and public spaces. In private spaces, women, girls, and SGM's are violated by their family members or extended relations. Violence at the hands of a known perpetrator, like intimate partner violence (Women Win, n.d), is quite common.

Over the decades, the feminist movements have demanded space for women in public spaces in contrast to traditional norms of women (ActionAid, 2019). However, poor infrastructure, lack of policing, and unplanned urbanization increased the risk of women, girls, and SGM experiencing forms of violence, due to which women, girls, and SGM experience sexual harassment and other forms of violence in public spaces – on streets, means of transport, and even schools and offices – regularly. Harassment and intimidation in public places such as schools and workplaces, eve-teasing, and online harassment are some

ways women, girls, and SGMs are violated in public spaces. Thus, it is imperative that these spaces must be critically scrutinized to protect and promote women's, girls', and SGM's rights since such experiences impact their physical and mental well-being and hinder their professional lives. Furthermore, it is also essential to deconstruct gender identities, roles, and the need to decipher the impact of masculinity, femininity, and SGM identities on societal norms and values.

However, public spaces do not just function as a site of violence but can serve as a space for resistance and aid in preventing GBV. Therefore, the existing conditions of public spaces must be studied to better inform the relevant bodies (various service and security providers, policymakers, and the larger community) and develop approaches to respond to and prevent violence against women and girls in public spaces.

Laws in Practice and Action

In International norms and mechanisms, at the UN level, there is a Convention on the Elimination of All Forms of Discrimination against Women (CEDAW Convention) to eliminate violence against women and its Optional Protocol. Its Committee on the Elimination of Discrimination against Women (CEDAW Committee) oversees and provides views, measures, and recommendations to the member states on protecting and promoting women's and girls' rights.

At the regional level, numerous regional conventions have explicitly stated a state obligation to combat GBVAW. These conventions include the Council of Europe Convention on preventing and combating violence against women and domestic violence, 2011 (Istanbul Convention), Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women, 1994 (Convention of Belém do Pará), and Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2003 (Maputo Protocol).

Since 1991, Nepal has been a state party to CEDAW. Over the years of its membership, Nepal has gone through political, social, and economic changes. This has been reflected in women's rights and the women's movement. During the third cycle of Universal Periodic Review (UPR), Nepal was recommended to ratify ILO Violence and Harassment Convention 190. In addition, Nepal has ample gender-responsive laws, policies, and strategies at the national level. The Constitution of Nepal has guaranteed women's rights as fundamental rights of a Nepali woman citizen. Along with Human Trafficking and Transportation Act (2007), Domestic Violence (Crime and Control) Act (2009), Witchcraft-related Accusation (Crime and Punishment) Act, Sexual Harassment at the Workplace (Elimination) Act (2015), Right to Safe Motherhood and Reproductive Health Act (2018), National Plan of Action against Trafficking of Women and Children (2012), National Strategy to End Child Marriage (2016) and National Strategy and Action Plan on Gender Empowerment and Ending Gender-Based Violence (2018) have attempted to protect and promote women's and girls' rights. However, despite the legislation created for women's rights, there are 100 provisions in 43 acts that are discriminatory to Nepalese women (Ghimire, 2022)

Thus, despite the significant changes in legislation excluding legal loopholes. Women's rights are enshrined in national legislation and international norms and mechanism. There has been a substantial normative and substantive gap (WOREC, 2021). In addition, the issues faced by SGM are often sidelined and in shadow by the protective sphere of the state.

OBJECTIVES

1. Examine elected women representatives as both potential survivors in their executive and administrative functions as well as collaborative partners in addressing GBV and women's safety in public spaces

2. Analyze the impact of GBV on women and girls' access to essential services, availability of gender-friendly services in public spaces such as police, and government offices

3. Explore the accessibility of healthcare facilities, including health posts, hospitals, and One-stop crisis management (OCMC).

METHODOLOGY

The research was conducted using a mixed method to examine the research questions qualitatively. A pre-set of the questionnaire was prepared to thematically analyze the cases and patterns of gender-based violence in public spaces. They were asked to interviewees in three districts; Dang, Morang, and Udayapur. The questionnaire was designed based on the SNAP framework. The tools chosen were Desk Review, Focus Group Discussions (FGD), Key Informant Interviews (KII), and Case Stories. Participants were purposely sampled in collaboration with the WOREC programs team and WOREC district offices.

Desk Review

For desk review, existing academic and non-academic materials on the subject of public spaces and GBV were reviewed. Apart from that, legislation regarding GBV and reports on media was also reviewed to enrich the understanding of the context and issue, which helped to design the checklist.

Focused Group Discussion

For FGD, four focus groups were conducted at each district level. The participants were purposively sampled. One focus group included GBV service providers such as representatives from OCMC, other healthcare providers, police, elected women's representatives, and the women, children, and senior citizen's officers. The second focus group included Community Based Organizations (CBOs), including organizations that offer rescue and shelter services for survivors of GBV and networks and organizations of sex workers and entertainment workers. The third focus group included women's groups such as mother's groups, community-based psychosocial workers, and women's cooperatives, and the fourth FGD was conducted among the adolescent girls' groups. In total, eight FGD were taken.

Key Informant Interview

Key Informant Interviews were conducted with elected women representatives, representatives of the police, health service providers, LGBTIQA+ communities, and women with disabilities. In total, eighteen KIIs were done.

Social Norms Analysis Plot (SNAP)[1]

The framework helped to draw the pattern and trends of existing societal norms and values. It further helped to see how individuals who deviate or confirm from existing norms are perceived in society through sanctions and consequences.

Number of FGD /KII and participants involved in the research.

Respondents	Number of FGD			Number of KII			
	Udayapur	Morang	Dang	Udayapur	Morang	Dang	Total Participants
CBOs and other self representing group working on GBV	1	1	1				24
Womens Group	1	1	1				24
Womens Representatives				4	4	4	12
Girls Group	1	1	1				24
Sex workers					1	1	2
People with disability				1	1	1	3
OCMC				1	1	1	3
Psychosocial counselors				1	1	1	3
LGBTIQ					1	1	2
Health Service Provider				1	1	1	3
CDO				1	1	1	
Police				1	1	1	3
Pro Bono lawyer				1	1	1	
other Service providers	1	1	1				24
Total	4	4	4	11	13	13	127

Figure 4 : Number of FGD /KII and participants involved in the research.

DISTRICT PROFILE

Dang

The district is home to 548,140 (2021 census). It covers an area of 2,955 km². The district falls under the Lumbini Province. The district consists of two sub-metropolitan cities, one municipality, seven rural municipalities, and 100 wards. The study was done in Tulsipur Sub Metropolitan city and Dangisarn Rural Municipality. The Tulsipur Sub Metropolitan City has 19 wards, 141,528 population, and an area of 384. 63 km². The Dangisaran Rural Municipality has seven wards, a 21,484 population, and an area

1 SNAP framework is derived by philosopher Cristina Bicchier on his theory of social norms- using one's belief about what others do and one's belief about what others expect one to do. The framework aids in assessing the existing norms and values that influence an individual to perceive social expectations (empirical and normative expectations).

of 110.7 km².

S.N	Type	Fiscal year (071/072)	Fiscal year (072/073)	Fiscal year (073/074)	Fiscal year (074/075)	Fiscal year (075/076)	Fiscal year (076/077)	Fiscal year (077/078)	Fiscal year (till Kartik 078)
1	Rape	19	33	34	43	68	44	73	37
2	Attempt to rape	9	8	16	20	21	23	27	14
3	Polyandry	-	5	2	5	28	14	40	12
4	Domestic Violence	56	87	180	197	161	115	141	47
5	Suicide	171	96	35	29	83	113	234	28
6	Social Violence	15	20	4	25	3	1		
7	Accusation as witches	2		-	6	2	0	5	3
	Total	259	251	272	325	366	310	520	141

Figure 1: The situation of GBVAW of Dang, District Police Office, Dang, November 2021(Mangsir 2078)

Morang

The district is home to 960,859 (2021 census). The district falls under Province No.1. It covers an area of 1,855 km$^{2.}$. The district consists of one metropolitan city, eight municipalities, eight rural municipalities, and 159 wards. The study was done in Biratnagar Metropolitan city, Sunwarshi Municipality, and Patahrishanishchare Municipality. The Biratnagar Metropolitan city has 19 wards, 214,663 population, and an area of 77 km². The Sunwarshi Municipality has 9 wards, 50,758 population, and covers an area of 106.4 km². The Patahrishanishchare Municipality has 10 wards, 62,440 population, and covers an area of 78.89 km².

S.N	Type	Fiscal year (071/072)	Fiscal year (072/073)	Fiscal year (073/074)	Fiscal year (074/075)	Fiscal year (075/076)	Fiscal year (076/077)	Fiscal year (077/078)	Fiscal year (till Kartik 078)
1	Rape	60	54	66	77	119	91	129	34
2	Attempt to rape	35	17	27	48	57	55	37	8
3	Polyandry	17	17	13	23	38	32	49	13
4	Domestic Violence	118	122	73	25	11	7	5	4
5	Suicide	71	84	105	71	88	110	115	42
6	Homicide	4	5	9	13	5	6	11	1
7	Accusation as witches	1	1		1	2	2	3	2
8	Caste Dis-crimination			1		2	3	3	
9	Child Mar-riage				3		1	3	
10	Child Sexual Abuse					10	10	11	6
11	Kiddnapping	2	3		1	3	7	6	5
	Total	308	293	294	262	335	324	372	115

Figure 2: District Police Office, Morang, December 2021(Mangsir 2078)

Udayapur

The district is home to 315,429 (2021 census). The district falls under Province No.1. It covers an area of 2,063 km^2. The district headquarter is Triyuga. The district consists of four municipalities, four rural municipalities, and 75 wards. The study was done in Triyuga Municipality, Katari Municipality, Chaudandigadi Municipality, and Rautamai Rural Municipality. The Triyuga Municipality has 16 wards, and 87,557 population and covers an area of 547. 43 km². The Katari Municipality has 14 wards, 56,146 population, and covers an area of 424. 89 km². The Chaudandigadi Municipality has 10 wards, 48,574 population and covers an area of 283. 78 km². The Rautamai Rural Municipality has eight wards, 23,481 population, and covers an area of 204. 08 km².

	Type	Fiscal year (071/072)	Fiscal year (072/073)	Fiscal year (073/074)	Fiscal year (074/075)	Fiscal year (075/076)	Fiscal year (076/077)	Fiscal year (077/078)	Fiscal year (till Kartik 078)
1	Rape	22	19	17	29	37	45	47	35
2	Attempt to rape	15	13	10	17	17	16	16	7
3	Polygamy	9	5	4	6	18	20	13	9
4	Polyandry	0	0	0	0	0	0	0	0

5	Child marriage	1	1	0	1	2	1	5	1
6	Domestic Violence	105	113	154	153	116	111	112	136
7	Suicide	32	26	30	23	33	46	52	40
8	Social Violence	55	60	19	27	56	49	98	60
9	Accusation as witches	1	1	0	0	0	0	0	0
10	Trafficking	2	2	3	2	1	1	0	0
	Total	242	240	237	258	280	289	343	288

Figure 3: District Police Office, Udayapur, December 2021(Mangsir 2078)

FINDINGS

1. Elected Women Representatives

1.1 Survivors in Administrative and Executive Functions

Elected women representatives reported facing various types of violence besides sexual violence, such as discrimination in work division, partie's denial of tickets to deserving women candidates in local elections of 2017, and lack of acceptance of their leadership in their administrative and executive functions. A representative even remarked, "Females like us who work in public organizations are more vulnerable to violence." On the one hand, all women representatives faced violence owing to their gender, while on the other, women representatives with other marginalized identities faced more violence due to their multiple marginalizations.

Dalit women representatives, for instance, also experienced discrimination based on caste in addition to other forms of gender-based violence. A Dalit woman representative shared that she was invited to a function in her role as an elected representative and was brought a plate of food as soon as she arrived to prevent her from touching the food at the buffet.

Elected women representatives claimed that their political parties had discriminated against them in the local elections of 2017. They complained that younger men were given the opportunity to run for mayor rather than deserving senior women candidates. Similarly, less outspoken women with little experience were given the ticket. It was found that political parties used women's participation in tokenistic ways and included women they felt would have the least opinions and create the least hurdles regarding policy, planning, and implementation.

A woman representative emphatically remarked, "not just one political party, but all political parties have given women the deputy's seat everywhere. A woman who can fulfill the role of a deputy could have also performed the role of a head" Women were considered inferior and incapable, which is why they were given deputy positions. Moreover, deputy mayors also conveyed being discriminated against at their work.

> *"The workload is substantial, but the deputy mayor's work is overshadowed or overstepped by the municipality. In the absence of a Mayor, the Deputy Mayor assumes the role of Mayor but our bureaucracy, society, and representatives also underestimate the Deputy Mayor even though we have come through the same competition."*

Women representatives shared that there was no comparison based on actual work done. Instead, men were automatically given respect regardless of their performance, while women had "to fight to get even basic authority." Women representatives were also not given the information they needed to perform their roles by the bureaucrats or male elected officials. Women representatives even reported not having the information regarding the activities of their wards.

Within the various decision-making committees at the local levels, men were reported to hold executive positions, and women were just included as members. In the words of a Dalit ward member, "There are 29 divisions and committees at the local level; only men are coordinators of these committees." A Dalit woman representative shared that while she was recommended for the municipal executive and the judicial committee, her name was removed from both owing partly to her caste and partly because people feared she would cause trouble as she was outspoken. Her name was initially approved for the municipal assembly, but overnight, the municipal executive intervened and replaced her with a non-Dalit woman.

Moreover, among Dalit and non-Dalit women representatives, Dalit women representatives were considered lower in the hierarchy. For example,

> *"In our municipality, Judicial committee consists of one deputy mayor, one woman ward member - from privilege caste, and one Dalit woman ward member. The deputy mayor is superior in the hierarchy, but the other two council members are on equal terms in the committee. However, the non-Dalit woman is considered senior, and the leadership and capability of the Dalit member are always questioned. The Dalit woman representative always feels that she is given less responsibility in terms of work distribution, decision-making, facilitating discussions, and studying cases. Out of the three committee members, only the non-Dalit member is assigned to chair the meetings."*

In addition to exclusion from decision-making spaces, some women representatives who were in such spaces remarked that it was difficult to get their voices heard and their proposals for programs accepted. Moreover, women representatives expressed that they were not given the respect owed to their positions. For instance, male peers did not visit the respective office when a female deputy mayor assumed the responsibility as a mayor in the absence of the mayor because they deemed it beneath them to have to greet her with respect.

Women representatives stated that society was not accepting of women in leadership roles and that they were subject to a variety of sanctions when they did not conform to the norm of women as housewives and followers. These sanctions often took the form of slander. For instance, a reprsentative added, "If a woman is knowledgeable and intelligent, people will speak ill of her behind her back and attempt to demean and ridicule her."

Male colleagues also participated in such antiques and attempted to defame elected women representatives. A male official defamed an elected woman representative by implying she had sexual relations with him as it is linked with the honor of a woman. A women representative who was interviewed after-hours raised the possibility that because she stayed out late, other people might have negative opinions towards her.

1.2 Collaborative Partners in Addressing GBV in Public Spaces

GBV in public spaces was essentially not a subject of discourse or an area of priority for elected women representatives. In their functions in the mediation committee or the judicial committee, or even as mediators, they mainly dealt with disputes between husband and wife and other civil matters such as disputes regarding lending, borrowing, and land. Their primary role in disputes was to mediate reconciliation, including in the cases of physical domestic violence. They cannot take punitive measures in their roles, which circumscribes their ability to perform as effective collaborative partners in addressing GBV. For example,

> *"If someone is physically harmed, comes to us crying, or is kicked out of the house, we try different tactics to deal with the perpetrator, like giving them warnings."*

In their roles as mediators of GBV, there have been some achievements. For instance, they expressed that because they were also women, women who had experienced GBV found it easier to approach them and share their problems. Similarly, the deputy head of a rural municipality shared that they had introduced a policy that a woman must occupy one of the two significant posts as head or secretary in users' committees, after which there was much more meaningful participation of women.

Another woman representative had established a fund for GBV survivors. Women could use the fund for legal assistance, hospital bills, and travel. They could also receive up to 25,000 NRs. to establish a means of livelihood. Women representatives also mentioned that they frequently wrote applications for women who lacked the necessary writing skills and referred them to concerned authorities when cases were outside their jurisdiction.

Awareness building was a priority for elected women representatives, and most of the activities around GBV were around creating awareness in the community. Rallies, sticking posters, and training on matters such as child marriage and domestic violence were the most common activities that women representatives conducted on GBV.

Various factors hindered women representatives' effectiveness as collaborative partners in curbing GBV. Firstly, they expressed the practice of out-of-court settlements. Money and influence were reported to determine the outcome of GBV cases, and even rape cases were reported to be settled out of court. An elected representative shared,

> *"People are advising dropping the case because it was a family issue and also due to financial reasons. In some instances, we have retracted the cases after great disappointment. I will give you an example, One of the respondent, who is also a women right activist, goes empowered to advocate a case of rape. The family requests her to pursue the case forward, and she goes for discourse for five days. On the sixth day, however, the family might have settled out of court without her knowledge."*

Social sanctions such as victim-blaming and concern over losing one's honor discouraged a survivor from reporting a case or seeing a case through. The elected women representative moreover opined, *"There are many cases where the survivors don't take any action against the perpetrator mainly due to the stigma of embarrassment, the survivor's reputation, her future, marriage and the way the society views the survivor and her family."*

This limited elected women representatives' ability to effectively deliver justice. In a case where a male teacher abused a girl student, the survivor did not admit to the incident with the authorities. The parents refused to file a formal complaint, as a result of which elected women representatives shared that they couldn't take serious action against the perpetrator. Instead, the teacher was sent to another school.

Moreover, elected women representatives were also at risk of being blackmailed into saving perpetrators. Often individuals who supported the survivor were also at risk of facing sanctions and being blamed for manipulating the survivor when they were willing to reconcile with the perpetrator or did not want to file a case.

Women representatives also worked around various resource constraints such as lack of gender-friendly infrastructures, psychosocial counselors, and training. For example, hearings were often conducted in the elected representatives' offices, where privacy could not be maintained due to the lack of space. Psychosocial counsellors reportedly had to hold counselling sessions in the survivor's home or the municipality office's storage room. In the absence of psychosocial counselors, elected women representatives were counseling with no training. Mediation committee members had also not received complete training.

1.3 Gatekeepers and Reproducers of Norms that Contribute to GBV

As members of the society, elected women representatives reproduced various norms that contributed to GBV, such as victim-blaming. For example, a representative claimed, "Sometimes survivors become survivors due to reasons like being unable to communicate clearly with their partner and not being able to understand their partners' problems."

Women representatives also claimed that some women were made-up survivors who did not acknowledge their problems and their fault in being survivors of domestic violence. For instance, an elected representative brought up a case of a woman whom her husband had physically abused; claimed that she

had wasted all the remittance upon another man with whom she had an affair. Arguments would not arise if the wife did not have an actual affair.

Similarly, elected woman representatives saw their roles as protectors of heteronormative family structures rather than as protectors of citizens' rights outlined by the constitution. They insisted on reconciliation sometimes to the detriment of the survivor's wellbeing. As an example, despite the survivors' unwillingness to reconcile, elected women representatives attempted to reconcile a case in which the husband severely abused the wife multiple times. When she was repeatedly sent back to live with the perpetrator, who constantly physically abused her and provided no support, the survivor attempted suicide by drinking poison. When mediation took place multiple times, women representatives told survivors to continue living in their perpetrators' houses, where they were at risk of further violence:

> *"Women who have been the survivors of gender-based violence are advised not to leave their homes during the mediation process. It would be difficult to settle a case later if she had to leave home. This is how things work in our society, and we expect females to stay at home."*

Elected women representatives shared that the reputation of the ward depended on whether they could reconcile cases or not. They expressed that their roles and goals were to maintain the family and ensure it remains stable and does not separate. This insistence on reconciliation often came at the expense of justice for the survivor. Women representatives even acknowledged that the survivors were usually made to compromise. They said, "we tell the survivors they can settle the case among themselves instead of going through the court procedure as such cases are common in society."

They discouraged survivors from going to court or separating whether or not that was the best outcome for the survivor. When survivors approached her, a representative said, "A filed case will not benefit either side. It finally takes. If I go to the courts, I will have to spend a few thousand. There is no guarantee of success." This meant women were frequently forced to accept their situations where they were continuously abused.

2. Weak redressal mechanism and rape culture

Survivors' access to public services and support from the redressal mechanism was severely limited because of numerous shortcomings in the redressal mechanism and the prevalence of a culture that accepts violence as a norm and vilifies the survivor instead.

2.1. Weak redressal mechanism forcing survivors to put up with violence

In general, women, LGBTQIA+ communities, and marginalized communities already face plenty of barriers in accessing essential public services like healthcare, education, and administrative support from government offices. The situation gets worse when it comes to seeking services as a survivor of GBV. On a superficial examination of the current redressal mechanism for GBV - primarily the Women, Children and Senior Citizen Service Center (WCSC) of Nepal Police, Mediation Committee at ward level, Judicial Committees at the municipal level, public hospitals and OCMCs, and District Courts - many perceive that justice is accessible to female survivors of violence in Nepal. However, sixty-six percent of women

survivors of physical and sexual violence do not report these incidents or even reveal the violence they face (Ministry of Health, New Era & ICF, 2017). This gap in perceived access to justice and reality results from multiple weaknesses in the redressal mechanism. This research has identified the following loopholes in the public redressal mechanism, which prevents it from creating an enabling environment for survivors to report cases and serve justice.

Mistrust resulted from limited to no contact between ordinary citizens and agencies in the redressal mechanism.

First of all, legal literacy is already low in Nepal limiting survivors' access to justice (Nepal, 2018). So, people, especially survivors of GBV from marginalized communities, are unaware of concerned authorities capable of helping them. To make things worse, there are few to no relationship and trust-building initiatives from the agencies in the redressal mechanism with ordinary citizens. As a result, even those aware of the appropriate agency to contact are reluctant to seek justice. One of our participants reported feeling scared of the police even when she has done nothing wrong because of social conditioning that suggests the police's main duty is to punish people rather than assist those seeking justice. Another adolescent participant, who has never reported violence she has faced, when asked how she feels about reporting those cases to the police, stated, *"If we go alone (to the police station to report violence), I don't think they (the police) will believe it."* Other participants of the discussion echoed similar sentiments regarding their perception of these agencies, especially the police. This discomfort emerging from the sense of alienation from agencies in the redressal mechanism further prevents survivors from seeking help.

Dismissive and demeaning behavior of service providers towards clients

Some survivors pursue justice despite a sense of alienation towards public agencies and then experience additional violence at the hands of service providers in these agencies. Participants reported being asked intrusive and often unnecessary questions in a demeaning manner while seeking service. During one participant's visit to the police station to flee her abusive husband's beatings, she was sexually harassed and mocked by officers who asked how often she had sexual relations with her husband. After such treatment from police personnel, she dropped the thought of seeking help and eventually left the abusive husband. The perpetrator never even got reprimanded by authorities for abusing her.

Similarly, another adolescent participant recalled being scolded harshly in public by a health service provider for arriving late at the COVID-19 vaccine center from school to get vaccinated. She shared that she felt extremely humiliated and did not get vaccinated in that center. Such experiences have discouraged her from seeking services from public service providers. She and other adolescent girls in the group also recalled being scolded in ward offices for taking cases (of violence) despite their young age. *They were asked, "What do children have to do with gender-based violence complaints in ward offices?*" They shared that they are often dismissed due to their young age when they visit public offices with legitimate concerns.

Lack of meaningful representation of women and LGBTIQA+ people within the redressal mechanism

Participants reported feeling uncomfortable in various public service agencies due to the lack of female or LGBTQI+ staff to listen to their concerns and assist them. One of the LGBTQI+ participants shared difficulty explaining nuances of challenges facing the community while seeking help from agencies in the redressal mechanism. Likewise, while sharing experiences seeking services from heavily male-dominated public offices, another participant said, *"Males predominate even in the wards. The male's one word silences us all, and we are unable to carry on."* Participants across different age groups and districts shared this sentiment. They reported feeling more comfortable sharing their problems and concerns with female officials in these positions. Meanwhile, they also emphasized the need to have gender-sensitive and survivor-friendly female personnel for the process to be more supportive and convenient for service seekers. In the absence of personnel of same gender sexual identity in public offices, survivors often refrained from seeking help.

Mistrust towards the integrity and transparency of public agencies

The service seekers had little to no faith in the integrity and transparency of public agencies. Statements like the following were common in almost every discussion with service seekers in this research.

"The ones (survivors) with power and access can easily get justice, the rest cannot"; "If I am a GBV survivor and I'm a part of an organization (human rights organization), they (agencies in redressal mechanism) will help me with ease, they will accept my case with ease. But, if I am not affiliated, they will not take my case."

Participants also shared a case where a survivor, a minor with a disability, failed to give authorities the exact date when she was raped. Medical reports showed that the survivor was raped, but the alleged rapist was still acquitted without further investigation. The participants believed that the alleged rapist was set free because he had the power and access to influence the justice system wrongfully. At the same time, the survivor did not have such influence.

In addition to that, individual cases of police refusing to file cases of violence, lawyers being compelled to mail complaints so that police are forced to register them, survivors being coerced to drop charges under active involvement of local representatives and personnel of redressal mechanism; caseworkers being influenced to leave the survivor alone to fend themselves were common everywhere. Due to mistrust towards the due process and agencies in the redressal process, survivors refrain from seeking help or reporting cases.

Furthermore, the participants were also not confident that their cases and information would be kept confidential by personnel in the redressal mechanism or other public offices. When asked about her reluctance to seek SRH services from public hospitals, one participant said, *"There is no privacy at all. If we go for treatment in the public hospitals in our community, the entire story of our misery is gossiped about in the village."* The situation is not very different in highly sensitive spaces like police stations or judicial committees either. One case worker said, *"There is no privacy in the police station. Women*

(survivors) must have a private space to discuss their issues. But, even the women's cell is crowded. Due to the crowded environment, many people choose not to speak up." Another case worker added that unless activists accompany survivors and request privacy, agencies in redressal mechanisms do not care about maintaining secrecy. As survivors and communities cannot be certain about the integrity of the agencies and personnel in redressal mechanisms and respect for their dignity, they refrain from pursuing justice.

Complex redressal mechanism

A public lawyer shared with us that survivors of GBV frequently drop cases in the middle of court appeals even if they manage to take perpetrators to court. She shared that the survivors and their families are often coerced to settle matters outside the court. The survivors also find it challenging to manage resources and time to pursue the case. Moreover, lengthy legal procedures also tend to prevent the survivors from continuing with the cases. Similarly, many of our participants reported that survivors are discouraged from pursuing cases further because of the expectations and demands to produce evidence of violence. A transgender participant shared that the police asked her sex worker friends to bring along the perpetrators to the police station if they wanted to file a case of assault. Similarly, a caseworker shared the plight of a 16 years old orphan, a survivor of rape, who was asked for details of three generations of her ancestors before moving ahead with her case. The caseworker said, "There is no way a person like her, who cannot gather evidence and documents, get justice." Another case worker shared challenges in ushering marginalized and illiterate survivors to redressal agencies. She shared that the survivors are expected to pay individuals or companies to write letters of complaint as public authorities hardly write those applications and letters for the survivors. The redressal mechanism, which requires survivors to present legal documents, produce written letters of complaint, and collect evidence, can easily restrict survivors from seeking service and support.

Preference for reconciliation over survivors' safety and wellbeing

A legal advisor of a judicial committee shared the story of a marital rape survivor who was sent back to her perpetrator husband by the committee despite the repetition of violence against her even after the judicial committee hearings. The survivor initially reported her husband's physical assault to the judicial committee. Upon further probing the matter, the committee discovered that the assault resulted from marital rape. The judicial committee has sent the survivor back home with the perpetrator by encouraging reconciliation, despite the fact that it is clear from the law that no rape case can be resolved through reconciliation and must instead be reported to the police and brought before a court. Just because the survivor has filed the case under the heading of physical assault and not marital rape, the judicial committee has been pushing for reconciliation. Similarly, another local representative shared a case where the survivor of domestic violence attempted suicide after being repeatedly sent back home with her abusive husband by the mediation committee of her ward since her husband wanted to reconcile. Tragically, the mediation committee still insisted to reconcile with her husband for their children's sake after she attempted suicide due to constant abuse.

In both of these cases, the survivors were sent back to live with their abusive husbands, who continued to abuse them during the redressal process. Only one of these two survivors got emancipated from the

abusive husband after inflicting such great harm on herself. Another is forced to live with the rapist husband, who got nothing more than a slap on the wrist from the redressal process.

Since the redressal mechanism is frequently found in choosing reconciliation over the safety and wellbeing of the survivor, the majority of our participants shared the sentiment of one participant reflected through this statement, "Even when we bring cases of violence out in public, report it to the police, it will be reconciled, and we are forced to return to the same house. We are repeatedly confronted with such violence." Such an unhealthy obsession with reconciliation at the cost of a survivor's wellbeing has discouraged many survivors from seeking help and justice.

Lack of survivor-centered and disability-friendly physical infrastructures

A representative of one of the OCMCs in our research area shared that they have been providing counseling as well as medical services in a one-room office. The participant reported challenges in ensuring the comfort and privacy of survivors even when the cases are highly sensitive. She is forced to take survivors, usually survivors of sexual assault, to the gynecology ward, coordinate with the department, and then finally arrange for a private examination room to conduct a primary medical examination of the survivor. In the absence of physical infrastructure with proper space and facilities, survivors and service providers face different troubles and difficulties.

Similarly, during our visit to one of the judicial committees, we found out that the committee has been operating from a single room which incorporates a hearing room, secretariat, as well an office of the legal advisor. Survivors are forced to dictate their plight in front of random strangers and unrelated parties who freely walk in and out of the room as they please. Sometimes, the strangers also stay back to offer unsolicited advice or comments on the discussed issues. Moreover, many public buildings lack infrastructures that ensure access for persons with disability to those spaces.

2.2. Rape Culture

The pushback from communities and even agencies in redressal mechanisms against legal provisions and structural arrangements to prevent GBV; active involvement of communities to protect perpetrators; the vilification of activists and individuals who push for justice; and similar activities are the result of rape culture. Rape culture is where sexual violence against women is seen as a normal occurrence and is accepted easily. However, this culture does not demonstrate similar tolerance towards those who attempt to hold the perpetrators accountable. Instead, it tries to police each and every aspect of the survivor or potential survivor's life and places the burden of preventing violence entirely on their shoulders. This study found that rape culture is deeply ingrained in our communities, preventing survivors of violence from accessing support and justice. The following are some ways in which rape culture manifested in our research areas.

Normalizing violence and blaming survivors

Participants reported GBV being trivialized and dismissed not just by their families and communities but also by personnel in the redressal mechanism. GBV was seen as a norm that survivors must either quietly

accept or completely alter their lifestyle just to reduce the chances of violence. This perception was familiar not just in communities but also in specialized agencies in redressal mechanisms. The degree of acceptance of violence as a norm was reflected well in a statement of one of our respondents, who said, “A female police once told me that getting one - two slaps or kicks from husband is normal; it isn’t domestic violence as such.” Though service providers are trained in some ways to address GBV, they are seen to be demonstrating a deeply ingrained rape culture that pushed survivors of violence further away from the redressal mechanism. Communities also actively protected perpetrators, coerced survivors to drop charges against perpetrators if they somehow managed to press charges, and even before that, created an unfavorable environment for survivors to share their experiences.

During one of our discussions with activists, a participant shared receiving unsolicited calls and sexual advances from a stranger with whom she shared a seat in a journey. Other participants in the discussion were quick to shame the participant for sharing her contact number with someone she did not know very well. None of the participants questioned the perpetrator’s behavior. Such scrutiny towards survivors’ behavior and no sanction towards the perpetrators were very common. Survivors faced such sanctions not just from the community but also from their families. An adolescent participant shared how her family scolded her constantly for being harassed and catcalled by boys in her locality. They blamed her clothing choices instead of the boys’ behavior. Similarly, another case worker shared a case where a teenager was raped by her uncle, and when she and her mother pressed charges against the perpetrator, they got boycotted by their family, even the father. Amid this backdrop, survivors were forced to silently endure violence or face additional violence in the course of their pursuit of justice.

Vilifying families, individuals, and institutions that reprimand perpetrators

Even though the redressal mechanism is very complicated for the majority of survivors, and their chances of being taken seriously become higher when case workers accompany them, they are vilified equally by their colleagues in redressal mechanisms and their communities. One participant shared, “Every time we take up cases against influential and powerful perpetrators, many people – even respected community leaders close to the perpetrators – start threatening us or influencing our families to stop us from pursuing the case.” Another participant added, “There are many rumors about us receiving large amounts of money for enabling survivors to bring perpetrators to justice, so they can easily discredit us and suppress our voices.” The activists pursuing justice in cases of GBV, especially cases related to violence from family, are labeled as home wreckers. Such practices discourage case workers and isolate survivors so they can be easily coerced to drop the case or reconcile with their perpetrators.

When rape culture is coupled with the aforementioned weaknesses in redressal mechanism, they form powerful barriers preventing survivors from accessing justice to GBV and essential public services that support their physical as well as the growth of the socio-political network.

3. Healthcare Facilities as Both Sites of Recourse and Violence

Gender-based violence is also a major public health issue since it has detrimental consequences on the health of an individual. Survivors of gender-based violence often suffer severe short-term and long-term

consequences, including physical injuries, mental health problems like depression, anxiety, and post-traumatic stress disorders, and are more prone to acquiring chronic conditions like hypertension (The Asia Foundation, 2021). They can also experience sexual and reproductive health problems, such as unintended pregnancy, other gynecological issues, sexually transmitted infections, Human immunodeficiency virus (HIV), and even loss of life. As a result, survivors of GBV require the use of health care services and resources.

Health services also constitute one of the most important sites for addressing GBV in both immediate and long-term responses. On the one hand, medical centers are often the first point of contact for care, as many survivors of GBV approach healthcare centers in the immediate aftermath of the event for treatment. On the other hand, survivors' medical records and other evidence gathered from such institutions constitute one of the most critical elements of any legal proceedings. Therefore, health care facilities are essential for attending to any injuries and ensuring recovery of the survivors, and their mechanisms are vital to address the violence through the legal and criminal justice mechanisms.

According to the Ministry of Health and Population, Nepal has a total of 6934 healthcare facilities, among which 4863 are public healthcare facilities (Ministry of Health and Population, n.d). Among these, the largest number of healthcare facilities, 3808, are health posts, compared to 125 hospitals throughout the country. This means women are statistically more likely to go to these health posts for primary care. These health care facilities can potentially provide a safe space for the survivors, where they can share experiences of violence and receive the necessary support. But the health care providers should ensure that survivors have confidence that they are in safe hands. Therefore, these health care facilities should be survivors centered and provide uniform and holistic care without discrimination.

3.1 Access to Healthcare

The Constitution of Nepal has guaranteed the rights relating to health as a fundamental right. It encompasses the right to equal access to health services and information regarding health treatments. Similarly, it stipulates women's right to reproductive health, including safe motherhood. The constitution also underlines the role of the states in ensuring the enjoyment of health services and facilities required at reproductive age.

Several other regulatory frameworks complement the constitutional provisions. The Public Health Service Act 2075 guarantees the rights of all citizens to access free health services, including those related to family planning, abortion, and reproductive health. The Right to Safe Motherhood and Reproductive Health Act 2075 explicitly highlights the right of all women and teenagers to access education, information, counseling, and service relating to sexual and reproductive health in a safe and acceptable manner. The act also accords individuals the right to choose reproductive health services. Likewise, the act makes several provisions to make family planning, reproductive health, safe motherhood, safe abortion, emergency obstetric and newborn care disability and adolescent friendly.

It also emphasizes the principle of non-discrimination, including that of gender and sexuality when receiving sexual and reproductive health. Similarly, it also requires local governments to appropriate necessary budgets for motherhood and reproductive healthcare at local levels.

A Lack of Women-Friendly Healthcare Facilities

Women are often discouraged from seeking healthcare due to the unavailability of gender-friendly services at health centers. Although the participants accepted that, at present, every ward had a health post, and healthcare was relatively accessible, these were not without problems. One of the study participants' most recurring issues was the lack of female doctors and female staff at healthcare facilities. While women were more likely to open up about their health conditions with female service providers, they were not comfortable sharing their health details with male doctors and, thus, were reluctant to seek their services.

Similarly, some participants also mentioned that adequate attention was not provided to health services that women required. As a result, in some places, women were not receiving all the services they were entitled to. For example, a participant from Dang district mentioned that uterine cancer and breast cancer were quite prevalent in the area. However, women had to travel to hospitals in other areas to receive these treatments due to the lack of specialized doctors and equipment in local healthcare centers. This caused a delay in treatment, sometimes at the cost of lives. Recognizing that women from rural areas had even more difficulty getting healthcare attention, some municipalities conducted health camps. However, these camps were found to be inadequate.

The physical infrastructures of the health service centers also posed a barrier for women. The lack of a separate consultation room sometimes compromised the privacy of women who were already hesitant with sharing their private health issues. Some participants preferred going to larger hospitals because they felt those places had the space and resources to make them comfortable and maintain confidentiality. However, this depended on women's economic backgrounds, which affected their access to quality health services.

Sexual and Reproductive Health of Unmarried Women and Adolescent Girls: A Taboo

Women often find it challenging to discuss their sexual and reproductive health issues as these continue to be associated with shame in our society. This is particularly true for unmarried women, for whom discussing sexual and reproductive health is considered taboo. Even participants who were married shared that it was difficult for them to talk about their sexual and reproductive health, especially to a male gynecologist. Some women even concealed issues like uterine prolapse, due to the unavailability of female health providers and other times due to the lack of awareness or feelings of shame. At the same time, patriarchal norms and values also pose a threat to women in seeking such health services, as pointed out by a participant who shared that she was asked for written consent from her husband, who was abroad when she went to get a permanent contraceptive procedure done at a government hospital in Morang.

Accessing these facilities is even more difficult for young women. First is the issue of information. For instance, a significant number of adolescent participants were unaware of the sexual and reproductive health services available in the local health care facilities. Young participants said that information on sexual and reproductive health rights (SRHR) at schools was also limited. Second, those who had the information also had negative experiences. The environment of the healthcare facilities was not supportive of young women and girls, especially unmarried ones. A participant noted that one of the first questions health care providers ask is about marital status and to ascertain if the patient is sexually active.

In a society where people cannot openly discuss their sexual and reproductive needs, these questions, although essential, can negatively impact the patients if posed incorrectly. Similarly, participants shared that health care providers can be rude and even scold young unmarried girls who come to seek help. They stated that when unmarried women come in with sexual and reproductive health issues, healthcare providers sometimes question their integrity or assume they are sex workers.

There is also a lack of trust in doctors among young women to keep their sexual life private or to understand the patient's perspective. A young participant shared that when they went to health posts, details of their personal life would be gossiped about in the entire village by the time they got home. There is little assurance from the health clinics that the patient's health details will remain private. Similarly, there are also not enough rooms for sexual and reproductive health consultations and counseling which puts the privacy of adolescents and young girls at risk. Young girls are also reluctant to seek service alone as staff looks upon them with suspicion or neglect because of their age. A young participant from Udayapur shared that staff in the health posts tend to disregard their needs unless they say their mothers sent them to the health post. They feel that their other health needs would not be taken seriously at all because they are mocked even for asking for sanitary pads. As one service provider participant pointed out, there are significant trust issues at government hospitals, as these places are public and young girls are afraid they might accidentally meet someone they know. This is evident in abortion cases as well. According to one informant, as government hospitals sometimes require a guardian as an insurer to accompany girls throughout the process of abortion, which is even more lengthy for unmarried women who can even be cited as ineligible, girls prefer to go to private hospitals, which can offer more privacy.

Gender-based violence survivors and physical and mental health care service: A need to build trust

Survivors of gender-based violence require both mental and physical support. However, in many cases, the incidents of GBV are brought to the local bodies like the Judicial Committee, especially when these are caused by known perpetrators where reconciliation via mediation is the first choice. Participants pointed out that cases of GBV are referred to health centers based on the severity of the physical abuse. Even if such cases are directly taken to the hospitals, the hospitals do not readily admit the survivors and ask for police reports.

When the hospitals accept cases, the survivors are provided with psychosocial counseling as well as physical treatment. However, fear of stigma often discourages survivors from seeking health services. Survivors frequently try to conceal their problems because they are unsure whether or not the service providers will understand or react negatively to them. A psychosocial counselor shared that survivors are also often afraid to share the details of their case or reveal their issues because they are worried they will lose their honor or tarnish the image of their families. They consider the cases of GBV to be a household issue, and as a result, they cannot open up or even ask for physical treatment. She added that, at times, women come seeking treatment for GBV, masking the actual physical assault with accidental injuries.

OCMCs are specifically designed to treat violence-affected patients where they are checked for physical injuries. However, patients cannot go to the OCMC directly but are referred to it via Outpatient Department (OPDs). Oftentimes, incidents of violence go unreported because the doctors are not trained to identify cases of GBV. Psychosocial counseling is also provided at the OCMC, while other organizations and

even local bodies in collaboration with different non-governmental organizations provide psychosocial counseling. Privacy is cited as one of the main issues when providing psychosocial counseling as local bodies and even health posts and OCMCs sometimes do not have adequate rooms to conduct such sessions. This can affect the quality of counseling and even impact trust among survivors. There is also a probability of gender discrimination impacting mental health treatment. One participant pointed out that mental health issues of men tend to be associated with workload and family responsibility, while mental health issues of women are seen to be the result of excessive sexual desire. This can create prejudice against patients, especially women, and result in misdiagnosis.

Healthcare services, and Persons with Disabilities and Persons from LGBTIQA+ Communities

People from minority backgrounds also find it challenging to navigate the healthcare systems. Many healthcare facilities are reported to lack the infrastructure to support persons with disabilities (Van Hess et al., 2015). Participants shared that most health centers did not have accessible physical infrastructures to assist the movement of persons with disabilities like ramps, tactile tiles, or lifts, and assistive devices like wheelchairs were also lacking. Other times health service providers were not accommodating of the needs of persons with disabilities. A participant from the Morang district who has an acquired disability shared her experiences visiting government hospitals in the area. When she asked for assistance, people not only refused to take her to the consultation rooms in the various wings of the hospital despite the fact that they were far apart and there were no wheelchair provisions made, but they also reprimanded her for complaining. She added that there are instances where medical examinations for people with disabilities are denied.

Similarly, most health centers also do not have facilities like sign language interpreters, which can impact access to health services. Another participant from Dang district mentioned a case of a 12-year-old girl with a hearing impairment who had come to seek health service with her mother. However, the service provider denied her mother access to the consultation room, depriving the girl of health services. A young child with disabilities was denied essential medical care because there was a lack of understanding of the needs of people with disabilities and the laws governing minors.

Likewise, people belonging to the LBGTIQA+ communities also face difficulties accessing healthcare services as they have many inconveniences accessing medical services. A lack of understanding of how to deal with persons from this community and the existing stigmatization of its members creates barriers to health services. The health needs of the people from the community were frequently disregarded, and they even faced harassment at the hands of health professionals, including being subjected to a barrage of pointless questions from doctors who were also reluctant to write them the necessary prescriptions. For instance, a participant from the Blue Diamond Society shared that when they accompanied their transgender identifying friend to the hospital for a non-sexual nature of health issue, the doctor asked them questions that were irrelevant to the existing condition, like if they as a transgender person had their period or if could have a baby or not.

3.2 Healthcare facilities as Sites of Violence

In addition to being a space for seeking services, health care centers can also be places where violence

occurs. Violence in medical facilities may be faced by both service seekers and service providers. Individuals engaged in the medical professions can abuse the power hierarchy between the service seeker and the service provider to make inappropriate advances and, at other times, engage in abusive behaviors disguised as medical interventions. Although the Government of Nepal has introduced the Sexual Harassment at Workplace (Prevention) Act, 2014 (2071), which has provisions for complaint mechanisms within the workplace, the implementation of the act has been weak.

Health Professionals as perpetrators of violence against patients

One of the most common experiences of harassment shared by participants was the one perpetrated by the male doctors. Instances of doctors asking to unnecessarily take clothes off, inappropriate touching of body parts, and seeking to examine parts of the body not relevant to the health issue were common occurrences. Cases of rape by doctors have also been reported. One participant from Udayapur mentioned a case in which a doctor sexually assaulted a woman who had come to seek help for her menstruation issues after learning that she had gone through menopause. However, when she shared the incident with her family, they refused to support her, and she had to resort to her relatives. Once the incident went public, the doctor shut down his clinic, but the case never reached the legal system.

Another participant, an adolescent girl, stated that the male doctor inappropriately touched her and asked her irrelevant questions under the excuse of changing her wound dressing. Similarly, members of the LGBTIQ+ communities face harassment from doctors who not only ask inappropriate questions about their sexuality but also laugh at or verbally harass them and are reluctant to provide necessary treatment.

Health professionals being harassed at the hands of co-workers

Health workers also face harassment in their workplaces, sometimes in the form of physical abuse and other times in the form of over-sharing. These experiences can be unfavorable and cause inconvenience for the female health workers and staff, and even disrupt their work. A participant shared that some male colleagues often sexualized the subjects of family planning and reproductive health at work in front of the female colleague who, citing discomfort, had to leave the place where such conversation occurred. Likewise, a female health worker's integrity might be questioned due to her dealings with a male patient. Another participant who worked as a psychosocial counselor shared that once, she had to stay in with a male patient longer than her usual patients. When she left the room, the staff mischaracterized the appointment and cast innuendos and aspersions.

Lack of redressal mechanisms

Despite such incidents of harassment being frequent at medical facilities, the mechanisms to address such violence are often weak or non-existent. Often, patients are afraid of facing reprisal or fearing their reputation will be at stake. So, they would rather avoid the hospital where they face such harassment and go elsewhere. A participant, for example, stated that she was asked to remove her clothes unnecessarily by a male doctor for contraceptive injection. Even though she wanted to resist, she could do nothing. And this was not a sole incident; several other women were affected by the doctor's behavior. However, the doctor stayed in the same place.

Other times, when co-workers harass healthcare workers, they tolerate such behaviors because either the hospital management changes often or they are not aware of mechanisms in place to address workplace violence. In some cases, survivors retaliated, like in the case of the participant from the LGBTIQA+ community who had accompanied their friend to the doctor and spoke against the doctor's unnecessary and inappropriate questioning, which eased their consultation procedure. But such cases remain rare and isolated, as patients are either unaware of any mechanisms to report such incidents or such complaint procedures are non-existing.

Healthcare facilities are important not just for providing health services but also for creating awareness about sexual and reproductive health rights and gender-based violence. However, they often fail to recognize incidents of GBV due to prevalent social norms, lack of resources, and even awareness of the legal and ethical responsibilities of GBV. Other times, these spaces themselves host perpetrators knowingly or unknowingly or enable an environment of harassment due to the lack of complaint mechanisms. Public spaces like health centers are essential in delivering just, inclusive and equal public services. They are also an important structure in addressing GBV. Therefore, all relevant parties, including policymakers, local bodies, and professionals, must pursue interventions to ensure that the country's health institutions function, keeping in mind the frequency of gender-based violence in public spaces.

CONCLUSION

Public spaces are common for each individual to access their rights to mobility and agency. It is also a common denominator for numerous crimes and violence. This study provided testimony on how public spaces can amplify GBV. Furthermore, it reflected a dire situation of girls, women, and marginalized gender rights in de jure and de facto aspects. Despite the socioeconomic and political changes in the nation, GBV still affects women, girls, and the marginalised gender. Deeply rooted patriarchal norms and toxic masculinity prevailed in all the structures of family, society, and state, which served as a barrier to the emancipation of women and girls.

The study found that the lacuna presented in defacto and dejure aspects can only be filled if the conversation of GBV is considered on a large scale beyond the peripheries of creating gender-friendly legislation. With the aid of the SNAP framework, the study found out that despite the gender-friendly legislation, without the implementation of that legislation, the changes are non-existent. Even when the legislation has been implemented, the changes would be regressive without the normative shifts in people's lives.

Therefore, the scope and dimensions of GBV must be considered in; urban planning, developing gender-friendly infrastructure, correcting the mindset of an individual by removing internalized misogyny, providing a forum for elected women representatives to act beyond the role of tokenism, creating a network and support for young girls and queer to reach out to their guardians, access and availability of health care and services in all frontiers for women, girls, and SGM.

RECOMMENDATION

Elected Women Representatives

1. State and political parties must value and respect the contributions that women have made to the social and political development of the nation and acknowledge that they have a right to lead.
2. Conduct and continue the social transformation campaign to ensure that the resources of their families, communities, and nations are fully accessible to women's representatives.
3. Create the infrastructures necessary to guarantee that those affected get the respectable assistance they require.
4. To support survivors, make sure that there are adequate human resources available, such as psychosocial counsellors and assitants who can assist with application and complaint writing.
5. Ensure women's proportional and inclusive rights to participation and leadership.

Healthcare Facilities as Both Sites of Recourse and Violence

1. Provide training to healthcare professionals to help identify potential survivors of GBV and ways to effectively and compassionately communicate with them.
2. Provide orientation to healthcare professionals to properly deal with patients from LGBTIQA+ communities, including seeking consent before asking personal questions.
3. Provide training to health workers on the rights and needs of persons with disabilities.
4. Build disability-friendly physical infrastructures like a ramp, tactile tiles, and braille signposts and also provide assistive devices like white cane and wheelchairs.
5. Train or provide sign language interpreters in healthcare centers.
6. Train service providers about the concept of consent and confidentiality.

   Build separate rooms for counseling to maintain privacy.
7. Provide training on legal provisions on GBV at the healthcare centers and appoint a GBV focal person.
8. Develop and implement complaint mechanisms on workplace harassment.
9. Ensure effective implementation of the Sexual Harassment at Workplace (Prevention) Act, 2014 and amend it to cover all forms of violence at the workplace.
10. All the informal sectors also need to be covered by the the Sexual Harassment at Workplace (Prevention) Act, 2014.
11. Provide more female doctors to ensure sexual and reproductive health rights of women and adolescents.

12. Provide specialized doctors and equipment to diagnose and treat sexual and reproductive health issues.
13. Provide training and awareness programs on mental health issues.
14. Increase public awareness of GBV and associated health risks.
15. Conduct awareness regarding sexual and reproductive health rights of adolescents for students, teachers, and parents.
16. Sensitize staff on the SRHR needs of adolescents.
17. Regularly monitor the quality and effectiveness of services provided to women and adolescents.

Ensure survivors' access to dignified redressal

1. Provide agencies in redressal mechanisms with necessary infrastructures, training, and support to offer competent, impartial, and professional services.
2. Create platforms that bridge the gap between service providers and clients, so people do not fear approaching agencies in the redressal mechanism.
3. Ensure that survivors have hassle-free access to the GBV Elimination Fund.
4. Ensure proportional representation of all communities in the redressal mechanism.
5. Offer additional support and resources to the survivors so they can pursue cases until they receive justice.
6. Simplify the redressal mechanism to make it survivor friendly for survivors from all backgrounds.
7. Encourage and safeguard caseworkers who support both survivors and the redressal mechanism.
8. Monitor agencies in redressal mechanisms to ensure they are not further perpetrating violence on survivors.
9. Increase gender-based violence awareness and education in society.
10. Counter rape culture deeply ingrained in our society through education.
11. Prioritize and appropriately address the complaints of survivors of gender-based violence if the survivor lodges a verbal or written complaint with a judicial body regarding the injustice.
12. Create and implement a social rehabilitation policy that protects the survivor's dignity.

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Questionnaire checklist

AWARENESS ABOUT GBV IN PUBLIC SPACES

- Can you please share with us your understanding of GBV in public spaces?
- Which public spaces are more prone to GBV and what are its types?
- Can you identify the survivors vulnerable groups?
- Who engages in GBV in public spaces? [Perpetrators]
- How is GBV in public spaces different from violence at home? [Probe a little on domestic violence]
- Why do you think GBV in public spaces exists?
- Are there any related social and cultural norms?
- What are the gender roles and historical accounts of discrimination?
- Are there any other possible reasons/causes for GBV in public spaces?

Questions for women-elected representatives

In addition to the above questions, also explore:

- Their understanding of public spaces.
- Their understanding of GBV [Beyond the general understanding of violence, sexual abuse, etc. Also examine if they realize subtle abuses in the workplace, such as differences in work priorities, responsibilities allocated, work freedom, etc.]
- Why do such practices exist? [Draw from social and cultural norms]
- How are they performing their job inside their workplace?
- Are they aware of their roles and responsibilities?
- Who makes a decision in their workplace (ward, Palika)? What is their role in decision making? How are their views/opinions/ thoughts taken in the ward /Palika and other public meetings? How does the community take their leadership?
- What is the reporting mechanism if elected women representatives are harassed or violated at work or any other public space? If there is a reporting mechanism, is it in practice? Do they report? If not, why?

Incidents/ cases of GBV in public spaces faced by different relevant groups (women, young girls, etc.)

- What is the general nature of cases experienced by vulnerable groups? [Question for the vulnerable groups with whom we will be interacting]
- Request examples, cases, or stories.

- What kind of cases related to GBV in public spaces are usually reported at your institution? [Question for the respective law enforcement agencies, government institutions, health institutions, etc.]
- Ask for examples/ cases/ stories
- Do the respective government institutions/ authorities think it is their responsibility to contribute towards mitigating/ curbing GBV in public spaces?
- With women elected representatives, explore specific experiences about work-place discrimination, abuse, and physical/ emotional/ psychological violence
- Request for examples/ cases/ stories
- Do they have information and access to different government funds, subsidies, GBV funds, government planning, budgeting, and other local government resources? If yes, explore? If not, what is the reason?
- Do they represent in different users /consumers committees? If yes, what is their role? Who makes the decision?

Health

- What is their knowledge of gender friendly services: Concepts, laws, government policies
- What was their experience of receiving services in their health institutions? How sexual and reproductive health issues (menstruation, pregnancy; before marriage, after marriage, abortion, contraceptives, uterine prolapse, virginal infection, white discharge) of girls and women, GBV survivors are responded to by the health workers?
- Do they have knowledge of Sexual Harassment at Workplace Act? Is the act functional?

ACTING UPON CASES OF GBV IN PUBLIC SPACES

Questions for vulnerable groups

- Can you share with us the organizations/ institutions that can be contacted/ relied upon in cases of GBV in public spaces?
- Ask individually about their trust in specific institutions like family, police, ward offices, municipality offices, health institutions, etc. [Trust in terms of anonymity, confidence that their issue will be heard and actions will be taken, etc.] *What does women and girls expect from service providers?
- Have you ever contacted these organizations yourself? If yes, can you please share your experience?
- If you have not contacted these organizations yourself so far, would you do so if you face such circumstances yourself? Why? [Ask which organizations/ institutions they would go to first]
- If you have not contacted these organizations yourself so far, do you know someone from your community or outside who has done so? Can you share with us some examples of how well the issues were addressed or not? *Are women and girls sanctioned by service providers for reporting/ not reporting the incidents?

- With women elected representatives, build on earlier discussion around their understanding and experiences of violence
- How do they react?
- If women elected representatives have ever reacted to discrimination (if any), what were their experiences? Are the male counterparts in the workplace receptive? Or do they usually dismiss?

Questions for institutional stakeholders

- What are the existing policies and practices towards addressing GBV in public spaces?
- What are the national policies and practices ?
- Whate are the local policies and practices?
- What are the institutional policies and practices ?
- How does your institution/ organization handle such cases?
- Can you give some examples?
- What are the referral mechanisms in place?
- Do they encourage seeking justice or reconciliation?
- Is the Sexual Harassment at Workplace Act functional?

Health:

- Respondants knowledge on gender friendly services: concepts, laws, acts
- How are they practicing gender friendly services in their health institutions? How sexual and reproductive health issues (menstruation, pregnancy; before marriage, after marriage, abortion, contraceptives, uterine prolapse, virginal infection, white discharge) of girls and women, GBV survivors are responded to by the health workers?
- Do they have psychosocial counselors or women health counselors?
- Do they have knowledge of Sexual Harassment at Workplace Act ? Is the act functional?
- What are their practices/plans for the development of gender friendly infrastructural development at the local level?

Questions for Elected women representatives

In addition to the above:

- About the mechanism in Judicial Committee regarding GBV
- About their roles in judicial committee for cases of GBV
- Their partnership with other bodies like the police and court
- Types/no of cases for reporting

- How many cases are resolved in judicial committee? How many go to courts/police?
- Who reports? Against whom?
- What do the "survivors" expect of judicial committee?
- Any sanctions to those reporting cases of GBV?

Questions for CBOs

In addition to the above questions, also explore:

- What are certain norms prevalent in the community that impacts GBV and create GBV/ and its reporting? (In public space)
- Who in the community supports/sanctions reporting of GBV?
- What happens if someone deviates from those norms?
- How does the community sanction "survivors"? "Perpetrators" in GBV?
- How do families sanction women and girls who report such cases?

CURBING GBV IN PUBLIC SPACES AT ITS ROOT/ BREAKING THE BARRIER

- In your opinion, what can be done to expand awareness about GBV in public spaces? [Beyond the general understanding of GBV as sexual abuse, domestic violence, discrimination, etc., increasing public awareness about subtle violence/ abuse – issues of prioritization, dignity, sense of self-worth, etc.]
- What root causes can be addressed and how?
- What tupe of Social and cultural norms and expectations exist ?
- What are the traditional gender roles that exist in your family and community?

RATER FORMAT to understand and evaluate norms change under SNAP framework

To be filled by researchers after each consultation

Respondent group: ____

Location: ____

Date of consultation: ____

AWARENESS ABOUT GBV IN PUBLIC SPACES

1. The respondent has good awareness about the commonly talked about/ reported GBVs (domestic violence, sexual abuse, etc.)

Strongly agree	Agree	Neutral	Disagree	Strongly disagree

2. The respondent has good awareness about subtle forms of GBVs (workplace discrimination, challenge in dignity and sense of self-worth, etc.)

Strongly agree	Agree	Neutral	Disagree	Strongly disagree

3. The respondent has good awareness about social and cultural norms resulting in GBV in general

Strongly agree	Agree	Neutral	Disagree	Strongly disagree

INCIDENTS/ CASES OF GBV IN PUBLIC SPACES

1. Respondent himself/ herself has experienced or witnessed instances of GBV in public spaces in their communities

Strongly agree	Agree	Neutral	Disagree	Strongly disagree

2. Based on the responses of particular respondent/ group of respondents, it can be understood that GBV in public spaces is rampant in the respective research location

Strongly agree	Agree	Neutral	Disagree	Strongly disagree

ACTING UPON CASES OF GBV IN PUBLIC SPACES - A (Applies only for the groups/ individuals likely vulnerable)

1. Respondent is knowledgeable about the referral mechanisms to address GBV in public spaces

Strongly agree	Agree	Neutral	Disagree	Strongly disagree

2. Respondent has full confidence upon the existing government institutions and national/ local policies/ mechanisms to address GBV in public spaces

Strongly agree	Agree	Neutral	Disagree	Strongly disagree

3. Identify the three most reliable institutions, as opinionated by the respondent *(Choose only three)*

a. Family

b. Police

c. OCMC

d. Non-government organizations

e. Health institutions

f. Ward offices

g. CDO office

h. Others (Please specify):

ACTING UPON CASES OF GBV IN PUBLIC SPACES - B (Applies only for service delivery institutions)

1. The institution has gender friendly environment and can be accessed in the case of GBV

Strongly agree	Agree	Neutral	Disagree	Strongly disagree

2. The institution is powerful enough/ has enough authority to investigate into and/ or prosecute perpetrators of GBV in public spaces

Strongly agree	Agree	Neutral	Disagree	Strongly disagree

3. The institution demonstrates readiness to remain at the disposal of victims of GBV in public spaces

Strongly agree	Agree	Neutral	Disagree	Strongly disagree

4. The institution has evidence of acting upon the cases of GBV in public spaces in past

Strongly agree	Agree	Neutral	Disagree	Strongly disagree

5. The institution needs capacity building, sensitization about GBV in public spaces

Strongly agree	Agree	Neutral	Disagree	Strongly disagree

CURBING GBV IN PUBLIC SPACES AT ITS ROOT/ BREAKING THE BARRIER

1. The respondent is knowledgeable about the root causes of GBV in public spaces

Strongly agree	Agree	Neutral	Disagree	Strongly disagree

2. The respondent realizes it is important to break the barrier and curb GBV in public spaces at its root

Strongly agree	Agree	Neutral	Disagree	Strongly disagree

3. The respondent has strong recommendations/ proposed solutions to break the barrier and curb GBV in public spaces at its root

Strongly agree	Agree	Neutral	Disagree	Strongly disagree

महिला पुनर्स्थापना केन्द्र, ओरेक
बालकुमारी, ललितपुर
पोष्ट बक्स: १३२३३ । फोन नं: ०१-५१८६०७३, ०१-५१८६३७४
ईमेल: ics@worecnepal.org | WOREC Hotline No.: 1660-01-78910
वेबसाईट: www.worecnepal.org

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