Sexual and Reproductive Health and Rights (SRHR)

Policy Brief

The purpose of this brief is to highlight the importance of sexual and reproductive health and rights of women in Nepal as well as to discuss the gaps and challenges in the policies and programs with a feminist perspective.

REPRODUCTIVE HEALTH is the absolute physical, mental and social well being related to the reproductive system throughout the life cycle.

REPRODUCTIVE RIGHTS are those of couples and individuals to freely decide the timing, number and spacing of their children, and to access information and care in all matters related to reproduction and sexuality.

SEXUAL HEALTH is a state of physical, mental and social well being in relation to sexuality throughout the life cycle.

SEXUAL RIGHTS includes the right to not be subjected to sexual violence.

.Adapted from ICPD Plan of Action

SRHR:

SRHR incorporates the rights of all people, regardless of age, gender and other characteristics, to make choices regarding their own sexuality and reproduction, provided that their rights do not infringe on the rights of others. Thus, it promotes reproductive decision-making; freedom from forced abortion; access to information and appropriate reproductive education; freedom from harmful traditional practices and gender based violence and freedom to express one's sexuality.

Since sexual rights entered mainstream human rights discourse in the early 1990s, it has tried to broaden the understanding of traditional human rights covenants to include sexuality-related issues; conceptualize sexual and reproductive health and rights; and articulate sexual autonomy and the right to pleasure.[1] "Autonomy is intimately and intrinsically connected with many fundamental human rights, such as liberty, dignity, privacy, security of the person, and bodily integrity."[2] It asserts the right of a woman to make decisions concerning her fertility and sexuality free of coercion and violence. The notion of choice, consent and confidentiality gets highlighted through reference to autonomy. However, the journey so far has not been effective due to the difficulties of reaching a political agreement among different stakeholders involved. The most widespread and institutionalized component has been the health and reproductive rights based articulations of sexuality.

In 1994, Program of Action adopted by 179 governments at the International Conference on Population and Development (ICPD) held in Cairo recognized the human rights of women, including their reproductive rights and health. This was a groundbreaking process as prior to this, the focus was mainly on family planning, fertility control and safe motherhood emerging from concern about population control. ICPD defined "reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents."The most noteworthy "consensus documents" are the Universal Declaration of Human Rights, and the Declaration and Program of Action of the World Conference on Human Rights, Vienna, June 1993.Others include "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" as guaranteed by Article 12 of the International Covenant on Economic, Social and Cultural

[1] Sexual Rights and Social Movements in India, Working Paper 2006, p.6.

[2] Carmel Shalev, Rights to Sexual and Reproductive Health - the ICPD and the Convention on the Elimination of All Forms of Discrimination against Women. Paper presented at the International Conference on Reproductive Health, India, March 1998.

Rights (1964) (ICESCR).Similarly, International Covenant on Civil and Political Rights (1964) (ICCPR) and the Convention on the Elimination of All Forms of Discrimination Against Women (1978) (CEDAW) are also relevant to the enjoyment of sexual and reproductive rights. The commitment was also reaffirmed in 1995 World Conference on Women in Beijing (1995) and other subsequent conferences.

Population Perspective Plan (PPP) 2010-2031 has been formulated with a multidisciplinary approach to integrate population aspects with economic and social mostly focusing on poverty reduction, gender mainstreaming, and social inclusion. The plan also attempts to address Nepal's commitments in endorsing plans of action related to population issues in various international forums, particularly the 1994 International Conference on Population Development and the 2000-2015 MDGs.

Ministry of Health and Population, 2010.

At the State level:

Nepal has endorsed International Conference on Population & Development (ICPD) (1994) Program of Action (PoA), Beijing Platform for Action (1995) and Millennium Development Goals (MDG) (2000). Similarly, it has ratified the Convention on the Elimination of Discrimination against Women (CEDAW) in 1991 without reservations and the Convention on the Rights of the child (CRC) in 1990.Thus, Nepal has committed itself to implementing programs on reproductive health, reproductive rights and sexual health. The Interim Constitution of Nepal has asserted that "Every woman shall have the right to reproductive health and other reproductive matters." 20 (2) It created a 'space' for women to demand and assert their health rights and control over their own body and reproductive lives. A full range of reproductive rights include but is not limited to access to health services, access to information/ education, freedom from abuse and other coercive actions. It includes everything women need concerning control over their body to live a life of dignity free from violence including State violence.

Of the Sixteen health policies which were introduced in the 1991–2011 period, the following are mostly relevant to impact women's health:

National AIDS Policy, 1995 (updated in 2011)
National Mental Health Policy, 1995
National Safe Motherhood Policy, 1998
National Nutritional Policy and Strategies, 2004
National Safe Abortion Policy, 2006
National Skilled Birth Attendants Policy, 2006
Policy on Quality Health Services, 2007
Free Essential Health Care Policy, 2008
Free Delivery Policy, 2009

Review of National Health Policy 1991, MOHP.

Some SRH problems:

- Sexuality is a taboo in Nepal which leads to a reluctance to discuss and address sexual health issues.
- Poverty and food insecurity limits women to assert their SRHR and forces them into practices which violates their right to bodily integrity.
- People are stigmatized if they do not conform to socially accepted norms of behavior, for example adolescents who have sex before marriage and people who articulate different sexuality.

- Mostly women are economically dependent on men, and have limited power to claim their SRHR. Due to unequal power relations based on gender, women are often unable to refuse sex or negotiate safe sex or access health services.

- Violence against women leads to violation of SRHR. Some traditional practices and beliefs also affect sexual health and access to services.

Sexual and reproductive health problems continue to affect the lives of women in Nepal.

Although it is important to move beyond the health oriented focus of SRHR, it should not be minimized as unimportant but should be supplemented further with socio-political analysis of power structures. Following points need to be noted.

- Girls in the age group 15-19(29%) who are already in formal marriage lack access to critical information on SRHR and related services.[3]

- 87% of women in Nepal would either like to delay the birth of their next child or want no additional children.[4]

- Unmet need for family planning for girls in the age group 15-19 is 42% and for 20-24 age group is 37%.[5]

- 25% of women of reproductive age in Nepal experience unplanned pregnancies.[6]

- 47% of girls who first had sex before the age 15 were forced against their will.[7]

- Only 29% of women have ever heard of emergency contraception and only 0.1 percent have actually used it. [8]

- 17 % of girls in the age group 15-19 have already had a birth or are pregnant with their first child.[9]

- 18% of women in the reproductive age are undernourished (BMI < 18.5 kg/m2) and 35 % in the age group 15-49 are anemic, nutritional deficiencies such as anemia is often exacerbated during pregnancy.[10]

- The median age at first marriage among women aged 25-49 is 17.5 years and the median age at first intercourse among women age 25-49 is 17.7 years which is slightly

[3] Government of Nepal, Ministry Of Health And Population, Population Division, Nepal Demographic and Health Survey, 2011, p.65.

[4] Nepal Demographic and Health Survey, preliminary report, 2011.p.10

[5] Nepal Demographic and Health Survey, 2011, p.104.

[6] Ibid.90.

[7] Ibid.239.

[8] Ibid.94.

[9] Ibid.83.

[10] Ibid.184.

high, suggesting that women in general initiate sexual intercourse at the time of their first marriage, with few exceptions.[11]

- Although maternal mortality ratio (MMR) in Nepal decreased between 1996 and 2006, from 539 to 281 deaths per 100,000 births, it is still very high.[12]

- Uterine prolapse affects about 10% of women nationally.[13]

- Unplanned pregnancies expose women to the risk of unsafe abortion. Unsafe abortion is the cause of up to 20-27% of maternal deaths in hospitals which is significantly higher than the global average of 13% despite the legalization of abortion in 2002.[14]

- Suicide accounted for 10% of deaths among women of the reproductive groups (15-49) in 1998 which increased to 16% in 2008/09.[15]*

- Data collection at the national level for rape cases are missing. The report by WOREC Nepal [16] gives a glimpse of this issue. Of the total cases of Violence against women analyzed from July 2011 to June 2012 a total of 110 of cases of rape and 36 cases of attempted rape were reported.*

- Similarly, according to Anbeshi 2012, there were 33 cases of human trafficking/transportation on women for the same time period.[17]

Sexuality and Rights

The issue of 'sexuality was ignored previously'. How we understand sexuality is very important in bringing rights into sexuality. This argument stresses that sexuality needs to be understood in the context of power and social relationships and not just in terms of disease prevention or violence.

Further, this argument establishes that sexuality should be articulated to incorporate aspects of "choice, pleasure, and dignity, as well as diverse understandings of the body, desires, and sexual preferences."[18] Additionally, it must be discussed within a broad

[11] Ibid.70.

[12] Ministry of Health and Population [MOHP], New ERA, and Macro International Inc., 2007.Nepal DHS 2011,p.119.

[13] Institute of Medicine, 2006). Nepal Demographic and Health Survey (DHS),2011,p.143.

[14] Advocating Accountability: Status Report on Maternal Health and Young People's Sexual and Reproductive Health and Rights in South Asia (Nepal), 2010.p.55.

[15] Pathak LK,Malla D,Pradhan A,Rajlawat R. Maternal Mortality and Morbidity Study(MMMS, 1998);Pradhan A, Suvedi BK, Barnett S, Sharma S, Puri M,Poudel P, Rai Chitrakar S, Pratap NKC, Hulton L, Maternal Mortality and Morbidity Study(MMMS, 2008/09).Family Health Division, Department of Health Services, Ministry of Health and Population, Government of Nepal, Kathmandu, Nepal; Pradhan A, Poudel P, Thomas D, Barnett S. A review of the evidence: suicide among women in Nepal. Options consultancy services Ltd, UKaid and UNFPA, 2011, p.10.

[16] Anbeshi- A Year Book on Violence against Women in Nepal, 2012, Worec Nepal. *It should be noted that most of the cases of rape as well as suicide do not get reported or are underreported for various reasons.

[17] Ibid.

[18] Sexual Rights and Social Movements in India, Working Paper 2006.

spectrum of issues that shape access to resources, opportunities and options for economic activity, livelihoods, and survival. Women's access to resources, opportunities and mobility are sanctioned through gender-biasness and social restrictions. Their sexuality is controlled in the name of chastity.

The present context is the best time to demand for sexual rights for breaking the deeply rooted silence around the issue. At the practice level of asserting SRHR, it should be underscored that the consequences of claiming rights in the name of sexuality should not further marginalize the minorities. It should create a 'space' for them to demand their sexual rights in a just and fair way. The aim must be to move beyond this argument: "a sex worker can access (rights discourse) as a victim, but never assert her right to sex work within it."[19]

SRHR, Poverty and Food Security

SRHR issues are overshadowed by persistent poverty and women with unmet basic needs and food security. The issue of food security affects the well being of women to the extent of having control over their bodies.[20] To address the linkage of food security[21] and poverty in line with SRHR, there should be proper linkage with policy makers to move in an integrated way with various ministries like agriculture, health and women's ministries for a holistic change. Unless the root causes are addressed to ensure better access to health and food women's conditions cannot be improved.

Issues raised during the civil society forum:

The social and structural change was felt as needed to facilitate the implementation of the SRHR policies. As mentioned by one activist, the real change will not happen if we don't change the way society thinks. It was felt that there was a need to speak clearly about sexual rights as the issue was silenced even in "progressive and politically correct spaces."

Sexual rights entail not just legal equality, but ability to exercise control/power over one's body according to one's choice. SRHR can be a strategic tool of challenging social norms that discriminate individuals who ascribe to different sexual behavior and practices than that of the predominant one. As mentioned earlier, it can create a platform where alliances can be made with various groups that have been vulnerable to abuse because of their identities for e.g., sex workers, entertainment workers and LGBTIQ etc. The issue of sexuality has not been prioritized even by the progressive groups in Nepal to the extent it should be due to continuous backlash by the fundamentalist view that uphold the dominant religious discourse on gender and

[19] CREA, SANGAMA, TARSHI. 2005. A Conversation on Sexual Rights, p.9. New Delhi: CREA

[20] Dr. Renu Rajbhandari, WOREC Nepal - Nepal Narrative of the on the linkages between poverty, food security and sexual and reproductive health and rights in Nepal and the Asia-Pacific region, Asian-Pacific Resource & Research Centre for Women (ARROW),2012.

[21] The three pillars of food security –i.e. "Food security is built on three pillars: Food availability: sufficient quantities of food available on a consistent basis, Food access: having sufficient resources to obtain appropriate foods for a nutritious diet", Food use: appropriate use based on knowledge of basic nutrition and care, as well as adequate water and sanitation. World Health Organization. (2012). Food Security. Trade, foreign policy, diplomacy and health.

sexuality. The future focus on SRHR should be able to create spaces for conversations to impact broader structures of power.

It has to be acknowledged that poverty impacts women and girls in terms of access to food and nutrition, access to education and access to other opportunities. The increasing data on suicide shows the unmet need for urgent intervention for a woman who is trapped in a situation where she has no recourse against violence, abuse and discrimination. Thus, SRHR should assure women suffering from violence a possibility to access justice.

The forum also discussed the impact of poverty to be predominantly structural in nature which denies women access to and control over resources and opportunities and as well as control over their bodies. Thus, SRHR in general needs to be analyzed in a broad context and dealt with through multi-sectoral approaches rather than with just a focus on health. The recent trend of the free market policies has also impacted women's bodies both negatively and positively. The lack of clear concrete policies magnifies the detrimental social consequences of migration. The increasing trend of male migration has added burden to the already heavy chores of women. Similarly, trend of female migration without effective gender sensitive laws and policies have increased vulnerability of women migrants to labor and sexual exploitation. It has also impacted the lives of those who are left behind. Thus, most women as well as the children are subjected to huge psychological and emotional problems.

Conclusion:

The paper concludes that SRHR should be strengthened to promote equality to women and the other marginalized population. Without SRHR all other human rights (civil and political, economic and social) have limited power to advance the well-being of women and vice-versa.

SRHR should incorporate the idea that sexuality must be critically analyzed with and within the discourse of power which controls individual's sexuality. This will help us to understand sexuality by moving beyond the issues of reproduction, health and violence to incorporate its other dimensions. Since previous focus does not exactly provide for sexual rights as an end in themselves, the need becomes to understand non-health focused understandings of sexuality and rights to enable conditions for social and sexual freedom. This way SRHR can help emphasize on the exiting articulations of human rights to be more inclusive.

It is not that poverty issues have not been raised before but a feminist analysis of poverty is needed integrating a larger agenda to explore ways to incorporate local realities and women's specificities for achieving the goals of ICPD. With this holistic vision it will be possible to assert SRHR. Furthermore, it must be supplemented with processes that lead to true human rights accountability and monitoring practices including access to remedies for sexual and reproductive rights violations.

Although policies are in place in Nepal, the implementation level is ineffective. The norms of sexuality embedded in State policies, laws and practices need change to ensure a space where women can assert their sexual and reproductive rights.

Recommendations:

- **Ensure access, availability, affordability and quality health services.**
  Safe and accessible reproductive health services (safe abortion, maternal health services, pre-natal care, emergency obstetric care, safe delivery and post-natal care, skilled birth attendants, maternity leave etc.) are needed and services should be guaranteed throughout the life-cycle.

- **Ensure appropriate reproductive education, information and services to all age groups.**
  Provide necessary package of sexual and reproductive health information and services. Ensure youth-friendly approaches that respect the right to confidentiality as well as specific approach to address the needs of older women.

- **Increase awareness regarding SRHR.**
  Awareness raising in community through engagement of people from different groups to help change the dominant views that are detrimental to women. This requires efforts to involve male members, elders, community leaders, traditional and religious leaders etc.)

- **Ensure proper implementation of relevant laws and policies.**
  Focus on the timely and effective implementation of laws that guarantee women their social, cultural, economic, civil and political rights while protecting SRHR of vulnerable groups (adolescents, unmarried young women and mothers, widows, single mothers, migrants, indigenous communities and those belonging to ethnic or sexual minorities, sex workers, and people living with HIV).

- **Demand measures to end impunity against VAW.**
  Impunity must be addressed through proper implementation of various plans and policies while providing women and girls with effective protection, access to justice and at the same time helping prevent VAW occurring in the first place.

- **SRHR needs to be dealt with through multi-sectoral approach.**
  To address the linkage of food security and poverty in line with SRHR, proper linkage needs to be established with policy makers from various ministries like agriculture, health and women's ministries etc.