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TRULY LEAVING NO ONE BEHIND: Ensuring Sexual and Reproductive Health and Rights for All in Nepal

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Introduction. In 2015, Nepal was amongst the 193 governments globally that adopted the 2030 Agenda for Sustainable Development and its 17 sustainable development goals (SDGs).[1] This development provides new advocacy opportunities for sexual and reproductive health and rights (SRHR), a critical issue in Nepal.

SRHR is covered in several goals and targets of the 2030 Agenda, the new universal global development framework to measure global progress on social, economic, and environmental dimensions which replaced the Millennium Development Goals (MDGs).[2, 3] The inclusion of various aspects of SRHR in the SDGs is crucial because it will serve as the benchmark for the next 15 years in improving access to critical services, information, and promoting individual autonomy.[4]

Why SRHR? Sexual and reproductive and rights (SRR) are intrinsic human rights, encompassing respect for bodily integrity; the right to choose one's partner; the right to decide on sexual relations without coercion, intimidation, violence, and discrimination; and having autonomy on when and how many to have children.[5] SRHR also includes the right to life with access to information and non-discriminatory services that are available and accessible.[6] Denying this

Notes and References

[1] United Nations, *Transforming Our World: The 2030 Agenda for Sustainable Development* (New York: United Nations, 2016), accessed July 11, 2017, https://goo.gl/VzfThq.

[2] These include goals 3 (Ensure healthy lives and promote wellbeing for all at all ages), 4 (Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all), and 5 (Achieve gender equality and empower all women and girls). Read more: Sneha Barot, et al., *Sexual and Reproductive Health and Rights Indicators for the SDGs: Recommendations for Inclusion in the Sustainable Development Goals and the Post-2015 Development Process* (New York and Washington DC: Guttmacher Institute, 2015), accessed July 11, 2017, https://goo.gl/HEa9R1.

[3] It should be noted that there are gaps in the 2030 Agenda, such as the exclusion of sexual rights, which needs to continue to be pursued through further advocacy particularly at the national level.

[4] Barot, et al., *Sexual and Reproductive Health and Rights Indicators for the SDGs.*

right to people represents a complete failure of a society and a governing body to understand and respect the essence of life.

The full achievement of SRHR for all is vital in achieving the global development agenda and in "creating a world that is just, equitable, and inclusive."Ensuring SRHR of all individuals has many positive impacts on individual, families, societies, communities, and the nation as a whole. It not only saves lives, but empowers people to make informed decisions.

The full achievement of SRHR for all is vital in achieving the global development agenda and in "creating a world that is just, equitable, and inclusive."[7] Ensuring SRHR of all individuals has many positive impacts on individual, families, societies, communities, and the nation as a whole. It not only saves lives, but empowers people to make informed decisions. This also contributes to significant economic gains; it has shown to improve productivity and increase rates of education, which lead to greater economic growth.[8] Moreover, sexual and reproductive rights are critical components of gender equality.[9] When women and girls do not have full access to SRHR, their ability to contribute economically, socially, and politically to their communities is severely constrained.

SRHR Issues in Nepal. Despite Nepal being in a decade-long armed conflict and its political instability, Nepal was able to make significant progress in achieving MDG 5, on improving maternal health.

For MDG target 5A (Reduce maternal mortality by three-quarters between 1990 and 2015), Nepal was able to make great strides in reducing maternal mortality ratio (MMR) from 850 maternal deaths per 100,000 live births in 1990 to 170 in 2013.[10] The main reasons for maternal death in Nepal is post-partum hemorrhage, followed by pre-eclampsia and eclampsia, abortion complications, obstructed labor, direct causes, and puerperal sepsis.[11] Half of the deliveries also occur at home without a skilled birth attendant.[12] These issues were addressed by various government-aided programmes and policies meant to assure the availability of services for women's maternal and reproductive health, such as the Maternal Incentive Scheme (2005), Safe Delivery Scheme Programme (2006), and the Antenatal Initiative Programme (2011). Additionally, under a policy on delivery by skills birth attendants (SBA), an estimated 4,500 SBAs were trained from 2006 to 2013, resulting in an increase in skilled birth attendance from 19% in 2005 to 50% in mid-2013.[13]

However, although Nepal was able to reduce MMR considerably, disparities among age groups and social groups exist and needs to be addressed. MMR is lowest among women aged

5 Universal Access Project, *Briefing Cards: Sexual and Reproductive Health and Rights (SRHR) and the Post-2015 Development Agenda* (New York: Family Care International, 2015), accessed July 11, 2017, http://goo.gl/KrJomg.

6 Carmel Shalev,"Rights to Sexual and Reproductive Health—The ICPD and the Convention on the Elimination of All Forms of Discrimination Against Women" (presentation, International Conference on Reproductive Health, Mumbai, India, March 15-19, 1998), accessed July 11, 2017, http://goo.gl/1jm9JA.

7 Universal Access Project, *Briefing Cards*.

8 Ibid.

9 Nurgul Djanaeva, "Gender Equality, Sexual and Reproductive Health and Rights, and the 2030 Sustainable Development Agenda: Moving Ahead at the National Level in Kyrgyzstan for Better Financing, Implementation, Monitoring, and Accountability," *ARROW for Change Supplement* (2015), accessed July 11, 2017, http://goo.gl/7epVWC.

10 Nepal National Planning Commission, *Nepal Millennium Development Goals: Progress Report 2013* (Kathmandu: National Planning Commission and United Nation Development Program, 2013), accessed July 11, 2017, http://goo.gl/JiDTLP.

11 Ibid.

12 Ibid.

13 Ibid.

20-34 years old and highest among 35 and under 20 years old. Among the social groups, Muslims (318) have the highest rate of MMR, followed by Madheshis (307) and Dalits (273). Janajati (207), Brahmins/Chhetris (182), and Newars (105) have the lowest MMR.[14]

For target 5B (Achieve universal access to reproductive health by 2015), Nepal was able to make progress in most of the indicators—reducing adolescent birth rate, providing antenatal care coverage, achieving CPR, and unmet need for family planning. The adolescent birth has decreased from 110 per 1,000 in 2000 to 70 per 1,000 in 2015. However, the data varies among development regions—east (66) and west (75) have lower adolescent birth rates than the central (88), mid—western (95), and far—western (93) development regions.[15] This could be due to inadequate implementation of progressive laws on child marriage. Child marriage has been illegal since 1963 in Nepal, and the minimum age of marriage for both women and male is 20 under Nepalese law. Nevertheless, according to Human Rights Watch, the government of Nepal is not taking significant steps to end child marriage, which has life-long ramifications in the lives of boys and girls.[16]

Antenatal care coverage (ANC) increased from 48.5% in 2000 to 73.7% in 2005 and to 85% in 2011.[17] Programmes like the Antenatal Initiative Programme (2011) provided incentives for mothers to complete four antenatal care visits, deliver in a health facility, and attend one post-natal care. However, this programme lacked consistency, as in 2011, only about half of the mothers who made a first ANC visit made the fourth visit.[18] Moreover, the data indicated disparity across development regions and mothers' educational status.[19]

The contraceptive prevalence rate (CPR) and the unmet need for family planning made the least progress. The CPR was stagnant; in the periods 2009/10, 2010/11, and 2011/12, it was 43%, 44%, and 43% respectively. CPR varies significantly between districts that are remotely situated and those that are more advantaged with easy access to facilities.[20] Likewise, the data for unmet need for family planning indicates variation between regions, with the lowest unmet need being among women residing in the hills at 41%, compared with women residing in the western region at 47.8%. As well, unmet need is highest among women aged 15-24 years old at 41.5%, indicating that adolescent and young people are the ones with unmet need for family planning.[21] CPR is a key indicator in monitoring and evaluating the government's family planning programmes, and an assessment on why these are not working needs to be done.

Perhaps a key reason is that the availability and accessibility of SRHR services remains a constraint. Many communities are often unaware of the above-mentioned initiatives due to lack of information dissemination. Health facilities are not always available where populations are concentrated, and it may take hours or even days to reach a health facility.[22] Quality is also an issue, as in many health care facilities, there are not enough capable staff

[14] Ibid.

[15] Jhabindra Prasad Pandey, et al., *Maternal and Child Health in Nepal: The Effects of Caste, Ethnicity, and Regional Identity: Further Analysis of the 2011 Nepal Demographic Health Surveys* (Calverton, Maryland, USA: Nepal Ministry of Health and Population, New ERA, and ICF International), accessed July 11, 2017, http://goo.gl/Fg9Yyv.

[16] Human Rights Watch, *Our Time to Sing and Play: Child Marriage in Nepal* (USA: Human Rights Watch, 2016), accessed July 11, 2017, http://goo.gl/gKA9t8·

[17] Nepal National Planning Commission, *Nepal Millennium Development Goals.*

[18] Ibid.

[19] The ANC coverage was 31, 56, 66, and 82% for no, primary, secondary, and post-secondary education respectively.

[20] Among the districts, Parsa had the highest CPR, fulfilling the indicator. Other nine districts, including Rautahat, Makwanpur, Saptari, Dhanusa, Sarlahi, Morang, Mahottari, and Lalitpur, had CPR between 55% and 67%. More than half (43) of the districts had a moderate CPR between 30% and 55 %, whereas the other 22 districts had a substantially lower CPR.

[21] Pandey, et al., *Maternal and Child Health in Nepal.*

[22] Nepal National Planning Commission, *Nepal Millennium Development Goals.*

to deliver maternity services nor are there enough frontline health workers to provide 24/7 services. Moreover, frequent power cuts and inadequate equipment and drugs means that the service may be barely functional. Additionally, most governments initiatives have focused on reproductive health and rights, and put less emphasis on sexual health and sexual rights.

A few issues like uterine prolapse, obstetric fistula, safe abortion, and *chhaupadi* have been neglected. Uterine prolapse and obstetric fistula are major examples of maternal morbidity in Nepal.[23] Uterine prolapse affects 10% of Nepalese women,[24] and is a result of overwork after delivery, insufficient recovery time between pregnancies, and inadequate child spacing, pregnancy at a young age, and demanding labor during pregnancy.[25] Women with uterine prolapse are stigmatised as they are considered 'impure,' and hence, many fear accessing health care.[26] A 2007 study by the Center for Agro-Ecology and Development reported that in Nepal, about 32% did not tell anyone about their condition. Of these, 66% cited embarrassment as the reason for their silence, while 10% believed it was a normal condition for a woman's uterus.[27] Likewise, obstetric fistula affects women physically, socially, and emotionally, as women face isolation and humiliation from family and friends. Currently, 4,362 women are living with obstetric fistula and there are 200-400 new cases in Nepal every year.[28] While obstetric fistula treatment has a 90% success rate, many women fail to attain services as they lack the information that it can be treated.

One of the ways to prevent these two conditions is to discourage child marriage and adolescent pregnancy. Adolescent mother's pelvises are underdeveloped, and the risk of fistula in girls aged 10-14 is estimated to be as high as 88%.[29]

The government of Nepal is making progress in laws and policies to assure availability and accessibility of abortion services. In 2016, the government of Nepal drafted a directive for free safe abortion services, although data on the implementation still needs to be gathered on its effectiveness. Additionally, a Reproductive Health bill has been drafted and is in a process of being approved by the parliamentarians. Nevertheless, challenges still remain. Even though abortion has been legalised since 2002, unsafe abortion remains an issue as it remains one of the reasons for high MMR. One of main issues seems to be the social acceptability of abortion. In many communities, abortion is considered as 'killing' and is a taboo. Many women are stigmatised from society for having an abortion and face various ramifications for attaining the services like exclusion from any cultural or festivals, alienation, and insults.[30] In some cases, the health care providers have an unfriendly attitude towards women who are seeking abortion, which also leads to women seeking services from unregistered health care centers or buying abortion pills without any prescription or seeking a counsel.[31]

Another issue that has been neglected by the government is *chhaupadi*, a harmful practice that affects women and girls where in women and girls

[23] Aleksandra Perczynska and Daniel Coyle, "Child Marriage as a Health Issue—Nepal Case Study," United Nations Human Rights Office of the High Commissioner, accessed July 11, 2017, http://goo.gl/b6nXXD.

[24] Bijoyeta Das, "Uterine Prolapse: The Hidden Agony of Nepalese Women," *Al Jazeera;* June 9, 2014, accessed July 6, 2017, http://goo.gl/1jffS9.

[25] Perczynska and Coyle, "Child Marriage as a Health Issue."

[26] Ibid.

[27] Bijoyeta Das, "Nepal's Menstrual Exiles," *Al Jazeera*, February 10, 2014, accessed July 6, 2017, http://goo.gl/oL54Xp.

[28] UNFPA Nepal, "Fact Sheet: Obstetric Fistula in Nepal" (Kathmandu: UNFPA, 2016), accessed July 11, 2017, http://goo.gl/Wfjdqr.

[29] Perczynska and Daniel Coyle, "Child Marriage as a Health Issue."

[30] Shanta Laxmi Shrestha and Aliza Singh, *Baseline Study Report: The Status of Abortion Stigma and Its Effect on Women in Nepal* (Kathmandu: INROADS and Beyond Beijing Committee, 2015).

[31] Ibid.

are kept in isolation sheds during their menstruation and childbirth. This stems from the harmful belief that women are considered 'impure' and untouchable during these periods, and hence are not allowed to touch anything or anyone. Due to lack of access or knowledge about products, such as sanitary pads, many women use reusable pads, which requires a clean source of water to wash, and which is not available during their menses. Additionally, after childbirth, women are required to stay in the shed, unwashed for 12 days after delivery until a purifying ceremony *(nwaran)* is performed, preventing them from being able to access the post-natal care services they need.[32] This tradition not only isolates women, but affects their mental health, nutrition, and hygiene.[33] It also puts women and girls at risk of attack from wild animals and sexual violence. Moreover, this practice violates women and girls' SRHR, as it views women's bodies as unclean and devalues them. It leads ultimately, to a wider disregard of women and girls,[34] and ultimately, to gender inequality. This ritual is very prevalent in rural areas, with 95% women following it in Achham district for example.[35] While the Government of Nepal has banned this harmful practice since 2005, there has not been a single case of punishment, fine, or reprimanding of perpetrators.[36]

Government Action for the Implementation of SDGs. Nepal has made progress in incorporating the SDGs in its 14th National Plan for three years and have identified priorities areas. There are two committees, the Steering Committee and the Implementation and Monitoring Committee, who are overseeing the implementation process of SDGs in Nepal. Additionally, in relation to SRHR, the new constitution itself has guaranteed this, stating, "Every women has a right to safe motherhood and reproductive health."[37] While the new constitution does not specifically say reproductive and sexual rights, one of the main progress in this front is the recognition of LGBTI rights in the new constitution.[38] Nevertheless, there are gaps. While the government has developed a Comprehensive Sexuality Education policy framework, it only addresses the health aspect, and not delivered as following a life cycle approach and rights-based comprehensive sexuality education (CSE). Moreover, scarcity of trained teachers for CSE is a big issue.[39]

Barriers in Achieving SRHR and the SDGs. There are three main barriers to achieve SRHR and the SDGs in Nepal—political instability and lack of accountability, the uneven implementation of existing policies, and inadequate financing for SRHR. These barriers are interlinked to one another.

Political Instability and Lack of Accountability. After a decade-long armed conflict, an interim constitution was adopted in 2007, but Nepal only promulgated the new constitution in September 2015. Nepal remains politically unstable. Since 1990, no government has completed its full term of five years as a prime minister,[40] and Nepal has just inaugurated its 25th prime minister in its 26 years of democracy.[41] In 2016, Nepal has changed its government for the 9th time in the last eight years, and there is a huge possibility of seeing another change in the

32 Nepal National Planning Commission, *Nepal Millennium Development Goals.*

33 Das, "Nepal's Menstrual Exiles."

34 Emma-Claire LaSaine, "Why Menstrual Hygiene Remains a Challenge in Nepal," The Borgen Project, July 31, 2015, accessed July 11, 2017, http://goo.gl/Erivv9.

35 Das, "Nepal's Menstrual Exiles."

36 Das, "Nepal's Menstrual Exiles."

37 Ministry of Law, Justice, and Parliamentarian Affairs,"The Constitution of Nepal," September 20, 2015, accessed July 11, 2017, http://goo.gl/NBP1w9.

38 Ibid.

39 UNFPA, "Fact Sheet: Comprehensive Sexuality Education in Nepal" (Kathmandu: UNFPA, 2016), accessed July 11, 2017, http://goo.gl/kDz6WA·

40 Peoples Review, "Political Instability Obstructs Economic Development," July 20, 2016, accessed July 11, 2017, http://goo.gl/yJnygC.

41 James Bennett, "Nepal Inaugurates 25th Prime Minister in 26 Years amidst Post-earthquake Delays," *Australian Broadcasting Corporation,* August 5, 2016, accessed July 11, 2017, http://goo.gl/jqa9gj.

government in the near future.[42] These frequent changes in governments hinder the country's development and economic growth, suppressing agricultural activity, and undermining the expansion of service sectors like tourism and finance. With the recent earthquakes, these have reduced the GDP growth rate to 3% in 2015.[43] Annually, about 300,000 Nepali, men, women, and youth migrate for work, driven by unemployment. Additionally, prioritisation of issues changes according to the government in power, which leads to lack of implementation of existing policies and laws, and lack of government commitment and political will. Frequent changes in government thus diminish accountability, as the question arises on who to hold accountable. To achieve the goals and targets set in achieving SDGs, political stability is indispensable.

Frequent changes in government thus diminish accountability, as the question arises on who to hold accountable. To achieve the goals and targets set in achieving SDGs, political stability is indispensable.

Implementation of Existing Laws and Policies. Political stability is required for the implementation of programmes so that these are not discontinued due to lack of commitment and political will from the government. Nepal has always been progressive on committing to various different policies, plans, and strategies, but implementation is challenging due to socio-political, cultural, governmental, geographic, and economic barriers. This is more obvious at the district level, where education and awareness on new policies, programmes, and strategies are absent. Additionally, there is often inadequate infrastructure and ineffective lines of responsibility to coordinate among governmental organisations and between agencies.[44] In some cases, where implementation plans are in place, monitoring and evaluation mechanisms are not.

Financing for SRHR. The Nepali government has reduced its budget for health, prioritising infrastructure more. For the fiscal year of 2017/2018, only NPR31.78 billion (USD30,862,288.94) has been allocated to health from the total estimated budget of NPR1.278 trillion (USD12,410,951,940). This is a reduction of 13.32%[45] from the last fiscal year of 2016/2017, when NPR36.66 billion (USD35,601,369.18) was allocated. This will mean inadequate financial support from the government to address health in general, and SRHR in particular. Adequate allocation of budget is required for SRHR services, education, and information for every terrain in Nepal and for all population groups. In many cases, due to geographical terrains, health care services and information are not available, so many women use local remedies instead of considering health care.

Financing is very essential to the implementation of SDGs as many strategies and plans have failed in the past due to lack of sustained funding. For example, during the period of the

42 Kamal Dev Bhattarai, "Nepal's Unending Political Instability," *The Diplomat*, July 26, 2016, accessed July 6, 2017, http://goo.gl/aVvbso.

43 Nepal National Planning Commission, *Sustainable Development Goals 2016-2030: National (Preliminary) Report* (Kathmandu: National Planning Commission, 2015), accessed July 11, 2017, http://goo.gl/4DekbG.

44 Ibid.

45 Rudra Pangeni, "Ministries Still Hesitant to Delegate Authority to Local Units," My Republica, May 31, 2017, accessed July 11, 2017, http://goo.gl/pwLZHX.

MDGs, there was a resource gap of NPR15 billion (USD1,456,684,500) between years 2011 and 2015 for MDG3.[46] With Nepal currently facing economic and environmental vulnerabilities, and with almost 50% of the Nepali health budget coming from international aid,[47] it will be difficult for Nepal to implement the SDGs without foreign assistance. The National Planning Commission has admitted that "Nepal must resort to international financing to meet the resource gap for financing the SDGs." It thus called on "developed countries to fully implement their official development assistance commitments, including giving 0.7 percent of GNI as ODA to developing countries of which 0.15 to 0.20% should be provided to LDCs."[48]

Recommendations. To be able to fulfill universal access to SRHR in Nepal for all by 2030, the government should use a holistic, life cycle approach, and invest in rights-based comprehensive sexuality education, as well as universal access to comprehensive, quality sexual and reproductive health services that are available, accessible, and acceptable. These services should include contraception, safe abortion services, maternal health (including promotion of regular antenatal check-ups and delivery by skilled birth attendants, and timely referral for management of life-threatening complications), and adolescent sexual and reproductive health services. These services should be also accessible even in times of conflicts, disasters, and other emergencies. The government also needs to train health care providers in providing counseling and to deliver any services without any prejudice.

Additionally, outreach programmes and other strategies should be developed to inform and reduce stigma for issues such as abortion, adolescent sexuality, uterine prolapse and obstetric fistula, as well as to foster affirmative views on sexuality. Women and girls should not be prevented from attaining services due to the fear of discrimination and stigma, and a conducive women-centered, youth-friendly environment should be established. Likewise, all policies that already exists and supports women's and young people's SRHR should be implemented and monitoring mechanisms should be established and laws such as the reproductive health bill needs to be enacted without delay.

To truly leave no one behind, the government needs to focus on garnering disaggregated data and utilise these data to form new strategies to reduce disparities. Only then can the challenges faced by marginalised groups—whether because of age, geographic location, socio-economic status, sexual orientation and gender identities and expression, caste, disabilities, and ethnicity, amongst other categories—in accessing services be addressed. The government also needs to focus on increasing the participation of women and youth, as they are the enforcers in bringing the SDGs into reality.

46 Nepal National Planning Commission, *Nepal Millennium Development Goals.*

47 Sudeep Uprety and Bipul Lamichhane, "Health Budgeting and Financing in Nepal: Policy Perspectives" (Discussion Paper), August 2016, Health Research and Social Development Forum (HERD), accessed July 11, 2017, http://goo.gl/F63ZMx.

48 Nepal National Planning Commission, *Sustainable Development Goals 2016-2030.*

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