

# Comprehensive reproductive health care services during COVID19 in Nepal: An analysis through Reproductive Justice Framework

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## Abstract

Reproductive health care services are fundamental human rights of every individual, which are also stated by various international instruments. Nepal is also part of these international commitments and has reflected its commitment in the nation's plan, strategy, and programs. Though significant efforts have been made to fulfill and improve the sexual and reproductive health care services in Nepal, women and marginalized communities are still deprived of the services. During the COVID-19 pandemic, the utilization of reproductive health services declined which is aggravating the situation and threatening to reverse the progress made so far. The article reviews the accessibility of comprehensive reproductive health services through the framework of reproductive justice during the COVID-19 in Nepal. Reproductive Justice is not only a framework for liberty for marginalized communities but also ethical guidance for policymakers and service providers.

**Keywords:** COVID-19, Sexual and Reproductive Health, Reproductive Justice, Nepal

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**Tweetable abstract:** Autonomy and utility of services among women and marginalized communities have been compromised creating unjust access to comprehensive reproductive health care during COVID-19 in Nepal.

## Introduction

Comprehensive Reproductive health care services include family planning services, maternal health services, prevention and appropriate care of Reproductive Tract Infections (RTIs), Sexually Transmitted Infections (STIs), Human Immuno Deficiency Virus (HIV) and Acquired Immuno Deficiency Syndrome (AIDS) and other sexual and reproductive health conditions, education, counseling and information on human sexuality, surveillance and appropriate referrals and diagnosis on Gender-Based Violence [1].

The poor health literacy, geographical barriers, unavailability of qualified health professionals and medical equipment are some of the reasons for poor utilization of reproductive health services by Nepalese women [2–4]. According to Nepal living standard survey 2011, 41% of rural households do not have access to a health facility and 79.6% do not have access to a public hospital within half an hour from their home [5]. According to Nepal Demographic and Health Survey (NDHS) 2016, only one in two married women in Nepal uses the family planning method while one in four married women have an unmet need for family planning. The median age for marriage for girls is 17.9 years and 17% of adolescent women age 15–19 are already pregnant or mothers [6]. Regarding, safe abortion services, only 38% of women are aware about abortion services [6]. Violence against women is considered a major public health problem across the world and in Nepal, 22% of women since age 15 have experienced violence at least once [6].

The term Reproductive Justice (RJ) was contrived in 1994 by a group of black women at a pro-choice health care reform at Chicago right before ICPD in Cairo which is now a gradually growing framework and tool which focuses to assemble both reproductive rights and social justice that identifies multiple oppressions intersects to result in reproductive oppression thus compromising social justice and human rights of women [7,8]. RJ is regarded as the exclusive power and ability of women and girls to make salubrious decisions regarding their bodies, sexuality and reproduction to achieve complete physical, social and mental welfare in all spheres of their life [9]. RJ aims at changing social and political systems and unjust practices with the purpose that every individual could experience reproductive liberty and public good (10). Existing systemic oppression, inequality, and inadequate effort from various stakeholders to provide comprehensive reproductive health care services of women can be solved through a comprehensive reproductive justice framework. RJ framework transforms individual and institutional efforts into a movement and makes the community aware of their rights and system (government, policymakers, service providers) about their duties to provide comprehensive reproductive health care services [11].

This article presents and analyzes available data and narrative regarding reproductive health care service during COVID-19 in Nepal obtained through research articles, newspapers and story sharing by people and organizations. This article further discusses through

these stories and information regarding how reproductive justice for women and marginalized communities during public health emergencies can be obtained using theoretical guideline and conceptual tools of reproductive justice such as: analyzing power dynamics, centering marginalized communities and identities and intersectionality (12). Thus, in this article, we present RJ as a framework that will help decision-makers for better ethical decision making and reduce ethical dilemmas to foresee comprehensive reproductive health as an urgent need during a crisis [7].

### **Situation during COVID-19 and lockdown**

In Nepal, a nationwide lockdown declared on March 24, 2020 in response to COVID-19 imposed strict measures where complete mobility restrictions imposed with the functioning of health services limited to "essential service" such as emergency medical service, and essential foods [13,14]. The government of Nepal shifted its complete focus on tackling the COVID19 situation due to which reproductive health care services were less prioritized during the COVID19 pandemic resulting in the reduced utilization of SRH services [15]. The fear of disease transmission has brought confusion among people to access the basic reproductive health services [16,17]. Many women and girls have been compelled to bypass their regular medical checkups because of fear of contracting the virus [18,19].

The first person who died from the novel coronavirus in Nepal was a postpartum woman of age 29 years during the period of nationwide lockdown [20]. At least 24 women have died as a result of birth related complications during the first two months of the nationwide lockdown and 60,000 pregnant women were deprived of health care [21,22]. Pregnant women faced roadblocks to access the routine antenatal care and delivery services [23]. A large number of women were compelled to give birth at home or die on the way to health facilities (22). Family Planning Association of Nepal (FPAN) has reported declined in safe abortion (53%), post-abortion care(55%) and family planning (47%) services during COVID-19. The reasons were limited hospitals services, increased bed occupancy, scarce logistics such as contraceptive devices, oral pills, misoprostol drugs [24].

The public health emergencies have had a harsh effect on the national HIV program of Nepal. Out of ever enrolled 34,822 beneficiaries, only 19,805 were on Anti-retroviral Therapy (ART) treatment in between January to June 2020 (25). This clearly shows that the utility of comprehensive SRH services during the COVID 19 pandemic has decreased creating unjust accessibility, allocation and distribution of information and services. The testing for Prevention of Mother to Child Transmission (PMTCT) services also declined between December 2019 and June 2020 [26].

This reflects reproductive health care of women was ignored and not prioritized by the Government of Nepal in its immediate emergency response, affecting women's reproductive autonomy. The complexities and intersectional social, political, economic and cultural issues brought up during the lockdown such as power dynamics, geographical topography, accessibility to service, gender discrimination, and denial of reproductive health care as "urgent need" all had the impact on SRH related indicators. The ethical urgency of prioritizing lockdown, quarantine and isolation and treatment of COVID-19 patients by the Government of Nepal has neglected prioritization of minimum essential service package for women and gender minorities.

### **Analyzing Health system through Reproductive Justice Framework Intersectionality**

Intersectionality respects commonality in experience (identity) and recognizes layers of systemic inequalities that hinder access to reproductive health care. As an imperative component of the RJ framework, intersectionality offers a theoretical and practical lens to encounter and analyze interlocking factors of oppression during COVID19 in the context of Nepal. The concept of intersectionality allows people to claim their identity and help people achieve human rights [7].

In Nepal, Marginalized women such as commercial sex workers, women with disabilities, Bhutanese women refugees, transgender community, etc. are more vulnerable due to systemic exclusion and find it harder to access service during the COVID-19 situation(27,28). The organizations working for the HIV-infected population provided door-door services however, lockdown made it hard for them to reach among HIV-infected people with services due to limited mobility and permits [29].

Less priority is given to fertility care services during public health emergencies though the incidence of infertility is found higher among young women aged 25-29 years and women from indigenous communities in Nepal (30,31). Women with infertility face social isolation at times fear losing marital relationships and sometimes violence-induced death(32). This also shows the reproductive health need was very different based on individual social status, gender role, economic status, sexuality, and politics during COVID19 situations. Nepal's effort to tackle COVID19 did not embrace an intersectional approach enough to reach the unreached and it is reflected through poor health system response, inadequate coordination between stakeholders, unavailability of disaggregated data and gender blindness in formulation and implementation of COVID19 guidelines and process. To tackle future public health catastrophes, it is necessary to reinforce the health system of Nepal and ensure the participation of marginalized groups during policy formation for procedural justice. Health Post, a basic health delivery point of Nepal, needs to be strengthened to deliver health services including comprehensive SRH services (onsite or referral) not to mention the capacity of the health care providers at a local level.

### **Analyzing power system and structure**

Power is the production of effect that shapes the capacity of people to determine their circumstances and fate [33]. RJ provides an opportunity to have fresh thinking about the powerful and powerless and guides better power dynamics to ensure comprehensive reproductive health care. Analyzing power system, structure and their dynamics reflects how the various structure of power such as legislative power,

judicial power and power system such as 'power to' and 'power over' affects reproductive health care for women and marginalized communities and how these power dynamics can be balanced.

The Government of Nepal released COVID and non-COVID Health Service Guideline 2020, the guideline has prioritized services for emergency, acute and chronic conditions, essential health service and ambulance service [34]. However, the guideline fails explicitly to promote beneficence of beneficiaries by prioritizing access to maternal care, gender affirmative health service, contraceptive service, safe abortion service and access to the sanitary products as guaranteed by Constitution of Nepal 2019 [35]. The Health sector emergency response plan also remains quiet and fails to guide Nepal's health sector to reach marginalized population with reproductive health care [34].

The Government of Nepal established COVID-19 Crisis Management Centre at the provincial and local level as an effective coordination mechanism to develop an action plan to address COVID-19 situation [36,37]. However, CCMC was not effective enough to recognize and decentralize comprehensive sexual and reproductive health services such as facilitate and mobilize resources, coordinate with health centers including COVID-19 hospitals and address complexities including supply of medical equipment, medical supplies and other goods [36,37].

Nepal government also implemented smart lockdown to address socio-economic hardships that were arisen due to lockdown during COVID-19. It did acknowledge the degree of vulnerability and provided greater flexibility, but it failed to mention women and marginalized communities in its justification section [36]. COVID-treatment care and chronic patient were prioritized during the hard lockdown and mixed lockdown mechanisms; however, no gender-specific, no marginalized focus plan to prioritize SRH service was mentioned. Though covid and other guideline prioritize pregnancy as emergency care, there are evidences where hospitals were reluctant to take new cases unless it was very urgent as suggested by the government, which reflects implementation gap though the policy was in place [15].

Interim guidance on Reproductive, Maternal, Newborn and Child health (RMNCH) during COVID-19 on paper has been an exceptional document to not only prioritizes RMNCH need but also proposes ways to deliver services during lockdown and crisis. It promotes home delivery practices through skilled health professionals, telemedicine services for obstetric care, surplus availability of medical supplies and equipment, safe mobility of pregnant women to obstetric care services and urges health care centers to prioritize RMNCH services [38]. However, evidences show different scenarios; maternal deaths were reported due to unavailability of a life saving drug misoprostol to manage postpartum hemorrhage to home births [39]. The scarcity of Personal protective equipment (PPEs) in hospitals added anxiety to pregnant women opting for institutional deliveries, resulting in delays to seeking services. This resulted in a 200% increase in maternal mortality during the 2-month lockdown period [22].

This reflect that the guideline on RMNCH merely remained within the documents failing in its implementation and that marginalized and vulnerable women were left behind to fight for their own lives with limited resources and access to the SRH services. However, there are some good initiatives from the Government of Nepal during the COVID-19 pandemic. For example, National Women Commission (NWC) together with community-based organizations provided legal counseling, psycho-social counseling and shelter support and reporting mechanism for those in need to stop gender-based violence during this crisis [40].

The gap in the current COVID-19 policy formulation and its implementation clearly shows the blurred vision of the Nepal Government to have a concrete implementation, monitoring and evaluation plan which could have facilitated access to SRH services and reaching those in need [41]. Reproductive health care service is not just a choice but also a matter of accessibility in reproductive justice. Thus, power structures within the healthcare system need to collaborate to ensure health care justice among the marginalized population during such unprecedented times. The government and Covid-19 Crisis Management Centre (CCMC). (Specify full form first) in particular could have mobilized transport entrepreneurs to ease the mobility of people to access health services at health institutions during the crisis to increase the mobility of people to ensure easy access to SRH care and service. Mobilization of the ever-increasing social enterprise providing reproductive health service and information, private hospitals providing uninterrupted service at affordable cost and private companies facilitating the supply of reproductive commodities could help the accessibility, affordability and feasibility of reproductive health care service and information. Moving forward it is important that government already start to mobilize Civil Society Organizations (CSOs) and the private sector to rebuild and restart the reproductive health care and services during post lockdown period [42].

Adoption of the ethical principle of no-wrongdoing (non-maleficence) while planning and providing service can support and guide political and bureaucratic decisions during such pandemic. Cost-effective analysis or cost-benefit analysis could be beneficial to understand if or not prioritizing comprehensive reproductive health needs centering marginalized communities during humanitarian crisis yield utility in health care service and delivery. Exceptional political solidarity, pragmatic, and strategic plans for crisis management, inclusion, and recognition of sexual and reproductive health care as essential service during public health emergencies and robust channeling mechanism to decentralize reproductive health service is necessary for Nepal.

### Centering marginalized women and identities

The final component centering marginalized women and identities reviews inclusiveness of marginalized population in national plan and service during COVID19. Women are a heterogeneous group. Their lived experiences and needs for SRH services become even more diverse when such identities overlap one another. Thus, it is essential to acknowledge heterogeneity and diversity within women while developing health service plans and delivery mechanisms [43].

According to the 2016 Nepal Demographic and Health Survey, a higher proportion of marginalized women delivered at home (47%) than non-marginalized women (26%)[6]. In Nepal, inequalities according to socioeconomic factors prevail in the utilization of health

services in maternal health. Women in the highest wealth quintile (85%) and the highest educational status (90%) were more than two times significant to deliver at a health facility compared to women in their counterparts with the lowest wealth quintile and educational status(6). Devkota et.al. reports that home delivery is associated with the low educational level of the mother and wealth status while the longest travel time to the nearest health facility also contributed to health delivery [44].

During the lockdown of COVID-19, the ventilators for neonates after the delivery were limited in government hospitals to access service and the private hospitals were too expensive to afford [45]. Women in the post-partum period who were dependent on their husbands' daily wages were bound to compromise on daily nutritional diet as their husbands were jobless due to lockdown(15). A study reports decreasing trend in the institutional births by 52.4% during the first two months of lockdown, and women from relatively disadvantaged ethnic groups were affected more than those in more advantaged groups, indicating a widening equity gap due to COVID-19 [46]. Unavailability of public transport and numerous health facilities and fears of Covid-19 transmission led to an upsurge of home delivery During COVID 19 and lockdown period, most of the women who delivered their baby at home were assisted first by untrained traditional birth attendants and traditional healers even in the presence of obstetric complications rather going directly to the birthing centers. These practices further delayed in seeking, reaching and receiving in time and put the women and newborns more at risk [32]. Nepal aims to reach the target set by Sustainable development goals 2030- decrease maternal mortality ratio to less than 70 per 100,000 live births by 2030 but the situation mentioned above would hinder to reach the goal.

The prevailing patriarchal society of Nepal emphasizes on males/ husbands decision over women/females decisions. In such situation, the rural and marginalized women have less decision-making rights which forces them to experience systemic oppression and inequalities thus compromising women's autonomy for reproductive information, care, service, right and justice (47). Only 23% solely makes decisions regarding their own health care [6]. Women face multiple challenges in accessing health care services such as lack of awareness about the facility providing services, the unpaid domestic work of women, financial barriers, lack of enabling environment, disrespectful care and long traveling time [48]. Reproductive Justice can be a key concept to promote equity acknowledging diversity and privilege within the group of women which instills individual freedom and choice related to SRH information and services ensuring the least harm even during pandemic situations. For this, it is important to prioritize, and center marginalized women, decentralize power and control over resources, meaningful engagement in decision making and capacity strengthening of marginalized women to increase accessibility to information and comprehensive SRH services. Nepal has poor data management resulting in limited access and availability of disaggregated data, which is a hindrance, to guide the evidence-based discussion to prioritize and emphasize effective and efficient strategies which are important to break the homogeneity of the issue and center marginalized women and communities [49]. Thus, disaggregated knowledge production and process of knowledge production centering marginalized women particularly during the public health pandemic is an urgent need.

## Conclusion

The evidence from the lockdown period clearly explains how autonomy and utility of service among women and marginalized communities have been compromised creating unjust access to comprehensive reproductive health care. Analysis of health system and situation through components of RJ has shown how intersectionality, centering marginalized communities and analyzing power structure and dynamics could help ensure the autonomy of beneficiary, reduce harm and produce maximum benefit. It also helps to distribute health care and does justice for those who are affected by the pandemic. The RJ fulfills the need for gender-sensitive discussion, and gender mainstreaming while planning and implementing comprehensive reproductive health services during emergencies' intervention thus centering marginalized individuals and communities. Thus, gender analysis and attitude to move away from the notion of 'urgent need' are keys to tackle the humanitarian crisis and its adverse effect among women and marginalized communities. This will support taking a stride forward to the commitment made regarding human rights, comprehensive reproductive health. If not, it won't take long to inverse the decade of progress attained in reducing maternal mortality ratio, increasing institutional delivery, increase in contraceptive prevalence rate, increase in ART enrollment and access to reproductive health care service by the country. This paper is based on articles and information available during the study period thus may not include recent data and information available. Primary researches are recommended to understand the impact and experience of COVID-19 among marginalized women.

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