

GAGE Digest

Policy and legal analysis notes: Nepal

A review of the National
Adolescent Health and
Development Strategy in Nepal

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Introduction

The return to multiparty democracy in Nepal in 1990 created the space for significant health sector reform, with a focus on adolescent sexual and reproductive health (SRH). Initially, this was driven by the need to control fertility rates and to address maternal and child mortality, given the links to child marriage. At a later stage, however, adolescent health was framed as a rights issue. The need to tackle social and cultural practices such as child marriage provided the impetus to policy-makers to consider adolescents' SRH needs.

To understand the policy context for adolescent health, wellbeing and bodily integrity in Nepal, we reviewed the National Adolescent Health and Development Strategy (NAHDS) 2000.¹

We used a political economy analysis lens to explore the policy adoption process and implementation challenges. We aimed to:

- identify the key actors driving the adoption of the NAHDS and what influenced them to adopt this strategy
- determine how the NAHDS adoption process was influenced by previous policy legacies, and by international ideas and national discourses on SRH rights and inclusion

- assess the extent to which the NAHDS has been implemented, highlighting points of resistance and blockages.

The research used historical process tracing methodology, consisting of stakeholder mapping of the NAHDS adoption process based on the information gathered from former officials and other experts, alongside a review of literature on adolescent SRH. Other activities included developing a timeline of the strategy, reviewing secondary documents and identifying key informants using a snowballing method. Interviewees included ministry officials, staff from national and international non-governmental organisations (NGOs), donors, academics and policy experts hired specifically for drafting the strategy. The analysis of available documents from the ministries, donor agencies and civil society organisations (CSOs) also helped to create a clear picture of the policy adoption process, the nature of resistance from different actors, and the gaps in implementation at national and subnational levels.

This note provides a brief summary of our findings. We draw some conclusions on the usefulness of political economy analysis for understanding the politics and the complexities of policy and legal change, and reflect on how this approach can support research and programming.

¹ The strategy has been implemented on a piecemeal basis and is currently under revision. This strategy was selected because it had: (a) a component that addressed violence against women and girls (VAWG); (b) clear links to two of the six capability domains (education and health) that the Gender and Adolescence: Global Evidence (GAGE) research programme is exploring; and (c) an established operational structure for implementation. Moreover, the choice of NAHDS was also informed by the programme intervention areas agreed at the time between GAGE and World Vision, focusing on sexual and reproductive health (SRH) rights and sex education in Nepal. GAGE is currently involved in an evaluation of World Vision's interventions in Morang district on the peer learning programme, Rupantaran ('transformation'), as well as Room to Read Nepal's Girls' Education Programme (GEP) in two districts (Nuwakot and Tanahun).

The story of the strategy (2000–2017)

Contextual factors

The adoption of the NAHDS and its subsequent revision resulted from positive shifts within Nepali political and policy space, and alignment of the interests of key players who were lobbying for this policy change.

During the 1990s, adolescents were targeted as a specific group under the health policy. This shift in targeting adolescents resulted from medical professionals having to deal with high rates of adolescent pregnancy and associated risks (abortion, maternal death) at the district level. As these risks related to adolescent pregnancy were discussed at policy level it led to shifts in how public institutions and the government began to view adolescents' health needs. Despite this shift in views, it was still difficult for officials from the Ministry of Health (MoH) to convince other government agencies and also the donors to invest in programming that specifically targeted adolescents. This is because Nepal also had competing health-care issues such as tackling HIV and AIDS, malaria, high rates of maternal mortality rates and child mortality. It was the National Reproductive Health Strategy (NRHS) formulated in 1998 that helped draw attention to adolescents as a group.

The National Reproductive Health Strategy had identified the need for an integrated reproductive health-care approach, and adolescent health was one of the components of its eight basic elements identified under this strategy. To implement the National Reproductive Health Strategy, the MoH formed two committees with representation from all line ministries and development partners, including a policy-level Reproductive Health Steering Committee (RHSC) and an implementation-level Reproductive Health Coordination Committee (RHCC). These committees played a crucial role in endorsing key decisions (such as guaranteeing adolescents access to family planning services, irrespective of marital status). The relevant line ministries (Population and Environment, Education, Women Children and Social Welfare, and Youth Sports and Culture) were tasked with designing programmes that would create safe and supportive environments for adolescents, together with strategies for their effective implementation.

How did the Strategic Plan evolve?

Nepal's participation in the International Conference on Population and Development (ICPD) in Cairo in 1994

helped to bring SRH issues to the forefront of the domestic health agenda. Preparations for the UN Conference on Women in Beijing (1995) also created space for interactions between policy-makers and women's rights NGOs, and for discussions on reproductive health in Nepal, including adolescents' needs. Alongside this opening up of the policy space, research produced by local CSOs also provided the momentum for framing adolescents' SRH needs within a rights-based approach, highlighting the importance of reproductive rights and making the case for focusing on adolescents as a distinct group. Opinion polls (for example, on the legalisation of abortion) were also used to create public space to discuss women's right to life and health. Studies by government agencies also highlighted the extent of the problem: for instance, one in four adolescent girls (aged 15–19) were already mothers or pregnant with their first child; teenage childbearing was common in rural and urban areas (MOHP, 2011). These reports stressed the need for adolescents to have better access to sexual health education, healthcare services and family planning measures, especially as adolescents are prone to high-risk sexual behaviour.

At the beginning of the last decade, the Nepal government also started implementing the Programme of Action (PoA) developed for meeting its commitment to the ICPD. This provided further impetus for delivering services to the adolescents. In order to fulfil its commitment, the government created three new ministries (Population and Environment, Women and Social Welfare, and Youth, Sports and Culture) – all of these ministries were identified as key players in the delivery of the strategy.

International development partners such as the World Health Organization (WHO), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), GIZ (German Development Cooperation) and the United Kingdom's Department for International Development (DFID) played a crucial role in supporting the Nepal government to develop strategies to address fundamental human rights. These gradual but steady shifts in national and international discourses helped to create a conducive environment for the development of the NAHDS.

What does the strategy include?

The NAHDS' main objectives were to increase availability of and access to information about adolescent health and development, increase access to and uptake of counselling services, and provide opportunities to sensitise adolescents, service providers and educators. After the

strategy was endorsed, the Family Health Division (FHD) developed a technical implementation guideline in 2001.

The strategy and its guidelines have been revised over the years because of new laws passed that pertained to women's rights or health-care provision. The guidelines have also changed based on the results from piloting different projects. The revised strategy includes provision of abortion services to unmarried adolescents, which is unusual for a country like Nepal. This was not initially included in the strategy as the Abortion Bill was still under consideration in the Parliament. Any changes made to service provision under the proposed law would have to be addressed by the strategy. However, both the Abortion Bill and also subsequent changes proposed about the provision of government services for abortion was opposed by Christian and Hindu religious groups. However, the strategic use of evidence by the women's movement and health-sector actors served to counter resistance during parliamentary debates. CSOs also played a critical role by conducting research and drafting legal documents, which ultimately convinced policy-makers, politicians and disgruntled groups to endorse the bill. The Abortion Bill was finally passed in 2002. The law allowed for provision of abortion services for unmarried adolescents. It also identified adolescents over 16 years of age as autonomous agents who did not require parental permission to access those services.

The government has been implementing the strategy through various pilot programmes and decided to expand adolescent SRH as a pilot programme in 26 districts in the Mid-Western and Far-Western regions in 2007, and as of 2015, it was providing services through 1,034 adolescent-friendly clinics in 70 districts (UNFPA, 2015).

At present, the Adolescent Health Unit of the FHD is in charge of implementing the National ASRH Programme which is the key programme for implementing various components of the strategy. Since ASRH is a multi-sectoral programme, the government has made some strategic interventions to create an enabling environment for adolescents through three major programmes, in close coordination with the line ministries:

- adolescent-friendly services (AFS) in public health facilities
- comprehensive sexuality education (CSE) in schools
- the Rupantaran programme for out-of-school adolescents and community interventions for key stakeholders.

Key findings

Our political economy analysis reveals the following key findings.

Key actors

- The development of the 2000 NAHDS was led by the Family Health Division (FHD), part of the Ministry of Health. Interviews indicated that certain individuals in leadership positions in the FHD played a pivotal role in delivering the strategy. Government action was largely motivated by the need to tackle maternal deaths, address demographic shifts, and to portray Nepal as a 'modern' country. It also needed to be seen to be making progress on adolescents' needs in order to secure donor funds.
- Donors have been influential in promoting the adolescent SRH agenda in Nepal, particularly DFID and the United States Agency for International Development (USAID), UNFPA and WHO. GIZ, DFID and the European Union (EU) played a key role early on, with funding for pilot projects. Save the Children Nepal, UNFPA and WHO played a key role in the subsequent revision of the strategy.
- Nepal's federal restructuring is likely to increase uncertainty and exacerbate challenges around implementation of the NAHDS, since there are no clearly defined coordination and collaboration arrangements in place among the central government, seven provincial governments and 753 local governments.

Influence of international discourse and events

- The international discourse on reproductive rights and various international conferences influenced how the adolescent SRH rights agenda was framed in national policy circles. These also provided the impetus for the government to act. The ICPD and the Programme of Action adopted in 1995 in Beijing were catalysts for the paradigmatic shift on the issue of adolescent health and development internationally, and also in Nepal.
- The Maoist insurgency and post-conflict transition opened up space in Nepal for discussion on rights and inclusion. The MDGs and SDG discourses also influenced how key actors approached the revision of the strategy, with donors introducing a framework aligned with the UN's Global Strategy for Women's, Children's and Adolescents' Health. This allowed for the development of an accelerated framework for member

states such as Nepal to achieve the SDGs, especially in relation to women, children and adolescents.

Implementation (including operational architecture)

- In 2015, the Ministry of Health and Population revised the NAHDS to include the broad principles and framework of action provided by the UN Global Strategy for Women's, Children's and Adolescents' Health (2016–2030). The revision was also partly needed as an initial step for implementing the 2030 Agenda for Sustainable Development in Nepal. The government argued that though the NAHDS and adolescent health programmes had been developed and implemented, satisfactory progress had not yet been made. The revised NAHDS acknowledges the diversity of adolescents' needs, based on their location (rural/urban), class, and caste and ethnic background. (At the time of writing, the revised strategy has not yet been endorsed by the MoH due to frequent changes in personnel.)
- The initial focus of the NAHDS was on developing implementation guidelines and identifying key actors to implement it. Pilot projects were necessarily piecemeal and limited in scope. Implementation was problematic because of resource gaps as well as the failure to retain skilled personnel. Changes in the political context, which slowed down the processes for developing implementation mechanisms, also seem to have played a part.
- Despite extensive guidance available intended to ensure that adolescent-friendly health centres provide confidential, non-judgemental counselling and services, the attitudes of some health personnel towards adolescents seeking SRH support continue to act as a barrier (particularly to girls seeking abortion services).
- Coordination with the Ministry of Education (MoE) on implementing sex education programmes in schools – a key part of the NAHDS – proved to be challenging. The MoE had introduced basic sex education (grades 6–10) but there was little movement towards including elements of the NAHDS strategy. In 2013, the sex education curriculum was revised to incorporate information on adolescent sexuality and SRH. However, overcoming ingrained conservative norms and

attitudes to sex and sexuality also proved challenging at a variety of levels. For instance, teachers (often male) were too embarrassed or uncomfortable to teach the subject, especially to female students.

Challenges

The adolescent SRH programme faces financial as well as programmatic challenges, exacerbated by other contextual factors, including the following:

- Health workers in adolescent-friendly centres are not adequately trained, and lack resources to upgrade the facilities to ensure privacy. There is insufficient monitoring and supervision of the services these centres provide. There is also a need to take into account the increasing use of the internet and social media and the diverse nature of the adolescent population in Nepal, to develop effective outreach and communications programmes that address the needs of urban and technology-savvy adolescents as well as those in remote rural areas.
- Funding remains a major barrier to effective implementation. Government funding for such programmes has always been scarce; the bulk of funds for adolescent SRH comes from external partners, which undermines sustainability given shifts in donor funding strategies.
- There is a lack of coordination between line ministries and lack of clarity on roles and responsibilities of each ministry. There are tensions between the Ministry of Health and Population and the Ministry of Education over who will pay the salary of nurses in schools, and over their respective roles in menstrual hygiene management. Within the new federal system, implementation will be even more difficult because basic primary health-care services and resources will fall under the purview of local government.
- Recent shifts in state–donor relations may influence how the NAHDS is implemented. Although the state is dependent on donors for funding, government interviewees expressed some unease, stating that donors have their own agenda and prevent the government taking the lead. The delay in approval of the revised NAHDS also indicates the government's apathy towards adolescent health issues.

Conclusion

The NAHDS has had successes, albeit limited, in the nearly 19 years since its launch and subsequent development of implementation plans and programmes. There have been gains in adolescent health and development from a human rights perspective, with increased access, changed behaviour and creation of enabling conditions. There is also greater recognition of the importance of adolescents' SRH rights. However, based on our political economy analysis findings, we anticipate a range of challenges – governance, programmatic and financial – in the implementation of the strategy.

- Programme design needs to take into account the new provincial structure, involving new sets of actors in charge of SRH rights and issues at the district level. Nepal's recent transition to federalism and consequent decentralisation also present obstacles for the operationalisation and eventual implementation of the revised strategy, as there are no clear guidelines yet. It remains to be seen how adolescent SRH issues will be incorporated in the new structures at local level; but as the revised strategy has ensured greater integration in and alignment with international treaties and standards – coupled with decades' worth of groundwork already in place – it could have positive and life-changing impacts on adolescents in Nepal. There may be lags in assigning key personnel to relevant posts and also in terms of division of clear authority and power among actors at the sub-national and national levels. However, there is also scope for greater impact at local level through engaging with local governments, given that they will have extensive powers for setting priorities and designing programmes.
- At the national level, for gaining traction from government on adolescent SRH rights, the FHD remains a key player. Our analysis indicates that resistance within government around promoting bodily integrity and sexual autonomy for adolescents could be reduced

through strategic and instrumental framing that puts adolescent health and maternal mortality centre stage. A key area of intervention would be to change attitudes and social norms around how SRH is approached by state agencies at both the local and national levels.

- Conservative social norms limit the influence that can be wielded by the FHD, donors and health experts over certain agendas, particularly sex education in schools. Innovations that focus on communicating with adolescents on sex education would be welcomed by the state, and there is interest in this within the MoE nationally, but resistance remains at implementation level. Moreover, generating evidence is important for Nepal, as the agenda for inclusion in SRH rights gains momentum but remains inadequately translated in implementation, despite being mentioned in policy.
- Development partners and researchers will have to carefully navigate existing tensions between state agencies (though these seemed relatively less within the FHD and MoH) and donor agencies, and how they present or position themselves to different bodies in Nepal – including at the subnational and local levels.
- Apart from providing evidence and technical advice, CSOs have played only a limited role in the adoption and implementation of the NAHDS. Development actors should consider what kinds of partnerships they want to develop, at local and subnational levels, to build alliances, and at the national level for advocacy (which may mean reaching out beyond health research organisations).

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