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Emerging Challenges in Family Planning Programme in Nepal

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ABSTRACT

Family planning is a priority program of the Government of Nepal. Despite political instability in the last two decades, Nepal has achieved remarkable progress in the overall status of reproductive health, including family planning. Married women of reproductive age have been increasingly using contraceptive from 1980s to2006. However, Nepal Demographic Health Survey 2011 has shown unexpected results on contraceptive prevalence rate. There had been a notable decline in the prevalence rate between 2006 and 2011, creating concerns among various stakeholders working in family planning programs. This paper analyzes this situation and identifies possible reasons for the stagnated contraceptive prevalence rate in Nepal. High proportion of spousal separation, an increased use of traditional methods, abortion, emergency contraception, and a lack of innovative approaches to cater services to difficult-to-reach or special sub-groups are possible reasons. To improve the contraceptive prevalence, the family planning program should be implemented more strategically. Further data analysis, initiation of best practices to fulfill family planning needs of special groups, functional integration of family planning services into general health services, effective counseling and behavior change communication to prevent unwanted pregnancies, and increased access to modern family planning methods could be the stepping stones to improve contraceptive prevalence rate and the overall FP program in Nepal.

Keywords: abortion; emerging challenges spousal separation; emergency contraception; family planning; Nepal.

INTRODUCTION

The family planning programme started in developing countries in the 1960s to enhance prospects for socioeconomic development by reducing population growth.[1] In Nepal, the concept was introduced in the same period. Since the beginning, the Government of Nepal (GON) has implemented various approaches to fulfill family planning needs of individuals and couples. Family planning is now an integral part of the health system of Nepal. Despite political instability and armed conflict in the last decade, Nepal has made remarkable progress in the use of modern contraceptives methods, especially during the period between 1996 and 2006.[2] Nepal has received international awards for improving its maternal and child health status.[3,4] However, Nepal Demographic Health Survey *2011* has shown unexpected results on contraceptive prevalence rate (CPR). Although CPR of all methods increased from 48% in 2006 to 50% in 2011, there was a slight decrease in CPR of modern methods from 44.2% to 43.2% during the same period.[2] The sudden break in the momentum of CPR was a cause for concern for stakeholders working in this area.

This paper, last in the six article series, aims to identify possible factors for this decline and ways to address them for better results.

LITERATURE REVIEW

Secondary desk review was conducted for this article. Authors looked at published documents, reports, journal articles, as well as relevant websites.

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Current Family Planning Service Delivery System in Nepal

Family planning (FP) is a priority programme of the Ministry of Health and Population (MoHP) and a component of the reproductive health package and essential health care services of the Nepal Health Sector Program II (2010-2015).[5] FP services are available through government, social marketing, and private health facilities and are available free of cost in public health facilities. Currently, temporary FP methods (male condoms, pill, and injectables) are provided on a regular basis through health posts, sub health posts, primary health care Outreach Clinics, and periphery level health workers and volunteers (condoms and resupply of pills). Methods such as IUCD and implants are available at selected hospitals, primary health care centers, and health posts where trained human resource is available.[6] Depending on the district, sterilization services are provided at static sites or through scheduled "seasonal" or mobile outreach services. Almost all district FP maternal and child health (MCH) clinics supply all temporary FP methods.[7]

FP services are also available through social marketing at subsidised rates through different outlets and available free of cost in select clinics and hospitals managed by non-governmental organizations. Private clinics and hospitals also provide paid FP services.

Review of Family Planning Programme in Nepal

There are a number of indicators to measure the progress of the family planning programme, however, the MOHP has selected three impact indicators; total fertility rate (TFR), adolescent fertility rate (AFR), and CPR as a part of the Millennium Development Goals (MDGs).[5] The MOHP aims to reduce TFR from 5.3 to 2.5 children per woman from 1991 to 2015 and adolescent fertility rate from 127to 70 per 1000 adolescents from 1996 to 2015; and increase CPR from 24 to 67 percent from1991 to 2015.[5] This article will analyze the situation of the family planning program in Nepal primarily in relation to the above three indicators, but not limiting to them shows the trend in CPR over time. CPR increased from 3 percent in 1976 to 48 percent in 2006 (Figure 1).[8] However, after 2006, it has remained constant. The NDHS 2011 has shown CPR to have increased marginally to 50% for all methods, while a small decline was observed in CPR of modern methods, indicating difficulty to achieve the target of 67% by 2015.[2]

AFR was 145 per 1000 adolescents in 1976, reducing to 127 by 1996, 98 by 2006 and 81 in 2011.[2,10] If the current trend continues, Nepal will achieve the MDG target to reduce AFR to 70 by 2015.

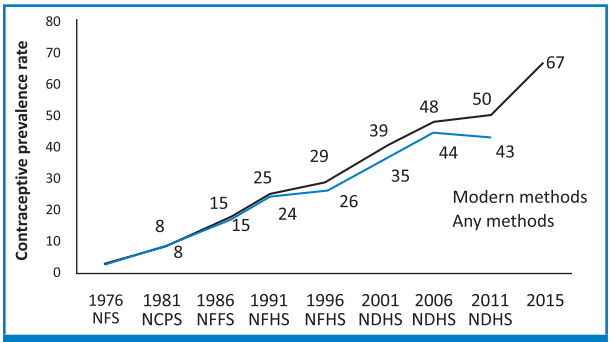

Figure 1. Contraceptive prevalence rate (1976 - 2011)[2,8,9]

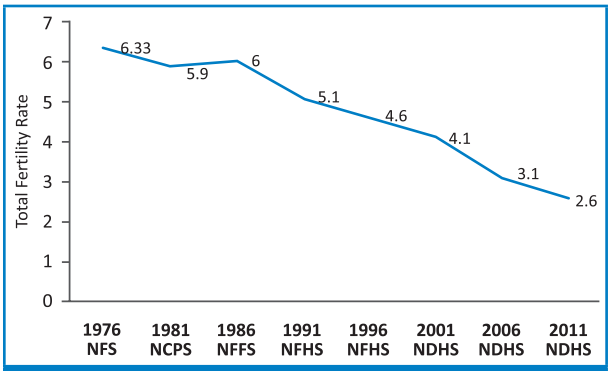

Figure 2. Trends of total fertility rate in Nepal, 1976-2011[2,8,9]

Nepal had high TFR until 1991, after which it declined from 5.09 to 2.6 in 2011, indicating that Nepal is likely to achieve the MDG target of 2.5 by 2015.[2]

There has been improvement in method mix. In 1986, the proportion of VSC to spacing was 84% to 16%.[9] In 2011, the ratio had changed to 46% to 54%.[2] Despite these positive changes, female sterilization is still the most widely used FP method, but the use of IUCDs and implants is still very low.

The percentage of planned pregnancies is increasing: according to the NDHS 2011, 74.4% (three in four births) in the five years preceding the survey were planned, 12% were mistimed, and 13% were unwanted.[2] The level of knowledge of at least one modern FP method in Nepal is almost universal among both women and men.[8] However, a more comprehensive knowledge on family planning methods is still limited.

In addition to the above indicators, there has been a steady decline in the preferred number of children. The mean ideal number of children among currently married women over the last fifteen years decreased from 2.9 children in 1996 to 2.1 children in 2011. Nationally, the proportion of teenage pregnancies declined from 24 percent in 1996, 21% in 2001, 19% in 2006, and to

17% in 2011.[2] Birth interval increased from 32 months in 1996, 34 months in 2006, and to 36 months in 2011,[2,8] showing that individuals or couples in Nepal desire fewer children and use spacing methods.

Unmet need is another important indicator of the family planning programme. In Nepal, unmet need declined noticeably between 1996 to 2006, falling from 31% in 1996, 28 percent in 2001, and to 25 percent in 2006.[8] However, the NDHS 2011 shows slight increase in unmet need for FP (27%).[2]

Overall, there is improving trends in FP- related indicators except CPR and unmet need in Nepal. The stagnation in the last couples of years is not only a problem for Nepal, but also for other developing countries as the annual rate of increase in CPR in almost all regions was lower than it had been during 1990s.[11]

Factors Contributing to Stagnation in CPR

Under this section, we discuss five different demographic and programmatic factors that may offer some explanation as to why CPR has not increased in the recent past. Each factor is examined separately, but some of them may be related and may explain the reason for non-use of family planning methods; for example spousal separation may be associated with the use of emergency contraception or even abortions. Further analysis of NDHS 2011 on the determinants of fertility will shed more light on this subject. Possible reasons for the stagnation in CPR are described below.

High Spousal Separation

Data from the Department of Foreign Employment Promotion in 2009-10 shows that Nepalese migrate to work in 105 countries globally, mostly to India, Malaysia, Qatar, Saudi Arabia, UAE, Korea, Japan, England, and so forthe. This trend of out-migration has been increasing over the years, particularly among males.[12] The preliminary findings of the Census 2010 shows that among the total population of 28 million, about 2 million were out of the country, of which the majority are in the reproductive age group.[13] The Mid-term Survey by the Nepal Family Health Program II (NFHP II) in 2008/2009 and the NDHS 2011 also showed similar result - 32% or about one third of couples were separated due to migration. Spousal separation does not necessarily imply an absence of coital activity; yet, the FP needs of separated couples differ significantly from those who are cohabiting.[14] Wives of the migrants who are using temporary methods discontinue, in order to avoid rumors about infidelity when their husbands are away from home. The data from NDHS 2011 showed that the most common reason for discontinuing FP methods is husband living away (40%). On the other hand, the Mid-term Survey also showed that of the couples who were living together, 62% were using some type of FP methods.[2,15]

A recent qualitative study conducted by NFHP II in 2012 regarding FP needs of migrant couples in Nepal revealed that a majority of wives of migrant males do not make any prior arrangements on the use of FP methods before the husbands return at home. In addition, very few couples used a FP method during the first night of sexual intercourse. Wives of male migrants face barriers such as fear of being accused of infidelity, denial of FP services by service providers, and reservations with regards to asking for FP services when their husbands are away from home.[16] Because all married women of reproductive age are included in the denominator when calculating CPR, it has contributed to the decline in CPR. In a setting where spousal absence is common and increasing, assessing FP program performance using conventional measures of contraceptive prevalence and unmet need may be misleading.[14]

Increase in Traditional Methods

The use of FP methods like rhythm and withdrawal protect pregnancies to some extent but are less effective than modern methods. The FP programme does not promote traditional methods. However, there has been an increasein using these methods in the last two decades. Only 1% of currently married women were using any type of traditional methods in 1991,[9] increasing to 2.5% in 1996, 3.9% in 2001 and 3.7% in 2006.[7] However, according to NDHS 2011, use of any traditional methods almost doubled (6.5 %),[2] which may have contributed to a reduction in the CPR of modern FP methods. Effective counseling, behavior change and communication approaches, and increasing the availability of modern methods could help people switch from traditional to modern methods.

Increase in Access And Use Of Abortion

Due to the introduction of medical abortion technology, abortion services are more easily available below district level in the government and majority of private health facilities. Nepal began providing comprehensive abortion care (CAC) services in 2004 through government, non-government, and private health institutions, wlhich are now available in all 75 districts.[16-18] In the government sector, CAC services have extended to the primary health care center level. Due to the easy availability of abortion services, the number of women seeking abortions has been increasing every year (see figure 3).[19-22] The number of abortion cases is recorded only at certified CAC sites, but many abortion cases occur in non CAC, certified sites, which is not recorded properly.

Therefore, estimates of the annual number of abortion cases are significantly higher than official statistics.

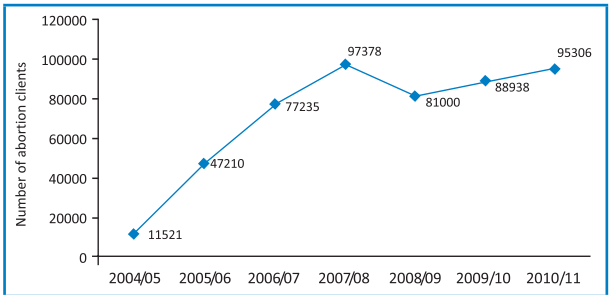

Figure 3.Trends of CAC service users[19-22]

A study conducted at the Maternity Hospital, Kathmandu in 2005 revealed that among the abortion clients, 97% were married and living together with their spouse and the average number of children was only two. The majority (57.4%) of women did not want another child. Among them, about three out of five women (61.5%) reported using a method to space or prevent unwanted pregnancies before.[23] A similar study conducted at the same hospital in 2009 found that 56 percent reported using FP methods.[24] Many of the abortions could have been avoided through the use of effective contraceptives.[23]

Increase in Use of Emergency Contraception

Although Emergency Contraception (EC) is part of the FP programme, there is no system in place within the government's health information system to collect data about the use of EC. PSI/Nepal initiated "Postinor 2" as a part of social marketing efforts in June 2004 through select outlets. CRS also started marketing "Postinor 2" in 2005. In June 2009, CRS launched the "E-Con", which is available all over Nepal. In addition to these, Indian brands are available in the market, for which the number of sale is unknown. However, it is clear that the sale of EC increased remarkably in the last five years. There was a three-fold increase in the sale of EC between FY 2008/09 to 2009/10.[21,22] In FY 2010/11, CRS alone sold 247,776 packets of EC in Nepal.[6] There is a possibility that individuals and couples may opt to use EC to prevent pregnancies rather than for unprotected sex.

Repositioning FP Programmes

In the past decade, a lot has changed with regards to the reproductive health needs of individuals and couples. Although current family planning approaches have been able to fulfill FP needs of certain groups of people, there are other groups whose needs have not been met. Unmet FP need is high among married adolescents, residents of rural areas, hill and mountain regions, and certain ethnic groups. There are also about one third of wives whose husband are away from home with different FP needs. The FP strategies and approaches have to be modified and tailored to meet the needs of these sub-groups among the population.

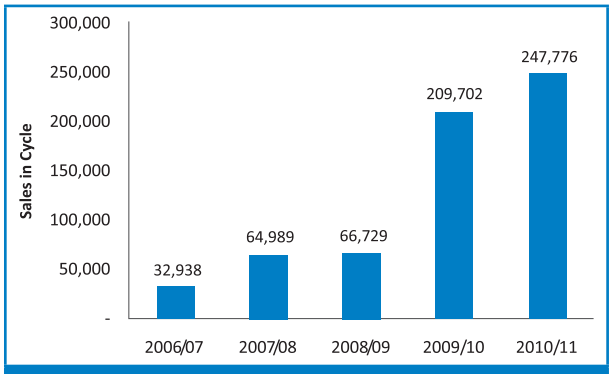

Figure 4. Trends of sales of emergency contraception "Econ"[6,19-22]

WAY FORWARD

To strengthen FP services in the country, especially for the rural and marginalised communities, all concerned individuals and organisations need to collaborate and harmonize their programmes. First, it is necessary to further analyze the data to identify factors contributing to the gap and accordingly plan the programmes that address them. The FP programme should adopt best practices to fulfill FP needs of special groups like migrants, postpartum and post-abortion mothers, married adolescents, poor individuals/couples living in rural, hill and mountain areas as the existing general programme cannot effectively fulfill their needs.

Although family planning is integrated within the general health system of Nepal, it could be more effectively integrated into maternal health (antenatal, delivery, post natal, morbidity clinics), child health (immunization, growth monitoring, general check up), HIV/AIDS, CAC, and post abortion care services. In addition, when women of reproductive age or their spouse visit health facilities, sincere attempts should be made to provide them with FP information and services.

Use of emergency contraception and abortion are increasing steadily in Nepal. Both methods prevent unwanted pregnancies in certain circumstances, therefore are essential components of reproductive health. However, this increase is a sign of failure of the family planning programme. It is not wise to use emergency contraception and abortion as alternatives to family planning methods. The FP programme should therefore develop a strategy to increase awareness about the importance of FP to prevent unwanted pregnancies and discourage the use of emergency contraception and abortion as a method of FP.

Healthy timing and spacing of pregnancy have many benefits for mothers, children and family members, but many people are still unaware of the right time of first pregnancy and the healthy spacing period. Messages about healthy timing and spacing should be widely disseminated down to the community level through effective BCC approaches. Studies and programmes implemented in other countries have already proven that FP is the best approach to improve the health, economy, education, environment and overall quality of life.[24] Advocacy should be done widely from the center to the community level about the importance of FP for generation of additional resources and creating an enabling environment.

Nepal has faced demographic challenges due to the high rate of spousal separation caused by migration for employment. In the current situation, the conventional methods of calculating CPR and unmet need do not give the real picture of the country. Discussions should be held to identify the proper way of calculating CPR and unmet need of the country by disaggregating FP use by the residence status of husbands.[14] This will provide a real picture of CPR and unmet need in the countries with high spousal separation due to migration.

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CONFLICT OF INTEREST

We declare no conflict of interest for this article.

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