NEPAL: MATERNAL AND REPRODUCTIVE HEALTH AT A GLANCE

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KEY MESSAGES:

• Nepal has made a remarkable progress in achieving the MDGs – especially in extreme poverty and education.

• Nepal has achieved MDG 5 but only one in three births is attended by skilled medical personnel. Disparities exist in access to maternal care by residence and wealth quintiles.

• The total fertility rate has declined to 2.4 in 2012, along with increased contraceptive use at 50 percent. High unmet need of 27 percent still remains.

• Nutritional deficiencies for pregnant and lactating women remain a challenge.

• Nepal has initiated a number of key interventions to respond to increased adolescents’ needs for health services, improve accessibility and quality of services at local level, and enhance equitable access to services through micro-planning exercise and provision of financial protection.

Country Context

Nepal is one of three landlocked South Asian countries. In 2012, its population was 27 million and per capita income $1,470. The economy grew despite the 1996-2006 conflict but it did not accelerate post-conflict. Economic growth slowed to 3.6 percent in FY13; a rebound to 4.5 percent is expected in 2014. The economy is centered on subsistence agriculture. Remittances provide significant household income—more than 25 percent of GDP.

Nepal has reduced poverty by 2.5 percentage points yearly since 2004. It achieved MDG 1 by halving extreme poverty. Since 2010-11, 25 percent of the population lives below the poverty line, nearly a 30 percentage point drop from 1995-96.1,2

The large youth population—36 percent under 15—is an opportunity to benefit from the demographic dividend. Nepal is likely to achieve most health-related MDGs. Nepal achieved MDG 4 as the current U5MR and IMR is 41.6 and 33.6 per 1,000 live births. It has made excellent progress in education. Net enrollment in primary education increased from 64 percent in 1990 to 95.3 percent in 2013.1,2

Nepal eliminated gender disparities in primary and secondary education. Women hold one in three national parliamentary seats. Wage employment by women in the non-agricultural sector more than doubled from under 19.9 percent in 2009 to 44.8 percent in 2011. However, the gender gap, especially in adult literacy, needs improvement: 71 percent for males and 46.7 percent for females above age 15. Nepal ranks 102 of 148 countries in the Gender Inequality Index (2012).3
NEPAL: MDG 5 STATUS

MDG 5A indicators

- Maternal mortality ratio (MMR; maternal deaths per 100,000 live births) – UN estimate: 190
- Births attended by skilled health personnel (percent): 36

MDG 5B indicators

- Contraceptive prevalence rate, any method (percent): 49.7
- Adolescent fertility rate (births per 1,000 women ages 15–19) – WDI: 73.7
- Antenatal care with health personnel (percent): 58.3
- Unmet need for family planning (percent): 27


MDG Target 5a: Reduce the MMR by three-quarters, between 1990 and 2015

Nepal has made great progress over the past two decades on maternal health, resulting in its achievement of MDG 5.1 The MMR fell from 790 deaths per 100,000 live births in 1990 to 190 in 2013 (figure 1), for an average annual decline of 6 percent.4

Fertility

Fertility has been declining. Between 1990 and 2012, the total fertility rate (TFR) fell from 5.2 to 2.4 (figure 2).1

The contraceptive prevalence rate (CPR) has been increasing over the past 20 years. The CPR (any method) increased from 24.1 percent in 1991 to 49.7 percent in 2011 (figure 2).1 Modern methods are the main choice of contraceptives and are used by 43.2 percent of currently married women. Female sterilization (15.2 percent), injectables (9.2 percent) and male sterilization (7.8 percent) are the most commonly used form of modern methods. Traditional methods are used by 6.5 percent of currently married women. There is still an unmet need of 27 percent.5

Birth intervals of less than 24 months are considered too short: 20.9 percent of children are born within 24 months of the previous birth. The median number of months since the preceding birth is 36.2 months.5

The median age at first marriage among women aged 25-49 is 17.5 years and that at first birth among the same cohort is 20.2 years. The share of women age 15-19 that have begun childbearing is 16.7 percent. The adolescent fertility rate is 73.7 births per 1,000 women age 15–19.1

Pregnancy Outcomes

Complete and timely antenatal care (ANC) is a necessary component for positive pregnancy outcomes. As of 2011, 58.3 percent of women sought ANC from a skilled provider; about 50 percent of women received the recommended four or more ANC visits; 86.4 percent of women had their blood pressure measured (a component in the package of ANC services).5

Skilled birth attendance (SBA) is critical for reducing maternal deaths. SBA increased from 7.4 percent in 1991 to 36 percent in 2011 (figure 3).1 The majority of births are delivered at home with institutional delivery accounting for only 35.3 percent of all births (26 percent in public sector facilities, 7.2 percent in private sector facilities, and 2.1 percent in NGO facilities). The most
common reason for not delivering in a health facility was the belief that it was not necessary (62.2 percent). Other reasons include: distance to health facility/no transport (13.5 percent), not customary (9.5 percent), child delivered before reaching facility (8 percent), and cost (4.5 percent).5

Postnatal care is another important component for maternal health, especially for managing post-delivery complications: 44.5 percent of women sought this type of care from a qualified provider within the recommended first two days of delivery.5

Of women of reproductive age, 72 percent identified at least one problem in accessing health services when sick. The most common reason was not wanting to go alone (60.2 percent), followed by getting money for treatment and distance to a facility (about 47 percent each) and getting permission (12.6 percent).5

Equity in Access to Maternal Health Services
Inequity in access to maternal health services is a barrier to achieving MDG 5. While utilization of antenatal care has been increasing throughout the years, wide disparities remain. Women in urban areas were more likely to seek antenatal care (87.9 percent) from a qualified professional than their rural counterparts (54.9 percent) (figure 4).5

There is also a large gap between wealth quintiles in receiving antenatal care: 91.8 percent of women in the richest quintile received ANC from a qualified professional, but only 33.3 percent of women in the poorest quintile (figure 5).5

Similar disparities are also found in SBA: 72.7 percent of urban women are assisted during delivery by a medically qualified professional but only 32.3 percent of rural women (figure 6).5
Considerable variations in SBA also exist among wealth quintiles. Women in the richest quintile are eight times more likely than women in the poorest quintile to have SBA. Only 10.7 percent of women in the poorest quintile receive skilled birth attendance compared with 81.5 percent in the richest quintile (figure 7).5

Key Strategies to Improve Maternal and Reproductive Health Outcomes

Respond to increasing demands for sexual and reproductive health from youth and adolescents. Nepal has initiated a number of key interventions to expand SRH services to its large youth and adolescent populations to keep girls in school to prevent teenage pregnancy, as well as to improve the nutrition of young mothers, and to provide comprehensive sexuality education in schools.

Improve accessibility and quality of RMNCH services at the community and facility levels. The Government of Nepal will work towards strategically mapping birthing centers and providing the facilities with basic and comprehensive EmONC to increase institutional deliveries. Emergency funds for referral services are now available at community level. Expansion is underway of the Birth Preparedness Package, which includes information about FP, nutrition, and supplies of chlorohexidine lotion/ misoprostol. The quality of existing birthing centers needs to be improved in terms of availability of human resources and drugs.

Enhancing equitable access to RMNCH services. Nepal has adopted a series of new supply-side interventions that include micro-planning exercises for FP services, specifically in low contraceptive prevalence rate (CPR) districts, and provision of financial protection in utilizing health services. In addition, mobilizing private sectors and international NGOs to reach the unreached populations will be necessary. From the demand side, the government will strengthen and expand behavior change communication campaigns by mobilizing peer educators in remote and poor areas, focusing on enhancing males' roles as partners to improve FP uptake, and linking safe motherhood incentive programs to FP uptake.

References:
1 World Bank. World Development Indicators 2014: Accessed 19 May 2014
2 Nepal:Country Program Snapshot. March 2014, the World Bank
3 UNDP. 2013 Human Development Report Gender Inequality Index

Nepal has been working to improve access to services through the Aama Safe Motherhood program. The program provides free delivery services throughout the country, as well as supply- and demand-side incentives to increase use of these services.6

Nutrition

A BMI less than 18.5 kg/m2 is considered thin or undernourished and 18.2 percent of women age 15-49 are in this category. In addition, 35 percent of women are anemic; 28.9 percent are mildly anemic; 5.7 percent are moderately anemic; and 0.3 percent are severely anemic. Nutritional deficiencies are a problem for pregnant and lactating women, and taking micronutrients is one way to address the problem: 40.3 percent of mothers receive a vitamin A dose in the first two months after the birth of their last child.5

The Health, Nutrition and Population Knowledge Briefs of the World Bank are quick reference on the essentials of specific HNP-related topics summarizing new findings and information. These may highlight an issue and key interventions proven to be effective in improving health, or disseminate new findings and lessons learned from the regions.

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