Technical Brief

Socioeconomic determinants of inequalities in use of sexual and reproductive health services among currently married women in Nepal

Introduction

Universal access to and utilisation of sexual and reproductive health care services, have been used by various governments as a crucial strategy in achieving universal health coverage[1]. Family planning (FP) services can save women's lives by reducing unintended and high-risk pregnancies and unsafe abortions. Institutional delivery is one of the most important factors in reducing the number of maternal deaths through complications during delivery[2]. The lack of evidence on the degree and nature of socioeconomic related inequalities impedes policy and programme implementation to enable equitable use of sexual and reproductive health services by the vulnerable and underserved populations in Nepal. The main objective of the study was to examine the status and socioeconomic determinants of inequalities in utilisation of selected reproductive health services (modern contraceptive methods and institutional delivery) among currently married women in Nepal.

Methodology

A mixed methods approach was used. Secondary data were obtained from the Nepal Multiple Indicator Cluster Surveys (NMICSs) and Nepal Demographic and Health Surveys (NDHSs). Data from NMICS 2014 and 2019 were used for trend analysis of the prevalence of sexual and reproductive health indicators. NDHS 2011 and 2016 were used to examine the trend for the intention to use FP methods. Inequalities were measured using a ratio that evaluates disparity in utilisation of sexual and reproductive health services between the richest (highest wealth quintiles) and the poorest (lowest wealth quintiles), and a concentration index. A binary logistic regression analysis was carried out to determine the adjusted effect of each factor on the dependent variables. Fifteen semi-structured qualitative interviews were conducted with federal, provincial and local-level key stakeholders from government (all three levels) and development partners, using a key informant interview guideline. The qualitative data were transcribed and translated into English and analysed. Qualitative information were gathered to supplement quantitative findings.

Results

Use of modern contraceptives

The prevalence rate of modern contraceptive use has not increased over the past 13 years, staying at around 44 percent from 2006 to 2019. Key informants agreed that use of modern contraception had remained stagnant and mentioned various reasons for this trend: spousal separation (couples living apart), FP services being replaced by Medical Abortion (MA) and Emergency Contraceptive (EC) and an increasing number of people preferring natural methods of contraception.

"I think, the practice of using self-MA and EC have also replaced the FP service utilisation" Participant, 10

Table 1 Trend of Modern Contraceptive Prevalence Rate: 2006–2019 (%)

	NDHS 2006	NDHS 2011	NDHS 2016	MICS 2014	MICS 2019
Poorest	30.3	35.6	41.8	44.1	43.8
Second	40.6	41.1	44.8	46.8	47.5
Middle	46.8	43.3	42.6	50.1	44.8
Fourth	48.2	45.3	41.7	48.9	45.3
Richest	53.9	48.9	43.0	45.4	39.7
All	44.2	43.2	42.8	47.1	44.2
Richest to poorest difference	*23.6*	*13.3*	*1.2*	*1.3*	*-4.1*
Ratio (richest to poorest)	*1.78*	*1.37*	*1.03*	*1.03*	*0.91*

Inequality in use of modern contraceptive methods

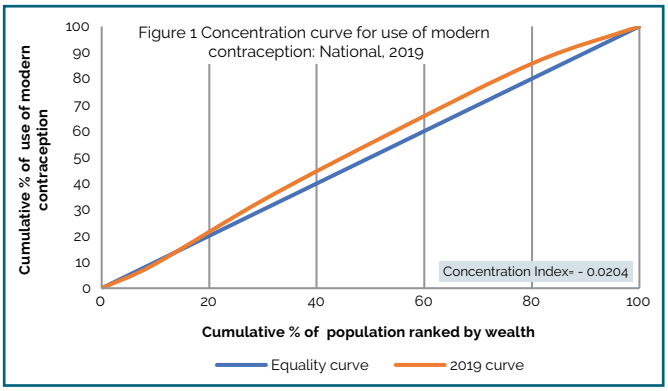
The inequality in use of modern contraceptives can be seen clearly by wealth status, province and other sociodemographic characteristics. The value of the concentration index (-0.0204) indicates that use of modern contraception is higher among the poor. The prevalence of use of modern contraception among the poorest increased by 13.5 percentage points between 2006 and 2019. In the same period, it decreased by 14.2 percentage point among the richest. It is notable that the richest-to-poorest difference has decreased over time. The richest-to-poorest difference was high (23.6) in 2006, decreasing to 13.3 percentage points in 2011 and further to 1.2 percentage points in NDHS 2016. The scenario depicted by the NMICS data differs slightly: the richest-to-poorest difference was 1.3 percentage points in 2014 and the difference was negative in 2019. In 2019, the prevalence of modern contraceptive use was higher among the poorest (43.8%) than the richest (39.7%). NMICS data from 2019 shows that the richest-to-poorest differences were negative in all provinces except Karnali Province.

Key informants suggested that the gap in equitable access in utilisation could be the result of programmes not being able to focus on target groups.

"We haven't yet catered for adolescents, Muslims, urban poor, ethnic minorities, people living in hard-to-reach areas, poor, marginalised, gender and sexual minorities, people living with disabilities. The other reason could be educated people know about the safe period" Participant, 4

[1] UN (2013). Resolution adopted by the General Assembly on 12 December 2012

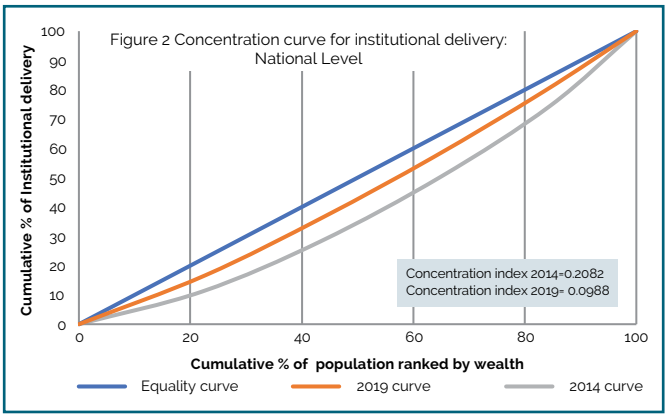
[2] WHO (2013). Analysing Progress on Commitments to the Global Strategy for Women's and Children's Health (Geneva: WHO)



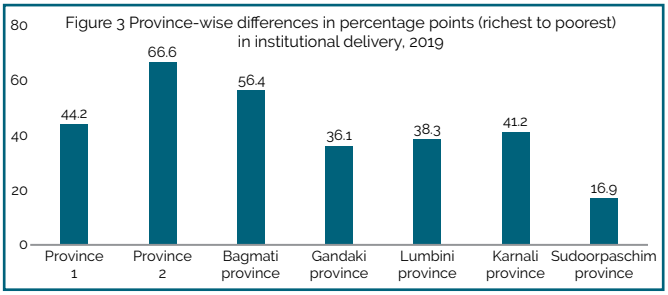
The multivariate analysis showed that wealth status, province, age of women, education, number of children born, level of media exposure, age of husband and 'husband has another wife' variables were significant predictors of use of modern contraception.

Institutional delivery

The utilisation of institutional delivery has increased over time. Institutional delivery varied largely by wealth quintile in both 2014 and 2019. Institutional delivery was highest among the richest wealth quintile in both surveys (91% in 2014 and 96% in 2019).



The richest-to-poorest difference was large in 2014 (62.8) and reduced to 38.8 percentage points in 2019. Furthermore, the value of the concentration index was 0.2082 in 2014, decreasing to 0.0988 in 2019, which indicates that inequality between the richest and poorest has been decreasing over time. Province-wise comparison shows that the richest-to-poorest difference in institutional delivery was very high in Province 2 (66.6%) and low in Sudurpashchim Province (16.9%). Similarly, the richest-to-poorest difference was higher in rural areas than urban areas (44.7% vs 35.6%) and among those who were illiterate (difference 45.1).



Consistent with the quantitative findings, key informants noted that utilisation in rural areas and among poor communities is not satisfactory. Factors hindering uptake of institutional delivery included: geographical difficulty; lack of access to well-equipped health institutions/birthing centres; lack of skilled birth attendants in service delivery sites; and insufficient travel incentives for poor and rural women.

Conclusion

The study investigated three main markers of utilisation of reproductive health services: use of modern contraception, intention to use contraception and institutional delivery. Prevalence of modern contraception showed no significant change over the past decade. The growing inclination of people towards natural methods, increase in the use of MA and EC and increasing trend of spousal separation due to foreign labour migration were some of the factors hypothesised by key informants to explain the plateauing of the contraceptive prevalence rate. The analysis of NMICS found that there is a disproportionate concentration of modern methods among the poor. The important predictors of use of modern contraception were wealth status, province, age of women, education, number of children born, high exposure of mass media and the age of husband.

This study showed that the utilisation of institutional delivery has increased over time. Although the richest-to-poorest gap has decreased over time, institutional delivery is still higher among the richest quintile. Qualitative findings showed that the major obstacles for accessing institutional delivery for the poor include: cultural and socioeconomic norms of specific communities; inaccessible health institutions/birthing centres, especially in hilly and remote areas; and lack of trained skilled birth attendants in service delivery sites.

The effectiveness of the programme is linked with improvement in certain indicators, such as reduction in total fertility rate, maternal mortality and incidence of unsafe abortion. However, programmes need to be tailored, focusing on awareness, outreach activities, making all five FP commodities available in all health institutions, strengthening the supply side and mobilising the private sector to meet the targets of reproductive health programmes. Although institutional delivery has increased over the time among both richest and poorest, the utilization of institutional delivery is still lower among poorest especially in province 2. Therefore program should focus on poor and marginalized population.

Both quantitative and qualitative findings show mass media is one of the strongest predictors to increase utilization of family planning services and institutional delivery. It would be better if program use media platform to spread extensive awareness about service availability and benefit of service utilization.

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