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Brief Communication

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Current Reproductive Health Status of Nepalese Women

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Nepal made remarkable progress in improving both maternal and neonatal health in last two decades. This is due to various factors: policy, strategy, guidelines and standards being in place, and the programs like Safe Motherhood policy. Also increasing in the number of the skill Healthcare Providers, having free maternal Health Services, incentive schemes to improve antenatal care, and postpartum visits, birth preparedness package and also preparing for complication management.

As a result, there have been impressive increases in institutional deliveries, increase in antenatal visits, home visits by health care providers during postpartum period has increased to 70%.[1] Quality improvement initiatives, such as the Maternal and Perinatal Death Review, minimum standard of health facility assessment tools, routine clinical monitoring, and supportive onsite supervision visits are stated in policy documents and guidelines as a means for improving quality of care.

Maternal mortality ratio has decreased from 536 per 100,000 live births in 1996 to 151 per 100,000 live births in 2021.[2] As per Sustainable Development Goals (SDG) target, we have to decrease it to further 70 per 100,000 live births[3] which will require an accelerated effort! If you look at province wise MMR, there is marked inequalities between provinces. MMR is highest in Lumbini 207 per 100,000 live births and 172 per 100,000 live births in Karnali province while lowest in Bagmati province 98 per 100,000 live births[2]. Higher education, women's awareness, access to health services/providers 24X7 could be some the factors that Bagmati has better maternal health outcomes compared to the other provinces.

If we look at the maternal death, 50 percent of death is occurring among the age group between 15 to 19 and between 20 to 34.[2] Though the legal age of marriage is 20 years in Nepal, child marriage is prevalent and pregnancy related deaths is highest in this age group.

National data shows that the median age of marriage in Nepal is 18.[3] years. The median age at marriage is lowest in Madhesh province at 16.[6] years of age which means 50% of girls are married by the age of 16.[6] years in Madhes. It is the highest in Bagmati province at 19.[9] years. If we look at median age of marriage by ethnicity, it is the lowest in Muslim community at 16.[5] years of age and highest in janajati and Brahmin/Chhetri at around 19.[1]

In two provinces Madhesh and the Sudurpaschim, the girls are getting married before age 15, leading to the early marriage, early childbirth, and the adolescent mortality is being very high because they are not able to reach to the health facility as and when needed. There is disparity among the ethnic groups like the Madheshi Muslims because they also get married at younger age group and mortality again is very high.[1]

Health facility delivery shows an increasing trend in Nepal. The health facility delivery has increased from 10 percent in 2001, to 79 percent in 202.[21] The SDG target is to reach 90% by 2030, which looks highly achievable3. However, the inequalities in health facility delivery is concerning. In 2022, the highest wealth quintile has nearly 97% health facility delivery whereas in lowest wealth quintile, it is only 65%. Similarly, the difference in between province in also high. Madhesh province has lowest health facility delivery rate at 67%.[1] We need to focus why women are still reluctant to seek

health services in these provinces. Unless we understand their concerns we cannot formulate strategies to improve these indicators.

Nepal has maintained the population growth at near above the replacement level. The national total fertility rate, as defined by average number of children a woman would have in her lifetime, is in decreasing trend, from 4.1 to 2.1 in 2021. But difference in TFR is huge between no education group and school completion group. Shown TFR in no education group is still 3.3 and it is only 1.6 among women having SLC or higher education. The difference in between province is also high. Madhesh province has highest TFR at 2.7 and Gandaki province has lowest TFR at 1.4. But the uptake of family planning among the young married adolescent is only 14.2 %, especially in Madhes province.[1]

The uptake of Postpartum family planning is low in Nepal. The proportion of postpartum family planning uptake is lowest at Sudurpaschim and Madhesh province at around 0.2%.[4]

Breastfeeding practice is not satisfactory and it is decreasing over the years. Less than three out of five mothers reported follow of recommended breastfeeding practice. It varies by province. Karnali and Sudur Paschim province has high percentage of women doing good practice where as Bagmati has lowest. It appears that breastfeeding rates are on the decline among well-educated and urban populations.[1]

Early childhood mortality, mainly under 5 mortality and infant mortality are in declining trend. But, the decline in neonatal mortality rate is slow. The neonatal mortality rate is stagnant at 21 per 1000 live births in 2016 and 2022.[1] The SDG target is to reduce the neonatal mortality rate to 12 per 10,000 live births by 2030.[3]

Demographic health survey had asked women 15-49 years' age group on whether they faced any problem in seeking medical advice or treatment for themselves when they were sick. In Karnali province, 83% women reported facing some problem in seeking care. Similarly, 74% and 73% of women reported problem in seeking care at Koshi and Madhesi province respectively. The least number of women reported problem in seeking care in Bagmati province at 57%.[1] The cited reasons for problems in seeking medical advice or treatment were getting permission to go to doctor, getting money for medical consultation or treatment, long distance to health facility and not wanting to go alone. This shows the socio economic and cultural barriers faced by women in seeking care.

Anemia is a problem that affects both children and women of childbearing age.. Madhesh province has highest burden of anemia followed by Lumbini. Although the percentage of anemia among women has decreased over the years1.

If we compare few indicators in between four countries Bangladesh, India, Pakistan and Nepal. Under five mortality rate and infant mortality rate of Nepal is lower than Bangladesh, India and Pakistan. It is interesting to note that institutional delivery rate of Bangladesh in only 51%,[5] much lower than Pakistan at 72%,[6] but infant mortality rate and under 5 mortality rate is higher in Pakistan. Nepal has institutional delivery rate at 79%[1] which is higher than Bangladesh and Pakistan but slightly lower than of India at 90%.[7] Physical/sexual violence by intimate partner is highest in India at 29%7, and of Pakistan and Nepal is nearly same at around 24%.[1,6]

Road Ahead:

Evidence suggests the NMR and MMR are highest among disadvantaged groups, who have poorer coverage of routine MNH visits and receive poorer quality of care during those routine visits. This means disadvantaged women have poor access to recommended interventions and/or the health system is inefficient in delivering those interventions during routine MNH visits.

- Microplanning in those pockets where these women reside, multipronged strategy to be taken, increase awareness, girl's education is crucial, spacing for young adolescents, Antenatal care at PHC outreach, home visits, distributing necessary medications, vaccinations, identifying the health facility (birth preparedness)
- Improve the quality of Antenatal care: Talk about nutrition, to pregnant woman and family, explain about danger signs when to go to the health facility specially identify hospital beforehand. The local government should be able to refer the complicated cases on timely manner, where needed airlifting can save mother and new born.
- The maternal mortality rate is decreasing but still very high, we need to expedite the activities in order to achieve sustainable development goal
- Neonatal mortality is stagnant; we need to identify the challenges behind this in order to improve the outcomes
- Disparity among provinces needs political commitment, local leadership, community involvement, specially youth and public/private partnerships at all levels is crucial.
- Focus on Adolescent Sexual Reproductive Health especially targeting provinces with early marriage/childbirths.

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