

FAMILY PLANNING: THE HIDDEN NEED OF MARRIED ADOLESCENTS IN NEPAL

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KEY MESSAGES:

- Guaranteeing adolescent access to family planning is critical in preventing early childbearing and catalyzing socioeconomic gains.
- Married adolescents need and demand family planning in Nepal, but few use contraception. Only 30 percent of their demand is met.
- Limited empowerment and education, male migration, social norms, poor outreach services and supply constraints are some of the factors responsible for adolescents' low use of contraception.
- Strengthening outreach services, improving providers' capacity to meet the special needs of married adolescents, and establishing a program targeting short term husband separation (<3 months) can increase contraceptive use.

Introduction

In Nepal, both early marriage and motherhood still place adolescents and their children at a great disadvantage. In 2011, one-third of girls aged 15-19 were already married. About 60 percent of them were pregnant or had at least one child, and one in ten had two living children (Nepal Demographic Health Survey, 2011).

Together with the health risks that adolescents and their babies face during childbirth, adolescent girls are more likely to be poor, uneducated, nonusers of contraception, have an unplanned pregnancy, and have repeated unsafe abortions. On average one-third of births or pregnancies to married adolescent mothers in Nepal are either mistimed or unwanted, and over two-thirds of adolescent mothers have their second child within 24 months of their first birth. Poor young women are three times more likely to be married by 18 years, and twice as likely to become mothers than women in the top wealth quintile.

Delaying first births and ensuring healthy birth intervals among adolescents are the central mechanisms to a healthy and productive life, and the reason why access to family planning for adolescents is critical. Delaying childbearing, even for a year or two, could prevent premature maternal and neonatal mortality, allowing young girls to gain more education and work experience, among other benefits (Sonfield, A., K. Hasstedt, et al. (2013).

Despite governmental efforts in improving women's sexual and reproductive health (SRH) (Ministry of Health and Population 2014), adolescents' low uptake of contraception is a persistent and serious problem in Nepal. More than half of Nepali married adolescents desire to delay childbearing, but only 17 percent use any method of contraception. Adolescent modern contraceptive use has remained at 14 percent without remarkable change since 2006 (Khatiwada N. 2013). The low levels and lack of progress over time in contraceptive use among adolescents is a complex problem that requires immediate action. In 2011, 70 percent of

adolescents' demand for family planning in Nepal was not met. Over 2 in 5 married adolescents had an unmet need for family planning contributing to 30 percent of the overall unmet spacing need of family planning in the country. This proportion places Nepali adolescents' contraception needs as one of the highest in the South Asia region. Using the latest population data (2011) this translates to an unmet need of approximately 140,000 adolescent girls.

This brief aims to understand why married adolescents in Nepal have low contraceptive use and a high unmet need for family planning, providing policy recommendations based on a literature review, interviews with key-informants, and a comprehensive analysis of secondary data from household surveys (NDHS 2006-2011). Given that early childbearing in Nepal still occurs primarily within marriage, the brief addresses the needs of female married adolescents which are often overlooked by policy-makers. However, it is important to note that unmarried adolescents are progressively engaging in sexual activity in Nepal increasing their risks for contracting an STI or an unplanned pregnancy that warrants special attention.

STUDY FINDINGS

Ensuring access to and effective use of family planning among adolescents requires demand and supply factors, as well as an enabling environment and a legal framework (Allison Glinski, Magnolia Sexton et al. 2014). Efficient contraceptive use comprises five critical aspects of fertility regulation decision-making: a) desire to delay or limit childbearing; b) desire to use family planning to delay childbearing; c) be empowered to express and demand family planning; d) access to family planning services; and e) provision of adolescent-friendly services (Allison Glinski, Magnolia Sexton et al. 2014). The following sections present the study findings based on the NDHS 2011 analysis.

A) DO MARRIED ADOLESCENTS WANT TO DELAY OR LIMIT CHILDBEARING?

Married adolescent girls tend not to be considered in need of contraception, in particular at the initial stages of their reproductive life. Yet, increasing economic and labor opportunities have modified the expected returns to education and the opportunity cost of childbearing. As a result, both ideal family size and intentions to delay childbearing among married adolescents are changing. Results from the analysis found that in Nepal, more than half of Nepali married adolescents would prefer to wait at least two years to have a baby or limit childbearing altogether, regardless of the number of children they already have. Individual preferences are influenced, nonetheless by social norms. A preference to have a male child and having a baby shortly after marriage prevails in Nepal. As a consequence, adolescents (especially the poor and less educated) are less likely to postpone or delay childbearing.

Adolescent's pregnancy intentions vary across ethnic groups and ecological regions. Whereas more than half of married adolescent girls from the Brahman, Chhetri or Janajati groups would prefer to delay childbearing, Muslim and Dalit

couples were more likely to prefer early childbearing. Regional differences are noteworthy as well. A majority of married adolescents living in the mountainous regions who have not yet started childbearing would like to delay their first birth, in comparison to young girls in the Terai region. This is consistent with the finding that these communities follow more traditional behaviors regarding marriage and family formation (for example, dowry, cross-border marriage, etc).

B) CHOOSING FAMILY PLANNING? KNOWLEDGE AND AWARENESS

Eight out of ten married adolescents not using contraception reported the intention to use family planning in the future. Yet, very few will do it. The fear of side effects and a negative impact on fertility or one's health were among the main reasons for not using contraception among married adolescents (following husband separation and postpartum amenorrhea). Knowledge and awareness can guide adolescent decision-making by dispelling misconceptions and clarifying questions. Yet adolescents tend to be poorly informed about reproductive matters (Regmi, Simkhada et al. 2008). In Nepal, as in other countries, most adolescents are aware of at least one modern child spacing method such as condoms and the pill. However, only one-fourth reported knowing the four main child spacing methods (condom, pill, injections and emergency contraception), and only 65 percent reported knowledge on both IUD and implants.

Most importantly, Nepali married adolescents lack practical knowledge on family planning methods such as awareness about side effects, methods' characteristics and effectiveness, and where to obtain them. For instance, only one in three married adolescent non-users of contraception were aware they can get contraceptives from either health posts or sub-health posts. Only one in ten mentioned both places as a source of family planning. Users of contraception also appear to have incomplete knowledge about method efficacy. Among married adolescents who wanted to limit childbearing altogether, 40 percent were using condoms or withdrawal as a limiting method.

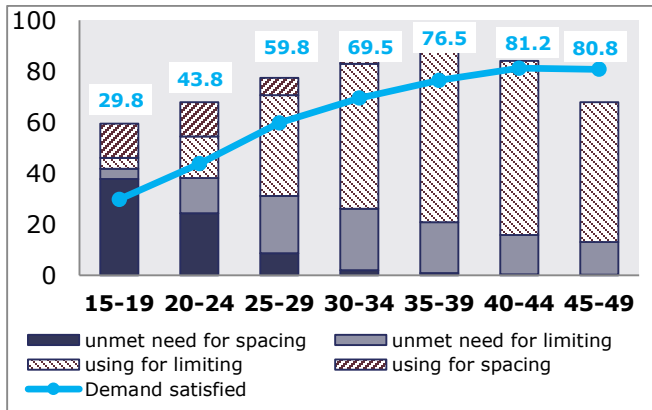
C) AGENCY AND FAMILY PLANNING: EMPOWERING GIRLS

Young married women in Nepal have low decision-making power within marriages that may limit their ability to make independent and informed decisions on reproductive issues. Not only do two-thirds of Nepali married adolescents depend on other family members or their husbands to seek medical care but also husbands tend to be the sole decision makers regarding contraception and pregnancy in marriages (Sharma, Verma et al. 2001). A large age gap difference among couples and arranged marriages and dowry practices leads to unbalanced power dynamics within marriage. Adolescents are also more prone to suffer from domestic violence starting with their first sexual experience (Puri, Shah et al. 2010). This type of violence undermines girls' control of their sexual and reproductive life and can lead to acute consequences.

DEMAND FOR CONTRACEPTION AMONG ADOLESCENTS

Married adolescents have the lowest rate of contraceptive use and the lowest proportion of demand satisfied among ever-married women in reproductive age (Figure 1).

Figure 1. Demand for family planning, by age group

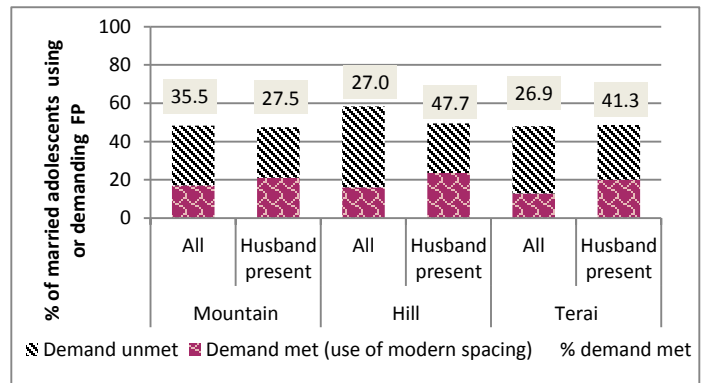


Source: Author with data from *Nepal Demographic and Health Survey 2011*

Among married adolescents who adopted a family planning method, the most common were condoms (6.5 percent) injections (4.9 percent) and pills (3 percent). In comparison to Bangladesh, a country with a similar early marriage prevalence but a higher contraceptive use (three times that of Nepal), pills contributed to 26 percent of the contraceptive prevalence rate (CPR) among adolescents versus 3 percent in Nepal. Depo-Provera was the second most prevalent method in both countries, and long-lasting methods such as the IUD and implants among adolescents was the least common.

A multivariate analysis from the NDHS (2006 and 2011) indicates that primary/secondary education, higher wealth quintile (4th vs poorest), ecological region (Mountain vs Terai), age (15-17 vs 18-19) and receiving family planning outreach visits or information at the health center are important predictors of contraceptive use among married adolescents. Male migration has been identified as one important factor explaining the extent of unmet need and the low rates of child spacing methods in Nepal. Our analysis highlights the urgent need to target adolescents whose husbands are absent between one week and 3-months (half of the husbands from this group are migrant workers) as this population group constitutes an extremely high-risk group for unplanned pregnancies. Among this group 80 percent of adolescents want to delay or limit their next birth, but contraceptive use among them is negligible and discontinuation is very high (even among condom users). Effective counseling on method use and efficacy are essential to meet their contraceptive needs.

Figure 2. Family Planning demand and husband separation



Source: Author with data from *Nepal Demographic and Health Survey 2011*

Data analysis by ecological region (Figure 2) indicates that girls in the Mountain and Hills are more likely to use modern contraceptive methods (condom, pill, DEPO, IUD, Implants) in comparison to adolescents in the Terai. The Mountainous region has also a higher share of demand satisfied than the other two regions (36 percent versus 27 percent). Yet, it is important to note, that unmet need is more prevalent in the Hills region, therefore, once male migration is taken into account the difference across ecological regions is reversed with the Hill regions having the highest demand satisfied (48 percent) among resident couples, whereas only 28 percent of women with a resident husband in the mountainous regions have their demand for contraceptives met (Figure 3). Also, it is essential to consider that in every region more than half of married adolescents are still at risk of early childbearing.

ACCESS TO FAMILY PLANNING

Family planning is a key priority for the Government of Nepal. It is a component of the essential health care services mandated by the Nepal Health Sector Programme II (NHSP-II), which the World Bank in collaboration with other development partners supports. The National Family Planning program aims to address the needs of poor and vulnerable populations. Yet, frequently, neither health providers nor public health programs that target adolescents address the special needs of married adolescents. As a result married adolescents face significant and very often hidden barriers to access family planning.

Barriers concerning the quality of care, such as issues related to infrastructure and lack of separate space, confidentiality and privacy, quality and lack of training, workload of health workers and their availability, and opening hours greatly affect the likelihood of a married adolescent seeking family planning at the health center. As a result, only 6 percent of new users of contraception are adolescents. While half of married adolescents received their contraceptives from government sources mainly at the sub-health post level, 70 percent obtained condoms from pharmacies and private clinics, despite health posts providing them free of charge. Similarly, both emergency contraception and the use of long acting reversible

contraception (LARC) are not promoted nor is counseling for adolescent women (Tamang, Govind Subedi et al. 2010).

Increasing educational materials and provider training in adolescent friendly services can improve confidentiality and informed choice at public facilities. This is contingent upon staff capacity and the availability of commodities in each health post. Furthermore, outreach visits and information at health centers can help overcome these barriers and ensure informed choice. However, outreach services for married adolescents has been and continues to be scant in Nepal, with only one in ten married adolescents reporting that they have been reached by a family planning worker or were provided with information at a health center. Yet, adolescents who were visited were three times more likely to use contraception than those who were not visited.

Conclusions and recommendations

The study findings indicate that both generating demand and addressing supply constraints need to be addressed to increase effective contraceptive use. Understanding married adolescents' special needs and preferences requires strengthening outreach services and quality of care at the sub-health level, and adopting innovative approaches focused on reaching high-risk groups. Listed below are specific recommendations:

- Empowering adolescents with practical knowledge and life skills can reduce misconceptions and increase contraceptive use.
- Ensuring outreach counseling and contraceptive distribution for married adolescents. Both female community health (FCHV) and village health workers need to be trained to address adolescents' needs by developing separate strategies for unmarried and married adolescents. Promoting outreach home visits to married adolescents by both experienced and younger CHWs (<5 percent of FCHV are less than 25 years) would constitute a skill-mix delivery model that can result in a much higher level of contraceptive use and discussion among adolescents and young women.
- Continue scaling-up adolescent-friendly services prioritizing sub-health posts. Ensuring confidentiality and appropriate hours. Ensuring that health staff is trained, encompassing strategies for married and unmarried adolescents, and integrating these services within the family planning program. Monitoring and evaluation are also essential to capture shortage and health staff turnover.
- Designing IEC interventions preferably through various channels including FCHVs visits targeted to adolescent and young wives with short-term husband separation (0--3

months) who represent one quarter of unmet needs, on effective use of non-permanent methods, particularly barriers methods such as condoms.

- Innovative contraceptive delivery modalities through training and distribution of contraceptives in private outlets such as beauty parlors, henna painters, tailors and seamstress etc.

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