Country Context

Nepal is a low income country in South Asia, with 55 percent of the population subsisting on less than US $1.25 per day.¹ Nepal's economy is centered on subsistence agriculture. Remittances from abroad are a significant source of income for households, accounting for 23 percent of GDP in 2009.² Nepal's government has developed comprehensive health strategies, prioritizing interventions to achieve the MDGs. In 2010, the GoN and a number of development partners signed a Joint Financing Arrangement, further harmonizing the support for the health sector.³ Nepal has been making progress in maternal health. In 2005, the Safe Delivery Incentive Program was launched in all 75 districts of Nepal, and was found to effectively increase coverage of skilled birth attendance by providing demand-side financing for safe delivery.⁴

Nepal's large share of young population (37 percent of the country population is younger than 15 years old) provides a window of opportunity for high growth and poverty reduction—the demographic dividend. But for this opportunity to result in accelerated growth, the government needs to invest more in the human capital formation of its youth.

Gender equality and women's empowerment are important determinants of women's reproductive health. Higher levels of women's autonomy, education, wages, and labor market participation are associated with improved reproductive health outcomes.⁵ Nepal continues to promote gender equality. Sex ratio, the number of males per 100 females in the population, is considered a summary measure of women's status because it reflects gender differences in survival rates; a sex ratio greater than 100 signals low status of women. Nepal's sex ratio is 100, and along with Sri Lanka, has the lowest sex ratio in South Asia.⁶ Beyond this summary measure, there are gender disparities in school enrollment at the primary and secondary level. In 2000, at the primary level, the ratio of girls' to boys' enrollment was 79. Similarly, fewer girls than boys are enrolled at the secondary level with a female to male ratio of 86 in 2005.⁷ Forty five percent of females aged 15 and older are literate. Nearly 80 percent of adult women aged 15 and older participate in the labor force.⁸ Most female participation is in agriculture; in 2000, share of women's employment in non-agricultural work was estimated to be 15 percent. Gender inequalities are reflected in the country's human development ranking; Nepal ranks 128 of 157 countries in the Gender-related Development Index.⁹

Nepal: MDG 5 Status

**MDG 5A indicators**
- Maternal Mortality Ratio (maternal deaths per 100,000 live births) *UN estimate* ³⁸⁰
- Births attended by skilled health personnel (percent) ¹⁸.⁷

**MDG 5B indicators**
- Contraceptive Prevalence Rate (percent) ⁴⁸
- Adolescent Fertility Rate (births per 1,000 women ages 15–19) ⁹⁸
- Antenatal care with health personnel (percent) ⁴³.⁷
- Unmet need for family planning (percent) ²⁴.⁶

Source: Table compiled from multiple sources.

* The Nepal MMM Study 2008/09 is ²²⁹.

**MDG Target 5A: Reduce by Three-quarters, between 1990 and 2015, the Maternal Mortality Ratio**

Nepal has been making progress over the past two decades on maternal health. Using the 2008 UN estimate it is not yet on track to achieve its 2015 targets but it is on track when using the 2008/2009 MMM Survey data.¹⁰

**Figure 1 • Maternal mortality ratio 1990–2008 and 2015 target**


**World Bank Support for Health in Nepal**

The Bank’s new *Interim Strategy Note* under preparation (P124037) is scheduled to be approved by the Bank’s executive Board on September 13, 2011.

**Current Projects:** P117417 Second HNP and HIV/AIDS Project ($129.15)

**Pipeline Project:** First 1,000 Days Project

**Previous Health Project:**
- P040613 Nepal Health Sector Program Project
- P110731 NP-Health Sector Additional Financing ($42m)
Key Challenges

High Fertility

Fertility has been declining over time but is still high among the poorest. Total fertility rate (TFR) dropped significantly over a decade, from an average of 4.6 births per woman in 1996 to 3.1 births per woman in 2006. The use of modern contraception varies by socioeconomic characteristics. Modern contraceptive use is 54 percent among women in the wealthiest quintile compared to 30 percent among women in the poorest quintile (Figure 4). Similarly, modern contraceptive use is 42 percent among married women with no education and 46 percent for those with secondary education and above. Modern contraceptive use is 43 percent for rural women and 54 percent for urban women. Female sterilization is the most commonly used method (18 percent), followed by injectables (10 percent), and the pill (3.5 percent). In contrast, use of long-term methods such as intrauterine device and implants is negligible.

Figure 2 = Total fertility rate by wealth quintile

![Figure 2](image)


However, wide disparities exist with women in wealthiest quintile having TFR below the replacement level of 2.1 while women in the poorest quintile have a high TFR of 4.7 (Figure 2). Similarly, TFR is lowest among women with secondary education and above (1.8) compared to women with no education (4.7).

Adolescent fertility is high (98 births per 1,000 women aged 15–19 years) and adversely affects not only young women’s health, education and employment prospects but also that of their children. Births among 15–19 year olds are associated with the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother.

Early childbearing is prevalent especially among the poor. In Nepal, most births take place within marriage, and the median age at marriage is 17 years. Births closely follow marriage; among 20–24 year olds the mean gap between marriage and first birth was about 23 months. About a quarter of women aged 25–49 had given birth before reaching age 18, while over half had a birth by age 20. The prevalence of early childbearing varies by socioeconomic characteristics. About 40 percent of the poorest 20–24 year old women have given birth before reaching 18 as compared to 30 percent of their richer counterparts (Figure 3). This poor-rich gap in prevalence of early childbearing was very small among the oldest cohort of women; this gap appears to have widened among the younger cohort of women.

Nearly half of married women are using contraception. Compared to the use of traditional methods (4 percent), married women predominantly use modern contraceptive methods (44 percent). The use of modern contraception varies by socioeconomic characteristics. Modern contraceptive use is 54 percent among women in the wealthiest quintile compared to 30 percent among women in the poorest quintile (Figure 4). Similarly, modern contraceptive use is 42 percent among married women with no education and 46 percent for those with secondary education and above. Modern contraceptive use is 43 percent for rural women and 54 percent for urban women. Female sterilization is the most commonly used method (18 percent), followed by injectables (10 percent), and the pill (3.5 percent). In contrast, use of long-term methods such as intrauterine device and implants is negligible.

Figure 3 = Percent women who have had a child before age 18 years by age group and wealth quintile

![Figure 3](image)


Unmet need for contraception is high at 25 percent indicating that women may not be achieving their desired family size. Unmet need for contraception is highest among women in the poorest quintile (32 percent) as opposed to those in the wealthiest quintile (25 percent).

Nepal’s abortion laws were updated in 2002 to allow any women to elect abortion at 12 weeks or less gestation, and up to 18 weeks for health reasons, but only one-third of women know abortion is legal. Induced abortion is not uncommon with 10 percent of Nepali women reporting having had induced abortion 5 years prior to the 2006 DHS. Further, among women who had miscarriage of induced abortion, 58 percent had complications.

Infertility and health concerns of modern contraceptive methods are the predominant reasons women do not intend to use them in future. Nearly two-fifths (38 percent) of women not intending to use contraception indicated they had difficulty getting pregnant as the main reason while another 17 percent cited health concerns. Further, 12 percent expressed opposition to use, primarily by themselves, their husband, or due to their religion but religious opposition was higher at 44 percent among women aged 15–49 years. Lack of knowledge was cited by less than a percent of women while cost and access are lesser concerns, indicating further need to strengthen family planning services.

Poor Pregnancy Outcomes

Less than half of pregnant women receive antenatal care from skilled health personnel (doctor, midwife, or nurse). Forty-four percent of pregnant women received antenatal care from skilled health personnel with 29 percent making the recommended four or more antenatal visits. The antenatal services needs to be improved given that three-fourths of pregnant women are anaemic (defined as...
haemoglobin < 110g/L) increasing their risk of preterm delivery, low birth weight babies, stillbirth and newborn death.\textsuperscript{15}

Compared to use of antenatal care, a much smaller proportion, 19 percent deliver with the assistance of skilled health personnel predominantly in the public sector. While 51 percent of women in urban areas delivered with skilled health personnel, only 14 percent of women in rural areas obtained such assistance. Similarly, 58 percent of women in the wealthiest quintile received assistance from skilled birth attendants compared to just 5 percent among the poorest quintile (Figure 5).\textsuperscript{11} Haemorrhage continues to be the leading cause of maternal death, and contributes 24 percent to maternal causes, a decrease from 41 percent in 1998.\textsuperscript{16}

Postnatal care is effectively used mostly by those women who delivered in a health facility. Of those women who did not give birth in a health facility, 77 percent never received a postnatal care versus 11 percent among women who delivered in a health facility. Further, only 22 percent received a postnatal check-up within two days.

Over half of women who indicated problems in accessing health care cited concerns regarding unavailability of service providers, drugs not being available, and not wanting to go alone (Table 1).\textsuperscript{11} Supply side factors, such as continued use of practices which are not evidence based, lack of appropriate staff, essential drugs, and weak referral system contributed to poor maternal outcomes.\textsuperscript{16}

Human resources for maternal health are limited with only 0.21 physician per 1,000 population but nurses and midwives are slightly more common, at 0.46 per 1,000 population.\textsuperscript{1}

<table>
<thead>
<tr>
<th>Reason</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least one problem accessing health care</td>
<td>86.4</td>
</tr>
<tr>
<td>Concern no provider available</td>
<td>57.1</td>
</tr>
<tr>
<td>Not wanting to go alone</td>
<td>54.3</td>
</tr>
<tr>
<td>Concern no drugs available</td>
<td>53.6</td>
</tr>
<tr>
<td>Concern no female provider available</td>
<td>50.4</td>
</tr>
<tr>
<td>Concern about security</td>
<td>48.8</td>
</tr>
<tr>
<td>Distance to health facility</td>
<td>40.5</td>
</tr>
<tr>
<td>Having to take transport</td>
<td>39.0</td>
</tr>
<tr>
<td>Getting money for treatment</td>
<td>38.8</td>
</tr>
<tr>
<td>Getting permission to go for treatment</td>
<td>7.0</td>
</tr>
</tbody>
</table>


STIs/HIV/AIDS prevalence is low but unsafe practices increase risk for transmission

The prevalence of HIV in Nepal is less than 1 percent and HIV is primarily concentrated among injection drug users, migrant workers, and female sex workers.

Knowledge of HIV/AIDS among women is low. Only 58 percent of adult women know that routine condom use can reduce the risk of HIV transmission. Further, only 28 percent of young women ages 15–24 and 44 percent of young men have comprehensive HIV knowledge.

Technical Notes:
Improving Reproductive Health (RH) outcomes, as outlined in the RHAP, includes addressing high fertility, reducing unmet demand for contraception, improving pregnancy outcomes, and reducing STIs.

The RHAP has identified 57 focus countries based on poor reproductive health outcomes, high maternal mortality, high fertility and weak health systems. Specifically, the RHAP identifies high priority countries as those where the MMR is higher than 220/100,000 live births and TFR is greater than 3. These countries are also a sub-group of the Countdown to 2015 countries. Details of the RHAP are available at www.worldbank.org/population.

The Gender-related Development Index is a composite index developed by the UNDP that measures human development in the same dimensions as the HDI while adjusting for gender inequality. Its coverage is limited to 157 countries and areas for which the HDI rank was recalculated.

### Development partners support for reproductive health in Nepal

<table>
<thead>
<tr>
<th>WHO</th>
<th>Health systems strengthening; FP research/training; Safe motherhood; Newborn care; STIs/HIV/AIDS training, surveillance, PMTCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNFPA</td>
<td>FP; Safe motherhood; STIs/HIV/AIDS training, advocacy, technical support, RH camps; Suicide/mental health; RH/MNH health education and communication</td>
</tr>
<tr>
<td>UNICEF</td>
<td>Safe motherhood; Newborn care; STIs/HIV/AIDS community-based activities, PMTCT; RH/MNH health education and communication</td>
</tr>
<tr>
<td>USAID</td>
<td>Health systems strengthening</td>
</tr>
<tr>
<td>GIZ</td>
<td>Health systems strengthening; Adolescent sexual and reproductive health; STIs/HIV/AIDS BCC intervention</td>
</tr>
<tr>
<td>NHSSP</td>
<td>Health systems strengthening</td>
</tr>
<tr>
<td>Pooled funding partners (AusAID, DfID, GAVI, KfW, World Bank)</td>
<td>Health systems strengthening, overall program support</td>
</tr>
</tbody>
</table>
Key Actions to Improve RH Outcomes

Strengthen gender equality
- Educate and empower women and girls to make reproductive health choices. Build on advocacy and community participation, and involve men in supporting women’s health and wellbeing.

Reducing high fertility
- Address the issue of opposition to use of contraception and women’s concerns regarding the side-effects of modern contraceptive methods.
- Promote the use of ALL modern contraceptive methods, including long-term methods, through proper counseling which may entail training/re-training health care personnel.
- Secure reproductive health commodities and strengthen supply chain management to increase the use of modern contraceptives further.
- Strengthen post-abortion care (treatment of abortion complications with manual vacuum aspiration, post-abortion family planning counseling, and appropriate referral where necessary) and link it with family planning services.

Reducing maternal mortality
- Promote institutional delivery through provider incentives and generating demand for the service. During antenatal care, educate pregnant women about the importance of delivery with a skilled health personnel and getting postnatal check. Encourage and promote community participation in the care for pregnant women and their children and address the issue of women wanting someone to accompany them to the health facility.
- Implement risk-pooling schemes and make emergency transport arrangements or provide transport vouchers to women in hard-to-reach areas.
- Target the poor and women in hard-to-reach rural areas in the provision of basic and comprehensive emergency obstetric care (renovate and equip health facilities).
- Address the inadequate human resources for health by training more midwives and deploying them to the poorest or hard-to-reach districts.

Reducing STIs/HIV/AIDS
- Help maintain the low infection rate by communication, information and make available voluntary testing and counseling through the antenatal care system.
- Focus HIV/AIDS education efforts on adolescents and youth and other high risk groups including IDUs, sex workers and their clients, and migrant workers.

References:
13. Staff calculations based on DHS 2006.
Nepal commits to recruit, train and deploy 10,000 additional skilled birth attendants; fund free maternal health services among hard-to-reach populations; and will ensure at least 70% of primary health care centers offer emergency obstetric care.

Nepal will also double coverage of PMTCT; reduce unmet need for family planning to 18%, including by making family planning services more adolescent friendly and encouraging public-private partnerships to raise awareness and increase access and utilization.

Nepal will work to improve child health and nutrition through rolling out the Community Based Integrated Management of Childhood Illnesses Program from 27 districts to all 75 districts in the country; maintaining de-worming and micro-nutrient supplementation coverage at over 90%; and implementing effective nutrition interventions (using innovative programs such as cash transfers to pregnant and lactating women and other community based interventions).