Access to family planning services in Nepal – barriers and evidence gaps

POLICY BRIEF

MIGRANTS

This policy brief is based on the findings of a literature review and a stakeholder consultation conducted as part of support to Family Planning in Nepal by DFID and USAID, in partnership with the Family Health Division, Ministry of Health.

The original study is one of a series commissioned in 2014 by DFID and USAID to better understand factors affecting access to, and use of family planning services among selected population groups in Nepal:

- **migrant workers and their spouses;**
- **the urban poor;**
- **young people;**
- **Muslim communities.**

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High unmet need, but significant knowledge gaps

There is considerable evidence suggesting the existence of high unmet need for, and lower use of, family planning among male migrant workers and their wives who remain at home. The association of migration and exposure to sexually transmitted infections (STIs) and HIV through returning migrants has also been well researched.

In contrast, there is scarce literature on the barriers to the use of health and family planning services in the context of spousal separation. There have been small scale research interventions, most yet to be adapted and brought to scale. Studies tend to focus on the wives of male migrants – we know less about the needs of migrant women.

The need for a systemic focus

The findings point to the need of approaching migration in a comprehensive way – at various levels and across a variety of programmes and initiatives.

Policy level: The National Family Planning Programme in Nepal needs to go beyond its natural realm and specifically address the needs of migrant couples (intended as couples where one spouse has migrated for foreign employment). Measures aimed specifically at migrants **should become a clear, identifiable component of the National Family Planning Programme**. Interventions should be tailored to specific local contexts, after piloting.

Programme level: Any contact with a migrant worker (or their spouse) should trigger the application of specific protocols by government health workers, health volunteers and private family planning providers. If they already exist, such protocols should be revised and updated.

For example, women should be asked early on whether their husbands are migrants, and if so: Does the couple want more children? Are they using contraceptives? Would they like advice on contraceptive options and protection from STIs? Men should be asked if they are migrants, and if so offered counselling on STIs and HIV and on the adoption of an appropriate family planning method (both by husband and wife).

Service delivery level: Much can be done by public and private providers to increase the availability of all contraceptive commodities and to improve the quality of care. Quality improvement efforts should be targeted at improving the training of health care providers and at removing misconceptions and attitudes that may stigmatise wives of migrants using family planning while their husbands are away. Appropriate counselling skills among health workers and volunteers are crucial.

Community level: Interventions should focus on increasing awareness about family planning in the context of migration, and on modifying attitudes about the use of family planning by migrants' wives that can result in prejudice and stigma. FCHVs should be part of such efforts by targeting specific information and advice to households with migrants.

The existing literature focuses on the wives of male migrants – less is known about the family planning needs of women seeking employment opportunities abroad, though it is acknowledged that they are doing so in ever greater numbers.

Given the scale of migration, the case for providing dual protection to women seems fully justified and urgent.

The importance of safe contraceptive and HIV prevention options that women can own and manage has long and widely been recognised.

Targeting both spouses, when one is a migrant

Programmes and initiatives can achieve a virtuous circle of protection if they **focus on couples**, taking into account the differing needs of those who migrate, and those who remain at home.

Male migrants: Various measures could be taken, or at least tested, to mitigate health risks to male migrants. For example:

- Strengthening pre-departure briefings to increase awareness of sexual health issues. The literature on these briefings is very scarce, so more research might be appropriate.
- Reaching out to migrants returning to visit the family, with an emphasis on the prevention, detection and treatment of STIs, and on encouraging the adoption of family planning – jointly with their wives – depending on the couple's reproductive preferences.
- Multi-country focused strategies in coordination with destination countries might, in principle, help to address some issues through interventions at source, transit and destination. However, the evidence on these approaches is limited.

Wives of migrants: We know less about the situation of wives, however we do know that they are vulnerable not only when their husbands return home but also when they are away, through increased workload and multiple stresses, and through stigma that discourages the use of family planning in their husband's absence.

It is crucial to increase women's awareness of risk – **the dual risk of HIV or STI infection and of unwanted pregnancies** – and enhance the use and supply of all dual protection methods. The importance of safe contraceptive and HIV prevention options that women can own and manage has long and widely been recognised in the context of the global HIV response – this is not always achievable with the male condom alone.

Given the scale of migration – now and likely in the future – **the case for providing dual protection to women seems fully justified and urgent**.

Beyond family planning programmes

It is also important to integrate the implications of migration into other national programmes or initiatives, for example those targeted at young people, who are either the migrants of tomorrow or migrants themselves, and socio economic programmes with a poverty reduction focus. This will require close collaboration between the Ministry of Health and other ministries.

This brief is based on: *Uprety S, Khatri R, Baral SC, Regmi S (2016). Access to family planning services by migrant couples in Nepal: barriers and evidence gaps. A review of the literature. HERD International and Mott MacDonald.* Available at:www.herdint.com

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