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

POLICY BRIEF

MUSLIM COMMUNITIES

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 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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Interpreting the data with care

Although we know that use of family planning among Muslim communities in Nepal is lower than among other groups, all indicators should be interpreted carefully and **simplistic causal links between low contraceptive use and religion should be avoided**.

Several broader factors are likely to play an important role – poverty and social disadvantage, low access to education and limited women's empowerment for example. Adopting a health angle alone has limitations given that the issues at play go beyond health and development.

Many information gaps remain

The specific factors and barriers affecting access, use and choice of contraceptives among Muslims in Nepal are not well known or documented. We identified three main types of gaps.

Population based survey data

There is a need for **more sophisticated statistical analysis** of Demographic and Health Survey data, which should be extended to other statistical data sources such as household surveys and Multi-Indicator Cluster Surveys. Analysis should better control for the many confounding variables and identify the degree to which caste, ethnicity and regional identity actually do influence the documented outcomes.

In-depth qualitative research

There is a need for research on the perceived or real demand side factors within Muslim communities: very few of the existing studies contain original empirical data about what Muslims actually believe, do, want or need.

It is important that any research is **free from pre-conceived ideas** about what Muslim women want or need, and it is conducted in ways that enable different members of Muslim communities (and women in particular) to freely express their opinions and concerns, and that they are not stigmatised as 'a problem community'.

This type of research is, by definition, time consuming and requires advanced qualitative research skills – it is not the same as 'market research' where 'desire' for specific contraceptives is gathered before the behavioural patterns and needs of the communities have been properly explored and understood.

Supply side studies

Such research is absent yet necessary to better understand whether certain reported attitudes or 'misconceptions' about family planning are in fact rooted in poor service quality and other accessibility or acceptability issues.

Studies should be conducted among public and private sector family planning providers serving Muslim communities. They should explore,

for example, the extent to which services in Muslim predominant areas are delivered by health workers (including Muslim health workers) who understand and are able to communicate effectively with their clients. We recommend **primary research combining qualitative and quantitative data**. We note, however, that HMIS data is of limited value because of large recording and reporting errors, as shown in recent evaluations of family planning interventions conducted as part of this project'.

In many settings religion has been observed to play a role in family planning use, however it is the way in which the teachings of Islam in relation to family planning are interpreted that accounts for some of the differences observed in family planning use, and not religion in itself.

Muslim women should have access to the full range of methods to choose from according to individual preference – choice should not be limited because of preconceptions about what they would want as 'Muslims'

Next steps

The existing information gaps make it impossible to recommend specific interventions. The literature shows increasing recognition of the issues surrounding access to quality health care by minority groups or in less accessible geographical areas of Nepal: it is worth **revisiting the recommendations of two previous studies** in particular, as they have emphasised several approaches that would increase the relevance and effectiveness of potential interventions:

- Voices from the Community: Access to Health Services: A Rapid Participatory Ethnographic Evaluation and Research (PEER) Study. (Thomas et al 2012)
- Caste, Ethnic and Regional Identity in Nepal: Further Analysis of the 2006 Nepal Demographic and Health Survey (Bennett et al 2008).

These studies stress the importance of avoiding contributing to stigma and stereotyping, and that proven interventions with high quality care are essential for Muslim women just as much as they are for other women. Muslim women should have access to the full range of methods to choose from according to individual preference – **choice should not be limited because of preconceptions about what they would want as 'Muslims'**.

Implicitly, these studies also stress the importance of community participation in any intervention to ensure acceptability, feasibility and local buy-in from key stakeholders, including women and their partners, but also religious leaders and other gatekeepers.

This brief is based on: *Shrestha N, Arjyal A, Joshi D, Maharjan U, Regmi S, Baral SC (2016). Access to family planning services by Muslim communities 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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