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ACCESS TO MATERNAL, NEONATAL, AND CHILD HEALTH SERVICES IN REMOTE AREAS OF NEPAL - STUDY FINDINGS

THE MAIN POINTS

The main findings of a 2013 study on access to maternal, neonatal, and child health (MNCH) services in five remote and mountainous Nepalese districts were as follows:

- 27% of people in the five districts (202,000 people) lived more than eight hours travel from their district headquarters including 63% of people in Bajura district.
- There was an incremental decline in the proportion of normal and complicated deliveries carried out in health institutions from the district HQs outwards. The availability of MNCH services showed the same trend.
- Many women in Nepal face home, community, and service-based barriers to accessing and using MNCH services. Remoteness increases service barriers including the availability and quality of services. The women in the five remote districts faced the additional barriers of longer distances to health facilities, difficult terrain and the associated higher costs of accessing services, which compound the generally higher levels of poverty.
- Women and babies in mountain areas are thus more at risk of negative health outcomes.

BACKGROUND

In 2013 a study was carried out on women and children's access to MNCH services in remote areas of Nepal. Using mountain areas as a proxy for remoteness the study analysed access to these services in remote areas in general and in detail in five remote districts. The main rationale for the study was that Nepal's health policies, plans, service provision and budget allocations insufficiently address the health needs of women and children in Nepal's remote areas.

SERVICE ACCESS AND USE IN REMOTE AREAS OF NEPAL

The analysis of national level data showed that there is a lower use of maternal newborn and child health (MNCH) services and a higher use of traditional health practices in Nepal's mountain areas. As a result women there have short birth intervals, proportionately far fewer institutional deliveries, are half as likely as hill and Tarai women to have their births attended by skilled birth attendants (SBAs), and have poorer access to emergency obstetric care (EOC). There are also higher rates of newborn and under-5 mortality in mountain areas (Figure 1).

Concerned government agencies: The Family Health Division (FHD) and the Child Health Division (CHD).

Support: The World Bank and the Nepal Health Sector Support Programme (NHSSP) provided financial and technical support for this study.

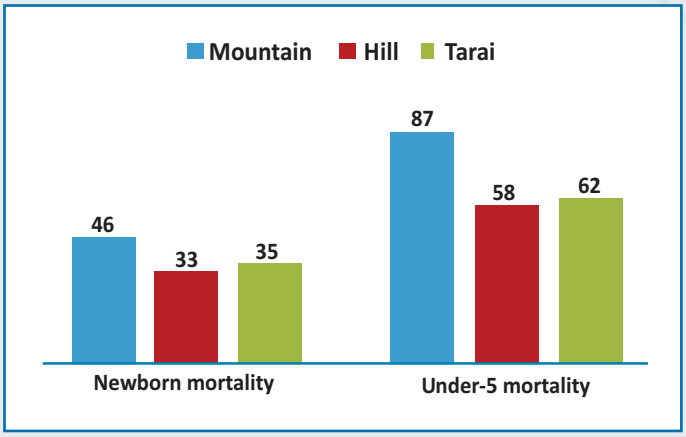

Figure 1: Newborn and under-5 mortality rates in Nepal per 1,000 live births (Nepal Demographic and Health Survey, 2011)

THE CASE STUDY SAMPLE

The study analysed data from district and health institution records and collected primary data from Bajura, Rukum, Gorkha, Rasuwa and Taplejung districts. Four of these districts have high rates of poverty and their remoter village development committees (VDCs) are even poorer. Data was collected in each of the five districts from:

- the district hospital (= 'district HQs');
- one health facility located less than eight hours travel time from the district HQ (= 'less remote' facilities/ VDCs); and
- one health facility located more than eight hours travel distance from the district HQ (= remote facilities/VDCs).

This gave a sample of three levels of remoteness in each district. Primary data was collected from focus group discussions and interviews with service providers, clients and the furthest communities in each facility's catchment area.

STUDY FINDINGS ON USE AND PROVISION OF MNCH SERVICES

The use of MNCH services varied across the five districts. Bajura district had the highest use of MNCH services including the highest institutional delivery rate and met need for emergency obstetric care (Table 1). This was probably due to the greater number of birthing centres, the good responsiveness of service providers, the ready availability of SBAs, active female community health volunteers (FCHVs), VDCs providing stretchers, and the efforts made to provide warm environments in health facilities.

The typically rugged terrain of Nepal's mountain areas

Table 1: MNCH status indicators in less remote and remote areas of the five study districts

VDCs/residence of women	Percentage of VDCs with a birthing centre	Proportion of institutional deliveries (by residence of women)$_2$	Emergency obstetric care (EOC) met need[1] (by residence of women)
Bajura VDCs less than 8 hrs from HQ	63%	65%	82%
Bajura VDCs 8 hrs+ from HQ	68%	38%	15%
Gorkha VDCs less than 8 hrs from HQ	35%	29%	19%
Taplejung VDCs less than 8 hrs from HQ	24%	21%	10%
Rasuwa VDCs less than 8 hrs from HQ[3]	45%	13%	2%
Rukum VDCs less than 8 hrs from HQ	26%	13%	36%
Rukum VDCs 8 hrs+ from HQ	36%	12%	13%
Taplejung VDCs 8 hrs+ from HQ	10%	9%	7%
Gorkha VDCs 8 hrs+ from HQ	0%	5%	3%

Source: HMIS records
Note 1: The % EOC met need figures are % of women who received treatment among the estimated number of complication cases.
Note 2: The data on women from district centres is not included in this table.
Note 3: All Rasuwa VDCs lie within 8 hours travel time to the district HQ.

Overall, there was a pattern of increasingly poor access to and use of MNCH services the further away and more difficult the journey to the district HQ was (Figure 2):

- The proportion of institutional childbirths was two times higher in district HQs than in the other parts of the districts.
- The met need for emergency obstetric care in the remote VDCs was less than a half that in the 'less remote' VDCs and less than a third of the rate in the district HQs.

The proportion of births taking place in health institutions was highest in Bajura in all three types of areas with 94% of women in district HQs, 65% of women in less remote and 38% in remote VDCs giving birth in health institutions. Only 5% and 9% of women had institutional births in the remote VDCs of Gorkha and Taplejung.

The study concluded that this pattern is largely due to the following barriers to MNCH services. Some related responses of study participants are given in the box on page 3.

a. Home and community based barriers — There was a strong preference for home births and traditional healers, which can delay seeking modern health care. Financial barriers were also a major barrier. In addition, traditional socio-cultural practices, women's work burdens, and lack of knowledge and awareness about health were found to limit women's decision-making power and mobility to seek health care.

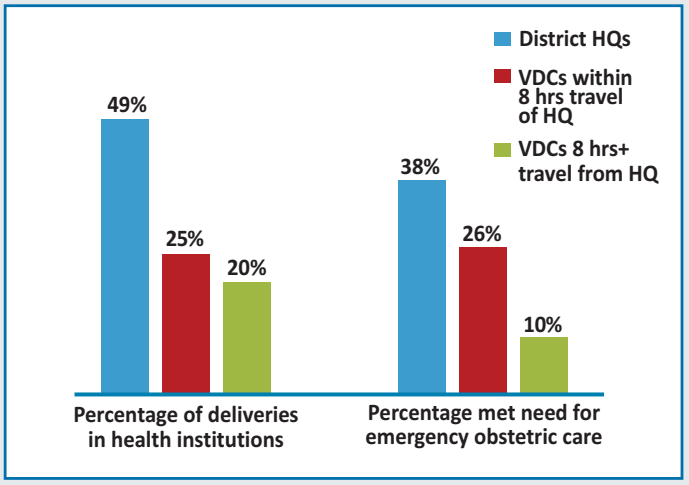

Figure 2. Remoteness affects access to maternal and newborn health care services in the five study districts (2011/12)

b. Journey based barriers — Difficult terrain and long journey times to modern health services are major barriers in Nepal's mountains with steep and narrow paths that pass through forests and uninhabited areas. These difficulties are exacerbated by monsoon rains, winter snows and the limited availability of services in these areas.

The five districts only have a few roads, many of which are closed in the monsoon. Within the study VDCs, emergency cases were usually carried to health institutions in *doko* baskets or stretchers, often entailing high porterage costs. Some settlements within the study VDCs lie 4-8 hours travel time from a birthing centre and 31% of people in the five districts live more than eight hours travel from a district hospital that provides caesarean sections.

c. Service based barriers — The limited number of female service providers, shortages of skilled health personnel, inadequate drinking water at health facilities, lack of room heating and insufficient waiting rooms in hospitals were raised as major barriers to accessing and using care. And only three of the district hospitals provided caesarean sections. In the study's health posts and sub-health posts the weakest service areas were long-term family planning and medical abortions. Further, in the study districts the remote VDCs had far fewer birthing centres than VDCs closer to the district HQs (see Table 1). And there was no birthing centre in the 17 remote VDCs of Gorkha district. Overall, the availability of MNCH services mostly depended on the availability of trained care providers and medicines.

A patient being carried along a narrow path
Credit: United Mission to Nepal

d. Availability of health workers and drugs — The lack of adequate health workers and drugs are also significant barriers to health care provision:

- The lack of skilled female service providers and the unavailability of essential services at many health facilities were concerns in several places. While there was a resident SBA in 37% of the remote VDCs, only 29% of health facilities in these areas provided delivery services.
- In the remote facilities, auxiliary nurse-midwives and maternal and child health workers were mostly local people (thus encouraging service use).
- FCHVs provided a means of health service delivery in some settlements in remote VDCs of the study area for the lack of any alternative. But it is known from other studies that FCHVs in remote areas tend to be less active and literate.
- Lack of adequate staff accommodation is a major disincentive for health workers to serve in remote areas.
- A large number of drugs had expired at Rukum and Rasuwa district hospitals and in the remote health facilities in Gorkha and Bajura. Further, concerns were expressed by some clients about the need to purchase medicines that should be freely available under MoHP's free essential health care programme, and some said this made them reluctant to visit health facilities.

Views of study respondents about access to health services

- "They first go to try and exorcise the ghost from their body (*bhootfyalnu*), and only after this fails do they come to the health post." — Skilled birth attendant, Rasuwa
- "25% of women do not receive health care in time due to having too much domestic work." — HFOMC member, Bajura
- "I don't know what to do to stop getting pregnant. When I ask my husband he says that women who take Depo Provera can't carry heavy loads. He asks me who will then do the housework?" — Woman, Taplejung
- "People living in most northern areas have to walk 3 to 5 days to reach the district hospital." — District health officer, Taplejung
- "Nowadays women have access to health services more than in our time. People are aware of family planning and limit children. The situation has changed." — Mother-in-law, Gorkha

RECOMMENDATIONS

The following recommendations are aimed at the study's key informant group of experts on MNCH, the government's Safe Motherhood and Neonatal Sub Committee and other decision makers.

The following policy initiatives are needed to promote health service provision in remote areas:

1. Develop and implement a strategy for MNCH services in remote areas.
2. Establish a remote areas desk in the Department of Health Services.
3. Prioritise remote districts when scaling-up community health services.

Help communities to overcome the home-based and local socio-cultural practices that negatively impact access to and the use of health services:

4. Mobilise mothers' groups, traditional healers, men and local leaders to improve maternal and neonatal health.
5. Adapt the government's behaviour change communications strategy for MNCH and family planning for remote areas.

Help overcome the barriers of difficult terrain and long distances to health services:

6. Establish community-based emergency funds in mothers' groups, EOC referral funds in health facilities and district hospitals, and reduce out-of-pocket spending on transport by emergency cases.
7. Locate birthing centres more rationally to serve unserved populations.
8. Increase the transport incentive for deliveries in mountain and remote districts.
9. Strengthen the capacity of FCHVs in remote areas and promote more home visits by them.
10. Provide mothers' groups in remote areas with stretchers and doko baskets for carrying patients to health facilities.

Overcome service-related barriers:

11. Ensure the continuous availability of all comprehensive emergency obstetric and neonatal care (CEONC) signal functions at district hospitals.
12. Establish and strengthen health services, including birthing centres and family planning and safe abortion services, in strategically located health facilities.
13. Strengthen referral systems by ensuring adequate linkages with higher level hospitals including via mHealth technologies.
14. Improve the terms and conditions of staff posted to remote locations, including by enabling them to spend time at district hospitals to enhance their skills and by considering higher salaries and allowances for locally recruited health workers in remote locations.
15. Consider contracting out health service provision to NGOs and the private sector in remote areas.

Improve health service governance:

16. Strengthen supervision and monitoring in remote areas including by health facility operation and management committees (HFOMCs) and via social auditing.
17. Introduce context-specific and need-based planning at the district level with additional resources provided to cover remote area-specific needs.
18. Strengthen reproductive health coordination committees (RHCCs) in remote districts.
19. Partner with private teaching hospitals to strengthen service delivery and civil society networks to work on demand side governance in remote areas.

Delivering in a birthing centre, such as this one in Jumla, can save the lives of women and babies

THE WAY AHEAD

The study identified the following potentially high impact strategies:

1. Make district level planning more context specific and district health office (DHO)/district pubic health office (DPHO)-led. Provide flexible funds to DHOs and DPHOs to implement tailored, evidence-based activities in remote locations.
2. Fine-tune technical interventions to fit the contexts of remote areas.
3. Ensure the availability of district managers and supervisors, and if necessary support DHOs and DPHOs to implement and monitor remote area activities.
4. Use NGOs, community based organisations and private sector partners to improve access to and use of services in remote areas.

From August 2014, the Family Health Division has introduced the following package of interventions to increase access to maternal and newborn health (MNH) services in the study districts of Taplejung, north-eastern Nepal:

1. At the district hospital, enhancing staffing, funding, equipment and supplies and providing referral funds and emergency referral support for obstetric complication cases where CEONC service are not available 24/7.
2. Prioritising and selecting strategically located facilities in remote areas to be upgraded to birthing centres, strengthening and motivating HFOMCs to mobilise local resources, training and coaching health workers on MNH competencies, providing obstetric first aid, and contracting NGOs to mobilise communities to improve their access to health services.
3. Implementing the Equity and Access Programme (EAP) that includes behaviour change communication; mobilising women's groups; supporting and strengthening FCHVs; promoting post-partum home visits by social mobilisers; mobilising husbands, community leaders and traditional healers; establishing emergency funds and improving the functionality of outreach clinics.

The overall aim is to inform the development of strategies for MNCH in remote areas, and the preparation of the Nepal Health Sector Strategy Implementation Plan (2015-20).

The Nepal Health Sector Support Programme (NHSSP) is funded and managed by DFID and provides technical assistance to the Nepal Health Sector Programme (NHSP-2). Since it began in January 2011, NHSSP has facilitated a wide variety of activities in support of NHSP-2, covering health policy and planning, human resource management, gender equality and social inclusion (GESI), health financing, procurement and infrastructure, essential health care services (EHCS) and monitoring and evaluation. For more information visit www.nhssp.org.np