PULSE
UPDATING YOU ON HEALTH DEVELOPMENTS

# 4. THE EFFECTS OF GEOGRAPHY ON ACCESS TO HEALTH SERVICES

## GEOGRAPHICAL BARRIERS

The Access to Health Services Study (Thomas et al. 2012) gathered the views of women and poor and marginalised people on how geographical factors affect their access to health services.

## PHYSICAL DISTANCE

The distance that people live from services can facilitate or prevent access. The following inter-related factors have financial and opportunity costs:

- physical distance;
- time taken to reach a facility;
- perception of distance; and
- lack of transport.

These challenges are further exacerbated by seasonal factors such as the much greater difficulty of crossing watercourses in the monsoon season. The distance people live from health facilities affects and interacts with many of the other barriers that women and poor and excluded people face accessing health services. Those described by study participants as of key importance are shown in Figure 1 marked with an asterisk.

It is important to note that these barriers not only relate directly to the journey to access health care, but interact with home- and community-based factors that deter the use of distant services, and with service-related barriers at health facilities that affect willingness and confidence to seek care.

## THE ACCESS TO HEALTH SERVICES STUDY

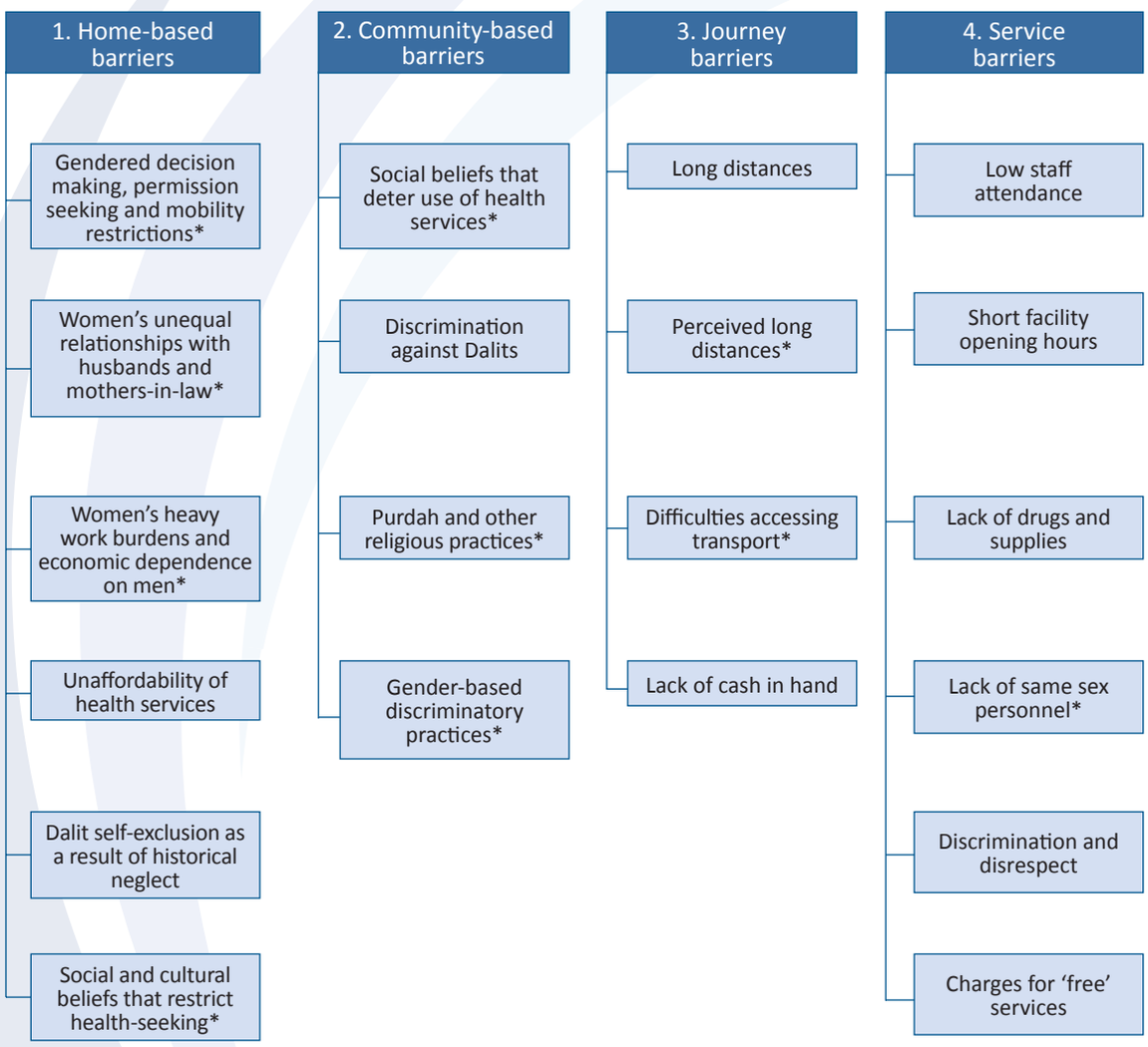
A study was carried out in 2012 to understand the socio-cultural, economic and institutional barriers that poor and excluded people face accessing health services in Nepal. It used the rapid participatory ethnographic evaluation and research (rapid PEER) method, which is designed to explore sensitive issues with non- and low literate marginalised populations. Rapid PEER interviews happen in the third person to avoid response biases and are carried out by 'ordinary' members of target groups to elicit frank responses. The study examined experiences of accessing essential health care services at sub-health posts, health posts and outreach clinics.

Six social groups were studied: Chepangs, Muslims, Madhesi Dalits, Other Backward Classes (OBCs or other Madhesi castes), hill Dalits, and poor hill Chhetris and Brahmins, thus covering caste, ethnic, and religious differences. Each group was studied in two districts giving 12 sub-studies with 374 interviews in all.

Eight briefing notes have been produced to disseminate the findings. Note 1 gives the background and methodology while notes 2, 3 and 4 present the findings on the effects on accessing health care of poverty, caste and ethnicity (2); gender (3) and geography (4). Note 5 presents the findings on access to family planning, note 6 on access to safe abortions, note 7 on access to maternal health services and note 8 on access to child immunisation services. The study report (Thomas et al. 2012) is available at http://www.nhssp.org.np/gesi/Nepal%20PEER%20Revised%20Report.pdf

*Pregnant woman being carried to hospital in a doko basket*

**Figure 1: Barriers Related to Distance from Services**




** Denotes the most important perceived barriers to accessing health services*

## HILL AND TARAI DIFFERENCES

The latest quantitative data shows clear differences in access to health services between Nepal's Tarai (southern plains) and hill areas:

- A larger proportion of households in the Tarai live within 30 minutes of a health post (78%) in comparison with hill areas (49%) where 8% live more than two hours away from a health post (CBS 2011).

- The unmet need for family planning is higher in hill districts (30% of respondents) than in the Tarai (25%) (MoHP et al. 2012).

- The non-use of antenatal care (20% hills, 10% Tarai), the prevalence of home births (66% hills, 57% Tarai) and the likelihood that birthing assistance is provided by a relative (53% hills, 27% Tarai) are all higher in the hills than in the Tarai (MoHP et al. 2012).

- Women's participation in decision-making is lower in the Tarai than in the hills while the proportion of women who have experienced physical violence since passing their fifteenth birthday is higher in the Tarai (28%) than in the hills (17%) (MoHP et al. 2012).

The current study found major variations between the hills and Tarai in terms of both the physical distance from and time taken to access health services. It also found corresponding differences in terms of opportunity costs, particularly given the greater amount of time hill women spend on domestic and farm work.

> "Due to distance, many people do not like to go to the hospital. It can be five to six hours' walk. And it is too far to go to the health post. It can take up to three hours of walking."
>
> Female, Dhading

> "Men and women living far from the sub-health post experience difficulties in taking services offered. There is no transportation. People depend on rickshaws and carts as vehicles; but the gravelled road is almost 3 km long and vehicles don't always run."
>
> Female, Rautahat

The extent to which financial costs impact access to health services depends on the availability of transport (which is less in hill areas) and the level of poverty in households. Poor households have little disposable cash given the competing demands of school costs, food and health care. Study participants said that, where women and children's health is perceived as a lesser priority (particularly for antenatal care visits, institutional deliveries and the immunisation of children), money may not be made available. Furthermore, the distance from such services may be too far, or it may take too long to travel by foot and therefore services will not be accessed. The possibility of access may also depend on seasonal factors, such as livelihood workloads and water levels in streams and rivers.

The above issues are most likely to impact hill women, although issues such as perceptions of the need to access health services, poverty and domestic labour also affect women in the Tarai.

Acharya and Cleland (2000) found that perceptions of the distance to health services were an important barrier in Tarai and hill areas. The importance of perceived distance was also highlighted by participants of the current study. In hill areas, where most people are used to covering large distances by foot, perceptions of distance are influenced by distance, terrain, time taken, lack of transport (public and private) and costs incurred.

The study found that Tarai participants were more influenced by the means of available transport (on foot, by bicycle or by vehicle) and seasonality as watercourses fill up and some roads become impassable in the rainy season. While in the hills only a long round trip of say six to eight hours on foot was said to inhibit visits to health services, in Tarai areas a lack of transport to travel 3 km along a gravelled road was just as influential for deciding whether or not to visit the nearest health facility. Further, the willingness to pay for transport for institutional delivery was found to be very low (especially in Muslim households) as transport charges were considered high, alongside the common belief that delivery should happen at home.

*Many people in rural Nepal have to cross rivers to reach their destinations.*

## ISSUES TO CONSIDER

1. The perceived and actual distance to a health facility varies by physical and social environment and time of year. How can this be taken into account when planning local-level service delivery and to optimise access to specific services such as outreach camps for uterine prolapse repair and contraception?

2. Can awareness-raising be targeted at the main gatekeepers of women's access to care (husbands and mothers-in-law) to overcome married women's dependence on household decision-makers for seeking care and for cash to pay for transport? Inter-generational perceptions of the value of preventive services are also likely to impact this.

3. How to up-scale the women-led management of community-based emergency funds and develop local solutions in different ecological areas? Options could include:
   - identifying areas with severe transport problems;
   - identifying appropriate means of local transport to respond to these problems;
   - mobilising resources from VDCs, municipalities, chambers of commerce, businesses and INGO-run projects; and
   - leveraging corporate social responsibility to reserve places for emergency health cases on planes, buses and local vehicles.

4. How to develop and strengthen health system referral mechanisms from female community health volunteers and community level health facilities to higher level facilities?

5. How to provide more efficient transport mechanisms to transfer referral patients?

6. Can greater efforts be invested in community-based outreach services and the positioning and enhancing of local services, such as birthing centres, so that they better reach the poorest and most excluded people?


*The expanding road network means that ambulances are becoming a realistic option in many parts of the country.*

## REFERENCES

Acharya, LB and J Cleland (2000). 'Maternal and Child Health Services in Rural Nepal: Does Access or Quality Matter More?' *Health Policy and Planning*, 15 (2), pp 223-229.

CBS (2011). *Nepal Living Standards Survey (NLSS) 2010/11.* Kathmandu: Central Bureau of Statistics.

MoHP, New ERA, and ICF International Inc. (2012). *Nepal Demographic and Health Survey 2011.* Kathmandu: Ministry of Health and Population, New ERA, and ICF International.

Thomas D et al. (2012). *Voices from the Community: Access to Health Services: A Rapid Participatory Ethnographic Evaluation and Research (PEER) Study, Nepal.* Kathmandu: Ministry of Health and Population and Nepal Health Sector Support Programme.

*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.*