PULSE
UPDATING YOU ON HEALTH DEVELOPMENTS

7. BARRIERS TO ACCESSING MATERNAL HEALTH SERVICES

GENDER-BASED RESTRICTIONS

The Access to Health Services Study (Thomas et al. 2012) identified the barriers that poor rural women in Nepal's hills and Tarai face accessing antenatal care and institutional delivery services. Gender norms, gender-based decision making in the home, and gender-based discriminatory practices in communities create multiple barriers that delay, prevent or deny women from accessing maternal health services. These barriers interact with and amplify other determinants of access, such as poverty and geography, which deter women from receiving maternal care.

GENDER GETS IN THE WAY

The study found that women's subservience to their husbands and elders means that they need to get permission to visit health facilities. Their heavy domestic and other work burdens, especially in the hills where livelihoods are more demanding, leave women short of time. This situation is compounded when other household members perceive maternal health care as unnecessary or too costly, or as a way of women avoiding arduous and time-consuming domestic duties (see Note 3).

Older women's experiences of pregnancy and delivery further feed the view that antenatal care and institutional delivery are unnecessary. Lacking control over resources or cash, most women depend on their husbands and parents-in-law for money to access health services; and when it is denied they can be threatened with punishment for asking.

Social controls on women's mobility and their use of public spaces were said to apply to women from all social backgrounds. Women need to be accompanied to a facility by their husbands or a family member, with consequent opportunity costs and impacts on their willingness to seek care. The frequent lack of female health providers and restrictions on women being treated by male personnel was said to be a further constraint.

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

A nurse listening to the foetus of a women who is about to give birth

BELIEFS NEED TO CHANGE FOR IMPROVED PRACTICES TO FOLLOW

Social, cultural and religious beliefs have a strong impact on access to health services in Nepal and contribute to gender inequality and social exclusion.

The study found that pregnancy is viewed as a 'natural' process of 'normal' woman. The same common view was identified by Brunson (2010) and Pradhan et al. (2010). Older women tend to view maternal health services, and particularly institutional delivery, as unnecessary at best, and at worst creating mental and physical dependency among younger women. As a result, there were said to often be inter-generational conflicts, with younger women's desires to access formal services being perceived as 'weakness' to carry a pregnancy and give birth without external support.

62% of the women who did not deliver in a health facility said this happened because it was not felt necessary.

MoHP et al. 2012

The widespread disapproval of 'weakness', or accusations of being 'educated' or 'modern', and thus reluctant to conform to traditional social expectations, are exacerbated by the negative impact that seeking care often has on households as a result of the financial and opportunity costs. These attitudes, reinforced by traditional socio-cultural values concerning how women should behave, can place pressures on women to deliver at home (see also Brunson 2010).

The common belief that pregnancy is normal and requires no special care or attention contributes to the risks of miscarriage and uterine prolapse. Approximately 10% of women in Nepal are affected by uterine prolapse (UNFPA and Sancharika Samuha 2007), which results in pain, embarrassment, and in some cases, gender-based violence and rejection by husbands, families and communities.

THE JOURNEY IS DIFFICULT

Women's lack of decision making autonomy, lack of cash in hand, and restrictions on their public actions make them dependent on others for seeking care and organising the logistics to reach services. While it was reported that the incentives for antenatal care and institutional delivery were an enabling factor, it was said that they did not compensate for the direct and opportunity costs of travelling to and from health facilities, and did not overcome the socio-cultural norms and values that incline women towards home-based deliveries.

The decision to travel to health services is affected by the physical distance and terrain to be covered, the availability of transport, the time it takes to reach a service point, the availability of cash-in-hand to pay for expenses and the perceived distance to a health facility.

78% of surveyed Tarai households were within 30 minutes of their nearest health post.

49% of hill households were within 30 minutes of their nearest health post.

8% of hill households were more than two hours away from their nearest health post.

Nepal Living Standards Survey 2010/11 (CBS 2011)

These barriers vary by ecological area. People in hill areas have to negotiate greater distances, the poorer availability of transport and the longer journey times together with the greater opportunity costs and the heavier impacts on livelihoods as a result of being away from home for extended periods. The deterrent of living far away from a facility was also reported by Acharya and Cleland (2000), who found that the uptake of maternal and child health services was twice as high in rural areas with a health post within the community. MoHP et al. (2012) found that the uptake of antenatal care and institutional delivery in the hills decreased as the time taken to reach the facility increased. No such relationship was found in the Tarai.

"It's a long way to hospital along the riverside, which is risky on the one hand, and on the other, they need to pay porters and buy snacks for the porters but do not have money."

Female, Dhading

The current study also identified the perceived distance to a health facility as an important barrier to access in the Tarai. Whereas a round trip of six to eight hours on foot would inhibit a hill resident from visiting health services, the lack of public transport along a 3km gravel road was said to be just as influential on decision making in Tarai areas. The willingness to pay for transport for institutional delivery, despite the availability of the Aama Programme 'transport incentives' for all women who deliver in an institution, was

found to be very low across the study areas. This was linked to the actual costs and social and geographical factors, and the perception among study respondents that the skills available in local health facilities were not superior to skills available in communities for delivery at home.

A mother, with her baby, heading home after giving birth at Koshi Zonal Hospital

CASTE AND ETHNICITY ALSO GET IN THE WAY

Caste and ethnicity add a further dimension of vulnerability for accessing primary health services. Caste-based discrimination was reported by Madhesi and hill Dalit participants, with Madhesi Dalits reporting more discrimination at health facilities and within the wider society.

Dalit participants reported that caste-based discrimination by service providers resulted in:

- the non-provision to Dalits of treatment and medicines that were available at health facilities and outreach services (e.g. home visits by female community health volunteers) and were said to be provided to other castes;
- Dalits usually having to wait longer than others at facilities, often being the last to be treated, and, as a result, often returning home without treatment;
- a reluctance by service providers to touch Madhesi Dalits, meaning that physical examinations of them are usually not carried out; and
- discourteous and limited verbal communication.

Within their communities, Madhesi Dalits said they were discouraged from accessing routine services by other community members, and denied assistance by people from other castes during emergencies. Such discrimination compounds family pressures on women not to seek care, and exacerbates the challenges of reaching services.

The impact of externally-imposed social exclusion, together with deeply ingrained cultural and social marginalisation, results in self-exclusion from available services owing to women's lack of belief that they will receive quality services and from the desire to avoid discrimination.

"Health workers treat non-Dalit women well and do their check-ups immediately. But they don't treat Dalits well and uneducated women, they don't check up well. They don't touch us."

Female, Saptari

"Caste-based discrimination is not completely abolished. Even if we pay, high-caste people don't allow us to use their bullock cart to take the pregnant women to hospital when she is in labour. Two years ago the wife of a local man was in labour and he wanted to take her to the health facility. But the high-caste people did not let him use their bullock cart on rent. Even the high-caste women don't go to help if a Dom (low caste Dalit) woman is in labour. No one gave transport to her. They tried her delivery at home, but the traditional attendant did not come to help. She was in labour since the morning, and gave birth to twins in the afternoon. But the babies were dead.

Because of caste discrimination, the local high-caste traditional birth attendant and high-caste people did not help, so she gave birth to dead children. Dom are discriminated against by both high castes and other Dalits."

Male, Saptari

SUPPLY SIDE GAPS AMPLIFY BARRIERS

The lack of birthing centres in rural and remote areas, and the non-attendance of medical professionals at home births were the most commonly mentioned barriers to accessing skilled birth attendance at deliveries. As a result, women face time-consuming journeys to distant facilities and incur opportunity and direct costs. Such constraints, blended with social norms and the need to acquire family permission, deter women from delivering at institutions despite the availability and awareness of financial incentives under the Aama Programme.

These barriers, compounded by the predominance of male staff at health facilities and women's shyness to reveal their private body parts to them, affects the demand for antenatal care and institutional delivery. High levels of staff absenteeism and short and irregular facility opening hours also affects women's and their families' willingness to invest time and money in maternal care.

"Even though husbands and mothers-in-law ask them to go, women feel shy to show their secret organs to someone. It is better to just die at home."

Female, Dhading

ISSUES TO CONSIDER

1. What can be done to change social norms in the home to enable women to more easily access maternal health services?
2. Can behaviour change communication (BCC) inputs be strengthened to address the socio-cultural and religious beliefs that undermine maternal health?
3. How to strengthen localised BCC approaches to raise awareness of the benefits of attending four antenatal care visits, institutional delivery, postnatal care and the dangers of home-based deliveries? And how can associated messages be targeted to different genders, generations and family members?
4. How to scale up successful community mobilisation interventions, including through:
   - inter-generational and couple relationship-building communication tools;
   - the women-led management of community-based emergency funds; and
   - community-led emergency transport solutions including those supported by village development committees (VDCs)?
5. How can government health facilities and authorities work with other government agencies and civil society organisations to mobilise communities, empower women, and persuade husbands and in-laws to support women's use of maternal health services?
6. How to strengthen the training and supervision of frontline health workers and FCHVs to improve their interpersonal communication and counselling skills, and to equip them as change agents and influencers.
7. What can be learned from the Aama Programme in terms of its ability to help ultra-poor and geographically excluded people overcome financial barriers when they have to travel beyond district headquarters for services?
8. How can birthing centres be made more accessible to poor and excluded communities. Is there value in locating them to support clusters of underserved and high-population VDCs?
9. Can birthing centres be provided with more support from district and referral hospitals, by for example rotating staff?
10. Can NGOs and private providers be contracted to provide outreach and facility-based maternal health services in underserved areas?
11. Is it possible to address human resource gaps, including the need for a mix of female and male staff in all facilities and to reduce avoidable staff absences through better supervision and monitoring?
12. What can be done to make more portable ultrasound machines and trained nurses available to extend antenatal care services to underserved areas?

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