



Nepal Safer Motherhood Project
a part of HMGN Safe Motherhood Programme

**Impact of Conflict on Accessibility of EOC
Health Services**

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ABBREVIATIONS AND ACRONYMS

AHW	Auxiliary Health Worker
BEOC	Basic Essential Obstetric Care
CBO	Community Based Organisation
CDO	Chief District Officer
CEOC	Comprehensive Essential Obstetric Care
DFID	Department For International Development (UK)
DoHS	Department of Health Services
EOC	Essential Obstetric Care
FCHV	Female Community Health Volunteer
HMGN	His Majesty's Government Nepal
HSSP	Health Services Support Programme
INGO	International Non-Governmental Organisation
MCHW	Maternal and Child Health Worker
MIS	Monitoring Information System
NFE	Non Formal Education
NGO	Non-Governmental Organisation
NSMP	Nepal Safer Motherhood Project
PHC	Primary Health Care Centre
RHCC	Reproductive Health Coordination Committee
SDF	Social Development Facilitator
SDO	Social Development Officer
TBA	Traditional Birth Attendant
UNICEF	United Nations Children's Fund
UMN	United Mission of Nepal
USAID	United States Agency for International Development
VDC	Village Development Committee (refers both to council and to geographical area)
VHW	Village Health Worker

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EXECUTIVE SUMMARY

This study investigated the effect of civil conflict on women's ability to access and utilise essential obstetric care services. Other conflict-impact studies have focused on the impact on project implementation and on the impact on health workers and their services. This study focuses on the local communities' perspective and assesses how the restrictions and changes in project activities have affected NSMP's ability to influence care-seeking attitudes and behaviours. A conflict-impact checklist was developed to monitor the impact of conflict on access to EOC.

The study assessed 16 VDCs targeted by NSMP in four districts situated in both terai and mid-hills regions. Based on topic guides, experienced local interviewers performed in-depth interviews with pregnant women and their families, recently delivered women and their families, 'treatment managers', FCHVs, and local health workers. A focus group discussion with a mothers group was held in each VDC. The researchers also interviewed NSMP partner staff in all districts.

Theory on increasing access to health services has identified three delays in care-seeking behaviour: decision making, reaching facilities, and getting care. This study has looked at the impact of the civil conflict on these delays and the related barriers: knowledge, decision-making, transport, finance, services and referral.

Key Findings

Impact on the three delays

The impact of Nepal's civil conflict on access to and utilisation of EOC facilities has added a relatively small additional barrier to the existing barriers to seeking, reaching, and obtaining care. The major impact has been on transport during the night, when curfews are imposed and mobility is severely restricted, although daytime transport facilities are also affected by long delays at security check posts, reductions in frequency of public transport, and diminishing social support at the community level.

Decreases in employment opportunities, reduced income from produce sales, and significant reluctance to lend money to poorer people under the current circumstances increased the economic barriers to accessing health services.

In the most severely affected areas, health service availability has been reduced since health staff have often left their postings due to harassment by Maoists. Delivery of medicines has been restricted by the security forces.

Fear caused by the civil conflict delays decision-making due to hesitations over travel safety and also reduces social support within communities. Although knowledge of obstetric danger signs and the potential of medical intervention do not seem to have been affected by the conflict, in heavily affected areas many knowledgeable people have left their communities due to the conflict.

The impact of the conflict has hardly changed the relative weighting of the barriers of delay. This means that though the larger impact may be on transport, the focus of efforts to overcome barriers to access, still need to be on decision-making and referral.

Impacts on NSMP activities

The civil conflict has affected the effectiveness of the project interventions in two ways. One is that many of the emergency funds, which had been established in order to overcome financial access barrier, have been either closed down or looted by Maoists. Some transport schemes also have been cancelled. The other impact concerns the disruption of many community groups, caused by restrictions on group gatherings imposed by security forces as well as by Maoists threats against development activities. In combination with the decreased field presence of partner staff to support local groups, this is impeding community-level safer motherhood activities and dissemination of knowledge.

NSMP and its partners have initiated some alternative activities, like mass media, non-formal education materials, and printed newsletters. Various factors like unavailability of batteries and fear of listening to radio during curfew hours limited the effectiveness of radio campaigns. The proposed NFE classes and dissemination of printed materials are susceptible to conflict impacts, as in many areas classes are stopped due to the security situation, and the security forces do not allow printed material to be brought into the most heavily affected areas.

Key Recommendations

The following recommendations may mitigate the impacts of the conflict on access to EOC health facilities. A full and more detailed set of recommendations can be found in Section 5.

- NSMP should take the lead in fostering dialogue with security forces to overcome the barriers created by the security regulations, while involving the partners¹ in the process.
- The solutions negotiated with the security forces should be disseminated to the communities, including them in the safer motherhood messages;
- NSMP and its partners should work with community groups to institute arrangements that protect funds collected for obstetric emergencies and that ensure the swift availability of porters. This might include elements of conflict-management counselling, to overcome disproportionate fear;
- Groups of Dalit and the poor should be specifically targeted knowledge dissemination and attitude-changing efforts. The study found indication that the Maoist conflict is actually enforcing segregation in many communities. Historical conclusion is a primary justification for the Maoist conflict and if not addressed the programme may reinforce segregation and deprivation;
- The project and its partners should regularly review their project activities from the perspective of “do no harm” methodology, to prevent that NSMP activities in the communities are exacerbating the conflict by enforcing segregation and giving disproportionate benefits for some population groups;
- Partners should be stimulated to plan realistically and to take the conflict situation into account without being overwhelmed by it, using conflict-management tools like conflict profile, risk assessment, and coping capacity assessment;
- Partners should be stimulated to find effective ways to monitor the conflict impact in the communities as well as the impact of their activities. This will help them plan their activities according to community needs and obstacles. The monitoring checklist developed in this study would be one element of this process. NSMP and its partners should ensure that the conflict impact-monitoring checklist is used not only as a diagnostic tool, but that the collected information is used for identification of possibilities for conflict impact mitigating activities.

¹ Partners: Those organisations (NGOs, local agencies and local government bodies, networks) that have a long-term relationship with NSMP for the implementation of the project.

1. INTRODUCTION

The DFID-supported Nepal Safer Motherhood Project (NSMP) aims to support HMGN's National Safe Motherhood Programme by contributing to improved maternal health in selected districts. It has two components: **service provision**, under which systems to manage services for women of reproductive age will be established (including improvements to the physical infrastructure of hospitals, equipment and supplies, and training of personnel), and **increasing access**, which seeks to improve the social context for and access to midwifery and obstetric services within the supported districts to enable women to utilise those services.

The project is currently working in an environment of civil conflict that affects the rural communities' livelihoods in many aspects. The purpose of this study is to investigate the impact of conflict on women's ability to access and utilise midwifery and EOC services in the NSMP-supported districts. As the degree of conflict is constantly changing, a one-off study can only provide a snapshot of the situation. Therefore, a second objective of the study is the design of a monitoring tool that can be used by the project team to undertake ongoing monitoring.²

Although NSMP has seen some increase in the essential obstetric care (EOC) and midwifery utilisation figures at the supported hospitals, these have not been to the degree anticipated in the project design and utilisation levels remain unacceptably low. The project's field-based knowledge on why allopathic services are often not sought suggests that addressing barriers to access takes considerable time and also that the project's expectations may have been unrealistic even in the most peaceful of times. Therefore the extent to which the escalation of the current civil conflict within Nepal has exacerbated this situation is difficult to determine. For example, although anecdotal evidence suggests that women and their families are increasingly reluctant to travel, particularly at night, analysis of small-scale, facility-based data does not show a clear downward trend in cases arriving at night or a decrease in admissions from distant VDCs.

Given NSMP's role as a flagship safe motherhood programme, both nationally and internationally, it is useful to investigate further the effect of civil conflict on women's ability to access and utilise EOC services. This is potentially a very broad area of investigation, as social context and community support structures are being affected by the conflict and this may have both positive and negative effects on women's position, decision-making power, access to resources, and so on. This research also examined how restrictions and changes to Increasing Access component activities by the partners are affecting NSMP's potential to influence care-seeking attitudes and practices at the community level.

At the very moment this study was started, the conflict began to subside following the announcement of a cease-fire and upcoming negotiations. This has changed the situation in the affected areas dramatically, increasing mobility and creating a general calm. It gave the investigators better opportunities to visit remote VDCs in the NSMP districts.

The methodology of research is explained in section 2 of this report. Section 3 on the findings describes the impact of the conflict on the communities as well as on the project activities and their efficacy. In section 4 the monitoring tool is presented, though additional piloting is still required. Finally in section 5 recommendations for conflict impact mitigation are formulated, that can be realistically incorporated in the projects activities. Though it is recognised that the project itself could become a factor in the civil conflict, it is beyond the scope of this study to address the issue of conflict mitigation.

² See Annex A for the Terms of Reference.

2. METHODOLOGY

2.1 Objectives

The broad objectives of this study are:

- to explore and quantify the effects of the current conflict on utilisation of midwifery and EOC in NSMP-supported districts;
- to explore how restrictions and changes to Increasing Access component activities by the partners are affecting the NSMP's potential to influence care-seeking attitudes and practices at the community level; and
- to design and generate simple tools to undertake ongoing monitoring of conflict impacts, which can be integrated in the existing data-collection processes.

The main questions are how the conflict has influenced the normally existing barriers to accessing health services and whether it has created any additional barriers at the community level.

Additional questions concern the effectiveness of the NSMP programme under a situation of civil conflict. How has conflict affected the (organisational) community structures used by NSMP and its partner organisations to promote care seeking? How have activities been affected and how effective are the alternative approaches?

This study will give a momentary assessment of the current situation, but it will also identify ways in which civil conflict affects the utilisation of midwifery and EOC services and provide the tools for ongoing monitoring in this respect.



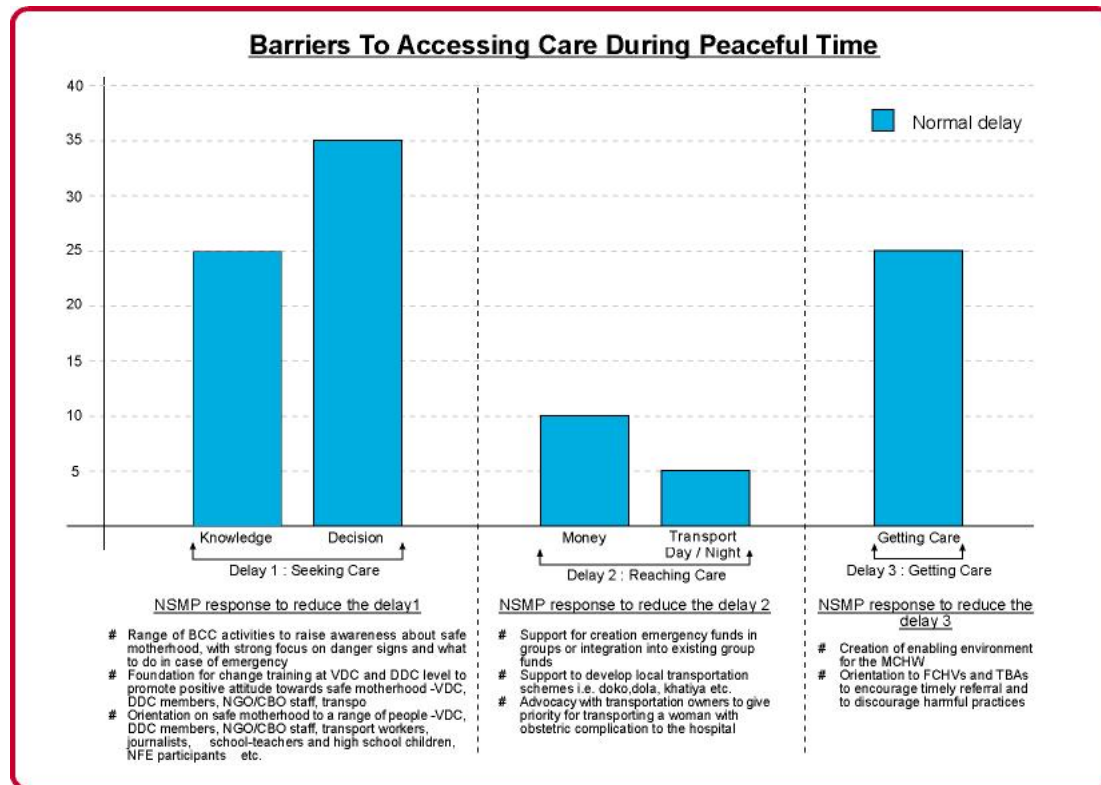
Research design

The conceptual framework for investigating the impacts of civil conflict on accessibility and utilisation of EOC services was based on the model of three delays in health care seeking behaviour. NSMP has detailed this model into five barriers: knowledge, decision-making, transport, finance, services and referral. Figure 1 shows the relative contribution of the different barriers to total delay in service utilisation as estimated on basis of some other studies³ and the experience of NSMP staff. The study took these five barriers as starting point to identify changes in care seeking behaviour, recognizing that potentially new barriers were created by changes in the communities due to the civil conflict, like migration and security regulations, and that the conflict might have even positive impacts.

The study was designed as a rapid assessment, taking into consideration the limitations the conflict itself poses on the research. Field visits to the study areas were to be completed within one day, as staying overnight might be risky, travelling after dark is not advisable, and curfews are imposed in the district capitals. Also, group-level tools for data collection needed to be restricted, because larger group meetings are difficult in the most affected areas, due to fear and security concerns.

Figure 1.

³ FHD, Maternal Mortality and Morbidity Study, 1998; Manadhar, Mary, Obstetric Health Perspectives of Magar and Tharu Communities: A social Research Report to Inform the Nepal Safer Motherhood Project's IEC Strategy, March 2000.



Data collection focused on interviews with households with pregnant (8-9 months) and recently delivered (less than 1 month) women and FCHVs, to understand the individual perspectives at the community level. In each VDC one focus group discussion with a mothers group was organised, and village health staff (and where possible other village leaders) were interviewed to gain a wider community perspective.

Interviews that reviewed complicated deliveries were held in the hospital at the district capital. Further understanding of the dynamics of the care-seeking process was obtained through interviews with 'treatment managers' - people who had arranged for transport to a health facility or called the local health worker for home treatment.

Finally, interviews with partner staff and NSMP district staff investigated the programme's constraints and changes, as well as how these will influence increased access to obstetric care at the community level. Cross-checking of findings was done during these interviews when applicable; otherwise cross-checking occurred during the sharing session at the end of the district visit. The time frame of the study is delineated in Annex A.

2.3 Selection of districts and VDCs

It was never intended to do a full-scale study of all districts. Taking into account the diversity of the districts covered by the NSMP programme, four representative districts were studied. Selection criteria included:

- the level of conflict experienced by NSMP staff in these districts (higher levels of conflict would increase the visibility of impacts and our chances of detecting them within a short study);

- the type of obstetric care available at the NSMP-supported hospital (both BEOC and CEOC facilities were looked at to reveal any differences in facilities as perceived by the communities);
- geographical setting (transport barriers vary considerably between lowland areas in the terai and the mid-hills areas); and
- the time NSMP had been working in the district. (The programme has first-phase and second-phase districts. As work on increasing access and improving health facilities should have already shown results in the first-phase districts, we expected impacts of the conflict on the programme to be more noticeable there.)

There are no first-phase districts with BEOC facilities. The CEOC facilities at Jumla, the only second-phase district with such facilities, have not yet been completed. The second-phase terai districts Rupendehi and Nawalparasi have hardly been affected by the conflict. Therefore, in consultation with NSMP, Kailali (CEOC, first phase, terai); Surkhet (CEOC, first phase, hill/inner terai); Baglung (CEOC, first phase, hill); and Myagdi (BEOC, second phase, hill) were selected for this study.

To achieve a reasonable coverage per district without spending too much time in each one, four NSMP-targeted VDCs in different areas of the district were selected, based on:

- severity of the conflict (moderately to severely affected according to NSMP's rating⁴);
- distance (2 VDCs about 1 hour distant by foot, presuming relatively easy access to hospital, and 2 VDCs about 3 hours distant by foot, representing less easy access to hospital, but within one day's reach for the researchers); and
- implementing partner organisation⁵ (including various partners).

The 16 selected VDCs are shown in the district maps in Annex C.

2.4 Questionnaires

In-depth interview questionnaires (Annex D) were developed based on a list of indicators developed from interviews with staff from NSMP and other health programmes. This preliminary analysis was discussed with the national office staff. Interview topics related to regular barriers to access and potential additional problems: reasons for going or not going to hospital, decision-making processes, transport, finances, migration, security, knowledge of danger signs, perception and availability of health facilities, functioning of mothers groups. Questionnaires were written in Nepali for use by the field interviewers.

⁴ As part of the security monitoring of NSMP the district staff in consultation with national staff evaluate at a regular basis the project VDCs for intensity of the conflict. This rating is mostly related to the potential of the project and its partners to continue working in these communities. Thus the rating is subjective and may be influenced by the partners' attitude and judgement.

⁵ Since its second phase, NSMP is no longer implementing directly, but works in partnership with NGOs, local government bodies and local agencies for the implementation of the project.

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⁷ Since its second phase, NSMP is no longer implementing directly, but works in partnership with NGOs, local government bodies and local agencies for the implementation of the project.

2.5 Interviewers

In each district a team of six to eight female interviewers was given an orientation on the purpose of the interviews and the process of the fieldwork (see Annex E). Experienced interviewers were contracted through one of the local partner NGOs, considering the sensitivity of the interview topics and the need for careful but rigorous probing. The interviewers were not necessarily regular staff of the NGO. The interviewers' level of experience differed among districts, with Surkhet and Baglung having the weakest interviewers.

2.6 Research process

At the start of the fieldwork in each district, a stakeholder meeting of all involved partners, including police and CDO, was organised. This meeting shared the objectives of the research and solicited the different organisations' perceptions of the conflict's impact in that district.

The national and international researchers then interviewed NSMP's individual partner organisations. There was no separate topic guide for these interviews, but the main indicators were kept in mind and findings from that and other districts were reflected upon.

All interviewers made one-day VDC visits accompanied by a district-level field co-ordinator contracted from one of the partner NGOs, the NSMP Social Development Facilitator, and one or both researchers, travelling to the VDC by road as far as possible, and then by foot. Previously, partner field staff or health-post staff had been asked to call for a mothers' group meeting and to identify individual respondents. Where appropriate, immediately after entering the VDC area interview staff would start inquiring about households with pregnant or recently delivered women and local FCHVs - also identifying cases in more distant wards unknown to health workers and partners. In this way interviewers would spread out as widely as possible over the VDC area. However, this approach could not be followed in some of the most affected areas where the interviewers' movement was restricted by fear of encounters with Maoists. Upon returning from the field, a one-hour review meeting between interviewers and researchers shared field experiences and first findings.

After the fieldwork, the interviewers were involved in a one-day (two days for Baglung and Myagdi) participatory analysis of the findings. This was particularly valuable in getting a shared impression of the community conditions and in backing up notes taken during interviews with the interviewers' personal recollections of the respondents' circumstances.

Based on the participatory analysis, a presentation of the preliminary findings in each district was prepared. A meeting with the direct partner organisations shared the results, soliciting feedback and additional commentary for the final report.

3. IMPACT OF CONFLICT

3.1 Experience of other agencies

Discussions with other development organisations concerning the conflict's impact on health service accessibility and utilisation revealed that most had been evaluating the impact on service delivery rather than on utilisation. Explorations of the conflict's impact concentrate on how development programmes influence the conflict and in turn on the influence of the conflict on programme implementation. This study's perspective seemed to be unique.

Due to the lack of previous study, there were no baseline data against which to quantify changes in utilisation due to the conflict. UNICEF is involved in a similar programme on safer motherhood. Their figures show an increase in utilisation over the past three years, but it is hard to determine what a normal increase in EOC utilisation would have been in the absence of civil conflict.

Well-recognised UMN hospitals appear to have experienced a drop in admissions from remoter areas and districts. This could indicate to a general decrease in care seeking due to the conflict, but figures to substantiate this impression are not available. Moreover, other confounding factors could be involved. Previously this had been the only quality hospital in the region, but recently services in other districts have been improved, thereby covering part of the demand.

According to a USAID report⁸ and the experiences of HSSP⁹, harassment and threats by both Maoists and security forces have exacerbated the chronic lack of qualified staff in remote communities, thus decreasing service delivery in these areas. Many health workers have requested reallocation, but there are no hard figures to indicate whether this is more than usual. The mobility of health workers has decreased, as they are reluctant to travel. Outreach clinics are defunct in affected areas. In some districts the security forces have stringently restricted the provision of medicines to rural areas, reducing the availability of appropriate treatment. People adapt their health-care seeking behaviour according to their perceptions of (the availability of trusted) health-post staff. HSSP staff cited a FCHV who said she did not like to refer for treatment, as no staff were available at the health post. Any decrease in community perceptions of health staff's availability and ability to serve will definitely influence service utilisation.

3.2 Impact of the conflict on the research

Although conceived and designed earlier, this study eventually took place during a cease-fire. Many of the worst restrictions on mobility had been lifted, and people were much more relaxed than during previous months. The community visits and interviews we executed would have been much more difficult under the full conflict.

Notwithstanding the truce, there was a reluctance to talk about issues related to the conflict. People preferred to discuss the current relaxed situation rather than ponder the frightened state they had lived in over the past year. People would simply deny any knowledge about matters related to the conflict, except for well-known incidents that could be regarded as facts. In the most-affected areas, interview staff encountered people frightened of them as a


⁸ Martínez, Esperanza C., Hari Koirala, Primary Health Care Services in Nepal, October 2002

⁹ Unpublished field visit reports, HSSP

result of the conflict. Some people did not answer the call at their doors because they were afraid the interviewers might be Maoists. Other people invited the interviewers inside their homes, as they did not like to be seen talking with outsiders. This fear has restricted the amount of in-depth insight that could be obtained through this rapid assessment style of research, even while using staff that was from the same district or even village.

On some occasions during discussions with groups of eight to ten people in the market area of a village, security forces or Maoists questioned staff about the purpose of their presence. In one particular Maoist-controlled area, they were allowed to proceed only after negotiations during which they stated that this was a research project rather than an (I)NGO project aiming for development interventions with foreign donor money.

3.3 Impact of conflict at household/community level

The theory on increasing access to health services has identified three delays in care-seeking behaviour: seeking care, reaching facilities, and getting care. This study found that although all three were exacerbated by the civil conflict, the major impact was on reaching facilities due to transport and travel difficulties 

Having said that, we should stress that delays caused by the conflict are only relatively small additional aspects to the barriers that normally exist, even though in some very tragic cases these additional delays have proven fatal. The cases of assisted and unassisted home deliveries and (emergency) hospital deliveries studied show that the traditional attitude towards women's health, delivery risks, and health care; the geographical restrictions put on transport; and poverty-generated economic constraints on care seeking are still the major obstacles. However, these obstacles are exacerbated by the current conflict. In the following sections the impact on the barriers to access is described for different levels of conflict, varying from limited, moderately and significantly to heavily affected areas.

3.3.1 Seeking care: attitude, knowledge, decision making

Attitudes towards safer motherhood have not been influenced by the conflict. The mind-set that deliveries will take place at home as they always have, even when minor problems occur, prevails. The current study reconfirms all NSMP's previous work concerning this attitude and the related delays in care-seeking behaviour. Changes in attitudes and behaviours are very slow, as these are so culturally engraved that fast transformation can hardly be expected.

Those households that prefer hospital deliveries for uncomplicated cases and are in the position to send pregnant women to town (to stay with relatives) before the end of their term continue to do so, as these town centres are perceived to be safer than the villages. In many cases these well-off people have been migrating to the urban areas due to fear of the conflict anyway. Poorer families that have been advised by village based health workers to use hospital deliveries, face more problems than previously due to the increased living costs caused by the conflict. In this respect the poor bear a larger conflict impact.

Decision-making and referral

The processes of deciding to go and call for help and of bringing patients to health facilities are slowed down only in areas heavily affected by the conflict. In these areas the number of male household members has been significantly reduced, leaving the decisions concerning health expenses to the female household members. It was found that women are still very

hesitant to take this kind of decisions and will wait to seek advice or approval from male relatives or neighbours. No signs were found of a potentially empowering effect of the absence of the man from the household, notwithstanding Maoist propaganda for women rights. More importantly, knowledgeable and respected people who normally would take leadership roles in such emergencies have often left, or are less accessible. Particularly at night, it has become more difficult to ask advice from relatives, neighbours, and nearby TBA and FCVH who would otherwise be consulted before taking major steps involving financial expense. Fear of answering the door at night, in addition to fear of walking outside at night, restricts the availability of people who can give appropriate suggestions and take decisions.

During times of high conflict there was a noticeable reluctance to travel longer distances if not urgently required. People were afraid of strangers they might encounter on the road, even in daytime. They did not like the hassle of the check posts on the way, though frequent travellers got used to them. Also people did not like to be away from home, fearing that something might happen during their absence. However, interviewees gave us to understand that these deliberations would have far less impact on travel decisions in clear cases of real delivery emergencies, because at such time they would be able to convince either the Maoists or the security forces of the purpose of their trip. The main fear would be of getting caught in a crossfire in a highly disputed area.

Knowledge and NSMP intervention activities

In some areas, where the programme had been working actively and effectively with the communities, knowledge levels of women and their families have increased. Differences with the dissemination of information are more related to the different ways of social mobilisation used by the partners than to the conflict. Still, a small random sample studied by rapid assessment shows that many women are not being reached by the community activities. The social distrust created by the conflict will further increase these kinds of coverage problems in the communities, due to the high degree of social segregation in Nepalese society. At this moment such conflict impact on dissemination activities could not yet be substantiated.

Knowledge dissemination has been hampered to some extent, as partner agencies involved in social mobilisation for safer motherhood and the community groups they target have problems functioning in areas even moderately affected by the conflict. The programme has come up with some alternatives for direct community-based mobilisation, which are further discussed in section 3.3.3. As this was not a longitudinal study, it was not possible to determine if knowledge retention was influenced by the conflict.

It had been anticipated that Maoist might have a possible positive impact on knowledge levels if they included women health messages in their propaganda. Those people who were willing to talk about the Maoist campaigns in their villages told that they only talked about women rights in general, but never about women health issues. Actually some people said the Maoist caused women health problems because they made the young women pregnant. Being affiliated to the Maoists will make these women more fearful to access government health facilities.

3.3.2 Reaching care: transport

Travel at night

All interviewees identified official and self-imposed curfews as the major conflict-induced obstacle affecting emergency obstetric care. Depending on the intensity of the conflict and the vicinity of army camps, travel at night is hardly possible in many areas. In less affected

areas people will walk to nearby houses and facilities, but in heavily affected areas people lock themselves in their houses for the whole night. Torches and other lights are not permitted, complicating movement along narrow paths and in hilly areas. Walking in bigger groups on the one hand is felt to be less frightening because of the protection offered by the others, but on the other hand it adds more danger because of suspicion that any group may be a combat or patrol unit.

Such restrictions on night time movement create problems both when calling health staff to a patient's home, and when attempting to carry women to health facilities. If it is felt that time can be spared, people postpone seeking care until dawn. Only nearby health workers like TBAs, FCHVs, and traditional healers are called. The possibility of calling qualified staff like MCHWs and AHWs depends on vicinity, strictness of curfew, and (related to this) their willingness to come at night. Yet, if the situation is urgent people will start out at night time, hoping they can get permission from the security forces. Maoists are said not to obstruct people travelling for health emergencies.

As a response to the conflict, in some districts the security forces have been given orientation by one of the NSMP partner NGOs on the needs of delivering women with complications and what they can do to help. They have become aware of the problems imposed by curfew, and generally permit patients to travel to hospitals and assist patients by providing transport where possible. The big problem is that many people, particularly uneducated, poorer, low-caste people, are not aware that they can get permission for night travel. For those who are aware, they may not be able to contact the security forces to get permission and help. Moreover, people need to be able to express the urgency of the situation. The study found a few incidents in which low ranking army personnel did not allow patients to continue their travel beyond their camps or check posts. In other cases the patient was let through quickly, but the accompanying people, even the husband, were detained for a while.

Check posts

The security forces have established check posts along the roads for all passing vehicles. These check posts create delays of up to 2 hours, often doubling travel time by public transport to hospital. Delays depend upon the number of passengers in a vehicle, the number of vehicles in line for the check post, the amount of luggage, and the thoroughness with which the luggage is searched. Even during the present cease-fire, when the searching of individual persons has become rather relaxed, checking a full bus takes about 10 minutes. During periods of high conflict, vehicles would have to wait in line and were not allowed to move forward until the previous car was done with. In heavily affected areas people were not allowed to get out of their waiting vehicles, so they could not easily request priority for emergency patients. However, in most cases patients would not be asked to exit the vehicle for individual checking.

A number of check posts close at night, completely stopping vehicular transport at night except for ambulances and other people who can communicate with the security forces to request permission. Unfortunately many villagers and even PHC health staff are not aware of the availability of ambulances, as apparently they have not been advertised widely. The costs of hiring an ambulance are also relatively high.

Communication

Both the Maoists and the security forces have been cutting down almost all village telephone connections. These telephones were an important means of communication for remote villages, and made requests for ambulances or other transport to meet patients at road

heads¹⁰ possible. This can drastically shorten the time of transport, as otherwise patients have to be carried the whole way to hospital.

In the conflict situation telephones are about the only means to contact security forces to get permission to travel during curfew, without having to expose oneself to the possibility of being shot at first sight. Even within bazaar areas, many people do not have access to phones and will not dare to go to the hospital at night.

Reduction in number and regularity of public vehicles

Although previously public transport in many places was quite limited, the conflict has further reduced the service. Apart from night curfews on vehicular movement, in heavily affected areas security forces have also prohibited vehicles from staying at the road heads overnight. Therefore the first morning service and the last evening service are delayed, as vehicles have to pass check posts before closing/curfew time. Along pitch roads formerly served by night buses, no vehicles can be found at night. Also, formerly when cars could stay overnight they could be called upon for emergency cases.

The delays at check posts as well as a drop in passenger numbers have reduced the number of vehicles on some routes; services have become far less regular. The transport associations have closed some routes that are shorter or easier, as did the Maoists, who in some areas did not allow any motorised transport (including motorbikes). In some areas they dug trenches in the roads as ambushes and to obstruct free movement.

The reduced vehicular movement is increasing travel time, though the degree depends on the specific routes and conditions of each settlement.

Fear

People are afraid of police and army forces patrolling the villages, interrogating them, sometimes going from house to house beating the males up, and killing innocent people without any investigation because they happen to be at the wrong spot at the wrong time. The more the area is under dispute, the more common this kind of incident. People are afraid of Maoists for the donations they ask, for the trouble they get with the security forces if they feed or lodge them, because they retaliate and punish people who stand out, and because of stories that youngsters are kidnapped and forced to enter their forces.

In significant and heavily affected areas this fear is inhibiting normal activities - like seeking help in emergencies and even working the fields - perhaps more than the actual barriers imposed by the conflict.

Social support

In heavily affected areas, fear is inhibiting normal social support among neighbours and friends. Under normal circumstances neighbours and relatives would help each other out - for example by carrying and accompanying the ill to the hospital. But it has become more difficult to call people for advice and help. Less close friends will consider the risks of travel and the encounters they may have en route. Indications were found that social support across castes was further diminished due to mistrust about potential linkages with the other side. These factors, combined with fewer men around to carry a delivering woman, do

¹⁰ A road head is the end of a road. Particularly in the hill areas of Nepal, dirt roads wind off into the rural areas until they simply end possibly left for further construction later. People from even remoter areas have to walk to these road heads to access vehicular transport.

increase the time needed to arrange for transport after the decision to seek care has been taken, particularly at night, but it is hard to quantify this.

Migration

People leaving the villages can be categorised into four types: politically active people, the well-to-do, unemployed youngsters, and poor wage labourers.

In moderately and significantly affected areas the political active and well-to-do people are forced out of the villages into the urbanised areas of district headquarters and Kathmandu as they take refuge against donations, extortion, threats of physical punishment, and killings. These people often leave with the whole family, including children who are sent for education and women. The loss of this category often reduced the availability of people who could take the leadership and mediator roles in health emergencies. Also leadership in other community organisations is sometimes wanting.

In significant and heavily affected areas unemployed youngsters were stimulated to look for opportunities elsewhere in the country, and abroad, provided they could afford the initial investment to do so. Often there seems to be a major economic component in this type of migration that is reinforced by the harassment of the security forces and the threat of Maoist recruitment.

Poor labourers from heavily affected areas are severely harassed by the security forces who suspect them of being Maoists, simply because they are poor and live in these areas. Whenever possible these men will also leave their villages to find employment elsewhere.

This three-fold reduction in males in villages affects the number of people available to carry the ill from the village to health post, hospital, or nearest transport.

NSMP intervention: transport schemes

The programme has motivated groups and communities to prepare schemes for faster arrangement of transport. Where established, these schemes are generally still functional. In rare cases the security forces have captured stretchers, and dokos have been burned in one significantly affected area. The forces were suspicious that Maoists might use these to transport their wounded and dead.

Figures do not reveal any changes in actual use of such facilities, but many partners do not collect these data very accurately. Even when data are available, the transportation schemes were started only shortly before or after the state of emergency, so the time period is too short to allow firm conclusions to be drawn. Many schemes had not yet been used for delivery cases, although they had been used for carrying other ill people.

3.3.3 Reaching care: economic barriers

Reluctance to borrow


Poor people are not trusted to repay their loans, both because of Maoist propaganda that interest should not be paid and that loans to moneylenders do not need to be repaid at all, as well because poor people have fewer sources of income due to the conflict. Therefore people in the villages who could provide money are not willing to give loans to people who need them. No mentioning was made of increased interest rates. In heavily affected areas,

Maoists are known to destroy loan agreements. This prospect makes it difficult for moneylenders to put pressure on people to repay their debts.

Households that have family members working abroad are still readily provided with loans.

Smaller money reserves in the villages

Businessmen and wealthier families tend to keep smaller cash reserves in their homes, as they are afraid to lose it in forced donations. Therefore the availability of cash in the moderately to heavily affected areas has decreased, making it more difficult to find money to borrow, even if people are willing to borrow or loan money.

In significant and heavily affected villages, migration  as reduced the number of moneylenders. Most banks have been closed either after looting or as preventive measures, eliminating possibilities of using jewellery as warrants for bank loans, as was often practised by the poor.

These two factors cause increased delay in finding the money required for hospital treatment.

Reduction in employment

In heavily affected areas Maoists have halted or at least restricted construction work. Businesses have been closed, out of fear of both forced donations and security forces.

Agricultural employment is also reduced as landlords have often left the villages, sometimes leaving only one family member to look after the property. Interest in cultivating the land is sometimes lessened due to lack of markets and restrictions on trading imposed by Maoists and security forces. Retirement of government officials from remoter areas has decreased the demand for milk and vegetables.

At the same time, the cost of living has increased. Prices of food and other necessities have sometimes doubled, as trading has decreased and people are afraid to travel to town.

These developments have decreased village incomes and reduced on- and off-farm employment opportunities for (daily) wage labourers, creating additional economic barriers to health care.

NSMP intervention: emergency fund management

The programme has stimulated groups to set up emergency funds to provide loans for obstetric care. The study revealed that in moderately to heavily affected areas, many of these funds are experiencing problems or have become dysfunctional – largely due to conflict, but there are other contributing factors. Further details are provided in section 3.3.1. Reports of emergency funds only reflect the amounts saved and outstanding loans, but do not provide any insight into frequency of utilisation or repayment trends. Some partners have monitored this information, others not. It would have required too much time to gather and analyse these figures for this study, but it is advisable to get these data from the groups and watch them carefully. Such data could provide useful insights into the functioning of these funds and identify further support required including prospects for the delivery of such support.





3.3.4 Getting care: health services

Accessibility

In most investigated VDCs health post staff had not been reduced due to conflict. Three cases were found where staff had left or had not come to their posting out of fear. On the other hand, an AHW who had accepted a position in a remote and affected area within the last year claimed to have experienced hardly any problems. Where health post staff were not living near the health post, they tended to come less frequently, sometimes only turning up for scheduled vaccination days. Though a heightened perception of risk is a valid reason, it was felt that in some of these cases the conflict was used as an excuse for such absences, because none of the interviewed health workers said they been threatened by either side of the conflict. One interview with a hospital delivery case revealed that in their remote and significantly affected village most health post staff had left because of extortion by the Maoists, who demanded a levy on their monthly salaries.

Outreach clinics were closed due to conflict in significantly and heavily affected areas, reducing accessibility of services. Health workers indicated that they were more reluctant to attend patients at home. In moderately to heavily affected areas, they often admitted they had told community members that at night time they should bring patients to the health worker's house, instead of calling them for home consults. Villagers said the health workers tended to charge higher fees for home treatment, citing the hazards of the conflict as the reason.

The July 2002 Prime Minister's decision to dissolve local bodies has posed some problems regarding the effective management of health posts. Because VDC chairmen also served as the health post support committee chairmen, these committees are now without a leader and, consequently, no longer meet.  committees oversee issues like medicine supply and requests for staffing, which are now  more difficult to manage.

In significantly affected areas some private medical shops have been closed by the security forces on suspicion of treating Maoists and providing them with drugs. Others have problems getting medical supplies for their shops, due to security restrictions.

Utilisation

Few reliable figures relating to the actual utilisation of the health facilities exist. DoHS MIS division does have some information on health post utilisation, but these are only data aggregated at district level. It was beyond the scope of this research to pursue collection and further analysis of these limited data.¹¹

The information collected by the NSMP-supported CEOC district-level hospitals does show a slow but steady increase of normal as well as emergency deliveries at their premises. As nobody knows how much hospital utilisation might have increased under normal circumstances, it is difficult to draw conclusions from these data.¹² The fall-back in emergency cases that was noticed in Baglung district in 2001 is highly related to the periods of absence of the only doctor that can do caesarean sections, and is therefore probably not related to the civil conflict. A second and further explanation for this reduction could be the

¹¹ It might be worthwhile to explore the possibilities to include conflict related influences in the facility-based maternal death audit. As there exists no registration of maternal death outside facilities, this is feasible only for maternal death or morbidity not reaching facilities.

¹² Considering the inexistence of desegregated data by socio-economic status or caste of admissions, analysis of which population groups are using facilities are not possible.

fact that MCHW got trained in treatment of retained placenta and postpartum, reducing the need for emergency obstetric care.

A similar project by UNICEF, also in conflict-affected districts, does show greater increases in utilisation over the last three years. They claim this is because in their increasing access component they work only with government health workers, who would have fewer problems operating than NGO partners would¹³. However, analysis from one NSMP-supported hospital, where increase over the last year has been the highest, indicates that the increase in hospital delivery cases is related to the district capital's population increase due to the conflict. A similar increase is seen in general hospital admissions. This might be true for the UNICEF hospitals as well.

The data of a recent analysis of the distances from which women do come showed discrepancies with earlier monitoring figures on EOC utilisation, making interpretation slightly precarious. However, there is a clear relationship between transport facilities and travel time (not distance per se), and utilisation of hospital services. The increase in hospital deliveries comes mainly from the areas in shorter distance of the hospital, up to 6 hours travel. Though the concentration of increased hospital utilisation around the district centre could be caused by the conflict hampering travel from further away areas, there is a number of other explanations as well. Already more people from the nearby VDCs visited the hospital and they communicate their positive experiences with the hospital delivery services in life saving cases in their communities, therewith creating awareness and behaviour change. Awareness activities on safer motherhood have been concentrated in the VDCs nearer to the district capital (partly due to the conflict restrictions on these activities). Also under normal circumstances the transport barrier is probably higher in further away areas, because of the greater effort that it takes.

A comparison of day and night admissions over the last two years did not reveal any change, but unfortunately in the last year of the emergency many admission times were omitted in the records.

Thus, the data available do not allow us to conclude that utilisation has been impacted by the conflict. This reinforces the impression that, except for delays in arrangements during night time, in real emergencies people still find ways to come for hospital care. In some cases, however, these additional delays may prove to be fatal.

3.4 Hospital case studies

This research included 19 case studies of deliveries at the district hospitals. Cases were selected from the total number of hospital deliveries, omitting all normal deliveries from residents of the bazaar area and nearby VDCs hardly affected by the conflict. These cases were analysed in detail to discover the contribution conflict-related delays made to the total delay in reaching the hospital.

In most cases the main delay was in waiting too long before deciding to go to hospital at all. Six cases decided to go to hospital within 12 hours; other cases waited between two and five days (36 to 110 hours) before making the decision. The normal delays of finding money, arranging transport, and travel time were the main obstacles to overcome before reaching

¹³ There seem to be controversy over the issue who has better abilities to continue working in conflict-affected areas. Though health staff seems to be less affected by the Maoist, government staff in general has more often than not withdrawn from conflict areas due to the extortion they face. On the other hand local NGOs have often managed to continue working even in heavily affected areas. However, in the worse areas they too have been told to leave.

the hospital. These normal delays accounted for a minimum of one hour and a maximum of 15 hours. In two cases travel was further delayed until the following morning, because travel at night was difficult, not only due to curfew or conflict, but also due to normal lack of public transport and the steep and narrow path. In one case the family had to stay another night at home because they missed the last bus while arranging for money.

A 21-year-old Magar woman pregnant with her second baby came from a remote VDC to Surkhet district hospital.

- After 5 days of labour pain she was referred to hospital by the FCHV and AHW, who already suspected a stillbirth;
- The decision was delayed over money issues. Though the decision to go was made at noon, they missed the 1 o'clock bus because they were still arranging the loan;
- Although there was a mothers group in the village and the delivering woman was a member, she could not access the emergency fund because the day before someone else had taken a 10,000 NRs loan, depleting the fund. Therefore they had to arrange a loan with someone else in the village: 10,000 NRs at 2% interest per month;
- The economic situation of the family is not such that money would be a restriction on going to hospital. The husband is a carpenter and works in construction; also other family members are earning incomes;
- The patient was taken to the nearest road on a charpai (rope bed), which took 15 minutes, to catch the first morning bus at 9 o'clock the next day. Eight friends and the FCHV helped carry her to the road. By bus it takes about three and half hours to reach Birendranagar. The road is seasonal and walking to town would have taken one full day;
- There are two check posts before reaching the hospital, one in Bangasal that took about 15 minutes and the other at Radio Nepal office, which lasted only 5 minutes. The woman felt slightly uncomfortable because they were in a hurry and still everybody got searched;
- Hospital admission and treatment were fine. She had a caesarean section to remove the stillborn baby and was recovering slowly.

Most of the delay was caused by limited bus services from her home village and the problems in taking loan. The conflict had hardly any effect, only a relatively short delay at the check posts.

In seven cases the conflict had some impact on the delays incurred, in most cases by increasing the travel time by 15 minutes to 2 hours, due to check posts on the route to the hospital. Compared to the other delays, this was minimal. In two cases extra time was required to borrow money, because the economic situation of the family had been affected due to lack of wage labour opportunities. In one case professional assistance was called only in the morning, because the mother-in-law was alone and did not dare to go out at night. Yet, when a private health worker was called next morning he did not immediately refer to hospital either. The woman was referred only after a second visit of the health worker in the afternoon.

How should these additional conflict-related delays be evaluated? Should the additional delay be set off against the normal time required to reach care after the decision to go has been made, or should it be compared to the total delay, including the long time taken before deciding to go to hospital? Especially in relation to delays caused by night curfews, people have a tendency to blame only the conflict for a number of fatal cases that have occurred, but earlier delays in making decisions and preparatory arrangements also contribute to the deaths of either mother or child before reaching medical attention. When looking at such cases in detail, it becomes much more complicated to reach straightforward conclusions about the decisive cause of death. For example, in a case that was related to the research team outside the research framework, a woman was being carried to hospital by a group of villagers from a remote village. It was night so no other transport was available. The group was about to bump into a security force patrol and out of fear hid in a house on the route, still eight hours walking from hospital. Subsequently the woman delivered a stillborn baby. This

stillbirth is blamed on the conflict, but people tend not to consider whether she would have been in time for a safe delivery had she been carried without security delays. Nor do they consider how long she had been waiting in labour pains before setting out for the hospital. At the moment the story was told the interviewers did not further probe these issues either, but it is quite probable that the long travel time from her village to the hospital would have delayed medical intervention too long in any case.

A 22 year-old-woman having her first baby came to Dhangadi Zonal hospital from Kanchanpur district.

- The woman had been having light labour pains for about 3 days, when around 11 o'clock evening the pains became severe. Her mother-in-law did not feel she could go for the doctor then, because the husband was not at home and no one else was there, and it takes three hours to walk to the doctor;
- Next morning around 6 o'clock the local private health worker was called, arriving around 8 o'clock. He said the baby would come easily and left again;
- At 12 o'clock the pain escalated and the health worker was called again. He then referred her to hospital;
- The mother-in-law and husband took the decision to go around 4 o'clock in the afternoon. There was no confusion about whether to go to the hospital, as she could not deliver even under supervision of a doctor;
- The woman was brought to the hospital in a bullock cart (dunlop) borrowed from a relative. Family members helped in arranging the transport, which took about 1 hour. The transport took 8 hours, though the local bus would have taken only 3 hours. The family did not know about the ambulance service in Dhangadi;
- The family had put aside 2000 NRs from the family income to cover the cost of delivery. Part of the money was used for treatment at home by the local health worker. The rest of the money was not sufficient to cover the hospital costs, so they had to borrow more from relatives, who could also hardly spare it. It will take a long time to pay back;
- There is an emergency fund, but neither the delivering women nor her mother-in-law is a member of mothers' group. Non-members are charged 5% interest per month, which they felt was too expensive;
- There were no security problems from either side, because even during curfew hours you can walk. They were stopped for ½ an hour for interrogation at the first check post, but after that the other check posts were informed, and they had no more problems on the rest of the way, and all check-posts opened easily;
- The delivering woman did not face any problem during admission and treatment at the hospital, even though it was her first time in Dhangadi.

This case experienced some delays in calling qualified health personnel due to the nightly hour. Yet, when this private doctor came to attend, initially he also postponed referral. Conflict caused some delay in reaching the hospital, but this was relatively little compared to the total travel time and previous delays.

In other cases the conflict's impact may be more important, as in the following case of bleeding after delivery that required hospitalisation. Because it was night and no vehicle was available due to security restrictions, someone walked to the security forces at the district headquarters and called them to pick up the woman from the village and bring her to hospital. It took about four hours for the security forces' vehicle to arrive in the village, while a direct jeep from the village to hospital would have taken only one hour. The woman died before she could be brought to the hospital. In this case the long delay was not just caused by the curfew, but even more so by the fact that no vehicles were allowed to stay in the village overnight, so there was no fast means of transport immediately available. It is not known how long she had already been bleeding before it was decided to take her to hospital, nor if the decision was delayed due to hesitation about travelling during curfew time.

The hospital cases studied for this research did all reach hospital safely. The delays they experienced due to conflict were very limited. Though it should be considered that the study

was undertaken during a ceasefire, when the situation was much more relaxed than during the height of conflict, from these cases we can only conclude that the conflict has a relatively small additional impact. A cursory examination of the fatal cases allows an argument that the conflict does cause a number of preventable maternal and child mortalities, but even in these cases the conflict is often not the only cause, as some people might claim. Such cases should be monitored and studied carefully to uncover the actual elements causing death and to find ways to mitigate the conflict impacts.

3.5 Impact of conflict at programme level

The changes and restrictions in community-level project activities in themselves may limit further increases in service utilization. During the fieldwork and discussions with the partners, a number of issues that have restrained access emerged, though it is hard to quantify this. In the affected areas many groups face problems in their effective functioning, the supervision and support to groups and individuals by the partners is reduced, and some of the alternatives, though very inventive, may not be that effective in severely affected areas.

The research could not clearly identify differences in ability to cope with the conflict between different organisational partners (e.g. NGO, Local Government Agencies and Line Agencies). The differences in conflict affectedness between the researched VDCs and differences in working modalities of the partners created too many confounding factors. There are some indications that NGOs manage to negotiate more elbowroom than government agencies that appear often restricted by official security regulations or use this as an excuse. Voluntary organisations like NRCS have problems operating in even limited conflict affected areas, as they feel they cannot pressure the volunteers to put themselves at risk.

All partners tended to overrate their ability to operate in the affected areas. They seemed to fear a negative evaluation of their programme implementation and the resulting budget cuts or discontinuation of the programme. Problems that communities had implementing some of the programme suggestions for increasing access at the community level, like emergency funds and group meetings, were either not known to them or negated.

Moreover, not all partners seem aware of other factors affecting access to health services at the community level, that were identified by the research team. They often talked about conflict-related issues like curfew, migration and displacement, and dwindling social support in sweeping generalised statements, without specifying these additional barriers in certain areas or VDCs. This could be due to perceived hazards of sharing too detailed information, but it may well be that many partners have rather limited knowledge of the actual field situation. This is partly because they have not yet analysed how important these issues are for their programme achievements. More importantly, they probably do not have access to this kind of information at the community level, also due the restrictions on field visits posed by the conflict.

3.5.1 Project intervention at group level

In the more affected areas groups are functioning less regularly or not at all. As the groups are an important mediator for the programme in promoting safer motherhood knowledge and activities, this significantly affects the project's potential to increase safer motherhood.

Gathering

In the least-affected areas the groups are not experiencing many problems and are still gathering on a regular (monthly) basis. Generally meeting hours have been adapted to daytime to avoid walking during dark and curfew hours.

In more affected areas people are afraid to gather in bigger groups for any reason. This prevents mothers groups from gathering for their monthly discussion and fund raising. Fear causes groups to gather less regularly and fewer people to come to the meetings that are held, reducing the outreach of these community groups.

In heavily affected areas the security forces actively restrict groups gathering. The study found one group that was actually detained by suspicious army personnel when they were gathering for a safer motherhood meeting. On the other hand, people are also afraid of Maoist interventions in these groups, which will make them more vulnerable to security forces repression. Also, Maoists prohibit the activities of groups that are perceived to be too successful in their social mobilisation, saying that these groups distract attention from the main objectives of the people's war. However, in some cases groups have been able to continue functioning despite rather intensive Maoist presence.

It appears that in some cases the Maoist conflict is being used as an excuse to cover up internal problems in group functioning unrelated to the conflict. Problems are generally related to misuse or stealing of group funds. The conflict situation becomes the pretext to oppose gathering, as a group meeting might expose the guilty due to group pressure. At the same time, the conflict inhibits group members from speaking out against these persons, as they fear retaliation.

Leadership

Displacement of the more educated, knowledgeable, and socially active people from the affected villages to urban areas has left a number of groups without effective leadership. This happens particularly in areas dominated by Maoist control.

Many internal problems that disrupt group functioning appear not to be directly related to the conflict. At the same time internal frictions are re-inforced by the conflict. The conflict situation reduces the trust among group members. Though it cannot be proved in numbers, there seemed to be an increase in segregation of groups according to caste and ethnicity, discouraging those people who form the minority to leave the group voluntarily. This is often based on the perception that certain groups are more susceptible to linkages with the different parties in the conflict. Some members have family with the army or police. In some cases there is clear evidence that some members are Maoists.

Emergency funds

As mentioned in section 3.1.3, emergency funds established by the community groups have been experiencing problems in their functioning and management due to the conflict situation. Apart from this, many groups are not particularly clear about the purpose and management of the funds. With many development organisations focusing on saving and credit as community mobilisation activity, people have specific expectations of a fund. Funds provide credit to their members. Yet a rather large amount of the emergency fund is kept with the treasurer or another representative, to provide health emergency loans and the money is not activated for other purposes. If people are not completely clear about the fund's purpose, to them it seems that the leaders are collecting the funds for their own benefit, and some groups break up due to fights over these funds.

The Maoist conflict and propaganda against loan repayment appear to provoke problems with repayment within the groups that do use part of their fund for non-health-related credit. Though saving and credit groups have more often problems with repayment, now some members are using the conflict not to repay their loans, either by preventing gatherings or by other excuses. Groups and individual members find it more difficult to put social pressure on the defaulters, as they do not know what the consequences might be if either of the conflict parties gets involved. Decreasing repayment causes the fund to have less emergency cash available, hampering effective financial management in occasions of need. In the end many of these groups become defunct over these financial matters, ending this loan opportunity.

In a few incidents group members have run off with the emergency fund money, leaving the group. These cases are not directly related to Maoists, though there may be linkages.

In heavily affected areas Maoists have put pressure on the groups to dissolve the fund, by threatening to take the money otherwise. Village CBOs are not allowed to use external money from NGOs, INGOs or other donors for their development activities. Most of these groups have decided to split the money among themselves, so the fund is no longer functional. Only a few groups have divided the money to hide it in their individual houses for emergency cases. Yet, they are afraid to face problems when they need to use the money, as the Maoists will question them about where the money comes from. This is particularly the case for groups who resisted theft by Maoists. In a number of occasions the money has actually been looted.

Information dissemination in the communities

The groups have few inputs for discussing and increasing knowledge regarding safer motherhood other than the training received by their group leaders or FCHVs. This study found that some FCHVs have only limited knowledge themselves. For example, there is confusion between mother and child health messages regarding reduced workload, healthy diets, and danger signs. Also it is hard for them to differentiate between danger signs during pregnancy and those during or after delivery. They have problems in clearly describing the dangers, even though they seem to recognise them when they see them during an actual delivery. But their inability to express clearly what they have learned will impede their ability to teach and discuss the details with the groups.

It is possible the groups need more regular information inputs to allow discussion of issues like danger sign knowledge, need for emergency funds, and other safer motherhood issues.

3.5.2 Partner functioning

Field presence

Though partners tend to sketch a bright picture of their continuing possibilities of implementing their activities in communities, partner presence at the field level has been reduced, and community activities have had to be executed in a less open way. Larger group gatherings have had to be stopped both due to Maoists as well as security forces. Workshops and training have been reallocated from the VDCs to urban areas, where big gatherings were not threatening to both staff and participants.

In limited and moderately affected areas staff is more careful in planning activities in the communities. In significantly and heavily affected areas field visits by higher staff are reduced or totally stopped. Some partners are taking the opportunity of the cease-fire to visit these areas now.

In significantly affected areas community-based staff were often withdrawn from their postings if they were not locals. Locally hired staff could mostly continue working, but in a less open way. In a limited number of heavily affected areas, partners have been explicitly told to stop their activities in the VDCs completely.

Support for FCHV and other information agents

As mentioned the groups need regular input of ideas and information to continue motivation for safer motherhood activities, as well as retention of knowledge. Yet, most partners have had to reduce their contact with their groups, depending on the level of conflict in working areas. This reduced support impairs the capacity of the groups to promote safer motherhood.

On the other hand, some partners were not planning such intensive support of the groups and their leaders.

Continuation of activities

Though activities are being carried on in most areas, there has been delay in implementation. In some areas training of the group leaders was delayed by the conflict and therefore knowledge was gained only recently and safer motherhood related activities were not yet fully grasped. In the worst affected areas activities have been completely discontinued

Some activities like training are probably less effective in heavily affected areas, because intensity and attention are reduced. Due to curfews and fear of walking at night shorter trainings are planned.

3.5.3 New programme initiatives

Radio

In 2002 NSMP launched actively local radio programmes discussing safer motherhood topics. Considering the reduced ability to work in more direct interventions at community and household level due to the civil conflict, more attention was given to the radio programme than previously intended. The programme has received much response from the villagers, showing that many people are listening to it. Still, this study identified a number of problems with this new approach, partly conflict-related.

Many households in the villages do not have radios. Others do, but the main household members have priority in choosing the programmes to listen to. Others mention they do not have free time to listen to the radio.

In significantly and heavily affected areas, people fear using their radios after dark or after curfew hours, and broadcast times may need to be adapted, though much earlier will interfere with working hours. In some of these areas the security forces do not allow batteries (and even radios) to be imported, making the use of radios impossible.

As a result many people interviewed were not aware of the programme, or did not listen to it. People who do listen do not always understand the full messages and often find it difficult to remember the messages afterwards. Only few respondents mentioned they got their knowledge on danger signs from the radio. The opportunity of radio messages backed up by local intervention activities and vice versa has been lost due to the conflict.

Relatively more FCHV know about the programme, compared to other respondents. Though the radio programme could be a good source of information for the group leaders for input on safer motherhood, this is not yet happening. One of the reasons is probably that the timing does not allow for group gatherings during radio broadcast.

In sum, the effectiveness of the radio programme in promoting safer motherhood is probably still lower than active community interaction. However, it is one of the ways to still reach out to otherwise remote populations at a relatively low cost.

Non-formal education

New safer motherhood materials have been developed for the use in non-formal education (NFE) programmes, and these programmes are still running, even in affected areas. During this study we asked people about NFE classes, whether there were currently classes, if they participated, and if they had learned anything about safer motherhood. This last question was a bit preliminary, as the materials have not yet been actively distributed. There seem to be problems with the distribution of the book, not related to the conflict.

Almost none of the investigated VDCs reported giving NFE classes recently, which is of more concern. Some people commented that NFE classes could not be held because of the conflict. NFE classes are only organised on request of the VDC, and possibly the current situation has reduced the number of requests, though where they had been planned the classes are running, adapting class hours to curfew hours. As with the mothers groups, coverage seems to be limited, especially excluding Dalits and the poor. This may not be an active exclusion, but some Dalits said they did not feel comfortable joining NFE classes, as they thought it would be too difficult for them.

Thus it is doubtful whether NFE classes can fill the gap created by reduced partner presence in the communities. It will surely be effective in creating knowledge among people who can access the classes.

Printed materials

When deciding to shift towards using more printed materials, it was taken into account that illiterates should still be an important target group of the programme. The assumption is that literate people will help to disperse the messages to the illiterate. A problem in this transfer of knowledge is that in most affected areas groups are not functional, preventing printed information from being discussed in groups. In the most affected areas, even interpersonal communication between, for example, FCHVs and other mobilisers and pregnant household is restricted due to limited mobility caused by fear even during daytime.

In the most affected areas printed materials like newspapers, magazines, and posters were not permitted beyond security check posts. It is not clearly understood how negotiable this is for safer motherhood information newsletters.

3.6 Conclusions

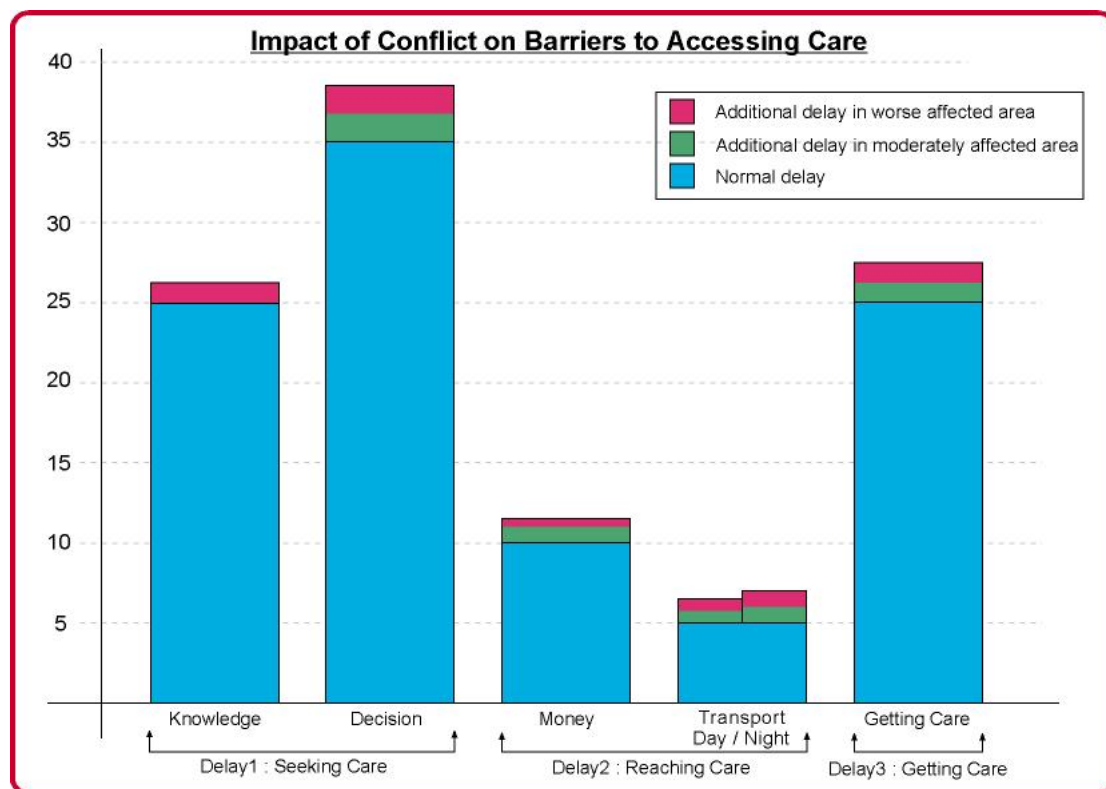
3.6.1 Impact on the three delays

Detailing how the different elements of increasing access to essential obstetric care have been impacted by the conflict, contributing to the three main delays, may have created an

idea that these additional barriers are huge. However difficult it is to quantify the mainly qualitative findings of this study, the researchers do not feel that that is a realistic perspective. Our impression is that the delays caused by the conflict are relatively small additions to normally existing barriers, even though in some very tragic cases these additional delays have proven fatal.

An attempt has been made to give a weighting to the relative impact of the conflict on the different barriers to access and utilisation of care, to synthesis the findings of this study and visualise them in a graph. Figure 2 presents the normal relative contribution of the different barriers of the three delays (knowledge, decision-making, money, transport, getting qualified care), as shown in figure 1 and adding up to 100%. The additional barrier created by the conflict is shown for each aspect, both for moderate and for severely affected areas, as estimated by the researchers. For each individual aspect this is only 1% or 2% of the total, but added up they account for a 11% increase in total delay in heavily affected areas, showing a total 111% delays in figure 2. The quantification is based on a personal judgement of the findings by the researchers, and is open to discussion as for the exact figures. However, the main debate should focus on the implications of these outcomes.

Figure 2.



Care seeking

The first delay of seeking care is divided into the barriers of knowledge and decision-making. Knowledge can again be separated into knowledge about danger signs during pregnancy and delivery, and knowledge of available health services. Combined these two contribute about 25% to the delays in normal situations. This study has mainly focused on knowledge of danger signs, but the findings can be extrapolated to knowledge of health services. Our findings indicate that the barrier caused by lack of knowledge is increased by about 5% in severely conflict-affected areas compared to normal circumstances. This is attributed to two

conflict impacts: increased migration and displacement of knowledgeable and educated people from the communities, and conflict-related problems in knowledge dissemination.

Decision-making is a complicated process very much related to knowledge and social environment as well as to individual household perceptions about the difficulty of arranging money and transport to reach the health facilities (the second delay). Under normal circumstances this is a major hurdle, accounting for as much as 35% of total delays. The civil conflict has affected decision-making mainly by the absence of male family members and decreasing mobility, which creates difficulties in consulting relatives, neighbours, TBAs, FCHVs, and qualified local health workers. Further impacts are due to hesitation over travel at night, both to call assistance at home, as well as to reach hospital facilities. This barrier accounts for approximately 5% of the delay in moderate conflict situations and 10% in the worst-affected areas.

Reaching care

The main physical barriers to reaching obstetric health care facilities are finance and transport. Both money and transport availability have been considerably impacted by the conflict. Though under normal circumstances these barriers are thought to account for only 10% and 5% of total delays, respectively, the largest relative increase in delays caused by the conflict is found in these two obstacles.

Money availability is affected by a significant decrease in the willingness to lend money to non-relatives and poor families, who are most in need of loans. This reluctance is partly caused by the worsened economic perspective of these families, who often depend on daily wage labour for their survival. The conflict has decreased employment opportunities and income from sales of produce, while living costs have increased. Also, potential moneylenders are generally keeping less cash at home for fear of extortion. The normal financial barrier is probably increased by 10% in moderately affected areas and 15% in worse conflict areas.

The impact of conflict on transport differs during day and night. During daytime transport is delayed at all security check posts, particularly for vehicular transport, often doubling travelling times. In general less public transport is plying the roads, in some areas explicitly prohibited by either security forces or Maoists, in other areas by lack of travellers and reduction in long distance buses. Fear of being caught in a crossfire or of encountering either party in the conflict reduces the mobility of people beyond their immediate community and is decreasing social support in road inaccessible areas, for example for carrying patients. This is exacerbated by the migration of men from the worst-affected areas. The additional delay caused by the daytime transport barriers at is estimated as 15% in areas of moderate conflict and 30% in the worst-affected areas.

At night additional obstacles are created by curfew and closed check posts. These barriers can be overcome if people know how to handle or have relations with the security forces, but many people don't. This intensifies fear of night travel and further decreases social support at night. In many areas vehicles are not allowed during the night, whereas before the conflict they were available. Therefore the conflict impact on transport at night is higher, probably a 20% increase in moderately affected areas and 40% in worse affected areas, as compared to the normal transport delays.

Though the conflict impact on the transport barrier is the highest, because the transport barrier normally contributes only some 5% to the total delays in health care seeking behaviour, the absolute additional barrier is relatively smaller, than for example the additional decision making barrier.

Getting care

After reaching health facilities there are delays in getting the attention of qualified personnel and the necessary medical supplies. Under normal circumstances this barrier is thought to make up 25% of total delays. The impact of the conflict on the actual availability of services should be considered separately for two types of health facilities. The (sub-) health posts and PHCs in the worst affected areas are having problems with absence of staff and restrictions in medicine supplies. At the hospitals of district capitals where water or electricity was cut off or that were under attack and where hospital staff tended to disappear, these additional problems in service delivery are affecting the immediate care of patients. Therefore it is thought that the conflict impact in getting health care is approximately 5% additional in moderately affected areas and 10% in worse affected areas.

Conclusion

The impact of the conflict has hardly changed the relative weighting of the barriers of delay. Even though the impact on the transport barriers is the major change, as it is thought to be one of the lesser barriers in peaceful times, the additional barrier created in transport is actually rather small. It is even small when compared to, for example, the 'little' additional effect on decision-making. This means that though the larger impact may be on transport, the focus of efforts to overcome the newly created barriers, still need to be on decision-making and referral.

As mentioned in various previous sections the poorer strata in the communities appear to feel the conflict impact on accessing EOC disproportionately. Their social network does not give them easy access to negotiate night travel with security forces. As they depend on wage labour, they are most affected by the economic impacts of the conflict. And unintentionally poorer and lower caste people might be left out from community activities propagating safer motherhood, due to community segregation, their lesser time availability for meetings and lower level of education. When trying to mitigate the conflict impact on access to EOC, special focus should be given to these groups in the communities.

3.6.2 Impact on the programme

The Increasing Access component of the NSMP programme is working to diminish the barriers that cause the first two delays. The conflict is affecting their ability to work directly with the communities to increase knowledge and change attitudes towards obstetric emergencies that require professional attendance. This social mobilisation work implemented by the partners has been affected, as partner staff are no longer able to work in the affected areas. Programme management was very aware of this conflict impact and has been counteracting it through alternative activities like mass media approaches (e.g., the radio programme "Amaa") and printed information materials (NFE classes and safer motherhood newsletters).

However, the dissolution of groups in the conflict-affected areas is decreasing the effectiveness of these new approaches to a certain extent. The lack of group meetings and activities is hampering the community-level dissemination of these alternative information inputs.

At the same time conflict impacts are revoking or delaying earlier achievements of the programme in communities in the worst affected areas. Quite a number of emergency funds have been cancelled or looted, in a situation where actually more loan opportunities are needed due to reluctance and lack of normal loan facilities, as well as a regression in the

overall economy. A few transport schemes have been affected, with the security forces destroying or capturing the means of transportation. Therefore the provision of stretchers by the programme has been delayed in some districts. The programme now needs to look for options to protect and reinforce their original achievements in the conflict-affected areas, as well as for different arrangements for transport and finances that will not be disturbed by the conflict.

4. DEVELOPMENT OF A MONITORING TOOL

A major output of this assignment is the development of a monitoring tool to continue examining the conflict impact as described in this study. Preparatory discussions with security advisors of DFID and other development organisations have provided some useful information on the do's and don'ts of monitoring conflict. Based on these concepts, a monitoring tool has been developed based on the following principles:

- Community-based information must be obtained through partner organisations and their formal and informal relations with the communities, as regular monitoring field visits by NSMP staff are not possible under the conflict situation. Even partners will have to rely on indirect information in the most affected areas where they can not continue working physically;
- Information should be shared among partners in a compiled form that does not identify informants or organisations. Yet, the specific information that is collected by NSMP for specific working VDCs of individual partners, should lead to further discussion for follow-up at the personal level;
- To limit the additional burden of conflict monitoring, only information directly related to the issues most directly affecting access to obstetric health services and which are likely to change according to the level of conflict should be collected.

4.1 Tool development


A short checklist of conflict-related indicators was chosen as the preferred monitoring tool (see Annex J). The initial monitoring checklist was developed based on preliminary analysis of the study results in Kailali and Surkhet. It was tested at the beginning of the final meeting with the Surkhet partners, who filled in the list as to their knowledge, after a short orientation. Based on their comments, adaptations were made in phrasing and scales, and the same procedure of testing was followed at the sharing meeting in Kailali.

Most problems were experienced with the scale used for rating the intensity of manifestations of conflict impact, as the scale was intended to be two-sided, including both positive and negative changes¹⁴. Therefore statements and scales were modified to reflect only degrees of negative impacts. These adapted monitoring checklists were then tested with the partner organisations in Baglung and Myagdi. Checklists were given to partner staff at the stakeholders meeting and collected and discussed at the time of interview. No major changes were deemed necessary after the second round of testing, though the need for a manual clarifying the scope of some issues was noted. This manual has now been developed and discussed with the Increasing Access manager at the national NSMP office (Annex K).

¹⁴ As the study was done during ceasefire a number of positive changes was already noticed, like shorter curfew hours, permission to stay overnight at road heads, and opening up of a previously closed bus-route. These findings urged to include also room for positive changes, but as this resulted too difficult, priority was given to the negative impacts.

4.2 Piloting in other districts

The developed monitoring checklist will now be piloted in two districts not covered by the current study, working with two or three partners in two or three VDCs. The NSMP SDOs and SDFs will be oriented on implementing this conflict-impact monitoring. Based on the monitoring manual included in the annexes, instructions will be given on data collection, data analysis, and reporting. Potential difficulties in data collection and sharing will be discussed and solutions examined.

After orientation the SDOs will be asked to provide a half-day orientation on the checklist to the partners, after which these will be able to pilot the monitoring tool in one or two of their project VDCs. Monitoring forms filled in by partners will be analysed in a participatory way by the SDO, who will prepare a short report for sharing with the partners. The report should mention the outcomes as well as problems encountered in data collection and analysis. The researchers will evaluate and if necessary adapt the monitoring tool further, based on an independent analysis of the completed formats, comparison of various interpretations  the comments made by the district staff.

4.3 Data collection

Collecting data does not require extensive separate VDC field visits involving interviews. Most information can be collected informally along with the partner's regular planned field activities. Field staff should seek the information required for monitoring from different people in the villages and crosscheck that information among those informants. The checklist is then filled in based on the total impression obtained. Information should be collected at least quarterly, with intermediate updates if significant changes occur in the short term.

When field visits did not occur during a three-month period (or were not possible due to the conflict situation), information can be collected through interviews with informants from the VDC who visit the District Headquarters, or even through informal inquiry of other local sources. The checklist should never be filled in by the VDC informants themselves, but always by trained partner staff who have had open discussions on the different issues with one or more informants, to get a balanced understanding of the situation in the VDC. Though direct field-based information is definitely preferable if available, the main purpose should be to get reliable information. In case no information is available for one or more of the indicators, this should be noted, rather than assuming that the situation is unchanged.

For NSMP's monitoring purposes, a limited number of VDCs will be selected on the basis of covering the different regions of a district. These VDCs could be determined by consensus of the RHCC of each district. It is expected that each partner will monitor one or two conflict-affected VDCs where they work. For government partners it may be necessary to obtain authorisation for field-level staff to be involved in this kind of monitoring and information sharing.

4.4 Use of data

Collected data can be stored at the district level in a simple Excel database, adding up results from subsequent reports to determine the overall impact, though care should be taken to interpret the information in a qualitative way rather than quantitatively. Ideally, partner organisations should be monitoring all their NSMP programme VDCs, for their own interest. For NSMP it will be enough to monitor a limited number of VDCs in the different regions of a district. Reporting to the RHCC and NSMP national office should compile information from

the different VDCs being monitored, to prevent disclosure of information sources creating vulnerabilities. On the basis of the monitoring information, possibilities for activities that can mitigate the impact of conflict can be identified and proposed.

Even during periods of reduced conflict, this monitoring of conflict impact should continue until return to a completely normal situation. Some consequences of the conflict that are slow in returning to normal may need additional attention from the programme to address the barriers they cause to care-seeking behaviour and access to obstetric health care. We particularly anticipate that changes in social support and money-lending practices that have occurred due to the conflict might last long beyond the termination of the conflict in terms of signing a peace agreement or withdrawal of the security forces to barracks.

4.5 Potential problems in monitoring

Discussions with the partner staff and analysis of the completed monitoring checklists revealed some issues to consider in monitoring the conflict impact.

1. It was felt that many partners were reluctant to tell about the impact of the conflict on their ongoing activities. This was associated with the apparent feeling that their performance was evaluated in general terms, even though it was stressed again and again that the study was intended to understand the way the conflict was hindering them in their performances. There seemed to be a common fear they might lose the NSMP programme if they had to admit to large delays or other problems in their work with the communities.
2. Most of the partner organisations interviewed have a tendency to monitor activities (process monitoring), rather than the effects or outcomes of those activities. For example, they will report that a training session was conducted successfully, but not actively monitor how the trained group is using the acquired skills and knowledge in the community. Monitoring of effects is further hampered by their reduced field presence due to the conflict. Therefore some partners do not seem aware of particular problems related to health access or other programme problems at the community level.
3. Participatory approaches notwithstanding, some partner organisations appear to think very much from a programme and organisational perspective, rather than from a community point of view. They may therefore have problems reporting on conflict issues from the immediate community perspective.
4. Whether local NGOs remain able to gather the required information when they are unable to pay regular field visits to their working areas remains an open question. Though some NGOs do have local staff in the VDCs who can gather information, many don't anymore and will have to rely on informal contacts with these areas to collect the monitoring data. The idea of working with key local informants from the VDCs when they visit the NGO offices in the district capital is viable, but also warrants some precautions. In the current conflict even more strongly than under normal circumstances, everyone has their own interests to defend. Therefore information will be coloured and probably incomplete. Information from key informants will need to be crosschecked with other sources, which are hard to come by, and creates the risk of exposing them.
5. As mentioned previously in section 3, all people are afraid to discuss the conflict with others. There is always a risk of being exposed for your views or sympathies, which could prove dangerous with either or both sides of the conflict. This further complicates information gathering, even though some information is completely fact based.

6. During pre-testing, some staff of government partners hesitated to fill in the checklist, as they did not feel authorised to provide this kind of information. In general INGOs have been experiencing reluctance at the part of government departments to monitor and specify the impact of the conflict on their operations and services. Thus where NSMP has government-related organisations as partners, it can be expected that reporting will not always be accurate.

Thus it might be reconsidered whether the programme partners are the appropriate channels for collecting information on these issues. Alternative informants, like journalists or human rights activists, have probably concerns over their independent image, in case they would take on a monitoring role for a donor sponsored project. Thus, for the moment the partners still seem to be the best intermediaries between the communities and NSMP for monitoring purposes.


5. RECOMMENDATIONS

This study has been limited to assessing the impact of the Maoist conflict on accessibility and utilisation of essential obstetric care. The findings indicate that there is a limited but very real impact on accessibility, mostly due to increases in the second delay, reaching care, particularly at night during curfew.

While the Maoist conflict is a very tangible conflict at the moment, there are many other conflicts in the communities related to deep-rooted social, economic, and caste discrimination. The study found indications that the Maoist conflict is actually enforcing this segregation in communities. These problems should be properly addressed when implementing awareness raising and access increasing programmes, because otherwise these programmes will benefit the better-off while intensifying the exclusion of the poor, Dalit, and desperate. Exclusion is part of the ground for the Maoist conflict, and if it is not addressed such conflict may revive. At any rate discrimination and inability to reach out to these underprivileged groups encumber the development impacts of the programme.

1. We recommend that NSMP more specifically target currently excluded groups of Dalit and the poor for knowledge dissemination and attitude changing efforts. Either more attention should be given to including them in existing groups, or separate groups should be formed and linked with the other groups through networking activities.
2. The project and its partners should regularly review their project activities from the perspective of “do no harm” methodology, to prevent that NSMP activities in the communities are exacerbating the conflict by enforcing segregation, giving disproportionate benefits for some population groups, or other unanticipated impacts.

The study found a quite limited increase in knowledge among the target groups. It is expected that this finding will be reflected also by the knowledge-survey analysis that is currently being done. When this leads to planning any strengthening of the awareness-raising programme, it will be necessary to keep the conflict circumstances in mind in two ways.

3. The intermediaries used for information dissemination  the methods used to raise awareness should be reconsidered, reflecting the conflict situation in the villages including collapsing groups and reduced mobility. NSMP has already begun doing this by radio programmes and development of NFE materials on safer motherhood, but other possibilities and adaptations might still be conceived.
4. The messages on safer motherhood and the appropriate actions to take in case of emergency need to address the current conflict situation. Issues like permission to travel during night curfew, alternative transport options, and safe ways of managing emergency funds should be included.

The study revealed that many of the major obstructions and delays caused by the conflict are related to intervention by the security forces to contain the conflict.

5. NSMP should take the lead fostering dialogue with the security forces to seek suggestions on how to overcome these barriers, while involving the partners in the process. The main issues relate to communication to seek help and permission to travel (related to the cutting of telephone lines), establishing procedures so that check posts can be approached at night without endangering the people seeking health care, and restrictions on public vehicles that otherwise could be available to transport patients.

6. The solutions established by dialogue with the security forces should be disseminated to the communities, including them in the safer motherhood messages.

Some of the highly affected communities have problems arranging enough people to carry the ill to hospital due to increased migration and diminishing social support.

7. NSMP and its partners should work with these communities to establish group arrangements that secure the swift availability of porters and accompanying people in case of emergency. Such discussions could involve an element of conflict management counselling, to overcome disproportionate fear.

The conflict is causing increased economic barriers to the access of health care, because employment and income are decreasing and possibilities of borrowing money for treatment have been reduced. Even the main solution to the economic barriers offered by the programme, the emergency funds, is experiencing problems in maintaining functionality under the crisis. Many people in the communities still do not know they can access the fund even if they are not members, though at a higher interest rate. The main conflict-related problem is how to protect these funds from looting by Maoists or by unreliable group members.

8. The programme partners and their groups should promote awareness about the accessibility of the emergency funds into the wider communities, particularly to the poor, who are more desperate under the current conflict situation. This may even increase their acceptability with the Maoists, as funds are raised locally.
9. The programme and its partners should work with the groups on methods to safeguard the funds, while keeping them accessible. Possible solutions include putting the money in a bank account and establishing agreements with local moneylenders that they advance the most urgent money and be repaid immediately from the emergency fund. This warranty might help to overcome their reluctance to lend to poor and disadvantaged people.
10. The programme and its partners should collect detailed information on emergency fund utilisation and repayment trends, to be able to detect problems in fund management and support groups in tackling problems. This information should be duly analysed and evaluated.
11. NSMP should advocate with the health posts and hospitals for emergency funds or funds for the poor, and promote awareness about the existence of such funds. An important aspect in the establishment and accessibility of these funds for the poorest of the poor is the formulation, implementation and monitoring of clear policies regarding who is eligible to use the fund. At this moment selection of people for free treatment is often rather arbitrary. Care should be taken to avoid unnecessary administrative burden. There may be lessons to be learned from similar local level exemption schemes/ equity funds.

The conflict also affects the efficacy of the programme itself in increasing access. Partners were not always realistic in their estimates of the impact they are experiencing. Adapting their planning and activities to the conflict reality will improve their performance and should aim to mitigate conflict impact on access and utilisation of EOC.

12. Partners should be stimulated to plan realistically and to take the conflict situation into account without being overwhelmed by it, using conflict management tools like conflict profile, risk assessment, and coping capacity assessment.

13. Partners should be stimulated to find effective ways to monitor the conflict's impact in the communities as well as the impact of their activities. This will help them plan their activities according to the community's needs and obstacles in the current civil conflict situation. The monitoring checklist developed in this study would be one element in this monitoring process, but does not fully indicate the ways they can obtain the required information.

14. NSMP and its partners should ensure that the conflict impact-monitoring checklist is used not only as a diagnostic tool, but that the collected information is used for conflict impact mitigation. This will require training of staff to analyse and interpret the collected data, and to use the information for identification of possibilities for conflict impact mitigating activities, as well as the institutionalisation of such process in both NSMP and its partners.

In heavily affected areas, groups (which are the channel for information dissemination and safer motherhood promotion activities) have collapsed, negatively impacting the efficacy of the programme.

15. In areas where group gatherings are no longer possible, FCHVs and other group mobilisers should be encouraged to promote and disseminate the safer motherhood concept at the family and individual levels. This might require some incentives, as they will have to overcome their fear of travelling instilled by the conflict.

The dissemination of safer motherhood messages by radio programmes was less effective than hoped due to limited access to radios among the target groups; knowledge retention was poor.

16. In areas where small group gatherings are possible, radio listeners' groups could be promoted to listen to the programmes dealing with safer motherhood issues and discuss these in order to increase retention of disseminated information.

Though not all the impacts of Nepal's civil conflict can be addressed by local solutions like these, we expect that these 16 recommendations will help the programme and its partners to cope with the challenges posed by the country's civil conflict.

ANNEX A: TERMS OF REFERENCE: SMALL-SCALE STUDY OF THE IMPACT OF CONFLICT ON EOC SERVICE UTILISATION

Background

The DFID-supported Nepal Safer Motherhood Project (NSMP) aims to support HMGN's National Safe Motherhood Programme by contributing to improved maternal health in selected districts. It has two components: *service provision* under which systems to manage services for women of reproductive age will be established - including improvements to the physical infrastructure of hospitals, equipment and supplies, and training of personnel; and *increasing access* which seeks to improve the social context for and access to midwifery and obstetric services within the supported districts in order to enable women to utilise services.

Whilst NSMP has seen some increase in the essential obstetric care (EOC) and midwifery utilisation figures at the supported hospitals these have not been to the degree anticipated in the project design and utilisation levels remain unacceptably low. The project's extensive field based knowledge on the complexities of why allopathetic services are often not sought suggest that addressing these access barriers to access takes somea considerable time and hence also that the project's expectations may have been unrealistic – even in the most peaceful of times. Therefore, the extent to which the escalation in the current conflict within Nepal has been exacerbated contributed to by this situation is very difficult to determine. There is anecdotal evidence to suggest that women and their families are increasingly reluctant to travel, particularly at night. However, analysis of small-scale, facility-based data do not show a clear downward trends of decreasing in cases arriving at night or a decrease in admissions from distant VDCs and which does not bear out as such the conclusions cannot easily be substantiated.

Given the role of NSMP as a flag ship safe motherhood programme, both nationally and internationally, the team feel the need to investigate further the effect of conflict on women's ability to access and utilise EOC services. This is potentially a very broad area of investigation as social context and community support structures are being effected by the conflict and this may have both positive and negative effects on women's position, decision-making power, access to resources etc.

As the degree of conflict is constantly changing, a one-off consultancy can only provide a snapshot of the situation. However, we deem it important to include research into how restrictions and changes to Increasing Access component activities by the partners are affecting the potential of NSMP to influence care seeking attitudes and practices at the community level. Explore only to what extent the conflict is impacting on issues of access to services and what the perceived benefits and risks of utilization are, does not recognize that the change and restrictions in project activities at community level itself is possibly a factor that limits further increases to service utilization.

Therefore, in light of the above, the emphasis will be on a robust study covering a minimum /total of 4 districts. The major technical output of the consultancy will be the design of tools which can be used on a regular basis by the project team in order to undertake ongoing monitoring.

Purpose of the Assignment

To design and undertake a (maximum of) 4-district consultancy exploring and attempting to quantify the effects of the current conflict on utilisation of midwifery and EOC in NSMP-

supported districts. Through the consultancy process, simple tools should be designed and generated (which can be utilised ideally using only existing data collection processes) which can be used by NSMP for future, regular data collection and ongoing analysis (ideally though weaving tools into existing data collection processes).

Tasks

1. Undertake background reading of reports generated around the conflict in Nepal;
2. Fully brief him/herself on the project, including its current data collection and reporting systems and processes;
3. Update him/herself on the other similar work underway by other external development partners in analysing the effect of the conflict on rural Nepali's;
4. Source a national consultant, providing a brief shortlist of 2/3 possible candidates, review with Project Director and appoint;
5. With team, determine role of national consultant within the study and compile TORs;
6. Drawing on his/her own experience and that of other external development partners (see point 3 above), design a study to explore the extent to which the current conflict situation is deterring utilisation of EOC services within NSMP-supported districts. The study should focus on the immediate effects of the conflict situation on the potential users (and their families) and concentrate especially specifically on exploring the extent to which the conflict has effected issues of access to services and the perceived benefits and risks of utilising services. The study design should include a component of developing, field testing and finalising tools for use by NSMP to continue to monitoring the immediate direct effect of the conflict on utilisation of EOC services;
7. Brief the NSMP team on the study design and incorporate comments feedback;
8. Implement the study – this may require managing a small field-based team;
9. As part of the study's iterative process, draw out produce simple tools for use in ongoing conflict monitoring by NSMP. Ideally, it should be possible to integrate Tthese tools should ideally be integrated into the existing mechanisms and processes used by NSMP to collect their data;
10. Test tools with district staff from other districts not visited during the consultancy period;
11. Document the study background, process and results, as well as and present the tools generated, in a short report not exceeding 20 pages;
12. Throughout the working and reporting period close co-ordination should be kept maintained with the Project Director and staff, along parameters as agreed at the consultancy outset of the consultancy.

Location

The consultancy will be based in Kathmandu but will involve travel up to four NSMP-supported districts in order to undertake fieldwork.

Outputs

The consultant will produce a report of the study not exceeding 25 pages. A draft of this report will be shared with the NSMP team before finalisation. The completed document will be re-submitted to Options and the NSMP team within 10 days of the end of the consultancy period.

Timeframe

The consultancy will be for a total of 49 Days, undertaken in January-March 2003.

Person Specification

Essential:

- Familiarity with Nepal - its social and institutional context and the current conflict situation;
- He/she should have a background in both social development, research, and in the area of conflict;
- Background in social development, research.

Desirable:

- Previous work undertaken in Nepal to analyse the effects of the conflict on the population;
- He/she should have a background in both social development and conflict;
- Experience in the health sector, reasonable spoken Nepali.

ANNEX B: TIME SCHEDULE STUDY

M = Monique

B = Basu Dev

F = Facilitator NSMP

P= Partner staff

FI = Field interviewers

C = Coordinator

	Mon	Tue	Wed	Thurs	Fri	Sat	Sun	Sun	Mon	Tue	Thurs	Friday
date	Feb 10	Feb 11	Feb 12	Feb 13	Feb 14	Feb 15	Feb 16	Feb 24	Feb 25	Feb 26	Feb 27	Feb 28
KAILALI												
Travel	KTM to Kailali						Kailali to Surkhet	Surkhet to Kailali				Kailali to KTM
NSMP staff disc.												
Exploration VDC		M + B + F + P										
Tool preparation		M + B	M + B	M + B	M + B							
Stakeholder intro meeting				M + B + F								
Training of interviewers					M + B + FI							
District interviews		M / B		M / B				M / B	M / B			
Cases hospital						FI / M + F		FI + C	FI + M			
Health staff VDC interviews			M + B + C + F			B + C		FI + C	B + C	B + C		
Mothers group FGD			M + B + C + F			B + P + FI		FI + C	FI + F	FI + F		
Household cases VDC			M + B + C + F			FI + F		FI + C	FI + F	FI + F + M		
Tools testing in community			M + B + C + F									
Analysis of material											M + B + C + FI	
Evaluation of tools											M + B	
Tools sharing with partners												M + B + P + F
Reflection with stakeholders												M + B + P + F

SURKHET	Thurs	Fri	Sat	Sun	Mon	Tue	Wed	Thurs	Friday
date	Feb 16	Feb 17	Feb 18	Feb 19	Feb 20	Feb 21	Feb 22	Feb 23	Feb 24
Travel	Kailali to Surkhet								Surkhet to Kailali
NSMP staff disc.	+ C								
Stakeholder intro meeting		M + B + F + C							
Training of interviewers			M + B + FI + C						
District interviews		M + B						M + B	
Cases hospital					FI / M			FI / M	
Health staff VDC interviews				M + B + F + C	M / B + C	M / B + C	B + C		
Mothers group FGD				M + B + FI	FI + F	FI + F	FI + F		
Household cases VDC				FI	FI + M	FI + M	FI + M		
Analysis of material								M + B + FI	
Tools testing with partners								M + B + P	
Tools evaluation with partners								M + B + P + F	
Reflection with partners								M + B + P + F	

Explanation:

M = Monique B = Basu Dev

F = Facilitator NSMP

P = Partner staff

FI = Field interviewers C = Coordinator

BAGLUNG	Mon	Tue	Wed	Thurs	Fri	Sat	Sun	Mon	Tue	Wed	Thurs
date	Mar 3	Mar 4	Mar 5	Mar 6	Mar 7	Mar 8	Mar 9	Mar 10	Mar 11	Mar 12	Mar 13
Travel	KTM to Baglung		Baglung to Beni					Baglung to Beni		Baglung to PKR	PKR to KTM
NSMP staff disc.											
Stakeholder intro meeting	M + B + F + C										
Training of interviewers		M + B + C + FI									
District interviews	M + B						M				
Cases hospital			FI	FI	FI	FI	FI				
Health staff VDC interviews			M + C	M + C	M + C	M + C					
Mothers' group FGD			M + F	FI + F	FI + F	M + F					
HH cases VDC			FI + F	FI + M	FI + F	FI + F					
Tools testing; partners	M + P	M + P					M + P				
MYAGDI	Mar 2	Mar 3	Mar 4	Mar 5	Mar 6	Mar 7	Mar 8	Mar 9	Mar 10	Mar 11	Mar 12
Stakeholder intro meeting			B + F + C								
District interviews			B + F								
Cases hospital			FI	FI	FI	FI	FI				
Health staff VDC interviews				B + C	B + C	B + C	B + C				
Mothers group FGD				B + F	FI + F	FI + F	FI + F				
HH cases VDC				FI + F	FI + F	FI + F	FI + F				
Tools testing; partners			B + P	B + P	B + P						
Analysis material								M + B + FI + F	M + B + FI + F		
Evaluation tools										M + B + P	
Reflection with partners										M + B + P + F	

Explanation:

M = Monique

B = Basu Dev

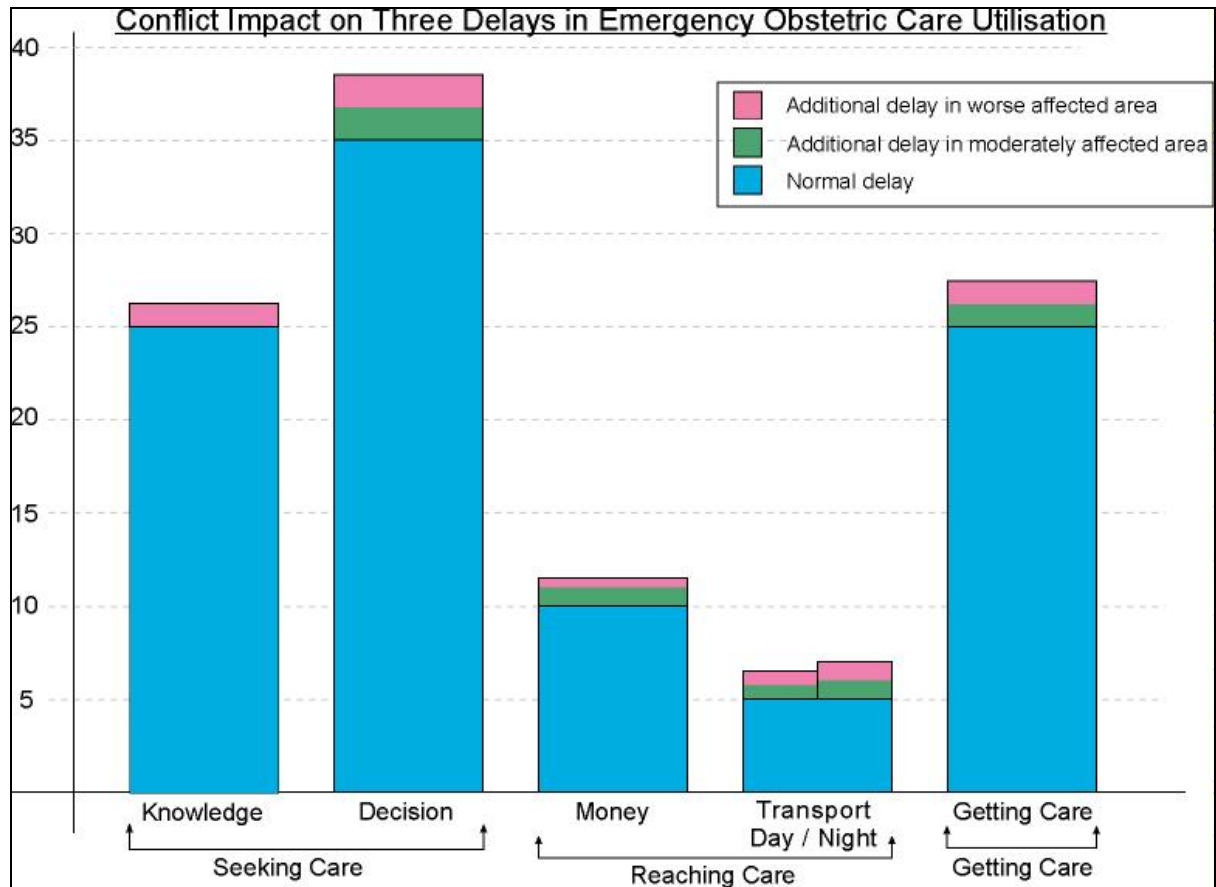
F = Facilitator NSMP

P = Partner staff

FI = Field interviewers

C = Coordinator

ANNEX C: DISTRICT MAPS INDICATING STUDIED VDACS



ANNEX D: QUESTIONNAIRES

Main Issues for Discussion

1. Mothers group
2. Danger signs
3. Health services
4. Financial barriers
5. Transport barriers
6. Migration
7. Security

Mothers Group FGD (Nepali)

We are doing a small research on health care for deliveries. [partner organisation] has been working in this village on this issue, and we would like to know what has changed since then.

1. How is this group currently functioning? No of meetings / attendance.
We guess you have you been discussing a lot of women's health issues in your mothers group. How often did you talk about deliveries and their complications in this group?

2. What did you learn about deliveries and the danger signs?

3. Have you heard about the radio programme "Aama"?

What did you learn from that?
Did you discuss it in the group?

4. Are there NFE classes on pregnancy and delivery in your village?

What did you learn from that?
Did you learn about pregnancy and delivery anywhere else?

5. Where would you go for help in case of an emergency during child delivery?

6. How do you feel about the service of the health workers in this village?

7. How is your medical Emergency Fund functioning?

Any problems?

8. Did your village arrange for a transport scheme? (means of transportation)

How does it function?
Any problems?

**9. Is seasonal migration from your village different compared to previous years?
Does the amount of (young/male) people absent cause any problems in the village?**

Organising / Financial / Transport
Could women do the carrying in case there are no men?

10. What has changed due to migration in who takes the decision-making in the household, concerning (for example) deliveries?

11. How do you consider the security situation in your village?

And how is the security situation on the way to the district capital?

12. Does the current situation affect your mobility?

How about medical emergency cases?

13. What do you think of the political women?

Do you think the political people do treat women differently?

QUESTIONNAIRE FOR HOSPITAL, (SUB) HP, OR PHC DELIVERY CASES (NEPALI)

You have come to hospital for the delivery of your child. We are doing a study on hospital care for deliveries. Would you mind talking to us for half an hour and telling about the reasons why you came to the hospital and how your trip to the hospital went? Our conversation will be purely confidential.

1. For what reason did you decide to come to hospital?

2. Who took the decision to go to hospital?

What had happened to your pregnancy (or during delivery) before you decided to go to hospital?

Did you experience any problems during your pregnancy?

What kind of problem did you have during delivery?

How long had you been experiencing labour pains before it was decided to go to hospital?

What time of the day was it when the decision was made?

3. Was there any hesitation to take the decision?

Were there any problems at admission or treatment in the hospital?

Perception of health services

4. Were you sure if the hospital could help you with your delivery complication?

Did you first go to some other health facility before coming to the hospital?

5. Did you ask advice from any health worker? (TBA, FCHV, MCHW, ANM, VHW, AHW)

Were any health workers available to you?

Could you have easily contacted them?

Do the health workers come for home visits if requested?

Are there enough medical supplies at the (Sub) Health Post / PHC of your village?

Are there other places in your village where you can get medical supplies or drugs?

Transport barriers

6. When did you start arranging for transport to the hospital?

7. Who was involved in arranging the transport?

8. Did you have trouble finding someone to help you arrange the transport?

What kind of transport did you use? Do you know there is an ambulance in Dhangadi?

What kind of path/road comes from your village/house to the hospital?

How much time walking?

How much time by transport?

How long did it take to arrange for the transport after it was decided to go to hospital for your delivery?

Were there any problems when arranging transport?

Is there a transport scheme in your village? If yes, did you use it/was it helpful?

Financial barriers

9. Did you need to make arrangements for the money required for the hospital?

Was it at home, or had you to go find it from elsewhere?

When did you start arranging the money? (many days before, or at time of labour pain)

What kind of arrangements were made? (talk to family, emergency fund, own savings)
Who was involved in arranging the required funds for transport / medical care / food and lodging in town?
Where did you get the money? (break down if necessary)
Does your village have a medical Emergency Fund? If so, did you use that fund? /Are you a member?

10. Was the money a reason to reconsider whether to go to hospital?

Did you know approximately how much your treatment would cost?
If you took a loan: How long do you think it will take you to pay back?
From what income you will be paying back?
Has your economic situation changed a lot over the last two years?
How did it change?
Did you request a subsidy from the hospital or other organisation for your treatment?

Knowledge of danger signs

11. Did you ever hear about the danger signs during pregnancy and delivery?

From whom or where did you hear about this?
Are you a member of a mothers group in your village?
How often do you attend the mothers group meetings?
Did you talk about women's health issues in your mothers group?
Are NGO / HW staff sometimes present at these meetings?

12. Have you heard about the radio programme "Aama"?

Did you ever listen to it? (Who informed you about it?)
Have you ever participated in NFE classes? When?

13. Did you learn anything about pregnancy and delivery at NFE classes?

Did you learn about pregnancy and delivery anywhere else?

Security barriers

13. How is the current situation in your village? (two weeks before and now)

14. Did the current security situation in any way influence the decision to come to the hospital?

Is there a curfew in your village?
Could you move inside your village (to the neighbours) during curfew hours?
Could you travel to the health post during curfew hours?
Was it curfew time when you decided to come to hospital?

15. Are there any checkpoints (from either side) on the way from your village to the hospital?

Had you problems in passing the checkpoints?
Did you get held up at the checkpoints? If so, how much time?
How do you feel about being checked at the checkpoint?
Were you afraid of the people at the checkpoint and how they would treat you?
Would you be able to negotiate permission for travel with SF?
Were you in any doubt about people you met on the way to the hospital?
Were you afraid to encounter some strangers on the way?
How would you feel about me visiting your village if you did not know me?
Do the political parties ever organise meetings at your village?
Did they ever talk about women's health and other women's issues?

How do you feel they look upon the role of women?

Migration issues

16. Can I ask for the composition of your household?

Joint family / Nuclear family / No of male / No of female / No of Children

17. Is anybody from your household migrated for labour currently?

How long will he/she stay away?

Was the migrated person earning money from wage labour?

Do they send money during their absence?

Who is doing the tasks (in the HH) that the migrated person did previously? (share between the household members, with support from neighbours and relatives, labour is hired, nobody does it)

Does the money the person sends contribute to paying the household expenses?

Have more / other people from your village migrated (to India)?

How many? More people than last year? How many more?

Have whole families been migrating from your village?

For what reasons? What kind of families?

18. Can I ask your age?

Which village (VDC and ward) do you come from?

What is your jaat?

QUESTIONNAIRE FOR HOME DELIVERY CASES (NEPALI)

You have recently got a baby and you delivered your baby at home. We are doing a study on health care for deliveries. Would you mind talking to us for half an hour and telling about the delivery and your family? Our conversation will be purely confidential.

For interviewer to note down:

Village (VDC and ward) where the interview was done:

1. Can I ask your age?

2. Can I ask for the composition of your household?

Joint family / Nuclear family / No of male / No of female / No of children

Did you have any children before this baby?

Circumstances of delivery

3. Where was your baby born?

Was anybody with you when you delivered your baby?

Did they do anything to help and support you during the delivery?

How did the delivery happen?

Did you experience any problems during your pregnancy?

Did you have any kind of problem during delivery?

How long had you been experiencing labour pains before giving birth?

Did any problems occur after delivery?

4. Did you at any moment consider calling for help during the delivery?

Who would you have called?

Perception of health services (1)

5. Did you at any moment consider going to hospital for your delivery?

For what reason would you have decided to go to hospital?

Who would have taken the decision to go to hospital?

6. Would you know if the hospital could have helped you with your delivery complication?

Would you have gone first to some other health facility, or straight to hospital?

Perception of health services (2)

7. Did you ask advice about your pregnancy and delivery from any health worker?

(TBA, FCHV, MCHW, ANM, VHW, AHW) If so, with whom did you talk? What did they say?

Were any health workers available for you?

Could you have easily contacted them?

Do the health workers come for home visits if requested?

Are there enough medical supplies at the (Sub) Health Post / PHC of your village?

Are there other places in your village where you can get medical supplies or drugs?

Knowledge of danger signs

8. Did you ever hear about the danger signs during pregnancy and delivery?

From whom or where did you hear about this?
Are you member of a mothers group in your village?
How often do you attend the mothers group meetings?
Did you talk about women's health issues in your mothers group?
Is there sometimes NGO / HW staff present at these meetings?

9. Have you heard about the radio programme "Aama"?

Did you ever listen to it?
Have you ever participated in NFE classes? When?

10. Did you learn anything about pregnancy and delivery at NFE classes?

Did you learn about pregnancy and delivery anywhere else?

Transport barriers

11. If you would have needed to go to hospital would it be difficult to arrange for transport?

12. Who would you ask to help arrange the transport?

13. Would you have trouble finding someone to help you arrange the transport?

What kind of transport would you use?
What kind of path/road goes from your village/house to the hospital?
How much time walking?
How much time by transport?
How long would it take to arrange for the transport after it was decided to go to hospital for your delivery?
Is there a transport scheme in your village? If yes, could you use it/would it be helpful?

Financial barriers

14. Did you make arrangements for the money in case you had to go to hospital for your delivery?

And now you delivered at home you may have also some costs to cover, isn't it?
What kind of arrangements were made? (talk to family, emergency fund, own savings)
Who would decide on the arrangements for the required funds for transport / medical care / food and lodging in town?
Where would you get the money? (break down if necessary)
Does your village have a medical Emergency Fund? If so, would you use that fund? /Are you a member?

15. Was money a reason to consider when you decided to deliver at home?

Did you know approximately how much your treatment would cost?
If you took a loan: How long do you think it would take you to pay back?
From what income would you pay back the loan?
Has your economic situation changed a lot over the last two years?
Why and how did it change?

Migration issues

16. Is anybody from you household migrated for labour currently?

How long will he/she stay away?

Who is doing the tasks (in the HH) that the migrated person did previously? (share between the household members, support from neighbours and relatives, labour is hired, nobody does it)

Was the migrated person earning money from wage labour?

Do they send money during their absence?

Does the money the person sends contribute to paying the household expenses?

Have more / other people from your village migrated?

How many? More people than last year? How many more?

Have whole families been migrating from your village?

For what reasons? What kind of families?

Security barriers

17. How is the current situation in your village? (two weeks ago and now)

18. Did this security situation in any way influence the decision not to go to hospital?

Is there a curfew in your village?

Could you move inside your village (to the neighbours) during curfew hours?

Could you travel to the health post during curfew hours?

19. Are there any checkpoints (from either side) on the way from your village to the hospital?

Do you hesitate to pass the checkpoints?

How much time would you be held-up at the checkpoints?

How do you feel about being checked at the checkpoint?

Would you be able to negotiate permission for travel with SF?

Would you be afraid to encounter strangers on the way to hospital?

How would you feel about me visiting your village, as you do not know me?

Do the political parties ever organise meetings at your village?

Did they ever talk about women's health and other women's issues?

How do you feel they look upon the role of women?

Personal profile:

Jaat?

QUESTIONNAIRE FOR VILLAGE PREGNANT CASES (NEPALI)

The FCHV told us that you are pregnant and are to have your baby soon. We are doing a study on health care for deliveries. Would you mind talking to us for half an hour about these matters? Our conversation will be purely confidential.

For interviewer to note down:

Village (VDC and ward) where the interview was done:

1. Can I ask for the composition of your household?

Joint family / Nuclear family / No of male / No of female / No of children
Did you have any children before this pregnancy?

Knowledge of danger signs

2. Did you ever hear about the danger signs during pregnancy and delivery?

From whom or where did you hear about this?
Are you a member of a mothers group in your village?
How often do you attend the mothers group meetings?
Did you talk about women's health issues in your mothers group?
Are NGO / HW staff sometimes present at these meetings?

3. Have you heard about the radio programme "Aama"?

Did you ever listen to it?
Have you ever participated in NFE classes? When?

4. Did you learn anything about pregnancy and delivery at NFE classes?

Did you learn about pregnancy and delivery anywhere else?

Circumstances of delivery

5. Where do you think you will be delivering your baby?

Will there be anybody with you when you deliver your baby?
Do you know what they will do to help and support you during the delivery?
Did you experience any problems during your pregnancy?

6. Did you go for antenatal check-up during this pregnancy?

Perception of health services

7. Did you ask advice about your pregnancy and delivery from any health worker (TBA, FCHV, MCHW, ANM, VHW, AHW)? If so, with whom did you talk? What did they say?

Were any health workers available to you?
Could you have easily contacted them?
Do the health workers come for home visits if requested?
Are there enough medical supplies at the (sub) health post / PHC of your village?
Are there other places in your village where you can get medical supplies or drugs?

8. Have you considered going to hospital for your delivery?

For what reasons would you decide to go to hospital?
Who would take the decision to go to hospital?

9. If any problem would occur during your delivery, whom would you call for help?

What kind of problems can they help to solve?

10. Would you at any moment consider going to hospital for help with the complication of your delivery?

Would you have gone first to some other health facility, or straight to hospital?

11. Would you know if the hospital could help you with your delivery complication?

Transport barriers

12. If you would need to go to hospital, would it be difficult to arrange for transport?

13. Who would you ask to help arrange the transport?

14. Would you have trouble finding someone to help you arrange the transport?

What kind of transport would you use?

What kind of path/road goes from your village/house to the hospital?

How much time walking?

How much time by transport?

How long would it take to arrange for the transport after it was decided to go to hospital for your delivery?

Is there a transport scheme in your village? If yes, could you use it/would it be helpful?

Financial barriers

15. Did you make arrangements for the money in case you have to go to hospital for your delivery?

What kinds of arrangements are made? (talk to family, emergency fund, own savings)

Who would decide on the arrangements for the required funds for transport / medical care / food and lodging in town?

Where would you get the money? (break down if necessary)

Does your village have a medical emergency fund? If so, would you use that fund? /Are you a member?

16. Is money a reason to consider when deciding if you will go to hospital in case of an emergency?

Do you know approximately how much your treatment would cost?

If you took a loan to pay the treatment: How long do you think it would take you to pay back?

From what income you would pay back the loan?

Has your economic situation changed a lot over the last two years?

How did it change?

Migration issues

17. Is anybody from you household migrated for labour currently?

How long will he/she stay away?

Do they send money during their absence?

Does the money the person sends contribute to paying the household expenses?

Was the migrated person earning money from wage labour?

Who is doing the tasks (in the HH) that the migrated person did previously? (share between the household members, support from neighbours and relatives, labour is hired, nobody does it)

Have more / other people from your village migrated?

How many? More people than last year? How many more?
Have whole families been migrating from your village?
For what reasons? What kind of families?

Security barriers

18. How is the current situation in your village? (two weeks before and now)

19. Will the security situation in any way influence the decision whether to go to hospital?

Is there a curfew in your village?

Could you move inside your village (to the neighbours) during curfew hours?

Could you travel to the health post during curfew hours?

20. Are there any checkpoints (from either side) on the way from your village to the hospital?

Do you hesitate to pass a checkpoint?

How much time would you be held up at the checkpoints?

How do you feel about being checked at the checkpoints?

Would you be able to negotiate permission for travel with SF?

Would you be afraid to encounter strangers on the way to hospital?

How would you feel about me visiting your village as you do not know me?

Do the political parties ever organise meetings at your village?

Did they ever talk about women's health and other women's issues?

How do you feel they look upon the role of women?

Respondent profile:

Can I ask your age?

What is your jaat?

Family member, or pregnant woman herself?

QUESTIONNAIRE FOR VILLAGE-LEVEL TREATMENT MANAGERS/ ORGANISERS (NEPALI)

We have been told by [delivered household] that you (recently helped)/(would have helped) them in a case of emergency during the delivery of the baby to organise the transport and such. We are doing a study on transport to hospitals of emergency deliveries. Would you mind talking to us for half an hour and telling about how you would organise the trip to the hospital and in what cases you would really think that it is necessary. Our conversation will be purely confidential.

For interviewer to note down:

Village (VDC and ward) where the interview was done:

1: Can I ask your age?

2. For what reason would a delivering woman go to hospital?

3. Who took (would take) the decision to go to hospital?

Do you know how long the new mother had been in labour or having trouble before they asked you to help them arrange transport?

What time of the day was it when the decision was made to go to hospital?

4. Was there (would there be) any hesitation to take such decision?

Transport barriers

5. When did you start arranging for transport to the hospital?

6. Who else was involved in arranging the transport?

What kind of transport did you use?

What kind of path/road comes from your village/house to the hospital?

How much time walking?

How much time by transport?

How long did it take to arrange for the transport after it was decided to go to hospital for your delivery?

7. Were there any problems when arranging transport?

Did you have trouble finding people to accompany the transport?

8. Is there a transport scheme in your village? If yes, did you use it/was it helpful?

Financial barriers

9. Did the family make arrangements for the money required for hospital beforehand?

What kinds of arrangements were made previously?

Were you involved in arranging the money for transport / medical care / food and lodging in town (at the time of going to the hospital)?

Who else was involved in arranging the required funds?

Where did they get the money? (break down if necessary)

Does your village have a medical Emergency Fund? If so, could the family use that fund?

/Are they a member?

10. Were the cost and getting the money a reason to reconsider whether to go to hospital?

Did you know approximately how much the treatment would cost?

If people took a loan: How long do you think it will take them to pay back?

From what income would they be paying back?

Has their and the village economic situation changed a lot over the last two years?

How did it change?

Perception of health services

11. Were you sure whether the hospital could help you with the delivery complication?

Did you first go to some other health facility before coming to the hospital?

12. Did you ask advice from any health worker? (TBA, FCHV, MCHW, ANM, VHW, AHW)

Are any health workers available in the village?

Could you have easily contacted them?

Do the health workers come for home visits if requested?

Are there enough medical supplies at the (sub) health post / PHC of your village?

Are there other places in your village where you can get medical supplies or drugs?

Knowledge of danger signs

13. Did you ever hear about the danger signs during pregnancy and delivery?

14. Have you heard about the radio programme “Aama”?

Did you ever listen to it?

Have you ever participated in NFE classes? When?

15. Did you learn anything about pregnancy and delivery at NFE classes?

Security barriers

16. How is the current situation in your village? (two weeks ago and now)

17. Did this security situation in any way influence the way you (would have) arranged the trip to the hospital?

Is there a curfew in your village?

Could you move inside your village (to the neighbours) during curfew hours?

Could you travel to the health post during curfew hours?

Was it curfew time when you decided to come to hospital?

18. Are there any checkpoints (from either side) on the way from your village to the hospital?

Had you problems to pass the checkpoints?

Did you get held up at the checkpoints? If so, how much time?

How do you feel about being checked at the checkpoint?

Were you afraid of the people at the checkpoint and how they would treat you?

Would you be able to negotiate permission for travel with SF?

Were you in any doubt about people you met on the way to the hospital?

Were you afraid to encounter strangers on the way?

How would you feel about me visiting your village if you do not know me?

Do the political parties ever organise meetings at your village?

Did they ever talk about women's health and other women's issues?

How do you feel they look upon the role of women?

Migration issues

19. Can I ask for the composition of your household?

Joint family / Nuclear family / No of male / No of female / No of children

20. Is anybody from your household migrated for labour currently?

How long will he/she stay away?

Do they send money during their absence?

Does the money the person sends contribute to paying the household expenses?

Was the migrated person earning money from wage labour?

Who is doing the tasks (in the HH) that the migrated person did previously? (share between the household members, support from neighbours and relatives, labour is hired, nobody does it)

Have more / other people from your village migrated?

How many? More people than last year? How many more?

Have whole families been migrating from your village?

For what reasons? What kind of families?

Did the migration and absence of a lot of people cause you any problems when arranging for the transport?

Respondent profile:

Can I ask your age?

What is your jaat?

Family member, or pregnant woman herself?

QUESTIONNAIRE FOR FCHV / MCHW (NEPALI)

We are doing a small research on health care for deliveries. [The partner organisation] has been working in this village on this issue, and we would like to know what has changed since then. Would you mind talking to us for half an hour and telling about the health care situation in this village recently? Our conversation will be purely confidential.

For interviewer to note down:

Village (VDC and ward) where the interview was done:

Perception of health services

1. Do pregnant women go regularly for antenatal check-up during pregnancy?

Where do they have to go for ANC?

2. How is the health worker staffing at the (sub) health post? (AHW, VHW, MCHW, ANM) How was this two years ago?

Are the health workers attending regularly at the (sub) health post?

Do the health workers visit the communities of the VDC regularly?

Do the health workers (MCHW, VHW) conduct regular outreach clinics?

Do the health workers go for home visits if requested?

Do they come at night?

3. Are there enough medical supplies at the (sub) health post / PHC of your village?

Are any essential drugs missing from the stock?

Is this different from two years ago?

Are there other places in your village where you can get medical supplies or drugs?

Circumstances of delivery

4. Where do most women deliver their babies?

Will there be anybody with them when they deliver the baby?

What will they do to help and support the delivering mother during delivery?

5. Do any women go to hospital for a normal delivery?

In case of complication do they call for help from the health post?

6. Do women go to hospital/HP in case of a complication during delivery?

7. Has this happened in this village during the last month?

Normal barriers

8. Are there any problems in reaching the hospital?

9. How is transport arranged?

Is there a transport scheme in this village?

Is it difficult to find people to bring/accompany a delivering women to hospital?

10. Are there any problems for families to find enough money?

Is there a medical Emergency Fund in the village?

How many other moneylenders are there in the village?

Has this changed in the last two years?

11. Do people ask more often for reduction in medical charges?

Is there any fund available at the (sub) health post for such poor cases?

Has the dissolution of the VDC committees influenced the running of the health post?

Financial situation/migration

12. Has the economic situation in the village changed during the last two years?

Can the poor households find enough wage labour to support their families?

Are there any families who do not have a wage earner?

13. Have many people from this village migrated for labour elsewhere?

How many? More people than last year? How many more?

How long will they stay away?

Do they send money during their absence?

Have whole families been migrating from your village?

For what reasons? What kind of families?

14. Does the migration and absence of a lot of people (men) cause you any problems when arranging for transport?

15. Has the migration changed anything in the household management of families?

Who makes the main decisions if there are no adult men in the household?

How are difficult decisions like going to hospital for a complicated delivery taken?

For FCHV only (for other health staff / villagers continue with mobility)

16. How do you feel about organising the mothers group?

What kinds of issues have you been discussing recently?

17. Have you been discussing pregnancy and delivery in the last three months?

Do you have enough information and material to share?

Do you get any advice for the mothers group from the health workers at the (sub) health post?

How long has it been you have met any of the health workers?

How often do you meet people from the [partner organisation]?

18. Have you heard about the radio programme “Aama”?

Do you ever listen to it?

Can you use that information for the mothers group meetings?

Are there any NFE classes in this village?

19. Do you know whether they learn anything about pregnancy and delivery at NFE classes?

Mobility

How do you like walking through the village?

How do you like walking from this village to the next village?

How far is the (sub) health-post from the nearest villages?

Where do you live/stay? Is that far away from the health post?

Can people come to fetch you at home in case of an emergency? Do they?

Security

20. How is the current situation in your village? (two weeks ago and now)

21. Does this security situation in any way influence the way you are working in this VDC?

Is there a curfew in your village?

Could you move inside your village (to the neighbours) during curfew hours?

Could you travel to the health post during curfew hours?

Was it curfew time when you decided to come to the hospital?

22. Does the security situation influence the safety of a trip to the hospital in town?

23. Are there any checkpoints (from either side) on the way from your village to the hospital?

Do you have problems to pass the checkpoints when walking?

Does it take extra time to pass a checkpoints? If so, how much time?

How do you feel about being checked at the checkpoints?

Would you be able to negotiate permission for travel with SF?

Were you afraid to encounter strangers on the way?

How do you feel about me visiting your village, as you do not know me?

Do the political parties ever organise meetings at your village?

Did they ever talk about women's health and other women's issues?

How do you feel they look upon the role of women?

24. Have you ever been approached or threatened by the political parties?

25. Have you ever had problems with the security forces?

QUESTIONNAIRE FOR DISTRICT PARTNER STAFF

We are doing research on the conflict's impact on the accessibility of EOC health facilities by the communities, as well as the impact on NSMP's programme of health care for deliveries. Would you mind talking to us for half an hour? Our conversation will be purely confidential.

Yet to be done:

Questionnaire for District Health Staff

Forgotten?

How does absence of the men of the household affect the decision process at the time of delivery?

ANNEX E: LIST OF INTERVIEWERS

DISTRICT	NAME	POSITION	REMARKS
KAILALI	Mr. Jeevan Basnyt Ms. Samikshya Ojha Ms. Rajani Chaudhary Ms. Urmila Oli Ms. Rambali Mahato Ms. Rameshwori Chaudhary Ms. Pramila Ghimere Ms. Saubhagya Shahi	Coordinator Interviewer Interviewer Interviewer Interviewer Interviewer Interviewer Partner Staff WDO	Ex-CCS staff Only partially involved
	Ms. Tara Chaudhary Ms. Prema Chaudhary	SDF/NSMP SDF/NSMP	Only partially involved Only partially involved
SURKHET	Mr. Suresh Tiwari Ms. Parbati Thani Ms. Parbati Sharma Ms. Nirmala Regmi Ms. Laxmi Chaudhary Ms. Shobha Tiwari Ms. Manrupa Kharel Ms. Sarala Regmi	Coordinator Interviewer Interviewer Interviewer Interviewer Interviewer Interviewer Interviewer	SAC staff Only partially involved
	Ms. Madhu Acharaya Ms. Menuka Dhakal	SDF/NSMP SDF/NSMP	Only partially involved
BAGLUNG	Mr. Chandra Mani Sharma Ms. Sarada Sharma Ms. Ranju Sharma Ms. Purna Kala Thapa Magar Ms. Ruma Malla Ms. Kun Tisa Puta Ms. Indra Ajali Ms. Chandra Achal Ms. Mana Keshi	Coordinator Interviewer Interviewer Interviewer Interviewer Interviewer Interviewer Interviewer Interviewer	BYC staff Only partially involved
	Ms. Sangeeta Shrish	SDF/NSMP	
MYAGDI	Ms. Durga Karki Ms. Dewa Pun Ms. Ghambhira Acharaya Ms. Juna Garbuja Ms. Rubina Pun Ms. Tej Kumari Sharma Ms. Gyanu Baniya Ms. Khar Maya Garbuja Ms. Amrita	Coordinator Interviewer Interviewer Interviewer Interviewer Interviewer Interviewer Interviewer Interviewer	MILAN staff
	Ms. Tham Kumari	SDF/NSMP	

ANNEX F: BAGLUNG DISTRICT ANALYSIS

Analysis Baglung

In Baglung district the four VDCs covered by the conflict impact study were Resha, Kusmi Sera, Bihun, and Harichaur. The impact of the conflict on accessibility of health facilities in the district is analysed on the basis of the qualitative information received from respondents interviewed in these four VDCs. The situation is described for three different stages of the conflict - pre-emergency, before ceasefire, and current. For each topic general remarks are followed by discussion of conflict-related issues, starting from least affected situations and culminating in impacts found in the worst affected areas.

General Impression

The fieldwork took place after the ceasefire, and the situation in all four VDCs was much more relaxed than before. Considering the circumstances, it was decided to include Harichaur, a VDC six hours (three hours by car and three hours by foot) from Baglung bazaar, and to stay the night in the village. We felt that information from such a remote area would give a better impression of the total conflict impacts in the district overall, complementing information from the nearby VDCs.

The research team had no confrontations with Maoists and could move freely in all selected VDCs. The security forces were still strict - not allowing any vehicular movement before 7 am or after 6:30 pm - which put the main limitations on the fieldwork. When passing checkpoints, the team was questioned extensively about the purpose of their travel.

Most tension was felt in Harichaur, where a strict night time curfew was still imposed in the whole valley. Most businesses in the village were still closed due to the conflict. Several respondents suspected the interviewers might be Maoists.

The conflict's impact on general village security and the accessibility of health facilities was lowest in Bihun, followed by Kusmi Sera, Resha, and Harichaur, which was most affected due to its remoteness.

Security

Before emergency

- Two years ago Maoist activity was much more open:
 - asking donations and food;
 - harassment of political leaders and the better-off.
- The banks in Harichaur (looted) and Kusmi-Sera (fear) had already been closed two years ago.

Security features during the conflict

- After emergency the situation for the better-off in the villages improved slightly, as due to regular army patrolling, Maoists could operate less overtly.
- Situations for the poor got much worse, as they were more confronted with the restrictions imposed by the security forces.

- People were getting squeezed between the security forces and the Maoists, who were both pressuring them, though this was less so in Bihun;
- Security forces fiercely interrogated anyone who aroused their least suspicion - even people going to water their fields at evening got beaten up;
- Security forces in civilian clothing would instigate conversations that supported the Maoists and then beat people up;
- In Resha, Kusmi-Sera, and Bihun, there was and is no official curfew, but people are afraid to walk outside at night as they might encounter either security forces or Maoists;
- In Harichaur a 6 pm to 6 am curfew was imposed, with no permission to use lights or torches. People were not even able to go outside to the toilet;
- The ceasefire has hardly caused any relaxation of these conditions, especially around the Harichaur army camp (Ward 8 & 9). Curfew still lasts from 7 pm to 4 am, and if lights are used at night, the next morning the security forces will come to interrogate the occupants;
- The most important element causing problems is a widespread, intense fear based on commonly-known incidents of killing and kidnapping by either security forces or Maoists. Such events have happened in nearly all VDCs.

Resha: 2 people kidnapped by Maoists.

Kusmi-Sera: 5 people kidnapped.

Harichaur: 1 person killed by the Maoists,
1 killed by security forces.

Bihun: 2 people manhandled by Maoists,
1 person killed by security forces.

In all VDCs some government buildings were destroyed.

Effect on health workers

- In all VDCs it had become very difficult to call health workers to attend any emergencies at night.
- This is reinforced by the health workers, who have informed clients that they could not be called at nighttime. (Resha: after 6 pm, Bihun: from 11 pm until 5 am.)
- Taking or carrying the ill to the health facility for treatment at night was further complicated in areas where people were not allowed torches on the trails.
- In Resha, Kusmi-Sera, and Bihun the situation has relaxed after ceasefire - although people still lock themselves in early, now they will go to call health workers in case of emergency. Not so in Harichaur.

Negotiation of night travel with security forces

- Most people think that they will not be able to negotiate permission to travel at night in case of an emergency.
- Those who think they can negotiate such permission are the educated, better-off, and connected (aphne maanche) people.
- One of the main problems in negotiating with the security forces is the lack of communication, as in most villages the telephones are not functional. But the same situation applies in the bazaar area of Baglung, where only the better-off people have telephones at home, and people prefer not to come outside to ask neighbours or others.
- However, cases that do inform the security forces are generally helped to reach hospital facilities.

Social support

- Many people said they would not answer calls on their doors at night, out of fear of who it might be. It is therefore more difficult to contact help.
- Apart from problems in mobility at night, it has become more difficult to find people willing to help and carry in case of an emergency at night (fear) and even at daytime (Harichaur: hassle with checkpoints).

During the interviews some actual examples of delays caused by the curfew were found:

- A small number of cases from various VDCs decided to wait till dawn before calling trained health workers, as they hoped the problem (long labour or retained placenta) would solve itself and did not want to go at night. This is an issue of general attitude reinforced by the current conflict situation.
- An uncomplicated referral case from Harichaur was advised to go to Baglung only next morning, as she would have had trouble travelling during curfew hours. This had no further consequences.
- In Harichaur a party carrying a woman with infection after delivery was stopped by security forces and had to stay the night in a lower-caste house. The woman died the next day while being carried to hospital.
- In Resha a bleeding case needed to be carried to hospital in Baglung during curfew hours. It was very difficult to find men for the carrying, as the Maoists controlled the route and people didn't like to encounter them. Before Baglung the rather big group of 15 persons divided to go to a telephone via a back road and inform the security forces. The army first advised them to come the next morning and had to be convinced that this was a case of life and death. At the checkpoint everybody was interrogated about name and origin, which caused further delay. The total delay was estimated as at least one hour.
- A person from Banepa (Baglung municipality, 1 hour walk) needed a hospital delivery and labour pains started just before curfew hours. They informed the army by phone and got an army car to pick her up and bring her to hospital. The army's intervention probably shortened the time elapsed before the hospital was reached.

Migration

Normal migration

- Some areas have a long tradition of labour migration, either seasonal (Resha) or long term to foreign countries (Harichaur, Resha), mainly by men to supplement household incomes;
- Labour migration was far less common in Kusmi and Bihun.

Conflict-related migration

- There has been a slight increase in labour migration due to the conflict, as a component of fear has been added to the economic pressure previously experienced (mainly in Harichaur, somewhat in Resha and Kusmi, and hardly at all in Bihun);
- A number of politically involved people have left their villages for the safety of larger towns and cities;
- Teachers from closed boarding schools have left the VDCs, reducing the numbers of community leaders and educated people in the area;
- The conflict has caused richer families to leave for Terai or Kathmandu, as they were more targeted for donations and could also afford to migrate, especially in Harichaur;

- The wish to educate their children at better quality private boarding schools has contributed to this dislocation, as all boarding schools in the Harichaur area were forced to close;
- The poor are in no financial position to migrate and tend to stay behind in the villages.

Impact of migration

- Migration due to conflict has increased the transportation and financial barriers in Harichaur.

Porters for the ill

- Households have more problems in finding even relatives to carry the ill, as there are fewer men available;
- A group of two to five now people asks up to 10.000 NRs to carry a sick person to Baglung (2000 – 5000 NRs per person per day!), whereas the previous rate had been about 600-700 NRs per porter.

Loans

- As the richer people have left the villages, poor people have more trouble obtaining loans from them;
 - There is less cash available due to migration (fewer people to give employment), so it is more difficult even to borrow enough money from relatives.
- This situation does not exist in the other visited VDCs of Baglung.

Economic Barriers

General setting

- In a few cases the registration costs for ANC were an obstacle to going for check-up, as at Resha;
- Women do come for ANC, but not for delivery, as that costs 200 NRs (Harichaur FGD);
- The poor and Dalits have problems in calling health workers for home visits, as they ask a lot of money.

Reduced income and cash available

- Day labourers find less employment due to a slowdown in the economy;
- Health workers charge higher fees for home visits due to the conflict situation: up to 7000 NRs (Harichaur, Kusmi-Sera);
- Costs of living increase as foods and other necessities get more expensive in the villages (up to double), as transport is reduced, and as village people are afraid to undertake the travel to town (Harichaur, Kusmi-Sera);
- Selling of agricultural produce is problematic due to lack of markets in the village and different prohibitions. In Resha millet was previously sold to make rakshi, and in Harichaur there is less business generally;
- Many businesses have closed their shops (Harichaur);
- Sales of land are not permitted by Maoists (Harichaur).

Reduced loan opportunities

- The well-off (those with income from abroad) have hardly problems in borrowing money, as people trust them to repay loans;
- Well-off people going to Baglung no longer bring cash from home and instead take loans from relatives in town or businessmen in the bazaar;
- Moneylenders are reluctant to give loans to the poor, as they are not sure they can repay due to reduced employment opportunities (all VDCs except Bihun);
- Businessmen and well-off people keep less cash at home to provide loans;
- There is a general sense of mistrust that creates an unwillingness to provide loans;
- Businessmen and well-off people don't want to give loans, as Maoists have said that the poor don't have to pay interest (all VDCs);
- Businessmen and well-off people don't give loans, as they are afraid that Maoists will burn the loan agreement papers (Resha, Harichaur);
- Banks have closed and cannot provide loans using jewellery as security (Harichaur, Kusmi Sera).

Impact on project interventions: Emergency funds

- Emergency Funds in Bihun were started recently, and pay for the means of transport at once. Groups feel secure enough to start money collection;
- Emergency Funds in Resha were only started two months ago, mainly to raise money for transport schemes. Problems with establishing these funds are more related to unclear objectives and group regulations than to conflict issues;
- Only five funds have been started in Kusmi-Sera, mostly recently. No problems were encountered in fund mobilisation;
- Some emergency funds have been affected by the conflict (Harichaur);
 - In 2 wards the money was looted by Maoists;
 - In 1 ward the Amaa Samuha resisted looting but has now divided the money and hidden the register. They cannot mobilise the fund, as they are afraid the Maoists will ask them for clarification.

Transport Barriers

General transport setting

- During emergency, checkpoints at Baglung opened at 7 am, and no cars were allowed to stay the night over at Godabane (the road head on the way to Harichaur), so the first jeep would arrive at around 9 am. The last jeep had to leave at 2 pm as the checkpoint closed at 4 pm. This reduced the availability of vehicles from Harichaur and Bihun considerably;
- After truce the situation has eased, and cars are allowed to stay the night. The first car now leaves around 5 or 6 am, as the checkpoint at Baglung still opens at 7. At evening it stays open until 6:30 pm, so now the last cars leave around 4:30;
- Although Bihun is on the road to Godabane, it has always had (and still has) the problem that cars arrive fully packed, so jeeps hardly stop to pick up passengers. To get a car, people may have to walk to the starting point to reserve a jeep, which takes about one to two hours;
- The road to Dobila bazaar, road head for Resha VDC, is essentially the same as to Godabane and has to deal with the same checkpoint in Baglung. It is only one hour from

Baglung bazaar. Car availability has always been confined to early morning and late afternoon. However, hours have changed and availability has decreased slightly.

Specific conflict impacts on transportation

- Delays at check posts depend on the number of people in the car and the number of cars lined up at the checkpoint at the time of arrival. Delays are at least 15 minutes and can last up to 2 hours or more;
- During emergency, people were not allowed to leave the cars queued at the check post, making it more difficult to bring forward labouring or ill women who needed immediate hospital attendance;
- Fewer vehicle services per day were available due to restrictions against staying the night at the road heads;
- No vehicles were available from the road heads for emergency night trips.

Impacts on project interventions: transport schemes

- During emergency the security forces banned the sales of doko and rope (to make ghundri) in Baglung bazaar. It was also prohibited to make dokos in the villages;
- Prepared dokos of the transport schemes in two wards of Banepa were burned by suspicious security forces, who thought they might be used by Maoists to transport their wounded or dead (Baglung municipality);
- Other transport schemes have not been affected. Many schemes only started recently;
- The incident in Banepa caused NSMP to reconsider providing stretchers to the Safer Motherhood groups.

Health Services

General setting

- Health workers tend to look at the economic situation of the family when providing emergency home visits and to attend more to “aphne maanche”;
- A common attitude is that people should be brought to the HP for treatment (Harichaur).

Impact on service availability

- Health services have hardly suffered under the conflict;
- In general HP staffing does not seem to be directly affected by conflict. None of the interviewed staff mentioned harassment or other problems;
- Staff not attending their postings are absent for other personal reasons;
- The AHW of Bihun is not attending the office, probably not related to the conflict, but because he runs a medical shop in Pokhara and there are already several private medicals in Bihun. He may use the conflict as an excuse, though;
- The position of doctor is vacant at Harichaur PHC. The doctor is working in Beni, which is not as remote and has better services. The conflict situation may have reinforced his reluctance to move. However, the new AHW has come to Harichaur only six months ago and does not experience any problems;

- The position of doctor is vacant at Kusmi-Sera PHC. This is partly conflict related, because the doctor was a victim of extortion by one of his patients who threatened to report him to the Maoists;
- The mobility of the health workers has been decreased, especially regarding more distant wards.

Medicinal supplies

- Supplies of medicine are generally lacking, but that was also the case before conflict. This is often blamed on the HW, who have their own private medical shops;
- Supplies of medicine to health posts were still received from Baglung DPHO during emergency, and continue to be, though there has been a budget cut;
- HW seem to use the conflict situation to excuse the reduced supplies of medicine at the HP;
- Private medical shops have problems acquiring medicines, as the security forces suspect them of treating Maoists;
- In Bihun private clinics have misused the name of the HP to get medicines, which caused delays in supplying medicine to the HP. A peon had to go to the Baglung check post to certify that these were HP medicines.

Impact of VDC dissolution

- HP support committees are functioning less adequately without VDC members;
- VDC members would normally help with the control of medical supplies. As the AHW is not there and the VDC is dissolved, the medicines rest unopened at the HP (Bihun);
- As VDC members are no longer present at the HP committee, there can be less pressure to get a current vacancy filled and other PHC projects completed (Harichaur).

Decision-making

- Not much difference in decision-making was found, though the process of making arrangements has become more problematic and longer, due to conflict;
- The decisions for treating women in labour are generally made by the mother-in-law and other elder women in the household - often after consulting neighbours, relatives, and TBAs - as they are present to observe any complications;
- We did not encounter any household in our study that mentioned traditional healers as a viable source of advice and support for treatment;
- In cases of patients referred to hospital, generally the village health workers like MCHW, FCHV, or AHW are asked for their advice and support before the decision is made;
- After being informed, the senior male household members (father-in-law, husband) decide if they can and will arrange for transport and money. They are the gatekeepers with access and control.

Knowledge of Danger Signs

- There was no obvious impact of the conflict on the ability to transfer Safer Motherhood messages to the communities, as most groups were still functional;

- The overall impression is that the retention of knowledge of danger signs is low, for all types of respondents except the FCHVs;
- Most people who can mention some signs have limited ability to separate symptoms according to pregnancy, delivery, and post-partum;
- Dalit and the poor seem to have less knowledge;
- Pregnant and delivered women had hardly any knowledge;
- Some mothers-in-law do know some signs, mostly from radio, FCHVs, or health workers;
- Male household members seemed to have little knowledge of danger signs. Any knowledge they have comes mainly from radio and some FCHVs;
- The FGDs reflected difficulties in the transfer of knowledge. While most FCHVs had quite a good knowledge of danger signs, their mothers group members had much less knowledge.

FCHV Functioning

FCHV supervision and guidance

- FCHVs are still receiving refresher meetings by AHW and MCHW staff every six months. These meetings have not been affected by the conflict;
- Further support for FCHVs from health workers is limited. In Harichaur some FCHVs complained that they had to learn about national vaccination campaigns from the radio because no personal message was received from the HP;
- Partners have provided Safer Motherhood trainings to FCHVs, except for Kusmi Sera, where training was given to the LDFB group chairpersons;
- Partners do not provide further support to FCHVs;
- AMK is providing training on Safer Motherhood to FCHVs in Kusmi-Sera and Bihun;
- AMK is also providing information materials (posters and key rings) to FCHVs.

Radio

- Most of the FCHVs in Baglung are listening to the radio programme “Amaa”.
- They use this to strengthen their own knowledge.
- They do tell others also to listen to the programme.
- It is still too early to tell if they will use it as material for the Amaa Samuha meetings.

Mobility

- Mobility of FCHVs in their communities at daytime has not been affected much;
- Fear reduces mobility of FCHVs at night significantly, particularly around army and police camps;
- In case of emergency in remoter areas that have no (official) curfew, FCHVs will walk within their own cluster of neighbours (3 VDCs);
- In Harichaur even going to the toilet at night was a problem, so FCHVs would not even attend their neighbours at night.

Functioning of mothers groups

- There were no problems with organising Amaa Samuha meetings in most places, though meeting times had to be arranged outside of curfew/night hours;
- In Harichaur, as the group fund was looted, one FCHV stopped leading the Amaa Samuha. The group could not manage themselves and is discontinued;
- Unclear policies of partners seem to cause some problems in group management in Resha, as it is uncertain who are expected to be members of the Emergency Fund committee;
- In other VDCs the Emergency Funds were only started recently. Understanding of emergency funds' purposes seems to be weak and causes problems in the general group management;
- In Kusmi-Sera some LDF groups have separated Emergency Funds from their main funds.

Transport schemes

- Not all FCHVs have started preparing dokos for their group's transport schemes;
- A common problem with the dokos in the hills is that people do not want to reuse them, as they fear contagion;
- In Harichaur there is hardly any practice of using dokos to carry the ill. Some richer wards have arranged for stretchers in their communities.

Pregnant Women and their Families (8 Case Studies)

Antenatal care

- Most pregnant women had gone a few times to get ANC, though some obstructions like lack of money and embarrassment were found;
- Some people go to a private medical shop or to the district hospital, as they give these more trust and do not need to pay the 5 NRs to get registered;
- ANC visits were not affected by conflict;
- Most of our cases went for medical checks when they experienced serious problems during the current pregnancy;
 - One case had bleeding in the 3rd month and went to hospital in Baglung, where they said it was not a problem;
 - One case had swollen hands and feet and regularly went for check-up to Baglung hospital, as she had had two stillbirths before this pregnancy;
 - One case had swollen hands and feet and went to a private medical shop;
 - One case had lower belly pains and went for check-up at the PHC;
 - One case had weakness and dizziness and did not go for check-up.
- No one from the respondents we met had made any preparations for money or transportation in case of an emergency during delivery, though almost all were in their eighth or ninth month of pregnancy;
- In principle people prefer home deliveries. Only when serious problems occur will they go to hospital;
- In case of problems during delivery they will call for help and after referral go to hospital. Money and transport are only arranged at that very moment.**

Home Deliveries (8 Delivered Women and 8 Family Respondents)

- Of the home delivery cases interviewed, 6 were primaries and 10 had previously delivered;
- About half of the cases had received some information on safe pregnancy and delivery, mostly from health workers or family members. Some had heard the information on radio or from training (CYC / AMK);
- Some problems occurred during pregnancy;
 - One case had painful hands and feet and swollen veins. She went for check-up to Baglung, but the sisters said it was not a problem;
 - Two cases had headache and dizziness as well as lower stomach pain, but did not consult any health workers.
- Some problems occurred during delivery;
 - After a baby's head had emerged, one of its shoulders got stuck in the birth channel; A TBA was called to help the delivery manually;
 - After a long labour of 16 hours (14 hours low intensity, 2 hours strongly), the baby was delivered. The placenta was retained for 7 more hours, but nobody was called. This was not due to curfew as the baby was born around 4 pm;
 - One low-caste woman had labour pains for 3 days, but stayed at home till the child was born. The placenta did not come by itself, and a TBA was called who removed it manually. This caused the woman a lot of blood loss, but the TBA said this was normal and should stop within the next day. Fortunately nothing happened;
 - One case did not want to tell her family she was experiencing labour pains, as it was night and she did not want to disturb her family;
 - Three cases (of which one was a woman alone) could not call neighbours or friends for help, because it was night and they feared going out. These are the only cases that were influenced slightly by the conflict.
- None of the problem deliveries had at any moment considered going to hospital;
- Three cases called for attendance by a TBA at the delivery, two of which were at night-time. For this level of support no clear influence of the conflict can be found under the current truce situation;
- It appears that the attitude of relying first and foremost on a TBA prevents women from going to hospital;
- Respondents said that money and transport were not impediments for going to hospital;
- No problems created by increased migration were seen.

Treatment Managers' Experiences (8 Cases)

Treatment managers were interviewed to better understand the problems encountered in arranging transport and money under the current circumstances. During the field work, in the villages of Baglung only two cases that had been brought to hospital recently were found, even though the definition was widened to include cases from the previous three months. One other case went to the PHC. Other cases that called a health worker at home were found and interviewed. This limited number of hospital cases in the recent past could indicate a low rate of use of health facilities for obstetric care. The different barriers to seeking qualified care are illustrated by the cases, presented in numbered order.

- The obstructions experienced by the respondents were mainly related to normal transport and economical barriers;
- Only the cases of Harichaur had additional problems due to conflict in the form of curfew and shortage of cash.

Reasons for seeking (local) health workers' support

1. 2 days of labour; AHW was called.
2. 5 days of labour without telling the mother-in-law; AHW was called.
3. 20 hours of labour (doubt regarding whether to call help, not influenced by conflict); called HA from PHC.
4. After delivery the placenta was retained for 12 hours. The neighbours advised that it was no problem and the HA was only called when urine got obstructed.
5. Mother-in-law thought the child might be in a breech position and sent her daughter-in-law to the PHC, where the child was born normally.
6. An expecting mother felt lower stomach pain and went to PHC for check-up. She was referred to Baglung hospital, as it was her first child. Waited till next morning as they would have had problems travelling during curfew and had to arrange for money.
7. Previous caesarean case, so the family did not want to take any risk and sent the expecting mother to Baglung hospital before labour pains were experienced.
8. 1 day labour; private HW was called.

Transport problems

1. Went walking to call HW - no problem, as it was daytime and HP was near.
2. Went walking to call HW - no problem, as it was daytime.
3. Went walking to call HA - no problem, as it was daytime.
4. Went walking to call HA - no problem, as it was daytime.
5. Expecting mother walked herself to the PHC during daytime (no stretcher in the community). Was carried back on stretcher after delivering.
6. Expecting labouring mother walked all the way to Baglung herself (10½ hours); did not take the jeep from road head, as she was afraid it would be dangerous due to the bad road condition.
7. Expecting mother was taken by reserved jeep to Baglung.
8. Went walking to call a nearby private health worker.

Economic barriers

1. Husband has regular income as a teacher. Though it has been five days, AHW has not yet been paid as he lives nearby and did not ask.
2. Loan was taken to pay. Sons are working abroad and will send money; otherwise some goats will be sold.
3. No arrangements had been made but they had enough money in the house as the husband is a teacher and father-in-law has a service job, so there is regular income. If necessary they can also sell some grain.
4. Poor nuclear family had to ask for loans from neighbours, which was a bit difficult.
5. Laure family did not have enough cash at home and therefore had to ask neighbours for loans. This was no problem, as these know that it will be quickly repaid with money from the bank in Baglung.

6. Loan was taken from neighbours. Son has just left for Malaysia and they will have to sell some grain and goats to repay the loans.
7. Sons are in Indian army and send money regularly. The family could pay from its own resources.
8. Family owns a small shop and gets income from it. They may have to sell some grain and goats as well.

Hospital Delivery Case Studies (3 Cases)

- Reasons to go to hospital: mostly serious problems clearly showing the indicated danger signs;
 - previous uterine prolapse and due to that painful pregnancy, a little bleeding;
 - caesarean after 6 days labour and previous caesarean;
 - labour for 2 days and urinal tract obstruction;
 - considerable bleeding after delivery (not further interviewed).
- Direct family members (mostly mothers-in-law) and neighbours were most likely to help.

Case 1

This Brahmin woman having her first baby came from Kudule Ward 10 of Banepa, Baglung municipality.

- The woman came to Baglung hospital in the morning for normal ANC check-up, but the doctor said he expected nothing to happen for the next two weeks. That same evening labour pains began;
- Immediate decisions were held, as it was already getting late and it would soon be curfew. Though the pregnant woman preferred to stay and deliver at home, her mother and father-in-law convinced her to return to hospital;
- The army was called for permission to travel during curfew. They arranged for a car to pick the family up and bring them to the hospital. Thus transport was no problem;
- Financial resources were no problem for hospital treatment;
- Though in the morning registration for a check-up had been bothersome, admission and treatment at night went very smoothly;
- No delays were incurred, as it was a relatively nearby place and telephone communication with the army was possible.

Conflict impact might actually have been positive, as the army provided transport and the family otherwise probably would have walked to hospital.

Case 2

This Magar woman of 31 years delivering her second child came from Pipale Ward 6, Rakhu VDC in Myagdi.

- The woman experienced labour pains in her home in the village for five days before deciding to go to the health post. One reason for this delay was that her husband was in Saudi Arabia;
- She walked herself to the health post;

- From the health post she was referred to Myagdi hospital by the MCHW;
- As she needed to be carried down from her village to Beni, the family started arranging a chair from a separate (higher caste) settlement. These people were quite reluctant to lend the chair. As it was night by the time they had arranged the chair they decided to wait until morning, as the path leading down the hill to hospital was difficult to attempt at night;
- The doctor in Myagdi referred her to Baglung hospital for caesarean;
- From Myadgi it was difficult to find a jeep. The family did not have enough money for a reserved car and other drivers did not want to take her for four hours;
- The family had problems borrowing money. The husband had previously worked in construction, but could no longer find employment in the village (district) and had therefore left. No message or money had yet been received from him. The 7000 NRs the family brought on their first trip to Baglung was not enough to cover the expenses, and the mother-in-law had returned to the village to search for more;
- The check post caused no delays, as they let the delivery case through with priority;
- There were no problems at admission, even though it was Saturday and they had feared further delays due to absence of staff. They were desperate not to have to go to Pokhara, as that would have further increased their expenses, but everything went very smoothly and caesarean was done within one hour.

This is a showcase of delays caused by general decision, transport, and financial barriers, slightly exacerbated by the conflict due to increased problems borrowing money.

Case 3

This Brahmin woman aged 22 was delivering her second child and came from Dulunge VDC Ward 5.

- The family let the woman stay at home with labour pains for two days. The decision to go to hospital was only made after the woman experienced problems passing her urine, which they felt was a serious complication;
- No advice from any health worker was sought in making this decision;
- This family was relatively well-to-do and had no problems gathering the required money;
- As the road reaches her settlement and jeeps stop there, no problems arranging transport were experienced. The family could afford to reserve a car to go to hospital;
- No problems were encountered at admission.

The only delay was due to decision-making; no conflict-related delays were found in this case.

Partners' Perspective: Baglung

In Baglung district, NSMP is implementing its Increasing Access programme component through a number of partners. These partners were interviewed to assess the impact of conflict on their programmes and their ability to promote care-seeking behaviour and access to essential obstetric care (EOC).

- CYC
- WDO
- DCRDC
- Local Development Fund Board/DCC (LDFB)
- District Health Office

The findings of these interviews are compiled below.

1. Through which community groups (for example, Amaa Samuha) are they promoting safer motherhood with the population?

WDO is implementing two similar programmes of its own through which women's groups are promoting safer motherhood: the Jagriti Income Generation programme and the Women Development programme. The Jagriti programme has a budget for locally based mobilisers, who can therefore better supervise and support their women's groups, while the WD programme has less staff availability. In both programmes women's groups local FCHV are involved, but these also run separate mothers groups for health issues, apart from these women's groups.

LDFB is working through their mix LDF groups that have been mobilised for institutional and economic development. The leaders of these groups have been trained in safer motherhood. In each VDC two groups have been selected for a focused SM approach, promoting emergency funds and transport schemes. Other groups are working on SM as per their interest, and have followed suit as they observed the focus groups. The LDF groups are supposed to have 80% HH population coverage. FCHVs are included in these groups if interested.

DCRDC groups were mobilised according to the interest communities expressed during their first needs assessment meetings with village leaders. They work mostly with mixed groups, because in their experience women's groups have more problems with decision making. Therefore they started putting male advisors with the women's groups. In Resha there was some confusion about the type of group; originally they worked through a village-level community leaders group. Now they have been shifting towards ward-level groups, mobilised either by a female leader or FCHV, because the main committee had problems in giving follow-up and support.

CYC is working through local, existing groups and has safer motherhood integrated into its group work. For four months they have maintained a register book for each group in which they report all group meetings and group savings.

2. Did the partners experience any problems in mobilising community groups and organising group meetings, as a result of the conflict situation?

WDO group meetings are continuing without problems, but are now meeting at daytime as it is difficult to gather at night. WDO could continue working in VDCs that were within a day's travel, but they could not stay overnight, as management - afraid of kidnapping of its staff - did not allow them to. Local staff had no such problems, as they are only low rank.

Formation of Emergency Fund was delayed, but is now working. A delivering woman can borrow for 15 days interest free. However, in Harichaur the committee had to hide and divide the money.

LDF groups do not experience problems in their weekly meetings. The work is coordinated through their VDC network.

DCRDC had good response regarding the main village committee emergency fund and was raised well. Creating ward-level Emergency Funds was more difficult due to mistrust. This is partly because of the conflict, but mainly due to vagueness about the objectives. Many

groups run into problems because they do not have clear activities except for savings, and there are too many different groups in the villages. Inclusion of Dalit is a problem.

CYC groups are doing fine, experiencing no problems with Maoists, as they work transparently. Fundraising and management continue normally, though in some groups there seem to be problems with leadership due to displacement of educated people to Butwal and Kathmandu. As the group registration only began a short time ago, CYC does not know how Emergency Funds have been functioning. Till now repayment does not seem to be problematic. Delivered women get 15 days of interest-free loans, and those who have used it have all been repaying on time. They claim other target groups have continued work actively.

3. Were there delays in implementing group related activities, and to what extent was this caused by the conflict situation in the VDCs?

WDO had to postpone some training in Harichaur due to the killing of a teacher by the Maoists. Also, they had to arrange their activities according to the agricultural seasons' workload. It was planned for Asoj and they went with a big group only in January, making special sleeping arrangements. Other VDCs were not affected in this way. In some cases delays and postponements were due to conflict, either justified or as a pretext.

LDFB started the group leader orientation about 8 months ago (Asoj). No problem in execution.

Reorientation by DCRDC towards ward-level groups took place only in the past 6 months. The groups are now building up Emergency Funds from donations and monthly fees. Part will be separated for Emergency Funds, and the rest can then be used for other activities like loans with interest. DCRDC is not experiencing problems in their health-related programmes. They can be implemented as planned.

CYC experienced some delay in working in the remote VDCs , as they could work less openly and had to figure out when to visit the different places. Previously they had used microphones at meetings, or could send letters to the VDC chair. Now they have to visit each and every cluster. Also training time needs to be shorter, as people want to go home early; people don't move at night. CYC has definitely experienced conflict-related delays, and has only recently revisited most remote areas.

4. Were any field-staff of the partner organisation based in the working VDCs?

WDO has field staff based in each Jagriti programme VDC. Also, during the conflict local staff stayed in the VDCs, but the field office for WD-programme in Harichaur is now unstaffed.

LDFB has one social mobiliser staff in each programme VDC. They still have all staff in the field. The Maoists have not targeted the programme.

DCRDC has no field-based staff, but are paying regular visits to their working areas. Previously one staff member was based in Resha, but she was retired for other reasons.

CYC had local field staff in some VDCs. Staff from remoter VDCs had to be retired.

5. Has the number of field visits for support and monitoring by higher district-level (not field based) partner staff been reduced due to fear created by the conflict?

WDO say they could go for less regular visits in the field, as they have to be communicating about the situation in the villages.

LDFB say they have problems making regular field visits, due to restrictions in mobility.

DCRDC states there has been no reduction in mobility due to the conflict.

CYC admits that field visits have been reduced.

6. Was there a reduction in supervision / monitoring of community-group meetings, and does this affect efficacy in dispersing the Safer Motherhood messages?

Both LDFB and DCRDC claim no reduction in mobility in the communities. Monitoring of behaviour change is done on a regular basis as planned by the programme. Therefore they feel there has not really been an impact on this level.

WDO, though admitting some problems for group gatherings, said the groups were moving forward very confidently, pointing out one particular group. The Harichaur women's group has evolved into a registered organisation. They have a new way of arranging credit through the Baglung bank, while previously they were using Harichaur bank, which was looted and closed.

7. Did the partners experience any problems while implementing activities, like dissemination of information and messages on safer motherhood to the communities, as planned? Did they adapt planning to the conflict situation by changing, reducing, rescheduling, or eliminating activities?

WDO says that they are still doing all activities, but a bit slower.

LDFB has made no changes whatsoever. Funds, credits, and interest are running smoothly.

No changes in planning for DCRDC.

CYC needed to reschedule some activities, but are continuing and implementing well. They are more active in nearby VDCs these days, and had to stop working in the remote VDCs for a while.

8. Were changed or alternative activities thought to be as effective as previously planned activities?

None of the partners seemed to have seriously reflected upon the effectiveness and impact of their Safer Motherhood activities in the communities. There was limited discussion of the effect of the conflict-related changes in leadership on creating VDC-wide community organisation-based support for safer motherhood issues and obstetric health care awareness.

9. Are communities open and interested in the Safer Motherhood programme, or do they express any other priorities?

Safer motherhood was a very new issue in the LDF groups, but everybody is very interested, as it is a new angle after seven years of institutional and economic development issues.

Till now Emergency Funds have not been used for delivery cases, only for other ill people. At first LDFB said they should use the funds only for emergency cases, but the money became immobile and now groups are advised to use funds for other matters as well.

For DCRDC there may be still some confusion, but many groups did prepare emergency dokos and are now waiting for stretchers. The groups seem to take enough interest still.

CYC suspects that people are less able to focus their attention due to tension, and that a lot of the information provided to them is lost as a result. People show less initiative, and there is less follow-up activity.

10. Other community problems that reduce access to health facilities

People are not as supportive anymore. If someone would call for help (ghuar), previously everybody would come; now they all close their doors.

One fatal delivery case in Sigana (Asar '59) might be conflict related. The child was in breech and they did not go to the health post. The saasu tried to take the child with her hand, but the child died. It was at night time, so perhaps they did not want to go because of curfew, or other people did not want to help, but th DFB staff are not sure.

Some AHWs are afraid to stay at the HP because they will be called by Maoists to provide treatment and later be hassled by security forces for giving it.

Telephones are not functioning in most VDCs, where they had been previously.

In some areas people are afraid to walk even during the day.

The knowledgeable people, who were most targeted, have left the remoter VDCs for Baglung and Butwal. This causes less access to health care, due to less leadership.

Prices have gone up tremendously, even in Baglung bazaar., so life has become more expensive for the poor. This eventually will also influence the accessibility and utilisation of health facilities.

ANNEX G: KAILALI DISTRICT ANALYSIS

Analysis Kailali

In Kailali district the four VDCs covered by the conflict impact study were Hasuliya, Malakheti, Masuriya, and Sahajpur. The impact of the conflict on accessibility of health facilities in the district is analysed on the basis of the qualitative information received from respondents interviewed in these four VDCs. The situation is described for three different stages of the conflict - pre-emergency, before ceasefire, and current. For each topic general remarks are followed by discussion of conflict-related issues, starting from least affected situations and culminating in impacts found in the worst affected areas.

General Impression

The effect of the conflict on general village security and accessibility of health facilities could be summarised as follows: Malakheti was least affected, Masuriya and Sahajpur were significantly affected, and Hasuliya was most affected, being dominated by Maoist control. Currently, the situation in the visited VDCs is relaxed after ceasefire, except for Hasuliya.

In the aftermath of the threats during the conflict people are not very willing to talk about the conflict or any problems with security forces or Maoists. There is a great deal of fear among the people due to commonly known killings both by security forces and Maoists and kidnapping by Maoists.

In Sahajpur, when the interviewers went to one respondent's house, the lady did not respond at first, as she suspected they were Maoists. It took quite some time to find her in a corner of the house and - with the help of a local FCHV - to convince her to grant an interview. This respondent did not talk openly until the very end of the interview.

Hasuliya is severely affected by Maoists, and the local partner felt it would be necessary to ask permission to visit the VDC. The researchers decided it was worth trying, in order to get a better perspective on the situation in heavily affected areas. With the help of the local study coordinator, permission to undertake interviews in the village was obtained from the local Maoist leaders, on the condition that this was being done purely for research purposes and not for any (I)NGO project. It clearly indicates the severity of the situation in Hasuliya. During the visit the research team had a clear sense of tension in the area, specifically in the main market area of the village. The interviews were taken in quiet places like inside respondents' houses.

Security

Before emergency

- Two years ago there was no curfew;
- Ordinary people were free to move without fear anywhere within or outside their villages;
- Maoists at that time had targeted only police and political leaders.

Security features during conflict

- Several cases of kidnapping, killing, manhandling, beating, and fierce interrogation are rumoured in all four VDCs. Some examples cited by the interview respondents follow.

Masuriya:

- People have been killed by both sides;
- The whole village was threatened because the army got inside their houses and took the young boys with them.

Sahajpur:

- Households are threatened to send one family member for the Maoist cause.

Hasuliya:

- The army killed one young man working in a field, when his Maoist friend who was working with him fled from the patrol;
- Maoists kidnapped several political leaders;
- Maoists assassinated one former Member of Parliament who was from Hasuliya.

Malakheti:

- No incidents were related.
- After the state of emergency was declared, curfew was imposed on the highway, in many main bazaars, and in Dhangadi.
- Even when no curfew is imposed people are afraid to walk at night.
- People are afraid to talk to strangers, because they might be security personnel or Maoists.
- Women were hesitant to visit their parents' home (Maiti) because they were afraid of travel and didn't want to walk that far.
- People are squeezed between security forces and Maoists.
- People are more afraid of security forces than of Maoists.
- Maoists mostly talk very nicely and do not harass people; nevertheless people are afraid of potential punishments if they do not obey them.
- Army personnel beat people when they come searching their homes.
- People who are suspected of feeding, lodging, or making donations to Maoists are heavily interrogated and often subsequently arrested.
- Maoists force people to provide donations and food, threaten kidnapping of young people to join the militia, and ask for food and donations. If they refuse people are subject to severe punishment. Maoists are imposing three stages of punishments: monetary fine, people's action (jana karbai), and killing (safaya).
- People are afraid to work alone in the fields or in the forest; they try to go in groups of two or three, but not more, because group gatherings are also suspicious.
- People were not allowed to move in small groups, also not at daytime, in Masuriya and Hasuliya.
- Torchlights were not allowed while walking at night in Masuriya and Hasuliya.
- Maoists have been imposing clear restrictions on NGO, INGO, and project workers implementing their programmes. This has been most explicit in their core areas like Hasuliya.

- In Hasuliya, Maoists did not allow people to walk in between the villages (a kind of curfew also at daytime) over the trails; they could move in bullock cart only.
- In Hasuliya, people used to shut the shops and hide inside their houses if they heard that the army had reached Phulbari (the next nearby village).

Effect on health workers

- People feel it is more difficult to call health workers during the night, because of the situation. They do not like to go themselves, and health workers are also reluctant to move at night.
- Health workers often claim that they are attending home visits at night, though the village people do not confirmed this (Malakheti, Masuriya, and Sahajpur).
- In Hasuliya health workers clearly say they do not attend home visits at night.

Destruction of infrastructure

- Telephone line in Malakheti is functioning.
- Security forces have disconnected telephone lines in Hasuliya and Masuriya to stop Maoists' communication, and Maoists destroyed the tower in Sahajpur.
- The cutting of telephone lines has caused further obstruction in bringing pregnant women to hospital and accessing medical services in Dhangadi.
- Before the ceasefire, the VDC office buildings of all four VDCs were destroyed.

Attitude of security forces

- Behaviour of security forces towards pregnant and labouring women in public transport varies significantly between persons.
- Security forces generally allow bringing pregnant women to hospital for delivery when informed beforehand.
- After reaching the first checkpoint, the security forces will inform other checkpoints on the route that a patient is coming and needs to pass undisturbed.
- There are some examples of army help in bringing ill people to hospital during curfew, even providing transport.
- The Nepal Red Cross Society has advocated with the security forces to allow their ambulances to bring sick people in general and delivering/pregnant women in particular to hospital during curfew at night
- Many VDCs where telephone lines have been disconnected do not have communication systems to seek permission from security personnel.

After ceasefire

- The duration of night curfew has been reduced, or completely cancelled. But many people are confused now about the exact hours and therefore still do not have the confidence and courage to walk outside after dark.
- People from Hasuliya still have to undergo fierce interrogation and thorough checks by the security forces, because all people from their village are considered suspicious.
- Movement of Maoists in the villages has been increasing recently.
- Maoists are still recruiting students to join their militia at Hasuliya.

Migration

Normal labour migration

- A tradition of long-term economic migration to India exists in all four VDCs, but is most prominent in Sahajpur and Malakheti. Mostly the male family members migrate and visit the family every one or two years.
- Sometimes only one elderly man stays at home for the ploughing and the others go abroad to earn money.

Conflict-related migration

- Economic migration has increased during the emergency period.
- Many Tharu men, who did not used to migrate, are now working in India, sometimes even bringing their wives and families.
- Political leaders and exploiters are displaced from their villages due to fear of extortion, kidnapping, and punishment by both security forces and Maoists (Hasuliya, Masuriya, and Sahajpur).
- Shop owners and relatively better-off people have moved to Dhangadi for the comparative safety and protection of the town.
- In the last half-year many poor young men have moved to Dhangadi to work as fruit sellers and cycle rickshaws, because of lack of local employment and fear of Maoists.
- Women (particularly from Malakheti) are now joining their husbands in migrating.
- Almost all young men still living in Hasuliya VDC appear to be Maoists. A considerable number of students left the village due to fear being kidnapped by the Maoists.

Impact of migration

- The work burden for women staying behind has increased considerably.
- As many potential moneylenders have left the village, it has become difficult to find loans, especially for poor families (Hasuliya and Masuriya).
- Due to migration, it is difficult to find enough porters to carry ill people to hospital in remote parts of Sahajpur.
- In some groups leading members of the mothers' groups have migrated, leaving the group without leadership. In one case in Malakheti nearly all group members left for India with their families, searching for jobs and security.

Economic Barriers

Employment

- Conflict has reduced employment and income-generating opportunities in the local communities.
- Local boarding schools have closed down, causing teachers to lose their jobs.
- Part-time jobs in local shops and eating establishments have decreased, because employers have closed their shops and often left the villages, due to the conflict.

- Job opportunities for agricultural labourers have been limited, because landowners have left the village from fear of being kidnapped, manhandled, or beaten up both by Maoists and security forces (Sahajpur and Masuriya).
- Maoists do not allow landowners to sell their produce, and so they are less interested in cultivating their land.
- Farmers and land labourers are afraid to work on the land, because of security forces patrolling (Hasuliya).
- Maoists have taken all grains as donation, leaving people with little for themselves (Hasuliya).

Reduction in income and cash money

- Because it is difficult to get wage labour in the village, income is reduced due to the conflict.
- There is little cash available due to unemployment.
- Sales of agricultural products (ginger, vegetables) have been reduced, as people are afraid to go to the market to sell and fewer outside traders are visiting the affected villages (Sahajpur, Hasuliya, Masuriya).
- Migrated people experience more problems sending money home (Sahajpur, Hasuliya).
- In Hasuliya 80% of the local shops have been closed.
- People are only allowed to sell their own harvested produce; traders are not allowed to do business. Therefore it is extremely difficult for local small farmers to sell their products in the market (Hasuliya).

Less loan availability

- Previously it was easier to get loans, but nowadays people do not trust to give loans.
- With many businesses closed, it is more difficult to find moneylenders in the villages.
- The bank in Hasuliya was blasted, so the operation was shifted to the district headquarters. Therefore richer people have more problems accessing their money during an emergency.

Impact on project intervention: Emergency funds

- In all VDCs the mothers groups or other (women's) groups established Emergency Funds. Considerable amounts of money have been deposited by most mothers' groups.
- Many interviewed people were not members of the groups and were often not aware that the emergency fund was also accessible by them, though at a higher interest rate.
- The operation of the Emergency Funds has had serious problems in at least some groups of all four VDCs.
- In the recent past the repayment of loans has decreased drastically (Malakheti and Masuriya).
- Some people quit the group after taking a loan, often using the conflict as an excuse. This makes other group members and other groups more suspicious about the real intentions of the persons promoting the emergency funds (Malakheti, Sahajpur).
- The Maoists threatened to capture the complete fund (both savings and credit fund, including provided matching fund and emergency fund), so the group members at Hasuliya decided to divide the money among themselves and discontinue the fund. It is estimated that in total about 2.5 million rupees have been distributed among the group

members in five VDCs covered by CCS. Many group members felt this was the only way to safeguard the money.

Transport Barriers

General transport setting

- The Terai part of Kailali district has relatively good accessibility by dirt roads, and people can be transported on bullock carts, tractors, and motorcycles. However, the gravel roads are often not in good condition and get worse during monsoon.
- Accessibility in Sahajpur is more restricted due to the hilly geography. People from remoter parts have to walk four hours to reach the asphalt road to Dhangadi.
- From Malakheti main bazaar the travel to the district hospital in Dhangadi is first over a dirt road for half an hour to the main road and then another half hour by pitch road. There are two checkpoints on the route.
- The marketplace of Sahajpur is linked to Dhangadi by asphalt road. The bus ride takes 3½ hours. There are three checkpoints on the route.
- Travel from Masuriya to the hospital takes about 1.5 hours over the east-west highway and down south to Dhangadi. There are four checkpoints on the route.
- The shortest way to the market place of Hasuliya is one hour by dirt road via Fulbari VDC. Maoists have banned the regular hour-long bus service by this route, as well as the longer route via the east-west highway that takes 5 hours. The only road link to Hasuliya was via India—one and half hours by bus, followed by one and half hours of walk or a half hour of cycle ride. On this route people have to cross a river by a ferry that is controlled by the Maoists. After the ceasefire, one bus a day has been allowed on the longer route via the highway, leaving in the morning to Dhangadi and returning in the afternoon.
- Although recently there have been four ambulances stationed in Dhangadi that could provide emergency transportation services to all four VDCs, most people in the VDCs do not know about them, even the health staff in Chaumala PHC. Also, due to lack of telephone facilities people from Hasuliya, Masuriya, and Sahajpur cannot call the ambulance for emergency services.
- A local factory provides its vehicle for emergency delivery and other cases in Malakheti.

Specific impacts of the conflict on transport provisions

- Before ceasefire security forces did not allow vehicles to ply the highways at night from 6 pm to 5 am, and curfew in the market areas lasted from 7 pm till 5 am.
- Since ceasefire the duration of curfew has been reduced to 7 hours, from 9 pm to 4 am. Checkpoints are closed from 7:30 pm to 4 am.
- Due to the restrictions on night buses, also fewer buses are driving at daytime.
- Public transport services have become irregular on the Sahajpur (Dadeldhura) road.
- The reduced bus service is also caused by lack of passengers due to unwillingness to travel except in unavoidable circumstances.
- People hesitate to carry patients because they are afraid to walk in bigger groups.
- Maoists restricted motor vehicles on all dirt roads in the villages. On some routes trenches were dug in the roads to prevent vehicular movement.
- There have been ambushes on the east-west highway, making people afraid to travel over that road.

Impact on project interventions

- Many mothers groups in Hasuliya, Masuriya, and Malakheti have made provision for local transport schemes like bullock cart (dunlop) and rope-bed (khatiya).
- Bullock carts are the most common form of transportation, particularly in Terai regions. Though people are afraid to walk in groups to carry a person, they feel safe travelling by bullock cart, even at night.
- In Sahajpur, groups were provided with stretchers. The stretchers are provided free of cost to delivering women but nominal rent is charged for other patients. Until now these schemes have not experienced any problems, though the security forces are sometimes suspicious.

Health Services

Impact on service availability

- The conflict has had a limited but noticeable effect on availability of health staff and services in the VDCs studied.
- Even during emergency, most health personnel were in place at the health centres and health posts (Malakheti, Masuriya, Sahajpur).
- Absence or infrequent attendance by health workers is mostly related to personal matters and not conflict. Sometimes conflict is used as an excuse.
- Health staff are often slow to come when called upon, particularly in Sahajpur.
- During strikes (Nepal Bandh) no staff are available at the health post.
- Health staff do not visit the remoter areas of the VDC, even at daytime (Malakheti).
- Health post staff state they will attend nearby houses at night.
- If a pregnant woman gets problems at night the health post staff will not come due to fear, but if the woman is carried to their home they will attend her.
- According to VHW the outreach clinic is still operational in Sahajpur.
- The army has fiercely interrogated VHW in Sahajpur for carrying an autoclave and asked for some kind of government seal on the box in future.
- In Hasuliya, the outreach clinics are no longer functioning, due to the situation.
- Some of the health post staff in Hasuliya have left their positions because of pressure by both sides.

Perception of health facilities

- If the health post is far from home people have less tendency to go for vaccination, ANC, or consultation in case of illness.
- People feel the health post and hospital take a lot of money for registration and treatment. This is one reason not to come for consultation.
- Staff are even more expensive when called at home, so that is a reason not to call them.
- People complain that sometimes MCHW charges too much treating delivering women. According to their economic situation she asks 2,000 to 7,000 NRs (Hasuliya).
- People tend to go to the private medical shop in the bazaar.

Medicine supplies

- Since the community support committee has been formed, there are medicines and health staff at the health post, but people complain they have to pay for the medicines.
- Private medical shops have hassle from security forces in getting medicine supplies.
- Health post in-charge has his own supply of medicines, which he sells (Sahajpur).
- There is a ban on medicine supplies from Nepal, but people can get medicines from India (Hasuliya).
- Three of the previous six medical shops have closed due to problems with donations to the Maoists and restrictions by the army (Hasuliya).

Decision-making

General observations

- Most people think delivery can be done at home, so there is always a delay in deciding to go to hospital. People don't want to go to hospital because of embarrassment (laaj).
- Sometimes the husband would decide to take his wife to hospital, but then the mother-in-law and sisters-in-law convince the couple that delivery can be done at home.
- The mother-in-law and husband make the decisions for taking loans.
- The husband, relatives, and neighbours arrange for transport.
- If people have better knowledge they can take the decision more easily.
- People will ask advice of FCHV and MCHW before making the decision.

Conflict impact

- A number of situations that delay decision-making have been slightly affected by the conflict, but also exist under normal circumstances.
- Decision-making is delayed if there is no man in the house.
- At night decision-making is delayed when people know there is no bus or public transport.
- Due to the bad relationships among villagers, it has become more difficult to find loans, and therefore it is very difficult to take a decision to go to hospital.
- At night decision-making is delayed if police patrols and Maoists are around or if checkpoints must be passed.
- In general, conflict has a limited effect on the decision-making process.

Knowledge of Danger Signs

General observations

- Knowledge is relatively good in Hasuliya and Masuriya, where input by CCS (monthly support) and NSMP (good access during first phase) was better.
- Knowledge is comparatively low in Malakheti, where input by WDO is via their own groups and less focused on safer motherhood.
- FCHVs with knowledge of danger signs often lacked ability to differentiate the danger signs during pregnancy, delivery, and post-partum stages.
- Only about half of the interviewed women were members of local mothers' or women's groups, and of them only a few had basic knowledge of the danger signs.
- Most pregnant and home-delivered women did not receive information about danger signs and other related advice for safer pregnancy and delivery. Only a quarter of the interviewed households had some limited knowledge about danger signs like swollen feet and hands, and excessive bleeding. Those who know have been informed by their FCHV, or learned at the mothers group meetings.
- In a few cases, the mothers-in-law who are members of the mothers' groups have a little knowledge of danger signs.
- Husbands in general do not know about danger signs.
- None of the treatment managers could tell about the danger signs. One mother-in-law said she had heard about it before, but had forgotten now.
- Often the mothers-in-law are members of the mothers groups and not their daughters-in-law, who therefore do not get information on safer motherhood and danger signs.
- Many of the people from low economic conditions and Dalits appear to be excluded from the mothers' groups and often also lack other access to safer motherhood information. Probably, therefore, they have no knowledge of danger signs at all.

Conflict impact on project interventions

Group meetings

- Many groups have stopped meeting, so women indicated that they could no longer discuss these matters in group meetings.
- Respondents in Hasuliya said they used to have regular inputs from the field staff, which no longer occur due to conflict.

Radio

- Some people mentioned they had no radio at home and therefore could not listen to informative radio programmes.
- Most people did not know about the radio programme "Amaa".
- Most FCHVs and mothers group members were not listening the radio programme regularly.
- Two women may listen to the "Amaa" programme, but they could not remember the name.
- In winter the timing of the programme is a bit late; some people already are in bed.

- Due to late timing and evening curfew, listening together and discussing afterwards is not possible.

NFE classes

- None of the delivering women discussed the danger signs in the NFE classes.
- In remoter areas NFE classes are not running because of the conflict.
- At present, in Sahajpur there are no NFE classes, and in earlier NFE classes the safer motherhood component was not incorporated.
- In Hasuliya, it is not possible to convene the NFE classes due to conflict.

FCHV Functioning

FCHV supervision and support

- Partner staff have reduced their regular field visits of due to the conflict situation, thus decreasing general support and supervision.
- Currently, group leaders in Malakheti have more support than those in the other three VDCs, though a FCHV from that VDC mentions they get guidance only during training, not when they meet health or organisation staff at other times.
- CCS was providing regular inputs to FCHVs during monthly VDC meetings for orientation on messages, but had to withdraw its programme from Hasuliya due to severe Maoist threats. The local FCHV said it was hard to continue explaining about safer motherhood, since the partner staff no longer come to meet her, due to conflict.
- Many FCHVs mentioned other subjects discussed in the groups—like diarrhoea, pneumonia, family planning, and malnutrition—more than safer motherhood issues and danger signs.
- The health workers request reports from the FCHVs, even though they themselves do not go into the field anymore (Hasuliya).

Mobility

- FCHVs in Malakheti, Sahajpur, and remote parts of other VDCs say they are able to move within their own villages even at night.
- FCHVs in the market areas of Masuriya and Hasuliya find it very difficult to offer support at night, even after the ceasefire, as they do not dare to go.
- The FCHV in Masuriya is the only person that can call the health workers from the health post at night, because they recognise her voice.
- One FCHV in Hasuliya went to call a nearby private medical doctor in the middle of the night for a serious health emergency case (not delivery), but he kept silent. After that she went to the houses of the health post staff, but they refused to come, due to the cold they said.
- Previously the FCHV would walk freely and confidently through her village, but during the conflict she walked in fear, even during daytime (Sahajpur, Hasuliya).
- FCHVs in Hasuliya had problems in moving about their villages with bags on their shoulders due to harassment by army, as FCHVs do not have any identity card to introduce themselves.

Mothers groups' functioning

- Fewer people are attending the group meetings.
- A substantial number of leading women are leaving the groups, partly due to migration, rendering the groups less dynamic.
- In Masuriya most groups are still meeting, though only once in three months and in some cases only as a formality, as no clear discussions are held. Some people left the groups because they did not want to contribute to the Emergency Fund.
- The effect of mothers groups is moderate, because groups meet irregularly and are no longer actively mobilising people to promote safer motherhood (Sahajpur).
- The wives of security personnel who are members of mothers groups have left the groups due to fear, resulting closure of some groups in Hasuliya, Masuriya, and Sahajpur.
- Internal problems with repayment of loans have disrupted the functioning of some groups in Malakheti and Sahajpur.
- Some groups in Sahajpur were only active during the fundraising period until they gained the 3,000 NRs matching fund. After that they stopped regular meetings.
- Some other groups in Sahajpur did not meet due to the security situation—women's husbands would not allow them to go.
- Quite a number of mothers group members in Hasuliya have joined the Maoists, resulting in dissolution of the groups.
- FCHVs cannot convene regular meetings in Hasuliya because the Maoists do not permit them to, and the people are wary to sit together because of the security forces. Danger signs have to be explained individually, but workers cannot meet everybody, because they are not always at home. Because group meetings are not possible, FCHVs also have to go house to house for vaccination and vitamin A campaigns.

Emergency funds

- The conflict has affected the Emergency Funds and other funds of mothers groups in all VDCs under study.
- One effect of conflict has been reduced repayment of loans. There is a tendency to make conflict an excuse not to repay loans from the Emergency Fund or using the fund for wrong purposes, particularly in Malakheti and Sahajpur. Though the fund is still there, people who have taken loans are playing around with it.
- Group funds, including the Emergency Fund, have been closed and divided, because the Maoists did not allow any saving or credit activities, especially when foreign money was involved (Hasuliya).
- The group fund in Malakheti has been put in the bank to prevent looting, but now people cannot access the money in case of emergency.

Pregnant Women and their Families (8 Cases)

Antenatal care

- Half of the pregnant went regularly for ANC; the rest went only once or twice. Some causes for ignoring ANC were embarrassment, lack of awareness, and no family motivation.
- Many women hide their pregnancy and go for check-up only in the eighth month.

- Women do not share the information they get from the health worker at check-up with their husbands.
- ANC visits in general were not affected by conflict.

Two cases went for advice when they experienced problems during the current pregnancy:

- One case had a minor problem of weakness during pregnancy and was taken to a private clinic.
- One case had common weakness associated with dizziness and lower back pain. She was not taken to the hospital, but consulted a local TBA.

Delivery

- Out of the eight cases interviewed, most women said they would consider going to hospital only when complications occur.
- One pregnant woman said she would like to go to hospital for delivery, but her opinion is not counted in the family.
- In general the mother-in-law, husband, and other male members of the family take the lead in making decisions to take delivering women to hospital, as it incurs expenses and other logistic arrangements.
- In case of problems during delivery the families will call for help and advice first from relatives, neighbours, and TBAs.
- If the local TBA and FCHV cannot solve the problem, MCHWs and other health workers are called according to availability. If necessary the health workers will refer the delivering women to hospital, which may require convincing the family.

Emergency preparations

- Most families, except among the better-off ones, do not arrange the money in advance.
- Only two out of eight families had put some money aside for the expenses of delivery.
- Two other families were confident they could borrow money from the Emergency Fund of the mothers group in the village.
- In the other cases money could be an obstacle but not a complete barrier to taking a delivering woman to hospital. They would borrow or take loans from relatives and other neighbours.
- Transport is only arranged at the very moment it is required for health emergency.

Home Delivery Cases (8 Delivered Women and 5 Family Respondents)

- Out of 13 home delivery cases interviewed, 8 respondents were recently delivered women; the others were either mothers-in-law or husbands.
- The youngest delivering woman was 19, and the oldest 35. The average age of delivering women was 24.6 years.
- Out of the 13 cases 3 women were having their first baby and the rest had had previous pregnancies. One case delivered her ninth child.

Antenatal care

- Only a quarter of the interviewed cases went to ANC check-up, either at the PHC or the HP. One case was checked by the FCHV.
- One case said that she wanted to go for ANC but her husband never took her.

The following problems were experienced during pregnancy among the cases:

- One woman had fever and fainting during 4th month of pregnancy. She went to Dhangadi hospital and got medicines and an injection, but they didn't explain anything.
- Dizziness and bleeding, pain in the waist. Was not treated due to lack of money.
- One case used to have abdominal pain during pregnancy. The TBA was consulted and she said the baby was fine.

Home deliveries and some of the problems

- Most pregnant women and family members prefer home delivery and do not want to go to hospital. However, in some cases the family had thought beforehand to go to hospital if difficulties should arise.
- Two thirds of the cases had called a TBA to attend the delivery. In one of these cases there was also a Tharu traditional healer (guruwa).
- The other home deliveries were attended by their elder female family members.
- In two cases the husband was also present at the delivery but did not help. One husband did not even wake up during a delivery at night.
- Most deliveries were normal and without problems, experiencing labour pains for half an hour up to ten hours.

Four cases had some problems during delivery:

- The woman who fainted during pregnancy delivered after only 3 hours of labour pains, but fainted again after delivery and her newborn baby lay unattended on the bare ground for half an hour. Her mother, who was with her, would not touch the baby according to tradition.
- One case had slightly prolonged labour of over 12 hours. She was attended by a trained TBA and later a health worker was called. The baby was born normally. The woman said she would have gone to hospital, but not till after two days.
- One case had only one hour of labour pain, but excessive bleeding while delivering. The family could not take her to hospital due to lack of money.
- In one case a local health worker was called after 2 days of labour pain, and the baby was delivered after administering an injection. The delivering woman herself thought she would have liked to go to hospital at that moment, but she did not tell anyone in the family.

Emergency preparations

- Only three cases arranged money for delivery expenses in advance. Two had saved from their family income, and the other took a loan from the mothers group.
- Other cases did not arrange money in advance to cover the expenses.
- Most delivering women know about the community's Emergency Fund, but do not know its current operational situation.

- Only about half of the interviewed women were members of the local mothers group. A few of them had some knowledge of danger signs.
- Six delivering women would have told husbands to arrange transport, while others would have told the neighbours or relatives because their husbands were out of the village to work.
- Transport would have been a barrier to taking a delivering woman to hospital in hilly regions (Sahajpur), because it would have been difficult to carry the patient to the road in a stretcher. It is difficult to find people to carry, particularly during the day when everyone is working in the fields.
- In Terai VDCs, bullock carts, tractors, and even regular busses are more easily available, either at home or in the community.

Conclusion

- Conflict was not the reason for failing to go to hospital in any case. In case of perceived health emergency, it would have been arranged.
- Lack of money was in one case the reason a postpartum woman experiencing troubles was not taken to the hospital.

Treatment Managers' Experiences (6 Cases Studied)

During fieldwork in the villages of Kailali district, only five cases were found that had been brought to hospital recently. Their "treatment managers" were interviewed to understand the problems encountered in arranging transport and money under the current conflict situation. One other case was on her way to a private clinic when the baby was born. All these cases had either obvious reasons to seek a hospital delivery, like a previous stillbirth, or were within reasonable reach of health facilities.

No hospitalised cases were found in Hasuliya, so no treatment managers were interviewed during the fieldwork. This could be related to the increased transport barriers and security problems faced when travelling to hospital from Hasuliya, making people more hesitant to undertake the trip. However, no fatal or nearly fatal cases were found that would indicate such stringent barriers.

The obstructions experienced by the respondents were mainly related to normal transport and economic barriers, but there were also delays related to night curfew.

Reasons for seeking health workers' support:

1. First pregnancy: went to Dhangadi hospital as soon as labour pain started, as decided by the mother-in-law (Masuriya).
2. Because her first baby had died, she wanted to deliver at hospital. Labour pain started at 7 pm and since midnight she wanted to go, but due to conflict there was a lack of transport at night (Sahajpur, Ward 8).
3. Following slight labour pains of four days and then unbearable labour pain since 2 am, the sister-in-law took her to hospital next morning (Malakhethi, Ward 9).
4. After heavy labour pains of 2½ days, the nurse was not found at the health post, so they took her to a private medical hall (Malakheti, Ward 10).

5. After two days of labour in a first pregnancy, the woman was taken to the health post where she was examined and suggested to go to hospital (Sahajpur, Ward 6).
6. After three days of labour pains she went to the health post for a check-up and the MCHW advised her to go to hospital. It was her first pregnancy and she was over time by three weeks (Masuriya).

Transport problems

1. It is $\frac{1}{2}$ an hour to the road ($1\frac{1}{2}$ km); the husband carried his delivering wife. From there we took a bus that dropped us at the hospital after paying 50 NRs extra. The bus trip took $2\frac{1}{2}$ hours. No problems.
2. The mother-in-law started looking for people to help carrying around 3 am. It took about half an hour to carry her over a slippery and steep path to the tarmac road, from where they could catch a bus around 7 am. The bus takes about four hours to reach the hospital. No further problems.
3. They were rather near the road and the bus came immediately after they decided go to hospital, so it went all very rapidly. The bus took $1\frac{1}{2}$ hours due to security check.
4. They went by dunlop from some relative, which took quite a while to arrange (45 min). To reach the private medical shop it took about $2\frac{1}{2}$ hours, but delivery took place before they could reach a doctor. No further problems.
5. The area is very hilly and the steep uphill footpath to Sahajpur bazaar takes about 2 hours. She was carried in a dhoka with help of the neighbours. It was another 4 hours by bus to Dhangadi.
6. The TBA that attended her supported the labouring woman during the 10 minute walk to the road. The husband arranged a microbus to go to Dhangadi.

Economic barriers

1. Arranged money from Emergency Fund loan, where she is a member.
2. Took a loan from 2,000 NRs from the mothers group. That was enough to pay the bills and it will be paid back from the ginger harvest.
3. Money was put aside at home before delivery. We spent 650 NRs on transportation and medicines. Previously there was a mothers group fund, but it was disrupted due to theft by the chairwomen.
4. Waited a little longer before deciding to go to hospital, because they cannot really afford the costs. Could not save money in advance and took 1,200 NRs loan from the neighbour, who accompanied her to the clinic. Will pay back at harvest time.
5. They could not find a loan in the village and took a loan from their relatives in Sahajpur. They had thought treatment at the hospital would cost them 1,200 NRs, but in the end it was 1,500 NRs. If they had not gotten that loan, they would have returned home.
6. The husband had put aside some money. They have a shop, so money was not a problem. They were told it would cost 3,000 NRs, but after all it only cost them 500 NRs.

Security barriers

1. No problems.
2. Previously there would be irregular busses at night, but due to emergency the checkpoint is closed between 6 pm and 7 am, so they could not travel at night.
3. It took $\frac{1}{2}$ hour at the checkpoint, even though we told them that there was a delivering woman to be brought to hospital.
4. Went in the morning, so there was no problem with curfew.

5. Their bus was stopped for half an hour at the checkpoint, but they had no problems when checking, because she was a delivering woman.
6. No problems, as it was during daytime. They were stopped briefly at the checkpoint.

Hospital Delivery Case Studies (8 Cases)

Eight hospital cases were interviewed. In three cases the families of delivered women were interviewed, because the woman herself was too weak. Since emergency many more people have to come to live in Dhangadi for security reasons - increasing the number of deliveries, both normal and complicated, at hospital, particularly from the bazaar area.

The interviewed cases were partly selected on basis of the level of emergency experienced when brought to hospital and the remoteness of their home from hospital. No normal delivery cases from Dhangadi bazaar area were interviewed. Some of the reasons to go to hospital follow.

1. Prolonged labour pain for 3 days and complications in delivery.
 2. Prolonged labour pain and fear, as her sister had died while delivering.
 3. Private "doctor" was called after 5 days of labour pain and referred to hospital.
 4. Prolonged labour pain for 2 days and early rupture of membrane.
 5. Prolonged labour pain.
 6. Prolonged labour pain, constipation, and problems urinating.
 7. Referred by TBA as she was not able to deliver the baby.
 8. Very painful abdomen for a long time and told by the doctor to come for a caesarean next week, when she came to Dhangadi hospital for a check up.
- In most cases senior female family members, neighbours, and local community groups helped with the arrangements of transport and money.

Case 1 came to Kailali hospital from Rugin VDC Ward no 1, a 24 year old woman having her first baby.

- ◆ After three days of prolonged labour pain the local TBA, FCHV, and MCHW referred her to hospital, saying they could not do the delivery themselves.
- ◆ Decision was delayed for two days because the family hoped she could deliver at home.
- ◆ There were no problems calling qualified assistance, because the health post is only 10 minutes from their home. She also had 4 regular ANC check ups and TT vaccine during her pregnancy.
- ◆ They went on a bicycle to the road head, which took 10 minutes, From there they hired a reserved jeep; it is only 1 hour drive from Rugin to the hospital.
- ◆ There was no check post on the way to the hospital and no other security problems. The delivering woman came to the hospital around 4 pm, but she knew that one should seek permission of the security forces to come to the hospital at night or during curfew.
- ◆ The family had put aside some money during pregnancy. The woman's family will cover the cost of treatment from the family income. The couple themselves have no job. The family was aware of the cost of treatment.
- ◆ The delivering woman did not face any problem during admission and treatment at the hospital.

Conflict had no impact on this case.

- The delivering woman's only knowledge about danger signs was that the baby could be in breech, which she heard from neighbouring women. She did listen to the radio, but had never listened to the radio programme "Amaa".
- The current security situation is better compared to two weeks ago. But now the Maoists organize cultural programs and meetings during the day also. They talk about women's rights and unity for struggle, but not about women's health. They come to people's houses and forcefully ask for food and shelter. They even do not consider problems of pregnant and delivering women.

Case 2 came to Kailali hospital from Kalika VDC Ward no 6 (hospital interview). She is a young woman aged 19 having her first baby.

- ◆ The woman herself decided she wanted to go to hospital because her had sister died in labour. Therefore she was not confident about her delivery, even in hospital.
- ◆ The neighbours and the nurses at the hospital where she had gone for ANC check-up also advised her to go to hospital.
- ◆ She had been having minor labour pains for one week and when the labour pains became severe at 6 am, they decided to go to hospital.
- ◆ The husband took her to hospital by motorcycle. It took about half hour to arrange the motorcycle, which they borrowed from a friend. The road was quite muddy, but there is a wooden bridge over the river. The ride to hospital took about one hour. A bus would have taken 2 hours and walking takes 4 - 5 hours. The village did not have any transport scheme.
- ◆ The husband had saved money from his regular salary as a mechanic in a motor garage to cover the cost of treatment. The family had estimated the cost as about 5000 NRs, but in case the expenses could not be covered with the money they had, the husband could take loan for the rest of the money. They were not aware of any Emergency Fund in the village.
- ◆ There is one checkpoint near Dhangadi, but they were not stopped, so no further delays. However they were a bit worried whom they might encounter on the road.
- ◆ The delivering woman did not face any problem during admission and treatment at the hospital.

Conflict had no impact on this case.

- The delivering woman had no knowledge of danger signs. She does not know about a mothers group in her village. She did not listen to the radio. She did not learn about safer motherhood in school (studied till class 8).
- There is a curfew in the village from 7 pm onwards, but you can still go to your neighbours. She did not have any problem going to hospital or medical clinic.

Case 3 is a 22 year old woman having her first baby, who came to Kailali district hospital from Kanchanpur district. (Interview with mother-in-law aged 40.)

- ◆ The woman had experienced light labour pains for about 3 days, when around 11 pm the pains got severe. Her mother-in-law felt she could not go and call the doctor then,

because the husband was not at home, no one else was there, and it takes three hours to walk to the doctor.

- ◆ Next morning around 6 am the local private health worker was called, who arrived around 8 o'clock. He said the baby would come easily and left again.
- ◆ At noon the pain escalated and the health worker was called again. He then referred her to hospital.
- ◆ The mother-in-law and husband decided to go around 4 pm. There was no confusion about whether to go to hospital, as she could not deliver even under supervision of a doctor.
- ◆ The delivering woman was brought to the hospital in a bullock cart (dunlop) borrowed from relative. Family members helped arrange the transport, which took about 1 hour. The transport took 8 hours, though the local bus would have taken only 3 hours. The family did not know about the ambulance service in Dhangadi.
- ◆ The family had put aside 2000 NRs from to cover the cost of delivery. Part of the money was used for treatment at home by the local health worker. The rest was not sufficient to cover the hospital costs, so they had to borrow more money from relatives, who could hardly spare it. It will take a long time to pay back.
- ◆ There is an Emergency Fund, but neither the delivering woman nor her mother-in-law is a member of mothers group. Non-members are charged interest of 5% per month, which they felt was too expensive.
- ◆ There were no security problems from either side, because even during curfew hours you can walk. They were stopped for ½ an hour for interrogation at the first checkpoint, but from there the other checkpoints were informed, and they had no more problems on the rest of the way, because all checkpoints opened easily.
- ◆ The delivering woman did not face any problem during admission and treatment at the hospital, even though it was her first time in Dhangadi.

This case experienced some delays in calling qualified health personnel due to the nightly hour. Yet, when this private doctor came to attend, initially he also postponed referral to hospital.

- The delivering woman had no ANC check-up during her pregnancy due to embarrassment. She had no major problems during pregnancy.
- The mother-in-law had no knowledge of danger signs. However, she knows that the mothers group does talk about safer motherhood. She does listen to the radio, and had never participated in NFE classes.
- Currently the security situation is better compared to two weeks ago. There are no problems from either side. There is no curfew in the village so mobility even at night is not a problem.

Case 4 is a 23 year old woman delivering her fourth baby, who came to Kailali district hospital from Nauga VDC, Bintabashi gau Ward 1.

- ◆ After labour pain for 2 days, the membranes ruptured at 11 pm. Next morning around 7 am her older sister-in-law, mother-in-law, and father-in-law decided to bring her to hospital. She herself also wanted to come to hospital, as her first pregnancy had miscarried and she was looking for a safer delivery.
- ◆ The family did not have a single penny, so it took 2 hours to find two shop owners in the village and borrow 2000 NRs from them. The emergency fund did not have any money, as it was lent to others. The delivering women is not a member of the mothers

group, but it would have been possible to borrow as her sister-in-law is a member. It will take about six months to repay the loan, as they have to wait till next harvest.

- ◆ It took about half an hour to reach the village of Baisebichuwa, from where a tractor was rented. The delivering woman was brought to hospital by tractor in 1½ hours. Walking would have taken 2½ hours. They did not know about the ambulances in Dhangadi.
- ◆ The two checkpoints on the way to the hospital stopped her for only 5 minutes each. They wrote the number of the tractor and called the district police.
- ◆ The delivering woman did not face any problem during admission and treatment at the hospital. The baby was delivered by caesarean.

The main barriers in this case were lack of money and arrangement of transport. There was only a slight delay due to the security checkpoints.

- The delivering woman knew some danger signs from the FCHV, who goes to everybody individually to explain. She is a member of the mothers group and was attending regular monthly meetings.
- The delivering women had irregular ANC check-ups at the local village health post, by motivation of the FCHV. She had no major problems during pregnancy.
- There is no curfew in the village, but mobility at night is a problem. The security forces used to check all the houses. They would only ask questions.
- Especially unmarried men are migrating to Bombay for labour.

Case 5 is a 19 year old woman from Malakheti VDC Tegari Ward 7, and this is her fourth baby (hospital interview).

- ◆ The woman did not mention her labour pains until after two days the pains became unbearable. The family then waited another two days before deciding to bring the woman to hospital.
- ◆ If they had discussed the matter with the other villagers they might have decided earlier. Eventually, her husband's brother told the father-in-law to bring the woman to hospital, as the husband was not home.
- ◆ The older sister-in-law had put aside 1500 NRs previously. As a member of the mothers group she took 1000 NRs at 2% interest from the Emergency Fund. They requested the brother-in-law for more money, calling him at his army camp, and he sent another 500 NRs.
- ◆ The delivering woman was brought to Attaria in a reserved motor-rickshaw. She had to walk only 5 minutes to the road and travelled about half an hour in the rickshaw.
- ◆ In Attaria they went to a private medical shop where they stayed for more than half an hour, but that "doctor" could not do the delivery.
- ◆ Subsequently they took the public bus to Dhangadi and walked to the hospital, which in total lasted another hour.
- ◆ The checkpoints were no problem. Because she was travelling in a reserved motor rickshaw and she was pregnant, they did not check her.
- ◆ The delivering woman did not face any problem during admission and treatment at the hospital. They reached the hospital at 4 pm. There was a bed free for her and the child was born by caesarean section at 5 pm.

The main delays in this case were caused by lack of decision-making, money arrangements, and transport. Conflict did not cause any delays.

- The delivering woman went three times for ANC check-up and TT-vaccination at the health post in the village. She had some problems during the first trimester, for which she had a video-scan and some treatment at Dhangadi hospital.
- The delivering woman had hardly any knowledge of danger signs, though she says her sister-in-law, who is a member of the mothers group, tells her all. She herself is not a member. The group is not meeting at the moment.
- Currently the security situation is better compared to two weeks ago. My brother-in-law is an army personnel, so we were very afraid. There is a curfew in the village, so though we can go to the neighbours at night, we cannot reach the road and its shops, or the health post. The army will shoot at you. But fortunately, I got ill during daytime.

Case 6 came to Kailali district hospital from Dibiya gau Ward no 5 of Narayanpur VDC. She is a young woman aged 18 having her first baby.

- ◆ The woman got labour pain after she fell while mud-washing the floor, in the eighth month of her pregnancy. She told her mother-in-law that same day.
- ◆ After two days she was suffering constipation and she could not urinate anymore. She went to a private local medical shop that gave her medicines, but these did not cure the problems during the next day.
- ◆ Then at night the father-in-law and mother-in-law decided to take her to Dhangadi hospital, because they thought the baby might die. They waited till next morning to arrange the transport, as they had to wait for the first bus from Tikapur. They were not aware of the ambulances available in Dhangadi.
- ◆ The father-in-law arranged the money for treatment and transport. Part he had as savings at home and part he borrowed from relatives. The money will be paid back from the next wheat harvest sales.
- ◆ The family had their own dunlop bullock cart to take the woman from her home to Tikapur bus station. The delivering woman was brought to hospital by local bus, accompanied by her husband, mother-in-law, and sister-in-law. The bus drive took 6 hours, much longer than the usual three hours, because of all the checkpoints on the way. From the bus stop in Dhangadi it took about half hour to reach the hospital by cycle rickshaw.
- ◆ The woman had no problems at admission. Her sister had been living in Dhangadi previously and therefore she knew some people in the hospital. The baby was born normally.

The conflict situation prolonged the bus trip, doubling the time it took to reach Dhangadi from Tikapur, due to the several checkpoints on the way. Other larger delays were incurred before, when first help was sought at the local medical shop and no public transport was available at night.

- The woman did not go for ANC because she did not know about it. She is not familiar with the local FCHV. The health post is too far away and the MCHW does not come to her village.
- The family prefers to go to a nearby private medical shop, rather than to the health post, because medicines are less expensive. They did not want to go to the PHC in Tikapur, because they thought they would be referred to Dhangadi anyway. They stated the staff does not do good work and is only charging registration fees.
- The delivering woman did not have knowledge of danger signs. She knows about the existence of mothers groups, but there is no mothers group in her village.

- The delivering woman did not tell much about the current conflict and security situation. She had heard of the curfew in Tikapur, but she did not experience any problems. She could go anywhere and do her work as usual. She would not dare to walk at night, but in a dunlop it is no problem to travel at night.

Case 7 came to Kailali district hospital from Malakheti VDC. Interview with the husband, a 56 year old man. She is his second wife and is having her second child.

- ◆ Her severe labour pains started at night and then she wanted to go to hospital.
- ◆ The local TBA was called, but she expressed her inability to deliver the baby.
- ◆ The husband then decided to take her to hospital.
- ◆ They did not have any money ready, and the neighbours could not lend any money. He thought he might try and arrange money in Ataria, on the road to Dhangadi hospital.
- ◆ They first consulted the health post. The health post staff also suggested taking her to hospital, as her situation appeared critical.
- ◆ It took a while to arrange the bullock cart to bring her first to the health post and from there to Ataria. The dirt road to Ataria takes about half an hour by bullock cart.
- ◆ After reaching Ataria he borrowed 1,000 NRs from a police officer he knew.
- ◆ Then they took the bus from Ataria to Dhangadi, which lasted about half an hour. At the bus park he could not find a rickshaw, so he took his wife by the hand and walked with her to the hospital.
- ◆ They had no problems passing the checkpoint on the road to Dhangadi.
- ◆ There were no problems at admission. He requested free treatment, because as a wage labourer he had only a little money and otherwise his wife might have died. So he only had to pay for the medicines and the transport, which totalled 1,500 NRs.

This couple faced mainly economical problems when seeking obstetric care. No conflict-related barriers were identified.

- The delivering woman did not go for ANC and vaccination. His first wife also did not go for ANC during her pregnancy.
- The delivering woman and her husband knew that long labour was a danger sign. She was not a member of the mothers or women's group in her village. Both husband and wife had never listened to the radio programme "Amaa".

Case 8 came to Dhangadi hospital from Masuriya VDC Ward no 9. She is a young Brahmin woman of 20 years, having her first child.

- ◆ She had a difficult pregnancy, with much abdominal pain. She went for check-up to Chaumala PHC to get cured from this pain, but at that time she only got medicines, which didn't help her much.
- ◆ When the pain got worse and she could not sit or stand anymore, her mother-in-law decided she should go to Dhangadi hospital for a proper check-up. The hospital doctor confirmed that she should have a caesarean section and asked her to come back the next Sunday.
- ◆ Husband and wife travelled on Saturday to Dhangadi. It took them 45 minutes to walk to the road. It was 1½ to 2 hours by bus to Dhangadi. The three checkpoints on the way took some extra time, but as a pregnant woman she did not need to come out of the bus.

- ◆ The husband has a job as a teacher and had saved some money for the delivery. They had to borrow more money from neighbours, and took other loans as well, because it was a hospital delivery. The total costs will be about 8,000 NRs. They will have no problems repaying the money. There is a Emergency Fund in the village and her older sister-in-law is a member, but they did not try to borrow from the fund.
- ◆ There were no problems at admission.

As this case was aware of the need for a caesarean previously, they could arrange money in advance and had no delays due to transport problems.

- The delivering woman knew about the danger signs. Her sister-in-law, who is a member of the mothers group, told her about it and the FCHV has explained about safer motherhood. She has also listened to the radio programme “Amaa”.
- She has not much confidence in the capacities of the local health post staff, but she has not gone there yet.
- Though before ceasefire villagers were even afraid to walk around the village at daytime, this would not have kept them from going to hospital in an emergency.

Partners’ Perspective: Kailali

Kailali partner analysis

In Kailali NSMP is implementing its Increasing Access programme component through a number of partners. The following partners were interviewed to understand the possible impact of conflict on the efficiency of activities promoting increased access to health services for essential obstetric care (EOC):

District Health Officer,
NRCS,
Women Development Office (WDO),
CCS.

Following is a compilation of excerpts of these discussions with the partners.

Through which community groups (for example Amaa Samuha) are they promoting safer motherhood with the population?

DPHO is working through mothers groups with FCHVs in promoting safer motherhood messages in the communities.

NRCS is working with mothers groups in all wards of Dhangadi municipality. A new batch of FCHVs has been trained for the area, as there was no provision of the FCHVs in municipalities. The FCHVs have been active in mobilising mothers groups that are seen as instrumental in promoting the safer motherhood concept in the community. Efforts are underway to create an Emergency Fund in each mothers group. This was not possible due to lack of fund management and credit management skills among mothers groups.

WDO is working through small groups formed for economic activities at ward and VDC level to promote knowledge of safer motherhood. WDO had established a VDC-level Emergency Fund, which could be accessed by the members of the ward-level groups. However the fund

is not easily accessible to most people. People who cannot pay the monthly membership fee are not eligible for emergency loans.

CCS was working with the groups they had mobilised in a community development programme in partnership with Action Aid. These groups had a credit fund, with a matching fund from the organisation. The Emergency Fund was separated from the main funds. However, CCS has withdrawn its activities from the communities due to conflict.

Did the partners experience any problems in mobilising community groups and organising group meetings, as a result of the conflict situation?

DPHO: The revolving Emergency Funds within mothers groups have been established but have minimal effect due to conflict. However, Emergency Funds in many groups are not functioning due to lack of proper orientation, appropriate rules and regulations, and periodical monitoring.

NCRS is not seeing any problems in its groups. The mothers groups led by FCHVs are meeting regularly once a month.

WDO has experienced hardly any problems with its groups. The VDCs where they are working with NSMP are affected relatively little by the conflict, though some groups do ask for more tangible support, apparently by mouth of Maoist-related persons.

CCS's groups had to dissolve, as a result of their own success. Maoists wanted the groups to work for them, or stop activity altogether. The mothers groups are no longer functional as they could not meet regularly due to fear of both army and Maoists. Many group members have joined Maoists, particularly in Hasuliya.

Maoists have threatened those who use any NGO money in villages. As a result, the group decided to distribute the savings along with CCS matching fund among the members equally. The repayment rate of loans has dropped drastically, causing difficulties in mobilizing the group fund especially in emergency cases.

The Women Development Section groups are no longer functional in the village, causing further problems in financial transactions.

Were there delays in implementing group related activities, and to what extent was this caused by the conflict situation in the VDCs?

As most groups seemed already well established before emergency, this question was not asked in Kailali,.

Were any field-staff of the partner organisation based in the working VDCs?

DPHO admits that there have been threats to health personal but states that all staff are still working effectively in the health posts, except from a "normal" 5% vacancy. Some staff are afraid of staying in the health posts due to pressure from both sides.

Maoists are not negative towards the District Public Health Office compared to their feelings regarding NGO and INGO staff. However, movement of health staff in the remoter areas of the VDCs is reduced. Security forces have restricted movements of health workers - especially MCHW, FCHVs, and TBAs - particularly at night.

NRCS has no field staff staying in the VDCs, as they are completely volunteer based.

WDO has field staff in the VDCs; they say they do not have any problems in the NSMP programme VDCs.

CCS had local field staff and one supervisor in the VDCs, but first had to retire their field office and then to stop working with the field staff, some of whom decided to leave their homes and settle in the district headquarters because of fear.

Has the number of field visits for support and monitoring by higher district-level (not field based) partner staff been reduced due to fear created by the conflict?

DPHO claims that support to the health workers at the field level continues despite the conflict. However the visits to heavily effected areas have been reduced and are not regular.

As NRCS does not have staff in the field, all the activities related to Safer Motherhood are implemented completely by local volunteers. However, the district committee members and the branch staff make regular field visits for monitoring in less remote areas. The staff members are not visiting the more remote areas of the municipality partly due to fear; after all they are volunteers. People are afraid of travelling due to ambush on the roads. So far Red Cross has not been threatened.

WDO is functioning normally, paying normal field visits, though there are some problems in the villages. It is more difficult for them to ask questions, as people are suspicious. Three VDCs (not in NSMP's area for WDO) are so affected that no government staff are allowed to work there.

Since CCS has withdrawn its activities from the field due to conflict, there is no reason for them to make field visits.

Was there a reduction in supervision / monitoring of community-group meetings, and does this affect efficacy in dispersing the Safer Motherhood messages?

NRCS has several coordinators, each responsible for managing 15 FCHVs. The coordinators provide necessary support and coaching to the FCHVs, who ultimately are responsible to provide support to the groups. They meet the FCHVs once every two months. During the meetings various issues related to safer motherhood, women's health, environment, waste management, and health services are discussed. The meetings also attempt to monitor the proper use of available health services by the public. As a result of regular meetings and support, the FCHVs should be able to provide necessary support to the community groups.

In the WDO areas, the community groups are meeting but the frequency has been reduced and regularity is not maintained. As a result in some groups the mechanism of monitoring loans and repayment is not functioning effectively.

In CCS areas, the groups are dissolved and do not meet.

Did the partners experience any problems while implementing activities, like dissemination of information and messages on safer motherhood to the communities, as planned? Did they adapt planning to the conflict situation by changing, reducing, rescheduling, or eliminating activities?

Most partners said no problems were encountered.

CCS's newsletter publication could not be implemented due to conflict.

Were changed or alternative activities thought to be as effective as previously planned activities?

NRCS planned activities with no conflict considerations. Planning was not revised to cope with the conflicting situation. Problems were not encountered in implementing planned activities. However, planned expansions of geographical areas have been postponed for the time being.

CCS could not implement some activities like teachers' orientation due to conflict, especially after emergency. The venues of some training programs were changed to Dhangadi from the villages due to conflict, which incurred additional travel costs.

Are communities open and interested in the Safer Motherhood programme, or do they express any other priorities?

People have lost their confidence to share thoughts and ideas. They hesitate to talk with any unknown people due to fear of both army and the Maoists.

Other community problems that reduce access to health facilities

There are five ambulances in the districts, but many people, especially in the remoter VDCs, do not know about this. From many conflict-affected places it is difficult to call the ambulances, as there are no telephone facilities. Hence, the service is not accessible to all patients.

Night mobility has been restricted due to curfew. People could bring delivering women to hospital after informing the security forces, but many people, particularly the poor, lack of the means and confidence to do this. Moreover, public telephone booths are closed at night and not every house has a phone connection. Duration of curfew has been reduced after ceasefire, but it is still imposed.

ANNEX H: MYAGDI DISTRICT ANALYSIS

Analysis Myagdi

The four Village Development Committees (VDC) investigated in Myagdi district were Jyamrukot, Singha, Rakhu Bhagawati, and Babiyachaur. The impact of the conflict on accessibility of health facilities in the district is analysed on the basis of the qualitative information received from respondents interviewed in these four VDCs. The situation is described for three different stages of the conflict—pre-emergency, before ceasefire, and current. For each topic general remarks are followed by discussion of conflict-related issues, starting from least affected situations and culminating in impacts found in the worst affected areas.

General Impression

Among the four VDCs covered by the study, Babiyachaur was the most affected, followed by Singha, Jyamrukot, and Bhagawati VDCs. The current situation of all four VDCs is relatively relaxed compared to before ceasefire, though in Babiyachaur external NGOs and INGOs are still facing disturbances and restrictions to their work.

A great deal of intense fear remains among the people as an aftermath of torture, killing, and kidnapping by both Maoists and the army. There is lack of trust among people because the army used come in civil dress or disguised as Maoists. This is particularly true among poor and Dalit people, who were seen as Maoists even without proof. Therefore it is extremely difficult to get information from villagers, as they do not talk, either because they have no information or they are afraid.

The study team encountered a small group of Maoists distributing pamphlets promoting participation of local people at a district-level convention of pro-Maoists student union. In the focus group discussion in Rakhu, some of the participants got emotional because they had lost their family members or been tortured from either the Maoist or the army side. In Jyamrukot the Maoists are moving freely, spreading fear among people. In the Jyamrukot health post building there are wall paintings of sensitive nature, creating psychological pressure among the villagers. In Bhagawati Maoists were threatening to close local schools for an indefinite period.

Security

Before emergency

- Before emergency there was no curfew and people could walk during the night and use the light of an electric torch or flame.

Security features during conflict

- Since emergency, curfew in the market areas of the VDCs was from 6 pm till 5 am, which also affected movement of people in remote villages due to fear.

- People were not allowed to walk during the night or to light torches.
- People were not allowed to move in small groups.
- There was a restriction against putting on lights at home until last month.
- Maoists asked for donations (for darbang programme and golmech).
- People were forced to go to Maoist discussions.
- Maoists forced people to provide donations and food, subjecting people to severe punishment if they refused.
- The army pressured people with interrogation and subsequently detention if they found people had succumbed to Maoists' requests.
- People would hide in their houses when someone came, because of fear.
- People were very afraid of fighting during the night. They were afraid of bombs and afraid of being hit by a bullet.
- Maoists sometimes called bandhs, blocking all movement.
- Maoists also threatened to kidnap young people to join militia.
- People have been kidnapped.
- On some occasions there has also been curfew during the day for some time (Singha). Gathering in groups, arranging a picnic, or staying outside were forbidden.
- In Babiyachaur curfew was imposed in remote areas and forest areas.
- Maoists imposed restrictions on NGO, INGO, and project workers implementing their programmes in Babiyachaur.

Effects on health workers

- Due to fear of the Maoists, health workers have come to work on time for the last two years.
- The army has closed private medical clinics in the villages.
- In Bhagawati and Jyamrukot the health workers claim that they are attending home visits at night, which was not confirmed by the people.
- Health workers ask people to bring the sick for treatment at their residences and will not make home visits at night.
- Neighbours, TBAs, and MCHW hesitate to refer patients to hospital at night, due to fear and reduced mobility caused by the conflict.
- The curfew and fear have made it impossible to meet health workers at night in Singha and Babiyachaur.

Communication and transportation

- Telephones in the villages are cut down by army to stop the Maoists' communication (Singha) or destroyed by the Maoists (Bhagwati, Babiyachaur). Jyamrukot VDC did not have telephone connection. This makes communication for transport arrangements and permission of the security forces impossible.
- The common Maoist slogan, "one person one doko" has discouraged people from making doko to carry sick people and pregnant women to hospital.

Attitude of the security forces

- People in the district headquarters can get help to reach hospital at night if they inform the security forces, but often cannot communicate with them.

- The army in Beni bazaar is helpful in bringing pregnant and delivering women to hospital. They have provided transport and other facilities to people, especially during curfew.
- Recently one pregnant woman from Jyamrukot was taken to hospital in time for safe delivery after informing the army from Mangalaghat.
- The army allows pregnant women to be brought to hospital for delivery on prior information, but people in the villages do not have the means, courage, or confidence to inform the army.
- Checkpoints on the road to hospital cause delays.
- People from certain very affected VDCs were checked more strictly, causing still more delay (Singha, Babiyachaur, Jyamarukot).
- Following a fatal delay in taking a bleeding postpartum case to hospital in Baglung, the army in Beni bazaar took a leadership role in establishing a fund to support education, health, and emergency accessibility to poor people of all VDCs, by collecting money from different sources.

After ceasefire

- Since ceasefire people are allowed to move during the night.
- Curfew is delayed till 9 pm.
- People are allowed to gather fodder and firewood from the jungle.
- People still get afraid, though to some extent peace has come.
- Maoists are still collecting donations and asking for meals.
- Maoists sent back a group of forest conservation baseline-survey enumerators.
- After ceasefire in Babiyachaur, the Maoists forcefully expelled a street drama group performing a safer motherhood drama after capturing their musical equipment and drama scripts.

The following actual cases of delays due to security situation were found during the interviews with the community people.

- In Singha, a pregnant woman who could not be taken to hospital due to curfew at night gave birth to a dead baby.
 - In Singha, a pregnant woman who could not be taken to the hospital due to curfew at night died.
 - In Jyamrukot a baby was found whose mother had died during delivery due to delay in taking her to the hospital, as villagers were to afraid to travel at night though there was no curfew in the village. This case came from Baglung district, but his aunt in Jyamrukot is taking care of the baby.
- Security forces forcefully stopped one pregnant woman on her way to hospital for delivery; subsequently she died due to delay in reaching hospital in Beni bazaar.

The intense fear found in the villages is based on incidents like the following examples cited by interviewees:

- VDC buildings of all four VDCs have been destroyed during the conflict.
- Police posts were closed.

In Babiyachaur

- A handicapped person was shot at, but not hit, when he went outside to the toilet at night.

- A young boy was killed in the market, beaten to death by the army.
- A boy from Singha was killed in a funeral procession held during curfew, before emergency.
- Maoists looted two shops.
- The police post was closed.
- The army does not allow organisations and political parties to arrange meetings; these had to close down.
- In a nearby VDC (Dakhang), Maoists killed a political worker at 2 am.

In Singha

- Three persons under treatment at Tatopani (hot water spring) were shot dead by the army without any warning, at 4 am. These three persons did not know about the curfew in the village.
- One person collecting herbs in the local forest was shot dead by security forces.
- The army attacked a Maoist worker's house.
- Maoists killed a teacher and kidnapped several others.
- Five army personnel were killed in ambush by Maoists.
- FCHV was imprisoned for 4 days (after organising a group meeting).
- The husband of a mothers group member was killed by security forces.
- The army had blasted houses of many poor families in Singa and neighbouring VDCs.

In Jyamrukot

- Maoists killed a NC political worker in his home, when daughter had just delivered.
- Maoists kidnapped the school headmaster.
- The army beat the peon of the HP.
- The army put an FCHV's husband (a teacher) in prison for providing food to the Maoists.
- Students of grades 9 and 10 were arrested and released on bail by the army.
- Saving and credit was closed due to fear.

In Bhagawati

- Nothing really happened, but there are a lot of rumours causing fear.

Migration

Normal migration

- In all VDCs people migrated to India and Persian Gulf countries, due to their economic situation (more in Rakhu and Jyamrukot).
- Traditionally one young male from each household migrates for work. They visit their families once every two years.

Conflict-related migration

- Economic migration has increased due to insecurity.
- Poor people are migrating because they can no longer make a living; employment opportunities have been reduced.
- Relatively better-off people are migrating because they fear being looted of their property.
- In most places some complete families are migrating for security reasons, particularly richer families and families of teachers and political party representatives (more in Babiyachaur, Singha, and Jyamrukot).
- All private boarding schools have closed, causing migration of the teachers and people wishing to provide quality education to their children (particularly in Babiyachaur).
- Due to rumours that Maoists will use human resources and/or attack district headquarters, migration has increased.
- Some youngsters who cannot afford to emigrate stay away from the village for a short time until the rumour dies down.
- Migration of youth has increased due to the “one doko per person” campaign of the security forces (more in Bhagwati).
- Labourers are migrating from Babiyachaur, because both Maoists and the army trouble them, and they don’t get jobs either.
- A tendency for such migrants to return was visible, especially after ceasefire.

Impact of migration

Money

- It has become difficult to find loans, as most people who could lend money have left or been displaced from the village, especially in Singha and Babiyachaur.
- Households that have family working abroad can get loans, but not those who live in the village (more in Bhagawati).

Porters

- Those of high caste can get people to carry their ill, but it is difficult for low-caste people to find porters if they do not have “afno manche” (Bhagawati).
- Fear of being identified as Maoists by the security forces makes it difficult to find people to carry the ill to hospital.
- Migration has caused delays in transport management due to lack of men in most VDCs (more in Jyamrukot, where migration was already high previously).
- Neighbours are available to carry sick people, but not enough for funeral processions (Jyamrukot).
- Nevertheless, we found no cases of delivering and pregnant women who were not taken to hospital due to lack of people to carry.

Economic Barriers

General setting

- Money is an obstacle to ANC in a few cases in all VDCs, especially among Dalit and poor families.

- In all the VDCs, there are people who cannot go to hospital due to economic reasons.

Reduced employment and income

- Conflict has significantly reduced employment opportunities, particularly in construction, reinforcing poverty in all VDCs.
- Fewer jobs are available because rich people who provided employment have been displaced.
- Businesses have been closed.
- Less money is coming to the community from migrated people.
- There are few opportunities to sell village commodities in Singha and Babiyachaur.
- Closure of boarding schools has reduced the income of teachers (Babiyachaur and Singha).
- Tatopani at Singha has been far less popular since the incident; business has gone down tremendously and the market was closed.

Loan availability

- Willingness to lend money for treatment has been reduced drastically, in all four VDCs, among richer people due to fear that poor people could not repay the loan as they are losing income opportunities and employment.
- Since banks are now centralized in the district headquarters, people have problems in withdrawing money at the time of emergency (Singha, Babiyachaur).

Impact on project intervention: Emergency funds

- Recently Emergency Funds have been set up in all four VDCs to help with emergency situations (some delayed due to conflict). The oldest Emergency Fund is only nine months old.
- Therefore conflict has had minimal effect on Emergency Funds in all four VDCs.
- Until now, use of Emergency Funds to meet emergency expenses has been minimal in all four VDCs. Expenses of one emergency delivery case have been met by the Emergency Fund in Bhagawati and Singa VDC.

Transport Barriers

General transport setting

- The marketplaces of Singha and Babiyachaur are connected to Beni by a seasonal dirt road.
- Many remoter communities in Babiyachaur, Singha are up to three hours from the road.
- It takes one hour by car from Singha to Beni. There is one checkpoint.
- Vehicles were not allowed to stay overnight in Singha until two months ago. Now cars have to bring back their keys from Singha bazaar to Beni before evening curfew. A limited number of vehicles can stay at the bazaar to be in line for next morning.

- The road touches Jyamrukot VDC, but it is a brisk three-hour walk from the road head to the distant communities of Jyamrukot.
- From Bhagawati people have to walk over a steep, difficult path to reach the road head at Galeshwor in two to four hours. Public vehicles and taxis go from Galeshwor, taking 20 minutes to reach the hospital. There is one checkpoint just before Beni.
- Without being paid, no one is ready to carry delivering women to hospital (specifically in Bhagwati).

Specific impacts of conflict on transport provisions

- Vehicular transports are not available at night.
- There is curfew in Beni from 9 pm till 4 am and it is extremely difficult to bring patients to the hospital during curfew.
- The security post in Beni opens only at 7 am, restricting the early movement of vehicles.
- Until two months ago checkpoints caused extreme delays for people from Babiyachaur and Singha, who had to undergo fierce interrogation.
- In most VDCs, but specifically in Bhagawati, there are difficulties finding people to carry sick persons or pregnant women to hospital at night, primarily due to fear.
- Security forces have seized doko from households during the emergency. And rumours of "one man one doko" had discouraged people from keeping doko in the house.

Impact on project interventions

- Few Ama Samuha or other groups have a local transport scheme like doko, perhaps partly due to delays in the programme activities of partner organisations.
- It is considered a sign of bad luck to prepare the means to carry pregnant women in advance.
- People are also reluctant to reuse the doko.
- No direct restrictions on the transport schemes were found.

Health Services

Perception of health services by communities

- Villagers have generally positive perceptions of most workers at health posts.
- In Babiyachaur there is an experienced TBA who is very much trusted by all people. She does not ask clients to pay her; one can give according to one's own wish.
- In case of complication during delivery, the local TBA, MCHW, or AHW is called, on recommendation of the neighbours or FCHVs.
- People also call Bhaidya, but in cases he cannot handle (like retained placenta), they will need to call AHW.
- Patients are taken to the health posts or hospitals only if TBA or MCHW refers.
- Health post staff ask fixed rates.
- The AHW in Jyamrukot is not accepting fees, which creates a positive perception.
- Most health posts do not have funds to support poor people. But at the discretion of the health workers, a few poor patients are treated free.
- The AHW in Bhagwati charges 3000 NRs for a delivery. It is less expensive to go to Beni hospital for maternity service.

Perception of hospital services

- In hospital people feel ignored and that the staff doesn't tell them anything.
- Though service is less costly in Myagdi hospital and treatment is fast, people do not like the nurses, who used to get angry with them, beat and scold them, and do not provide enough medicines.
- People who know the mid-level health workers get better health services.
- When the doctor is present in hospital service, sufficient medicines will be provided.
- In one case a baby died when its mother was sent to Baglung hospital for further treatment after delivery. Now people are not sure whether the Beni hospital is properly taking care of newborn babies.

Conflict impact on service availability

- In all the VDCs health workers of good qualifications remained during the conflict. Two reasons for their presence were found: fear of punishment by Maoists and that the staff was mostly local.
- A few health workers not attending to their duty are using conflict as an excuse.
- None of the health workers interviewed were threatened either by army or Maoists.
- Health workers don't walk at night; if someone calls they were ready to go, but no one called them.
- Health workers could not move outside during night, but since the ceasefire they do come for home visits till 9 pm.
- Some health workers do not want sick people to be brought to their private home during the night.
- In Singha there is no MCHV, and if the talks between government and Maoists are not successful the AHW can't stay there anymore.
- The outreach clinics are not functional due to security problems (Singha, Babiyachaur).

Medicine supplies

- Medicine supplies as granted by the district health office can be easily obtained.
- Private medical shops have hassles from security forces in getting supplies of medicines.
- One medical shop was closed after emergency in Singha.

Impact of VDC dissolution

- The health posts already handed over to the local governing bodies are facing problems in making crucial decisions, as the health post managing committee chaired by VDC chairman does not meet due to dissolution of the VDCs.
- The health posts are also not getting financial and other support that they used to get due to dissolution of the local bodies.

Decision-making

General setting

- In general the father- and mother-in-law make the decision for treatment.
- Mothers-in-law make the decision when there is no husband.
- In the absence of the senior male members, the family seek advice of the closest male members or neighbouring males to make decisions about hospitalisation.
- Self-decision of pregnant women is lacking.
- One woman, who herself was an FCHV, requested others to take her to hospital, as her in-laws live separately and the husband lives abroad.
- Anybody can make the decision for treatment, but there is confusion at the crucial moment.
- Often a leading person to make the decision is lacking at the right moment.
- FCHVs suggest and take decisions as well.
- Decision-making in such a crucial moment is influenced by advice of neighbours, experienced relatives, and health workers.
- If they know about the danger signs, community people also decide to go to hospital; in a case in Singha and another from Babiyachaur, women with bleeding were provided with money and sent to Baglung for treatment even though they themselves did not want to go. However, the family still does not know how to repay the loan of Rs 5000 taken to cover the emergency expenses.

Conflict impact

- In general, conflict has minimal effect on the decision-making process.
- Not much difference in decision-making in relation to perceived health hazards was found.
- The process of arranging transport and money has become more problematic and longer due to conflict, and this delays decision-making somewhat.
- Furthermore, one pregnant woman with labour pain died, as there was no one to make an early decision to take her to hospital. When the decision was taken towards evening, it was too late to reach hospital in Beni due to curfew.

Knowledge of Danger Signs

General observations

- In general respondents from Singha had more or less full knowledge compared to respondents from other VDCs. Respondents in Singha said that they are having regular inputs from the field facilitator of WDO and from radio programmes.
- One out of four pregnant women did know the danger signs she had learned from the radio and the WDO playgroup. The others had a limited idea of some signs.
- About half of the home-delivering women had no idea about danger signs.
- Those delivered women who had some idea knew about bleeding and retained placenta. One mentioned dizziness.

- Family members in general had limited knowledge, mainly about bleeding and wrong position of the baby. They pretended to know more, but actually knew very little. One person mentioned fever and swelling.
- Fathers-in-law tended to talk about good diet and other mother and child health care issues rather than danger signs. One husband had learned about danger signs from the radio.
- Knowledge about danger signs is also limited among FCHVs. In Singha, Babiyachaur, and Bhagwati most could explain only some signs; in Jyamarukot knowledge was even more limited.
- People from low economic conditions and Dalits had less knowledge of danger signs than other respondents.
- Some people say they have heard about danger signs, but have forgotten completely what they are.

Project interventions

- The knowledge FCHVs have seems insufficient to allow them to disseminate important information to the mothers groups, as shown by the limited knowledge of most group members.
- In many meetings there is no discussion about safer motherhood.
- In some areas there is NFE, but in most areas classes are closed due to conflict.

Obstacles in using knowledge

- Even when people know about danger signs, they seem reluctant to go to hospital, because of abuse by the nurses. It is different for people who have “aphno manche” at the hospital.
- A mother-in-law sent her daughter-in-law to hospital for delivery, even though she had no knowledge.
- Conflict impacted the dissemination of knowledge, as many groups are not holding regular meetings and FCHVs do not feel free to move about the villages to explain the danger signs to pregnant women and their families.
- The study could not determine whether retention of danger sign knowledge has decreased due to the conflict tensions.

FCHV Functioning (8 Interviews)

FCHV supervision and guidance

- FCHVs are having normal 6-month meetings with HP and DPHO.
- There are no FCHV in most of the LDFB groups (Bhagawati).
- Training to FCHVs and other group-leaders was continued during emergency, sometimes called to Beni.
- Even during the emergency period, support to FCHVs continued, but it was gradually reduced as the severity of the conflict increased.
- In critical situation contact between partners (NSMP) and FCHVs became less; they got less input.

- Singha and Jyamrukot are enjoying comparatively more support than Bhagawati and Babiyachaur.
- In Singha and Jyamarukot, INF is working with the FCHVs.
- Most FCHVs and Ama Samuha members were not listening the radio programme regularly, except in Singha.

Mobility

- Till two months ago people even feared to walk around the village at daytime. At night movement was impossible.
- People cannot move outside while security forces are patrolling.
- FCHVs in Singha, Jyamrukot, and Bhagawati claim that they are able to move within their own villages even at night.
- People come to call FCHVs at night also, but they are afraid to go, especially in Babiyachaur and Singha market areas.
- One FCHV of Babiyachaur went to call an experienced trained TBA at one-hour walking distance together with her male friends.
- A few FCHVs were direct victims of the conflict:
 - One FCHV was under intense supervision when her husband was in jail for 13 months (Jyamarukot).
 - One FCHV was put in jail for 4 days and later released on bail (Singha).
 - One FCHV got beaten up by Maoists for organising a mothers group.
- Even after ceasefire, night movement within their own village is not possible,.

Mothers groups' functioning

- Mothers groups are not overtly arranging meetings.
- One group that stopped meeting after the FCHV was detained started again after ceasefire.
- Even registered mothers groups were not active, but since ceasefire they are considering starting again (Bhagwati).
- In Jyamarukot almost all groups were not functioning due to the conflict.
- One group's papers were all destroyed in a fire, so for a short time regular meetings could not be held (Babiyachaur).
- Security forces do not permit group gatherings, and have obstructed group meetings in heavily affected areas.
- Maoists threatened and closed down a mothers group (it has recently started depositing in Emergency Fund again).
- Where there has been action against mothers groups, people don't want to arrange meetings in the name of a mothers group. They wish to have another name. (In a ward of Singha it is under discussion whether WDO or PDDP.)

Emergency funds

- Emergency funds have been established in all VDCs (Singha, Bhagwati only recently).
- No looting or closures of group funds have been reported.

- In some emergency funds there have been donations from FUG and CBO (Bhagawati), teachers (Babiyachaur), or business (Singha).
- Clear operational and lending policies of the Emergency Fund committees are yet to be formed. Ad-hoc decisions under the leadership of local elites are the rule so far.
- In VDCs where WDO and LDFB are working there is lack of coordination between the mothers groups, the organisation's groups, and the Emergency Fund group. This has led into confusion among the members and increased the frequency of the meetings—a difficulty for hardworking farmers.
- They have established main-committee and sub-committees of the Emergency Fund.
- In some Emergency Fund committees the FCHV is the member secretary.

Transport schemes

- Many of the VDCs have no doko or chairs available due to rumours of "one man one doko per household" to be charged by the Maoists and restrictions in making and selling doko.
- In Singha bazaar doko are not made, because the road is nearby and vehicles are available.
- Some groups feel they need financial support to make a transport scheme (Jyamarukot).
- An FCHV thinks it would be easier if she would keep the transport means at her place.

Pregnant Women and their Families (8 Cases)

Antenatal care

- Most interviewed pregnant women went for ANC check-up a few times.
- In some cases the family explicitly sent the pregnant woman for checking.
- Some people went to Beni or Baglung hospital or private clinic for better service, as many women come to the district headquarters for shopping and other work.
- People do not like to go to HP for check-ups because of lack of female staff.
- One woman did not go at all, as the family said they had not gone in their ancestors' times either. She went to the dhami-jhankri instead.
- ANC check-up is done only in FCHV influenced area (Jyamarukot).
- Conflict appears to have hardly any influence on ANC.

Most of the cases went for medical check when they experienced serious problems during the current pregnancy.

- One case with swollen feet and hands went to hospital in Beni, where they found it was not a problem.
- One case had swollen hands and feet and went to hospital in Baglung. Upon her return she went to a local TBA in Babiyachaur for confirmation.
- Once case had lower belly pains and went for check-up at the Beni hospital.
- One case had weakness and dizziness in the first trimester, but did not go for check-up.

Emergency preparations

- Two (better-off) families had arranged money for delivery in advance—one because they knew they needed to go to hospital for a complicated delivery (breech).
- Some families were not aware of the existence of an Emergency Fund.
- Transport is arranged at the moment itself, as it is not perceived as a big problem. Preparing doko in advance is not considered auspicious.
- Chairs for carrying can also be arranged from the school.
- A few people said dokos could not be made due to the conflict (SF).

Home deliveries versus hospital delivery

- People feel it is better to deliver a baby at home with family and friends.
- In case of problems during delivery they will call for help and after referral go to hospital. Money and transport are only arranged at that very moment.
- Some don't want to go to hospital because it is costly.
- One pregnant woman said she would like to deliver in hospital, but her family will not allow her (for a normal delivery).
- Even though people know about the advantages of a hospital delivery, they will not go.
- Some people are not sure the hospital will take good care of the baby.
- Most pregnant women had no idea about the existence of groups where safer motherhood is being discussed (Jyamarukot).

Home Delivery Cases (8 Pregnant Women and 8 Family Members)

- Among 16 home delivery cases interviewed, six were having their first baby and the others had had previous pregnancies. One case was a fifth pregnancy.

Antenatal care

- About half of the interviewed women did not go for ANC. The others went often to Beni hospital, as it is easily combined with other work in town and female nurses are available. Many do not complete the full four visits for ANC. One woman preferred to be checked by the local TBA, but took the iron tablets from the HP.
- Most of the delivered women received some information concerning safer pregnancy and delivery from senior female members of the family, TBAs, and health workers.

The following problems were observed among these cases.

- Weakness, therefore went for check-up in Beni.
- Prolonged pregnancy till 11th month (= into 10th), with stomach cramps and dizziness.
- Swollen hands and feet; went to Baglung hospital for treatment, where they were told the child was “bango”, and she should deliver in hospital. The baby was born at home before the expected date.
- Fever, nothing else - treatment by dhami jhankri.
- Stomach, back, and heart pain - no treatment.
- Heart pain and leg cramps in thighs - no treatment.

Home deliveries and some of the problems

- Most delivered women and family members prefer home delivery and do not want to go to hospital.
- None of the normal delivery cases ever considered going to hospital, though in some cases the family had thought to go to hospitals in case of danger signs.
- In all but one case the women delivered their babies with some attendants like senior female members of the family, mothers-in-law, or neighbours.
 - That case, of 3.45 hours labour, had no attendance at all, because she did not want to disturb anybody at night.
- Many normal deliveries had a TBA attending the delivery.
 - Baby born easily, attended by TBA, woman felt weak afterwards.
 - No problems during delivery, trained TBA attended the delivery.
 - 12 hours of labour pain, TBA came to attend the delivery.
 - No problems during delivery, couldn't call neighbours during the night, but the TBA was called.
 - 7-8 hours labour, ANM was called.
 - 4 hours of labour at night time, a neighbour attended. The TBA and FCHV had gone to a training, and so we could not call them.
 - 5 hours labour, no attendance by HW, because it was delivered quickly and also because it was night.
- In many cases with complications, trained health workers were called to treat some visible problems during delivery. In only one case was no action taken due to the night curfew.
 - 21 hours labour attended by TBA, later private HW (a family relative) was called.
 - 2 days of labour pain and bleeding afterwards. TBA and ANM attended the delivery. She got cured of bleeding by taking medicines. (Had been advised to deliver in hospital.)
 - 6 hours labour pain, loosing blood for 10 days after. Previous deliveries had included labour pain for 4-5 days. After delivery she had "biya bokeko" and fever for 2 days, and went to Beni for treatment.
 - 1½ hours of strong labour pains, retained placenta for 1 hour. FCHV advised going to hospital but they did not go because it is far. It was daytime so security was not a big problem.
 - After 12 hours of labour pain baby was delivered, but placenta was retained for very long time (8 – 10 hours). The family was worried to go at night. People were already arranging a chair for transport, when the placenta finally came out by itself.
- In two cases a retained placenta was removed (pulled out) by a TBA / FCHV, instead of calling qualified health workers.
- 5 hours labour, placenta retained for 4-5 hours, FCHV pulled it out, but after that the urine was blocked; she took medicines and after 4-5 hours the urine did come again.
- 24 hours labour, placenta retained and removed manually by TBA. Had thought of calling the AHW as advised by FCHV, but the TBA could remove it herself. Five days of bleeding and stomach pain after delivery.

Conclusions

- In only one case was conflict a main barrier not to take the case to hospital, or to call qualified help.
- In most cases finance, culture, and traditions are barriers to getting appropriate help quickly.
- Transport was not a barrier to take the cases to hospital.

Treatment Managers' Experiences (4 Cases)

In Myagdi four treatment managers - people who helped arrange transport for a delivery emergency - were interviewed to understand the problems encountered in arranging transport and money under the current conflict situation. Three of them actually reached the hospital; one interviewed case was on the way to hospital when the baby was born.

The obstructions experienced by the respondents were mainly related to normal economic barriers. One case delayed till next morning, partly due to night curfew and insecurity, but also due to the condition of the steep footpath. The cases are described below, with numbering staying consistent throughout the different issues.

Reasons for seeking health worker's support

1. Long labour. First someone suggested taking hot ghee. Delivery came naturally while on the way to hospital. Upon return home, the placenta was retained for 8 hours and the doctor was called (J).
2. Long labour since previous day, but the woman only told in the morning (J).
3. Long labour for 4 or 5 days (B).
4. Bleeding before delivery. Waited from 10 am till 5 pm before deciding (S).

Transport problems

1. Used a stretcher to reach the road. Would have gone further by vehicle, but then the delivery took place.
2. Had to walk for half an hour over a steep trail, with a chair to carry the delivering woman.
3. Used to doko to carry the woman for two hours to the road, and from there it was 20 minutes by vehicle. After referral they took a taxi to Baglung for one hour. It took two hours to arrange the doko, after the decision was made. And they had to negotiate for 15 minutes over the taxi price.
4. It took half an hour to wait for the bus to come. It would have been two hours walking, but only 45 minutes by bus. (Before 3 pm there are hardly any buses.)

Economic barriers

1. They borrowed 1000 NRs from friends. They did not use the Emergency Fund. There were no problems in arranging the money.
2. Made their own arrangements with family for money. There is an Emergency Fund, but they are not members.

3. It took a while to take a loan of 3000 NRs from a relative. They will have trouble repaying because they are wage labourers and make hardly 200 NRs a day.
4. The money was arranged previously as the doctor had already said she had to go to hospital due to garolo.

Security barriers

1. No problems.
2. No problems, no curfew time when they decided to go to hospital.
3. The woman could have gone in the evening, but went only the next morning due to the difficult path and security.
4. No problems.

Hospital Delivery Case Studies (4 Cases)

In Beni hospital most cases are normal deliveries from the local market area. Complicated cases from villages tend to go to Baglung hospital, because it has better facilities and advanced equipment.

In Myagdi district four hospital cases were interviewed, only one of which was interviewed in hospital. The other three were interviewed at home in the villages after their return from hospital (two in Singha and one in Bhagawati).

Three cases were taken to hospital due to extremely long labour. One case decided to go to hospital a month previous to delivery.

1. Prolonged labour pain for 5 days and severe back pain.
 2. Prolonged labour pain for 5 days associated with swollen feet and hands, and urinary obstruction.
 3. Minor abdominal and back pain, prolonged labour pain for 11 hours, first baby.
 4. Mild fever for one month prior to delivery and prolonged labour pain for 3 days.
- In most cases senior family members, neighbours, and local community groups helped with arranging transport and money.

Case 1 came to Beni hospital from Ghara, Ward 8 in Sikha VDC. Second baby of 23 year old woman of joint Chhettri family (hospital interview).

- ◆ Decided to go to hospital after 4 days of labour pain, severe back pain, and cramp in the legs.
- ◆ Decision delayed because the villagers told her to take herbal medicines. The local health worker was not called because he lives far away and the family does not trust him.
- ◆ Decision to go to hospital was finally made in the morning by the husband and in-laws. The woman wished to go to hospital, but thought she could not tell her family.
- ◆ Arrangements for transport were started immediately after the decision. The family had a doko at home, which they first had to cut to prepare. It took quite a while to find a porter because their house is rather remote from the neighbours. They walked for more

than 6 hours, of which the pregnant woman walked one hour to make the delivery easier. After reaching Galeshwor they hired a reserved vehicle to go to the hospital. It was the daytime and they did not have any problem on the way.

- ◆ There were two checkpoints on the route, but security forces did not check due to health emergency and because they travelled in a reserved vehicle.
- ◆ Money was arranged at home. The husband works abroad and money was saved from the start of pregnancy.
- ◆ The doctor in the hospital was from their own village and they did not encounter any problem in admission and treatment. Due to this other staff also behaved properly and provided necessary services.

No conflict related delays, only delay in decision-making and long travel route.

Case 2 came from Rakhu, Bhagawati VDC, first to Beni hospital and from there referred to Baglung hospital (village interview).

- ◆ The woman stayed at home for three days of light and two days of severe labour pain. She had swollen hands and feet, and her urine was obstructed. Considering the severity of the case and prolonged labour pain, the community members and neighbours pressured the husband to take her to hospital.
- ◆ The local health assistant was consulted, who advised taking her to hospital, because he thought the baby was in breech.
- ◆ Money was the main problem; after the initial decision it took two hours before enough money was arranged to go to hospital. An older brother-in-law gave some money and neighbours collected donations due to the poor economic condition of the family. The husband is a construction labourer and does not have regular sources of income. Currently he did not have any job due to the conflict situation in the village.
- ◆ As the money collected from donations was not sufficient to cover the cost of transport and treatment, the husband took an additional NRs 5000 loan from a local businessman.
- ◆ It took another two hours to arrange doko to carry the delivering women. There was problem in finding people to carry her in doko because she was a Dalit and higher caste people would not carry her. Finally an elder brother-in-law agreed to carry her to the nearest road head at Galeshwor. They did not have enough money to hire a reserved jeep and it took some time to find a regular vehicle to Beni. In total the transport to Beni took two and half hours.
- ◆ They also took a regular vehicle from Beni to Baglung, which lasted another two hours.
- ◆ The security situation in the village and on the way did not cause delay, though there were at least three checkpoints before reaching Baglung hospital.
- ◆ There were no problems in admission and treatment in the Beni and Baglung hospitals. However, the behaviour of the mid-level health staff in Beni towards the patient was not good.

Conflict-related delays were not encountered during travel. The main problem was the financial situation of the family, which seemed even worse due to conflict.

Case 3 went to Beni hospital from Singha VDC Ward 6. This was the first baby of a 20 year old woman from a Chhettri family (village interview).

- ◆ The husband and mother-in-law had decided to go to hospital for the delivery already one month before, because it was her first baby, on advice of the TBA.
- ◆ The pregnant woman was having minor abdominal and back pain. She also had mild fever during the last month of pregnancy. The family was convinced that the fever was due to witchcraft (“bokshi”) and called the jhankri, but also had a check-up at the hospital in Beni.
- ◆ Labour pain started in the evening and they went to hospital next morning. Delay was not due to conflict, but simply because it was night and labour pains were not yet severe.
- ◆ The decision was quite fast, as the family had saved sufficient money (NRs 16,000) to cover the transport and treatment. The husband had won the Dhukuti 12,000 and the woman has her own shop. She is also president of the Emergency Fund that currently has 5000 NRs in reserve.
- ◆ It was half an hour walk to the road and from there they went in a relative’s vehicle to Beni hospital, a 45 minute drive. They were referred to Baglung for caesarean section.
- ◆ There is only one checkpoint to come to Beni, but they had no delay in travel.
- ◆ They had no problem in admission and treatment.

No conflict-related or any other problems.

Case 4 came from Singha VDC, Ward 6 to Beni hospital. First child of a 20 year old woman of a joint Chhettri family (village interview).

- ◆ She had labour pain for 11 hours, from 2 am till 1 pm, when they decided to go; a slightly prolonged labour.
- ◆ Local health workers suggested admitting the case to hospital.
- ◆ Initially both the pregnant woman and the family members were reluctant to go to hospital, as she preferred to deliver at home. The decision was delayed by three hours in all. The vehicle had already been engaged once, but sent off again.
- ◆ The mother-in-law decided to go to hospital for the delivery as advised, because it was her first baby.
- ◆ The family had financial problems, as the mother-in-law had only NRs 500 at home, which was not sufficient to cover the treatment cost. Later on they requested a 2000 NRs loan from the mothers group, of which the mother-in-law is a member.
- ◆ It was only ten minutes walk to the road, so the patient walked herself. They had to wait for about half hour to catch a regular public transport jeep coming from Tatopani. It takes about 45 minutes to reach Beni.
- ◆ There is only one checkpoint coming from Singha, and for a delivering woman they make no problems these days.
- ◆ They had no problem in admission and treatment at Beni hospital, as one of the nurses in the hospital was a relative of the family.

No conflict-related effect or delays were found in this case. The main issue in delay seemed to be the money.

Partners' Perspective: Myagdi

In Myagdi NSMP is implementing its different programme components through several partners. The following partners were interviewed to assess the possible impact of conflict in increasing access to essential obstetric care (EOC). NSMP had also implemented Safer Motherhood programmes in many VDCs directly, but in coordination with the District Public Health Office.

- Women Development Office (WDO)
- Local Development Fund Board/DDC (LDFB)
- District Health Office
- MILAN

Excerpts of these discussions with partners follow:

Through which community groups (for example Amaa Samuha) are they promoting safer motherhood with the population?

Two partners, LDFB and WDO, are working through their existing groups formed to promote savings and mobilizing those funds for productive credits. MILAN works with the Community Forestry User's Groups (CFUGs), integrating safer motherhood promotional activities with other existing activities.

Local Development Fund Board (LDFB) established its partnership with NSMP in 2001. The working modality of LDFB has a provision of covering 80% of the community. Hence it is easier to disseminate information to a larger section of people through their groups. Their groups are mixed, targeting households and not specifically women.

Women Development Office started its partnership with NSMP in 2001. WDO works through its existing economic groups, integrating a safer motherhood component in other regular activities.

MILAN is a fairly new partner and has yet to implement any activities related to promoting safer motherhood. The organization is attempting to integrate the safer motherhood component in two of ten VDCs covered by the Livelihood and Forestry Program (LFP).

Did the partners experience any problems in mobilising community groups and organising group meetings, as a result of the conflict situation?

LDFB admits that they have encountered some problems in organizing group meetings and mobilizing communities for their regular activities. The problems include difficulties in gathering people for safer motherhood activities, and recently expulsion of a street drama group disseminating safer motherhood messages by Maoists, in Babiyachaur. The partner has also changed the training venue due to destruction of the scheduled venue. Reduction in loan repayment rate was observed. Restriction in mobility both by Maoists and security forces especially in Babiyachaur was observed.

WDO claims they have not faced major conflict-related problems in mobilizing communities in the promotion of safer motherhood. Groups are functioning smoothly, loan repayment rates have not changed in most working areas except in Singa where the women's group are facing problem due to low repayment rate of loans specially due to conflict.

MILAN has planned several programmes for next year and is confident of implementing them without any conflict-related effect, as the present situation has improved.

The follow-up activities and regular programme monitoring have been severely affected in most working areas of all partners alike.

Were there delays in implementing group related activities, and to what extent was this caused by the conflict situation in the VDCs?

Many training programs, workshops, and other capacity building initiatives either have been cancelled, postponed or changed in venue. The regular Chairman Manager Convention (CMC), a regular meeting of group representatives of LDFB, have been affected specially due to fear. As a result two CMC meetings were cancelled during the emergency period.

WDO mentioned that there was no delay in the implementing group related activities.

Were any field-staff of the partner organisation based in the working VDCs?

LDFB has its motivators in each VDC, sometimes combining two smaller VDCs with only few groups under one field worker. In the present situation, the motivator working in Babiyaichaur and Singha VDCs is not placed in the VDC, but makes regular field visits.

The WDO field staff have been withdrawn from the field offices and are making field visits. However, the frequency of field visits has been limited, due to fear and rumour of conflict.

DHO confirmed withdrawal of several health post staff from affected areas. However, none of the health post staff from four VDCs under study have been withdrawn. In all four VDCs selected for study, the health post staff are placed and are attending the office. In most cases the staff are local.

MILAN has placed one animator each in working VDCs under the Livelihood and Forestry Program. All the ten animators are working in the VDC and most of them are local.

Has the number of field visits for support and monitoring by higher district-level (not field based) partner staff been reduced due to fear created by the conflict?

Field visits of the higher staff of all partners have been reduced drastically due to conflict. As a result they are less able to provide support and on-site coaching to the field level staff and groups they are working with. The causes for this are pressure from both Maoists and the army, as well as rumours.

Was there a reduction in supervision / monitoring of community-group meetings, and does this affect efficacy in dispersing the Safer Motherhood messages?

With many community groups suspended or dissolved due to problems convening meetings and pressure by the security forces as well as the Maoists, the functionality of these groups in promoting safer motherhood messages has decreased. However, in some cases with more or less motivation by partner staff, individual group leaders are still actively promoting safer motherhood on a more personal level in their immediate neighbourhoods.

LDFB staff attends regular monthly CMC meetings and also visits the groups regularly in the less effected areas. But the field visits in the highly affected areas have become irregular. Frequency of field visits in the less affected areas has also been limited.

According to the WDO staff they are making regular field visits and are supporting the groups in implementing the safer motherhood promotional activities without any problems.

Since MILAN staff are placed locally it is expected that they would be able to provide regular supervision and inputs to the group leaders.

Did the partners experience any problems while implementing activities, like dissemination of information and messages on safer motherhood to the communities, as planned? Did they adapt planning to the conflict situation by changing, reducing, rescheduling, or eliminating activities?

Partners were not able to implement all other activities as planned. Rescheduling, change in venue of trainings and workshops, and change of approach are common conflict-coping strategies adopted by partners.

LDFB stopped working directly with the community and started meeting only leaders in the CMC meeting as part of change in approach. LDFB feels that they have lost direct contact with the communities but have developed strong relationships with the leaders. It is easy for them to work but there are chances of people's voices not being heard while planning programmes that should benefit people.

MILAN has not yet made any significant change in approach except changing venue and rescheduling, which had no direct impact on effectiveness of the programme. However, change of venue might incur additional cost.

Are communities open and interested for the Safer Motherhood programme, or do they express any other priorities?

Communities have demonstrated a great deal of interest in the Safer Motherhood programme. As a result, the community groups (like the economic groups being promoted by LDFB and WDO), as well as community forestry groups, are taking initiatives to establish Emergency Funds for delivering and pregnant women. In a few cases community forestry groups, local community based organizations, and local teachers have made financial contributions to the emergency fund.

ANNEX: I SURKHET DISTRICT ANALYSIS

Analysis Surkhet

The four Village Development Committees (VDCs) investigated in Surkhet district were Chhinchu, Jarbuta, Dashrathpur, and Kunathari. The impact of the conflict on accessibility of health facilities in the district is analysed on the basis of the qualitative information received from respondents interviewed in these four VDCs. The situation is described for three different stages of the conflict - pre-emergency, before ceasefire, and current. For each topic general remarks are followed by discussions of conflict-related issues, starting from least affected situations and culminating in impacts found in the worst affected areas.

General Impression

The conflict's effect on the general village security situation and the accessibility of health facilities could be rated as follows: Chhinchu, limited; Jarbuta moderately affected; and Dashrathpur and Kunathari, worst affected. Before ceasefire, Maoists' local governing bodies called Jan Sarkar were formed in all four VDCs, identifying them as highly affected by the conflict. However, the general situation of all VDCs except Kunathari is relaxed since the ceasefire. Kunathari and Dashrathpur were most affected before ceasefire, and the effects of fear and distrust are still visible there. Jarbuta was moderately affected, and Chhinchu (relatively near the road) was only affected in a limited way.

There is lack of trust among people at all levels. People fear strangers, and therefore it is difficult to obtain information from them, as they do not want to talk due to fear.

Local health workers and partner NGO staff suggested the study team not visit the remoter areas of Kunathari VDC due to security reasons. Most respondents were invited to the main bazaar areas. Only one other area was visited to meet respondents at an outreach clinic. During the visit several red flags and Maoist banners were seen in the village. In other VDCs the team's interviewers ventured out to more remote areas in different wards. In these VDCs people also were not very willing to talk openly about their problems with security forces or Maoists, especially in Jarbuta and Dashrathpur. People in Kunathari were more confident than others. Many respondents made the statement, "If there are Maoists in Kunathari we all are Maoists; if not no one is Maoist".

Upon arriving in the main bazaar of Kunathari, the study team encountered the Maoist's local area commander and had to explain the objectives and process of the study to him. He allowed the interviews, but requested that we add an extra question regarding the people's dissatisfaction towards Maoist activities in the past. The question was added and at the end of the field visit a generalised list of dissatisfactions was given to the Maoists for their consideration.

The local MCHW, who was one of the respondents, revealed that the Maoist commander encountered by the team had stayed at her house the night before. As she had received prior information of study team's visit to Kunathari and she still had to inform mothers group members and other respondents, she told him everything about the study to get his approval for her work before leaving her house.

Security

Before emergency

- Maoist activity had started long before emergency and two years ago people were scared of demands and punishments from the Maoist side. However, people were free to move without fear anywhere within and outside their villages.

Security features during conflict

- After emergency, curfew was imposed in the market areas of Chhinchu, Dashrathpur, and Kunathari. General curfew hours were from 7 pm till 5 or 6 am.
- Curfew also affected the movement of local people in remoter villages due to fear.
- People in Jarbuta, where no official curfew was imposed, would lock themselves in their houses after dark.
- There is a road curfew in Chhinchu bazaar, and during emergency vehicles were not allowed to pass the checkpoint between 6 pm and 6 am.
- Particularly in Jarbuta and Dashrathpur, where security forces and Maoists moved regularly in and out, people got squeezed between the conflicting parties.
- Maoists demanded that people provide donations, food, and shelter.
- Security forces would patrol and check houses for Maoist presence or support. People, especially men, would face fierce interrogation and beating.
- In Kunathari, the team observed a number of houses of poor families blasted by the army, which charged the owners either with being Maoists or with feeding and sheltering them.
- Punishment by Maoists upon refusal to support them could be monetary fine, people's action, or even death.
- There were also rumours of Maoists' kidnapping young people to join their militia.
- Both in Dashrathpur and Kunathari dry cells of batteries, packets of instant noodles, beaten rice, and magazines were not allowed to be sold, or brought in from outside. Nowadays this has been relaxed, but still the businesspeople need to get special permission from district administration to bring those commodities in bulk. At least one respondent in Dashrathpur said that she was not able to listen to the radio programme, as the batteries were not available.
- People were not allowed to move in small groups in Kunathari.
- Night curfew was also imposed in remote areas of Kunathari VDC.
- Torchlights were not allowed to be used at night in Kunathari.

Infrastructure and communication

- The security forces have disconnected telephone lines in Jarbuta, Dashrathpur, and Kunathari, to cut down on Maoist communication. The telephone lines in Chhinchu are functional.
- During the emergency and before ceasefire, Maoists destroyed physical infrastructure like VDC buildings in all four VDCs. Health posts were spared, except from Jarbuta Ward no 4, where an outreach clinic room was inside the VDC building.

Effect on health workers

- Due to night curfews and fear it was difficult to call health workers at night in all four VDCs. Even now it is difficult to get health workers to respond to night calls for home visits.
- Health workers are reluctant to move at night and ask people to bring patients to their residences for treatment.
- In Chinchu and Jarbuta the health workers claim that they are attending home visits at night, which was not confirmed by the people.
- In Kunathari and Dashrathpur health workers do not attend home visits at nights.

Attitude of security forces towards obstetric care

- Many respondents, especially the partners, said that army in Surkhet allows transportation of pregnant women for delivery during curfew if they receive prior information.
- In most VDCs people face difficulties in informing security forces due to lack of telephone lines.
- In areas with frequent patrols, people are afraid to meet the security forces en route, even before reaching a checkpoint.

After ceasefire

- After declaration of ceasefire curfew measures have relaxed.
- In Birendranagar bazaar, curfew is now from 8:30 pm till 4 am, while before it was from 7 pm till 5 am.
- Even though curfews are now shorter, people do not have the confidence or courage to move after dark in main market areas.
- Since ceasefire the roadblocks are still in effect, and vehicles cannot move after 6:30 pm. Returning from Dashrathpur the study team got delayed because the car broke in the middle of jungle. When they reached Chhinchu they had to plead with the army for permission to drive back to Birendranagar town. They were allowed to pass through only after extensive checking of everybody's identity cards and other belongings.
- Current rumour in Birendranagar is that even after ceasefire, Maoists are restricting NGO, INGO, and project workers from implementing their programmes in the westernmost VDCs of Surkhet district. However, the study team has observed a fair number of blue plated project vehicles moving up to Babiyachaur, which is beyond Kunathari and considered to be most affected area.

The following cases of delays due to the security situation were related by the villagers:

- In Dashrathpur, a delivering woman was trapped in a crossfire between the army and Maoists. She was lucky to survive after hiding herself, but her arrival at hospital was delayed by three hours. Under normal circumstances it takes only one hour by bus or three hours on a stretcher to reach Chhinchu.
- One pregnant woman could not be administered anti-rabies vaccine due to Nepal Bandha. She died later of rabies in Kunathari.
- One delivering woman coming to hospital from Taranga was detained by the police at the checkpoint for 15 minutes, and the attending husband was not allowed to accompany her for more than one hour.

- One delivering woman was carried on a stretcher to Birendranagar from Kunathari during Nepal Bandha, which took 10 hours. In normal circumstances it is three hours drive in a bus.

The general fear expressed by many people can be explained by the following examples of incidents of violence.

Chhinchu:

- Two policemen and one civilian were killed by Maoists.

Jarbuta:

- Army personnel searched the villages house by house, marking each checked house, and charging people with supporting Maoists, beat up all the male family members during a regular search campaign.
- One man and one woman were killed by security forces.
- One Dalit man got killed by Maoists.

Dashrathpur:

- The army severely beat one young boy, who was seriously injured and is undergoing treatment in Surkhet hospital.
- The army killed one pregnant woman after someone informed on her as a Maoist.
- One man was killed by Maoists.

Kunathari:

- A group of 18 people carrying a delivering woman encountered an army patrol. The local MCHW took them into her house, and hid them in a cold room for the entire night. This resulted in a stillbirth of the baby.
- Maoists have burnt the agriculture service centre, resulting in scarcity of necessary seeds for the farmers.
- One mentally handicapped person was killed by the security forces.

Migration/Displacement

Normal migration

- There has been a tradition of labour migration from Surkhet.
- Poor families from Chhinchu and Dashrathpur tended to have male family members migrating to India.
- From Jarbuta many families have relatives in the army or police force.

Conflict-related migration

- People from other heavily affected VDCs are coming to Chhinchu bazaar for their own safety.

- Trends of economic migration have been slightly increased during the conflict situation, particularly in Dasharathpur.
- Few better-off people are left in the villages, as they have migrated and live in Kathmandu or district headquarters depending on their economic situations.
- A number of students in Dasarathpur attending SLC examination left the village to stay elsewhere for safe and quiet study, due to fear of being kidnapped by Maoists.
- Many men have been displaced due to fear of donations, kidnapping, and fierce interrogation in Kunathari and Dashrathpur.
- After the ceasefire, such migrants tended to return.
- In Kunathari, political leaders have left the village due to fear of both security forces and Maoists.
- Most of the young people either joined Maoists or left the village, especially in Ward no 1 of Kunathari VDC, which is in a remote area.

Impact of migration

- It has become more difficult for poor people to find loans, as many businesses have closed and fewer moneylenders are around, especially in Kunathari.

Economic Barriers

Employment

- Conflict has significantly reduced the employment and income opportunities in the communities, reinforcing poverty.
- Government is no longer undertaking construction of physical infrastructure due to security reasons and thus has reduced employment, particularly for part-time construction labours (Dashrathpur and Chhinchu).
- In Dasharathpur employment opportunities in the government agriculture research centre have been limited, as the centre has reduced its activities compared to previous years, due to the conflict.

Reduced cash

- Cash flows in the communities have been significantly reduced because trading opportunities have been limited (Chhinchu, Kunathari, Dashrathpur).
- Agricultural marketplaces have been closed, which directly affects small farmers who make their living by selling their vegetable and other products in the market.
- Demand for agricultural products like vegetables, milk, and meat has been drastically reduced, because most outside people working in the villages have left due to closure of offices—either due to security reasons or because Maoists destroyed them, particularly in Dasharathpur. Apart from limiting sales, this has also decreased the market price for these products.
- In Kunathari the local rice mill and hotels have closed.
- People are going to Birendranagar to purchase daily commodities.

- Although market prices for local products have decreased, farmers have to pay more to purchase commodities of daily needs, because many shops have closed and supply reduced.

Reduction in loan availability

- Since the banks have shifted their operations from Kunathari and Dashrathpur to district headquarters, even richer people have problems withdrawing money at times of emergency.
- The willingness of richer people to lend money for treatment has been reduced drastically in all four VDCs, due to the fear that poor people could not repay their loans as they are losing income opportunities and employment.

Impact on project intervention: Emergency funds

- There are Emergency Funds within many Ama Samuhas in all VDCs. Significant amounts have been previously deposited in Emergency Funds.
- During conflict many problems in fund mobilization and repayment were seen.
- A reduction in loan repayment rate has been observed. However, some people are also using conflict as an excuse not to repay loans.
- People are using conflict as an excuse to quit the group after borrowing.
- In some groups in Jarbuta and Kunathari, problems with repayment were such that many people left the groups.
- In Chhinchu a fund was looted and closed down till ceasefire.
- In Dashrathpur Maoists do not allow group gathering and fund raising. Some groups try to continue secretly.

Transport Barriers

General transport setting

- Chhinchu bazaar is a one-hour bus drive over the main road from Surkhet. Some remoter parts are connected by dirt road, but mostly people must walk to the road. There are two checkpoints before reaching the hospital, one before leaving Chhinchu bazaar, and another when reaching Birendranagar. The road is under night curfew.
- A dirt road leading from Chhinchu to Ramghat takes about half an hour. From Ramghat there were two buses leaving early morning, but due to the conflict this has been reduced to only one. Dashrathpur bazaar is on the other side of the river from Ramghat, and can be reached in a 20 minute walk. Total travelling time from Dashrathpur to Birendranagar hospital is about two hours. However, the remoter parts of the VDC that were previously connected by a more direct road to Birendranagar now closed by the security forces, are 3 to 4 hours further.
- Jarbuta Wards 2 to 4 are connected to Birendranagar by dirt road, which takes about one hour to drive. Nowadays cars do not come to the village, because of the conflict. A short-cut walking path leads to the hospital in little over an hour. After three quarters of an hour you reach a road and there are houses with phones. There is no checkpoint on the route.

- From Jarbuta Ward 7 there is a steep path that passes an army camp, it takes about 2 hours to walk from the village to hospital. Travel at night is impossible, as people do not dare to pass the army camp.
- Kunathari is a 3½ hour drive by bus over a seasonal dirt road. Bus service to Birendranagar passes three times a day at 11 am, 1 pm, and 2 pm. This was not reduced during emergency. There are two checkpoints on the route to the hospital, one at Bangasal and another near the Radio Nepal office.

Specific impacts of the conflict on transport

- There is an ambulance in Birendranagar that could provide service to all four VDCs, but many people in the VDCs do not know about it. Due to lack of telephone facilities, people from Kunathari, Dasahrathpur, and Jarbuta cannot call the ambulance. The ambulance does not dare come to Jarbuta due to the security situation, whereas normally it used to come even at night.
From remote parts of Jarbuta it is difficult to find people to carry sick persons or pregnant women to hospital at night, primarily due to fear.
- During emergency, security forces seized doko from households in Kunathari and Dashrathpur.

Impact on project interventions

- Most Ama Samuha in all VDCs have made a provision for local transport schemes like doko and dola.
- In Dasharathpur, Kunathari, and Chinchu many groups also have a stretcher. Stretchers are provided free of cost to delivering women, but a nominal rent is charged to other patients.
- The army retained a stretcher at the checkpoint upon return from hospital to Kunathari.

Health Services

Impact on service availability

- Even during emergency, most health personnel were in place at the health centres and health posts.
- The two main causes of the health personnel's regular attendance to their duties are that most of them are local residents and fear the Maoists should they leave. The few health workers who have left are using the conflict as an excuse.
- Outreach clinics in Kunathari and Jarbuta are functioning except for one destroyed examination room in Ward 4. VHWs have no problem moving from one village to other to operate outreach clinics.
- None of the health workers interviewed were threatened either by army or Maoists.
- Nevertheless, conflict has had some clear impact on service availability in Surkhet.
- In Jarbuta, health post staff come less frequently, because they do not live near the health post and do not like the daily travel in conflict-affected areas. However, the VHW is still executing outreach clinics in the villages.

- A hospital delivery case explained that in Salkot, a remote VDC, most health workers have left after an argument between the ANM and the Maoists over a monthly levy on their salary. Only two staff currently stay in the village.
- Due to restricted mobility caused by the conflict, neighbours, TBAs, and MCHWs are more hesitant to refer patients to hospital at night.
- The FCHV in Dashrathpur lives in the village and though she does not walk far at night, she will come to neighbours.
- The MCHW from Kunathari does not go out at night, but does attend night calls at her home.

Perception of health services by communities

- In general people have positive attitudes towards the health services.
- The MCHW's service has been well appreciated by people in Kunathari.
- People do not like the behaviour of the health post personnel in Dashrathpur and Jarbuta.
- People from the lower wards in Jarbuta go to Birendranagar hospital, because it is nearer than the HP and provides better services.
- The MCHW in Chhinchu seems to ask first whether people will pay her, before she comes for home visits.
- Staff of Dashrathpur are said to restrict medicines to people, even when they are available at the HP.

Medicine supplies

- Some health posts do have problems obtaining supplies of medicines and other equipment, due to security restrictions.
- Private medical shops are hassled by security forces in getting medicine supplies.
- After emergency security forces closed one medical shop in Dashrathpur and one in Kunathari, preventing the extension of their licences, charging them with treating Maoists.
- It is more difficult to run the health posts. As the VDCs are not functioning, there is no decision making. The dissolution of the local bodes is an indirect effect of the conflict.

Decision-making

- In general the conflict has had minimal effect on decision-making power and process.
- Mothers-in-law usually make all crucial decisions in consultation with senior male members of the family.
- For money matters, the male family members have the main decision power.
- In absence of the senior males, families seek advice from their closest male members or neighbouring males to make decisions regarding hospitalisation.
- Some male respondents involved in arranging transport and finance revealed that decision making in such crucial moments is influenced by the advice of neighbours, experienced family members, and health workers.
- Knowledgeable persons who suggest decisions will be supported by public opinion of neighbours and other villagers.
- At night-time the gathering of these types of consultation groups is restricted, partly due to conflict.

Knowledge of Danger Signs

- Almost all FCHVs had relatively good knowledge of danger signs. They could name the most important signs, though they could not differentiate among pregnancy, delivery, and post-delivery.
- About half of the home-delivery respondents had some knowledge of danger signs, naming two or three. In general the delivered women had less understanding than their senior family members.
- Two out of eight pregnant cases had some vague knowledge of danger signs.
- Most male members of the family had little knowledge of danger signs.
- People from low economic conditions and Dalits had less knowledge of danger signs than other respondents.
- Members of the mothers groups and other groups disseminating safer motherhood knowledge had relatively more knowledge than other women.
- In general respondents from Chhinchu and Kunathari had better knowledge than respondents from other VDCs.
- Respondents in Chhinchu said that they are having regular inputs from the field staff and from radio programmes.
- A few respondents said they were members of a mothers group, but that they do not discuss safer motherhood issues.

Impact of Conflict on Project Interventions

Group meetings

- Conflict-related problems in mothers group meetings are probably affecting the dissemination of knowledge through these groups.

Radio

- Many of the people interviewed in Surkhet were not aware of the radio programme “Amaa”.
- A number of FCHVs did listen to the radio programme “Amaa” and think it is useful to the group members.
- Half of the families had no radio at home, and did not listen to any programme.
- One respondent mentioned she does not have decision power to listen to programmes she might like.
- People who do listen to “Amaa” sometimes have limited understanding of the content, or find it difficult to remember the messages afterwards.
- Some people mention they cannot listen to the radio because they do not dare to listen to the radio after dark/curfew (Jarbuta and Chhinchu).
- Some people mention they cannot listen to the radio because batteries are not allowed in the area (Kunathari and Dasharathpur).

NFE classes

- In Kunathari the new NFE book has not yet arrived and NFE classes have been postponed.
- Most respondents mentioned there were currently no NFE classes in their village; they were not sure if this was conflict induced.

FCHV Functioning (8 Interviews)

FCHV supervision and guidance

- Generally, in all four VDCs, support to and supervision of the FCHVs has been reduced due to restriction in field visits of partner staff caused by conflict, fear, and rumours.
- Chhinchu and Dashrathpur have more support than Kunathari and Jarbuta.
- Workshops and other inputs have been limited, especially after emergency.
- Promotional literature was not allowed either by army or by Maoists in Kunathari.
- FCHVs do not use the radio programme “Amaa” to discuss safer motherhood matters in the mothers groups.

Mobility

- FCHVs in Jarbuta, Chhinchu, and remote parts of other VDCs claim that they are able to move within their own village even at night.
- Night movements within their own village is not possible even after ceasefire, especially in Kunathari and Dasharathpur market areas.
- Dashrathpur residents had to limit their movement within the village even during the day.

Mothers group functioning

- FCHVs feel that coverage of mothers groups needs to expand to cover more pregnant and delivering women. At least half of the pregnant and delivering respondents were not members of the groups. In many cases only the mothers-in-law, who are neither pregnant nor delivering, are members.
- Mothers groups led by FCHVs were having difficulties in convening meetings due to fear of both army and Maoists. Groups are gradually reviving after ceasefire.
- One mothers group in Chhinchu was looted and stopped meeting after that incident.
- Some mothers groups in Jarbuta are meeting less frequently due to problems with repayment.
- Other women's groups in Jarbuta are still functional.
- In some cases groups of wives of security personnel caused closure of the mothers groups, particularly in Kunathari.
- FCHVs felt that some groups in Kunathari were dissolved due to internal problems, but that the conflict was used as an excuse.
- Due to security reasons husbands do not allow wives to attend the group (Kunathari).
- Maoists have forbidden meetings in Dashrathpur. Also, the security forces do not approve of group gatherings.

Emergency funds

- FCHVs have their own perceptions of Ama Samuha, Emergency Fund, and transport scheme.
- Most FCHVs know about the Emergency Fund in all VDCs.
- Many groups in most VDCs have formed a clear policy of interest-free loans for delivery but with interest of 5% per month to other health emergencies.
- Looting and problems with repayment have caused problems in the management of the Emergency Funds.
- In Jarbuta one group has banked the fund money in Birendranagar to prevent looting. In case of emergency they borrow money from villagers, who are assured of repayment with an Emergency Fund cheque.

Pregnant Women and their Families (8 Cases)

Antenatal care

- Less than half of the cases went irregularly for ANC at the local health post; others didn't go at all. Some obstructions like embarrassment (laaj), distance of the health posts, and lack of free time were found.
- ANC visits were not affected by conflict in any of the four VDCs.
- Some people go to local TBAs. Most pregnant women seek advice from senior and experienced female family members or neighbours.
- Health workers mostly gave advice concerning diet and rest during pregnancy, not about danger signs or other safer motherhood issues.

Note that all three cases that experienced problems during the current pregnancy went for medical check-ups.

- One case is experiencing continuous abdominal pain and headache.
- One case had continuous severe low back pain.
- One case had weakness and dizziness in the first trimester and did not go for check-up.

Delivery

- In principle people prefer home deliveries. All families say they will bring the delivery to hospital only in case of problems.
- Few respondents - both pregnant women and their families- excuse not going to hospital on the basis of previous successful home births.
- One family said explicitly they could use such money better for their food and household expenses, than for a hospital delivery.

Emergency preparations

- In case of problems during delivery first people will call neighbours, then health workers, and after referral go to hospital.
- Money and transport are only arranged at that very moment. (Three families made arrangements to have some financial reserves for the delivery. These families all had some kind of regular income.)
- Most respondents state that money would not be barrier to go to hospital. It will be arranged with the help of neighbours, Emergency Fund, or moneylenders.
- Most respondents feel that it would not be difficult to arrange transport at the time of emergency.

Home delivery cases (delivered women and family respondents)

- Among ten home delivery cases interviewed, six interviews were with the delivering women and four with the families.
- The youngest delivering woman among the respondents in Surkhet was 19 and the oldest 30. The average age of delivering women was 22.5 years.
- Only one case was having a first baby. Four cases were second pregnancies, two cases third, and three cases fourth.

Antenatal care

- Only half of the home delivery cases went for ANC check-up, mostly at the health post with MCHW or ANM. Some cases mentioned they were afraid to go (laaj).
- The following problems were visible among these cases.
- There was some bleeding during pregnancy - no treatment.
- For two months she could not sleep, had stomach pain, and painful feet - no treatment.

Home deliveries and some of the problems

- Most cases did not consider going to hospital previous to the delivery. They would go only in case of emergency.
- Two cases did not deliver in hospital, though they had been advised to, due to economic circumstances. One of these cases was very young (17), and it was her first baby. The family would have gone to stay in Dhangadi in the last month of pregnancy, but they did not have enough money, or family in town to stay with. The other case only called the MCHW and got treatment from her.
- Most women had family attendants, and some also TBA or qualified MCHW during the delivery. Only one woman delivered her baby alone.
 - She delivered on her own because she was angry with the other villagers and did not want to call for their help. Her husband is away.
 - In a number of cases, no medical help was called, notwithstanding the existence of obvious danger signs. This was not related to the security situation.
 - There was quite a lot of bleeding during and after delivery, but according to the mother-in-law it was not necessary to go to hospital.
 - Only half an hour labour, but the placenta was retained for 1 hour. Did not call for help.

- 5 days of labour pain.
- Long labour (exact number of hours unspecified), but while discussing the situation with neighbours, the baby was born. Mother had two days of diarrhoea after delivery.
 - However, most cases did call for qualified assistance when problems arose. In one case there was a delay in calling assistance, because of night curfew.
- Labour pain for 2 days and bleeding before delivery, the MCHW was called to attend the case. Economic situation of the family led them to decide not to go to hospital.
- Born after 4 days of light labour pains. She could notice the child stop moving and wanted to call the MCHV (a relative) or go to hospital, but it was curfew, so the MCHW could come only next morning. The baby was born naturally and safely.
- Baby was born after five hours of labour, but was abnormal with an open skull and died one day later. FCHV came to have a look after delivery and advised taking the baby to hospital, but it died.
- 12-13 hours of labour pains; the MCHW was called and then it was not necessary to go to hospital.
- 22 hours of beginning labour and one hour strong labour. Called TBA to attend the delivery and MCHW when it became difficult.

Emergency preparations

- One husband did make arrangements for money for the delivery; other families were unprepared.
- Most delivering women and their families were not members of the Emergency Fund.
- Two of them expressed they would not be able to access the fund even though they knew of its existence.

Conclusion

- Conflict was not a strong barrier to call for qualified assistance or take the cases to the hospital, except for one case where night curfew caused a further delay in calling help for an already prolonged labour.
- A few cases indicated they would have been reluctant to go to hospital due to the conflict situation, but that in an emergency it would have been arranged.
- Financial barriers were found to be much stronger in limiting peoples care seeking behaviour.

Treatment Managers' Experiences (8 Cases)

- In the villages of Surkhet district five cases were interviewed that had actually gone to hospital. One other interviewed case went to the PHC and two others called a health worker at home. These eight cases are presented in numbered order.
- In these areas the more difficult delivery cases tend to be sent to hospital, at least if they can get advice from either a TBA or FCHV.
- The obstructions experienced mainly related to normal transport and economic barriers, but some were related to night curfew and lack of transport due to the conflict.

Reasons for seeking health worker's support

1. Caesarean case in hospital, as advised by the TBA because of long labour (Ch).
2. Was advised by neighbours and TBA, because of long labour (D).
3. Retained placenta for whole night, a TBA was called around 2 pm, who sent them to hospital (Ch).
4. Labour for more than 12 hours, the MCHW was called (K).
5. Labour for more than 24 hours, TBA was asked for advice (D).
6. Day-long labour with bleeding; decision was taken immediately after the labouring woman told about her condition, which she had hidden for a whole day (J).
7. Labour for more than a day; an FCHV was called at 8 pm, and she advised going to hospital. The decision was finally taken at 5 am, due to the curfew at night (J).
8. Labour for more than 12 hours; a TBA was asked for advice, and then she was taken to the MCHW (K).

Transport problems

1. No problems in calling the TBA, but transport to hospital was delayed due to unavailability of public transport at night. There is no phone to call any transportation at night. In the morning she walked supported by others from the village to the main road. A khatia or charpai was not necessary as the road is nearby. Then they had to wait some time for the regular bus.
2. There was a landslide on the road and there was no vehicle available, so they carried her with a charpai to the health centre.
3. Two people carried her to the road by charpai, which took about 15 minutes. Then they had to wait about 30 minutes for the bus. By bus it took about 1½ hours to reach the hospital.
4. It was not a problem to call the MCHW, as there is no curfew.
5. The delivering woman was carried by khatia to the road. The khatia was at the mothers group. From the main road it took 1½ hours by bus. It took about 45 minutes to arrange for people to carry the woman.
6. It took about 3 hours to arrange the people for carrying and to borrow money. She was carried half way on a stretcher, from which point she could take a vehicle. In total it took 45 minutes to reach hospital.
7. It took 4 hours to arrange the transport. She was carried about half an hour by stretcher till there was transport. From there she went by vehicle. It took 2 hours to reach the hospital after the final decision was made.
8. It took about 2 or 3 hours to reach the MCHW.

Economic barriers

1. No problems; arranged money from own resources and emergency fund loan.
2. There was no money available for transport, so they delayed making a decision. They had to take a loan, but there will be problems repaying it.
3. Grandfather arranged for a loan after taking the delivering woman to hospital.
4. No special money was needed, as the delivery took place at home.
5. They took a loan from family members; no money was arranged in advance.
6. The father-in-law borrowed about 6000 NRs from neighbours, which he will repay in about two years from agricultural produce. Recently there is no Emergency Fund in the village.
7. Borrowed about 3000 NRs, which will be repaid by the tailoring job.
8. Expenses with the MCHW were reasonable, so no problems arranging the money.

Security and conflict-related barriers

1. No problems, even at the two checkpoints.
2. No difficulties in this case. Another case had her brother taken into custody when he brought her to hospital.
3. Though one can visit from one house to another during curfew, they did not call the TBA during the night. The checkpoint took only 10-15 minutes.
4. No problems; delivery was during daytime.
5. No problems; could have gone to the health post at night as it is nearby. Waited for ½ an hour at two army checkpoints.
6. No problem, as it was daytime. No checkpoints.
7. Decision was delayed at night-time due to curfew. There are no checkpoints on the road to the hospital.
8. No problem.

Hospital Delivery Case Studies (4 Cases)

In Surkhet district four hospital cases were interviewed, all at hospital.

- Three cases were taken to hospital due serious problems during delivery.
- One case came mainly for reasons of safety and comfort.
- In most cases senior family members and neighbours helped arrange transport and money.

Case 1 came to Surkhet hospital from Itram in Birendranagar municipality. She is a 32 year old Thakuri woman having her fourth baby.

- ◆ The delivering women knew some of the danger signs during pregnancy and delivery from a radio programme, but she had no symptoms of danger signs.
- ◆ She had regular ANC check-ups at hospital during her pregnancy.
- ◆ It was the normal delivery. After having labour pain since the previous day, the family, particularly the husband, decided to go to hospital during daytime. The family had trust and confidence in the delivery and treatment in hospital.
- ◆ Since Itram is not very far, the delivering women walked to the hospital. Other means of transport like stretcher and vehicle were not necessary.
- ◆ The family had previously arranged money from their own income to cover the cost of treatment.
- ◆ There was no checkpoint on the way to hospital and no problem related to the security situation. The woman came to hospital at daytime, but she knew that one could seek permission of the security forces to come at night or during curfew.
- ◆ Since the woman had previous contact with the doctor during ANC, she had no problem in admission and treatment at hospital.

No conflict-related delays were found in this case.

Case 2 came to Surkhet from Taranga VDC. She is a 22 year old Thakuri woman having her second pregnancy. Her first baby was a miscarriage in the fifth month, and this baby also came too early in the eighth month and died.

- ◆ After prolonged labour pain for three days the husband took her to hospital.
- ◆ She did not have prior consultation with health workers or any ANC, as the health workers and health post are far (2 hours) from her house.
- ◆ Three or four young men carried her to hospital in a doko. The neighbours and relatives helped in preparing the doko, which they had in their own home. The trail was difficult going, and they walked from 8 am to 5 pm to reach hospital.
- ◆ On the way to hospital they were scared of both police and Maoists. They were also afraid that Maoists might loot the money they had borrowed.
- ◆ The money to cover the treatment and transport cost was arranged one day before coming to the hospital by taking loans from relatives and a neighbour at 4% per month. There was no Emergency Fund in the community.
- ◆ The woman needs prolonged post-delivery treatment, as her legs are paralysed and she could not contain her urine flow for 7 days, so tremendous costs have accumulated. They have no family to stay with in Birendranagar so food and lodging are expensive, and during the first days five relatives were taking care of the patient. The family will have problems repaying the loan from subsistence farming. The husband used to work as a labour migrant in India and is considering going back to earn additional income.
- ◆ There was one checkpoint on the way to the hospital at Bangasal, and they were detained 15 minutes. The accompanying husband was detained for about one hour and could not go to the hospital together with his wife.
- ◆ The family had no problem in admission to hospital and treatment, even though they did not know anyone in Birendranagar.

The main delays in seeking and reaching obstetric care were financial and knowledge related. However there was a slight delay due to conflict, caused by the detention of the couple at the checkpoint entering Birendranagar.

Case 3 came to Surkhet from Lekhparajul. The woman is about 24 years old and this is her second baby.

- ◆ After labour pain for two days the husband decided around 5 am to take her to hospital.
- ◆ She did not have prior consultations with health workers, because the health workers and health post are far (one hour) from her house and in the wrong direction for going to hospital. (She went for ANC in Chhinchu.)
- ◆ They had a doko at home and it took the family only 5 minutes to cut it into shape for her, but they did not start doing this until half an hour after deciding to go.
- ◆ The trail is not easy and it took about one hour to reach the nearest road at Chhinchu to catch the bus. They had to wait for one hour to get a bus and then it was about one hour to reach Birendranagar bus-park. They had to walk another 15 minutes to reach the hospital.
- ◆ The family knew that there is an ambulance in Birendranager but it takes ½ hour to walk to the nearest phone, so they decided to carry her directly to the nearest road to catch the bus to hospital.
- ◆ The father-in-law had put some money aside, and the delivering woman had saved some money herself. The rest of the money was arranged by borrowing from relatives, after the decision to go to hospital was taken. The family guessed they might need 12,000 NRs, but the actual costs of this caesarean section were only 10,000 NRs. There was no Emergency Fund in the community, but it was not difficult to arrange the

money. Since the husband is a teacher there will be no problem in repaying the loan, which might take about one year.

- ◆ There was one checkpoint on the way to Chhinchu, but the checking was completed in 5 minutes, as there were only a few people.
- ◆ There were no problems at admission. The baby was delivered safely by caesarean section.

Apart from the sheer distance from her home village to hospital and the transport delays this created, no delays were incurred after the decision to go to hospital was taken.

- The delivering woman knew some of the danger signs during pregnancy and delivery from the radio (not the “Amaa” programme). She herself was not a member of the local mothers group, but her mother-in-law was.

Case 4 came from Salkot Ward no. 8 to Surkhet district hospital. She was a 21 year old Magar woman and already had one son.

- ◆ After 5 days of labour pain she was referred to hospital by the FCHV and AHW, who already suspected a stillbirth.
- ◆ The decision was delayed over money issues. Though they made up their mind to go at noon, they missed the 1 o'clock bus, because they were still arranging the loan.
- ◆ There is a mothers group in the village and the delivering woman is a member, but she could not access the Emergency Fund, because the day before someone else had taken a 10,000 NRs loan, depleting the fund. Therefore they had to arrange a loan with someone else in the village: 10,000 NRs at 2% per month.
- ◆ The economic situation of the family is not such that money would be a restriction on going to hospital. The husband is a carpenter and works in construction; also other family members earn income.
- ◆ The patient was taken to the nearest road on a charpai (rope-bed), which took 15 minutes, to catch the first bus at 9 am next day. Eight friends and the FCHV helped carry her to the road. By bus it took 3.5 hours to reach Birendranagar. The road is seasonal and walking to town would have taken a full day.
- ◆ There are two checkpoints before reaching the hospital, one in Bangasal that took about 15 minutes and the other at the Radio Nepal office, which lasted only 5 minutes. The woman felt slightly uncomfortable because they were in a hurry and still everybody got searched.
- ◆ Hospital admission and treatment were fine. She had a caesarean section to get the dead baby out and was recovering slowly.

Major delay was caused by limited bus services from her home village and the problems in taking loan. Conflict had hardly any effect; only at the checkpoints.

Partners' Perspective: Surkhet

In Surkhet NSMP is implementing its Increasing Access programme component through a number of partners. The following partners were interviewed to understand the conflict's impact on the implementation of their Increasing Access activities:

- Sustainable Development Fund (SDF),
- Women Development Office (WDO),
- Social Awareness Centre (SAC).

Excerpts of discussions with the partners follow:

Through which community groups (for example Amaa Samuha) are they promoting safer motherhood with the population?

Social Development Fund (SDF) started its partnership with NSMP in 2001 and is covering 9 VDCs, some of them highly affected by the conflict. SDF works with its existing groups formed to promote economic activities like savings and productive lending schemes. A Safer Motherhood component has been integrated within the groups. They have also made a provision of a fund for emergencies within the groups.

Women Development Office extended its partnership with NSMP in 2001 and started working with its existing groups in the area of Safer Motherhood also. WDO works with the ward-level groups formed basically for the promotion of savings, credit, and micro enterprises among poor women.

After establishing its partnership with NSMP, SAC started integrating the Safer Motherhood concept in its existing women's groups originally formed for literacy promotion, women's rights education, and advocacy. In the new working areas they started promoting specific Safer Motherhood groups. In many areas SAC now works in both modalities, integrating in existing groups as well as mobilising specific groups, to promote Safer Motherhood. They will soon be looking into the matter of exclusion of certain groups of women from the groups, to increase coverage.

Did the partners experience any problems in mobilising community groups and organising group meetings, as a result of the conflict situation?

SDF faced many problems in mobilizing community groups and organizing group meetings, especially in highly effected areas. They had to withdraw programme implementation from all highly affected areas in the north-western part of the district. But the community mobilization programmes in less affected areas have been implemented successfully. There were problems in organizing group meetings due to fear of both security forces and Maoists. However, some strong groups were proactive in organizing meetings without bringing them to the notice of the Maoists or security forces.

WDO completed many of the planned activities related to Safer Motherhood though venues outside the most affected VDCs. The programmes include organizing education for people from different segments of society, street drama, folk song competitions, gatherings of pregnant women, and interaction programmes. However, some of the programmes like street drama could not be completed as planned. They also faced problems in organizing group meetings, as the Maoists have prohibited collecting regular savings.

SAC could not continue working for Safer Motherhood in one VDC, because they use external staff to disseminate information. There is a people's government formed in the VDC and they did not allow NGO work, because they requested a hospital instead of workshops. Their own group work they do continue with local staff.

In the other NSMP target VDCs they could negotiate working on Safer Motherhood. Yet, group meetings are convened less regularly, and the attendance has been reduced considerably. In the affected areas people are not confident enough to mobilize savings due to rumours of looting by the Maoists. The Maoists did not allow organizing the street drama promoting safer motherhood in two VDCs. It is now being organized only in Surkhet valley.

Were there delays in implementing group-related activities, and were these caused by the conflict situation in the VDCs?

Many training programmes in highly affected areas were cancelled and rescheduled, or the venue was changed to moderately affected areas. This has definitely delayed the implementation of group-related activities in SDF's working area. SDF had also changed its programme implementation strategy by entrusting implementation responsibility to local Community Based Organizations and VDC representatives.

WDO rescheduled the activities planned for the significantly affected area to a less affected area. Some activities like interaction between pregnant wives and husbands were more difficult to organise, as many men had migrated from severely affected areas. The programme was redesigned and organized in a less affected area with mothers-in-law replacing husbands.

SAC has experienced some delays due to the security situation in the VDCs. The staff could not visit the project areas, so the implementation process has become longer. Local people were identified to implement the programmes. Further, internal management slackness has been enforced by conflict, causing delay in the implementation of group-related activities.

Were any field-staff of the partner organisation based in the working VDCs?

SDF had posted their staff in the field to work with the group in implementing its regular programme and incorporating Safer Motherhood, but the field staff were withdrawn from the most affected areas.

WDO had placed staff in their field offices. It was not possible for the staff to stay in the field due to pressure for donation and levy. In many cases they were also threatened not to implement programmes. Some field staff also make conflict an excuse not to stay in the field in remote areas not highly affected by the conflict.

SAC had mobilized field-based local volunteers to implement programmes at the community level. These local volunteers are accountable to the SAC Focal Person.

Has the number of field visits for support and monitoring by higher district-level (not field based) partner staff been reduced due to fear created by the conflict?

Since emergency, higher-level staff of SDF have not visited the field, especially in affected areas. This has limited support to the groups and monitoring of field activities.

Senior staff of WDO had not visited the field for the last year. Field visits were limited mainly due to rumours and restrictions put by the district administration, rather than actual conflict threats.

In the relaxed situation after ceasefire, senior staff of both SDF and WDO have recently started their field visits.

Field visits of the senior SAC officials including Focal Persons have been reduced considerably due to conflict, affecting implementation of the planned activities and monitoring of the activities being implemented by the local volunteers.

Was there a reduction in supervision / monitoring of community group meetings and does this affect efficacy in dispersing the Safer Motherhood messages?

SDF staff have reduced their field visits to monitoring and supervision. SDF has made local ward members responsible for monitoring the group activities. However, the current field situation is unknown to SDF.

Due to absence of field staff and limited field visits by the senior staff, the group-level monitoring in WDO's working areas has been considerably reduced. It is not possible to assess its effect on efficacy in dispersing Safer Motherhood messages.

The monitoring visits of senior SAC staff have reduced considerably, particularly in highly conflict-affected areas. SAC had to rely totally on the local volunteers in the programme implementation process. As a result, the quality of activities being implemented at a local level could not be ensured. Likewise, accuracy and authenticity of the Safer Motherhood messages being delivered by local volunteers could not be guaranteed. In the severely effected areas SAC could not confirm the completion of all planned activities.

Did the partners experience any problems while implementing activities, like dissemination of information and messages on safer motherhood to the communities, as planned? Did they adapt planning to the conflict situation by changing, reducing, rescheduling or eliminating activities?

In the SDF working areas, particularly in highly effected areas, the loan repayment rate has reduced from 80% before conflict to 60% now. SDF could not implement many capacity-building programmes aimed at disseminating information and message related to safer motherhood. SDF did adapt the planning by changing the training venues and rescheduling the venues, but the Safer Motherhood programmes were eliminated from highly effected areas. They have also made strategic changes in programme implementation by working through local Community Based Organizations rather than working directly in the community.

WDO experienced many problems like harassment and threats to staff both by Maoists and security forces. Staff were harassed for donations and levies. They had problems in implementing training, orientation, and other Safer Motherhood programmes. WDO made changes in the programmes by changing venue and time of training. In some cases it was more difficult to work with the original target population. The exchange workshop between pregnant women and their mothers-in-law and husbands had only a few men involved. In some areas they targeted more strongly on students' training instead of teachers'. There is a tendency for both husbands and teachers to leave the villages due to fear of the Maoists and security forces. Another strategic shift is that WDO has started working more closely with the local people, promoting local, people-based organizations like cooperatives. This was found to be effective, as these could work in the community without any harassment, whereas WDO was having problems working with the local community groups they have promoted.

SAC started its partnership with NSMP when conflict was escalating. Accordingly, conflict was considered while planning the activities. Still, due to the conflict some planned mass gatherings were not possible, and they had to work with specific target groups only. SAC had to withdraw its activities from one VDC due to conflict. As an alternative they have been

actively involved in activities like the radio programme “Amaa” and in distributing posters and producing newsletters that do not need mass gatherings or direct involvement of partner staff in the communities.

Were changed or alternative activities thought to be as effective as previously planned activities?

SDF is not in a position to monitor the programmes being implemented with the changed strategy, as staff cannot visit the field.

From the letters they receive in response, SAC feel the radio programme has a wide coverage and reaches a very diverse public. They even get letters from people who can hardly read or write. Though they are also targeting ethnic groups, they do not think there is a language problem, as they try to use common Nepali.

Are communities open and interested in the Safer Motherhood programme, or do they express any other priorities?

People are open and interested in the Safer Motherhood programme, and it is one of their priorities. However, they feel that only awareness-raising for safer motherhood is not sufficient and that some hardware programmes should be integrated with the software programme. The hardware programmes identified by the people from the working areas include improving health post facilities, availability of transport schemes like stretchers, and so on.

Overall, people are paying less attention to health matters, as they are very much focused on the security problems they experience.

Other community problems that reduce access to health facilities

Migration of the politically active people, local elites, and youth from the villages has considerably affected the local people in accessing health facilities, especially in highly effected areas where SDF works.

In the SAC working areas, the Maoists have asked for forced donations and levies from health workers, and have looted medicines from health posts.

ANNEX J: MONITORING CHECKLIST

Conflict Impact Monitoring Sheet

Partner:
District:
Monitoring VDC:.....
Reporting Date:

1. Public transport vehicles reaching the main bazaar of the VDC or the nearest main road have: *

- Significantly increased
- Slightly increased
- No difference
- Slightly decreased
- Significantly decreased

Describe how:

2. Due to the conflict there are destructions or obstructions in the trail / road from VDC to hospital

Non 0 1 2 3 4 5 Very significantly increased

Describe:.....

3. Are there any restrictions by either side in the means of transportation (like doko, bus) allowed?

Not permitted:

4. How much is the total delay in time to reach hospital from the village due to different checkpoints, transport limitations, and obstructions?
.....hours.

5. Conflict has reduced the employment opportunities in the community.

Non 0 1 2 3 4 5 Very significantly reduced*

Describe:.....

6. Conflict has reduced the possibilities to sell villagers' own production (agricultural and other).

Non 0 1 2 3 4 5 Very significantly reduced*

Describe:.....

7. The current situation has reduced the willingness of moneylenders, traders, businessmen, friends, and relatives to lend money, due to lack of trust in repayment.

Non 0 1 2 3 4 5 Very significantly reduced

Describe:.....

8. Management of Emergency Funds by mothers groups is dysfunctional due to

a. Lack of trust

Non 0 1 2 3 4 5 Mistrust significantly increased*

b. Lack of control and supervision

Non 0 1 2 3 4 5 Significantly *

c. Other (please explain)

Non 0 1 2 3 4 5 Significantly

9. Are mothers group meetings affected by conflict?

- All groups meet
- Groups meet irregularly
- Not all members come to the meetings
- Some groups don't meet
- Most groups don't meet

Explain:

10. Fear to gather at one place

- Nobody is afraid
- Some are afraid
- Many are afraid
- Most are afraid
- Everybody is afraid

Explain:

11. Reduced attendance of the health workers (except for) at the health service (health post / sub-health post / PHC)

Not 0 1 2 3 4 5 Significantly reduced *

Describe:.....

12. Health workers go less often for home treatment and ask patients to come to their place instead (particularly at night)

Not 0 1 2 3 4 5 Significantly increased *

Describe:.....

13. Reduction in number of medical shops in the VDC

Not 0 1 2 3 4 5 Significantly reduced *

14. What is the duration of curfew?

Fromo'clock till o'clock (.....hours)

15. Increased tendency of people not to leave the house at night due to fear.

Not 0 1 2 3 4 5 Significantly increased *

16. Decreased mobility at daytime in and between villages, due to fear of either side.

Not 0 1 2 3 4 5 Significantly decreased *

17. Increased number of males leaving the village because they can't stay.

Not 0 1 2 3 4 5 Significantly increased *

18. Increased reluctance (of community people) to help with arrangements for transport in case of emergency

Not 0 1 2 3 4 5 Significantly increased *

19. Any means of communication and information closed or prohibited due to conflict

- Telephone
- Letters
- Newspapers and magazines
- Health literature
- Others:

Please describe any other changes due to conflict observed in the communities

.....

.....

.....

.....

.....

Source of information:

- Informal information
- Local informant
- Field visit

How much has the conflict reduced your (partner's) ability to work in this VDC?

- Not changed
- Work continues normally, but is slightly fearful
- Some areas of the VDC are difficult to visit due to the conflict
- We can work in the VDC, but cannot call for larger meetings
- We can hardly access the VDC due to the conflict

ANNEX K: MANUAL FOR MONITORING

Manual for Monitoring Checklist

This monitoring checklist is to help NSMP and its partner organisations identify and monitor the difficulties communities experience in accessing health facilities and, specifically, essential obstetric care. To work effectively in the project areas will require adapting activities and messages to the additional problems faced by communities in accessing services. Thus we should know the type and degree of problems faced by different communities. This monitoring sheet should give the required information.

The indicators have been developed on the basis of the main obstructions identified in a rapid field assessment. These can be summarised as: (additional) problems in transport (Q 1 to 4), economic resources (Q 5 to 8), possibilities for the communities to share and support each other in Safer Motherhood (Q 9 and 10), availability of health services (Q 11 to 13), and security and community issues (Q 14 to 19).

The Increasing Access component is based on the concepts of three delays and four barriers. The main additional delay is experienced in the second delay: reaching the health facilities. In the areas where NSMP is working, the availability of health personal has not significantly changed. But this should be watched carefully, as health workers are definitely key persons in referral of emergency cases to hospital.

How Should this Monitoring Sheet be Used?

This sheet should be filled in for one specific VDC at a time. We suggest that partners monitor all VDCs they work in, for their own information. For reporting to NSMP, a limited number of VDCs will be selected on the basis of covering different regions of a district. NSMP will compile the collected information for the regular quarterly sharing meeting of the RHCC / District Safer Motherhood Committee.

Which VDCs have to be monitored is determined by common agreement of the RHCC of each district. It is expected that each partner will monitor one (or two) conflict-affected VDCs they are working in.

The information should be collected at least quarterly, with intermediate updates if significant changes occur in the short term.

Collecting information does not require extensive separate VDC field visits involving interviews. Most information can be collected informally along with regular (planned) field activities of the partner. Field staff should talk to different people in the villages to seek the information required for monitoring, and crosscheck information among these informants. The checklist is then filled in based on the total impression obtained.

If field visits did not occur in the past three months (or are not possible due to the conflict), information can be collected through interviews with informants from the VDC who visit the district headquarters, or even through informal inquiry of other local sources. The checklist should never be filled in by the VDC informants themselves, but always by trained partner staff who have had open discussions on the different issues with one or more informants, to get a balanced understanding of the situation. Though direct field-based information is definitely preferable if available, the main purpose should be to get reliable information.

In case no information is available for one or more of the indicators, this should be noted, rather than assuming that the situation is unchanged.

The SDOs of NSMP will analyse the collected data. Generalised outcomes will be shared with the RHCC / SM committees.

The scale used for many of the indicators should be marked as follows:

Statement: Something has increased (* as compared with previous report)

Scale:

Non 0 1 2 3 4 5 Significantly

If nothing has changed since the previous reporting, the scale should be ticked at 0.

The growing numbers indicate growing amounts of change, for example:

(1) = “just a little”, (2) = “some”, (3) = “quite”, (4) = “much”, (5) “very significantly”.

Thus if it has increased “very significantly” it should be ticked at 5, while if it has changed just “some” it should be ticked at 2.

(In a sense it is like a teacher grading an exam.)

Some statements say something has decreased. In these cases the largest decrease should be marked as 5, while no change should be ticked at 0.

Statements have been written to monitor increasing conflict impacts on the different indicators. In case of ongoing peace processes, these statements may be invalid and would need different answers. Alternative answers can then be given under “describe”.

For a few statements a series of explicit answers have been given. Please tick the box in front of the right answer.

As compared to previous report ♣

Please note the ♣ mark at the end of most statements. In the footnote it says, “As compared to previous report”. The monitoring sheet should be filled in comparing the current situation with the situation as reported three months before.

For example, if fewer vehicles come to the main bazaar compared to before the conflict, but this number has not decreased over the last three months, the current reporting should be “no change” (0) for Statement 1.

Describe how

The open line given for most statements is to provide additional explanation of how the situation has specifically changed.

For the example of the decrease in vehicles reaching the main bazaar, this could be: “vehicles are not allowed to stay overnight”, or “the checkpoint en route to the district capital closes earlier, so the last vehicles are leaving now at 4 o’clock”.

These descriptions will give a better insight to the problems faced. The more detailed and explanatory the descriptions of the changes are, the more valuable such information becomes. Where appropriate, negotiations or other actions to mitigate the obstacles could be undertaken on the basis of this information.

Further Details and Explanations of the Indicators

Below are further explanations clarifying the information sought by the statements of the monitoring sheet. However, the monitoring should not be restricted to the examples given, as these are based only on the experiences of the research team. Other possibly related effects should also be included in the rating of the changes.

Statement 1: Public transport vehicles reaching the main bazaar of the VDC or the nearest main road have increased or decreased.

This statement measures the availability of transportation by road, from the nearest point where people can reach it from the VDC. Changes could involve:

- fewer vehicles coming to the place,
- vehicles available for less time per day, for example due to check-posts or restrictions by the security forces,
- bus routes that have been closed either by the drivers or the conflicting parties.

Statement 2: Due to the conflict there are destructions or obstructions in the trail / road from VDC to hospital.

This statement measures damages to infrastructure, like blasted bridges and trenches in the road, intentionally caused by either of the conflict parties, that could cause need for detours and lengthier routes.

Statement 3: Are there any restrictions by either side in the means of transportation (like doko, bus) allowed?

In some areas either side prohibits the use of certain types of transport and carrying. This could further increase transporting time.

- In some districts dokos cannot be sold in the market, and aren't allowed to be made in the villages.
- Similarly, in some areas no cars or motorcycles are allowed on the roads.

Please indicate which means of transport are restricted and, if appropriate, by which side.

Statement 4: *How much of the total delay in reaching hospital from the village due to different checkpoints, transport limitations, and obstructions?*

Damage to the road may cause longer routes to be travelled, prohibition of means of transport like cars will increase the time needed to travel a route, and stops at different checkpoints will cause delay.

Make a realistic calculation, summing up how much time is involved with each of these delays along the normal (quickest) route to reach hospital from the VDC's main bazaar.

This question summarises the problems in reaching the hospital due to transport barriers caused by the conflict. Thus the estimate should be taken seriously.

Statement 5: *Conflict has reduced the employment opportunities in the community.*

This statement is an indicator of the possibilities the local poor have to earn money by wage labour.

If many landowners have left the village and therefore the agricultural labour requirement is low, if economic activities like construction, logging, and many businessmen have left the community, daily labourers will find little work available. These are some examples of the aspects to consider when rating this statement. Lower incomes will reduce the accessibility of health facilities.

Statement 6: *Conflict has reduced the possibilities to sell one's own production (agricultural and other).*

For many households selling (agricultural) produce like grains and livestock is an important way to get cash to repay loans. In some areas the trading and transport restrictions put by the conflict cause problems in the sales of household produce.

Statement 7: *The current situation has reduced willingness of moneylenders, traders, businessmen, friends, and relatives to lend money, due to lack of trust in repayment.*

This statement measures the accessibility of cash resources in an emergency.

It has been found that in conflict affected areas people are less willing to provide loans to (poor) people, as they are not sure whether the loan will be paid back.

- Maoists have been advocating that interest does not need to be paid, or even full loans do not need to be paid.
- In some areas loan agreements have been looted and burned. Social control on repayment has been declining.

Statement 8: *Management of community group funds, particularly Emergency Funds, is dysfunctional.*

This statement and its subheading explore different problems with management of the Emergency Fund by the mothers groups. These could be:

- Lack of trust between the group members,
- Weak accounting,
- Lack of social control for repayment,
- Internal conflicts in the group, etc.

Still other reasons could occur.

Statement 9: *Are (mothers) group meetings affected by conflict?*

This statement measures the effectiveness of group mobilisation for promoting safer motherhood and dissemination of information into the communities. If groups can convene less frequently, are losing members, or are even dissolved completely, they can no longer function as intermediates between health services and communities. Several situations like lack of leadership, internal conflicts, problems with funds, and outside threats can influence groups' functioning.

Statement 10: *Fear to gather at one place.*

This statement is an indication of the level of disturbance of social cohesion caused by fear due the conflict. One aspect of this social disturbance is the problems with mothers group meetings. But the fear has much deeper impact on the social cohesion and functioning of communities. If people fear to gather, this will influence their ability to support each other and act jointly.

Statement 11: *Reduced attendance of the health workers (except for ...) at the health service (health post / sub-health post / PHC).*

This statement seeks to assess the availability of health staff for emergency health treatment at the VDC level.

In some cases attendance will have actually increased compared to before the conflict. The monitoring is only interested in reduction in attendance due to conflict. In many cases (non-local) health workers:

- work shorter hours,
- come less frequently,
- or have left the post for an indefinite time.

All these aspects are included in attendance.

Statement 12: *Health workers go less for home treatment and ask patients to come to their place, particularly at night.*

This statement assesses the accessibility of health care for women within their own communities. Much obstetric care can be offered by health workers in the village. Often it is easier for people to call the health worker to come to a patient's home, rather than carrying the patient to the health post. Though before conflict the willingness to come for home visits differed widely among individuals, the current situation is keeping many health workers from treating patients at home. They explicitly ask patients to be brought to them, particularly at night.

Statement 13: *Number of medical shops functional in the VDC.*

This statement measures the availability of health services and medical supplies apart from the government.

In some areas private medical shops have closed down because of problems in getting sufficient medical supplies for their shops, or because they were suspected by one side of aiding the other. Medical shops are often important health resources for local communities.

Statement 14: *What is the duration of curfew? (hours)*

For people who cannot contact the security forces, curfew imposes severe problems in reaching health facilities. Security forces extend the duration of curfew from earlier in the evening to later in the morning depending on the severity of the local conflict situation. In some cases curfew has been imposed during daytime.

Statement 15: *Increased tendency of people not to leave the house at night due to fear.*

Even though no official curfew may be declared, people do not like to go out at night. This statement tries to measure how much the fear will prevent people from seeking health care at night.

Statement 16: *Decreased daytime mobility in and between villages, due to fear of either side.*

In some areas fear is affecting mobility so much that people prefer not to go far from home even during daylight.

This statement tries to measure how much the fear will prevent people from seeking health care at daytime.

Statement 17: *Increased number of males leaving the village because they can't stay.*

This statement measures the reduced availability of males in the communities for managing transport and money in case of emergencies.

As we are only looking for changes due to conflict, ordinary long-term or short-term labour migration should not be included. The rating for this statement should be given considering only people who have left the VDC for fear of threat and maltreatment.

Statement 18: *Increased reluctance (of community people) to help arrange for transport in case of emergency.*

This statement measures the degree to which it has become more difficult to find people to help carry people from the village to the hospital.

In several areas people have indicated that it is more difficult to find people to help transport patients. This can be due to:

- uneasiness with the hassle of checkpoints,

- fear of encounters on the way, and
- suspicion towards for people who call at their door (at night).

Statement 19: *Any means of communication closed or reduced due to conflict.*

Lack of means of communication can cause problems in arranging transport, as neither ambulances nor the army can be called in case of emergency during curfew hours. Many villages that previously had public telephones are now cut off. In some cases written messages are not allowed by either side of the conflict, which could cause problems in borrowing money from relatives in town. Other restrictions can affect communication and access to health facilities.

Sources of information

Informal information: Informal inquiry of local people

Informant interview: Interviews with (key) informants from the VDC visiting the district headquarters

Field visit: Information collected during regular (planned) field activities of the partner