Increasing Access

Nepal Safer Motherhood Project

Issue Sheet 6

The Challenge

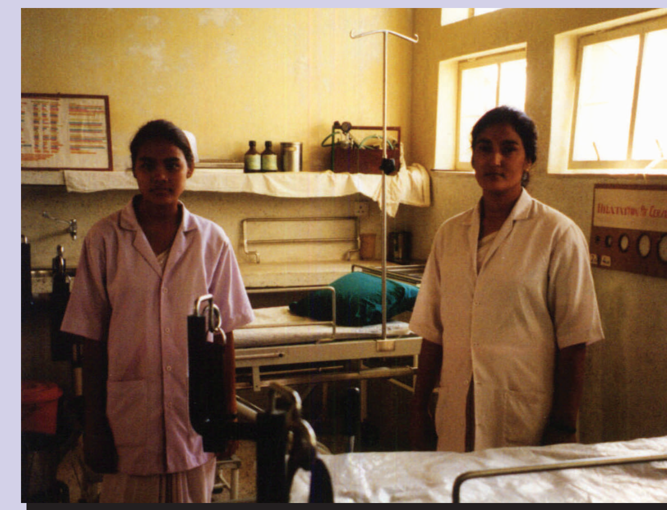
The high rates of maternal mortality among poor women in Nepal are linked to low utilisation of obstetric care services. Underlying determinants include widespread poverty, the low status of women, early female marriage, high parity and low family planning use and a weak health service. At a more immediate level, the low levels of utilisation are generally attributed to three delays (deciding to seek care, reaching a care facility, and receiving treatment), and five barriers (knowledge, attitudes, finances, transport, and availability and quality of service). The Department of Health Services has recognised that improved availability of obstetric services alone will not lead to increased utilisation unless social context and access issues are also addressed. NSMP has worked with government and non-government partners to research and develop mechanisms to overcome specific delays and barriers, empower women, mobilise families and communities, and create an enabling environment for accessing care.

Key Issues

The NSMP "increasing access" package has targeted community members (reproductive age women, men, older women, village leaders, transport workers and journalists) and local health workers (including government health workers, health volunteers, traditional birth attendants and traditional healers). A partnership approach drew on the strengths of existing community structures and groups, and mobilised local government institutions and actors for safe motherhood. Strategic and operational partnerships were developed with government and non-government organisations to implement different elements of the package, and institutionalise safe motherhood within society. In particular, NSMP has worked with district level committees, such as the Reproductive Health Co-ordination Committee, to ensure an institutional base for local safe motherhood access activities, and with Maternal and Child Health Workers (MCHWs) and Female Community Health Volunteers (FCHVs), who serve as a critical interface between the community and health institutions.

The package addressed five key areas of need. The first focussed on community level awareness raising and advocacy about safe motherhood issues, using a broad range of approaches and media, such as radio, street drama, videos, posters and inclusion of safe motherhood information in formal and non-formal education classes. Community groups and networks provided the means of delivering information and empowering women and their families to mobilise peers and influential people in the community to promote positive behaviour change. The Birth Preparedness Package (Jeevan Suraksha) has been used as a tool for promoting increased intra family communication about pregnancy and birth preparation. A second area of need was stakeholder advocacy and skills development, including partners, policy makers, practitioners, teachers and local government and line agency staff. A variety of orientations, workshops and refresher trainings provided skills and knowledge about the requirements for a healthy pregnancy and birth, and the danger signs indicating an obstetric complication. Through these activities safe motherhood messages were internalised and participants motivated to take responsibility for safe motherhood issues and give them the priority they deserve.

Community-based emergency funds and transport schemes were developed to address a third key area, the barriers of cost and transport availability. Through these schemes money is collected for emergency funds, which are managed by community groups with the support of partners and line agencies, and local health workers and volunteers. Low cost loans from these funds are available at short notice to cover the medical, transport and other related costs of emergency obstetric services. An additional component facilitates prompt movement of women in an emergency, through the provision of stretchers, dokos (baskets), bicycle ambulances (modified rickshaws) and other local transport systems, awareness-raising of taxi, bus and ambulance owners/drivers, and establishment of linkages with other emergency funding schemes to help cover transport costs. However, experience shows that current emergency fund schemes are not able to cover



all the expenses associated with an obstetric emergency particularly if a caesarean section is required. A fourth need was for an effective referral system between communities and health institutions, including sub health posts, primary health care centres, and higher care centres such as district and zonal hospitals. This component focussed on developing the ability of community based health workers to recognise danger signs and refer cases to appropriate facilities as quickly as possible. In addition efforts were made to increase the confidence of community members in the services available, and to increase their understanding of the importance of speedy referral.

Finally, support was provided for policy development and improved practice within the Department of Health Services, including community and rights-based initiatives such as posting citizen charters and fee schedules at hospitals to ensure costs are known in advance, as well as graphic and written presentation of messages to target both literate and non-literate audiences.

Achievements and Lessons Learned

Since the implementation of the increasing access package at the beginning of Phase Two of NSMP in 2001, NGO and line agency partners have begun to demonstrate greater understanding of safe motherhood issues and increased confidence about addressing them. This has resulted in improved knowledge, awareness and practices at community and household level, increased utilisation of health practitioners and institutions for antenatal check ups and normal births, and a decrease in the use of high-risk traditional practices associated with pregnancy and birth.

However, progress in achieving increased and timely use of emergency services has been slower, possibly because of the more significant costs involved. Changes have been documented through the innovative Key Informant Monitoring tool (KIM), and the establishment and mobilisation of emergency funds and transport schemes in project-targeted communities are additional indicators. The collaborative approach, involving decision-makers, women and their families, community health workers, NGO partners and line agencies, has succeeded in bringing more women to services, and taking more services to women, by mobilising people to reflect upon the information provided and change their behaviour accordingly.

Increased access cannot be achieved with a single input, either in terms of time, knowledge or activity. It requires continuous effort on the part of government and local stakeholders, using a variety of specific and adaptive strategies and initiatives to create an enabling environment for change. This means encouraging people to utilise health services and helping service providers and and facilities to ensure quality of care, through a process that is participatory and dynamic, based on good practice, use of local knowledge and perceptions, institutional and infrastructural development. Key areas are education, the provision of local funding, transport and linkages with effective referral mechanisms. Less tangible, but equally important are positive service provider attitudes, mutual trust, responsiveness, accountability, honesty and quality of care, both at established facilities and during outreach programmes targeting socially marginalised and vulnerable communities.

Questions Remaining

In order to ensure positive changes are continued, a proactive approach to the design and implementation of future increasing access strategies is needed. Research should be conducted into ongoing socio-economic, political and cultural changes in access. Local cultural values, norms, beliefs and practices should be recognised, and creative ways found to enable trusted local practitioners to acquire the necessary skills to play their part in safe motherhood. Inputs should also expand from simple awareness-raising to increasing knowledge and promoting better practices aimed at sustained behavioural change. This includes more technical input and support to local staff, volunteers and groups, and provision of social knowledge to promote further development and mobilisation of community-based emergency schemes, expansion of a working referral system and increased empowerment and participation of women and their families.

The Nepal Safer Motherhood Project (NSMP) was initiated in 1997 as a collaboration between the Nepal Ministry of Health and the UK Department for International Development (DFID).