Study on Utilisation of Emergency Obstetric Care (EmOC) in Selected Districts of Nepal

Executive Summary

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1. Introduction

1.1 Background

Nepal has made satisfactory progress in many areas of health and social development. However, high maternal mortality of 539 per 100,000 live births (HMG/N, 1996) remains a major challenge for the country. His Majesty's Government of Nepal, having had endorsed the Millennium Declaration remains committed to reduction of maternal mortality by two thirds (129-213/100,000 live births) by 2015.

The Ministry of Health's (MoH) current strategy is to increase utilisation of quality maternal services at primary health care centres and hospitals through establishment of basic and comprehensive emergency obstetric care (EmOC) facilities; and through skilled attendance at the community level by trained maternal and child health workers (MCHWs). For monitoring progress towards sustained increase in utilisation, a system based on the UN process indicators has been developed and managed by Family Health Division, of Department of Health Services. The EmOC monitoring system has been rigorously developed and reasonably well managed. However, constraints for measuring trends in utilisation exist as the system only captures data from a few public facilities and the trend in utilisation of private facilities are not currently measured by the system.

1.2 Objectives

The objective of this study was to assess the trend in EmOC utilisation in public and private health facilities. To assess the practices of MCHWs in management and referral of obstetric cases and experiences of mothers who used the EmOC facilities and factors for sustainability of EmOC services.

1.3 Methodology

This descriptive and exploratory study was based in six purposively selected terai and hill districts of Rupandehi, Nawalparasi, Kapivastu, Kaski, Baglung and Saptari. All facilities providing EmOC services from public and private sectors were selected for the study.

The number of EmOC facilities and the performance of the signal functions were determined through the interview with key informant and review of records. In the process of data collection, the flow of obstetric patients was identified to show where and how the data was recorded by interviewing the medical recorder, nurses and managers of the selected facilities. The most complete and accurate registers maintained in the facilities, for the period of five years, were

[1] The full document and other related documents can be found on web: www.nsmp.org

reviewed. They were the admission, labour and delivery, maternity, operation theatre and discharge register.

The MCHWs of eight selected VDCs in each district were interviewed to explore their practices in case management and referral; the facilitating and hindering factors in provision of services at the community level.

Semi-structured interviews explored the actual experiences of mothers who had used EmOC facility. The interview focussed on natal practices, advice on referral, decision making in the family, distance from EmOC facility, and any support from community for transportation, finances etc. Their perceptions on services at the facility, problems faced and suggestions for improving utilization were also explored.

The health sector reform strategy of MoH, focuses on decentralisation for improving accountability of local bodies[2]. Hence, sustainability of EmOC services was explored with them.

The indicators used to asses the utilisation of EmOC services were calculated using the UN Process Indicators. To determine the population size in a given district, the 2001census was used.

2. Findings

2.1 UN Process Indicators

2.1.1 Amount of EmOC services

The UN process indicator recommends the minimum of 4 Basic and 1 Comprehensive EmOC facility for every 500,000 population. The indicator for the number of BEmOC facilities was not met in any of the districts, even in those with adequate numbers of CEmOC facilities. The indicator for the number of CEmOC facilities was over met in Rupandehi and Kaski. Kapilvasu had no facility providing CEmOC services. Both Saptari and Nawalparasi had only 0.8 facilities for every 500,000 population, while the recommended level was 1.3 facilities.

2.1.2 Geographic distribution of facilities in study districts

The facilities, both public and private in all districts were clustered around the urban and peri urban areas, while large parts of population in the rural and remote areas remained virtually without services.

2.1.3 Proportion of all births at facility

If less than 15% of all births in the population take place in EmOC facilities, it is certain that some women who need lifesaving EmOC services are not receiving it. Except for Rupandehi, and Kaski, all other districts were far below this minimum acceptable level.

2.1.4 Met need for EmOC

This indicator gives the proportion of women estimated to have obstetric complications treated at EmOC facilities. If the met need is less than 100%, one can conclude that some women with

[2] Local bodies were the District level line agencies (e.g. DPHO, DHO, WDO, DEO etc) the local representatives of HMG's various ministerial departments, Local government agencies established to support DDC, the locally elected government bodies responsible for coordinating, managing and administering all development, administrative and monitoring activities at the district and Reproductive Health Coordination Committees under FHD, MoH , the district level information sharing, advocacy, coordination, and policy development network.

complications are not receiving the medical care they need. The results indicated that in none of the surveyed districts this indicator has been met. The situation is worse in districts such as Nawalparasi, Baglung, Kapilvastu and Saptari.

2.1.5 Caesarean sections as percentage of all births

If fewer than 5 percent of all births are caesarean sections, some women who need caesarean sections are not receiving it. Except Kaski district, in all districts surveyed the needy women did not receive caesarean sections services. Providing this service at the facility requires the availability of skilled surgeon, as this was not fulfilled, the results were not surprising. The priority therefore should lie in increasing the availability of appropriately skilled doctor in the districts to perform such surgery.

2.1.6 Case fatality rate

CFR measures the quality of EmOC performance at the facility level. This indicator is thus more meaningful for taking actions locally. The results indicated the number of deaths recorded at the facility is too few to make any meaningful comparison or inferences in most districts.

2.2 Utilisation of Health Facilities

2.2.1 Trends of users by types of health facility

There is a shift in utilisation towards private facilities. In Rupandehi, only 50% of all deliveries are currently occurring in public facilities; three years ago, this figure was 67.1%. This also corresponds to other services like complication managed. The findings of caesarean sections are quite remarkable; in 2057-58, 70.1% of caesarean sections were preformed in public sector. This has almost reversed in 2060-61 with 64.6% of caesarean sections in private facilities. In contrast to Rupandehi, the shift to the private sector is not evident in Nawalparasi, Baglung, Kapilvastu and Saptari, where this sector has not emerged yet.

2.2.2 Trends of EmOC users by Caste/Ethnicity

Dalit population was studied as proxy of "poorest group". In Baglung, the proportion of Dalits using EmOC services was a mere 8.9 % in 2056/57, and has increased to 17.1% in 2060/61. In Rupandehi, Brahmin/Chhetri constituted 58.8% of the total users while their proportion in the population is 22.5% of women of reproductive age. Dalits and janajati though making up 74% of the women of reproductive in the population, constitute only 36% of the users. Brahmin/Chhetri consistently constituted the major users of EmOC services - ranging from 71.1% in Baglung to 38.1% in Nawalparasi district.

Further analysis of the trend of utilisation of public and private facilities by dalits in two districts, Rupandehi and Nawalparasi revealed that of all the Dalit users, 82% used the public facilities in the year 2057/58, and 69% in the year 2060/61. Likewise in Nawalparasi, of the total Dalit users, 94% utilised public facilities.

The analysis was done for Brahmin/Chhetri, in 2057/58, 26% used private EmOC facilities, this trend changed to almost 65% in 2060/61. Likewise, for the Dalit population the proportion of users in private sector was 18% (total number of users was only 49) in 2057/58, which rose to 32% in 2060/61. The results indicated that there has been a shift in the choice of facility for utilising the private facilities both by the Brahmin/Chhetri and Dalit population.

2.2.3 EmOC utilisation and the distance from the facility

Over 80% of the users in terai districts came from a distance of less than four hours from the facility, and a little more than half of them used private facilities. Those coming from a distance of more than 8 hours, only a fourth used private facilities. In Nawalparasi, 63.9% were from a distance of less than two hours and this figure in Baglung was 38.3%.

2.2.4 EmOC utilisation by distance from the facility and caste/ethnicity

For both Brahmin Chhetri and Dalit groups, access to the facility in relation to distance was the same with above 80% coming from a distance of less than four hours in terai districts. In Baglung, this figure was 35.35 of Brahmin Chhetris and 50% of Dalit users came from a distance of less than four hours from facility.

2.2.5 Trend in utilisation and place of residence

The utilisation of EmOC services were consistently higher in VDCs in close proximity to the facilities. Areas adjacent to the roads also seem to have better utilisation. However, utilisation from VDCs distant from the roads is also gradually increasing as is the overall pattern of utilisation.

2.2.6 Inflow and outflow patterns in utilisation between districts

It is common for users to choose other districts for availing CEmOC services. The reasons for this may be geographic proximity, ease of transportation, availability of skilled service provider, perceived quality and cost of services. The study attempted to identify EmOC users visiting facilities outside their district of residence.

In Rupandehi, the inflow from adjoining districts of Nawalparasi and Kapilvastu continue to rise. From Nawalparasi, considerable numbers visit facilities in Chitwan and Rupandehi and this trend was increasing. This may have implications for calculation of UN Process Indicators for Nawalparasi district, which does not consider such users. In Baglung, the number of users coming to EmOC facilities has shown gradual increment, the proportion of users coming from the district itself is however, coming down, (77% in 2056/57 and 64% in 2059/60). The inflow from adjoining districts is rising, and at the same time, outflow to adjoining districts of Palpa and Rupandehi were rising.

2.3 Mothers perspectives

Out of the 96 mothers interviewed, 67.71% used public and the rest private EmOC facilities. Brahmin and Chhetri comprised 41%, hill ethnic groups (Gurung, Tamang, Magar and Rai) 18% and Dalits 15%. TBAs provided help for 35% with another 30% using health personnel before coming to the EmOC facility. Only 2% of the mothers made decision themselves, for 83% decisions were made by male members of the family and mothers in-law making decision for 10%.

2.3.1 Referral

Most mothers (65%) bypassed the lower facility as there was preference for higher and private facilities; 33% utilised district (public) hospitals, 21% private drug retailers, and another 24% private hospitals and clinics before coming to the CEmOC facility. The determinants for preference were availability of full range of services 35%, geographic proximity of the hospital 22%, availability of specialists 13% and 9% each for better quality of services and lower costs.

2.3.2 Problems faced

Problems with transportation were faced by 48%; and for 57% of these mothers, it was financial. Only 8% of the mothers' availed ambulance for reaching EmOC facility which was perceived as expensive. The amount of money expended at the facility varied with 52% of mothers spending less than 3000 Rs. at the facility. Though poor funds were available in the hospitals, only one mother had actually received free service and four mothers had a quarter of their charges waived off.

2.3.3 Suggestions

To improve utilisation of services, the mothers suggested availability of better quality services closer to homes, kind and fair behaviour of service providers, strengthening 24 hour hospital emergency services, free services for poor, availability of emergency funds in the community, community actions to raise awareness on importance of skilled care to include decision makers in the family and the availability of means of transportation.

2.4 Perspectives of MCHWs

Out of 51 MCHWs interviewed, majority (76%) belonged to Brahmin/Chhetri, and the rest from hill and terai ethnicities. None of them came from the dalit community.

2.4.1 Traditional beliefs and practices in the community

Preference for TBAs was common for all VDCs, MCHWs summoned only if the TBAs failed. Traditional harmful beliefs lead to complacency and delay in seeking care. Some other harmful traditional practices like application of abdominal pressure to rid the mother of dirty blood from her system and for delivering the placenta were described. The practice of ritual impurity during delivery and postnatal period limited the possibilities for other family members to help mother or baby with complications.

2.4.2 Response of community towards MCHWs

General belief that MCHW would manage most problems with appropriate care at home itself, made acceptance of advice on referral difficult. Mothers erroneously labelled it as lack of competence on the MCHW's part. Fear of costs involved with utilisation of hospital services, and lack of financial preparedness for such an eventuality lead to delay.

2.4.3 Referral practices

Self reported estimates of referral by MCHWs ranged from a low of 1 to a high of 10 cases in one year. Geographic accessibility and the availability of the range of services were the usual criteria for the choice of referral site. Referral forms were not in use and there was no system of referring the mother back for follow-up and continuity of care by the higher facility.

2.4.4 Practice of MCHW for replenishment of used items of the kit box

Used items of the kit box were replenished from the service charges recovered from the families. There was lack of uniformity in the service charges between the different districts and even among different VDCs of the same district. It was difficult to recover cost from families due to reluctance to pay the MCHW, who was a salaried government employee. Charging for services or for the used items of the kit box supplied by the government was hence considered a malpractice by the communities.

2.4.5 Facilitating factors

Support from the health system, refresher training and the kit box facilitated the MCHW's work. Support from the FCHVs, TBAs and the community at the time of emergency by arranging the means of transportation, carrying the mothers when no other means were available and the availability of emergency funds were appreciated.

2.4.6 Suggestions of the MCHW

Most of the suggestions of MCHWs for improving utilisation of EmOC centred on community actions for improving community awareness on care during pregnancy, birth preparedness, recognition of danger signs, use of skilled attendant at birth and the importance of referral to hospitals in case of complication.

2.5 Sustainability of EmOC Services:Stakeholders Perspective

> *"The issue of maternal health is not an agenda of health sector alone. It would be impossible to solve the problem of maternal mortality if health sector alone took the responsibility".*
>
> Chief District Officer, Saptari

The following key issues were identified during group discussions:

2.5.1 Coordination, collaboration and resource generation

Lack of integration of measures to reduce maternal mortality with activities of other sectors, like poverty reduction, income generation, population and environment, agriculture and nutrition at the operational level. Lack of clear understanding on how other sectors could help contribute towards reduction of maternal mortality. Hence, a district level strategic planning exercises to identify appropriate actions and its coordination from different sectors was suggested. Mobilisation of local governmental bodies, DDC in particular for generation of resources, the allocation of which must follow recommendation of RHCC.

2.5.2 Charity and emergency fund for poor patients

Lack of assessment criteria, to identify the real poor and guideline regarding the use of poor patient along with ignorance among users regarding the availability of such funds, and the process involved for availing it interfered with the optimal utilisation of this fund.

2.5.3 Human resources management

The main problem in most districts was the unfilled sanctioned posts, frequent staff transfer, without the concurrence of local managers and the retention of skilled service providers.

2.5.4 Recommendations from the Stakeholders

Decentralisation at the operational level

3. Discussion

The study methodology depended entirely on the quality of data maintained at the health facilities. The available data from the routine records presents a number of serious difficulties, particularly in data requirements for calculation of UN Process Indicators. The culture of information generation and its use at the facility and the district level is yet to develop, and this has contributed in

discrepancies in the data that is being recorded at the facility (used by this study) and what is being reported.

The need for stringent data recording, monitoring and technical back stopping could not be over emphasised. To ensure uniformity of recording and reporting, orientation of all involved starting from the doctors to nurses and the medical recorder is necessary to ensure that there is understanding on why the data is being generated, ensure that the recording is according to the guideline of UN Process Indicator; there is uniformity in registers maintained and avoidance of double counting. Routine statistics must be regularly discussed among the staff, managers and the stakeholders so that corrective actions could be taken locally. Evidence based management system will help to improve the utilisation of services by helping the managers to take appropriate and timely corrective measures.

4. Recommendations of the study

4.1 On information system

There is a need for updating the information on the importance of stringent data recording, monitoring and technical back stopping right at the facility level so that corrective actions could be taken locally, in essence the decentralised management of health services.

4.2 On increasing utilisation of services

Measures to reduce cost barrier for increasing utilisation like making delivery services in government health institution free along with proper implementation of poor funds. Strengthening mechanism for transportation, ensuring the continuous availability of skilled and competent human resources and community empowerment on importance of seeking skilled care during delivery, recognition of complications and the importance of referral

4.3 On creating enabling environment for MCHWs

Creation of an enabling environment for dealing with issues such as work condition, availability of supportive supervision, support and recognition, acceptance by the community, and support from the VDCs all needs strengthening. Exploration for alternative means for replenishing the consumables of the MCHW's kit box and service charge for home delivery to reduce the cost barriers, particularly for poor and marginalized women.

4.4 On sustainability

- Strengthening intrasectoral and intersectoral coordination. Strategic planning at the operational level for coordinated and meaningful actions for maternal mortality reduction from different sectors
- RHCC to plan and recommend for mobilisation of budget from local governmental agencies for safe motherhood activities
- Development of human resource strategy for safe motherhood programme. Continuity of services to be the prime consideration when transfers are made which, must be in concurrence of local managers; opportunity for skill up gradation for all categories of health workers.