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Utilization of rural maternity delivery services in Nawalparasi and Kapilvastu District: A Qualitative Study

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Abstract

Increasing the proportion of births attended by skilled health providers is likely the key factor in reducing maternal and perinatal morbidity and mortality. Study objectives were to identify key factors influencing the utilization delivery services and stakeholders' perceptions about these services. The study utilized focus group discussions and in-depth interviews with a diversity of community members users and nonusers , dalit women and health facility staffs to gain insights about the factors influencing use of trained attendants. Field researchers were trained to use FGD guides and interview schedules, and then gathered information on the perspectives of the women and their families and health staff. In Nawalparasi and Kapilvwastu we conducted a comparative study to compare on factors affecting the volume of delivery services.In Nawalparasi the deliveries in the pervious six months was relatively large number from hospital and PHCC whereas in Kapilvastu the delivery was in smaller number. The vast majority of women planned to have a home delivery attended by relatives and/or a Trained Birth Attendants and to reserve attendance at a health facility as a back-up plan in case of prolonged labor and complications. Ritual pollution considerations interfere with a decision to seek delivery in a facility, especially in the Western Hills. The cost recovery scheme ("incentives") deals with a major factor which inhibits use of health facilities. TBAs can encourage clients to deliver in health facilities. Staffs feel that the large number of vacant positions inhibits availability of services and requires strenuous efforts on their part to cover for vacancies.

Key Words: Maternity, delivery, health staff

Introduction

Increasing the proportion of births attended by trained health providers is likely the key factor in reducing maternal and perinatal morbidity and mortality [1]. In Nepal, the provision of skilled assistance is starting from a relatively low level since the vast majority of women deliver at home without trained attendants. In 2001, a Demographic and Health Services (DHS) study found: "Nearly 90 percent of women deliver at home and 55 percent deliver with the assistance of a friend or relative. In only 9 percent of home births are clean delivery kits used [2,3,4]. The 2006 DHS Preliminary Results suggest that substantial progress is being made in a variety of reproductive health measures, including the proportion of mothers delivering with trained attendants and in health facilities: "…19 percent of babies are delivered by a doctor or nurse/midwife,

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and 14 percent are delivered at a health facility [5]. This represents an improvement over the 2001 DHS figures. However, despite renewed attention and the recent progress in increasing the coverage by trained attendants, there is an enormous challenge to be overcome in providing services to the 80 percent of women still in need. This challenge is especially apparent with regard to the removal of institutional barriers faced by dalit (poor, marginalized, low caste) women who were found in a recent survey to account for only about 15 percent of the population but 30 percent of the maternal deaths [6]. The institutional barriers cited for dalit women not receiving trained birth attendance included: lack of awareness about maternal and neonatal health (MNH) issues and available services; low status of women and lack of decision-making power; expensive services/treatment; lack of birth preparedness, and especially, lack of transport to a health facility in an emergency [7]. Study objectives were to identify key factors influencing the utilization of health facilities for deliveries, describe stakeholders' perceptions (including both community and health professionals) about these services and their use.

Materials and methods

Two service sites were selected; one was Nawalparasi and other Kapilvwastu. It was a comparative study between functioning site: (Nawalparasi) where the deliveries in the pervious six months were relatively high number whereas in Kapilvwastu the deliveries were in smaller number.

Secondary data were collected from PHCC, DPHO, DDC, HP, and SHP from two districts. The sites receive varying levels of support from a variety of international agencies and represent two different district of varied culture, and serve clients of varying ethnic groups. Focus group discussion was conducted with different groups of people like father/father in law, mother/mother in law, sister in law, FCHVs, TBAs. A substantial amount of discussion and interview material was collected and transcribed in Nepali. Extensive summaries were prepared in English containing a large number of translated direct quotes.

Results

A. Family and Community Perspectives

1. Birth presentation

The majority of families indicated that they did not have enough savings to pay the delivery costs and transport associated with a delivery at a health facility. Although they often recognize that the birthing experience would be safer and less frightening with trained staff in attendance and generally they would like to have such attendance (especially at their homes), many know that they can not afford it. .

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"At the time of delivery we managed money about Rs. 2,000 -- 3000. We don't have money for emergencies. We borrow from our relatives."

Several fathers-in-law, FGD, Nawalparasi

"*We decided that until and unless there is a problem, we don't want to go to a health facility for delivery. We can manage everything (all other expenses) with the money which we would have to pay the health facility*."

Woman, nonuser, Kapilvwastu

2. Dalit women:

Very poor dalit women in Kapilvastu who received a special focus in the study, reported that they engaged in less preparation for delivery. This lack of preparation has a strong economic basis.

"*We do not do any kind of preparation before delivery. It's not in our culture. Even the workload is similar to other times. We have to carry heavy loads on our back, and we get no time for adequate rest. I was given dried ginger to eat to minimize bleeding.*"

Dalit woman, Kapilvwastu

It was encouraging to note, however, that none of the actual facility users reported experiencing any caste based discrimination from the service providers at any of the facilities included in this study.

"I have been to the facility many times and have never experienced discrimination by the staff. It is however, difficult for us to go there due to financial reasons, poverty is our main barrier."

Dalit woman, nonuser, Kapilvwastu

It was interesting to note that dalits themselves reported engaging in the practice of untouchability. In Kapilvastu, the mother-in-law of a dalit woman had helped with the delivery, but the family asked a lower caste dalit, a chamar, to cut the umbilical cord.

"It is believed in our society that a chamar must cut the chord. Our family must not perform this activity. And if they did, no one would drink water from them." (meaning that they would themselves become the lowest among the dalits).

Dalit mother-in-law, nonuser, Kapilvwastu

3. Seeking ANC Care:

Informants reported the advice they were given:

"*Nowadays everyone says we need to go to hospital for checkups during pregnancy and for vaccination."*

Mother-in-law, nonuser, Nawalparasi

"*In my first delivery, a TBA was invited and the umbilical cord was cut by the old method. But this time, they managed safe delivery kit and soap to bathe the baby. It is because last time we didn't know about safe delivery but now we are informed about it by the ANC clinic and the media."*

Woman, nonuser, Kapilvwastu

"Delivery occured on the ground floor. Before it was done in the cowshed (because of ritual pollution considerations) but now it was done in a clean room."

Women, nonusers, FGD, Nawalparasi

5. Negative Attitudes toward Health Facilities Among Nonusers:

Indeed, women and their family members have a vast array of negative views on the health facilities -- the cost, associated gender issues that arise, lack of staff experience, shortage of medicines, and perhaps most importantly, the behavior of the staff -- imposed restrictions on family presence in the delivery room, criticism of food provided to the mother, perceived lack of sympathy, and more.

"*We don't want to go to the health facility for delivery because health workers' attitudes towards poor people like us are absolutely not good".*

"They shout at us. They don't answer our questions. They are always angry and irritated with us. Besides this, it is expensive as well."

All women of FGD, nonusers, Kapilvwastu

"Most of the women feel uneasy when men (in the health facility) handle deliveries."

Mother-in-law, nonusers, FGD, Nawalparasi

6. Positive Attitudes Among Users:

Two themes that frequently arose in discussions about delivery in health facilities are: (1) safety and security, and (2) cleanliness.

"Most of them want to be delivered by nurses, and they think hospital will be safe and the patient is taken care with all kinds of cleanliness."

Mother-in-law, nonuser, FGD, Nawalparasi

7. Bringing Health Facility Workers to Assist with Home Delivery:

Many respondents saw the value of calling trained staff to their home but noted the economic difficulties of doing so:

"It is very good to make delivery at home by calling skilled doctors and nurses but it is expensive for us. It would be better if skilled doctors and nurses come home to provide free service for delivery because it will make us tension free and will be easy."

Women, nonusers, FGD, Kapilvwastu

All of the women participating in a FGD in kapilvwastu, despite being nonusers of health facilities, liked the idea of being attended by a trained provider in their own home, where perhaps the locus of control remains more with the family:

"It will be better if we call health worker at home because we can be confident under him or her, family members can know why and how to do safe delivery, and how to care for baby well."

All women, nonusers, FGD, kapilvwastu

8. Attitudes toward Use of Local TBAs:

Orsin, et al., reported that only five percent of a large cross-sectional sample of women indicated that their last birth was attended by a TBA in Makwanpur, a largely Tamang district south of Katmandu [8].

"*An experienced TBA is available. She can check whether the fetus is in the right position. She can help the mother bathe afterwards and see that she gets proper rest. She will remind us to take vaccinations."*

Mother-in-law, nonuser, FGD, Nawalparasi

"*Delivery usually takes place at night. An experienced TBA is close by. We would only need the hospital if complications develop*."

Husband, nonuser, FGD, Nawalparasi

"*TBAs provide quality care cheaper and have friendly and helpful behavior."*

Husband, nonuser, FGD Nawalparasi

9. Views of TBAs towords Colloborating with the Health Facility Staff:

International agencies have recommended that the training of TBAs should shift away from trying to make them more skillful providers and towards their collaboration with health facilities, which encourages them to refer and accompany women for delivery at the facility [9]. Discussions with TBAs were held in only a few of the communities. Several examples of generally positive relationships were reported by TBAs, but the comments also included some reservations.

"*The relationship with the health posts solely depends upon the attitude of those in-charge. In the past we were often called by them and had to report about the work we did in the field every three months. But they do not call us these days. They do not care about our work."*

TBA, interview, Nawalparasi

"*Even though I accompanied a woman for delivery at the health facility, I was not allowed in the delivery room. They said: 'Go away you old hag. Your ideas have been eaten by the mice!'"*

TBA, FGD, Kapilwastu

10. Choosing Trained Staff:

As is the case in many other countries, there is little or no evidence that Nepalese women or other family decision-makers are familiar with who is and is not classified as trained staff. They appear to know that the sub-health post (SHP) does not have trained staff available. When they arrive at a facility, they report that they receive service from whoever is on duty. In response to the question, "Who attended the delivery?" All fathers-in-law of women delivered in health facilities in Nawalparasi reported that they had not selected a person in advance of arrival for delivery, nor did they make any choice about who would serve them once they arrived at a health facility. They did not appear to know the background or training of the person on duty who would assist with their daughter-in-laws' birth.

11. Ritual Pollution Considerations (especially in Kapilwastu):

In Nepal there is widespread concern that childbirth is a ritually polluting event. The pregnant woman's blood from the delivery, the cord, her placenta, and the baby are considered ritually polluting to varying degrees and lengths of time. Even being in the presence of a pregnant woman after her water breaks is sometimes considered polluting. The amount of time required for the pollution to dissipate varies from 3-11 days in different ethnic groups. It is believed that:

"*The gods will be offended if anyone touches these things. Men should not even look!"*

Women, nonusers, FGD, Nawalparasi

Cutting the cord is especially polluting and is done by the lowest caste women available. On the other hand, TBAs sometimes advise against going to a health facility because they want to receive the fee from cutting the cord. One researcher reported that the ritual pollution considerations were important even in middle and upper class urban families, especially in the Brahmin and Chettri communities. The Western Hill districts were reported to be the most rigid about ritual pollution considerations.

"*After delivery no one will carry women mainly because they have the bad tradition of not touching women after delivery. It is also the fact that they have no knowledge of delivery by skilled nurses and doctors."*

Facility Staff, Group Discussion, Kapilvwastu

It is unclear whether the respondent's comments about ritual pollution are consonant with their actual behavior, especially at the critical time that a woman is experiencing prolonged labor and the family realizes she needs assistance of a trained provider.

12. Comments on Maternity Incentive Scheme:

Women who seek a facility delivery for their first or second child receive an incentive of Rs. 500 – 1500, depending on whether they reside in the Terai (Rs. 500.), the Hills (Rs.1000), or the Mountainous Regions of the country (Rs. 1500). Men in an FGD in Nawalparasi reported that the allowances were too small:

"We know that there is provision of delivery allowances for the first two births. But usually people tend to spend more while they give birth to a child and the allowances given by government are a very small amount."

Husband, nonuser, FGD, Nawalparasi

In Kapilvastu, female community health volunteers (FCHVs) did not know of the incentive scheme. In addition, there were numerous reports that families had to wait long periods to receive the payments, and therefore needed to borrow cash for the delivery anyway. Researchers also found some evidence of possible corruption in the implementation of the program.

B. Views of Facility Staff and District Development Committee (DDC) Members

Factors Promoting a High Volume of Delivery Service:

"*I feel people prefer coming here because we provide quality service for a very nominal charge, behave well with the clients, and provide appropriate counseling. Our location is accessible and transportation (ambulance) service is also provided at low cost. The information on services that are available has spread by word of mouth and has impacted positively on service utilization."*

Medical Officer, Dumkauli PHC

Factors Inhibiting Delivery Service:

Many barriers to utilization were also presented in interviews held with DDCs, facility in-charges and other staff. Facility staff feel that the large number of vacant positions inhibits availability of services and requires strenuous efforts on their part to provide needed services. Many also feel constrained in service provision by a lack of adequate incentives, training, equipment and drugs. They also reported concerns about not being supplied a decent residence which is safe and secure, and inadequate professional advancement opportunities and appropriate educational opportunities for their children.

On the other hand, staff who works hard reported that they feel that they do not receive any encouragement, recognition or incentives and that their morale deteriorates. Staff problems can seriously impact the ability of the facilities to improve the environment for delivery services.

"*We have not been able to make staff nurses and ANMs available at all the facilities. As this is a remote district, they do not want to come or if they do, would not want to stay here long enough to provide services."*

DPHO, Nawalparasi

"*In this place awareness building is not happening (and) the staff positions are never filled. Staffs are changed frequently and those who are available are unable to be in the people's hearts. There is social discrimination by caste."*

Staff, group discussion, Kapilvwastu

Conclusion

The vast majority of women planned to have a home delivery attended by relatives and/or a TBA and to reserve attendance at a health facility as a back-up

plan in case of prolonged labor and complications. This plan was influenced greatly by the perceived high cost of transport and the fees at health facilities. Economic issues were especially important to dalit women, as was concern about possible caste discrimination. Birth preparation was found to be mainly an economic activity conducted by husbands and fathers-in-law. Birth preparation activities for the mother and other female relatives include acquiring and preparing special nutritious food, cleaning the location selected in the home for delivery, and sometimes obtaining a delivery kit. ANC care is becoming an accepted norm. Awareness raising programs, along with ANC, have created widespread knowledge of the importance of ANC and delivery in a clean environment.

The respondents perceived many benefits of home delivery. It is seen as much less expensive and easier. All the family can assist. The mother can be fed the appropriate foods. Relatives, neighbours, and the TBA can provide oil massage, women can use the desired delivery position, and no one will shout at them if they complain of pain. Attitudes toward health facility staff behavior among non-users were predominantly negative. Users (15 - 20 percent of the female population) had more positive views. Bringing trained workers to the home was considered desirable but not affordable. Attitudes toward TBAs managing normal deliveries were positive.

Ritual pollution considerations interfere with a decision to seek delivery in a facility, especially in the Western Hills. The cost recovery scheme ("incentives") was made to promote the use of health facility. However, the potential positive impact is hindered inhibiting the use of health facilities due to weak planning and implementation, lack of knowledge, delays in payments, and the potential for corruption. TBAs can encourage clients to deliver in health facilities. However, many TBAs report several instances of insults from staff that effectively keep them away.

Staff Perceptions: Staff feels that the large number of vacant positions inhibits availability of services .They also feel constrained in the provision of services by lack of adequate training, equipment and drugs, lack of a decent residence which includes safety and security, lack of professional advancement opportunities and appropriate educational opportunities for their children.

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