TAMPEREEN YLIOPISTO

TERVEYSTIETEEN LAITOS

Lisääntymisterveydenhuollon haasteet ja naisten hyvinvointi vähiten kehittyneissä maissa

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1. Johdanto

Tämän kirjallisuuskatsauksen tavoitteena on kuvata ja analysoida kehitysmaiden naisten lisääntymisterveyden nykytilannetta ja siinä 1900-luvun lopulla tapahtuneita muutoksia. Terveydenhuollon toimintamallit ja ongelmat antavat katsaukselle käytännöllistä näkökulmaa. Nepalissa vuonna 1996 tekemääni kenttätutkimukseen ja siellä kerättyyn aineistoon perustuva opinnäytetyöni[1] tarjoaa vertailukohteen. Keskeinen käsite työssä oli lisääntymisterveydenhuoltopalvelujen laatu ja sen merkitys terveyspalvelujen käyttöön, tehokkuuteen ja toimivuuteen. Nyt lähestyn lisääntymisterveydenhuollon kysymyksiä ajankohtaisen kirjallisuuden kautta laajemmasta näkökulmasta. Keskityn kuitenkin nimenomaan vähiten kehittyneiden maiden tilanteeseen ja palaan aina uudestaan Nepalin tilanteeseen.

Tutkimuskohteena on nimenomaan *naisten* lisääntymisterveys ja terveydenhuolto, mutta muita sukupuolispesifisiä terveysongelmia ja niihin liittyvää naisnäkökulmaista terveydenhuollontutkimusta tässä ei käsitellä. (ks. esim. Doyal 1998). Kysymys ei ole miesten lisääntymisterveydenhuollon tarpeiden aliarvioimisesta eikä toisaalta kehitysmaiden naisten muiden ongelmien kieltämisestä vaan ongelman rajauksesta. Pyrkimys holistiseen ymmärtämiseen edellyttää kuitenkin naisen kokonaishyvinvointiin vaikuttavien asioiden tarkastelua, esimerkkinä hiv/aids-epidemia, joilla on merkittäviä yhteyksiä esimerkiksi siihen, että äitiyskuolleisuus ei laske. Maailmanlaajuisesti vähintään 500 000 naista kuolee vuosittain raskauteen tai synnytykseen liittyviin komplikaatioihin ja miljoonat kärsivät muista seksuaali- ja lisääntymisterveyteen vaikuttavista ongelmista.

Lähdeaineisto perustuu tiedonhakuun Medlinesta, ISI Web of Sciencesta, Cinahlista, Poplinesta, EBSCOhostista, WHO:n ja Unicefin tietokannoista sekä lähdeviitteitä

[1] Rouvinen (1996) Quality of care in reproductive health services at five government health posts in Siraha District, Eastern Nepal. A dissertation. University of Liverpool.

seuraamalla. Lähteistä on valittu lähinnä vuoden 1995 jälkeen julkaistut artikkelit ja niistä on jouduttu tekemään rajua karsintaa, koska asiasta on kirjoitettu hyvin paljon.

2. Lisääntymisterveys kehityksen indikaattorina

Lisääntymisterveydenhuolto kattaa ne terveydenhuollon palvelut, joita ihmiset tarvitsevat voidakseen turvallisesti ja tyytyväisenä toteuttaa itseään seksuaalisessa käyttäytymisessä ja lisääntymiseen liittyvissä elämän vaiheissa. Naisen tai pariskunnan halutessa ajoittaa raskaudet ja valita lasten määrän, siihen tulee tarjota turvalliset ja asianmukaiset keinot. Päämääränä on myös turvata syntyvän lapsen hyvä terveys. (Fathalla 1992[2])

Kehityksen ja kehitysmaan määrittely ei ole yksiselitteistä ja siitä on käyty laajaa keskustelua. Yksinkertaisimmillaan kehittymättömyyttä mitataan alhaisella bruttokansantuotteella, mutta taloudellinen deprivaatio on hyvin suhteellista. Sosiaaliantropologi Sahlins (1972) toteaa, että keräilytaloutta harjoittaneen san-heimon (bushmannit) voidaan sanoa eläneen eräänlaisessa yltäkylläisyydessä kun katsotaan tilannetta heidän omasta näkökulmastaan ja lisäksi usein nähdään esimerkkejä maallisen rikkauden ja hyvinvoinnin ja toisaalta tyytyväisyyden usein suoranaisesta kielteisestä verrannollisuudesta. Perustellusti siis myös inhimillisen hyvinvoinnin indikaattorit kuten lapsi- ja äitiyskuolleisuus ja esimerkiksi keskimääräinen elinikä ovat myös laajasti käytettyjä arviointivälineitä kehitysmaa-arvioinnissa.

YK luokittelee maat seuraavasti: 1) kehittyvät maat (developing countries), 2) vähiten kehittyneet maat (least developed countries) ja 3) teollistuneet maat (industrialized countries). Vuoden 2002 vähiten kehittyneiden maiden listaan kuuluu 49 valtioita. Maiden kansantulo henkeä kohti on alle 900 dollaria, mutta lisäksi tilanne niissä sekä

[2] *"Reproductive health implies that people have the ability to reproduce, to regulate their fertility and to practise and enjoy sexual relationships. It further implies that reproduction is carried out to a successful outcome through infant and child survival, growth and healthy development. It finally implies that women can go safely through pregnancy and childbirth, that fertility regulation can be achieved without health hazards and that people are safe in having sex." (Fathalla 1992, 36)*

inhimillisen kehityksen että taloudellisen haavoittuvuuden osalta on muita kehitysmaita heikompi. Inhimillistä kehitystä mitataan seuraavilla tekijöillä: keskimääräinen kalorien saanti, siis ravinnon saatavuus, lapsikuolleisuus, koulunkäynnin yleisyys ja aikuisten lukutaito. Taloudellista heikkoutta kuvaa maataloustuotannon heilahtelut, viennin heikkous ja suuret rakenteelliset vaikeudet kehittyä ja nousta köyhyyden kierteestä. (UNCTAD 2002)

Edelleen kuitenkin käytetään myös yleiskäsitettä *kehitysmaat* (developing countries) tai *matalan tulontason maat* (poor-income countries). Tässä katsauksessa tutkin tilannetta vähiten kehittyneissä maissa, mutta yksinkertaisuuden vuoksi käytän usein termiä *kehitysmaa(t).*

YK:n humanitaariset organisaatiot ovat myös tehneet luokittelua kukin tahollaan, mutta nyt WHO, Unicef ja UNFPA ovat pääsemässä yhtenäiseen käytäntöön sekä tietojen keräämisestä että niiden esittämisestä. Äitiyskuolleisuutta pidetään edelleen tärkeänä terveydentilan ja terveyspalvelujen toimivuuden indikaattorina. Useimmissa kehitysmaissa kaikki terveystilastot perustuvat hyvin pitkälle arviointiin, eli indikaattorien luotettavuusmarginaali on usein varsin iso. Helpommin selvitettävissä on koulutettujen synnytysavustajien suhteellinen lukumäärä ja keisarinleikkausten määrä. Näitä tietoja ei ole vielä systemaattisesti tilastoitu. Sen sijaan arvioidaan sitä kuinka moni raskaana olevista naisista käy ’neuvolassa’ tai lääkärillä ja kuinka moni synnyttäjistä saa synnytyksessä apua koulutetulta henkilöltä. (UNICEF 2002, WHO 2001)

Taulukossa 1 esitetään indikaattorit maaryhmien keskimääräiset lisääntymisterveyden ja lisääntymisterveydenhuollon toimivuuden indikaattorit. Lisäksi taulukossa on esimerkkinä muutamien eri ryhmiin kuuluvien maiden indikaattoreita. Tieto on ajankohtaisin saatavilla oleva, mutta perustuu enimmäkseen vuoden 1995 tietoihin. (UNICEF 2002)

Taulukko 1. Lisääntymisterveydenhuoltoon liittyvät hyvinvoinnin ja terveydenhuollon toimivuuden indikaattorit

	Äitiyskuolleisuus no/100.000 kuolemantapaukset 100000 elävän lapsen synnytystä kohti vuoden aikana (MMR, maternal mortality ratio)	**Elinaikainen kuolemanriski 1 per x** elinikäinen kuoleman todennäköisyys raskaus- tai synnytys-komplikaation takia (Lifetime risk)	**Prenataalinen terveydenhoito-kontakti %** tutkimus tai hoito vähintään kerran raskauden aikana, prosentteina	**Avustettu synnytys %** synnytyksessä koulutettu avustaja	**Ehkäisymenetelmän käyttö %** ne parisuhteessa elävät naiset, jotka käyttävät ehkäisyä (CPR, contraceptive prevalence rate)	**Synnytysten määrä** elinaikainen keskimääräinen synnytysten määrä naista kohden (Fertility rate)
Vähiten kehittyneet maat	1000	16	53	27	32	5,4
Malawi	580	21	89,7	54,8	21,9	6,5
Nepal	830	21	27	11,9	28,5	4,7
Kehittyvät maat	440	61	65	53	65	3,0
Sri Lanka	60	610	98,4	94,1	66,1	2,1
Thaimaa	44	1100	85,9	?	72,2	2,1
Brasilia	260	130	85,7	91,5	76,7	2,2
Teollistuneet maat	12	4	98	98	78	1,6
Suomi	6	7700	100	100	77,4	1,6

Lähde: UNICEF (2002)

3. Naisen elämän tärkeät ja kriittiset vaiheet

3.1. Raskaus ja synnytys - turvallisen äitiyden tavoite

Äitiys kehitysmaissa ei ole turvallinen kokemus. Taulukosta 1 näemme, että esimerkiksi nepalilaisen naisen riski kuolla elinaikanaan synnytykseen on huomattavan suuri (1/21) verrattuna suomalaisen naisen hyvin pieneen riskiin (1/7700). Se että 98 % raskauden tai synnytyksen komplikaatioihin menehtyvistä naisista kuolee kehitysmaissa, on helposti selitettävissä terveydenhuollon resurssien ja tason heikkoudella ja sillä, että vähätkin resurssit, sairaalat ja henkilökunta, keskittyvät kaupunkeihin. (Donnay 2000)

Terveydenhuoltoa eikä sen järjestäjiä ei voi kuitenkaan yksinään pitää syyllisenä huonoon tilanteeseen; äitiyskuolleisuus on osa kehitysmaiden ihmisten kaikkinaista huono-osaisuutta ja ennen kaikkea se on seurausta naisten sosiaalisen aseman rajoituksista. Cook ja Dickens (2002) ajattelevat monien muiden tapaan, että perussyyt löytyvät ensinnäkin sukupuolisidonnaisesti epätasaisesti jakautuvasta koulutuksesta, josta seuraa heikot mahdollisuudet hankkia hyvä työ ja toimeentulo ja toiseksi perinteisesti alisteinen yhteiskunnallinen asema hidastaa positiivista muutosta. Kysymyksessä on siis lopulta tasa-arvo- ja ihmisoikeuskysymys.

YK:n useiden alajärjestöjen yhteistyönä aloitettu ‘Turvallinen äitiys’ -kampanja (Safe Motherhood Initiative) sai alkunsa 1987 Nairobin konferenssissa. Päätavoite oli puolittaa äitiyskuolleisuus vuoteen 2000 mennessä (Koblinsky ym. 1994). Positiivista kehitystä on tapahtunut, mutta tavoite ovat toistaiseksi kaukana. Itse asiassa positiivinen kehitys tapahtui lähinnä ennen 1990-luvun vaihdetta ja enemmän Latinalaisessa Amerikassa ja Aasiassa kuin Afrikassa. Muutamaa poikkeusta lukuun ottamatta kuolleisuus ei enää laske. (AbouZahr 2001, Craft 1997, UNICEF 2002) Syitä tähän voidaan ja on syytä etsiä poliittistaloudellisista tekijöistä, kuten 1990-luvun kehitysapuun panostettujen resurssien pienenemisestä, uusliberalistisesta vapaan yrittäjyyden tuomasta julkisten palvelujen

purusta myös kehitysmaissa, mutta merkittävä tekijä on myös hiv-epidemian negatiivinen vaikutus. (Preble ym. 1994)

Äitiyskuolleisuus ei ole ainoa raskauden komplikaatio, vaan siihen liittyy monia sekä hoidolla parannettavia että pysyviä ongelmia. Jokaista kuolemantapausta kohden kymmeniä naisia kärsii synnytyskomplikaatioista[3], joista osa aiheuttaa puhtaasti lääketieteellisiä haittoja, mutta osa tuo mukanaan myös merkittäviä sosiaalisia ongelmia ja voi johtaa naisen syrjäytymiseen. Esimerkiksi pahasti pitkittyneen synnytyksen aiheuttama kohdun repeämä hoidetaan lähes poikkeuksetta kohdun poistolla, jonka seurauksena nainen ei voi enää synnyttää ja etenkin lapsettomassa avioliitossa seuraukset ovat naiselle merkittävät.

Pitkittyneen synnytyksen toinen yleinen komplikaatio on synnytyskanavan fistulat, joista tavallisin on vesico-vaginaalinen fistula. Kudosvaurion saanut nainen joutuu hyvin todennäköisesti loppuiäkseen eristetyksi normaalielämästä kontrolloimattoman virtsan vuotamisen takia. Fistuloiden määrää ei pystytä tilastoimaan, koska suurin osa niistä on pitkittyneiden kotisynnytyksien komplikaatioita ja vain murto-osa naisista pääsee koskaan hoitoon, mutta WHO:n maailmanlaaja prevalenssiarvio on 2 miljoonaa tapausta. Esimerkiksi yksin Nigeriassa arvellaan 200 000 naisen kärsivän ongelmasta ja Etiopiassa yhdessä fistulan hoitoon erikoistuneessa sairaalassa hoidetaan kirurgisesti vuosittain noin 1200 tapausta. (Kelly 1999)

Äitiysneuvolan uudistaminen

Jo vuosia on pohdittu (esim. Rooney 1992) raskaudenaikaisen ennaltaehkäisevän hoidon (antenatal care, Suomessa *äitiysneuvola*) todellista merkitystä kehitysmaissa. Päämääränä on ollut seuloa riskiraskaudet ja ohjata kyseiset äidit synnyttämään valvottuihin oloihin ja siten vaikuttaa äitiys- ja vastasyntyneiden lasten kuolleisuuteen.

[3] Donnayn (2000) arvio on, että yhtä kuolemantapausta kohden 30 kärsii komplikaatioista, siis neljännes kaikista synnyttävistä naisista.

Teija Kulmala (2000) raportoi väitöskirjassaan Malawista, että riskisynnyttäjien seulonta ei vastannut todellista riskien hallintaa. 74 % neuvolan asiakkaista luokiteltiin riskiryhmään yleisti hyväksytyn kriteerilistan mukaisesti. Heistä kuitenkin vain 30 % tuli synnyttämään terveyskeskukseen tai sairaalaan niin kuin riskiryhmään kuuluvien odotettiin tekevän. Riskianalyysin sensitiivisyys oli korkea, mutta spesifisyys matala. Tämä johti toisaalta laitossynnytysten rajallisten resurssien turhaan käyttöön normaalisynnytyksissä, toisaalta synnyttäjien välinpitämättömyyteen ja kun lisäksi vakavat synnytyskomplikaatiot ovat usein niitä, joita ei voida ennalta ennustaa (verenvuodot ja pitkittynyt synnytys), tuloksena oli, että otoksen 795 synnyttäjistä kuoli 4, mikä vastaa 500 kuolemaa /100000 elävän lapsen syntymää kohti eli suhde oli sama kuin Malawissa yleensä. (Kulmala 2000)

Kulmalan tutkimus tukee löydöksiä neuvolan hyödyllisyyden kyseenalaistamisesta, joita on raportoitu useista maista (esim. McDonagh 1996, Prual 2000). Myös Nepalin Sirahassa vuonna 1996 haastatellut naiset ilmaisivat selvästi omaa tyytymättömyyttään tarkastusten hyödyllisyydestä ja samaa tukee Jahnin ja kumppaneiden (2000) terveyspalvelujen analyysi vuodelta 1997 toiselta puolelta Nepalia. Sirahan naiset arvioivat palvelussa olevan puutteita intimiteetin suojelemisessa, neuvonnassa, kunnioittavassa kohtelussa, naispuolisen hoitajana puuttumisessa ja kokemuksessa siitä, että se eivät hyötyneet mitään käynnistään lukuun ottamatta mahdollista tetanus-rokotusta (Rouvinen 1996). Jahn löysi raskauden ajan tarkastuksissa samoja puutteita ja toteaa lisäksi, toisin kuin Kulmala Malawista, että riskiraskauksien rekisteröiminen oli hyvin satunnaista ja se ei perustunut synnytyshistoriaan. Lisäksi jonkinlaisten kommunikaatio-ongelmien myötä asiakkaalle ei edes kerrottu suosituksesta mennä sairaalaan synnyttämään. (Jahn ym. 2000)

Ongelmana on ollut muun muassa se, että raskauden edistymisen seuranta on siirretty sellaisenaan kehittyneemmistä maista eikä ole otettu huomioon resurssien, tavoitteiden ja olosuhteiden erilaisuutta. WHO julkaisi uudet kontrolloituun tutkimukseen perustuvat ohjeet äitiysneuvolakäyntien määrän ja sisällön suhteen vuonna 1996; tavoitteena on

siirtyä rutiininomaisista työvoimaa ja aikaa kuluttavista toimenpiteistä yksilölähtöisempään tilanteen arvioon ja tilanteen adekvaattiin hoitoon (WHO 1996). Uuden käytännön toimivuudesta ja muutoksen hyödyllisyydestä ei ole vielä seurantaa.

Äitiysneuvolaan panostus yksinään ei siis näytä vaikuttavan äitiyskuolleisuutta alentavasti. Tosin vielä vuonna 1998 julkaistu artikkeli (Pinotti & Drezzett 1998) väittää päinvastaista ja esimerkkinä annetaan Portugalin tilastot vuosien 1970 ja 1987 välillä, jolloin äitiyskuolleisuus laski 77:stä 7:ään. On kuitenkin selvää, että positiivinen kehitys siellä oli tulosta monien tekijöiden yhteisvaikutuksesta ja jo lähtötilanne oli kokonaan toinen kuin kehitysmaissa.

WHO ja UNICEF kuitenkin jatkavat lisääntymisterveydenhuollon arvioimista myös sen mukaan kuinka monta prosenttia raskaana olevista naisista on läpikäynyt ainakin yhden raskauden seurantaan koulutetun henkilön tarkastuksen. Jopa vähiten kehittyneissä maissa keskimääräinen luku on 53 %, mutta Nepalissa vain 27 %. (UNICEF 2002). Vuonna 1995 siellä raportoitiin prosentiksi vain 15 ja esimerkiksi Sirahan alueella toiminta oli silloin vasta vaivalloisesti alkamassa (Rouvinen 1996).

Äitiysneuvolan tavoitteena on myös edistää syntyvien lasten terveyttä ja Kulmalakin toteaakin, että äitiysneuvola voi estää perinataalikuolleisuutta merkittävästi jos se pystyy estämään ennenaikaiset synnytykset esimerkiksi hoitamalla raskaudenaikaisen malarian (Kulmala 2000). Lisäksi äitiysneuvola on usein keino tavoittaa raskaana olevat naiset tetanusrokotusta varten ja suotuisissa oloissa se voi toimia terveyskasvatuksen foorumina - Nepalissa jälkimmäinen ei esimerkkitutkimusten mukaan toteudu (Jahn 2000, Rouvinen 1996).

Kuka hoitaa synnytyksen?

Kun on siis päädytty siihen, että neuvolatoiminnasta on varsin vähän hyötyä äitiyskuolleisuuden laskemisessa, katseet on käännetty kysymykseen synnytyksen hoidosta. Vain harvassa kulttuurissa nainen on perinteisestikään synnyttänyt yksin,

mukana on joko sukulainen tai kylän ‘viisas vaimo’. Näiden *kyläkätilöiden* olemassaolon, kokemuksen ja aseman hyödyntäminen on ollut yksi ‘Turvallinen äitiys -kampanjan’ perusajatuksista.

Kyläkätilöt (traditional birth attendants, TBA) rekrytoidaan ja koulutetaan auttamaan synnyttäjiä paremmin kuin ennen. Kuten Kamal (2000) toteaa laajan analyysinsa pohjalta, on hyvin vaikea todeta kuinka merkittäviä tuloksia on saavutettu. Kyläkätilöiden rekrytoinnissa, ohjauksessa ja seurannassa sekä mahdollisen palkkiojärjestelmän järjestämisessä on paljon ongelmia, mutta useissa maissa, esimerkiksi Nepalissa, tullaan vielä pitkään luottamaan heidän palveluihinsa. Lisäksi he usein välittävät tietoa muista terveysasioista ja jakavat ehkäisyvälineitä. (Kamal 2000, Rouvinen 1996)

Koulutetuiltakaan kyläkätilöiltä ei kuitenkaan voi odottaa enempää kuin normaali-synnytyksen hygieenisen hoidon ja komplikaatioiden havaitsemisen niin ajoissa, että synnyttäjä ehtii siirtyä sairaalaan. On tunnistettu yleisesti, että niin kauan kun ei ole mahdollisuutta suorittaa keisarinleikkausta, yllättävien komplikaatioiden, kuten pitkittynyt tai pysähtynyt synnytys tai synnytyksen jälkeinen verenvuoto, usein kohtalokkaita seurauksia ei voida merkittävästi vähentää. Alemman tason hoitomahdollisuudet esimerkiksi terveysasemilla eivät normaalisti tarjoa merkitsevästi mitään parempaa kuin hygieenisesti hoidettu kotisynnytys. Ongelma on usein se, että lähin sairaala on ehkä liian kaukana, sinne ei ole saatavilla kuljetusta, kulttuurisidonnaiset tekijät estävät tai hidastavat matkaan lähtöä tai hoito maksaa liikaa. (Donnay 2000, Kamal 2000.)

On myös muistettava, että hoitoon pääsy ja muodollisesti pätevä henkilökunta ei takaa hyviä tuloksia. Jahn havainnoi Nepalista kuinka joka seitsemäs keisarinleikkaus ja joka neljäs riskitarjontasynnytys päättyi sikiön kuolemaan (Jahn 2000). Toisaalta on myös esimerkkejä siitä kuinka sairaanhoitajatason henkilökunta pystyy adekvaatin koulutuksen ja olojen puitteissa toimimaan hyvin tehokkaasti, jopa suorittamaan menestyksekkäästi istukan käsinirrotuksia ja keisarinleikkauksia (Donnay 2000).

Kairon vuoden 1994 väestö- ja kehityskonferenssissa ehdotettiin tavoitteeksi, että vuoteen 2005 mennessä 80 % synnytyksistä olisi asiantuntijoiden hoitamia (AbouZahr 2001). Edelleen kuitenkin vähiten kehittyneissä maissa vain viidesosassa synnytyksistä on mukana sairaanhoidollisen tai kätilön koulutuksen saanut avustaja. Nepalissa luku on vieläkin pienempi, noin 10 %. (UNICEF 2002)

3.2. Perhesuunnittelu ja abortti

Tilastojen mukaan modernien ehkäisymetodien saatavuus on parantunut kaikkialla maailmassa merkittävästi. Vähiten kehittyneiden maiden parisuhteessa elävistä naisista käyttää nyt (vuonna 2002) ehkäisymenetelmiä 32 %, kun luku kymmenen vuotta aiemmin oli 18 %. Nepalissa kehitys on ollut vastaava, prosenttilukujen ollessa hieman matalammat. (UNICEF 2002)

Naisen ja parin mahdollisuus säädellä syntyvien lasten lukumäärä ja ajoitus on todettu olevan merkittävää naisen terveyden kannalta, mutta samanaikaisesti se on palvellut väestöpoliittisia päämääriä väestön kasvun kontrolloijana. Eräitä perhesuunnittelu-ohjelmia onkin kritisoitu toimimisesta nimenomaan naisen itsemääräämisoikeuksia ja jopa terveystavoitteita vastaan sen sijaan että olisi edistetty niitä. (Pinotti & Drezzet 1998)

Nepalin Sirahassa haastatellut 60 naista olivat nuoria, keski-ikä 24 vuotta. Heistä kuusi oli jo sterilisoitu, joista yksi tosin oli toimenpiteestä huolimatta raskaana (raskaus oli alkanut ennen toimenpiteen suoritusta). Lisäksi 14 muuta oli säännöllisiä ehkäisyn, lähinnä injektoivan hormonivalmisteen (Depo-Proveran®), käyttäjiä. Suurelta vaikuttava käyttäjämäärä otoksessa (33 %) ei vastaa väestön prosentuaalista osuutta, mutta oleellinen löydös oli naisten oma kommentointi ja tyytymättömyys neuvontaan ja tarjottujen vaihtoehtojen puute. Kun hindulaisuuteen pohjautuvaan kulttuuriin kuuluu ehdoton vaatimus lasten ja poikalapsen olemassaolosta, nuoren muutaman kerran synnyttäneen naisen sterilisoimisen voidaan sanoa olevan epäeettinen toimenpide, koska kyse on

olosuhteista missä lapsikuolleisuus on edelleen korkea. Lisäksi sterilisointiin suostuville maksettiin palkkio, jolloin asiakkaan mahdollisuus vapaaseen valintaan oli heikentynyt. (Rouvinen 1996, 1996b julkaisematon)

Nepalin tilanne ei ole poikkeuksellinen. 1990-luvun alussa Saõ Paolossa Brasiliassa tehty tutkimus paljasti, että jopa 50 % naisista oli sterilisoitu alle 30 vuoden iässä vaihtoehtojen puutteessa. Merkittävä syntyvyyden väheneminen saavutettiin, mutta kyseenalaisella menetelmällä. (Pinotti & Drezzet 1998)

Keskimääräinen synnytysten tiheys (fertility rate) on laskenut kaikkialla, mutta alueiden väliset erot ovat edelleen suuret. Vähiten kehittyneissä maissa nainen synnyttää keskimäärin 5,4 kertaa, kehittyvissä maissa 3,0 ja teollisuusmaissa 1,6. Nepal kuuluu aktiivisesta väestöpolitiikastaan huolimatta alimpaan ryhmään luvulla 4,7.

Monien maiden asukkaiden ongelma on edelleen puutteellinen tieto perhesuunnittelun mahdollisuuksista ja sen saatavuus, joka johtuu joko maantieteellisistä, taloudellisista tai uskonnollispoliittisista syistä tai näiden yhdistelmistä. Arvellaan esimerkiksi, että Afrikan Saharan eteläpuolisissa köyhissä maissa vain noin puolet ehkäisyä kaipaavista pariskunnista pystyy käyttämään moderneja metodeja. Tilannetta kuvataan termillä ‘unmet needs’ (täyttämätön tarve). (UNICEF 2002)

Abortti

Raskauden keskeytys on ollut kautta aikojen tapa rajoittaa perheen lasten lukua tai yritys välttää muuten epätoivotun raskauden loppuunsaattaminen riippumatta siitä, onko se ollut yhteisön moraalisten normien tai lainsäädännön hyväksymää. Useissa kehitysmaissa sekä itse aiheutettu että lääketieteellisesti suoritettu abortti on edelleen laiton lukuun ottamatta äidin henkeä uhkaavaa tilannetta. Niissäkin maissa, missä se on laillinen toimenpide, hoitoon pääsy on hyvin rajallista taloudellisten ja maantieteellisten syiden sekä sosiaalisen painostuksen takia. (Bernstein & Rosenfield 1998)

Usein myös lääkärit tekevät laittomia abortteja jopa sairaalaolosuhteissa, mutta palvelu on useimmille liian kallista tai kaukana ja niin naiset joutuvat turvautumaan puoskareihin. WHO:n arvio on että vuosittaisesta 50 miljoonasta abortista noin 20 miljoonaa on virallisesti laittomia ja samanaikaisesti käytettyjen menetelmien takia vaarallisia naisen terveydelle. Ne aiheuttavat komplikaatioina verenvuotoa, tulehduksia, kohdun ja muiden elinten vaurioita, hedelmättömyyttä ja kuolemantapauksia. Edelleen arvioidaan, että vähintään joka viides äitiyskuolleisuuden uhreista kuolee abortin seurauksiin, noin 70 000 naista vuodessa. On selvää, että todellisia lukuja ei ole saatavissa, ei aborttien määrästä eikä komplikaatioista edes kehittyneemmän rekisteröinnin maissa. (Bernstein & Rosenfield 1998, Koblinsky ym. 1994)

Siitä että abortin laillistaminen ja turvallisten aborttien saatavuus on ehkä tärkein yksittäinen tekijä naisten terveyden ja hyvinvoinnin edistämisessä on runsaasti näyttöä. Vielä turvallisempi vaihtoehto on tietenkin tehokkaiden ehkäisymenetelmien saatavuus ja käyttö. Poliittiset ja uskonnolliset mielipiteet ja käsitykset asiasta ovat kuitenkin erityisen voimakkaita ja estävät monessa maassa rationaaliseen ajatteluun pohjautuvan päätöksenteon, jonka voisi kuvitella pohjautuvan ei vain terveydellisten haittojen ehkäisyyn vaan naisen päätösvaltaan omasta kehostaan ja elämästään. (Bernstein & Rosenfield 1998)

Nepalissa abortti on ollut täysin kielletty ja sen tehneitä naisia tuomittu vankeusrangaistuksiin. Syyskuussa 2002 annettiin uusi liberaali laki, joka sallii raskauden keskeytyksen pyynnöstä 12 raskausviikkoon asti ja 18 viikkoon asti raiskaus- ja insestitapauksissa tai äidin terveyden vaarantuessa. Laki yksin ilman terveydenhuollon kapasiteettia ei takaa toiminnan toteutumista, mutta muutos on merkittävä askel. (Ipas 2002)

3.3. HIV ja muut sukupuolitaudit

Aikuisten hiv-tartunta on kehitysmaiden näkökulmasta on heteroseksuaalisissa suhteissa tarttuva sukupuolitauti. Taudin muut verikontaktiin perustuvat tartuntatiet on huomioitava, mutta ne ovat lukumääräisesti huomattavasti vähemmän merkityksellisiä. Perinataalinen tartunta äidistä sikiöön joko raskauden, synnytyksen aikana tai imetyksen kautta on puolestaan lasten tartuntojen lähde. Viruksenkantajaäidin riski siirtää tartunta lapseen on noin 25-35 % ja seurauksena jossain maissa jopa viidennes kaikista hiv-tartunnoista ja vastaavasti kuolemantapauksista on pediatrisia. Tartuntariskiä merkittävästi vähentävä raskauden aikana annosteltava antiretroviruslääkitys (esim. zidovudine) lääkitys selektiiviseen keisarinleikkaukseen vähentää tartuntariskin jopa 1 %:iin, mutta hoito on toistaiseksi vain harvojen osan saatavilla. (Preble ym. 1994, UNAIDS 2000)

Useimmissa kehitysmaiden raskaudenajan terveystarkastuksissa jätetään syfilis ja muut sukupuolitaudit tutkimatta. Kuitenkin esimerkiksi Etelä-Afrikassa seulonnat ovat paljastaneet, että kaikista naisista noin 25 %:lla ja raskaina olevista jopa 50 %:lla on vähintään yksi sukupuolitauti (Colvin 2000). Malawin maaseudun otoksessa syfilistä sairasti 9 % ja hivin kantajia oli 17 % (Kulmala 2000). Tansaniassa tehty kontrolloitu ja randomisoitu tutkimus (Grosskurth 1995) näytti selvästi, että kohderyhmän tehokas sukupuolitautien, nimenomaan gonorrean, hoito alensi hivin tarttumisriskiä jopa 40 %:lla. Samoin on osoitettu, että muita sukupuolitauteja sairastavat levittävät myös hiv-infektiota erittäin tehokkaasti: luonnollisesti ehkä keskimääräistä useimpien sukupuolikontaktien kautta, mutta myös biologisten mekanismien kautta. (Colvin 2000)

Huolimatta siitä, että sukupuolitaudit ovat lähes poikkeuksetta antibiooteilla helposti parannettavissa, niistä suuri osa jää hoitamatta johtuen puuttuvista klinikoista ja laboratoriotesteistä, huonosta hoitoon hakeutumisesta, hoidon suhteellisesta kalleudesta ja koordinoimattomista ja epäasiallisista hoitomenetelmistä, joista muun muassa puuttuu lähes täydellisesti partnerien etsintä. Näin sekä hoitamattomien sukupuolitautien haitat ja

tartunnat yleistyvät entisestään ja samalla ylläpidetään alttiutta myös hivin leviämiseen. (Colvin 2000)

Naisten osuus hivin kantajista kehitysmaissa on noin 50 prosenttia, jossain maissa kolmannes kaikista naisista on viruksen kantajia. Naisten mahdollisuus välttää infektio on usein hyvin pieni johtuen heidän sosiaalisesti heikosta asemastaan. Nuorten tyttöjen vastentahtoinen joutuminen vanhempien miesten seksuaalitarpeiden tyydyttäjiksi on lisääntynyt uskomuksesta, että seksi on turvallisempaa heidän kanssaan kuin suuremmalla todennäköisyydellä jo infektoituneiden naisten kanssa. Tyttöjen infektioalttius on puolestaan suurempi jo sukupuolielinten kehittymättömyyden takia. Lisäksi aikuistenkin naisten mahdollisuus neuvotella seksiin suostumisesta tai kondomin käytöstä on usein mahdotonta käyttäytymistapojen mukaan, esimerkiksi avioliitossa, tai se on taloudellisesti mahdotonta. (Ankomah 1999, Preble & Elias 1994, Tinker 2000)

Afrikan aids-epidemialle on ollut tyypillistä syyllistää naispuoliset prostituoidut kaiketi siksi, että ensimmäiset tapaukset olivat joko prostituoituja tai riskikäyttäytyviä miehiä, mutta muun muassa tutkimus Ghanasta korostaa, että virallisen ja näkyvän prostituution lisäksi monet muutkin seksisuhteet perustuvat taloudelliseen hyötyyn. Lisäksi modernisaatio on tuonut esiaviollisen seksuaalikäyttäytymisen normaaliksi, mutta naisen neuvotteluvara on edelleen rajoitettu. Pelkästään naisiin suunnatut valistuskampanjat eivät tuota tulosta. (Ankomah 1999) Levityksessä oleva naisten kondomi saattaa parantaa naisen mahdollisuuksia itsemääräämiselle ja omille valinnoille (UNAIDS 2002).

On kuitenkin maita, joissa kulttuurisidonnaisista sukupuolikäyttäytymissäännöistä johtuen sukupuolitautien esiintyminen on huomattavasti vähäisempää, lähinnä islamilaiset maat, mutta toisaalta mikään maa ei ole voinut sulkea rajoja niin täydellisesti että virusten kulku estettäisiin. Aidsia esiintyy kaikkialla, mutta toistaiseksi eteläisen Afrikan maiden jopa yli 30 % aikuisväestön hiv-prevalenssi on lyömätön. Nepalissa sen arvioidaan olevan 0,5 % (UNAIDS 2002)

3.4. Lapsettomuus ja lapsen sukupuoli

Lapsettomuus ei ole kehitysmaiden väestöpolitiikassa eikä terveydenhuollon ongelmissa kärkisijoilla, mutta yksityisen ihmisen ja perheen elämässä se on usein kuitenkin erittäin merkittävä ongelma. Jos elämäntarkoitukseksi mielletty lisääntyminen ei onnistu, siitä seuraa sekä henkinen että sosiaalinen kriisi, joka johtaa usein syylliseksi arvellun naisen syrjäytymiseen esimerkiksi avioeron kautta. (Fathalla 1992)

Larsen (2000) on tutkinut primäärin ja sekundäärisen hedelmättömyyden esiintymistä 28 Afrikan maan demografisten ja terveystutkimusten tilastoista. Primääriksi hedelmättömyydeksi määriteltiin se, jos nainen ei ole synnyttänyt elävää lasta 7 vuotta avioliiton solmimisesta. Sen esiintyminen jää useimmissa maissa alle 3 %:in. Toissijainen hedelmättömyys, 5 vuotta synnytyksestä ilman uutta elävän lapsen synnytystä, on sen sijaan yleisempää, esimerkiksi Keski-Afrikan tasavallassa jopa 23 %. (Larsen 2000) WHO:n arvio on, että maailmalaajuistesti jopa 80 miljoonaa pariskuntaa kärsii infertiliteetistä (Fathalla 1992).

Larsenin tutkimuksessa ei tutkittu hedelmättömyyden syitä eikä seurauksia, ainoastaan ehkäisymenetelmiä käyttävät naiset pyrittiin karsimaan otoksesta. Muiden tutkimusten mukaan tärkein syy vastentahtoiselle lapsettomuudelle kehitysmaissa on sukupuolitautien ja laittomien aborttien aiheuttamat tulehdukset ja komplikaatiot (Colvin 2000, Fathalla 1992).

Useiden traditioiden tai uskontojen vaikutusalueella, Kiinassa, islamin ja hindulaisuuden piirissä, nimenomaan poikalapsen saaminen on vielä tärkeämpää kuin muualla. WHO:n mukaan 38 maassa arvostetaan poikalasta merkitsevästi enemmän kuin tyttöä. Nepalissa terveystyöntekijä selitti alhaista ehkäisymenetelmien käyttöä seuraavasti: “Sinulla täytyy olla vähintään yksi poika tullaksesi hyväksytyksi yhteisössäsi, varmistuaksesi kuoleman jälkeisestä elämästä ja pitämään huolta omaisuudestasi kuolemasi jälkeen” (Rouvinen

1996, 84). Esimerkiksi Intiassa, Kiinassa ja Etelä-Koreassa tarve saada poikalapsi on tuonut tilanteen, jossa harjoitetaan selektiivistä sikiöiden abortointia, tyttövauvojen tappamista ja hylkäämistä ja Kiinassa raskauksien rekisteröimättä jättämistä, mikä sitten evää mahdollisuuden käyttää äitiysneuvola- ja synnytyspalveluja. (Fathalla 2000)

3.5. Sukupuolielinten traditionaalinen silpominen

Tyttölasten sukuelinten silpominen (female genital mutilation, FGM) on toimenpide, josta aikaisemmin käytettiin nimitystä naisten ympärileikkaus. Siinä vahingoitetaan genitaalialueen luontaista anatomiaa vaihdellen 'rituaalisesta' klitoriksen haavoittamisesta niin sanottuun infibulaatioon, jossa poistetaan kaikki naisen ulkoiset sukupuolielimet ja vulva ommellaan lähes kiinni. Jälkimmäistä käytetään arvioiden mukaan noin 15 %:ssa kaikista tapauksista. Toimenpide on edelleen arkipäivää 28 lähinnä afrikkalaisessa ja Arabian niemimaan valtiossa. Arviolta 2 miljoonaa eri-ikäistä tyttöä (0–14) joutuu toimenpiteen kohteeksi vuosittain tehden silvottujen naisten kokonaismääräksi 100-130 miljoonaa. (AI 2002, Fathalla 2000, Rushwan 2000)

Silpominen aiheuttaa primääriongelmia toimenpiteen suorittamisen jälkeen: jopa fataalia verenvuotoa ja tulehduksia, lisäksi riskinä ovat myös hepatiitti- ja hiv-tartunnat. Mutta toimenpiteen merkitys naisen seksuaali- ja lisääntymisterveyden kannalta on vielä merkittävämpi. Infibuloiduilla naisilla sukupuolielämän aloittaminen ei yleensä onnistu ilman uutta leikkausta, toimenpiteen tarkoituskin on poistaa naiselta seksuaalisen nautinnon kokemus[4] ja synnytyskomplikaatioiden riski on huomattavan suuri etenkin ilman asiantuntevaa avustusta tapahtuvissa synnytyksissä. Pitkittynyt synnytys, repeämät ja fistulat ovat havainnoituja seurauksia, joiden määrällistä esiintyvyyttä ei kuitenkaan laajalti ja luotettavasti rekisteröidä. (AI 2002, Rushwan 2000) Helsingissä vuosina 1993-94 synnyttäneiden somalinaisten synnytyksissä (n=67) ei ollut merkittäviä eroja

[4] "Circumcision makes women clean, promotes virginity and chastity and guards young girls from sexual frustration by deadening their sexual appetite." Mrs Njeri, a defender of female genital mutilation in Kenya (AI 2002)

verrattuna suomalaiseen vertailuaineistoon keisarileikkausten eikä episiotomialeikkausten määrässä, mutta imukuppisynnytyksiä tehtiin enemmän ja repeytymiä oli huomattavasti enemmän (28 % : 2 %). Somaliassa kaikki naiset ovat läpikäyneet silpomisen. (Mölsä 1994)

Samana vuonna haastateltiin 130 Suomessa asuvaa somalinaista, joista vain 5 % ei ollut kokenut silpomista; he olivat muuttaneet lapsina Suomeen. Naiset kertoivat, että 79 % silpomisen suorittajista oli ollut terveydenhoitokoulutuksen saaneita henkilöitä ja 19 %:ssa tapauksista suorituspaikka oli sairaala tai klinikka. (Mölsä 1994) Prosenttiosuudet tuskin vastaavat maassa asuvan väestön tilannetta, maaseudulla toimenpiteen suorittaja on useimmiten maallikko, mutta lääkintähenkilökunnan osallistuminen osoittaa selvästi, että koulutus tai ns. sivistys ei sinänsä muuta suhtautumista tradition tärkeyteen. Lisäksi voidaan kysyä, että eikö olekin parempi, että leikkelyn suorittaa sairaanhoitaja hygieenisesti kuin että se tehdään salaa ja huonosti kotona? Toimenpide on kuitenkin kielletty sekä ihmisoikeuksien nimissä että lääketieteellisen tiedon mukaisesti sekä YK:n elimissä että useiden valtioiden[5] lainsäädännössä (AI 2002, Fathalla 2000, Rushwan 2000).

3.6. Köyhyyden, traditioiden ja olosuhteiden merkitys

Lisääntymisterveys ei ole irrallaan ihmisen muusta hyvinvoinnista. Hyvinvoinnin puute altistaa naisen monille sairauksille, jotka lisäävät lisääntymisterveyden riskejä. Kehitysmaiden köyhille ihmisille tyypillinen jatkuva ravinnon niukkuus ja puutteellisuus estää luuston ja elimistön normaalin kehittymisen ja voi aikanaan aiheuttaa synnytyskomplikaatioita ahtaan lantion takia. Mikroravinteiden, raudan, jodin ja vitamiinien puute vaikutta sekä raskaana olevan naisen että syntyvän lapsen terveyteen. Väitetään myös perustellusti, että äitiyskuolleisuutta esiintyy nimenomaan perheissä ja olosuhteissa, missä jo tytöt pitävät luonnollisena sen, että he syövät jos jotain jää jäljelle

[5] Maakohtaiset tiedot löytyvät Amnesty Internationalin sivulta <http://www.amnesty.org/ailib/intcam/femgen/fgm9.htm> 29.10.02

ja joissa naisen kuolema synnytykseen hyväksytään normaalina ilmiönä. (Donnay 2000, Tinker 2000)

Terveydelle haitallisten traditioiden merkitys korostuu sukuelinten silpomisessa, mutta myös jokapäiväiseen elämään kuuluvat piirteet, esimerkiksi ruoka-aineisiin ja lapsen ruokintaan liittyvät rajoitukset aiheuttavat ongelmia. Synnytyksen hoito traditionaalisin menetelmin tuo mukanaan epähygieenisyyttä, joka koituu usein sekä äidin mutta varsinkin lapsen haitaksi. Rokottamattoman äidin lapsen tetanusriski on suuri, jos napanuora hangataan poikki kivellä tai modernimmin esimerkiksi sandaalilla. Nepalin kyläkätilöt kertoivat lisäksi, että ennen koulutusta heillä oli tapana hieroa synnyttävän naisen vatsaa ja jopa talloa sitä jaloillaan joko synnytyksen nopeuttamiseksi tai istukan poistamiseksi. (Rouvinen 1996c julkaisematon, Tinker 2000)

Raskaus altistaa malariatartunnalle myös endeemisen malarian maissa, missä normaaliväestöllä yleensä on jonkin asteinen immuniteetti ja toisaalta malaria vaarantaa raskaana olevan terveyden aiheuttamalla anemiaa ja suoranaisesti parasitemia-kuormituksen takia. Sen on myös todettu olevan yksi merkittävä tekijä ennenaikaisten synnytyksen syynä ja siten perinataalikuoleman esiintymisessä (Kulmala 2000). Samoin tuberkuloosi, hepatiitti ja aids manifestoituvat usein raskauden aikana siten, että ilman pätevää hoitoa ne johtavat kuolemaan. Myös normaalisti viattomina pidetyt suolistoloiset aiheuttavat anemian, joka sitten synnytyksen verenvuodon takia saattaa olla kohtalokasta. Mitä komplisoituneempi raskaus on, sitä enemmän siitä on uhkia myös syntyvän lapsen terveydelle. (Donnay 2000, Preble & Elias 1994)

4. Haasteet ja mahdollisuudet

Lisääntymisterveyden ongelmat kulminoituvat äitiyskuolleisuuteen. Sen alentaminen on edelleen konkreettinen ja selvä tavoite lisääntymisterveydenhuollon järjestäjille alkaen hallituksista, kansainvälisiin organisaatioihin ja paikallistason terveydenhuollon

toimijoihin. Tilastojen ja kirjallisuuden mukaan edelleen noin 1400 naista kuolee päivittäin syihin, joista suurin osa voitaisiin estää. Vähiten kehittyneet maat kantavat tästä tragediasta suurimman taakan. (Cook & Dickens 2002, UNICEF 2002). Hyvästä tahdosta ja ulkomaisesta avusta huolimatta näiden maiden saavutukset tilanteen korjaamiseksi ovat toistaiseksi olleet heikot.

Hyvästä poliittisesta tahdosta on esimerkkinä Nepal, jolla on ollut kansallinen perhesuunnitteluohjelma jo vuodesta 1968 ja 'Turvallinen Äitiys' -kampanja on ollut sen prioriteettiohjelma vuodesta 1991 lähtien. Vuosien mittaan lisääntymisterveydenhuolto on integroitu perusterveydenhuollon ohjelmaan. Päämäärät ovat olleet 1) lisätä äitiyshuollon saatavuutta ja käyttöä, 2) parantaa pääsyä sairaalatason hoitoon (referral system), 3) lisätä perhesuunnittelumetodien saatavuutta ja käyttöä, 4) lisätä kansanvalistusta ja 5) parantaa naisten laillista ja sosioekonomista statusta. (HMG 1993, Rouvinen 1996) Tavoitteet sisältyvät täysin esimerkiksi Donnayn (2000) UNFPA:n edustajana antamiin prioriteetteihin ja ovat oletettavasti siis tehokkaita. Kuitenkin Nepalin tilanne ei ole parantunut merkittävästi muuten kuin tasaisesti laskevan perhekohtaisen lapsiluvun suhteen, mikä on merkittävä saavutus, mutta johon johtaneita metodeita on arvosteltu. Nähtäväksi jää kuinka nopeasti syyskuussa 2002 annettu laki aborttien laillistamisesta tulee vaikuttamaan äitiyskuolleisuuteen.

Donnay (2000) esittää toiveikkaasti, että jopa yksittäisillä terveydenhuollon osa-alueiden kehittämisprojekteilla voidaan parantaa naisten terveydentilaa, etenkin jos siten pystytään tarjoamaan tarvittava obstetrinen hoito (essential obstetric care, EOC), johon kuuluu olennaisena pääsy hätätapauksissa asianmukaiseen leikkaushoitoa tarjoavaan sairaalaan. Toiseksi esitetään koko terveyspalvelujärjestelmän kehittämistä siten, että laadukas ja 'naisystävällinen' sukupuoliroolikäyttäytymisen ymmärtävä perhesuunnittelu ja prenataalinen hoito olisi kaikkien saatavilla. Kolmanneksi korostetaan yhteiskunnan eri sektorien integraatiota sekä miesten ja poikien osallistamista. (Donnay 2000)

Kun kuitenkin esimerkiksi Nepalissa enemmistö väestöstä elää tuntien tai päivien kävelymatkojen päässä lähimmästä terveysasemasta, jonka antama hoidon taso lisäksi on usein vähintäänkin kyseenalainen (vrt. Jahn ym. 2000, Rouvinen 1996), niin sekä Nepalin omat että kansainvälisen yhteisön hyvät suunnitelmat toimivat lähinnä vain retoriikan tasolla. Kun lisäksi Nepalissa ja lukuisissa muissa vähiten kehittyneissä maissa on taloudellisen kehittymättömyyden lisäksi ja taustalla pitkiä ja vakavia sotien ja turvattomuuden kausia, ja kun koulutuksen puutteeseen ja uskonnollisiin käsityksiin sidoksissa olevat traditiot säilyvät erityisen vahvoina perinteisessä agraarikulttuurissa, niin sinänsä kunnioitettava pyrkimys naisten aseman ja oikeuksin parantamiseksi on käytännön tasolla utopiaa - niin kauan kunnes yhteiskunnassa tapahtuu merkittäviä muutoksia.

Useat lisääntymisterveyttä pohtivat kirjoittajat palaavat Sri Lankan esimerkkiin positiivisena poikkeuksena.. Sri Lanka on pienen kansantulon (700 dollaria /hlö/vuosi) maa ja se on myös kärsinyt sisäisistä poliittisista ristiriidoista. Siellä on kuitenkin saavutettu merkittävä äitiyskuolleisuuden väheneminen. Se laski vuosien 1930 ja 1990 välillä arvioidusta 555:stä noin 45:een ja on siis nykyisellään pienempi kuin eräissä teollistuneissa maissa (esim. Viro 80, Venäjä 75).

Hyvinvoinnin kehitys on saavutettu panostamalla kätilöiden ja lääkärien koulutukseen ja heidän sijoitukseensa sinne missä ihmiset asuvat, ilmaiseen terveydenhuoltoon ja terveysasemien (primary care unit) rakentamiseen niin, että etäisyys sellaiseen on korkeintaan 5 kilometriä. Samanaikaisesti myös muilla yhteiskunnan osa-alueilla on tapahtunut merkittäviä muutoksia: koulutus on ilmaista ja molemmat sukupuolet hyödyntävät sitä ja niinpä naisten lukutaitoisuus on nyt 90 % ja heidän keskimääräinen avioitumisikänsä on noussut 25 vuoteen. Nainen synnyttää keskimäärin vain 2,1 lasta ja hänen sosiaalinen asemansa on huomattavan hyvä ja tasa-arvoinen. (Cook & Dickens 2002, Donnay 2000, Koblinsky ym. 1999)

Yhteenvetona voidaan todeta, että hyvän laadun merkitys sekä hoitotilanteissa, hoitajan tai lääkärin ja asiakkaan suhteessa, teknisissä toimenpiteissä, terveydenhuollon suunnittelussa ja resurssien jakamisessa on merkittävä osa lisääntymisterveydenhuollon monitahoista haastetta. Hyvin toteutuneella terveydenhuollolla voidaan sekä pelastaa ihmishenkiä että tuottaa elämänlaatua, mutta se ei koskaan yksinään pysty parantamaan naisen asemaa.

Hyvinvoinnin saavuttaminen edellyttää ennen kaikkea sellaista poliittista päätöksentekoa ja taloudellisten resurssien jakoa, mikä käytännön tasolla mahdollistaa inhimillisen kehityksen. Köyhien maiden rakenteellinen haavoittuvuus (vrt. UNCTAD 2002) on sidoksissa niiden heikkoon asemaan maailmankaupan markkinoilla ja merkittäviä muutoksia ei ole näköpiirissä. Köyhyyden kasaantuminen jatkuu ja se kulminoituu naisten kärsimykseen.

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QUALITY OF CARE IN REPRODUCTIVE HEALTH SERVICES AT HEALTH POSTS IN NEPAL

Contradiction between user expectations and provider perceptions

Kaisa Rouvinen, RN, PHN, MCommH[1]

Objective: The aim of the study was to assess the quality of reproductive health care services at health posts in Siraha District, Nepal.
Methods: The structure of care was evaluated by studying health post facilities and service delivery arrangements according to set standards. The health personnel perceptions were explored by semi-structured interviews using a topic guide approach. The level of patient satisfaction was investigated by conducting exit-interviews using a structured questionnaire with closed and open-ended questions.
Results: The low utilisation of reproductive health services in the study area and the dissatisfaction of users shows that there is need for intensive quality improvement. There were deficiencies in the structure of the service, but the more striking finding was the existing contradiction between quality perceptions of service providers and users.
Conclusion: The research gave both providers and users a chance to express their opinions about the quality and what should be done to improve it. Several weaknesses of the care at the health posts were found, but recognising them does not guarantee any change if a mechanism of ongoing process of quality assurance is not set up.

Keywords: Quality of care, reproductive health, staff motivation, patient satisfaction, Nepal, PHC

INTRODUCTION

Reproductive health care

Women have special needs in health care. The term reproductive health covers those needs. In this paper the term is used to cover the whole spectrum of health services from family planning (FP), pregnancy care and gynaecological services to new-born and child care including EPI (expanded programme on immunisation). Reproductive health universally and in developing countries is a sensitive issue. It takes on political dimensions because the indicators such as maternal mortality, infant and under five mortality are frequently used to judge the status of the health care and the level of development of a country. Population policies are surrounded with political, economical, traditional and religious factors.

Attempts to address reproductive health problems take place in most developing countries under the Primary Health Care (PHC) programmes. The Safe Motherhood Initiative was launched in 1987 as a commitment by representatives of over 45 countries to reducing maternal mortality and morbidity by one-half by the year 2000. Today's maternal mortality

[1] The study was conducted as a partial fulfilment for a Masters Degree in Community Health at the Liverpool School of Tropical Medicine (UK) in 1996

rates vary from two per 100 000 live births in many developed countries up to over a thousand in some less developed countries.[1]

Women in Siraha

Women in Siraha, a district situated in the eastern lowlands of Nepal, belong to a population whose health status generally is poor. Life expectancy of Nepalese people at birth is approximately 53 years. In addition as women their well-being is affected by many factors. The safety of contraceptives, the sequences of STD and HIV, the risks of unwanted or frequent pregnancies, as well as the consequences of infertility are their burdens. Due to traditional, social and economic reasons they often are not in a position to seek adequate help, even if it were actually available.

A particular feature of the population in Siraha is the existence of marginalised ethnic groups and castes. The proportion of low castes is 11%. Over ninety percent of people are Hindus and seven percent are Muslims. The illiteracy rate amongst women is around 84% and 57% for men. Both rates are higher than the national figures (75% and 46%). The main source of income is farming (rice), but even locally up to 70% of people are landless and dependent on daily wages.[2,3,4]

In Nepal the government is committed to promoting both Safe Motherhood and Family Planning. The integrated primary health care system, with the health post as the basic unit, is a framework for the implementation of reproductive health services. The accepted policy stresses the need to stabilise population growth, the protection of pregnant women and lactating mothers and children under five (that is all included in MCH and FP services).[5] In Siraha the Ministry of Health operates 12 health posts and 22 sub-health posts with the support of Save the Children US in Nepal (SC/US), that is a non-governmental organisation (NGO) working in collaboration with the District Health Office. The study interpreted in this paper was initiated by the agency for their needs of planning and implementing of the work.

In Siraha the utilisation of public health services, especially on the preventive side is low. According to a baseline study conducted in 1995, 16.6% of men and only 9.2% of women had visited a health post for any reason during the previous six months. Both ante-natal care (AN) attendance (9,8%) and contraceptive prevalence rate (13.9) are lower than the national average (15.5% and 21.3).[3] The maternal mortality rate in Nepal is 515 and although not informed, it can not be less in Siraha.

Quality in health care

One reason for the low utilisation may be the poor quality of available services. The aim of ensuring high quality in health care has always been a part of the medical and nursing care professions. Normally, the high quality of a product or a service is seen as the achievement of a pre-set standard or target. In health care it means meeting the needs of patients following the accurate professional standards. The costs to the organisation and the limits set by authorities are other factors to be taken into account. Ethical, political and financial questions all influence prioritising and decision making.[6,7]

Avedis Donabedian approaches quality assessment from three dimensions: structure; process of care; and outcome of care. He emphasises the multidimensional nature of quality.[8,9] He has however been criticised by saying that the dimensions are more categories of care than categories of quality.[6] Robert Maxwell's dimensions are said to illustrate *quality* more precisely.[10] The latest description of the dimensions may be found in Offei et al used in a quality assurance project in Ghana. The following illustration (table 1) has been combined from Maxwell and Offei et al. [11 -12]

Table 1 Illustration of the Maxwell's quality dimensions (Maxwell 1992, Offei et al 1995)

Dimensions of quality	Illustration of dimensions
Access	Geographic, financial, organisational, linguistic, physical access "What do people think of it?" (Maxwell)
Relevance to need	Does the service reflect the needs of the community?
Effectiveness	Do the results of the service reach the technical standards?
Equity	Do all the patients or groups of patients receive equal treatment with same appropriateness?
Social acceptability	Are the patients' cultural values, beliefs and attitudes respected? Are privacy and confidentiality safeguarded?
Efficiency and economy	Is the service producing the greatest possible output with available resources (input)? How does the unit cost compare with the same type of units elsewhere?

One recent framework for the work in quality assessment was developed by Judith Bruce.[13] Her special subject of interest is reproductive health care. She has a list of impacts of good care; knowledge, satisfaction and health of the client as well as acceptance and continuity of contraceptive use. Her model has been used in several studies evaluating family planning services in developing countries. [14,15,16]

Health care providers' job motivation and its impact on quality of health care

The reasons for poor health care can be found in the structure, but as the health workers are the key persons in the service delivery process, the impact of their performance is significant. In aiming to improve quality of care, the motivation as well as the skills of health providers need to be focused on.

Motivation of the staff or of an individual employee is a basic issue in management of organisations when aiming for good results or good products. It has been identified as an key factor in improving quality of health care alongside management commitment.[17]

Aitken in his article from Nepal describes how a permanent job within a government health system provides a secure, although meagre source of income. His conclusion is that there is an implicit theory accepted by the staff and the management that the main purpose of the district public health office is to provide an income for its staff. The official purpose of providing health services to the community therefore receives less emphasis. Consequently the staff is not self-directed to improve the job performance especially taking account the numerous de-motivating factors they face in their work. [18]

User satisfaction

User satisfaction has been seen as contributing to service utilisation and compliance rates, but several authors declare that it has become a legitimate and desired outcome in itself. Therefore it should not be treated as an optional perspective of quality - it is itself quality.[9,19,20,21]

A review of studies conducted in the UK by Williams (1994) shows that most of the users are rather uncritical when interviewed in surveys. The care must be extremely poor before they express dissatisfaction. However, when the interviewees are given an opportunity to express themselves in their own terms, responding to open-ended questions, they unveil critical opinions. [19,22]

Williams showed that high user satisfaction has two important positive consequences: better appointment keeping and improved treatment compliance.[19] In preventive health care user satisfaction plays perhaps a still more remarkable role as was shown in the studies reviewed by Simmons and Elias.[23] Appointment keeping, adoption of contraceptive use and overall method continuation were related to good provider-client interaction. Poorly-informed, badly-treated clients do not return for appointments as was shown in a study in Benin concerning MCH services.[24] On the contrary, the satisfaction caused by "*being treated like a person"* results greater acceptance and sustained use of services which was the clear finding in a study at a family planning and MCH clinic in Chile.[25]

Studies in Benin and in Nepal have shown that especially people who are most vulnerable due to low socio-economic or educational status and in Nepal due to low caste background are least likely to use preventive services. The reasons for this are, of course, multiple but one main reason is the fear of being prejudiced against due to low status or simply not being treated with conventional dignity.[24,26]

METHODS

The study approach was descriptive and evaluative. The aim was to promote analysis of the results with the view of developing recommendations for improvement of quality of care. The data was collected by using both quantitative and qualitative methods. The rationale was to have a multifaceted picture of the quality of care in the study location. Methods used were;-

1. Inventory of facilities and evaluation of service arrangements at five health posts chosen purposively according to the requirement of the NGO working in the field
2. Semi-structured in-depth interviews of 14 health workers involved in reproductive health care using a topic guide approach. The subjects were five male health assistants who are in charge of the health post, six male auxiliary health workers and three female auxiliary nurse midwives
3. Exit interviews with 60 female health post users from five separate health posts, who visited the health facility for any type of reproductive health service. There was a plan for sampling, that however became irrelevant due to very low service utilisation. Therefore all the consenting clients were interviewed. The refusal or non-response rate was low. Interviews were conducted by using a structured questionnaire with closed and open-ended questions.

RESULTS

The evaluation of health posts showed that there were crucial deficiencies in basic equipment and facilities - such as lack of examination beds, sphygmomanometer, scales etc. On the other hand all the health posts had full staffing, and essential infrastructure such as buildings and road network were present. The cleanliness of the dressing rooms and the compounds can be found unsatisfactory. At one health post where the muddy water floods the health post several times during a monsoon the effort to keep tidy is extremely difficult.

The chronic deficiency of medicine affects both curative and preventive care. The family planning supply was well in order. The service delivery concerning MCH and FP is still in need of specific attention both in terms of quality and availability. Health education and counselling are not valued as activities. A private room for counselling was available at three health posts.

Health care providers' perception about the quality of care

Job satisfaction experienced is generally high. Only two out of fourteen interviewed health workers said that they were not very interested in their jobs. The prime reason for being contented comes mostly from the pleasure of serving and helping people. Three people mentioned that because they are carrying out good work, people love and respect them and that makes them happy.

In spite of general satisfaction all health workers encounter problems, too. Lack of medicines and low salaries were almost universal issues. Health post leaders were concerned about service arrangements; they mentioned problems caused by political influences and insufficient manpower as well as by lack of community support. Midwives emphasised providing safe and good services to women; their special concern is deliveries. The issue of client-provider interaction did not come up in the interviews without probing, but occasionally it was recognised as an important factor.

The health workers' perception of users' expectations and satisfaction reflects how they rate their personal or institutional performance. Generally, they see clients as ignorant recipients of the service. They think that clients come to the health post only to obtain medicines, contraceptives or vaccines. In spite of the fact that the medicine supply is scarce, the health workers think that most of the users are still satisfied with the service.

The health workers' perception of what is good quality in health care is not very formulated and it emphasises technical aspects of the health care. The suggestions of what would improve the quality of care at the health post reflect both practical the needs of the health post and their own motivation. Salary increase, training and promotion would motivate them. Supervision is not considered an important issue, more important is a sufficient supply of medicine and adequate facilities.

Client's point of view

The mean age of the women interviewed was 24 years. It is though necessary to mention that the age was often an estimation concluded together by the informant herself, the researcher and the research assistant The respondents were all married and all except four had children alive. The average number of children was 2.55. The distribution of religion and castes represents the population in average.

Altogether forty percent has received some education; in most cases only non-formal education that means adult literacy classes. Almost 80% of women are occupied in household activities and in the farming for their families. Small trade is the main occupation of five women. Eight respondents (13.3%) belong to landless families and are involved in paid daily labour.

Important findings of how clients perceive quality of care were;-

Fifty percent of all respondents had felt that they were not afforded sufficient privacy and confidentiality during examination. Half of family planning clients felt they that had not received enough information about different methods or that they had even been given wrong information. Nine out of fourteen felt that they did not know enough about their current method. Two informants on the contrary said that they received good advice.

Closely related to receiving correct information is the continuity of service. This is extremely important for family planning and EPI clients, but all the patients should know if they need to return for further appointments or if their treatment has been finished. Most of women who did not know if they are expected to come back or when they should come were mostly clients of curative care. But also five AN clients and one mother of a child of EPI programme and one FP client did not know the date when they should return. All in all, 26.7% were ill or non-informed.

Continuity also includes a constant supply of contraceptives, vaccines or other necessary drugs. All vaccines and contraceptives were available almost without an exception. The problem was the insufficient supply of medicines that is needed in ante natal, delivery, and child health care.

Being treated with dignity and respect by providers during the visit to a health post is important for the client. The majority, 72%, felt they were treated politely. Nine people (15%) said the they were treated unfriendly or roughly. Thirteen percent had no opinion. There were no other associations between dignity experience and client's background; the religion or caste, education or occupation except that none of the untouchables or daily wage labourers had experienced impoliteness or at last they did not express it.

The clients' perception of the quality of care was clearly illustrated by their comments how they had experienced the visit. Forty three percent of respondents were more or less satisfied. Fifty percent were clearly dissatisfied. Satisfaction or dissatisfaction had no clear associations to users' background nor to the reason for the current visit.

The most common reason for dissatisfaction was the lack of medicine supply (26/60). The next most frequently mentioned (13/60) reason was lack of thorough examination. Other reasons were that they did not receive good advice or that they had experienced rough or careless behaviour of the staff. In addition mistrust was expressed by three people who

believed that staff members sell the government medicines privately. Two persons told of an abscess the child had acquired after last vaccination. Four people expressed the need for a female health worker. Six people said that the health post is hardly of any use. *"I have lived here for all my life, I know. They don't have medicines, but if they get some, they use them as they want. If they don't get medicines they should give advice and good care to the people, but they don't care."*

In spite of the dissatisfaction almost all clients (93%) see the health post as the place where to return for curative care. The intention to use the health post for family planning and ante-natal services is lower (70-76%).

CONCLUSION

Full staffing and reasonable facilities at the health posts as well as high self-esteem of health workers are an existing prerequisite for good quality in health care in the study location. However deficiencies in service arrangements reduce overall quality and several problems cause reduction in staff motivation as well as in user satisfaction.

The lack of medicines is a priority issue when the quality is assessed from the perspectives of both health service providers and users and is a reason which providers recognise as a cause of patient complaints. Providers however assume that it is the only reason for dissatisfaction, which is not true.

Health post users expect decent interpersonal relations and professional competence. They do not agree with the providers' point that because the setting is 'only a health post', not much service is to be expected. Users expect providers to listen to them, pay attention to their problems and conduct a thorough examination. The mother who had walked over two hours for her child's vaccination did not have a chair offered while the child was vaccinated. The mother who brought her new-born baby for a check -up did receive vitamin pills, but nobody even looked at her child. The woman who had lost her individual FP card was roughly refused the contraceptive injection (Depo-Provera) she was due.

Health providers accuse clients of ignorance and unwillingness to change behaviour. Users complain of inadequate information or lack of information. Many of them do not know when they should return to the health post. Many feel they do not know enough about the family planning method they are using. Users' expectations and the providers' perception of the quality are highly contradictory.

The conclusion is that the quality of care within reproductive health care services at the health posts studied is generally low and needs attention. - The study was initiated by the concern that the utilisation of public health care and reproductive health services is low in the study location. The assumption of the connection between poor quality of care and low utilisation is acceptable; but the significance of it could not be proved in this study.

When comparing the results of this study to other studies where user satisfaction has been queried[19,22], the dissatisfaction of the clients in Siraha seem to be significant, taking into account that satisfaction expressed is usually high regardless of the setting of the service. Two conclusions can be drawn. Firstly, the level of the quality at these health posts is

indeed poor and secondly, the methods used in this study succeeded in revealing users' actual critical opinions.

The proportion of women in the sample who have attended non-formal education classes was threefold compared with the proportion amongst all women in the district. This emphasises the importance of it in increasing knowledge and interest in seeking out formal health care.

The ongoing assistance by the NGO involved is significant; specifically promoting non-formal education in the district; providing training for the staff at the health posts; and organising sufficient equipment and essential medicine supply (including iron supplements, children's antibiotics and medications for obstetric emergencies) together with a sound control system and enhancement of treatment skills. Judging priority and feasibility, needs however thorough consideration of available resources.

More complicated however is the question of awakening health workers to the needs and expectations of clients and to commit themselves to improving quality. Therefore the priority recommendation based on this study is to set up a mechanism of ongoing quality assurance, where health providers are active participants - quality assurance which builds quality assessment, monitoring and improvement into working practices of a health service unit.

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QUALITY OF CARE IN REPRODUCTIVE HEALTH SERVICES AT FIVE GOVERNMENT HEALTH POSTS IN SIRAHA DISTRICT, EASTERN NEPAL

Kaisa Rouvinen

A dissertation submitted to the University of Liverpool (School of Tropical Medicine) in partial fulfilment of the degree of Master in Community Health 1996

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I am also indebted to the interviewees, the women who I met at the health posts. They patiently answered my questions and shared many deep concerns about their lives with me. I learned a lot.

"Didi", my Nepalese sister, I would like to return your beautiful greeting

"***Be happy wherever you go***"

with a sincere hope that the health care near you will improve and

it will help you to have a fulfilled and happy life.

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LIST OF ABBREVATIONS AND ACRONYMS

AHW	Auxiliary Health Worker
AN / ANC	Ante Natal Care - the MCH provided to pregnant women
ANM	Assistant / Auxiliary Nurse Midwife
AVSC	Name of an organisation (Access to Voluntary and Safe Contraception)
CHV	Community Health Volunteer
COC	Combined oral contraceptive pills
DHO	District Health Office
DPHO	District Public Health Officer
DoH	Department of Health Services
EPI	Expanded Programme on Immunisation
FCHV	Female Community Health Volunteer
FP	Family Planning programme or service
HBV	Hepatitis-B Virus
HIV	Human Immuno-deficiency Virus
HMG	His Majesty's Government of Nepal
HP	Health Post
HPI	Health Post in Charge
MCH	Mother and Child Health Care
MCHW	MCH Worker
MoH	Ministry of Health
NFE	Non-formal education
ORT / ORS	Oral Re-hydration Therapy / Solution
PNC	Post Natal Care - the MCH provided to a mother and to the new born baby after the delivery
SC/US	Save the Children US
SC-C	Save the Children Health Post Co-ordinator
SHP	Sub Health Post
STD	Sexually Transmitted Disease
TBA	Trained Birth Attendant
UNICEF	United Nations Children's Fund
VDC	Village Development Committee
VHW	Village Health Worker
VSC	Voluntary Surgical Contraception
WHO	World Health Organisation

GLOSSARY

Client / user / patient	a person who visits a health post for a consultation for preventive or curative service
Depot-holder	a lay person in the village who has a supply of contraceptives and ORS for distribution
Mukhiya	a clerk at a health post
Peon	a messenger, an untrained health post worker
Study client	the study client of this study was the representative of Save the Children US in Nepal
Terai	the lowlands in Southern Nepal facing Indian border

EXECUTIVE SUMMARY

This study was conducted in May-October 1996 as a partial fulfilment for a Masters Degree in Community Health at the Liverpool School of Tropical Medicine. The field work was carried out in the Nepalese lowlands (Terai) in Siraha District in July-August.

The study client, Save the Children US in Nepal, has an ongoing programme in the district, that aims to improve accessibility, acceptance and use of MCH, Family Planning and other reproductive health care services within the existing public health care system. This study set out to explore and describe the current level of quality of care provided at five government health posts and to formulate recommendations as how to improve it.

The specific objectives of the study were
1) to evaluate the health post facilities and service delivery arrangements
2) to explore the health personnel's perceptions about the quality of care they provide
3) to describe the perceived level of users' satisfaction

The data collection methods used were:
- inventory of facilities and evaluation of service arrangements at the health posts
- semi-structured in-depth interviews of 14 health workers involved in reproductive health care using a topic guide approach
- exit interviews with 60 female health post users using a structured questionnaire with closed and open-ended questions
- key informant discussions with primary health care experts and stakeholder representatives
- informal discussions with other health post employees, community health workers and community members

The results of evaluation of the structure show that there are deficiencies in facilities and service arrangement, and that the service coverage, except in the EPI programme, is fairly low. On the other hand all the health posts have full staffing, and essential infrastructure such as buildings and road network are present.

Health personnel perceive the care they provide as good, except for a problem of an insufficient supply of medicines. They recognise many de-motivating factors affecting their work, but generally they are satisfied with their roles as health providers.

The majority of users (2/3) are not satisfied with the care they receive. They complain about the lack of medicine, inappropriate examination, insufficient information and the lack of dignity they experience in the provider-client relationship.

The conclusion is that the quality of care within reproductive health care services is generally low and needs attention. The high self-esteem and motivation level of providers as well as the fruitful co-operation between the District Health Office and SC/US provide a sound prerequisite for future quality improvement.

The recommendations based on the study are that SC/US continues to support health posts by providing assistance in forms of training and staff (assistant nurse-midwife interns); helps the DHO in organising sufficient equipment and medicine supply for the reproductive health care service; and explores possibilities to expand support to sub-health post level. Secondly, initiation of a quality assurance mechanism to promote permanent change and improvement in quality of care is strongly recommended.

CHAPTER 1. INTRODUCTION

This study evaluates quality of health care in a rural setting in Nepal within the government primary health care system. The initiative was devised by the study client, Save the Children US (SC/US) in Nepal, and the research was undertaken as a partial requirement for the degree of Masters in Community Health at the Liverpool School of Tropical Medicine.

This chapter presents the background and origin of the study, the study process and basic information about the study location.

1.1. THE CLIENT AND THE CONCERN

1.1.1. Save the Children US in Nepal

The client, Mrs. Chandra Rai, the Public Health Program Director of Save the Children US in Nepal, had presented a study topic of assessment of quality of care in the project area of SC/US at health post level in Siraha District in rural Nepal.

Save the Children US has been working in Nepal since 1981. The organisation has contributed to community development and health care programmes. The three main strategies have been Primary Health Care (PHC), non-formal education and institutional development.

The agency currently has staff working in nine districts of Nepal. The three districts where SC/US manages its own community development programmes are Gorkha, Siraha and Nuwakot. In six other districts SC/US has posted staff to work within other NGOs. In addition to this the agency implements a scholarship programme in fifteen districts.

At national level the Memorandum of Understanding with the Ministry of Health was signed in 1993. It highlights the aim of improving the status, well-being and opportunities for development involving women, children and their families in Nepal.

1.1.2. Save the Children Siraha project

Of special interest to the client was the Siraha project in the Terai, in Eastern Nepal where the organisation has been working since 1991 collaborating with local District Health Office. The project is called “Empowering Women for Family Planning and Reproductive Health Program in Siraha District”. It was started in 1995 and it will run for five years.

The programme emphasises improving primary health care services, extending contraceptive choice, appropriate management of STDs (including increasing knowledge of HIV) and empowering women to take advantage of available services. The strategies include supporting and strengthening the existing public health structure, empowering women through non-formal education (NFE) and developing outreach strategies towards men and marginalised ethnic groups. (SC/US 1994)

SC/US is implementing the program through and in collaboration with the twelve government health posts in the district. The organisation has posted a health assistant to work as a health post co-ordinator at each health post.

The main activity is training of health post staff in order to increase the quality of service delivery. The second strategy is the training of grass-root level health workers; village health workers (VHW) , traditional birth attendants (TBA) and community members who act as "depot-holders" (they have a supply of contraceptives at home for distribution) and hence widen the access to contraceptives. Thirdly, training and education of key community members using relevant information as well as education and communication (IEC) materials as a way of securing their support for the programme's aims. (SC/US 1994)

1.1.3. Problem statement

The utilisation of public health services, especially on the preventive side is low in Siraha. According to a baseline study conducted in the district in 1995, 16.6% of men and only 9.2% of women had visited a health post for any reason during the previous six months. (CREHPA 1996) Both ante-natal care (AN) attendance and contraceptive prevalence rate (CPR) are lower than the national average. (See table 1-2)

One reason among others for the low utilisation may be the poor quality of available services. Bruce (1990) and Jain (1992) suggest that good quality has a positive impact on the family planning client's knowledge, satisfaction and health as well as acceptance and continuing use of contraception.

Mrs. Chandra Rai had recognised a need to improve the quality of services at the health posts. The organisation has had the experience of working in the district for several years. She emphasised the need to focus the support SC/US is providing the health posts on the most necessary aspects. She also wanted to prioritise needs. The findings were to be communicated to the donors of the agency as well as to the local health authorities.

The study therefore had the practical aim of providing useful suggestions for the planning and implementation of the work at the health posts.

1.2. THE STUDY

1.2.1. Study question

The study question was formulated according to the concern of the client:

What is the level of quality of care in MCH, reproductive health and family planning services at five government health posts in Siraha District?

1.2.2. Aim and objectives of the study

The aim was to conduct a research which would provide to the study client the information she needs and to formulate recommendations of how to improve the reproductive health and family planning services.

The general objective of the study was the following:

To assess the quality of health care services provided in the government health care system at five health posts in Siraha District, Nepal. The focus is on reproductive health, family planning and MCH services.

The specific objectives were:

1. to evaluate the facilities at the health posts and service delivery arrangements according to set standards
2. to explore health personnel perceptions about the quality of care they provide
3. to describe the level of users' satisfaction

1.2.1. Action plan and accomplishment of the study

The study was planned to be carried out over eight weeks of work in Nepal in July and August 1996 - of which three weeks were reserved for data collection in Siraha. The study was to be a descriptive evaluation. Both quantitative and qualitative methods were used.

The reference population was the clientele of MCH, reproductive and family planning clinics at the five government health posts and the health post personnel at those health posts. A comparison between different locations was planned.

The methods to be used were :

1. Discussions with key informants. Key informants were members of the project staff both in Kathmandu and locally in Siraha District as well as representatives from the local health authority.

2. Informal discussions with community health workers and community members.

3. An assessment of facilities, staffing and service arrangements through observation and questioning of personnel at the health posts . A review of the records was included in order to establish the utilisation level of the services.

4. Semi-structured interviews of the staff who are involved in reproductive health services. A topic guide was developed for interviews. The aim was to explore their perception of the quality of the service, what influences it and what they think could be done to improve the quality of care.

5. A sample of health post users was to be interviewed using a structured questionnaire. The method was exit-interview. The purpose was to find out the level of user satisfaction.

   An interpreter was to be hired to work as an translator; to translate the questionnaire into Maithali , conduct the user interviews in the presence of the researcher and to assist in the staff interviews according to needs. The staff interviews were tape recorded.

   The plan was fulfilled with some changes. Due to the restricted availability of the interpreter, the actual field work was completed in two and half weeks. Secondly due to very low utilisation of MCH and FP clinics the plan to take a sample of informants became unnecessary. Instead all the clients using the service on the days of study were interviewed. Thirdly the comparison between health posts in different locations or otherwise showed no relevance after investigations. The level of services as well as the locations resemble each other almost without exception.

1.3. STUDY LOCATION

1.3.1. Nepal

Nepal is a kingdom situated between India and China in Southern Asia. The total area covers 140 800 square km, which stretches from subtropical flat lowlands (the Terai) to the world's highest peaks, the Himalayas. Nepal claimed its independence in 1768. Since 1990 it has had a multiparty democratic political system. Over 90% of people are Hindus, although the distinction with Buddhism is not always clear. A minority group of people living mostly in the Terai practise Islam. The total population (1995 est.) is 21.5 million. Forty-three percent of people are under the age of 15. Life expectancy at birth is approximately 53 years.

Nepal is one of the poorest countries in the world. Agriculture provides a livelihood for more than 90% of people, but the produce depends on the timing, intensity and duration of monsoon rains. More than 40% of people are undernourished. Soil erosion and deforestation are current environmental issues. In addition to agriculture, the country produces textiles and carpets and the tourist industry is flourishing. (CIA 1995)

Health profile

The health services in Nepal are administered by Ministry of Health. Regional Health Directorates (5) and District Health Offices (75) form the organisational structure for the delivery of primary health care. The basic unit for implementation is a Health Post (HP). More details of the function of the system is presented in the next chapter (Literature review) under the heading Primary Health Care in Nepal.

Health indicators show the poor health status of the Nepalese people. However especially infant and under-five as well as maternal mortality rates have decreased drastically over the last thirty years. The annual population-growth rate has grown proportionally in spite of the decrease in the total fertility rate. The table 1-1 shows the trends and the goals for essential indicators.

Table 1-1 Trends of selected health indicators in Nepal and future goals

Year / Health indicator	1950	1970	1990	1995	Goal for 2001
Maternal mortality rate (MMR)			860	515	400
Infant mortality rate (IMR)	229	157	96	85	76/50
Under five mortality rate	340	234	165/137	120	106/70
Annual population growth rate	1.7	2.3	2.6	2.5	2.4
Total fertility rate	6.3	6.0	5.7	5.2	4.7
Contraceptive prevalence rate (CPR)		(1981) 6	17	21.3	37.2

Source HMG Safe Motherhood DoH 1996, USAID Info 1996

1.3.2. Siraha District

Siraha District is situated 420 Km away by road (10-12 hours by bus) south-east of Kathmandu. It is a densely populated district in the Terai facing the Indian border. The area covers 1188km^2. It is one of the seven districts of Sagarmatha Zone in the Eastern Region. The district contains 111 Village Development Committees (VDC) and one municipality (Lahan). The population census in 1991 records a total population of 460,122. In 1995 the estimate was 525 840 (HMG 1995).

The population is ethnically diverse although the majority (85%) are Maithali-speaking indigenous Terai people. A particular feature of the population is the existence of marginalised ethnic groups and castes. The proportion of low castes is 11%. The dominant caste is Yadaw (26.2%) as in four of the other Terai districts. Over ninety percent of people are Hindus and seven percent are Muslims. The illiteracy rate amongst women is around 84% and 57% for men. Both rates are higher than the national figures (75% and 46%). (HMG 1993, CREHPA 1995)

The East-West Highway and several all weather roads towards India secure a fairly good accessibility within the district. The main source of income is farming (rice), but even locally up to 70% of people are landless and dependent on daily wages (SC/US 1995b).

Health services and health statistics

The District Health Office is situated adjacent to a hospital in the town centre of Siraha. Another district hospital is in Lahan. Neither of the hospitals conduct major operations. The referral hospital for emergencies is in Janakpur. Well-off people use hospitals in India. However in Lahan there is the privately-run Sagarmatha Eye Hospital, which receives patients from both sides of the international border.

The Ministry of Health operates 12 health posts and 22 sub-health posts. There are no primary health centres. In Lahan there is a private auxiliary health workers training institute established two years ago (Yogendra 1996).

The Fertility, Family Planning and Health Status Survey in 1991/1992 report and the Annual Health Report from the years 1994/1995 give the information about health indicators as seen in table 1-2. There are obvious inaccuracies in the reporting system, the figures give however a picture of the trends; the vaccination coverage indicators show a strong improvement, but the use of MCH or FP in Siraha has not increased and not reached the national average.

Table 1-2 Health indicators in Siraha district and comparison with national figures

Indicator	Siraha district		Eastern region	Nepal
Year	1991	1995	1995	1995
AN at least 1 visit for each pregnancy	9.8	9.7	16.8	15.5
Delivery attended by a midwife or a doctor	(5.7)	0.8	2.6	3.1
BCG	81.7	109	78.7	84.5
DPT 3	38.8	81.3	73.4	76.8
Measles	48.6	78.4	69.2	78.2
FP CPR	(21)	13.9	24.1	21.3
- sterilisation (female)	18.0	10.7	17.4	15.9
- Depo-Provera	0.4	0.6	2.8	2.5
- COC Pills	0.2	1.3	1.55	1.0
Access to potable water	51.6			31 (rural 1991)
Access to sanitation	1.3			3 (rural 1991)

Source: USAID Info 1996, HMG 1993b, HMG 1995

CHAPTER 2. LITERATURE REVIEW

The following topics are discussed in this literature review:

1) A restricted global view to issues of Primary Health Care. The review is limited to the essential points concerning women's health in developing countries.

2) Primary Health Care in Nepal; the focus being in the policy and practicalities of organising reproductive health care services.

3) The issue of quality in health care is reviewed including the definition of quality, evolution and different approaches to quality assessment and currently used methods of measurement.

4) Three selected issues arising from the literature which provide perspectives from which to explore the objectives of this study:-

    a) The structure of the health care facilities and its relevance in quality assessment.
    b) The health care providers' job motivation; what influences it and what is its impact on the quality of care?
    c) User satisfaction - does it measure quality and what implications does it have?

2.1. GLOBAL VIEWS OF WOMEN'S HEALTH

This section describes core issues in women's health; the focus is on the main problems occurring in developing countries.

Women have special needs in health care. The term *reproductive health* covers those needs. An explicit definition of reproductive health is given by WHO representative M.F. Fathalla (1992):

"Reproductive health implies that people have the ability to reproduce, to regulate their fertility and to practise and enjoy sexual relationships. It further implies that reproduction is carried out to a successful outcome through infant and child survival, growth and healthy development. It finally implies that women can go safely through pregnancy and childbirth, that fertility regulation can be achieved without health hazards and that people are safe in having sex."

A detailed list of elements of reproductive health services is adopted from a Family Health International (Hardee & Yount 1995) working paper:

- Family planning
- Pregnancy care
- STD/AIDS services
- Counselling and IEC concerning sex education, STDs/AIDS, FP and abortion
- Promotion of breast feeding
- Infertility services (prevention and management)
- Gynecological service
- Abortion related services
- Newborn / child care

Not all the sources and experts include all the elements, for instance 'child care', into the concept of reproductive health care. In this study alongside reproductive health the term 'MCH' (maternal and child health care) is used to broaden the target to include both women and children under age of five years.

Attempts to address reproductive health problems take place in most developing countries under the Public Health Care system. The Primary Health Care (PHC) programme, initiated by WHO/UNICEF, has been, since the Alma Ata conference in 1978, the main strategy in providing "health for all". The means include health promotion, disease prevention, treatment and rehabilitation. The Safe Motherhood Initiative was launched in 1987 as a commitment by representatives of over 45 countries to reducing maternal mortality and morbidity by one-half by the year 2000. Today's maternal mortality rates vary from two per 100 000 live births in many developed countries up to over a thousand in some less developed countries. (Koblinsky et al. 1994)

Since the Safe Motherhood Initiative different methods for reducing morbidity and mortality have not only been promoted but studied carefully. Most maternal deaths occur around the time of delivery, therefore appropriate strategies to prevent them at this stage are one of the priorities. The value of ante-natal care in terms of reducing maternal mortality is a point of debate. More clear evidence of positive impact is available from increased use of family planning methods. Legal safe abortion is a highly effective way to prevent deaths and morbidity as well as infertility. In addition the nutrition, education and socio-economic status of the woman and her family are important factors. (Koblinsky et al. 1994, Rooney 1992)

Infertility may not be an important problem from the viewpoint of demographers, who see unchecked population growth as a threat, but it has a serious impact on the mental and social health of individuals and couples around the world. WHO estimates that there are up to 80 million infertile couples in the world. In developing countries the reason for this is often preventable - the consequence of serious infections caused by STDs. (Fathalla 1992)

Fertility regulation and family planning programmes, on the contrary, receive constant attention. The contraceptive prevalence has risen world-wide up to 50% (1990). But in developing countries there still is a big unmet need for contraceptive availability and use. In Africa, only 25% of women who did not want more children, practised any method of contraception according to WHO statistics in 1990. In Asia and Latin America the figures were 43% and 57%. (Fathalla 1992)

One indicator of the unmet need for contraception is the prevalence of induced abortion. In many countries the termination of a pregnancy is illegal, which encourages unsafe practices especially in developing countries and causes a huge amount of complications; the estimate is that between 20% to 40% out of half a million yearly maternal deaths are due to abortion complications. (Koblinsky et al. 1994)

Women's well-being is affected by many factors. The safety of contraceptives, the sequences of STD and HIV, the risks of unwanted pregnancies, as well as the consequences of infertility, are mostly women's burdens, especially in developing countries where, due to traditional, social and economic reasons, women are often not in a position to seek adequate help, even if it were actually available.

2.2. PRIMARY HEALTH CARE IN NEPAL

This section gives background information about the PHC system in Nepal and, because the focus of the study is on women's health, issues to be discussed further are Safe Motherhood and Family Planning.

The National Health Policy of Nepal (HMG 1991) declares the government's commitment to provide primary health care to all the population through an integrated system of preventive and curative services. Priority is given to people in rural areas - where 90% of the population resides. The basic unit of the service is a health post. Sub-health posts serve more basic needs in the villages. The first level of referral is the district hospital or the primary health centre, if district has one.

Each ilaka (administrative section of a district) has a health post. The number of sub-health posts at village development committee (VDC) level is growing constantly, but it is still far below the target which is almost 4000 set by His Majesty's Government (HMG) in 1991. At the moment 25% of them exist. A reason for not reaching the goal is said to be insufficient community participation (HMG 1993c, Shrestra 1996).

In theory, health posts should be staffed by a health assistant (HA), who works as a the health post in-charge (HPI), two auxiliary health workers (AWH) and one assistant nurse-midwife (ANM) plus a clerk and messengers (peon). The lack of trained health professionals reduces the level of care. More than half of the district hospitals do not have any physicians and 65% of health posts have no health assistants working there. (Shrestra 1996)

Attached to each health post are village health workers (VHW) and MCH-workers, who are employees and work at sub-health posts or in outreach work in the VDCs. Community health volunteers (CHV) and female community health volunteers (FCHV) as well as trained birth attendants (TBA) are unpaid workers who after some locally arranged training participate in health promotion activities, especially in environmental health, EPI, FP and MCH.

Preventive care is an essential issue; up to seventy percent of the patients who attend a clinic or a hospital in Nepal have a problem that could have been prevented (JNMA 1994). However in spite of the broad discussion surrounding the importance of preventive medicine and favourable official policies, problems can still be identified. A government paper in 1993 lists the core problems *"of physical facilities and manpower with administrative and financial management*" (HMG 1993c). Recent opinions still stress poor management or mismanagement and a lack of comprehensive development as reasons for inefficiency. Integration of services and the decentralisation of power and resources have been carried out inadequately. Work-force development especially has not been effective. (Aitken 1994, Shrestra 1996).

Depending on the source the health indicators of the country vary to some extent. Available information however highlights serious maternal and child mortality rates. Ministry of Health figures calculate the life expectancy for women as three years less than for men (HMG 1996). To improve the situation the government has set specific goals. The strategies and achievements are presented in the next paragraph.

2.2.1. Safe Motherhood and Family Planning

As in most developing countries the health status of women in Nepal has received only minimal attention, states Jean Baker (1994). But the government and Ministry of Health have not been unreceptive to the issue. A government supported family planning

program was established already in 1968. In the National Health Policy in 1991 the Safe Motherhood was identified as a priority program.

In the plans for 1992-1997 "Family Planning and Maternal and Child Welfare" was integrated into basic primary health services. The policy stressed the need to stabilise population growth, the protection of pregnant women and lactating mothers and children under five. The goals were 1) to increase the accessibility, availability and utilisation of maternal health care facilities; 2) to strengthen referral services for maternity care; 3) to increase the availability, accessibility, and use of family planning methods; 4) to raise public awareness; and 5) to improve the legal and socio-economic status of women. (HMG 1993, 1993b)

Baker calls for action instead of 'rhetoric' (Baker 1994). But if the statistical figures are at all reliable[1] there has been a tremendous decrease in maternal mortality rate between years 1990 and 1995 (see table 1-1) as well as a reasonable decline in infant and under five mortality rates. The use of family planning has steadily but slowly increased. How has it been achieved?

The aim to increase awareness about population and health issues and to provide people with the knowledge and understanding they need to enable them to make decisions regarding family size, contraceptive use and use of maternal and child health care has been successfully fulfilled. Awareness and practice of family planning have increased considerably. According to a national survey in 1991 over ninety percent of married women knew at least one FP method, although on average 34% of married women did not want more children, but still only 24% were actual users. (Thapa & Pandey 1994)

A variety of information, education and communication methods (IEC) has been used to disseminate information. Multimedia and locally adopted methods such as dramas and wall paintings (see appendix1), non-formal education and literacy classes, which focus on the adult female population (Corr 1991) and training of school teachers and community health workers, specifically TBAs, are all diffusion channels which have been created. (HMG 1996b).

Assistant (auxiliary) nurse midwife training was started to improve maternal and child health services in the rural population. They are trained to carry out basic health services including FP, MCH, EPI and treatment of children's diarrhoeal and upper respiratory diseases. They train TBAs and FCHVs locally (see appendix 1). Their role includes the direction of MCH activities. (CTEVT 1995)

The number of ANMs is not yet sufficient for all the health posts (Aitken 1994). Bentley (1995) questions their acceptance by community as most of them come from urban areas and are maybe considered 'alien and superior'. The experience in Siraha District on the contrary has shown that lack of ANM at a health post is one of the constraints of delivering MCH and FP services due to women refusing examinations by male health workers (SC/US 1995).

Since 1974 thousands women from villages have been trained to be TBAs. Training has been conducted by both the government and by non-governmental agencies. Their main duty is to promote safe pregnancy and deliveries. They are voluntary workers and due to lack of financial incentives their motivation to serve has not always been high, but they have brought about a remarkable change in delivery practices in some places. Their selection has not always been adequate; factors such as influential relations rather than

[1] Especially MRR varies very much depending on the source. The figures used here are the information published by HMG of Nepal.

experience as a *practising* birth attendant has caused women, who would be accepted by the community, left out of selection. (Levitt 1988, Minden 1992)

MCHW training is a recent initiative. They are also locally recruited women, who having obtained basic knowledge of reproductive health, will work at sub-health posts. (HMG 1996)

2.3. QUALITY IN HEALTH CARE

The aim of ensuring high quality in health care has always been a part of the medical and nursing care professions. This section of the literature review studies definitions of the quality, different approaches to the assessment of it, methodological issues of measuring it and finally the specific aspects of quality assessment in developing countries.

2.3.1. What is quality?

Quality can be defined as a state of excellence or goodness. A common expression in literature is that quality is in the eye of the beholder; it means different things for different people. The degree of it depends on place, time, needs and expectations of the judging person. (Vuori 1991)

It is also said that quality in health care is 'notoriously' difficult to define. Tension easily arises between different stakeholder perspectives. Patients, professionals and those who hold the funds of health care may all have different views of what constitutes 'good quality'. Ethical, political and financial questions all influence prioritising and decision making. (Ellis & Whittington 1994)

Normally, the high quality of a product or a service is seen as the achievement of a pre-set standard or target. In health care it means meeting the needs of patients following the accurate professional standards. The costs to the organisation and the limits set by authorities are other factors to be taken into account. (Øvretveit 1994, Offei et al 1995) Unequal distribution of resources on a global scale adds another dimension to the assessment of quality in different settings.

2.3.2. Approaches to assessment of quality in health care

The issue of quality in health care is as old as health care itself. Ellis and Whittington (1994) use a three phase picture to describe the evolution of it.

The embryonic phase was when quality assurance mechanisms existed, but they were implicit and not specifically referred to as quality assurance measures. The Hippocratic Oath in medicine can be taken as an example. This period continued until the 19th century. (Ellis & Whittington 1994)

The famous British nurse Florence Nightingale (1820-1910) represents the *emergent period* when regular observation, review and improvement of care started to become explicit. The focus was gradually shifting from measuring outcome to the process of care; which was done by making direct observations at doctors' surgeries and hospitals in the USA (Donabedian 1978, Ellis & Whittington 1994)

The mandatory period started at the end of 1970s. From 1980 onwards both the medical and nursing domains have produced a lot of practical initiatives and a vast quantity of literature on themes including the following (Ellis & Whittington 1994):

- definitions of quality and quality assurance
- measurement and methodology in quality assurance
- participation in quality assurance
- the organisational contexts of quality assurance
- the relationship between cost and quality

Koch (1994) presents the evolution from the nursing approach. She describes the emergence of scientific methods for assessing quality as reflecting methods developed in business, industry and education. In nursing this meant a wave of patient-opinion surveys and the use of instruments, e.g. audit tools. In all cases, boundaries and quality criteria were selected by health care professionals. It was the period of **measurement-oriented** *first generation evaluation*.

Second-generation evaluation is **objective-oriented**. The nursing process, first described by Yura and Walsh in the early 1970s, is an example of this. It involves the process of assessing, planning, intervening and evaluating nursing care. (Yura & Walsh 1980)

The *third-generation evaluation* is **judgement-oriented**. Quality assurance committees fulfil the roles of judges and evaluators. The setting of standards is carried out by experts. (Koch 1994)

Finally, the participation of stakeholders received more attention. The *fourth generation evaluation* is a model of evaluation which aims to include all the human, political, social, cultural and contextual elements that are involved. It derives from the field of education. It is **negotiation-oriented**. Fulfilment requires the commitment of all stakeholders as well as a willingness to share power and to change. (Koch1994) Table 2-1 provides a summary of the described evolution of approaches with examples of applications.

Table 2-1 Evolution of quality assurance in health care (Ellis & Whittington 1994 and Koch 1994)

Ellis - Whittington	Examples of Applications	Koch	Examples of Applications
1. Embryonic phase	universal medical standards	**1. Measurement oriented**	audit tools, patient opinion surveys
2. Emergent phase	observations, emphasis on quality of outcome	**2. Objective oriented**	nursing process; evaluation as a cycle
3. Mandatory period	quality assurance mechanisms	**3. Judgement oriented**	quality assurance committees
		4. Negotiation oriented	quality assurance process and cycle

Two people have greatly influenced the elaboration of quality assurance - first in medical care in the UK and the USA since the 1980s: Avedis Donabedian and Robert Maxwell.

Donabedian (1980,1988) approaches quality assessment from three dimensions: structure; process of care; and outcome of care. He emphasises the multidimensional nature of quality. His categories are still perhaps the most used concept for scientific

work in quality assessment and assurance. Ellis and Whittington (1994) however criticise him saying that the dimensions are more categories of care than categories of quality.

They prefer Maxwell's (1984) *dimensions of quality;* access, relevance to need, effectiveness, equity, social acceptance and efficiency and economy.

Maxwell's dimensions are widely accepted. He himself refers to them again in 1992 and sums up how they have been used at different levels of health care. He also revisits the underlying concepts (Maxwell 1992). The latest description of the dimensions may be found in Offei et al (1995) used in a quality assurance project in Ghana. The following illustration (table 2-2) has been combined from Maxwell and Offei et al.

Table 2-2 Illustration of the Maxwell's quality dimensions (Maxwell 1992, Offei et al 1995)

Dimensions of quality	Illustration of dimensions
Access	Geographic, financial, organisational, linguistic, physical access "What do people think of it?" (Maxwell)
Relevance to need	Does the service reflect the needs of the community?
Effectiveness	Do the results of the service reach the technical standards?
Equity	Do all the patients or groups of patients receive equal treatment with same appropriateness?
Social acceptability	Are the patients' cultural values, beliefs and attitudes respected? Are privacy and confidentiality safeguarded?
Efficiency and economy	Is the service producing the greatest possible output with available resources (input)? How does the unit cost compare with the same type of units elsewhere?

The terms; quality assessment and quality assurance are often used indiscriminately in literature, but they can be defined as follows (Doyle & Haran 1996):-

- **Quality assessment** is the process to determine what is the level of quality of the health service.
- **Quality *assurance*** is a management system which builds quality assessment, monitoring and improvement into working practices of a health service unit.

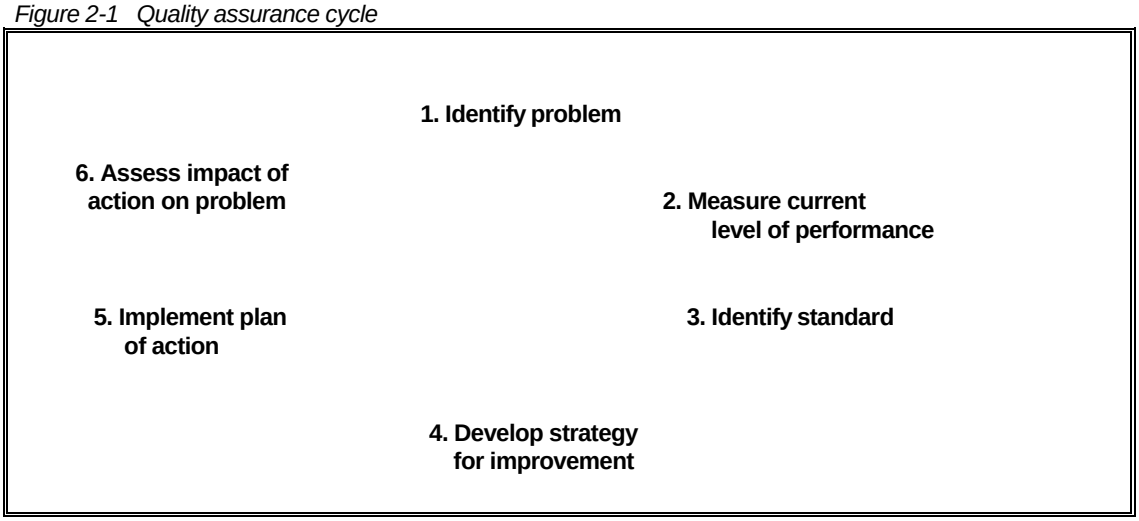
Quality assurance fulfils the aspects of fourth generation evaluation. It has been recently used as a method to improve quality of care by many institutions and organisations, in both developed and developing countries. The following definitions describe an ideal quality assurance programme (Brown et al 1995, Offei et al 1995):-

- It is oriented towards meeting the needs and expectations of the patient and the community
- It focuses on the work and activities of health care providers and on the processes of health care delivery
- It uses data to analyse the processes
- It encourages a multi-disciplinary team approach

It is also important to follow the standards set by national guidelines and to take local resources into account. Reerink & Sauerborn (1996) argue that the evidence of the successfulness of the method is weak but exists. It requires however that efforts are supported by a national policy framework. If not, the results are only 'scattered examples of quality excellence without a comprehensive improvement'.

The method aims at optimal quality through a practical process called '*quality assurance cycle'*. (Brown et al. 1995, Offei et al. 1995, Doyle & Haran 1995) The following (fig. 2-1) is a simplest form of the cycle.

Figure 2-1 Quality assurance cycle



Source: Doyle & Haran 1995

Most of the work in quality assessment was done in *curative* services until the late 1980s. To date there has still been little research and few projects done around the issue of quality in preventive health care. One recently widely utilised framework was developed by Judith Bruce (Bruce 1990) for use in evaluation of family planning programmes. She argues that the client's perspective is the most important way to assess quality if one is concerned with the program's efficiency and impact.

The categorisation of the elements of family planning service are in the table 2-3, which also describes the impacts of successful care.

Table 2-3 Elements of quality in family planning service (Bruce 1990)

Elements of quality	Impacts of good quality
Choice of methods	Client knowledge
Information given to clients	Client satisfaction
Technical competence	Client health
Interpersonal relations	Contraceptive use
Follow-up and/ continuity mechanism	• continuity
Appropriate constellation of services	• acceptance

Her model was used as the rationale for a study conducted in Nepal (Baker et al. 1994) where two family planning clinics in Kathmandu Valley were evaluated. The researchers suggest that the initial point of Bruce's model is that the client has valid opinions. But as a matter of fact the methods of their study included only observations, no client opinions were asked for. It seems that Jain's (1992) comment that Bruce's model is unusual and rarely used as a tool because its vantage point is the individual client's perspective, is valid.

However, the findings of the study by Baker et al. relate strongly to Bruce's issues: insufficiency in information-giving and counselling; gaps in technical competence and clinical handling; and problems in provider-client relation such as insensitivity to client's need for privacy or respect (Baker et al. 1994). Bruce's model was also used in a review of studies into fertility and contraceptive use in poor urban areas in developing countries by Mamdani et al. (1993). The elements of quality were chosen to describe the issues where family planning services needed improvement or more attention in the study locations.

AVSC (a family planning organisation) uses, in its reproductive health and family planning programme evaluation, a model called COPE (client-oriented provider-efficiency). They have developed guides for self-assessment of service. The issues of interest are clients' rights to information, access, choice, safety, privacy and confidentiality, dignity, opinion, comfort and continuity . However, AVSC recognises also the service providers' needs for satisfying supply and site infrastructure, good management and supervision as well as for training and information. (AVSC 1995)

The self-assessment method AVSC uses is one of the tools developed because of the need to have cheap and effective quality assurance methods in developing countries. The need to evaluate health care there arose when generally poor quality and poor utilisation and cost-effectiveness of governmental primary health care services was recognised in late 1980s. A common assumption was that with more money and more staff everything would become better. A new approach was to study more closely service delivery processes in health care. (Reerink & Sauerborn 1996)

For that purpose different types of observation check lists and indicators for quality measurement have been developed. The World Health Organisation (WHO) has introduced standardised treatment protocols and practical guides for evaluation of vertical programmes. USAID sponsored a project called PRICOR (Primary Health Care Operations Research). The project conducted evaluations of specific health programmes, mostly in child survival, in twelve countries. (Roemer & Montoya-Aquilar 1988, Brown et al. 1995, De Geyndt 1995)

The next section introduces three specific aspects in health care quality and approaches used to explore them.

2.4. SELECTED ISSUES IN QUALITY OF HEALTH CARE

There are various aspects in quality of health care as reviewed previously. In this section three selected issues arising from the literature and relevant for the study objectives are studied:-

1) The structure of the health care and its relevance in quality assessment
2) The health care providers' job motivation and its impact on the quality of care
3) User satisfaction; does it measure quality and what implications does it has?

2.4.1. The structure of the health care and its relevance in quality assessment

Structure is one of the basic elements when assessing quality in health care. The theme is discussed here by explaining what the structure includes and what are the implications of evaluating it.

Structure refers to the characteristics of the setting where care occurs. It includes material resources (such as buildings, equipment, budget, supply), human resources (such as number of qualified personnel) and organisational structure; management and the organisation of service delivery (such as staff duties and recording and reporting systems) (Donabedian 1988).

While health care is a universal phenomenon, the inputs, and consequently the structure, are the points where the need to contextualise is inevitable when attempting to evaluate them adequately. We need to know who and where we are evaluating, and instead of choosing the maximum quality, it is preferable to choose the optimal quality. (Donabedian

1988) This means comparing quality indicators with established standards in the country or area of the study (Garner et al 1990).

Structural evaluation is important because of its association with the process and outcome of the service; good structure increases the likelihood of good outcome. (Baker et al. 1994) Nevertheless it has also been concluded that the relationship between structural characteristics and the quality of outcome seem actually to be rather weak. (Donabedian 1988, Reerink & Sauerborn 1996) Øvretveit (1994), on the contrary, sees improvements in 'management quality' leading to improved provider performance and user satisfaction.

Physical accessibility and availability of the service, sufficient supply of medicines and time management as well as general efficiency and economy can be addressed through structural evaluation. Infection prevention procedures concerning safety of the clients (and providers) are important. (Baker et al. 1994)

Cost-effectiveness is a consequential aspect everywhere in the public sector health care. Because the input is the costly part of health care, there is a justified interest among administrators and donors to evaluate the structure from this point of view. This can ensure that the limited resources are used adequately. (Jain 1992, Garner et al. 1990) Mistakes, duplication and waste of resources can be eliminated (Øvretveit 1994).

2.4.2. Health care providers' job motivation and its impact on quality of health care

Motivation of the staff or of an individual employee is a basic issue in management of organisations when aiming for good results or good products. Simmons & Simmons (1992) list workers' motivation as an key factor in improving quality of health care alongside management commitment. This section describes first the job motivation theory of Frederick Herzberg (Herzberg et al 1993) as a background to the topic. Secondly a case study from Nepal of the health system management at the district level will be presented.

Herzberg concludes that motivation is influenced by two types of factors, 'hygienic factors and satisfiers'. The hygienic factors are basic needs of a employee (such as salary, job security, working conditions). They prevent dissatisfaction, but they do not add motivation. The actual satisfiers are internal characteristics of the job such as achievement, recognition, responsibility and the work itself. Blunt and Jones (1992) suggest that the theory might be useful in studying organisations in the African context (in developing countries), where fulfilment of basic needs is often greater priority for workers than in developed countries. Highlighting the importance of work itself might improve motivation. (Blunt & Jones1992, Aus 1993).

The explicit article by Aitken (1994) illustrates several reasons for poor motivation of health personnel and what happens thereafter:

Generally, a permanent job within a government health system provides a secure, although meagre source of income. In Nepal constant staff transfers reduce the security of individual workers. Bribery, nepotism and politics play roles in the process. On the other hand some individuals succeed in taking advantage of the transfers or of the permanent secure income (which does not depend on the job performance or even attendance at the health post). While they are occupied with conducting other jobs or studying they do not commit themselves completely to the work at the health post. Aitken concludes that jobs are seen as salaries not as duties. (Aitken 1994)

Aitken is concerned, if the training of the health workers is always appropriate. Many health posts are not fully staffed and therefore e.g. the AWH often performs duties more

suitable to an ANM. Workers normally do not see this as a problem, but the outcome of the performance might not be the desired. But because there are no job descriptions, there is also no criteria to evaluate performance. (Aitken 1994)

All workers want to have more training, but often re-fresher courses are taken only as a means to earn extra money from daily allowances. Little effect on practice has been observed, therefore Aitken concludes that training is nearly useless from that point of view. But because health professionals in Nepal have little opportunities for promotion, training is almost the sole way of motivating staff, it still has its value. (Aitken 1994)

Supervision is not seen as useful in the view of the grass root level worker. The one who benefits is the supervisor as he receives an allowance for his work. Supervision involves mainly checking of staff attendance and the fulfilment of numerical targets such as EPI coverage. Service quality is not an issue. (Aitken 1994)

Aitkens's conclusion is that there is an implicit theory accepted by the staff and the management that the main purpose of the district public health office is to provide an income for its staff. The official purpose of providing health services to the community therefore receives less emphasis. Consequently the staff is not self-directed to improve the job performance especially taking account the numerous de-motivating factors they face in their work. (Aitken 1994)

2.4.3. User satisfaction

One way of measuring quality of care is to ask for the users' perception of the quality. The fourth-generation evaluation (see 2.3.2) draws all the stakeholders into the process and the user is one of the important ones. In this section a couple of partially differing views of value of measuring user satisfaction will be presented, and secondly the consequences of the poor or high level of satisfaction will be discussed.

'Consumerism' is a concept developed in the commercial world where the customers' opinion has always been seen and understood to be a very important factor. But as Øvretveit (1990, 1994) argues in health care the "customers" (patients) do not always know what they need or they may even ask for treatments which may be harmful to them. Therefore a professional definition of what the client really needs has to be included into the assessment of quality of health services.

Additionally, the users of the health service may not have sufficient knowledge and understanding of the available resources. Therefore user's judgement might be incomplete, if Øvretveit's definition "*quality is meeting customer's requirements at the lowest cost*" (Øvretveit 1990) is to be followed.

User satisfaction has been seen as contributing to service utilisation and compliance rates, but several authors declare that it has become a legitimate and desired outcome in itself. (Donabedian 1988, Williams 1994, Vuori 1987,1991) Therefore it should not be treated as an optional perspective of quality - it is itself quality. "*Care cannot be of high quality unless the patient is satisfied*". (Vuori 1991) Certain aspects of care especially are best judged by the service users; such as amenities and interpersonal relations.

A review of studies conducted in UK in the medical field (Williams 1994) shows that most of the users are rather uncritical when interviewed in surveys. The care must be extremely poor before they express dissatisfaction. As a result the overall satisfaction appears to be high, over 90%. However, when the interviewees are given an opportunity to express themselves in their own terms, responding to open-ended questions, they unveil critical opinions. (Williams 1994, Batchelor et al. 1994)

Williams showed that high user satisfaction has two important positive consequences from the perspective of medical care: better appointment keeping and improved treatment compliance. The compliance is better because of the patient has higher intention to follow instructions. (Williams 1994). In preventive health care user satisfaction plays perhaps a still more remarkable role. It clearly effects the continuity of service use, as was shown in the studies reviewed by Simmons and Elias (1992). Appointment keeping, adoption of contraceptive use and overall method continuation were related to good provider-client interaction.

Bruce in her framework (1990) has a wider list of impacts of good care; knowledge, satisfaction and health of the client as well as acceptance and continuity of contraceptive use (see table 2-3). Her subject of interest is reproductive health care, but the theory is adaptable to any kind of preventive health work. Poorly-informed, badly-treated clients do not return for appointments as was shown in a study in Benin concerning MCH services (Bichmann et al. 1991). On the contrary, the satisfaction caused by "*being treated like a person"* results greater acceptance and sustained use of services which was the clear finding in a study at a family planning and MCH clinic in Chile (Vera 1993).

Studies in Benin and in Nepal have shown that especially people who are most vulnerable due to low socio-economic or educational status and in Nepal due to low caste background are least likely to use preventive services. The reasons for this are, of course, multiple but one main reason is the fear of being prejudiced against due to low status or simply not being treated with conventional dignity (Bichmann 1991, Schuler 1987). On the other hand a finding from the studies made in UK concerning the National Health Services (NHS) is that the patients from lower social classes more often express satisfaction. They are apt to accept low standards due to lack of choices. (Batchelor et al. 1994)

2.5. CONCLUSION

A conclusion of the review of the issues of reproductive health, primary health care in Nepal and the quality of health care is given in this section.

Reproductive health universally and in developing countries is a sensitive issue. It takes on political dimensions because the indicators such as maternal mortality, infant and under five mortality are frequently used to judge the status of the health care and the level of development of a country. Population policies are surrounded with political, economical, traditional and religious factors. From the point of view of the women themselves reproductive health is an issue of extreme importance concerning their own and their children's well-being and often survival.

WHO and UNICEF are promoting women's and children health. Several governments world wide have adopted the Safe Motherhood initiative into their policies. In Nepal the government is committed to promoting both Safe Motherhood and Family Planning. The integrated primary health care system, with the health post as the basic unit, is a framework for the implementation of reproductive health services.

Quality of care is an issue that has received a lot of attention in recent decades both in the developed and developing worlds. A less explored field is the association between the structure of health care, process of care and the user satisfaction in *preventive health service.* There is however evidence that poor quality causes user dissatisfaction and

under-utilisation of services and hence slows down the optimal results of available health care.

The reasons for poor health care can be found in the structure, but as the health workers are the key persons in the service delivery process, the impact of their performance is significant. In aiming to improve quality of care, the motivation as well as the skills of health providers need to be focused on.

Low utilisation of public health services should act as a sign of the need to assess the quality of care. To find out the user and the non-user perspectives is necessary - as Maxwell asks “what do people think of it”. Is the service maybe inaccessible, irrelevant or otherwise non-acceptable?

CHAPTER 3. METHODOLOGY

The research question of this study was regarding the quality of health care within the government primary health care system at health post level in Siraha district, in rural Nepal. The focus was on reproductive health care services as the interest of the study client, Save the Children US in Nepal, is to support health posts in providing good health services for women in the district.

This was a descriptive and evaluative study. The study design was established to explore the study question from different angles and to promote analysis of the results with the view to developing recommendations for improvement of the quality of care; hence assisting the study client in her endeavours to support the district public health programme.

The specific objectives were:

1) to evaluate the health post facilities and service delivery arrangements
2) to explore the health care providers' perceptions about the quality of care they provide
3) to describe the level of users' satisfaction

The strategies and tools used to find out necessary information are summarised in the table 3-1. The details of the methods are then described in regard to each individual objective using the following sequence:-

a) study location or population
b) selection of informants
c) issues and variables used to explore the objective
d) tools and strategies of data collection

After that the methods used throughout the study; pre-testing and translation; data storage and analysis; and methods and constraints of ensuring quality of data will be described.

Table 3-1 Strategies and tools used in data collection

Specific objectives	Strategies of data collection	Tools used for data collection
evaluate HP facilities and service strategies	• inventory of facilities • review of secondary data • observation • key informant discussions	• inventory form / checklist
explore health care providers' perceptions of quality of care	• semi-structured interviews with health workers • key informant discussions	• topic guide
describe the level of users' satisfaction	• exit interviews of HP users • informal discussions with community members	• structured questionnaire with closed and open-ended questions

3.1. EVALUATION OF HEALTH POST FACILITIES AND SERVICE ARRANGEMENTS

3.1.1. Study location

The study covered five government health posts in Siraha District, in Eastern Region of Nepal. The health posts were: Lahan, Malahaniya, Bhagwanpur, Bhaluwai and Khirauna. The map of Nepal and the district with location of health posts is available in appendix 2.

3.1.2. Selection of health posts

The five health posts named were included in the study because of the requirement of the study client, SC/US. The organisation had shortly before carried out an evaluation of seven other health posts in the district and the remaining five were to be evaluated now.

3.1.3. Issues and variables used to explore the objective

The structure and the service delivery arrangements were examined concerning the issues shown in the table 3-2. The issues were chosen in accordance with SC/US based on the requirements of the organisation and the experience of the researcher.

Table 3-2 Issues evaluated regarding health post facilities and service delivery arrangements

1. Location and accessibility	• geographical location • location to referral hospitals • availability of transport
2. Target population and service coverage	• population the HP is serving • selected service coverage indicators
3. Sub health posts and outreach work and staffing	• number of sub-health posts under the HP • outreach clinics the HP is running • HP staff including VDC level employees and voluntary workers
4. Waiting facilities at the health post	• sheltered waiting area with seating • toilets • drinking water
5. Room facilities for MCH and FP	• adequately equipped consultation room • counselling room with adequate privacy
6. Infection prevention	• functioning high level disinfection (HDL) facilities • process of disinfection • availability of complete hand washing facility • functioning waste disposal system
7. Equipment and instruments	• functioning basic instruments
8. Contraceptive and essential drug supply	• supply of relevant contraceptives • supply of basic drugs for MCH service • availability of vaccines
9. IEC material and activities	• presentation and availability of IEC material • “health talk” as health post activity • training courses of community workers
10. Record keeping and reporting	• individual cards of FP, MCH and EPI clients • registration books • monthly reports
11. Management and supervision	• daily opening time; scheduled or not • presence of job description • frequency of supervisors’ visit and the purpose of them seen by HP staff

3.1.4. Tools and strategies of data collection

The evaluation of facilities, staffing and service delivery was done by observation, questioning and reviewing secondary data at the health posts.

A inventory form developed by the study client was used. (See appendix 3). The form had been used by the client to evaluate seven other health posts recently and therefore the continuation was seen as an advantage. The form was modified to some extent to cover not only family planning but all MCH services. It was also decided to add information about population statistics in order to be able to estimate the coverage of services.

The health posts were visited up to three times, except for Khirauna HP, which was visited only once, as it was just resuming its normal daily activities after flooding. The main reason for repeat visits was data collection for other aspects of the research ie, staff and user interviews, but it also provided a chance to re-check information for evaluation and provided extra opportunity to meet all the staff members.

3.2. EXPLORING HEALTH CARE PROVIDERS' PERCEPTIONS ABOUT THE QUALITY OF CARE

3.2.1. Study population

The study population included all the health personnel of the health posts who are directly involved in MCH and FP services; health post in-charges (HPI), auxiliary health workers (AHW) and assistant nurse midwives (ANM). The total number of them at the five health posts was 20.

3.2.2. Selection of informants

All the HPIs, AHWs and ANMs present on the days of study visits were included into study population. Nobody refused to collaborate. The total number of interviews carried out was fourteen. .

3.2.3. Issues and variables used to explore the objective

The issues used to explore health care providers' perceptions about the quality of care they provide are listed in the table 3-3. The focus was on the health worker's personal perspective. As all the workers, especially HPIs and ANMs participate in all the activities carried out at the health post, no strict division between experiences in regard to health care generally and specifically reproductive health service was made. The issues however included a question of low utilisation of FP and MCH.

Table 3-3 Issues used in the topic guide in health providers interviews

- Background of the health worker: qualification, term of service at the health post
- Job satisfaction; problems, motivation
- Perception of good quality in health care
- If the care fulfils the requirements of quality
- Perception of user satisfaction
- What should be done to improve quality of care at the health post
- What the specific reasons are for low utilisation of FP and MCH services

3.2.4. Tools and strategies of data collection

The method for collecting information about health providers' perceptions was to conduct *semi-structured interviews* using *a topic guide* approach.

As the aim was to explore the perceptions of a smallish professional study population a semi-structured interview method was chosen because it tends to generate in-depth information, which was desirable. The topics and issues to be covered in the interview are specified in advance (topic guide), but the wording and the sequence of the questions are decided as the interview proceeds. The interview is fairly informal and therefore the informant can bring new aspects into the discussion. (Patton 1990)

The topic guide (table 3-3) was developed through reviewing literature and discussions with local key informants. In the process of the research, as informants showed more interest for some aspects than for others, it was adjusted accordingly.

The interviews were conducted by the researcher with direct interpretation into Nepali or Maithali and back into English with the help of the interpreter, except three interviews where the interviewee preferred to speak English. The discussions were tape recorded. Each interview lasted from 20 minutes to one hour.

3.3. DESCRIBING THE LEVEL OF USERS' SATISFACTION

3.3.1. Study population

The study population was the clientele of MCH, reproductive and family planning services of the health posts.

3.3.2. Selection of informants

The user exit-interviews were to be conducted with a minimum of 50 informants. The intended sample size was not based on statistical calculations. Instead, approximately ten users from each health post were considered to represent the actual reproductive health service clientele of the health posts and to give desired in-depth information of the perceptions of the users. Secondly, convenience reasons such as the scattered rural location and possible constraints due to monsoon rains were taken into consideration.

The plan was to take a sample of informants by including every second departing client up to a maximum of 20 people per each health post. At the early stage of the research process it was understood that sampling was irrelevant due to very low service utilisation. Therefore all consenting clients were interviewed. The refusal or non-response rate was low but occurred when clients tended to depart the consultation in groups and they were impatient to go home. One informant broke off before finishing the interview; her responses are included into the results accordingly. The total number of the informants was sixty.

3.3.3. Issues and variables used to explore the objective

The issues to be examined in order to find out the health post user's perceptions were divided into background information and issues which describe the experienced satisfaction. Thirdly, suggestions for improvement of health care were asked in order to prioritise the perceived weak points.

Background information

The demographic data; age; number of children; caste and religion; education and occupation; and the distance from home to the health post and transport were

background variables. The reason of the current visit to health post was also recorded. Definitions and measurement of the variables are in appendix 4.

Issues affecting the level of user satisfaction

Health service users form their perceptions of the quality of care in regard to the individual needs and expectations and, of course, according to what happens in the actual process during the visit to the health post. The issues explored were; access; privacy and confidentiality; safety and cleanliness; information and choice; continuity and supply; interpersonal relations; and dignity and satisfaction. They were chosen based on the work of different sources (Maxwell 1984, Bruce 1990, AVSC 1995). The topics were measured by using one or more variables as follows (table 3-4):-

Table 3-4 Issues used when assessing user satisfaction

Issue:	Variables:
Access	• problems on the visit due to the length of consumed time • length of the waiting time • problem experiences during the waiting at health post
Privacy and confidentiality	• privacy during the consultation
Safety and cleanliness	• cleanliness of health post environment
Information and choice	• chance to ask questions • informed choice of FP methods • sufficient knowledge of the current method
Continuity and supply	• continuity of care • supply of remedies
Interpersonal relations, dignity	• respect in client-provider interaction
Satisfaction	• personal experience in regard to the received care • level of satisfaction measured on the scale: excellent, quite good, no opinion, fairly poor, poor • plan to use service in the future

Users' suggestions for the improvement of the quality of care

Users' suggestions for improvement of the quality of care at the health post were asked for in an open-ended question. The answers were categorised as follows: more consistent supply of medicines, cheaper fees, more female staff, better qualified staff, change in staff attitudes or behaviour, better treatment, better facilities and other issues.

3.3.4. Tools and strategies of data collection

The strategy for investigating and describing users' satisfaction was to conduct health post client exit-interviews using *a structured questionnaire* with closed and open-ended questions. (See appendix 5.A. and 5.B. for both the English and the Maithali versions of the questionnaire)

A structured questionnaire, where specific questions are defined in advance and asked in the same order to all the respondents, was chosen because the method ensures that all the informants answer the same questions. It facilitates the analysis of the data as most of the responses can be pre-coded. The method is therefore suitable for a large sample. The open-ended questions allow a variety of expressed views as well as deeper and personal information. They also help to avoid over-ratings in satisfaction which is a risk

for "yes-no" responses, which tend to result favourable answers. (Patton 1990, Batchelor et al 1994)

The interviews were individual. They were conducted by the interpreter in the local language, Maithali, in the presence of the researcher. The interviews took place after the informant had finished her consultation with health care providers and while she was leaving the facility. Each interview lasted between 15 to 30 minutes.

3.4 ADDITIONAL DATA COLLECTION METHODS

Additional methods of data collection were used to find out and widen the picture of arrangements in reproductive health services in Nepal and locally in Siraha and to explore the perceptions of quality of the available care. The methods were as follows:

- Discussions with key informants. Key informants were chosen purposely. They were members of the SC/US project staff both in Kathmandu and locally in Siraha District including SC/US health post co-ordinators; the Head of Family Health Division in Ministry of Health in Kathmandu, the District Public Health Officer in Siraha; the Excutive Chief of the AHW Training Centre in Lahan; and the project co-ordinator of FP-organisation 'AVSC' in Kathmandu.

- Informal discussions with other health employees at health posts and community health workers as well as community members. The following people among others were met; peons, mukhiyas, ANM students, a VDC chairman, village health workers; TBAs; FCHVs; depot-holders; teachers; men in tea shops; and a local Nepalese Red Cross worker.

The original plan to conduct a community study as a part of assessment of the quality of care was abandoned after extensive discussions with the client and with the overseas tutor as the need of the client was to concentrate on evaluation of the activities at the health posts.

3.5. PRE-TESTING AND TRANSLATION

A local teacher who was fluent in English, Nepali and Maithali, was hired to work as an interpreter. He translated the structured questionnaire into Maithali. The text was translated back into English by another person in order to ensure the accurate translation. As the interpreter did not have medical background, some clarifications of terms and on the topic itself was needed.

The questionnaire was pre-tested at Golbazaar health post, which is outside the study location, by conducting six exit-interviews. Some amendments in wording and expressions were made. The results from pre-testing were not included in the results.

The topic guide for semi-structured interviews was discussed thoroughly with the interpreter in order to familiarise him with its contents, but no pilot interviews were carried out.

3.6. DATA HANDLING AND STORAGE

Inventory forms were filled in during the observation at the health post and re-checked after the visit and necessary clarifications were made on the next visit. Forms were stored until the analysis stage.

The exit-interview questionnaires filled in by the interpreter were checked after each interview by the researcher and again at the end of each day. Questionnaires were kept safe until the data analysis.

The recorded tapes of staff member interviews taken in Maithali were transcribed by the interpreter. Interviews in English transcribed by the researcher. It was done word by word. All the material was typed up and stored on floppy disks.

3.7. DATA ANALYSIS

The information on the structural evaluation was compiled into tables and a summative report was written.

The quantitative data from structured exit-interviews was categorised, coded and entered into a computer using the software package “Epi Info 6”, that includes a statistical program. Errors in the data entry were ruled out by entering it twice. The analysis was carried out using software analysis methods. An analysis for associations between demographic data and variables measuring user satisfaction was carried out, but no extensive statistical analysis (such as cross tabulations for statistical significance) was done in order to avoid errors due to the relatively small sample size and lack of random sampling.

The qualitative data was analysed by developing categories for collected information. The topic guide was used as a guideline. The data was processed using the “cut and paste” method and arranged accordingly. Quotations were chosen for the purpose of illustrating expressed opinions when reporting results.

3.8. QUALITY ASSURANCE AND ENCOUNTERED CONSTRAINTS IN DATA COLLECTION

Quality of information was kept in mind throughout the data collection process. This section describes the methods of ensuring quality and constraints which might have had an effect on quality of data.

The evaluation of health post facilities and other input was done on repeat visits (up to three), which gave a chance to re-check or add information, which was necessary because all the health post staff was not present at the same time. Unfortunately, in spite of repeated visits, two ANMs never appeared. They would have been in the position to give the most accurate information about FP and MCH activities.

In the health provider interviews confidentiality was stressed, but because of difficulties to ensure complete privacy during the interview a certain amount of tension was experienced specially on sensitive issues. In spite of this an element of trust was created with most of the interviewees and the opinions seemed to be genuine.

The staff interviews were tape recorded in order to avoid disturbance by taking notes during discussion and to ensure a full record of information through transcription. The technique of interviews in regard to tape recording improved over the course of the process. Two of the translations made by the interpreter were checked by another person and they were found to be accurate. Still it is to be expected that some of the expressions lost their full meaning in the process of translation.

The exit-interviews were conducted in a neutral situation; individually, outside the health post building and using the language in which the interviewee was comfortable. But privacy and sometimes individual opinions were very difficult to maintain for cultural and also for circumstantial reasons. This might have had an influence on the responses - but on the other hand it might have been only the researcher who was disturbed.

The question of the interpreter being a man when exit-interview informants were women, was discussed with the representatives of the study client. The opinion was that it would not cause embarrassment or bias in responding because of the fairly neutral topic and because the female researcher was to be present in each interview. This was the experience seen when the work proceeded.

The training of the interpreter and pre-testing of the questionnaire as well as planning of the process was done as thoroughly as possible taking account the limited time schedule.

A lack of local knowledge caused some problems such as difficulties in locating the health posts and therefore some time was lost. The tight time schedule of the field work due to the restricted availability of the interpreter was a constraint, but the quality of the data was not affected.

CHAPTER 4. RESULTS

The data for this study was collected in Nepal in July-August 1996. The field research took place in Siraha District at five government health posts; Lahan, Malahaniya, Bhagwanpur, Bhaluwai and Khirauna. The study included an evaluation of the health post facilities and service arrangements there, an exploration of health providers' perceptions, and an inquiry of health post users' point of view.

The people interviewed were 14 staff members and 60 female health post users. The data collection methods were semi-structured interviews of staff members and structured exit-interviews of users. Additional information was collected from discussions with key informants in SC/US offices in Kathmandu and Golbazaar and in the District Health Office in Siraha as well as from informal discussions with other health workers and community members.

The results are presented in this chapter under following headings:

1) Evaluation of the health posts facilities and service arrangements
2) Health care providers' perception about the quality of care
3) Quality of care from the users' point of view
4) Summary of results

4.1. EVALUATION OF HEALTH POST FACILITIES AND SERVICE ARRANGEMENTS

The evaluation includes the inventory of facilities and recording of the arrangements for MCH and FP service delivery and service statistics. The results are presented in summative form. The detailed findings from each health post are found in appendix 6.

4.1.1. Location and accessibility

The five health posts are situated in Siraha District, Sagamatha zone, in the Eastern Terai of Nepal. A map of the district showing the health post locations is in appendix 2. One health post is on the outskirts of a town, the others are situated in village centres. All of them are accessible by car all year round except Lahan and Khirauna health posts, which during the monsoon rains are either on the wrong side of the river or frequently hit by excessive flooding, which does not hinder the pedestrian access though.

The East-West Highway and several all-weather roads towards India provide a good road network. The theoretical distance to a district hospital is one hour maximum by car from all the health posts. However, lack of public or indeed any transport and the minimal resources of people means the referral system does not always function.

4.1.2. Target population and service statistics

The catchment area each health post serves consists of 6 to 11 Village Development Committees (VDC). In addition one health post serves a municipality. The total population varies from 35,000 to 52,000 people. The number of women eligible for family planning (age between 15-49 years) runs between 8,300 and 12,000. The number of expected pregnancies in every year is between 1,670 and 2,200 and the number of children under one year varies from 950 to 1,935.

The service statistics are taken from the Ashad 2053 / June 1996 health post monthly report. Most of the activities reported include only the service provided at the health post itself; therefore no service coverage can be calculated for MCH or FP services. Only one HP reported five deliveries. - TBAs told *in informal discussions* that they attend practically all the deliveries in their respective villages.

The number of AN visits was between 16 and 98 and of PN visits between 0 and 10. The number of FP visits varied from 16 to 240 per health post, the total number at the five health posts being 441. Out of these visits 15% were visits by new clients. Depo-Provera is the mostly used method - 84% of all the visits. Condom distribution is not recorded, as they are available in 'condom boxes' to be taken without any control.

EPI statistics include all the service given in the working area. Therefore a rough vaccination coverage estimation can be calculated.[2] BCG coverage varies from 45% (one HP) to 100% (all other HPs). DPT and Polio third dose coverage is between 26% and 72%, most HPs reaching over 50%. Measles coverage varies from 33% to 85%. Coverage for TT first dose is good, between 75% and 100% except at one health post (35%). The second dose coverage is between 50-88%, except at one health post it was 28%. Hardly anybody gets the fifth dose.

4.1.3. Sub-health posts, outreach clinics and staffing

All the health posts are in charge of 3 to 7 sub-health posts. Two health posts have been instructed to open new SHPs in the near future. Two out of five health posts are running outreach clinics in their target VDCs.

All the health posts are at the moment fully staffed except the positions of clerks (mukhiya) in three HP. Two of them are officially still in place, but not present in person. Only one sub-health post has an auxiliary health worker as a person in charge, the others are run by village health workers and MCH workers.

Save the Children US has appointed an additional auxiliary health assistant as a health post co-ordinator to each health post. In addition SC/US arranges assistant nurse-midwife- (ANM) students from Jiri Technical School to work at the health post on a temporary basis. Three out of the five health posts have a student at the present.

The rotation of the staff is fast. Three Health Post In-charges (HPI) have been in their current posts less than one year. One HPI on the contrary has worked there for a period of ten years. Eight out of the ten AHWs have served at the current health post less than three years. All ANMs except one have been in their posts less than one year.

4.2.4. Waiting facilities at health posts

All the health posts have an sheltered waiting area for the clients, but not necessarily seats for a large number of clients. Three of five health posts have functioning toilets. All have a well with a pump in the compound and the water is potable.

4.1.5. Rooms for counselling and MCH and FP services

Counselling activities are mainly planned to take place in the MCH room (3/5). At one health post waiting area serves as a counselling corner. At one HP neither a specific counselling nor a MCH room has been set aside.

[2] EPI coverage is calculated dividing the estimated target population by twelve (months) and then calculating the percentage of the vaccinated ones from that figure.

Three of existing four MCH-FP rooms are well organised and clean, but only two has an examination bed. Privacy for counselling or consultation is obtainable in three cases, but the practice of closing doors is not common.

4.1.6. Infection prevention

All the health posts suffer inadequacies in the cleanliness and order of dressing rooms. The equipment for handling instruments according High Level Disinfection (HLD) is available, but the process followed seems to be only partially appropriate. Used instruments lie around for long periods. No decontamination solution is available. The boiled instruments are kept in the boiling container in the water.

Complete hand washing facilities are available at three health posts, partially at one and at the last one the staff uses the pump in the compound for hand washing.

Waste disposal system (waste container to collect the daily waste, a pit or a incinerator for dispose of it) is in place in all but one health post. Two health posts manage to keep the system working excellently. Two others allow waste to spread in the compound; one does not have a system.

4.1.7. Equipment and instruments for use in MCH and FP

All the health posts have a scale for weighing adults. But only three have a baby scale or a measure for height (for children and pregnant mothers). All have a stethoscope and four are in possession of a foetuscope. A working sphygmomanometer is available at three health posts. All the instruments are used in all the activities at each health post.

4.1.8. Availability of contraceptives and essential medicines

The supply of contraceptives: Depo-Provera injections including disposable needles and syringes, oral contraceptive pills and condoms, is sufficient. None of the health posts had been out of stock in the past six months. For IUD and Norplant insertions clients are referred to district hospitals. VSC takes place at special camps during the dry season.

Essential drugs for MCH care or delivery complications are scarce. Only two health posts out of five had iron tablets, none had multivitamins. Three had antipyretic tablets. Only one had any type of antibiotics. Three health posts had intravenous infusion solutions.

Tetanus and other vaccines are available on specific EPI days, usually once a month at the health post and on outreach days in VDCs.

4.1.9. IEC material and activities

All the health posts are provided with health educational wall paintings and posters sufficiently. The material is adapted to the local culture. Both locally known languages; Nepali and Maithali are used. All the health posts have flip charts on topics of FP and MCH including ORT.

“Health talks” are not adopted as a part of the daily activity at a health post. No health education lecture were heard during the twelve days of observation. And the best response for question of holding them was given by an AWH: “*maybe, sometimes*”.

Three out of the five health posts were instead currently involved of running refresher training for TBAs, FCHVs or VHWs together with SC/US staff.

4.1.10. Record keeping and reporting

The system of record-keeping varies a lot in spite of that new cards for Child Health, Maternal Health, EPI and Family Planning have been recently introduced. All the health posts use registration books for daily activities.

Individual cards are used for FP, ANC and EPI vaccination programmes. In one health post the cards (FP and AN) are given to the client without retaining a copy at the health post. In one case cards are kept in good order. In others there is no order or no cards. From one HP the adequate information about the practice was not available. Post natal care, although reported in monthly reports, does not get special attention in recording.

Monthly reports to the District Health Office are sent regularly from all the health posts. The DHO does not provide feedback based on reports.

4.1.11. Health post management and supervision

On all the days of observation the health posts opened on time. At least one staff member was present at 10 o'clock in the morning. On the other hand there is quite a lot of flexibility in staff attendance. As one HPI said *"I never find all my staff at the health post"*

One exceptional health post has designed job descriptions for staff. DHO supervisors visit health posts, approximately once every one or two months. The activity they undertake is seen by HP staff to be first of all examining records and making suggestions for improvements.

4.1.12. Conclusion

The overall quality of facilities at the five health posts is similar. There are basic deficiencies in equipment and facilities at many health posts - such as lack of examination beds, blood pressure apparatus, scales, foetuscopes. The chronic deficiency of medicine affects both curative and preventive care, especially ANC. The FP supply is well in order.

The cleanliness of the dressing room or the compound needs attention in every case. In Khirauna where the muddy water floods the health post several times during a monsoon the effort to keep tidy is extremely difficult. The situation would need principal attention.

All the health posts have full staffing including ANMs. But the service delivery concerning MCH and FP is still in need of specific attention both in terms of quality and availability. Health education and counselling are not valued as activities; although at the time of the survey the staff was involved in training sessions.

4.2. HEALTH CARE PROVIDERS' PERCEPTION ABOUT THE QUALITY OF CARE

The results in this section originate from the qualitative data from semi-structured in-depth interviews of health care providers from five health posts covered in this study.

The study population was composed of 14 people in total:
- 5 health assistants who are in charge of the health post (HPI)
- 6 auxiliary health workers (AHW)
- 3 auxiliary nurse midwives (ANM)

All HPIs and AHWs are male. ANMs are female. The interviewees' term of service at the current health post varied from a couple of days to ten years. It is necessary to mention that the opinions of the health workers with a short experience from this health post were obviously effected by their experiences at other health posts.

The results are presented without linking individual opinions to specific health posts. The issues covered are:

1) Health worker's personal job satisfaction and experience as a health care provider
2) Health worker's perception of what is good quality of care
3) Health worker's perception of the users' expectations (are the users satisfied)
4) What could be done to improve quality of health care
5) What are the specific reasons for low utilisation of FP and AN services

4.2.1. Job satisfaction and experience as a health care provider

Job satisfaction experienced is generally high. Only two out of fourteen said that they are not interested in their jobs. The prime reason for being contented comes mostly from the pleasure of serving and helping people. Three people mentioned that because they are carrying out good work, people love and respect them and that makes them happy.

"This is how I want to spend rest of my life, serving people." (AHW, 20 years 'work experience)

In spite of general satisfaction all health workers encounter problems, too. The problems can be defined into two categories:

a) Constraints in providing good care to the patients
b) Issues which reduce personal motivation

The problems are mentioned in table 4-1 without prioritising or quantifying them. Lack of medicines and low salaries were almost universal issues. One HPI said he was satisfied with his salary and ANMs did not bring the topic up. HPIs were more concerned about service arrangements than others; they mentioned problems caused by political influences and insufficient manpower as well as by lack of community support. Due to financial difficulties many health workers have additional jobs or they are looking for other opportunities.

Table 4-1 Problems causing de-motivation in health care

	Constraints in providing health care	Issues reducing personal motivation
HPI	• no drug supply on time • no manpower or money for preventive work • not enough medicines • staff members involved in politics and not following HP rules • staff members have other duties in the district health office or elsewhere • no facilities for training (training hall) • problem of flooding • no community support	• low salary • no accommodation for family • insecurity due to isolated HP location • problems with bad tempered patients • not enough refresher courses
AHW	• not enough or proper medicines • no medicine supply on time • insufficient equipment • poor furniture • poor educational level of clients	• low salary • no accommodation facilities • no encouragement • lack of training • fear of transfer • no chance for upgrading or promotion
ANM	• no facilities; no examination beds • no instruments • no medicines • no training for Norplant or IUD • lack of job description • no time for MCH because of other duties at HP	• fear of transfer • transport problem

4.2.2. Health workers' perception of what is good quality in health care

The quality of care at health post is perceived generally as very positive:

"*We give good service*" (HPI)

"*The service is good at its level - this is a health post*." (HPI)

The health workers did not recognise any written standards or protocols they should follow in order to provide good care. The weekly or monthly schedule for different services was mentioned as a guideline. But all the informants were convinced that they know what they are expected to do because of their qualifications.

According to health workers the good health service includes education and motivation of people directly at the health post and using different channels such as village health workers and school teachers. HPIs and AHWs see 24-hour service as important. ANMs emphasise providing safe and good services to women; their special concern is deliveries. The issue of client-provider interaction did not come up in the interviews without probing, but occasionally it was recognised as an important factor.

"*How can I examine patient without anything? No BP set, no fetusope, no gloves."* (ANM)

"I have to keep the delivering mother on the floor and sometimes to assist without gloves." (ANM)

"*Behaviour is very important in the field of treatment. I think if the 'doctor' is polite, the patient becomes satisfied and he believes that the medicine will work better. If the 'doctor' is impolite, the patient gets irritated and most probably he does not follow advice - and he does not buy the medicines which were written in the prescription*." (AHW)

An ANM student posted to a health post six months previously mentioned cleanliness as an important factor to protect client's health. She referred to proper sterilisation and order at the health post.

4.2.3. Health workers' perception about users' expectations

The health workers' perception of users' expectations and satisfaction reflects how they rate their personal or institutional performance. The majority of them think that users are totally or reasonably satisfied with the care. Four out of fourteen said that users most probably are dissatisfied. The reason for dissatisfaction was said to be the insufficient medicine supply:

"Most of the people are satisfied with the care they get here, but sometimes when they don't get medicines, they are dissatisfied." (AHW)

*"When we give medicine, they are satisfied. But when we don't give medicine, they are dissatisfied. When the staff gives advice, they do not care about it. They want medicine. That's what they come for." (*AHW)

The neighbouring hospital was mentioned as an excuse for lack of concern about the quality of care. On the other hand one critical opinion explained that sending many patients to hospitals causes users to become dissatisfied.

"*Yes, probably in this area they don't expect more, because there is a hospital. They can go there, if they need*." (HPI)

"*No, they do not trust us. It depends on the performance of the staff. Treatment requires that certain rules are followed. If we cannot give good treatment they have to go to hospital and they do not like it."* (AHW)

4.2.4. Health workers' suggestions for improvement of health care

Health care providers were asked to give their suggestions for what would improve the quality of care at the health post regardless of it being feasible or not at the moment. The full list of suggestions is attached in appendix 7.

The need for sufficient equipment or better facilities was mentioned several times, but adequate drug supply was the top priority Although one person concluded that there would never be enough medicines due to misuse of them.

"*We don't need any expensive equipment or instruments. We have what we need. The main thing is medicine. Sometimes even TB patients have to discontinue their treatment for lack of medicine. It is the main problem*." (HPI)

"*We don't have sufficient medicines, but whatever medicines we have, they are used in improper places, in improper ways*." (AHW)

Salary increase and functioning system of daily allowances on top of the provision of a regular salary for working in outreach programmes as well as residence facilities were important for many respondents.

Training was mentioned by almost everybody as a means to increase motivation and to improve quality of care. ANMs would like to get more technical training (for IUD and Norplant insertion) in order to be able to serve people better. Two HPIs felt that they receive sufficient training on different topics. Others see a need for more training for themselves and for staff. Five out of six AHWs would like to have more training. One of them did not see training as useful at all:

"*In the name of training people only spend time. They say they get good information and knowledge, but for some reasons they do not apply it. If it is a ten days training, they spend the time, get the allowances and come back. Secondly, whatever we learn in training, we cannot apply at the health post because of lack of instruments."* (AHW)

The health posts are supervised by the District Health Office. The visits are made by different officials theoretically once a month, but in reality it is more seldom. The health workers were asked if they find the current supervision system useful. One HPI thought that supervision is very useful, because it makes the worker active and alert. One ANM and one AHW also agreed that the system is not too bad - the supervisors give some advice. All others who commented were more negative in their perception and did not find supervision useful at all.

"They give advice we already know." (HPI)

"It is only a formality…..They check only records; they don't give any advice." (AHW)

4.2.5. What are the specific reasons for low utilisation of FP and AN services

All the health workers did not agree that the utilisation of FP and AN services is low. Siraha District Public Health Officer (Murli 1996) wanted to highlight that all the couples in need of family planning are using it. Last year (1995/1996) the district had a target of 18,000 VSC operations and they reached 22,750, which is remarkable. But as discussed previously (Chapter 1) the CPR is still low in the district.

Most of the health workers recognise reasons for the rejection of the use of available FP service. Most of the reasons are dependent on the user's knowledge, attitudes and behaviour. Hardly any connection between quality of care and utilisation is recognised. Two AHWs confessed that "*we have neglected to motivate them*". Culture and religion related reasons were repeated. ANMs recognised more practical aspects such as the actual side-effects of pills and Depo-Provera and lack of choice of methods. List of mentioned reasons is in appendix 7.

"Family planning is a matter of awareness. Due to lack of education and illiteracy people are difficult to motivate. People in our society believe that children are a gift from God." (AHW)

"Many women believe that after an surgical operation (VSC) they will become weak and they cannot work hard anymore. Next is that in our society people who adopt permanent FP loose their social status. They cannot go to temple and worship gods and goddesses; they become somehow unholy." (AHW)

AN care is considered useful although not yet working well and the lack of medicines is recognised as a main problem.

"It is useful, if things are well managed. It is no use to check patients, if there is nothing to give." (AHW)

"It is useful. We get a chance to counsel them about FP. We find out the growth of the baby. We talk about immunisation and we give TT vaccine to the mother. We advise her to take vitamins. - But many women do not come." (HPI)

What could be done to change behaviour? Health workers believe in education - general and health education. Knowledge should be increased among all the people including men and the elderly people. One AWH mentioned again the need for daily allowances for

outreach work. Mostly the informants refer to FCHVs, VHWs and TBAs, who are supposed to move from house to house and motivate people.

4.2.6. Conclusion

Most of the health workers like their work in spite of the many de-motivating factors they face. Their perception of what is good quality in health care is not very formulated and it emphasises technical aspects of the health care. Generally, they see clients as ignorant recipients of the service. They think that clients come to the health post only to obtain medicines, contraceptives or vaccines. In spite of the fact that the medicine supply is scarce, the health workers think that most of the users are still satisfied with the service.

The suggestions of what would improve the quality of care at the health post reflect both practical the needs of the health post and their own motivation. Salary increase, training and promotion would motivate them. Supervision is not considered an important issue, more important is a sufficient supply of medicine and adequate facilities.

4.3. QUALITY OF CARE FROM THE USERS' POINT OF VIEW

This section describes users' experience and perception of the quality of the care they received at the health post. The results originate from the structured client exit interviews. They are mainly quantitative, but also qualitative information from open-ended questions is used.

The associations between user opinions and specific health posts are ignored. Initially, for ethical reasons - to avoid focusing attention on certain health posts or health workers - and, secondly, in order to maintain validity of results. The sample was not equally distributed between health posts, and therefore opinions would easily be given unfair emphasis, if presented accordingly. Statistical significance has not been looked for.

4.3.1. The sample

The sample consists of 60 female informants from five separate health posts, who visited the health facility for any type of reproductive health service The distribution of the informants according to the health posts and the type of visits is shown in table 4-2.

Table 4-2 Distribution of informants according to health post and the reason of the current visit

Type of the visit / HP	Lahan	Malahaniya	Bhagwanpur	Bhaluwai	Khirauna	Total
Antenatal	1	5	9	0	1	16 (26.7%)
Post natal	2	0	2	0	0	4 (23.3%)
FP 1st visit	0	1	0	0	0	1 (1.7%)
FP revisit	2	4	0	7	0	13 (21.7%)
EPI	9	0	0	0	0	9 (15%)
Child sick	0	2	4	6	2	14 (23.3%)
Reproductive health problem	0	2	0	1	0	3 (5%)
Total	14	16	15	14	3	60 (100%)

Sample characteristics

The background variables asked concerned age, marital status, number of living children, religion and caste, education, occupation and access to the service in regard to the distance from home to the health post and availability of any means of transport.

The informants were very young as shown in the bar chart (figure 4-1). The mean age was 24 years. The respondents were all married and all except four had children alive. (figure 4-2). The average number of children was 2.55.

Figure 4-1 Age distribution

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Figure 4-2 Number of children

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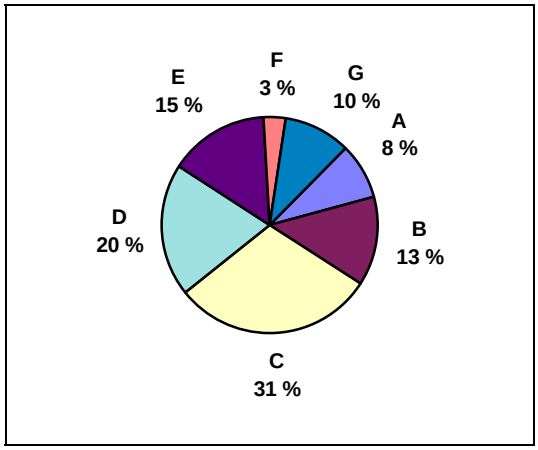
Ninety percent of the informants were Hindus and they were from twenty castes. The rest were Muslims. All the 'levels' of castes were present in the sample as shown in figure 4-3 of the caste distribution where one group represents Muslims.

Figure 4-3 Castes and religious background

Group	No of informants n=60	Castes:
A	5	Brahmin, Baral, Dhakal, Thakur
B	8	Yadaw
C	18	Donwar,Sah,Sudi.Teli, Chaudhari, Pandit,Mahto
D	12	Kiot, Rai,Mandal
E	9	Sadai,Dusadha,Pasman, Raibdas
F	2	Bhujel
G	6	Muslems



Educational background was asked regarding the school level the respondent had finished or if she had attended non-formal education. Altogether forty percent has received some education; the secondary level was the highest (figure 4-4). Most of the women in the category 'none' did not attend school at all. Four of them said that they would like to participate in NFE, but parents-in-law oppose it.

Figure 4-4 Educational background of the informants

Education	No of informants
none or a few classes	36
finished primary school	6
finished secondary school	8
attended non-formal education (NFE)	10
Total	60

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Almost 80% of women are occupied in household activities and in the farming for their familis. Small trade is the main occupation of five women. Eight respondents (13.3%) belong to landless families and are involved in paid daily labour, which is more than the percentage (7.1%) amongst the women in the district in average. (CREHPA 1996).

The distance from home to the health post is expressed as a walking time, because it turned out to be the most consistent and probably most reliable measure instead of varying figures of kilometres, 'kos'[3] and miles. - although it is still an estimation. Twenty two percent had to walk more than one hour one-way. Twelve respondents said that a bus service is available, but only five of them used it for the current trip.

The time consumed on the visit includes the trips, the waiting and consultation at the health post. The time used for a combined visit to the local market was not supposed to be included. The majority, 72%, needed more than one but less than three hours for the journey.

4.3.2. Perceptions of the quality of care

When exploring the health service users' perceptions of the quality of care the following issues were studied and will be reported subsequently:-

- Access to use health post
- Privacy and confidentiality during the consultation, cleanliness of environment
- Information and choice regarding FP methods and other concerns
- Continuity of care and supply of remedies
- Interpersonal relations / dignity
- Satisfaction concerning the service

Access to use health post

Majority (71.7%) of respondents felt that the time spent during the their visit to health post caused problems for them. There is a clear correlation between the length of consumed time and problem experience as shown in the line chart (figure 4-5).

Figure 4-5 Correlation between length of consumed time and problem experience on a visit to a health post

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Other factors creating problems for accessing health care are for instance family finances and relevance of the service. Two people mentioned that they lose their daily wage when visiting the health post. The service fee (2 Nepal Rupees) is too costly according to 1/3 of respondents, especially when they compare it with the service and medicines they receive.

The waiting time at the health post between arrival and consultation was seen reasonable by 56.7% of respondents. In spite of long waits mentioned by the rest 40%, only 8.4% of

[3] Kos is a Nepalese measurement of distance, around two miles

all recalled any specific problems caused. Problems of getting food or drink was mentioned by four informants and a lack of toilet facilities by one.

Privacy and confidentiality during the consultation, cleanliness of environment

Fifty percent of respondents had felt that they were not afforded sufficient privacy and confidentiality during examination, fifteen percent were undecided and 35% were satisfied. There was no significant association between the type of the visit and expressed satisfaction.

The general environment at the health post or the examination facilities perceived to be clean enough by 71.7% of respondents. For nine people, the question was irrelevant and they could not give opinion. Eight women were not satisfied. One person mentioned that since the SC/US office has been at the health post, the situation has improved.

Information and choice

The family planning clients, 14 women, were asked two questions about the information and knowledge they had received about different FP methods and about the methods they were currently using. Did they feel that the received enough information to be able to make an informed choice regarding different types of contraceptives and to continue using the chosen method safely? These questions referred to their entire history of visiting the health post.

Half of respondents felt they that had not received enough information about different methods or that they had even been given wrong information[4]. Nine out of fourteen felt that they did not know enough about their current method. Two informants on the contrary said that they received good advice and therefore they are not worried about possible side-effects of contraception.

All 60 respondents were asked if they during the consultation had had an opportunity to ask what they wanted to know. Seventy-two percent replied that they had. Eighteen percent said they had not had the chance or that they were not well advised. Non-response was 10%.

Continuity of care and supply of remedies

Closely related to receiving correct information is the continuity of service. This is extremely important for FP and EPI clients, but all the patients should know if they need to return for further appointments or if their treatment has been finished. The results in table 4-3 show that the women who did not know if they are expected to come back or when they should come are mostly clients of curative care. But also five AN clients and one mother of a child of EPI programme and one FP client did not know the date when they should return. All in all, 26.7% were ill or non-informed.

Continuity also includes a constant supply of contraceptives, vaccines or other necessary drugs. Only 45% of the respondents received all the remedy they needed. As shown in the table 4-8 all vaccines and contraceptives were available. (One family planning client did not receive her Depo-Provera injection because she had lost her card.) The problem is the insufficient supply of medicines. Only two out of 16 AN clients and three out of 14

[4] One woman had been told by a health worker that she should not choose VSC, because she would become weak and would not be able to support her old husband.

Another woman had been refused Depo-Provera by health workers after giving birth and told to wait until her menstruation starts. Now the baby was eight months old and she was afraid of being pregnant again.

sick children received all necessary drugs. The medication AN clients need is fundamentally iron or vitamin supplements and Tetanus vaccine.

Table 4-3 Continuity of care and supply of remedies

Type of visit	Knows the date for next visit	Does not know when to return	No need to return	Cannot say if she needs to come back	Received all the remedies	Did not receive prescribed medicine	Did not need anything
AN	10	5	0	1	2	14	0
PN	4	0	0	0	1	3	0
FP 1st visit	1	0	0	0	1	0	0
FP revisit	10	1	1	1	11	1	1
EPI	7	1	0	1	9	0	0
Child sick	4	4	6	0	3	11	0
Self sick	0	2	1	0	0	3	0
Total	36 (60%)	13 (21.7%)	8 (13.3%)	3 (5%)	27 (45%)	32 (53.3%)	1 (1.7%)

Interpersonal relations - dignity

Being treated with dignity and respect by providers during the visit to a health post is important for the client. The respondents were asked how did the staff members treat them. The responses were coded into three categories a) friendly and politely b) impolitely, c) “cannot say”. The majority, 72%, felt they were treated politely. Nine people (15%) said the they were treated unfriendly or roughly. Thirteen percent had no opinion.

There were no other associations between dignity experience and client’s background; the religion or caste, education or occupation except that none of the untouchables or daily wage labourers had experienced impoliteness.

Satisfaction

The users’ perception of the quality of care is clearly illustrated by their responses to questions concerning experience at the visit. Descriptive responses about their experience (quotations are in appendix 8) were categorised as follows:

Clearly satisfied (28%), some complaint (15%), clearly dissatisfied (50%). Seven percent of the respondents did not give any comment.

The most common reason for dissatisfaction was the lack of medicine supply (26/60). The next most frequently mentioned (13/60) reason was lack of thorough examination. Eleven people complained that they did not receive good advice. Five persons told about the rough or careless behaviour of the staff. In addition mistrust was expressed by three people who believed that staff members sell the government medicines privately. Two persons told of an abscess the child had acquired after last vaccination. Four people expressed the need for a female health worker. Six people said that the health post is hardly of any use.

Most of the satisfied clients did not mention any specific reasons for that except two people who told that they had received good advice regarding feeding a baby or for tackling the side-effects of Depo-Provera.

Secondly the level of quality according to the respondent's perception was expressed on the scale: poor, fairly poor, no opinion, quite good, excellent. The results support the descriptive findings; thirty five percent of respondents think that the quality is good or excellent and 57% see it as poor or fairly poor. The distribution of opinions is shown in the figure 4-6.

Figure 4-6 The users' perception of the quality of care at the health post
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Use of the health post in the future

Because the quality of health services may influence people's behaviour concerning the use of them, the informants were asked what is their plan concerning this particular health post and their future needs regarding FP, ANC, delivery help or curative care.

Most of informants (93%) will come to the health post again when they themselves or a child needs medical care. The intention to use FP, AN or delivery services was lower; out of the respondents who were eligible[5] for family planning or MCH and midwifery services, 70-76% were planning to use the health post if a need deems. See figure 4-7.

Figure 4-7 Intention to use health post in the future in regard to different needs
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4.3.3. Suggestions for improvement for the quality of care at a health post

In order to prioritise the weaknesses perceived by users, the informants were asked to give suggestions for improvements. Each respondent could mention three different points. One third of them found the question irrelevant and did not give any suggestions - some were satisfied and some did not plan to return to the health post. The suggestions were ranked according to the frequency they were mentioned (figure 4-8). The need for more medicines is the priority. Cheaper service fee and changes in the personnel of health post (female or better qualified staff) were mentioned far less often.

Figure 4-8 Ranking of suggestions given by health post users for improvements of quality of care
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4.3.4. Conclusion

The perceptions of the quality of care at the health posts have no clear associations to users' background nor to the reason for the current visit. Equally, more than half of respondents expressed general or specific dissatisfaction. The quality of care from users' point of view is not high.

A major reason for dissatisfaction is found to be the insufficient supply of medicines. But this and the related issue of service fee are not the only reasons. The problems due to long walking distance, lack of privacy during consultation, an unsatisfactory reception, poor information concerning family planning methods or the next appointment were frequently mentioned determinants of reduced satisfaction.

Around one third of users were satisfied with the service. Their reasons were first of all decent interpersonal relations and proper service. The waiting time, waiting facilities or cleanliness of the health post play hardly any role in quality perceptions.

[5] Eligible for FP means women who did not undergo VSC. Eligible for MCH services means women who use no or temporary methods of FP.

In spite of the dissatisfaction almost all clients see the health post as the place where to return for curative care. The intention to use the health post for family planning and ante-natal services is lower, but still reasonable high.

4.4. SUMMARY OF RESULTS

Full staffing and reasonable facilities at the health posts as well as high self-esteem of health workers are an existing prerequisite for good quality in health care in the study location. However deficiencies in service arrangements reduce overall quality and several problems cause reduction in staff motivation as well as in user satisfaction.

The lack of medicines is a priority issue when the quality is assessed from the perspectives of both health service providers and users and is a reason which providers recognise as a cause of patient complaints. Providers however assume that it is the only reason for dissatisfaction, which is not true. A community member from a tea shop close to a health post reflected in an informal discussion the feelings of both health post users and community members:

"*I have lived here for all my life, I know. They don't have medicines, but if they get some, they use them as they want. OK, if they do not get medicines they should give advice and good care to the people, but they don't care."*

Health post users expect decent interpersonal relations and professional competence. They do not agree with the providers' point that because the setting is 'only a health post', not much service is to be expected. Users expect providers to listen to them, pay attention to their problems and conduct a thorough examination. The mother who had walked over two hours for her child's vaccination did not have a chair offered while the child was vaccinated. The mother who brought her new-born baby for a check -up did receive vitamin pills, but nobody even looked at her child. The woman who had lost her individual FP card was roughly refused the Depo-Provera injection she was due.

Health providers accuse clients of ignorance and unwillingness to change behaviour. Users complain of inadequate information or lack of information. Many of them do not know when they should return to the health post. Many feel they do not know enough about the family planning method they are using. Users' expectations and the providers' perception of the quality are highly contradictory.

CHAPTER 5. DISCUSSION

The overall striking need to improve women's health has been addressed through several programmes. Besides the unequal distribution of resources and deficiencies in terms of governmental/political prioritisation the issue of *quality of available services* receives more attention now than before. In Nepal reproductive health care is a priority issue; family planning programmes have been given attention for years, ante-natal care and midwifery services are under development. The level of the quality of currently available care, including effectiveness and acceptance of it, is a major issue when evaluating the present situation and planning for future to improve the status of women.

The results of this study show that the quality of health care at the five health posts examined needs attention. The good infrastructure such as existing buildings, full staffing, which is exceptional in Nepal, and expansive road network serve as an excellent frame for the service development. The collaboration between the District Health Office and Save the Children US adds a lot of potential to the efforts of providing quality health care to the population.

The quality of care was assessed in this study from three different angles; 1) structure, 2) providers' and 3) users' point of view. It was studied using a variety of methods. In this chapter the results and their implications are discussed from the point of health service management, planners and specifically from the point of the study client, SC/US. The methods used are also appraised.

5.1. IMPACTS OF STRUCTURE OF HEALTH CARE ON QUALITY OF THE SERVICE

The role of health posts is critical in providing primary health care to people. In regard to reproductive and MCH services, it is the place where, in addition to the basic family planning and maternal health care which is planned to be available at all levels starting from outreach and sub-health post level, some more specific services are arranged: such as provision of IUD; basic laboratory service; and detection and management or referral of maternal and obstetric complications (Thapa 1995). This requires functioning facilities and a relevant service delivery system.

This section reviews issues of accessibility, clinical settings and procedures, and service delivery arrangements including the impact of non-formal education.

5.1.1. Accessibility

The government's aim (HMG 1996) to provide a health facility within at most one hour's walking distance can be seen as a relevant goal, compared the increasingly problematic experience for the women attendees as soon as the length of time consumed during a visit was more than one hour. The majority of the study population needed to take more than one hour for a visit. However, this study did not explore whether the women came to the facility nearest their houses. But as still to date the level of service at sub-health posts is lower than planned regarding staffing and facilities, the health posts are obviously visited more frequently.

Accessibility does not mean only geographical access; social, cultural and financial acceptability are also important. In the context of the study location the role of a female health worker is very important. The need for a 'sister' was an issue often mentioned both

in interviews and in informal discussion with community members. The strategy of SC/US to post ANM students to health posts is good, because they can fill the gaps in the absence of the ANM. However the role and tasks of students might need clarifying in order to benefit the clientele most.

The financial burden of visiting a health post is not only due to the service fee. People compare the payment with the outcome - the service or medicines they get - and they are dissatisfied. Daily labourers, in addition, lose the wage of the day; the need to visit a health post must be urgent before deciding if they can afford a visit. In the study population the proportion of daily labourers was higher than in average in the district. All the reasons for this could not be figured out; but it can be concluded that at these health posts low status is not a hindrance to patients' approaching health workers as it was shown to be elsewhere in Nepal in the article by Schuler et al. (1985).

In order to reduce problems of accessibility the DHO is expanding the sub-health post net. But as long as the sub-health posts are not able to offer decent basic health care, they will not reduce people's need to come to health posts. Therefore alongside of supporting health posts, the quality of care at sub-health posts needs intensive attention.

5.1.2. Clinical settings and procedures

Baker et al.(1994), when evaluating FP clinics in Nepal, found a lot unsatisfactory procedures and estimated their impact to be high in reducing efficiency of the service. The current study was made in health post settings where both FP and maternal care is very basic; there is no provision of IUD insertions nor any equipment or medicines for assisting in complicated deliveries. Hence, although the inadequacies found in infection prevention and the management of the dressing room are important, they are not crucial from the point of the reproductive health care system.

Depo-Provera vials are supplied together with disposable needles and syringes which ensures safe injections. Items which need attention are procedures including handling of needles and syringes for the EPI programme; establishing a proper waste disposal system in the compound; decontamination of surfaces and instruments and adequate use of gloves. The protection of providers and the awareness of the Hepatitis-B Virus and HIV transmission need attention.

ANMs showed willingness to broaden the options of family planning methods, but as long as the infection prevention management is at the level of today, any methods requiring proper disinfection are not recommended.

The arrangement of counselling and examination rooms and facilities is not satisfactory. Ensuring privacy is essential. Waiting facilities do not affect the well being of the users and they are prepared to wait as long as needed without complaint. Baker et al. (1994) and the results of this study agree on the importance of client-provider interaction. Even if the client may not be in the position to judge the medical appropriateness of the treatment or care as Øvretveit (1990) argues, she knows exactly if the health worker was interested in her or her child's problem and if she had a chance to ask what she wanted to know.

5.1.3. Service arrangements

The reproductive health care services are integrated with other health post activities. The service delivery is delegated to ANMs, but as ANMs are not always present, other health workers are obliged to conduct it. Aitken's 1994 worry of the competence of auxiliary health workers to carry out tasks of MCH and FP is justified based on the results of this

study. Many women who came for an ante-natal check-up, were not checked at all or advised. Of course, the cultural limitations to interaction have to be taken on board before aiming to change practices.

Ante-natal care

The ANC utilisation in the district is far behind the national average, but as the DPHO and many health workers emphasised, the whole idea of ANC has only recently been accepted. Still to date the quality of ANC at the health posts studied is on average low. ANMs are well motivated and skilled but in general there is no screening for risk cases or other preventive action available. According to the baseline study (CHERPA 1996) seventy percent of both women and men in the area recognise the need for ANC.

Of course, the wide debate about the usefulness and effectiveness of ANC (Rooney 1992) has to be kept in mind when assessing the activity. Is it useful or relevant to invite women to come to a health facility, when there is 'nothing to give' and where even the referral system for risk cases or delivery complications does not function? One invaluable achievement in the district is the wide reach of the Tetanus vaccination programme; TT first and second dose coverage is fairly high. The activity takes place within the EPI programme.

The arrangement of the EPI programme, however, with its vaccination day operating only once a month, does not promote smooth service delivery: these special EPI days at the health post or in outreach clinics are packed with babies and pregnant women and the ideal opportunity for pregnant mothers to receive a through AN check-up is lost because of the work load. The logistics is obviously the key point. It would be worthwhile to study possibilities to integrate and expand EPI activities with other services such as ANC.

The health providers interviewed as well as the author believe that education and knowledge are the keys to improving health status. Therefore it is highly recommended that use all the opportunities are taken to counsel women, and one would ideally be the ante-natal consultation. 'Health talks' (lecture or group discussion) are not favoured in the context, but also individual counselling opportunities are missed by ignoring the chance to meet pregnant women when they attend the health post.

Delivery care

Even adequate ANC is not enough to reduce maternal mortality. Professional delivery care is important. (Rooney 1992) ANMs assist women in deliveries, both at the health posts and in homes, but due to under-reporting or under-activity the attendance figures are very low. Government policy implies immediate delivery assistance should be given by the trained TBAs. The assessment of the role of TBAs or the impact of it was not an objective in this study, but the importance of their job performance was frequently underlined.

TBAs themselves are proud of their knowledge and skills. They tell that they attend practically all the deliveries in their respective villages, which contradicts the results in the baseline study (CHERPA 1996) where the TBAs had assisted in only eight percent of deliveries on average and thirty-two percent of deliveries in the previous project area of SC/US. Untrained traditional birth attendants had assisted in half of the cases. This supports Levitt's (1988) finding about the common inappropriateness of the selection process for TBAs.

The health post staff together with SC/US co-ordinators is involved in the training of community level workers including TBAs. This enhances availability and quality of basic health services in communities. However it is necessary to evaluate the acceptance of

the trained people by the community and to consider if the selection of them needs re-organising

Nevertheless the newly acquired skills and knowledge provide only a part of the picture: *A group of TBAs, who were attending a training course at the health post, told in an informal discussion that one young mother had died 'yesterday' in child birth. The new born baby was still alive, but because the mother would return as a 'spirit' anyway and collect him, he was going to die, too. So there was no use in even trying to keep the baby alive.*

Beliefs and traditions, the whole variety of alternative health care, economic factors and the lack of basic education, all make efforts to influence the health and health seeking behaviour of the population a multifaceted process.

Impact of Non-formal Education

As a component of the current programme, "Empowering Women for Family Planning and Reproductive Health Program in Siraha District", SC/US has been organising within, the public health structure, non-formal education. This has presumably brought change, not only in increasing literacy, but in increasing knowledge and interest in seeking out formal health care. The proportion of women in the study population who have attended NFE was threefold compared with the proportion amongst all women in the district. The school attendance of the informants was also remarkable high: 23% against 3.4% of the all women. (CREHPA 1996)

The target of adult education has been the female population. As the illiteracy of women in the district is almost 90% against 59% of men and the percentage of women who have finished primary school is only 1.7% against 11.7% of men (CREHPA 1996), the focus is correct. But as the health workers pointed out, one powerful reason for neglecting family planning is ignorance combined with old beliefs, which affect both women and men as well as the influential elderly. Therefore male-oriented educational programmes are needed, too.

The conclusion is that to ensure acceptance of the FP and MCH programmes non-formal education has to continue.

Family Planning

Arrangement of family planning services is involves health posts, sub-health posts and community health workers. The supply of contraceptives is plentiful. Still the utilisation of the service is low, although also opposing opinions were given. The main method used is VSC. The need to emphasise temporary methods has been recognised at national policy level (Thapa 1995) as well as by SC/US (1994). Health workers however almost without an exception associate the term family planning with VSC. ANMs are the exception and they see the need for a variety of methods.

Both Save the Children US and the DHO run sterilisation camps. SC/US also offers STD/gynaecology service at the camps (SC/US 1994). A suggestion presented by Thapa and Kalyan (1994) of providing long-term temporary methods such as IUD and Norplant at the camps deserves consideration. The health post staff, specifically ANMs, could be trained for counselling and screening of candidates as well as for follow-up of clients including IUD removal. Norplant removal has to be carried out by specialists.

The promotion of temporary methods, which are currently available, needs emphasising in training offered to the staff in order to better meet the needs of their clientele. The neglected prevalence of STD and HIV infections requires emphasis on condom use. Secondly condom use as an option can be recommended because it relieves women

from the burden of the frequently experienced side-effects of hormonal contraception methods.

Over half of FP clients and many other informants had concerns over different aspects of contraception. Unmet questions show that the current service has in general not been able to provide high quality family planning. The finding coincides with Baker et al. (1994) results from FP clinics in Kathmandu Valley concerning inadequate counselling and information. Therefore all efforts to improve staff attitudes, skills and knowledge are encouraged.

5.2. HEALTH WORKERS' ROLE

A comment of a non-medical health post employee "*People think that the health workers are doctors, but they are not doctors. They are here to give health education and advice to people. But they don't do it*" perhaps describes grass-root level reasons why the primary health care service in Nepal has not been only a success. The gap between the official tasks of the system, expectations and needs of the people and the real action and outcome is wide. Reasons are various; health workers' role and performance influence is crucial.

The health workers have high self-esteem in regard to their professional performance. Some recognise a need for new knowledge, especially if it comes in the form of refresher courses or a scholarship abroad. But the basic feeling is that they are competent in their duties. As a reflection they think that the clients are satisfied with the service they provide. Several informants, however, stated that due to the low level of education some patients are ignorant and therefore unable to understand limitations of the service available.

5.2.1. Users' expectations contradicting providers' perceptions

The users are dissatisfied. But is the reason their limited capacity to understand health care processes? While only around 35% of the clients felt that they had enough privacy during consultation, when less than half of them had received sufficient information of the different family planning methods and about the side-effects and implications of the current method, when only 70% knew when they have to return to health post and when 15% had been treated clearly impolitely by the health care provider, their justified dissatisfaction is a sign of awareness, not ignorance.

Bruce (1990) describes the effects of *good* quality in health care as being to do with client's knowledge, satisfaction, health and constant use of family planning methods. Women who participated in this study showed the following signs of *poor* service quality; numerous questions about obtaining, use and side-effects of contraception methods and deep worries about their own health or well being of their child.

The insufficient medicine supply is a very important issue which affect all but FP and EPI service. It is a constant cause of user dissatisfaction and because a lot of mistrust is attached to the issue - the staff is accused of misusing drugs by selling them privately or reserving them for special patients - it fuels a conflictive disapproval in the provider-client relationship.

A technique to measure the level of quality perception was to inquire about the client's future plans to use the health post regarding different needs. The intention to use health post was significantly lower for preventive rather than curative services. Of course, what a person says in a interview situation does not necessarily predict the real action. Neither is

the quality of care the only factor influencing the health seeking behaviour of an individual. But in spite of the possible impact of confounding factors, we can conclude that the results agree with the findings by Bichman et al (1991) and Vera (1993) about the link between the level of user satisfaction and FP and MCH service utilisation.

When comparing the results of this study to other studies where user satisfaction has been queried (Williams 1994, Batchelor 1994), the dissatisfaction of the clients in Siraha seem to be significant, taking into account that satisfaction expressed is usually high regardless of the setting of the service. Two conclusions can be drawn. Firstly, the level of the quality at these health posts is indeed poor and secondly, the methods used in this study succeeded in revealing users' actual critical opinions.

5.2.2. Implications of health workers' perceptions for improvement of quality

The gap between users' and health care providers' quality perceptions brings with it the crucial question of how to influence health providers' attitudes and determine how they would be enabled to re-think and assess the quality of the care they provide and to consider its impacts on their clients' health seeking behaviour.

If we accept Aitken's (1994) theory about the hidden pragmatic purpose of the district public health system in Nepal, that '*it exists in order to provide income for its staff*', we fall into a deep hole. It seems, indeed, that some of the employees see their job more as a secure chair in which to sit and receive benefits rather than anything else. But fortunately, that is only one side of the picture. The brighter side is that there are well motivated health professionals with positive attitudes towards their work and the aims of primary health care.

Criticism of the service delivery process and their own performance is restricted. One reason might be the fact that the course and content of the health workers' training, specifically AHWs, is quite limited (1 year). Ethical or philosophic background and standards of nursing and health care have not received much attention. Health workers appear to have never studied consumerism or cost-effectiveness. Perception of hygiene standards is generally vague. This does not underestimate the appropriateness of their training and (non-existing) job descriptions in the context. But it warns about expecting that they were looking at health care from the Florence Nightingale or from Avedis Donabedian perspective.

The quality assessment of the structure and process of service delivery, such as the inventory of facilities in this research, reaches at most the level of the third-generation evaluation (Koch 1994). The standards are set by the experts and the procedure is judgmental - how much ever you try to soften it. Certainly, this kind of evaluation has its value, because it gives baseline information and the results can lead to improvements made by management.

Fourth generation evaluation approaches the process comprehensively, and because the participation of all the stakeholders is required, it can thus enhance change in attitudes and in practices. (Koch 1994). This research gave both providers and users a chance to express their opinions about the quality and what should be done to improve it. The results are valid. But recognising them does not guarantee any change if a mechanism of ongoing process of quality assurance is not set up.

5.2.3. Job motivation

As the consciousness and participation of health workers is essential for improving quality and for successful quality assurance, it is necessary to look at the factors that

affect their motivation. Motivation was affected by two types of factors: 1) constraints and inadequacy in providing health care to the clients; and 2) factors which reduce personal motivation.

The scarcity of even the most basic drugs is a big reason of dissatisfaction among users and a headache for health workers. Only the contraceptive supply is well organised. EPI vaccines are also sufficient in quantity, but the distribution and availability is not always adequate. Essential drugs for maternal care such as iron and vitamin supplements, as well as antibiotics or any medicines needed in the case of obstetric complications, are not available.

Secondly the lack of instruments or laboratory supplies is a de-motivating factor - specially for ANMs who feel helpless not being able to perform even simple examinations such as measuring blood pressure or checking haemoglobin or sugar or protein in urine. Appropriate equipment including an examination couch and sufficient supply of instruments would increase staff motivation and at the same time ensure higher quality in maternal and reproductive care.

Personal motivation is affected by problems of low salary, poor accomodation facilities, lack of promotion prospects and fear of transfer and other political influences. Due to low salaries staff members conduct two jobs, keep a medicine shop or dream of a better (paid) job within an NGO. According to Herzberg's two-factor theory (1993) these issues are basic needs of employees. They cause dissatisfaction, but fulfilling them does not yet really improve motivation.

The experience of satisfaction the health workers told about has its roots in the character of the work; the feeling of having done a good job by serving fellow citizens. These are Herzberg's 'motivation factors'. From a manager's point of view it is worthwhile to note, that influencing motivation factors does not always require financial resources. Simmons & Simmons (1992) see supportive 'worker-oriented and worker-friendly management' as an effective way to improve motivation and consequently quality of health care.

Lack of support and encouragement was mentioned by many informants. The current supervision was not seen as beneficial. A counteraction would be 'low-pressure' supervision by visits with emphasis responding to the practical needs of health care providers. The problem-solving and facilitative approach, instead of inspection and control, encourages workers. However, a finding in a case study in Zambia about supervision warns not to put too much hope in the results of the input of 'motivation' factors without assessing the basic needs first (Aus1993).

Training as a source of motivation, as it was detailed by most health workers, is questionable. Presumably, it might improve the personal well being of the worker (daily allowances, entertainment), but not necessarily job performance. As Aitken (1993) concluded, usually not much change has taken place in the practices after training.

In this study the participation in refresher training was not explored and therefore its impact on knowledge or behaviour can not be determined. However the previously mentioned basic error in the health workers' perception of the concept 'family planning' - they normally associate it with VSC - after all the training they have received, indicates that a follow-up mechanism for the outcome of training is indeed necessary.

Fast staff rotation is a recognised constraint in organising training. It makes it difficult to provide courses for all the workers as needed. The rotation seems though to be an issue beyond control of both SC/US and the District Health Office. Training nevertheless must

continue for improving health providers' skills and knowledge as well as to enhance their motivation to participate in the improvement of the service quality.

5.2.4. Quality assurance cycle

The method recommended for ensuring continuos quality improvement and assurance at health posts is to follow a '*quality assurance cycle'*, that was discussed in Chapter Two (2.3.2)

A simple example of how quality assurance could work in the context of health posts is presented in the table 5-1. The process requires a team approach. The team would consists of representatives from the DHO, the SC/US, the community, eventually health posts committee, and the health post staff. The process however requires that all the staff members are involved.

Table 5-1 An example of the function of quality assurance cycle at a health post

Step in quality assurance cycle	Action at health post
Identify problem	In discussions and brainstorming, an observation comes out: "*quite a lot of women complain of lack of privacy during consultation*"
Measure current level of performance	• How do we work? Does every woman have a private consultation; is the door closed or open; do other staff members or other clients enter room while examining or talking with the client • How many women complain? We will ask them.
Identify standard	• How should it be; is it necessary to have privacy? • What do our guidelines say • What does our culture demand? We decide our standard to be that every woman will have a chance to talk to the health worker alone, one by one
Develop strategy for improvement	We develop a strategy: • the peon looks after clients and does not allow them to enter consultation room while it is occupied • every health worker keeps the door of the consultation room closed while examining a client • the patient flow will be arranged so that there will be no cluster of clients waiting for the same step of service
Implement plan of action	All the workers follow the agreed strategy
Assess impact of action on problem	How did it work? Are the clients now more satisfied? Is it worthwhile to continue like this?
Identify problem	What is our next problem?

5.3. CONCLUSIONS

This study describes the quality of care at the five health posts. A comparison of the structural quality between these and the other health posts in the district which have been in partnership with Save the Children US for a longer time will be useful[6]. The results will serve the organisation at the planning stage concerning the continuation of the project.

[6] The report of the evaluation conducted by SC/US in 1996 was not yet available

The results of this study provide a lot of information concerning weaknesses of the care at the health posts. The scarcity of medicine supply affects care tremendously in both curative and MCH services. Recognising the importance of this means that ensuring basic medicines for especially MCH (including iron supplements, children's antibiotics and medications for obstetric emergencies) can be recommended together with ongoing control system and enhancement of treatment skills.

However the drug supply is not the only point which needs consideration. The concerns expressed by health providers varied from very practical wishes such as having a telephone or a fan at the health post to the more complicated issues of improving work morale, salary, training and housing. Judging priority and feasibility, which inevitably is a crucial concern for the DHO and the NGO involved, needs through consideration of available resources.

More complicated however is the question of awakening health workers to the needs and expectations of clients and to commit themselves to improving quality. Therefore the priority recommendation based on this study is to set up a mechanism of ongoing quality assurance, where health providers are active participants.

The low utilisation of reproductive health services in the study area and the dissatisfaction of users shows for both the DHO and SC/US that there is need for intensive quality improvement.

5.4. COMMENTS ON METHODS USED IN THE STUDY

The results of this study revealed a variety of views, which disclosed the study question of quality in health care. The evaluation of the structure of the health posts, the perspectives of health care providers and users, provided information for each specific objective of the study. The chosen methods were appropriate.

Nevertheless an additional method of obtaining a more accurate picture of the processes of care would have been to conduct direct observations of provider-client interactions.

The study was initiated by the concern that the utilisation of public health care and specially family planning and MCH services is low in the study location. The user perspective exposed several deficiencies in the quality of care. Therefore an assumption of the connection between poor quality of care and low utilisation is acceptable; but the significance of it could not be proved in this study.

The decision to abandon the community study was correct taking into account the priority of the study client and feasibility of the study process . However, as the current 'users' are only a minority in the target population of the health posts, there is obviously a lot of covered information within the community. To unveil those factors affecting the issue would need research focusing on community behaviour and perceptions.

The methods used to approach providers and users deserve attention. Semi-structured in-depth interviews of staff members produced material, which would not have been achieved by using a structured interview model. The structured questionnaire with open-ended questions used in users' exit-interviews was an useful method. It facilitated easy analysis of results, but the open-ended questions still allowed informants to express themselves freely enough to ensure the trustworthiness of information.

CHAPTER 6. RECOMMENDATIONS

The following are the recommendations to the study client. They are based on the results and conclusions of this study.

The Save the Children US project "Empowering Women for Family Planning and Reproductive Health Program in Siraha District" is already fulfilling many of the activities recommended but they are mentioned in order to emphasise the importance of them.

Support of MCH and FP service

- Continue to enhance knowledge, skills and approach of health workers and hence improve quality, acceptance and use of service by providing them with training and by offering practical supervision and support at the sites. The issues to be given special attention are:
    - improved counselling of FP clients in regard to adequate information about different family planning methods and their consequences
    - privacy during consultation and counselling
- Explore the possibilities of ensuring that health providers have adequate facilities, instruments and medicine supplies to conduct their service according to national guidelines.
- Assist health posts to arrange and improve infection prevention. Special attention should be given for the issue of HBV and HIV transmission.
- Continue provision of posting intern ANM students to health posts and to clarify their role and tasks
- Expand the support to sub-health posts as adequate.

Information and education activities

- Continue the IEC and non-formal education activities as before and to seek more channels to reach men in addition to focusing on women.

Quality assurance

- Ensure on-going and permanent quality improvement at health posts by setting up quality assurance mechanisms, where the following principles are met:
    - establishment of a quality assurance team with representatives of all the stakeholders
    - participation and involvement of all the health post staff
    - involvement of community representatives
    - focus on the work and process rather than on the external input
    - development of own standards for locally identified problems

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APPENDICES

APPENDIX 1 PHOTPGRAPHS: WALL PAINTINGS AND TBA TRAINING

Photograph 1. Wall paintings. Public awareness raising about the benefits of a small family and about different FP methods in Siraha district

Photograph 2. Training of TBAs by the ANM and other health post staff in Bhagwanpur

APPENDIX 2 MAPS OF NEPAL AND SIRAHA DISTRICT

APPENDIX 3 INVENTORY FORM FOR HEALTH POST FACILITIES

INVENTORY FOR FACILITIES AVAILABLE AT THE HEALTH POST AND SUMMARY OF SERVICE STATISTICS

Health Post visited (Name)_____

Health Post Number (Code)_____

Dates of visits_____ / _____ / _____

Name of observer _____

1. Did the health post open in time? (one service provider reported to work at 10.00 a.m. or earlier = OPEN)

Date	Yes/No/No information

2.a. Number days per week FP service is offered _____

2.b. Number days per week MCH services are offered _____

3. Is there a sign announcing that FP and MCH services are available? Yes/No/NI _____

Section I. Staffing

4. Indicate the number of staff and voluntary workers working in the MCH/FP at his health Post, and in the field area served by this Health Post.

Designation	No of staff in place	No of vacancies	No of deputed staff	Length of service at this HP
Health Post in Charge				
Auxiliary Health Worker				
Assistant Nurse Midwife				
Mukhiya				
Peon				
Village Health Worker				
MCH worker				
FCHV				
TBA				
Other (specify)				

Remarks _____

Section ll. Facilities Inventory

5. Indicate whether a room is currently being used for the following services. If two services are provided in one room, please, note it.

Designation	Room in use Yes/No	Remarks
Examination room		
Dressing room		
Dispensary		
MCH room		
Waiting room/area		
Storeroom		
HPI office		
SC-C office		
Other (specify)		

Waiting room facilities

6. Is there a system for forming a queue? Yes/No/NI _____

   Remarks _____

7. Is the waiting area protected against both rain and sun? Yes/No/NI _____

8. Is there seating for all clients? Yes/No/NI _____

9. Are toilets available? Yes, functioning _____
   Yes, not functioning _____
   No _____
   NI _____

Section lll. IEC Materials and Activities

10. The number of different FP and other reproductive health topic posters on the walls: _____

11. Which kind of IEC material are available?

Type of material	Tick if available	Remarks
Flip chart		
Brochures / pamphlets		
Information sheet		
Other		

12. Is the presentation of the material appropriate to the local population? (Note: presentation means type of material, appropriate deciptions in dress, background etc)

Yes/No/Partially/NI _____ Remarks _____

13. Was a "health talk" (group lecture or discussion with clients) held today?

Date	Yes/No/NI

13.a. If yes, were visuals used during the presentation? Yes/No/NI _____

13.b. If yes, did the presenter solicit questions from the audience? Yes/No/NI _____

13.c. If yes, did it include a topic of family planning or other reproductive health ? Yes/No/NI ____

13.d. If yes, did clients ask any questions or discuss with the presenter? Yes/No/NI _____

13.e. If yes, were important factual errors made by the presenter? Yes/No/NI _____

Remarks _____

Section lV Counselling facilities

14. Is auditory privacy maintained in the counselling room/area? Yes/No/NI _____

15. Is visual privacy maintained in the counselling room/area? Yes/No/NI _____

Section V. Medical examination facilities

16. Is there a separate room for examinations? Yes/No/NI ____

16.a If no, is there a separate area within another room for examinations? Yes/No/NI_____

16.b. If separated area, how the area is arranged?
Curtained-off area?____
Other (specify) _____

17. Is auditory privacy maintained in the examination area? Yes/No/NI _____

18. Is visual privacy maintained in the examination area? Yes/No/NI _____

19. Is there an adequate source of light in the examination room? Yes/No/NI _____

Section Vl. Infection Prevention

20. Is clean water available at the HP site?
Yes, but water is not potable ____
Yes, water is potable ____
Not available ____
No information ____

21. Are complete hand washing facilities available? (Note: "Complete" means one bucket for hand washing, on bucjet for waste water, a jug and soap) Yes/No/NI _____

22. Is the examination area clean? (Note: “Clean” means floors swept and mopped)

Yes/No/NI _____ Remarks _____

23. Is there a waste container in the examination area?

Yes, but container is dirty ___
Yes, and container is clean __
No ___
No information ___

24. Is the dressing room clean? (Note: “Clean” means floors swept and mopped, instruments kept in containers and medical preparations labelled and in clean bottles)

Yes/No/NI _____ Remarks _____

25. Is there a waste container in the dressing room?

Yes, but container is dirty ___
Yes, and container is clean __
No ___
No information ___

26. Is decontaminate cleaning solutions available? Yes/No/NI _____

27. Are High-level Disinfection (HDL) or sterilization facilities available and in working order? (Note HDL requires stove, kerosene, container for boiling, container for instrument storage, forceps for handling instruments. Sterilisation requires an autoclave)

Yes, HDL ___
Yes, sterilisation ___
Yes, both ____
No ___
No information ___

28. Are syringes and needles handled properly by HDL or sterilisation after use?
Yes/No/NI _____

29. Is there a medical waste disposal system in place? Yes/No/NI _____

If yes, please, describe system _____

_____

29.a. If yes, is medical waste being properly disposed? Yes/No/NI _____

Section VII. Equipment and Commodities Inventory

30. How many of each the following type of equipment is available for FP and reproductive health services?

Type of equipment	No in working order	Remarks
Blood pressure set		

Stethoscope		
Weighing scale		
Height measure		
Fetuscope		
Urine testing set		
Baby scale		
Thermometer		
Kidney dishes		
Bucket for waste disposal		
Examination bed		
Other (specify)		

30.a. Are there gloves available?

Yes, non-disposable gloves, amount _____
Yes, disposable gloves, amount _____
Not available ____
No information ____

31. Record whether the HP Provides each of the following methods and if YES, check and count the total number of contraceptives available at the moment.

Type of contraceptive	Provided at HP Yes/No	Quantity available
A. Pills (no of cycles)		
B. Depo-Provera, vials		
syringes and needles		
C. Condoms (no of pieces)		
D. Other (spesify)		

31.a. Record are the following essential drugs available for MCH services?

Type of medicine	Available Yes/No/NI	Remarks
Iron tablets		
Multivitamin tablets		
Antipyretic preparations		

Antibiotics, any type		
IV-Infusion solution		
TT-vaccine		
Other (specify)		

32. Is there an inventory of FP commodities? Yes/No/NI _____

33. Are the FP commodities stored according to their expiration dates? Yes/No/NI _____

34. Are the storage facilities adequate? (Note: "Adequate" means no exposure to rain and sun, protected form rats and pests) Yes/No/NI _____

35. Is there a system for ordering supplies? Yes/No/NI _____

36. If yes, please describe the system:

As needed ___
Regularly (e.g. quarterly, monthly) ___
Other (specify) _____

37. Were there a stock-out during last six months for any of the contraceptives?

Type of contraceptive	Stock-out Yes/No/Do not know
Pills	
Depo-Provera	
Condoms	
Other (specify)	

Section VIII. Record Keeping and Reporting

38. Is a separate record card kept for each family planning client? Yes/No/NI _____

39. Is a separate record card kept for each ANC client? Yes/No/NI _____

40. Is a separate card kept for each PNC client? Yes/No/NI _____

If there is NO separate cards kept, go to question 44.

41. Are the client addresses recorded in sufficient detail on the cards to allow follow-up? (Is there a village name, road address, a house number?)

Type of card	Address sufficient	Address insufficient	No information	Not applicable
FP record card				
ANC record card				
PNC record card				

42. In what condition are the systems of storing record cards?

Type of card	System well ordered	System partially ordered, still usable	System disordered, not usable	Not applicaple
FP record card				
ANC record card				
PNC record card				

43. How are the record filed?

Filing system	FP cards	ANC cards	PNC cards
No filing system			
Alphabetically by surname			
Alphabetically by first name			
By patient number			
Other (specify)			
Not applicable			

44. Are there daily activity registers for FP, ANC and PNC?

Daily activity register	Yes/No/NI
FP	
ANC	
PNC	

45. What are the records / registers used for? (Do not prompt, but probe for any other uses by asking: Any other uses?)

Use	Tick, if mentioned
Sending reports	
Following up clients, if they do not return	
Keeping track of client's medical experience	
Ordering supplies	
Quality control / medical standards	
Other (specify)	

46. Are reports sent about FP, ANC and PNC services provided? If yes, when was last report sent, and was feedback received?

Type of service	Reports sent Yes/No	When was last report sent, name of the month	Feedback received Yes/No	No information	Remarks

Section lX. Management and Supervision

47. Are there copies of written job descriptions outlining staff responsibilities?
Yes/No/NI _____

47.a If yes, ask to see a copy: Seen/not seen _____

48. Is there a current, written duty roster for the clinic? Yes/No/NI _____

48.a. If yes, ask to see a copy: Seen/not seen _____

49. Does a supervisor come to this facility? Yes/no/NI _____

49.a. If yes, what is the supervisor's name and position?
Name _____ Position _____

49.b. If yes, what do they do while visiting? (Do not prompt, but probe for any other activities by asking: Is there anything else they do?

Activity	Tick if mentioned
Observe FP or MCH service delivery	
Inquire about service delivery problems	
Make suggestions for improvement	
Examine the records	
Offer praise for good work	

50. How many times in the last six months has a supervisor come to the HP?
Number of times_____
Don't remember ____

Section X. Target population and service statistics

51. What are the target population figures of the HP; total population, women between 15-45 of age, estimated pregnancies per year, children under one year?

Target population	Number	Remarks

Total population		
Women between 15-45years		
Pregnancies per year		
Children under one year		

52. Record the following FP statistics for the last complete month:

Last month was _____

Type of FP service	New acceptors	Revisits	Total no of visits	Remarks
Pills				
Depo-Provera				
Condoms				
Other (specify				

52.a. How many sterilisation camps have been held during past 12 months at the HP

No of camps/NI _____

52.b. How many clients have been sent to sterilisation camps during past 12 months

No of referrals/NI _____

53. How many MCH clinics have been held at the HP and in outreach within last month?

Site of service	No of clinics/ NI
at HP	
at outreach sites	

54. How many clients received FP and MCH services in the past year?

FP new acceptors	FP re-visits	Total no of FP visits	ANC 1. visits	ANC re-visits	ANC no of total visits	PNC visits	Total no of MCH visits

55.. Record the following reproductive health service statistics for the last complete month:

Service provided	No of consultations		
	new visit	re-visits	total no
Deliveries			
ANC			
PNC			
Nutrition and growth monitoring			

ORT			
Consultations for STDs			
EPI programme			
Other (specify)			

55.b. Record the EPI statistics from the last complete month:

TT					BCG	DPT / Polio			Measles
1.	2.	3.	4.	5.		1.	2.	3.	

Comments on any items or issue:

_____

_____

_____

_____

_____

APPENDIX 4. BACKGROUND VARIABLES

Variables assessing background of a health post user

Name of variable:	Definition:	Measurement:
AGE	Age in years stated by the informant or estimated by the researcher in consensus with the informant	Age between 15-20, 21-25, 26-30, 31-35, 36-40 or 41-45 years
CHILDREN	Number of children alive to date	Number of children
CASTE	Caste as stated by the informant	Caste groups A-G[7] Group A - the highest castes. Group B, Yadaws, is the dominant caste in the district Group C and D - middle castes. Group E - untouchables Group F, Bhujel, is a hill caste. Group E represents Muslims .
EDUCATION	The finished level of school or participation in NFE	None Primary Secondary High school or higher Non-formal education
OCCUPATION	As stated by the informant	Household activities Small trade Daily wage labour
DISTANCE	Distance from home to health post as stated by the informant in walking time	less than 30 minutes 30-59 minutes 60-120 minutes more than 2 hours
TRANSPORT	Availability of other transport than walking	None Bus or truck
TODAY'S TRANSPORT	How did the informant come today to the health post	On foot By bus or truck
TRAVEL TIME	Time that the informant estimates to use for whole trip to HP and back home	less than 30 minutes 30-59 minutes 60-120 minutes more than 3 hours
VISIT	The main reason of the informant's today's visit to HP as stated by the informant	AN - pregnant woman PN - visit with a new born baby EPI - visit for immunisation of a child FP first visit FP revisit Visit for child's illness (under five) Visit for reproductive health problem

[7] The castes were categorised according to caste groups used by SC/US health post co-ordinators in their statistical data and using the knowledge of local persons (Ram 1996).

APPENDIX 5.A STRUCTURED QUESTIONNAIRE FOR USER EXIT INTERVIEW

Kaisa Rouvinen
Quality of health care in rural settings - Nepal

QUESTIONNAIRE FOR MCH OR FP CLINIC USER EXIT INTERVIEW

Greeting.
I am conducting a research as a part of my studies and therefore I am asking people's opinions about different things in health care. I would like to ask you a few questions.
I do not write your name down anywhere and all you tell is strictly confidential. So I hope you feel free to give your ideas. May we continue?

Date _____ Health post _____ ID _____

Section 1. Socio-demographic data

1. Age in years _____

2. Marital status 1. single
2. married
3. separated
4. widowed

3. Number of children alive _____

4. Religion _____ 5. Caste _____

6. Education : (finished level)
1. None
2. Primary
3. Secondary
4. Higher
5. Participated Adult Education Programme
6. No answer

7. Occupation:
1. Household activities
2. Farmer
3. Small trader
4. Daily wage labour
5. Other
6. No answer

8. Distance from the Health Post _____km / _____walk in minutes / _____ by car in minutes (as appropriate)

9. Is there a transport other than walking available?
1. No
2. Yes, specify _____

Section 2. Questions about the people's perception of the quality of the service

10. What was your reason to visit the health post today?

1. You came for an ante-natal check-up
2. Your came for a post-natal check-up
3. You brought your new born baby for check-up
4. You came for family planning: Family planning first visit
5. Family planning follow-up visit
6. Other reason , specify_____

11. By what means of transportation did you come? 1. On foot
2 Other, specify _____

12. How much time will you spend on the whole trip to HP and back home? _____ minutes/ hours

13. Does the time consumption cause you problems? 1. Yes
2. No
3. Cannot say

14. The waiting time between you arrived at the HP and the time you saw a staff member for consultation, how did you find it ?
1. Reasonable
2. Too long
3. Cannot say

15. While you were waiting did you have any problems?
1. Getting food or drink
2. Using toilet
3. Other, specify
_____
4. No problems

16. How did the staff treat you?
1. Friendly and politely
2. Impolitely
3. Cannot say
4. No answer

.
17. Did you have a chance to ask what you wanted to know?
1. Yes
2. No
3. Cannot say

17. b FP clients only
Do you think you have received enough information about different methods of Family Planning?
1. Yes
2. No
3. Cannot say

17. c FP clients only
Do you feel that you now know enough about the method you have chosen? (effectiveness, side-effects etc.)
1. Yes
2. No
3. Cannot say

18. Was everything clean enough?
1. Yes
2. No
3. Cannot say

19. Did you have enough privacy during the examination? 1. Yes
2. No
3. Cannot say

20. Do you know when you have to come next time?
1. Yes
2. No
3. Cannot say
4. No need to come

If yes, please, tell the date _____

21. Did you get the contraceptives or medicine you were prescribed?
1. Yes
2. No
3. Did not need anything
4. Do not know

22. How was the care you received generally ? Please tell how did you feel ?

_____

_____

22. b How would you describe the level of the care ? (do not probe)
1. Poor
2. Fairly poor
3. Cannot say
4. Quite good
5. Excellent

23. Do you plan to attend this health post in the future if you need

a)Family Planning?
0. Not applicable
1. Yes
2. No
3. Cannot say

b) Ante Natal Care
0. Not applicable
1. Yes
2. No
3. Cannot say

c) Help during a delivery
0. Not applicable
1. Yes
2. No
3. Cannot say

d) If you yourself or your child is ill
1. Yes
2. No
3. Cannot say

Section 3. People's suggestion for improvement

24. What are the most important things what should be improved at the Health Post ?
(tick all suggestions up to three, use probing only if needed)

0. Nothing, I am satisfied
1. More staff
2. More female staff
3. More medicine or different family planning methods
4. Cleaner rooms
5. Change in staff attitudes or behaviour
6. Better trained or qualified staff
7. Cheaper fees
8. Cannot say
9. Something else, specify

_____

25. Do you want to say anything else concerning your health needs?

_____

_____

_____

_____

_____

_____

Thank you very much for your assistance!

APPENDIX 5.B MAITHALI TRANSLATION OF THE QUESTIONNAIRE

APPENDIX 6 EVALUATION OF HEALTH POST FACILITIES AND SERVICE ARRANGEMENTS

Table 1. Location and accessibility, Target population, Sub-health posts, Outreach clinics and Staff

	Location and accessibility	Target population [1]					Sub health posts	Staff at the health post and in the field area										Outreach clinics
Name of health post		No of VDCs	Total pop.	Women in age 15-49	Expected pregnancies per year	Children under one year		HPI	AHW	ANM	MUK	PEON	VHW	MCHW	FCHV	TBA	SC-C [2]	Remarks: Length of service	For MCH & EPI
Lahan	in town, but on the other side of a big river, dry season OK, ½ hour walk to the district hospital	5 VDC + 1 municipal	52300	12000	1990	1935	4	1	2	1	-	2	1 +4	+4	45	14	1	HPI 8 m AWH 2 / 1 y ANM 7 m	YES 2 VDC
Malahaniya	all weather road, 3 Km from highway, 1 hour by car to Lahan or Siraha hospitals	9 VDC	47200	11100	1790	1750	3	1	2	1	1	2	2+3	3	81	14	1	HPI new AWH 2 y / 1 m ANM 1 y ?	YES 4 VDC
Bhagwanpur	all weather road, bus service available 15 Km 40 min by car to Lahan	9 VDC	42300	9150	2200	1140	3 plan to open 5 new	1	2 + 1	1	1	2+3	6+3	+3	69	14	1 + S	HPI 10 y AWH 5 y / 1 m ANM 8 y	NO
Bhaluwai	all weather road, bus service avalable,1 ½ hour walk from Siraha (DHO and hospital)	9 VDC	35200	8300	1800	952	3 plan to open 1 new	1	2	1	?	2	9+3	+3	81	30	1 + S	HPI 2 y AWH 7 / 2 y ANM new	NOT YET
Khirauna	all weather road until the village - to HP dry season OK, but in monsoon when floods, inaccessible, 1 hour walk from Siraha	11 VDC	44000	10120	1670	1630	7	1	2	1	?	2	4+7	+7	99	17	1 + S	HPI 1 m AWH 2 y / new ANM 1 m	NO

1. Population statistics as received from HP. If numbers of target groups were not available, following estimations are used:
Women in age 15-49 23% of total population. Expected pregnancies per year 3,8% of total population. Children under one year 3,7% of total population

2. Save the Children/US has appointed a person as a health post coordinator (SC-C) for each health post. In addition SC/US provides interim ANM students (S) from Jiri Technical School to work with the coordinators and with the HP ANMs .

Table 2. Facilities for MCH and FP Services and Infection Prevention

	Waiting facilities			Rooms for counselling and examination		Infection prevention							
Name of health post	Sheltered area with seating	Functioning toilets	Drinking water	Counselling	MCH & FP[1]	Hand washing facilities	Dressing room	Waste container	HLD in place	Deconta mination solution available	Process of handling used instruments	Waste disposal system in place	Waste disposal handling
Lahan	PARTLY veranda, no seats	YES	YES	MCH room Privacy OK	YES, room clean, no exam bed	YES complete[2]	CLEAN, but disorder	YES "clean"	YES	NO	PARTIALLY OK	YES Pit and burning	OK
Malahaniya	YES veranda	YES	YES	MCH room Privacy OK	YES	YES complete	NOT CLEAN	YES dirty	YES	NO	Not seen	YES Pit	Partially
Bhagwanpur	YES	NO	YES	NO	YES, but very disorganised, no exam bed	NO except pump	NOT CLEAN	Carton box for sharps	YES	NO	Not seen	YES Pit and burning	OK
Bhaluwai	YES	YES	YES	MCH room Privacy OK	YES small room, well functioning	YES complete	NOT CLEAN	YES dirty	YES	NO	Not seen	YES Pit	Partially Waste around compound
Khirauna	YES	NO	YES	Waiting area No privacy	NO	YES partially	NOT CLEAN	YES clean	YES not in use	NO	Not in use	NO	No system

1. A separate room where MCH or FP clients can be consulted parallel with curative service
2. Complete means one bucket for hand washing, a soap and a bucket for waste water

Table 3 Equipment and commodities for use in MCH and FP services

	Equipment / instruments								Contraceptives and medicines							
Name of health post	Scale	Height measure	Baby scale	BP set	Stetho scope	Foetus scope	Torch or kerosene lamp	Depo-Pro-vera vial [1]	Pills cycle	Condoms	Iron tabl	Multi-vitamnin tbl	Para-cetamol or equiv.	Anti-biotics - any	IV infusion - any	TT vaccine
Lahan	YES	YES	YES	(YES)[3]	YES	NO	YES	220	500	12000	YES	NO	YES	NO	YES	once a month
Malahaniya	YES	YES	YES	YES	YES	YES	YES	30	900	10000	NO	NO	NO	NO	NO	once a month
Bhagwanpur	YES	YES	YES	NO[4]	YES	YES	No inform	350	500	12000	NO	NO	NO	NO	NO	once a month
Bhaluwai	YES	NO	NO	YES	YES	YES	Electricity no bulbs	385	295	7900	YES	NO	YES	NO	YES	once a month
Khirauna[2]	YES	NO	NO	YES	YES	NO	No inform.	No inform "enough"	No inform "enough"	No inform "a lot"	NO	NO	YES	YES	YES	twice a month

1. All health post have equal number of disposable needles and syringes for Depo-Provera injections
2. The staff member who has keys of the store room was not present
3. "Too old"
4. Disappeared

Table 4. IEC materials and activity, Record keeping and Reporting

	IEC material			Health talks	Record keeping			Reporting
Name of health post	FP posters on walls [1]	Other MCH posters [1]	Other material	On the days of observation	FP	ANC	PNC[3]	Reports sent regularly including last month
Lahan	6	2	1 flipchart	NO (2) No inform (1)	individual cards well in order registration book	individual cards well in order registration book	Not used	YES
Malahaniya	5	4	1 flipchart	NO (2) No inform (1)	no information[4]	no information[4]	no information[4]	YES
Bhagwanpur	5	2	flipcharts pamflets	NO (3)	individual cards no order registration book	individual cards, but hardly used registration book	Not used	YES
Bhaluwai	5	6	flipharts pamflets	NO (2)	individual cards given to client, no copy at HP registration book	individual cards given to client, no copy at HP	Not used	YES
Khirauna	2	6	flipchart [2] pamflets	NO (1)	no information	two cards seen	Not applicable	YES

1. includes wall paintings
2. not seen
3. PNC seem to be non-existing, eligible clients are most of the time registered as OPD patients
4. ANM not present, other staff was not involved even did not have access to information

Table 5. Management, Supervision, Service statistics and Schedule of service

	Health post management			Supervision	Service statistics according to the last monthly report (Ashad 2053/ June 1996)												Schedule of service at health post	
Name of health post	Written job descrip tions	Written duty roster	Health post was opened in time on the days of obs.[1]	DHO supervisors visits in last six months	ANC visits	PNC visits	Delive ries at HP	Immunisation <1 y BCG Measles	DPT& Polio 1.-3.		TT 1.-5.	Pills visits new	revisit	Depo-Provera visits new	revisit	Condom distribution[2]	FP service offered	MCH service offered
Lahan	NO	NO	YES (2) No inform (1)	3	98	10	-	174	136 105 118	104	124 94 93 5 5	2	9	40	189	not recorded	everyday	every Wednesday + EPI twice a month
Malahaniya	NO	NO	YES (2) No inform (1)	6	26	2	-	130	132 130 81	64	167 71 20 17 7	1	3	9	19	not recorded	everyday	every Wednesday + EPI once a month
Bhagwanpur	YES, but not seen	NO	YES (3)	6	9	7	5	119	92 115 86	102	84 84 83 25 3	11	7	10	7	not recorded	everyday	every Wednesday + EPI once a month
Bhaluwai	NO	NO	YES (2)	6	48	4	-	120	150 72 77	79	103 94 46 10 8	14	15	7	80	2277	everyday	starting service
Khirauna	NO	NO	YES (1)	No information	16	-	-	61	53 44 36	45	49 39 21 11 12	6	-	6	4	not recorded	everyday	starting service

1. Opened in time means at least one service provider reported at HP at 10.00 am
2. Condoms are mostly distributed freely from “condom boxes”

APPENDIX 7. FINDINGS FROM HEALTH PERSONNEL IN-DEPTH INTERVIEWS

Health workers' suggestions what would improve quality of care at the health post

HPI	• "If all the staff would come and work here, it would be good" • better facilities for staff residence • salary increase • timely supply of medicine • budget on time • training for staff • a NGO project to support work • training hall • diversion of flood waters
AHW	• political consensus regarding transfers and work morale • better facilities, i.e. dressing room • better facilities for staff residence • sufficient drug supply • daily allowance system for outreach programme • better salaries • training, refresher courses • education for people • a fan for ventilation
ANM	• more staff for MCH and FP • more chance to concentrate in MCH and FP instead of dispensing medicine and other jobs • salary increase • sufficient drug supply • training for new FP methods • adequate instruments and equipment • more health education material, pamphlets, to distribute • a telephone

Reasons for low utilisation of FP service seen by health care providers

HPI	• lack of awareness among people • illiterate people are difficult to motivate • children are blessing or gift of God • elders (mother-in law, father-in-law) do not like FP • people are too shy to use condoms • pills and Depo-Provera have side-effects • attitudes • social beliefs • religious reasons • poverty (sons bring wealth) • low level of female education • couples want more children
AHW	• fear of side-effects of FP methods • fear of becoming constantly weak after VSC • you need to have at least one son to be accepted in the society and to be sure about your access to heaven after death and to have some one to take care of your property • fear of loosing a child, a son, by death • illiteracy • superstition, old beliefs • religious reasons: - Muslims do not officially accept - a person who has adopted VSC is considered somehow unholy, she or he cannot go to the temple and . . worship gods and goddesses • lack of knowledge • lack of education • no time to come to HP because of workload • disagreement between wife and husband • fears - "we have neglected to motivate them" • health workers are not working as they should - they do not persuade people
ANM	• people use FP only after they have a certain number of children • fear of side-effects • lack of knowledge about different methods • side-effects; bleeding, nausea, headache • Norplant and IUD are not available • women have wrong concepts

APPENDIX 8. USERS' EXPRESSIONS OF THE QUALITY OF CARE. QUOTATIONS.

Clearly satisfied:

◊ For two years I have been coming here. The service is satisfactory.
◊ I feel all right
◊ I am satisfied
◊ It is nice. We get medicine in time. I am satisfied. (relative)
◊ I got some advice how to make porridge for the baby. I feel happy
◊ It is good
◊ I think it is all right
◊ I got DEPO injection and I go home. I am satisfied.
◊ It is satisfactory
◊ It was well enough.
◊ I am satisfied.
◊ I feel it is good.
◊ I think it is OK.
◊ It was not bad.
◊ I think it is fine
◊ I feel satisfied.
◊ I am happy with the care.

Some complaint:

♦ It is satisfactory. Sometimes they do not have medicines.
♦ Last time the vaccine was not given properly. The child got an abscess.
♦ Not satisfactory, but they are friendly, because they know me.
♦ Examination was good today. But I did not get any medicine. I am not happy.
♦ I think it was satisfactory. Last time the child got an abscess.
♦ It is OK with DEPO, otherwise not so good. But they told me wrong things about permanent method. "A staff member" said that I should not have minilab, because I may become so weak and I have to be strong in order to support my old husband.
♦ It is not good. No medicine. But FP is OK. I am not worried about the side-effects because the sister has told me everything and I believe her.
♦ It was somehow good. But I did not get advice for my stomach pain that I have had since the beginning of the pregnancy.
♦ They always tell us to buy medicines from outside.

Clearly dissatisfied:

- I am not satisfied , because they do not give medicine. Examination was good today. The staff is careless. They are not afraid of anybody.
- The service was not satisfactory. They did not have vaccine today.
- It was not satisfactory. They were so busy.
- Sister (ANM) was not here I wanted to talk to her. It is almost useless to come . I got only a few tablets. No examination. (AN client)
- It should have been female staff to do the job. (give the injection)
- They do not give good care. They do not give medicine. They sell them.
- It is not good. Doctor did not open the wound. I have to buy medicines.

- It is not good. Doctor did not look at the ear of my child. They do not give good medicine. We have to buy them. They probably sell them.
- The care is poor. We do not get enough medicines.
- I think the care is poor. They sell all the good medicines. We get nothing. I am not satisfied with the advice given by health worker. I am worried for my health.
- The care is not good. They never give us good medicine. They do not advise me either. I would like to use FP. I do not want more children. My baby is already eight months, but I do not have menstruation and they only tell me to wait.
- Their behaviour is rough. I am not satisfied with the care. Sister is not often here, anyway she sends everybody to hospital.
- I was not examined at all. They only asked what do I want. When ever we come they say there is no medicines, not even for worms. Coming here is useless. Sister is not here; many times women come, but because there is no (female) nurse, we go home.(AN client)
- Almost no use to come here. No medicine. No advice. I am worried about side-effects of DEPO. I would like to stop it, but what should I do then?
- No, it is not good. They did not examine me at all. I am not satisfied. I need to get pregnant again. I need to get a son. But my menstruation is irregular. They do not advise about anything
- Not good at all. We do not get good medicine. Always the same, if at all. And they do not advise either.
- It was a terrible mess. I lost my card and they did not give DEPO. I am so sorry. I wept. Nobody cares.
- It is not satisfactory. If they give medicine, it is always the same tablets. No good medicine. They advise us to buy them in their own medicine shops.
- The care is not good at all. We never get any good medicine
- Not satisfying. Sister did not examine me. Blood pressure they took. That is all. We do not get good medicines.
- I am not satisfied. They do not give medicine even if they have it.
- Doctor did not even look at the baby, although I paid card. I am not happy. I do not see any use of HP. We do not get any good check-up, any treatment, any medicine.
- No good care. We do not get any medicine. We go to India for treatment, if necessary.
- They do not give any medicine. One has to pay 2 Rupees, but gets no medicine. No use.
- They did not examine my child, his ear. And they did not give any medicine. I will not come back here.
- I have no faith in treatment here. We always get the same medicine. I will never come here again.
- I came for TT. I did not get it. They say I will get it sometimes later, but I will deliver soon. Is it useful to have vaccination after it?
- It is the same at every HP. We do not get good medicine. And no good advice.
- No good care. They do not have medicine, they say. I am unsatisfied
- The service is not well. I did not have a chair to sit, while my child was vaccinated. I need FP, but I do not know how to get it.

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