

Quality Care for Maternal and Neonatal Health (MNH) Services at Primary Health Care Settings in Nepal: A Case Study

Shalik Ram Dhital^{1*}, Madhu Koirala², Sunita Dhungel³, Vickie Owens⁴, Ravi Kanta Mishra¹ and Arja R Aro³

¹Ministry of Health, National Health Education, Information and Communication Center (NHEICC), Teku, Kathmandu, Nepal

²Pokhara University, The National Open College, Sanepa, Lalitpur, Nepal

³The University of Southern Denmark, Unit for Health Promotion Research, Esbjerg, Denmark

⁴Queensland Health (State health department) Australia

*Corresponding author: Shalik Ram Dhital, Ministry of Health, National Health Education, Information and Communication Center (NHEICC), Teku, Kathmandu, Nepal, E-mail: shdhi08@gmail.com

Received date: 12 Apr 2016; Accepted date: 02 Jun 2016; Published date: 07 Jun 2016.

Citation: Dhital SR, Koirala M, Dhungel S, Owens V, Mishra RV, et al. (2016) Quality Care for Maternal and Neonatal Health (MNH) Services at Primary Health Care Settings in Nepal: A Case Study. *J Epidemiol Public Health Rev* 1(4): doi <http://dx.doi.org/10.16966/2471-8211.126>

Copyright: © 2016 Dhital SR, et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Abstract

Maternal and neonatal health morbidity and mortality remain public health challenges in developing countries, including Nepal. The study was completed in one of the districts of Terai of Nepal where facilities are located within a mountainous region. This study aimed to explore expectations of mothers concerning maternal and neonatal care from the local health care facilities and to determine prevailing problems and possible solutions to problems encountered. The case study was completed with mothers who had delivered their baby and with the implementation of scientific qualitative data collection methods. The cases were recorded just prior to their discharge from health facilities or following the birth at their home and transcripts of the interviews were retained. Both positive and negative experiences were observed about the pregnancy, delivery and post-natal services for mothers within the Banke district. We observed mixed experiences throughout these case studies.

Case Study

Project overview and context

Maternal and neonatal health (MNH) care service is one of the most important components of Reproductive Health. It is important to improve the reproductive health status through the provision of equitable and high quality health care and health promotion, especially for mothers and children [1]. Maternal and neonatal care service is one of the most important pillars of the Safe Motherhood Initiative. Addressing maternal and neonatal health means ensuring that all women receive the care they need to be safe and healthy throughout pregnancy and childbirth. The health and interests of mother and child cannot be separated [2]. Due to the wide socio-economic differences the high quality reproductive health varies considerably between different regions of the world. Throughout human history pregnancy and childbirth have been major contributors to death and disability among women [3]. The maternal mortality ratio is 7.2/100000 live births in Australia [4], 6/100000 live births in Denmark [5], 30/100000 live births in Sri Lanka [6] and 170/100000 live births in Nepal [7]. Infant mortality rate is still very high, 37 per 1000 live births in Nepal [8]. The neonatal mortality accounts for 23/1000 live births in Nepal [9], whereas in Denmark it is 3/1000 live births, and 5/1000 live births in Sri Lanka [10]. The major causes for maternal deaths are hemorrhage (27.1%), hypertensive disorder (14%), sepsis (10.7%), unsafe abortion (7.9%), embolism (3.2%) and other direct (9.6%) and indirect causes account for 27% in the world [11]. Neonatal deaths are due to prematurity (16%) birth asphyxia (11%), Neonatal sepsis (7%), Congenital anomalies (5%), Pneumonias (3%), Neonatal tetanus (1%) and other causes (3%) [12]. These deaths are associated to three delays and as much as 67.4 % women giving birth die at home due to delay in taking the decision to seek medical assistance; 11.4% die due to delay in reaching appropriate health

care facilities; and 21.1% die due to delay in accessing the appropriate care at health care centers in world [13].

The Auxiliary Nurse Midwives (ANMs) are trained health workers working in different levels of health care settings (a) Health Post (HP), (b) Primary Health Care Centers (PHCC), (c) District Hospitals, (d) Zonal, sub-regional and Regional Hospitals, and (e) National Hospital of Nepal [14]. Predominantly they work in the field of maternal and neonatal services to increase access to health care for pregnant and parenting women and their children in the rural areas of Nepal [15], which are primary health care settings of Nepal. They are the most stable staff category at every facility level. The majority of sanctioned ANM posts in rural facilities are filled and the majority of the ANMs filling these posts are working [16]. It is important to establish the relationship between ANM and mothers who receive MNCH services.

Research practicalities

The study was conducted in only one district of Nepal. This district is nondescript although does have reasonable (middle rank since its HDI value between 0.500 and 0.549) [17], facilities in terms of road, water, electricity, markets, facilities etc compared to other remote districts like, Mugu, Dolpa, Kalikot, Humla, Bajura, Bajhang, Solukhumbu, Manang, Mustang, Salyan, Rukum etc. The maternal and neonatal care services of this district observed as poor at primary health care settings. On the other hand, the relative ease of access to health facilities can be interpreted as meaning that maternal and neonatal care services in the study settings might be better than elsewhere where access is much more difficult. However, the idea is to learn from the contextual issues so that the knowledge and practice gathered might be considered applicable in other similar areas as a basis of further study.

Research settings and design

This study was conducted in Banke district, located between longitudes 81.0° 29'– 82.0° 8' E and latitude 27.0° 51'–28.0° 20' N. Banke is one of the 75 districts of Nepal [18], The district Baharaich of Utter Pradesh, India is in its South and the Nepalese districts Salyan, Bardiya and Dang are in the North, Bardiya in West and Dang and Bahraich in East. Nepalgunj is the district head quarter of this district and it is one of the industrial and business places of Mid and Far Western Region of Nepal. The district stretches from East to West with maximum length 84 km and average width of 40 km, and the total geographical area is 2337 square km [18]. The Banke district has an estimated total population of 465783 [19], and the sex ratio is 105.66/ 100 female [18]. The ethnic groups are Muslim, Tharu, Newar, Thakali, Gurung, Tamang and Magar. They speak Abadhi, Hindi, Magar, Maithili, Newari, Tharu and Urdu including Nepali language. The climate of this district is tropical and sub-tropical and the minimum and maximum temperature is 4.2 Deg C and 46 Deg C respectively [18]. According to the District Profile report of Banke there are 10 hospitals in total (Allopathic 6, Ayurvedic 4), two nursing homes, one Medical College, three Primary Health Care Centres, nine Health Posts and 35 Sub Health Posts. The total numbers of medical doctors are 132, which covers a population of 2923 per doctor for medical care. Similarly, 203 Auxiliary Nurse Midwives (ANMs) and Nurses and 153 Health Assistants (HAs) and Auxiliary Health Workers (AHWs) are working in different health institutions in the area. [19], Primary Health Care Centers (PHCCs, n=3), Health Posts (HPs, n=8) and Sub Health Posts (SHPs, n=8) as well as among their registered clients (24 in number) as a participants [20]. A non-experimental, descriptive cross-sectional study was applied. The data were collected through; focus group discussion (FGDs), and observation (inspection, record review and case studies).

Method in Action

Qualitative study methods were applied in this study and during that time a special case study was done which showed the real situation of quality of maternal and neonatal health care services of Banke district Nepal.

Institutional delivery at Bankatuwa PHCC in 2010

A 16-year-old Devkota Brahmin caste mother came in for an institutional delivery in Bankatuwa Primary Health Care Centre (PHCC) Banke on April 15th, 2010. This young woman was a primigravida who was progressing normally and who had never complained of any health problem during her pregnancy. Her labour started around 7:00 AM and she was observed by the health staff to be doing well. Nine hours after reaching the PHCC she had a normal delivery handled by the Auxiliary Nurse Midwives (ANMs). Her mother-in-law and father-in-law were present and they received their grandchild once the ANMs had prepared the baby following the birth and completed their checks. They were looking forward to welcoming a grandson; however the mother gave birth to a daughter. They quickly accepted their granddaughter and everyone was happy. Following the birth, the researcher asked the mother about her experiences with the delivery and the services at Bankatuwa PHCC. She spoke honestly about the delivery and how she had no problems throughout the pregnancy. This new mother was happy with the institutional delivery and staff services and stated she would like to encourage other pregnant women for an institutional delivery as she felt it was safe, she was well cared for and after the delivery she received certain free post-natal services with the Nrs. 500 incentive from the Nepalese Government. The clients satisfaction ensure if there is a positive attitude of health staff, timely and regular available of health services, availability of good quality of resources, establish political stability, create transparent working environment.

Home delivery at Banke district in 2010

An 18-year-old illiterate woman delivered her first baby at home with the help of a female neighbor. Her husband was at work at the time as a local rickshaw driver and she lived about a 5minute walk from the local health institution. The area in the house where she delivered the baby was near the kitchen and reportedly contaminated. The Traditional Birth Attendant (TBA) was out of the village and could not be located. The placenta was out but the neighbor did not cut the cord at the time of the birth. Two hours after the birth they called an ANM from the nearby Jaispur Health Post and they came to the home and cut the baby's cord using a sterile blade and gloves. The mother was happy after receiving free maternal service from ANM where mother and baby's health was well. Mothers knew both ANM and TBA but they did not know their responsibilities rather both can perform delivery. The mother and her family's impression were positive towards natal care provided by ANM.

Delivery practice experiences expressed by focus groups

During the focus group discussions mothers discussed their experiences of delivery and described the role of TBAs in the community. Overall they felt TBAs can provide a better service in the community.

Mother's experience about auxiliary nurse midwives (ANMs)

A 32-year-old mother described her experiences during focus group discussion and expressed her opinion as: - "I do not know about ANMs; I delivered three babies at home without any maternal assistant. Nobody told me about health services".

Practical Lessons Learned

1. The researcher conceived the idea from previous working experiences and evidence shown by articles and national reports of a sub-optimal quality of maternal and neonatal health services in Nepal.
2. Sensitize health staff especially ANM for quality maternal and neonatal health care service
3. Analysis of the maternal and neonatal health status of Banke district, Nepal
4. Triangulation method helpful for getting details information and in depth knowledge and skills
5. Confidence building to take on a vital role for project design and implementation

Conclusion

The Auxiliary Nurses Midwives (ANM) have reasonable maternal and child health knowledge however there remains some identified skill and knowledge deficits related to how they manage mothers and their newborns at the primary health care settings involved in this study. Some ANMs displayed negative attitudes toward the mothers during some of the deliveries which for some mothers were more difficult than the pregnancy and post-natal care. The quality of the deliveries conducted in institutions by Skilled Birth Attendants (SBAs) in this study were inferior to other health workers as compared to the national figures, however the SBA training had only just commenced in this region at the time of the study.

It should be noted that due to a low health sector budget allocation by the government, timely supply of resources and medicines was less than adequate. It was observed that staff accountability was not scrutinized by supervisors and there were accounts of rude and careless behavior by staff. Absenteeism of health workers was prevalent although it was apparent it would be more likely to be their supervisors who were absent for no justifiable reason. Management committees at these facilities were not active or influential when it came to the supervision of staff or monitoring

of health services they were employed to deliver [20]. It was also made clear to the researcher that clients are unaware of the level of service they should expect as a minimum.

One final observation was that mothers in general give more importance to the wellbeing of their babies rather than to their own health checkups. It is felt this is because mothers normally go to a health institution when their children are acutely unwell.

Exercises and Discussion Questions

1. In this study the researcher observed the quality of care experienced by birthing mothers in some areas of Nepal. What does this mean for the quality of services delivered by MNH?
2. What are the criticisms of this study?
3. What are the mothers' expectations for good quality care from the MNH service?
4. What might be the methodological consideration of this study?
5. What are the corrective measures of quality of MNH?

Further Readings

1. Bornstein T (2001) Quality improvement and performance improvement different means to the same end? Quality assurance project's information out let: center for human services Bethesda, MD 20814- 4811 USA Vol. 9 p -6 (Nov 1 2001)
2. Chowdhury S, Hossain AS, Halim A (2009) Assessment of quality of care in maternal and newborn health services available in public health care facilities in Bangladesh: Bangladesh Med Res Coun Bull 2009; 35: 53-56
3. Dhital, R Shalik (2010) Assessment of the Quality care on Maternal and Neonatal Health Care services of Banke district of Nepal. Unpublished M.Sc Public Health thesis. The University of Southern Denmark.

Learning Outcomes

“By the end of this case study the researcher should be able to”:

Understand the mother's honest opinion about the maternal and child health services in primary health care settings.

Apply theoretical aspects into practical purposes.

Lobby policy makers, implementers, and researchers to improve the quality of health services.

Contributor Biographies

Shalik Ram Dhital finished the Post Graduate Diploma in Health Promotion and Education Course from the Tamilnadu Dr. MGR Medical University in 2003 and Master of Science in Public Health/ Health Promotion from the University of Southern Denmark (SDU), under state education scholarship. Soon after his master degree he continue started work in the Government of Nepal with preventive, promotive and curative health service and also worked for Operational Research under Nepal Health Sector Support Program as well as in the World Bank Nepal for research component and he is currently working in NHEICC as a Health Education Officer.

Madhu Koirala and Sunita Dhungel also completed their Master of Science in Public Health SDU and Madhu currently working in the National Open College affiliated by Pokhara University as a Assistant Professor and Director for Research and Development. Vickie Owens completed

her MPH (Primary Health Care) through Flinders University, Australia with one semester completed at SDU, Esbjerg Campus, Denmark as part of a scholarship and currently she is working in the Queensland Health (state health department) Australia. Ravi Kanta Mishra has received his Bachelor in Public Health and Master in Public Administration degree from the Purbanchal and Tribhuvan University respectively and he also has finished his Master in Public Health from the Tribhuvan University, Nepal. Currently he is working in the NHEICC as a Public Health Officer and Professor Arja R. Aro is working for Health Promotion Research at SDU, Esbjerg Campus, Denmark.

References

1. Make every mother and child count (2005) Improving maternal, new borne and child health in the South East Asia Region. World Health Organization, India.
2. Knippenberg R, Lawn JE, Darmstadt GL, Begkoyian G, Fogstad H, et al. (2005) Systematic scaling up of neonatal care in countries. *Lancet* 365: 1087-1098.
3. (2009) Women and Health; Today's Evidence Tomorrow's Agenda. World Health Organization.
4. (2015) Maternal Death in Australia. Australian Institute of Health and Welfare.
5. WHO, UNICEF, UNFPA, World Bank Group, and United Nations Population Division, Maternal Mortality Estimation Inter-Agency Group (2015) Maternal Mortality in 2008-2015.
6. WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division (2015) Trends in Maternal Mortality: 1990 to 2015. World health organization.
7. Adhikari R (2016) Maternal and Child Health Where does Nepal stand on MDGs 4 and 5? New Norms and Forms of Development. Kathmandu, Nepal.
8. The World: Infant Mortality rate (2016) - Top 100+. Geobe.se.
9. (2015) Nepal meets new MDG target. Kathmandu post.
10. (2015) Mortality rates, neonatal (per 1,000 live births). The World Bank.
11. Say L, Chou D, Gemmill A, Tuncalp O, Moller AB, et al. (2014) Global causes of maternal death: A WHO systematic analysis. *The Lancet Glob Health* 2: e323–e333.
12. (2015) Causes of child mortality. World Health Organization.
13. (2016) The “The Three delays” at the root of maternal mortality. The Borgen project.
14. Nepal Health Sector Support Programme (2013) Human Resources for Health, Nepal country Profile. Ministry of Health and Population.
15. Piedade EM (2004) Voices from the field: Auxiliary nurse-midwives of Nepal. University of Massachusetts, Amherst.
16. RTI International (2009) Human Resource Strategy Options for Safe Delivery. Research Triangle Park, NC, USA.
17. (2014) Nepal Human Development Report. Government of Nepal National Planning Commission.
18. (2005/2006) District profile. Banke, District Development Committee, Banke Nepal.
19. District Public Health Office (2009) Annual report of Banke, Nepal
20. Dhital SR (2010) Assessment of the Quality care on Maternal and Neonatal Health Care services of Banke district of Nepal. Unpublished M.Sc Public Health thesis. The University of Southern Denmark.