Voices from the Community: Access to Health Services
A Rapid Participatory Ethnographic Evaluation and Research (PEER)
Study, Nepal

**Government of Nepal (GoN), Population Division
Ministry of Health and Population (MoHP), with support from
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ACRONYMS

Aama	Aama Surakshya Programme
AHW	Auxiliary Health Worker
ANC	Antenatal Care
AWPB	Annual Work Plan and Budget
BCC	Behaviour Change Communication
CBO	Community-based Organisation
CBS	Central Bureau of Statistics
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organisation
DDC	District Development Committee
DFID	UK Department for International Development
DoHS	Department of Health Services
D(P)HO	District (Public) Health Office
DSF	Demand-side Financing
EAP	Equity and Access Programme
EHCS	Essential Health Care Services
EPI	Expanded Programme on Immunisation
FCHV	Female Community Health Volunteer
FP	Family Planning
GBV	Gender-based Violence
GESI	Gender Equality and Social Inclusion
GoN	Government of Nepal
HFOMC	Health Facility Operation and Management Committee
HP	Health Post
HQ	Head Quarters
IEC	Information, Education, and Communication
IFA	Iron/Folic Acid
IIDS	Indian Institute of Dalit Studies
IPC	Interpersonal Communication
IUCD	Intrauterine Contraceptive Device
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MMMS	Maternal Mortality and Morbidity Study
MoHP	Ministry of Health and Population
NDHS	Nepal Demographic and Health Survey
NGO	Non-governmental Organisation
NHSP	Nepal Health Sector Programme
NHSP-1	First Nepal Health Sector Programme
NHSP-2	Second Nepal Health Sector Programme
NHSSP	Nepal Health Sector Support Programme
NHTC	National Health Training Centre
NLSS	Nepal Living Standards Survey
NPC	National Planning Commission
NPR	Nepalese Rupees
OBC	Other Backward Class
OCMC	One-stop Crisis Management Centre
OCP	Oral Contraceptive Pill
OPMCM	Office of the Prime Minister and Council of Ministers
ORC	Outreach Clinic
PEER	Participatory Ethnographic Evaluation and Research

PHCC	Primary Health Care Centre
PNC	Postnatal Care
PR	Peer Researcher
SBA	Skilled Birth Attendant
SHP	Sub-Health Post
SMS	Short Message Service
STS	Service Tracking Survey
SWAp	Sector-wide Approach
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
VDC	Village Development Committee
VHW	Village Health Worker

EXECUTIVE SUMMARY

The objective of this study was to gain an in-depth understanding of the socio-cultural, economic, and institutional barriers to accessing health services experienced by poor and excluded women and men in Nepal. Grounded upon evidence from household and facility surveys of health service use and household practices, the study focussed on examining community members' experiences of accessing specific services provided within the Essential Health Care Services (EHCS) package. The study focused on four services, Family Planning (FP), maternal health care, safe abortion, and child immunisation services, provided at Village Development Committee (VDC) level through Sub-Health Posts (SHPs), Health Posts (HPs), and outreach extension activities.

The study identified a core set of social determinants of access – gender, poverty, caste/ethnicity/religion, geography, seasonality, and supply-side factors – that interact and play out in different ways in different contexts to produce a multi-layered web of demand- and supply-side barriers to accessing health services. The social determinants are not prioritised, each being significant, although they have differing levels of influence in different contexts.

Social determinants of access	Impact of determinants on specific social groups	Access to health services
Poverty	Women, men, and children	Maternal health
Gender	Poor people	Immunisation
Caste/ethnicity/religion	Caste, ethnic, and religious groups	Safe abortion
Geography	Remote dwellers	Family planning
Seasonality		
Supply-side factors		
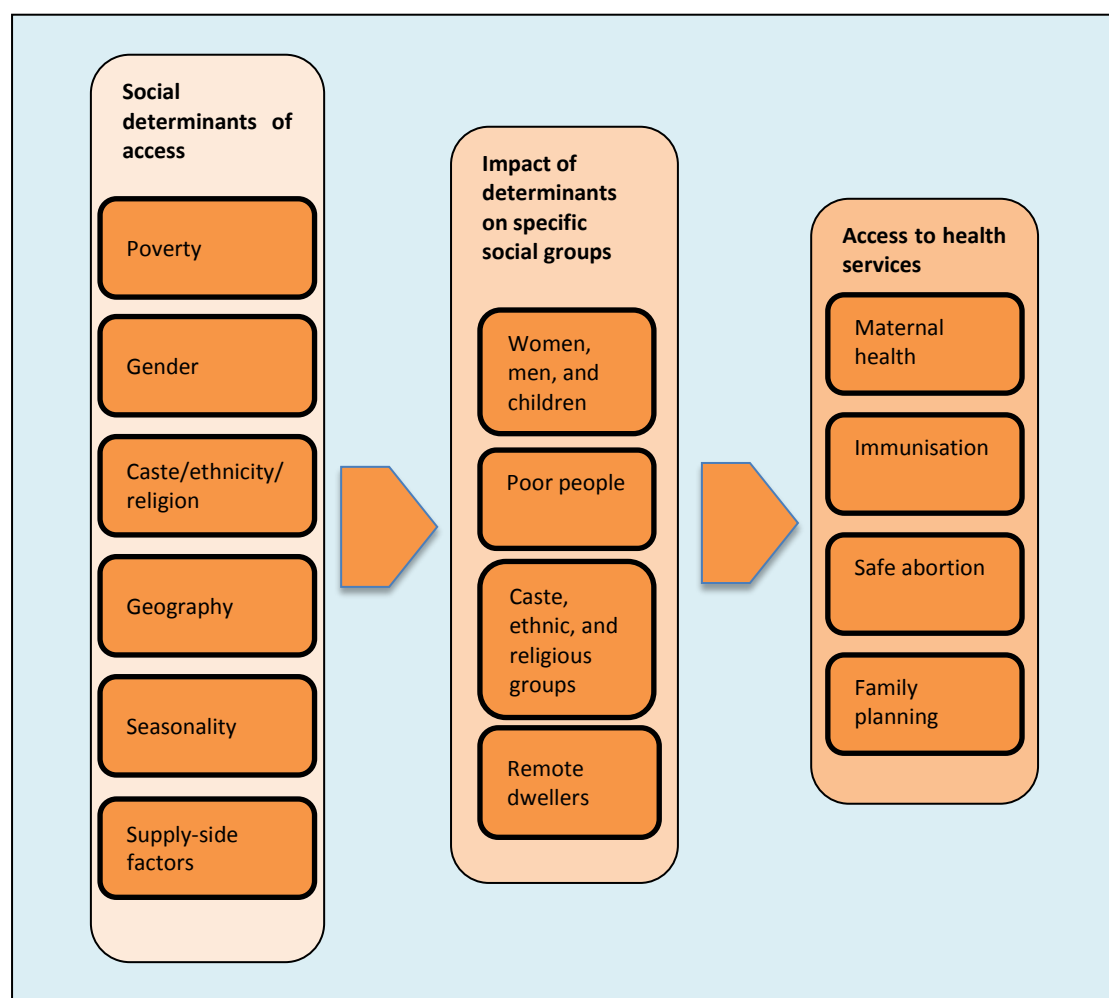
The social determinants of access interact with the complex realities of people's lives to create barriers along the pathway of care from the home to the health delivery point. The interconnectedness of the barriers amplifies their influence in inhibiting service use, and contributes to the delayed, reduced, and non-use of EHCS, and the decision that many poor people make to use traditional healers.

The main findings of the study are presented around six thematic areas that have the greatest influence on poor women's and men's access to services.

A.   Gender-based decision making in the home, and the need for women to seek permission from guardians to leave the home, were common to all geographical areas and social groups in the study, and constituted a major constraining factor to women's and children's access to health services. Family control over women's mobility and their use of public space means that they are dependent on husbands or other approved family members to accompany them to a health facility, and face punishment if they break social codes. Generational differences in the perceived value of health services, and older women's views that younger women use visiting health services as a way of avoiding their domestic responsibilities, further deter daughters-in-law from seeking permission to access care.

Implications for policy makers: The deeply ingrained and personal nature of gender norms, and the effect these have on social relationships, impact women's and children's access to EHCS, and spotlight the need for social change in the home if access to health services is to be enabled. This calls for a greater focus of the health sector on women's empowerment and social mobilisation approaches to raise women's agency and increase their access to financial resources. To be effective these programmes will need to include and influence husbands and family gatekeepers to support such social change. It calls for a recognition that health services can no longer be separated from family practices and norms. The Government of Nepal's (GoN's) Equity and Access Programme (EAP) provides a platform from which to work, and the experience upon which institutional systems to support community mobilisation programmes can be designed.

B.   Women's work burden and economic dependence on men: Women's heavy work burden, particularly in the Hill region, where food security is more difficult to achieve, means that women in the Hill and Terai regions have limited time to seek health care. This is further compounded by the pressures of the extended family on women to fulfil their work duties and to be at home. Women's economic dependence on men in all areas leaves them without control of assets or cash and dependent on husbands or in-laws to finance the cost of health care. Lack of time, resources, and social permission to visit health services makes it particularly difficult for women to access time-sensitive services or those that require repeat visits, such as Antenatal Care (ANC) and immunisation.

Heavy and arduous labour places women at risk, particularly from miscarriage and uterine prolapse. This is reinforced by the social beliefs that pregnancy is a normal event without special needs and allowances, resulting in women resuming heavy work shortly after delivery. One impact is an extremely high prevalence of uterine prolapse, which itself causes women shame, stigma, and physical pain.

Implications for policy makers: The extreme poverty and challenging livelihood conditions that many poor people face, particularly in the Hill region, highlights the need for multi-sectoral solutions to address the livelihood, poverty, and out-of-pocket spending factors that hinder access to services. For the health sector, these findings also raise the importance of making emergency funds accessible to very poor people (and especially women) in the community and at the facility level. Such funds may be the only means by which women and the very poor can mobilise the cash needed to organise transport and pay for health services and their associated costs.

C.   Distance to services: living at a distance from health services results in a host of barriers linked to the journey involved in reaching facilities. Factors such as restrictions on women's movements outside the home, the physical distance between the home and service site, the terrain that has to be traversed, the time taken to reach a facility, the costs involved, and the impact of seasonal factors, such as flooding, add to the challenges poor people face in accessing services outside of their community.

Implications for policy makers: Bringing services closer to where poor and excluded people live is fundamental to increasing access to services and coverage levels. Whether this is through the siting of birthing centres, enhanced Outreach Clinics (ORCs), or holding of special camps, as for uterine prolapse repair, such services need to be of standard quality, reliable, affordable to the user, and sustainable. This in turn calls for improved district- and facility-level planning of services for poor and excluded populations.

D.   Social, cultural, and religious beliefs
The study identified a number of social, cultural, and religious beliefs that impact on access to the four focal services of FP, safe abortion, maternal health services, and immunisation. For example:
- Acceptance of FP is affected by the strong son preference that persists in Nepal across social groups, and the gossip and backbiting that users face, particularly in the Terai where people have less privacy.

- The social framing of abortion as immoral inhibits access to and use of safe abortion services, compounding the supply-side challenges of location and affordability. Abortion is widely associated with marital distrust and suspicion of relationships outside marriage, and is widely believed to be illegal despite legal changes which came into effect in 2002.

Implications for policy makers: Existing social beliefs, interwoven with barriers linked to the determinants of access, combine to deter poor and excluded women and men from using EHCS. Addressing social, cultural, and religious beliefs in a respectful and persuasive manner calls for greater investment in Behaviour Change Communication (BCC) targeted at women, their family gatekeepers, and local stakeholders in a cultural and context specific manner. Training and supervision of frontline workers so as to improve their Interpersonal Communication (IPC) and counselling skills, and equip them to be change agents and influencers is also important.

E.   Poverty, caste, ethnicity, and religious identity: Poor people, independent of their caste/ethnic/religious identity, share common constraints to accessing services linked to:
- Lack of education and awareness about health issues
- Restrictive influences from other household members
- Inability to afford transport
- Inability to afford medicines
- Feelings of indignity and shame as a result of discrimination by service providers.

In addition to poverty-linked constraints, poor people experience vulnerability related to their caste/ethnic/religious identity. In practice, Other Backward Class (OBC), Dalit, Muslim, Brahmin/Chhetri, and Chepang respondents regularly labelled themselves both by ethnic/caste/religious group and by economic/educational status, never solely by one factor. Often it was the combination of ethnicity/caste/religion, poverty, and lack of education and information which were identified as factors leading to non- and inadequate access to services.

Implications for policy makers: Policy makers and health practitioners need to pay attention to the specificities of poverty, caste, ethnicity, and religion, and the positive and negative impacts that these social identities have on service access. It is important to note that barriers associated with being poor and excluded (and female) occur across all social identities, and that simple association by caste/ethnic/religious group is inadequate as a basis for health service planning and delivery; similarly, missing the caste/ethnicity/religious factor can lead to ineffective service delivery. Strategies reported for enhancing access to services amongst excluded groups need to be scaled up: for example, recruiting health workers to reflect the diversity of the local population; targeting outreach to locally excluded groups dependent on traditional healing or inhibited by religious norms;

building partnerships with local religious and cultural leaders; and sharing new ideas within diverse community populations to initiate dialogue around restrictive social values.

F.   Supply-side barriers: The main barriers reported to impact access to services were staff attendance and related opening hours, and the direct and indirect cost of services. Staff absenteeism and short opening hours affected trust in services and deterred people from travelling to facilities, which might incur fruitless costs. While service barriers were similar in Hill and Terai areas, they were often experienced differently as a result of specific features of service delivery and user expectations. For example, in Terai areas these barriers were described as resulting in overcrowded health services and the use of 'briefcase doctors'.[1] In Hill areas, the barriers were compounded by a lack of alternative local private providers and thus greater use of traditional healers.

Indirect costs, including transportation, were often greater than the direct costs charged at the facility level, especially in the Hills, where transport access was limited. Reports of free services being charged for, including immunisation, illustrate gaps in accountability of service providers, and gaps in knowledge and confidence of users to challenge such payments. These findings may not be new, but this study has illustrated how service deficiencies exacerbated demand-side barriers, and added to the multiple levels of exclusion that poor women and children faced in accessing services. For example, delays in receiving care at the facility strengthened family resistance to women seeking care for themselves and their children.

Implications for policy makers: Staffing issues are the most influential factor on uptake of services. Key issues needing to be addressed are: ensuring appropriate numbers of staff are allocated to individual facilities; mobilising local resources to boost staff numbers and staff diversity; increasing staff attendance and reducing avoidable absences; enhancing supervision and monitoring to reduce absenteeism; and placing a mix of male and female staff in each facility.

The cost of using health services is unaffordable for many poor people, who often forego services or choose alternative traditional providers who are perceived to be more affordable. This suggests that it is necessary, firstly, to review the effectiveness of financial incentive programmes such as the Aama Surakshya Programme (Aama) and free drugs to ensure they are adequately reaching the poorest and enabling their financial access, and, secondly, to develop a comprehensive health financing strategy to enable poor people's access to health services in a sustainable and efficient manner.

Headline recommendations for the Ministry of Health and Population (MoHP)

1. Improve the quality of care and delivery of peripheral health services

Improving the quality, responsiveness, and delivery of peripheral health services is fundamental to improving coverage of the poor and underserved as these are the services to which they have greatest access on the grounds of social permission, affordability, and distance. This will take a multi-faceted health systems and institutional response, and we appreciate that this is work in progress and an important goal of the government. Based on the findings of the Rapid Participatory Ethnographic Evaluation and Research (PEER) study, we believe this will require:

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[1] The Nepali term for this is '*Jhole daktor*', meaning 'the Doctor who always carries medicine in his bag'. These 'Jhole daktors' are found mostly in the Terai region of Nepal. They provide health services to people at home, and often have some basic or preliminary medical/health care training. However, they do not have any official status, they are not regulated by any governmental bodies, and do not fit within the formal health care system.

- Increasing the availability of staff and their skills to recognise and address issues experienced by women, the poor, and the excluded

- Extending facility opening hours

- Increasing the Gender-Equality-and-Social-Inclusion- (GESI-) responsiveness of service delivery

- Increasing the social diversity of the health workforce.

2. Introduce a new initiative to improve access to services in remote areas

The complexity of access in *remote areas* requires a multi-faceted response addressing demand- and supply-side barriers, and leveraging government agencies, civil society, and business stakeholders. We recommend that the government earmark funding for a special initiative to pilot and test different approaches in a small number of districts, within a variety of remote conditions and communities. It should be designed to become an innovative programme addressing many of the issues of geographical exclusion constraining access of different social groups in different areas of Nepal.

3. Work in partnership with other agencies to address social and cultural factors

To address the social and cultural beliefs and practices that hinder access to services and negatively affect health and well-being, communities need to be mobilised, women empowered, and husbands and in-laws persuaded to allow women to use health services as needed. This will require localised and effective Information, Education, and Communication (IEC)/BCC, and political commitment and support at all levels. We recommend that the MoHP work in partnership with other government agencies and Civil Society Organisation (CSOs), as planned in the Second Nepal Health Sector Programme (NHSP-2), to support the social change process and the communication efforts required at the family, community, and society levels. This will require the establishment of systems and procedures to enable government to support non-governmental partners to work effectively with different social groups at the local level, with strong governance frameworks and coordination.

4. Strengthen local-level planning at district and facility levels

The identification of families, communities, and social groups that are excluded or underserved, and the reasons for their exclusion is fundamental to improving coverage. Local-level planning at district and facility levels requires more systematic and regular mapping of both the geographical areas and social groups that are not using services and the reasons why, in order to better plan and target services to reach underserved populations.

5. Introduce flexible district-level funds targeted to reaching unreached groups

Generic service delivery approaches cannot overcome the specific barriers faced by different social groups in accessing services. To enable context- and need-specific strategies and service delivery approaches, we recommend the introduction of flexible district funds targeting unreached groups under the authority of the District (Public) Health Officer.[2] Guidelines would need to be developed to frame the objectives of the fund, mechanisms for implementation, and procedures for monitoring and accountability. We suggest that the fund be designed so that it also encourages facility-level providers to identify, plan, and better serve unreached and excluded groups, possibly through conditional transfers based on performance against utilisation by target populations.

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[2] This has recently been identified as an intervention by Management Division in their Annual Work Plan and Budget (AWPB) of 2012-13 but has as yet not been implemented.

6. Strengthen Health Facility Operation and Management Committees and leveraging of local stakeholders

Health Facility Operation and Management Committees (HFOMCs) are an important governance platform for making services more responsive to the needs of local women, the poor, and the excluded. We recommend that the capacity of HFOMCs is built to ensure that they have greater awareness of unreached populations and have the skills needed to identify, plan, direct and monitor the delivery of services to unreached populations, by, for example, leveraging of local supporting stakeholders such as VDCs and Non-governmental Organisations (NGOs). Secondly, it will be necessary to broaden the membership to include women and men from underserved areas to ensure their experiences and voices are included, and to revise the HFOMC guidelines to make it mandatory to address issues of women and the excluded.

7. Strengthen accountability and transparency of local health services

This study shows that access to information on entitlements and the availability of services among poor and excluded communities is poor and often incomplete. Although many people perceived services to be of poor quality, respondents rarely raised their voices to make demands on providers, and seek accountability for the gaps in service delivery or for the charges that they paid for supposedly free services. We recommend that accountability and transparency be increased at the local level through, for example: better public dissemination of information such as the provision of Aama entitlements, the availability of free care, and the timings of facilities; strengthening the capacity of HFOMCs to provide oversight of service delivery, and to respond to local needs and demands; and strengthening mechanisms to monitor and act on irregularities within the health system through the supervision and monitoring system, and the complaints system, as well as through community-driven processes such as social audit and public hearing.

8. Policy implications to address gender issues

The findings of this study, particularly around the need for changes in the home, and Gender-based Violence (GBV), including sex-selective abortion, suggest the need for policy and programme development in specific areas. The need to take health interventions into the home – to elicit change in the socio-cultural values that act as barriers to health outcomes – is key. This will require policy recognition of the need for MoHP to have a greater, more active influence on the social and gender norms that inhibit women's and children's access to EHCS; further, it will require the prioritisation of related programmes and operational modalities, such as BCC programmes targeted at men and family gatekeepers, and the establishment of flexible district funds.

9. Inter-sectoral coordination to address socio-economic barriers

Given the multi-sectoral nature of barriers to access, we recommend that MoHP advocate to, influence, and work with the National Planning Commission (NPC), the Office of the Prime Minister and Council of Ministers (OPMCM), and other ministries to develop a multi-sectoral policy and plan of action to address the barriers faced by women, the poor, and the excluded in accessing health services and improving health outcomes. As with the Multi-sector Nutrition Plan, developed to address malnutrition, this enabling access to health plan will need to be led by the NPC with specific roles and responsibilities assigned to different ministries to address issues of livelihoods, transport, social norms, discrimination, and exclusion of women and people of different social groups.

1 INTRODUCTION

The Government of Nepal (GoN) has achieved impressive health gains for its citizens despite conflict and other difficulties. The First Nepal Health Sector Programme (NHSP-1) – the first health Sector-wide Approach (SWAp) in Nepal – ended in mid-July 2010, and the Second Nepal Health Sector Programme (NHSP-2) is now underway, with the goal of improving utilisation of essential health care and other services, and the health status of the people of Nepal.

One objective of NHSP-2 is to reduce cultural and economic barriers to accessing health services, and harmful cultural practices. Demographic, household, and facility-based surveys provide quantitative evidence of health practices and service use in Nepal. These quantitative studies indicate that gender, caste, wealth, ethnicity, and geographic location remain highly correlated with vulnerability and access to health services. Qualitative research is needed to better understand the multiple and complex barriers that influence health service utilisation trends among women and men from poor and socially excluded groups.

The objective of this study, which took place between August and October 2012, was to gain an in-depth, contextualised understanding of socio-cultural, economic, and institutional barriers to accessing health services (public and private sector) experienced by poor and excluded[3] women and men. The study focussed on understanding community members' experiences of accessing specific services (Table 1) provided within the Essential Health Care Services (EHCS) package, at Village Development Committee (VDC) levels, including Sub-Health Posts (SHPs), Health Posts (HPs), and outreach extension activities.

Table 1: Health Service Areas Researched

Health area	Reason for study
Family planning (FP)	The Nepal Demographic and Health Survey (NDHS) data (2006-2011) indicate: [4] • An increase in unmet need for contraception (25%-27%) • A slight decrease in Contraceptive Prevalence Rate (CPR) (44%-43%) • Static unmet need for contraception among Brahmin/Chhetris (26%) and Muslims (37%) • An increase in unmet need for contraception amongst Dalits (27%-31%), Terai/Madhesi other castes (44%-47%), and Janajati (24%-28%) groups[5] • Decreases in CPR amongst Brahmin/Chhetri (44%-43%) and Janajati (47%-45%) groups • Static, low CPR amongst Muslims (23%) • A decrease in Total Fertility Rate (TFR) at national level (3.1-2.6) but an increase amongst Muslims (4.6-4.9).
Safe abortion	Unsafe abortion is still a significant cause of maternal morbidity/mortality. Between 2008 and 2009, 7% of maternal mortality resulted from unsafe abortion.[6] Since medically safe abortion has been added to the reproductive health services in NHSP-2, there is a need to better understand why access to medical safe abortion is limited.
Maternal health care	NDHS data indicate improvements in maternal health care, but great inequity in accessing services between different socio-economic groups. Between 2006-2011 there were increases in the percentage of pregnant women: • Attending at least four Antenatal Care (ANC) visits (29%-50%) • Receiving Iron/Folic Acid (IFA) tablets or syrup during their last pregnancy (59%-80%) • Having deliveries conducted by a Skilled Birth Attendant (SBA) (19%-36%).

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[3] 'Excluded' research participants included Dalits, Adibasi Janajatis, Madhesis, Muslims, people of geographically remote areas, women, and the poor. Owing to sampling limitations, other excluded groups were not included.

[4] Bohra, N *et al*. (2012) *NHSP-2 Logical Framework (2010-2015) Achievements in 2011 against targets.* Kathmandu, Nepal: MoHP, GoN.

[5] There are limitations in the comparability of NDHS datasets owing to the size of some caste/ethnic groups; trend data by caste/ethnicity need to be treated with caution.

[6] Pradhan A *et al*. (2010) *Nepal Maternal mortality and morbidity study 2008/2009*. Family Health Division, Department of Health services (DoHS), MoHP, GoN.

Health area	Reason for study
	In 2011, more Brahmin/Chhetri women (64%) attended at least four ANC visits, in comparison to Dalits (40%), Janajatis (46%), Terai/Madhesi other castes (36%), and Muslims (35%). Differences persist with respect to deliveries by a SBA (46% of Muslims, 45% of Brahmin/Chhetris, 40% of Terai/Madhesi other castes, 27% of Dalits, and 29% of Janajati groups).
Child immunisation	Immunisation is a successful child health programme in Nepal in terms of overall coverage and equitable utilisation. However, between 2006-2011, NDHS data for measles immunisation rates showed: • Increases amongst Brahmin/Chhetris (90%-92%), Terai/Madhesi other castes (81%-82%), Dalits (71%-89%), and Janajati groups (87%-94%) • A decrease amongst Muslims (77%-57%)

2 METHODOLOGY

2.1 Rapid PEER

Rapid Participatory Ethnographic Evaluation and Research (PEER) is a well-established, rapid, highly participatory methodology designed to explore sensitive issues with non-literate/poorly educated, marginalised populations. This approach provides in-depth insight into the beliefs, behaviours, and understandings of the target population, and highlights underlying drivers of behaviour change and existing perspectives on health interventions.

A key feature of Rapid PEER is that all interviews are conducted in the third person. Interviewees are **not** asked to talk about themselves. They are asked to talk about "other people they know" or what other people in their social network say. The use of third-person interviewing techniques avoids a normative response bias, where interviewees give replies which reflect what they feel they **should** say rather than identifying what people **actually** say and do. In some instances interviewees and Peer Researchers (PRs) chose to talk about their own experiences but this is a voluntary rather than a required component of the method.

The Rapid PEER process:	
Days 1-2:	Rapid PEER training workshop with PRs.
Day 3:	PRS interview their first friend.
Day 4:	Rapid PEER specialist de-briefs PRs about interview 1.
Day 5:	PRs interview their second friend.
Day 6:	Rapid PEER specialist debriefs PRs about interview 2.
Day 7:	Final workshop with PRs.
Following days:	Rapid PEER specialist undertakes desk-based data coding and analysis.

Non-elite 'ordinary' members of the target group (see Section 2.2) were trained to become PRs. The PRs carried out in-depth conversational interviews designed to obtain targeted information from others in their own social group. The key questions, which formed the structure of the conversational interview, were agreed in advance with the research study team,[7] and were then translated by PRs into colloquial Nepali. Non-literate PRs drew pictures to represent each question.

2.2 Sampling

Nepal's population is highly varied, with 125 ethnic groups/castes identified in the 2011 Census.[8] These are categorised into seven main caste/ethnic groups: Dalit (11.8%); Other Backward Classes (OBCs)[9] (12.9%); Brahmin/Chhetri (32.5%); Newar (5.4%); Janajati (31.8%); Muslim (4.3%); and Other (1.3%). These seven groups are further sub-divided into 11 groups based on whether they are located in the Hills (Pahadi) or the Terai (Madhesi) (see Appendix 1).

Within the resource limits of the study, a small number of highly-excluded social groups were selected as the focus of the qualitative research (Table 2), based on findings of the NDHS 2006.[10] Two studies were carried out in each of three Hill districts and three Terai districts. Criteria for district selection were: location; density of target group population; and feasibility of fieldwork and oversight by the study team.

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[7] Led by the National Lead Researcher (Kapil Dahal), supported by the Nepal Health Sector Support Programme (NHSSP) Gender Equality and Social Inclusion (GESI) team and 12 Field Researchers.

[8] Central Bureau of Statistics (CBS) 2012.

[9] We have chosen to use this terminology as the group prefers to call themselves by this name. We are aware that other terms have been used to name this group: Disadvantaged Non-Dalit Terai Caste (Health Management Information System); Terai/Madhesi other castes (other government documents); and OBC (NPC, Ministry of General Administration, and Ministry of Local Development documents).

[10] The NDHS 2011 data were not available at the start of this study. See MoHP *et al.* (2007) *Nepal Demographic and Health Survey 2006*, Kathmandu, Nepal: MoHP.

Six social groups were chosen – Chepang, Muslim, Madhesi Dalit, Madhesi OBCs, Hill Dalit, and poor Hill Chhetri/Brahmin – covering caste, ethnic, and religious differences, so that each was studied in two of the six districts. Specific reasons for group selection in different districts are explained in Appendix 3.

Table 2: Sampling Framework

HILL DISTRICTS		
DOTI	**MAKAWANPUR**	**DHADING**
1. Hill Dalit	1. Hill Janajatis (Chepang)	1. Hill Janajatis (Chepang)
2. Hill Brahmin/Chhetri	2. Hill Brahmin/Chhetri	2. Hill Dalit
TERAI DISTRICTS		
RAUTAHAT	**BANKE**	**SAPTARI**
1. Madhesi Dalit	1. Muslim	1. Madhesi Dalit
2. Muslim	2. OBCs	2. OBCs

Each of the twelve studies followed the same process. Led by a team of two Field Researchers (one woman and one man) each of the 16 PRs (four men and 12 women) interviewed two members of their social network, resulting in a total of 374 interviews from the twelve studies (not all PRs were able to undertake two interviews).

2.3   Data collection

In each study, the 16 PRs were split into two thematic groups: eight focusing on maternal health and immunisation, and eight focusing on FP and safe abortion.

Interviews were held in places chosen by respondents as private, safe, non-threatening, and comfortable. PRs (often non-/semi-literate) did not record conversations or take notes during the interview.

2.4   Debriefing interviews

Each PR undertook two interviews and participated in two debriefing interviews over a four-day period. A data collection sheet (Appendix 5) was used to guide the debriefing process, during which Field Researchers took detailed notes. These became the written data set.

> **Interview Guide:**
> Each PEER Researcher used six questions/prompts to guide the conversational interviews:
> - Tell me about the health services women/men use locally.
> - Why do women/men use [insert health service]?
> - Why do women/men find it difficult to use these services?
> - What influence do women and men have on women's access to services? What influence do women have on men's access to services?
> - Tell me a story about a woman/man who has found it difficult to use these services.
> - What local changes would enable people to access these local services better?

2.5   Data analysis

Once data collection and debriefing were completed at each site, PRs participated in a local analysis workshop (see the agendas in Appendices 6 and 7). These were followed by in-depth systematic and rigorous thematic analysis of all data, which was undertaken by two experienced social scientists. Data were tabulated using Excel spreadsheets.

2.6   Ethical considerations

The study design and PR training addressed key ethical issues (see Appendix 8). These included: ensuring confidentiality and anonymity, obtaining informed consent from PRs and respondents, ensuring realistic expectations regarding the outcomes of the study, and protecting relationships of trust between PRs and respondents.

3 KEY FINDINGS

3.1 Analytical framework

Rapid PEER studies provide large quantities of in-depth, contextually specific data, which strongly reflect the voice of the participants. Reporting the findings of twelve individual yet interrelated PEER studies in a way that is useful to government and policy makers requires making challenging decisions about how best to present the data so that it both represents the voice of service users and has a clear, concise analytical narrative which reflects the needs of external audiences.

The analytical framework adopted (Figure 1) is a schematic approach to considering barriers and enablers of access to care, giving consideration to and making sense of the multiple and complex issues that comprise the social determinants of access; the impact these have on specific social groups (the full list of social groups included in the study are shown in Table 2; a small number of groups are used as 'mini case-studies' to illustrate specific issues); and how, in turn, these social determinants influence ease or difficulty of access to four specific health services.

Figure 1: Analytical Framework
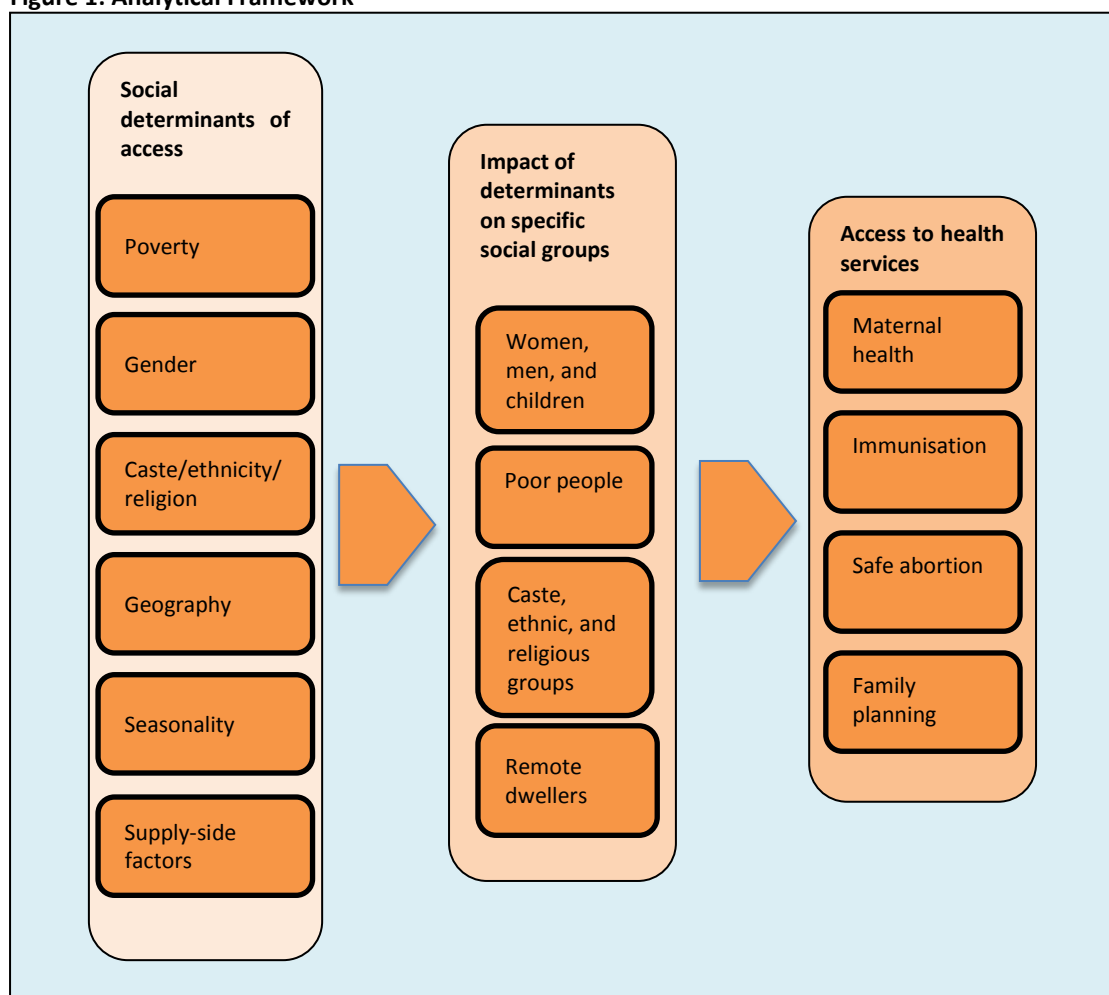
The different components of the analytical framework are not prioritised, each being significant, although they have differing levels of influence in different contexts. These are highlighted throughout the report. Multiple social determinants of access exist; those shown in Figure 1 were identified as particularly significant during data analysis, based on the extent to which they featured in interview narratives.

This structure for reporting the findings of the study provides a useful framework against which to consider appropriate actions from the perspective of different external audiences. However, it is important to remember that the determinants of access are, in reality, intrinsically interconnected across a spectrum of issues that, in turn, can act as barriers to accessing services (Figure 2). The figure below illustrates how the social determinants of access interact with the complex realities of people's lives to create barriers along the pathway of seeking care from the home to the health delivery point. These interconnected bar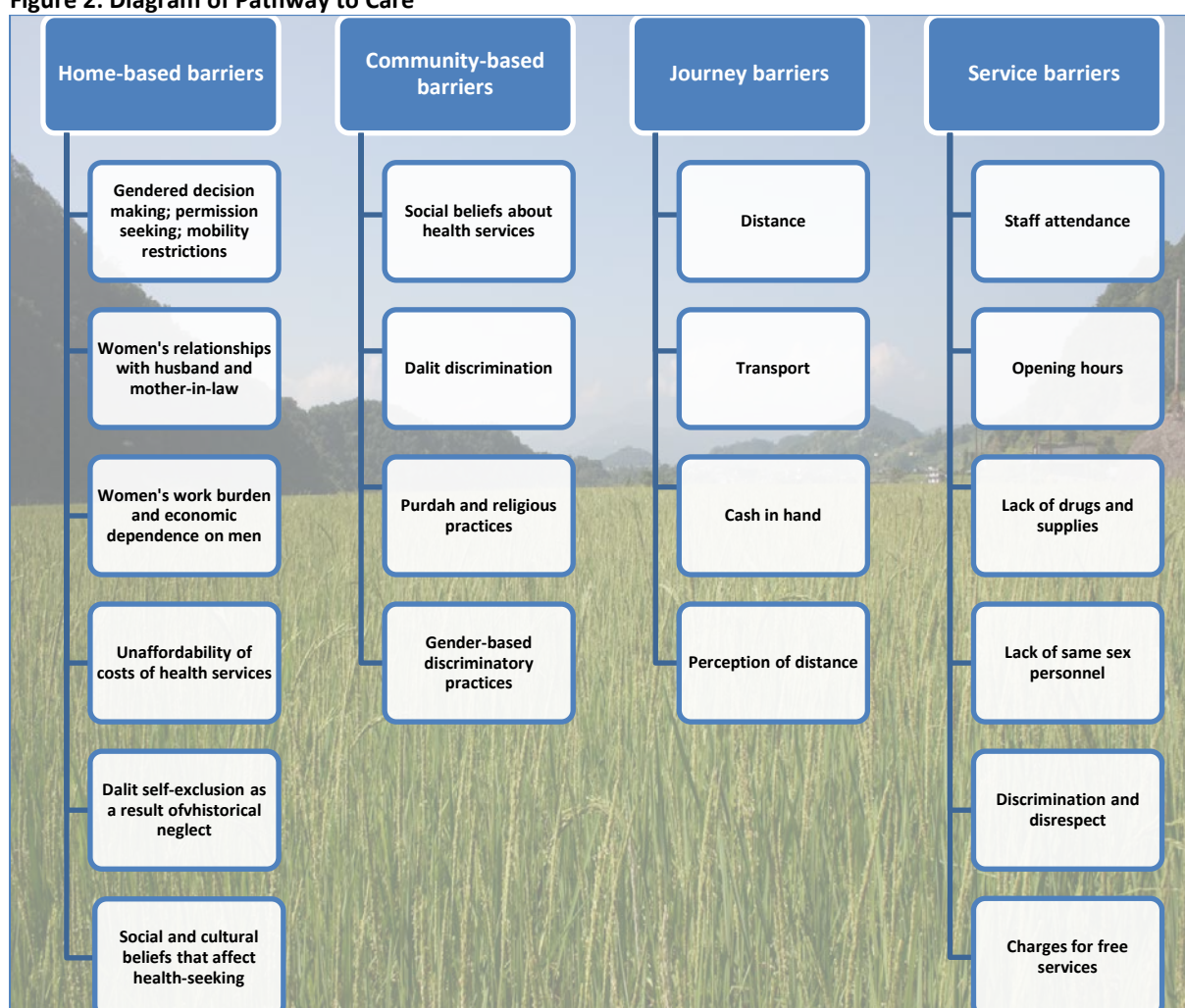riers create a multi-layered web that constrain poor and socially excluded people, particularly women, from accessing health services.

The figure below highlights those barriers that were most often mentioned by participants during the research, and which form the focus of our analysis in this paper. As the reader will see, we use this pathway to plot how each of the thematic issues reported on manifests itself along the pathway to care, and amplifies its level of influence on access to services.

Figure 2: Diagram of Pathway to Care

Home-based barriers	Community-based barriers	Journey barriers	Service barriers
Gendered decision making; permission seeking; mobility restrictions	Social beliefs about health services	Distance	Staff attendance
Women's relationships with husband and mother-in-law	Dalit discrimination	Transport	Opening hours
Women's work burden and economic dependence on men	Purdah and religious practices	Cash in hand	Lack of drugs and supplies
Unaffordability of costs of health services	Gender-based discriminatory practices	Perception of distance	Lack of same sex personnel
Dalit self-exclusion as a result of historical neglect			Discrimination and disrespect
Social and cultural beliefs that affect health-seeking			Charges for free services

The context of poverty and hardship found among study populations permeates all aspects of the findings, and underpins all sections in this report. The level of poverty within a household is also highly significant. The qualitative nature of this study means that it is difficult to differentiate specifically between the poor and ultra-poor, but it is important to remember that the poor are not a homogeneous group. Although they may be affected by similar issues, the level of disadvantage is likely to be greater for ultra-poor households, for women in those households, and for households (e.g. of Dalits) experiencing other dimensions of social exclusion.

3.2 Gender-based decision-making barriers

Household-level decision making is strongly gendered in both the Hills and Terai. Women lack the autonomy to access health services for themselves or their children without the permission of their husband or mother-/father-in-law. These household-level gatekeepers have substantial influence in preventing, restricting, or enabling young women's access to health services; for example, NDHS 2011 data showed that only 45% of currently married women participate in decisions pertaining to health care, major household purchases, and visits to family/relatives.[11] Looking at the pathway to care presented earlier, we find that gendered decision making creates barriers for women and children in the home, is reinforced by the social beliefs and norms upheld by the community, and impacts on women's ability to negotiate journey-based barriers. Gender norms also inhibit women and men being treated by health personnel of the opposite sex. Gendered decision making and the gender norms on which they rest are therefore interlinked with multiple barriers that people face along the pathway to seeking care, and constitute a major constraint to accessing health services.
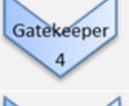
3.2.1 Gender and age

> *Only 45% of currently married women participate in decisions about health care. (NDHS 2011)*

Married women, who are intended to be a key beneficiary of EHCS, experience a double disadvantage in terms of their ability to access them. The disadvantage of their gender is compounded by generational hierarchies of power, which mean that women (regardless of educational and income levels) must seek permission from 'guardians of the house' (primarily a woman's husband, but also his parents) before accessing health services. This permission is not always given. Owing to men's labour migration in both the Hills and Terai[12] and, therefore, frequent absence from the household, the influence of a woman's parents-in-law and other household members is often decisive. Women's long and strenuous burden of work further reduces opportunities and time available to access health care.

Box 1: Household Hierarchy for Decision Making

Household-level gatekeepers	Implications for interventions
Gatekeeper 1 — Husband	• Increase men's understanding and willingness to reduce their control of women
Gatekeeper 2 — Mother-in-law	• Increase awareness of importance of seeking care
Gatekeeper 3 — Older sister-in-law	• Increase willingness to encourage health-seeking behaviour
Gatekeeper 4 — Other male family members	• Increase willingness to enable Health-seeking behavior
Gatekeeper 5 — Other female family members	• Encourage intra-household communication about health needs
Woman seeking access to health care	• Increase autonomy • Increase willingness to seek permission to access care

As a result of the dual barrier of gender and age, married women are frequently unable to access health services for themselves and their children, or are deterred from seeking permission to access health services (Box 1) since failure to conform to established norms leads to punishment, including Gender-based Violence (GBV), particularly in the Terai where gender norms are stricter.[13,14,15]

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[11] MoHP *et al.* (2012).

[12] NDHS 2011 reports outward migration from 43.7% of households in the Hills and 49% of households in the Terai.

[13] This was also found in: Joshi, SK and J Kharel (2008) "Violence against women in Nepal – an overview", *http://www.academia.edu/183952/Violence_against_Women_in_Nepal_--_An_Overview* [accessed 29/11/12].

[14] See, for example, Maternal Mortality and Morbidity Study (MMMS) 2008/09 (Pradhan *et al.* (2010)).

> *Some mothers-in-laws compare their past with their daughter-in-law's present and say that they didn't go for health facilities even for given birth to 5/7 children at that time. So they think that these days the daughter-in-law go to health care services just because they don't want to work at home* (Female, Saptari, Study 1)
>
> *"If we take longer time in the health post the mother-in-law scolds. We have many works at home. Because of this many people don't go to the health post"* (Female, Banke, Study 1)

Intra-household social relationships and gender-based practices are established, expected, and accepted from one generation to the next. These are powerful barriers to changing relationships at the household level. Increasing married women's timely access to health services is further compounded by perceptions among other household members that a daughter-in-law is using health-seeking behaviour as a way of avoiding physically arduous and time-consuming domestic duties. From a generational perspective, older women also make comparisons to the way they were as young women (when there were no local health services to access). Their assertions about the past, and links to the present, imply that access of health services is unnecessary, based on their own experiences.[16]

The multiple gatekeepers identified in Box 1 are key agents of change in terms of increasing women's access to health services. Open communication between husband and wife[17] was perceived as vital if women were to gain increased access to health services. It also enabled them to reach shared decisions to access services that might transgress socially accepted behaviour, such as FP and safe abortion. Similarly, supportive mothers-in-law provided daughters-in-law with the permission, time, and financial resources to access care. Participation in women's groups[18] was particularly significant in increasing women's decision-making opportunities.

3.2.2 Family and community control over women's use of public space

Control over women's use of public space is sanctioned by both household members and the wider community. The types of restrictions imposed on women, the reasons for this and the perceived benefits to the family of conforming to these social norms are shown in Table 3.

Understanding these perceived benefits is important as it provides insight into how interventions and counter-arguments through media and other messaging approaches need to be phrased. It presents the evidence that needs to be provided to family gatekeepers to support a shift towards the relaxation of women's use of public space in order to access health services.

Table 3: Gender-based Restrictions on Women's use of Public Space

Key group/location	Type of restriction	Key reason	Perceived benefits
Muslim	Religious - Absence from public spaces	Religious belief (purdah)	Conforming to religious norms
All, but particularly Terai	Social - Absence from public spaces	Demonstrates the 'discipline' of the household and woman and the good 'character' of the woman as she does not 'mix' with men or	Increased social status for the household (prestige)

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[15] For a more detailed discussion about GBV, see: Pradhan, A. *et al.* (2011) *A review of the evidence: suicide among women in Nepal*, Options Consultancy Services Limited, the UK Department for International Development (DFID), and United Nations Population Fund (UNFPA).

[16] These findings were also found in the following studies: Brunson, J (2010) "Confronting maternal mortality, controlling birth in Nepal: the gendered politics of receiving biomedical care at birth", *Social Science and Medicine*, 71, pp 1719-1727; Pradhan *et al.* (2010).

[17] See also: Furuta, M and S Salway (2006) "Women's position within the household as a determinant of maternal health care use in Nepal", *International Family Planning Perspectives*, 32(1), pp 17-27.

[18] This has been found in a number of studies, including: KC Ashish *et al.* (2011) "Community participation and mobilisation in community-based maternal, newborn and child health programmes in Nepal", *Journal of Nepal Health Research Council*, 9(19), pp 101-6; Morrison, J *et al.* (2005) "Women's health groups to improve perinatal care in rural Nepal", *BMC Pregnancy and Childbirth*, 5(6).

Key group/location	Type of restriction	Key reason	Perceived benefits
		participate in political places	
All, but particularly Terai	Social - Absence from public spaces	Risk of sexual infidelity	Control over women's physical and emotional sexuality
Hill Bahun-Chhetri	Cultural - Temporary removal from the home - Temporary absence from public	Female impurity *(chhau)* during menstruation, childbirth, and postpartum	Perceived avoidance of 'contamination' of other individuals/households
All	Safety - Absent from public spaces after dark	Security	Safety of the individual woman

The impact of restrictions on women's mobility and their presence in public spaces is that a woman needs to be accompanied by her husband or a permitted family member when outside the family home and requires a male interlocutor as she is not permitted to be seen conversing with a strange man. In addition, women should not be in public spaces after dark; the reason for this restriction is said to be their security, but there is also suspicion about the risk of women seeking romantic assignments with other men.

If a woman cannot be accompanied to the health centre by her husband, household members, or other women from the community, she is not permitted to go alone as this creates suspicion that she may meet secretly with another man. As a result, these restrictions substantially limit women's opportunity to access health services.

"It is considered a prestigious thing for women to stay at home as they are then disciplined. Even the guardians of the family also want the 'prestige' of the family asking her to stay at home" (Female, Saptari, Study 1).

"A Chapang man of Bumrang married at 18 to a girl of 16. Now they have six children. Last year, she went to the health post for the vaccine of her youngest child with a man from the same locality who was also going for his son's vaccine. They went together to hospital. After immunisation, the two had khaja (snacks) together. One man from the same community saw them and reported to the husband about it. The husband could not control his fury and right at her arrival, he battered her cruelly to wounds" (Female, Dhading, Study 1).

These norms and expectations are reinforced through gossip within the community, particularly in the Terai where more densely populated areas result in a lack of privacy and greater social control over women's movements. When a woman does break these social codes, the husband or other household members likely punish the woman in order to prevent this happening again, and to preserve the social status of her husband and, possibly, the household.

The long-term, ingrained, and personal nature of gender norms, and the effect these have on social relationships, point to the importance of seeking change in the home. This is a private sphere and is often seen as being beyond the scope of health interventions. However, given how critical gender norms are to enabling access to health care, the findings of this study point to the need for systematic and sustained government efforts to influence social norms in the home. Such efforts need to be led by local community members if change is to be owned and sustainable, and inclusive of men and other household decision makers, as the notions of "masculinity" need to be changed. This will require a holistic Behaviour Change Communication (BCC) approach, with different messages targeted at different genders, generations, and household members. Successful social mobilisation initiatives, such as the GoN's Equity and Access Programme (EAP), which is grounded on women's groups, provide a model from which the Ministry of Health and Population (MoHP) can work.

Table 4: Summary of Gender-based Barriers Affecting Access to Health Services

Barrier	Restrictions on access to health services	Key affected areas/populations
Gendered decision-making and permission-seeking processes, and women's dependence on husbands and parents-in-law	-Young married women are doubly disadvantaged as a result of traditional gender- and age-related hierarchies of power. -Women lack the autonomy to make health-related decisions for themselves or their children. Household-level gatekeepers are influential in preventing, restricting, or enabling access to services. -Household-level permission needed to access all health services. -Access to health services frequently delayed or denied by household-level gatekeepers (husband, mother-in-law, other household members). -Women lack access to cash to pay for transport, snacks, and health service costs.	All women
Social and cultural beliefs	-Older women consider pregnancy as 'normal' and formal health care as unnecessary.	All women
	-Female impurity during menstruation, childbirth, and postpartum restricts women's movements and interaction.	Bahun-Chhetri, Hills
	-Strong beliefs and dietary practices regarding the treatment of women and children.	OBC women
	-Son preference leading to multiple pregnancies.	All women, particularly OBC and Muslim
GBV	-Failing to conform to existing gender norms results in punishment, including GBV. -Physical and psycho-social GBV reinforces men's (and mothers'-in-law) control in the home, and permission-seeking norms.	All
	-GBV is widely prevalent in all areas but perceived as more so in the Terai.	All women, stronger in Terai
	-Women's need for access to health services increases as a result of GBV, although ability to access services is reduced, as the perpetrator is in the home.	All women, stronger in Terai
Women's work burden	-Women's work burden fulfilling domestic and productive duties decreases their access to health services. -Heavy work increases risk of miscarriage and uterine prolapse.	All women
Control over women's use of space	-Women's access to public space limited owing to religious, cultural, and social constraints. -Security issues also limit women's freedom of movement. -Lack of women's access to public space increases household prestige, especially in the Terai. -Lack of access to public space reduces suspicion of infidelity.	All women
Lack of cash	-Women depend on husbands and/or parents-in-law to pay for cost of reaching and using health services.	All women
Lack of travel autonomy	-Women need to be accompanied by their husband or a permitted member of the family.	All women
Lack of same-sex health staff	-Women and men feel shy to receive reproductive and maternal health services from the opposite sex.	All women and men

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Implications

- Household-level gatekeepers are key agents of change in increasing women's access to services. There is a need to focus on social mobilisation and BCC to:
  - o   Increase their awareness of the importance of women's and family health-seeking behaviour.
  - o   Encourage their willingness to enable women and children to seek health care.
  - o   Support intra-household and inter-generational communication about health needs and benefits of health care.
  - o   Change male attitudes about the need to control women.
- At the individual level, there is a need to support women through community mobilisation and empowerment approaches to:
  - o   Increase their ability to negotiate within households.
  - o   Increase their willingness to seek permission to access care.
  - o   Increase their confidence to take decisions about family health and well-being, and influence family members.
  - o   Increase their control over financial resources.
- Service providers need to be skilled and motivated to stimulate and encourage behaviour change and to affect local attitudes that reinforce gender inequality.
- Interventions need to be tailored to the local social, cultural, economic, and geographical context.

Political commitment needs to be forged to focus on bringing about change in the home.

3.3   The burden of women's work and economic dependence on men

In all study areas there are high expectations on married women to both undertake domestic duties and contribute to the household's efforts to generate enough food and income to survive.[19] Women's heavy work burdens and economic dependence on men and/or their parents-on-law are interrelated with other gender-based norms in the home and community, and fuel the many journey barriers that poor people face, such as the availability of cash to pay for transport, in accessing health services.

While livelihood work burdens fluctuate by season, women's domestic duties in both Hills and Terai are constant and are gender- and age-sensitive. It is unlikely that other household members will, or are able to, undertake this work in order to allow a daughter-in-law the opportunity to access health services to meet her own or her children's health needs. Men face social stigma if they undertake domestic work such as cleaning, washing, or child care while their wife is away from home. Older women in the household, for example the mother-in-law, frequently view accessing health services,

> "Women from village have to work on home from 6am to 9pm. because of this it is difficult for them to go for the health service in the health post" (Male, Dhading, Study 1).
>
> "Those services like immunisation, where there is a fixed date for seeing the health worker. This makes it difficult to manage health problems during the peak working months" (Female, Makawanpur, Study 1).
>
> "I haven't slept well for years as always there is a small child. One day I got up late and hence couldn't complete my morning chores on time – my husband beat me so much" (Muslin Woman, Banke, Study 1).

particularly for preventive services such as routine child-immunisation, as an opportunity for married women to avoid their domestic duties. Women with a high number of children (e.g. in Muslim households) experience this work burden more keenly and are unable to find time at all for tasks other than cooking and taking care of children.

The time- and labour-intensive nature of Hill-based livelihoods exacerbates rural women's lack of

> "A 45-year-old non-Dalit woman from a family has been suffered from the problem of uterus prolapse for the last 20 years, when she slipped on her way to home after taking cattle from jungle just four days after her delivery. She now has problems to walk and work. In spite of knowing that it can be treated she could not do it because of her economic condition and unavailability of the health facilities near to her village." (Female, Doti, Study 1).

opportunity to access health care. Additional seasonal pressures, such as weeding, harvest, and festivals, further limit women's opportunities to be absent from the home. If they leave, there is a substantial risk of punishment from family members (especially from sisters- and mothers-in-law when the woman's husband is working away) for not fulfilling their duties. As a result, wives are forced to deprioritise health-seeking behaviour for them and their children, and/or delay accessing health services until it is possible for them to spend time away from their domestic and livelihood duties.

This particularly impacts on child and reproductive health care that is time-sensitive, for example immunisation (which requires completion of a series of interventions), or obtaining contraceptive services, such as supplies of condoms, the Oral Contraceptive Pill (OCP), or injectable contraception. This leaves individuals susceptible to unwanted health outcomes. When medical treatment required women and children to seek treatment over a number of visits, the programme of care was not always completed.

3.3.1   The impact of workload on health

Multiple health risks increase as a result of women's domestic and livelihood responsibilities. Maternal and Child Health (MCH) risk is compounded by young women's lack of direct access to

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[19] This was also found in the MMMS 2008/09 (Pradhan *et al.*, 2010).

cash. Men, or if they are absent the mother-in-law, control the household's economic resources (Table 5).[20]

The problem of miscarriage, and uterine prolapse as a result of heavy work soon after delivery has been highlighted by other literature, including the NDHS 2011.[21] Uterine prolapse is the most frequently reported cause of poor health among women of reproductive age and menopausal women, with approximately 10% of women nationally affected.[22] It results in pain, embarrassment and, frequently, GBV and rejection by the husband, family and community. Government efforts to repair uterine prolapse are increasing nationally, particularly through camps, but no participants in this study reported accessing these.

Table 5: Increased MCH Risk as a Result of Domestic/Livelihood Workload

Key location	Vulnerable group	Challenge	Health impact
All areas, but particularly in the Hills as a result of the time invested in livelihood activities	Women	Unable to access time-specific services, e.g. repeat contraceptive services	-Unintended pregnancy
		Physically heavy workload throughout pregnancy and soon after delivery	-Miscarriage -Uterine prolapse -GBV -Social stigma/rejection
	Children	Failure to access routine immunisation	-Vulnerability to preventable disease

Poor women experience multiple barriers to maintaining good health after delivery, and in accessing care when it is needed. Women's economic dependence on men is a serious constraint. Women are unable to earn sufficient money themselves (when they are allowed to work) and rely on men when cash is required for their own or their children's health. Men's control over household economic resources also increases women's lack of autonomy in decision making. It was frequently reported that husbands believe it is sufficient to supply women with food rather than cash with which to buy household necessities. As a result, women have specifically to request financial assistance from either their husband or mother-in-law if money is needed to access services. If requested and then denied, they face the risk of punishment, including expulsion from the household.

Table 6: Summary of the Impact of Women's Work Burden and Economic Dependence on Men on Access to Health Services

Barrier	Key location	Impact	Health implications
Domestic labour	Hills and Terai	Delays to general health-seeking behaviour.	• Impact of ill-health increased in severity/over time
Livelihood labour	Hills	Seasonally-increased delays to general health-seeking behaviour.	• Reduced institutional delivery
		Prevention of access to time-sensitive services, e.g. repeat contraceptives (women) and routine immunisation (children).	• Unintended pregnancy (women) • Preventable disease and increased risk of under-nutrition (children)
		Heightened maternal health risk, particularly miscarriage and uterine prolapse.	• Loss of life • Infertility • Chronic ill-health • GBV • Social stigma/expulsion from the household
Economic	Hills and Terai	Increased dependence on household-level	• Increased impact of ill-health for women

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[20] See also Pradhan, A *et al.* (2011).
[21] MoHP *et al.* (2012).
[22] See, for example: UNFPA and Sancharika Samuha (2007) *Booklet in Uterine Prolapse*; Pant, A (2005) 'Managing genital prolapses in women of rural Nepal', www.anmf.net/projects/2005projects.04kmh001.htm [accessed 29/11/12].

dependence		gate keepers for access to services.	and children • Reduced institutional delivery

Implications
- Links between poverty, livelihood security, and out-of-pocket expenditure on health-seeking behaviour point to the importance of multi-sectoral solutions.
- Importance of strengthening community- and facility-level emergency funds that poor women can access.
- Need to strengthen existing Demand-side Financing (DSF) programmes to cover fully the out-of-pocket spending of the poor and ultra-poor.
- Community-level wealth ranking led by the National Planning Commission (NPC) opens up the opportunity to identify the ultra-poor and target health subsidies to them.

Uterine prolapse
- The importance of an appropriate gap between delivery and resuming heavy labour needs to be emphasised to those responsible for decision making at household level.
- Greater efforts are needed to de-stigmatise and increase communication around uterine prolapse, alongside increasing household-level gatekeepers' awareness of the relative ease of repair.
- Awareness needs to be increased of the presence and significant potential benefits of government-provided camps to repair uterine prolapse.

The possibility and potential benefits of providing free transport to camps repairing uterine prolapse should be investigated and costed.

3.4   Distance from services

The distance people live from health facilities affects and interacts with many of the other barriers that women, the poor, and the excluded face in accessing health care. Those which were described as being of key importance are shown in the shaded boxes in the diagram below (Figure 3). It is important to note that these not only relate directly to the journey ('journey barriers') but interact with home- and community-based factors that deter use of distant services, as well as with service-related barriers at the health facility which affect the willingness and confidence to seek care.

Figure 3: Barriers Related to Distance from Services

Home based barriers	Community based barriers	Journey barriers	Service barriers
Gendered decision making; permission seeking; mobility restrictions	Social beliefs about health services	Distance	Staff attendance
Women's relationships with husband and mother-in-law	Dalit discrimination	Transport	Opening hours
Women's work burden and economic dependence on men	Purdah and religious practices	Cash in hand	Lack of drugs and supplies
Unaffordability of costs of health services	Gender based discriminatory practices	Perception of distance	Lack of same sex personnel
Dalit self-exclusion due to historical neglect			Discrimination and disrespect
Social and cultural beliefs that affect health seeking			Charges for free services

Distance from services is a key factor in terms of facilitating or preventing access. Four factors are influential, and these are intrinsically inter-connected with financial and opportunity costs (Table 7). Challenges are further exacerbated by seasonal factors such as flooding.

There are, unsurprisingly, major variations between the Hills and Terai in terms of both physical distance from and time taken to access services. Correspondingly, there are similar differences in terms of opportunity costs, particularly given Hill women's time constraints related to their livelihood responsibilities.

Table 7: Factors Impacting on Distance from Services

Key factor	Inter-connected challenge	Seasonal challenges
Physical distance	Poverty/lack of cash	
Time taken	Financial cost	Flooding
Perception of distance	Opportunity cost	
Lack of transport	Time poverty	

- 78% of Terai households live within 30 minutes of the nearest HP.
- 49% of Hill households live within 30 minutes of the nearest HP.
- 8% of Hill households live more than two hours away from the nearest HP. (Source: Nepal Living Standards Survey (NLSS) 2011 and Maternal Mortality and Morbidity Study (MMMS) 2008/9)
- Uptake of MCH services is twice as high in rural areas when there is a HP in the community. (Source: Acharya & Cleland 2000)

The extent to which financial costs impact on access to services depends on a) the availability of transport (less common in Hill areas) and b) the level of poverty within the household. Poor households will have little 'disposable' cash, and there are likely to be competing demands for the little they do have, e.g. school fees, food etc. If women and children's health is perceived as a lesser priority (particularly, for example, in the case of ANC visits, institutional delivery for women, or routine immunisation for children) then money will

not be made available; the distance from services may be too far, or take too long, to travel by foot and, therefore, services will not be accessed. Poor households may not be in a position to make these decisions and possibility of access may depend on seasonal factors, such as livelihood demands and flooding.

The above issues are most likely to impact on Hill women, although issues such as the perceived need to access health services, poverty, and domestic labour are cross-cutting and also affect women in the Terai.

In a study by Acharya and Cleland (2000),[23] people's perception of the distance to services was an important barrier in both the Terai and Hills. The importance of perceived distance was also highlighted by respondents in this study. In Hill areas, perceptions of distance are influenced by distance, terrain, time taken, lack of transport (public and private), and costs incurred.

> "Due to distance, many people do not like to go to the hospital. It can be five to six hours' walk. And it is too far to go to the health post. It can take up to three hours of walking" (Female, Dhading, Study 1).
>
> "Men and women living far from the SHP experience difficulties in taking services offered. There is no transportation. People depend on rickshaws and carts as vehicles, but the gravelled road is almost 3km and vehicles don't always run" (Female, Rautahat, Study 1).

In the Terai, perception of distance is influenced more by the means of transport (on foot, bicycle, vehicle) and seasonality, as rivers become fuller and roads impassable in the rainy season. Whereas a round trip of six to eight hours on foot might inhibit a Hill resident from visiting health services, the lack of public transport over a 3km gravel path was just as influential on decision making in Terai areas. The willingness to pay for transport for institutional delivery was found to be very low (especially in Muslim households) as charges were considered high, and there was a belief that delivery should happen at home.

Table 8: Summary of the Impact of Distance on Access to Health Services

Barriers		Key location	Impact
Overarching issue	**Specific challenge**		
Physical distance	• Mobility of person seeking care • Age of person seeking care	Hills	Access to services likely to be least among: • Hill women and children • Poorest households • Female-headed households, e.g. due to male migration • Women and children in households where perceived 'non-essential' health care, e.g. ANC, institutional delivery, and routine immunisation, is not prioritised by household decision makers
Terrain			
Time taken	• Conflict with other duties • Security	Hills	
Transport	• Availability • Difficult for women to mobilise support to help with transportation, e.g. porters • Shortage of men to carry people to facilities	Hills	
	• Type	Terai	
Seasonality	• Flooding	Terai	
	• Livelihood demands	Hills	
Cost	• Financial • Lack of rapid access to cash	Hills and Terai	
	• Opportunity	Hills and Terai	

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[23] Acharya, LB and J Cleland (2000) "Maternal and child health services in rural Nepal: does access or quality matter more?" *Health Policy and Planning*, 15 (2), pp 223-229.

> **Implications**
> - Invest greater efforts in providing community-based outreach services and positioning and enhancing local services such as birthing centres so that they reach the poorest and most excluded, and are sustainable.
> - Perceptions of distance vary by physical and social environment. This needs to be taken into account in planning local-level service delivery. Perceptions of distance are not static: they may vary through the year. This needs to be considered in the provision of specific services, such as outreach camps (for uterine prolapse repair and contraception), in order to optimise opportunities for access.
> - The challenge of distance is compounded for married women by their dependence on household decision makers to prioritise the need for health care, and for access to cash for transport charges. Generational perceptions of the value of preventive services are likely to impact on this. There is a need to target awareness-raising to gatekeepers of women's access to care (husbands and mothers-in-law in particular).
> - Upscale practices of women-led management of community-based emergency funds.

3.5 The impact of social, cultural, and religious beliefs on uptake of specific services

Social, cultural, and religious beliefs have a particularly strong impact on access to services in Nepal, and contribute to gender and social exclusion. This section of the report concentrates on the impact of beliefs on the use of the four focal services of the study, and the following section addresses the issues related to belonging to specific caste, ethnic, or religious groups.

3.5.1 Family planning services

Women wishing to use FP services face the risk of gossip among community members. Wives using FP methods fear being accused of having a sexual relationship outside marriage. This was a particular fear among women in Terai areas, as a result of the closer proximity of houses in villages, stricter social control and gender discrimination, higher levels of GBV, and lower levels of women's participation in decision making.[24]

> *"If a husband takes his wife to the health facilities for family planning, villagers back bite him and say 'what type of 'boy' is this? He started serving his wife'. So even ask his parents to scold him. Men do not use means of family planning. They are not allowed to use by their wives and mothers. They ask, son will be weak, who will earn to feed us?"* (Female, Saptari, Study 1).

Men in both the Hills and Terai who show willingness to use FP methods, or support their wife during health check-ups, also become the target of community gossip and are ridiculed by community members and discouraged from using services. Other socio-cultural values also inhibit uptake of FP methods: for example, Hindus and Muslims, in particular, view children as 'a gift from God' and pregnancy is seen as a blessing to the couple and the family.

> *"It is difficult to take family planning services because there is the saying 'one son is not a son' and, as one ox cannot pull the plough, two oxen are required to pull the plough. When a couple have a son, the son is for them. But the daughters will go to another's home in the future. In our community a son is necessary, two sons, one is not enough. They believe that as the number of sons is more then they earn more money"* (Female, Doti, Study 2).

Son preference is an additional factor in limiting uptake of FP methods and creates reluctance to use temporary or permanent FP methods until at least one son has been born. Men without sons feel (and are) discriminated against through exclusion from a range of social events and opportunities, such as public gatherings, meetings, and access to financial loans from other community members. Married couples without sons are also stigmatised and described in derogatory terms ('*Niputi*' among Madhesi Dalits in Saptari District, and '*Aputo*' among Hill Brahmin-Chhetri in Makawanpur District).

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[24] MoHP *et al.* (2012).

In some study areas, a single male child is considered insufficient: infant mortality is high, and male children bring both future financial security and respect from the wider society. This leads to multiple pregnancies regardless of the existing number of daughters or the woman's health.

"We do not use Depo as it causes pain and sometimes bleeding into women which makes them weak and unable to do daily work for survival. Those who used Depo for the first time had continuous bleeding for a month. A woman of the early twenties, mother of two daughters and a son, used Depo but suffered from bleeding within a month. She was taken to Majhimtar hospital which referred to Gajuri but the bleeding did not stop. In the meantime, a baby was born. Within one month of the birth, she was taken to Majhimtar two times but still the bleeding continued. Later she was taken to Kurinta where the bleeding stopped but the incident still scares the Chepang women away from using Depo" (Female, Dhading, Study 1).

Among Hindu populations, male vasectomy is discouraged strongly on religious grounds: it is believed to lead to impurity and thus exclusion from rituals which are highly significant to Hindu life ('*shraddha*'), such as lighting a funeral pyre. Muslims strongly believe that their holy scriptures forbid male or female vasectomy, and that temporary FP methods are contrary to religious directives.

The influence of socio-cultural and religious beliefs is further strengthened by widespread concerns among men and women over the side effects of temporary and permanent FP methods (Table 9). Stories about side effects spread rapidly among communities. When the outcome is negative, there is a widespread impact on willingness to adopt FP methods that are already perceived as threatening to individuals' and couple's physical and emotional well-being.

Table 9: Disadvantages Associated with Family Planning Methods

FP method	Temporary/ permanent	Disadvantage/side effect	Gender affected
OCP	Temporary (short-term)	• Weakness • Sickness	Women
Injectable contraceptive (Depo-Provera)	Temporary (long-term)	• Weight increase • Excessive bleeding	
Contraceptive implants (Norplant)	Temporary (long-term)	• Unexpected changes to the menstrual cycle • Increased risk of infidelity/adultery • Increased distrust within married relationships	
Intrauterine Contraceptive Device (IUCD) (Copper T)	Temporary (short-term)	• Pain during and after fitting	Women
Condoms	Temporary (short-term)	• Breaking • Becoming stuck inside women leading to abdominal and pelvic pain • Spread disease • Reduced sexual pleasure for men	Men and Women
Sterilisation	Permanent	• Physical weakness • Abdominal and back pain • Risk of sexual infidelity	Women
Sterilisation (vasectomy)	Permanent	• Physical weakness leading to inability to work • Risk of sexual infidelity • Religious impurity (Hindus) • Religious ban (Muslims)	Men

3.5.2 Safe abortion services

NDHS 2011 data describe the context within which safe abortion services are being delivered:[25]

- Of the pregnancies ending in the five years preceding the NDHS 2011, 8% ended in abortion. Abortion was more likely amongst women aged 35-49 years, as the pregnancy order increased, in urban areas, and amongst the highest wealth quintiles.
- Some 38% of women aged 15-49 believe that abortion is illegal.
- The proportion of women who do not know the circumstances for legal abortion is higher in Terai (43%) than Hill areas (32%), amongst women with no education (54%), and is inversely proportional to wealth (61% of women in the lowest quintile, in comparison to 25% of those in the highest quintile).
- Nearly half of women who had had an abortion in the five years prior to the survey said that they had paid more than 1,500 Nepalese Rupees (NPR) for their most recent abortion.

- Knowledge of a safe abortion services is higher amongst women in Terai (65%) than Hill areas (50%).[26]
- The majority of women (69%) did not use post-abortion care services, even when they suffered from complications after their most recent abortion.

The social framing of abortion as immoral inhibits access to and use of safe abortion services,

> *"It is infanticide. Abortion is bad. If the wife suggests aborting, the husband would suspect her and quarrel with her that she is carrying the baby of another man, as he thinks that if it would have been his child she would not think of abortion"* (Male, Dhading, Study 2)

compounding the challenges of location and affordability. Abortion is widely associated with marital distrust and suspicion of relationships outside marriage; it is also viewed as sinful. This, together with other religious and spiritual beliefs, means that that abortion is believed to have a negative impact on this and future lives. It is also widely believed to be illegal, despite legal changes which came into effect in 2002.

Despite these views, however, abortion does take place, and for a variety of reasons, one of the key being son preference in the Hills and Terai.[27] This not only reduces uptake of FP services, but also increases covert uptake of sex-selective abortion in order to limit the number of girl children, particularly in areas where the dowry system impacts on household finances. Notably, growing instances of sex-selective abortion in the Hills were also identified in this study.

Strong stigmatisation against abortion practices is widespread, and women in the Terai reported concerns that seeking abortion services would lead to accusations of aborting another man's baby. Nevertheless, abortion is reported as common within Terai and Hill communities when associated with sex selection. Deciding on abortion after identifying the sex of the foetus means that surgical rather than medical abortion is necessary. This carries increased potential health risks. To reduce women's risks

> *"In recent days as the tradition of giving dowry is increasing people do not want to have many daughters. After three or four daughters people prefer to identify the sex of foetus and decide whether to give birth or go for abortion. These days it cost 10-12 lakhs for the marriage of a daughter so even women want to go for abortion if they have many daughters"* (Female, Saptari, Study 2).

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[25] MoHP *et al.* (2012).

[26] Another study, based on qualitative exit interviews, indicated that many women were not aware of either medical or surgical abortion methods, or the difference between these, prior to visiting a clinic. This inhibits informed choice prior to, and at point of contact with, health professionals. See: Tamang, A *et al.* (2012) "Factors associated with choice of medical or surgical abortion among women in Nepal", *International Journal of Gynecology and Obstetrics*, 118, pp S52-S56.

[27] See also: Lamichhane, P *et al.* (2011) "Sex-selective abortion in Nepal: a qualitative study of health workers' perspectives", *Women's Health Issues*, 21-3S, pp S37-S41.

there is a need to ensure that women have access to safe abortion services as soon as possible to limit the risks of resorting to unsafe practices, or surgical abortion.

Safe abortion services are only available in urban areas and are often unaffordable for rural women due to the costs charged by public and private service providers, coupled with the time and cost of

> *"There is no safe abortion service in the health post of the village but one can do abortion of unwanted pregnancy outside the village. Or if there is no safe abortion service in the village, some women take herbal medicine for abortion, but then they can suffer from over bleeding. Some women die because they don't access health services"* (Female, Doti, Study 1).

travel, and loss of vital household labour. Reports of charges by both public and private providers vary widely and were further compounded by the reported frequency of unexpected complications, which lead to additional costs. The high costs associated with safe abortion services form a barrier to women's access and lead to increased likelihood of unwanted pregnancies or uptake of unsafe abortion services, with a high risk of complications leading to maternal mortality.

The physical and financial challenges of gaining access to health facilities, social and cultural factors which prohibit abortion, illegality of sex-selective abortion, and lack of local safe abortion services (for non sex-selective abortion) all result in delayed access to services and increased likelihood of women using unsafe local traditional methods to abort unwanted pregnancies.

3.5.3 Maternal health

Pregnancy is viewed as a 'natural' process of a 'normal' woman.[28] As a result, older women, in particular, view maternal health services (particularly institutional delivery) as unnecessary at best, and, at worst, creating mental and physical dependency among younger women. In other words, reducing what are seen as necessary individual resources such as stoicism, resilience, and physical strength. As a result, there is often generational conflict between older women and those younger women whose desire to access formal services[29] is perceived as resulting from weakness and a physical inability to carry a pregnancy to full-term and give birth safely without external support.

Disapproval of this 'weakness', or accusations of being 'educated' or 'modern' and thus reluctant to conform to traditional social expectations, are exacerbated by the negative impact that seeking what is perceived as 'non-essential' care often has on the entire household, as a result of the financial and opportunity costs incurred. These attitudes, complemented by strong socio-cultural values, result in pressure on women to deliver at home rather than accessing institutional deliveries, despite the availability of financial incentives.[30]

> *"Mothers-in-law tell the stories from their time and ridicule the daughter-in-law as a weak woman if the latter wants to go for pregnancy check-up"* (Male, Banke, Study 2).
>
> *"I gave birth to six children and did not go to hospital for check-up and injection. Why do you need to go there?"* (Female, Makawanpur, Study 1).

3.5.4 Child immunisation

Although uptake of child immunisation is generally high, there is still a need to increase coverage for all children. Obstacles to child immunisation are influenced by many of the issues described in the preceding sections, such as distance from and cost of services. Immunisation is a preventive service and thus is not always prioritised by households where access to services is difficult because of terrain, lack of transport, absence of men to assist with transport, and financial or opportunity costs. Older female heads of households are more likely to view child immunisation as unnecessary based

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[28] These findings were also found in the following studies: Brunson, J (2010) "Confronting maternal mortality, controlling birth in Nepal: the gendered politics of receiving biomedical care at birth", *Social Science and Medicine*, 71, pp 1719-1727; Pradhan *et al.* (2010).
[29] MoHP *et al.* (2012).
[30] See also Brunson (2010).

on their own life experiences, and thus be less willing to invest time and money on accessing services in the absence of ill-health.

Take-up of child immunisation varies according to a number of factors:
- Immunisation coverage varies inversely with **birth order**, e.g. 91% of first-born children have been fully immunised, compared with 60% of children of birth order six and over.
- **Geographical location** is also important, e.g. 85% of children are fully immunised in the Terai, in comparison to 90% in Hill areas.
- The **education level of the mother** is positively associated with uptake of immunisation, e.g. children of women with no education (78%) are less likely to be immunised than children of educated women (above 90%).
- **Caste/ethnicity** affects the take-up of immunisation, with Muslims (57%) having much lower coverage than others (88%).
(Source: MoHP et al (2012)

In addition to these social and structural challenges, two interconnected factors inhibit access to child immunisation services: lack of awareness of the health benefits, and anxiety and misunderstanding of the side effects of immunisation.

Although awareness of child immunisation services is widespread, lack of understanding of the potential benefits is reinforced by older women's views; social control over married women's use of time and space limits their access to information sources or social networks outside the family which could build knowledge and confidence to challenge family norms. The women also face difficulty in completing immunisation schedules, particularly if the (often extended) family is large, with many young children**.**

Misunderstanding of the immunisation process and likely short-term side effects are important barriers to completing the correct dosage. Side effects range from children being upset by the pain of the injection, to fever lasting for several days. The risk of mothers being scolded, punished, or beaten if children become upset or are ill or need additional health care with associated cost implications as a result of immunisation decreases the likelihood that women will access immunisation services without family consensus. In a few cases, stories which suggest immunisation as the cause of death of young children circulate around communities. These further decrease willingness to access preventive services.

"A lady of ward nine gave birth to a son. When the child got the first vaccine, it only cried and nothing happened. But the second time when it got vaccine there was swelling in the child's thigh. Even pus came from there. After treatment, 10-15 days after, the child recovered. But, now the woman is thinking of not taking her child for next immunisation because after that immunisation, they had to spend NPR 500 (in the child's treatment) so she is thinking of not going there for next vaccine" (Female, Saptari, Study 1).

Table 10: Summary of the Influence of Social, Cultural, and Religious Beliefs on Uptake of Specific Services

Service	Belief	Key location/ group	Outcome
FP	Use of FP methods is perceived to result from/lead to relationships outside marriage	All, but particularly Terai	• Men supporting/using FP methods are subject to ridicule
	Son preference	All	• Reluctance/delay in using FP methods • Sex-selective abortion • Uptake of unsafe traditional practice
	Uptake of FP methods goes against religious beliefs	Hindu Muslim	• Lack of use of FP methods
	FP methods have negative side effects	All	• Lack of uptake of modern methods • Uptake of traditional methods
	Male vasectomy leads to impurity	Hindu	• Exclusion from important religious rituals and functions
	Male and female sterilisation reduce strength and can lead to long-term morbidity	All	• Lack of uptake owing to fears about inability to carry out domestic labour and livelihood activities and added health care costs
Safe abortion	Son preference	All	• Reluctance/delay in using FP methods
	Dowry system		

	Abortion associated with relationships outside marriage		• Sex-selective abortion • Uptake of unsafe traditional abortion practices • High levels of surgical abortion
Maternal health	Institutional delivery is seen as unnecessary by older people	All	• Reduced uptake in the absence of ill-health • Generational conflict • Lack of reduction in home-based delivery
	ANC and institutional delivery create mental and physical dependency		
Child immunisation	Routine side effects viewed as harmful	All	• Lack of uptake, owing to generational gate-keepers of access to care, mixed with work burdens and women's lack of control over their time and movements • Immunisation seen by some as creating rather than preventing ill-health • Mother punished if child shows side effects
	Benefits are not well understood		

Implications

- Accessing preventive services (e.g. ANC and child immunisation) is often not prioritised. This is unlikely to change unless structural (e.g. transport) and social barriers are reduced, alongside reinforcing information about the benefits of these services (need for a two-pronged approach).
- The long-term benefits of preventive health services need to be emphasised in terms of increasing individual and household well-being through potential reduction in financial costs (for emergency health care) and time lost from domestic labour and livelihood activities.
- Potential agents of change (household-level gatekeepers, religious leaders, and traditional healers) should be targeted in terms of social mobilisation and health-messaging about the health benefits of MCH services. Successful intergenerational and couple relationship-building communication tools should be applied at scale as part of community mobilisation programmes.
- Health service providers need to explain in advance the likely/potential side effects of child immunisation.
- Greater effort needs to be placed by the health sector on affecting decision making within the family. This will require improved counselling skills of health workers and Female Community Health Volunteers (FCHVs), as well as greater coordination and synergistic working with other government departments and civil society.

3.6 Poverty, caste and ethnicity, and religious identity

This section of the report examines the specific effect that poverty and caste/ethnicity[31] have on access to health services. As is shown in the previous sections, multiple factors influence access to services of poor people, including cost of services, gender relations, and quality of service delivery, which cross-cut caste and ethnicity. The study found that poor men and women from all caste/ethnic groups experienced, often similar, difficulties in accessing health services.

Narratives from poor people from OBC, Brahmin/Chhetri, Dalit, Muslim, and Janajati populations reveal generic barriers to accessing care, and at facilities themselves. These include:

- Lack of education and awareness about health issues
- Restrictive influences from other household members
- Inability to afford transport
- Inability to afford medicines
- Feelings of indignity and shame as a result of discrimination by service providers.

These reflect the economic[32] (e.g. absolute terms of low income) and social dimensions of poverty[33] (e.g. empowerment, ability to go without shame) and appear to be experienced independent of the caste or ethnic or religious group to which a person belongs.

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[31] In accordance with common practice in Nepal, we use caste/ethnicity to include religious groups (i.e. Muslims).
[32] World Health Organization (2012) *Poverty*, http://www.who.int/topics/poverty/en/ [accessed 5/12/12].

"One OBC man of 18 years was unmarried. He calls himself Beggar Saradu. He struggled to get enough money for medicine of general fever from the health post on two occasions. Once when he went to the health post at 10am the health personnel told him to come around 2pm, but when he was there the health personnel did not check him. They returned him by saying that he has bad smell" (Male, Saptari, Study 1).

"There was a Dalit woman in Budhathum. She was married at 16 and became pregnant at 18. It was her first child. Her husband had gone to Malaysia for work. Her in-laws did not allow her to go for prenatal check-up, saying, "Where is the money to use service? We can't give it. You can't afford. It's a waste of money." One day her labour pain started and they had only jhakri performed for her for four days of labour pain. She was not taken to the health post because of money and because of the in-laws. On the fourth day, she gave birth to a dead son. The placenta did not descend, and the mother died" (Female, Dhading, Study 2).

"I don't have money. My husband works in a brick factory in a neighbouring village, and he can't save any money from there. If some health problem occurs we have to borrow money to buy medicine… We are also a Muslim family. Women are kept hiding from others, inside veil. The health centre is very far so pregnant women can't walk that far, and the transport costs are too high" (Female, Rautahat, Study 1).

However, while poverty is a major determinant of access to health services, the findings from this study show that caste and ethnicity can add a further dimension of vulnerability in accessing services. In practice, respondents regularly labelled themselves both by ethnic/caste group and by economic/educational status, never solely by one factor. Often it was the combination of ethnicity/caste, poverty, and lack of education and information which were identified as factors leading to non- and inadequate access to services.

To illustrate the interplay of barriers for specific social groups, we present those findings that were more specific to (a) Hill and Madhesi Dalits, (b) Chepang, and (c) Muslim respondents. While there is not a specific section on OBC participants, it is important to emphasise that they were as affected by barriers relating to gender, work burden, distance to services, and the social beliefs affecting each of the four health service areas as other social groups involved in this research.

OBC groups perform poorly: Health trends illustrate the need for a concerted effort to improve access to health services amongst OBC people. For example, in the 2011 Service Tracking Survey (STS), OBC (Terai/Madhesi other castes) was the social group with the lowest awareness of free health care; according to the latest NHDS data, only 36% of OBC women, along with 35% of Muslims and 40% of Dalits, attended at least four ANC visits in 2011. For these reasons, as outlined in the recommendations, due care and attention should be paid to the local circumstances of members of the OBC group – as well as other groups – in local- and national-level planning to improve access to health services

Factors linked to the caste/ethnic/religious identity of Chepang, Dalit, and Muslim communities that reduce access to services are:

- *Spiritual beliefs,* which interact with poverty and distance from services to reinforce the likelihood of traditional practices being selected over modern health services in the case of Chepang communities.
- *Discrimination* based on caste, often leading to self-exclusion among Hill and Madhesi Dalits.
- *Religious beliefs,* which result in non-acceptance (or covert uptake) of some services, such as FP or safe abortion as in the case of Muslims.

It is recognised that this is a simplified schematic approach, as the boundaries between different types of exclusion and their impact on different groups are blurred and overlap, but it does provide a relatively practical framework as a starting point from which to consider the way in which caste/ethnic/religious identity interacts with other factors such as poverty, gender, and geography

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[33] Oxford Poverty and Human Development Initiative (2012) *The missing dimensions of poverty data*, http://www.ophi.org.uk/research/missing-dimensions/ [accessed 5/12/12].

to increase or reduce access to and uptake of services. Three short 'case studies' are used to illustrate this and highlight the ways in which vulnerability is experienced by three different groups.

3.6.1 Seeking alternatives to modern health services (Chepang)

In many sites examples were given of women's use of traditional healers. Their use, however, was most strongly reported among the ultra-poor, who cannot afford the costs associated with accessing modern health services, and Chepang residents in the hill sites of Dhading and Makawanpur.

The Chepang use traditional healers (*'jhakris'*) for the following reasons:

- Belief that illness is caused by angry ancestral Gods
- Lack of information and awareness of modern medicine and local health services
- Fear of unknown procedures and side effects of modern medicine
- Lack of access to local health facilities
- Poverty.

The use of traditional healers is more common among the Chepang who spend substantial time living in the forest. These groups are the least aware of, often free, services available at public health facilities. Many Chepang are moving from traditional to Christian beliefs, and use of traditional healers is being replaced by belief in prayer to cure ill-health. Use of traditional and faith-based healing practices specifically in relation to key health service areas are shown in Table 11.

Table 11: Summary of Reasons for Accessing Traditional/Faith-based Healers

Health service area	Reason	Impact
FP	• Traditional healers provide herbs to prevent and promote pregnancy • Fear of side effects from modern contraceptive methods	• Non-use of public health services • Delayed use of public health services • Escalation of morbidity and mortality
Abortion	• Secrecy can be maintained at an affordable price, providing there are no complications	
Child immunisation	• Fear of side effects of modern immunisation • Belief that reactive use of traditional healers will enable illness to be cured	
Maternal health	• Traditional birthing practices preferred • Payment in-kind is accepted (e.g. food/alcohol)	

3.6.2 Caste-based barriers to access of health services amongst Madhesi and Hill Dalits

In contrast to the apparent preferred alternative to modern medicine described above, Madhesi and Hill Dalits provide an example of a population group among whom care is frequently desired but unavailable (or poorly provided) owing to exclusion on the basis of caste.

Caste-based discrimination was reported by Madhesi and Hill Dalit respondents. Evidence in Hill areas included complaints relating to mistreatment from health outreach workers, delayed treatment through preference given to other castes, and not being given free supplies. Data from Madhesi Dalit respondents, however, were more detailed, more emotive, and indicated more regular discrimination at health facilities and within the wider society.

> *"One female community health volunteer locally tells Dalits that she does not like to go to the house of the Dalits even when they call her. Because of such behaviours of the female community health volunteer some Dalit women have left taking consultation from her and are without support"* (Female, Doti, Study 1).

> *"The health workers treat non-Dalit women well and do their check-up immediately. But they don't treat well Dalits and uneducated women, they don't check up well. No touching us"* (Female, Saptari, Study 1).

Caste-based discrimination by service providers was experienced in three ways:

- *Lack of access to care:* Treatment and medicine which was believed to be available at health facilities was not received, and outreach services were also reported to be withheld from Dalit patients, e.g. home visits by FCHVs, which were provided to other caste groups.
- *Delayed access to care:* Dalits from both Hill and Terai areas reported that they have to wait longer than others at facilities, are often the last to be treated, and, as a result, often have to return home without treatment.
- *Poor quality care:* Reluctance by service providers to have physical contact with Madhesi Dalits results in lack of physical examinations, discourteous and limited verbal communication and withholding non-essential treatment such as de-worming.

> *"Socially, caste-based discrimination is not completely abolished. Even if we pay, high-caste people don't allow us to use their bullock cart to take the pregnant women to hospital when she is in labour. Two years ago the wife of a local man was in labour and he wanted to take his wife to the health facilities, but the high-caste people did not let him use their bullock cart in rent. Even the high-caste women don't go to help if a Dom woman is in labour. No one gave transport to her. They tried her delivery at home, but the traditional birth attendant did not come to help them. She was in labour since the morning, and gave birth to two twins in the afternoon at around 2pm. But both of the children were dead. Because of caste discrimination, the local high-caste traditional birth attendant and high-caste people did not help them, so she gave birth to dead children. Dom are discriminated by both high caste and other Dalits"* (Male, Saptari, Study 1).

Madhesi Dalits also face **discriminatory practices by other community members.** This is experienced in two ways:

- From higher castes, *discouraging Dalits from accessing routine services* (which further compounds existing pressure on women from husbands and parents-in-law not to access care).
- From higher castes, *failing to provide assistance to Dalits during emergencies* (this exacerbates existing challenges of distance from services, terrain, and lack of transport).

The impact of externally-imposed social exclusion, together with deeply ingrained cultural and social marginalisation, combines to result in frequent self-exclusion from available services, owing to lack of belief that they will receive quality services or through desire to avoid discrimination. The process of self-exclusion is fluid, however, and is influenced by both age and gender, with examples given of older people sending younger men, women, and children to health services, or husbands sending women to 'test out' access to see whether health worker practices have changed.

Table 12: Summary of Caste-based Discrimination Experienced by Dalits

Type of discrimination	Examples	Impact
Community-based discrimination	Dalits discouraged by others from accessing routine services	-Non-use of services, in part due to self-exclusion
	Lack of assistance provided to Dalits by higher castes at the time of emergencies	-Delayed use of services -Substandard quality of care
Service provider discrimination	Services provided to others withheld from Dalits	-Higher morbidity and mortality
	Longer waiting times for Dalits than others in receiving treatment, or being treated last	
	Unwillingness to physically touch Madhesi Dalits	

3.6.3 Faith-based barriers to accessing health services: the case of Muslims

Given the existing evidence for a need to better engage Muslim populations in formal health service provision, it is particularly important to understand the impact of faith-based beliefs and the practice of purdah on access to services.

The interpretation of Islam in Nepal results in non-acceptance of particular services such as safe abortion or FP. However, religious codes of practice such as purdah have a broader impact on reducing/preventing women's and girls' access to a wider range of services.

The importance of both following religious teachings and not being perceived by others within and outside the family of transgressing religious codes of practice increase control and punishment of women by parents-in-law and husbands.

The practice of purdah, in particular, limits communication between a married woman and men other than her husband, places strict control over women's mobility and use of space outside the home.

NDHS data from 2006 and 2011 highlight an increasing need to better engage Muslim populations in formal health service provision due to:
- Highest, and increased, TFR (4.6-4.9)
- Decreased measles immunisation rate (77%-57%)
- Continued unmet need for FP (at 37%, the highest for any ethnic/caste group)
- Increased CPR (17%-23%)
- Lowest (though increased) rates of attendance for at least four ANC visits (18%-35%) and of receipt of IFA tablets or syrup (54%-75%)
- Comparatively low (though increased) rate of institutional deliveries (12%-32%), compared to other groups in Terai areas.
(Source: Bohra et al (2012)

The inability of women to communicate with male doctors extends beyond talking about personal and private issues, impacting on all aspects of health, while the problem of women having to reveal their bodies to male doctors also leads to lower uptake of services involving intimate procedures, such as those involved in maternal health, abortion, and FP services.

"Muslims do not take pregnant women to the sub-health post or health post. The religious leaders prohibit for that. Even the man feels ashamed on doing this as she reveals her body" (Female, Banke, Study 1).

"In the birthing centre of the health post, male staffs also come in. Women feel very embarrassed by this, because they will be without burka" (Male, Banke, Study 1).

The importance of not being seen to transgress religious codes of practice leads to anxiety about becoming a source of gossip within the community and bringing shame on both the individual and the household.

Table 13: Summary of the Influence of Poverty and Caste/Ethnicity on Access to Services

| Challenge	Key group	Impact
Economic dimensions of poverty	All	- Inability to afford transport - Inability to afford medicines - Inability to afford associated costs (e.g. of tests)
Social dimensions of poverty	All	- Lack of education and awareness about health issues - Restrictive influences from other household members - Varying degrees of exposure to available services
Discrimination	Dalits	Feelings of indignity and shame as a result of discrimination by service providers
Spiritual beliefs	Chepang	Seeking alternative providers
Religious beliefs	Muslims	- Verbal and physical contact avoided between women and male service providers - Strict codes of conduct for women - Strict religious directives regarding FP and abortion

Implications

- Lack of access to care, delayed access to care, and poor quality care need to be addressed. At present, exclusion from services (either self-imposed or imposed by others, e.g. service providers) results in all three, and to utilisation of alternative sources of care, particularly traditional healers.
- Specific measures need to be put in place to increase opportunities for the most vulnerable to access routine and emergency services, including possible revisions to existing financial subsidy programmes and referral systems.
- Direct and opportunity costs of accessing care are greatest for the poorest and those most marginalised by caste/ethnicity/religion. The potential negative financial and social impacts (at household and community level) of attempting to access care are significant. As a result, it is particularly important that efforts to access facilities should be successful (in terms of facilities being open) and result in a positive experience (in terms of receiving sensitive, quality care from providers, and where possible same-sex providers).
- Increased awareness of health entitlements and benefits of accessing services is essential for household-level decision makers as well as women themselves.
- Support community-based programmes that foster spousal support and strengthen community outreach services to enable men and women to covertly go against cultural or religious norms.

3.7   Supply-side barriers

Supply-side, or service-related, barriers that reduce or prevent access to care are experienced directly at the point of service delivery, but also interact with and sometimes fuel related social, financial, and geographical barriers in the home and community, and in the journey to services. Service-related barriers, for example, impact on willingness to invest time and money on the journey to the facility, and the willingness of mothers-in-law to allow daughters-in-law time away from their domestic duties. The diagram below illustrates how service barriers link and synergise with other barriers along the pathway to care.

Figure 4: Supply-side Barriers and their Interconnected Effect on Access to Services
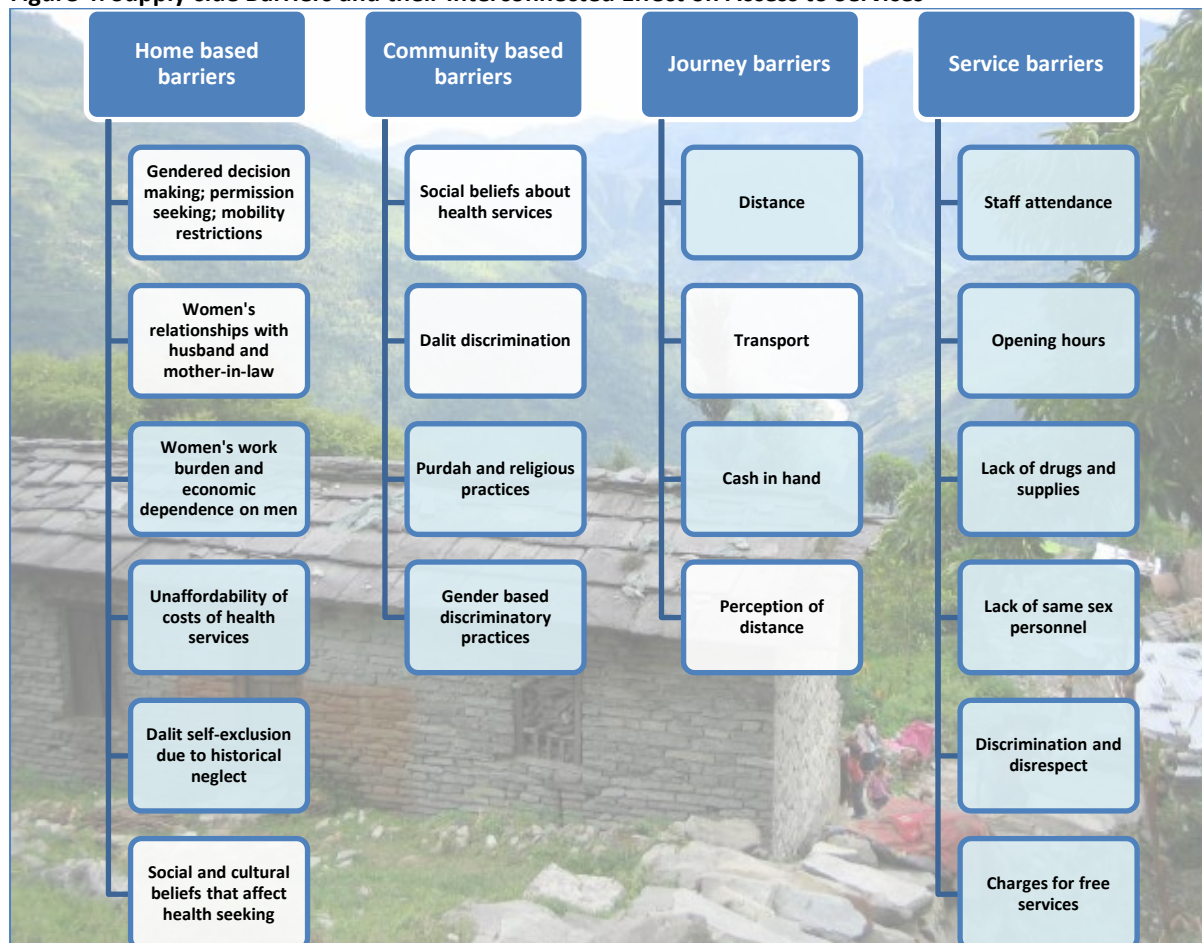
A range of supply-side barriers are experienced in both the Hills and Terai which affect the direct and indirect costs of health care and impact on the uptake of EHCS, and the extent to which people resort to the use of traditional healers (Figure 5).

Figure 5: Impact of Supply-side Gaps on Direct and Indirect Costs and Service Uptake
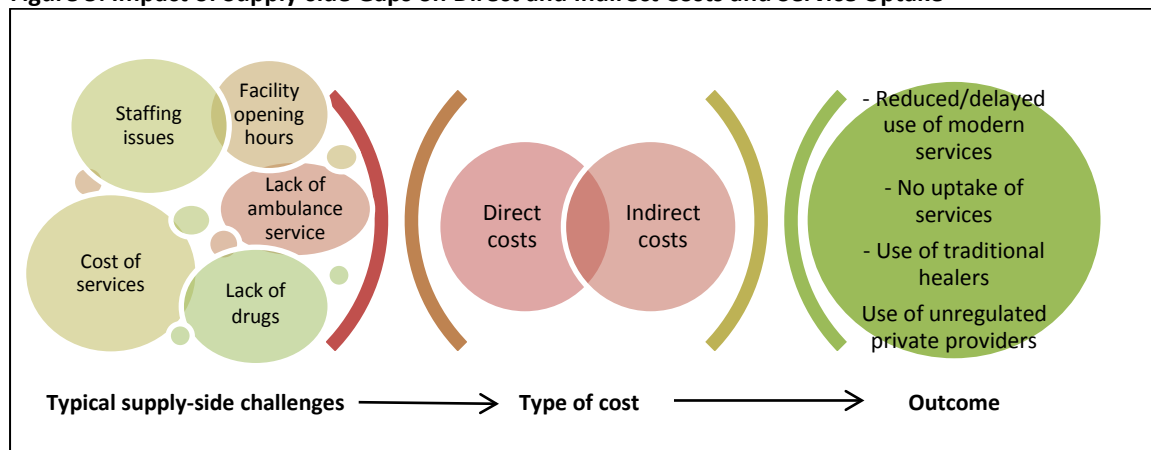
Although the main barriers to service use (lack of staff and direct and indirect costs) are relatively similar in both the Hills and Terai, they are often experienced differently as a result of specific features of service delivery and user expectations. For example, in Terai areas, these barriers were described as resulting in overcrowded health services and, therefore, the use of 'briefcase doctors'.[34] In Hill areas, the barriers were compounded by a lack of alternative local private providers and thus greater use of traditional healers.

3.7.1 Service provider attendance and facility opening hours

Facilities are often open for short periods of time, most commonly between 10.30 a.m. and 2.00 p.m., and only on a few days each week. As previous sections of this report have shown, accessing health facilities is challenging for many people, owing to multiple challenges associated with gaining family approval to seek services, distance from services, lack of transport, and the time taken to reach facilities, etc. Women, in particular, are constrained, because of their domestic and (sometimes) livelihood responsibilities, which must be completed before leaving the home.

> *"No health worker will be there in the health facilities. They come at around 12 noon and return after 2pm, which causes difficulties for us. Or before 10.30am health centres don't open and after 2pm no one stays there. So we have to return without treatment"* (Male, Saptari, Study 1).

High levels of absenteeism among facility staff and limited opening hours further limit access to

> *"Sometimes there will be only the nurse, but there will be no doctor in the health post. People are asked to come back the next day. So people cannot get services"* (Female, Dhading, Study 2).

service providers, even when facilities are actually reached, since many people seeking services do not arrive until service providers are working their way through a queue of patients and are not accepting new arrivals. As a result, people are sent away without being seen. In other instances the facility may not open at all because of staff absenteeism. This is a clear example of the interplay between supply-side and socio-cultural barriers to accessing care.

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[34] The Nepali term for this is '*Jhole daktor*', meaning 'the Doctor who always carries medicine in his bag'. These 'Jhole daktors' are found mostly in the Terai region of Nepal. They provide health services to people at home, and often have some basic or preliminary medical/health care training. However, they do not have any official status, they are not regulated by any governmental bodies, and do not fit within the formal health care system.

Lack of specific skills among facility staff, particularly relating to FP services (such as fitting implants, IUCDs, or undertaking vasectomy and minilaparotomy operations), was reported in many study areas, and has also been found in other studies,[35] adding to the inaccessibility of services.

The unpredictability of both opening hours and staffing at HPs and SHPs means that knowledge of the benefits of utilising health services, and encouragement by peers and family members to do so, is offset by uncertainty as to whether:

- A facility will be open
- Service providers will be at the facility
- The facility, if open and staffed, will be over-crowded
- Free drugs will be available and if not, whether the user can afford to purchase them from alternative sources
- Treatment will be withheld because of limited opening hours, staff limitations, or discrimination
- Time and money will be wasted in fruitless travelling.

As a result, local people become discouraged from using facilities, trust in the ability of health services to provide for their needs decreases, and utilisation of traditional healers and unregulated private providers increases. In contrast, staff who were perceived to be dedicated to their work, were available at health services, actively encouraged people to attend the facility, and treated them well at point of contact, as well as making efforts to raise awareness of available services, were described as significantly increasing people's willingness to invest time and money in travelling to health facilities.

3.7.2 Indirect cost of services

The indirect costs of accessing services are substantial for many households, and have largely been covered earlier in the report. The key indirect costs of a return journey to a health centre include transport fees, clothing, shoes, food, and porters to carry someone who is a delivery case, or ill and in need of treatment. These costs were more commonly talked about in the Hill areas and were often described as being greater than the actual costs of procedures and treatment.

> "It's a long way to hospital along the riverside which is risky on the one hand and on the other, they need to pay porters and buy snacks for the porters but do not have money" (Female, Dhading, Study 1).

3.7.3 Direct cost of services

The STS 2011 showed that 90% of outpatients at district hospitals, Primary Health Care Centres (PHCCs), HPs, and SHPs were aware of, and receiving, their entitlements to free EHCS. This is a marked increase from 2008/09, although the rate of increase was slower at HPs and SHPs than in other health facilities, and was also lower in Hill than in Terai districts. [36]

> "They charge NPR 50 in pregnancy check-up for urine test at the health post, but we don't have that money" (Female, Banke, Study 1).
>
> "Even Rawatik and Chamar have the problem of money also there. Their economic condition is weak. They have not taken these services from the bazaar. They even do not know about the free service" (Female, Banke, Study 2).

Many households participating in this PEER study in both Terai and Hill areas had much lower levels of knowledge of their health entitlements. This, combined with very limited access to cash and the impact of both indirect and opportunity costs, such as loss of productive labour, is influential in preventing people from accessing services, particularly if local alternatives such as briefcase doctors or traditional healers are present and available.

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[35] See Acharya and Cleland (2000) and Pradhan *et al.* (2010).

[36] Suvedi *et al.* (2012).

Of concern, however, is that just as the STS 2011 showed that 31% of outpatients reported having paid for services that should have been free (including drugs), so respondents in this study also reported having to pay for free services, such as vaccinations and urine tests. Not only is this in direct conflict with their health entitlements but it also contributes to the perception of poor and cash-limited households that services are unaffordable, in part at least because of the direct cost of services and medication, and results in the distrust of the service providers and their corrupt practices.

The cost of safe abortion services was reported to be particularly prohibitive, both in terms of the fees charged and because it involved travel to urban areas which were often far away. As a result rural women are particularly disadvantaged.

3.7.4 Lack of same-sex health personnel

Traditional social norms of communication between men and women, particularly outside the household, create challenges in interaction with health workers as the absence of same-sex health personnel means transgressing conventions relating to male-female interaction and physical contact.

Women in Nepal across all social groups (though with slightly fewer constraints amongst some groups of Janajati women), are required to be quiet and submissive in their communication, particularly with men, older women, and those of higher status, in terms of wealth, caste, education, household status etc. For Muslim and OBC women this is further compounded by religious beliefs and adoption of purdah. The power imbalance between male users and health service providers is also substantial and complex (for example in the case of rural men and female health workers). Thus communication challenges are heterogeneous and affected by generation, wealth, ethnicity, religion, and caste among other factors.

These issues, together with the often personal nature of issues such as FP, delivery, and safe abortion etc., mean that shyness reduces the amount and content of communication between those seeking and those providing services. It is also often sufficient to prevent people from accessing services. This was reported as an important barrier, particularly in relation to FP services and institutional delivery, across all twelve study sites, and in other studies.[37] Given the prohibitive costs of accessing services outside the local area and social pressure from elders and in-laws, women were often left with no other option but to give birth at home.

> "Most of men and women are not taking health services like family planning and safe abortion service because they are shy to talk to other sex" (Female, Doti, Study 1).
>
> "Even though husbands and mothers-in-law ask them to go, women feel shy to show their secret organs to someone. It is better to just die at home" (Female, Dhading, Study 1).

The contradiction between different 'ways' of communicating within the home and within a health facility, and the challenge this presents were often overlooked by service providers. Similarly difficult is shedding deeply entrenched expectations of gendered behaviour, which, for example, deter men from seeking FP services from FCHVs.

3.7.5 Overcrowded health services in Terai study areas

Health facilities in Terai areas are particularly overcrowded as a result of the greater density of population living within a (relatively) close radius to health facilities (as identified in 2011 STS data[38]).

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[37] See, for example, Pradhan, A. *et al*. (2010).
[38] Suvedi *et al.* (2012).

Overcrowding of health services had a two-fold impact:

- Doctors and health workers limited the number of patients they claimed to be able to see and sent the rest home, requesting that they visit another time.

> *"The sub-health post is often heavily crowded and there is only one doctor and he cannot check up all the people visiting there"* (Male, Banke, Study 1).

- Waiting times were long, impacting on women's domestic and livelihood duties, and often resulting in punishment when they returned home, and deterring them from future visits.

3.7.6 The use of 'briefcase doctors' in Terai areas

Overcrowded health services meant that respondents felt it necessary to look for alternative options. In Terai studies, respondents used local 'briefcase doctors' or private medical pharmacies, who were often more easily accessible.

> *"Often I buy medicines from the briefcase doctors. They carry their medicals tools and equipment in their bags"* (Male, Banke, Study 1).

> *"Health staff are there but not in the morning, evening and night time, so, they have to wait – better to go to witchdoctor for traditional healing who is available anytime"* (Female, Dhading, Study 1).

'Briefcase doctors' were largely assumed to be qualified doctors, and were viewed as enhancing access to health services. However, several associated risks should be highlighted: at the time of study, briefcase doctors were not registered in any government institutions; there is no accreditation of skill and knowledge levels; they are not monitored and regulated by any agency; and they charge for services which should be free at public HPs.

3.7.7 Lack of private health services in Hill areas

There are fewer alternative providers of modern health services in Hill areas. The private drug stores that do exist are often run by staff from the local health facility, and provide drugs but not consultations. As a result, people living in Hill areas have limited access to either public or private services. This challenge, combined with long distances to health facilities, associated costs, staff absenteeism, and restricted opening hours, results in traditional healers often being used instead.

3.7.8 Lack of ambulance services

The lack of an ambulance service in most study areas, irrespective of terrain, curtails access to health services. However, people living in Terai areas had greater expectations of transport facilities and the opportunities these would provide to access health facilities in local towns and cities. This resulted in higher levels of dissatisfaction at the poor quality/absence of an ambulance service.

3.7.9 The impact of supply-side challenges on uptake of four focal services

The cost of **safe abortion services** provided by both public and private service providers varied widely and often involved additional costs due to complications. As a result, many women either continue with an unintended pregnancy or use cheaper local, unsafe abortion methods instead. Even if safe abortion services were available locally, it is questionable whether women would use them, owing to the sensitivities and moral framing of abortion and uncertainty over its legality. Further research, drawing on primary evidence along existing secondary data, would be required to explore how best to provide confidential local services and increase public acceptance of safe abortion as a legal method which has a very substantially reduced risk of morbidity and mortality than use of traditional or unsafe methods.

> *"There is no safe abortion service in the health post of the village but one can do abortion of unwanted pregnancy outside the village. Or if there is no safe abortion service in the village, therefore some women take herbal medicine for abortion, but then they can suffer from over bleeding. Some women die because they don't access health services"* (Female, Doti, Study 1).

Two key supply-side barriers reduce access to **FP** services. The first is the lack of same-sex health workers from whom to seek FP services. The second is the lack of trained local services providers with the expertise to provide specific FP services. For short-term and medium-term contraceptive methods this meant limited staff trained to fit an implant or an IUCD at peripheral facilities. For permanent FP methods, there were neither the staff nor the facilities to operate on men or women. Additionally, the side effects of FP methods were a deterrent.

Key service-related barriers to accessing **maternal health** include: the predominance of male staff, coupled with women's shyness in revealing private body parts to males; the lack of birthing centres in rural and remote areas; and the non-attendance of service providers at home deliveries. The often prohibitive costs of accessing services outside the local area, and elders' and in-laws' perception of the lack of need for institutional delivery, means that women are often left with no other option but to give birth at home.

Of the four service areas, the fewest barriers were associated with access to **child immunisation** services. This supports NDHS 2011 data indicating the high take-up of child vaccination services. The percentage of children aged 12-23 months who are fully immunised has doubled in the past 15 years, from 43% in 1996 to 87% in 2011.[39] This is in part due to outreach services, which have taken services closer to the home and contributed to the normalisation of child immunisation. The barriers that do exist are more related to demand-side issues (e.g. belief that there was no need for completing an immunisation cycle or that side effects such as fever are dangerous), which the supply side has not fully taken into consideration.

Table 14: Summary of the Influence of Supply-side Constraints on Access to Services

Challenge	Key location	Outcome
Cost of services, e.g. safe abortion	All	
Charges for free health entitlements, e.g. immunisation and urine tests	All	• Delayed uptake of modern services • Reduced uptake of modern services • No uptake of modern services • Use of traditional healers • Use of unsafe and costly services from private providers
Staffing, e.g. absenteeism, limited facility opening hours, lack of same-sex staff	All	
Lack of private modern service providers	Hills	
Transport, e.g. frustration at lack of ambulance service	Terai	

Implications
- Staffing issues are influential on uptake of services and are experienced in different ways; key issues needing to be addressed are: ensuring appropriate numbers of staff are allocated to individual facilities, drawing on local resources as needed, staff attendance and reducing avoidable absences, increased supervision and monitoring to reduce absenteeism, and placing a mix of male and female staff in each facility.
- Frustration at lack of services for referral and transport can be more significant in areas where their presence is seen as possible and having an immediate impact, rather than where their introduction would require substantial infrastructure improvement.
- Increase knowledge of entitlements through public information campaigns and strengthen local accountability mechanisms to reduce charging for free services and drugs.
- Strengthen referral transport systems and support communities and VDCs to develop local emergency transport solutions.
- Increase and strengthen the delivery of outreach and home-based services to reduce travel time and costs to the user of visiting facilities; for those services that need to be provided in a facility setting, explore the possibility of DSF mechanisms such as vouchers to help users overcome costs of reaching them.

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[39] MoHP *et al.* (2012).

4   RECOMMENDATIONS

This study, and other evidence in Nepal and globally, have shown that access to services is dependent on a complex mix of factors operating at individual, family, and community levels on both supply and demand sides.

The recommendations set out below seek to strengthen the government's health services as well as the health systems that underpin them, to deliver accessible EHCS to women, the poor, and excluded groups. The recommendations are presented in three sections and are targeted to their respective audiences:

- The first section concentrates on health systems and policy implications and is targeted at stakeholders in the Ministry.

- The second set of recommendations offer practical and programme-related suggestions to the technical divisions which oversee the four focal services of the study.

- The third set of recommendations address the main demand-side barriers – informational, socio-cultural, geographical, transport, and financial – which interplay with health service barriers and are relevant to policy makers, sector specialists, technical programme managers, and district authorities.

4.1   Headline recommendations for the MoHP

The study found a number of common barriers and service gaps facing women and their families in accessing FP, immunisation, maternal health, and safe abortion services. They point to the need for improvements in the way health services at the district level and below are planned, managed, and delivered to increase access to, and use of, all four of the focal services under investigation, and the broader package of EHCS at the primary level. (See Appendix 10 for discussion of enablers reported to increase access to services).

4.1.1   Improve quality and delivery of peripheral-level health services

Contrary to survey findings (e.g. STS 2011) that suggest a widespread user perception that quality of services is satisfactory, this study found that poor and excluded women and men were critical of quality-of-care shortcomings. Access to services was found to be undermined by: short and unreliable opening hours; absenteeism and the non-availability of staff; lack of privacy, especially for women; and disrespectful, discriminatory behaviour towards women, Dalits, and the very poor. These findings may not be new, but this study has illustrated how service deficiencies exacerbated demand-side barriers, and added to the multiple levels of exclusion that poor women and children faced in accessing services.

Improving the quality and delivery of peripheral health services is fundamental to improving coverage of the poor and underserved as these are the services to which they have greatest access on the grounds of social permission, affordability, and distance. This will take a multi-faceted health systems and institutional response; we appreciate that this is work in progress and an important goal of the government. Based on the findings of the Rapid PEER study we suggest:

4.1.1.1   Raising the availability of staff:

First, there needs to be a thorough understanding of the reasons for non-availability at the local level. Reasonable causes of absences may include training, pregnancy, child care responsibilities, and lack of staff quarters. Such reasonable workplace absences could be addressed through short-term

replacements, provision of child care support in the workplace, and provision of accommodation. Every effort needs to be made at the district level to address reasonable absences. In addition, we recommend that the National Health Training Centre (NHTC) review the length and modality of training programmes in order to reduce the length of time staff spend on training away from the workplace.

4.1.1.2 Increasing opening hours:

The study found that many people were unaware of the official opening hours of HPs and SHPs, and that facilities were generally open for fewer hours than the official daily requirement of 10 a.m. to 4 p.m. (where the period from 2 p.m. to 4 p.m. is commonly kept aside for administrative purposes). We recommend that MoHP authorise peripheral facilities to adhere to longer opening hours of six hours per day, and for health workers to agree the opening timings with the local community. Greater public dissemination, using a variety of media, of the opening hours and services offered at each facility is also needed.

4.1.1.3 Improving Gender-Equality-and-Social-Inclusion- (GESI-) responsive service provider behaviour:

o   We recommend that the ministry introduce a Code of Conduct for Health Workers to promote respect and dignity in the way that health workers communicate and treat all peoples.

o   To reward positive behaviour, we suggest greater use of appreciation certificates, non-financial rewards, and recognition by district authorities of staff that are outstanding in their efforts to reach excluded groups. Health Facility Operation and Management Committees (HFOMCs) can play a useful role in identifying those who are outstanding contributors. The example from Dhading, where service providers favour people travelling long distances, ensuring that when they arrived at the HP, they know they will be seen and be able to return home as quickly as possible, is an approach to be replicated.

o   Strengthen the Interpersonal Communication (IPC) skills of the health workforce through training, supervision, and monitoring, particularly at the local level, to encourage and enable women to access services.

4.1.1.4 Increasing social diversity among health workers:

The study clearly identified the cultural and social behaviour patterns which inhibit access to, and use of, health services by people of different social groups. To be able to recognise and respond to such issues, diversity amongst health workers is essential, as their perspectives and understanding of community dynamics will assist the poor and excluded to be better informed about services, and will build confidence to access health facilities.

To tackle discrimination against Dalits specifically, we recommend that the MoHP seek to increase the number of Dalit FCHVs and other health workers, and promote non-Dalit champions within the health system. Beyond service delivery, to build the confidence of Dalit people, we suggest the government work with Civil Society Organisations (CSOs) on untouchability in the community, and link with wider social mobilisation programmes addressing social discrimination.

4.1.2 New initiative to improve access to services in remote areas

The complexity of access in remote areas requires a multi-faceted response addressing demand and supply-side barriers, and leveraging government agencies, civil society, and business stakeholders. We recommend that the government earmark funding for a special initiative to pilot and test different approaches in a small number of districts, within a variety of remote conditions and communities. This would include districts where the majority of the population lives in remoteness, and those with small populations living in remote pockets. This initiative will need to be designed to

become an innovative programme (like the Aama Surakshya Programme (Aama)) addressing many of the issues of geographical exclusion constraining access of different social groups in different areas of Nepal.

4.1.3 Work in partnership with other agencies to address social and cultural factors

To address the social and cultural beliefs and practices that hinder access to services and negatively affect health and well-being, communities need to be mobilised, women empowered, and husbands and in-laws persuaded to allow women to use health services as needed. This will require localised and effective Information, Education, and Communication (IEC)/BCC delivered in a culture- and context-specific manner, and political commitment and support to the recognition that health services can no longer be separated from family practices and norms.

We recommend that the MoHP work in partnership with other government agencies and CSOs, as planned in NHSP-2, to support the social change process and the communication efforts required at the family, community, and society levels. This will require the establishment of systems and procedures to enable government to support non-governmental partners to work effectively at the local level, with strong governance frameworks and coordination.

4.1.4 Strengthen local-level planning at district and facility levels

The identification of families, communities, and social groups that are excluded or underserved, and the reasons for this exclusion, is fundamental to improving coverage. It is important to note that barriers associated with being poor and excluded (and female) occur across all social identities, and that simple association by caste/ethnic group is inadequate as a basis for health service planning and delivery, and similarly, that ignoring caste/ethnicity can lead to ineffective service delivery. Local-level planning at district and facility levels requires more systematic and regular mapping of the geographical areas, and social groups that are not using services and the reasons why, in order to better plan and target services to underserved populations.

We recommend a similar process at the facility level to identify who is not using services and why. Based on such analysis, in consultation with stakeholders, the facility can target services and health promotion to underserved populations. This could include additional Outreach Clinics (ORCs) in difficult-to-reach areas, community health clinics, engaging additional FCHVs to target excluded groups, or rotating specialists and doctors into health facilities in remote areas. A facility-level action plan to improve coverage of unreached populations in the facility catchment area, developed with the support of the HFOMC, can provide a focus for mobilising local stakeholder support and for monitoring processes.

4.1.5 Introduce flexible district-level funds targeted to reaching unreached groups

Generic service delivery approaches cannot overcome the specific barriers faced by different social groups in accessing services. There is therefore a need to tailor service delivery approaches to the needs and context of local communities and the excluded groups within them. For example, while awareness-raising through mothers' groups may be feasible for some social groups, this may be inappropriate for others, such as Muslim women who are restricted in their movements outside the home, and who need more doorstep services.

To enable context- and need-specific strategies and service delivery approaches, we recommend the introduction of flexible district funds targeting unreached groups under the authority of the District (Public) Health Officer.[40] Guidelines would need to be developed to frame the objectives of the fund, mechanisms for implementation, and procedures for monitoring and accountability. We suggest that

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[40] This has recently been identified as an intervention by Management Division in their AWPB of 2012-13 but has as yet not been implemented.

the fund be designed so that it also encourages facility-level providers to identify, plan for, and serve unreached and excluded groups, possibly through conditional transfers based on performance against utilisation by target populations.

4.1.6   Strengthen HFOMCs and leveraging of local stakeholders

HFOMCs that have the capacity to understand and address the barriers faced by women, the poor, and the excluded, can be a driving force for inclusive development and health service delivery. We recommend that HFOMC membership be broadened, specifically to involve local community women, and members from poor and excluded populations who are representative of the local area. We also recommend that the capacity of HFOMCs is built to raise their awareness of the disadvantages faced by remote and excluded groups in accessing health services, and to equip HFOMCs with the skills necessary to improve the delivery of services to unreached populations.

This will also entail strengthening the capacity of HFOMCs to leverage local stakeholders – e.g. VDCs, District Development Committees (DDCs), local businesses, Non-governmental Organisations (NGOs) and other CSOs – for resource mobilisation, implementation partnerships, and advocacy. For example: practical support and partnerships could be forged to fund the referral costs of the ultra-poor, organise local transport solutions to connect distant communities to service sites, and integrate health messages and information into local community development programmes.

HFOMCs must also be strengthened to monitor service delivery and service providers, and be part of community-based monitoring practices. MoHP might consider providing block grants to local HFOMCs (learning from the practice in the education sector to School Management Committees) which will enable them to work more effectively. Accountability mechanisms would need to be established with clear supervision and reporting lines.

4.1.7   Strengthen accountability and transparency of local health services

This study shows that access to information on entitlements and the availability of services among poor and excluded communities is poor. Although many people perceived services to be of poor quality, citizens rarely raised their voices to make demands on providers, and seek accountability for the gaps in service delivery.

We recommend that accountability and transparency be increased at the local level through:
o   Better public dissemination of information, such as the provision of Aama entitlements, the availability of free care, and the timings of facilities
o   Strengthening the capacity of HFOMCs to provide oversight of service delivery, and respond to local needs and demands
o   Strengthening mechanisms to develop/initiate and maintain a cordial relationship between service providers and users
o   Strengthening mechanisms to monitor and act on irregularities within the health system through the supervision and monitoring system, and the complaints system, as well as through community-driven processes such as social audit and public hearing
o   Drawing on learning from governance experiments in Nepal, such as the Local Health Governance Strengthening Programme, and social auditing, to take successful initiatives to scale
o   Sanctioning illegal practices and discriminatory practices and behaviour through improved governance and stronger human resource management
o   Acknowledging and honouring local bodies, health providers, teachers, students, and others who have demonstrated initiative and good practice in addressing the needs and priorities of women, the poor, and the excluded, and who have improved governance practices in health services.

4.1.8 Policy implications

The findings of this study, particularly around the need for changes in the home, and GBV, including sex-selective abortion, suggest the need for policy and programme development in specific areas. The need to take health service interventions into the home – to elicit change in the socio-cultural values that act as barriers to health outcomes – is key. This will require policy recognition of the need for MoHP to have a greater, more active influence on the social and gender norms that inhibit women's and children's access to EHCS; further, it will require the prioritisation of related programmes and operational modalities, such as BCC programmes targeted at men and family gatekeepers, and the establishment of flexible district funds.

4.1.9 Inter-sectoral coordination

Given the multi-sectoral nature of access, we recommend that MoHP advocate to, influence, and work with the NPC, Office of the Prime Minister and Council of Ministers (OPMCM), and other ministries to develop a multi-sectoral policy and plan to address the barriers faced by women, the poor, and the excluded in accessing health services and improving health outcomes. As with the Multi-sector Nutrition Plan, developed to address malnutrition, this enabling access to health plan will need to be led by the NPC, with specific roles and responsibilities assigned to different ministries to address issues of discrimination and exclusion.

4.2 Programme-specific recommendations

The table below (table 15) sets out recommendations specific to the four services investigated by the study.

Table 15: Recommendations for Immunisation, FP, Maternal health and Safe Abortion Services

Health service	Practical steps to be taken by Department of Health Services (DoHS), district managers, and health workers
Immunisation	• Review and strengthen the implementation of 'Reaching Every District' to bring services close to all children, especially those from poor and excluded communities. • Provide capacity building to Village Health Workers (VHWs), Auxiliary Health Workers (AHWs), and contracted service providers on addressing the barriers to immunisation and achieving universal coverage experienced by different social groups. • Continue identifying left out/drop-out children and communities, and the reasons for non-use of/drop-out from immunisation, through household visits, review of existing data, and consultations with local leaders and communities. Include this as an activity in the programme directives sent out to districts after the Annual Work Plan and Budget (AWPB) approval. • Develop a local plan for immunisation in consultation with local communities, including excluded groups. This will include the reasons why some children are not using services, including such factors as misconceptions about side effects, knowledge of immunisation completion, delays at service points, and convincing community and family decision makers of the need for, and importance of, immunisation. The service response may include: (i) targeted communication (e.g. household visits by FCHVs, mothers' groups, Imams talking to Muslim communities, VDC meetings); (ii) targeting of ORCs; (iii) follow-up by HFOMCs to ensure that children not immunised are included in the future; (iv) social mobilisation. • Contract service providers that represent the communities they serve, and strictly monitor performance with support from the community. • Monitor the take-up of immunisation amongst left-outs/drop-outs at the facility and district level, design additional approaches, and provide extra inputs to fill gaps.
FP services	• Understand the reasons why couples are not using FP methods in the local community (e.g. lack of information/concern of side effects/lack of availability of service/social pressure). • Develop targeted communication approaches based on local contexts to reach women, men, parents-in-law, and community influencers. This may involve IPC at the home, use of satisfied clients and couples to share experiences amongst wider community members, information-sharing via mothers' groups, women's groups, and community events, and Imams as communication agents. • Through partnerships with local NGOs, develop mobilisation strategies using male mobilisers to inform men about the use of FP devices and change attitudes towards women's use of different contraceptive options.

Health service	Practical steps to be taken by Department of Health Services (DoHS), district managers, and health workers
	• Enhance skills of service providers so that they can provide quality services close to the community (HP/SHP/ORC). Provide training to Auxiliary Nurse Midwives to deliver IUCDs and Norplant with appropriate supervision and support; improve counselling skills of health providers for both motivation of couples and post-FP acceptance advice. • Provide improved quality of services at FP camps, including counselling of couples before and after acceptance. • Test the provision of a voucher to compensate sterilisation clients, to support coverage of transport, food, and rest. • Strengthen the monitoring of communication activities and the take-up of services; identify underserved communities, and through consultations develop interventions to address poor access.
Maternal health (iron, deworming, tetanus vaccination, ANC, institutional deliveries)	• Understand why women are not using maternal health services or dropping out. • Develop communication approaches to reach women, men, and in-laws to recognise the benefits of four ANC visits, institutional deliveries, Postnatal Care (PNC), and the dangers of home-based delivery. • Review Aama programme to measure its ability to overcome the financial barriers faced by the ultra-poor and geographically excluded where communities have to travel beyond District Head Quarters (HQs) for services. Develop additional financial support to increase access of these groups, an Aama +. • Develop innovative approaches to functionalise birthing centres that are accessible to poor and excluded communities. For example, positioning birthing centres to support a cluster of VDCs where there are underserved and high-population areas, and where the birthing centres can also receive support from district and referral hospitals, including, for example, rotational staff. • Contract NGOs/private providers to provide services in underserved areas with monitoring by government. • Develop local and long-distance transport mechanisms for referrals from birthing centres to hospitals. • Functionalise birthing centres in the periphery in partnership with VDCs, HFOMCs, local NGOs, and other stakeholders.
Safe abortion services	• Develop communication strategies to raise *awareness* of the availability of safe abortion services, the dangers of "unsafe/traditional" abortion methods; *inform* families of the illegality of sex-selective abortion, the circumstances where abortion is legal, the consequences of unsafe abortion on the health of the woman, and the benefits of FP to prevent unwanted pregnancies; and raise the *value* of the girl child, and women's empowerment. This will require IPC, group-based communication, mass media, and inter-sectoral work to support empowerment of women and girls. • Expansion of safe abortion services in strategic peripheral locations in remote rural districts. • Develop communication messages and social mobilisation to address the social and cultural beliefs and attitudes around abortion, including stigma and taboos. These will need to be tailored to the local context and population, and involve community-wide approaches and champions. • Train service providers to provide client-oriented counselling to counter repeat abortion. • Strengthen the monitoring of sex determination tests in both private and public facilities, and enforce sanctions on provision of sex-selective abortion, which could include the closure of private clinics.

4.3 Recommendations specific to demand-side barriers

Poor and excluded people, especially women of these groups, face multiple and interconnected barriers to accessing all health services. In this section we focus on the underlying gender, socio-cultural, informational, geographical, transport, and financial barriers that inhibit access to services, and present action that government can take to address them.

Table 16: Steps to be taken to address underlying barriers that inhibit access to services

Thematic issues	Steps to be taken by MoHP/DoHS/district authorities
Gender: increase women's decision-making power, and	• Strengthen and expand existing women's empowerment programmes, such as MoHP's EAP, ensuring that women of different social groups are reached in a context-specific manner. • Strengthen existing and establish new mothers' groups to inform, build confidence, and

Thematic issues	Steps to be taken by MoHP/DoHS/district authorities

reduce the constraints placed on women's mobility and interaction with men and in public spaces	sustain discussion.
	• Increase interaction and IEC/BCC with men and mothers-in-law to change beliefs and attitudes, and make these messages specific to the social group, e.g. for OBCs and Muslims.
	• Increase interaction between family decision makers (husband and wife and/or mother-in-law and daughter-in-law).
	• Inform migrant husbands of the availability of and requirement for different health services for themselves and their families.
	• Work with and through FCHVs, mothers' groups, women's self-help groups, local and religious leaders, local influentials, NGOs/Community-based Organisations (CBOs), and local government bodies to increase acceptability of women's interaction outside the family and household, and promote women's agency, through:
	   o Training of FCHVs and mothers' groups
	   o Partnering with local CSOs
	   o Targeting local flexible funds to reaching unreached populations and increasing access to services.
	• Link with existing government initiatives, such as Local Government and Community Development Programme of Ministry of Federal Affairs and Local Development.
	• Strengthen and improve local-level planning and implementation of tailored outreach services.
	• Strengthen advocacy and linkages with other line ministries (e.g. Ministry of Education, Ministry of Local Development, and Ministry of Women, Children and Social Welfare) and CSOs for empowering women.
	• Develop a national programme or plan (like the Multi-stakeholder Nutrition Plan) for a multi-sectoral intervention to address the social determinants of access to health services.

Prevent, treat, counsel, and support survivors of GBV	• Strengthen women's decision-making powers as described above to reduce the incidence and social acceptability of GBV. • Strengthen FCHVs' and mothers' groups' capacities to mobilise against GBV, and support victims in accessing services. • Train and support local health workers and FCHVs to share information and communication on GBV services. • Build capacity of health service providers to recognise and provide sensitive and appropriate treatment of GBV survivors. • Strengthen One-stop Crisis Management Centres (OCMCs) to improve access and quality of treatment of GBV survivors. Use the health system to inform people at all levels about OCMC services, and to encourage GBV survivors to use them. • Strengthen linkages with other relevant ministries and programmes, (e.g. paralegal committees, CSOs, police) to address and respond to local-level violent incidents at joint district and community levels.
Increase access to information	• Improved IPC through FCHVs, health workers, HFOMCs, mothers' groups, schoolteachers, and local religious leaders. • Enhance access to information through accessible media such as community radio and Short Message Service (SMS) communications. • Diffuse local messages through accessible (visual) media, • Gather, develop, and disseminate information that enables women and men to understand the importance and availability of services.

Improve access to affordable and reliable transport	• Develop local solutions in different ecological areas, through:
	   o Identifying areas with severe transport problems
	   o Identifying appropriate means of local transport to respond to the problem
	   o Mobilising resources with VDCs, municipalities, Chambers of Commerce, businesses, and international NGO projects
	   o Making reservations for emergency cases on planes, buses, local vehicles, etc.
	• Develop and strengthen health system referral mechanisms from the community to different health facilities, along with efficient transport mechanisms.

Overcome the cultural barriers that Muslims face in accessing services	• Work with religious leaders to:
	   o inform them of the availability and benefits of health services and promote timely use of services;
	   o disseminate information from religious scripts about women's rights and endorsement of FP use.
	• Develop appropriate targeted interventions including IEC/BCC materials for Muslim communities.
	• Promote mixed mothers' groups with Muslims and non-Muslims.

Thematic issues	Steps to be taken by MoHP/DoHS/district authorities
	• Increase the number of Muslim FCHVs. • Link with other social mobilisation programmes and CSOs addressing moral beliefs constraining access.
Reduce the high dependence of Chepangs on traditional and spiritual healers	• Orientation training of traditional and spiritual leaders on the need for, and availability of, government health services. • Mobilisation and ongoing contact and communication between the health system and traditional and spiritual leaders. • Inform the Chepang community of the benefits of traditional healing, and the simultaneous need to seek allopathic health care.
Reduce the discriminatory behaviour and practices of service providers towards Dalits	• Orient, supervise, and monitor service provider behaviours for non-discrimination. • Incentivise treatment and delivery of services to Dalit communities. • Increase the number of Dalit service providers at the peripheral level, including FCHVs. • Mobilise Dalit communities for improved health and raise awareness of their entitlements. • Work in partnership with CSOs on the eradication of untouchability.

Reduce the financial barriers of the poor and ultra-poor	• Support indirect health costs of very poor people:
	   o Identify the ultra-poor based on tools such as wealth ranking developed by NPC.
	   o Establish and strengthen community-based funds; leverage VDC funds.
	• Strengthen existing DSF programmes to cover fully the out-of-pocket spending of the poor and ultra-poor.
	• Develop a national health financing strategy that is pro-poor.