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

Project overview and context

Maternal and neonatal health (MNH) care service is one of the most important components of Reproductive Health. It is important to improve the reproductive health status through the provision of equitable and high quality health care and health promotion, especially for mothers and children [1]. Maternal and neonatal care service is one of the most important pillars of the Safe Motherhood Initiative. Addressing maternal and neonatal health means ensuring that all women receive the care they need to be safe and healthy throughout pregnancy and childbirth. The health and interests of mother and child cannot be separated [2]. Due to the wide socio-economic differences the high quality reproductive health varies considerably between different regions of the world. Throughout human history pregnancy and childbirth have been major contributors to death and disability among women [3]. The maternal mortality ratio is 7.2/100000 live births in Australia [4], 6/100000 live births in Denmark [5], 30/100000 live births in Sri Lanka [6] and 170/100000 live births in Nepal [7]. Infant mortality rate is still very high, 37 per 1000 live births in Nepal [8]. The neonatal mortality accounts for 23/1000 live births in Nepal [9], whereas in Denmark it is 3/1000 live births, and 5/1000 live births in Sri Lanka [10]. The major causes for maternal deaths are hemorrhage (27.1%), hypertensive disorder (14%), sepsis (10.7%), unsafe abortion (7.9%), embolism (3.2%) and other direct (9.6%) and indirect causes account for 27% in the world [11]. Neonatal deaths are due to prematurity (16%) birth asphyxia (11%), Neonatal sepsis (7%), Congenital anomalies (5%), Pneumonias (3%), Neonatal tetanus (1%) and other causes (3%) [12]. These deaths are associated to three delays and as much as 67.4% women giving birth die at home due to delay in taking the decision to seek medical assistance; 11.4% die due to delay in reaching appropriate health care facilities; and 21.1% die due to delay in accessing the appropriate care at health care centers in world [13].

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

Research practicalities

The study was conducted in only one district of Nepal. This district is nondescript although does have reasonable (middle rank since its HDI value between 0.500 and 0.549) [17], facilities in terms of road, water, electricity, markets, facilities etc compared to other remote districts like, Mugu, Dolpa, Kalikot, Humla, Bajura, Bajhang, Solukhumbu, Manang, Mustang, Syan, Rukum etc. The maternal and neonatal care services of this district observed as poor at primary health care facilities; and 21.1% die due to delay in accessing the appropriate care at health care centers in world [13].

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

Abstract

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

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Home delivery at Banke district in 2010

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

Delivery practice experiences expressed by focus groups

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

Mother’s experience about auxiliary nurse midwives (ANMs)

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

Practical Lessons Learned

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

Conclusion

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

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

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

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

**Exercises and Discussion Questions**

1. In this study the researcher observed the quality of care experienced by birthing mothers in some areas of Nepal. What does this mean for the quality of services delivered by MNH?

2. What are the criticisms of this study?

3. What are the mothers’ expectations for good quality care from the MNH service?

4. What might be the methodological consideration of this study?

5. What are the corrective measures of quality of MNH?

**Further Readings**

1. Bornstein T (2001) Quality improvement and performance improvement different means to the same end? Quality assurance project’s information out let: center for human services Bethesda, MD 20814- 4811 USA Vol. 9 p -6 (Nov 1 2001)


**Learning Outcomes**

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

- Understand the mother’s honest opinion about the maternal and child health services in primary health care settings.
- Apply theoretical aspects into practical purposes.
- Lobby policy makers, implementers, and researchers to improve the quality of health services.

**Contributor Biographies**

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

Madhu Koirala and Sunita Dhungel also completed their Master of Science in Public Health SDU and Madhu currently working in the National Open College affiliated by Pokhara University as a Assistant Professor and Director for Research and Development. Vickie Owens completed her MPH (Primary Health Care) through Flinders University, Australia with one semester completed at SDU, Esbjerg Campus, Denmark as part of a scholarship and currently she is working in the Queensland Health (state health department) Australia. Ravi Kanta Mishra has received his Bachelor in Public Health and Master in Public Administration degree from the Furbanchal and Tribhuvan University respectively and he also has finished his Master in Public Health from the Tribhuvan University, Nepal. Currently he is working in the NHEICC as a Public Health Officer and Professor Arja R. Aro is working for Health Promotion Research at SDU, Esbjerg Campus, Denmark.

**References**


