

Support to the Safe Motherhood Programme

Equity and Access Programme KAP Study: Summary of Findings

*"A woman died in that village. Her family was poor and not able to meet basic needs for food and clothing. She lives with her husband, mother-in-law, sister-in-law and brother-in-law. They didn't permit her to go for antenatal checks in her pregnancy. They didn't let her go out to attend meetings or discussions in the community. They made her do heavy work at home. She experienced a long and difficult labour of four days but the family didn't take her to the health post. Finally she was taken to the PHC where she was referred to the district hospital. But they didn't take her there. Instead they took her home. After some time she died."*¹

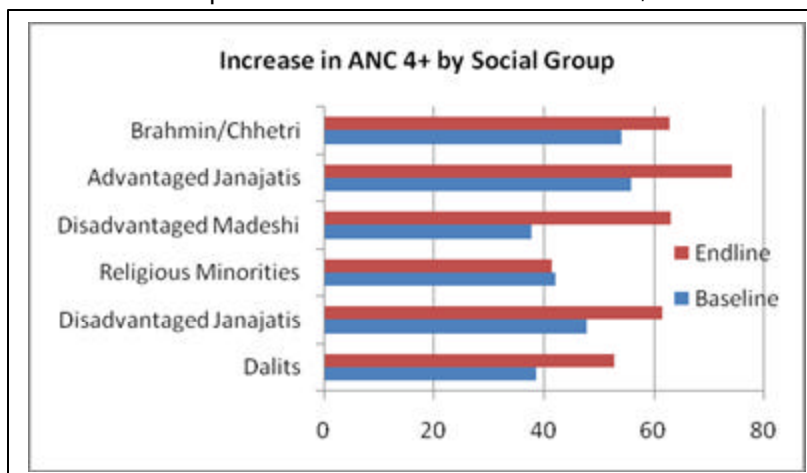
Headline Achievements

What is the Equity and Access Programme (EAP)? Launched in 2006, EAP is a community mobilisation programme aimed at improving maternal and newborn health (MNH) among the poor and excluded. Operational in full in 8 districts spread across the country, covering the Terai and Hills, it has been implemented by ActionAid Nepal and New Era in partnership with district level NGOs, and through close coordination and the support of the Department of Health Services (DoHS), and district authorities. In 2008, DoHS funded and rolled out the equity and access model to 2 additional districts, and in 2009, has scaled up its Financial Aid to support a further 8.

*"Women are aware of their rights. They go to groups and participate in savings. They have developed the confidence that they can make a difference."*²

The EAP takes a rights based approach to raise demand for maternal and newborn health services, and in pursuit of greater equity and social inclusion, targets the poor and socially excluded. Built on a "tried and tested" package of inputs that work together – women's groups, community based emergency funds and transport schemes, localised behaviour change communications, and the social mobilisation of family members and local stakeholders – the programme aims to empower women and create an enabling environment for improved MNH. With a strong focus on building local capacity and fostering local change agents, the programme works with existing institutional structures and actors, including district health officers and health providers, district administration, village development committees, political parties, private providers, NGOs, CBOs, FCHVs and women's groups, to forge coalitions for change at district level and below.

What impact has it had and who has benefitted? Implemented between September 2006 and June 2009, the programme has achieved impressive results in forming VDC and district level women's networks and cooperatives. In terms of health outcomes, Baseline and Endline household surveys,



service records, and qualitative research capturing the voices of women, health service users, and health providers, line up to show dramatic increases in MNH knowledge, attitudes and practices; headline messages are presented below.

While all social groups have benefitted from

¹ Dailekh, Paduka VDC; KIM 2009.

² Chitwan, Kalyanpur VDC, KIM 2009, see Manandhar, Mary, 2009, "Positive changes EAP district profiles".

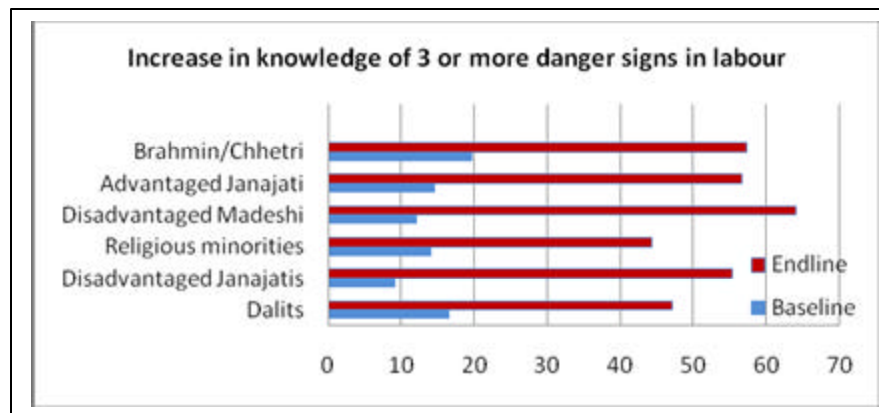
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improved MNH indicators, Dalits and Disadvantaged Janajatis, two social groups that have lagged behind national level health improvements have benefitted particularly well.

Antenatal care: Take-up of 4 or more ANC visits has increased from 45% to 60% at Endline and equity has increased. Service records from EAP areas show similar levels of increase as the baseline and endline surveys, with 4+ ANC rising 36% over the first 2 years of the programme. The equity gap between use of ANC by Brahmin/Chhetris and Dalits, Disadvantaged Janajatis and Disadvantaged Madeshis respectively, has declined. Notably women exposed to EAP have a significantly higher ANC use rate than others.

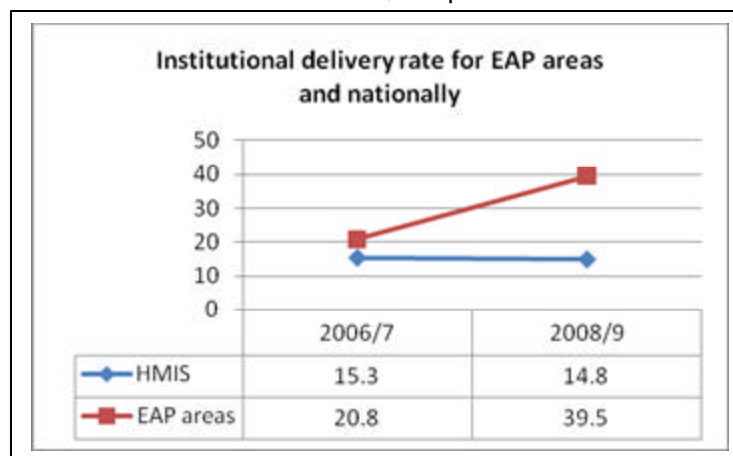
Hand in hand with increasing ANC has been a massive increase in the use of iron tablets for 90 days or more during pregnancy, rising from 12.3% at Baseline to 65.5% at the end of the programme, with Dalits, Disadvantaged Janajatis, and Muslims increasing up-take more than 5-fold.

Knowledge of the danger signs in pregnancy, labour and the post-partum period is fundamental to timely and appropriate care seeking. Among recently delivered women, their husbands and mothers-in-law, knowledge has more than doubled over the programme period, with the largest



knowledge gain among Relatively Disadvantaged Janajatis. Moreover, women exposed to EAP have significantly better knowledge than others, confirming women's groups as effective channels of information.

Delivery practices: while the programme mobilised women, their families and communities to reflect and act upon the social norms, traditional practices and cultural beliefs that work against safe motherhood, policy and service level improvements have synergistically increased access to services. Improvements in district level obstetric services, the introduction of the Safe Delivery Incentive Programme (SDIP) and the more recent introduction of free delivery services, have all contributed to increased access to obstetric care, and provided a conducive environment for EAP to work with the



district health team to foster community participation in the management of health services, and generate demand.

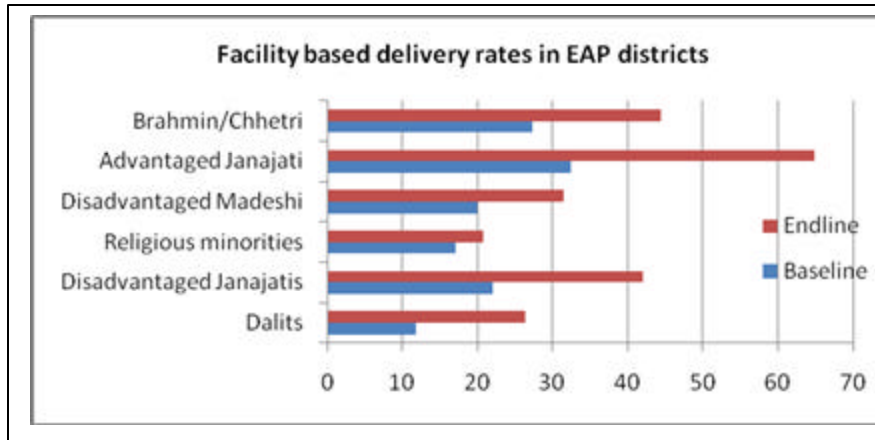
By the end of the programme a staggering 85% of respondents reported that women should deliver in a facility, including 80% of mothers-in-law, one of the target groups of EAP, and a key stakeholder in shifting birthing practices. The Endline household survey found 40% of

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recently delivered women gave birth in a health facility, up from 21% at Baseline and over double the national rate of 15% in 2008-9³. Correspondingly, the number of women delivering with a skilled provider doubled from 19% to 41% with the vast majority delivering in a facility and only a small minority in the home⁴. Service records from the programme areas chart the same upward trend in institutional deliveries, with an average increase of 29% during the first 2 years of the programme

Broken down by social group, the rise in facility based deliveries has been greatest among Dalits (123%). Rapid gains have also been made by Advantaged Janajatis (99%) and Disadvantaged Janajatis (91%), with lower improvements among Brahmin/Chhetris (62%), and Disadvantaged Madeshi (57%), and lowest gains among Muslims and other religious minorities (21%).

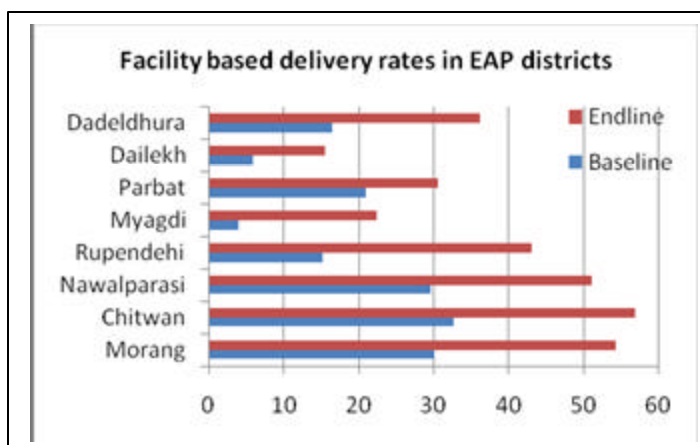
Nevertheless, advantaged groups continue to have higher institutional delivery rates than the



socially disadvantaged, and we find that while demand and supply interventions have significantly increased access to, and use of institutional deliveries for some socially excluded groups, they have yet to overcome

the strong bias that the better-off and advantaged have higher rates of facility based deliveries, a bias that persists across the world⁵.

Regional and district variation is evident with institutional delivery rates much higher in Terai districts than Hills. Various factors appear to contribute to this situation, better availability and



physical accessibility of obstetric services in the Terai, lower Human Development Indicators in the Far Western and Mid Western regions, and stronger traditional and religious beliefs and practices surrounding pregnancy and birthing in the West. Nevertheless, across all EAP districts, facility delivery rates have increased over the course of the programme, and all have higher rates than the national average of 14.8% for 2008-9.

With tradition the primary factor for women choosing to deliver at home, tipping the institutional delivery rates calls for greater focus on communication and mobilisation approaches to support

³ HMIS, DOHS.

⁴ This correlates with the findings of the SDIP Impact Evaluation, 2008.

⁵ Gwatkin D., Rustein S., Johnson K., Pande R., Wagstaff A., 2000, Socioeconomic differences in health, nutrition, and population – 45 countries. Washington DC: World Bank.

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women, their families and communities to challenge harmful practices and redefine the social norms that underpin pregnancy and childbirth behaviours.

Emergency obstetric care: better informed, better prepared, and better availability of emergency obstetric care has translated into more rational care seeking and increased treatment of obstetric complications, rising by 32% within the first 2 years of the programme.

Contribution or attribution? From the endline survey we find that women exposed to EAP have better knowledge of the danger signs, higher ANC rates, better knowledge of SDIP, and are more likely to use an emergency transport scheme. Although in the absence of control sites, it is not scientifically possible to attribute changes in health outcomes, without doubt EAP has made an important contribution both in raising demand and in supporting local health services to be more responsive.

Greater social equity? What more needs to be done: EAP has contributed to reducing the social inequities in use of MNH services but unevenly. While Dalits and disadvantaged Janajatis, have benefitted particularly well, disadvantaged Madeshi castes and Muslims and other religious minorities have fared less well. Future programming will need to place stronger emphasis on reaching disadvantaged Madeshi castes and Muslims and other religious minorities through more tailored communication and mobilisation approaches, and addressing supply side barriers such as social discrimination. Success of EAP in the Hills and Terai also calls for the programme's adaptation to mountain districts where development indicators of remote communities trail behind.

The road ahead: coherent with Government goals of public-private-partnership, and the Ministry of Health and Population's draft Gender Equity and Social Inclusion Strategy, the equity and access approach fits neatly into the policy frame and political landscape. With past investments in design and development, it is estimated that scaling the approach up nationally will cost approximately Rs40 million or US \$540,000⁶ for 3 years of support per district; this includes support for implementation of the community and social mobilisation approach at VDC and district level plus centrally led mass media, behaviour change communications, and advocacy activities. Such targeted investments will lever significant returns both for MNH and women's development, and make an important contribution to realising the MDGs.

*"Women have formed groups. They have started to speak about their rights. They help by providing money to those in need. They don't feel shy going for pregnancy check ups and tell about this. They take iron pills daily, collect the money in the group and make decisions of who should get money. Numbers of groups have increased. After forming the group, they decided to build temporary toilets and later built a permanent toilet. Earlier they could not even tell their names and introduce themselves but now they can share many things. They can tell about not to get pregnant immediately after marriage, and to take the 3 month injection. ... Women have become leaders and nowadays things have changed. Women can also read and write, learn after tours to different places and learned from observing from other villages."*⁷

⁶ US\$1:NRs74

⁷ Myagdi, Okharbott VDC: KIM 2009.