

People's Perspective on Access to Health Care Services in a Rural District of Nepal

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ABSTRACT

Introduction: Over the past several decades, Nepal has attempted to increase the access of health care services, however progress toward achieving high coverage of health care services in rural communities is still low. Therefore this study attempts to provide a perspective on access to basic health care services in government health facility.

Methods: Descriptive cross-sectional study with quantitative and qualitative methods was designed and applied to identify the access to health care services. The study population were people who were sick within three months prior to the study where basic sampling unit was household. Total sample size was 96 through the application of simple random sampling method. Bivariate analysis with 95% confidence interval was used to identify the association of variables with access to health care services.

Results: Among the total population, 28% of households in the study area received health care services at government health facility. The reasons for not accessing health care were insufficient drugs (61%), distance (22%), staff unavailability (19%), sickness (9%), money (7%), and facility hours (4%). Sex, ethnicity and distance were found significantly associated with access to health care services.

Conclusions: Less than one third of households had access to health care services in government health facility. Addressing the important factors such as drug problems, staff unavailability, long distance to health institutions and inconvenient health facility hours may help to increase access to health care services at government health facility.

Keywords: Access, government health facility, health care services, perspective

INTRODUCTION

Increasing the people's access to basic health care services at peripheral level has remained always a focus of Government of Nepal. Nepal has been trying to make effective health service delivery to the people since 1991. National Health Policy 1991, Second Long Term Health Plan (SLTHP) 1997-2017, Nepal Health Sector Program Implementation Plan (NHSP-IP) 2004-

2009 and NHSP-IP second 2010-2015 have focused on decentralization and expansion of essential health care services below district level.¹⁻⁴

Free health care policy was the spirit of people's movement in 2006 and was based on citizen's rights

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without being discriminated.⁵ The interim constitution 2007 has emphasized that every citizen shall have the rights to basic health services free of cost.⁶ In spite of all these policies, less attention have been paid to ensure the access to health care services to the people.^{7,8} Access to health care services in peripheral government health facilities that is health post (HP), sub health post (SHP) and primary health care center (PHCC) is quite low, that is only 43% of household in Surkhet had received care at government health facilities.⁹ Very few surveys have been conducted to identify access to health care services in Nepal, particularly in rural districts. So, the objective of the study was to measure the access to health care services in peripheral government health facilities and identify the peoples' perspective on access to health care services.

METHODS

A descriptive cross-sectional study was conducted in Salma Village Development Committee (VDC), Jajarkot, Nepal from June to September 2009. A mix of both quantitative and qualitative research methods were applied for the study. Quantitative study technique included interview through structured questionnaire. Similarly, qualitative study technique included key informant interview among Female Community Health Volunteers (FCHVs), school teachers, VDC personnel and non-formal leaders. The ethical approval was taken from ethical review committee of Department of Sociology and Anthropology of Birendranagar Multiple Campus, Tribhuvan University. Respondents were explained about the objectives, harm and benefits of the study and ensured confidentiality. For this purpose verbal informed consent was taken from each respondent before interview. The households (HHs) with sick member within three months prior to the study were included. Similarly those HHs, which did not have any sick member within three months prior to study were excluded and replaced by neighbor households. If a household which had more than one sick member was visited, then the information about more recent sick member was gathered to minimize the recall bias. The ethnic classification of households was based on the classification of Health Management Information System of Nepal for the analysis of data.

The sample size was calculated using the formula $n = \frac{z^2pq}{d^2}$, where $Z = 1.96$ (for 95% confidence interval), 'p' was taken to be 50%. The desired precision 'd' was $\pm 10\%$. So the sample size was calculated to be 96. For the sampling, Salma VDC was selected randomly from 30 VDCs of Jajarkot. Then, three wards were selected randomly out of 9 wards which accounted 282 households that was the sampling frame for the study. From the sampling frame, the required sample size was

obtained randomly by applying random table which was 34% of the sampling frame. The basic sampling unit was household for the study.

The measure of access has two components; firstly, the proportion of households with sick members who went to a government health facility; and secondly, among the sick members the proportion of people who went to a government health facility and received care⁹. The first (F) is defined as:

Number of HHs with sick members who went to government health facility

$F = \frac{\text{Number of HHs with sick members who went to government health facility}}{\text{Number of HHs with sick members}}$

and the second (C) as:

Number of HHs with sick members who went to government health facility and received care

$C = \frac{\text{Number of HHs with sick members who went to government health facility and received care}}{\text{Number of HHs with sick members who went to government health facility}}$

So, the percent of households who had access to government health care services, defined as the proportion of households that had a sick member in the past three months who went to a government facility and received care (A) = $F \times C$.

Epi Info 3.5.1 and SPSS 16 were used for data analysis. First, univariate analysis was done to calculate variable frequencies and percentages and bivariate analysis was applied to determine the factors associated with access to health care. Epi Info cross tabulation was used to calculate odds ratios and p-values.

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RESULTS

Over half (56%) of the households were Brahmins/Chhetris followed by Dalits (30%) and Janajatis (14%). More than half of the households were living at a distance more than one hour from a government health facility, which reflects the remoteness of the studied VDC. Nearly 60% of the patients were female among them about half of the patients were in age group 15-49 years. Twenty percentages of the patients were children under five years of age. Almost 85% of people were ill within the period of two months and few were between 60 to 90 days before the study.

From this study, 41.6% of sick households went to a government health facility and 67.5% of those received health care. So, the actual access to government health facility as per the given definition was 28.1%. Figure 1 shows the extent of access to government health care services for the people of the study area.

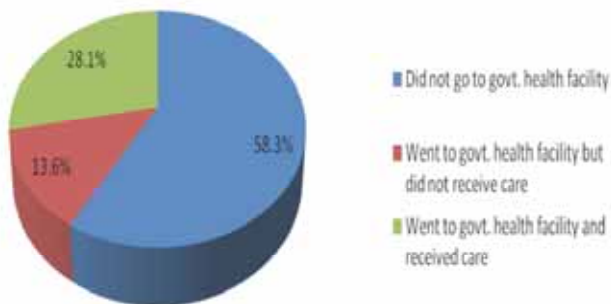


Figure 1. Extent of access to health care services in government health facility

Table 1 shows that the reasons for those who went to health facility but did not receive health care services and for those who didn't seek health care services from government health facility. Finally, these two components were merged together, so that all those 72% of households that did not go to government health facility or did not receive health care (i.e., did not access to health care services). The important reasons given for not having access to health care at government health facilities were insufficient drugs, long distance to reach health facility, rude behavior of health facility staffs, patient not sufficiently sick, financial problems, and inconvenient facility hours. The most important reason of not accessing was insufficient drugs or poor quality drugs (61%).

Table 1. Reasons for no access to health care services in government facility

SN	Variable	N	Number (%)
1	Reason for going to but not receiving care at government facility	13	Drug problems
			11 (84.6)
			Not possible
			1 (07.7)
			Staff problem
			5 (38.5)
			Money problem
			0 (00.0)
2	Reason for not going to or not receiving care at government facility	69	Facility hour inappropriate
			1 (07.7)
			Waiting time long
			0 (00.0)
			Other
			1 (07.7)
			Drug problems
			42 (60.8)
			Too far away
			15 (21.7)
			Staff problem
			13 (18.8)
			Not sufficiently sick
			6 (08.7)
			Money problem
			5 (07.2)
			Facility hour inappropriate
			3 (04.3)

Factors associated with access to health care services Table 2 shows the variables that are associated with access to health care services. Age did not seem to be statistically significant however the age group 15-49 years had 1.5 times higher access than those of 0-4 years ($p=0.469$). Sex and caste had significant association with access to health care services. Female had 2.6 times less access to health facility as compared to male which is statistically significant ($p=0.030$). Dalits had significantly more access to government health facility than Brahmins/Chhetris (odds ratio = 3.06, $p=0.018$). While analyzing the association by combining Dalits and Janjatis to compare with Brahmins/Chhetris, they had 2.6 times more access to health services which is statistically significant ($p=0.027$).

It has been found that distance has strong statistical significance. People living within an hour or closer to the health facility had about 3 times more access to health care services than those living farther away ($OR=3.35$, $p=0.01$). The livestock and household size were not significant and the associations were weak. Relatively wealthy people were 1.23 times less likely to have access to health care as those having livestock worth less than 15,000 rupees ($p=0.707$). Similarly, households having five or fewer members were 1.38 times more likely to access health care services than larger households ($p=0.486$).

Table 2. Factors associated with access to health care services

Factor	Total	Yes (%)	Odds Ratio	p-value
Age of patient				
0-4*	19	7 (36.8)		
5-14	14	3 (21.4)	0.47	0.340
15-49	45	21 (46.6)	1.50	0.469
>=50	18	6 (33.3)	0.86	0.823
Sex of patient				
Male*	39	17 (43.6)		
Female	57	13 (22.8)	0.38	0.030
Caste of patient				
Brahmin/Chhetri*	54	14 (25.9)		
Janjati	13	5 (38.4)	1.79	0.367
Dalit	29	15 (51.7)	3.06	0.018
Caste(dichotomous)				
Brahmin/Chhetri	54	14 (25.9)		
Dalit/Janjati	42	20 (47.6)	2.60	0.027
Livestock value				
Rs 0-15000*	19	6 (32.0)		
Rs ≥ 15000	59	16 (27.0)	0.81	0.707
Household size				
≥6*	60	16 (27.0)		
0-5	36	12 (33.0)	1.38	0.486
Distance				
≤ 1hour*	45	17 (38.0)		
1-2 hours	24	7 (29.0)	0.68	0.474
>2 hours	26	4 (15.0)	0.30	0.046
Distance(dichotomous)				
>1 hour*	50	11 (22.0)		
≤1 hour	45	17 (38.0)	3.35	0.01

* Reference group

DISCUSSION

Less than one third of households in the study area had access to government health care services. This result is remarkably less to the figure obtained from the health access survey conducted by International Rescue Committee Nepal in Surkhet in September 2008 (43%)⁹. The primary reason for not accessing government health care was insufficient drugs in the health facility. This result suggests that the drugs which has to be free and year round available are more often not available at government health facility. The information generated through key informant interview also explained that unavailability of drugs at government health facility was a major problem of not accessing health care services. If the year round availability of drugs were made, access is expected to be increased remarkably. Insufficiency of drugs was overwhelmingly the reason that people who went to government facilities but did not receive adequate treatment. This result was found to be supported by a study conducted by Nepal Health Research Council that revealed lack of infrastructure, equipment, drugs and shortage of staff hampered service provision for both free as well as paying patient.¹⁰

Lack of money was not found to be a major problem in accessing health care services. However, one third of respondents who received care had to pay money for the services, despite the fact that all care in government health facility has to be free of cost. Similar result was found in a study conducted in Surkhet in 2008 where 18% of respondents who received health care from government health facility paid money for the services⁹.

A study conducted in Surkhet showed no statistically significant association between access and poverty,⁹ however, this study showed a weak association. Perhaps high accessibility by poor people in this study might be due to the timing of endorsing free health care policy other than the study conducted in Surkhet. Other reason was found from the key informant interview that wealthy people were more likely to use of private health facilities for their convenience despite expensive services.

Sex and caste had significant association; however age was not statistically significant with access to health care services. Female had significantly less access to health care services as compared to male. This might be because women have less freedom to decide to seek care for their health problems due to socio-cultural norms. Dalits had significantly more access to government health facility than Brahmins/cChhetris. The in-depth interview with FCHVs disclosed that Dalits are more often sick than Brahmins/Chhetris

and they, compared to Dalits, prefer to go to private health facilities such as private medical shops in the VDC or in the district headquarter with the perception of better treatment. Small households had twice as likely to receive care than those of large household size. However, there is no obvious reason why household size is related to receiving care. Further in-depth study would be necessary to explore the reasons of seeking health care facility predominantly by small size family.

The issue of long distance to reach the government a facility (27% of those did not seek treatment) is more difficult than the drug issue to solve. Distance is important in determining access, especially economic distance measured in terms of travel time or transportation cost. Economic distance determines the range of goods and services.¹¹ A study in Nigeria revealed that the location of the household, the attitude of the people towards specific health care facilities, and the facilities available were found to influence the choice of health care by the people of the state.¹² One approach would be for the government to make accessibility of primary health care outreach clinics (PHC/ORCs). In addition, this study found that only 4% of households received health care from outreach clinics. Therefore, the government should come up with special strategy to enhance adequate utilization of PHC/ ORC.

Village Health Workers (VHWs) and Maternal and Child Health Workers (MCHWs) have to be in the field for 20 days per month as per the government rule, but in reality they just work in the field for about three to four days per month during immunization clinics. Placing them more regularly and effectively to more remote wards would help to provide health care to those people living far away from the health facility. Increasing the role of Female Community Health Volunteers (FCHVs) can also be done, but not as an optimal solution, since they are volunteers. Moreover, in Jajarkot there are wards that require hours of hiking to pass through, which may limit their role as volunteer.

Availability of staff was an issue for 19% of the people who did not access health care services. A study conducted in Indonesia indicates that quality is an important determinant of utilization of health services. The most important quality measure is human resource availability.¹² This problem can be addressed by ensuring better time management of health facility staff, increasing their motivation, and giving them better training. These solutions are easy to say but harder to implement. However, this study suggests that ensuring availability of staff during office hour is necessary. A surprising number of households did not seek health care services because they didn't feel sick enough to

visit health facility. This might be true because people are more concerned about the diseases when it is serious enough to seek immediate care. A study in Nigeria also showed that number of factors such as the nature of illness influence the choice of health care by the people.¹³

This study showed that people who did not go to government health facility received care from traditional healers (3.7%) and home remedy (11.1%). Similar study in Nigeria showed that many people in the study area go to traditional health practitioners when their first action at self-medication fails to produce satisfactory results.¹³

However the study was carefully designed and conducted, there were some limitations. The primary limitation was that all illnesses were potentially included in the study, however many people would not attempt to seek care for simple illnesses such as common cold and headache. A more accurate access could be measured if people with serious illnesses were included for the study. Further study with multivariate analysis is imperative to establish the association by adjusting possible confounders to measure the access.

CONCLUSIONS

About one third of the study population who were sick received care at peripheral health facilities such as Sub Health Post, Health Post and PHCC, indicates people in Salma VDC have low access to health care services in government health facility. From the people's perspective, the primary reason for not accessing health care services from government health facility was insufficient or unavailability of drugs. Therefore, the year round availability of drugs should be made available to improve access to health care services. The other important factors affecting access to health care services were staff unavailability, long distance to reach health institutions and inappropriate health facility hours.

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