



Utilizing Roving Auxiliary Nurse Midwives to Reach Hard-to-Reach Communities

Enhancing the reach of formal health services by addressing deep-seated social, cultural, structural and geographic barriers.

Addressing barriers to family planning (FP) use can be complex. The modern contraceptive prevalence rate (mCPR) among currently married women in Nepal has increased from 26% in 1996 to 43% in 2016, but there has been no change in the mCPR over the past decade (NDHS, 2016). Furthermore, CPR and rates of met need for family planning (FP) are lower among certain caste/ethnic and religious groups (NDHS, 2011). Despite overall improvements in reproductive health outcomes in Nepal, the existing health system faces challenges in improving access to quality services among these hard-to-reach (HTR) groups. The Government of Nepal is supporting the introduction of a new cadre of community-level health workers with increased training and capacity to provide services and to address barriers to FP use, especially among HTR groups.

In partnership with the Family Health Division (FHD) and the Rupandehi District Public Health Office (DPHO) within the Ministry of Health (MOH), the Fertility Awareness for Community Transformation (FACT) deployed “roving” Auxiliary Nurse Midwives (RANMs) in select communities of Rupandehi District, Nepal to provide FP services at the household level.

How do RANMs fit into Nepal's goals?

The introduction of RANMs is consistent with Government of Nepal policies around expanding equitable access to and quality of community level health services under the Nepal Health Sector Strategy 2015-2020 (NHSS 2015-20).

Such a strategy also contributes to the “Reaching the Unreached Strategy” (RTU 2016-2030). In addition to “reach”, the integrated household and community approach to health service provision offers a significant opportunity to address the multiple barriers contributing to poor health access, particularly among HTR groups.

Structurally, linking the RANMs directly with their respective health center for supervision and reporting aims to strengthen perceived links between health services and the communities they serve – thus enhancing both reach and quality of formal health services. Understanding how these RANMs actually contribute to universal health coverage will continue to provide important policy-level information.

What services did RANMs provide?

Addressing the needs of HTR communities required RANMs to raise awareness and develop trusting relationships within communities: Utilizing a community-nursing approach, RANMs defined and addressed health needs at both individual and community levels. This began with a catchment area community and household needs assessment in collaboration with local leaders.

The household assessment provided the RANMs with information to identify households not currently reached by the health system, and to prioritize and monitor the needs of their clients for direct services or through referrals to the health facility. The community assessment helped the RANMs identify key groups or stakeholders in the community who could enhance their work.

The individual / household health services package (table) addressed a range of reproductive health needs. Repeated home visits increased rapport between RANMs and clients, established trust and facilitated initial discussions about general health concerns. RANMs were trained and provided with materials to help increase involvement of spouse and other family members in education and counseling discussions when appropriate. Whole-family inclusion helped to address some social and gender barriers limiting service utilization within these HTR communities.

The RANMs extended their service to the community level in meaningful ways that reinforced their health messaging and commitment to the community. The RANMs used four principal strategies at the community level:

Collaboration with Female Community Health Volunteers (FCHVs): FCHVs

introduced the RANMs to the community; helped to identify priority households; implemented group education sessions jointly; and referred clients to the RANM. The RANM, in turn, provided technical support and credibility to FCHV activities.

Provided group education sessions:

Regularly, RANMs provided group-health education sessions in their communities. Including playing health education games (Pragati games).

Engaged with community members:

RANMs maintained strong working relationships with influential community members and leaders. These relationships helped to ensure that messages and initiatives were disseminated across the community.

RANM HEALTH SERVICES PACKAGE

Family Planning

- Counsel and provides pills, condoms, SDM, LAM, injectables, and refers clients for long-acting and permanent methods
- Manage supply and waste disposal
- Engages husbands and other family members
- Follows up with discontinued clients

Antenatal Care

- Conducts ANC visits to pregnant women; includes husband and other family when appropriate
- Counsels on pregnancy expectations, danger signs for each stage, birth preparedness, breastfeeding and newborn care, family planning, and influence of social and gender norms on pregnancy and newborn care:
 - Pregnancy expectations, healthy behaviors, and education on pregnancy, labor, postnatal and newborn danger signs
 - Maternal nutrition
 - Birth preparedness
 - Breastfeeding and essential newborn care
 - Family planning
- Conduct physical exam if requested
- Refers to health facility for complications/danger signs, antenatal checkups and for delivery

Postnatal and Newborn Care (PNC)

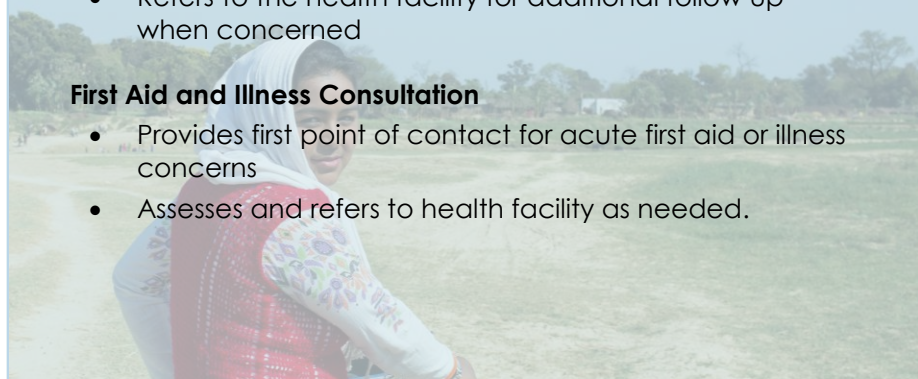
- Conducts 2nd and 3rd PNC home visits including maternal and newborn physical examination, counseling on postpartum danger signs and breast feeding; provision of essential newborn care
- Counsels on postpartum family planning
- Identifies postnatal and neonatal danger signs and timely referral for newborn or maternal illnesses

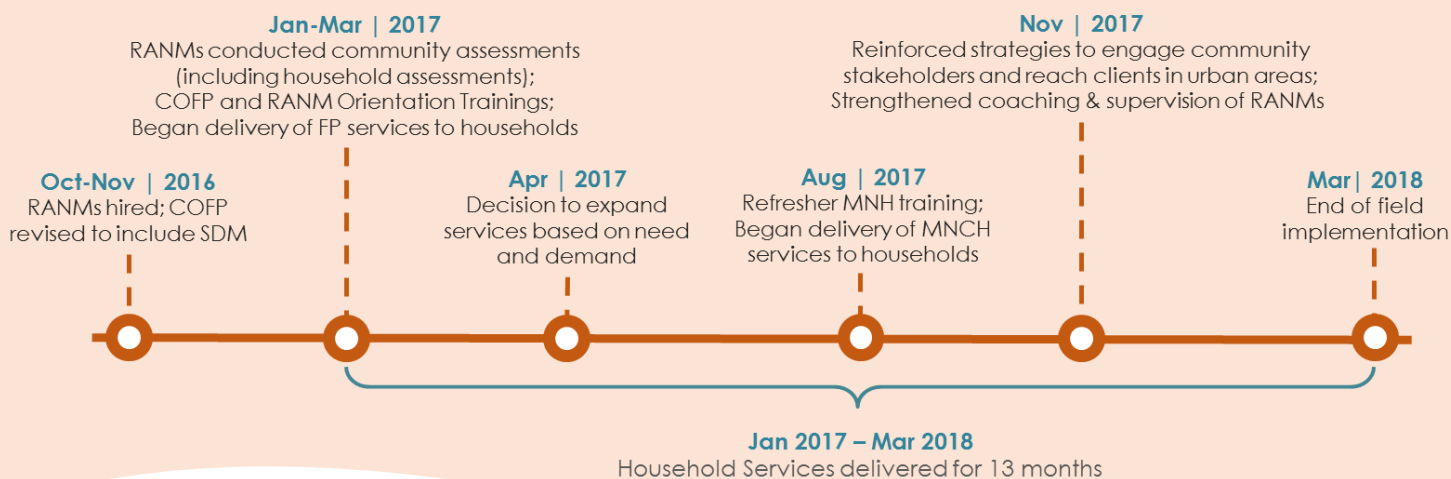
Nutrition Counseling

- Performs middle upper arm circumference (MUAC) measurements for under-five children
- Provides nutrition education
- Refers to the health facility for additional follow up when concerned

First Aid and Illness Consultation

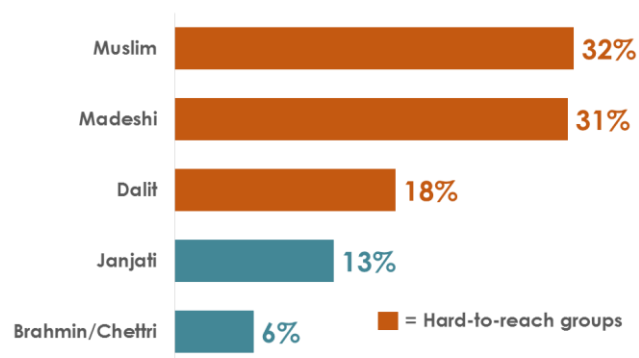
- Provides first point of contact for acute first aid or illness concerns
- Assesses and refers to health facility as needed.





Who Did RANMs Reach?

- 81% of primary RANM contacts were from hard-to-reach groups (Muslim, Madeshi, and Dalit ethnicities).
- Among all home visits conducted, 62% included contact with the spouse or in-laws of the primary client.
- 24% of individual primary contacts included direct service provision. Of these, 30% were pregnancy-related care and 20% were FP services.
- 46% of individual contacts were below the age of 26.



Community Survey Results

Survey and qualitative data collection conducted in RANM communities

A pre-post representative sample of 424 women participated in a community survey and focus group discussions and in-depth interviews to assess the RANM intervention. Women were all between 15 – 25 years old and were spread across several communities in Rupandehi. Thus, not all of the women surveyed had access to RANM services. Participants from two additional study arms within Rupandehi were used for comparative purposes below.

Study findings suggest that RANMs effectively reached isolated communities in Rupandehi. More than 72% of RANM clients were from either the Madhesi or Muslim communities (see graph). Interactions with RANMs were not limited to the client, as a quarter of participants discussed FP with the RANM and their spouse, while many others reported friends, siblings and parents present during RANM visits.

Activities and conversations within the sites served by RANMs may have led to changes in social norms/pressures experienced by many married women. Women were 2.3* [CI: 1.3, 3.9] times less likely to report pressure to have a son and 2.6* [CI: 1.1, 5.9] times less likely to report pressure to have a child immediately after marriage than women in non-RANM sites.

As described above, RANMs established an enabling environment for FP uptake through games and counseling. At endline, women in RANM sites were 2.7* [CI: 1.8, 4.2] times more likely to have a high fertility awareness score than women in the non-RANM sites. They were also 2.5 [CI: 1.2, 5.3] times more likely to be using and FP method and 3.3 [CI: 1.5, 7.2] times more likely intend to use an FP method in 3 months than women in the non-RANM sites**.

*Controlling for age, ethnicity, religion, and marital status. $p < 0.05$

**Controlling for fertility awareness, FP norms, and spousal migration. $p < 0.05$



"We give information on family planning, the devices used for it, and its benefits. We have depo, pills, condoms and CycleBeads. We hand out whichever they prefer. Apart from the choices we have, if they want anything else we give references as well."

Amrita B.K., RANM

HOW DO YOU INTEGRATE RANMS TO REACH HTR COMMUNITIES?

In coming years, the government of Nepal intends to utilize RANMs in sites across the country. This initiative has identified some key tips and lessons learned.

Lessons Learned

Due to the pilot nature of this initiative, the project was able to make adjustments throughout implementation, allowing identification of lessons learned from these adaptations.

- Expanded services that included Maternal Newborn care, nutrition and first aid, allowed the RANM to initiate relationships and develop trust with potential clients. This facilitated introduction of family planning, and also offered opportunities to also address social and gender norms within the couple and the household.
- A clearly-organized caseload management system, through the Client Log, facilitated the identification, prioritization, and tracking of needed services.
- Urban catchment areas required RANMs to be flexible in their strategies to serve people: reaching open work-sites (i.e.; brick makers at the river's edge) and facilitating access to new clients who were not at home during the day. New RANM programs will benefit from joint (RANM & health facility) planning within different types of communities.
- There is not a "one size fits all" approach for reaching clients. Open communication and the ability to adjust approaches are key to success.

Remaining Questions

Given the experimental nature of this intervention, there are still questions to answer as the effort moves forward.

- Establishing a clear set of criteria to identify, prioritize and retain clients (particularly HTR clients) for caseload management and follow-up was challenging. More work is needed to determine an appropriate number of households for an individual RANM's caseload, that includes targets for monthly activities (both household and community activities). This will include processes for moving clients in and out of the RANM's caseload.
- Considering recent changes in government structures in Nepal, responsibility for programmatic and funding support of the RANMs should be determined to maximize effectiveness. Given different barriers and challenges, further development of urban strategy adaptations at the community level is needed.

1 Sedgh, G. Unmet Need for Contraception in Developing Countries: Examining Women's Reasons for Not Using a Method. Guttmacher Institute, 2016

2 High Impact Practices in Family Planning (HIPs). Mass Media: Reaching audiences far and wide with messages to support healthy reproductive behaviors. USAID, 2017