Health Care Workers’ Opinions, Attitudes and Perceptions of Primary Care Service Delivery for Chronic Diseases in a Rural Setting in Nepal

Ross Gillespie (Nuffield Centre for International Health and Development, University of Leeds)

1 Introduction

- Non-communicable diseases (NCDs) are the leading global cause of death and disproportionately affect low- and middle-income countries (LMICs), such as Nepal.
- Cardiovascular disease (CVD), the most common NCD accounted for 28% of deaths in Nepal in 2016. National figures suggest this could rise to 35% by 2020.
- The majority of Nepalese live in rural areas, though Nepal’s population is rapidly urbanising.
- There is disparity in the rise of modifiable NCD risk factors in rural compared with urban areas to include tobacco smoking, alcohol consumption, sedentary lifestyle and poor diet.
- First point-of-care is provided by health posts (HPs) and primary health care centres.
- These posts are run by health care workers of variable training levels: auxiliary staff, nurse-midwives, health assistants and GPs.
- It aims to reduce burden by tackling modifiable risk factors with a focus on primary care and preventative measures.
- CVD was used as a tracer to explore strengths and weaknesses of rural primary care service delivery from the perspective of primary health workers.

2 Aims

- To explore health workers’ opinions of the cardiovascular health services that are currently provided in rural primary care facilities in Nepal.
- To discover how health workers’ perceive the role of the health facility as well as the quality and accessibility of cardiovascular health services.
- To identify any opportunities or strategies to improve cardiovascular health services.

3 Methodology

Data Collection: Cross-sectional qualitative semi-structured interviews.

When?: May 2018
Where: Dolakha Region, Nepal

Who?: Participant Demographics

<table>
<thead>
<tr>
<th>Who?</th>
<th>Participant Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Interviewees</td>
<td>10</td>
</tr>
<tr>
<td>Age Range (years)</td>
<td>23-58 (Mean = 33)</td>
</tr>
<tr>
<td>Sex (M:F)</td>
<td>6:4</td>
</tr>
<tr>
<td>Experience (years in role)</td>
<td>0.5-37 (Mean = 9.8)</td>
</tr>
<tr>
<td>Principle language of interview</td>
<td>English: 5, Nepalese: 5</td>
</tr>
<tr>
<td>Rurality (hours to nearest city, by public transport)</td>
<td>6-14.5 (Mean = 11.15)</td>
</tr>
</tbody>
</table>

Table 1: Patient Demographics

Ethical Approval was granted from the University of Leeds.

Data Analysis: Transcripts were analysed by thematic content analysis using both a priori codes drawn from literature and emergent codes that arose during analysis.

Limitations: Financial and temporal restrictions resulted in lack of triangulation of data. Sampling was affected by logistical limitations as most travel was on foot thus, views may not represent those of other rural Nepalese health workers. Language barriers hindered researcher-participant fluency in conversation.

4 Findings

Some of the medicines we do have for hypertension… but we cannot give them for a daily basis. If they come, we give for short time and refer to higher centre. HA02 Capacity to treat is limited by resources.

“From this Health Post, normally if [the patients] show any sign and symptoms about CVD we refer to higher centre.” HW 10 Main role of rural facility is referral.

“Some of the medicines we do have for hypertension…but we cannot give them for a daily basis. If they come, we give for short time and refer to higher centre.” HA02 Capacity to treat is limited by resources.

[Services] are not enough actually. In the rural setting patients are being declined” HA09 Some workers suggest services are inadequate.

“Some of the medicines we do have for hypertension…but we cannot give them for a daily basis. If they come, we give for short time and refer to higher centre.” HA02 Capacity to treat is limited by resources.

“From this Health Post, normally if [the patients] show any sign and symptoms about CVD we refer to higher centre.” HW 10 Main role of rural facility is referral.

“Some of the medicines we do have for hypertension…but we cannot give them for a daily basis. If they come, we give for short time and refer to higher centre.” HA02 Capacity to treat is limited by resources.

[Services] are not enough actually. In the rural setting patients are being declined” HA09 Some workers suggest services are inadequate.

We need ECG…we have to take training about the ECG machine and how to use and give reports…” HA06 New equipment must coincide with training and supervision to be useful.

“Maybe if our government has some policy they will provide education [about CVD]” HA04 Policy needs to be enforced and outcomes monitored to evaluate intervention. NGOs and gov’t are key role players.

5 Discussion & Conclusions

- Rural primary care services mainly refer to higher centres - a limited role that fails to address local health needs.
- Health workers recognise lack of equipment, specialist staff, finance and policy as barriers to meeting health needs.
- In collaboration with rural facilities, government and NGOs are responsible for effectuating change to NCD service delivery.
- Policy must be supported with good governance, supervision and monitoring to maximise impact on lifestyle.

6 Acknowledgements

Many thanks to Professor Tim Ensor for supervision and support throughout. Thanks to LED Nepal, the hosting charity for provision of translator and guide. Kind thanks to all participants for their contribution to the research.