Access Barriers to Health Services in Nepal

Current Thinking of Policy Planners

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– German Technical Cooperation –
Health Sector Support Programme
Department of Health Services
Teku, Kathmandu, Nepal
T +977 1 4261404
F +977 1 4261079
E hssp@gtz.org.np
I www.gtz.de/nepal

Author

Basu Dev Neupane

Editors

Dr. Friedeger Stierle
Professor Dr. Konrad Obermann
Dr. Rajendra Kumar BC

Photo

GTZ Archive

Design

Kiirtistudio

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GOVERNMENT OF NEPAL
MINISTRY OF HEALTH
& POPULATION

Ramshahpath, Kathmandu, Nepal
Phone: 4262987, 4262590, 4262802,
4262706, 4262935, 4262862

5 November 2009

The Government of Nepal has made political commitment for the health of the people at the highest level by declaring "Basic Health as Human Rights" in the Interim Constitution of Nepal 2007 for the first time in the history of Nepal. The Interim Constitution has outlined a vision of an inclusive society, where people of all race and ethnic group, gender, caste, religion, political belief, social and economic status live in peace and harmony, and enjoy equal rights without discrimination. This vision is the guiding principal for policies, plans, and programs of the MoHP. The vulnerable community development plan (VCDP) of 2004 recommended in its action plan institutional capacity building to ensure the formulation of specific policy of social inclusion at MoHP, DoHS and district level, including supporting national centers such as Nepal Health Training Centre, Nepal Health Education Information and Communication Center etc. To develop a coherent approach to overcoming access barriers will have to rely on thorough knowledge, understanding and concurrent views of the responsible policy makers, administrators and managers at the different levels. This depends i.e. from the availability of concise, evidence based information to concerned policy makers at different levels.

In order to assess the current use of study findings for policy formulation in the area of access barriers to health services, MoHP has conducted a study to assess the relevance of operational studies on health policy formulation and to capture the current thinking of policy planners on access barriers along with their suggestions for removing these barriers.

The MoHP would like to appreciate the technical and financial support provided by GTZ/GFA Consulting Group GmbH, and acknowledges the inputs of the Thematic Task Team members (Dr. Baburam Marasini, Mr. Yogendra Gauchan, Mr. Giri Raj Subedi, Mr. Parashu Ram Shrestha, and Dr. Rajendra Kumar BC) to steer the whole process. The study greatly benefited from the guidance and cooperation of Dr. Friedeger Stierle, Dr. Susanne Grimm, Professor Dr. Konrad Obermann, and Mr. Christian Caspar.

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Dr. Y. V. Pradhan
Chief
Policy, Planning and International
Cooperation Division

Acronyms

ASK	Aama Surakshya Karyakram
CDP	Community Drug Programme
DDC	District Development Committee
DfID	Department for International Development
DHO	District Health Officer
DHS	Demographic Health Survey
DoHS	Department of Health Services
DOTS	Directly Observed Treatment Schemes
DPHO	District Public Health Officer
ED	Essential Drugs
FHD	Family Health Division
FHCP	Free Health Care Policy
FHCS	Free Health Care Services
FCHV	Female Community Health Volunteers
GoN	Government of Nepal
HDI	Human Development Index
HEFU	Health Economics and Finance Unit
HFMC	Health Facility Management Committee
HMIS	Health Management Information System
HP	Health Posts
HuRDIS	Human Resource Development Information System
ICU	Intensive Care Unit
IEC	Information, Education and Communication
IRC	International Rescue Committee
LMIS	Logistics Management Information System
MCHW	Maternal Child Health Worker
MDG	Millennium Development Goal
MIS	Maternal Incentive Scheme
MoHP	Ministry of Health and Population
NGO	Non-Governmental Organisation
NSMP	Nepal Safer Motherhood Project
OT	Operation Theater
PHCC	Primary Health Care Centres
RTI	Research Triangle Institute
SBA	Skilled Birth Attendant
SHP	Sub Health Posts
SMIS	Safe Motherhood Incentive Scheme
ToR	Terms of Reference
VDC	Village Development Committee
VHW	Village Health Worker

Executive Summary

Background

A number of operational studies have indicated that people in general and poor people in particular in Nepal are facing various barriers in accessing health services. In response to this, the Interim Constitution of Nepal has recognised health as a basic human right and the government has introduced many programmes aimed at removing such barriers. Prevailing views of policy makers are important in removing the access barriers to health services. This study aims to assess the relevance of operational studies on health policy formulation and to capture the current thinking of policy planners on access barriers along with their suggestions for removing these barriers. The study methodology rests on in-depth interviews of 26 (22 male and 4 female) policy planners, and a review of selected operational studies.

Key Findings

On the supply side, important factors causing barriers in accessing health services were: unstable political situation (including conflict and absence of strong political commitment), human resource related aspects (posting, retention, behaviour / attitude and competence of health workers), and coverage and quality of services (opening hours, quality of general services, availability of specialised services and privacy of the patients at facilities) as identified by more than two-thirds of respondents. Additionally, limited supply of equipment and drugs and lack of public trust in government health facilities were also the barriers identified by less than 10 percent of respondents.

Similarly, on the demand side, nearly three quarters of respondents mentioned poverty, lack of proper education / awareness / information, culture / religion / language, geographical location and gender / caste as the barriers. Moreover, nearly all respondents indicated some policy-related aspects such as weak monitoring, poor coordination and managerial system and redundant and even contradictory policies which hinder access to health services indirectly.

About three quarters of respondents considered that operational study findings could contribute to removing the barriers to health services by supporting the formulation of conducive policies, designing effective programmes, strengthening implementation processes and developing policy guidelines. Moreover, nearly half of the respondents felt that findings of selected recent studies had been successfully translated into policies and programmes.

Two thirds of the respondents believed that the findings of "Coping with the Burden of Cost (2003)", led to a policy paper introducing a Maternity Incentive Scheme (MIS). Similarly, a study undertaken jointly by Care-Nepal and RTI (2009) contributed to revising the policy

by assessing the operational challenges of free health care services. In addition, the government, in response to these study findings, has formulated a human resources strategy and has considered the formulation of a new National Health Policy (1991).

The Government has made many policy decisions which have contributed to removing access barriers, as reflected in recent studies. For example, the Aama Surakshya Karyakram (ASK) (Safe Motherhood Programme) has contributed to raising the number of institutional deliveries and the Free Health Care Policy (FHCP) has contributed to increasing access of poor people to health services. However, most respondents felt that the FHCP is not free from operational challenges. The respondents also raised questions about its sustainability and the effectiveness of its practices, such as the appropriate identification of the poor.

Nevertheless, most respondents strongly felt that a structured process is required to translate study findings into policy and programmes. Importantly, a policy paper needs to be developed on the basis of research findings which subsequently can be translated into programmes with regular monitoring, lobbying and follow up. More than fifty percent of respondents indicated some important factors that contribute to translating the findings of a study into policy. Those factors are needs identification, government ownership, donors' interest as per international commitment such as MDG, substantial institutional memory and coordinated efforts of all stakeholders in policy advocacy.

Conclusions

The policy planners have a clear understanding about fundamental access barriers as their views basically match the findings of operational studies. However, all the respondents perceived geographical distance - a key access barrier indicated in most studies - as the unavoidable reality of the country which needs to be tackled by other policy interventions. Similarly, many respondents did not perceive cross cutting issues, such as low socio-economic status of women, as significant barriers, unlike the findings of some operational studies. Instead, political factors and conflict are the access barriers that are not found in the operational studies but were mentioned by substantially large number of respondents. Respondents viewed that a great deal of impunity and limited compliance of rules by health workers are mainly a consequence of an unstable political situation. These factors have created low morale and low self esteem among middle level managers.

Some practical recommendations of the respondents to remove access barriers in health are seeking political commitment to comply with government policies, long-term programme implementation without frequent changes, amending the National Health Policy and strengthening Health Facility Management Committees.

Operational studies can contribute to policy and programme formulation to remove access barriers if the studies are commissioned carefully with active and meaningful engagement of government, donors and other stakeholders. There are some excellent examples of translating study findings into policies and programmes that have contributed to removing access barriers to a greater extent. However, there are still existed some key barriers such as inadequate public trust in government health facilities, unsustainable donor-driven programmes, inadequate political commitment, and politicisation of health workers, which need to be minimized for effective implementation of policies, plans, and programmes aimed at removing barriers to accessing health services.

1. Introduction

The Interim Constitution of Nepal, 2063 (2007) has guaranteed health as a basic human right. Accordingly, the Government of Nepal (GoN) has envisioned an inclusive society where every citizen irrespective of gender, caste, religion, political faith and economic status will enjoy equal basic health rights. The government has also introduced many programmes that contribute to removing various barriers so that the people can access health services. However, in the current political, social and economic situation of Nepal, ensuring easy access to basic health services without nominal barriers is a significant challenge to health service providers, policy planners and practitioners.

In Nepal, a number of studies related to access barriers in health services have been conducted in the recent past. Most of these studies have concluded that people in general and poor people in particular have to face different barriers in accessing health services. It has generally been argued that a number of studies have been carried out but their use in formulating policies and plans is often poor. One of

the reasons behind this could be the lack of dissemination of those study findings to the attention of key policy / decision makers. Further, it has also been argued that viewpoints held by policy makers often contradict the findings of the studies. Some policy makers who actually take part in the studies themselves generally have positive views towards study findings while another group of policy makers who are left out often question the validity of such operational studies. Such conflicting viewpoints of different policy makers have a very significant influence on the policy formulation process. In many instances, although policy makers themselves argue that the government policies are not good, they are still responsible for executing those policies. This indicates that the views of the policy planners are not captured thoroughly while formulating polices, which in turn leads to difficulties during the implementation phase.

Realising the significance of thorough knowledge, understanding and concurrent views of the responsible policy makers towards access barriers in health services, this rapid assessment has been commissioned to capture their views.

2. Objectives

This study aims to assess the relevance of operational studies on access barriers for health policy making. Specific objectives of the study were to:

- Gather policy planners' current thinking (perception) on access barriers in health services and seek their suggestions / recommendations in minimising / removing barriers.
- Explore the extent of acceptability of policy-relevant information generated from operational studies.
- Explore the extent of use of recent operational study findings on policy formulation or dialogue.

3. Methodology

A rapid qualitative assessment has been made to capture the current thinking of the policy planners about access barriers to health services by reviewing selected operational studies and carrying out in-depth interviews based on a pre-developed check list (Annex – I). The respondents for this study (Annex – II) include Regional Health Director, District Health / Public Health Officer, Health Administrators, Divisional Directors and Managers.

Key Questions

In-depth interviews with the respondents were carried out based on the following key questions:

- What is the current thinking (perception) of policy makers about recent empirical findings on access barriers to health services?
- Do policy makers view central government programmes and policies as appropriate?
- What are the basic requirements for the delivery of evidence-based information on policy-relevant subjects from the viewpoint of policy makers?

The understanding of policy planners on recent study findings was assessed. For this purpose, recent operational studies were reviewed and their findings were compared with the current thinking of the policy planners on access barriers to health services. Findings are divided into five major categories: Access barriers (further divided into supply side, demand side and intermediary barriers), Relevance of operational studies in removing access barriers, Major findings of the operational studies, Recommendations by policy planners to remove access barriers and Conclusion. A summary matrix of key findings along with the recommendations is presented in Annex – III.

4. Findings

4.1 Current Thinking of Policy Planners on Access Barriers

Respondents' views on access barriers have been examined below by grouping them into three categories, namely: supply side barriers, demand side barriers and intermediary barriers.

4.1.1 Supply Side Barriers

A. Unstable Political Situation

Almost all respondents felt that the unstable political situation prevailing in the country is the most significant factor in impeding people's access to health services. The unstable political situation has negatively affected the quality of health services as well as people's access via various channels as explained below.

a. ***Poor Accountability:*** Most policy makers felt that health service providers have little accountability towards their duty, role and responsibilities. Health workers also do not seem to be accountable and responsible to the local people.

b. ***Politicisation:*** Formation of unions is the right of health workers, but over the last few years, different unions of health workers have promoted a culture of politicising all administrative and governance-related activities rather than working to safeguard the rights and interests of health workers. Health workers who have good links with top political leaders are able to use their influence to enjoy substantial benefits and are placed in relatively less remote areas. Those who do not have good political links are forced to stay in remote areas for longer periods of time. There is a severe lack of discipline and respect to the chain of command among health workers. Due to heavy political influence, the existing chain of command has been virtually broken in the health structure and system.

Training and other opportunities are not properly distributed among the health workers. Instead, often political links and influence are the basis of selection for training, exposure and other opportunities for capacity development. Most health workers who have good political connections are protected by their political network even if they do not engage in the health facilities. This has created a situation in which they act with impunity and this has also contributed to low self esteem, lack of motivation and frustration among other health workers.

Further, most health workers who have no political links are de-motivated mainly due to unjustified career ladder and poor practice of any merit-based promotion policy endorsed by MoHP. These factors have ultimately affected the quality of health services adversely, especially at the primary level health facilities.

Political instability has caused frequent change in the government, leading to changes in health priorities even to the extent that they contradict existing policies.

c. ***Conflict:*** Frequent and unpredictable strikes and 'bandas' for even minor reasons have affected access to health services. Such strikes have been disrupting even ambulatory and emergency services. As the result, many complicated cases have resulted in preventable fatalities. This applies particularly to TB patients who are deprived of necessary medicines under DOTS. Supplies of medicines in general are also affected.

B. Health Workers

Number, retention, behaviour and competence of health workers were highlighted as another set of barriers in accessing health services by a significantly high number of study respondents.

a. ***Retention of Health Workers:*** Most policy makers and planners felt that there are frequent absences of health workers in health institutions, especially in remote areas. This deters local people from accessing diagnosis, treatment and technical counseling. Moreover, absence of health workers in the health facilities for long periods of time leads to under-utilisation of available equipment, which ultimately gets rusted and unusable.

If the rules and regulations are followed effectively without political interference, it will be easier to retain the health workers in the health facilities. In Dhading district, all 50 VDCs have an adequate number of supplies of drugs. During the rainy season, there is increased vulnerability to epidemics of communicable diseases, no health workers are allowed to apply for leave and must remain in the health facilities. The result of this policy is that the district does not have any epidemics (for example, unlike Jajarkot).

Some of the reasons for health workers not to stay in the health facilities include – politicisation, centralised training and workshops, no replacement of the health workers who are on study leave for longer duration of time and unscientific 'Kosh' system for travel allowance (Kosh is a traditional unit to measure distance which roughly equals to one and half kilometer. Travelling allowances are paid to the government staff on the Kosh basis when they are walking. Particularly in remote areas, staffs claim long travelling days, as they are required to walk four Kosh a day. Accordingly they are absent from the facilities for considerable periods). Such Kosh system works as an incentive for the health workers to spend longer time in travelling. Health workers are also found to be reluctant to stay in their duty station in remote areas due to isolation, lack of information access and risk of political and communal conflicts. The medical curricula do not cover even the most essential social dimensions (such as services to humanity, social responsibilities of health workers, social values and ethical norms) which are prerequisites for motivating the health workers to be passionate and committed to work in the remote areas.

Patan Hospital has made a mandatory provision of deputing the medical doctors to the remote areas for one month in a year on a rotational basis. The doctors working in the remote areas will have direct access to information so that they can consult in difficult cases with the consultants and other senior staffs. This way Patan Hospital is serving the remote areas where other health workers were reluctant to stay.

b. ***Number:*** The existing health service system does not have an adequate number of skilled and qualified health workers to meet the growing needs of the population. Particularly, the number of specialised health service providers (Anesthetists, Pathologists, Gynecologists, and Chest Physicians etc), especially in the tertiary level health facilities, is limited. This situation is preventing people from accessing health services in general.

c. ***Frequent Transfers:*** After every change in government, many health workers are transferred from one place to other. This does not allow health workers to build rapport and stability in the community and as a result people do not feel comfortable in the delivery of health services from the health institutions. This also has a detrimental effect on maintaining institutional memory, mainly due to lack of proper handover and takeover mechanisms after transfer of staffs at higher ranks in the hierarchy.

d. ***Attitude and Behaviour:*** Behaviour and attitude of health workers is a consequence of their socialisation process and is not only

health-sector related. Health workers have developed a superiority complex and feel that they are civil 'masters' not 'servants'. Moreover, respondents believe that health workers perceive the patients as a burden to them and they even misbehave with the patients while delivering the services. Health workers also believe that they are indispensible and no one can take action against them. Generally, health workers behave rudely with patients while they are working in the government health facilities. In their private clinics, however, they are polite and kind with their patients. The reason for this variation is self interest, but it could also be due to work load, lack of proper incentives, and frustration due to politics and policies.

e. ***Skill and Competence:*** In many of the primary level health facilities, the health workers lack proper skills and competence to handle the patients while providing health services like family planning, delivery of babies and many others. This is mainly due to lack of proper needs based training. In particular, health workers are very weak in counseling patients.

Various dimensions of supply side barrier are shown in Figure 1.

C. Health Facilities

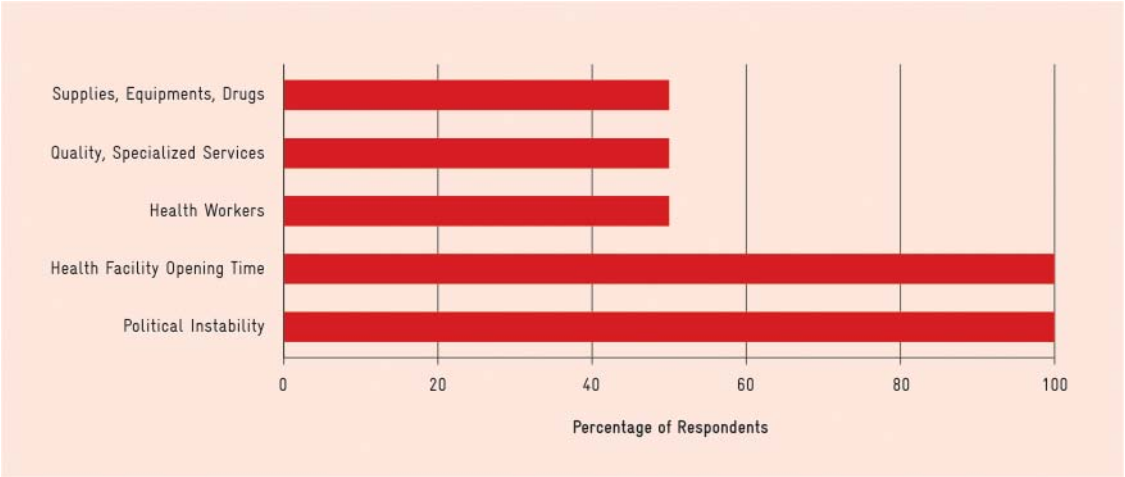
A large number of respondents expressed the view that opening hours, quality of services, specialised services and privacy in the health facilities are also impeding people in accessing health services.

a. ***Opening Time:*** There was a strong concern of the policy planners about the opening hours of the health facilities, especially at the primary level. The respondents viewed that the current opening time of the health facilities (10 am to 2 pm) at the primary level is not appropriate. Workers, students and job holders cannot visit the facilities during these hours and are therefore deterred from accessing health services.

b. ***Quality:*** Health institutions do not meet the required standards to maintain the quality of the services in terms of availability of trained, competent and skilled human resources, adequacy of supplies / drugs / equipments, client-provider relationship, infrastructure (OT, ICU, etc) and opening times. Additionally, most of the health workers in the primary level are not trained in dispensing drugs, and pharmacies at the tertiary level hospitals are not functioning in most cases.

In curative health, it is extremely important to ensure the quality of health facilities as

Figure 1. Supply Side Barriers



they are the place where people come to demand health services, whereas the health workers often visit the households in preventive health care.

c. ***Specialised Facilities:*** People are reluctant to seek health services due to limited availability of patient-friendly facilities. Many people with physical disabilities cannot visit primary health facilities as there are no frequent services through camps. Senior citizens hesitate to visit health facilities as comfortable seating arrangements in the waiting rooms are not available in all health facilities.

d. ***Privacy:*** Women often do not feel comfortable to get checked up by male health workers because of privacy concerns. At the same time, inadequacy of physical infrastructure prevents privacy in treatment. Respondents mentioned that women who deliver their babies in health facilities use the same room that serves both as an administrative room as well as a delivery room.

D. Supplies, Equipments and Drugs

Limited supplies, inequitable distribution and irrational use of drugs in most primary level health facilities also prevent people from accessing health services. Often the drugs and other supplies do not reach the health facilities in time and consequently health facilities find it increasingly difficult to meet the growing needs of the people. This is caused by a combination of lack of a proper and timely distribution system as well as poor managerial skills on the part of health facility managers.

E. Limited Trust on Governmental Health Facilities

Many people at the community level have no trust in the quality of governmental health institutions and they are reluctant to visit the health facilities. Most people have a general perception that health facilities are closed most of the time, have a shortage of health workers, and drugs as well as other consumables are usually out of stock.

4.1.2 Demand Side Barriers

A. Poverty

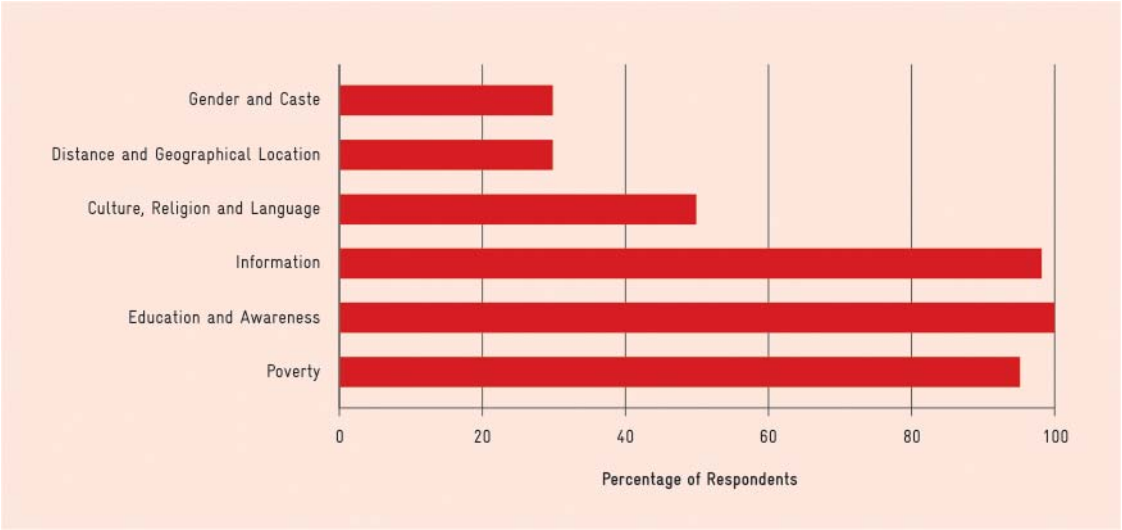
A majority of respondents stated that roughly one third of the people are trapped in a vicious circle of poverty (poverty leads to poor health as people cannot afford to pay the cost of health services; poor health prevents people from earning opportunity and due to low income they cannot afford to pay for the services). Poor people cannot afford to pay the transportation cost even if the cost of treatment for primary care is free. Additionally, there is the issue of opportunity cost as family members and other supporting individuals have to lose their wages when they accompany a patient to visit health facilities for services. In the case of pregnant women, at least three/four other family members, relatives and neighbours are generally needed to get the patient to the health facility for delivery of the baby.

Government has made a provision of providing free services to poor people but the task of identifying the actual poor is extremely difficult. There are no clear guidelines and indicators to identify the poor. As a result, often relatively richer people who identify themselves as poor are also considered poor. On the other hand, even needy poor people do not get much required health services free of cost when they fail to convince the concerned officials that they are poor.

B. Education and Awareness

People in remote areas are usually uneducated and the level of awareness is low and as a result, they have poor health-seeking behaviour. People are often not aware of the availability of specific health services at any level of health facility. There are not adequate promotional activities to raise awareness. People have a tendency to visit health facilities only when they have a significant problem due to sickness. They do not care for preventive measures.

Figure 2. Demand Side Barriers



Various dimensions of demand side barrier are shown in Figure 2.

C. Information

Mechanisms to disseminate meaningful information, education and communication materials through the media accessible to poor people in the remote areas are very weak. As a result, most needy people do not get information. Use of information technology has been limited to simple measures in spite of huge amounts of resources being spent on information technology. Furthermore, the government investment on promotional materials is very low.

D. Cultural, Religion and Language

People have the conservative belief that they should not die in the hospital so many elderly people are reluctant to visit a hospital. There is tendency of women to deliver their baby at home just because their mother-in-law insists on it. There are many other cultural and religious stigmas that are responsible for people not adequately using health services available at the heath facilities. Diverse practices in different societies and different religions also prevent people from accessing health services.

In most parts of Terai and in some of the Mountain regions, language is another barrier to patients as they cannot express their concerns in the language they speak and understand. In particular, women patients hesitate to express their problems freely and frankly.

E. Distance and Geographical Location

Often the people who are near to the health facilities are the ones who access health services easily. People from distant clusters are not able to visit the health facilities mainly due lack of transportation services and also because of

The laboratory test service in the National Public Health Laboratory is available at a very nominal cost, the quality of service is very good as standard equipment is used and the laboratory technicians are well trained. In spite of this, poor people do not come for the service as they are not aware of it. As a result, relatively low cost service is being used mostly by rich people who have access to information. Even the health workers engaged in the private health facilities go to the government facility for good quality service but promote private clinics to the patients, so health workers themselves are barriers to accessing good quality services.

their inability to pay the travel cost. Although the location of the health facilities is often decided by the Village Development Committee (VDC), it is usually influenced by the political interest rather than local needs. Geographical distance accompanied with rough terrain also causes a problem in accessing health services but this is the bitter reality of the country. Policy makers should be able to remove this barrier by ensuring functional location of the health facilities.

Out of 14 districts selected for devolution probably Chitwan is the only district to practice entire principles of devolution. In Chitwan the fund allocated to the district health programme is channeled to the District Development Committee after approval of the DDC board and then to DHO. DHO then instructs the bank to transfer funds to respective health facilities. In the health facilities the Health Facility Management Committee (HFMC) is responsible for managing the fund. Monthly salary to the health workers is paid; drugs and other supplies are purchased. The inclusive HFMC is very active in monitoring and supervision and to ensure the quality of service and the retention of health workers. As a result 99 percent of health workers are retained in the health facilities. It was possible only because the HFMCs are given not only responsibility but also authority and resources. This could be replicated in other districts.

F. Gender, Caste

The health system and health policy as such do not exclude anyone on the basis of ethnicity, language, caste and religion. However, there is a considerable lack of functional policies targeted to bring indigenous groups of people such as Raute, Chepang and many others to the health facilities. As a result, these people are historically excluded from accessing health services. Further, extreme case of gender inequality persists in society. Women are still the subject of discrimination and as a result they are often deprived of different health services.

In most villages families take a long time to decide whether to seek even the freely available health services in government health facilities. Often the decision making process is male-dominated.

4.1.3 Intermediary Barriers

Nearly all respondents have indicated some barriers that hinder access to health services indirectly, which could be termed as intermediary barriers. The indirect barriers are related mainly to policies and programmes and include a weak monitoring system, weak coordination and redundant policy. Thus, these barriers could also be considered to be policy barriers.

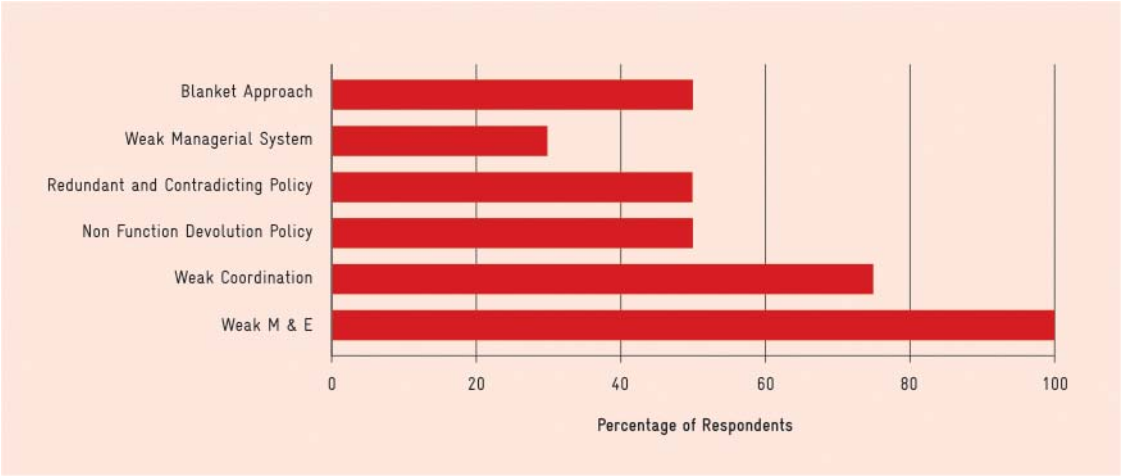
A. Weak Monitoring, Supervision and Evaluation

Government institutions function with very good monitoring tools, processes and systems, but the implementation aspect is not so effective. The system of reward and punishment on the basis of monitoring results does not operate effectively. District Health Officer / DPHO responsible to monitor health workers and health institutions do not have an effective monitoring capacity. The role of the Regional Directorate in monitoring and supervision is not very clear. Weak monitoring and supervision have also resulted in placement of health workers contrary to the principle of 'right person in the right place'.

B. Weak Coordination

Coordinating mechanisms with the NGO and private sectors are so weak that they allow these sectors to work in the place of their convenience instead of covering areas with the most need. Within the government system, inter- and intra-departmental coordination is also very weak. This has resulted in the production and dissemination of uncoordinated training and Information, Education and Communication (IEC) materials by national

Figure 3. Intermediary Barriers



and international agencies going beyond the national training and IEC policy and priority. Weak coordination also prevails in higher level management. Most high level managers work in isolation without meaningful coordination.

Various dimensions of Intermediary barrier are shown in Figure 3.

C. Non Functional Devolution Policy

The policy of devolution in the selected 14 districts across the country is not functioning properly. The main aim of devolution was to ensure local level management of the health services, but it has been limited to the transfer of budget through the District Development Committee (DDC), simply adding one more layer in the process of an already delayed budget release mechanism.

D. Redundant and Contradicting Policy

a. ***National Health Policy:*** The health policy formulated in 1991 has been redundant as it is affecting in delivery of quality health services. National population has almost doubled now compared to 1991 when the policy was formulated and the organizational structure of health ministry remains same. Many policies are also found to contradict each other. (Example: a health worker of 4th level is not promoted even after working for three and half years, whereas a health worker of 2nd level is promoted to 4th level after working only for 18 months).

b. ***Budget Release Process:*** The existing process does not allow timely release of budget to the district and health facility level. This prevents the health facilities from delivering services in time. Often, due to frequent changes in government, priorities also change and these changes in turn have a detrimental effect on the budget release process.

c. ***Focus on Preventive Health Care:*** For last 20 years, curative health care has been neglected and the priority of government health policy has been on preventive health services only.

E. Inability to disseminate health service provisions to the household level.

F. A weak managerial system that cannot prevent frequent and centralised training to health workers, leaving managers with an inability to fulfill vacant posts when the health workers are on study leave.

G. A blanket approach to supplying drugs, equipments and other supplies. There is no

mechanism to ensure local level planning to meet local needs.

(Note: A summary of the current thinking of policy planners on the access barriers to health services along with their suggestions to remove the barriers is presented in a tabular from in Annex – III)

4.2 Relevance of Operational Studies in Removing Access Barriers

4.2.1 Relevance of Operational Studies

More than three quarters of the respondents, mainly administrators and managers, considered that the findings of operational studies could contribute to the removal of barriers to health services. Some of the recommended techniques were formulation of conducive policies, designing of effective programmes, strengthening of the programme implementation process, modification of the programme implementation mechanism, development of policy guidelines and its timely amendment. Almost ten percent of the respondents also spelled out those operational studies are relevant in changing the programme title to make it more catchy and appropriate to suit the spirit of the policy and programme.

Roughly ninety percent of the respondents were equally concerned about proper use of study findings to be translated into policy and subsequently into programme design. More than half of the respondents, mainly high level policy planners, felt that findings of some recent studies were successfully translated into policy and programmes as they were tactfully followed up with series of proven and effective efforts.

A. Coping with the Burden of Cost

More than half of the respondents highlighted the operational study "Coping with the Burden of Cost (2003)" by Tim Ensor et al and viewed that findings of the study were effectively translated into policies and programmes. The study commissioned by the Family Health Division and funded by the National Safer Motherhood Project (NSMP) / DfID had recommended conditional cash transfers to women to support them in accessing health facilities to deliver their babies. The Health Economics and Financing Unit (HEFU) at the Ministry of Health and Population (MoHP) was proactive in elaborating the study recommendation into a policy paper after thorough debate and discussion with various stakeholders. The policy paper suggested introducing a Maternity Incentive Scheme (MIS) to provide cash incentives to mothers delivering their babies in government health facilities, as well as corresponding incentives to health workers and support to health facilities in low Human Development Index (HDI) districts.

B. Process Monitoring, Process Evaluation and Impact Evaluation of Maternity Incentive Scheme

The incentive scheme was implemented across the country without considering the policy recommendation of piloting it in limited number of districts and subsequently expanding in other districts. As a result, different operational complications were encountered. Three operational studies were carried out respectively on process monitoring, process and impact evaluation to address the emerging need to modify operational processes after two years of MIS implementation. On the basis of the recommendations made by these three operational studies, the MIS operational guideline was amended. The Family Health Division (FHD) along with the MoHP developed yet another policy paper that recommended provision of incentives to all delivering mother by removing the parity condition. Subsequently, the MIS was changed into the Safe Motherhood Incentive Scheme (SMIS) to make it more appropriate. With

these provisions, the desired outcome, for example to raise the number of institutional deliveries, was not met even if the access barriers were addressed to the greater extent.

Besides the cost of transportation, operational studies found that the most significant barrier is the institutional cost and recommended that such costs should be covered since many women were not in a position to cover them. The SMIS was branded as Aama Surakshya Karyakram (ASK) that covers the cash incentive to mothers to cover the transportation cost, free institutional delivery and incentive to the health workers. Subsequently, the ASK was reviewed after one month of implementation and that review recommended a change in the unit cost being provided to health facilities as it does not meet the requirements. Following the recommendation, a policy paper was prepared and the unit cost to the 25-bedded hospital was increased.

C. Examining the Impact of Nepal's Free Health Care Study

First Facility Survey Report (2009): In response to the constitutional provision of health as people's right, the GoN has introduced the programme of FHCS across the country. This provision was made after a thorough discussion at the policy level and a policy paper was also developed. Nevertheless, a number of operational challenges were faced during the implementation due to absence of appropriate policy guidelines. Nearly half of the respondents felt that the operational studies are useful not only in policy formulation but also in strengthening the implementation process. In this regard, the respondents provided an example of the study undertaken jointly by GoN, Care-Nepal and RTI-Nepal to assess the operational challenges of FHCS. The study suggested improvements to the access of the poor and *Dalits*; improved Health Management Information System (HMIS) monitoring of the marginalised; increased funding for district health services and a substantially increased budget for drugs.

Translating the operational study into action, GoN has extended the FHCS beyond the Primary Health Care Centre (PHCC) level. In response to the recommendation made by the study, the issue of equity was addressed by making a provision for free health services to targeted groups (ultra poor, poor, senior citizens, people with disabilities and FCHV) at District Hospitals across the country. In response to the recommendation of raising drug supply to the health facilities, the government has increased the essential drugs (ED) list to 40 items in district hospitals, 35 to PHCC and 25 to Sub-health Post (SHP), including the drugs for obstetrical delivery services.

D. Retention of Human Resources

Less than half of the respondents expressed the view that GoN has drafted a new strategy that will be effective soon in response to some operational studies such as Coping with the Burden of Cost, Evaluation of MIS and Demographic Health Survey (DHS). These studies have indicated the difficulty of retaining health workers in remote areas, which subsequently affected the delivery of quality health services.

E. Human Resource Study

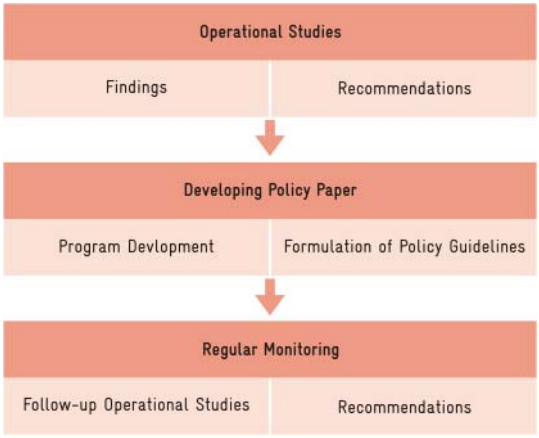
Less than ten percent of the respondents indicated that the GoN has formulated a Human Resource Strategy to fill vacant positions in response to the findings of the human resource study undertaken by RTI.

F. Revision of the National Health Policy

Less than ten percent of the respondents expressed the view that the government is taking the initiative to formulate new national health policies in response to the recommendations made by number of operational studies.

4.2.2 Factors that Contribute to Translating Study Findings into Policy and Programmes

Several studies discussed earlier are some of the excellent examples, as described by more than half of the respondents, of translating the findings of operational studies into policies and programmes and modifications to meet emerging needs and challenges. The following chart illustrates the necessary actions needed to translate the research findings into policy:



The respondents have also indicated some unavoidable factors that contribute to translating the study findings into policy. It was highlighted that the findings of the operational studies will be translated into policy formulation and debate only if:

- The study is commissioned on the basis of identified needs
- The study process is owned by the government
- It is consistent with donors' interests associated with international commitments, such as MDG
- It is substantiated by institutional memory
- Recommendations of the study are followed by coordinated efforts of all stakeholders in policy advocacy

4.3 Current Thinking of Policy Planners on Recent Government Initiatives to Remove Access Barriers

Following the findings of several operational studies, the government has made many policy decisions to remove barriers to access to health services. The recent data and information have indicated that the government initiative has certainly contributed in reducing the barriers. However, in the actual field, the availability of quality health services has not yet been assured. This raises concerns about the quality of data and information.

4.3.1 Free Health Care Services

Most respondents felt that the FHCP was enforced with a good intention of increasing access of poor people to health services. Though FHCP is not enough to provide complete health services, the policy provisions have contributed to increasing the number of out-patients in the health facilities. At the same time, this has also led to corruption, misuse of equipment and irrational use of drugs. Further, a large segment of poor people still are not aware that services in the health facilities are really free. As a result, only those people who usually have access to information are availing themselves of free services. Many poor people are deprived of the services simply because they are not aware that services are free.

Drugs are supplied on a blanket approach without assessing disease pattern and morbidity trends. This results in irrational use of medicines. People have a tendency to demand and hoard extra quantity of drugs to ensure their treatment in the future. They often demand drugs and other consumables for other members of the family as they do not need to pay.

The free health care policy does not cover laboratory and other clinical tests. Only at the district level are tests covered for patients below

Health facilities with functional birthing centres have increased community trust and localised services have been further strengthened. Unfortunately, however, even in Kathmandu district, which is much more accessible, provision of 24 hour services is functional only in three out of eight birthing centres. This was made possible due to additional resources provided to the centres.

15 and above 61 years of age. Further, in the view of respondents, the policy of FHCS in one hand is not sustainable for longer periods of time and, on the other hand, FHCS has made other well-established schemes such as the Community Drug Programme (CDP) non-functional. Presently, people are getting only ED even in those places where the CDP was effectively functional earlier.

Health workers are found to be less accountable for the management of FHCS. The FHCS Programme, in general, is still centralised except that some authority is granted to the health facilities to purchase medicines at the local level.

4.3.2 Aama Surakshya Karyakram (Safe Delivery Incentive and Free Delivery Care)

Significantly, a large number of respondents felt that the free delivery care service has contributed to raising the number of institutional deliveries. However, some respondents said that the incentive programme is not appropriate as it cannot be sustained and eventually the situation will revert to the way it was before. This shows that even the policy planners are not convinced that the incentive scheme is an intervention for longer term behavioural change, through which people who once have the experience of delivering babies in health facilities will continue that practice in the future even after the incentive is withdrawn. The provision of incentives to health workers who visit households for deliveries has been another barrier to the encouragement of institutional deliveries as such incentives continue to promote home delivery. The incentive scheme at the urban level is irrelevant as the amount provided is not significant for middle class urban people. On the other hand, the incentive amount could be increased for rural poor women.

The provision of 24 hours services in health facilities with birthing centres is not being practiced and monitored effectively mainly due to absence of skilled birth attendants (SBA) specially during nights.

4.3.3 Outreach Clinic

The monthly outreach clinic provides immunization and other services in the vicinity of the households and has helped in reducing geographical barriers.

4.3.4 Referral System

The number of patients seeking services at the primary level has increased in general. However, due to lack of an effective referral mechanism, barriers to accessing higher level necessary health services have not been removed. Although provision of specialised treatments for the disabled, for senior citizens and for children at the tertiary level health facilities is intended, the weak referral system results in barriers to accessing these services.

4.4 Selected Operational Studies and Thinking of Policy Planners

4.4.1 Major Findings of Selected Operational Studies

Following are the major findings of some selected operational studies:

A. Coping with Burden of Cost (Tim Ensor et. al, 2003)

The study has indicated cost as the main barrier in accessing health facility for delivery. Subsequent studies on monitoring of the MIS have suggested some procedural changes and policy amendments.

B. Overcoming Barriers to Health Services (Tim Ensor and Stephanie Cooper, 2004)

This study has suggested an analysis of the demand for health care on the broader perspective of livelihood framework (natural, physical, economical, cultural and social) as it is the means of obtaining desired capabilities.

C. Access to Health Care in Rural Jajarkot District (International Rescue Committee, 2009)

This study found that lack (or perceived lack) of drugs (44%), facility too far away (36%), patient not sufficiently sick (21%), inadequate facility hours (13%), non-availability of staffs (10%), and not enough money (9%) are the impeding factors to accessing health care in rural Jajarkot district.

4.4.2 Comparison of Findings of Operational Studies and Current Thinking of Policy Planners

In comparing study findings with the current thinking of policy planners on access barriers, the following observations are made:

- In general terms, policy planners have a clear understanding of access barriers as their understanding is basically consistent with the findings of operational studies. There are some discrepancies, however, on specific elements:
  - Geographical distance as the access barrier indicated in most studies does not match with the current thinking of the respondents. While the majority of the respondents agreed that geographical distance is a barrier, some argued that such barriers in a country with the geography of Nepal are inevitable and cannot be changed. This is very much a policy-related barrier, as the location of most health facilities is decided not on the basis of need but on political influence.
  - Some cross-cutting issues such as low socio-economic status of women as indicated in other operational studies did not appear as a significant barrier in the perception of many respondents.
  - Other studies have suggested that demand for health care should be analysed within the livelihood framework and not only on the basis of financial poverty. Most respondents in this study said that the current means of identifying the poor is not appropriate as it is only on the basis of self declaration. In this situation, the actual poor who do not have access to information are deprived of health services.
- The following barriers mentioned by the respondents were not indicated by any studies reviewed during this study:
  - Most policy-related barriers mentioned by the policy planners (such as weak monitoring, weak coordination, non-functional devolution policy, weak local management capacity, redundant national health policy and many others) are not found in the studies reviewed.
  - Almost 100 percent of the respondents expressed the view that lack of political commitment coupled with an unstable political situation is a major access barrier. It was felt that due to lack of political commitment there is a great deal of impunity and limited compliance of rules by health workers. The health workers are heavily politicised and they are using their political influence not to comply with rules and regulations. This has created low morale and self esteem among powerless middle level managers who are facing difficulty in executing their duties. None of the studies reviewed has indicated political factors as barriers to accessing services.

- Similarly, none of the studies reviewed has indicated conflict as one of the barriers. Conflict has been indicated by a substantially large number of respondents as one of the key barriers in accessing health services.

4.5 Recommendations of Policy Planners in Removing Access Barriers

Following are the recommendations made by the respondents in removing access barriers in health services.

A majority of the respondents suggested the following:

a. Almost all respondents recommended seeking political commitment for the longer term, to continue and expand new programmes and also to implement the policy effectively at all levels. It was also suggested that political commitment be sought to discourage the use of political influence.

b. Almost all respondents suggested that adequate infrastructure should be provided (mainly at SHP, HP and PHCC level) in appropriate places and in consultation with local people to meet growing needs, without being influenced by politicians.

c. Nearly two thirds of respondents suggested further strengthening of HFMC by revisiting their structure and clarifying their terms of reference. They felt that HFMC are not functional in most districts mainly due to ongoing absence of local bodies. The new terms of reference should include effective monitoring of the service delivery system including the presence of health workers, quality of services and transparency in purchase of medicines and equipments. A clear and simple Monitoring and Supervision Guideline should be developed and implemented effectively after appropriate orientation and training. The District Health / Public Health Office should remain as a court and listen to the concerns and complains of local people. Strengthening of HFMC is also expected to foster social accountability, social capital and the demanding capacity of the community. Authority for reward and punishment should be given to HFMC by making clear provisions in the terms of reference (ToR).

Nearly half to around one-third of respondents suggested the following:

d. Nearly half of the respondents recommended amending the National Health Policy of 1991 with a clear vision, defined health priorities and refined organisational structure, including provision of curative and public health departments. A Health Finance Unit at the central level should be established in the new structure, with a mandate to remove financial barriers. The Health Finance Unit should have sub-units at the District level. This unit should be given responsibility for maintaining health accounts from the district to national level in an acceptable framework that should be reviewed periodically. The national health account should aim at calculating the unit cost of institutional treatment, the number of health workers involved and the disease burden.

e. About half of the respondents felt that the cost effectiveness of recently implemented government initiatives such as FHCS, ASK should be assessed and replicated only if they are found cost effective and beneficial to the poor. Mandatory provisions for management audit should not be limited to financial audit only. Social auditing could be practiced to ensure cost effectiveness and accountability of health workers that could subsequently contribute to quality health services.

f. Nearly one third of the respondents recommended that health services should not be viewed in isolation of other socio-economic factors. Construction of infrastructure, supply of medicines and placement of health workers are not the only constituents of health services. A holistic approach should be taken with obvious links to other services such as drinking water, education, income generation.

g. About one third of the respondents suggested that decentralisation should be practiced in its true spirit by stopping the centralised blanket approach. This is expected to ensure resource allocation on the basis of local needs, morbidity patterns and trends.

h. About thirty percent of the respondents suggested making people literate and knowledgeable about different aspects of health so that people can access information and change their health-seeking behaviour. Localised health services should be promoted by further strengthening and motivating health workers such as FCHV, Village Health Worker (VHW), and Maternal Child Health Worker (MCHW) who conduct door to door visits.

i. About ten percent of the respondents felt that a publicly-sponsored health insurance scheme could be one of the best mechanisms to ensure easy access of health services even to the poor people. This could be initiated from the formal sector, trade unions, bureaucrats, and army and police personnel.

The following were the suggestions from a relatively small number of respondents (less than 10%):

j. Information technology can be used at its maximum possible level to disseminate the information. A simple provision of easy, simple and accessible to all health workers such as 'facebook' should be developed for exchange of information and sharing experience. Information barriers could be removed by developing national and district level databases by integrating HMIS, Logistics Management Information System (LMIS) and Human Resource Development Information System (HURDIS).

k. Tertiary level health institutions could take the initiative to send their health workers to remote areas to work for certain period of time on a rotational basis, as practiced by Patan Hospital.

l. The medical curriculum should be revised to include a social dimension so that health workers are motivated and encouraged to work in remote areas.

5. Conclusions

It could be concluded in this study that the policy planners have a clear understanding of general types of access barriers as their views basically match the findings of operational studies. Moreover, operational studies can play an important role in policy and programme formulation to remove access barriers if the studies are commissioned carefully with active and meaningful engagement of government, donors and other stakeholders. There are some excellent examples of the study findings that have been translated into policies and programmes and have contributed in minimizing access barriers to the greater extent. However, policy formulation and programme design are not sufficient to remove barriers to the desired level. The prevailing trend of people to lose their trust in government health facilities for a number of reasons, unsustainable donor driven programmes, ever-changing national health priorities, a high level of continued impunity, lack of discipline and too much politicisation of health workers as a result of political instability and lack of political commitment are the key barriers to accessing health services. These factors also have a detrimental effect on implementation of policies, plans and programmes aimed at removing barriers.

Annexes

Annex I

Discussion Check List

1. What is your opinion on the operational studies being carried out by many organisations?
   a. Relevance
   b. Effectiveness
   c. Usefulness in initiating policy dialogue and policy formulation
2. What is your opinion on access barrier in health services?
   a. What are the factors that prevent people in asserting their rights and accessing health services in general?

      Depending on the answer, probe on following factors;

      i. Demand Side:
         - Economical – poverty (rich, poor, opportunity cost)
         - Natural – geographical terrain (mountain, hill, terai, rural/urban)
         - Social – inclusion/exclusion (people with disability and aging), gender, education
         - Cultural practices – religion
         - Political – information, delay in decision making at the institutional level and family level

      ii. Supply Side:
         - Competence, capacity, behaviour of health workers and their presence in health facilities especially in rural and remote area?
         - Budget allocation and fund flow system/procedure
         - Availability of drugs and equipments
         - Monitoring and feed mechanism
         - Rapid development and expansion of the programmes related to social security sector

   b. Who do you think about the most vulnerable groups of people in accessing health services?

   Women, children, dalits, janajati, elderly people, disabled

   c. What do you think about the reasons for these people being vulnerable in accessing health services?
   d. What is your opinion on some of the key findings of recent studies on access barrier to health?

i. Supply Side:
    1. 24 hours service availability
    2. Unavailability of services and its associated cost
    3. Unavailability of trained health workers
    4. Unavailability of drugs
    5. Equipment
    6. Clinical and programme implementation protocol
    7. Lack of affordability of travel cost
    8. Language barrier with patients
    9. Gender bias for health care
    10. Poor referral linkages
    11. Lack of transparency
    12. Distribution of work- untrained persons for specific skilled work i.e. Nurses at OPD

ii. Demand Side:
    1. No coordination with health and NGO working for vulnerable community development so that the community mobilisation is not done
    2. Unavailability of trained health workers and high cost of health services
    3. Health service providers are not receptive and sensitive to patient care as per the socioeconomic condition of the patient
    4. Lack of services in public health facilities
    5. Un-affordability of cost of travel to health facilities
    6. Lack of knowledge on free health policy for target groups
    7. Socio cultural barriers such as language barrier and inferiority complex and gender bias for health care seeking
    8. Less acceptance towards modern medicine
    9. Absence of health workers during office hours
    10. Distance factors
    11. Tendency to use services/medicine from private sectors

e. What do you think about the major causes for these barriers?

f. What has been the trend in removing/adding more institutional barriers to access health services?

g. Which recently formulated government policies, guidelines and practices helped in removing barriers to access health services? (Probe -- Free health care services, Maternity incentive scheme, free delivery care services etc)

h. What do you think about the basic requirements on the delivery of evidence-based information on policy relevant subjects?

i. What challenges are you facing regarding the drugs, human resources and financial aspect after the implementation of the FHCP?

j. What are your concerns about the FHCP? What would you suggest in order to improve the implementation of the FHCS?

Annex II

List of Respondents

1. Dr. Thakur Raj Adhikari, Director, Department of Ayurved, DoHS, Teku, Kathmandu
2. Mr. Radha Raman Prasad, Director, Department of Drug Administration, Bijulibazar, Kathmandu
3. Dr. S.S. Tiwari, Director, Management Division, DoHS, Teku, Kathmandu
4. Dr. Puspa Malla, Director, National Tuberculosis Centre, Bhaktapur
5. Dr. Surendra Serchan, Act. Director, Mental Hospital, Lalitpur
6. Mr. Bhogendra Raj Dotel, Asst. Director, Family Health Division, DoHS, Teku, Kathmandu
7. Mr. Bishnu Paudel, Officiating Director, National Leprosy Control Centre, DoHS, Teku, Kathmandu
8. Mr. Laxmi Raman Ban, Director, National IEC Centre, DoHS, Teku, Kathmandu
9. Mr. Arjun Bahadur Singh, Director, National Health Training Centre, DoHS, Teku, Kathmandu
10. Mr. Kedar Paneru, Under Secretary, Ministry of Finance, Singadurbar, Kathmandu
11. Mr. Sanjaya Khanal, Under Secretary, National Planning Commission, Singadurbar, Kathmandu
12. Dr. Biswa Raj Khanal, Officiating Director, Epidemiology Disease Control Division, DoHS, Teku, Kathmandu
13. Dr. Sheela Verma, Director, Maternity Hospital, Thapathali, Kathmandu
14. Dr. Rajesh Gongal, Director, Patan Hospital, Lalitpur
15. Dr. Geeta Shakya, Chief, National Public Health Laboratory, DoHS, Teku, Kathmandu
16. Dr. Saroj Prasad 'Rajendra', Director, Shukra Raj Tropical and Communicable Disease Hospital, Teku, Kathmandu
17. Mr. Mahesh Puri, Regional Leprosy TB Officer, Surkhet
18. Mr. Chuda Mani Bhandari, DPHO, Kathmandu
19. Mr. Daud Mahommad, DHO, Dhading
20. Mr. Ramesh Adhikari, DPHO, Surkeht
21. Mr. Bal Bahadur Mahat, DHO, Bardiya
22. Mr. K.S. Gadar, DPHO, Banke
23. Mr. Jaya Bahadur Karki, DPHO, Bhaktapur
24. Dr. Ananda Shrestha, Regional Director, Mid-Western Region,Surkeht
25. Dr. Hari Sapkota, Act. Medical Superintendent, Regional Hospital, Surkhet
26. Dr. Suresh Tiwari, General Secretary, Nepal Public Health Association

Annex III

Key Findings and Recommendations – A Summary

Summary of the key findings is presented in a tabular form below that includes issues, intermediary barriers and primary barriers in accessing health services along with key recommendations of policy planners for removing the barriers.

For the purpose of this study, issues, intermediary and primary barriers are defined as follows:

Issues

Important subjects for debate and argument that affect the accessibility of health services and are under discussion or consideration. Issues often emerge from current social, political, economical, natural and physical condition of Nepal and have direct or indirect effect on accessibility of common people to health services being delivered by the government.

Intermediary Access Barriers

Factors that are indirectly impeding people in accessing health services but are not responsible directly for preventing people from accessing health services.

Primary Access Barriers

Factors that are directly minimising rights or opportunities of people in accessing health services.

Issues	Access Barriers in Health Services		Recommendations
	Intermediary	Primary	
Supply Side			
Political Instability	Politicisation of health workers, Lack of accountability among health workers and managers	Frequent Banda, Unpredictable strike, Blockade, Attack in ambulance	Seek political commitment to minimise political instability at least (a) to stop frequent transfer of health workers (b) to end impunity (c) to stop political protection to those not staying in the health facilities

Issues	Access Barriers in Health Services		Recommendations
	Intermediary	Primary	
Supply Side			
Human Resource	Inadequate posting of health workers in general, Vacant positions and Limited number health workers to provide specialised services	Frequent absenteeism of health workers specially in remote area; lack of friendly behaviour with the patients; lack of motivation and passion to work in the community; low self-esteem due to extreme politicisation of the health workers; less competent health workers	Revise National Health Policy of 1991 with balanced focus on curative and preventive health care, Incorporating other social dimensions in health curriculum
Capacity Building	Centralised trainings and workshops	Lack of appropriate and need-based training programme	
Governance	Frequent transfer of health workers, Lack of discipline, Impunity, Weak monitoring and supervision system, Policy of reward and punishment not functional	Lengthy budget release process, Policy of devolution not functional	Ensure effective management of health facilities by strengthening and restructuring Management Committees and their responsi-bilities, Ensure localisation of health services by strengthening and mobilising FCHV, MCHW, VHW etc, Make the mandatory provision of 'management audit' of health services
Health Facilities	Lack of privacy specially for women, Limited availability of specialised services for elderly people, disabled and women	Lack of public trust on government health facilities, Opening time of health facilities not compatible with local needs, Unavailability of health workers as per need, Poor infrastructure, Inadequate training and skill development to health workers, Very poor referral services	
Supplies, Drugs and Equipment	Irrational use of drugs, Poorly managed distribution system	Lack of adequate and timely supply of drugs/equipment	
Demand Side			
Poverty	Opportunity cost, Low social capital due to poverty	Trapped in vicious circle of illiteracy, Poor health, Low income and isolation	Examine all five dimension of poverty (economical, social, physical, natural and human) and develop a clear set of indicators to identify poor people; Implement a publicly sponsored health insurance scheme to enhance accessibility

Issues	Access Barriers in Health Services		Recommendations
	Intermediary	Primary	
Demand Side			
Education and Awareness	Lack of awareness due to low level of education	Not familiar with emergency health problems, Poor health care seeking behaviour, Superstitious belief and faith	Ensure policy of making people 'health literate'
Information	No serious attention on information/ education/communi-cation package and its proper dissemina-tion, Centralised and Uncoordinated IEC materials	Inadequate information on FHCS, Aama Surakshya Karyakram and 24 hour delivery service, Locals not aware about the freely available services at health facilities	Revise the National Health Policy to emphasise the development and dissemination of IEC materials in a more coordinated way, Maximise the use of information technology in exchange of information and experience sharing, Develop national and district databases by integrating HMIS, LMIS and HuRDIS.
Culture, Religion and Language	Inability to express the health problems in a language other than mother tongue, Diverse religious practices in different religions	Religion does not permit going outside the house for treat-ment, shyness, objection from family members	
Geography	Inappropriate location of health facilities	Health facilities too far from the home	Resist political pressure in deciding location of health facilities
Gender, Caste and Ethnicity	No policy provision to bring excluded people to the health facilities	Delayed and male-dominated decision-making practice	

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