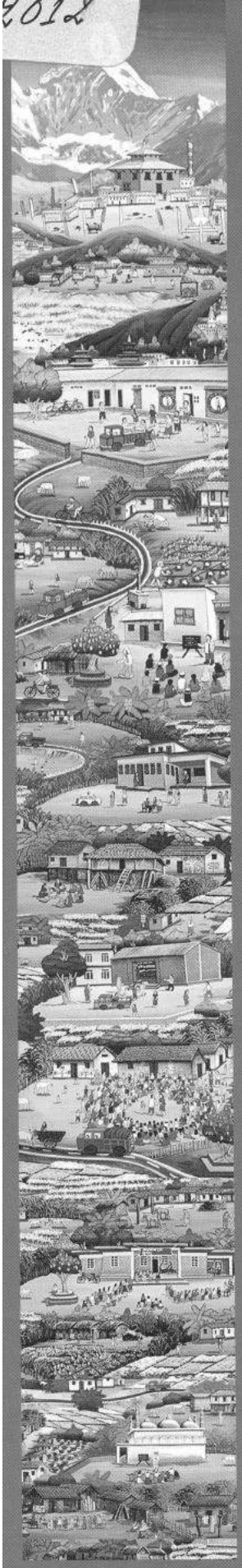

Changes in Health System and Services

Comparisons between 2008 and 2011

March 2012

USAID
FROM THE AMERICAN PEOPLE

NFHP • NEPAL FAMILY HEALTH PROGRAM

Changes in Health System and Services

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Nepal Family Health Program II
Patan Dhoka, Oasis Complex
Kathmandu, Nepal

USAID FROM THE AMERICAN PEOPLE

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ABBREVIATIONS

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
AHW	Auxiliary Health Worker
ARI	Acute Respiratory Infection
BCC	Behaviour Change Communication
BL	Baseline
BP	Blood Pressure
CB-IMCI	Community Based Integrated Management of Childhood Illness
CPD	Core Program District
DDC	District Development Committee
DHS	Demographic and Health Survey
DoHS	Department of Health Services
DPHO	District Public Health Office
EL	Endline
EPI	Expanded Program on Immunization
EOC	Emergency Obstetric Care
EOP	Emergency Order Point
FCHV	Female Community Health Volunteers
FEFO	First Expiry First Out
FP	Family Planning
GoN	Government of Nepal
HA	Health Assistant
HF	Health Facility
HFOMC	Health Facility Operation and Management Committee
HMIS	Health Management Information System
HIS	Health Information Systems
HP	Health Post
HSSA	Health System and Service Assessment
IP	Infection Prevention
IUCD	Intra Uterine Contraceptive Device
KII	Key Informant Interview
LMIS	Logistics Management Information System
MCHW	Maternal and Child Health Worker
MDG	Millennium Development Goal
MMWS	Monthly Monitoring Worksheet
MNCH	Maternal, Neonatal and Child Health
MNH	Maternal and Neonatal Health
M&E	Monitoring and Evaluation
MoHP	Ministry of Health and Population
Mg	Milligram
NA	Not Applicable

NFHP	Nepal Family Health Program
NPC	National Planning Commission
NGO	Non Governmental Organization
NHSP	Nepal Health Sector Program
ORC	Out Reach Clinic
ORS	Oral Rehydration Solution
PHCC	Primary Health Care Center
PNC	Postnatal care
SHP	Sub Health Post
SPA	Service Provision Assessment
Sr.	Senior
TSV	Technical Support Visit
USAID	United States Agency for International Development
VHW	Village Health Worker
VDC	Village Development Committee
WHO	World Health Organization

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SUMMARY OF FINDINGS

The 2011 Health System and Service Assessment (HSSA) was conducted to assess the changes in the performances of health facilities (HFs) in various aspects of service delivery and facility management in the Core Program Districts (CPDs) of NFHP II after its launch in 2008. A baseline (BL) survey of all 1,126 rural HFs was accomplished in 2008 in 18 CPDs and an endline (EL) survey of sample HFs was done in 2011 in the same districts. In the EL, sub-health posts (SHPs) were sampled using systematic random procedures while all Health Posts (HPs) and Primary Health Care Centers (PHCCs) were surveyed (census). This resulted in a sample of 284 SHPs, 56 PHCCs and 153 HPs with a total sample size of 493 rural HFs of the 18 CPDs. In the EL, the questionnaire used in the 2008 BL was used to maintain comparability between the two surveys. Data collection was accomplished by NFHP II field staff during November-December 2011.

Data was entered into the EPI Info software and analyzed in SPSS 13.0. Data of the HFs of both surveys were pooled for analysis. Changes have been documented by comparing EL data with the BL data. Results are disaggregated by HF type. The analysis of data, interpretation of results and report writing was done by the M&E team.

Service Delivery

Overall, HF infrastructure has improved. The number of HFs owning the HF building, number of rooms, provision of waiting area/room for clients, separate store, ANC care/examination/delivery room and table in the examination room increased in all HF types in EL. The number of PHCCs with no in-patient beds has also declined to 11% from 16%. Waste management practices has improved in all HF types with remarkable changes observed in availability of functioning client toilets (35% to 57%) and maintenance of cleanliness in HFs (62% to 86%). Puncture proof containers are now available in almost all HFs and 82% of HFs used properly. Four-fifths of HFs were burning waste in a pit or in a specially made pit.

Regularity of selected services has also improved as more HFs were providing CB-IMCI, antenatal, delivery and postnatal services in EL than in BL. Remarkable improvement was observed in providing delivery services from SHPs (22%) which was almost negligible in BL. Most of the HFs (86%) provides 24-hour delivery services. Technical staff staying at HF has increased (25% vs 31%). PHCCs and HPs offering long-acting FP methods have increased remarkably. However, organization of PHC outreach-clinics (ORCs) and EPI clinics has not improved.

Health Workforce

The availability of technical staff in HFs is poor, limiting the volume and quality of health services. Medical Officers (MO) and Staff Nurses are least likely to be filled-in (nearly 50%). The filled-in percent for the other cadres of staff was 85% or more. Overall, the percent of filled-in positions for technical staff declined in all HF types in EL, with the highest decline being for a doctor in PHCCs (from 79% to 47%).

The percent of GoN technical staff currently working remains almost unchanged and above 95% in SHPs and HPs but has slightly declined in PHCCs. Staff support from other sources has increased (5% in BL vs 18% in EL). HPs received more staff support from other sources than SHPs and PHCCs.

Although a high percentage of GoN staff were currently working, when looking at the number, their availability is poor. For example, the mean number of MOs and Staff Nurses currently working was less than 0.4 per PHCC. However, the mean number of ANMs per PHCC was 2.1 and that of AHW was 1.7. The ratio of specific cadres of staff to SHPs and HPs is less than one, indicating unavailability of at least one specific cadre of staff in a HF. MOs were lacking in three in six PHCCs and Staff Nurses in two-thirds of the PHCCs. Between 10% to 25% of HFs were lacking other various category of staff.

More than two-thirds of health workers of all types attended meetings/workshops/trainings in the last six months preceding the survey. On average, MOs, staff nurses, ANMs, HAs/senior AHWs and AHWs were away from their duty station for at least a month because of these events. For other types of staff, it ranged from 10 to 15 days.

Medical Products and Technologies

Availability of all major, basic instruments at HFs increased in EL than in BL. However, availability of thermometers, kidney trays and emergency obstetric care kits for home delivery decreased. The availability of three contraceptives (condoms, pills and depo) increased from 88% to 96%. However, the availability of four tracer drugs (Cotrim, ORS, iron and vitamin A) declined considerably from 82% to 51%, and that of seven key commodities declined from 76% to one-half between the two surveys. More than four-fifths of the HFs maintained first expiry first out (FEFO) in EL which was only one-half in BL. Similar improvement was also reported in updating stock books.

In the EL, availability of nine different clinical guidelines, protocols and job aids were found in nine out of ten HFs, and have increased from the BL. The availability of the FP counseling kit boxes and MNH job aids was found in the majority of the PHCCs and HPs in EL. The Informed Choice poster was displayed visibly in 95% of HFs - an increase by 54 percent points from BL.

Health Information Systems

Timely submission of Health Management Information System reports to a higher level has increased across all HF types and stands at 96%. Almost the same percentage of HFs were sending Logistics Management Information System reports to the districts on time. Monthly monitoring worksheets (MMWs) are being updated in more HFs, with most updates coming from PHCCs. Although there were improvements in maintaining consistency between records and registers for various services in the 2011 survey, the consistency between FP registers and reports was poor. Data use in program management measured in terms of displaying updated service statistics in HFs increased. Flex charts distributed by NFHP II was available in nearly 90% of the ilaka HFs and three-fifths demonstrated its proper use (updated data).

Although supportive supervision to HFs has increased (70% in EL vs 57% in BL), there lacks improvement in quality of supervision (written feedback).

Leadership and Governance

The management of HFs by the local community improved after the BL. Currently, Health Facility Operation and Management Committees (HFOMC) exist in all rural HFs, with about 60% of SHP and HP HFOMCs and a quarter of PHCC HFOMCs having the required number of members. Most of the HFOMCs (90%) had received orientation on their roles and responsibilities. An increasing number of HFOMCs are meeting every month, with the mean number of meetings held in the last 12 months being 5.2 in BL and 7.9 in EL. Women's participation in HFOMCs was high in both the surveys and is 96% at present while the participation of Dalits has also increased (58%). However, an improvement in minuting the meeting outcomes is needed.

There have been improvements in ilaka-level meetings and HF staff meetings. HFs reporting no ilaka-level meeting in the past one year decreased from 18% to 8%, with the mean number of meetings held in the last 12 months increasing from 8.1 in BL to 10.2 in EL. The review of MMWS during ilaka-level meetings has also improved. Similarly, HF staff monthly meetings increased from 52% in BL to 66% in EL, although improvement is needed in the regularity and quality of the staff meetings. As reported by HF staff, improvements were seen in organizing FCHV meetings, as only 7% of HF staff reported no FCHV meeting in the last one year in EL, versus two in four in BL.

The FCHV Fund is now available in all HFs, while in one-half of the HFs the FCHV Endowment Fund was included into the FCHV Fund. The amount in the FCHV Fund has increased remarkably: almost all HFs had funds above NRs. 50,000 in EL as opposed to only 28% of HFs in BL. VDC and community support to FCHVs also increased after the BL (60% vs 75%).

The display of the Citizen Charter in HFs has increased remarkably, with 90% HFs displaying it in EL compared to less than one-half in BL.

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Health System and Service Assessment Districts

Prepared by: Nepal Family Health Program II (NFHP II), USAID

CHAPTER - I: INTRODUCTION

This chapter presents the background information of the study which includes descriptions of the Nepal Family Health Program (NFHP) II and the), rationale for carrying out the Health System and Service Assessment (HSSA), objectives of the assessment and organization of the report.

1.1 Nepal Family Health Program II

NFHP-II is a five year (2007-2012) bilateral program between the Ministry of Health and Population (MoHP) and United States Agency for International Development (USAID). Its goal is to improve the provision and use of public sector Family Planning/ Maternal and Neonatal Child Health (FP/MNCH) and related social services and support the Government of Nepal's (GoN) intention to reduce fertility and mortality, as expressed in the Health Sector Strategy, 2004; the Nepal Health Sector Program 2 (NHSP 2), 2010-2015; and Second Long Term Health Plan, 1997-2017.

NFHP-II works in 22 districts of Nepal as Core Program Districts (CPDs) and covers nearly 37% of the country's population. These districts are Jhapa, Morang, Siraha, Bara, Dhanusha, Mahottari, Parsa, Rautahat, Sarlahi, Sindhuli, Banke, Dailekh, Dang, Jumla, Kalikot, Pyuthan, Rolpa, Salyan, Surkhet, Kanchanpur, Mugu and Bajhang. Ten of the districts are clustered in the central/eastern regions and the remaining 12 are clustered in the mid and far-western region.

NFHP-II is committed to strengthening peripheral public health services and increasing utilization of key FP/MNCH services. As such NFHP-II is working through the GoN's existing service delivery system in the 22 CPDs. There are a total of 1,362 health facilities including 28 hospitals, 73 Primary Health Care Centers (PHCCs), 195 Health Posts (HPs), and 1,066 Sub Health Posts (SHPs) in the NFHP-II CPDs (DoHS, 2005/2006).

1.2 Rationale for the health system and service assessment

Both population and health facility-level information and indicators are important to plan and measure success of programs. While the population-level indicators provide information on the impact of programs at the household level, the health facility-level information tells us what is actually happening at the level of service delivery (input, process, costs, output, and quality). Such information is needed for monitoring and improving facility-level performance and service quality as this will have greater impact at the community level. Population-level indicators when complemented by facility-level indicators, provide a comprehensive measurement of any program outcomes. The importance of quality of service provision is being recognized, as evidenced by the NHSP 2 which has emphasized health facility surveys (MoHP, 2010).

As NFHP-II aims to improve the delivery of FP/MNCH services from the government's existing service delivery points, it supports these institutions in the provision of quality health services. The support includes capacity development of staff, provision of equipment, drugs and supplies, infection prevention (IP), system strengthening, behavior change communication, etc. The program impacts are measured on a periodic basis by doing cross-sectional surveys, with overall long-term impact measured through the Demographic and Health Survey (DHS). It is also equally important that periodic assessment of facility-based services be done in order to improve the quality of service provision at the facility level.

In view of this, at the beginning of NFHP II, a census of rural health facilities was conducted in 18 CPDs by the program staff. The purpose was to prepare Village Development Committee (VDC) health system profiles of the NFHP II CPDs. This included collecting information from the health facilities and group discussions with Female Community Health Volunteers (FCHVs). The information collected was useful to understand the village health situation, provide focus on where program efforts at the service delivery-level was required, and also served as a benchmark for measuring the facility-level performance and service quality. This information was provided to and used by the respective District/Public Health Offices (D/PHOs) and other agencies in developing their own programs. This follow-up survey 2011 conducted on the sample of rural health facilities will provide an assessment of NFHP II's support in health facility-level service delivery as well as help plan to strengthen the service delivery points for the remaining period of NFHP II.

1.3. Objectives of the health system and service assessment

The overall objective of the follow-up HSSA was to assess the changes in facility-level performance and service quality after the launch of NFHP II.

Specifically the HSSA sought to:

i. Measure changes in provision of health services at the rural health facilities in terms of human resources, infrastructure, equipment, IP practices, guidelines, drugs and commodities, and health facility management,
ii. Help provide broader technical support needed for the health facilities that is not covered through routine technical support visit tools, and
iii. Gather additional information that is useful for planning but were not collected during the baseline study.

1.4 Organization of the report

This report has seven chapters. The first chapter provides background information of the assessment while the second chapter explains its methodology. Chapters three to seven present the findings of the survey which are arranged according to the five out of six health system building blocks recommended by the World Health Organization (excludes Financing) (WHO, 2009). However, it is to be noted that the indicators used in the surveys do not perfectly match the indicators prescribed by WHO to measure the building blocks of the health system.

CHAPTER – II: METHODOLOGY

This chapter presents the methodology that was used to carry out the HSSA. It includes district and health facility selection, data collection instruments, survey implementation timeline, and data analysis and quality assurance.

2.1 Selection of districts and health facilities

The follow-up survey was carried out in the 18 CPDs where baseline was conducted in 2008. As the baseline was not conducted in Jhapa and Morang, and the two United Mission to Nepal (UMN)-supported districts Mugu and Bajhang (which did not receive full, integrated program support from NFHP II), these districts were excluded from the follow-up survey.

The selection of health facilities was done on a sample basis. The samples were determined to adequately represent the district situation, and to ensure comparisons with the baseline estimates. It should be noted that the number of rural health facilities in the CPDs range from as low as 21 in Kanchanpur to a high of 108 in Siraha. This required oversampling in the districts with fewer health facilities in order to get the district picture. In view of this, the districts were categorized into three:

1. districts with 75 or more rural health facilities,
2. districts with 35-74 rural health facilities, and,
3. districts with less than 35 rural health facilities.

Table 2.1: Distribution of sample size

Districts	Number of rural health facilities				Sample Size
	PHCC	HP	SHP	Total	
Siraha	4	10	92	**106**	**35**
Dhanusha	5	9	88	**102**	**34**
Mahottari	3	6	67	**76**	**25**
Sindhuli	3	9	41	**53**	**27**
Rautahat	4	7	85	**96**	**32**
Sarlahi	5	10	84	**99**	**33**
Bara	4	11	83	**98**	**32**
Parsa	4	7	71	**82**	**27**
Rolpa	2	9	40	**51**	**26**
Pyuthan	2	11	35	**48**	**24**
Dang	3	10	26	**39**	**20**
Salyan	2	9	36	**47**	**24**
Banke	3	8	35	**46**	**23**
Surkhet	4	8	38	**50**	**25**
Dailekh	3	5	47	**55**	**28**
Kalikot	1	9	19	**29**	**29**
Jumla	1	8	20	**29**	**29**
Kanchanpur	3	7	10	**20**	**20**
Total	**56**	**153**	**917**	**1,126**	**493**

The number of districts falling into the first, second and the third categories are 7, 8 and 3, respectively. The sample size calculated is one-third from the first category, one-half from the second category, and census of all the health facilities from the last category (<35). This resulted in a total sample size of 493 which is about 44% of the total number of rural health facilities (1,126) in the 18 CPDs. Refer to Table 2.1.

The sample of each district was further distributed into three categories of the health facilities i.e. Primary Health Care Center (PHCC), Health Post (HP) and Sub-Health Post (SHP) so as to represent all the categories. As the number of PHCCs and HPs in a district are fewer than SHPs, to ensure comparability at the aggregate level, all PHCCs and HPs were censused. Within each district, SHPs were selected following a systematic random procedure. However, given the sample size, it was not possible to disaggregate data by type of health facilities for individual districts.

2.2 Data collection instruments and methods

During the baseline in 2008, information was sought from health facilities, key informants (KI), and FCHVs. This information was found useful for NFHP II's program development. However, for the follow-up survey, information was collected only from the health facilities, as the primary intent was to monitor changes in service provision at the health facility-level as a result of program efforts.

For comparison purposes the health facility-level instrument had to be similar to the baseline, therefore, the instrument that was used for the HSSA during the baseline was reviewed and updated in consultation with the technical teams of NFHP II.

The instrument used in the 2011 HSSA covered the following information:

- Human resources,
- Infrastructure,
- Equipment,
- Drugs and other supplies,
- Provision of services, including outreach and EPI clinics,
- Communication materials including protocols and guidelines,
- IP practices,
- Support from health facility operation and management committees (HFOMC),
- Resource generation, and
- Data quality and use

The data collection methods included interviews with service providers, observation of health facilities and stock books, HFOMC meeting minutes and review of other registers. The methods used in the endline were similar to the baseline survey.

The questionnaire used in the survey is provided in Annex B of this report.

2.3 Survey implementation

The follow-up assessment was conducted by the NFHP-II Monitoring and Evaluation (M&E) Team, in coordination with other technical teams. Data collection was done by NFHP II district-based staff which was carried-out during November and December 2011. Data entry was carried out during field work. After completion of data entry, data were cleaned, followed by data analysis in January 2012.

2.4 Data entry and analysis

2.4.1 Data entry

EPI Info software was used for data entry. The database developed for the baseline in 2008 was updated by the central M&E team and then shared with the two regional office M&E teams. The two data processing persons stationed at regional offices were oriented on the database, and later entered data into the software.

2.4.2 Data quality assurance

A two day comprehensive training was organized in both field offices for all program staff of 18 CPDs who were supposed to collect information for the HSSA. The training used different methods including mock interviews to make the staff more familiar with the tool. As NFHP II uses a Technical Support Visit (TSV)

approach for improving performance in routine program monitoring and as many questions in the HSSA tool were already in the TSV tool, district staff were familiar with the contents of the HSSA, which made the two day-orientation proceed efficiently. Field work was monitored by the M&E team and the regional office based-staff. Before the data were entered into the database, all the completed questionnaires were thoroughly checked at each regional office.

2.4.3 Data analysis

The 2008 HSSA was a census of all the rural health facilities of the 18 CPDs and the 2011HSSA was a sample of health facilities. Therefore, the 2011 health facility sample was matched with that from the baseline in 2008. The data for the health facilities were pooled and analyzed for comparison purpose. This helped avoid the sampling that was different in the two surveys. Data tables for key information were disaggregated by 18 CPDs. Since the use of the HSSA is also for evaluating NFHP-II inputs at the service delivery points, selected data have been generated by each facility in a matrix for each district separately. The results have been expressed mainly in percentages and numbers. Means and ranges have been also used where appropriate.

2.5 Utilization of the results of HSSA

The HSSA was conducted by NFHP II staff who are also responsible for improving service provision in the districts. Since the data generated from the HSSA tool complemented the data generated from NFHP II integrated TSV tools, it provided a broader picture of the health facility situation. Therefore, data gathered from the HSSA provided further input for improving service delivery in the sampled health facilities during data collection. NFHP II also plans to share HSSA data of each district with the respective district program managers for resource mapping. Moreover, the district data sets will be also established in a user-friendly format at the respective D/PHOs for future use.

CHAPTER – III: SERVICE DELIVERY

Strengthening service delivery is a key strategy to accomplish Millennium Development Goal (MDG). This includes delivery of interventions to reduce child mortality, maternal mortality and burden of other communicable and non-communicable diseases. NFHP II focuses on community-level and other peripheral FP/MNCH services and works primarily in support of public sector services in close coordination with social marketing, non-governmental organizations and private sectors. This chapter presents findings on different aspects of service delivery such as infrastructure, waste management practices, and provision of services from both static and out-reach centers of the public health facilities.

3.1 Availability of infrastructure

Availability of basic infrastructure is essential for smooth functioning of primary health care services and serves as a strong basis for optimal implementation of the health care system. As such, the program provides support to improve infrastructure with emphasis on improving availability and access to quality health services through technical, financial and logistical support. Table 3.1 presents the changes in availability of infrastructure between the two survey periods.

Noteworthy improvements in availability of infrastructure for most of the indicators (Table 3.1) can be seen. About 71% of health facilities already had their own building during baseline which reached 77% at endline. The mean number of rooms in a health facility increased from 4.6 at baseline to 5.6 at end line with 100% PHCCs and 97% HPs having 4 or more rooms at endline. There has been improvement in availability of waiting room/area for clients as well as furniture for sitting in the waiting room/area. While the former increased by about nine percent points, furniture in waiting room/area increased by about 25 percent points. It is also notable that all of the PHCCs and HPs at present have a separate store room.

The greatest improvement can be observed in the availability of electricity followed by ANC/examination/delivery room at health facilities. Nearly two-thirds of the health facilities had electricity at endline compared to only two in four at baseline. Similarly, ANC/delivery/examination room was available in 81% of health facilities compared to 58% at endline. Likewise, there has been improvement in the provision of clients' waiting room/area and furniture in the waiting area. Their availability has increased in all types of health facilities. HFs providing 24-hour services, ie HPs and PHCCs, need staff quarters. More than one half of the HPs and more than two-thirds of the PHCCs had staff quarters which remained almost unchanged from the first survey to the next. Less that 5% of the SHPs also had staff quarters in both surveys, possibly because of the existence of birthing facilities.

In addition, the availability of delivery tables was also assessed during the endline survey. This information was not collected during the baseline survey, therefore the data reflects the present scenario. Thirty-eight percent of SHPs and more than 85% of HPs and PHCCs had delivery beds. It should be noted that not all SHPs are birthing centers; therefore, most SHPs not having a delivery bed is normal. In-patient beds are required at PHCCs. The survey showed that the number of PHCCs not having any in-patient beds declined to 11% from 16%.

A question was added in the endline to assess the type of emergency transport available in the HFs and the results revealed that ambulance was available at only 14% of the total HFs and this proportion was greatest (43%) at PHCCs. The most common transportation during emergencies was the stretcher which was available in nearly two-thirds of the PHCCs and HPs and one-half of the SHPs. Basket carriers were also used by nearly 16% of the HFs. It is of concern that 19% of the HFs do not have any means of emergency transport.

Table 3.1 Percent distribution of health facilities with various infrastructures by type of facilities

Infrastructure	SHP (N=284)		HP (N=153)		PHCC (N=56)		Total (N=493)	
	BL	EL	BL	EL	BL	EL	BL	EL
Own building	59.1	65.1	90.2	94.8	76.8	92.9	**70.8**	**77.5**
Compound wall/fenced	20.8	30.6	47.7	58.8	55.4	75	**33.1**	**44.4**
Number of rooms in HFs:								
1	15.8	10.2	1.3	0.7	5.4	0.0	**10.1**	**6.1**
2	26.4	19.0	2.6	0.0	0.0	0.0	**16.0**	**11.0**
3	29.6	29.2	6.5	2.0	5.4	0.0	**19.7**	**17.4**
4+	28.1	41.5	89.6	97.3	89.2	100.0	**54.2**	**65.5**
Mean (room)	2.9	3.4	6.2	7.4	9.1	11.9	**4.6**	**5.6**
Availability of Staff quarter	2.5	3.2	56.2	55.6	69.6	67.9	**26.8**	**26.8**
Waiting room/area safe from sunlight and rain	76.8	85.9	89.5	96.1	83.9	98.2	**81.5**	**90.5**
Health facilities that have furniture for sitting clients in waiting room/ area	60.6	91.8	75.2	98.0	87.2	94.5	**68.7**	**94.2**
Availability of a separate store	56.3	64.1	94.8	96.1	98.2	100	**73.0**	**78.1**
ANC/examination room/delivery room	45.1	71.8	69.9	92.2	87.5	98.2	**57.6**	**81.1**
Availability of a table in client examination room	75.0	82.4	83.7	91.5	92.9	100	**79.7**	**87.2**
Availability of a Delivery bed		38.0		88.2		96.4		**60.2**
Number of in-patient beds								
0					16.1	10.7		
1					3.6	7.1		
2					10.7	26.8		
3+					69.6	55.4		
Mean					2.9	2.8		
Electricity	23.9	46.5	53.6	82.4	73.2	98.2	**38.7**	**63.5**
Emergency transport								
Ambulance		5.6		19.6		42.9		**14.2**
Rickshaw ambulance		3.5		14.4		10.7		**7.7**
Doko (Basket Carrier)		14.4		19.0		12.5		**15.6**
Stretcher		51.4		64.1		64.3		**56.8**
Others		19.7		22.9		28.6		**21.7**
Nothing		27.5		6.5		7.1		**18.7**

3.2 Resources and practice for waste management

Lack of proper waste management facilitates the spread of infection and diseases at health facilities. A loopho in infection control practices allows the spread of infection from patients to health care workers, other patien and attendants and vice versa. It is therefore imperative for health care facilities to maintain basic infecti prevention (IP) practices. IP practices which, when used appropriately, restricts the spread of infectio Adequate safe water supply, proper management of sharps and health care waste including alternatives incineration play major roles to reduce burden of diseases in health care settings.

NFHP II has supported the GoN maintain IP practices in health care settings through capacity building (need-based whole site IP strengthening), logistics support and TSVs. This section presents the current scenario of infection control practices by types of health facilities and compares the changes between the two surveys.

Considerable progress can be observed in IP practices in all types of health facilities between the two survey periods except in the availability of incinerator and practice of waste disposal by incineration. This is because incinerator support for health facilities was done during NFHP I and was discontinued during the NFHP II period. The practice of waste disposal by burning them in specially made pits has increased at all types of health facilities. A notable improvement was observed in cleanliness of health facilities, which increased by 25 percentage points between the two surveys and stands at 86% in the endline. Availability of water in HF premises has increased from 51% in baseline to 69% in endline with the greatest change observed in PHCCs and HPs followed by SHPs. Similarly, availability of a client toilet at health facilities increased from 64% in baseline to 78% in endline, the change being greatest at SHPs. More than 95% of health facilities at the time of endline survey had puncture-proof containers for disposing sharps and needles compared to 77% at baseline. Refer to Table 3.2.

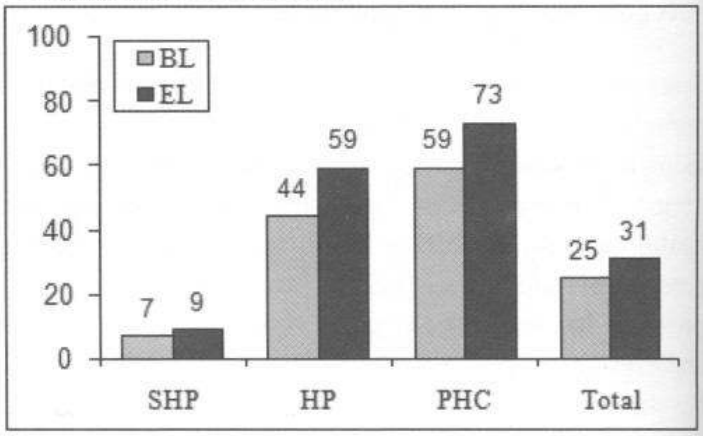
Table 3.2 Distribution of health facilities with resources and waste management practice by type of health facility

Resources and practices of waste management	SHP (N=284)		HP (N=153)		PHCC (N=56)		Total (N=493)	
	BL	EL	BL	EL	BL	EL	BL	EL
Availability of water into premises	37.7	56.7	66.0	79.7	78.6	98.2	**51.1**	**68.6**
HFs with running water into the building	6.0	16.2	24.8	45.1	46.4	71.4	**16.4**	**31.4**
Availability of client toilet	47.9	67.2	84.3	93.5	87.5	94.6	**63.6**	**78.5**
Functioning and clean	25.0	47.9	50.3	67.3	46.4	75.0	**35.3**	**57.0**
Functioning but not clean	13.0	10.9	21.6	20.3	28.6	14.3	**17.4**	**14.2**
Not functioning	9.9	8.5	12.4	5.9	12.5	5.4	**11.0**	**7.3**
No toilet	52.1	32.7	15.7	6.5	12.5	5.4	**36.3**	**21.5**
Health facilities that are clean	58.0	84.1	64.7	90.2	75.0	87.5	**62.0**	**86.4**
Availability of Puncture Proof container	72.5	95.1	81.7	98.7	83.4	96.4	**76.7**	**96.3**
Puncture Proof Container, HFs that used properly	46.8	78.2	54.3	88.2	57.1	83.9	**50.3**	**81.9**
Availability of Incinerator	15.	9.5	32.0	25.5	39.3	28.6	**23.1**	**16.6**
Practice of waste disposal: Incinerated	11.3	7.3	26.1	18.3	23.2	14.3	**17.2**	**11.6**
Burned in pit	65.5	57.0	58.2	41.2	50.0	44.6	**61.5**	**50.7**
Not burned	8.8	4.9	6.5	1.9	14.1	1.8	**8.7**	**3.7**
Burned in specially made pit	0.0	25.4	9.2	35.9	12.5	37.5	**12.2**	**30.0**
Placenta Pit		8.8		44.4		76.8		**27.6**

3.3 Technical staff staying in health facilities

Among all the HFs surveyed 31% have at least one technical staff staying in the HF all the time at present which is an increase by six percentage point from baseline (Figure 3.1). An increment was observed in all HF types, with the highest in PHCCs followed by HPs. Less than 10% of the SHPs had a technical staff staying there in both the surveys. Though the availability of staff quarters did not improve by very much at endline (Table 3.1), the proportion of HFs where a technical staff stays at the HF increased slightly at endline.

Figure 3.1: Health Facilities with technical staff staying there all the time



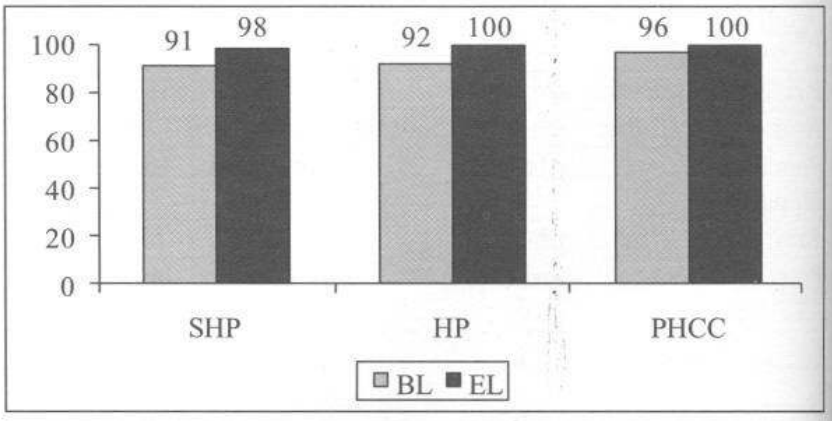
3.4 Provision of health services

Health services are the most evident component of any health system, be it to users or the general public. The status of service provision at any particular health facility reflects the status of key resources, staff, equipment, information and finances.

Figures 3.2 and 3.3, and Tables 3.3 and 3.4 provide data on availability of selected maternal, child and family planning services and the days of the week these services are available in the health facilities. While Table 3.3 provides data on availability of selected maternal health services, Table 3.4 provides data on availability of FP services.

Noticeable improvement has been observed in all the indicators for service provision at health facilities between the two survey periods. As shown in Figure 3.2 CB-IMCI service was available in more than 90% of the health facilities at baseline and availability of this service was almost universal at endline.

Figure 3.2: Availability of CB-IMCI service throughout the week by type of health facility



As shown in Table 3.3 improvement is evident in availability of antenatal care, delivery services and postnatal services at all health facility levels. The percentage of SHPs that do not provide antenatal care service has declined from 11% at baseline to 4% at endline, and postnatal services from 17% to 4%. However, it is a concern that one-third of PHCCs still do not provide ANC services every day of the week. Postnatal service is important for both mothers and newborns. This service is available in almost all health facilities regardless of the level, with service provided most of the working days. Because the GoN has recognized more SHPs and HPs as birthing centers, its service availability has also been increasing. One-fifth of the SHPs and about one-half of HPs had delivery service at endline. The change in providing delivery service all day was greatest in HPs followed by SHPs, with changes in 30 and 18 percentage point respectively between baseline and endline.

Table 3.3: Changes in availability of specific maternal health services in a week in the health facilities

Maternal health services	Survey round	SHP (N=284)				HP (N=153)				PHCC (N=56)			
		No service	1-3 days	4-5 days	All days	No service	1-3 days	4-5 days	All days	No service	1-3 days	4-5 days	All days
Antenatal services	BL	10.6	20.1	0.1	68.7	4.6	26.8	2.6	66.0	0.0	37.5	8.9	53.6
	EL	3.9	22.5	0.4	73.2	0.0	20.9	0.0	79.1	0.0	32.1	0.0	67.9
Delivery services	BL	96.1	0.0	0.0	3.9	47.7	0.7	0.0	51.6	14.3	0.0	0.0	85.7
	EL	78.2	0.0	0.0	21.8	18.3	0.0	0.0	81.7	1.8	0.0	0.0	98.2
Postnatal Service	BL	16.5	3.5	0.0	79.9	9.2	8.5	0.0	82.4	1.8	8.9	1.8	87.5
	EL	3.9	7.0	0.0	89.1	1.3	1.3	0.0	97.4	0.0	1.8	0.0	98.2

Those health facilities providing delivery services were also asked whether service was available 24-hours or during office hours only. This information was collected only in the endline survey therefore changes cannot be measured. As evident from Figure 3.3, 95% of the SHPs, 86% of the HPs and nearly nine in ten PHCCs (89%) were providing 24-hour delivery services. The evidence of 24-hour delivery services in almost all the surveyed PHCCs is encouraging.

Figure 3.3: Percent of health facilities with availability of delivery services for 24 hours

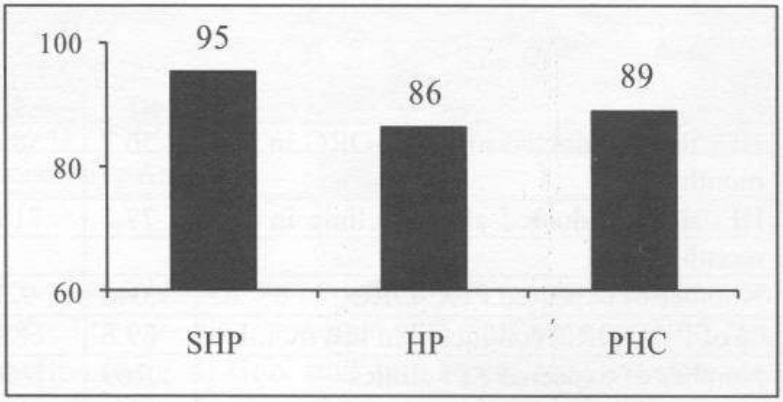


Table 3.4 shows changes in availability of FP services in the health facilities. Most of the services except long-acting family planning methods and sterilization are available throughout the week in most of the health

Table 3.4: Changes in availability of family planning services in a week in the health facilities

FP services	Survey round	SHP (N=284)				HP (N=153)				PHCC (N=56)			
		No service	1-3 days	4-5 days	All days	No service	1-3 days	4-5 days	All days	No service	1-3 days	4-5 days	All days
Depo-Provera	BL	2.8	0.4	0.4	96.8	0.0	1.3	0.0	98.7	0.0	8.9	3.6	87.5
	EL	0.4	0.4	0.0	99.3	0.0	2.0	0.0	98.0	0.0	3.6	1.8	94.6
IUCD	BL	100	0.0	0.0	0.0	92.8	0.7	0.0	6.5	57.1	1.8	0.0	41.1
	EL	98.2	0.0	0.0	1.8	67.1	2.0	0.0	30.7	23.2	3.6	1.8	71.4
Implant	BL	100.0	0.0	0.0	0.0	97.4	0.7	0.0	2.0	75.0	1.8	0.0	23.2
	EL	98.6	0.0	0.0	1.4	70.6	2.6	0.0	26.8	37.5	0.0	1.8	60.7
Male sterilization	BL	100.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	98.2	1.8	0.0	0.0
	EL	100.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	98.2	0.0	0.0	1.8
Female sterilization	BL	100.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	98.2	1.8	0.0	0.0
	EL	100.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0

facilities. Family Planning sterilization is usually performed by a trained medical officer, therefore no improvement was observed due to lack of officers (discussed in the health workforce chapter of this report). However, improvement was seen in service provision for long-acting family planning. The changes are most evident in PHCCs followed by HPs. Not only has service availability increased in PHCCs and HPs but their availability throughout the week also has improved significantly.

In addition to services provided by health facilities in static facilities, there is also the provision of Primary Health Care Outreach Clinic (PHC ORC) and EPI clinics in each catchment area. Generally these clinics are organized in 3 to 5 pre-arranged locations per VDC once a month. Achieving and sustaining high coverage of all vaccines in the districts and VDCs is the motto of the immunization program. One of the key challenges of the National Immunization Program includes fluctuating immunization coverage, which can be improved if the EPI clinics are conducted effectively and regularly. The PHC-ORC program at present faces serious challenges to meet its objective due to scarcity of human resources and logistics supply. It should be noted that NFHP II does not carry out any interventions for PHC-ORC and EPI clinics apart from their monitoring. Most of the indicators show declining performance of PHC-ORC and EPI clinics between the two survey periods except for indicator "conducted all PHC-ORC in last month" which remained constant (55% vs 56%) (Table 3.5). Declining performance is most prevalent in HPs followed by SHPs. All indicators show that the less PHC ORCs are being carried out than EPI clinics.

Table 3.5: Conduction of PHC-ORC and EPI clinics according to type of health facility

	SHP (N=284)		HP (N=153)		PHCC (N=56)		Total (N=493)	
	BL	EL	BL	EL	BL	EL	BL	EL
HFs that conducted all PHC-ORC in last month	56.7	58.4	51.6	54.9	57.1	50.0	**55.2**	**56.4**
HFs that conducted all EPI clinic in last month	77.1	71.1	77.8	68.6	75.0	76.8	**77.0**	**70.9**
Number of expected PHC-ORC	1,046	928	515	460	201	200	**1,762**	**1,588**
% of PHC-ORC conducted in last month	69.8	68.5	62.5	58.0	58.2	65.0	**66.4**	**65.1**
Number of expected EPI clinics	1,269	1,256	703	699	262	272	**2,234**	**2,227**
% of EPI clinics conducted in last month	87.3	79.2	86.8	78.9	85.1	83.5	**87.0**	**80.2**

CHAPTER - IV: HEALTH WORKFORCE

The availability of basic health services, the frequency with which these services are offered, the presence of qualified staff, and the accessibility of the health care system all contribute to client utilization of services in a health facility (NBS and Macro, 2007). The ability of a country to meet its health goals depends largely on the knowledge, skills, motivation and deployment of the people responsible for organizing and delivering health services. Evidence shows that there is a direct and positive relationship between the number of health workers and population health outcomes (WHO, 2010).

In Nepal, depending upon the type of public health facility, the health workforce varies. At the district level, a district hospital has the largest number of health workforce provisioned. Below the district level there are PHCCs, HPs and SHPs, each with different levels and numbers of staff sanctioned by the GoN. A PHCC has a Medical Officer, a Staff Nurse, and a Laboratory Assistant, which are not designated in the HPs and SHPs. In terms of number of staff sanctioned, PHCCs have the most, followed by HPs and SHPs. It should be also noted that some of the HPs and SHPs have been up-graded as birthing centers, where there may be the provision of more than one assistant nurse midwife (ANM). Moreover, the GoN is upgrading MCHWs to ANMs (*padnam*), although to date the sanctioned position at a SHP exists only for the MCHW, not for the ANM. In addition to the number of GoN sanctioned positions, a health facility may have additional staff recruited locally, supported by the Village Development Committees (VDCs) and I/NGOs. Some of the health facilities are also supported with staff from the NPC and D(P)HO. Table 4.1 provides the number of sanctioned positions of GoN staff in a health facility below the district level.

Table 4.1: Sanctioned positions by type of health facility

Type of staff	SHP	HP	PHCC
Medical officer			1
Staff nurse			1
ANM		1	3
HA/Sr. AHW		1	1
AHW	1	2	2
VHW	1	1	1
MCHW	1		
Laboratory Assistant			1
Administrative Assistant		1	
Total	**3**	**6**	**10**

This chapter discusses human resources that are available in the GoN rural health facilities, including staff filled-in, and currently available in the different GoN health facilities below the district level. In addition, it also discusses absenteeism of GoN health workers from their workstation due to trainings, workshops and meetings.

4.1 Position Filled-in

Human resource development and deployment should act together, and health services should be delivered through a team approach. Nepal's health system is facing imbalances in the skill mix of staff at the district level and also practical problems in geographic distribution of staff, with about 40 percent of the sanctioned positions unmanned (WHO, 2007). Therefore, deployment and retention of health sector staff remains a major problem in Nepal. In order to address the issues of health sector human resources, NHSP 2 aims to take several measures such as skill enhancement, performance-based and retention-based payments, updating of Human Resources Information System (HuRIS), etc (MoHP, 2010). As deployment of human resources is one of the most important components of a health system, data on sanctioned and filled-in positions was collected for the survey. Table 4.2 compares information on positions that are filled-in out of the total sanctioned positions between the two surveys. It should be noted that NFHP II has a limited role in fulfilling positions at the health facilities. During TSVs, when health facility staff are not present, concerned health facility officials are advised

to request for health workers from the district. Moreover, the DPHO is made aware of the unfulfilled or vacant position at the health facility and its effect on delivery of quality health services.

Table 4.2: Percent of positions filled-in by type of health facility

Type of staff	SHP		HP		PHCC	
	BL	EL	BL	EL	BL	EL
Medical officer					79.2	47.4
Staff Nurse					39.6	42.6
ANM			86.5	90.3	78.3	86.0
HA/Sr. AHW			95.4	86.1	92.7	93.0
AHW	94.7	94.1	91.4	84.2	90.2	93.6
VHW	84.8	77.9	94.6	81.8	95.7	85.1
MCHW	90.6	85.6				
Lab Assistant					96.3	78.6
Total	**90.0**	**86.1**	**91.6**	**85.8**	**81.9**	**78.8**

The HP of Bardibas, Mahottari has been upgraded to hospital but data on some technical staff (doctor, staff nurse, lab Assist. etc) is not included in the table.

Overall, the percent of filled-in technical positions declined at all types of health facilities, with the greatest decline seen at HPs (6 percent points) between the baseline and endline surveys. Analysis by type of health providers reveals that filled-in positions for Medical Officers in the PHCC has declined considerably from 79% at baseline to 47% at endline whereas there has been some increase in the filled-in positions of Staff Nurses (40% vs 43%). More ANMs were also filled-in after the baseline in both HPs and PHCCs. The filled-in positions for health assistants (HAs)/senior auxiliary health workers (AHWs) and AHWs has declined in HPs but remains almost unchanged between baseline and endline in PHCCs and SHPs. The number of staff filled-in is given in Table 4.2, Annex-B.

4.2 GoN staff currently working

In both the surveys, health facility staff were asked the number of GoN staff currently working at the health facilities. Those GoN staff that were away from the health facility for more than one month were considered not currently working whereas those away for less than one month were considered currently working. The data excludes staff recruited from other sources such as VDC, I/NGOs and temporary support from the National Planning Commission (NPC), etc. Table 4.3 provides the percent of GoN technical staff who were working in the sampled health facilities. As depicted in the table, the percent of GoN technical staff currently working remains almost unchanged between the baseline and endline surveys. The percent of GoN technical staff currently working among those filled-in posts was 89%, 96% and 99% in the PHCCs, HPs and SHPs, respectively, at endline with corresponding figures for baseline being 93%, 95% and 99%. These figures also indicate that, among those filled-in positions, a higher proportion of GoN technical staff were available in SHPs followed by HPs and PHCCs.

Table 4.3: Percent of GoN staff currently working among the filled-in by type of health facility

Type of staff	SHP		HP		PHCC	
	BL	EL	BL	EL	BL	EL
Medical officer					85.7	77.8
Staff Nurse					76.2	73.1
ANM			93.0	97.7	88.6	84.4
HA/Sr. AHW			94.4	96.2	100.0	98.1
AHW	99.3	98.9	92.5	94.4	99.0	93.2
VHW	98.3	95.6	97.8	97.3	100.0	100.0
MCHW	98.4	100.0				
Lab Assistant					92.3	93.2
Total	**98.7**	**98.5**	**94.6**	**96.1**	**93.3**	**89.2**

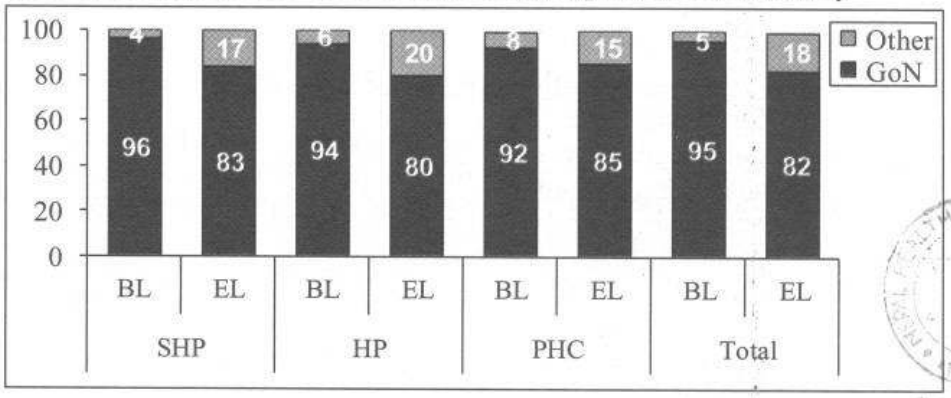
In the endline survey among those filled-in, nearly eight in ten officers and seven in ten staff nurses were currently working in PHCCs. Comparisons with the baseline data indicate that these cadres of staff currently working has slightly declined in PHCCs. The presence of village health workers (VHWs) remains almost unchanged regardless of type of health facility or the survey, with more than 95% currently working among those filled-in. Similarly, there is some decline in percentage of AHWs currently working in PHCCs (99% vs 93%) but remains almost unchanged in HPs and SHPs. Of those filled-in, almost all maternal and child health workers (MCHWs) in SHPs were found working at the time of both surveys.

Although a high percentage of GoN staff are seen currently working, when looking at the numbers, their availability is very poor. For example, in the endline only 21 officers and 19 staff nurses were reported currently working in 56 PHCCs, with the mean number currently working being less than 0.4 per PHCC. However, the mean number of ANMs per PHCC was 2.1 and that of AHWs was 1.7. The ratio of specific cadres of staff to SHP and HP except AHWs in HP is less than one. Please see Annex-B for the number of GoN staff currently working.

4.3 Staff support from sources other than GoN sanctioned

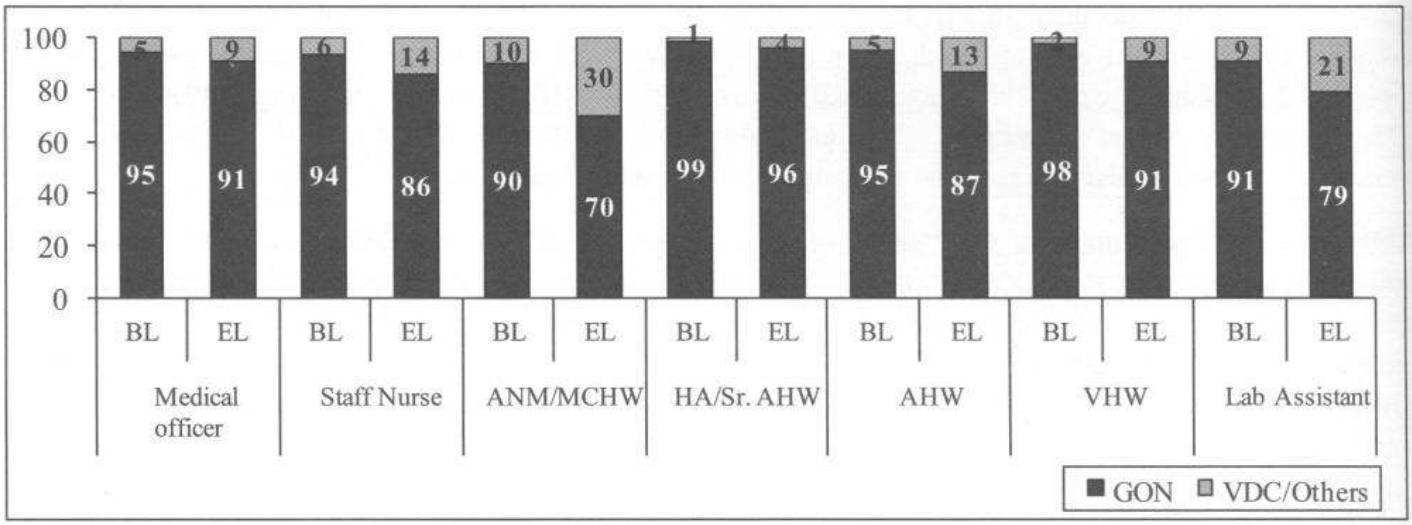
As discussed in the beginning of this chapter, health facilities are getting staff support from sources other than the GoN. An important source of support has been the VDCs, INGOs and NGOs. Figure 4.1 shows the distribution of technical staff from the GoN and other sources. "Other" includes GoN staff that are supported on a temporary basis through, for example, the NPC. It should be kept in mind that the technical staff for which data is presented includes officers, staff nurses, ANMs, HAs/Sr AHWs, AHWs, MCHWs and Lab Assistants. It does not include other technical staff nor does it include the administrative staff, although health facilities receive staff support for administrative work too. Overall, at baseline only 5% of the total health providers were supported by sources other than the GoN, which increased to nearly one-fifth (18%) at endline. Of the 18% from other sources at EL, more than one half (56%) alone came from VDCs (data not shown) - an increase by 2 percent points from the baseline. This indicates that there is increasing participation of other sources in the delivery of health services. The biggest support of technical staff from other sources has been to the HPs (20%) followed by SHPs (17%) and PHCCs (15%).

Figure 4.1: Distribution of currently working health providers (technical) by source of recruitment by type of health facility



In Figure 4.2, cadres of staff that are currently working by source is presented. ANMs/MCHWs were the cadres that were supported most (30%) from other sources both in baseline as well as in endline. This is followed by Lab Assistants (21%), Staff Nurses (14%) and AHWs (13%). Data also indicate there is support for Medical Officers from other sources, particularly the NPC. As discussed above, the support of staff from other sources has increased from the baseline. The type of staff support to local HF from VDC is presented in section 7.8 of the chapter Governance and Leadership.

Figure 4.2: Distribution of currently working health providers (technical) by source of recruitment according to cadres of staffs



4.4 Staff availability

In both baseline and endline surveys, among the staff currently working, information on number of staff present at health facilities at the time of survey was also observed and noted. The observation recorded all sources of staff i.e. GoN, NPC, DPHO, VDC and I/NGOs etc, therefore information presented in table 4.4 is not confined to GoN staff only.

Data indicates that not all health providers were seen at the health facilities during the endline survey. Nearly one half (47%) of officers and more than one-third (36%) of staff nurses reported to be currently working were not observed on the day of the health facility visit. Similarly, about one-fourth of various cadres of staff were also not seen in the HPs and SHPs. When the staff presence data from endline was compared with the baseline data, it was found that the presence of technical staff improved in all types of health facilities. Moreover, presence of different cadres of staff was almost the same in all types of health facilities, with about three-fourths of technical staff being available in the endline survey. With the exception of a decline in VHWs at SHPs, there was a higher presence of staff in the endline survey in all types of health facilities. For information on number of staff presence please refer to Table 4.4 of Annex A.

Table 4.4: Percent of staff (all sources) available in the health facility on the day of observation among those who are currently working (all sources) by type of health facility

Type of staff	SHP		HP		PHCC	
	BL	EL	BL	EL	BL	EL
Medical officer					39.5	52.7
Staff Nurse					52.9	63.6
ANM/MCHW	70.6	71.2	73.0	79.8	69.7	75.9
HA/Sr. AHW			74.5	75.2	67.3	78.2
AHW	82.7	85.9	68.9	77.7	67.6	83.8
VHW	70.3	65.0	64.5	66.7	70.2	75.0
Lab Assistant					64.2	71.2
Total	**74.8**	**74.7**	**69.9**	**76.2**	**65.1**	**76.0**

In Table 4.5 the percentage of health facilities that do not have specific staff that are currently working is presented. The biggest shortage of currently working staff at endline was for a medical officer, followed by a staff nurse. Medical officers were not available in three in five PHCCs and staff nurses were not available in

two-thirds of the PHCCs. Depending upon type of health facility, between one-fifth to one quarter of the health facilities were lacking VHWs. Similarly, at endline ANMs were found currently working in all PHCCs, 86% of the HPs, and in slightly more than that in SHPs (89%).

Comparisons of the two survey data indicate that availability of health providers has deteriorated in all types of health facilities. For example, there is an increase in unavailability of currently working staff such as officers, HAs/Sr AHWs, VHWs, and Laboratory Assistants. The increase in availability of ANMs/MCHWs could be because some of them were upgraded from MCHW after the baseline survey. Moreover, these cadres of staff are supported from other sources therefore they are closely monitored for the delivery of health services. There is some improvement in availability of Staff Nurses as they were available in one-third of the PHCCs at endline compared to 29% at baseline.

Table 4.5: Percentage of HFs that do not have specific cadre of staff currently working by type of health facility

Type of staff	SHP (N=284)		HP (N=153)		PHCC (N=56)	
	BL	EL	BL	EL	BL	EL
Medical officer					35.7	58.9
Staff Nurse					71.4	66.1
ANM/MCHW	10.2	11.3	25.5	13.7	12.5	0.0
HA/Sr. AHW			11.8	19.6	8.9	12.5
AHW	7.0	3.2	11.8	11.1	1.8	3.6
VHW	16.9	25.0	11.1	26.1	17.9	21.4
Lab Assistant					10.7	19.6

4.5 Duration away from the health facility

Enhancing health providers' skills through training, workshops and other mechanisms is important for effective delivery of quality health services. On the other hand, frequent or long term absence of health facility staff from their work station deprives community people in getting the desired health services. In this context, information on whether each GoN technical staff of the health facility currently working attended trainings, workshops or meetings away from the health facility preceding the last six months of the survey, was collected at endline. This information was not collected at baseline. It is cautioned that the six-month data may not provide a clear picture if there is seasonal or monthly variations in attending the meetings or workshops over a period of one year. A better picture would have been formed had data been collected for the one year preceding the survey.

Table 4.6: Percent of health facility staff (GoN) who attended trainings, meetings and workshops in the last six months preceding the survey

Type of GoN staff	SHP	HP	PHCC	Total
Medical officer			66.7	**66.7**
Staff Nurse			68.2	**68.2**
ANM		83.2	88.2	**85.7**
HA/Sr. AHW		95.1	98.0	**95.9**
AHW	97.4	90.2	76.6	**91.4**
VHW	91.8	75.7	70.6	**84.6**
MCHW	86.8			**86.8**
Lab Assistant			78.4	**78.4**

Overall, a considerable proportion of all GoN technical staff were away from the health facility for reasons related to trainings or workshops or meetings in the last six months preceding the survey. Two-thirds of the officers and Staff Nurses, and more than 85% of other categories of staff (except Lab Assistants) such as AHWs and MCHWs from SHPs, and ANMs from PHCCs were reported to be away or had participated in those events in the last six months (Table 4.6).

At endline, GoN staff of the sampled health facilities who reported they had participated in the trainings/workshops/meetings in the last six months preceding the survey were further asked the number of days spent at these events. It should be noted that the information also includes number of days spent for travel as this will show the actual number of days away from their work station. The information provided in Table 4.7 reveals that on average, over one and a half months was spent to attend meetings, etc by the ANMs of PHCCs and 25 days by the ANMs of HPs. HA/AHWs of HPs and PHCCs were away for about five weeks and one month, respectively. Officers, Staff Nurses and AHWs were away for nearly one month. The average number of days for trainings/workshops/meetings attended by the VHWs, MCHWs and Lab Assistants is much lower in comparison to other cadres of staff. The latter spent less than 15 days attending meetings, etc during the last six months. These data indicate that the training or workshops were more focused on building the capacity of staff other than VHWs, MCHWs and Lab Assistants. In other words, the latter cadre of health providers were available in their work station for longer durations than the other cadre of staff.

Table 4.7: Average number of days attended trainings, workshops or meetings by the health facility staff (GoN) in the last six months preceding the survey

Type of GoN staff	SHP	HP	PHCC	Total
Medical officer			29.8	**29.8**
Staff Nurse			27.1	**27.1**
ANM		24.6	47.5	**32.9**
HA/Sr. AHW		36.0	31.0	**34.5**
AHW	27.4	27.8	26.6	**27.4**
VHW	10.8	9.5	7.1	**10.1**
MCHW	11.8			**11.8**
Lab Assistant			15.4	**15.4**

CHAPTER - V: EQUIPMENTS, DRUGS AND PROGRAM MATERIALS

The WHO framework for health systems mentions equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost effectiveness, and their scientifically sound and cost-effective use as one of the six building blocks of a well-functioning health system. Essential medicines are intended to be available within the context of functioning health systems at all times, in adequate amounts, at appropriate dosages, with assured quality, and at a price that individuals and the community can afford (WHO, 2010).

The MDG 8, Target 8.E stresses increasing access to affordable essential drugs in developing countries. It defines access to medicines as having medicines continuously available and affordable at public or private health facilities or medicine outlets that are within one hour's walk of the population (WHO, 2010).

This chapter of the report presents the findings of HSSA related to the availability of instruments, drugs and other supplies including behavior change communication (BCC) posters and the management of these drugs in the surveyed rural public health facilities.

5.1 Basic instruments

A service provider needs different instruments to examine a client and thereafter to prescribe drugs, provide counseling or refer to a higher level of health facility. Therefore, the availability of basic, functioning instruments was assessed in the surveyed health facilities. Stores, OPD and other examination and counseling rooms of the surveyed health facilities were observed to assess the availability of 21 different types of instruments, which were also checked by the interviewer to understand their functionality. Table 5.1 presents data on the proportion of health facilities that had at least one set of the selected medical instruments available and functional at the time of survey. Out of the 21 instruments, only 5 were added for the endline survey. The availability of Stethoscopes and Fetoscopes was universal in both the surveys. The availability of four instruments- BP apparatus, ARI timers, Weighing scales for adults, and Salter scales has increased from baseline to endline and is above 90% in the latter survey. However, the availability of some key instruments such as Thermometers, Kidney trays and EOC kits for home deliveries decreased across all types of health facilities at endline. The instruments mentioned above are necessary in every health facility to render health services; therefore, unavailability of any one item in a health facility is a matter of concern.

Refrigerators are essential to maintain the vaccine cold chain and a functional one was available in only one-quarter of the health facilities. However, three-quarter of the PHCCs had a functioning refrigerator at endline which is an increase from two-thirds at baseline. Similarly, 4 out of 10 HPs had a functioning refrigerator at endline which is an increase of six percent points from the baseline. Autoclaves/boilers are essential for sterilization but 16% of the health facilities did not have a functioning one at the time of the survey and the proportion was highest in the SHPs.

With respect to the availability of the five instruments that was assessed only during the endline survey, a functioning delivery set was found in more than 80% of the HPs and PHCCs, whilst only about one-quarter of the SHPs had them. The fact that fewer SHPs have delivery sets is not surprising because not all SHPs have birthing centers. Episiotomy sets were available in about one-third of the total health facilities with highest in PHCCs (80%). Neonatal resuscitation sets were available in nearly two-thirds of all types of health facilities (Table 5.1).

Table 5.1: Percentage of health facilities with availability of basic functional instruments

Type of instruments	SHP (N=284)		HP (N=153)		PHCC (N=56)		Total (N=493)	
	BL	EL	BL	EL	BL	EL	BL	EL
General Examination								
Stethoscope	95.4	99.3	97.4	100.0	96.4	100.0	**96.1**	**99.6**
Blood Pressure apparatus	87.3	97.5	93.5	97.4	96.4	98.2	**90.3**	**97.6**
Weighing scales for adults	83.8	94.7	90.8	94.1	92.9	96.4	**81.7**	**94.7**
Thermometer	79.2	81.7	85.6	81.0	83.9	82.1	**87.8**	**81.5**
Kidney Tray (600 cc)	89.4	50.4	95.4	83.0	96.4	91.1	**92.1**	**65.1**
IV set with cannula and fluid	18.0	43.3	37.3	66.7	67.9	83.9	**29.6**	**55.2**
Maternal Health								
Fetoscope	93.7	97.5	98.0	100.0	100.0	100.0	**95.7**	**98.6**
Delivery Set		23.6		83.0		94.6		**50.1**
Episiotomy set		14.8		54.2		80.4		**34.5**
Cheattle forceps w/jar, stainless steel	67.3	60.6	60.9	69.9	83.9	87.5	**66.9**	**66.5**
Kerosene Stove	52.1	67.6	64.7	85.6	76.8	85.7	**58.8**	**75.3**
Dressing Set	59.9	67.3	72.5	82.4	82.1	87.5	**66.3**	**74.2**
Suture set	50.4	51.1	62.1	78.4	82.1	87.5	**57.6**	**63.7**
EOC kit for home delivery	50.0	29.6	54.2	20.3	58.9	21.4	**52.3**	**25.8**
Child and Newborn Health								
De lee's suction or other suction apparatus		42.3		65.4		73.2		**52.9**
Pan scale		31.3		61.4		85.7		**46.9**
Neonatal Resuscitation set		52.5		77.1		85.7		**63.9**
ARI Timer	87.0	97.2	84.3	94.1	85.7	98.2	**86.0**	**96.3**
Salter scale	89.4	93.0	87.6	92.8	91.1	92.9	**89.0**	**92.9**
Others								
Refrigerator	4.9	10.6	32.7	39.2	67.9	75.0	**20.7**	**26.8**
Autoclave/boiler	30.6	75.4	70.6	94.8	92.9	98.2	**50.1**	**84.0**

5.2 Basic supplies and drugs

The availability of basic supplies and drugs is presented in Table 5.2. In total, it consists of 19 items which were checked at the HFs during the survey. Most of the supplies and drugs were available in more than 90% of the surveyed health facilities in both the surveys. Other drugs and supplies were available in about one-half to three-quarters of the total health facilities in both the survey rounds. However, the availability of some important drugs such as Cotrimoxazole, Iron tablets, and Chloroquine has declined considerably across all types of health facilities. It is noteworthy to mention that the availability of Magnesium Sulphate Injection increased from 4% at baseline to 66% at endline and Oxytoxin from one quarter to three quarters during the same period.

It appears that there was some shortage of Gentamicin Injection, Zinc, Oxytocin at baseline but this improved at endline. There was a huge shortage of Magnesium Sulphate Injection in all levels of health facilities at baseline but has improved much at endline.

Table 5.2 also shows availability of all four tracer drugs (Cotrimoxazole, ORS, Iron and Vitamin A), all three contraceptives (condoms, pills and depo) and all seven key commodities (condom, pills, Depo, Cotrimoxazole, ORS, Iron and Vitamin A.) at the time of survey. It is a concern that 82% of health facilities at baseline had all four tracer drugs which decreased to 51% at endline. This decline may be because of the country-wide shortage of iron and cotrimoxazole at the time of the endline survey. Availability of various contraceptives enhances method choice among potential family planning clients. Availability of all three contraceptives has increased by 8 percent point at endline from that at baseline (88%). The availability of the seven key commodities remains at one-half at endline, which is a considerable decline (26 percent point) from the baseline (Figure 5.1). The decline in availability of the 7 key commodities is mainly due to shortages of iron and cotrimoxazole.

Table 5.2: Percentage of health facilities with availability of basic supplies and drugs at the time of survey

Drugs and other supplies	SHP (N=284)		HP (N=153)		PHCC (N=56)		Total (N=493)	
	BL	EL	BL	EL	BL	EL	BL	EL
Child Health								
ORS packets	94.7	94.4	98.7	95.4	98.2	94.6	**96.3**	**94.7**
Cotrimoxazole-paediatrics	91.2	71.8	96.7	76.5	94.6	78.6	**93.3**	**74.0**
Amoxicillin 250 mg	73.6	94.4	75.2	95.4	85.7	98.2	**75.5**	**95.1**
Zinc	48.6	94.4	51.0	94.8	50.0	96.4	**49.5**	**94.7**
Gentamycin Injection	13.7	85.9	29.4	92.8	70.9	96.4	**24.9**	**89.2**
Ciprofloxacin	31.0	70.1	80.4	86.9	92.9	85.7	**53.3**	**77.1**
Maternal Health								
Iron folate tablets	93.7	64.4	96.1	71.9	96.4	73.2	**94.7**	**67.7**
Vitamin A Capsule	92.6	98.6	95.4	98.7	94.5	100.0	**93.5**	**98.8**
Albendazole 400 mg	94.0	91.5	96.7	96.1	94.6	89.3	**94.9**	**92.7**
Metronidazole 200 mg	95.8	95.4	95.4	97.4	98.2	98.2	**95.9**	**96.3**
Paracetamol 500 mg	90.5	94.0	93.4	96.1	100.0	98.2	**92.3**	**95.1**
Oxytocin	13.0	69.0	30.1	84.3	57.1	94.6	**23.3**	**76.7**
Magnesium sulphate Injection	2.5	56.3	5.2	75.8	10.7	91.1	**4.3**	**66.3**
Family Planning								
Condom	88.0	95.4	93.5	100.0	98.2	98.2	**90.9**	**97.2**
Pills	96.1	97.5	99.3	100.0	100.0	100.0	**97.6**	**98.6**
Depo	98.6	100.0	99.3	100.0	98.2	100.0	**98.8**	**100.0**
Others								
Chlorine powder	8.5	29.6	28.1	63.4	58.9	76.8	**20.3**	**45.4**
Chloroquine	46.8	37.3	67.3	58.2	83.6	78.6	**57.2**	**48.5**
HRZE	75.0	82.7	94.1	98.7	94.6	98.2	**83.2**	**89.5**
Availability of								
All 4 Tracer drugs*	78.5	47.2	87.6	54.9	83.9	60.7	81.9	51.1
All 3 Contraceptives**	84.2	93.3	92.8	100.0	96.4	98.2	88.2	95.9

Note: * Cotrimoxazole, ORS, Iron and Vitamin A
** Condom, Pills and Depo

Figure 5.1: Proportion of HFs with availability of 7 key commodities at the time of survey

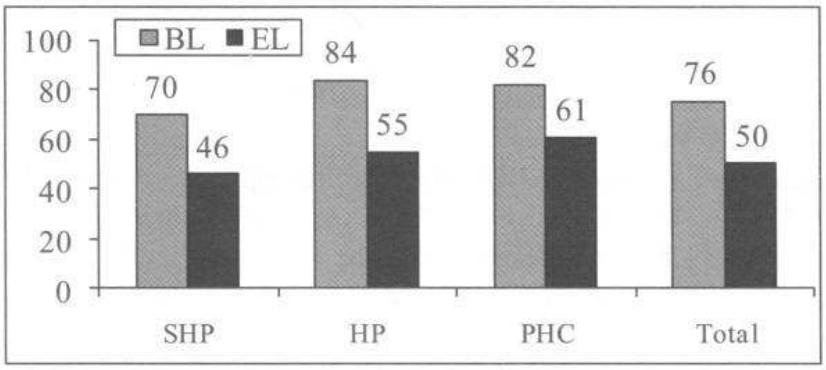


Table 5.3 shows the availability of the 19 supplies and drugs for the following month. This question was asked at those HFs which had commodities available at the time of the survey. Information on availability was not done by looking at the Emergency Order Point (EOP) but was calculated by asking the HF in-charge or other service providers.

Table 5.3: Percentage of HFs with basic supplies and drugs adequate for next one month

Drugs and supplies	SHP (N=284)		HP (N=153)		PHCC (N=56)		Total (N=493)	
	BL	EL	BL	EL	BL	EL	BL	EL
Child Health								
ORS packets	69.7	63.0	77.8	62.7	91.1	62.5	**74.6**	**62.9**
Cotrimoxazole-paediatrics	74.6	51.1	73.9	53.6	83.9	58.9	**75.5**	**52.7**
Amoxicillin 250 mg	48.6	89.8	51.6	93.5	57.1	92.9	**50.5**	**91.3**
Zinc	39.8	83.8	45.8	81.7	46.0	91.1	**42.2**	**84.0**
Gentamycin Injection	6.0	80.6	20.9	83.7	60.0	89.3	**16.6**	**82.6**
Ciprofloxacin	16.9	59.2	64.1	73.2	78.6	73.2	**38.5**	**65.1**
Maternal Health								
Iron folate tablets	77.5	52.8	86.2	56.2	89.1	50.0	**81.5**	**53.5**
Vitamin A Capsule	76.8	92.6	82.4	95.4	80.0	92.9	**78.7**	**93.5**
Albendazole 400 mg	83.5	87.0	82.4	92.2	87.5	85.7	**83.6**	**88.4**
Metronidazole 200 mg	88.4	92.3	90.2	92.2	96.4	92.9	**89.9**	**92.3**
Paracetamol 500 mg	76.1	87.0	81.0	90.2	91.1	94.6	**79.3**	**88.8**
Oxytocin	9.2	66.2	22.2	77.8	37.5	87.5	**16.4**	**72.2**
Magnesium sulphate Injection	2.1	56.0	3.9	73.9	8.9	87.5	**3.4**	**65.1**
Family Planning								
Condom	73.9	81.3	85.0	90.2	92.9	89.3	**79.5**	**85.0**
Pills	90.1	92.3	91.5	94.8	96.4	94.6	**91.3**	**93.3**
Depo	92.6	97.2	95.4	98.7	94.6	98.2	**93.7**	**97.8**
Others								
Chloroquine	37.3	35.9	60.1	56.2	71.4	75.0	**48.3**	**46.7**
HRZE	67.6	79.9	85.6	93.5	85.7	92.9	**75.3**	**85.6**
Chlorine powder	6.0	22.9	21.6	47.7	42.9	55.4	**15.0**	**34.3**
Availability of								
All 4 Tracer drugs*	39.4	24.6	45.8	25.5	57.1	25.0	**43.4**	**24.9**
All 3 Contraceptives**	65.8	75.0	78.4	85.0	85.7	82.1	**72.0**	**78.9**

Note: *Cotrimoxazole, ORS, Iron and Vitamin A
** Condom, Pills and Depo

5.3 Other Program Materials

5.3.1 Guidelines and Protocols

Table 5.4 shows the availability of 12 selected guidelines/protocols in health facilities at the time of the survey. These guidelines/protocols are necessary at health facilities because they serve as job aids for rendering quality services to clients. The availability of all materials improved from baseline to endline except for the availability of the HMIS recording and reporting guideline, which remained the same (78%). The availability of FP counseling flip charts, IMCI chart booklets, cotrim dose cards, home therapy cards for ARI cases and the FCHV Fund guideline was more than 90% of the total health facilities at endline, with not much variation by HF types. The availability of the FP counseling kit box and MNH job aid was collected only at endline. Data shows that nearly 6 out of 10 health facilities had these materials and both of these items were available the least in SHPs.

Table 5.4: Percentage of health facilities with availability of Guidelines/Protocols

Guidelines/BCC materials	SHP (N=284)		HP (N=153)		PHCC (N=56)		Total (N=493)	
	BL	EL	BL	EL	BL	EL	BL	EL
National Medical Standard Vol. I	17.6	71.5	22.2	88.9	26.8	96.4	**20.1**	**79.7**
FP counseling Flip chart	51.8	89.4	59.5	97.4	71.4	96.4	**56.4**	**92.7**
IMCI Chart Booklet	82.4	95.8	85.6	99.3	91.1	98.2	**84.4**	**97.2**
Cotrim Dose Card	72.9	95.8	69.9	94.8	64.3	89.3	**71.0**	**94.7**
Home Therapy Card for ARI cases	70.4	92.6	66.7	90.2	58.9	87.5	**68.0**	**91.3**
Zinc counseling card	39.4	88.4	43.1	89.5	32.1	89.3	**39.8**	**88.8**
Storage Guideline	32.4	73.9	37.9	87.6	32.1	94.6	**34.1**	**80.5**
HFOMC Guideline	43.3	64.8	42.5	70.6	42.9	82.1	**43.0**	**68.6**
FCHV Fund Guideline	59.5	89.4	74.5	93.5	71.4	89.3	**65.5**	**90.7**
HMIS recording and reporting guideline	73.6	73.2	86.3	82.4	89.3	89.3	**79.3**	**77.9**
FP counseling kit box		29.9		94.8		96.4		**57.6**
MNH job aid		45.1		64.7		87.5		**56.0**

5.3.2 Display of program posters

Program posters are useful for creating awareness and increasing demand for health services among clients. In order to support districts to deliver high quality FP/MNCH services, NFHP II assists in designing and distributing program posters.

Table 5.5: Percentage of health facilities displaying different posters in a visible place

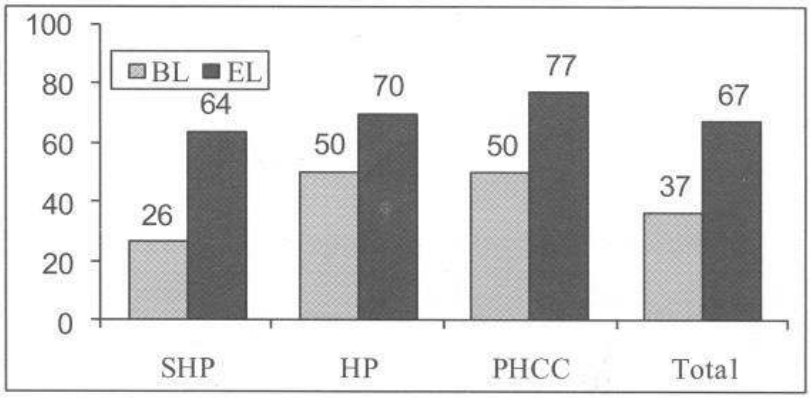
BCC Posters	SHP (N=284)		HP (N=153)		PHCC (N=56)		Total (N=493)	
	BL	EL	BL	EL	BL	EL	BL	EL
Family Planning	53.5	93.0	62.1	95.4	51.8	96.4	**56.0**	**94.1**
Informed Choice	39.1	94.4	42.5	95.4	44.6	98.2	**40.8**	**95.1**
Safe motherhood	52.5	91.2	70.6	95.4	71.4	98.2	**60.2**	**93.3**
Nutrition	36.6	64.8	49.7	68.0	41.1	85.7	**41.2**	**68.2**
Immunization	45.8	64.1	59.5	78.4	50.0	76.8	**50.5**	**70.0**
Diarrhea/ARI	40.5	78.9	52.9	85.6	35.7	80.4	**43.8**	**81.1**
Newborn care		66.2		71.2		67.9		**68.0**

The display of 7 program posters (FP, Informed Choice, Safe motherhood, Nutrition, Immunization,

Diarrhea/ARI and Newborn Care) related to FP/MNCH in the surveyed health facilities is presented in Table 5.5. The posters were considered displayed and available only if they were displayed in the waiting area/room or in the examination room and is visible to the clients. The proportion of health facilities displaying the program posters increased remarkably from baseline to endline across all types of health facilities. The availability of FP posters, Informed Choice posters, and Safe motherhood posters was above 90% in all types of health facilities at endline. The availability of newborn care-related posters was checked only at endline and the findings reveal that nearly 7 out of 10 health facilities had them displayed in a visible place.

Questions related to the supply of program posters from the ilaka/district to the HFs in the last 6 months preceding the survey was asked. Figure 5.4 displays that receiving any program material from the ilaka/district has increased by 30 percent points from the baseline to endline (37% vs 67%). Among the three types of health facilities, improvement is noted across all types, with greatest improvement at SHPs, where the increment was about two and half folds. Despite this achievement, SHPs were less likely to have received program posters than the PHCCs and HPs in the last six months.

Figure 5.4: Proportion of HFs by types receiving at least one program posters in the last six months



CHAPTER - VI: HEALTH INFORMATION

The main objective of the health information system (HIS) is to monitor health services, evaluate progress towards targets, and support health activity planning and development of health policy guidelines. Among many HIS, NFHP II supports primarily the Health Management Information System (HMIS) and Logistics Management Information System (LMIS). In the current HMIS, 38 forms are being used for recording and reporting with recording of more than 1,131 variables, out of which more than 125 indicators are regularly monitored. Similarly, 12 different forms are used for recording and r porting of logistics. This chapter discusses data quality of HMIS and LMIS, use of data, and supervision received.

6.1 Data quality

It is mandatory for all SHPs to submit monthly HMIS progress reports to ilaka health facilities by the 3rd of each month. The ilaka level health facility compiles the progress reports of each facility including their own and submits them to the District Public Health Office (DPHO) by the 7th of each Nepali month. In the case of the LMIS report, it should be sent by the 7th day of each completed trimester.

Table 6.1: Percentage distribution of health facilities according to reporting status and data quality

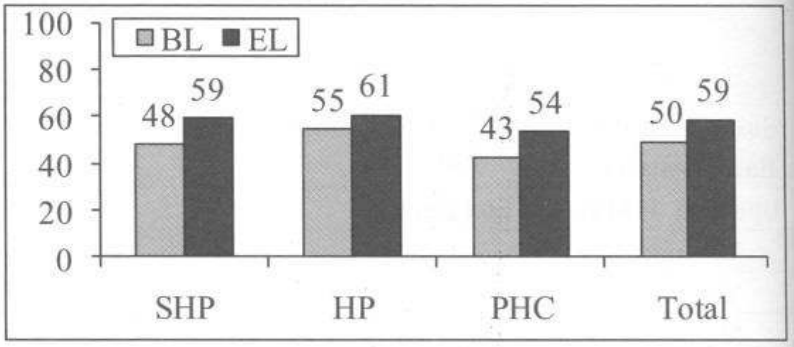
MIS and data quality	SHP (N=284)		HP (N=153)		PHCC (N=56)		Total (N=493)	
	BL	EL	BL	EL	BL	EL	BL	EL
Submitted HMIS report of last month to Ilaka/District	90.8	97.9	84.3	94.1	70.9	91.1	**86.6**	**95.9**
Updated MMWS of last month								
Yes, updated	28.7	44.4	49.0	51.6	41.1	62.5	**36.5**	**48.7**
Yes, unable to see	11.3	9.2	9.2	11.8	3.6	8.9	**9.8**	**9.9**
Not updated	59.9	46.5	41.8	36.6	55.4	28.6	**53.8**	**41.4**
User/clients match correctly in different records								
Pills new and current users	50.2	60.1	54.6	65.4	41.1	62.5	**50.5**	**62.0**
Depo new and current users	48.0	59.0	54.6	60.8	42.9	53.6	**49.5**	**58.9**
Clients served from PHC ORC	69.6	79.3	62.5	83.9	66.1	69.6	**66.9**	**79.6**
Clients served from EPI Clinic	81.9	85.4	81.6	90.6	69.6	82.1	**80.4**	**86.6**
Clients served by FCHVs	74.0	77.9	72.4	81.9	71.4	76.8	**73.2**	**79.0**
Pneumonia treatment by FCHVs	65.0	83.6	59.9	84.6	64.3	78.6	**63.3**	**83.3**
HFs that submitted LMIS report of last quarter to district		95.4		94.8		96.4		**95.3**
Match between Stock book and LMIS report among HFs where both the documents were available		**N=271**		**N=145**		**N=54**		**N=470**
Pills cycle		84.1		89.0		94.4		**86.8**
ORS		86.3		86.9		94.4		**87.4**
Zinc		85.6		88.3		94.4		**87.4**
Amoxycillin 250 MG		83.8		84.1		90.7		**84.7**

Health facilities have to send HMIS reports to the concerned higher authority on time. Overall, the submission of timely reports has improved. The percentage of health facilities that submitted HMIS reports on time is 96% at endline - an increase of nine percent points from the baseline. Timely submission of HMIS reports has improved in all health facilities types, with remarkable improvement noted for PHCCs (from 71% at baseline to 91% at endline) followed by HPs and SHPs.

Health facilities should update their monthly monitoring worksheets (MMWS) before reporting to the higher authority. This indicator has also improved from 37% at baseline to 49% at endline. Although endline data indicates that two in five health facilities still do not update their MMWS, there has been remarkable improvement in updating MMWS for PHCCs (41% vs 63%) followed by SHPs (29% vs 44%).

Consistency and quality of data is crucial in management information systems. Because of this, the survey also tried to assess quality of HMIS and LMIS data by reviewing the health facility records and consistency of data of different recording and reporting formats. For this, records of new and current users of pills and depo (HMIS 13) were verified with that of the reports (HMIS 32). With regards to consistency of data, there has been remarkable improvement from baseline to endline. The improvement for quality of pills data was up by 11 percent points and for depo by nine percent points. In addition to matching records and reports of pills and depo users, there has been improvement in data quality of PHC ORC, EPI clinics and FCHV registers (Table 6.1and Figure 6.1). Despite this improvement, much more effort is needed to improve data quality, as data on pills and depo in two in five health facilities were not matching at endline.

Figure 6.1: Consistency between records and reports of depo new and current users



Though not done during the baseline survey, some quality indicators with regards to the LMIS were collected during endline. Almost 95% of health facilities had sent quarterly LMIS reports on time. While looking for consistency between stock records in stock registers and quarterly reports, over 8 out of 10 HFs showed consistency in different commodities (Pills, ORS, Zinc and Amoxicillin) with quality of recording/reporting being better in PHCCs.

6.2 Data use

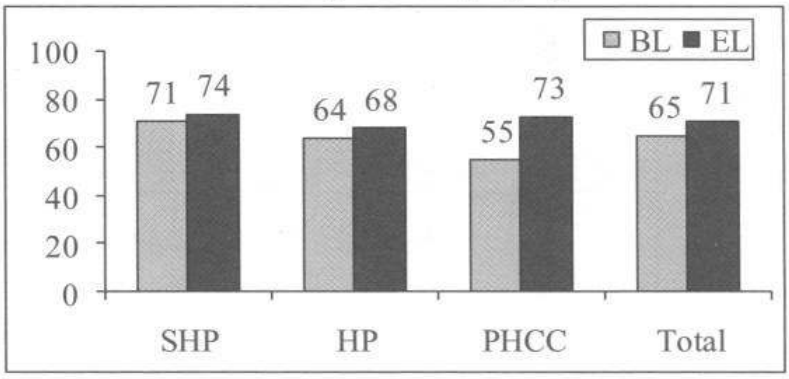
Use of data at all levels is necessary for better program performance. Display of maps of catchment areas, expected population, and analyzed data are regarded as one of the measures of data-use, therefore this information was collected for this survey.

Table 6.2: Health facilities that have used data

Data display	SHP (N=284)		HP (N=153)		PHCC (N=56)		Total (N=493)	
	BL	EL	BL	EL	BL	EL	BL	EL
HFs displaying map of their catchment area	15.6	26.4	22.2	37.9	12.5	37.5	**17.3**	**31.2**
HFs displaying summary of expected groups of catchment area	11.7	31.3	27.5	51.6	16.1	53.6	**17.1**	**40.2**
HFs displaying any service data/information	19.5	30.6	41.2	62.7	39.3	58.9	**28.5**	**43.8**
HFs with Data Display Flex distributed by NFHP II				88.2		87.5		
Among those displaying Data Flex Chart, % displaying updating data				60.0		65.3		

Although an improvement of almost two times was seen in the display of maps of the health facility catchment areas and expected population, these figures remain very low (Table 6.2). Nearly one-third of the health facilities were displaying maps of their catchment area and two in five health facilities were displaying the population figures at the endline survey. The improvement is higher in HPs than in other types of health facilities. The survey also collected information on display of service data at the health facilities, which has also improved from 29% at baseline to 44% at endline (Table 6.2). The data display should be updated regularly so that the current situation with regards to services can be assessed. Seventy-one percent of health facilities at the endline versus two-thirds at baseline had updated the data that were displayed in the health facilities (Figure 6.2).

Figure 6.2: Percentage of HFs updating service data/information among those displaying



As one of the initiatives for improving data quality and use, NFHP II distributed Data Display Flex Charts to the PHCCs and HPs (Ilaka level) at its CPDs. Since this initiative began after the baseline survey, only data from the endline is presented in table 6.2. About 9 out of 10 Ilaka level health facilities had the charts displayed at the health facility, of which three in five HPs and two-thirds of PHCCs had them updated with the most recent data (Table 6.2).

6.3 Supervision received

Facilitative supervision is essential for improving performance of the health workforce. NFHP II has been working to strengthen the supervision system at the district level and below. One of the supervisory tasks is to increase joint supervisions in peripheral health facilities during TSVs that are conducted by NFHP II staff. For the survey, health facility in-charges were asked to get the information on frequency of supervision from the DPHO and the quality of such supervision.

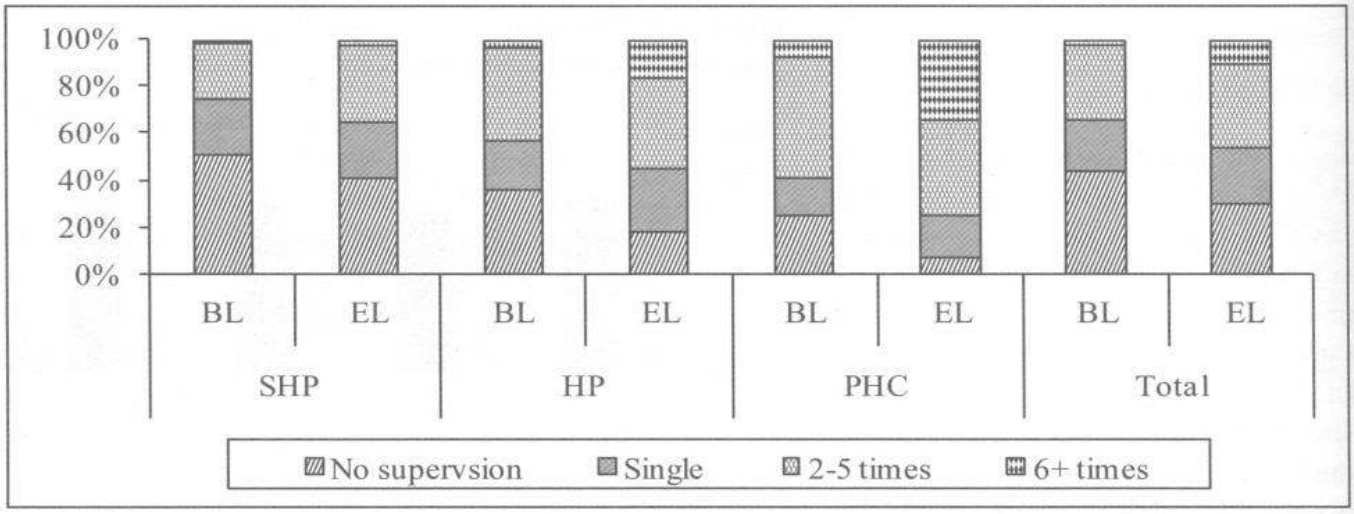
The baseline data indicates that about two in five health facilities were not supervised in the last six months preceding the survey which has decreased to one in three at endline, indicating that frequency of supervision

Table 6.3: Distribution of health facilities that received supervision in the last 6 months

Number of times supervised	SHP (N=284)		HP (N=153)		PHCC (N=56)		Total (N=493)	
	BL	EL	BL	EL	BL	EL	BL	EL
Not at all	51.2	40.8	35.3	17.6	25.0	7.1	**43.3**	**29.8**
1	23.7	23.6	21.6	26.8	16.1	17.9	**22.2**	**23.9**
2-5	23.7	33.1	39.7	39.2	51.8	41.1	**31.9**	**36.0**
6+	1.4	2.5	3.4	16.4	7.1	33.9	**2.6**	**10.3**
Mean	0.92	1.32	1.6	2.64	2.23	3.66	**1.28**	**2.0**
Among HF that received supervision, % that received suggestions by reviewing recording and reporting by their supervisor	68.1	64.9	67.7	63.5	66.7	69.2	**67.7**	**65.0**

has increased, across all HF types (Table 6.3 and Figure 6.3). The frequency of supervision received is highest in PHCCs, with a mean number 3.6. This is followed by HPs (mean 2.6) and SHPs (mean 1.3). Though the frequency of supervision increased after the baseline survey, the quality of supervision has not improved. For example, in both of the surveys, the quality of supervision measured through whether or not the supervisor provided suggestions by reviewing records and reports remained about two-thirds (Table 6.3).

Figure 6.3: Frequency of Supervision in the last 6 months



CHAPTER – VII: LEADERSHIP AND GOVERNANCE

Leadership and governance in building a health system involves ensuring the existence of strategic policy frameworks that are combined with effective oversight, coalition-building, regulation, attention to system design and accountability (WHO, 2010). However, the importance of leadership and governance in improving health outcomes are inadequately monitored and evaluated. In the Nepalese public health system below the district level, leadership and governance can be monitored by the functionality of the locally constituted bodies looking after the management and operation of the health facilities. These b ›dies have the mandate for planning and the managing most of the activities of the health facilities, including the organization of staff meetings at the HF level and participation in the meetings above it, organization of FCHV review meetings and support to FCHVs, and display of citizen charter. The health facility operation and management committee (HFOMC) is the responsible body to ensure the above activities are carried out at local HFs.

This section therefore presents the findings of the HSSA which could be used as measures of leadership and governance at HFs. It includes the existence, structure and activities of HFOMCs, HF staff meetings, ilaka and district level meetings, FCHV meetings, support extended to FCHVs, and display of citizen charter.

7.1 Structure of Health Facility Operation and Management Committee (HFOMC)

The MoHP of Nepal has recognized decentralization of health services as one of the overarching sector reform strategies and key to achieving the MDGs. In line with this, 1,433 peripheral health facilities of 28 districts were handed over to local bodies (VDC) between 2003 and 2006 and a local HFOMC was formed at each health facility to operate and manage all the affairs. Even in those districts where the HFs is not handed over to the local bodies, HFOMCs are required to be formed for the management of health-related matters.

Structurally, the HFOMCs at the HP and SHP level comprise of 9 members, and includes the VDC chairperson as the committee chair, local HF in-charge as the member secretary and seven other members. It also ensures the inclusion of at least four females and two *dalits* or *janajatis* in the committees. In PHCCs, the HFOMCs have 13 members, which is chaired by a member of the DDC of the related constituency where the PHCC is located. It also ensures representation of at least three females and two *dalit/janajati* members in the committee.

Table 7.1 displays that HFOMC formation is almost universal in the HSSA facilities in both the surveys. The findings reveal that three-fifths of the SHPs and HPs had the desired number (9) of members in the HFOMCs at endline, which has doubled from the baseline. Four out of ten had more members than desired at baseline, which decreased at endline to two and three out of ten in the SHPs and HPs, respectively. The situation at PHCCs is different – although the

Table 7.1: Percentage of HFs with HFOMC formed and its structure

	SHP (N=284)		HP (N=153)		PHCC (N=56)	
	BL	**EL**	**BL**	**EL**	**BL**	**EL**
Formation of HFOMC	100	99.3	98.0	99.3	94.6	100.0
Number of members in HFOMC						
Desired *	30.3	61.3	28.2	57.2	18.9	26.8
Less than desired	29.2	19.9	31.5	15.8	60.4	53.6
More than desired	40.5	18.8	40.3	27.0	20.8	19.6
Mean	9.8	9.2	9.6	9.5	13.4	12.2
HFOMCs with 3 (PHCC) or 4 (SHP/HP) females	26.0	46.8	21.3	42.7	33.9	44.6
*Note: *9 for SHP and HP; 13 for PHCC*						

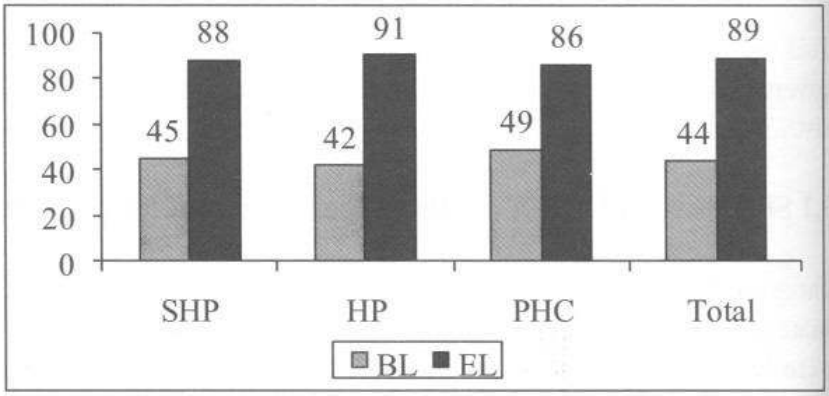
desired number of members (13) in the HFOMCs increased from baseline to endline, it is still low (27%). The majority of the HFOMCs formed at the PHCCs had less than 13 members in both the surveys (60% at baseline and 54% at endline). The mean number of HFOMC members has decreased in all health facilities from baseline to endline but is above the desired number in SHPs and HPs and less than the desired number in PHCCs.

With respect to the presence of the desired number of females in the HFOMCs, there has been an increase from baseline to endline across all HF types but the endline values are still below one-half in all HFOMCs, showing that more effort is required to increase women's involvement in local health committees.

7.2 Orientation on HFOMC roles and responsibilities

As displayed in Figure 7.1, at baseline, less than one-half of the staff at all three types of health facilities interviewed claimed that their HFOMC members had received orientation on health facility management and operation amongst HFs where HFOMC was formed. At endline more than four-fifths (89%) claimed the same. The greatest improvement from 42% at baseline to 91% at endline was noted at HPs. It should be noted that NFHP II oriented HFOMCs of 13 districts out the 18 on health facility management and operation.

Figure 7.1: Percentage of HFOMC members oriented on HF management and operation among those having HFOMC



The comparison of data on HFOMC orientation on roles and responsibilities between HFMSP program and non-program HFs showed variations in results (Table 7.2). In program HFs at baseline, mere 26% of the HFs claimed of getting orientation on HFOMC's roles and responsibilities which increased to all HFs at endline. In the non-program HFs, 79% HFs at baseline reported of getting orientation on HFOMC's roles and responsibilities, which declined to 68% at endline.

Table 7.2: Proportion of HFOMCs oriented on roles and responsibilities by HFMSP and non-HFMSP HFs

HF types	Program HFs		Non-program HFs		Total	
	BL (N=318)	EL (N=323)	BL (N=169)	EL (N=167)	BL (N=487)	EL (N=490)
SHP	25.8	99.5	78.4	67.0	**44.7**	**87.9**
HP	26.7	100	77.8	70.5	**42.0**	**91.4**
PHCC	25.8	100	81.8	65.2	**49.1**	**85.7**
Total	**26.1**	**99.7**	**78.7**	**67.7**	**44.4**	**88.8**

7.3 Regularity and quality of HFOMC meetings

Meeting every month to discuss various issues related to health service management is one of the key functions of the HFOMCs. There has been an increase in holding meetings every month from baseline to endline. At baseline, only 7% of HFOMCs claimed meeting every month which tripled to 22% at endline. The improvement was seen across all types of health facilities with greatest improvements in PHCCs (from 19% to 36%). A few SHPs and PHCCs did not meet even once in the past one year at endline, whereas there were no HPs which did not meet even once. At baseline, nearly one-half (48%) of the HFOMCs met 1 to5 times a year whereas at endline, one-half met 6 to 11 times. Overall, the proportion of HFOMCs not meeting at all has declined to 2% from 9%.

Table 7.3 compares the mean number of HFOMC meetings held in the last one year between program and non program HFs. It is found that there has been remarkable progress in frequency of HFOMC meetings in the program HFs from baseline to endline (5.2 vs 9.7) and this progress is observed across all HF types. In the non-program VDCs, the mean number of HFOMC meetings held in the past one year declined across all HF types and is 4.5 at endline. Overall, in all HF surveyed, mean number of HFOMC meetings increased from 5.2 to 7.9.

Table 7.3: Mean number of HFOMC meetings held in the last 12 months by HFMSP and non-HFMSP HFs

HF Types	Program HFs		Non-Program HFs		Total	
	BL	EL	BL	EL	BL	EL
SHP	4.5	9.5	4.9	4.1	**4.7**	**7.6**
HP	5.8	9.4	5.4	5.3	**5.7**	**8.2**
PHC	7.0	11.7	6.6	5.0	**6.8**	**9.0**
Total	5.2	9.7	5.3	4.5	5.2	7.9

Table 7.4 also presents when the last HFOMC meeting was held in the HSSA facilities. This information is confined among those who reported there was meeting held in the last 12 months. A majority of the HFOMCs met in between one to two months before the survey date. Only 6% of the HFOMCs at baseline met in the same month when the survey was conducted which nearly tripled (17%) at endline. The most recent meeting was held three months preceding the survey in 4 out of 10 health facilities at baseline which decreased to one-quarter at endline. These data indicate that HFOMC meetings were being held more frequently after the baseline.

A good-quality HFOMC meeting could be described as a meeting that is participated by at least 51% of the members, including dalit and females, where decisions are minuted, action plans are prepared and responsibilities are shared. The HSSA collected information on the most recent HFOMC meeting covering some of the key quality aspects. The proportion of health facilities which were able to show the minutes of the

Table 7.4: Distribution of HFs by number of HFOMC meetings in the last 12 months

No. of HFOMC meetings	SHP		HP		PHCC		Total	
	BL (N=284)	EL (N=282)	BL (N=150)	EL (N=152)	BL (N=53)	EL (N=56)	BL (N=487)	EL (N=490)
0	12.0	3.2	5.3	0.0	3.8	3.6	**9.0**	**2.2**
1-5	50.4	27.7	48.7	23.7	32.1	19.6	**47.8**	**25.5**
6-11	33.1	49.3	37.3	55.9	45.3	41.1	**35.7**	**50.4**
12 or more	4.6	19.9	8.7	20.4	18.9	35.7	**7.4**	**21.8**
Mean	4.7	7.6	5.7	8.2	6.8	9.0	**5.2**	**7.9**
Among those who held meeting, timing of last meeting								
	N=245	N=273	N=139	N=152	N=50	N=54	N=434	N=479
Same month	5.3	16.1	7.9	17.8	6.0	14.8	**6.2**	**16.5**
1-2 months before	53.9	56.8	55.4	59.2	64.0	59.3	**55.5**	**57.8**
3+months before	40.8	27.1	36.7	23.0	30.0	25.9	**38.2**	**25.7**

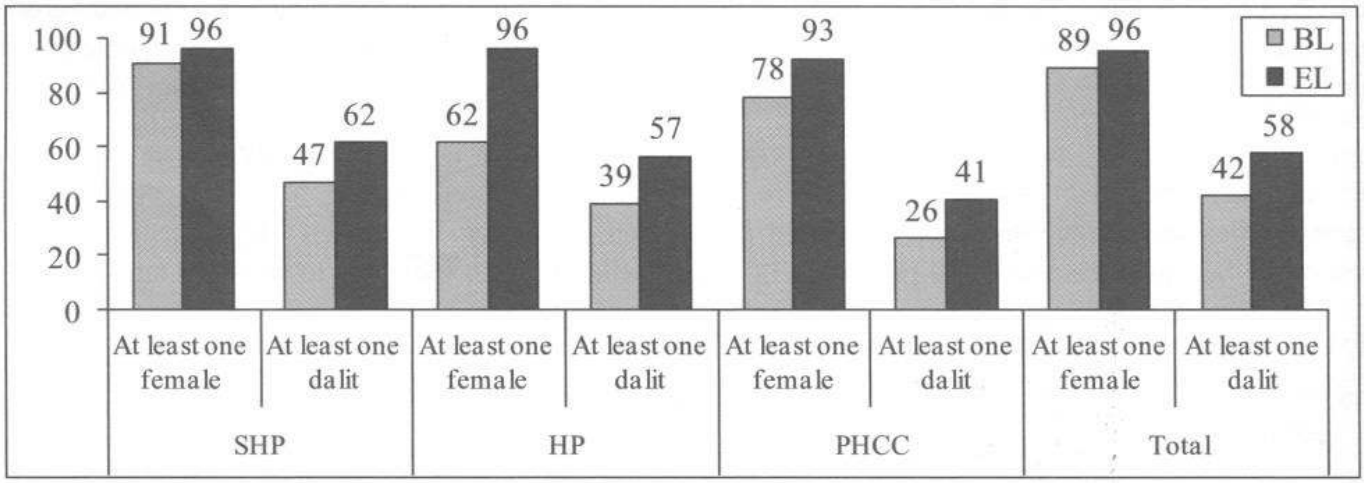
most recent HFOMC meetings was high (87%) in both the surveys. In both rounds of the HSSA, about 11% of the HFs claimed that they had minuted the most recent meeting, but could not produce it. HFOMCs at PHCCs had the highest proportion of meetings held with minutes in the baseline but had the lowest for the same at endline (90% vs 80%). Slight improvement was observed in minute-keeping practice from baseline to endline at SHPs but no changes were seen at HPs. In total, about one percent of the HFs did not keep minutes of the last HFOMC meeting in both the surveys. Refer to Table 7.5. It is of concern that although the number of HFOMC meetings has increased, there is no corresponsing increase in the practice of keeping minutes.

Table 7.5: Distribution of HFs which had minute of the last HFOMC meeting

Recording of HFOMC meeting	SHP		HP		PHCC		Total	
	BL (N=250)	EL (N=273)	BL (N=141)	EL (N=152)	BL (N=51)	EL (N=54)	BL (N=442)	EL (N=479)
Yes, with record	86.0	89.7	87.9	86.8	90.2	79.6	**87.1**	**87.7**
Yes, without record	11.2	9.5	11.3	11.2	9.8	20.4	**11.1**	**11.3**
No minute	2.8	0.7	0.7	2.0	0	0	**1.8**	**1.0**

The participation of at least one female in the most recent HFOMC meeting was high (89%) at baseline which further increased to 96% at endline (Figure 7.2). Similarly, the participation of at least one dalit member increased from 42% at baseline to 58% at endline. Although participation of dalits has increased across all types of health facilities, it remains low in PHCCs. It should be noted that the HFOMC ensures inclusion of both *dalits* and *janajatis* but there are a few VDC with no *dalit* populations.

Figure 7.2: Proportion of the last HFOMC meetings participated by at least one female and one dalit member



7.4 Ilaka and district level meetings

Every month the SHP in-charges and ilaka in-charges are required to participate in the ilaka and district level meetings respectively to discuss about HMIS and other management/administrative issues. Table 7.4 shows that there has been an increase in the proportion of health facilities that reported the conduct of ilaka level (for SHPs) and district level (for HPs/PHCCs) meetings in the past one year. At baseline, 52% of the health facilities reported this which increased to 68% at endline. The proportion of health facilities claiming no ilaka/district level meetings has declined from 18% at baseline to 8% at endline. The improvement is better in SHPs than that in HPs and PHCCs. On average, there have been 8.1 meetings at baseline in a year which increased to 10.2 at endline. During the tenure of NFHP II, there have been efforts to improve meetings both in regularization as well as its quality.

It is often the health facility in-charge who attends ilaka/district level meetings (80% at baseline and 86% at endline), although there are times that other staff from the health facility also attend. The pattern is similar in SHPs and HPs but is a little different in PHCCs where a considerable proportion of the district meetings was also attended by other staff besides the in-charge.

Table 7.6 : Proportion of HFs conducting or participating in the Ilaka/district level meetings

	SHP (N=284)		HP (N=153)		PHCC (N=56)		Total (N=493)	
	BL	EL	BL	EL	BL	EL	BL	EL
Number of Ilaka/district level meeting held in last 12 months								
0	10.9	6.0	30.1	11.1	19.6	7.1	**17.8**	**7.7**
1-5	13.4	3.5	11.1	8.5	14.3	8.9	**12.8**	**5.7**
6-11	15.8	18.0	19.6	20.3	21.4	17.9	**17.6**	**18.7**
12+	59.9	72.5	39.2	60.1	44.6	66.1	**51.7**	**68.0**
Mean	8.9	10.6	6.8	9.4	7.7	10.0	**8.1**	**10.2**
Person who participated in the last ilaka/district meeting								
HF in charge	81.8	88.8	85.0	86.8	57.8	69.2	**80.0**	**85.9**
Other than HF Incharge	14.6	9.4	12.1	11.8	35.6	30.8	**16.3**	**12.5**
No one	3.6	1.9	2.8	1.5	6.7	0.0	**3.7**	**1.5**
Reviewed MMWS in the last ilaka/district meeting								
Reviewed MMWS	37.3	45.5	40.4	45.5	42.9	50.0	**38.7**	**46.0**

Although the practice of reviewing the Monthly Monitoring Worksheet (MMWS) increased at endline, it is below one-half in both survey rounds which is a concern. At baseline 39% of the health facilities reviewed the MMWS during the ilaka/district meetings which increased to 46% at endline.

7.5 Health facility staff meeting

Monthly meetings with HF staff are pivotal in strengthening the management system and routine service delivery at health facilities. Figure 7.3 shows that the proportion of health facilities holding regular staff meetings has increased by 14 percent point from baseline to endline (52% to 66%). In both rounds, holding regular staff meetings was lowest in the SHPs, followed by HPs and the PHCCs.

Figure 7.3: Proportion of HFs holding regular staff meeting

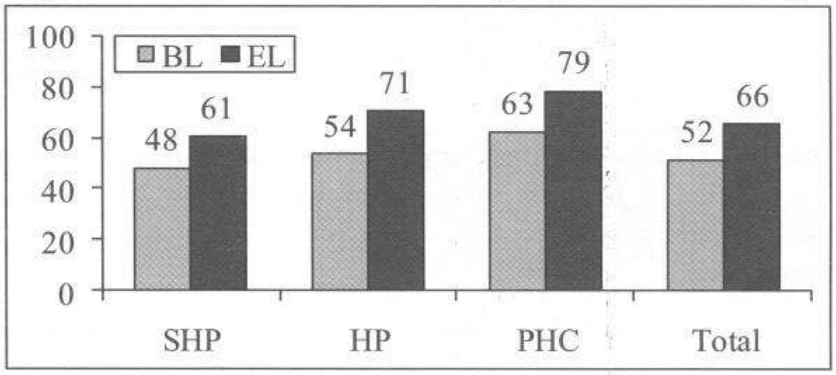


Table 7.7 provides information on the frequency of the staff meetings. Those HFs which claimed of meeting regularly were asked additional questions on the number of meetings held in the last one year.

Table 7.7: Among HFs holding regular staff meeting, the frequency of the meetings

Frequency of staff meeting	SHP		HP		PHCC		Total	
	BL (N=137)	EL (N=172)	BL (N=82)	EL (N=108)	BL (N=35)	EL (N=44)	BL (N=254)	EL (N=324)
Every month	74.5	69.8	61.0	47.2	52.8	38.6	**67.1**	**58.0**
Every 2-3 months	20.4	19.2	28.0	33.3	30.6	36.4	**24.3**	**26.2**
Every 4-5 months	1.5	3.5	4.9	4.6	8.3	13.6	**3.5**	**5.2**
Every 6 months or more/ irregular	3.6	7.6	6.1	14.8	8.3	11.4	**5.1**	**10.5**

Among the health facilities that claimed regular staff meetings, the HFs holding a meeting every month in the last one year has declined from 67% to 58%. In about a quarter of health facilities, the staff meetings were held every two to three months in both the rounds of the survey. Between 3-4% of the health facilities in both rounds were meeting every 4 to 5 months, while a sizable proportion (5% at baseline and 11% at endline) were meeting every six months or more. These results show that there have not been improvements in regularity of HF staff meetings.

Those facility respondents who reported to have monthly staff meetings were further asked about the quality of the staff meetings such as keeping meeting minutes, reviewing HMIS and developing action plans during the most recent staff meeting. With regards to keeping minutes and making action plans, there have not been improvements since baseline (Table 7.8). Less than one-half of HFs minuted the discussion and were able to show it when requested for in both the surveys. Although about 10% of the health facilities claimed keeping minutes of the last meeting, they could not show it when asked. More than one-half did not keep minutes of the last meeting in both the surveys. The least number of meeting minutes could be observed in SHPs (29%). Similar findings were seen for developing action plans - only those who minuted meeting decisions developed action plans.

Table 7.8: Distribution of HFs with different activities done in the last staff meeting

Meeting minute and action plan	SHP		HP		PHCC		Total	
	BL (N=137)	EL (N=172)	BL (N=82)	EL (N=108)	BL (N=35)	EL (N=44)	BL (N=254)	EL (N=324)
Minute available								
Yes, observed	24.8	29.0	43.9	44.4	58.3	59.1	**35.7**	**38.3**
Yes, unable to observe	8.8	4.7	11.0	8.4	11.1	15.9	**9.8**	**7.4**
No minutes	66.4	66.3	45.1	47.2	30.6	25.0	**54.5**	**54.3**
Action plan developed								
Yes, observed	18.2	28.5	45.1	45.4	47.2	56.8	**31.0**	**38.0**
Yes, unable to observe	9.5	4.7	11.0	5.6	8.3	15.9	**9.8**	**6.5**
No action plan	72.3	66.9	43.9	49.1	44.4	27.3	**59.2**	**55.6**
Reviewed HMIS	81.6	83.7	68.3	77.8	38.9	68.2	**71.3**	**79.6**

Some improvements have been noted with respect to reviewing HMIS data during the last staff meeting. Overall, eight out of ten health facilities at endline versus71% at baseline claimed that they reviewed HMIS in the most recent staff meeting.

7.6 FCHV meetings

The local health facility should organize FCHV meetings on a monthly basis to discuss about recording/reporting, commodities in stock and other issues. The assessment revealed an increase in the number of health facilities organizing such meetings. At baseline, the mean number of FCHV meetings held in a year was 5.7 which nearly doubled to 10.1 at endline (Table 7.9). At baseline, only one-third of the health facilities claimed that they had organized such meetings every month which doubled (65%) at endline. Moreover, at baseline, 39% of the health facilities did not organize any FCHV meetings in the past one year which sharply declined to 7% at endline. The greatest improvements in organizing FCHV meetings is noted for PHCCs.

Although an improvement in organizing FCHV meetings is noted, there has not been an improvement in participation of FCHVs in the meetings as the mean number of their participation in the last meeting declined from 12 to 11. The mean number of FCHVs in the sample health facilities was 12.3 in both the rounds of the assessment. Overall, the disaggregation of the results by HF type show that the participation of the FCHVs in the most recent meeting has declined slightly in SHPs and HPs.

Table 7.9: Proportion of HFs holding FCHV meetings in the last 12 months

Frequency of FCHV meetings	SHP (N=284)		HP (N=153)		PHCC (N=56)		Total (N=493)	
	BL	EL	BL	EL	BL	EL	BL	EL
No meeting	39.6	5.6	38.6	8.5	33.9	8.9	**38.6**	**6.9**
1-5	13.1	6.3	14.4	6.5	14.3	0.0	**13.6**	**5.7**
6-11	14.1	26.1	15.7	20.9	19.6	7.1	**15.2**	**22.3**
12+	33.2	62.0	31.4	64.1	32.1	83.9	**32.5**	**65.1**
Mean	5.6	10.0	5.9	9.8	6.0	10.8	**5.7**	**10.1**
Average number of FCHVs in the VDC	11.7	11.9	12.9	12.5	13.8	14.0	**12.3**	**12.3**
Average number of FCHVs participating in the last meeting	11.9	10.3	12.2	11.0	11.9	12.4	**12.0**	**10.7**

7.7 FCHV Fund and support

The Nepal Government has made a decision to provide Rs. 50,000 to every VDC to establish an FCHV Fund to support FCHVs. A five member fund management committee was formed at the VDC level to manage the fund, which is chaired by an FCHV. FCHVs can take loans from the fund at a minimal interest rate when needed, after fulfilling the required procedures and receiving an approval of the committee. If the fund management committee approves, Mothers Group members and people residing in the same VDC are also eligible to get the loans from FCHV Fund. Funds for FCHVs can be generated from the VDC, other organizations and individuals and from the money collected as interest from its users. Before the FCHV Fund was established, the FCHV Endowment Fund existed for several years, which did not benefit the FCHVs as desired. After the introduction of the FCHV Fund in 2009, the endowment funds were required to be transferred into the FCHV Fund.

In addition, it is required that the local bodies recognize the voluntary contribution of FCHVs in providing health, information and education services to the local dwellers by providing various support to them. NFHP II has provided intensive support to implement and monitor the utilization of the FCHV Fund in four districts. The FCHV Fund was already in existence in 94% of the health facilities at baseline, which at endline was found in all of the health facilities (Table 7.10). At endline, a question was added whether the previous endowment fund was included in the current FCHV Fund. Slightly more than one-half (53%) of the respondents confirmed that it had been included. Across HF types, the highest proportion of those that included the endowment fund in the current FCHV fund was the PHCCs (60%).

Table 7.10 : Proportion of HFs having FCHV Fund

FCHV Fund	SHP (N=284)		HP (N=153)		PHCC (N=56)		Total (N=493)	
	BL	EL	BL	EL	BL	EL	BL	EL
FCHV fund established	94.0	100	92.8	99.3	96.4	100	**93.9**	**99.9**
Endowment fund included in the FCHV fund		50.7		54.5		60.0		**52.8**

At baseline, a majority of VDCs had less than Rs. 50,000 in the FCHV Fund but at endline the percentage of HFs having more than Rs. 50,000 increased to 98% in aggregate, indicating that there has been much increase in the FCHV Fund amount (Table 7.11). Similarly, compared to only 2% of HFs at baseline, 12% of HFs at endline had an amount higher than Rs.100,000. The mean amount of fund increased from Rs 50,302 to Rs 81,035.

Table 7.11: Amount of FCHVs Fund by type of health facilities

Amount in FCHV Fund (Rs)	SHP		HP		PHCC		Total	
	BL (N=267)	EL (N=284)	BL (N=142)	EL (N=152)	BL (N=54)	EL (N=56)	BL (N=463)	EL (N=493)
=<50,000	74.2	2.5	67.6	1.3	83.0	3.6	**73.2**	**2.2**
50,001-100,000	23.5	87.0	31.7	83.7	17.0	87.5	**25.2**	**86.0**
≥100,001	2.3	10.6	0.7	15.1	0.0	8.9	**1.5**	**11.8**
Mean	50,566	79,627	49,951	83,945	49,934	80,222	**50,302**	**81,035**

Table 7.12 depicts that there has been remarkable increase in VDC or community support to FCHVs in the last 12 months preceding the survey from baseline (60%) to endline (75%). The majority of this support was in the form of cash which was three-fifths (61%) at baseline and fourth-fifths (82%) at endline. Less than a quarter of the VDCs/communities each also provided in-kind support to FCHVs or the mother groups helped FCHVs during their work in both rounds of the assessment. Disaggregated data shows that of all the three types of health facilities, VDC support was highest in PHCCs followed by HPs and SHPs.

Table 7.12: Percentage of VDC or Community providing support to FCHVs in the last 12 months

VDC/community support to FCHVs	SHP (N=284)		HP (N=153)		PHCC (N=56)		Total (N=493)	
	BL	EL	BL	EL	BL	EL	BL	EL
Yes (supported)	57.7	74.3	64.1	75.2	62.5	78.6	**60.2**	**75.1**
Types of Support								
Cash support	60.8	82.0	57.3	80.9	71.9	81.8	**60.9**	**81.6**
Support from Mothers group	18.4	16.6	24.4	13.9	23.3	11.4	**20.8**	**15.1**
In-kind support	17.0	21.3	22.4	20.9	24.2	25.0	**19.6**	**21.6**
Other support	33.8	7.6	22.5	8.7	18.8	2.3	**28.4**	**7.3**

7.8 VDC support to HF

In the HSSA questions on the support provided to local HF by VDC in the last three years period was also asked. Overall, 77% of the total HFs at baseline claimed that they were supported by their VDCs in the last three years period which increased to 82% at endline. In both the surveys, greater proportion of SHPs received such support than the other two HF types. The comparisons of this data between program and non-program HFs revealed that support from VDCs to HFs was much greater in program VDCs in both the surveys. Refer to Table 7.13.

Table 7.13: Health facilities receiving support from VDC in the last three years

HF types	Program HFs (N=323)		Non-program HFs (N=170)		Total (N=493)	
	BL	EL	BL	EL	BL	EL
SHP	86.3	94.0	68.6	61.8	**79.9**	**82.4**
HP	85.2	91.7	48.9	57.8	**74.5**	**81.7**
PHCC	81.8	93.9	52.2	52.2	**69.6**	**76.8**
Total	**85.4**	**93.2**	**61.2**	**59.4**	**77.1**	**81.5**

Table 7.14 presents the type of support provided by VDC to the local HF. The results reveals that one very significant support extended to local HFs by VDCs has been on staffing. All HFs which reported of receiving support from VDC in the last three years period were enquired about the type of support they received. It was found that one-third of the surveyed VDCs supported for staff at the baseline which nearly doubled to 60% at endline. Staff support was greater in SHPs and HPs. Other important supports which VDCs provided to local HFs were cash and maintenance of HF building which increased from baseline to endline. Other supports such as paying rental for HF building, supporting for drugs, equipments and furniture were also reported in a few HFs but such supports have declined from baseline to endline.

Table 7.14 : Type of support provided to local HF by VDC

Type of support	SHP		HP		PHCC		Total	
	BL (N=227)	EL (N=234)	BL (N=114)	EL (N=125)	BL (N=39)	EL (N=43)	BL (N=380)	EL (N=402)
Hired staff	35.2	61.5	29.8	62.4	23.1	48.8	**32.4**	**60.4**
Paying rental/provided building/room for free	19.8	14.1	7.0	4.8	5.1	2.3	**14.5**	**10.0**
Land for HF building	12.8	17.5	6.1	7.2	10.3	16.3	**10.5**	**14.2**
Maintenance of building	21.7	32.5	25.4	20.2	17.9	23.3	**22.4**	**27.6**
Furniture	16.7	17.1	14.0	11.2	12.8	0	**15.5**	**13.4**
Drugs and supplies	41.0	25.6	30.7	19.2	28.2	18.6	**36.6**	**22.9**
Cash support	21.6	29.9	41.2	38.4	38.5	51.2	**29.2**	**34.8**
Other support	22.5	26.1	25.4	24.0	20.5	25.6	**23.2**	**25.4**

Staff support from VDCs to HF was further analyzed by HFMSP and non-HFMSP health facilities. Staff support in the HFMSP HFs was much higher than in the non-HFMSP HFs in both the surveys and there was remarkable increase from baseline to endline across all types of HFs. In the program HFs at baseline, 113 staffs were hired in support of VDCs which increased to more than two folds at the endline (306). In the non-program HFs, 23 staffs were supported at baseline which increased to 43 at endline (Figure 7.4). Out of all the staff supported in both the program and non- program HFs, the support was greatest in SHPs and least in PHCCs.

Figure 7.4: Proportion of HFs by type of receiving staff support from VDC in HFMSP and non-HFMSP HFs

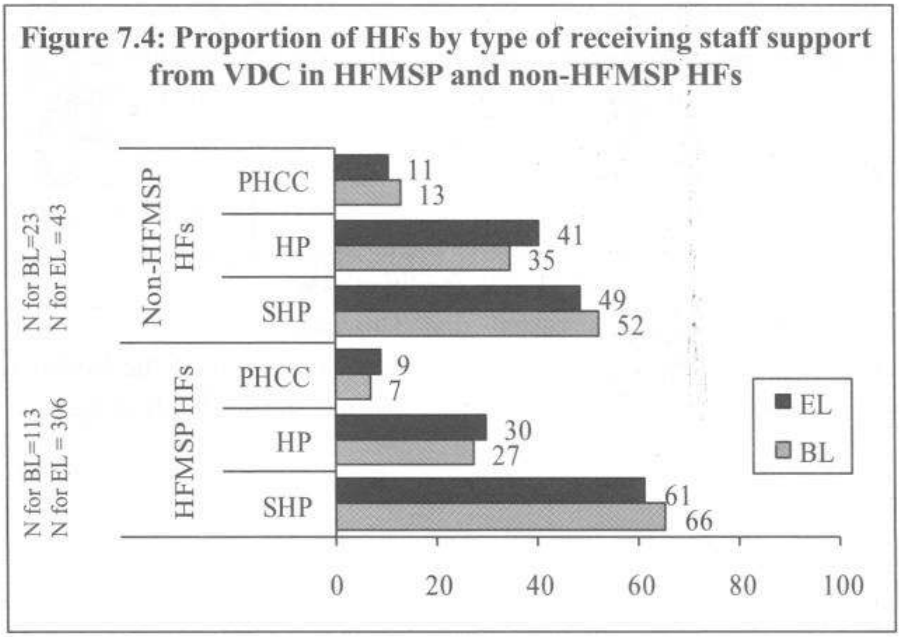


Table 7.15 displays the distribution of technical and non-technical staff out of all staff supported by VDCs. Results reveal that in the HFMSP program HFs, out of total staff hired, proportion of technical staff was greater than peons (58% vs 43%) at endline, which contrasts the results at baseline where proportion of peons was higher than technical staff (61% vs 39%). The majority of the technical staff hired were ANM and MCHW followed by AHW and VHW. In non-program HFs, three-fifths of staff hired in both the surveys was peons and other administrative staff. These findings suggest that in the program HFs there has been a better mix of both technical and support staff in human resource support than in non-program HFs.

Table 7.15: Number of staff supported by VDC in HFMSP and non-HFMSP HFs

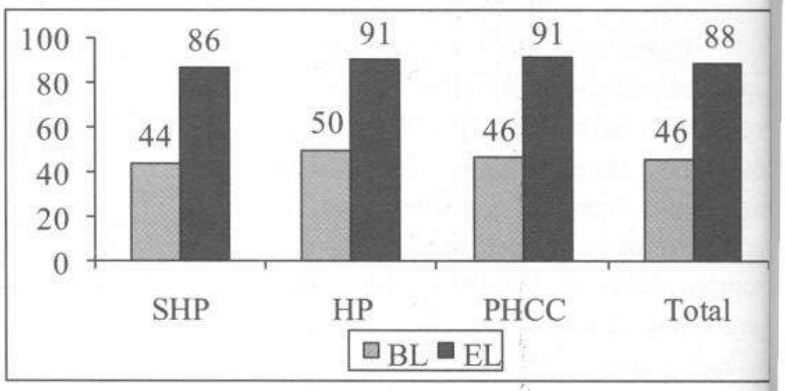
HF types	Program HFs						Non-Program HFs					
	Technical staff		Peon		Total		Technical staff		Peon		Total	
	BL	EL	BL	EL	BL	EL	BL	EL	BL	EL	BL	EL
SHP	20	105	54	83	**74**	**188**	3	9	12	14	**15**	**23**
HP	21	63	10	28	**31**	**91**	3	8	2	8	**5**	**16**
PHC	3	8	5	19	**8**	**27**	2	2	1	2*	**3**	**4**
Total	44	176	69	130	**113**	**306**	8	14	15	23	**23**	**43**
%	**38.9**	**57.5**	**61.0**	**42.5**	**100.0**	**100.0**	**34.8**	**37.8**	**65.2**	**62.2**	**100.0**	**100.0**

* includes one admin assistant

7.9 Citizen Charter

The Citizen's Charter is a piece of information which portrays a systematic effort to focus on the commitment of an organization towards its citizens with respect to standard of services, information, choice and consultation, non-discrimination and accessibility, grievance remedy, courtesy and value for money. This is one of the most widely used indicators to measure governance in health. According to the Local Self Governance Act of Nepal, it is the responsibility of every health facility or its management committee to display the Citizen's Charter in the facility.

Figure 7.5: Proportion of HFs displaying Citizen Charter



During this survey, the display of the citizen's charter in the surveyed health facilities was observed. The results reveal that Citizen's Charters were displayed by a great majority (88%) of the health facilities at endline which is a remarkable improvement from baseline (46%) (Figure 7.5). The findings are fairly similar across all types of health facilities.

REFERENCES

Department of Health Services. 2009. Annual Report. Department of Health Services. 2007/2008. Ministry of Health and Population. Government of Nepal.

Engender Health. Infection Prevention. 2011. A reference booklet for health care providers. Available from: http://www.engenderhealth.org/files/pubs/qi/ip/ip-ref-en.pdf.

Ministry of Health and Population (MoHP). 2010. *Nepal Health Sector Programme-II (NHSP-II) 2010-2015.* MoHP. Government of Nepal. 2010.

National Bureau of Statistics (NBS) (Tanzania) and Macro International Inc.. 2007. *Tanzania Service Provision Assessment Survey 2006.* Dar es Salaam, Tanzania: National Bureau of statistics and macro International Inc.

Nepal Family Health Program II. About us. [cited 2012 13/02/2012] Available from: http://nfhp.jsi.com/About/about.html

World Health Organization. 2010. *Monitoring the Building Blocks of Health Systems: A Handbook for Indicators and Their Measurement Strategies.* World Health Organization. 2010. Geneva.

World Health Organization. 2009. *System Thinking for Health Systems Strengthening.* World Health Organization. 2009. Geneva.

World Health Organization. 2007. *Health System in Nepal: Challenges and Strategic Options*. World Health Organization. Country Office for Nepal. 2007.

World Health Organization. 2004. Practical guidelines for infection control in health care facilities 15/02/2012]. Available from: http://www.searo.who.int/linkfiles/publications_practicalguidelinSEAROpub-41.pdf.

World Health Organization. Health Service Delivery: Available from: http://www.who.int/healthsystems/topics/delivery/en/index.html.

Table 4.2: Number of positions filled-in by type of health facility

Type of staff	SHP (N=284)		HP (N=153)		PHCC (N=56)	
	BL	EL	BL	EL	BL	EL
Medical officer					42	27
Staff Nurse					21	26
ANM			115	131	123	141
HA/Sr. AHW			144	130	51	53
AHW	267	272	213	197	101	103
VHW	235	204	139	112	44	40
MCHW	251	244				
Lab Assistant					52	44
Total	**753**	**720**	**611**	**570**	**434**	**434**

The HP of Bardibas, Mahottari has been upgraded to hospital but data on some technical staff (officer, staff nurse, lab Assist. etc) is not included in the table.

Table 4.3: Number of GoN staff currently working among the filled-in by type of health facility

Type of staff	SHP		HP		PHCC	
	BL	EL	BL	EL	BL	EL
Medical officer					36	21
Staff Nurse					16	19
ANM			107	128	109	119
HA/Sr. AHW			136	125	51	52
AHW	265	269	197	186	100	96
VHW	231	195	136	109	44	40
MCHW	247	245				
Lab Assistant					48	41
Total	**743**	**709**	**576**	**548**	**404**	**388**

Table 4.4: Number of staff (all sources) available in the health facility on tl day of observation among those who are currently working (all sources) by ty of health facility

Type of staff	SHP		HP		PHCC	
	BL	EL	BL	EL	BL	EL
Medical officer					15	12
Staff Nurse					9	14
ANM			94	178	83	107
HA/Sr. AHW			102	97	35	43
AHW	225	255	144	171	75	98
VHW	166	141	89	78	33	33
MCHW	187	240				
Lab Assistant					34	37
Total	**578**	**636**	**429**	**524**	**284**	**344**

ANNEX-B

Health System and Service Assessment
D(P)HO/NFHP-II
Health Facility (PHCC, HP and SHP) Questionnaire

Identification	Codes
NAME AND CODE OF DISTRICT_____.....	☐☐
NAME AND CODE OF VDC_____.....	☐☐☐
WARD NUMBER.....	☐
NAME OF HEALTH FACILITY_____	
TYPE OF HEALTH FACILITY.....	PHCC.....1 Health Post.....2 Sub-health Post.....3
NAME OF RESPONDENT_____	
POSITION AND CODE OF RESPONDENT_____.....	Facility Incharge.....1 Nurse/ANM.....2 HA/AHW.....3 Other _____.....6 (Specify)
NAME OF INTERVIEWER_____	
DATE INTERVIEWED.....	☐☐ ☐☐ ☐☐ DAY MONTH YEAR

Informed Consent

Namaste. My name is _____. We are here from NFHP-II on behalf of the D(P)HO in knowing more about health services and providing technical support. We are doing survey of sample health facilities of this district. We will be asking you questions about various health services and will ask to see you various records. The information about your health facility will be used by the D(P)HO and organizations supporting services in your facility, for planning service improvement. The data collected from your facility will be kept confidential.

You may refuse to answer any question or choose to stop the interview at any time. Do you have questions about the survey? Do I have your agreement to proceed?

_____ _____

(Indicate respondent's willingness to participate) Date

May I begin the interview? Yes

No (Stop interview)

200: Infrastructure

(INSTRUCTION: This inventory should be completed by observing the facility and through discussion with the Incharge/staff of the health facility).

Q. #	Question	Codes	Skip
201	Is this the health facility's own building or rented in building or someone's building for which rent has not to be paid?	Own ..... 1 Rented-in..... 2 Others but no rent to be paid.....3	
202	Does the facility has compound wall/fencing?	Yes ..... 1 No 2	
203	How many rooms does the facility has?	Number..... ☐	
204	Does the facility has a waiting room/area for clients where they are protected from sun and rain?	Yes ..... 1 No 2	→ 206
205	Is furnitures available for sitting to the clients in the waiting room/area?	Yes ..... 1 No 2	
206	Does the facility has a separate examination room/area for ANC/delivery?	Yes ..... 1 No 2	→ 206b
206a	Is the separate examination room available for ANC only, delivery only or for both services?	ANC only..... 1 Delivery only..... 2 Both (ANC and delivery in separate)...3 Both (ANC and delivery in same room)...4	
206b	Is there a delivery bed available in the delivery room/area?	Yes ..... 1 No 2	
207	Does the facility has a separate store room?	Yes ..... 1 No 2	
208	Is there a table available in the client examination room?	Yes ..... 1 No 2	
209	Does HF has water into its premises?	Yes ..... 1 No 2	→ 211
210	Does the facility has running water inside the building?	Yes ..... 1 No 2	
211	Does the facility has a toilet in functioning condition that is available for clients to use?	Yes, functioning and clean..... 1 Yes, functioning, not clean..... 2 Yes, not functioning..... 3 No client toilet..... 4	
212	Does the facility has electricity?	Yes ..... 1 No 2	
215	How many beds are there in the facility? (If none, record "00")	Number:..... ☐☐	
216	Does the facility has a staff quarter?	Yes ..... 1 No 2	
217	Does a trained health provider live on the facility premises?	Yes ..... 1 No 2	
217 a	What kind of emergency transport service is available in this HF/VDC?	Ambulence.....1 Rikshwa ambulence.....2 Doko.....3 Strecher.....4 Other _____ (Specify) ....5 None.....6	

300: Staffing

What is the staff situation in the health facility?

Type of staff	301	302	303	304			305
	Number sanctioned	Number filled-in	Number away for 1 or more months (e.g. Training, vacation, deputation etc)?	Number currently working			Number present today at the time of visit (RECORD OBSERVATION)
				Govt.	VDC	Other	
Medical officer							
Staff Nurse							
ANM							
HA/Sr. AHW							
AHW							
VHW							
MCHW							
Lab Assistant							
Adm. Assistant							
Store Keeper							
Office Aide							

Note: Q 301-303 is applicable for government staff only.
Q 304 excludes staff who are away for more than one month (see Q 303).
Q 304: The NPC appointed staff should be recorded in other column. Similarly, staff supported from I/NGOs should also be recorded as other.
Q 305 applies to all staff (GoN, VDC and other) available during your visit.

305a. Please provide me the following details of the government staff who are working in this HF?

Type of GoN staff	How many months the person has been serving in this district?	During the last 6 months.....		
		How many trainings did s/he attend?	How many days s/he attended the trainings (including travel time)?	How many days s/he attended meetings/workshops that were organized away from this HF(including travel time)?
Medical officer				
Staff Nurse-1				
Staff Nurse-2				
ANM-1				
ANM-2				
ANM-3				
HA/Sr. AHW				
AHW-1				
AHW-2				
VHW				
MCHW				
Lab Assistant				
Store Keeper				

400: Service Provision and Infection Prevention

Now I would like to talk to you the days of a week some of the services this health facility provides, and the number

of clients on each days registered in the Master Register.

(INSTRUCTION: Q 401 a-i should be asked, and 402 record observation. Circle codes that applies. If a service is not provided at all or daily, do not circle any codes i.e leave blank)

	Services	401. On what days of a week .....(service) is available?						
		Every day	SUN	MON	TUE	WED	THU	FRI
a.	IMCI?	7 (next service)	1	2	3	4	5	6
b.	Antenatal services?	7 (next service)	1	2	3	4	5	6
c.	Delivery services?	7 (next service)	1	2	3	4	5	6
d.	Postnatal Service?	7 (next service)	1	2	3	4	5	6
e.	Depo-Provera?	7 (next service)	1	2	3	4	5	6
f.	IUCD?	7 (next service)	1	2	3	4	5	6
g.	Implant?	7 (next service)	1	2	3	4	5	6
h.	Male sterilization?	7 (next service)	1	2	3	4	5	6
I.	Female sterilization?	7 (Q 402)	1	2	3	4	5	6
402	Total no. of clients registered last day in Master Register: (Record Observation)	☐☐☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐

Q. #	Question	Codes	Skip
402 a	If delivery service available, is the service provided during office hours only or it is provided throughout 24 hours?	Office hours only..... 1 24 hours..... 2	

(INSTRUCTION: Q 403- 409a should be recorded through observation)

Q. #	Question	Codes	Skip
403	Assess general cleanliness of the facility (A facility is clean if the floors are swept and counters and tables are wiped and free of obvious dirt or waste. A facility is not clean if obvious dirt or waste or broken objects are on the floors or counters).	Facility Clean..... 1 Facility Not Clean..... 2	
404	Is there a Puncture Proof Container?	Yes ..... 1 No 2	→ 406
405	Is it being used properly?	Yes ..... 1 No 2	
406	Does the facility has a Incinerator?	Yes ..... 1 No 2	
407	How is the waste that is collected and removed offsite disposed?	Incinerated..... 1 Taken to local dump and burned..... 2 Taken to local dump and not burned..... 3 Taken to health care waste disposal/burning pit and burned..... 4 Other _____ (Specify) 6	

Q. #	Question	Codes	Skip
408	Is there a ORT Corner established in the health facility?	Yes ..... 1 No 2	→ 409a
409	Is the ORT corner currently functional?	Yes ..... 1 No 2	
409a	Is there a placenta pit within the HF premises?	Yes ..... 1 No 2	

500: Equipments/Instruments and Supplies

501. Do you have the following equipments/instruments in **working condition** in the health facility?

(INSTRUCTION: Information contained in this section should be recorded based on the observation).

	Basic equipments	Functional Number
a.	Stethoscope?	Number:..... ☐
b.	Thermometer?	Number:..... ☐
c.	Blood Pressure apparatus?	Number:..... ☐
d.	Cheattle forceps w/jar, stainless steel?	Number:..... ☐
e.	Kerosene/Gas Stove?	Number:..... ☐
f.	Dressing Set?	Number:..... ☐
g.	Suture set?	Number:..... ☐
h.	Kidney Tray (600 cc)?	Number:..... ☐
i.	ARI Timer?	Number:..... ☐
j.	Fetescope?	Number:..... ☐
k.	EOC kit for home delivery?	Number:..... ☐
l.	Weighing scales for adults?	Number:..... ☐
m.	Weighing scales for babies?	Number:..... ☐
n.	IV set with cannula and fluid?	Number:..... ☐
o.	Refrigerator?	Number:..... ☐
p.	Autoclave/boiler/Steam HLD?	Number:..... ☐
p-1.	Delivery set?	Number:..... ☐
p-2	Episiotomy Set?	Number:..... ☐
p-3	Neonatal Resuscitation set?	Number:..... ☐
p-4	De lee's suction or other suction apparatus?	Number:..... ☐
m-1	Pan Scale?	Number:..... ☐

Now I would like to talk to you for some of the supplies and items that this health facility uses to provide the health services, and the adequacy of each supply for the **next one** month?

	Supplies	502 Is ...(supply) currently available?	503 Is.....(supply) adequate for next ONE month?	Skip
a.	Condom?	Yes ..... 1 No ....(Next supply)..... 2	Yes ..... 1 No 2	
b.	Pills?	Yes ..... 1 No ....(Next supply)..... 2	Yes ..... 1 No 2	
c.	Depo?	Yes ..... 1 No ....(Next supply)..... 2	Yes ..... 1 No 2	
d.	ORS packets?	Yes ..... 1 No ....(Next supply)..... 2	Yes ..... 1 No 2	
e.	Cotrimoxazole-paediatrics?	Yes ..... 1 No ....(Next supply)..... 2	Yes ..... 1 No 2	
f.	Iron folate tablets?	Yes ..... 1 No ....(Next supply)..... 2	Yes ..... 1 No 2	
g.	Vitamin A Capsule?	Yes ..... 1 No ....(Next supply)..... 2	Yes ..... 1 No 2	
h.	Albendazole 400 mg ?	Yes ..... 1 No ....(Next supply)..... 2	Yes ..... 1 No 2	
I.	Ciprofloxacin?	Yes ..... 1 No ....(Next supply)..... 2	Yes ..... 1 No 2	
j.	Amoxicillin 250 mg?	Yes ..... 1 No ....(Next supply)..... 2	Yes ..... 1 No 2	
k.	Metronidazole 200 mg?	Yes ..... 1 No ....(Next supply)..... 2	Yes ..... 1 No 2	
l.	Paracetamol 500 mg?	Yes ..... 1 No ....(Next supply)..... 2	Yes ..... 1 No 2	
m.	Gentamycin?	Yes ..... 1 No ....(Next supply)..... 2	Yes ..... 1 No 2	
n.	Zinc?	Yes ..... 1 No ....(Next supply)..... 2	Yes ..... 1 No 2	
o.	Chlorine powder (bleach/ Virex)	Yes ..... 1 No ....(Next supply)..... 2	Yes ..... 1 No 2	
p.	Oxytocin?	Yes ..... 1 No ....(Next supply)..... 2	Yes ..... 1 No 2	
q.	Chloroquine?	Yes ..... 1 No ....(Next supply)..... 2	Yes ..... 1 No 2	
r.	R. D. Zone?	Yes ..... 1 No ....(Next supply)..... 2	Yes ..... 1 No 2	
s.	Magnessium sulphate?	Yes ..... 1 No .....(Q 504)..... 2	Yes ..... 1 No 2	
504	Are the drugs managed according to the FEFO system? (check at least 5 items?	Yes ..... 1 No 2		
505	Has the stock book been updated?	Yes ..... 1 No 2		

506. Do you have the following documents and BCC materials in the health facility?

	Question	Codes	Skip
a.	National Medical Standard Vol. I?	Yes ..... 1 No 2	
b.	FP counseling Flip chart?	Yes ..... 1 No 2	
b-1	FP kit box?	Yes ..... 1 No 2	
c.	IMCI Chart Booklet?	Yes ..... 1 No 2	
d.	Cotrim Dose Card?	Yes ..... 1 No 2	
e.	Home Therapy Card for ARI cases?	Yes ..... 1 No 2	
f.	Zinc counseling card?	Yes ..... 1 No 2	
g.	Storage Guideline for health commodities?	Yes ..... 1 No 2	
h.	HFOMC Guideline?	Yes ..... 1 No 2	
I.	FCHV Fund Guideline?	Yes ..... 1 No 2	
j.	HMIS recording and reporting guideline?	Yes ..... 1 No 2	
j-1	MNH Job-aid?	Yes ..... 1 No 2	
	RECORD ITEMS k-p-1 "YES" IF THE MATERIALS ARE DISPLAYED IN CLIENTS WAITING ROOM/AREA. OTHERWISE RECORD "NO"		
k.	Family Planning Poster?	Yes ..... 1 No 2	
l.	Informed Choice Poster?	Yes ..... 1 No 2	
m.	ANC/delivery (RH) related poster?	Yes ..... 1 No 2	
n.	Nutrition Poster?	Yes ..... 1 No 2	
o.	Immunization Poster?	Yes ..... 1 No 2	
p.	Diarrhea/ARI Poster?	Yes ..... 1 No 2	
p-1	Newborn related poster?	Yes ..... 1 No 2	
507	Have you received any BCC materials from the district in the last 6 months?	Yes ..... 1 No 2	
508	Is there a Citizen Charter displayed?	Yes ..... 1 No 2	

600: Management Systems

Q. #	Question	Codes	Skip
601	Is there a HFOMC?	Yes ..... 1 No 2	→ 611
602	How many members are in the HFOMC?	Number:..... ☐☐	
603	How many women are the members of the HFOMC?	Number..... ☐☐	
604	How many Dalits are the member of the HFOMC?	Number..... ☐☐	
605	Have HFOMC members received orientation on the conduct of the health facility?	Yes ..... 1 No ..... 2 Don't know..... 8	
606	How many HFOMC meetings were held in the last 12 months?	None..... 0 Number:..... ☐☐	→ 611
607	When was the last HFOMC meeting held during the last 12 months?	Months ago..... ☐☐	
608	Was the outcome of the last meeting minuted? May I see it?	Yes, record observed..... 1 Yes, reported, not seen..... 2 No record maintained..... 3	
609	How many women members participated in the last meeting?	Number:..... ☐	
610	How many Dalit members participated in the last meeting?	Number:..... ☐	
611	Has this health facility received any support from the VDC in the last 3 years?	Yes ..... 1 No 2	→ 613
612	What kind of support it has received from the VDC in the last 3 years? (MULTIPLE ANSWER)	Hired HF staff ..... 01 Pays office rent/free building..... 02 Provided land for building..... 03 Building/compound construction/repair. 04 Furniture support..... 05 Supported medicines/other supplies..... 06 Cash support/fund generation..... 07 Other Support _____ ...96 (Specify)	
613	How many PHC/ORC in a month are expected in the VDC?	Number:..... ☐	
614	How many PHC/ORC were organized in the last month?	Number:..... ☐	
615	How many child immunization clinics in a month are expected in the VDC?	Number:..... ☐	
616	How many child immunization clinics were organized in the last month?	Number:..... ☐	
617	How many FCHVs are in this VDC?	Number:..... ☐☐	
618	How many FCHV meetings were organized in the last 12 months?	None..... 0 Number..... ☐☐	→ 620

Q. #	Question	Codes	Skip
619	How many FCHVs participated in the last meeting?	Number..... ☐☐	
620	Does this VDC have an FCHV Fund to support FCHV activities?	Yes ..... 1 No 2	→ 622
621	How much amount is in the FCHV Fund?	Rs..... ☐☐☐☐☐☐	
621a	Is the endowment fund merged to FCHV fund?	Yes ..... 1 No 2	
622	In the last 12 months has the local community or VDC provided any support to the FCHVs?	Yes ..... 1 No 2	→ 624
623	What kind of support the local community or the VDC has provided to FCHVs in the last 12 months? (MULTIPLE ANSWER)	Support from mother's group to carry out FCHV work..... 1 Cash support..... 2 In-kind incentives (sari, umbrella, torch or other items)..... 3 Other Support _____ (Specify) 6	
624	Does this facility have routine meetings for reviewing managerial or administrative matters?	Yes ..... 1 No 2	→ 629
625	How often do meetings to discuss the facility managerial and administrative matters take place?	Monthly or more often..... 1 Every 2-3 months..... 2 Every 4-6 months..... 3 Less than every 6 months or irregularly..4	
626	Is an official record of managerial meetings maintained? (If yes, ask to see some minutes/record from the most recent meeting)	Yes, record observed..... 1 Yes, reported, not seen..... 2 No record maintained.....3	
627	Was there review of HMIS data during the last meeting?	Yes ..... 1 No 2	
628	Is there a Plan of Action/meeting minute developed based on the meeting? Can I see it?	Yes, record observed..... 1 Yes, reported, not seen..... 2 No record maintained.....3	
629	How many Ilaka/district level meetings were held in the last 12 months?	None.....0 Number..... ☐☐	→ 632
630	Who from this HF participated last time in the Ilaka/district level meeting?	None.....1 Facility Incharge.....2 Other person _____ (Specify position) 6	→ 632
631	In the last Ilka/district meeting you participated was the Monthly Monitoring Worksheet of your HF reviewed?	Yes ..... 1 No ..... 2 Don't know..... 8	
632	Did you send the last month progress report (HMIS 32) to the Ilaka/district on time?	Yes ..... 1 No 2	
633	Have you updated Monthly Monitoring Worksheet of the last month? May I see it?	Yes, record updated..... 1 Yes, reported, not seen..... 2 No record updated..... 3	
634	How many times did the Ilaka/district supervisor visited your health facility in the last 6 months?	None.....0 Times..... ☐☐	→ 700

Q. #	Question	Codes	Skip
635	Did the supervisor review and make written comments on recording and reporting in any of the visits?	Yes ..... 1 No 2	

800: Data Quality and Use

801. Now I would like to talk to you for some of the health statistics of this health facility.

802a	Did the HF send the last quarter LMIS?	Yes ..... 1 No 2	→ 803
802b	If Yes, review last quarter data from stock book and verify with last quarter LMIS form. Does the data match?	Yes / No Pills? 1 / 2 ORS? 1 / 2 Zinc? 1 / 2 Amoxycillin 250 mg? 1 / 2	
803	Review last month's data from FP register and verify with HMIS 32: Do users match for:	Yes / No Pills new and current users? 1 / 2 Depo new and current users? 1 / 2	
804	Review last month's data from HMIS 31 and verify with HMIS 32. Do number of clients served match/correctly recorded for:	Yes / No From PHC ORC? 1 / 2 From EPI Clinic? 1 / 2 From FCHVs? 1 / 2 Pneumonia Rx by FCHVs? 1 / 2	
808	Does the facility have displayed a map of its catchment area?	Yes ..... 1 No 2	
809	Does the facility have displayed summary of target groups (e.g. Population, U5 population, expected pregnancies etc) of its catchment area?	Yes ..... 1 No 2	
810	Does the facility have displayed any service data/information?	Yes ..... 1 No 2	→ 812
811	Are these data/information for the most recent year/period?	All data are for most recent year/period... 1 Only some are for recent year/period.....2 None are for most recent year/period..... 3	
811a	Is there a Data Flex Chart supported by NFHP displayed at this HF?	Yes ..... 1 No 2	→ END
811b	Is the data on Flex Chart updated?	Yes ..... 1 No 2	

THANK YOU FOR YOUR COOPERATION