DISTRICT HEALTH SYSTEMS ASSESSMENT WITHIN INTER-SECTORAL CONTEXT

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Research Report

District Health Systems Assessment within Inter-sectoral Context

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Prof Dr Chop Lal Bhusal

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Acronyms

AHW	Auxiliary Health Worker
AMDA	Association of Medical Doctors Asia
ANC	Antenatal Care
ANM	Assistant Nursing Midwife
APD	Acid Peptic Disorder
ARI	Acute Respiratory Infection
ASRH	Adolescent Sexual and Reproductive Health
BDS	Blue Diamond Society
CBNCP	Community Based Neonatal Care Package
CDO	Chief District Officer
CMA	Community Medicine Auxiliary
DACC	District AIDS Coordination Committee
DAgO	District Agriculture Office
DAO	District Administration Office
DAyC	District Ayurveda Center
DDC	District Development Committee
DEO	District Education Office
DFO	District Forest Office
DHC	District Health Committee
DHMT	District Health Management Team
DHO	District Health Office
DLSO	District Livestock Service Office
DM	Diabetes Mellitus
DOTS	Directly Observed Treatment System
DPHO	District Public Health Office
DUDBC	Department of Urban Development and Building Construction
DWSC	District Water Supply Corporation
DWSS	Department of Water Supply and Sewerage
EDP	External Development Partner
ERB	Ethical Review Board
FCHV	Female Community Health Volunteer
FGD	Focus Group Discussion
FNCCI	Federation of Nepalese Chamber of Commerce and Industry
FP	Family Planning
FPAN	Family Planning Association Nepal
FY	Fiscal Year
GBV	Gender Based Violence
GI	Gastro Intestinal
HA	Health Assistant
HF	Health Facility
HFOMC	Health Facility Operation and Management Committee
HMIS	Health Management Information System

HP	Health Post
HR	Human Resource
HSA	Health System Assessment
HTN	Hypertension
IDI	In-depth Interview
IMCI	Integrated Management of Childhood Illness
INGO	International Non Governmental Organization
ISC	Inter-Sectoral Coordination
IYCF	Infant and Young Child Feeding
JE	Japanese Encephalitis
LDO	Local Development Officer
LRTI	Lower Respiratory Tract Infection
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MO	Medical Officer
MoHP	Ministry of Health and Population
NCDs	Non Communicable Diseases
NGO	Non Governmental Organization
NHRC	Nepal Health Research Council
NHSP IP	Nepal Health Sector Program Implementation Plan
NHSSP	Nepal Health Sector Support Program
NRCS	Nepal Red Cross Society
ODF	Open Defecation Free
OPD	Out Patient Department
ORC	Outreach Clinic
PABSON	Private and Boarding School's Organization Nepal
PHCC	Primary Health Care Center
PHC	Primary Health Center
PID	Pelvic Inflammatory Disease
PNC	Postnatal Care
PUO	Pyrexia of Unknown Origin
RH	Reproductive Health
RHCC	Reproductive Health Coordination Committee
RHD	Regional Health Directorate
SHP	Sub Health Post
SN	Staff Nurse
STI	Sexually Transmitted Infection
TB	Tuberculosis
URTI	Upper Respiratory Tract Infection
VDC	Village Development Committee
VHW	Village Health Worker
WASH	Water Sanitation and Hygiene
WHO	World Health Organization
WVIN	World Vision International Nepal

Executive Summary

The WHO defines health systems as "all the organizations, institutions, and resources that are devoted to producing health actions". Health sector projects engage with all levels and elements of the health system and frequently encounter constraints that limit their effectiveness. There are four key functions of the health system: (1) stewardship (often referred to as *governance*), (2) financing, (3) human and physical resources, and (4) organization and management of service delivery. On the other hand, Inter-sectoral coordination among the different actors in the district that directly or indirectly has a role in strengthening and supporting the health system forms an important component of improved health system. The Alma Ata declaration has already reiterated inter-sectoral coordination as one of its main component in achieving Health For All. In the NHSP IP II (2010-2015), the MoHP has clearly put forward its stand in the importance of Inter-sectoral coordination and collaboration and to have a lead role in areas of its comparative advance. This study was aimed to describe the major four key functions of the health systems and find out the situation of inter-sectoral coordination that may have an equally important role in improving the function of health system. Furthermore, we also tried to identify on which areas of health systems requirements the inter-sectoral coordination & collaboration plays a role.

In the above context to achieve the above said objectives we chose two districts each from three ecological belts on the basis of performance indicators as reported by MoHP for the year 2066/67. Hence the districts selected for the study were Sarlahi and Rupandehi from Terai, Bhaktapur and Kaski from Hill and Sidhupalchowk and Rasuwa from Mountain. Within the selected district an in depth interview with the chief of DHO or DPHO as well as group interview with relevant personnel of D(P)HO was carried out using semi structured questionnaire. FGDs were also conducted with the organizations of health and non health sectors in the district along with D(P)HO chief and personnel of D(P)HO. Furthermore, a semi structured group interview was carried out with the In Charge and selected personnel as well as HFOMC members of one selected PHC in every district. The data received in such way was transcribed and then edited. The quantitative information was tabulated which was then summarized fro key findings. The findings from the FGDs which was mainly focused on finding out the situation of Inter-sectoral coordination were summarized in four key thematic areas namely Existing Situation of Coordination, Problems and Constraints, Potential Areas for Coordination and Who should lead.

The key findings in relation to the major key functions of district health systems showed that the overall management of the district health system happens under the leadership of chief of D(P)HO with the cooperation of all the personnel in different sections. The PHCs on the other hand have HFOMC in all of them as a management structure where members from marginalized, women and dalit are included and participate in the meetings in all the PHCs.

The financial management issues of the district offices mainly happen in a predetermined pattern that is decided and directed from the central level. None of the districts received budget on time and none of the finance head and chief of D(P)HO are satisfied with that. Most of the public HFs of districts are found to be charging fees for some of their services.

None of the chief's are satisfied with the allotted posts for the HFs. The number of posts of HR in the D(P)HO are filled in almost all the districts except one. The HFs in the district have many areas of lacking in terms of HR fulfillment. The situation is worse with the lower level facilities the worst being the SHPs. Most of the PHCs included in the study suffered with the deficient number of staffs. Community involvement and participation is visible in the form of youth and mother's groups in all the districts except one involved in some or the other health and health related issues. All of the PHCs are found providing services related to priority health activities. However, in terms of disease prevention and control as well as treatment of certain diseases such as NCDs the PHCs are not found to be capable enough and do not have the resources.

Inter-sectoral coordination and collaboration of the health system within the health sectors exist only to a very limited extent which usually happens with non public HFs in health camps, preventive and promotive health service, immunization and urban health. In some of the districts traditional healers and practitioners of traditional medicine are involved in some meetings. Most of the districts also have coordination with NGOs and the major areas are Disaster, HIV/AIDS, RH, WASH, ASRH. Inter-sectoral coordination with the sectors beyond health is limited mainly to DEO, DDC and DAO as well as some activities with agriculture and livestock services. The major activities include immunization, school health, water supply, sanitation, malnutrition, zoonotic diseases. Also these offices have representation in the various committees in the district.

The major constraints for inter-sectoral coordination to be effective is lack of its planning and enforcement. The key areas where inter-sectoral coordination could be important are preventive and promotive health care, waste management, water supply and sanitation, health service utilization, pesticides and human health, agriculture and nutrition, air pollution. In terms of specific diseases, diarrheal diseases, VBDs, nutritional disorders, NCDs, ARI and TB are some of the important areas where inter-sectoral coordination could be important.

The main components in the district health system that needs an immediate attention are number of new posts to be created to fulfill the deficit, provision of area specific incentives and benefit packages. Bottom up approach should be enhanced for effective for effective planning and management. Inter-sectoral effort should be initiated from the central level and implemented in all the levels. Key areas need to be identified which will have significant impact on public health system by promoting inter-sectoral coordination.

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Chapter I – Introduction

1.1 Background

Defining a health system has become more challenging in a globalized world, due to the multiplicity of actors intervening on different scales and the increasing interactions between global health policies and local health systems. Analyzing health systems consist in understanding how health systems are structured and governed. Every country has a unique health system characterized by the role of the government in the health system, the values of the health system, the model of financing and its history [1].

The WHO defines health systems as "all the organizations, institutions, and resources that are devoted to producing health actions". Health sector projects engage with all levels and elements of the health system and frequently encounter constraints that limit their effectiveness. There are four key functions of health system i.e. stewardship, financing, human and physical resources and organization and management of service delivery. District health system can be described as the review of the organization and management of a health system in terms of its structures, managerial processes, priority health activities, community participation and the availability and management of resources [2].

The Health Systems Assessment (HSA) process allows countries to systematically and rapidly assess their national health system and provides policymakers and program managers with information on how to strengthen the health system. The approach provides a comprehensive assessment of key health systems functions, organized around six technical modules: governance, health financing, health service delivery, human resources, medical products management, and health information systems [3].

Inter-sectoral coordination among the different sector in the district that directly or indirectly has a role in strengthening and supporting the health system forms an important component of improved health system. The Alma Ata declaration has already reiterated inter-sectoral coordination as one of its main component in achieving Health for All. Health outcomes in populations are the product of three factors: the size of effect of the

intervention; the reach or penetration of an intervention into a population and the sustainability of the effect.[4] Health outcomes require inter-sectoral collaboration between the health sector and other sectors of government.[5] Inter-sectoral action includes various participants and takes diverse forms. Inter-sectoral action encompasses development of partnerships and action between different sectors e.g., health, justice, education and the development of partnerships at different levels of government or non-governmental organizations.[5]

The factors determining the health behaviors may be seen in various contexts: physical, socio-economic, cultural and political. Therefore, the utilization of a health care system, public or private, formal or non-formal, may depend on socio-demographic factors, social structures, level of education, cultural beliefs and practices, gender discrimination, status of women, economic and political systems, environmental conditions, disease pattern and health care system itself. Policy makers need to understand the drivers of health seeking behavior of the population in an increasingly multiple aspects of health care system.[6] Human resources for health are central to managing and delivering health services, and in most countries account for a high proportion of national budgets assigned to the health sector. Defining precisely human resources for health can help to identify opportunities and constraints and the potential impact of human resources for health on population health.[7]

Financing is a key element of the health system and is an issue of how much money should be invested where to allocate the funds to obtain the best value for money. Efficiency and equity are the two objectives of health financing. Understanding the financing system of health system consists of identifying the various sources of funding of the health system (i.e., taxes, health insurance, user fees, international aid) and where this money is spent (i.e., types of expenses covered (equipment, maintenance, running costs, consumables, medicine, salaries), types of activities covered , and type of facility funded (primary, secondary or tertiary levels)). Understanding how money is allocated by government and which sources of funding are used can be of great interest for organizations on to advocate for better equity in the allocation of resources.[1]

Understanding Health systems have now become the priority focus of researchers and policy makers, who have progressively moved away from a project-centered perspective. The new tendency is to facilitate a convergence between health system developers and disease-specific program managers in terms of both thinking and action, and to resolve both approaches: one focusing on integrated health systems and improving the health status of the population and the other aiming at improving access to health care.[1]

Health action is defined as any set of activities whose primary intent is to improve or maintain health. Within these boundaries, the concept of performance is centered on three fundamental goals: improving health, enhancing responsiveness to the expectations of the population, and assuring fairness of financial contribution. Improving health means both increasing the average health status and reducing health inequalities. The measurement of performance relates goal attainment to the resources available. Variation in performance is a function of the way in which the health system organizes four key functions: stewardship, financing, service provision; and resource generation. By investigating these four functions and how they combine, it is possible not only to understand the proximate determinants of health system performance, but also to contemplate major policy challenges. [8]

Strengthening health systems requires a wide range of skills not only to be able to issues in various areas (e.g., governance, management, finance) but also to be able to collaborate with diverse actors that have different agendas and priorities. Health system strengthening also requires a paradigm shift within international health.[1]

Improvements in public health are determined not only by effective health services and interventions, but also through an approach that includes other sectors and influences broader structural and systematic barriers to health.[9] Most decision-makers and resources in the health sector are understandably focused on illness and disability related issues. The health sector has potentially leading role to play in addressing a much broader range of determinants of health beyond medical determinants. [5] Vicious cycle between poverty and poor health demonstrates the importance of linking the activities of the health sector with those of other sectors such as education, housing, water and sanitation, labor, public works, transportation, agriculture, industry, and economic development.[10]

1.2 Statement of the Problem

Effective interventions exist for many priority health problems in low income countries; prices are falling, and funds are increasing. However, progress towards agreed health goals remains slow. There is increasing consensus that stronger health systems are keys to achieve improved health outcomes in developing countries. Recent evidence suggests that many low-income countries are unlikely to achieve the MDG health targets by 2015. [11]

Policy analysis is an established discipline in the industrialized world, but its application to developing countries has been limited. The health sector in particular appears to have been neglected issue in developing countries.[12] Several authors have stressed the fact that many policy reforms fail because of poor formulation or implementation of health policy. [13]

Nepal is making slow and steady progress in the direction of achieving Millennium Development Goals (MDGs) with increasing sensitivity on equity and inclusiveness among development planners, advocates and practitioners. Health and education indicators are improving for poor and marginalized community though the increment is still below the expectations. [14]

In Nepal about 58% of the Ministry's budget is allocated directly to district program (FY 2009/2010). However, not much progress has been made in decentralizing management of health facilities and involving local bodies in planning health services in districts. (NHSSP, 2010) Maintaining equitable access to quality health services still pose a challenge due to many reasons in Nepal. The coverage of health services has fluctuated over the years with improvement in some programs and stagnation in many.[15]

In Nepal health information systems and surveys are not well coordinated, and therefore their use by managers, policy makers and EDP is unnecessarily limited. Information provided is difficult to evaluate because representative statistics were not always available for indicators of the results framework. (NHSSP, 2010) Without a better understanding of the sources and uses of health care in both the private and public sectors, it is difficult to determine how the government should respond to people's increasing health care needs, and with what resources.[16]

Good health systems should be able to deliver effective and quality health care services to the needy in a cost effective way.[3] Most countries manage to offer the essential health services at all levels of care despite the relatively low level of inputs. However, their level of quality and equity is debatable. The general trend is that provision of the essential health services is more at the higher levels of care prompting concerns for the populations served at lower levels of care. There is also a tendency to have wide variations in the performance of service delivery geographically as well as at the different levels of the health systems.[17] The governance function is mainly under the responsibility of the government. The Ministry of Health has the responsibility of improving the health status of the populations, ensuring equal access to health services for every socio-economic group of society, ensuring that the resources are distributed so that health services can respond the needs to the population and providing general guidance to the actors of the health sector.[1]

1.3 Rationale of the study

The basic goal of any health system is to ensure access to quality care. The new public health agenda will require major changes in the way health authorities; local authorities can improve to manage their group and activities.[18] Policy makers, service providers and the general public have come to appreciate that the health of a population is linked to factors beyond the health care system.[5]

The Government of Nepal has recognized health care as a basic human right, as acknowledged in the Interim Constitution of Nepal 2063 (2007), and has declared that it is the state's responsibility to ensure people's health. This has placed increasing pressure on the government to improve the delivery of health services, quantitatively and qualitatively, down to the grassroots levels.[16] The Three-Year Interim Plan also emphasizes primary health care for poor and excluded groups, aiming to eliminate geographical, economic, gender-based, and cultural barriers to ensure access to health care services for all.[16] In Nepal ministry of health and population had ensured to adopt multi-sectoral approach for both health and non health interventions that promotes access and utilizations of services (NHSSP, 2010).

In Nepal major progress has been made with the introduction of the Free Health Services Programme, as well as other schemes dedicated for specific health conditions and risks such as the Safe Motherhood scheme Aama Programme. The current health system provides only limited support to meet health costs. There is also a need to understand how well public funds target the poor and how benefits are distributed across socio-economic groups.[19] Nepal spends over 5.6 percent of its GDP on health, yet health outcomes change only marginally.[16] In Nepal prevention and public health functions do not cover all fields of public health, in the broadest sense. These broadly defined public health functions, such as emergency plans, environmental protection, water supply and sanitation, and so forth, is not included as health expenditures, but they certainly affect the quality of life. In Nepal new data are needed to assist policymakers and planners in formulating new policies and implement them.[16] Through NHSP IP II (2010-2015), the MoHP has clearly put forward its stand in the importance of inter-sectoral coordination and collaboration and to have a lead role in areas of its comparative advance. Furthermore, it aims to identify and incorporate activities in the Annual Work Plan and Budget and then implement accordingly.

In Nepal government exercises its stewardship function by developing, implementing, and enforcing health policies. With the current health sector policy, Ministry of Health and Population (MoHP) aims to improve health system performance and promote the health of the people. An example of strong government stewardship in health sector can be found in the recent years, where the governments' proactive approach to implement free health care policy and *Aama Surakshya Karyakaram* for reducing targeted burden of diseases and maternal mortality rate.

Along with the routine components of the government in the health system, a proper coordination and collaboration with other actors apart from that of the MoHP certainly plays an important role in the improvement of service delivery as well the overall outcome of the key functions of the health system. In this context, some districts in the country are found to be better in terms of its health indicators and coverage, whereas some are still struggling hard to achieve its better health indicators and coverage.

This study tried to identify and analyze the factors that are responsible to major four key functions of the health systems as well as other contributors such as inter- sector coordination that may have an equally important role in improving the function of health system. Thus it will try to provide relevant information to policy makers, researcher and other workers working in health sector to evaluate and revise policy.

Analyzing these factors this study tried to answer why some districts were performing better than others, and materialize the lessons learnt of district health systems practices to support improving process and linkages of planning and budgeting at different tire within the district. It would further analyze the mismatch of responsibility and authority at local level by exploring the evidence based information within the inter-sectoral context such as education, health & non-health I/NGOs, civil society organization, private and government agencies, etc.

1.4 Objectives

- To describe the major four key functions of the district health systems: (1) stewardship, (2) financing, (3) human & physical resources, and (4) organization & management of service delivery,
- To find out the situation of inter-sectoral coordination and collaboration in the district,
- To identify the potential areas of inter-sectoral coordination towards improvement of health systems, and
- To analyze the mismatch of responsibility and authority at local level with in the concept of inter-sectoral linkages.

Chapter II – Methodology

2.1 Study Type

The design of the study was descriptive study using combined method where majority of data was collected using qualitative methods such as FGD, IDI.

2.2 Study Area

Six districts were purposively selected based on the performance indicators developed by MoHP in terms of health indicators as reported by the MoHP for the year 2066/67. Two categories of the districts were selected from each of three ecological regions. Bajura (Mountain), Kaski (Hill), and Rupandehi (Terai) among better performing districts while Manang (Mountain), Bhaktapur (Hill), and Sarlahi (Terai) districts among the lowest performing districts were decided to be included in the study. In case of Hill district Kathmandu was on the top of the list however was purposively omitted and Kaski was chosen which stood second in the ranking of 2066/67. However, during the implementation of the study the two districts chosen from Mountain could not be accessed due to their geographical location and unavailability of transport facilities on time. Hence, Rasuwa was chosen in place of Bajura and Sindhupalchowk in place of Manang. Within the districts the study was carried out in either DHO or DPHO as well as one selected PHCC

2.3 Study Duration

The study was carried out from June 2012 to November 2012.

2.4 Study Population

The study population comprised of D(P)HO and PHCC personnel of the selected districts. From the D(P)HO the participants were the chief of the D(P)HO, public health administrator, personnel from finance and administrative section. For the FGD the participants were from different organizations within the health sector and non health sectors in the district. In case of PHCC, the PHCC in charge, medical officer, senior level personnel as well as members of the HFOMC were the study participants. The participants were decided on the basis of requirement of such level of personnel to provide the required

information for the study. Hence, the selection of individuals for the interview and discussion was judgmental.

2.5 Data Collection Method

Interview

For the interview in D(P)HO and PHCC semi structured questionnaire was adapted from the guidelines developed by the WHO regional office for Africa for the assessing the operationality of district health systems. The tools were adapted to the country context by considering the local reality in terms of the health system and its components. Some of the questions relating to inter-sectoral coordination which is an area of focus of the study which was not covered by the guidelines were added to the adapted questionnaire. After finalization of the questionnaire it was then pre tested in the DPHO Kathmandu and Bishnudevi PHCC of Kathmandu district for district and HF questionnaire respectively. The modifications wherever required in terms of content, language and coherence of the questions.

A written informed consent from the chief of the D(P)HO incase of district and in charge of the HF in case of PHCC was obtained prior to starting the task of interview after they read and understood the purpose and method of the study. Group interview was then carried out in the district and HF using respective questionnaires. Probing was done in between wherever required.

The annual report of each of the district was used to gather certain information required for the study. Information relating the financial resources was gathered from the finance personnel and similarly, information related to the HR of the district as a whole was gathered from the personnel in the administration.

Focus Group Discussion (FGD)

Guideline for the FGD was developed on the basis of objectives which were basically designed to bring out the issues of inter-sectoral coordination, its situation and importance from the participants of organizations within health as well as non health sectors within

the district. The guidelines were accordingly used in the FGD. The sessions of the FGD was facilitated by one of the investigators and the other investigator functioned as a rapporteur and noted down the issues raised. The discussion was facilitated step by step using the guideline and finally concluded with the key points on which almost all of the participants came into consensus.

2.6 Data Processing and Analysis

The data from the questionnaire was entered in a format developed in MS Excel which was then tabulated as per the major sections of the questionnaire. Following the tabulation of the data the interpretation was written in terms of the major headings. This process was done for the data of district as well as HF. The issues covered in the FGD were transformed to the soft copy including major consensus areas. The data processing, analysis and interpretation was done by the investigator himself.

2.7 Reliability and Validity

To ensure the validity of the participant's responses, the investigator himself was involved in the data collection for both quantitative and qualitative methods. The information gathered in each visit to the D(P)HO or HF was checked on the same day. The points noted down by the rapporteur were rewritten simultaneously after completing the task of FGD. Additional information collected apart from the set questionnaire or detail information within the set questionnaire for the quantitative part was also transformed to another sheet/diary on the same day. Information about the district profile was noted down from the annual reports of the districts taken during the data collection. Expert meetings were held during the proposal finalization and tools development which included senior level representatives from MoHP.

To maximize the reliability of the information, the adapted tools were checked thoroughly to ensure that the questions suit for the local context and that included all the relevant information of the country's district health system. Similarly, the semi structured questionnaire of both district and HF was pretested in D(P)HO Kathmandu and Bishnudevi PHCC, Kirtipur respectively.

2.8 Limitations of the Study

- The study was only carried out in the 6 districts which does not meet the recommendation of WHO for the district health system
- Only one HF and that being PHCC covered to represent the HFs of the district which may not be sufficient enough to give a good picture of the situation of HFs

However, the selection of the districts was based on the ranking developed by the MoHP and two districts each from every ecological belt was taken for the study. The PHCC also to a great extent represents the HFs as the situation in most of the HFs including PHCC and HP is similar.

2.9 Ethical Consideration

Ethical approval was taken from the ERB of NHRC for conducting the study. The study participants were briefed about the study objectives and methods thoroughly prior to conducting the interview and prior to conducting the FGD. Written consent was taken with chief of D(P)HO and HF In charge respectively in case of district and HF. None of the individual details of any of the personnel in district or HF has been used during analysis and report writing.

Chapter III – Findings of the Study

3.1 Background Characteristics

3.1.1 District

The total population of the six districts taken for the study ranged from about 50 thousand (Rasuwa) to above 900 thousand (Rupandehi). In the similar fashion the population of WRA in Rasuwa is 13428 and 242,209 in Rupandehi. Similarly, the under 1 year population ranges between just above 1000 to above 21000 whereas, theunder 5 year population ranges between nearly 6000 to nearly 10500.

The top five diseases for Terai districts are mainly from GI Disorders which is in descending order, PUO, Intestinal Worms, Boils, Headache, Gastritis for Sarlahi. On the other hand, in the hill districts it is predominantly respiratory infection. For Kaski it is URTI, LRTI and Gastritis among top 3 out of top 5 diseases whereas for Bhaktapur district it is LRTI, APD, Falls/Injuries in the top three. The chiefs of D(P)HO believe that the scenario could be little different in the community as their view in response to the query of top five diseases in the district apart from those reported in HMIS. The personnel from Sarlahi believe that Vector Borne Diseases such as Kalazar and NCDs such as Renal Disease and Cardiac Disorders could be major conditions that might not have been reported in the HMIS. In case of Rupandehi, the DPHO believes that Skin Diseases could be high in the district. On the other hand, it could be STI and Nutrition related disorders in Kaski district and NCDs in case of Bhaktapur district. The personnel of Rasuwa DHO believe that the district could have high burden of Diarrheal disease, worm infestation, alcoholic disorders apart from those in the top list as per the HMIS. In Sidhupalchowk, HIV/AIDS could be the major disease that is being missed out in the report.

3.1.2 HF (PHCs)

The catchment population of the 6 PHCs (Lalbandi, Sarlahi; Basantapur, Rupandehi; Sishuwa, Kaski; Changunarayan, Bhaktapur; Jibjibe, Rasuwa and Melamchi, Sindhupalchowk) ranges between 13000 to nearly 60000. The population of WRA also seem to be in the similar proportion the lowest being 3349 (Jibjibe) and the highest being

14307 (Sishuwa). The under 1 year population ranges from 300 to just above 1500 and the range of under 5 year population is 1780 to 5553.

Major means of transportation in the Terai districts are Motorcycle, Bicycle, Public Bus and Cart. For the hill district it is mainly Public Buses and Walking. On the other hand, for the mountain district it is mainly walking especially in terms of Jibjibe, whereas, Melamchi even being in the mountain district the people there have access of public buses and people also use Motorcycle to reach to the HF. There are 4 villages in the catchment area of Lalbandi that are inaccessible for about 3 months in monsoon due to flood. Similarly, Basantpur village og Basnatapur PHC is also inaccessible for ORC service during the same period with the same reason. On the other side, Malepatan of Sishuwa PHC is very hard to access and is quite far for ORC service as there is no possibility of having any vehicle (Public or Private). Similarly, Thaibung and Kalikasthan of Jibjibe catchment area is inaccessible during monsoon for abour 3 months due to landslide and very slippery way for providing ORC services. The other 2 PHCs Melamchi and Sishuwa do not have any areas that are inaccessible for more than a week in a year for providing ORC service.

Top Five Diseases as per HMIS and HF Personnel

Skin diseases, gastritis, ARI, Diarrhea and PID are top 5 diseases for Lalbandi whereas LRTI, Boils, Headach, Dermatitis and Scabies are among the top 5 for Basantapur. For the PHCs in hill districts it is mainly respiratory infection as is the case with the overall district. URTI, Gastritis, Injuries/Falls, viral influenza, diarrhea are among top 5 according to HMIS for Sishuwa and it is URTI, APD, LRTI, Falls/Injuries, skin diseases in the top 5 for Changunarayan. In case of mountain district, ARI, typhoid, Acute Gastro enteritis, viral fever and APD takethe top slot in descending order for Jibjibe as per HMIS.

The personnel of Lalbandi feel that Pneumonia, PID, Enteric Fever, Skin Diseases could have the high burden in the district as these cases might not have been reached the HF to be included in the HMIS. HIV/AIDS is the condition that might have high burden in Sishuwa whereas in case of Changunarayan there could be a high number of NCDs such as HTN, DM and not being included in the HMIS to the extent it should have been. The personnel of

Jibjibe also have the similar opinion as NCDs such as HTN, bronchial asthma could have a high burden in the community.

3.2 Management Structures

3.2.1 District

The overall management of D(P)HO and the HFs within the districts are being managed by the chief of D(P)HO with the support of personnel in the district. There does not seem to be any special structure in any of the districts such as District Health Management Team (DHMT) or District Health Committee (DHC) to take care of the issues of managing the D(P)HO and HFs.

All the districts except Rupandehi have Citizen Charter in the district office to display its activities and related information of accomplishing that. And the charter was found to be placed in the area visible by the people. The frequency of staff meeting in all the districts is once a month. However, in case of Sindhupalchowk it was found that the staffs dint want to attend the meeting. And sometimes it goes up to 6 months without any staff meeting. This could probably be due to the unwillingness of staffs for change in their routine way of working in the office as per the chief of DHO.

3.2.2 HF (PHCs)

HFOMC and its functioning

All the 6 PHCs selected for the study had HFOMC in them. The HFs had guidelines for HFOMC members on their roles and responsibility except the HFs of mountain districts. The number of members range from 9 to 13 and the members of HFOMC of all the HFs were oriented except for that of Melamchi PHC. The members understand their roles and responsibilities; most of them in majority of the HFs and some in the remaining HFs. Marginalized, Women and Dalit in the HFOMC participate in the meetings in all HFs and also take an active part in the decision making process in all the HFOMCs. The HFOMC meet once every 2 months in Melamchi, once a month in Lalbandi and Jibjibe whereas once every 3 months in the remaining 3 PHCs. In case of Jibjibe PHC even though the meeting is

scheduled to be once in a month, the last meeting was 6 months ago. This is because there is no one as an in charge of HF, no Medical Officer is currently on position. The vice chairman of HFOMC says *"we do not have a doctor for more than 6 months and the senior most staff is retired and the HF is managed by senior AHW who has been hired in contract".*

The number of meeting ranged from 3 to 12 in the last 12 months. The meeting minutes are used as a recording tool for the issues dealt or discussed by HFOMC and the minute of last meeting was available for viewing at the time of interview. The minute of last meeting had reference to the points agreed upon in the previous meeting.

Main Actions taken by HFOMC in the last year

In Lalbandi, the HFOMC organized a free cancer examination campaign, managed for FCHV dress and allowance, made provision for 24 hrs emergency services among some of the major tasks in the last year. The HFOMCs of Sishuwa, Changunarayan, Jibjibe took initiation for Building construction and it is under construction now. Apart from that HFOMC at Jibjibe also constructed small buildings which are being used for non local staff accommodation. Melamchi PHC on the other hand, organized health camps and took some staffs in contractual service in the past year.

Functions of HFOMC & D(P)HO as per HF personnel

The personnel of almost all the HFs believe that the HFOMCs should play a supervisory role and thus supervise and monitor the activities of PHCs. They also should support the functioning of PHC in day to day basis. The Medical officer of Sishuwa PHC believe that they should act as bridge between HF and community people and should aware people about HF and thus contribute in the utilization of HF by people. Similar opinion is that of Changunarayan personnel. The staffs of PHC feel that the HFOMC members should try for the bottom up approach for managing the issues of PHC. Melamchi as well as other PHCs believe that the HFOMC also should take lead role in infrastructure development.

On the other hand, regarding the functions of D(P)HO the HF personnel believes that they should strengthen the supply system and maintain good coordination with HFs. The DPHO should take lead role in the financial; HR and other management issues as well as

monitoring the HFs say the personnel of Basantapur PHC in Rupandehi. The D(P)HO should not only look for the infrastructure development but also ensure the facilities over there and ensure the consistent availability of HR in the HFs as per the personnel of Chagunarayan PHC. The D(P)HO should ensure equitable distribution of resources to the HFs says the medical officer of Sishuwa. The staffs of Jibjibe and Melamchi believe that HR retention and support in technical issues is the role of D(P)HO. They should ensure the enabling environment for HR retention in the HFs.

All the HFs except Basantapur PHC has citizen charter and is placed in well visible are. In case of Basantapur, the citizen charter is ready to be delivered by the district. All of the HFs have updated the charter with the latest inclusion of services in the HF such as AAMA program, Free Health Care Services etc.

Three PHCs namely Basantapur, Changunarayan and Jibjibe are found to be disclosing their statement of expenditure to the public. Social audit is found to be done in PHCs except Sishuwa and Melamchi and all of them who had social auditing of their HF disseminated the findings. The in charge of HF discussed the plan and policy with the staffs in some of the PHCs. The major reason for one of the PHC (Jibjibe) for not discussing the plan being in charge not present and the senior staff retired.

The staff meeting in most of the HFs happened once a month. In case of Lalbandi and Changunarayan it happens twice a month and once every 3 months respectively. In case of Jibjibe though the provision is to have meeting once a month but has not happened since last 9 months.

3.3 Health and Health Related Resources Management

3.3.1 Financial Management

3.3.1.1 District

The financial management issues of the district offices mainly happen in a predetermined pattern that is decided and directed from the central level. With regards to the release of budget, none of the finance head and chief of D(P)HO are found to be satisfied. None of the districts received budget on time. The major reason for the delay and felt by every district was the delay in the release order of budget from the central level which mainly applied for the portion of budget that comes from the donors. Some district such as Kaski has to say that the annual program is delayed so the budget gets delayed. The account officer of Bhaktapur believes that the administrative process is too long. It has to be looked for some solution for the smooth functioning of the district.

Regarding the other issues related to budget management within the district, it was found that all of the chiefs of district share the budget with the focal persons. The district has as such no role in allocating the budget to different activities which indeed comes in a preset allocation to different headings. The level of authority of the district in various financial processes varied in some of the headings for 6 districts.

Authority on paying the staff salaries is not applicable, they just act as facilitator. Sarlahi, Bhaktapur and Sindhupalchowk have partial authority in purchasing drugs whereas the account officer of other 3 districts mentioned that they have full authority on purchasing drugs. All the districts have full authority in purchasing supplies such as linen, cleaning materials, stationery etc, repairing equipments and maintaining buildings as well as vehicles. However, Bhaktapur, Rasuwa and Sindhupalchowk district offices mentioned that they only have partial authorities in purchasing equipment.

Accounting Procedures

All of the district offices use accounting procedures, financial reports, periodic auditing visits both internal and external.

Some of the public HFs of districts except Bhaktapur and Rasuwa are found to be charging fees for some of their services. The services that are charged mainly are laboratory services, diagnostics such as X-Ray, Medical Abortion etc.

3.3.1.2 HF (PHCs)

All the PHCs except Changunarayan PHC at Bhaktapur had some level of income at HF level. The income ranged from 700 per month (Jibjibe) to 30000 per month (Melamchi). Lalbandi and Basntapur has 18000 and 11000 per month respectively as the HF level income. The sources of income were almost similar for all the HFs mainly being Emergency and Lab services.

Level of Authority

Most of the HFs has partial authority with regards to purchasing drugs. Basantapur and Jibjibe PHC mentioned that they have full authority to purchase drugs. Almost all (except Sishuwa) PHC have full authority to purchase supplies such as linen, cleaning materials, stationery. Purchasing equipment, maintaining buildings, repairing equipments are within full authority for most of them. Lalbandi, Sishuwa and Changunarayan have partial authority for purchasing equipments. Changunarayan and Melamchi have partial authority even for repairing equipments whereas Sishuwa and Changunarayan have partial authority for maintaining buildings as well. In contrast, Basantapur PHC was even found that they have full authority for utilizing money for tiffin, allowances for lab, nurses etc.

Services being charged

The services being charged in the HFs include OPD, Emergency services and Laboratory for Sarlahi, Lalbandi whereas other HFs which take fees for services charge for Laboratory and other diagnostic services including X Ray as well as Medical Abortion. The charge for OPD service in Lalbandi was done as per the decision of HFOMC and that is being used for certain allowances and incentives for staffs who are working extra time. There is provision for exemption of services in all the HFs and the mechanism is identifying the ultra poor and destitute and the decision is taken by HF In charge. The other groups who are exempted from the charges include elderly above 60 years, FCHVs, disabled and marginalized people.

3.3.2 Human Resources Management

3.3.2.1 District

HR and Facilities for HR

All the districts have overview of HR of the HFs in the district with them. Various issues of HR such as job descriptions, housing and incentives were tried to be explored whether that exists in the district. It shows that all of the district offices have job descriptions for all members except Bhaktapur D(P)HO. Almost none of the districts have rotation system and training plan for the staffs. Rotation system for some of the staffs and training plan for all the staffs exist in Rupandehi district. The training plan also exists for some of them in Kaski district. Rasuwa has housing for all the staffs and Rupandehi and Sindhupalchowk have housing facilities for some of the staffs. Similarly, Rupandehi, Kaski and Sindhupalchowk have provision of Incentives for some of the staffs. Remaining other districts; Sarlahi and Bhaktapur neither have housing for staffs nor the provision of incentives for any of the staffs.

HR Retention

In an overall picture of HR in the districts, it was found that none of the chief's are satisfied with the allotted posts for the HFs. One of the probable reasons for the deficient number of staffs is no new recruitment by the government. Other reasons are low incentives for working in mountain districts and lack of enough facilities. The living cost is quite high and the planning on these issues is done from the central level and nobody working in this area represent in such planning. Rupandehi district on the other hand do not seem to be having any deficiency in the number of staffs. The chief mentions *"It is very hard to convince them to go to the remote areas of the district. Otherwise the number appears to be enough"*

Similarly, the chief of DHO Rasuwa believes *"Bottom up approach is required for ensuring enough retention of staffs which is not happening".* One another problem as mentioned by him is regarding the policy of medical officer placement. Medical Officers who have graduated by using Ministry of Education scholarship are placed in different facilities but

they somehow complete their 2 years term of mandatory service at times by taking long leaves of around 3 to 4 months.

On the ways to improve retention of HR it is deemed necessary that housing is provided for all the non local staffs and simultaneously produce local staffs or train local staffs as mentioned by the chief of D(P)HO Sarlahi. Provision of local contract of staffs especially for the lower level staffs would be important; more salary for contractual staffs and incentives in any form would also help. The chief of Bhaktapur D(P)HO believes the mechanism of giving *PADNAAM* to different posts has been creating problems, there should be clear distinction on different levels. The chief of DHO Rasuwa believes there should be special package for certain districts which are deprived of basic facilities. There should be equitable distribution and differences among different districts regarding the facilities. Even there should be distinction between districts of Himalayan region. Not all the mountain districts are similar in geography for example.

Time given by District (Public) Health Officer in almost all the districts was quite high except for that of Bhaktapur district. The officers hardly go out of the district and even very rarely to the center. While in the district however, majority of them seem to be out of office in most working days for about 50 % and even up to 75 % of time. This happens usually for the meetings in other district level organizations. In contrast the scenario is quite different with 2 mountain districts as they spend 99 to 100 % time in the office in working days. Sometimes they work on holidays as well.

Human Resource Status at different levels

District (Public) Health Office

The DPHO at Sarlahi has almost all posts filled except few such as 1 post is vacant for HA out of 2, 1 post is vacant of Malaria Inspector out of 2 and then 1 post vacant of Office Helper out of 3. In contrast to Sarlahi Rupandehi DPHO does not have any posts vacant, rather there are few posts where extra staffs (Phasil) are working? There are 2 HA, 1 health education technician and 1 cold chain assistant as *Phasil, w*hereas all other posts are filled. Similarly, Kaski also has 1 vector control supervisor *phasil* and all other posts filled as per

the norms. The scenario is similar with Bhaktapur district as well. There are quite a lot of posts with extra staffs such as 1 FP assistant out of 1 post sanctioned 1 leprosy assistant with only 1 post sanctioned. Similarly, 1 vector control assistant and 1 health education technician are *Phasil* for which no posts are sanctioned. On the other hand DHO Rasuwa neither has any posts vacant nor has any extra staffs in any of the posts sanctioned. The scenario is similar with Sindhupalchowk DHO. It just has 1 post *Phasil* that is a post of health education technician.

District Hospital

Out of the 6 districts selected for the study, only four of them had district hospitals as Rupandehi and Kaski did not have it. Out of those 4 districts with district hospitals, the HR data of Bhaktapur could not be achieved and the two mountain districts had hospitals within the DHO and not as a separate entity. However, the staffing structure is separate for hospitals and public health sector. Sarlahi had a separate district hospital.

Sarlahi DH has so many posts vacant starting from the Medical Officer (MO), the 4 posts sanctioned for MO is filled with 3 contractual service MOs and it doesn't have any permanent MOs in the post. Similarly the only one post each sanctioned of HA and Nayab Subba is also vacant. All the posts of Staff Nurse (4) are vacant and 1 post out of 3 of Office Helper is vacant. The situation with Sindhupalchowk is almost similar. None of the posts of MO (2) are filled and same is the case with HA (1), Medical Record Officer (1), Lab technician (1), computer assistant (1), nayab subba (1). Three posts of office helper/peon are vacant out of 11 posts sanctioned. In contrary, Rasuwa DH has all the posts filled as per the sanctioned posts except MOs. There is only one MO out of the 4 posts sanctioned.

PHCs/HPs/SHPs

In terms of HR of the HF Sarlahi seems to be the one with most deficient number of staffs in the PHC. Out of the 5 posts of MOs (one each in the 5 PHCs in district) there is only one post filled. Same is the case with Staff Nurse (SN). One post is vacant for lab assistant out of 5 sanctioned one each in every PHC. The posts of HAs are filled though. The other terai

district Rupandehi as such does not have any staff deficient in case of PHCs. Rather there are few posts with extra staffs. One HA and one office helper is *Phasil.*

All the posts including MO, SN, HA are filled in Kaski district PHCs as per the sanctioned posts. Bhaktapur on the other hand has few staffs extra in the categories ANM and AHW which is because of upgrading of the MCHWs and VHWs respectively.

The mountain district especially Rasuwa has major lacking in terms of staffs in PHCs. The major posts in the only PHC of Rasuwa that of MO (1), HA (1), AHW (2) are vacant. The PHC is being managed by a Sr AHW who is serving in the contractual service. The case with PHCs in Sindhupalchowk is slightly different. The vacant posts of MOs are filled with MOs hired in contractual services. 1 post of HA out of 3 in 3 PHCs is vacant. Similarly, 2 ANMs out of 6 sanctioned and 3 AHWs out of 6 sanctioned are vacant.

HPs

In Sarlahi, 6 posts of HA out of 16 sanctioned are vacant. The situation in Rupandehi is also not better. Only 7 posts are filled out of 19 sanctioned for HA, 48 posts filled for AHW out of 57 sanctioned and 31 posts filled out of 38 sanctioned. On the other hand, there are 4 Kharidar's placed in different HPs (*Phasil).*

The case with Kaski seems to be better in terms of posts filled, all 11 posts sanctioned each of HA, AHW, ANM are filled. Bhaktapur on the other hand, has 4 out of 11 posts of HA vacant, whereas there are 3 AHWs, 1 ANM and 4 peons extra.

In case of mountain districts, Rasuwa has 3 posts of HA out of 8, 4 posts of AHW out of 8, 7 posts of ANM out of 8 vacant. Similarly, 6 posts of VHW out of 8 are vacant. Sindhupalchowk similarly has severe lacking of the top most post of HP that is HA. It only has 2 posts of HA filled out of 10. It also has 2 posts vacant of ANM out of 10 and 7 posts of VHW vacant out of 10.

SHPs

In case of SHPs the case is disastrous with all the 27 posts of ANM and 18 posts of AHW being vacant in Sarlahi district. There are 10 vacant posts of AHW out of 90 and 1 vacant

post of ANM out of 45 in Rupandehi. All the 35 office helpers being posted in different SHPs are *Phasil.* Kaski has no staffs deficient in SHPs. Bhaktapur has 1 post vacant for AHW and 8 office helpers *Phasil* with no posts sanctioned. Similarly, there are 4 vacant posts of AHW vacant out of 9 and 5 vacant posts of ANM out of 9. The situation with SHPs of Sindhupalchowk is worse as there are only 24 AHWs, 30 ANMs and 63 MCHWs out of 65 sanctioned for each post.

3.3.2.2 PHC

The HR status of the PHCs selected for the study (1 each from the 6 districts) shows a few deficiencies in number of staffs even in the sanctioned posts. Lalbandi PHC at Sarlahi does not has the single post of Staff nurse filled. The case with MO is worse in the sense that the post seems filled in the paper but no MO does duty in the PHC and he just receives salary from the district. All other posts seem to be filled except the post of VHW out of 1 and one office helper out of 2. The sanctioned posts are too less as per the number of patients they are seeing everyday in the OPD. This number is sometimes more than that of the district hospital in single day.

In case of Basantapur PHC at Rupandehi all the sanctioned posts are filled except the post of staff nurse. One sweeper has been hired by HFOMC for whom there is no sanctioned post in the HF.

The situation in both the Hill districts taken for the study seems to be good in terms of number of posts filled. All the posts sanctioned for Sishuwa PHC in Kaski are filled. However, the HF personnel and HFOMC members believe that the approved number is not enough. Same is the case with Changunarayan PHC in Bhaktapur, all the posts are filled as per the sanctioned posts

The case with Melamchi PHC, Sindhupalchowk is also quite similar with that of Hill districts as most of the posts are filled accept HA and lab assistant. However, it is worse with the Jibjibe PHC in Rasuwa. Both the posts of HA and MO are vacant. The HF is being managed by AHW and that too they are in the contractual service.

HR Management in PHCs

Three of the selected PHCs are found to have job descriptions for the staffs whereas Lalbandi, Basnatapur and Jibjibe do not have the job descriptions. The PHCs in the mountain district have housing for some of the staffs and PHCs except Sishuwa and Jibjibe have the provision of incentives for some of the staffs. The HF personnel of Jibjibe and Melamchi are found to be satisfied with the services for them whereas staffs from hill and terai PHCs are found to be dissatisfied to very dissatisfied regarding the services to them.

HFOMC has recruited staffs in the PHCs except Sishuwa and Jibjibe mainly helper, peon, sweeper. HFOMC at Melamchi however has hired CMA and Lab assistant as well both of them one each in number. Apart from the regular staffs most of the PHCs generally have some students providing health services as they are there for On the Job Training. This was not found in Changunarayan and Jibjibe.

All the PHCs open for health service from 10 to 2 PM and all are open 24 hours for emergency services except Sishuwa. Melamchi has MOs available even for 24 hours emergency whereas rest of them has CMA and ANMs.

3.3.3 Infrastructure, Equipment and Supplies

3.3.3.1 District

Sindhupalchowk appears to have the existing space enough for the functioning of DHO whereas all the other districts have the space inadequate and that is mainly for store. Apart from the extra space required for store, Rasuwa need additional space for the management team's office, Rupandehi for warehouse and cold room, and Sarlahi for training purpose.

Physical conditions such as lighting, sanitation, watery supply, ventilation, cleanliness and refrigeration of vaccines seem to be fully adequate in all the district hospitals wherever applicable (4 out of 6 districts) and in all the PHCs of 6 districts. The conditions in the HPs also are similar in Sarlahi and Rupandehi except refrigeration of vaccines which is not available in HPs of these two districts. All the HPs in all districts have adequate lighting and some of the HPs have adequate sanitation, water, ventilation, cleanliness. None of the HPs

have refrigeration of vaccines except Bhaktapur where all the HPs have it. On the other hand all the SHPs in Sarlahi district have adequate physical conditions such as Lighting, Sanitation, Water, Ventilation whereas some of the SHPs do not have adequate cleanliness. In case of other districts as well it is mixed findings some of the SHPs have adequate conditions and some do not have.

The proportion of HFs with telephone facilities range between 20% and 66%. However, HFs in Rasuwa do not have telephone facilities whereas on the other hand all the HF personnel use mobile phones in cent percent of the HFs. But there is no mechanism of reimbursement of the cost of mobile phone except for some of them in Rupandehi district.

All the districts have adequate transportation for supervision and provision of supplies and none of them have it for outreach services whereas only Rasuwa has Ambulance of its own for the transfer of emergency cases. Resources seem to be adequate for maintaining their transportation. Bhaktapur in fact has one vehicle for supervision and provision of supplies but the vehicle is not suitable for the said purpose as it is a small vehicle which can carry very less medicine and other supplies.

3.3.3.2 PHC

Infrastructure

The building of all the PHCs is state owned and none except Melamchi PHC does have enough space. However, Lalbandi and Basantapur are planning to construct new buildings whereas three other PHCs already have buildings under construction. All the PHCs have provision of night beds except Sishuwa PHC and the number of beds approved is 3 for all the PHCs. Lalbandi and Jibjibe have 3 beds functioning and Basantapur and Changunarayan have 2 beds each whereas Melamchi has 6 beds functioning.

Electricity is continuous available in Jibjibe and Melamchi PHCs only and they also have back up source of energy as Generator. The other 4 PHCs which don't have continuous availability of electricity and two of them do not have any back up. Two other PHCs Basantapur and Changunarayan has battery/UPS and solar as a backup respectively. There

is no provision of heater for the winter season in any of the HFs. Changunarayan, Jibjibe and Melamchi have accommodations for some of the staffs and it is located within the HF.

WASH

The most common source of water is piped water supply within HF for all VDCs except Lalbandi and Basantapur where it is Tubewell/Boring. All the PHCs except Sishuwa have hand wash basins for staffs. Lalbandi, Changunarayan and Melamchi have separate toilet for staff and patients. Basantapur, Sishuwa and Changunarayan do not have enough waiting space for patients.

Equipments and Supplies

Telephone facility is available in all the PHCs except Jibjibe and the telephone is available for out of office hours. Changunarayan has Ambulance for emergency cases. None of the HFs have vehicle for outreach services which seems to be an important necessity. Refrigerator is available in all the PHCs but 24 hrs power supply is guaranteed only in Basantapur, Jibjibe and Melamchi.

Store management procedures are all followed in every PHC and they have the standard list of equipments for the HF. The store is managed by AHW/ANM. PHCs except Lalbandi and Basantapur have medical waste management guidelines and also have enough resources to maintain that and all 4 of them use Incinerator. Changunarayan also has placenta pit. The 2 PHCs of terai districts manage the waste in temporary pit and burning.

Lalbandi, Basantapur and Sishuwa PHCs are dissatisfied to very dissatisfy with the availability of resources such as basic equipment, stationery, linen and cleaning materials. Changunarayan PHC is satisfied for all these resources. Jibjibe and Melamchi are satisfied for some of the resources only.

HFOMC Lalbandi

The Chairman of HFOMC at Lalbandi PHC says

"Service to the people by the current staffs is satisfactory. But the problem is of the doctor. Irregular staff meetings; there should be staff meeting every month to solve the problem what the staff has. Concrete area where this HF can do a lot and is necessary to act is Snakebite. There is no enough provision for snakebite treatment. A lot of people die because of unavailability of human resource to deal with those cases and unavailabity of treatment. Another pertinent area is RTA. No provision of Post mortem at HF level. Human resource and provision of the facility is most.

No availability of diagnostic facilities. X ray is not available and no HR for it. Dog bite treatment is also not there. The major lacking is VHW and doctor. For the delivery facility provision of O2 is not in place hence in case of such situation patients have to be sent away. Number of patients visiting the OPD is often more than the district hospitals. People from other district (Sindhuli – southern part) all visit this HF.

The number of peons (office helpers) is a serious problem. Provision of free health services but there is not enough human resource to provide the services. It is better to leave the HFOMC to decide and provide services on their discretion taking minimal charges. There is cooperation from every political system."

3.4. Managerial Process

3.4.1 District

Planning

All the districts have annual district health plan however, in districts Bhaktapur, Rasuwa and Sindhupalchowk it does not get implemented

Generally, DDC, staff of HFs are involved in the planning by all districts however only some of them involve representatives from non public HFs, representatives of community organizations, NGOs and donors (EDPs). The central and regional level plays initiation, facilitation and advisory role in the development of plan. On the other hand none of the HFs has annual health plans.

All the D(P)HO has district health maps with them which contains location of public HFs. Rupandehi and Sindhupalchowk have also included location of non public HFs in the map.

Drug Management and HMIS

All the districts have list of essential drugs of HFs in the district. Some of the HFs receive drugs occasionally from some other sources such as DDC. Some of the HFs purchase drugs on their own and the budget for that is usually from HFOMC.

All the HFs in the past year has submitted HMIS reports and the HMIS data is analyzed in the district except in Sindhupalchowk. The data is used to monitor the disease trends by developing graphs, charts, diagrams and tables. Feedback on the basis of analysis is given to the HFs by all districts except Sindhupalchowk. The HMIS reports are verified by a special team of the district on certain scheduled time by visiting the HFs and using tally sheets to match the record in the register.

Community Involvement

There are youth and mother's groups in all the districts except Rasuwa involved in some or the other health and health related issues. The major activities and the most common ones that these groups are involved in are health awareness, health camps for all the districts. In Rupandehi they are also involved in income generating projects, water supply projects and sanitation. In Sindhupalchowk these groups are also involved in FP service, immunization, safe motherhood.

Community has not contributed to any of the HFs in Sarlahi in terms of HR, Finance and materials and buildings. In the case of other districts community are found contributing financial resources and materials/buildings to some HFs.

Community people can provide feedback to the district through community representatives in meetings. Suggestion box are kept in Kaski and Rasuwa.

3.4.2 PHC

Guidelines, Standards and Norms

All of the PHCs have guidelines required for Immunization, management of child with diarrhea, management of child with fever, referral of obstetrical emergencies. The last one is not available in only one PHC that is Changunarayan.

Supervision is carried out by the district regularly in most of the districts. The number of supervisory visits by the D(P)HO in the last 6 months is 1 to 3 for Basantapur, Sishuwa, Jibjibe and Melamchi whereas it is 6 for Lalbandi and 12 for Changunarayan.

All the HFs have list of essential drugs of PHC. Some of the drugs for the top 5 diseases as per the HMIS that were not available in the last 3 months are ORS, Zinc and Cotrim for Lalbandi. Sishuwa, Changunarayan and Jibjibe did not have this kind of problem. Basantapur had scarcity of antifungal, steroid ointment. Similarly, Melamchi PHC had scarcity of Cotrim, CPM and Iron tablets. The pertinent reasons for this could be lack of need based supply mechanism. Meanwhile, tablets are not accepted by parents for children, and provision of syrup/suspension does not exist.

There are private pharmacies in the catchment areas of Lalbandi, Sishuwa, Changunarayan, Melamchi and Jibjibe. There are no places where people can buy drugs in the catchment area of Basantapur. In Jibjibe and Melamchi there is a private pharmacy just next to the compound of HF.

Referral Mechanism

Referral notes are used when patients are referred from lower to higher level in HFs except Lalbandi and Sishuwa. They do not give feedback reports back to lower level and they also do not receive any when they receive patients back to them. There is no provision of ambulance except in Changunarayan. Other mechanisms such as communication system and payment exemption also do not exist in any of the HFs.

HMIS and Reporting

All of the HFs has submitted HMIS reports in the past 12 months. They did not have any shortage of forms but Melamchi and Jibjibe PHCs they have some problems related to HMIS reporting such as report preparation, lack of HR, lack of proper orientation and training. All of the HFs keeps a copy of reports with them and analysis also is done by the HF staffs except for that of Jibjibe and Melamchi. PHCs such as Lalbandi, Basantapur and Sishuwa even use that analysis in terms of planning new activities and any changes required in the area of focus and service provision. They also receive feedback on reports from district except Changunarayan and Melamchi.

The process of verification of HMIS data is by tallying the data with the record registers in HFs by the team from district.

Community Involvement

Top diseases in the community according to Community representatives

The top diseases that the community representatives (members of HFOMC) feel that they have in their community varies slightly with the different PHCs. The community representatives of Basanatapur, Sishuwa and Changunarayan PHCs believe that the major diseases in their community are TB, Typhoid, Pneumonia, diarrheal diseases and other

respiratory problems. In case of Lalbandi and Melamchi it is NCDs namely, HTN, DM, Arthritis. Representatives in Lalbandi PHC also believe that they have significant problem of TB, Kalazar and Malaria. In case of Jibjibe it appears to be slightly different, the major diseases in the community are uterine prolapsed, hydrocele/hernia, bronchial asthma, pneumonia.

Community Groups and their contribution

In Lalbandi and Sishuwa it is only Mother's group that are involved in health issues whereas in Changunarayan, Jibjibe and Melamchi there are Youth groups as well who are involved in health issues. Basantapur PHC in its catchment area has other groups and committees such as women's savings committee, social mobility committee. Major activities of these groups are health education, awareness, support in immunization activities, DOTS, health camps. Some PHCs such as Basantapur, Jibjibe also have other activities such as income generating projects, water supply and sanitation projects and care for environment. Melamchi PHC on the other hand has groups involved in alcohol prevention, gender issues and domestic violence.

Some groups in the areas of Lalbandi, Basantapur and Melamchi have received some fund support from government and occasionally from community members.

The community members can provide feedback through representatives in the meetings, in person in most of the PHCs. The community members of Lalbandi PHC feel that if the PHC could be upgraded to a hospital it could do a lot for the community in response to where HF staffs could do more than they are currently doing. Similarly, members from Basantapur feel that number of beds could be increased, maternity services could be provided more effectively than present.

3.5 Priority Health Activities of PHCs

3.5.1 Health Information and Education

All the PHCs provide this to certain extent. Basantapur PHC personnel mentions that it would be better that if we could have IEC materials in local language. Medical officer at Sishuwa PHC feels that it would be better if we have a clear direction from district.

3.5.2 Basic Immunizations

Immunizations services including immunization days are being undertaken by every PHCs and they feel that is should be undertaken at this level. However, some constraints are VHWs are less in number or almost not available in some PHCs and there are no new posts created. Existing VHWs are also given *PADNAAAM* as AHW so this has been a hindering factor.

3.5.3 Reproductive Health

RH services including FP services, ANC, PNC are provided by all the PHCs. PHCs except Sishuwa and Changunarayan also provide assisted delivery service. HF personnel at Lalbandi and Basantapur feel that space is less and maintaining privacy is difficult for us for these kinds of services. Furthermore, ASRH services are provided by Changunarayan, Melamchi and Jibjibe PHCs and Basantapur PHC personnel feel that eventhough it is not provided now, these are the services that have to be undertaken at this level. Personnel from other PHCs who are providing the service somehow also feel that this can be delivered more effectively in a better way.

3.5.4 Disease Prevention and Control

The diseases prevention and control activities for major diseases of importance for the area have been undertaken by almost all PHCs wherever applicable. Prevention and control activities for diseases such as TB, Leprosy, and Diarrheal Diseases are being undertaken by all the PHCs. PHC except Changunarayan and Jibjibe also have effective prevention and control activities of Malaria. Melamchi PHC of Sindhupalchowk being a mountain district also undertake this activity as the catchment area lies in the lowland and is at potentially

risk of this disease. In case of communicable diseases such as HIV/AIDS and STIs some of the PHCs provide some services but not completely and the personnel believe that this should be undertaken and a lot can be done beyond just counseling.

On the other hand the situation with NCDs (mainly DM, HTN, Mental disorders, Malnutrition) is also somewhat similar, partial activities happen for these diseases in all the PHCs but can be done more with emphasis on prevention and control. More activities should come from the top including training and other support. Vector borne diseases such Kalazar, Dengue and JE also are being focused in the areas wherever applicable (Terai districts). Astonishingly there are no prevention and control activities are not in place for dengue and JE in both the Terai districts' PHCs and they believe it should be done. Prevention and control activities on Rabies and Snakebite do not exist except Basantapur PHC where it exists for Rabies. The major reason seems to be it is not being implemented and there is no support for this area.

3.5.5 Treatment of Specific Diseases

Treatment of Malaria is provided by all the PHCs except Jibjibe and Changunarayan PHCs. TB treatment on the other hand is provided by all the PHCs and treatment for STIs is provided only by Basnatapur, Changunarayan and Jibjibe. Mental disorders only by Changunarayan PHC. The major concern is about the major NCDs namely HTN and DM for which treatment even if provided by the HFs is very limited. None of the PHCs have medicines for DM and they only have one drug for HTN in every PHCs which is not enough to treat HTN. None of the PHCs have any treatment/management facility for disability (blindness, deafness and physical disabilities).

3.5.6 Other services

School health program and outreach services are being undertaken by all the PHCs. Some of the PHCs mention that it is quite difficult to provide ORCs without any infrastructures and vehicles. Some PHCs such as Basantapur, Changunarayan and Melamchi have anti tobacco activities to certain extent. Changunarayan PHC does it as they have the Practical Approach to Lung health (PAL) implemented there and they also do some activities related

to prevention of alcohol and substance abuse whereas none of the other PHCs have this activity. Eye and ear care is provided by Changunarayan and Jibjibe PHC as they (some of the staffs) have undertaken training. Oral health service is provided by Basantapur and Changunarayan PHCs. This is because they have had trainings for this but unfortunately they do not have logistics required for that. Other activities such as community rehabilitation, home care for HIV and other conditions are not in the activity of any of the PHCs.

3.5.7 Strategies

IMCI and DOTS are implemented in all the PHCs and Lalbandi PHC has more number of patients and is having difficulty to manage with current number of staffs in the HF. CBNCP is implemented only in Changunarayan PHC. Personnel of Lalbandi have taken training but not implemented. IYCF is not found to be implemented in any PHCs.

3.6 Inter-sectoral Coordination

3.6.1 District

Within Health Sectors

Inter-sectoral coordination and collaboration of the health system within the health sectors was tried to be explored for three major actors' namely traditional healers and traditional medicine practitioners, non public health services, non public sectors working in health related areas.

Only 2 districts (Sarlahi, Rasuwa) mentioned that they have some activities in coordination with traditional healers/traditional medicine practitioners. The major activities are in the area of TB, Leprosy, Health Education in case of Sarlahi and in Rasuwa they have been involved in various meetings at the district.

With the non public health services (private HFs, NGOs, Mission) the entire district except Sarlahi have certain level of activities. The major activities include health programs, health camps for Rupandehi; Preventive & promotive health service, monitoring and supervision

for Kaski; Immunization & Urban health for Bhaktapur; participation in monthly meeting for Rasuwa; Safe motherhood, TB for Sindhupalchowk.

All the districts have certain level of activities with non public sectors especially NGOs working in the areas related to health directly and indirectly. In Sarlahi, there is FPAN, NRCS, BDS & Chetana to name a few and their working areas are FP, Safe motherhood, Disaster, HIV/AIDS, RH etc. In Rupandehi AMDA works in MCH; WVIN&SUAAHARA in nutrition. Similarly, in Kaski NRCS works in Disaster, WASH, ASRH, Naulo Ghumti works in HIV/AIDS. In case of Rasuwa district NGOs such as NRCS, SUAAHARA have been actively coordinating with the district in the areas such as Nutrition. Other NGOs in Rasuwa also act jointly in events such as breast feeding, old age day, condom day. In Melamchi again there is SUAAHARA working in nutrition and MDM working in safe motherhood. In all these districts these organizations work jointly with D(P)HO in many instances and maintain a good level of coordination.

Furthermore, traditional health practitioners and non public health services have representation in the district committees in Kaski, Rasuwa and Melamchi.

Non Health Sectors

Inter-sectoral coordination with the sectors beyond health was also tried to be explored with special focus to education system , agriculture, livestock services, administrative system, local development, WASH, building and roads, economic system, industry and commerce as well as NGOs. It is seen that all the districts have regular and good coordination with education system including DEO, PABSON and schools within the district. Similarly all of the districts maintain a good coordination with DAO, DDC. In case of agriculture and livestock services Bhaktapur and Rasuwa do not have enough coordination. Sarlahi and Rupandehi have some level of coordination with industry and commerce sector mainly FNCCI. Also Rupandehi and Sindhupalchowk have certain level of coordination with NGOs in non health sectors. None of the districts have any cooperation, coordination with economic system in the district.

With regards to the representation of these sectors in the district committees, Education System (DEO & PABSON), administrative and local development (DAO, DDC) have representatives in the district committee in all the districts. Agriculture and livestock services (DAgO, DLSO) have representatives in the district committees except Rasuwa. None of the districts have representatives from economic system (banks, cooperatives), Industry and Commerce as well as NGOs in the district committees.

Major Activities

Sarlahi

School health, different days celebration are the major activities with education system. Prevention and control of zoonotic activities are the major activities with DLSO.

Rupandehi

School health with education system, meetings discussion on issues related to agriculture and health with DAgO, Joint monitoring with Industry and Commerce, close coordination in every activity with DAO & DDC are some of the major activities.

Kaski

Immunization, deworming, school health with education system; malnutrition, zoonotic diseases, influenza with DAgO & DLSO; MCH clinic and urban health DAO are some of the major activities.

Bhaktapur

Immunization, deworming, school health with education system; urban health market monitoring with DAO; activities related to water sanitation and hygiene with DWSS/DWSC are some of the major activities.

Rashuwa

School health, adolescent peer groups formation, deworming with education system; health camps with FNCCI; Water supply with DWSS are some of the major activities.

Sindhupalchowk

School health, TB awareness, deworming with education system; Nutrition, behavior change, sustainable approach for food habit with DAgO, Sanitation and water supply with DWSS/DWSC are some of the major activities.

3.6.2 HF (PHCs)

Activities relating to the PHCs in terms of coordination with traditional healers, it is found that in some PHCs traditional healers refer patients to the HF which was found in Lalbandi, Changunarayan, Jibjibe and Melamchi. Majority of the PHCs except Lalbandi undertake some level of joint activities in coordination with private organizations working in health sector. The activities mainly are health camps, and certain programs such as combined service in ORC, TB program etc.

3.7 Findings from Focus Group Discussion

Participating organizations

Women's and Child Welfare Office

District Livestock Service office

District Agriculture Office

Regional Health Directorate

District Development Committee

Nepal Red Cross Society

PABSON

N PABSON

Department of Urban Development and Building Construction, District Office

Family Planning Association Nepal, District Office

NGO Federation Nepal, District Office

FNCCI, District Office

Municipality Office

Zonal/District Ayurveda Center

District Education Office

DPHO

Department of Water Supply and Sewerage, District Office

District Water Supply Corporation

Major NGOs working in Health and Health related sector

3.7.1 Sarlahi

3.7.1.1 Existing Situation of Coordination

Planning meeting is undertaken in DDC and discussion is organized in DDC. Every organization submits their program and an annual plan for the district is made. The issue of coordination and collaboration is not found to be given prime importance in that kind of meeting. The chief of DHO says *"there are about 50 different programs related to TB in the district but many a times DDC is not aware of that. Discussion environment is not available."*

Coordination meetings usually do take place and is mostly called by the DPHO and most of the institutions invited participate. Quarterly meeting occurs for the analysis of the activities of that quarter. There was a good cooperation by all the stakeholders (Offices) in the beginning. However, it is not the same now. The problem is: *It is health program so do it yourself, why do you need others?*

Coordination is getting too complex. There have been few works in the sector of renewable energy which shows certain level of coordination says DDC representative. There exists a certain level of coordination among different organizations say most of the participants. FPAN believes that there is full cooperation by the DPHO especially in the field of reproductive health. There are frequent meetings called by DPHO but the participation from different organizations is quite low. There has been a good initiative for coordination by DHO but there is lack of cooperation by other organizations say some of them.

3.7.1.2 Problems and Constraints

"In the name of coordination and collaboration there are meetings held but the decisions made in the meetings are weakly implemented", a staff of DPHO. Hence there should be a mechanism developed to implement the issues discussed. There is no timely reporting by private sector. They should be motivated to report on time. At times the report of entire 12 months is sent together. Patients are being sent to private HFs from public HFs may be due to lack of speciality services as well as many times the lack of resources. On the other hand, legal provision is also equally pertinent problem. There is no any compelling situation to abide by so as to decrease or manage the waste. The enforcement is weak. There is no

adequate safe water supply. The available supply is not enough for the increasing urban development. "*Treated water is an issue far, only raw water is also not available"* says one of the participants.

3.7.1.3 Potential areas and what can be done further

There are a number of diseases whose burden could be reduced with good inter-sectoral effort such as food borne diseases, diarrheal diseases, and vector borne diseases. There could be an important role of awareness and awareness rising regarding waste management could be an example. There needs to be even closer coordination for issues related to management of certain diseases. For example "*Tuberculosis may be due to Bovine TB where it needs a combined effort to tackle and manage the problem*", says the representative from DLSO. A joint approach is required to regulate the market especially the food sector. There should be frequent monitoring and supervision by all the concerned organizations. The programs need to be shared by major offices. Preventive services need to be made strong. The curative services are costly. There should be emphasis on areas such as education and sanitation so as to prevent many water sanitation related health problems. On the other hand solid waste management has been hampering the drainage system. To manage these kinds of problem there should be involvement of different sectors such as Municipality, Administration, DWSS and they should act in a coordinative way. Representative from DWSS feels *"there should be a legal provision in terms of proper solid waste management, may be an example could be fine system and proper implementation of that".*

3.7.1.4 Who should lead?

The lead role should be taken by DDC. The municipalities should be motivated. The DHO takes initiation in certain issues but municipality seems to be not happy. For e.g. DHO plans for insecticide spraying but municipality says the quality of insecticide is not good. DDC seems to be the weakest actor. The DDC has power and also the resources to act on these issues. There should be clear policy developed for inter-sectoral coordination and there should be legal provision and practical laws and legal provisions should be ensured. On the other hand, DDC appears to be ready to take the lead role but every organization or the

actors should have a clear guidelines and description of the responsibilities. Behavior change cannot happen overnight. There should be repeated reinforcements to bring change. For issues related to sanitation and hygiene this is the important aspect hence need to be carried out by a joint effort and there should be involvement of the people, the community.

3.7.2 Rupandehi

3.7.2.1 Existing Situation of Coordination

Different committees exist and coordination with other organizations begins with these committees. DACC, RHCC, population committee as well as different area wise committee exist and they coordinate with NGOs in the respective sectors. Role of different organizations is clear. Activities move forward in a coordinated way. e.g. DACC – involves various organizations working in HIV AIDS. There are frequent meetings. Generally the initiation is taken by DPHO. Private hospitals and organizations are also kept within the system and are usually involved in various meetings. Different programs of GoN are generally given to different organizations. Committees generally include LDO and CDO says DPHO chief. Any kind of lacking or any issues in the public relating to health directly or indirectly is generally complained to District Administration Office. Then the DAO calls for the meetings and probing done on the issues. At this time the coordination and cooperation is important says the representative of DAO. The activities of NGOs generally happen in close coordination with DPHO. Some of the organizations work with FCHVs and Women's groups and they coordinate accordingly. Technical support is also received from DPHO says the representative of WVIN one of the NGO participating in the discussion.

Meetings are generally conducted when there has to be some planning for health camps, RH camps, uterine prolapse camps. Expertise sharing is usually in the practice. Meetings are conducted also to mobilize resources and successfully carry out such public health activities. Representative of NGO Federation mentions, "*Conflict affected groups and situation of GBV are tried to be tackled in a joint way".* Joint monitoring team involving private sectors, NGO and DPHO is in practice and is an important area which needs continuation to make the ISC a strong mechanism. Social audit is done jointly involving

various organizations. DPHO, Butwal Municipality Office and DFO has involved collaboratively in the herbs plantation, school ayurveda health education, farmers training, disaster/epidemic preparedness, awareness about ayurveda treatment system says the NGO Federation representative. There has been involvement of 7 different organizations in SUAAHARA program which is primarily focusing on nutrition and health mainly through agriculture, animal husbandry and sanitation/hygiene.

The representative of Water Supply Corporation feels coordination is usually good in certain issues when there is any outbreak, other episodes sudden occurrence of disease. The corporation usually cooperates for water sample (coliform unit) test. Education office represents in various committees in the district. Profound examples of their involvement and coordination are dengue prevention activities, school health program from children.

3.7.2.2 Problems and Constraints

The DWSC generally functions on its own for the distribution and services related to water supply. There is no coordination as such with other organizations in these issues. There is some support for the chlorination by the municipality office. Health awareness is must. There is no practice of segregation for waste management. This is most needed. There are not enough indicators to measure the level of performance. If we could increase the indicators there could be some increase in the performance as well as inter-sectoral coordination. The representative from the Sidhharthanagar Municipality says there are different organizations working in the sector of health directly or indirectly but there are not many activities in coordination. This is very much lacking especially in the area of health. Organizations are based in the municipality and in the district rather than being placed locally. They only work when there seems to be direct benefit for the organizations. For e.g. insecticide spray not implemented but demand is high. Health seeking behavior of people is different. People visit hospitals in India rather than coming to local hospitals. "*There has been poor coordination in the ward level for implementing program"*, an experience of Bal Vita Program a NGO working in Nutrition.

3.7.2.3 Potential areas and what can be done further

Awareness rising is important especially in the issue of TB. Demand creation to improve the utilization of health services. NGO Federation representative believes, *"Increased awareness will increase the access and thus utilization of health services".* There should be enough and good coordination between DPHO and Municipality. Municipality representatives believe that three important sectors health, environment and sanitation should launch program in good coordination with DPHO. Health awareness programs can be given to 100 -150 people every year focusing on different diseases. Health camps could be organized in coordination with different NGOs. Coordination is must. Major areas where inter-sectoral coordination is important are WASH, drinking water, school sanitation program (child to child approach) believe most of the participants. Performance monitoring could be another way to improve the functioning and coordination desired. Ministerial coordination is the starting point. There should be initiation from the central level then only will it be possible for having a good inter-sectoral coordination at the lower level. Reporting system has to be enhanced. For this also the involvement of different organizations is important. For e.g. demand creation can be done by the local NGOs and hence the improvement in service utilization is possible.

3.7.2.4 Who should lead?

In the matter directly related to health the lead should be taken by DPHO. Following that there should be area wise leading of the programs. Every sector should take the lead where there appears to be major role of that sector. Municipality should take lead in certain areas such as urban health.

3.7.3 Kaski

3.7.3.1 Existing Situation of Coordination

There are meetings, discussions in certain issues. Inter-sectoral coordination is not a new issue and has been stated by the Alma Ata declaration and further reiterated by different policy related documents in Nepal as well. Representative from RHD says there is a certain level of coordination existing with education system and with the community organizations at the community level. The existing coordination is in the national programs/ campaigns such as immunization campaign, school health program. There are meetings, discussions at the region and the district as well. A significant example in this district is the declaration of ODF zone which as per the group was possible only because of several organizations' support. "*The education system, NGOs, local level community organizations, everyone has played its role to make it possible"* says chief of DPHO. The district office of DWSS as mentioned by the representative has very limited activities and there are committees existing for various activities but with limited functioning. DDC has to say that for the national programs there has been continuous support and coordination even at the VDC level for e.g. ODF zone declaration. There is a huge network in certain sectors such as HIV AIDS network which is proving effective. Also various NGOs have been cooperating well in other areas as well.

3.7.3.2 Problems and Constraints

The culture of working together in coordination and collaboration has not yet developed. Everyone works individually. The problem or setback is the areas where inter-sectoral coordination can play role has to be identified and the related organization on who should take lead to be specified. (DPHO) However, there are many areas where organizations within the public (government) health system do not have a clear role and authority to regulate the malpractice in the health service delivery. In this context coordination with private sector is a far reach area. One of the participant mentions *"There are a number of health institutions in the city as well as the periphery but most of them are registered neither with the region nor with the district"*.

In some areas (HFs) there has been only construction and no HR. So only by the action of one organization there cannot be an overall achievement and thus every aspect of it should be clearly thought of says DUDBC. There is no continuation and the matter of sustainability is a big question especially when there are certain special programs. Lead role should be taken by the organization in their areas of concern and there should be a mechanism of bringing all other organizations together with their clear role in coordination and where required collaboration. The gap is that the policies are old, the organogram is old, and the working areas are not clearly defined on who should do what. *This is lacking in the system*. For e.g. the aspect of environmental health has been an area of importance but neither there is a post in DPHO for this sector nor there is in any other organization. Local governance act has said that local government should take initiation but there is lack of clearly defined roles. There should be planning from the central level itself. DDC representative says "f*or e.g. if we look within the health system, there is a serious lack of human resource but Public Service Commission is not carrying out its function and why can't the MoHP make it happen by bringing AADHYADESH when other ministries can do it"*

3.7.3.3 Potential areas and what can be done further

DPHO says health education is must for solving the problems of pesticides use and improving the quality of food in the market so as to finally improve the nutritional health of the public. Potential areas could be agriculture, nutrition. Inter-sectoral coordination and collaboration should be in every level. The cycle begins from the production level when we talk about the foods in the market, the agricultural products. There has been increased use of pesticides and thus leading to increased pollution. There has been training and awareness regarding quality agriculture practice but still there are improper practices of harvesting and bringing agriculture products to the market for e.g. vegetables with pesticides

The focus should be in preventive measures. Regulation has to be from the concerned sector. For e.g. in agriculture the malpractice should be regulated by agriculture office. The other actions such as awareness rising can come from other organizations such as NGOs,

Education sector. Furthermore, municipality can play an important role in case of quality control of food in the market and thus contribute in the nutrition health of the public.

Disability in children could be due to the pesticides which is unknown and has to be investigated says representative of Women and Children office. This could be because of low awareness and poor educational and socio economic status. Furthermore, there are evidences of substance abuse among pregnant mothers which could be another deteriorating factor for child's health. These can be tried to solve with multi-sectoral approach by the involvement of health, education, administrative offices in the district where developing awareness and motivating people would be required.

To ensure the availability of clean drinking water coordination has to be built among different sectors. Agriculture with the aim of finally providing healthy food, the attempt should begin from the production level, making the land healthy. This could be achieved by starting from training the farmers where different NGOs can play an important role. Similarly in the areas of education and agriculture the DPHO may take lead role and take other organizations hand in hand. There are certain areas where a collaborative effort may prove strong and effective. There are new disease trends developing in the community, which could be tried to be solved with inter-sectoral approach. Representative from FNCCI says there are organizations who work alone on their own for e.g. Lions club and they usually focus on health camps and blood donation camps. They can be motivated to bring activities in preventive health with support and coordination of other organizations. Awareness programs, market monitoring probably DPHO also can have role in it. For e.g. during livestock product monitoring in the market not only the personnel from DLSO but there also should be person from the DPHO. The key is to identify the areas first where inter-sectoral coordination and collaboration could be effective and prioritize them and then prepare guidelines with clearly defined roles and responsibilities of different organizations.

3.7.3.4 Who should lead?

The lead should be taken by the DPHO and contribution by all sectors. The administrative system may have the role to regulate the activities and practices

3.7.4 Bhaktapur

3.7.4.1 Existing Situation of Coordination

There has been a good coordination in general especially with DAO, DDC, DH and all other organizations says DPHO chief. However, Ayurveda is seriously missing in the process. The coordination and even participation in the meetings is severely lacking. The representative of DDC believes there is a strong coordination with different organizations. Coordination with 24 different offices and 25-30 NGOs is being done properly. However, the lead of DDC is usually in the development related issues. The coordination exists with grass root level organizations to different top level organizations in the district. There are around 14 different committees including a committee for indigenous people. A good level of awareness exists for declaring ODF zone among the VDCs. The DLSO representative mentions a committee exists for the problem of bird flu, District Bird Flu Committee and that has a regular meeting which involves different stakeholders. Apart from this the coordination and cooperation exists for different animal related problems such as Rabies.

3.7.4.2 Problems and Constraints

The meetings and the representation happens in a pre decided pattern. Representative from DAO mentions that meetings happen only if there is a pre set committee from the central level and coordination rarely happens at the district level. While planning nutrition related programs there used to be good coordination with agriculture office especially on the tasks of specifying the nutritive values of different foods that could be grown especially in the kitchen garden. But this does not happen now says DPHO chief. To carry the activities within the district in a joint way there is lack of budget says the representative from DAO.

3.7.4.3 Potential areas and what can be done further

The coordination with Department of Urban Development and Building Construction is very important in case of this district to have houses with good ventilation and light which has ultimate link with disease conditions such as TB. But the resources are very less to

promote all these kind of activities says DDC representative. Major proportion of the fund goes to social structure and quite less amount for the development related issues.

We could work together with DDC for organic pesticides. Representative from DAgO feels nutrition support program in the form of kitchen garden promotion can be another component where ISC could play a role and that is lacking now. Multivitamins and minerals rich food could be promoted in coordination with agriculture sector. It would be good to have coordination and cooperation in certain issues such as women's health camps. District Hospital can put technical contribution and other DPHO can coordinate with the support of DDC and DAO in certain areas such as Women's health and various major health problems in the district says DH representative and most of the participants agree to that. "*Drug abuse is another important area where we can work together",* believes DAO. We may start from awareness raising programs. It would be good to have some sort of financial support for this kind of problems. But the issue may be who should take lead. Hence, it would be good to have a fixed focal organization specified with the task of taking lead in different areas. T*he major areas the most of the participants believe that require a strong inter-sectoral coordination and collaboration are Food and Nutrition, Water Supply, Market Monitoring for food products, Waste management, Sanitation and Hygiene and Agriculture.* However it should be clear on who will take the lead and who will be the support organizations.

3.7.4.4 Who should lead?

The issue of market monitoring relating to food products such as meat and dairy can be given to Municipality and other organizations can support by strengthening the coordination.

3.7.5 Rashuwa

3.7.5.1 Existing Situation of Coordination

There are different committees within the DHO. The representation of various organizations is effective and there exists a good coordination. There is a regular schedule of meetings. Different days and events celebration occur with coordination and full

cooperation of all the organizations in the district. The DDC is involved in every activities initiated by DHO says the chief of DHO. The representative of DLSO mentions there was a committee for Bird Flu prevention during the situation when there was high risk of potential outbreak which showed the potential of joint effort. Representative of DEO admits there is a clear relation with DHO. We are jointly involved in different programs, in particular school health. Teachers are also mobilized for various other programs such as Vit A distribution and de-worming program.

3.7.5.2 Problems and Constraints

The activity for the district starts from the planning that actually comes from the centre. The district is directed to act in a certain direction. Within the district the annual planning meeting with DDC occurs around Mangshir and the programs have to be started by the Shravan of same fiscal year. So the meeting gets limited to papers believes the chief of DHO. There are consumers committees and they conduct training programs on their own feels representative of DWSS.

3.7.5.3 Potential areas and what can be done further

In case of zoonotic diseases DLSO can play a very important role in close relation with DHO. The main focus is behavior change for nutrition. DHO has the main role for proper coordination among the actors within the district says one of the NGO working in Nutrition. *Public health nutrition* has to be strengthened through a sustainable development of agriculture. Direct participation of agriculture sector is not present. The DHO should take initiation in this sector. Trainings could be given to community members focusing on production mechanism and ultimately motivating them for nutritious food. The issue of availability at local levels should be considered. The emphasis should be on the local food whose production can be enhanced. Use of kitchen garden should be encouraged. This will ensure the sustainability of the program.

Preventive and promotive health is the area where inter-sectoral coordination and collaboration is important. Bottom up approach is required. Push planning will be important rather than pull planning. However, the initiation should be from central level.

The activity if gets focused only in the district level it is not going to be enough. Different groups such as Women's group and many other groups that are formed by various organizations are seen to be acting in the community. At times there are many programs of same nature in the community taken forward by different groups. Hence, there should be a clear goal and vision on what exactly is required to be done and there should be joint effort from different actors. This will ensure the sustainability of the program. On the other hand public participation, community ownership is important for the program to be successful. Therefore, joint programs through community level groups can be an effective way to achieve good health of people.

In terms of specific diseases, conditions such as ARI, pneumonia require joint effort which could be tackled by reducing Indoor air pollution. DHO alone cannot work and it requires other sectors that could ensure the reduction of indoor air pollution probably by enhancing the use of improved cooking stove. *Skin disease* for example can be prevented by ensuring clean water and developing awareness of people for hygiene maintenance. Similar situations may be appropriate for *diarrheal diseases*. "*Nutrition, health and sanitation hence go hand in hand and is the most important area where coordination and collaboration among different actors*", believe most of the participants

Traditional healers are one of the important groups in the community who can contribute a lot to overall improvement of health status of the people. At many circumstances they are the first contact point of the people while seeking health care. Referral mechanisms can be strengthened mobilizing the traditional healers. Belief towards the system is lacking, people still have strong belief towards Dhami/Jhankri. School health and nutrition can be the area where CHD and department of education can work together along with other organizations in the local level. School de-worming program is another example where health and education sector could go hand in hand. For the inter-sectoral effort to be effective, there should be development of certain policies and programs at the central level and it should involve district level organizations at the time of planning. The major drawback is lack of attention in the sustainability issues. Child nutrition program failed because of this issue. Some of the activities can be planned in the district level as well.

3.7.6 Sindhupalchowk

3.7.6.1 Existing Situation of Coordination

There was a 3 years program on education agriculture and health which was phased out just around 2 months ago. The program with the main focus on education included DAgO, DEO, DHO, DDC, DAO, DLSO and it aimed at improving health of people through education system by enhancing agriculture system, says the representative of DEO. For the non formal education there is a committee with LDO as president and members from agriculture, education, health, journalists, DDC and women's office. Teachers are being involved in the health issues especially for developing awareness. SUAAHARA as a new program involving health and education sector has been started. Representative of DWSS mentions a committee exists in the district and it has developed a district strategic plan and has been preparing to declare ODF zone by 2017. There has been a good level of awareness regarding the importance of ODF. In the first phase 37 VDCs have already declared ODF zone. For achieving this teachers are mobilized and people have been made fully aware.

3.7.6.2 Problems and Constraints

The agriculture office in the district is not generally involved in the activities of DHO. The programs are run on their own. No attempt has been made for any joint effort except the recent program brought by SUAAHARA and some other organizations such as JICA program.

Health system is thought of to be of only DHO and ayurveda never comes as a part of health system. Ayurveda is just not limited to herbs. There are so many areas where ayurveda as an organization could contribute a lot in strengthening the health system and finally improving the public health status. Food and lifestyle is the most important area where joint effort of DHO, DEO and Ayurveda could contribute to overall public health system. However, Ayurveda is being ignored. District Ayurved Center can also be part of awareness rising along with education system. For any behavior change communication strategies brought forward by any organization Ayurveda is not used. Agriculture, Ayurveda, Education and DHO should go hand in hand. *Working alone is never enough*.

(Representative from DAyC) Lead should be taken by DHO. Agriculture takes the initiation on certain issues directly related to that which has final link with health.

The initiation should come from top. It cannot be done by the initiation from district level. People will not benefit unless and until it comes from top. Discussions are held but implementation is poor. This issue has to be tackled in the district level. The decisions are usually circulated all the time but not implemented.

3.7.6.3 Potential areas and what can be done further

The major areas where inter-sectoral coordination could play an important role are WASH, nutrition mainly through strengthening agriculture system, health education and awareness believe most of the participants.

Chapter IV – Discussion

The diseases in the top list for majority of the districts are GI Disorders, respiratory infection, falls/injuries as per the HMIS. NCDs could have equally higher burden in almost all the districts and VBDs in case of Terai districts whereas HIV/AIDS also seems to be with higher burden in one of the mountain district. Some of the VDCs of the catchment area of some PHCs are inaccessible for about 3 months in the monsoon due to floods and few VDCs in the mountain due to landslides.

There does not seem to be any special structure in any of the districts such as District Health Management Team (DHMT) or District Health Committee (DHC) to take care of the issues of managing the D(P)HO and HFs. This is instead being managed by the whole team of DHO or DPHO under the leadership of the chief. The PHCs on the other hand have HFOMC in all of them as a management structure where members from marginalized, women and dalit are included and participate in the meetings in all the PHCs.

The financial management issues of the district offices mainly happen in a predetermined pattern that is decided and directed from the central level. None of the districts received budget on time and none of the finance head and chief of D(P)HO are satisfied with that. In this context decentralization in health system with decentralizing resource allocation can be kept in the horizon. An assessment of the processes associated with the allocation of health resources in the decentralized system in Newzealand after a system of purchasing health services by a centralized purchasing agency was replaced by 21 district health boards (DHBs) which are responsible for both providing health services directly and for purchasing services from non-government providers in 2001. The assessment showed that Decentralized decision-making is starting to make some inroads towards achieving some of the government's objectives with respect to resource allocation and purchasing.[20] Some of the public HFs of districts except Bhaktapur and Rashuwa are found to be charging fees for some of their services. The public HFs have a certain level of income on their own and the resources generated by that are utilized as incentives and salary to certain contractual staffs in the HF.

All the districts have overview of HR of the HFs in the district with them and almost all of the district offices have job descriptions for all members. However, none of the chief's are satisfied with the allotted posts for the HFs. One of the probable reasons for the deficient number of staffs is no new recruitment by the government. Other reasons are low incentives for working in mountain districts and lack of enough facilities. One of the districts on the other hand do not seem to be having any deficiency in the number of staffs. The chief mentions *"It is very hard to convince them to go to the remote areas of the district. Otherwise the number appears to be enough".* Similarly, the chief of another DHO believes *"Bottom up approach is required for ensuring enough retention of staffs which is not happening".* Producing local HR, provision of local hiring of lower level staffs, provision of extra facilities for contractual staffs, provision of incentives could be some of the ways to improve the retention of staffs.

The number of posts of HR in the D(P)HO are filled in almost all the districts except one. Instead some of them have extra staffs posted. The HR status of HFs including DH wherever applicable does not seem to be satisfactory. Almost none of the districts where they have DH have all the posts of HR filled as per sanctioned. The lacking is mainly the MO, SN, HA. In case of PHCs/HPs/SHPs majority of the districts have deficiency in the number of staffs for the PHCs in the district. The staffs that are mostly deficient are MO, SN, HA and office helpers in most of the PHCs. Some of the posts of ANM and AHW are also vacant. The situation of HR in lower level facilities seem to be poor than the higher levels. The case with SHPs in almost all the districts is worse and nearly all of them suffer with lacking of the sanctioned posts being filled.

Most of the PHCs included in the study suffered with the deficient number of staffs. Some of them do not have MO and some even do not have a permanent HA. The building of all the PHCs is state owned and none except one PHC in one of the mountain districts do have enough space. However, the PHCs in Terai districts are planning to construct new buildings whereas three other PHCs from that of mountain and hill already have buildings under construction. One of the PHC has Ambulance for emergency cases. None of the HFs have vehicle for outreach services which seems to be an important necessity. Refrigerator is available in all the PHCs but 24 hrs power supplies are not guaranteed in all of them. Most

of the PHCs have medical waste management guidelines and also have enough resources to implement and maintain that and all 4 of them use Incinerator. One of the HF also has placenta pit.

Almost all the districts have annual district health plan. However, the plan is not a kind of approved one and many of the activities run in a routine predetermined pattern in most of the districts. Generally, D(P)HO, DDC, staff of HFs are involved in the planning by all districts however only some of them involve representatives from non public HFs, representatives of community organizations, NGOs and donors (EDPs). On the other hand none of the HFs has annual health plans. The lack of an approved annual district health plan seems to be one of the hindering factors for proper planning and true implementation of the plan.

All the districts have list of essential drugs of HFs in the district. Some of the HFs receives drugs occasionally from some other sources such as DDC. All the HFs in the past year has submitted HMIS reports and the HMIS data is analyzed in almost all the districts. All of the HFs has submitted HMIS reports in the past 12 months. The process of verification of HMIS data is by tallying the data with the record registers in HFs by the team from district. HMIS reporting could be an important tool for performance evaluation and requires to be done in a proper manner. This requires frequent training of the HF staffs as well as enough supply of logistics. In the current study though the logistics required for HMIS reporting was not an issue in any of the HFs. However, one of the HFs in Mountain districts felt that frequent orientation and training to the staffs is important. An assessment of a PHC health management information system from PHC Managers' perspectives in Nigeria showed that majority of the respondents (n=11) believed that staffing at PHC level was inadequate. Only 5 (27.8%) of the managers had training specific to completing HMIS forms. Nonetheless 14 reported that report submissions were timely. Twelve (12) of the managers judged that the data collected were always or sometimes accurate. Though only 5 crosschecked data to verify accuracy of the submissions. Results of this study show major gaps in the structure of the HMIS at the PHC level which is responsible for gathering data onward to the federal level that culminates in epidemiological and health information for the country.[21] This

study on the other hand shows that all the HFs studied from all three ecological belts reported on time.

Top diseases in the community according to Community representatives differ slightly from that reported by the HF. In Terai districts they believe that they have high burden of VBDs whereas in hill and mountain districts they believe that it is NCDs which leads the list. There are women's group and youth group in the catchment area of almost all the PHCs and mainly act on the areas of health awareness, health camps and related areas. There are youth and mother's groups in all the districts except one involved in some or the other health and health related issues. The major activities and the most common ones that these groups are involved in are health awareness, health camps for all the districts. The involvement of community groups is crucial for the sustainability of the health interventions. A review paper presenting evaluation findings and lessons learned from the Partnership for the Public's Health (PPH), had generally positive overall results; in particular, of the 37 partnerships funded continuously throughout the 5 years of the initiative, between 25% and 40% were able to make a high level of progress in each of the Initiative's five goal areas. It showed that health departments able to work effectively with community groups had strong, committed leaders who used creative financing mechanisms, inclusive planning processes, organizational changes, and open communication to promote collaboration with the communities they served.[22]

Health information and education, basic immunizations and basic RH services are provided by all of the PHCs in relation to priority health activities in HFs. Some of the PHCs also provide assisted delivery and ASRH services. The major lacking for these services are inadequate number of VHWs for immunization services, lack of privacy areas for ASRH services. These services could be further enhanced by providing enough logistics, drugs and availing additional spaces meanwhile providing training on different components. The diseases prevention and control activities for major diseases of importance for the area have been undertaken by almost all PHCs wherever applicable. In case of communicable diseases such as HIV/AIDS and STIs some of the PHCs provide some services but not completely and the personnel believe that is should be undertaken and a lot can be done beyond just counseling. On the other hand the situation with NCDs (mainly DM, HTN,

Mental disorders, Malnutrition) is also somewhat similar, partial activities happen for these diseases in all the PHCs but can be done more with emphasis on prevention and control. The major concern on the side of disease treatment regarding treatment of NCDs mainly DM, HTN for which there are no drugs available in the HFs except one single drug for HTN. The list essential drugs that are now provided for the PHCs need to be updated and should include drugs for these kinds of problems. School health program and outreach services are being undertaken by all the PHCs. Some of the PHCs mention that it is quite difficult to provide ORCs without any infrastructures and vehicles. Anti tobacco activities and activities against prevention of alcohol and substance abuse as well as community rehab and home care are not being offered by any of the HFs which is the areas HFs should be doing. IMCI and DOTS are implemented in all the PHCs CBNCP is implemented only in Changunarayan PHC. IYCF is not found to be implemented in any of the PHCs.

Inter-sectoral coordination and collaboration of the health system within the health sectors exist only to a very limited extent which usually happens with non public HFs in health camps, preventive and promotive health service, immunization and urban health. In some of the districts traditional healers and practitioners of traditional medicine are involved in some meetings. There exists a certain level of coordination with the NGOs in the district in different areas which can be further expanded and strengthened to include many other related sectors. A study carried out to understand the development of inter-sectoral participation in the three intervention municipalities of Stockholm Diabetes Prevention Programme (SDPP) case studies with a longitudinal assessment recognized wide participation of various interest groups in planning and implementing activities whereas local resources, the representation of the leadership and the extent of the network were perceived as more restricted. The extent of partner engagement increased due to focusing on activities approaching multi-sector collaboration and institutionalization.[23] An evaluation of a participatory strategy based on the Eco health approach was done whose aim was to promote inter-sector ecosystem management to decrease Aedes aegypti infestation and prevent dengue transmission in the municipality of Cotorro, in Havana city. The strategy ensured active participation by the community, diverse sectors, and government in the production of healthy ecosystems. The findings showed timely and integrated measures for prevention and control were developed, thereby decreasing the

risk of vector proliferation and local dengue transmission.[24] This shows that the inter sector participatory approach would be effective in reducing the burden of various diseases.

Meetings and joint activities in some of the areas happen in the district with different offices in the district in both health as well as non health sectors. Activities with the NGOs working in the health sector is usually carried out in full coordination with the D(P)HO and it happens usually for the areas of focus of the NGOs. Inter-sectoral coordination among stakeholders and organizations can influence the individual determinants of health. Facilitating convergence among top level sectors and organizations can aid in development of public health systems that are responsive to the health and well being and aspirations of the people.[25] It is clear that inter-sectoral collaboration has become a right of passage for finding solutions to complex problems that each sector on its own cannot solve. Inter-sectoral collaboration is above all an intrinsic need.[26]

Some of the districts are also involved in areas of herbs plantation, disaster/epidemic preparedness along with Municipality and forest office. Almost all of the districts have certain level of activities in the area of nutrition, WASH in coordination with district offices in related sectors as well as NGOs working in those sectors. ODF declaration, school health, health camps are some of the significant areas where there appears to be a good inter sectoral coordination. Some other areas of joint effort that currently exists are joint market monitoring in some districts, prevention and control of zoonotic diseases, Vit A distribution in some other districts.

A case study research was done to explore integration of health and social care for learning and knowledge management using qualitative method and involving an interrogation of relevant documentary material, together with 25 in-depth interviews with strategic managers and professionals. The infrastructure for learning and knowledge management was constructed around a collaborative culture characterized by a coherent strategic framework; clarity of purpose based on new models of service; a collaborative leadership approach that was facilitative and distributed; and, a focus on team working to exploit the potential of multidisciplinary practice, generic working and integrated management.[27]

The major constraints for inter-sectoral coordination to be effective is lack of its planning and enforcement. For it to be effective it should start from the central level and there

should be specification of the lead organization by having specification on the lead role and support role as per the different areas. Legal provision is also equally important in certain areas to make the joint effort of different sectors an effective one. The culture of working together in a joint way has not developed yet. Most of the times the health sector is left alone with the statement, *"it is the health matter so you do it on your own"* Health working with industry to promote fruit and vegetables in Western Australia which was a five year plan implemented in 1990 proved to be effective. The fruit and vegetable industry was engaged through information sharing, consultation, working groups and joint promotions. There were both need and opportunity for each sector to work together. Health had commitment, expertise and resources to plan implement and evaluate the campaign. Industry had established channels of communication within the supply chain. Sustained health sector presence provided incentive, endorsement and policy direction. Resources and infrastructure limited partnership sustainability. Greatest potential for success occurred when participants' contributions were closely aligned to their core business and there was a body responsible for coordinating action.[28]

The key areas where inter-sectoral coordination could be important are preventive and promotive health care, waste management, water supply and sanitation, health service utilization, pesticides and human health, agriculture and nutrition, air pollution. In terms of specific diseases, diarrheal diseases, VBDs, nutritional disorders, NCDs, ARI and TB are some of the important areas where inter-sectoral coordination could be important. There is consensus amongst community members, local practitioners and policy and decision makers on the need for an inter-sectoral approach to health, environment and living conditions as reported by a study analyzing the processes of linking various sectors involved in six health and environment projects developed at the local or regional level in Brussels-Capital. The analysis of the different projects demonstrates the lack of awareness by specialists, in this case being environmental, of the composition and complexity of the interaction between multiple aspects of life when trying to link with other sectors. Finally, the viable preservation and continuation of overarching, universal approaches are impeded by the lack of recognition and absence of funding for interventions which aim at affecting multiple aspects of life.[29]

Chapter V – Conclusion and Recommendations

5.1 Conclusion

The geographical condition of the country acts as a major limitation to provide basic health care services in many part of the country. Some of the VDCs of the catchment area of some PHCs in Terai districts are inaccessible for about 3 months in the monsoon due to floods and few VDCs in the mountain due to landslides.

The overall management of the district health system happens under the leadership of chief of D(P)HO with the cooperation of all the personnel in different sections. Almost all the districts have Citizen Charter with updates of latest inclusion of services by the health system. The staffs meet regularly at an interval of one month in almost all the districts. The PHCs on the other hand have HFOMC in all of them as a management structure where members from marginalized, women and dalit are included and participate in the meetings in all the PHCs. Almost all the HFs have citizen charter in place and with the inclusion of all the latest information about the services being provided by the HFs.

The financial management issues of the district offices mainly happen in a predetermined pattern that is decided and directed from the central level. None of the districts received budget on time and none of the finance head and chief of D(P)HO are satisfied with that. Some of the public HFs of districts except Bhaktapur and Rashuwa are found to be charging fees for some of their services.

All the districts have overview of HR of the HFs in the district with them. Almost all of the district offices have job descriptions for all members. In an overall picture of HR in the districts, it was found that none of the chief's are satisfied with the allotted posts for the HFs. The number of posts of HR in the D(P)HO are filled in almost all the districts except one. The HFs in the district have many areas of lacking in terms of HR fulfillment. The situation is worse with the lower level facilities the worst being the SHPs. Most of the PHCs included in the study suffered with the deficient number of staffs.

Majority of the districts in the survey do not have space enough for the proper functioning of the district offices. The main reason for the additional space is for store purpose and

somewhere for other office rooms. All the districts have adequate transportation for supervision and provision of supplies and none of them have it for outreach services whereas only one of the mountain districts studied has Ambulance of its own for the transfer of emergency cases.

The building of all the PHCs is state owned and none except one of the PHC in mountain district do have enough space. However, PHCs studied from Terai districts are planning to construct new buildings whereas three other PHCs already have buildings under construction. One of the PHC has Ambulance for emergency cases. None of the HFs have vehicle for outreach services which seems to be an important necessity. Refrigerator is available in all the PHCs but 24 hrs power supplies are not guaranteed in all of them.

Almost all the districts have annual district health plan. However, the plan is not a kind of approved one and many of the activities run in a routine predetermined pattern in most of the districts. On the other hand none of the HFs has annual health plans. All the HFs in the past year has submitted HMIS reports and the HMIS data is analyzed in almost all the districts. The process of verification of HMIS data is by tallying the data with the record registers in HFs by the team from district.

Community involvement and participation is visible in the form of youth and mother's groups in all the districts except one involved in some or the other health and health related issues.

All of the PHCs are found providing services related to priority health activities. However, in terms of disease prevention and control as well as treatment of certain diseases such as NCDs the PHCs are not found to be capable enough and do not have the resources. The PHCs are also not capacitated to provide anti tobacco activities and activities on prevention of alcohol and substance abuse as well as community rehabilitation and home care for certain diseases. Top diseases in the community according to Community representatives differ slightly from that reported by the HF. In Terai districts they believe that they have high burden of VBDs whereas in hill and mountain districts they believe that it is NCDs which leads the list.

Inter-sectoral coordination and collaboration of the health system within the health sectors exist only to a very limited extent which usually happens with non public HFs in health camps, preventive and promotive health service, immunization and urban health. In some of the districts traditional healers and practitioners of traditional medicine are involved in some meetings. Most of the districts also have coordination with NGOs and the major areas are Disaster, HIV/AIDS, RH, WASH, and ASRH. Inter-sectoral coordination with the sectors beyond health is limited mainly to DEO, DDC and DAO as well as some activities with agriculture and livestock services. The major activities include immunization, school health, water supply, sanitation, malnutrition, zoonotic diseases. Also these offices have representation in the various committees in the district.

Meetings and joint activities in some of the areas happen in the district with different offices in the district in both health as well as non health sectors. Activities with the NGOs working in the health sector is usually carried out in full coordination with the D(P)HO and it happens usually for the areas of focus of the NGOs. Some of the districts are also involved in areas of herbs plantation, disaster/epidemic preparedness along with Municipality and forest office. Almost all of the districts have certain level of activities in the area of nutrition, WASH in coordination with district offices in related sectors as well as NGOs working in those sectors. ODF declaration, school health, health camps are some of the significant areas where there appears to be a good inter-sectoral coordination. Some other areas of joint effort that currently exists are joint market monitoring in some districts, prevention and control of zoonotic diseases, Vit A distribution in some other districts.

The major constraints for inter-sectoral coordination to be effective is lack of its planning and enforcement. For it to be effective it should start from the central level and there should be specification of the lead organization by having specification on the lead role and support role as per the different areas. Legal provision is also equally important in certain areas to make the joint effort of different sectors an effective one. The culture of working together in a joint way has not developed yet. In majority of situations the health sector is left alone to act in major public health issues. The key areas where inter-sectoral coordination could be important are preventive and promotive health care, waste management, water supply and sanitation, health service utilization, pesticides and human

health, agriculture and nutrition, air pollution. In terms of specific diseases, diarrheal diseases, VBDs, nutritional disorders, NCDs, ARI and TB are some of the important areas where inter-sectoral coordination could be important.

5.2 Recommendations

- District health management team or district health committee seems to be a requirement to provide an effective management of components of district health;
- Financial resources management in the district has to be ensured with timely provision and release of budget;
- New posts creation in order to increase the number of personnel in every level is very crucial;
- HR retention in remote areas has to be given prime importance by developing situation and area specific benefit packages;
- Areas inaccessible for basic health services have to be identified and a separate provision to be made for ensuring availability of basic health care services;
- The D(P)HO and HFs in the district should be ensured with adequate space;
- Infrastructure development should be planned on the need and context specific way rather than blanket approach;
- D(P)HOs should be promoted to have an approved annual health plan;
- Bottom up approach should be promoted in planning the activities for the district;
- The priority health activities of the HFs should be reviewed on timely basis and inclusion of services for new disease trends should be ensured;
- The inter-sectoral effort should be taken above the existing activities of meetings and discussions;
- Initiation should be done from the central level for inter-sectoral coordination to be implemented effectively with a clear direction;
- There should be provision of enough resources and area wise lead organization should be determined to implement inter-sectoral coordination.

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Annexes

Annex 1 Tables of the Findings

3.1 Background Characteristics

3.1.1 District

Background Characteristics						
Characteristics	**Sarlahi**	**Rupandehi**	**Kaski**	**Bhaktapur**	**Rasuwa**	**Sindhupalchowk**
Total Population	759,780	918,282	380,527	274,469	53,770	376,088
Women of Reproductive Age	140,319	242,209	83,402	80,667	13,428	95,278
Under 1 Yr Population	16,434	21,467	6,531	7,761	1,176	8,261
Under 5 Yr Population	102,776	104,245	20,602	21,242	5,850	39,695
Top 5 Diseases as per HMIS	PUO, Intestinal Worms, Impetigo/Boils/Furunculosis, Headache, Gastritis (APD)		LRTI, URTI, Gastritis, Headache, Tonsilitis	Dental Caries/Toothache, Gastritis/APD, URTI, ARI/LRTI, Falls/Injuries/Fractures	ARI/LRTI, Gastritis(APD), Falls/Injuries/Trauma, Headache, URTI	Headache, ARI/LRTI, Gastritis, URTI, Falls/Injuries/Fractures
Top 5 Diseases as per Chief of D(P)HO	Hepatitis B, Kalazar, Cancer, Renal Disease, Cardiac Disorder	Skin Diseases	ARI, Skin Diseases, STI, Nutrition disorders	HTN, DM, Cancer, Renal Diseases	ARI, Diarrhea, Skin Diseases, Worm infestation, Alcoholic Disorders	HIV/AIDS

3.1.2 PHCs

Background Characteristics						
	Lalbandi	**Basantapur**	**Sishuwa**	**Changunarayan**	**Jibjibe**	**Melamchi**
Catchment Population	44,281	37,879	57,188	23,014	13,129	31,507
Women of Reproductive Age (15-49)	10,037	9,909	14,307	6,832	3,349	7,971
Under 1 Yr Population	932	878	1,513	657	300	691
Under 5 Yr Population	5,553	4,298	5,249	1,780	1,489	3,327
Proportion of Rural Population	0.00	0.00	10.28	0.00	100.00	
Proportion of Urban Population	100.00	100.00	89.72	100.00	0.00	
Major Means of transportation	Motorcycle, Bicycle, Bus, Cart	Bicycyle, RIckshaw, Tractor, Trolley/Cart	Public Buses	Local Bus, Walking	Walking, Stretcher (home made), Doko	Bus, Motorbike, Walking
Area Inaccessible for ORCs for more than a week	Narayan Khola, Kalinjor, Patharkot, Parwanipur Monsoon for about 3 months	Basantapur,Flood,Monsoon 3 Months	Malepatan, Too far difficult to reach, no vehicle		Thaibung, Kalikasthan - Monsoon Landslides, Slippery way 3 mths	
Top 5 Diseases (HMIS)	Skin Diseases, Gastritis, ARI, Diarrhea, PID	LRTI, Impetigo/Boils, Headache, Dermatitis, Scabies	URTI, Gastritis, Falls/Injuries/Fractures, Viral Influenza, Presumed Non Infectious Diarrhea	URTI, APD, LRTI, Falls/Injury, Skin Diseases	ARI, Typhoid, Acute Gastro Enteritis, Viral Fever, APD	
TOp5 Diseases (HF Personnel)	pneumonia, PID, Enteric Fever, Skin Infection		HIV/AIDS, Medical Abortion	URTI, Fall Injury, Enteric Fever, Diarrheal Diseases,HTN,DM	HTN, Arthritis, Bronchial Asthma, PID, Prolapse	AGE/APD, ARI, Enteric Fever, Viral Fever

3.2 Management Structures

3.2.1 District

Characteristics	Sarlahi	Rupandehi	Kaski	Bhaktapur	Rasuwa	Sindhupalchowk
District Level Committees	Yes	Yes	Yes	Yes	Yes	Yes
Citizen Charter	Yes	No	Yes	Yes	Yes	Yes
Placement of Citizen Charter	Infront of main building, wall of generator room		Side of Main Entrance	Front Wall	In the Front wall of Hospital	Infront of Hospital
Frequecny of Staff Meeting	Once a Month	Once a Month	Once a Month	Once a Month	Once a Month	Once a Month
Last Meeting	1 Month Ago	1 Month Ago	1 Month Ago	1 Month Ago	1 Month Ago	6 Months Ago

3.2.2 PHC

	Lalbandi	Basantapur	Sishuwa	Changunarayan	Jibjibe	Melamchi
HFOMC and it Functioning						
HFOMC Guidelines	Yes for all Members	Yes for all Members	Yes for all Members	Yes for all Members	No	No
Number of Members	13	9	13	11	12	9
Members Oriented	Yes for all Members	Yes for all Members	Yes for all Members	Yes for all Members	Yes for all Members	No
Last Orientation (months ago)	4	1	24	48	6	
Members Understanding roles & responsibility	Yes All Members	Yes Some Members	Yes All Members	Yes All Members	Yes All Members	Yes Some Members
Participation in Meetings by Marginalized	Yes All Members	Yes All Members	Yes All Members	Yes All Members	Yes All Members	Yes Some Members
Participation in Decision making Process by Marginalized	Yes All Members	Yes All Members	Yes Some Members	Yes All Members	Yes All Members	Yes All Members

People						
Frequency of HFOMC Meeting	Once a Month	Once every 3 Months	Once every 3 Months	Once every 3 Months	Once a Month	Once every 2 Months
Number of Meetings in the past year	12	4	6	3	7	7
Meeting Minutes	Yes	Yes	Yes	Yes	Yes	Yes
Last Meeting Minute Available	Yes	Yes	Yes	Yes	Yes	Yes
Reference of Last Meeting	Yes	Yes	Yes	Yes	Yes	Yes
Last Meeting	1	1	1	1	6	1
Main Actions by HFOMC last year	Free Cancer Examination Campaign, FCHV Uniform & Allowance, Mosquito net, 24 Hrs Emergency	Boundary, Incinerator	Buidling Construction	Vaccine Campaign, land for Building, Dashain Allowance for Driver, prize distribution FCHV	Drugs purchase, minor equipments, small buildings constructed, Inititation for Infrastructure	Health Camp, HR in contractual Service
Inclusion of HFOMC information in annual report	Yes	Yes	Yes	Yes	Yes	Yes

Other Management Issues						
	Lalbandi	**Basantapur**	**Sishuwa**	**Changunarayan**	**Jibjibe**	**Melamchi**
Functions of HFOMC (HF Personnel)	Advice about functioning, Provision of incentive, Extra Staffs	Supervisory Role Responsible Participation in all activities	Check & Balance, Monitroing, Regulation of Routine Activities, Service Feedback, Bridgre between Community n HF, awareness & information	Bridge between HF n people, Awareness, support to HF Staffs, Monitoring	Issues of HF to be solved, monitoring activities, bottom up approach to be tried	Support, Motivation, Community Mobilisation, Facilitation, Infrastructure Development
Functions of D(P)HO (HF Personnel)	Supply System Strong, Maintaining Good Coordination with HFs	Leading role, finance & other management, monitoring	Supervisory Role, Program as per the locality, Health service quality, planning of annual activities, transparency & equity in financing & other support	Not only HR, Infrastructure, Facilities	HR maintenance, drugs & other supplies, Supply need based medicines and logistics	HR retention environment, Support in Technical Issues, optimum HR Maintenance

Any other Committees in HF	No	No	Yes	No	No	Yes
Name of Committees			Quality Assurance Committee (HF+HFOMC)			MR Campaign, Construction
Citizen Charter in HF	Yes	No	Yes	Yes	Yes	Yes
Placement of Citizen Charter	Inside Building, infront of incharge roo	Yet to be Delivered from DPHO	Building under construction so in the store now	Main Building		Inside Main gate Above OPD Registration Desk
Citizen Charter Updated	Yes		Yes	Yes	Yes	Yes
Disclosure of Expenditure to the Public	No	Yes	No	Yes	Yes	No
Frequency of Disclosure		Once a Year		Once a Year	Once a Year	
Social Audit (Months ago)	12	6	0	6	9	
Dissemination of Findings of Social Audit	Yes	Yes		Yes	Yes	
Discussion of Plan Policy	Yes with Staffs	Yes with Staffs		Yes with Staffs	No	No
Reasons for not Discussing					Incharge Not Present, Senior Staff Retired	
Frequency of Staff Meeting	Twice a Month	Once a year, plan to have monthly	Once a Month	Once every 3 Months	Once a month but not happening, last meeting 9 mth ago	Once a Month
Last Meeting (Months ago)	1	1	1	4	9	2

3.3 Health and Health Related Resources Management

3.3.1 Financial Management

3.3.1.1 District

Characteristics	Sarlahi	Rupandehi	Kaski	Bhaktapur	Rasuwa	Sindhupalchowk
Release of Budget on Time	No	No	No	No	No	No
Pertinent Reasons for the Delay	Delayed release of donor fund, statements not given on time or not satisfactory	Not Allocated in time, reason lies at the centre, no release order till third or last quarter for donor fund	Annual program delayed, no release order esp donors part, sometimes money spent but no release later on	Release order of donors budget usually around falgun, chaitra, Admin process too long	No release order on time, esp budget from donors, often not given as permitted, sometimes budget received in 8th or 12th mth, salary is not enough	Not releases from the central level
Sharing of Budget with all Focal Persons	Yes	Yes	Yes	Yes	Yes	Yes
Role of District in allocation of Funds to Activities	No	No	No	No	No	No
Level of Authority of the District in Use of its Budget						
Salary	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Drugs Purchase	Partial	Full	Full	Partial	Full	Partial
Purchasing Supplies such as Linen, Stationery, Cleaning Materials etc	Full	Full	Full	Full	Full	Full
Purchasing Equipment	Full	Full	Full	Partial	Partial	Partial
Repairing Equipment	Full	Full	Full	Full	Full	Full
Maintaining Buildings	Full	Full	Full	Full	Partial	Full
Maintaining Vehicles	Full	Full	Full	Full	Full	Partial

Accounting Procedures	Full	Full	Full	Full	Full	Full
Financial Reports	Full	Full	Full	Full	Full	Full
Periodic Auditing Visits	Full	Full	Full	Full	Full	Full
Public HFs Charging Fees for services	Yes	Yes	Yes	No	No	Yes
Proportion of those charging	Some	Some	Some			Some
Major services that are charged	DH, PHC -lab, Xray except TB leprosy malaria	laboratory, MA	MA,			Dist Hospital for Lab, X ray, USG, procedures

3.3.1.2 PHC

Financial Management						
	Lalbandi	**Basantapur**	**Sishuwa**	**Changunarayan**	**Jibjibe**	**Melamchi**
Income at HF level	Yes	Yes	Yes	No	Yes	Yes
Sources of Income	Emergency and Lab Services	Lab Services			Lab Services	CAC, Lab, Xray, Emergency
Average Monthly Income	18,000	11,000			700	30,000
Level of Authority of HF						
Salary	NA	NA	NA	NA	NA	NA
Purchasing Drugs	Partial	Full	Partial	Partial	Full	Partial
Purchasing Supplies such as linen, stationery	Full	Full	Partial	Full	Full	Full
Purchasing Equipment	Partial	Full	Partial	Partial	Full	Full
Repairing Equipment	Full	Full	Full	Partial	Full	Partial
Maintaining Buildings	Full	Full	Partial	Partial	Full	Full
Maintaining Vehicles	NA	NA	NA	Full	NA	NA
Other Issues		Tiffin,				

		Allowances(lab, Nurses, MA) - Full				
Fees for Services	Yes	Yes	Yes	No	Yes	Yes
Services being Charges	OPD, Emergency, Lab	MA, Laboratory	MA		Laboratory	Lab, Xray, Delivery
Provision of Exemption	Yes	Yes	Yes		Yes	Yes
Mechanism of Exemption	Over 60 Years, Ultra Poor, FCHV, Disabled, marginalized - hf incharge	By HF Incharge for genuine cases	HF Incharge Decision		Senior Citizen, Poor, Marginalized, decided by HF Incharge	Poor & Destitute, Decision of HF Incharge

3.3.2 Human Resources Management

3.3.2.1 District

	Lalbandi	Basantapur	Sishuwa	Changunarayan	Jibjibe	Melamchi
HR Overview in the District	Yes	Yes	Yes	Yes	Yes	Yes
Job Descriptions	Yes All Members	Yes All Members	Yes All Members	No	Yes All Members	Yes All Members
Rotation Plan	None	Some	None	None	None	None
Training Plan	Some	All	Some	None	None	None
Career Plan	None	None	None	None	None	None
Housing	None	Some	None	None	All	Some
Incentives	None	Some	Some	None	None	Some
Probable Reasons of Deficient Number of Staffs	retention problem, VHW decreasing no new recruitment, No exams by PSC, no authority for district to hire, local production nil	Not deficient as such but personnel do not want to go to remote area		As per norms ok. but the alooted posts are not enough, No provision of helpers	Living Cost very high, Facility less, Central level planning, no bottom up approach	No New posts created, and no vacancy for existing posts also, AHW, HA,LAb, Xray, Peon not being sent
Ways to improve Retention of HR	Provide housing, and train/produce local people	Incentives, More salary for contractual staffs, lonr term training for remote staffs		Provision of local contract of helpers, clear distinction between diff posts, do not give PADNAAM	separate pacjage required location specific, need based supply by seeing exact situation, discuss with people serving there, remote allowance	Whole system needs change, doctors required, need based planning required
DHO out of Office	hardly once a month	Very Infrequent		Around 25 to 30 %	for a month	Almost nil
Reasons for not being in Office	Due to the work load in office do not generally go out	Field Visit, Occasionally to the centre		Usually in the meetings/seminars	Central level meeting	Doesn't usually go to the centre/region
Proportion of Hours Spent in the Office (%)	25	50		40	99	100
Purpose of being out of Office	meeting in the district with other organizations, DDC, DAO, Women's Office	different programs, training, workshops, district (DDC, DAO) meeting, Line agency meeting, supervision, joint supervision		meetings in other different offices		

HR Status District

		Human Resource Status - District (Public) Health Office																	
	Type of Personnel	**Sarlahi**			**Rupandehi**			**Kaski**			**Bhaktapur**			**Rasuwa**			**Sindhupalchowk**		
		Sanctioned	Filled	Remarks	Sanctioned	Filled	Remarks	Sanctioned	Filled	Remarks	Sanctioned	Filled	Remarks	Sanctioned	Filled	Remarks	Sanctioned	Filled	Remarks
1	Public Health Officer	1	1		1	1		1	1		1	1		1	1		1	1	
2	Account Officer				1	1													
3	Section Officer				1	1					1	1							
4	Accountant	1	1					1	1		1	1		1	1		1	1	
5	HA	2	1		2	4	Phasil -2	2	2		2	2		2	2		2	2	
6	Stat Assistant	1	1		1	0		1	1		2	1		1	1		1	1	
7	PH Nurse							1	1		1	1		1	1		1	1	
9	Typist	1	1		2	2		1	1		1	1					1	1	
10	AHW										0	0							
11	ANM										2	2							
12	Computer Asst							1	1		1	1							
13	Vector Control Supervisor							0	1	Phasil 1									
14	Immunisation Supervisor	1	1		1	1		1	1		1	1		1	1		1	1	
15	FP Assistant	1	1		1	1		1	1		1	2	Supreme Court	1	1		1	1	
16	TB Leprosy Assistant	1	1		1	1		1	1		1	2	Stay Order	1	1		1	1	
17	Lab Technician				1	1					1	1					1	1	

18	Health Education Technician				0	1	Phasil 1	1	1		0	1	Phasil				1	1	Phasil 1
19	Vector Control Assistant				0	1					0	1	Phasil						
20	Lab Assistant	2	2		3	3					1	1		1	1				
21	Nayab Subba	1	0					1	1		1	1		2	2		1	1	
22	Malaria Inspector	2	1	retd	2	0													
23	Cold Chain Assistant	1	1		1	2	Phasil 1	1	1		2	2		1	1		1	1	
24	Kharidar	1	1		1	1		1	1		1	1					1	1	
25	Sub Accountant	1	1					1	1		1	1					1	1	
26	Driver	1	1		1	1		1	1		1	0							
27	Peon/Office Asst	3	2		3	3		4	4		4	4		3	3		4	4	

Human Resource Status - District Hospital

	Type of Personnel	Sarlahi			Rupandehi			Kaski			Bhaktapur			Rasuwa			Sindhupalchowk		
		Sanctioned	Filled	Remarks	Sanctioned	Filled	Remarks	Sanctioned	Filled	Remarks	Sanctioned	Filled	Remarks	Sanctioned	Filled	Remarks	Sanctioned	Filled	Remarks
1	Medical Superintendent	1	0											1	1		1	1	
2	Medical Officer	4	0	Contract 3										4	1		2	0	
3	HA	1	0														1	0	Temporary Staff Working
4	Medical Record Officer	1	1														1	0	
5	Radiographer	1	1											1	1		1	1	Going to be transfer

																			red
6	Lab Technician	2	2											1	1		1	0	
7	Computer Asst	1	1														1	0	
8	Nayab Subba	1	0											1	1		1	0	
9	Staff Nurse	4	0											2	2		4	4	2 Study Leave
10	AHW													3	3		2	2	
11	ANM													2	2		2	2	
12	Dark Room Assistant	1	1											1	1		1	1	
13	Lab Asst	1	1											1	1		1	1	
14	Asst Accountant													1	1				
15	Kharidar	1	1														1	1	
16	Peon	2	2											5	5		11	8	
17	Cook	1	1																
18	Cook Asst	2	2																
19	Helper	3	2																
20	Sweeper	1	1											1	1				

HR Status HFs in the District

Human Resource Status - PHC/HP/SHP																			
	Type of Personnel	**Sarlahi**			**Rupandehi**			**Kaski**			**Bhaktapur**			**Rasuwa**			**Sindhupalchowk**		
		Sanctioned	Filled	Remarks	Sanctioned	Filled	Remarks	Sanctioned	Filled	Remarks	Sanctioned	Filled	Remarks	Sanctioned	Filled	Remarks	Sanctioned	Filled	Remarks
1	Medical Officer	5	1		5	5		3	3		2	2		1	0		5	5	Contract
2	HA	5	5		5	5	Vacant 1, Phasil 1	3	3		2	2		1	0		3	2	
3	Staff Nurse	5	1		5	3	1 SN Absent	3	3		2	2		1	1		3	1	
4	ANM				14	14		3	2		6	9	MCHW upgraded	3	3		6	4	
5	AHW				10	10		3	2		6	7	VHW upgraded	2	0		6	3	
6	Lab Asst	5	4		5	5					2	2		1	1				
7	Asst Accountant													1	0				
8	VHW				5	5		1	1					1	1		3	3	
9	Office Asst/Peon	5	5		9	10	Phasil 1	2	2		4	4		2	2				
	HP																		
1	HA	16	10		19	7	Phasil 1	11	11		11	7		8	5		10	2	
2	AHW				57	48	Phasil 1	11	11		26	29	VHW upgraded	8	4		10	10	
3	ANM				38	31		11	11		15	16		8	1		10	8	
4	Kharidar				0	4	Phasil 4							1	1				
5	VHW													8	2		10	3	
6	Office Assistant Peon	16	16								7	11	Phasil - 4	8	8				
	SHP																		

1	AHW				90	80		34	34		16	17	VHW upgraded	9	5		65	24	
2	ANM				45	44					8	8							
3	VHW													9	4		65	30	
4	MCHW													9	8		65	63	
5	Office Asst			27 Posts of ANM & 18 AHW vacant	0	35	Phasil 35				0	8	Phasil - 8						

3.3.2.2 HR Status Selected PHCs

	Type of Personnel	Lalbandi			Basantapur			Sishuwa			Changunarayan			Jibjibe			Melamchi		
1	Medical Officer	1	1	Absent but receives salary from DPHO	1	1		1	1	at least 2 required	1	1		1	0		1	2	Contract
2	HA	1	1		1	1		1	1	at least 1 more	1	1		1	0		1	0	Major Lacking HA/CMA, Hence quite Unsatisfatory
3	Staff Nurse	1	0		1	0	Kaaj (DPHO) since 1 yr	1	1	at least 1 more	1	1		1	1		1	1	
4	ANM	3	3		3	3		3	3	at least 2 more	3	3		3	4	1 in contract	3	3	
5	AHW	2	3		2	2		2	2	at least 2 more	2	3	1 VHW just for attendance	2	2	Both contract	2	1	
6	Lab Asst	1	1		1	1		1	1	at least 1 more	1	1		1	1		1	0	
7	Asst Accountant																		
8	VHW	1	0								1	1		1	1				
9	Office Asst/Peon	2	1		3	3		2	2	at least 1 more	2	2		2	2		2	3	Contract
10	Sweeper				0	1	HFOMC												

HR Management PHC

	Lalbandi	Basantapur	Sishuwa	Changunarayan	Jibjibe	Melamchi
Provision of following for the Personnel						
Job Descriptions	No	No	Yes	Yes	No	Yes
Housing	No	No	No	No	Some	Some
Incentives	Some	Some	No	Some	No	Some
Degree of Satisfaction in those provisions	Very Dissatisfied	Dissatisfied	Dissatisfied	Dissatisfied	Satisfied	Satisfied
Staff Recruited by HFOMC	Yes	Yes	No	Yes	No	Yes
Type & Number of Staffs	Peon 3	Sweeper, 1		Driver,1 - Ambulance		CMA 1, Lab Asst -1, Office Helper - 1
Other service providers in HF	Students for On the Job Training	Paramedical Students	Nursing students occasionally, lab Assistants as volunteer			CMA, ANM for OJT
Opening Hours	10 to 2, 24 hrs emergency	10 to 2, 24 hrs maternity	10 to 2	10 to 2, 24 hrs emergency	10 to 2, 24 hrs emergency	10 to 2, 24 hrs emergency
Provision of Emergency Services	Yes	Yes	0	Yes	Yes	Yes
Type of Personnel available 24 hrs	CMA, ANM, HA, Peon	Sweeper, ANM, Office Assistant		SN,ANM, Office helper	AHW, ANM	Doctors

3.3.3 Infrastructure, Equipment & Supplies

3.3.3.1 District

Adequacy of Current Space	No	No	No	No	No	Yes
Purpose of Extra Space	Store too less space for drugs, Training Centre	Warehouse is small, separate space for cold room		Store	Store, Management team's office	
Process/Plan of Construction or Hiring	Yes	No	Yes	No	No	
Physical Conditions in District Hospital						
Lighting	Full	NA	NA	Full	Full	Full
Sanitation	Full	NA	NA	Full	Full	Full
Water	Full	NA	NA	Full	Full	Partial
Ventilation	Full	NA	NA	Full	Full	Full
Cleanliness	Full	NA	NA	Full	Full	Full
Space	None	NA	NA	Full	Full	Full
Refrigeration of Vaccines	Full	NA	NA	Full	Full	Full
Physical Conditions in PHCs						
Lighting	Full	Full	Full	Full	Full	Full
Sanitation	Full	Full	Full	Full	Full	Full
Water	Full	Full	Full	Full	Full	Full
Ventilation	Full	Full	Full	Full	Full	Full
Cleanliness	Full	Full	Full	Full	Partial	Full
Space	Full	Full	Full	Full	Partial	Full
Refrigeration of Vaccines	None	Full	Partial	Full	Full	Full
Physical Conditions in HP						
Lighting	Full	Full	Full	Full	Full	Full
Sanitation	Full	Partial	Partial	Partial	Full	Partial
Water	Full	Full	Partial	Partial	Full	Partial
Ventilation	Full	Full	Full	Partial	Full	Partial
Cleanliness	Full	Full	Full	Partial	Partial	Partial
Space	Full	Full	Full	Partial	Partial	Partial
Refrigeration of Vaccines	None	None	None	Full	Partial	None
Physical Conditions in SHP						
Lighting	Full	Full	Partial	Full	Partial	Partial

Sanitation	Full	Partial	Partial	Partial	Full	Partial
Water	Full	Partial	Partial	Partial	Full	Partial
Ventilation	Full	Full	Full	Partial	Full	Partial
Cleanliness	Partial	Partial	Full	Partial	Partial	Partial
Space	None	Partial	Full	Partial	Partial	Partial
Refrigeration of Vaccines	None	None	None	Full	None	None
Proportion of HF with Telephone	20.00	60.00	66.00	80.00	0.00	30.00
Proportion of HF Using Mobiles	100.00	100.00	100.00	100.00	100.00	100.00
Mechanism of Reimbursement for Mobile Use	No	Yes	No	No	No	No
Adequacy of Transportation						
For Supervision, provision of supplies	Yes	Yes	Yes	Yes	Yes	Yes
Outreach Services	No	No	No	No	No	No
Transfer of Emergency Cases	No	No	No	No	Yes	No
Adequacy of Resources to maintain Transportation	Yes	Yes	yes	yes	No	Yes
Use of Store Management Procedures	Yes	Yes	Yes	Yes	Yes	Yes

3.3.3.2 PHC

Infrastructure, Equipment & Supplies						
Infrastructure	**Lalbandi**	**Basantapur**	**Sishuwa**	**Changunarayan**	**Jibjibe**	**Melamchi**
Status of Building	Government Owned	Government Owned	Government Owned	Government Owned	Government Owned	Government Owned
Adequacy of Space	No	No	No	No	No	Yes
New Plan	Planning to Constuct	Planning to Constuct	Under Construction	Under Construction	Under Construction	
Provision of Night Beds	Yes	Yes	No	Yes	Yes	Yes
Approved no of beds	3	3		3	3	3
Functioning beds	3	2		2	3	6
Accomodation for Non Local Staffs	No	No	No	Yes	Yes	Yes
Location of Accomodation				Within the HF	Within the HF	Within the HF
Continuous availability of Electricity	No	No	No	No	Yes	Yes
Back up Source of Power	No	UPS/Battery	No	Solar	Generator	Generator
Adequacy of Lighting	Yes	Yes	Yes	Yes	No	Yes
Provision of Heater for Winter	No	No	No	No	No	No
Most Commonly used Source of Water	Tubewell/Boring	Tubewell/Boring	Piped Water Supply in HF	Piped Water Supply in HF	Piped Water Supply in HF	Piped Water Supply in HF
Hand wash Basins	Yes	Yes	No	Yes	Yes	Yes
Separate Toilet for Staff	Yes	No	No	Yes	No	Yes
Separate Toilet for Patients	Yes	Yes	No	Yes	No	Yes
Waiting Space for Patients	Yes	No	No	No	Yes	Yes

Equipment and Supplies

	Lalbandi	Basantapur	Sishuwa	Changunarayan	Jibjibe	Melamchi
Equipment & Supplies						
Availability of Telephone	Yes	Yes	Yes	Yes	No	Yes
Phone facility out of Office hours	Yes	Yes	Yes	Yes		Yes
Ambulance or Vehicle for Emergency cases	No	No	No	Yes	No	No
Vehicle for Outreach Services	No	No	No	No	No	No
Availability of Refrigerator	Yes	Yes	Yes	Yes	Yes	Yes
24 hrs Power supply for Generator	No	Yes	No	No	Yes	Yes
Standard list of Equipments for the HF	Yes	Yes	Yes	Yes	Yes	Yes
Use of Store Management Procedures	Yes	Yes	Yes	Yes	Yes	Yes
Personnel managing Store	CMA/AHW	AHW	AHW	Sr AHW	AHW	ANM
Medical Waste Management Guidelines	No	No	Yes	Yes	Yes	Yes
Resources for that	No	No	Yes	Yes	Yes	Yes
Waste management procedure	Burning, Temporary Pit	Temporary tank, Incinerator just Constructed	Incinerator	Incinerator, Placenta Pit	Incinerator	Incinerator
Level of Satisfaction with the availability of Resources						
Basic Equipment	Very Dissatisfied	Dissatisfied	Dissatisfied	Satisfied	Satisfied	Very Dissatisfied
Stationery	Very Dissatisfied	Very Dissatisfied	Very Dissatisfied	Satisfied	Dissatisfied	Very Dissatisfied
Linen	Satisfied	Very Dissatisfied	Very Dissatisfied	Satisfied	Dissatisfied	Satisfied
Cleaning Materials	Very Dissatisfied	Very Dissatisfied	Very Dissatisfied	Satisfied	Satisfied	Satisfied

3.4 Managerial Process

3.4.1 District

Planning						
District Plan	Yes	Yes	Yes	Yes	Yes	Yes
Implementation of the Plan	Yes	Yes	Yes	No	No	No
Involvement in the Process of Planning						
DDC	Yes	Yes	Yes	Yes	Yes	Yes
Staffs of HFs	Yes	Yes	No	Yes	Yes	Yes
Representatives of Non Public HFs	No	No	No	Yes	No	Yes
Representatives of Community Groups	No	No	Yes	Yes	No	Yes
NGOs	No	No	Yes	Yes	No	Yes
Donors	No	No	Yes	Yes	No	Yes
MoHP	NA	NA	NA	NA	NA	NA
DoHS	NA	NA	NA	NA	NA	NA
RHD	NA	NA	NA	NA	NA	NA
Role of the Central/Regional Level in Planning Process	Initiation and advice on the development	Facilitation Only	Initiation of plan development	Advice on the development of plan	Advice on the development of plan	No Significant Role
Inclusion of MnE of its Implementation in the Plan	Yes	Yes	No	Yes	Yes	Yes
Specification of Person Responsible for MnE	Yes	Yes	No	Yes	Yes	No
HFs Having Health Plans	None	None	None	None	None	None

Drug Management and HMIS						
List of Essential Drugs of HFs in the District						
Hospitals	Yes	NA	NA	Yes	Yes	Yes
PHC	Yes	Yes	Yes	Yes	Yes	Yes
HP	Yes	Yes	Yes	Yes	Yes	Yes
SHP	Yes	Yes	Yes	Yes	Yes	Yes
HFs receiving Drugs from	Yes	No	No	No	Yes	No

any other Source						
HFs Purchasing Drugs on their Own	Yes	Yes	Yes	Yes	Yes	Yes
Proportion of HFs Purchasing Drugs	around 1/5th	Some	Some	Some	Very few	Some
Financial Source for Drug Purchase	VDC/HFOMC	HFOMC Budget	HFOMC	HFOMC Budget	HFOMC	HFOMC Budget
District Health Map in D(P)HO	Yes	Yes	Yes	Yes	Yes	Yes
Inclusion in the Map						
Location of Public HFs	Yes	Yes	Yes	Yes	Yes	Yes
Location of Non Public HFs	No	Yes	No	No	No	Yes
Catchment Population of HFs	No	Yes	No	yes	yes	yes
Proportion of HFs Submitting HMIS reports for the past year	100	100	100	100	100	100
Analysis of HMIS data by the District	Yes	Yes	Yes	Yes	Yes	No
Mechanism of Use of Such Data	Feedback by making graphs/charts	Bar, Charts, and Feedback to HFs	Suggestions and feedback using the findings	Disease Trends Every Quarter	Feedback using bras/charts	
Feedback to HFs in response to the Data	Yes	Yes	Yes	Yes	Yes	No
HMIS Report Verification Process	Matching with register once in 6 months	On the spot data, Joint Supervision	Routine process by matching the register	By data verification team tallying the record	By the supervisors annually, Ilaka meeting	Internal and External Verification
Health Achievements Display	Yes	Yes	Yes	Yes	Yes	No
Provision of such Achievements to HFs	No	Yes	No	Yes	Yes	No

Community Involvement

Community Involvement						
Community Groups in the District	Yes	Yes	Yes	Yes	No	Yes
List of the Groups involved in Health Issues	Mother's Group (Esp highway)	Women's Group, Youth Groups	Studen's Society, Women's group, youth Groups	Women's Group, Youth Groups		Mother's group
Guidelines on their Relationship with District	No	No	No	No		Yes
Major Activities of those Groups	Health Awareness	health awareness, Income generating projects, water suppply projects	Health awareness, preventive apsects of health, sanitation	health awareness, health camps		Immunization, FP, Safe Motherhood
Community Contribution to Public HFs						
HR	No	No	No	No	No	Yes for Some Facilities
Financial Resources	No	Yes for Some Facilities	Yes for Some Facilities	No	No	Yes for Some Facilities
Materials or Buildings	No	Yes for Most Facilities	Yes for Some Facilities	Yes for Some Facilities	Yes for Some Facilities	Yes for Some Facilities
Feedback Mechanism by Community People	Community Representatives in Meetings, User Satisfaction Survey	Suggestions during programs meetings	Suggestion Box, Consumer forum, Civil Society	During Discussion Meetings	Suggestion Box, Review of Complaints	Community representativeness in Meetings

3.4.2 Managerial Process PHC

Guidelines, Standards and Norms	Lalbandi	Basantapur	Sishuwa	Changunarayan	Jibjibe	Melamchi
Immunization Session	Yes	Yes	Yes	Yes	No	Yes
FP Provision	Yes	Yes	Yes	Yes	Yes	Yes
Management of a Child with Diarrhea	Yes	Yes	Yes	Yes	Yes	Yes
Management of a Child with Fever	Yes	Yes	Yes	Yes	Yes	Yes
Referral of Obstetrical Emergencies	Yes	Yes	Yes	No	Yes	Yes
Supervision & Monitoring						
Number of Supervisory visits by DPHO	6	2	1	12	3	2
Changes made a result of MnE Visit	NA	Yes	NA	Yes	Yes	Yes
Examples of Changes		Program Wise Indicator			Report Writing	Reporting System Being Improved
Number of Supervisory Visits by others	0	2	1		0	1
Organizations Doing Supervision		Centre (DoHS)	RHD/DoHS			Central Level
List of Essential Drugs for this HF	Yes	Yes	Yes	Yes	Yes	Yes
Drugs unavailable for top 5 Diseases	Diarrhea - ORS, Zinc; Pneumonia – Cotrim	Impetigo/Boils - Antifungal, Dermatitis - Steroid Ointment	No	Syp/Susp for paediatric use	No	Cotrim, CPM, Fe Tab
Reasons for that	Not Sent as per demand, Generally less as number of pts very high	Not Included in the List		Tablets not accepted by people for children		Not supplied as per demand, not managed from district, not transported on time, List insufficient
Places where people can buy or obtain drugs except this HF	Not for profit hospital and Private pharmacy	Nil	Private Pharmacy	Private Pharmacy	Private Pharmacy	NA

Referral Mechanism and HMIS	Lalbandi	Basantapur	Sishuwa	Changunarayan	Jibjibe	Melamchi
Referral Mechanism						
Referral note from lower to higher level	No	Yes	No	Yes	Yes	Yes
Feedback reports back to lower level	Yes	NA	No	No	No	No
Ambulance Systems	NA	NA	No	Yes	No	NA
Communication Systems	No	No	No	No	No	No
Payment Exemption of showing Referral Note	No	NA	No	No	No	NA
Reciept of Referral Reports with pts referred back	No	No	No	No	No	No
HMIS and reporting						
Submission of all reports in last 12 months	Yes	Yes	Yes	Yes	Yes	Yes
Any shortage of forms	No	No	No	No	No	No
Any other problems in reporting					Report Preparation, Lack of HR, Training & Orientation	No proper orientation training, SHP report not proper intact
Copy of Reports Submitted kept in HF	Yes	Yes	Yes	Yes	Yes	Yes
Analysis by the HF Staffs	Yes	Yes	Yes	Yes	No	No
Examples of Such Analysis	Master Chart	Chart, Graphs, Bar Diagrams, Tables	Graphs, Charts	Charts, Graphs		
Use of Information by Staffs	Increase the number of staffs, ask for more drugs	Planning, Improvement of Care	If targets decreased discuss accordingly for solutions			
Process of Verification of HMIS data	See Register, Tally the record with register	Using a Format, matching register, checking monthly register	Tally teh data in tally sheet using data from register	Register Matching	Supervisors from district tally the record	Routine supervision & during other supervision, matching the register
Receipt of Feedback from District on reports submitted	Yes	Yes	Yes	No	Yes	No

3.5 Priority Health Activities of the PHCs

Priority Health Activities																		
Public Health Intervention	**Lalbandi**			**Basantapur**			**Sishuwa**			**Changunarayan**			**Jibjibe**			**Melamchi**		
	Undetaken	Should it be Undertaken	Remarks	Undetaken	Should it be Undertaken	Remarks	Undetaken	Should it be Undertaken	Remarks	Undetaken	Should it be Undertaken	Remarks	Undetaken	Should it be Undertaken	Remarks	Undetaken	Should it be Undertaken	Remarks
Health Information & Education	Yes	Yes		Yes	Yes	People can't understand materials, better in local language	Yes	Yes	Directives from district is required	Yes			Yes			Yes		
Basic Immunizations																		
National Immunization Program	Yes	Yes	No VHWs	Yes	Yes	VHW Not Availble	Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes	
Immunization Days	Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes	
Reproductive Health																		
FP Services	Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes	
ANC	Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes	
Asst Deliveries	Yes	Yes	Space Less, Privacy Difficult	Yes	Yes	Partly, with Episiotomy	No	No		No	No		Yes	Yes		Yes	Yes	
PNC	Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes	
ASRH	No	No		No	Yes	No in the Program	No	Yes	No separate	Yes	Yes	Less Effective, No	Yes	Yes		Yes	Yes	

									program, goes combined, can be done better			Separate Counseling						

Diseases Prevention & Control

Disease Prevention & Control	Undertaken	Should it be Undertaken	Remarks	Undertaken	Should it be Undertaken	Remarks	Undertaken	Should it be Undertaken	Remarks	Undertaken	Should it be Undertaken	Remarks	Undertaken	Should it be Undertaken	Remarks	Undertaken	Should it be Undertaken	Remarks
Malaria	Yes	Yes	Test kit not available free	Yes	Yes	RDT test kit limited, only combined kit, RDT + but Slide neg	Yes	Yes		No	No		No	No		Yes		
TB	Yes	Yes		Yes	Yes	Lab test reagent problem	Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes	
Leprosy	Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes	
HIV/AIDS	No	Yes	Not Implemented	No	Yes	Not Started but Should be there	No	Yes	Only Counseling, can do more	Yes	Yes	Counseling	No	No		Yes	Yes	
STIs	No	Yes	Not Implemented	Yes	Yes		No	Yes	Only Counseling	Yes	Yes		No	No		Yes	Yes	
Mental Disorders	No	Yes	Not Implemented	No	Yes	Not in the Program, need training	No	Yes		Yes	Yes	basic mental health	Yes	Yes		No	No	
DM	Yes	Yes		Yes	Yes	No Medicine in the lisr	No	Yes		Yes	Yes		Yes	Yes		No	No	

HTN	Yes	Yes		Yes	Yes	Not Adequate Medicine, Only One Medicine	No	Yes		Yes	Yes		Yes	Yes		Yes	Yes	
Malnutrition	Yes	Yes		Yes	Yes		No	Yes		Yes	Yes		Yes	Yes		Yes	Yes	
Diarrheal Diseases	Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes	Not Applicable	Yes	Yes	
Kalaazar	Yes	Yes	No Supply of K-39	No	Yes	No Program	No	No	Not Applicable	No	No	Not Applicable	No	No	Not Applicable	No	No	Not Applicable
Dengue	No	No		No	Yes	Occassionally Dengue Like cases Seen	No	No	Not Applicable	No	No	Not Applicable	No	No	Not Applicable	No	No	Not Applicable
JE	No	No		No	Yes	Only Preventive Measures	No	No	Not Applicable	Yes	Yes		No	No		No	No	
Rabies	No	No		No	Yes	No Vaccine and other required logistics	Yes	Yes	Occasionally	No	No		No	No		No	No	
Snakebite	No	No		No	Yes	No ASV and other logistics	No	No		No	No		No	No		No	No	

Treatment of Specific Diseases

Treatment of Specific Diseases	Lalbandi			Basantapur			Sishuwa			Changunarayan			Jibjibe			Melamchi		
	Undetaken	Should it be Undertaken	Remarks	Undetaken	Should it be Undertaken	Remarks	Undetaken	Should it be Undertaken	Remarks	Undetaken	Should it be Undertaken	Remarks	Undetaken	Should it be Undertaken	Remarks	Undetaken	Should it be Undertaken	Remarks
Malaria	Yes	Yes		Yes	Yes		Yes	Yes		No	No		No	No	Not Applicable	Yes	Yes	
TB	Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes	
STIs	No	No		Yes	Yes		No	No		Yes	Yes		Yes	Yes		No	No	
Mental Disorders	No	No		No	No		No	No		Yes	Yes		No	No		No	No	
DM	Yes	Yes	No Medicines	No	Yes	No medicines	Yes	Yes	No Medicines	Yes	Yes	No Medicines	No	No	No Medicines	No	No	No Medicines
HTN	Yes	Yes		Yes	Yes	Limited Medicines	Yes	Yes	Limited Medicines	Yes	Yes	No Medicines	Yes	Yes		No	Yes	No Medicines
Disability (Blindness, Deafness, Physical)	No	No		No	No		No	No		No	No		No	No		No	No	

Other Services	Lalbandi			Basantapur			Sishuwa			Changunarayan			Jibjibe			Melamchi		
School health	Yes	Yes	Inadequate HR,	Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes	
Outreach Services	Yes	Yes	No Vehicles, Inadequate HR	Yes	Yes	No buildings, Physical infrastructure	Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes	
Community Rehab, Home Care for HIV and Other Conditions	No	No		No	No		No	No		No	No		No	No		No	No	

Anti Tobacco Activities	No	No	Not in Program	Yes	Yes	Some activities under health education	No	No	Not in Program	Yes	Yes	PAL Program	No	No	Not in Program	Yes	Yes	Very few activities
Prevention of Alcohol & Substance Abuse	No	No	Not in Program	No	No		No	No	Not in Program	No	No		Yes	Yes	Counseling, Awareness	No	No	
Eye & Ear Care	No	No	Not in Program	No	No	Not in Program	No	No	Not in Program	Yes	Yes		Yes	Yes	Training Taken	No	No	
Oral Health	No	No	Not in Program	Yes	Yes	Training Taken but no logistics, dental chair, dental set, equipments	No	No		Yes	Yes		No	No		No	No	
Strategies																		
IMCI	Yes	Yes	Less HR, Increasing OPD pts, No extra Space	Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes	Training Taken	Yes	Yes	
DOTS	Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes		Yes	Yes	Training Taken	Yes	Yes	
CBNCP	No	Yes	Only Training taken, not Implemented	No	No	Not Available	No	No		Yes	Yes		No	No		No	No	
IYCF	No	No	Not Aware	No	No	Not Aware	No	No	Not Aware	No			No		Not Aware	No		Not Aware

Community Involvement & Inter-sectoral Coordination

	Lalbandi	Basantapur	Sishuwa	Changunarayan	Jibjibe	Melamchi
Community Involvement						
Top 5 Diseases in the Community (By Community representatives	HTN, DM, TB, Kalaazar, Malaria	TB, Diarrheal Disease, Pneumonia, Typhoid, Skin Diseases	TB, Typhoid, Pneumonia, Respiratory Illness	TB, Diarrheal Diseases, Respiratory Problems, Wounds/Boils, Dysentery	Uterine Prolapse, Hydrocele/Hernia, Pneumonia, Bronchial Asthma, Jaundice	Arthritis (Hyperuricemia), HTN, DM, Diarrheal Diseases
Community Groups involved in Health	Women's Group	Women's Committee, Social Mobility Committee, Women's Savings Committee	Women's Group	Women's Group, Youth Group	Women's Group, Youth Group	Women's Group, Youth Group
Major Activities of the Groups	Health Education, Awareness and Counseling	Health Awareness and Communication, mobilization of resources, income generating projects, water supply projects, care for environment	Immunization, Health Awareness	First Aid, DOTS, Health Camps	Health Awareness, health camps, Water supply projects, Care for the environment	Health Camps, Health Awareness, Alcohol Prevention, Gender Issues, Domestic Violence
Community Contribution to HF		Materials and Buildings but from VDC with land contribution from Community	Materials and Buildings	No	Communal Labor, Financial resources, materials & buildings	No
Fund Support for the Community	government	Government	No	No	No	Occasionally from Community members
Feedback Mechanism by Community		Through the meeting, CSOs, Ward Representatives	Review of Complaints, Involvement of Community Representatives in Meetings	Direct in Person	Community representatives in Meetings	Representatives in meetings
Areas where HF Staffs could do more	If it could be upgraded to Hospital more people could take service	Continuous Doctor Service, Maternity Services, Addition of number of beds, Staff increment	Services are enough, however, maximum utilization of existing manpower			
Inter-Sectoral Coordination						
With Traditional Healers/Health Practitioners	Traditional healers refer pts to HF	No	No	Occasionally Pt referral by Traditional healers	Traditional healers (Ayurveda) - Pt referral	Occasional Pt referral by traditional healers

Non Public Health Providers	No, there are some organizations but they function on their own, some coordinate with DPHO	Yes with a NGO (Namuna) in TB Program	Yes with Community Hospital, Combined Service with ASHA Clinic for ORC (Vehicle)	Health camps Health Education by private/NGO	Yes Community Hospitals - Provide basic medicines	Yes, family planning camps, health camps

3.6 Inter-sectoral Coordination - District

Inter-sectoral Coordination and Collaboration - Health Sectors						
Traditional Healers/Ayurveda Practitioners	Yes	No	No	No	Yes	No
Activities with Traditional Healers	TB, Leprosy, Health Education	Reporting but not continuous			Meetings	
With Non Public Health Services	No	Yes	Yes	Yes	Yes	Yes
Activities with them		Health Programs, Camps	Preventive & promotive health service, monitoring, supervision	Immunization, Urban Health	Monthly meeting	Safe motherhood, TB
Non Public Sectors working in Health or Health Related Issues	Yes	Yes	Yes	Yes	Yes	Yes
Activities with them	FPAN - FP, Safe motherhood, Delivery incentive, NRCS - Disaster. BDS - AIDS. Chetana - FP,RH	AMDA- MCH, WVIN - Nutrition, SUAAHARA - Nutrition, NGOs - AIDS	NRCS - Disaster, WASH, ASRH. Nauloghumti - Promote coordinate gov activities	Submission of reports by almost all non public facilities	Red Cross, SUAAHARA, Eye Clinic - Camps, Events breast feeding, old age day, condom day	SUAAHARA - Nutrition, MDM - Safe Motherhood
Representation in the Committees in District						
Traditional Health Practitioners	No	No	Yes	No	Yes	Yes
Non Public Health Services	No	No	Yes	No	Yes	Yes

Inter-sectoral Coordination and Collaboration - Non Health Sectors						
Any Activities in Coordination/Collaboration						
Education System (DEO)	Yes	Yes	Yes	Yes	Yes	Yes
Agriculture and Animal Offices	Yes	Yes	Yes	No	No	Yes
Economic System (Banks Cooperatives)	No	No	No	No	No	No
Industry & Commerce	No	Yes	No	No	No	No
Administrative System (DAO, DDC, Security)	Yes	Yes	Yes	Yes	Yes	Yes
Physical Environment (DWSS)	No	No	Yes	Yes	Yes	Yes
NGOs	No	Yes	No	No	No	Yes
Representation in the Committees in District						
Education System (DEO)	Yes	Yes	Yes	Yes	Yes	Yes
Agriculture and Animal Offices	Yes	Yes	Yes	Yes	No	Yes
Economic System (Banks Cooperatives)	No	No	No	No	No	No
Industry & Commerce	No	No	No	No	No	No
Administrative System (DAO, DDC, Security)	Yes	Yes	Yes	Yes	Yes	Yes
Physical Environment (DWSS)	Yes	Yes	Yes	Yes	Yes	Yes
NGOs	No	No	No	No	No	No
Major Activities with Non Health Sectors	Education - School Health, Diff days celebration. Animal - Prevention and control of Zoonotic Diseases	Education System - School health, Agri/Animal - meetings/Discussion, Industry - joint monitoring, Admin - Close Coordination every activity, representation in committees	Education - Immunization, Dworming, School health. Agri/Ani - Malnutrition, Zoonotic Diseases, Influenza. Admin - MCH Clinic, Urban health	Education - School health, Immunization, Deworming. Admin - Urban health, Market Monitoring. Phy - WASH	school health, adolescent peer group, deworming, health camps with FNCCI, meetings with admin, water with DWSS	Education - School Health, TB awareness, Deworming. Agri - Nutrition, Behavior change, sustainable approach for food habit, env - sanitation, discussion on health & env impact of road n building

Annex 2 Questionnaire

1.1 District Questionnaire

Government of Nepal

Nepal Health Research Council, Ramshah Path, Kathmandu

District Questionnaire

"District Health Systems Assessment within an Inter-sectoral Context"

Information

We are a team of Nepal Health Research Council an autonomous body under Government of Nepal and we are here to conduct a study entitled "District health systems assessment within an inter-sectoral context". The **main objective** of this study is *to assess the functionality of the district health system within four major functions of health system that is stewardship (governance), financing, human and physical resources as well as organization and management.* At the same we aim *to explore the inter-sectoral coordination and collaboration occurring in the district among the different actors within the health sector as well as actors beyond health sector that may or would contribute to the health system*. To achieve these aims we would be using a set of questionnaires consisting some open as well as some close ended questions which we will use to conduct an interview with the chief of the D(P)HO or DHC. Furthermore, we also plan to conduct two focus group discussions with actors within the health sectors and beyond the health sector. In both the discussion we would want to have the members of D(P)HO. This assessment is purely for the research purpose. The findings will help the management team of your district to improve its efficiency in functionality and help the planners at the central level for future planning and policy making relevant to the health system of this district as well as other district. Furthermore, by knowing the status of ISC in the district and finding out the key areas where ISC could be important it would help the planners to plan for increased activities under ISC. However, we would like to assure that we are not here for any other purpose such as monitoring your work and assessing your individual efficiency. Your answers will remain anonymous and we will not use any of your identifications while reporting the findings as well as disseminating it in the future. We expect that you will fully cooperate us in achieving our objectives and spare out a time of around 60 to 90 minutes for completing the interview and also giving another hour for the discussion in the next day.

SECTION 1: BACKGROUND CHARACTERISTICS

1. District: Sarlahi☐ Bhaktapur ☐ Kaski ☐ Rashuwa☐Rupandehi ☐ Sindhupalchowk ☐
2. District demographic profile *(From Annual Report)*: Reference year:
   2.1 Number of households _____
   2.2 Number of women of child bearing age (15–49 years) _____
   2.3 Number of children under one year (0–11 months)_____
   2.4 Number of children under five years (0–59 months) _____
   2.5 Sex ratio (number of males/number of females) _____
   2.6 What percentage of the population of the district lives in:
      i. Rural areas _____ %
      ii. Urban areas _____ %
3. Is it possible to tell on the basis of the health management information system which five diseases had the highest consultation rates in the district public health facilities in the past calendar year?
   3.1 Yes ☐ If yes, please list the five diseases
   3.2 No ☐ If no, please continue with question 5
      i. _____
      ii. _____
      iii. _____
      iv. _____
      v. _____
4. List the five diseases that you believe have the heaviest burden on the communities in the district (*in order of importance). {The previous list is different in most cases, from the diseases in the community because people do not consult HF for all diseases}*
      i. _____
      ii. _____
      iii. _____
      iv. _____
      v. _____

SECTION 2: MANAGEMENT STRUCTURES

5. Fill in Table 1 with respect to District Health Management Structures. *(Ask for the organogram)*

Table 1

Characteristics	District Health Committee Yes No
1. Is the structure in place?	☐ ☐
2. Does it have guidelines on its functions and responsibilities?	☐ ☐
3. Have meetings been held in the past 12months? If yes, a) how many? b) how often?	☐ ☐ ---------- ----------
4. Are there records of these meetings? (i.e. minutes)	☐ ☐
5. Does the structure/D(P)HO have authority to make decisions on: ➢ District health plans? ➢ District health budget? ➢ Personnel e.g. posting or transfers? ➢ Purchase of drugs and other medical supplies?	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

6. Do the staff members of the D(P)HO have job descriptions?
   ☐ **Yes** (all members)
   ☐ **Yes** (some members)
   ☐ **No**

7. Are there any other committee's in place? **Yes** ☐ **No** ☐

If yes please list them.

_____

_____

8. Do you have citizen charter? **Yes** ☐ **No** ☐
9. If yes where is it placed? (Also observe)_____
10. How frequently do you have staff meeting?
    - 10.1 Twice a month
    - 10.2 Once a month
    - 10.3 Once in three months
    - 10.4 Once in six months
    - 10.5 Others_____
11. When did you have your last meeting? _____

SECTION 3: HEALTH AND HEALTH-RELATED RESOURCES FUNDING AND FINANCIAL MANAGEMENT

12. Is there a district health budget? **Yes** ☐ **No** ☐
13. Indicate the sources, the components and the amounts in the current district budget in Table 2 below: *(Use a copy of the budget of the past financial year to fill the table)*

    Which financial year do the data relate to? _____

Table 2

Source	**Specification of the budgeted amounts**						
	Provided funds		Recurrent costs (a)		Capital costs (b) *(costs for long term assets)*	Total costs (a+b)	% of total district funds
	Yes	No	Salaries	Operations			
Central government							
Local government							

NGOs							
Community							
Donors							
Other sources (specify)							
Budget Total							

14. Do you receive the funds that you are supposed to on time? **Yes** ☐ **No** ☐
15. Mention the pertinent or probable reasons for such kind of delay in fund transfer.

    _____

    _____

    _____
16. Do you share and discuss the budget with all the focal persons within the district? **Yes** ☐ **No** ☐
17. Did the DHC D(P)HO have a role in the allocation of funds to activities for the current financial year? **Yes** ☐ **No** ☐
18. Indicate which level of authority the district has in the use of its budget for each specified area.

		Full	**Partial**	**None**	**NA**
18.1	Paying staff salaries	☐	☐	☐	☐
18.2	Purchasing drugs	☐	☐	☐	☐
18.3	Purchasing other supplies such as linen, stationery, cleaning materials	☐	☐	☐	☐
18.4	Purchasing equipment	☐	☐	☐	☐
18.5	Repairing equipment	☐	☐	☐	☐
18.6	Maintaining buildings	☐	☐	☐	☐
18.7	Maintaining vehicles and motorcycles	☐	☐	☐	☐

19. Indicate whether the following financial monitoring systems are in use. (*Check on existence and actual use*).

	Existence		Actual use	
	Yes	**No**	**Yes**	**No**
Financial records	☐	☐	☐	☐
19.1 Accounting procedures	☐	☐	☐	☐
19.2 Financial reports	☐	☐	☐	☐
19.3 Periodic auditing visits	☐	☐	☐	☐

19.4 Others (please specify) _____

Cost Recovery

20. Do the public health facilities in the district charge fees for services? **Yes** ☐ **No** ☐

20.1 If yes, what proportion charges fees? **All** ☐ **Some** ☐

20.2 For which services do they charge fees?

_____

_____

Human Resources

21. Does the DHC / D(P)HO have an up-to-date overview of the personnel in the public health facilities in the district? **Yes** ☐ **No** ☐

21.1 Indicate for the three categories (DHO, hospitals, PHCs, HPs, SHPs) the types of personnel in the district, the number and type of personnel currently in post and the numbers required according to the establishment or staffing norms. Also include the degree of satisfaction according to the D(P)HO with the numbers currently provided for in the establishment for the whole district. (*Include health, administration and support personnel—provide information for all public health facilities*) *{Elaborate and probe, if deficient and unsatisfied then pertinent/probable reasons for that and note it.}*

	District Health Office			District Hospital			Other Hospitals		
Type of personnel	Number required according to establishment or norms	Number of personnel currently in post	Satisfaction with current establishment or norms*	Number required according to establishment or norms	Number of personnel currently in post	Satisfaction with current establishment or norms*	Number required according to establishment or norms	Number of personnel currently in post	Satisfaction with current establishment or norms*
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

* *Scale: Very Dissatisfied = 1; Dissatisfied = 2; Satisfied = 3; Very satisfied = 4; Undecided = X*

	District Health Office			District Hospital			Other Hospitals		
Type of personnel	Number required according to establishment or norms	Number of personnel currently in post	Satisfaction with current establishment or norms*	Number required according to establishment or norms	Number of personnel currently in post	Satisfaction with current establishment or norms*	Number required according to establishment or norms	Number of personnel currently in post	Satisfaction with current establishment or norms*
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									

	PHCC			HP			SHP		
Type of personnel	Number required according to establishment or norms	Number of personnel currently in post	Satisfaction with current establishment or norms*	Number required according to establishment or norms	Number of personnel currently in post	Satisfaction with current establishment or norms*	Number required according to establishment or norms	Number of personnel currently in post	Satisfaction with current establishment or norms
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

* *Scale: Very Dissatisfied = 1; Dissatisfied = 2; Satisfied = 3; Very satisfied = 4; Undecided = X*

22. Indicate whether the following exist in the district and the degree of satisfaction with the current situation according to the D(P)HO.

		Exists for: Degree of satisfaction*		
		All	**Some**	**None**
22.1	Job descriptions	☐	☐	☐
22.2	Staff rotation systems	☐	☐	☐
22.3	Training plan	☐	☐	☐
22.4	Career plans	☐	☐	☐
22.5	Housing for personnel	☐	☐	☐
22.6	Incentives	☐	☐	☐

23. What are the probable/pertinent reasons for the deficient number of staffs?

_____

_____

24. In your opinion how could we improve the retention of the health personnel in these areas?

_____

_____

25. In the last year for how long were you out of the office? *(Also observe the attendance)*_____

26. Please list the major reasons in that year for not being in the office.

_____

_____

27. Generally in a day how many hours do you spend in office?_____

28. For what activities do you use those hours not spending in the office?

_____

_____

Infrastructure, Equipment and Supplies

29. Is the currently available space sufficient? **Yes** ☐ **No** ☐

30. If no, for what purpose the space is not enough?_____

31. If not is there any process/plan for new construction or hiring new place?

Yes ☐ **No** ☐

32. Indicate the adequacy of the following physical conditions in the public health facilities in the district according to the interview team.

Characteristics	District Hospitals		PHCs		HPs		SHPs	
	Yes	No	Yes	No	Yes	No	Yes	No
Lighting	☐	☐	☐	☐	☐	☐	☐	☐
Sanitation Facilities	☐	☐	☐	☐	☐	☐	☐	☐
Water	☐	☐	☐	☐	☐	☐	☐	☐
Ventilation	☐	☐	☐	☐	☐	☐	☐	☐
Cleanliness	☐	☐	☐	☐	☐	☐	☐	☐
Space	☐	☐	☐	☐	☐	☐	☐	☐
Refrigeration of vaccines	☐	☐	☐	☐	☐	☐	☐	☐

33. Indicate the percentages of public health facilities in the district that use the following means for their communication with the district health office. (*For all facilities in the district; **fill in 0** if the communication means is not used at all. If the information is unavailable tick the box under DNK)*.

		Percentage of facilities	DNK
33.1	Telephone (in health facility)	|_|_|_|%	☐
33.2	Telephone (elsewhere, e.g. police, public phone)	|_|_|_|%	☐
33.3	Mail sent through postal system	|_|_|_|%	☐
33.4	Mail sent through ad hoc messengers	|_|_|_|%	☐
33.5	Radio (elsewhere, e.g. police)	|_|_|_|%	☐
33.6	Personal Mobile	|_|_|_|%	☐
33.7	Others (specify)	|_|_|_|%	☐

34. If they use public phone or mobile, is there a mechanism of cost reimbursement?

Yes ☐ **No** ☐

35. Does the district have adequate transportation for:

		Yes	No
33.1	The district health management team (to carry out supervision, provision of supplies etc.)?	☐	☐
33.2	Health facilities to provide outreach services?	☐	☐
33.3	Transfer of emergency cases?	☐	☐

36. Does the district have sufficient resources to maintain its transportation? ☐ ☐

37. Do district store management procedures include the use of ledgers, asset registers, inventory, bin-cards, etc? **Yes** ☐ **No** ☐ **N.A** ☐

38. Are there any difficulties in store management procedures? **Yes** ☐ **No** ☐

39. If yes please list them _____

SECTION 4: MANAGERIAL PROCESSES

Planning

40. Does the district have a district health plan? *(It should be indicated whether the district has an approved health plan to guide the implementation of district activities)*

Yes ☐ **No** ☐

40.1 If yes, what period does the plan cover? From: __ /__ / ___ To: __ / __ / ___

40.2 Is the plan being implemented? ☐ ☐

40.3 If no, give the reasons why.

_____

41. Who have been involved in the development of the plan?	**Yes**	**No**	**N.A.***
41.1 District Development Committee / Local government	☐	☐	☐
41.2 District Health Committee	☐	☐	☐
41.3 Staff of health facilities	☐	☐	☐
41.4 Representative(s) of non-public health facilities	☐	☐	☐
41.5 Representative(s) of community organizations/groups	☐	☐	☐
41.6 NGOs	☐	☐	☐
41.7 Donors	☐	☐	☐
41.8 Ministry of Health & Population, MoHP (Central level)	☐	☐	☐
41.9 Department of Health Services, DoHS (Central level)	☐	☐	☐
41.10 Regional Health Directorate, RHD (Regional level)	☐	☐	☐

41.11 Others, please specify: _____

42. What role has the central level (MoHP, DoHS or RHD) played in the development of the plan?	**Yes**	**No**	**N.A.**
42.1 Initiated the development of the plan	☐	☐	☐
42.2 Developed the plan	☐	☐	☐
42.3 Provided advice on the development of the plan	☐	☐	☐

42.4 Allocated budget to activities ☐ ☐ ☐

42.5 Other, please specify:_____

43. Does the health plan include monitoring and evaluation of its implementation?

Yes ☐ No ☐

44. If yes, does the plan specify who will be responsible for the monitoring and evaluation?

Yes ☐ No ☐

45. How many facilities in the district have health plans? _____

Drug Management

46. Indicate whether a list of essential drugs for the various types of health facilities is available in the district:

		Yes	**No**
46.1	Hospitals	☐	☐
46.2	PHCCs	☐	☐
46.3	HPs	☐	☐
46.4	SHPs	☐	☐

47. Do any of the HFs in the district receive drugs from any other sources besides district? **Yes** ☐ **No** ☐ **N.A.** ☐

47.1 If yes list the sources for that

_____

_____

_____

48. Do any of the HFs in the district purchase drugs on their own?

48.1 If yes what percentage do so? _ _ %

48.2 What are the major sources of money for that?

_____

_____

Health Management Information System and Research	**Yes**	**No**
49. Does the D/PHO have a district health map?	☐	☐
If yes, does it contain up-to-date information on the following?		
49.1 Location of public health facilities	☐	☐
49.2 Location of private health facilities	☐	☐
49.3 Catchment population of health facilities	☐	☐

50. Do you know how many health facilities in the district have submitted all health information reports for the past year? **Yes** ☐ **No** ☐ **N.A.** ☐

50.1 If yes, please indicate the number. |_|_|

51. Is health information system data received from the health facilities being analyzed *(for disease trends and trends of HF utilization)* by the district health management team?

Yes ☐ **No** ☐

51.1 If, yes how is the information used?

_____

52. Does the district level provide feedback to the health facilities in response to reports and forms submitted by them? **Yes** ☐ **No** ☐

53. Is there a method of verification of the HMIS reports sent by the HFs?

53.1 If yes how is it done?_____

54. Are health activity monitoring mechanisms such as charts or diagrams showing recent health achievements in the district being made? **Yes** ☐ **No** ☐

54.1 If yes, are such charts and diagrams made available to health facilities in the district? ☐ ☐

55. Have health systems research household surveys or other operational studies been carried out in the district? **Yes** ☐ **No** ☐

55.1 If yes, please give examples of studies carried out recently:

_____

Public Health Initiatives

56. Have the district launched any new public health interventions in the recent past (*within 5 years*) **Yes** ☐ **No** ☐

56.1 If yes please list the interventions/special programs launched with area of focus (*use additional sheet if necessary*)

_____

57. Are any non public organizations (I/NGOs, Bilateral agencies etc) running special public health programs for the district currently or within 5 years **Yes** ☐ **No** ☐

57.1 If yes please list the interventions/special programs launched with area of focus (*use additional sheet if necessary*)

_____

_____

Community Involvement

58. Are there community development groups operating in the district? **Yes** ☐ **No** ☐
(*E.g. community-based organizations, village or town committees, women's or youth committees*)

58.1 If yes, list the groups that are involved in health issues:

_____

_____

	Yes All	**Yes Some**	**No**
58.2 Are there guidelines on their relationship with the district health structures?	☐	☐	☐

58.3 If yes, what major issues do these guidelines cover:

_____

	Yes	**No**	**N.A.**
59. Are women's groups involved in health activities/issues?	☐	☐	☐
60. Are youth groups involved in health activities/issues?	☐	☐	☐
61. Indicate whether the community structures in the district carry out community activities such as:	**Yes**	**No**	**N.A.**
61.1 Health or health-related projects	☐	☐	☐
61.2 Mobilization of resources for health	☐	☐	☐
61.3 Income generating projects	☐	☐	☐
61.4 Water supply	☐	☐	☐
61.5 Care for the environment	☐	☐	☐
61.6 Others_____			

62. Have any communities contributed the following resources to public health facilities within the district in the past three years? *(Tick DNK for 'do not know').*

	Yes for Most Facilities	**Yes for some facilities**	**No**	**DNK**
62.1 Human resources (e.g. through communal labour or payment of staff salaries)	☐	☐	☐	☐
62.2 Financial resources (e.g. donations, gifts)	☐	☐	☐	☐
62.3 Materials or buildings	☐	☐	☐	☐

63. Indicate whether the community groups identified in question 49, have received funds from the following sources in the past year

	Yes	No	DNK
63.1 Government	☐	☐	☐
63.2 NGO	☐	☐	☐
63.3 Community members	☐	☐	☐
63.4 Other donors	☐	☐	☐

64. Does the community have access to the following mechanisms for giving feedback to the health staff in the district on the quality and relevance of health services provided?

	Yes	No
64.1 Suggestion box	☐	☐
64.2 Review of complaints	☐	☐
64.3 Involvement of community representatives in meetings	☐	☐
64.4 User satisfaction survey	☐	☐

64.5 Other, specify: _____

SECTION 5: INTERSECTORAL COORDINATION & COLLABORATION

Coordination and Collaboration with other ACTORS in the Health System

	Yes	No	N.A.
65. Do DHC/D(P)HO and traditional health (Ayurveda) Practitioners in the district undertake collaborative activities?	☐	☐	☐

65.1 If yes, list some of these activities?

_____

_____

65.2 Are the traditional health practitioners represented in the District Health Committee? **Yes** ☐ **No** ☐

66. Does the D(P)HO undertake collaborative activities with the non-public health services (e.g. private, mission, or NGO owned) in the district? **Yes** ☐ **No** ☐

66.1 If yes, list some of these activities?

_____

_____

66.2 Are the non-public health facilities represented on the District Health Committee D(P)HO? **Yes** ☐ **No** ☐

67. What collaborative activities with the traditional health practitioners in the district are in place?

	All	Some	None
67.1 Agreements on referral of patients with defined conditions	☐	☐	☐

67.2 Submission of reports for the health information system ☐ ☐ ☐

67.3 Notification of cases of specific diseases (e.g. polio, cholera etc.) ☐ ☐ ☐

67.4 Other, specify _____

68. What collaborative activities with the non-public health facilities in the district are in place? **All Some None**

68.1 Agreements on referral of patients with defined conditions ☐ ☐ ☐

68.2 Submission of reports for the health information system ☐ ☐ ☐

68.3 Notification of cases of specific diseases (e.g. polio, cholera etc.) ☐ ☐ ☐

68.4 Other, specify _____

69. Is there any collaboration and/or coordination with non public sectors (Private, NGOs, CBOs etc.) working in the sector of health and health related issues **Yes** ☐ **No** ☐

If yes list the organizations that the D(P)HO collaborates with area of collaboration and/or coordination *(Also explore for any other health care system)*

	Organizations	Collaborative Activities
i.	_____	_____
ii.	_____	_____
iii.	_____	_____
iv.	_____	_____
v.	_____	_____
vi.	_____	_____
vii.	_____	_____
viii.	_____	_____
ix.	_____	_____
x.	_____	_____

Collaboration with other ACTORS in the System besides Health

70. Do D(P)HO teams and non health sectors in the district undertake collaborative activities? **Yes** ☐ **No** ☐

71. Does the D(P)HO conduct activities in coordination and/or collaboration with the following sectors? **Yes No N.A.***

71.1 Education System (DEO, PABSON) ☐ ☐ ☐

a. If yes please list some of the activities

_____

_____

b. Is there any representative from the DEO in the D(P)HO? ☐ ☐ ☐

71.2 Agriculture & Animal Husbandry (DAgO, DAHO) ☐ ☐ ☐

a. If yes please list some of the activities

_____

_____

b. Is there any representative from the DEO in the D(P)HO? ☐ ☐ ☐

71.3 Economic System (Banks & Cooperatives) ☐ ☐ ☐

a.If yes, please list some of the activities

_____

b.Is there any representative from these organizations in the D(P)HO? ☐ ☐ ☐

71.4Industry & Commerce (Food, Tobacco etc) ☐ ☐ ☐

a. If yes, please list some of the activities

_____

_____

b. Is there any representative from these organizations in the D(P)HO? ☐ ☐ ☐

71.5Political/Policy System (DAO, Security Systems, VDCs, Municipalie☐ ☐

a. If yes, please list some of the activities

_____

_____

b. Is there any representative from these organizations in the D(P)HO? ☐ ☐ ☐

71.6Physical Environment System (DWSS, DoTM, DUDBC) ☐ ☐ ☐

a. If yes, please list some of the activities

_____

_____

b. Is there any representative from these organizations in the D(P)HO? ☐ ☐ ☐

71.7NGOs, Unilateral & Bilateral Agencies ☐ ☐ ☐

a. If yes, please list some of the activities

_____

_____

b. Is there any representative from these organizations in the D(P)HO? ☐ ☐ ☐

71.8 Others, please specify:

_____

72 What collaborative activities with the non health sectors in the district are in place?
(Explore, elaborate, probe on special programs if found existing in terms of components)

	All	**Some**	**None**
72.1 Agreements on joint development of programs that directly or indirectly affect health	☐	☐	☐
72.2 Discussion meetings on issues of health & environment impacts of building & road construction	☐	☐	☐
72.3 Agreements on school health activities	☐	☐	☐
72.4 Discussion meetings on incorporation of health matters in education curricula	☐	☐	☐
72.5 Joint activities in prevention and control of zoonotic diseases with DAHO	☐	☐	☐
72.6 Joint activities in prevention of occupation health hazards with DAgO	☐	☐	☐

72.7 Others, specify _____

Comments of the Assessment team

_____

_____

_____

_____

_____

_____

Thank You for your Co-operation!

1.2 HF Questionnaire

Government of Nepal

Nepal Health Research Council, Ramshah Path, Kathmandu

HF (PHC) Questionnaire

"District Health Systems Assessment within an Inter-sectoral Context"

Information

We are a team of Nepal Health Research Council an autonomous body under Government of Nepal and we are here to conduct a study entitled "District health systems assessment within an inter-sectoral context". The **main objective** of this study is *to assess the functionality of the district health system within four major functions of health system that is stewardship (governance), financing, human and physical resources as well as organization and management.* At the same we aim *to explore the inter-sectoral coordination and collaboration occurring in the district among the different actors within the health sector as well as actors beyond health sector* that may or would contribute to the health system. To achieve these aims we would be using a set of questionnaires consisting some open as well as some close ended questions which we will use to conduct an interview with the chief of the D(P)HO or DHC. Furthermore, we also plan to conduct two focus group discussions with actors within the health sectors and beyond the health sector. In both the discussion we would want to have the members of DHC. This assessment is purely for the research purpose. The findings will help the management team of your district to improve its efficiency in functionality and help the planners at the central level for future planning and policy making relevant to the health system of this district as well as other district. Furthermore, by knowing the status of ISC in the district and finding out the key areas where ISC could be important it would help the planners to plan for increased activities under ISC. However, we would like to assure that we are not here for any other purpose such as monitoring your work and assessing your individual efficiency. Your answers will remain anonymous and we will not use any of your identifications while reporting the findings as well as disseminating it in the future. We expect that you will fully cooperate us in achieving our objectives and spare out a time of around 60 to 90 minutes for completing the interview and also giving another hour for the discussion in the next day.

SECTION 1: BACKGROUND CHARACTERISTICS

1. District: Sarlahi ☐ Bhaktapur ☐ Kaski ☐ Rashuwa ☐ Rupandehi ☐ Sindhupalchowk ☐
2. Name of health facility: _____
3. Demographic profile of the catchment population: Reference year_____

   3.1 Population in the catchment area |_|_|_|_|_|_|_|_|___

   3.2 Number of women of child bearing age (15–49 years) |_|_|_|_|_|_|_|_|___

   3.3 Number of children under one year (0–11 months) |_|_|_|_|_|_|_|_|___

   3.4 Number of children under five years (0–59 months) |_|_|_|_|_|_|_|_|___

   3.5 What percentage of the catchment population lives in:

   Rural areas _____ % Urban areas _____ % ___

4. In Table 1 below, list, in order of frequency of use, the means of transport commonly used by the

communities in the catchment area to access health services. Then complete the rest of the table.

Table 1

Means of transport	Available all year round?		If no, for how long is it not available? (number of weeks per year)
_____	Yes	No	_____
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____

5. Are any parts of your catchment area inaccessible from the health facility, such as for outreach services, for one week or more in a year? (Inaccessibility means that the area cannot be reached by any available means of transport).

Yes ☐ If yes, please continue with question 6.1.

No ☐ If no, please go to question 7.

5.1 List the main villages or areas affected and the number of weeks per year that they are inaccessible:

Geographical area	Reason for inaccessibility	Period of the year	Number of weeks per year
a. _____	_____	_____	_____
b. _____	_____	_____	_____
c. _____	_____	_____	_____
d. _____	_____	_____	_____

6. What are the five diseases that had the highest consultation rates in the facility in the past calendar year? (List them in the order of the number of consultations according to the health management information system).

   6.1 _____ 6.4 _____

   6.2 _____ 6.5 _____

   6.3 _____

7. In your opinion, what are the most prevalent diseases/conditions within the communities in the catchment area? (Question to be addressed to health facility personnel. Record in order of importance). *(probing required)*

   7.1 _____ 7.4 _____

   7.2 _____ 7.5 _____

   7.3 _____

SECTION 2: MANAGEMENT STRUCTURES

8. Does this HF have a Health Facility Operational Management Committee (HFOMC)? **Yes** ☐ **No** ☐
9. Does it have guidelines on its functions and responsibilities**?**
   i. **Yes** (for all members) ☐
   ii. **Yes** (for some members) ☐
   iii. No ☐
10. How many members are there in the HFOMC? _____ ☐ ☐
11. Has the HFOMC members been oriented about their roles and responsibilities?
    11.1 **Yes** (all members) ☐
    11.2 **Yes** (some members) ☐
    11.3 **No** ☐
12. When was the last time majority of the HFOMC members oriented? _____
13. Do the members of the HFOMC understand their roles and responsibility?
    13.1 **Yes** (all members) ☐
    13.2 **Yes** (some members) ☐

13.3 **Yes** (Majority) ☐
13.4 **No** ☐

14 Do HFOMC members such as marginalized, dalit, women and other sectors people generally participate in the meetings?

14.1 **Yes** (all members) ☐
14.2 **Yes** (some members) ☐
14.3 **No** ☐

15 Do HFOMC members such as marginalized, dalit, women and other sectors people generally actively participate in the decision making process?

15.1 **Yes** (all members) ☐
15.2 **Yes** (some members) ☐
15.3 **No** ☐

16 How frequently does the committee meet?

16.1 Once a month ☐
16.2 Once every 3 months ☐
16.3 Twice a year ☐
16.4 Others (specify)_____

17 Have meetings been held in the past 12 months? **Yes** ☐ **No** ☐

17.1 If yes, how many? _____

18 Are there records of these meetings? (i.e. minutes) **Yes** ☐ **No** ☐

i. Is the minute available for the most recent meeting of HFOMC?
ii. If available, do the minutes from the first meeting have any reference to the agreed action points of the last meeting?

19 When did the committee meet last time? _____

20 What have been the main actions taken by the HFOMC over the last year? Please list

_____

_____

21 Did the annual progress report include information on the HFOMC? **Yes** ☐ **No** ☐

22 Has the HFOMC recruited any local health personnel? **Yes** ☐ ☐**No**

23 If not, have any meetings been held to transfer authority and responsibility to the HFOMC for health personnel recruitmen☐**Yes** ☐**No**

24 In your opinion, what are the functions of the HFOMC?

(This question should be addressed to the personnel of the health facility and recorded without additions from the assessment team).

_____

_____

_____

25 In your opinion, what are the functions of the District Health Committee or D/PHO management team?

(This question should be addressed to the health facility personnel and recorded without additions from the assessment team).

_____

_____

_____

26 Are there any committees at facility level other than HFOMC? ☐ **Yes** ☐ **No**

If yes please name them _____

_____

27 Do you have citizen charter in the facility?

i. Where is this citizen charter placed? *(also observe)*_____

ii. Has the citizen charter been updated to include free drugs, Aama, gender based violence and outpatient? ☐ **Yes** ☐ **No**

iii. If yes please list the name of updated information

_____

28 Does the health facility disclose the statement of expenditure to the general public?

Yes ☐ **No** ☐

How frequently is this information disclosed?

28.1 Once a year ☐

28.2 Once every two years ☐

28.3 Others (specify)_____

29 When was a social audit undertaken in this facility? Please mention (mm/year) _____

29.1 Were findings from the social audit disseminated? **Yes** ☐ **No** ☐

30 Do you discuss the plan, policy among the members? **Yes** ☐ **No** ☐

30.1 If not what are the reasons for that? _____

31 How frequently do you have staff meeting?

31.1 Twice a month ☐

31.2 Once a month ☐

31.3 Once every 3 months ☐

31.4 Others (specify)_____

31.1 When did you have your last staff meeting? Please mention (dd/mm/year) _____

SECTION 3: HEALTH AND HEALTH-RELATED RESOURCES FUNDING AND FINANCIAL MANAGEMENT

32 Does this facility have any income source at this level? **Yes** ☐ **No** ☐

32.1 If yes, indicate the sources, the components and the amounts in the current facility budget in the following table*. (probe on what happens to remaining money)*

Sources	Average Monthly income	Expenditure	Expenditure components

33 In the current fiscal year, have you received fund from the government office for health and health related matters? **Yes** ☐ **No** ☐

34 Do you receive the funds that you are supposed to on time? **Yes** ☐ **No** ☐

i. Mention the pertinent or probable reasons for any delay in fund transfer.

_____

ii. If this PHC didn't receive the full amount as it was requested for its first and second trimester, please mention the pertinent or probable reasons for such kind of fund cut off.

_____

35 Indicate the level of authority the health facility has in the use of its budget for each specified area.

		Full	Partial	None	NA
i.	Paying staff salaries	☐	☐	☐	☐
ii.	Purchasing drugs	☐	☐	☐	☐
iii.	Purchasing other supplies such as linen, stationery and cleaning materials	☐	☐	☐	☐
iv.	Purchasing equipment	☐	☐	☐	☐
v.	Repairing equipment	☐	☐	☐	☐
vi.	Maintaining buildings	☐	☐	☐	☐
vii.	Maintaining vehicles	☐	☐	☐	☐
viii.	Others (specify)_____				

Cost Recovery

36 Does your health facility charge fees for its services? **Yes** ☐ **No** ☐

36.1 If yes, for which services? _____

37 Is there a mechanism for payment exemption in the facility for those who cannot afford the fees? Yes ☐ No ☐ N.A. ☐

ii. If yes, describe the mechanism(s) in place (e.g. who are exempted from payment and who decides who should be exempted).

_____

Human Resources

38 List the posts of all personnel working in the health facility (for posts where personnel are not working full-time, indicate the proportion of time required e.g. 0.5 for half the time required), the number of personnel needed according to the establishment and the degree of satisfaction that the personnel have with the numbers provided for in the establishment. (*Probe for the reasons for satisfaction and dissatisfaction)*

Post	Number required according to establishment or norms	Number of personnel currently in post	Satisfaction with the establishment*
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			

***** *Scale: Very Dissatisfied = 1; Dissatisfied = 2; Satisfied = 3; Very satisfied = 4; Undecided = X*

39 Indicate whether the following exist for the personnel in the facility and the degree of satisfaction

of the personnel with the current situation.	**Exist for:**			**Degree of satisfaction***
	All	**Some**	**None**	
i. Job descriptions	☐	☐	☐	_____
ii. Rotation systems	☐	☐	☐	_____
iii. Training plans	☐	☐	☐	_____
iv. Career plans	☐	☐	☐	_____
v. Housing for personnel	☐	☐	☐	_____
vi. Incentives	☐	☐	☐	_____

***** *Scale: Very Dissatisfied = 1; Dissatisfied = 2; Satisfied = 3; Very satisfied = 4; Undecided = X*

40 Does this facility have any staff recruited by the HFOMC?

i. If yes how many?

ii. Please list them with the categories

_____
_____
_____
_____

41 In addition to the above recorded staffs, please list any other staffs/health service providers who are not officially assigned to this facility but work here routinely providing client services since last quarter of the year?

_____
_____
_____
_____

42 What are the usual hours of opening and closing for this facility? Please mention_____

43 Are there trained health workers present at the facility at all the times (24 hours a day) for emergencies? **Yes** ☐ **No** ☐

44 What types of trained worker are always present (24 hours a day) for emergencies? Please mention _____

45 Is there a trained health worker available away from the facility but officially on call at all the times outside of opening hours?

i. Yes (always) ☐
ii. Yes (sometimes) ☐
iii. No ☐

Infrastructure, Equipment and Supplies

46 What is the status of this building?

i Government owned ☐
ii VDC owned ☐
iii Community owned ☐
iv On rent ☐
v Others (specify)_____

46.1 Is the available space sufficient? **Yes** ☐ **No** ☐

46.2 If no, have you requested or planning for new construction or renting some other building or space? **Yes** ☐ **No** ☐

47 Does this facility have any beds for overnight stays? **Yes** ☐ **No** ☐

i. How many beds have been approved for this health institution? Please mention in number ___

ii. How many beds are functional in this health institution? Please mention in number ____

48 Is there accommodation available for non local staffs? **Yes** ☐ **No** ☐

48.1 If yes where is it located?

i Inside HF ☐
ii Within 5 minutes walk ☐
iii Within 30 minutes walk ☐
iv Others (specify)_____

49 Is continuous electricity available through out? **Yes** ☐ **No** ☐

49.1 If not for how many hours a day is it interrupted (load shedding)? Mention (hrs)_____

49.2 What is your back up source of power for when your main source of electricity is unavailable?

i Generator ☐
ii Battery/UPS ☐
iii Others (specify)_____

49.3 Is there any availability of renewable energy sources at the facility such as bio gas or solar power etc? **Yes** ☐ **No** ☐

49.4 Is the available lighting sufficient? **Yes** ☐ **No** ☐

49.5 Is there a provision of gas/other heater for winter days? **Yes** ☐ **No** ☐

49.6 Does it have continuous availability of the fuel (gas/kerosene)? **Yes** ☐ **No** ☐

50 What is the most commonly used source of water for the facility?

i. Piped supply in the facility ☐
ii. Public tap/tubewell ☐
iii. Others (specify)_____

50.1 How much time does it take to reach the nearest water outlet from the health institution? Mention in minutes_____

50.2 Do you have hand wash basins for the staffs? **Yes** ☐ **No** ☐

50.3 Do you have separate toilet/latrine available for staff use? (if not probe) **Yes** ☐ **No** ☐

51 Is there a waiting area/space for patients where they are protected from sun and rain?
Yes ☐ **No** ☐

52 Is there a toilet or latrine in functioning condition that is available for patient use?
Yes ☐ **No** ☐

52.1 Is there a separate latrine for women? **Yes** ☐ **No** ☐

53 Does the facility have a functioning phone that can be used by staff to receive emergency calls?
Yes ☐ **No** ☐

53.1 Is the phone available out of office hours? **Yes** ☐ **No** ☐

54 Does this facility have an ambulance or vehicle for emergency transport for patients?
Yes ☐ **No** ☐

55 Does this facility have vehicle for providing outreach services? **Yes** ☐ **No** ☐

55.1 Are these vehicles functional? **Yes** ☐ **No** ☐

55.2 Does the health facility have adequate resources to maintain their transportation?

Yes ☐ **No** ☐

56 Is there a refrigerator available? **Yes** ☐ **No** ☐

56.1 If yes, does the fridge have a guaranteed power supply for 24 hours? **Yes** ☐ **No** ☐

57 Does the health facility have a standard list of equipment that should be available in your facility according to the established norm? **Yes** ☐ **No** ☐

58 Does the health facility use store management procedures such as ledgers, asset registers, inventory, bin-cards, etc? **Yes** ☐ **No** ☐

58.1 If yes who manages this?_____

59 Does the health facility have the following for disposal of medical waste such as used needles, syringes, bottles, expired drugs etc:

		Yes	**No**	**N.A.**
59.1	Guidelines	☐	☐	☐
	If yes, are they used?	☐	☐	☐
59.2	Resources	☐	☐	☐
	If yes, are they adequate?	☐	☐	☐

59.3 How are these waste managed?_____

60 Indicate the degree of satisfaction with the availability of the following resources in the facility (According to the facility personnel):

		Degree of satisfaction*
60.1.	Basic equipment	|_|
60.2.	Stationery	|_|
60.3	Linen	|_|
60.4.	Cleaning materials	|_|

**Scale: Very Dissatisfied-1, Dissatisfied-2, Satisfied-3, Very satisfied-4, Undecided-X*

SECTION 4: MANAGERIAL PROCESSES

Planning

61 Does the facility have a plan of action in place? **Yes** ☐ **No** ☐

61.1 If yes, what period does the plan cover? From: ___ / __ / __ To: ___ / __ / __

61.2 Is the plan being implemented? **Yes** ☐ **No** ☐

If no, why not? _____

61.3 Were the following involved in the development of the plan?

	Yes	**No**	**N.A.***
i. Staff of the health facility	☐	☐	☐
ii. Village Development Committee	☐	☐	☐
iii. District Health Management Team	☐	☐	☐
iv. Representatives of community organizations/groups	☐	☐	☐
v. Members of the health facility			
vi. Others, please specify: _____			

*N.A. = not applicable

Guidelines, Standards and Norms

62 Indicate whether guidelines on the following issues are available and in use by staff in the health facility:

	Available		**In use**	
	Yes	**No**	**Yes**	**No**
i. How to run an immunization session	☐	☐	☐	☐
ii. Family planning provision	☐	☐	☐	☐
iii. How to manage a child with diarrhea	☐	☐	☐	☐
iv. How to manage a child with fever	☐	☐	☐	☐
v. Referral of obstetrical emergencies	☐	☐	☐	☐
vi. Indicate other guidelines in use:_____				

Supervision and Monitoring

63 Are the following documents available in your health facility to the DHC / D(P)HO team during supervision?

	Yes	**No**
i. Supervision checklist	☐	☐
ii. Supervision plan or schedule	☐	☐
iii. Reports of past supervision visits	☐	☐

64 How many supervisory visits were carried out at your health facility in the past 6 months by the DHC / D(P)HO team? |_|_|

Yes	**No**	**N.A.**
☐	☐	☐

i. Have changes been made as a result of these visits?
ii. If yes, give some recent examples:

_____

_____

iii. How many supervisory visits were carried out at your health facility in the past 6 months by other groups? |_|_|
iv. Who carried out these visits? _____

Drug Management

65 Do you have a list of essential drugs for your facility? **Yes** ☐ **No** ☐ **N.A** ☐

Indicate whether the drugs for the facility, in part or in full, are received/purchased from the following sources:

i.	Government drug or medical stores in the district	☐	☐	☐
ii.	Government regional drug or medical stores	☐	☐	☐
iii.	Private drug wholesaler in the district	☐	☐	☐
iv.	Private drug wholesaler elsewhere	☐	☐	☐
v.	NGO or other not for profit association	☐	☐	☐

66 For each of the five diseases listed under question 6, indicate the most frequently prescribed drug(s) and the number of days that they were unavailable in the health facility in the 3 months prior to the assessment. (Check in the tally sheets).

	Disease	**Name of drug**	**No. of days unavailable**
66.1a	_____	_____	|_|_|
66.1b	_____	_____	|_|_|
66.1c	_____	_____	|_|_|
66.2a	_____	_____	|_|_|
66.2b	_____	_____	|_|_|
66.2c	_____	_____	|_|_|
66.3a	_____	_____	|_|_|
66.3b	_____	_____	|_|_|
66.3c	_____	_____	|_|_|
66.4a	_____	_____	|_|_|
66.4b	_____	_____	|_|_|
66.4c	_____	_____	|_|_|
66.5a	_____	_____	|_|_|

66.5b _____ _____ |_|_|

66.5c _____ _____ |_|_|

66.6 If some drugs were not available, what were the reasons?

_____

67 Indicate whether the population can buy (or obtain) drugs in the catchment area of the facility from
the following: *(Observe and note if there is a private pharmacy in the compound)*

		Yes	No	N.A.
i.	Public health facility	☐	☐	☐
ii.	Not for profit hospital or clinic (e.g. mission, NGO)	☐	☐	☐
iii.	Private drug vendor(s) or pharmacy	☐	☐	☐
iv.	Other sources (please specify) _____			

Referral Mechanisms

68 What mechanisms does the health facility staff use to refer patients to other health facilities?

		Yes	No	N.A.
i.	Referral notes (from a lower to a higher level)	☐	☐	☐
ii.	Referral feedback reports (back to lower level)	☐	☐	☐
iii.	Ambulance systems	☐	☐	☐
iv.	Communication systems (e.g. radio call, telephone, etc.)	☐	☐	☐
v.	Exemption from payment on showing referral note	☐	☐	☐
vi.	Other mechanism(s) in place (please specify):			

_____

	Yes	Sometimes	No
69 Do you receive referral reports when patients are referred back to you?	☐	☐	☐

Health Management Information System

	Yes	No
70 Have you submitted all health statistics reports in the past 12 months?	☐	☐
i. Have you had any shortages of health statistics forms in the past 12 months?	☐	☐
ii. Were there other constraints to the preparation and submission of these report	☐	☐

iii. If yes, please describe the main constraints for submitting these reports:

_____

_____

v.	Do you keep copies of the health statistics reports you submit?	☐	☐
vi.	Are health statistics being analyzed by the staff of the facility? (E.g. comparing the figures over time)	☐	☐

If yes, give examples:

_____

(graphs, charts, etc.)

_____

vii. Are health statistics used by the staff of the facility? **Yes** ☐ **No** ☐

If yes, give examples: _____

71 Is there a verification mechanism in place for the HMIS data reported? **Yes** ☐ **No** ☐

If yes, How is it done?_____

72 Have you received any feedback from the district level (such as reports, graphs, comparisons with statistics from other facilities) in response to reports or forms that were submitted in the past 12 months? **Yes** ☐ **No** ☐ **N.A.** ☐

If yes, give examples: _____

SECTION 4: PRIORITY HEALTH ACTIVITIES

73 Please fill in Tables 72.1 to 72.5 based on information provided.

73.1 Indicate the public health interventions being undertaken by the health facility, whether

they should be undertaken at this level according to the health service norms (e.g. a defined health package), any constraints faced in their implementation, and the reasoning behind their initiation or lack thereof.

SN	Public Health Intervention	Undertaken (Y/N)	Should it be undertaken at this level (Y/N)	Constraints faced in implementation	Reasoning behind action or inaction at this level
1.	Information and education for health				
		Basic Immunizations			
2.	NIP				
3.	National Polio Immunization Days				
4.	Others (Specify)				
		Reproductive Health			
5.	Family Planning				
6.	Antenatal Care				
7	Assisted Deliveries				
8	Postnatal Care				
9	Adolescent Sexual Health				
		Diseases Prevention and Control			
10	Malaria				
11	Tuberculosis				
12	Leprosy				
13	HIV/AIDS				
14	Other STIs				
15	Mental Disorders				
16	Diabetes Mellitus				

17	Hypertension				
18	Malnutrition				
19	Diarrheal Disease				
20	Kalaazar				
21	Dengue				
22	Japanese Encephalitis				
23	Rabies				
24	Snakebite				
25	Others (specify, use extra space if more)				

73.2 Indicate the diseases that are being treated at the health facility, whether they should be treated at this level according to the norm (e.g. the local minimum health package), any constraints faced and the reasoning behind unexpected treatment or lack thereof.

SN	**Treatment of Specific Diseases**	**Treated (Y/N)**	**Should it be undertaken at this level (Y/N)**	**Constraints faced in implementation**	**Reasoning behind action or inaction at this level**
1.	Malaria				
2.	Tuberculosis				
3.	STIs				
4.	Mental Disorders				
5.	Diabetes Mellitus				
6.	Hypertension				
7.	Disability (Blindness, deafness, physical)				
8	Others (Specify)				

73.3 Indicate whether the health facility staff are providing the following services, whether they should be provided according to the norm (e.g. health package), any constraints faced, and the reasoning behind the unexpected provision or lack thereof. *(Elaborate, probe on services in terms of components)*

SN	Service	Implemented (Y/N)	Should it be undertaken at this level (Y/N)	Constraints faced in implementation	Reasoning behind unexpected action or inaction at this level
1.	School Health				
2.	Outreach Services				
3.	Community rehabilitation				
4.	Home care for HIV/AIDS patients				
5.	Home care for patients with other conditions				
6.	Anti tobacco activities				
7.	Prevention of alcohol and substance abuse				
8.	Mental Health				
9.	Eye and ear care				
10.	Oral Health				
11.	Others (Specify)				

73.4 Indicate whether the following strategies are being implemented by the health facility, whether they should be implemented according to the norm (e.g. health package) and any constraints faced:

SN	Strategy	Implemented (Y/N)	Should it be implemented at this level (Y/N)	Constraints faced in implementation	Reasoning why it is or is not undertaken at this level contrary to what is expected
1.	Integrated Management of Childhood Illness (IMCI)				
2.	Directly observed treatment short course (DOTS)				
3.	HIV/AIDS community prevention and care package				

4.	Community based new born care package (CBNCP)				
5.	Infant and young child feeding practices (IYCF)				
6.					
7.	Others (specify)				

73.5 Indicate whether the personnel of the health facility are involved in the following areas and if yes, describe briefly any activities being carried out this year:

SN	Programmes	Involved (Y/N)	Description of activities carried out this year
1.	Family food security and safety		
2.	Safe water Supply		
3.	Sanitation		
4.	Disaster Preparedness		
5.	Accident prevention – Home		
6.	Accident prevention – Workplace		
7.	Accident prevention – road traffic		
8.	Child abuse		
9.	Domestic violence		
10.	Others (specify, use extra space if more)		

SECTION 5: COMMUNITY INVOLVEMENT

(Questions in this section should be addressed to the community representatives who are invited for the interview; health personnel should not influence the answers.)

74 What are the five most important diseases in the communities that use this health facility? (Record

in order of importance).

i. _____ iv. _____

ii. _____ v. _____

iii. _____

75 Are community development groups operating in communities that use this health facility? (E.g. community-based organizations, village or town committees, women's or youth committees).

Yes ☐ **No** ☐

If yes, please continue with question 75.1.

If no, please go to question 79.

75.1 If yes, list those that are involved in health issues.

_____

_____

75.2 Are women's groups involved in health activities/issues? **Yes** ☐ **No** ☐

75.3 Are youth groups involved in health activities/issues? **Yes** ☐ **No** ☐

76 Indicate whether community groups in the catchment area carry out the community activities listed below.

		Yes	**No**
i.	Health or health-related projects	☐	☐
ii.	Mobilization of resources for health	☐	☐
iii.	Income generating projects	☐	☐
iv.	Water supply projects	☐	☐
v.	Care for the environment	☐	☐
vi.	Others (Specify)		

77 Have the communities in the catchment area contributed the following resources to the health facility in the past three years?

		Yes	**No**
i.	Human resources (e.g. through communal labour payment of staff salaries)	☐	☐
ii.	Financial resources (e.g. donations, gifts)	☐	☐
iii.	Materials and buildings	☐	☐

78 Indicate whether the community groups identified in question 74 have received funds from the following sources in the past three years.

		Yes	**No**
i.	Government	☐	☐
ii.	NGO	☐	☐
iii.	Community members	☐	☐
iv.	Other donors	☐	☐

79 Does the community have access to the following mechanisms for providing feedback to the health staff on quality and relevance of health services provided?

		Yes	**No**
i.	Suggestion box	☐	☐
ii.	Review of complaints	☐	☐
iii.	Involvement of community representatives in meetings	☐	☐
iv.	User satisfaction survey	☐	☐
v.	Other, specify: _____		

80 Please list five health or health-related areas where the health facility personnel could do more than they are presently doing.

i. _____
ii. _____
iii. _____
iv. _____
v. _____

SECTION 5: INTERSECTORAL COORDINATION & COLLABORATION

Collaboration with other ACTORS in the Health System

81 Does the health facility undertake collaborative activities with traditional health practitioners (Ayurveda, Homeopathy, Naturopathy, Amchi, Acupuncture) in the catchment area?

	Yes	No	N.A.
81.1 If yes, list some of these activities.	☐	☐	☐

_____

_____

81.2 Do those traditional health practitioners refer patients to the HF?	☐	☐	☐
81.3 Does the health facility refer patients to traditional health practitioners?	☐	☐	☐
81.3 Do traditional healers (Dhami, Jhankri, lama, gubhaju etc) refer patients to the health facility?	☐	☐	☐
81.4 Does the health facility refer patients to traditional healers?	☐	☐	☐

82 Are there any non-public health providers (e.g. private, mission, or NGO owned) in your catchment area?

Yes ☐ If yes, please continue with question 81.1.

No ☐ If no, please go to question 82.

82.1 Does the health facility undertake collaborative activities with the non-public health services in the catchment area? **Yes**☐ **No**☐ **N.A.** ☐

If yes, list some of these activities.

_____

83 Is there any collaboration/coordination with non public sectors (Private, NGOs, CBOs etc.) working in the sector of health and health related issues **Yes** ☐ **No** ☐

If yes list the organizations that the PHC collaborates with area of collaboration

	Organizations	Collaborative Activities
83.1.1	_____	_____
83.1.2	_____	_____
83.1.3	_____	_____
83.1.4	_____	_____
83.1.5	_____	_____
83.1.6	_____	_____
83.1.7	_____	_____
83.1.8	_____	_____
83.1.9	_____	_____
83.1.10	_____	_____

84 Is there any collaboration and/or coordination with public/non public sectors (Private, NGOs, CBOs etc.) working in the area beyond health? **Yes** ☐ **No** ☐

If yes list the organizations that the PHC collaborates with area of collaboration

	Organizations	Collaborative Activities
84.1.1	_____	_____
84.1.2	_____	_____
84.1.3	_____	_____
84.1.4	_____	_____
84.1.5	_____	_____
84.1.6	_____	_____
84.1.7	_____	_____
84.1.8	_____	_____
84.1.9	_____	_____
84.1.10	_____	_____

Comments of the Assessment team

_____

_____

_____

_____

_____

_____

_____

Thank You for your Co-operation!

Annex 3 FGD Guidelines

Nepal Health Research Council, Ranshahpath, Kathmandu
FGD Guidelines
"Distrcit Health System Assessment within Inter-sectoral Context"

District Health System (D/PHO) and Non Health Sectors

Non health Sectors

- Education System – District Education Office (DEO), Private and Boarding School Organization Nepal (PABSON), Science and Technology (if any), Information Technology
- Food and Nutrition System – District Agriculture Office (DAgO), District Animal Health Office (DAHO), Department of Food Technology and Quality Control
- Economic System – Banks/Financial Institutions/Cooperatives, Food and Tobacco Industry, FNCCI
- Political/Policy System – District Administration Office (DAO), Security Systems, VDCs, Municipalities
- Physical Environment System – Department of Water Supply and Sewerage (DWSS), Department of Urban Development and Building Construction (DUDBC), Organizations working in the sector WASH

1. Is there any coordination/collaboration among health and non health sectors? (elaborate on coordination/collaboration for e.g. joint effort to manage important health problems, meeting and discussions on issues related to health, communication on these issues)
2. What kind of relation/coordination? (Any meetings, representation in DHC or vice versa)
3. Who takes the initiation on the issues?
4. Is there regular schedule of meetings?
5. What about the participation? (Do all the invitees participate whenever invited)
6. What about infrequent/occasional discussion on health issues?
7. What are the major issues currently covered/discussed in the meetings/discussions?
8. What could be the important areas where Inter-sectoral Coordination (ISC) plays an important role?

9. Which groups of health problems require ISC? (Direct this question to DHC/Hospital/HF)
10. Who should take the lead role in the coordination?
11. Is there any problem/obstacles faced for the ISC activities?
12. Can few of them be named/listed?
13. Any problem in implementing the activities planned/discussed?
14. What sort of problems are being faced?

District Health System (D/PHO) and Organizations within the health sector

- Traditional health practitioners – Ayurveda (Homeopathy, Naturopathy, Acupuncture, Amchi if any)
- I/NGOs, CBOs, Private organizations and civil societies

1. Is there any coordination/collaboration in the issues of health?
2. Are there any joint efforts that take place together with other actors working in the health sectors?
3. What are those areas of ISC?
4. Any meetings/discussions about health issues jointly?
5. Who takes the lead in these joint efforts?
6. What are the issues generally discussed?
7. Is there any definite plan in place for this kind of coordination/collaboration/discussion?
8. Which are the potent areas that could be covered and sought for solution through ISC?
9. What are the particular diseases of national importance that require ISC?
10. What could be important ISC activities for improving the efficiency of health system?
11. In what way this activity would help?
12. Is it important to have coordination among different systems of medicine providing health care to the community?
13. Is there any activity in place occurring in coordination? What kind of activities are in place?
14. Does there exist a mechanism of referring the patients among the different systems? Dose it occur two way?
15. Is there any representation of the traditional systems of health care in seminars workshops/meetings?

16. What could be the potent area where ISC among the different systems could be effective? In what way should it be taken further?
17. Who should take the lead?
18. What could be the contribution of DHMT and what could be the contribution of other systems of Medicine?

Annex 4 Information Sheet & Consent Forms

3.1 Information Sheet and Consent Form - District

जिल्ला स्वास्थ्य प्रणाली अध्ययनको जानकारी पत्र (जिल्ला)

टोली प्रमुखको नाम : डा. कृष्ण कुमार अर्याल

संस्थाको नाम : नेपाल स्वास्थ्य अनुसन्धान परिषद्, रामशाहपथ, काठमाण्डौं ।

अनुसनधानको शीर्षक : District Health Systems Assessment within an Inter-sectoral Context.

म डा. कृष्ण कुमार अर्याल नेपाल स्वास्थ्य अनुसन्धान परिषद्को बरिष्ठ अनुसन्धान अधिकृत पदमा कार्यरत छु । हामी ६ जिल्लामा जिल्ला स्वास्थ्य प्रणालीको अध्ययन गरिरहेका छौं ।

अनुसन्धानको उद्देश्य:

नेपालमा जिल्ला स्वास्थ्य प्रणालीको कार्य प्रणाली सम्बन्धि अन्ययन अनुसन्धान हेतु यस अध्ययन को उद्देश्य जिल्लाको जनस्वास्थ्य कार्यालय अन्तर्गत स्वास्थ्य प्रणालीहरु कसरी काम गरिरहेका छन् सो अध्ययन गर्नु हो । यसको साथ साथै सो कार्य प्रणालीमा Inter-sectoral समन्वय र सहकार्य कसरी भईरहेको छ सो अध्ययन गर्नु अर्को महत्वपूर्ण उद्देश्य हो ।

कार्यप्रणाली:

यस अध्ययन पुरा गर्न साथै उक्त उद्देश्यहरु हासिल गर्न हामीले देशका ६ वटा जिल्ला चुनेका छौ । ति मध्ये ..... पनि एक हो । हामीले यहाँ एउटा विस्तृत प्रश्नावली प्रयोग गरि जिल्ला जनस्वास्थ्य प्रमुख संग जानकारी संगाल्ने छौ । साथमा यहि जिल्ला भित्र स्वास्थ्य क्षेत्र र स्वास्थ्य बाहेकका क्षेत्रमा कार्य गरिरहेका संस्थाहरुसँग D(P)HO बाट प्रतिनिधि राखी दुईवटा फरक फरक FGD गर्ने छौं ।

फाईदाहरु:

यस अध्ययन तथा यसमा प्रयोग गरिने विधिबाट तपाईहरुलाई व्यक्तिगत रुपमा सिधै फाइदा नभएतापनि यसबाट आउने Findings ले तपाई लगायत देशभरिका जिल्लाहरुको जिल्ला स्वास्थ्य प्रणाली सुधार्न मद्दत गर्ने छ ।

हानी/नोक्सानी:

यस अध्ययन मार्फत हामी तपाईहरुको व्यक्तिगत कार्य र Performance जाँच्न अथवा निरीक्षण गर्न आएका होइनौं । यसबाट तपाईहरुलाई कुनै नोक्सानी हुनेछैन ।

गोपनीयता:

यस सर्वेक्षणबाट प्राप्त जानकारीहरु पूर्णत गोप्य राखिनेछन र यसलाई कतै Report गर्नु पर्दा कसैको पनि व्यक्तिगत विवरण खुल्ने छैन ।

भाग लिने वा नलिने अधिकार:

यस अनुसन्धानमा भाग लिने वा नलिने अधिकार पूर्णत तपाईमा निहित छ । तथापी यो कार्य हाम्रो आफ्नै देशको स्वास्थ्य प्रणाली सुधार्ने हेतु भएकाले यहाँले पूर्ण सहयोग गरि आफ्नो अमूल्य समय दिनुहुनेछ भन्ने आशा राख्दछौं ।

कसलाई सम्पर्क गर्ने:

यदि तपाईसँग केही प्रश्नहरु छन् भने तपाई अहिल्यै अर्थात अन्तर्वार्ता लिने व्यक्ति सँग पछि पनि सोध्न सक्नुहुनेछ । जसका लागि डा. कृष्ण अर्याल अथवा विजय कुमार झा सँग नेपाल स्वास्थ्य अनुसन्धान परिषद्, काठमाण्डौंको फोन नं ०१४२५४२२०।४२२७४६० मा सम्पर्क राख्न सक्नुहुनेछ । वा इमेल मार्फत krish.aryal@gmail.com or jhabijay@gmail.com मा सम्पर्क गर्न सक्नु हुनेछ ।

जिल्ला स्वास्थ्य प्रणाली अध्ययनको मन्जूरीनामा:

माथि उल्लेख गरिएका जानकारी मैले आफै पढेको हुँ । मलाई सबै किसिमको प्रश्न सोध्ने अवसर दिइएको थियो । यस अनुसन्धानमा म स्वैच्छिक रुपमा भाग लिंदै छुँ ।

अन्तर्वार्ता दिनेको नाम :

हस्ताक्षर :

मिति :

अन्तर्वार्ता लिनेको नाम : डा. कृष्ण कुमार अर्याल

हस्ताक्षर :

मिति :

3.1 Information Sheet and Consent Form - PHC

जिल्ला स्वास्थ्य प्रणाली अध्ययनको जानकारी पत्र (प्राथमिक स्वास्थ्य केन्द्र)

टोली प्रमुखको नाम : डा. कृष्ण कुमार अर्याल

संस्थाको नाम : नेपाल स्वास्थ्य अनुसन्धान परिषद्, रामशाहपथ, काठमाण्डौं ।

अनुसनधानको शीर्षक : District Health Systems Assessment within an Inter-sectoral Context.

म डा. कृष्ण कुमार अर्याल नेपाल स्वास्थ्य अनुसन्धान परिषद्को बरिष्ठ अनुसन्धान अधिकृत पदमा कार्यरत छु । हामी ६ जिल्लामा जिल्ला स्वास्थ्य प्रणालीको अध्ययन गरिरहेका छौं ।

अनुसन्धानको उद्देश्य:

नेपालमा जिल्ला स्वास्थ्य प्रणालीको कार्य प्रणाली सम्बन्धि अन्ययन अनुसन्धान हेतु यस अध्ययन को उद्देश्य जिल्लाको जनस्वास्थ्य कार्यालय अन्तर्गत स्वास्थ्य प्रणालीहरु कसरी काम गरिरहेका छन् सो अध्ययन गर्नु हो । यसको साथ साथै सो कार्य प्रणालीमा Inter-sectoral समन्वय र सहकार्य कसरी भईरहेको छ सो अध्ययन गर्नु अर्को महत्वपूर्ण उद्देश्य हो ।

कार्यप्रणाली:

यस अध्ययन पुरा गर्न साथै उक्त उद्देश्यहरु हासिल गर्न हामीले देशका ६ वटा जिल्ला चुनेका छौ । ति मध्ये ..... पनि एक हो । हामीले यहाँ एउटा विस्तृत प्रश्नावली प्रयोग गरि प्राथमिक स्वास्थ्य केन्द्र (PHC) प्रमुख संग जानकारी संगाल्ने छौ । साथमा यस PHC मा अवस्थित व्यवस्थापन समिति (HFOMC) का सदस्यहरु सँग एउटा छलफल (FGD) गर्ने छौं ।

फाईदाहरु:

यस अध्ययन तथा यसमा प्रयोग गरिने विधिबाट तपाईहरुलाई व्यक्तिगत रुपमा सिधै फाइदा नभएतापनि यसबाट आउने Findings ले तपाई लगायत देशभरिका जिल्लाहरुको जिल्ला स्वास्थ्य प्रणाली सुधार्न मद्दत गर्ने छ ।

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अन्तर्वार्ता दिनेको नाम :

हस्ताक्षर :

मिति :

अन्तर्वार्ता लिनेको नाम :

हस्ताक्षर :

मिति :

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