Barriers to Effective Policy Implementation and Management of Human Resources for Health in Nepal

6 Role of Civil Society in Human Resources for Health

A Report of Operational Research

MAY 2012

EUROPEAN UNION

MERLIN

SOCIETY FOR LOCAL INTEGRATED DEVELOPMENT
1997
SOLID/Nepal

Disclaimer

This publication is part of an Operational Research entitled "Barriers to Effective Policy Implementation and Management of Human Resources for Health in Nepal" under the project ***Support to Health Workforce Through Civil Society Engagement*** funded by European Union and the Ladham Trust. The contents of this publication are the sole responsibility of SOLID Nepal and can in no way be taken to reflect the views of the funding organisations.

Cover Photo © SOLID Nepal 2011

Design & Printings

The Creative Hands (SELF-MOTIVATED, INDEPENDENT & CREATIVE DEAF GROUP)
Chhetrapati, Kathmandu, Nepal

Principal Investigator

Dr Khem Bahadur Karki (MBBS, MPH)

Report Writer

Mr Bidhan Acharya (MA Population, Ph.D. Scholar)

Recommended citation

Society for Local Integrated Development Nepal (SOLID Nepal) and Merlin Nepal. Barriers to Effective Policy Implementation and Management of Human Resources for Health in Nepal: Role of Civil Society in Health Resources for Health. Lalitpur, Nepal: SOLID Nepal; 2012

Government of Nepal
Ministry of Health & Population
Phone: 4. 262987
262590
262802
262706
262935
262862
Ramshahpath, Kathmandu
Nepal

Ref: .....

Date: .....17th July 2012.....

Preface

Ministry of Health and Population has committed, through its second Nepal Health Sector Programme Implementation Plan (2010-2015), to improve the health and nutritional status of the people by providing them equal opportunity to receive quality health care services free of charge or at affordable cost thereby contributing to poverty alleviation. The ministry promotes access to and utilisation of essential health care and other health services, emphasising services to women, children, and poor and excluded. The plan and programmes are focused to changing risky life styles and behaviours of most at-risk populations through behaviour change and communication interventions.

The health sector requires competent and motivated health workforce to achieve the stipulated goals and targets of the health plan and the programmes. Nepal health sector is facing critical human resources for health (HRH) crisis for service delivery. Deployment and retention, production of skill mix human resources and their equitable distribution, availability, productivity, performance and accountability of the human resources for health are some of the major issues to be addressed by the health system. On the other hand, non-communicable diseases, accident and injuries and other new emerging diseases will require more epidemiologists and public health experts. A scientific and robust strategic plan for managing HRH both in public and private sectors, maintaining equilibrium in supply and demand, delivering efficient services to people so as to achieve MDGs, is now a prime concern for the Ministry.

The Ministry of Health and Population has prepared a HRH Strategic Plan (2011-2015) aiming to ensure the equitable distribution of appropriately skilled human resources for health to support the achievement of health outcomes in Nepal and in particular the implementation of Nepal Health Sector Progamme-2 (NHSP-2). The HRH Strategic Plan has given main focus to achieve the appropriate supply of the heath workers, equitable distribution of them, improved health workers performance, effective and coordinated HR planning, management and development across the health sectors.

Both the NHSP-2 and HRH Strategic Plan has highlighted the need of operational researches to find out the bottlenecks of health system in terms of policy implementation and HRH management there by to recommend the appropriate actions to strengthen the health system.

This operational research carried out by Society for local Integrated Development Nepal (SOLID Nepal) and Merlin with financial support from the European Commission and Ladham Trust helps to generate empirical evidence highlighting the key gaps and existing challenges in six key areas : a) Distribution and skill mix of HRH, b) Training, recruitment , placement and retention, c) performance and accountability, d) HRH management, e) working conditions and f) Civil Society Organisation's engagement . This will definitely support MoHP for further human resources planning and its effective implementation.

The MoHP would like to thank SOLID Nepal, Merlin, the European Union and Ladham Trust for carrying out this research. There is great appreciation to all research and logistics teams for their efficient work and to the research participants, for their valuable contribution to the research study.

Dr. Praveen Mishra
Secretary

Kupondole - 1, Lalitpur
PO Box 8975, EPC 1641
Kathmandu, Nepal

T (977-1) 5544250
F (977-1) 5544450
E Kathmandu@merlin-nepal.org

Foreword

It is my great pleasure to introduce this report on the *Barriers to Effective Policy Implementation and Management of Human Resources for Health in Nepal*. This report was the result of a comprehensive piece of nationally representative operational research, conducted by Society for Local Integrated Development (SOLID) Nepal in partnership with Merlin Nepal, which encompassed all Nepal's development regions and ecological belts. That research and, subsequently, this report were made possible with the financial assistance of the European Union and the Ladham Trust.

Every man, woman, youth and child has the right to enjoy the highest attainable standard of physical and mental health. The practical realisation of this right, however, has one significant precondition: To enjoy the highest attainable standard of health, every individual must first have access to suitably qualified and motivated health workers. While fundamental, this requirement remains a major challenge in many countries, particularly those which have significant geographical, economic and/or human resource constraints.

The Nepal Health Sector Programme – Implementation Plan II (NHSP-IP II, 2010-2015) mentions that Nepal has experienced a 35% growth in population since 1991, however the public workforce only increased by 3% during the same period, and approximately 25% of the total health workforce are unskilled. While having an adequate number of qualified health workers physically in place is obviously vital to ensuring access to quality healthcare, so too is the distribution and mix of those health workers, the quality and appropriateness of their training, their workplace performance and accountability, the effectiveness of their management structures and their working conditions. All of these contributing factors were assessed and analysed as part of this operational research.

SOLID and Merlin also recognise the proactive role civil society organisations (CSOs) can play in regard to human resources for health. As such, the current and potential roles of CSOs were considered throughout this research.

It is our hope that this publication will not only provide a holistic picture of the current health worker situation in Nepal, but also present all stakeholders engaged in Nepal's health sector with tangible recommendations which will, in turn, facilitate every Nepali accessing their right to the highest attainable standard of health.

More information on the importance of health workers and the challenges they face can be found on Merlin's Hands Up for Health Workers campaign site: **www.handsupforhealthworkers.org.**

Catherine Whybrow
Country Director
Merlin Nepal

स्थानीय एकीकृत विकास समाज नेपाल
Society for Local Integrated Development Nepal

Acknowledgements

It is our immense pleasure to bring forth the series of reports of operational research entitled "Barrier to Effective Policy Implementation and Management of Human Resources for Health in Nepal" under the project "Support to Health Workforce through Civil Society Engagement". This operational research highlighted six crucial thematic areas of Human Resources for Health (HRH) in Nepal: 1) Distribution and skill mix of health workforce; 2) Recruitment, training, placement and retention of health professionals with an emphasis on public-private partnership; 3) Health workforce performance and accountability; 4) HRH management from central to district level; 5) Working conditions of health workforce; and 6) Role of civil society in HRH.

We would like to express our heartfelt thanks to the secretary of Ministry of Health and Population, Dr. Prabin Mishra for his steady and constructive support from the very beginning of the project. We highly acknowledge the senior officials from the ministry namely Dr. Baburam Marasini, *Senior Public Health Administrator;* Ram Chandra Khanal, *Senior Public Health Administrator* and Kabiraj Khanal, *Undersecretary* for their support in each and every step of the operational research especially for thorough review of the research findings and providing substantial inputs. Our sincere thanks also go to other officials in the ministry and its departments for their valuable supports.

It will be a true injustice if we do not acknowledge Mr. Raghu Ghimire, an *HRH expert in Nepal* for his selfless reviewing of the reports and providing valuable feedbacks in all the reports. We are also indebted to Prof Dr. Chop Lal Bhusal, *Chairman;* Dr Shanker Pratap Singh, *Member Secretary*, Nepal Health Research Council for their encouragement and guidance in the research processes. Dr Rajendra BC, a well known researcher has also contributed a lot to refine and make the research meaningful. Thank you Dr BC.

We never forget associate professors, Dr. Amod Kumar Poudyal and Bidhan Acahrya for their great contribution in research design and also report writing.

We also would like to mention a constant support provided throughout the research from Catherine Whybrow, *Country Director* (Merlin Nepal). We are equally thankful to Maxime Piasecki former *Country Director,* Dr. Mukesh Prajapati, *Former Country Health Director,* Dr. Sayed Masoom Shah, *and Former Country Health Programme Manager of Merlin* Nepal for their inputs in the research process. We highly appreciate the work done by Gabriella Saunders for enriching the reports. Similarly, we are equally indebted to Lizzy Berryman, *Health Advisor;* Dr. Rajesh Narwal, *Health Officer;* Marta Persian, *Regional Programme Coordinator;* Dr. Samson Agbo, *Head of Health;* Gabor Beszterczey, *Head of Asia Region;* Katherine Schwarz, *Former Regional Programme Coordinator;* Pete Jones, *Former Programmes Assistant* and Charlotte Rooney, *Programmes Assistant* of Merlin UK for their valuable feedbacks and suggestions in research processes and reports.

Sincere gratitude goes to the energetic and innovative report writing teams from both SOLID Nepal and Merlin Nepal, without their creative penning, the reports would not have come to this form.

Lastly, we are very much thankful to European Union and Ladham Trust for providing the fund for the whole project. We are also very much grateful to the entire SOLID Nepal Team as well as Merlin Nepal for their continued support. We highly acknowledge all the individuals, institutions and stakeholders who have actively participated in this research processes.

Dr. Khem B. Karki,
Executive Director/Principal Investigator
SOLID Nepal
May 2012

Head Office
Satdobato, Lalitpur
GPO Box No. : 9565 Kathmandu, Nepal
Tel. No. 977-1-5-548455, Fax : 977-1-5-553770
Email : solidnepal@wlink.com.np, Website : www.solidnepal.org.np

ACRONYMS

AHW	Auxiliary Health Worker
ANM	Auxiliary Nurse Midwife
CBO	Community Based Organisation
CMA	Community Medical Assistant
CSO	Civil Society Organisation
CTEVT	Council for Technical Education and Vocational Training
DDC	District Development Committee
DfID	Department for International Development
DHO	District Health Office
DoHS	Department of Health Services
DPHO	District Public Heath Office
EC	European Commission
EDPs	External Development Partners
FCHV	Female Community Health Volunteer
FGD	Focus Group Discussion
FPAN	Family Planning Association of Nepal
HA	Health Assistant
HFOMC	Health Facility Operation and Management Committee
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HP	Health Post
HRH	Human Resources for Health
HuRDIS	Human Resource Development Information System
HuRIS	Human Resource Information System
I/NGO	International Non-Governmental Organisation
KII	Key Informant Interview
MCHW	Maternal and Child Health Worker
MDGs	Millennium Development Goals
MoGA	Ministry of General Administration
MoHP	Ministry of Health and Population
Msc	Masters in Science
NDHS	Nepal Demographic and Health Survey
NFCC	Nepal Fertility Care Centre
NGO	Non-governmental Organisation
NHSP IP	Nepal Health Sector Programme Implementation Plan
NSI	Nick Simons Institute
PHC	Primary Healthcare Centre
SBA	Skill Birth Attendant
SHP	Sub-Health Post
TU	Tribhuvan University
UNFPA	United Nations Population Fund
VDC	Village Development Committee
VHW	Village Health Worker
WHO	World Health Organisation

GLOSSARY

Ecological Belts	Nepal is made up of three ecological belts running laterally across the country: the Mountain belt in the northern highlands, Hill in the central belt, and Tarai lowland plains in the southern belt.
Basic-level HWs	Basic-level HWs have received Technical School Level Certificates (TSLC). They are trained for 12-18 months, primarily through affiliated institutions of CTEVT and are able to provide basic services in their trained areas.
Birthing Centre	A health facility with the equipment and skilled birth attendants to assist women to give birth safely.
Deputation	Deputation is the secondment of personnel, irrespective of the numbers of sanctioned posts, for a given period of time.
Development Regions	For administrative purposes, Nepal is divided up into five Development Regions: Eastern Development Region (EDR), Central Development Region (CDR), Western Development Region (WDR), Midwest Development Region (MDR), and Far Western Development Region (FWDR).
Facilities	For the purpose of this report, facilities can mean either those provided to health workers i.e. housing, or those in the health centre i.e. x-ray machines.
High-level HWs	High-level health workers have obtained either a Bachelor or Post-Graduate degree in Health Sciences. These high-level health workers provide more advanced services and are produced by different universities and autonomous academic institutes, and their affiliated institutions.
HRH	Human Resources for Health (HRH) include those 'engaged in actions whose primary intent is to enhance health' (1).
Ilaka	A segment within a district that comprises several, largely homogeneous VDCs. There is one Health Post in each Ilaka.
Mid-level HWs	Mid-level health workers have attended a three-year training course (Proficiency Certificate-Level or Diploma-Level courses). They perform a curative, preventative, and diagnostic function, and are responsible for supervising the basic-level HWs. They are produced primarily by affiliated institutions of CTEVT, and by Tribhuvan University (TU), Kathmandu University (KU) and B.P. Koirala Institute of Health Sciences (BPKIHS).
Paramedical	Paramedical staff are a section of the health workforce representing basic and mid-level technical categories, including Health Assistants, Auxiliary Health Workers, Laboratory Technicians, Laboratory Assistants, Radiographers, Anaesthetic Assistants, Ophthalmic Assistants, Physiotherapy Assistant.
Sanctioned posts	Sanctioned posts are posts that have been centrally approved by the MoHP within health institutions.
Safe Abortion	Legal abortion performed by certified medical staff in registered health facilities.
Skill mix	The 'combination of different health workers that produce a given level of healthcare' (2).
Wards	These refer to clusters within the VDC, of which there are 9 in each VDC.

DESCRIPTIONS OF NEPALI HEALTH STAFF ACRONYMS

AHW Auxiliary Health Worker: AHWs are trained for one year after secondary school. They are the Sub-Health Post in-charge and also service providers in the HP, PHC and Hospitals. Their main role is to provide promotive and preventive care in the community and refer to primary healthcare facilities.

ANM Auxiliary Nurse Midwife – ANMSs are based at Health Posts to Conduct maternal and child health care services. They are trained for 18 months and like the MCHW, the ANMs main job is to conduct antenatal clinics, provide TT immunization, nutrition education, conduct normal deliveries, recognise danger signs and refer women for appropriate care. ANMs also conduct post natal clinics and provide immunization services for children. They counsel couples and provide planning services. ANMs are also responsible for the supervision of MCHWs.

FCHV Female Community Health Volunteers – FCHVs are grassroots government health volunteers based in their respective Wards and selected by the Mothers' Groups. They are responsible for delivering health messages to the Mothers' Group and distributing pills, condoms, polio drops, oral rehydration salts and Vitamin A. The government provides training and refresher training to them.

HA Health Assistant – HAs are based in Health Posts as the Health Post In-charge, holding a Proficiency Certificate in Medical Science (General Medicine). They perform curative and preventative roles and are responsible to supervise the Health Post staff and Sub-Health Posts in their area. HAs report to the District Public Health Officer (DPHO) at district level.

MCHW Maternal and Child Health Worker: MCHWs are selected mainly from the local VDC. MCHWs are based in Sub-Health Posts to provide maternal and child health services, after receiving six months' training. MCHWs conduct antenatal clinics, provide TT immunization, post natal clinic nutrition education, and conduct normal deliveries. They also provide counseling to couples on family planning and provide Family Planning services. They are also responsible for conducting EPI clinics and PHC/ORCs.

SBA Skilled Birth Attendant: "An accredited health professional, such as a midwife, doctor or nurse, who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period and in the identification, management and referral of complications in women and newborns"(2).

VHW Village Health Worker: VHWs are the community level government employee with six months' initial training. Together with MCHWs, they conduct outreach clinics in their villages, and are involved in immunization of children under the age of one year. In addition, they distribute contraceptive pills, condoms and refer clients for other methods of family planning. They supervise FCHVs and attend Mother's group meetings. They also provide health education in the village.

EXECUTIVE SUMMARY

Background: This study "The Role of Civil Society in Human Resources for Health" is one of six research reports on "Barriers to Effective Policy Implementation and Management of Human Resources for Health in Nepal." The objective of the study is to analyse the role of civil society engagement in enhancing health service delivery in Nepal.

Current national health policies and strategies of Nepal illustrate the government's commitment to involving Civil Society Organisations (CSOs) in improving Human Resources for Health (HRH) through the decentralisation of health service delivery and the handover of facilities to the Health Facility Operation and Management Committee (HFOMC). However, these have not sufficiently specified CSOs roles.

Methodology: A cross-sectional descriptive study was conducted using mixed method with observation checklist. Fifteen districts representing eco-developmental regions of Nepal were selected using multi-stage cluster sampling method. Out of 404 sample, 747 health workforce from 375 health institutions were interviewed (<10% non-response rate) using the Probability Proportionate to Size method as per WHO guideline. Observation was carried out in 256 health facilities. Further, secondary review was carried out for triangulation of findings.

Key Findings: Qualitative data indicated a gap on policy implementation, health sector decentralization and CSOs involvement to improve HRH. Nearly 75 percent respondents had opined that the political parties were supporting the health institutions in the grassroots. It was found that the support from the CSO was better in Hill (54.9%) compared to Tarai (46.9%) and Mountain (46.7%). The support was significantly different between rural and urban [$p < 0.05$, CI 95%]. Mean Index score of effectiveness of CSOs was found highest in Hills (0.3036) followed by Mountains (0.2669) and Tarai (0.2589) [Cronbach's α=0.8057]. While analysing the manifestos of 9 major political parties, only 5 of them have mentioned policy statements on HRH production, distribution and implementation whereas only one party has highlighted strategies with peoples' participation.

Conclusion and Recommendations: The government should recognise, reorganise and formalise the role of civil society in policy documents and should seek participation of CSOs in the formulation of policies and strategies related to HRH. The urban based CSOs should be strengthened.

The Ayurvedic centres, I/NGOs and Private outlets should be regulated through a guideline to operate in coordination with DPHO so that the roles of CSO in district as a whole could be assessed. The PHCs need to take lead in establishing the coherent relationship with local CSOs, HP and SHP too. Constructive dialogue, planning and mobilisation around the health workforce to broaden the extent of social determinants of health are needed in collaboration with GOs, I/NGOs and private sector should be ensured. Studies and researches related to the involvement of CSO in HRH planning, policy making, managing and implementing the programmes is needed.

The district level governance should establish an effective coordination between DDC and DPHO, it should utilise local media and use efforts to enhance the involvement of civil society in health programmes. It should also identify the areas that are unsecured and with low social prestige for HRH within district and periodically counsel the CSOs for making better environment. Most crucially the CSOs should reward better performing HRH and have a social audit of institutions as well as health workers.

TABLE OF CONTENTS

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

TABLES

FIGURES

CHAPTER I INTRODUCTION

1.1 Background and Issues

1.1.1 Civil Society Defined

Among the various definitions of civil society, the WHO definition is more commonly used in health research:

"The common understanding is that civil society embraces the general public at large, representing the social domain that is not part of the State or the market. Lacking the coercive or regulatory power of the State and the economic power of market actors, civil society provides the social power of its networks of people. Its ideas, information, services and expertise are used to advance the interests of people by seeking to influence the State and the market. It is a sphere where people combine for their collective interests to engage in activities with public consequence"(3).

Civil society refers to "the arena of un-coerced collective action around shared interests, purposes and values"(4-5). It can be defined broadly as the space in society where collective citizen actions take place. There is a complex set of actors, activities, interests, values and also the expected outcome of such interplays that makes civil society a complex phenomenon (6).

Civil Society Organisations (CSO) represent a wide range of non-profit organisations such as registered charities, non-governmental organisations, community groups, women's organisations, faith-based organisations, professional associations, trade unions, self-help groups, social movements, business associations, coalitions and advocacy groups (7). Civil Society consists of mutual and public benefit organisations, which serve to balance the rights of individuals to exercise their freedoms and the need for protection of the public (8). The term CSO is used in this paper to indicate a wide range of civil society actors including non-profit NGOs, local health related groups including Mothers' groups, health management committee etc.

Generally, the public policy domain is pressurised by the demands of civil society, which reflects the agendas of pressure groups and particular decisions of the authorities. Thus in broad, civil society comprises of non-governmental (or even private) formal or informal institutions that put forward the people's versions for better policies and management. They might often have interactions with authorities from grassroots to central level. Therefore, civil society engagement in the policy making, preparation of plans and

strategies and monitoring are important for the success of implementation, because without the support of civil society organisations, government initiatives are not necessarily reflective of the population.

CSOs act as direct service providers, either in co-operation with the state, contracted by the state, or in areas where the state has ceased to operate. CSOs provide promotive, preventive, curative and rehabilitative health services (9-14). CSOs have emerged as major service providers in Africa, growing in number and in programme size. Additionally, the figures across Asia have also showed similar patterns. CSOs occupy the role of junior partners, which have had an important role in advocating on behalf of local people for improved state services. Therefore, there is no doubt that CSOs have a vital role in improving human resources for health in the Nepal.

1.1.2 Definition of HRH

The definition of Human Resource for Health (HRH) adopted for this study is the personnel affiliated to health service delivery, who examine the patients, provide nursing assistance, paramedical staff or a medical practitioner, who has the capacity to prescribe medicines and give non-medical recommendations. Thus HRH comprises of technical personnel with highly specialised competencies who hold PhDs, Masters or Bachelors in relevant and specific areas to the junior staff (such as junior helper to VHW, and VHW to AHW) with no formal medical or health related education or training. In addition, the public health managers and administrators in the government mechanism also fall within the HRH category.

1.1.3 Civil Society in the Nepali Context

Nepali civil society has a political base and the existence of community based activities without political affiliation is rare. The human resources involved in local to central level governance have either political links or links based on the caste and creed (15).

The District Development Committee (DDC) is the body that approves the programmes for the forthcoming fiscal year and reports its demands for development projects to the National Planning Commission (NPC) in the central government. The DDC is formed with the representatives of all political parties that prevail at the local or Village Development Committee (VDC) level. Thus planning requires a bottom up approach that emerges at VDC level to be approved by the NPC. This vertical ladder of the planning process shows a stream of political and bureaucratic processes that is largely inclusive of political or civil society activities.

The civil society in the context of health service delivery is basically focused on the political, and, to some extent the social, activism in the selected clusters. The health facilities management committee, political parties, individuals related to schools and their management committees, NGOs, youth groups, mother groups and other local level organisations are considered the envoys of civil societies

1.2 Objectives

The overall objective of the report is to analyse the role of civil society engagement in enhancing the health service delivery in Nepal. Health service delivery is associated with the efficiency of human resource for health (HRH), and the specific objectives can be found below.

- To assess the perception of HWs regarding the impact of civil society organisations in current consultation processes;
- To analyse the effectiveness of civil society organisations in service delivery by HRH;
- To analyse the level of support from political parties to the health institutions and HRH;
- To examine the magnitude of involvement of civil society in planning and implementation processes of health service delivery at local level;
- To examine the interrelationships and cooperation between civil society and HRH;
- To evaluate the role of health facility management committees;
- To evaluate the efficiency of civil societies in terms of workplace security.

1.3 Significance

The research will support the design and implementation of health service delivery at grassroot level in Nepal which includes policy making in order to positively change the quality of life of the people. This document aims to provide policy alternatives for local, central and executive government in order to enhance the quality of health service delivery in Nepal.

CHAPTER II OVERVIEW OF THE INTERRELATIONSHIP BETWEEN CIVIL SOCIETY AND HUMAN RESOURCES FOR HEALTH

2.1 The Global Context

Civil society and non-state organisations have a long history of involvement in public health, and have grown in scale in recent years, with a profound impact on the health of populations around the globe (16). People, as part of Civil Society, have an important role in influencing health policies. Particularly among resource-poor populations, CSOs have been motivated to improve health care delivery and advocate for improved access to health resources (17). One of the most significant developments in the recent past has been the 1978 Alma Ata declaration, which is considered a landmark for recognising people's participation in health systems as central to Primary Health Care and for recognising the role of Civil Society in improving health outcomes (18). The 'manner in which the state responds to these changes, and the extent to which civil society actors are recognized and included in health policies and programmes, are some of the critical factors determining the course of public health today' (16, 19).

In recent years, CSOs have become more prominent, more visible and more diverse all over the world. One of the factors influencing the growth of CSOs has been the increased challenge to imbalances of power between the state and its structures on the one hand and civil society on the other. The CSO networks have been formed within and across countries to promote a wider and more 'transnational' support of public interests on global policy issues such as human rights, environment, debt, development and health. The WHO framework for CSO support puts forward the ways in which CSOs can help to enhance health system (see Table 1).

Table 1: Health System Functions Contributed by CSOs

Health system function	Examples of roles of CSOs
Health services	Service provision; Facilitating community interactions with services; Distributing health resources such as condoms, bed nets, or cement for toilets; and Building health worker moral and support.
Health promotion and information exchange	Obtaining and disseminating health information; Building informed public choice on health; Implementing and using health research; Helping to shift social attitudes; and Mobilising and organizing for health.
Policy setting	Representing public and community interests in policy; Promoting equity and pro-poor policies; Negotiating public health standards and approaches; Building policy consensus, disseminating policy positions; and Enhancing public support for policies.
Resource mobilization and allocation	Financing health services; Raising community preferences in resource allocation; Mobilising and organising community co-financing of services; Promoting pro-poor and equity concerns in resource allocation; Building public accountability and transparency in raising, allocating and managing resources.
Monitoring quality of care and responsiveness	Monitoring responsiveness and quality of health services; Giving voice to marginalised groups, promoting equity; Representing patient rights in quality of care issues; and Channelling and negotiating patient complaints and claims.

Source: *WHO, 2002. WHO and Civil Society: Linking for Better Health*

Though the involvement of CSOs is encouraging, many field CSOs (local NGOs and CBOs) do not possess adequate skills and knowledge to advocate for the effective implementation of policy and provisions as well as monitor implementation.

2.2 Civil Society and HRH in Nepal

In Nepal, the concept of community health volunteers was initiated with the introduction of Public-Private Partnerships (PPP) in the Ministry of Health Seventh Five Year Plan (1985-90). The plan also focused on involving the community in the provision of health staff costs (20). During the Ministry of Health's Ninth Five Year Plan (1997-2002), a Medium Term Strategic Plan (MTSP) was introduced which highlighted the promotion of public-private-NGO involvement in the health sector, with emphasis on regulatory and partnership management

systems including financial management. With this partnership, decentralisation began with the formation of Local Health Facility Management Committees which helped to identify the roles and responsibilities of stakeholders (21).

The process of CSO involvement in health care delivery has been slow (22). However, many other forms of partnerships exist, and many non-governmental organisations, clubs/groups, health management committees, mothers groups and professional associations have been established in Nepal. Among the registered non-governmental organisations in Nepal there is a lack of information on the total numbers working in health service delivery. However, it is widely accepted that they are active partners in implementing and supporting health service delivery (23).

The NHSP IP- II has also put considerable emphasis on partnering with the NGO community in order to provide basic health services, especially to poor, marginalised communities and in order to establish more specialised services in the rural areas.

The Health Facility Operation and Management Committees (HFOMCs) are active in Hospitals, PHC, HP, SHP and Ayurvedic Centres. The HFOMCs have a socio-political interest to cater for the poor and marginalised in order to ensure popular support. Evidence suggests that locally employed staff are effective in providing services around the clock including the recruitment of ANMs in HPs by the local HFOMCs. The utilization of ANMs locally is both culturally acceptable and more permanent. (22). The DHO in the Hill belt stated *"The provision of temporary recruitment is available but the allocated budget is not sufficient."*

The Ministry of Health and Population (MoHP) handed over 1,433 local health institutions to the local HFOMCs but the decision-making power, structure and accountability has not changed. The reasons behind this could be due to less empowered local stakeholders, poorly defined roles of local community based organisations (CBOs), ineffective HFOMC and a lack of direction for institutions and training schemes. However, Nepal Health Sector Programme Implementation Plan II (NHSP-IP II) has recognized the role of civil society organisations and individuals stating that *"there is a need for engaging citizens and communities actively and holding the service provider accountable to local people"* (24). There is also a need to initiate an open policy process where stakeholders' views are valued. For this purpose, CBOs need to be involved in the health planning and policy processes, including Joint Annual Reviews. Regular organisation of public hearings at different levels of health governance will also help strengthen voices and accountability (22).

Research suggests that CSO interventions were supportive to the health needs of poor people, they reached populations poorly served by the state, and were driven by a commitment to values, rights and social justice goals (25). In a study in Nepal, CSOs were found to encourage healthy practices and to improve utilization of existing maternity services among low income women (25). In Nepal various CSOs are involved in the health sector to aid in state outreach programmes to grassroots; however, the effectiveness of their roles is to be assessed carefully.

2.2.1 Political Commitment to Involving CSOs in HRH

Current national health policies and strategies of Nepal have illustrated the government's commitment to involve CSOs in improving human resources for health, especially by strengthening training centres and academic institutions, and increasing community participation.

The three year interim plan document of 2007 mentioned, in addition to the above, the role of civil society with special references to provide facilities for the victims of armed conflict during the last fifteen years in Nepal. The document also acknowledged the role of NGOs and institutions working at grassroot level in different areas of the country (26). The role of non-governmental organisations and informal sectors (that include CSOs) in enhancing the quality of services, and the mobilization of human financial and infrastructural resources (26) would be supported by subsidies for general and eye-related health services to the poor in health service outlets managed by the non-governmental or private sectors. However, there was no mechanism mentioned for this (26). There was a commitment to effectively implement the safe motherhood and skilled birth attendance programme as a campaign (26). In addition, the health related plan mentioned establishing a semi-autonomous body in coordination of non-governmental agencies to improve sexual health and prevent HIV/AIDS (26). However, despite the establishment of the Chairpersonship of the Minister for Prevention of HIV, AIDS and Communicable Diseases in 2007, its efficacy is not yet visible. Although there have been plans to incorporate district level statistics in the national information system (26), there is a lack of coordination between district and central levels and poor management of information.

The Three Year Plan 2011-13 document of Nepal is the latest record of government commitment in public policies and programme implementation. It states that community level organisations should be given priority in managing health service delivery at local level (26). Similarly it advocates for an enhanced local level health service delivery system by seeking participation of community level support for the infrastructural development of health outlets (26). The commitment of the government for Ayurvedic medicine is also reflected in the document, but in reality, it is a challenge to gain support for this system of health (26). Furthermore, alongside formal and informal sector support, child and adolescent health, especially in relation to female health is identified as a crucial component of community level assistance.

The level of commitment of the government in involving CSOs in the process of development of health services and national policy making in Nepal is lacking. The roles CSOs play in implementing programmes, reporting and monitoring are as yet undefined. Further planning on these roles, ready for the next consecutive year would beneficial. For the integration of CSOs into the health service to be effective, government attitudes need to change.

2.2.2 Extent and Effectiveness of Implementation

CSOs including non-profit organisations such as NGOs, local groups/bodies, are providing a range of important services in health. CSOs have emerged as major service providers in various countries including Nepal. CSOs, such as Nick Simons Institute (NSI) have played an important role in getting doctors and health workers in rural locations. They develop an innovative support programme and their capacity building of staff through various trainings like in-service training of SBA has been very effective. Though the involvement of CSOs is encouraging, many field CSOs (local NGOs and CBOs) do not possess adequate skills and knowledge to advocate for the effective implementation of the policy and provisions as well as monitor the implementation.

CHAPTER III METHODOLOGY

A cross-sectional descriptive study, using both qualitative and quantitative research methods, was conducted in 15 districts of Nepal to obtain comprehensive information on the Human Resources for Health (HRH) situation in the country.

3.1 Primary Data Collection and Analysis

3.1.1 Quantitative Methods

3.1.1.1 Sample Design

A multi-stage cluster sampling method was used to select a representative sampling frame for this study (see Appendix 1). Of the 75 districts in Nepal, 15 districts were selected, one from each of the three ecological belts (Mountain, Hill and Tarai) and each of the five development regions (Far-Western, Mid-Western, Western, Central and Eastern) using a random sampling method.

Table 2: Selected Districts for Research Study, Nepal 2011

Development Region / Ecological Belt	Far-western	Mid-western	Western	Central	Eastern
Mountain	Darchula	Mugu	Manang	Rasuwa	Sankhuwasabha
Hills	Doti	Pyuthan	Palpa	Lalitpur	Panchthar
Tarai	Kailali	Bardiya	Kapilvastu	Dhanusha	Jhapa

The sampling frame consisted of 5,146 health institutions in the selected 15 districts, including Government Hospitals (Regional, Zonal or District), Primary Health Centres, Health Posts, Sub-health Posts, Ayurvedic Centres, Non-governmental and Private health outlets. A total of 404 health institutions were then selected using the Probability Proportionate to Size (PPS) method, based on the size of health institution by available HRH, as per WHO guidelines (27) (see Appendix 2). Out of the selected health institutions, data was collected from 375 health facilities (see Appendix 3). A total of 29 health facilities were not included in the study due to the unavailability of staff, demonstrating a response rate of 93 per cent.

3.1.1.2 Research Participants

Research participants were service providers including Doctors, Specialists, Nurses, Midwives, Public Health Workers, Health Assistants, Auxiliary Health Workers, Laboratory Technicians, Radiographers and Pharmacists.

3.1.1.3 Data Collection Tools and Processes

An interviewer-administered questionnaire was carried out by Public Health graduates with 747 health workers from the 375 selected health institutions in 15 districts, selected on the basis of WHO guidelines. Self-appraisal forms were also completed by 54 doctors, 218 nurses and 324 paramedical staff from within the sampling frame, with the exclusion of 20 respondents due to lack of complete information. An observation checklist was also carried out by research supervisors in 256 health facilities, in keeping with WHO standards of observing at least one third of health facilities from the sampling frame.

3.1.1.4 Data Analysis

Quantitative data was entered into a computer software system (EpiData 3.1) by trained data entry personnel. In order to validate the data, 10% was randomly cross-checked by Public Health Officers. After editing and cleaning, the data was transferred onto a statistical software package (SPSS 17.0) for analysis.

3.1.2 Qualitative Methods

3.1.2.1 Research Participants

Based on availability, a total of 645 participants were selected for the qualitative study, which aimed to support quantitative research findings (see Appendix 4). Participants were selected from the following groups: service providers, as in section 3.1.1.2, and also inclusive of Female Community Health Volunteers (FCHVs), Maternal and Child Health Workers (MCHW); service users, such as exit-patients of health service outlets; and lastly the facilitator group which included members of Government Health Institutions including District Public Health Office, District Health Office, District Development Committee, and Village Development Committee; Professional Associations; Civil Society Organisations and people working in Trade Unions and the field of advocacy, civil rights, media and social campaigns; local leaders, social workers and school teachers.

3.1.2.2 Data Collection Tools and Processes

Key data collection tools included Focus Group Discussions (FGDs) and Key Information Interviews (KIIs), conducted by Public Health graduates. A series of 74 FGDs were held, with at least one group of service providers, service users and Health Management Committees in each district. Purposive sampling was used to

select 29 informants to take part in semi-structured KIIs. A consultation workshop was also held with MoHP, NHRC and other key stakeholders to discuss findings and recommendations.

3.1.2.3 Data Analysis

Qualitative data was transcribed and translated into English, and was then analysed according to different thematic areas based on the relevant research objectives. The data was then triangulated with quantitative and secondary data findings.

3.2 Secondary Data Collection and Analysis

A review of the literature on national and international research papers on HRH was carried out. The review also included key national MoHP health Policies, Plans and Acts, as well as key information on Civil Society Organisations. Findings from the secondary data were triangulated with both qualitative and quantitative data.

3.3 Validity and Reliability

1. A standard statistical tool was used to determine the sample size and sampling strategy to reduce systematic error in the design phase of the study, based on WHO Standards.
2. Internal consistency reliability was ensured in quantitative data analysis by obtaining Cronbach's Alpha on key variables (>0.85).
3. To avoid questionnaire information bias, questionnaires were pre-tested in three districts, and feedback from the pre-test was incorporated into the final questionnaire design to improve validity and reliability.
4. To avoid interviewer information bias, interviewers, who were Public Health graduates, were trained for two days on data collection tools and methods according to WHO standard protocols.
5. Regular supervision visits were carried out, with appropriate feedback ensured from the central level during the collection of data.
6. Triangulation of primary and secondary data ensured consistency of the research data.

3.4 Ethical Issues

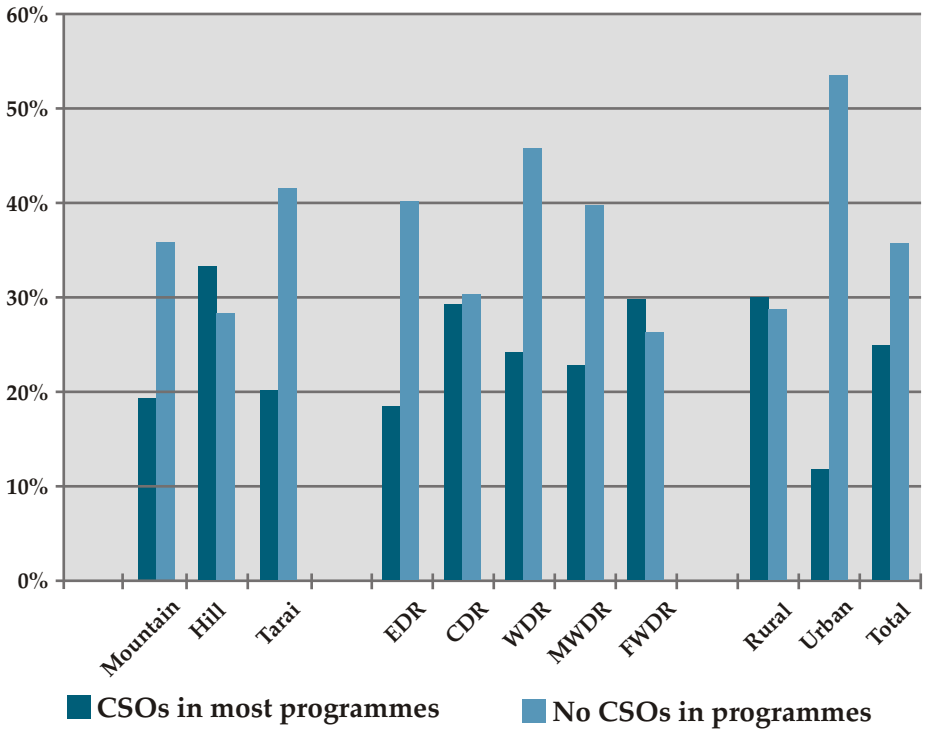
Ethical approval for this study was obtained from the Nepal Health Research Council (NHRC), and researchers adhered to national NHRC standard operating procedures and ethical guidelines for health research. Informed consent was obtained from each respondent, and confidentiality in terms of information disclosed and identity of respondents was ensured.

CHAPTER IV ROLE OF CIVIL SOCIETY IN IMPLEMENTATION OF HRH RELATED POLICIES

4.1 Role of Civil Society in Current Consultation Processes

The research assessed the level of involvement of CSOs in policy making, planning and implementation processes. Nearly one quarter (24.8%) of health workers within the sample reported that CSOs were involved in the planning and implementation process of the health institutions.

Figure 1: Involvement of CSOs in Planning and Implementation Process



Source: *HRH Field Survey 2011*

There was greater involvement of CSOs in the Hill ecological belt, and in the Far Western Development Region (FWDR) and Central Development Region (CDR) than in the other development regions (see Appendix 5). The data indicates that CSOs were more involved in rural areas in comparison with urban areas.

Analysis of the data also indicated that civil society organisations were more supportive in rural areas rather than in urban areas. Modernisation and urbanisation are found to negatively affect or weaken the interrelationships between civil society organisations and health institutions. A statistical analysis was performed to assess the validity of premise that there was decreased support from civil society in urban areas and also found significantly different in term of CSOs' support to health institutions [CI 95%; p value 0.000]. Also when calculated with coded values for support as 0 for "none" and 1 for "some", there was no overlap between the lower and upper bounds. (Table 3).

Table 3: Statistical Analysis of Supports of CSOs to Health Institution, by Urban Rural Areas, Nepal 2011

Areas	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Min	Max
					Lower Bound	Upper Bound		
Rural	534	0.5847	0.49809	0.02155	0.5063	0.5910	0.00	1.00
Urban	213	0.3709	0.48418	0.03318	0.3055	0.4363	0.00	1.00
Total	**747**	**0.4980**	**0.50033**	**0.01831**	**0.4621**	**0.5339**	**0.00**	**1.00**

Analysis of Variance Urban	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	4.813	1	4.813	19.710	0.000
Within Groups	181.934	745	0.244		
Total	**186.747**	**746**			

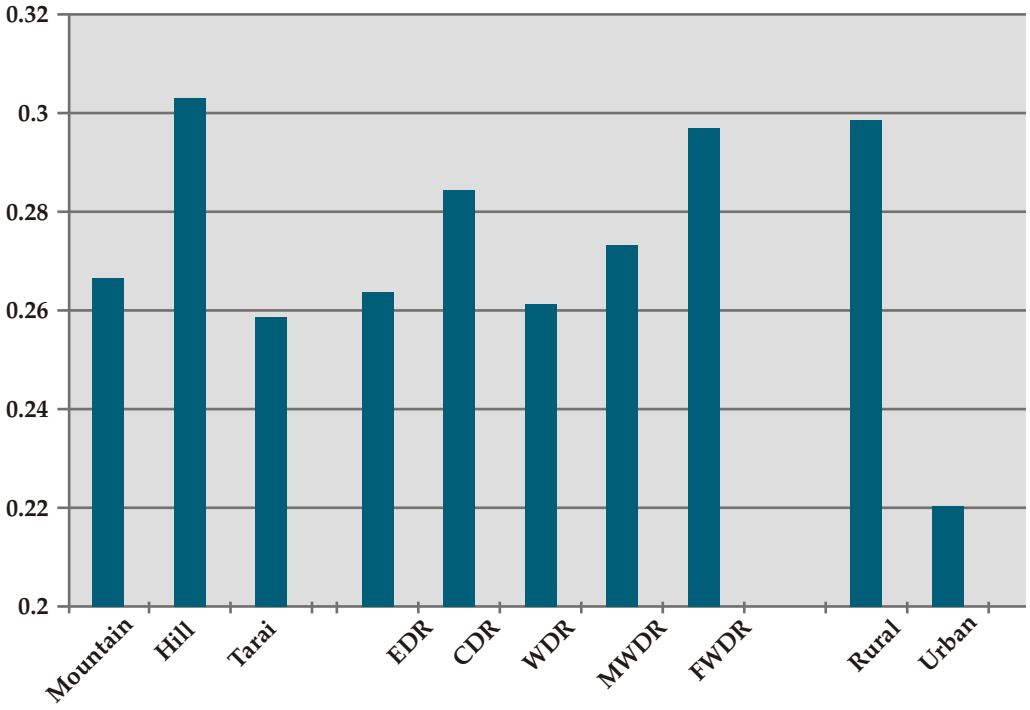
Supports of CSOs (0: None; 1: Some)

4.2 Effectiveness of CSOs

For the purpose of this study, the effectiveness of CSOs was measured according 40 variables which included: the frequency of visits to the health institution from local management committee members, support provided from CSOs in terms of planning and implementation of health services, security, recruitment, provision of equipment and support in running periodic health camps. It is assumed for the purpose of this study that effectiveness involves a multidimensional approach, comprising the support from CSOs to institutions and HRH and the level of interplay among HRH, health institutions and CSOs to ensure developments in health outlets and HRH. A composite index of effectiveness of CSOs was calculated (see Appendix 6 for details of indexing process).

It should be noted that the variables included for the construction of composite index do not guarantee that these are the only correlations responsible for effectiveness of CSOs. However, they represent a wide range of activities in which CSOs are directly and or indirectly taking part in to help, manage and enhance the HRH.

Figure 2: Mean of the Index of the Effectiveness of CSOs by Locational Variables



Source: *HRH Field Survey 2011*

Calculations from the effectiveness index found a low value for the effectiveness of CSOs (0.2765). Reasons for this were beyond the scope of the operational research; however, they indicate the need to strengthen CSOs to ensure their effective contribution to enhancing the multidimensional aspects of health institutions and HRH. Geographically, the rural areas, FWDR and CDR and the Hills ecological belt. (See Appendix 7)

Among the ecological belts, the Hill belt was found to have the highest score (0.3036), followed by the Mountain and Tarai areas. In the development regions, the FWDR had the highest score, CDR was second, MWDR was third, EDR was fourth and WDR was the lowest. This could be attributed to the difference in individual perceptions and the level of active participation of CSOs in various programmes. Since this index embraced almost all activities, and the Alpha value in derived high (0.8057), the index in Table 3 appears a more reliable representation of CSO effectiveness than the individual answers presented in Figure 2.

When the total effectiveness of CSOs was further segmented into low, medium and high categories, 15 percent of health workers reported that CSOs in the Hill belt were highly effective as opposed to 6.8 percent in the Tarai belt and 5.8 percent in the Mountain belt (see Appendix 8). Similarly, PHCs, HPs, and SHPs reported a higher level of CSOs effectiveness among the institutions, HAs and AHWs were ranked high among the personnel, and Panchthar, Pyuthan, Doti, Lalitpur, Sankhuwasabha and Dhanusha were found to have high levels of effectiveness among the districts (see Appendix 8).

Room for Enhancing Effectiveness

Focus group discussions (FGD) with Health Facility Management Committees in Pyuthan revealed that they were working as a pressure group for obtaining facilities and had contributed to the recruitment of Health Workers at the SHP, HP and PHC levels. The district level CSOs, by and large, had understood that their role was to carry out periodic checking of the stocks, quality aspects of the services and the filling of local health posts.

The FCHVs in Panchthar district commented that they did not receive adequate respect from the CSOs, despite their tireless work. The absence of doctors at the field level for different reasons created gap between the HRH and CSOs that in turn, was found to affect the effectiveness of CSOs.

Participants in one of the FGDs in Dhanusha expressed their dissatisfactions regarding the politician's influences. However, it was acknowledged that the management committees comprised of CSOs were catalytic in constructing the physical infrastructure in a number of districts and for providing the additional positions (human resources) in government as well as non-government health outlets.

A doctor in Pyuthan mentioned that there was a need for the Health Coordination Committee at district level to increase the effectiveness of CSOs. It could work as a pressure group for the incorporation of health issues in national annual plan document.

4.3 Role of Civil Society in Maternal and Child Health (MCH) Programmes

A primary role of health workers and facilities is in the implementation of maternal and child health programmes. The below case studies raise several issues which identify potential roles for CSOs. These issues include community-relevant health system management, monitoring and realistic expectations of health worker skills, and the wider interrelationship between the community and HRH. These case studies also emphasise the potential role of community representative bodies to facilitate community participation and enhanced communication between health workers and the people they support.

Health Worker Beaten: Potential Role of CSOs in Conflict Mediation

Mr Basudev (changed name), 31, had saved the life of a woman by helping her to deliver a breech child. He had not handled such cases before. Basudev was using his common sense of health practices.

After attempting for several hours to correct the position of the baby to allow for a natural birth, he was able to deliver the baby. The umbilical cord was wrapped around the neck and the baby was bluish. He first took care of the baby, removed the cord, and gradually the baby began to breathe. He handed over the boy to the midwife and turned his attention to providing the mother with the best attention he could provide. The mother was also out of danger.

His reluctance in the beginning because of his inadequate training, and skills later became a cause for anger among the villagers. They accused him of withholding his skills in order to receive money, or to avoid using local resources. The confrontation became violent, and somebody nearby informed the police. By the time they arrived, the woman's relatives had beaten him almost to death. Through the intervention of other local people, and eventually the police, his life was saved but he is understandably still affected by this event.

Discrimination on the Basis of Caste and Creed

An ANM in Panchthar was discriminated against due to her caste. Though she was there to help in the delivery of a baby, the family were ready to bring the woman in labour outside into the yard instead of letting the ANM go inside the house. She managed the delivery outdoors, creating minimal privacy with pieces of clothes. She recalled this event as a frustrating one. In the meantime, she had a fracture and had received no support. She requested a transfer and also filed a case against the discriminators. When she was posted in another HP she was fully supported by community people and was providing her service in a better manner.

4.4 Support of Political Parties and Community Members

It was found that approximately three quarters of the respondents (74.3%) felt that the political parties were supporting the health institutions at the grassroots level. The urban areas had obtained less support compared to their rural counterparts (see Appendix 9).

The PHCs, Health Post and Sub-Health Posts had obtained support from the political leaders and local communities in terms of advocacy for improvements in health services and mass mobilisation for health (see Appendix 10).

The coverage of services by the Ayurvedic centres, as well as the private and NGOs, is not well documented in many of the official documents. These institutions obtained less support from the communities. Most support was focused on the PHCs, HPs and SHPs. I/NGOs are often assumed to have donors to operate their programmes; therefore they received less support from the community (see Appendix 10).

Management Committee for Infrastructure

The FGDs conducted in Jhapa, Kapilvastu, Dhanusha, Kailali, Doti and Darchula have indicated that there were several instances of local supports for the infrastructure, machinery and the human resource in PHCs, HP and SHP. Even the committee provided financial support for an Ayurvedic Aushadhalaya (Health Post) in Dhanusha.

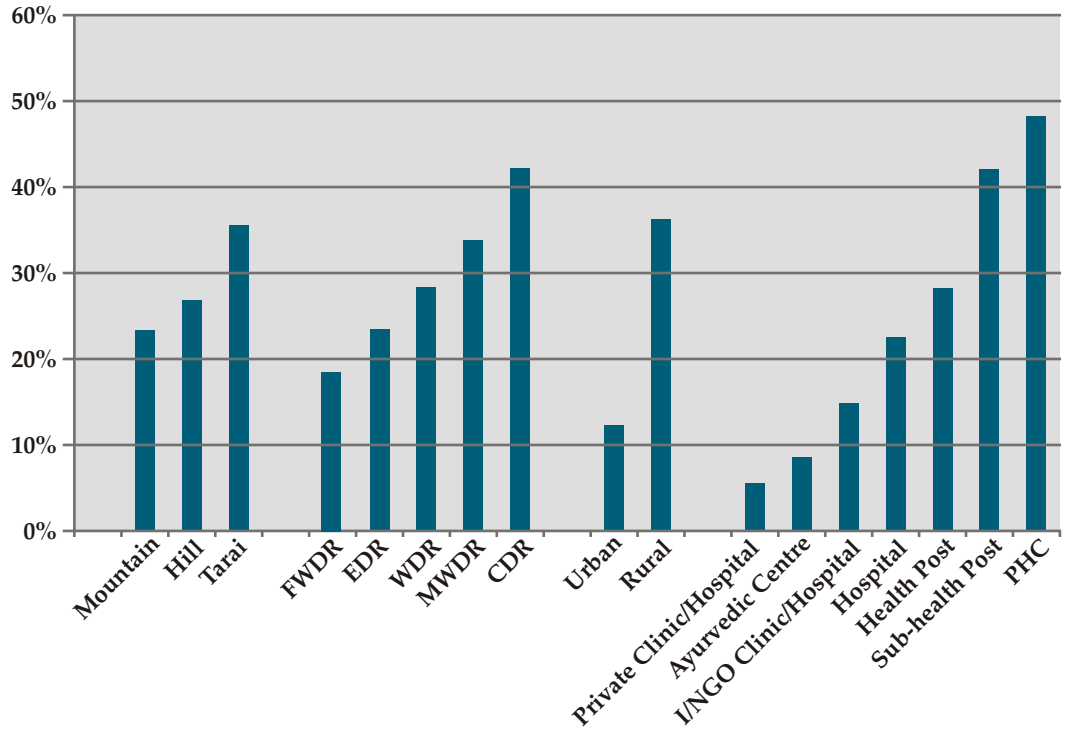
4.5 Cooperation between CSO and Institutions as well as HRH

Though there are a number of variables behind the collaborative attempts to help health institutions avail local support from CSOs, some of the issues incorporated in the survey tools are discussed below.

4.5.1 Committees for Prevention of Diseases

There are committees formed in collaboration with CSOs for the prevention of diseases and epidemics. A higher percentage of Health Workers in the Hill belt (35.5%) reported the existence of such committees compared to the Tarai (26.8%) and Mountain belt (23.3%) (see Appendix 11). Among the development regions CDR had highest percentage (42.2%) and FWDR had the lowest (18.4%) one. The gap between rural (36.3%) and urban (12.2%) was considerable. Among the institutions PHC (48.1%), SHP (42.0%) were in high ranking whereas Private Clinics (5.5%) and Ayurvedic Centres (8.6%) were the lowest ranked (see Appendix 11).

Figure 3: Formation of Committees in Collaboration with CSOs



Source: *HRH Field Survey 2011*

4.5.2 Involvement in National and Local Committees

Representation of HRH in National level committees was much higher in urban than rural contexts in the CDR as opposed other development regions, and the Hills when compared with the other ecological belts. A slightly similar pattern was observed for the committees formed at the local level with higher leverls of support in urban areas, the CDR and the Hills belt (see Appendix 11).

Almost half of the respondents based in PHC reported collaborations with CSOs, followed by the respondents in Sub-health Posts. The urban based hospitals, private clinics had less interaction with local CSOs. Among the personnel, the paramedical like HAs/AHWs and the nursing staff had more collaboration with local CSOs than other cadres of heath staff (see Appendix 11).

A comparison between the involvement of HRH in national level bodies and grassroots based pressure groups demonstrated that the PHCs, HPs and SHPs and most of their employees as HAs/AHWs and ANMs, were more involved in local level pressure groups with CSOs, but less in the national level bodies.

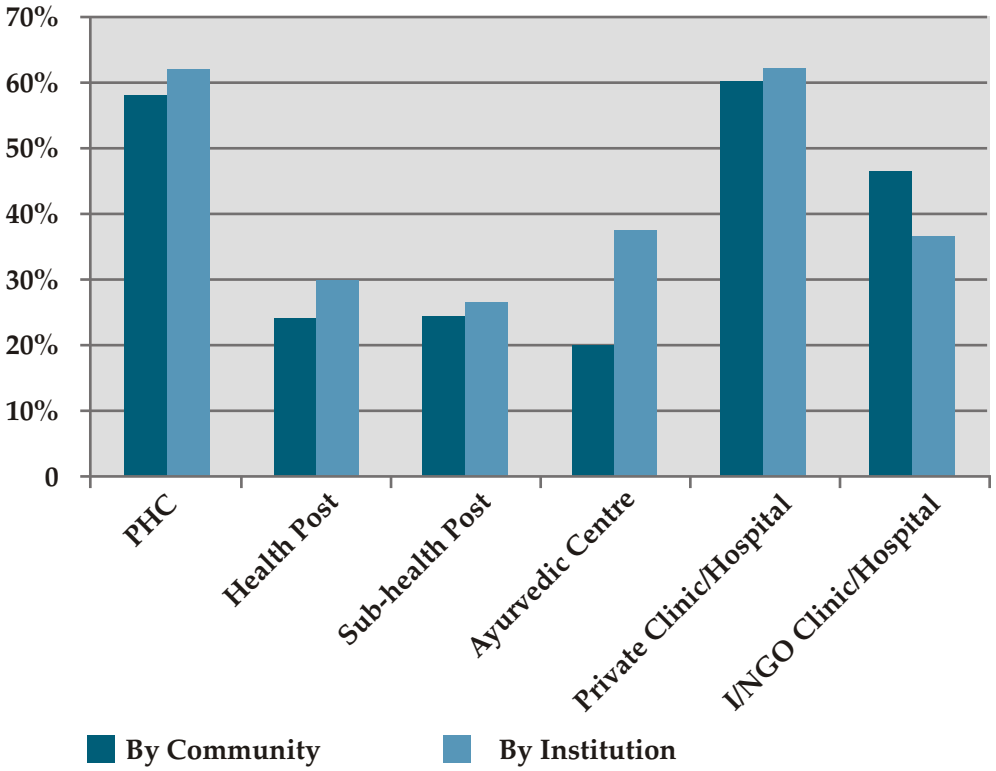
These two conditions indicated that the doctors, specialists and technicians were much more involved in the national level bodies. Involvement in the grassroots based CSOs and their activities was more associated with the paramedical personnel such as HAs/AHWs etc.

4.5.3 Periodic Health Camps in Cooperation of Each Other

The frequency and success of the periodic health camps are the result of local support to the health institutions. The CSOs often use their awareness of disease prevalence to identify the need for health camps, and participate in their implementation in cooperation with health institutions. CSOs and health institutions must have the interactive roles. The survey tool attempted to gather the information on the number health camps are arranged by health institutions and by CSOs. The FWDR was found to have slightly less camps than other regions. This variable had higher percentage of responses for the urban areas compared to rural. The PHCs and the private clinics were found to arrange or support to more health camps than other institutions (see Appendix 11).

Ayurvedic Centres were less involved in arranging the health camps. The technical human resources were observed to be more involved in such camps than paramedical personnel. Nursing staff were also more involved in health camps than HAs and AHWs (see Appendix 11).

Figure 4: Health Camps Organised in Cooperation of the Community and Health Institution



Source: *HRH Field Survey 2011*

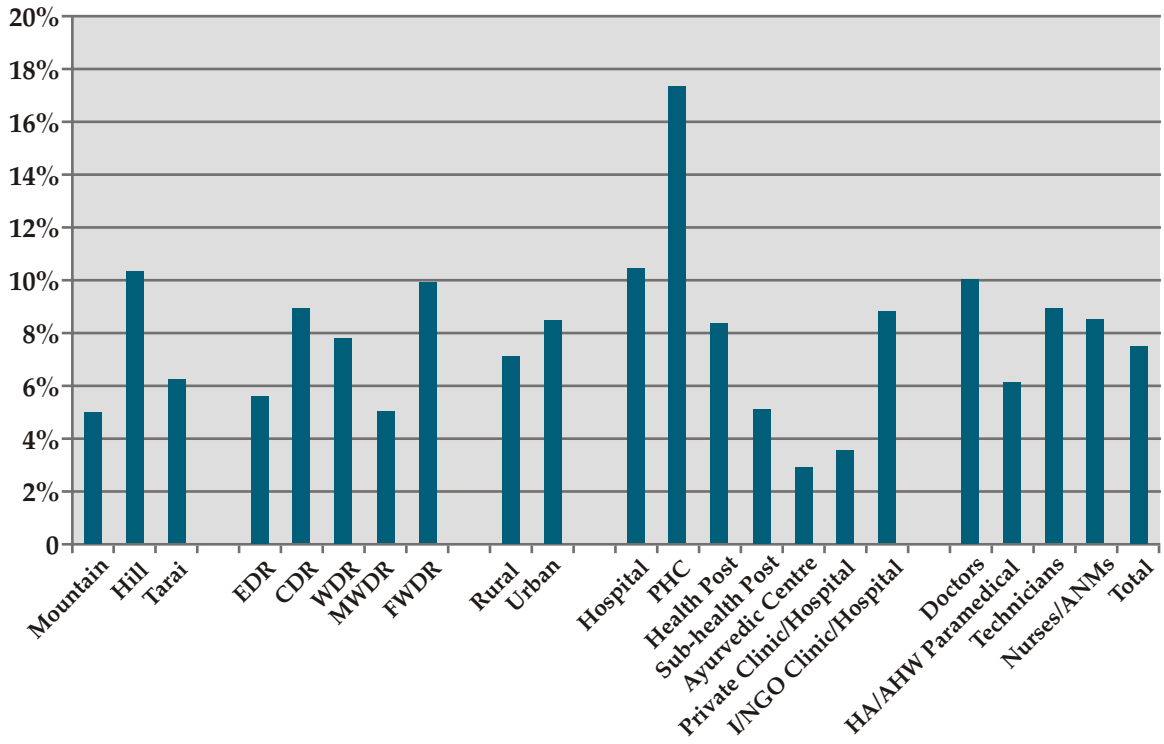
4.5.4 Reward to the Health Personnel by CSOs

Rewards provided to the health workers by CSOs is an important indicator to show the relationship between them. Altogether, 7.5 percent of respondents were aware of the rewards system. Though the percentage of doctors (10%) was higher, other indicators did not show that they maintained better relationship with CSOs. Similarly, the paramedical staff such as HA/AHW were less rewarded compared to nursing staff and technicians.

In general, more than 92 per cent of interviewed health workers were not aware that local communities rewarded Health Workers for their good services.

A communication gap between the HRHs and local civil society is suggested by this situation - almost all HRHs had no idea about the local communities' rewards systems. It indicated the need for rethinking in the tradition of 'expression of thanks' in the oriental societies. Ayurvedic Centres and their HRHs in this manner were found least engaged in civil society interactions (see Appendix 11 for details).

Figure 5: Knowledge on HRH Rewarded by CSOs



Source: *HRH Field Survey 2011*

4.6 Involvement of Civil Society in Planning and Implementation Process

There has been a gradual attempt by the Government of Nepal to handover the management system of health institutions to communities. For this process to be successful, high level of involvement of CSOs in both planning and delivery of health services is required. Only 7.6 per cent of the respondents had observed that CSOs were involved in planning of all programmes, 17.1 percent in most of the programmes, and 39.5 per cent of some of the programmes of the health outlets. Thus CSOs have 'Some Involvement' in programme planning in 64.3 per cent of the total responses (see Appendix 12).

Interestingly and similar to the trends in CSOs involvement, the Hill belt, FWDR region, rural areas, Sub-health, and the HAs/AHWs paramedical staff scored higher on the CSOs role in planning for the health institutions. The involvement of CSOs in planning, implementation and monitoring of the health institutions was more pronounced in the rural hills, and with the help of paramedical staff (see Appendix 12).

In relation to the types of CSOs that were involved in the planning and implementation processes almost six out of 10 respondents stated that they were the HFOMCs, which outnumbered the other types of CSOs. Management of HWs is the responsibility of the HFOMC at the local level. The HFOMC makes decisions on the management of staff, the physical infrastructure, and requests for the supply of drugs and equipment, as well as managing the mobilisation of resources within that catchment area. The HFOMC also has the responsibility to plan, implement and monitor the programme and maintain good governance.

The HFOMC monitors the filling of all sanctioned posts and recommends staff for deputation, trainings and workshops. The committee also approves the leave of staff for up to 7 days and refers to the District authority for the leave greater than one week. The committee also has authority to recruit the additional staff based on the need and the budget availability.

The support of the HFOMCs was higher at the PHCs, HPs and SHPs compared to other institutions. Almost seven out of 10 respondents in these institutions stated that HFOMCs were present in the planning process. Again Ayurvedic centres were found almost isolated from the CSOs. Enhanced involvement was recorded in the responses of HAs and Nurses, six of whom among 10 had acknowledged the role of HFOMCs. The FWDR among the development regions was found mobilising the HFOMC more than others in planning of health institutions. Though Hills outnumbered other belts the gap was minimal (see Appendix 12).

The same pattern was observed in the involvement of Local Agencies and Local Informal Groups (see Appendix 13).

Slightly different figures were observed for I/NGOs which were closer to health institutions in CDR than other regions. The facilities and accessibilities in the central region may have attracted them towards the health institutions in this area (see Appendix 13).

4.6.1 Frequency of Management Committee meetings

The HFOMCs were made more vigilant by the presence of CSOs. HFOMCs met monthly in half of the institutions (49.9%), 17.9 per cent met quarterly, and another 10.4 per cent met once in four months indicating that 78.2 per cent had regular meetings. At least eight out of 10 respondents reported that their HFOMC had a meeting at least once in the last four months (see Appendix 14).

Health professionals seem to have little knowledge on the involvement of civil society organisations in management committees (see Appendix 14). There are three possible explanations. Firstly, the professional personnel were unaware of the management committee and other activities. Secondly, there was the poor knowledge of doctors with their negligence in mobilising local civil society for the benefit of health institutions. And thirdly, hospital management in urban centres (both public and private) did not furnish staff with information regarding their management committee, its meeting and decisions to the doctors as well.

CHAPTER V ROLE OF CIVIL SOCIETY IN MONITORING AND ENHANCING THE QUALITY OF HUMAN RESOUCE FOR HEALTH

5.1 Awareness of Civil Society in Public Health Concerns

5.1.1 Views of Political Parties in Public Health

The agenda of the political parties are reflected in public policy and further strengthens the implementation from central to grassroots level. The political cadres at local level are also usually oriented in the policies of their respective parties; therefore, the standpoints put forward by the political parties, to some extent, are important to drive policy related issues on the concern areas. Nepal's public health arena is also guided by the views of political parties as mentioned in their election manifestos.

The health issues appearing in the manifestos were divided into nine segments: 1. Policy Formulation, 2. Production of HRH, 3. Distribution of HRH, 4. Career Development of HRH, 5. Implementation of Programmes, 6. Resource Allocation, 7. Monitoring and Evaluation, 8. Seeking People's Participation and 9. Overall Coverage of Health Concerns. A careful examination of the available election manifestos of the major political parties showed that the health related policies were not well articulated in most of the manifestos. Only two of them were explicit about the production of HRH, distribution was only mentioned specifically in two of the documents. The poorest segment was the career development of HRH. The second poorest depiction was monitoring and evaluation. Similarly, resource allocation was not an issue for all parties.

Though the government's policy is transferring responsibility to the community and HFOMCs for operating the health institutions in community level, the political parties were found to be less concerned about the people's participation. Manifestos mentioning policies related to people's participation in advancement of health services and their interrelationships with HRH were rare. (see Table 4).

There is need to orient political parties on how the issues related to health can be addressed. A gap between the health professionals and political parties is observed in this context. Health professionals affiliated to political parties have not been able to effectively communicate bhow the health sector should be addressed in their respective policy documents.

Table 4 : Issues Related to Health in the Manifesto of Major Political Parties, Nepal, 2003-2007

Characteristics	Some of the Major Political Parties							
	CPN-M	NC	CPN UML	MJF	RPP	NSP	NLPP	CPN ML
1. Policy Formulation	3	4	4	NA	2	3	4	3
2. Production of HRH	4	3	4	NA	1	1	3	3
3. Distribution of HRH	3	4	4	NA	3	4	4	4
4. Career Development of HRH	2	2	3	NA	3	1	2	2
5. Implementation of Programmes	3	4	4	NA	2	2	2	3
6. Resource Allocation	2	3	4	NA	3	1	2	3
7. Monitoring and Evaluation	1	2	2	NA	2	1	3	2
8. Seeking People's Participation	3	2	5	NA	1	1	2	4
9. Overall Coverage of Health Concerns	3	3	4	NA	3	2	3	3
Total	**24**	**27**	**34**	**NA**	**20**	**16**	**25**	**27**

Score -
1: Non existence,
2: Poorly mentioned,
3: Mentioned with no Programme,
4: Programme also mentioned;
5: Mentioned Policy, Programme and Implementing Strategy

Political Parties and the page number of their manifesto, mentioning the policies

CPN-M - Communist Party of Nepal (Maoist) - pp 19
NC - Nepali Congress - pp 12, 22
CPN UML - Communist Party of Nepal (United Marxist Leninist) - pp 33, 34
MJF - Madhesi Jana-Adhikaar Forum, pp ..
RPP - Rastriya Prajatantra Party, pp 6, 7
NSP - Nepal Sadbhawana Party, pp 8
NWPP - Nepal Workers and Peasants Party, pp 12
CPN ML - Communist Party of Nepal (Marxist, Leninist), pp 16

5.1.2 Effectiveness of CSOs in Enhancing the Quality of Health

There were mixed views in the KIIs. There were also community specific perceptions and realities regarding the associations between CSOs and the health system. A commonly held view was the need of communities to be responsible in health service delivery. A Coordination of the activities of NGOs at local level is important for quality services and mitigation of redundancy.

A statistical analysis of mean efficiency of CSOs was utilised to observe their clustering and dispersion. It was found that PHCs, SHPs and Health Posts were more effective in service delivery than other institutions where they were working with CSOs (see Appendix 15).

CSOs and Health Institutions

The KIIs with service users, service providers and service managers revealed some distinct features related to interrelationships between CSOs and health outlets. They are summarised in some major points below by the name of district. Repeated versions are omitted.

Bardiya	-	political parties very often create hindrances to quality HRH, people elected in management committee have no knowledge on health
Darchula	-	people are not serious about health institutions and HRH in Nepal because border areas have access to health in nearby Indian townships; people should be educated with their duties towards health system; private sector is doing well, but is expensive; a civil monitoring is needed; CSO can help in providing accommodation to HRH
Dhanusha	-	rampant poverty prohibits community people from contributing to health
Doti	-	coordination among GOs, NGOs and other organisations is needed for specialisation and diversification to make services better
Jhapa	-	poor people are supported, VDC source has helped but not adequate; Management committee had meeting once in seven years; an Ayurvedic centre had an MC non-functional for 10 years
Kailali	-	CSOs support is positive; adequate is done, post are created by VDCs and management committees
Kapilvastu	-	conflict between and among people affects the quality of health services, peace is prerequisite for better health facilities; NGOs are to be monitored for their service and avoid duplication
Lalitpur	-	people deprived of education and health facilities as well as by government services are being catered by NGOs; community people be made responsible in implementing health programmes;
Manang	-	none
Mugu	-	CSOs can raise the question of quality of services

Palpa	-	community people are friendly creating conducive environment to HRH
Panchthar	-	community people complain, but do not get involved; they should show their interests in health service delivery system
Pyuthan	-	support to health institution is appreciable by providing land by a pilgrimage spot and construction of building by the CSOs; health programmes are isolated from the NGOs to a large extent, they can work together for betterment
Rasuwa	-	none
Sankhuwasabha	-	different stakeholders need to solve the health problems

5.2 Role of Health Facility Operation and Management Committees

The role of HFOMC was assessed by the number of activities performed in support to health institutions. It was found that more respondents in Mountain had observed Excellent, Good and Modest support rendered by the HFOMC compared to other ecological belts. However, in totality of all sorts of assistance by all other agencies that constituted CSOs, the Hill belt was rated higher than the other belts.

Among the development regions, the HFOMCs in FWDR were performing well when the modest and higher levels of support were combined. The urban HFOMCs were weaker than those in rural areas. The PHCs, HPs and SHPs were in a better position compared to other facilities in terms of availing the support from the HFOMCs. The personnel's perception revealed that HA and AHW groups had experienced much more support from the HFOMC than others (see Appendix 16). This information indicates that HFOMCs were more active in PHCs, HPs and SHPs . This is coherent with government policies.

Four districts were found to provide local level financial support to staff in the health institutions. This support was provided in a SHP in Sankhuwasabha, in a HP and an NGO in Bardiya, in a PHC in Kailali, and in a HP in Doti (see Appendix 17).

5.3 Perception of HRH on Security and Social Prestige at Workplace

There was a positive correlation between the effectiveness of CSOs and the feeling of job security by health workers. Areas which had highly effective CSOs had a higher percentage of health workers feeling "Extremely Secured." Similarly, areas where the CSOs recorded a low level of effectiveness had lower percentages in staff sense of security (see Appendix 18).

Another variable which was taken into consideration was the level of social prestige and recognition as experienced by the health workers. Similar to the feeling of security, a high percentage of social prestige felt by HRH in areas with a high effectiveness of CSOs. These percentages decline in tandem (see Appendix 18). It was also found that even a medium level of CSOs effectiveness had an association with better security and social prestige.

This indicates that CSOs effectiveness in supporting to health institutions and HRH was one of the determinants for the psychological state of health workers in regard to perceptions of security and social prestige (*for details see operational report area one*).

5.4 Civil Society and Some Reasons for Retention of HRH

Efficiency of CSOs and cooperation of people towards health institutions are the determining factors for the retention of human resource. The dimensions (variety) and direction (negative or positive) of social relationships result in push or pull factors.

A clear cut direction is observed towards positivity between the efficiency of CSOs and perception of HRHs towards the social life in the work-place. This positivity indicated that in the areas where the CSOs were found better, the HRHs had perceived as good places to live and work (Table 5).

Its statistical association examined with Gamma coefficients showed a modest positive association (0.259) with level of significance in 99.9 per cent.

Table 5: Index of Efficiency of Civil Society and Social Life in Work Place of HRH, Nepal 2011

Index of Efficiency of Civil Society	Social Life in Work Place		Total
	Not Good	Good	
Low	49	184	233
Medium	51	223	274
High	24	216	240
Total	**124**	**623**	**747**

Statistical Examination of Ordinal Scale Variables				
Ordinal by Ordinal	**Value**	**Asymp. Std. Error(a)**	**Approx. T(b)**	**Approx. Sig.**
Gamma	0.259	0.074	3.360	0.001
N of Valid Cases	747			

CHAPTER VI CONCLUSIONS AND RECOMMENDATIONS

On the basis of qualitative and quantitative findings discussed in chapter four and five, the following summary of major findings are concluded below.

6.1 Conclusions

6.1.1 Role of Civil Society

In general, civil society organisations were found to be more supportive in rural areas rather than in urban areas.

Effectiveness of CSO in HRH

- Overall effectiveness of CSOs, in terms of the frequency of visits to health institutions from local management committee members, support provided from CSOs in terms of planning and implementation of health services, security to health workers, recruitment, provision of equipment and support in running periodic health camps was found to be relatively poor in Nepal. Among the ecological belts, CSOs were most effective in the Hill belt, and least effective in the Tarai.
- Lack of implementation of government policies regarding transfer of responsibility of health institutions to the community has been identified as an issue. Major obstacles included the lack of resources required to transfer ownership.

Role of Civil Society in MCH Programs

- CSOs were required to focus on improving Reproductive Health and Maternal and Child Health programmes.

Support of Political Parties and Community Members

- Political parties and community members in rural areas were more supportive of the health institutions than in urban areas. The Mountain belt, and EDR excelled above others. The PHCs, Health Posts and Sub-Health Posts obtained support from political leaders and local communities, whereas Ayurvedic centres obtained the least support.

Formation of Committees and Participation

- Almost half of the PHCs and fewer Sub-Health Posts had committees which included members from CSOs. Minimal involvement of management committees in Ayurvedic centres and those working in the Mountain belt in the national bodies and local pressure groups were noticed.
- More than 90 per cent of HWs had no knowledge about the incentives provided by the community.

6.1.2 Involvement of Civil Society in Health System

Planning and Implementation Process

- In total, 60 per cent of respondents observed the involvement of CSOs in the process of planning, implementation and monitoring of the health institutions.
- I/NGOs were more concentrated in health institutions in the CDR.

Management Committee and Frequency of Meeting

- The presence of civil society through the HFOMC was vital. There were a higher frequency of regular meetings at the PHC, HP and SHP levels.
- In many private outlets and hospitals in urban and Tarai areas, doctors and other personnel had no knowledge of the existence and frequency of meetings with the HFOMC, and often they were unaware of the management committee.

6.1. 3 Civil Society Awareness and Public Health Concerns

Effectiveness of CSOs

- The role of the CSOs in the Hill belt was more effective than in Mountain and Tarai. CSOs were also more effective in FWDR, then CDR, MWDR, EDR and WDR respectively. CSOs in rural were found to be more effective than in urban areas.
- Effectiveness of CSO was higher in PHCs, SHPs and HPs than other institutions .

Effectiveness of Health Facility Operation and Management Committee

- The HFOMCs were more active in FWDR and at the PHC, HP and SHP levels.
- The HA and AHW groups had experienced much more support from the HFOMC than other cadres of health workers.
- A few of the HFOMC were found providing support to the salary of staff, equipment and other expenses in health facilities.

Civil Society, Security and Social Prestige

- The feeling of security and higher social prestige experienced by HWs was higher where CSOs were more effective.

6.2 Recommendations

On the basis of above findings and conclusions following recommendations are made for different agencies.

6.2.1 For Central Government

- The MoHP should recognise, reorganise and formalise the role of civil society in policy documents and seek engagement of CSOs in the formulation of policies, strategies and projects related to health service delivery from national to grassroots level. Ensure the meaningful engagement of CSOs in HRH policy formulation, HRH research and implementation.
- The MoHP should actively encourage the input of CSOs, particularly in urban areas and the Tarai belt. Adopt measures to encourage the interest of civil society in managing health institutions.
- The MoHP should encourage a bottom-up approach to planning through the involvement of the local community in health policy making, programme designing,

implementation and monitoring. Use print, electronic, audio - visual as well as live methods, such as drama, to persuade people to own the health programmes nationally.

- Foster studies and research related to the involvement of civil society in need assessments, policy-making, and the managing and implementing of programmes in health institutions.
- Improve communication between local authorities and local development bodies in HRH planning and decision-making, through monthly working groups involving VDC, DDC and CSOs (including HFOMCs, Mothers' Groups etc.). The purpose of these meetings would be discussions and adjustments to human resources at local level.

6.2.2 For Regional Government

- Ensure the involvement of civil society in needs identification and the formulation of policies, strategies and projects related to health by creating regular opportunities for dialogues and space for feedback, communication and sharing of information/data.
- Monitor all DDCs focusing their compliance for endorsement of health issues by DDC council, to incorporate them in the overall development planning of coming fiscal year.
- Monitor periodically the effectiveness of CSOs in health institutions and encourage to handover the management to communities.

6.2.3 For District Level Government

- The DDCs should maintain a record of CSOs involved in the health sector and solicit their input for identifying the prevalence of diseases in particular areas within district, preparing strategies and implementing projects to cope the health problems of the population.
- The preparation of a health plan for the next year, based on the past trends and current morbidity pattern, by DPHO , forward it to DDC for endorsement by DDC Council and send to MoHP and NPC for its inclusion in the 'Red Book' of programmes of the government.
- Establish effective coordination between DDC and DPHO to avail the support from civil society for health programmes. Include peoples' representatives in different health related committees formed by the DPHO.
- Monitor the role of HFOMC in all institutions in general; and strengthen the role of civil society in Ayurvedic, Homeopathy and others traditional sectors of medicine in particular.
- Consult and obtain recommendations of HFOMC in nominating the personnel for long term training and studies.
- Identify the areas that are insecure and with low social prestige for HRH within district and periodically counsel the local political parties and CSOs to improve the environment.
- Annual awards to the best CSOs (clubs, communities) which have recognised and supported health workers and institutions.
- District management teams should work together with CSOs to provide an accurate budget to ensure standards are met for the management of the health institutions and their infrastructure.
- Establish coordination between Department of Health Services and Department of

Ayurveda from Central to VDC level through monthly meetings to discuss roles, responsibilities and areas of common management. Create an environment through joint planning meetings to enhance the capacity of health-civil society actors to engage with and positively intervene in the policy making process, to monitor and drive policy implementation and to ensure accountability in the functioning of health systems.

6.2.4 For Health Institutions

- The PHCs need to take lead in establishing the coherent relationships with local CSOs for themselves, HPs and SHPs .
- Organise regular health camps by PHCs, HPs and SHPs, jointly with Ayurvedic centres wherever possible in coordination with civil society organisations.
- Recognise and reward annually CSO people for their supports to health institution that encourages a vice-versa reward of HRH by CSOs.
- Mobilise School and Colleges, Local Agencies and Local Informal Groups for awareness activities or mass campaigns.

6.2.5 For Civil Society, Communities and Families

- The HFOMC should be appointed at all health facility levels, including Ayurvedic Centres, in order to strengthen the coordination between those health facilities and the district.
- Conduct an 'HRH Audit' as part of the social audit that allows local communities to "audit" how the staff transfers are made and how local funds are being used for recruitment.
- The CSOs must be prepared to take joint responsibility for managing the local level health institutions; however, a modality for resource allocation by the government should be finalised with the help of a task force.
- The CSOs collectively should work as a pressure group for health issues to be covered by the resolution of DDC Councils to incorporate them in the plan of consecutive years.
- The CSOs can play an important role in supervising and monitoring the trainings and skills of VHWs, MCHVs and FCHVs to obtain improved Reproductive Health and Maternal and Child Health services.
- Utilise local media to inform people of current health issues, the CSOs role in health management and to highlight key issues in health management.

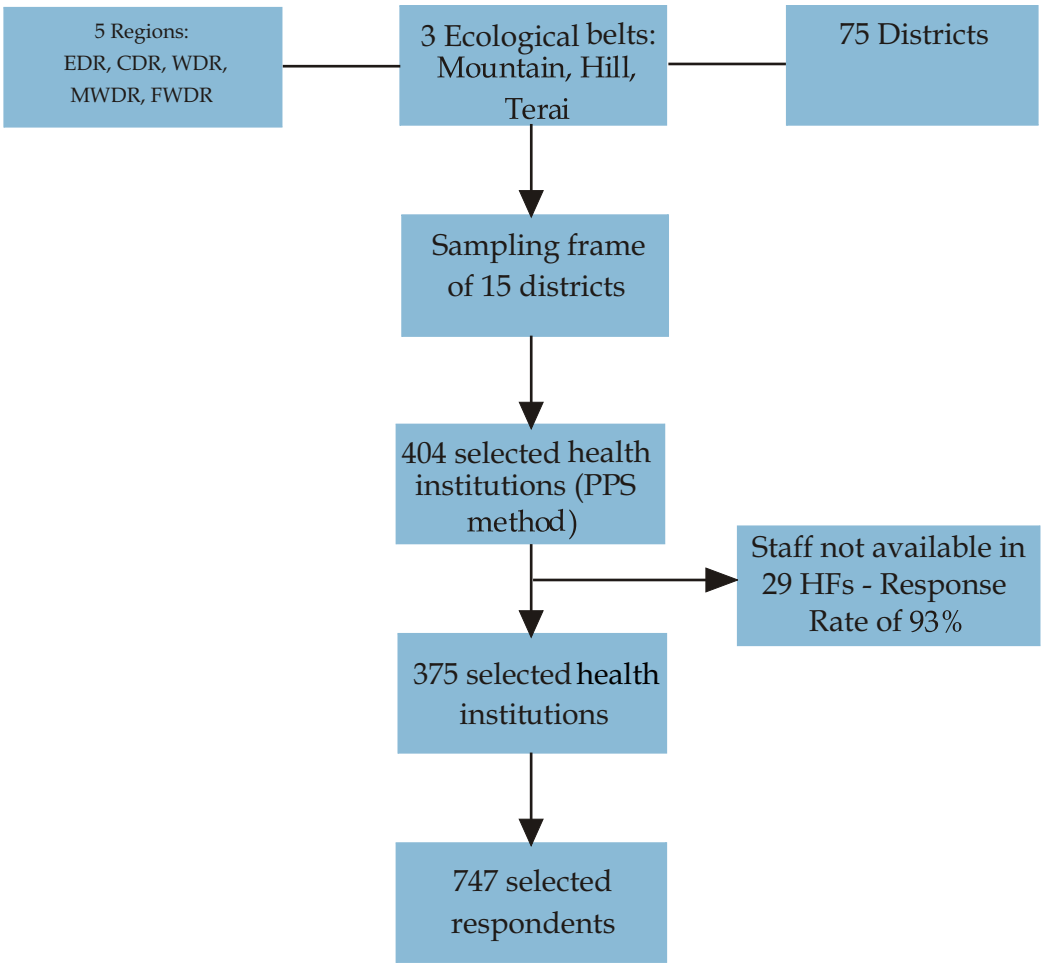
REFERENCES

1. WHO SEARO. Health Systems Development- Human Resources for Health. [Electronic] 2008 [updated June18, 2008; cited 2012 February 16]; Available from: *http://www.searo.who.int/en/section1243/section1308.htm*
2. WHO, ICM, FIGO. Making pregnancy safer: the critical role of the skilled attendant. Geneva, Switzerland: WHO; 2004.
3. World Health Organization. Understanding Civil Society issues for WHO: World Health Organization; 2002.
4. Douma N, Klem B. Civil War and Civil Peace, A Literature Review of the Dynamics and Dilemmas of Peacebuilding through Civil Society. The Hague, Netherlands: Institute of International Relations 'Clingendael'; 2004.
5. Merkel W, Lauth H. Systemwechsel und Zivilgesellschaft. Welche Zivilgesellschaft braucht die Demokratie? Aus Politik und Zeitgeschichte. 1998;6 (7):3-12.
6. Malena C, Finn Heinrich V. Can we measure civil society? A proposed methodology for international comparative research. Development in Practice. 2007 2012/05/23;17(3):338-52.
7. Civil Society International. What is Civil Society? [Electronic] 2003 [cited 2012 February 19]; Available from: *http://www.civilsoc.org/whatisCS.htm.*
8. Uprety U. A Reflection on the Legal Framework for Civil Society in Nepal. The International Journal of Not-for-Profit Law. 2011;13(3).
9. Zaidi SA. Institutional failure, state failure or the failure of "civil" society? The rural water supply and sanitation sector in Pakistan. The Lahore Journal of Economics. 1999;5:71-90.
10. Brinkerhoff D, McEuen M. New NGO partners for health sector reform in Central Asia: family group practice associations in Kazakhstan and Kyrgyzstan. Special Initiatives Report. 1999;19:1-29.
11. Carter J. The power of partnership: the eradication of guinea worm diseases. Cooperation South Journal. 1999:140-7.
12. Kahssay H, Baum F. The role of civil society in district health systems: hidden resources: Division of Analysis, Research and Assessment, WHO; 1996.
13. Munishi G, Yazbeck A, Deroeck D, Lionetti D. Private sector delivery of health care in Tanzania. Major Applied Research Paper No 14. Washington: World Bank; 1995. p. 1-88.
14. World Bank. Private and Public Initiatives: Working together in health and education: Improving health care in Uganda is a private matter. Washington: World Bank; 2002.
15. Asian Development Bank (ADB), Department for International Development (DFID), International Labour Organization (ILO). Nepal: critical development constraints. Mandaluyong City, Philippines: Asian Development Bank; 2009.
16. World Health Organisation. Civil Society Initiative (CSI): NGOs and Health. Geneva, Switzerland: WHO; [cited 2012 February 16]; Available from: *http://www.who.int/civilsociety/health/en/.*
17. World Health Organisation. Strategic alliances: The role of civil society in health. Geneva, Switzerland: WHO; 2001 [cited 2012 February 3]; Available from: *www.who.int/civilsociety/documents/en/alliances_en.pdf.*

18. World Health Organisation. WHO and Civil Society: Linking for Better Health. Geneva, Switzerland: WHO; 2002 [cited 2012 February 3]; Available from: *http://www.who.int/civilsociety/documents/en/CSICaseStudyE.pdf.*
19. Jareg P, Kaseje DCO. Growth of civil society in developing countries: implications for health. The Lancet. 1998;351(9105):819-22.
20. Paudel NR. Health Policy Design and Implementation in Nepal: A Policy Discussion. International Conference on 'Challenges of Governance in South Asia' December 15-16; Kathmandu, Nepal2008.
21. Government of Nepal. Ninth Five Year Plan (1997-2002), a Medium Term Strategic Plan (MTSP). Kathmandu: National Planning Commission, Government of Nepal; 1997.
22. Central Bureau of Statistics. Preliminary Report of the National Population Census 2011. Kathmandu: National Planning Commission; 2011.
23. WHO SEARO. Country Health System Profile Nepal. WHO [updated July 27, 2007; cited 2012 March 12]; Available from: *http://www.searo.who.int/en/Section313/Section1523_6867.htm.*
24. Ministry of Health and Population (MoHP) [Nepal]. Nepal Health Sector Programme Implementation Plan II (NHSP-IP II) 2010-2015 Final Draft. Kathmandu: Ministry of Health and Population, Government of Nepal 2010.
25. Loewenson R, editor. Civil society contributions to pro-poor, health equity policies. Annotated Bibliography on Civil Society And Health; 2003: World Health Organisation, Training and Research Support Centre Zimbabwe.
26. National Planning Commission. Three Year Interim Plan (2007/08 – 2009/10). Kathmandu: National Planning Commission, Government of Nepal; 2007.
27. World Health Organization. Assessment of Human Resources for Health: Survey instruments and guide to administration: WHO, Geneva; 2002.

APPENDICES

Appendix 1: Sampling Method



Appendix 2: Derivation of Sample Size

Major features of sample determination:

1. Total Institutions = 5146

2. Total Hospitals, PHC/HC and HP = 1000

3. Proportion of Targeted Health Facilities = 1000/5146= 0.194

4. The formulae for calculating the sample size

$$n= Z^2_{1-a/2} *p*(1-p)*deff*(1+nr)/d^2$$

Where:

$Z^2_{1-a/2}$ = 5% level of significance=1.96

p = proportion of the targeted coverage of health institutions

Note: Since all categories of health workforce are found in District Hospital, Primary Health Care Centres/ Health centres and Health Posts, the total number of these institutions (1000) is divided by the total health institutions (5146) in the country to calculate the proportion.

deff = Design effect, which is set as to minimize sampling variability caused by cluster sampling

The design effect set for this sample determination is 1.5

nr = Non response rate, which is an estimated rate for the non-response of respondents and it is set as 10 percent (0.1) in this sample selection.

d = Allowable error, which is usually considered as 0.05 that indicates its range from 14.4 to 24.4 percent.

The equation for deriving the sample size is given as below.

$$n= Z^2_{1-a/2} *p*(1-p)*deff*(1+nr)/d^2$$

or $n= (1.96)^2*0.194*1.5*(1+0.1)/0.05^2$

or n= (3.84*0.16*1.5*1.1)/0.025

or n= 1.01/0.025

or n= 404

Appendix 3: Total Number of Institutions by Districts, Ecological Belts and Development Region

SN	Development Region	Ecological Belt	District	Selected Number of Institutions							
				District Hospital	PHCC/HC	Health post	Sub-Health Post	I/NGO - Clinic	Private Institution	Ayurvedic	Total Institution
1	Far-Western	Mountain	Darchula	1	1	5	10	0	0	1	18
2	Far-Western	Hills	Doti	1	1	4	16	1	0	3	26
3	Far-Western	Tarai	Kailali	1	2	3	13	2	1	2	24
4	Mid-western	Mountain	Mugu	1	1	1	4	2	0	0	9
5	Mid-western	Hills	Pyuthan	1	1	5	14	0	1	1	23
6	Mid-western	Tarai	Bardiya	1	1	3	9	6	0	1	21
7	Western	Mountain	Manang	1	0	2	1	0	0	1	5
8	Western	Hills	Palpa	1	1	4	23	1	0	3	33
9	Western	Tarai	Kapilbastu	1	1	3	27	1	0	1	34
10	Central	Mountain	Rasuwa	1	1	3	2	2	1	1	11
11	Central	Hills	Lalitpur	2	1	4	12	17	5	1	42
12	Central	Tarai	Dhanusa	1	2	4	37	2	0	3	49
13	Eastern	Mountain	Sankhuwasaba	1	1	4	10	1	1	2	20
14	Eastern	Hills	Panchthar	1	1	4	12	1	0	0	19
15	Eastern	Tarai	Jhapa	1	2	3	18	9	6	2	41
	Selected number of institutions by ecological belts										
1	Mountain			5	4	15	27	5	2	5	63
2	Hills			6	5	21	77	20	6	8	143
3	Tarai			5	8	16	104	20	7	9	169
	Selected number of institutions by development region										
1	Far-Western Development Region			3	4	12	39	3	1	6	68
2	Mid-Western Development Region			3	3	9	27	8	1	2	53
3	Western Development Region			3	2	9	51	2	0	5	72
4	Central Development Region			4	4	11	51	21	6	5	102
5	Eastern Development Region			3	4	11	40	11	7	4	80
	Total Nepal			**16**	**17**	**52**	**208**	**45**	**15**	**22**	**375**

Source: *HRH Field Survey 2011*

Appendix 4: Qualitative Data Collection

District	Focus Group Discussions (FGD)							Key Informant Interviews (KII)				Grand Total of Participants
	Management Group		Service Providers		Service Users		Total # of FGD	Management Group	Service Provider	Service User	Total # of KII	
	# of FGD	# of Participants	# of FGD	# of Participants	# of FGD	# of Participants						
Sankhuwasabha	1	9	1	10	1	12	-	-	-	-	-	-
	1	6	-	-	-	-	-	-	-	-	-	-
	1	12	-	-	-	-	-	-	-	-	-	-
Total	3	27	1	10	1	12	5	0	1	0	1	50
Panchthar	-	-	1	8	1	10	-	-	-	-	-	-
	-	-	1	13	1	6	-	-	-	-	-	-
	-	-	-	-	1	9	-	-	-	-	-	-
	-	-	-	-	1	7	-	-	-	-	-	-
Total	0	0	2	21	4	32	6	0	1	0	1	54
Jhapa	1	7	1	6	1	8	-	-	-	-	-	-
	-	-	1	10	-	-	-	-	-	-	-	-
	-	-	1	6	-	-	-	-	-	-	-	-
Total	-	7	3	22	1	8	5	1	1	0	2	39
Dhanusha	1	7	1	12	1	8	-	-	-	-	-	-
	-	--	-	-	1	10	-	-	-	-	-	-
Total	1	7	1	12	2	18	4	1	1	0	2	39
Lalitpur	-	-	1	4	1	9	-	-	-	-	-	-
	-	-	-	-	1	7	-	-	-	-	-	-
Total	0	0	1	4	2	16	3	1	1	1	3	23
Rasuwa	1	7	1	7	1	7	-	-	-	-	-	-
Total	1	7	1	7	1	7	3	0	1	0	1	22
Palpa	1	8	1	8	1	8	-	-	-	-	-	-
	1		1	7	1	9	-	-	-	-	-	-
	-	-	-	-	1	9	-	-	-	-	-	-
Total	2	8	2	15	3	26	7	1	1	0	2	51
Manang	-	-	1	7	1	10	-	-	-	-	-	-
Total	0	0	1	7	1	10	2	1			1	18
Kapilvastu	1	8	1	7	1	7	-	-	-	-	-	-
	1	6			1	6	-	-	-	-	-	-
Total	2	14	1	7	2	13	5	0	1	0	1	35
Mugu	1	14	-	-	1	8	-	-	-	-	-	-
Total	1	14	0	0	1	8	2	0	0	0	0	22
Pyuthan	1	6	1	7	1	9	-	-	-	-	-	-
	1	7	-	-	1	11	-	-	-	-	-	-
	-	-	-	-	1	9	-	-	-	-	-	-
Total	2	13	1	7	3	29	6	0	3	0	3	52
Bardiya	1	6	1	8	1	8	-	-	-	-	-	-
	-	-	1	8	1	9	-	-	-	-	-	-
	-	-	1	7	-	-	-	-	-	-	-	-
Total	1	6	3	23	2	17	6	1	2	1	4	50
Doti	1	8	1	9	1	11	-	-	-	-	-	-
	1	8	1	6	1	8	-	-	-	-	-	-
Total	2	16	2	15	2	19	6	0	1	1	2	52
Darchula	1	16	1	7	1	17	-	-	-	-	-	-
	1	8	-	-	1	15	-	-	-	-	-	-
Total	2	24	1	7	2	32	5	0	4	0	4	67
Kailali	1	9	1	6	1	6	-	-	-	-	-	-
	1	6	1	6	1	6	-	-	-	-	-	-
	-	-	-	-	1	9	-	-	-	-	-	-
	-	-	-	-	1	9	-	-	-	-	-	-
	-	-	-	-	1	12	-	-	-	-	-	-
Total	2	15	2	12	5	42	9	0	1	1	2	71
Grand Total	20	158	22	169	32	289	74	6	19	4	29	645

Appendix 5: Involvement of CSOs in Planning and Implementation of the Programmes in Health Institution, Selected Districts, HRH Survey Nepal

Variables	Involvement of CSO in Planning and Implementation						Total	
	In Most Programmes		In Some Programmes		In No Programmes			
	N	%	N	%	N	%	N	%
Ecological Belts								
Mountain	23	19.2	54	45.0	43	35.8	120	100.0
Hill	91	33.3	105	38.5	77	28.2	273	100.0
Tarai	71	20.1	136	38.4	147	41.5	354	100.0
Development Regions								
EDR	36	18.3	82	41.6	79	40.1	197	100.0
CDR	56	29.2	78	40.6	58	30.2	192	100.0
WDR	28	24.1	35	30.2	53	45.7	116	100.0
MWDR	23	22.8	38	37.6	40	39.6	101	100.0
FWDR	42	29.8	62	44.0	37	26.2	141	100.0
Place of Work								
Rural	160	30.0	221	41.4	153	28.7	534	100.0
Urban	25	11.7	74	34.7	114	53.5	213	100.0
Total	**185**	**24.8**	**295**	**39.5**	**267**	**35.7**	**747**	**100.0**

Source: *HRH Field Survey 2011; N: Number of Cases;%: Percentage within the category*

Appendix 6: Calculation of Index of Effectiveness of CSOs in Supporting to HRH and Health Institutions as Well

Included Variables (according to the sequence in questionnaire):

- ✓ Frequency of visit in the health institutions by
  - Social worker
  - Politicians
  - CSO members
  - Member of management committee
- ✓ Action taken for planning
  - Community discussion
  - Discussion - institution vs. support committee
- ✓ Level of the support from
  - Management committee and others
  - NGOs
  - Local Club
  - CSOs
  - Management committee and others
- ✓ Dispute/ argument with the local people regarding the treatment
- ✓ Involvement of local people in solving dispute
- ✓ Level of support for the local people's access
- ✓ Source for locally recruited staff
  - VDC, Municipality, DDC (that includes people's representatives in all party committee)
  - NGOs
  - Private sector (involves community people)
  - Local community

- ✓ Support for additional equipments and facilities.
  - VDC, Municipality, DDC (that includes people's representatives in all party committee
  - NGOs
  - Private sector (involves community people
  - Local community
- ✓ Local involvement to prevent the newly emerging diseases
- ✓ Level of support received for organisation's annual programming and implementation from
  - VDC, Municipality, DDC (that includes people's representatives in all party committee)
  - Management Committee
  - Local Community
- ✓ Feeling of prestige and dignity while working in community
- ✓ Level of support from the members, political leaders and local community for this institution
- ✓ Committee formed from the participation of local political and social representatives (group for the prevention of disease epidemic, prevention of TB & Diabetes?)
- ✓ Three groups for the prevention of disease epidemic, prevention of TB & Diabetes
- ✓ Technical staff involved or represented in the local committee, pressure group or any other type of committee.
- ✓ Support of health institutions to local community, clubs or other organisations operated periodic health camp and campaigns
- ✓ Support received from local community for health camp and campaigns organised by health institution
- ✓ Local community awarding HRH for their good work
- ✓ Civil society involvement in planning and implementation of the program
- ✓ Types of CSOs involved in planning and implementation of the program.
  - Management committee
  - NGOs
  - Local clubs
  - Groups formed in local level

There are three types of questions with options as:

a. 1. Yes, 2. No;

b. 1. Extremely positive, 2. Somewhat positive, 3 Neither positive nor negative, 4. somewhat negative and 5. Extremely Negative

c. 1. Extremely negative, 2. Somewhat negative, 3. Neither negative nor positive 4. Somewhat positive 5. Extremely positive

Method:

In case of (a) Yes was coded 1 and others as 0; whereas in case of (b) alternatives 1, 2 and 3 were coded as 1 and others as 0; and in case of (c) alternatives 3, 4, and 5 were coded as 1 and others as 0. All values Added and divided by 40 to derive Index score. It serves as interval scale variable.

Index ranged from 0.03 to 0.65. Mean can be derived directly. For further grouping, the difference (0.65-0.03=0.62) was divided into three segments Low as 0.03 to 0.24, Medium as 0.24 to 0.45 and High as 0.45 to 0.65.

Limitation:

Sometimes the indifferent cases previously coded as 3 in (b) and (c) might influence the index, but the effect will be minimal.

Appendix 7: Effectiveness of CSOs

Characteristics	Mean	N	Std. Deviation
Ecological Belts			
Mountain	0.2669	120	0.1060
Hill	0.3036	273	0.1214
Tarai	0.2589	354	0.1184
Development Regions			
EDR	0.2640	197	0.1264
CDR	0.2848	192	0.1231
WDR	0.2616	116	0.1092
MWDR	0.2735	101	0.1186
FWDR	0.2972	141	0.1096
Location			
Rural	0.2990	534	0.1124
Urban	0.2202	213	0.1177
Types of Institutions			
Hospital	0.2205	106	0.1172
PHC	0.3413	52	0.1004
Health Post	0.3091	121	0.1058
Sub-health Post	0.3111	276	0.1043
Ayurvedic Centre	0.1607	35	0.0959
Private Clinic/Hospital	0.2186	55	0.1004
I/NGO Clinic/Hospital	0.2404	102	0.1287
Service Category of HRH			
Doctors	0.2200	80	0.1098
HA/AHW Paramedical	0.2938	376	0.1186
Technicians	0.2527	56	0.1113
Nurses/ANMs	0.2737	235	0.1189
District			
Panchthar	0.3340	39	0.1177
Jhapa	0.2390	114	0.1248
Sankhuwasabha	0.2665	44	0.1163
Dhanusha	0.2829	79	0.1175
Rasuwa	0.2681	18	0.1042
Lalitpur	0.2895	95	0.1314
Manang	0.1938	8	0.0998
Palpa	0.2858	53	0.1058
Kapilvastu	0.2482	55	0.1091
Pyuthan	0.3032	39	0.1241
Mugu	0.2446	14	0.0889
Bardiya	0.2578	48	0.1185
Doti	0.3271	47	0.1134
Kailali	0.2763	58	0.1105
Darchula	0.2917	36	0.0967
Total	**0.2765**	**747**	**0.1193**

Source: *HRH Field Survey 2011* *Cronbach's α : 0.8057*

Appendix 8: Effectiveness of CSO by Spatial Variables, Type of Institutions, Technicians and Districts, HRH Survey Nepal

Variables	Efficiency of CSO in Category						Total	
	Low		Medium		High			
	N	%	N	%	N	%	N	%
Ecological Belts								
Hill	65	23.8	167	61.2	41	15.0	273	100.0
Tarai	131	37.0	199	56.2	24	6.8	354	100.0
Mountain	37	30.8	76	63.3	7	5.8	120	100.0
Development Regions								
EDR	74	37.6	101	51.3	22	11.2	197	100.0
CDR	59	30.7	112	58.3	21	10.9	192	100.0
MWDR	30	29.7	61	60.4	10	9.9	101	100.0
FWDR	31	22.0	97	68.8	13	9.2	141	100.0
WDR	39	33.6	71	61.2	6	5.2	116	100.0
Types of Institutions								
PHC	6	11.5	32	61.5	14	26.9	52	100.0
Health Post	23	19.0	84	69.4	14	11.6	121	100.0
Sub-health Post	50	18.1	195	70.7	31	11.2	276	100.0
I/NGO Clinic/Hospital	47	46.1	48	47.1	7	6.9	102	100.0
Hospital	54	50.9	48	45.3	4	3.8	106	100.0
Ayurvedic Centre	27	77.1	7	20.0	1	2.9	35	100.0
Private Clinic/Hospital	26	47.3	28	50.9	1	1.8	55	100.0
Service Category of HRH								
HA/AHW Paramedical	95	25.3	237	63.0	44	11.7	376	100.0
Nurses/ANMs	75	31.9	139	59.1	21	8.9	235	100.0
Technicians	21	37.5	32	57.1	3	5.4	56	100.0
Doctors	42	52.5	34	42.5	4	5.0	80	100.0
District Name								
Panchthar	7	17.9	24	61.5	8	20.5	39	100.0
Pyuthan	9	23.1	22	56.4	8	20.5	39	100.0
Doti	6	12.8	33	70.2	8	17.0	47	100.0
Lalitpur	30	31.6	51	53.7	14	14.7	95	100.0
Sankhuwasabha	14	31.8	25	56.8	5	11.4	44	100.0
Jhapa	53	46.5	52	45.6	9	7.9	114	100.0
Dhanusha	24	30.4	49	62.0	6	7.6	79	100.0
Kailali	18	31.0	36	62.1	4	6.9	58	100.0
Palpa	13	24.5	37	69.8	3	5.7	53	100.0
Rasuwa	5	27.8	12	66.7	1	5.6	18	100.0
Kapilvastu	21	38.2	31	56.4	3	5.5	55	100.0
Bardiya	15	31.3	31	64.6	2	4.2	48	100.0
Darchula	7	19.4	28	77.8	1	2.8	36	100.0
Manang	5	62.5	3	37.5	0	0.0	8	100.0
Mugu	6	42.9	8	57.1	0	0.0	14	100.0

Source: *HRH Field Survey 2011*

Appendix 9: Support to Health Institutions by Political Leaders and Local Community by Spatial Variables, Nepal 2011

Characteristics	Level of Support by Political Leaders and Local Community												Total	
	Excellent		Good		Modest		Not good		Don't Know		Not Stated			
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Ecological Belts														
Mountain	6	5.0	90	75.0	10	8.3	5	4.2	9	7.5	0	0.0	120	100.0
Hill	13	4.8	187	68.5	15	5.5	15	5.5	34	12.5	9	3.3	273	100.0
Tarai	13	3.7	246	69.5	33	9.3	13	3.7	48	13.6	1	0.3	354	100.0
Development Regions														
EDR	11	5.6	146	74.1	9	4.6	4	2.0	24	12.2	3	1.5	197	100.0
CDR	9	4.7	117	60.9	22	11.5	12	6.3	26	13.5	6	3.1	192	100.0
WDR	3	2.6	88	75.9	7	6.0	4	3.4	13	11.2	1	0.9	116	100.0
MWDR	1	1.0	73	72.3	5	5.0	5	5.0	17	16.8	0	0.0	101	100.0
FWDR	8	5.7	99	70.2	15	10.6	8	5.7	11	7.8	0	0.0	141	100.0
Rural Urban Localities														
Rural	26	4.9	401	75.1	38	7.1	20	3.7	44	8.2	5	0.9	534	100.0
Urban	6	2.8	122	57.3	20	9.4	13	6.1	47	22.1	5	2.3	213	100.0
Total	**32**	**4.3**	**523**	**70.0**	**58**	**7.8**	**33**	**4.4**	**91**	**12.2**	**10**	**1.3**	**747**	**100.0**

Source: *HRH Field Survey 2011; N: Number of Cases, % Percentage*

Appendix 10: Support to Health Institutions by Political Leaders and Local Community by Type of Institutions, Nepal 2011

Characteristics	Level of Support by Political Leaders and Local Community												Total	
	Excellent		Good		Modest		Not good		Don't Know		Not Stated			
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Hospital	3	2.8	56	52.8	12	11.3	12	11.3	22	20.8	1	0.9	106	100.0
PHC	3	5.8	42	80.8	3	5.8	1	1.9	3	5.8	0	0.0	52	100.0
Health-post	3	2.5	92	76.0	10	8.3	7	5.8	7	5.8	2	1.7	121	100.0
Sub-Health-post	16	5.8	217	78.6	19	6.9	7	2.5	16	5.8	1	0.4	276	100.0
Ayurvedic Centers	0	0.0	23	65.7	2	5.7	4	11.4	5	14.3	1	2.9	35	100.0
Private Clinic/Hospital	1	1.8	36	65.5	3	5.5	1	1.8	12	21.8	2	3.6	55	100.0
I/NGO Clinic/Hospital	6	5.9	57	55.9	9	8.8	1	1.0	26	25.5	3	2.9	102	100.0
Total	**32**	**4.3**	**523**	**70.0**	**58**	**7.8**	**33**	**4.4**	**91**	**12.2**	**10**	**1.3**	**747**	**100.0**

Source: *HRH Field Survey 2011; N: Number of Cases, % Percentage*

Appendix 11: Cooperation Between CSOs and Institutions as well as HRH

Variables	Cooperation Between CSOs and Institutions as well as HRH												Total	
	A		B		C		D		E		F			
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Ecological Belts														
Mountain	28	23.3	6	5.0	10	8.3	36	30.0	39	32.5	6	5.0	120	100
Hill	97	35.5	49	17.9	58	21.2	103	37.7	107	39.2	28	10.3	273	100
Tarai	95	26.8	39	11.0	68	19.2	118	33.3	123	34.7	22	6.2	354	100
Development Regions														
EDR	46	23.4	21	10.7	30	15.2	74	37.6	78	39.6	11	5.6	197	100
CDR	81	42.2	36	18.8	45	23.4	83	43.2	82	42.7	17	8.9	192	100
WDR	33	28.4	11	9.5	19	16.4	41	35.3	40	34.5	9	7.8	116	100
MWDR	34	33.7	4	4.0	20	19.8	28	27.7	34	33.7	5	5.0	101	100
FWDR	26	18.4	22	15.6	22	15.6	31	22.0	35	24.8	14	9.9	141	100
Place of Work														
Rural	194	36.3	40	7.5	93	17.4	160	30.0	178	33.3	38	7.1	534	100
Urban	26	12.2	54	25.4	43	20.2	97	45.5	91	42.7	18	8.5	213	100
Types of Institutions														
Hospital	24	22.6	27	25.5	25	23.6	44	41.5	44	41.5	11	10.4	106	100
PHC	25	48.1	3	5.8	6	11.5	30	57.7	32	61.5	9	17.3	52	100
Health Post	34	28.1	10	8.3	23	19.0	29	24.0	36	29.8	10	8.3	121	100
Sub-health Post	116	42.0	18	6.5	53	19.2	67	24.3	73	26.4	14	5.1	276	100
Ayurvedic Centre	3	8.6	3	8.6	2	5.7	7	20.0	13	37.1	1	2.9	35	100
Private Clinic/Hospital	3	5.5	8	14.5	8	14.5	33	60.0	34	61.8	2	3.6	55	100
I/NGO Clinic/Hospital	15	14.7	25	24.5	19	18.6	47	46.1	37	36.3	9	8.8	102	100
Service Category of HRH														
Doctors	12	15.0	16	20.0	16	20.0	32	40.0	37	46.3	8	10.0	80	100
HA/AHW Paramedical	145	38.6	33	8.8	72	19.1	121	32.2	120	31.9	23	6.1	376	100
Technicians	9	16.1	10	17.9	12	21.4	22	39.3	25	44.6	5	8.9	56	100
Nurses/ANMs	54	23.0	35	14.9	36	15.3	82	34.9	87	37.0	20	8.5	235	100
Total	**220**	**29.5**	**94**	**12.6**	**136**	**18.2**	**257**	**34.4**	**269**	**36.0**	**56**	**7.5**	**747**	**100**

** Multiple answers,

Source: *HRH Field Survey 2011; N: Number of Cases, % Percentage*

Legends:

a. Committee formed in the participation of local political and social representatives (group for the prevention of disease epidemic, prevention of TB and Diabetes)

b. Involvement of this institution at National level Health related committees

c. Technical staff of institution involved or represented in the local committee, pressure group or any other type of committee

d. Local community, clubs or other organisations operating periodic health camps and campaigns with support from this institution

e. Institution operating periodic health camps and campaigns with support received from local community

f. Health worker of this institution rewarded for their good work by local community

Appendix 12: Involvement of CSOs in Planning

Characteristics	Involvement of CSOs in Planning of Health Institution				Total	
	No Involvement		Some Involvement			
	N	%	N	%	N	%
Ecological Belts						
Mountain	43	35.8	77	64.2	120	100.0
Hill	77	28.2	196	71.8	273	100.0
Tarai	147	41.5	207	58.5	354	100.0
Development Regions						
EDR	79	40.1	118	59.9	197	100.0
CDR	58	30.2	134	69.8	192	100.0
WDR	53	45.7	63	54.3	116	100.0
MWDR	40	39.6	61	60.4	101	100.0
FWDR	37	26.2	104	73.8	141	100.0
Place of Work						
Rural	153	28.7	381	71.3	534	100.0
Urban	114	53.5	99	46.5	213	100.0
Types of Institutions						
Hospital	52	49.1	54	50.9	106	100.0
PHC	16	30.8	36	69.2	52	100.0
Health Post	30	24.8	91	75.2	121	100.0
Sub-health Post	65	23.6	211	76.4	276	100.0
Ayurvedic Centre	22	62.9	13	37.1	35	100.0
Private Clinic/Hospital	34	61.8	21	38.2	55	100.0
I/NGO Clinic/Hospital	48	47.1	54	52.9	102	100.0
Service Category of HRH						
Doctors	42	52.5	38	47.5	80	100.0
HA/AHW Paramedical	117	31.1	259	68.9	376	100.0
Technicians	20	35.7	36	64.3	56	100.0
Nurses/ANMs	88	37.4	147	62.6	235	100.0
Total	**267**	**35.7**	**480**	**64.3**	**747**	**100.0**

Source: *HRH Field Survey 2011; N: Number of Cases, % Percentage*

Appendix 14: Frequency of Meetings of Management Committee

Characteristics	Frequency of Meetings of Management Committee (Percentage of Responses)							
	Monthly	Quarterly	Once in a Four Month	Annually	No HFMOC	Don't Know	Not Stated	Total
Ecological Belts								
Mountain	49.2	13.3	15.8	6.7	5.0	6.7	3.3	**120**
Hill 50.2	17.9	11.7	4.8	4.0	9.2	2.2	273	
Tarai	50.0	19.5	7.6	4.8	5.4	10.7	2.0	**354**
Development Regions								
EDR	64.5	10.7	4.1	2.5	3.0	11.7	3.6	**197**
CDR	34.4	28.1	10.9	3.6	7.8	12.0	3.1	**192**
WDR	31.9	18.1	26.7	12.1	3.4	5.2	2.6	**116**
MWDR	54.5	16.8	8.9	3.0	5.0	10.9	1.0	**101**
FWDR	62.4	14.9	6.4	6.4	4.3	5.7	0.0	**141**
Place of Work								
Rural	54.7	17.8	11.8	5.8	3.0	4.5	2.4	**534**
Urban	38.0	18.3	7.0	3.3	9.4	22.1	1.9	**213**
Types of Institutions								
Hospital	31.1	20.8	10.4	7.5	0.9	29.2	0.0	**106**
PHC73.1	13.5	9.6	1.9	0.0	1.9	0.0	52	
Health Post	61.2	17.4	13.2	5.0	0.0	2.5	0.8	**121**
Sub-health Post	55.1	20.7	11.6	6.2	1.1	1.4	4.0	**276**
Ayurvedic Centre	14.3	8.6	17.1	2.9	42.9	8.6	5.7	**35**
Private Clinic/Hospital	52.7	7.3	3.6	1.8	5.5	25.5	3.6	**55**
I/NGO Clinic/Hospital	41.2	19.6	5.9	3.9	13.7	14.7	1.0	**102**
Service Category of HRH								
Doctors	42.5	15.0	8.8	6.3	12.5	13.8	1.3	**80**
HA/AHW Paramedical	51.1	19.7	11.4	5.9	4.0	4.8	3.2	**376**
Technicians	46.4	10.7	14.3	1.8	5.4	21.4	0.0	**56**
Nurses/ANMs	51.5	17.9	8.5	4.3	3.4	12.8	1.7	**235**
Total (%)	**49.9**	**17.9**	**10.4**	**5.1**	**4.8**	**9.5**	**2.3**	**747**
Number	**373**	**134**	**78**	**38**	**36**	**71**	**17**	

Source:*HRH Field Survey 2011; N: Number of Cases in Categories, % Percentage*

Appendix 13: CSOs Involved in Planning and Implementation Process of Health Institutions, Nepal 2011

Characteristics	CSOs Involved in Planning and Implementation Process (Percentage of Responses)							
	Health Facility Management Committee	NGO/ INGOs	Private Health Service Providers	School and Colleges	Local Agencies Clubs	Local Informal Groups	Others	N
Ecological Belts								
Mountain	60.8	30.0	11.7	49.2	38.3	42.5	0.0	120
Hill	66.7	39.9	31.9	56.0	54.6	54.2	1.8	273
Tarai	52.0	30.8	27.1	41.8	35.6	33.1	0.3	354
Development Regions								
EDR	54.8	32.0	26.9	45.2	39.6	36.5	1.0	197
CDR	58.3	46.9	37.0	47.9	46.4	49.5	0.5	192
WDR	51.7	15.5	25.9	45.7	43.1	37.9	0.0	116
MWDR	59.4	30.7	10.9	46.5	37.6	32.7	0.0	101
FWDR	70.2	36.9	22.7	56.0	46.8	51.1	2.1	141
Place of Work								
Rural	67.2	37.5	27.5	57.3	49.1	50.4	0.9	534
Urban	37.6	25.4	23.5	25.4	27.7	22.1	0.5	213
Types of Institutions								
Hospital	46.2	29.2	17.0	24.5	31.1	24.5	0.9	106
PHC	69.2	44.2	36.5	67.3	61.5	65.4	1.9	52
Health Post	71.9	33.9	25.6	62.0	47.1	50.4	0.0	121
Sub-health Post	73.6	37.3	29.3	62.7	51.4	53.6	1.4	276
Ayurvedic Centre	20.0	8.6	8.6	17.1	25.7	20.0	0.0	35
Private Clinic/Hospital	32.7	20.0	30.9	23.6	27.3	23.6	0.0	55
I/NGO Clinic/Hospital	38.2	41.2	27.5	31.4	32.4	26.5	0.0	102
Service Category of HRH								
Doctors	37.5	21.3	22.5	20.0	28.8	25.0	1.3	80
HA/AHW Paramedical	64.1	35.9	27.4	58.0	48.9	47.9	0.8	376
Technicians	53.6	33.9	28.6	37.5	39.3	39.3	0.0	56
Nurses/ANMs	58.7	35.3	25.5	44.7	39.1	40.0	0.9	235
Total	**58.8**	**34.0**	**26.4**	**48.2**	**43.0**	**42.3**	**0.8**	**747**

Source:*HRH Field Survey 2011; N: Number of Cases in Category, % Percentage*
** Multiple Answers, totals do not sum to 100.

Appendix 15: Efficiency of CSO by Type of Health Institutions, Nepal 2011

Characteristics	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Min	Max
					Lower Bound	Upper Bound		
PHC	52	0.3413	0.10035	0.01392	0.3134	0.3693	0.15	0.53
Sub-health Post	276	0.3111	0.10427	0.00628	0.2987	0.3234	0.08	0.63
Health Post	121	0.3091	0.10582	0.00962	0.2900	0.3281	0.10	0.55
I/NGO Clinic/Hospital	102	0.2404	0.12873	0.01275	0.2152	0.2657	0.05	0.65
Hospital	106	0.2205	0.11720	0.01138	0.1979	0.2431	0.03	0.55
Private Clinic/Hospital	55	0.2186	0.10037	0.01353	0.1915	0.2458	0.05	0.48
Ayurvedic Centre	35	0.1607	0.09593	0.01621	0.1278	0.1937	0.08	0.53
Total	**747**	**0.2765**	**0.11929**	**0.00436**	**0.2679**	**0.2851**	**0.03**	**0.65**

Source: *HRH Field Survey 2011; N: Number of Cases, % Percentage* ***p value : 0.000***

Appendix 16: Level of Support of HFMOC to Health Institutions, Nepal 2011

Characteristics	Level of Support of Health Facility Management Committee							Total	
	Excellent	Good	Modest	Not good	Very Poor	Don't Know	Not Stated	N	%
Ecological Belts									
Mountain	9.2	15.8	33.3	5.8	24.2	10.8	0.8	**120**	**100.0**
Hill	7.7	16.8	26.7	6.2	31.5	7.3	3.7	**273**	**100.0**
Tarai	4.0	16.9	24.6	7.6	24.3	20.9	1.7	**354**	**100.0**
Development Regions									
EDR	7.6	12.2	29.9	9.1	17.3	20.3	3.6	**197**	**100.0**
CDR	3.1	12.5	19.8	5.2	42.7	12.5	4.2	**192**	**100.0**
WDR	4.3	21.6	25.0	8.6	31.0	9.5	0.0	**116**	**100.0**
MWDR	8.9	16.8	32.7	4.0	19.8	15.8	2.0	**101**	**100.0**
FWDR	7.8	24.8	29.1	6.4	20.6	11.3	0.0	**141**	**100.0**
Place of Work									
Rural	6.0	20.8	28.5	6.6	26.2	10.5	1.5	**534**	**100.0**
Urban	6.6	6.6	22.5	7.5	28.6	23.9	4.2	**213**	**100.0**
Types of Institutions									
Hospital	5.7	11.3	33.0	7.5	13.2	27.4	1.9	**106**	**100.0**
PHC	11.5	30.8	36.5	0.0	17.3	1.9	1.9	**52**	**100.0**
Health Post	5.8	24.8	32.2	7.4	19.8	9.9	0.0	**121**	**100.0**
Sub-health Post	6.5	21.4	27.2	6.9	28.3	8.3	1.4	**276**	**100.0**
Ayurvedic Centre	0.0	2.9	20.0	0.0	65.7	2.9	8.6	**35**	**100.0**
Private Clinic/Hospital	5.5	1.8	12.7	3.6	43.6	25.5	7.3	**55**	**100.0**
I/NGO Clinic/Hospital	5.9	5.9	17.6	12.7	28.4	26.5	2.9	**102**	**100.0**
Service Category of HRH									
Doctors	6.3	10.0	20.0	8.8	28.8	22.5	3.8	**80**	**100.0**
HA/AHW Paramedical	6.9	20.7	27.9	5.9	29.5	7.2	1.9	**376**	**100.0**
Technicians	7.1	5.4	37.5	5.4	23.2	17.9	3.6	**56**	**100.0**
Nurses/ANMs	4.7	15.3	24.7	8.1	23.0	22.1	2.1	**235**	**100.0**
Total (%)	**6.2**	**16.7**	**26.8**	**6.8**	**26.9**	**14.3**	**2.3**		**100.0**
Number	**46**	**125**	**200**	**51**	**201**	**107**	**17**	**747**	

Source:*HRH Field Survey 2011; N: Number of Cases, % Percentage*

Appendix 17: Staff Managed by the local Level in Health Institutions, Nepal 2011

Districts	Institutions				
	PHC	HP	SHP	NGO	Total
Sankhuwasabha	-	-	1	-	1
Bardiya	-	1	-	1	2
Kailali	1	-	-	-	1
Doti	-	1	-	-	1
Total	1	2	1	1	5

Source:HRH Field Survey 2011; N: Number of Cases, % Percentage

Appendix 18: Security and Social Prestige of HRH by Effectiveness of CSOs, HRH Survey 2011

Characteristics	Effectiveness of CSOs in Category						Total	
	Low		Medium		High			
	N	%	N	%	N	%	N	%
Security in Workplace								
Extremely Secured	31	13.3	82	18.6	19	26.4	132	17.7
Well Secured	131	56.2	271	61.3	45	62.5	447	59.8
Not Thought About	42	18.0	42	9.5	3	4.2	87	11.6
Somewhat Unsecured	22	9.4	31	7.0	3	4.2	56	7.5
Extremely Unsecured	5	2.1	14	3.2	2	2.8	21	2.8
Don't Know	1	0.4	1	0.2	0	0.0	2	0.3
Not Stated	1	0.4	1	0.2	0	0.0	2	0.3
Social Prestige in Workplace								
High	34	14.6	100	22.6	26	36.1	160	21.4
Much	77	33.0	203	45.9	30	41.7	310	41.5
Some	97	41.6	126	28.5	15	20.8	238	31.9
Not Much	17	7.3	12	2.7	1	1.4	30	4.0
Not at All	2	0.9	0	0.0	0	0.0	2	0.3
Don't Know	2	0.9	1	0.2	0	0.0	3	0.4
Not Stated	4	1.7	0	0.0	0	0.0	4	0.5
Total	**233**	**100.0**	**442**	**100.0**	**72**	**100.0**	**747**	**100.0**

Source: *HRH Field Survey 2011; N: Number of Cases, % Percentage*

Field Research Team

Research Management Team
SOLID Nepal

Dr. Khem B. Karki
Bhuwan Baral
Manju Neupane
Raju Prajapati
Binod Kumar Maharjan
Sarita Chhetri
Marichman Shrestha
Tika Adhikari
Jun Bahadur Tamang

Merlin Nepal

Catherine Whybrow
Anant Nepal
Dr. Khakindra Bhandari
Chandika Shrestha
Sajana Amatya
Daman Baij

Research Assistants

Dr Achyut Raj Karki
Ajit Acharya
Anita Bajgain
Anup Adhikari
Chandani Rana

Research Supervisors

Badri Prasad Mainali
Barsha Rijal
Chandra Laxmi Bhasima
Dinesh Bhandari
Kabita Adhikairi
Kalpana Rimal
Mona Giri
Pasang Devi Tamang
Pratiksha Khadka
Ranjila Joshi
Ranju Bhandari
Roshani Poudel
Sandeep Silwal
Sangita Bajgain
Sarita Adhikari
Shekhar Adhikari
Yubaraj Budhathoki

Quantitative Data Entry/ Qualitative Data Transcription

Barsha Rijal
Chandra Laxmi Bhasima
Dip Prasad Khatiwada
Kirti Sagar Baral
Latshering Glan Tamang
Mona Giri
Mingma Glan Tamang
Pasang Devi Tamang
Pratikshya Khadka
Radha Devi Gurung
Roshni Poudel
Sarita Chhhetri

Research Enumerators/ Interviewers

Anil Kumar Jha
Anita Tako
Archana Shrestha
Bala Ram Aawasthi
Basanta Katwal
Basanti Thapa
Bhanu Neupane
Bharat Bhandari
Chhaya Kumari Shrestha
Dhankala Kunwar
Dilip Khanal
Dipak Tamang
Durga Rokaya
Ganesh Prasad Shrestha
Govinda Sharma Neupane
Gyanu Ojha
Hemlal Kunwar
Jit Bahadur Shrestha
Keshav Ojha
Khem Raj Baniya
Kishor Shrestha
Laxmi Rawal
Laxmi Shah
Mahabir Yadav
Mahesh Prasad Shah
Manu Dulal
Parmeshwori Shah
Puspa Pandey
Ram Dhulari Rana
Ram Nath Shah
Randip Kumar Kunwar
Renu Gupta
Roshan Neupane
Sabita Acharya
Sandesh Bahadur Sunar
Sarita KC
Shankar Bhattarai
Shreejana Chaudhary
Sita Neupane
Suman Shrestha
Suman Tamang
Sundar Singh Bohora
Sunil Adhikari
Sunita Kandel
Tara Nath Fulara
Yeshu Bai Rai

Society for Local Integrated Development Nepal (SOLID NEPAL)
Satdobato, Lalitpur
GPO Box No : 9565, Kathmandu, Nepal
Phone : 977-1-5548455, Fax : 977-1-15553770
Email : solidnepal@wlink.com.np
Web : www.solidnepal.org.np