A Study Report on
Document Learning from Emerging Experiences in Universal Free Health Care, Particularly those Primary Level Health Workers and Citizens from Marginalized and Disadvantaged Communities

Submitted to
World Health Organization (WHO)

Submitted by
Nepal Health Research Council (NHRC)

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Study Team

Dr. Chop Lal Bhusal	Team Leader
Dr. Shanker Pratap Singh	Team Advisor
Dr. Chitra Bahadur Budhathoki	Program Coordinator
Ms. Pearl Banmali	Deputy Senior Research Officer
Ms. Namita Ghimire	Research Officer (Sociologist)
Ms. Puspa Thapa	Assistant Research Officer
Ms. Rijan Bhurtel	Assistant Research Officer
Ms. Ganu Neupane	Assistant Research Officer

Submitted to

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Ramshah Path, Kathmandu Nepal

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Dr. Chop Lal Bhusal
Executive Chairman & Team Adviser of the Study

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Abbreviations and Acronyms

PHC	Primary Health Care
PHCC	Primary Health Care Centre
HP	Health Post
SHP	Sub-Health Post
DA	Daily Allowances
DH	District Hospital
EHCS	Essential Health Care Services
FCHV's	Female Community Health Volunteers
GoN	Government of Nepal
HDI	Human Development Index
HF	Health Facility
ID	Identification Card
MDG	Millennium Development Goals
QoL	Quality of Life
TA	Transportation Allowances
TB	Tuberculosis
VDC	Village Development Committee
ASL	Authorized Stock Level
COFP	Counseling on Family Planning
EDL	Essential Drug List
EOP	Emergency Order Point
FP	Family Planning
HI	Health Institutions
HFMC	Health Facility Management Committee
HW	Health Workers
LHDI	Lowest Human Development Index

Chapter One

1. Background of the Study

Nepal with a population of 23 million *(Census 2001)* is one of the poorest countries in the world with the annual per capita income of US$240 per year, GDP per capita value in 2007/08 was 1,550 PPP US$ *(MOHP Nepal, 2004)*. More than 30% of population lives below the national poverty line. The share of out of pocket expenditure in the total health expenditure is 62 percent *(Prasai et al 2006)*, and many of the poor people do not have right access to treatment during illness. Unequal distribution of health facilities continues to be a major public health problem in Nepal. Although there is an improved trend of mortality among infants and children *(DHS 2006)* but the sub national health indicators show considerable disparities across the country's geographical regions and social classes.

To minimize inequality in access to health services, the Government of Nepal (GoN) has initiated the free health service policy targeting the poor, vulnerable and marginalized people to increase their access to and use of health care services.

The concept of User's Fee to support the functioning of the primary health care was introduced in 1987 under the Bamako Initiative. Since then there have been a lot of debates over the role and effectiveness of user fees for many years. There have been efforts to introduce waiver and exemption policies as an ideal way to reduce the negative impact of user fees on poor clients. Experience and available evidence suggest that waiver and exemption mechanisms were generally ineffective in low-income countries *(Bitran and Giedion, 2003)*. Evidence shows that fees raise little money and tend to be an inequitable and inefficient means of funding health care to improve access to basic health services by the poor *(Pearson 2004)* has given a strong verdict to support the removal of user fees.

Introduction of slected district

Dolakha is mountainous district of Janakpur zone in the central development region of Nepal. Its total land area is 2191sq Km. and its borders contiguous with Solukhumbu and Ramachhap the east, Ramachhap and Sindhupalchock in the south, Sindhupalchock in the west and with the Tibetan Autonomous Region of People's Republic of China in the north. Sitali, the lowest part of the district has an altitude of 723 meter whereas Mt.Gaurishankar, the highest part of the district is 7134 meter above sea level. Dolakha district is felt in a LHDI, so the free health care program was implemented as policy indicated for LHDI district. Dolakha district has not so equipped

Medical facility, thought 1 district hospital, 1 Private hospital, 2 PHCs, 10 HPs and 43 SPHs are trying to cover whole district.

Selected Health Institution for field visit:

- Jiri District Hospital,
- Charikot PHC,
- Suri PHC,
- Dolakha HP,
- Namdu HP,
- Lamabagar HP,
- Boach HP,
- Kabre SHP,
- Makaibari SHP,
- Malu SHP,
- Aalmpu SHP

1.2 Free Health Care Service Policy

In Magh 2063, GoN introduced the targeted Free Health Services (FHS) Policy to the poor, vulnerable and marginalized in 25-bed hospital and Primary Health Care Center (PHCC) in the district.

Before implementing the universal free care services, the policy provided free services only to the inpatient and emergency care for the poorest families (families who are deprived of adequate food in less than 6 months), the destitute, elderly, disabled, and Female Community Health Volunteers (FCHVs). Provision was also made to exempt 50 percent of user fees for inpatient and emergency care for families who would be deprived of adequate food within 6 to 12 months *(MOHP, 2006a)*. It covered consultation and treatment, minor surgeries, emergency obstetric care- either comprehensive or basic, where available, X-rays, laboratory services, essential drugs and medical supplies. MOHP made commitment to increase the health budget to ensure provision of resources required for the people's health needs *(MOHP, 2006)*. In the year Poush 2064, the policy was expanded further to include free outpatient services in SHP and HP for the poor and destitute. In the year 2065Mangsir, universal free health services was made available in all Primary Health Care Centers (PHCCs), Health posts (HPs) and Sub health posts (SHPs) in the country. The ambitious goal of the policy is to increase access to utilization of basic health care services, particularly by excluded and marginalized groups.

1.3 Rationale of the Study

Since the beginning of the policy implementation process, several concerns over implementation problems have been raised among the policy makers and implementers *(MOHP/HSRSP, 2008)*. There is a need to understand how other health reform policies (such as decentralization, public private partnership, Community Drug Program, CDP) influences the policy of free health care services.

There were a number of reasons, for making the free health care services, the focus of an in-depth evaluation. In this area, there were very few efforts taken to explore the experience of user fee removal and also the policy was not piloted. Therefore, there was an urgent need to assess implementation procedures, and provide guidance and constructive criticism on how implementation might be improved and expanded. Also there is a question to be answered whether the money has been utilised effectively on the program.

The evaluation can help assess the integrity of the established monitoring system and fulfil the information gaps on the process of implementation and impact of the policy. The evaluation of free health care services had been provided further policy guidance to the GoN. Nepal's experience in implementing free health care services could be an evidence for other countries to start such initiatives.

1.4 Objectives

1.4.1 General objectives:

To document the experiences on the universal free health care services particularly of the health workers of the primary level and citizens from marginalized and disadvantaged communities.

1.4.2 Specific objectives:

- To assess the service utilization status before and after implementation of free health care services at different level of health institution, by gender, age and ethnicity.
- To assess the availability and sufficiency of health care providers.
- To find the difficulties experienced by the disadvantaged and lower ethnic groups in the catchment area of service facilities.

Chapter Two

2. Methodology of the study

2.1. Study design:

The study adopted both quantitative and qualitative method of data collection. This study is a descriptive study.

2.2. Study Site:

Dolakha district.

2.3. Sampling Procedure:

Data was collected through purposive sampling method. Dolakha district is selected for the study since it is one of the low HDI district. For quantitative study, record review was done from one district hospital located at Dolakha district. Similarly, out of two PHCs of the district, both of them were included. Considering all the practical factors, out of 10 HPs of this district, four of them were purposively selected. Purposively out of four only three SHPs were selected.

2.4. Data Collection Methods:

Data were collected through qualitative and quantitative procedure. Data on Health facility were collected through observation, records, and interviews with health service providers.

During the field visit, the study team met with the members of the Health Facility Management Committee, Health workers, FCHVs and recipients of different health institution. During discussion, the team interacted on different issues like CDP and FHCS, availability and sufficiency of drug at health facility, drug procurement, and public perception on FHCS, financial management, and human resource management. Observation was made on the barriers and facilitating factors of the free health care services.

Semi-structured interviews were conducted to supplement the data obtained from the quantitative assessment. Open-ended questions were asked. Two broad types of respondents were included, those in the providing end, and those in the consuming end. The providing end comprised of clinical staff of the district hospital (medical officer, Sub health posts, health posts and PHCCs in-charges. The main area of discussion was the district health system, its structure and function, implementation.

In addition, the DHO chief, district focal person for FHCS program, and responsible person for finance were also interviewed. The health system, delivery of FHS, its effects, and the role of

confounders to its effects formed the major focus of interviews. An interview guideline was used for such interviews. [Annex].

Record review

Three years OPD record was obtained from district hospital, PHCCs, Health Posts and Sub Health Post. A format for record review was used. [Annex] The records of health service users were noted to see the utilisation of health services by the groups under study (i.e. ethnicities, gender and age).

Focus Group Discussions (FDG)

The focus group discussions (FGD) and interviews were conducted with the members of the health facility management committee, service users and FCHVs. Key informant interviews were conducted with the health administrators to know the status and intensity of implementation, how the policy had been interpreted and how it was perceived.

The gathered information provided insight into the implementation process and allowed to explore issues relating to quality of care, motivation of health workers, and financial sustainability. The consuming end comprised of the users visiting the health facilities. They were asked about their views on the implementation of FHCS and other questions pertinent to organisation of health services.

2.5. Data management

The main steps in analysis of qualitative data included – transcription of the interviews and FGD typing of transcription, colour coding and grouping in matrices with main domains for analysis and summarization. Similarly, the quantitative data was coded for computer entry and processed in SPSS software program.

2.6. Limitation of the study

1. Incomplete recordkeeping at most of the health facilities impeded data collection. The financial information is mostly based on interview with In-charges of different health facilities,

2. The records of the users profile could not specify the category of the target group due to lack of records in all study districts.

Chapter Three

3.1. Awareness of the free health care services

In the study area, most the health facilities displayed the citizen charter. In the study districts excluding some Thami and Dalits community, most of the community people were found to be aware of Free Health Care Services. Most of the study population was aware of the free OPD tickets, free medicines, and free delivery services from the health centers.

Although majority of the people were aware of the free drugs and services, some do not prefer to go to government health centers because of the long distance and limited services and drugs provided by the government health centers.

Source of information regarding the free health services for the community people were primarily from the people that have visited Health Facilities (HF) during illness. Other means of information were through FM radio, FCHVs, neighbors, friends, relatives, and Health Management Committee. Most of them were found to be positive towards the free medicines available from the government health facility whereas some of the respondents were found doubting on quality of free medicines.

> ***"Thami community including other Dalit groups, residing far from the SHP have poor access to health service. Besides, they were not properly informed about the free health services. Because of this cause, they don't come here for treatment." FGD with FCHVs and health management community (HMC)***

Regarding free delivery services, most of the community people were found to be informed and experienced on service utilization. In Dolakha district it was found that the Thami and Dalits women had never delivered their babies in health institutions till date.

One of Thami women said;

> ***"No, no….. we never go to health post for delivery, it's our tradition. We give birth at our own home."***

Some people were found to be going to private health facilities. The reason was that they were provided with liquid medicines which they found easy for their children to take rather than swallowing the tablet form.

Service Providers:

Most of the service providers were found to be informed about the free health care policy before being implemented and also they were notified when the targeted free health program converted into universal free health service.

3.2. Implementing procedure

In Dolakha district, Community Drug Program (CDP) was running in all Health Institutions before implementation of free health care services. Service seekers had to pay certain amount of money for tickets according to level of Health Institutions. It is completely free in now days.

Initially, most of them got orientation of free health care services for 2-3 days and were provided with guidelines but later on, they did not get any refresher trainings. Some of the health providers had experience of sudden implementation of free health care program without any orientations and guidelines.

Regarding the actual implementation of the policy at community level, the meeting was held for Health Facility Management Committee, which was followed by orientation to FCHVs, and Mother Groups. They are the key persons for information dissemination to the community level regarding available free health care services.

3.3. Achievements of Free Health Care Services

By viewing the health register from the health facilities and also from the experience of the health facility in-charge, one could say that after the implementation of Free Health Care Policy, flows of the patient have increased, and the most benefited are the marginalized and disadvantage people. Before implementing the program, only most of the old cases visited health facilities and now one could see the flow of new cases, also the policy has made the health facilities in charge in easy access to the drugs.

3.4. Service provider's views towards implementation of free health care services

Service providers experienced both the positive and negative influence on service utilization after the policy. During CDP, drugs were sold in subsidized rates and daily 20 to 30 patients visited the health facility, but now 60 to 70 patients visited daily. One of the reasons for increasing patient flow is the provision of free health care services.

SHP in-charge said;

"Some clients want to take medicines for their neighbors too. In case we provide it, they don't utilize it properly."

The health facility workers faced problems in managing the drugs because local people tried to take more of the drugs for their family members as well as for their own future health problems. Such a tendency leads to over use or misuse of drugs. Community people must be informed, "Drugs shouldn't be taken without presenting and checking patient." Therefore, community people need to be made aware of proper use of freely available drugs.

3.5. Issues raised by local people

Most of the community people said that most of the villagers did not relied on traditional healers for the treatment. Most traditional healers suggested their clients to visit the health facilities for treatment when the condition of the patient did not improve. Those marginalized and poor people who had not easy access to health facility visited traditional healers. Surel communities were found to worship their family god *"NAYA BUDHANI"* in case of heartburn.

Rich people directly visited private clinics / hospitals. Only in severe cases, people who were able to afford transportation cost having some minimum amount with them visits the hospitals / clinics. People in need of medical help during the closed hour of SHP were forced to consult with the drug retailers/local private practitioners. Most of the private clinics provided strong antibiotics that cured the illness instantly but SHP often provided mild drugs which took time to cure the illness. Thus this is one of the reasons; some people developed the doubt on the drug quality provided by the SHP. Thus these people preferred to visit the private clinics or drug retailers.

One of the women sadly expressed;

"We are really helpless. We do not want to die. So we go to private even if we are to take loans. We cannot get full medicinal from government institutions and next thing; doctors usually do not stay there. We poor are forced to be sufferer from every side."

One woman from Dudhpokhari V.D.C said;

"It takes one whole day to reach nearby Health Post. Even if we go there, no medicines and doctors we get. What to do?"

Community people expressed their opinions to make free health services more effective. Their top demands were provision of well trained health personnel in health facility, twenty four hour availability of health personnel and comprehensive health service with maximum category of drugs all free of cost in health centre.

One male from Surel community said;

*"**We don't fall ill only during 10:00 - 4:00. My sister died 5 years ago because she started her labor pain after 6 pm. No doctor was in PHC, my sister died when peon went to call doctor."***

Mobilization of local resources was one of the issues raised by them. Majority of them wanted home delivery by trained health personnel because of the long distance of the health centers from their hometown. In some Thami and Dalit community; majority of them were unknown about free health policy. So, they suggested that such information must be promoted through public mass media like radio to make program more effective.

3.6. Issues related to management of drugs and staffs

Because of geographical structure of Dolakha district, there is serious problem on drug transportation. Though there is some assistance from Kreditanstalt Fur Wiederaufbau (KfW)in Dolakha district, almost all health facilities in-charges said that drug scarcity is the main problem. Medicine was supported by KfW before 4-5 years back, which provided Tab Cotrim, Syrup Cotrim, Cetamol, Diazepam, Adhesinve Tape etc available in co-ordination with DPHO.

Most of the Health Institutions lack basic health equipments along with medicines of EDL. Particularly, scarcity of essential medicines became the major factor of dispute among community people.

Regarding drugs availability, the fact is unleashed that system of drug availability without considering the patient flow in all HF was inappropriate.

In-Charge of one SHP expressed;

"The government supplied the drugs considering the health problems and prevalence of diseases in the local context. Same quantity of drugs in given to all in same quantity for the HFs where daily patient flow is 10 and 30 in number. Is it fair?"

The government has maintained uniformity declaring certain items of essential drugs for SHP, HP and PHC irrespective of mountain, Hill and Terai. The prevalence of certain diseases in hill, mountain and Terai is not same. In hill, people often suffer from diarrhea, dysentery, Jaundice, Typhoid and other water born diseases frequently in summer and rainy season. The government should supply the drugs considering seasonal and ecological variation of diseases and health problem. Otherwise, health facilities always have to face shortage of drugs required for treatment of certain diseases

Regarding staffs, the biggest complaint from most of the community people was the absence of health workers even during office hour. About half of them were dissatisfied with staffs that frequently disappeared during the working hours. There were also some health workers who treated the villagers even after their working hours and the villagers showed their gratitude to these workers.

One community people expressed;

"Though 12-13 staff is there, nobody remains available except peon. What is this system?"

Most sanctioned posts of HFs were fulfilled but comparing to the workload it was inadequate. Some SHPs had managed the workload by recruiting the staffs like ANM or Office Assistant with the support from the VDC. In some SHP, where there were few staffs shared their bitter experiences. Due to the absence of health staffs they had to visit the DPHO for medicines and it caused the loss of many days.

One SHP in-charge said;

"Me myself handle the responsibily of VHW. Post of peon is managed from VDC. MCHW has to visit community. In such situation, only peon is left whenever I go to Charikot for medicines.."

3.7. Ownership and Accountability

Due to the lack of communication and regular interaction between service providers and community people there was a lack of ownership among the local people. Some members of HFMCs expressed that their roles in managing drugs has weakened because the health post in-charge alone has the authority of making the decision about forwarding demands of the medicines. It was highlighted that services providers should be responsible for managing drugs required for the people.

People are found to be enthusiastic and optimistic in gradual extension and improvement of free health care services. Local people were not clear regarding the roles in management of the service after termination of the CDP program. Therefore, ownership of community should be created through regular interaction program and involvement of local people in management of health services and collecting resources required for the health facilities.

3.8. Effectiveness and Sustainability

Only government support is not sufficient to manage free health care services effectively in sustainable manner. Local people should be involved in the management of the services and help in generating the additional resources required for the service implementation. Although most participants in interaction program, mentioned that the free health care services were being implemented for the benefit of all people, utilization of health service is seen very low and one of the reason is due to the lack of awareness and interaction between service providers and service users.

Most people think that the government should be held responsible for every aspect of the services. In order to sustain and to implement the program effectively concerned stakeholders including service users should also be involved in the process and execution of free health services. Both service providers and receivers have realized that to increase the effectiveness of the free health care policy, working staffs and quantity of available medicines should be increased.

3.9. Key issues emerged from FGD& In-depth interview

FGD& In-depth interview were conducted at selected health facilities of Dolakha district. The following issues relating to the free health care services were obtained.

All people in Dolakha district were not well informed of free health care services though messages were claimed to be circulated among the local people. Dhami people living away from health facilities were reported to be less aware of free health care services.

Not even all the members of HFMCs were informed about management of drugs and implementing procedure of free health care service. Members of HFMCs and health service providers did not meet regularly after the implementation of free health care services. The health service providers did not see the significant roles of HFMCS in management of drugs under free health care service.

Some people who had no faith on treatment and medicines of health facilities were likely to bypass the government health facility; rich people often seek medical help from private clinics or hospitals. Certain communities including some rich and poor people still did not like to visit health facilities due to various reasons.

However, supply of drugs had been slightly increased after implementation of free health care services; health service providers have faced problem on shortage of some drugs including syrups which seem to be common.

Some HP In charges said;

"If we give them full course, medicines will be only for two months. In this way, what will be the impact of incomplete dose of antibiotics among community? It is a serious issue."

Only 22 items at SHP and 32 items of drugs at PHC were not adequate to meet demand of local people. Some In-charge stressed that the government should provide budget to buy drugs as per

need of the health facility. If it is not possible, the government should visit the local health facility and assessed the actual need of drugs and population coverage, and then drugs should be supplied as per the local needs and population.

Existing pattern of health staff is inadequate to meet workload induced by the increased patient flow. The government should promote the SHP into HP and HP into PHC and PHC into community hospital .So that number of health staff required infrastructure should be increased as per requirement of health facilities.

There was some misunderstanding and lack of ownership over free health care services among local people, due to lack of communication and interaction. They realized that there should be regular interaction/communication and involvement of local people in management of free health care services for developing feeling of ownership and implementing services effectively and sustainable manner.

3.10. Views regarding Maternity Incentive Scheme (MIS)

The community people were seen pleased from the Maternity Incentive Scheme. From this scheme they received free delivery services and monetary benefit. Most of the people seemed to be aware of the free delivery. Despite knowing the free health delivery services, there were some marginalized and disadvantage group that did not utilized the services. Also similar situation was seen in some specific communities like Thami and Dalits. The reason shown was due to the traditional belief and long distance to the health facilities.

3.11. Recording and reporting of expenditure

Only few health facilities were found to have maintained the detail of the expenditure. DPHO reimburse the expenses on quarterly basis. The allocation of budget on different heading was decided by HFMC. Though there was proper recording on income and expenditure, reporting part to the upper level was found lacking. In some HFs there was no recording system; they only did the storing and distributing of the drugs.

Chapter Four

Findings of the study

This chapter provides the findings derived from this study. The total sample included in this study was 97808 from Jiri District Hospital, Charikot PHC, Suri PHC, Dolakha HP, Namdu HP, Gogar HP, Boch HP, Alampu SHP, and Makaibari SHP of Dolakha district from Shrawan 2063 to Paush 2065. The findings which are described in this chapter mainly further categorized in the following basis: Age group, sex group, Ethnic group and Types of cases. This section provides the detail description of these variables which are used in this study.

Table 3.1 Age and sex distribution of subjects attending at health institution Dolakha.

Age Group	**Fiscal Year**					
	2063/64		**2064/64**		**2065/66**	
	Male (%)	**Female (%)**	**Male (%)**	**Female (%)**	**Male (%)**	**Female (%)**
0-5 Year	1877(18.83)	2740(14.02)	3088(17.89)	3516(15.59)	1946(18.23)	2841(15.96)
5-10 Year	820(8.22)	1087(5.56)	1136(6.58)	1335(5.92)	937(8.78)	1440(8.09)
10-15 Year	1013(10.16)	1255(6.42)	1540(8.92)	1624(7.20)	1060(9.93)	1419(7.97)
15-20 Year	1042(10.45)	2326(11.90)	1614(9.35)	2578(11.43)	1014(9.5)	1659(9.32)
20-25 Year	1104(11.07)	3361(17.20)	2289(13.26)	3478(15.42)	1073(10.05)	2255(12.67)
25-30 Year	814(8.16)	2122(10.86)	1469(8.51)	2125(9.42)	781(7.32)	1686(9.47)
30-35 Year	546(5.48)	1786(9.14)	1115(6.46)	1780(7.89)	672(6.30)	1383(7.77)
35-40 Year	506(5.08)	1218(6.23)	778(4.51)	1256(5.57)	366(3.43)	764(4.29)
40-45 Year	568(5.70)	1073(5.49)	1115(6.46)	1378(6.11)	844(7.91)	1264(7.1)
45-50 Year	451(4.52)	666(3.41)	830(4.81)	841(3.73)	457(4.28)	700(3.93)
50-55 Year	355(3.56)	561(2.87)	732(4.24)	668(2.96)	458(4.29)	682(3.83)
55-60 Year	210(2.11)	389(1.99)	371(2.15)	593(2.63)	264(2.47)	463(2.6)

60-65 Year	156(1.56)	262(1.34)	290(1.68)	438(1.94)	221(2.07)	381(2.14)
Above 65 Year	507(5.09)	696(3.56)	894(5.18)	945(4.19)	581(5.44)	869(4.88)
Total	**9970**	**19543**	**17261**	**22555**	**10672**	**17801**

Table 3.1 shows age and sex wise distribution of subjects attending at health institution during different fiscal years. The study enumerated a total of 29,511 subjects during FY 2063/64, 39,816 subjects during FY 2064/65 and 28,480 subjects during FY 2065/66 with females outnumbering males at 66.22 percent during FY 2063/64, 56.65 percent in FY 2064/65 and 62.65 percent during FY 2065/66. Exposure to different reproductive health problems among female population is major factor for consulting health institutions in higher proportion in comparison to female.

Study also revealed that 18.83 percent during FY 2063/64, 17.89 percent in FY 2064/65 and 18.23 percent in FY 2065/66 of male child under five were treated at health institution whereas 14.02 percent during FY 2063/64, 15.59 percent in FY 2064/65 and 15.96 percent in FY 2065/66 female child were treated at health institution of Dolakha.

Similarly 37.21 percent male and 26.01 percent female age below 15 years were treated during FY 2063/64, 33.39 male and 28.71 percent female under 15 years were treated during FY 2064/65 and 36.94 male and 32.01 percent female age under 15 years were treated during FY 2065/66.

Study revealed that among the under 15 male seeks treatment more than female. Study revealed that 45.94 percent male and 60.83 percent female age 15-45 years were treated during FY 2063/64, 48.55 male and 55.84 percent female age 15-45 years were treated during FY 2064/65 and 44.51 male and 50.61 percent female age 15-45 years were treated during FY 2065/66. Study revealed that among the age 15-45 female seeks treatment more than male due to gender based problem.

Study also revealed that 5.09 percent male and 3.56 percent female above 65 seek health service during FY 2063/64, similarly 5.18 percent male and 4.19 percent female in FY 2064/65 and 5.44 percent male and 4.88 percent female above 65seek health care during FY 2065/66.

Figure 3.1.1 Age and sex distribution of subjects attending health institution at Dolkha (2063/64).

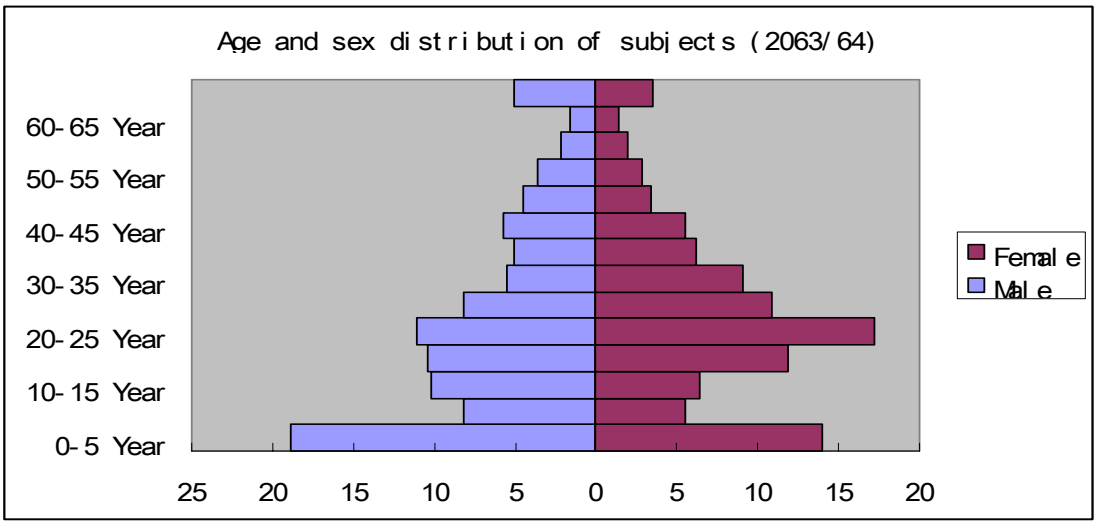


Figure 3.1.2 Age and sex distribution of subjects attending health institution at Dolkha (2064/65).

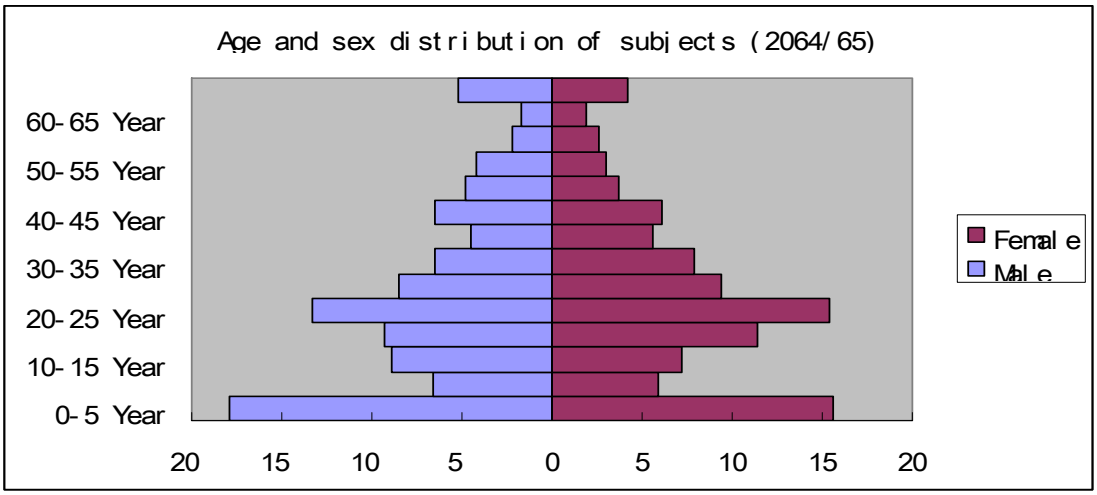


Figure 3.1.3 Age and sex distribution of subjects attending health institution at Dolkha (2065/66).

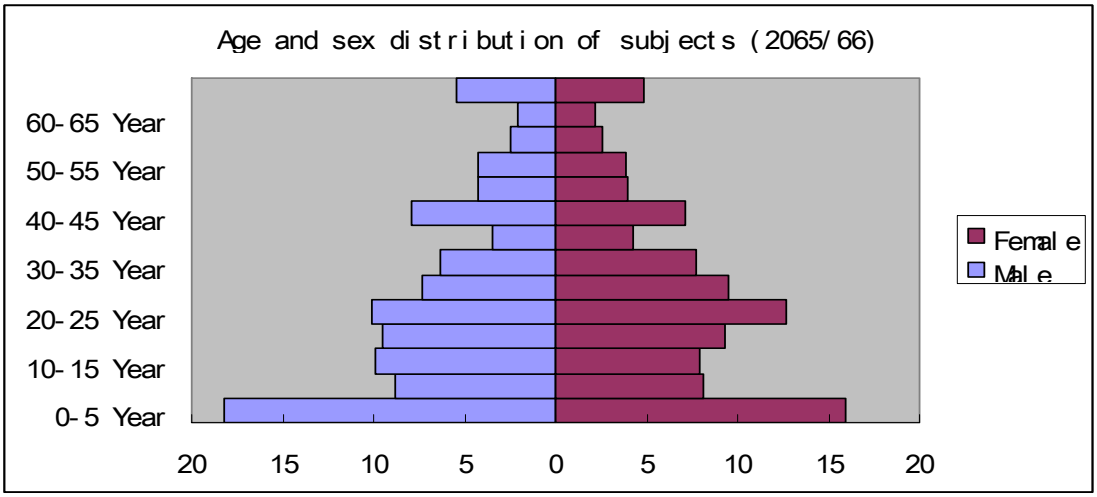


Table 3.2 Trend of cases attending at different level health institution.

Health Institution	Fiscal Year					Total
	2063/64		2064/65		2065/66	
	Shrawan to Paush	Magh to Ashadh	Shrawan to Paush	Magh to Ashadh	Shrawan to Paush	
District Hospital	5304(30.5)	4504(37.2)	5322(25.6)	3793(19.9)	7049(24.8)	25972(26.6)
PHC	4853(27.9)	1374(11.3)	5329(25.7)	4171(21.9)	6533(22.9)	22260(22.8)
HP/SHP	7243(41.6)	6240(51.5)	10105(48.7)	11097(58.2)	14891(52.3)	49576(50.7)
Total	17400 (100)	12118(100)	20756(100)	19061(100)	28473(100)	97808(100)

(Note: Value in the parenthesis is percent)

Figure 3.2 Trend of cases attending at different level health institution.

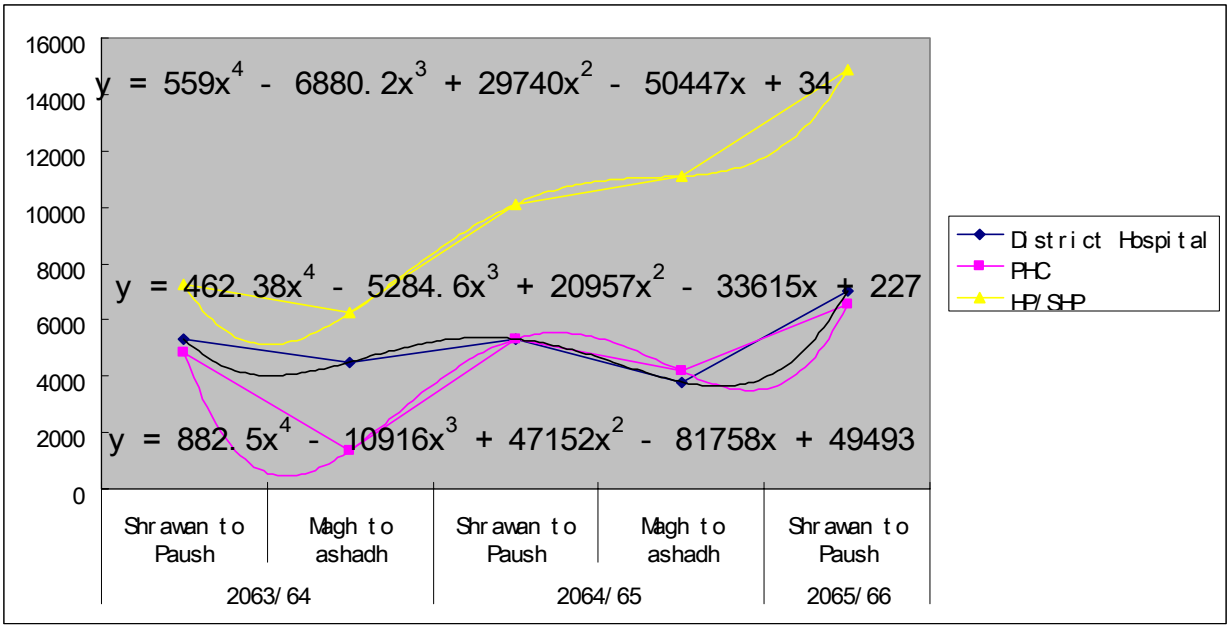


Table 3.2 describes the trend of cases attending at different level of health institution and study revealed that though trend of cases attending at district hospital is cyclic and increasing with $Yt = 882.5x^4 - 10916x^3 + 47152x^2 - 81758x + 49493$. Similarly the trend of cases attending at PHC were also cyclic and increasing $Yt = 462.38x^4 - 5284.6x^3 + 20957x^2 - 33615x + 227$. The seasonal variation was very high among the cases attending at PHC. Whilst the trend of increasing cases attending at peripheral level health institution were $Yt = 559x^4 - 6880.2x^3 + 29740x^2 - 50447x + 34$.

Table 3.3Trend of gender distribution of cases attending at District Hospital.

Gender	Fiscal Year					Total
	2063/64		2064/65		2065/66	
	Shrawan to Paush	Magh to Ashadh	Shrawan to Paush	Magh to Ashadh	Shrawan to Paush	
Male	2241(73.2)	1391(30.9)	2313(43.5)	1548(40.8)	2449(34.7)	9942(38.3)
Female	3063(26.8)	3113(69.1)	3009(56.5)	2245(59.2)	4600(65.3)	12967(61.7)
Total	5304(100)	4504(100)	5322(100)	3793(100)	7049(100)	25972(100)

(Note: Value in the parenthesis is percent)

Figure 3.3 Trend of gender distribution of cases attending at District Hospital.

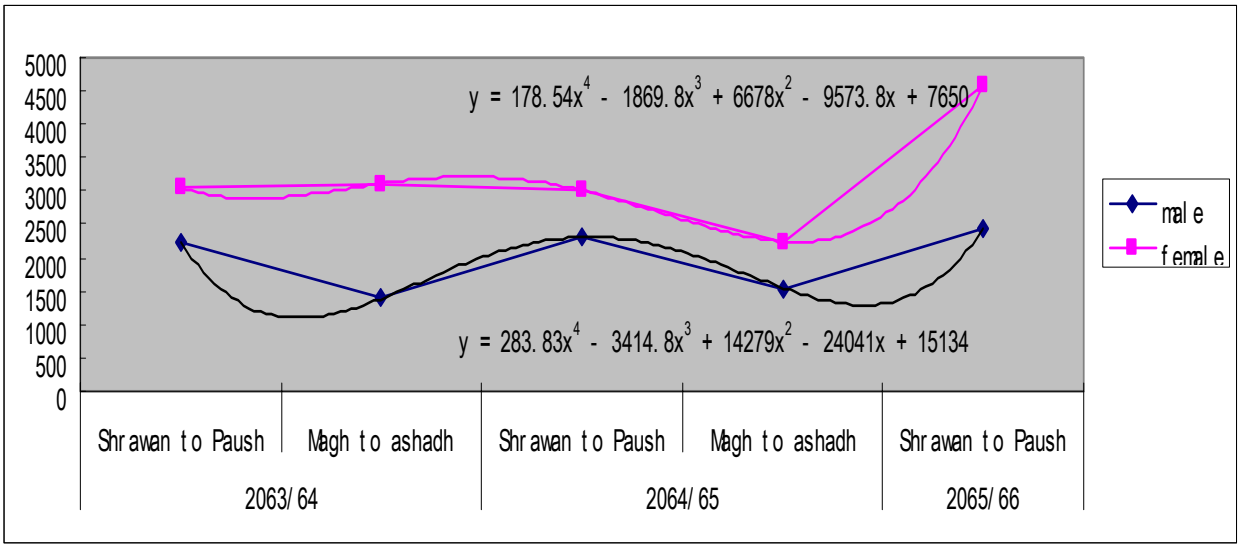


Table 3.3 describes on trend of sex distribution attending at district hospital and study revealed that trend of male cases attending at district hospital shows seasonal variation 73.2 percent male in first half of FY 2063/64 were treated while only 30.9 percent of male were treated in second half of same fiscal year and similar trend in FY 2064/65 but increasing with $Yt = 283.83x^4 - 3414.8x^3 + 14279x^2 - 24041x + 15134$. While trend of female attending at district hospital were also increasing Yt = 178.54x4 - 1869.8x3 + 6678x2 - 9573.8x + 7650. The trend of male and female attending district hospital increasing with constant 15134 and 7650 respectively with the seasonal slope.

Table 3.4 Trend of gender distribution of cases attending at PHC.

Gender	Fiscal Year					Total
	2063/64		2064/65		2065/66	
	Shrawan to Paush	Magh to Ashadh	Shrawan to Paush	Magh to Ashadh	Shrawan to Paush	
Male	1236(25.5)	275(20)	2062(38.7)	1436(34.4)	2204(33.7)	7213(32.4)
Female	3616(74.5)	1099(80)	3267(61.3)	2735(65.6)	4329(66.3)	15046(67.6)
Total	4852(100)	1374(100)	5329(100)	4171(100)	6533(100)	22259(100)

(Note: Value in the parenthesis is percent)

Figure 3.4 Trend of sex distribution of cases attending at PHC.

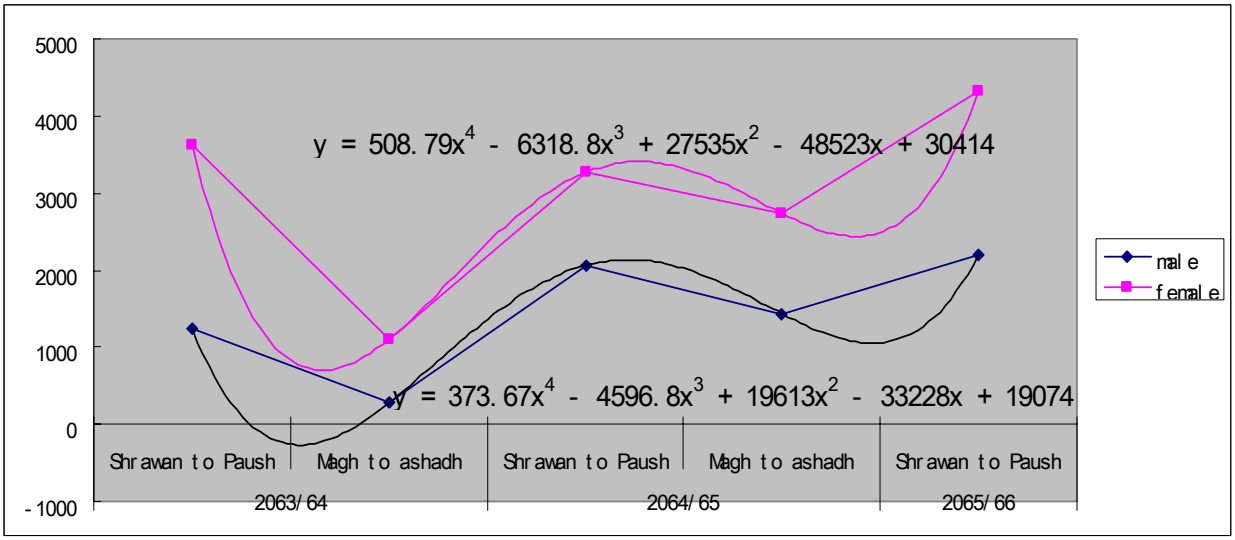


Table 3.4 describes on trend of sex distribution attending at PHC and study revealed that trend of male and female cases attending at PHC shows high seasonal fluctuation that 25.5 percent male in first half of FY 2063/64 were treated while only 20 percent of male were treated in second half of same fiscal year and similar trend in FY 2064/65 but increasing at first half 38.7 percent were treated while in second half 34.4 percent were treated. It shows cyclic but progressive trend with $Yt = 373.67x^4 - 4596.8x^3 + 19613x^2 - 33228x + 19074$. While trend of female attending at PHC were 74.5 percent in first half of the fiscal year while 80 percent at the second half of the fiscal year 2063/64 attending at PHC, similarly 61.3 percent in first half and 65.6 percent were in second half of the fiscal year 2064/65 were attending at PHC shows the trend is cyclic and increasing $y = 508.79x^4 - 6318.8x^3 + 27535x^2 - 48523x + 30414$.

Table 3.5 Trend of gender distribution of cases attending at HP/SHP.

Gender	Fiscal Year					Total
	2063/64		2064/65		2065/66	
	Shrawan to Paush	Magh to Ashadh	Shrawan to Paush	Magh to Ashadh	Shrawan to Paush	
Male	2624(36.2)	2203(35.3)	4748(47)	5154(46.4)	6019(40.4)	20748(41.8)
Female	4617(63.8)	4035(64.7)	5356(53)	5943(53.6)	8872(59.6)	28823(58.2)
Total	7241(100)	6238(100)	10105(100)	11097(100)	14891(100)	49572(100)

(Note: Value in the parenthesis is percent)

Figure 3.5 Trend of gender distribution of cases attending at HP/SHP.

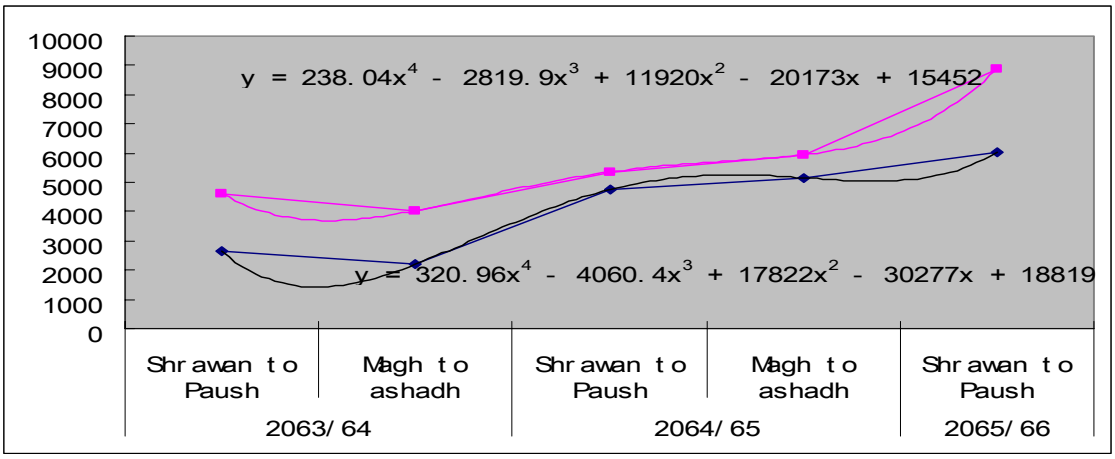


Table 3.5 describes on trend of sex distribution attending at HP/SHP and study revealed that trend of male and female cases attending at HP/SHP were 36.2 percent male in first half of FY 2063/64 were treated while 35.3 percent of male were treated in second half of same fiscal year and similar trend in FY 2064/65 at first half 47 percent were treated while in second half 46.4 percent were treated shows linear trend with $Yt = 320.96x^4 - 4060.4x^3 + 17822x^2 - 30277x + 18819$. While trend of female attending at HP/SHP were 63.8 percent in first half of the fiscal year while 64.7 percent at the second half of the fiscal year 2063/64 attending at HP/SHP, similarly 53 percent in first half and 53.6 percent were in second half of the fiscal year 2064/65 were attending at HP/SHP shows the trend is increasing $Yt = 238.04x^4 - 2819.9x^3 + 11920x^2 - 20173x + 15452$. The trend of male and female attending HP/SHP was increasing with constant 18819 and 15452 respectively.

Table 3.6 Trend of ethnic distribution of cases attending at District Hospital.

Ethnic Group	Fiscal Year					Total
	2063/64		2064/65		2065/66	
	Shrawan to Paush	Magh to Ashadh	Shrawan to Paush	Magh to Ashadh	Shrawan to Paush	
Dalit	280(5.3)	327(7.3)	245(4.6)	164(4.3)	233(3.3)	1249(4.8)
Disadvantaged Janajatis	3035(57.2)	1573(35.2)	3022(56.8)	2210(58.3)	3994(56.7)	13834(53.3)
Disadvantaged non dalit Terai caste groups	16(0.3)	12(0.3)	26(0.5)	17(0.4)	1(0.001)	72(0.3)
Relatively advantaged janajati	343(6.4)	475(10.6)	358(6.7)	218(5.7)	409(5.8)	1803(7)
Upper caste groups	1630(30.7)	2084 (46.6)	1671(31.4)	1184(31.2)	2412(34.2)	8981(34.6)
Total	5304(100)	4471 (100)	5322(100)	3793(100)	7049(100)	25939(100)

(Note: Value in the parenthesis is percent)

Figure 3.6 Trend of ethnic distribution of cases attending at District Hospital.

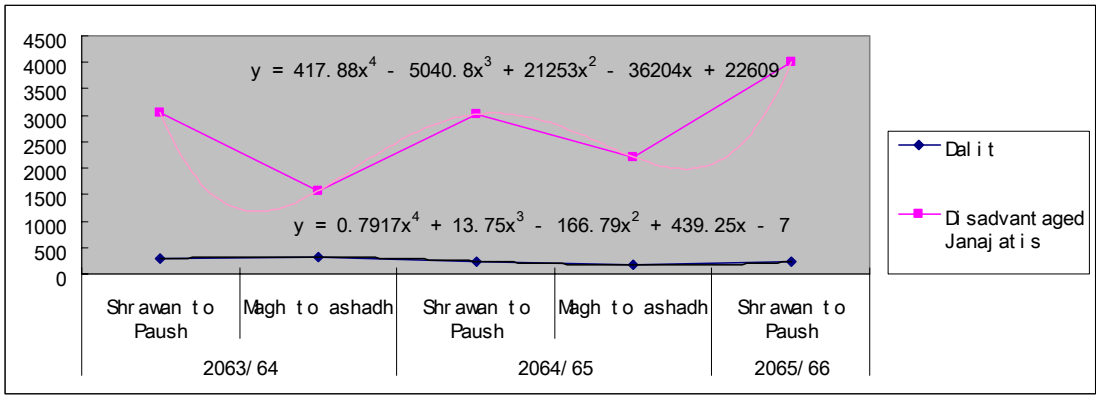


Table 3.6 describes information on trend of ethnic distribution of case attending at District Hospital and study revealed that the trend of access to district hospital by Dalits were 5.3 percent in first half of FY 2063/64 and 7.3 percent in second half of same fiscal year. Similarly 4.6 percent in first half of FY 2064/65 and 4.3 percent in second half of the same fiscal year and 3.3 percent in first half of FY 2065/66. The study shows the utilization of health service by Dalit were decreasing trend $Yt = 0.7917x^4 + 13.75x^3 - 166.79x^2 + 439.25x - 7$. Similarly the trend of access to district hospital by Disadvantage Janajatis were 57.2 percent in first half of FY 2063/64 and 35.2percent in second half of same fiscal year. Similarly 56.8 percent in first half of FY 2064/65 and 58.3 percent in second half of the same fiscal year and 56.7 percent in first half of FY 2065/66 . The study shows the utilization of health service by Disadvantage Janajatis were increasing trend $Yt= 417.88x^4 - 5040.8x^3 + 21253x^2 - 36204x + 22609$.

Table 3.7 Trend of ethnic distribution of cases attending at PHC.

Ethnic Group	Fiscal Year					Total
	2063/64		2064/65		2065/66	
	Shrawan to Paush	Magh to Ashadh	Shrawan to Paush	Magh to Ashadh	Shrawan to Paush	
Dalit	209(4.7)	49(3.6)	514(9.7)	415(10.1)	417(6.4)	1604(7.4)
Disadvantaged Janajatis	1933(43.4)	541(39.6)	1887(35.7)	1345(32.8)	1754(27)	7460(34.4)
Disadvantaged non dalit Terai caste groups	25(0.5)	11(0.8)	15(0.3)	29(0.5)	44(0.6)	124(0.5)
Relatively advantaged janajati	507(11.4)	159(11.6)	684(13)	468(11.4)	855(13.1)	2673(12.3)
Upper caste groups	1782(40)	605(44.3)	2180(41.3)	1840(44.9)	3434(52.8)	9841(45.3)
Total	4456(100)	1365(100)	5280(100)	4097(100)	6504(100)	21702(100)

(Note: Value in the parenthesis is percent)

Figure 3.7 Trend of ethnic distribution of cases attending at PHC.

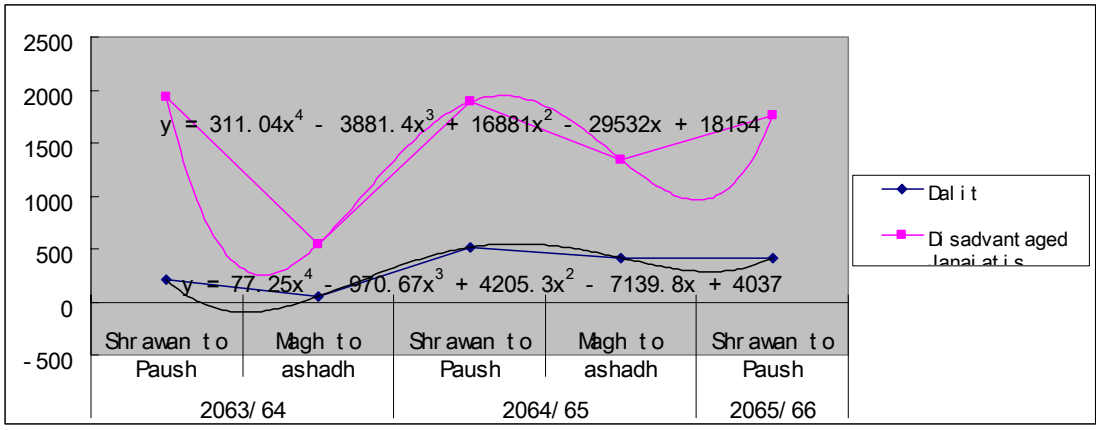


Table 3.7 describes information on trend of ethnic distribution of case attending at PHC and study revealed that the trend of access to PHC by Dalit were 4.7 percent in first half of FY 2063/64 and 3.6 percent in second half of same fiscal year. Similarly 9.7 percent in first half of FY 2064/65 and 10.1 percent in second half of the same fiscal year and 6.4 percent in first half of FY 2065/66. The study shows the utilization of health service by Dalit were increasing trend Yt = $77.25x^4 - 970.67x^3 + 4205.3x^2 - 7139.8x + 4037$. Similarly the trend of access to PHC by Disadvantage Janajatis were 43.4 percent in first half of FY 2063/64 and 39.6 percent in second half of same fiscal year. Similarly 35.7 percent in first half of FY 2064/65 and 32.8 percent in second half of the same fiscal year and 27 percent in first half of FY 2065/66. The study shows

the utilization of health service by Disadvantage Janajatis were increasing trend $Yt = 311.04x^4 - 3881.4x^3 + 16881x^2 - 29532x + 18154$.

Table 3.8 Trend of ethnic distribution of cases attending at HP/SHP.

Ethnic Group	Fiscal Year					Total
	2063/64		2064/65		2065/66	
	Shrawan to Paush	Magh to Ashadh	Shrawan to Paush	Magh to Ashadh	Shrawan to Paush	
Dalit	550(7.8)	522(8.8)	943(9.7)	463 (4.2)	1147(8.1)	3625(7.6)
Disadvantaged Janajatis	2481(35.4)	2261(38.1)	4968(51.3)	5547(50.1)	6592(46.4)	21849(45.6)
Disadvantaged non dalit Terai caste groups	50(0.7)	28(0.5)	117(1.2)	188(1.7)	275(1.9)	658(1.4)
Religious minorities	23(0.3)	11(0.2)	7(0.1)	4(0.1)	19(0.1)	64(0.1)
Relatively advantaged janajati	624(8.9)	739(12.5)	808(8.3)	1208(10.9)	1567(11)	4946(10.3)
Upper caste groups	3288(46.9)	2369(39.9)	2846(29.4)	3656(33)	4616(32.5)	16775(35)
Total	7016(100)	5930(100)	9689(100)	11066(100)	14216(100)	47917(100)

(Note: Value in the parenthesis is percent)

Figure 3.8 Trend of ethnic distribution of cases attending at HP/SHP.

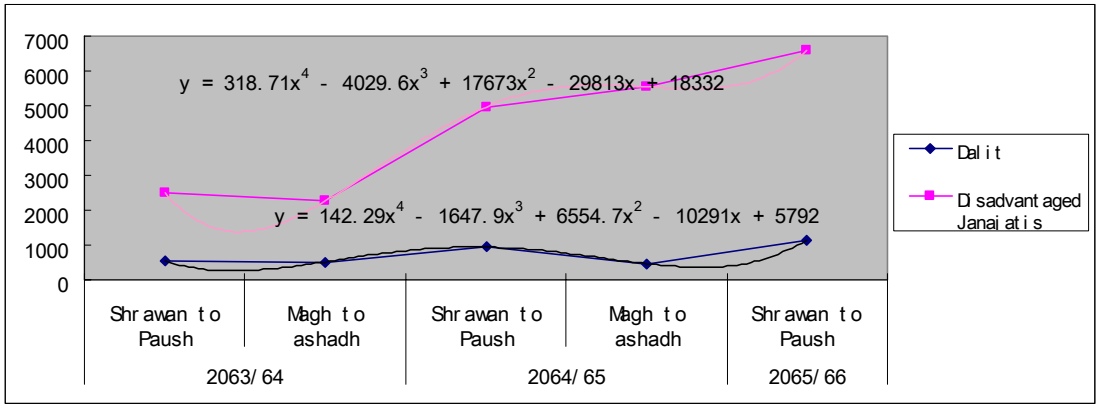


Table 3.8 describes information on trend of ethnic distribution of case attending at HP/SHP and study revealed that the trend of access to HP/SHP by Dalit were 7.8 percent in first half of FY 2063/64 and 8.8 percent in second half of same fiscal year. Similarly 9.7 percent in first half of FY 2064/65 and 4.2 percent in second half of the same fiscal year and 8.1 percent in first half of

FY 2065/66. The study shows the utilization of health service by Dalit were increasing trend Yt = $142.29x^4$ - $1647.9x^3$ + $6554.7x^2$ - 10291x + 5792. Similarly the trend of access to HP/SHP by Disadvantaged Janajatis were 35.4 percent in first half of FY 2063/64 and 38.1 percent in second half of same fiscal year. Similarly 51.3 percent in first half of FY 2064/65 and 50.1 percent in second half of the same fiscal year and 46.4 percent in first half of FY 2065/66 . The study shows the utilization of health service by Disadvantage Janajatis was increasing trend Yt = $318.71x^4$ - $4029.6x^3$ + $17673x^2$ - 29813x + 18332. Indeed the study revealed that Disadvantage Janajatis were more benefited with fee health care service program than Dalits at Peripheral level health institutions.

Table 3.9.1 Trend of ethnic distribution of cases stratified with gender attending at District Hospital.

Ethnic Group	**Fiscal Year**					**Total**
	2063/64		**2064/65**		**2065/66**	
	Shrawan to Paush	**Magh to Ashadh**	**Shrawan to Paush**	**Magh to Ashadh**	**Shrawan to Paush**	
Male						
Dalit	80(3.6)	123(8.9)	65(2.8)	52(3.4)	73(3)	393(4)
Disadvantaged Janajatis	1275(56.9)	531(38.5)	1294(55.9)	891(57.6)	1332(54.4)	5323(53.6)
Disadvantaged non dalit Terai caste groups	8(0.4)	7(0.5)	11(0.5)	11(0.7)	1(0.1)	38(0.4)
Relatively advantaged janajati	197(8.8)	110(8)	218(9.4)	119(7.7)	166(6.8)	810(8.2)
Upper caste groups	681(30.4)	609(44.1)	725(31.3)	475(30.7)	877(35.8)	3367(33.9)
Total	2241(100)	1380(100)	2313(100)	1548(100)	2449(100)	9931(100)
Female						
Dalit	200(6.5)	204(6.6)	180(6)	112(5)	160(3.5)	856(5.3)
Disadvantaged Janajatis	1760(57.5)	1042(33.8)	1728(47.4)	1319(58.5)	2662(57.9)	8511(53.2)
Disadvantaged non dalit Terai caste groups	8(0.3)	0(0)	15(0.5)	6(0.3)	0(0)	29(0.2)

Relatively advantaged janajati	146(4.8)	365(11.8)	140(4.7)	99(4.4)	243(5.3)	993(6.2)
Upper caste groups	949(31)	1475(47.8)	946(31.4)	709(31.6)	1535(33.4)	5614(35.1)
Total	3063(100)	3086(100)	3009(100)	2245(100)	4600(100)	16003(100)

(Note: Value in the parenthesis is percent)

Table 3.9.1 describes information on sex stratified analysis on ethnic distribution of cases attending District Hospital, Dolakha and study revealed that 3.6 percent of Dalit male utilized services at District Hospital in first half of FY 2063/64, while 8.9 percent utilized services at second half of the same fiscal year. Similarly 2.8 percent were utilized services at District Hospital in first half of FY 2064/65 and 2.4 percent utilized services at second half of the year and 3 percent utilized services at first half of the FY 2065/66. Study also revealed that 56.9 percent disadvantaged Janjatis male utilized services at District Hospital in first half of FY 2063/64, while 38.5 percent utilized services at second half of the same fiscal year. Similarly 55.9 percent utilized services at District Hospital in first half of FY 2064/65 and 57.6 percent utilized services at second half of the year and 54.4 percent utilized services at first half of the FY 2065/66. Table also offers information that 6.5 percent of Dalit female utilized services at District Hospital in first half of FY 2063/64, while 6.6 percent utilized services at second half of the same fiscal year. Similarly 6 percent utilized services at District Hospital in first half of FY 2064/65 and 5 percent utilized services at second half of the year and 3.5 percent utilized services at first half of the FY 2065/66. Study also revealed that 57.5 percent female from disadvantaged Janjatis utilized services at District Hospital in first half of FY 2063/64, while 33.8 percent utilized services at second half of the same fiscal year. Similarly 47.4 percent utilized services at District Hospital in first half of FY 2064/65 and 58.5 percent utilized services at second half of the year and 57.9 percent utilized services at first half of the FY 2065/66.

Table 3.9.2 Trend of ethnic distribution of cases stratified with gender attending at PHC.

Ethnic Group	**Fiscal Year**					**Total**
	2063/64		**2064/65**		**2065/66**	
	Shrawan to Paush	**Magh to Ashadh**	**Shrawan to Paush**	**Magh to Ashadh**	**Shrawan to Paush**	
Male						
Dalit	59(5.4)	10(3.7)	211(10.3)	200(14.5)	120(5.5)	600(8.6)
Disadvantaged Janajatis	444(40.6)	91(33.3)	726(35.5)	478(34.6)	621(28.3)	2360(33.8)
Disadvantaged non dalit Terai caste groups	6(0.5)	2(0.7)	2(0.1)	7(0.5)	15(0.7)	32(0.5)

Relatively advantaged Janajati	117(10.7)	36(13.2)	246(12)	157(11.4)	271(12.4)	827(11.8)
Upper caste groups	467(42.7)	134(49.1)	858(42)	540(39.1)	1166(53.2)	3165(45.3)
Total	1093(100)	273(100)	2043(100)	1382(100)	2193(100)	6984(100)
Female						
Dalit	150(4.5)	39(3.6)	303(9.4)	215(7.9)	297(6.9)	1004(6.8)
Disadvantaged Janajatis	1489(44.3)	450(41.2)	1161(35.9)	867(32)	1133(26.3)	5100(34.7)
Disadvantaged non dalit Terai caste groups	17(0.5)	9(0.8)	13(0.4)	15(0.6)	27(0.6)	81(0.6)
Religious minorities	2(0.1)	0(0)	0(0)	5(0.2)	2(0.1)	9(0.1)
Relatively advantaged janajati	390(11.6)	123(11.3)	438(13.5)	311(11.5)	584(13.5)	1846(12.5)
Upper caste groups	1315(39.1)	471(43.1)	1322(40.5)	1300(47.9)	2268(52.6)	6676(45.4)
Total	3363(100)	1092(100)	3237(100)	2713(100)	4311(100)	14716(100)

(Note: Value in the parenthesis is percent)

Table 3.9.2 describes information on sex stratified analysis on ethnic distribution of cases attending PHC, Dolakha and Study revealed that 5.4 percent of Dalit male utilized services at PHC in first half of FY 2063/64, while 3.7 percent utilized services at second half of the same fiscal year. Similarly 10.3 percent utilized services at PHC in first half of FY 2064/65 and 14.5 percent utilized services at second half of the year and 5.5 percent utilized services at first half of the FY 2065/66. Study also revealed that 40.5 percent male belonging disadvantaged Janajatis utilized services at PHC in first half of FY 2063/64, while 33.3 percent utilized services at second half of the same fiscal year. Similarly 35.5 percent utilized services at PHC in first half of FY 2064/65 and 34.6 percent utilized services at second half of the year and 28.3 percent utilized services at first half of the FY 2065/66. Table also offers information that 14.94 percent of Dalits female utilized services at PHC in first half of FY 2063/64, while 4.5 percent utilized services at second half of the same fiscal year. Similarly 3.5 percent were utilized services at PHC in first half of FY 2064/65 and 9.4 percent utilized services at second half of the year and 7.9 percent utilized services at first half of the FY 2065/66. Study also revealed that female 44.3 percent disadvantaged Janjatis utilized services at PHC in first half of FY 2063/64, while 41.2 percent utilized services at second half of the same fiscal year. Similarly 35.9 percent were utilized services at PHC in first half of FY 2064/65 and 32 percent utilized services at second half of the year and 26.3 percent utilized services at first half of the FY 2065/66.

Table 3.9.3 Trend of ethnic distribution of cases stratified with sex attending at HP/SHP.

Ethnic Group	Fiscal Year					Total
	2063/64		2064/65		2065/66	
	Shrawan to Paush	Magh to Ashadh	Shrawan to Paush	Magh to Ashadh	Shrawan to Paush	
Male						
Dalit	182(7.2)	159(7.6)	365(8.1)	219(4.3)	405(6.9)	925(6.5)
Disadvantaged Janajatis	909(35.9)	810(38.7)	2755(61)	2688(52.2)	2791(47.5)	7162(50.1)
Disadvantaged non dalit Terai caste groups	17(0.7)	11(0.5)	66(1.5)	139(2.7)	155(2.6)	233(1.6)
Religious minorities	8(0.3)	2(0.1)	1(0.1)	1(0.1)	9(0.2)	12(0.1)
Relatively advantaged janajati	226(8.9)	271(13)	291(6.4)	551(10.7)	644(11)	1339(9.4)
Upper caste groups	1189(47)	839(40.1)	1037(23)	1547(30.1)	1868(31.8)	4612(32.3)
Total	2531(100)	2092(100)	4515(100)	5145(100)	5872(100)	14283(100)
Female						
Dalit	368(8.2)	363(9.5)	578(11.2)	244(4.1)	742(8.9)	1553(8)
Disadvantaged Janajatis	1572(35.1)	1451(37.8)	2213(42.8)	2859(48.3)	3801(45.6)	8095(41.7)
Disadvantaged non dalit Terai caste groups	33(0.7)	17(0.4)	51(1)	49(0.8)	120(1.4)	150(0.8)
Religious minorities	15(0.3)	9(0.2)	6(0.1)	3(0.1)	10(0.1)	33(0.2)
Relatively advantaged janajati	398(8.9)	468(12.2)	517(10)	657(11.1)	923(11.1)	2040(10.5)
Upper caste groups	2099(46.8)	1530(39.9)	1809(35)	2109(35.6)	2748(32.9)	7547(38.9)
Total	4485(100)	3838(100)	5174(100)	5921(100)	8344(100)	19418(100)

(Note: Value in the parenthesis is percent)

Table 3.9.3 describes information on sex stratified analysis on ethnic distribution of cases attending HP/SHP, Dolakha and Study revealed that 7.2 percent of Dalit male utilized services at HP/SHP in first half of FY 2063/64, while 7.6 percent utilized services at second half of the same fiscal year. Similarly 8.1 percent were utilized services at HP/SHP in first half of FY 2064/65 and 4.3 percent utilized services at second half of the year and 6.9 percent utilized

services at first half of the FY 2065/66. Study also revealed that 35.9 percent disadvantaged Janjatis male utilized services at PHC at first half of FY 2063/64, while 38.7 percent utilized services at second half of the same fiscal year. Similarly 61 percent male utilized services at HP/SHP in first half of FY 2064/65 and 52.2 percent male utilized services at second half of the year and 47.5 percent utilized services at first half of the FY 2065/66. Table also offers information that 8.2 percent of Dalit female utilized services at HP/SHP in first half of FY 2063/64, while 9.5 percent utilized services at second half of the same fiscal year. Similarly 11.2 percent were utilized services at HP/SHP in first half of FY 2064/65 and 4.1 percent utilized services at second half of the year and 8.9 percent utilized services at first half of the FY 2065/66. Study also revealed that female 35.1 percent disadvantaged Janjatis utilized services at HP/SHP in first half of FY 2063/64, while 37.8 percent utilized services at second half of the same fiscal year. Similarly 42.8 percent were utilized services at HP/SHP in first half of FY 2064/65 and 48.3 percent utilized services at second half of the year and 45.6 percent utilized services at first half of the FY 2065/66.

Table 3.10.1 Trend on new and old case attending at District Hospital.

Types cases	**Fiscal Year**					**Total**
	2063/64		**2064/65**		**2065/66**	
	Shrawan to Paush	**Magh to Ashadh**	**Shrawan to Paush**	**Magh to Ashadh**	**Shrawan to Paush**	
New cases	4796(90.4)	3865(85.8)	4837(90.9)	3516(92.7)	6148(87.2)	23162(89.2)
Old cases	508(9.6)	639(14.2)	485(10.1)	277 (7.3)	901(3.8)	2810(10.8)
Total	5304(100)	4504(100)	5322(100)	3793(100)	7049(100)	25972(100)

(Note: Value in the parenthesis is percent)

Table 3.10.1 describes trend of new and old cases attending at district hospital and study revealed that 90.4 percent new cases attended at district hospital at first half of FY 2063/64, while 85.8 percent new cases attended at hospital at second half of the same year. Similarly 90.9 percent new cases attended hospital at first half of FY 2064/65 and 92.7 percent attended at second half of same fiscal year and 87.2 percent new cases attended at district hospital at first half of the FY 2065/66. So study revealed that the trained is increasing with $Yt = 435.08x^4 - 5050.2x^3 + 20375x^2 - 33232x + 22268$.

Table 3.10.2 Trend on old and new case attending at PHC

Types cases	Fiscal Year					Total
	2063/64		2064/65		2065/66	
	Shrawan to Paush	Magh to Ashadh	Shrawan to Paush	Magh to Ashadh	Shrawan to Paush	
New cases	3745(77.2)	865(63)	3280(61.5)	4071(97.7)	5822(89.1)	17783(79.9)
Old cases	1108(22.8)	509(37)	2049(38.5)	100(2.3)	711(10.9)	4477(20.1)
Total	4853(100)	1374(100)	5329(100)	4171(100)	6533(100)	22260(100)

(Note: Value in the parenthesis is percent)

Table 3.10.2 describes on trend of new and old case attending at PHC and study revealed that 77.2 percent new cases attended at district hospital at first half of FY 2063/64, while 63 percent new cases attended at PHC second half of the same year. Similarly 61.5 percent new cases were attended PHC at first half of FY 2064/65 and 97.7 percent attended at second half of same fiscal year and 89.1 percent new cases attended at PHC at first half of the FY 2065/66. So study revealed that the trend is increasing with $Yt = 395.96x^4 - 5112.8x^3 + 23425x^2 - 43305x + 28342$.

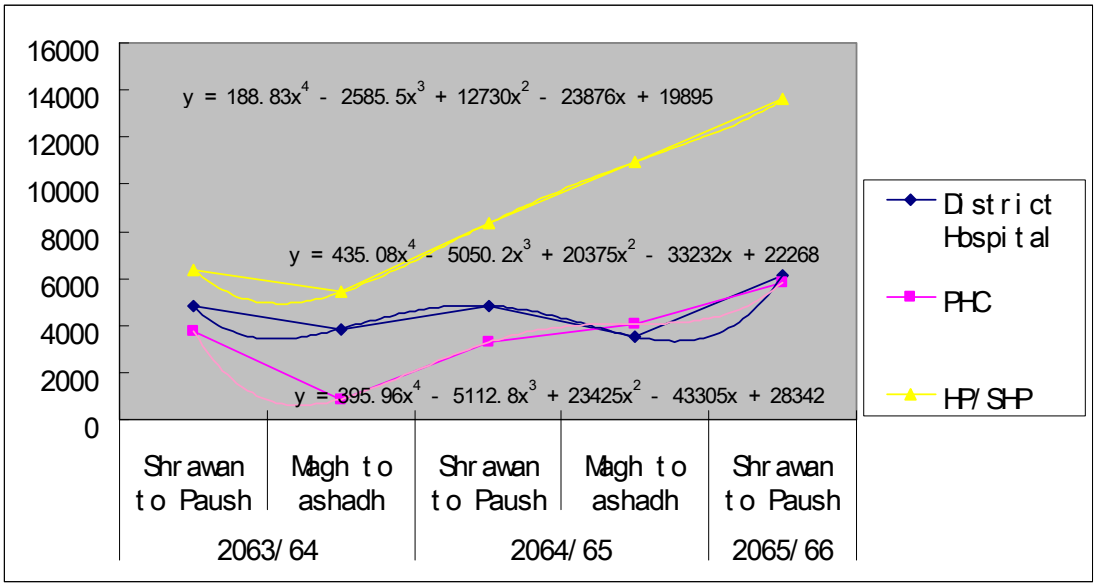
Table 3.10.3 Trend on old and new case attending at HP/SHP

Types cases	Fiscal Year					Total
	2063/64		2064/65		2065/66	
	Shrawan to Paush	Magh to Ashadh	Shrawan to Paush	Magh to Ashadh	Shrawan to Paush	
New cases	6353(87.7)	5402(86.6)	8327(82.4)	10945(98.6)	13605(91.4)	44632 (90)
Old cases	890(12.3)	838(13.4)	1777(17. 6)	152(1.4)	1286(8.6)	4943 (10)
Total	7243(100)	6240(100)	10105(100)	11097(100)	14891(100)	49576 (100)

(Note: Value in the parenthesis is percent)

Table 3.10.3 describes on trend of new and old case attending at HP/SHP and study revealed that 87.7 percent new cases attended at district hospital at first half of FY 2063/64, while 86.6 percent new cases attended at HP/SHP second half of the same year. Similarly 82.4 percent new cases were attended HP/SHP at first half of FY 2064/65 and 98.6 percent attended at second half of same fiscal year and 91.4 percent new cases attended at HP/SHP at first half of the FY 2065/66. So study revealed that the trained is increasing with $Yt = 188.83x^4 - 2585.5x^3 + 12730x^2 - 23876x + 19895$.

Figure 3.9 Trend on new case attending at different level health institution at Dolakha.



Chapter Five

Conclusion and Recommendation

5.1 Conclusion

The study has identified important information on utilization of universal free health service. The experience and understanding of the service providers and community people regarding different aspects of free health care services has been shared.

It is concluded that after implementing free health care services, flow of patients have been increased in government health facility. However, most marginalized and poor living far from the health facilities is still seen deprived from such services, because of lack of information regarding the services and difficult access to the health services.

The study found that there is lack of human resources in most of the health facilities. Also it was found that there is lack of community ownership; most people felt that it is only the responsible of the government for implementing free health care services. Without the involvement of the community people free health care services cannot be sustainable and effective. Community people and service providers felt that they need to have regular interaction between them regarding the services provided by the health institutions.

Regarding sex wise consultation, male are found consulting health facilities in higher proportion than female in all age groups i.e. under-5, under-15 and above 65 except during reproductive age in all three fiscal years.

Concerning seasonal variation, people are found going health institutions during Shrawan to Poush in higher proportion compared to Magh to Ashad. There is no seasonal fluctuation regarding new visits. After implementation of free health care services, new cases coming to health facilities are in increasing trend.

Majority of population are from disadvantaged Janajatis in Dolakha. Therefore, regarding ethnicity wise distribution, disadvantaged Janajatis are major population for utilizing services following by upper caste groups. There is cyclic trend of different ethnic groups attending health institutions in reference to two seasons in both fiscal years.

5.2 Recommendations

- Trained health worker must be requited on time.
- Drug should be provided according to patient flow and regional variation.
- The budget allocated for free care needs to be released in a timely manner. Budget headings of line items that included free care funds must be clear and specific.
- The free care monitoring committees needs to become functional: their roles and responsibilities should be clear and documented.
- There should be need to provide regular supervision and support so all health care workers develop good communication, coordination, with community people.

Reference:

Bitran, R and U. Giedion (2003). “Waivers and Exemptions for Health Services in Developing Countries” Washington DC, World Bank

Burnham, G. et al. (2004) “Discontinuation of cost sharing in Uganda. Bull World Health Org. 82 (3): 187-195

Ministry of Health and Population, (2006a). “Guideline for free essential health care services for poor and destitute people” Government of Nepal, Kathmandu

Ministry of Health and Population, (2006b). “Position paper of the Ministry of Health and Population "Government of Nepal, Kathmandu

Ministry of Health and Population, Management Division, Department of Health Services/Health Sector Reform Support Programme (MOHP/HSRSP), (2008), “Monitoring Strategies for Pro-poor Essential health Care Services and Toolkit” Government of Nepal, Kathmandu

Pearson, M. (2004). “The case for abolition of user fees for primary health services.” London, DFID Health Systems Resource Centre

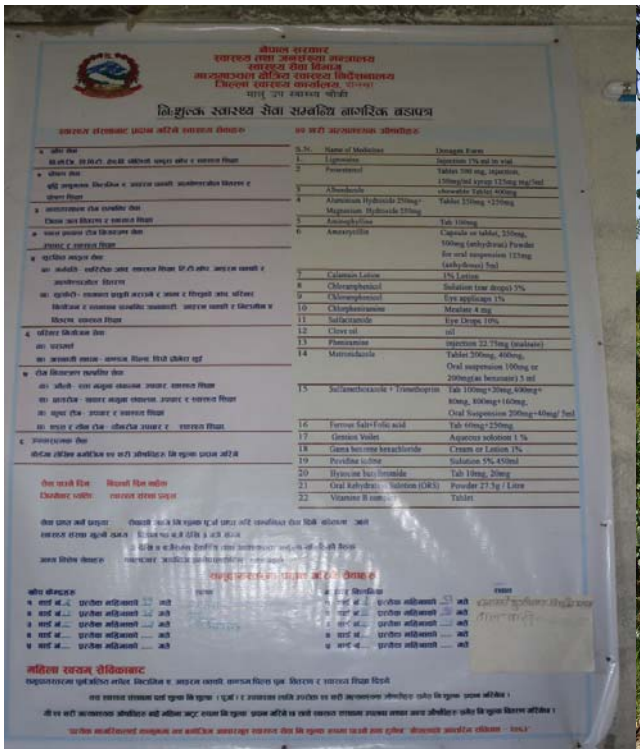
Prasai DP, Karki D, Sharma TM, Ganwali D, Subedi GR, Singh AB (2006). Nepal National Health Accounts, 2001-2003, GoN/Ministry of Health and Population, Katmandu.

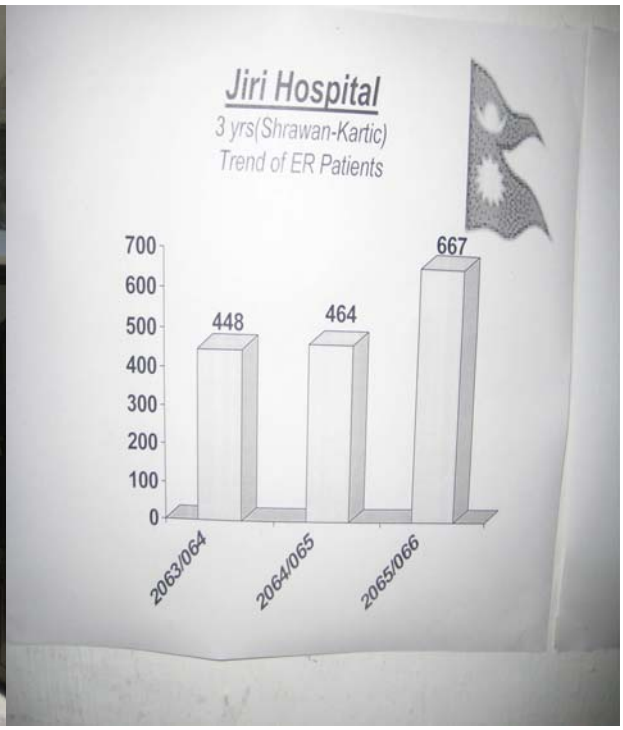
Annex – I: List of Participants

S. N.	Name	Designation	Address	Remarks
1	Bijuli Nepali		Malu -5	
2	Gyan Bahadur Mijar		Malu -5	
3	Ambika Nepali		Malu -5	
4	Masali Mijar		Malu -5	
5	Juna Nepali		Malu -5	
6	Pabitra Mijar		Malu -5	
7	Ganga Nepali		Malu -5	
8	Tanka Prasad		Malu -5	
9	Nar Bahadur Nepali		Boach- 3	
10	Tej Bahadur Pariyar		Boach -3	
11	Luxmi Priyar		Boach-4	
12	Lal Bahadur Nepali		Boach-4	
13	Jeevan Nepali		Boach-4	
14	Krishna Bahadur Pariyar		Boach-4	
15	Rajesh Bimal		Boach-4	
16	Chandra Bahadur Nepal		Boach-4	
17	Ms. Apsara Khadka		Boach-4	
18	Dr. Ram Chandra Shrestha		Boach-4	
19	Shyam Khadka		Boach -3	
20	Ms. Sita Khadka		Boach -3	
21	Mr. Basudev Karki		Boach -3	
22	Kishor Basnet		Boach -3	
23	Devraj Nepali		Boach -3	
24	Nawaraj Pariyar		Boach -3	
25	Ashok Nepali		Boach -3	
26	Kaji Nepali		Boach -3	
27	Hari Kumari Surel		Suri	
28	Tika Maya Surel		Suri	
29	Shiva kumari Surel		Suri	
30	Sarasoti Surel		Suri	
31	Parmila Surel		Suri	
32	Man Bir Surel		Suri	
33	Devi Maya Surel		Suri	

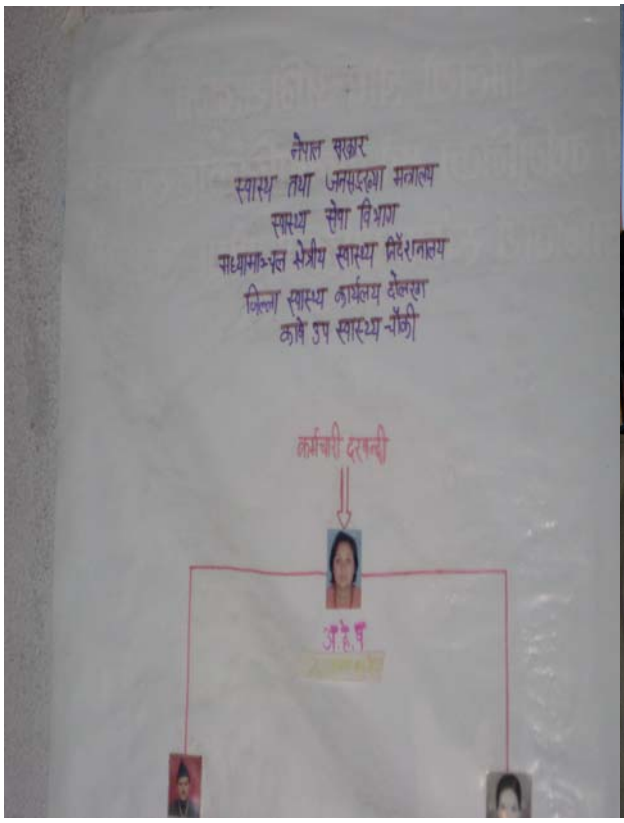
Annex – II

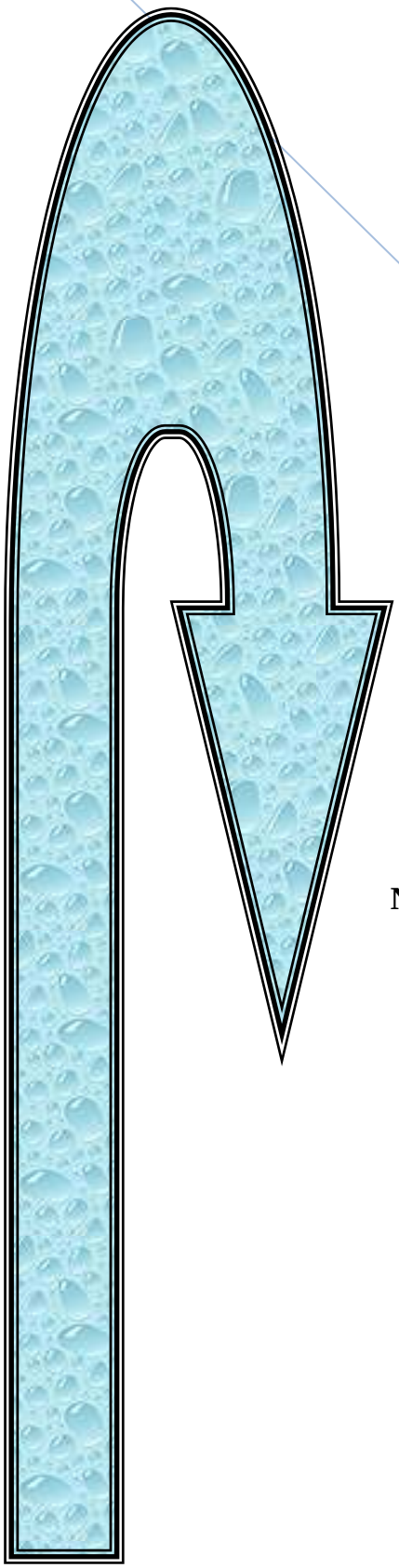
Photographs




Jiri Hospital
3 yrs(Shrawan-Kartic)
Trend of ER Patients
700
600
500
400
300
200
100
0
448
464
667
2063/064
2064/065
2065/066


काठ्रे उप-स्वास्थ्य चौकीबाट संचालन गरिने स्वास्थ्य कार्यक्रमहरू
सेवाहरू
प्रेषण सेवा ।
-उप-स्वास्थ्य चौकी काठ्रे


नेपाल सरकार
स्वास्थ्य तथा जनसंख्या मन्त्रालय
स्वास्थ्य सेवा विभाग
मध्यमाञ्चल क्षेत्रीय स्वास्थ्य निर्देशनालय
जिल्ला स्वास्थ्य कार्यालय दोलखा
काठे उप स्वास्थ्य-चौकी
कर्मचारी दरबन्दी



Submitted by

Nepal Health Research Council (NHRC)
Ramshah Path, Kathmandu, Nepal
Phone: 977-1-4254220/2227460
Fax: 977-1-4262469
E-mail: nhrc@healthnet.org.np
Website: http://www.nhrc.org.np