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Assessing Implementation of Nepal's Free Health Care Policy

Third Trimester Health Facility Survey Report

Ministry of Health and Population
Government of Nepal
December 2009



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This survey presents the findings of the second facility survey for health facilities throughout Nepal. It examines the impact of the government's free health care policy on such areas as human resources, drug availability and distribution, user profiles, and service utilization, concluding with a number of recommendations. Funding was provided by the U.K. Department for International Development (DFID) through the Health Sector Reform Support Programme (HSRSP). RTI International and CARE Nepal provided technical assistance. The CARE team that conducted the survey included Team Leader, Jhabindra Bhandari, Monitoring Officers, Hari Prasad Bhusal, Khem Narayan Pokhrel, and Assistant Monitoring Officers, Md. Kahful Wara, Dil Bd. Dhat, Pratibha Shah, Om Prakash Biswakarma, Hari Lal Dhakal, Lal Bahadur Khadka, Radha Subedi, Durga Sapkota, Nisha Sharma, Rajeev Banjara, Nara Bd. Biswakarma, Upama Adhikari, and Hasta Bd. Hitang. The opinions expressed herein are those of the authors and do not necessarily reflect the views of DFID.

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Survey Team

Abbreviations

ANM	Auxiliary Nurse Midwife
DHS	Demographic Health Survey
DPHO	District Public Health Office
EDL	Essential Drug List
FCHV	Female Community Health Volunteer
GoN	Government of Nepal
HDI	Human Development Index
HMIS	Health Management Information System
HP	Health Post
LMIS	Logistic Management Information System
MCHW	Maternal and Child Health Worker
MoHP	Ministry of Health and Population
NRs	Nepalese Rupees
PHCC	Primary Health Care Centre
SHP	Sub-health Post

I. Executive Summary

1.1 Rationale, Objectives, and Methodology

Since its beginning in 2006, Nepal's free health care policy has expanded to include more district health facilities, providing essential health care services (EHCS) free of charge to all or to selected disadvantaged groups. The intended beneficiaries of these services have been the poor, marginalized castes and ethnic groups, otherwise deprived or destitute, disabled, elderly, and female community health volunteers (FCHVs). Delivery services—normal, complicated and caesarean sections—are now free of charge to all women at government facilities nationwide.

To measure the impact of free health care policy on services, the survey looked at the flow of programme funds, status of human resources, and availability and status of drug supplies. It also reviewed trends in the profiles of service users, current costs for medications, the operating hours of health facilities, publicly available information about free care, and the management of the programme in districts.

To complete the third survey, a team surveyed 13 districts, including 15 hospitals, 15 primary health care centres (PHCCs), 47 health posts (HPs) and 91 sub-health posts (SHPs) as it did for the first two surveys. From April to June 2009, team members reviewed records from a four-month period: mid-November 2008 to mid-March 2009.

The following survey findings are based on records and interviews with staff as part of a health facility survey, and exit interviews with clients at these facilities.

1.2 Human Resources, Availability of Drugs, and Facility Operations at District Facilities

- The budget allocated for free care increased by 24 percent between FY 2007/08 and 2008/09 from US\$ 9.2 million to US\$ 11.4 million.
- The facilities' average number of filled positions remained the same at almost 90 percent while staff on leave or seconded dropped to 6 percent at HPs and SHPs. At district hospitals and PHCCs, filled positions improved to almost 83 percent and staff on leave or seconded decreased to almost 4 percent.
- The percentage of sanctioned positions filled by paramedics and ANMs and MCHWs increased marginally between second and third intervals, at HPs and SHPs. At hospitals and PHCCs, positions filled by doctors and nurses decreased by 20 percent and 8 percent, respectively, and positions filled by paramedics increased by 14 percent.

- HPs and SHPs with stock-outs of essential drugs lasting more than a week increased by 19 percent, whereas stock-outs increased by 96 percent at hospitals and PHCCs.
- Consultation and operating hours in HPs and SHPs did not change much. Total hours open, therefore, remained almost same.
- The average time for drugs to reach health facilities from the regions and districts increased for all types of health facilities, except district hospitals.
- Fewer hospitals and PHCCs publicly displayed a citizen charter that had free care messages (9 percent decrease) than before.
- Fewer health facilities held monitoring committee meetings (16 percent reduction). In particular, 25 percent fewer PHCCs convened these meetings. On the other hand, the percentage of hospitals holding these meetings remained same.

1.3 Findings for Universal Free Care at Health and Sub-health Posts

- Use by Dalits increased and they continue to use services at HPs and SHPs proportionally higher than their numbers. Janajatis decreased use by almost 10 percent. The proportion of Madhesi users did not change much. Muslim users increased a little during the period and still used services proportionate to their population.
- The proportion of women using outpatient care increased only slightly.
- The average cost for drugs per outpatient visit decreased by 14 percent.

1.4 Findings for Targeted Free Care at District Hospitals and Primary Health Care Centres

- More targeted beneficiaries used outpatient (43 percent), inpatient (34.5 percent) and emergency (30 percent) services.
- The proportion of Dalit outpatients (14.0 percent) during the third trimester was slightly lower than their population proportion. Janajati outpatients increased to slightly higher than their population proportion. The number of Mahdesis and Muslim outpatients decreased but remain close to their population proportions. Use of outpatient care by women increased and was slightly higher than their population proportion.
- Among the marginalised groups, Dalits used inpatient services relatively less (8.5 percent) than before but continued to use inpatient care in greater numbers than their population proportion. Use of inpatient care by Muslims increased to

their proportion in the population. Janajatis decreased their use by 13 percent but used inpatient care almost proportionate to their population.

- Madhesis use of emergency care decreased in the third trimester, but it was almost equal to their population proportion. Use by Muslims also decreased to below their proportion in the population.
- More women used inpatient care (73 percent) than before, a 12.5 percent increase.

1.5 Findings from Interviews with Managers in Charge and Clients

- Funds did not flow smoothly from the MoHP to all the health facilities. Delay in depositing the subsidy in health facility's account continues to be a problem. However, there was considerable improvement between the second and third trimesters in requesting and receiving the letter authorising the purchase of drugs and in insufficient funds allocated for the transport of drugs.
- Insufficient drug supply, full or nearly expired, or low quality medications dramatically increased between the second and third trimesters. The push system led resulted in an insufficient supply of the right drugs and unneeded drugs of low quality.
- 41 of 168 health facilities were under staffed because of absenteeism without notice or seconding.
- More managers complained about the lack of diagnostic equipment and crowding by people who are not seeking treatment.
- More than half (58 percent) of interviewed clients were fully satisfied with existing services, 40 percent were partially satisfied, and 2.5 percent were not satisfied.
- Nine out of ten clients (91 percent) related their satisfaction to the behaviour of health workers, 74 percent to the availability of medications, 79 percent to privacy, and 68 percent to range of services.
- Among the reasons given for dissatisfaction, unavailable drugs (26 percent), the range of services provided at the health facility (19 percent), and the behaviour of health workers (9 percent) were most often mentioned.
- When health providers prescribed essential drugs from the essential drug list (EDL), they most often prescribed one or two of these drugs (81 percent). The health facility then fully dispensed 67 percent of the medications, while another 29 percent were partially dispensed, and 3 percent not dispensed at all.

II. Introduction

2.1 Background

Pro-poor Health Policy

Recent changes in Nepal's political and economic climate have had a profound impact on the health sector and evolution of the country's national health policy. As a result of the People's Movement of 1990, sub-health posts (SHPs) were set up to deliver health services in every village run by a Village Development Committee. A primary health care centre (PHCC) with a birthing facility also opened in each electoral constituency. Over the years, this system was strengthened until the Ninth Plan (1997-2002) shifted the national focus toward alleviating poverty. The Ministry of Health and Population (MoHP) then readjusted by formulating a new plan, which was officially endorsed as the Second Long-term Health Plan (1997-2017).

In 2007, for the first time in the country's history, the government explicitly endorsed health care as a basic human right in the Interim Constitution of Nepal 2063. This rights-based approach implies a commitment to form an inclusive society, where people of all ethnic groups, genders, castes, religions, political beliefs, and social and economic status enjoy equal rights, without discrimination. It also reinforces the state's proactive responsibility for its people's health.

The rights-based approach has become the guiding principal for all the policies, plans, and programmes of the MoHP. The resulting 10-Points Position Paper commits the MoHP to achieving higher standards of health for all Nepali people, with an emphasis on reaching economically and socially marginalized individuals, women, and certain ethnic groups and castes in various geographical areas. The MoHP's Three-Year Interim Plan (2007 to 2010) refines this emphasis: it will focus specifically on eliminating geographical, economic, gender-based, and cultural barriers to ensure access to health care services for all.

Approach and Intended Beneficiaries of the Pro-poor Health Policy

On December 15, 2006, the Government of Nepal (GoN) drafted a policy providing emergency and inpatient services at district hospitals and PHCCs that are free of charge nationwide and outpatient care free of charge in low HDI districts to the poor, destitute, underserved, and elderly, people living with physical and psychological disabilities, and female volunteers known as Female Community Health Volunteers (FCHVs). Then in October 2007, the GoN declared all health services at health posts (HPs) and sub-health posts (SHPs) free of charge to all, so people could more easily access and use essential health care services. Universal free care was extended to PHCCs in January 2009, free outpatient care to the targeted groups was expanded to all districts, 40 essential drugs became free of charge to all at district hospitals, and deliveries became free of charge for

all women at all government institutions nationwide. These policies are intended to reduce financial barriers to seeking care, provide relief to poor families, promote the utilisation of essential health care services, increase maternal and newborn survival, and ultimately improve the health status of the population. The free care policy covers consultation and treatment, minor surgeries, obstetric emergencies, both comprehensive and basic emergency obstetric care (as available), X-rays, laboratory services, essential drugs (for a week), and transport by ambulance to a higher level facility when referred

2.2 Rationale for Monitoring

While the free health care policy has been in place for some time, information on its potential impact has been limited. The success of the policy depends on careful monitoring so that key information is available to policymakers and programme managers.

For example, baseline information on user fees has been missing since these fees have been underreported in the existing Health Management Information System (HMIS). We do not know the amount of revenue lost from abolishing user fees, nor what impact this will have. Very little current data exist for average user fees per visit/day or per case, and little is known about the allocation and use of user fees. Without this and other information, policymakers cannot fully weigh the advantages and disadvantages of free services.

Recently, RTI International conducted a survey of seven district hospitals and five private hospitals purposively selected based on distributional criteria to reflect diversity in development regions, ecological belts, poorer and better-off HDI districts, and size of the hospital. A consumer survey was conducted at the selected hospitals where the consumers were receiving treatment as outpatient, emergency, and inpatient service users. Exit interviews were conducted with 403 consumers at the public and private hospitals.

It was found that district hospitals were less than fully utilised. More outpatients and inpatients can be accommodated without requiring an expansion of the existing facilities, and hospitals' operating hours for outpatient service could be easily extended. The contribution of user fees to the incomes of the district hospitals, at 25 percent, was significantly higher than previously assumed. User fees were important because they supported a different expenditure pattern that seems to be more conducive to better performance for the hospital. For example, one-fourth of user fees were used to give incentives to the health staff, which is crucial in enhancing staff's morale and increasing productivity. Funds from the government budget are not allowed to be used to pay for incentives.

It was also found that the extended targeted free care policy announced in January 2009 was likely to improve the health equity substantially at a reasonable cost. Under this extended target policy, the poorest, the poor, and the disadvantaged will receive all

three services free of charge in all district hospitals. Listed essential drugs available in the hospitals will be provided free of charge to the target population. The non-poor (the three higher household wealth quintiles) will still pay the user fees for all services in the hospitals and buy the drugs from the local market. The extended target policy would also minimize the loss of user fees and therefore limit the negative impact on providers or services. In contrast, abolishing all user fees and providing essential drugs free for everybody at district hospitals did not fare as well. Such a policy would cost twice as much as the current policy, affect provider morale by eliminating incentives, and most undesirably, reduce the health equity by subsidizing the non-poor for using public health services.

Similarly, certain information on users and non-users of services has been unavailable. Why do poor and marginalized groups use services less than their wealthier counterparts? What proportion of the poor really benefit from free care and how many resources are used in serving them? The poorest families and excluded households living in remote areas may not get any information on free care or benefit as much as households with better access to information and health facilities. Policymakers need to ensure that poor and marginalized groups are the actual beneficiaries of free care, and not crowded out by people with more resources. Effective monitoring systems help to assess who, in fact, are the “winners and losers” of free care, and can facilitate the delivery of care.

Policymakers and managers also need more data on the availability and utilisation of human resources, equipment, and facilities in order to estimate additional resources required to meet the expected increase in demand. Although funding has increased, shortages and stock-outs of essential drugs will probably occur at health facilities. Quality of care may also deteriorate from higher demand and insufficient resources.

In short, monitoring both service delivery and demand for services will help to solve problems and ensure smooth implementation of the free care policy. It will also provide important information on the quality of free services.

2.3 Objectives

The objectives of the monitoring strategy that the MoHP adopted were:

- To assess the selected health facilities in each district in terms of their available human resources, essential drugs, equipment, and supplies, as well as the quality of their free care.
- To assess trends in service utilisation by poor and socially excluded groups, compared with more advantaged groups, and to relate these findings to socioeconomic status.
- To assess knowledge about the availability of free health care, as well as actual health-care seeking behaviour of users and non-users.

- To assess the impact of the free care policy in reducing out-of-pocket payments.

The third health facility survey is an effort to meet some of these objectives.

III. Methodology

3.1 Survey Design, Sampling Procedures, and Sample Size

To assess the pro-poor health policy, the survey used a quantitative, cross-sectional design. The survey team conducted a health facility survey at different types of health facilities in 13 districts, as well as interviews with clients in these settings. The survey questionnaire and the interview guidelines came from the MoHP's monitoring strategy.

Selection of Districts

The team used a purposive sampling method to draw 13 representative districts from the clusters defined by the 2006 Demographic and Health Survey (DHS). It applied the following criteria to select the districts:

- one district was selected from each DHS cluster (for a total of 13 districts)
- the district had a Human Development Index (HDI) that reflected the average HDI of the cluster
- the district was representative of the socio-economic status of the cluster
- the district was physically accessible from a managerial point of view

The regional distribution of the sampled districts is as follows:

1. Eastern: Taplejung, Udayapur, Siraha
2. Central: Sindhupalchok, Makawanpur, Mahottari
3. Western: Baglung, Nawalparasi
4. Mid-western: Rolpa, Dolpa, Banke
5. Far Western: Doti, Kailali

The figure below shows the sampled districts in their DHS clusters. Table 1 indicates the percentage of facilities that were surveyed in these districts.

Table 4: Number of health facilities and people in the sampled districts

Cluster	District	HDI Rank (out of 75)	Total health facilities, population, and households					Sampled health facilities and households					
			Hospitals	PHCCs	HPs	SHPs	Population	Households	Hospitals	PHCCs	HPs	SHPs	Households
Eastern Mountain	Taplejung	36	1	2	8	43	146,944	26,240	1	1	3	6	300
Eastern Hill	Udayapur	21	1	2	9	35	331,308	59,162	1	1	3	5	270
Eastern Terai	Siraha	51	2	3	12	93	647,274	115,585	2	1	5	14	600
Central Mountain	Sindhupalchok	54	1	2	11	65	340,615	60,824	1	1	4	10	450
Central Hill	Makawanpur	31	1	4	10	30	447,381	79,889	1	2	4	5	330
Central Terai	Mahottari	59	1	3	6	67	624,250	111,473	1	1	2	10	390
Western Hill	Baglung	19	1	3	9	49	319,829	57,112	1	1	3	7	330
Western Terai	Nawalparasi	25	1	5	8	63	554,143	98,954	1	2	3	9	420
Mid-western Hill	Rolpa	65	1	1	10	40	232,189	41,462	1	1	4	6	330
Mid-western Mountain	Dolpa	67	1	0	9	14	32,968	5,887	1	0	3	3	180
Mid-western Terai	Banke	29	1	2	10	35	443,728	79,237	1	1	4	5	300
Far Western Hill	Doti	60	1	2	10	39	229,504	40,983	1	1	4	6	330
Far Western Terai	Kailali	46	2	5	8	30	725,508	129,555	2	2	5	5	360
Total number			15	34	120	603	5,075,641	906,364	15	15	47	91	4,590
% of total									100	44	39	15	0.51

3.2 Monitoring Techniques

Trimester health facility surveys, client exit interviews, and annual household surveys were selected as techniques for monitoring pro-poor health policy of the MoHP. This monitoring report for the second trimester is based on the findings of a health facility survey and client exit interviews.

Health Facility Survey

The survey team used the health facility survey instruments to collect information on:

adequacy of the programme budget and allocation of funds;
availability of care providers at health facilities;
availability of essential drugs (supply and consumption);
per visit drug costs for outpatient care;
management aspects of the free care programme;
client characteristics and volume visiting health facilities.

Existing records at the health facilities were the source of data on the budgetary funds received and spent, drug supply and consumption, status of human resources, and use of outpatient, inpatient, and emergency services. Other data came from the Health Management Information System (HMIS), Logistic Management Information System (LMIS), and discussions with managers in charge at the facilities.

The third health facility survey used facility records from the previous four months (trimester), from mid-November 2008 to mid-March 2009. The team compared the findings from this trimester with those of the first and second surveys.

Client Exit Interviews

The survey team also followed exit interview guidelines to collect the following information from clients:

level of clients' satisfaction;
reasons for their satisfaction and dissatisfaction;
drug prescribing and dispensing practices.

At each HP and SHP, the team interviewed one client who had come for health services as he or she exited. They interviewed two clients as they left each hospital and PHCC.

3.3 Limitations of the Survey

1. At many of the hospitals and PHCCs, recordkeeping was incomplete for orders of drug supplies and dispensing drugs to the facility's units.
2. To develop information on expenditures for commodities and utilisation of services, the team had to collect and analyze disaggregated data.

- This survey only partially shows the pattern of public expenditures, service utilisation, and availability of care providers and of drugs. It does not reflect the complete picture of supply and demand for health services at the district level.

IV. Human Resources, Availability of Drugs, and Facility Operations at District Facilities

The universal free care programme, announced in October 2007 and implemented in January 2008, provides free health care services to all citizens at health posts (HPs) and sub-health posts (SHPs) nationwide. This means that people are neither charged at registration nor for essential drugs provided at the HPs or SHPs. During part of the survey period under review, universal free care was expanded to PHCCs, 40 essential drugs were made free of charge for all, and deliveries became free of charge for all women.

4.1 Monitoring Funds for the Free Care Programme

Major inputs to free care include the budgetary allocation of funds and proportion of allocated funds actually expended, as well as the availability of trained care providers and essential drugs at health facilities. The budget allocated for free care increased by 24 percent between FY 2007/08 and 2008/09 from US\$ 9.2 million to US\$ 11.4 million.

Table 2: Free Health Care Budget

Amount in '000, Exchange rate: US\$ 1 = NRs. 75

Category	2007/08			2008/09			Percentage change in budget
	NRs.	US\$	Share (%)	NRs.	US\$	Share (%)	
Provision and Management Support	168,492	2,246.56	24.38	192,200	2,562.67	22.41	14.07
Drugs*	522,518	6,966.91	75.62	665,480	8,873.07	77.59	27.36
Grand Total**	691,010	9,213.47	100.00	857,680	11,435.73	100.00	24.12

Source: MoHP 2007, 2008a; MoF 2007, 2008b

* Includes the drugs purchased from Primary Health Care Services - DHO, HP and SHP (70-3-122) (NRs. 59,118,000); Drug Supplies and Equipment (70-3/4-610), (NRs. 160,000,000); and Regional Medical Stores (NRs. 50,000,000) for 2007/08.

**Total free health care budget, includes NRs. 150,000,000 subsidy for service charges (user fees) based on patient volume for 2008/09.

4.2 Monitoring Human Resources for the Free Care Programme

Having sufficient numbers of trained health care workers on the job at district facilities is vital to the delivery of free health care services. During the third interval, about the same number of staff were available to deliver services as during the second interval. Filled positions at HPs and SHPs decreased by less than 1 percent, while staff on leave or seconded decreased by 10 percent between the third and second intervals.

Table 3: Status of human resources at HPs and SHPs

Status of human resources	First interval	Second interval	Third interval	% change
Total sanctioned positions	468	469	470	0.2
% of positions filled	88.6	89.6	89.4	-0.2
% on leave or seconded	10.8	6.9	6.2	-10.1

However, during the third trimester, filled positions in hospitals and PHCCs increased by 8 percent, while staff on leave or seconded decreased significantly from the second trimester. The holiday season during the second trimester may have been a factor contributing to the significant increase in leave and secondment but the decrease between the third and first intervals is also large at 29 percent.

Table 4: Status of human resources at district hospitals and PHCCs

Status of human resources	First interval	Second interval	Third interval	% change
Total sanctioned positions	492	492	498	1.2
% of positions filled	78.5	76.6	82.7	8.1
% on leave or seconded	5.5	13.7	3.9	-71.5

At HPs and SHPs, the main health care providers who have received health care training are auxiliary nurse midwives (ANMs), maternal and child health workers (MCHWs), and paramedics. On average, filled positions for paramedics remained about the same between the second and third intervals, while filled positions for ANMs and MCHWs grew by 3.4 percent.

Table 5: Retention of key health care providers at HPs and SHPs

Type of care providers	% of positions filled			% change
	First interval	Second interval	Third interval	
ANMs/MCHWs	88.6	91.0	94.1	3.4
Paramedics	85.0	89.1	89.2	0.1

The key care providers at district hospitals and PHCCs, are doctors, nurses, and paramedics. Their availability is essential to providing quality services and satisfying users. The percentage of sanctioned positions actually filled by doctors and nurses decreased at these facilities by 20 percent and 8 percent, respectively, but positions filled by paramedics increased by 14 percent.

Table 6: Retention of key health care providers at district hospitals and PHCCs

Type of care providers	% of positions filled			% change
	First interval	Second interval	Third interval	
Doctors	77.3	79.7	63.9	-19.8
Nurses	68.0	80.5	74.4	-7.6
Paramedics	83.4	80.5	91.8	14.0

4.3 Monitoring of the Availability of Drugs for the Free Care Programme

To give adequate care, staff members need to provide essential drugs when necessary. This trimester, however, a greater number of HPs and SHPs had stock-outs of essential drugs that lasted more than a week (19 percent increase).

Table 7: Change in stock-outs of drugs lasting more than a week at HPs and SHPs

First interval%	Second interval%	Third interval %	% change
66.7	71.9	85.4	18.8

Essential drugs also became less available at district hospitals and PHCCs as stock-outs lasting more than a week increased greatly, by 96 percent.

Table 8: Change in stock-outs of drugs lasting more than a week at hospitals and PHCCs

First interval %	Second interval %	Third interval %	% change
30.0	39.2	76.5	95.7

HPs and SHPs each experienced 13 percent more stock-outs during the third trimester.

Table 9: Stock-outs of essential drugs longer than a week at HPs and SHPs

Stock-out of essential drugs	First interval			Second interval			Third interval		
	% of HPs n=47	% of SHPs n=91	Total % n=138	% of HPs n=47	% of SHPs n=91	Total % n=138	% of HPs n=47	% of SHPs n=91	Total % n=138
No stock-outs	34.1	32.9	33.3	29.8	26.4	28.1	17.0	13.2	14.5
1-5 items	25.5	20.9	22.5	40.4	36.3	38.4	25.5	36.3	32.6
6-10 items	17.0	34.1	28.3	12.8	24.2	18.5	29.8	35.2	33.3
11-15 items	14.9	10.9	12.3	8.5	9.9	9.2	23.4	15.4	18.1
16 or more items	8.5	1.1	3.6	8.5	3.3	5.9	4.3	0	1.4
Total % of facilities with stock-outs	65.9	67.1	66.7	70.2	73.6	71.9	83.0	86.9	85.4

Delays in procurement could help account for stock-outs. In this period, most districts faced the problem of stock outs primarily due to delays in drugs from the regions reaching the districts, as well districts delaying deliveries to peripheral health facilities. Also, health facilities did not receive adequate supplies of drugs to meet their needs.

PHCCs experienced more of an increase in these stock-outs (from 40 to 93 percent) compared to hospitals (from 38.5 to 60 percent). Stock-outs for both involved more items during the third trimester.

Table 10: Stock-outs of essential drugs longer than a week at hospitals and PHCCs

Stock-outs of essential drugs	First interval			Second interval			Third interval		
	% of hospitals n=15	% of PHCCs n=15	Total % n=30	% of hospitals n=15	% of PHCCs n=15	Total % n=30	% of hospitals n=15	% of PHCCs n=15	Total % n=30
No stock-outs	73.3	66.7	70.0	61.5	60.1	60.8	40.0	6.7	23.3
1-5 items	13.3	13.3	13.3	7.7	13.3	10.5	33.3	33.3	33.3
6-10 items	0.0	3.3	1.7	23.1	13.3	18.2	13.3	33.3	23.3
11-15 items	6.7	6.7	6.7	0.0	13.3	6.7	6.7	20.0	13.3
16 or more items	6.7	0.0	3.4	7.7	0.0	3.9	6.7	6.7	6.7
Total % of facilities with stock-outs	26.7	23.3	25.1	38.5	39.9	39.2	60.0	93.3	76.7

4.4 Monitoring of Facility Operations for the Free Care Programme

The mere availability of trained staff and drugs at health facilities at a certain time do not ensure that clients will receive services. To guarantee clients' access to good care, procedures for allocating providers' time and resupplying drugs regularly also need to be in place. To measure these, the team looked at the breakdown of facilities' operating hours and the average time drugs took to reach health facilities from the region or district.

Consultation hours in HPs and SHPs decreased by 0.1 hour, but their recording and reporting hours increased by 0.2 hours. As a result, total operating hours increased by 0.1 hour

Table 11: Average hours of operation at HPs and SHPs

Activity	First interval	Second interval	Third interval	Change in hours
Outpatient services	4.2	4.2	4.1	-0.1
Recording and reporting	1.8	1.1	1.3	0.2
Total hours open	6.0	5.3	5.4	0.1

Drugs become less available at health facilities if new shipments take a long time to reach outlying HPs and SHPs from regional and district health offices. On average, drugs arrived at all types of health facilities from the regions and districts, except district hospitals, in more days than during the first and second intervals.

Table 12: Time taken for drugs to reach health facilities from the region or district

Type of health facilities	Average days			Change In days
	First interval	Second interval	Third interval	
District hospitals (n=15)	16.4	13.8	2.0	-11.8
PHCCs (n=15)	19.1	13.5	16.9	3.4
Health posts (n=47)	20.6	15.2	30.0	14.8
Sub-health posts (n=91)	24.3	15.2	32.1	16.9
Total days (n=168)	20.1	14.4	20.4	6.0

In the third interval, the terrain, whether mountain, hill or Terai, does not show a clear relationship with the time taken for drugs from the region or district to reach health facilities, except in the Mid-Western region. It is expected that deliveries to health facilities in the mountains take significantly longer than in the hills or Terai. However, the time taken between the three ecological zones varies dramatically between the five regions. The long average time for drugs to reach facilities in all regions of the Terai except the Mid-Western region can in part be attributed to civil disruptions and rising transportation costs associated with the disruptions.

Table 13: Average time for drugs to reach health facilities from the region or district

	Days to hospitals	Days to PHCCs	Days to HPs	Days to SHPs	Total Days
District	n=15	n=15	n=47	n=91	n=168 facilities
<i>Eastern region</i>					
Taplejung (mt)	0	3	4	3	3
Udayapur (hill)	0	74	65	72	53
Siraha (Terai)	0	8	23	39	18
<i>Central region</i>					
Mahottari (Terai)	2	0.0	28	42	18
Sindhupalchok (mt)	NA	38	30	29	24
Makawanpur (hill)	NA	36	37	40	28
<i>Western region</i>					
Baglung (hill)	NA	9	40	26	19
Nawalparasi (Terai)	NA	1	13	28	11
<i>Midwestern region</i>					
Banke (Terai)	NA	11	8	7	7
Rolpa (hill)	NA	5	37	27	17
Dolpa (mt)	NA	NA	62	74	34
<i>Far-western region</i>					
Doti (hill)	NA	5	8	8	5
Kailali (Terai)	NA	13	43	22	20
Average days	2	16.9	30.6	32.1	20.4

NA: no supply during the trimester.

Hospitals and PHCCs in particular need to follow certain processes to effectively serve the intended beneficiaries. These include notifying people about the provision of freecare services to targeted groups and assigning responsibility to an individual to oversee the freecare services from the district office.

People can more easily make decisions about using free services when information on these services is publicly available. District hospitals and PHCCs are supposed to display a citizen charter indicating that they provide free care services to designated groups. In this third period, 9 percent fewer hospitals and PHCCs publicly displayed a citizen charter that included a message about their free care services.

Table 14: Citizen charters with message about free care services

Is free care mentioned in the citizen charter?	First interval			Second interval			Third interval		
	% of hospitals	% of PHCCs	Total %	% of hospitals	% of PHCCs	Total %	% of hospitals	% of PHCCs	Total %
	n=15	n=15	n=30	n=15	n=15	n=30	n=15	N=15	N=30
Yes	73.3	53.3	63.3	82.3	64.3	73.3	73.3	60.0	66.7
No	26.7	46.7	36.7	17.7	35.7	26.7	26.7	40.0	33.3

The implementation guidelines for free care services clearly state that a person must be assigned to keep an eye on issues related to freecare services in facilities. Nearly a quarter more facilities had an officer overseeing free care between the first and second trimesters. However, one less hospital had a district officer responsible for free care in the third interval compared to the second.

Table 15: Health facilities with a district officer responsible for free care

Was a district officer for free care assigned?	First interval			Second interval			Third interval		
	% of hospitals	% of PHCCs	Total %	% of hospitals	% of PHCCs	Total %	% of hospitals	% of PHCCs	Total %
	n=15	n=15	n=30	n=15	n=15	n=30	n=15	N=15	n=15
Yes	60.0	33.3	46.7	73.3	66.7	70.0	66.7	NA	66.7
No	40.0	66.7	53.3	26.7	33.3	30.0	33.3	NA	33.3

Since the implementation of the free health care services is frequently changing, it is essential for a monitoring committee to meet in each facility and discuss issues related to freecare as they arise. The survey found that the percentage of facilities holding monitoring committee meetings decreased by 27 percent. The decline in monitoring meetings held is attributable to a decline among PHCCs during the third trimester.

Table 16: Monitoring committee meetings held at hospitals and PHCCs

Monitoring committee meetings held in past 4 months	First interval			Second interval			Third interval		
	% of hospitals	% of PHCCs	Total %	% of hospitals	% of PHCCs	Total %	% of hospitals	% of PHCCs	Total %
	n=15	n=15	n=30	n=15	N=15	n=30	n=15	n=15	n=30
No meeting held	53.3	40.0	46.7	60.0	13.3	36.7	60.0	33.3	46.7
1-2 meetings held	40.0	20.0	30.0	33.3	46.7	40.0	33.3	26.7	30.0
3-4 meetings held	6.7	13.3	10.0	6.7	26.7	16.7	6.7	40	23.3
5 or more meetings held	0.0	26.7	13.4	0.0	13.3	6.7	0	0	0
Total % of facilities holding meetings	46.7	60.0	53.4	40.0	86.7	63.4	40.0	66.7	53.3

V. Findings for Universal Free Care at Health and Sub-health Posts

5.1 Monitoring the Outputs from Offering Universal Free Care

The purpose of universal free care is to increase access for all people at HPs and SHPs. For this reason, users encounter no charges to register or to obtain any of the 35 essential drugs provided at the HPs and 25 essential drugs at the SHPs at the time of the survey. The survey looked at changes among groups using the HPs' and SHPs' services, as well as the per-visit cost for drugs covered by the government.

The Dalit, Janajati, Madhesi, and Muslim groups have historically been marginalized and have performed poorly as measured by indicators of poverty, health, nutrition, family planning, education, women's empowerment and media exposure (Bennett, et al. 2008). Between the second and third intervals Dalits and Muslims increased their use of free services by 2.5 and 5.4 percent, respectively. Use by Brahmins/Chhetries and Newars increased by 3.4 percent and 49 percent, respectively, although relatively few Newars use the services. Use by Madhesis and Janajatis decreased by 4.5 and 9.6 percent, respectively.

Table 17: Caste and ethnicity of clients using HPs and SHPs

Caste/Ethnic group	% of population	% of outpatient visits			% change
		First interval	Second interval	Third interval	
Brahmin/Chhetries	25.6	23.7	26.2	27.1	3.4
Madhesi/Terai	17.9	18.3	17.9	17.1	-4.5
Dalit	16.7	22.5	21.3	21.8	2.5
Newar	3.3	2.73	2.6	3.9	48.9
Janajati	30.6	25.97	27.9	25.2	-9.6
Muslim	3.5	6.78	3.5	3.7	5.4
Others	2.4	0.00	0.6	1.2	96.7
Total %	100.0	100.0	100.0	100.0	-

However, a higher proportion of Dalits during the third trimester continue to use free health care services than their population would suggest.

Women are also intended beneficiaries of free care. Women made up a slightly larger share of the clients using the HPs and SHPs (1.1 percent more) in this period than in the second period.

Table 18: Gender of clients using outpatient services at HPs and SHPs

Gender	% of population	% of outpatient visits			% change
		First interval	Second interval	Third interval	
Females	53.4	55.9	55.6	56.2	1.1
Males	46.6	44.1	44.4	43.8	-1.4
Total	100	100.0	100.0	100.0	

Overall, more women than men visited the HPs and SHPs for health services. While Kailali district showed the most striking difference (63 percent women versus 37 percent men) as it did during the previous interval.

In terms of cost to the government for free essential drugs at HPs and SHPs, the per visit drug cost dispensed for outpatient visits was NRs 22.0 during the third interval, a decrease in the per visit cost of NRs 13.74.

Table 19: Drug costs and outpatient visits at HPs and SHPs

	First interval	Second interval	Third interval	Change
Total outpatient visits	178,268	229,050	186,691	-42,359
Total cost of drugs dispensed to outpatients (NRs)	3,984,889	8,185,646	4,109,912	-4,075,734
Drug cost per outpatient visit (NRs)	22.35	35.74	22.0	-13.74%

Cost for drugs per visit at HPs and SHPs varied from NRs 9 to 40 among the districts. Drug cost per visit was cheapest in Rolpa and most expensive in Doti.

Table 20: Drug cost and outpatient visits at HPs and SHPs by districts

District	Total outpatient visits	Total cost of drugs dispensed to outpatients (NRs)	Drug cost per outpatient visit (NRs)
Taplejung	7,636	203,059	26.6
Udayapur	9,794	190,230	19.4
Siraha	35,427	533,280	15.1
Mahottari	13,563	509,515	37.6
Sindhupalchok	10,995	324,111	29.5
Makawanpur	8,018	319,768	39.9
Baglung	8,188	91,624	11.2
Nawalparasi	16,416	184,373	11.2
Banke	17,633	490,169	27.8
Rolpa	18,669	167,481	9.0
Dolpa	3,468	111,323	32.1
Doti	11,843	473,463	40.0
Kailali	25,041	511,517	20.4
Total	186,691	4,109,912	22.0

VI. Findings for Targeted Free Care at Hospitals and Primary Health Care Centres

The free care programme for intended beneficiaries, the first phase of the government's policy, provided free emergency and inpatient care to the poorest, less poor, destitute, disabled, elderly (60 years and over), and FCHVs in all districts at district hospitals and PHCCs.

The government grouped districts into two categories for free care based on the Human Development Index (HDI) of each district. In one category, the 35 districts with the lowest HDI provided outpatient, inpatient, and emergency free care, while in the other category, 40 higher-HDI districts provided only inpatient and emergency care free of charge. While this division existed during the first trimester (mid-March to mid-July 2008), from mid-July 2008 onward, all district hospitals and PHCCs added free outpatient care for designated beneficiaries. Therefore the six districts in this sample that are high HDI districts began providing free outpatient care during the second trimester.

6.1 Monitoring the Outputs from Offering Targeted Free Care

To ensure that the free care services in hospitals and PHCCs were serving intended beneficiaries, the survey looked at these groups' use of outpatient, inpatient and emergency services.

There was a significant difference in the use of outpatient services by targeted groups between the second and third periods. The very poor continue to represent the largest proportion of users among the intended beneficiaries. It is possible that patients unable to pay are identifying themselves as very poor rather than poor or destitute.

Table 21: Targeted groups using outpatient care

Targeted groups	% of outpatients			
	First interval	Second interval	Third interval	% change
Very Poor	16.6	17.5	34.5	97.14
Poor/Deprived	2.1	2.3	5.4	134.78
Destitute and helpless	0.0	0.0	-	0.00
Disabled	0.1	0.1	0.2	100.00
Senior citizen	1.5	1.6	2.6	62.50
FCHVs	0.0	0.1	0.1	0.00
Total of targeted groups	20.3	21.6	42.8	98.15

Intended beneficiaries increased their use of inpatient care by 49 percent. Among these users, the very poor used inpatient care the most (18.6 percent of discharges) and increased their utilisation by 19 percent. The poor and destitute increased use of inpatient care significantly but the proportions are very small.

Table 22: Targeted groups using inpatient care (discharges)

Targeted groups	% of inpatients (discharges)			% change
	First interval	Second interval	Third interval	
Very Poor	9.9	15.6	18.6	19.2
Poor/Deprived	1.5	3.1	11.8	280.7
Destitute and helpless	0.2	0.6	0.0	0.0
Disabled	0.2	0.1	0.1	0.00
Senior citizen	2.9	3.3	3.9	18.2
FCHVs	0.4	0.4	0.1	-75.00
Total of targeted groups	15.2	23.1	34.5	49.4

Intended beneficiaries also increased their use of emergency care by 25 percent. Among these groups, the very poor (21.4 percent) used emergency care the most, an increase of 68 percent. The poor decreased their use of emergency care to less than 5 percent. The number of disabled decreased greatly but only represents a fraction of the beneficiaries.

Table 23: Targeted groups using emergency care (discharges)

Targeted groups	% of emergency patients (discharges)			% change
	First interval	Second interval	Third interval	
Very poor	19.1	12.74	21.4	68.0
Poor and deprived	3.3	5.87	4.7	-19.9
Destitute and helpless	0.2	1.14	0.0	0.0
Disabled	0.7	0.29	0.1	-65.5
Senior citizens	8.8	3.33	3.7	11.1
FCHVs	1.2	0.5	0	-100.0
Total of targeted groups	33.3	23.9	29.9	25.3

During the past three trimester surveys, Taplejung, Mahottari, Rolpa and Dolpa districts were not targeting free care to the intended beneficiaries but providing free outpatient, inpatient and emergency care to all at district hospitals and PHCCs.

Like the HPs and SHPs, free care services at hospitals and PHCCs are particularly aimed at the marginalized castes and ethnicities. There was a 19 percent increase of Dalits using outpatient care. The percentage served during the third trimester is slightly less than their population proportion. The percentage of Janajatis using outpatient care increased by 35 percent. Their percentage use during the third round is slightly higher than their population proportion. The percentage of Madhesis in the Terai using outpatient services decreased by 28 percent between the second and third trimesters, and use by Muslims decreased by 44 percent. However, use by both groups remains almost as much as their population proportions.

Table 24: Caste and ethnicity of people using outpatient care

Caste/Ethnic groups	% of population	% of outpatients			
		First interval	Second interval	Third interval	% change
Brahmin/Chhetries	25.58	29.2	25.47	28.6	12.29
Madhesi/Terai	17.94	20.89	20.87	15.1	-27.65
Dalit	16.70	12.55	17.29	14.0	-19.03
Newar	3.29	5.15	4.42	3.6	-18.55
Janajati	30.64	23.78	25.86	34.9	34.96
Muslim	3.47	8.36	6.03	3.4	-43.62
Others	2.38	0.07	0.06	0.4	566.67
Total %	100.00	100.00	100.00	100.00	

Among inpatients, use by Madhesis increased by 43 percent, whereas use by Dalits and Janajatis decreased. Inpatient care for Muslims increased marginally. Madhesis, Dalits and Muslims are using inpatient care proportionate to their populations. Use by Janajatis has dipped almost 2 percentage points below their population proportion.

Table 25: Caste and ethnicity of people using inpatient care (discharges)

Caste and ethnic group	% of population	% of inpatient care (discharges)			% change
		First interval	Second interval	Third interval	
Brahmin/Chhetries	25.6	22.5	25.8	25.5	-1.2
Madhesi/Terai	17.9	17.4	15.4	22.0	43.0
Dalit	16.7	17.6	18.7	17.1	-8.5
Newar	3.3	4.5	3.3	2.7	-18.9
Janajati	30.6	34.8	33.3	28.8	-13.4
Muslim	3.5	3.2	3.5	3.6	2.0
Others	2.4	0.0	0.0	0.3	-
Total %	100.0	100.0	100.0	100.0	--

There was a large increase in the number of Janajatis using emergency care in the third trimester, as there was for Newars and Brahmins/Chhetries. The proportion of Madhesis, Dalits, and Muslims using emergency services decreased between the second and third trimesters. However, Madhesis, Dalits and Janajatis are still using emergency care proportionate to their populations.

Table 26: Caste and ethnicity of people using emergency care (discharges)

Caste/Ethnic groups	% of population	% of emergency care			% change
		First interval	Second interval	Third interval	
Brahmin/Chhetries	25.6	31.3	19.4	24.6	26.7
Madhesi/Terai	17.9	11.0	29.2	18.5	-36.8
Dalit	16.7	23.5	19.6	16.7	-14.7
Newar	3.3	2.9	3.0	4.6	53.2
Janajati	30.6	27.1	23.2	32.8	41.1
Muslim	3.5	3.1	4.8	2.6	-44.9
Others	2.4	1.1	0.8	0.3	-67.5
Total %	100.0	100.0	100.0	100.0	

Dalits were using outpatient services in most of the sample districts near to their population proportions—slightly under or over. The scenario is similar for Madhesis and Janajatis. However, use of outpatient care in Banke during the third trimester was quite different for Madhesis and Janajatis. Madhesis in Banke represent 39 percent of the population but less than 2 percent used outpatient care. Whereas Janajatis represent only 8 percent of the population but 29 percent used outpatient care. In Dolpa, Janajatis are 39 percent of the population but only 5 percent used outpatient services. In both Banke and Dolpa, Brahmins/Chhetries were using outpatient care disproportionately higher than their population proportions (Brahmins/Chhetries are also using outpatient services disproportionately higher (63 percent) than their population proportion in Baglung (43 percent)).

The scenario for use of inpatient care in the sample districts is similar to use of outpatient care by castes/ethnicities. Dalits are using inpatient care in the sample districts in proportions near to their population proportions, except in Baglung, Dolpa, and Doti where their use is much higher than their population proportions. Madhesis were using inpatient services disproportionately high in three districts where they represent a significant percentage of the population. However, as was the case for use of outpatient care in Banke, Madhesis are not using inpatient care in numbers that represent their presence. Janajatis, as inpatients, number more than twice their population proportion in Banke, but underutilise inpatient care in three other districts.

The use of emergency care in the sample districts during the third trimester is also similar to use of outpatient and inpatient care by castes/ethnicities. Dalits are using emergency care in the sample districts in proportions near to their population proportions, except in Baglung and Kailali where their use is considerably higher than their population proportions. Madhesis were also using emergency care disproportionately high in the same three districts where they represent a significant percentage of the population, but were not using emergency care in numbers that represent their presence in Banke. Janajatis, however, were using emergency care in numbers more than three times their population proportion in Banke and represented only 6 percent of emergency cases in Dolpa where they are 39 percent of the population.

Figure 1: Utilisation of services by the very poor at hospitals and PHCCs (in percent)

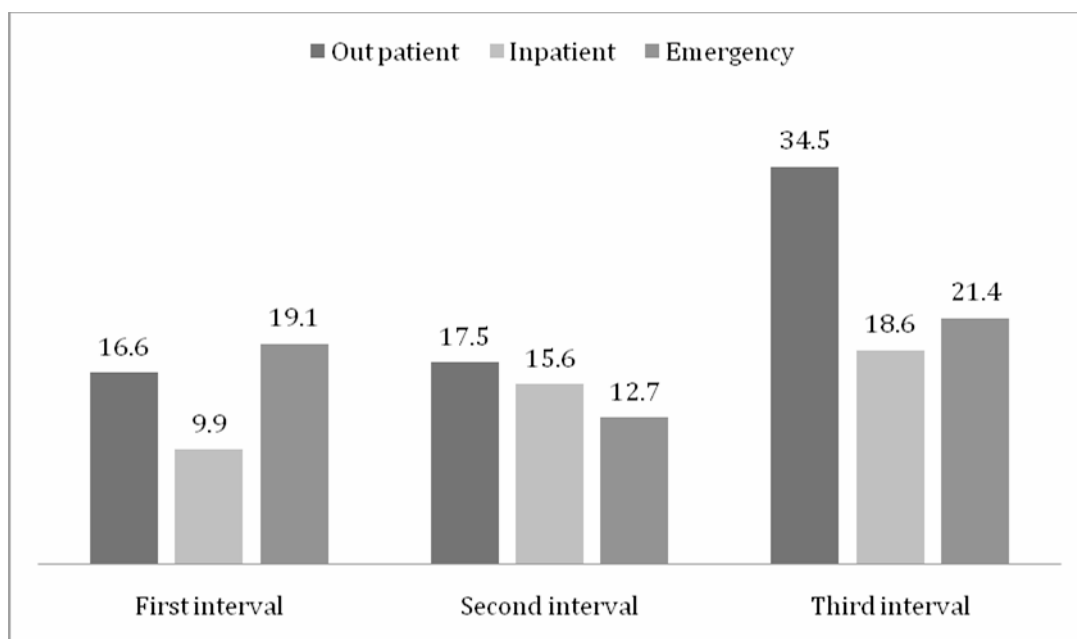
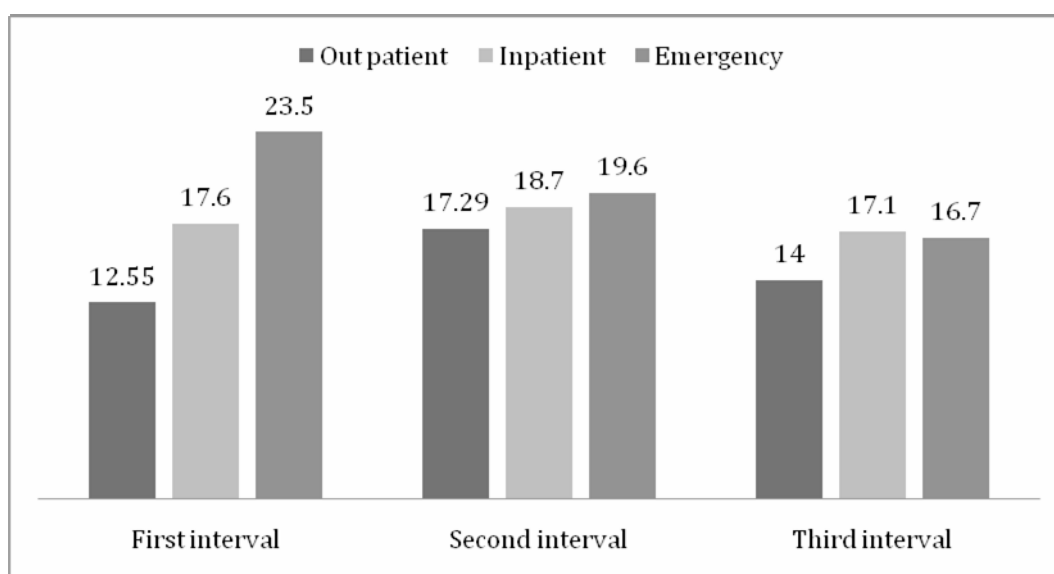


Figure 2: Utilisation of services by Dalits at hospitals and PHCCs (in percent)



Use of outpatient services by gender didn't change much between trimesters. Use by females increased slightly

Table 27: Gender of targeted groups using outpatient care

Gender	% of population	% of outpatients			% change
		First interval	Second interval	Third interval	
Females	53.4	53.7	51.8	54.9	5.98
Males	46.6	46.3	48.2	45.1	-6.43
Total	100.0	100.0	100.0	100.0	-

Use of inpatient care by women increased considerably in the third trimester as it did in the second trimester. Women increased their use of inpatient services by 13 percent in the third interval and had increased their use by 22 percent in the second. The significant increase over 8 months suggests institutional deliveries are increasing as a result of the maternal incentive programme.

Table 28: Gender of targeted groups using inpatient care (discharges)

Gender	% of population in district	% of inpatients (discharges)			% change
		First interval	Second interval	Third interval	
Females	53.4	53.0	64.6	72.7	12.5
Males	46.6	47.0	35.4	27.3	-22.9
Total	100.0	100.0	100.0	100.0	-

Women also increased their use of emergency care between the trimesters.

Table 29: Gender of targeted groups using emergency care (discharges)

Gender	% of population in district	% of emergency care (discharges)			% change
		First interval	Second interval	Third interval	
Females	53.4	44.8	49.9	51.1	2.4
Males	46.6	55.2	50.1	48.9	-2.4
Total	100.0	100.0	100.0	100.0	-

With a few exceptions, women used outpatient care proportional to their district populations. Use by women was high in Sindhupalchok and Kailali.

In most districts, use of emergency care by gender was proportional to their populations. More women received emergency care in Kailali and more men in Dolpa than their population proportions.

VII. Findings from Interviews with Managers in Charge and Clients

The survey team included informal interviews with managers in charge as part of the health facility survey. In addition, the team conducted exit interviews with clients at each facility in the sample. This section covers those findings.

7.1 Identifying Issues in Managing Health Facilities

In discussions with the managers in charge, the team identified specific problems the managers encountered in managing finances, drugs, human resources, and services. Their answers provide helpful insights into the findings related to inputs and processes.

Currently, funds do not flow effortlessly from the MoHP to the districts. The district health offices delay their written requests to the MoHP for authorization to release funds from the district government banks. The MoHP, in turn, responds slowly to the district health offices' requests. As a result, available funds are insufficient to cover the transport of drugs. The funds that are made available reflect neither the population's health needs nor the numbers of clients seen at the facilities.

Table 30: Major issues in financial management (n=168 facilities)

Problems	Frequency
Delay in depositing the subsidy in health facility's account	18
Insufficient funds allocated for the transport of drugs	5
Delay in requesting and receiving the letter authorizing the purchase of drugs	2
Morbidity or caseload of facilities not considered when allocating funds to HPs and SHPs	1

Similar problems exist in drug procurement and management. Managers delay their selection of drug suppliers from those who bid because of the cumbersome bidding process. Stores are not well managed because too many staff members work in the store but lack sufficient training to keep accurate records. The supplies they do have on hand are near expiration and do not match the orders they have submitted.

Table 31: Major issues in drug management(n=168 facilities)

Problems	Frequency
Insufficient drug supply, full of nearly expired, low quality medications	72
Drug supply unreflective of orders because of push system	29
Inadequate practice in recording requisition forms and maintaining the stock ledger	4
Store management undermined by too many assigned technical staff	3
Difficulty in selecting suppliers due to the complex, time-consuming bidding system	2

Outside of the stores, the health facilities often lack sufficient staff. Their staff members take leave without notice, or receive approval, sometimes through political pressure, for leave or transfer without consideration for staffing needs. The staff members who remain need to be motivated to improve their performance.

Table 32: Major issues in human resource management(n=168 facilities)

Problems	Frequency
Insufficient technical staff due to absenteeism without notice and seconding	41
Lack of coordination between health facilities and the DPHO for approving the leave of subordinate staff	5
Regional and political pressure to transfer, second, or contract with staff	0
Lack of motivation among staff	0

The facilities lack the equipment to meet the needs of patients for diagnostic tests, blood transfusions, and emergency care. Meanwhile, the premises are often crowded with patients wanting to obtain drugs when they are available or with people accompanying patients.

Table 33: Major issues in service management(n=168 facilities)

Problems	Frequency
Lack of equipment or facilities for blood transfusions, laboratory analysis, or X-rays	20
Overload of patients not needing treatment	16
Lack of facilities to operate emergency services at PHCCs	2

7.2 Identifying Issues from the Clients' Perspectives

The exit interviews at different health facilities provided information on clients' satisfaction and their experience in obtaining drugs.

More than half (58 percent) of the clients said they were fully satisfied with the existing services at the facilities, while 40 percent were partially satisfied, and 2.5 percent were not satisfied at all.

Table 34: Background characteristics of interviewed clients

Characteristics	Percent
<i>Gender (n=198)</i>	
Male	39.4
Female	60.6
<i>Caste and ethnicity (n=198)</i>	
Brahmin/Chhetries	33.8
Madhesi/Terai	11.6
Dalit	17.2
Newar	2.0
Janajati	30.8
Muslim	4.0
Other	0.5
<i>Level of satisfaction (n=198)</i>	
Fully satisfied	57.7
Partially satisfied	39.9
Not satisfied	2.5

Nine out of ten clients (91 percent) linked their satisfaction to how health workers behaved. Access to medications (74 percent) and privacy (79 percent) also pleased clients. What displeased clients the most were unavailable drugs (26 percent), limited range of services (30 percent), and the behaviour of health workers (8.5 percent).

Table 35: Reasons for satisfaction and dissatisfaction (n=198 clients)

Reason	% of reasons for satisfaction	% of reasons for dissatisfaction
Health worker's behaviour*	90.9	.8.5
Availability of drugs	74.1	25.9
Privacy of services*	78.8	19.0
Range of services available in health facility*	68.4	30.3

(* missing data)

In terms of drugs, most clients' prescriptions were for one or two items, whether from the essential drug list (EDL) or not. The facilities dispensed two thirds of prescriptions in full amounts and one-quarter partially. Another 2.7 percent were not dispensed at all.

Table 36: Drug prescribing practices (n=198 clients)

Average number of drug items	% of drugs prescribed	% of drugs prescribed from EDL
1-2 items	55.4	80.6
3-4 items	40.0	19.4
5-6 items	4.6	-

VIII. Determining Ways to Strengthen Gains

8.1 Conclusions

This survey reveals encouraging news for the free care policy. The HPs and SHPs increased the number of providers on the job while district hospitals and PHCCs focused attention on the free services for designated groups. Nevertheless, maximizing use by intended beneficiaries will be undermined unless the government can maintain or increase funding and human resources while the district health offices and facilities develop ways to improve their management processes to support these services.

Human Resources, Availability of Drugs, and Facility Operations

- The budget allocated for free care increased by 24 percent to US\$ 11.4 million.

- The facilities' average number of filled positions remained the same at almost 90 percent while staff on leave or seconded dropped to 6 percent at HPs and SHPs. At district hospitals and PHCCs, filled positions improved to almost 83 percent and staff on leave or seconded decreased to almost 4 percent.
- The percentage of sanctioned positions filled by paramedics and ANMs and MCHWs increased marginally between second and third intervals, at HPs and SHPs. At hospitals and PHCCs, positions filled by doctors and nurses decreased by 20 percent and 8 percent, respectively, and positions filled by paramedics increased by 14 percent.
- HPs and SHPs with stock-outs of essential drugs lasting more than a week increased by 19 percent, whereas stock-outs increased by 96 percent at hospitals and PHCCs.
- Consultation and operating hours in HPs and SHPs did not change much. Total hours open, therefore, remained almost same.
- The average time for drugs to reach health facilities from the regions and districts increased for all types of health facilities, except district hospitals.
- Fewer hospitals and PHCCs publicly displayed a citizen charter that had free care messages (9 percent decrease) than before.
- Fewer health facilities held monitoring committee meetings (16 percent reduction). In particular, 25 percent fewer PHCCs convened these meetings. On the other hand, the percentage of hospitals holding these meetings remained same.

Universal Free Care

- Use by Dalits increased and they continue to use services at HPs and SHPs proportionally higher than their numbers. Janajatis decreased use by almost 10 percent. The proportion of Madhesi users did not change much. Muslim users increased a little during the period and still used services proportionate to their population.
- The proportion of women using outpatient care increased only slightly.
- The average cost for drugs per outpatient visit decreased by 14 percent.

Targeted Free Care

- More targeted beneficiaries used outpatient (43 percent), inpatient (34.5 percent) and emergency (30 percent) services..

- The proportion of Dalit outpatients (14.0 percent) during the third trimester was slightly lower than their population proportion. Janajati outpatients increased to slightly higher than their population proportion. The number of Mahdesis and Muslim outpatients decreased but remain close to their population proportions. Use of outpatient care by women increased and was slightly higher than their population proportion.
- Among the marginalised groups, Dalits used inpatient services relatively less (8.5 percent) than before but continued to use inpatient care in greater numbers than their population proportion. Use of inpatient care by Muslims increased to their proportion in the population. Janajatis decreased their use by 13 percent but used inpatient care almost proportionate to their population.
- Madhesis use of emergency care decreased in the third trimester, but it was almost equal to their population proportion. Use by Muslims also decreased to below their proportion in the population.
- More women used inpatient care (73 percent) than before, a 12.5 percent increase.

Interviews with Managers in Charge and Clients

- Funds did not flow smoothly from the MoHP to all the health facilities. Delay in depositing the subsidy in health facility's account continues to be a problem. However, there was considerable improvement between the second and third trimesters in requesting and receiving the letter authorising the purchase of drugs and in insufficient funds allocated for the transport of drugs.
- Insufficient drug supply, full or nearly expired, or low quality medications dramatically increased between the second and third trimesters. The push system led resulted in an insufficient supply of the right drugs and unneeded drugs of low quality.
- 41 of 168 health facilities were under staffed because of absenteeism without notice or seconding.
- More managers complained about the lack of diagnostic equipment and crowding by people who are not seeking treatment.
- More than half (58 percent) of interviewed clients were fully satisfied with existing services, 40 percent were partially satisfied, and 2.5 percent were not satisfied.
- Nine out of ten clients (91 percent) related their satisfaction to the behaviour of health workers, 74 percent to the availability of medications, 79 percent to privacy, and 68 percent to range of services.

- Among the reasons given for dissatisfaction, unavailable drugs (26 percent), the range of services provided at the health facility (19 percent), and the behaviour of health workers (9 percent) were most often mentioned.
- When health providers prescribed essential drugs from the essential drug list (EDL), they most often prescribed one or two of these drugs (81 percent). The health facility then fully dispensed 67 percent of the medications, while another 29 percent were partially dispensed and 3 percent were not dispensed at all.

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