Service Tracking Survey

2013

Nepal Health Sector Programme II

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FOREWORD

The Service Tracking Survey (STS) 2013 was conducted by the Ministry of Health and Population (MoHP), with technical assistance from the Nepal Health Sector Support Programme (NHSSP), and executed by Health Research and Social Development Forum (HERD). The design and implementation was overseen by a technical working committee (TWC) with representatives from government, external development partners and NHSSP advisors.

The survey was designed to collect the relevant information needed to provide national level estimates of key indicators that can monitor the following over time: the Aama Programme and free health care; health service governance; human resources; drug supply and storage; quality of care and the progress against the NHSP 2 logical framework.

I believe that this report provides crucial information to help monitor the results of NHSP 2, and to help plan for NHSP 3. I would like to thank all of those who contributed to the successful completion of the STS 2013.

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The Service Tracking Survey (STS) 2013 was conducted under the aegis of the Public Health Administration Monitoring and Evaluation Division (PHAMED), Ministry of Health and Population (MoHP) of the Government of Nepal with financial support provided by UKAID while technical assistance was provided by the Nepal Health Sector Support Programme (NHSSP). The survey was implemented by Health Research and Social Development Forum (HERD), a local research firm with experience in conducting such surveys in the past. We express our deep sense of appreciation to the technical experts in the different fields of health for their valuable input in the various phases of the survey. Our sincere gratitude goes to all the members of Technical Advisory Committee for their time, support and valuable input. We would like to extend our sincere gratitude to Dr. Tirth Raj Burlakoti, Officiating Secretary, MoHP for his guidance and valuable input. We would also like to express our gratitude to the officials of programme divisions and centres. Our special thanks goes to the HERD officials and data collection team. Similarly, we would like to extend our gratitude to the organisations that have contributed to the successful completion of the survey. Finally it would be remiss of us not to extend our deepest gratitude to all the respondents for their time in responding to the survey.

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ACRONYMS

4ANC	Four Antenatal Care Visits Programme
AA	Anaesthesia Assistant
Aama	Aama Surakshya Programme
AFS	Adolescent-friendly Services
AHW	Auxiliary Health Worker
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
AWPB	Annual Work Plan and Budget
BEONC	Basic Emergency Obstetric and Neonatal Care
CB-NCP	Community-based Newborn Care Programme
CDP	Community Drug Programme
CEONC	Comprehensive Emergency Obstetric and Neonatal Care
CHD	Child Health Division
CS	Caesarean Section
CSPro	Census and Survey Processing System
DOTS	Directly Observed Treatment, Short-course
D(P)HO	District (Public) Health Office
DDC	District Development Committee
DoHS	Department of Health Services
DTCO	District Treasury Control Office
EDCD	Epidemiology and Disease Control Division
EHCS	Essential Health Care Services
EPSEM	Equal Probability Sampling Method
FCHV	Female Community Health Volunteer
FEFO	First Expired, First Out
FHD	Family Health Division
FMIP	Financial Management Improvement Plan
FP	Family Planning
FY	Fiscal Year
GAAP	Governance and Accountability Action Plan
GESI	Gender Equality and Social Inclusion
GoN	Government of Nepal
HA	Health Assistant
HDB	Hospital Development Board
HDC	Hospital Development Committee
HDI	Human Development Index
HERD	Health Research and Social Development Forum

HFOMC	Health Facility Operation and Management Committee
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSIS	Health Sector Information System
HP	Health Post
HRH	Human Resources for Health
HSRSP	Health Sector Reform Support Programme
I/NGO	International Nongovernmental Organisation
IMCI	Integrated Management of Childhood Illnesses
IU	International Unit
IUCD	Intrauterine Contraceptive Device
LF	Logical Framework
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCHW	Maternal and Child Health Worker
MD	Management Division
MDG	Millennium Development Goal
MDGP	Doctor of Medicine, General Practitioner
MIS	Maternity Incentive Scheme
MO	Medical Officer
MoHP	Ministry of Health and Population
MRP	Manual Removal of Placenta
MVA	Manual Vacuum Aspiration
n	Sample size
NA	Not Applicable
NCP	Newborn Care Programme
NDHS	Nepal Demographic and Health Survey
NGO	Nongovernmental Organisation
NHEICC	National Health Education, Information, and Communication Centre
NHP	National Health Policy
NHSP-1	First Nepal Health Sector Programme
NHSP-2	Second Nepal Health Sector Programme
NHSSP	National Health Sector Support Programme
NID	National Immunization Day
NPC	National Planning Commission
NPR	Nepali Rupees
O/G	Obstetrician/Gynaecologist
ORS	Oral Rehydration Solution
OT	Operating Theatre
PHCC	Primary Health Care Centre
PHC-ORC	Primary Health Care Outreach Clinic
PHCRD	Primary Health Care Revitalisation Division

PHN	Public Health Nurse
PNC	Postnatal Care
PPICD	Policy, Planning, and International Cooperation Division
PSU	Primary Sampling Unit
PV	Per Vaginal
SBA	Skilled Birth Attendant/Attendance
SDIP	Safe Delivery Incentive Programme
SHP	Sub-Health Post
SN	Staff Nurse
SPSS	Statistical Package for Social Science
SSMP	Support to Safe Motherhood Programme
SSU	Secondary Sampling Unit
STD	Sexually Transmitted Disease
STS	Service Tracking Survey
SWAp	Sector-wide Approach
TB	Tuberculosis
TSA	Treasury Single Account
USG	Ultrasonography
VDC	Village Development Committee
VHW	Village Health Worker
W/V	Weight/Volume

STS 2013: EXECUTIVE SUMMARY

A. INTRODUCTION

The First Nepal Health Sector Programme (NHSP-1), from 2004 to 2009, was the first health programme in Nepal to adopt a Sector-wide Approach (SWAp). Building on the foundation, success, best practices and lessons learnt from NHSP-1, a comprehensive health sector plan for the health sector for 2010 to 2015 was formulated, the Second Nepal Health Sector Programme (NHSP-2). NHSP-2 has a greater focus on increasing access to and utilization of Essential Health Care Services (EHCS) components, particularly among women, the poor and excluded groups. The revised Logical Framework (LF) in NHSP-2 has 12 goal-level indictors, 14 purpose-level indicators, 19 outcome-level indicators, and 42 output-level indicators. One of the objectives of the Service Tracking Survey (STS) 2013 is to monitor some of the health system-related indicators in the LF. The first STS was undertaken in 2011, and it has since been conducted on an annual basis, making STS 2013 the third STS.

B. METHODOLOGY

STS 2013 is a nationally representative cross-sectional survey, which uses a two-stage sampling design. Firstly, one district was randomly selected from each of 13 sub-regions, resulting in three districts from the Mountain, five from the Hill and five from the Terai regions. Secondly, facilities were selected within each of the 13 districts. All public hospitals and Primary Health Care Centres (PHCCs) were selected for the study, while a sample of Health Posts (HPs) and Sub-Health Posts (SHPs) was selected using an Equal Probability Sampling Method (EPSEM). All 17 public hospitals (nine district hospitals and eight higher-level hospitals, including: one Regional hospital, one Sub-regional hospital, two Academies of Health Sciences, and four Zonal hospitals), all 39 PHCCs, 100 HPs, and 68 SHPs were selected for the study from 13 districts. The study uses three questionnaires: a health facility questionnaire administered to 224 health facilities, an exit interview administered to 819 outpatients, and an exit interview administered to 447 maternity clients or those who experienced complication during puerperium. Data were collected between 10 July and 14 August 2013. The data were double entered into Census and Survey Processing System (CSPro) 5.0 and analyzed by using Statistical Package for Social Science (SPPS) version 16. In order to obtain nationally representative results, the data for the total facilities and the client data were weighted.

C. KEY FINDINGS

The key findings of the survey, presented as per the survey objectives, are as follows:

Objective 1: To monitor indicators in the revised NHSP-2 log frame (LF)

A LF was developed to monitor the progress of NHSP-2, comprising of 12 goal-level, 14 purpose-level, 19 outcome-level and 42 output-level indicators. STS 2013 is the source for 13 LF indicators. The progress made, against the targets set, has been summarized in Table 0.1.

Table 0. 1: Status of LF Indicators in 2013

Already achieved 2013 target	On track to reach 2015 target	Off track to reach 2015 target
• Percentage of clients satisfied with their health care provider at public facilities • Percentage of health facilities with at least three females and at least two Dalit and Janajati members in Health Facility Operation and Management Committees (HFOMCs) and Hospital Development Boards (HDBs) • Percentage of districts with at least one public facility providing all Comprehensive Emergency Obstetric and Neonatal Care (CEONC) signal functions 24/7 • Percentage of safe abortion (surgical and medical) sites with long-acting Family Planning (FP) services • Percentage of HPs that are birthing centres providing deliveries 24/7	• Percentage of health facilities that have undertaken social audits as per MoHP guidelines in the current or last FY	• Percentage of health posts with at least five FP methods • Percentage of sanctioned posts that are filled: doctors at PHCCs • Percentage of sanctioned posts that are filled: doctors at district hospitals • Percentage of sanctioned posts that are filled: nurses at PHCCs • Percentage of sanctioned posts that are filled: nurses at district hospitals • Percentage of district hospitals that have at least one Obstetrician/Gynaecologist (O/G) or Doctor of Medicine, General Practitioner (MDGP), five nurses trained as Skilled Birth Attendants (SBAs), and one anaesthetist or Anaesthesia Assistant (AA) • Percentage of PHCCs providing all Basic Emergency Obstetric and Neonatal Care (BEONC) signal functions 24/7

Table 0.2 compares LF indicators from STS 2011, 2012 and 2013 with 2015 target, and the assumed application of these during the anticipated follow on programme NHSP-3, a detail list of indicators to be monitored during NHSP-3 is presented in the table 0.10.

The comparison reveals that the percentage of clients who are satisfied with the health care providers at public facilities is higher than the 2015 target of 80% as found by all three STS reports. Studies have found that client's low level of expectation from the health system results in large number of satisfied clients which could be a possible explanation for large number of satisfied clients than the set target as shown by the STS reports. Further, respondents might not give negative opinions about the service they have just utilized during exit interviews while providers may also perform better when they are aware that they are being observed or their clients are being interviewed, suggesting the need to consider possible alternative methods to assess clients satisfaction in future health facility surveys.

The percentage of health facilities having at least three females and at least two Dalits and Janajati members, on the health facility management and operational committees (HFOMC), has increased from 2011 to 2012 with the most pronounced increase between 2012 and 2013. NHSP-2 has put greater focus on mainstreaming GESI and integration of GESI in its policies and programmes. It has also emphasized on orienting staff on GESI principles and practices and strengthening local accountability mechanism where female and excluded are represented. Orientation has been carried out to health workers in all 75 districts and GESI technical working group has also been formed in 73 districts. This could have contributed to increased inclusion of females, Dalits and Janajatis in HFOMC and made HFOMC more functional. Moving forward one recommendation would be to consider monitoring the active participation of females, Dalits and Janajatis in decision making in subsequent health facility surveys.

The percentage of districts with at least one public facility providing all CEONC signal functions 24/7 has significantly increased between STS 2011 to STS 2013 and has crossed the 2015 target. In 2013, all districts had at least one public facility which provided all CEONC signal functions, and this might be due to either the selection of higher number of referral hospitals in this round or increase of services due to availability of CEONC fund. Furthermore, a wider confidence interval is observed in table 0.9, indicating the need for monitoring precisely this indicator in the future.

The percentage of HPs that are birthing centers providing 24/7 service has exceeded the 2015 target. However, this indicator is limited to providing information on only the estimated proportion of HPs with birthing centers which is essential to estimate coverage; this study recommends including the indicator in further rounds of health facility surveys, to ensure a more balanced estimate of coverage and continuity of services at birthing centers.

There has also been a steady increase in the percentage of safe abortion sites with long acting FP services between STS 2012 and STS 2013 and the 2015 target has already been achieved. This increase can be attributed to increased promotion of the long acting method by the government considering their cost effectiveness and long term benefits. The strategy has emphasized on expanding IUCD services to PHC and HP level along with focused and continued monitoring.

The percentage of health facilities that have undertaken social audit as per the MoHP guidelines is numbers wise generally on track to meet the 2015 target. However, there was a decrease between STS 2011 and STS 2013, due to the delay in introducing the new guidelines in 2012 which stalled scale up and the new guideline has impacted the ability to make strict comparisons with the previous survey given the changes made. This indicator should be monitored in NHSP-3 as it is essentially captures information related to social accountability.

All the human resource related indicators are off track against the 2015 targets and have been decreasing between STS 2011 and STS 2013. Over the three years period, the largest decline has been observed in percentage of filled sanctioned posts of nurses in PHCCs which could be due to transfer out, end of contract or leaving for other reasons and these indicators are essential to be monitored in NHSP-3.

None of the district hospitals had at least one obstetrician/gynaecologist or MDGP, five nurses trained as SBAs and one anesthesia assistant and the 2015 target for this is 80%. Given this lack of improvement in the district hospitals with availability of the CEONC staff, the target for 2015 is unlikely to be met despite the freeze on recruitment being removed and a commitment to mobilize a further 14,000 employees by the MoHP.

The percentage of PHCCs providing all BEONC signal functions 24/7 in 2013 is off track to reach 2015 target. This percentage nearly doubled in STS 2012 than that of 2011 but again decreased in 2013. This could be due to unavailability of human resource or essential equipment. In 2013, only 23% doctors and 38% nurse's positions were filled at PHCC. However, it is essential to monitor during NHSP-3 to ensure the focus remains on this agreed priority.

The percentage of HPs providing at least five FP methods are off track to 2015 target, however, the increment was more than doubled in STS 2013 than STS 2012. This drastic increased could be due to greater emphasis of the government in promoting long acting reversible contraceptives and training of health workers to ensure their availability up to HP level. In STS 2013, HPs providing IUCD and implant

services were 33% and 29% respectively, suggest the indicator should be monitored during NHSP-3, as the availability of long acting FP methods is most preferred method by client.

Table 0. 2: Progress of LF Indicators from STS 2011 – STS 2013

Code	Indicators	STS 2011 (%)	STS 2012 (%)	STS 2013 (%)	2015 Target (%)
OC 2.6	Percentage of clients satisfied with their health care providers at public facilities	96	90	89	80
OP 1.3	Percentage of health facilities with at least three females and at least two Dalit and Janajati members in HFOMCs/HDCs	42	49	72	100
OP 4.5	Percentage of districts with at least one public facility providing all CEONC signal functions 24/7	39	62	100	76
OP 4.7	Percentage of HPs that are birthing centres providing deliveries 24/7	79	98	97	≥80
OP 4.8	Percentage of safe abortion (surgical and medical) sites with long-acting FP services	NA	56	91	≥90
OP 8.1	Percentage of health facilities that have undertaken social audits as per MoHP guidelines in the current or last FY	27	14	15	25
OP 3.1	Percentage of sanctioned posts that are filled: doctors at PHCCs	50	23	23	90
	Percentage of sanctioned posts that are filled: doctors at district hospitals	69	56	47	90
	Percentage of sanctioned posts that are filled: nurses at PHCCs	74	59	39	90
	Percentage of sanctioned posts that are filled: nurses at district hospitals	83	83	55	90
OP 3.2	Percentage of district hospitals that have at least one obstetrician/gynaecolologist or MDGP, five nurses trained as SBAs, and one anaesthetist or AA	13	0	0	80
OP 4.6	Percentage of PHCCs providing all BEONC signal functions 24/7	14	36	23	70
OP 4.9	Percentage of HPs with at least five FP methods	13	8	18	60

Objective 2: To monitor the implementation of the Aama and Free Health Care Programmes

Aama Programme

- All district hospitals and PHCCs were implementing the Aama Surakshya (Aama) Programme. However, a quarter of higher-level hospitals (25%) and nearly one-third of HPs (32%) were not. Implementing the Aama Programme is optional for SHPs, and 20% have chosen to do so. However, despite claiming to be implementing the Aama Programme a few district hospitals and PHCCs were not paying transport incentives to clients.
- The level of awareness of transport incentives was significantly associated with caste/ethnicity and educational level of maternity clients ($p<0.05$); however, awareness of free delivery care was not significantly associated with ecological zone, caste/ethnicity or level of education ($p>0.05$).
- One-third (33%) of district hospitals and nearly 40% of PHCCs reported not receiving institutional costs for the services they offered under the Aama Programme.
- Public display of Aama beneficiaries was practiced by over three-quarters (77%) of health facilities. Facility notice boards were the most common place for disclosing Aama beneficiaries by district hospitals (86%), PHCCs (61%), and HPs (70%), while higher-level hospitals (80%) and SHPs (50%) most commonly displayed them during HFOMC meetings.
- Among those who had received delivery services, 57% of maternity clients had made at least some payments related to delivery services, and 3% had paid for services related to complications. Payments were more common in district hospitals (84%) and higher-level hospitals (49%) than elsewhere.
- Of the maternity clients who had paid for services, 52% had paid for medicine, 28% for sanitation staff, 25% for sanitary pads, and 24% for registration fees.
- Among those who had paid for delivery services, maternity clients had paid, on average 3,600 Nepali Rupees (NPR) for delivery/Caesarean Section (CS) services.

Free Health Care Programme

- Most outpatients (84%) were aware that they were entitled to free care. The level of awareness about free care was significantly associated with ecological zone ($p<0.05$).
- Nearly all (98%) of the outpatients who had paid for services in hospitals had been requested to pay for the services received.

- Outpatients were most commonly charged for registration fees in all levels of health facilities (60% of hospitals, 9% of PHCCs, and 2% of HPs) and free medicines (47% of hospitals, 7% of PHCCs, and 1% of HPs).

Objective 3: To monitor the financial management capacity of health facilities (including a detailed accounting of the flow of services and finance)

- Most health facilities (98%) received budget from MoHP/D(P)HO. Hospital Management Committees (43%) and donor agencies (44%) were also important sources of funding for hospitals, while municipalities/Village Development Committees (VDCs) were a key source of income for lower-level health facilities, such as PHCCs (64%), HPs (76%), and SHPs (59%).
- On average, 42% of facilities below district level generate income from laboratory fees. Emergency service charges were also a source of income for all higher-level hospitals, 7% of PHCCs, and 20% of HPs. People are usually less prepared for costs associated with emergency care and hence these charges could pose a significant barrier to accessing care.
- Almost all health facilities had received a budget during the last FY, except for two hospitals and one HP. Only 12% of facilities had received their budget as per demand, while 31% of facilities had requested it more than four times.
- A greater proportion of PHCCs (85%) had received a full budget compared to other levels of health facility. Two-fifths (40%) of hospitals had not received their full budget; reasons given for its not being released included: priority being given to other sectors (33%), lack of budget in the ministry (13%), and delayed budget release (13%).
- Of the total health facilities that were interviewed, two-thirds of hospitals (67%) and SHPs (65%), and half of HPs (51%) and PHCCs (49%) had not spent their full budget, largely due to the delay in receiving the budget.
- D(P)HOs were the primary source of medical products for lower-level health facilities, i.e. SHPs (91%), HPs (89%), and PHCCs (82%). Hospitals were more likely to procure items locally by putting out calls for tender (86%).
- The good practice of preparing and submitting financial reports is quite uncommon in lower-level health facilities. Insufficient human resources for financial management were reported by 38% of PHCCs, 17% of HPs, 14% of hospitals, and 5% of SHPs as the main reason for not submitting financial reports.
- On average, 84% of health facilities had conducted an internal financial audit at least once a year;

however, quarterly internal audits were remarkably low. A greater proportion of hospitals (81%) were likely to have conducted external financial audits compared to HPs (26%), PHCCs (18%), and SHPs (10%).

Objective 4: To monitor the quality of care, including client experiences

Quality of Care

- Burning was the most regular method of waste disposal for almost all health facilities (100% of both hospitals and PHCCs, 95% of HPs, and 94% of SHPs).
- A puncture-proof bin for disposing of needles and sharps was available and was properly used in all hospitals, 82% of PHCCs, 73% of HPs, and 59% of SHPs. The availability and proper use of red bins for disposing of blood and blood-stained products was low in lower-level health facilities (59% of PHCCs, 46% of HPs, and 41% of SHPs) as compared to hospitals (76%).
- More than two-thirds (67%) of PHCCs had faced problems with regard to shortages of equipment in the last FY, a proportion greater than in HPs (47%), SHPs (37%), and hospitals (36%). The most common problems faced were shortages of X-ray machines in hospitals and aneroid blood pressure machines (35% of PHCCs, 28% of HPs and 24% of SHPs) were facing problems with regards to blood pressure instruments in lower-level health facilities.
- A greater proportion of PHCCs (41%) were facing problems with regards to supplies as compared to HPs (35%), SHPs (25%), and hospitals (24%). None of the hospitals had excess equipment (excess as a result of either a greater amount being supplied than needed or items not required in the health facility being supplied, e.g. an ultrasonography machine being supplied to a district hospital that was not eligible for ultrasonography services). However, 5% of PHCCs, 7% HPs, and 4% SHPs did have excess equipment supplied. PHCCs had equipment in the facility unused as a result of untrained manpower (49%) or lack of electricity (43%).
- In the last Fiscal Year (FY), around half of PHCCs (51%), 44% of HPs, 35% of hospitals, and 29% of SHPs had faced the problem of equipment not working as a result of breakages. Regular maintenance of equipment by mobilizing maintenance teams across facilities was the primary recommendation made by health facilities to overcome this obstacle.
- A greater proportion of hospitals had Quality Improvement Committee Plans (36%) than lower-level health facilities, such as PHCCs (31%), HPs (27%), and SHPs (19%).
- Around one-tenth of PHCCs (11%), 10% of HPs, and 8% of SHPs had faced the problem of essential equipment being broken when last performing a delivery.

- Many HPs (85%), SHPs (83%), PHCCs (60%), and hospitals (47%) had not used a partograph during the last delivery performed. Among those who had not used a partograph, all hospitals, 90% of PHCCs, 81% of HPs, and 70% of SHPs had not perceived its use to be necessary.
- With regards to newborn care immediately after delivery, 11% of PHCCs, 8% of HPs, and 6% of hospitals had bathed the newborn within 24 hours. Maternity clients were advised to initiate breastfeeding within an hour of delivery by health service providers from all HPs and SHPs, 95% of PHCCs, and 85% of hospitals.
- Government hospitals were the most common referral outlet for both CSs and assisted deliveries for all levels of health facilities (75% of hospitals, 71% of PHCCs, 83% of SHPs, and 81% of HPs). The practice of referring patients without monitoring their vital signs persists in a small percentage of PHCCs and SHPs (5%).
- CEONC services were provided in 87% of higher-level hospitals and 78% of district hospitals. Of the facilities (both higher-and district-level hospitals) providing CEONC services, all hospitals were providing all CEONC signal functions round the clock.
- Among the health facilities providing BEONC, only 48% had all seven BEONC signal functions available 24/7. Over half of PHCCs (56%) were providing BEONC services, while 67% of HPs and nearly one-fifth of SHPs (19%) functioned as birthing centers providing delivery services.
- The majority of hospitals (94%), PHCCs (87%), and HPs (66%) had provided postpartum FP services, compared to just 40% of SHPs.
- All HPs officially registered as safe abortion sites provided post-abortion FP services; however, 4% of PHCCs and 14% of hospitals did not.
- Stock-outs of Intrauterine Contraceptive Devices (IUCDs) were seen in 7% of both hospitals and PHCCs and 3% of HPs.

Clients' Experience

- Maternity clients were more likely to be satisfied with free delivery services than with transport incentives (hospitals: 41% vs. 31%; PHCCs: 70% vs. 34%; HPs: 70% vs. 47%; and SHPs: 100% vs. 50% respectively).
- Most (85%) maternity clients and outpatients (90%) were satisfied with the services they had received from the health facilities.
- The top five recommendations made by maternity clients to improve the health facility in which they had delivered were: maintaining clean and hygienic health facilities (35%); providing an

adequate number of beds (23%); free services (13%); having helpful staff (13%); and encouraging good behaviour among health workers (13%).

- The top five recommendations made by outpatients to improve the health facility that they had attended were: maintaining cleanliness and hygienic health facilities (19%); increasing the availability of competent and skilled health workers (18%); maintaining privacy (9%); increasing the number of female service providers (9%); and reducing waiting times (7%).

Objective 5: To collect information related to governance and Gender Equality and Social Inclusion (GESI) on the provision of health services at health facilities.

Governance and Accountability

- More than a quarter of health facilities at all levels had conducted a social audit in the last FY (2068/69). However, with the exception of PHCCs (28%), less than one-fifth of health facilities had conducted a social audit as per the MoHP guidelines. Public gatherings were the most common method for disclosing the results of the social audit, favoured by 60% of hospitals, 62% of PHCCs, 45% of HPs, and 22% of SHPs.
- Decisions incorporated into the Annual Work Plan and Budget (AWPB) were implemented by 40% of hospitals, 80% of PHCCs, 60% of HPs, and 55% of SHPs. Infrastructure improvements and increasing service quality are the most common actions that have been implemented.
- More than a quarter of hospitals (29%) did not have a Citizen's Charter. Citizen's Charters are more common and more frequently visible and in a readable form at lower-level health facilities than at hospitals.
- More than three-fifths of SHPs (66%) and HPs (62%) did not have a formal suggestion and complaint procedure, a greater proportion than encountered in PHCCs (46%) and hospitals (20%). Furthermore, 45% of hospitals, 43% of PHHCs, 30% of HPs, and 38% of SHPs did not take any action even though they had received suggestions and complaints from service users.
- Of those facilities with available and functional HFOMCs/HDCs, 69% of hospitals, 48% of SHPs, and 37% of HPs reported that they met most commonly according to need, while nearly half of PHCCs (46%) met at least once a month.
- On average, health workers from lower-level health facilities spent three hours per month on recording and reporting; those from hospitals spent six hours. The main reasons identified for not providing adequate time for recording/reporting were: inadequate skills of health workers in recording, and high workloads.

- More than half of PHCCs (52%), 41% of hospitals, 39% of HPs, and 27% of SHPs had approved supervision plans.
- Hospitals (65%) were least likely to have received a supervisory visit. The major recommendations for facilities that did receive a visit were: for hospitals to ensure women received their Aama incentives on time (91%); for PHCCs to ensure that the facility was clean and hygienic (78%); and for HPs (81%) and SHPs (87%) to improve the quality of data recording and reporting.

GESI

- There was little difference observed in the level of awareness about free health care between different ethnic groups (P>0.05).
- A higher proportion (14%) of Brahmins/Chhetris and Janajatis paid for services that should have been offered free of charge by the facility. All of the Janajatis, Newars, and Muslims that had paid for services had been asked by health workers for payment. Most commonly they were charged for registration fees and medicines.
- Women from Brahmin/Chhetri (90%) and Newar (87%) castes were more likely to be aware of free delivery care than those from other castes, while Terai/Madhesi caste women were the least likely to be aware (78%).
- The difference in levels of knowledge about transport incentives between ethnic groups was statistically significant.
- Terai/Madhesi (98%) and Muslim (92%) maternity clients were more likely to have received transport incentives than Janajati (69%), Newar (77%), and Brahmin/Chhetri (75%).
- Female outpatients (27%) were more likely to have requested a companion during care than male outpatients (22%); 16% of female outpatients had been permitted a companion.
- The gender balance was satisfactory in Facility Management Committees at all levels of health facilities; however, Janajatis were entirely absent from committees in HPs, as Dalits were from those in district hospitals.
- Some hospitals (60%) and PHCCs (54%) had undertaken activities to reach women as a target group. Hospitals were more likely to provide services targeting the poor, physically disabled and destitute.

D. STS KEY INDICATORS

Table 0. 3: Key STS Indicators for the Free Health Care

Indicators	STS 2011	95% Confidence Interval (CI)	STS 2012	95% Confidence Interval (CI)	STS 2013	95% Confidence Interval (CI)
% of outpatients aware of entitlement to free care	92.1	83.1–96.6	93.2	88.8–95.8	88.8	71.2–96.2
% of Dalit and Janajati outpatients aware of entitlement to free care	80.6	50.3–94.3	91.2	84.3–95.7	90.8	64.3–98.2
% of outpatients who paid for care under the free care policy	11.3	6.2–19.7	20.6	14.1–29.0	10.0	2.2–36.1
% of Dalit and Janajati outpatients who paid for care under the free care policy	5.5	2.4–12.4	20.3	12.1–29.5	8.6	1.5–36.2

Table 0. 4: Key STS Indicators for the Aama Programme

Indicators	STS 2011	95% CI	STS 2012	95% CI	STS 2013	95% CI
% of hospitals, PHCCs, and HPs implementing Aama	88.0	77.2–94.1	67.0	42.1–85.0	76.8	59.9-80.0
% of maternity clients aware of transport incentive	81.4	54.3–94.2	90.9	86.6–94.3	82.8	73.9–89.1
% of Dalit and Janajati maternity clients aware of transport incentive	82.8	55.2–95.0	85.8	75.3–92.2	75.9	63.9–84.9
% of maternity clients aware of free delivery care	78.3	43.2–94.5	92.9	88.3–96.0	82.4	78.6–85.5
% of Dalit and Janajati maternity clients aware of free delivery care	83.1	47.6–96.4	91.5	79.5–96.7	81.2	69.2–89.3
% of maternity clients who paid for delivery care	50.3	25.2–75.2	12.2	6.7–21.2	56.4	36.7–74.3
% of Dalit and Janajati maternity clients who paid for delivery care	57.3	20.4–84.0	7.5	4.0–15.9	60.3	38.0–78.9

Table 0. 5: Key STS Indicators for the Financial Management

Indicators	STS 2011	95% CI	STS 2012	95% CI	STS 2013	95% CI
% of facilities that spent all the funds received	26.7	14.1–44.8	23.1	16.9–30.7	38.4	27.1–51.1
% of facilities with a bank account	94.6	74.4–99.1	100	NA	97.2	91.7–99.1
% of facilities that disclosed their income and expenditure to the public	81.9	67.7–90.8	73.6	61.8–82.8	64.6	51.8–75.5
% of facilities that conducted a final audit in the last FY	15.3	9.6–23.5	20.0	11.4–32.6	14.8	5.8–33.1

Table 0. 6: Key STS Indicators for the Governance and Accountability

Indicators	STS 2011	95% CI	STS 2012	95% CI	STS 2013	95% CI
% of health facilities that undertook social audits as per MoHP guidelines in the last FY	27.4	17.4–40.4	13.7	8.2–22.0	14.7	7.0–28.5
% of facilities that conducted a social audit in the last FY, made findings public, and incorporated recommended actions in AWPB	22.0	15.0–31.0	7.4	1.9–24.5	11.4	6.8–18.6
% of facilities with a Citizen's Charter placed in a visible location that included information on free drugs, outpatient services and Aama (if Aama-implementing facility)	58.4	43.8–71.8	55.4	40.0–69.7	19.0	9.6–34.1
% of facilities with a health management committee (HFOMC/Hospital Development Committee (HDC)) meeting on a monthly basis	37.1	22.3–54.8	30.9	23.8–39.0	30.9	20.7–43.4
% of health facilities with at least three females and at least two Dalit and Janajati members in HFOMCs and HDCs	46.0	36.5–55.8	55.1	34.1–74.4	70.3	54.1–82.5

Table 0. 7: Key STS Indicators for the Human Resources

Indicators	STS 2011	95% CI	STS 2012	95% CI	STS 2013	95% CI
% of sanctioned positions that are filled						
Doctors at PHCCs	50.0	35.1–64.9	22.6	8.8–46.9	23.1	5.7–70.4
Doctors at district hospitals	68.9	46.7–79.6	63.0	35.6–78.8	47.1	12.2–69.5
Nurses at PHCCs	73.8	60.5–83.8	58.7	44.9–73.3	38.5	33.2–44.0
Nurses at district hospitals	83.3	74.3–89.6	82.7	75.1–91.1	55.3	48.4–57.1

Table 0. 8: Key STS Indicators for the Drug and Supply

Indicators	STS 2011	95% CI	STS 2012	95% CI	STS 2013	95% CI
% of facilities with drugs stored in a cool and dry place	86.8	64.0–96.1	29.3	21.0–39.3	37.1	19.5–59.0
% of facilities with drugs stored as per First Expired, First Out (FEFO) principles	87.9	76.5–94.2	84.4	76.3–90.1	76.9	59.1–88.5
% of PHCCs with at least one fridge with guaranteed power 24/7	47.6	24.3–72.0	48.4	40.2–56.7	46.2	29.5–63.8
% of maternity clients who paid for drugs	15.2	6.3-32.2	7.3	3.5–14.7	28.5	12.4-52.8

Table 0. 9: Key STS Indicators for the Quality of Care

Indicators	STS 2011	95% CI	STS 2012	95% CI	STS 2013	95% CI
% of facilities with comprehensive biomedical waste management in place (puncture-proof bin for needles; bin for disposing of plastics; bin for disposing of blood-/fluid-stained items; pit for placenta/deep burial)	12.5	8.5–17.9	21.9	16.8–28.2	7.2	4.1–12.4
% of CEONC facilities providing all CEONC signal functions 24/7	71.4	26.4–94.6	100	NA	100	NA
% of district hospitals providing all CEONC signal functions 24/7	8.3	0.7–53.2	50.0	37.0–60.3	77.8	39.0–95.0
% of districts with at least one facility providing all CEONC signal functions 24/7*	38.5	21.5–58.8	61.5	38.9–80.1	100	NA
% of BEONC facilities providing all BEONC signal functions 24/7	40.9	20.1–65.5	72.8	55.4–88.3	60.2	43.5–74.8
% of PHCCSs that provide all BEONC signal functions 24/7*	21.1	8.1–45.7	39	10.3–72.6	23.1	12.1–39.6
% of HPs that are birthing centres providing deliveries 24/7*	79.2	51.6–93.1	97.7	87.5–99.6	97.1	87.2–99.4
% of safe abortion sites with long-acting FP services*	91.4	77.8–97.0	56.1	17.4–88.5	91.4	74.2–97.5
% of district hospitals providing male and female permanent FP services	33.3	9.6–70.2	57.1	34.4–77.2	55.6	16.4–88.8
% of HPs with at least five FP methods*	13.3	5.8–27.9	7.6	4.1–13.5	18.0	10.9–28.3
% of outpatients who thought the facility was overcrowded	30.9	20.2–44.1	33.8	27.1–41.3	30.1	17.7–46.3
% of maternity clients who thought the maternity department was overcrowded	23.6	13.9–37.0	29.2	17.5–44.6	48.1	20.8–76.5
% of clients (maternity and outpatients) satisfied with the cleanliness of the health facility	45.4	35.2–56.0	74.8	69.2–83.0	71.8	58.6–82.0
% of clients (maternity and outpatients) satisfied with the provisions made to ensure privacy	54.1	37.2–70.0	69.6	61.5–76.4	60.7	52.9–67.9
% of clients (maternity and outpatients) satisfied with their health care*	95.8	91.5–98.0	89.5	82.4–97.3	89.0	80.6–94.0

Note: The shaded indicators, marked with an asterisk (*) are included in the NHSP-2 LF

Indicators to be monitored in NHSP-3

Table 0. 10: List of Indicators Recommended to Monitor in the NHSP 3

Indicators
% of hospitals, PHCCs, and HPs implementing Aama
% of maternity clients aware of transport incentive
% of Dalit and Janajati maternity clients aware of transport incentive
% of maternity clients aware of free delivery care
% of Dalit and Janajati maternity clients aware of free delivery care
% of maternity clients who paid for delivery care
% of Dalit and Janajati maternity clients who paid for delivery care
% of facilities that disclosed their income and expenditure to the public
% of health facilities that undertook social audits as per MoHP guidelines in the last FY
% of health facilities with at least three females and at least two Dalit and Janajati members in HFOMCs and HDCs
% of sanctioned positions that are filled
Doctors at PHCCs
Doctors at district hospitals
Nurses at PHCCs
Nurses at district hospitals
% of maternity clients who paid for drugs
% of facilities with comprehensive biomedical waste management in place (puncture-proof bin for needles; bin for disposing of plastics; bin for disposing of blood-/fluid- stained items; pit for placenta/deep burial)
% of district hospitals providing all CEONC signal functions 24/7
% of districts with at least one facility providing all CEONC signal functions 24/7
% of BEONC facilities providing all BEONC signal functions 24/7
% of PHCCs that provide all BEONC signal functions 24/7
% of HPs that are birthing centres providing deliveries 24/7
% of safe abortion sites with long-acting FP services
% of district hospitals providing male and female permanent FP services
% of HPs with at least five FP methods
% of clients (maternity and outpatients) satisfied with their health care

CHAPTER 1: INTRODUCTION

This report presents the findings from the Service Tracking Survey (STS) 2013, which is the third nationally representative health facility survey conceived to monitor the progress of the Second Nepal Health Sector Programme (NHSP-2). STS 2013 measures the achievements against: the NHSP-2 Logical Framework (LF), Aama Surakshya (Aama) and Free Care Programmes, governance and Gender Equality and Social Inclusion (GESI) issues, and quality of care. The survey was led by the Ministry of Health and Population (MoHP), within the Government of Nepal (GoN), with technical support from the Nepal Health Sector Support Programme (NHSSP), and executed by the Health Research and Social Development Forum (HERD). Data collection was conducted from 10 July to 14 August 2013 from 224 health facilities, 447 maternity clients, and 819 outpatients. This introductory chapter provides a general overview of NHSP-2, including the relevant LF indicators, the rationale for conducting the STS, and its objectives.

1.1 NEPAL HEALTH SECTOR PROGRAMME

The GoN introduced a National Health Policy (NHP) in 1991 that aimed to improve the health status of the population through increasing access to primary health care services. Following this, various sub-sector health policies, strategies, and plans were developed and implemented within the health sector. The 'Health Sector Strategy: An Agenda for Reform' was introduced in 2003, with the intention of moving the health sector towards strategic planning and a Sector-wide Approach (SWAp). The First Nepal Health Sector Programme (NHSP-1), conducted from 2004 to 2009, was the first health programme in Nepal to adopt a SWAp.

Building on the foundation laid by the NHSP-1 and its success, GoN formulated NHSP-2 for 2010–2015. The best practices and lessons learnt in the course of implementing NHSP-1 were capitalised upon and used in developing NHSP-2. NHSP-2 is a national guiding document for the health sector and focuses on meeting the health-related Millennium Development Goals (MDGs): 1 (partly)[1], 4[2], 5[3], and 6[4]. NHSP-2 offers a strong foundation to scale up cost-effective and evidence-based health programmes delivering successful results. It has a greater focus on increasing access to and utilization of Essential Health Care Services (EHCS) components, particularly among women, the poor and excluded groups.

[1] Eradicate Extreme Poverty and Hunger
[2] Reduce Child Mortality
[3] Improve Maternal Health
[4] Combat HIV/ AIDS, Malaria and Other Diseases

Goal and Objectives

The health sector goal, as stated in the NHSP-2, is to improve the health and nutritional status of all Nepalese citizens, especially of the poor and excluded. It intends to contribute to poverty reduction by providing equal opportunities for all to receive high-quality and affordable health care services. In order to achieve the expected results of improved health status, the following objectives were set for NHSP-2:

- To increase access to and utilization of quality EHCS.
- To reduce harmful cultural and economic barriers to accessing health care services in partnership with non-state actors.
- To improve the health system to achieve universal coverage of EHCS.

Log Frame

To monitor the success of NHSP-2, a results framework was created in 2010. The original results framework was subsequently revised in 2012 and is now called the LF. The LF consists of 12 goal-level indictors, 14 purpose-level indicators, 19 outcome-level indicators, and 42 output-level indicators. Like previous surveys, the STS 2013 is the source of data for 13 (one outcome and 12 output) of the NHSP-2 LF indicators (Table 1.1).

Table 1. 1: LF Indicators Monitored by STS 2013

S.N	Indicators
OC 2.6	Percentage of clients satisfied with their health care at public facilities
OP 1.3	Percentage of health facilities with at least three female and at least two Dalit and Janajati members in Health Facility Operation and Management Committees (HFOMCs) and Hospital Development Committees (HDCs)
OP 3.1	Percentage of sanctioned posts that are filled: doctors at Primary Health Care Centres (PHCCs)
	Percentage of sanctioned posts that are filled: doctors at district hospitals
	Percentage of sanctioned posts that are filled: nurses at PHCCs
	Percentage of sanctioned posts that are filled: nurses at district hospitals
OP 3.2	Percentage of hospitals that have at least one Obstetrician/Gynaecologist (O/G) or Doctor of Medicine, General Practitioner (MDGP), five nurses trained as Skilled Birth Attendants (SBAs), and one anaesthetist or Anaesthesia Assistant (AA)
OP 4.5	Percentage of districts with at least one public facility providing all Comprehensive Emergency Obstetric and Neonatal Care (CEONC) signal functions 24/7
OP 4.6	Percentage of PHCCs providing all Basic Emergency Obstetric and Neonatal Care (BEONC) signal functions 24/7
OP 4.7	Percentage of Health Posts (HPs) that are birthing centres providing deliveries 24/7
OP 4.8	Percentage of safe abortion sites with long-acting Family Planning (FP) services
OP 4.9	Percentage of HPs with at least five FP methods
OP 8.1	Percentage of health facilities that have undertaken social audits as per MoHP guidelines in the current or last Fiscal Year (FY)

1.2 RATIONALE FOR CONDUCTING STS 2013

NHSP-2 requires information to monitor progress on its objectives. However, only some of this information is available from the government's routine data collection systems, such as the Health Management Information System (HMIS). There is a clear need for additional data collection, including facility-based and household surveys, which can give the comprehensive picture of NHSP indicators and objectives. The STS evolved from previous health-facility-based surveys. The Family Health Division (FHD) of MoHP, with the Support to the Safe Motherhood Programme (SSMP), also undertook facility surveys in 2009 and 2010, using instruments similar to those used in the Health Sector Reform Support Programme (HSRSP) study. The major focus of these studies was to monitor the achievements of the Aama Programme, quarterly cash flows, and services provided. In contrast, STSs are carried out to gather additional facility-based information on human resources and quality of care, including the Aama Programme. These surveys are also designed to inform health-related programmes at the health facility and community levels. To date, three STSs have been conducted in three consecutive years (2011, 2012, and 2013).

1.3 OBJECTIVES OF STS 2013

- To monitor indicators in the revised NHSP-2 LF
- To monitor the implementation of the Aama and Free Health Care Programmes
- To monitor the financial management capacity of health facilities (including a detailed accounting of the flow of services and finance)
- To monitor the quality of care, including client experience
- To collect information related to governance and GESI.

1.4 STRUCTURE OF REPORT

This report consists of eleven chapters. Chapter one provides a brief description of NHSP-2 and the rationale and objectives of STS 2013. Chapter Two describes the methodology of the STS 2013 in detail (survey design, sampling strategy, questionnaire design, selection and training of data collection team, data collection, data management, and limitations of the survey). Chapter Three presents the background characteristics of facilities (infrastructure, water and sanitation, communication, and ambulance provision) and clients' characteristics. Chapters' four to eleven present the findings of the Free Care Programme, the Aama Programme, financial flow, governance and accountability, human resources, drug supply and storage, quality of care, and progress against the NHSP-2 LF indicators respectively. Each chapter contains an introduction, results, and key findings.

CHAPTER 2: METHODOLOGY

The sampling strategy used for STS 2013 is similar to the previous STSs, with the following factors taken into consideration:

- The data were nationally representative (but did not provide district-level estimates)
- The key indicators can be monitored over time and data are therefore comparable with STS 2011 and STS 2012
- The districts were randomly selected for each survey, but all regions and ecological zones should be represented in all surveys, and
- All public hospitals within the selected districts were included, along with a proportion of PHCCs, HPs, and Sub-Health Posts (SHPs).

2.1 SURVEY DESIGN

STS 2013 is a nationally representative cross-sectional survey. The sampling strategy used in this survey was a two-stage sampling design:

- In the first stage of sampling, one district was randomly selected from each of 13 sub-regions. Therefore, the districts were the Primary Sampling Units (PSUs), and one PSU was selected per stratum (sub-region). This resulted in three districts being selected from the Mountain region, five from the Hill region, and five from the Terai region.
- In the second stage, the facilities were selected within each of the 13 districts. The higher the level of facility, the greater the probability of being selected: all public hospitals and PHCCs from the selected districts were included and an Equal Probability Sampling Method (EPSEM) was used to select HPs and SHPs.

2.2 SAMPLE DESIGN

2.2.1 District Selection

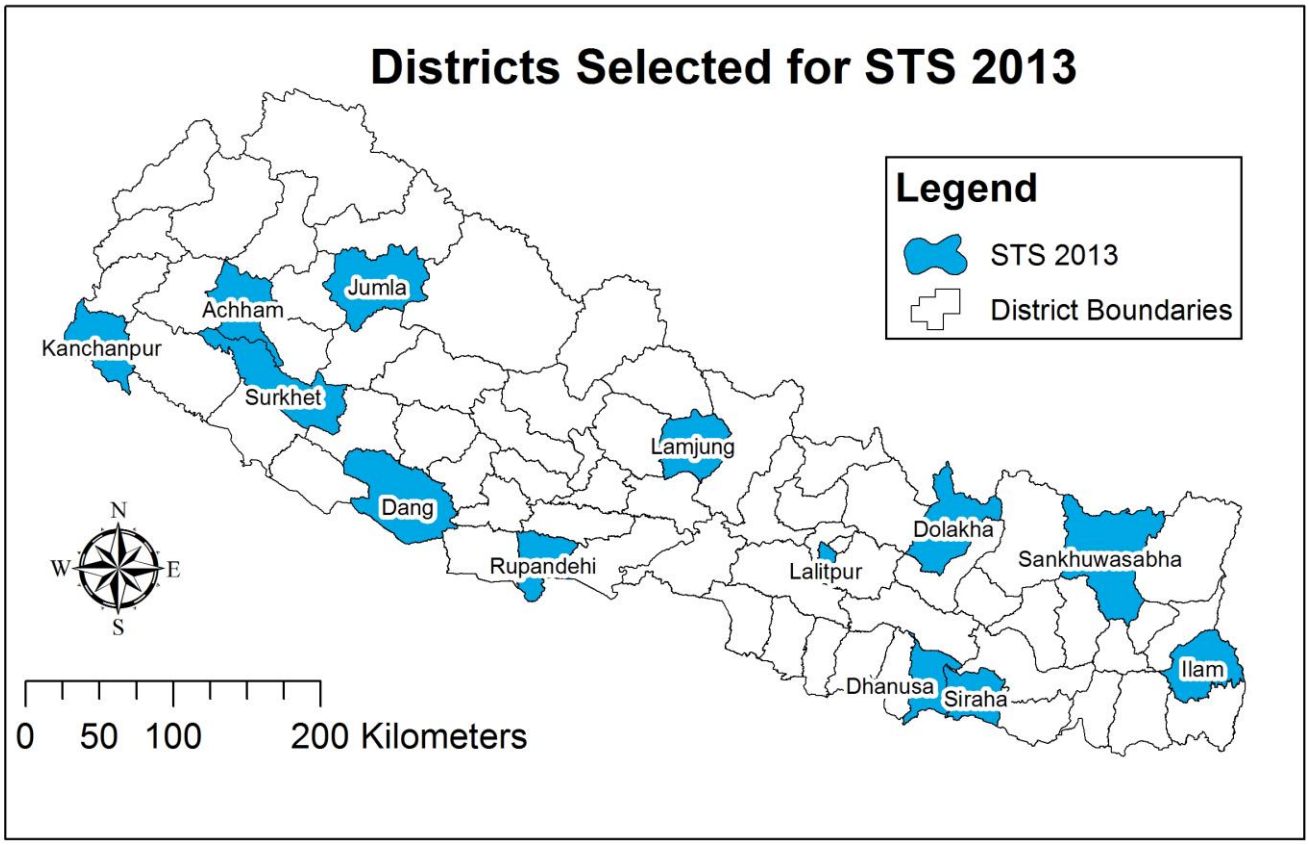
To make the sample nationally representative, the STS follows the cluster design sampling method adopted by the Nepal Demographic and Health Survey (NDHS), which stratified Nepal into three eco-zones and five development regions, and subsequently into 13 sub-regions (the mountain districts in the Western, Mid-western, and Far-western are combined in to one sub-region owing to their relatively small population). In a similar approach to that used by MoHP and HSRSP for the 2009 and 2010 Facility

Surveys, and STS 2011 and 2012, one district was randomly selected from each of the 13 sub-regions for the STS 2013 (Table 2.1, with selected districts in bold). Figure 2.1 shows the geographical distribution of the districts selected for STS 2013.

Table 2. 1: Districts Selected for STS within the 13 Sub-regions (Selected for STS 2013 in Bold)

S.N	Sub-regions	Districts
1	Eastern Mountain (3)	Taplejung, **Sankhuwasabha**, Solukhumbu
2	Central Mountain (3)	Sindhupalchowk, **Dolakha,** Rasuwa
3	Far-/Mid-/Western Mountain (10)	Dolpa, Bajura, Bajhang, Darchula, **Jumla,** Kalikot, Mugu, Humla, Manang, Mustang
4	Eastern Hill (8)	Udaypur, Panchthar**, Ilam,** Dhankuta, Tertathum, Bhojpur, Okhaldhunga, Khotang
5	Central Hill (9)	Makwanpur, Sindhuli, Ramechhap, Kavreplanchowk, **Lalitpur**, Bhaktapur, Kathmandu, Nuwakot, Dhading
6	Western Hill (11)	Baglung, Gorkha, **Lamjung,** Tanahu, Syangja, Kaski, Myagdi, Parbat, Gulmi, Palpa, Argakhanchi
7	Mid-western Hill (7)	Rolpa, Pyuthan, Rukum, Salyan, **Surkhet,** Dailekh, Jajarkot
8	Far-western Hill (4)	Doti, **Achham,** Dadeldhura, Baitadi
9	Eastern Terai (5)	**Siraha,** Jhapa, Morang, Sunsari, Saptari
10	Central Terai (7)	Mohattarai, **Dhanusha,** Sarlahi, Rautahat, Bara, Parsa, Chitwan
11	Western Terai (3)	Nawalparasi, **Rupandehi,** Kapilbastu
12	Mid-western Terai (3)	Banke, **Dang,** Bardiya
13	Far-western Terai (2)	Kailali, **Kanchanpur**

Figure 2. 1: Map of Districts Selected for STS 2013



2.2.2 Health Facility Selection

Details of all public health facilities in the selected districts were obtained from HMIS. Each District (Public) Health Office (D(P)HO) was consulted to ensure the details were complete and up to date. As Table 2.2 shows, similar proportions of health facilities (by level) were selected in STS 2013 as in STS 2011 and 2012. However, the total number of facilities was higher in 2013, with 224 facilities compared to 169 in STS 2011 and 198 in STS 2012.

Table 2. 2: Number of Facilities by Type in Selected Districts (Total and STS 2013 Sample)

S.N	Districts	Population (2011)	Human Develop-ment Index (HDI) Rank (2004)	Hospitals		PHCCs		HPs		SHPs	
				Total	Sample	Total	Sample	Total	Sample	Total	Sample
1	Sankhuwasabha	158,742	19	1	1	2	2	16	9	19	1
2	Dolakha	186,557	35	1	1	2	2	19	8	32	4
3	Jumla	108,921	68	1	1	1	1	11	6	17	3
4	Illam	290,254	12	1	1	4	4	12	5	31	5
5	Lalitpur	468,132	3	1	1	3	3	16	8	21	3
6	Lamjung	167,724	28	1	1	2	2	12	6	44	7
7	Surkhet	350,804	31	2	2	3	3	24	11	38	4
8	Achham	257,477	72	1	1	2	2	17	8	54	9
9	Siraha	637,328	64	2	2	4	4	20	8	83	14
10	Dhanusha	754,777	37	1	1	5	5	17	8	79	11
11	Rupandehi	880,196	8	2	2	5	5	18	9	45	5
12	Dang	552,583	22	2	2	3	3	15	8	20	2
13	Kanchanpur	451,248	18	1	1	3	3	11	6	7	0*
Total in STS 2013		**5,264,743**		**17**	**17 (100%)**	**39**	**39 (100%)**	**208**	**100 (48%)**	**490**	**68 (14%)**
STS 2012		**4,883,433**		**16**	**16 (100%)**	**39**	**30 (77%)**	**192**	**79 (41%)**	**456**	**72 (16%)**
STS 2011		**4,101,042**		**16**	**16 (100%)**	**38**	**28 (76%)**	**110**	**45 (41%)**	**536**	**80 (15%)**

**Note: In Kanchanpur district one SHP was initially selected for the study; however, during data collection this SHP (Jhalari SHP) was upgraded to HP.*

Selection of Hospitals and PHCCs

As in previous STSs, all 17 public hospitals in the study districts were selected for the study. The public hospitals in the selected districts include eight higher-level hospitals (one Regional hospital, one Sub-regional hospital, two Academies of Health Sciences, and four Zonal hospitals) and nine district-level hospitals.

If the list of frame contains 100 or fewer facilities, all the facilities will be selected for the study (Measure evaluation Manual: Sampling Manual for facility survey, 2001). Hence, we selected all 39

PHCCs in the study districts for STS 2013; the sampling procedure for PHCCs was different from that used previously in STSs 2011 and 2012.

Selection of HPs and SHPs

Given the context of SHPs being upgraded into HPs by MoHP, a smaller proportion of SHPs (14%) and a higher proportion of HPs (48%) were selected in STS 2013 compared to previous years.

HPs: Five to eleven health posts were selected from each of the 13 districts proportionately to result in 48% of HPs being selected. However, only 41% were selected in STS 2011 and 2012 (Table 2.2).

SHPs: One to fourteen SHPs were selected from each of the 13 districts proportionately, resulting in 14% of SHPs being selected, compared to 16% and 15% in STS 2012 and 2011 respectively (Table 2.2).

Step 1: The HPs and SHPs were listed separately for each district. They were arranged and numbered in serpentine order, commencing at one corner of the sampling frame (for example, the northwest).

Step 2: Systematic sampling was then used to select the facilities. The sample was selected using the interval I = N/n, where N is the number of health facilities in the sampling frame in each district and n is the sample size. A health facility between the intervals was randomly selected; the other required health facilities were subsequently selected using the same interval. Using the same approach, 100 HPs and 68 SHPs were selected from 13 districts.

2.2.3 Outpatient Exit Interviews

A total of 819 outpatient exit interviews were conducted across the 13 districts (27% in hospitals, 21% in PHCCs, 35% in HPs, and 16% in SHPs). The district-wise distribution of outpatient exit interviews is shown in Table 2.3. Some SHPs have very few or even no outpatients.

Table 2. 3: District-wise Distribution of Outpatient Exit Interviews

Districts	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)	Total outpatients (N)
Ilam	19.2	32.7	28.8	19.2	52
Sankhuwasabha	24.4	15.6	55.6	4.4	45
Siraha	16.5	25.8	32.0	25.8	97
Dolakha	17.0	32.1	34.0	17.0	53
Dhanusha	23.0	25.3	32.2	19.5	87
Lalitpur	37.5	23.8	30.0	8.8	80
Lamjung	33.9	12.5	30.4	23.2	56
Rupandehi	47.3	14.9	23.0	14.9	74
Dang	44.2	15.4	34.6	5.8	52
Jumla	10.5	13.2	57.9	18.4	38
Surkhet	33.8	21.3	40.0	5.0	80
Achham	12.9	10.0	38.6	38.6	70
Kanchanpur	25.7	28.6	45.7	0.0	35
Total	**27.1**	**21.0**	**35.4**	**16.5**	**819**

2.2.4 Maternity exit interviews

A total of 447 exit interviews of women who had recently delivered or experienced complications during puerperium were conducted across the 13 districts (87% in hospitals, 8% in PHCCs, 4% in HPs, and less than 1% in SHPs). The district-wise distribution of maternity clients exit interviews is shown in Table 2.4. As a result of HPs' and SHPs' low case loads and the short data collection period, the survey teams were unable to interview many maternity clients in HPs and SHPs.

Table 2. 4: District-wise Distribution of Maternity Exit Interviews

Districts	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)	Total Maternity Clients (N)
Illam	78.9	10.5	10.5	0.0	19
Sankhuwasabha	64.7	5.9	29.4	0.0	17
Siraha	77.0	21.3	1.6	0.0	61
Dolakha	45.5	45.5	9.1	0.0	11
Dhanusha	96.8	0.0	3.2	0.0	62
Lalitpur	96.8	3.2	0.0	0.0	31
Lamjung	100	0.0	0.0	0.0	30
Rupandehi	93.8	4.6	1.5	0.0	65
Dang	95.3	3.1	1.6	0.0	64
Jumla	70.0	10.0	20.0	0.0	10
Surkhet	84.1	4.5	6.8	4.5	44
Achham	25.0	58.3	16.7	0.0	12
Kanchanpur	95.2	4.8	0.0	0.0	21
Total	**86.6**	**8.5**	**4.5**	**0.4**	**447**

2.3 QUESTIONNAIRE DESIGN

As in STS 2011 and 2012, three different questionnaires were used in the STS 2013, as follows:

1. Health facility questionnaire
2. Exit interview with outpatients
3. Exit interview with maternity clients (who had recently given birth at the facility or had visited that facility for a maternal complication during puerperium).

Minor changes were made to the STS 2012 survey instruments for 2013 following suggestions from key stakeholders, and the final versions were approved by MoHP. Table 2.5 shows the sections of the questionnaires and desired respondents.

Table 2. 5: Sections Covered in Questionnaire and Desired Respondents

Section	Heading	Desired respondents
Facility Questionnaire		
1	Background Introduction of the facility	Facility In-charge
1	Facility Characteristics, Infrastructure, Functionality and Available Services	Facility In-charge
2	Governance and Accountability	Facility In-charge
3	Quality of Care	Facility In-charge
4	Aama Programme	Focal person of Aama Programme/Public Health Nurse (PHN)
5	Drug Supply and Storage	Storekeeper/focal person of free care
6	Human Resources	Administration officer/Facility In-charge
7	Financial Flows	Account officer/Facility In-charge
Exit Interview Questionnaire		
Exit Interview: Outpatients		Outpatients
Exit Interview: Maternity Clients		Women who had recently delivered in the facility or experienced complication during puerperium

2.4 TOOL TRANSLATION AND FINALISATION

The survey tools were first developed in English and then translated into Nepali. Translated copies of the tools were circulated to key personnel of different sections of the Department of Health Services (DoHS) (FHD, Epidemiology and Disease Control Division (EDCD), Child Health Division (CHD), National Health Education, Information, and Communication Centre (NHEICC), Primary Health Care Revitalization Division (PHC-RD), and Management Division (MD)), NHSSP, and MoHP (Policy, Planning, and International Cooperation Division (PPICD) and Monitoring and Evaluation (M&E) Section) for comments on their relevant sections. Following discussions and comments from the key representatives from MoHP, DoHS, and NHSSP, the questionnaires were finalized by HERD.

2.5 SELECTION OF FIELD RESEARCHERS

A total of fifty-six field researchers (supervisors and enumerators) were recruited, all of whom had an academic background in public health, nursing, medicine, or sociology, with particular experience in health. During selection, the experience of working at health facilities, on previous STSs, and of data collection was desirable. Experience in health systems research, strong written skills, familiarity with the local context, and the ability to work as part of a team were also taken into account when selecting field researchers.

Supervisors: Thirteen district supervisors were recruited, one for each district. Supervisors were identified based on their previous experience, qualifications, leadership qualities, and team mobilization skills.

Enumerators: Forty-three enumerators were recruited, ranging from two to five per district depending upon the number of health facilities.

2.6 TRAINING AND ORIENTATION

Field Researchers (Supervisors and Enumerators)

A five-day training programme was organized for fifty-six field researchers from 30 June to 4 July 2013. All representatives from MoHP, NHSSP, and DoHS attended the training session on the first day of training. A Training Manual was produced to aid training and provide a point of reference during data collection. The training included an introduction to STS, objectives, approach, ethical issues, survey instruments, reporting, quality assurance, operational issues, and field monitoring. Theoretical backup was given to the field researchers on different sections of the questionnaire by respective section heads from DoHS. The main focus of the training was on clarity of content, skip instructions within the questionnaire, sequencing and phrasing of questions in local language, and practice in interviewing techniques. An additional one-day orientation session was provided to the supervisors a day before departing to field. Role plays, presentations, group discussions, mock interviews, and field practice techniques were employed during the training period to enrich the knowledge of field researchers on content and develop their skills in administering questionnaires and obtaining pertinent answers.

Training of Data entry clerks

A one-day training session was organized for eight data entry clerks. They were oriented on the use of the Census and Survey Processing System (CSPro) database and ways of maintaining consistency in data entry. Possible areas where errors might occur during data entry were highlighted. To maintain consistency and quality in data entry, a Data Entry Manual was designed and implemented throughout the data entry period.

2.7 DATA COLLECTION

To maintain the consistency and quality in data collection across 13 districts, a detailed Survey Field Manual was developed and distributed to all field researchers. They were strictly instructed to use the Survey Field Manual during data collection. Thirteen data collection teams were formed, comprising of one supervisor for each district. Data collection was performed from 10 July to 14 August 2013. Depending upon the number of health facilities, the availability of maternity clients and outpatients, and the difficulty of the geographical terrain, it took between 22 and 37 days per district to complete the work. Some of the teams extended their data collection days owing to the unavailability of maternity clients in the sample facilities; others were obliged to revisit health facilities as the health workers

responsible for providing the information needed had been unavailable during the first visits. General strikes also forced teams to return at a later date. The unavailability of maternity clients for interview in some districts led to an increase in the number interviewed in other districts. During the data collection period, all field researchers (supervisors and enumerators) were provided with a bag, raincoat, torch, jacket, and a first aid kit with essential medicine. For the protection and safety of tools, they were also given sufficient polythene bags and folders.

2.8 SUPERVISION AND SUPPORT

Monitoring and supervision visits were made soon after data collection started so that any problems could be identified and rectified immediately. Representatives from the Technical Working Group, GoN, NHSSP, and HERD made frequent visits to the survey sites. The research team based at the central level planned to visit all 13 districts and made monitoring visits accordingly. A monitoring desk was established at the central office of HERD to check for any problems, monitor the progress, and provide necessary technical support as and when required. The monitoring desk was open during office hours as well as out of hours. A central core team at HERD dealt with technical issues in the field daily. For monitoring purposes, monitoring forms and formats were developed for field researchers and used during the data collection period.

2.9 QUALITY ASSURANCE

Quality assurance starts from the development of the questionnaire to the finalization of the report. To make the questionnaire comprehensive and to ensure that the questions are in line with NHSP-2 LF indicators, an expert review (from MoHP, DoHS, and NHSSP) of the questionnaire was carried out. A Training Manual, Survey Field Manual, and Data Entry Manual were produced and used across the training period, data collection period, and data entry period respectively, to maintain quality and consistency in the work. Keeping quality in mind, a rigorous and intensive five-day training programme was organized for field researchers by experts from MoHP.

During fieldwork, all completed questionnaires were checked by the supervisors in the district before sending them to the central office at HERD for data entry. Feedback was provided to the enumerators during data collection. Any issues arising from central-level supervisory visits were immediately circulated to all districts by a HERD coordinator. Frequent mobile phone contact with core team members at HERD was maintained to address any concerns immediately. To reduce the chance of data entry errors, the data entry software was developed to have the same appearance as the questionnaire, and all data were double entered. Supervisors with experience in data entry and processing were

recruited as data cleaning and coding officers. The report was finalized after a meticulous review by internal and external experts.

2.10 ETHICAL CONSIDERATIONS

Before data collection began, formal approval from the selected districts and facilities was requested with an authorized letter from MoHP. Before starting an interview, enumerators informed all of the respondents of the purpose of the survey and showed authorization letters from MoHP and the D(P)HO. Exit interview clients (outpatients and maternity clients) were informed that they were under no obligation to participate in the survey, and that if they did choose to participate, all responses would remain confidential. The enumerators subsequently requested consent from the respondents to begin the interview.

2.11 DATA MANAGEMENT

2.11.1 Database Design: Three databases, one for each survey tool, were developed in CSPro 5.0. The databases were pre-tested before data entry started and any errors were fixed.

2.11.2 Coding: Open-ended responses were coded prior to data entry. Completed questionnaires were assigned unique ID codes.

2.11.3 Data Entry: The data entry personnel received a one-day orientation session. They were closely monitored by the database designer, and back-up files were created each day to prevent data loss.

2.11.4 Data Cleaning: Consistency checks and content cleaning were carried out and outliers in continuous variables were checked. Any suspect data were cross-checked against hard copies of completed questionnaires.

2.11.5 Data Analysis: Statistical Package for Social Science (SPSS) software (version 13) was used for data analysis. Frequency tables of all variables were produced, along with cross tabulations with level of facility for all the facility-level data and key Socio-demographic information (such as caste/ethnicity and ecological zone) for exit interview data.

2.11.6 Weighting:

Facility data:

- In order to produce nationally representative results, when data from all facility levels were combined, it was necessary to calculate appropriate weights based on the sample design (see Annex A: Weight calculation). The weighting has eliminated any bias related to the different probabilities of selecting different levels of facility. Without weighting, the lower-level facilities are underrepresented, given the lower proportion selected, and the higher-level facilities are overrepresented, given the higher proportion selected. The data were post-stratified, so that the data from each level of facility were weighted in proportion to the number of facilities at each level of facility nationally, using data from the DoHS Annual Report 2010/11. However, with weighting, the total figures are naturally more reflective of performance at the lower-level health facilities given their higher numbers. Given the large differences in expectations between different levels of facilities for many indicators, a more accurate picture of performance may be gained by looking at the data for the levels of facility individually, rather than the combined figure.
- The data presented for each level of facility individually were unweighted, as the weight applied to each level was constant. It was not felt appropriate to give, for example, one PHCC more weighting than another PHCC just because it was selected from a larger sub-region and so had a lower probability of being sampled. There is no evidence of greater similarities between facilities within one sub-region compared to facilities from another, and indeed results from neighbouring facilities can often be in stark contrast to one another.
- Different weights were applied to assess the functionality of CEONC facilities, BEONC facilities, birthing centres, and safe abortion services. These were calculated based on the distribution of the different level of facilities within these categories at the national level.

Client data:

- As with the total facility data, it was necessary to calculate appropriate weights for the client exit interview data based on the sample design, to produce nationally representative results. The weighting has eliminated any bias related to the different probabilities of selecting different levels of facility (Annex A).
- The exit client interview data were also weighted to eliminate any bias related to the different first stage probabilities of selecting one district from each sub-region. There are differences in

the level of utilization at each facility level between sub-regions and, without weighting, the characteristics of the larger sub-regions would be under-represented and the characteristics of the smaller sub-regions would be over-represented.

- The data were post-stratified so that the data from each sub-region and level of facility are weighted in proportion to the expected utilization of health services, using data from the DoHS Annual Report 2010/11 for the outpatient exit interviews and the NDHS 2011 for the maternity exit interviews.
- The weights for both outpatients and maternity clients were trimmed: any weights greater than ten were allocated a weight often and any weights less than 0.1 were allocated a weight of 0.1, which resulted in the results from ten maternity clients having their weights trimmed.
- However, when describing the characteristics of clients in Section 3.24, some of the data were not weighted (*unweighted data were marked as unweighted at the foot of the table*) because the objective in this case was to describe the achieved sample, not the characteristics of Nepal.

2.12 SIGNIFICANCE TESTS AND INTERVAL ESTIMATION

The sampling design involved the selection of only one PSU (district) within each sub-region (stratum), and also involves post-stratification; such a design cannot be acknowledged precisely in the data analysis. However, we approximate this design as the selection of districts within strata defined by ecological zones (Mountain, Hill and Terai). We acknowledged the weighting of the data, the approximate stratification, and the two-level clustering (districts as PSUs and facilities as Secondary Sampling Units (SSUs)) while computing statistical tests and confidence intervals, using the complex survey functions of SPSS. Statistical tests were performed for the client data to assess the differences in utilization by ecological zone, caste/ethnicity, and facility level. However, significance tests were not performed to assess differences by facility level when using the facility survey data owing to the small number of hospitals sampled and the high sampling fractions of some facility levels, particularly hospitals.

- We have used the complex survey adaptations of the chi-squared test for the categorical variables.
- We have reported significance with a *p*-value of <0.05 (significant at the 5% level).
- Confidence intervals were computed for the key variables in each chapter, including all NHSP-2 LF indicators.

2.13 LIMITATIONS OF THE STUDY

The major limitations of the STS 2013 were as follows:

- The STS is a cross-sectional survey and hence provides information at one point of time.
- The timing of data collection for STS 2013 (10th July to 14th August) varies slightly to STS 2012 (22nd August to 17th October) and STS 2011 (12th September to 25th October) may affect comparison over time.
- The survey was designed to produce nationally representative estimates, but not sub-regional or district estimates.
- For most findings data are presented separately for each level of facility, as aggregate data mask the vast differences between the levels and are hence misleading. However, the resulting sample sizes for the higher level facilities are small.
- Some of the sample sizes are small, especially when disaggregating the results by caste/ethnicity, ecological zone and level of health facility, and hence further research may be needed to confirm these observations.
- Only descriptive findings and associations have been reported: no causal relationships have been deduced from data.
- This study was based solely on quantitative data collection. Additional qualitative research could help to provide a more in-depth explanation of the findings observed.

CHAPTER 3: BACKGROUND CHARACTERISTICS

3.1 INTRODUCTION

This chapter provides an overview of background characteristics, physical infrastructure, and functionality of the sampled health facilities, as well as the characteristics of exit clients (outpatients and maternity) interviewed. The STS 2013 data collection team visited total of 224 health facilities (17 hospitals, 39 PHCCs, 100 HPs, and 68 SHPs) and interviewed 1,266 health service recipients (447 maternity clients and 819 outpatients). Similar to the STS 2012, the data have been weighted, where appropriate, to ensure that the findings are nationally representative. In Section 3.2.4, the data, describing the characteristics of the achieved sample of exit clients, are not weighted: they are presented as such to help understand the sample rather than to make inferences for Nepal as a whole.

3.2 RESULTS

3.2.1 Infrastructure

Ownership of Building

Table 3.1 illustrates the ownership status of the health facility building. All hospitals (100%) had their own building. Similarly, 97% of PHCCs and 82% of HPs had their own building, but less than three-quarters of SHPs (72%) did.

Table 3. 1: Ownership of Facility Building, by Level of Facility

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Own building	100	97.4	82.0	72.1
Village Development Committee (VDC)/ Municipality/Rented	0.0	2.6	18.0	27.9
Total facilities (N)	**17**	**39**	**100**	**68**

Source: STS facility questionnaire

Presence of Compound Wall/Fencing Wire

Enumerators were asked to observe the presence of compound wall or fencing wire. Table 3.2 shows that 71% of hospitals had a secure compound wall or barbed wire protection. More than half (54%) of the PHCCs had secure compound walls compared to 35% of HPs and 24% of SHPs.

Areas in Need of Repair or Maintenance

Physical infrastructure, i.e. the building of the health facility, is also an important factor determining the quality of services being provided by the health facility. On observing the areas in need of repair or maintenance, it was found that 41% of hospitals had doors in need of repair or maintenance, 31% of the PHCCs needed walls and floors repairing, 32% of HPs needed roof maintenance, and 31% of SHPs needed toilets and doors repairing (Table 3.2).

Table 3. 2: Presence of a Compound Wall or Barbed Wire and Areas that Needed Repair or Maintenance

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Presence of secure compound wall or barbed wire protection:				
Secure compound wall or barbed wire protection	70.6	53.8	35.0	23.5
Unsecured compound wall or barbed wire protection	17.6	15.4	24.0	8.8
No compound wall or barbed wire	11.8	30.8	41.0	67.6
Areas in need of repair or maintenance:				
Wall	52.9	30.8	35.0	41.2
Windows	52.9	48.7	48.0	48.5
Toilet	52.9	43.6	40.0	30.9
Route from compound entrance to main building	47.1	41.0	60.0	58.8
Roof	47.1	48.7	32.0	42.6
Floor	47.1	30.8	39.0	38.2
Doors	41.2	38.5	40.0	30.9
Total facilities (N)	**17**	**39**	**100**	**68**

Source: STS facility questionnaire

Staff Accommodation

MoHP has endorsed a policy of round-the-clock availability of health service providers offering free delivery services. Most hospitals had permanent accommodation for the head of the institution (88%), nursing staff (82%), and other health workers (65%). However, the likelihood of having accommodation was low at lower-level facilities. Permanent accommodation was more common for nursing staff/Auxiliary Nurse Midwives (ANMs): it was present in 82% of hospitals, 74% of PHCCs, and 34% of HPs. Meanwhile, 65% of hospitals, 67% of PHCCs, and 36% of HPs had provision of overnight accommodation for nursing staff (Table 3.3).

Table 3. 3: Facilities with Permanent and Overnight Accommodation

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Permanent accommodation for:				
Head of institution	88.2	59.0	20.0	0.0
Nursing staff/ANMs	82.4	74.4	34.0	1.5
Other health workers	64.7	23.1	14.0	0.0
Overnight accommodation for:				
Nursing staff/ANMs	64.7	66.7	36.0	1.5
Other health workers	52.9	41.0	22.0	1.5
Total facilities (N)	**17**	**39**	**100**	**68**

Source: STS facility questionnaire

Table 3.4 shows the capacity of health facilities to accommodate nursing staff. It was found that more than half (57%) of hospitals had permanent accommodation that could hold five to ten nurses, compared to 7% of PHCCs and 3% of HPs. Meanwhile, more than half (55%) of the PHCCs could hold three or more nurses, and 82% of HPs could hold one or two nurses.

Table 3. 4: Number of Nursing Staff that Can Be Housed in Permanent Accommodation

Number of staff	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
1–2	0.0	44.8	82.4	100
3–4	14.3	48.3	14.7	0.0
5–10	57.1	6.9	2.9	0.0
11–15	28.6	0.0	0.0	0.0
Total facilities that have permanent accommodation for nursing staff (N)	**14**	**29**	**34**	**1**

Source: STS facility questionnaire

Waiting Space

The survey collected information on the availability and adequacy of waiting space from facility staff and clients. According to facility staff, all of the hospitals (100%) provided waiting space for clients seeking outpatient care. On comparing the findings among lower-level health facilities, there was not a great deal of variation between them: staff at eight out often lower-level health facilities (PHCCs, HPs, and SHPs) reported waiting space for patients being available. However, for all levels of health facility, only seven out often facility staff acknowledged that the space was sufficient.

From the client perspective, outpatients from SHPs (56%) were less likely than those at hospitals (68%), PHCCs (79%), and HPs (71%) to think that the waiting space for patients' was adequate. On the other hand, 67% of maternity clients from the hospitals, 88% of those from PHCCs, and 87% of those from HPs

reported having adequate waiting space. The apparently higher percentages of satisfaction about the waiting space provided by SHPs and HPs may have arisen as a result of the small sample size (Table 3.5).

Table 3. 5: Waiting Area for Clients and Companions

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Staff reporting of facility waiting space:				
Waiting area/space for outpatients	100	84.6	80.0	79.4
Total facilities (N)	17	39	100	68
Sufficient waiting area/space for outpatients	70.6	69.7	73.8	68.6
Total facilities having waiting area/space (N)	17	33	80	54
Client (outpatients) reporting of adequate waiting space:				
Adequate waiting space for outpatients	68.2	79.1	70.5	56.4
Adequate waiting space for outpatient companions	64.8	71.5	69.6	47.2
Total outpatients (N)	222	172	290	135
Client (maternity clients) reporting of adequate waiting space:				
Adequate waiting space for maternity clients	66.5	88.0	87.2	100
Adequate waiting space for maternity companions	46.5	86.0	72.3	100
Total maternity clients (N)	**387**	**38**	**20**	**2**

Source: STS facility questionnaire, maternity client exit interview, and outpatient exit interview

Availability and Adequacy of Separate Delivery Room

All hospitals (100%), 97% of PHCCs, and 64% of HPs had separate delivery rooms. However, only 21% of SHPs had separate delivery rooms. Staff at most hospitals (82%) and PHCCs (82%) reported that their delivery rooms were adequate. Similarly, staff from more than three-quarters of hospitals (77%) and PHCCs (79%) described their delivery tables as adequate, followed by those from HPs (58%) and SHPs (57%). The likelihood of being afforded privacy in the delivery room was lower in SHPs (79%) than in higher-level facilities (Table 3.6).

Table 3. 6: Availability and Adequacy of Separate Delivery Room

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Separate delivery room	100	97.4	64.0	20.6
Total facilities (N)	**17**	**39**	**100**	**68**
Adequate delivery room	82.4	81.6	73.4	64.3
Adequate delivery table	76.5	78.9	57.8	57.1
Adequate delivery kit	94.1	89.5	85.9	78.6
Adequate privacy	94.1	97.4	92.2	78.6
Total facilities with separate delivery room (N)	**17**	**38**	**64**	**14**

Source: STS facility questionnaire

Power Supply

Electricity was a common source of power supply in most health facilities. Although all hospitals sometimes had access to electricity, only 47% had round-the-clock supply; the likelihood of having electricity 24/7 was even lower at PHCCs (23%), HPs (18%), and SHPs (9%). Table 3.7 highlights that the nationwide shortage of electricity is having a direct impact on the delivery of health services. Generators were a common source of power in hospitals (88%), and solar power was often used as alternative source in lower-level health facilities (in 31% of HPs, 28% of PHCCs, and 21% of SHPs).

Table 3. 7: Availability of Power Supply

	Hospitals		PHCCs		HPs		SHPs	
Total facilities (N)	**17**		**39**		**100**		**68**	
Sources of power supply:	Available (%)	Available 24/7 (%)	Available (%)	Available 24/7 (%)	Available (%)	Available 24/7 (%)	Available (%)	Available 24/7 (%)
Electricity	100	47.1	84.6	23.1	76.0	18.0	45.6	8.8
Kerosene	41.2	29.4	48.7	23.1	32.0	19.0	33.8	17.6
Generator	88.2	58.8	23.1	15.4	0.0	0.0	0.0	0.0
Diesel	70.6	47.1	10.3	10.3	0.0	0.0	0.0	0.0
Solar power	35.3	29.4	28.2	23.1	31.0	23	20.6	20.6
Biogas	11.8	11.8	7.7	7.7	11.0	9.0	20.6	8.8
Others	5.9	5.9	7.7	5.1	6.0	5.0	5.9	4.4

Source: STS facility questionnaire

3.2.2 Water and Sanitation

Water

Table 3.8 presents the main source of water for health facilities. The findings reveal that piped water was the most frequent source of water, with the tube well the next most common. Nearly two-thirds of hospitals (65%), over half of PHCCs (59%) and HPs (51%), and nearly one-third of SHPs (32%) had piped water.

Outpatients and maternity clients were asked about the availability of drinking water in the health facility they had attended. Most maternity clients (93%) and over three-quarters of outpatients (78%) reported having had drinking water available in PHCCs. Similarly, more than two-thirds (68%) of the outpatients reported having had drinking water available at SHPs. Unlike in lower-level facilities, a considerably lower proportion of hospital maternity clients (58%) and outpatients (60%) reported having had drinking water available in the facility. Although 100% of maternity clients from SHPs reported having had drinking water available in the maternity ward, it should be noted that the number of clients was very low (two).

Table 3. 8: Main Source of Water

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Source of water:				
Pipe	64.7	59.0	51.0	32.4
Tube well (ground water through hand pump)	17.6	33.3	24.0	32.4
Water bought (bottle, jar, tanker)	5.9	0.0	0.0	1.5
Well	0.0	2.6	9.0	1.5
Borehole (ground water through motor pump)	5.9	2.6	0.0	1.5
Fall spring	0.0	0.0	1.0	1.5
No water source	5.9	2.6	15.0	29.4
Total facilities (N)	**17**	**39**	**100**	**68**
Availability of drinking water:				
For outpatients	60.4	78.3	69.9	67.6
Total outpatients (N)	**222**	**172**	**290**	**135**
For maternity clients	58.0	92.6	80.1	100
Total maternity clients (N)	**387**	**38**	**20**	**2**

Source: STS facility questionnaire, maternity client exit interview, and outpatient exit interview

The survey sought information on the availability of a sink with running water and soap in the health facilities. The data illustrate that sinks with running water were available at maternity units/wards and labour rooms in all hospitals (Table 3.9). However, the proportion of facilities having a sink with running water substantially decreased with level of facility, indicating poor infrastructure at the lower-level health facilities. A similar scenario for the availability of soap/alcohol rub for handwashing was observed.

Table 3. 9: Availability of Sink, Running Water and Soap

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Availability of sink with running water in:				
Maternity unit/ward	100	71.1	38.8	6.3
Labour room	100	71.1	43.5	2.1
Operating theatre	93.8	5.3	0.0	0.0
Availability of soap/alcohol rub for handwashing:				
Maternity unit/ward	100	84.2	48.2	18.8
Labour room	100	78.9	55.3	10.4
Operating theatre	93.8	7.9	0.0	0.0
Total facilities having water available (N)	**16**	**38**	**85**	**48**

Note: In total, 37 health facilities do not have water available.

Source: STS facility questionnaire

Sanitation

The availability of functional toilets was assessed by observation as a sanitation parameter. It was found that all the hospitals had a functional toilet. However, nearly one quarter of the hospitals (24%) were lacking separate toilets for women that were functional; and 6% did not have an easily accessible toilet for women in labour. More than one-third (35%) of SHPs did not have functional toilet facilities, compared to 10% of PHCCs and 14% of HPs. Lower-level health facilities were shown to be more likely to lack functional toilet facilities for women than upper-level health facilities.

Furthermore, health care clients were asked about the availability of toilets in the facility. A slightly greater proportion of PHCC clients (91%) reported that there had been a toilet available for outpatients than their counterparts in hospitals (87%), HPs (87%), and SHPs (75%). Likewise, a slightly higher percentage of maternity clients at hospitals (99%) reported toilets having been available than those at PHCCs (97%) and HPs (89%) (Table 3.10).

Table 3. 10: Availability of Functional Toilets

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Facility:				
Functional toilets	100	89.7	86.0	64.7
Total facilities (N)	**17**	**39**	**100**	**68**
Functional toilets for women	76.5	37.8	18.4	12.2
Total facilities having toilets (N)	**17**	**37**	**87**	**49**
Easy accessible toilet for women in labour in the maternity ward/labour room	94.1	64.1	25.0	5.9
Total facilities with maternity ward/labour room (N)	**17**	**39**	**100**	**68**
Outpatients:				
Toilet available for outpatients	87.0	90.5	86.7	75.2
Total outpatients (N)	**222**	**172**	**290**	**135**
Maternity clients:				
Toilet available for maternity	99.2	97.2	88.9	100
Total maternity clients (N)	**387**	**38**	**20**	**2**

Source: STS facility questionnaire, maternity client exit interview, and outpatient exit interview

3.2.3 Communication and Ambulance Provision

Availability and Functionality of Phone

Most hospitals (88%) surveyed operated a functional telephone service 24 hours a day, but 6% of the hospitals had no telephone service at all. Access to a telephone was less common at lower-level facilities: only 36% of PHCCs, 16% of HPs, and 3% of SHPs had access to a telephone 24 hours a day. It

should be noted that more than 70% of HPs and over 90% of SHPs were deprived of telephone lines (Table 3.11).

Table 3. 11: Availability and Functionality of Phone

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Functional phone, 24/7	88.2	35.9	16.0	2.9
Functional phone, but not 24/7	5.9	5.1	7.0	4.4
Phone available but not functional	0.0	2.6	4.0	0.0
No phone available	5.9	56.4	73.0	92.6
Total facilities (N)	**17**	**39**	**100**	**68**

Source: STS facility questionnaire

Availability and Functionality of Ambulance Service

Over nine out of ten HPs (94%) and SHPs (99%) did not have a facility ambulance service (Table 3.12). However, nearly three-quarters of the hospitals (71%) and over one-fifth (21%) of the PHCCs had round-the-clock facility ambulance services. Organizations providing ambulance services to health facilities were also assessed during the survey: 71% of hospitals, 31% of PHCCs, 22% of HPs, and 13% of SHPs had ambulance services provided by external/other organizations.

Table 3. 12: Availability and Functionality of Ambulance Service

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Functioning facility ambulance 24/7	70.6	20.5	6.0	0.0
Functioning facility ambulance, but not 24/7	0.0	2.6	0.0	0.0
Non-functioning facility ambulance	11.8	0.0	0.0	1.5
No ambulance available	17.6	76.9	94.0	98.5
Ambulance service provided by other organisation	70.6	30.8	22.0	13.2
Total facilities (N)	**17**	**39**	**100**	**68**

Source: STS facility questionnaire

3.2.4 Exit Client Characteristics

In STS 2013, 1,266 exit interviews were conducted: 819 (65%) with outpatients and 447 (35%) with maternity clients. At HPs and SHPs, the desired number of outpatients and maternity clients could not be interviewed within the time frame of the data collection owing to the facilities' smaller caseload (Table 3.13). The majority of maternity clients interviewed were from hospitals (87%), especially Zonal (32%) and District hospitals (29%), while most of the outpatients interviewed were from either HPs (35%) or hospitals (27%), which reflects their higher caseloads (Table 3.14). In this section, data are not weighted in order simply to describe the sample rather than make inferences for Nepal as a whole.

Table 3. 13: Proportion of Exit Interviews Conducted in Each District

Districts	Maternity clients (%)	Outpatients (%)
Illam	4.3	6.3
Sankhuwasabha	3.8	5.5
Siraha	13.6	11.8
Dolakha	2.5	6.5
Dhanusha	13.9	10.6
Lalitpur	6.9	9.8
Lamjung	6.7	6.8
Rupandehi	14.5	9.0
Dang	14.3	6.3
Jumla	2.2	4.6
Surkhet	9.8	9.8
Achham	2.7	8.5
Kanchanpur	4.7	4.3
Total exit interviews (N)	**447**	**819**

Note: Percentages presented in the table are unweighted
Source: STS maternity client exit interview and outpatient exit interview

Table 3. 14: Exit Interviews by Type of Facility

Type of facility	Maternity clients (%)	Outpatients (%)
Hospitals:	86.6	27.1
Academy of Health Science	8.3	4.2
Regional hospital	8.1	2.4
Sub-regional hospital	9.8	1.8
Zonal hospital	31.5	8.1
District hospital	28.9	10.6
PHCCs	8.5	21.0
HPs	4.5	35.4
SHPs	0.4	16.5
Total clients (N)	**447**	**819**

Note: Percentages presented in the table are unweighted.
Source: STS maternity client exit interview and outpatient exit interview

Place of Residence

Table 3.15 shows the distribution of those interviewed by place of residence. More than two-thirds (69%) of the maternity clients were urban residents. In contrast, most of the outpatients interviewed were rural residents (88%). The higher proportion of outpatients in a rural setting is linked to the higher proportion of lower-level health facilities covered in the survey. Most of the maternity clients (83%) and outpatients (72%) seeking care from hospitals were urban residents.

Table 3. 15: Distribution of Clients Surveyed in Exit Interviews, by Place of Residence

Clients	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)	Total (%)
Maternity clients:					
Urban	82.6	1.9	0.0	0.0	68.9
Rural	17.4	98.1	100	100	31.1
Total maternity clients (N)	**387**	**38**	**20**	**2**	**447**
Outpatient clients:					
Urban	71.6	3.6	1.7	0.0	11.9
Rural	28.4	96.4	98.3	100	88.1
Total outpatients (N)	**222**	**172**	**290**	**135**	**819**

Note: Percentages presented in the table are unweighted
Source: STS maternity client exit interview and outpatient exit interview

The majority of outpatients resided in the same district as that in which the facility they attended was located (91% of hospital and PHCC clients, 88% of HP clients, and 89% of SHP clients). However, over a quarter of maternity clients seeking care in hospitals (28%) or PHCCs (32%) were from a district other than that in which the health facility was located (Table 3.16).

Table 3. 16: Patients Residing in District Same as or Different from that in which Facility is Located

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Outpatients:				
Same district	91.0	91.2	88.0	88.9
Different district	9.0	8.8	12.0	11.1
Total outpatients (N)	**222**	**172**	**290**	**135**
Maternity clients:				
Different district	27.6	32.4	6.1	0.0
Same district	72.4	67.6	93.9	100
Total maternity clients (N)	**387**	**38**	**20**	**2**

Note: Percentages presented in the table are unweighted.
Source: STS maternity client exit interview and outpatient exit interview

Demographic Characteristics of Clients

The Socio-demographic characteristics of the outpatients and maternity clients interviewed in the survey are presented in Table 3.17. A relatively high percentage of both outpatients (42%) and maternity (39%) clients were in the youngest age group, i.e. under the age of 20 years. The mean age for women attending maternity services was 23 years, while the average age for outpatients' was 27 years for men and 30 years for women. All maternity clients were married, along with 61% of outpatients.

The caste-wise distribution of maternity clients shows that nearly one-third of those interviewed were Brahmin/Chhetri (31%), with Terai/Madhesi (25%) the next most common caste. Similarly, the ethnic group most frequently represented among outpatient clients was Brahmin/Chhetri (31%), followed by Terai/Madhesi (23%), and Janajati (22%). Nearly two-thirds of maternity clients (64%) had completed secondary education, compared to 35% of outpatients. The majority of maternity clients (87%) and outpatients (86%) were Hindu.

Table 3. 17: Socio-demographic Characteristics of Clients Surveyed in Exit Interviews

Characteristics	Maternity clients (%)	Outpatients		
		Female (%)	Male (%)	Total (%)
Age:				
<20	38.8	37.5	48.7	41.7
20-24	27.7	8.9	7.8	8.5
25-29	23.5	12.5	6.4	10.2
30-34	5.9	5.7	5.9	5.8
35-39	3.5	5.6	3.3	4.7
40-45	0.6	29.8	27.9	29.1
Mean age (years)	**23.0**	**29.8**	**27.4**	**28.9**
Marital status of patient:				
Married	100	67.7	49.3	60.7
Widow/widower	0.0	5.3	1.5	3.8
Divorced	0.0	0.1	0.4	0.2
Never married	0.0	27.0	48.8	35.2
Caste/Ethnicity:				
Brahmin/Chhetri	31.4	30.6	32.2	31.2
Terai/Madhesi Other Caste	25.2	19.7	27.1	22.5
Janajati	22.7	24.1	18.7	22.1
Dalit	13.1	18.6	16.3	17.8
Muslim	4.1	3.2	3.0	3.1
Newar	3.6	3.8	2.7	3.4
Education status:				
Never attended school	24.1	52.0	31.6	44.3
Primary education	12.1	15.6	28.6	20.5
Secondary education	42.7	27.5	33.1	29.6
Further education	21.1	4.9	6.8	5.6
Religion:				
Hindu	87.3	85.1	87.2	85.9
Buddhist	7.2	8.7	7.6	8.2
Islam	4.1	3.4	3.0	3.2
Christian	1.0	1.7	2.0	1.8
Kirat	0.4	1.1	0.2	0.8
Total (N)	**447**	**484**	**335**	**819**

Note: Percentages presented in the table are unweighted.
Source: STS maternity client exit interview and outpatient exit interview

3.2.5 Seeking Health Care

3.2.5.1 Decision Making in Seeking Health Care

Nearly three-fifths of maternity clients (59%) and 65% of outpatients seeking care were involved in the decision-making process in regard to seeking care. Around six in ten female clients were involved in such

decision making: 59% of maternity clients and 64% of outpatients. Other family members were also involved in deciding when to take mothers to a health facility for delivery: over two-thirds of husbands (67%) and over half of parents-in-law (51%).

A very small percentage of outpatients (0.7%) and maternity clients (4%) were dissatisfied with the decision-making process and its outcome. Among the maternity clients who had sought care, 63% had decided to go to the health facility during the first 12 hours of labour pain, and 21% before labour pain had begun. The remaining clients (16%) had only decided to visit the health facility after at least 12 hours of labour pain or after having experienced a complication following delivery (table not shown).

Table 3. 18: Distribution of Maternity Clients and Outpatients by Decision Making in Seeking Health Care

	Maternity clients (%)	Outpatients		
		Female (%)	Male (%)	Total (%)
Self	59.1	63.8	68.1	65.4
Mother/father	0.0	24.7	32.0	27.4
Husband	67.4	25.0	3.3	16.8
Parents	18.7	0.0	0.0	0.0
Parents-in-law	50.7	4.8	1.5	3.6
Son/daughter	0.1	6.3	3.3	5.2
Brother/sister	7.1	3.8	3.9	3.8
Brother-/sister-in-law	15.3	2.3	0.7	1.7
Other relative	9.6	2.5	8.6	4.8
Female Community Health Volunteer (FCHV)	7.7	6.1	1.2	4.2
Village Health Worker (VHW)	0.3	0.3	0.2	0.2
Wife	0.0	0.2	3.3	1.4
Friend/neighbour	0.7	0.7	1.6	1.0
Health worker	0.1	0.0	0.2	0.1
Total clients (N)	**447**	**484**	**335**	**819**

Note: Percentages presented in the table are unweighted/percentage total may exceed 100 as a result of multiple responses.
Source: STS maternity client exit interview and outpatient exit interview

3.2.5.2 Accessing the Health Facility

Three in ten maternity clients (30%) had used an ambulance to access delivery care; public transport (16%) and private vehicles (16%) were the next most popular modes of transportation. However, a sizeable percentage of maternity clients had walked (15%) to reach the health facility. As expected, none of the patients visiting the general outpatient department had used an ambulance to reach to the health

facilities. Most (83%) outpatients had visited the health facility by foot, suggesting that most had attended a health facility within walking distance of their home. Rickshaws, rickshaw ambulances, bullock carts, and stretchers/dokos had also been used by maternity clients as means of transportation for seeking maternity care (Table 3.19).

Table 3. 19: Mode of Transportation Used by Maternity Clients and Outpatients in Reaching Health Facility

	Maternity clients (%)	Outpatients		
		Female (%)	Male (%)	Total (%)
Ambulance	30.4	0.0	0.0	0.0
Private vehicle	15.6	1.5	1.4	1.5
Public transport (bus, minibus, etc.)	16.2	9.1	7.0	8.3
Rickshaw	4.5	0.4	0.3	0.3
Rickshaw ambulance	4.4	0.0	0.0	0.0
Bullock cart/horse cart	3.0	0.0	0.0	0.0
Carried (e.g. stretcher, doko)	4.3	0.9	0.0	0.6
Bicycle	0.0	4.4	10.7	6.8
Walking	15.1	84.2	81.0	83.0
Taxi/van/rented	9.7	0.0	0.0	0.0
Motorcycle	0.7	0.0	0.0	0.0
Tractor	0.2	0.0	0.0	0.0
Total clients (N)	**447**	**484**	**335**	**819**

Note: Percentage total may exceed 100 as a result of multiple responses
Source: STS maternity client exit interview and outpatient exit interview

Outpatients were asked if the opening and closing hours of the facility were convenient for them. Nearly three-quarters (73%) reported that the opening and closing hours of the facilities were convenient to them. However, nearly one-fifth (18%) said that only the opening hours were convenient for them. There is little difference between the perceptions of male and female clients regarding opening hours (Table 3.20).

Table 3. 20: Convenience of Opening and Closing Times of Health Facilities for Outpatients

Convenience of opening times	Female (%)	Male (%)	Total (%)
Yes, both are convenient	73.5	73.3	73.4
Yes, only opening hour is convenient	18.8	15.5	17.6
Yes, only closing hour is convenient	0.9	3.3	1.8
Inconvenient	6.8	7.8	7.2
Total	**484**	**335**	**819**

Source: STS outpatient exit interview

The distance from clients' homes to the health facility, transportation costs incurred in reaching the health facility, and the time taken to reach the facility were recorded (Table 3.21). Among the maternity clients and outpatients who knew the distance (in kilometres) travelled to reach to the health facility, the median distance from the home to the health facility was eight kilometers for maternity clients, and one kilometre for outpatients. It took maternity clients on average 30 minutes to reach the health facility, compared to 20 minutes for outpatients. Maternity clients had paid more for transportation (median=NPR 600) than outpatients (median=NPR 50), reflecting the above finding that outpatients were more likely to have walked and maternity clients were more likely to have used ambulance services.

Table 3. 21: Distance, Cost of Transportation, and Time Taken to Reach Facility

	Maternity clients	Outpatients		
		Female	Male	Total
Distance (km):				
Median	8.0	1.0	2.0	1.0
First quartile	2.0	1.0	1.0	1.0
Third quartile	22.7	5.0	4.0	4.0
Total maternity and outpatients (N)	**243**	**244**	**214**	**458**
Cost (NPR):				
Median	600.0	50.0	30.0	50.0
First quartile	200.0	30.0	20.0	25.0
Third quartile	1,500.0	114.7	100.0	100.0
Total clients who had paid for transport (N)	**314**	**80**	**44**	**124**
Time taken (min):				
Median	30.0	20.0	20.0	20.0
First quartile	15.0	10.0	10.0	10.0
Third quartile	61.2	30.0	45.0	45.0
Total clients (N)	**447**	**484**	**335**	**819**

Source: STS maternity client exit interview and outpatient exit interview

Most maternity clients (99%) were accompanied to the facility, while many male (53%) and female (40%) outpatients attended alone (Table 3.22). Maternity clients were most commonly accompanied by their husbands (63%), other family members or relatives (55%), and/or their mothers- or fathers-in-law (47%). Meanwhile, a greater proportion of female outpatients (23%) were accompanied by their mothers/fathers than male outpatients (14%).

Table 3. 22: Distribution of Companions Accompanying Maternity Clients and Outpatients

Companion	Maternity clients (%)	Outpatients		
		Female (%)	Male (%)	Total (%)
Husband	63.4	10.3	0.1	6.5
Other family member/relative	55.4	11.4	10.0	10.9
Mother-/father-in-law	47.0	2.3	0.0	1.4
Mother/father	23.9	14.6	23.4	17.9
Friend/neighbour	6.0	3.0	3.8	3.3
FCHV	3.8	1.0	0.2	0.7
Son/daughter	0.0	9.4	5.1	7.8
Brother/sister	0.0	6.8	4.3	5.9
Brother-/sister-in-law	0.0	6.3	0.3	4.0
Wife	0.0	0.0	3.6	1.4
Self/no other person	0.4	40.3	53.3	45.2
Total clients (N)	**447**	**484**	**335**	**819**

Note: Percentage total may exceed 100 as a result of multiple responses
Source: STS maternity client exit interview and outpatient exit interview

3.2.5.3 Barriers Faced Prior to Arrival at Health Facility

Difficulty in obtaining permission to seek care was not a major issue among maternity clients or outpatients. However, difficulty in travelling during pregnancy/labour/after delivery (71%) and the length of time taken travelling to the health facility (39%) were identified as major problems faced by maternity clients prior to arrival. The main difficulties experienced by outpatients prior to arrival were: long travel times (28%); no one being available to accompany them (13%); and difficulty in finding transportation (10%).

Table 3. 23: Difficulties Faced by Maternity Clients and Outpatients Prior to Arrival at Health Facility

Difficulties	Maternity clients (%)	Outpatients		
		Female (%)	Male (%)	Total (%)
Difficulty travelling during pregnancy/labour/after delivery to reach health facility	71.0	6.5	0.0	4.0
Travel time to reach health facility too long	39.2	27.8	27.4	27.6
Difficulty in finding means of transportation	30.7	12.2	6.8	10.2
Total cost expensive	28.6	4.3	2.7	3.7
Travel costs expensive	26.9	4.2	3.3	3.9
No one available to care for child at home	8.5	4.9	3.0	4.2
Difficulty obtaining permission to seek care	6.4	2.6	0.5	1.8
No one available to accompany care seeker	5.5	11.0	15.0	12.5
No men available to transport care seeker	3.6	14.2	5.1	10.8
Total clients (N)	**447**	**484**	**335**	**819**

Source: STS maternity client exit interview and outpatient exit interview

3.2.6 Client Receipt of Services

More than three-quarters (78%) of outpatients had received general curative services (for fever, headache, minor injuries/wounds, weakness, abdominal pain, lethargy, dizziness, etc.). The different types of services received by outpatients are presented in Table 3.24.

Table 3. 24: Services Received by Outpatients

	Female (%)	Male (%)	Total (%)
General curative services	75.9	80.0	77.5
Diarrhoea	7.1	9.4	8.0
Acute respiratory infection	4.1	10.1	6.4
Antenatal Care (ANC)/Postnatal Care (PNC)	8.4	0.0	5.2
Ear, Nose, and Throat problem	4.0	3.5	3.8
FP services	5.1	0.9	3.5
Others	2.7	3.4	3.0
Chronic disease	2.7	1.7	2.3
Immunisation	2.5	1.0	2.0
Skin problem	2.0	1.4	1.7
Tuberculosis (TB)	1.1	1.1	1.1
Urinary Tract Infection	0.4	1.2	0.7
Total clients (N)	**484**	**335**	**819**

Note: Percentage total may exceed 100 as a result of multiple responses
Source: STS outpatient exit interview

Maternity clients were asked the reasons for choosing to deliver in a health facility; over two-thirds (68%) of clients felt that facility deliveries were safer than home deliveries. Similarly, around a quarter of

maternity clients reported that the presence of a SBA (28%) and the health facility's good reputation (23%) were the main reasons for delivering in the facility. Meanwhile, only 17% cited free delivery care and transport incentives (6%) as a reason for choosing a health facility delivery. Recommendations of health workers (16%), the health facility being nearby (14%) and the availability of female staff (5%) were other reasons mentioned by maternity clients.

Table 3. 25: Reasons for Choosing to Deliver in Health Facility by Maternity Clients

Reasons	Total (%)
Safer than home delivery	68.0
Presence of SBA	28.3
Health facility has a good reputation for delivery services	23.3
Delivery care is free	17.2
Health worker recommended	15.6
Nearby health facility	13.6
Provision of transport incentive	6.2
Had complication (i.e. before arriving at facility)	5.3
Female staff	5.1
Clients are treated well	2.4
For protection of mother and child	1.5
Health facility provide wide range of services	0.7
Recommendation of mother/family members	0.6
No other health facility is accessible	0.3
Friend/neighbour recommended	0.3
Did not deliver in facility	0.2
Same doctors from private institution deliver here	0.1
Referred by health facility	0.1

Note: Percentage total may exceed 100 as a result of multiple responses
Source: STS maternity client exit interview

Nine out of ten (90%) of the 447 maternity clients interviewed had had normal deliveries, 7% had been by Caesarean Section (CS), and 3% had been assisted, most of which were vacuum deliveries, with just 0.1% conducted using forceps.

Women who had experienced an assisted delivery or CS were asked the reason why, and their discharge slip was checked: nearly half (46%) of the women reported foetal distress, and over one-third reported prolonged labour (37%) as the main reason for not having anormal delivery (Table 3.26).

Table 3. 26: Mode of Delivery and Reason for Assisted Delivery/CS (Maternity Clients)

	Maternity clients (%)
Mode of delivery:	
Normal delivery	89.9
Forceps (instrument to pull baby out)	0.1
Vacuum (instrument to suck baby out)	2.8
CS	7.2
Total maternity clients (N)	**447**
Reason for assisted delivery/CS:	
Foetal distress (according to discharge slip/prescription)	45.9
Prolonged labour (according to discharge slip/prescription)	36.8
Maternal complication (according to discharge slip/prescription)	14.5
Previously had CS (according to discharge slip/prescription)	9.9
Breech presentation (according to discharge slip/prescription)	8.2
Multiple pregnancy (according to discharge slip/prescription)	3.1
Ask to delivery by CS (according to discharge slip/prescription)	2.9
Suffer from chronic disease (according to discharge slip/prescription)	0.0
Total maternity clients who had an assisted delivery or CS (N)	**43**

Source: STS maternity client exit interview

Maternity clients were interviewed about the duration of their labour: 78% of maternity clients had delivered their baby within 12 hours of the onset of labour, and 18% between 13 to 24 hours after labour had begun. Prolonged labour pain was experienced by only 3% of maternity clients. The average length of labour was ten hours (Table 3.27).

Table 3. 27: Duration of Labour

Duration of labour period (hours)	Maternity clients (%)
0–12	78.3
13–24	18.4
>24	3.3
Average length of labour (hours)	10.0
Total maternity clients (N)	**430**

Note: 17 cases are excluded because labour time was not known
Source: STS maternity client exit interview

3.3 KEY FINDINGS

- All the hospitals (100%) and 97% of PHCCs owned their buildings, compared to 82% of HPs and 72% of SHPs.
- More than half (54%) of PHCCs had a secure compound wall compared to 35% of HPs and 24% of SHPs.
- Fifty-seven per cent of hospitals had permanent accommodation that could hold five to ten nurses, but only 7% of PHCCs and 3% of HPs did.
- All hospitals and 97% of PHCCs had a separate delivery room, compared to 64% of HPs and 21% of SHPs.
- Almost one quarter of hospitals did not have functional women-only toilet facilities.
- The median time taken to reach the health facility was 30 minutes for maternity clients and 20 minutes for outpatients.
- Sixty-three per cent of maternity clients were accompanied to the health facility by their husbands.
- Most maternity clients (90%) had a normal delivery, with 7% having a CS.

CHAPTER 4: FREE HEALTH CARE

4.1 INTRODUCTION

The Interim Constitution of Nepal 2063 has emphasized that every citizen has the right to basic health services free of cost as provided by the law. The objectives of the free health care policy are: to secure the rights of citizens to health services; to increase access to health services, especially for the poor, ultra-poor, destitute, disabled, senior citizens, and FCHVs; to reduce morbidity and mortality, especially of the poor, marginalized, and vulnerable people; to secure the responsibility of the state towards the people's health services; to provide high-quality EHCS effectively; and to provide equity of health services. Some of the landmarks reached in the Free Health Care Programme by the GoN include:

2006: the poor, people living with disabilities, senior citizens, and FCHVs became eligible for free emergency and inpatient services in district hospitals (up to 25 beds) and PHCCs.

2008: all citizens became eligible for free health care at HPs and SHPs.

2009: all citizens became eligible for selected essential drugs (Annex C: Essential drug, Table C1) and delivery care. Targeted population groups (poorer people, poor/destitute/helpless people, people living with disabilities, senior citizens (60+ years), and FCHVs) became eligible for all services at district hospitals (up to 25 beds) free of charge.

At present, according to government policy, range of services are provided free of cost for all citizens in public health facilities. The services include: FP, immunisation, ANC, delivery care, PNC, Integrated Management of Childhood Illness (IMCI), TB, leprosy, malaria, kala-azar, lymphatic filiariasis, and HIV/AIDS and Sexually Transmitted Disease (STD) diagnosis and treatment.

This chapter describes the provision of free health care services, clients' knowledge about free health care services, and payment made by clients for various free health care services. A total of 819 outpatients were interviewed from nine district hospitals, 39 PHCCs, 100 HPs, and 68 SHPs. The findings were disaggregated by type of the health facility, ecological zone, and caste/ethnicity.

4.2 RESULTS

Table 4. 1: Indicators under Free Care in NHSSP LF STS 2013

Indicators	STS 2011	95% CI	STS 2012	95% CI	STS 2013	95% CI
% of outpatients aware of entitlement to free care	92.1	83.1–96.6	93.2	88.8–95.8	88.8	71.2–96.2
% of Dalit and Janajati outpatients aware of entitlement to free care	80.6	50.3–94.3	91.2	84.3–95.7	90.8	64.3–98.2
% of outpatients who paid for care under the free care policy	11.3	6.2–19.7	20.6	14.1–29.0	10.0	2.2–36.1
% of Dalit and Janajati outpatients who paid for care under the free care policy	5.5	2.4–12.4	20.3	12.1–29.5	8.6	1.5–36.2

4.2.1 Awareness of Free Health care

Overall, 89% of outpatients were aware of free health care. Outpatients from the mountain region (93%) were more likely to be aware about entitlement to free health care than those from the hill (91%) and Terai (86%) regions, which is statistically significant (Table 4.2). The awareness of free care prior to the arrival at a health facility is significantly associated with ecological zone (p=0.002). Friends/neighbours were the main source of information about free care to outpatients from mountain (55%) and Terai (54%) regions, while facility staff were the main source of information for outpatients from the hill region (32%).

Table 4. 2: Awareness of Free Health Care among Outpatients, by Ecological Zone

	Mountain (%)	Hill (%)	Terai (%)	Total (%)	*p*
Aware of entitlement to free health care	93.4	90.8	85.9	88.8	0.006
Aware to free health care prior to arriving at facility	92.3	78.1	81.8	81.1	0.002
Total outpatients (N)	**136**	**338**	**345**	**819**	
Source of information:*					
Friend/neighbor	54.9	30.9	53.6	43.1	
Family members/relatives	48.3	27.1	46.0	37.3	
Health provider	37.8	23.2	36.0	30.2	
Facility staff	25.7	32.2	21.9	27.1	
FCHV	17.8	23.6	14.3	19.0	
Radio/FM	19.2	14.0	11.3	13.3	
Television	1.4	6.9	6.4	6.1	
Self/study	3.3	4.2	0.3	2.4	
District health office	0.0	4.3	0.9	2.4	
Poster/pamphlet	0.6	1.2	0.5	0.9	
Citizen's Charter	3.2	0.0	0.2	0.4	
Others (public hearing/HDC/Nongovernmental Organisation (NGO))	0.0	1.0	0.0	0.4	
Total outpatients aware of free care (N)	**127**	**280**	**283**	**690**	

**Percentage total may exceed 100 as a result of multiple responses; Source: STS outpatient exit interview*

There was little difference in the level of awareness of free health care among outpatients by caste/ethnicity (p>0.05). Similarly, there was little difference in awareness of free care prior to arrival at the health facility among outpatients by caste/ethnicity (Table 4.3). When clients were asked about their source of information about free care, 54% of Terai/Madhesi, 44% of Brahmin/Chhetri and 43% of Janajati clients mentioned friends/neighbours, while around two-thirds (68%) of Muslim and 44% of Newar clients mentioned health providers, and 32% of Dalit clients mentioned facility staff.

Table 4. 3: Awareness of Free Health Care among Outpatients, by Caste/Ethnicity

	Brahmin/Chhetri (%)	Terai/Madhesi other caste (%)	Dalit (%)	Newar (%)	Janajati (%)	Muslim (%)	Total (%)	*p*
Aware of entitlement to free health care	87.9	85.6	91.0	84.9	91.5	95.2	88.8	0.406
Aware of free health care prior to arriving at facility	84.6	83.1	76.1	84.9	75.5	95.2	81.1	0.603
Total outpatients (N)	**331**	**142**	**136**	**26**	**164**	**20**	**819**	
Source of information:*								
Friend/neighbour	43.7	53.5	29.1	21.9	43.2	65.4	43.1	
Family members/relatives	33.2	46.8	29.3	39.2	35.0	71.3	37.3	
Facility staff	30.0	22.2	32.4	20.2	28.3	2.8	27.1	
FCHV	26.6	14.2	28.1	3.4	10.8	0.0	19.0	
Health provider	26.8	34.8	30.3	43.7	22.7	68.3	30.2	
Radio/FM	21.1	6.9	12.1	0.0	13.0	5.5	13.3	
Television	10.5	3.5	4.9	14.3	3.1	2.7	6.1	
D(P)HO	6.6	0.0	0.0	0.0	0.0	11.4	2.4	
Poster/pamphlet	1.5	0.0	1.3	0.0	0.8	0.0	0.9	
Citizen's Charter	1.3	0.0	0.0	0.0	0.0	0.0	0.4	
Self/study	1.6	0.0	4.9	0.8	4.3	0.0	2.4	
Public hearing	0.0	0.0	1.7	0.0	0.0	0.0	0.3	
HDC	0.4	0.0	0.0	0.0	0.0	0.0	0.1	
Total outpatients aware of free care (N)	**281**	**119**	**115**	**18**	**139**	**18**	**690**	

**Percentage total may exceed 100 as a result of multiple responses*
Source: STS outpatient exit interview

4.2.2 Payments for Free Care by Outpatients

Table 4.4 illustrates the money paid by outpatients when seeking care. In total, nearly one in five (19%) outpatients had paid money for the services they had sought. Almost all outpatients from hospital (97%) and one-fifth from PHCCs (21%) had paid for the services they had sought; however, all 135 outpatients

at SHPs had received free care. Payments made for services sought by outpatients were significantly associated with ecological zone and caste/ethnicity (p<0.05). Outpatients who had paid were asked whether they had been asked to pay or had paid voluntarily. A high number of clients (nine out of ten) who had paid had been asked to pay at hospitals, PHCCs, and HPs. When asked about the reasons for having paid, outpatients from hospitals pointed to payments for registration fees (82%) and medicine (60%), while PHCC outpatients had had to pay for laboratory services (48%) and registration fees (44%). Compared to the hill region (48%), a greater proportion of outpatients from mountain (61%) and Terai (65%) regions had paid for registration.

Table 4. 4: Services Paid for by Outpatients

	Paid money for the service sought (%)	Total outpatients (N)	Was told to pay (%)	Paid for registration (%)	Paid for medicine (%)	Paid for laboratory services (%)	Paid for X-ray/ultrasound (%)	Total outpatients who paid for services (N)	*p*
Type of health facility:									
Hospitals	97.1	**222**	97.6	81.9	59.6	16.5	23.4	**217**	
PHCCs	20.8	**172**	92.8	43.7	29.0	47.5	0.0	**42**	
HPs	6.0	**290**	92.2	29.4	32.8	44.1	0.0	**18**	
SHPs	0.0	**135**	0.0	0.0	0.0	0.0	0.0	**0**	
Ecological zone:									0.022
Mountain	17.9	**136**	98.0	60.7	49.0	7.8	2.4	**34**	
Hill	19.8	**338**	98.3	47.9	57.4	15.2	15.9	**129**	
Terai	17.6	**345**	94.3	64.5	51.2	33.2	25.9	**114**	
Caste/ethnicity:									0.005
Brahmin/Chhetri	24.3	**331**	96.5	76.5	48.6	23.2	14.0	**133**	
Terai/Madhesi Other Caste	15.3	**142**	97.6	83.9	51.2	30.4	40.9	**36**	
Dalit	13.3	**136**	95.1	67.1	66.7	33.4	11.5	**34**	
Newar	14.9	**26**	100	95.3	84.1	4.7	0.0	**9**	
Janajati	19.7	**164**	98.5	59.5	56.2	9.2	15.3	**60**	
Muslim	12.9	**20**	74.0	100	45.6	28.3	28.3	**5**	
Total	18.6	**819**	96.6	73.7	54.0	22.2	18.9	**277**	

Source: STS outpatient exit interview

Table 4.5 presents the type of the services used and amount paid by outpatients for care by level of facility. The findings show that the median payment for registration fees was NPR 10 at hospitals, twice that reported by clients at PHCCs and HPs (NPR 5). Similarly, the median value for payments for medicine was higher at hospitals (NPR 195) than at PHCCs (NPR 150) and HPs (NPR 120). However, for

laboratory fees, no substantial differences were found between hospital (NPR 155) and PHCC clients (NPR 150). Overall, the charges for services were higher at hospitals than at lower-level facilities.

Table 4. 5: Service Type Used and Amount Paid by Outpatients for Care by Level of Facility (Median and Quartiles)

	Hospitals	PHCCs	HPs	Total
Registration fee (NPR):				
Median	10.0	5.0	5.0	10.0
1st quartile	10.0	5.0	5.0	5.0
3rd quartile	20.0	5.0	5.0	18.8
Total patients who paid registration fee (N)	**186**	**23**	**7**	**216**
Medicines (NPR):				
Median	195.0	150.0	120.0	180.0
1st quartile	90.0	61.3	67.5	90.0
3rd quartile	350.0	250.0	547.5	325.0
Total patients who paid for medicines (N)	**135**	**8**	**4**	**147**
Laboratory fee (NPR):				
Median	155.0	150.0	80.0	147.5
1st quartile	62.5	90.0	60.0	72.5
3rd quartile	292.5	230.0	142.5	250.0
Total patients who paid laboratory fee (N)	**32**	**19**	**9**	**60**
X-ray/ultrasound fee (NPR):				
Median	250.0	.	.	250.0
1st quartile	150.0	.	.	150.0
3rd quartile	500.0	.	.	500.0
Total patients who paid X-ray/ultrasound fee (N)	**47**			**47**

Source: STS outpatient exit interview

Reasons for payment for free services were sought from outpatients. The most common reasons for respondents having paid for services were: that they were told that medicines were not included on the free drug list (39%) and that registration fees were compulsory (31%). Three out of ten (31%) Brahmin/Chhetri patients reported that registration fees were compulsory, and 30% reported that the medicine that they bought was not included in the free drug list; 30% stated that they would not receive any services unless they paid. Similarly, around two-thirds of Janajatis reported that the medicine they bought was not included on the free drug list (35%) or were told that they would not get treatment unless they paid (29%). Likewise, 36% of Dalits reported that medicines were not included on the free drug list, while one-third reported that the registration fee was not free-of-charge (37%).

More than half of outpatients from the mountain region (54%), 20% of those from the Terai and 17% from the hill region reported that they were told that they would not get treatment unless they paid. Two-fifths (40%) of the patients from the hill region reported that the medicine was not included on the

free drug list, and 36% were compelled to pay a registration fee. Other reasons for making payments for services in facilities are described in Table 4.6, disaggregated by caste and ecological zone.

Table 4. 6: Reasons for Payment for Health Care by Caste and Ecological Zone

Reasons for payment	Medicine not included in free drug list (%)	No free drugs in stock (%)	I was told I would not get treatment unless I paid (%)	I was told I was not eligible for free services (%)	I was told that free services were not available at this facility (%)	Registration fee was compulsory (%)	I was told to buy medicine (%)	I was asked to help the institution (%)	Free health services were not available (%)	I found everybody paying for services (%)	Total outpatients who paid for registration and medicine (N)
Caste/ethnicity											
Brahmin/Chhetri	30.0	2.9	29.5	1.8	9.0	30.5	1.1	0.0	0.8	1.2	**80**
Terai/Madhesi other caste	78.1	25.9	1.6	0.0	22.5	28.1	7.5	0.0	0.0	0.0	**16**
Dalit	36.2	10.3	0.0	1.1	25.3	37.3	13.0	0.0	0.0	0.0	**17**
Newar	37.4	0.0	0.0	0.0	0.0	62.6	0.0	0.0	0.0	0.0	**2**
Janajati	35.3	0.9	29.2	2.4	4.9	25.6	5.4	1.6	0.0	0.0	**36**
Muslim	19.6	52.1	28.3	0.0	0.0	52.1	0.0	0.0	0.0	0.0	**5**
Ecological zone											
Mountain	19.1	2.4	53.8	0.0	20.7	16.5	2.0	0.0	0.0	0.0	**23**
Hill	40.4	0.0	16.8	0.0	3.4	36.7	5.5	0.8	0.7	1.0	**73**
Terai	42.4	22.1	19.9	4.0	19.7	26.4	3.6	0.0	0.0	0.0	**60**
Total	**39.1**	**8.7**	**21.7**	**1.5**	**11.4**	**30.7**	**4.4**	**0.4**	**0.4**	**0.5**	**156**

Note: Percentage total may exceed 100 as a result of multiple responses
Source: STS outpatient exit interview

4.3 KEY FINDINGS

Awareness of free care

- Most outpatients (89%) knew that they were entitled to free care which was 89% in STS 2013, 93% in STS 2012 and 90% in STS 2011.
- The awareness about entitlement to free care prior to the arrival at health facility is significantly associated with ecological zone ($p<0.05$) as found by STS 2013 as well as STS 2012 and STS 2011. Higher proportion of outpatients from mountain and hill were more aware than those of Terai.
- Friends/neighbours were the most common sources of information on free care for outpatients in 2013 and in 2011, but there was a big decline in the percentage reporting this between the

two surveys which was 61% in 2011 and 43% in 2013. Likewise, family members were the second most common source in 2011 (33%) and 2013 (37%).

Payment made for free care

- Despite the provision of free care, STS 2013 found that 19% of outpatients had paid for care that should have been provided free of charge, although the percentage has reduced since STS 2011 (31%).
- None of the outpatients seeking care from SHPs had paid for the services they had received. Outpatients were most commonly charged for registration fees in all levels of health facilities (60% of hospitals, 9% of PHCCs, and 2% of HPs) and free medicines (47% of hospitals, 7% of PHCCs, and 1% of HPs). Nearly all (98%) of the outpatients who had paid for services in hospitals had been requested to pay for the services received.
- The discrepancies above are in part explained by the fact that free health care is specific to certain facilities and to certain goods and commodities and for some items there are no written guidelines or stipulated procedures which leads to charges but not everything is free and for greater clarity and understanding it is recommended guidelines are developed and made public and in the case of the poor exemption procedures detailed.

CHAPTER 5: AAMA PROGRAMME

5.1 INTRODUCTION

The Aama Programme was established in 2005 under the name the Maternity Incentive Scheme (MIS) and later renamed as the Safe Delivery Incentive Programme (SDIP). This programme provided incentives to women who deliver in health facilities. In 2009, the government removed user fees for all delivery services at government health institutions nationwide and merged two schemes. These two components and the Four Antenatal Care Visits Programme (4ANC) incentive payments were merged in 2012 and are now commonly known as the Aama Programme. This programme aims to reduce barriers that prevent service users from accessing care as required. The schemes ultimately target the poor and underserved so as to increase access to essential maternal health services and to enhance equity in service utilization.

The Aama Programme focuses on four major components:

I. **Transport incentives for institutional delivery:** A cash payment is made to women immediately at the time of discharge following institutional delivery: NPR 1,500 in the mountain region, NPR 1,000 in the hill region, and NPR 500 in the Terai region.

II. **Free institutional delivery services:** A payment is made to the health facility to ensure the provision of free delivery care. For a normal delivery, health facilities with fewer than 25 beds receive NPR 1,000, and health facilities with 25 or more beds receive NPR 1,500. For complicated deliveries, health facilities receive NPR 3,000, and for CSs they receive NPR 7,000. Unit costs for management of some complications and CSs can also be claimed.

III. **Financial incentives after completion of 4ANC:** A cash payment of NPR 400 is made to women on completion of four ANC visits (during the 4th, 6th, 8th and 9th months of pregnancy), following institutional delivery, and at their first PNC visit.

IV. **Incentives to health workers for home deliveries:** A cash payment of NPR 100 is made to health workers who attend home deliveries. Copies of birth registrations or death certificates need to be produced to claim an incentive for home deliveries.

This chapter reviews the information regarding maternal health gathered from 135 health facilities implementing the Aama Programme and 447 exit client interviews with maternity clients. The health facilities that were included in the study but were not implementing the Aama Programme have been

excluded from the analysis. This chapter includes findings from the health facility tool and maternity exit interviews. The health facility tool reviews all the components within the Aama Programme: transport incentives for both delivery and ANC, unit costs for health facilities, home delivery incentives, types of deliveries conducted by health facilities, and the financial aspects of the programme. The exit interviews review: the level of knowledge among women about the Aama Programme; clients' perspectives towards the programme; women's involvement in the decision-making process; barriers while seeking, reaching, and receiving care; and financial costs of delivery at health facilities.

5.2 RESULTS

Table 5. 1: Indicators under Aama Programme in NHSSP LF STS 2013

Indicators	STS 2011	95% CI	STS 2012	95% CI	STS 2013	95% CI
% of hospitals, PHCCs, and HPs implementing Aama	88.0	77.2–94.1	67.0	42.1–85.0	76.8	59.9–80.0
% of maternity clients aware of transport incentive	81.4	54.3–94.2	90.9	86.6–94.3	82.8	73.9–89.1
% of Dalit and Janajati maternity clients aware of transport incentive	82.8	55.2–95.0	85.8	75.3–92.2	75.9	63.9–84.9
% of maternity clients aware of free delivery care	78.3	43.2–94.5	92.9	88.3–96.0	82.4	78.6–85.5
% of Dalit and Janajati maternity clients aware of free delivery care	83.1	47.6–96.4	91.5	79.5–96.7	81.2	69.2–89.3
% of maternity clients who paid for delivery care	50.3	25.2–75.2	12.2	6.7–21.2	56.4	36.7–74.3
% of Dalit and Janajati maternity clients who paid for delivery care	57.3	20.4–84.0	7.5	4.0–15.9	60.3	38.0–78.9

5.2.1 Aama Programme Implementation

One-third (33%) of health facilities were implementing the Aama Programme. All of the district-level hospitals (100%) and PHCCs (100%), along with most HPs (68%) and some SHPs (19%), were implementing the Aama Programme. During the survey, 25% of higher-level hospitals (two) were not implementing the Aama Programme. In facilities implementing the Aama Programme, staff at almost all hospitals, HPs, and SHPs reported that they always provided transport incentives. However, staff at 5% of PHCCs reported that they had never provided transport incentives even though they were implementing the Aama Programme (Table 5.2).

There is a provision within the programme for incentive payments to health workers who provide delivery services at home. The complexities of submitting birth certificates to receive home delivery

incentives, however, may explain why most of the health facilities reported that they did not offer home delivery incentives.

Table 5. 2: Health Facilities Implementing Aama by Type

	Higher-level hospitals (%)	District hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)	Total (%)
Facilities implementing Aama Programme	75.0	100	100	68.0	19.1	32.9
Total facilities (N)	**8**	**9**	**39**	**100**	**68**	**224**
Provide transport incentives:						
Always	100	88.9	94.9	100	100	98.8
Sometimes	0.0	11.1	0.0	0.0	0.0	0.4
Never	0.0	0.0	5.1	0.0	0.0	0.8
Offer cash incentives to health workers attending home deliveries:						
Always	0.0	0.0	5.1	4.4	7.7	5.7
Sometimes	0.0	0.0	0.0	0.0	7.7	3.4
Never	100	100	94.9	95.6	84.6	90.9
Total facilities implementing Aama Programme (N)	**6**	**9**	**39**	**68**	**13**	**135**

Source: STS facility questionnaire

5.2.2 Procedure Used to Claim Transport Incentives

When asked about the procedure for claiming transport incentives, staff at all higher-level health facilities and district hospitals, along with 97% of those at PHCCs, 96% of those at HPs, and 92% of those at SHPs, reported that forms had to be completed to claim transport incentives (Table 5.3). Some facilities reported that ANC cards needed to be submitted to claim delivery transport incentives, although guidelines stipulate that such submissions were only necessary for ANC incentive claims.

Table 5. 3: Procedures to Claim Transport Incentives

	Higher-level hospitals (%)	District hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)	Total (%)
Fill out form	100	100	97.3	95.6	92.3	94.7
Show ID card	16.7	33.3	40.5	32.4	30.8	32.5
Show ANC card	83.3	55.6	70.3	73.5	92.3	81.0
Total facilities implementing Aama Programme (N)	**6**	**9**	**37**	**68**	**13**	**133**

Note: The two PHCCs were not providing transportation incentives at the time of survey because they hadn't yet received budget from the district. These two PHCCs were therefore not included in the analysis.
Source: STS facility questionnaire

5.2.3 Disclosure of Aama Beneficiaries

According to the Aama Programme Guidelines, the names of service recipients who have received Aama incentives should be disclosed in public places in order to increase demand and transparency. It was observed that lower-level health facilities (i.e. SHPs (69%) and HPs (65%)) were more likely to disclose lists of Aama beneficiaries in public places than district hospitals (56%), PHCCs (54%), and higher-level hospitals (50%). About 22% of the HPs and district hospitals had a list available but had not disclosed it to the public. Likewise, one-third of higher-level hospitals and 11% of district hospitals had not maintained a list of beneficiaries (Table 5.4).

Table 5. 4: Disclosure of Aama Beneficiaries

	Higher-level hospitals (%)	District hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Disclosed list of Aama beneficiaries:					
Disclosed list to public	50.0	55.6	53.8	64.7	69.2
List available, but not disclosed to public	0.0	22.2	17.9	22.1	15.4
Reportedly kept list, but not seen	16.7	11.1	17.9	5.9	15.4
Did not maintain list	33.3	11.1	10.3	7.4	0.0
Total facilities implementing Aama Programme (N)	**6**	**9**	**39**	**68**	**13**

Source: STS facility questionnaire

Of those facilities that had disclosed lists of Aama beneficiaries, 67% of higher-level hospitals, 75% of district hospitals, 56% of PHCCs, 46% of HPs, and 56% of SHPs had disclosed their names in HFOMC meetings. The standard practice recommended by the guidelines is to display beneficiaries on health facility notice boards; all district hospitals, 78% of HPs, 75% of PHCCs, and 33% of higher-level hospitals and SHPs had disclosed a list of beneficiaries on facility notice boards.

Table 5. 5: Place where Information Related to Aama Programme Beneficiaries is Disclosed

	Higher-level hospitals (%)	District hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Public display of Aama beneficiaries	50.0	55.6	53.8	64.7	69.2
Total facilities implementing Aama Programme (N)	**6**	**9**	**39**	**68**	**13**
Place disclosed:*					
During HFOMC meeting	66.7	75.0	56.3	46.3	55.6
Facility notice boards	33.3	100	75.0	78.0	33.3
VDC/District Development Committee (DDC) notice boards	0.0	0.0	0.0	4.9	0.0
Annual VDC/DDC gathering	0.0	25.0	6.3	9.8	22.2
Community gathering at health facility	0.0	0.0	0.0	2.4	10.0
Others	0.0	0.0	0.0	14.6	22.2
Total facilities disclosed Aama beneficiaries (N)	**3**	**4**	**16**	**41**	**9**

**Percentage totals may exceed 100 as a result of multiple responses*
Source: STS facility questionnaire

5.2.4 Amount Received vs. Amount Paid

Table 5.6 shows the amounts that each level of facility received from the centre and paid to service recipients as per the travel incentive scheme of the Aama Programme. A greater proportion of 4ANC funds received from the centre was paid to service recipients by PHCCs (101%) and higher-level hospitals (100%) than by SHPs (96%), HPs (94%), and district hospitals (83%). In the case of transport incentives, HPs paid out 109% of funds received from the centre, while district hospitals, PHCCs, and HPs paid out 98%. HPs had paid transportation incentives from their own health management committee fund as there had been a delay of more than four months in releasing budget from central level; hence over one hundred per cent payment of transportation incentives was observed in HPs. During the Aama Programme rapid assessment, a few health facilities mentioned that the considerable delay in receiving funds from the central level resulted in their using money from other sources as well.

Table 5. 6: Amount Received and Paid out under 4ANC and Travel Incentive Schemes, by Facility Level

	4ANC					Transport				
	Higher-level hospital	District hospital	PHCCs	HPs	SHPs	Higher-level hospital	District hospital	PHCCs	HPs	SHPs
Total received (NPR)*	2,604,800	969,600	1,128,600	1,254,800	108,000	14,239,500	5,825,500	4,385,500	4,543,000	460,600
Total paid out (NPR)*	2,604,800	807,600	1,136,800	1,173,600	103,200	10,162,350	5,698,000	4,309,300	4,945,500	451,600
% of received money that has been paid out**	100.0	83.3	100.7	93.5	95.6	71.4	97.8	98.3	108.9	98.0
Total clients (N)	6,512	2,915	4,327	4,966	329	2,604,800	807,600	1,136,800	1,173,600	103,200
Total facilities implementing Aama (N)	**6**	**9**	**39**	**68**	**13**	**6**	**9**	**39**	**68**	**13**

**Note: Six facilities are excluded from this analysis as they lacked complete records, although they were implementing the Aama Programme.*

***The percentage exceeds 100 in PHCCs and HPs because the health facilities had paid a greater amount to maternity clients than they had received as expected from the centre. They managed to pay the incentives from other sources: some health facilities had taken loans and/or drawn money from other programmes or their own personal accounts.*

Source: STS facility questionnaire

5.2.5 Receipt of Institutional Costs by Facility

One-third (33%) of district hospitals, 18% of HPs, and 8% of SHPs had not received institutional costs for FY 2069/70 (Table 5.7). Health facilities were asked about the reasons for not having received the entire institutional costs. Of those facilities which had not, two-thirds of hospitals (67%), one-fifth of PHCCs (20%), and one-quarter of HPs (25%) reported that they had not claimed at all. Similarly, one-third of the hospitals (33%), and around a quarter of PHCCs (27%) and HPs (25%), reported that they had not claimed at the right time. One-third of the HPs (33%) and 13% of PHCCs reported having no budget in the district. Other reasons reported by PHCCs and HPs were that complete reports were not submitted and that budget was not released from the district; a few HPs had not conducted any deliveries and were therefore not entitled to receive the entire amount.

Table 5. 7: Facility Did Not Receive Entire Amount of Institutional Costs (FY 2069/70)

	Higher-level hospitals (%)	District hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Facilities did not receive entire amount (institutional costs)	0.0	33.3	38.5	17.6	7.7
Total facilities implementing Aama Programme (N)	**6**	**9**	**39**	**68**	**13**
Reason for not receiving the entire amount:*					
Programme had money deficit		0.0	6.7	8.3	0.0
Did not claim at right time		33.3	26.7	25.0	0.0
Did not claim at all		66.7	20.0	25.0	0.0
No budget in district		0.0	13.3	33.3	0.0
Others		0.0	26.7	8.3	100
Don't know		0.0	6.7	0.0	0.0
Total facilities that did not receive entire institutional costs amount (N)		**3**	**15**	**12**	**1**

**Percentage total may exceed 100 as a result of multiple responses*
Source: STS facility questionnaire

5.2.6 Awareness of Aama Programme

Free Delivery Services

Women from the mountain region (92%) had higher levels of awareness of free delivery care than those in the Terai (83%) and hill (79%) regions. Most women from mountain (93%), hill (87%), and Terai (86%) districts were aware of free delivery care prior to arrival at the health facility. Brahmin/Chhetri women (90%) were more likely to have been aware of free delivery care than other castes (Table 5.8). Women with a higher level of education (i.e. above secondary education) were more likely to be aware (95%) than those with secondary education (80%), primary education (83%), and who had never attended school (79%). However, awareness of free delivery care among the maternity clients was not significantly associated with ecological region, caste/ethnicity, or level of education (p>0.05).

Similarly, among maternity clients who were aware of free care, there was not any marked difference observed in the awareness of free delivery care prior to arrival at health facilities by ecological zone, caste/ethnicity, or level of education (p>0.05).

Table 5. 8: Awareness of Free Delivery Care, by Ecological Region, Caste/Ethnicity and Educational Level

	Awareness of free delivery care (%)	*p*	Total maternity clients (N)	Awareness of free delivery care prior to arrival (%)	*P*	Total maternity clients aware of free delivery care (N)
Ecological zone:						
Mountain	92.1	*0.147*	38	92.5	*0.613*	36
Hill	78.7		106	87.3		88
Terai	83.1		273	85.9		232
Caste/ethnicity:						
Brahmin/Chhetri	89.6	*0.382*	146	88.2	*0.406*	132
Terai/Madhesi other caste	77.5		91	84.2		75
Dalit	84.3		68	87.7		56
Newar	86.9		10	100		9
Janajati	78.7		89	87.3		75
Muslim	79.2		13	80.7		9
Education:						
Never attended school	78.8	*0.083*	88	81.5	*0.279*	73
Primary education	82.5		54	87.1		44
Secondary education	80.2		196	86.6		166
Further education	93.4		79	93.3		73
Total	**82.4**		**417**	**86.7**		**356**

Note: 30 cases (from a hospital) are not included in analysis
Source: STS maternity client exit interview

Over two-fifths (44%) of the maternity clients reported that health care providers were a key source of information, along with friends/neighbours (37%), family members/relatives (35%), and FCHVs (33%). In the mountain and hill regions, FCHVs were the main source of information on free delivery care, while in the Terai region, health providers were the main source of information (Table 5.9).

Table 5. 9: Source of Information on Free Delivery Care

Sources	Mountain (%)	Hill (%)	Terai (%)	Total (%)
FCHV	40.3	41.4	28.2	32.6
Family member/relative	40.1	20.7	40.8	35.2
Friend/neighbour	34.4	31.2	39.7	37.0
Health provider	33.3	33.9	49.8	44.3
Facility staff	28.1	23.4	22.5	23.1
Husband	10.5	4.3	17.8	13.6
Radio/FM	7.9	19.2	3.2	7.9
Poster/pamphlet	2.6	2.0	2.4	2.3
Television	0.0	10.5	2.7	4.7
Self study/school	0.0	8.3	0.2	2.4
VDC	0.0	0.4	0.0	0.1
Total maternity clients aware on free delivery care (N)	**36**	**88**	**232**	**356**

Note: 30 cases (from a hospital) are not included in analysis/percentage total may exceeds 100 as a result of multiple responses
Source: STS maternity client exit interview

Transport Incentives

The survey sought information about awareness on transport incentives disaggregated by ecological region, caste/ethnicity, and educational status. Most women (99%) from the mountain region were aware of transport incentives, compared to 86% of those in Terai and 72% of those in hill districts. Most women from mountain and hill (92%) districts were aware prior to their arrival to the health facility; however, only 75% of women in the Terai were. The awareness of transport incentives varied significantly by ecological zone, caste/ethnicity, and educational level of maternity clients (p<0.05). Similarly, significant differences were observed in the awareness of transport incentives prior arrival to the health facilities by ecological zone and caste/ethnicity of maternity clients, while awareness was not significantly associated with level of education of maternity clients (Table 5.10).

Table 5. 10: Awareness of Transport Incentive Care by Ecological Zone, Caste/Ethnicity, and Educational Level

	Awareness of transport incentive (%)	*p*	Total Maternity clients (N)	Prior to arrival (%)	*p*	Total maternity clients having awareness of transport incentive (N)
Ecological zone:						
Mountain	98.9	0.005	38	92.0	0.007	37
Hill	72.4		106	92.3		79
Terai	86.0		273	75.4		221
Caste/ethnicity:						
Brahmin/Chhetri	82.5	0.007	146	88.7	0.003	118
Terai/Madhesi other caste	90.7		91	69.7		82
Dalit	81.9		68	78.0		52
Newar	95.1		10	65.9		9
Janajati	70.5		89	88.5		65
Muslim	94.2		13	92.4		11
Education:						
Never attended school	91.4	0.051	88	79.1	0.284	77
Primary education	87.3		54	81.4		46
Secondary education	74.5		196	78.6		146
Further education	88.5		79	88.2		68
Total	**82.8**		**417**	**80.8**		**337**

Note: 30 cases (from a hospital) are not included in analysis
Source: STS maternity client exit interview

Table 5.11 presents the source of information on transport incentives. Overall, health providers (45%) were the main source of information, followed by friends/neighbours (35%). The most common disseminator of information on transport incentives varies across the ecological regions: FCHVs in the mountain (44%) and hill (34%) regions, and health providers in the Terai (52%) region.

Table 5. 11: Source of Information on Transport Incentives

Sources	Mountain (%)	Hill (%)	Terai (%)	Total (%)
FCHV	43.8	34.4	27.4	30.3
Friend/neighbour	42.6	27.2	36.4	34.5
Health provider	35.2	30.3	51.7	45.2
Family member/relative	19.4	6.3	33.0	25.3
Health facility staff	19.1	29.8	25.7	26.3
Radio/FM	7.4	18.5	7.0	10.0
Poster/pamphlet	2.4	1.6	2.9	2.6
Television	0.9	8.1	1.9	3.4
Self study/school		2.5	0.5	1.0
Total maternity clients who aware of transport incentive (N)	**37**	**79**	**221**	**337**

Note: 30 cases (from a hospital) are not included in analysis/Percentage total may exceed 100 as a result of multiple responses
Source: STS maternity client exit interview

5.2.7 Clients' Perceptions of Free Delivery and Transport Incentive Payments

Table 5.12 presents women's perceptions about the benefits of free delivery care and transport incentives. More than half (54%) of women mentioned that free delivery care encouraged women to deliver in a facility, and 37% of women said that free care enabled poorer women to deliver in a facility. However, 5% reported that there was nothing beneficial about free delivery care. With regards to transport incentive payments, 42% of women mentioned that it encouraged women to deliver in a facility, 40% mentioned that it covered all costs associated with delivery, nearly one-third (32%) reported that it enabled mothers and infants to have safe care, and 22% stated that it saved the lives of mothers and infants.

Table 5. 12: Perceived Benefits of Free Delivery Care and Transport Incentives

Perceived benefits of free delivery care	%	Perceived benefits of transport incentives	%
Encourages women to deliver in facility	54.3	Encourages women to deliver in facility	42.4
Enables poorer women to deliver in facility	36.6	Covers all costs associated with delivery	39.6
Makes facility deliveries possible for all	29.5	Safe care for mother and baby	31.7
Nothing good about it	4.8	Saves life of mothers and babies	22.4
Everything is good	4.3	Incentives cover some expenses	7.4
Saves life of mother and child	3.5	Nothing good about it	2.3
Incentive covers some expenses	2.4	Everything is good	1.6
Others	1.9	Poor women gain a greater benefit	0.8
Don't know	4.0	Don’t know	5.8
Total clients aware of free delivery care (N)	**356**	**Total clients aware of transport incentives (N)**	**337**

Note: Percentage totals exceed 100 as a result of multiple responses

Source: STS maternity client exit interview

Table 5.13 presents patients’ views on what is not good about free delivery care and transport incentive payments. More than one-third (34%) of women said that everything was good about free delivery. However, a quarter of the women reported that people were not aware of free delivery care, and 21% said that medicines were not being given free of charge. Regarding transport incentive payments, 29% of women said that everything was good. However, more than a quarter (26%) of the women said people were not aware of the incentive and that it did not cover all costs associated with delivery. Medicines were not free of charge, as reported by 13% of maternity clients.

Table 5. 13: Patients' View on What Is Not Good about Free Delivery and Transport Incentives

Free delivery care	**%**	**Transport incentives**	**%**
Everything is good	33.8	Everything is good	28.8
People are not aware of incentive	24.5	People are not aware of incentive	26.2
Medicines are not free of cost	21.1	Insufficient to cover all costs associated with delivery	25.5
Not beneficial to poor	11.0	Medicines are not free of cost	12.6
Staff still charge for services	8.3	Laboratory tests are not free	11.0
Laboratory services are not free	1.7	Not beneficial to poor	11.2
Others	2.8	Delay in receiving	3.1
Don't know	15.2	Incentive is not enough	2.4
		Does not provide incentive/difficult to get from providers	1.2
		Difficult to get full amount	1.2
		Men misuse the incentives/should not allow husband to receive	0.1
		Don't know	8.4
Total clients aware (N)	**356**	**Total clients aware (N)**	**337**

Note: Percentage total may exceed 100 as a result of multiple responses

Source: STS maternity client exit interview

5.2.8 Receipt of Transport Incentive Payments and Payment for Delivery Services by Maternity Clients

Receipt of transport incentives and payments for delivery expenses for delivery services by women were disaggregated by ecological zone, caste/ethnicity, and educational level. Overall, 83% of maternity clients had received transport incentives (Table 5.14). Looking at the ecological data, women from the Terai region (93%) were more likely to have received transport incentives than those from hill (67%) and mountain (42%) districts. Of those who had paid for services, all maternity clients from hill districts (100%), 94% from Terai districts, and 85% from mountain districts had been told to pay for delivery services. The receipt of transport incentives by maternity clients was significantly associated with ecological zone and caste/ethnicity (p<0.001).

The women who visited higher-level hospitals (86%), district hospitals (83%), and PHCCs (83%) were somewhat more likely to have received transport incentive payments than those visiting HPs (61%). With regards to delivery expenses, over four-fifths (84%) of women in district hospitals had paid delivery costs, compared to just under half (49%) in higher-level hospitals and just under one-fifth in PHCCs (18%) and HPs (18%). Payment made for delivery expenses was highly associated with the type of health facility (p=0.001). Similarly, clients being told to pay for services was also significantly associated with ecological zone, caste/ethnicity, and type of health facility (p<0.05).

Table 5. 14: Receipt of Incentive Payments and Payment for Delivery Care by Ecological Zone, Caste/Ethnicity, and Level of Health Facility

	Received transport incentive (%)	*p*	Paid delivery expenses (%)	*P*	Total maternity clients (N)*	Was told to pay (%)	*p*	Voluntarily offered to pay tips (%)	Both (%)	Total maternity clients who paid (N)
Ecological zone:										
Mountain	41.9		43.3		38	85.4		5.6	9.1	9
Hill	67.0	0.001	67.9	0.507	106	100	0.044	0.0	0.0	77
Terai	93.0		52.5		273	94.4		2.5	3.1	176
Caste/ethnicity:										
Brahmin/Chhetri	75.5		56.5		146	98.2		0.9	0.9	94
Terai/Madhesi other caste	97.8		50.9		91	94.0		5.9	0.2	54
Dalit	83.7	0.029	59.3	0.643	68	100	0.043	0.0	0.0	43
Newar	77.6		86.7		10	100		0.0	0.0	6
Janajati	69.6		58.9		89	91.4		0.0	8.6	55
Muslim	92.0		58.1		13	100		0.0	0.0	10
Type of health facility:										
Higher-level hospital	85.5		49.0		228	98.7		0.0	1.3	148
District hospital	83.4	0.323	83.8	0.001	129	96.7	0.000	2.6	0.7	100
PHCC	83.1		17.8		38	100		0.0	0.0	11
HP	61.1		18.0		20	0.0		14.7	85.3	3
SHP	0.0		0.0		2	0.0		0.0	0.0	0
Total	**82.6**		**56.4**		**417**	**95.9**		**1.8**	**2.3**	**262**

Source: STS maternity client exit interview

5.2.9 Reasons for Paying for Delivery Services

Over half (56%) of maternity clients had paid for delivery services, including treatment for maternal complications (Table 5.14). Staff at health facilities provided various reasons for requiring payment for delivery services. About 22% of clients reported that they had been told that there were no free drugs in stock and were compelled to pay for medicines. Similarly, 16% women reported paying for gloves, while 14% had paid as the health worker asked for payment. Furthermore, 13% of clients had paid for laboratory services and 12% for sanitary staff. Notably, 11% of women reported that they had been told they would not receive treatment unless they paid for services (Table 5.15).

Table 5. 15: Reasons for Paying for Delivery Services

Reasons for paying for delivery services among those who paid for services	%
No free drugs in stock	22.1
No knowledge about free delivery services	22.0
Had to buy gloves	15.7
Health worker asked to pay money	13.7
Laboratory service was not free	12.8
It was mandatory to pay to sanitary staff	11.8
Was told I would not get any treatment unless I pay	11.0
For birth certificate	7.7
Was told to buy sanitary pads	5.2
Prescribed drug was not free essential drug	4.4
Was told that free delivery service is not available at the facility	4.2
Registration fee was mandatory	2.6
Discharge fee	2.5
Was told to buy delivery instruments	1.9
Was told the facility was short of money	1.4
As tips	1.3
Was told that I was not eligible for free delivery service	0.9
Staff were not available at free drug distribution centre	0.8
For X-ray	0.8
Don't know	0.5
Total maternity clients who paid (N)	**262**

Note: Percentage total may exceed 100 as a result of multiple responses
Source: STS maternity client exit interview

Although the GoN has endorsed the Aama Programme, which offers free delivery care and transport incentive payments, 53% of women had paid for delivery services (excluding complication services). Table 5.16 shows that of the clients who had paid for services, 52% of clients had paid for medicine (which should be free of charge in all Aama-implementing health facilities), 29% had paid sanitation staff, 25% had paid for sanitary pads, and 24% had paid for registration.

Table 5. 16: Percentage of Maternity Clients Paying and Median Amount Paid by Reason for Payment

Paid for the service sought in health facility	Maternity clients (%)	Median (NPR)
Yes, for delivery services	52.7	
Yes, for complication services	2.5	
Yes, for both services	1.3	
Not paid for any of services	43.6	
Total maternity clients (N)*	**417**	
Paid for medicine	52.3	500
Paid to sanitation staff	28.5	200
Paid for sanitary pads	25.1	65
Paid for registration	24.4	10
Paid for gloves	18.3	80
Paid to sanitation staff as tips	10.3	200
Paid for delivery/CS	0.6	3,600
Paid for management of complication	1.7	930
Paid to health worker (tips)	0.4	550
Paid for delivery equipment	4.5	175
Paid for other item/service	58.0	175
Total maternity clients who paid for delivery (N)	**262**	**370**

**Note: 30 cases (from a hospital) are not included in analysis/percentage total may exceed 100 as a result of multiple responses*
Source: STS maternity client exit interview

5.3 KEY FINDINGS

Aama implementation

- All of the district-level hospitals (100%) and PHCCs (100%), along with most HPs (68%), were implementing the Aama Programme. The percentage of HPs implementing the Aama programme has increased since 2012 (53%).
- Even though SHPs are not obliged to implement the Aama Programme, the STS 2013 showed 19% are currently doing so voluntarily, with support from government. This has increased from STS 2012 (11%).
- STS 2013 found that all higher-level hospitals, HPs, and SHPs implementing the Aama Programme always provided transport incentives to maternity clients. This is a big improvement from STS 2012 for HPs (58%) and SHPs (50%).

Disclosure of Aama beneficiaries

- The disclosure of lists of Aama beneficiaries to the public in STS 2013 was relatively low at all levels of health facility. Nearly two third of HPs and SHPs while nearly half PHCCs, district and higher level hospitals were displaying Aama beneficiaries to public. Compared to 2012 there was a big improvement in the percentage of district hospitals (29%), HPs (48%) and SHPs (25%), displaying beneficiaries, however, no change was seen for higher level hospitals (50%), and a reduction in the % of PHCCs doing so (54%).
- Facility notice boards were the most common place for disclosing list of Aama beneficiaries at District hospitals (86%), and were also commonly used at PHCCs (61%) and HPs (70%). Higher-level hospitals (80%) and SHPs (50%) had commonly displayed lists of beneficiaries during HFOMC meetings in 2013.

Receipt of institutional costs

- STS 2013 found that one-third (33%) of district hospitals and 39% of PHCCs had not received institutional costs for the deliveries they had conducted. The reasons district hospitals for why they had not received funds included not submitting claims (67%) or not submitting claims on time (33%). Similar reasons were also reported by PHCCs, HPs, and SHPs. A third of HPs (33%) and 13% of PHCCs also reported a lack of budget at district level. As per STS 2012, comparatively less hospitals (14%) and PHCCs (17%) had not received the entire amount.

Awareness of Aama Programme

- Women residing in mountain districts (92%) were more likely to be aware of free delivery care than women from the Terai (83%) and hill (79%) districts, which is similar to the findings of STS 2011 (Mountain 100%, Hill 84% and Terai 78%). This may well be because of knowledge gained from a precursor programme, which was implemented mostly in mountain districts.
- There was no significant differences in awareness of free care or awareness of free delivery care prior arrival to the health facility by ecological zone, caste/ethnicity, or level of education ($p>0.05$).
- STS 2013 has shown that awareness of transport incentives and awareness before arrival to the facility were significantly associated with maternity clients' ecological zone and caste/ethnicity ($p<0.05$). However, no significant differences were reported by STS 2011 and 2012 between different ethnic groups and ecological zones.

Receipt and payment made for services

- Women from the Terai (93%) were more likely to have received transport incentive payments compared to those in hill (67%) and mountain (42%) regions (p=0.001). This is consistent with the findings of STS 2012 for the terai; (96%), but the percentage receiving in the hill (93%) and mountain districts (73%) is far lower in 2013.
- There is a significant difference in the likelihood of maternity clients paying for delivery services by type of health facility ($p<0.05$) in STS 2013. However, no significant differences between level of health facility and client payment for delivery expenses were reported in STS 2012 and STS 2011.
- In STS 2013 payments for delivery care were most common by maternity clients visiting district hospitals (84%) which was only 16% in STS 2012. Whereas in 2012, clients visiting SHPs were most common to pay for delivery service (33%).
- The three main reasons why maternity clients had paid for services were: unavailability of free drugs (22%), lack of knowledge about free delivery services (22%), and payment for gloves (16%).
- Findings of STS 2013 show that 53% of maternity clients had paid for delivery services. This is a large increase from STS 2012 (12%). In STS 2013 52% had paid for medicine (compared to 23% in 2012), 29% had made payments to sanitation staff (compared to 19% in STS 2012), and 25% had paid for sanitary pads, 24% for registration (compared to 49% in STS 2011), and 5% for delivery equipment.
- On average, in STS 2013 women had paid NPR 3,600 for delivery/CS services and NPR 930 for the management of maternal complications.

CHAPTER 6: FINANCIAL MANAGEMENT

6.1 INTRODUCTION

The MoHP realizes the importance of strengthening financial management practices across the nation and has endorsed the Financial Management Improvement Plan (FMIP). This plan intends to strengthen the MoHP's current practices in financial planning, accounting procedures, the internal control system, financial reporting, monitoring, and auditing, and transparency measures. It further intends to enhance the capacity of the human resources working in the planning and financial management sectors.

This chapter presents the financial management system of 222 health facilities. Two of the health facilities were excluded from the analysis as there was no responsible person to provide information on financial management during the data collection period. This section describes the sources of income, expenditure by health facilities, budget received and spent, and financial reporting status by facilities, and other financial procedures for FY 2069/70.

6.2 RESULTS

Table 6. 1: Indicators under Financial Management in NHSSP LF STS 2013

Indicators	STS 2011	95% CI	STS 2012	95% CI	STS 2013	95% CI
% of facilities that spent all the funds received	26.7	14.1–44.8	23.1	16.9–30.7	38.4	27.1–51.1
% of facilities with a bank account	94.6	74.4–99.1	100	NA	97.2	91.7–99.1
% of facilities that disclosed their income and expenditure to the public	81.9	67.7–90.8	73.6	61.8–82.8	64.6	51.8–75.5
% of facilities that conducted a final audit in the last FY	15.3	9.6–23.5	20.0	11.4–32.6	14.8	5.8–33.1

6.2.1 Source of Income

Table 6.2 presents sources of income by facility type. Staff at almost all levels of health facilities (86% of higher-level hospitals, all district hospitals, 95% of PHCCs, 99% of HPs, and 98% of SHPs) reported the MoHP/D(P)HO as a major income source. As registration was free of cost at lower-level health facilities, budget from MoHP/D(P)HO was provided to lower-level facilities to cover registration costs of patients. Other sources of funding for higher-level facilities included the DDC (43%), donors (29%), and other internal sources (43%). For district hospitals, donors (44%) and other internal sources (44%) were the major sources of income. A substantial proportion of lower-level health facilities (64% PHCCs, 76% HPs and 59% of SHPs) reported VDCs as major source of income (Table 6.2). Other internal sources of

income included: laboratory fees, emergency fees, and registration fees, building rent, abortion service fees, and interest from bank accounts.

Table 6. 2: Source of Income, by Facility Type

Source of income*	Higher-level hospitals (%)	District hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
MoHP/D(P)HO	85.7	100	94.9	99.0	98.5
DDC	42.9	11.1	15.4	8.1	11.8
Municipality/VDC	14.3	11.1	64.1	75.8	58.8
Donor	28.6	44.4	10.3	6.1	4.4
Others	42.9	44.4	25.6	10.1	5.9
Total facilities (N)	**7**	**9**	**39**	**99**	**68**

Note: One hospital and one HP are not included in this analysis as there was no responsible person to provide the Information; the percentage total may exceed 100 as a result of multiple responses
Source: STS facility questionnaire

Table 6.3 shows the budget received by health facilities in FY 2069/70 by facility type. It was found that most of the budget, at all levels except SHP, came from MoHP/D(P)HO. MoHP accounted for 96% of the budget at higher-level hospitals, and three-quarters of the budget at PHCCs (75%), but just over half at district hospitals (55%), and less than half at SHPs (41%). Half of the budget of SHPs (50%) and over a quarter of the budget for HPs (29%) were from the municipality/VDC. This shows that decentralized planning and budgeting has been implemented to some extent in lower-level health facilities. Though higher-level and district hospitals reported the municipality to be a source of income (Table 6.2), it was observed that there was not any actual budget recorded in these facilities from such a source.

Table 6. 3: Amount and Proportion of Budget Received in Last FY, by Source of Income and Facility Type

	Higher-level hospitals		District hospitals		PHCCs		HPs		SHPs	
	Amount (million NPR)	%	Amount (million NPR)	%	Amount (million NPR)	%	Amount (million NPR)	%	Amount (million NPR)	%
From MoHP/D(P)HO	264.5	96.1	65.4	55.0	19.5	74.9	15.1	60.8	2.7	41.1
From DDC	0.2	0.1	0.1	0.1	1.4	5.4	1.3	5.2	0.2	3.0
From municipality/VDC	0.0	0.0	0.0	0.0	2.1	7.9	7.1	28.7	3.3	50.2
From donors	1.5	0.5	12.3	10.4	0.7	2.6	0.3	1.2	0.3	4.1
From others	9.1	3.3	41.0	34.5	2.4	9.1	1.0	4.1	0.1	1.5
Total budget	**275.2**	**100**	**118.8**	**100**	**26.1**	**100**	**24.8**	**100**	**6.7**	**100**
Total facilities (N)	**6**		**9**		**39**		**99**		**68**	

Note: Two hospitals and one HP are not included in this analysis as there was no responsible person to provide the information
Source: STS facility questionnaire

6.2.2 MoHP Budget Receipt and Expenditure

Table 6.4 includes the median budget received by health facilities in FY 2069/70, the number of times the budget was requested, and the frequency with which the budget was received. The median budget received was greatest at hospitals (NPR 10,924,000), followed by PHCCs (NPR 187,795), HPs (NPR 81,000), and SHPs (NPR 12,750).

Hospitals were asked the frequency of budget requests and receipts in 2069/70. Lower-level health facilities, such as PHCCs, HPs, and SHPs, are not cost centres and are not involved in requesting and receiving budget from government directly; rather, they receive budget from the D(P)HO and are therefore not included in the analysis of requesting and receiving budget. Just over half of hospitals had requested a budget once or twice a year (53%) whereas one-third (33%) had requested it four times or more. The median number of times a budget had been requested was two. Two-thirds of hospitals had received a budget once or twice a year, but some institutions had received it three (13%) or four (13%) times a year. Meanwhile, a small number of institutions (7%) had never received a budget. The median number of times a budget had been received was one.

Table 6. 4: Median Amount of MoHP Funds Received, and Number of Times Hospitals Requested and Received Budget from Government

	Hospitals	PHCCs	HPs	SHPs
Amount received from D(P)HO during last FY (NPR):				
Median	10,924,000	187,795	81,000	12,750
1st quartile	6,819,000	47,000	14,300	8,561
3rd quartile	37,000,000	451,000	264,700	32,596
Total facilities receiving budget during last FY (N)	**15**	**39**	**99**	**68**
Budget requested to the government in FY 2069/70 (%):				
Once or twice a year	53.3			
Three times a year	13.3			
Four times or more	33.3			
Median requested times	**2**			
Budget received from government in FY 2069/70 (%):				
Never	6.7			
Once or twice a year	66.7			
Three times a year	13.3			
Four times or more	13.3			
Median times received	**1**			
Total facilities with records available (N)	**15**			

Note: Two hospitals and one HP are not included in this analysis as there was no responsible person to provide the information
Source: STS facility questionnaire

Health facilities were asked whether they had received a full budget or not as allocated. The data show that most PHCCs (85%) had received a full budget as allocated for them. Over three-quarters of HPs (79%) and SHPs (78%) had received a full budget: there was no significant difference between lower-level health facilities. However, only 60% of hospitals had received a full budget.

Reasons were sought from staff at health facilities as to why they had not received a full budget. Staff at one-third of the hospitals reported that priority was given to other sectors, with 17% reporting that either there was a lack of budget at the MoHP or the budget was not allocated or released. Staff at half of the PHCCs and 40% of the SHPs mentioned that the budget was not allocated, and 33% of those at HPs mentioned that there was a budget deficit.

Table 6. 5: Receipt of Full Budget and Reasons for Non-receipt of Full Budget, by Facility Type

	Hospitals (%)	**PHCCs (%)**	**HPs (%)**	**SHPs (%)**
Received full amount	60.0	84.6	78.8	77.9
Total facilities with records available (N)	**15**	**39**	**99**	**68**
Reasons for not receiving full amount:				
Priority given to other sector	33.3	16.7	23.8	13.3
Lack of budget at MoHP	16.7	0.0	4.8	6.7
Budget was not allocated	16.7	50.0	9.5	40.0
Delay in budget release	16.7	16.7	14.3	0.0
Budget deficit	0.0	0.0	33.3	13.3
Delay in financial report submission	0.0	16.7	4.8	6.7
Budget deducted	0.0	0.0	9.5	6.7
Political issue	0.0	0.0	0.0	6.7
Don't know	16.7	0.0	9.5	6.7
Total facilities with records available (N)	**6**	**6**	**21**	**15**

**Two hospitals and one HP are not included in this analysis as there was no responsible person to provide the information*

Source: STS facility questionnaire

Staff at numerous health facilities reported that they had not spent their entire allocated budget: 67% of hospitals, 49% of PHCCs, 51% of HPs and 65% of SHPs. Among those health facilities who had not spent the full amount, hospitals (40%), PHCCs (16%), HPs (24%), and SHPs (23%) reported delay in receiving budget as the most common reason for not spending the full amount. Another reason frequently cited was delay in releasing the budget: 40% of hospitals, 24% of HPs, 16% of PHCCs, and 7% of SHPs had encountered this problem.

Table 6. 6: Reasons for Not Spending Total Allocated Budget by Facility Type

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Did not spend full amount	66.7	48.7	50.5	64.7
Total facilities (N)*	**15**	**39**	**99**	**68**
Reasons for not spending full amount:**				
Delay in receiving budget	40.0	15.8	24.0	22.7
Delay in releasing the budget	40.0	15.8	24.0	6.8
Transfer of human resources	20.0	5.3	2.0	4.5
Decrease in caseload	10.0	0.0	0.0	2.3
Budget was not allocated	10.0	5.3	8.0	11.4
Saving for contingency plan	10.0	10.5	24.0	13.6
Posts are vacant	10.0	0.0	0.0	0.0
Transfer/retirement/carelessness of VDC secretary	0.0	0.0	2.0	11.4
Bank account is not in the name of Health Facility In-charge	0.0	0.0	0.0	4.5
Decision was not made by HFOMC	0.0	10.5	2.0	4.5
No need to spend	0.0	31.6	24.0	18.2
Allocated to build physical infrastructure	0.0	0.0	2.0	9.1
HFOMC provided salary for contract staff	0.0	0.0	2.0	0.0
Previous year's budget was used	0.0	5.3	0.0	0.0
Necessary goods were not purchased	0.0	0.0	2.0	2.3
Expenditure should be equal for all services	0.0	0.0	2.0	0.0
Total facilities that did not spend full amount (N)	**10**	**19**	**50**	**44**

**Two hospitals and one HP are not included in this analysis as there was no responsible person to provide the information*

***Percentage total may exceed 100 as a result of multiple responses*

Source: STS facility questionnaire

6.2.3 Procurement Process

Health facilities were asked about their procurement processes. Most hospitals (88%) procured items locally, while most lower-level health facilities (91% of SHPs, 89% of HPs, and 82% of PHCCs) had received items from the D(P)HO. Those facilities that used local procurement were asked about the specific procurement procedure followed for procuring goods: 86% of the hospitals tendered, whereas 13% of PHCCs, 10% of SHPs, and 4% of HPs requested quotations (Table 6.7).

Table 6. 7: Procurement Process for Medical Products by Type of Facility

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Procurement process:*				
Local procurement by health facility	87.5	59.0	26.3	14.7
Sent by regional medical store	31.3	0.0	6.1	7.4
Sent by D(P)HO	12.5	82.1	88.9	91.2
Total facilities (N)	**16**	**39**	**99**	**68**
Procedure for local procurement:*				
E-bidding	14.3	0.0	0.0	0.0
Tender	85.7	4.3	0.0	0.0
Quotation	64.3	13.0	3.8	10.0
Agreement with Sajha Sansthan	35.7	0.0	0.0	0.0
Direct procurement	50.0	95.7	100	90.0
Total facilities who performed local procurement (N)	**14**	**23**	**26**	**10**

Note: One hospital and one HP are not included in this analysis as there was no responsible person to provide the information
**Percentage total may exceed 100 as a result of multiple responses*
Source: STS facility questionnaire

6.2.4 Reporting and Audits

Table 6.8 presents facilities that submitted financial reports in FY 2068/69. The data show that a little over half of the HPs (58%), hospitals (56%), and PHCCs (54%) had submitted a financial budget. Meanwhile, only 41% of the SHPs had submitted a financial report. Further, health facilities were asked about the reasons for not submitting a financial report: 57% of hospitals reported that there was still time to submit a report, while 29% reported that report preparation was ongoing. Similarly, 39% of PHCCs reported a lack of human resources in the finance section, while 22% mentioned a delay in clearing an advance. Given that STS data were collected during the last month of the FY 2069/70, a remarkable proportion of health facilities (29% of hospitals, 11% of PHCCs, 19% of HPs, and 30% of SHPs) reported that they were still preparing a financial report.

Table 6. 8: Facilities that Submitted a Financial Report in FY 2069/70

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Submitted financial report	56.3	53.8	57.6	41.2
Total facilities (N)	**16**	**39**	**99**	**68**
Reasons of not submitted financial report:*				
There is still time to submit	57.1	16.7	23.8	25.0
Report preparation is going on	28.6	11.1	19.0	30.0
Lack of human resources in finance section	14.3	38.9	16.7	5.0
Delay in clearance of advance taken by focal person	0.0	22.2	9.5	12.5
Provision of monthly reporting	0.0	0.0	4.8	2.5
District has not shown concern for it	0.0	0.0	2.4	0.0
Financial report is not usually submitted	0.0	0.0	11.9	15.0
Staff are busy on other works	0.0	0.0	2.4	5.0
Meeting of HFOMC has not been held	0.0	5.6	4.8	7.5
Health Facility In-charge is new	0.0	5.6	2.4	0.0
Auditor's office has not reported yet	0.0	0.0	2.4	0.0
Budget is not allocated to health facility	0.0	0.0	4.8	2.5
Bills and financial slips are submitted to district	0.0	0.0	2.4	2.5
Total facilities not submitting the report (N)	**7**	**18**	**42**	**40**

**Percentage total may exceed 100 as a result of multiple responses; one hospital and one HP are excluded from the analysis.*

Source: STS facility questionnaire

District Treasury Control Offices (DTCOs) are responsible for conducting internal audits of government health facilities. All of the hospitals (100%) had conducted an internal audit, compared to 51% of HPs, 46% of PHCCs, and 25% of SHPs. Lower-level health facilities that had conducted an internal audit were more likely to have done this only once (100% of SHPs, 92% of HPs, and 83% of PHCCs) than hospitals (44%). Auditor General Offices are responsible for conducting external audits. Hospitals (81%) were more likely to have had an external audit than HPs (26%), PHCCs (18%), and SHPs (10%) (Table 6.9). However, a smaller proportion of health facilities had received an external audit in STS 2013 than had been observed in STS 2012, in which 100% of hospitals, 45% of PHCCs, and 15% of SHPs had received an external audit.

Health facility staffs were asked about the recommendations from the external audit. The main recommendations made following external audit were: for hospitals, comprehensive maintenance of financial details (23%); and, for PHCCs (29%) and HPs (19%), and recording of financial transactions. The details of recommendations made following external audit are illustrated in Table 6.9.

Table 6. 9: Frequency of Internal Audit and Timing and Recommendations of External Audit, by Type of Facility

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Internal audit conducted for FY 2069/70	100	46.2	50.5	25.0
Total facilities (N)	**16**	**39**	**99**	**68**
Number of times internal audit conducted:				
Once	43.8	83.3	92.0	100
Twice	18.8	5.6	6.0	0.0
Three times	31.3	5.6	0.0	0.0
Four times	6.3	5.6	2.0	0.0
Total facilities (N)	**16**	**18**	**50**	**17**
External (final) audit conducted for FY 2069/70	81.3	17.9	26.3	10.3
Total facilities (N)	**16**	**39**	**99**	**68**
Timing of external (final) audit:				
First trimester of the following year	69.2	71.4	65.4	85.7
Second trimester of the following year	23.1	28.6	15.4	14.3
Third trimester of the following year	7.7	0.0	19.2	0.0
Major recommendation made following external audit:*				
No suggestion	30.8	42.9	34.6	71.4
Cash should be kept in bank	7.7	0.0	11.5	0.0
Purchase plan should be published in newspaper	15.4	0.0	7.7	0.0
Achievement of target	15.4	0.0	0.0	0.0
Use of Nagadi Kitab	0.0	14.3	7.7	0.0
Proper management of Journal voucher	0.0	14.3	11.5	0.0
Fulfillment of vacant posts	15.4	0.0	0.0	0.0
Update logistics stocks	15.4	14.3	7.7	0.0
Auction of old goods	0.0	0.0	3.8	0.0
Financial details should be maintained comprehensively	23.1	14.3	11.5	14.3
To spend budget according to determined heading	7.7	14.3	3.8	0.0
Timely release of foreign aid	7.7	0.0	0.0	0.0
Recording of financial transactions	0.0	28.6	19.2	14.3
Proper conduction of activities/computerised recording	7.7	0.0	3.8	14.3
Maintenance of single bank account	0.0	0.0	3.8	0.0
Timely financial audit/conduct regular final audit	7.7	0.0	3.8	0.0
Financial transaction through A/C payee cheque	7.7	0.0	0.0	0.0
HFOMC should decide when purchasing goods	0.0	0.0	3.8	0.0
Payment of tax on purchases	0.0	0.0	3.8	0.0
Total facilities who had conducted external final audit (N)	**13**	**7**	**26**	**7**

*Note: One hospital and one HP are excluded from the analysis; *Percentage total may exceed 100 as a result of multiple responses*
Source: STS facility questionnaire

6.2.5 Bank Account and Bank Balance

All 39 PHCCs had a bank account, as did the majority of HPs (98%) and SHPs (97%). However, two of the sixteen hospitals reported that they did not have a bank account at the moment. The median amount held in bank accounts was high in hospitals (NPR 1.06 million) compared to PHCCs (NPR 0.15 million),

HPs (NPR 0.08 million), and SHPs (NPR 0.03 million). Meanwhile, 94% of hospitals were located in districts in which Treasury Single Accounts (TSAs) had been implemented, along with 74% of PHCCs, 74% of SHPs, and 66% of HPs.

Table 6. 10: Access to Bank Account and Bank Balance

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Have bank account	87.5	100	98.0	97.1
Total facilities (N)	**16**	**39**	**99**	**68**
Bank account balance (NPR):				
<10,000	7.1	5.1	9.3	19.7
10,000–100,000	0.0	25.6	44.3	56.1
100,000–1,000,000	35.7	56.4	42.3	19.7
1,000,000–5,000,000	28.6	10.3	1.0	0.0
5,000,000+	14.3	0.0	0.0	0.0
Don't know	14.3	2.6	3.1	4.5
Available bank balance (NPR):				
Median	1,058,663.5	145,228.5	77,272.0	32,000.0
1st quartile	823,749.3	64,600.0	24,648.0	12,400.0
3rd quartile	1,824,242.5	453,000.0	177,150.5	80,000.0
TSA implemented in the district	**93.8**	**74.4**	**65.7**	**73.5**
Total facilities (N)	**16**	**39**	**99**	**68**

Source: STS facility questionnaire

6.3 KEY FINDINGS

Source of income

- STS 2013 found that for almost all (98%) health facilities, the main source of income was the MoHP/D(P)HO. Similarly, MoHP was the main financer for all level of health facilities in STS 2011 and 2012.
- Higher-level hospitals had also received support from DDCs (43%). PHCCs (64%), HPs (76%), and SHPs (59%) were more likely to have received funds from municipalities/VDCs than other levels of facility in 2013. VDC or Municipality was also an additional financier for many lower level facilities in 2012 and 2011.
- A higher percentage (44%) of district hospitals had received funds from donor agencies than higher-level hospitals (29%), PHCCs (10%), HPs (6%), and SHPs (4%) in STS 2013.

MoHP budget receipt and expenditure

- Sixty-seven per cent of hospitals had received budget from the government once or twice during the FY 2069/70; and 33% had requested a budget four times or more in a year in STS 2013.
- Most PHCCs (85%), HPs (79%), SHPs (78%) and hospitals (60%) received the full budget as allocated. The reasons reported by hospitals who had not received the full budget were: priority being given to other sectors (33%), a lack of budget in MoHP (17%), and delays in the budget being released (17%).
- STS 2013 found that around two-thirds (67%) of hospitals and SHPs (65%), and around half of HPs (51%) and PHCCs (49%) had not spent the full amount of their budget. Delays in receiving the budget constituted the main reason for this under spend. Around two-third of hospitals (69%) did not spend the full amount in 2012. No need to spend (33%) and a delay in receiving the budget (27%) were the major reasons for not spending the full amount.

Procurement

- The findings of STS 2013 show that lower-level health facilities, i.e. SHPs (91%), HPs (89%), and PHCCs (82%), had received items from D(P)HOs. Fourteen of the sixteen hospitals had used local procurement, largely using calls for tender (86%) in 2013 while 87% of hospitals had used local procurement in 2012, among which only 64% used tender.
- Lower-level health facilities who had procured locally had largely done so by requesting quotations in 2013 while they had purchased directly from vendors in 2012.

Report and auditing

- Only 58% of HPs, 56% of hospitals, 54% of PHCCs, and 41% of SHPs had submitted their financial report for FY 2068/69. Facilities stated that there was still sufficient time to submit the report and/or that its preparation was ongoing. Reasons for not submitting financial reports in 2013 include the lack of human resources in the finance section (39% of PHCCs, 17% of HPs, 14% of hospitals, and 5% of SHPs).
- More than four-fifths (84%) of health facilities (all SHPs, 92% of HPs, 83% of PHCCs, and 44% of hospitals) that had conducted an internal audit had conducted this only once. None of the SHPs and only 2% of HPs and 6% of PHCCs and hospitals, that had conducted an audit, had done so four times in a year.
- Hospitals (81%) were more likely to have received an external audit than HPs (26%), PHCCs (18%), or SHPs (10%) in STS 2013.

- Following an external audit, it was recommended that hospitals: properly maintain their financial details; update stocks of drugs and supplies; publish their purchase plan in newspapers; and fill vacant positions. Recommendations for lower-level health facilities included: improved management of the Goswara voucher; use of the Nagadi Kitab; placing cash deposits in the bank; spending the budget as per the allotted headings; and recording of financial transactions.

CHAPTER7: GOVERNANCE AND ACCOUNTABILITY

7.1 INTRODUCTION

Governance ensures that the needs of the public are served efficiently, effectively, and fairly. Citizens and regulators are calling for higher levels of transparency and accountability in all areas of health care service delivery. NHSP-2 recognizes that there must be strong governance and accountability systems in place if health service provision is to be improved. In 2010, MoHP produced a Governance and Accountability Action Plan (GAAP), which aims to make services more client-centred and providers accountable to those that they serve, with a particular focus on improving care for the poor and excluded.

This chapter describes findings from STS 2013 that are related to governance and accountability. It explores the use of social audits, Citizen's Charters, transparency and disclosure measures, and HFOMCs/Hospital Development Boards (HDBs). Additionally, it assesses measures taken to improve GESI, the management and handling of suggestions and complaints, staff meetings, HMIS, supervision visits, and emergency and contingency plans.

7.2 RESULTS

Table 7. 1: Indicators under Governance and Accountability in NHSSP LF STS 2013

Indicators	STS 2011	95% CI	STS 2012	95% CI	STS 2013	95% CI
% of health facilities that undertook a social audit as per MoHP guidelines in the last FY	27.4	17.4–40.4	13.7	8.2–22.0	14.7	7.0–28.5
% of facilities that conducted a social audit in the last FY, made findings public, and incorporated recommended actions into Annual Work Plan and Budget (AWPB)	22.0	15.0–31.0	7.4	1.9–24.5	11.4	6.8–18.6
% of facilities with a Citizen's Charter placed in a visible location that included information on free drugs, outpatient services, and Aama (if Aama-implementing facility)	58.4	43.8–71.8	55.4	40.0–69.7	19.0	9.6–34.1
% of facilities with a health management committee (HFOMC/HDC) meeting on a monthly basis	37.1	22.3–54.8	30.9	23.8–39.0	30.9	20.7–43.4
% of health facilities with at least three females and at least two Dalit and Janajati members in HFOMCs and HDCs	46.0	36.5–55.8	55.1	34.1–74.4	70.3	54.1–82.5

7.2.1 Social Audits

A health sector social audit is a process by which citizens audit government health services. The major objectives of social auditing are: to monitor how resources are used; to understand who is benefiting; to increase transparency; and to hold service providers and officials to account. Under the Local Authority Financial Administration Regulations, 2007, GoN committed to making social audits mandatory for all programmes within four months of the completion of each FY.

However, this is yet to be fully implemented. In 2009, the FHD, DoHS, developed a social audit model linked to the Aama Programme; in the same year, the MD, DoHS, also developed a social audit with broader scope, covering all health service provision. In 2012, the DoHS, under the leadership of the PHCRD, harmonized the two sets of social audit guidelines and developed comprehensive social audit guidelines for the health sector. These specified that health facilities from SHPs to district hospitals and urban health clinics should undertake social audits. The new guidelines were piloted in two districts and implemented in an additional 20 districts in 2011/12. D(P)HOs are expected to develop action plans to ensure that social audits are operational in 30% of health facilities in their district by 2015.

The practice of social audit was most common in PHCCs (41%) and HPs (35%). However, for all levels of facilities except PHCCs (28%), less than 20% were conducting social audits as per the MoHP guidelines. Among the facilities that had undertaken social audit in the last FY, a greater proportion of hospitals (18%) had used a score card than PHCCs (13%) and HPs (9%). None of the SHPs were using scorecards while performing social audits.

Among those health facilities that had conducted a social audit, public gatherings were the most common method for disclosing their results, employed by 60% of hospitals, 63% of PHCCs, 46% of HPs, and 22% of SHPs. A proportion of health facilities at every level had discussed the issues and findings of social audits during HFOMC meetings, or displayed the results of social audit on the facility notice board (Table7.2). In contrast with other facilities, PHCCs were sometimes found to have disclosed their social audit findings on VDC notice boards (6%) and at DDC meetings (6%).

The survey explored whether the recommendations made during the social audit in the last FY were incorporated into the AWPB. Among those facilities that had performed a social audit in FY 2068/69, 44% of SHPs, 31% of HPs, 25% of PHCCs, and 20% of hospitals were incorporating decisions made during social audit into the current year's (FY 2069/70) AWPB. However, in many facilities, the AWPB was not observed. Among those facilities who had conducted social audit in FY 2069/70, 40% of hospitals, 80% of

PHCCs, 61% of HPs, and 56% of SHPs had incorporated the decisions made during social audit into their Annual Work Plan and Budget (AWPB).

The four most significant actions implemented by the hospitals were infrastructure improvements, increases in service quality and in the number of beds in the facility, and provision of dental services. The actions implemented varied between different levels of facilities: those such as human resources management, increasing immunization coverage, and improving toilet and water facilities occurred mostly at lower-level facilities.

Table 7. 2: Social Audits Undertaken in FY 2069/70

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Social audit in the FY 2069/70	29.4	41.0	35.0	26.5
Social audit as per MoHP guidelines	11.8	28.2	18.0	13.2
Use scorecard for social audit	17.6	12.8	9.0	0.0
Total facilities (N)	**17**	**39**	**100**	**68**
Method used to disclose findings from social audit*				
HFOMC meeting	40.0	25.0	57.1	77.8
Facility information board	20.0	18.8	17.1	27.8
Public gathering	60.0	62.5	45.7	22.2
VDC notice board	0.0	6.3	0.0	0.0
DDC meeting	0.0	6.3	0.0	0.0
Did not disclose	0.0	0.0	8.6	0.0
Report not available	0.0	6.3	2.9	0.0
Recommended actions from the social audit conducted in 2068/69 incorporated into AWPB for 2069/70				
Work plan was observed	20.0	25.0	31.4	44.4
Work plan was not observed	60.0	50.0	45.7	27.8
No work plan	0.0	12.5	8.6	27.8
Don't know	20.0	6.3	8.6	0.0
Social audit was not performed in 2068/69	0.0	6.3	5.7	0.0
Total facilities with social audit in the last FY (N)	**5**	**16**	**35**	**18**
Proportion of recommended actions from the social audit conducted in 2068/69 implemented	40.0	80.0	60.6	55.6
Total facilities with social audit in FY 2068/69 and FY 2069/70 (N)	**5**	**15**	**33**	**18**
Most significant actions implemented:				
Infrastructure/construction	50.0	33.3	40.0	30.0
Improving service quality/continuity of service/increasing access to services	50.0	16.7	10.0	10.0
Providing dental services	50.0	0.0	0.0	0.0
Increasing the number of beds in health facility	50.0	0.0	0.0	0.0
Human resource management (employee's salary/lodging/contract)	0.0	50.0	15.0	20.0
Management of drinking water	0.0	16.7	15.0	30.0
Regarding Citizen’s Charter	0.0	8.3	10.0	20.0
Construction of toilet	0.0	0.0	10.0	10.0
Increasing the coverage of immunisation services	0.0	8.3	10.0	0.0
Keeping suggestion box	0.0	0.0	5.0	20.0
Regarding Aama Programme	0.0	0.0	10.0	0.0
Regarding FCHVs	0.0	0.0	5.0	10.0
Provision of laboratory services	0.0	0.0	5.0	0.0
Management of outreach clinic	0.0	0.0	0.0	10.0
Management of electricity	0.0	0.0	0.0	10.0

Asking for goods from donor agencies	0.0	0.0	0.0	10.0
Management of equipment in health facility	0.0	0.0	5.0	0.0
Waste management in health facility	0.0	8.3	0.0	0.0
Keeping the record of income and expenses in health facility	0.0	8.3	0.0	0.0
Total facilities who implemented recommended actions from the social audit conducted in 2068/69 (N)	**2**	**12**	**20**	**10**

**Percentage total may exceed 100 as a result of multiple responses*
Source: STS facility questionnaire

7.2.2 Citizen's Charters

When asked about the availability of the Citizen's Charter, more than a quarter of hospitals (29%) did not have one. Fewer lower-level health facilities lacked a Citizen's Charter: only 21% of SHPs, 15% of HPs, and 8% of PHCCs. The majority of PHCCs (87%) had a readable Citizen's Charter, while 71% of HPs, 68% of SHPs, and 59% of district hospitals had a Citizen's Charter in readable form. A further 12% of hospitals and SHPs, 14% of HPs, and 5% of PHCCs had a charter at the facility but it was not clear and readable (Table 7.3).

Among those facilities that had a Citizen's Charter, 58% of district hospitals, 47% of PHCCs, 33% of HPs, and 24% of SHPs had their Citizen's Charter outside the building and in a visible place. Health service providers from the facilities who had a Citizen's Charter were asked about its content. Health service providers from every HP, 94% of PHCCs and SHPs, and 90% of hospitals reported there being information on free drugs in the Citizen's Charter, while 100% of those at district hospitals and PHCCs, 98% of those at SHPs, and 93% of those at HPs reported including information on outpatient services.

Every hospital with a Citizen's Charter included information on the Aama Programme, along with 94% of PHCCs; such information was less common at HPs (55%) and SHPs (15%). However, among health facilities implementing the Aama Programme, 82% of PHCCs, 67% of hospitals, 56% of HPs, and 46% of SHPs included information on the Aama Programme in a Citizen's Charter.

Table 7. 3: Availability and Content of Citizen's Charters by Facility Level

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Availability of Citizen's Charter:				
Charter available: observed and readable	58.8	87.2	71.0	67.6
Charter available: observed but not clearly readable	11.8	5.1	14.0	11.8
Charter not available	29.4	7.7	15.0	20.6
Total facilities (N)	**17**	**39**	**100**	**68**
Location of Citizen's Charter:				
Outside building: visible place	58.3	47.2	32.9	24.1
Outside building: not visible place	16.7	0.0	1.2	1.9
Inside building: visible place	25.0	52.8	58.8	61.1
Inside building: not visible place	0.0	0.0	7.1	13.0
Total facilities having Citizen's Charter (N)	**12**	**36**	**85**	**54**
Charter includes information on:				
Free drugs	90.0	94.1	100	93.5
Outpatient services	100	100	93.0	97.8
Aama Programme	100	94.1	54.9	15.2
Total facilities with Citizen's Charter (N)	**10**	**34**	**71**	**46**
Proportion of Aama-implementing health facilities including information on Aama Programme in Citizen's Charter	66.7	82.1	55.9	46.2
Health facilities implementing Aama Programme (N)	**15**	**39**	**68**	**13**

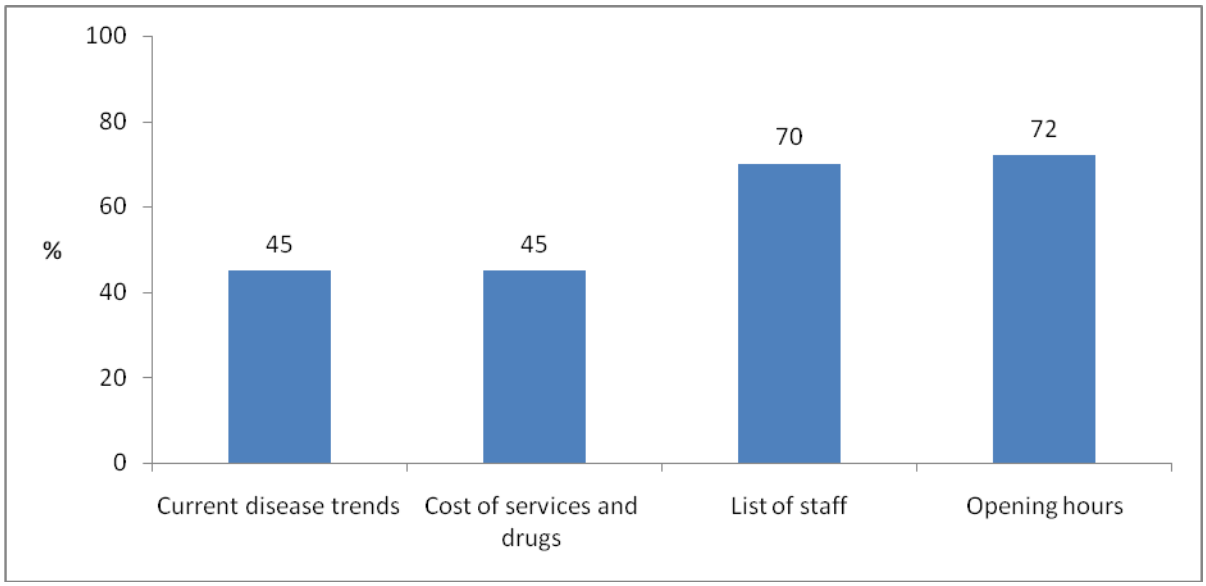
Source: STS facility questionnaire

7.2.3 Transparency and Disclosure Measures

Nearly three-quarters of health facilities displayed information on opening hours (72%) and staff (70%). Less than half of health facilities displayed information on the cost of services and drugs (45%) and current disease trends (45%) (see Figure 7.1).

HFOMC meetings or notice boards were the most common means of disclosing information, irrespective of content (Table 7.4). HFOMC meetings (55%) were the most common procedure for disclosing current disease trends. Facility notice boards were widely used for displaying the costs of service and drugs (51%), a list of working staff (57%), and office opening hours (44%).

Figure7. 1: Type of Information Displayed by Health Facilities (N=224)



Source: STS facility questionnaire

Table 7. 4: Information Displayed by Information Source

	Current disease trends (%)	Cost of services and drugs (%)	List of staff (%)	Opening hours (%)
Methods of disclosure:				
During HFOMC meeting	55.4	27.0	42.2	38.7
In yearly gathering of VDC/DDC	19.2	3.4	7.5	9.1
Notice boards of facility	15.9	50.9	56.5	44.0
Review meeting	8.5	0.3	0.0	0.0
Mass/women group/FCHV gathering	6.4	0.6	0.2	0.0
Notice boards of VDC/DDC	5.6	0.0	5.7	3.1
Displayed at school	5.0	0.0	1.6	0.0
Community gathering at health facility	3.1	2.5	2.1	5.1
Notice displayed inside institution's building/room	2.5	0.3	3.8	1.8
Mass media	1.0	0.4	0.0	0.0
Through FCHV committee	0.4	0.4	0.0	1.8
Citizen's Charter	0.0	23.0	0.0	8.7
Displaying on the wall of health institution	0.0	0.3	0.5	3.5
Social audit	0.0	0.3	0.2	0.0
Total facilities with disclosed information as per topic (N)	**101**	**102**	**157**	**161**

**Percentage total may exceed 100 as a result of multiple responses*
Source: STS facility questionnaire

7.2.4 Facility Management Committees

HFOMCs and HDCs were available and functional at almost all lower-level health facilities: at 100% of PHCCs, 99% of HPs, and 97% of SHPs. However, HDCs were available and functional in just over three-quarters (77%) of hospitals.

Of those facilities with available and functional HFOMCs/HDCs, 69% of hospitals, 48% of SHPs, and 37% of HPs reported that they met most commonly according to need, while nearly half of PHCCs (46%) met at least once a month (as specified in the GoN guidelines for HFOMCs and HDCs). A few facilities met only once in six months, or less frequently. Nearly 50% of those health facilities with available and functional HFOMCs/HDCs who knew the date of their last meeting reported that they had met within the last month (Table 7.5).

Table 7. 5: Frequency of HDC/HFOMC Meeting

	Hospitals (%)	**PHCCs (%)**	**HPs (%)**	**SHPs (%)**
HFOMC/HDC available and functional	76.5	100	99.0	97.1
Total facilities (N)	**17**	**39**	**100**	**68**
Frequency of HDC/HFOMC meetings:				
At least once a month	15.4	46.2	37.4	28.8
Every 2–3 months	15.4	17.9	21.2	21.2
According to need	69.2	35.9	37.4	48.5
Every 4–6 months	0.0	0.0	3.0	1.5
Every 2 years	0.0	0.0	1.0	0.0
Total facilities having functional HFOMC/HDC (N)	**13**	**39**	**99**	**66**
Timing of last HFOMC/HDC meetings:				
Within last month	46.2	50.0	50.0	50.8
2–3 months ago	23.1	41.7	35.7	26.2
4–6 months ago	23.1	5.6	9.2	12.3
7–12 months ago	7.7	2.8	3.1	10.8
A year ago	0.0	0.0	2.0	0.0
Total facilities having functional HFOMC/HDC with date of last HFOMC/HDC meeting (N)*	**13**	**36**	**98**	**65**

***Five cases are excluded from the analysis of timing of last HFOMC/HDC meetings because of a lack of information*

Source: STS facility questionnaire

Where HFOMCs existed, the median number of members on each committee was nine for all facility levels except for PHCCs (11 members). There was equal representation of female members (three on average) in HFOMCs across the different lower-level health facilities; however, at district hospitals female representation on HDCs was very low (only one female member on average). Representation of

Janajatis was similar across all health facilities (one member), except at HPs (two members). Dalit representation in HFOMCs was consistent across the lower-level health facilities; however, Dalits were not represented in HDCs (Table 7.6).

Table 7. 6: Sex and Caste/Ethnic Makeup of HFOMCs/HDCs by Facility Level

	Hospitals			PHCCs			HPs			SHPs			Total		
	Median	1st quartile	3rd quartile	Median	1st quartile	3rd quartile	Median	1st quartile	3rd quartile	Median	1st quartile	3rd quartile	Median	1st quartile	3rd quartile
Total members	**9.0**	**8.0**	**11.0**	**11.0**	**9.0**	**13.0**	**9.0**	**8.0**	**11.0**	**9.0**	**7.8**	**11.0**	**9.0**	**8.0**	**11.0**
Males	7.0	7.0	9.5	8.0	7.0	10.0	6.0	5.0	8.0	6.0	4.0	8.0	7.0	5.0	8.0
Females	1.0	0.5	2.0	3.0	2.0	3.0	3.0	2.0	4.0	3.0	3.0	4.0	3.0	2.0	4.0
Total Dalit members	**0.0**	**0.0**	**0.0**	**1.0**	**1.0**	**2.0**	**1.0**	**1.0**	**2.0**	**2.0**	**1.0**	**2.0**	**1.0**	**1.0**	**2.0**
Dalit (males)	0.0	0.0	0.0	1.0	0.0	1.0	0.0	0.0	1.0	1.0	0.0	1.0	1.0	0.0	1.0
Dalit (females)	0.0	0.0	0.0	0.0	0.0	1.0	1.0	0.0	1.0	1.0	0.0	1.0	1.0	0.0	1.0
Total Janajati members	**1.0**	**0.0**	**1.5**	**1.0**	**0.0**	**4.0**	**2.0**	**1.0**	**3.0**	**1.0**	**0.0**	**4.0**	**1.0**	**1.0**	**3.0**
Janajati (males)	1.0	0.0	1.0	1.0	0.0	3.0	1.0	0.0	2.0	1.0	0.0	2.0	1.0	0.0	2.0
Janajati (females)	0.0	0.0	0.5	0.0	0.0	1.0	1.0	0.0	1.0	1.0	0.0	2.0	1.0	0.0	1.0
Total facilities with active HDC/HFOMC (N)	**13**			**39**			**99**			**66**			**217**		

Source: STS facility questionnaire

Table 7.7 shows the presence and participation of women and marginalized caste/ethnic groups on HFOMCs/HDCs, and initiatives taken to increase their number. Three-quarters (75%) of the health facilities had at least three female members in their HFOMC/HDC. However, when disaggregated by level of health facility, the results show that only lower-level health facilities had at least three female members in their HFOMCs/HDCs: 79% of SHPs, 68% of HPs, and 56% of PHCCs, but none of the hospitals, had three or more female members on their HFOMCs/HDCs. Ninety per cent of HPs, 88% of SHPs, and 85% of PHCCs had at least two Dalit or Janajati members in their HFOMCs; however, in hospitals, less than a quarter of HDCs (24%) had at least two Dalit or Janajati members among their number.

Compared to lower-level health facilities, a greater proportion of hospitals had taken initiatives to increase the number of female and Dalit/Janajati members on HDCs/HFOMCs; however, the percentages are nevertheless small (15% for female and 8% for Dalit/Janajati initiatives). Health facility staff were asked what proportion of HFOMC members had been oriented on their roles and

responsibilities; staff at all hospitals (100%), at 89% of HPs, and at 82% of PHCCs and SHPs reported that they had oriented all HDC/HFOMC members.

Among the health facilities with Dalit/Janajati members in their HFOMCs/HDCs, 71% of hospitals, 56% of HPs and SHPs, and 53% of PHCCs reported that Dalit/Janajati members always participated in decision-making processes. Likewise, of the facilities with female members in their HFOMCs/HDCs, three-fifths (60%) of hospitals reported that female members were always involved in decision-making processes.

Table 7. 7: Presence, Participation and Initiatives for the Inclusion of Women and Marginalised Caste/Ethnic Groups in HFOMC/HDCs, by Facility Level

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)	Total (%)
Have at least three female members	0.0	56.4	68.0	79.4	74.5
Have at least two Dalit/Janajati members	23.5	84.6	90.0	88.2	86.8
Have at least three female and at least two Dalit/Janajati members	0.0	51.3	64.0	75.0	70.3
Total facilities (N)	**17**	**39**	**100**	**68**	**224**
Taken initiatives to increase the number of:					
Female members	15.4	5.1	4.0	1.5	2.4
Dalit/Janajati members	7.7	0.0	3.0	4.5	4.1
Total facilities with active/functional HFOMC/HDC (N)	**13**	**39**	**99**	**66**	**217**
Oriented members on roles and responsibilities:					
All	100	82.1	88.9	81.8	86.2
More than half	0.0	12.8	7.1	13.6	9.7
Less than half	0.0	0.0	2.0	4.5	2.3
None/don't know	0.0	5.2	2.0	0.0	1.9
Total facilities with active/functional HFOMC/HDC (N)	**13**	**39**	**99**	**66**	**217**
Dalit and Janajati members participate in decision-making process:					
Always	71.4	52.6	55.7	56.1	55.8
Most of the time	28.6	39.5	36.1	37.9	37.0
Sometimes	0.0	2.6	4.1	3.0	3.4
Rarely	0.0	2.6	4.1	3.0	3.4
Never	0.0	2.6	0.0	0.0	0.5
Total health facilities with Dalit/Janajati member in HFOMC/HDC (N)	**7**	**38**	**97**	**66**	**208**
Female members participate in decision-making process:					
Always	60.0	51.3	58.2	51.5	54.9
Most of the time	30.0	33.3	31.6	39.4	34.3
Sometimes	0.0	5.1	7.1	4.5	5.6
Rarely	10.0	5.1	3.1	3.0	3.8
Never	0.0	5.1	0.0	1.5	1.4
Total health facilities with female member in HFOMC/HDC (N)	**10**	**39**	**98**	**66**	**213**

Source: STS facility questionnaire

The facilities were asked if they were undertaking any activities to increase the capacity of HFOMC/HDC members. A limited number of facilities performed activities to increase the capacity of health workers, less than three in ten (27%) facilities overall. Among health facilities that performed capacity-building activities, all hospitals (100%), 67% of PHCCs, 57% of HPs, and 56% of SHPs were enhancing their members' monitoring capacity for human resource regulation (Table 7.8).

Table 7. 8: Capacity-building Activities Undertaken for HFOMC/HDC Members, by Facility Level

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)	Total (%)
Capacity-building activities under taken for HFOMC/HDC members	23.1	30.8	28.3	24.2	27.2
Total facilities with active HFOMC/HDC (N)	**13**	**39**	**99**	**66**	**217**
Activities conducted for HFOMC/HDC					
Exposure visits to high-performing HFOMCs/HDCs	0.0	16.7	21.4	12.5	16.9
Enhance monitoring capacity for human resource regulation	100	66.7	57.1	56.3	61.0
Total facilities undertaken capacity building activities (N)	**3**	**12**	**28**	**16**	**59**

Source: STS facility questionnaire

7.2.5 GESI

Nearly three-fifths of hospitals (59%) and over half of PHCCs (54%) had carried out activities to increase the accessibility of health care for women, but such activities were less common at HPs (44%) and SHPs (32%). Hospitals were more likely to provide services targeting women, the poor, the physically disabled, and destitute than other facilities, while PHCCs were most likely focusing on the activities to reach the mentally ill. Efforts to reach Dalits were slightly more likely to be undertaken at SHPs (27%) than at other types of health facility (Table 7.9).

Among those health facilities that were trying to reach target groups, more than half (54%) were expanding outreach services (58% of SHPs, 59% of HPs, 53% of PHCCs, and 17% of hospitals) and nearly half (49%) were focusing on awareness programmes (50% of SHPs, 46% of HPs, 57% of PHCCs, and 33% of hospitals). More than half of hospitals (58%) were organizing special camps, and half of them (50%) were providing user-friendly services. Three-quarters of facilities (71% of hospitals, 77% of PHCCs, 74% of HPs, and 75% of SHPs) had no means of identifying people's needs, but among those who did, data analysis (13%) and mapping (10%) were the most common methods used.

Table 7. 9: Activities to Reach Socially Excluded Groups, by Facility Level

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)	Total (%)
Tried to reach the following target groups:					
Women	58.8	53.8	44.0	32.4	43.3
Those living in remote areas	29.4	33.3	39.0	35.3	36.2
Dalits and Janajatis	17.6	17.9	23.0	26.5	22.8
Poor/very poor	52.9	25.6	16.0	27.9	24.1
Mentally ill	5.9	33.3	12.0	2.9	12.5
Physically disabled	41.2	28.2	18.0	10.3	19.2
Destitute	35.3	25.6	17.0	16.2	19.6
Total facilities (N)	**17**	**39**	**100**	**68**	**224**
Type of activity:					
Expanding outreach services	16.7	53.3	59.3	57.9	53.7
Organising special camps	58.3	33.3	18.5	10.5	23.1
Focused awareness programmes	33.3	56.7	46.3	50.0	48.5
Provide user-friendly services	50.0	33.3	31.5	15.8	29.1
Establishing maternity centre	0.0	0.0	1.9	0.0	0.7
Free services to people with disability	8.3	3.3	0.0	0.0	1.5
Financial assistance from VDC/municipality	0.0	0.0	1.9	0.0	0.7
Nutrition programme	8.3	0.0	0.0	2.6	1.5
Training of community people	0.0	0.0	1.9	2.6	1.5
Distribution of clothes to delivered women	0.0	0.0	1.9	0.0	0.7
Total facilities trying to reach target group (N)	**12**	**30**	**54**	**38**	**134**
Means of identifying those in most need:					
No means of identifying	70.6	76.9	74.0	75.0	74.6
Mapping	11.8	7.7	11.0	8.8	9.8
Identifying with the help of women's group/FCHVs	0.0	2.6	0.0	4.4	1.8
Discussion at health facility management meeting	0.0	0.0	1.0	0.0	0.4
Data analysis	17.6	12.8	13.0	11.8	12.9
Formation of community health unit	0.0	0.0	1.0	0.0	0.4
Total facilities (N)	**17**	**39**	**100**	**68**	**224**

Source: STS facility questionnaire

7.2.6 Suggestions/Complaints Mechanism

Most hospitals (82%) had a formal complaint and suggestion procedure. However, such procedures were less common at lower-level health facilities, especially in HPs (38%) and SHPs (34%). Among those facilities that had a formal complaint and suggestion mechanism, 93% of hospitals and 81% of PHCCs used a suggestion box for complaints and suggestions. The telephone was the most common mechanism in HPs (47%) and SHPs (65%) (Table 7.10).

The average number of suggestions and complaints received per facility over the last 12 months ranged from two to seven. Based on the suggestions and complaints received, 27% of hospitals had made improvements in human resources, while 38% of SHPs, 21% of PHCCs, and 16% of HPs had made improvements in the adequacy of their drug supply. However, 45% of hospitals, 43% of PHCCs, 30% of HPs, and 38% of SHPs had taken no action as a result of the suggestions or complaints reported.

Table 7. 10: Procedures for Dealing with, and Actions Taken on, Suggestions or Complaints, by Facility Type

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Provision of formal suggestion/complaints procedure for patients:				
Yes	82.4	53.8	38.0	33.8
No	17.6	46.2	62.0	66.2
Total facilities (N)	**17**	**39**	**100**	**68**
Type of suggestion/complaints procedure:*				
Complaint/recommendation box	92.9	81.0	44.7	13.0
By phone	57.1	33.3	47.4	65.2
Focal person assigned	50.0	38.1	34.2	30.4
By email	28.6	0.0	0.0	0.0
By post	21.4	4.8	0.0	0.0
Total facilities having provision of formal suggestion complaints procedure for patients (N)	**14**	**21**	**38**	**23**
Interquartile range of number of suggestions/complaints received over the last 12 months:				
Median	0.0	1.5	6.5	5.0
1st quartile	0.0	0.0	4.0	2.0
3rd quartile	6.0	7.0	46.3	10.5
Actions taken on suggestions and complaints made:*				
Human resource management	27.3	7.1	13.5	9.5
Adequate management of health services being provided	18.2	0.0	10.8	0.0
Construction of physical infrastructure	18.2	0.0	2.7	4.8
No need to take any action	9.1	7.1	2.7	9.5
Adequate supply of medicine	9.1	21.4	16.2	38.1
Decision was made to recruit ANM	0.0	0.0	2.7	0.0
Regular immunisation clinic conducted	0.0	0.0	2.7	0.0
Conducting outreach clinic regularly	0.0	7.1	2.7	0.0
Providing regular services from health facility	0.0	0.0	5.4	4.8
Complained to higher authority	0.0	7.1	13.5	9.5
Management of referral system	0.0	0.0	2.7	0.0
Regular cleanliness of health facility was managed	0.0	7.1	2.7	0.0
Medicines not in the free drug category cannot be provided for free	0.0	0.0	2.7	0.0
Health workers asked improve behaviour/be sensitive to clients	0.0	14.3	0.0	0.0
Adequate management of ambulance service	0.0	0.0	2.7	0.0
No action taken	45.5	42.9	29.7	38.1
Total facilities receiving at least one formal suggestion (N)	**11**	**14**	**37**	**21**

**Percentage total may exceed 100 as a result of multiple responses*
Source: STS facility questionnaire

7.2.7 Staff Meetings

Table 7.11 presents the frequency and timing of staff meetings disaggregated by level of health facility. Less than half of the health facilities had conducted a staff meeting at least once a month (46%). Furthermore, 18% of SHPs, 9% of HPs, and 8% of PHCCs had never conducted a meeting. Nearly three-quarters (71%) of hospitals and PHCCs (71%), and nearly two-thirds of HPs (65%) and SHPs (64%), had conducted a meeting within the last month.

Table 7. 11: Frequency and Timing of Staff Meetings, by Facility Type

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)	Total (%)
Frequency of staff meetings:					
At least once a month	41.2	46.2	48.0	44.1	46.0
At least once every two months	11.8	0.0	7.0	5.9	5.8
At least once every trimester	5.9	7.7	3.0	2.9	4.0
At least once every six months	0.0	0.0	1.0	4.4	1.8
At least once every year	0.0	0.0	1.0	0.0	0.4
According to need	41.2	38.5	31.0	25.0	31.3
Never	0.0	7.7	9.0	17.6	10.7
Total facilities (N)	**17**	**39**	**100**	**68**	**224**
Timing of last staff meeting:					
Within last month	70.6	70.6	65.1	64.0	66.3
2–3 months ago	29.4	17.6	22.9	18.0	21.2
4–6 months ago	0.0	5.9	8.4	10.0	7.6
7–12 months ago	0.0	5.9	3.6	8.0	4.9
Total facilities having information on last staff meeting (N)	**17**	**34**	**83**	**50**	**184**

Note: Total 16 facilities had no record of or information about the last staff meeting
Source: STS facility questionnaire

7.2.8 Health Management Information System

When asked about the receipt of HMIS tools, 10% of both PHCC and SHPs, and 8% of HPs reported receiving tools before the start of the FY. Similarly, SHPs (49%) were more likely to have received HMIS forms within one month of the start of the FY than HPs (41%), PHCCs (36%), and hospitals (24%). Some facilities also reported stock-outs of HMIS tools during the last FY, and this was approximately twice as common in lower-level health facilities (26% of PHCCs, 27% of HPs, and 23% of SHPs) as in hospitals (13%). However, two of the seventeen hospitals stated that they did not use HMIS tools. Stock-outs were most common for the following HMIS tools: HMIS 32, 4, 5, 29, 34, 35, 36, and 38 (Table 7.12).

Table 7. 12: Stock-outs of HMIS Tools in the Last FY, by Facility Type

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Received tools:				
Before start of the FY	0.0	10.3	8.0	10.3
Within 1 month of start of FY	23.5	35.9	41.0	48.5
2–3 months	52.9	33.3	31.0	25.0
More than 3 months	0.0	15.4	11.0	8.8
Did not receive tools	11.8	0.0	0.0	0.0
Don't know/can't say	5.9	5.1	6.0	5.9
Total facilities (N)	**17**	**39**	**100**	**68**
Stock-out of any HMIS tools in the last FY	13.3	25.6	27.0	23.5
Tools frequently run out of:*				
HMIS 32	50.0	40.0	29.6	62.5
HMIS 4	50.0	30.0	18.5	6.3
HMIS 2	0.0	30.0	14.8	6.3
HMIS 1	0.0	30.0	14.8	0.0
HMIS 16	0.0	20.0	14.8	6.3
HMIS 5	50.0	10.0	7.4	12.5
HMIS 29	50.0	0.0	14.8	0.0
HMIS 31	0.0	0.0	7.4	18.8
HMIS 3	0.0	10.0	3.7	12.5
HMIS 10	100	0.0	3.7	6.3
HMIS 13	0.0	10.0	7.4	6.3
HMIS 27	0.0	10.0	7.4	6.3
HMIS 6	0.0	0.0	7.4	6.3
HMIS 9	0.0	10.0	3.7	6.3
HMIS 12	0.0	0.0	11.1	0.0
HMIS 17	0.0	0.0	0.0	12.5
HMIS 30	0.0	0.0	7.4	0.0
HMIS 6	0.0	0.0	3.7	0.0
HMIS 7	0.0	0.0	3.7	0.0
HMIS 20	0.0	0.0	3.7	0.0
HMIS 28	50.0	0.0	0.0	0.0
HMIS 34	50.0	0.0	0.0	0.0
HMIS 35	50.0	0.0	0.0	0.0
HMIS 36	50.0	0.0	0.0	0.0
HMIS 38	50.0	0.0	0.0	0.0
Total facilities who received HMIS form (N)	**15**	**39**	**100**	**68**

**Percentage total may exceed 100 as a result of multiple responses*
Source: STS facility questionnaire

Table 7.13 presents the time spent by staff on HMIS data recording and reporting. The majority of HPs (96%) had spent enough time on recording and reporting, as had staff at PHCCs (95%), SHPs (93%), and hospitals (73%). Among those facilities who had not committed enough time to recording and reporting, the reasons given for not having done so included: inadequate technical and administrative staff (by 50% of hospitals, 25% of HPs, and 40% of SHPs), and recording and reporting not being a high priority (by 25% of hospitals, 50% of HPs, and 40% of SHPs). Additionally, half of hospitals (50%) and PHCCs

(50%), and one quarter (25%) of HPs reported that there was a high workload related to services, and half of PHCCs (50%), one quarter of hospitals (25%) and HPs (25%), and one-fifth of SHPs stated that staff did not have the requisite recording and reporting skills. The average amount of time that health workers spent on reporting and recording was three hours per month. Facility-wise disaggregation shows that lower-level health facility staff spent less time on recording and reporting than those at hospitals.

Table 7. 13: Median Time Spent by Staff on Data Recording/Reporting

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
% of health facilities that reported spending enough time on data recording/reporting	73.3	94.9	96.0	92.6
Total facilities with records (N)	**15**	**39**	**100**	**68**
Reasons for not spending enough time:*				
Inadequate technical and administrative staff	50.0	0.0	25.0	40.0
High workload related to services	50.0	50.0	25.0	0.0
High administrative workload	50.0	0.0	25.0	0.0
Recording and reporting is not a high priority	25.0	0.0	50.0	40.0
No recording and reporting skills with staff	25.0	50.0	25.0	20.0
Unavailability of human resources for recording and reporting	25.0	0.0	0.0	0.0
Absence of staff during recording and reporting	0.0	0.0	25.0	20.0
Total facilities with staff not spending enough time (N)	**4**	**2**	**4**	**5**
Time spent by the staff on data recording/reporting (min):				
Median	360.0	180.0	180.0	180.0
1st quartile	185.0	120.0	120.0	120.0
3rdquartile	1,200.0	300.0	240.0	225.0
Total facilities with records (N)	**15**	**39**	**100**	**68**

**Percentage total may exceed 100 as a result of multiple responses*
Source: STS facility questionnaire

Health facilities were asked about the use of HMIS data. A substantial proportion of health facilities (93% of hospitals, 92% of PHCCs, 98% of HPs, and 97% of SHPs) reported using HMIS data to report to centres, districts, and/or Ilakas, and also to inform stakeholders (93% of hospitals, 92% of PHCCs, 87% of HPs, and 90% of SHPs). Lower-level health facilities (54% of PHCCs, 53% of HPs and 44% of SHPs) had used HMIS data to develop VDC/DDC health profiles; however, only 20% of hospitals were using it for a similar purpose. Lower-level health facilities used the data to manage drugs and select a suitable site for Primary Health Care Outreach Clinics (PHC-ORCs). A slightly higher proportion of PHCCs (56%) used HMIS data to identify unreached populations as compared to hospitals (40%), HPs (53%), and SHPs (44%) (Table 7.14).

Table 7. 14: Use of HMIS Data, by Facility Type

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Informing stakeholders	93.3	92.3	87.0	89.7
Reporting to the centre/district/Ilaka	93.3	92.3	98.0	97.1
Annual health work plan	86.7	97.4	80.0	79.4
Service monitoring/supervision	73.3	84.6	77.0	72.1
Management of drugs	73.3	87.2	87.0	86.8
Management of instruments and supplies	66.7	82.1	76.0	75.0
Management of human resources	66.7	51.3	59.0	50.0
Programme formulation, such as National Immunization Day (NID), Mop-up, etc.	46.7	74.4	73.0	72.1
Selection of suitable location for PHC-ORC	40.0	79.5	88.0	88.2
Increasing coverage of services	66.7	79.5	80.0	66.2
Identification of unreached population	40.0	56.4	53.0	44.1
Development of VDC/DDC health profile	20.0	53.8	53.0	44.1
Total facilities having information (N)	**15**	**39**	**100**	**68**

Note: Percentage total may exceed 100 as a result of multiple responses
Source: STS facility questionnaire

Enumerators observed the completed HMIS forms from the last FY (2069/70). More than six out of ten lower-level health facilities (62% of HPs, 63% of SHPs, and 69% of PHCCs) had filled in the monthly monitoring sheet completely, but only four in ten hospitals (40%) had. The monthly monitoring sheet was not available in over a quarter of hospitals (27%) and around one-eighth of HPs (12%) during the period that data were being collected (Table 7.15).

Table 7. 15: Health Facilities with Filled Monthly Monitoring Sheets, by Facility Type

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Completely filled	40.0	69.2	62.0	63.2
Partially filled	20.0	20.5	22.0	25.0
Not filled	13.3	5.1	4.0	7.4
Monthly monitoring sheet not available (during time of visit)	26.7	5.1	12.0	4.4
Total health facilities with information on monthly monitoring sheets (N)	**15**	**39**	**100**	**68**

Source: STS facility questionnaire

Staff from around a quarter (26%) of PHCCs and hospitals (24%) reported that they had a very high workload due to recording and reporting work (excluding HMIS). One-third (33%) of PHCCs and HPs, 35% of Hospitals, and 29% of SHPs reported a fair workload, even if there were forms other than HMIS that required filling in. However, a small percentage of HPs (5%) and SHPs (1%) stated that the workload in recording and reporting was very high (Table 7.16).

Table 7. 16: Workload Related to Recording and Reporting Other than HMIS, by Facility Type

Workload related to recording and reporting other than HMIS	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Very high	23.5	25.6	5.0	1.5
High	29.4	17.9	11.0	7.4
Fair	35.3	33.3	33.0	29.4
Low	0.0	5.1	13.0	13.2
Very low	11.8	17.9	38.0	48.5
Total facilities (N)	**17**	**39**	**100**	**68**

Source: STS facility questionnaire

Staffs at health facilities were asked for their suggestions on improving the HMIS recording and reporting process. One of the most common recommendations was the provision of an online electronic system of reporting, a suggestion which increased in frequency with increasing level of facility (4% of SHPs, 15% of HPs, 26% of PHCCs, and 33% of hospitals) (Table 7.17). Ease in recording and reporting tools was recommended by a higher percentage of PHCCs (33%) and HPs (25%) than SHPs (16%) and hospitals (7%). A slightly higher proportion of SHPs (37%) suggested the need for additional training on HMIS tools, compared to higher-level facilities.

Table 7. 17: Suggestions to Improve the HMIS Recording and Reporting Process, by Facility Type

Suggestions to improve HMIS recording/reporting	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Online/electronic system of reporting	33.3	25.6	15.0	4.4
Provision of training of HMIS tools	26.7	20.5	29.0	36.8
No need for improvement	13.3	10.3	12.0	0.0
Provision of separate forms for hospitals (zonal/regional/sub-regional)	13.3	0.0	0.0	0.0
Recording and reporting forms should be made easier/updated	6.7	33.3	25.0	16.2
Timely availability of HIMS tools	6.7	12.8	14.0	19.1
Review of recording and reporting process and feedback base	6.7	5.1	2.0	0.0
Provision of administrative person for recording and reporting	6.7	5.1	0.0	1.5
Verification of data received from HMIS	6.7	2.6	1.0	0.0
HSIS form is not appropriate for hospital	6.7	0.0	0.0	0.0
All the recording and reporting forms should be in similar	0.0	5.1	7.0	4.4
Work division for recording and reporting	0.0	2.6	5.0	1.5
Availability of HMIS form according to register	0.0	2.6	4.0	1.5
Forms filled by FCHVs/Maternal and Child Health Workers (MCHWs) should be arranged uniformly	0.0	0.0	3.0	4.4
Timely recording and reporting by health institution	0.0	2.6	2.0	4.4
There should be monitoring system of recording and reporting	0.0	0.0	2.0	4.4
Provision of allowance and refreshment cost to health workers	0.0	0.0	1.0	1.5
Health workers should allocate sufficient time for recording	0.0	2.6	0.0	1.5
Supervision of recording and reporting process time and again	0.0	0.0	2.0	0.0
Recording and reporting forms filled in by FCHVs/MCHWs are not adequate	0.0	0.0	1.0	1.5
Total facilities with information (N)	**15**	**39**	**100**	**68**

Note: Percentage total may exceed 100 as a result of multiple responses
Source: STS facility questionnaire

7.2.9 Supervision

Overall, 87% of health facilities had had supervisory visits from higher-level authorities in the last FY. On average, HPs had had four, and SHPs had had three, supervisory visits from Ilaka level over the last FY. Similarly, the average number of supervisory visits received in the last year, across all levels of health facility, was four for district-level visits, and two for regional-and central-level visits. Lower-level health facilities were more likely to receive supervisory visits from Ilaka and district levels than from regional and central levels (Table 7.18).

Table 7. 18: Supervision Visits in the Last FY, by Facility Type

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)	Total (%)
Had a supervisory visit in the last FY	64.7	94.9	92.0	79.4	86.6
Visits from Ilaka level					
Mean number of visits	0.0	0.0	3.7	2.4	2.9
Total visits	**0**	**0**	**28**	**39**	**67**
Visits from district level					
Mean number of visits	4.5	6.1	4.8	2.0	4.3
Total visits from district level (N)	**2**	**36**	**87**	**47**	**172**
Visits from regional level					
Mean number of visits	2.1	1.8	1.9	5.0	2.0
Total visits from regional level (N)	**8**	**14**	**20**	**1**	**43**
Visits from central level					
Mean number of visits	2.9	1.0	1.5	1.5	1.6
Total visits from central level (N)	**7**	**11**	**18**	**2**	**38**
Visits from all levels					
Mean number of visits	4.2	6.9	6.3	3.6	5.6
Total visits (N)	**11**	**37**	**92**	**54**	**194**

Source: STS facility questionnaire

Following supervision visits, a high percentage of hospitals (91%) received feedback that they needed to ensure that women received their Aama transport incentive payments on time. Other recommendations commonly fed back to hospitals included: the need for timely reporting, and for clean and hygienic health facilities, ensuring the availability of both services and human resources (all 82%), and ensuring free care and quality data recording and reporting (both 73%). The need to improve the quality of data recording and reporting, better maintenance of hygiene (both 78%) and ensuring the availability of drugs (76%) and services (73%) were four of the recommendations most commonly fedback to PHCCs. Improving the quality of recording and reporting was the recommendation most frequently feedback to HPs (82%) and SHPs (87%) (Table 7.19).

Table 7. 19: Type of Feedback Received from Supervision Visits, by Facility Type

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Ensure that women receive Aama incentive on time	90.9	67.6	45.7	14.8
Report on timely basis	81.8	64.9	57.6	57.4
Better hygiene/cleaner facility	81.8	78.4	67.4	75.9
Ensure availability of services	81.8	73.0	59.8	72.2
Ensure availability of human resources	81.8	59.5	56.5	51.9
Increase service coverage	72.7	73.0	77.2	75.9
Increase service provision	81.8	73.0	65.2	70.4
Improve quality of data recording and reporting	72.7	78.4	81.5	87.0
Ensure people receive free care	72.7	62.2	56.5	66.7
Greater focus on services to women	72.7	54.1	55.4	57.4
Ensure availability of drugs	72.7	75.7	63.0	77.8
Greater focus on Dalits, Janajatis, and other excluded groups	63.6	48.6	39.1	50.0
Total facilities that had received a supervision visit (N)	**11**	**37**	**92**	**54**

Note: Percentage total may exceed 100 as a result of multiple responses

Around three-quarters of HPs (77%), SHPs (76%), PHCCs (73%) and hospitals (73%) were advised to increase their service coverage (Table 7.19). The six services whose coverage hospitals were most commonly encouraged to increase were: surgical services (38%), maternity services (38%), and the Aama Programme (25%), immunization services (25%), ANC services (32%), and PNC services (13%). Increasing immunization and FP services were the most common service coverage recommendations made for PHCCs, HPs, and SHPs (Table 7.20).

Table 7. 20: Feedback Given on Increasing Service Coverage, by Facility Type

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Increase service coverage	72.7	73.0	77.2	75.9
Total facilities with a supervision visit (N)	**11**	**37**	**92**	**54**
Type of services told to increase coverage of:*				
Increasing surgical services	37.5	0.0	0.0	0.0
Maternity service	37.5	22.2	14.1	2.4
Immunisation service	25.0	48.1	63.4	65.9
Aama Programme	25.0	14.8	11.3	9.8
ANC services	12.5	7.4	21.1	24.4
PNC services	12.5	14.8	19.7	19.5
FP	0.0	14.8	25.4	43.9
Outreach clinic service	0.0	18.5	8.5	14.6
Directly Observed Treatment, Short-course (DOTS)/TB	0.0	7.4	9.9	2.4
Slide collection of TB	0.0	11.1	4.2	7.3
Nutrition program	0.0	14.8	2.8	4.9
Outpatients service	0.0	0.0	4.2	7.3
Slide collection of malaria	0.0	3.7	4.2	0.0
Provide regular service from health facility	0.0	0.0	1.4	2.4
Japanese encephalitis	0.0	7.4	0.0	0.0
PMTCT programme/HIV/AIDS	0.0	7.4	0.0	0.0
Free medicines	0.0	0.0	1.4	2.4
Overall coverage of service of health facility	0.0	3.7	0.0	0.0
Measles	0.0	3.7	0.0	0.0
Communicable diseases	0.0	0.0	0.0	2.4
IMCI services	0.0	0.0	1.4	0.0
Polio programme	0.0	0.0	1.4	0.0
Health education	0.0	3.7	0.0	0.0
Diarrhoea	0.0	0.0	1.4	0.0
Kala-azar	0.0	3.7	0.0	0.0
Mental health services	0.0	3.7	0.0	0.0
Total facilities receiving feedback (N)	**8**	**27**	**71**	**41**

**Percentage total may exceed 100 as a result of multiple responses*
Source: STS facility questionnaire, maternity client exit interview, and outpatient exit interview

Health workers were asked whether the supervision visits received were supportive or not. Staff from 5% of HPs and 9% of SHPs said that the supervision visits had been very unsupportive. Recommendations to improve supervision and feedback were sought: regular supervision was the most widespread suggestion, made by 41% of hospitals, 33% of PHCCs, 45% of HPs, and 38% of SHPs. Other suggestions to improve supervision and feedback mechanisms are shown in Table 7.21. Around half (54%) of PHCCs, 41% of hospitals, 39% of HPs, and 28% of SHPs had approved a supervision plan.

Table 7. 21: Suggested Ways to Improve Supervision and Feedback, by Facility Type

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
How supportive was the supervision				
Very unsupportive	0.0	0.0	5.4	9.3
Unsupportive	9.1	13.5	9.8	5.6
Neither supportive nor unsupportive	36.4	16.2	17.4	24.1
Supportive	27.3	54.1	55.4	51.9
Very supportive	27.3	16.2	12.0	9.3
Total facilities with a supervision visit (N)	**11**	**37**	**92**	**54**
Suggested ways to improve supervision and feedback:*				
Regular supervision	41.2	33.3	45.0	38.2
Timely management of prerequisites for improving weaknesses	11.8	5.1	18.0	10.3
Provision of written feedback	5.9	7.7	8.0	10.3
Immediate action according to feedback	0.0	5.1	4.0	11.8
Supervision should be based on format to ensure quality	5.9	7.7	4.0	7.4
There is no such issue/everything is OK	5.9	7.7	3.0	7.4
Prior information of supervision	0.0	10.3	2.0	4.4
Encouragement/positive feedback should also be given	11.8	5.1	3.0	1.5
Provision of skilled staff for supervision	0.0	5.1	3.0	2.9
Supervision should be done from higher levels	5.9	0.0	4.0	2.9
The process of supervision should be monitored	0.0	2.6	3.0	2.9
Support from centre to implement feedback	5.9	0.0	1.0	5.9
Oral feedback	0.0	2.6	3.0	0.0
Regular supply of drugs	0.0	2.6	1.0	1.5
Recording and reporting process of supervision	0.0	2.6	2.0	0.0
Service-specific monitoring and feedback system	0.0	5.1	0.0	1.5
Timely/quickly feedback	5.9	2.6	0.0	1.5
Timely availability of documents before supervision	0.0	0.0	1.0	1.5
Aama Programme should be implemented in health facilities	0.0	0.0	1.0	0.0
Health facility should have its own building	0.0	0.0	1.0	0.0
Supervisors should be friendly	0.0	2.6	0.0	0.0
Areas of improvement should also be flagged	0.0	0.0	1.0	0.0
Don't know	23.5	10.3	10.0	11.8
Total facilities (N)	**17**	**39**	**100**	**68**
Have approved supervision plan	41.2	53.8	39.0	27.9
Total facilities (N)	**17**	**39**	**100**	**68**

**Percentage total may exceed 100 as a result of multiple responses*
Source: STS facility questionnaire

7.2.10 Contingency Plan

Around three-fifths (59%) of hospitals, half (51%) of PHCCs, and a quarter (25%) of HPs had an emergency contingency plan; most SHPs (96%) reported that they did not. Across all facilities with emergency contingency plan, only 35% of hospitals and 21% of PHCCs and HPs had held a meeting to discuss their plans. Among those facilities that had an emergency contingency plan, a greater proportion of PHCCs (65%) and HPs (60%) than hospitals (50%) and SHPs (33%) also had a plan for women and children (Table 7.22).

Table 7. 22: Presence of Emergency Contingency Plan for Health Services During Conflict or Emergency Situation, by Facility Type

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)	Total (%)
Have Emergency Contingency plan	58.8	51.3	25.0	4.4	25.9
Had meeting on Emergency Contingency plan	35.3	20.5	21.0	10.3	18.8
Total facilities (N)	**17**	**39**	**100**	**68**	**224**
Have Emergency Contingency plan for women and children	50.0	65.0	60.0	33.3	58.6
Total facilities having Emergency Contingency plan (N)	**10**	**20**	**25**	**3**	**58**
Observation of Meeting time:					
Observed meeting minutes	33.3	37.5	42.9	42.9	40.5
Meeting minutes not observed	66.7	62.5	57.1	57.1	59.5
Budget allocated in the last AWPB (2069/70) for implementing the emergency plan	50.0	12.5	23.8	28.6	26.2
Total facilities had meeting on Emergency Contingency plan (N)	**6**	**8**	**21**	**7**	**42**

Source: STS facility questionnaire

7.3 KEY FINDINGS

Social audits, disclosure of information, Citizen's Charter

- STS 2013 found that only 15% of health facilities had undertaken social audits as per the MoHP guidelines in the last FY. Nearly three in ten (27%) health facilities had conducted social audit in the last fiscal year in STS 2011. This decreased between STS 2011 and STS 2013, as the guideline had just been introduced in 2012, so the previous survey this was not measured as per the MOHP guideline. Social audits were somewhat more common in PHCCs (28%) and HPs (18%) than in other health facilities in 2013 which is consistent to STS 2011 which has shown 39% of PHCCs, 25% of district hospitals, 38% of HPs and 25% of SHPs had conduced social audit in 2011.
- Public gatherings were the most common method for disclosing the results of social audits at hospitals (60%) and PHCCs (63%), while HFOMC meetings were most frequently used by HPs

(57%) and SHPs (78%). The decisions incorporated into the AWPB following a social audit were implemented by 40% of hospitals, 80% of PHCCs, 61% of HPs, and 56% of SHPs. In contrast to this, facility information board was the most common method for disclosing results of social audit at hospitals (100%) while public gathering were most common methods at PHCCs (33%), HPs (29%) and SHPs (58%).

- A minority of hospitals (29%), SHPs (21%), HPs (15%), and PHCCs (8%) did not have a Citizen's Charter as found by STS 2013. Overall 23% of health facilities did not have a Citizen's Charter in 2012, which included 19% of hospitals and PHCCs, 15% of HPs and 35% of SHPs. STS 2011 had found that although there was not much change for hospitals (12%) and PHCCs (29%), the percentage of HPs (96%) and SHPs (78%) that did not have a charter was far higher. The percentage of hospitals not having citizen's charter has increased over the three STS reports from 2011 to 2013 while it has decreased for SHP, HP and PHCCs.

Facility management committees

- STS 2013 shows that the number of women on facility management committees was similar to that proposed in the guidelines in all level of health facilities; however, the representation of Janajatis in HPs and Dalits in district hospitals was lower than the guidelines stipulate. STS 2012 had shown that nearly half (49%) of the health facilities fulfilled the requirement which has increased to 70% in 2013. Lower level health facilities (58% SHPs, 52% HPs and 39% PHCCs) were more likely to meet the criteria than hospitals (8%).

GESI

- Nearly three-fifths of hospitals (59%) and over half of PHCCs (54%) had undertaken activities to target women in STS 2013. This was similar to STS 2012: 50% hospitals and 58% PHCCs had carried out activities to reach women as a target group.
- STS 2013 found that hospitals had specifically targeted the poor (53%), the physically disabled (41%), and the destitute (35%) while in 2012, the proportion of hospitals targeting poor (44%), and physically disabled and destitute (31%) was slightly lower.
- STS 2013 has found that nearly half of the PHCCs (48%) and HPs (52%) and 43% of SHPs had targeted activities for those living in remote areas. while SHPs were most likely to have focused on reaching Janajatis.

Suggestions/complaints mechanism

- Most hospitals (82%) had a formal suggestions/complaints procedure in STS 2013, similar to STS 2012 (81%). However, in STS 2013: 46% of PHCCs, 62% of HPs, and 66% of SHPs did not have one, which is a big reduction compared to 2012 for PHCCs (74%), HPs (81%) and SHPs (90%).
- About 45% of hospitals, 43% of PHCCs, 30% of HPs, and 38% of SHPs had not taken any action based on the reported suggestions and complaints in STS 2013.

Staff meetings

- Nearly half of facilities at every level had monthly staff meetings: 41% of hospitals, 46% of PHCCs, 48% of HPs and 44% of SHPs. Findings of STS 2012 had shown that 44% of hospitals, 55% of PHCCs, 54% of HPs and 44% of SHPs had monthly meetings while 63% hospitals, 54% PHCCs, 76% HPs and 55% SHPs held monthly meeting in 2011. The findings indicate that the trend is declining for all level of facilities.

HMIS

- Stock-outs were most common in lower-level health facilities (26% of PHCCs, 27% of HPs, and 24% of SHPs). The most common stock-outs were of HMIS tools 32, 4, 36, 37, and 38.
- On average, health workers spent three hours per month on reporting and recording. The median value for lower-level facilities was three hours, while for hospitals it was six hours.
- Of those health facilities that reported not having spent enough time on data recording/reporting, one-third reported that they had inadequate technical and administrative staff for recording and reporting activities, with a similar proportion stating that recording and reporting was not a high priority.
- On observation, only 40% of hospitals, 69% of PHCCs, 62% of HPs, and 63% of SHPs had filled in their monthly reporting forms completely.

Supervision

- STS 2013 found that PHCCs (95%) and HPs (92%) were more likely to have received a supervisory visit in the last year than hospitals (65%) and SHPs (79%). The percentage of health facilities having supervisory visits has increased in comparison to STS 2012 for PHCCs, HPs and SHPs. In 2012, 88% hospitals, 77% PHCCs, 76% HPs and 72% SHPs had a supervisory visit in the last fiscal year.

- Around half (54%) of PHCCs, 41% of hospitals, 39% of HPs, and 28% of SHPs had an approved supervision plan.

Contingency plan

- Around three-fifths of hospitals (59%), half of PHCCs (51%), and a quarter of HPs (25%) had an emergency contingency plan while most SHPs (96%) did not. In contrast to this, 69% of hospitals, 32% of PHCCs, 32% of HPs and 18% of SHPs had emergency contingency plan in 2012. The findings indicate increasing trend for PHCCs while decreasing trend for all other facilities.

CHAPTER 8: HUMAN RESOURCES FOR HEALTH

8.1 INTRODUCTION

The Human Resource Strategic Plan envisioned ensuring equitable distribution of appropriate skilled Human Resources for Health (HRH) to support the achievement of health outcomes in Nepal and in particular, the implementation of NHSP-2, developed by MoHP. National guiding policies and plans have emphasized human resources as an important component to be considered to provide high-quality health care to the general public. A number of HRH challenges and constraints that are affecting the delivery of health services and the achievement of health outcomes have been identified, and this plan proposes a range of strategies and issues to address these challenges in the five-year plan period. This plan recommends that the staffing projections made in the 2003 Strategic Plan for HRH be reassessed in light of the evolving political context and changing policies concerning health issues.

The Health Service Act (1997) makes provision for the management of health workers employed by MoHP and provides guidance on the recruitment, deployment, promotion, and discipline of health workers. Since its enactment, the act has had a number of amendments and it appears to have a degree of flexibility that make it responsive to a dynamic and evolving health system, and to a diverse and multicultural health workforce.

This chapter describes the findings related to human resources at 222 health facilities. Information was sought on sanctioned and filled positions, provision for hiring staff on contracts, and adequacy of staff numbers. This section also presents the training received by health workers, specifically on the Newborn Care Programme (NCP), IMCI, FP (Intrauterine Contraceptive Devices (IUCDs) and implants), Ultrasonography (USG), and Adolescent-friendly Services (AFS).

8.2 RESULTS

Table 8. 1: Human Resources Indicators Included in the NHSSP LF STS 2013

Indicators	STS 2011	95% CI	STS 2012	95% CI	STS 2013	95% CI
% of sanctioned positions that are filled						
Doctors at PHCCs	50.0	35.1–64.9	22.6	8.8–46.9	23.1	5.7–70.4
Doctors at district hospitals	68.9	46.7–79.6	63.0	35.6–78.8	47.1	12.2–69.5
Nurses at PHCCs	73.8	60.5–83.8	58.7	44.9–73.3	38.5	33.2–44.0
Nurses at district hospitals	83.3	74.3–89.6	82.7	75.1–91.1	55.3	48.4–57.1
% of district hospitals that have at least one O/G or specialist MDGP, five nurses trained as SBAs, and one anaesthetist or AA	31.2	14.5–55.0	0.0	NA	0.0	NA
% of PHCCs with at least one Medical Officer (MO), one Health Assistant (HA)/senior AHW, one Staff Nurse (SN), two AHWs, three ANMs, and one laboratory assistant in filled positions	7.1	0.6–47.8	9.7	4.8–18.4	0.0	NA
% of category-A HPs with at least one HA/senior AHW, two AHWs, and one ANM in filled positions	53.3	19.2–84.6	38.7	22.2–59.8	13.1	18.3–63.6
% of category-B HPs with at least one HA/senior AHW, one AHW, and one ANM in filled positions	20.0	8.7–39.6	16.7	9.7–24.5	13.1	4.7–31.4
% of SHPs with at least one AHW, one MCHW, and one VHW in position	50.0	37.8–62.2	44.4	31.9–64.9	47.1	28.8–66.1

8.2.1 Sanctioned and Filled Positions

Higher-level hospitals

The number of sanctioned positions varies between different levels of facility, and between hospitals of the same level. The DoHS Operating Manual stipulates the official number of sanctioned positions for each position at higher-level hospitals. The extent to which the higher-level hospitals sampled in STS 2013 have met them is described in Table 8.2 (column a).

The sampled districts in STS 2013 contained eight higher-level hospitals. However, information from two hospitals was not included in the analysis as there was no responsible person to provide the required information. The total number of sanctioned posts for these six higher-level hospitals was 289, of which 72% were filled. All the sanctioned positions for AHWs and most of those for ANMs (96%), laboratory assistants/technicians (89%), HAs (88%), and MOs (78%) were filled. However, only 33% of the MDGP and anaesthetist positions were filled (Table 8.2, column e).

Table 8. 2: Number of Sanctioned Positions, and Proportion that are Filled, at Higher-level Hospitals

Position	(a) Official number of sanctioned positions (range across facilities) (N)	(b) % of hospitals with the required number of sanctioned positions	(c) % of hospitals that have filled all of their sanctioned positions	(d) No. of sanctioned positions at all hospitals (N)	(e) % of sanctioned positions filled at all hospitals
O/G	1–2	100	50.0	7	57.1
Paediatrician	1–2	100	66.7	7	71.4
MDGP	1–11	100	33.3	18	33.3
Anaesthetist	1	100	33.3	6	33.3
MO	1–13	100	50.0	46	78.3
Sister/matron/nursing inspector	1–3	100	50.0	14	50.0
SN	18-–4	100	0.0	115	65.2
ANM	3–4	100	83.3	22	95.5
HA	1–2	100	83.3	8	87.5
AHW	4–6	100	100	28	100
Laboratory assistant/technician	1–6	100	66.7	18	88.9
All		100	0.0	289	71.6
Total facilities (N)	**6**				

Source: STS facility questionnaire

District-level hospitals

All the district hospitals met the Operating Manual's requirement for the number of sanctioned positions (Table 8.3). Of the total nine sampled district hospitals, most of the AHWs (86%), 78% of HAs, 77% of ANMs, and 76% of laboratory assistant/technician positions were filled. More than two-thirds (36%) of the MOs and half (53%) of the SN positions were filled at all district hospitals. Overall, 68% of the 125 sanctioned positions were filled across the nine district hospitals (Table 8.3, column e).

Table 8. 3: Number of Sanctioned Positions, and Proportion that are Filled, at District-level Hospitals

	(a)	(b)	(c)	(d)	(e)
Position	**Official number of sanctioned positions (range across facilities) (N)**	**% of hospitals with the required number of sanctioned positions**	**% of hospitals that have filled all of their sanctioned positions**	**No. of sanctioned positions at all hospitals (N)**	**% of sanctioned positions filled at all hospitals**
MO	1–3	100	33.3	17	36.0
SN	3–10	100	0.0	38	52.7
ANM	2–4	100	66.7	22	77.3
HA	1	100	77.8	9	77.8
AHW	2–4	100	77.8	22	86.4
Laboratory assistant/technician	1–2	100	55.6	17	76.5
All		100	0.0	125	68.0
Total facilities (N)	**9**				

Source: STS facility questionnaire

PHCCs

Table 8.4 presents the number of sanctioned positions, per position, which a PHCC is required to have. All of the 39 PHCCs in the sample fulfilled the requirements for the number of sanctioned positions that they should have (Table 8.4, column b).

Of the sanctioned positions in PHCCs, 82% of laboratory assistants/technicians, 87% of AHWs, 70% of ANMs and 56% of HAs had been filled; however, the percentage of PHCCs that had filled all of their sanctioned positions was below one quarter (23%) for MOs, 38% for SNs, and nearly 50% for ANMs (Table 8.4, column c).

The total number of sanctioned positions for all the 39 PHCCs was 352, of which 65% had been filled, with variation across different positions: 87% of AHWs, 82% of laboratory assistants/technicians, and 70% of ANMs. However, the sanctioned positions filled at PHCCs for MOs and SNs were low: 28% and 38% respectively (Table 8.4, column e).

Table 8. 4: Number of Sanctioned Positions, and Proportion that are Filled, at PHCCs

	(a)	(b)	(c)	(d)	(e)
Position	**Official number of sanctioned positions (range across facilities) (N)**	**% of PHCCs with the required number of sanctioned positions**	**% of PHCCs that have filled all of their sanctioned positions**	**No. of sanctioned positions at all PHCCs (N)**	**% of sanctioned positions filled at all PHCCs**
MO	1	100	23.1	39	27.6
SN	1	100	38.5	39	38.5
ANM	3	100	48.7	118	70.3
HA	1	100	56.4	39	56.4
AHW	2	100	76.9	78	87.2
Laboratory assistant/technician	1	100	82.1	39	82.1
All		100	7.7	352	65.1
Total facilities (N)	**39**				

Source: STS facility questionnaire

HPs

HPs are divided into two categories by ecological region: those in the Terai region are category A (39 HPs sampled) and those in the hill and mountain regions are category B (61 HPs sampled). The DoHS Operating Manual stipulates that both categories of HP should have sanctioned posts for one HA and one or two ANMs. However, there should be two or three AHWs in category-A HPs, and just one or two in category-B HPs.

Table 8.5 shows that all categories A and B HPs met the requirement for the number of sanctioned HA, ANM, and AHW positions.

Compared to category-B HPs (13%), category-A HPs were more likely (36%) to have filled all sanctioned positions. Breaking this down by type of position, 79% of ANM, 54% of HA, and 69% of AHW sanctioned positions in category A had been filled, compared to 61% of ANM, 31% of HA, and 87% of AHW sanctioned positions in category B.

Of the actual positions sanctioned, 73% of the 420 positions had been filled. Three-quarters of ANM positions (75%) and 89% of AHW positions had been filled, compared to only 40% of HA positions.

Table 8. 5: Number of Sanctioned Positions, and Proportion that are Filled, at HPs

Position	Terai (category A)			Mountain/hill (category B)			All	
	Official number of sanctioned positions (range across facilities) (N)	% of HPs with the required number of sanctioned positions	% of HPs that have filled all of their sanctioned positions	Official number of sanctioned positions (range across facilities) (N)	% of HPs with the required number of sanctioned positions	% of HPs that have filled all of their sanctioned positions	Total sanctioned positions at all HPs (N)	% of total sanctioned positions filled at all HPs
ANM	1–2	100	79.5	1–2	100	60.7	127	74.8
HA	1	100	53.8	1	100	31.1	100	40.0
AHW	2–3	100	69.2	1–2	100	86.9	193	88.6
All		100	35.9			13.1	420	72.9
Total facilities (N)	**39**			**61**			**100**	

Source: STS facility questionnaire

SHPs

The DoHS Operating Manual stipulates that SHPs should have at least one AHW, one MCHW, and one Village Heath Worker (VHW). All of the 68 sampled SHPs had the required number of sanctioned positions (Table 8.6, column b).

Of the sanctioned positions, 88% of the SHPs had at least one AHW position filled as per requirement and 85% SHPs had at least one MCHW sanctioned position filled. However, only 54% of SHPs had at least one VHW position filled (Table 8.6, column c).

Overall, 72% of the 204 positions sanctioned at the SHPs were filled. The percentages of these sanctioned positions that were filled varied by position, with most MCHWs (85%) and AHWs (88%) positions filled, but just over half (54%) of the VHW sanctioned positions filled (Table 8.6, column e).

Table 8. 6: Number of Sanctioned Positions, and Proportion that are Filled, at SHPs

	(a)	(b)	(c)	(d)	(e)
Position	**Official number of sanctioned positions (range across facilities) (N)**	**% of SHPs with the required number of sanctioned positions**	**% of SHPs that have filled all of their sanctioned positions**	**No. of sanctioned positions at SHPs (N)**	**% of sanctioned positions filled at all SHPs**
AHW	1	100	88.2	68	88.2
MCHW	1	100	85.3	68	85.3
VHW	1	100	54.4	68	54.4
All		100	47.1	204	72.1
Total facilities (N)	**68**				

Source: STS facility questionnaire

One member of staff at each facility was asked about the effect of staff shortages on service provision. Staff shortages reportedly affect service delivery at 88% of hospitals, 69% of PHCCs, 49% of HPs, and 44% of SHPs. Staff at hospitals most commonly reported that shortages affect general curative and inpatient services (36%), delivery services (29%), surgery (29%), and anaesthesia (21%). Similarly, curative and inpatient services were most commonly affected in PHCCs (52%), HPs (41%), and SHPs (50%). Immunization and outreach clinics were also affected by staff shortages at 47% and 37% of the SHPs respectively (Table 8.7).

Table 8. 7: Effect of Staff Shortages on Service Delivery

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Staff shortages affect service delivery	87.5	69.2	49.0	44.1
Total facilities (N)	16	39	100	68
Type of services:*				
General curative services and inpatient services	35.7	51.9	40.8	50.0
Delivery services	28.6	22.2	32.7	3.3
Surgery	28.6	7.4	0.0	0.0
Anaesthesia	21.4	0.0	0.0	0.0
FP	14.3	11.1	4.1	10.0
Emergency	14.3	14.8	0.0	0.0
Electrocardiogram/X-ray/video-X-ray	14.3	3.7	2.0	0.0
PNC/ANC service/safe motherhood	7.1	11.1	14.3	16.7
Lab	7.1	18.5	8.2	
Medical abortion	7.1	3.7	4.1	0.0
Gynaecology	7.1	0.0	0.0	0.0
Pathology	7.1	0.0	0.0	0.0
Ear, nose, and throat	7.1	0.0	0.0	0.0
Dermatology	7.1	0.0	0.0	0.0
Mental health services	7.1	0.0	0.0	0.0
Viral epidemic management	7.1	0.0	0.0	0.0
Snakebite management	7.1	0.0	0.0	0.0
AFS	0.0	0.0	2.0	0.0
DOTS/TB	0.0	7.4	0.0	0.0
Counselling services	0.0	0.0	2.0	0.0
Community-based NCP (CB-NCP)	0.0	3.7	0.0	0.0
Nutrition programme	0.0	3.7	0.0	0.0
Immunization services	0.0	11.1	14.3	46.7
Outreach clinic programme	0.0	0.0	16.3	36.7
Office management/administration services/stores/accounts	0.0	22.2	16.3	10.0
Aama Programme	0.0	11.1	12.2	0.0
IMCI	0.0	3.7	2.0	13.3
Maternal and Child Health (MCH) clinic services	0.0	0.0	2.0	0.0
Total facilities (N)	**14**	**27**	**49**	**30**

**Percentage total may exceed 100 as a result of multiple responses*
Source: STS facility questionnaire

8.2.2 Service Contracts

Table 8.8 shows the sanctioned staff currently deputed in and out at the time of survey. It was found that a greater proportion of staff was deputed in than deputed out across all levels of health facility, except SHPs.

At district hospitals, a greater proportion of staff was deputed in (9% of sanctioned positions) than out (4%). The members of staff most likely to be deputed in at hospitals were: AHWs (22% of sanctioned staff), sister/matron/nursing inspectors (21% of sanctioned staff), and ANMs (21% of sanctioned staff). Paediatricians (29% of sanctioned staff) were more likely to be deputed out at hospitals than any other position. AHWs were the cadre most commonly deputed in (17%) and out (13%) at PHCCs, while at HPs AHWs were the most commonly deputed in (17% of the sanctioned staff) and ANMs the most commonly deputed out (9% of sanctioned staff). The cadres most deputed in and out at SHPs were AHWs (9%) and VHWs (7%) respectively.

Table 8. 8: Sanctioned Staff Currently Deputed In and Out, as a Percentage of the Total Sanctioned Staff Across Facilities at Each Level

	Sanctioned staff currently deputed in		Sanctioned staff currently deputed out	
	N	**%**	**N**	**%**
Hospitals				
O/G	0	0.0	0	0.0
Paediatrician	0	0.0	2	28.6
MDGP	2	11.1	1	5.6
Anaesthetist	0	0.0	0	0.0
MO	3	4.8	2	3.2
Sister/matron/nursing inspector	3	21.4	0	0.0
SN	3	2.0	6	3.9
ANM	9	20.5	3	6.8
HA	1	5.9	0	0.0
AHW	11	22.0	1	2.0
Laboratory assistant/technician	5	14.3	0	0.0
Total	**37**	**8.9**	**15**	**3.6**
PHCCs				
MO	1	2.6	0	0.0
SN	0	0.0	2	5.1
ANM	5	4.2	4	3.4
HA	4	10.3	1	2.6
AHW	13	16.7	10	12.8
Laboratory assistant/technician	2	5.1	3	7.7
Total	**25**	**7.1**	**20**	**5.7**
HP				
ANM	14	11.0	12	9.4
HA	4	4.0	1	1.0
AHW	32	16.6	16	8.3
MCHW	1	7.1	0	0.0
VHW	1	2.3	2	4.5
Total	**52**	**10.9**	**31**	**6.5**
SHP				
AHW	6	8.8	2	2.9
MCHW	0	0.0	3	4.4
VHW	2	2.9	5	7.4
Total	**8**	**3.9**	**10**	**4.9**
Total staff	**122**	**8.4**	**76**	**5.2**

Source: STS facility questionnaire

8.2.3 Skills Mix

Table 8.9 shows the skills mix at higher-level and district hospitals. Higher-level hospitals had a higher percentage of SNs (26% of staff compared to 18%) and MOs (22% of staff compared to 17%) than district hospitals. However, higher-level hospitals had a lower percentage of HAs (2%) compared to district hospitals (8%), and a lower percentage of ANMs (13% compared to 25%).

Table 8. 9: Skills Mix at Higher-level and District Hospitals (Includes Filled, Contract, Deputed In and Excludes Deputed Out)

Position	Higher-level hospital positions (%)	District hospital positions (%)
O/G	0.7	
Paediatrician	1.0	
MDGP	2.4	
Anaesthetist	0.5	
MO	21.5	17.2
Sister/matron/nurse inspector	3.2	
SN	26.1	17.8
ANM	13.2	25.4
HA	2.4	7.7
AHW	19.3	21.3
Laboratory assistant/technician	9.8	10.7
Total number in position (N)	**410**	**169**

Source: STS facility questionnaire

Table 8.10 present the skills mix at PHCCs, HPs, and SHPs. At PHCC level, 40% of the staff were nurses (5% SNs and 36% ANMs), 29% AHWs, 10% HAs, 13% Laboratory assistants/technicians, and 8% MOs. At HPs, 47% were ANMs, 24% AHWs, 14% HAs, 12% VHWs, and 4% MCHWs. More than four in ten (44%) members of staff at SHPs were AHWs, one-third (33%) were laboratory assistants/technicians, and 23% were VHWs.

Table 8. 10: Skills Mix at PHCCs, HPs, and SHPs (Includes Filled, Contract, Deputed In and Excludes Deputed Out)

Position	PHCC (%)	HP (%)	SHP (%)
MO	7.8		
SN	4.7		
ANM	35.5	46.5	
HA	10.0	13.8	
AHW	29.3	23.5	44.4
Laboratory assistant/technician	12.8		
MCHW		4.0	32.7
VHW		12.3	22.8
Total number in position (N)	**321**	**400**	**171**

Source: STS facility questionnaire

Table 8.11 shows the service–contract mix of staff. Filled positions are directly employed by the facility. The table shows the number of positions filled minus those members of staff who were deputed out to another facility. Deputed-in positions show the number of staff members contracted at another facility that have been deputed into the facility they were working in at the time of the survey. Contract positions are staff employed by HDCs/HFOMCs and other agencies, such as the National Planning Commission (NPC), FHD, D(P)HO, DDC, VDC, and International NGOs (I/NGOs).

Overall, there was a greater number of staff working (1,471) than the number of sanctioned positions (1,448). Higher-level hospitals had 142% of positions filled relative to the number sanctioned, and district hospitals had 135%. In higher-level hospitals, there was a higher number of AHWs (282%) than sanctioned, and likewise for ANMs (246%), laboratory assistants/technicians (222%), and MOs (191%). Nearly two-thirds (64%) of the total staff in higher-level hospitals were contracted. Among them, 157% of sanctioned positions for AHWs and 136% of those for ANMs were filled. Similarly, among the total staff contracted (63%) in district hospitals, more staff positions were filled than the numbers of sanctioned positions for ANMs (196%), MOs (171%), and AHWs (164%).

The opposite scenario was observed in health facilities below district level, where the number of filled posts was less than the number of sanctioned positions. In PHCCs, 91% of the sanctioned positions were filled. Likewise, in both HPs and SHPs only 84% of the sanctioned positions were filled. Across all facilities, only around six out of ten were sanctioned government staff; the remaining 35% were contract staff. Very low percentages of staff were contracted at lower-level health facilities: one-quarter of staff at PHCCs (25%), 30% at HPs, and 8% at SHPs.

Table 8. 11: Service–contract Mix, Numbers of Staff, and Proportions Relative to the Total Number Sanctioned

	Filled, excluding deputed out		Deputed-in positions		Contract positions				Total staff in position		Total sanc-tioned positions (N)
					All		HDC/HFOMC				
	N	%	N	%	N	%	N	%	N	%	
Higher-level hospitals											
O/G	3	42.9	0	0.0	0	0.0	0	0.0	3	42.9	7
Paediatrician	4	57.1	0	0.0	0	0.0	0	0.0	4	57.1	7
MDGP	5	27.8	2	0.1	3	16.7	1	5.6	10	55.6	18
Anaesthetist	2	33.3	0	0.0	0	0.0	0	0.0	2	33.3	6
MO	35	76.1	3	0.1	50	108.7	30	65.2	88	191.3	46
Sister/matron/nurse inspector	7	50.0	3	0.2	3	21.4	0	0.0	13	92.9	14
SN	70	60.9	3	0.0	34	29.6	8	7.0	107	93.0	115
ANM	20	90.9	4	0.2	30	136.4	21	95.5	54	245.5	22
HA	7	87.5	0	0.0	3	37.5	2	25.0	10	125.0	8
AHW	27	96.4	8	0.3	44	157.1	32	114.3	79	282.1	28
Laboratory assistant/technician	16	88.9	5	0.3	19	105.6	12	66.7	40	222.2	18
All positions	**196**	**67.8**	**28**	**0.1**	**186**	**64.4**	**106**	**36.7**	**410**	**141.9**	**289**
District-level hospitals											
MO	7	41.2	0	0.0	22	129.4	1	5.9	29	170.6	17
SN	20	52.6	0	0.0	10	26.3	1	2.6	30	78.9	38
ANM	15	68.2	5	0.2	23	104.5	15	68.2	43	195.5	22
HA	7	77.8	1	0.1	5	55.6	2	22.2	13	144.4	9
AHW	19	86.4	3	0.1	14	63.6	8	36.4	36	163.6	22
Laboratory assistant/technician	13	76.5	0	0.0	5	29.4	1	5.9	18	105.9	17
All positions	**81**	**64.8**	**9**	**0.1**	**79**	**63.2**	**28**	**22.4**	**169**	**135.2**	**125**
PHCCs											
MO	9	23.1	1	0.0	15	38.5	0	0.0	25	64.1	39
SN	13	33.3	0	0.0	2	5.1	0	0.0	15	38.5	39
ANM	79	66.9	5	0.0	30	25.4	6	5.1	114	96.6	118
HA	21	53.8	4	0.1	7	17.9	1	2.6	32	82.1	39
AHW	58	74.4	13	0.2	23	29.5	11	14.1	94	120.5	78
Laboratory assistant/technician	29	74.4	2	0.1	10	25.6	7	17.9	41	105.1	39
All positions	**209**	**59.4**	**25**	**0.1**	**87**	**24.7**	**25**	**7.1**	**321**	**91.2**	**352**
HP											
ANM	70	55.1	14	0.1	102	80.3	49	38.6	186	146.5	127
HA	39	39.0	3	0.0	13	13.0	4	4.0	55	55.0	100
AHW	58	30.1	13	0.1	23	11.9	11	5.7	94	48.7	193
MCHW	14	100	1	0.1	1	7.1	0	0.0	16	114.3	14
VHW	44	100	1	0.0	4	9.1	2	4.5	49	111.4	44
All positions	**225**	**47.1**	**32**	**0.1**	**143**	**29.9**	**66**	**13.8**	**400**	**83.7**	**478**
SHP											
AHW	58	85.3	6	0.1	12	17.6	2	2.9	76	111.8	68
MCHW	55	80.9	0	0.0	1	1.5	1	1.5	56	82.4	68
VHW	34	50.0	2	0.0	3	4.4	1	1.5	39	57.4	68
All positions	**147**	**72.1**	**8**	**0.0**	**16**	**7.8**	**4**	**2.0**	**171**	**83.8**	**204**
Total staff	**858**	**59.3**	**102**	**0.1**	**511**	**35.3**	**229**	**15.8**	**1471**	**101.6**	**1448**

Total (N) =Total Sanctioned Position (% as total sanctioned post)

Source: STS facility questionnaire

8.2.4 Training

The survey recorded the number of staffs who have received training on the following: NCP, IMCI, IUCDs, implants, USG, AFS, Skilled Birth Attendance (SBA), Advanced Skilled Birth Attendance (ASBA), Operating Theatre (OT) management, and anaesthesia. Table 8.12 presents the percentage of facilities at the time of data collection with at least one permanent member of staff in filled positions (i.e. excluding those contracted or deputed in) that has/have ever received training in these services.

Higher-level hospitals

Most (83%) higher-level hospitals had at least one MO trained in USG. More than two-thirds (67%) of higher-level hospitals had at least one MO trained in IMCI and/or ASBA. Equal proportions (67%) of higher-level hospitals had at least one sister/matron/nurse inspector trained in IMCI and/or SBA. All of the hospitals had at least one SN and one ANM trained in IUCDs and/or SBA. Two-thirds of the hospitals (67%) had HAs trained in IMCI, while all of the hospitals had AHWs trained in IMCI. Only one-third (33%) of the hospitals had laboratory assistants/technicians trained in IMCI.

District hospitals

More than one-fifth (22%) of the district hospitals had at least one MO trained in IMCI and/or USG. Most (89%) hospitals had at least one SN and/or ANM trained in SBA. Likewise, over half of district hospitals (56%) had at least one HA trained in IMCI, while two-thirds (67%) had at least one AHW who had been given similar training.

PHCCs

Only 5% of PHCCs had at least one MO trained in IMCI. Most (85%) PHCCs had ANMs trained as SBAs while only one-third (33%) had an SN who had received SBA training. Nearly three-quarters (72%) of PHCCs had ANMs trained in IMCI, 64% in IUCDs, and 36% in implants and/or AFS. Nearly half (49%) of PHCCs had HAs trained in IMCI, whereas 80% of PHCCs had AHWs trained in IMCI. Meanwhile, 8% of PHCCs also had laboratory assistants/technicians trained in IMCI and/or AFS.

HPs

More ANMs were trained at HPs. Nearly two-thirds (62%) of HPs had ANMs trained in IMCI, 47% in SBA, and 30% in NCP. More than one-third (34%) of the HPs had an HA, and 84% of HPs had an AHW, trained in IMCI.

SHPs

Nearly three-quarters (72%) of SHPs had at least one AHW trained in IMCI, and 21% in NCP. Similarly, 57% of the SHPs had at least one MCHW trained in IMCI, and 35% of the SHPs had at least one VHW trained in IMCI. Only 12% of SHPs had at least one AHW who had received training in AFS.

Table 8. 12: Training Received at the Health Facility by at Least One Staff Member in Filled Positions (Excluding Other Contract and Deputed In) by Position and Type of Health Facility

	NCP (%)	IMCI (%)	IUCD (%)	Implants (%)	USG (%)	AFS (%)	ASBA (%)	SBA (%)	OT management (%)	Anaesthesia (%)
Higher-level hospitals (N=6)										
MO	50.0	66.7	50.0	50.0	83.3	33.3	66.7	0.0	0.0	0.0
Sister/matron/nurse inspector	50.0	66.7	50.0	50.0	16.7	16.7	0.0	66.7	33.3	16.7
SN	83.3	83.3	100	83.3	50.0	50.0	0.0	100	83.3	83.3
ANM	50.0	83.3	100	83.3	33.3	33.3	0.0	100	50.0	0.0
HA	50.0	66.7	16.7	16.7	16.7	33.3	0.0	0.0	0.0	0.0
AHW	66.7	100	16.7	16.7	16.7	33.3	0.0	0.0	0.0	0.0
Laboratory assistant/technician	0.0	33.3	16.7	16.7	16.7	16.7	0.0	0.0	0.0	0.0
District-level hospitals (N=9)										
MO	11.1	22.2	0.0	1.0	22.2	11.1	11.1	0.0	0.0	0.0
SN	44.4	55.6	44.4	2.0	0.0	33.3	0.0	88.9	22.2	0.0
ANM	44.4	55.6	44.4	1.0	0.0	33.3	0.0	88.9	33.3	0.0
HA	33.3	55.6	0.0	0.0	0.0	22.2	0.0	0.0	0.0	0.0
AHW	22.2	66.7	0.0	1.0	0.0	22.2	0.0	0.0	0.0	0.0
Laboratory assistant/technician	11.1	11.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PHCCs (N=39)										
MO	2.6	5.1	0.0	0.0	0.0	2.6	2.6	0.0	0.0	0.0
SN	20.5	20.5	23.1	7.7	0.0	10.3	0.0	33.3	2.6	0.0
ANM	33.3	71.8	64.1	35.9	0.0	35.9	0.0	84.6	5.1	0.0
HA	15.4	48.7	2.6	12.8	2.6	30.8	0.0	0.0	0.0	0.0
AHW	25.6	79.5	0.0	5.1	0.0	30.8	0.0	0.0	0.0	0.0
Laboratory assistant/technician	5.1	7.7	0.0	0.0	0.0	7.7	0.0	0.0	0.0	0.0
HPs (N=100)										
ANM	30.0	62.0	28.0	20.0	0.0	22.0	0.0	47.0	0.0	0.0
HA	20.0	34.0	3.0	4.0	0.0	18.0	0.0	0.0	0.0	0.0
AHW	38.0	84.0	1.0	8.0	0.0	36.0	0.0	0.0	0.0	0.0
SHPs (N=68)										
AHW	20.6	72.1	0.0	0.0	0.0	11.8	0.0	0.0	0.0	0.0
MCHW	22.1	57.4	0.0	0.0	0.0	2.9	0.0	0.0	0.0	0.0
VHW	10.3	35.3	0.0	0.0	0.0	2.9	0.0	0.0	0.0	0.0

Source: STS facility questionnaire

Staffs in temporary positions were less likely to have received training in NCP, IMCI, IUCDs, implants, USG, AFS, SBA, ASBA, OT management, and anaesthesia than staff in permanent positions. Table 8.13 presents the percentage of facilities at the time of data collection with at least one member of staff in filled positions (deputed-in and other contract) who had ever received training in these services.

Higher-level hospitals

Half (50%) of the higher-level hospitals had at least one MO trained in IMCI and/or USG, while one-third (33%) had at least one MO trained in NCP. Half (50%) of the hospitals had at least one sister/matron/nursing inspector trained in NCP and/or IMCI while only one-third (33%) had a sister/matron/nursing inspector who had received training in IUCD, implants, and/or SBA. Only 17% of hospitals had at least one MO, sister/matron/nursing inspector, SN, and/or AHW who had received training in AFS, while a similar proportion had at least one sister/matron/nursing inspector and/or SN who had received training in anaesthesia. One-third of the hospitals had at least one ANM trained in NCP, IMCI, IUCD, implants and/or SBA. One-third of the hospitals had at least one AHW trained in NCP and/or IMCI. Only 17% of the hospitals had laboratory assistants/technicians trained in IMCI.

District-level hospitals

One-third (33%) of the district-level hospitals had at least one MO trained in IMCI and/or ASBA. Similarly, one-third of hospitals had at least one SN who had been trained in SBA, while 22% had at least one SN trained in NCP, IMCI, and/or IUCD. Similarly, 44% of the district hospitals had at least one ANM trained in IMCI, while 22% hospitals had an HA trained in IMCI. One-third of the district hospitals had at least one AHW trained in IMCI.

PHCCs

One in ten PHCCs had at least one MO trained in NCP, 5% had a MO trained in IMCI and/or AFS. More than a quarter (28%) of the PHCCs had at least one ANM trained in IMCI, while 18% had an ANM trained in NCP, and 21% had an ANM who had received SBA training. Ten per cent of PHCCs had at least one AHW trained in IMCI, while only 5% had AHWs trained in NCP and/or AFS.

HPs

Nearly one-fifth (19%) of the HPs had an ANM trained in IMCI. Similarly, 18% of HPs had an ANM trained in NCP, and 15% had a SBA-trained ANM. One in ten HPs had an AHW trained in IMCI. Only 2% of the HPs had HAs trained in IMCI.

SHPs

SHPs were less likely to have trained staff. Very few SHPs had AHWs trained in IMCI (4%) and 3% of the SHPs had VHWs trained in IMCI.

Table 8. 13: Training Received at the Health Facility by at Least One Staff Member in Filled Positions (Deputed In and Other Contract) by Position and Type of Health Facility

	NCP (%)	IMCI (%)	IUCD (%)	Implants (%)	USG (%)	AFS (%)	ASBA (%)	SBA (%)	OT management (%)	Anaesthesia (%)
Higher-level hospitals (N=6)										
MO	33.3	50.0	16.7	16.7	50.0	16.7	16.7	0.0	0.0	0.0
Sister/matron/inspector	50.0	50.0	33.3	33.3	0.0	16.7	0.0	33.3	0.0	16.7
SN	16.7	16.7	33.3	16.7	16.7	16.7	0.0	33.3	16.7	16.7
ANM	33.3	33.3	33.3	33.3	0.0	0.0	0.0	33.3	16.7	0.0
HA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
AHW	33.3	33.3	16.7	16.7	0.0	16.7	0.0	0.0	0.0	0.0
Laboratory assistant/technician	0.0	16.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
District-level hospitals (N=9)										
MO	11.1	33.3	0.0	1.0	22.2	0.0	33.3	0.0	0.0	0.0
SN	22.2	22.2	22.2	1.0	0.0	0.0	0.0	33.3	11.1	0.0
ANM	22.2	44.4	11.1	0.0	0.0	0.0	0.0	22.2	11.1	0.0
HA	11.1	22.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
AHW	22.2	33.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Laboratory assistant/technician	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PHCCs (N=39)										
MO	10.3	5.1	2.6	0.0	0.0	5.1	0.0	0.0	0.0	0.0
SN	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
ANM	17.9	28.2	10.3	5.1	0.0	5.1	0.0	20.5	0.0	0.0
HA	0.0	5.1	2.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0
AHW	5.1	10.3	0.0	0.0	0.0	5.1	0.0	0.0	0.0	0.0
Laboratory assistant/technician	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
HPs (N=100)										
ANM	18.0	19.0	8.0	5.0	0.0	4.0	0.0	15.0	0.0	0.0
HA	0.0	2.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0
AHW	4.0	10.0	0.0	0.0	0.0	2.0	0.0	0.0	0.0	0.0
SHPs (N=68)										
AHW	0.0	4.4	0.0	0.0	0.0	1.5	0.0	0.0	0.0	0.0
MCHW	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
VHW	1.5	2.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Source: STS facility questionnaire

8.2.5 Attendance

Enumerators checked the staff attendance registers at facilities for the last FY (2069/70). The GoN has developed a standard register using the same format for all levels of government facilities. It includes the number of days: in attendance at the health facility, on field supervision, in training, on deputation, on leave, and on public holidays. Table 8.14 presents the attendance for all staff at each level.

Staff at higher-level hospitals (with the exception of paediatricians, SNs, and sisters/matrons/nurse inspectors) spent more than 70% of the time in attendance at their respective health facilities. District hospital staffs were in attendance at their respective facilities for more than 70% of time, with the exception of MOs, SNs, and ANMs. At lower-level health facilities, staffs were less likely to spend time at their facilities. MOs at PHCCs had spent 21% of their time on leave during the last FY.

Table 8. 14: Breakdown of Attendance by Position and Type of Health Facility

	In attendance (%)	On field supervision (%)	In training (%)	On deputation (%)	On public holidays (%)	On leave (%)	Not recorded (%)
Higher-level hospitals (N=6)							
O/G	77.7	0.0	2.2	3.7	4.1	12.3	0.0
Paediatrician	59.8	0.0	1.0	5.3	5.6	9.6	18.6
MO	72.9	0.0	1.6	3.6	5.6	6.9	9.2
Sister/matron/nurse inspector	69.0	0.0	2.0	4.4	5.0	6.8	12.8
SN	63.1	0.0	1.5	6.9	6.0	19.9	2.6
ANM	75.8	0.0	0.8	0.4	9.3	8.8	4.9
HA	73.2	0.0	0.8	0.5	11.3	5.8	8.4
AHW	85.0	0.0	0.6	0.4	6.5	6.0	1.6
Laboratory assistant/technician	78.1	0.0	1.1	2.4	9.7	5.9	2.9
District-level hospitals (N=9)							
MO	69.2	0.6	2.4	1.2	4.5	11.1	11.0
SN	64.1	0.1	5.8	6.1	5.1	14.7	4.1
ANM	68.1	0.0	3.3	6.1	6.8	13.0	2.7
HA	72.0	0.7	3.2	7.7	5.3	9.6	1.6
AHW	78.3	0.0	3.2	2.5	5.9	8.0	2.0
Laboratory assistant/technician	72.8	0.1	1.5	3.4	12.4	9.7	0.0
PHCCs (N=39)							
MO	43.3	0.8	5.5	15.4	12.3	21.1	1.6
SN	58.2	0.4	2.9	5.6	11.8	14.9	6.2
ANM	66.2	0.4	4.7	7.0	12.3	8.7	0.7
HA	56.7	2.5	4.8	12.1	14.5	6.0	3.3
AHW	62.2	0.6	3.8	11.4	13.3	7.1	1.7
Laboratory assistant/technician	63.0	0.2	1.9	9.9	16.5	6.3	2.2
HPs (N=100)							
ANM	66.4	0.4	3.2	8.0	15.1	4.5	2.4
HA	52.0	2.7	4.6	11.9	18.0	6.5	4.4
AHW	54.1	1.2	4.0	13.5	17.5	6.3	3.4
MCHW	52.7	0.7	4.3	14.5	14.4	12.9	0.4
VHW	49.2	0.4	2.0	25.7	16.8	5.0	0.9
SHPs (N=68)							
AHW	54.3	0.9	5.2	10.4	17.1	6.9	5.2
MCHW	55.3	0.2	3.2	18.6	15.2	6.7	0.8
VHW	55.6	0.1	1.9	20.5	15.1	4.1	2.7

Source: STS facility questionnaire

8.2.6 Demographic Characteristics of Staff

Sex-wise disaggregation shows that most obstetricians/gynaecologists, paediatricians, MDGPs, MOs, HAs, and AHWs were male, whereas most SNs and ANMs were female. However, a small percentage of male SNs was recorded in higher-level hospitals (4%) and district hospitals (3%) (Table 8.15).

Table 8. 15: Breakdown of Staff by Sex

	Female (%)	Male (%)	Total (N)
Higher-level hospitals (N=6)			
O/G	25.0	75.0	4
Paediatrician	0.0	100	5
MDGP	18.2	81.8	11
MO	7.0	93.0	86
Sister/matron/nurse inspector	100	0.0	13
SN	96.4	3.6	112
ANM	94.5	5.5	55
HA	10.0	90.0	10
AHW	18.8	81.3	80
Laboratory assistant/technician	15.0	85.0	40
District-level hospitals (N=9)			
MO	23.1	76.9	26
SN	96.8	3.2	31
ANM	97.8	2.2	45
HA	7.7	92.3	13
AHW	13.9	86.1	36
Laboratory assistant/technician	0.0	100	18
PHCCs (N=39)			
MO	12.0	88.0	25
SN	100	0.0	17
ANM	99.2	0.8	118
HA	12.1	87.9	33
AHW	13.6	86.4	110
Laboratory assistant/technician	13.6	86.4	44
HPs (N=100)			
ANM	100	0.0	195
HA	3.6	96.4	55
AHW	12.2	87.8	188
MCHW	100	0.0	18
VHW	18.0	82.0	50
SHPs (N=68)			
ANM	100	0.0	35
AHW	10.7	89.3	84
MCHW	97.7	2.3	43
VHW	8.3	91.7	36

Source: STS facility questionnaire

The breakdown of staff by caste and ethnic group is shown in Table 8.16 below. The most frequently represented caste among staff was Brahmin/Chhetri, followed by Janajati. There was very little representation of Dalit and Muslim communities. The Brahmin/Chhetri ethnic group, followed by Janajatis, was most likely to hold senior positions.

Table 8. 16: Breakdown of Staff by Caste

	Dalit (%)	Janajati (%)	Terai/Madhesi other caste (%)	Muslim (%)	Newar (%)	Brahmin/ Chhetri (%)	Others (%)	Total (N)
Higher-level hospitals (N=6)								
O/G	0.0	25.0	0.0	0.0	0.0	75.0	0.0	4
Paediatrician	0.0	0.0	0.0	0.0	20.0	80.0	0.0	5
MDGP	0.0	9.1	9.1	0.0	9.1	72.7	0.0	11
MO	4.7	9.3	23.3	0.0	9.3	52.3	1.2	86
Sister/matron/nurse inspector	0.0	0.0	7.7	0.0	23.1	69.2	0.0	13
SN	1.8	3.6	11.6	0.0	3.6	76.8	2.7	112
ANM	0.0	10.9	9.1	1.8	5.5	70.9	1.8	55
HA	0.0	0.0	20.0	0.0	0.0	80.0	0.0	10
AHW	1.3	10.0	12.5	2.5	0.0	70.0	3.8	80
Laboratory assistant/technician	0.0	7.5	20.0	0.0	2.5	67.5	2.5	40
District-level hospitals (N=9)								
MO	3.8	3.8	11.5	0.0	15.4	57.7	7.7	26
SN	3.2	19.4	6.5	0.0	25.8	38.7	6.5	31
ANM	2.2	33.3	6.7	0.0	22.2	35.6	0.0	45
HA	0.0	7.7	23.1	0.0	0.0	61.5	7.7	13
AHW	2.8	19.4	16.7	0.0	11.1	50.0	0.0	36
Laboratory assistant/technician	0.0	5.6	11.1	5.6	22.2	50.0	5.6	18
PHCCs (N=39)								
MO	0.0	4.0	32.0	0.0	8.0	56.0	0.0	25
SN	0.0	17.6	0.0	0.0	11.8	70.6	0.0	17
ANM	2.5	22.9	6.8	0.0	5.1	61.9	0.8	118
HA	3.0	12.1	24.2	0.0	9.1	48.5	3.0	33
AHW	2.7	16.4	22.7	0.0	4.5	52.7	0.9	110
Laboratory assistant/technician	2.3	20.5	22.7	0.0	2.3	50.0	2.3	44
HPs (N=100)								
ANM	4.6	19.0	4.1	0.0	5.6	66.2	0.5	195
HA	1.8	1.8	23.6	1.8	7.3	63.6	0.0	55
AHW	5.3	14.4	16.5	0.5	5.3	56.9	1.1	188
MCHW	0.0	33.3	5.6	0.0	11.1	50.0	0.0	18
VHW	8.0	10.0	14.0	0.0	6.0	62.0	0.0	50
SHPs (N=68)								
ANM	2.9	5.7	8.6	0.0	11.4	71.4	0.0	35
AHW	2.4	10.7	31.0	0.0	1.2	51.2	3.6	84
MCHW	7.0	11.6	25.6	0.0	9.3	46.5	0.0	43
VHW	0.0	5.6	13.9	2.8	8.3	69.4	0.0	36

Source: STS facility questionnaire

8.2.7 Staff Turnover

Staff turnover was assessed at all levels of health facility. MOs were slightly more likely to join than leave in higher-level hospitals. However, MOs, SNs, and ANMs were more likely to leave district hospitals. Similarly, SNs, ANMs, and AHWs in PHCCs, and AHWs and MCHWs at SHPs, were more likely to leave than join. In contrast, staff were more likely to join HPs rather than leave.

Table 8. 17: Staff Turnover in the Last FY

	Staff who joined							Staff who left									Ratio joined to left
	Joined as new staff		Transferred in		Contract renewed		Total	Retired		Transfer out		Contract ended		Left for other reasons		Total	
	N	%	N	%	N	%		N	%	N	%	N	%	N	%		
Higher-level hospitals (N=6)																	
O/G	0	0.0	0	0.0	0	0.0	0	0	0.0	0	0.0	0	0.0	0	0.0	0	-
Paediatrician	0	0.0	1	100	0	0.0	1	0	0.0	0	0.0	0	0.0	0	0.0	0	-
MDGP	1	33.3	2	66.7	0	0.0	3	1	25.0	3	75.0	0	0.0	0	0.0	4	0.8
Anaesthetist	0	0.0	0	0.0	0	0.0	0	0	0.0	0	0.0	0	0.0	0	0.0	0	1
MO	10	38.5	5	19.2	11	42.3	26	2	9.5	8	38.1	11	52.4	0	0.0	21	1.2
Sister/matron/nurse inspector	0	0.0	1	25.0	3	75.0	4	0	0.0	1	33.3	2	66.7	0	0.0	3	1.3
SN	4	20.0	10	50.0	6	30.0	20	1	4.8	13	61.9	7	33.3	0	0.0	21	1.0
ANM	0	0.0	1	50.0	1	50.0	2	0	0.0	1	33.3	2	66.7	0	0.0	3	0.7
HA	1	33.3	0	0.0	2	66.7	3	0	0.0	0	0.0	2	100	0	0.0	2	1.5
AHW	0	0.0	3	42.9	4	57.1	7	0	0.0	1	16.7	5	83.3	0	0.0	6	1.2
Laboratory assistant/technician	0	0.0	0	0.0	3	100	3	0	0.0	0	0.0	3	100	0	0.0	3	1.0
District-level hospitals (N=9)																	
MO	9	64.3	3	21.4	2	14.3	14	0	0.0	12	50.0	10	41.7	2	8.3	24	0.6
SN	3	50.0	3	50.0	0	0.0	6	1	9.1	5	45.5	5	45.5	0	0.0	11	0.5
ANM	3	27.3	1	9.1	7	63.6	11	1	5.9	1	5.9	13	76.5	2	11.8	17	0.6
HA	2	40.0	0	0.0	3	60.0	5	0	0.0	0	0.0	3	60.0	2	40.0	5	1.0
AHW	2	33.3	0	0.0	4	66.7	6	0	0.0	1	33.3	2	66.7	0	0.0	3	2.0
Laboratory assistant/technician	0	0.0	1	50.0	1	50.0	2	0	0.0	0	0.0	1	100	0	0.0	1	2.0
PHCCs (N=39)																	
MO	9	81.8	0	0.0	2	18.2	11	0	0.0	2	28.6	4	57.1	1	14.3	7	1.6
SN	2	40.0	2	40.0	1	20.0	5	1	14.3	5	71.4	1	14.3	0	0.0	7	0.7
ANM	11	52.4	10	47.6	0	0.0	21	3	10.7	13	46.4	10	35.7	2	7.1	28	0.8
HA	5	62.5	3	37.5	0	0.0	8	1	14.3	4	57.1	1	14.3	1	14.3	7	1.1
AHW	6	46.2	7	53.8	0	0.0	13	3	17.6	8	47.1	4	23.5	2	11.8	17	0.8

Laboratory assistant/technician	4	44.4	5	55.6	0	0.0	9	1	12.5	5	62.5	0	0.0	2	25.0	8	1.1
HPs (N=100)																	
ANM	25	36.8	21	30.9	22	32.4	68	6	10.7	11	19.6	32	57.1	7	12.5	56	1.2
HA	8	38.1	12	57.1	1	4.8	21	1	6.7	8	53.3	4	26.7	2	13.3	15	1.4
AHW	9	18.8	33	68.8	6	12.5	48	2	6.5	13	41.9	13	41.9	3	9.7	31	1.5
SHPs (N=68)																	
AHW	6	33.3	7	38.9	5	27.8	18	3	11.1	12	44.4	10	37.0	2	7.4	27	0.7
MCHW	0	0.0	0	0.0	0	0.0	0	0	0.0	3	100	0	0.0	0	0.0	3	-
VHW	0	0.0	2	50.0	2	50.0	4	3	33.3	2	22.2	4	44.4	0	0.0	9	0.4

Source: STS facility questionnaire

8.3 KEY FINDINGS

Sanctioned/filled positions

- STS 2013 showed that less than three-quarters (72%) of the 289 sanctioned positions in higher-level hospitals were filled. This is lower than the findings of STS 2012 which had shown that 85% of the sanctioned posts were filled in higher level hospitals.

- Over two-thirds (68%) of the sanctioned positions in district hospitals were filled. However, nearly two-thirds (64%) of sanctioned positions for MOs, and almost half (47%) of those for SNs, were not filled. STS 2012 had shown that around four-fifths (79%) of the positions of district hospitals were filled which is higher than in 2013. Only 50% of SNs and 36% MOs position were not filled. Similarly, 81% of the sanctioned positions at district hospitals were filled in 2011. The percentage of filled sanctioned position in district hospital is found to be in decreasing trend form 2011 to 2013.

- Out of 352 sanctioned positions at PHCCs, 65% were filled as found by STS 2013. Nearly three-quarters (72%) of MO and almost two-thirds (62%) of ANM sanctioned positions were not filled. However, 87% of sanctioned positions for AHWs, 82% of those for laboratory assistants/technicians, and 70% of those for ANMs were filled. Medical officers (77%) accounted the largest share of unfilled position in STS 2012 while only 36% SN and 39% ANM positions were filled. Relatively low number of staff nurse (43%), medical officer (50%) and health assistant (50%) were filled in 2011.

- STS 2013 has shown that nearly three-quarters (73%) of sanctioned positions in HPs, and 72% in SHPs, were filled. A quarter (25%) of ANM, 12% of AHW, and 60% of HA positions were vacant in HPs, while 12% of AHW, 15% of MCHW, and 46% of VHW positions were vacant in SHPs. Large number of vacant positions of VHW could be because of no new recruitment in this position and up gradation of the existing VHWs to AHWs. Likewise, according to STS 2012, 41% of ANM positions, 32% AHW and 46% HA positions of HPs were vacant which is higher than that found by STS 2013. In case of SHPs, 90% of AHWs, 71% of MCHWs, 63% of VHWs were filled which accounted for 75% of total filled positions in SHPs.

- STS 2013 found that most hospitals (88%) and PHCCs (69%) reported that staff shortages had affected service delivery. Three quarters of staff at health facilities had mentioned that staff shortages affected service delivery in 2012 which was 69% in hospitals, 81% in PHCCs, 73% in HPs and 71% in SHPs. The 2013 STS also found that general curative and inpatient services were the most commonly affected services, reported by 36% of hospitals, 52% of PHCCs, 41% of HPs, and 50% of SHPs.

- Positions as obstetricians/gynaecologists, paediatricians, MDGPs, MOs, HAs, and AHWs were largely filled by men, while nursing positions (sisters/matrons/nurse inspectors, SNs, and ANMs) and MCHW positions were predominantly filled by women.

- Across every level of health facility, the majority of senior positions were held by staff from the Brahmin/Chhetri caste/ethnic group. There was very low representation of Dalits and Muslims across all health facilities. This is similar to the findings of STS 2011.

CHAPTER 9: DRUG SUPPLY AND STORAGE

9.1 INTRODUCTION

The supply and storage of drugs enhance the provision of high-quality services and are a core part of any health system. Drug storage space for health commodities, including cold storage for vaccines, is essential for ensuring effective delivery of health services at all levels, while the drug supply indicates the effective, adequate, and equitable distribution of drugs from the central store to the lower-level health facilities without degrading the quality. Every year, considerable quantities of drugs and other health commodities are damaged and rendered unusable because of poor storage conditions. Improving drug storage is a priority for the MoHP. Monitoring the supply and storage of drugs is central to the implementation of NHSP-2. This chapter assesses drug supply and storage, including place of storage and the availability of functioning refrigerators, and explores drug shortages, the frequency of expired drugs, and payment by clients for drugs. Annex C lists essential drugs by level of health facility.

9.2 RESULTS

Table 9. 1: Indicators under Drug Supply and Storage in STS 2013

Drug supply and storage	STS 2011	95% CI	STS 2012	95% CI	STS 2013	95% CI
% of facilities with drugs stored in a cool and dry place	86.8	64.0–96.1	29.3	21.0–39.3	37.1	19.5–59.0
% of facilities with drugs stored as per First Expired, First Out (FEFO) principles	87.9	76.5–94.2	84.4	76.3–90.1	76.9	59.1–88.5
% of PHCCs with at least one fridge with guaranteed power 24/7	47.6	24.3–72.0	48.4	40.2–56.7	46.2	29.5–63.8
% of maternity clients who paid for drugs	55.0	25.9–81.0	54.3	37.9–69.9	38.3	28.1–49.6

9.2.1 Storage

Table 9.2 describes the storage of drugs that do not require cold chain management. Every hospital and PHCC stored their drugs in a locked room, but a few HPs (7%) and SHPs (10%) stored their drugs in an unlocked room. All hospitals (100%), and most PHCCs (92%), HPs (95%), and SHPs (85%) stored drugs in a dry place.

Table 9. 2: Storage of Drugs that Do Not Require Refrigeration, by Facility Type

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Storage of drugs				
In a locked room	100	100	93.0	89.7
Total facilities with information on storage (N)	**16**	**39**	**100**	**68**
Place of storage				
Directly on the floor	31.3	5.1	15.0	8.8
On a raised platform	81.3	87.2	85.0	86.8
On shelves	93.8	92.3	92.0	70.6
In an unlocked cabinet	68.8	61.5	48.0	36.8
In a locked cabinet	50.0	64.1	66.0	88.2
Exposed to direct sunlight	0.0	5.1	5.0	7.4
Stored in cool place (below 25°C)	56.3	61.5	44.0	35.3
Exposed to damp/water	6.3	12.8	3.0	11.8
Stored in a dry place	100	92.3	95.0	85.3
Enumerator could not observe	0.0	7.7	9.0	5.9
Total facilities with information on storage (N)	**16**	**39**	**100**	**68**

Source: STS facility questionnaire

Health facilities were asked about the functionality of their refrigerators. Over two-fifths of hospitals (44%) had more than four functional refrigerators for maintaining a cold chain; however, a substantial proportion of SHPs (96%), HPs (59%), and PHCCs (23%) did not have a single functional refrigerator. Among the health facilities with functional refrigerators, 80% of SHPs, 63% of hospitals, 58% of HPs, and 56% of PHCCS had enough refrigerators available to store all drugs that required a cold chain. Of the facilities with no refrigerators, 88% of PHCCs and 62% of HPs used an icebox to store drugs on the day of immunization. Among the health facilities using refrigerators, the majority of hospitals (89%), PHCCs (79%), and HPs (86%), and all SHPs, maintained the temperature of the refrigerator at the time of the survey (Table 9.3).

Table 9. 3: Storage of Drugs that Require Cold Chain/Refrigeration, by Facility Type

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Functional refrigerators				
None	0.0	23.1	59.0	95.6
1	6.3	53.8	37.0	4.4
2	31.3	20.5	4.0	0.0
3	18.8	2.6	0.0	0.0
4+	43.8	0.0	0.0	0.0
Total facilities (N)	**16**	**39**	**100**	**68**
Availability of refrigerators to store all drugs that require cold chain	62.5	55.6	57.7	80.0
Total facilities with functional refrigerators (N)	**16**	**36**	**52**	**5**
Storage of drugs that require cold chain where refrigerators are not available				
Use of iceboxes	20.0	6.3	38.1	0.0
Use of iceboxes on the day of immunization	80.0	87.5	61.9	100
Total facilities where refrigerator is not available or not adequate for refrigeration (N)	**5**	**16**	**21**	**1**
Temperature				
Temperature of the refrigerators OK	88.9	78.6	85.7	100
Total facilities with information on temperature of refrigerator (N)	**9**	**14**	**14**	**1**
Temperature of the iceboxes OK	40.0	30.0	27.3	NA
Total facilities with information of temperature of icebox (N)	**5**	**10**	**11**	**NA**

Source: STS facility questionnaire

Just under two-thirds of (63%) hospitals stored their drugs according to FEFO principles. This was less common at lower-level facilities, with less than half of SHPs (49%), PHCCs (46%), and HPs (42%) doing so (Table 9.4).

Table 9. 4: Storage of Drugs in Accordance with FEFO Principles, by Facility Type

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
All	62.5	46.2	42.0	48.5
Most	37.5	46.2	36.0	26.5
Some	0.0	7.7	17.0	14.7
None	0.0	0.0	5.0	10.3
Total facilities with information (N)	**16**	**39**	**100**	**68**

Source: STS facility questionnaire

Table 9.5 describes the drugs that were found to be stored past their expiry date at the time of visit. SHPs (22%), hospitals (19%), and HPs (16%) had drugs in stock past their expiry date. The expired drugs most commonly encountered were: aluminium hydroxide + magnesium hydroxide tab 250mg (at 13% of hospitals and 3% of PHCCs), magnesium sulfate injection (at 13% of Hospitals, 8% of PHCCs, 6% of HPs,

and SHPs), zinc sulfate (at 6% of hospitals, 10% of PHCCs, 5% of HPs, and 2% of SHPs), gentamycin injection (at 6% of hospitals, 5% of PHCCs, 5% of HPs, and 6% of SHPs), and oxytocin injection (at 6% of hospitals, 5% of PHCCs, 4% of HPs, and 6% of SHPs).

Table 9. 5: Drugs Most Likely to be Stored Past Their Expiry Date at Time of Visit, by Facility Type

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Albendazole cap/tab 400mg	6.3	2.6	2.0	2.9
Aluminium hydroxide + magnesium hydroxide tab 250mg	12.5	2.6	0.0	0.0
Amoxicillin cap/tab 250mg	6.3	2.6	0.0	1.5
Amoxicillin dispersible tablet 125mg	6.3	2.6	0.0	0.0
Chloramphenicol 1% eye application	6.3	2.6	1.0	1.5
Ciprofloxacin cap/tab 250mg	6.3	2.6	0.0	0.0
Depo-Provera	6.3	2.6	1.0	0.0
Ferrous salt + folic acid cap/tab 60+0.4mg	6.3	2.6	1.0	0.0
Gamma benzene hexachloride 1% lotion	6.3	5.1	0.0	0.0
Hyoscine butylbromide cap/tab 10mg	6.3	2.6	0.0	0.0
Metronidazole cap/tab 200mg	6.3	2.6	1.0	2.9
Oral Rehydration Solution (ORS)	6.3	2.6	3.0	0.0
Paracetamol cap/tab 500mg	6.3	2.6	1.0	2.9
Providone iodine 5% solution	6.3	2.6	1.0	0.0
Sulfamethoxazole + trimethoprim cap/tab 100/20mg	6.3	2.6	1.0	1.5
Vitamin A cap/tab 200,000IU	6.3	2.6	3.0	0.0
Zinc sulfate 20mg	6.3	10.3	5.0	1.5
Vaccine DPT, HepB, Hip (pentavalent) vial	6.3	2.6	1.0	0.0
Gentamycin injection 80mg/2ml	6.3	5.1	5.0	5.9
Oxytocin Injection, 10 IU in 1ml ampoule	6.3	5.1	4.0	5.9
Magnesium sulfate injection, 1gm/2ml (50 % W/V)	12.5	7.7	6.0	5.9
Compound solution of sodium lactate (Ringer's lactate)	6.3	2.6	3.0	1.5
Any expired drugs in stock at the time of visit	18.8	15.4	16.0	22.1
Total facilities having information (N)	**16**	**39**	**100**	**68**

Source: STS facility questionnaire

9.2.2 Availability

Health facilities should ensure the constant availability of essential drugs. Compared to lower-level health facilities (72% of PHCCs, 69% of HPs, and 87% of SHPs), fewer hospitals (50%) had experienced stock-outs of essential drugs in the last FY. A greater proportion of SHPs (87%) had experienced stock-outs than other health facilities.

Hyoscine butylbromide, ciprofloxacin, amoxicillin, chroramphenicol, and gamma benzene hexachloride were the drugs which most commonly experienced stock-outs.

Table 9. 6: Experience of Stock-outs of Essential Drugs at Health Facilities during the Last FY, by Facility Type

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Experience of stock-outs in the last FY	50.0	71.8	69.0	86.8
Total facilities (N)	**16**	**39**	**100**	**68**
Drugs with stock-outs in the last FY:*				
Albendazole cap/tab 400mg	25.0	14.3	4.3	6.8
Aluminium hydroxide + magnesium hydroxide tab 250mg	37.5	25.0	23.2	20.3
Amoxicillin cap/tab 250mg	0.0	42.9	36.2	40.7
Amoxicillin dispersible tablet 125mg	12.5	35.7	44.9	49.2
Chloramphenicol 1% eye application	50.0	32.1	24.6	42.4
Ciprofloxacin cap/tab 250mg	25.0	46.4	34.8	32.2
Depo-Provera	0.0	3.6	5.8	10.2
Ferrous salt + folic acid cap/tab 60+0.4mg	25.0	35.7	36.2	32.2
Gamma benzene hexachloride 1% lotion	25.0	39.3	39.1	47.5
Hyoscine butylbromide cap/tab 10mg	50.0	53.6	55.1	45.8
Metronidazole cap/tab 200mg	25.0	0.0	13.0	15.3
ORS	0.0	25.0	27.5	23.7
Paracetamol cap/tab 500mg	37.5	10.7	14.5	18.6
Providone iodine 5% solution	12.5	14.3	15.9	10.2
Sulfamethoxazole + trimethoprim cap/tab 100/20mg	25.0	21.4	21.7	30.5
Vitamin A cap/tab 200,000IU	25.0	17.9	14.5	8.5
Zinc sulfate 20mg	37.5	7.1	13.0	13.6
Vaccine DPT, HepB, Hip (pentavalent) vial	0.0	3.6	4.3	0.0
Gentamycin injection 80mg/2ml	12.5	25.0	14.5	11.9
Oxytocin Injection, 10 IU in 1ml ampoule	12.5	14.3	13.0	8.5
Magnesium sulfate injection, 1gm/2ml (50 % W/V)	25.0	10.7	13.0	6.8
Compound solution of sodium lactate (Ringer's lactate)	37.5	3.6	17.4	23.7
Total facilities with experience of stock-out (N)	**8**	**28**	**69**	**59**

**Percentage total may exceed 100 as a result of multiple responses*
Source: STS facility questionnaire

Table 9.7 presents the frequency of stock-outs of essential drugs in those health facilities that had experienced one or more such stock-outs during the last FY. All of the 22 essential drugs had been out of stock at least once in the FY at one or more facilities. Oxytocin injections had been out of stock four times during the last FY in the one hospital that had experienced stock-out. One PHCC had 12 stock-outs of vaccine DPT, Hep B, Hip (pentavalent) vial in the last year. Affected HPs had an average of almost three stock-outs of sodium lactate and metronidazole in a year, and affected SHPs had an average of three folic acid stock-outs in a year.

Table 9. 7: Number of Stock-outs of Essential Drugs in Last FY, and Number of Facilities Experiencing Any Stock-outs for Each Drug

	Hospitals			PHCCs			HPs			SHPs		
	Mean	Range	N	Mean	Range	N	Mean	Range	N	Mean	Range	N
Albendazole cap/tab 400mg	1.0	1–1	2	1.5	1–2	4	1.3	1–2	3	1.5	1–3	4
Aluminium hydroxide + magnesium hydroxide tab 250mg	1.3	1–2	3	1.4	1–3	7	1.9	1–6	16	1.7	1–4	12
Amoxicillin cap/tab 250mg	-	-	-	1.3	1–3	12	1.6	1–6	25	1.5	1–5	24
Amoxicillin dispersible tablet 125mg	1.0	-	1	1.6	1–4	10	1.8	1–5	31	1.6	1–4	28
Chloramphenicol 1% eye application	1.3	1–2	4	1.7	1–4	9	2.1	1–12	17	1.8	1–5	25
Ciprofloxacin cap/tab 250mg	2.0	1–3	2	1.6	1–3	13	1.9	1–8	24	2.4	1–8	19
Depo-Provera				1.0	-	1	1.3	1–2	4	1.5	1–3	6
Ferrous salt + folic acid cap/tab 60+0.4mg	1.0	1–1	2	2.5	1–10	10	2.2	1–12	25	3.0	1–12	19
Gamma benzene hexachloride 1% lotion	1.5	1–2	2	2.7	1–10	11	1.9	1–12	27	2.8	1–12	28
Hyoscine butylbromide cap/tab 10mg	1.5	1–3	4	2.4	1–5	15	2.1	1–6	38	1.9	1–5	27
Metronidazole cap/tab 200mg	1.0	1–1	2				2.8	1–12	9	2.3	1–3	9
ORS	0	0	0	3.1	1–8	7	2.3	1–10	19	1.9	1–5	14
Paracetamol cap/tab 500mg	1.3	1–2	3	1.0	1–1	3	1.7	1–3	10	1.4	1–2	11
Providone iodine 5% solution	2.0	-	1	1.5	1–3	4	2.0	1–6	11	1.2	1–2	6
Sulfamethoxazole + trimethoprim cap/tab 100/20mg	1.0	1–1	2	2.7	1–9	6	1.4	1–3	14	1.5	1–4	18
Vitamin A cap/tab 200,000IU	1.5	1–2	2	3.0	1–1	5	1.2	1–2	10	1.6	1–3	5
Zinc sulfate 20mg	1.7	1–3	3	2.0	1–3	2	1.2	1–2	9	1.4	1–2	8
Vaccine DPT, HepB, Hip (pentavalent) vial	-	-	-	12.0	-	1	1.7	1–3	3			
Gentamycin injection 80mg/2ml	1.0	-	1	1.6	1–2	7	1.2	1–2	10	1.6	1–2	7
Oxytocin Injection, 10 IU in 1ml ampoule	4.0	-	1	1.3	-	4	1.0	1–1	9	1.2	1–2	5
Magnesium sulfate injection, 1gm/2ml (50 % W/V)	1.0	1–1	2	1.7	1–3	3	1.1	1–2	9	1.0	1–1	4
Compound solution of sodium lactate (Ringer's lactate)	2.0	1–4	3	1.0		1	2.8	1–12	12	2.4	1–10	14
Total facilities that experienced any stock-out (N)	**8**			**28**			**69**			**59**		

Note: Percentage total may exceed 100 as a result of multiple responses
Source: STS facility questionnaire

For those facilities experiencing at least one stock-out, Table 9.8 shows the total number of days of stock-outs for each drug in the last FY. The median number of days for which vitamin A capsules were out of stock at hospitals was 98. Vaccines DPT, HepB, Hip (pentavalent) vial were out of stock at one PHCC for 225 days in the last year. Amoxicillin dispersible tablets (125mg) were out of stock for a median value of 88 days at HPs in the last year. Notably, oxytocin injections were out of stock all year at one SHP, and magnesium sulfate injections were out of stock all year at two SHPs.

Table 9. 8: Number of Days for Which There Were Stock-outs of Essential Drugs

	Hospitals			PHCCs			HPs			SHPs		
	Median	Interquartile Range	N	Median	Interquartile Range	N	Median	Interquartile Range	N	Median	Interquartile Range	N
Albendazole cap/tab 400mg	22.5	-	2	31.0	15–181	4	30.0	-	3	55.0	19–96	4
Aluminium hydroxide + magnesium hydroxide tab 250mg	20.0	-	3	15.0	1–26	7	30.0	20–45	15	51.5	30–90	12
Amoxicillin cap/tab 250mg	-	-	-	61.5	17–106	12	25.0	11–62	25	27.5	15–77	24
Amoxicillin dispersible tablet 125mg	30.0	-	1	90.0	28–143	10	88.0	30–171	31	60.0	30–119	29
Chloramphenicol 1% eye application	67.5	34 –296	4	30.0	11–299	9	50.0	20–300	17	64.0	30–155	25
Ciprofloxacin cap/tab 250mg	141.0	-	2	30.0	13–60	13	52.5	30–90	24	100	48–279	19
Depo-Provera	-	-	-	49.0	-	1	32.0	8–57	4	31.5	14–134	6
Ferrous salt + folic acid cap/tab 60+0.4mg	102.5	-	2	30.0	20–7	10	60.0	15–95	25	50.0	25–95	19
Gamma benzene hexachloride 1% lotion	65.0	-	2	60.0	20–111	11	42.0	20–90	27	82.5	31–128	28
Hyoscine butylbromide cap/tab 10mg	45.0	17–128	4	48.0	15–153	15	40.0	21–90	37	45.5	29–98	26
Metronidazole cap/tab 200mg	76.5	-	2	-	-		30.0	18–60	9	50.0	23–80	9
ORS	-	-	-	17.5	9–42	6	15.0	7–40	19	20.5	9–74	14
Paracetamol cap/tab 500mg	35.0	-	3	44.0	-	3	19.0	12–42	10	18.0	11–65	11
Providone iodine 5% solution	35.0	-	1	24.0	7–55	4	16.0	13–30	11	27	16–38	6
Sulfamethoxazole + trimethoprim cap/tab 100/20mg	187.5	-	2	54.5	13–159	6	47.5	17–70	14	46.5	15–131	18
Vitamin A cap/tab 200,000IU	97.5	-	2	59.0	21–230	5	16.0	4–135	10	30.0	15–98	5
Zinc sulfate 20mg	25.0	-	3	19.0	-	2	43.0	25–75	9	37.5	10–83	8
Vaccine DPT, HepB, Hip (pentavalent) vial	-	-	-	225.0	-	1	30.0	-	3	-	-	-
Gentamycin injection 80mg/2ml	145.0	-	1	45.0	11–143	6	30.0	19–65	10	145.0	65–365	7
Oxytocin Injection, 10 IU in 1ml ampoule	51.0	-	1	47.0	-	3	12.5	3–26	4	365.0	-	1
Magnesium sulfate injection, 1gm/2ml (50 % W/V)	115.0	-	1	150.0	-	2	30.0	8–281	4	365.0	-	2
Compound solution of sodium lactate (Ringer's lactate)	92.0	-	1	-	-	-	75.0	19–304	4	195.0	-	2
Total facilities that experience Stock-out (N)	**8**			**28**			**69**			**59**		

Source: STS facility questionnaire

9.2.3 Drug Stock-out at the Time of Visit

Of the 22 essential drugs, only seven were available in all the hospitals at the time of visit. The essential drugs that were most commonly out of stock in hospitals were: chloramphenicol 1% eye application capsule, sulfamethoxazole + trimethoprim capsule/tablet 100/20mg (25%), amoxicillin dispersible tablet 125mg, ciprofloxacin capsule/tablet 250mg, and Gamma benzene hexachloride 1% lotion (18%). Chloramphenicol was out of stock in 18% of PHCCs and SHPs (Table 9.9).

Table 9. 9: Stock-out of Essential Drugs at Time of Visit

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Chloramphenicol 1% eye application capsule	25.0	17.9	12.0	17.6
Sulfamethoxazole + trimethoprim cap/tab 100/20mg	25.0	7.7	2.0	7.4
Amoxicillin dispersible tablet 125mg	18.8	2.6	15.0	14.7
Ciprofloxacin cap/tab 250mg	18.8	7.7	7.0	13.2
Gamma benzene hexachloride 1% lotion	18.8	12.8	10.0	22.1
Albendazole cap/tab 400mg	0.0	2.6	0.0	1.5
Paracetamol cap/tab 500mg	12.5	0.0	1.0	2.9
Vitamin A cap/tab 200,000IU	12.5	5.1	3.0	2.9
Vaccine DPT, HepB, Hip (pentavalent) vial	12.5	15.4	28.0	
Aluminium hydroxide + magnesium hydroxide tab 250mg	6.3	5.1	2.0	5.9
Amoxicillin cap/tab 250mg	6.3	7.7	7.0	8.8
Depo-Provera	6.3	0.0	0.0	0.0
Zinc sulfate 20mg	6.3	2.6	1.0	4.4
Magnesium sulfate Injection, 1gm/2ml (50 % W/V)	6.3	2.6	12.0	22.1
Hyoscine butylbromide cap/tab 10mg	6.3	10.3	10.0	13.2
Compound solution of sodium lactate (Ringer's lactate)	6.3	0.0	9.0	16.2
ORS	0.0	0.0	4.0	4.4
Ferrous salt + folic acid cap/tab 60+0.4mg	0.0	2.6	2.0	11.8
Providone iodine 5% solution	0.0	2.6	2.0	1.5
Metronidazole cap/tab 200mg	0.0	0.0	1.0	1.5
Gentamycin injection 80mg/2ml	0.0	10.3	6.0	11.8
Oxytocin injection, 10 IU in 1ml ampoule	0.0	2.6	7.0	16.2
Total facilities with information on stock-outs (N)	**16**	**39**	**100**	**68**

**Percentage total may exceed 100 as a result of multiple responses*
Source: STS facility questionnaire

9.2.4 Drug Stock-outs

Table 9.10 presents the drugs that facility staff reported as having the most problems with stock-outs in the last FY. Nearly two-thirds (65%) of SHPs, HPs (60%), and PHCCs (62%) reported problems as a result of stock-outs of drugs, around twice the proportion of hospitals (31%) that did. The essential drugs most commonly reported as having problems with stock-outs are shown in the Table 9.10, by level of facility.

Table 9. 10: Essential Drugs Most Commonly Reported as Having Problems with Stock-outs in Last FY, by Type of Facility

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Problems with drug stock-outs during the FY 2069/70				
Problem due to stock-out	31.3	61.5	60.0	64.7
No stock-out	62.5	30.8	34.0	30.9
No problem despite stock-out	6.3	7.7	6.0	4.4
Total facilities (N)	**16**	**39**	**100**	**68**
Drugs reported to have most problems**				
Amoxicillin cap/tab 250mg/150mg or 200mg/syrup*	20.0	29.2	33.3	20.5
ORS 27.5gm/litre*	0.0	16.7	13.3	18.2
Paracetamol cap/tab 500mg/syrup*	20.0	0.0	11.7	20.5
Ciprofloxacin cap/tab 250mg/500mg*	0.0	8.3	13.3	13.6
Iron tab/cap*	20.0	16.7	16.7	2.3
Hyoscine butylbromide cap/tab 10mg/20mg*	0.0	20.8	11.7	4.5
Gamma benzene hexachloride 1% lotion*	0.0	8.3	1.7	18.2
Sulfamethoxazole + trimethoprim cap/tab/syrup (co-trimoxazole)*	0.0	4.2	6.7	11.4
Amoxicillin dispersible tablet 125mg*	0.0	0.0	5.0	11.4
Ferrous salt + folic acid cap/tab (60+0.4mg)*	0.0	8.3	6.7	4.5
Metronidazole cap/tab 200mg oral syrup/suspension*	0.0	0.0	5.0	9.1
Benzoic acid + salicylic acid (6% + 3%)*	0.0	8.3	5.0	2.3
Chloramphenicol 1% eye application (ointment)*	20.0	0.0	3.3	4.5
Folic acid cap/tab*	0.0	4.2	3.3	4.5
Albendazole cap/tab 400mg/syrup*	0.0	4.2	1.7	4.5
Compound solution of sodium lactate (Ringers lactate)*	20.0	0.0	1.7	4.5
Calamine lotion*	0.0	4.2	1.7	2.3
Furosemide + spironolactone*	0.0	0.0	1.7	4.5
Gentamycin injection 80mg/2ml*	20.0	0.0	0.0	2.3
Oxytocin injection 10 IU In 1ml ampoule*	0.0	4.2	1.7	0.0
Atenolol tab*	0.0	4.2	1.7	0.0
Chlorpheniramine tab 4mg*	0.0	4.2	1.7	0.0
Ciprofloxacin eye/ear drop 0.3% W/V*	0.0	4.2	0.0	2.3
Clove oil*	20.0	0.0	0.0	2.3
Sodium chloride 0.9% isotonic (normal saline)*	20.0	0.0	1.7	0.0
Chloramphenicol cap 250mg/500mg/oral suspension 125mg/5ml *	0.0	4.2	1.7	0.0

Sulfamethoxazole tab*	0.0	4.2	0.0	2.3
Aluminum hydroxide + magnesium hydroxide tab 250mg*	0.0	0.0	1.7	0.0
Vitamin A cap/tab	0.0	8.3	1.7	2.3
Depo-Provera	0.0	0.0	1.7	4.5
Zinc sulfate 20mg	0.0	4.2	1.7	2.3
Povidone iodine 5% solution	0.0	0.0	1.7	0.0
Salbutamol tab 4mg/200 mcg/syrup	0.0	0.0	1.7	0.0
Tetracycline tab/cap 250mg/500mg	0.0	4.2	0.0	0.0
HRZE (adult) tab	0.0	0.0	1.7	0.0
Chloroquinine tab	0.0	0.0	0.0	2.3
Salicylic acid	0.0	0.0	1.7	0.0
Chloramphenicol eye drop	0.0	0.0	0.0	2.3
Total facilities having stock-out problem (N)	**5**	**24**	**60**	**44**

Essential drugs under free care
***Percentage total may exceed 100 as a result of multiple responses*
Source: STS facility questionnaire

9.2.5 Health Care Providers' Responses to Stock-outs

Health care providers were asked what they did when stock-outs of drugs included under the free care policy occurred. Notably, health care providers from 93% of hospitals and 82% of SHPs asked patients to buy drugs from private institutions, while 85% of PHCCs and HPs requested an emergency supply of drugs. Substituting with similar drugs was more common at PHCCs (59%) than at other facilities.

Table 9. 11: Provider Responses to Stock-outs of Drugs Included under the Free Care Policy

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Substitute with similar drugs	40.0	59.0	49.0	47.1
Provide what is available even if not full course	6.7	20.5	20.0	11.8
Tell patients to buy in private institution	93.3	79.5	74.0	82.4
Request emergency supplies of the drug	80.0	84.6	85.0	79.4
Just say that we don't have the drug	20.0	15.4	8.0	14.7
Don't tell patient that they need that drug	6.7	7.7	4.0	10.3
Total facilities having information (N)	**15**	**39**	**100**	**68**

Source: STS facility questionnaire

9.2.6 Community Drug Scheme (for Drugs Not Included in Free Health Care Policy)

The Community Drug Programme (CDP) was introduced in Nepal in order to ensure the availability of drugs (other than essential drugs) all year round. A slightly greater proportion of hospitals (13%) had implemented a community drug scheme, compared to lower-level facilities (8% of PHCCs, 6% of HPs, and 3% of SHPs), although percentages were low at all levels.

Nearly three-quarters (73%) of hospitals had reviewed their drug supply in the last FY, but just 41% of PHCCs and HPs, and 34% of SHPs, had done so.

Table 9. 12: Provision of Community Drug Schemes and Review of Drug Supply

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Community drug schemes for non-essential drugs	13.3	7.7	6.0	2.9
Review of the drug supply in the last FY (2068/69)	73.3	41.0	41.0	33.8
Total facilities having information (N)	**15**	**39**	**100**	**68**

Source: STS facility questionnaire

9.3 KEY FINDINGS

Storage

- STS 2013 found that few HPs (7%) and SHPs (10%) stored drugs in an unlocked room while all hospitals and PHCCs stored drugs in a locked room. The percentage of SHPs (4%) storing drugs in an unlocked room is higher than that shown by STS 2012. There has been improvement in storage of drugs in locked room as STS 2011 had shown only half health facilities (52%) stored drugs in a locked cabinet and hospitals were less likely to do so.
- All hospitals had at least one functional refrigerator in both STS 2013 and 2012 while 6% hospitals did not have a functional refrigerator according to STS 2011. But 23% of PHCCs, 59% of HPs and 96% of SHPs did not have a single functional refrigerator as found by STS 2013 which is lower than in 2012. STS 2012 had shown that 29% PHCCs, 62% HPs and 86% SHPs had no functional refrigerator which was 25% for PHCCs, 53% for HPs and 79% SHPs in 2011 (STS 2011).
- Among the facilities with functional refrigerators, 80% of SHPs, 63% of hospitals, 58% of HPs, and 56% of PHCCs had enough refrigerators to store drugs that required a cold chain.
- STS 2013 found that nearly two-thirds of hospitals (63%) stored their drugs according to FEFO principles. Less hospitals (38%) in 2012 whereas more hospitals (81%) in 2011 had stored their drugs in this manner.
- The percentage of SHPs and HPs storing expired drugs has decreased in 2013 compared to 2012 while that of hospitals has slightly increased. In 2013, 22% of SHPs, 16% of HPs and 19% of hospitals were found to have drugs in stock that had passed their expiry date while 33% SHPs and HPs and 18% hospitals had stored expired drugs in the stock as found by STS 2012.
- In facilities that had experienced stock-outs, one hospital had been without oxytocin four times in the last financial year, one PHCC had been without Vaccine DPT, Hep B, Hip (Pentavalent) vials 12 times, HPs had experienced stock-outs of sodium lactate and metronidazole on average three times in the last FY, and SHPs had been without folic acid on average three times.

Availability

- Health care providers from 93% of hospitals and 82% of SHPs had asked patients to buy drugs from a private institution if a drug under the free care policy had happened to be out of stock, while 85% of PHCCs and HPs had requested the emergency supply of drugs. Higher number of SHPs (88%) has asked for private purchase in case of stock out in 2012 while and majority hospitals (75%), PHCCs (87%) and 86% HPs requested emergency supplies of the drug as shown by STS 2012 which was 63% hospitals, 61% PHCCs, 60% HPs and 51% SHPs in 2011. Substituting with similar drugs was more common in PHCCs (59%) than in other facilities as found by STS 2013.

CHAPTER 10: QUALITY OF CARE

10.1 INTRODUCTION

Increasing the utilization of health services will not necessarily improve health outcomes: services must also be characterized by excellence in delivery and meet benchmarks for good quality. There is no universally accepted definition of quality of care. The World Health Organization defines quality of care using six dimensions, requiring health care to be: *effective*, delivering evidence-based health care that results in improved health outcomes; *efficient*, maximizing use of resources; *accessible*, providing timely and geographically reasonable health care; *acceptable/patient-centered*, taking into account the wishes of service users and their communities; *equitable*, delivering the same quality of service to all; and *safe*, minimizing risks and harm to service users. Better quality of care can result in the greater use of health services, better uptake of health programmes by individuals and communities, and better health outcomes for the population, especially for children and women.

STS 2013 collected information on a range of quality of care indicators, including: biomedical waste, patient satisfaction, adherence to professional standards, and provision of health care services. In this chapter, data from 224 health care facilities, and 447 maternity client and 819 outpatient exit interviews, have been analyzed. The quality of care framework is presented as inputs, processes, and outputs (see Annex D). Some components of quality of care have already been covered in separate chapters, and this chapter presents those that remain.

10.2 RESULTS

Table 10. 1: Quality of Care Indicators in the NHSP-2 LF

QUALITY OF CARE	STS 2011	95% CI	STS 2012	95% CI	STS 2013	95% CI
% of facilities with comprehensive biomedical waste management in place (puncture-proof bin for needles; bin for disposing of plastics; bin for disposing of blood-/fluid-stained items; pit for placenta/deep burial)	12.5	8.5–17.9	21.9	16.8–28.2	7.2	4.1–12.4
% of CEONC facilities providing all CEONC signal functions 24/7	71.4	26.4–94.6	100	NA	100	NA
% of district hospitals providing all CEONC signal functions 24/7	8.3	0.7–53.2	50.0	37.0–60.3	77.8	39.0–95.0
% of districts with at least one facility providing all CEONC signal functions 24/7*	38.5	21.5–58.8	61.5	38.9–80.1	100	NA
% of BEONC facilities providing all BEONC signal functions 24/7	40.9	20.1–65.5	72.8	55.4–88.3	60.2	43.5–74.8
% of PHCCSs that provide all BEONC signal functions 24/7*	21.1	8.1–45.7	39	10.3–72.6	23.1	12.1–39.6
% of HPs that are birthing centres providing deliveries 24/7*	79.2	51.6–93.1	97.7	87.5–99.6	97.1	87.2–99.4
% of safe abortion sites with long-acting FP services*	91.4	77.8–97.0	56.1	17.4–88.5	91.4	74.2–97.5
% of district hospitals providing male and female permanent FP services	33.3	9.6–70.2	57.1	34.4–77.2	55.6	16.4–88.8
% of health posts with at least five FP methods*	13.3	5.8–27.9	7.6	4.1–13.5	18.0	10.9–28.3
% of outpatients who thought the facility was overcrowded	30.9	20.2–44.1	33.8	27.1–41.3	30.1	17.7–46.3
% of maternity clients who thought maternity department was overcrowded	23.6	13.9–37.0	29.2	17.5–44.6	48.1	20.8–76.5
% of clients (maternity and outpatients) satisfied with the cleanliness of the health	45.4	35.2–56.0	74.8	69.2–83.0	71.8	58.6–82.0

facility						
% of clients (maternity and outpatients) satisfied with the provisions made to ensure privacy	54.1	37.2–70.0	69.6	61.5–76.4	60.7	52.9–67.9
% of clients (maternity and outpatients) satisfied with their health care*	95.8	91.5–98.0	89.5	82.4–97.3	89.0	80.6–94.0

Note: The shaded indicators, marked with an asterisk (*), are included in the NHSP-2 LF/All facilities providing CEONC services comes under the facilities providing BEONC services

10.2.1 Inputs

Biomedical waste management

Proper management of biomedical waste is critical as it can be hazardous for both the environment and public health. Many facilities used more than one method. Burning was the most common method for the disposal of biomedical waste for all facility types (100% of hospitals and PHCCs, 95% of HPs, and 94% of SHPs). Burial was the second most common method of waste disposal, employed by 94% of hospitals and SHPs, and 87% of PHCCs and HPs (Table 10.2). Only 35% of hospitals, 26% of PHCCs, and 11% of HPs used an incinerator for waste management purposes. Burning waste and burial were the only methods used by SHPs for biomedical waste management.

Table 10. 2: Methods Used for Disposing of Biomedical Waste

Type of Disposal	**Hospitals (%)**	**PHCCs (%)**	**HPs (%)**	**SHPs (%)**
Incinerator	35.3	25.6	11.0	0.0
Bury in a pit	94.1	87.2	87.0	94.1
Burning	100	100	95.0	94.1
Through dumping site	35.3	2.6	3.0	0.0
Others (placenta pit/re-use)	11.8	5.1	2.0	0.0
Total facilities (N)	**17**	**39**	**100**	**68**

Note: Percentage total may exceed 100 as a result of multiple responses
Source: STS facility questionnaire

All the hospitals, 82% of PHCCs, 73% of HPs, and 59% of SHPs included in the study had separate puncture-proof bins for disposing of needles and sharps at the time of visit to the health facility. Almost three-quarters (76%) of hospitals were using separate colour-coded red and blue bins for waste management, and most (65%) had green bins for disposing of organic waste (Table 10.3). The use of a placenta pit was highest in hospitals (94%), reducing with level of facility, from 77% of PHCCs to 55% of HPs and 13% of SHPs.

Table 10. 3: Availability of Separate Bins for Biomedical Waste Disposal

Type of bin	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Puncture-proof bin for disposing of needles/sharps	100	82.1	73.0	58.8
Red bin for disposing of blood-/fluid-stained items	76.5	59.0	46.0	41.2
Blue bin for disposing of non-infectious items	76.5	48.7	42.0	33.8
Green bin for disposing of organic waste	64.7	38.5	28.0	20.6
Placenta pit/deep burial	94.1	76.9	55.0	13.2
Total facilities (N)	**17**	**39**	**100**	**68**

Note: Percentage total may exceed 100 as a result of multiple responses
Source: STS facility questionnaire

Supplies and equipment

Supplies

Staffs at health facilities were asked about shortages and use of supplies and equipment in the last FY. Two-thirds (67%) of PHCCs had faced problems with regards to shortages of equipment in the last FY, a proportion that was higher than at HPs (47%), SHPs (37%), and hospitals (35%). Of those hospitals with equipment shortages, half were facing shortages of X-ray machines. Among those facilities with shortages, PHCCs (35%), HPs (28%), and SHPs (24%) were facing problems with regards to blood pressure instruments (aneroid). The list of equipment shortages by level of health facilities is shown in Annex B, Table B1.

With regards to the shortage of supplies, PHCCs (41%) were again more likely to have faced problems than HPs (35%), SHPs (25%), and hospitals (24%). The key supplies of which there had been shortages in the last FY were: catheters, bed sheets, and mattresses in hospitals; and oxygen cylinders, bed sheets, catheters, and utility gloves in PHCCs. The detailed list of supplies shortages by level of health facility is shown in Annex B, Table B2.

Equipment

Broken equipment in the facilities is a major concern. More than half (51%) of PHCCs had faced problems with broken equipment, as had 44% of HPs, 35% of hospitals, and 29% of SHPs. The detailed list of broken equipment by level of health facility is shown in Annex B, Table B3.

None of the hospitals had equipment available that was not used. However, staff at a small number of PHCCs (5%), HPs (7%), and SHPs (4%) reported that there was equipment in the facilities that was not

required. Vacuum sets, thermometer, autoclave electric, and forceps were surplus to requirements in PHCCs (Annex B, Table B4).

Nearly half (49%) of PHCCs reported that there was equipment available in the facility that was not in use as they lacked staff trained to handle it; 29% of hospitals, 18% of HPs, and 9% of SHPs faced a similar problem. The detailed list of equipment not in use owing to untrained manpower by level of health facility is shown in Annex B, Table B5.

Over two-fifths (43%) of PHCCs had equipment available but not used owing to a lack of electricity, along with 20% of HPs, 18% of hospitals, and 15% of SHPs (Table 10.4). The items of equipment most commonly reported by each type of facility as not being used were: perennial lights and foot-operated suction machines (33%) at hospitals; refrigerators for vaccines and other drugs at PHCCs (67%) and HPs (50%); and thermometer autoclave in SHPs (20%). The full list is presented in Annex B, Table B6.

Table 10. 4: Shortages and Usage of Supplies and Equipment in Last FY

	Hospitals (%)	**PHCCs (%)**	**HPs (%)**	**SHPs (%)**
Faced any problems with regards to shortages of equipment in last FY	35.3	66.7	47.0	36.8
Faced any problems with regards to shortages of supplies in last FY	23.5	41.0	35.0	25.0
Faced any problems with regards to breakages of equipment in last FY	35.3	51.3	44.0	29.4
Any equipment present in the facility that is not needed or surplus to requirements for the services delivered	0.0	5.1	7.0	4.4
Any equipment present in the facility that no one is trained to use	29.4	48.7	18.0	8.8
Any equipment present in the facility that is not used for other reasons, e.g. no power supply	17.6	43.6	20.0	14.7
Total facilities (N)	**17**	**39**	**100**	**68**

Note: Percentage total may exceed 100 as a result of multiple responses
Source: STS facility questionnaire

Staffs at health facilities were asked about their experiences of receiving the equipment they had requested (Table 10.5). Notably, a greater proportion of SHPs (16%) than hospitals (12%), HPs (10%), or PHCCs (5%) had always received their requested equipment. However, there is still huge space for improvement given the low percentages across all levels of facility. Furthermore, 7% of SHPs had never received the equipment requested, along with 5% of PHCCs, 3% of HPs and 0% of hospitals.

Table 10. 5: Experiences in Receiving Equipment Requested

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Received requested equipment:				
Never requested equipment	23.5	5.1	2.0	0.0
Always	11.8	5.1	10.0	16.2
Most of the time	29.4	28.2	30.0	20.6
Sometimes	17.6	33.3	32.0	32.4
Rarely	17.6	23.1	23.0	23.5
Never	0.0	5.1	3.0	7.4
Received correct specifications:				
Never requested equipment	17.6	5.1	1.0	0.0
Always	11.8	7.7	14.0	16.2
Most of the time	29.4	20.5	22.0	23.5
Sometimes	17.6	25.6	27.0	23.5
Rarely	23.5	33.3	26.0	19.1
Never	0.0	7.7	10.0	17.6
Received supplies on request:				
Never requested equipment	17.6	5.1	2.0	4.4
Always	11.8	12.8	24.0	14.7
Most of the time	29.4	35.9	26.0	32.4
Sometimes	23.5	33.3	31.0	27.9
Rarely	17.6	10.3	13.0	14.7
Never	0.0	2.6	4.0	5.9
Total facilities (N)	**17**	**39**	**100**	**68**

Source: STS facility questionnaire

Table 10.6 shows whether a review of equipment had been undertaken in the last FY (2068/69). More than half of the hospitals (53%) and PHCCs (51%) had undertaken an equipment review. When staff were asked whether an equipment-swapping system would be useful, those at PHCCs (87%) were slightly more likely to support an equipment-swapping system than those at HPs (83%) or SHPs (79%).

Table 10. 6: Review of Equipment in the Last FY and Attitude Towards Equipment Swapping

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Had review of the equipment	52.9	51.3	47.0	44.1
Would like equipment swapping system	76.5	87.2	83.0	79.4
Total facilities (N)	**17**	**39**	**100**	**68**

Source: STS facility questionnaire

Table 10.7 below describes the suggestions made by health facility staff for improving the supply and management of equipment and supplies. Compared to hospitals (76%), a higher percentage of PHCCs (97%), HPs (93%), and SHPs (90%) made recommendations. Goods being supplied quickly, as per demand, was the most common recommendation made by all levels of health facilities (35% of hospitals, 46% of PHCCs, 35% of HPs, and 31% of SHPs) followed by needs-based supply, regular on-time availability, and a system of purchasing at local level.

Table 10. 7: Recommendations for Improving the Supply Management Systems for Equipment and Supplies

Type of recommendation	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Goods supplied per demand	35.3	46.2	35.0	30.9
Supply of goods based on needs assessment of the facility	11.8	10.3	11.0	13.2
Regular and timely availability of equipment and goods	11.8	7.7	11.0	8.8
Provision of purchasing locally/by focal person	5.9	7.7	10.0	5.9
Pull system properly implemented	0.0	10.3	6.0	8.8
Goods provided directly from centre	0.0	7.7	5.0	8.8
Central-level supervision of goods and equipment supplied	5.9	0.0	5.0	5.9
Delivery (transportation) to the institution confirmed	5.9	0.0	5.0	4.4
M&E of supplied goods from district	5.9	5.1	4.0	0.0
Demand slip attached with HMIS should be supplied	0.0	0.0	3.0	2.9
Regular replacement and maintenance system for goods/equipment	0.0	2.6	2.0	2.9
Others	5.9	20.5	15.0	11.8
No suggestion	23.5	2.6	7.0	10.3
Total facilities (N)	**17**	**39**	**100**	**68**

Note: Percentage total may exceed 100 as a result of multiple responses
Source: STS facility questionnaire

More than 80% of all levels of facilities made suggestions to improve the existing repair and maintenance system for equipment (Table 10.8). Regular maintenance of equipment by mobilization of maintenance teams was the top recommendation made by hospitals (29%), PHCCs (26%), HPs (28%), and SHPs (21%). Deployment of technical staff at the district level (29%) was the second most common

recommendation made by hospitals, whereas training health facility staff in maintenance of equipment was a key recommendation made by PHCCs (15%) and HPs (17%).

Table 10. 8: Recommendations for Improving the Repair and Maintenance of Equipment

Type of recommendation	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
No suggestion	11.8	12.8	13.0	20.6
Regular maintenance by mobilizing maintenance team at facility	29.4	25.6	28.0	20.6
Technical staff deployed at district level	29.4	2.6	5.0	7.4
Training for health facility staff	11.8	15.4	17.0	8.8
Regular budget allocated to health facility for maintenance	5.9	15.4	6.0	7.4
Skilled human resources should be used for maintenance	5.9	10.3	2.0	2.9
Higher-level management of system of exchanging goods	0.0	5.1	14.0	20.6
Equipment repaired at district and supplied to facility	0.0	10.3	8.0	8.8
Establishment of repair centre	0.0	7.7	8.0	2.9
Regular supervision of equipment and goods	0.0	2.6	3.0	1.5
Not working/damaged goods should be thrown/dumped	5.9	0.0	2.0	0.0
Supply of high-quality equipment and goods	0.0	2.6	0.0	0.0
Total facilities (N)	**17**	**39**	**100**	**68**

Note: Percentage total may exceed 100 as a result of multiple responses
Source: STS facility questionnaire

Good practice

Quality Improvement Committee and Plans

A higher percentage of hospitals had Quality Improvement Committees (41%) and Plans (35%) than lower level-health facilities (Table 10.9). Quality Improvement Plans (31% PHCCs, 27% HPs and 19% SHPs) were slightly more common than Quality Improvement Committees (21% PHCCs, 25% HPs and 18% SHPs) at lower-level health facilities.

Table 10. 9: Presence of Quality Improvement Committee and Plan

Characteristics	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Presence of Quality Improvement Committee	41.2	20.5	25.0	17.6
Presence of Quality Improvement Plan	35.3	30.8	27.0	19.1
Total facilities (N)	**17**	**39**	**100**	**68**

Source: STS facility questionnaire

Last delivery

All the hospitals, 90% PHCCs, 61% of HPs, and 18% of SHPs had conducted a delivery in the month preceding data collection. The availability of equipment at the last delivery was discussed during

interviews with health service providers. Among those facilities that had conducted a delivery in the last month, 11% of PHCCs reported that essential equipment was not available as it was broken at the time of delivery, along with 10% of HPs and 8% of SHPs. When asked about the availability of all necessary equipment, 11% of PHCCs, 7% of HPs, and 6% of hospitals reported that they didn't have all the equipment necessary to perform deliveries (Table 10.10).

Table 10. 10: Status of Equipment While Conducting the Last Delivery

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Delivery conducted in health facility in the last month	100	89.7	61.0	17.6
Total facilities (N)	**17**	**39**	**100**	**68**
Delivery set was ready	100	100	100	100
Delivery set was complete	100	100	95.1	100
Delivery set was sterilized	100	100	100	100
Any essential equipment was broken	5.9	11.4	9.8	8.3
All necessary equipment was available	94.1	88.6	93.4	100
All equipment was sterilized	100	97.1	100	100
All necessary supplies were available	100	97.1	88.5	100
All necessary drugs were available	100	97.1	95.1	91.7
Delivery table disinfected since previous client	100	94.3	100	100
Floor disinfected since previous client	100	91.4	95.1	100
Total facilities conducted delivery in health facility in last month (N)	**17**	**35**	**61**	**12**

**Percentage total may exceed 100 as a result of multiple responses*
Source: STS facility questionnaire

Over half of hospitals (53%) had used oxytocin before delivery, a practice less common at lower-level health facilities (40% of PHCCs, 17% of SHPs, and 15% of HPs). When asked the reason for giving oxytocin before delivery, all hospitals reported that it had been administered because of complications during delivery. However, among facilities that had given oxytocin, all SHPs (100%) and a sizeable percentage of HPs (67%) and PHCCs (71%) reported its use to be routine practice. In regards to reasons for not giving oxytocin after delivery, two health facilities (one HP and one SHP) reported that it had not been used as there had been no complications (Table 10.11).

When maternity clients were asked whether they had been given anything by service providers to accelerate labour, 30% of those from hospitals, 22% of those from PHCCs, and 18% of those from HPs reported that they had been given something by injection by health workers to induce labour.

Table 10. 11: Provision of Oxytocin to Women Before and After Delivery

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Delivery conducted in health facility last month	100	89.7	61.0	17.6
Total facilities (N)	**17**	**39**	**100**	**68**
Oxytocin given				
Before delivery	52.9	40.0	14.8	16.7
After delivery	100	100	98.4	91.7
Total facilities that had conducted a delivery in last one month (N)	**17**	**35**	**61**	**12**
Reason for giving oxytocin before delivery				
Complication during delivery	100	28.6	33.3	0.0
Routine practice	0.0	71.4	66.7	100
Total facilities that had given oxytocin before delivery (N)	**9**	**14**	**9**	**2**
No complication	0.0	0.0	100	100
Total facilities not having given oxytocin after delivery (N)	**0**	**0**	**1**	**1**
Clients reporting whether health workers had tried to accelerate labour				
No	60.6	77.8	60.2	100
Yes, administered something in injection form	29.8	21.7	17.9	0.0
Don't know	9.1	0.6	21.9	0.0
Medicine/tablet was crushed and fed	0.2	0.0	0.0	0.0
Artificial rupture of membrane	0.4	0.0	0.0	0.0
Vaginal insertion of medicine	0.1	0.0	0.0	0.0
Total number of maternity clients (N)	**387**	**38**	**20**	**2**

Source: STS facility questionnaire, maternity client exit interview

All SHPs, 95% of HPs and hospitals, and 89% of PHCCs reported that they had checked the mother's pulse at least once an hour during labour. Nine out of ten of the hospitals (94%), PHCCs (91%), and SHPs (92%) reported checking the blood pressure of mothers at least once an hour during labour, but this was slightly less common at HPs (85%). All hospitals and SHPs reported that they had checked the foetal heart beat at least once in an hour during the last labour (Table 10.12).

Among those health facilities that had had a delivery in the last month, 85% of HPs, 83% of SHPs, 60% of PHCCs, and 47% of hospitals had not used a partograph for the last delivery. Among those who had not used a partograph, the predominant reason for non-use was that it was felt that it had not been required (100% of hospitals, 90% of PHCCs, 81% of HPs, and 70% of SHPs). Additional reasons included a lack of partographs in the facility (reported at 5% of PHCCs) and an absence of oxytocin (reported by 10% of HPs) (Table 10.12).This finding shows that health workers felt it was important to use partographs in the cases where they administered oxytocin.

The reasons behind not checking a mothers' pulse at least once during labour in the last delivery were also assessed (Table 10.12). Time constraints due to high caseloads, no perceived need and

unavailability of health staff, and normal progress of patients were the reasons reported by a hospital that had not checked mother's pulse rate at least once during delivery. The same reasons were reported by 25% of PHCCs, and 67% of HPs.

Facilities that had not checked the mother's blood pressure at least once an hour during labour were asked the reasons why. The one hospital that failed to check the mother's blood pressure once an hour reported that they had checked it at least once every two hours. However, lower-level facilities appeared more complacent: one-third of PHCCs and HPs reported that they did not perceive it to be necessary, while a similar proportion of PHCCs (33%) and a greater proportion of HPs (44%) had not checked mothers' blood pressure every hour as the patients were said to be progressing normally (Table 10.12). High caseloads, foetal deaths, and normal progress were the reasons reported by one-third (33%) of PHCCs for not checking the foetal heart beat at least once an hour during labour.

Table 10. 12: Maternal and Infant Monitoring for Last Delivery During Last Month

Characteristics	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Examination:				
Administration of oxytocin	52.9	40.0	14.8	16.7
Checked mother's pulse at least once an hour during labour	94.1	88.6	95.1	100
Checked mother's blood pressure at least once an hour during labour	94.1	91.4	85.2	91.7
Checked foetal heartbeat at least once in an hour during labour	100	91.4	96.7	100
Total facilities conducting deliveries in last one month (N)	**17**	**35**	**61**	**12**
Reasons for not using partograph:*				
Didn't think there was a need	100	90.5	80.8	70.0
No partograph available	0.0	4.8	0.0	0.0
No provision of oxytocin	0.0	0.0	9.6	0.0
No complication/normal delivery	12.5	19.0	17.3	30.0
Total facilities not using partograph (N)	**8**	**21**	**52**	**10**
Reason for not checking mother's heart beat at least once an hour during labour:*				
Didn't have time because of high caseload	100	0.0	0.0	0.0
Didn't think there was a need	0.0	25.0	0.0	0.0
Progress was normal	0.0	50.0	66.7	0.0
Was under the inspection of health worker	0.0	0.0	33.3	0.0
No health staff to check	0.0	25.0	0.0	0.0
Total facilities not checking pulse (N)	**1**	**4**	**3**	**0**
Reasons for not checking mother's blood pressure at least once an hour during labour:*				
Didn't think there was a need	0.0	33.3	33.3	100
Normal progress	0.0	33.3	44.4	0.0
Was under the inspection of health staff	0.0	0.0	11.1	0.0
Insufficient number of staff	0.0	33.3	0.0	0.0
Checked at least once every two hours	100	0.0	33.3	0.0
Total facilities not checking blood pressure (N)	**1**	**3**	**9**	**1**
Reason for not checking foetal heart beat at least once an hour during labour:*				
Didn't have time because of high caseload	0.0	33.3	0.0	0.0
Didn't think there was a need	0.0	0.0	100	0.0
Foetal death	0.0	33.3	0.0	0.0
Normal progress	0.0	33.3	0.0	0.0
Total facilities not checking foetal heartbeat (N)	**0**	**3**	**2**	**0**

**Percentage total may exceed 100 as a result of multiple responses*
Source: STS facility questionnaire

It is encouraging that all delivery attendants reported that they had used sterilized gloves during the last delivery (Table 10.13). However, the use of gloves was not practised by one (3%) of the PHCCs during Per Vaginal (PV) examination, giving the reason that gloves are not required during PV examination.

Table 10. 13: PV Examinations and Use of Gloves/Aprons During Last Delivery

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Use of sterilized gloves and plastic apron during delivery:				
Used sterilized gloves during delivery	100	100	100	100
Used plastic apron during delivery	94.1	91.4	95.1	83.3
Total facilities conducting deliveries last month (N)	**17**	**35**	**61**	**12**
PV examination and use of sterilised gloves:				
PV examination performed during last delivery	100	97.1	100	100
Wearing sterilised gloves during PV examination	100	97.1	100	100
Total facilities conducting deliveries (N)	**17**	**35**	**61**	**12**
Reason for not using sterlised gloves during PV examination:				
Did not think there was a need	0.0	100	0.0	0.0
Total facilities not performing PV examination (N)	**0**	**1**	**0**	**0**

Source: STS facility questionnaire

The lithotomy position had been practised at 77% of PHCCs, 64% of HPs, 59% of hospitals, and 58% of SHPs for the last delivery (Table 10.14). International good practice encourages women's choice in the position of labour and evidence suggests that the supine position is more effective than the lithotomy position.

Table 10. 14: Position of Mother During Labour While Conducting Last Delivery

Position practised in last delivery	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Supine	41.2	22.9	36.1	41.7
Lithotomy	58.8	77.1	63.9	58.3
Total facilities conducting delivery in last month (N)	**17**	**35**	**61**	**12**
Woman's preferred position during delivery (reported by health workers)				
Supine	11.8	11.4	23.0	25.0
Lithotomy	64.7	65.7	54.1	50.0
Squatting	11.8	11.4	6.6	16.7
Lateral tilt	0.0	0.0	3.3	0.0
As said by health worker	11.8	5.7	6.6	8.3
Don't know	0.0	5.7	6.6	0.0
Total facilities conducting delivery in last month (N)	**17**	**35**	**61**	**12**

Source: STS facility questionnaire

Service providers were asked if they had faced any problems during the last delivery (Table 10.15). Service providers from more than one-third (35%) of hospitals, 31% of PHCCs, 26% of HPs, and 25% of SHPs reported that they had not faced any problems during the last delivery. The most common problem faced by hospitals during the last delivery performed was overcrowding as a result of patient's

companions (18%); at PHCCs (23%) and SHPs (25%), problems with water and electricity were the main concern, and at HPs (23%), limited clinical staff presented difficulties.

Table 10. 15: Main Difficulties Faced During the Last Delivery

Main difficulties faced during delivery	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
No problem	35.3	31.4	26.2	25.0
Water and electricity problems	11.8	22.9	16.4	25.0
Insufficient equipment and supplies	0.0	17.1	21.3	25.0
Limited clinical staff	0.0	11.4	23.0	16.7
No/limited equipment/supplies	11.8	14.3	4.9	8.3
Lack of SBA	11.8	11.4	6.6	0.0
Inappropriate infrastructure	0.0	2.9	11.5	8.3
Lack of delivery space/no delivery room	0.0	2.9	8.2	8.3
Crowd of patient companion	17.6	2.9	1.6	0.0
Others	23.5	11.4	16.4	8.3
Total facilities conducting a delivery in the last month (N)	**17**	**35**	**61**	**12**

Note: Percentage total may exceed 100 as a result of multiple responses
Source: STS facility questionnaire

Every health facility but one (PHCC, 3% of total PHCCs) reported that the newborn had been wiped and wrapped immediately after delivery. The majority of facilities (76% of hospitals, 80% of PHCCs, 93% of HPs, and 92% of SHPs) had waited more than 24 hours before bathing the newborn, although the length of delay was sometimes not known, particularly at hospitals (Table 10.16).

Table 10. 16: Newborn Care Practices

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Newborn wiped and wrapped immediately after delivery	100	97.1	100	100
When was newborn first bathed?				
Within 24 hours	5.9	11.4	0.0	8.3
After 24 hours	76.5	80.0	93.4	91.7
Don't know	17.6	8.6	6.6	0.0
Total facilities conducting deliveries in last month (N)	**17**	**35**	**61**	**12**

Source: STS facility questionnaire

Cleanliness

Enumerators observed the cleanliness of health facilities' delivery tables and the availability of cleaning products. A slightly higher percentage of lower-level health facilities (94% of PHCCs, and 92% of HPs and SHPs) than hospitals (88%) had a clean floor around the bed. While assessing the delivery table, it was observed that all SHPs, but not all hospitals, PHCCs, and HPs, had a delivery table with both a clean

surface and clean hinges (Table 10.17). Cleaning equipment and disinfectant were accessible in the delivery room at 94% of hospitals, 86% of PHCCs, 93% of HPs, and 92% of SHPs.

Table 10. 17: Cleanliness of Delivery Table and Availability of Cleaning Products

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Floor around bed	88.2	94.3	91.8	91.7
Surface of delivery table	100	91.4	93.4	100
Hinges of delivery table	94.1	88.6	86.9	100
Cleaning equipment and disinfectant readily available in the room where patients deliver	94.1	85.7	93.4	91.7
Total facilities conducting deliveries (N)	**17**	**35**	**61**	**12**

Note: Percentage total may exceed 100 as a result of multiple responses
Source: STS facility questionnaire

Maternity clients were asked about the advice they had been given by service providers after delivery. The majority of maternity clients at hospitals (85%) reported having been advised to breastfeed within an hour of delivery; around two-thirds (66%) had been given advice on exclusive breastfeeding and a similar proportion (66%) on immunization, with fewer having been advised about postnatal danger signs (54%), newborn danger signs (52%), and/or FP (39%). Advice on breastfeeding within an hour after delivery was more common at PHCCs (94%), SHPs (100%) and HPs (100%) than at hospitals (85%) (Table 10.18).

Table 10. 18: Advice Given by Health Service Providers to Maternity Clients After Delivery

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Postnatal danger signs	53.9	73.8	83.0	100
Newborn danger signs	52.1	67.9	85.3	50.0
To breastfeed within an hour of giving birth	85.0	94.1	100	100
Exclusive breastfeeding for six months	65.8	67.4	89.5	100
FP	39.4	65.4	40.1	0.0
Immunisation	65.8	84.8	90.7	100
Total maternity clients	**387**	**38**	**20**	**2**

Note: Percentage total may exceed 100 as a result of multiple responses
Source: STS maternity client exit interview

Companions

Maternity clients and outpatients were asked whether they had requested a companion when seeking care and, if so, whether their companion had been accepted by health care providers.

More than half (52%) of maternity clients had requested a companion during delivery, of whom 59% had received a companion during labour, 33% during delivery, and 48% after delivery. It is notable that the percentage was lowest during delivery. A slightly greater proportion of female (28%) outpatients had requested a companion than their male counterparts (23%), and a greater proportion of male outpatients had visited health facilities alone (49% vs. 37%) (Table 10.19).

Table 10. 19: Maternity Clients and Outpatients Requesting any Companion While Seeking Care

	Maternity clients (%)	Outpatients		
		Female (%)	Male (%)	Total (%)
Requested a companion at any time during care	52.1	27.5	22.6	25.6
No	47.9	35.8	28.7	41.3
Came alone	0.0	36.7	48.7	33.1
Total clients (N)	**447**	**484**	**335**	**819**
Companion permitted by the health provider				
Yes – during treatment	14.8	15.8	6.5	12.7
Yes – during labour	59.1	0.0	0.0	0.0
Yes – during delivery	33.2	0.0	0.0	0.0
Yes – after delivery	48.2	0.0	0.0	0.0
No	8.9	84.2	93.5	87.3
Total clients that requested a companion at any time during care (N)	**245**	**142**	**84**	**226**

Source: STS maternity client exit interview

Referral Systems

Government hospitals were the type of facility to which patients were most commonly referred, irrespective of the level of health facility from which they were referred (Table 10.20). The health facilities most likely to have referred clients to mission-/NGO-run hospitals were hospitals (12%) and PHCCs (10%).

Table 10. 20: Frequency of Referral to Facility Type

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Government hospital	70.6	71.8	70.0	64.7
PHCC	0.0	2.6	11.0	19.1
HP	0.0	0.0	1.0	8.8
Ayurvedic facility	0.0	0.0	1.0	0.0
Private hospital	5.9	5.1	3.0	1.5
Private clinic	5.9	0.0	0.0	1.5
Medical college/teaching hospital	5.9	10.3	8.0	1.5
Mission/NGO hospital/community hospital	11.8	10.3	6.0	2.9
Total facilities (N)	**17**	**39**	**100**	**68**

Source: STS facility questionnaire

The survey collected information on the time taken to travel to, and distance to, the nearest referral facility. The median time taken to travel to the nearest referral facility, using the quickest means of transportation, was two-and-a-half hours for hospitals, one-and-a-half hours for both PHCCs and HPs, and two hours for SHPs. Eight per cent (8%) of hospitals, 13% of HPs, and 20% of SHPs reported that the nearest health facility was less than five kilometres away. About 69% of hospitals reported that it was more than 51 km (Table 10.21).

Table 10. 21: Time Taken to Travel to, and Distance to, Nearest Referral Facility (Using Quickest Means of Transport)

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Time taken to reach nearest health facility (min)				
1st Quartile	48.3	36.1	30.0	30.0
Median	160.4	79.4	77.0	105.0
3rd Quartile	403.0	180.0	180.0	240.0
Total facilities that refer and reported time (N)	**17**	**39**	**100**	**68**
Distance to nearest referral facility				
Less than 5 km	7.7	0.0	12.9	19.7
6–10 km	7.7	12.5	15.3	21.3
11–20 km	7.7	25.0	27.1	26.2
21–50 km	7.7	50.0	32.9	27.9
51 km and above	69.2	12.5	11.8	4.9
Total facilities that refer clients and reported distance (N)	**13**	**32**	**85**	**61**

Source: STS facility questionnaire

Service providers were asked if they had referred clients for CS and/or assisted delivery (Table 10.22). PHCCs were most likely to have referred clients for CS (90%) and assisted delivery (77%). SHPs (50%) and

HPs (81%) most commonly reported government hospitals as the usual place of referral for CS and assisted delivery.

Table 10. 22: Referral for CS/Assisted Delivery

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Ever refer for CS	47.1	89.7	65.0	17.6
Ever refer for assisted delivery	29.4	76.9	63.0	17.6
Total health facilities (N)	**17**	**39**	**100**	**68**
Usual place of referral for CS:				
Government hospital	75.0	71.4	81.5	83.3
PHCC	0.0	2.9	0.0	0.0
Private hospital	0.0	2.9	0.0	0.0
Medical college/teaching hospital	12.5	11.4	13.8	8.3
Mission/NGO hospital/community hospital	12.5	11.4	4.6	8.3
Total health facilities referred CS cases (N)	**8**	**35**	**65**	**12**
Usual place of referral for assisted delivery:				
Government hospital	80.0	70.0	81.0	50.0
PHCC	0.0	3.3	4.8	33.3
Private hospital	0.0	3.3	0.0	0.0
Medical college/teaching hospital	0.0	13.3	9.5	8.3
Mission/NGO hospital/community hospital	20.0	10.0	4.8	8.3
Total health facilities referred assisted delivery cases (N)	**5**	**30**	**63**	**12**

Source: STS facility questionnaire

Among maternity clients at health facilities that referred for CS, the average time taken to reach the closest referral facility was six hours from SHPs, two hours from HPs, one-and-a-half hours from PHCCs, and more than two hours from hospitals. Among health facilities that referred for assisted deliveries, the average time taken to reach the closest referral facility was four hours from SHPs, one-and-a-half hours from HPs, more than one hour from PHCCs, and two-and-a-half hours from district hospitals (Table 10.23).

Table 10. 23: Median Time to Reach the Referral Facility for CS and Assisted Delivery

	Hospitals	PHCCs	HPs	SHPs
For CS (min):				
1st Quartile	45.0	30.0	52.5	135.0
Median	135.0	90.0	120.0	360.0
3rd Quartile	172.5	180.0	270.0	465.0
Total health facilities that referred CS cases (N)	**8**	**35**	**65**	**12**
For assisted delivery (min):				
1st Quartile	60.0	30.0	45.0	135.0
Median	150.0	75.0	90.0	240.0
3rd Quartile	285.0	195.0	180.0	405.0
Total health facilities that referred assisted delivery cases (N)	**5**	**30**	**63**	**12**

Source: STS facility questionnaire

All hospitals and almost all (97%) PHCCs and HPs ensured the condition of patients before referring to another health facility; however, 18% of SHPs were found not to be doing so. Based on observation of referral slips for the last cases referred, just 47% of hospitals, 18% of PHCCs, 8% of HPs, and 14% of SHPs had maintained the vital signs of the patients being referred (Table 10.24). Five per cent (5%) of both PHCCs and SHPs had referred patients without monitoring their vital signs before referral.

About 94% of hospitals, 85% of PHCCs, 82% of HPs, and 72% of SHPs reported using referral slips but the enumerators were not able to verify all cases. Health workers accompanied patients to referral facilities in less than two-fifths of cases. Just 24% of hospitals, 28% of PHCCs, 16% of HPs, and 7% of SHPs had provided emergency funds to cover transportation and treatment costs for women suffering from maternal complications (Table 10.24).

Table 10. 24: Ensuring Patient's Condition before Referral

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Ensure patients' condition before referral to higher level facilities	100	97.4	97.0	82.4
Total health facilities (N)	17	39	100	68
Vital signs stable for the last referral				
Yes, seen by enumerator	47.1	18.4	8.2	14.3
No, seen by enumerator	5.9	2.6	1.0	
Yes, not seen by enumerator	41.2	63.2	81.4	69.6
No, not seen by enumerator	5.9	10.5	9.3	10.7
Vital signs not monitored before referral	0.0	5.3	0.0	5.4
Total health facilities ensuring patients' condition before referral (N)	**17**	**38**	**97**	**56**
Referral slip provided for last referral case				
Yes, seen by enumerator	41.2	20.5	8.0	8.8
Yes, not seen by enumerator	52.9	64.1	74.0	63.2
Total health facilities (N)	**17**	**39**	**100**	**68**
Clinical person accompanied the client to the referral hospital during last complicated referral	41.2	43.6	39.0	35.3
Total health facilities (N)	**17**	**39**	**100**	**68**
Facility provided emergency funds to cover the cost of transportation and treatment when required by women suffering from a maternal (antepartum, intrapartum or postpartum) complication	23.5	28.2	16.0	7.4
Total health facilities (N)	**17**	**39**	**100**	**68**

Source: STS facility questionnaire

10.2.2 Outputs

Provision of Services

Maternity services

The majority of higher-level (88%) and district (78%) hospitals were officially classified as CEONC facilities; the remaining 12% of higher-level hospitals and 22% of district hospitals were classified as BEONC facilities. Over half of PHCCs (56%) were classified BEONC facilities. Two-thirds (67%) of HPs, 44% of PHCCs, and 19% of SHPs were classified as birthing centres (Table 10.25).

Table 10. 25: Proportion of Facilities Officially Recognized as CEONC/BEONC Facilities or Birthing Centres

	Higher-level hospitals (%)	District hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
CEONC facility	87.5	77.8			
BEONC facility	100	100	56.4	1.0	
Birthing centre	NA	NA	43.6	67.0	19.1
None of the above	NA	NA	0.0	32.0	80.9
Total Health facilities (N)	**8**	**9**	**39**	**100**	**68**

Note: All CEONC facilities have BEONC services available

Source: STS facility questionnaire

Provision of normal delivery care

All the higher-level and district hospitals provided round-the-clock normal delivery services, along with 95% of PHCCs, 66% of HPs, and 19% of SHPs. One PHCC was not providing normal delivery services 24/7, even though it was a birthing centre; however, it had only recently been upgraded to PHCC level. All CEONC and BEONC facilities offered normal delivery services 24/7, but 6% of birthing centres were not providing round-the-clock normal delivery services (Table 10.26).

Table 10. 26: Availability of Normal Delivery Services

Availability of normal delivery services by level of facility	Higher-level hospitals (%)	District hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Available	100	100	100	68.0	20.6
Available 24/7	100	100	94.9	66.0	19.1
Total (N)	8	9	39	100	68
Availability of normal delivery services by category of services offered by health facilities		**CEONC facilities (%)**	**BEONC facilities (%)**	**Birthing centres (%)**	
Available		100	100	100	
Available 24/7		100	100	93.8	
Total health facilities having delivery services (N)		**14**	**25**	**98**	

Source: STS facility questionnaire

Provision of BEONC services

All CEONC facilities provided all BEONC signal functions round the clock, but 60% of BEONC facilities did not (Table 10.27). Two percent of birth centres provided all BEONC signal functions round the clock, with over 80% administering uterotonic drugs 24/7.

Table 10. 27: Availability of BEONC Services

	CEONC facilities (%)	BEONC facilities (%)	Birthing centres (%)	Total (%)
Perform assisted vaginal delivery (vacuum or forceps)	100	64.4	3.9	27.7
Available 24/7	100	56.5	1.6	25.2
Parenteral antibiotics	100	92.1	62.2	72.1
Available 24/7	100	84.2	52.8	64.2
Uterotonic drugs (e.g. parenteral oxytocins, misoprostol)	100	96.0	85.8	89.4
Available 24/7	100	96.0	80.3	85.6
Anticonvulsants/sedatives (magnesium sulfate)	100	92.1	67.3	77.8
Available 24/7	100	92.1	64.0	73.4
Manual Removal of Placenta (MRP)	100	87.8	37.8	54.4
Available 24/7	100	83.8	37.0	53.1
Remove retained products if incomplete abortion (e.g. Manual Vacuum Aspiration (MVA))	100	68.4	7.8	30.0
Available 24/7	100	64.4	7.0	28.8
Neonatal resuscitation (e.g. with bag and mask)	100	87.7	63.0	72.0
Available 24/7	100	87.7	59.9	69.8
All BEONC services available	100	48.2	2.3	22.7
Available 24/7	100	40.3	2.3	21.3
Total health facilities with delivery services (N)	**14**	**25**	**98**	**137**

Source: STS facility questionnaire

All higher-level hospitals and 89% of district hospitals provided all seven BEONC signal functions 24/7; however, the proportions of PHCCs (23%) and HPs (2%) providing such services were low. All district hospitals provided assisted vaginal delivery (either vacuum or forceps), parenteral antibiotics, anticonvulsants, and uterotonic drugs round-the-clock. Administration of uterotonic drugs, anticonvulsants, parenteral antibiotics, and neonatal resuscitation were the most commonly available signal functions in PHCCs (Table 10.28).

Table 10. 28: Availability of BEONC Services According to Type of Health Facility

	Higher-level hospitals (%)	District hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Perform assisted vaginal delivery (vacuum or forceps)	100	100	38.4	5.0	0.0
Available 24/7	100	100	33.3	3.0	
Parenteral antibiotics	100	100	89.7	53.0	20.6
Available 24/7	100	100	76.9	41.0	13.2
Uterotonic drugs (e.g. parenteral oxytocins, misoprostol)	100	100	92.3	69.0	25.0
Available 24/7	100	100	89.7	60.0	20.6
Anticonvulsants/sedatives (magnesium sulfate)	100	100	87.2	58.0	16.2
Available 24/7	100	100	82.1	51.0	14.7
MRP	100	88.9	77.0	35.0	1.5
Available 24/7	100	88.9	74.4	34.0	1.5
Remove retained products if incomplete abortion (e.g. MVA)	100	100	48.7	5.0	0.0
Available 24/7	100	100	43.6	5.0	0.0
Neonatal resuscitation (e.g. with bag and mask)	100	88.9	82.1	52.0	10.3
Available 24/7	100	88.9	82.1	48.0	8.8
All BEONC services available	100	88.9	28.2	2.0	0.0
Available 24/7	100	88.9	23.1	2.0	0.0
Total facilities (N)	**8**	**9**	**39**	**100**	**68**

Source: STS facility questionnaire

Provision of CEONC services

All CEONC facilities (seven CEONC higher-level hospitals and seven CEONC district hospitals) provided the two additional CEONC signal functions (blood transfusion and CS) round the clock (Table 10.29).

Table 10. 29: Availability of CEONC Services

	All CEONC facilities (%)	CEONC higher-level hospitals (%)	CEONC district hospitals (%)	At least one facility in district providing service (%)
Perform blood transfusion	100	100	100	100
Available 24/7	100	100	100	100
Perform CS	100	100	100	100
Available 24/7	100	100	100	100
All CEONC services	100	100	100	100
Available 24/7	100	100	100	100
Total facilities (N)	**14**	**7**	**7**	
Total districts (N)				**13**

Source: STS facility questionnaire

FP services

Condoms, oral contraceptive pills, and injectables were available in all levels of health facility. IUCD services were available in all hospitals. However, a small percentage of hospitals (6%) were still not providing implant services. Around one-third of HPs were providing IUCD (33%) and implant (29%) services. Mini-laparotomy (63%) and vasectomy services (75%) were only provided by hospitals (Table 10.30).

Table 10. 30: Provision of FP Methods

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Temporary methods:				
Condom	100	100	100	100
Oral contraceptive pill	100	100	100	100
Injectable	100	100	100	100
IUCD	100	79.5	33.0	1.5
Implant	93.8	61.5	29.0	0.0
Permanent methods:				
Mini-laparotomy	62.5			
Vasectomy	75.0			
Total facilities providing FP services (N)	**16**	**39**	**100**	**68**

Source: STS facility questionnaire

Stock-outs of FP methods at the time of visit are presented below in Table 10.31. Stock-outs of condoms were observed in 1% of SHPs, and stock-outs of oral contraceptive pills in 3% of PHCCs. There were no stock-outs of these methods at other levels. Stock-outs of IUCDs were observed in 6% of hospitals and PHCCs, and in 3% of HPs. Injectables were the only method in stock in all health facilities at the time of visit.

Table 10. 31: FP Devices in Stock at Time of Visit

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)	Total (%)
Condom	100	100	100	98.5	99.6
Oral contraceptive pill	100	97.4	100	100	99.6
Injectable	100	100	100	100	100
Total facilities providing FP services (N)	**16**	**39**	**100**	**68**	**223**
IUCD	93.8	93.5	97.0	100	95.1
Total facilities with IUCD services (N)	**16**	**31**	**33**	**1**	**81**
Implant	93.3	100	96.6		97.1
Total facilities with implant services (N)	**15**	**24**	**29**		**68**

Source: STS facility questionnaire

A greater proportion of PHCCs (18%) had experienced a stock-out of at least one FP commodity in the last FY, compared to hospitals (13%), HPs (10%), and SHPs (9%). Hospitals reported stock-outs of IUCDs and implants (an average of one per year), whereas HPs reported stock-outs of all five commodities (Table 10.32).

Table 10. 32: Number of Stock-outs of FP Methods in the Last FY

	Hospitals	PHCCs	HPs	SHPs	Total
% of facilities that had experienced stock-out of at least one FP commodity	12.5	17.9	10.0	8.8	11.2
Total facilities assessed (N)	**16**	**39**	**100**	**68**	**223**
Average number of stock-outs per year for facilities with stock-outs of one or more commodity (N=7):					
Condom	0	1.0	1.5	1.0	1.3
Oral contraceptive pill	0	1.0	1.3	1.0	1.2
Injectable	0	0.0	1.5	1.5	1.5
IUCD	1.0	1.0	1.0		1.3
Implant	1.0	1.5	1.0		1.2

Source: STS facility questionnaire

Table 10.33 below shows the availability of postpartum FP, post-abortion FP, and AFS at health facilities. A greater proportion of hospitals (94%) and PHCCs (87%) provided postpartum FP services than HPs

(66%) or SHPs (40%). All HPs recognized as safe abortion sites provided post-abortion FP services. However, 13% of hospitals and 3% PHCCs did not have any provision of FP services following abortion.

Provision of AFS at health facilities is a focus area for the GoN in addressing adolescent reproductive health issues. Around 60% of hospitals and HPs did not have AFS. AFS were most common at PHCCs (64%) and least common at SHPs (7%).

Table 10. 33: Availability of AFS and Postpartum and Post-abortion FP Services

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Provision of post-partum FP	94.1	87.2	66.0	39.7
Total facilities (N)	**17**	**39**	**100**	**68**
Provision of post-abortion FP	86.7	96.6	100	NA
Total safe abortion site (N)	**15**	**29**	**16**	**0.0**
Provide AFS	41.2	64.1	38.0	7.4
Total facilities (N)	**17**	**39**	**100**	**68**

Source: STS facility questionnaire

Client experience

Client experience is a vital indicator for quality of care. Their level of satisfaction with issues such as waiting time, behaviour of health workers, and time taken to receive overall services is an important determinant of future service utilization. If a person receives poor quality care, his/her experiences will often be shared across the community and will therefore have an impact not just on their own future use of services, but also that of others.

Waiting time

Over a quarter (29%) of maternity clients had received services immediately upon arrival in the health facility. In addition, nearly one-third (32%) of maternity clients reported having received services within ten minutes of arrival in the health facility. The level of dissatisfaction regarding health facility waiting times was similar for both maternity clients (11%) and outpatients (12%). There was no significant difference observed in the level of satisfaction between male (82%) and female (82%) outpatients regarding waiting times. Among outpatients, the waiting times for male (mean time: 26 minutes) and female patients (mean time: 28 minutes) were similar (Table 10.34).

Table 10. 34: Waiting Time between Arrival and First Assessment by a Provider and Level of Satisfaction (Maternity Clients and Outpatients)

	Maternity clients (%)	Outpatients		
		Female (%)	Male (%)	Total (%)
Waiting time (min):				
Seen immediately (0)	28.5	10.2	4.7	8.2
<10	32.3	37.2	41.9	39.0
10–30	24.2	31.5	33.3	32.2
30–60	5.6	14.0	12.9	13.6
60–120	3.8	4.7	4.4	4.6
>120	5.6	2.4	2.7	2.5
Mean time (min)	**26.8**	**28.4**	**26.0**	**27.4**
Satisfaction regarding facility waiting time:				
Very satisfied	27.8	14.7	15.6	15.1
Satisfied	52.5	67.1	65.9	66.7
Neither satisfied nor unsatisfied	8.6	5.8	7.6	6.5
Unsatisfied	8.6	11.4	9.6	10.7
Very unsatisfied	2.4	1.0	1.3	1.1
Total clients (N)	**447**	**484**	**335**	**819**

Source: Source: STS maternity client exit interview and outpatient exit interview

Cleanliness

Nearly one-fifth (19%) of maternity clients, 14% of female outpatients, and 22% of male outpatients were dissatisfied with the cleanliness of the facilities (Table 10.35).

Table 10. 35: Satisfaction with the Level of Cleanliness

	Maternity clients (%)	Outpatients		
		Female (%)	Male (%)	Total (%)
Very satisfied	7.2	11.7	9.3	10.8
Satisfied	62.4	63.3	60.2	62.1
Neither satisfied nor unsatisfied	10.9	10.9	8.6	10.0
Unsatisfied	15.7	12.0	17.0	13.9
Very unsatisfied	3.8	2.2	4.8	3.2
Total clients (N)	**447**	**484**	**335**	**819**

Source: STS maternity client exit interview and outpatient exit interview

Privacy and confidentiality

Clients have a right to privacy and confidentiality when receiving health care. This includes privacy and confidentiality during counselling, physical examinations, and clinical procedures, as well as in the handling of clients' medical records and other personal information. Out of the 447 maternity clients

interviewed, 94% reported that they had delivered in separate room, 81% had had curtains on all windows and doors, and 49% had had a curtain between/around beds while receiving maternity care.

Similar percentages of male (63%) and female (60%) outpatients reported that privacy had been maintained by not allowing any unknown persons into the room during consultation and treatment (Table 10.36). A slightly higher percentage of male (55%) than female clients (48%) reported the provision of a separate room for treatment.

Table 10. 36: Measures Used to Maintain Privacy

Maternity clients (yes only)	(%)	Outpatient clients (yes only)	Female (%)	Male (%)	Total (%)
Delivered in separate room	94.2				
Unknown person not allowed in the room during delivery	84.4	Unknown person not allowed in the room during consultation and treatment	63.2	60.2	62.1
Curtains on all windows and doors	81.3	Provision of curtain on doors and windows	30.9	24.1	28.3
Divider between beds	43.8	Availability of separate room for treatment	47.7	55.2	50.5
Curtain between/around beds	48.8	Availability of separate counselling room	32.4	29.5	31.3
Total clients (N)	**447**	**Total clients (N)**	**484**	**335**	**819**

Note: Percentage total may exceed 100 as a result of multiple responses
Source: STS maternity client exit interview and outpatient exit interview

Two-thirds (67%) of maternity clients stated that they were satisfied with the level of privacy. Among outpatients, very few were dissatisfied/very dissatisfied (6%) while 61% of males and 55% of females were satisfied/very satisfied (Table 10.37).

Table 10. 37: Satisfaction of Maternity Clients and Outpatient Exit Clients with the Level of Privacy Maintained in the Health Facility

	Maternity clients (%)	Outpatients		
		Female (%)	Male (%)	Total (%)
Very satisfied	4.0	4.2	5.2	4.6
Satisfied	62.7	51.1	55.9	52.9
Neither satisfied nor unsatisfied	23.7	38.5	34.4	37.0
Unsatisfied	7.8	6.2	4.3	5.5
Very unsatisfied	1.7	0.0	0.2	0.1
Total clients (N)	**447**	**484**	**335**	**819**

Source: STS maternity client exit interview and outpatient exit interview

Overcrowding

Over half (56%) of maternity clients reported that the facility overall was overcrowded, and 48% complained about overcrowding in the maternity department. Three in ten of both male and female outpatients complained about overcrowding in the health facility while visiting the outpatient department (Table 10.38).

Table 10. 38: Overcrowding of the Facility/Maternity Department Reported by Clients

	Maternity clients (%)	Outpatients		
		Female (%)	Male (%)	Total (%)
Overcrowding at health facility				
Yes	55.9	29.9	30.4	30.1
No	43.0	70.1	69.6	69.9
Don't know	1.1	0.0	0.0	0.0
Total clients (N)	**447**	**484**	**335**	**819**
Overcrowding at Maternity Department/Unit				
Yes	48.1			
No	50.6			
Don't know	1.3			
Total clients (N)	**447**			

Source: STS maternity client exit interview and outpatient exit interview

Providers

Types of providers

Maternity clients in health facilities were most commonly attended to by nurses/ANMs (85%). However, both female (53%) and male (61%) outpatients were most frequently attended to by HAs/AHWs (Table 10.39).

Table 10. 39: Type of Service Provider Attending to Outpatients and Maternity Clients

	Maternity clients (%)	Outpatients		
		Female (%)	Male (%)	Total (%)
Doctor	13.2	14.2	18.0	15.6
Nurse/ANM	84.7	26.7	14.5	22.1
FCHV	1.3	0.0	0.0	0.0
Don't know	0.9	3.8	4.8	4.2
HA/AHW	0.0	52.7	61.4	56.0
VHW	0.0	2.2	0.4	1.5
Office Assistant	0.0	0.1	1.0	0.5
Lab assistant	0.0	0.1	0.0	0.1
MCHW	0.0	0.1	0.0	0.1
Total clients (N)	**447**	**484**	**335**	**819**

Source: STS maternity client exit interview and outpatient exit interview

Sex of Providers

Clients receiving maternity and outpatient care were asked about the sex of their main provider and how comfortable they felt with them. Only 8% of the maternity clients had received delivery services from male providers. Among those who had received services from males, 38% would have preferred a female provider.

Regarding the sex preference of health providers among outpatients, 23% of females who had seen male service providers would have preferred to see a female provider. A very small percentage of men who had seen female providers felt uncomfortable (3%) (Table 10.40).

Table 10. 40: Comfortable with Sex of Health Worker, by Sex of Client

	Maternity clients		Outpatients			
			Female		Male	
	Preferred same sex (%)	Total (N)	Preferred same sex (%)	Total (N)	Preferred same sex (%)	Total (N)
Sex of health worker:						
Male	38.3	**35**	23.0	**310**	0.3	**224**
Female	0.1	**385**	0.0	**191**	3.2	**79**
Total	2.9	**447**	19.0	**484**	2.1	**335**

Source: STS maternity client exit interview and outpatient exit interview

Explanation and advice

Clients receiving maternity and outpatient services were asked whether they were satisfied with the information received from health care providers. More than two-thirds (69%) of maternity clients were satisfied with the explanation and advice received from health workers while seeking care. Similarly, 87% of outpatients were satisfied with the information received from health facilities (Table 10.41).

Table 10. 41: Satisfaction with Information Received from Providers

	Maternity clients (%)	Outpatients		
		Female (%)	Male (%)	Total (%)
Very satisfied	11.2	10.1	12.1	10.9
Satisfied	57.7	74.8	76.9	75.6
Neither satisfied nor unsatisfied	26.4	12.9	7.5	10.9
Unsatisfied	4.4	2.2	2.8	2.4
Very unsatisfied	0.3	0.0	0.8	0.3
Total clients (N)	**447**	**484**	**335**	**819**

Source: STS maternity client exit interview and outpatient exit interview

Skills of health care providers

More than 85% of maternity clients and 89% of outpatients were satisfied or very satisfied with the skills of health care providers. Very few (3% of maternity clients and 4% of outpatients) were dissatisfied or very dissatisfied with the providers' skill in delivering health care services (Table 10.42).

Table 10. 42: Satisfaction with Provider Skill Level

	Maternity clients (%)	Outpatients		
		Female (%)	Male (%)	Total (%)
Very satisfied	17.3	12.4	11.0	11.9
Satisfied	67.6	77.1	77.8	77.4
Neither satisfied nor unsatisfied	11.7	7.0	7.0	7.0
Unsatisfied	2.9	3.5	4.2	3.8
Very unsatisfied	0.4	0.0	0.0	0.0
Total clients (N)	**447**	**484**	**335**	**819**

Source: STS maternity client exit interview and outpatient exit interview

Provider attitude and behaviour

Six per cent of maternity clients reported that they had been scolded by health care staff while seeking care. The perceived reasons for being scolded were: that providers treat everyone badly (48%); that providers do not care about patients (36%); and because the maternity client had cried too much during delivery (25%). The most common reasons for being scolded reported by outpatients were: ignorance of health workers towards patients (81% of males and 43% of females), and old age of health care providers (14% of males and 57% of females) (Table 10.43).

Table 10. 43: Clients Scolded by Staff and Perceived Reason for Clients Being Scolded

	Maternity clients (%)	Outpatients		
		Female (%)	Male (%)	Total (%)
Clients scolded by staff	5.8	1.2	0.4	0.9
Total clients (N)	**447**	**484**	**335**	**819**
Perceived reason for scolding by clients				
Treat everyone badly	48.4	9.7	0.0	8.0
Ignorance of health workers towards patients	35.8	81.3	43.2	74.8
Mother cried too much during delivery	25.1	0.0	0.0	0.0
Old age of health care provider	5.5	14.1	56.8	21.4
Giving birth to too many children	0.0	9.0	0.0	7.4
Don't know	7.2	0.0	0.0	0.0
Total clients scolded (N)	**21**	**5**	**2**	**7**

Note: Percentage total may exceed 100 as a result of multiple responses
Source: STS maternity client exit interview and outpatient exit interview

Provider politeness

The majority (83%) of maternity clients was satisfied with health workers' politeness while receiving services; the proportion was even higher among outpatients (95% of females and 96% of males). Very few maternity clients (21 clients) reported impolite behaviour from health workers. The perceived reasons behind such impoliteness were that the health workers treated everyone very badly (50%) and didn't care about the patients (37%) (Table 10.44).

Table 10. 44: Satisfaction with Providers' Politeness

	Maternity clients (%)	Outpatients		
		Female (%)	Male (%)	Total (%)
Satisfaction with the politeness of the staff consulted:				
Very satisfied	12.8	16.1	20.5	17.8
Satisfied	69.9	78.4	75.1	77.2
Neither satisfied nor unsatisfied	11.1	3.9	4.3	4.0
Unsatisfied	6.0	1.6	0.1	1.1
Very unsatisfied	0.3	0.0	0.0	0.0
Total clients (N)	**447**	**484**	**335**	**819**
Perceived reason for impoliteness:*				
Treat everyone badly	50.4	82.1	0.0	79.3
They don't care about patients	36.9	17.9	100	20.7
Mother cried too much during delivery	7.8	0.0	0.0	0.0
Gender	5.0	0.0	0.0	0.0
Don't Know	10.0	0.0	0.0	0.0
Total clients treated impolitely (N)	**21**	**5**	**1**	**6**

**Percentage total may exceed 100 as a result of multiple responses*
Source: STS maternity client exit interview and outpatient exit interview

Client satisfaction

Likes and dislikes

Maternity clients were asked what they liked or disliked about the delivery care they had received. Most commonly, clients liked the provision of free delivery services (41% of hospital clients, 70% of PHCC and HP clients, and 100% of SHP clients), followed by safe care (40% of clients in hospitals and HPs, and 50% of those in PHCCs and SHPs); transportation incentives (31% of clients in hospitals, 34% of clients in PHCCs, 47% of clients in HPs, and 50% of clients in SHPs); the helpful attitude of health workers; short waiting times; and the clean and hygienic conditions of health facilities (Table 10.45).

The most common dislikes reported by maternity clients were: a lack of cleanliness (22% overall), scarcity of beds and bed linen (21% overall), and a lack of privacy (9% overall). Unclean/unhygienic hospitals (26%), the lack of bed linen (20%), late provision of incentives (25%), and long waiting times (50%) were the most commonly disliked aspects reported by maternity clients in hospitals, PHCCs, HPs, and SHPs respectively.

Table 10. 45: Maternity Clients' Likes and Dislikes About Delivery Care

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)	Total (%)
Clients liked:					
Did not like anything about facility	5.9	0.0	0.0	0.0	4.9
Helpful health provider	28.6	29.1	79.7	0.0	30.9
Free delivery service	40.9	70.2	70.2	100	45.9
Transport incentives	30.9	34.4	47.4	50.0	32.2
Didn't have to wait too long	22.6	49.4	22.9	0.0	25.7
Clean and hygienic	16.3	17.4	17.6	0.0	16.4
Provide clothes/cap for the child	0.5	0.0	0.0	0.0	0.4
Plenty of beds	3.2	0.0	0.0	0.0	2.6
Safe care	39.5	49.7	39.7	50.0	40.8
Able to handle complications	7.1	12.2	0.0	0.0	7.4
Free food	3.4	21.9	0.0	0.0	5.4
Skilled health workers	0.3	0.4	0.0	0.0	0.3
Everything is good	5.6	20.9	14.8	0.0	7.8
Provision of ambulance service	0.4	0.0	0.0	0.0	0.3
Regular check-up of patients	0.1	0.0	0.0	0.0	0.1
Clients disliked					
Health provider unhelpful/ignored client	5.4	0.4	0.0	0.0	4.5
Health provider rude/abusive	7.5	0.4	0.0	0.0	6.3
Health provider not competent/skilled	2.3	0.6	0.0	0.0	2.0
Long waiting time	7.5	0.6	0.0	50.0	6.5
Did not discharge on time	5.9	0.7	0.0	0.0	5.0
Provided incentive late	0.5	8.3	25.0	0.0	2.6
Charged for delivery items	4.8	0.7	0.5	0.0	4.1
Charged money by staff	4.2	0.7	0.0	0.0	3.6
Hospital is not clean/hygienic	25.9	0.8	6.0	0.0	21.9
Lack of beds	24.1	5.5	14.5	0.0	21.3
Lack of bed linen	18.5	19.9	0.0	0.0	17.7
Lack of privacy	10.1	2.3	3.9	0.0	8.9
Perform unnecessary internal examinations	6.6	0.7	0.0	0.0	5.6
Male sex provider	2.6	0.0	0.0	0.0	2.2
Health Institution asks to buy medicine and commodities	3.1	0.0	6.6	0.0	2.9
Drinking water/toilet facility unhygienic/unmanaged	3.0	0.0	2.8	0.0	2.6
Others	4.2	11.3	6.0	0.0	5.1
Total maternity clients (N)	**387**	**38**	**20**	**2**	**447**

Note: Percentage total may exceed 100 as a result of multiple responses
Source: STS maternity client exit interview

Comparison of previous delivery with current

History of previous delivery

Women that had had a facility delivery were assessed about their previous history of delivery (Table 10.46). More than two-fifths (44%) had previously given birth. More than one-third (35%) of mothers who had previously given birth had delivered their previous child at home. Half of those who had previously delivered in a facility had had their previous delivery at the same facility.

Table 10. 46: Place of Previous Delivery (Maternity Clients)

	Maternity clients (%)
Delivered previously:	
First delivery	55.7
Delivered previously	44.3
Total clients (N)	**447**
Place of previous delivery:	
Home	34.8
Health facility	65.2
Total clients delivered previously (N)	**184**
Type of health facility:	
This facility (facility currently being attended)	50.0
Public hospital	29.2
PHCC	9.8
HP	1.4
Private clinic	2.6
Private/teaching hospital	6.8
NGO/missionary hospital	0.2
Total clients previously delivered in a facility (N)	**120**

Source: STS maternity client exit interview

Service compared with previous delivery

While comparing their most recent delivery with their previous delivery, nearly two-thirds (65%) of maternity clients reported that there had been no difference in the care received (Table 10.47). However, while some clients reported better staff behaviour (46%), better care (39%), and reduced costs (25%) for their most recent delivery, others reported that their most recent delivery had actually been costlier (33%), and that the care had been worse (20%) than experienced at the birth of their previous child.

Table 10. 47: Comparison of Last Delivery with Previous Delivery (Maternity Clients)

	Maternity clients (%)
No difference	65.2
Cost less	24.5
Cost more	32.6
Better care	39.2
Worse care	20.1
Better staff behavior	46.0
Worse staff behavior	10.0
Cleaner/more hygienic	43.2
Total clients previously delivered in a facility (N)	**120**

Note: Percentage total may exceed 100 as a result of multiple responses
Source: STS maternity client exit interview

Satisfaction with maternity and outpatient care

Maternity clients' and outpatients' levels of satisfaction with the health care received are summarized in Table 10.48. Clients' satisfaction with the care received, willingness to visit the facility in the future, and willingness to recommend the facility to the others were explored. The level of satisfaction with the care received was very high (indicated by the percentages reporting that they were satisfied/very satisfied with the care they had received) among both maternity (86%) and outpatient (91%) clients. A similar proportion of maternity clients and outpatients (4%) were dissatisfied with the service they had received.

Two per cent of outpatients stated that they would not be willing to visit the facility in the future, as did 4% of maternity clients (note that 30% did not plan to have any more children). Almost all outpatients (97% of males and 96% of females) stated that they would recommend the facility to others.

Table 10. 48: Satisfaction with Care Received

	Maternity clients (%)	Outpatients		
		Female (%)	Male (%)	Total (%)
Satisfaction with the care received:				
Very satisfied	12.9	14.8	15.6	15.1
Satisfied	72.8	77.0	73.6	75.7
Neither satisfied nor unsatisfied	10.7	4.4	6.7	5.3
Unsatisfied	3.3	3.7	4.1	3.9
Very unsatisfied	0.3	0.1	0.0	0.1
Would you visit this facility again:				
Willing to visit the facility again	56.1	93.6	97.5	95.1
Not willing to visit the facility again	3.7	2.1	0.9	1.6
Not intending to have any more children	29.8	NA	NA	NA
Don't know	10.4	4.3	1.6	3.3
Would you recommend this facility to others:				
Yes		95.6	96.7	96.1
No		1.8	1.7	1.8
Don't Know		2.6	1.5	2.2
Total clients (N)	**447**	**484**	**335**	**819**

Source: STS maternity client exit interview and outpatient exit interview

Recommendations for improvement

Both maternity clients and outpatients were asked to make recommendations to improve services. Both made similar suggestions, which are detailed in Table 10.49 below. The recommendations most commonly suggested by maternity clients were: maintaining clean/hygienic health facilities (35%), improvement/continuity of free services (14%), more helpful behaviour from health workers (13%), and better behaviour of health workers (11%). The top five recommendations made by outpatients were: maintaining cleanliness/hygiene (19%), increasing availability of competent and skilled health workers (18%), proper management of drinking water and toilet facilities (13%), shorter waiting times (13%), and maintaining privacy (10%). About 17% of maternity clients and 16% of outpatient clients responded that everything was good in the facility and required no improvement.

Table 10. 49: Major Recommendations by Maternity Clients and Outpatients

Suggested improvements	Maternity clients (%)	Outpatients (%)
Clean/hygienic health facility	35.0	19.3
Everything is good	17.5	16.1
Free services	13.6	7.4
Staff should be helpful	12.9	5.8
Staff should have good behavior	11.1	3.5
Shorter waiting time	9.5	12.9
Maintenance of privacy	9.0	10.4
Do not charge for items	7.0	1.5
Staff should be competent/skilled	7.0	18.2
Provision of health facility nearer to home	4.6	9.0
Female provider	4.2	9.5
Availability of more services at health facility	3.2	7.4
Availability of ambulance in health facility	2.8	1.2
Adequate/enough waiting space	2.4	2.5
Proper management of drinking water and toilet	10.8	13.2
Total clients who made a suggestion (N)	**447**	**819**

Note: Percentage total may exceed 100 as a result of multiple responses
Source: STS maternity client exit interview and outpatient exit interview

10.3 KEY FINDINGS

Biomedical waste management

- The findings of STS 2013 indicate that burning was the most commonly used method of waste disposal, reported by all hospitals and PHCCs, 95% of HPs, and 94% of SHPs. Burning followed by burying in a pit were the most common method of waste disposal as found by STS 2011 and 2012. 88% hospitals, all PHCCs, 99% HPs and 92% SHPs used burning as a method of disposal of biomedical waste as shown by STS 2012 while STS 2011 had found that 81% hospitals, 86% PHCCs, 82% HPs and 85% SHPs had used burning in 2011 (STS 2011). The percentage of health facilities using burning as the method of waste disposal has increased from 2011 to 2013. Incinerators were employed by 35% of hospitals, 26% of PHCCs, and 11% of HPs; however, the practice was not observed at SHPs.
- 100% of hospitals, 82% of PHCCs, 73% of HPs, and 59% of SHPs had separate puncture-proof bins for disposing of needles and sharps. Nearly nine in ten hospitals (94%) and 90% PHCCs used puncture proof bins as found by STS 2012. Over three-quarters of hospitals (76%) had red bins

for disposing of blood-/fluid-stained items in 2013 while more than four-fifth hospitals (88%) had such bins in 2012.

- Based on their capacity to provide delivery services, a higher proportion of hospitals (94%) had used a placenta pit/deep burial than of PHCCs (77%), HPs (55%), or SHPs (13%). Equal proportion of hospitals were using placenta pit as shown by STS 2012.

Supplies and equipment

- STS 2013 has found that more than one-third (35%) of hospitals, 67% of PHCCs, 47% of HPs, and 37% of SHPs had faced problems with regards to shortages of equipment in the last FY. The percentage of health institutions facing shortage of equipments was lower in 2012: hospitals (25%), PHCCs (45%), HPs (43%) and SHPs (33%) (STS 2012).
- Half of the hospitals with equipment shortages were facing shortages of X-ray machines; among those facilities with shortages, PHCCs (35%), HPs (28%), and SHPs (24%) were facing problems with regards to blood pressure instruments (aneroid).
- Higher percentages of PHCCs (41%) were facing problems regarding supplies than HPs (35%), SHPs (25%), and hospitals (24%). Over the last FY, the supplies of which there had most commonly been shortages were: catheters, bed sheets, and mattresses in hospitals; and oxygen cylinders, bed sheets, catheters, and utility gloves in PHCCs.
- STS 2013 found that about 35% of hospitals, 51% of PHCCs, 44% of HPs, and 29% of SHPs reported problems with delivery services as equipment was broken at the time. Higher percentage of hospitals (50%) and SHPs (51%) while lower percentage of PHCCs (35%) and HPs (34%) experienced such problems as found by STS 2012.
- There was excess equipment supplied to 5% of PHCCs, 7% of HPs, and 4% of SHPs; however, this problem did not exist in hospitals as found by STS 2013 while 6% hospitals, 23% PHCCs, 8% HPs and 4% SHPs had excessive equipment in 2012 which is higher than that found by STS 2013. In 2013, untrained manpower was reported by 49% of PHCCs, 29% of hospitals, 18% of HPs, and 9% of SHPs as the major reason for equipment in the facility not being used. Having equipment that no services providers were trained to use was most common in PHCCs (42%) as shown in STS 2012.
- STS 2013 has shown that over two-fifths (43%) of PHCCs had equipment available but not used owing to a lack of electricity, along with 20% of HPs, 18% of hospitals, and 15% of SHPs.
- The recommendation most frequently made by every type of health facility (35% of hospitals,

46% of PHCCs, 35% of HPs, and 31% of SHPs) was that goods should be supplied quickly and as per demand. Timely supply of goods was the most common recommendation in STS 2012 as well.

- More than 80% of all types of facilities made suggestions for improvements to the existing equipment repair and maintenance system. Regular maintenance of equipment by mobilizing maintenance teams across facilities was the top recommendation; made by 29% of hospitals, 26% of PHCCs, 28% of HPs, and 21% of SHPs.

Good practices

- Findings of STS 2013 show that higher percentage of hospitals had Quality Improvement Committees (41%) and Plans (35%) than lower level-health facilities. About 32% of facilities had a quality improvement plan in 2012 and lower level facilities (HPs 44% and SHPs 28%) were least likely to have the plan than hospitals (50%) and PHCCs (55%) (STS 2012).
- During the last delivery performed, 11% of PHCCs, 10% of HPs, 8% of SHPs, and 6% of hospitals faced problems with essential equipment not being available as it was broken at the time.
- Few health facilities (below 10%) reported unavailability of essential equipment necessary for providing delivery services.
- STS 2013 found that over half of hospitals (53%) and 40% of PHCCs gave oxytocin to maternity clients before delivery, largely as a result of complications during delivery at hospitals, but few as routine practice in other facilities which is higher than that shown by STS 2012. Less than one-third delivery attendants had given oxytocin to mother before delivery in 2012 and four-fifths in hospitals, PHCCs and HPs and all in SHPs had given due to complication.
- Around half (47%) of hospitals, 60% of PHCCs, 85% of HPs, and 83% of SHPs did not use a partograph during the last delivery performed as found by STS 2013. Use of partograph was higher in STS 2012 where only 6% hospitals and less than half of PHCCs, HPs and SHPs were not using it during last delivery.
- In addition, very few health facilities did not check the mother's pulse rate at least once an hour during the last delivery performed in both STS 2013 and 2012.
- Gloves were not used during PV examination in 3% of PHCCs as found by the present STS report while all health facilities were using sterilized gloves as shown by STS 2012.
- The most common problem faced by hospitals during the last delivery performed was overcrowding as a result of patients' companions (18%). At PHCCs (23%) and SHPs (25%)

problems with water and electricity were the main concern while at HPs (23%), limited clinical staffs were the most likely cause of difficulties. Inadequate staff, lack of electricity and other equipments and lack of available beds were the main problems in 2012 (STS 2012).

- Every health facility, with the exception of one PHCC (3% of total) wiped and wrapped newborns immediately after delivery. A slightly greater proportion of PHCCs (11%) than of hospitals (6%) or HPs (8%) had bathed newborns within 24 hours. NDHS 2011 shows that one in two newborns is bathed within an hour of birth and three in four newborns are bathed within 24 hours.
- Breastfeeding within an hour of delivery was suggested to maternity clients by 85% of hospitals, 94% of PHCCs, and all HPs and SHPs. NDHS 2011 has shown that less than half of children (45 percent) were breastfed within one hour of birth.
- Of maternity clients who had requested companions, 59% received companions during labour, 48% after delivery, and 33% during delivery. Percentage receiving companion has increased in 2013 than in 2012. STS 2012 showed that 44% used companion during delivery, 67% after delivery and 65% during labour.
- Among general outpatients, males were more likely to visit health facilities alone than females in 2013.
- District hospitals were the facility to which maternity clients at lower-level health facilities requiring CS or assisted delivery were most commonly referred. Among maternity clients at health facilities that referred for CS, the average time taken to reach the closest referral facility was six hours from SHPs, two hours from HPs, one-and-a-half hours from PHCCs, and more than two hours from hospitals.

Service provision

- The findings of STS 2013 show that 88% of higher-level hospitals and 78% of district hospitals were providing CEONC services. Only 50% in 2012 and 44% district hospital in 2011 provided CEONC service (STS 2012 and STS 2011).
- More than half (56%) of PHCCs had basic BEONC services, while 67% of HPs and 19% of SHPs had birthing centres. Numbers of HPs and SHPs who are birthing centres have also increased in 2013. According to STS 2012, 58% PHCCs provided BEONC services and 39% PHCCs, 58% HPs and 11% SHPs were birthing centres. On the other hand, 56% hospitals, 46% PHCCs were BEONC facility and 50% PHCCs, 53% hospitals and 11% SHPs were birthing centres in 2011.
- All higher-level and district hospitals were providing round-the-clock normal delivery services in

both STS 2013 and STS 2012; however, 5% of PHCCs and 34% of HPs were not providing 24 hour service in 2013. Higher which is around half (42%) HPs and 85% SHPs did not provide such service in 2012.

- STS 2013 has found that each CEONC facility provided all BEONC signal functions round the clock which is consistent with STS 2012, while two-fifths (40%) of BEONC facilities provided all BEONC signal functions 24/7 in 2013. In 2012, 64% of BEONC facilities had provided all BEONC signal functions on a 24-hour basis which is less than that in 2013.
- All CEONC sites had both blood transfusion and CS services round the clock which are consistent with STS 2012 but only 71% CEONC sites had provided blood transfusion according to STS 2011.
- Condoms, oral contraceptive pills and injectables services were available in all types of health facilities. A small proportion of hospitals (6%) were not providing implant services in 2013 which was slightly higher (12%) in STS 2012. In addition, more than half (58%) PHCCs and 85% HPs did not provide implant service in 2012.
- In STS 2013, stock-outs of IUCDs were observed in 6% of hospitals and PHCCs, and 3% of HPs. Though rare, shortages of condoms were found most commonly in SHPs, and stock-outs of oral pills most frequently in PHCCs. In 2012, 11% of facilities experienced stock out of at least one temporary family planning method in the last fiscal year as found which was 6% in hospitals and PHCCs, 8% in HPs and 17% in SHPs.
- STS 2013 has found that majority of hospitals (94%), 87% of PHCCs, 66% of HPs, and 40% of SHPs provided postpartum FP services. All HPs with safe abortion sites offered post-abortion FP services. However, 3% of PHCCs and 13% of hospitals did not have post-abortion FP services. STS 2012 showed that all hospitals, 97% PHCCs, 67% HPs and 21% SHPs were providing post-partum family planning services. Except SHPs, the percentage for other health facilities was higher in 2012 compared to 2013.
- Around 40% of both hospitals and HPs, and 64% PHCCs and 7% SHPs provided AFS in 2013 while 58% of the PHCCs, 32% HPs and 6% of SHPs were providing AFS in 2012 (STS 2012).

Client experiences

- More than two-fifths of maternity clients in hospitals (41%), 70% of those in both PHCCs and HPs, and all of those in SHPs liked the provision of free delivery services in the facility, while 31% of maternity clients in hospitals, 34% of those in PHCCs, 47% of those in HPs, and 50% of those in SHPs liked transportation incentives being provided. Some clients showed dissatisfaction with

the services provided, commonly standards of cleanliness, supply of mattresses and bed linen, and privacy in facilities. Nearly 18% of maternity clients and 14% of outpatient clients were unsatisfied with the level of cleanliness as shown by STS 2012. Similarly, the same report showed that 14% maternity and outpatient clients were unsatisfied with the level of privacy.

- STS 2013 showed that majority of maternity clients (86%) and outpatients (91%) were satisfied with the services they had received. However, 4% of outpatients and maternity clients were dissatisfied. The level of satisfaction for both maternity clients and outpatients was very high with 90% reporting that they were satisfied/very satisfied with the care they received in 2012 (STS 2012).
- STS 2013 has found that most outpatients (95%) were willing to visit the facility in the future and only 2% unwilling. Slightly more (99%) of the outpatients were willing to revisit the health facility as shown by STS 2012. Only 4% of the maternity clients said they were not willing to visit the facility again in both STS 2013 while slightly lower (3%) of maternity clients had said they were not willing to visit the facility again according to STS 2012.

The top five recommendations from maternity clients

- Maintaining clean/hygienic health facilities (35%);
- Improvement/continuity of free services (14%);
- More helpful behaviour from health workers (13%);
- Better behaviour of health workers (11%); and
- Proper management of drinking water and toilet facilities (11%).

The top five recommendations from outpatients

- Maintaining clean/hygienic health facilities (19%);
- Increasing availability of competent and skilled health workers (18%);
- Proper management of drinking water and toilet facilities (13%);
- Shorter waiting times (13%); and
- Maintaining privacy (10%)

CHAPTER 11: PROGRESS AGAINST NHSP-2 LF TARGETS

11.1 INTRODUCTION

In 2012, a LF was developed and endorsed by MoHP to monitor the objectives of NHSP-2. The LF contained various indicators for monitoring the progress of NHSP-2.

This chapter presents the major findings for the NHSP-2 LF indicators against the targets set.

Table 11. 1:Indicators in the NHSP-2 LF

Code	Indicators
Client satisfaction with health services	
OC 2.6	% of clients satisfied with their health care providers at public facilities
Availability of health services	
OP 4.5	% of the district with at least one public facility providing all CEONC signal functions 24/7
OP 4.6	% of PHCCs providing all BEONC signal functions 24/7
OP 4.7	% of HPs that are birthing centres providing deliveries 24/7
OP 4.8	% of safe abortion (surgical and medical) sites with long-acting FP services
OP 4.9	% of HPs with at least five FP methods
Availability of the human resources	
OP 3.1	% of sanctioned doctors and nurses posts at PHCCs and hospitals that are filled
	% of sanctioned posts that are filled: doctors at PHCCs
	% of sanctioned posts that are filled: doctors at district hospitals
	% of sanctioned posts that are filled: nurses at PHCCs
	% of sanctioned posts that are filled: nurses at district hospitals
OP 3.2	% of district hospitals that have at least one O/G or MDGP, five nurses trained as SBAs, and one anaesthetist or AA
Governance and accountability	
OP 1.3	% of health facilities with at least three females and at least two Dalit and Janajati members in HFOMCs and HDCs
OP 8.1	% of health facilities that have undertaken social audits as per MoHP guidelines in the current or last FY

11.2 RESULTS

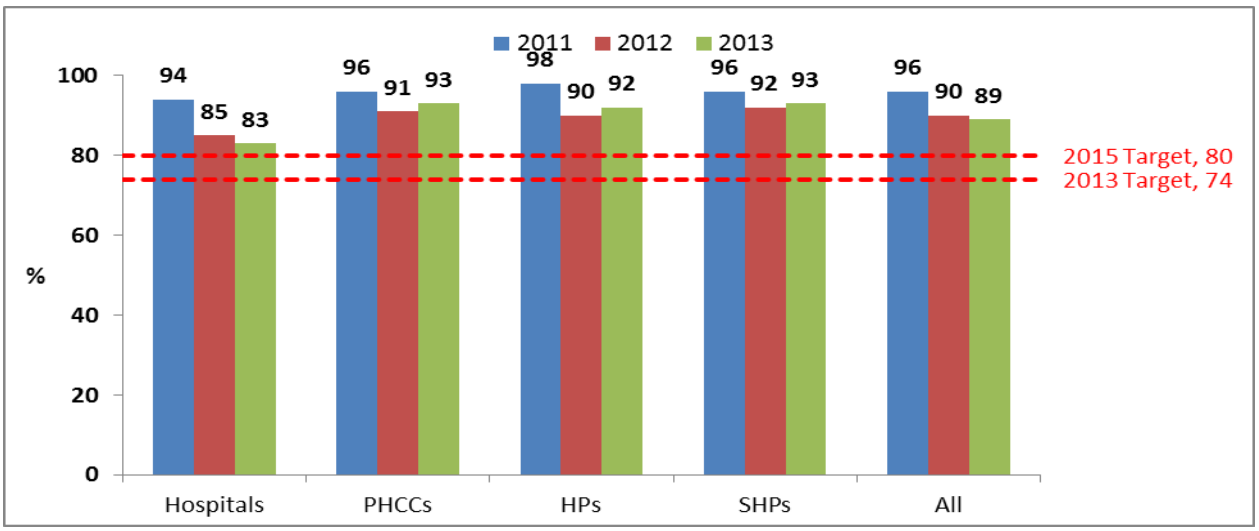
11.2.1 Client Satisfaction with Health Services

OC 2.6 % of clients satisfied with their health care providers at public facilities

Similar rating scales to those used in STS 2012 were employed to capture clients' satisfaction and dissatisfaction; the rating scale was different in STS 2011. The scale used to capture satisfaction had 'very satisfied' and 'satisfied' at the positive end of the rating, and 'unsatisfied' and 'very unsatisfied' at its negative end, keeping a neutral option in the middle to record indifference. Clients' satisfaction is difficult to measure as it is affected by client's expectation and knowledge. Clients commonly underreport dissatisfaction, especially at exit interviews given that they are conducted at health facilities. It is therefore necessary to be cautious when interpreting the results.

The majority (89%) of clients were satisfied with the services they had received at health facilities, which exceeds the targets set by NHSP-2 for 2013 (74%) and 2015 (80%) (Figure 11.1). When compared with 2012, only minor differences were seen, with a 2% decrease at hospitals, and small increases at PHCCs (93% in STS 2013, compared to 91% in STS 2012 and 96% in STS 2011), HPs (92% in STS 2013, compared to 90% in STS 2012 and 98% in 2011) and SHPs (93% in STS 2013, compared to 92% in STS 2012 and 96% in STS 2011). All levels of health facilities exceeded the targets set by NHSP-2 for 2015 in three consecutive years of STS; however, the more positive results in STS 2011, compared to 2012 and 2013, might be the result of the different rating scale used.

Figure 11. 1: Percentage of Clients Satisfied with Health Care at Public Health Facilities



Source: STS maternity client exit interview and outpatient exit interview

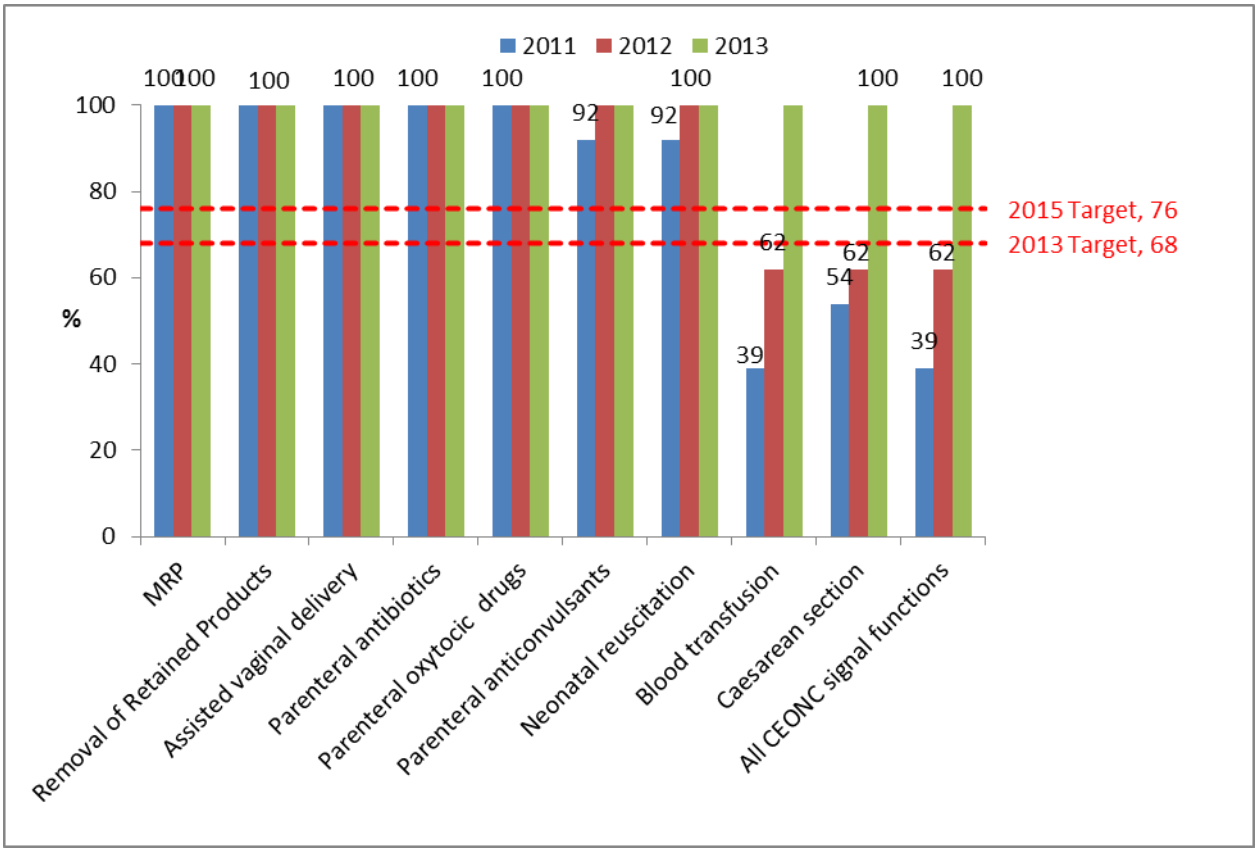
11.2.2 Availability of Health Services

CEONC services

OP 4.5 % of district with at least one public facility providing all CEONC signal functions 24/7

All selected districts had at least one CEONC facility providing all signal functions 24/7. There has been considerable improvement in STS 2013 (100%) compared to STS 2011 (39%) and STS 2012 (62%). The targets set by NHSP-2 for 2013 (68%) and 2015 (76%) have been exceeded (Figure 11.2).

Figure 11. 2: Percentage of Districts with at Least One Facility providing all CEONC Signal Functions 24/7



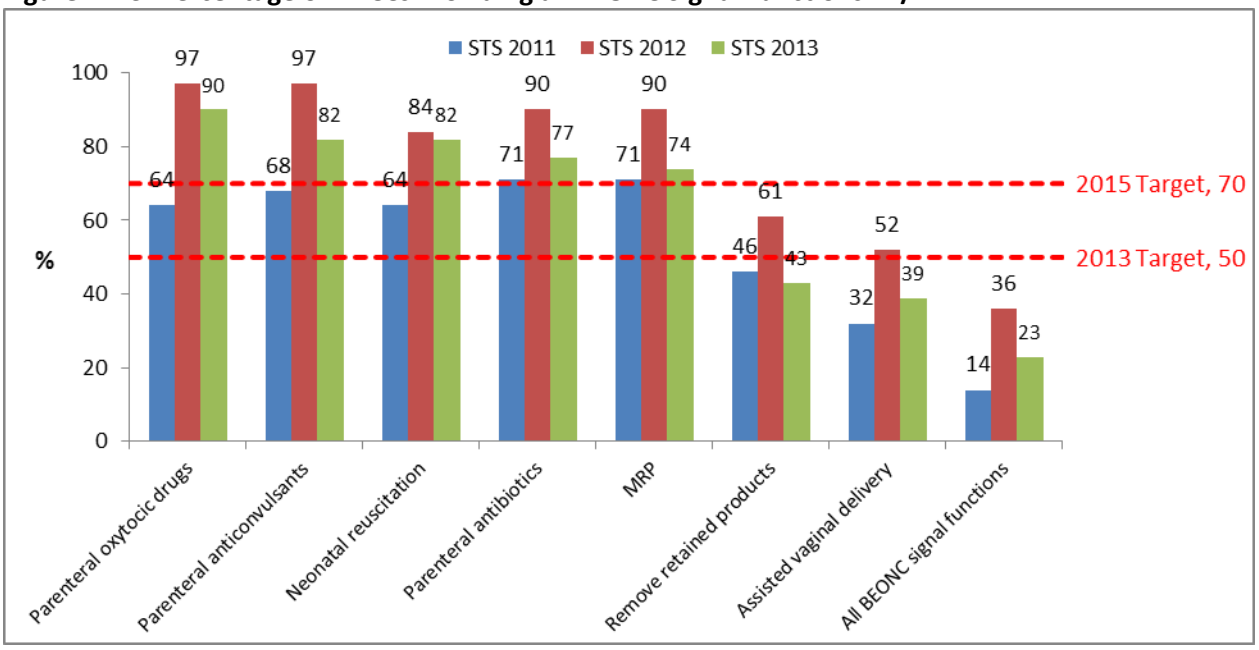
Source: STS facility questionnaire

BEONC services

OP 4.6 % of the PHCCs providing all BEONC signal functions 24/7

Less than a quarter (23%) of PHCCs were providing all BEONC signal functions 24/7 (Figure 11.3). Compared to STS 2011, the percentage of PHCCs providing all signal functions appeared to increase in 2012, but a decrease in the percentage was observed in STS 2013 (23%) from STS 2012 (36%). More than one-third (39%) were providing assisted vaginal delivery. Considering the findings, extensive efforts are required to meet the target set by NHSP-2 for 2015 (70%).

Figure 11. 3: Percentage of PHCCs Providing all BEONC Signal Functions 24/7

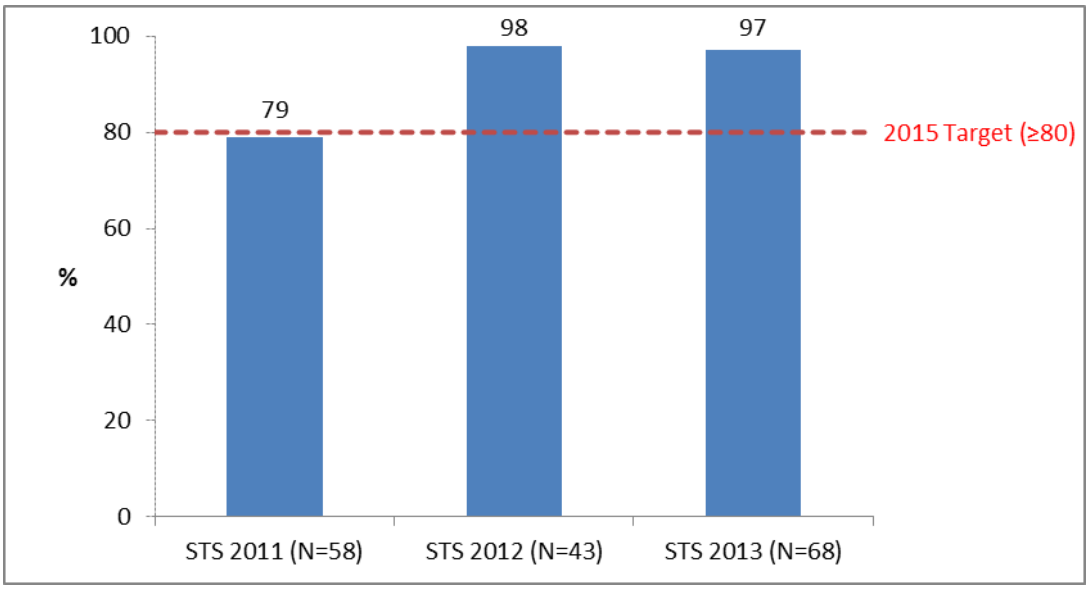


Source: STS facility questionnaire

Delivery services

In STS 2013, 97% of HPs were providing round-the-clock delivery services, a proportion similar to that recorded in STS 2012 (98%) and an increase of 18% from STS 2011 (79%). STS 2013 had already reached the target (80%) set by NHSP-2 for 2015 (Figure 11.4).

Figure 11. 4: Percentage of HPs that are Birthing Centres Providing Deliveries 24/7



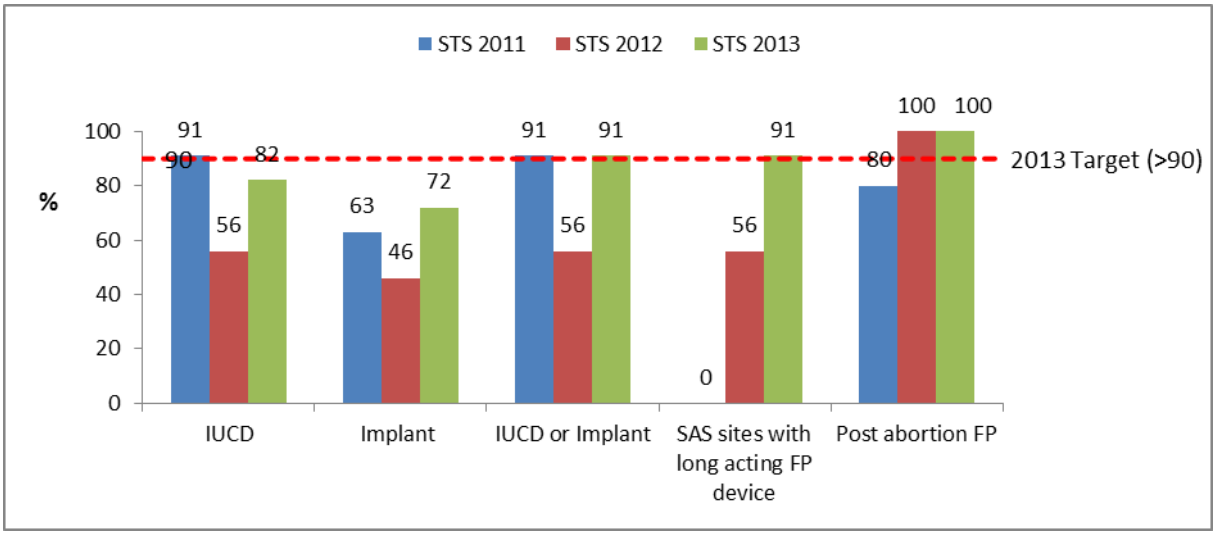
Source: STS facility questionnaire

FP services

OP 4.8 % of safe abortion (surgical and medical) sites with long-acting FP services

In 2013, the percentage of safe abortion sites with at least one long-acting FP method (91%) met the target (90%) set by NHSP-2 for 2013, and was found to be increased as compared to 2012 (87%). Similarly, the percentage of safe abortion sites providing long-acting FP devices also increased to 91% in STS 2013 from 56% in STS 2012 (Figure 11.5).

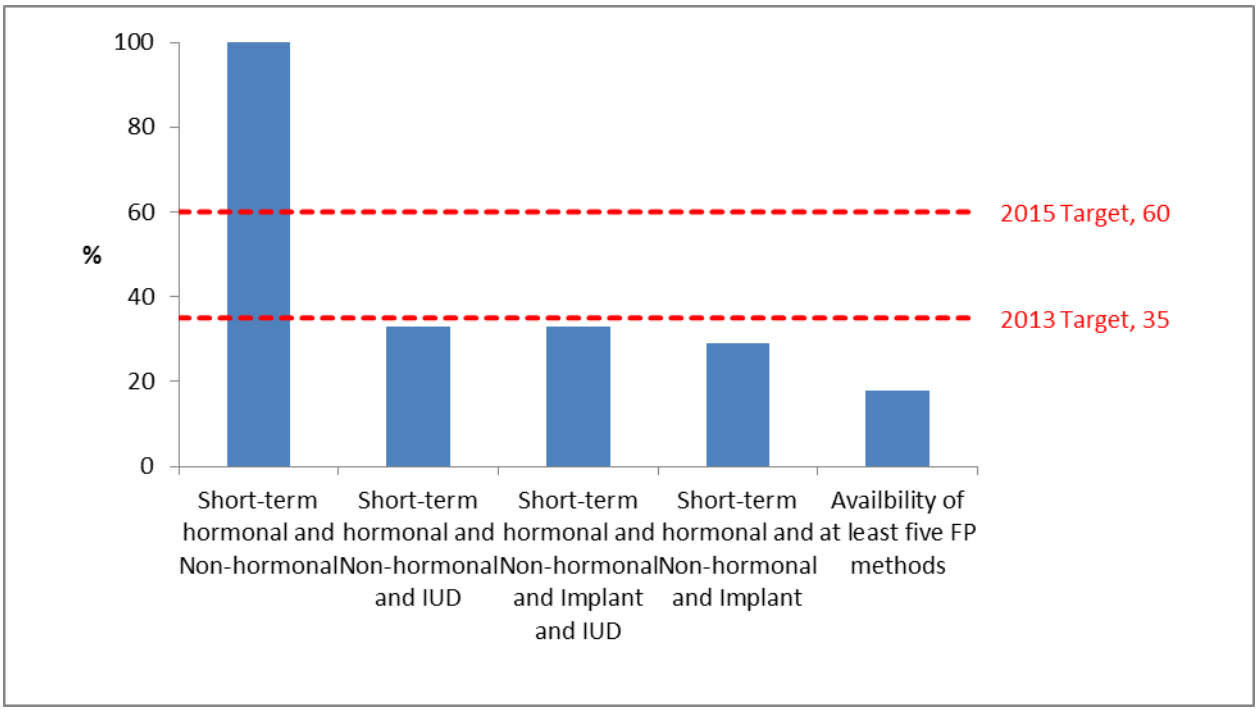
Figure 11. 5: Percentage of Safe Abortion Sites with Long-acting FP Devices and Post-Abortion FP Services



Source: STS facility questionnaire

Similar to the findings from STS 2011 and 2012, STS 2013 also showed that all HPs provided short-term hormonal (pills and injectables) FP methods and condoms. However, a substantial increase in the proportion of facilities providing IUCDs (33% in 2013, from 17% in 2012) and implants (29% in 2013, from 15% in 2012) was observed (Figure 11.6). Similarly, the proportion of HPs with at least five FP methods showed an increase of 10% (from 8% in 2012 to 18% in 2013). However, the availability of five FP methods remained low and did not meet the target set by NHSP-2 (35%) for 2013.

Figure 11. 6: Percentage of HPs with at Least Five FP Methods (N=100)



Source: STS facility questionnaire

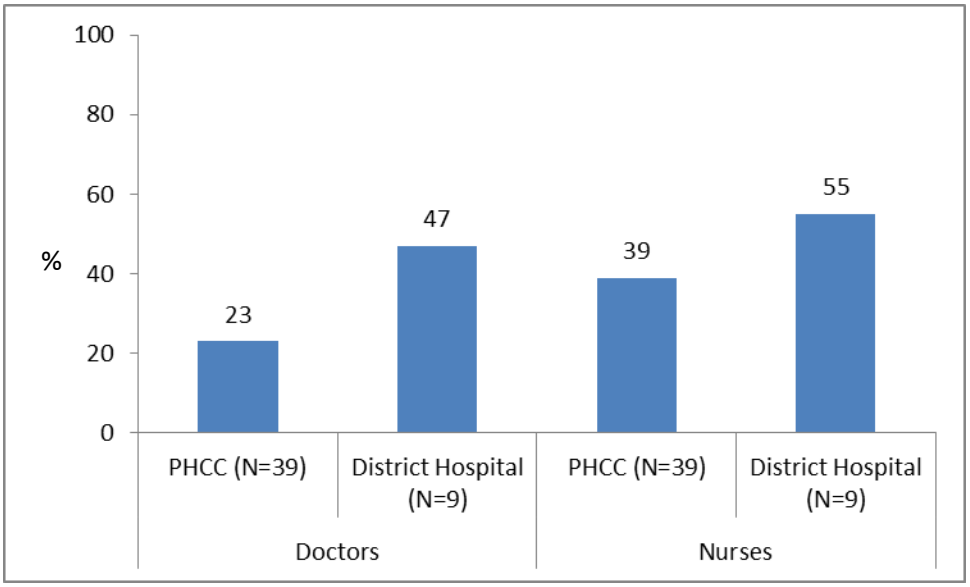
11.2.3 Availability of Human Resources

Doctors and nurses

STS 2013 found that less than half of district hospitals and less than a quarter (23%) of PHCCs had all sanctioned doctor posts filled. Similarly, more than half of district hospitals (55%) and 39% of PHCCs had all sanctioned posts for nurses filled (Figure 11.7). There has been a large decrease in the percentage of PHCCs that have all sanctioned nurse posts filled (39% in 2013 compared to 59% in 2012). Likewise, there has been a large decrease in the percentage of district hospitals with all sanctioned doctor posts filled (47% in 2013 compared to 63% in 2012) (Table 11.2). The target set for 2013 (88%) was not met. Looking at the present status it also seems unlikely that the target set for 2015 will be met.

OP 3.1 % of sanctioned doctors' and nurses' posts at PHCCs and hospitals that are filled

Figure 11. 7: Percentage of Sanctioned Doctors' and Nurses' Posts at PHCCs and Hospitals that are Filled (2013)



Source: STS facility questionnaire

Table 11. 2: Percentage Trends of Sanctioned Doctors'and Nurses' Posts At PHCCs and Hospitals that Are Filled

	STS 2011				STS 2012				STS 2013			
	Doctors (%)	**95% CI**	**Nurses (%)**	**95% CI**	**Doctors (%)**	**95% CI**	**Nurses (%)**	**95% CI**	**Doctors (%)**	**95% CI**	**Nurses (%)**	**95% CI**
Hospitals	68.9	46.7–79.6	83.3	74.3–89.6	63.0	35.6–78.8	82.7	75.1–91.1	47.1	12.2–69.5	55.3	48.4–57.1
PHCCs	50.0	35.1–64.9	73.8	60.5–83.8	22.6	8.8–46.9	58.7	44.9–73.3	23.0	5.7–70.4	38.5	33.2–44.0

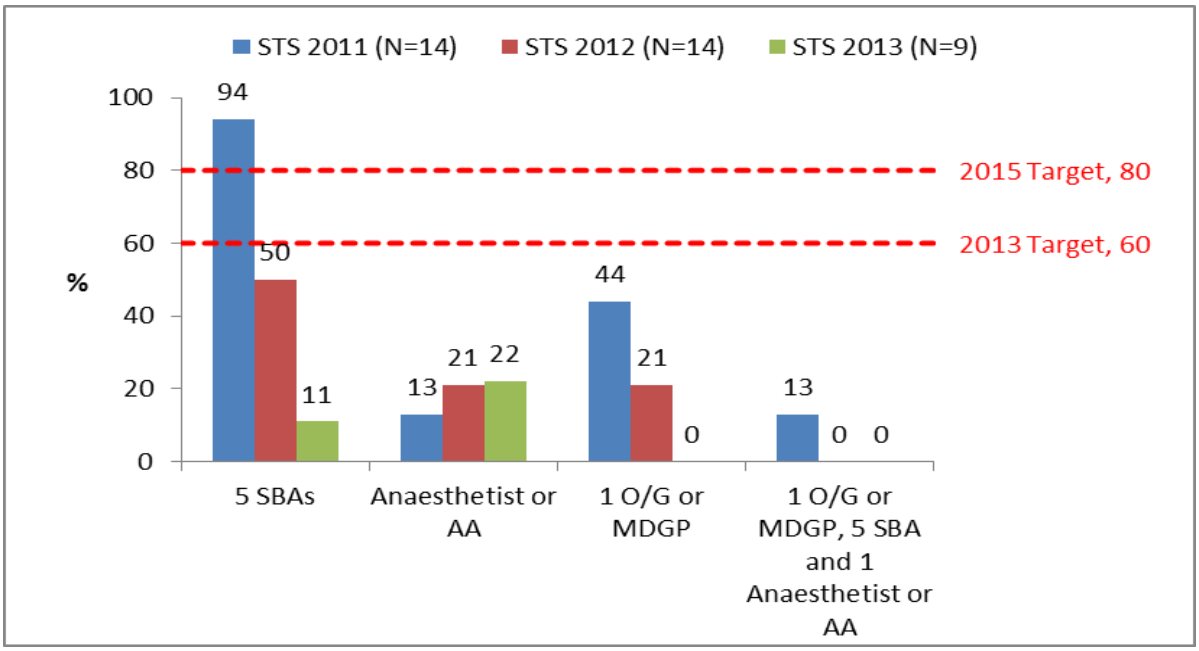
Source: STS facility questionnaire

CEONC staff

OP 3.2 % of district hospitals that have at least one O/G or MDGP, five nurses trained as SBAs, and one anaesthetist or AA

As found in STS 2012, STS 2013 showed that not a single district hospital was able to meet all the criteria for the CEONC staffing indicator, even though the availability of CEONC services was good compared to previous years. There has been a substantial decrease in the number of CEONC staff from the previous surveys. Only 11% of district hospitals had at least five nurses trained as SBAs, compared to half of the hospitals (50%) in STS 2012. Nearly half (44%) of district hospitals had an O/G or MDGP in STS 2011, and more than one-fifth (21%) had one in 2012, but not even a single hospital reported having an O/G or MDGP in STS 2013. Despite the unavailability of O/Gs, all the CEONC facilities had all CEONC signal functions available 24/7. This might be because the Medical Officer who had performed ASBA training had provided CS services in presence of an AA. The availability of anaesthetists was more or less similar in STS 2013 (22%) to STS 2012 (22%). Given the lack of improvement in the availability of CEONC staff in district hospitals, the target for 2015 is unlikely to be met.

Figure 11. 8: Percentage of District Hospitals with at Least One O/G or MDGP, Five Nurses Trained as SBAs, and One Anaesthetist or AA



Source: STS facility questionnaire

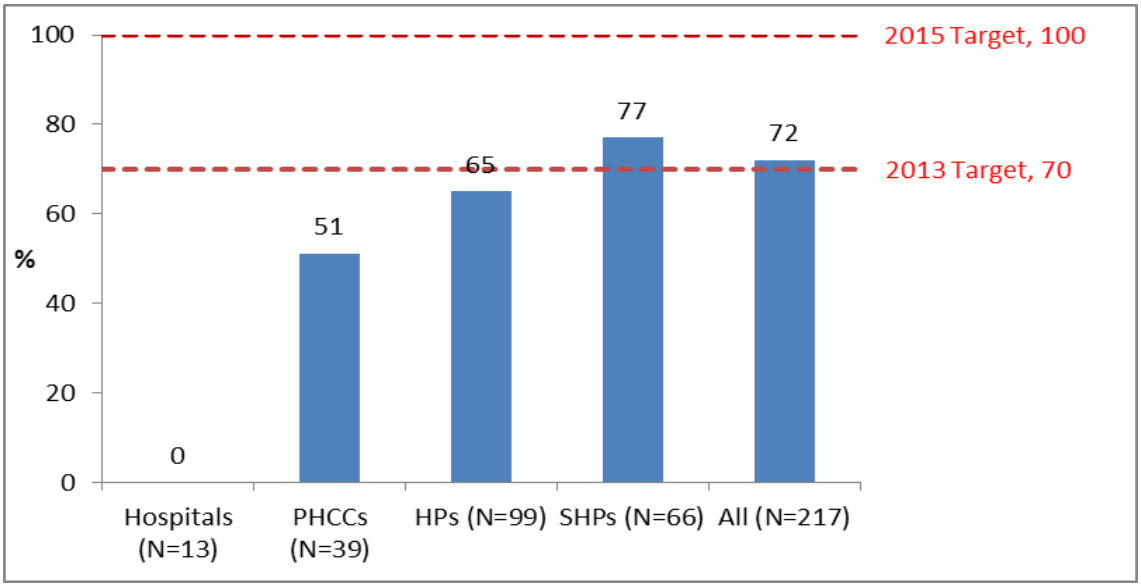
11.2.4 Governance and Accountability

Representation of disadvantaged groups in HFOMC/HDCs

OP 1.3 % of health facilities with at least three females and at least two Dalit and Janajati members in HFOMCs and HDCs

Findings from STS 2013 showed that not even a single hospital had at least three females and two Dalit and Janajati members in their HDCs. Overall, nearly three-quarters (72%) of HFOMCs/HDCs had at least three female members and two Dalit and Janajati members (Figure 11.9). SHPs met the target set by NHSP-2 for the year 2013. However, PHCCs (51%) and HPs (65%) were still lagging behind in achieving the target set. Considering the findings for STS 2013, the target for 2015 (100%) is likely to be met by SHPs and HPs. The findings for health facilities with at least three females and at least two Dalit and Janjati members in HFOMCs and HDCs over three years from STS 2011 to 2013 is shown in Table 11.3.

Figure 11. 9: Percentage of HFOMCs/HDCs with at Least Three Female Members and Two Dalit and Janajati Members (STS 2013)



Source: STS facility questionnaire

Table 11. 3: Percentage of HFOMCs/HDCs with at Least Three Female Members and Two Dalit and Janajati Members (STS 2011–2013)

	STS 2011 (%)	STS 2012 (%)	STS 2013 (%)
Hospitals	13	8	0
PHCCs	43	39	51
HPs	40	52	65
SHPs	49	58	77
All	42	49	72

Source: STS facility questionnaire

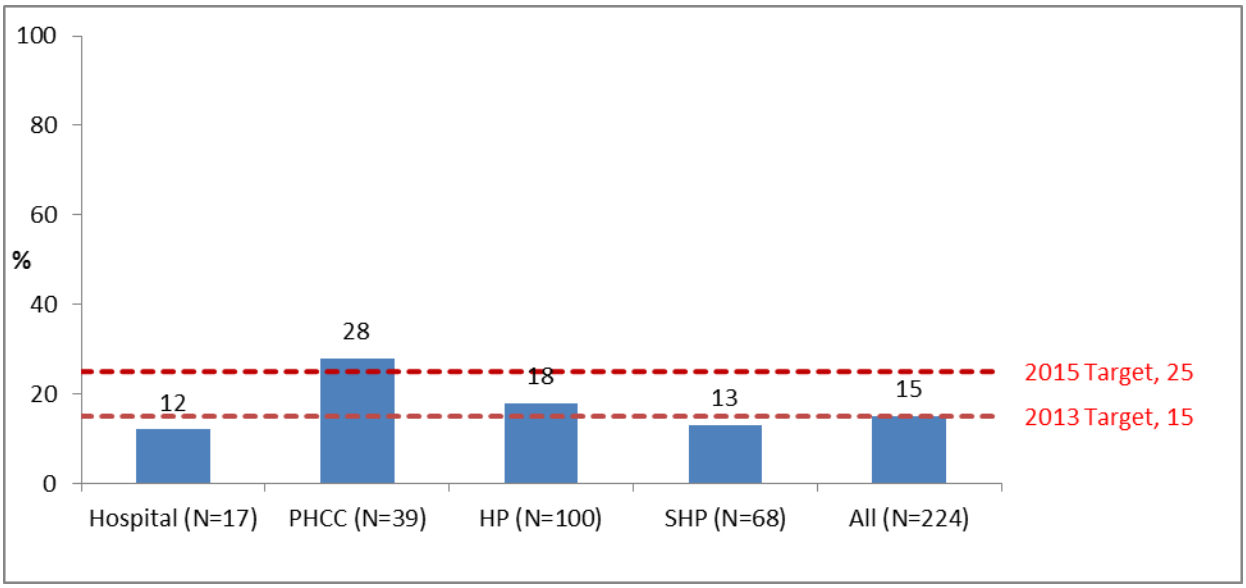
Social audits

OP 8.1 % of health facilities that have undertaken social audits as per MoHP guidelines in the current or last FY

STS 2013 found that 15% of health facilities had conducted a social audit as per MoHP guidelines in the last FY, which met the target, set by NHSP-2 for the year 2013. However, variations are observed between the different levels of health facilities, with only 12% of hospitals and 13% of SHPs conducting social audits as per the MoHP guidelines in last FY (Figure 11.10). Looking at the 2013 figure, this indicator is still on track to reach the 2015 target (25%).

In 2013, there was a decrease in the percentage of hospitals, PHCCs, and HPs that had conducted social audits. Percentages for STS 2011 and STS 2012 were similar (See Table 11.4)

Figure 11. 10: Percentage of Health Facilities that Undertook Social Audits in the Last FY as per MoHP Guidelines



Source: STS facility questionnaire

Table 11. 4: Percentage of Health Facilities that Undertook Social Audits in the Last FY as per MoHP Guidelines (STS 2011–2013)

	STS 2011 (%)	STS 2012 (%)	STS 2013 (%)
Hospitals	25	25	12
PHCCs	39	39	28
HPs	38	23	18
SHPs	25	10	13
All	31	14	15

Source: STS facility questionnaire

Table 11.5 a:: Comparison of Achievement of LF Indicators Measured by STS 2013 Against Targets

Code	Indicators	Achieved 2011 (%)	Achieved 2012 (%)	Achieved 2013 (%)	Target		
					2011 (%)	2013 (%)	2015 (%)
OC 2.6	Percentage of clients satisfied with their health care providers at public facilities	96	90	89	68	74	80
	Hospitals	94	85	83	-	-	-
	PHCCs	96	91	94	-	-	-
	HPs	98	90	92	-	-	-
	SHPs	96	92	93	-	-	-
OP 1.3	Percentage of health facilities with at least three females and at least two Dalit and Janajati members in HFOMCs/HDCs	42	49	72	-	70	100
	Hospitals	13	8	0			
	PHCCs	43	39	51			
	HPs	40	52	65			
	SHPs	49	58	77			
OP 3.1	Percentage of sanctioned doctors and nurses posts at PHCCs and hospitals that are filled						
	Percentage of sanctioned posts that are filled: doctors at PHCCs	50	23	23	85	88	90
	Percentage of sanctioned posts that are filled: doctors at district hospitals	69	56	47	85	88	90
	Percentage of sanctioned posts that are filled: nurses at PHCCs	74	59	39	85	88	90
	Percentage of sanctioned posts that are filled: nurses at district hospitals	83	83	55	85	88	90
OP 3.2	Percentage of district hospitals that have at least one obstetrician-gynaecolologist or MDGP, five nurses trained as SBAs, and one anaesthetist or AA	13	0	0	-	60	80
	Five nurses trained as SBAs	94	50	11			
	One O/G or MDGP	44	21	0			
	One anaesthetist or AA	13	21	22			

Table 11.5 b: Comparison of Achievement of LF Indicators Measured by STS 2013 Against Targets (Cont.)

Code	Indicators	Achieved 2011 (%)	Achieved 2012 (%)	Achieved 2013 (%)	Target		
					2011 (%)	2013 (%)	2015 (%)
OP 4.5	**Percentage of districts with at least one public facility providing all CEONC signal functions 24/7**	39	62	100	-	68	76
	MRP						
	Available	100	100	100			
	Available 24/7	100	100	100			
	Removal of retained products						
	Available	100	100	100			
	Available 24/7	100	100	100			
	Assisted vaginal delivery						
	Available	100	100	100			
	Available 24/7	100	100	100			
	Parenteral antibiotics						
	Available	100	100	100			
	Available 24/7	100	100	100			
	Parenteral oxytocic drugs						
	Available	100	100	100			
	Available 24/7	100	100	100			
	Parenteral anticonvulsants						
	Available	92	100	100			
	Available 24/7	92	100	100			
	Neonatal resuscitation						
	Available	92	100	100			
	Available 24/7	92	100	100			
	Blood transfusion						
	Available	46	62	100			
	Available 24/7	39	62	100			
	CS						
	Available	54	62	100			
	Available 24/7	54	62	100			
	At least one facility in district providing all CEONC signal functions						
	Available	39	62	100			
	Available 24/7	39	62	100			

Table 11.5 c: Comparison of Achievement of LF Indicators Measured by STS 2013 Against Targets (Cont.)

Code	Indicators	Achieved 2011 (%)	Achieved 2012 (%)	Achieved 2013 (%)	Target		
					2011 (%)	2013 (%)	2015 (%)
OP 4.6	**Percentage of PHCCs providing all BEONC signal functions 24/7**	14	36	23	-	50	70
	MRP						
	Available	82	90	74			
	Available 24/7	71	90	74			
	Removal of retained products						
	Available	50	61	44			
	Available 24/7	46	61	44			
	Assisted vaginal delivery						
	Available	39	55	31			
	Available 24/7	32	52	31			
	Parenteral antibiotics						
	Available	79	90	77			
	Available 24/7	71	90	77			
	Parenteral oxytocic drugs						
	Available	79	97	90			
	Available 24/7	64	97	90			
	Parenteral anticonvulsants						
	Available	71	97	82			
	Available 24/7	68	97	82			
	Neonatal Resuscitation						
	Available	82	84	82			
	Available 24/7	64	84	82			
	All BEONC functions						
	Available	21	42	23			
	Available 24/7	14	39	23			
OP 4.7	**Percentage of HPs that are birthing centres providing deliveries 24/7**	79	98	97	≥80		
	Available 24/7	79	98	97			
	Available but not 24/7	21	0	3			
	Not available	0	2	0			
OP 4.8	**Percentage of safe abortion (surgical and medical) sites with long-acting FP services**		56	91	≥90		
	IUCDs	91	56	80			
	Implants	63	46	72			
	IUCDs or implants	91	56	91			
	Post-abortion FP	80	100	100			

Table 11.5 d: Comparison of Achievement of LF Indicators Measured by STS 2013 Against Targets (Cont.)

Code	Indicators	Achieved 2011 (%)	Achieved 2012 (%)	Achieved 2013 (%)	Target		
					2011 (%)	2013 (%)	2015 (%)
OP 4.9	**Percentage of HPs with at least five FP methods**	13	8	18	-	35	60
	Short-term hormonal and non-hormonal	100	100	100			
	Short-term hormonal and non-hormonal and IUCDs	36	17	33			
	Short-term hormonal and non-hormonal and implants	16	15	29			
	Short-term hormonal and non-hormonal and IUCDs and implants	13	8	33			
OP 8.1	**Percentage of health facilities that have undertaken social audits as per MoHP guidelines in the current or last FY**	31	14	15	5	15	25
	Hospitals	25	25	12			
	PHCCs	39	39	28			
	HPs	38	23	18			
	SHPs	25	10	13			

11.3 KEY FINDINGS

Five of the 13 indicators have exceeded the targets set by NHSP-2 as shown in Table 11.6 below. The indicators that have exceeded the targets are: client satisfaction with health care providers, health facilities with at least three females and at least two Dalit and Janajati members in HFOMCs/HDCs, districts with at least one public facility providing all CEONC signal functions 24/7, safe abortion sites with at least one long-acting FP method, HPs that are birthing centres offering delivery services round the clock, and health facilities that have undertaken social audits as per MoHP guidelines.

Table 11. 6: NHSP-2 LF Indicators that Have Achieved the 2013 Target

Code	Indicators	STS2013 (%)	Target		
			2011 (%)	2013 (%)	2015 (%)
OC 2.6	Percentage of clients satisfied with their health care providers at public facilities	89	68	74	80
OP 1.3	Percentage of health facilities with at least three females and at least two Dalit and Janajati members in HFOMCs/HDCs	72	-	70	100
OP 4.5	Percentage of districts with at least one public facility providing all CEONC signal functions 24/7	100	-	68	76
OP 4.8	Percentage of safe abortion (surgical and medical) sites with long-acting FP services	91	≥90		
OP 4.7	Percentage of HPs that are birthing centres and providing deliveries 24/7	97	≥80		
OP 8.1	Percentage of health facilities that have undertaken social audits as per MoHP guidelines in the current or last FY	15	5	15	25

Four major NHSP-2 LF indicators are still off track, did not achieve the 2013 target, and are unlikely to achieve the targets set for 2015: less than a quarter (23%) of PHCCs and less than half (47%) of district hospitals had all sanctioned posts filled for doctors, while not even a single hospital had targeted CEONC staff (at least one obstetrician-gynaecolologist or MDGP, five nurses trained as SBAs and one anaesthetist or AA). Lack of improvement in this indicator suggests that the target set for 2015 (80%) is unlikely to be met. The other two indicators that are not likely to meet the 2015 targets are: the percentage of PHCCs providing all BEONC signal functions round the clock (70%); and the percentage of HPs with at least five FP methods (60%).

Table 11. 7: NHSP-2 LF Indicators that Will Not Achieve the 2015 Target

Code	Indicators	STS 2013 (%)	Target		
			2011	2013	2015
OP 3.1	Percentage of sanctioned posts that are filled: doctors at PHCCs	23	85	88	90
	Percentage of sanctioned posts that are filled: doctors at district hospitals	47	85	88	90
	Percentage of sanctioned posts that are filled: nurses at PHCCs	39	85	88	90
	Percentage of sanctioned posts that are filled: nurses at district hospitals	55	85	88	90
OP 3.2	Percentage of district hospitals that have at least one obstetrician-gynaecolologist or MDGP, five nurses trained as SBAs, and one anaesthetist or AA	0	-	60	80
OP 4.6	Percentage of PHCCs providing all BEONC signal functions 24/7	23	-	50	70
OP 4.9	Percentage of HPs with at least five FP methods	18	-	35	60

Annex A: weight Calculation

Table A1: Health facility weights

Level of facility	Sampling frame*		Sample facility		facility weight
	N	%	N	%	
Hospital	95	2.31	17	7.59	0.30
PHCC	209	5.09	39	17.41	0.29
HPs	676	16.45	100	44.64	0.37
SHPs	3129	76.15	68	30.36	2.51
Total	4109	100	**224**	100.00	1.00

*Note: *Annual report 2011/12*

Table A2: Outpatient weights

Weight - Outpatient exit interview	Users (Population)*		Exit (Sample)		Weight	Trimmed weight
	N	%	N	%		
Eastern mountain hospital	103296	0.43	11	1.34	0.32	0.32
Central mountain hospital	49750	0.21	9	1.10	0.19	0.19
Far-/Mid-/Western mountain hospital	162780	0.68	4	0.49	1.40	1.40
Eastern hill hospital	261592	1.10	10	1.22	0.90	0.90
Central hill hospital	465441	1.95	30	3.66	0.53	0.53
Western hill hospital	588374	2.47	19	2.32	1.06	1.06
Mid-western hill hospital	224123	0.94	27	3.30	0.28	0.28
Far-western hill hospital	138878	0.58	9	1.10	0.53	0.53
Eastern Terai hospital	432941	1.81	16	1.95	0.93	0.93
Central Terai hospital	497025	2.08	20	2.44	0.85	0.85
Western Terai hospital	54720	0.23	35	4.27	0.05	0.10
Mid-western Terai hospital	361953	1.52	23	2.81	0.54	0.54
Far-western Terai hospital	253057	1.06	9	1.10	0.97	0.97
Eastern mountain PHCC	54745	0.23	7	0.85	0.27	0.27
Central mountain PHCC	81952	0.34	17	2.08	0.17	0.17
Far-/Mid-/Western mountain PHCC	75661	0.32	5	0.61	0.52	0.52
Eastern hill PHCC	161091	0.68	17	2.08	0.33	0.33
Central hill PHCC	302386	1.27	19	2.32	0.55	0.55
Western hill PHCC	345368	1.45	7	0.85	1.69	1.69
Mid-western hill PHCC	208826	0.88	17	2.08	0.42	0.42
Far-western hill PHCC	70450	0.30	7	0.85	0.35	0.35
Eastern Terai PHCC	413166	1.73	25	3.05	0.57	0.57
Central Terai PHCC	418173	1.75	22	2.69	0.65	0.65
Western Terai PHCC	119161	0.50	11	1.34	0.37	0.37
Mid-western Terai PHCC	151072	0.63	8	0.98	0.65	0.65
Far-western Terai PHCC	204824	0.86	10	1.22	0.70	0.70
Eastern mountain HP	152161	0.64	25	3.05	0.21	0.21
Central mountain HP	118395	0.50	18	2.20	0.23	0.23
Far-/Mid-/Western mountain HP	333092	1.40	22	2.69	0.52	0.52

Eastern hill HP	412045	1.73	15	1.83	0.94	0.94
Central hill HP	548059	2.30	24	2.93	0.78	0.78
Western hill HP	658630	2.76	17	2.08	1.33	1.33
Mid-western hill HP	466593	1.96	32	3.91	0.50	0.50
Far-western hill HP	249798	1.05	27	3.30	0.32	0.32
Eastern Terai HP	617638	2.59	31	3.79	0.68	0.68
Central Terai HP	490687	2.06	28	3.42	0.60	0.60
Western Terai HP	175052	0.73	17	2.08	0.35	0.35
Mid-western Terai HP	367602	1.54	18	2.20	0.70	0.70
Far-western Terai HP	228805	0.96	16	1.95	0.49	0.49
Eastern mountain SHP	282983	1.19	2	0.24	4.86	4.86
Central mountain SHP	310781	1.30	9	1.10	1.19	1.19
Far-/Mid-/Western mountain SHP	454309	1.90	7	0.85	2.23	2.23
Eastern hill SHP	957187	4.01	10	1.22	3.29	3.29
Central hill SHP	1200857	5.03	7	0.85	5.89	5.89
Western hill SHP	1684245	7.06	13	1.59	4.45	4.45
Mid-western hill SHP	1184631	4.96	4	0.49	10.16	10.00
Far-western hill SHP	646877	2.71	27	3.30	0.82	0.82
Eastern Terai SHP	2007058	8.41	25	3.05	2.76	2.76
Central Terai SHP	2111048	8.85	17	2.08	4.26	4.26
Western Terai SHP	722665	3.03	11	1.34	2.25	2.25
Mid-western Terai SHP	1281036	5.37	3	0.37	14.66	10.00
Total	**23863039**	**100**	**819**	100.00		

**Source: Health Management information system: FY 2011/2012*

Table A3: Maternity client weights

Weight - Maternity exit interview	Users (Population)*		Exit (Sample)		Weight
	N	%	N	%	
Eastern mountain hospital	8	0.57	11	2.46	0.23
Central mountain hospital	13	0.93	5	1.12	0.83
Far-/Mid-/Western mountain hospital	27	1.93	7	1.57	1.23
Eastern hill hospital	54	3.87	15	3.36	1.15
Central hill hospital	163	11.67	30	6.71	1.74
Western hill hospital	131	9.38	30	6.71	1.40
Mid-western hill hospital	43	3.08	37	8.28	0.37
Far-western hill hospital	18	1.29	3	0.67	1.92
Eastern Terai hospital	195	13.96	47	10.51	1.33
Central Terai hospital	229	16.39	60	13.42	1.22
Western Terai hospital	95	6.80	61	13.65	0.50
Mid-western Terai hospital	59	4.22	61	13.65	0.31
Far-western Terai hospital	56	4.01	20	4.47	0.90
Eastern and central mountain PHCC	3	0.21	6	1.34	0.16
Far-/Mid-/Western mountain PHCC	1	0.07	1	0.22	0.32
Eastern hill PHCC	18	1.29	2	0.45	2.88
Central and western hill PHCC	26	1.86	1	0.22	8.32
Mid-western hill PHCC	31	2.22	2	0.45	4.96
Far-western hill PHCC	6	0.43	7	1.57	0.27
Eastern and central terai PHCC	27	1.93	13	2.91	0.66
Western Terai PHCC	51	3.65	3	0.67	5.44
Mid-western Terai PHCC	13	0.93	2	0.45	2.08
Far-western Terai PHCC	17	1.22	1	0.22	5.44
HP	78	5.58	20	4.47	1.25
SHP	35	2.51	2	0.45	5.60
Total	1397	100.00	447	100.00	

Annex B: Quality of Care

Table B1: Experienced shortages of equipment in last fiscal year

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
B.P Instruments (Aneroid)	16.7	34.6	27.7	24.0
ENT Diagnosis Set	0.0	11.5	21.3	20.0
Dressing Set	0.0	7.7	19.1	20.0
Suture Set	16.7	11.5	17.0	12.0
Dressing Drum	0.0	0.0	8.5	16.0
Steam Sterilizer	0.0	0.0	4.3	16.0
Stethoscope	0.0	15.4	4.3	12.0
Weighing Machine	0.0	0.0	10.6	12.0
Torch Light	16.7	3.8	6.4	12.0
Thermometer Autoclave (Electric)	16.7	15.4	8.5	8.0
Forceps	0.0	7.7	10.6	8.0
Scissor	0.0	3.8	6.4	8.0
Weight Machine Newborn	0.0	7.7	4.3	8.0
Thermometer	0.0	0.0	2.1	8.0
Fetoscope	0.0	0.0	0.0	8.0
Normal Delivery Set	0.0	3.8	10.6	4.0
Autoclave (Non- Electric)	0.0	7.7	6.4	4.0
Autoscope	0.0	0.0	6.4	4.0
Suction set	0.0	3.8	4.3	4.0
Cheatle Forceps with Jar	16.7	0.0	2.1	4.0
Resuscitation set (Pediatric)	0.0	3.8	2.1	4.0
Kidney Trays	0.0	3.8	0.0	4.0
Four Burner Stove/Gas and gas Stove	0.0	3.8	0.0	4.0
Baby warmer	0.0	3.8	0.0	4.0
Resuscitation set (Adult)	0.0	0.0	0.0	4.0
I&D Set	0.0	0.0	0.0	4.0
Delivery focused light/perineal light	0.0	11.5	6.4	0.0
Suction Machine Foot Operated	0.0	7.7	6.4	0.0
Height Machine	16.7	3.8	4.3	0.0
Implant Insertion and Removal Set	0.0	11.5	2.1	0.0
Dental instrument	0.0	0.0	6.4	0.0
Electric /Solar Refrigerator for Vaccines and Medicines	0.0	7.7	2.1	0.0
Vacuum set	0.0	7.7	2.1	0.0
X-ray machine	50.0	0.0	0.0	0.0
B.P Instruments (Pediatric)	16.7	7.7	0.0	0.0
Tongue Depressor	0.0	0.0	4.3	0.0
Rechargeable Emergency Lamp	0.0	0.0	4.3	0.0

Speculum	0.0	0.0	4.3	0.0
Suture Removal Set	0.0	3.8	2.1	0.0
Episiotomy Set	0.0	0.0	2.1	0.0
Measuring Tape	0.0	0.0	2.1	0.0
Manual vacuum abortion sheer	0.0	0.0	2.1	0.0
Pediatric Suction Catheters	16.7	0.0	0.0	0.0
Generator	16.7	0.0	0.0	0.0
Auto analyzer	16.7	0.0	0.0	0.0
centrifuge	16.7	0.0	0.0	0.0
ECG machine	16.7	0.0	0.0	0.0
OT light	16.7	0.0	0.0	0.0
Oxygen concentrator meter	16.7	0.0	0.0	0.0
Metal Catheter (Different Sizes)	0.0	3.8	0.0	0.0
IUCD Insertion and Removal Set	0.0	3.8	0.0	0.0
Cervical tear repair sheet	0.0	3.8	0.0	0.0
USG	0.0	3.8	0.0	0.0
Total facilities (N)	**6**	**26**	**47**	**25**

Table B2: Experienced shortages of supplies in last fiscal year

	Hospitals (%)	**PHCCs (%)**	**HPs (%)**	**SHPs (%)**
Catheters	50.0	25.0	11.4	17.6
Bed sheet	50.0	31.3	22.9	11.8
Mask	0.0	12.5	14.3	17.6
I/V Cannula	0.0	6.3	14.3	17.6
Dustbin	25.0	0.0	11.4	17.6
Bucket	0.0	6.3	5.7	17.6
Pills	0.0	6.3	5.7	17.6
Apron	0.0	18.8	11.4	11.8
Suture materials	0.0	0.0	11.4	11.8
Blanket	0.0	18.8	14.3	5.9
Mug	0.0	6.3	17.1	5.9
Bed	25.0	6.3	14.3	5.9
I/V stand	0.0	12.5	11.4	5.9
Utility Gloves	0.0	18.8	8.6	5.9
Oxygen	25.0	25.0	2.9	5.9
Virex	0.0	12.5	8.6	5.9
Surgical Gloves	0.0	18.8	2.9	5.9
Condom	0.0	0.0	8.6	5.9
Pillow	0.0	25.0	14.3	0.0
Soap/Detergent	0.0	0.0	2.9	5.9
Rag	25.0	0.0	0.0	5.9
Mattress	50.0	31.3	5.7	0.0
Stretcher	0.0	0.0	0.0	5.9
Bleaching Solution	0.0	12.5	5.7	0.0

Cidex	0.0	18.8	2.9	0.0
Depo-Provera	0.0	6.3	5.7	0.0
Curtain	0.0	6.3	5.7	0.0
Implant	0.0	18.8	0.0	0.0
Drainage bag Disposable Syringe	0.0	0.0	5.7	0.0
IUCD	0.0	6.3	2.9	0.0
I/V Set	0.0	6.3	2.9	0.0
Makintosh	0.0	6.3	2.9	0.0
Sodium Hypochloride Towel	0.0	0.0	2.9	0.0
Cotton and Gauge	0.0	0.0	2.9	0.0
Gas stove	0.0	0.0	2.9	0.0
Computer	25.0	0.0	0.0	0.0
Printer	25.0	0.0	0.0	0.0
UPS	25.0	0.0	0.0	0.0
Bed screen	25.0	0.0	0.0	0.0
Urinal (small size-ss)	25.0	0.0	0.0	0.0
Shelf to keep medicine	25.0	0.0	0.0	0.0
Chair	25.0	0.0	0.0	0.0
Table	25.0	0.0	0.0	0.0
Filter	25.0	0.0	0.0	0.0
Trolley to carry patient	25.0	0.0	0.0	0.0
Chemical drum	25.0	0.0	0.0	0.0
Total facilities (N)	**4**	**16**	**35**	**17**

Table B3: Experienced equipment breakages in last fiscal year

	Hospitals (%)	**PHCCs (%)**	**HPs (%)**	**SHPs (%)**
B.P Instruments (Aneroid)	16.7	40.0	34.1	35.0
Weighing Machine	16.7	0.0	27.3	25.0
Forceps	0.0	10.0	13.6	20.0
ENT Diagnosis Set	16.7	10.0	9.1	20.0
Stethoscope	0.0	20.0	6.8	15.0
Scissor	0.0	5.0	9.1	15.0
Dressing Set	0.0	0.0	9.1	10.0
Torch Light	0.0	5.0	4.5	10.0
Steam Sterilizer	0.0	0.0	4.5	10.0
Suture Set	33.3	5.0	11.4	5.0
Thermometer Autoclave (Electric)	16.7	10.0	4.5	5.0
Thermometer	0.0	5.0	4.5	5.0
Cheatle Forceps with Jar	0.0	10.0	2.3	5.0
Weight Machine Newborn	0.0	0.0	4.5	5.0
Dressing Drum	0.0	5.0	2.3	5.0
Suction Machine Foot Operated	33.3	30.0	4.5	0.0
Autoclave (Non- Electric)	16.7	0.0	15.9	0.0
Fetoscope	0.0	0.0	2.3	5.0

I&D Set	0.0	0.0	2.3	5.0
Autoscope	0.0	0.0	0.0	5.0
Oxygen cylinder	0.0	0.0	0.0	5.0
B.P Instruments (Pediatric)	33.3	5.0	6.8	0.0
Electric /Solar Refrigerator for Vaccines and Medicines	16.7	10.0	6.8	0.0
Vacuum set	0.0	15.0	2.3	0.0
X-ray machine	33.3	5.0	0.0	0.0
Delivery focused light/perineal light	0.0	0.0	4.5	0.0
Suture Removal Set	0.0	0.0	2.3	0.0
Normal Delivery Set	0.0	0.0	2.3	0.0
IUCD Insertion and Removal Set	0.0	0.0	2.3	0.0
Tongue Depressor	0.0	0.0	2.3	0.0
Four Burner Stove/Gas and gas Stove	0.0	0.0	2.3	0.0
Speculum	0.0	0.0	2.3	0.0
Suction set	0.0	0.0	2.3	0.0
Solar system	0.0	0.0	2.3	0.0
Resuscitation set (Adult)	16.7	0.0	0.0	0.0
Scaling machine	16.7	0.0	0.0	0.0
Auto analyzer	16.7	0.0	0.0	0.0
Centrifuge	16.7	0.0	0.0	0.0
ECG machine	16.7	0.0	0.0	0.0
Pulse oxymeter	16.7	0.0	0.0	0.0
Manual vacuum abortion sheer	16.7	0.0	0.0	0.0
Water pump	16.7	0.0	0.0	0.0
Emergency kit box	16.7	0.0	0.0	0.0
Rechargeable Emergency Lamp	0.0	5.0	0.0	0.0
Timer	0.0	5.0	0.0	0.0
Total facilities (N)	**6**	**20**	**44**	**20**

Table B4: Have unwanted or excessive equipment in last fiscal year

	PHCCs (%)	**HPs (%)**	**SHPs (%)**
Insulin tester	0.0	14.3	33.3
Cheatle Forceps with Jar	0.0	0.0	33.3
Tongue Depressor	0.0	0.0	33.3
Endoscopy machine	0.0	0.0	33.3
B.P Instruments (Aneroid)	0.0	28.6	0.0
Vacuum set	50.0	14.3	0.0
Steam Sterilizer	0.0	14.3	0.0
Electric /Solar Refrigerator for Vaccines and Medicines	0.0	14.3	0.0
ENT Diagnosis Set	0.0	14.3	0.0
Test tube	0.0	14.3	0.0
Microscope	0.0	14.3	0.0

Water pump	0.0	14.3	0.0
Oxygen cylinder	0.0	14.3	0.0
Thermometer Autoclave (Electric)	50.0	0.0	0.0
Forcep	50.0	0.0	0.0
Total facilities (N)	**2**	**7**	**3**

Table B5: Have equipment that no one is trained to use in last fiscal year

	Hospitals (%)	**PHCCs (%)**	**HPs (%)**	**SHPs (%)**
Autoclave (Non- Electric)	0.0	5.3	22.2	33.3
Dental instrument	0.0	0.0	11.1	33.3
Vacuum set	0.0	10.5	11.1	16.7
Oxygen cylinder	0.0	5.3	5.6	16.7
X-ray machine	20.0	42.1	5.6	0.0
ENT Diagnosis Set	0.0	0.0	0.0	16.7
Microscope	0.0	5.3	16.7	0.0
ECG machine	20.0	10.5	0.0	0.0
Resuscitation set (Pediatric)	0.0	5.3	5.6	0.0
Suction Machine Foot Operated	0.0	5.3	5.6	0.0
Endoscopy machine	40.0	0.0	0.0	0.0
Pediatric Suction Catheters	0.0	10.5	0.0	0.0
IUCD Insertion and Removal Set	0.0	0.0	5.6	0.0
Electric /Solar Refrigerator for Vaccines and Medicines	0.0	0.0	5.6	0.0
Autoscope	0.0	0.0	5.6	0.0
Forcep	0.0	0.0	5.6	0.0
Generator	0.0	0.0	5.6	0.0
Vasectomy set	0.0	0.0	5.6	0.0
Suction set	0.0	0.0	5.6	0.0
Fax machine	20.0	0.0	0.0	0.0
USG	20.0	0.0	0.0	0.0
Thermometer Autoclave (Electric)	0.0	5.3	0.0	0.0
Steam Sterilizer	0.0	5.3	0.0	0.0
Resuscitation set (Adult)	0.0	5.3	0.0	0.0
Oxygen concentration machine	0.0	5.3	0.0	0.0
Scissor	0.0	5.3	0.0	0.0
Manual vacuum abortion sheer	0.0	5.3	0.0	0.0
Nebulizer	0.0	5.3	0.0	0.0
Implant/Norplant set	0.0	5.3	0.0	0.0
Total facilities (N)	**5**	**19**	**18**	**6**

Table B6: Have equipment not able to use in last fiscal year

	Hospitals (%)	PHCCs (%)	HPs (%)	SHPs (%)
Electric /Solar Refrigerator for Vaccines and Medicines	0.0	29.4	50.0	20.0
Thermometer Autoclave (Electric)	0.0	23.5	35.0	20.0
Autoclave (Non- Electric)	0.0	11.8	5.0	30.0
Nebulizer	0.0	11.8	0.0	20.0
Delivery focused light/perineal light	0.0	11.8	5.0	10.0
X-ray machine	33.3	29.4	0.0	0.0
Microscope	0.0	11.8	5.0	0.0
Oxygen concentration machine	33.3	5.9	0.0	0.0
Generator	0.0	11.8	0.0	0.0
Stethoscope	0.0	0.0	5.0	0.0
B.P Instruments (Aneroid)	0.0	0.0	5.0	0.0
Steam Sterilizer	0.0	0.0	5.0	0.0
Weight Machine Newborn	0.0	0.0	5.0	0.0
Weighing Machine	0.0	0.0	5.0	0.0
Scissor	0.0	0.0	5.0	0.0
Solar system	0.0	0.0	5.0	0.0
ICU ventilator	33.3	0.0	0.0	0.0
Suction Machine Foot Operated	0.0	5.9	0.0	0.0
ECG machine	0.0	5.9	0.0	0.0
Heater	0.0	5.9	0.0	0.0
Suction set	0.0	5.9	0.0	0.0
Thermometer	0.0	5.9	0.0	0.0
Total facilities (N)	**3**	**17**	**20**	**10**

Annex C: Essential Drug List

Lignocaine (lidocaine) Inj. 2% ml (HCl) in Vial	Vitamin B complex Tab
Paracetamol Cap/tab 500mg	Metoclopramide (perinorm) Inj. 5 mg/ml in 2 ml ampoule
Paracetamol Inj. 150mg/ml	Compound sodium Lactate inj. solution (Ringers' lactate)
Paracetamol Syrup 125mg./ 5ml.	Sodium chloride Inj.
Chlorpheniramine Tab 4mg	Charcoal activated Powder 10gm in Sachet
Pheniramine Inj. 22.75mg	Atropine sulphate Inj. 60.5mg in 1ml ampoule
Albendazole (Chewable Tab 400mg)	Ciprofloxacin Tab 250 mg
Metronidazole Tab 200mg	Benzoic acid + Salicylic acid (whitefield's ointment) (6% + 3% w/w)
Metronidazole Tab 400mg	Atenolol Tab 50mg
Metronidazole Benzoate Oral Sus 100mg/5ml	Frusemide Tab 40mg
Metronidazole Benzoate Oral Sus 200mg/5ml	Promethazine Hydrochloride Tab (25mg) (Avomine)
Amoxycillin Cap/Tab 500mg	Dexamethazone Inj. 4mg/1ml ampoule
Amoxycillin Cap/Tab 250mg	Salbutamol (Tab 4mg)
Amoxycillin disp. tab 125mg	Oxytocin Inj. 10 I. U. in 1 ml ampoule
Amoxycillin disp. tab 250mg	Aminophylline Tab
Sulfamethoxazole+ Trimethoprim (cotrim) Tab 100mg+20mg	Magnesium Sulphate Inj.
Sulfamethoxazole+ Trimethoprim (cotrim) Tab 400mg+80mg (SS)	Gentamycine Inj.
Sulfamethoxazole+ Trimethoprim (cotrim) Tab 800mg +160mg DS	Aspirin Tab
Sulfamethoxazole+ Trimethoprim (cotrim) 200mg+40mg/5ml	Phenobarbitone Tab
Ferrous salt + Folic acid Tab 60mg iron + 400mg Folic acid	Chloramphenicol Cap., Pouder, Sus.
Calamine Lotion (Lotion 15%)	Alprazolam Tab
Gamma benzene hexachloride 1% cream or lotion	Dextrose solution Inj
Povidine Iodine Solution 5% 450ml	Cirpofloxacin Eye & Ear drops 0.3% w/v
Aluminium hydroxide + Magnesium hydroxide Tab 250mg + 250mg	Ciprofloxacine Eye ointment 0.3% w/v
Hyoscine butylbromide (Buscopan) Tab 10mg	Cloramphenicol Eye Applicaps 1%
ORS Sachet Powder, 27.5g/lit	Clove Oil