Review of Integrated Health Camp for Southern Humla District

Supported by Humanist Action for Human Rights (HAMU)
Implemented by Centre for Victims of Torture, Nepal (CVICT)

Submitted To
Humanist Action for Human Rights (HAMU)

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By

Organisation Development Centre (ODC)
Developing Healthy Organisation through People

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List of Acronyms

ADB	Asian Development Bank
AHW	Auxiliary Health Worker
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
BS	Bikram Samvat (Nepali calendar)
CA	Constitution Assembly
CBO	Community Based Organisation
CBS	Central Bureau of Statistics (GoN)
CDD	Diarrhoea Diseases
CDO/r	Chief District Office/Officer (District Administrative Officer of each district)
CPN (Maoist)	Communist Party of Nepal – Maoist
CVICT	Centre for Victims of Torture, Nepal
DAO	District Administrative Office (also know as Chief District Office)
DDC	District Development Committee
DHO/r	District Health Office/Officer
DHS	Department of Health Services
EC	Executive Committee
ED	Executive Director
FCHV	Female Community Health Volunteer
FY	Fiscal/Financial Year (For Nepal the FY is from Mid-July to Mid-July)
GoN	Government of Nepal (the post-April 2006 term for Nepal's Government)
HEF/HAMU	Humanistic Action for Human Rights
HIV	Human Immunodeficiency Virus
ICIMOD	International Centre for Integrated Mountain Development
IG	Income Generation
INGO	International Non-Governmental Organisation
Kg/s	Kilogram/s
Km	Kilometres
LDO/r	Local Development Office/Officer
LSGA	Local Self Governance Act (1999)
M&E	Monitoring and Evaluation
MCHW	Mother and Child Health Worker
MDG	Millennium Development Goals
MLD	Ministry of Local Development (GoN)
MOHP	Ministry of Health and Population (GoN)
NGO	Non-Governmental Organisation
NPC	National Planning Commission
NRs.	Nepalese Rupees (denoting Nepalese currency)
ODC	Organisation Development Centre
PHCC	Primary Health Care Centre
PMC	Project Management Committee
PNC	Post-natal Care
S/HP	Sub /Health Post
SWC	Social Welfare Council (GoN)
TBA	Traditional Birth Attendant
ToR	Terms of Reference
UML	United Leninist Marxist

UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
US/$	United States / Dollar
VDC	Village Development Committee
VHW	Village Health Worker
WB	World Bank

Acknowledgement

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We are very grateful to, the Board Members and all staff members of CVICT who actively participated in the process. The Team heartily thank them for open interaction and warm hospitality during the process. The feedback and suggestions provided by the Board members and the senior staff members during the review process and in the report write-up have been greatly appreciated.

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Organisation Development Centre (ODC)

1 Background Context

1.1 Situation in Nepal

Nepal is a country of tremendous natural diversity, stretching along the central Himalayas. Its physical geography can be divided into five regions that range from the southern Terai plains at less than 100 metres to the northern high mountains that rise to nearly 8,850 m. This enormous range of alt6itude has resulted in a variety of ecological zones that have had a significant impart on the lives of local inhabitants. In times past, the rugged and remote landscape isolated people into distinct communities with their own languages and cultures. However, in recent centuries, migration has blurred the geographic boundaries between groups to some extent.

Nepal is one of the poorest countries in the world and is among the 50 "least developed countries", as defined by the UN General Assembly. Per capita income in 2004 was US$ 300.[1] In terms of human and social development, Nepal ranks 136 out of the 177 countries in the Human Development Index.[2] Nepal is driven by political, economic and social crisis. The combination of poverty, social exclusion and political conflict systematically undermines the rights of women and children, particularly in rural areas. The escalation of the conflict since 2001 has increased and diversified vulnerabilities for children and women such as separation from families, extended periods as household heads, poorer access to basic social services, and possible recruitment into Maoist forces.

The 2001 census estimated the population of Nepal at 23.15 million, with a male-to-female sex ration of 99.8.[3] The population is very young; almost half (46 percent or 10.6 million) are children aged less than 18 years.

1.2 Humanist Action for Human Rights (HAMU)

Humanist Action for Human Rights (HAMU) was founded in 1994, and practices a rights-based approach to development. HAMU particularly supports projects that aim to strengthen the rights and capabilities of the most marginalised groups in society, such as women and children, ethnic minorities, casteless/untouchables, and sexual minorities.

1.3 Centre for Victims of Torture, Nepal (CVICT)

The Centre for Victims of Torture, Nepal (CVICT) was established in 1990, as a non-governmental, non-profit-making organisation registered in District Administrative Office Kathmandu Nepal Registered No (168/047/048) and Affiliated with the regulatory body Social Welfare Council (SWC). The organization's main aim is to rehabilitate victims of torture and trauma, and to advocate for the prevention of human rights violations and abuses. It provides medical, psychosocial and legal services at the centre and community level (through mobile health clinic) to those in need, and strives to treat all clients fairly, without discrimination on the basis of gender, age, caste, religion, ethnicity, economic status or any political affiliation.

1.4 Integrated Health Camp for Humla District

[1] Ministry of Finance, Economic Survey 2004/05, Ministry of Finance, Kathmandu, 2005
[2] UNDP, Human Development Report 2005, United National development Programme (UNDP), New York, 2005
[3] Central Bureau of Statistics, Population Monograph of Nepal, Volume I and II, Central Bureau of Statistics, Kathmandu, 2003

CVICT has been working in partnership with HAMU since May 2004 for the identification, planning, organisation and management of mobile health clinics in Nepal. The partnership began as a result of a preliminary assessment by HAMU representatives who visited Nepal prior to the inception of the project.

CVICT identified and designed the project "Health Camp for Humla" based on past working experiences of organizing mobile health clinics in rural areas of Nepal and also as a result of its surveys in the district. CVICT during the survey found dozens of households where members, often women, were in desperate need of health services but were unable to get access to the regular government health facilities. In order to provide relief to the suffering women, CVICT in consultation with HAMU, developed the project with the aim of providing access to essential health services to the conflict affected population in Humla so that its effort contributed to the peace building process in the country by giving assistance to all groups and parties.[4]

Humanist Action for Human Rights (HAMU) with the funding from Norad provided funding of Euro 8,500 for a mobile health camp organised by CVICT in the district of Humla. The camp was to be conducted by CVICT using a combination of local volunteers and their own personnel.[5]

2 Scope of the review

2.1 Rationale

Humanist Action for Human Rights (HAMU), as an organization, had committed to conducting programmatic reviews at the end of the project phase in order to reflect on the past achievements and struggles, the methods used, make appropriate plans for the future and engage in continuous improvement and learning within programmes and across the organization.

It was in this context that Organisation Development Centre (ODC) was requested to submit a proposal to carry out the programme review of the project.

2.2 Purpose and Objectives

The primary purpose of this review was to reveal the results of the HAMU/Norad - funded "*Integrated Mobile Health Camps"* in Simkot of Humla district. The review was to access program effectiveness, impact, organisation management, partnership relationship, project process monitoring and documentation, identifying the best practises and future roles in the changing context.

The specific objectives were to:

- *Assess whether the needs of the target group have been properly identified and prioritized*
- *Examine the assumptions made and risks identified during the design stage and assess the degree of flexibility of the project design to respond to changes in the programmes implementation environment*
- *Examine whether the inputs and output project meet the project objectives*
- *Analyze and identify the operational strengths and weaknesses at project level and provide necessary suggestions for further improvement*

[4] Norad Application form for individual agreements, 2008, PART 2, No. 3, HEF/HAMU , GLO-3413, 2008, 2.3 Description of Project, a

[5] Terms of Reference (ToR) for evaluation of mobile health camp in Simikot, Humla, HAMU, 2008

- *Assess whether the external environment (political, economic, security) affects the achievement of the project and outline the challenges that may have impacted the effectiveness of the project/s*
- *Assess if the resources (financial, human and capital) allocated for the project is adequate*
- *Assess whether the project has succeeded in including women, children and marginalized groups*
- *Assess how/whether the project has managed to strike a balance between ethnic groups and different dividing lines among the population, the general attitude of conflict sensitivity and its practical implications*
- *Have organisations/local institutions i.e. district health post and Red Cross the capacity/capability to ensure follow- up? Has there been created some sustainable structures for continuation and further development of health welfare?*

Please refer to Annex – 1 for the detail of the Terms of Reference (ToR).

2.3 Methodology and process used in the review process

The approach chosen for the review has been guided by participation, inclusion, and transparency. The review team has tried to ensure that the communities, CVICT and the funding partner have felt a sense of ownership to the findings and recommendations. Other principles have been:

- *Designed to lead to action:* the review has attempted to give advice and recommendations that are realistic, feasible, and doable, so that the communities and CVICT will take action where there is room for improvement
- *Evidence-based and in accordance with ethical standards:* All findings are substantiated by documented or anecdotal evidence from relevant sources using triangulation
- *Communication and transparency:* The consultants tried to ensure that the evaluation was undertaken in a gender sensitive and transparent manner towards all stakeholders, in addition to ensuring that information was managed in a sound manner

With regards to the methodology utilised in the review process has been divided in four phases namely; (i) preparatory phase, (ii) field survey, (iii) analysis and (iv) report-writing and presentation of report. The overall time allocated for this assignment was in total rounded to 26 days shared between the two consultants (a Team Leader and a Team Member).

The programme review commenced with a desk study of relevant project documents. Then the team developed indicative interview questionnaire checklist based on the review criteria proposed in the ToR and discussed above and the information gathered through document review.

A preparatory session was organised with the senior members of CVICT who were directly involved in the project. In order to make the review relevant and useful for all, the review team adopted a learning and participatory approach. A total of 3 participants representing project staff and the Executive Director of CVICT were present. After a thorough explanation of the session's goal and purpose, the participants were introduced to the tools that were prepared for the purpose of the evaluation. The participants then discussed and decided on the sample and itinerary for the field study. *Please see annex 2 and 3 for outline of the tools and itinerary of the assignment respectively.*

Extensive field visit was undertaken from 4th to 8th November 2008, in the project site i.e. Simkot of Humla district. During the field work the review team, interacted with over 50 members of the communities. The interactions were carried out with women's groups, local volunteers,

hospital staff, partner organisations (NGOs and the Nepal Red Cross Society), and the local leaders. *Please refer to annex 4 for list of individuals and groups interacted with and the list of local resources.*

Information obtained from interview/interaction, meetings and field visits were analyzed and presented in the form of a review report as per the review framework (i.e. on the basis of the review criteria).

After the field visit, the review team presented preliminary findings for discussion and clarification to the Executive Director/Programme Coordinator of CVICT before writing up the draft report.

Relevant and critical comments, suggestions, and inputs obtained during presentation and from individuals have been incorporated in the report. Prior to the finalisation of the review report, the draft report had been circulated to members of CVICT and HAMU for additional comments, suggestions, clarifications and inputs.

3 Major findings

The review team acknowledged considerable progress in addressing the needs of the most disadvantaged people in the targeted district through the integrated mobile health camp. However, the review team also found areas where improvements could be done and have recommendations in order to maximize the access to health and health education and to improve the lives of the communities living in the remote areas of the district.

3.1 Health Status of Nepal

As per the National Census of 2001, Nepal is one of the very few countries in the world where a woman's average lifespan is less than that of a man. This is contributed by the fact of the low number of health providers in a country where the ratio of population is 18,439 per doctor, 4,987 per nurse, 2,349 per hospital bed and 2,071 per health care provider. Other contributing factors in the delivery of primary health care services are that of the quality of health services at the rural health institutions which is either very poor or unavailable because of the lack of medical supplies and supporting facilities, as well as shortages in health personnel. Management of the health delivery system is weak, resulting in poor services.

The sub health post is usually the first point of contact for basic health services within the community, and is also the referral point for community-based health volunteers. Each level above the sub health post is also a referral point, and can be a first place of contact as well. At the sub health post, health post, and primary healthcare centre levels, the activities are supervised and monitored by the District Public Health Office (DPHO) or the District Health Office (DHO).

According to the health policy of Nepal, each sub health post has one Auxiliary Health Worker (AHW), one Village Health Worker (VHW) and one Maternal Child Health Worker (MCHW). Each health post has one Health Assistant, two Auxiliary Health Workers and one Auxiliary Nurse Midwife. Each primary healthcare centre has one Medical Officer (a doctor), one Health Assistant, two Auxiliary Health Workers, one Staff Nurse, and three Auxiliary Nurse Midwives. According to a study by DFID, poor human resources development and management policies have left large numbers of posts within the public health service vacant. This has particularly affected remote areas, where many sub health posts and health posts are persistently without

health workers; in many of the remote districts, district hospitals operate without doctors.[6] The conflict has also had an impact on the full-time availability of health professionals in the health facilities.

A common characteristic running through all analysis of the causes of mortality of women and children in Nepal is the reluctance of families to utilize the government-supported health service. This reflects the reality that many patients are not properly assessed and treated, and their caregivers are poorly advised.

As part of the Nepal Multiple Indicator Surveillance programme in 1997, people were asked about their overall perception of the quality of the health service. Only eight per cent thought it to be good. Fifty-nine per cent rated the service as neither good nor bad, and 33 per cent considered it to be bad.[7] The main problems identified were lack of medicines, poor condition of the facility, the "bad" attitude of staff, and the lack of staff at certain times.

Against this background, the government has focused on improving health services available at the community level. One of the strategies is the setting up of the Health Management Information system (HMIS), which gathers nationwide data on health service delivery. And during the national census inclusion of the health data, one of the examples is the table of health data provided in the table below.

Table showing the comparative diseases between the country and Humla district

Top Ten Diseases Accounting for Morbidity in the country*		**Common diseases found in Humla mobile health camp**
Abdominal Pain	0.96	Abdominal pain
Acute Respiratory Infection (ARI)	3.13	ARI
Chronic Bronchitis	1.06	Arthritis
Diarrhoea Diseases (CDD)	3.35	COPD
Ear Infection	1.40	Diarrhoea
Gastritis	1.95	Ear Infection
Intestinal worms	2.82	Eye infection
Pyrexia of unknown origin	2.02	Gastritis
Skin Diseases	5.51	Intestinal Worms
Sore Eye and Complaints	0.93	Skin Disease
		Toothache
Source: Statistical Yearbook of Nepal, 2001		*CVICT Report*

[6] Development Resource Mobilisation Network, Report on Decentralisation and Sector Devolution in Nepal, Department of International Development (DFID, UK), Kathmandu, 2005

[7] NPC/UNICEF Nepal/New ERA, Nepal Multiple Indicator Cluster surveillance, Cycles 1-6, (January to March 1995), NPC, UNICEF Nepal, New ERA, Kathmandu, 1996

3.2 District Overview

3.2.1 Humla District

a. Geography

Humla district is situated in the north western corner of Nepal. The district is geographically in the Karnali zone and administratively in the mid-western development region of Nepal. It is located between 29° 35' to 30° 70' north latitude and 81° 18' to 82°10' east longitude, and spans an area of 6,134 km^2. Elevation ranges from 1,219 to 7,337 meters. It borders with Mugu district

in the east; Bajhang district in the west; Bajura district in the south and Tibetan autonomous region of China in the north. Administratively, the district is divided into 27 VDCs Simkot is the district headquarters. Almost two percent of the district lies in the middle mountains, 22 percent lies in the high mountains and 76 percent lies in the high Himalayas. The district has temperate, cool temperate and alpine hypothermic zones. The average annual rainfall is 686 mm. *See the map of Humla district with the VDCs.*

b. Demography

Humla is one of the most sparsely populated districts in Nepal. According to the 2001 census, the population of the district is 40,595 of which 19,633 are females and 20,962 are males. This population is distributed in 6,953 households with an average household size of 5.84 individuals. The population density is 7.21 persons per km^2. About 40.1 per cent of the population are under 15 years old, and 6.4 per cent are 60 years and over. The district is diverse in terms of ethnicity and language. According to the 2001 census, there are 41 castes/ethnic groups. These include Chhetri (43.8 per cent), Thakuri (19.6 per cent), Lama (13.9 per cent), Brahmin (6.2 per cent), and the occupational castes of Cobblers (*Sarki)*, Black Smiths (*Kami)* and Tailors (*Damai)* (8.9 per cent). Other castes/ethnic groups, each consisting of less than five per cent, make the remaining 7.5 per cent of the population. According to the 2001 census, 17 languages are spoken in the district. The most prevalent are Nepali (84.3 per cent) and Lama (10.3 per cent). The 2001 census recorded 84.4 per cent Hindu and 12.6 per cent Buddhist in religion. Population density and its growth rate are 7.21 persons/m^2 and 1.99 respectively.

c. Access to the District

Humla district lacks road facilities suitable for motorized vehicles. The only access to the district from other areas of Nepal is through air or on foot. At present, mule trails and tracks are the major transport system of the district. Because of mountainous and sloping areas it is very expensive to construct even such narrow ways and since construction of motor roads is too expensive. The construction of mule

trails and tracks as well as small bridges is being done on a regular basis with support from NGOs, INGOs and budget received from GoN to the DDC. Transportation of goods by air is extremely expensive and it leaves traders at the mercy of traffickers who are among the few who can afford this mode of transportation. From Nepalgunj to Simkot the charter price in NRs. 120 per kilogram.[8] [*Source: www.kantipuronline.com on 2 November 2008] The nearest airport to fly to the district is from Jumla, followed by Surkhet and then Nepalgunj (See map for the air network links).*

d. Socio-economic features

According to the development indicators of districts of Nepal 2003 produced jointly by SNV, ICIMOD and CBS/HMGN, Humla ranks 74th out of 75 districts of Nepal in Composite Index of 29 indicators reflecting different aspects of the level of development performance. The district ranks 73, 72 and 73rd in Poverty and Deprivation, Infrastructure Development and Women's Empowerment Indexes respectively. In many of the other indicators the district falls below 70 among 75 districts. Humla is the poorest and the most backward district of Nepal, where livelihoods are critical, mainly on account of harsh environmental conditions and remote location. Productivity of agricultural land is low due to difficult terrain and rain shadow area which is situated across the Saipal Himal and agricultural production hardly supports three to nine months for household consumption. Indeed, Kaguno [*Setaria*], Chino [*Panicum miliaceum*], Marsya [*Amaranthus*] Fapar [*Fagopyrum tataricum*], Uwa [*Hordeum vulgare*], Kodo [*Eleusine coracana Gaertn*] are the main staple food along with many seasonal wild edible food

According to the national census of 2001 about 85.9 per cent of the population over 10 years old are economically active. The dependency ratio is 87 per 100 people of the active age group (15-59 years) (CBS, 2002).

Among other ethnic communities in Humla, Lama has a comparatively good living condition. In the past, they practiced the polyandry system of marriage which prevented them from splitting the properties after marriage, as in Thakuri and Chhetri communities. Moreover, birth rates are lower than for other communities, as all brothers share a single wife. However, this indigenous marriage system - which is more compatible with resource scarcity in the mountain – now-a-days has started to vanish as new generations who are exposed to modern society and education are not willing to share a single woman amongst the siblings. In contrast, those who live in the hills and valleys in the southern regions are living in more dire conditions. There is widespread food deficiency. It is the Hindu community who owns most of the fertile agricultural land in the south. However, a practice of polygamy has resulted in large families and population, with small land holdings. The communities in the south have a system of growing various local crops according to the climate conditions. However, this system of diversification of agriculture has not resulted in greater production. There has been increasing deforestation due to the clearing of large amounts of forest land.

3.2.2 Health and development

The health delivery service in the district is supported with 1 hospital, 10 health posts, 16 sub-health posts and 5 private medical stores. With all these facilities according to the DHO the standard of health services has not improved as expected, due to the lack of primary human resources, equipments for medical tests and availability of necessary medicines. Due to inadequate resources the people of Humla are facing problems of common diseases like diarrhoea, worms, acute respiratory infection, whooping cough, etc. Also the lack of safe drinking water and sanitation has resulted in the prevalence of transmittable diseases like

[8] www.kantipuronline.com Published on "The Kathmandu Post" dated 2nd November 2008

dysentery, pneumonia, typhoid, measles and malaria. Due to the lack of food grains, 60 percent of the population suffer from malnutrition. The status of women and children has become vulnerable. Only 2 % of births are attended by trained health workers. Only 7 percent of mothers and children are receiving post natal services and 38.5 percent of children are found completely immunised

As per the information provided by the district health office, health camps are periodically held in the district centre. Over the past few years organisations such as the Government of Nepal, Nepal Red Cross, Nepal Trust have provided camps for a range of services that have been well utilised by the needy people coming as far as from the villages taking a six-days walk. The viewpoint of the communities utilising the health camp is that they are assessed by the doctors and get free full course medicines or treatment. They do not want to visit the health facilities for various reasons such lack of staff, poor conditions of the facilities, bad attitude of the staff, no proper assessment and lack of medicines.

3.3 Project overview

The project was designed as an "Integrated Health Camp in Humla District" to be implemented by CVICT in partnership with the local institutions mobilising local volunteers and resource persons with the following aspects:

Objective: To assist in medical and psycho-social wellbeing of conflict affected population and to contribute to the peace building process by building social networks and structures among people around healthcare and heighten the level of health information and creating awareness of rights for governmental health services.

Purpose: To provide essential health services to those in need of it to a target group of around 500 rural people affected by conflict in southern parts of Humla district.

Outputs:

- *Estimation about 500 men, women and children will be treated for common diseases with appropriate medicines and surgical intervention,*
- *Over 50 men, women and children having psychosocial problems will be supported with counselling and psycho-social care*
- *About 1,000 people will be aware about the preventive practices for commonly preventable diseases like, diarrhoeal diseases, malnutrition, vaccine preventable diseases, psychosocial illnesses etc*

The main activities to achieve these outputs include:

- *Provide essential medical and surgical facilities to the target population*
- *Provide psycho-social counselling and care to the people affected by psychosocial problems*
- *Provide health education sessions on prevention of diarrhoea, malnutrition, vaccine preventable diseases, maternal health etc. Due to the revised budget, the health awareness programme will be conducted during the clinics without providing health education materials.*

The project was initially planned for 5 days i.e. September 5 through to 9th, 2008 with the target of providing primary health check up supported with full medicines.

3.4 Achievements

3.4.1 Selection of site

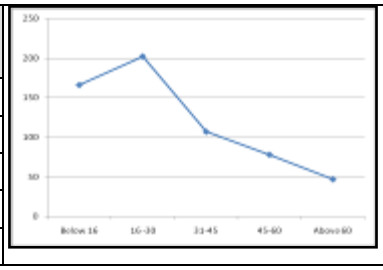
Initially the project was planned for southern part of Humla district where more then 50% of the district population live with worst health conditions. Later the project was re-designed and planned to be organised at Simkot, the district headquarter due to various factors which included cutting down the project budget from (NOK 244, 423 to NOK 75,000 (30.68%) of the actual figures). With the cutting down of the budget by more then 69% there had to be adjustments made like travel facilities, space, local health professionals, number of beneficiaries to be served and other.

3.4.2 Check-up and medicine service provided to 600 persons

Going through the records of the local volunteers and the local coordinator it was found that 775 people had registered their names for the check up, while the CVICT documented report indicates a total of 600 were provided the service. Of the 600 receiving the services the age wise distribution showed that there were people of all ages visiting the camp and the maximum age group was of the range 16 to 30 with 33.7%. *See table below for the detail of the age group*:

Table showing the Age-wise Distribution

Age group	Number	%
Below 16	166	27.7
16 - 30	202	33.7
31 - 45	107	17.8
45 - 60	78	13.0
Above 60	47	7.8



Source: CVICT Project Report

3.4.3 Developing local level partnership and coordination

The project has been able to develop relationship between CVICT and local level organisations including the Nepal Red Cross Society's Humla district chapter, the Humla District Heath Office, local NGOs working in the district, the District Administrative Office and District Police.

3.4.4 Promoting the activities and linkage with CVICT

Using the opportunity CVICT has been able to raise awareness in the district on conflict and trauma related issues and availability of CVICT's rehabilitation centre services.

3.5 Project Approach

3.5.1 Local resource mobilisation

As stated in the project application to Norad, CVICT was involved in the total planning, implementing, monitoring and reporting the whole programme. CIVICT also mobilised most of the professionals that it has from the centre including the medical ones. Together with the initiative of HAMU the actual performance of the project has been evaluated in relation to the initial plans.[9]

The project has involved local individuals in some form or the other. As an entry point the project identified a local coordinator from Shreenagar VDC, Mr. Navaraj Mahatara, through CVICTs contact.

The local resource person in turn identified 4 local volunteers/social mobilisers for 5 days i.e. 2 days for the informing the community about the health camp and 3 days to help out in documentation and management of the camp.

Please refer to annex - 5 - for the detail roles of the team members and their names.

During the interaction with the CVICT members it was stated that CVICT has always put high emphasis on the involvement of community in all the planning, prioritisation and implementation of its activities. The communities are involved in their needs identification and prioritisation of activities. The field coordinator and the volunteers in the project were to link the community plans with the overall objectives, principles and values of the project during the information dissemination and project implementation.

3.5.2 Information dissemination

The local coordinator and the volunteers/social mobilisers went from place to place providing information to the community members about the camp. Local FM radio operated by the local NGO also supported in disseminating the information. Posters, banners and pamphlets were posted at different public places. *See a picture of a banner posted in the Simkot bazaar*

3.5.3 Collaboration and partnership with local organisation

The team found out that the actual health camp was implemented by working in close collaboration with the District Health Office and the local Red Cross Society. Collaboration with the Red Cross Society and the DHO was done with the intention to contribute to the efficiency and sustainability of the project. The service seekers were to receive followed-up support through the local Red Cross Society and DHO in the future.

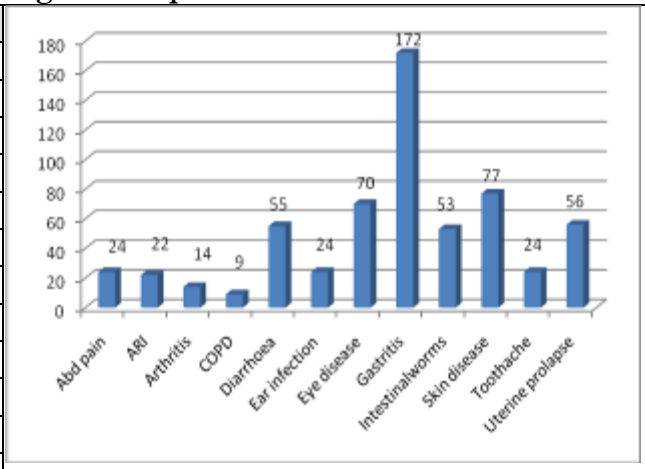
The project team had to seek the assistance of the District Administrative Office (DAO) and the District Police for managing the mob due to the heavy rush of service seekers. In the process the project staff also established close relations with the DAO and the District Police personnel.

[9] Norad Application form for individual agreements, 2008, PART 2, No. 3*, HEF/HAMU , GLO-3413*, 2008, 2.2 Local Partner e

As the review team was reviewing the project, CVICT's project team was in the process of preparing a detailed report about the disease pattern and other health issues of the communities and provide a copy to the District Health Office. This report was to help in the process of future project design and service delivery of health services in the area by the government. The CVICT team during the time of writing this report was still in the process of preparing the report, which was said to be provided to the implementing partners i.e. DHO, the local Red Cross Society and the funding partner HAMU.

Table showing the cases diagnosed during the camp

Disease	Number	%
Abdominal pain	24	4.0
ARI	22	3.7
Arthritis	14	2.3
COPD	9	1.5
Diarrhoea	55	9.2
Ear infection	24	4.0
Eye infection	70	11.7
Gastritis	172	28.7
Intestinal worms	53	8.8
Skin disease	77	12.8
Toothache	24	4.0
Uterine prolapsed	56	9.3



Source: CVICT Project Report

The DHO and the local Red Cross Society would be happy to receive the copy and provide the follow-up support in the future.

3.5.4 Provision of biscuits and medicines

Recognising the seriousness of malnutrition of the people of Humla CIVICT, as a means of providing some nutrition, planned and provided the service seekers who had come to the camp from far away districts, with biscuits during the first day and second day of the camp but was unable to do so on the third day as the provision ran out.

The intention of providing the biscuits was to assist the service seekers to have some nutrition which was perceived to be good. However during the interaction at the field, the respondents felt that it had been unnecessary because it attracted many local students who rushed in to receive the biscuits rather than have health check-up.

After the check-ups the patients were provided with medicines as per their diagnosis. In addition to the specific medicine CVICT has acknowledged the fact that malnutrition is the outcome of many interrelated causes including inadequate food intake and unhealthy environment. CVICT also provided Vitamin B complex and de-worming tablets to most of the patients till the stock lasted. *See the details of the provisions received by the service seekers day-wise in the table below and also a picture of medicine distribution.*

Table showing the provisions received by the service seekers

Day	Check-up	Medicines	Biscuits
One	For all	For all	For all
Two	For all	As per stock for 500	As per stock for 500
Three	For all		

Source: Field interactions

A large quantity of medical drugs was in the form of dispensable tablets (DT) because of transportation difficulty. Small children preferred liquid solutions, which are a general practise in the country; and the parents were not comfortable giving them tablets.

According to the responses provided by the respondents in the field, the management of the drug supplies was good but could be improved significantly. The staff nurses also provided medicines, but due to the rush of handling the flow of service seekers, they were not clearly communicating which drug was for what, when it had to be taken and how.

The rural people in Nepal do not have the knowledge or concept that all medicines have to be taken in precise timings and in full course. So time needs to be set aside by support staff (other then doctors) in order to provide the patient and their caretakers on individual basis diagnosis made, the treatment they are getting and what they need to do for being cured. During the consultation and counselling the side effects if any if they do not take full dose of medicines provided would be beneficial and helpful.

Due to lack of clear communication it was found during the field visit that many of the persons receiving medicines had not taken the drugs provided to them or had taken just few and kept the rest for future use or said they had not used it because they did not know which drug was for what cure. The project has taken the time to write the instruction as to how to take the medicines but since most of the service seekers were illiterate they could not read.

3.5.5 Cases documentation

The project has documented the identified cases during the camp for future references with details of age, sex, occupation, VDC and case history.

The cases were documented at the community level by the local resource person supported by the local volunteers and at the central level by CIVICT. The DHO and the local Nepal Red Cross Society do not have their own documentation of the event.

3.6 Competency of CVICT

CVICT has the experience and expertise of conducting mobile clinics for victims of torture and trauma in different parts of the country since 1990. In 2006, 18 mobile clinics were organized in more conflicted districts although there was political instability due to the armed conflict.

When assessing the skills of CVICT staff, the review team found out that CVICT has a strong and positive image among beneficiaries and stakeholders, partners and other local agencies as an independent institution with a significant knowledge base in the area of local governance and

community development which has been built on the basis of direct experience and learning of the project and rigorous research in the communities working through groups.

The value addition of CVICT in the project implementation has been knowledge contribution; continuous learning, mobilisation and using of the community members, sharing of experiences, interactions, scenario analysis and linking the organisation with various networks. The "independent" image of CVICT has also added to its credibility, and to the resource materials and knowledge generated.

The identification and development of "community resource volunteers" that have been capacitated in implementing the project adds to CVICT's value-added and capacity in social mobilisation and local level project implementation, especially in women's participation and linking with the DHO.

Over the last decade, CVICT has been supporting conflict victims with the main purpose to rehabilitate them, and to advocate for the prevention of human rights violations and abuses. As part of the programme it provides medical, psycho-social and legal services to the needy at the centre and community level (through mobile health clinic), and strives to treat all clients fairly, without discrimination on the basis of gender, age, caste, religion, ethnicity, economic status or political affiliation.[10]

It has already been stated that CVICT has both the experience and expertise to conduct mobile clinics. As an organisation working for the conflict victims it has organised many mobile health clinics for victims of torture and trauma in different parts of the country since 1990. In 2006 alone 18 mobile clinics were organized in more conflict affected districts, where there was high political instability due to the armed conflict.[11] The team has not analysed the data to confirm this argument since the ToR was to focus only on the Humla project.

CVICT states that it has a strong network with local NGOs; Community based organizations and local governmental authorities. Volunteers, staff, district counsellors have worked in close coordination with community/local authorities. The medical camp was an initiative for local health authorities to develop more permanent and sustainable welfare services for Humla.[12] During the review, the team focused its attention at the centre, where the medical professionals (doctors), nurses/counsellors and the project coordinators were directly involved. And in the district where the local resources were hired and mobilise for the event, therefore no comments have be made in this regards

3.7 Relevance of the process and outcomes (in the context of project goal and objectives & socio-economic and political context)

In post conflict Nepal there is an urgent need to initiate programmes to mitigate the negative impact of destroyed lives and properties of the poor people. Social outcasts, marginalised ethnic communities, women, youth, and children fall under these vulnerable groups. These victims of the conflict, discriminatory cultural and religious practices, and human rights abuses have benefited less from the 50 years of social, economic and political progress. Besides being conflict

[10] Norad Application form for individual agreements, 2008, PART 2, No. 3*, HEF/HAMU , GLO-3413*, 2008, 2.2 Local Partner, a

[11] Norad Application form for individual agreements, 2008, PART 2, No. 3*, HEF/HAMU , GLO-3413*, 2008, 2.2 Local Partner, b

[12] Norad Application form for individual agreements, 2008, PART 2, No. 3*, HEF/HAMU , GLO-3413*, 2008, 2.2 Local Partner, f

victims, women have been economically and socially discriminated. Support for most of the poor and marginalized who are most seriously affected have often been ad-hoc and benefits have been short-lived.

Nepal is at a crucial political and social transitional stage, with an elected Constitutional Assembly (CA), which is mandated to pass the legislation and a new Coalition Government in place. The new interim government has made strong statements about poverty alleviation, social inclusion, reconciliation, reconstruction and rehabilitation. The socio-economic conditions in most of the poorer districts in Nepal remain poor. Poverty and social exclusion has not improved even two years after the comprehensive peace agreement was signed and an interim government was installed. A study conducted in 10 districts of Nepal in 2007, to determine the Capacity Gaps that prevented them from achieving the Millennium Development Goals (MDGs) found out that poverty continues to be endemic in most of these districts. Those Local NGOs which are working with the poor and the marginalised have limited capacity to deliver the required services to the poor. The report stated that there is an urgent need to address poverty and social exclusion through enhancing the capacity of Local NGOs in order to ensure effective service delivery and support to the poor and the excluded. The report indicated that quick action needs to be taken to address the poverty and social exclusion problems in most of the districts covered by the study (Ken Afful 2007). The socio-political environment in most of the districts covered in the study is currently highly volatile.

The recently ended conflict and the low intensity localised conflict have affected the poor and the most vulnerable communities in the rural areas. The people in the high hills which is thinly populated and has some of the most excluded groups in Nepal and highly prone to serious health problems continue to suffer from negligence by the centre.

Other communities affected by the violence and other social discrimination still await help. These victims including youth, women and children have bitter experiences from the conflict. The conflict is said to have created more widows and orphans and has increased the suicide rate, especially amongst women. The suicide rate of women has increased at an alarming rate, reaching 1.5 percent of all deaths of single women. These poor marginalized and excluded groups have not been able to reap the benefits of development even during the post conflict political and social transition. Conflict victims are yet to be compensated and rehabilitated. The resources allocated by the state for these groups are low and even the benefits of allocated resources have not reached the targeted groups.

Despite efforts made by international, national and local development agencies and non-government organisations (NGOs), these excluded groups (women, dalits, indigenous nationalities, madhesis, the poorest, inhabitants of the remote areas and destitute) continue to live in poverty and are continually discriminated against. It is therefore an urgent need for development agencies to scale-up post conflict peace, reconciliation, reconstruction and development projects through health camps, education, economic empowerment to help these communities and groups to lift themselves out of poverty and social degradation. Supporting these vulnerable groups to work together to rebuild their lives and communities are the best ways to heal the wounds caused by the conflict, improve their living standards and to work together for sustainable peace and development.

So the initiation of health camps such the Humla Mobile camps do provide relief and support to the poor and needy people of the rural area who do not have access to government services.

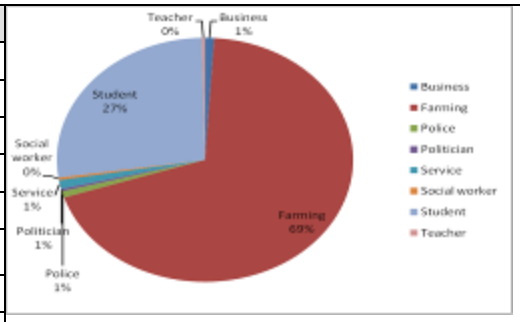
3.8 Effectiveness and sustainability

3.8.1 Effectiveness

The effectiveness here refers to results of the project and the project purpose. The project has envisaged an increase in the participation of women seeking health services for themselves and their children. Sixty nine per cent of the service seekers are from the group who earn their living from their own land, which yields very low income and the other highest group is the students 27% who are also not earning. So providing the service to people who do not have their own income source indicates that the project had has effect in the target group. *See table below for the profession/occupation service seekers.*

Table to show the Occupation /Profession Distribution

Occupation	Number	%
Business	6	1.0
Farming	414	69.0
Police	5	0.8
Politician	2	0.3
Service	7	1.2
Social worker	2	0.3
Student	162	27.0
Teacher	2	0.3

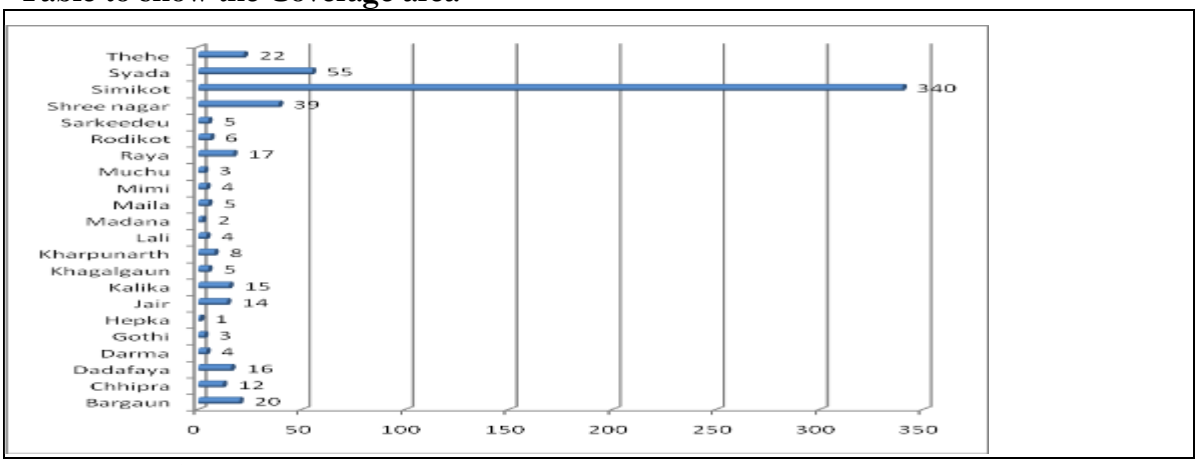


Source: CVICT Project Report

The project has been able to provide service to the rural communities where the access to the health service is very week. But going through the norms of mobile health camps communities having to come to the camp by walking for 2 to 4 days one ways was a concern for the service seekers.

The other issues to be discussed and have been highlighted by those which the team has interacted with is, so far most of the health camps (general or specific) have been organised in the district headquarters and the maximum number of service receivers have always been people from areas nearest to it, therefore the most remote areas always get neglected. *See the coverage area table below:*

Table to show the Coverage area



Source: CVICT Project Report

As indicated in the report 57% of the service seekers were from Simkot VDC the district headquarters, 25% were from the surrounding VDC (Saida, Chhipra, Bargaun, Dadafaya, Khagalgaun, Thehe, Hepka and Raya) while the VDC of the Southern part accounts for 14% (Maula, Madana, Shreenagar, Kalika, Jaire, Gothi and Sakeedeu) and the rest 4%.

The review team did not have the data to support the participation of the members in terms of ethnic groups, but it is felt that more proactive effort needs to be made to design mechanism to encourage the participation of ethnic minorities and the disadvantaged groups into the programme. Similarly, the remote VDCs of the southern regions of the district should be given special priority in future projects. Special consideration, longer duration, special focus with full medical package may need to be developed. Follow-up support using the local health institution with close home monitoring would have had more impact of the programme.

To encourage the participation of ethnic minorities and the disadvantaged groups into the programme, CIVICT may even need to be more mobile in terms of the team rather than encouraging the communities to arrive that the designated venues.

3.8.2 Sustainability

The project has anticipated sustainability of the project activities through the process of linking the project activities with the district health office and the local Red Cross Society.[13]

In the context of sustaining the outcomes of the project it was said that there would be a component of health awareness, prevention and counselling activities. But since there was a lot of pressure from the side of service seekers, the team was able to provide only limited or minimal advice and counselling service.

The community members and local leaders that had been involved in providing information to the team is of the view that they are aware of the need to seek health services if the family member falls sick but due to their economical constraint, and also lack of health service providers in the local health facilities i.e. the district hospital, health post and sub health post in the district they do not go. Most wait for the health camps to be organised. Health camps in the district have become an event to anticipate and participate. The practise of organising such health camps on regular basis could weaken the essential health system as envisioned by the government's local self government act and polices. *See table for the local self government act's health facility management provision.*

The health sector has been among the first four sectors to be devolved in local bodies, in accordance with the Local Self-Governance Act. Local Health Management Committees (LHMC) has been established for each health facility, and funds are channelled through the DDC and VDC to the respective LHMC.

Another major setback to the health sector devolution is that LHMC has not been able to function as envisaged because VDC Secretaries are not present (the VDC Secretary is the chair of the LHMC). Another issue is DDCs lack of technical capacity to function as the administrator of sub health post and health posts.

Devolution has made local supplementary funding easier, so that the centrally allocated funds for local health facilities can be supplemented for example at DDC or LHMC level. However, so far this opportunity has in most cases not been fully utilised, often due to lack of funds and/or planning capability.[14]

[13] Norad Application form for individual agreements, 2008, PART 2, No. 3*, HEF/HAMU , GLO-3413*, 2008, 2.3 Description of Project, o

[14] Development Resource Mobilisation Network, Report of Decentralisation and Sector Devolution in Nepal, Department for International Development (DFID UK)< Kathmandu, 2005.

Here the team would like to put up the question as to whether HAMU can be part of the process of building the local capacity so that essential health service is strengthened.

People surveyed for the Nepal Multiple Indicator Surveillance said that staff at government heath facilities was often rude and insensitive.[15] They also said that they were given poor advice, with minimal diagnostic support. A common complaint was the lack of privacy available at sub heath posts and health posts, and the lack of female staff available to deal with "female" problems. Many people have little trust in health services providers. Lack of accountability and lack of transparency among staff were the top two perceived reasons for corruption (bribery) in the health sector in Nepal in a recent study by Transparency International. All these factors mean that patients are either not taken to government health facilities for medical treatment or are taken when alternative options have been exhausted. This results in people waiting for the health camps or deaths that might have been prevented with prompt and effective treatments.

Nearly all community members are aware of their health issues; they talk openly about it and also know the service they need. In most cases during the interaction with the review team the community members expressed their view that proper diagnosis needed to be prioritised first and then only provide prescription for treatment.

The DHO and the local Red Cross Society with its current resources (human professionals, infrastructure, medical, equipments and management) feel that they would not be able to provide the health services as indicated by the government policies and regulation. They feel that the external support would be required, they would only be able to provide support during the events organised through external support.

Further more, the project had anticipated that a follow-up of the patients would be organised by the DHO in coordination with the Red Cross Society. During the field visit the review team found out that none of the service seekers that had participated in the health camp had gone to the hospital for follow-up. *See Annex – 6- for the details of health service delivery system in Nepal.*

The team is of the opinion that health camps may be a way of making people aware of their needs to have regular check-ups (assessment) and develop the practise of seeking health care service, but it is not at all a way to sustain the system.

3.8.3 Efficiency

As a way of implementing the project in an efficient way CVICT has collaborated and made every effort to partner the programme activities with the local individuals, NGO, health institution and local leaders of the project area. Their involvement has been in all aspect of the project's planning process and had an active role in support, supervision/ monitoring and evaluation during implementation. They were also key implementing partners during the health camp and supervision.

[15] NPC/UNICEF Nepal/New ERA, Nepal multiple Indicator Cluster Surveillance, Cycles 1-6, (January to March 1995), National Planning Commission (NPC), UNICEF Nepal, New ERA, Kathmandu, 1996

The team members of the project and their details were the following

Persons	#	Base	Days of involvement	Daily rates
Doctor	2	CVICT	7 days including travel	Not Applicable
Doctor	1	DHO	3 Camp days	NRs. 2,000
Staff Nurse/Counsellor	1	CVICT	7 days including travel	Not applicable
Staff Nurse	1	DHO Staff	3 Camp days	NRs. 1,500
Coordinator	1	CVICT	7 including travel	Not Applicable
Local Coordinator	1	Shreenagar VDC	20 days	NRs. 2,000
Social Mobilisers	4	Local	12 days each	NRs. 1,500
Volunteers	4	Local	7 days	*Actual (food & lodge)*
Runner	1	DHO Staff	3 Camp days	NRs. 1,000
Source: Field visit survey and CVICT inputs. See Annex 4(h) for the names of Social Mobilisers & Volunteers				

600 persons were provided check-ups and medicine support during the three days camp by three professional doctors using the project amount of Euro 8,500 (equivalent to NRs. 850,000).

Going through the analysis of the plan and achievements the initial plan and actual service provided to the service seekers show that the quantity has been achieved more and the cost per head has come down significantly but the team has raised the question on the quality, time and place in regards to the project implementation. *See details of the analysis in the table below.*

Table to show the analysis of the project implementation

	Plan	Actual	Remark
Number of patients	500	600	100 additional
Days	5 days	3 days	2 days less
Doctors	3	3	
Per day patient target	100	200	Double then planned
Check-up time per person	10.8 minutes	5.40 minutes	½ the time as anticipated
Total project cost	NRs. 850,000	NRs. 850,000	
Cost per person	NRs. 1,700	NRs. 1,417	NRs. 283 less per person
Place of Implementation	Simkot, Humla	Simkot	
Source: Information analysis			

The administration of the fund (budgeting as well as disbursement, recording, accounting and reporting) plays a very important role in the efficient utilisation of the funding support. The team was provided with the financial transaction by the local resource person, who disbursed the funds for the volunteers. Other disbursements were directly done by the Project Coordinator and the central office staff (the Staff Nurse/Counsellor). The review team however, has not looked into the books of accounts.

The programme activities relating to the project were planned in such a way that implementing organisation CVICT did not have to incur additional cost. The service of the local resource persons was procured in advance (local coordinator, volunteers, doctor, nurse and support staff). The medicinal stock was purchased in advance, so when the stock ran out patients were told about it and hence they could not receive any. The camp team did not stay more than the number of allocated days in the district. In fact the project target of providing service to 500 patients of the district was achieved in 3 days, 2 days earlier then anticipated, so the camp team gained 2 days in total. In the way of gaining the 2 days the anticipated expenses were reduced significantly on the professional fee, DSA and hotel charges.

During the interactions with the community and the staff at the DHO it was found out that the camp provided assessment service through the doctors only, the team did not have any pathological, radiography or other investigative service from the hospital. For proper investigation it was strongly felt that additional investigative services were lacking in the project.

The government healthcare system provides free drugs and consultation for patients; it has been unable to ensure the year-round availability of essential drugs at the community level (district hospital, primary healthcare centre, health post and sub health post). Government supplies to these health facilities last for only 3-4 months a year. This situation discourages people from using these health facilities, and compels patients to buy drugs from other sources, usually private medical shops. In remote areas, especially in Humla, private medical shops are seldom available and people may have to travel for several hours to obtain the drugs they need, often at a high price. This is beyond the capacity of many poor families.

In 1995, the Department of Health Services launched the Community Drug Programme, where were launched districts phase wise. Some districts have full coverage, in others, not all facilities in the district implement the programme. The Community Drug Programme encourages each Local Health Facility Operation and Management to introduce fees for their service, and then utilise the funds raised in the way for replenishing the drug supply. Where the Community Drug Programme is implemented, people have to pay a one-time users' (or registration) fee, which is normally around NRs. 2- 5. Then, they must pay for medicines, which are discounted by at least 15 per cent from the retail price. There is also a mechanism for exempting the poorest from paying fro medicines.

This system has ensured the year-round supply of drugs at low process. It has also activated co-management of local health services with the community, and has enabled health facilities to assess their annual drug need more precisely. The Community Drug Programme has improved the availability of essential drugs at the community level, and is being expanded through various plans.

Should HAMU consider linking the programme to this system for sustainability and efficiency is the question that the team puts forth.

3.9 Result and outcomes

The primary data from the field visits and the secondary data derived from the literature review shows that there has been significant level impact in the community as a result of the programme.

The direct result and outcomes as observed have been that over 600 community members received check-up service from professional health practitioners. Of the over 600 patients receiving check-up (assessment service), the first 500 received medicines for their diagnosed diseases supplemented with vitamin B complex and de-worming tablets.

On the third day when the patients flow was beyond 500 and the supply of drugs and biscuits ran out the patient voluntarily requested the project team to provide them with the check-up service from the doctors. The patient as pre the request of the patients provided the check-up service with the drug prescriptions, which the patients were to buy from the local medical shops.

Since there has not been any follow-up by the patients to the hospital or the DHO/local Red Cross Society members going to the community members, there is no record or analysis as to how many of them who received medicines from the camp took the complete course. While the review team was in the field nearly 50% of the respondents showed medicines that were not being taken due to various reasons such as:

- *Did not get immediate relief after taking a few*
- *Did not know the proper time of intake*

- *Lost faith in their medication since they saw that most of the fellow members had also been given the same medicine (de-worming, vitamin B complex)*
- *Wanted to save it for rainy days (when they got really sick)*
- *Were too sick to take all the medicine at the same time*

3.10 Advocacy and/or influencing policies and programmes

The project did not have a direct strategy and activities in the area of initiating advocacy and/or influencing policies and programme of government and other organisations and stakeholders. But since the camp was organised in the district headquarters where all the local leaders, government line agencies and the district's main health facility (district hospital) are based, the activities of the project has had indirect influence in the advocacy and policy of the district.

CVICT, through its activities, has been pushing forward the issues of human rights, relief and rehabilitation and livelihood activities for the conflict affected victim throughout the country. And Humla has been one of the districts where the conflict has had maximum impact.

3.11 Conflict and the Health Service

The conflict has affected the health services in a number of ways; staffing at health facilities, harassment of health workers, health service provision, and damage to and use of health facilities.

It is widely acknowledged that the level of staffing at many health institutions of the district were often sub-optimal. Although this was true prior to the conflict, it is likely that the conflict caused understaffing to become more widespread and for longer periods of time.

The experienced gained by CVICT during these difficult times of the conflict have enabled them to develop conflict sensitive capabilities. More over CVICT has been at the frontline of the conflict and operated during the period using the experience in development programmes in their own communities and also in organising the health camps. CVICT has developed a good understanding of the conflict dynamics including the root causes of conflict in their work area. They have also taken the measure to adjust programmes accordingly to minimize any foreseeable negative contribution to the conflict or maximise their role in local peace building.

In post conflict Nepal there is an urgent need to initiate programmes to mitigate the negative impact of the destroyed life and property of the many poor people due to past conflicts and other harsh social practices. Among these vulnerable groups are social outcastes, marginalised ethnic communities, women, youth, and children. These victims of the conflict, discriminatory cultural and religious practices, and human rights abuses have benefited less from over 50 years of social, economic and political progress Nepal has made than other accepted groups. Besides the conflict, there are victims especially women who are socially discriminated against. Support for most of the poor and marginalized who are most seriously affected have often been ad-hoc and benefit have been short-lived. Therefore the project has been designed and delivered in a timely manner.

3.12 Challenges and Learning points

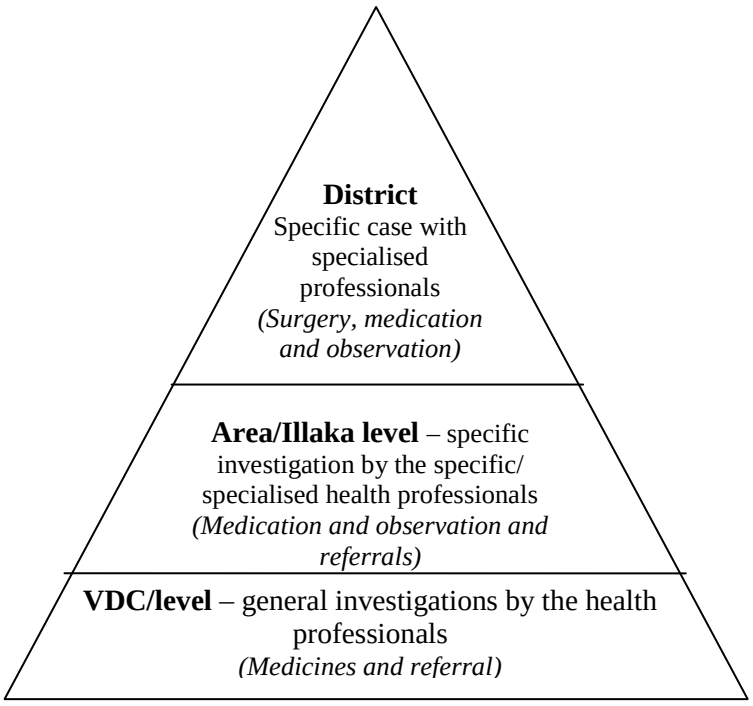
While there were lot of benefits for the project and the community through the mobile camps there were also challenges that had to be addressed. And most prominent challenges that the review team was able to identify were in the areas of:

Challenges	Ways that CVICT addressed them
▪ *Coordinating with local leaders, while CVICT did not have its own office or staff in the district*	▪ *Recruitment of a local resource person for 20 days i.e. Mr. Navaraj Mahatata*
▪ *Identifying the target group in advance and setting the maximum limit*	▪ *Managing the camps with maximum limit and also providing service to additional people that came till the medical stock lasted* ▪ *After the medical stock ran out check-up service was provided to others*
▪ *Conducting the camps at the community level who do not have access and are not at the district level, where all the resources of the district are based*	▪ *Firstly giving priority to the people who came from outside the district headquarters*
▪ *Focusing on the preventive measures rather than curative*	▪ *This activity did not take place*
▪ *Linking the process of follow-up with the local level health facilities (SHP, HP, PHCC and district hospital)*	▪ *No action was initiated*
▪ *Balancing the process of primary health care support with more specific and in-depth diagnosis with treatment*	▪ *More in-depth programme for future is envisioned*
▪ *Balancing general check-up and care with that of specific cases i.e. women's reproductive health, eye, ENT, oral health, surgical, family planning etc.*	▪ *Specific cam envisioned for the future*

4 Recommendations

The health camp project has shown a positive impact on beneficiaries. There is a need to continue with the programme and to initiate an extension to the other conflict affected areas in the next phase of the programme. Better planning and coordination with the local stakeholders can make future programmes more successful which will ultimately contribute to the better health, economic empowerment, peace and harmony among the people.

The review team also suggests that camps should be a series of events coordinated at different levels with the use of more professional health service providers and referral system, rather than just being one event in order to make it more effective. *See diagram below.* The events should include a strong element of monitoring and follow-up at different levels through the mobilisation of local health institutions.



Based on the above analysis, discussions and observations in the field and at the central level, the review team offers a few recommendations. These recommendations provided by the team in order to improve the specific areas of the project are not in order of priority or any time scale. Therefore the team suggests that CVICT, along with the stakeholders prioritise these recommendations and develop an action plan so that it can be carried out in terms of operational (immediate) and strategic (long-term) plan before moving on to developing to new project of such nature.

- *Team Formation in coordination with local community leaders*
- *Inclusion of monitoring and evaluation as part of the project activity*
- *Clear, timely and specific communication of the services – who will get the service when*
- *Screening camps prior to the general camps using local resource health professionals (ANM, HA, AHWs, MCHs and FCHVs)*
- *Specialised team with full resources (medicines and equipments)*
- *General camps leading to specifics (as per the need of the community)*
- *Documentation and record keeping by the local level health facility*
- *Having adequate equipments facilities at the camp – power backup, pathology and radiography*
- *More coordination with the local stakeholders*
- *Set aside ample time to communicate with the service seekers on the purpose and use of the drugs including the side effects if any*
- *Develop an effective and practical follow-up system for the patients to monitor their patients' following the prescription of the doctor, its effect on their health and the behavioural change.*
- *For greater efficiency utilisation of fund through appropriate allocation and utilisation, budgeting system should be strengthened with proper mechanism for monitoring (budget tracking).*
- *This type of project should not be an event but progressive events so it should be medium term with the focus on developing the capacity of the local service delivery mechanism*

Annex

Annex – 1 - Terms of Reference (ToR) for review of mobile health camp in Simikot, Humla

Background: HAMU – Humanist Action for Human Rights - has together with Norad provided funding for a mobile health camp organised by CVICT in the district of Humla. The camp is to be conducted by CVICT using a combination of local volunteers and their own personnel. HAMU/Norad has previously supported similar operations in cooperation with CVICT, but has not previously conducted an independent evaluation of the activities.

The following operations/activities are to be evaluated:

MOBILE HEALTH CAMP
Location: Simkot, Humla
Implementing partner: CVICT
Approximate grant: € 8500

QUESTIONS TO BE ANSWERED:

- *Assess whether the needs of the target group have been properly identified and prioritized*
- *Examine the assumptions made and risks identified during the design stage and assess the degree of flexibility of the project design to respond to changes in the programmes implementation environment.*
- *Examine whether the inputs and outputs project meet the project objectives.*
- *Analyze and identify the operational strengths and weaknesses at project level and provide necessary suggestions for further improvement.*
- *Assess whether the external environment (political, economic, security) affects the achievement of the project and outline the challenges that may have impacted the effectiveness of the project/s*
- *Assess if the resources (financial, human and capital) allocated for the project adequate.*
- *Assess whether the project has succeeded in including women, children and marginalized groups.*
- *Assess how/whether the project has managed to strike a balance between ethnic groups and different dividing lines among the population, the general attitude of conflict sensitivity and its practical implications.*

- **Sustainability**

- *Have organisations/local institutions i.e. district health post and Red Cross the capacity/capability to ensure follow- up? Has there been created some sustainable structures for continuation and further development of health welfare?*
- *Are there organisations/partners/communities that have copied, scaled up or replicated project activities beyond the current project coverage area?*
- *Lesson learned from the project.*

1. Obligations of the Evaluator

The obligations and work performed by the evaluator is to be:

1. To evaluate the operation
2. Provide independent national perspective in the evaluation
3. Work jointly with CVICT team finalizing evaluation methods including interview questions

4. Interpret the qualitative data collected through in-depth and semi structured interviews, focus group discussions, and meetings with key stakeholders including final beneficiaries, local health officers, volunteers
5. To issue draft report to HAMU and relevant Partner.
6. To issue final report to HAMU and relevant Partner.

2. Obligations of HAMU

The obligations and work performed by HAMU is to be:

1. Inform the partner of the external evaluation to be conducted and to provide the evaluator with requested information.
2. Provide information for the evaluator to contact Partner.
3. Provide status report from Partner.
4. Inform Partner of other matters related to the evaluation.

3. Obligations of CVICT

The obligations and work performed by CVICT are to be:

1. To provide Evaluator with all necessary information regarding project.
2. To assist evaluator in getting to the project area.
3. Work jointly with Evaluator team finalizing evaluation methods including interview questions

4. Time Schedule of Evaluation

18. September 2008	Start of work
15. November 2008	Issue draft report – first version
30. November 2008	Issue draft report – second version
10. December 2008	Receive written comments from partner
20. December 2008	Issue the final report

Annex – 2 - Tool for Field Study

Review of Integrated Health Camp for Southern Humla District

Supported by Humanist Action for Human Rights (HAMU)
Implemented by Centre for Victims of Torture, Nepal (CVICT)

November/December 2008

Background Information

Humanist Action for Human Rights (HAMU) - has together with Norad provided funding for a mobile health camp organised by Centre for Victims of Torture (CVICT), Nepal in the district of Humla. The camp was conducted by CVICT using a combination of local volunteers and their own personnel. HAMU/Norad has previously supported similar operations in cooperation with CVICT, but has not conducted an independent evaluation of the activities.

The primary purpose of this evaluation is to reveal the results of the HAMU/Norad - funded "*Mobile Health Camps*" in Simikot of Humla district, which was carried out on September 4th through to 8th, 2008. The evaluation will access program effectiveness, impact, organisation management, partnership relationship, project process monitoring and documentation, identifying the best practises and future roles in the changing context.

Objectives

The primary purpose of the evaluation is to reveal the result of the HAMU/Norad funded project "*Mobile Health Camps*" in Simikot of Humla district. It also intends to understand the results of the programs in the project area. The evaluation should serve as a learning exercise.

The specific objectives are:

1. Assess whether the needs of the target group have been properly identified and prioritized
2. Examine the assumptions made and risks identified during the design stage and assess the degree of flexibility of the project design to respond to changes in the programmes implementation environment.
3. Examine whether the inputs and outputs project meet the project objectives.
4. Analyze and identify the operational strengths and weaknesses at project level and provide necessary suggestions for further improvement.
5. Assess whether the external environment (political, economic, security) affects the achievement of the project and outline the challenges that may have impacted the effectiveness of the project/s
6. Assess if the resources (financial, human and capital) allocated for the project adequate.
7. Assess whether the project has succeeded in including women, children and marginalized groups.
8. Assess how/whether the project has managed to strike a balance between ethnic groups and different dividing lines among the population, the general attitude of conflict sensitivity and its practical implications.
9. Have organisations/local institutions i.e. district health post and Red Cross the capacity/capability to ensure follow- up? Has there been created some sustainable structures for continuation and further development of health welfare?

Evaluation Objectives (Focus Area)

The evaluation will be guided by the following evaluation framework keeping in mind the key questions raised in the ToR.

Focus area	Criteria of assessment
Efficiency	*How economically inputs (resources, expertise, time, etc.) are converted into outputs*
Effectiveness	*The extent to which the objective has been achieved*
Impact	*Positive and negative changes and effects caused by the intervention*
Relevance	*Whether the objectives are in keeping with the priorities of the target group and the recipient and donor's policies*
Sustainability	*The likelihood that the positive effects of an intervention will continue after external support has been completed*
Participation	*The Level of community participation and ownership*

Sampling: The evaluation is proposed to be carried in Simikot of Humla district where project has been implemented through CVICT partnership and interact with the team members and related staff of CVICT at Kathmandu.

1. Service seekers *(women, parents, male)* Humla
2. Team Leader CVICT Office at Kathmandu
3. Medical Doctors Kathmandu
4. Counsellors/Staff Nurse Kathmandu
5. CVICT's Staff and Board Members CVICT Office at Kathmandu
6. District Programme Coordinator Humla
7. Local Staff Nurse District Hospital, Humla
8. Local Volunteers/Social Mobilisers Humla
9. District Health Officer (DHO) District Health Office, Humla
10. Chief District Officer (CDO) District Administration Office (DAO), Humla
11. Nepal Police *(including female members)* District Police Office (DPO), Humla
12. Partner NGOs

Methodology and process for the evaluation

The primary sources of information will be

(i) Literature
(ii) Individual interaction (using **relevant** sample questions)
(iii) Focus group discussions with key targets groups (community beneficiaries – using **relevant** sample questions)
(iv) Feedback and discussion on the findings

Sample questions to be asked to find out the specific objective that the team has been asked to review.

1. Assess whether the needs of the target group have been properly identified and prioritized

    a) How was the need of the target group identified and prioritised?
    b) Who were involved during the design and planning of the project?
    c) How was the location of the project identified and decided?
    d) Were there any changes in the initial plan and actual implementation of the project?
    e) If yes, why did the change take place?
    f) How were the local communities/organisations involved in the planning, implementation and monitoring of the project?
    g) If you were to run another health camp in the near future what would you do differently?
    h) Why do you say so?

2. Examine the assumptions made and risks identified during the design stage and assess the degree of flexibility of the project design to respond to changes in the programmes implementation environment.

    a) What were your expectations and assumptions of the projects?
    b) How much of the expectation were met and what could not be met?
    c) Why do you think so?
    d) What flexibilities were adopted during the implementation of the programme?
    e) What differences did it have on the impact, target group and resources with the changes adopted?

3. Examine whether the inputs and outputs project meet the project objectives.

    a) How do you see the activities initiated by the project being continued in the district?
    b) Why do you think so?
    c) Do you know who much the project cost and from where did the fund come from?
    d) Do the activities need funds to continue?
    e) If yes, how much will it cost (monthly, yearly)?
    f) For what will the funds be needed?
    g) Where will the funds come from? Or need to come from?
    h) Should there be a documentation of the activities and fund mobilisation?
    i) Why do you think so?
    j) How should maintain the documentation of the activities and funds?
    k) Who should be responsible for maintaining them?

4. Analyze and identify the operational strengths and weaknesses at project level and provide necessary suggestions for further improvement.

    a) How do you see CVICT implementing such projects in the future?
    b) Why do you think so?
    c) Do you think CVICT have enough resources (expertise, management, equipments and networks) to implement such programmes?
    d) If CVICT is to implement such project in the future what capacities should it develop?

5. Assess whether the external environment (political, economic, security) affects the achievement of the project and outline the challenges that may have impacted the effectiveness of the project/s

   a) What external factors influenced the impact of the project?
   b) How did you managed or minimised the negative impacts?

6. Assess if the resources (financial, human and capital) allocated for the project adequate.

   a) How do you compare the project activities in relation to other projects and programmes?
   b) Why do you say so?
   c) Could the project activities have been carried in a different way to save cost, time and other resource?

7. Assess whether the project has succeeded in including women, children and marginalized groups.

   a) How did you or your family member get selected to benefit from the programme?
   b) What were the process/criteria for being selected?
   c) Why do you think so?
   d) Can the process be improved in the future?
   e) If yes, how?

8. Assess how/whether the project has managed to strike a balance between ethnic groups and different dividing lines among the population, the general attitude of conflict sensitivity and its practical implications.

   a) How do you think of the composition of the team for the project?
   b) How were you or your organisation involved in the project?
   c) What was your role in the project?
   d) How was the roles and responsibilities allocated to different member in the ream?
   e) How could the team be made more effective and efficient in the future?
   f) Was the project team able to work with the local government line agencies and NGOs?
   g) If in the future you are included in the team for implementing similar project what would you do differently and why?

9. Have organisations/local institutions i.e. district health post and Red Cross the capacity/capability to ensure follow-up? Has there been created some sustainable structures for continuation and further development of health welfare?

   a) What were the capacity building elements of the project?
   b) Have the local institutions own the project?
   c) Who is responsible to conduct the follow-up the project activities?
   d) How and in what form?
   e) What will be done to follow-up the activities of the project?

10. Are there organisations/partners/communities that have copied, scaled up or replicated project activities beyond the current project coverage area?

    a) As a result of the project what policies and activities changes have you observed in the service delivery of the government line-agencies and other organisations? What are the different activities of the project that you and your organisation have been involved in as result of the project?
    b) Has the involvement increased or decreased from the project initiation to the recent days?
    c) Why do you think the increase/decrease has happened?

11. Impact: How the needs of the most vulnerable including women, children and poor have been addressed by the project.

    a) What do you think were the objectives of the project?
    b) To what extent has the project objectives been fulfilled?
    c) What has been the impact as the result of the project and its activities for you as in individual, in the family, women, children, community and society as a whole?
    d) Relevance of the process and outcomes (in the context of project goal and objectives & socio-economic and political context)
    e) As a result of the project and its programmes what changes have you observed in your own life, family, community and society?
    f) How do you assess the projects programmes/activities, were they based on the needs of the community?
    g) Why do you think so?
    h) How do you see the relevance of the programme and process in bringing the observed changes?
    i) What would have the conditions if the project and its programmes were not carried out?

12. Identify and document the learning learnt and challenges faced by the partners, community and the project

    a) For you personally as being involved in the project activities what has been your learning?
    b) What aspect of the project did you like and enjoyed the most?
    c) Did you face any challenges?
    d) If yes, what were the challenges?
    e) How did you manage to overcome the challenges?

13. Lesson learned from the project.

    a) What were your personal or organisation learning from the project?
    b) How has the learning been documented?
    c) Were the learning project shared with any other person(s) or institution(s)?
    d) If yes, with whom and in what form?
    e) How would you use the learning in designing, implementing and monitoring of future projects?

14. Comments and suggestion if any for (HAMU, CVICT or the Evaluation team)

Annex - 3 – Itinerary for the filed visit and the interaction

Date	Activity	Persons/Groups	Place
Sept 29th	Initial planning meeting	CVICT project staff	CVICT - Kathmandu
Oct 27th	Interaction at CVICT	Project related staff	CVICT - Kathmandu
Nov 4th	Travel		Kathmandu – Nepalgunj
Nov 5th	Travel		Nepalgunj to Simkot of Humla
Nov 5th - 7th	Interaction at the field	Sampled groups	
Nov 8th	Travel		Simkot to Nepalgunj
Nov 8th	Travel		Nepalgunj to Kathmandu
Nov – 15th	Draft Report Presentation		CVICT and HAMU
Dec end	Second Draft Report		CVICT and HAMU
Jan end	Final Report Presentation		CVICT and HAMU

Annex – 4 – List of individuals and groups interacted with

a. Community Members of Shreenagar VDC

1. Mr. Akhbar Bhandari
2. Mr. Hansh Fadera
3. Mr. Nar Bhandari
4. Mr. Netra Bhandari
5. Ms. Chodani Bhandari
6. Ms. Sushma Bhandari

b. Community Members in Simkot VDC

1. Mr. Kamal Rokaya
2. Mr. Man Bahadur Rokaya
3. Mr. Mithun Hamal
4. Ms. Bhrikuti Rokaya
5. Ms. Bhunti Rawat
6. Ms. Gayiyala Rokaya
7. Ms. Gyan Puri Rokaya
8. Ms. Hanshu Rawat
9. Ms. Himani Rokaya
10. Ms. Jassu Rawat
11. Ms. Jauka Rokaya
12. Ms. Kali Rawat
13. Ms. Laguna Rokaya
14. Ms. Nochhuli Rawat
15. Ms. Panchakali Rokaya
16. Ms. Vijaya Rokaya

c. Lama community member from Simkot VDC

1. Ms. Chhiring Angbo Lama
2. Ms. Chhiring Pasang Lama
3. Ms. Dolma Lama
4. Ms. Kangdol Lama
5. Ms. Khijing Lama
6. Ms. Kundole Lama
7. Ms. Pema Thanngjen Lama
8. Ms. Sarjanbu Lama
9. Ms. Thangjuma Lama
10. Ms. Usha Lama

d. Local Coordinator and Social Mobiliser

1. Mr. Navaraj Mahatara — Local Programme Coordinator
2. Ms. Pembuch Lama — Local Social Mobiliser

e. NGO Partner and Local Leaders

1.	Mr. Bijay Bhandar	CPN Maoist District Committee Member
2.	Mr. Birkha Bahadur Mahat	RPP Central Member
3.	Mr. Chkka Bahadur Lama	Local Elite Member
4.	Mr. Gagat Bhasyal	Karnali Dalit Development Counsel
5.	Mr. Gora Singh Bohora	CPN Unity Centre Member
6.	Mr. Gorakh Bista	Journalist
7.	Mr. Jeevan Bahadur Shahi	NC District Chairperson
8.	Mr. Kal Bahadur Hamal	CPN UML Vice Secretary
9.	Mr. Kamal Bohora	HR Alliance
10.	Mr. Kamal Chattyal	RCWR Member
11.	Mr. Karna Rokaya	Nepal Red Cross Society – Humla District Chapter
12.	Mr. Katten Lama	CPM Maoist District Secretary
13.	Mr. Naina Sing Rawat	RPP District Chairperson
14.	Mr. Nandda Bahadur Rokaya	RDP Director
15.	Mr. Parbat Sunwar	Dalit Representative
16.	Mr. Prem Lama	NC District Member
17.	Mr. Raj Bahadur Rokaya	HCDA Board Member
18.	Mr. Shiva Raj Sharma	CPN UML District Secretary
19.	Mr. Sonam Singh Gurung	CNP Unity Centre District Member
20.	Ms. Laxmi Buddha	Democratic Women Forum

f. District Hospital Members (Simkot)

1.	Mr. Gambu Sharpa	Senior AHW
2.	Mr. Ramesh Shrestha	AHW
3.	Ms. Sarita Bohara	Public Health Nurse
4.	Ms. Shanti Rawal	Staff Nurse

g. CVICT Office

1.	Ms. Ganga Laxmi Awal	Project Coordinator/Team Leader
2.	Dr. Yagya Ratna Shakya	General Physician
3.	Ms. Asha Dahal	Staff Nurse/Counsellor

h. List of Local Social Mobilisers and Volunteers

Social Mobilisers	Volunteers
Mr. Rupak Rokaya	Ms. Nórmala Sunuwar
Mr. Promod Jung Bogati	Ms. Sarita Lama
Mr. Man Bahadur Mahatara	Ms. Sarita Rokaya
Ms. Pema Lama	Mr. Amrit Rawat
Soruce: CVICT	

Annex - 5 - Roles of Team members and their names:

a. **Team Leader:** Lead the team members and Coordinate overall Mobile Health Camp.
   i. *Ms. Ganga Laxmi Awal, Project Coordinator CVICT*

b. **Medical Doctor:** Physical examination, assessment of psychological status, treatment of physical illnesses, referral for further investigation, and referral to local health institutions or CVICT's Kathmandu centre.
   i. Dr Sarvesh Sharma, General Physician and DHO of Humla
   ii. Dr. Atit Baskota, General Physician
   iii. Dr. Yagya Ratna Shakya,, General Physicia

c. **Counsellors:** Case work, documentation, assessment of psychosocial status and assist doctor. Public awareness about the torture related issues and referral for the right rehabilitation.
   i. Ms. Asha Dahal, Staff Nurse

d. **Staff Nurse:** Distributing medicines, checking blood-pressure of clients.
   i. Ms. Sarita Bohara, Public Health Nurse
   ii. Ms. Shanti Rawal, Staff Nurse

e. **Volunteer:** Inform about the health camp to the community people, help for documentation.
   i. Mr. Amrit Rawat
   ii. Ms. Nórmala Sunuwar
   iii. Ms. Sarita Lama
   iv. Ms. Sarita Rokaya

f. **Social Mobilizer**: Mobilize in social activities

   i. Mr. Man Bahadur Mahatara
   ii. Mr. Navaraj Mahatara
   iii. Mr. Promod Jung Bogati
   iv. Mr. Rupak Rokaya
   v. Ms. Pembuch Lama

Annex – 6 - Health Service Provision System and Professionals in Nepal

Professional	Hospital	PHC	HP	SHP	Remark
Doctor	✓	✓	X	X	
Health Assistant/Sr. AHWs	✓	✓	✓	X	
Nurses (Staff Nurse)	✓	✓	✓	X	
AHWs / CMAs	✓	✓	✓	✓	
VHWs	X	✓	✓	✓	
MCHWs	X	X	X	✓	

Health Management System: Ministry of health and the main stakeholders in the health and the development partners have worked with a shared vision for the sector, which includes sectoral objectives, and the policy framework for achieving them and it involves number of steps and number of support system. In the government sector, the main responsibility for health services falls to the MOH and its DOHS, although there are also health services provided by other Ministries and local authorities. At the regional level, which is directly under MOH, the Regional Directors are responsible for technical backstopping as well as programme supervision. At the district level and below, since the LSGA has been approved, DDC and VDC are functionally responsible for delivery of health services. Within the MoH, the structure varies between districts. Sixty-one districts being managed by the DHO with the support of the DPHO and remainder of the 14 are managed solely by the DPHO. The next level of health care is provided by the PHC (172 being functional out of 202). There are about 710 health post (HP) and more then 3,000 sub-health posts (SHP).

Currently MoH has prepared the NHSP-IP 2003 –2007 with the support of the Programme Preparation Team (PPT) coordinated by the PPICD of the MoH and a Core Group consisting of the MoH/DoHS, EDP, MoF, MoLD and private and NGOs. In which there are three management changes that are envisaged during the implementation of the NHSP-IP. These are:

a. GoN taking responsibility of implementing current projects either implemented directly by the EDPs or though separate project arrangements.
b. Decentralisation will clear performance management, and
c. Central Departments moving towards more of a facilitator/financier role than the provider role.

It is envisage at all these three management changes would require substantial reorganisation within the health sector.

PPN/PNP: NGOs and private sectors are largely independent although most private providers are also employed in the public sector. The private sector is also growing much faster than it can be regulated. NGOs are a significant source of basic services in some rural areas: they provide community based mother and child health, family planning and other essential health services. There is no effective system in place for ensuring that the services delivered by the private sector provide value for money. This is extremely important given GoN's commitment to equity and the significant proportion of health spending which is out of pocket expenditure spent in the private sector. To promote public – private partnerships in healthcare delivery, an assessment is being conducted of the current regulatory framework for private sector healthcare delivery; an assessment will be conducted of the current regulatory framework for private sector health care delivery and business. Working models of public-private partnerships will be documented to guide policy discussions. Experience of commissioning or contracting has brought in some success in Nepal. During this programme period, this will be further expanded. The MoH

capacity will be enhanced for setting of standards and policies and the DoHS capacity strengthened/developed for performance management and contracting procedures.

Decentralisation: Nepal, through Local Self Governance Act (LSGA, 1999) and subsequent guidelines, has embarked on a multi-sectoral process of decentralisation of government functions, including health services. Decentralisation of peripheral health facilities will be designed to address those aspects of health facility management and services that are currently designed to address those aspects of health facility management and services that are currently identified as problems amenable to local solutions, while at the same time avoiding large changes in programmes that have successful models. Decentralisation of health facilities (Sub-Health Posts) to VDC health management committees has already begun in 2002, will be completed in 12 districts by June 2003 and will expand steadily to all districts over the next few years. The decentralisation process is now in transition and as such the respective roles and responsibilities of the DoHS, the Regions, the Districts, sub district levels and other Ministries, in particular MoLD and National Planning Commission (NPC) are yet to be finalized. There needs to be a detailed assessment of capacity at all levels and the necessary steps taken to develop capacity to make the existing system respond to the implementation challenge. Decentralisation focal point at MoH will prepare phased plan for decentralisation with clarification of roles of different agencies and funding modalities.

Hospital Development Boards have been formed for all government hospitals and for 12 district hospitals. The MoH in addition to the capacity development for performance management and quality standard setting will further extend the hospital autonomy to all public sector hospital.

A brief description of the different service delivery levels in the district and who they are staffed by (i.e. hospital, PHCC, HP and SHP and outreach clinics)

Sub Health Post: SHP is the first level of the health service delivery institutions that provides health services through preventive, promotive and curative services and treatment of minor ailments. The 10th Five Year Plan envisage to have one SHP at each VDC (i.e. 3995 VDCs) providing service to an average of 4000 people. SHPs are to be handed over to the VDCs and to be managed by community under the chairmanship of VDC chairperson.

HP: In addition to the services provided by SHP, HP provides training to FCHV, TBA and MCHW and supervises and monitors the activities of SHP. HP provides regular service during working days and its services coverage ranges from 5 – 15 VDCs depending on the area and terrain of a particular district.

PHC: Having provision of medical officer, PHC provides all services of HP in a better level of health services with regard to preventive, promotive and curative facilities. PHC also provides in-patient curative care as they have few beds to provide simple medical, surgical and maternity services. PHC can extend services on mobile and out-reach basis like vasectomy and mini-laporoscopy, refresher in-service training, conduct epidemiological studies, etc.

The 10th Five Year Plan envisage to have one PHC at each constituencies targeting to a total to a total of 205.

District Hospital: In addition to the services provided by PHC, District hospital supervises and monitors the activities of PHC, HP and SHP within the district. Guidelines/standards for efficient functioning of DH, is the need of the day.

Community Health institutions and Hospitals

Health institutions and Hospitals are being managed and infrastructures are developed also with the initiatives of community at local level.

Types of services provided by District Hospitals

1. Preventive and promotive services:
   - Temporary and permanent family planning – pills, condoms, Depo-Provera and I-UD and vasectomy operation on regular basis
   - Sterilisation camp as per schedule provided by Department of Health
   - Health education on CDD, ORT and nutrition
   - ARI
   - Communicable disease control – educate community about environmental and personal hygiene
   - Diarrhoea disease control
   - Immunization – DPT, BCG, Polio, Measles, TT
   - Nutrition – Vitamin A capsule distribution, iodise oil injection, iodine capsule distribution, distribution of iron and folic acid tablets to pregnant women, deworming, nutrition education, promotion of breast feeding and complementary feeding
   - Epidemic control and tuberculosis
   - Leprosy
   - HIV/AIDS and STD
   - Health education
   - Malaria and Kalazar
   - Safe Motherhood
   - Provide regular ante-natal check-up and conduct safe delivery
   - Provide post-natal care and prevention of post-natal complication
   - Encourage from family planning acceptance

Out-reach clinics

District Hospital conduct out-reach clinic at selected catchments area. Purpose of the out-reach clinic is to increase accessibility to health services to a maximum number of people possible through mobilisation of grass-root level health workers as well as through increased mobilisation of a pool of community volunteers such as FCHV, TBA, village leaders and social workers.

2. Curative Services

   - General OPD
   - Indoor services
   - Rehydration therapy
   - Lab facility and X-ray facility
   - Conduct delivery
   - Take care of complicated pregnancy – natal, post-natal and neo-natal complications and make referrals as needed
   - Give priorities to the patient referred by PHC, HP and SHP

Health Personnel at District Hospitals

District Health Officer	1
Medical Officer	2
Health Assistant (HA)	1
AHW	2
ANM	2
Lab Technician	1
Lab Assistant	1
Radiographer	1
Assistant Radiographer	1
Medical Recorder	1
Administration Assistant *(Subbha)*	1
Administrative Assistant *(Kharidar)*	1
Peon/Sweepers/Guard	11

An outline of the services included in the Essential Health care services package and which levels/facilities they are provided at. (The Jan 2003 'Essential Health Care Services in Nepal: service models, programmatic needs and costs' is a good report which gives most of this information).

The services included in the Essential Health Care Services package are grouped under four categories:

1. Reproductive health (family planning, Safe motherhood and new born care
2. Child health (integrated management of childhood illnesses, immunisations, Vitamin A, other nutrition programme)
3. Communicable disease control *(Tuberculosis, Leprosy, HIV/AIDS STDs, Victor borne diseases)*
4. Outpatient Services (i.e. other infectious diseases)

Implementation of the services:

a. **At the community level,** most health services are provided either by community health volunteers or the VDC health facility (either as outreach or within the facility). The most prominent community worker is the Female Community Health Volunteer (FCHV). FCHVs were first recruited in the 1980s from among mother's groups organisation at the ward level. Subsequently some districts have increased the numbers of FCHVs on a per population basis and about 47,000 are registered. At first FCHV activities were limited to health promotion activities through monthly mother's group activities, distribution of ORS and family planning supplies, and minor first aid. In the 1990s FCHVs were retained to provide twice yearly vitamin A distribution to children 6 months to 5 years. In 21 districts FCHVs have been further trained to provide community based treatment of uncomplicated pneumonia. FCHVs have been used on a pilot basis for a variety of other health programmes. FCHVs are not paid, but receive a small allowance for twice-annual refresher training (two days each time). They may also receive allowances for special activities, such as polio, campaigns. VDCs have been encouraged to provide support to FCHVs of various sorts, including the establishment of endowment funds to pay minor expenses.

Other community workers include trained traditional birth attendants (TTBAs) of which 15,000 are recognised by the public health system. They receive no public payments, but have been included in training in the past and are active in some health programmes. The malaria control programme has recruited Passive Case Detection (PCD) volunteers to collect blood slides from persons with fever, but this programme is relatively inactive at present.

b. **At the SHPs**, which have four staff position

An Assistant Health Worker (AHW) is generally in-charge and responsible for in-facility curative care and family planning services.

A Village Health Worker (usually male) is responsible for immunisation and other outreach activities.

A Maternal and Child Health Worker (MCHW) is responsible for maternal care, including home deliveries, outreach family planning services and assisting with other outreach activities. Both the VHW and MCHW supervise the FCHVs.

Finally, a Peon is hired for housekeeping and administrative tasks. In practice, there can be considerable cross coverage of responsibilities. For example, it is not uncommon for experienced peons to provide curative care either assisting the AHW or on their own.

c. **At the Health Post level**, the staff allocation increases to seven

Curative care is provided by two staff, including a Health Assistant and an AHW, the VHW is the same as in the SHP, the MCHW is replaced by an Assistant Nurse Midwife (ANM), and there is one administrative clerk and two peons. Health posts provide a similar range, but higher level of services as a SHP, and are meant to serve in a supervisory and referral relationship to the SHP. In practice, most supervision is from the district level and most patients needing referral prefer to go directly to a private provider or the district level. Both SHP and HPs tend to have minimal diagnostic equipment and no laboratory services.

d. At the Primary Health Care Centre

In one VDC per electoral constituency for the national parliament the HP has been upgraded to a Primary Health Care centre (PHC), some of which are referred as a Health Centre (HC). The PHC has allocation for 14 staff including one Medical Officer (physician) and one staff nurse and a lab assistant. Most PHCs also have a small number of inpatient beds, primarily for normal deliveries (although a few provide basic emergency obstetric care services). In terms of public health and outreach activities, the PHC serves the same functions as lower level facilities. PHCs do have laboratories and so can serve as diagnostic centre (e.g. for tuberculosis).

e. The District Public Health Office

At the district level there is a District Public Health Office (DPHO) of variable size. The DPHO is responsible for planning, monitoring and supervision of all lower level public health facilities. There are 12-20 technical staff per DPHO, 3-10 administrative staff and 4 or 5 support staff, including a driver for most districts. The DPHO has no direct

service responsibilities but does serve as the reference laboratory for tuberculosis and malaria slides.

All but five districts have either a district hospital (66) or a higher level zonal/regional hospital (12) or receive hospital services through an NGO hospital (2). Hospitals vary considerably in size and staff, with some providing only minimal inpatient services, while others are large referral centres. Standards for district hospitals include two to three doctors, tow to nine staff nurses, and provisions for laboratory, radiology, pharmacist and sometimes dental services. There are 2 to 6 ANMs and a similar number of AHWs, along with administrative and support staff for a total of 23-46 persons. Zonal hospitals are larger. Hospitals are not administratively under the DPHO, but in many cases the Medical Superintendent of the district hospital is also the District Health Officer, aiding in coordination.

Devolution of the Sub-health post to Village Development Committee (VDC)

A detailed programme of phase-wise implementation has been developed to devolve sub-health post (SHP) management to the village development committees (VDCs). Keeping in view the current on-going conflict in the country, 12 districts for SHP-handover and orientation were identified to be covered by the end of June 2003. These districts incude Kaski, Jhapa, Rupandehi, Morang, Bhaktapur, Chitwan, Sunsari, Mahottari, Bhanke, Kapilvastu, Kanchanpur and Lalitpur. The handover and orientation process has been initiated according to the guidelines and directives developed by the MoH.

A two-day orientation package to the staff and SHP management committee members were organise on-site for each of the SHPs. The Director of the National Health Training Centre (NHTC), Department of Health Services was given the responsibility for managing the devolution process. In coordination with External Development Partners, the MOH developed the guidelines for handover, as well as, an orientation manual that explains new roles and responsibilities.

To support the implementation process different donors working in different districts of Nepal, in the health sector took up the responsibility to provide financial and human resource assistance and launching programme. The programme was aimed at management capacity building of counterparts – District Health Offices and District Level Health Facilities in the selected districts. The goal of the programme was to provide better health outcome to the target population through efficient management of available Human, Physical and Financial resources.

Source: different sources