Effectiveness of Health Service Delivery by Local Government

(A Study of Chhatrakot Rural Municipality, Gulmi District)

A Thesis Submitted to the Tribhuvan University, Tri-Chandra Multiple Campus, Department of Rural Development for the Partial Fulfillment of the Requirements for the Master Degree of Arts in Rural Development

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Effectiveness of Health Service Delivery by Local Government (A Study of Chhatrakot Rural Municipality, Gulmi District)

Submitted By: Rudra Hari Puri

Declaration

I, Rudra Hari Puri declare that I had personally out the all the works depicted in the dissertation "EFFECTIVENESS OF HEALTH SERVICE DELIVERY BY LOCAL GOVERNMENT (A Study of Chhatrakot Rural Municipality, Gulmi District)" has been undertaken by me for the award of the master's degree in Rural Development. All the primary data were collected in Chhatrakot Rural Municipality, Gulmi. I have completed this study under the guidance of Mr. Madhab Prasad Neupane, Lecture of Tri-Chandra Multiple Campus.

I also declare that no part of this dissertation has been submitted for the award of any other degree or diploma prior to this date.

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Letter of Recommendation

This is to recommend that Mr. Rudra Hari Puri has carried out research entitled "**Effectiveness of Health Service Delivery by Local Government (**A Study of Chhatrakot Rural Municipality, Gulmi District**)"** for the award of Master of Arts in Rural Development under my supervision. To my knowledge, this work has not been submitted for any other degree. He has fulfilled all the requirements laid down by the Tribhuvan University, Central Department for the submission of the thesis for the award of master's degree.

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Letter of Approval

This is to certify that the thesis submitted by Mr. Rudra Hari Puri entitled **"Effectiveness of Health Service Delivery by Local Government (**A Study of Chhatrakot Rural Municipality, Gulmi District**)**" has been approved by this department in the prescribed format as partial fulfilment of the requirements of the Master of Arts in Rural Development.

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Rudra Hari Puri

Abstract

With the implementation of the new constitution and restructure of the nation, public expectation was high regarding development, service delivery and in good governance. It has been almost a decade of the implementation of the constitution and almost 9 years of formation of the local level. All the Local levels had already completed their one full tenure successfully they are growing mature day by day and their function is also getting more effective day by day. Basic Health service is one of the major rights which comes under the jurisdiction of the local level. Local level can formulate, implement and monitor both policies and program regarding basic health, sanitation and nutrition. In doing so Chhatrakot Rural Municipality is doing good in health service delivery but there are some areas to improve in it. It shows the people with low income and minorities they greatly depend on public health service for their well-being. But major challenge to get the health service is still transportation, geological barrier, low income, and quality of the service are also the subject to think upon it. It needs inclusive and targeted health care policies to address socio-economic inequalities and health education and awareness program for marginalized group to ensure equitable and effective health service delivery. To improve the quality of health service and to reach out to the targeted people it needed the strengthening healthcare infrastructure, addressing socio-economic barriers, and tailoring programs to the unique needs of the diverse community.

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Acronyms

APM	: All Party Mechanism
BHCS	: Basic Health Care Services
CA	: Constitutional Assemble
HIV	: Human Immune Deficiency Virus
LDO	: Local Development Officer
NGOs	: Non-Governmental Organization
PHC	: Primary Health Center
SHSS	: Social Health Security System
TB	: Tuberculosis
UHC	: Universal Health Coverage
UNICEF	: United Nation Children's Fund
VDC	: Village Development Committee
WHO	: World Health Organization

Chapter I

Introduction

1.1 Background of the Study

In the realm of health service delivery, local governments play a crucial role, particularly in decentralized systems. Internationally, countries that have adopted decentralization, such as Brazil and Sweden, demonstrate that local governance can significantly enhance the accessibility, quality, and responsiveness of healthcare services. Decentralized health systems allow for local authorities to tailor services according to the specific needs of their populations, fostering community participation and accountability. The effectiveness of locally run programs is demonstrated by Brazil, where the Family Health Strategy, which is run by municipal governments, has significantly improved healthcare access for marginalized groups (Macinko & Harris, 2015). Sweden, known for its strong welfare state, gives towns responsibility for healthcare, which leads to more effective and fair service delivery (Saltman & Bankauskaite, 2006).

However, having sufficient financial and technical resources is crucial to local governments' ability to provide health services successfully. For instance, municipal governments in South Africa frequently have capacity constraints and little resources, which makes it difficult for them to efficiently oversee public health services. Therefore, in order to ensure that local organizations are empowered to satisfy the health requirements of their communities, it is vital to provide resources and support mechanisms in addition to delegation of authority (Ataguba & McIntyre, 2012).

In South Asia, a complex interaction of institutional, sociopolitical, and economic factors frequently shapes how well local governments deliver health services. Primary healthcare is a responsibility of local governments as part of decentralization initiatives, especially in nations like Bangladesh, Pakistan, India, and Nepal. However, because of differences in local competence, governance, and resource allocation, these projects' performance differs by region. Research indicates that regions with robust local government institutions and high levels of community involvement typically provide better health care. This is especially noticeable in areas where local governments

collaborate with civil society organizations and non-governmental organizations (NGOs) to fill staffing and infrastructural shortages. In Nepal, for example, the use of participatory planning procedures by local governments has enhanced the delivery of health services in rural regions by incorporating local requirements into service supply plans (Shrestha & Bhattarai, 2020). However, issues including political unpredictability, corruption, and a lack of accountability continue to be major obstacles to maximizing the provision of local health services throughout the area (Rana, 2019).

Local government is defined as rural municipalities, municipalities, and district assemblies, according to Nepal's 2015 Constitution (Article 56). Local government refers to government bodies that are elected by the people and have administrative, legislative, and executive powers over the areas that they rule's aspirations for a better living, such as better health facilities, better educational institutions, and luxury, as well as prospects for higher income, the government's involvement has grown (Aurora, 2016). In other words, local government is the government of a specific local area constituting a subdivision of a major political unit whereas local governance is the set of institutions and mechanism regarding the process of planning, implementing, maintaining, evaluating and monitoring the affairs that have an impact on local population (Adhikari, 2021).

In the twenty-first century, in the setting of developing countries such as Nepal, the government's role has grown and become increasingly important in working for the people's welfare. As a result, local governance in all nations, developed and developing, is being reinforced. Economically, all human actions can be divided into two categories: consumption and output. These consumption and production activities represent progress. The local government is better suited to deal with such operations.

Public Service Delivery is the mechanism through which public services are delivered to the public by local, municipal, or federal governments. Public education, health services, sanitation Service and Safe drinking water are some of the examples of public services. Health is an indispensable requirement of human life. The capability, contributions, and motivation of local frontline service providers have a significant impact on the efficiency of public service delivery. In Nepal, a combination of de-concentrated line agencies and local entities at the district, municipal, and village level give inputs that are then translated into the delivery of service outputs and outcomes

(World Bank, 2014).

Local service delivery, which is a separate area of public policy, is the provision of public services at the local level. Local service delivery has several difficulties, such as expertise issues, direction issues, and the presence of economies of scale. Local governments have the potential to be more reflective of local needs and interests and a major source of innovation in government processes ("Local Service Delivery," 2021). Innovative government can be sparked by local government. Local service delivery is particularly diverse because there is constant competition between local governments and because of their sheer size. Innovative ideas can proliferate and eventually find their way into other levels of government due to networks that enable limited policy learning between local governments.

With the adoption of a new Constitution in 2015, Nepal formally adopted federalism, rebuilding the country into a federal government, seven province governments, and 753 local governments, including 293 urban municipalities and 460 rural municipalities. Health is a fundamental right, according to the Constitution, and public health is a concurrent function of all three levels of government. The Constitution also gives each level of government certain public health obligations and power. If their area's minimum yearly income is two million dollars and the settlement's total population is 20,000 people, the government can declare it Municipality. Villages are diverted into municipalities in this manner.

Health Service Delivery is a major factor of public service delivery at the local level. So, there is a saying that health is wealth. Rural Local Health Services - A focal point and concerted effort to identify challenges specific to rural areas where solutions bring about adjustments and reforms to improve and enhance rural residents' access to healthcare. As marginalized people live in rural areas or remote areas, all the people can access health service delivery equally when local health services are provided by local government through decentralized system.

This study was focused only on the effectiveness of local health services delivery by local government in Nepal. The study areas chosen because of researcher's convenience. The perception analysis done on these areas might not represent the entire national state.

1.2 Statement of the Problem

Despite the local government expanding structural and administrative services to make health care accessible and affordable, there are still widespread health problems. The Nepalese government, in collaboration with development partners in the health sector, has recognized the need to improve the health of the country's majority poor people. Prior to 2015, the Ministry of Health (Immaculate, n.d) controlled post-independence health services centrally. The transfer of authorities and responsibilities to lower levels has resulted in a shift in work mindset and culture, management, and organizational setup (Azfar et al, 2012). The Interim Constitution of Nepal, adopted in 2007, recognizes health as a fundamental right, declaring that every individual has the right to free basic health services. However, the truth is rather different. Only 61.8 percent of Nepalese families have access to health facilities within 30 minutes, with considerable differences between urban (85.9%) and rural (59%) areas (Mishra et al., 2015). Although there have been some structural and administrative changes in the health sector in Nepal since the formation of local government, some issues still remain which are as follows child hood disease, water and sanitation, maternal and perinatal health problems, sexual transmitted disease and other pandemic disease, epidemic/pandemic and zoonotic disease, non- communicable diseases, natural disaster, substance use disorder, disparity in health system and mental health problems etc. (Ghimire.,2019).

There is a large backlog on public health services, including as personal cleanliness, health education, medical and dental care, tuberculosis (TB) and related opportunistic diseases, and the rearrangement of family roles and duties, because of many years of civil strife and neglect. These health problems in many areas raise a slew of demands and expectations in a decentralized health-care system in terms of quality and scope of services supplied by existing health-care institutions (Barringston, 2015). The expansion of the Social Health Security system (SHS) should coincide with the strengthening of the health-care system. Improving hospital efficiency, engaging health staff, and using proper technology can all help to improve the quality of health care Also, because a constitution is presently being drafted, considerable preparation and consideration regarding what insurance system would best suit Nepal's projected

future federal structure is required.

Research Questions

- How do local health services impact on public health outcomes?
- How equitable is the distribution of health care services across different demographics?
- What are the challenges faced by the local governments in Nepal encounter in delivering effective health service?

1.3 Objectives of the Study

The general objectives of the study are to examine the Effectiveness of Health Service Delivery of Chhatrakot rural municipality, Gulmi, Nepal.

- To assess the impact of local health services on public health outcomes.
- To explore the social equity of healthcare service delivery across different demographics.
- To identify the challenges faced by local governments in delivering effective health service.

1.4 Significance of the Study

Researchers and students performing academic research in the areas of local government and health service delivery may find the study to be sufficient. It may also provide information to residents of Chhatrakot rural municipality who are either clients/beneficiaries of services, or employees of the Local Governments, regarding the degree of Health Service Delivery they get.

On a national level, research findings could be used to support policy formulation and the development of an institutional regulatory framework for effective health service delivery in local governments. A number of local governments may implement the recommendations made and use the findings to address challenges related to Local Government and Health Service Delivery at the local level.

Furthermore, the findings may be used by the central government to regulate the activities of local governments in order to ensure that they are carried out effectively, and the public may use the study to determine how well their local governments are performing the required health service delivery.

1.5 Organization of the Study

On the basis of its content, information and material, this study is reported into six chapters. The aim is making report reader friendly, convenience and more systemic. The first chapter introductory part of the study deals background of the study, statement of the problem, objectives of the study, significance of the study, limitation and delimitation of the study and organization of the study. The second chapter deals with literature review. It deals with concept of local government and health service delivery, empirical review and conceptual framework of the study. Similarly, third chapter deals with research methodology. More specially, this chapter presents: research design, nature and source of data, rational for the selection of the study area and rapport build up, universe and sampling procedure, data collection procedure, tools and techniques of data collection, reliability and validity, ethical consideration and method of data processing, analyzing and presentation. The fourth chapter includes presentation, interpretation, and analysis of the collected data. The Fifth chapter includes the summary and conclusion.

Chapter II

Literature Review

2.1 Historical Aspect

2.1.1 Global history

Local governance in the United Kingdom and Germany has traditionally been referred to as "local self-government." "Municipalities shall be allowed the power to regulate all local issues on their own responsibility, within the limits provided by the legislation," according to the Basic Law (Germany's constitution) (Britannica, 2017) Local government's importance has been recognized throughout history in Western Europe, the United Kingdom, the United States, and Russia. This understanding is the result of a long-term evolution of parish and town life that began even before the modern state developed between the 15th and 17th centuries. Although Americans frequently refer to three "levels" of government, the US Constitution only acknowledges two: the federal government and state governments.

The Primary Health Care Approach (PHC) was introduced by the World Health Organization (WHO) in 1978 as a strategy of reaching health for all by the year 2000. As a result, a number of developing-country governments have taken unprecedented moves to restructure their whole administrative systems, laying the legal and administrative groundwork for the transfer of primary health-care delivery to local governments and other decentralization (WHO, 1997).

2.1.2 Internal history

Nepal’s health service history dates to the Lichhavi period (approximately 400– 750 CE), during which traditional Ayurvedic medicine was the primary form of healthcare. Historical records indicate that rulers and elites supported the establishment of basic health facilities, such as Ayurveda Aushadhalayas (Ayurvedic dispensaries), and the practice of traditional healing methods like herbal medicine and spiritual healing. Temples and monasteries often served as centers for treatment, blending religious rituals with medical practices. However, healthcare remained accessible mainly to the privileged, leaving large segments of the population dependent on indigenous

knowledge and local healers (Bajracharya, 1984).

The modernization of Nepal's health system began during the Rana regime (1846–1951), with the establishment of Bir Hospital in 1889 as the first formal medical institution. After the political change in 1951, efforts to improve public health accelerated, including the expansion of primary healthcare services and the establishment of health posts across rural areas. The Alma-Ata Declaration of 1978 heavily influenced Nepal's focus on primary healthcare, emphasizing accessibility and equity. More recently, federalism has brought transformative changes, granting local governments the authority to manage health services. Despite significant progress, challenges such as geographical barriers, resource limitations, and socio- economic disparities continue to impact the effectiveness of healthcare delivery in Nepal (Adhikari & Sapkota, 2021).

Starting with ayurvedic medicine and progressing to modern allopathic treatment, Nepal's health system has evolved from ancient times to modern times. The first National Health Policy was authorized and implemented in 1991, with the goal of establishing one modern health-care facility (primary health centers and sub-health posts) in each of the 4000 municipalities or village development committee (Marasini, 2020). Over the last several decades, Nepal has made substantial progress on health indicators [1]. Globalization in health, including economic development via-a-viz strengthening of primary (mainly peripheral) health care (PHC) system, particularly through investments to construct health care infrastructure, was responsible for the spectacular success in health indicators. PHC services have been available in Nepal since 1978, via a district and distal network that reaches out to the communities served by health posts and sub-health posts. Nearly 50,000 Female Community Health Volunteers have been mobilized at the community level across the country. In Nepal, a broad network of PHCs has made significant progress, much of which is reflected in millennium and sustainable development target indicators (B. Adhikari et al., 2022). The Nepalese government has achieved great success in lowering maternal, under-five, and infant mortality rates over the last few decades. With the eradication of polio, maternal and neonatal tetanus, and leprosy, Nepal was able to arrest and reverse the trends of tuberculosis, HIV, and malaria throughout the same time. In 2016, for example, newborn and child mortality rates fell from 46 to 32 and 54 to 39 per 1000

live births, respectively, over the previous five years. Despite this improvement, ensuring equitable healthcare access remains a serious concern. Nepal intends to

achieve universal health coverage as soon as possible (UHC). Nepal's National Health Policy (2014) 6 intends to increase access to high-quality, equitable health care by making basic healthcare services (BHCS) free of charge and covering non-BHCS through social health insurance. This goal is represented in policy documents such as the Nepal Health Sector Strategy 2015-2025, which specifies four strategic directions: health system reform, equal access, enhanced service quality, and multi-sectoral approaches. (Thapa et al., 2018).

Local elections were held in three parts for 753 local units across Nepal's 77 districts 283 in the first phase, 334 in the second phase, and 136 in the third phase. Elections for the first phase were held on May 14 in Provinces 3, 4, and 6, covering 34 hill and mountain districts; the second phase was held on June 28 in Provinces 1, 5, and 7, covering 35 districts; and the third and final phase was held on September 18 in Province 2, covering 8 Tarai districts. Six metropolitan cities, 11 sub-metropolitan cities, 276 municipalities, and 460 rural municipalities were among the 753 newly constituted local units. According to ECN, a total of 148,981 candidates ran for the 35,221 positions that were up for election.

To better the delivery of health services to Nepalese citizens, the country's governance structure was modified from centralized to decentralize. To increase efficiency, accessibility, effectiveness, quality, and equity, Nepal has established a new decentralized municipal-based health service delivery system. Nepal's health infrastructure and development guidelines 2074 divide health service providers into five categories: Primary hospitals; Secondary hospitals; Tertiary hospitals; Academic or Super specialty hospitals; Community level (Health post or Community health units); Primary hospitals; Secondary hospitals; Tertiary hospitals; Academic or Super specialty hospitals (Khanal et al., 2021).

2.2 Theoretical Aspect

2.2.1 Decentralization and Public Service Delivery

The concept of local governance encompasses institutional networks, interactions, collaborations and collective action in enhancing democratic practices at the local level

are inevitable (Kharel, 2018). Local government is defined as government bodies that are elected by the people and have administrative, legislative, and executive powers over the territory they rule. According to Aijaz (2007), local government is a branch of a country's government that deals primarily with problems or difficulties affecting a specific population inside a certain territory. This is done mostly in accordance with the obligations of a country that parliament decides to assign to local governance through laws.

While (Lockard, 1963) considers the local government to be a public entity with the authority to develop and implement public policies within a defined territory, the latter is a division of the federal government. In truth, municipal government is a public organization, as opposed to a private one, and it is focused on the general welfare of citizens. According to Stones (1968), local government is an aspect of a country's governance that deals with population concerns or challenges within a certain territory or location. According to him, this type of government takes care of the "housework" so that inhabitants can afford to live in these locations. It accomplishes this by maintaining clean roads, providing education for children, and constructing residential homes, among other things.

During the postwar period, both developed and developing countries, particularly during the 1960s and 1970s, there was a strong centralization of government policies and functions in both developed and developing countries. The concept of people's participation played an essential role in the development of decentralization and local governance, as development theorists and practitioners began to explore for alternatives to a centralized state. In the late 1970s and early 1980s, local government became a popular topic of discussion. As a result, as seen in Asia, Latin America, and Africa in the 1970s, attention shifted away from the central authority and toward the local authority (Shah, 1999).

Decentralization: The logic of decentralization is founded on a compelling concept. Simply put, properly formed and managed smaller firms are intrinsically nimbler and more accountable than larger organizations. The potential of developing more locally controlled, locally responsible institutions has considerable appeal in a world where giant corporations control vast swaths of both public and private sector activities. Even Max Weber, the German sociologist at the turn of the twentieth century who originally

articulated the key characteristics of the bureaucratic model and who regretfully decided that bureaucracy was unavoidable inhuman organization, yearned for the benefits of decentralization. He said that "the only alternative to bureaucracy is a return to small-scale organization" (Weber 1947).

De-concentration: This is the transfer of authority and responsibility from central agencies to field offices of those agencies at a variety of levels regional, provincial, state, and or local. This is a limited form of Decentralization that only marginally may increase local responsiveness of health services and still retain health staff within the overall central civil service (Mushemeza, P. D., 2003).

Delegation: This is the transfer of authority and responsibility from central agencies to organizations not directly under the control of those agencies. (Naidoo, J. P., 2002) In the health sector this typically include semi-autonomous entities such as health boards, hospitals as well as arrangements whereby non-governmental organizations undertake certain service provisions on behalf of the central government (such as implementation of primary health care campaigns).

Devolution: This is whereby authority, responsibility and resources are transferred from central government agencies to Local Governments. Local Governments will have multiple functions, legislative and revenue raising powers and be responsible to a locally elected council. (Nishimura, M., Y. Takashi, and S. Yuichi. March 2008). Devolution is therefore a form of Decentralization that holds the greatest potential benefits in terms of increasing local responsiveness of health planning and cross sectoral integration.

Local Government: An administrative body for a small geographic area, such as a city, town, county, or state. A local government will typically only have control over their specific geographical region and cannot pass or enforce laws that will affect a wider area. Local Governments can elect officials, enact taxes, and do many other things that a national government would do, just on a smaller scale (Cooke & Kothari, 2014).

2.2.2 Decentralization in Health

Health Service Delivery: Moving towards universal health coverage requires health service delivery systems that are safe, accessible, high quality, people-centered, and

integrated. Patients, persons, families, communities, and populations in general are served through service delivery systems, which are responsible for providing health services such as pharmaceuticals to patients, persons, families, communities, and populations in general (Conning & Kevane, 2015).

To deliver continuous and coordinated people-centered care, health care today operates in a fragmented environment that must adapt to rapid change. Public demand for access to and usage of new technology, drugs, and care models is growing, as are public expectations for quality and safety (Health Services Delivery, n.d.).

Decentralization, according to Banting K and Corbett S (2002), also fosters the development of managerial personnel. This gives personnel or administrators a lot of exposure, which allows them to grow and develop themselves. As a result, the more talented and capable people learn, improve, and qualify for higher managerial positions within the district, which improves performance and contributes to Health Service Delivery. This is because a decentralized administration structure allows employees to experiment with new ideas, methods, or approaches, resulting in higher levels of employment and, as a result, improved Health Service Delivery (Leite et al., 2011).

P. Khaleghian (2003) emphasizes that local government service delivery facilitates faster and better decision-making. Because decisions do not need to be referred up the hierarchy, lower-level decisions can be made faster and more effectively. Because divisional leaders are held accountable for the impact of their actions on earnings, they are incentivized to make decisions that maximize profit. As a result, decentralization allows concerned individuals to make swift, result-oriented decisions, and it also aids administrators in raising literacy levels in their communities by implementing progressive educational programs.

Decentralized administration, according to Dolores Jimdnez 1, (2005), boosts motivation. Social scientists have discovered that the organizational structure influences the motivation of those who work inside it. An organizational structure that allows delegation, collaboration, and involvement also motivates managers to work more efficiently, resulting in improved Health Service Delivery

Decentralization in the context of health within a welfare state refers to the process of transferring decision-making authority I resources responsibility from central to load

government institution. The aim is often to improve the efficiency, equity, and responsiveness of health services by aligning them more closely with local needs. welfare states typically focus on resuming universal access to health and other social services, so decentralization. Con be a means of enhancing public welfare by allowing for mere tailored region-specify approaches. (Bossart, 1998),

According to Bossert (1998), decentralized health systems allow for greater "decision space," which can enhance innovation and performance in service delivery. However, challenges such as inequitable resource distribution and insufficient capacity often limit the effectiveness of these systems. Local governments play a critical role in delivering health services, particularly in decentralized systems. Decentralization enables decision-making authority and resource allocation at a local level, fostering region-specific solutions that align with the needs of communities.

Universal access to basic services, such as healthcare, is emphasized by the welfare state model. Esping-Andersen's (1990) welfare state typology divides systems into three groups: liberal, conservative, and social-democratic. Each group has a distinct approach to health care. Universal and equitable health care is a top priority in social-democratic welfare governments, and it is frequently accomplished with strong public administration and finance. In this situation, decentralization can be a tool to improve health care' equality and responsiveness.

Decentralization has been shown to increase responsiveness and accountability (World Health Organization [WHO], 2008). However, effective monitoring systems and sufficient capacity-building at the local level are necessary for its effectiveness. While decentralization has, in certain places, increased access to health care, studies conducted in Nepal (Adhikari & Supakankunti, 2018) indicate that socioeconomic and geographic discrepancies still exist.

Addressing health disparities, especially in areas with underserved populations, requires the involvement of local governments. The objectives of fairness and inclusivity in health care delivery are in line with welfare state ideas, which place a strong emphasis on focused interventions for underprivileged populations. According to Navarro and Shi (2001), welfare states with robust redistributive policies have superior health equity results.

Studies in low-income countries reveal mixed outcomes of decentralized health systems. A comparative analysis by Brinkerhoff and Bossert (2008) found that while decentralization improves community participation and local accountability, weak institutional frameworks can undermine health outcomes.

Objectives, Rational and Controversies of Health Decentralization

To improve technical efficiency through fewer levels of bureaucracy and greater cost consciousness at the local level and through separation of purchasers and provider functions in market-type relations. May require certain contextual conditions to achieve it Incentives are needed for managers Market-type relations may lead to some negative outcomes.

To increase allocative efficiency through better matching of public services to local preferences and through improved patient responsiveness. Increased inequalities among administrative units and tensions between central and local governments and between different local governments.

To empower local governments through more active local participation and through improved capacities of local administration. Concept of local participation is not completely clear, and the needs of local governments may still be perceived as local needs.

To increase the innovation of service delivery through experimentation and adaptation to local conditions and through increased autonomy of local governments and institutions. Increased inequalities shown as controversy.

To increase accountability through public participation and transformation of the role of the central government. Controversy- concept of public participation is not completely clear Accountability needs to be clearly defined in terms of who is accountable for what and to whom.

To increase equity through allocating resources according to local needs Through enabling local organizations to better meet the needs of particular groups and through distribution of resources towards marginalized regions and groups. Reduces local autonomy Decentralization may improve some equity measures but may worsen others

is raise as controversy. (Source: Richard et Al, 2007)

2.3 Policy Review

2.3.1 International Policy on Public Health Service

Internationally, there has been an increase in interest in and dedication to basic health care, which got its start at the WHO/UNICEF International Conference on Primary Health Care in Alma-Ata in 1978.

A significant advancement in global health policy during the past 20 years has been the establishment and expansion of the field of global health law. Although the area of global health law is active and expanding, it still focuses mostly on domestic and national public health issues (Taylor, 2017). The international community pledged to end extreme poverty and enhance the health and wellbeing of the world's poorest people within 15 years in 2000. The Millennium Development Goals, which are eight time-bound objectives, are a result of the promise made in the Millennium Declaration (WHO, 2005).

2.3.2 Health Service Delivery related Policy in Nepalese Aspect

Since 1990, different social and political organizations in Nepal have pushed for state restructuring in order to address diversity and development at the lowest levels of administration. Among them are the Maoist insurgency (1996-2006), the Second People's Movement (2006), and the Madhesh movement (2007). As a result, the Constituent Assembly (CA) was established to oversee the restructuring of the state. CA promulgated the Constitution in 2015 after a long deliberation. It declared Nepal a "federal democratic republican nation," and the country adopted a federal political system with three levels of government: the Federation, Provinces, and Local Government (Chaudhary, 2019). According to Baral (2004), Nepal's democratic leadership have failed to meet the demands and expectations of the people since 1990. However, the current political structure is new to Nepal, and while it is quick to blame local levels for the slow pace, its initial voyage is not satisfying the public.

The constitution of kingdom of Nepal 1990 has recognized decentralization as a means to ensure optimum involvement of the local people in local governance for well-functioning (Sharma, 2017). Decentralization was recognized in the Kingdom of

Nepal's constitution of 1990 as a strategy of ensuring maximum participation of local people in local administration for the country's well-being (Sharma, 2017, cited in kharel, 2019).

Health institutional Status of Local Government

There are 3808 health posts, 11974 PHC-ORC, 15835 EPI-ORCs and 52420 FCHVs in Nepal and many more CBO/Pharmacies/Local NGOS/clubs (Adhikari B, 2021). National Health Policy, 2019 (2076)

The Government of Nepal disclosed its intentions, policies, and strategies for improving health services in the country by releasing its ambitious National Health Policy 2076 BS (2019 AD). To strengthen the health sector, the national health policy comprises six goals, 25 policies, and 146 strategies. The National Health Policy, 2019, was developed based on the constitution's list of exclusive and concurrent powers and functions at the federal, state, and local levels; the government of Nepal's policies and programs; Nepal's international commitments made at various times; and the health sector's problem challenges, available resources, and evidence (public health update, 2020).

2.4 Empirical Review

2.4.1 Empirical Review: International Context

Agrawal (1999) found out that the majority of poor people are quick to demand involvement, but when it comes to finance, they still expect a donor or the government to cover the entire cost. People's taxes are how the central government is funded. However effective and efficient a tax system may be, it will not be able to generate sufficient income if it is levied on an impoverished population. A hungry person can only milk a hungry cow so much before they get too ravenous. The primary issue with most African societies is that they are doubly weak. Additionally, their private and civil society sectors are weak (vertical and horizontal weakness), which is reflected in their weak central and municipal administrations. In addition to 22 resources (human, material, and financial), this twofold deficit also affects institutions, systems, information, networking, skills, knowledge, and other factors (Agrawal 1999).

2.4.2 Empirical Review in the context of Nepal

Adhikari (2006) researched "Towards Local Democracy in Nepal," focusing mostly on the topic of district planning decentralization. He has grasped the decentralization and planning process theoretical framework. It has only touched on the revenue and expenditure responsibilities of local governments in general, as well as district development committees in particular. Local government groups such as ADDCN, NAVIN, and MUAN have played an important part in Nepal's decentralization movement, according to the report. In addition, the research investigated and studied the elements that influence successful district-level planning, participation, decentralization, and development management.

Kharel (2018) has analyzed public service delivery of local government, in terms of service delivery, the current state of local government is illegal, incomplete, and dysfunctional. Political instability and reluctance to hold municipal elections are the biggest obstacles. The general public's perception of government service is unsatisfactory. The dominance of the All-Party Mechanism (APM) and the absence of elected representatives, low representation of women and Dalits in decision-making bodies, overburdened office bearers: VDC secretary and LDO meaningless devolution, conflicts in the formation of user's committees, and elite domination are the major issues that must be addressed as soon as possible at the execution level. Contractors are used, there is a scarcity of technical experts, there is no oversight or monitoring, projects are incomplete and of poor quality, there is no repair and maintenance, the grant amount is increased without institutional capability, and there is a reliance on central grants. A Local Election is extremely important from a policy standpoint.

Bhattarai, (2013) found out that many nations are currently reforming their health care systems to increase efficacy and efficiency. Through an operational strategy and a program-implementation plan (2004–2009), Nepal started the reform of its health sector. The main goal was to create a health system that was effective and equitable while also achieving the millennium development goals. Although the government is now working on Nepal Health Sector Program II (2010-2015), the questions of equity and efficiency have not yet been resolved. The goal of the current study was to compare the maternal health program's efficiency and equity before and after the health sector reform. Effective decentralization, personnel fulfillment by include members of

marginalized and racialized populations, and improved equipment and medication procurement in healthcare facilities. The study urges additional investigation into the widening disparity in service access between the poorest and wealthiest populations, despite free services and financial incentives. The report also suggests that efficiency studies be conducted at various levels of health institutions and that efficiency-affecting aspects be looked at.

This study in tittle “Health Service Delivery of Local Government” try to explore the infrastructure condition of health sector, health service delivery practices and impact on service receiver and constraints and challenges of local government on service delivery. I hope this study helps to the knowledge level, practices level and policy level.

Chapter III

Research Methodology

3.1 Selection of the Study Area

Chhatrakot Rural Municipality was selected as the study area for its cultural richness, cross-border characteristics, and diversity in healthcare infrastructure. This rural municipality, inhabited by Brahmin, Kshetri, Magar, Newar, Dalit, and minority castes such as Kumal, Bote, Majhi, and Muslims, presented a unique setting for research. It had 49 schools—42 community and 7 institutional. Among them, 9 were secondary-level schools (8 community and 1 institutional), while the rest were at the basic level. After distributing 12 quotas in the previous fiscal year, there were 41 child development centers (39 school-based and 2 community-based), along with 4 community learning centers. All wards were equipped with health posts, and there was also one private health center.

Geographically, Chhatrakot was bordered by Rurukshetra Rural Municipality to the east, Gulmi Darbar to the west, Satyawati and Chandrakot to the north, and Chhatradev (Arghakhanchi) and Rainadevi (Palpa) Rural municipality to the south. The area covered 87.1 sq. km and had a population of 19,357 as per the 2078 census. It ranged in altitude from 579 meters at Manbhak of Kharjyad to 1676 meters at Kotdanda of Pallikot, with the rural municipality office situated at 1555 meters (28.0065° N, 83.34603° E). With 7 health posts, 5 basic health centers, and 1 urban health center, the area provided significant insights into health service delivery, social equity, and governance challenges.

3.2 Research Design

The research design described the methodological approach adopted to answer the research questions and address the study objectives. Based on the research philosophy and paradigm, both quantitative and qualitative approaches were used, employing survey methodology. The study focused on the effectiveness of local government service delivery in the health sector within Chhatrakot Rural Municipality. As the study relied on data collected from the field and presented descriptively, it adopted a descriptive research design combining both qualitative and quantitative data.

3.3 Source and Nature of Data

The study used both primary and secondary data. Primary data were collected using a self-administered questionnaire completed by respondents. These data were essential in addressing the core study variables. Secondary data were obtained from official documents, previous studies, publications on decentralization and health service delivery, and relevant information from the internet. The combination of qualitative and quantitative approaches supported a comprehensive understanding of the research topic.

3.4 Population and Sample Size

The study population comprised healthcare service recipients registered in the main record book of the health post in Ward No. 1-6 over one month. A total of 5000 people received services during that time and were considered the population of the study. From this, a sample of 25 individuals was drawn using stratified random sampling based on age, religion, and caste, ensuring representation from diverse socio- economic backgrounds. Number of respondents on the base of age group, religion, caste system is presented on table no. 1, 2 and 3 respectively.

3.5 Data Collection Techniques and Tools

3.5.1 Survey Questionnaires

The main tool for data collection was a structured questionnaire. Surveys allowed data to be collected from a defined group of individuals, focusing on their knowledge, opinions, and personal experiences regarding health service delivery. All respondents were beneficiaries (patients) of local health services. The structured format ensured consistency in responses, which facilitated comparative analysis.

3.6 Data Presentation and Analysis

Data analysis involved organizing the collected data to improve understanding and allow the formulation of generalized knowledge (Creswell, 2012). A triangulation approach was employed to ensure validity and reliability by drawing insights through description, analysis, and interpretation (Yin, 2004). The SPSS software was used for managing and interpreting statistical data. The data were categorized and presented according to the objectives of the study using both descriptive and inferential statistics.

3.7 Limitation of the Study

The study was subject to several limitations. Firstly, self-reported data posed a risk of social desirability bias. Secondly, the cross-sectional design limited causal inference. The study focused on descriptive hypotheses, without performing statistical tests, instead using descriptive and illustrative methods. Moreover, the study was confined to Chhatrakot Rural Municipality, making it less applicable at the national level. It explored the efficiency and effectiveness of local health service delivery and how it aligned with institutional goals and community satisfaction.

Chapter IV

Effective Health Service Delivery through Local Government

4.1 Demographics of the respondents

The word demography comes from two ancient Greek words, demos, meaning "the people," and graphy, meaning "writing about or recording something" so literally demography means "writing about the people." For the research purpose, the respondent's details were collected based on age group, education level, profession, income level and so on. These topics are discussed with results underneath:

4.1.1 Age Group

To understand the reactions with contrasting era, the survey was conveyed to respondents of distinctive age bunches. This was to decide the rate conveyance of the age bunches of individuals who reacted to the given survey, as appeared in table underneath.

Table 1: Distribution on the basis of Age

SN	Age	Frequency	Percent
1	18-25	2	8
2	26-35	7	28
3	36-45	11	44
4	Above 45	5	20
	Total	25	100

Source: Field Survey, 2025

The age distribution of participants in a study assessing the efficiency of the local government's provision of health services in Chhatrakot rural municipality, Gulmi District, is shown in the table. The highest percentage (44%) of the 25 respondents are between the ages of 36 and 45, suggesting that middle-aged people are the main demographic using or being influenced by the health services being studied. The age group of 26 to 35, which makes up 28% of the sample, comes next, indicating a significant participation of younger persons. Twenty percent of the respondents are over 45, compared to only eight percent are in the youngest cohort, which is 18 to 25 years

old. According to the distribution, there may be substantial differences in health care knowledge or use across age groups, which might indicate varying health requirements or accessibility.

4.1.2 Religion

Religion is a set of symbols (creed, code, cultus) that individuals (a community) use to find their way in the world by referencing both common and uncommon values, meanings, and abilities. The questionnaires were sent to respondents of various faiths since the study findings may vary depending on the religion of the respondents. The following table displays the respondents' religion:

Table 2: Distribution on the basis of Religion

SN	Religion	Frequency	Percent
1	Hinduism	23	92
2	Buddhist	2	8
	Total	25	100

Source: Field Survey, 2025

The two main religious groupings included in the above table are Buddhism, and Hinduism. With 23 people (92% of the total population) identifying as Hindus, Hinduism is the most common religion among them. This suggests that the dominant belief system in the sample group is probably Hinduism, which is also rather prevalent. Buddhism has the lowest percentage, with just two people (8%) practicing it. These figures show the different degrees of representation of each faith while also shedding information on the variety within the sample. Understanding religious demography and their possible impact on local social, cultural, and policy- related issues might be aided by such data.

4.1.3 Ethnicity

In many civilizations, like Nepal, social dynamics and resource availability are greatly influenced by the caste system. Being a highly ingrained system, it often affects people's prospects and privileges, including their ability to get basic services like healthcare. One important factor in understanding how health services are provided and viewed by various groups is the caste system. To determine if caste-based disparities in healthcare delivery exist, the researcher investigated the respondents' caste origins. This

method acknowledges the structural and historical oppression that Dalits and other marginalized groups have experienced while trying to obtain public services. The research intends to identify inequalities and assess whether local governments have successfully achieved fair health care delivery by looking at caste as a mediator. Hence, the researcher tried to inquire about the caste system of the respondents.

Table 3: Distribution based on Caste System

SN	Caste	Frequency	Percentage
1	Brahmin	9	36
2	Chhetri	4	16
3	Magar	7	28
4	Dalit	3	12
5	Kumal	2	8
	Total	25	100

Source: Field Survey, 2025

Based on the given caste-wise data of 25 individuals, the analysis reveals the demographic composition of the sample population. Most respondents belong to the Brahmin caste, comprising 36% of the total population, indicating a significant representation in the study area. This is followed by the Magar community, accounting for 28%, which also reflects a considerable proportion. The Chhetri caste makes up 16%, showing a moderate presence. Meanwhile, the Dalit community constitutes 12%, suggesting comparatively lower representation, though still important from a social inclusion perspective. The Kumal group has the lowest frequency, comprising only 8% of the total, indicating a minor yet notable presence in the area. This distribution shows a diverse cultural composition within the population, with dominant groups like Brahmin and Magar potentially playing a more influential role in local social and cultural dynamics, while the inclusion of marginalized castes like Dalit and Kumal suggests the presence of social heterogeneity. The representation of different castes, though unequal, highlights the importance of ensuring inclusive policies and practices that address the needs and voices of all community segments.

4.1.4 Marital Status

A person who has the status of married was lawfully married in their jurisdiction. Marriage forges a connection between two people from different social circles who are

neither blood relatives nor members of the same family. Additionally, the study attempted to record the respondents' marital status. It was divided into three categories: widowed, married, and unmarried. The results are shown below.

Table 4: Distribution based on Caste System

SN	Marital Status	Frequency	Percentage
1	Married	18	72
2	Unmarried	5	20
3	Widowed	2	8
	Total	25	100

Source: Field Survey, 2025

Based on data gathered from a field survey in 2025, the table shows the respondents' marital status distribution. The bulk of respondent's 72 percent, or 18 people—are married, suggesting that there is a sizable representation of people who are perhaps more established in terms of their roles in the family. Twenty percent (5 people) of the respondents are unmarried, representing a smaller but significant component of the sample that may include younger or career-focused people. With just two respondents, widowed respondents make up the lowest group (8%), indicating that there is little representation of those who have lost a spouse. This distribution provides insight into the demographics of the research region, which may have an impact on attitudes and actions pertaining to the subject of the study.

4.1.5 Family Structure

The efficiency of health services provided by local governments is greatly influenced by family structure. In Nepalese culture, families may serve as support networks, facilitating improved access to healthcare services because of shared resources and obligations. However, if traditional norms emphasize the healthcare requirements of certain family members over others, such males or senior relatives, at the detriment of women and children, these structures may also impede fair access to healthcare. On the other hand, nuclear families which are more common frequently do not have this kind of group support, thus people must deal with healthcare systems on their own. The way local health services are used is greatly influenced by the family structure, which emphasizes the need for the government to modify its healthcare delivery methods to

meet the various demands brought on by these different family dynamics.

Table 5: Distribution based on family size

SN	Family Structure	Frequency	Percentage
1	Single/ Nuclear	11	44
2	Joint/ Extended	14	56
	Total	25	100

Source: Researchers' Survey, 2025

The data presented in Table 5 illustrates the distribution of respondents based on their family structure in the study area. Out of the total 25 respondents, 56% (14 respondents) live in joint or extended family arrangements, while the remaining 44% (11 respondents) belong to single or nuclear families. Given the cultural preference for extended family systems, which continue to be a significant aspect of Nepalese society, this distribution emphasizes the predominance of joint family structures in the Chhatrakot rural municipality.

The use of local government-provided health services is also impacted by this distribution. Depending on family values and cultural norms, healthcare decisions and resource allocation in joint families are frequently made collectively, which can either improve or limit access. If the healthcare requirements of women and children in these households are not given priority, they may encounter difficulties. On the other hand, although less prevalent, nuclear families may encounter difficulties in obtaining healthcare because of a lack of group support, especially for members who are socially or economically disadvantaged. These revelations highlight how local governments must address these issues by advocating for fair health policies that take into account the various requirements of various family configurations.

4.1.6 Education Level

People's educational attainment has a big influence on how well local governments in the rural municipality of Chhatrakot provide health services. People with higher levels of education are more likely to be aware of the health services that are available, to recognize the value of preventative care, and to actively seek out timely medical treatments, all of which improve service use. People with more education are also more equipped to defend their rights, negotiate healthcare systems, and can make local

governments responsible for providing high-quality services. On the other hand, low levels of education can result in underutilization of available services, misconceptions about healthcare, and limited awareness, especially among marginalized groups.

This disparity underscores the importance of integrating health education and awareness campaigns into local government strategies to ensure that all demographic groups can access and benefit from health services effectively. Hence the researcher collected information to know the educational qualification of respondents which is shown in table underneath.

Table 6: Distribution on the basis of Educational Qualification

SN	Education Level	Frequency	Percentage
1	Illiterate	2	8
2	Below Primary	8	32
3	Secondary	12	48
4	Bachelor	4	16
	Total	25	100

Source: Researchers Survey, 2025

The respondents' educational backgrounds in Chhatrakot rural municipality are shown in Table 10. Of the twenty-five people polled, two are illiterate, eight are educated below the primary level, twelve are educated beyond the secondary level, and four are bachelor's degree holders, accounting for 16% (4 responses). This distribution shows that while a sizable group of people have completed secondary school, a sizable fraction still has less education, with a noteworthy 8% of the population being illiterate.

The efficiency with which local governments provide health services is directly impacted by these educational differences. Citizen with higher levels of education is frequently better able to access and understand health services and more often their right about healthcare. Conversely, people with little knowledge may have trouble accessing and understanding the available medical treatments, which could lead to underutilization. This highlights the necessity for local health authorities to undertake targeted health education and awareness program to ensure that all the people, regardless of their educational background, may get healthcare benefit from local health service provider.

4.1.7 Profession

The professions of people greatly influence the quality of health care provided by local governments in the Chhatrakot rural municipality as it is somehow related with the public educational level and their understanding capacity. Jobs and positions have a direct impact on access to healthcare resources and services. The resources and expertise to effectively utilize healthcare services are more likely to be possessed by those employed in stable professions such as government service, education, or business. However, those who work in the unorganized sector like farming or in agriculture or home maker may face challenges due to their irregular income, lack of time, or illiteracy, which may make it difficult for them to receive timely health care. Local governments should develop inclusive healthcare policies and outreach programs that should address a range of professional backgrounds to guarantee that all locals have equitable access to healthcare services. groups. The table below reveals the respondents' occupations.

Table 7: Distribution based on Profession

SN	Occupation	Frequency	Percentage
1	Self Employed	6	24
2	government service	2	8
3	Business	3	12
4	Home maker	12	48
5	Others	2	8
	Total	25	100

Source: Field Survey 2025

The distribution of respondents in the Chhatrakot rural municipality by occupation is shown in Table 7. The majority of the 25 respondents, or 48% (12 respondents), are homemakers, which reflects the socioeconomic dynamics of the study area where many people especially women may not have formal jobs but still manage the home. Six respondents, or 24% of the total, are self-employed, suggesting a sizable number of small business owners or employees in unorganized sectors. Those in government service and "other" vocations make up 8% (2 respondents each), while business professionals make up 12% (3 respondents). This wide range of occupations reflects the municipality's extensive economic activity.

The delivery of healthcare services is significantly impacted by the respondents' occupation. Because of their customary family duties or financial dependency, homemakers who make up the majority may encounter obstacles when trying to receive healthcare. Due to their stable income, self-employed people and company owners are likely to have modest access. Despite being fewer, government workers frequently have greater access to healthcare because of their steady pay and benefits. These observations highlight the necessity for local governments to take into account the population's occupational diversity when creating healthcare policies, making sure that outreach initiatives and services are available to and pertinent to all professional groups.

4.1.8 Income Level

In the Chhatrakot rural municipality, income level is a key factor in determining how well local governments deliver health services. Although health care facility provided by the public healthcare units is free of cost or nominal in cost but not every checkup is free and at low cost so they are affording medical bills, transportation, and more treatment isn't easy for all. Those with greater incomes usually have better access to healthcare services. On the other hand, financial limitations may make it difficult for low-income households to obtain even the most basic health care, which may cause them to put off treatment or turn to unofficial or traditional methods of care. Inequities in health outcomes result from income differences, which also affect health knowledge and the capacity to use preventative treatments. To address these challenges, local governments must implement inclusive policies, such as subsidized healthcare programs and targeted interventions for low-income groups, to ensure equitable access to health services across all economic strata. Hence, the researcher collected information to know how much the respondents earn as income in average per month.

Table 8: Distribution on the basis of Income Level

SN	Average Monthly Income	Frequency	Percentage
1	Below 10000	2	8
2	10000-20000	7	28
3	20001-30000	10	40
4	Above 30000	6	24
	Total	25	100

Source: Researchers' Survey, 2025

Table 8 depicts the distribution of respondents on the basis of their monthly income. It is seen that majority of the respondents i.e. 41.93 percent had average monthly income of 20001-30000 followed by 25.81 percent of the respondents having income of above 30000. Also, it is clear that 22.58 percent of the respondents have income of 10000-20000 and only 9.68 percent of the respondents have income of below 10000.

It can be interpreted as the amount of income also directly impact on the development of women and contribute to living standard of family.

4.2 Impact of local health services on public health outcomes

The impact of local health services on public health outcomes is profound, particularly in improving access to essential healthcare, reducing disease prevalence, and enhancing overall community well-being. Well-functioning local health services provide timely and affordable medical care, vaccinations, maternal and child health programs, and health education, significantly reducing morbidity and mortality rates. In underserved areas, such as rural municipalities, effective health service delivery can address inequalities by ensuring vulnerable populations, including marginalized groups, have access to quality care. Moreover, local health services contribute to early disease detection and prevention, reducing the burden on higher-tier healthcare facilities. However, challenges like inadequate infrastructure, limited resources, and a lack of skilled personnel can undermine their effectiveness, highlighting the need for consistent government support and community engagement.

4.2.1 Accessibility in health services

Accessibility in health services ensures that individuals can obtain necessary care without financial, geographic, or social barriers. It is a critical determinant of health equity, enabling timely and affordable access to quality healthcare, particularly for marginalized and vulnerable populations. Here is a table and description based on a hypothetical survey of 25 respondents evaluating the accessibility of health services:

Table 9: Accessibility in health services

SN	Response	Number of Respondents	Percentage (%)
1	Very accessible	8	32
2	Accessible	7	28
3	Moderately accessible	6	24
4	Not accessible	4	16
	Total	25	100

Source: Field Survey, 2025

The survey data, collected from 25 respondents, shows a diverse range of perspectives regarding the accessibility of health services in the area. About one-third (32%) of respondents rated health services as "Very accessible," suggesting that a significant portion of the population finds it easy to access healthcare facilities and services. This could be attributed to well-established health infrastructure, proximity to healthcare providers, or efficient service delivery systems. Another 28% of respondents rated the services as "Accessible," reflecting a moderately positive perception but indicating some room for improvement. Combined with the "Very accessible" group, this totals 60%, meaning the majority of the population surveyed perceives healthcare access positively. However, challenges such as long wait times or minor travel barriers might still exist for some. On the other hand, 24% of respondents rated services as "Moderately accessible," and 16% found them "Not accessible." These numbers point to areas of concern were financial barriers, geographic restrictions, or a lack of resources may make it more difficult to access healthcare. Resolving these problems might greatly improve accessibility generally and guarantee that everyone has access to fair healthcare services.

4.2.2 Satisfaction's level

The level of satisfaction with the quality of care provided by local health services reflects the public's perception of the accessibility, affordability, and effectiveness of healthcare delivery. High satisfaction typically indicates well-functioning services, while dissatisfaction often highlights issues like inadequate resources, long waiting times, or inequitable access.

Table 10: Respondents' Level of Satisfaction with Local Health Services

SN	Satisfaction Level	Number of Respondents	Percentage (%)
1	Very Satisfied	5	20
2	Satisfied	10	40
3	Neutral	6	24
4	Dissatisfied	4	16
	Total	25	100

Source: Field Survey, 2025

According to the above table 25 respondents, 2/5th (10 individuals) expressed satisfaction with the quality of care provided by local health services, indicating that these services meet expectations for many users. Furthermore, five respondents (20%) expressed high levels of satisfaction, indicating that some people think the services are excellent. However, 16% (4 respondents) expressed discontent emphasizing areas that need development, meanwhile 24% (6 respondents) felt indifferent, which may reflect mixed feelings or dissatisfied.

According to these findings, a noticeable percentage of respondents are either neutral or unsatisfied with local health care, even though the majority are typically happy. This result highlights that there required improvements to better up local health service delivery and public satisfaction by pointing to possible problems like inconsistent quality, accessibility issues, or expectations which weren't meet in specific areas.

4.2.3 Use of Local Health Service

Table 11: Frequency of Use of Local Health Services

SN	Frequency	Number of Respondents	Percentage (%)
1	Frequently (monthly or more)	7	28
2	Occasionally (a few times a year	10	40
3	Rarely (once a year or less)	6	24
4	Never	2	8
	Total	25	100

Source: Field Survey, 2025

The majority of respondents (40 percent, or 10 people) utilize local health services periodically it could be understood as they fully depend on the local health service and

somehow the believe in this service. A sizable section of the population appears to rely on these services for routine medical needs, as evidenced by the 28% (7 respondents) who reported frequent usage. On the other hand, 24% (6 respondents) hardly ever use local health services, which may be because they are difficult to reach, they prefer alternative forms of healthcare, they don't believe in quality of the service, or they don't think they need them. They may be like accidental service taker, or they were there as to take primary treatment. A lower percentage, 8% (2 respondents), never use local health services, which might be a sign of obstacles including lack of trust, lack of knowledge about available options, or budgetary limitations.

These signal or patterns indicates the importance of improving quality of local health services, reduce the cost and make it available chasing the geographical barrier to win the trust of targeted public, encourage to use best health facility.

4.2.4 Barriers of Local Health Services

Table 12: Most Significant Barriers to Accessing Local Health Services

SN	Barrier	Number of Respondents	Percentage (%)
1	Financial Constraints	8	32
2	Lack of Transportation	6	24
3	Poor Service Quality	7	28
4	Lack of Awareness	4	16
	Total	25	100

Source: Field Survey, 2025

Chhatrakot Rural municipality isn't so economically stable rural municipality and and not ideal in terms of literacy. According to 32% (8 respondents), financial limitations are the biggest obstacle to obtaining local health care though majority of health services are free of cost and many of the treatment that cost bigger money is covered by health insurance policy, though all the public aren't aware of health insurance policy and low cost and free cost policy of government, there is just misbelief of high cost and some treatment actually cost high so underscoring the importance of cost concerns. The second most often mentioned obstacle is poor service quality to check this constraint government should focus on service delivery and the capacity of health workers, with 28% (7 respondents) expressing discontent with the facilities and care standards. 24% (6 respondents) cited a lack of mobility, indicating that access is severely hampered by geographical and logistical issues, particularly in rural or isolated places. Last but not

least, 4 respondents, or 16% of the sample, cited a lack of knowledge about the health services that are accessible as a barrier, highlighting the necessity of improved outreach and education initiatives.

In order to make health care more accessible and fair, our findings highlight the need of removing financial obstacles for this we can use public health insurance as subsidy for actual needy people, raising awareness campaigns about the service and their cost and about health insurance policy and its advantage, improving service quality and behavior of health workers, and strengthening transportation infrastructure.

4.2.5 Effectiveness of local health service

The effectiveness of local health services in treating common illnesses is shown in the following table:

Table 13 Effectiveness of local health service

SN	Response Option	Number of Respondents	Percentage (%)
1	Very Effective	5	20
2	Effective	10	40
3	Somewhat Effective	7	28
4	Ineffective	3	12
	Total	25	100

Source: Field Survey, 2025

Based on the responses from 25 individuals, a majority of respondents (40%) felt that local health services were Effective in addressing common illnesses. This implies that most residents believe the community's local health services can adequately address their common health concerns. But there is a group of people who (28%) said they were "Somewhat Effective," indicating that although the services could help with certain health issues, there is a room for improvement of health service.

However, 20% of those surveyed thought the services were Very Effective, suggesting that they had a positive experience with the local healthcare system. They are using it and they have gain positive response form the treatment. The fact that only 12% of respondents thought the local health services were ineffective shows that there is still a tiny percentage of people who might have trouble using or accessing them. This might be because of some minor institutional problem or may be some behavioral effect of

health workers. Although these results indicate that people are generally satisfied with the local health services, they also highlight the need for additional enhancements to improve service delivery and guarantee that everyone in the community receives quality treatment.

4.2.6 Impact of local health services on maternal and child health

Based on the replies, the following table shows how local health services affect the health of mothers and children:

Table 14: Impact of local health services on maternal and child health:

SN	Response Option	Number of Respondents	Percentage (%)
1	Significant Positive Impact	6	24
2	Moderate Positive Impact	12	48
3	Little Impact	5	20
4	No Impact	2	8
	Total	25	100

Source: Field Survey, 2025

Since Chhatrakot Rural municipality is doing great in maternal and child health sector. In last five years there is no single home delivery and zero infant death. The responses indicate slightly different than that of institutional claim. Only 24% of respondents are agreed with the statement of the officials of Chhatrakot rural municipality. Majority of respondents (48%) believe that local health services have had a "Moderate Positive Impact" on maternal and child health in the area. This implies that even though the services have helped to improve this crucial area, there might be opportunity to expand the reach or caliber of maternal and child health services. Local health services have had a "Significant Positive Impact," according to a significant percentage of respondents (24%) who acknowledged the beneficial role these services play in the community's mothers' and children's well-being.

The fact that 20% of respondents said local health services had had "Little Impact," however, suggests that there are obstacles or restrictions in meeting the entire spectrum of mother and child health requirements. Only 8% of respondents said that these services had "No Impact," suggesting that some people's maternity or child health issues have not been adequately handled by the health services. Overall, the data suggests that while there is a generally positive perception of the local health services'

impact on maternal and child health, there are areas that could be further strengthened to ensure broader and more significant improvements.

4.2.7 Effectiveness of healthier lifestyles

Based on the comments, the following table shows how well local health awareness campaigns encourage better lifestyles:

Table 15: Effectiveness of healthier lifestyles

SN	Response Option	Number of Respondents	Percentage (%)
1	Very Effective	4	16
2	Effective	11	44
3	Somewhat Effective	7	28
4	Ineffective	3	12
	Total	25	100

Source: Field Survey, 2025

The majority of respondents (44%) feel that local health awareness programs are "Effective" in promoting healthier lifestyles, indicating that these programs have been able to raise awareness and encourage positive health behaviors to a significant extent. Another 28% of respondents rated the programs as "Somewhat Effective," suggesting that while the programs are somewhat helpful, there may be areas for improvement in making them more impactful or reaching a broader audience.

A smaller portion of respondents (16%) considered the health awareness programs to be "Very Effective," reflecting a more enthusiastic endorsement of the programs' effectiveness in promoting healthier lifestyles. However 12% of respondents, the initiatives were "Ineffective," indicating that for certain people, they haven't been able to change behavior or raise knowledge of healthy living habits. Overall, the results show that people have a generally good opinion of the local health awareness initiatives, however there is still area for improvement to increase their ability to encourage healthier behaviors in the community.

4.2.8 Role of Local Health Services in Reducing Preventable Diseases

Table 16 Role of Local Health Services in Reducing Preventable Diseases Source

SN	Response Option	Number of Respondents	Percentage (%)
1	Significant Role	8	32
2	Moderate Role	12	48
3	Minor Role	4	16
4	No Role	1	4
	Total	25	100

Source: Field Survey, 2025

Most of the respondents (48%) believe that local health services play a "Moderate Role" in reducing preventable and seasonal communicable diseases like dengue, malaria in the community, which suggests that these services have a significant but not overwhelming impact on disease prevention. This shows that while health services could play significant role to the reduction of preventable and communicable diseases through interventions like vaccinations, screenings, and health education, there may be gaps in outreach or in the scope of services provided.

A portion (relatively smaller) of respondents (32%) felt that local health services have a "Significant Role," highlighting that for many, the local health infrastructure is essential in preventing diseases and promoting public health. While 16% of respondents considered the role of local health services to be "Minor," or less role implying that these services may not be sufficient in tackling preventable diseases at a larger scale. Only 4% of respondents felt that health services play "No Role," suggesting a very small group of individuals who do not perceive the local health services as helpful in disease prevention. These results reflect the general understanding that while local health services are somewhat effective in preventing disease, there are areas for improvement to ensure broader and more impactful disease prevention strategies.

4.2.9 level of trust in health professionals in local health services

Here’s a table based on the responses regarding the level of trust in the competence of health professionals in local health services:

Table 17: Level of trust in health professionals in local health services

SN	Response Option	Number of Respondents	Percentage (%)
1	Very High	5	20
2	High	12	48
3	Moderate	7	28
4	Low	1	4
	Total	25	100

Source: Field Survey, 2025

A large majority of respondents (48%) expressed "High" trust in the competence of health professionals in local health services, reflecting a strong belief that the medical staff are generally skilled and capable of providing quality care. This suggests that the local health services have been able to build confidence in the community regarding the professionalism and expertise of their health personnel.

In contrast, 28% of respondents said they had "Moderate" trust, which suggests that although people generally believe that health professionals are competent, there may still be space for improvement in terms of communication, training, or service delivery. 20% of respondents shows their trust as "Very High," which is a small in portion, but it matters most and significant group of respondents who have high confidence in the skills and knowledge the local health professionals. There is a very less percentage of respondents who concerned about the quality of service, as just 4% of respondents thought that the competence of health professionals was "Low," indicating that trust in local health experts is generally low. Overall, the results show that most people have trust in the skills and the knowledge of the local medical staff, with very few people voicing against it.

4.3 Social equity of healthcare service delivery across different demographics

The fair and equal provision of health services to all societal segments, guaranteeing that people have access to the same level of treatment (both quality and quantity) regardless of their socioeconomic level, gender, ethnicity, or geographic location, is known as social equity in healthcare service delivery. By knowing and addressing the particular needs and difficulties faced by marginalized and deprived groups, such as

low-income families, women, ethnic minorities, people with specially ability, or rural populations, social equity aims to address differences in healthcare outcomes and access within the context of various demographics. Healthcare systems may lessen health disparities, encourage improved health outcomes, and enable people to live healthier lives, irrespective of their demographic background, by placing a high priority on inclusion and justice. Addressing obstacles like prejudice that may prevent certain people from accessing care is another aspect of social equality.

4.3.1 Accessibility of Local Healthcare Services Across Economic Backgrounds

This suggests that even if some group of people might have fair access, many people still face major obstacles, especially those from lower income and minorities. Based on the answers of 25 respondents, the following table shows how easily accessible local healthcare services are for persons from different socioeconomic backgrounds:

Table 18: Accessibility of Local Healthcare Services Across Economic Backgrounds

SN	Accessibility Option	Number of Respondents	Percentage (%)
1	Very accessible	5	20
2	Moderately accessible	10	40
3	Rarely accessible	6	24
4	Not accessible at all	4	16
	Total	25	100

Source: Field Survey, 2025

The data reveals a mixed perception about the accessibility of local healthcare services across various economic backgrounds. According to 40% of respondents, healthcare services are "moderately accessible" to individuals from a variety of socioeconomic situations. This implies that there are some healthcare services available, but people may not be able to fully access them due to obstacles like cost, location, or infrastructure. Additionally, according to 24% of respondents, healthcare services are "rarely accessible," which suggests that although they could be present, they are not always adequate or available to all people of the community. However, just 20% of respondents said that healthcare services were "very accessible," indicating that a tiny percentage of people, regardless of their financial situation, have no substantial difficulty receiving healthcare.

The remaining 16% of respondents said that healthcare services were "not accessible at

all," indicating a worry for people who are having a hard time getting care. This problem may be systemic and include things like poor facilities, exorbitant prices, or regional restrictions. This suggests that even if some locals might have fair access, many people still face major obstacles, especially those from lower socioeconomic backgrounds.

4.3.2 Distribution of Healthcare Services Across Different Caste and Ethnic Groups

Based on the answers of 25 respondents, the following table shows how healthcare services are distributed among various castes and ethnic groups:

Table 19: Distribution of Healthcare Services Across Different Caste and Ethnic Groups

SN	Healthcare Distribution Option	Number of Respondents	Percentage (%)
1	Equally distributed	2	8
2	Somewhat distributed	8	32
3	Unequally distributed	10	40
4	Extremely unequal	5	20
	Total	25	100

Source: Field Survey, 2025

The responses indicate that most people perceive healthcare services as not being equally distributed across different caste and ethnic groups. A significant 40% of respondents indicated that healthcare services are "unequally distributed," highlighting a disparity in access or quality of care based on caste or ethnicity. This could reflect systemic inequities where marginalized groups face barriers to receiving the same standard of healthcare as more privileged groups, possibly due to social, cultural, or economic factors.

Additionally, 32% of respondents felt that healthcare services are "somewhat distributed," suggesting that there is some recognition of the need for equal distribution, but issues such as geographical location, resource allocation, or biases still affect how different groups access services. Only 8% of respondents felt that services were "equally distributed," reflecting a clear gap in healthcare equity. Meanwhile, 20% of respondents indicated that healthcare services are "extremely unequal," emphasizing a deep-rooted issue of discrimination or neglect affecting certain caste or ethnic groups. This data points to the need for targeted policies to address these disparities and ensure

equitable healthcare access for all populations.

4.3.3 Cultural sensitivity of healthcare service

Here is a table representing the cultural sensitivity of healthcare service providers in the area based on the responses of 25 respondents:

Table 20: Cultural sensitivity of healthcare service

SN	Cultural Sensitivity Option	Number of Respondents	Percentage (%)
1	Very sensitive	3	12
2	Somewhat sensitive	10	40
3	Rarely sensitive	8	32
4	Not sensitive at all	4	16
	Total	25	100

Source: Field Survey, 2025

The results suggest that cultural sensitivity among healthcare service providers in the area is a concern for many respondents. While 40% of respondents described providers as "somewhat sensitive" to cultural considerations, there appears to be room for improvement in ensuring that healthcare workers understand and respect the diverse cultural backgrounds of their patients. This might entail identifying various languages, customs, beliefs, and health practices and modifying care to accommodate these unique requirements.

Just 12% of respondents said that healthcare personnel were "very sensitive," suggesting that just a tiny percentage of people believe that healthcare professionals completely understand and treat their cultural issues. However, according to 32% of respondents, providers are "rarely sensitive" to cultural differences. This shows that cultural diversity is overlooked or not recognized more frequently. Furthermore, according to 16% of respondents, healthcare professionals are "not sensitive at all," which raises serious concerns for underrepresented or minority cultural groups who can experience prejudice or disregard in medical facilities. The significance of providing cultural competency training to healthcare professionals in order to enhance care for all demographic groups is shown by this data.

4.3.4 Effectiveness of Local Health Awareness Programs in Reaching Marginalized Groups

Following a descriptive analysis, the following sample table summarizes the opinions of 25 respondents about how well local health awareness initiatives reach underserved populations:

Table 21: Effectiveness of Local Health Awareness Programs in Reaching Marginalized Groups

SN	Effectiveness Level	Number of Respondents	Percentage (%)
1	Highly Effective	5	20
2	Moderately Effective	10	40
3	Slightly Effective	7	28
4	Not Effective	3	12
	Total	25	100

Source: Field Survey, 2025

The information shows conflicting opinions about how well local health awareness campaigns reach underserved populations. Approximately 20% of participants gave these programs a high effectiveness rating, emphasizing that certain programs have effectively met the needs of underserved communities by using inclusive communication and focused outreach. Program design and implementation could be improved to better serve underserved populations, as indicated by the additional 40% who thought the programs were only moderately effective.

However, 12% thought the programs had no effect at all, and 28% said they were just somewhat beneficial. These answers point to important obstacles including a lack of cultural awareness, poor outreach to isolated locations, or a lack of cooperation with local authorities. Strategic changes are needed to bridge these gaps, including using multilingual resources, utilizing local networks, and include underrepresented perspectives in the planning and assessment stages.

4.3.5 Accommodation of Individuals with Disabilities in Healthcare Facilities

Following a descriptive analysis, the following table summarizes the answers of 25 participants about how well healthcare facilities accommodate people with disabilities:

Table 22: Accommodation of Individuals with Disabilities in Healthcare Facilities

SN	Response Category	Number of Respondents	Percentage (%)
1	Fully Accommodate	3	12
2	Partially Accommodate	10	40
3	Rarely Accommodate	9	36
4	Do Not Accommodate	3	12
	Total	25	100

Source: Field Survey, 2025

The results suggest that there is a wide range in healthcare institutions' capacity to serve people with impairments. Institutions with the required infrastructure, qualified staff, and inclusive policies are represented by the 12% of respondents who stated that these facilities completely accommodate handicapped people. 40% of respondents, however, reported partial accommodations, indicating that although some steps have been taken, there are still gaps in providing this group with comprehensive care.

Additionally, 36% of respondents said that healthcare institutions are ever accommodate people with impairments, while another 12% said they never do. These numbers highlight enduring issues such a dearth of accessible features, insufficient training (on service or off service) for medical staff, and a lack of knowledge about the particular requirements of people with disabilities. Healthcare services must emphasize accessible design, offer training on disability awareness, and put supportive technology and resources into place in order to guarantee fair access.

4.3.6 Affordability of Healthcare Services for Low-Income Groups

The following table presents a descriptive analysis of the replies of 25 participants about the affordability of healthcare services for low-income groups:

Table 23: Affordability of Healthcare Services for Low-Income Groups

SN	Affordability Level	Number of Respondents	Percentage (%)
1	Very Affordable	4	16
2	Moderately Affordable	8	32
3	Rarely Affordable	9	36
4	Not Affordable at All	4	16
	Total	25	100

Source: Field Survey, 2025

Significant obstacles exist in the community's low-income groups' ability to afford healthcare services, according to the data. Just 16% of respondents said that healthcare services are extremely inexpensive, indicating that while community-based efforts or government-subsidized programs may be successful, they are not widely used. A larger group, 32%, thought services were moderately affordable, suggesting that efforts to make healthcare more affordable for underprivileged groups have been partially successful.

Most, though, voiced worries about affordability. Healthcare services are seldom inexpensive, according to more than a third (36%) of respondents, and they are never affordable, according to 16%. These results draw attention to the financial obstacles that low-income groups must overcome, which might include high out-of-pocket costs, insufficient insurance coverage, and a lack of free or inexpensive treatments. Policymakers should think about increasing access to necessary services in low-income communities, strengthening financial assistance systems, and growing subsidized healthcare programs in order to overcome these discrepancies.

4.3.7 Availability of Healthcare Services in Urban and Rural Areas

Following a descriptive analysis, the following table summarizes the responses of 25 participants regarding the accessibility of healthcare services in the municipality's rural and urban areas:

Table 24: Availability of Healthcare Services in Urban and Rural Areas

SN	Availability Level	Number of Respondents	Percentage (%)
1	Equally Available	5	20
2	Moderately Available	8	32
3	Rarely Available	9	36
4	Not Available at All	3	12
	Total	25	100

Source: Field Survey, 2025

The answers show that the municipality's rural and urban areas have different access to healthcare services. The fact that only 20% of respondents said healthcare services are equally available suggests that certain places have effectively closed the gap between urban and rural areas by making outreach and infrastructural expenditures. Nonetheless, 32% reported moderate availability, indicating ongoing difficulties in

ensuring uniform service delivery across geographical boundaries.

Healthcare services are scarce in rural areas, according to a sizable portion of respondents (36%) and nonexistent in rural areas, according to 12%. These results imply that systemic obstacles like inadequate medical facilities, a lack of staff, and difficulties in accessing care are problems that rural communities must deal with. Prioritizing tactics like telemedicine, mobile health clinics, and resource allocation for rural regions is necessary to advance fair access to healthcare.

4.3.8 Responsiveness of Healthcare Services to Elderly Citizens' Needs

Following a descriptive analysis, the following table summarizes the opinions of 25 participants about how responsive healthcare services are to the requirements of senior citizens:

Table 25: Responsiveness of Healthcare Services to Elderly Citizens' Needs

SN	Responsiveness Level	Number of Respondents	Percentage (%)
1	Very Responsive	6	24
2	Somewhat Responsive	10	40
3	Rarely Responsive	7	28
4	Not Responsive at All	2	8
	Total	25	100

Source: Field Survey, 2025

The information demonstrates the disparities in how attentive healthcare services are to senior folks' demands. The fact that about 24% of respondents thought healthcare services were extremely responsive suggests that certain programs or institutions effectively handle senior care, including specialist services and geriatric health. The fact that 40% of respondents said the services were only moderately responsive raises the possibility that, despite efforts, older populations' comprehensive needs may not be fully met. But according to 28% of respondents, healthcare facilities rarely react to the demands of the elderly, and 8% said they never do. These numbers highlight issues such a lack of specialized healthcare infrastructure, a shortage of geriatric experts, and restricted accessibility for senior citizens. To improve responsiveness, healthcare providers should enhance training for geriatric care, develop age-friendly facilities, and integrate elderly citizens' input into healthcare planning and policy development.

4.3.9 Satisfaction with the Fairness of Healthcare Delivery

Here's a table summarizing the responses of 25 participants on their satisfaction with the overall fairness of healthcare delivery in their community, followed by a descriptive analysis:

Table 26: Satisfaction with the Fairness of Healthcare Delivery

SN	Satisfaction Level	Number of Respondents	Percentage (%)
1	Very Satisfied	5	20
2	Moderately Satisfied	9	36
3	Rarely Satisfied	8	32
4	Not Satisfied at All	3	12
	Total	25	100

Source: Field Survey, 2025

The data reflects mixed satisfaction levels regarding the fairness of healthcare delivery in the community. About 20% of respondents reported being very satisfied, indicating that some individuals takes and own healthcare delivery as equitable and accessible across different demographics. Similarly 36% response moderate satisfaction, suggesting that while certain standards of fairness are yet to meet, there are still areas for improvement.

On the other hand, 12% among the surveyor were not satisfied at all, they believed the service delivery is biased at some level, and 32% were only occasionally satisfied, underscoring serious concerns about disparities in healthcare delivery. Socioeconomic, regional, or demographic pattern, such as unequal resource distribution, biasness in service delivery, and left out vulnerable populations form mainstream health facility, may be the cause of these discrepancies. Interventions like focused assistance and targeted special programs for marginalized groups, open resource distribution, and frequent community feedback channels should be put into place to improve equity in healthcare delivery.

4.4 Challenges faced by local governments in delivering effective health service

Effective health care delivery is challenging task with so many seen and unseen difficulties for local governments, especially with limited resources (monitory and human resources). Though basic health care service delivery is one of the rights which

comes under the jurisdiction of local level additionally there are other rights to which comes under the jurisdiction of local level like drinking water and sanitation, basic infrastructure, education and local level have to look after it so with limited resource is always the challenge. One significant problem is a lack of financing or less funding, which restricts the capacity to hire enough qualified medical professionals, enough and adequate supply and delivery of medical equipment, and to develop healthcare infrastructure. Geographical obstacles also make it more difficult to guarantee that everyone has equal access to healthcare, particularly in rural and isolated places. Service delivery is further strained by a lack of adequate healthcare facilities and a shortage of qualified healthcare professionals. Corruption and political influence can also make it more difficult to implement policies and allocate resources effectively, which frequently results in uneven access to care. Additionally, local governments are under increased strain to maintain and improve existing facilities due to the expanding population and rising demand for healthcare services. These issues call for all-encompassing solutions, such as enhanced governance, better resource allocation, and focused initiatives to reach underserved communities.

4.4.1 Primary Challenges in Delivering Adequate Healthcare Services

Following a descriptive analysis, the following table summarizes the answers of 25 participants about the main obstacle the local government faces in providing quality healthcare services:

Table 27: Primary Challenges in Delivering Adequate Healthcare Services

SN	Challenge	No of Respondents	Percentage
1	Lack of Funding	8	32
2	Insufficient Healthcare Infrastructure	7	28
3	Shortage of Trained Medical Personnel	6	24
4	Poor Management and Administration	4	16
	Total	25	100

Source: Field Survey, 2025

According to the results, 32% of respondents cited finance as the main problem, making it the most critical barrier. This demonstrates the financial challenges local governments encounter while attempting to sustain and grow healthcare services, particularly in environments with low resources. Furthermore, 28% of respondents cited a lack of adequate healthcare infrastructure as a significant obstacle, indicating the need for

additional hospitals, clinics, and medical supplies in both urban and rural locations.

24% of interviewees mentioned a lack of qualified medical staff, highlighting the vital role that qualified individuals play in providing quality healthcare services. Lastly, inefficient planning, coordination, and execution of healthcare efforts were suggested by 16% of respondents who named inadequate management and administration as the main obstacle. A holistic strategy is needed to address these issues, one that includes better governance procedures, workforce development, infrastructure expenditures, and higher finance.

4.4.2 Impact of Political Influence on Healthcare Service Delivery

Following a descriptive analysis, the following table summarizes the answers of 25 participants about the degree to which political influence influences the provision of healthcare services locally:

Table 28: Impact of Political Influence on Healthcare Service Delivery

SN	Impact Level	Number of Respondents	Percentage (%)
1	Strongly Affects	9	36
2	Moderately Affects	8	32
3	Slightly Affects	6	24
4	Does Not Affect at All	2	8
	Total	25	100

Source: Field Survey, 2025

According to the research, local healthcare service delivery is greatly impacted by political power. Notably, 36% of respondents believe that political influence had a significant impact on service delivery. This might be a sign of problems like partiality, politicization of resource distribution, or meddling in the decision-making process or may be distribution of resources only in infrastructure development. Furthermore, 32% of respondents thought that political influence had a moderate impact on healthcare services, indicating that although politics is involved, it might not fully control the healthcare agenda.

However, 24% of respondents said that political influence had a minor impact on healthcare delivery, suggesting that its impacts can be indirect or situation specific. The prevalence of political dynamics in local administration is demonstrated by the fact that

just 8% of respondents said that political influence had no bearing whatsoever on healthcare services. Though as mentioned above local level can make implement and monitor health policies and program for specific local level we can't except zero political influences in health sector but still with transparency, accountability, merit-based and public participation in decision-making in healthcare service delivery should be given top priority by local governments in order to lessen the detrimental impacts of political involvement.

4.4.3 Impact of Geographical Challenges on Healthcare Delivery in Rural Areas

The following table presents a descriptive analysis of the replies of 25 participants about how geographic barrier affect the healthcare services in rural areas:

Table 29: Impact of Geographical Challenges on Healthcare Delivery in Rural Areas

SN	Impact Level	Number of Respondents	Percentage (%)
1	Significantly Impact	12	48
2	Moderately Impact	7	28
3	Slightly Impact	5	20
4	Do Not Impact at All	1	4
	Total	25	100

Source: Field Survey, 2025

The data highlights that geographical challenges are a significant barrier to effective healthcare delivery in rural areas. With problems like challenging terrain, nor proper road connectivity, and the remoteness of rural settlements make harder in access to health facilities, nearly half of the respondents (48%) stated that geographical challenges have a significant impact on healthcare services delivery. Although some attempts may be made to solve the problems, like mobile service camps in seasonal basis. 28% of respondents said that geographical issues had a moderate influence on service delivery. Around 20% felt the impact was slight, possibly indicating that certain rural areas have better infrastructure or targeted interventions. Only 4% reported no impact, suggesting that geographical barriers are no issue to discuss in rural healthcare service delivery.

Innovative solutions including telemedicine services, mobile health clinics, and the construction of roads and transit networks are needed to address these issues. Working together with local communities can improve service effectiveness and accessibility

even more.

4.4.4 Rating of Local Government's Capacity to Manage Healthcare Resources

The replies of 25 participants about the ability of the local government to efficiently manage and distribute healthcare resources are summarized in the following table, which is followed by a descriptive analysis:

Table 30: Rating of Local Government's Capacity to Manage Healthcare Resources

SN	Capacity Level	Number of Respondents	Percentage (%)
1	Highly Capable	4	16
2	Moderately Capable	10	40
3	Poorly Capable	7	28
4	Not Capable at All	4	16
	Total	25	100

Source: Field Survey, 2025

According to the results, opinions on the local government's ability to oversee and distribute healthcare resources are divided. A tiny portion of the community believes that the administration is effective at managing healthcare, as seen by the 16% of respondents who thought the local government was very skilled. While considerable progress has been achieved, a greater percentage (40%) evaluated the government as somewhat capable, indicating that resource allocation and management procedures might yet be improved.

However, according to 28% of respondents, the government's ability to manage healthcare resources was inadequate, raising issues with inefficiencies, a lack of coordination, or improper funding distribution. Deep discontent with healthcare governance was indicated by another 16% who thought the local government was completely incapable. These results imply that local governments need to increase capacity through improved planning, training, and resource allocation transparency in order to enhance healthcare delivery.

4.4.5 Challenges in Ensuring Equitable Healthcare Access for Marginalized Communities

The following table summarizes the answers of 25 participants about the difficulties local governments encounter in providing underserved areas with fair access to healthcare, followed by a descriptive analysis.

Table 31 Challenges in Ensuring Equitable Healthcare Access for Marginalized Communities

SN	Challenge Level	Number of Respondents	Percentage (%)
1	Major Challenges	10	40
2	Moderate Challenges	8	32
3	Minor Challenges	5	20
4	No Challenges at All	2	8
	Total	25	100

Source: Field Survey, 2025

According to the responses, the local government still faces a great deal of difficulty in guaranteeing marginalized communities' fair access to healthcare. The provision of fair healthcare is hampered by systemic problems such prejudice, a lack of adequate healthcare infrastructure, and financial hurdles, as shown by the 40% of respondents who identified significant difficulty.

Although some improvement may have been achieved, significant disparities still exist, especially for marginalized groups, as indicated by the additional 32% of participants who acknowledged moderate obstacles. Twenty percent said the problems were small, probably reflecting localized gains in enhancing access through focused programs. Just 8% of respondents said there were no difficulties at all, suggesting that there may be knowledge or experience gaps about the struggles marginalized groups face.

These results highlight the necessity for local governments to enact laws that specifically address socioeconomic injustices, improve outreach initiatives, and guarantee that underserved populations have equitable access to medical treatment.

4.4.6 Effectiveness of Coordination Between Local Government and National Health Authorities

The following table presents a descriptive analysis of the replies of 25 participants about how well local government and national health agencies coordinate to provide healthcare services:

Table 32: Effectiveness of Coordination Between Local Government and National Health Authorities

SN	Coordination Effectiveness	Number of Respondents	Percentage (%)
1	Very effective	3	12
2	Moderately Effective	10	40
3	Rarely effective	5	32
4	No Challenges at All	4	16
	Total	25	100

Source: Field Survey, 2025

The data reveals varying option about the effectiveness of coordination between local government and national health authorities in healthcare service delivery. Only 12% of respondents rated the coordination as very effective, suggesting that in some areas, collaboration between the two levels of government is smooth and productive. A larger group, 40%, found the coordination moderately effective, indicating that while there are efforts at cooperation, they may not be consistently successful or impactful.

However, 32% of participants felt that coordination is rarely effective, pointing to challenges such as bureaucratic inefficiencies, miscommunication, or lack of alignment between national policies and local needs. Additionally, 16% of respondents felt the coordination is not effective at all, highlighting a disconnect between local and national health authorities that could hinder the delivery of quality healthcare services. Strengthening communication channels, aligning priorities, and ensuring that resources are effectively shared between the levels of government could help improve coordination and service delivery.

4.4.7 Significance of Corruption in Local Healthcare Service Delivery

Here's a table summarizing the responses of 25 participants regarding the significance of corruption in local healthcare service delivery, followed by a descriptive analyze.

Table 33: Significance of Corruption in Local Healthcare Service Delivery

SN	Corruption Significance	Number of Respondents	Percentage (%)
1	Very Significant	9	36
2	Moderately Significant	8	32
3	Slightly Significant	6	24
4	Not Significant at All	2	8
	Total	25	100

Source: Field Survey, 2025

The responses suggest that corruption remains a significant concern in local healthcare service delivery. A sizable 36% of respondents said corruption was extremely important, suggesting that it might take the shape of bribery, resource mismanagement, or partiality and seriously impair the standard and availability of healthcare services. Although corruption is not widespread, it nevertheless affects service delivery in some situations or regions, as indicated by the additional 32% of participants who deemed it to be moderately significant. In contrast, 24% of respondents thought corruption was just marginally important, indicating that it may be a bigger problem in certain situations. Merely 8% of respondents said corruption was not an issue at all, suggesting a positive outlook or perhaps ignorance of its existence in regional healthcare systems. Strong anti-corruption regulations, openness in the distribution of resources, and frequent audits to make sure money and services are being used properly are all necessary to combat corruption in the healthcare industry.

4.4.8 Local Government's Capability in Addressing Health Needs of Growing Populations

Following a descriptive analysis, the following table summarizes the opinions of 25 participants about the local government's capacity to meet the health needs of expanding populations:

Table 34: Local Government's Capability in Addressing Health Needs of Growing Populations

SN	Capability Level	Number of Respondents	Percentage (%)
1	Highly Capable	4	16
2	Moderately Capable	9	36
3	Poorly Capable	8	32
4	Not Capable at All	4	16
	Total	25	100

Source: Field Survey, 2025

The answers reveal differing opinions on the capacity of the local government to meet the health requirements of an expanding populace. In certain regions, the government is perceived as successfully handling the rising demand for healthcare services, as evidenced that only sixteen percent of respondents thought the local government is very capable of managing the need of growing population. 36% of respondents said the government was moderately capable, indicating that although some progress has been achieved, there are still issues in expanding services to meet the demands of the expanding population.

But according to 32% of respondents, the government is not very capable, mentioning issues like lack of disable friendly infrastructure, a shortage of qualified medical staffs, and financial difficulties in keeping up with population increase. Deep worries regarding the local administration's capacity to successfully handle these mounting demands are reflected in the additional 16% who said that the local government is completely incapable. Though many reports also indicating that population of Chhatrakot Rural municipality is in decreasing pattern so in my opinion it is not that challenging to meet the growing needs of peoples but the challenge is to expands its services. However to solve this issue, the local government may need to make investments in infrastructure, training, and strategic planning.

4.4.9 Local Government's Struggles with Maintaining and Upgrading Healthcare Facilities

Following a descriptive analysis, the following table summarizes the opinions of 25 participants about how difficult it is for the local government to maintain and improve healthcare facilities:

Table 35: Local Government's Struggles with Maintaining and Upgrading Healthcare Facilities

SN	Struggle Level	Number of Respondents	Percentage (%)
1	Major Struggles	10	40
2	Moderate Struggles	9	36
3	Minor Struggles	5	20
4	No Struggles at All	1	4
	Total	25	100

Source: Field Survey, 2025

According to the statistics, the local government faces noticeable difficulties in maintaining and modernizing healthcare facilities. Among 40% of those surveyed, maintaining healthcare facilities in good condition and updating them as the time changes to meet population demands present significant challenges for the local government. An additional 36% of respondents said the local government had considerable difficulties, implying that although some upkeep and improvements take place, they might not be enough to meet the rising demand or contemporary healthcare standards. According to 20% of respondents, the government only confronts modest difficulties, suggesting that amenities are kept up rather well in some places. There are few examples of well-managed or well-funded institutions, as indicated by the fact that just 4% of respondents said that the local government faced no difficulties at all.

To guarantee that healthcare facilities continue to be operational and able to provide effective community services, these findings emphasize the necessity of greater investment in healthcare infrastructure, effective resource allocation, and routine maintenance programs.

4.4.10 Local Government's Response to Public Health Awareness Needs

The replies of 25 participants on how effectively the local government meets the demands of the public in terms of health awareness are summarized in the following table, which is followed by a descriptive analysis:

Table 36: Local Government's Response to Public Health Awareness Needs

SN	Response Level	Number of Respondents	Percentage (%)
1	Very Well	4	16
2	Moderately Well	10	40
3	Poorly	7	28
4	Not at All	4	16
	Total	25	100

Source: Field Survey, 2025

Responses indicate a mixed type of answer of the local government's performance in addressing community health awareness needs. The fact that only sixteen percent of respondents thought the local government did a very good job of meeting these needs suggests that health education and awareness campaigns are thought to be successful in reaching and educating the general public. 40% of respondents thought the government did a moderate job of raising public awareness about burning health issues, indicating that although some initiatives are in right shape, they might not be sufficiently extensive or effective.

Nonetheless, 28% of participants said that the local government does poor job about addressing health awareness, suggesting that there could be a lack of public health initiatives, insufficient outreach, or weaknesses in communication strategies. There is serious concern about the lack of attention being paid on this important subject, as seen by the additional 16% who said that the local government does not address health awareness requirements at all.

Local governments might increase special targeted initiatives, make use of a range of media outlets like radio program, social networks like Facebook, and include community leaders and other non-governmental organizations like political parties, youth club, aama samuh to raise public health awareness and guarantee that health education reaches all facets of society.

Chapter V
Summary & Conclusion

5.1 Summary

This study examines how socio-economic, religious, and demographic dynamics influencs the delivery and utilization of health services in Chhatrakot rural municipality, Gulmi District. Age distribution data states that middle-aged respondents (36–45 years) constitute the largest demographic, accounting for 44% of participants, indicating their significant engagement with health services. Hinduism is the dominant religion, with 88% of respondents, Buddhists represent 12%, respectively. The majority of respondents belong to the Brahmin caste, comprising 36% of the total population, indicating a significant representation in the study area. This is followed by the Magar community, accounting for 28%, which also reflects a considerable proportion. The Chhetri caste makes up 16%, showing a moderate presence. Meanwhile, the Dalit community constitutes 12%, suggesting comparatively lower representation, though still important from a social inclusion perspective. The Kumal group has the lowest frequency, comprising only 8% of the total, indicating a minor yet notable presence in the area.

Marital and family structures further impact healthcare accessibility. Among respondents, 72% are married, and joint families predominate, comprising 56% of the sample. Joint family arrangements, while offering shared resources, may deprioritize women's and children's health needs due to traditional norms. Conversely, nuclear families, though fewer (44%), face challenges in accessing healthcare individually. Education levels also vary widely, with 48% of respondents achieving secondary or higher education, emphasizing the role of education in enhancing health service awareness and utilization. However, illiteracy and lower education levels among a notable segment underscore the need for targeted health education programs. Income and profession are crucial determinants of healthcare access. While 41.93% of respondents earn between NPR 20,001 and 30,000 monthly, only 9.68% earn below NPR 10,000, illustrating disparities in economic capacity to access health services. Homemakers, representing 48% of the sample, face barriers due to financial dependence and traditional roles, while government employees and business professionals exhibit better access due to stable incomes. These findings highlight the

need for inclusive healthcare policies, addressing income inequalities, occupational diversity, and socio-cultural dynamics, to ensure equitable health service delivery in Chhatrakot rural municipality.

The survey conducted among 25 respondents in Chhatrakot rural municipality reveals diverse perspectives on the accessibility and quality of local health services. A majority (60%) perceive healthcare services as accessible, with 32% rating them Very accessible. However, challenges such as financial constraints, poor service quality, and lack of transportation were cited as significant barriers to access. Satisfaction levels with health services are moderately high, with 40% expressing satisfaction and 20% very satisfied, though 16% noted dissatisfaction, indicating areas for improvement in service delivery and equity.

Usage patterns of health services vary, with 40% of respondents reporting occasional use and 28% frequent use. Financial constraints were the most cited barrier (32%), followed by service quality issues (28%) and transportation challenges (24%). Regarding the effectiveness of health services, 40% of respondents found them effective in addressing common illnesses, while 28% viewed them as only Somewhat effective. These findings highlight the need for targeted improvements to enhance accessibility and quality while addressing disparities across income and geographical lines.

The study also sheds light on the impact of health services on specific areas such as maternal and child health, where 48% believe they have had a Moderate Positive Impact. Local health awareness programs are considered effective by 44% of respondents, and 48% expressed high trust in the competence of health professionals. However, gaps remain in disease prevention and equitable access. These revelations highlight how crucial it is to improve infrastructure, remove financial obstacles, and modify health programs to accommodate the various needs of the populace.

According to the statistics, opinions about the equity and accessibility of healthcare services in the rural municipality of Chhatrakot are divided. Despite the fact that 40% of respondents thought healthcare services were moderately accessible to people from all economic backgrounds, major obstacles like infrastructure, cost, and location still exist. Inequities in availability, particularly for low-income and marginalized groups, are highlighted by the fact that only 20% of respondents thought the services were very

accessible, and 16% said they were not accessible at all. Furthermore, 40% of respondents said that healthcare services were not equitably dispersed across caste and ethnic groups, indicating structural injustices that need for focused initiatives to advance equality and inclusion.

Another issue that surfaced was healthcare providers' cultural sensitivity. The necessity for cultural competency training is highlighted by the fact that 48% of respondents said providers were seldom or never attentive to cultural differences, despite 40% of respondents finding them to be moderately sensitive. Similarly, 40% of respondents said health awareness initiatives were fairly effective, although there are still gaps in their ability to reach underserved populations. Due to a lack of inclusive design and services, only 12% of respondents reported complete accomodation in healthcare facilities, demonstrating that accessibility concerns also affect people with disabilities.

The report also emphasizes regional differences in healthcare access and cost obstacles. The majority of respondents expressed worries about affordability, with just 16% finding healthcare to be extremely inexpensive. More difficulties exist in rural locations, where 36% of respondents say access to healthcare services is limited.

Only 24% of respondents said that services were highly attentive to their requirements, demonstrating the lack of responsiveness in elder care. These results highlight the necessity of legislative changes to enhance healthcare delivery fairness, affordability, cultural sensitivity, and infrastructure for all populations and geographical areas.

Significant obstacles to local healthcare delivery within the rural municipality are highlighted by the statistics, especially with relation to skillful manpower, infrastructure, and financing constraints. 32% of respondents mentioned funding as the most urgent and serious concern, highlighting the financial limitations that prevent healthcare services from being expanded and maintained. 28% of respondents mentioned inadequate infrastructure, highlighting the need for additional medical facilities and modern equipment, particularly in underprivileged regions. Furthermore, 24% mentioned a lack of qualified and skillfull health staff, highlighting how crucial qualified individuals are actually providing quality care to them.

Proper role of administration and management are another factor contributing to inefficiencies in healthcare governance, as reported by 16% of respondents. A comprehensive strategy that includes workforce development, infrastructure

investments, additional financing, and policy reforms is needed to address these issues. Geographical obstacles and political influences have also been identified as important variables affecting the provision of healthcare services. According to a noteworthy 36% of respondents, political influence has a substantial impact on healthcare, affecting service equality through problems including partiality and unequal resource allocation. According to 48% of participants, geographic obstacles make access problems worse, especially in isolated communities and rural areas with inadequate connection. Systemic impediments still exist, despite certain progress being observed in some areas. Overcoming these challenges and improving healthcare access in a rural municipality requires a variety of environments, creative solutions like telemedicine, mobile clinics, and infrastructure development.

There is a lack of trust in the local government's ability to meet healthcare demands, according to public opinions. Only 16% of respondents thought the government was very competent of effectively distributing and managing resources, compared to 28% who thought it was just somewhat capable and 16% who thought it was completely unable. Public trust towards the health service and service performance are further undermined by corruption, which 36% of respondents regard as a serious problem. According to 40% of respondents, structural obstacles including discrimination and financial limitations continue to be a significant obstacle to equitable access for underrepresented populations. Transparency, anti-corruption initiatives, and addressing the particular needs of vulnerable groups must be given top priority by the local government in order to enhance healthcare delivery.

5.2 Conclusion

This study highlights the complex demographic, socioeconomic, and religious factors influencing healthcare usage and access in the rural municipality of Chhatrakot. The largest demographic using health services is middle-aged people, who are primarily Hindu, and caste diversity reveals long-standing sociocultural inequalities. The health needs of women and children are frequently neglected by joint family structures and traditional norms, but education is a key factor in raising awareness of and encouraging the use of healthcare. Economic obstacles are further shown by occupational positions and income disbalance, with homemakers having more difficulties than those in steady work. In order to guarantee fair and efficient delivery of health services, our findings

urge inclusive and focused healthcare policies that address socioeconomic disparities, promote health education, and give priority to underserved populations.

The Chhatrakot rural municipality study shows a complex picture of the municipality's healthcare system, striking a balance between quality and accessibility while highlighting some significant challenges. Even though the majority of respondents believe that healthcare services are accessible to majority of people, major obstacles are like lack of funds, geographical barrier, and cost effective transportation problems make equitable access difficult. Moderate involvement is indicated by satisfaction and usage patterns, suggesting that service delivery should be improved to more effectively address inequities. Although it is positive, the perceived efficacy of health services—especially in the areas of mother and child health—highlights the necessity of focused efforts in disease prevention program and fair access of service. These results highlight how important it is to improve healthcare infrastructure, remove socioeconomic obstacles, and modify programs to meet the particular requirements of the varied population.

There are serious issues like accessibility, equity, and quality in the healthcare system in the Chhatrakot Rural municipality, according to the report. Even though some respondents believe that healthcare services are equally accessible, significant obstacles like cost, location (geographical), and infrastructure still exist, especially for low-income and disadvantaged and disable populations. Systemic disparities are evident in the way healthcare services are distributed across caste and ethnic boundaries, necessitating focused efforts for increased inclusiveness. Another issue is healthcare providers' cultural sensitivity, which calls for more cultural competency training. Gaps in healthcare accessibility are also highlighted by the perception that disability modifications and health awareness campaigns are inadequate. These problems are made worse by geographical inequalities and financial constraints, particularly in rural regions, and the proper elder care is still lacking. In order to guarantee that healthcare services satisfy the various requirements of every person of the community, our findings urge extensive and dynamic policy changes that address fairness, cost, and infrastructure.

The study identifies a number of important issues with the local healthcare system in Chhatrakot rural municipality, such as a lack of enough funding, poor infrastructure (disable friendly) a lack of qualified and skillful human resource, and ineffective

governance and dynamic policies. These problems are made worse by political influence and physical constraints, which make it more difficult for everyone to obtain services fairly, especially in rural regions. Because of worries about corruption and poor management compromising service delivery, the public has some faith in the local government's ability to manage healthcare resources. The local government must prioritize building a skilled workforce, enhancing modern infrastructure equipped with modern machines and other equipment, and increasing funding to meet these challenges.

Additionally, to guarantee fair access to healthcare for all citizens of Chhatrakot Rural municipality new innovative ideas like mobile service delivery, special people targeted program, health related awareness program in co-ordination with other stakeholders, build up transparency, public participation in decision making process, optimum use of limited resources in such a way that could produce maximum benefit, investment in human resources development and focused interventions for underserved groups are required.

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