CHAPTER I
INTRODUCTION

This chapter provides introduction of the study. It includes background of the study, statement of problem, objective, limitation, and significance, organization of the study. Apart from this, it also includes definition of key terms used in this research.

1.1 Background

Health is the basic need of human being. It is also a right of people. However, people in the present Stratified World are not getting it equally. The Interim Constitution of Nepal 2063 BS stated for the first time that every citizen should have the right to get basic health services free of cost from the state as provided for in the law. This makes "health for all", a fundamental human right. Giving emphasis to this commitment, Ministry of Health and Population has implemented a policy aimed at providing free health services.

Nepal is also one of the member countries of Alma-Ata conference held at former Soviet Union (Kazakhstan) in September 1978. The declaration of Alma-Ata formally adopted "Health for all beyond 2000" primary health care (PHC) as means for providing comprehensive, universal equitable and affordable health care services for all countries. The conference went so far as to address the economic and political steps needed to fund the initiatives.

The Alma-Ata declaration is promoting health for all. However, 34 years after its declaration, the utilization of health services especially by poor and marginalized has become a big problem in developing countries like Nepal. In our context, financial aspect has become an important barrier for the accessibility to health for all. The willingness to pay for the services cannot be equated with ability to pay for it. The issue of health for all is challenge for developing countries like Nepal.

In Nepal, formal health sector is organized through Ministry of Health and Population (MOHP) with central offices of various programmes. The MOHP is a large single

provider of formal health services. In vertical organizational structure, there are different institutions from Central, Regional District, Electoral Constituency, Ilaka and VDC level. So sub-health post exists at VDC level. Nepal is a country of rural population. Sub-health posts of VDC level are the first health service provider for rural people.

Much of rural Nepal is located in hilly or mountainous regions. The rugged terrain and the lack of proper infrastructure make it highly inaccessible limiting the availability of basic health care. In many villages, the only mode of transportation is on foot. This results in a delay of treatment. This can be detrimental to patients in need of immediate medical Attention. Most of Nepal public or private health care facilities are concentrated in urban areas. Rural health facilities of them lack of adequate funding. In 2009, Nepal had 10 health centre, 83 hospitals, 675 health posts and 3127 sub-health post which serve villages (MOHP, 2010).

Nepal is an under developed country with having high population growth 1.35 percentages and low economic growth because of poverty, illiteracy, geographical difficulties and socio-cultural factor the health status of people is in poor condition. Nepal has not only one of the world's worst health service systems but also some of the world worst health indicators it is ranked as 12^{th} poorest country in the world. As noted by Collins "It's notoriously unstable politics and mountainous terrain hinder development" (Collins 2006). On the basis of health indictors achieved till now, health status has positively changed but not as expected even through government has brought legal instruments epically for health and population, set health institution throughout the country. However, major issues remain standstill in population growth rate 1.35 percentages. Likewise, maternal mortality rate is (281 per 100000), life expectancy 62 years, infant mortality rate 48 per 1000 per live birth etc. are seen poor in comparison with the other south Asian Countries (MOHP, 2010). Besides regional disparities in health indicters between and among the rural and urban, ecological belts of Nepal are alarming on the availability of basic health facility. Front line health workers are not in sufficient numbers. They are not available at work place or remote areas in particular. Health institutions are not well equipped with sufficient medical tools. Therefore we can say that the state is not fulfilling its responsibilities to insure citizen's right to health.

In Nepal, there are different agencies involved to provide health services which can be categorized in the two type national health agency and international agency. Although, these national or International agencies are working to improve the health status of Nepalese people since more than 40 years. The services are urban centered, access of rural people is still poor (Sigdel, 1998).

In recent years to increase the access of health services several governments of low income countries decided to remove user fees in health sectors. In Nepal after the "peoples movement II," without the adequate pre-plan to respect the interest of people the government pass the bill about "Health Right" as a fundamental right in 'Interim Constitution of Nepal 2063BS". It has been five year that the primary health care Was made free but the government has not been able to provide facility to the people as intended. The effectiveness of this policy has been assessed in this micro level study in relation to access and quality of the services provided through sub-health post in Rapakot VDC of Syangja district.

1.2 Statement of Problem

In recent years, several governments of low income countries decided to remove user fee in health sector. A number of factors have led to such policy moves the evidence that user fees prevent people from accessing health services and hurt the poor in particular, a willingness to remove barriers to the attainment Millennium Development Goals, a greater concern for equity, and aid instruments favoring an increase in public spending in social sectors backed by political support from global actors.

Different international organization are also committed to help especially third world country among them UNICEF is also committed to supporting governments willing to remover user fees for services targeting children and pregnant women. In order to expand the knowledge base it has recently commissioned a study reviewing the experience of nationwide user fee removal in six sub-Saharan African countries (Burkina Faso, Burundi, Ghana, Liberia, Senegal and Uganda).The multi-country review has helped to identify strengths and weakness in the way governments have formulated and implemented the user fee removal policies. A key strength of the six countries experience reviewed is the clear leadership displayed by political leaders. In

the countries where there has been a smooth dialogue between the political leaders and the national programme managers, the formulation of reform benefited greatly. However, the eagerness of the political leaders to move rapidly has also sometimes confronted technicians with the obligation to implement an insufficiently prepared decision (Meessen, et. al., 2009).

In Nepal PHC has had a long history that was reinforced by declaration at Alma-Ata in 1991 culminated in national policy was a turning point in delivery of primary health care services in rural areas of Nepal. The most important contribution of the policy is that it increased the access to majority of people in Nepal by establishing health instruction spread throughout the country, sub-health post(SHP) and health post(HP) to deliver health services at VDC level (DOH, 2009).

Free health care policy is directed by Interim Constitution of Nepal 2007, which is the spirit of people's movement II. This policy is based on the citizen's rights policy of free health care is to provide primary health care services free of cost to every citizen and special attention that is to safety net to poor vulnerable and marginalized people. The objective of free health care policy are to secure the right of citizens to the health services, increases access to health services especially for poor, ultra-poor, destitute, disabled, senior citizens and FCHVS, reduce the morbidity and mortality especially to poor marginalized and vulnerable people, provide quality essential health care services effectively (MOHP, 2010).

After implementation user fee removal programme there were only few studies carried out to assess its effectiveness. There are some relevant studies at global level. For example, studies in Burundi, Liberia and Zambia showed that basic indicators such as health facility utilization or coverage rates are not routinely followed up by the health authorities in relation to implementation of free health care (Meessen, et. al., 2009).

Nepal has institutionalized the PHC approach in health policy, strategy and health care delivery system. However, this has not been effectively translated in actions. Health activities in the past were focused more on selective health care strategy in the form of diseases control immunization, vitamin A, Supplement action of oral rehydration solution use and contraceptive use. Nepal is one of the path ways to build

equitable comprehensive primary health care and its national health policy, strategy and health care delivery.

In Nepal, previous studies cover macro issues and only technical aspects were considered. They only focus on policy design and implementation (Gurung, 2009). Apart from this it focused on increment in quantity i.e. number of hospital, PHCC, HP and SHP (Karkee and Jha, 2010). Even the national health care policy also focused on increasing fund and investment to increase the health care access and quality (MOHP, 2010).

This study tries to fill the gap of information and evidences about the real situation of user free removal and its effectiveness at local level. For this, it tries to evaluate the user free removal in PHC from the users' perspective. This study also is guided by medical anthropological perspective and insights.

In VDC level sub-health post are the only key infrastructures of health services and free health service provider institution for rural people, especially poor, marginalized and disadvantage groups. The specific evidences are not available to understand whether the services have improved after removal of the user fees in the government health facilities. In line with this the study tries to answer following research questions.

- Are the services provided by sub-health post easily accessible to local people?
- Is the access increased after removal of the user fee or making service/medicines free?
- What is the general quality of services in the sub health post?
- What is the situation of relationship between service providers and users?

1.3 Objectives

The general objective of the study is to assess user's perception about free health services delivered by sub-health post at VDC level.

The specific objectives of the study are as follows:

- To analyze the people's access to services delivered by sub-health post in Rapakot VDC particularly after removal of user fee.

- To assess the quality of services provided by sub-health post in Rapakot VDC after user fee removal.

1.4 Limitations

This study is an academic study. It was under taken within limited time, budget and other resource. Through, it is the study of access and quality of free health services at VDC sub-health post level provided by government, this study covers single health post and by using purposive sampling of two ward of VDC. This study is only concerned with identifying people's perception towards quality and accessibility of services provided by sub-health post in rural area. However, the finding may be applicable among similar rural villages of Nepal.

1.5 Significances

A famous proverb "Health is wealth" helps to understand the importance of the health. Large number of population in Nepal are still under the line of poverty i.e. they are unable to pay high level health services cost especially provided by private sector in urban areas. The government of Nepal declared health as a fundamental right. Constitutional declaration is not a real solution of problem. This study has explored the condition of rural health service provided by government of sub-health post level.

The main significance of the study is to find out the impact of user fee removal policy in grass root level. Really needy people who were targeted by the policy were benefited from the policy and practice is the core concern of this study. The finding may useful for the government and non-government organization especially working in health sector. It also will be helpful for planner services who are working to provide health services in rural areas. It can be helpful for a further study on effectiveness of free health services its challenges and ways to improve the free health care policy.

1.6 Organizations

This study is divided into seven chapters. The first chapter deals with introduction part. The second chapter includes the literature review. The third chapter deals with research methodology. The fourth chapter is generated for the introduction of study area and description of respondents' socio-economic background. Similarly fifth and sixth chapters deal with analysis of variables and findings to show the actual situation

of the utilization health service delivery system as mentioned in objectives. Facts found from observation have been presented in sixth chapter. The last chapter provides summary of the study findings and conclusion based on the findings.

1.7 Definition of Key Terms

Access: It refers to the free availability of services which are declared by government of Nepal in sub-health post level at the time of when services recipients need.

Quality: Quality of services attributes the different aspects such as drug availability, surrounding cleanliness, response to the patient's queries health workers on duty and proper counseling, etc.

Free Health Care: The health services which has been freely delivered by public health institutions i.e. hospitals, primary health care centers, health posts and sub-health posts.

Primary Health Care: It covers basic services such as education on methods of preventing and controlling prevailing health problems promotion of food security with proper nutrition, adequate safe water supply and basic sanitation, maternal and child health including family planning, vaccination, preventing and controlling locally endemic diseases.

User fee removal: It is the programme launched by GON after people's movement II, in health sector to ensure citizens health right as a fundamental right especially at PHC level.

Utilization: Utilization of health services available in sub-health post of Rapakot.

CHAPTER II
LITERATURE REVIEW

This chapter provides a review of literatures pertinent to the study. The review is divided into two main sections namely theoretical overview and review of previous studies. Theoretical overview includes introduction of Medical Anthropology, Critical Medical Anthropological perspective and relationship between service provider and users. Previous studies reviews range from international to national researchers and articles published in different journals. Such review of the different literature has supported in shaping the study more systematically and adding values to it.

2.1 Theoretical/Conceptual Overview

Anthropology along with other sciences can contribute to understand human health as well as environmental health as series of socio-cultural and ecological order. However this seems to be largely underestimated in Nepal, Medical Anthropology is confused specially among Nepalese planner, policymaker as discipline merely studying tribal and less sophisticated societies and coulters. It also studies contemporary issues like unequal distribution and access of people to health services. In relation to this, a short introduction of Medical Anthropology and pertinent theoretical orientation and concepts has been reviewed.

2.1.1 Medical Anthropology

Medical anthropology (MA) is one of the youngest and most dynamic branches of the various branches of anthropology (Subedi, 2003). It concerns with a wide variety of health related issues, including the etiology of the disease, the preventive measures that human as a member of socio-cultural systems have constructed or devised to prevent the onset of diseases and the curative measures.

MA is the study of relationship between human culture and human health in a holistic perspective. "MA is a bio-cultural discipline concerned with the biological and socio cultural aspects of human behavior and with the ways they interact to health and diseases. It is the study of how social and environmental factor affect the health

awareness alternative ways of understanding and treating diseases" (Foster and Anderson, 1974).

People with more social economic and political power in a society are generally healthier. Inequality in health in socially stratified is not surprising. The poor usually have more exposure to disease because they live in more crowded conditions. And the poor are more likely to lake the resources to get quality care (Ember and Ember, 2008).

M.A. covers wide area to understand health illness, diseases and treatment practices. Critical Medical Anthropological perspective is one among them which links political economy of the health in Medical Anthropology.

In the beginning phase of development of MA, it developed same as Anthropological development. Study of non-western people their explanation of illness, treatment practice. More scientific investigations from anthropological perspective started only after from 1950s. Since, 1940 AD anthropologist started to engage in public health by helping health service provider and agencies to understand cultural differences in health behavior in 1974 AD. Society for medical anthropology was established. The field has been progressed beyond its roots and encompasses a wide range concerns issues. The sub field is increasing becoming interdisciplinary in terms of theory and methods.

After 2nd World War function of different health developing agencies including WHO, and anthropologist were invited in the health development in third world countries. Health interventions were increasingly informed by anthropological information. On the role of cultural differences in the health care development, later international agencies shaped the research agenda in medical anthropology.

Medical anthropology covers a broad area; it includes the concept of health, diseases and sickness from the people's perception according to their culture. In biomedical treatment process different pathological test and its interpretation are the ways for recognizing health, illness and sickness.

Anthropological medicine is a theory and practice that gives primary to sickness. It accepts social cultural roots of both professional and lay ideas and attitudes about sickness that fully recognizes the etiology of sickness in social cultural as well as physiological and environmental conditions that also affects socio-cultural effects in therapy and healing processes and respect social context of healing.

In biomedical settings anthropologist share occasionally called to assist with patients cultural traditions appear to hinder standard practice, because the physicians does not compliant because the patient does not accept prescribed therapy. The role of anthropologist to understand the context of patient as a ethnographer is also important while making treatment related decisions.

Listening to other all traditions are hallmarks of anthropological perspectives and practices. The central goal of listening is to understand how things look from the others point of view and it also pursuit of medical information and diagnosis.

In anthropological medicine, the physicians would be the understanding of patient conditions and circumstances, the development of etiological and therapeutic knowledge and technique, the effective communication of this knowledge and expertise to patients and the application of this knowledge for the assistance of patients and their communities in treating sickness and achieving patient and community goals. The ultimate burden of control and decision-making would rest with patients and their communities. The stresses and anxieties of medical practice would be buffered by sharing among physicians, by listening, by understanding context, by recognizing ethnic variation, by respecting, responding to an accommodating patient traditions and by recognizing healer themselves, the practice of anthropological medicine would sub-stationary enhance the condition of medicine (Hahn, 1995).

2.1.2 Critical Medical Anthropology

Critical medical Anthropology (CMA) is one of the key approaches in Medical Anthropology. It tries to understand health issues in the light of larger political and economic forces that pattern human relationship, shape social behavior and institutions at local and global level. Critical Medical Anthropology links political

economy of health in to MA which was missing in medical anthropology, and it seeks to uncover hidden cause of poor health as they relate to capitalism and imperialism, while examining health structures on micro and macro level. This theory has been strongly shaped by works of anthropologist Merril Singer. He explains CMA is a "System Challenging Praxis". Engaging in system challenging praxis involves unmasking the origin of social inequalities and its effort on health (Singer, 1986).

It is concerned with the relationship between micro and macro level issues. MA believes macro level structures and process are dominant and it should be analyzed, however macro level analysis of particular issues is also important to understand the relationship between society culture and health therefore it calls for integration between macro and micro level issues (Singer, 1986).

It puts emphasis in understanding health issues within the context of the class imperialist relationship inherent in capitalist world system, CMA concern with investigating social origin of illness. It maintains the discussion of specific health problems apart from macro level political and economic issues only serves to mystify social relationships that underlie environmental, occupational nutritional, residential and experimental conditions. Disease is not the straightforward outcome of an infectious agent or path physiologic disturbance. Instead, a variety of problems including malnutrition, economic insecurity, occupational risk, bad housing and lack of political power create an underling predisposing to disease and death. Importantly, the ultimate origin of these problems is not environmental or biological but social, namely the existence of inherently oppressive social relationships of production and expropriation.

A central arena of analysis within CMA is the nature and organization of the health care system that diffused hand-in-glove with capitalism, the system variously known as bio-scientific, western, allopathic, or cosmopolitan medicine (Singer, 1986). There is a growing concern with the nature of this health care system in medical anthropology. Generally, the important point of departure for critical medical anthropology is recognition of relationship of this medical system to its encompassing political economic environment. In this light, it is perhaps more accurate to refer to this system as a bourgeois medicine rather than to adopt any of the ill fitting descriptive labels in common currency. The term bourgeois medicine identifies a key

feature of this health care system, namely its role in the promotion of the hegemony of capitalist class specifically. Bourgeois medicine is not a "thing" or a set of procedures and treatments so much as it is a particular set of social relationships and ideology that legitimize them.

CMA also focuses on interrelationship between various medical systems (Medical Pluralism) In light of political economic context, it is concerned with the diversity and changing pattern of health care system and health related behavior found around the globe. It believes that modern world is cloth of many color woven together by penetrating threats of capitalistic mode of production and distribution.

CMA critically analyzes the condition of health, sickness and disease as well as health care system also. The unequal distribution of health services is the major concern in this study. There is inequality in health care services in Nepal. People living in rural area are far away from good health service. Both private and public sectors have been giving more priority to develop health institution in city areas.

People of low income and who are living in remote area are dependent on governmental free health service but they are not getting proper benefit from it. In this study critical medical Anthropological perspective is directly related with this issue.

2.1.3 Doctor-patient Relationship

Communication between doctor and patient is attracting an increasing amount of attention within health care studies. From the review of doctor-patient communication, specific communicative behaviors, the influence of communicative behaviors on patient outcomes are the most important aspect of doctor patient relationship.

Creating good interpersonal relationship exchanging information and making treatment related decisions are the different purpose of communication. Several communication behaviors that occur in consultations are instrumental (cure oriented) vs. (care oriented) behavior, verbal vs. non-verbal behavior, privacy behavior, high vs. low controlling behavior and medical vs. everyday language vocabularies. Consequences of specific physician behaviors on certain patient outcomes, namely

satisfaction compliance/adherence to treatment, recall and understanding of information and health status (Ong, et al., 1995).

Effective medical communication enables doctor and patient to make decisions about treatment. Traditionally the ideal doctor patient relationship was paternalistic: the doctor directs care and makes decisions about treatment. But in present time this approach has been replaced by the ideal of shared decision making, such practice has been applying in developed countries. In order to make such decisions patient needs information. In the case of Nepal, especially in rural area people do not have good health consciousness, knowledge and they were not getting information from the doctor also.

For the effective treatment good relationship between services provider and receiver is important. It also affects the access of services to the people doctor's careful observation and proper hearing to the patient problem may lead proper diagnosis of health problem. When health worker properly address the patients problem it leads the faith on services.

While describing doctor patient relationship these three models of relationship are also important. The first model is Model of Activity and Passivity. In this model doctor became active and patient passively follow doctor's treatment. The Second Model is the model of Guidance Cooperation. Where the doctor collects information from patient makes treatment related decision. The third model is The Model of Mutual Participant. In this model patients own experience provides reliable and important clues for therapy (Szasz, et. al., 1987). This type of model has been practiced in developed countries where the patient also conscious about their health, disease and sickness. But like developing countries the first type of model is seem mostly in practice. In the study area also this type of model has been found.

Health care provider's politeness and intimate behavior may convince patients and they would frequently visit that institution. Good doctor-patient relationship is one of the indicators of quality of health service. Amicable relationship and interaction in health service setting also affects users' choice and access to service.

2.2 Historical Development of Health Sector in Nepal

Good health is an important asset for every citizen for improving standard of living. Healthy human resource is essential for overall development. "Health is a fundamental right of people" is a globally accepted value which is also incorporated in the interim constitution of Nepal 2063 B.S. This indeed is a historical manifestation of the states responsibility towards insuring the citizen's right to health. The health care system development in Nepal is directly interrelated with planned development practice. Before planned development the organization structure of formal health care system was not well developed. After the establishment of democratic system in 1950AD the formal development practices were started.

2.2.1 Before Planned Economic Development

In the first half of 20th century, few formal health services were available in Nepal. Most of these services, which were curative in nature, were concentrated in urban areas. As a result, vast majority of rural population were born and died without knowing the existence of formal health services. The majority of them were dependent in traditional practitioners.

In 1933AD, the Department of Health services (DHS) was established (Sigdel, 1998:19). During this period, foreign assistance was not received and there were no virtually western medical workers. Between 1951 and 1955, emphasis was placed on training physician in India, a nursing school and Nepal's first NGO hospital was established. In 1954AD, a malaria project in Chitwan was launched representing the first government activity in area of primary health care. This was followed by the establishment of Nepal Malaria Eradication Organization in 1958.

2.2.2 After Planned Development

Planning simplifies reality by providing scheme of how to relate one's end and one's means with a specified period of time so that one can achieve some preferred goal by using resource, personnel and time.

Good health is an important asset for every citizen to improve living standard. Healthy human resources are essential for an overall development "Health is a fundamental right of people" is a globally recognized value. This is also incorporated

in interim constitution of Nepal 2063BS. Government of Nepal (GON) adopted sector-wide approach for designing and implementing public policies. Health policy is one of them. From 1975, Nepal's health policy was directed towards providing minimum services to maximum number of people. Following the declaration of 'Health for all' strategy in1978, GON undertook policy measures and programs for promotion of health at central level to VDC level.

During the first five year plan (1956-61) National Development plan was launched with the objectives of increasing gross domestic products, provide employment and improve leaving standards of people. Specifically, this plan has focus on institutionalization of curative services. During this period, Ministry of Health (1956) and Maternity Hospital (1956) were established.

During second three year plan (1962-65) as part of overall health program, emphasis was placed on both preventive and curative medicine for the first time. In 1962 a survey was initiated for smallpox. In addition pilot projects for leprosy (1963) and TB (1965) control program were lunched. For the third plan (1965-1970), more extensive efforts were developed to help plan health strategies for the future. The idea of rural health post was introduced. During this period vertical projects Smallpox Eradication (1967) and Family Planning and Maternal Child Health (1968) and Central Health Laboratory were established.

The period between the third and the forth development plan (1965-75) saw significant development in health organization and management of health services. One important development was that the concept of integration was promoted to organize health care in rural areas. The major aspect of "integration" is that the single purpose health workers in the vertical health programs were to be converted into multipurpose health worker who would do the work of several vertical workers, and provide simple health care, preventive care and health education (Sigdel, 1998:20).

As a part of the forth plan(1970-1975) Nepal's health priorities changed from emphasizing curative services to focusing more on preventive services. To help implement this strategy the GON established the instead of medicine, which sought both to produce new paramedical workers and to train existing medical personnel further.

During the fifth plan (1975-1980) the process of integrating vertical programmes into overall health infrastructure was further developed. For the purpose of promoting physical, mental and social health of people producing health sector manpower to make basic health services available to all the people reducing the mortality rate, and uplifting the average life expectancy, the fifteen year Long Term Health Plan (1975-1990) was implemented in 1976. The plan called for the expansion of basic health care services, to rural areas on gradual basis providing it at the village level for majority of the population and checking population growth to promote national development priorities included developing basic health services, popular rising family planning/maternity and child health services and producing health workers.

The sixth plan (1980-1985) document summaries the importance of preventive services as a key to checking the outbreak of infections and endemic disease. The aim was to provide preventive services through health posts, with village health workers and war level volunteer as front line worker. In urban areas, provision was also made for involvement of private sector to run hospitals under the overall policy guidelines of government. During the plan period a Decentralization Act (1982) was passed and planning was officially decentralized to the district and of health post hospitals, hospital bed were increased in the number but fail to achieve targeted goal.

2.2.3 Primary Health Care Revitalization Programme

In Nepal, PHC has had a long history that was reinforced by declaration at Alma-Ata, and in 1991 culminated in the National Health Policy endorsing PHC. National health policy 1991 was a turning point in delivery of primary health care services in rural areas of Nepal. The most important contribution of the policy is that it increased the access to majority of people in Nepal by establishing a total of 4020 health institutions spread thought out the country, Sub-Health Post (SHP) and Health Posts (HP) deliver health services at VDC level. Primary health care centers (PHCC) with 3 beds are established in each electoral constituency. Hospitals that have up to 25 beds provide outdoor, indoor and emergency services in districts (DOHP, 2009/2010).

The Seventh Development plan (1985-1999) was more specific in its commitment towards PHC. The main objective of the plan was to extend the coverage of family planning, maternal and child health activities. Similarly, it also aimed to making

preventive measure accessible and rise to the people's consciousness to combat the problem malnutrition.

The year 1990 assumes special importance to Nepal. The restoration of multiparty democratic system opens avenues for people to participate in the overall development process. In 1991 government launched a New Health Plan with major emphasis on co-ordination, decentralization and effective management with these objectives to improve the general health coordination of people in order to provide the health man power, to extend basic and primary health services to the villages to improve the health status of rural people to extend mother and child health services and family planning.

During the eight plans (1992-1997), it emphasized on providing "Health for all by 2000" bringing an improvement in public health status under the support of various donor agencies. The government of Nepal has prepared second Long Term Health Plan (1997-2017) covering all major dimension of health care in Nepal .The plan is guided by a vision of a health system in which there is equitable access to coordinated quality health care services in rural and urban areas characterized by self reliance full community participation decentralization effective and efficient management. Partnership among government, NGOs and private sectors are the police adopted by this plan (MOHP, 2001).

The ninth plan (1997-2002), had the objective of supporting poverty eradication by improving health status of the people with the help of preventive, promotional, curative and rehabilitative means of health services. The tenth plan (2002-2007) focused on the quality of health care through total quality management manpower, financial and physical resource.

Over the last five decades, providing Health Care to majority of the people has been the government strategy, one important is that the achievements of all five years periodic plans remains less than satisfactory. In spite of some growth in the health infrastructure in terms of hospital beds, human resources and institutions in the public sector, the great majority of the population are still not covered by formal sector.

At millennium summit of 2000, the member countries of United Nation adopted the millennium Declaration with the aim of bringing peace, security and development to all people. The MDG outlines major development priorities to be achieved by the year 2015. It has eight goals MOHP is directly responsible for three goals i.e. goal number 4,5 and 6 target were set to reduce by two third for under five mortality, three quarter for maternal mortality ratio and have halted for maternal mortality ratio and have halted by 2015 and begun to reverse the incidence of malaria and other diseases.

The three years interim plan (2007-2010) seeks to establish the right of citizen to free basic health services as per the principles of primary health services. Special programmes will be launched in an integrated manner with participation of government, private sector and NGOS to increase the citizens access to basic health services targeting those deprived of health care such as indigenous nationalities (Adibashi and Janajati), Dalits, people with disability and Madhesi people (MOHP, 2010). For this, plan has paid special attention on the essential health services, health sector reform and infrastructure development, decentralization of health institution management public-private partnership and health research. On basis of health indicators till now, health status has positively changed but not as expected even through government has brought legal instruments especially for health and population, set health institutions throughout the country. However, major issues remain standstill in population growth rate (1.8). Likewise, maternal mortality rate (281per 1000000), life expectancy (68 yrs), infant mortality rate (46 per 1000 per live birth etc. are seen poor in comparison with south Asian reason (CBS, 2011). Besides regional disparities in health indicators between and rural and urban, ecological belts of Nepal are alarming on the availability of basic health facility. Besides front line health worker are not insufficient numbers. They are not available at work place of remote areas in particular. Health institutions are not well equipped with sufficient medical tools and other logistic materials.

2.3 Health Care System in Nepal

Formal health sector is organized through ministry of health and population (MOHP) with central offices of various programmes. The MOHP is larger single provider of formal health services. In vertical organizational structure there are different institutions from Central, Regional, District, Electoral constituency, Ilaka and structure the department of health services as follows:

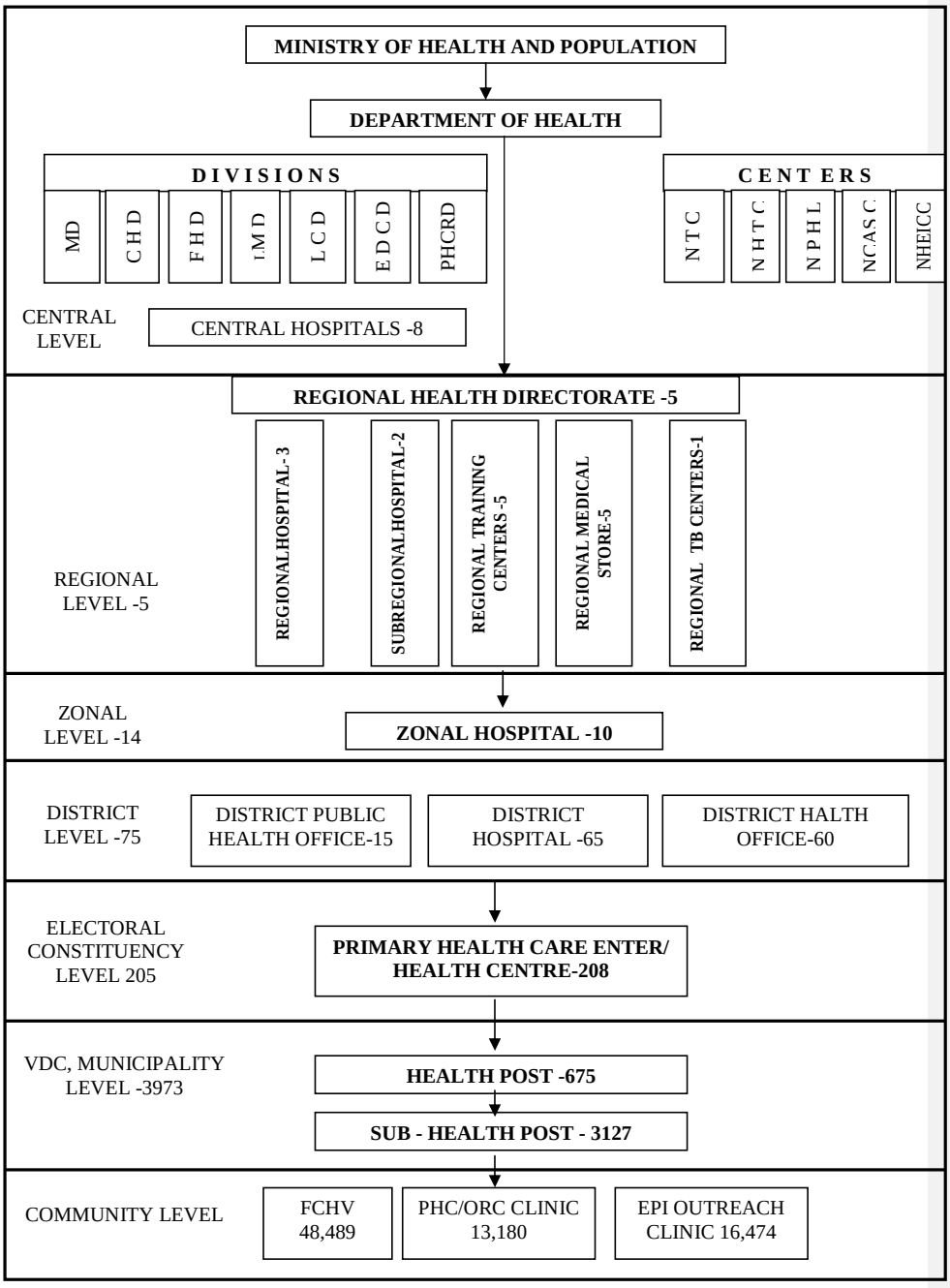

Figure 2.1: Health Care Structure of Nepal

Source: Department of Health, 2010.

The public sector health service delivery is through of a net work of institution. The organization is similar to politico-administrative system. Above table shows the service delivery channels from central to community level.

2.4 Review of Previous Studies

2.4.1 User Fee Removal at Global Level

Ensuring availability of supplies drug in particular and availability and motivation of staff are challenges for the successful implementation of these policies. The bases for the successful reform are: political leadership a clear understanding of the implication of the reform in the terms of resources, consultation of key stakeholders, technical leadership, agreement on the funding of the reform, a clear division of task, a robust channeling of funds and finally good monitoring and enforcement of the scheme.

In 1993, Zambia introduced user fees for health care in public facilities at all levels. Coming together with the macroeconomic reforms in1990s (so called structural adjustment programmes), the common theme was the removal of public subsidies and withdrawal of direct government provision of many social services including health care. However, the rallying cry for user fees was the promotion of community participation and empowerment. All this was to be accomplished under a decentralized health system in which a paying community would exercise accountability for how health care was planned and delivered (Masiya et. al., 2008).

Following fifteen years of implementing user fees great concerns have been raised about the role of user fees in health setting in which wide spread poverty dismal key health indicators are pervasive. Over time, several evaluations of user fees have reported both positive and negative effects. These gain and losses of policy are weighed differently by different stakeholder. However, the political and policy climate seems to favor a more direct policy to protect the rural poor at the very least. Against this background user fees were abolished, effective from 1 April 2006 (Masiya et. al., 2008).

The effect on user fees removal on aspects of utilization and quality of services, as the issue is still very topical in many African countries, the evidences and lessons

emerging from Zambia should help shape a workable and equitable future financing policy framework for the other poor countries.

After user fee removal in Zambia there was substantial increase in total utilization of public health services and an increment in drug consumption. Utilization of public health facilities was estimated to have increased by about 50% among the rural population over five years old. The districts with greater proportion of poor people recorded greater increase in utilization of their facilities. Drug consumption in rural districts was estimated to have increased by 40 percent. Staff workloads in rural districts also showed a slight increase after user fees were removed.

Removing user fees in the health sector is very appealing to political leaders. In the past, a few of these leaders thought that they could abolish user fees with the stroke of pen; they rapidly discovered that they are wrong. One dose not abolishes user fees; one replaces them with another way to found the health services. Establishing this alternative financing option requires its quantification, the identification of its source, the long term commitment of sponsor the institutionalization of the management and channeling of resources. These are things never secured with the stroke of a pen. Consultation analysis argumentation, communication and training sessions are some of the action s required to move forward. Technicians have a key role to play at this level (Meessen, 2009).

In the Zambian context, removing user fees in rural areas was seen as a potentially effective and pragmatic tool for bridging the socio-economic divide across the country and improving health quality. In terms of free market economics removing a price barrier is normally expected to raise the demand for most types of health care. The rationale for abolishing user fee for everyone was that utilization would increase, particularly among the poorest, which are more sensitive to price increases (Leighton, 1995). There was also a public health motive, which suggests that increasing access to primary health care would lead to appropriate health care seeking behavior and reduce the country's health burden.

For the effective implementation of policy we have to put forward a set of good practices to maximize the chances of a successful implementation of reform. Any reform has its share of annoyances; unexpected situations and error to correct.

However, the better the reform is prepared and implemented, the greater the chances of benefits are maximized for target group.

However, it remains an empirical question as to exactly how the removal of user fee has imported on utilization of health services and health equity. Poor households face several other barriers for seeking health care, such as traveling long distance to facilities, poor transportation means, and poor quality of care and a general lack of access to information.

User fee removal must be accompanied by supporting policies, especially on increased public finding and efficient distribution of drugs and related supplies. These measures are necessary to ensure that quality of care does not suffer. If quantity fails the poor often have to buy drugs or seek care of private facilities, these by negating the effects of user fee abolition (Masiye, et. al, 2008).

2.4.2 User Fee Removal in Nepal

In Nepal after the second popular peoples movement of 2006 the policies programmes activities of MOHP's officials are driven by the spirit and feeling of the movements. There has been a growing expectation of the people seeking for the basic health services improve their living condition. Primary health care has been incorporated in the interim constitution of Nepal as citizens fundamental right, including a provision that primary health care be made free of cost (MOHP, 2010).

When free health care policy is introduced, cost of user falls to zero. It might increase the tendency of unnecessary and over utilization of health care. It would increase in demand of health of care. Therefore, a clear policy, increment in the infrastructure and human resource management would be of outmost important before widespread implementation of this program. The quality of care in health facilities is likely to suffer due to inadequate staffing and infrastructure, in adequate supply of drugs. It is important that poor and excluded constitute the majority of those who would be benefited from this policy however, due to lake of proper monitoring this group had been left aside. The people in urban areas are more aware and most of these services are located in these areas only (Gurung, 2009).

Free removal tended to exacerbate the problems facing health systems and weaken their performance. On the other hand, in countries were fee removal was carefully planned and managed, there are signs of increased utilization of services and

indications that the poor benefited the most although this does not guarantee health benefit or sufficient welfare protection (Xu., et al., 2006).

Nepal has institutionalized the PHC approach in health policy, Strategy and health care delivery system. However, this has not been effectively translated in actions and the results are mixed. Nepal has gained impressive achievements in selective primary health care markers while gain in comprehensive health marker is not impressive. Health activities in the past were focused more on selective health care strategy in the form of diseases control, immunization vitamin 'A' supplementation oral rehydration solution use and contraceptive use (Karkee, et. al, 2010).

Health care programmes are crafted without people's meaningful participation prescriptions trickle down all the way from international health rings to rural villages. The programes designed by upper level and implement in low level were not complete successes when people are empower. It is very easy to process right based approach whereby can raise their voice making authority and responsible person more accountable (Bhurtyal and Ahikari, 2013).

2.5 Conceptual Framework

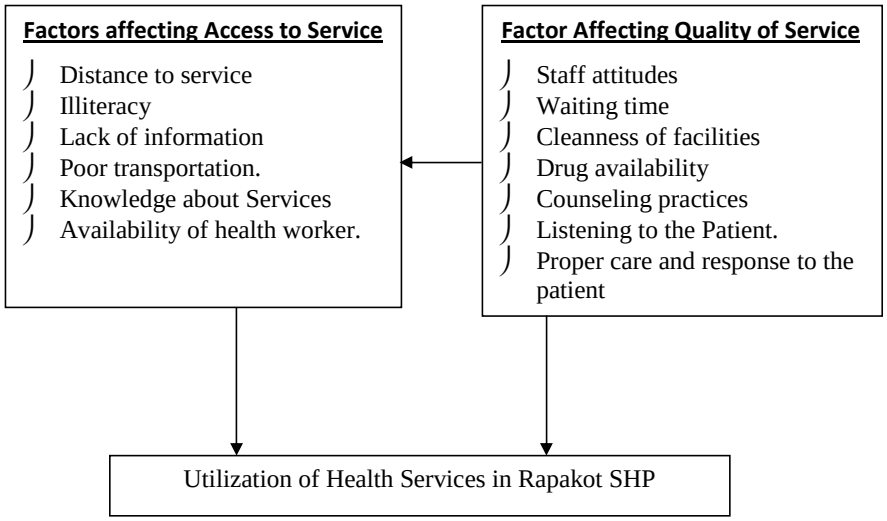

Figure 2.2: Conceptual Framework

This study is about the free health services given by public health institutions in VDC level by the government. In this study different aspect affecting to the effectiveness of

the services has been analyzed. However, the study doesn't consider macro-level factors. According to objectives, two aspects access to services and quality of services have been analyzed in conceptual framework by using different variables. Distance to service, illiteracy of patients, lack of information, poor transportation, economic status of patients, knowledge about free health services and availability of health worker are the main factors for affecting access. Staff attitudes, waiting time, cleanliness of facilities, drug availability, and good counseling practices, listening to the patients, proper care and response to the meeting patients are the different factors for affecting quality. If good quality of services is provided from sub-health post the access of services will also increase.

If the above mentioned aspects are in positive condition the utilization of services will be increased otherwise the service delivery system will not able to fulfill its objectives moreover it will fail it objectives and the effectiveness of services will be decreased. Condition and relationship of above variables have been described and analyzed in upcoming chapters.

CHAPTER III
RESEARCH METHODS

This chapter provides an overview of the research methods employed. It includes rational of the selection of study area, research design, data collection tools and technique and sampling design. In this research both primary and secondary data have been used. As per need to collect both type of data different tools and techniques were used which have been described in this chapter below.

3.1 Rationale of the Selection of the Study Area

Syangja is a hill district in western Nepal. The geographical location of the district is minimum 366 meters (Kaladee) to maximum 2512 meters (Panchase hill) height from the sea level (VDC Profile, 2065).

The health facilities provided by government in district are as follows. District hospital -1, primary health centers-3, health post-10 and sub health post-54. There are 60 VDC in district. Among them Rapakot is one. This lies western side of the district bordered by Parbat district. Among 54 sub-health post in district one of them is Rapakot VDC which is situated at ward no.9 of VDC According to data available from district profile (2065) the total population of V.D.C is 4496 and there are 883 households (VDC Profile, 2065).

Rapakot is ethnically diversified VDC of Syangja where Brahmin, Chhateri, Gurung, Dalit Castes (Kami, Damai and Sarki) and other caste also are inhabited. The reason for the selection of this site as sample is diversified socio-economic groups also help to comparison across groups. There are villages nearby and far from the health post which allow comparison. People in the study area have lack of easy access to services due to geographical and socio-economic barriers. Especially in selected area ward no. 9 is community of Janjati group and so called lower caste and ward no. 5 is community of so called higher caste Brahmin. Therefore, the study will be very useful to identify the access of health services to marginalize group and other groups as well. Therefore, it was considered suitable setting for the study.

On the basis of distance by using administrative boundary, among 9 wards of VDC, two wards were selected for the study. One is ward no. 9 in which the sub-health post is located and another is ward is 5 which is nearly 2 hours walk from the sub-health post.

3.2 Research Design

In this study, exploratory as well as descriptive designs were used. The exploratory research design was used for to explore the situation of access and quality of health services after it was declared free and the descriptive research design was used for to understand people's perception towards the services provided by sub-health post.

3.3 Nature and Source of Data

As per requirement of the study, both primary and secondary data were collected. But higher emphasis has been given to the collection of primary data. These primary data are both qualitative and quantitative priority has been given more to qualitative data by employing field work for interview schedule, questionnaires, observation and key informants interview. All the secondary data have been collected from different published and unpublished sources like book articles reports, journals, magazines, of website as per requirement.

3.4 Data Collection Techniques

On the basis of research objective and research questions data required for the study of following techniques were adopted to collect primary data.

3.4.1 Interview

Face to face interview method was used for collecting first hand data. A semi structured interview schedule was prepared based on the objectives of the research study containing both closed as well as open-ended questions. Based on the objective of the study mother of under five children was given main priority for the interview.

For getting insights on concerned aspects and for collecting more important qualitative data, key informant interview were also conducted with concern agencies and person. Such as VDC chairman, elderly man and women, knowledgeable person, member of village health committee, teacher village leader, social worker, and sub-

health post in-charge were considered as key informants. This interview was mostly unstructured.

3.4.2 Observation

Observation is one of the effective methods for collecting reliable and qualitative information. In this method, the role of observer is very significant. Observation was done in sub-health post, to collect information about service delivery system and quality particularly focusing on availability of equipment and medicines, hygiene maintenance, interaction between service provider and receiver, and referral system. A simple check-list was developed for the observation.

3.5 Sampling Design

To allow comparison two wards (5 and 9) were selected purposively for the study. Ward no. 5 is far from sub-health post and ward no. 9 is the ward where sub-health post lies. Before data collection, by using secondary source, researcher got information about number of households in study area. There were 92 households in ward no. 5 and 98 in ward no. 9. Household was taken as the unit of analysis. Firstly, researcher planned to collect the data from the respondent from all households. But in the course of field visit respondent were not available in each household. During first visit 63 and 65 respondents were found the houses in ward no. 5 and 9 respectively. One respondent was selected from each selected household. According to the need of research, mother of under 5 children, pregnant women and the people who had recently visited the sub-health post for service were given priority while selecting the respondent from the household.

In sum in this research multi-stage sampling has been used. Firstly, on the basis of distance two ward of VDC have been selected. Secondly, while selecting respondents from households' mother of under 5 children has been given first priority on the basis of availability the person who has recently gone health institution. If no one has gone health institution then head of the households selected as a respondents in this study.

Due to limited time and budget researcher did not made second attempt to collect the data where the respondent were not found in first visit and the size of simple was also sufficient (more than 65 percentage) for the study. Therefore among 190 households in two wards 128 households were selected as the sample of the study. Therefore, the sampling used in the study is purposive.

3.6 Problem Faced During the Field Work

No doubt research is not easy task that could be completed within a short duration of time or may take several of years depending on the depth of research. The researcher during the research period faces a lot of problems and difficulties to carry the research smoothly.

The field of research (site) was not well known to researcher. The researcher had to conduct rapport building in order to convince the respondents to get authentic and reliable information. It was very difficult for researcher to meet the respondents in time. Many of the respondents suspected in this regard, they repeatedly used to ask researcher the reason for interview.

3.7 Data Analysis and Presentation

Collected data have been analyzed both qualitatively as well as quantitatively. Quantifiable raw data have been analyzed by using computer software program SPSS. While presenting data, simple statistical tools like frequency and percentage have been used. Likewise tabulation and graphical representation have also been made.

Qualitative data have been managed manually and analyzed descriptively. In order to present some quantitative data figures, charts and diagram have been used. Efforts have been made to maintain the objectivity of data. Likewise, most importantly, efforts have been made to interpret data as anthropologically as possible.

CHAPTER IV
CHARACTERISTICS OF RESPONDENTS AND HOUSEHOLDS

This chapter focuses on general information of the study area and characteristics of respondents and households of the study sample. Socio-demographic aspect such as, sex gender, caste\ethnicity, religion, and educational status has been included in characteristics of respondents. Food sufficiency, main income source, types of family has been included in household characteristics.

4.1 Geographical Location of the Study Area

Rapakot VDCs is located in the Western part of Syangja district. It is 25km far from district headquarter. It lies $84^0$44' E to 83^0 46' Eastern longitude and 28^0 5' N to 28^0 7' Northern latitude It occupies 16.8 square km area of Darun and Arjunchupari VDCs which determine the boundary of VDC to east, western side of VDC is bounded by Parbat district, Aruchaure and Panchamul to North and Dhapuk Simal Bhanjang VDCs to the south. It is ethnically diversified VDC of Syangja where Brahmin Chhettri, Gurung Magar, Dalit caste (Kami, Damai, Sarki) and other caste inhabit mostly, Dalit and Gurung caste inhabited at the surrounding of sub-health post and Brahmin and Chhettri caste at distance from the sub-health post.

4.2 Characteristics of Respondents

4.2.1 Sex of Respondents

There is strong relation between gender income, economy and health condition in a society. There are biological differences between men women. Sex refers to the biological differences that are universal and unchanging while the term “gender” refer the social different that are learned created by men which are changeable over time. The number of respondents represent according to their sex/gender is given in the chart below.

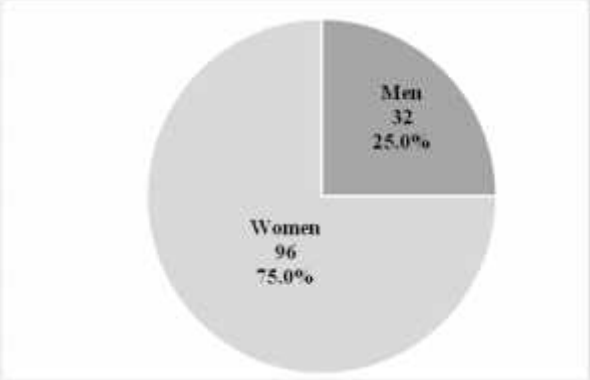

Figure 4.1: Percentage Distribution of Respondents by Gender

The figure 4.1 shows that three- fourth of the respondents are women which is 75 percentage of the total respondents and the remaining are men.The number of women respondents is three times largerthan men respondents because priority wasgiven to the mother of under five childern and member of the family who have recently taken health services from health post. Mostly women attend the clinic to seek services for the children.

4.2.2 Age Structure

Age is an ascribed status of an individual that determines different role and position of a person in the family and society. An age status is a social position to which one is assigned on the basis of age. That is one occupies age status when one's duties, activities, right and reward's are largely determined by one's age. Main priority has been given to mother of under five children because they have to visit health institution during pregnancy and after the birth of the baby. So the frequency of age group has seen in descending order from young to old which is given below in the table:

Table 4.1: Percentage Distribution of Respondents by Age

Age	Number	Percentage
15-24	43	33.60
25-39	54	42.18
40 Above	31	24.22
Total	**128**	**100**

Source: Field Survey, 2013.

From the table 4.1 we come to know that there are different age groups of people in t he study sample. It has been divided in to three categories. The respondent's ages between 15-24 years are 33.60 percentages and ages between 25-39 are 42.18 percentages. Similarly, the respondent's age above 40 years are 24.22 percentages. The average age of respondent is 31 years.

4.2.3 Caste and Ethnicity

In Nepal, disparities are also closely linked to the caste system of that divides population into dozen of heredity group. The lowest position in the social order is occupied by dalits (Rao, 2010 p.290). Although, caste based discrimination was outlawed in Nepal in 1963 A.D., it is still prevelent in Nepali Society.

The value belief source of income and owner ship of resource vary across group to group, community to community and caste to caste as well. Populationcomposition by caste and ethnicity of the study area has been presented in the table below.

Table 4.2: Percentage Distribution of the Respondents by Caste/Ethinicty

Caste	Number	Percentage
Brahmin	44	34.4
Chhettri	9	7.0
Gurung	22	17.2
Magar	3	2.3
Dalits	50	39.1
Total	**128**	**100**

Source: Field Survey, 2013.

Rapakot is the ethnically diversified VDC including Brahmin, Chhetri, Gurung, Magar and different dalit caste,(Kami, Dami, Sarki.). In the study sample,the percentage of Dalit respondents is high (39.1%). The ward which was selected for sample where the sub-health post lies was residental area of dalit groups. Therefore, in this sample number of dalit people were high.The second largest number of caste group is Brahamin that is 34.4 percentage. Apart from this, there are respodents from Chhetri and Janjati groups.

4.2.4 Religion

The concept of religion is more related to emotion and sentiment of people that derives people towards some benevolent doing. Thus it is incredibly imperative to trace the religious structure of an area to know about the level of development and progressive attitude to people as claimed by Max Weber (1978). The religious composition of the study area has been given below.

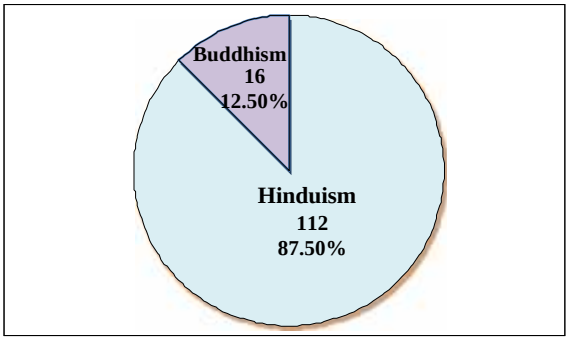

Figure 4.2: Percentage Distribution of the Respondents by Religion

The figure 4.2 shows that majority (87.5%) respondents follow Hindu religion and rest of them12.5percentage follow Buddhist religion. Janjati groups and Dalits people living in the study area also follow Hinduism so the frequency of it has been seen high.

4.2.5 Educational Status

The concept of socialization and learning are related often in separately from the concept of education. Batter knowledge and good health are interrelated variable. It is believed that educated people may have a good consciousness about health and

illness. For this research had made investigation about educational status of the respondents.

The education levels have been categorized into four categories viz. illiterate (the person totally unable to read and write), literate (up to primary level completed), Lower secondary to secondary level completed and Higher secondary above. The following table represents the education status of the respondents from both wards in general.

Table 4.3: Percentage Distribution of the Respondents by Level of Education

Level of education	Number	Percentage
Illiterate	15	11.7
Literate(up to primary level completed)	79	61.8
Lower Secondary to Secondary Level Completed	30	23.4
Higher Secondary Above	4	3.1
Total	**128**	**100**

Source: Field Survey, 2013.

Table 4.3 shows that small but a remarkable size 11.7 percentages of respondents were illiterate literate. Literate group includes those who have completed primary level education along with others who can read and write. They comprise 61.8percentagesof the total number of the respondents which was the largest percentage. There are very few respondents who have completed higher level education (3.1%).

From the above description we can see that the education status of the respondents is not good. Education level is related with health consciousness and service seeking behavior. Therefore it is one of the important background variables.

4.3 Characteristics of Households

4.3.1 Main Income Source of the Households

For the livelihood people living in the different community must have to involve in different kind of economic activities, such kinds of activities are known as occupation. In developing countries like Nepal the return of work or employment is not good. Working hours, working place and level of income are directly interrelated

with parson's health condition. People can involve different kinds of occupation according to their ability, interest and access. The susceptibility of diseases varies across according to their occupation. The researcher had made investigation about the occupational status of the respondents which has been presented in the table 4.6 below.

Table 4.4: Percentage Distribution of Respondents by Main Income Source of Households

Main source of income	Number	Percentage
Agriculture	85	66.4
Foreign Employment	15	11.8
Labour	9	7.0
Service	9	7.0
Business/Trade	6	4.7
Pension	4	3.1
Total	**128**	**100**

Source: Field Survey, 2013.

Table 4.4 shows that two third (66.4%) respondents reported their families' main income source as agriculture. Similarly, foreign employment has been seen as increasingly important source of income in the study area. The above data shows that agriculture was the main occupation of respondents; similarly the second source of income was foreign employment. Besides these daily wage labour, business and service were the income source of the respondents.

4.3.2 Food Sufficiency of Households by Own Production

Food sufficiency of households shows the economic as well as social prosperity of the family. Food is essential for each and every family because healthy families are the wealth of nation. During research, all the respondents were asked whether the production of their land is sufficient for to fulfill their needs. Food sufficiency status of the study area is given below.

Table 4.5: Percentage Distribution of Food Sufficiency of Household

Food sufficiency months	Number	Percentage
1-3 months	12	9.3
4-6 months	61	47.6
7-9 months	31	24.1
10-12 months	24	19.0
Total	**128**	**100**

Source: Field Survey, 2013.

Table 4.5 clarifies the situation of food sufficiency of the households in the study area. To denote total year it is divided into four categories. Even though, agriculture was the main occupation of respondents, only 19 percentages of them had agro-products sufficient for whole year. The main reason behind it is partition of land in to small sizes. Therefore, people are also engaged in other income generating activities like for subsistence.

4.3.3 Types of Family

Family is the basis of human society. Although the nature and structure of the family vary across society to society, a society without family is not known to us. Relationship between the members of the family is deliberately formed based on marriage and decent. The interpersonal relationships within family make the family an endurable social unit. The family is not only basis group it is viewed as an oldest institution of mankind which has the power to withstand social changes. The biological and social reproductions of family are indispensible for the society to maintain its continuity in the study are there was not great difference between the number and nuclear and joint family consists of married couple and their unmarried children and the joint family is the group of brother's families living together in which there is joint resident kitchen and property. The family types of study have been given in the table below.

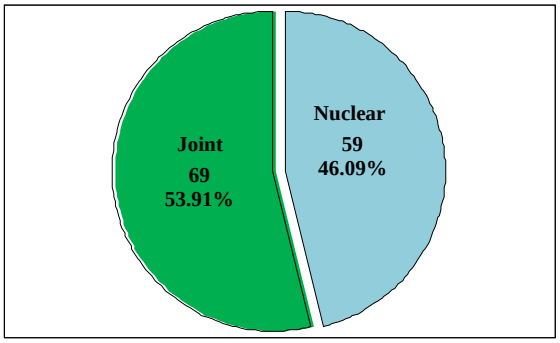

Figure 4.3: Percentage Distribution Types of Family of the Respondents

The above figure shows that majorities (53.91%) of the respondents' families are joint family and rests are nuclear families. There is not remarkable difference between the numbers of joint and nuclear families. The global scenario of nuclearisation of family is increasing day by day. But in study area the number of joint family is still high. It is also because for it was people living in the study area mainly involve in subsistence agriculture and foreign employment (son goes to foreign country for employment after marriage leaving his wife and children with parents).

CHAPTER V

UTILIZATION OF HEALTH SERVICES

This chapter deals with the access of health services in the study area. One important objective for the user fee removal in health care system was to increase the access of service to needy people. For the effective implementation of the policy proper infrastructure and adequate resources are important. Where user free removal was carefully planned and managed, there are signs of increased utilization of services and indications that the poor benefited the most otherwise this does not guarantee health benefit or sufficient protection

5.1 Knowledge about Free Ticket and Medicine

Knowledge of the person leads him/her to certain types of behavior. What types of behavior can people do that is depends on his/her knowledge. Similarly, health service seeking behavior is also based on person's knowledge. This study has been carried out five years after user fee removal. The knowledge about it in study area has been given in the table below.

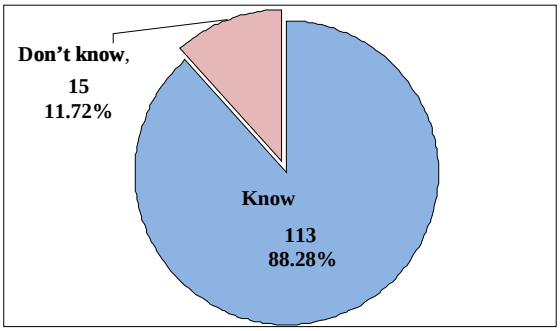

Figure 5.1: Knowledge about Free Ticket and Medicine of the Respondents

Most (88.28%) of the respondents reported that they knew the government has been providing free health services to people from sub-health post level also. Rest of others did not know about user fee removal. The data shows that that awareness about user fee removal policy is good but not complete yet.

5.2 First Place Selection for General Treatment

In the study area researcher made attempt to find out the choice of respondents at first for general treatment. Table 5.1 shows it clearly. Here geographical distance is a key factor affecting choice of treatment and access to services. Time factor is the main causes for this difference. The respondents from ward no. 5 have to spend more time to get services from sub health post. They have to walk for more than 1 hours whereas ward no.9 was not faced this problem. People from ward no.9 have to spend less time to visit sub-health where as word no.5 have to spend more time to take health services.

Table 5.1: First Place Selection for General Treatment

Category	Ward Number				Total	
	W.N. 5		W.N. 9		No.	%
	No.	%	No.	%		
Sub-health post	2	3.2	48	73.8	50	39.1
Private Clinics	26	41.3	10	15.4	36	28.1
Private Hospitals	31	49.2	6	9.2	37	28.9
Government Hospitals	1	1.6	0	0	1	0.8
Others	3	4.7	1	1.5	4	3.1
Total	**63**	**100**	**65**	**100**	**128**	**100**

Source: Field Survey, 2013.

The table 5.1 clearly shows that there is significant variation between two wards (5 & 9) As previously mentioned that ward no.5 is situated far away from sub health post and 9 is near to the sub-health post. The effect of distance has been seen in the above table also. Of the total respondents, only 39.1percentageschoose sub-health post for the general treatment. However, there is significant variation between the two wards. Most of the respondents (73.8%) from ward no.9 and small proportion that is (3.2%) form ward no.5 visited sub health post. Almost half of the respondents (49.2%) from ward no.5 reported that they visit private hospital for general treatment and while only a few (9.2%) from ward no 9 visited it. The data shows that distance and easiness to visit the SHP is facilities of transportation are the important factors for the selection of service providing institution.

5.2.1 Walking Time to Visit Sub-Health Post

In the study area there is no proper facility of transportation and motor able road. People have to walk one place to another place on steep path of hill. Distance is one of the major variables which affect the access of services walking time for the respondents to visit sub health post has been presented in the following table.

Table 5:2: Walking Time to Visit Sub Health Post

Category	Ward Number				Total	
	W.N. 5		W.N. 9		No.	%
	No.	%	No.	%		
<30 Minutes	0	0	59	90.7	59	46.20
30-60 Minutes	2	3.1	6	9.3	8	6.2
1-2 Hours	55	87.50	0	0	55	42.96
>2 Hours	6	9.4	0	0	6	4.7
Total	**63**	**100**	**65**	**100**	**128**	**100**

Source: Field Survey, 2013.

Most (90.3%) of the respondents from ward no.9 reported that they would reach sub-health post for less than 30 min walk which is significantly high in comparison with ward no 5. Most of the respondents (87.30%) from ward number 3 reported that they have to walk1 to 2 hours to reach sub health post. There are a few from the same wards that have to walk more than 2 hours to reach SHP. The data shows that people living in ward no .9 are easily getting health services in comparison with ward no.5.The above data shows that there are difficulties of getting health services to local people which affects the access of services.

Although the government of Nepal have declared to increase the access in health services developing health infrastructures up to 2015. People should get health facilities in rural areas maximum 30 minutes walk. But this condition of rural areas cannot lead to fulfill such an ambition of government.

5.3 Visit of Respondents after User Fee Removal

By applying free health care policy government desires to increase the access in health care services. All the respondents were asked whether they visited sub-health post after user free removal. The ward wise data about it has been presented in the table 5.3.

Table 5:3: Visit of Respondents after User Fee Removal

Category	Ward Number				Total	
	W.N. 5		W.N. 9		No.	%
	No.	%	No.	%		
Yes	31	49.2	54	83.1	85	66.4
No	32	50.8	11	16.9	43	33.6
Total	**63**	**100**	**65**	**100**	**128**	**100**

Source: Field Survey, 2013.

More than two third (66.4%) respondents had visited sub-health post after user fee removal, where 83.1percentagesare from ward no.9 and 49.2 percentages are from ward no. 5. There is remarkable difference between these two wards from total respondents 33.6 percentages were not visited sub-health post after user fee removal. Among them (50.8%) were from ward no.5 and (16.9%) from ward no.9. The data clarifies that larger number of population visited sub health post after user fee removal from ward no. 9 in comparison with ward no.5.

5.3.1 Causes for not Visiting Sub-health Post

During research the respondents who did not visited sub-health post were asked causes for not visiting sub-health post responses of the public who are going to take health service from sub-health post. Their responses on it have been given below.

Table 5.4: Causes for not visiting Sub-health Post

Causes	Number	Percentage
Cannot get medicine	41	95.3
No Proper counseling	40	93.0
Don’t believe in Services	38	88.4
Far away	30	69.8
Don't know	14	32.5

Source: Field Survey, 2013.

Note: Percentages are based on multiple responses of 43 cases.

Various causes were reported for not visiting sub-health post by the 43 respondents who did not visited sub-health post after user fee removal. Unavailability of medicine was reported by 95.3 percentages. Similarly, 93 percentages respondent reported that there was not proper counseling service, and 88.4 percentages respondent reported that they don’t have trust on services provided by sub health post. It indicates that only lifting user fee cannot be sufficient.

The above condition also can be analyzed through Critical Medical Anthropological perspective also. It seeks the unequal distribution of health services. Mostly, modern and advance health facilities are urban centered. Both public and private sectors are giving more priority to establish health service institution in urban areas. Rural people are always living in scarcity of health services. Public health institutions of Nepal are also guided by international donor's interest.

The staffs that are getting government salary and allowance will not be present there. Most of them are on leave and some arrive lately. They refer the minor case also to the private clinic.

The reality seen by the researcher during the time of research this VDC has not its own sub-health post building. Its own building is found under construction. Sub-health post is running under on story building with tin roof. There is no proper place to store the medicine provided. Medicine has been stored in such a place that there is the chance of spoilage within few days.

The sub-health post office was opened late in course of observation by the researcher. The whole health post has been under office assistance since HA is in on leave where as other personnel were in duty for immunization. Office is opened late. As per the information from the common people most of the staffs are absent for many days so it remains closed most of the times.

5.3.2 Condition for Visiting Sub-health Post

The respondents who have not visited sub-health post for any kinds of health services, researcher made queries about in which conditions would they visit sub-health post for the respondents those have not visited. They have given following conditions for visiting sub- health post, which has been presented in table 5.5.

Table 5.5: Condition for Visiting Sub-health Post

Service Should be Provided	Number	Percentage
Good health service	19	44.2
Medicine available	18	41.9
Qualified doctor should be available	16	37.2
Good counseling service	12	27.2
Similar service like private clinic facility	9	20.9
Doctor met all the time	6	14.0
Road and transportation	3	7.0

Source: Field Survey, 2013.

Note: Percentages are based on multiple responses of 43 cases.

On the basis of multiple responses of 43 cases many of the respondent reported good health services, availability of medicine, good counseling service and qualified doctor as their condition for visiting the facility. Few of the respondent reported facility of road and transportation. The user fee removal policy looks as a programme just for the sake of foreign donor agencies or in other words it seems to be working according as the interest of these agencies. It was launched without any necessary establishment of infrastructures and deployment of skilled man power.

5.4 Easiness to get Treatment after User Fee Removal

Researcher made a query about easiness to get health services after user fee removal with outpatient of sub-health post. Among all respondents who have visited sub-

health post after user fee removal. Among them there are 49.2 percentages from ward no.5 and 83.7 percentages from ward no.9. Their responses about easiness to access the services have been presented in table 5.6.

Table 5.6: Easiness to Get Treatment Before and After User Fee Removal

Ease of Treatment	Ward Number				Total	
	W.N. 5		W.N. 9		No.	%
	No.	%	No.	%		
Yes	14	45.16	30	55.55	44	51.8
No	7	22.88	6	11.1	13	15.2
Don't Know	10	32.23	18	33.33	28	33.0
Total	**31**	**100**	**54**	**100**	**85**	**100**

Source: Field Survey, 2013.

Table 5.6 shows that slightly more than half 51.8 percentage respondents reported that it has become easy to get health service from sub-health post after user fee removal. Among them 55.55 percentages are from ward no.9 and 45.16percentagesare from ward no.5. There were few but remarkable percentages who reported that it has not become easy. Rest of others (one third) remained undecided. We may say there is some positive indication but it may not be adequate.

5.5 Types of Health Services Taken from Sub-health Post

The researcher also attempted to explore what types of health services they have taken from sub-health post. The Following table presents more explanations about these subjects.

Table 5.7: Types of Health Services Taken form Sub-health

Types of health services	Number	Percentage
General Diseases	82	96.5
Immunization	47	55.3
Family Planning	38	44.7
Parental Services	32	37.6
Pregnancy services	20	23.5
Other	2	2.4

Source: Field Survey, 2013.

Note: Frequency of response is higher than simple size since the question was of multiple responses.

According to the table 5.8 different services were taken by respondents from sub-health post. Naturally treatment of the general disease was reported by most (96.5%) of the respondents. Similarly immunization and family planning were also reported by remarkable percentage of the respondents. From the above data it is clear that large number of respondents visited sub-health post for the treatment of general diseases like cut, burn injury, common cold, flu, skin diseases, fever, tooth ache, ear infection, head ache etc.

There are many important factors that have to be considered while providing services to rural place people. There were many factors limiting access to services, such as distance to facility/time access, type of severity of diseases, knowledge cultural factors, informal payments were also barrier to accessing health services. Besides, quality of service delivered by sub-health post is also an important factor. The next chapter analyses the quality aspect of the services delivered in the government health post.

CHAPTER VI

QUALITY OF HEALTH SERVICES PROVIDED BY SHP

This chapter deals with quality of health services in the study area in relation to dimensions like health care quality, drug availability, staff attitudes, waiting time, cleanness of facilities overall responsiveness to meeting patient needs and costs of seeking care. Such data provides an indirect way of measuring the quality of care and thereby the capacity of health facilities. Most of these dimensions were assessed from the perspective of patients.

This study makes an attempt at generating evidence on utilization and quality of services. In Zambia there was substantial increase in utilization of public health services and increase in drug consumption after user fee removal. The staffs' workloads in rural districts ware also slightly increased. However inadequate number of skilled health worker presents a major human resource threat to improving access of all (Masiy at el., 2008). Researcher has tried to assess similar and some location specific quality related variables in this study.

6.1 General Quality of Treatment

Most of the respondents visited sub-health post for the treatment of diseases like, chest pain and cough, common cold and fever, asthma, headache, diarrhea, wound, burn, scabies, swelling and body pain, for themselves or their children. Researcher attempted to know about effect of received treatment or them. The results have been shown in the table below:

Table 6.1: Effect of Treatment

Category	Number	Percentage
Very good	6	7.1
Good	44	51.8
Somehow good	32	37.6
Not good at all	3	3.5
Total	**85**	**100**

Source: Field Survey, 2013.

Majority, 51.8 percentages respondents reported that service provided by sub- health post is good and 37.6 percentages respondents reported that service were somehow good. A few 3.5 percentages of the rated health service as very bad. The above data shows that services given by sub-health are not satisfactory. It still needs more improvement in its quality.

6.2 Drug Availability

Availability of the needed medicine is one of the dimensions for quality care outpatients' response about getting medicine has been given in the chart below:

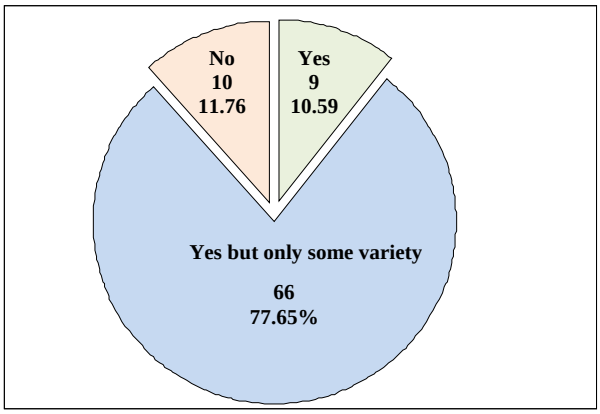

Figure 6.1: Drug Availability

An over whelming majority-77.65 percentages of the respondents reported that they got medicine free of cost but not complete as prescribed by doctor (health worker of sub- health post). However a few reported that they did not get any medicine from there during informal talk with them they reported that the service provider from sub health post suggested them to buy medicine from private clinics.

Sub- health post provides the medicine that was given from the District Health Office. Most of the medicine comes there being near to the expiry data and they will get expired in few days. The health worker said that the medicine for same purpose differs in private clinics and sub-health post. They said that the medicine from low grade companies came there in health post whereas good standard medicines go to private clinic.

In the course of close observation researcher also found that some medicine were expired and some were nearly going to be expired. Although the government of Nepal declared that 35 types of medicines are freely distributed from sub-health post, all of these medicines were not found there. The storage of medicine also was found in poor condition.

6.3 Behavior of Health Worker

Doctor's behavior to the patients also determine of quality care. Patient's satisfaction with aspects of health care such as availability and accessibility of services and the extent to which the physician communicates both information and concern is considered a valid indicator of quality of medical care (Edward et.al. 1985).Researcher attempted to examine behavior of doctors and other staffs from the patients' perspective. The following table presents more explanations about it.

Table 6.2: Behavior of Health Worker and Staff of SHP

Category	Number	Percentage
Very good	5	5.9
Good	65	76.5
Not good	11	12.9
Don't know	4	4.7
Total	**85**	**100**

Source: Field Survey, 2013.

Only 5.9 percentages respondents reported that behavior of doctor and other staff of the sub- health post is very good. Likewise 76.5 percentages respondents said that their behavior is good whereas12.9 percentages of the respondents reported the behavior of doctor and other staffs of the sub-health post is not good. Among them, most of the respondents were women, they said that they felt quite uneasy to tell their problem to male doctor and they also didn't understand the language of the provider.

Rapakot is one of the typical hilly villages of Nepal. The senior health worker of the sub-health post is from Terai region. So communication problem was found there. The understanding of technical terms of health, illness, and diseases also were the barriers for effective communication.

6.3.1 Listening to the Patients

For achieving high levels of patients satisfaction hearing about their problems is important factor. The ability of physician to communicate with concern, warmth and interest in the patient evoke a positive response from the patients.

Table 6.3: Listening to the Patients

Category	Number	Percentage
Heard properly	9	10.5
Heard	58	68.2
Heard a little	11	12.9
Didn't hear at all	7	8.4
Total	**85**	**100**

Source: Field Survey, 2013.

More than 68 percentages of the respondents reported that the health worker from sub- health post heard them properly about their problem. But12.9 percentages respondents said that they heard little and 8.4 percentages reported they didn't hear them about their problem properly.

The data shows that general response to the meeting patient from sub- health post is satisfactory. But there are some problems. There was a lingual problem between both parties. Since In charge and HA were from Terai region they have the problem in speaking in a way that the public can understand. This gap shows that it's has made difficulty in giving and taking services.

6.3.2 Response to the Patient Questions

Present consumerism in health care has challenged some traditional notion of the doctor patient relationship particularly in the areas of patient access to information about their health care. The patients satisfaction is linked with aspects of health care such as availability and accessibility of services and the extent to which the physicians communicates both information and concern which are considered a valid indicator of the quality medical care.

The researcher attempted to know about patient’s level of satisfaction on the response of health worker of sub health post which has been given in the figure 6.2.

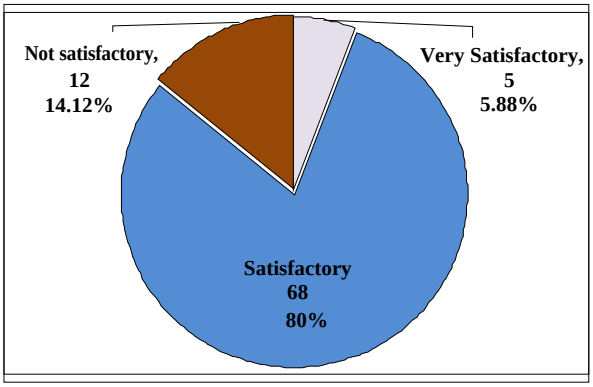

Figure 6.2: Response to the Patient Questions

Majority of the respondents 80 percentages reported that health worker from sub-health post give them satisfactory response. However remarkable number of the respondents 14.12 percentages reported that they don't get satisfactory response from them. The above data clarifies that all service receiver are not completely satisfied with the response from service provider.

To measure the quality of services provided by sub-health post analysis of doctor patient interaction is also one important aspect. During observation it was found that doctor make medical decision during treatment and patients were directed by doctor. Therefore there is a traditional type of doctor patient relationship. There is not the practice of shared medical decision.

6.4 Analysis of Data from Observation

In this study observation is one of the important techniques of data collection. For this, a check list was used which covered subject like physical condition of health facility, users' presence, availability of health workers, drugs availability and health worker-patient interaction.

6.4.1 Physical Condition of Health Facility

Sub-health post was running in a one storied tin roofed building. It has only three rooms and the walls were made by mud and stone this building was made for domestic purpose and was rented for sub-health post. Its own building was under construction. The space inside the existing building was very narrow for the staffs of sub-health post and patients. There was no separate room for storing medicines. Dispensary and waiting room were run in a single room. Similarly lack of pure drinking water toilet and furniture were affecting both users and service providers.

There were no good efforts for management of waste. There were no dustbins to collect the waste gathered. Around sub-health post garbage were scattered here and there. It was irony that there was no toilet in the health post and back side of the the building was used as public toilet. Because of this, smells of urine and stools was creating inconvenience for all. It was a shameful situation that health facility itself was creating risk for further transmission of infectious diseases through open defecation

6.4.2 Presence of Patients

This sub-health post was linked with graveled motorable road, but all the wards of VDC did not have access to this road. Therefore, this road did not increase the access of patients to health services. Because of steepy topography of land patient far away from the sub-health post had rarely visited it. Generally, there were average 12 users visiting the sub-health post.

Most of the service receivers were from same ward. It could be so because sub-health post was surrounded by Dalit community and most of them were poor in comparison with other communities. In some cases, they also were compelled to go to private clinics or hospitals because of frequent absence of health worker and lack of required medicines.

6.4.3 Presence of Health Worker and Communication Issues

During observation it was found that health workers were not arriving in their duties on time. Office assistant non-technician staffs used to came abit earlier than the health workers. It was found that main health worker remain absent frequently. Opening and closing times were not found consistent. In charge of sub-health post was from Terai region. Because of language difference, users had difficulty to communicate with the health workers.

6.4.4 Drug Availability

Those medicines where freely distributed from sub health post were not sufficient. Medicines were nearly at expiry date or in some cases expired also. Government of Nepal declared 35 types of medicines should be distributed freely from sub health post but during observation only 13 types of medicines were available there. In this regards staffs of sub-health post were blaming to district public health office for their poor delivery. There was compulsion for patients to buy free medicines from private dispensaries Therefore; the policy of user fee removal had limited improvement in utilization of the services.

CHAPTER VII

SUMMARY MAJOR FINDINGS AND CONCLUSION

This chapter provides an overview of the research. It includes summary, major findings, conclusions and recommendations of the study.

7.1 Summary

Comment [d1]: Problems, objective, study area and methods

This study was carried out in Rapakot VDC of Syangja district. It analyses users' perception about health services provided by the sub-health post in Rapakot VDC. Specifically it analyses accessibility and quality of services particularly after user fee removal. This study has explored and explained the importance of free health services for the grass root poor, ultra-poor, destitute, marginalized and vulnerable people from critical medical anthropological perspective.

Rapakot VDC was selected purposively for the study. The reason behind it is to allow comparison among diversified socio-economic groups. Both descriptive and exploratory research designs have been used in this study. The data were obtained mainly through semi-unstructured interviews and observation. Altogether 128 respondents from wards no.5 and 9 of selected VDC were taken for this research purpose. The main priority was given to the respondents from people who visited health institution for the treatment of health problems.

Collected data have been analyzed both qualitatively as well as quantitatively. Quantifiable raw data have been analyzed by using computer software program SPSS (for windows) While presenting data, simple statistical tools like frequency and percentage, tabulation and pie-chart have been used. Non-quantifiable qualitative date have been managed manually and analyze descriptively. In order to present some quantitative data figures and charts have been used. The major findings of the study have been given below.

Major Findings

- Most of the respondents (75%) were female because they were the most relevant respondents for the study.

- In terms of caste/ethnic background, the sample was diverse. Chhetris and Brahmins (41.4%) are the largest group. But there were remarkable percentage of Dalits (39.1%) and Janjatis (19.5%).
- Majorities (61.8%) of the respondents were literate and remarkable percentages (11.7%) of them were found illiterate.
- Only few (19%) were producing sufficient food though most (66.4%) of the respondents main source of income was agriculture.
- Most-88.28 percentages of respondents are aware about free health service from the sub health post but there are still a few (11.72%) were unaware about this.
- There was significant variation between two wards (5 and 9) in terms of receiving services from sub- health post. As a whole 39.1 percentages said that they go to the sub- health post for the treatment.
- From ward no 5 only 3.2 percentages are giving first priority to sub-health post whereas most (73.8%) of the respondents from ward number 9 go to sub-health post as their first choice of health facility. Distance was a main factor.
- Regardless of the user fees, factors like distance, lack of good medicine and proper counseling and lack of qualified service provider affected the utilization of the services.
- The respondents visited sub-health post for minor diseases such as immunization, contraceptives, pregnancy, services and various types of minor services.
- Majority (58.9%) of the respondents were positively responded (treatment quality is very good and good). But rests of others were not happy with the quality.
- Only few (10.59%) reported required drug is available which shows that most of others are not happy with drug availability situation.
- Most of respondents (85.88%) reported that the behavior of health workers in general is fine.
- Only few of respondents (14.2%) were found totally unsatisfied regarding listening to the patient.
- But observation showed hygiene and sanitary condition, waiting area, communication of service provider and users were the remarkable quality issues in the sub health post.

Comment [d2]: Only main finding

7.2 Conclusions

To secure the health right of the citizen the government of Nepal has launched the free health service delivery system. But it is the considerable matter if the policy of user frees removal working properly according to its objectives or not.

Government's policy of user fee removal at sub-health post level did not have remarkable impact on access. Obviously, the people who were near from the Sub-Health Post and economically poor were accessing services from the sub-health post. But others were accessing services from private clinics and hospitals. Not only distance, but also timely availability of health workers and required medicines are also affecting access and choices of basic health care services of the people in Rapakot VDC. Though government has policy to provide some basic medicine free of cost, but the medicine distributed from sub-health post were nearly at expiry date. Because of inefficient distribution mechanism, medicines were not delivered on time in health facility. We can conclude that only removing user fee and providing some medicines cannot increase the access and utilization of the services. Management and quality issues are of critical importance in increasing access and utilization. Those who are currently not using services can use the services from sub health post if they obtain good supply of medicines, quality services, good interaction of provider and consistency in delivery of services.

Although Rapakot is not so far from district head quarter Syangja and it is accessed by graveled road but health service delivery is poor from this we can speculate what are the services delivery conditions at remote areas of Nepal where we have to walk several days to reach there.

Quality of services was average. But there are several issues related with quality. Communication problem also existed because of cultural/lingual differences. Lack of appropriate infrastructure and availability of facilities like pure drinking water and toilet are affecting quality aspect. It is an irony that hygiene condition was very poor in the place like health facility. Not only lack of resources but also inefficient management is responsible for poor quality of services in the sub-health post. Improvement in the quality of services delivered by sub-health post is one of the important factors for increasing utilization of the services. Without parallel changes in

quality and consistency in services, the objectives of user fee removal policy cannot be achieved.

7.3 Recommendations

To materialize the objective of free health policy following reformatory aspects should be considered.

- To increase the access of people in service good road and transportation facility should be considered. For the people who were far from sub- health post regular outreach services should be provided.
- To improve the effectiveness of the health service provided by sub-health post regular monitoring and evaluation from concerned agency should be conducted.

Recommendation for further study

- Study on relationship between economic status of user and utilization of services is recommended
- It may be useful to conduct a study by taking two or more sub-health posts and conducting interview with patient in health setting so that we can study further gaps in user fee removal policy.

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APPENDIX-I

Interview Schedule

Date-20 / /

"Impact of User fee Removal on Access and Quality of Service"

A Study of Sub-health Post in Rapakot VDC., Syangja

Students Researcher-Prakash Poudel
P.N Campus, Pokhara

Recorded Date Ward no: - Tole:-

Part 'A' General Information about Socio- economic and Demographic status		
1	Name	…….
2	Age	….....Years
3	Cast/ethnicity	1. Brahmin 2. Chhetteri 3. Gurung 4. Dalits 5. …
4	Religion	1. Hinduism 2. Buddhism 3. Christian 4. Muslim 5. ……
5	Source of income of the family (Major one)	1. Agriculture 2. Labor 3. Trade 4. Employment 5. Foreign Employment 6……..
6	Education	1. Illiterate 2. Literate (Up to primary) 3. Secondary (Up to SLC) 4. Higher education (Above SLC ……..)
7	Types of Family	1. Nuclear 2. Joint 3……
8	Build up Home	1. Stone /brick walled and Tin roofed. 2. Stone/brick walled and stone roofed. 3. Stone/bricked walled and thatched roof 4. Wooden walled and thatched roof. 5…….
9	Do you have land to cultivate?	1. Yes 2. No 3. ……..
10	How long does it hold to feed by cultivating your land?	1. 3 months 2. 6 months 3. 9 months 4. Whole year 5……..
11	Number of children below 5 years in your family	……
Part 'B' An access to the Services.		
12	Where do you first go when you suffer from general diseases (Fever, head ache, Diarrhoea,etc)?	1. Health post 2. Private clinic or Nursing home 3. Government Hospital 4. Dhami /Jhkkri 5……
13	How much time does it take to reach up to sub-health post?	1. Half an hour 2. From half an hour to one hour 3. From one hour to two hours 4. More than two hours.
14	In sub-health post easily accessible from your village?	1. More easily accessible 2. Somehow accessible 3. Little bit accessible 4. Difficulty in access.
15	Do you know ticket and medicine are free at cost in sub-health Post?	1. Yes 2. No
16	Have you ever gone to sub health	1. Yes 2. No⇩**22** 3. Don know⇩**22**

	post after knowing ticket and medicine are of free cost?	
17	Have you meet doctor easily when you go sub-health post?	1. Yes, I have met. 2. No, I have not met.
18	Have you got medicine in free?	1. Yes, I have got 2. Little bit, I have got. 3. No, I have not got.
19	Has it become easy when sub-health post has started giving health services in free of cost?	1. Yes 2. No 3. Don't know
20	Either you or your family member has gone to sub-health post at the latest time?	1. yes ------ month -------- years 2. No⇩**23**
	For the respondent who have not gone to sub-health post for treatment.	1.
21	What are the reasons behind not going to sub-health post?	1. Distance from living place. 2. Not getting medicine. 3. No proper counseling service. 4. Lack of belief to service delivered by sub-health post.
22	What should be so that you go to sub-health post [**End of interview]**	…… …….
	For the respondents who have gone to sub health post.	
23	How many times have you gone to sub-health post from the beginning of 2069 B.S?	……. ……..
24	What kind of health service have your family taken from health post?	1. Service related to pregnancy. 2. Delivery service. 3. Immunization. 4. Family planning services. 5. General disease (fever, common cold etc).
25	How do you take an opening and closing time of sub-health post?	1. Good timing 2. OK 3. Little bit not ok 4. Not good 5. Don't know.
26	If opening time and closing time is not proper than what time would be appropriate?	……. From…… to…….
27	As three anyone in your family who has to take medicine regular for the diseases like HIV/AIDS, T.B etc?	1. Yes 2 No ⇩**29**
28	Where do you get that medicine from? (only one answer)	1. Sub-Health post 2. Private clinic Nursing home 3. Government Hospital 4. Medical shop 5……
29	In your opening what should be to get health service easily?	…….. ……
Part 'B' An access to the Services.		
30	In your family at the latest time, what service did you take?	…… …….
31	What do you feel after getting that service?	1. Best 2. Better 3. Not good 4 Very bad 5. Don't know

32	About behaviors of doctors and office personnel?	1. Good 2. Usual 3. Not good 4. Don't know
33	How much easy do you feel to tell about your diseases the doctors?	1. Easy 2. Not easy 3.Difficult 4. Very difficult
34	If not easy than why?	……..
35	How much attention do doctors pay when tell your problem to them?	1. Listen carefully 2. Simply they listen. 3. Little bit 4. Don't listen at all 5. Don't know
36	Any satisfied by the answers of questions raised by you?	1. Very satisfying one 2. Not satisfactory one 3. Don't answer properly
37	How do you feel an environment around the sub-health post?	1. Very clear 2. Usual 3. Not very clean 4. Dirty 5. Don't know
38	Have you ever been in quells in the sub-health post?	1. Yes 2. No.⇩**40**
39	If yes, How much time have you been quells?	1…….. Minute…….. hours
40	Do you get a medicine prescribed by the doctors of the sub-health post?	1. Yes 2. No 3. Sometime it is obtained 4. Don't know.
41	How do you take the service of health post when medicine and ticket of checking both are free of cost?	1. Improved significantly 2. Good 3. As usual 4. More worsen 5…….
42	As a whole, how do you take the service of sub-health post?	1. Very good 2. Good 3. Not good 4. Not good at all 5. Don't know
43	What do you have to say about the service of the sub-health post?	…….
Part 'D' If the Respondent is a mother of children below 5 years.		
44	Have you gone to sub health post for the latest time when you where pregnant?	1. Yes 2. No ⇩**47** 3. Don't know ⇩**47**
45.	How much time have you visited to the health post?	…….times
46	Where have you been visited for health check up?	1. Sub health post. 2. Private clinic and Nursing Home 3. Government Hospital 4. ……..
47.	Where had you giving birth to child lastly?	1. At Home 2. Private Hospital 3. Sub-health post 4. Government Hospital 5……
48	How have pregnant woman and mother of children been benefited by the service provided?	…….. ……

Thank you so much for your valuable information and time!

Check List for Service Providers

1.	Name :				
2.	Total staff Number:				
3.	Details of worker				
	Name	Post	Worker tenure	Permanent address	Remark
	A				
	B				
	C				
	D				
	E				
4.	When did you join this sub-health post?				
5.	Especially what types of patients are coming here for treatment?				
6.	Do the patients come for follow up as recommended?				
7.	Especially which caste group comes here for treatment?				
8.	Mostly patients from which word come here for treatment?				
9.	What was the main reason behind it?				
10.	Mostly who come here for the treatment among male or female?				
11.	Which age group of patients come here of the treatment?				
12.	Are you felling any difficulties while working in this sub-health post?				
13.	Do you think the number of patient has increased after user fee remount				
14.	What should be done to improve the quality of services delivered by sub-health post?				
15.	What should be done to improve the access of services delivered by sub-health post?				

Thank you so much for your valuable information and time!

Observation Check-least

Following aspects were observed under proposed research.

- Environment of surrounding sub-health post.
- Availability of infrastructures (i.e. Bench, chairs, tables, cupboards, water tap toilet etc.).
- Presence of patients in sub-health post.
- Interaction between service providers and receivers.
- Responses of service providers, service delivery system and referral system.
- Availability of Equipments, Condition of Equipments and availability of Medicines.

APPENDIX II

Photo Gallery

Some Photographs During Data collection.