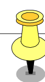

An Assessment on
Impact of Conflict on Delivery of Health Services

NEPAL HEALTH SECTOR PROGRAM

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Madhu Dixit Devkota
Principal Investigator

Executive Summary

1. Introduction

1.1 Context

Nepal has made significant improvements in the health outcomes over the past 15 years, as demonstrated by the most recently conducted Nepal Demographic and Health Survey, 2001 that child mortality was reduced by approximately 40 percent and the fertility rate reduced by 20%. His Majesty's Government of Nepal is committed to expanding the access, coverage and quality of essential health services as envisioned in the National Health Policy. To expand access to, and increase the use of essential health care services especially by underserved populations, the Health Sector Program is implemented by Ministry of Health and Population with the pooled fund support of Department for International Development (DFID) and the World Bank and other donors supporting in the traditional modes. Improved sector management in areas of health care financing, human resource management, supplies of logistics, behavior change communications, quality of care and the health information system are the sector management outputs to deliver the outlined program outputs of essential health care services in a decentralized and public private partnership modality.

1.2 Rationale of the study

The country is experiencing insurgency since 1996 when the Maoists declared "People's War". The intensity of the armed attacks and abuses against the civilian population and destruction of vital infrastructure has increased over the years and the governmental reform and developmental efforts have been largely paralyzed by the conflict which has taken over 5,000 lives. The present study is conducted to assess the impact of the current conflict situation on the delivery of essential health care services for the rural population of Nepal.

1.3 Objective of the study are to:

a) assess the impact of current country and security situation on health service delivery to rural areas of Nepal, and

b) recommend remedial measures

2. Methodology

Six districts (Banke, Bardia, Nuwakot, Rasuwa, Dolakha and Bhaktapur) were purposively selected; based on level of insurgency and from different ecological zones. Both qualitative and quantitative methodologies were applied to collect information. At the centre, interviews were conducted with central level managers and directors of both the governmental as well as health development partners. At the district level, interviews with district level managers, supervisors, and service providers both from the public health as well as related non governmental sectors; experiences of community level health volunteers and members of mothers group was obtained. Altogether 38 group discussions were conducted with 215 participants. The interviews focused on the experiences of service provision, functional status of the out reach clinics, situation of staff and supplies, supportive supervision, and experiences in dealing with insurgents and security personnel in addition to finding which agencies were able to work better in conflict situations, their coping mechanisms and suggestions for improving the essential health care service delivery in conflict affected areas.

3. Findings

3.1 Impact of conflict on health infrastructure

Health facilities had not been directly targeted by the insurgents, nevertheless the rampage of destruction against governmental buildings such as VDC offices has led to damaging those facilities that were attached or housed in the VDC buildings. Prior warning to evacuate the health facility was also reported before insurgents destroyed such government buildings. In Bardia, the residential building for health workers that was in close proximity to a security station could not be used as it had to be vacated every night due to fear of being caught in cross firing.

3.2 Impact of conflict on service provision

The out look of insurgents towards health programs and health workers was reported to be relatively positive as compared to other sectors. They supported the national immunization days for polio eradication program, second opportunity measles mass campaigns, and Vitamin A Supplementation & deworming campaigns and family planning sterilization programs by participating in the related advocacy efforts, allowed service providers to visit from DHOs and made allowances for vehicles to ply on the road for such events.

Outlying health facility based services in remote areas were provided by individual efforts and commitment of service providers who were working in isolation due to poor linkage and communication and supervision between the peripheral facilities and the district public health offices. The district officials are limited to visit peripheral health facilities due to threat and hard clearance procedures of district administration hence rely on the reporting from the periphery with no means of validation. Reports of insurgents looting of drugs of the community drug program were common, insurgents have been advising to community the drugs from the government should not be paid and be supplied free.

The PHC out reach clinics have an important role to play to improve the availability and access to essential health care services at the community level. There was a feeling of general fear, isolation and lack of support among the community level service providers. In-charge of the health facilities of many remote areas were on deputation to the district head quarter, necessitating the VHWs and MCHWs to provide services at the facility; leaving them with very little time for community level outreach work like running the out reach program or supervision. In none of the conflict affected districts, the monthly target for out-reach clinics was met.

Lack of functioning Local health management committees (LHMC) and its leadership and VDC secretary mostly staying at district head quarter has also contributed to the above stalemate. No option has been explored to keep LHMC running effectively either by central authorities or by Districts.

The targets for immunization were not met in Bardia, Banke, and Dolakha, whereas in Rasuwa which has the least number of EPI centers was picking up to achieve 90% of its target. In Nuwakot, it was reported that the EPI and PHC-ORCs were held jointly. In Bhaktapur 95% of monthly target for immunization clinics is met except in the cold winter months. Tuberculosis, affecting about 45% of the total population, is one of the major public health problems. Directly observed treatment short course (DOTS) was successfully meeting its target in all the districts for all months and did not seem affected by the insurgency.

3.3 Impact of conflict on health workers

The health workers in all conflict affected districts were instructed by the insurgents to be on standby to provide treatment to their cadres, abducted to provide services, forced to attend mass meetings and indoctrination programs, made to express their views regarding the armed conflict in public gatherings, and compelled to pay levy to insurgents. *"Everybody pays, almost all government health employees have been donating but most are hesitant to express it"*.

The security personnel warn the health workers against providing services to the insurgents and harass if health workers were unable to provide details of the service users and suspected the health workers to collude with the insurgents.

The health workers reported widespread apprehension, reluctance to travel to conflict-affected areas due to fear of arrests, ill treatment, and curtailment of freedom, both from the insurgents as well as the government security forces. *"Carrying an identity card makes us vulnerable from* insurgents *and not carrying one makes the security persons suspicious! There is danger from both sides, both move around with guns. (Reported in the meeting at Nuwakot).*

3.4 Impact of insurgency on management of quality health services in district

3.4.1 Human resource

The presence of the in-charge was looked into, as s/he was crucial for delivery of quality essential health care services from that facility. In Bardia district, there was a single doctor for the whole district, while all the other five positions lay vacant. In Bhaktapur, Banke, Dolakha and Rasuwa all the posts of the doctors at the PHCCs were occupied in Nuwakot only one out of three Primary Health Care Centres (PHCCs) had a doctor. Among the health posts of the study districts, between 30% (Banke) to 50% (Dolakha) of the positions of in charge at health posts were vacant with Nuwakot (70% vacant) the worst. The situation of sub health posts which are the first contact point for basic health services from institutional perspective was better with all positions of in-charge taken in Bhaktapur, Bardia, and Banke, and in the districts of Dolakha, Rasuwa, and Nuwakot, over three quarter of positions filled.

3.4.2 Supervision and monitoring

In conflict-affected areas, health and project personnel were reluctant to undertake field travel, because of vulnerability to intimidation in the form of interrogation, abduction and even life, from insurgents as well as the security personnel. Fear of being caught in crossfire and budgetary constraints. Consequently, supervisory activities had become confined only to safe and accessible areas from where returning back to headquarter was possible on the same day.

3.4.3 Logistics supplies

Transport of essential supplies and commodities into districts affected by the conflict had been increasingly difficult due to the presence of bandhs, roadblocks, checkpoints, as well as the destruction of bridges and airport towers. There were restrictions on government vehicles (with white number plates) to ply, necessitating the use of public transport, private motorcycles, bicycles as well as bullock-carts for distribution of supplies. Insurgency has meant increased transportation costs both at the centre and the district. Incidents of looting and vandalism by insurgents and uncertainty of supplies reaching on time due to unexpected bandhs have necessitated the maintenance of extra stock at the facilities.

3.5 Experiences of development partner

The working modalities of external development partners were based on formulation and strict adherence to the “Basic Operating Guidelines”. Prepared by the consortium of agencies working for development and humanitarian assistance in Nepal, this document has been accepted by His Majesty’s Government and is based on principles agreed internationally and consistent with the principles of the International Red Cross and Red Crescent Movement’s Code of Conduct. The principles focus on reducing poverty and improving the quality of life, respecting the wishes of the local communities, focusing on social inclusion, non acceptance of staff being subjected to harassment or violence, ensuring transparency of assistance and involvement of the poor in planning management, remaining apolitical and non sectarian, not make any forced contribution, and compliance of international humanitarian law and respect human rights.

Program readjustment to better cope and contribute to conflict transformation, by addressing the root causes was also tried. Some of these were: promotion of health as human right, protecting the rights of the health workers, safe guarding the neutrality of health facilities, promotion of good governance in health, targeting the poor and marginalized, social inclusion to balance disparities, and focus on youth. Improving the enabling environment, by improving emergency preparedness and response by strengthening district hospital, securing supplies, strengthening referral, up-grading communication system, essential infrastructure support and staff detainment incentives were all considered important and hence being tried.

3.6 Coping Mechanism

Public health sector has used appropriate local means of transportation to ensure distribution of drugs and supplies, used intermediaries like the human rights organizations to facilitate transportation of drugs, supplies and to ensure successful participation of communities in national health programs.

The external development partners have used different strategies like maintaining close contact between the field staff through regular monitoring by the central level teams, training to all staff on risk management, developing negotiating skills by practice and induction, and adopting a flexible strategy for field planning based on the information provided by the field partners and health workers regarding the movement of the insurgents, their programs and the security situation. Recruitment of local health workers, adopting innovative approaches through DHO for retention of staff; promotion of community incentives as peace dividends, keeping a low profile in the field and to work with smaller teams and making the program objectives and activities transparent were the methods of the central level offices.

The field level staffs of the development partners and CBOs were found to adopt different mechanisms to cope with the conflict situation. For example, bringing on board the concerned stakeholders including the insurgents with the help of CBOs, human rights organizations or the community (Banke, Dolakha); working in close collaboration with DPHO, implementing programs using either the government system or through CBOs, introducing themselves as staff of DPHO. Shifting the training venue to the district head quarter, not use office vehicle for field visits, and flexibility and rescheduling of the planned activities to cope with unplanned strikes and bandhs were some of the main coping mechanisms.

4. Few initiatives observed after the Royal takeover of February 1, 2005 on delivery of EHCS: In the districts of Achham, Doti and Surkhet, the Chief District Officer (CDO) had issued directives for all the government staff to take prior permission before visiting the communities and to report in person on return, impacting on supervision.

To avoid the disruption of health activities in the districts, the human rights organizations facilitated the negotiation with the insurgents earlier to February 1, 2005. However, this link was totally disrupted as the insurgents were no longer in contact with the human rights organizations anymore.

Undue pressure and influence to the public health service provider is proving difficult to avoid especially from political bodies. In the past, such undue pressures could be avoided by informing other political party if the pressure was not justified. However, this is not possible anymore in the absence of multiple functioning parties, making it difficult to cope with the situation (interaction with DHO, Nuwakot).

5. Conclusions & Recommendations:

Conclusions:

- In the current context, the delivery of services in rural areas by the existing public health system remains fragile and uncertain for assuring quality of care. The community level workers and volunteers continue to provide basic essential health care services, by using a variety of options and tactics to keep continuing but it does not allow space to assure quality of care? Does it serve the health requirement of local people when there is ground to doubt of critical supplies reaching to the facilities, positioning of deployed staffs, technical back-up support and supervision? Because status of all of these inputs are still questionable. Cost of such mechanisms and the quality of the services provided need to be further assessed.
- Insurgency has affected health services due to a large number of undesirable factors that impede a satisfying performance outcome. These are noted in the field as: intimidation, harassment, extortion and threats. Most of the health workers in the visited districts were compelled to pay levy and donations to the insurgent. Majority of government employees paid but were hesitant to express publicly.
- Special national campaigns such as National immunization days for polio immunization, and second opportunity measles immunization , biannual Vitamin A supplementation & deworming programs and family planning sterilization camps were not much affected. It is reported that insurgents supported such events by participating in the advocacy efforts and making allowances for the vehicles to ply on the road.
- Technical support visits and supervision has been confined to only safe and accessible areas. This is a great concern to ensure quality of care.
- Unpredictable bandhs (local strikes and transportation closure), road blocks and destruction of bridges and communication towers has badly affected the supply and distribution of commodities, drugs and vaccines.
- Health programs planning and implementation was adjusted in consideration of bandh calendar as a contingency plan.
- In the absence of locally elected bodies, the Local Health Management Committees were not functioning effectively and need to be empowered with the placement of socially acceptable and responsible persons.

- INGOs and the donor agencies are not presently implementing the activities directly at the field level and are implementing through governmental system (DPHOs). It is due to the reason that local NGOs and CBOs were too facing difficulties in executing the programs as they were disturbed by the insurgents. NGOs were advised to obtain permission from the insurgents for holding community level group meetings. They exerted pressure on the NGOs for declaring financial transactions under public auditing system which is noted a welcoming initiative.
- To put forward a strong voice to Government as well as to the insurgents, major EDPs have committed to Basic Operating Guidelines and pleaded both parties to adhere to it. Recently the government has in principle endorsed the above guidelines.
- Security forces were noted putting pressure on the health workers not to treat the insurgents. This is against the professional ethics of health service providers. Reports of harassment and humiliating behavior on the part of security personnel were also common.

6.1 Recommendations:

- Improving the confidence of health workers is an urgent priority. Such confidence building measures could be orienting them with Basic Operating Guidelines, training on conflict mitigating and negotiating skills and maintaining regular interaction with them by central and district managers that helps to boost their morale .
- Employee should be provided with necessary incentives, which could cover for insurance of self and dependants, opportunities for education and employment of the children and other dependants in the event of displacement, death, disability or other untoward incidents.
- Improvement in technical support and supervision in innovative modality by introducing a third party continuing technical and managerial supervision system in partnership with capable and experienced NGOs and private institutions.
- There is a need to assess the impact on the quality of health services which could be highly affected as a result of limitations by lack of adequate supervision and monitoring, staff working under threat and insecure situation, their occupancy in respective positions, irregular and interrupted supplies of essential drugs, vaccines and contraceptives, to examine how are they reaching community during Out Reach Clinics, Immunization sessions and other national programs including what could be best options to enhance quality of care and maintain staff motivation. It is also important to assess the cost involved in adopting such mechanisms.
- Central level authorities to monitor continuously conflict and health management system by developing a conflict and health monitoring approach and indicators in coordination with district officials and EDPs. This will guide to develop conflict sensitive health programs across all EHCS programs and program management support functions e.g. training, logistics, information system and financing. The one size fits all approach traditionally adopted is proven not serving the purpose.
- Local health management committees (LHMCs) are to be empowered and made more autonomous and not always be dependant on VDC or DDC authorities. An alternative model for devolving authority to the LHMC with improvement in their role and responsibility in tandem with frequent interaction and technical support from district, regional and central level to strengthen their capacity will be most contributing to the systemic performance than wait for the local bodies to come back. This will upscale local

ownership and participation. It can be introduced in a few districts and expanded in an incremental approach.

- Often it was recorded and reported by health providers that the security forces impose threat with undue harassment and derogatory words with service providers and pose threat in doubt of supporting the insurgents. A feed back to security forces to extend appropriate behavior with health workers be conveyed from central health authorities that helps development of right kind of interpersonal communication skills, respect for human values and human rights.
- Learn from other sectors what they are doing to continue services in the community level assuring quality and what they do as model conflict adaptive approaches.
- Maintaining linkage at both macro and micro levels to promote the strategic policy reforms as defined in the Health Sector Strategy and by adapting to the micro level that could result in greater impact of service delivery.
- Orientation of security forces at front lines level on Geneva Convention and other international resolutions and practices governing the rights and duties of health workers and other civilians.

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Abbreviations and acronyms

AHW	:	Auxiliary Health Workers
ANM	:	Auxiliary Nurse Midwife
BOG	:	Basic Operating Guidelines
CBO	:	Community Based Organization
CDP	:	Community Drug Program
CDR	:	Crude Death Rate
CIDA	:	Canadian International Development Agency
DANIDA	:	Danish International Development Assistance
DFID	:	Department for International Development
DHOr	:	District Health Officer
DOTS	:	Direct Observation Treatment Short course
DP/HO	:	District Public / Health Office
DPHOr	:	District Public health Officer
EHCS	:	Essential Health Care services
EPI	:	Expanded Program of Immunization
EU	:	European Union
FCHV	:	Female Community Health Volunteer
FGD	:	Focus Group Discussion
GTZ	:	German Technical Co-operation
GWP	:	General Welfare Pratisthan
HA	:	Health Assistant
HF	:	Health Facility
HMG	:	His Majesty's Government
HMIS	:	Health Management Information System
HP	:	Health Post
HSP	:	Health Sector Program
HSS	:	Health Sector Strategy
INGO	:	International Non Governmental Organization
INSEC	:	Informal Sector Service Centre
JICA	:	Japanese International Cooperation Agency
JIT	:	Joint Initiatives for Trafficking
LHMC	:	Local Health Management Committees
LMD	:	Logistic Management Division

LMIS	:	Logistic Management Information System
MCHW	:	Maternal & Child Health Worker
MoHP	:	Ministry of Health and Population
NDHS	:	Nepal Demographic and Health Survey
NFHP	:	Nepal Family Health Program
NGO	:	Non Governmental Organization
NID	:	National Immunization Days
NORAD	:	Norwegian Agency for Development Cooperation
NRCS	:	Nepal Red Cross Society
PHC ORC	:	Primary Health Care Out Reach Clinic
PHCC	:	Primary Health Care Center
RHD	:	Regional Health Directorate
RHDP/SDC	:	Rural Health Development Program/Swiss Agency for Development and Cooperation
SCF US	:	Save the Children Fund, United States
SDC	:	Swiss Agency for Development and Cooperation
SHP	:	Sub-health Posts
UMN	:	United Mission to Nepal
VDC	:	Village Development Committee
VHW	:	Village Health Worker

Chapter 1

Introduction

1.1 Context

Nepal has made significant improvements in the health outcomes over the past 15 years. The most recently conducted Nepal Demographic and Health Survey (NDHS 2001) demonstrated that Nepal has achieved significant gains in the health status of women and children in the past decade. Most notably, child mortality was reduced by approximately 40 percent and the fertility rate reduced by 20%. However, challenges still remain and Nepal continues to have some of the worst social indicators in the region. Currently the national under-five mortality rate is 91 per 1,000 live births and maternal deaths are estimated at over 539 deaths per 100,000 births (with some estimates as high as 1,500). Only 9% of deliveries occur in health institutions and 26% of newborns have low birth weight, which leaves them prone to illness and death in infancy[1]. There is wide variation in health status between the rural and urban populations, and between different socio-economic and ethnic groups. Inequitable childcare practices favoring boys, in which girls receive less nutritious foods and have less access to healthcare, also contribute to the poor health status of girls and women.[2]

As a result of the commitment of His Majesty's Government (HMG) of Nepal to expand access, coverage and quality of essential health services, as envisaged in the National Health Policy 1991, Ministry of Health and Population in collaboration with the external development partners developed the Nepal Health Sector Strategy - an Agenda for Reform (HSS) in 2003. The Health Sector Program (HSP) is a sector wide program management support to the Nepal Health Sector Program Implementation Plan (NHSP-IP) which is under implementation by Ministry of Health and Population (MOHP) to implement the HSS. HSP is implemented by MOHP under a pooled fund support of DFID and the World Bank, and from support of other donors too in order to implement the eight reform outputs as stated in the HSS. The main objective of the HSP is to expand access to, and increase the use of, essential health care services, especially by underserved populations. The Program and sector management outputs of the NHSP-IP are mainly focused to deliver the essential health care services in decentralized and public private partnership modalities and to improve the sector management in areas of health care financing, human resource management, supplies of logistics, behavior change communications, quality of care and the health information system.

1.2 Rationale for the study proposed – conflict and its impact on delivery of essential health care services (EHCS)

The country is experiencing insurgency since 1996 when the Maoists declared "People's War" in the country. The intensity of the armed attacks and abuses against the civilian population and destruction of vital infrastructure has increased over the years. According to Informal Sector Service Centre (INSEC), a local NGO working in human rights sector, over

1 NDHS, 2001
2 UNDP Human Development Report, 2000

5,000 people have died since February 1996, and the governmental reform and developmental efforts have been largely paralyzed by the conflict. The ongoing violence has disrupted the fragile national economy, adversely affected development programs, and curtailed recent decentralization initiatives to transfer authority, funds, and responsibility from centre to local communities.

However, as it is generally heard from Government officials, the key essential health care services in the districts of Nepal are mostly accepted unaffected by the conflict situation in the country even in the remote villages. But such general statement is only anecdotal and no reported evidences are found. Public health officials' visit to health facilities mostly for polio and measles immunization, Vitamin A supplementation and de-worming is reported not disturbed by government agencies. Whereas, frequent bandhs, transportation blockades and insurgency threats to public service providers are assumed most likely to affect the health service delivery due to lack of mobility, absence of service providers, lack of drugs and commodities and supervision visits by district and central health officials.

The present study was conducted to assess the impact of the current conflict situation on the delivery of essential health care services for the rural population, and to find out if any effect was apparent or perceived in the districts (Banke, Bardia, Dolakha, Nuwakot, Rasuwa and Bhaktapur), particularly over the last few months.

1.3 Objective of the study

The objectives of the study are to:

a) assess the impact of current country and security situation on essential health care service delivery in rural areas, and

b) recommend remedial measures.

Chapter 2

Methodology

Both quantitative and qualitative methodologies were applied at different levels of service delivery agencies to collect information regarding health service delivery through public health system. The focus was to review the current status of health service delivery:

- staffing and physical presence against sanctioned posts, staff salary received timely or not, staff's morale, motivation and working conditions and mobility for service provision,
- mobility and supply conditions of equipments, drugs and supplies and identification of the balance of difficulty- the insurgents or the security forces,
- assess if there is practical difficulty to mobilize community for public health, organize mothers' group meetings and outreach clinics, and the
- effect of local district health offices and local administration on service delivery.
- assess which of agencies e.g. public service providers, NGOs, CBOS are able to work better in conflict situations? Find out how staff and NGOs are dealing with the insecurity and what kind of assistance would be helpful to them in improving service delivery in these difficult circumstances,
- suggest means for improving service delivery in conflict-affected areas, and
- report if any evidence of mortality due to referral blockage such in case of obstetric emergencies, complicated delivery due to lack of service.

2.1 Selection of districts

Six districts were purposively selected; based on levels of insurgency and also from different ecological regions. The districts were Banke and Bardia (from terai); Nuwakot, Rasuwa, and Dolakha (from hill) and Bhaktapur, one of the valley district was included to compare with other districts because this district is assumed to be less affected than others.

2.2 Qualitative data collection

Qualitative approaches were used to collect data on the impressions and experiences of different categories of respondents. Mainly in-depth interviews, group interviews, informal discussions and focus group discussions were conducted using the guidelines developed to collect qualitative information, designed to adapt to the questions to be asked as indicated in the TOR (Refer annex 4.1, for FGD guidelines, tools 1-5).

In the centre, the Director of Logistic Management Division, officials of health development partners, and the Regional Director of Central Development Region were interviewed to explore their experiences and impressions regarding impact of conflict on their own health program and projects.

In the districts, interview and discussions were held with district health managers, supervisors, service providers (at PHCCs, HP, SHP), and Female community health volunteers (FCHVs) and community (members of mothers group). Managers and service providers of related non-governmental organizations (NGO) and community based organizations were also interviewed. Altogether thirty eight group discussions were held with

different category of respondents involved in health care service delivery. The total number of participants including the GO and NGOs was 215 (Refer annex 5, for types of participants).

Four peripheral health facilities were visited and the service providers of those facilities were interviewed. This included three HPs and one SHP in Nuwakot and Rasuwa districts, to observe the status of service delivery, its functional status, availability of human resources against the sanctioned positions, the logistic supplies, operational issues for delivery of health services, management and district level coordination issues due the conflict.

2.3 Quantitative data collection

Quantitative data on logistic management, presence of key staffing positions against the sanctioned posts in health facilities, functional status of EHCS in particular to immunization, DOTS, Out Reach Clinics (ORC) were also obtained.

2.4 Data management

The main steps in analysis of qualitative data included, transcription of the interviews, typing of the transcriptions, color coding and grouping in matrices with main domains for analysis and summarization. Similarly, the quantitative data was coded for computer entry and processed in Excel software program.

2.5 Quality assurance of data

Several approaches were adopted to assure the quality of data collection, compilation and analysis.

- Orientation to the field researchers
- Pre-testing of the questionnaires and interview guidelines followed by appropriate modifications.
- Data checking and computer entry
- Validation by summarizing and sharing of the key findings of the interview/discussion with the respondents and field researcher to verify with their first impressions.

2.6 Limitations

Of the several actors influencing the health service delivery and its utilization, this study has included service providers, development partners and a small section of the community. The other parties that influence the environment for service provision and its utilization could not be included in this study. Those would have been the insurgents themselves and the security forces. Their inclusion would certainly have enriched the conclusions and inferences of this study.

Chapter 3

Findings

This chapter deals with the impression and experiences of managers, supervisors and service providers at different levels of health institutions of the study districts. The participants of the study were the District Public Health Officers, District Health Officers, District Health Super visors, and other categories of service providers such as health assistant, auxiliary health worker (AHW), and auxiliary nurse midwives (ANM), mother and child health workers (MCHW), and village health workers (VHW). Some of the concerns of female community health volunteers (FCHV) and members of the mothers groups were also included. The major areas of the analysis of the findings were the impression and experiences of the participants on health service delivery in conflict situation.

3.1 Impact of conflict on health infrastructure

Health facilities had not been directly targeted by the insurgents. Nevertheless, the rampage of destruction by the insurgents against government buildings, such as VDC offices, had negatively impacted on the Sub-health Posts (SHP) that were attached or housed in those governmental buildings. In Banke, a SHP was totally damaged necessitating construction of a new building with the help of partners (as reported by DPHO Banke). Similarly the SHP at Ratmate in Nuwakot had also been destroyed.

It was interesting to find that in some instances the insurgents allowed the evacuation of the building by sending prior warning. For example, the telephone tower in Nuwakot was damaged by insurgents two years earlier. A prior warning for evacuation was sent to the health post located right next to the telephone tower, helping the health workers to shift to a secure place. Similarly, the in-charge of Ramche SHP, of Rasuwa district reported that, *"The VDC building that housed the SHP was burnt down by the insurgents; however, they allowed us to remove all our equipments and supplies before setting the building on fire"*.

Having the building alone was not enough, being able to use it appropriately was equally important as the study found out in Bardia. In this instance, conflict had made an existing residential building for health workers unusable. "*Every night we vacate the staff quarter and take refuge elsewhere; the policemen insist we do so. This is because the staff quarter is right next to the District Police Office and there is risk for the quarter to be caught in the cross fire or used by the insurgents to attack the police station"* (DHO staff Bardia).

3.2 Impact of conflict on service provision: It was disclosed during informal discussion with other development partners including United Mission to Nepal (UMN) in Mugu, and Kalikot; German Technical Cooperation (GTZ) in Doti, Baitadi, Dadeldhura and Achham; as well as the review of report on "Assessment of the Impact of Conflict on the Situation of Children and Women in a Conflict Affected District" (UNICEF, Jan 2005), that frequent bandhs, transportation blockades and dual threats to public service providers were most likely to affect the health service delivery; lead to shortage of drugs and commodities and supervision visits by district and central health officials due to lack of mobility. The case of Mira Sunuwar (see the box below) highlights the plight of patient:

Mira Sunwar 30 years of age from Dolakha district died on January 5th, 2005, she was suffering from urinary problem. The in-charge of the local health facility was away; hence, the family had no option but try taking her to Charikot PHCC, five hours drive away. Little did they know that it was a day of bandh, so no vehicles would ply. She died on the trail while being carried on a stretcher by the family. (FGD with health workers of Dolakha district).

3.2.1 Impact of conflict on facility based services: *"The insurgents have formally announced not to interfere with the health sector"* (DPHO Banke, reported as published in media). Their outlook towards the health workers and health program was also reported to be different and relatively positive as compared to other sectors. It was reported that the insurgents participated and helped in advocacy for national health program, like immunization days, Vit A supplementation, and FCHV training etc. On those days they allowed visitors and vehicles to ply in areas that were otherwise are out of bounds. This was however possible only if prior information about such programs was provided; otherwise, the insurgents resented people from outside to visit for supervision or monitoring particularly if no prior information was provided to them.

There was very poor communication between the district public health office and the peripheral facilities which were functioning in isolation. The District Health Officer of Nuwakot mentioned that, "*The services are just about being delivered by the efforts and commitment of individual service providers. We (DHO) are unable to supervise or monitor their activities; hence we must rely on the verbal claims or written report without the means of verification.* In such a scenario the services delivery was bound to be affected. *"In terms of overall performance of the system, most of the targets are likely to be unmet" DHO.* However, in Bhaktapur, there was no obvious disturbance to the health programs by the conflict situation.

The insurgents had their own health team comprising of health assistants, staff nurses, auxiliary nurse midwife and the like. They conducted orientation program for traditional healers for avoidance of delay and promotion of early referral to the health facilities. The insurgents even came forward with a proposal to work in collaboration with the health facility to develop of a model health service delivery system appropriate for the local needs and realities. (Reported in meeting with the health workers in Nuwakot, on 11.05.2005)

There were mixed responses regarding the influence of security personnel on health service delivery. In Banke and Bardia districts, the security forces were reported to have facilitated the service provision; with the production of identity cards for example, the health personnel

were allowed to travel freely, undergo less checking and have shorter waiting times. However, the role of security forces in Nuwakot was reported to be rather hindering with a hostile behavior, use of derogatory and abusive language as a common practice. (Health-workers, Nuwakot).

There were reports of looting of drugs by the insurgents from facilities. The insurgents resented having to pay for the drugs out of community drug program CDP) hence advise communities not to pay because they believe that drugs are provided by the government and it should be supplied free. In Surkhet, the drugs from CDP were being confiscated by the insurgents on a regular basis from almost all health facilities and it is defunct in Kavre district. It was reported that CDP was not operational in Nuwakot district. In Nuwakot HP, the health service providers were found maintaining two registers for free supply and CDP drugs naming it free and for sale to indicate that there is no CDP ongoing. It was also found that the drugs for sale were not sold as envisaged to be supplied in a discounted price (Nuwakot HP).

3.2.2 Impact on outreach program:

a. PHC Out Reach Clinic

Inadequate availability and access to health services at the community level are the major bottle necks in providing health services for households and families particularly the women and children. To address this problem, PHC Out Reach Clinics (ORC) were established as extensions of HPs and SHPs where staff (VHWs and MCHWs) from the respective facilities visit specific places to run clinics according to the predetermined schedule; once per month in three to five catchments area in a VDC at a predetermined date. The minimum services that they provide include health education, counseling and IEC, distribution of pills and condoms, antenatal services, treatment for minor aliments, referral and follow-up[3].

There was a feeling of general fear, isolation and lack of support among the service providers. *"There is fear in our hearts, even while commuting in the community and conducting health programs" (FCHV, Banke).* This reflects the provision of services through the outreach clinic which is one of the core elements of essential health care services.

In many remote areas, the in-charge of the health facility was on deputation to the district head quarter, the VHWs or MCHWs then must therefore provide services at the facility of a compromised quality. This also meant that there was very little time available for conducting ORCs or community level mobilization for health care and supervision.

The plight of pregnant women experiencing complications at the time of delivery on days of bandhs was worst, as mentioned by the service providers in all the studied districts. The local means of transportation like cart, doko (wicker baskets) or khatiya were being used to facilitate referral from the health facilities to reach hospitals.

In Bhaktapur district, which is not so affected by the insurgency, the ORCs were functioning comparatively in better condition than in other districts even in remote villages. Those ORCs in close proximity to hospital were not well operated because people preferred visit to hospitals and did not trust the VHWs and MCHWs at the ORCs.

[3] Annual Report, Department of Health Services, 2001-02

Table 1 Functional status of the ORCs in study districts, 2004-05

District	Monthly target	Oct/Nov	Nov/Dec	Dec/Jan	Jan/Feb	Feb/Mar	Mar/Apr
Bardia	170	117	168	114	95	169	135
Banke	147	114	138	102	99	136	117
Bhaktapur	54	46	60	37	49	42	47
Dolakha	165	104	107	136	115	135	119
Nuwakot*	191	NA	NA	NA	NA	NA	NA
Rasuwa	60	37	52	46	45	45	51

Source of data HMIS-33 (DPHO/DHO)

** Not available due to absence of responsible staff at the DHO.*

The above table indicates an irregular pattern of ORCs conducted from the health facilities. In most districts, the numbers of ORCs conducted were below the targeted numbers.

It could also be due to the result of dissolution of the local government where support and leadership from the local health management committee (chaired by VDC chairman) no longer existed and the health facilities in-charge (member secretary) became passive and a less motivated actor. This had also meant non-availability of the proposed budget for training of MCHW/VHW responsible for running the ORCs, leading to apathy among those who were to benefit.

b. Immunization

Table 2 below clearly indicates that the EPI targets were not met, with Bardia district fairing the worst and Bhaktapur the best. Rasuwa with a farily low number of EPI centres was noted scaling up achieving 90% of its target. In Nuwakot, it was reported that the EPI and PHC-ORCs were held in a combined settings.

Table 2 Functional status of the EPI centres in study districts, 2004-05

District	Monthly target	Oct/Nov	Nov/Dec	Dec/Jan	Jan/Feb	Feb/Mar	Mar/Apr
Bardia	311	166	174	91	104	144	140
Banke	285	246	261	236	202	243	230
Bhaktapur	82	78	77	46	77	78	81
Dolakha	165	126	142	149	156	168	143
Nuwakot*	191	NA	NA	NA	NA	NA	NA
Rasuwa	60	22	54	53	50	51	55

Source of data HMIS-33 (DPHO/DHO)

** Not available due to absence of responsible staff at the DHO.*

In Bhaktapur, there were about 2000 seasonal migrants working in the brick kilns. Most were internally displaced people from the conflict affected districts in search of a job. Their children were not covered by the immunization program. The DPHO was made aware and he is working to get them immunized.

c. DOTS program

Tuberculosis is one of the major public health problems affecting about 45% of the total population. To address this problem, directly observed treatment short course (DOTS) have been introduced throughout the country since April 2001. In the districts, the district hospital

and PHCCs were responsible for diagnosis and initiating treatment of TB. The HPs may function as sub-centre for supervision and providing DOTS treatment of patients on DOTS. However at the field level, the policy is not strictly adhered to and therefore there are more DOTS centre than that envisaged by the policy. Table 3 highlights this fact and also reveals that targets for all the districts are met for all months.

Table 3 Functional status of the DOTS centers in study districts, 2004-5

District	Monthly target	Oct/Nov	Nov/Dec	Dec/Jan	Jan/Feb	Feb/Mar	Mar/Apr
Bardia	7	7	7	7	7	7	7
Banke	9	9	9	9	9	9	9
Bhaktapur	4	4	4	4	4	4	4
Dolakha	4	4	4	4	4	4	4
Nuwakot*	8	NA	NA	NA	NA	NA	NA
Rasuwa	4	4	4	4	4	4	4

Source: DHO/DPHO, DOTS register

** Not available due to absence of responsible staff at the DHO.*

3.3 Impact of conflict on health workers:

"As health workers, we must provide service to all users irrespective of their political ideology. The security forces expect us to provide details of the service users. We are interrogated and harassed if we are unable to provide complete description and details of the clients. They warn us not to provide services to the insurgents. One of the health workers who provided treatment to insurgents was held for eight months in custody by the security personnel" (Reported by an informant to the research team in Nuwakot).

"Compared to other development workers, the health workers are in better position to travel to the conflict affected areas (across the river Rapti in Banke district) for service provision. As these areas are out of bounds for the security personnel, they grow suspicious about the health workers allowed by insurgents to travel to such areas, leading again to additional interrogation and harassment of the health worker by the security personnel" (DPHO Banke).

The health workers in almost all conflict affected districts mentioned that the insurgents had instructed them to be on standby for providing treatment to their cadres. "*They warn us to be on stand by to provide services to their cadres if needed. The security forces if they know of this fact deal with such events very severely. With the insurgents, you get opportunity to clarify your position; but with security persons, there was no such possibility (Health worker, Nuwakot).* At village level, at times the health workers are compelled to attend the mass meetings and insurgents' indoctrination programs; and during such events, they are expected to publicly express their views regarding the insurgency.

In all the conflict affected districts, the health workers in the communities admitted that they pay levy to insurgents. The rate varied from thirteen days salary for one year to 5% of the monthly salary. *"Everybody pays – almost all government health employees have been donating but most are hesitant to express it" (District health supervisor, Nuwakot).* The district level personnel were however, non-committal.

Being in the position to help the insurgents at their time of need for health care has in a way benefited some service providers to be in better footage to negotiate. *"The insurgents often*

bring in sick patients to the district hospital. This helps the health workers to develop rapport with them and to negotiate and avoid having to pay levy in lieu of the care provided to their patient" (reported by nurse from Nuwakot District Hospital).

Health workers are also harassed by the insurgents on doubt of being informants. This was particularly so if following the visit by health workers there were raids by security forces in that community. *"In Jajarkot, some months back, a VHW was abducted for two months by the insurgents on suspicion of being an informant of the security force"* (Reported in the meeting at DHO Banke).

3.4 Harassment both by security personnel and the insurgents

There was dilemma among health workers, the insurgents demanded for services while security personnel put pressure not to provide health service to the insurgents, causing tremendous stress to health workers. Caution needed to be exercised at every step with increased risk of vulnerability and threat to continue working. It is not the harassment by insurgents alone, it is equally caused by the security forces as well; both do not trust, one on suspicion of informants and the other for doubt of providing services to insurgents. *"Carrying an identity card makes us vulnerable from* insurgents *and not carrying one makes the security persons suspicious!" (District Supervisor, Nuwakot)* This meant prolonged search and interrogation and further delay in work.

"We are caught in a difficult position, there is danger from both sides, both move around with guns. The insurgents force us to pay or risk our life, while the security personnel assume we are supporting the rebels and reprimand us". "At times, it is difficult for us to differentiate whether they are security forces or the insurgents because both at times are in civilian outfits and address us as "hello comrade". Not responding to the salutation makes us vulnerable from both fronts. (MCHW of Ramche SHP and District Supervisor Nuwakot).

3.5 Impact of insurgency on management of quality health services in district

3.5.1. On human resource

The institutional framework of Department of Health Services puts the SHP at the lowest tier of health services. SHP is the first contact point for basic health services from institutional perspective. Each level above the SHP is a referral point in the network of delivery of essential health care services which moves upward from SHP to HP to PHCC on to district, zonal, regional and then to tertiary care centre. This study has tried to identify staffing situation of the key person in a health facility that is the head of the facility at the different levels. The in-charge is medical officer, health assistant and auxiliary health worker in PHCC, HP and SHP respectively. The presence of these staff is crucial for delivery of quality essential health care services from the respective facility. Therefore, the availability of these personnel was studied for the last six months period covering the months from October 2004 to April 2005.

Table 4 Presence of the medical officer: in-charge at PHCC during 2004/05

District	Total PHCC in district	Oct/Nov	Nov/Dec	Dec/Jan	Jan/Feb	Feb/Mar	Mar/Apr
Bardia	3	0	0	0	0	0	0
Banke	2	2	2	2	2	2	2
Bhaktapur	2	2	2	2	2	2	2
Dolakha	1	1	1	1	1	1	1
Nuwakot	3	1	1	1	1	1	1
Rasuwa	1	0	1	1	1	1	1

Source of data: Attendance Report

As indicated in table 4 above, Bardia district which is highly affected by insurgents has none of the PHCCs staffed by a medical officer during the six months of the study period. Similarly, in Nuwakot, out of three PHCCs, only in one PHCC the medical officer was in service. The two other PHCCs, Deurali and Kharanitar were managed by ANM and AHW respectively instead of a medical officer.

The qualitative study further revealed that in Bardia district, a solitary medical officer (DHO) was providing the services for the whole district while the position of five medical officers lay vacant. It was also reported that female service providers were reluctant to stay at their stations citing security reasons and frequently requested deputation to Nepalgunj (interview with DHO, Bardia).

Table 5 Presence of the health assistant and AHWS: in-charge at health post 2004/5

District	Total HP in district	Oct/Nov	Nov/Dec	Dec/Jan	Jan/Feb	Feb/Mar	Mar/Apr
Bardia	8	6	6	6	6	6	5
Banke	10	5	7	7	7	7	7
Bhaktapur	7	7	7	7	7	7	7
Dolakha	10	6	6	6	6	5	5
Nuwakot	10	3	3	3	3	3	3
Rasuwa	8	7	7	7	7	7	7

Source of data: Attendance Report

Among the HP of the study districts between 30% (Banke) to 50% (Dolakha) of the positions of in charge at health posts were vacant with Nuwakot fairing the worst (70% of positions vacant), without any significant change in the last three months. In Bhaktapur, all the positions were filled. Similarly, availability of AHWs at SHPs were studied for the six months period October 2004 to April 2005, please refer to table 6 below.

Table 6 Presence of the AHW: in charge at sub health post 2004/5

District	Total SHP in district	Oct/Nov	Nov/Dec	Dec/Jan	Jan/Feb	Feb/Mar	Mar/Apr

Bardia	22	22	22	22	22	22	22
Banke	35	35	35	35	35	35	34
Bhaktapur	12	12	12	12	12	12	12
Dolakha	43	36	36	35	33	31	37
Nuwakot	53	34	32	31	31	36	39
Rasuwa	9	7	7	7	7	7	7

Source of data: Attendance Report

It was satisfying to note that position of AHW as in charge of SHP in three districts Bhaktapur, Bardia, and Banke were all duly filled; and in Dolakha, Rasuwa, and Nuwakot, about three fourth of the posts were occupied.

Some SHPs were managed by VHW and MCHWs (DHO Nuwakot). The health workers did not want to stay at their station and preferred to work on deputation at the District Health Office or in urban areas.

In the past, there has been continual shortage of qualified health personnel, especially in rural areas of hill and mountainous districts. Lately there is a decreasing pattern in the fulfillment of the post of health workers in the high conflict districts. Understaffing had worsened as some rural health workers have been on deputation to the DHOs, following threats and intimidation from the insurgents. However, we were informed that this provision of deputation had been recently withdrawn by the government, necessitating the health workers to return to their work stations.

To summarize, there was widespread apprehension amongst health workers in the districts visited and many were reluctant to travel to conflict-affected areas due to fear of arrests and ill treatment both from the insurgents as well as by the security forces. The DHO level officials needed to get a clearance from Chief District Officers to go beyond the district headquarter and if they venture to go for a certain important reason, they are likely to be doubted as linking with Maoists. Therefore, the health service providers at the district and below did not like to take any kind of risk visiting peripheral health facilities that would likely risk facing many questions for the district administration.

3.5.2. Supervision and monitoring

In conflict-affected areas, health and project workers were found reluctant to undertake field travel, because they felt vulnerable to intimidation both by the insurgents as well as the security persons and fear being caught in crossfire.

"Nobody wants to visit field without extra remuneration for field visit. There is always risk of interrogation, abduction in addition to risk of life from the insurgents. Then we face interrogation and harassment from security forces" (Health worker, Nuwakot).

Difficulties due to geographic accessibility in remote areas were further compounded by the prospect of encountering insurgents; fear of personal security, and monetary demands. *"Supervision is carried out risking money as donations are asked by insurgents and life too, can we afford it?"* (Banke). Consequently, supervisory activities have become confined only to safe areas from where going and returning back to DHO is possible on the same day. *"The core message is that there is virtually no supervision at the district level for regular activities. The only way the DHO gets to know about the activities in the remote VDC is from staff that visits headquarter or sometimes even from the media"(DHO, Nuwakot).*

Health workers also mentioned instances of supervision of facilities from the insurgents. In Bankatti of Banke district, till February 2005, *"The members of Good Governance from the insurgents monitored the attendance registers of health workers, and sought clarification from those who were irregular"*.

3.5.3. Functioning of village level local health management committee

The decentralization act and regulations demand that the health facilities are managed by local bodies. For this purpose, Local Health Management Committees (LHMC) are formed in selected districts and given responsibility in managing the health facilities. However, on interaction and interview with LHMC, it was realized that the members were not fully aware of their roles and responsibilities and do not take ownership of the management of the health facilities.

The local health management committees were inactive in the absence of locally elected bodies and mass resignation of the village secretaries following threats by the insurgents. This has jeopardized the sole objective of the committee to get involved in local level participation to improve management by the local health management committees. This has implications on service delivery. However, another option tried by SHPs to be handed over for local management is that remaining within the guideline of the Ministry of Health, a LHMC was established (Ramche SHP of Rasuwa district) to initiate the process even in the absence of the VDC elected bodies.

3.5.4. Logistics supplies

Transport of essential supplies and commodities into the districts has been increasingly difficult due to *bandhs*, roadblocks, checkpoints, as well as the destruction of bridges and airport towers and fear created by the insurgents

Transportation of supplies to the peripheral facilities was also affected due to lack of vehicles. One vehicle each of the DHO at Banke and Bardia districts were confiscated and used by the security forces. Two more vehicles that were on use by them were burnt down by insurgents in Chitwan and Hetauda (as disclosed by Director LMD during interview). Similarly, one vehicle of the DHO in Nuwakot was burnt down by the insurgents because it used to carry security persons. Besides, the insurgents had placed restrictions on the government vehicles (with white number plates) to enter certain areas, which had necessitated the use of public transport, private motorcycles, bicycles as well as bullock-carts for distribution of supplies. Insurgency has implied increased transportation costs both at the central and the districts level. .

Incidents of looting of some drugs and medical supplies by insurgents have led it to be airlifted. With the support of EDPs this year, some essential supplies were eventually airlifted leading to delays in supplies reaching Dailekh, Jajarkot, Okhaldunga and Solukhumbu districts (Director, LMD). Such provisions may not always be feasible or cost effective. In February this year, drugs meant for Mugu in process of airlifting from Nepalgunj was looted on the way by the insurgents when a technical problem compelled the helicopter to land somewhere else. Drugs are also being taken away by the insurgents, *"they demand to see the store and take away whatever they need"* (Nuwakot). "*There is always fear of the drugs being looted while transporting or even from the facility"* (DHO Bardia). "*The security forces also demand oral rehydration solution packets from health workers" (Dolakha).*

Frequent and sudden strikes and road blocks necessitate maintenance of extra stock at the facility (Rasuwa). There had been delays in supply of vaccines and shortage of some drugs and oral rehydration solution but it was due to procurement delays by Logistics Management Division.

3.5.5 Community mobilization: In the current situation, there is less possibility of community mobilization from the DHO level and it was found that the local health facilities themselves conduct interactions with the communities (Nuwakot). During national campaigns for e.g. national immunization days, polio or measles campaigns or other national health programs, the communities participated well and were very supportive. Prior information to the insurgents about such events is provided seeking their informal clearance and during such events they extend support and participate in local level advocacy efforts (reported in Banke and Rasuwa).

Chapter **4**

Experiences of Health Development Partners

4.1 Experiences of development partner in the centre

Informal interviews were held with central level officials of Health Sector Support Program (HSSP) GTZ to find out about their working modalities in conflict situation. Some of the key approaches were:

a. Formulation and strict adherence to the "Basic Operating Guidelines"

Basic Operating Guidelines was prepared by the consortium of agencies working for development and humanitarian assistance in Nepal, this document has been accepted by His Majesty's Government and based on principles agreed internationally and in Nepal and were consistent with the principles of the International Red Cross and Red Crescent Movement's Code of Conduct. Those agencies adopting it were- GTZ, SDC, DFID, SNV, NORAD, JICA, DANIDA, EU, CIDA, etc. The principles focus on reducing poverty and improving the quality of life of Nepalese people, respecting the wishes of the local communities, focusing on social inclusion, non acceptance of staff being subjected to harassment or violence, ensuring transparency of assistance and involvement of the poor in its planning management, remaining apolitical and non sectarian, not make any forced contribution, and compliance of International Humanitarian Law and respect Human Rights.

b. Program readjustment:

HSSP/ GTZ had readjusted its health programs to the worsening conflict situation in the districts assisted with an aim to better cope with the risk and contribute to conflict transformation, particularly by addressing the causes as far as possible. Readjustment of programs was carried out in the following areas:

- Promotion of health as human right, by promotion of rights-based approach to health and protection of the rights of the health workers and safeguarding the neutrality of health facilities through advocacy action.
- Promotion of good governance in health.
- Targeting to poor and marginalized communities, social inclusion to balance disparities.
- Focus on youth
- Improving emergency preparedness and response by strengthening district hospital, securing supplies, strengthening referral, up-grading communication system, essential infrastructure support, and staff retainment incentives.

However, the details of the above adaptation work was not provided.

<u>Learning Experiences</u>

- *"It has not been easy, it is true we have had to make compromises; but incorporation of learning experiences into the program management, has made it easier to work even in conflict affected districts" (Team Leader, HSSP/ GTZ).*

4.2 Experiences of field level staff of health development partners

Study has tried to explore perception and practices of the field level staff of the development partners and community based organizations (Nepal Red Cross Society, NFHP, SCF US, Plan International, GWP, Community Health Promotion Centre, RHDP/SDC, JIT Nepal, and Marie Stopes Clinic) in the visited districts. The major focus of the analysis was on their experiences of working in conflict situation as follows:

Presence of External Development Partners (EDPs) at the field levels had been significantly reduced. Most reported to be working in collaboration with DPHO implementing the program either through DHO system or collaborating with CBOs. In the districts and community level, the programs of INGO/ NGO's are not allowed to be implemented directly. They needed to work under the shadow of DPHO so that programs were less visible. It was found that local NGOs and CBOs too were facing difficulties in executing the programs as they were directly or indirectly funded by donors hence disturbed by the insurgents. A press note was issued by the insurgents in Dolakha about three months earlier, urging the NGOs to register with their authority. NGOs were expected to obtain permission from the insurgents for holding community level group meetings. They exerted pressure on the NGOs for declaring financial transactions under public auditing system which is noted a welcoming initiative.

"*Although district staffs have never been told by the insurgents not to visit the communities, but deep inside our hearts there is fear*" (District Supervisor of an INGO, Banke). This summarizes the working morale of the field staff of I/NGOs.

Chapter 5

Coping mechanisms to ensure delivery of services

This chapter deals with the working modalities, coping strategies and mechanism adopted by the public health system and the health development partners to work in conflict situation.

5.1 Mechanisms adopted by the public health system

The district public health officers, in-charge of the facilities and service providers were interviewed about their contingency action plan under implementation. As the vehicles at the district health offices were confiscated by the security personnel; burnt down or not allowed to ply by the insurgents; or stranded due to bandhs, strategies were adopted to facilitate transportation of drugs and commodities to the peripheral facilities by the following means:

- Using public vehicles, bicycles, rickshaws and bullock carts.
- Changing the color of the number plate of the vehicles from white (governmental) to red (private) with the permission of security forces (reported both by the Regional Director, Central Development Region and the DHO, Nuwakot)
- Facilitating the transportation of commodities to the districts during bandhs by mediating dialogue with insurgents through some intermediary agency such as human rights organizations.

5.2 Mechanisms adopted by health development partners

a. Central level

- Maintaining close contact with the field staff through regular monitoring by the central level team.
- Training to all staff on risk and conflict management.
- Developing negotiating skills by practice and induction.
- Adopting a flexible strategy for field action planning based on the information provided by the field partners regarding the security situation, movement of the insurgents, and their programs to ensure that they did not coincide.
- Recruiting the local health workers.
- Providing monetary incentives through DHO for retaining the health workers.
- Promoting community incentives as peace dividend in the form of support for the local communities to rebuild the damaged infrastructure refurbish and/or upgrade the existing infrastructure.
- Keeping a low profile particularly in the field and working with smaller teams.
- Making the program objectives and activities transparent.

b. Field level

Field level staffs of EDPs and CBOs have adopted different mechanisms to cope with the conflict situation and at the same time to reform their roles and responsibilities. Some of the strategies are:

- Prior to introducing a new program, concerned stakeholders including the insurgents are informed and brought on board with the help of CBOs or human rights organizations. This strategy to ensure continuity of planned activities was described in Banke and Dolakha.
- Working in close collaboration with DPHO, while implementation of programs using either the government system or the CBOs.
- Introducing INGO programs and staff as that of DPHO. To this effect, most INGO staff was noted to be using identity cards issued from DPHO.
- Hiring local people for community level activities.
- Shifting training venue to the district head quarter, where you are not noticed.
- Avoiding danger and minimizing the risk for the field staff by keeping low profile while visiting field.
- Not using office vehicle for field visits.
- Working in coordination with local health workers and volunteers.
- Flexibility and rescheduling of the planned activities to cope with unplanned strikes and bandhs.

5.4: Few initiatives observed after the Royal takeover of February 1, 2005 on delivery of EHCS: In the districts of Achham, Doti and Surkhet, the Chief District Officer (CDO) had issued directives for all the government staff to take prior permission before visiting the communities and to report in person on return, impacting on supervision.

To avoid the disruption of health activities in the districts, the human rights organizations facilitated the negotiation with the insurgents earlier. However, this link was however disrupted as the insurgents were no longer in contact with the human rights organizations anymore.

Undue pressure and influence to the public health service provider is proving difficult to avoid especially from political bodies. In the past, such undue pressures could be avoided by informing other political party if the pressure was not justified. However, this is not possible anymore in the absence of multiple functioning parties, making it difficult to cope with the situation (interaction with DHO, Nuwakot).

Chapter 6

Conclusion and Recommendation

6.2 Conclusion

- In the current context, the delivery of services in rural areas by the existing public health system remains fragile and uncertain for assuring quality of care. The community level workers and volunteers continue to provide basic essential health care services, by using a variety of options and tactics to keep continuing but it does not allow space to assure quality of care? Does it serve the health requirement of local people when there is ground to doubt of critical supplies reaching to the facilities, positioning of deployed staffs, technical back-up support and supportive supervision because status of all of these inputs is still questionable. Cost of such mechanisms and the quality of the services provided need to be further assessed.
- Insurgency has affected health services due to a large number of undesirable factors that impede a satisfying performance outcome. These are noted in the field as: intimidation, harassment, extortion and threats. Most of the health workers in the visited districts were compelled to pay levy and donations to the insurgent. Majority of government employees paid but were hesitant to express publicly.
- Special national campaigns such as NIDs, measles, biannual Vitamin A supplementation and deworming programs and family planning sterilization camps, and polio campaigns were not much affected. It is reported that insurgents supported such events by participating in the advocacy efforts and making allowances for the vehicles to ply on the road.
- Technical support visits and supervision has been confined to only safe and accessible areas. This is a great concern to ensure quality of care.
- Unpredictable bandhs, road blocks and destruction of bridges and communication towers has badly affected the supply and distribution of commodities, drugs and vaccines.
- Health programs planning and implementation was to be adjusted in consideration of bandh calendar as a contingency plan.
- In absence of locally elected bodies, the Local Health Management Committees are not functioning effectively and therefore need to be empowered with the placement of socially acceptable and responsible persons.
- INGOs and the donor agencies are not presently implementing the activities at the field level but doing through governmental system (DPHOs) as it was found that local NGOs and CBOs were too facing difficulties in executing the programs as they were directly or indirectly disturbed by the insurgents. NGOs were expected to obtain permission from the insurgents for holding community level group meetings. They exerted pressure on the NGOs for declaring financial transactions under public auditing system which is noted a welcoming initiative.
- To put forward a strong voice to Government as well as the insurgents, major EDPs have committed to Basic Operating Guidelines and pleaded both parties to adhere to it. Recently the government has in principle endorsed the above guidelines.

- Security forces were noted putting pressure on the health workers not to treat the insurgents. This is against the professional ethics of health service providers. Reports of harassment and humiliating behavior on the part of security personnel were also common.

6.3 Recommendations:

- Improving the confidence of health workers is an urgent priority. Such confidence building measures could be orienting them with Basic Operating Guidelines, training on conflict mitigating and negotiating skills and maintaining regular interaction with them by central and district managers that helps to boost their morale .
- Employee should be provided with necessary incentives, which could cover for insurance of self and dependants, opportunities for education and employment of the children and other dependants in the event of displacement, death, disability or other untoward incidents.
- Improvement in technical support and supervision in innovative modality by introducing a third party continuing technical and managerial supervision system in partnership with capable and experienced NGOs and private institutions.
- There is a need to assess the impact on the quality of health services which could be highly affected as a result of limitations due to lack of adequate supervision and monitoring, staff working under threat and insecure situation, their occupancy in respective positions, irregular and interrupted supplies of essential drugs, vaccines and contraceptives, to examine how are they reaching community during ORCs, Immunization sessions and other national programs including what could be best options to enhance quality of care and maintain staff motivation. It is also important to assess the cost involved in adopting such mechanisms.
- Central level authorities to monitor continuously conflict and health management system by developing a conflict and health monitoring approach and indicators in coordination with district officials and EDPs. This will guide to develop conflict sensitive health programs across all EHCS programs and program management support functions e.g. training, logistics, information system and financing. The one size fits all approach traditionally adopted is proven not serving the purpose.
- Local health management committees (LHMCs) are to be empowered and made more autonomous and not always be dependant on VDC or DDC authorities. An alternative model for devolving authority to the LHMC with improvement in their role and responsibility in tandem with frequent interaction and technical support from district, regional and central level to strengthen their capacity will be most contributing to the systemic performance than wait for the local bodies to come back. This will upscale local ownership and participation. It can be introduced in a few districts and expanded in an incremental approach.
- Often it was recorded and reported by health providers that the security forces impose threat with undue harassment and derogatory words with service providers and pose threat in doubt of supporting the insurgents. A feed back to security forces to extend appropriate behavior with health workers be conveyed from central health authorities that helps development of right kind of interpersonal communication skills, respect for human values and human rights.
- Learn from other sectors what they are doing to continue services in the community level assuring quality and what they do as model conflict adaptive approaches.

- Maintaining linkage at both macro and micro level to promote the strategic policy reforms as defined in the Health Sector Strategy and by adapting to the micro level could result in greater impact of service delivery.
- Orientation of security forces on Geneva Convention and other international resolutions and practices governing the rights and duties of health workers and other civilians.

Annex I

Terms of Reference

Terms of Reference: Nepal Health Sector Program: Impact of conflict on Delivery of Health Services

Background: The Health Sector Program (HSP) is a sector wide program management support to the Nepal Health Sector Program which is under implementation by Ministry of Health and Population (MOHP) to implement the Health Sector Strategy – an Agenda for Reform (HSS). HSP is implemented by MOHP under a pooled fund support of DFID and the World Bank, fundamentally to implement the eight reform outputs as stated in the HSS. The main objective of the HSP is to expand access to, and increase the use of, essential health care services, especially by underserved populations. The NHSP-IP Program outputs are mainly focused to deliver the Essential Health care services in decentralized and public private partnership modalities and to improve the sector management in areas of health care financing, human resource management, supplies of logistics, behavior change communications, quality of care and the health information system.

Key essential health services in the districts of Nepal are generally accepted unaffected by the conflict situation in the country even in the remote villages. But such general statement is only anecdotal and no reported evidences are found. Public health officials' visit to health facilities mostly to programs of polio and measles immunization, Vitamin A and de-worming is reported not disturbed by Government agencies. Where as the frequent bandhs, transportation blockades and insurgency threats to public service providers are most likely to affect the health service delivery by absence of service providers, lack of drugs and commodities and supervision visits by district and central health officials due to lack of mobility.

This assignment is to assess the actual health service delivery situation in the rural hills and mountains of Nepal which are conflict prone and its impact in the current situation on the delivery of health services to the rural population of Nepal – the hills, mountains and Terai.

Objective of the assignment: are to; a) assess the impact of current country and security situation on health service delivery to rural areas of Nepal, and b) assess likely future scenario and recommend remedial measures.

Scope of the assignment: is to assess the health service delivery being made by the public health system. At least five districts will be visited in two in mountain, two in hills and two in Terai, representative of each development regions of the country and about 30 health facilities, 10 mother groups, and 15 FCHVs, 10 CBOs. The local communities, district, regional and central level health officials including district/local level NGOs, INGOs and field staff of donor organizations will be visited for focus group discussions and personal interviews. The team will try to compare areas with "reasonable" security situations to gauge the effect of the fighting as opposed to just normal difficulties in delivering health services. The information before and after with comparison to "secure" areas will make a compelling case and argument.

This would allow the study to go beyond anecdotes and determine quantitatively the effect of the insecurity. The use of previous health facility assessments and HMIS data is important and will examine to the extent areas where pre-existing "baseline" data on availability of drugs, staff, outreach, etc. are

available (look at LMIS data from LMD of DOHS).

1 Review the current status of health service delivery – staffing and physical presence against sanctioned posts, supply conditions of equipment, vaccines, contraceptives, staff salary received timely or not, other expenses met or not, staff's morale, motivation and working conditions.

2 As far as available make use of data of previous health facility assessments and HMIS data to examine to the extent areas where pre-existing "baseline" data on availability of drugs, staff, outreach, etc. are available (look at LMIS data from LMD of DOHS).

If above arrangements are not in place identify the reason.

- Mobility for services such as for immunization, outreach clinics, drugs and commodities supply form districts and regional medical stores
- If mobility is constrained for construction and transportation of drugs, where lays the balance of difficulty – the insurgents or security forces?
- Assess if there is practical difficulty to mobilize community for public health
- Campaign and organize mothers' group meetings and outreach clinics, find out they are actually happening or not, if not what is the reason?
- If there is noted any variation of services among the health facilities by geographical areas identify the actual factors in the filed that cause such variations.
- Does the support of local district health offices and local administration affect service delivery if so in what way? Do they facilitate or poise threat?
- Despite if any high level of threat and lack of support system even if the performance progress is noted reported of good and satisfactory level, explain the reason of it, and check for the reality of reported data e.g. Immunization coverage, TB DOTS coverage, etc.
- Assess which of agencies e.g. Public service providers, NGOs, CBOS are able to work better in conflict situations?
- Find out how staff and NGOs are dealing with the insecurity and what kind of assistance would be helpful to them in improving service delivery in these difficult circumstances.
- Compare service delivery status in areas with "reasonable" security situations to gauge the effect of the fighting as opposed to just normal difficulties in delivering health services
- Suggest means for improving service delivery in conflict-affected areas.
- Report if any reported evidence of mortality due to referral blockage such in case of obstetric emergencies, complicated delivery due to lack of service.

Execution of the assigned study: The study will be executed immediately by the local consultants and be completed in 30 man days and is planned to be complete as indicated below.

Work plan	Time frame
Contract award	April 27
Inception report	May 2
Field visit	May 3- May 12
Draft report presentation and discussion with the Bank	May 16
Final report submission	May 31

The consultant will report directly to Dr. Tirtha Rana, the World Bank Nepal. The consultant will be guided by Drs. Tirtha Rana, in terms of initial briefing and

guidance as well as for the quality control of the final products.

Expected outputs: The consultant will produce the reports: a) Inception report within five days of contract award, b) Field assessment report within 10 days of study by filed visits, c) A concise final report including findings and recommendations within three weeks of the assignment.

Qualification of the consultant: Public Health Specialist a strong experience of present health service delivery system of the Government, donors, NGOs/CBOs and INGO Understanding of current conflict situation and service delivery profile.

Annex

Schedule of field work

May-June 2005

Date	Duration	District	Team
01-04 May	4 days	Bhaktapur	One team
05-10 May	6 days	Banke, Bardiya and Dolakha	Three teams
11-14 May	4 days	Nuwakot, Rasuwa	Two teams

Annex

Approach for data collection

Details on data collection method as per the categories of the participants of the study

	Method of data collection	Source of information	Total
Central level	In-depth interview	Director LMD Health	1
	Group interview	Development Partners	1
Regional level	In-depth interview	RHD, CDR	1
District level	Group discussion	DP/HO and staff	6
	Group interview	NGO/CBO/ INGO field staff	5
	FGD	In-charges and staff of health facilities	7
Community level	FGD	MCHW and VHW	5
	FGD	FCHV	6
	FGD	Members of mothers group	6
		Total group discussions	**38**

Annex IV

Tools for data collection

FGD guideline

Tool 1. Group Discussion guideline for District managers/supervisors

Major contents of the discussion

The issues need to be discussed relating the conflict situation and coping strategies

- Regular activities in the district *(Probe on specific areas: list of activities, how the activities are being functioning)*
- Logistic management : Distribution of the drugs, vaccines, contraceptives, ORS etc *(Probe on problem, constrains and general opinion on logistic management)*
- Service delivery; Functional status of health facilities and the outreach centres *(Probe on regularity, reporting)*
- Supervision and monitoring: schedule of monitoring, regularity to use schedule (if not regular why not probe), impression on supervision (if there is supervision), experiences on supervision /monitoring, problem, constrain on supervision and monitoring activities faced by the supervisor during the field visit
- Suggestions to improve the health service delivery

Tool 2. FGD Guideline for Health Workers (in charges of HF) of peripheral health facilities (PHCC, HP and SHP)

Opinion/perception/observation in relation to service delivery and conflict situation

- Infrastructure of health facility
- Staffing and its impact in health program
- Working environment and its impact in health service delivery
- Functional states of regular facility based and the outreach services
- Barriers and disturbances in service delivery: Logistic supplies, supervision, mobility etc
- Practices of insurgences and the security forces: experiences and impressions
- Practices on supervision and impression on quality of service
- Problems and constrain to manage the facilities
- Supports and coordination with district level health authorities
- Community mobilization and health program
- Report if any reported evidence of mortality due to referral blockage such in case of obstetric emergencies, complicated delivery due to lack of service.
- Suggestions to improve the health service delivery

Tool 3. FGD Guideline for MCHW and VHW

Opinion/perception/observation in relation to service delivery and conflict situation

- Explore on list of activities conducted by the MCHW and VHW
- Working environment and service delivery? *(Program support, social environment, community responses etc.)*
- Situation on supplies: Vaccine, contraceptives, ORS etc. *(Probe on problem faced on transportation and service delivery)*
- How the district health offices and local development administration are coordinating with your facility
- Is there any problem/threat regarding service delivery e.g., EPI clinic, ORC clinic, DOTS centre (if there is any

threat*: Probe on level of problem/threat, the reason of problem/threat e.g. in EPI coverage/ Dots program)*

- **Community mobilization:** Assess if there is practical difficulty to mobilize community for public health Campaign and organize mothers' group meetings and outreach clinics,
- Explore if any reported evidence of mortality due to referral blockage such in case of obstetric emergencies, complicated delivery due to lack of service.
- Suggest means for improving service delivery in your area.

Tool 4. FGD Guideline for FCHVs and Mothers Group

Opinion/perception/observation in relation to service delivery and conflict situation

Major contents of the discussion on service delivery issues

- What are the community based health programs in your village please explain.
- What about the ORC outreach and EPI centre (regularity, if not regular why?)
- What are your experiences regarding community mobilization on National health campaign e. g., Vitamin A program, NID etc)
- Which NGO/CBO is most active in your community? What are their main functions and how they are serving your community?
- Explore if any reported evidence of mortality due to referral blockage such in case of obstetric emergencies, complicated delivery due to lack of service.
- Mothers meeting conduction (probe on regularity, frequency, if not regular why?)
- Problems faced on service delivery/utilization and coping practices
- Suggestions to improve the service delivery in your village.

Tool 5. Guideline to conduct Group interview with Central and District/local level development partners (CBO, NGOs, INGOs and staff)

Opinion/perception/observation in relation to service delivery and conflict situation

Main contents of the discussion

- Please explain regular activities of your organization especially on delivery of health services?
- Please share your experiences on problem faced regarding your health program and the coping mechanisms you adjusted. *(probe on details on the type of problems, problem creator and the coping strategies)*
- Suggest means for improving service delivery in the district

Annex **V**

List of participants

Participants of the study							Total
Director , Logistic Management Division							**1**
Central level officials of development partners							**3**
Regional Health Director							**1**
District level participants	**Banke**	**Rasuwa**	**Bardiya**	**Dolakha**	**Nuwakot**	**Bhaktapur**	
DHO/DPHO/PHO	1	1	2	1	2	1	**8**
District level supervisor	4	3	6	6	9	6	**34**
District level administrative staff	2	2	3	2	3	2	**14**
HA	2	0	3	2	4	3	**14**
ANM	2	2	3	2	1	3	**13**
AHW	4	3	1	4	3	2	**17**
VHW	3	2	2	4	5	5	**21**
MCHW	4	1	3	1	3	3	**15**
NGO/CBO Staff	6	2	3	4	3	0*	**18**
FCHV	7	6	6	4	5	4	**32**
Members of mother's group	6	5	5	3	5	0*	**24**
Total	**41**	**27**	**37**	**33**	**43**	**29**	**215**

** In Bhaktapur the discussion with mothers group and the development partners was not conducted.*