Secure Livelihoods Research Consortium

Researching livelihoods and services affected by conflict

Health services and users' perceptions of the state in Rolpa, Nepal

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About us

Secure Livelihoods Research Consortium (SLRC) aims to generate a stronger evidence base on how people make a living, educate their children, deal with illness and access other basic services in conflict-affected situations (CAS). Providing better access to basic services, social protection and support to livelihoods matters for the human welfare of people affected by conflict, the achievement of development targets such as the Millennium Development Goals (MDGs) and international efforts at peace- and state-building.

At the centre of SLRC's research are three core themes, developed over the course of an intensive one-year inception phase:

- State legitimacy: experiences, perceptions and expectations of the state and local governance in conflict-affected situations
- State capacity: building effective states that deliver services and social protection in conflict-affected situations
- Livelihood trajectories and economic activity under conflict

The Overseas Development Institute (ODI) is the lead organisation. SLRC partners include the Centre for Poverty Analysis (CEPA) in Sri Lanka, Feinstein International Center (FIC, Tufts University), the Afghanistan Research and Evaluation Unit (AREU), the Sustainable Development Policy Institute (SDPI) in Pakistan, Disaster Studies of Wageningen University (WUR) in the Netherlands, the Nepal Centre for Contemporary Research (NCCR), and the Food and Agriculture Organization (FAO).

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1 Introduction

This paper explores people's perceptions of government health services in Rolpa, Nepal, focusing especially on accessibility, effectiveness and accountability. It is based on a qualitative study conducted to explore in more detail the findings of a quantitative survey carried out in 2012. In-depth interviews with 52 respondents in Rolpa District documented people's experiences and expectations of health services and how these influence public perceptions of government. Among them 21 were Brahmin/Chhetris, 12 Dalit, and 19 Janajatis. Altogether half were men and half were female. The central question was: did good experiences with government health services lead to more positive perceptions of government and its legitimacy? And, conversely, did negative experiences undermine trust in government? Previous research has suggested that people's perceptions of government health services in Nepal are influenced by ethnicity, caste and gender (Askvik, Jamil and Dhakal, 2011; Devkota, 2008; UNDP, 2009). There are a limited number of studies that go beyond these lenses to examine supply-side factors such as the accessibility, quality (effectiveness) and accountability of services in Nepal.

2 Health Services in Nepal

Despite the disruption of the war, Nepal's health indicators have showed progress in recent years (MoHP et al., 2014). Since 1990, Nepal has experienced remarkable improvements in maternal and childhood mortality. In 1990 the under-five mortality rate per 1000 live births was 142, falling to 82 in 2000 and 42 in 2012. Over the same period, the maternal mortality rate decreased from 790 in 1990 to 430 in 2000 to 190 in 2013 (UNICEF and WHO, 2014), and Nepal has met the MDG target on child mortality and maternal mortality. The Nepalese government and the World Health Organisation have found that the use of maternal health services and increased rates of deliveries at health centres by skilled birth attendants is behind the decrease in maternal mortality and infant mortality (MoHP et al., 2014).

Nepal's insurgency and war (1996-2006) undermined already poor levels of health service and had a negative impact on socioeconomic and health indicators, particularly in western and mid-western hill areas, where the intensity of the war was high compared to the less-affected areas such as eastern Hill sub-region (Partap and Hill, 2012). More than a thousand Health Posts were destroyed (Devkota and Teijlingen, 2009; Ghimre, 2009) and government services and non-governmental initiatives in providing health facilities were negatively affected (Kieveilitz and Polzer2002; Pettigrew, Delfabbro and Sharma 2003; Devkota and van Teijlingen, 2010). Local governance units were vacated or displaced and elected functionaries were forced to flee the villages. The Maoists abducted health workers and captured medicines to treat their wounded cadres while government security forces accused local communities of supporting the rebellion. According to Aryal (2005, cited in Ghimire, 2009) the local administration ordered health centres not to supply strong antibiotics and medicines that could be used by Maoists. On the other hand, some say Maoist insurgents were less aggressive towards the health services compared to government forces because of their direct relations with local people in rural areas who they relied on for support (Devkota and van Teijlingen, 2010).

After the Comprehensive Peace Agreement in 2006, improving basic services was a government priority. Significant policy changes aimed to increase access to health care. The Interim Constitution of 2007 acknowledged health care service as a basic human right and in 2008 the Nepal Free Essential Health Care Policy was launched to provide free essential health care for primary health services. In 2009 this extended so that Health Posts were responsible for providing 32 different types of medicine free of cost (and Sub-Health Posts 22 types and the district hospitals 42 types). The numbers of free medicines were increased again in August 2014. The Free Delivery Policy (2009) encouraged babies to be delivered at health facilities by providing women with cash incentives and transport subsidies to attend public health facilities to give birth.

Box 1: Selected landmarks in Nepal's health plan, laws and polices

1975 – Long Term Health Plan (1975-90)
1978 – Nepal signs Alma Ata Declaration
1991 – National Health Policy
1993 – National Blood Policy (revised 2005)
1995 – National Drug Policy
1997 – Second Long Term Health Plan (1997-2017)
1998 – National Safe Motherhood Policy
1998 – National Reproductive Health Strategy
2002 – Nepal Health Sector Program Implementation Plan (2002-2009)
2003 – National Health Research Policy
2004 – National Nutritional Policy and Strategies
2005 – Safe Delivery Incentive Programme
2006 –National Skilled Birth Attendants Policy
2007 – Policy on Quality Health Services
2008 – Nepal Free Essential Health Care Policy
2009 – Free Delivery Policy

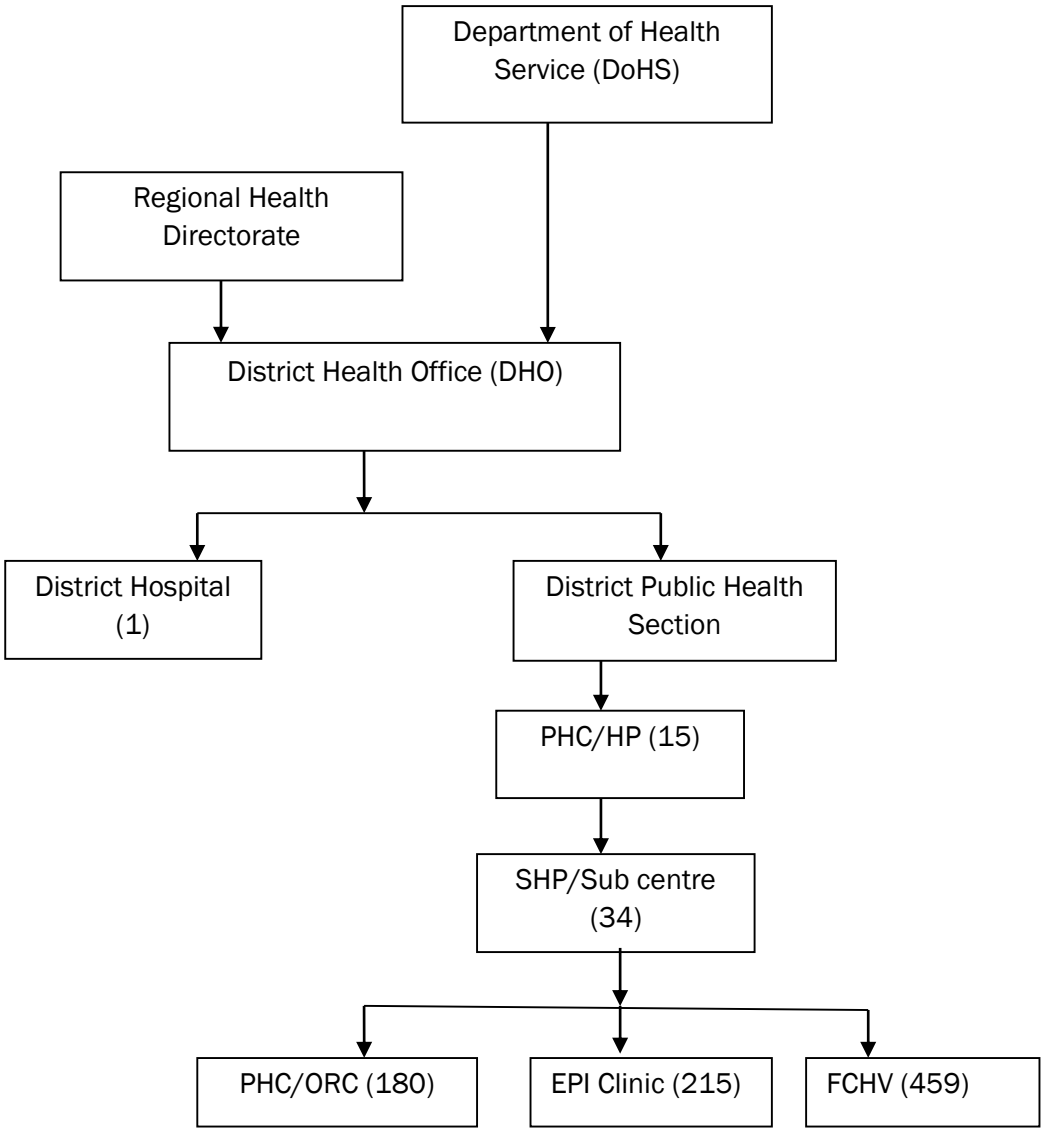
The structure of local health centres was established with the National Health Policy of 1991. There are five Regional Health Directorates responsible for backstopping and monitoring the districts. District Health Offices are accountable for the activities and output of District Hospitals, Primary Health Care Centres, Health Posts and Sub-Health Posts within the district. A number of Village Development Committees share a Health Post and there is a Sub-Health Post in each VDC. At ward level there are Primary Health Care (PHC) outreach clinics, Expanded Programme on Immunisation (EPI) outreach clinics, Female Community Health Volunteers[1] (FCHVs) and traditional birth attendants[2] (TBAs).

Health-posts and sub-health posts in Nepal are expected to provide essential health care services (EHCS) at the local levels. The EHCS are priority public health measures and are essential clinical and curative services for the appropriate treatment of common diseases. The Government of Nepal declared on 7 October 2007 delivery of essential health services free of cost through all Health and Sub-Health Posts to the reach of the poor and excluded groups (RECPHEC, 2010). The free maternity service was introduced to enable expecting mothers who could not afford private clinic fees to access free maternity health care. This provision (free health care and free maternity service) allows rural poor and marginal communities to access essential health services.

[1] The FCHV programme was launched in 1988 in 19 districts in the mid-west (Nepal's poorest region), with the purpose of improving maternal and neonatal care.

[2] Traditional birth attendants provide primary maternity care, based on the local traditions and practices of the communities, government has incorporate TBAs in modern health system to provide modern maternal care.

Figure 1: Hierarchy chart of health institution in Rolpa



The institutions of local government bear many responsibilities for these structures. The Local Self-Governance Act (LSGA) (1999) was introduced to devolve the powers, responsibilities and resources required to allow local governments to meet local needs. In practice, there has been limited devolution (both in programme and finance) in the health sector, and the central authorities have maintained control over most of the resources in the absence of local elected government officials (The Asia Foundation, 2012).

The lowest tier of governing unit is the Village Development Committee (VDC), which makes development plans and applies for the necessary funding to the District Development Committee (DDC), while the DDC receives its funds from the Ministry of Local Development. According to the LSGA, municipalities and VDCs are responsible for operating and managing village-level health centres (monitoring and ensuring the implementation of the mandates), Health Posts and Sub-Health Posts, primary health education and sanitation programmes, family planning, maternity and child care.

The DDC is responsible for coordination and monitoring of district level health institutions (e.g., hospitals, Ayurvedic dispensaries,[3] and health centres) and make arrangements for the supply of medicines and materials and equipment. Since the introduction of the LSGA in 1999, local government (VDCs, municipalities and District Development Committees) has had responsibility for coordinating and monitoring basic services like drinking water, health and education but has struggled to fulfil these responsibilities in practice.

Female Community Health Volunteers (FCHVs) work at grassroots level and provide community-based health education and services in rural areas, focusing on maternal and child health, and family planning. They contribute significantly to counselling and referring mothers and children to health facilities. They also play a key role in increasing community participation and helping to build awareness around health for rural women, especially among illiterate or marginalised groups (DoHS, 2014). They operate in remote areas and so reach poor, marginalised, socially excluded and under-served populations (MoHP et al., 2014; DoHS, 2014).

The role of the private sector in providing health care services is increasing. According to the Health Management Information System, there were 441 NGO and 669 private health institutions operating in 2013 in Nepal. Private health care providers tend to operate more in relatively developed and urban areas where there are more people who can afford their services.

[3] The offices providing Ayurvedic medicines to people

3 Analytical framework and methodology

3.1 Analytical framework

A close relationship between people and state is seen as facilitating better provision of public services (Bak and Askvik, 2005; Bouckaert et al., 2005; Evans, 1996; Fukuyama, 1995; Putnam, 1993, all cited in Askvik, Jamil and Dhakal, 2011). Rose and Greeley (2006: 4) argue that the state is legitimised through its services, 'where legitimacy is understood as the ability of the government to work in the interest of the public and demonstrate fairness to all groups in providing security and services.' A central question for the overall SLRC research programme is to explore whether these theoretical links between service delivery and legitimacy are borne out empirically.

In the framework developed for the study we hypothesised that people's experiences and perceptions of government legitimacy are shaped by the access to the government services and barriers they face. More specifically, people are more likely to have a positive perception of the government if they can easily access and utilise services and if local services help them satisfy important needs. Conversely, if people have difficulty in accessing or utilising services, they are more likely to have negative views of government. The experiences and perceptions of individuals with different social and demographic characteristics may be different, and we aimed to pick up on these differences in the research. The different dimensions (which are interlocking and interlinking) used in the research to understand the barriers to access and utilisation are:

- **Physical access** – the availability of service facilities in the local area and distance and time to reach them; availability/cost of transportation to reach these facilities; availability of heating in schools and clinics.

- **Financial access** – the extent to which cost (formal and informal fees and indirect charges, including transportation, food etc.) presents an obstacle to access and utilisation.

- **Social barriers** – the extent to which discrimination based on gender, ethnicity, caste, religion, social norms about intra-household decision-making, mobility of women, etc. presents an obstacle to access and utilisation. The perceptions of individuals with different social and demographic characteristics depend on the extent to which they have inclusive access to services and how effectively services address the specific vulnerabilities they have.

- **Administrative barriers** – the extent to which administrative hurdles, bureaucratic red tape and corruption present a barrier to access and utilisation of services.

We aimed to unpack people's perception of services in order to better understand various aspects that may have accounted for specific service delivery outcomes. Peoples' ability to access and utilise services partly depends on the behaviour of service provider, quality and reliability of those services. Hence service delivery effectiveness will be influenced by:

i. **Quality of services** – whether health workers provide good quality treatment and advice; the physical state of infrastructure, the level and regularity of maintenance and the extent to which this affects the quality of services.

ii. **Reliability of services** – the extent to which health facilities function regularly and staff are available to deliver services.

iii. **Behaviour of service** - providers including confidentiality, ethics – the extent to which service providers treat individuals in a fair, friendly and professional manner.

The paper also explores issues around accountability of services and the extent to which this influences people's perception of services (and their perceptions of the governments). This was examined on three levels:

i. The extent to which services are delivered in a responsive, transparent and accountable manner at various stages, including information dissemination, registration, delivery, and grievance redress.

ii. Citizens' ability to influence local government and hold local government officials accountable influences their perceptions of local government. This depends on the existing formal administrative arrangements (direct interaction with VDCs, participation in communal bodies such as management committees, civil society and voluntary groups) as well as informal channels for influencing local government.

iii. Finally, peoples' assessment of the central government and state legitimacy can be influenced by their expectations about the role of the state and whether its service delivery capacity matches these expectations.

3.2 Methodology

Qualitative research was conducted in September and October 2013. Two of the three research sites for the 2012 survey were selected for the qualitative research: Liwang VDC and Budagaon VDC. Data was collected from three wards in each VDC: in Liwang these were Reuga (ward number 4), Mulpani (ward 5) and Bazaar area (ward 6); in Budagaon, Kharka (ward 9), Simpani (ward 1) and Ranagaun (ward 5). Fifty-two in-depth interviews were conducted. Out of these participants (26 men and 26 were women), there were 21 Brahmin/Chhetris, 12 Dalit, and 19 Janajatis. Interviewees were selected purposively to include these different groups living in different geographical terrains in Rolpa. Included among the 52 households were 15 households surveyed in 2012. The interview guide was developed based on the analytical framework. Similarly, some quantitative data collected for the baseline survey are used in this paper.

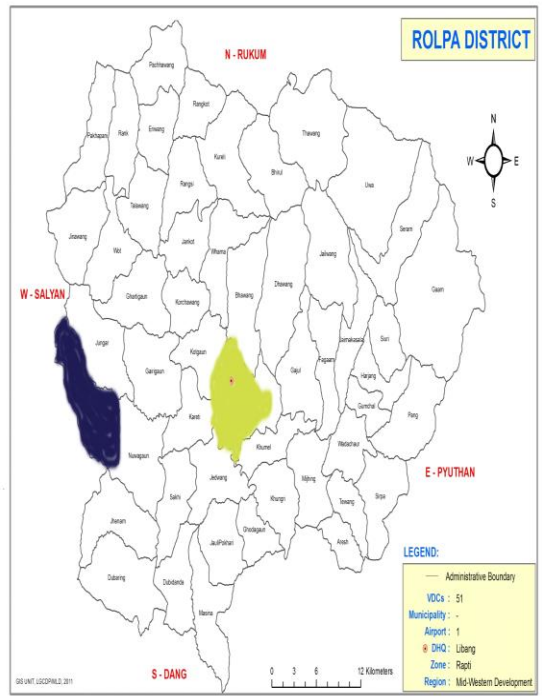
All of the research data were translated from the Nepali language to English and transcribed. Field notes were maintained every day. Data were coded manually and qualitative analysis was done.

This study does not reflect the views of service providers, focusing instead on how people perceive the government based on existing services from nearby Health Posts and Sub-Health Posts. The main focus of the research was on government-provided health services as opposed to private clinics. For the purpose of this paper, rich people are defined as those able to cover the costs of their family's health, education and food, and the poor are those who cannot.

The qualitative research builds on and was designed to complement a longitudinal panel survey the first round of which was carried out in 2012. A second round of the survey, where we will return to the same households, will be conducted in 2015/16. The survey aims to produce data on people's livelihoods, access to and experience of basic services, and people's perceptions of governance. Data was collected from 3,176 households in three districts – Bardiya, Ilam and Rolpa – between September and November 2012, and are representative at the village level (Upreti et al., 2014). Where appropriate,

this paper draws on the survey data to complement the qualitative findings or to point out where the quantitative and qualitative data seem to differ.

Figure 2: Location of study sites



4 Findings

The findings of the research will be discussed on the following sections. Section 4.1 explores people's perceptions about the accessibility of health services focusing on physical accessibility, financial accessibly, social barriers and administrative barriers. Section 4.2 deals with the effectiveness of health services in terms of the quality and reliability of service. Section 4.3 describes people's perceptions of local and central government based on the ability of each to ensure effective and accountable delivery at the local level. Section 5 draws conclusions.

4.1 Access to health services

4.1.1 Physical access

In this research we examine physical access to health services in terms of distance, the time required to reach them, the availability and cost of transportation, and geographical topography. As the research only focused on government Health Posts, it does not explore the accessibility of private health clinics. Topography and physical distance have long posed challenges for the health system in Nepal (Karkee and Jha, 2010). According to the World Food Programme (2007, cited in FAO, 2010), more than half of rural communities do not have access to health facilities. Difficult geographical terrain makes some medical staff unwilling to work in remote areas or to transport medicine and equipment throughout the country (Karkee and Jha, 2010; Harris, Wales, Jones and Rana, 2013). According to the Nepal Living Standard Survey Report 2011, about 59% of rural households in the country are within 59 minutes' walk of the nearest Health Post or Sub-Health Post and only 21% are within 30 minutes (compared to 83% of urban households) (CBS, 2012). The government plans to address this by increasing the number of service outlets through the country (DoHS, 2014).

The quantitative survey found that in Liwang the average time to a Health Post is 81 minutes (varying between 1 minute and 480 minutes), and in Budagaon it is 34 minutes (varying between 1 minute to 300 minutes) (Upreti et al., 2014).

Table 1: Time to get to a Health Post from home

VDC	Mean	Maximum	Minimum
Budagaon	34	300	1
Liwang	81	480	1

Source: Field survey data 2012

The explanations for longer times taken were physical geography, scattered settlements and the lack of roads. Sick people often need to be carried on someone's back or in a basket to reach a Health Post.

However, our study shows that physical accessibility is not people's only concern. Some people think that the establishment of a Health Post increases their access to health services, but others think this is not enough and ensuring the quality of services and the proper functioning of Health Posts is the priority.

Interviews showed that people's health care choices are influenced by a complex mix of factors around accessibility, perceived quality and cost. Private health services are largely concentrated in more

accessible areas and city centres and are expensive and therefore difficult for poor people from rural remote areas to access and afford (Upreti et al., 2012).

People living very close to government Health Posts in Liwang often do not benefit because they prefer to go to private medical units, while many of those who do visit the Health Posts come from far away. Out of 29 interviewees in Liwang, eight do not go to the government Health Post even though it is very close to their houses. Respondent 30 (24-year-old Janajati woman) said, 'My house is close to a Health Post, it is just five minutes' walk from my house…but I do not visit the Health Post'. She does not think the Health Post can provide the service she needs in a timely way and therefore prefers to use the private health service.

On the other hand, people living far from the government Health Post may prefer to use it because it is more affordable. Respondent 45 (22-year-old Brahmin woman) said,

My house is far from the Health Post and takes 60 minutes to reach, compared to only 30 minutes to private health units, but I prefer to go to the government Health Post because medicines and services are free of cost. I go to private health unit only when the Health Post does not cure the disease.

It is clear that irrespective of caste, ethnicity and gender, people choose health services based on affordability, quality and availability. Many people do not view the physical distance of Health Posts and Sub Health Posts as a major problem. But some elderly people do complain about distance as they need help to reach the Health Post. One 74-year-old man (Respondent 32) said: 'the Health Post is far from here and takes more than 30 minutes to reach. I cannot walk long distances and I need help of others to get there'. Likewise, a 71-year-old Dalit male (Respondent 4) said, 'I cannot go alone and most of the times my son takes me to Health Post for the check-up. But if he is not free to accompany me, I have to suffer'. Physical distance is also a concern for disabled people and some pregnant women.

Most of the better-equipped health service centres are located either in urban or market areas. When patients are referred to district hospitals, roads and transport are a concern. The district hospitals are located at district headquarters, which are hard for some to reach. A 57-year-old Janajati male (Respondent 13) of Budagaon said 'when the local Sub-Health Post refers to district hospital, the free services offered by the district hospital are not free for us because we need to pay for transportation, lodging and food.' The Rolpa district hospital is in Liwang, but people in Budagaon have to go to the district hospital of Dang District. Hence, the physical accessibility of Health Posts is not the main issue, but rather the services available.

4.1.2 Cost of accessing services and service quality

The cost of using free health services (including the cost of transport, lodging, food as well as opportunity costs) is an important factor in people's decisions. Richer Nepalis have been found to prefer the higher quality services provided by the private sector (Devkota, 2008) and our research supporters this general divide: richer people in Rolpa visit private clinics and hospitals in nearby cities or in Kathmandu, Butwal and Nepalgunj.

The main beneficiaries of free government services are poor and marginalised people. People with low incomes prefer to go to the Health Post or Sub-Health Post. Dalits and poor people travel long distances to for check-ups in government facilities. A 48-year-old Dalit male (Respondent 31) of Liwang said, 'I go the Health Post for minor check-ups and free medicines. We cannot get all services there, but we go there first'. A 35-year-old Janajati male (Respondent 36) in Budagaon said:

I first go to the Sub-Health Post. It is 45-minute walk. If we are lucky we can get free medicines and services there; if not we have to go to a private clinic. Most of the time we cannot be cured through

these services poor quality as well as required health services available at the Sub-Health Post so we need to go private medical service providers/pharmacies.

Interviewees from the comparatively well-off bazaar area of Liwang did not always know that health services from Health Posts are completely free mainly because of weak information dissemination. A number of respondents said they would have to pay a five-rupee registration charge – a fee that has not applied for many years. All the interviewees in Budagaon, on the other hand, knew that services from government health service centres are free. The people who complain that they have to pay a registration fee are those who stopped visiting government Health Posts years ago and whose first choice is now the private clinic.

In emergency situations people mostly go to private clinics or pharmacies because they assume that urgent treatment from Health Posts and Sub-Health Posts is not possible or effective. A 51-year-old Dalit male (Respondent 10) from Budagaon said:

I go to the Sub-Health Post first to know whether my need is fulfilled free of cost, if I can get service free from there, then I do not have to go to private if not only then I go. If the patient has a serious condition then we go private directly.

People in Liwang are comparatively better served because there is a Health Post and the district hospital with relatively good quality and accessible services. A 27-year-old Janajati woman in Liwang said, 'to go to district hospital is not problem in Liwang – we can easily go district hospital'. People in Budagaon are not as privileged as those in Liwang. Respondent 37 (a 50-year-old Janajati male) of Budagaon said that if the Health Post cannot cure him:

in that case I go to district hospital of Dang, but it needs money to reach there because there are transportation costs. Even if the case is serious there is need of more money for motor reservation, accommodation and food. It costs a large amount of money.

Sometimes people need to sell assets to reach the district and regional hospitals, aggravating their economic vulnerability. Most poor people in our study had to either get a loan or sell livestock to reach to the district hospital or zonal hospital. So they prefer to first go to the private medical shops and clinics closer to their houses. A 39-year-old female from Budagaon said, 'going to district hospital is more expensive than visiting a local private clinic'. Respondent 27 (male, Chhetri, 69 years old) from Budagaon said,

we could not go district hospital because it is very far and transport costs, so I do not go government hospital even though it is free; rather I go to private shop at Kapurkot. The cost to go to government health service centre in the urban area is higher than going to a private medical shop at nearby.

The location of complex services at the district, zone and capital level is not helpful for the poor people of rural remote areas. The numbers of private clinics and pharmacies are expanding and people who are able to afford them buy treatments and medicines from them, they are too expensive to poor people and this contributes to widening inequalities in health services.

4.1.3 Social barriers and discrimination

This section looks at the extent to which discrimination based on gender, ethnicity, caste or religion is affecting access to and utilisation of health services. Many observers have argued that the use of health service in Nepal is shaped by caste, ethnicity and gender (Devkota, 2008; Askvik, Jamil and Dhakal, 2011; UNDP, 2009). Devkota (2008) shows that between 2001 and 2005, utilisation of health services by the higher caste Brahmin/Chhetri (47.6%) was higher than that of Janajati (24.1%), Dalits (17%) and Muslims (3.6%). Among these visitors 55% were females.

The issues of exclusion and discrimination are a social legacy of the unification of Nepal. Nepal was established as a Hindu kingdom more than two hundred years ago. Hindu customs, values and traditions are deeply ingrained in Nepalese society and are nurtured in various state institutions (Askvik, Jamil and Dhakal, 2011). Poor and marginalised people have less access to different services because of caste and gender discrimination, lack of awareness and education (FAO, 2010). Many Dalit people with less education visit Health Posts and clinics only after first going to traditional healers, herbalists and shaman, visiting the Health Post and hospital for modern treatment if their problems get more complicated. Less educated and low caste people know less about the modern health system and often fail to go for follow-up treatment. Hence, their access always gets affected by caste, awareness and education.

Caste-based discrimination became illegal in 1963 but Bhattachan et al. (2002) list 205 existing practices of caste-based discrimination they encountered in their research, including various forms of denial of service, inhumane treatment, forced labour and so on. Such practices and their implications have undermined the health and education of lower caste people.

However, our research found little evidence of discrimination. The people we interviewed thought that they faced no discrimination at the health service centre. The quantitative data showed a statistically significant variation in levels of satisfaction by ethnicity of respondent in these two VDCs whereby Janajatis/indigenous and Dalit respondents tended to be somewhat more satisfied with the health service than Brahmin/Chhetris. In Budagaon, 88.7% of Dalits were satisfied compared to 83.6% of Janajatis and 81.8% of Brahmins. In Liwang, 68.4% of Dalits, 65.7% Janajatis and 65.3% of Brahmins were fairly satisfied. Our qualitative research uncovered no differences between the perceptions of male and female Dalits regarding discrimination. A 35-year-old Dalit woman (Respondent 17) in Budagaon said, 'there isn't any kind of discrimination in the Sub-Health Post: we are well behaved and equally respected at Sub-Health Post by health workers. Many years ago there used to be discrimination but now there are no such practices.' People are happy with the behaviour of health workers, who according to interviewees, treat all patients with respect.

It is observed that the discrimination people used to face has gone, which many see as a legacy of the Maoist war. Rolpa was the heartland of the Maoist insurgency, bringing devastation but also positive social change. The Maoists initially focused on class inequality but increasingly talked about caste, exploiting the feelings of discrimination and exclusion among the Dalits, indigenous people and Tarai Madhesis to attract people to their movement (Cameron, 2007). They formed a Dalit wing of the Maoist party and marginalised groups were given leadership roles in their communities, which built up their leadership capacity and confidence and decreased caste-based discrimination (Pyakurel, 2007). None of the 52 respondents said they perceived discrimination at health facilities. 30 participants said discrimination has been eliminated because of political change and the rise of voice of lower caste people, especially due to the Maoist war legacy; 12 said it was because times have changed; and 10 said they do not know the reason.

Although there is no evidence of current discrimination, the legacy of previous marginalisation and discrimination still has a psychological impact, especially among older Dalit people. Not being educated, elderly Dalit people feel uncomfortable talking freely with health workers about their health problems. A 51-year-old male Dalit in Budagaon (Respondent 10) said 'we [Dalit] feel that we do not know anything – if we ask things that could be wrong'. He feels uneducated and humiliated in front of upper caste people and feels backward, 'but my children would not feel like this because they are educated.'

According to Tiwari (2008), there is gender discrimination with regard to health services. But people's perceptions in our research do not reflect this. Women's levels of satisfaction were higher than men's. None of the 26 women interviewed said they felt discriminated against at health centres and they feel it is easy to share their health problems with female community health volunteers (FCHVs).

Education and political changes have empowered women in Rolpa and reduced gender discrimination. Education changes were mainly the outcome of the government policy and activities (e.g. education for all, literacy for women), while political changes were mainly related to the 1990s transition to multi-party democracy and of the civil war waged by the Maoists. Wider social change has also affected women; widows, who were supposed to wear white saris in the past, are now found wearing red saris, *tika* and glass bangles.

As with caste, social change can be traced to the insurgency. Women constituted a third of the Maoist People's Liberation Army and the Maoists encouraged women's participation and made laws against discrimination and polygamy.[4] A 40-year-old Dalit woman in Liwang (Respondent 8) said 'discrimination was very high before insurgency, but now it is not'. Respondent 24, a 42-year-old Dalit woman in Liwang said, 'As radio and television channels broadcast programmes related to equality between males and females, people have became informed and rational, which has ended such discrimination'. She explained:

The Maoist insurgency has made people more aware about it. At that time Maoist has made a kind of strong rule and punishment system for these kind of discrimination; as a result discrimination by upper castes has decreased. Leadership among lower caste people also developed during the insurgency and as a result discrimination decreased.

Rural people now have a much stronger sense of their rights because of education, awareness programmes, political change and legal rights, which means the old social barriers like visit of pregnant women to health posts are no longer very significant. A 37-year-old Dalit man (Respondent 16) from Liwang said, 'participating in the different awareness and advocacy programmes, now we can question to Health Posts why there are not sufficient medicines. However, we cannot force them to make the medicines available.' Women too are capable of asking about services but again they cannot change the situation to make the service any better.

4.1.4 Administrative barriers

This section looks briefly at the extent to which administrative issues present barriers to accessing and using services. There is no requirement for documentation and paperwork at health facilities, so even uneducated people can get services without any problems. Respondent 16, a 35-year-old Dalit male from Liwang, said 'there are no hassles and difficulties, no need of paperwork.' But the hours when the service is available and the lack of human resources do concern people. Health Post registration times are between 10 am and 2 pm, after which there is no registration for treatment. After 2 pm patients might get services if a sympathetic health worker wishes to help, but before 9 am there is no chance of getting help at the padlocked, empty buildings. People in a serious condition are forced to either visit a private clinic or wait for the next opening time. The research team observed a woman waiting at a Health Post for it to open with a sick baby.

[4] However, polygamy is still observed in some areas and practices if a woman can't produce a male heir by cheating to the law.

The availability of health services out of office hours is a real concern. 20-year-old Respondent 5 from Budagaon said, 'the Sub-Health Post gets closes at 2 pm and on Friday it opens for just two hours (10 am to 12 pm) and is closed on Saturday, so how can poor people benefit from such a service?' He asked why government does not think about these issues.

In both Liwang and Budagaon, the provision of health services in only office hours pushes people to the use of traditional treatments. Respondent 37 (a 50-year-old Janajati man) from Budagaon said, 'there is no service at night so I go for traditional treatment.' Though traditional medicine appears to be his second choice, he added: 'a numbers of times I have seen people go for this treatment and be cured so I believe in it'. Another problem is the lack of human resources that means there are not enough health workers. Some Health Posts are reportedly run by the office assistant when the health assistant and health workers are on leave or go on any kind of training. This has devalued the government health system.

4.2 Reliability of services and effectiveness

This section looks at how effectively services are delivered and people's assessments of the role of local government in delivering them. Effective service delivery refers to the quality and reliability of services, the extent to which health facilities function regularly, and the availability and behaviour of staff.

People are meant to benefit from free medicines, but many are disappointed that services are called free but not actually available. A 20-year-old Janajati youth (Respondent 43) from Liwang said, 'the Health Post is not enough: I went there because of fever but the health assistant checked me and suggested I buy medicines from the private health clinic. What then does free service and free medicines mean?' He added, 'if there is nothing then what is free?'

Experiences like this discourage people from visiting government health centres. People are only getting limited medicines like cetamol, electrolytes and metron; other medicines have to be bought from private shops. The Nepal Health Research Council reported that out of 32 free medicines only 18 are easily available at Health Posts. While 15 out of 22 types of medicines are usually found in Sub-Health Posts, other medicines are always scarce.[5] The Nagarik Daily Newspaper reports that there is a shortage of free medicines in 80% of health service centres in mountain areas, in 43% in hill areas and in 52% in the Terai region.[6] Some medicines like vitamin B complex tablets, eye drops and eardrops, medicines for respiratory diseases and several expensive medicines are always scarce.

The quality of the free medicines also came in for criticism from our respondents. Out of 52 participants 30 were not satisfied with the medicines' quality. The free medicines are not found to be as effective so people often have to buy others from private shops. A 29-year-old Janajati man (Respondent 11) from Budagaon said, 'we mostly go to private clinic rather than Sub-Health Post. There isn't any good medicine in Sub-Health Post … sometime we get medicines which are near to expiry date and some of them could even have expired'.

5 See more at: http://nagariknews.com/health/story/16448.html#sthash.ut3JmatX.dpuf
6 See more at: http://nagariknews.com/health/story/16448.html#sthash.ut3JmatX.dpuf

The quality of free medicines has often been questioned in the media, with stories of how some medicines go unused and expire in some places but are unavailable in others.[7] Some people link the quality of medicines provided by government with corruption. A government health worker said these medicines are of low quality because the suppliers of the medicines have opted for the low-budget tender process and pay commissions to the concerned authority. He said the government does not even check the quality of medicines because of the commission.

The perceived inadequacies of Health Posts extend beyond medicine quality. People complained that they are only geared to treating general health problems like fevers, coughs and colds. All the respondents wanted fully functioning Health Posts and Sub-Health Posts with senior health workers equipped with the necessary facilities. The unavailability of services at Health Posts makes people choose private health centres.

A 31-year-old woman from Liwang bazaar (Respondent 3) said she goes to the Health Post to get free medicines but does not use the other services like check-ups because they do not have the right equipment or a laboratory. She said, 'I used to go to the Health Post some years ago but most of the time they referred me either to the district hospital or to Nepalgunj, Kathmandu, because the treatment from the Health Post was not working'.

Respondent 5 (a 20-year-old Chhetri male) from Budagaon explains: 'The Sub-Health Post lacks infrastructure like benches, tables and beds. It lacks essential equipment (such as X-ray machines) for treatment as well'.

Box 2: Case study: Who is responsible for my wife's death?

People like to get services from government Health Post but due to lack of diagnosis equipment and laboratory facilities they have to switch to private health centres, but this brings its own risks. Some of them have untrained medical staff and have people report 'trial and error' treatment in private clinics that can worsen the condition of the patient.

A respondent from Budagaon 7 told us that his wife died because she received the wrong treatment at a nearby private clinic in Budagaon. A health worker had referred her to the district hospital but she chose to go to the private clinic because the district hospital was three hours away and too expensive to get to. She took the medicine and pain relief prescribed by the clinic but one night she died at night, vomiting blood. The post-mortem showed she had been taking the wrong medicines prescribed by clinic for her condition for a long time.

By the time her husband learned he had the right to sue the clinic for wrong treatment, it was too late. He blamed the government for the lack of equipment at the Health Post and its ineffective monitoring of the private clinic. He said, 'there are many such cases in rural areas, but no action is taken against these private clinics. They frequently move around. After that incident the person ran and clinic closed. In this case you can judge who is responsible for death of my wife and deplorable condition of my children?'

Women have traditionally given birth at home but FCHVs are now bringing pregnant women to Health Posts. A 24-year-old Janajati woman (Respondent 46) from Liwang said, 'I did not go to the private clinic for check up while I was pregnant. I went Health Post where there was a Female Community Health

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7http://nagariknews.com/health/story/16448.htmlhttp://swasthyakhabar.com/2014/02/6191.html, http://nagariknews.com/health/story/17074.html

Volunteer. She checked me; she also came frequently to my house to share information about pregnancy'.

The government transportation allowance provided under the Safe Delivery Incentive Programme (SDIP) is also helping to increase the rate of the child delivery in health centres. A 58-year-old woman (Respondent 9) from Budagaon said, 'throughout the service the transportation allowance was also useful.' Some women observe that although the pregnancy check-up is good at the Health Post, there are still no beds to keep patients under observation.

Women consult FCHVs on maternity health problems and reproductive health problems and also play a significant role in making people aware about the importance of vaccination and in distributing vitamin A capsules and worm medicine. It is not only women who appreciate this. A 20-year-old Chhetri man (Respondent 5) said, 'Female Health Workers suggest that we vaccinate our children. Our children are vaccinated with BCG, DPD etc.'

In sum, the establishment of the government Health Posts and Sub-Health Posts has helped a lot in improving women's maternal health. The roles played by FCHVs do more to demonstrate the effective presence of government health service than anything else.[8] However, people's expectations of curative health services are not being met, and this greatly decreases the effectiveness of government health services in the eyes of local people.

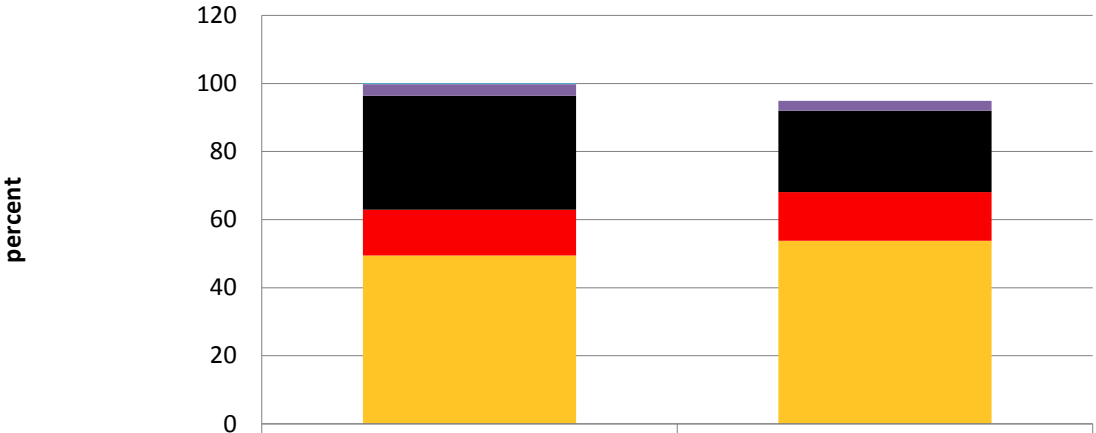
4.3 People's perceptions of the government and accountability

In this section, we explore people's perceptions of the accountability of service delivery and their assessment of the role of local government in overseeing service provision so that services are delivered in a responsive, transparent and accountable manner.

The quantitative data showed that people in Rolpa have a slightly better opinion of local government than central government: 49.5% of people think local government never reflects people's priorities, while 53.8% think the equivalent for central government (Upreti et al., 2014).

[8] FCHVs treat children with pneumonia, counsel families of children with coughs and colds on appropriate home care, distribute zinc tablets and vitamin A, and visit postnatal women.

Figure 3: To what extent do you feel that decisions of those in power at the local and central government reflect your own priorities



	Local Government	Central Government
Completely	0.2	0
To large extent	3.4	2.9
Only in some extent	33.5	23.9
Almost never	13.4	14.3
Never	49.5	53.8

Source: Adopted from Upreti et al. (2014)

The qualitative research found that people appreciate the role of local government in providing health services in a non-discriminatory manner and in establishing numerous Health Posts and Sub-Health Posts. They also appreciate the awareness programmes, vaccination campaigns, and recruitment of FCHVs, but they are generally very disappointed with the quality of treatment available for non-minor conditions.

Respondent 3, a 31-year-old Brahmin male, said, 'the local government has provided some minor medicines, so that the poor people who cannot afford check-ups in private medical centres can benefit … We should be thankful at least the state has provided this minimum service.'

Participant number 14 (a 60-year-old Janajati female) says, 'it is the state responsibility to provide services … Local government should take responsibility for providing good services to the local people for making their livelihood better'.

People say local government should do more to monitor Health Posts and Sub-Health Posts and make medicine available. Although the LSGA gives VDCs and DDCs the authority to monitor the Health Posts and Sub-Health Posts, in practice people do not see any intervention from these authorities. Respondent 9 (a 58-year-old Chhetri male) from Liwang said:

The VDC and DDC must be able to understand the needs of the community and they must provide the services needed by the patients. If they care about us, the local government must monitor why Health Posts have not been able to deliver medicines. They have not monitored anything. If they had monitored then wouldn't there be adequate medicines at the Health Post? If government cares about poor people then why are these health services not equipped like a fully functioning health service?

With the implementation of LSGA, the health facilities were handed over to the VDCs, but people do not see any kind of monitoring mechanism in place. The LSGA mandates the DDC to manage the district-level Health Posts, hospitals, Ayurvedic dispensaries, health centres, health offices and to make arrangements for the supply of medicines, materials and equipment. The DDC is also responsible for monitoring quality standards. But in practice, inspection, monitoring and evaluation do not appear to happen. Insufficient resources are provided for local government to manage all these functions (The Asia Foundation, 2012), while the central government fails to intervene.

The central government's lack of regulation and monitoring leads people to perceive that it is not committed to their health. The quantitative survey shows that people are more disappointed with central government than with local government. Respondent 39 (a 31-year-old Brahmin woman) said, 'The central government is not committed to providing better services because they have not been able to make programmes effective.'

People also raise the question of non-transparency of budget came from central to local level which is completely out of reach of people, while people want significant interference of central government. Respondent 24 (a 42-year-old Dalit woman) said:

I do not believe that central government is committed to local people …the monitoring is lacking, the amount of budget that the central level has provided must be transparent and its effectiveness at the local level must be analysed – the achievements of the budget spent so far must be calculated and recorded … Central government should exert control and evaluate all those programmes. Local government must provide services because they are only familiar with the local services that are required … the central level work is to estimate budget and make planning' and only local government provide services.

People blame central government corruption for all kinds of problems, whether concerning medicines, human resources, or the technical inefficiency of Health Posts and Sub-Health Posts. People said that at the central-level politicians and bureaucrats who are supposed to evaluate and manage local bodies are too busy making money or engaging in in power wrangles. Respondent 41 (a 50-year-old Chhetri man) said, 'the Kathmandu government has been the centre point of corruption for the political representatives. There is more corruption than programming in the government'.

People think central government should monitor private health facilities and pharmacies as well as government ones. The participation of the private sector is allowed under the National Health Policy of 1991 but the controlling and monitoring mechanisms are ineffective. Health workers who set up their own private clinic use government medicines but do not get investigated. There are many clinics and shops operating in Rolpa without the government's permission. There is no mechanism to monitor or regulate the sale of prescription drugs. Some respondents in Liwang say that there are clinics operating that have no medical knowledge but that avoid legal action because they have political support. There is also the problem of poorly regulated private providers prescribing unnecessary treatment, which leads to users facing financial problems and builds up resistance to drugs. On the other hand, good private clinics can also guarantee efficient, equitable and effective health care services.

According to the law on local self-government, people should be able participate in local governance, but there is little evidence of this in practice. The government introduced Health Facility Operational Management Committees (HFOMCs) to be involved in the management of health facilities and which are meant to include women, Dalits and marginalised people. In the absence of a locally elected body the HFOMC could be an effective way for the community to participate and influence service delivery but none of the participants in our research spoke of any committee fulfilling this role.

No participants said they knew about any committee that would give them a voice. People do not know about how to complain. Respondent 5 (a 20-year-old Janajati man) said, 'I do not make complaints. I do not know where to file concerns, and the authorities do not come to my areas asking if I have any'. In 52 interviews there was no mention of any committee that works between the people and the health authority.

In the absence of any elected local government bodies since 2002, local people have no mechanism for influencing improvements in the health of the Health Post (The Asia Foundation, 2012). All 52 interviewees said the absence of local elected body is a big problem in rural areas.

In sum, the provision of free medicines and basic health services has not changed people's perception about government because the services are not adequate to meet needs and because they do not see local or central government as playing an effective role in managing and monitoring services or in involving local people in accountability processes. There has been some progress, but it falls short of people's needs and expectations. Health Posts and Sub-Health Posts are not effective in providing curative treatment. Most people have very low levels of trust and confidence in both levels of government. People do not discern the central government's effective presence in health services. Its failure to evaluate and monitor the quality of the services is one of the reasons for rising dissatisfaction.

5 Conclusion

This paper set out to explore peoples' experiences with health care provision, how they accessed and utilised the health system, what they perceived about its effectiveness and how this influenced their views of government's performance.

Nepal's challenging geography means that for some people physical access to health posts is sometimes difficult. Cost is not a major problem as the Nepalese government has made primary health care and medicines free. In the past, discrimination based on caste and ethnicity was been a major barrier to access. Interestingly, all of the people interviewed stressed that these issues were no longer major barriers to access: the government's focus on equality and the legacy of the Maoist insurgency have made a real difference.

People's biggest concerns around health relate to issues of effectiveness. Health posts are only open for short periods, medicines are often unavailable, equipment is limited and there is a perceived lack of well-qualified staff. Consequently poor and less educated people still turn to traditional treatment methods (traditional healers, herbalists and shaman). This means that richer people primarily use higher-quality private clinics, while poorer people sometimes turn to poorly regulated private providers of highly questionable quality.

Poor people often see government Health Posts as the first port of call, but for anything more than minor ailments they still sometimes have to resort to private care. So the perceived poor quality of care available is people's main problem with government-run health services. People have more positive perceptions in the area of maternal and child health, with many using Health Posts during pregnancy and for vaccinations.

People did express dissatisfaction with the government's role in the health sector. As well as expecting government to do a better job of staffing and equipping government run Health Posts, people also complained about a lack of government regulation and monitoring of private health services. They feel unable to influence local health policies or complain about problems with health services. The theoretical devolution of responsibilities and establishment of Health Facility Operation and Management Committee (HFOMC) seems not to be working in practice in the study area.

Women and socially excluded Dalits are comparatively more satisfied than others but irrespective of gender, caste and ethnicity people clearly felt the need for government to focus on the quality of care provided as well as basic accessibility. The role of FCHVs in providing community-based health services and awareness in rural areas, especially on maternal and child health and family planning, is crucially important. Hence, developing their capacity and expanding services can greatly contribute to the government's aim of providing accessible health services to poor and marginalised communities.

Central government needs to translate polices into implementation to improve the quality and effectiveness of health service provision. The slow pace of decentralisation, inadequate supplies of equipment and drugs, weak supervision and the lack of skilled human resources are the most urgent concerns to be addressed. The coordination and monitoring provisions of the 1999 LSGA needs to be translated into practice and greater attention given to strengthening the capacity of local government. In the absence of more effective and accountable governance at central and local levels any legitimacy gains from providing health care services will remain limited.

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