

Health Services Assessment in Five Village Development Committee Areas Surrounding Sanfe Bagar, Achham

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Introduction and Aims

The purpose of this assessment was to develop a preliminary understanding of the state of health, disease, and health services in the immediate region that will be most served by the proposed Nyaya Health-Nepal Ministry of Health and Population Primary Health Centre (PHC) in Sanfe Bagar, Achham. The primary aim was not to make a rigorous quantitative assessment of any of the indicators assessed, but rather to develop a semi-quantitative and qualitative sense of community public health and health service utilization. This understanding, we hope, can enable us to better develop the PHC, after which time we can do the more rigorous epidemiological work required for surveillance and prevention activities. A secondary aim was to develop support from key community and government leaders for the project.

Methods

Site Visits and Interviews with Key Informants

The first part of our assessment consisted of making site visits to several of the health posts, hospitals, private medical offices, pharmacies, and government offices in the region. At these sites, we interviewed several key informants, including: 1) administrators, politicians, leaders, local headmasters; 2) community-based outreach workers; 3) healthcare providers, health assistants, midwives, pharmacists, private practitioners; 4) members of the target population. Some of the questions we posed to the key informants were: What are the greatest health needs in your community?; What have your community done to address these health needs?; What has the government/NGOs/foreigners done with respect to health?; What do people do to stay healthy?; Where do people typically go when sick? For pregnancy/delivery? For childcare?; Where are people referred for tertiary care? How well are public health programs (TB DOTS, immunization, etc.) functioning? What do people do to get water?; What would you like to see done in the realm of health services?; Where would a health center best be located?; How do you feel about the government and its role in health services?; How do you feel about foreigners and their role in health services? Although we had these questions in mind, the interviews were typically informally conducted and were more of conversations than formal interviews. Finally, we held a community meeting, attended by 21 community members (4 women) from in and around Sanfe, to discuss the project.

During the course of these meetings, we also attempted to identify persons who would support the project and/or whose approval would be required prior to proceeding. The specific contact information for these individuals are kept in a separate document (Nyaya Health Volunteer Guide).

Rapid Health Assessment (RHA)

To develop a semi-quantitative understanding of the basic demographic, health, and health services characteristics of the area, we undertook an RHA modified from the work of Satia et al. in rural Gujarat, India.¹ The underpinnings of their work was to offer a practical, quickly administered tool that could serve in local health planning and was developed as a specific critique to the top-down administrative structure of government-run health services in India. Our adaptation of the survey is shown in Appendix 1. The survey population consisted of villages in five Village Development Committee districts nearby to Sanfe Bagar: Mastamandu; Jaypaldevi; Ridikot, Siddeswor, and Ghughurkot. A convenience sampling method was employed, targeting several villages within each VDC and administering the survey to women who happened to be at home or in one of the family's fields nearby. This was done to save time and resources, given that each village typically took at least one hour walking to reach. The extra effort and money required

to do systematic survey on a larger sample did not seem warranted, given again that the aim of the study was merely to gain an institutional familiarity with the health of the region and not to make scientific conclusions.

The survey was translated into Nepali and piloted by two native Nepali speakers. Two native nepali speakers from the area conducted all the interviews. They were considered volunteers of the project, but were compensated 100 Rs. Nepali per half-day for their time. They were accompanied by a Nyaya Health expatriate volunteer, who helped in identifying villages to survey and in identifying errors or oversights in data recording. The survey questionnaires were administered to 58 households between April 20 and April 26, 2007, with one day spent per VDC. The survey took between 10 to 20 minutes per household to administer. Given the unscientific nature of the survey and the fact that it in and of itself was not benefiting the community, we desired to complete data collection and analysis within two weeks and for under \$100. Ultimately, the total cost of the survey including typing, printing, and compensation to interviewers, was \$45.

One could make VDC-level and district-level estimates from this survey. However, given that the study population was a convenience sample and the sample size was small, we did not find such estimates to be highly accurate nor particularly useful to the present aims.

For ease of discussion, the results and implications of both the qualitative and quantitative aspects of the survey are presented together.

Results and Implications

Population

Achham district in Far Western Nepal is home to 250,000 people and is extremely poor and undeveloped even compared with the national averages. Annual income averages \$141, while 92-95% of homes don't have electricity and the average level of education is 1-1.5 years of schooling. A staggering 60% of children are malnourished. Labor migration rates are among the highest in the country, with 40-90% of households having a member working seasonally in India. Not coincidental to these circumstances, this district is believed to have one of the highest rates of HIV in Nepal.

Development in Achham has been slow to progress, despite urban economic growth and health progress. The average income in Kathmandu is 4.5 times that of Achham and grew, in terms of purchasing power parity, more than \$300 dollars between 1996 and 2001, while dropping \$7 in Achham. Likewise, while the national literacy level rose 12% over this period, it only rose 1% in Achham, to 26%. Fifty-five percent of the population in Achham doesn't have access to safe drinking water, two and a half times the national average.

Sanfe Bagar itself has a large bazaar and is a main transit route for other parts of Achham and neighboring districts. The inhabitants of Sanfe bagar are relatively less poor than the villagers on the outskirts; they make their living by selling goods, food, and lodging to travellers. The outlying communities are all farmers, and the men do additional work wherever and whenever it can be found. The poorest-of-the-poor in the area are a community of migrants from the northern districts (primarily Bajura) who live in tents on the hills outside of Saphe and whose primary income comes from the sale of homemade liquor. They travel from the north for 4-5 months out of the year to escape the cold. They speak a Tibetan dialect and their Nepali is very difficult to understand even for native Nepali speakers. Most of them have already left; we spoke with one of the few remaining families, and it was clear that their health condition is terrible and that they pay excessive amounts for (often ill-advised) health care from the private practitioners. They were not included in the RHA, however.

The basic demographics of the population obtained through the RHA are shown in Table 1. The reported deaths and chronic conditions reported during the course of the survey are displayed in Table 2.

Support from key community members, leaders

In our trip to Mangalsen, the district headquarters, we obtained verbal support from the District Health Officer, Chief District Officer, and the DSP (chief of police). They all agreed to provide any aid they can to the project, and that we update them as we progress.

We spoke with some of the Maoist leaders in Sanfe, and a few attended our community meeting. They have integrated into the political system and were fully supportive. We had also met with the Maoist health-in-charge in Parliament in Kathmandu.

Other political, NGO, and business leaders and teachers also expressed support for the project. There was some discussion and debate about whether the clinic would be developed in Haat Bazaar or Airport Bazaar, but the inhabitants of Airport Bazaar were ultimately agreeable to the idea of the clinic being on the other side of the river. It was made clear to all parties that the clinic would serve all patients from whichever VDC. All the people who we talked to were clear that an MBBS doctor running a clinic anywhere in the area would be greatly appreciated and would receive the support of the Sanfe community.

It should be noted that we were careful to present it as an idea, a possibility, but that several community members started to talk about it with greater certainty. As such, community expectations, at least within Sanfe, are greater than we had tried to achieve.

Other than meeting with some healthworkers and teachers from the adjacent villages outside of Sanfe, we did not hold community-wide meetings in any of the adjacent villages. The reason for this was that we were still very much in a preliminary phase and it did not seem warranted to hold meetings in these villages. We had chosen to hold the meeting in Sanfe only because we were planning on renovating a building in Sanfe itself, and it was important that the inhabitants of the immediate vicinity be aware of what was going on. It will be important, however, as the clinic develops, to conduct outreach and receive input from the outlying communities that are away from the relative power base of Sanfe.

Socioeconomic situation

The median monthly household income was 2000 Rs (30\$US), or about 70 Rs. (\$1) per day. The national population survey of 2001 reported an annual per capita income in Achham of \$141, translating into approximately \$0.40 per day. The median ropanis per household was 3, and each ropani produces approximately from 5,000-10,000 Rs. per year. Illiteracy is particularly high among women, with 76% of the women surveyed being illiterate. Data from the 2001 population survey estimated 74% of adults in Achham to be illiterate. As the illiteracy rate reflects the state of the schools approximately 10-20 years back, this scenario has likely changed. Prior to thirteen years ago, there was only one functioning school in the area, in Bayalpata, and none in Sanfe. This, among other reasons, has contributed to the high illiteracy rates. In any case, the high illiteracy rates among current mothers will need to be accounted for in developing maternal and child health interventions.

The result that 45% of men in the survey are migrating for extensive periods of time to work in India confirms the high level of migration. This number was somewhat less than we had expected, both from other studies and from informal discussions with the public. This result may have been owing to sample bias, in that there was a bias towards the more accessible villages that may have had better access to work and land in Achham itself. Still, the result highlights that migration, and its attendant risks of communicable diseases and inconsistent care for chronic diseases, must be addressed by our proposed primary healthcare program. Poor or nonexistent communication with family members while in India is also the norm. The husband of one of the respondents had in fact been missing for two and one-half years after going to India for an ocular problem. Three other women we interviewed were single, for the following reasons: two husbands had died of HIV/AIDS and one husband had taken another wife.

Water and Sanitation

Excessive travel time to access water for consumption and sanitation does not seem to be a major issue in this community. There is in fact an abundance of rivers and streams in the area. Sanitation and water treatment is greatly lacking, however, and it is clear that water-borne diseases are endemic. At the district hospital, healthposts, and private medical practices, diarrheal diseases are among the most prevalent conditions. Only approximately 30% of the households surveyed had a toilet, and none of the toilets in the villages have functioning septic tanks. Drinking water treatment and waste disposal are huge and neglected areas that could potentially have an enormous impact on public health.

Health Services in and around Sanfe Bagar

As is typical for most of South Asia, 80-90% of healthcare activities are done by private medical practitioners. Most of that other 10% consists of vaccines, TB, and occasional healthcamps. There is typically one private "medical" (clinic) in each village, although Sanfe has five. The privates often work or have worked in the government as low-level practitioners (auxiliary health workers, health assistants, auxiliary nurse midwives). In the Nepali health system hierarchy, the major government-provided services in the area are as follows:

1) District Hospital in Mangalsen

This is the main referral center for the district of 250,000 people. It is highly inaccessible, however, given that the roads to it are unpaved. The road from Sanfe is slowly going to be making its way to Mangalsen, to be completed perhaps in 3 years. About 40 staff run both the hospital and district public health office, which is located in the hospital. Currently, the hospital and public health program is headed by the DHO, an MBBS doctor about 12 years experience, including public health experience. Laboratory and diagnostic capabilities include AFB smear, X-Ray, hemoglobin, manual CBC, glucose, HIV, bilirubin, gram stain, blood smear, urine and stool microscopy. They perform vacuum-assisted deliveries, manual removal of placenta, incision and drainage, suturing of lacerations, and external reduction and casting, but do not do c-sections or any other surgeries, blood transfusions, thoracentesis, or paracentesis. It has an inpatient unit with 8 beds, and is typically full. An operation theatre is being constructed by the German development agency GTZ and will be completed in 4 months.

2) Primary health centers (PHC). PHCs should be staffed by at least a doctor and be capable of running basic laboratory tests. There are two of these in all of Achham, but they are less accessible to the Sanfe Bagar communities than even the district hospital. According to the DHO, these are minimally functioning. Neither have a doctor. We did not visit these given their large distance from our catchment area.

3) Healthposts/sub-healthposts. These ideally would function as triage services run by the AHWs, HAs, and ANMs. We have not found a single one in the area that is functional beyond serving as relay stations for vaccination programs and distribution of some basic medicines. We visited the Masta Mandu, Hatikot, Siddeswor, Ridikot, and Jaypaldevi sub-healthposts, and there was little variation between them. They were typically staffed by an AHW or CMA, an ANM, a VHW, and a peon. The norm is that the government healthworkers operate private practices, and most posts have expired medicines; the medicines come once a year and within a few months the supply has ceased. The Badalgada hospital is functioning technically as a healthpost and is worth mentioning because it was originally the site that the Ministry desired Nyaya to renovate and staff. It operates a few days a week with staff of a CMA, an ANM, and a peon. Both the CMA and ANM have private practices that are more of a priority. The maintenance was very poor, and again had an old stock of expired medicines.

Outside of Achham, individuals can access services at the Doti District Hospital about 3.5 hours by bus from Sanfe (about 150 Rs). This hospital is equipped similarly to the Mangalsen hospital, except that the doctor only graduated from MBBS one year previously. After Doti, TEAM hospital in Dadeldura (about 8 hours away and 300-400 Rs. by bus). This mission hospital is the closest provider of surgical (including c-section) and transfusion services.

Medical Services Utilization

Given the inaccessibility of quality government-run healthcare, it is no surprise that the private medical sector is booming in the catchment area. This is a common phenomenon throughout Nepal and much of South Asia. The paltry services provided by the public sector cannot meet the demand for health services. Most of the government healthworkers we spoke with had private practices in addition to their work in the public sector. While the healthposts were typically abandoned, the private medical practices often had long lines of patients awaiting them starting early in the morning. Over 80% of the respondents in our survey stated that private medical practitioners were the first place they go for healthcare. The consequence of this was the large amount of money spent on healthcare. It is also likely that this on-site, fee-for-service structure serves to dissuade the poor from obtaining timely health care.

The private sector burden shouldered by citizens of the area is greatest in the area of catastrophic medical coverage. Sale of land and other equity was described as a common occurrence. Eleven (19%) of households had made at least one trip in the last year to India for medical care, and an additional two (3) had made the (typically longer) journey to Kathmandu. These trips last over one day of solid travel one-way, for medical services. The costs of these medical journeys were 510, 2500, 3000, 4000, 11000, 12000, 20000, 22000, 25000, 35000 Rs (two were not recorded). The median amount spent (Rs 11,500) is equivalent to nearly 6 months of the median household income. Only one household reported the use of the Mangalsen district hospital in the past year.

Cooking and indoor ventilation

All households reported using wood as the primary fuel source. Only one respondent mentioned the additional use of kerosene as a secondary fuel source. Although this was not directly asked, our observations were that individuals almost uniformly cook inside poorly ventilated kitchens using wood. This certainly presents a risk factor for chronic respiratory tract conditions, and warrants consideration for community public health engineering intervention.

Perinatal Services

Perinatal services are minimal. Of the 23 pregnancies within the last year, only 52% of women received at least one tetanus vaccine, 39% received iron supplementation, and 4% (1) received an HIV test (this was not given as part of routine perinatal care but rather coincidentally by an HIV-specific NGO; the result was negative).

Nineteen of the 30 births (63%) that were reported in the last two years were delivered by an untrained friend or relative. These all were performed free of charge and without the use of a safe delivery kit. The other eleven deliveries were as follows: 7 by a traditional birth attendant (cost: 1000, 1000, 1400, 1500, 2300, 3000, 3500 Rs.); one by a doctor in a hospital (cost: 1000 Rs.); one by an ANW (no cost.); one by a healthpost worker (no cost); and one by a private medical practitioner, likely a CMA (no cost). The proportion of births attended by health personnel was somewhat than government district health data from 2003-2004, which found 16% of deliveries to be attended by health personnel; the sampling bias of proximity to Sanfe Bagar likely accounts for this discrepancy.

Essential perinatal services conducted through community outreach will form a critical part of our primary healthcare activities.

Village Health Outreach

Fourteen (24%) of households had had a home visit in the last year by a village health worker, typically as part of one of the vitamin A or vaccination campaigns. None of these households had regular contact with a VHW outside of these campaigns. It is clear that the VHW system, integral in theory to the government's health scheme, is not functioning. Developing this system from a solid PHC base will be a major challenge to the public health aspects of the project.

Maternal and child health

Home birth by an untrained birth attendant under non-sanitary conditions remains the norm. Mothers will also utilize private medical services, particularly if there are any complications like maternal fever. The fees for these services are quite large, ranging from 500-3500 among the 9 respondents who used fee-for-service obstetrical care. The government has a program that provides women with 1000 Rs. to use perinatal services and deliver in the hospital. In this area, however, given the large distance to any hospital, this program does not seem to be operational. Given that this was a convenience sample targeting females who were available when we came to their village, we could not assess the degree of maternal deaths in the area. Given that 63% of births in the last were attended by a friend or relative, and an additional 23% by a traditional birth attendant, and only 26% used a safe delivery kit, preventable morbidity and mortality is certainly occurring.

Seven spontaneous abortions and eight elective abortions were reported. Two of the elective abortions occurred in a hospital; four by a private medical practitioner; and two by traditional healers. The large number of perinatal and childhood deaths reported was not unexpected, but points again to the dire state of maternal and child health services.

The most successful government-operated program in the area is childhood immunizations. Uniformly, the consensus among government officials and employees was that over 80% of children in Achham are covered by the vaccination program. The workers at healthposts that we visited described their cold chain adequately and said the vaccines do in fact come every month. Our small survey confirmed that above 80% of the children born in the last three years had received the vaccinations. These results are biased, of course, by the sampling method, and it is expected that the more remote villages that did not constitute part of the survey will have far less coverage.

HIV

HIV is a central health issue in the minds of the public, largely owing to massive public service campaigns in the form of radio, roadside advertisements, and workshops. This doesn't seem to have translated into tangible services for patients suffering from HIV/AIDS nor has it likely impacted prevention. In some ways these messages may have actually *increased* stigma by pointing out to everyone that HIV/AIDS is transmitted sexually and through drugs without concomitantly saying this is a treatable disease. It is also really the only disease that is targeted in this way—there are no such messages about TB, malnutrition, or respiratory or diarrheal diseases. ARVs remain available only in the Doti district hospital, which for most of the communities is 4-5 hours away.

One survey of migrants returning from Bombay found 8% of those tested to be seropositive for HIV. This survey was carried out six years ago, and more recent data is not available.

Tuberculosis

The RHA identified four cases of death and disability owing to tuberculosis. The DOTS program is minimally functioning, with sputum microscopy limited primarily to Mangalsen. Case finding rate in 2003-2004 was 41%, well below the WHO DOTS targets. Though Nepal boasts 100% DOTS coverage nationwide, it is clear that a single site for sputum microscopy is inadequate for the coverage of the large and inaccessible geography of Achham.

Our site visits revealed that no healthpost actually carried anti-tuberculosis medicines. Patients suspected of suffering from TB must register in Mangalsen, and the medicines are subsequently sent to the healthpost. Patients are then expected to arrive at the healthpost daily to receive their medicines. It is clear that establishing a primary health center in the area with TB diagnostic capability and that provides healthworker support for directly observed therapy could have a large impact on the quality of DOTS in the area.

Family Planning

The government's presence in the health sector is felt most, after immunizations, in family planning. The government runs semiannual to annual camps for vasectomies and "minilap", tubal

ligation. It also subsidizes condom distribution and provides depo provera free of cost. As such, these are the most common methods of family planning. Given the far greater cost and danger of tubal ligation, it is concerning that the prevalence of this form, relative to that of vasectomy, is so high. It will be important to promote vasectomy as the single most safe and effective form of permanent family planning. Despite this investment, elective abortion, typically by untrained practitioners and often, anecdotally, at advanced stages of gestation, remains quite common.

Disabled Children

Several disabled children were identified during the course of the survey; while this was not a primary aim of the study, this is certainly to be a major health issue in the area.

Suicide and mental health

Although this was not addressed by the survey, we did hear about the suicide by burning of one approximately twenty-year old female from Mastamandu who had one month previously given birth to her first child. Although this is anecdotal, it did highlight for us that mental health will also need to be addressed.

Table 1. Basic Demographics of Study Population

Characteristic	Value
Number of households covered	58
Number of people covered	384
Number of pregnancies in last two years	28
Number of deaths in last 2 years	9
Median Household Size	6 (3 to 15)
Median Monthly Household Income (Range)	2000 (0 to 5000)
Median Household Ropanis (Range)	6 (0 to 15)
Education (mother/father of household)	
Male: Illiterate	7 (13%)
Female: Illiterate	44 (76%)
Male: At least passed class 5 (primary)	20 (36%)
Female: At least passed class 5 (primary)	7 (12%)
Migration to India	
Husband has worked in India	26 (45%)
Husband worked in India for at least six months	20 (34%)
Husband worked in India for at least one year	17 (29%)
Electricity in household	41 (71%)
Water Source	
Stream	54 (93%)
River	4 (7%)
Handpipe	2 (3%)
Outside tap	4 (7%)
Bathroom Location	
Toilet	17 (29%)
River	4 (7%)
Forrest	12 (21%)
Field	25 (43%)
First-year Vaccinations (n = 31 children)	
Polio	27 (87%)
DPT	25 (81%)
TB	25 (81%)
Measles	28 (90%)
Childhood Vitamin A (n = 31 children)	25 (81%)
Median Number of Pregnancies (Range)	6 (3 to 15)
Family Planning	
Do not want to space pregnancies	3 (5%)
Want to space pregnancies but no method	9 (16%)
Condoms	12 (21%)
Iron Chakki	2 (3%)
Depo	6 (10%)
"Minilap" (tubal ligation)	11 (19%)
Vasectomy	9 (16%)
Husband died/away from house	6 (10%)
Perinatal care for pregnancies in last year (n=23)	
Received at least one tetanus shot	12 (52%)
Received iron supplementation	9 (39%)
Received HIV test	1 (4%)

Note: Some category values may sum to greater than 100% owing to the use of more than one method

Table 2. Causes of chronic disability and death

Chronic Health Conditions

65 year old male with asthma
60 year old woman with asthma
27 year old woman with asthma
56 year old women with TB
58 year old woman with TB
70 year old man with TB
11 year old boy with short stature / mental retardation
8 year old girl with mental retardation
54 year old woman with asthma
40 year old woman with HIV
2 year old girl with developmental delay/weakness

Deaths during the last 2 years

70 year old male of old age
65 year old male of heart problem
80 year old woman of old age
70 year old man of asthma
42 year old man of HIV/AIDS
40 year old man of HIV/AIDS
58 year old man of TB
1 year old boy of malnutrition
60 year old woman of fever subsequent to a wound infection

Table 3. Medical Service Utilization in the Last Month: By Symptoms

Symptom	N	Median Cost (Range)	Private Medical N(%)
Fever	28	200 (0 to 2500)	26 (96%)
Diarrhea	20	160 (0 to 1000)	14 (82%)
Skin Condition	4	650 (60 to 1000)	4 (100%)
Cough	14	200 (0 to 5000)	13 (100%)
Gynecological	9	800 (0 to 3000)	4 (100%)
Other	10	1000 (0 to 11000)	6 (75%)
Total costs, all symptoms	50	275 (0 to 12700)	67 (92%)

Note: In some cases the location of medical services was not indicated; these were excluded from the calculation of percent private medical.

Appendix: Rapid Health Services Survey Instrument¹

Basic Demographics

VDC: _____ Ward No: _____ Village Name _____
Household Name: _____
Total Number in Household _____
Ages of family members
Husband ____ Wife ____ Sons ____ Daughters ____
Dead family members:
Husband ____ Wife ____ dead Son ____ Daughter ____ Other ____
How much money did the household make last month: _____
Land (Ropanis): _____
How much time has husband spend away from Achham? months ____ years ____ Where? Nepal
India
Husband education Illiterate Primary Secondary
Wife's education Illiterate Primary Secondary
Caste ____ Religion ____
Water source 1: River 2. Well 3: Outside Tap 4: Hand Pump 5. Other
How much time does family spend each day to get your water? ____ minutes ____ hours
With what fuel do you cook? 1: Wood 2: Kerosine 3: Gas 4: Cow Dung 5: Electric heater
Electricity Yes/No
Toilet method 1: toilet 2: stream 3: river 4: field 5: jungle
Most of the time, do you have access to soap and water after toilet? Yes/No

Have there been any deaths during the last 12 months in your entire family?
Age ____ Woman ____ Man ____ Cause of death _____

Have there been any deaths in your entire family in the year before last (12 to 23 months)?
Age ____ Sex ____ Cause of deaths _____

Does anyone in the family suffer from a chronic illness?
TB / HIV / Blindness / Deafness / Can't Walk / Asthma
Diabetes (Sugar) ____ Other ____ Age ____ Woman ____ Man ____

Female / Male health worker visited in home ____ / didn't visit ____ Male/Female how many days ago ____

If someone gets sick in your family, whom do you visit first? Healthpost ____ Subhealth post ____
Medical ____ Traditional Healer ____ Other ____

In the past year, has any family member gone for medical treatment: Yes ____ No: ____
Where did the person go? Hospital: ____ Name: ____ Minutes ____ Hours ____
Health post name ____ Minutes ____ Hours ____
Sub-health post name ____ Minutes ____ Hours ____
Medical name ____ Minutes ____ Hours ____
Other ____ Minutes ____ Hours ____

In the past month, was there any illness in the family?
(a) Fever Yes ____ No ____ Age ____ Treatment Yes ____ No ____ Cost ____
Where was the treatment done? Healthpost ____ Sub-health post ____ Medical: ____
Traditional Healer: ____ Other: ____

(b) Diarrhea Yes ____ No ____ Age ____ Treatment Yes ____ No ____ Cost ____
Where was the treatment done? Healthpost ____ Sub-health post ____ Medical: ____
Traditional Healer: ____ Other: ____

(c) Skin disease Yes___No___ Age___ Treatment Yes___No___ Cost___
Where was the treatment done? Healthpost___ Sub-health post___ Medical:___
Traditional Healer:___ Other:_____

(d) Cough Yes___No___ Age___ Treatment Yes___No___ Cost___
Where was the treatment done? Healthpost___ Sub-health post___ Medical:___
Traditional Healer:___ Other:_____

(e) Gynecological Yes___No___ Age___ Treatment Yes___No___ Cost___
Where was the treatment done? Healthpost___ Sub-health post___ Medical:___
Traditional Healer:___ Other:_____

(f) Other Yes___No___ Age___ Treatment Yes___No___ Cost___
Where was the treatment done? Healthpost___ Sub-health post___ Medical:___
Traditional Healer:___ Other:_____

Immunizations

Regarding one to three year old children's vaccination. If more than one, ask about the eldest (under three years)

Age:_____ Vaccination card available:___ not available:___ don't know:___
Polio drop given:___ Not given:___ Don't know:___
TT vaccine given:___ Not given:___ Don't know:___
DPT vaccine given:___ Not given:___ Don't know:___
Nine month measles vaccine given:___ Not given:___ Don't know:___
Vitamin A given:___ Not given:___ Don't know:___

Perinatal care

Ask pregnant women and women with child less than one year of age.

TT vaccine given (number): _____ not given: _____
Iron tablet taken: _____ not taken: _____
HIV test done _____ not done _____
HIV test positive _____ negative _____ don't know _____
Within the past year, was a child born? Yes___ No___
At the birth of the child, who assisted? TBA___ Hospital Doctor___ [Sodeni]___
Other___ Health post___ ANM___
Expense of delivery (rupees) _____
Was a PATH delivery kit used? Yes___ No___

In the last 1-2 years (12-23 months), was a child born? Yes___ No___
At the birth of the child, who assisted? TBA___ Hospital Doctor___ [Sodeni]___
Other___ Health post___ ANM___
Expense of delivery (rupees) _____
Was a PATH delivery kit used? Yes___ No___

Miscarriages (Garbhapatan)

How many pregnancies? _____
Have you had an abortion/miscarriage? Yes___ no___
If you've done one, how many times? _____
If you've done one, who performed it and where was it done?
Health post___ Sub-health post___ Hospital___ Medical___
Local medicine___ Miscarriage___ Other_____

Family Planning

Is another child wanted? Yes___ No___
If another child is wanted, how many years later will you have it?

If you want to space your next child, which family planning method do you plan to use?

Condom_____ Birth control pill_____ Depo_____ Norplant_____ Other_____

If you don't want any more children, which method will you use? Vasectomy_____

Minilap_____ Laproscopy_____ Other_____

¹ Adapted from Satia JK, Mavalankar DV, Sharma B. 1996. Micro-level planning using rapid assessment for primary health care services. Health Policy and Planning 9(3): 318-330.

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